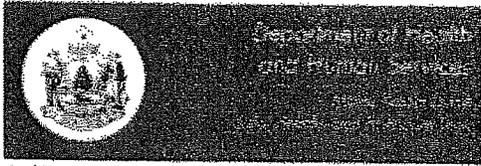


Attachment A



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

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

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

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

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

1. Please provide a current update on the # of referrals DHHS has received from the Federally-facilitated marketplace (FFM) for individuals assessed as potentiality eligible for MaineCare. How many individuals have been determined eligible and enrolled for coverage under current eligibility rules and under eligibility rules beginning January 1, 2014? How many individuals have been determined ineligible for MaineCare and referred back to the FFM for enrollment in a qualified health plan? DHHS provided this information on November 18th; the Advisory Committee is interested in the most up-to-date information.

Response: CMS is unable to send the application/account transfers at this time. They are sending a weekly file to FFM/assessment states which provides a name and an address of those individuals they have assessed that may be MaineCare eligible. Thus far, Maine has received 874 unique households consisting of 1799 individuals that have applied at the FFM and were assessed as potentially eligible for MaineCare. Due to the lack of the application/account transfer at this time from CMS, we are unable to process this information until CMS is technically prepared to transfer the required MAGI application for which a specific date has not yet been provided.

Since 10/1/2013 The State of Maine has had 1300 individuals apply for MaineCare via the State that were determined ineligible when their application was processed against our current non-MAGI rules. DHHS has processed those 1300 applications against the MAGI rules and have determined that 361 of the 1300 are eligible for MaineCare when employing the MAGI rules. The 361 have been notified and are scheduled for enrollment in MaineCare on 1/1/2014. The remainder have been notified and directed to the FFM.

2. Please provide information according to town of residence for those individuals identified by DHHS (and notified) who have lost eligibility or will lose eligibility for MaineCare coverage by category.

Response: Data will be sent shortly to respond.

Attachment A

3. Is DHHS providing any outreach or education about coverage alternatives through the FFM for those individuals determined ineligible for MaineCare? Please provide any notices or documents that are being used.

Response: Notices of decision when ineligible for MaineCare will include notice that the FFM will be receiving their information and contacting them regarding other coverage alternatives.

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

Response: Please see the spreadsheet below.

Attachment A

49670 PHIP Member Count by location w gender & age group			
Time Period: Paid Month			Aug 2013
Subsets			
			PHIP Members
			Members
County Current	Gender	Age In Years	
Androscoggin	Female	18 and under	43
		19 and over	42
	Male	18 and under	37
		19 and over	24
Aroostook	Female	18 and under	12
		19 and over	10
	Male	18 and under	11
		19 and over	11
Cumberland	Female	18 and under	68
		19 and over	61
	Male	18 and under	71
		19 and over	49
Franklin	Female	18 and under	12
		19 and over	7
	Male	18 and under	8
		19 and over	8
Hancock	Female	18 and under	8
		19 and over	6
	Male	18 and under	9
		19 and over	5
Kennebec	Female	18 and under	53
		19 and over	61
	Male	18 and under	58
		19 and over	29
Knox	Female	18 and under	7
		19 and over	14
	Male	18 and under	15
		19 and over	11
Lincoln	Female	18 and under	7
		19 and over	4
	Male	18 and under	10
		19 and over	7
Oxford	Female	18 and under	43
		19 and over	36
	Male	18 and under	49
		19 and over	23

Attachment A

County Current	Gender	Age In Years	
Penobscot	Female	18 and under	24
		19 and over	21
	Male	18 and under	32
		19 and over	18
Piscataquis	Female	18 and under	4
		19 and over	3
	Male	18 and under	3
		19 and over	1
Sagadahoc	Female	18 and under	7
		19 and over	8
	Male	18 and under	16
		19 and over	3
Somerset	Female	18 and under	24
		19 and over	17
	Male	18 and under	16
		19 and over	11
Strafford	Female	18 and under	2
		19 and over	1
	Male	19 and over	1
Waldo	Female	18 and under	17
		19 and over	14
	Male	18 and under	13
		19 and over	14
Washington	Female	18 and under	2
		19 and over	3
	Male	18 and under	2
		19 and over	1
York	Female	18 and under	41
		19 and over	28
	Male	18 and under	39
		19 and over	32

Attachment B

Maine State Innovation Model Objectives and Targets

	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<p>Secondary Driver</p> <p>Data-Informed Policy, Practice and Payment Decisions</p>	<p>Legend:</p> <p>OWS CDC HIN CDC MHMC</p>											
<p>Objective:</p> <p>Provide real-time notifications from the HIE to MaineCare and Health System Care Managers when MaineCare members are admitted or discharged from inpatient and emergency room settings across all provider organizations connected to the HIE</p>	<p>Go Live Target:</p> <p>October 1, 2013: Notifications available to 1,6001 Medicaid Providers & Care Managers across the state.</p> <p>Year 1 Target:</p> <p>Increase weekly average from 4502 to 5500 unique provider organization users either accessing the ED notifications or the HIE portal</p>				<p>Year 2 Targets:</p> <p>1) Increase making notifications available to 1,800 Medicaid Providers and Care Managers/Care Coordinators.</p> <p>2) Increase to average of 600 unique provider organization users either accessing the ED notifications or the HIE portal per week.</p>				<p>Year 3 Targets:</p> <p>1) Increase making notifications available to 2,000 Medicaid Provider & Care Managers/Care Coordinators.</p> <p>2) Increase to an average of 800 unique provider organization users either accessing the ED notifications or the HIE portal per week.</p>			
<p>Objective:</p> <p>Provide HIT and HIE adoption incentives to up to 20 Behavioral Health provider sites/organizations</p>	<p>Go Live Target:</p> <p>RFP requirements prepared for presentation to DIS.</p> <p>Year 1 Targets:</p> <p>20 Behavioral health organizations demonstrate live use</p>				<p>Year 2 Targets:</p> <p>20 organizations have access to the HIE portal and notifications and milestone 2 incentive delivered.</p>				<p>Year 3 Targets:</p> <p>All 20 organization's participating in e-quality measurement using the data submitted to the HIE and milestone 3 incentive delivered.</p>			
<p>Objective:</p> <p>Provide Health Information Exchange access to Behavioral Health providers</p>	<p>Go Live Target:</p> <p>RFP requirements prepared for presentation to DIS.</p> <p>Year 1 Targets:</p> <p>Up to 5 sites go live with bi-directional HIE participation.</p>				<p>Year 2 Targets:</p> <p>Up to 7 sites go live with bi-directional HIE participation.</p>				<p>Year 3 Targets:</p> <p>Up to 10 sites go live with bi-directional HIE participation.</p>			
<p>Objective:</p> <p>Provide a clinical dashboard to MaineCare from the HIE enabling MaineCare to clinically monitor MaineCare members' health care utilization and outcomes at the population and individual level. Develop and deploy real-time discrete data feeds for MaineCare Prescription data to HIN.</p>	<p>Go Live Target:</p> <p>Provide MaineCare BAA and DUA for AAG review and approval.</p> <p>Year 1 Targets:</p> <ol style="list-style-type: none"> 1. Consistent meeting with MaineCare established for MaineCare IT staff to facilitate discrete medication feeds and roles for the dashboard access. 2. DIS approval of data access strategy. 3. Go-Live with real-time medication feeds 4. Establishment of VPNs for MaineCare to access dashboard 5. Provide training for MaineCare staff in Dashboard use. 6. Make 291,000+ population data available in HIN Dashboard. 				<p>Year 2 Targets:</p> <ol style="list-style-type: none"> 1. Continued provision of Dashboard to MaineCare. 2. Consistent data flow for MaineCare medication information into the HIE. 				<p>Year 3 Targets:</p> <ol style="list-style-type: none"> 1. Continued provision of Dashboard to MaineCare. 2. Consistent data flow for MaineCare medication information into the HIE. 			

Maine State Innovation Model Objectives and Targets

	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<p>Secondary Driver</p> <p>Data-Informed Policy, Practice and Payment Decisions</p>	<p>Legend: OMS, SC, HIN, CDC, MHMC</p>											
<p>Objective:</p> <p>Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.</p>	<p>Go Live Target: As of October 1, 2013, criteria for PHR pilot prepared and finalized for presentation to the DIS in October.</p> <p>Year 1 Targets: Establishment of contract with pilot site, establish project management process for implementation, implementation of PHR CCD export by month 6. Demonstrated download of CCD by 5%5 of the pilot sites active PHR users w/in go-live period of project.</p>											
<p>Ensure effective management of SIM Payment Reform Subcommittee to promote sustainability of reform developed through SIM.</p>	<p>Go Live Target: Identify membership for Payment Reform Subcommittee.</p> <p>Year 1 Target: Provide support for Subcommittee in manner that supports active participation of membership.</p>				<p>Year 2 Targets: Provide support for Subcommittee in manner that supports active participation of membership.</p>				<p>Year 3 Targets: Provide support for Subcommittee in manner that supports active participation of membership.</p>			
<p>Health information to influence market forces and inform policy: track health care costs</p>	<p>Year 1 Target: Build claims database that spans Medicare, MaineCare and commercial populations of Maine. This will represent approximately 900K covered lives who are eligible to receive services from Maine's provider community. Providers include all 39 Maine hospitals and all other non-hospital providers in the state who contract with one or more commercial carriers, Medicare and/or MaineCare. (2) Develop/refine appropriate metrics and approach to measuring and tracking cost of care over time. (3) Publish initial edition of Healthcare Cost Fact Book and convene CEO Roundtable.</p>				<p>Year 2 Targets: (1) Maintain access to broadbased dataset. (2) Publish two updated editions of Fact Book. (3) Convene 2 additional CEO Roundtables, increasing attendance from 20 to 30 opinion leaders.</p>				<p>Year 3 Targets: (1) Maintain access to broadbased dataset. (2) Issue two additional updates of Fact book. (3) Convene two additional CEO Roundtables, increasing attendance from 30 to 50 CEOs.</p>			

Maine State Innovation Model Objectives and Targets

Secondary Driver Data-Informed Policy, Practice and Payment Decisions	Legend: ONS GOC HIN EDC MHMC	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16										
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4							
		Year 1 Targets: (1) Adoption of core set of metrics against which plan designs may be benchmarked.				Year 2 Targets: (1) Refined metrics, as appropriate, based on trends and on market experience (2) Increase in number of covered lives enrolled in plans incorporating narrowly constructed VBID, to include alignment of copays/deductibles, utilization of high value providers as determined by MHMC Get Better				Year 3 Targets: (1) Refined metrics, as appropriate, based on trends and on market experience										
Health information to influence market forces and inform policy; value based benefit design.																				
Health information to influence market forces and inform policy; identify common metrics across payers for public reporting and alignment with payment through the work of the PTE Workgroups.																				

Maine State Innovation Model Objectives and Targets

		Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Secondary Driver Data-Informed Policy, Practice and Payment Decisions	Objective: Ensure effective management of SIM Payment Reform Subcommittee to promote sustainability of reform developed through SIM	Legend:     											
	Health Information for Consumers/Improved Continuum of Care	Provide Health Information Exchange access to Behavioral Health providers.											
	Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.	Go Live Target: As of October 1, 2013, criteria for PHR pilot prepared and finalized for presentation to the DIS in October. Year 1 targets: Establishment of contract with pilot site, establish project management process for implementation, implementation of PHR CCD export by month 6. Demonstrated download of CCD by 5% of the pilot sites active PHR users w/in go-live period of											
	Go Live Target: Identify membership for Payment Reform Subcommittee.	Year 1 Target: Provide support for Subcommittee in manner that supports active participation of membership.											
	Go Live Target: RFP requirements prepared for presentation to DIS.	Year 1 Target: Provide support for Subcommittee in manner that supports active participation of membership.											
	Go Live Target: As of October 1, 2013, criteria for PHR pilot prepared and finalized for presentation to the DIS in October.	Year 1 Target: Provide support for Subcommittee in manner that supports active participation of membership.											
	Year 1 targets: Establishment of contract with pilot site, establish project management process for implementation, implementation of PHR CCD export by month 6. Demonstrated download of CCD by 5% of the pilot sites active PHR users w/in go-live period of	Year 2 Target: Provide support for Subcommittee in manner that supports active participation of membership.											
	Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.	Year 2 Target: Up to 7 sites go live with bi-directional HIE participation.											
	Provide Health Information Exchange access to Behavioral Health providers.	Year 2 Target: Up to 10 sites go live with bi-directional HIE participation.											
	Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.	Year 3 Target: Provide support for Subcommittee in manner that supports active participation of membership.											

Maine State Innovation Model Objectives and Targets

Secondary Driver Health Information for Consumers/Improved Continuum of Care	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	<p>Objective: Provide Learning Collaborative for MaineCare Health Homes</p> <p>Ensure effective management of SIM Delivery System Reform Subcommittee to promote sustainability of reform through SIM</p>	<p>Legend: DMS AOC HIN CDC MHMC</p>										
<p>Go Live Target: Launch Learning Collaborative to 82 new HH primary care practices, for a total of 157 participating HH practices; determine final NCCA status of 10 high risk practices (may not meet participation requirements by 12/31/13). Addition of 82 HH only practices reaches approximately 257,000 additional active (seen in past 2 years) patients with the medical home model</p> <p>Year 1 Target: Implement PCMH/HH Learning Collaborative, offering supporting for 100% of participating practices; provide QI support to ensure that 275% of the new 82 HH practices reach Must-Pass elements; and 275% practices implement Year 2 MaineCare screening requirements. Total combined active (seen in the past 2 years) patients reached with</p> <p>Go Live Target: Identify membership for Delivery System Reform Subcommittee</p> <p>Year 1 Target: Provide support for Subcommittee in manner that supports active participation of membership</p>	<p>Year 2 Targets: Clarify status of Maine enhanced payment for primary care practices; facilitating Learning Collaborative accordingly; Sustain PCMH/HH Learning Collaborative offering support for 100% of Year 2 participating primary care practices; Total combined active (seen in the past 2 years) patients reached with the medical/health</p> <p>Year 2 Targets: Provide support for Subcommittee in manner that supports active participation of membership</p>				<p>Year 3 Targets: Facilitate the Learning Collaborative offering support for 100% of Year 3 participating practices; Total combined active (seen in the past 2 years) patients reached with the medical/health home Learning Collaborative approximates 432,000 individuals.</p> <p>Year 3 Targets: Provide support for Subcommittee in manner that supports active participation of membership</p>							

Maine State Innovation Model Objectives and Targets

Objective:	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<p>Secondary Driver</p> <p>Health Information for Consumers/Improved Continuum of Care</p>	<p>Legend: OMS, IIC, HIN, CDC, MHM</p>											
<p>Provide Primary Care providers access to claims data for their patient panels (portals).</p>	<p>Year 1 Target: Complete design of portal and required analytics; data for MaineCare, Medicare and commercial populations will first be segregated with separate access due to challenges associated with the fundamental differences between the populations and the different risk profiles of the populations. Adoption by providers is voluntary, but it is estimated that 50 practices will adopt the</p>				<p>Year 2 Targets: Deliver portal functionality to all requesting providers. Estimated additional uptake: est. 20%, bearing in mind that adoption is voluntary.</p>				<p>Year 3 Targets: Deliver portal functionality to all requesting providers. Estimated additional uptake: est. 20%, bearing in mind that adoption is voluntary.</p>			
<p>Consumer engagement and education regarding payment and system delivery reform</p>	<p>Year 1 Target: Educate brokers, patient advocates, HR-Specialists, union leaders on merits of V81D. Outreach to 200 people.</p>				<p>Year 2 Targets: Continue education and outreach efforts, reaching for all major payer organizations and MaineCare.</p>				<p>Year 3 Targets: Continued outreach and education; reaching an additional 200 providers and individuals.</p>			
<p>Implementation of the National Diabetes Prevention Program (NDPP)</p>	<p>Go-Live Target: NDPP delivery, reimbursement for contracted NDPP provider sites to MaineCare beneficiaries.</p> <p>Year 1 Target: 5 out of 15 NDPP provider sites have written agreements and are delivering NDPP to MaineCare beneficiaries.</p>				<p>Year 2 Targets: 1) Policy developed by MaineCare and Maine CDC to support the sustainable structure for NDPP reimbursement. 2) PCMH/ACO care delivery structures are utilizing pre-diabetes/diabetes algorithm to</p>				<p>Year 3 Targets: 1) Over 15 NDPP provider sites have written agreements and are delivering NDPP to MaineCare beneficiaries. 2) 900 out of 29,312 NDPP eligible beneficiaries have completed program over 3 years of SIM</p>			

Maine State Innovation Model Objectives and Targets

	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<p>Secondary Driver</p> <p>Health Information for Consumers/Improved Continuum of Care</p>	<p>Legend:</p> <p>OMS OC HIN CDC MHMC</p>											
<p>Objective:</p> <p>CHW Pilot Project</p>	<p>Go Live Target: Transformed healthcare system integrates community health workers through a pilot that demonstrates CHWs as an effective, sustainable element.</p> <p>Year 1 Targets: 1. Contracts for 5 CHW pilot sites in place. 2. The 5 CHW pilot sites will have formal referral mechanisms with at least one and up to 3 providers.</p> <p>Year 2 Targets: 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less.</p> <p>Year 3 Targets: 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less.</p>											
<p>Implement MaineCare Behavioral Health Homes Initiative</p>	<p>Year 1 Target: Successfully recruit 15 Behavioral Health Home organizations (BHHOs) with 7000 enrolled members with SM/ SED. There are 75 Behavioral Health Organizations that currently provide services being transformed through Behavioral Health Homes, and about 24,000 members with SM/SED.</p> <p>Year 2 Targets: Increase enrolled members to 7700. 3 in-person learning sessions annually, monthly working group, monthly phone and webinar support for 15 BHHOs and partnering practices. There are 75 Behavioral Health Organizations that currently provide services being transformed through Behavioral Health Homes, and about 24,000 members with SM/SED.</p> <p>Year 3 Targets: Increase enrolled members to 8500 total. 3 in-person learning sessions annually, monthly working group, monthly phone and webinar support for 15 BHHOs and partnering practices. There are 75 Behavioral Health Organizations that currently provide services being transformed through Behavioral Health Homes, and about 24,000 members with SM/SED.</p>											
<p>Develop and Implement Physical Health Integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum.</p>	<p>Year 1 Target: Curriculum and training plan developed for Physical Health integration component to Mental Health Rehabilitation Technician/Community Training.</p> <p>Year 2 Targets: 500 direct service behavioral health individual providers trained in physical health integration.</p>											

Maine State Innovation Model Objectives and Targets

	Legend:	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Secondary Driver		Objective: Provide training to Primary Care Practices on serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities.											
Health Information for Consumers		<p>Year 1 Target: Curriculum and training plan developed for Adult Practice Sites Curriculum piloted at 5 Adult Practice Sites Training conducted at 15 pediatric sites</p> <p>Go Live Target: As of October 1, 2013, criteria for PHR pilot prepared and finalized for presentation to the DIS in October.</p> <p>Year 1 targets: Establishment of contract with pilot site, establish project management process for implementation, implementation of PHR CCD export by month 6. Demonstrated download of CCD by 5% of the pilot sites active PHR users w/in go-live</p>				<p>Year 2 Targets: Training conducted at 30 pediatric sites Training conducted at 55 adult practice sites</p>					<p>Year 3 Targets: Training conducted at 15 pediatric sites Training conducted at 60 adult practice sites</p>		
Consumer Engagement		Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.											
Health Information for Providers		Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.											

Maine State Innovation Model Objectives and Targets

	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<p>Secondary Driver Health Information for Providers</p> <p>Objective: Provide Primary Care providers access to claims data for their patient panels (portals).</p> <p>Provide practice reports reflecting practice performance on outcomes measures</p>	<p>Year 1 Target: Complete design of portal and required analytics; data for MaineCare, Medicare and commercial populations will first be segregated with separate access due to challenges associated with the fundamental differences between the populations and the different risk profiles of the</p> <p>Year 1 Target: Produce practice reports for all primary care practices indicating their interest in receiving them. While we will be able to produce reports for any primary care practice that serve a critical mass of patients, practices themselves must make the decision to actively request, review and use the reports. PCMH practices represent approximately 25% of primary care practices; all receive the reports. We estimated 10% of non-PCMH practices will choose to receive reports in Year One. Each new practice will receive an outreach visit.</p>				<p>Year 2 Target: Produce practice reports for all primary care practices indicating their interest in receiving them. We estimate that there will be an incremental increase of 20% in take up of reports in Year Two. Each new practice will receive an outreach visit.</p>				<p>Year 3 Target: Produce practice reports for all primary care practices indicating their interest in receiving them. Estimated new uptake is 45%, bringing "coverage" with practice reports to approx 50% of PC practices. Each new practice will receive an outreach visit.</p>			



Maine State Innovation Model Objectives and Targets

Secondary Driver Health Information for Providers	Legend: OMS OC HIN CDC MHMC	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective: Implementation of the National Diabetes Prevention Program (NDPP) CHW Pilot Project		Go Live Target: NDPP delivery reimbursement for contracted NDPP provider sites to MaineCare beneficiaries.				Year 2 Targets: 1) Policy developed by MaineCare and Maine CDC to support the sustainable structure for NDPP reimbursement.				Year 3 Targets: 1) Over 15 NDPP provider sites have written agreements and are delivering NDPP to			
		Go Live Target: Transformed healthcare system integrates community health workers through a pilot that demonstrates CHWs as an effective, sustainable element.				Year 2 Targets: 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less intensive service.				Year 3 Targets: 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less intensive service.			
Develop and implement Physical Health Integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum.		Year 1 Target: 1. Contracts for 5 CHW Pilot sites in place. 2. The 5 CHW pilot sites will have formal referral mechanisms with at least one and up to 3 providers.				Year 2 Targets: 500 direct service behavioral health individual providers trained in physical health integration.							
		Year 1 Target: Curriculum and training plan developed for Physical Health Integration component to Mental Health Rehabilitation Technician/Community Training.											

Maine State Innovation Model Objectives and Targets

	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<p>Legend:</p> <p>OMS CDC HIN CDC ARMC</p>												
<p>Secondary Driver(s)</p> <p>Health Information for Providers</p> <p>Provide training to Primary Care Practices on serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities</p>	<p>Year 1 Targets: Curriculum and training plan developed for Adult Practice Sites Curriculum piloted at 5 Adult Practice Sites Training conducted at 15 pediatric sites There are over 400 primary care practice sites in Maine.</p>				<p>Year 2 Targets: Training conducted at 30 pediatric sites Training conducted at 55 adult practice sites</p>				<p>Year 3 Targets: Training conducted at 15 pediatric sites Training conducted at 60 adult practice sites</p>			
<p>Aligned Payment Models</p> <p>Ensure effective management of SIM payment Reform Subcommittee to promote sustainability of reform developed through SIM.</p> <p>Implementation of the National Diabetes Prevention Program (NDPP)</p>	<p>Go Live Target: Identify membership for Payment Reform Subcommittee.</p> <p>Year 1 Target: Provide support for Subcommittee in manner that supports active participation of membership.</p>				<p>Year 2 Targets: Provide support for Subcommittee in manner that supports active participation of membership.</p> <p>Year 2 Targets: 1) Policy developed by MaineCare and Maine CDC to support the sustainable structure for NDPP reimbursement. 2) PCMH/ACO care delivery structures are utilizing pre-diabetes/diabetes algorithm to</p>				<p>Year 3 Targets: Provide support for Subcommittee in manner that supports active participation of membership.</p> <p>Year 3 Targets: 1) Over 15 NDPP provider sites have written agreements and are delivering NDPP to MaineCare beneficiaries. 2) 300 out of 25,312 NDPP eligible beneficiaries have completed program over 3 years of SIM</p>			

Maine State Innovation Model Objectives and Targets

Secondary Driver(s)	Legend:	Year 1				Year 2				Year 3			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<p>CHW Pilot Project</p> <p>Implement MaineCare Accountable Communities Shared Savings ACO Initiative</p>	<p>ONS</p> <p>CC</p> <p>PHN</p> <p>CDC</p> <p>MHMC</p>	<p>Objective:</p> <p>Transformed healthcare system integrates community health workers through a pilot that demonstrates CHWs as an effective, sustainable element.</p> <p>Year 1 Target:</p> <p>1. Contracts for 5 CHW Pilot sites in place.</p> <p>2. The 5 CHW pilot sites will have formal referral mechanisms with at least one and up to 3 providers.</p>											
		<p>Go Live Target:</p> <p>Issue RFA</p> <p>Year 1 Target:</p> <p>Implement Accountable Communities that impact 50,000 patient lives above and beyond those impacted through Medical Homes, 3.8% of Maine's 1.3M population. Patients are not limited to MaineCare members attributed under Accountable Communities, since all patients, regardless of attribution status and payer, should be impacted through improved care coordination incented under model.</p> <p>Achieve participation from 6 Accountable Communities, including providers under current Medicare and commercial ACOs within the State (all 4 major health systems plus group of FQHC's).</p> <p>Achieve 25,000 MaineCare lives to Accountable Communities, 8.9% of the 281,000 MaineCare population.</p>											
<p>Improved Continuum of Care/Aligned Payment Models</p>		<p>Go Live Target:</p> <p>Transformed healthcare system integrates community health workers through a pilot that demonstrates CHWs as an effective, sustainable element.</p> <p>Year 1 Target:</p> <p>1. Contracts for 5 CHW Pilot sites in place.</p> <p>2. The 5 CHW pilot sites will have formal referral mechanisms with at least one and up to 3 providers.</p>											
		<p>Year 1 Target:</p> <p>Provide all Accountable Communities with monthly utilization reports drilled down to the Primary Care practice level, and quarterly reports on actual TCOC to date and quality benchmark achievement.</p> <p>Achieve participation by all MaineCare Accountable Communities in 90% of bimonthly ACI learning collaborative meetings.</p> <p>Implement Accountable Communities that impact an additional 5,000 patient lives above and beyond those impacted through Medical Homes, reaching 4.2% of Maine's population.</p> <p>Achieve participation from 2 additional Accountable Communities.</p> <p>Achieve attribution of additional 2,700 MaineCare lives to Accountable Communities, 9.8% of the MaineCare population.</p>											
		<p>Year 2 Target:</p> <p>Provide all Accountable Communities with monthly utilization reports drilled down to the Primary Care practice level, and quarterly reports on actual TCOC to date and quality benchmark achievement.</p> <p>Achieve participation by all MaineCare Accountable Communities in 90% of bimonthly ACI learning collaborative meetings.</p> <p>Implement Accountable Communities that impact an additional 5,500 patient lives above and beyond those impacted through Medical Homes, reaching 4.6% of Maine's population.</p> <p>Achieve participation from 2 additional Accountable Communities.</p> <p>Achieve attribution of additional 2,000 MaineCare lives to Accountable Communities, 10.5% of the MaineCare population.</p>											
		<p>Year 2 Target:</p> <p>Provide all Accountable Communities with monthly utilization reports drilled down to the Primary Care practice level, and quarterly reports on actual TCOC to date and quality benchmark achievement.</p> <p>Achieve participation by all MaineCare Accountable Communities in 90% of bimonthly ACI learning collaborative meetings.</p> <p>Implement Accountable Communities that impact an additional 5,500 patient lives above and beyond those impacted through Medical Homes, reaching 4.6% of Maine's population.</p> <p>Achieve participation from 2 additional Accountable Communities.</p> <p>Achieve attribution of additional 2,000 MaineCare lives to Accountable Communities, 10.5% of the MaineCare population.</p>											
		<p>Year 3 Target:</p> <p>1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 50-50 clients for less intensive service.</p>											
		<p>Year 3 Target:</p> <p>Provide all Accountable Communities with monthly utilization reports drilled down to the Primary Care practice level, and quarterly reports on actual TCOC to date and quality benchmark achievement.</p> <p>Achieve participation by all MaineCare Accountable Communities in 90% of bimonthly ACI learning collaborative meetings.</p> <p>Implement Accountable Communities that impact an additional 5,500 patient lives above and beyond those impacted through Medical Homes, reaching 4.6% of Maine's population.</p> <p>Achieve participation from 2 additional Accountable Communities.</p> <p>Achieve attribution of additional 2,000 MaineCare lives to Accountable Communities, 10.5% of the MaineCare population.</p>											

Maine State Innovation Model Objectives and Targets

Secondary Driver(s) Aligned Payment Models	Legend: OMS CDC HIN CDC MHMC	Year 1 10/1/13-9/30/14				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Implement MaineCare Behavioral Health Homes Initiative		<p>Year 1 Target: Successfully recruit 15 Behavioral Health Home organizations (BHHOs) with 7000 enrolled members with SM/ SED. There are 75 Behavioral Health Organizations that currently provide services being transformed through Behavioral Health Homes, and about 24,000 members with SM/SED.</p>				<p>Year 2 Target: Increase enrolled members to 7700. 3 In-person learning sessions annually, monthly working group, monthly phone and webinar support for 15 BHHOs and partnering practices. There are 75 Behavioral Health Organizations that currently provide services being transformed through Behavioral Health Homes, and about 24,000 members with SM/SED.</p>				<p>Year 3 Target: Increase enrolled members to 8500 total. 3 In-person learning sessions annually, monthly working group, monthly phone and webinar support for 15 BHHOs and partnering practices. There are 75 Behavioral Health Organizations that currently provide services being transformed through Behavioral Health Homes, and about 24,000 members with SM/SED.</p>			
		<p>Go Live Target: Public supported with health communication messages that promote appropriate use of healthcare services and value of CHWs.</p>				<p>Year 2 Target:</p>				<p>Year 3 Target:</p>			
Health Information for Consumers	Patient Engagement Communication Project												



Maine Department of Health and Human Services

Proposed Changes to Medicaid State Plan
Personal Care Services:
September 2013 Updates

DRAFT 9/26/2013

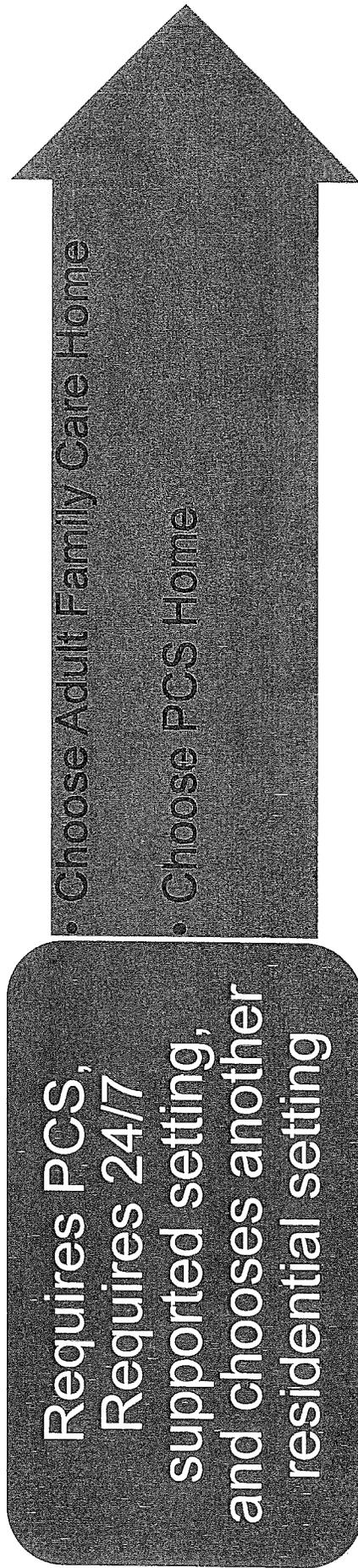
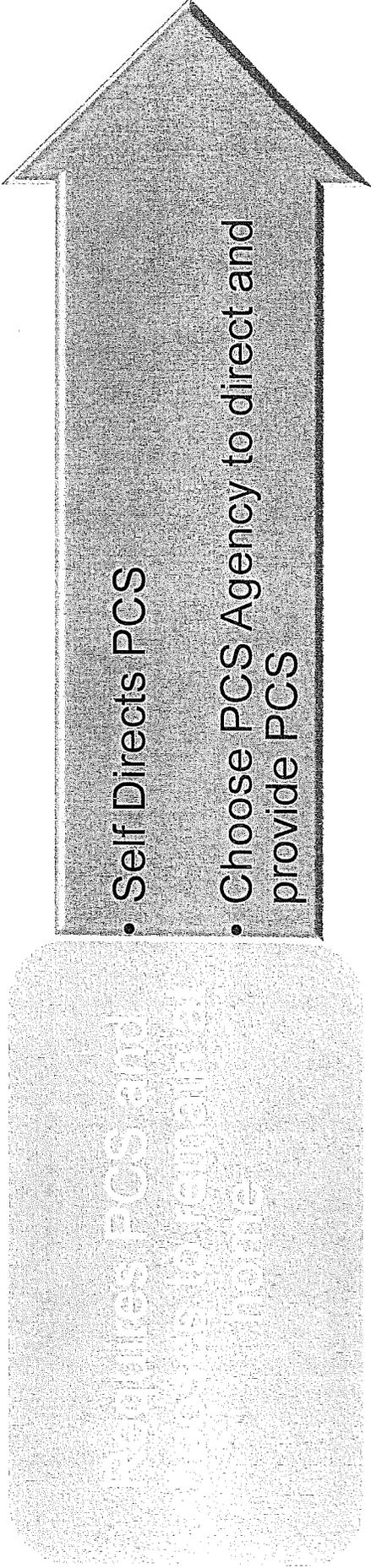
Details of Proposed Model



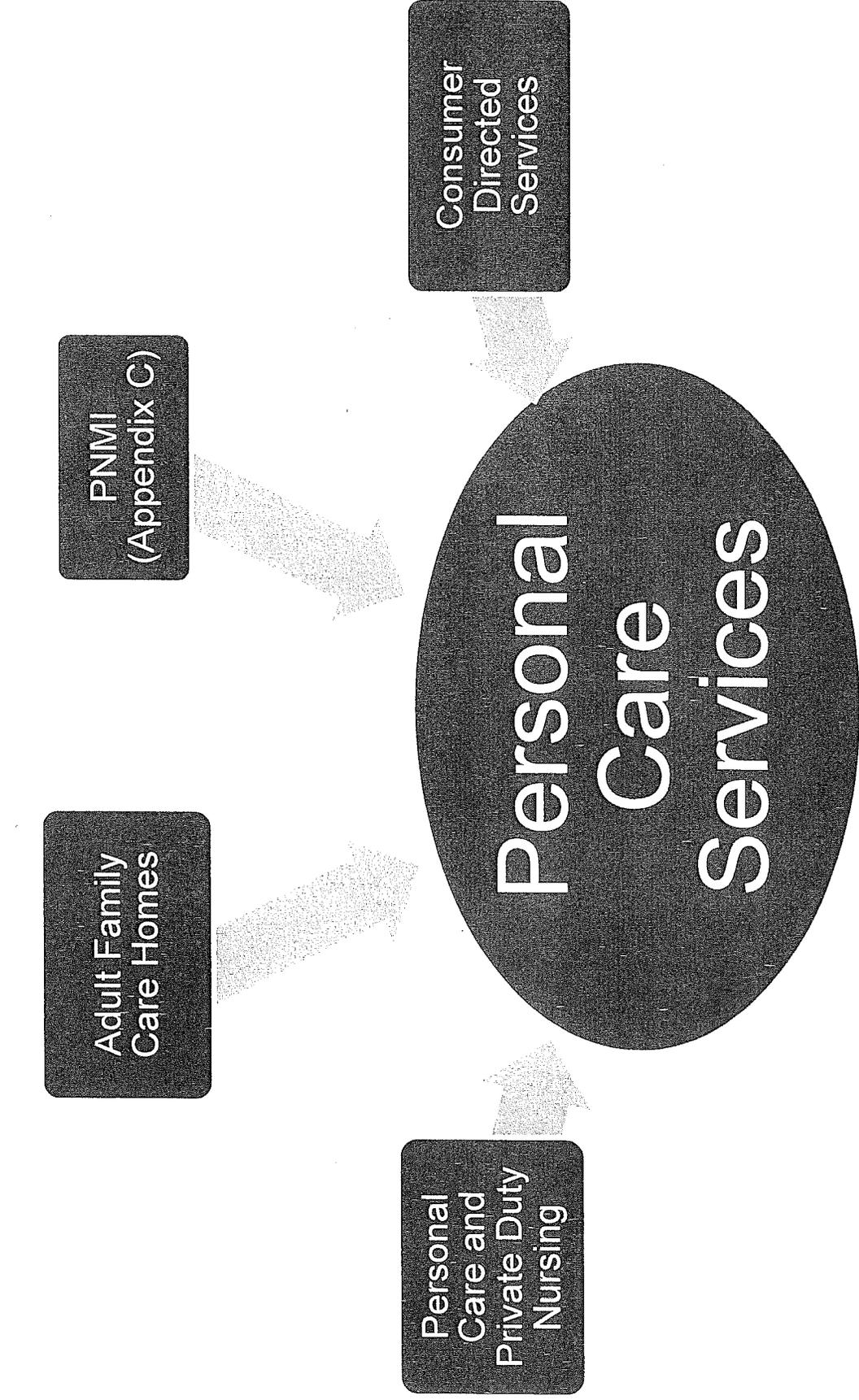
- Simplification and consolidation of reimbursement for Personal Care Services (PCS).
- Reimbursement for medically eligible members regardless of setting.
- Member choice for in-home PCS.
 - Self-directed
 - PCS Agency
- Member choice for licensed residential services
 - Personal Care Home
 - Adult Family Care Homes



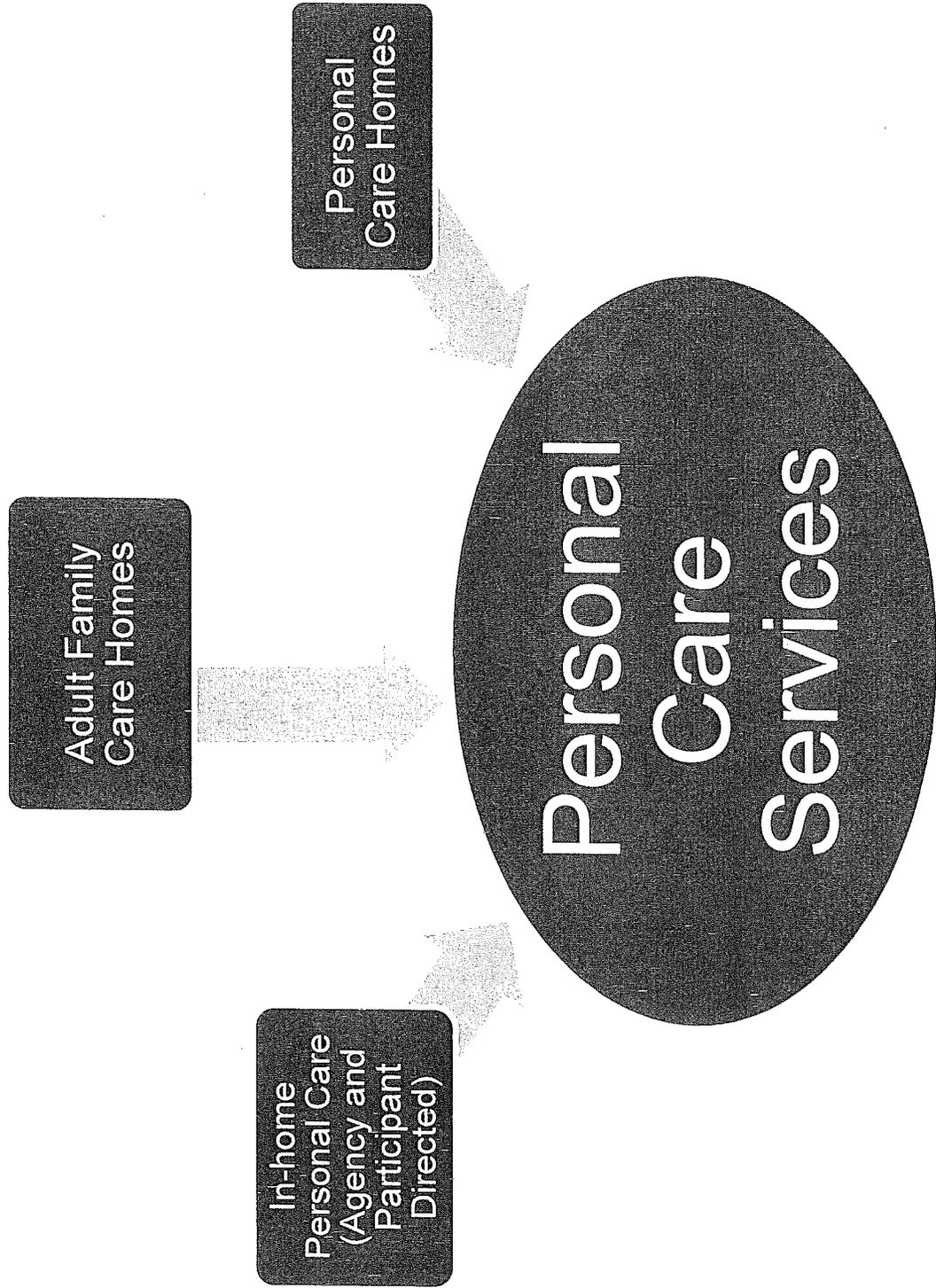
Personal Care Services and Consumer Choice



Medicaid State Plan Personal Care Services: Currently Model



Medicaid State Plan Personal Care Services: Proposed



Other Initiatives Related to Personal Care Services



- Recognition that Maine's long term care programs and services are interrelated and reform in one area has ripple effects throughout the entire system.
- There are several other on-going structural change initiatives that have as a goal streamlined eligibility, improved access and expanded community LTSS across all populations. Examples:
 - Public Law 2011, Chapter 422 (LD 683)
 - Resolve 2011, Chapter 71 (LD 1461)
- PNMI work must be coordinated and considered in light of these other structural change initiative as well as other initiatives such as development of a waiver for individuals with brain injury.

Medicaid State Plan Services



- As a Medicaid State Plan Service, CMS has several requirements regarding service delivery. These include but are not limited to standards around:

- ✓ Statewideness
- ✓ Comparability
- ✓ Free choice of provider

Medicaid State Plan: Personal Care Services



- State Plan Services include both mandatory and optional services.
- Personal Care Services is considered an Optional State Plan Service.
- Personal Care Services under the Medicaid State Plan are community (versus institutional) services.
- Note: CMS criteria around home and community setting limit Maine's options for funding of Appendix C other than through Medicaid State Plan.

Covered Personal Care Services



- **42 CFR § 440.167 Personal care services**
- Unless defined differently by a State agency for purposes of a waiver granted under part 441, subpart G of this chapter—
- (a) *Personal care services* means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease that are—
- (1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;
- (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and
- (3) Furnished in a home, and at the State's option, in another location.
- (b) For purposes of this section, *family member* means a legally responsible relative.

Medical/Functional Eligibility: Proposed



The State needs to establish medical eligibility for Personal Care Services that does not differ based on the setting in which the person receives the service.

Proposed eligibility:

- A member meets the medical eligibility requirements for Level I if he or she requires at least limited assistance plus a one person physical assist **with at least one (1)** of the following ADLs: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing, plus physical assistance with at least two Instrumental Activities of Daily Living; OR cueing seven (7) days per week for eating, toilet use, bathing and dressing.

This eligibility will apply across all sections of policy funded under Medicaid State Plan Personal Care Services (currently Sections 2, 12, 96, 97 Appendix C).

Minimum PCS Staffing Requirements: Proposed



The State must set forth minimum staffing qualifications for all Personal Care Services

Requirements for agency and licensed setting:

- Personal Support Specialist (PSS), a DHHS certification
- Others whose training or licensure exceeds these certifications (CNA, CRMA, HHA).

Requirements for self-direction

- Competency qualifications

Medication administration must be done by qualified staff

- CRMA cannot administer medications outside of a facility and without nursing supervision.

Service Utilization Limits: Proposed

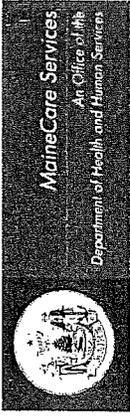
In-home services

- Service plan is authorized by independent assessment agency.
- 3 levels
- Annual review or when there is a significant change in member's circumstance.

Licensed residential setting

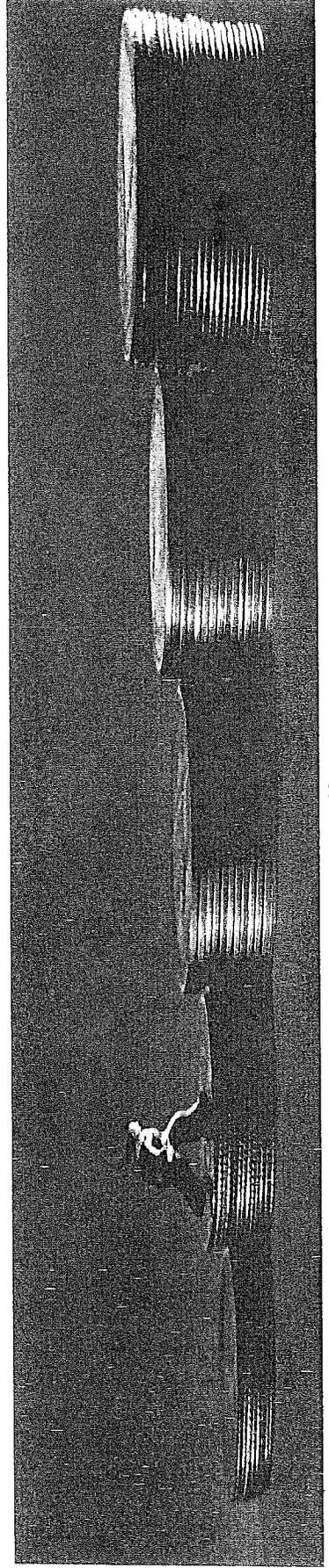
- Each member will be assigned a utilization category based on needs conducted by provider and reviewed by DHHS.
- Quarterly review or when there is a significant change in member's circumstance
- Reimbursement based on individual utilization category

Note: Daily rate versus 15 minute billing unit though this does not change requirement that only services actually provided will be reimbursed.



Rates for In-Home Personal Care Services

- Current:
 - Consumer Directed Services (Section 12) for Personal Support Specialists
 - \$10.44 per hour (15 minute units @ \$2.61 per unit)
 - Agency providers under Personal Care Services (Section 96)
 - \$15 per hour (billed in 15 minute units @ \$3.75 per unit)
 - Allows for added agency licensing requirements.
- Proposed:
 - \$10.44 per hour for Consumer Directed providers
 - \$15 per hour for Licensed PCS Agency providers



Adult Family Care Home Proposal



MaineCare Services
An Office of the
Department of Health and Human Services

- Independent Assessor determines member's medical/functional eligibility
- Current Per Diem Resource Grouping reimbursement maintained
- Base rate increased to be consistent with Independent Rate of \$10.44/hr.
- Resource Groupings estimate "average" member unable to live alone requires 5 hours PCS
- Independent Provider rate applied to daily per diem base rate
 - $\$10.44 \times 5\text{hrs} = \52.20



Attachment C

Proposed for PCS Homes



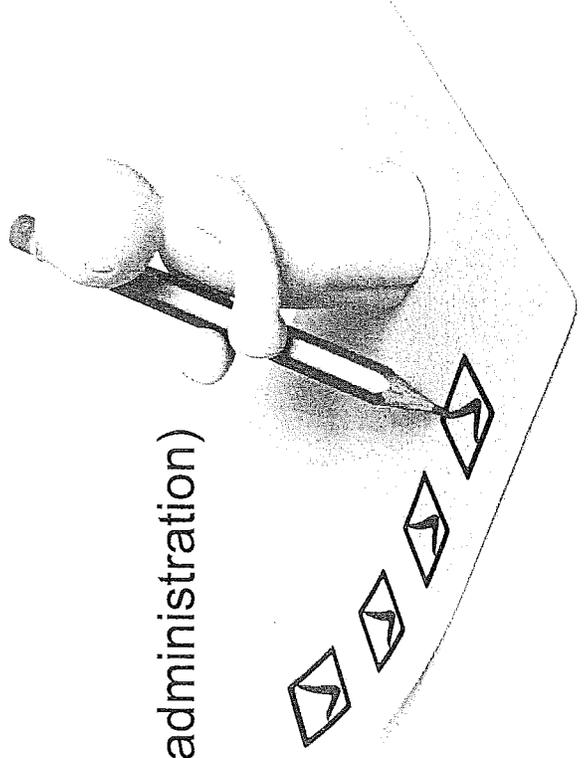
- Independent Assessor determines member's medical/functional eligibility
- Current Per Diem Resource Grouping reimbursement maintained
- Base rate increased to be consistent with Licensed PCS Agency rate \$15/hr.
- Resource Groupings estimate "average" member unable to live alone requires 5 hours of PCS
- Licensed Agency rate applied to daily per diem base rate
 - \$15 x 5 hours = \$75

Attachment C



Additional Considerations

- Service Plans and documentation
 - Provider responsibility
- Elimination of DHHS Audits
 - R&B negotiated between PCH and resident
- Staffing Impact
 - Training and certification may be necessary for some staff
- Medication Administration
 - Billed separately (currently \$6.32 per administration)
 - Subject to staffing requirements



Attachment D

Encumbrance #: CT 10A 20130924*1304
DHHS Agreement #: COM-14-411
Vendor/Customer #: VC 0000191734

STATE OF MAINE
DEPARTMENT OF Health and Human Services
Agreement to Purchase Services

THIS AGREEMENT, made this 16th day of September, 2013, is by and between the State of Maine, Department of Health and Human Services, hereinafter called "Department," and The Alexander Group, Inc., located at 22 Whispering Pine Terrace, Greenville, RI 02828, telephone number (401) 954-8288, hereinafter called "Provider", for the period of September 16, 2013 to May 15, 2014.

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and performed by the Department, the Provider hereby agrees with the Department to furnish all qualified personnel, facilities, materials and services and in consultation with the Department, to perform the services, study or projects described in Rider A, and under the terms of this Agreement. The following riders are hereby incorporated into this Agreement and made part of it by reference:

- Rider A - Specifications of Work to be Performed
- Rider B - Payment and Other Provisions
- Rider C - Rider B Exceptions
- Rider D - Additional Requirements
- Rider G - Identification of Country In Which Contracted Work Will Be Performed

WITNESSETH, that this contract is consistent with Executive Order 17 FY 08/09 or a superseding Executive Order, and complies with its requirements.

IN WITNESS WHEREOF, the Department and the Provider, by their representatives duly authorized, have executed this agreement in one original copy.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: William W. Boeschstein, Jr. *for*
William W. Boeschstein, Jr., Chief Operating Officer
And

THE ALEXANDER GROUP, INC.

By: Gary D. Alexander
Gary D. Alexander, Executive Director



Total Agreement Amount: \$925,200

Approved: Michael Alan Wanzel
Chair, State Purchases Review Committee

SEP 30 2013

Attachment D

BP 54 - AGREEMENT TO PURCHASE SERVICES



STATE OF MAINE
STANDARD AGREEMENT COVER PAGE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DHHS Agreement # COM-14-411
AdvantageME CT # CT 10A 20130924*1304

Community Agency Name: The Alexander Group, Inc.

Address: 22 Whispering Pine Terrace, Greenville, RI 02828

Program Name: _____ Service: Consulting

Geographic Area Served: Statewide

DHHS District # _____

DHHS Region # 1

Vendor/Customer #: VC0000191734

Agency Fiscal Year: July - June

FOR DEPARTMENT USE ONLY

Agreement Period

Type of Agreement

Effective Date: 9/16/2013
Termination Date: 5/15/2014
Amended Effective Date: _____
Amended Termination Date: _____

Contract-State Services
 Grant- Client Services

New
 Renewal
 Amendment
 Budget Rev.

CFDA #	ACCOUNT #	FY 2014 Enc.	FY 2015 Enc.	Agreement Total
1.	010-10A-1033-01-4073	\$ 17,280.00		\$ 17,280.00
2.	015-10A-4101-01-4073	\$ 69,120.00		\$ 69,120.00
3.	010-10A-3026-01-4073	\$124,560.00		\$124,560.00
4.	013-10A-3026-01-4073	\$124,560.00		\$124,560.00
5.	010-10A-3227-01-4073	\$313,035.17		\$313,035.17
6.	014-10A-3227-01-4073	\$276,644.83		\$276,644.83
7.				
8.				
9.				
TOTALS		\$925,200.00	\$	\$925,200.00

Agreement Routing:

Contract Administrator

Denice Baron

Denice.m.baron@maine.gov

BP 54 - AGREEMENT TO PURCHASE SERVICES

RIDER A
SPECIFICATIONS OF WORK TO BE PERFORMED

I. AGREEMENT FUNDING SUMMARY

Funds are provided under this Agreement for the provision of consulting services. The service descriptions are detailed in Section III Service Specifications and Performance Guidelines. The sources of funds and compliance requirements for this Agreement follow:

A. State General Fund **\$454,875.17**

Use of funds shall be in accordance with requirements detailed in the Maine Uniform Accounting and Auditing Practices for Community Agencies (CMR 10-144, Chapter 30); and with the terms of this Agreement.

B. Dedicated/Special Revenue **\$276,644.83**

C. Federal Funds **\$193,680.00**

Use of funds shall be in accordance with restrictions contained in the appropriate CFDA; with Federal OMB Circulars A-21, A-87, A-102, A-110, A-122, and A-133, as applicable; with CMR 10-144, Chapter 30, as applicable; and with the terms of this Agreement.

CFDA #93.558, Temporary Assistance from Needy Families, **\$69,120.00**
1402METANF, Administration of Children and Families

CFDA#93.778, Medicaid Administration, Medicaid Cluster, **\$124,560.00**
1405ME5ADM, Centers for Medicaid and Medicare Services (CMS)

II. GENERAL REQUIREMENTS

Reporting. The Provider shall submit reports in accordance with the specifications of the Department, according to the following schedule:

The Provider will present a monthly report to the Department evaluating the status of deliverables in process per the delivery summary outlined in the following section.

III. SERVICE SPECIFICATIONS AND PERFORMANCE GUIDELINES

A. Service Description:

This scope of work supports the Department's efforts to evaluate the entire public welfare system, including the Medicaid program, for potential reforms and increased flexibility through a possible global 1115B waiver, assess the feasibility of Medicaid expansion under multiple reform scenarios and review program integrity across the entire Department. The deliverables are described below.

BP 54 - AGREEMENT TO PURCHASE SERVICES

Task 1: Baseline Analysis and Review

Complete a baseline-econometric and data-driven analysis and review that will measure the degree of strengths, weaknesses, and opportunities, as well as identify the root causes of underperformance that will enable the Department to craft a global reform strategy. The Provider will assess, review the model, and measure the state's current programs, processes, practices and reforms. This will also include a basic assessment of Maine's public welfare data and data-mining capabilities.

Timeline for Completion September 16, 2013 to December 20, 2013*

Deliverable 1 – Maine's Public Welfare System Blueprint *Maine's Public Welfare System Blueprint will help Maine better understand its system's strengths, weaknesses, opportunities and threats, as well as the best options to accomplish global reform. The blueprint will outline recommendations for how and where resources should be deployed for the reform effort. Deliverable shall include sections of review and analyses related to each of the program areas outlined in Sections 1.1 and 1.2 below.*

Specific Components to be contained within Deliverable 1 – Maine's Public Welfare System Blueprint

1.1 Review and analyze current Medicaid program, operations, and its financial sustainability.

The Provider shall review Maine's entire Medicaid program, giving particular attention to the size, scope, and effectiveness of each of its current waivers. The review will include, but not be limited to:

- **Long-term care policies and programs.** The Provider will review the state's rebalancing of their long-term care efforts away from high-cost institutional venues and towards home- and community-based settings such as (but not limited to) shared-living arrangements, assisted living, remote health (medicine), at-home care across all populations and intellectual disability programs. The Provider will also analyze the efficacy of the state's plans for dual-eligible recipients. The dual-eligible population includes Medicare beneficiaries—those enrolled in traditional fee-for-service Medicare, Medicare Advantage or PACE plans, and individuals who are dually eligible for Medicare and Medicaid would also enroll in coverage through the exchange. Medicare beneficiaries would choose only among fee-for-service Medicare, Medicare Part-D plans, and federally qualified Medicare Advantage plans. This will include all institutionally based systems as well as home- and community-based alternatives.
- **Care-management systems.** The Provider will review Maine's plans for accountable systems of care as well as its current care management system for the Medicaid population. Health homes, primary care medical homes and hospital expenditures will be reviewed.
- **Pharmacy.** The Provider will review state Medicaid pharmacy practices and utilizations trends.
- **Purchasing strategies.** The Provider will review the state's current health-care purchasing methodologies for its delivery systems for Medicaid and welfare recipients.
- **School-based therapy services under special education.** The Provider will perform a school-based services utilization review by certified pediatric therapy experts. This review of educationally related therapy services include:
 - Motor-skill development (fine, gross and visual motor skills)
 - Graphic communication skills (handwriting, keyboarding, and drawing)
 - Mobility and safety
 - Sensory processing dysfunction
 - Preventative practices
 - Speech language therapy

BP 54 - AGREEMENT TO PURCHASE SERVICES

**The full school-based therapy services under special education review will commence November 15, 2013 and be completed by March 15, 2014. An initial review will be included in the report due December 20, 2013.*

1.2 Review and analyze remaining public-welfare programs:

- **Temporary Assistance for Needy Families (TANF) and employment programs.** After reviewing current program goals, efficiency and block-grant opportunities, the Provider will identify gaps where there is greater potential for integrating employment initiatives across all programs and populations.
- **SNAP and Food/Nutrition Programs.** The Provider will analyze the growth in the program and its overall efficiency toward achieving effectiveness in providing proper nutrition to needy populations.
- **Child Care Program.** The Provider will perform a systemic review of Maine's child-care program to achieve two goals.
 - The provider will identify potential changes that will yield efficiencies and reduce administrative and/or subsidy costs. The cost savings could be reinvested back in the program to reduce waiting lists.
 - The provider will review the daycare program to see how well the program is coordinated with the objectives and implementation of other welfare programs. In particular, the provider will examine how well the system is integrated and its impact on socio-economic goals.
- **Child-Support System.** Effective child-support enforcement is an important component of welfare systems. Empirically supported experience from other states demonstrates a large caseload of unwed mothers on TANF, and federal rules require these mothers to seek child support. The Provider will analyze the child-support system in relation to the welfare system for the State of Maine from three perspectives.
 - The provider will review current program measures and work with Maine officials to generate descriptive statistics on the intersection of child support and welfare programs.
 - The provider will review child-support policies and their implementation among the various welfare programs.
 - The Provider will review the effectiveness of child-support enforcement relative to welfare programs.
 - The Provider will make recommendations pursuant to these three perspectives.
- **Eligibility System and Entry into the System.** The Provider will provide a review of the Maine eligibility system, program eligibility and the overall entry into the system.

As part of this portion of the review, the Provider will review the State of Maine's pro-family and pro-work incentives and policies geared toward moving families and individuals up the economic ladder and off the public-welfare system.

Task 2: Deliver and deliver to the Department a recommended plan for achieving a global reform of Medicaid programs. The plan will include a recommended request for increased federal flexibility

- After analyzing and reviewing all options, the Provider will provide a recommended plan of action that would enable the State of Maine to achieve a global reform and redesign of all Medicaid programs to ensure a performance-driven system that will deliver maximum flexibility, efficiency, and cost-effectiveness.
- Using Maine's most current data, the Provider will develop a cost-benefit analysis of such a redesign and provide recommendations to achieving federal approval. The Provider will include the federal flexibility necessary to enact reform changes, as well as how the state might achieve some of the goals of a global reform without federal approval.

BP 54 - AGREEMENT TO PURCHASE SERVICES

- Finally, the Provider will craft and recommend a plan for improved coordination and integration of Medicaid and related welfare programs to achieve better outcomes. This includes the determination of what request Maine will make for increased flexibility from the federal government. This could be a global 1115B waiver, waiver consolidation or some other request for increased flexibility.

Timeline for Completion September 16, 2013 to December 20, 2013

Deliverable 2- Recommendations for System Reform *Recommended plan to achieve a global redesign of the Medicaid-welfare system and operations. The plan will be included in Maine's Public Welfare System Blueprint and will include a cost-benefit analysis of all recommendations. Report will include recommended plan for achieving any required federal approval necessary to implement suggested changes, including the assessment of a global 1115B waiver.*

Task 3: Deliver an initial feasibility study for a potential Medicaid expansion

Timeline for Completion September 15, 2013 to December 1, 2013

Deliverable 3- Medicaid Expansion Feasibility Study The Provider will review the proposed Medicaid expansion currently offered under the Affordable Care Act and offer a feasibility study for Maine. The study will include program impacts and analyses of other states decisions regarding Medicaid expansion. This study will include options related to Medicaid expansion under different reforms scenarios, including those recommended in *Deliverable 3 – Recommended Plan for System Reform*.

Task 4: Design and implement system-wide program integrity action plan - reduce fraud, waste and abuse of public welfare programs

- The Provider shall create a system-wide program-integrity plan designed to encompass all public welfare programs that will ensure that all programs, including global reforms, will provide for continuous improvements, be cost-effective, work toward preventing fraud, waste and abuse, and provide for care delivery in the right setting at the right time.

Timeline for Completion October 15, 2013 to May 15, 2014

Deliverable 4 – System-wide program integrity review and action plan) *The Provider will conduct a review of Maine's current program-integrity system and design and implement a system -wide program integrity action plan spanning the entire Department. The deliverables include a Program Integrity review and blueprint, outlined in the Program Integrity Action Plan, and the subsequent implementation of the action plan.**

**Note – to proceed from the Program Integrity review and development of action plan to the implementation phase of the Program Integrity action plan, the Department must accept the Program Integrity Action Plan and approve implementation.*

Specific components the Provider will deliver include, but are not limited to:

- 4.1 Create a Transformational Project Management Office
To carry out the specific goals and objectives of task 4
- 4.2 Create the plan for enterprise-wide program integrity
 - 1) Exhaustive inventory and assessment of DHHS processes, policies, IT systems, organizational structures, performance measures and personnel dedicated to program integrity.
 - 2) Perform gap analysis to identify areas of improvement and resource mapping
 - 3) Develop strategic plan for improving and enhancing program integrity at the Department
- 4.3 Develop consistent guidelines for Program Integrity and provide training across program offices
- 4.4 Create and develop consistent rules across program to reduce waste
- 4.5 Develop a budget tracking and fraud, waste and abuse data-deployment "dashboard" to enable continuous financial and budget data monitoring to provide ongoing program measurement to ensure program effectiveness

Attachment D

BP 54 - AGREEMENT TO PURCHASE SERVICES

4.6 Apply advanced data-analytics to link data silos and create "actionable intelligence" that can be used to address fraud, waste and abuse in the system

Task 5: "Welfare to Work" system enhancement

- The Provider will conduct an intensive review of the Department's "welfare to work" system which spans multiple offices of the Department but is focused in the Office of Family Independence in the Temporary Assistance for Needy Families and ASPIRE program. The analyses will align with activities in Deliverables 1, 3 and 4. The Provider will create a plan to align and enhance welfare to work efforts within the Department to incorporate performance-based payment methodologies, new and innovative employee incentives, and an initiative to incorporate the physically and intellectually disabled in the process.

Timeline for Completion October 15, 2013 to March 15, 2014

Deliverable 5 – "Welfare to Work" Enhancement *The Provider will conduct an assessment of Maine's "welfare to work" system and craft a recommended course of action to improve and enhance efforts to increase employment rates among those who are receiving a public benefit (specifically TANF/ASPIRE) and are able to work. This initiative will also include a review focused on increasing employment to those who are developmentally and physically disabled who desire employment. This deliverable will be delivered through a plan outlined in Blueprint 1, and shall include implementation of the plan.*

Monthly Report

The Provider will present a monthly report evaluating the status of deliverables in process to the Department.

Deliverables summary:

Deliverable	Target Date Due	Summary	Total Cost
Deliverable 1 – Econometric and data-driven analysis of Maine's Public Welfare System <u>Delivered via Maine's Public Welfare System Blueprint</u>	12/20/2013	Data-driven analysis of Maine public welfare programs and the best options to accomplish global reform to improve efficiency and effectiveness.	\$135,360
Deliverable 2- Plan for Global Reform <u>Delivered via Maine's Public Welfare System Blueprint</u>	12/20/2013	Recommended plan to achieve a global redesign of the Medicaid-welfare system and operations.	\$141,120
Deliverable 3- Medicaid Expansion Feasibility Study <u>Delivered in Medicaid Feasibility Study</u>	12/1/2013	Feasibility study of optional ACA Medicaid expansion in Maine, under multiple Medicaid system designs	\$108,000

Attachment D

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<p><i>Deliverable 4 – System-wide program integrity review and action plan</i></p> <p><i>Deliverable 4.1 – Program integrity review and action plan</i></p> <p><i>Deliverable 4.2 – Implement program integrity plan</i></p>	<p>5/15/2014</p>	<p><i>Conduct a system-wide program integrity review and develop and implement associated action plan</i></p>	<p>\$454,320</p>
<p><i>Deliverable 5 – “Welfare to Work” system enhancement</i></p>	<p>3/15/2014</p>	<p><i>The Provider will create a plan to align and enhance welfare to work efforts within the Department</i></p>	<p>\$86,400</p>

Rates Established

The Provider will deliver services through a group of individuals with a wide range of skill sets and variable hourly rates. The rate for each deliverable was established based on an estimated number of hours required by the Provider to complete each deliverable.

Payment Schedule

The Department will pay the Provider a monthly fee for the duration of the contract totaling to 60% of total contract, and will withhold additional payment totaling 40% of the Agreement, to be paid upon accepted completion of deliverable as outlined below.

Monthly Payment Schedule	Payment Amount
September 30, 2013	\$61,680
October 15, 2013	\$61,680
November 15, 2013	\$61,680
December 15, 2013	\$61,680
January 15, 2014	\$61,680
February 15, 2014	\$61,680
March 15, 2014	\$61,680
April 15, 2014	\$61,680
May 15, 2014	\$61,680
Total Monthly Payment	\$555,120
<i>Upon Accepted Completion of Deliverable – Target Due Date</i>	
Deliverable Schedule	Payment Amount
Deliverable 1 – December 15, 2013	\$75,000
Deliverable 2 – December 15, 2013	\$75,080
Deliverable 3 – December 1, 2013	\$70,000
Deliverable 4 – May 15, 2014	\$100,000
Deliverable 5 – March 15, 2014	\$50,000
Total Deliverables Payment	\$370,080
Total Agreement Payments	\$925,200

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RIDER B METHOD OF PAYMENT AND OTHER PROVISIONS

1. **AGREEMENT AMOUNT** The maximum amount payable under this Agreement is \$925,200.

2. **INVOICES AND PAYMENTS**

The Department will pay the Provider nine (9) monthly payments for the period ending May 15, 2014, upon receipt of an approved invoice. The Department will pay the Provider for completion of deliverables. The total payments will be based upon the schedule in Rider A up to a total of \$925,200. Payments are subject to the Provider's compliance with all items set forth in this Agreement and subject to the availability of funds.

3. **BENEFITS AND DEDUCTIONS** If the Provider is an individual, the Provider understands and agrees that he/she is an independent contractor for whom no Federal or State Income Tax will be deducted by the Department, and for whom no retirement benefits, survivor benefit insurance, group life insurance, vacation and sick leave, and similar benefits available to State employees will accrue. The Provider further understands that annual information returns, as required by the Internal Revenue Code or State of Maine Income Tax Law, will be filed by the State Controller with the Internal Revenue Service and the State of Maine Bureau of Revenue Services, copies of which will be furnished to the Provider for his/her Income Tax records.

4. **INDEPENDENT CAPACITY** In the performance of this Agreement, the parties hereto agree that the Provider, and any agents and employees of the Provider shall act in the capacity of an independent contractor and not as officers or employees or agents of the State.

5. **DEPARTMENT'S REPRESENTATIVE** The Agreement Administrator shall be the Department's representative during the period of this Agreement. He/she has authority to curtail services if necessary to ensure proper execution. He/she shall certify to the Department when payments under the Agreement are due and the amounts to be paid. He/she shall make decisions on all claims of the Provider, subject to the approval of the Commissioner of the Department.

6. **AGREEMENT ADMINISTRATOR**. All progress reports, correspondence and related submissions from the Provider shall be submitted to:

Name and Title: Denice Baron, Contract Administrator
Address: 11 SHS, 221 State Street
Augusta, Me 04333
Telephone: 207-287-2454
E-mail Address: Denice.M.Baron@maine.gov

who is designated as the **Agreement Administrator** on behalf of the Department for this Agreement, except where specified otherwise in this Agreement.

The following is designated as the **Program Administrator** for this Agreement and shall be responsible for oversight of the programmatic aspects of this Agreement.

Name and Title: Sam Adolphsen, Director of
Strategic Development
Address: 11 SHS, 221 State Street
Augusta, Me 04333-0011
Telephone: 207-975-6617
E-mail Address: Sam.adolphsen@maine.gov

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7. **CHANGES IN THE WORK** The Department may order changes in the work, the Agreement Amount being adjusted accordingly. Any monetary adjustment or any substantive change in the work shall be in the form of an amendment, signed by both parties and approved by the State Purchases Review Committee. Said amendment must be effective prior to execution of the work.

8. **SUB-AGREEMENTS** Unless provided for in this Agreement, no arrangement shall be made by the Provider with any other party for furnishing any of the services herein contracted for without the consent and approval of the Agreement Administrator. Any sub-agreement hereunder entered into subsequent to the execution of this Agreement must be annotated "approved" by the Agreement Administrator before it is reimbursable hereunder. This provision will not be taken as requiring the approval of contracts of employment between the Provider and its employees assigned for services thereunder.

9. **SUBLETTING, ASSIGNMENT OR TRANSFER** The Provider shall not sublet, sell, transfer, assign or otherwise dispose of this Agreement or any portion thereof, or of its right, title or interest therein, without written request to and written consent of the Agreement Administrator. No subcontracts or transfer of agreement shall in any case release the Provider of its liability under this Agreement.

10. **EQUAL EMPLOYMENT OPPORTUNITY** During the performance of this Agreement, the Provider agrees as follows:

a. The Provider shall not discriminate against any employee or applicant for employment relating to this Agreement because of race, color, religious creed, sex, national origin, ancestry, age, physical or mental disability, or sexual orientation, unless related to a bona fide occupational qualification. The Provider shall take affirmative action to ensure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age, national origin, physical or mental disability, or sexual orientation.

Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Provider agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

b. The Provider shall, in all solicitations or advertising for employees placed by or on behalf of the Provider relating to this Agreement, state that all qualified applicants shall receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age, physical or mental disability, or sexual orientation.

c. The Provider shall send to each labor union or representative of the workers with which it has a collective bargaining agreement, or other agreement or understanding, whereby it is furnished with labor for the performance of this Agreement a notice to be provided by the contracting agency, advising the said labor union or workers' representative of the Provider's commitment under this section and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Provider shall inform the contracting Department's Equal Employment Opportunity Coordinator of any discrimination complaints brought to an external regulatory body (Maine Human Rights Commission, EEOC, Office of Civil Rights) against their agency by any individual as well as any lawsuit regarding alleged discriminatory practice.

e. The Provider shall comply with all aspects of the Americans with Disabilities Act (ADA) in employment and in the provision of service to include accessibility and reasonable accommodations for employees and clients.

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f. Contractors and subcontractors with contracts in excess of \$50,000 shall also pursue in good faith affirmative action programs.

g. The Provider shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

11. **EMPLOYMENT AND PERSONNEL** The Provider shall not engage any person in the employ of any State Department or Agency in a position that would constitute a violation of 5 MRSA § 18 or 17 MRSA § 3104. The Contractor shall not engage on a full-time, part-time or other basis during the period of this Agreement, any other personnel who are or have been at any time during the period of this Agreement in the employ of any State Department or Agency, except regularly retired employees, without the written consent of the State Purchases Review Committee. Further, the Provider shall not engage on this project on a full-time, part-time or other basis during the period of this Agreement any retired employee of the Department who has not been retired for at least one year, without the written consent of the State Purchases Review Committee. The Provider shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

12. **STATE EMPLOYEES NOT TO BENEFIT** No individual employed by the State at the time this Agreement is executed or any time thereafter shall be admitted to any share or part of this Agreement or to any benefit that might arise therefrom directly or indirectly that would constitute a violation of 5 MRSA § 18 or 17 MRSA § 3104. No other individual employed by the State at the time this Agreement is executed or any time thereafter shall be admitted to any share or part of this Agreement or to any benefit that might arise therefrom directly or indirectly due to his employment by or financial interest in the Provider or any affiliate of the Provider, without the written consent of the State Purchases Review Committee. The Provider shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

13. **WARRANTY** The Provider warrants that it has not employed or contracted with any company or person, other than for assistance with the normal study and preparation of a proposal, to solicit or secure this Agreement and that it has not paid, or agreed to pay, any company or person, other than a bona fide employee working solely for the Provider, any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this Agreement. For breach or violation of this warranty, the Department shall have the right to annul this Agreement without liability or, in its discretion to otherwise recover the full amount of such fee, commission, percentage, brokerage fee, gift, or contingent fee.

14. **ACCESS TO RECORDS** As a condition of accepting a contract for services under this section, a contractor must agree to treat all records, other than proprietary information, relating to personal services work performed under the contract as public records under the freedom of access laws to the same extent as if the work were performed directly by the department or agency. For the purposes of this subsection, "proprietary information" means information that is a trade secret or commercial or financial information, the disclosure of which would impair the competitive position of the contractor and would make available information not otherwise publicly available. Information relating to wages and benefits of the employees performing the personal services work under the contract and information concerning employee and contract oversight and accountability procedures and systems are not proprietary information. The Provider shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to this Agreement and make such materials available at its offices at all reasonable times during the period of this Agreement and for such subsequent period as specified under Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP) rules. The Provider shall allow inspection of pertinent documents by the Department or any authorized representative of the State of Maine or Federal Government, and shall furnish copies thereof, if requested. This subsection applies to contracts, contract extensions and contract amendments executed on or after October 1, 2009.

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15. **TERMINATION** The performance of work under the Agreement may be terminated by the Department in whole, or in part, whenever for any reason the Agreement Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Provider of a Notice of Termination specifying the extent to which performance of the work under the Agreement is terminated and the date on which such termination becomes effective. The Agreement shall be equitably adjusted to compensate for such termination, and modified accordingly.
16. **GOVERNMENTAL REQUIREMENTS** The Provider warrants and represents that it will comply with all governmental ordinances, laws and regulations.
17. **GOVERNING LAW** This Agreement shall be governed in all respects by the laws, statutes, and regulations of the United States of America and of the State of Maine. Any legal proceeding against the State regarding this Agreement shall be brought in State of Maine administrative or judicial forums. The Provider consents to personal jurisdiction in the State of Maine.
18. **STATE HELD HARMLESS** The Provider agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims, costs, expenses, injuries, liabilities, losses and damages of every kind and description (hereinafter in this paragraph referred to as "claims") resulting from or arising out of the performance of this Agreement by the Provider, its employees, agents, or subcontractors. Claims to which this indemnification applies include, but without limitation, the following: (i) claims suffered or incurred by any contractor, subcontractor, materialman, laborer and any other person, firm, corporation or other legal entity (hereinafter in this paragraph referred to as "person") providing work, services, materials, equipment or supplies in connection with the performance of this Agreement; (ii) claims arising out of a violation or infringement of any proprietary right, copyright, trademark, right of privacy or other right arising out of publication, translation, development, reproduction, delivery, use, or disposition of any data, information or other matter furnished or used in connection with this Agreement; (iii) Claims arising out of a libelous or other unlawful matter used or developed in connection with this Agreement; (iv) claims suffered or incurred by any person who may be otherwise injured or damaged in the performance of this Agreement; and (v) all legal costs and other expenses of defense against any asserted claims to which this indemnification applies. This indemnification does not extend to a claim that results solely and directly from (i) the Department's negligence or unlawful act, or (ii) action by the Provider taken in reasonable reliance upon an instruction or direction given by an authorized person acting on behalf of the Department in accordance with this Agreement.
19. **NOTICE OF CLAIMS** The Provider shall give the Contract Administrator immediate notice in writing of any legal action or suit filed related in any way to the Agreement or which may affect the performance of duties under the Agreement, and prompt notice of any claim made against the Provider by any subcontractor which may result in litigation related in any way to the Agreement or which may affect the performance of duties under the Agreement.
20. **APPROVAL** This Agreement must have the approval of the State Controller and the State Purchases Review Committee before it can be considered a valid, enforceable document.
21. **LIABILITY INSURANCE** The Provider shall keep in force a liability policy issued by a company fully licensed or designated as an eligible surplus line insurer to do business in this State by the Maine Department of Professional & Financial Regulation, Bureau of Insurance, which policy includes the activity to be covered by this Agreement with adequate liability coverage to protect itself and the Department from suits. Providers insured through a "risk retention group" insurer prior to July 1, 1991 may continue under that arrangement. Prior to or upon execution of this Agreement, the Provider shall furnish the Department with written or photocopied verification of the existence of such liability insurance policy.
22. **NON-APPROPRIATION** Notwithstanding any other provision of this Agreement, if the State does not receive sufficient funds to fund this Agreement and other obligations of the State, if funds are de-appropriated, or if the State does not receive legal authority to expend funds from the Maine State Legislature or Maine courts, then the State is not obligated to make payment under this Agreement.

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23. **SEVERABILITY** The invalidity or unenforceability of any particular provision or part thereof of this Agreement shall not affect the remainder of said provision or any other provisions, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision or part thereof had been omitted.

24. **INTEGRATION** All terms of this Agreement are to be interpreted in such a way as to be consistent at all times with the terms of Rider B (except for expressed exceptions to Rider B included in Rider C), followed in precedence by Rider A, and any remaining Riders in alphabetical order.

25. **FORCE MAJEURE** The Department may, at its discretion, excuse the performance of an obligation by a party under this Agreement in the event that performance of that obligation by that party is prevented by an act of God, act of war, riot, fire, explosion, flood or other catastrophe, sabotage, severe shortage of fuel, power or raw materials, change in law, court order, national defense requirement, or strike or labor dispute, provided that any such event and the delay caused thereby is beyond the control of, and could not reasonably be avoided by, that party. The Department may, at its discretion, extend the time period for performance of the obligation excused under this section by the period of the excused delay together with a reasonable period to reinstate compliance with the terms of this Agreement.

26. **SET-OFF RIGHTS** The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any monies due to the Provider under this Agreement up to any amounts due and owing to the State with regard to this Agreement, any other Agreement, any other Agreement with any State department or agency, including any Agreement for a term commencing prior to the term of this Agreement, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Controller.

27. **ENTIRE AGREEMENT** This document contains the entire Agreement of the parties, and neither party shall be bound by any statement or representation not contained herein. No waiver shall be deemed to have been made by any of the parties unless expressed in writing and signed by the waiving party. The parties expressly agree that they shall not assert in any action relating to the Agreement that any implied waiver occurred between the parties which is not expressed in writing. The failure of any party to insist in any one or more instances upon strict performance of any of the terms or provisions of the Agreement, or to exercise an option or election under the Agreement, shall not be construed as a waiver or relinquishment for the future of such terms, provisions, option or election, but the same shall continue in full force and effect, and no waiver by any party of any one or more of its rights or remedies under the Agreement shall be deemed to be a waiver of any prior or subsequent rights or remedy under the Agreement or at law.

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RIDER C
EXCEPTIONS TO RIDER B

There are no exceptions to Rider B for this Agreement.

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RIDER D Additional Requirements

1. CONFIDENTIALITY. The provider shall comply with Federal and State statutes and regulations for the protection of information of a confidential nature regarding all persons served under the terms of this Agreement. In addition, the provider shall comply with Title II, Subtitle F, Section 261-264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, titled "Administrative Simplification" and the rules and regulations promulgated thereunder.

To the extent the Provider is considered a Business Associate under HIPAA, the Provider shall execute and deliver in form acceptable to the Department a Business Associate agreement (BA agreement). The terms of the BA agreement shall be incorporated into this Agreement by reference. The Department shall have recourse to such remedies as are provided for in this Agreement for breach of Agreement, in the event the Provider either fails to execute and deliver such BA agreement to the Department or fails to adhere to the terms of the BA Agreement.

2. LOBBYING. No Federal or State appropriated funds shall be expended by the Provider for influencing or attempting to influence, as prohibited by state or federal law, an officer or employee of any Federal or State agency, a member of Congress or a State Legislature, or an officer or employee of Congress or a State Legislature in connection with any of the following covered actions: the awarding of any agreement; the making of any grant; the entering into of any cooperative agreement; or the extension, continuation, renewal, amendment, or modification of any agreement, grant, or cooperative agreement. The signing of this Agreement fulfills the requirement that providers receiving over \$100,000 in Federal or State funds file with the Department with respect to this provision.

If any other funds have been or will be paid to any person in connection with any of the covered actions specified in this provision, the Provider shall complete and submit a "Disclosure of Lobbying Activities" form available at:

<http://www.whitehouse.gov/omb/grants/#forms>.

3. DRUG-FREE WORKPLACE. By signing this agreement, the Provider certifies that it shall provide a drug-free workplace by: publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Provider's workplace and specifying the actions that will be taken against employees for violation of such prohibition; establishing a drug-free awareness program to inform employees about the dangers of drug abuse in the workplace, the Provider's policy of maintaining a drug-free workplace, available drug counseling and rehabilitation programs, employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; providing a copy of the drug-free workplace statement to each employee to be engaged in the performance of this agreement; notifying the employees that as a condition of employment under the agreement the employee will abide by the terms of the statement and notify the employer of any criminal drug conviction for a violation occurring in the workplace no later than five days after such conviction.

The provider shall notify the state agency within ten days after receiving notice of criminal drug convictions occurring in the workplace from an employee, or otherwise receiving actual notice of such conviction, and will take one of the following actions within 30 days of receiving such notice with respect to any employee who is so convicted: take appropriate personnel action against the employee, up to and including termination, or requiring the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

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4. DEBARMENT AND SUSPENSION. By signing this agreement, the Provider certifies to the best of its knowledge and belief that it and all persons associated with the agreement, including persons or corporations who have critical influence on or control over the agreement, are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation by any federal department or agency.

The Provider further agrees that the Debarment and Suspension Provision shall be included, without modification, in all sub-agreements.

5. ENVIRONMENT TOBACCO SMOKE. By signing this agreement, the Provider certifies that it shall comply with the Pro-Children Act of 1994, P.L. 103-227, Part C, which requires that smoking not be permitted in any portion of any indoor facility owned, leased, or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments by Federal grant, Agreement, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or MaineCare funds, and portions of facilities used for inpatient drug or alcohol treatment.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

Also, the provider of foster care services agrees that it will comply with Resolve 2003, c. 134, which prohibits smoking in the homes and vehicles operated by foster parents.

6. MEDICARE AND MAINECARE ANTI-KICKBACK. By signing this agreement, the Provider agrees that it shall comply with the dictates of 42 U.S.C. 1320a-7b (b), which prohibits the solicitation or receipt of any direct or indirect remuneration in return for referring or arranging for the referral of an individual to a provider of goods or services that may be paid for with Medicare, MaineCare, or state health program funds.

7. PUBLICATIONS. When issuing reports, brochures, or other documents describing programs funded in whole or in part with funds provided through this agreement, the Provider agrees to clearly acknowledge the participation of the Department of Health and Human Services in the program. In addition, when issuing press releases and requests for proposals, the Provider shall clearly state the percentage of the total cost of the project or program to be financed with agreement funds and the dollar amount of agreement funds for the project or program.

8. OWNERSHIP. All notebooks, plans, working papers, or other work produced in the performance of this Agreement that are related to specific deliverables under this Agreement, are the property of the Department and upon request shall be turned over to the Department.

9. SOFTWARE OWNERSHIP. Upon request, the State and all appropriate federal agencies shall receive a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to do so, all application software produced in the performance of this Agreement, including, but not limited to, all source, object, and executable code, data files, and job control language, or other system instructions. This requirement applies only to software that is a specific deliverable under this Agreement, or is integral to the program or service funded under this Agreement, and is primarily financed with funding provided under this Agreement.

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10. PROVIDER RESPONSIBILITIES / SUB AGREEMENTS. The Provider is solely responsible for fulfillment of this Agreement with the Department. The Provider assumes responsibility for all services offered and products to be delivered whether or not the Provider is the manufacturer or producer of said services.

(a) Sub-agreements.

i. All sub-agreements must contain the assurances enumerated in Sections 10, 11, and 12 of Rider B and Sections 4, 5, 6, 7 of Rider D;

ii. All sub-agreements must be signed and delivered to the Department's Agreement Administrator within five (5) business days following the execution date of the sub-agreement.

iii. See Rider B Section 8.

(b) Relationship between Provider, Subcontractor and Department. The Provider shall be wholly responsible for performance of the entire agreement whether or not subcontractors are used. Any sub-agreement into which the Provider enters with respect to performance under this Agreement shall not relieve the Provider in any way of responsibility for performance of its duties. Further, the Department will consider the Provider to be the sole point of contact with regard to any matters related to this Agreement, including payment of any and all charges resulting from this Agreement. The Department shall bear no liability for paying the claims of any subcontractors, whether or not those claims are valid.

(c) Liability to Subcontractor. The requirement of prior approval of any sub-agreement under this Agreement shall not make the Department a party to any sub-agreement or create any right, claim or interest in the subcontractor or proposed subcontractor against the Department. The Provider agrees to defend (subject to the approval of the Attorney General) and indemnify and hold harmless the Department against any claim, loss, damage, or liability against the Department based upon the requirements of Rider B, Section 18.

11. RENEWALS. This Agreement may be renewed at the discretion of the Department.

12. NO RULE OF CONSTRUCTION. The parties acknowledge that this Agreement was initially prepared by the Department solely as a convenience and that all parties hereto, and their counsel, have read and fully negotiated all the language used in the Agreement. The parties acknowledge that, because all parties and their counsel participated in negotiating and drafting this Agreement, no rule of construction shall apply to this Agreement that construes ambiguous or unclear language in favor of or against any party because such party drafted this Agreement.

13. CONFLICT OF INTEREST. The Provider covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Provider further covenants that in the performance of this Agreement, no person having any such known interests shall be employed. (See also Rider B, #11 and #12.)

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RIDER G
IDENTIFICATION OF COUNTRY
IN WHICH CONTRACTED WORK WILL BE PERFORMED

Please identify the country in which the services purchased through this contract will be performed:



United States. Please identify state: Maine



Other. Please identify country: _____

Notification of Changes to the Information

The Provider agrees to notify the Division of Purchases of any changes to the information provided above.

Maine Revised Statutes

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§1825-A

Title 5:

§1825-C

ADMINISTRATIVE PROCEDURES AND SERVICES

Part 4: FINANCE

Chapter 155: PURCHASES

Subchapter 1-A: RULES GOVERNING THE COMPETITIVE BID PROCESS

§1825-B. Bids, awards and contracts

1. Purchases by competitive bidding. The Director of the Bureau of General Services shall purchase collectively all goods and services for the State or any department or agency of the State in a manner that best secures the greatest possible economy consistent with the required grade or quality of the goods or services. Except as otherwise provided by law, the Director of the Bureau of General Services shall make purchases of goods or services needed by the State or any department or agency of the State through competitive bidding.

[1991, c. 780, Pt. Y, §70 (AMD) .]

2. Waiver. The requirement of competitive bidding may be waived by the Director of the Bureau of General Services when:

A. The procurement of goods or services by the State for county commissioners pursuant to Title 30-A, section 124, involves the expenditure of \$2,500 or less, and the interests of the State would best be served; [1999, c. 105, §1 (AMD) .]

B. The Director of the Bureau of General Services is authorized by the Governor or the Governor's designee to make purchases without competitive bidding because in the opinion of the Governor or the Governor's designee an emergency exists that requires the immediate procurement of goods or services; [1995, c. 119, §1 (AMD) .]

C. After reasonable investigation by the Director of the Bureau of General Services, it appears that any required unit or item of supply, or brand of that unit or item, is procurable by the State from only one source; [1991, c. 780, Pt. Y, §70 (AMD) .]

D. It appears to be in the best interest of the State to negotiate for the procurement of petroleum products; [1989, c. 785, §2 (NEW) .]

E. The purchase is part of a cooperative project between the State and the University of Maine System, the Maine Community College System, the Maine Maritime Academy or a private, nonprofit, regionally accredited institution of higher education with a main campus in this State involving:

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(1) An activity assisting a state agency and enhancing the ability of the university system, community college system, Maine Maritime Academy or a private, nonprofit, regionally accredited institution of higher education with a main campus in this State to fulfill its mission of teaching, research and public service; and

(2) A sharing of project responsibilities and, when appropriate, costs; [2011, c. 555, §1 (AMD).]

F. The procurement of goods or services involves expenditures of \$10,000 or less, in which case the Director of the Bureau of General Services may accept oral proposals or bids; or [1999, c. 105, §2 (AMD).]

G. The procurement of goods or services involves expenditures of \$10,000 or less, and procurement from a single source is the most economical, effective and appropriate means of fulfilling a demonstrated need. [1999, c. 105, §3 (AMD).]

[2011, c. 555, §1 (AMD) .]

3. Report. By January 15th of each year the Director of the Bureau of General Services shall submit to the joint standing committee of the Legislature having jurisdiction over state and local government a report concerning any waivers from the competitive bidding provisions established in subsection 2, paragraph E.

[1991, c. 780, Pt. Y, §70 (AMD) .]

4. Registry of suppliers. Suppliers desiring to have their names entered on a registry of suppliers must submit a request to the Director of the Bureau of General Services in writing. The Director of the Bureau of General Services may prescribe the manner and form in which such a request must be submitted and may limit the number of names of out-of-state bidders on any registry. The name of any supplier entered in such a registry who fails to submit a bid on 3 consecutive proposals or invitations to bid may be removed from the registry at the discretion of the Director of the Bureau of General Services, except that the Department of Corrections remains on any registry until the Department of Corrections requests that the department be removed from that registry.

[1991, c. 780, Pt. Y, §70 (AMD) .]

5. Alternate bids. When, in bid forms and specifications, an article or material is identified by using a trade name and catalog number of a manufacturer or vendor, the term "or approved equal," if not inserted with the identification, is implied. There is a presumption that any reference to a particular manufacturer's product either by trade name or by limited description has been made solely for the purpose of more clearly indicating the minimum standard of quality desired. Consideration must be given to proposals submitted on approved equal alternate commodities to the extent that such action serves the best interest of the State. The bidder submitting a proposal on a commodity other than as specified shall furnish complete

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identification, descriptive literature or data with respect to the alternate commodity that the bidder proposes to furnish. Lack of such information on the bid must be construed to mean that the bidder proposes to furnish the exact commodity described. The State reserves the right to reject any bids, in whole or in part, to waive any formality or technicality in any bid and to accept any item in any bid.

[1989, c. 785, §2 (NEW) .]

6. Record of bids. Each bid, with the name of the bidder, must be entered on a record. Each record, with the successful bid indicated, must be open to public inspection after the letting of the contract. A bond for the proper performance of each contract may be required of each successful bidder at the discretion of the Director of the Bureau of General Services, with the approval of the Commissioner of Administrative and Financial Services.

[1991, c. 780, Pt. Y, §70 (AMD) .]

7. Awards to best-value bidder. Except as otherwise provided by law, orders awarded or contracts made by the Director of the Bureau of General Services or by any department or agency of the State must be awarded to the best-value bidder, taking into consideration the qualities of the goods or services to be supplied, their conformity with the specifications, the purposes for which they are required, the date of delivery and the best interest of the State. If the bidder that was initially awarded the order or contract does not perform, the Director of the Bureau of General Services may cancel the contract and award a new contract to the 2nd best-value bidder. The order or contract may not be awarded to a bidder that the Director of the Bureau of General Services determined was not in compliance at the time the initial bid was submitted.

[1997, c. 263, §1 (AMD) .]

8. Tie bids. The Director of the Bureau of General Services shall award contracts or purchases to in-state bidders or to bidders offering commodities produced or manufactured in the State if the price, quality, availability and other factors are equivalent.

[1991, c. 780, Pt. Y, §70 (AMD) .]

9. Determination of best-value bidder. In determining the best-value bidder, the Director of the Bureau of General Services or any department or agency of the State shall, for the purpose of awarding a contract, add a percent increase on the bid of a nonresident bidder equal to the percent, if any, of the preference given to that bidder in the state in which the bidder resides.

[1997, c. 263, §2 (AMD) .]

10. List of state preferences published. The Director of the Bureau of General Services on or before January 1st of each year shall publish a list of states that give preference to in-state bidders with the percent increase applied in each such state. The Director of the Bureau of General Services or any department or agency of the State may rely on the names of states and percentages as published in

determining the best-value bidder without incurring any liability to any bidder.

[1997, c. 263, §2 (AMD) .]

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11. Rulemaking; unfair competition. State departments and agencies may not achieve cost savings due to cost differentials that derive from a bidder's failure to provide health and retirement benefits to its employees. The State Purchasing Agent shall adopt rules governing the purchase of services and the awarding of grants or contracts for personal services to establish a basis for bid price and cost comparison among businesses that provide health and retirement benefits to their employees and those that do not provide these benefits. The rules must include a methodology for calculating bid price and cost differentials for services provided by businesses and state employees due to the provision of health and retirement benefits for employees. The rules must adjust the bid prices to establish an equivalent basis for bid price and cost comparison among businesses when awarding contracts and between businesses and state employees when determining whether or not a contract is permitted under section 1816-A. These rules must apply to all state departments and agencies. Rules adopted pursuant to this subsection are routine technical rules as defined in chapter 375, subchapter 2-A.

[2003, c. 501, §2 (NEW) .]

12. Vendor's fee. The State Purchasing Agent may collect a fee in an amount equal to 1% of the bid from a supplier of apparel, footwear or textiles with a winning bid under this section. The State Purchasing Agent shall apply the fee under this subsection to the costs of implementing and administering the state purchasing code of conduct under section 1825-L, including developing a consortium to monitor and investigate alleged violations of the code of conduct. The State Purchasing Agent shall adopt routine technical rules under chapter 375, subchapter 2-A to carry out the purposes of this subsection.

[2007, c. 193, §1 (NEW) .]

13. Vendor's fee report. By January 15th of each year the Director of the Bureau of General Services shall submit a report to the joint standing committee of the Legislature having jurisdiction over state and local government matters concerning revenue generated by the vendor's fee established in subsection 12.

[2007, c. 193, §2 (NEW) .]

14. Condition of doing business with the State. Notwithstanding any provision of law to the contrary, any purchase by the State of \$100,000 or more of tangible personal property, except for public utility purchases, as defined in Title 36, section 1752, subsection 17, or emergency purchases pursuant to subsection 2, paragraph B, may be made only from a person who is registered as a seller pursuant to Title 36, section 1754-B. As a condition of doing business with the State, the seller must collect, report and remit taxes in accordance with Title 36, Part 3. As provided in this subsection,

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the State is prohibited from doing business with a person who is not registered as a seller pursuant to Title 36, section 1754-B and is not in compliance with the requirement to collect, report and remit taxes pursuant to Title 36, Part 3. After notification of the award, the seller must provide the State Purchasing Agent with a valid retailer certificate issued by the State Tax Assessor within 7 business days. If the seller fails to provide the registration certificate within 7 business days, the State Purchasing Agent may cancel the award and make a new award pursuant to subsection 7. The State Purchasing Agent shall provide the State Tax Assessor with a copy of all contracts awarded pursuant to this section. The State Tax Assessor shall notify the State Purchasing Agent if at any time during the term of the contract the person is no longer registered or is not collecting, reporting and remitting taxes in compliance with the requirements of Title 36, Part 3. Until the noncompliance is corrected, the State Purchasing Agent may withhold any payments to the person.

[2007, c. 328, §1 (NEW) .]

SECTION HISTORY

1989, c. 785, §2 (NEW). 1991, c. 515, §1 (AMD). 1991, c. 780, §Y70 (AMD). 1993, c. 640, §1 (AMD). 1995, c. 42, §1 (AMD). 1995, c. 119, §§1-4 (AMD). 1995, c. 387, §1 (AMD). 1995, c. 625, §A5 (AMD). 1997, c. 263, §§1,2 (AMD). 1999, c. 105, §§1-3 (AMD). 2003, c. 20, §002 (AMD). 2003, c. 20, §004 (AFF). 2003, c. 501, §2 (AMD). 2007, c. 193, §§1, 2 (AMD). 2007, c. 328, §1 (AMD). 2011, c. 555, §1 (AMD).

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**The Revisor's Office cannot provide legal advice or interpretation of Maine law to the public.
If you need legal advice, please consult a qualified attorney.**

Office of the Revisor of Statutes

7 State House Station

State House Room 108

Augusta, Maine 04333-0007

Attachment F

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

Types of Service Agreements

1. Contract:

A contract is a written agreement between a provider and the State of Maine describing the services to be performed, the terms and conditions agreed to by the parties, the cost of the services and how payment will be made. The principal purpose of a contract is to purchase, lease, or barter property or services for the direct benefit of the government. A contract is generally awarded to a provider if the provider is the winner in a competitive bidding process (RFP). However, a contract may be awarded if there is a valid sole source justification. The contract document will be an Agreement to Purchase Services (BP-54), which is a legally binding written agreement between the provider and the Department.

2. Grant:

A grant is written agreement between a provider and the State of Maine describing the terms, conditions, and scope of performance or action that is expected of the provider. The principle purpose of a grant is the transfer of money, property, services or anything of value to the recipient in order to accomplish a public purpose of support with no substantial involvement between the State and the recipients during the performance of the activity. For example, an agreement under which a provider provides services directly to clients with no substantial involvement of the State would be a grant. A grant is generally awarded to a provider if the provider is the winner in a competitive bidding process (RFP). However, a grant may be awarded if there is a valid sole source justification. The grant document will be an Agreement to Purchase Services (BP-54), which is a legally binding written agreement between the provider and the Department.

3. Cooperative Agreement:

A Cooperative Agreement is an agreement between the State of Maine and the University of Maine System to jointly participate in a cooperative project under the terms of the General Policy Agreement for State/University Cooperative Agreements of September, 1989. A cooperative project is defined as "any activity of interest to the State of Maine where joint participation between the State and the University will improve the capacity of the State of Maine to provide services to the people of the State, and will enhance the ability of the University to further its teaching, research and public service missions". Any cooperative agreement must be approved by the Governor's Office prior to the execution of any agreement. Examples of projects that would meet these criteria include those that:

- A. provides training of students who may be candidates for employment to meet needs of the public and private sectors in Maine;
- B. support research and development projects that generate needed information or enhance the expertise of University faculty and research staff in areas needed by the State;
- C. provides public service that leads to the dissemination of University expertise to various constituencies in the State and/or that addresses critical State needs.

Attachment F

Service Contract Guidelines

1. Contracts: (When you need to purchase a service)

- Up to \$5,000
 - BP18 Required
- \$5,001 to \$10,000
 - Contact the Division of Purchases and explain what you need. They will help you figure out how to proceed. BP54 and BP37SS or BP37CA required.
- Over \$10,000
 - Subject to Request for Proposal (RFP)

2. Temporary Staffing Services Contracts

When requesting a temporary staffing service contract, a BP37TEMP form should be completed and provided to the Division of Purchases along with the BP18 or BP54 Contract form that is applicable. For all temporary staffing service contracts the following dollar thresholds apply to the procurement process:

- Up to \$10,000 – emailed quotes from three temporary staffing service vendors (contact Division of Purchases for a list of these vendors)
- \$10,001 to \$25,000 – email the job description(s) to all temporary staffing service vendors on the aforementioned list
- Over \$25,000 – Request for Proposals process required

Commodity Purchase Guidelines

A commodity is a good whose wide availability typically leads to smaller profit margins and diminishes the importance of factors other than price.

Before making a commodity purchase you need to ask these questions:

- Can the item be purchased from Central Warehouse? If yes, an AdvantageME Delivery Order (DO) is required.
- Is there a Master Agreement for this commodity on the Division of Purchases' website <http://www.maine.gov/purchases/contracts/pals.html>? If yes, a procurement card (p-card) transaction **OR** a DO is required.
- Is this a request for a printing job using an outside vendor (not Central Print)? Must process a Requisition (RQS) on AdvantageME (see process below). All print jobs must be handled by the Buyer that handles printing for the Division of Purchases. (Debbie.Jacques@maine.gov)

Items Under \$5,000: For items under \$5,000 (not printing or on Master Agreement) you can purchase using your p-card or do a simple Purchase Order (PO) in AdvantageME. If you are ordering multiple related items or quantities of similar items that have a unit price that is under \$5,000, but the total expense is over \$5,000, then the Division of Purchases will procure the items for you. Please follow the RQS process below or contact the Division buyer. The following website address will help you identify the appropriate Buyer to contact:
<http://www.maine.gov/purchases/commodities.shtml>

Attachment F

RQS Process: In order for the Division of Purchases to procure an item for you, we will need the detailed specifications of the requested item(s) attached to an RQS in AdvantageME. Please contact the Division if you need assistance creating an RQS. You will need to have the funding available and account coding ready in order to create an RQS. If you want an item made by a specific manufacturer, you will need to fill out a BP37SS form explaining why this is the only source of this item that is acceptable, and attach the form to the RQS.

DO Process: A DO is an AdvantageME procurement document for any item that is covered by a Master Agreement (MA) and is for any dollar amount. Any DO under \$5,000 requires only one level of approval, and over \$5,000 requires three levels of approval the last being a Purchases buyer. The DO account line(s) must use an encumbering (PR05) "event type", unless it is a Central Warehouse order. The Purchases buyer will be responsible for e-mailing the order(s) to the vendor. The ordering agency will be responsible for e-mailing the vendor the order if it is under \$5,000.

The Central Warehouse is set up as a vendor and your order will also be DO. Most orders will be under \$5,000 but you do not have to e-mail the DO to the Central Warehouse. These DOs have three levels of approval; 1) agency approval, 2) Central Warehouse (receiving the order) and 3) Central Warehouse (filling the order).

Executive Order 07 FY10/11, "An Order Establishing the State Procurement Review Committee"

This Executive Order requires that all contracts greater than \$3 million must be reviewed by the Attorney General's Office before going to provider for signature. Additionally, all contracts greater than \$1 million must be reviewed by the State Procurement Review Committee, which is made up of the Director of the Division of Purchases, the State Budget Officer, the State Controller, the Governor's Office, and – if the contract is IT related – the Chief Information Officer.

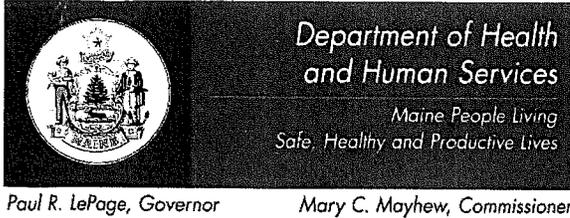
Procurement Card Usage

The State of Maine p-card program is mentioned above in several places. As a general overview, the p-card program has been established to create an efficient, time-saving method of payment for agencies and vendors alike. The p-card may be used for commodity purchases that are less than \$5,000 in total value (see Items Under \$5,000 above), or certain services under \$1,000 (please see "Low Value Service Guidelines" on our website, found at:

[http://www.maine.gov/purchases/procurement/documents/Low Value Services Guidelines.xls](http://www.maine.gov/purchases/procurement/documents/Low_Value_Services_Guidelines.xls)).

In order to acquire a p-card, an applicant must review the State p-card policy, sign an agreement, complete a one-page application form, and complete a training program. The aforementioned documents and all other details regarding the p-card program can be found on the Division of Purchases' website at the following address:

<http://www.maine.gov/purchases/procurement/index.shtml>



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

December 10, 2013

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

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

Re: DHHS Responses to questions regarding the PNMI/Cost of Care Audits, RAC Audits and School Audits for December 10th HHS meeting

PNMI auditing, Cost of Care auditing

1. Please provide statements from DHHS in response to the audits performed by the State Auditor on any PNMI's and the Cost of Care audit?

Response: Please find attached a copy of the audit with the Department response included. Attachment A

2. What action has DHHS taken in response to either audit?

Response: Please see Attachment A

3. Has either audit had an effect on the delivery of services to clients of DHHS?

Response: No

4. If so please provide information on actions taken by DHHS to protect any clients who might be affected.

Response: N/A

5. Please provide detail on the impact of the cost of care overpayments on the 2012-2013 and 2014-15 biennial budgets in the program budgets for each type of facility.

Response: The Department has implemented an internal recoupment process which has allowed us to identify and collect approximately \$23 million provider overpayments that were due to MIHMS system design flaws. We anticipate collecting an additional \$23 million over the course of the '14-'15 biennium. All cost of care recoupments have been figured into the current budget.

6. Has DHHS incorrectly paid PNMI's and nursing facilities because of the improper functioning of the computer systems with regard to cost of care at any time since the initial operation of the MIHMS system?

Response: Yes

7. If so please provide information on what time periods, for what categories of facilities, in what amounts DHHS has improperly paid?

Response: Please see the response to question 5

8. With regard the total of amounts owed please provide detail on what actions DHHS intends to take to recoup amounts owed by facilities.

Response: The Department works directly with each provider to agree on the total amount owed, then works with the provider to establish a reasonable and appropriate payment plan.

9. With regard to payments to facilities for which cost of care is required to be deducted by DHHS in calculating the proper payment please provide information on what actions DHHS plans to take and when to correct the ongoing overpayment of facilities.

Response: The Department has submitted a change request to Molina, the change has been approved by the State and we anticipate the fix will be implemented in the system by the end of January 2014.

10. If facilities have approached DHHS in order to repay overpaid amounts or otherwise attempt to return the overpayment please provide information on those communications, what action DHHS has taken in response and the final results of the communications.

Response: Please see the response to question 8

Recovery Audit Contractors

11. Please provide copies of any auditing contracts with RAC contractors.

Response: Please see attachments B and C

12. What amounts have the contractors identified to date as overpayments and what amounts have been repaid to DHHS as a result?

Response: \$24,597.84 has been repaid to date

13. What amounts have been paid to contractors as a result of repayments to DHHS?

Response: None

14. What amounts have the contractors identified to date as underpayments and what amounts have been paid to providers as a result?

Response: None

15. What amounts have been paid to contractors as a result of payment of underpayments to providers?

Response: None

Additional Update: The Department has continued to work with the providers in question and with our counterparts at CMS. Based on conversations with CMS, the issue of the incorrect servicing provider noted on claims will be considered an “educational opportunity” for the providers; no recovery of overpayments associated with this issue will be recovered at this time. Additionally, policy related to externs is a state based policy and is at the discretion of the State. Since the State is in process of changing its policy to reflect the current practice of dentists related to externs, it seems appropriate to audit based on the new policy. Accordingly the Department will not seek to recover for work completed by externs. Lastly, the Department is in the process of obtaining the services of a Maine Licensed Dentist to review the clinical portion of the findings. Once we have secured these services, the audit findings related to clinical issues will be reviewed and adjusted accordingly.

MaineCare auditing of school administrative districts

16. Please provide information on MaineCare auditing of school administrative districts during 2012-2013 and 2014-2015.

Response: Please see the attached letter sent the Education and Cultural Affairs Committee on August 2, 2013. Several of the audits are currently under appeal. Attachment D

17. Has the auditing caused DHHS or the Department of Education to take any action to pay underpayments or recoup overpayments?

Response: No

18. Has the auditing or the results of the auditing had any impact on school administrative districts or their employees or contracted providers of services or children who are MaineCare members?

Response: No

19. Has the auditing or the results of the auditing had any impact on children who are served through other programs, such as the school districts own programs or Child Development Services?

Response: No

20. Please provide information on actions taken by DHHS or DOE or any school administrative district as a result of these audits.

Response: DHHS continues to work with DOE and School Administrative Districts to ensure that services covered are appropriate and that adequate records are maintained to satisfy the needs of MaineCare and CMS.

Attachment A

STATE OF MAINE OFFICE OF THE STATE AUDITOR

66 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0066

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POLA A. BUCKLEY, CPA, CISA
STATE AUDITOR

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

October 29, 2013

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

Dear Commissioner Mayhew,

The Office of the State Auditor conducted a limited procedures engagement of the Department of Health and Human Services' computation and application of Cost of Care amounts to provider payments for the nine month period July 1, 2012 to March 31, 2013.

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

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

We thank Deputy Director Michael Frey, Director Bethany Hamm, Acting Director of Policy Beth Ketch, Director Stefanie Nadeau, and their staff, as well as the Department of Administrative and Financial Services (DAFS), Office of Information Technology and Department of Health and Human Services Service Center personnel for their assistance during this engagement.

Sincerely,

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

Pola A. Buckley, CPA, CISA
State Auditor

cc: Honorable Dawn Hill, Chairperson, Appropriations and Financial Affairs
Honorable Margaret Rotundo, Chairperson, Appropriations and Financial Affairs
Honorable Margaret Craven, Chairperson, Health and Human Services
Honorable Richard Farnsworth, Chairperson, Health and Human Services
Honorable H. Sawin Millett, Commissioner, Department of Administrative and Financial Services
Jim Smith, Commissioner, Office of Information Technology
Michael Frey, Deputy Director, DHHS
Herb Downs, Director, DHHS, Division of Audit
Ray Girouard, Director, Department of Administrative and Financial Services, DHHS Service Center
Bethany Hamm, DHHS, Director, Policy and Programs
Beth Ketch, DHHS, Acting Director of Policy
Stefanie Nadeau, Director, DHHS, Office of MaineCare Services

**Office of the State Auditor
Report on Limited Procedures Engagement – Cost of Care
Report Issued On October 29, 2013**

Summary

The Office of the State Auditor reviewed internal controls over the calculation, application and review of Cost of Care amounts assessed to long term care (LTC) facility residents for the first nine months of fiscal year¹ 2013. The term “Cost of Care” refers to a MaineCare member’s personal monthly required contribution towards his or her nursing home (NH) or private non-medical institution (PNMI) facility care. This amount is separately calculated for each resident based on their financial situation. In effect, Cost of Care is a “deductible” that an individual must pay to live in a Long Term Care (LTC) facility. LTC facilities collect this amount directly from residents eligible for the State LTC program, bill MaineCare for the usual and customary charges; and then, the claims processing system, the Maine Integrated Health Management Solution (MIHMS) is supposed to deduct the Cost of Care. LTC providers are required to return overpayments when MIHMS does not make this deduction.

The Office of Family Independence (OFI) coordinates eligibility for the various LTC Assistance Group programs that provide MaineCare benefits for certain Medicaid or state funded coverable group residents; and the Office of MaineCare Services (OMS) is responsible for payments to the NH and PNMI facilities in Maine. The Office of the State Auditor finds that improvements are needed. These needed improvements are identified in this report.

We found that known logical errors in the Automated Client Eligibility System (ACES) frequently cause income and expense information for LTC residents to be incorrect or missing. This results in Cost of Care assessments calculated by ACES to be incorrect. In order to address this, OFI personnel are required to apply “manual workarounds” to correct any errors they find in client case information pertaining to Cost of Care. Test results indicated that OFI staff did not always apply manual fixes correctly; and that other system errors remained undetected by staff altogether.

Furthermore, we found that MIHMS is not appropriately deducting Cost of Care amounts; and system edits were not appropriately set to deny, pend or re-open claims for review in two circumstances. In both circumstances, providers were or would be paid by both the resident and by MIHMS for the same monthly room and board costs. Immediately following is a description of the audit procedures performed, the results of those applied procedures and our conclusions and recommendations.

Range of Estimated Financial Impact

OFI Assessments: Total Cost of Care assessed to potential LTC residents for the first nine months of fiscal year 2013 was \$89 million. Audit procedures applied to our sample indicated that nine (or, about 15%) of the sixty Cost of Care assessments tested remained in error despite manual correction by OFI staff in some cases. The dollars associated with the 15% error rate were minor because income and expense errors offset each other.

OMS Payments: Based on eligibility calculations, the theoretical maximum² Cost of Care deduction from LTC provider payments for the first nine months of fiscal year 2013 is \$89 million. We estimate that the actual Cost of Care deductions that should have been taken for the first nine months of fiscal year 2013 are \$76 million (85%³ of \$89 million). We found that in a sample of sixty randomly selected claims and interim rates set by the Department, providers were overpaid by \$16,924 (or about 29%) of the total \$57,713 Cost of Care amounts. Twenty-nine percent of \$76 million is \$22 million, *annualized* this amounts to \$29 million. We know that DHHS has some procedures in place to recover these funds since the MIHMS implementation in 2010. However, we believe these procedures are far from adequate and do not address the root causes on a timely basis.

Included in the \$16,924 overpayment amount are \$6,324 of MIHMS payment processing errors identified in more detail below, for five NH payments and two PNMI facility payments.

¹ All references to a fiscal year are for the State fiscal year ending June 30.

² Not all individuals assessed a Cost of Care amount by OFI reside in a NH or PNMI. Some choose to stay at home, or remain in a hospital or other LTC facility type.

³ Nine of our original 60 item sample used to test OFI Assessments had to be replaced because they were not yet residing in an NH or PNMI. Therefore, our testing indicates that approximately 15% of individuals for whom a potential Cost of Care was calculated, were not yet residing in a NH or PNMI.

The remaining \$10,600 was because Cost of Care was not fully deducted from twenty-two other PNMI claims, or over 75% of the 30 PNMI claims sampled prior to payment. One issue is that although these PNMI payments were for residents eligible for Medicaid, Cost of Care deductions were not applied to all their monthly federal and State charges because such deductions are not allowed by this federal program for residents of PNMI facilities. The other issue is that these PNMI overpayments were primarily due to a nominal amount of \$1 per day being paid for room and board on an interim basis until costs are settled annually. Obviously, PNMI providers cannot function on a periodic payment of one dollar per day per resident. Except for the one dollar per day, DHHS classifies the payment as All Inclusive Comprehensive and Other Therapeutic Services, which we find to be misleading, at the least. DHHS has a manual partially effective procedure in place to recover overpayments from these providers. However, MIHMS continues to overpay; OMS continues to seek recoupment from providers; OMS provides some receivable amounts to HHSSC⁴ as a limited number of PNMI providers send in payments; OMS continues to track remaining balances and offset amounts; and applicable credits should be applied by HHSSC to the quarterly federal financial report. Some providers are cooperating, and some are not. This "overpay and recover" procedure cannot mitigate the fact that at any given time about \$27 million or more of State and federal money is not available for government use. It remains unclear why OMS has assumed sole financial responsibility for these overpayments, rather than with the HHSSC. The Service Center is ultimately responsible for crediting the federal share of these overpayments on the federal CMS-64 reports. This is a serious matter that deserves priority attention by the State.

Background

We originally discovered issues with Cost of Care while auditing Medicaid for fiscal year 2006. These issues might have existed prior to this date. Cost of Care amounts had not been deducted from NH or PNMI facility payments correctly; and the result is that providers were being paid both by the MaineCare member and by MaineCare.

Problems persist in the current MIHMS system.

Procedures

We performed the following procedures⁵ for the nine month period ending 3/31/2013:

- reviewed State law pertaining to Cost of Care,
- reviewed relevant sections of the State Medicaid Manual promulgated by the federal government, the MaineCare Eligibility Manual and the MaineCare Benefits Manual,
- evaluated OIT technical design documents that depict how ACES assesses Cost of Care for individuals and related mechanical and human controls,
- evaluated OMS and fiscal agent technical design documents that depict how MIHMS adjudicates Cost of Care for individuals and the related mechanical and human controls,
- determined whether the MIHMS system logic is correct,
- tested the accuracy of a sample of sixty Cost of Care assessments⁶ made by ACES for clients that are classified as members of certain DHHS program coverage groups residing in NH and PNMI facilities,
- tested the accuracy and success rate of manual compensating controls⁷ over the same sixty Cost of Care assessments,
- tested sixty claim payments to LTC providers to determine whether payments made to providers for monthly resident charges were reduced by Cost of Care amounts⁸,
- tested existing compensating controls, such as "pend or deny" edits in MIHMS, that would force resolution of payment errors related to Cost of Care for a sample of sixty NH and PNMI provider payments,
- tested the consistency of eligibility and Cost of Care information from system-to-system (ACES⁹ to MIHMS) through the DataHub¹⁰ for a sample of sixty claims,
- reviewed the adequacy of the DHHS process used by a contractor to measure and track the amounts due back from NH facilities that received overpayments because the correct Cost of Care amount was not deducted from payments for monthly resident costs,

⁴ HHSSC - Health and Human Services Service Center

⁵ not in order of importance

⁶ certain types of client income, expenses and allowances are used in this calculation

⁷ Part of the typical case management process is for OFI eligibility personnel to determine whether cost of care was computed correctly by ACES for each client, correcting errors as they are encountered and at times in a more directed manner.

⁸ Cost of care amounts that should be collected by LTC providers from the clients housed in their facility.

⁹ The ACES system electronically transfers cost of care amounts and other eligibility information for each client to the DataHub in an ongoing basis.

¹⁰ The DataHub is Maine's intermediary Health Care Information database system between ACES and MIHMS.

Attachment A

- reviewed the adequacy of the OMS controls in place to measure and track the amounts due back from PNMI facilities that received overpayments because the appropriate Cost of Care amount was not deducted from payments for monthly resident costs, and
- identified other issues that were detected during the audit that pertained to compliance with State law.

Results

Our testing of a sample of 60 randomly selected cases from all clients in a NH or PNMI residence assessed a Cost of Care for the period indicated that ACES incorrectly computed Cost of Care because known system errors caused income or expense information to be incorrect or missing for 13 of the 60 random Cost of Care assessments, as follows:

Instances	ACES Error Observed
10	ACES did not include all or part of State Supplement payments ¹¹ as income for SSI clients.
2	ACES miscalculated the spousal income allocation.
1	ACES failed to update annual SSI ¹² income from SVES ¹³ since 2009; and to list case on the SVES discrepancy report.
13	Total

In response, OFI has established manual workarounds or “fixes” as compensating controls to address such known ACES system design problems in automatically assessing Cost of Care to client cases. Test results indicated; however, that OFI staff did not correctly apply manual fixes or detect system errors for 9 of the 13 system errors, as follows:

Instances	Errors Observed
3	ACES did not include all or part of State Supplement payment as income for SSI clients.
6	OFI personnel did not detect system errors and apply manual fixes to client records.
9	Total

Continued on next page...

¹¹ A standard applies that is established by the State for the total SSI payment. The federal SSI payment and any countable income are deducted from the State standard. The remainder is the State Supplementation. This is typically an additional \$10 or \$15 per month, but can be as high as \$234 in some client cases.

¹² Supplemental Security Income (SSI) guarantees a minimum monthly income to people who are at least 65 years old, or blind, or disabled with limited income and resources.

¹³ State Verification and Exchange System

Attachment A

Our testing of a sample of 60 claim payments for the same clients and period tested above, indicated that Cost of Care for 8 (5 NH and 3 PNMI) claims were not correctly deducted from provider payments, because:

Instances	Errors Observed
4	Situation No. 1: Claims were found submitted for payment in a manner which could potentially be used to force a payment to be improperly paid from both MaineCare and from the client. We are not disclosing specific details of the issue in this report to avoid the possibility of compromising Department data and resources. However, we have notified appropriate Department management of the specific issues.
4	Situation No. 2: Retroactive Eligibility Payment Errors - MIHMS system edits were not actively set to reopen four tested claims when retroactive DataHub information was received by MIHMS and caused client Cost of Care and eligibility information to change only after NH or PNMI providers were paid for monthly resident costs. The end result is that the provider is or ultimately will be erroneously paid by both the client and by the State, so the State needs to recover the excess payment from the provider in some manner. A solution ¹⁴ to this retroactive Cost of Care and Eligibility assessment dilemma is being developed.
8	Total

The results of other tests we performed were not found to be problematic; or will be tested further during our testing of the federal Medicaid program.

Conclusions

We found important opportunities for needed improvement. These opportunities relate to key controls over system functionality and compensating controls that are in place to correct for known system deficiencies.

- (1) Known system errors, which occur consistently as ACES computes Cost of Care amounts, must be addressed by the Department. Allowing such errors to continue is inefficient and wasteful of financial and human resources. It creates too many opportunities for human error and testing indicates there is no guarantee that system errors will be detected through manual processes.
- (2) Systemic errors (caused by MIHMS and ACES system flaws) are predictable and typically can be resolved once identified. The root causes for MIHMS payment errors we detected were systemic and not isolated in nature, indicating these internal control weaknesses should be addressed by the Department. If not, payment errors and an opportunity for improper activity will continue.
- (3) Consistent and meaningful exception review on an ongoing basis would allow for timely detection and tracking of payment errors; and the efficient recovery of overpayments.

Root Causes

Systemic ACES and OFI deficiencies include:

- Known ACES system errors which occur consistently for Cost of Care calculations include:
 - (1) SSI recipients: not counting State Supplement payments between \$10 and \$234 per month as income
 - (2) NH residents: miscalculation of the monthly spousal income allocation¹⁵ and daily medical rates
 - (3) SSI recipients: not consistently updating all SSI income amounts from SVES
 - (4) SSI recipients: not reporting all instances of SVES failure on the SVES discrepancy report
 - (5) NH residents: computed spousal income allowance is off by about \$33 to \$37 per month
- Inefficient compensating controls because OFI personnel need additional training

Manual recalculations of Cost of Care amounts included arithmetic errors and misunderstandings regarding what client information should be considered when performing these computations. Also, correct procedures were not always followed by OFI staff as they applied manual fixes to ACES records.

¹⁴ TR#5620 - A trouble report (TR) is a system defect that the system contractor must fix for free, without additional negotiated funding.

¹⁵ This known system issue is referred to by OFI as, ACES task #13658.

Attachment A

Systemic MIHMS claim processing errors detected:

- No MIHMS system edit is set to pend or deny claims when they are submitted by a NH or PNMI facility provider in a certain way that we are intentionally not disclosing to protect Department resources

System edits that could resolve this matter were set to ignore during our testing. In all 4 instances detected within our sample, no Cost of Care amount was deducted from room and board costs prior to payment. The result is that the provider erroneously got paid by both the client and by the State.

- Compensating controls to detect and reopen claims for retroactive Cost of Care or other eligibility changes are insufficient

Electronic methods to detect instances when DataHub client eligibility and Cost of Care information is received by MIHMS exist only after payments are made are not set to reopen such claims for review by OMS to force resolution. Another 4 of the 60 claims we tested were such instances. It was also discovered that no State personnel were instructed to regularly generate and review exception reports or use other tools that can detect such retroactive eligibility or Cost of Care assessments to force resolution of claims previously paid in error.

- Fractured Communication

Improvement of cross system communication and review processes should continue to expand the pockets of understanding to a less selective group of personnel within the Department and in certain DAFS¹⁶ entities. The path from eligibility determination to MaineCare provider payments and ultimately to proper financial reporting is complicated involving multiple systems and complex business rules, which requires a large and diverse team of management, program, policy, financial and Information Technology (IT) experts, internal and external to the Department. The decision to outsource payment processing to a fiscal agent and the limitations of State agency resources adds additional complexity to this communications process. While the State and its contractors have developed communication channels, defining all user roles and responsibilities will need to continue in an ongoing basis, unless a more centralized approach to operations is put into place.

Recommendations

We recommend that OFI continue to improve internal controls to ensure that Cost of Care amounts are computed correctly for clients residing in LTC facilities, such as:

- coordinating the remediation of ACES system problems with DAFS - OIT¹⁷,
- continuing their efforts to review and correct client records related to income, expenses, personal needs allowances, and daily medical rates to compensate for ACES deficiencies in computing Cost of Care amounts, and
- providing additional training to staff who must make manual corrections to Cost of Care information in ACES.

We recommend that OMS continue to implement additional controls and system corrections that would allow Cost of Care amounts to be properly deducted from monthly NH and PNMI facility payments. These include:

- directing Molina to activate certain system edits that will cause LTC claims to pend, deny or reopen for manual review prior to paying providers (this will allow for more offsets against future claims),
- assigning more personnel to review exception reports or use other tools to detect and track errors for adjustment against future claims,
- ensuring that an adequate number of staff is assigned to track and manage the significant balances due back to the State from overpaid PNMI facilities, that staff is adequately educated, qualified, and employed on a permanent basis, and

¹⁶ DAFS (Department of Administration and Finances) - HHSSC (Health and Human Services Service Center) and OIT (Office of Information Technology).

¹⁷ Office of Information Technology

Attachment A

- providing comprehensive receivable, payment and offset information to the HHSSC; and consider transferring responsibility for overpayment accounting and collections activities to the HHSSC, subject to internal audit oversight.

Agency Responses

Agency contact, Acting Director of Health Care Management and Policy, OMS.

- The State's Change Management staff is researching a variety of solutions (to the undisclosed situation). No estimated date can be provided for a decision or implementation of a system change. In the interim, we will implement a manual review by State Quality Assurance staff to research and identify claims that meet the (undisclosed) criteria for adjustment. Also, the State is actively involved in a redesign of the reimbursement methodology for Private Non-Medical Institutions.
- Retroactive Cost of Care determinations obviously create collection problems. As was discussed in our 5/29/13 meeting with Molina and State staff, most claims in this situation have finalized before the COC information is received. The State has a dedicated resource who works on COC issues. She does not use the certain report that Molina referred to in our meeting, as we believe other tools are more useful; (but she does use) a different Molina-generated report and coordinates her findings with the State adjustment supervisor. Because your audit did show that our current efforts are incomplete, we will be reconsidering our overall COC review to see where it can be strengthened.
- The Cost of Care process has been corrected for members with Cost Reimbursement Boarding Home (Rate Code 53) coverage.

Attachment B

DEPT 10A
COPIES 2

CONTRACT/GRANT AUTHORIZATION RECORD
STATE PURCHASES REVIEW COMMITTEE

DEPARTMENT DHHS

CONTRACTOR: HEALTH MANAGEMENT SYSTEMS

NOTES: EXTENDED, RIDER A

RFP SELECTION CONTRACT AMENDMENT

BP37SS-T BP37SS-F BP37CA BP37AM BP37PA

DIRECTOR PURCHASES: Initials Date Comments:

Approval Klp 4/16 _____
 Conditional Approval _____
 Add'l Info Requested _____
 Action As Needed _____
 Disapproval _____

Additional Approvals if over \$1M, or at Division of Purchases' discretion

STATE BUDGET

OFFICER: Initials Date Comments:
 Approval _____
 Conditional Approval _____
 Add'l Info Requested _____
 Action As Needed _____
 Disapproval _____

STATE CONTROLLER: Initials Date Comments:
 Approval _____
 Conditional Approval _____
 Add'l Info Requested _____
 Action As Needed _____
 Disapproval _____

CIO: Initials Date Comments:
 Approval _____
 Conditional Approval _____
 Add'l Info Requested _____
 Action As Needed _____
 Disapproval _____

GOVERNOR'S OFFICE Initials Date Comments:
 Approval _____
 Conditional Approval _____
 Add'l Info Requested _____
 Action As Needed _____
 Disapproval _____

2012050904777	Date <u>4-16-13</u>
	Encumbered or <u>Unencumbered</u>

2

Division of Purchases' Amendment Authorization Form

Form Instructions: This form must accompany amendments being proposed for approval to existing contracts.

Program Administrator:	Herb Downs	Office/Division/Program:	Audit
Phone:	287-2778	CT Number:	10A 2012050900000004777
Amendment Amount:	\$0	DHHS Agreement Number:	AUD-12-001A
Amendment Date:	4-3-13	Revised Agreement Amount:	\$0
Provider/Vendor's Business Name and Address:	Health Management Systems 401 Park Avenue South, New York NY 11016		
VC Number:	VC1000036491		
Type of Service:	Unencumbered		
1. Specific Problem or Need for Amendment:			
Provide a full description of the amendment (what changes are being made to the contract) AND explain the necessity of the amendment (why the amendment needs to be done). Amendments are performed to make small changes to the scope of work, extend the termination date and/or change the cost of the agreement.			
<p>Extending the end date and changing the Rider A</p> <p>The provider has yet to produce anything under the contract so we'd like to give them 8 months to produce the deliverables. There's a clause in Rider A that states"</p> <p>Instead of renewing the contract as prescribed in Rider A (pasted above) the contract will be extended to provide the provider an opportunity to produce deliverables by the termination date.</p>			
2. Adjustment in Agreement Amount:			
If the amendment includes the addition or reduction of funds, describe how the amendment amount was determined. If the amendment did not include a change to the agreement amount, state "N/A" - this amendment does not modify the agreement amount.			
N/A			
Approved by CRM:	<i>Maryann Barakall</i>		
Date:	4/9/13		

Attachment B

DEPARTMENT OF HEALTH AND HUMAN SERVICES AGREEMENT FOR SPECIAL SERVICES – AMENDMENT

BY AGREEMENT of both parties this 4th day of April 2013, the Agreement for Special Services between the State of Maine, Department of Health and Human Services, hereinafter called "Department", and Health Management Systems, Inc., hereinafter called "Provider", is hereby amended as follows:

1. The termination date is extended from 04/30/2013 to 12/31/2013.
Reason: Giving the provider 8 months to produce deliverables outlined in the original contract.
2. The dollar amount of the contract is increased/decreased by \$N/A \$0.00 agreement
3. The Scope of Services in Rider A is amended as follows: Section II A. Contract Term: Please see attached Rider A

All other terms and conditions of the original Agreement dated 1 remain in full force and effect. WITNESSETH, that this Agreement is consistent with Executive Order 01 FY 11/12 or a superseding Executive Order, and complies with its requirements.

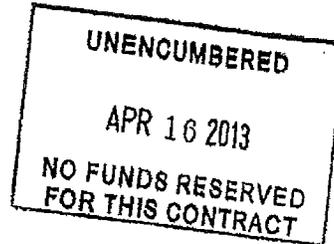
IN WITNESS WHEREOF, the Department and Provider, by their duly authorized representatives, have executed this amendment as of the day and year first above written.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: William W. Boeschenstein, Jr. for
William W. Boeschenstein, Jr.
Chief Operating Officer

PROVIDER: Health Management Systems, Inc.
(Provider Name)

By: William C. Lucia, CEO
William C. Lucia, CEO



Approved, State Purchases Review Committee Michael Alan Wenzel Date: APR 16 2013

(note: this section must be completed by using agency)

Previous Agreement Amount:	\$0.00	Encumbrance #:	10A 20120509000000004777
Amount of Increase or (Decrease):	\$0.00	DHHS Agreement #:	AUD-12-001A
Revised Agreement Amount:	\$0.00	Termination Date:	12/31/2013
Appropriation:	N/A	Vendor/Customer #:	VC1000036491

Attachment B



STATE OF MAINE
STANDARD AGREEMENT COVER PAGE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DHHS Agreement# AUD-12-001A
AdvantageME CT# 10A-20120509*4777

Community Agency Name: Health Management Systems, Inc.

Address: 401 Park Avenue South, New York NY 11016

Program Name: Divison of Audit/Program Integrity
Service: Auditing of MaineCare program billing

Geographic Area Served:

DHHS District #__ DHHS Region #__ Vendor/Customer #: VC1000036491
Agency Fiscal Year:

FOR DEPARTMENT USE ONLY

Agreement Period

Type of Agreement

Effective Date: 5/1/2012 Contract-State Services New
Termination Date: 4/30/2013 Grant- Client Services Renewal
Amended Effective Date: 05/01/2013 Amendment
Amended Termination Date: 12/31/2013 Budget
Revision

CFDA #	ACCOUNT #	FY 2013 Encumbrance	FY 2014 Encumbrance	Agreement Total
1.	Unencumbered	\$0.00	\$0.00	\$0.00
2.				
3.				
4.				
5.				
6.				
7.				

Agreement Routing: Agreement Administrator: Stacy McCurdy
Contract Relationship Manager Maryann Harakall

RIDER A

II. GENERAL REQUIREMENTS

- A. **Contract Term:** The contract is effective beginning May 1, 2012 through December, 31, 2013. This contract allows for one 18 month extension, which will be considered at the discretion of the Department.

Attachment C

AdvantageME CT Number: CT-10A-0120509
DHHS Agreement Number: AUD-12-001
Vendor/Customer#: VC1000036491 *8471*

STATE OF MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES Agreement to Purchase Services

THIS AGREEMENT, made this 1st day of May, 2012 is by and between the State of Maine, Department of Health and Human Services, hereinafter called "Department," and Health Management Systems, Inc., mailing address 401 Park Avenue South, New York City, NY 10016, hereinafter called "Contractor" for the period of 5/1/2012 to 4/30/2013.

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and performed by the Department, the Contractor hereby agrees with the Department to furnish all qualified personnel, facilities, materials and services and in consultation with the Department, to perform the services, study or projects described in Rider A, and under the terms of this Agreement. The following riders and attachments are hereby incorporated into this Agreement and made part of it by reference:

Rider A: Specifications of Work to be Performed
Rider B: Payment and Other Provisions
Rider C: Rider B Exceptions
Rider D: Additional Requirements
Rider G: Identification of Country in Which Contracted Work Will Be Performed
Attachment 1: Business Associate Agreement

WITNESSETH, that this agreement incorporates the requirements of the RFP (#201011820) and Contractor's proposal in response to that RFP by reference, and that Contractor agrees that if a conflict exists between the RFP or Contractor's proposal in response and this Agreement, the terms of this Agreement controls.

WITNESSETH, that this contract is consistent with Executive Order 01 FY 11/12 or a superseding Executive Order, and complies with its requirements.

IN WITNESS WHEREOF, the Department and the Contractor, by their representatives duly authorized, have executed this agreement in one original copy.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

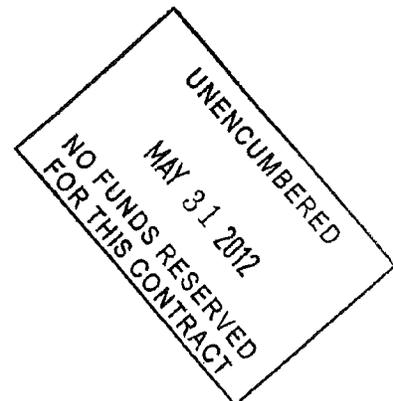
By: *William W. Boeschstein Jr.*
William W. Boeschstein Jr., Chief Operating Officer
And

HEALTH MANAGEMENT SYSTEMS, INC.

By: *William C. Lucia*
William C. Lucia, CEO

Total Agreement Amount: \$0.00

Approved: *Michael Alan Wanzel*
Chair, State Purchases Review Committee



MAY 3 1 2012



**STATE OF MAINE
STANDARD AGREEMENT COVER PAGE
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

DHHS Agreement# AUD-12-001
AdvantageME CT# 10A-20120509-%-4777

Community Agency Name: Health Management Services, Inc.

Address: 401 Park Avenue South, New York NY 11016

Program Name: Divison of Audit/Program Integrity
Service: Auditing of MaineCare program billing

Geographic Area Served:

DHHS District #__ DHHS Region #__ Vendor/Customer #: VC1000036491
Agency Fiscal Year:

FOR DEPARTMENT USE ONLY

<u>Agreement Period</u>	<u>Type of Agreement</u>
Effective Date: <u>5/1/2012</u>	<input checked="" type="checkbox"/> Contract-State Services <input checked="" type="checkbox"/> New
Termination Date: <u>4/30/2013</u>	<input type="checkbox"/> Grant- Client Services <input type="checkbox"/> Renewal
Amended Effective Date: <u> </u>	<input type="checkbox"/> Amendment
Amended Termination Date: <u> </u>	<input type="checkbox"/> Budget Revision

CFDA #	ACCOUNT #	FY 2012 Encumbrance	FY 2013 Encumbrance	Agreement Total
1.	Unencumbered			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
11.				

Agreement Routing: Agreement Administrator: Tom Collins
Purchased Service Manager: Melody Foster

RIDER A

SPECIFICATIONS OF WORK TO BE PERFORMED

I. AGREEMENT FUNDING SUMMARY

The purpose of this Agreement is to implement Maine's Medicaid Recovery Audit Contractor (RAC) Program and to reduce improper Medicaid and Maine Children's Health Insurance Program payments through the efficient detection and collection of overpayments, and the identification of underpayments, as required by Section 6411 of the Patient Protection and Affordable Care Act and associated federal regulations at 76 Fed. Reg. at 57.843-44 (42 CFR Part 455(F)). The service descriptions are detailed in Section III, Service Specifications and Performance Guidelines. The sources of funds and compliance requirements for this Agreement follow:

A. State General Fund \$Contingency fee

B. Dedicated/Special Revenue \$0

C. Federal Funds \$Contingency fee

Use of funds shall be in accordance with restrictions contained in the Patient Protection and Affordable Care Act and associated federal regulations at 76 Fed. Reg. at 57.843-44 (42 CFR Part 455(F); the appropriate CFDA; with Federal OMB Circulars A-110, A-122, and A-128; with CMR 10-144, Chapter 30, as applicable; and with the terms of this Agreement.

- CFDA# & Description (CFDA Title, award name, award no., federal awarding agency): 93.788, Medical Assistance program, Administration Payments, 1105ME5ADM, DHHS Centers for Medicare and Medicaid Services. \$Contingency
- CFDA# & Description (CFDA Title, award name, award no., federal awarding agency): \$
- CFDA# & Description (CFDA Title, award name, award no., federal awarding agency): \$
- CFDA# & Description (CFDA Title, award name, award no., federal awarding agency): \$

II. GENERAL REQUIREMENTS

- A. **Contract Term:** The contract is effective beginning May 1, 2012 through April 30, 2013. This contract allows for one 26 month extension, which will be considered at the discretion of the Department.
- B. **Reporting:** Contractor shall submit to the Program Administrator financial and performance reports in accordance with the specifications of the Department, as follows:
1. Reporting Requirements.

The following reports will be submitted by Contractor to the Program Administrator:

- a. Monthly Case Status Report shall be prepared and submitted to the Program Administrator by the 15th of each month and include, at a minimum; a listing of all cases and clearly identifying new cases opened during the month, with open and closed dates (if applicable), provider name, NPI or Provider ID #, provider type, case status, means by which overpayments or underpayments were identified, or the project's particular methodology or purpose; fraud and/or abuse issues identified and the cases that the Contractor recommends for referral to the Medicaid Fraud Control Unit (MFCU); type and date of correspondence mailed to providers; initial sum total overpayment and underpayment identified for each provider, the amount paid and the amount still owed. Additional information shall be provided as requested by the Program Administrator.
- b. State Fiscal Year to Date Summary Report shall be prepared and submitted to the Program Administrator by the 15th of each month with the Monthly Case Status Report and must include, at a minimum;
- Number of cases opened
 - Number of cases closed
 - Number of cases in progress
 - Original overpayments
 - Original underpayments
 - Adjustments
 - Current overpayment amount
 - Current underpayment amount
 - Amount received
 - Amount paid
 - Estimated contingency fee
 - Actual contingency fee

The report should include the current month and SFY to date, by provider type or other grouping that may be considered more appropriate and informative.

c. Provider Outreach Activities.

The Monthly Case Status Report shall have a section describing the Contractor's provider education and outreach activities accomplished during the previous month and upcoming activities planned.

d. Ad Hoc Reports

Contractor will submit such other data and reports as may be requested in writing by either the Program Administrator or the Agreement Administrator. Ad Hoc Reports shall be prepared and submitted in the format requested by the requesting Program Administrator or the Agreement Administrator within a mutually agreed upon time frame.

Ad Hoc Reports include but are not limited to:

- (a) Issues identified and discussed in meetings;
- (b) Issues regarding all of the reviews for one provider type;
- (c) Provider complaints – description of issues;
- (d) Legislative or auditor's inquiry;
- (e) Work matters identified by the Department.

e. Annual Report

The Contractor shall submit to the Department, within 20 days after the end of the State's fiscal year, June 30:

- (1) An Executive Summary Report of all Contractor activities, global recovery by year since Agreement inception, significant learning, recommendations and conclusions on all projects for the preceding state fiscal year.
- (2) An annual Provider Report for distribution to provider organizations containing:
 - Common review findings;
 - Information on how to prevent similar findings in future reviews;
 - Resource information;
 - Other information as directed by the Department.

2. Report Standards. The following procedure and standards apply to all reports:

a. The Contractor shall verify the accuracy and timeliness of reports, letters and data, screen them for completeness, logic and consistency, and proof the contents for spelling, grammatical, and mathematical errors. The reports will be legible, uniform in appearance, clean and presentable.

b. Contractor shall provide report design layouts of all reports to the Program Administrator and the Agreement Administrator. All final report design layouts will be subject to approval of the requesting administrator (the Program Administrator or the Agreement Administrator). All reports should be made

available in both electronic and paper format.

3. Noncompliance with Reporting Requirements

- a. If any reports due from Contractor are not provided within the time frames established herein, the Department will withhold 5% of the payments due under this Agreement until such reports are received, reviewed and accepted.
- b. Contractor's failure to provide reports and notify the Department in a timely manner in accordance with this Agreement may result in the delay of payment of funds and/or termination of this Agreement.

C. Records and Data Security:

1. Records

Contractor will maintain and retain financial and professional records sufficient to fully and accurately document the nature, scope and details of the services provided under the contract. Contractor agrees to retain such records for a period of not less than five (5) years from date of service or for such longer period as may meet other statutory requirements. If an audit or appeal is initiated within the required retention period, Contractor will retain such records until the audit or appeal is completed and a settlement has been made, but not less than five (5) years from date of service or for such longer period as may meet other statutory requirements. All such records, documents, communications and other materials shall be the property of the State, and shall be maintained by the Contractor in a central location and the Contractor shall be custodian on behalf of the State.

2. Data Security

- a. Contractor shall have and maintain contingency plans and a disaster recovery plan designed to restore any loss of protected information and to enable continuation of critical business processes for protection of the security of electronic Protected Health Information (PHI) while operating in emergency mode.
- b. Contractor shall ensure that all electronic mail communications that contain PHI are either sent securely, encrypted, or both;
- c. PHI on removable media shall be encrypted;
- d. If Contractor uses encryption software that the Department does not possess or license, Contractor shall pay all costs associated with acquiring and maintaining the software for the Department;
- e. Passwords to open encrypted files shall not be sent via the same media or transmission method as was used to send the original files;
- f. All data that is submitted to the Department in electronic format shall be sent securely;

- g. Contractor's systems shall contain controls to maintain information integrity and security.
- h. The Contractor shall notify the Department within 24 hours of discovery of:
(a) unauthorized systems access; (b) compromised data; (c) loss of data integrity, or (d) inability to transmit or process data;
- i. In the event of a breach of the security of sensitive data, Contractor shall immediately notify the Department to report all suspected loss or compromise of sensitive data within 24 hours of the suspected loss or compromise and shall work with the Department regarding recovery and remediation. Contractor shall be responsible for notifying all Maine residents whose sensitive data may have been compromised as a result of a breach of security caused by Contractor.
- j. The Contractor shall establish appropriate restrictions and safeguards against unauthorized access to all non-public data;
- k. The Contractor shall secure background checks on any employees with access to Department data to ensure that they have not been convicted of any program-related felonies and that they are not excluded from federal participation;
- l. The Contractor shall ensure that staff with access to PHI is trained regarding their obligations under HIPAA and the Health Information Technology Portability and Clinical Health (HITECH) Act.
- m. The Contractor shall implement all other necessary technical safeguards required by 45 CFR Sections 160 and 164.

D. Contractor's General Requirements:

1. Contractor shall provide all services in accordance with all applicable Federal and State statutes, regulations and rules; and, Department regulations, policies, and rules, as now or hereafter amended and the requirements described in this Agreement.
2. Contractor acknowledges Federal and Department regulations, guidance, rules and directives may change and the Contractor shall cooperate fully with the Department to make any necessary changes to the Agreement to accommodate new or changed Federal or Department regulations and their requirements. Until formal amendment of the Agreement is made, the Contractor shall perform such tasks or duties as required by regulations promulgated by the Secretary of Health and Human Services to carry out Section 6411 of the Federal Patient Protection and Affordable Care Act, amendments made thereto, including regulations with respect to conditions of Federal financial participation, as specified by the Secretary.
3. The Contractor shall coordinate recovery audit efforts with other contractors or entities performing audits of providers, including coordinating with Federal and State law enforcement, the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State Medicaid Fraud Control Unit.

4. Contractor shall be up-to-date on understandings and working knowledge of State and Federal regulations, the Department's MaineCare Benefit Manual, billing manuals, the MaineCare Provider Agreement, MaineCare Eligibility Manual, other conditions of participation for MaineCare providers, the Department's regulations and rules, and any other resource that governs the administration of MaineCare.
5. Contractor shall endeavor to facilitate and maintain positive working relationships with providers to help assure favorable resolutions to complex reimbursement and settlement issues.
6. Contractor shall endeavor to work with community providers in a professional and responsive way to maintain trust and not jeopardize provider relationships with the Department.
7. Contractor will permit the Department, the federal government and any other duly authorized government agency, in their sole discretion, to monitor all activities conducted by Contractor pursuant to the terms of this Agreement using any reasonable procedure, including but not limited to internal evaluation procedures, examination of program data, special analyses, on-site checking, formal audit examinations or any other procedure. Contractor similarly will permit the Department or any other duly authorized government agency access to any information system used to fulfill the terms of this Agreement. All monitoring controlled by the Department shall be performed in a manner that does not unduly interfere with Contractor's performance hereunder.
8. All reports, schedules, queries and data generated from MaineCare paid claims or any other MaineCare information remain the property of the Department and may not be used in any activity unrelated to the provision of services in this Agreement. The Department has the unlimited right to access all Contractor computer files and otherwise use, and to authorize others to use, all reports, schedules and data as the Department sees fit.

E. Contractor Expenses:

1. Contractor will be solely responsible for any expenses it incurs in implementing this Agreement, including travel expense.
2. Contractor will be responsible for any expenses incurred for any modification to any State computerized information system, including expenses incurred by the Department for repair, maintenance and other services necessary because of the contracting action. The contractor will not be responsible for any expense due to the system vendor for modifying or creating interfaces.

III. SERVICE SPECIFICATIONS AND PERFORMANCE GUIDELINES

Definitions:

Accounting Strings: Identifies the various funding sources used to pay claims, i.e., fund-department-appropriation-unit, etc.

CMS: Centers for Medicare and Medicaid Services.

CHIP: Maine Children's Health Insurance Program

Contractor: Means this RAC Contractor.

Covered Service: Means any payment under the MaineCare state plan or under any MaineCare waiver of the state plan, any payment in the State CHIP program, administered by the Department.

Department: Maine Department of Health and Human Services.

MECMS: Maine Claims Management System.

MIHMS: Maine Integrated Health Management Solution.

ICF MR: Intermediate Care Facility for Mental Retardation

PHI: Protected Health Information, as defined in HIPAA and HITECH laws. Title 42 CFR Parts 412, 413, 422 and 495. American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5). Title XIII Sect. 13001. Title 42 USC 201.

PNMI: Medicaid Private Non-Medical Institute services.

PROGRAM ADMINISTRATOR: Herb Downs, Director of Audit, or his designee will manage the RAC contract.

RAC: Medicaid Recovery Audit Contractor program.

A. AUDITS OUTSIDE THE SCOPE OF THIS AGREEMENT

1. The Contractor will not review the following claims: reviews of claims conducted by the Department's Program Integrity Unit; reviews conducted by the Department's Division of Audit; reviews by the State Auditor's Office; reviews by the Medicaid Fraud Control Unit (MFCU); reviews by the Centers for Medicaid and Medicare Services; reviews by the Office of the Inspector General (OIG); criminal investigations, provided the data is given to the Contractor by the Department.
2. The Contractor will not review claims or conduct reviews duplicative of reviews done in connection with DHHS Agreement Number: OMS-12-902, effective May 19, 2011, between the Department and Health Management Systems, Inc., or any successor contract. If a successor is named, the Department and/or the successor contractor shall submit the case review information to the Contractor.
3. The following types of claims and payments are excluded from this Agreement:
 - a. Claims and payments previously audited, or currently being audited by a different entity;
 - b. Claims and payments subject to criminal or civil recovery actions.

4. The Contractor shall not attempt recoupment from a MaineCare recipient ("member"). The Contractor is not authorized to contact or speak to a MaineCare recipient without prior written approval of the Department.

B. DEPARTMENT WRITTEN PRIOR APPROVAL REQUIRED

1. The Contractor shall not initiate any overpayment or underpayment audit or review, any kind of correspondence, send demand letters or begin recovery activities without the prior review and written approval of the Program Administrator.
2. The Contractor shall not compromise or waive any claims without the Department's prior written approval.
3. The Contractor shall not alter, change, forgive or excuse any written delivered demand for overpayment without the prior written approval of the Program Administrator.
4. The Contractor shall not compromise, release and/or settle an identified or possible overpayment without the prior written approval of the Program Administrator.
5. The Contractor shall obtain Program Administrator prior written approval before giving any response, whether written or oral, to providers regarding the outcomes of audits or final overpayment determination.
6. Contractor will cease activity regarding, and pursuit of, an audit, complaint or other project at any time upon the signed written direction of the Program Administrator. Contractor shall not receive any payment for audits or projects that it has been directed by the Program Administrator to cease activity regarding or pursuit of an audit, complaint or other project, regardless of the progress of the audit, complaint or project.

C. DATA BASE OF PROVIDER CONTACTS, PROGRESS OF AUDIT AND STATUS OF CASE

1. The Contractor shall create and maintain a database of provider contact information to properly address all provider correspondence to the individuals the providers themselves identify.
2. The Contractor shall develop and maintain a secure provider web portal to allow providers to view the claim detail and respond to their audits, obtain Contractor contact information, view and download various RAC project related letters, and to customize their addresses.
3. Status of Case: The Contractor shall make available to providers upon request information about the status of a Medical Record Review Project or Credit Balance Review Project – outstanding, received, review underway, review complete, case closed.

D. SCOPE OF OVERPAYMENT RECOVERY

1. The Contractor shall analyze and review Medicaid claims and CHIP claims, from all provider types, except as described in subsection A above. All audits are subject to prior written approval by the Department, as described herein.
2. The Contractor shall identify overpayments due to incorrect billing, processing errors or due to fraud, waste and abuse. The Department acknowledges that not all overpayments are due to fraud, waste and abuse by providers.
3. The Contractor shall analyze and review claims for Medicaid and CHIP, from all provider types, to identify overpayments due to incorrect billing, processing errors or due to fraud, waste and abuse as authorized by the Department.
4. The Contractor shall identify and recover credit balances, representing Medicaid overpayments to hospitals and other provider types, as prior approved by the Department. Examples of activities that may result in credit balance overpayments include, but are not limited to:
 - a) Duplicate payments;
 - b) Payments by third party payors;
 - c) Data entry errors; and
 - d) Incorrect edits or overrides in electronic filing.
5. The Contractor shall investigate other provider types, or specifically identified providers, for credit balances, when requested to do so by the Department.
6. MaineCare overpayments may include but are not limited to any of the following:
 - a) Fraud, waste and abuse;
 - b) Erroneous payment amounts for any covered service;
 - c) Payment for any non-medically necessary service;
 - d) Payment for any non-covered service;
 - e) Payment for any non-covered individuals (e.g. illegal aliens);
 - f) Payment where the provider is deceased or out of business;
 - g) Payments where the provider was not appropriately licensed at the time it was providing the service;
 - h) Payments where the provider and or provider subcontractors were not MaineCare providers at the time the service was delivered;
 - i) Payment made for an otherwise covered member, but temporarily ineligible for MaineCare services (e.g. member is residing in an IMD);
 - j) Incorrectly coded services;
 - k) Duplicate services;
 - l) Payments associated with claims made more than 120 days from the date of service (e.g. the timely filing period);
 - m) Payments made that should have been covered by a nursing facility provider, or a hospital provider, or an ICF-MR provider, or another State;
 - n) Duplicate payments;
 - o) Payments that should have been paid by third party payors, including Medicare;
 - p) Incorrect edits or overrides in electronic filing.

E. IDENTIFICATION NOTICE AND RECOVERY OF OVERPAYMENTS

1. The Department will send a paid claims file that includes accounting strings to the Contractor to audit for overpayments and underpayments.
2. The Contractor will audit and make findings and draft a Notice of Violation letter, along with spreadsheets and detail sheets, to Program Administrator or designee for approval. The spreadsheets will include all information required by the Department including columns of paid amounts, corrected paid amounts and overpayments due. Once approved by the Department, the Contractor will send the Notice of Violation letter and documentation to the provider, with a copy to the Program Administrator or designee. All correspondence and letters to providers will be sent certified mail. Additionally, a copy will be sent to DHHS, Financial Services.
3. Contractor will resolve all issues regarding the audit prior to referring provider to Financial Services for payment arrangements. All payment options, requests for offset and collections will be conducted by Financial Services.

If the Contractor receives any checks directly from the provider, the Contractor will immediately forward the checks to Financial Services and include an invoice with supporting detail for each check.

4. The Notice of Violation letter will contain the payment alternatives available to the provider, as well as the option to appeal the Notice of Violation, and will be consistent with 22 MRSA 1714-A. The Notice of Violation pattern letters will be prior approved by the Department.
5. If provider chooses to appeal the Notice of Violation, its appeal will follow the procedures set forth in the MaineCare Benefits Manual, Chapter I, Section 1.

F. PROVIDER APPEALS OF IDENTIFICATION OF OVERPAYMENTS

1. Contractor will provide the appropriate staff for testimony including, but not limited to, depositions and attendance at administrative and court hearing.
2. Contractor's staff will fully cooperate with the Program Administrator and legal counsel representing the Department by participating in the preparation of testimony, exhibits and development of arguments for administrative and court hearings, or for any other resolution process.
3. Contractor will timely provide to the Program Administrator and legal counsel representing the Department access to all pertinent books, documents, data files, papers and records related to this Agreement and services, including any audit, provided hereunder, at no expense to the Department.
4. All Notice of Violation letters will clearly identify the appropriate Contractor staff, and provide a viable telephone number, as the contact person for questions concerning the audit findings.

5. Contractor will immediately inform the Program Administrator upon any request for informal review (appeal) of the audit findings that it receives from providers and provide a copy of the informal review request along with all supplemental material submitted. Contractor will prepare an Informal Review Acknowledgment letter template for the Department's Program Integrity Manager's signature in accordance with Chapter XII of the Maine PI Procedures and Processes Manual at no additional cost to the Department. Contractor's staff will review all information submitted by the provider and prepare a report or presentation in a format or manner as requested by the Program Administrator or his/her designee assigned to conduct the Department's informal review, for his/her signature of the Final Informal Review Decision.
6. If a provider appeals the Final Informal Review Decision and requests an administrative hearing, the Contractor will immediately inform the Program Administrator of the request for an Administrative Hearing (appeal) of the audit findings that it receives from providers and provide a copy of such request. If a provider requests an Administrative Hearing, Contractor will comply with the process described in Chapter XIII of the Maine PI Procedures and Processes Manual, including the completion of the Fair Hearing Report Form and preparation of four complete exhibit books for use at the hearing at no additional charge to the Department. Contractor will prepare the exhibit books to the satisfaction of the Program Administrator and legal counsel representing the Department.

G. UNDERPAYMENT IDENTIFICATION

1. An underpayment is defined as a claim line that was paid at a lesser amount than allowed by MaineCare and the provider is owed money. If the provider's usual and customary fee is less than the MaineCare allowed amount that is not considered an underpayment. Examples of an underpayment would be: a claims processing system error where the system adjudicated the claim incorrectly and underpaid the provider; another example would be the Department did not have the correct/current payment amount in place for the date of service and the provider was paid an incorrect amount. The Department will send a paid claims file that includes accounting strings to the Contractor to audit for underpayments.
2. The definition of underpayment does not include situations where the provider has used an incorrect procedure code or when the provider erroneously bills for a lower level of service. The Department does not instruct providers on which codes to bill. If a provider neglects to submit a claim or additional claim lines and the time limit for submitting claims has gone by, the Department will not reimburse providers for omissions/errors made by the provider. If the provider bills at a lower unit amount, the Department will not reimburse for the unbilled units.
3. Reimbursement of underpayments will only be made when the Department or the claims processing system is responsible for the error that resulted in the provider being underpaid. Underpayments will only be paid within the timeline allowances as set forth in the MaineCare Benefits Manual, Chapter I, Section 1.
4. The Contractor will send reports of underpayments identified to the Program Administrator monthly. The Program Administrator will report back to the Contractor as to which, if any, underpayment identifications have been approved.

Once approved, the Contractor will send an underpayment letter to the provider, with a copy to the Program Administrator.

H. ONGOING DELIVERABLES

Customer Service Measures:

1. Contractor shall provide a contact person(s) to be available to the Department Monday through Friday, 8:00 a.m. to 5:00 p.m. Eastern Standard Time.
2. Contractor will provide a toll-free customer service telephone number in all correspondence sent to providers and shall staff the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. Eastern Standard Time.
3. Contractor shall receive provider data from the MMIS vendor and/or State and maintain provider approved addresses and points of contact based on information from State, MMIS vendor and/or provider.
4. Contractor shall accept submissions of electronic medical records on CD/DVD or via facsimile at the providers' request.
5. Contractor shall notify providers of overpayment findings within 60 calendar days.
6. Contractor, in cooperation with the Department, will develop an education and outreach program for providers, which shall include notification to providers of audit policies and protocols. Such program will be developed and functional within sixty (60) days from the start of performance of this Agreement.

Contractor Responsibilities:

1. Per CMS requirements, Contractor will employ at a minimum one full-time-equivalent Contractor Medical Director assigned to the scope of work within this Agreement who is a Maine-licensed Doctor of Medicine or Doctor of Osteopathy in good standing with the applicable Maine licensing authority and has relevant work and educational experience. The Department will submit a written request for an exception to this requirement to allow Contractor to employ a part-time Medical Director (as needed to complete medical reviews). This exception will become effective upon CMS approval.
2. Contractor will employ for the scope of work within this Agreement certified coders for the review of MaineCare claims.
3. Contractor will demonstrate to the satisfaction of the Program Administrator, at his or her written request at any time during this Agreement, that it maintains the technical capability to carry out all activities within the scope of this Agreement consistent with the requirements set forth in 42 CFR Part 455(F).
4. Contractor will provide other sufficient and appropriate staffing to carry out all activities within the scope of this Agreement and at all times shall utilize appropriately licensed and certified professionals as required to conduct audits of

services delivered by a diverse group of health care providers. Professionals shall be at all times in good standing with the appropriate Maine licensing authority.

5. Contractor will utilize a methodology, process and/or computerized fraud and abuse software tool by which it will identify providers or issues that it proposes to audit.

Other:

1. Contractor will bring any work determined by the Department to be non-compliant with this Agreement or related specifications into conformance within five (5) working days of written notice by the Program Administrator or Agreement Administrator, at no expense to the State.
2. Contractor will provide appropriately knowledgeable staff to attend meetings with the Department's staff and other State or Federal agencies as determined by the Department to discuss and interpret results of reports produced by the Contractor. Contractor will participate in meetings regularly scheduled or upon reasonable notice by the Program Administrator or his/her designee.
3. Contractor will submit to the Department a detailed overview, with supporting documentation, to justify each proposed audit. Contractor must obtain signed written approval of the Program Administrator for each audit on a case-by-case basis prior to Contractor starting the audit process with any provider. The Department has sole discretion in whether to grant approval of an audit of overpayment or underpayment. Upon receipt of the Program Administrator's written approval, Contractor shall audit provider claims.
4. Contractor will audit a provider(s) or issue(s) whenever so directed in writing by the Program Administrator. Such direction will consist of a Department-designed referral form signed by the Program Administrator that will include, at a minimum: the provider(s) name, MaineCare provider number(s) and/or NPI(s), and/or the issue to be audited, the dates of service range to be reviewed, the MaineCare claims data, and the appropriate MaineCare Benefits Manual section. Contractor will initiate an audit within 30 days of receipt of a referral.
5. Contractor will investigate overpayment related complaints regarding a provider, referred in writing by the Program Administrator, within 60 days and report its findings in writing to the Program Administrator in a format and with a scope of content approved by the Program Administrator. The Department and Contractor will review the findings to determine if an audit is justified and will determine the scope and approach of the audit. Contractor will perform a maximum of five (5) on-site audits quarterly, at the provider's business location upon written request by the Program Administrator.
6. Contractor will limit its audits to the five (5)-year time frame that providers are required to maintain records designated in the MaineCare Benefits Manual, Chapter I, Section 1.03-3 (available at <http://www.maine.gov/sos/cec/rules/10/ch101.htm>) - or a shorter timeframe as directed in a signed writing by the Program Administrator.
7. The Contractor may not review claims that are older than 3 years from the date of the claim, unless Contractor receives prior written approval by the Department.

8. Pattern Letters. The Contractor shall draft, submit to Program Administrator for approval the following pattern letters:
 - a. Introductory letters notifying providers about the contractual relationship between the Contractor and the Department; about provider expectation; general audit processes, etc.
 - b. Initial underpayment letter, associated spreadsheet and detail sheets; and
 - c. Notice of Violation letter for initial overpayment letter, associated spreadsheet and detail sheets. The Notice of Violation letter will comply with all requirements set forth in 22 MRSA 1714-A.

The Department will supply the Contractor with content requirements and guidance for all pattern letters.

Pattern letters may not be sent out to providers without the prior approval of the Department.

The Contractor shall, without objection, modify and edit pattern letters within 10 business days of the Department's request.

I. CONTRACT EXPIRATION – TRANSITION PLANNING

1. Within 15 days prior to the expiration of the term of this Agreement, Contractor will make available to the Department the opportunity to be briefed by the Contractor on any ongoing audits, projects and other activities that may not be completed prior to the expiration. If this Agreement is terminated other than upon expiration of the term, Contractor shall brief the Department on ongoing audits, projects and other activities within 15 days after the termination date.
2. Contractor will turn over to the Department all records of audits, projects and other activities involving providers that were initiated within the scope of this Agreement, and reports, schedules, queries and data generated from MaineCare paid claims or any other MaineCare information, within 10 business days after either the expiration or termination of this Agreement.

J. COORDINATION OF CONTRACTOR AUDIT RESPONSIBILITIES WITH OTHER CONTRACTORS FOR THE DEPARTMENT AND WITH FEDERAL AND STATE AGENCIES, INCLUDING THE STATE MEDICAID FRAUD CONTROL UNIT (MFCU).

1. The Contractor shall coordinate with the assistance of the Department the recovery audit efforts with other contractors or entities performing audits of MaineCare providers, including coordinating with Federal and State law enforcement, the Federal Bureau of Investigation, the Office of Inspector General of the U.S. Department of Health and Human Services, the Federal Bureau of Investigation, the Federal Centers for Medicare and Medicaid Services, the State Medicaid Fraud Control Unit, the Maine DHHS Division of Audit, the Maine DHHS Program Integrity Unit, the Maine Office of OPEGA, and the Maine State Auditor's office.

2. Whenever the Contractor has reasonable grounds to believe that fraud or criminal activity has occurred, the Contractor must report it immediately, in writing, within two business days, to the Program Administrator and to the Program Integrity Unit. Contractor will report the identification of the person or entity, provider NPI number or MaineCare ID and a written statement describing the nature and details of the fraud and abuse allegation. Contractor will immediately cease its related audit activities if requested by the Maine Attorney General's Office Healthcare Crimes Unit (Medicaid Fraud Control Unit) or by any other state or federal law enforcement unit, i.e., Office of Inspector General, U.S. Department of Justice, that elects to conduct an active investigation against a provider. Contractor will fully cooperate with any such investigation without condition and without cost to the Department.

K. DEPARTMENT DUTIES AND OBLIGATIONS

The Department will:

1. Provide Contractor with the website links to current provider bulletins, publications, policies, reimbursement rate websites, MaineCare Benefit regulations, MaineCare Eligibility Manual, and shall timely provide Contractor with copies of older versions upon request;
2. Facilitate information exchange between Contractor and the State's Medicaid fiscal agent about the MMIS data and its meanings;
3. Interpret MaineCare laws, policies, procedure bulletins and publications, as needed;
4. Assign and dedicate a Program Integrity staff person to coordinate all activities between Contractor and the Department;
5. Timely review all draft documents submitted by Contractor, by approving, denying, rewriting or requiring revisions;
6. Timely notify Contractor of all formal appeals and informal reconsideration requests;
7. Provide legal representation on behalf of Department during the provider appeal process of provider appeals of Contractor's identification of overpayments;
8. Provide help communicating and coordinating with other contractors and entities performing audits of providers;
9. Coordinate activities and interactions with Federal and State law enforcement, the Department of Justice, including the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the State Medicaid Fraud Control Unit;
10. Help Contractor identify associations, provider groups and other entities for provider outreach;
11. Notify Contractor of payments received, offsets taken and adjustments made.

RIDER "B"

METHOD OF PAYMENT AND OTHER PROVISIONS

1. **AGREEMENT AMOUNT.** The maximum amount payable under this Agreement to Contractor by the Department shall be at 10.85 % (percent) contingency fee rate for overpayments recovered and underpayments identified as set forth in this Agreement. Contractor is not due a contingency fee for payments or setoffs made more than one year from the expiration or termination of this Agreement.

Pursuant to the RAC federal regulations, 42 C.F.R. § 455.510(4), the contingency fee paid to Contractor may not exceed that of the highest Medicare RAC Contractor, as specified by the Centers for Medicare and Medicaid (CMS) in the Federal Register. If, during the time period of this Agreement, the maximum contingency fee percentage rate decreases below 10.85%, the Agreement's contingency fee percentage rate will decrease to the new Federal maximum percentage, on the effective date of the Medicare RAC Contractor contingency fee rate. (i.e., if the Federal maximum percentage rate drops to 10.00%, then this Agreement's contingency fee percentage rate will be decreased to 10.00%).

All costs incurred by Contractor associated with the performance of this Agreement, including travel, are solely the responsibility of the Contractor and shall be borne entirely by the Contractor regardless of whether any funds are actually recovered.

Payment to the Contractor for identification of underpayments and identification and recovery of overpayments, shall not exceed the total amount of overpayments recovered.

2. **INVOICES AND PAYMENT.** The Department will pay the Contractor as follows:

a. Invoices

Contractor shall submit invoices to the State on a monthly basis listing all contingent fees estimated to be owed to Contractor by the Department as a result of Contractor's audits and/or all overpayments, and/or underpayments that have been deemed by the Department to be reimbursable. The invoices will include a detailed report listing actual funds received by the State as a result of the Contractor's audits and/or underpayments that have been deemed as reimbursable. The Department will respond monthly with a reconciliation of Contractor's monthly invoice.

b. Payment

Underpayments: Payment for underpayments identified, after approval by the Department, will be paid within 30 days of receipt of the invoice, or such later time as determined by the Department, in order to comply with the federal requirement that the total payment to the Contractor does not exceed the total amount of overpayments recovered.

Overpayments: Payment for recovery of overpayments will be calculated and paid monthly based on overpayments received in that month from overpayment checks from providers and also from offsets made in that month to pay down the overpayment.

3. **BENEFITS AND DEDUCTIONS.** If the Contractor is an individual, the Contractor understands and agrees that he/she is an independent Contractor for whom no Federal or State Income Tax will be deducted by the Department, and for whom no retirement benefits, survivor benefit insurance, group life insurance, vacation and sick leave, and similar benefits available to State employees will accrue. The Contractor further understands that annual information returns, as required by the Internal Revenue Code or State of Maine Income Tax Law, will be filed by the State Controller with the Internal Revenue Service and the State of Maine Bureau of Revenue Services, copies of which will be furnished to the Contractor for his/her Income Tax records.

4. **INDEPENDENT CAPACITY.** In the performance of this Agreement, the parties hereto agree that the Contractor, and any agents and employees of the Contractor, shall act in the capacity of an independent Contractor and not as officers or employees or agents of the State.

5. **DEPARTMENT'S REPRESENTATIVE.** The Agreement Administrator shall be the Department's representative during the period of this Agreement. He/she has authority to curtail services if necessary to ensure proper execution. He/she shall certify to the Department when payments under the Agreement are due and the amounts to be paid. He/she shall make decisions on all claims of the Contractor, subject to the approval of the Commissioner of the Department.

6. **AGREEMENT ADMINISTRATOR.** All progress reports, correspondence and related submissions from the Contractor shall be submitted to:

Name and Title: Thomas Collins, Agreement Administrator
Address: DHHS-DPS, 221 State Street, SHS 11, Augusta, ME
04333
Telephone: (207) 287-8619
E-mail Address: thomas.collins@maine.gov

who is designated as the Agreement Administrator on behalf of the Department for this Agreement, except where specified otherwise in this Agreement.

The following is designated as the Program Administrator for this Agreement and shall be responsible for oversight of the programmatic aspects of this Agreement. A designee of the Program Administrator may act in place of the Program Administrator.

Name and Title: Herbert Downs, Director, Division of Audit
Address: DHHS-Audit and Program Integrity, 442 Civic Center
Drive, SHS 11, Augusta, ME 04333
Telephone: (207) 287-2778
E-mail Address: Herb.F.Downs@maine.gov

7. **CHANGES IN THE WORK.** The Department may order changes in the work, the Agreement Amount being adjusted accordingly. Any monetary adjustment or any substantive change in the work shall be in the form of an amendment, signed by both parties and approved by the State Purchases Review Committee. Said amendment must be effective prior to execution of the work.

8. **SUB-AGREEMENTS.** Unless provided for in this Agreement, no arrangement shall be made by the Contractor with any other party for furnishing any of the services herein contracted for without the consent and approval of the Agreement Administrator. Any sub-agreement hereunder entered into subsequent to the execution of this Agreement must be annotated "approved" by the Agreement Administrator before it is reimbursable hereunder. This provision will not be taken as requiring the approval of contracts of employment between the Contractor and its employees assigned for services thereunder.

9. **SUBLETTING, ASSIGNMENT OR TRANSFER.** The Contractor shall not sublet, sell, transfer, assign or otherwise dispose of this Agreement or any portion thereof, or of its right, title or interest therein, without written request to and written consent of the Agreement Administrator. No subcontracts or transfer of agreement shall in any case release the Contractor of its liability under this Agreement.

10. **EQUAL EMPLOYMENT OPPORTUNITY.** During the performance of this Agreement, the Contractor agrees as follows:

- a. The Contractor shall not discriminate against any employee or applicant for employment relating to this Agreement because of race, color, religious creed, sex, national origin, ancestry, age, physical or mental disability, or sexual orientation, unless related to a bona fide occupational qualification. The Contractor shall take affirmative action to ensure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age, national origin, physical or mental disability, or sexual orientation.

Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Contractor agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

- b. The Contractor shall, in all solicitations or advertising for employees placed by or on behalf of the Contractor relating to this Agreement, state that all qualified applicants shall receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age, physical or mental disability, or sexual orientation.
- c. The Contractor shall send to each labor union or representative of the workers with which it has a collective bargaining agreement, or other agreement or understanding, whereby it is furnished with labor for the performance of this Agreement a notice to be provided by the contracting agency, advising the said

labor union or workers' representative of the Contractor's commitment under this section and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

- d. The Contractor shall inform the contracting Department's Equal Employment Opportunity Coordinator of any discrimination complaints brought to an external regulatory body (Maine Human Rights Commission, EEOC, Office of Civil Rights) against their agency by any individual as well as any lawsuit regarding alleged discriminatory practice.
- e. The Contractor shall comply with all aspects of the Americans with Disabilities Act (ADA) in employment and in the provision of service to include accessibility and reasonable accommodations for employees and clients.
- f. Contractors and subcontractors with contracts in excess of \$50,000 shall also pursue in good faith affirmative action programs.
- g. The Contractor shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

11. **EMPLOYMENT AND PERSONNEL.** The Contractor shall not engage any person in the employ of any State Department or Agency in a position that would constitute a violation of 5 M.R.S.A. § 18 or 17 M.R.S.A. § 3114. The Contractor shall not engage on a full-time, part-time or other basis during the period of this Agreement, any other personnel who are or have been at any time during the period of this Agreement in the employ of any State Department or Agency, except regularly retired employees, without the written consent of the State Purchases Review Committee. Further, the Contractor shall not engage on this project on a full-time, part-time or other basis during the period of this Agreement any retired employee of the Department who has not been retired for at least one year, without the written consent of the State Purchases Review Committee. The Contractor shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

12. **STATE EMPLOYEES NOT TO BENEFIT.** No individual employed by the State at the time this Agreement is executed or any time thereafter shall be admitted to any share or part of this Agreement or to any benefit that might arise there from directly or indirectly that would constitute a violation of 5 M.R.S.A. § 18 or 17 M.R.S.A. § 3114. No other individual employed by the State at the time this Agreement is executed or any time thereafter shall be admitted to any share or part of this Agreement or to any benefit that might arise there from directly or indirectly due to his employment by or financial interest in the Contractor or any affiliate of the Contractor, without the written consent of the State Purchases Review Committee. The Contractor shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

13. **WARRANTY**. The Contractor warrants that it has not employed or contracted with any company or person, other than for assistance with the normal study and preparation of a proposal, to solicit or secure this Agreement and that it has not paid, or agreed to pay, any company or person, other than a bona fide employee working for the Contractor, any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this Agreement. For breach or violation of this warranty, the Department shall have the right to annul this Agreement without liability or, in its discretion to otherwise recover the full amount of such fee, commission, percentage, brokerage fee, gift, or contingent fee.

14. **ACCESS TO RECORDS**. The Contractor shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to this Agreement and make such materials available at its offices at all reasonable times during the period of this Agreement. The Contractor shall allow inspection of pertinent documents by the Department or any authorized representative of the State of Maine or Federal Government, and shall furnish copies thereof, if requested.

15. **TERMINATION**. The performance of work under the Agreement may be terminated by the Department in whole, or in part, whenever for any reason the Agreement Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Contractor of a Notice of Termination specifying the extent to which performance of the work under the Agreement is terminated and the date on which such termination becomes effective. The Agreement shall be equitably adjusted to compensate for such termination, and modified accordingly.

16. **GOVERNMENTAL REQUIREMENTS**. The Contractor warrants and represents that it will comply with all governmental ordinances, laws and regulations.

17. **GOVERNING LAW**. This Agreement shall be governed in all respects by the laws, statutes, and regulations of the United States of America and of the State of Maine. Any legal proceeding against the State regarding this Agreement shall be brought in State of Maine administrative or judicial forums. The Contractor consents to personal jurisdiction in the State of Maine.

18. **STATE HELD HARMLESS**. The Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims, costs, expenses, injuries, liabilities, losses and damages of every kind and description (hereinafter in this paragraph referred to as "claims") resulting from or arising out of the performance of this Agreement by the Contractor, its employees, agents, or subcontractors. Claims to which this indemnification applies include, without limitation, the following: (i) claims suffered or incurred by any Contractor, subcontractor, material man, laborer and any other person, firm, corporation or other legal entity (hereinafter in this paragraph referred to as "person") providing work, services, materials, equipment or supplies in connection with the performance of this Agreement; (ii) claims arising out of a violation or infringement of any proprietary right, copyright, trademark, right of privacy or other right arising out of publication, translation, development, reproduction, delivery, use, or disposition of any data, information or other matter furnished or used in connection with this Agreement; (iii) claims arising out of a libelous or other unlawful matter used or developed in connection with this Agreement; (iv) claims suffered or

incurred by any person who may be otherwise injured or damaged in the performance of this Agreement; and (v) all legal costs and other expenses of defense against any asserted claims to which this indemnification applies. This indemnification does not extend to a claim that results solely and directly from (i) the Department's negligence or unlawful act, or (ii) action by the Contractor taken in reasonable reliance upon an instruction or direction given by an authorized person acting on behalf of the Department in accordance with this Agreement.

19. **NOTICE OF CLAIMS.** The Contractor shall give the Contract Administrator immediate notice in writing of any legal action or suit filed that is related in any way to the Agreement or which may affect the performance of duties under the Agreement, and prompt notice of any claim made against the Contractor by any subcontractor which may result in litigation related in any way to the Agreement or which may affect the performance of duties under the Agreement.

20. **APPROVAL.** This Agreement must have the approval of the State Controller and the State Purchases Review Committee before it can be considered a valid, enforceable document.

21. **LIABILITY INSURANCE.** The Contractor shall keep in force a liability policy issued by a company fully licensed or designated as an eligible surplus line insurer to do business in this State by the Maine Department of Professional & Financial Regulation, Bureau of Insurance, which policy includes the activity to be covered by this Agreement with adequate liability coverage to protect itself and the Department from suits. Contractors insured through a "risk retention group" insurer prior to July 1, 1991, may continue under that arrangement. Prior to or upon execution of this Agreement, the Contractor shall furnish the Department with written or photocopied verification of the existence of such liability insurance policy.

22. **NON-APPROPRIATION.** Notwithstanding any other provision of this Agreement, if the State does not receive sufficient funds to fund this Agreement and other obligations of the State, if funds are de-appropriated, or if the State does not receive legal authority to expend funds from the Maine State Legislature or Maine courts, then the State is not obligated to make payment under this Agreement.

23. **SEVERABILITY.** The invalidity or unenforceability of any particular provision, or part thereof, of this Agreement shall not affect the remainder of said provision or any other provisions, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision or part thereof had been omitted.

24. **INTEGRATION.** All terms of this Agreement are to be interpreted in such a way as to be consistent at all times with the terms of Rider B (except for expressed exceptions to Rider B included in Rider C), followed in precedence by Rider A, and any remaining Riders in alphabetical order.

25. **FORCE MAJEURE.** The Department may, at its discretion, excuse the performance of an obligation by a party under this Agreement in the event that performance of that obligation by that party is prevented by an act of God, act of war, riot, fire, explosion, flood or other catastrophe, sabotage, severe shortage of fuel, power or raw materials, change in law, court order, national defense requirement, or strike or labor dispute, provided that any such event and the delay caused thereby is beyond the control of,

and could not reasonably be avoided by, that party. The Department may, at its discretion, extend the time period for performance of the obligation excused under this section by the period of the excused delay together with a reasonable period to reinstate compliance with the terms of this Agreement.

26. **SET-OFF RIGHTS.** The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any monies due to the Contractor under this Agreement up to any amounts due and owing to the State with regard to this Agreement, any other Agreement, any other Agreement with any State department or agency, including any Agreement for a term commencing prior to the term of this Agreement, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Controller.

27. **ENTIRE AGREEMENT.** This document contains the entire Agreement of the parties, and neither party shall be bound by any statement or representation not contained herein. No waiver shall be deemed to have been made by any of the parties unless expressed in writing and signed by the waiving party. The parties expressly agree that they shall not assert in any action relating to the Agreement that any implied waiver occurred between the parties which is not expressed in writing. The failure of any party to insist in any one or more instances upon strict performance of any of the terms or provisions of the Agreement, or to exercise an option or election under the Agreement, shall not be construed as a waiver or relinquishment for the future of such terms, provisions, option or election, but the same shall continue in full force and effect, and no waiver by any party of any one or more of its rights or remedies under the Agreement shall be deemed to be a waiver of any prior or subsequent rights or remedy under the Agreement or at law.

RIDER C
EXCEPTIONS TO RIDER B

No exceptions to Rider B are included in this contract, other than:

1. The term "Contractor" has been substituted for "provider" in Rider B for purposes of clarity and consistency with Rider A, and,
2. The Program Administrator for the Department may identify a designee to act on the Program Administrator's behalf.

Rider D Additional Requirements

1. Confidentiality.

Contractor shall comply with the provisions of this provision if it becomes privy to confidential information in connection with its performance hereunder. Confidential information includes, but is not necessarily limited to, any state records, personnel records, and protected health information of any individuals.

A. Confidentiality

Contractor shall keep all State records and information confidential at all times and will comply with all laws and regulations concerning confidentiality of information. Any request or demand by a third party for State records or any other confidential information in the possession of Contractor shall be immediately forwarded to the Program Administrator.

B. Health Insurance Portability & Accountability Act of 1996 ("HIPAA")

i. Federal Law and Regulations

Pursuant to federal law and regulations governing the privacy of certain health information, the Contractor, to the extent applicable, shall comply with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d – 1320d-8 ("HIPAA") and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160 and 164 (the "Privacy Rule") and other applicable laws, as amended.

ii. Business Associate Agreement

Federal law and regulations governing the privacy of certain health information requires a "Business Associate Agreement" between the Department and the Contractor. 45 C.F.R. § 164.504(e). Attached as Attachment 1 to Rider A, and incorporated herein by reference and agreed to by the parties is a HIPAA Business Associate Agreement for HIPAA compliance. Terms of the Business Associate Agreement shall be considered binding upon execution of this Agreement and shall remain in effect during the term of the Agreement including any extensions.

iii. Confidentiality of Records

The Contractor shall protect the confidentiality of all records and other materials containing personally identifying information that are maintained in accordance with the Agreement and comply with HIPAA rules and regulations. Except as provided by law, no information in possession of the Contractor about any individual constituent shall be disclosed in a form including identifying information without the prior written consent of the person in interest, a minor's parent or guardian. The Contractor shall have written policies governing access to,

duplication and dissemination of all such information. The Contractor shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. The Contractor shall provide its employees, agent and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted. No confidentiality requirements contained in this Agreement shall negate or supersede the provisions of HIPAA.

2. Lobbying. No Federal or State appropriated funds shall be expended by the Contractor for influencing or attempting to influence, as prohibited by state or federal law, an officer or employee of any Federal or State agency, a member of Congress or a State Legislature, or an officer or employee of Congress or a State Legislature in connection with any of the following covered actions: the awarding of any agreement; the making of any grant; the entering into any cooperative agreement; or the extension, continuation, renewal, amendment, or modification of any agreement, grant, or cooperative agreement. The signing of this Agreement fulfills the requirement that contractors receiving over \$100,000 in Federal or State funds file with the Department with respect to this provision. If any other funds have been or will be paid to any person in connection with any of the covered actions specified in this provision, the Contractor shall complete and submit a "Disclosure of Lobbying Activities" form available at <http://www.whitehouse.gov/omb/grants/#forms>.

3. Drug-Free Workplace. By signing this agreement, the Contractor certifies that it shall provide a drug-free workplace by: publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition; establishing a drug-free awareness program to inform employees about the dangers of drug abuse in the workplace, the Contractor's policy of maintaining a drug-free workplace, available drug counseling and rehabilitation programs, employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; providing a copy of the drug-free workplace statement to each employee to be engaged in the performance of this agreement; notifying the employees that as a condition of employment under the agreement the employee will abide by the terms of the statement and notify the employer of any criminal drug conviction for a violation occurring in the workplace no later than five days after such conviction.

The Contractor shall notify the state agency within ten days after receiving notice of criminal drug convictions occurring in the workplace from an employee, or otherwise receiving actual notice of such conviction, and will take one of the following actions within 30 days of receiving such notice with respect to any employee who is so convicted: take appropriate personnel action against the employee, up to and including termination, or requiring the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

4. Debarment and Suspension. By signing this agreement, the Contractor certifies to the best of its knowledge and belief that it and all persons associated with the agreement, including persons or corporations who have critical influence on or control over the agreement, are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation by any federal department or agency.

The Contractor further agrees that the Debarment and Suspension Provision shall be included, without modification, in all sub-agreements.

5. Environment Tobacco Smoke. By signing this agreement, the Contractor certifies that it shall comply with the Pro-Children Act of 1994, P.L. 103-227, Part C, which requires that smoking not be permitted in any portion of any indoor facility owned, leased, or contracted for or by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments by Federal grant, Agreement, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or MaineCare funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

Also, the provider of foster care services agrees that it will comply with Resolve 2003, c. 134, which prohibits smoking in the homes and vehicles operated by foster parents.

6. Medicare and MaineCare Anti-Kickback. By signing this agreement, the Contractor agrees that it shall comply with the dictates of 42 U.S.C. 1320a-7(b), which prohibits the solicitation or receipt of any direct or indirect remuneration in return for referring or arranging for the referral of an individual to a provider of goods or services that may be paid for with Medicare, MaineCare, or state health program funds.
<http://www.gpoaccess.gov/uscode/index.html>

7. Publications. When issuing reports, brochures, or other documents describing programs funded in whole or in part with funds provided through this agreement, the Contractor agrees to clearly acknowledge the participation of the Department of Health and Human Services in the program. In addition, when issuing press releases and requests for proposals, the Contractor shall clearly state the percentage of the total cost of the project or program to be financed with agreement funds and the dollar amount of agreement funds for the project or program.

8. Ownership. All notebooks, plans, working papers, or other work produced in the performance of this Agreement that are related to specific deliverables under this Agreement, are the property of the Department and upon request shall be turned over to the Department.

9. Software Ownership. Upon request, the State and all appropriate federal agencies shall receive a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to do so, all application software created and produced exclusively and specifically for the performance of this Agreement, including, but not limited to, all source, object, and executable code, data files, and job control language, or other system instructions. This requirement applies only to software that is a specific deliverable under this Agreement, and is primarily financed with funding provided under this Agreement.

10. Contractor Responsibilities/Sub-agreements. The Contractor is solely responsible for fulfillment of this Agreement with the Department. The Contractor

assumes responsibility for all services offered and products to be delivered whether or not the Contractor is the manufacturer or producer of said services.

a. Sub-agreements

1. All sub-agreements must contain the assurances enumerated in Sections 10, 11, and 12 of Rider B and Sections 4, 5, 6, 7 of Rider D;
2. All sub-agreements must be signed and delivered to the Department's Agreement Administrator within five (5) business days following the execution date of the sub-agreement.
3. See Rider B Section 8.

b. Relationship between Contractor, Subcontractor and Department: The provider shall be wholly responsible for performance of the entire agreement whether or not subcontractors are used. Any sub-agreement into which the Contractor enters with respect to performance under this Agreement shall not relieve the Contractor in any way of responsibility for performance of its duties. Further, the Department will consider the Contractor to be the sole point of contact with regard to any matters related to this Agreement, including payment of any and all charges resulting from this Agreement. The Department shall bear no liability for paying the claims of any subcontractors, whether or not those claims are valid.

c. Liability to Subcontractor: The requirement of prior approval of any sub-agreement under this Agreement shall not make the Department a party to any sub-agreement or create any right, claim or interest in the subcontractor or proposed subcontractor against the Department. The Contractor agrees to defend (subject to the approval of the Attorney General) and indemnify and hold harmless the Department against any claim, loss, damage, or liability against the Department based upon the requirements of Rider B, Section 18.

11. Renewals. This Agreement may be renewed at the discretion of the Department.

12. No Rule of Construction. The parties acknowledge that this Agreement was initially prepared by the Department solely as a convenience and that all parties hereto, and their counsel, have read and fully negotiated all the language used in the Agreement. The parties acknowledge that, because all parties and their counsel participated in negotiating and drafting this Agreement, no rule of construction shall apply to this Agreement that construes ambiguous or unclear language in favor of or against any party because such party drafted this Agreement.

13. Conflict of Interest. The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Contractor further covenants that in the performance of this Agreement, no person having any such known interests shall be employed. [See also Rider B, #11 and #12]

RIDER G
IDENTIFICATION OF COUNTRY
IN WHICH CONTRACTED WORK WILL BE PERFORMED

Please identify the country in which the services purchased through this contract will be performed:



United States. Please identify state: Maine, Massachusetts, Connecticut, Texas, Ohio, New York.



Other. Please identify country:

Notification of Changes to the Information
The Contractor agrees to notify the Division of Purchases of any changes to the information provided above.