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

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December 20, 2011

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

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

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

Re: Information provided by the Department of Health and Human Services in response to questions asked at the December 13th briefing on the Supplemental Budget.

DHHS budget shortfall:

Q # 1 Rep. Martin asked for a list of one-time funding needs and how much is required in General Fund and Federal Funds to meet those needs and what the funding needs are for the continuing shortfall.

Response: **See Attachment A**

Q # 2 Rep. Martin asked to see the Deloitte report "Incurred, but not paid."

Response: **See Attachment B**

Q # 3 Rep. Webster asked what MIHMS defects caused claim rejections and carry forwards from FY12 will cause carry forwards to FY13. Rep. Webster asked for the types of providers whose claims are not being paid on a timely basis. He also asked for information on carry forward balances and reasons from the last 5 years and what information was provided to this administration by the prior administration.

Response: DHHS is in the process of compiling this data and will forward once it is complete.

Q # 4 Rep. Webster asked what the assumptions were on enrollment when the FY12 and FY13 budgets were developed.

Response: The key assumptions used for increases in the membership volume consisted of unemployment and poverty rates. MaineCare enrollment started to increase approximately eight months after unemployment started to increase. The poverty rates in Maine started to rise approximately two years after unemployment started to rise. This one to two year lag between

the MaineCare enrollment changes and the unemployment and poverty levels in Maine will result in increasing membership for SFY 2012 and SFY 2013. The State Fiscal Year 2012 and 2013 budget request due-to increased enrollment was based upon the "actual" caseload counts of members through February 2011.

Q # 5 Rep. Martin asked for information on the deadlines imposed by federal CMS for the submission of claims by providers and for payment by DHHS and whether DHHS is paying in a timely manner.

Response: The following is the citation from CMS regarding timely filing of claims.

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42 CFR 447.45(b)(4)(d)
Timely processing of claims. (1) The
Medicaid agency must require providers
to submit all claims no later
than 12 months from the date of service.
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The following information is MaineCare's timely filing requirement in rule:

1.10-2 Time Limits for Submission of Claims

Effective 2/13/11

The following time limits apply unless waived under special circumstances by the Department. Providers have one (1) year from the date services are provided to file a claim correctly with the Department, regardless of when eligibility is verified, except claims for services provided before September 1, 2010 must be filed correctly within one (1) year from the date services are provided or by January 31, 2011, whichever is sooner. Since it is the responsibility of providers to verify eligibility, members may not be billed for covered services that have been denied by the Department for exceeding this time limit for claims submission because the provider did not verify eligibility. The time limit in this paragraph may be exceeded only as follows:

Effective 2/13/11

A. If eligibility for MaineCare is determined after a service is provided, providers have one (1) year from the date that MaineCare eligibility was granted to bill the Department, except that if eligibility was granted before September 1, 2010, the provider must file the claim correctly within one (1) year of the date eligibility was granted or by January 31, 2011, whichever is sooner.

Effective 2/13/11

B. In cases involving other insurance carriers or Workers' Compensation, claims must be filed correctly within one year from the date on the carrier's explanation of benefits, except if the explanation of benefits occurred before September 1, 2010, the provider must file the claim correctly within one (1) year of the date of the explanation of benefits or by January 31, 2011, whichever is sooner.

Shortfall analysis:

Crossover payments

Q # 6 How were these payments missed in baseline projections?

Response: In the MeCMS claims processing system we were not able to process crossover payments as they came from Medicare. These payments had to be handled manually and addressed at hospital cost settlement. With the implementation of MIHMS, we were able to begin processing these claims real time but these were not expenditures that have flowed through our claims processing system previously therefore, they were not part of the baseline expenditures.

Q # 7 Does the delay in DRG's contribute to crossovers not being budgeted?

Response: No. These are two separate initiatives.

Prior year claims – ARRA

Q # 8 Is 10.3 million the worst case scenario?

Response: This estimate was based on the first 5 months of data in SFY 2012.

** **See Attachment C** for a write up on MaineCare Claims Adjustments submitted previously on October 24, 2011.

PNMI/Room & Board

Q # 9 Why are the two COC saving initiative lines included in analysis?

Response: The Cost of Care savings initiatives are included in the analysis in order to present a complete document of the different factors contributing to the PNMI Room and Board account issue. It is not possible to demonstrate an accurate portrayal of the account and activity without also including the Cost of Care components. The Department's general fund baseline was reduced in the Biennial budget by $8.4 million to account for the recoupments of the Cost of Care and it is important that this information not be removed from the analysis. Please note, that both sides of the Cost of Care savings initiatives are included in the analysis. Therefore, although the savings initiatives are included in the upper portion of the analysis increasing the overall estimated cost of the program, they are subsequently included in the reductions in the bottom portion as well, eliminating the financial effects of inclusion altogether while not losing the detail of the different financial components of the account.

Q # 10 Break out RAC 53 # of members and expenditures – last 5 years. Provide a detail of expenses/services that hit this account.

Response: **See Attachment D** Initiative 7462 –Non Medicaid Elderly in a Residential Setting for the number of current members eligible and costs for SFY 2008 through SFY 2011.

Q # 11 Provide a summary of financial orders for this account for the last 5 years and identify which accounts we have taken money from.

Response: **See Attachment E**

Q # 12 Have provider rates been reduced due to cost of care collection?

Response: No

Membership Increase

Q # 13 Member months – does this column reflect new members (25,000)? Please describe How member months are derived.

Response: Yes. A Member Month is the total number of members enrolled in that month.

Q # 14 Please provide the current members/member months vs. projected.

Response: The revised three page report titled "ENROLLMENT – TOTAL MEMBERS ENROLLED" shows actual member months colored blue and the estimated member month's colored yellow. **See Attachment F**.

Q # 15 Do we have a trend pattern that flattens out growth?

Response: The trends are being tracked using statistics. As of the date of this analysis, the trend pattern is still rising and has not flattened out.

Structural Shortage

Q # 16 Why aren't FHM/Dirigo expenses reflected in this analysis?

Response:

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

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

Medicare A/B/D

Q # 17 Provide a summary of Medicare A/B/D budget requests

Response: **Attachment G** is a spreadsheet that reflects initiatives specifically related to Medicare A, B or D that were funded in various budget bills going back to FY06. In the Initiative Description section, there are 2 initiatives that reflect some italicized information related to whether or not the adjustments were one-time in nature.

Q # 18 How many members do we pay Part D premiums for?

Response: The average monthly members we have paid Part D premiums for this fiscal year has been approximately 49,400 members. This coming month's bill covers 50,319 members for Part D. **See Attachment H** for more detail.

Q # 19 With regard to Medicare Parts A, B and D expenditures, Rep. Webster and Sen. Rotundo asked for enrollment figures over time and current enrollment.

Response: **See Attachment I**

Q # 20 What is the average cost per member?

Response: Current cost per member for Part D premiums is currently $83.59. This fiscal year's average cost per member is $78.60. This number is low because the bills for the first two months of the current fiscal year were for billing periods in the last two months of fiscal year 2011 in which the stimulus funds had reduced the premium rate.

Q # 21 Are there eligibility changes at the federal level we need to be aware of?

Response: There are no changes currently proposed to eligibility at the federal level that we are aware of.

PIP

Q # 22 Commissioner Mayhew offered to bring information on the change in status of 2 hospitals and PIPS and payments for Mount Dessert Island Hospital (MDI) and Stephens Memorial Hospital. They are listed with GF impacts of $532,800 per year.

Response:

Mount Dessert Island Hospital's total annual PIP was increased from $3,192,688 to $3,922,454. This resulted in total increase to PIP expenditures of $729,766. Much of the increase was attributable to volume and costs associated with that increase.

Stephens Memorial Hospital changed from an acute care facility to a critical access hospital. This resulted in a total increase in inpatient payments in PIP to Stephens of $1,148,978 total State and Federal

Q # 23 Why are we not recognizing the additional expenses at settlement?

Response: When the change to MDI was made, and my error in not accounting for the move of Stephens from acute to CAH the following information was provided, the PIP calculation was based on estimated DRG payments in order to calculate the deferral amount. This dollar amount was projected to be $145 million dollars. We had seen a decline in discharges and it was projected that this decline would produce enough savings to cover the increase in annual PIP expenditures associated with these two hospitals. Recent projections show that we are trending at an annual expenditure of $84 million. This would provide $61 million in hospital savings this fiscal year associated with hospital services.

Q # 24 Please provide the language that authorized the Department to increase PIP's beyond budgeted amount.

Response: The Department did not increase PIP's beyond the budgeted amount. There is no specific budget amount for PIPs. In addition, the DRGs were expected to be under projected amount. See policy below regarding change to PIP and providing the Department with the authority to change PIP.

45.04-3 Interim PIP Adjustment

The Department initiates an interim PIP adjustment under very limited circumstances, including but not limited to, restructuring payment methodology as reflected in a state plan amendment; when a hospital "changes" categories (e.g., becomes designated critical access); or a hospital opens or closes resulting in a redistribution of patients among facilities.

Special Revenue

Q # 25 If utilization is up, why is there a revenue shortfall?

Response: We are not able to do an analysis of how utilization affects tax revenues at this time. However, the tax is on total revenue (MaineCare plus private pay) and decreases in private pay, at the expense of MaineCare, could result in lower overall tax revenue.

The tax revenues are a combination of 11 different tax sources, 8 of which are down, 2 are unchanged, and 1 is up, which results in our shortfall of $1,800,000.

MeCMS

Q # 26 Do we have CMS approval to pay these claims?

Response: Based on the current MaineCare rules, providers have one year from the date of service to submit clean claims for reimbursement. This requirement is also included in our state plan which has been approved by CMS.

Regarding the proposed DHHS supplemental budget:

Q # 27 The budget request is built on administrative savings of $13.6 million in FY12 and $17.1 million in FY12. Detail about these savings is needed.

Response:

DHHS Administrative Initiatives - General Fund Savings (in millions)

	SFY12	SFY13
Contract Reductions	7.70	4.40
Transition Clinical Services to Section 65	0.94	4.71
Transition Section 65 to CPT Codes	0.33	1.68
Nutritionals	0.43	0.86
Readmission Policy to 14 Days	0.62	2.48
Pharmacy AWP - 16%	0.14	0.70
Narcotics (14 day limit)	0.09	0.44
DME by Mail		0.50
IMD's Reduction to $500	0.07	0.28
Mandate EFT Payments	0.01	0.05
Eliminate Sales Tax	0.08	0.04
Childless Adult Wavier Freeze	1.80	
Third Party Liability	1.00	1.00
Emergency Room	0.50	
Total of Administrative Initiatives	13.7	17.1

Q # 28 Rep. Martin asked for the administration's plans for taking care of the elderly and disabled who will lose their homes in assisted living and residential care.

Response: **See Attachment J**

Q # 29 Rep Winsor asked for information on the alternative response child abuse prevention program, data on prevention outcomes and whether DHHS plans on taking on the role played by the alternative response programs.

Response:

- The Alternative Response Program is not a prevention program, as we refer to them reports alleging abuse and neglect has already occurred. They are referred families in which the level of abuse and/or neglect does not rise to the level for intervention by the State. While we refer reports to ARP with allegations of low to moderate severity child maltreatment, the actual severity is unknown until the assessment is completed. If the assessment reveals the children are in jeopardy, only the state casework staff can petition the Court for a Child Protection Order. The ARP must then contact our District office and immediately refer the family back to us. That is why no state has fully privatized child protection investigations.
- That said we do not have data on prevention outcomes.
- The children in foster care caseload carried by our staff have decreased by 545 children since January, 2009. Because of that, we have been able to progressively shift the work previously performed by the ARP agencies to our existing state child welfare staff. Therefore, we are able to further reduce funding to the ARP without adding any costs from state staff, because existing state staff would do the work. So far during this fiscal year we have averaged 90 cases per month referred to ARP's, statewide. Based on our workload expectations, it would take 11 caseworkers to complete that work. At an average cost of $60,000, including salary and fringe per caseworker, the total cost would be $660,000. Adding two supervisors at $75,000 each, salary and fringe, brings the total cost to $810, 000 per year for that workload to be accomplished by state staff. Compare that with the current costs of $2,580,000 in state general funds annually for ARP.

Q # 30 Rep. Martin asked for work session for information on lost federal funds and lost revenues to Maine hospitals.

Response:

The federal dollar impact by proposal for State Fiscal Year 2012 and 2013.

Initiative #	Initiative Name	SFY12 Federal Impact	SFY13 Federal Impact
7473	MaineCare Need	207,077,368	136,479,032
7478	FMAP Reduction		(11,920,338)
7474	Childless Adults		(37,060,403)
7424	Coverage 19 & 20	(1,898,564)	(10,021,863)
7411	Parents	(5,791,515)	(30,571,405)
7443	Vision	(250,663)	(1,323,161)
7461	Chiropractic	(114,901)	(606,525)
7434	Dental	(652,668)	(3,445,208)
7442	Occupational Therapy	(136,054)	(718,182)
7446	Podiatry	(110,904)	(585,423)
7427	Adult Family Care	(68,641)	(362,332)
7429	Ambulatory Surgical Center	(28,155)	(148,619)
7445	Physical Therapy	(172,084)	(908,373)
7480	Smoking Cessation Products	(138,580)	(724,363)
7430	Consumer Directed Attendent Services	(772,450)	(4,077,499)
7431	Targeted Case Management	(908,725)	(4,846,533)
7451	Sexually Transmitted Diseases Clinics	(45,771)	(241,610)
7448	Private Non-Medical Institutions		(104,043,080)
7465	Two Brand Limit	(2,023,465)	(9,838,860)
7487	MR Waiver Rate Reform		(5,053,691)
7471	Suboxone Limit	(1,082,650)	
7470	Crisis Services		(91,369)
7464	Crisis Access Hospitals	(503,794)	(1,987,455)
7481	Hospital Outpatient Reduction - 5%		(5,357,366)
7467	Hospital Outpatient Limit	(480,766)	(2,493,515)
7488	Hospital Inpatient Rate Reduction	(2,098,929)	(5,268,314)
7468	Hospital Inpatient Limit	(159,176)	(825,573)
7486	Children's Behavioral Services		(842,282)
Total Federal Impact		**189,638,913**	**(106,884,310)**

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

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

Q # 31 On the financial statement – the line that references "State only Hospital Costs" – who represents these costs/what eligibility group?

Response: The group covered on the "State Only Hospital Costs" line of the financial statement is the Temporary Coverage Individuals.

Q # 32 Are there hospital overpayments from prior FY that need to be collected? - (need to provide hospital document to committee that was shared in early 2011)

Response: There are no overpayments to hospitals from the prior year that need to be collected. As we discussed this past spring, there was concern regarding the payments to hospitals that we were paying in excess of the budgeted amount. During March we stopped various payments to hospitals and in some instances reduced their settlements to come in line with what each hospital should have received last year based on what our budget allowed for reimbursement.

Q # 33 Are there any items/accounts in the MaineCare Budget that are underspent?

Response: DHHS is compiling this data and will provide a response when it is complete.

Q # 34 On the financial statement – why would we draw down 1.5 billion with 671 million in spending vs. 1.49 billion with 791 million in spending?

Response: The 1.5 billion budget in authorized federal funds exceeded the amount needed based upon current FMAP rate to cover the authorized general funds. The amount of federal funds needed to cover the projected 792 million in general funds based upon current FMAP is approximately 1.49 billion.

Q # 35 On the financial statement – "Expenditure Transfers" – what taxes other than hospitals are included in this line? What amount?

Response:

Expenditure Transfers

What Taxes other than hospitals are included on this line?

Through November 14, 2011

Amounts in thousands ($000)	**FY 12**
PNMI Tax	6,150
Nursing Facility Tax	13,542
MR Provider Tax	6,666
Community Support Provider Tax	1,279
Residential Provider Tax	920
	28,557

Q # 36 SFY 2011 Claims paid in SFY 2012 – they would like detail for the $59,460,000. Not an estimate but the actual detail.

Response:

Detail for the Outstanding $59.4 Million SFY11 Claims to be Paid in SFY12	
"Pended" Charged Statuses from SFY11 as of November 14 (source: Claims System)	21,873,650
Estimate of Outstanding SFY11 Claims to be Billed/Adjusted	37,586,350

Q # 37 Prior year claims – assumption of impact in SFY 2013

Response:

The analysis of the State Fiscal Year 2013 "prior year claims, paid in the current year" was based upon the known current year issues and the assumption was that approximately 50% of the experience from SFY12, or approximately 22.5% greater than in SFY11, would be experienced in SFY13.

	SFY11 Paid, Incurred in SFY10	SFY13 Paid, Incurred in SFY12	Difference
Total	139,300,000	170,600,000	(31,300,000)
Federal Share	101,661,140	107,051,500	(5,390,360)
State Share	37,638,860	63,548,500	(25,909,640)
FMAP Adjustment - State	51,889,250		
State Share	51,889,250	63,548,500	(11,659,250)

Q # 38 When did you know about higher amount of claims carried over from 2011?

Response: As we monitored our cycle payments during October and early November, it became apparent that a contributing factor to those higher cycles was FY'11 claims that were being paid during that time. We then adjusted our forecast for FY'11 claims being paid in FY'12 for the AFA presentation on November 21st.

Q # 39 CMS 1500 claims – Why wasn't it included in budget?

Response: The hospital based CMS 1500 physician claims had previously been cost settled and payment was pushed off until settlements to the hospitals were paid. When we moved to a pay as you go system for these claims, we used the previous capped budget amount as the baseline. At this time due to current claims experience we anticipate to meet and significantly exceed what that amount was projected at.

Q # 40 Discussion of PNMI; communication with CMS.

Response: **See Attachment K** for PNMI updates provided to AFA July through November, 2011.

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

ATTACHMENT - A

Regarding Reasons for the DHHS Budget Shortfall

Representative Martin asked for a list of one-time funding needs and the amount of General Funds and Federal Funds Required to meet those needs and what funding needs are continuing.

Amounts in thousands ($000)	FY 12 General	FY 12 Federal	FY 12 Total	FY 13 General	FY 13 Federal	FY 13 Total
One-Time Needs						
B. Adjusments to ARRA Claims	$ 10,264	$ -	$ 10,264			
E. Savings Initiatives not Realized						
Implementing Medication Therapy	300	520	820			
Limiting Medical Assistance Benefits	1,280		1,280			
Savings in Children's Waiver	392	678	1,070			
Establish Maine Rx Program	30		30			
Cost of Care recoupment	2,100		2,100			
K. Special Revenue Shortfall	1,800		1,800			
L. MeCMS claims not paid during curtailment	3,489	6,044	9,533			
Total One-Time Needs	$ 19,654	$ 7,242	$ 26,895	-	-	-

	FY 12 General	FY 12 Federal	FY 12 Total	FY 13 General	FY 13 Federal	FY 13 Total
Structural Needs						
A. Crossover Payments	$ 13,270	$ 22,988	$ 36,258	$ 15,000	$ 21,258	$ 40,263
C. Prior year claims paid beyond expectation	29,891	51,778	81,669	11,700	19,705	31,405
D. PNMI Room & Board	19,347	-	19,347	19,347	-	19,347
F. CMS Form 1500 exceeding budget	10,489	18,169	28,658	12,700	21,389	34,089
G. Membership Increase	6,501	11,719	18,220	7,900	13,305	21,205
H. Structural Shortage	11,870		11,870	11,870		11,870
I. Medicare A, B, D premiums	11,503	(2,428)	9,075	10,200	8,689	18,889
J. PIP Payments	533	923	1,456	542	913	1,456
Total Structural Needs	103,403	103,149	206,552	89,259	85,260	178,524
Budget Workplan Savings Initiatives	(13,818.0)	(5,601.0)	(19,419)	(17,100.0)	(25,522.0)	(42,622)
FFY 13 FMAP Reduction				11,789.0	(11,789.0)	-
TOTAL NEEDS	$ 109,239	$ 104,789	$ 214,028	$ 83,948	$ 47,949	$ 135,902

Shortfall Thumbnails

A. Crossover Payments

- Hospital claims for members who have both Medicare and MaineCare and are at or below 150% of the Federal Poverty Level (FPL).
- MeCMS was not able to handle Crossovers and so they were paid at settlement.
  Consequently, they were not included in the baseline.
- MIHMS has been processing these claims on a current basis since go-live in September of 2010.
- The total impact for unbudgeted Crossover claims will be $13.3 million.

B. Adjustments to Claims previously paid with ARRA enhanced FMAP

- Claims with errors from prior years are reversed in full and repaid.
- Because claims are paid on a cash basis, current claims, including billing corrections from prior periods, are paid at the current FMAP.
  This results in the reversal of the ARRA enhancement and an increase in General Fund cost.
- Total cost to the General Fund will be $10.3 million.

C. SFY 2011 Claims paid in SFY 2012 above expectations

- SFY 2010 claims paid in SFY 2011 were $139 million. Adjusting for FMAP differences, this would incur $50.9 million in General Fund cost.
- SFY 2011 claims paid in SFY 2012 are projected at $220 million. General Fund cost will be $80.9 million.
- SFY 2012 over SFY 2011 General Fund cost will total $29.9 million above prior experience and expectation.

D. PNMI Room and Board Expenditures

- This account is historically underbudgeted with current needs being funded through transfers from the FMAP account during the year.
- Current budget is for $6.2 million with expected need of $25.0 million.
- In addition, $8.4 million of Cost of Care recoupments were included in the Budget Savings Initiatives, and removed from the account at the start of the year.
- Total need in this account is $33.4 million.
- Cost of Care collections will be increased to $14.1 million, resulting in a net need of $19.3 million.

E. Savings Initiatives Not Realized

- $4.1 million of Savings Initiatives will not be realized in SFY 2012 due to timing issues, and Maine Rx not being pursued.

F. Physician Claims exceeding projected budget

- Through 19 weeks, Physician CMS 1500 claims have been running at $1.372 million per week, which projects out to $71.396 annually.
- This is $28.7 million more than the projected $42.7 million annual budget.
- This results in $10.5 million in increased General Fund.

G. Membership increase

- Growth has been funded through May 2011
- Additional growth for the 13-month period ending in June 2012 results in $6.5 million increase in General Fund expenditures.

H. Structural Shortage

- Correcting for differences in FMAP and one-time expenditures, SFY 2012 budget is compared to SFY 2011 actual expenditures
- The comparison results in $11.9 million underfunding of the SFY 2012 and 2013 baseline budgets in the General Fund.

I. Medicare A, B, and D Premium Changes

- Medicare premiums have remained relatively flat over the past few years.
- An increase in Part D premiums in FY 2012 results in an additional $11.5 million which was not budgeted.

J. Increase in Hospital Prospective Interim Payments (PIP)

- Stephens Memorial and Mount Desert Island Hospitals had major changes in their cost structures after the budget was set.
- This resulted in $0.5 million of additional cost.

K. Special Revenue Shortfall

- The Revenue Forecasting Committee has revised downward the Special Revenue Forecast for tax collections.
- This will result in $1.8 million less in revenues available to cover General Fund expenses.

L. MeCMS claims not paid during curtailment

- Claims initially billed under the MeCMS system which needed to be rebilled but were not completed prior to the February 2011 shutdown of MeCMS.
- Because these claims were unpaid due to MeCMS limitations, we will continue to process them manually until all are paid.
- Total General Fund impact is forecasted at $3.5 million.

ATTACHMENT - B

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www.deloitte.com

Actuarial Memorandum

This report will show how Deloitte Consulting LLP ("Deloitte", "We") developed the MaineCare Medicaid Incurred but Not Paid (IBNP) claim liability estimate for State Fiscal Year 2011 (SFY2011) ending June 30, 2011. We will describe the data used, the assumptions that made, and the limitations in our analysis. We also document the issues encountered in the data process and make suggestions on procedural improvement for the next cycle. This report will describe the component pieces of the June 30, 2011 IBNP liability.

Background

We have been assisting MaineCare with its fiscal year-end IBNP estimation for the past six years. Due to the implementation of a new claims system, MeCMS, MaineCare had experienced issues in adjudicating claims in the past, especially during 2005 and 2006. Since 2006 the MeCMS system's ability to accurately adjudicate claims improved significantly. We have observed significant increases in the claims completion speed. However, MaineCare implemented another new claims system, MIHMS, in September 2010. We once again have observed an initial slowdown in claims processing after the implementation of this new system.

Due to the new claims system there is uncertainty as to how quickly claims are processed and paid. Because of this we reviewed the unpaid claim reserves using several different methods.

The first approach we used to estimate the unpaid claims reserves is the traditional approach using a standard claim triangle, and this is the approach we have used in previous years. This method is known as the modified completion factor method, and is described below. However, this method is only reliable if there is sufficient claims experience that can be used to identify how quickly claims are paid and if the claim payment process is somewhat stable during the experience period. With the move to the new MIHMS claims system in September 2010 there is not sufficient stable experience for the modified completion factor methodology to be completely reliable.

Because of this we used a second approach where we applied claim trend factors to SFY2010 ultimate incurred claims per member per month (PMPM) to estimate the SFY2011 ultimate incurred claims PMPM. The unpaid claim reserve for SFY2011 is then calculated as the incurred claims minus the claims paid as of June 30, 2011. We have described this method in detail below.

Finally, a third approach was used where we gathered SFY2011 incurred claims paid through mid-November 2011, pended claims as of mid-November and estimates of remaining unpaid claims to develop an estimate of the total reserve at June 30, 2011.

We have not included any allowance for administrative expenses in settling the outstanding claims, or any accruals needed for such administrative expenses at the end of SFY2011.

Summary of Results

We developed the IBNP estimates below:

State of Maine IBNP		
	Low Estimate	**High Estimate**
Total for Medicaid Services	$205,081,000	$374,631,000

Please note that these IBNP numbers do not include adjustments for hospital accruals and settlements.

Hospitals within the state are paid on a periodic interim payment (PIP) methodology and because a separate accrual is developed for settlements of those PIPs, we did not include separate IBNP estimates for hospitals.

We relied on claim information and enrollment data provided by the Office of MaineCare Services (OMS). We performed reasonableness checks on the data received and found the data from the MeCMS claim system to be reasonable when compared to information received in prior years. There is more uncertainty regarding the reasonableness of the MIHMS data due to the short period of experience with this new claim system. However, we believe the results of our analysis are reasonable due to the multiple methods used to estimate the unpaid claim reserve. The reasonability checks we performed are described in more detail at the end of this document. However, we did not audit the data for accuracy.

In our analysis we developed a range of possible IBNP estimates. Our range was developed by testing a number of possible claim runoff scenarios, trending incurred PMPMs from SFY2010, and gathering SFY2011 run-out through October 31, 2011 and claims backlog information to improve the accuracy of the estimates. The low-end represents more aggressive underlying assumptions while the high-end represents a more conservative approach. The endpoints of our range were determined by using the outputs from our various methodologies, a range of trend rates, and actuarial judgment. We note that the range of estimates is wider than in past years due to the higher uncertainty caused by the new claim system.

We examined the impact of the seasonality of claims in our independent calculation of the liability and reflected the effects of seasonality in determining our range of estimates.

Data

Data Received

Our calculation of the IBNP reserve amount was based on the following information provided by the OMS:

- Enrollment data by Medicaid program for each month between July 2008 and May 2011. Since the enrollment data for June 2011 was not provided, we set it equal to the enrollment for May 2011
- The Recipient Aid Category (RAC) codes which are specific for Medicaid members and the grouping of the RAC codes into Medicaid programs
- A list of provider IDs that identify in-state hospitals to be excluded from our analysis
- Claims data from the MeCMS system with incurred between July 2008 and August 2010 and paid between July 2008 and February 2011
- Claims data from the MIHMS system with incurred between September 2010 and June 2011 and paid between September 2010 and October 2011

We used claims incurred between July 2008 and June 2011 and paid from July 2008 through October 2011 to determine the IBNP at June 30, 2011. This gave us 36 months of incurred and 40 months of paid claims, which is typically considered sufficient for an IBNP analysis based on industry standards and Deloitte experience. However, due to the change in claims systems and since there was only ten months of data on the new claims system, there was not sufficient data to fully rely on the unpaid claim reserves calculated using the modified completion factor method.

Audit Findings Regarding Data Accuracy

We were provided an audit findings report relating to the eligibility determination. The findings state that:

The claims processing system (MeCMS) cannot currently perform all of its required functions and objectives. Four of six required subsystems are not fully functional. The Department of Health and Human Services converted to the new Medicaid Management Information System (MMIS) prematurely. The initial system breakdown can be attributed to (1) An inadequate system development effort (2) Lack of a formal risk management process (3) Lack of effective testing before going into production and (4) Procuring the services of a software vendor unfamiliar with the processing of medical claims. Improperly designed and implemented system controls and edit functionality creates a potential for disallowed costs and non-compliance with federal regulations.

The DHHS responded that it has contracted with Molina as its fiscal agent. The implementation was completed September 1, 2010. The Department is working with the fiscal agent to ensure that MMIS has all the required functionalities and to obtain the required Federal certification

Discussion of Analysis

IBNP

Modified Completion Factor Method (MCFM)

One methodology used to estimate the IBNP reserve amount as of June 30, 2011 was the Modified Completion Factor Method (MCFM). The claim reserves for most health care coverage can be suitably calculated using a Modified Completion Factor Method. This method assumes that the historical lag pattern will be an accurate representation for the payment of claims that have been incurred but not yet paid. An estimate of the unpaid claim reserves is calculated by subtracting period-to-date paid claims from an estimate of the ultimate aggregate payment for all incurred claims in the time period. The method is based on the paid development of claims incurred each month across future months to some month where no more payments are expected. Completion factors are calculated which "complete" the current period-to-date payment totals for each incurred month to estimate the ultimate expected payout.

Because claim experience and payment patterns may vary for different claimant populations or service categories, we split the Medicaid population into two groups based on existing Medicaid programs and calculated IBNP reserves separately for each group. The two population groups being used in our analysis are Aged/Disabled and Other. The Aged/Disabled population accounts for approximately 74% of all Medicaid claims. "Other" includes claimants in the following programs: Adult/Child, S-CHIP Medicaid Expansion, S-CHIP CubCare, Medicaid Expansion Parents and Childless Adult Waiver. They are grouped together because the individual programs are relatively small and the experience may not be credible standing alone.

Within each population, depending on the distribution of claims among several claim types, we modeled some claim lags separately where the data was credible to stand alone. Within the Aged/Disabled population, we modeled the following claim types separately – Professional, PNMI/CRBH and Nursing Facility. All other claim types, such as inpatient, outpatient, dental, home health, optical and transportation are aggregated into an "Other" lag due to limited claims in those service types. Within the Other population, the Professional and PNMI/CRBH claim types are modeled separately. All other claim types including inpatient, outpatient, nursing facility, dental, home health, optical and transportation are combined into one "Other" lag. The following tables demonstrate the claim distribution among claim types within each population for claims incurred and paid from July 2008 through June 2011.

FY09, 10, 11			
Population Group	Claim Type Name	Paid Amount	%
Aged/Disabled	Dental Claim	$ 14,245,598.69	0%
Aged/Disabled	Home Health/Hospice Claim	$ 49,821,809.39	2%
Aged/Disabled	Inpatient Claim	$ 36,718,740.88	1%
Aged/Disabled	Nursing Facility Claim	$ 755,867,551.57	23%
Aged/Disabled	Optical Claim	$ 2,595,817.68	0%
Aged/Disabled	Outpatient Claim	$ 27,580,083.00	1%
Aged/Disabled	PNMI/CRBH Claim	$ 567,629,588.42	18%
Aged/Disabled	Professional Claim	$ 1,683,317,233.62	52%
Aged/Disabled	Transportation Claim	$ 100,498,176.46	3%
Total		$ 3,238,274,600	100%

FY09, 10, 11			
Population Group	Claim Type Name	Paid Amount	%
Other	Dental Claim	$ 77,322,421.35	7%
Other	Home Health/Hospice Claim	$ 7,668,818.37	1%
Other	Inpatient Claim	$ 30,548,960.52	3%
Other	Nursing Facility Claim	$ 794,011.14	0%
Other	Optical Claim	$ 7,023,052.71	1%
Other	Outpatient Claim	$ 41,230,941.52	4%
Other	PNMI/CRBH Claim	$ 192,988,564.61	17%
Other	Professional Claim	$ 737,921,387.54	65%
Other	Transportation Claim	$ 40,142,129.05	4%
Total		$ 1,135,640,287	100%

The completion factor method is usually not employed without adjustment; however, with four months of run-out data, no adjustments were deemed to be necessary. However, the modified completion factor method is only accurate if an incurred date and paid date can be systematically recorded for each claim as it is adjudicated, fairly consistent lag patterns are exhibited in the progression of claims from incurred date to the date they are paid in full, and incurred periods have relatively short duration to the ultimate run-out. As noted previously, due to the change in claims systems the lag patterns developed cannot be fully relied upon, thus decreasing the reliability of this method. This methodology suggested a trend in the aggregate incurred claims per member per month between SFY2010 and SFY2011 of -7.7% which seems unusually low. We note that MaineCare has experienced low and even negative trends in the past and has implemented policy changes to reduce MaineCare costs. However, -7.7% is low compared to what we have observed in other state Medicaid programs.

The development of the reserve using this method can be found in Table 4A of the Appendix.

Incurred PMPM Trend Method

A second methodology used was to take the ultimate aggregate payment incurred PMPMs for SFY2010 and trend them to SFY2011 based on a range of trend rates to develop an estimate of the ultimate aggregated payment for all incurred claims. An estimate of the unpaid claim reserves is calculated by subtracting period-to-date paid claims from the estimate of the ultimate aggregated payment for all incurred claims.

To come up with a range of trends we reviewed several sources. We reviewed MaineCare historic trend rates which showed low and even negative trends in recent history. We also reviewed the trend rates we are seeing in other state's Medicaid programs and noted that negative trend rates occur in some of those programs. Finally, we reviewed the estimated SFY2011 impact of programmatic changes as provided by MaineCare. The approximate programmatic change impact, ignoring Inpatient costs and changes, is approximately -1.0%.

Based on this analysis we selected a trend of 0% for most categories of service. However, some categories of service already had paid claims at higher trend rates and in those categories we increased the trend to a point where the PMPM was slightly above what had already been paid. This adjustment was made to the Aged/Disabled PNMI/CRBH, and the Other Other lines of business and causes the aggregate trend rate to be 1.9%.

The development of the reserve using this method can be found in Table 4B of the Appendix.

Run-out and Pended Claims

A third methodology was also utilized. We gathered run-out claims data from July 1, 2011 through October 31, 2011 as well as the claims paid from November 1, 2011 through November 16, 2011. We also received a pended claims summary as of November 17, 2011. Finally we estimated the claims still unknown as of November 17, 2011 based on the SFY2010 claims that were still remaining to be paid after four months of run-out. The sum of these amounts provided us another estimate of the June 30, 2011 IBNP amount. This information can be found in Table 3 of the Appendix.

Provision for Adverse Deviation

We have added a 10% provision for adverse deviation to the remaining unpaid portion of our unpaid claim reserve estimates. Since we received data paid through October 31, 2011 a portion of the unpaid claim reserve at June 30, 2011 has already been paid and is known. The 10% provision for adverse deviation is only applied to the unknown portion of the unpaid claim reserves. Because the calculation of claim liabilities provides an estimate of the true liabilities that will emerge, a provision for adverse deviation for conservatism is normally appropriate.

The 10% provision for adverse deviation used in this year's analysis is consistent with the 10% used in the prior year.

Provision for Claim Payment Expense

A provision for claim payment expense (Loss Adjustment Expense) is also typically appropriate. This amount represents the expense attributable to payment of IBNP claims. Deloitte estimates do not include an assumption for administration costs associated with paying reserve claims applied to the IBNP. An accrual for these expenses is held under another account in the State of Maine financial statements. Actuarial Standard of Practice No. 42 also states "The actuary should determine a liability

for claim adjustment expenses associated with unpaid claims, unless such liabilities are included in the liability for unpaid claims or otherwise provided for appropriately." Based on work performed for other clients, a provision for claim settlement expenses typically ranges from 2.0% to 6.0% of the calculated IBNP reserve amount.

IBNR Summary

Based on the data received from MeCMS and MIHMS, and our analysis described above, our range of reasonable estimates for the June 30, 2011 unpaid claim liability is summarized in the following table.

State of Maine IBNP			
	Low Estimate	**Mid Estimate**	**High Estimate**
Grand Total for Medicaid Services	201,081,000	278,151,000	355,231,000
Margin – 10% of Unknown IBNP	4,000,000	11,700,000	19,400,000
Grand Total for Medicaid Services	**205,081,000**	**289,851,000**	**374,631,000**

Please note that these IBNP numbers do not include adjustments for hospital accruals and settlements.

Following is a summary of our logic in creating this range:

- **Low Estimate** – The low estimate of $205 million is based on the modified completion factor methodology (see Table 4A). As discussed above, this method is not completely reliable due to issues with the new claim system and the implied incurred claim trend of -7.7% seems unusually low. However, an alternative method (the "Run-Out and Pended Claims" method described above) produces a very similar result, which gives us confidence that this estimate is reasonable. Note that approximately $168 million amount has been paid by through November 16, 2011, which implies approximately $37 million is still outstanding as of November 16, 2011.

- **High Estimate** – The high estimate of $375 million is based on the incurred PMPM trend method (see Table 4B). As discussed above, this method is based on a 0% trend rate for most service categories and an aggregate trend rate of 1.9%. This trend rate appears to be reasonable based on our industry experience and our analysis of MaineCare historic trend rates, and recent programmatic changes. However, this estimate implies that approximately $206 million is still outstanding as of November 16, 2011, which is at the high end of the range that we believe is reasonable with 4.5 months of claim run-out. We believe that MaineCare would be receiving significant provider complaints with this amount still unpaid after 4.5 months and we have been told that this is not the case.

- **Mid Estimate** – The mid estimate of $290 million reflects the average of the low and high estimates. This estimate implies that approximately $120 million is still outstanding as of November 16, 2011.

Detailed IBNP results by population and modeled claim type are below:

State of Maine IBNP by Line of Business June 30, 2011 Estimates	Low End	High End
Aged/Disabled		
Professional Claims	70,400,000	102,560,000
PNMI/CRBH Claims	28,850,000	31,280,000
Nursing Facility Claims	40,180,000	77,060,000
Other Claims	12,711,000	15,241,000
Aged/Disabled Total	**152,141,000**	**226,141,000**
Other		
Professional Claims	28,520,000	99,970,000
PNMI/CRBH Claims	5,920,000	17,130,000
Other Claims	14,500,000	11,990,000
Other Total	**48,940,000**	**129,090,000**
Subtotal	**201,081,000**	**355,231,000**
Margin	**4,000,000**	**19,400,000**
Total	**205,081,000**	**374,631,000**

Reserve Total

Below is the Reserve Total, with the State and Federal shares. The reserve totals reflect mid estimates of the range.

	Total	State Share	Federal Share
IBNP with Margin	289,851,000	78,317,740	211,533,260

The state/federal share breakdown used is 27.02% / 72.98% per MaineCare.

In-state hospitals are paid on a periodic interim payment (PIP) methodology. As a separate accrual is developed to account for the settlements of those PIPs with the hospitals, we did not include separate IBNP estimates for in state hospitals in our IBNP estimates.

Recast of Prior Claim Liability Estimates

A look-back analysis, which compares an original reserve estimate for a past point in time to a revised estimate that includes a number of months of runoff, provides one indication of a reserving methodology's accuracy and appropriateness. It also provides a way to refine a methodology should the estimate vary materially from the eventual claims run-out. With additional run-out data through February 28, 2011, we have developed a revised estimate of the June 30, 2010 IBNP liabilities.

The following table displays the results of the recast June 30, 2010 IBNP claims liability estimate based on the data we received. The table values use paid claim data through February 28, 2011, which is the date that the MeCMS claims system stopped processing claims.

	Low	High
Deloitte's Recast at February 28, 2011 IBNP	**141,591,000**	**142,791,000**
Aged/Disabled	99,501,000	100,001,000
Other	42,090,000	42,790,000
Deloitte's Original FY10 IBNP Estimate*	**214,200,000**	**243,900,000**
Aged/Disabled	149,700,000	168,100,000
Other	64,500,000	75,800,000
Difference	**(72,609,000)**	**(101,109,000)**

These IBNP numbers do not include adjustments for hospital incurrals and settlements or interim payments. Deloitte's original SFY2010 IBNP estimates also do not include the 10% provision for adverse deviation reflected in the estimates recommended at June 30, 2010. The recasts for previous IBNP were based on actual payments made between July 1, 2010 and February 28, 2011 for claims with incurral dates between July 1, 2008 and June 30, 2010.

The SFY 10 IBNP estimates can be found in Table 1 of the Appendix, and the recast can be found in Table 2.

The table above demonstrates that the recast of the June 30, 2010 IBNP reserve as of February 28, 2011 is below our original estimates based on analysis of the data we received. While it is certain that actual future losses will not develop exactly as projected and may, in fact, vary significantly from the projections, we study the difference in the recast and original range of estimates to aid in the review of the redundancy or deficiency of prior estimates as well as the development of current-period liability estimates by providing a method to observe the impact of assumptions on the ending liability amount.

The differences between the recast and original range of estimates exist mainly for the following reasons:

- Change in payment pattern and conservatism built into the original estimates. The completion factor methodology was used in developing the original estimates. The method is based on historic claim payment patterns and it is more accurate when claim payment patterns are stable and less accurate when claim payment patterns are changing. With updated claims data, we observed that the claims payment speed has increased from SFY2010 to SFY2011 on the MeCMS claims system.

- We intentionally included conservatism in our assumptions last year since there were significant issues with the data we received last year, including duplicative records, missing records etc.

- The data provided last year included claims with estimated payments and we were not aware of this at the time. Since these claims are estimated and not known it is more appropriate to exclude them from our analysis. This year's analysis and recast estimate did not include these estimated payments.

  Because of the time elapsed since the incurrals, in our recast we assume that claims incurred in the first half of 2008 are 100% complete in payments. This is a reasonable assumption for claims with such long duration. Should there be additional unpaid claims for those dates, our recasts of the June 30, 2010 may be understated and the actual liabilities may be more accurately represented by the original estimates.

Comparison of June 30, 2010 Reserve and June 30, 2011 Reserve

	June 30, 2010	June 30, 2011*	% Difference
IBNP (including margin)	251,950,000	289,851,000	15.0%

* Please note that the reserve totals reflect mid estimates of the range

Limitations and Data Issues

Data Reconciliation

We compared the data provided to us with the control totals provided by the Maine IT team that extracted the data as a reasonability check on the data we received. The number of records and total dollars reconcile as shown in the table below.

MECMS Data:

	Raw Data	MMDSS Control	$ Difference	% Difference
# Of Lines	40,630,560	40,630,560	0	0%
Total $s	$4,943,299,833	$4,943,299,833	0	0%

MIHMS Data paid through 06/30/2011:

	Raw Data	MMDSS Control	$ Difference	% Difference
# Of Lines	16,525,475	16,525,475	0	0%
Total $s	$1,136,318,891	$1,136,318,891	0	0%

MIHMS Data incurred through 06/30/2011 and paid between 06/30/2011 and 10/31/2011:

	Raw Data	MMDSS Control	$ Difference	% Difference
# Of Lines	3,948,696	3,948,696	0	0%
Total $s	$175,609,922	$175,609,922	0	0%

We further investigated differences in monthly paid claims for the above period for claims we received for this year's analysis compared to claims we received for the previous year's analysis. The results showed that many months had differences in total payments ranging from -0.1% to 0.2% higher by month in SFY2010 and -0.2% to 2.3% higher by month in SFY2009. Note that these numbers include in-state hospital claims which are excluded from the IBNP analysis.

We also compared this year's data extracted into the claims triangles with the previous year's claims triangles for claims incurred and paid during the overlapping period from July 2008 to June 2010 and observed differences in the dollars. Note that these numbers include in-state hospital claims which are excluded from the IBNP analysis.

	SFY2010 Review	SFY2011 Review	$ Difference	% Difference
Incurred in SFY2009; Paid in SFY2009	$ 1,341,363,322	$ 1,337,283,008	$ (4,080,314)	-0.3042%
Incurred in SFY2009 and SFY2010; Paid in SFY2010	$ 1,619,013,839	$ 1,596,941,578	$ (22,072,261)	-1.3633%

Based on the above, the differences could have a minor impact on IBNP calculations and we believe that the data from the MeCMS claim system is reasonable. There is more uncertainty regarding the reasonableness of the MIHMS data due to the short period of experience with this new claim system. However, we believe the results of our analysis are reasonable due to the multiple methods used to estimate the unpaid claim reserve.

Our analysis is based upon data supplied by the State of Maine and the Office of MaineCare Services. We have not tested the accuracy of this data, and we have relied upon it in developing our estimates of the liabilities and reserves held.

The appropriateness of specific assumptions relates to their comparability to historical experience levels and trends. To the extent that the underlying data changes at some future date, the assumptions used in our analysis and the results generated may change, perhaps materially. Specifically,

- Although our method accounts for unbilled claims, if there is in fact a surprisingly large number of unbilled claims, our estimates of IBNP could be understated.

- Except for hospital settlements, we have assumed that PIP payments cover hospital claims and we have not included other hospital claims in the IBNP projection.

Constraints Experienced in This Year's Data Process

The data process was not as smooth this year as in the past since the data was being pulled from MECMS and the new claims system, MIHMS. There was more time needed to understand the different fields being supplied on the files pulled from MIHMS. Also, we had to receive a second extract of the MECMS data in order to obtain all information required. We were able to reconcile the data received this year with last year's data. In this section we note some of the issues experienced and resolved in the data process for future reference.

We provided a data request in June and received the data extract in late August / early September. Unlike last year, we did not find any duplicative records in any of the data files provided to us. While duplicative records were a major problem in prior years data extracts, we did not have that problem this year.

While working with Maine on the data extract for MIHMS, it was discovered that the paid claim amounts being supplied on the files pulled from MECMS were including some estimated payments. Sufficient run-out was not provided nor was the correct Provider ID field. This required Maine to re-pull the MECMS claims data files with additional fields. The paid amount used this year is lower than the amount used last year. However, the difference in the paid amount had a minor impact on IBNP calculations since these claims are largely IP claims which are excluded from our analysis.

Considerations For Future Analyses

The data process this year was not as smooth as previous years because data was being pulled from two data systems, one of which was the new MIHMS data system. Also, the discovery of incomplete fields being pulled from the MeCMS data system required a second pull. However, we expect that the process will be smoother next year since we have already gone through the process of pulling the data from the new MIHMS system this year and next year we will not need to receive MeCMS data. We will have slightly less than two years of data from the MIHMS system and it will need to be determined if that is sufficient period of claims to consider the completion patterns reliable.

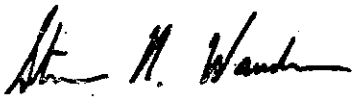
Conclusions

Based on our independent calculation of the estimated IBNP claim liability as of June 30, 2011, it appears that a reserve for IBNP between $205,081,000 and $374,631,000 and a reserve between $55,412,886 and $101,225,296 for the State share of MaineCare liabilities would be reasonable.

Please call me at (612) 397-4312 if you have any questions or comments.

Actuarial Opinion

I, Steven Wander, am a Principal for Deloitte Consulting, LLP. I am a member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion on the State of Maine accruals contained herein.



Steven Wander, FSA, MAAA
Principal
Deloitte Consulting LLP

Appendix

TABLE 1

Summary for SFY2010 (data includes hospital estimated payments)

Category	SFY 2010 Member Months	Paid PMPM at 6/30/10	Est % Complete at 06/30/10	SFY2010 Incurred PMPM	Reserve (Incurred SFY10)	Prior period reserve est.	Total reserve (mid pt)	Total reserve (highest)	Total reserve (lowest)
Aged/Disabled Professional	880,829	$ 628.65	88.88%	$ 707.33	$ 69,300,000	$ 17,050,000	$ 86,350,000	$ 90,500,000	$ 82,200,000
Aged/Disabled PNMI/CRBH	880,829	$ 190.19	89.86%	$ 211.65	$ 18,910,000	$ 11,040,000	$ 29,950,000	$ 31,500,000	$ 28,400,000
Aged/Disabled Nursing Facility	880,829	$ 291.46	91.77%	$ 317.60	$ 23,030,000	$ 1,570,000	$ 24,600,000	$ 26,300,000	$ 22,900,000
Aged/Disabled Other	880,829	$ 82.43	81.91%	$ 100.63	$ 16,030,000	$ 1,970,000	$ 18,000,000	$ 19,800,000	$ 16,200,000
Aged/Disabled Total	**880,829**	**$ 1,192.72**	**89.19%**	**$ 1,337.21**	**$ 127,270,000**	**$ 31,630,000**	**$ 158,900,000**	**$ 168,100,000**	**$ 149,700,000**
Other Professional	2,546,924	$ 101.62	87.30%	$ 116.41	$ 37,670,000	$ 10,430,000	$ 48,100,000	$ 51,700,000	$ 44,500,000
Other PNMI/CRBH	2,546,924	$ 22.57	88.44%	$ 25.52	$ 7,510,000	$ 2,490,000	$ 10,000,000	$ 10,600,000	$ 9,400,000
Other Other	2,546,924	$ 23.32	84.45%	$ 27.62	$ 10,940,000	$ 1,110,000	$ 12,050,000	$ 13,500,000	$ 10,600,000
Other Total	**2,546,924**	**$ 147.51**	**87.00%**	**$ 169.55**	**$ 56,120,000**	**$ 14,030,000**	**$ 70,150,000**	**$ 75,800,000**	**$ 64,500,000**
Grand Total	**3,427,753**	**$ 416.10**	**88.61%**	**$ 469.60**					
Grand Total Dollars		**$ 1,426,288,412**		**$ 1,609,678,452**	**$ 183,390,000**	**$ 45,660,000**	**$ 229,050,000**	**$ 243,900,000**	**$ 214,200,000**
Margin - 10%							**$ 22,900,000**	**$ 24,400,000**	**$ 21,400,000**
Final Reserve							**$ 251,950,000**	**$ 268,300,000**	**$ 235,600,000**

TABLE 2

Summary of SFY2010 recast based on updated paid data (excludes hospital estimated payments)

	SFY2010		SFY2010								
Category	SFY2010 Member Months	Paid PMPM at 9/30/10	21st Completed at 09/30/10	Incurred PMPM	Reserve (Incurred SFY10)	Prior period reserve est.	Total reserve (mid pt)	Total reserve (high est.)	Total reserve (low est.)	Change in Total Reserve
Aged/Disabled Professional	880,829	$ 618.38	91.25%	$ 677.70	$ 52,250,000	$ 700,000	$ 52,950,000	$ 53,050,000	$ 52,850,000	-38.68%
Aged/Disabled PNMI/CRBH	880,829	$ 190.19	92.08%	$ 206.55	$ 14,420,000	$ 340,000	$ 14,760,000	$ 14,810,000	$ 14,710,000	-50.72%
Aged/Disabled Nursing Facility	880,829	$ 291.49	92.64%	$ 314.66	$ 20,400,000	$ 530,000	$ 20,930,000	$ 20,980,000	$ 20,880,000	-14.92%
Aged/Disabled Other	880,829	$ 82.14	86.69%	$ 94.74	$ 11,110,000	$ 1,000	$ 11,111,000	$ 11,161,000	$ 11,061,000	-38.27%
Aged/Disabled Total	**880,829**	**$ 1,182.20**	**91.38%**	**$ 1,293.65**	**$ 98,180,000**	**$ 1,571,000**	**$ 99,751,000**	**$ 100,001,000**	**$ 99,501,000**	-37.22%
Other Professional	2,546,924	$ 98.34	89.57%	$ 109.79	$ 29,170,000	$ 530,000	$ 29,700,000	$ 29,800,000	$ 29,600,000	-38.25%
Other PNMI/CRBH	2,546,924	$ 22.60	92.20%	$ 24.51	$ 4,870,000	$ 560,000	$ 5,430,000	$ 5,580,000	$ 5,280,000	-45.70%
Other Other	2,546,924	$ 22.97	89.21%	$ 25.75	$ 7,080,000	$ 230,000	$ 7,310,000	$ 7,410,000	$ 7,210,000	-39.34%
Other Total	**2,546,924**	**$ 143.91**	**89.91%**	**$ 160.06**	**$ 41,120,000**	**$ 1,320,000**	**$ 42,440,000**	**$ 42,790,000**	**$ 42,090,000**	-39.50%
Grand Total	3,427,753	$ 410.72	91.00%	$ 451.36						
Total Dollars		$ 1,407,850,442		$ 1,547,140,213	$ 139,300,000	$ 2,891,000	$ 142,191,000	$ 142,791,000	$ 141,591,000	
Difference from Table 1*		$ (18,437,970)		$ (62,538,239)						
Remaining reserve							$ 3,100,000	$ 3,700,000	$ 2,500,000	
Margin - 10% on Remaining Reserve							$ 300,000	$ 400,000	$ 300,000	
Final Reserve							$ 142,491,000	$ 143,191,000	$ 141,891,000	

TABLE 3
Run-out and Pended Claims for SFY2011 Incurred Claims

	SFY2011 Run-out			Comments
	Claims paid 7/1/11 - 10/31/11	$	161,509,073	Obtained from SFY11 MIHMS run-out data provided by Nick Fabbricante
	Claims paid 11/1/11 - 11/16/11	$	6,732,298	Per email from Nick Fabbricante on 11/21/2011
	Claims backlog as of 11/17/2011	$	13,124,190	Per email from Nick Fabbricante on 11/17/2011 (60% paid/billed ratio applied to $21,873,650 billed in inventory)
	Remaining IBNP (see table below)	$	21,006,003	Calculated in table below
	10% Margin	$	3,413,019	10% margin applied to estimates of unknown reserve (considering backlog as unknown since don't know exact paid amounts)
	Total 6/30/2011 IBNP	**$**	**205,780,000**	

	SFY2011 IBNP After 4 Months of Run-out Development			
A	Claims paid July 2010 - October 2010 for SFY10 incurreds (from total claims triangle)	$	122,442,800	
B	SFY10 Reserve	$	142,491,000	
C = B - A	SFY10 reserve remaining after four months runout	$	20,048,200	
D	SFY10 Member Months		3,427,753	
E = C / D	PMPM	$	5.85	
F	SFY11 Member Months		3,591,514	
G = E * F	**SFY 11 reserve remaining after four months**	**$**	**21,006,003**	Assumed 0% trend

TABLE 4A

SFY2011 IBNP Development - Modified Completion Factor Method

	SFY2010			SFY2011									
Category	Member Months	Estimated Incurred PMPM	Implied Trend	Member Months	Paid PMPM at 6/30/11	[illegible]	Est. % Complete at 6/30/11	[illegible]	Estimated Incurred PMPM	Reserve at 6/30/11	[illegible]	Prior period reserve est.	Total reserve
Aged/Disabled Professional	880,829	$ 677.70	-5.3%	892,441	$ 563.58	$ 627.81	87.83%	97.84%	$ 641.67	$ 69,690,000	$ 57,326,444.65	$ 710,000	$ 70,400,000
Aged/Disabled PNMI/CRBH	880,829	$ 206.55	21.7%	892,441	$ 219.48	$ 248.83	87.32%	99.00%	$ 251.34	$ 28,430,000	$ 26,189,056.20	$ 420,000	$ 28,850,000
Aged/Disabled Nursing Facility	880,829	$ 314.66	-13.1%	892,441	$ 228.92	$ 264.13	83.75%	96.63%	$ 273.33	$ 39,640,000	$ 31,427,270.23	$ 540,000	$ 40,180,000
Aged/Disabled Other	880,829	$ 94.74	-3.0%	892,441	$ 77.67	$ 89.03	84.51%	96.87%	$ 91.91	$ 12,710,000	$ 10,142,628.78	$ 1,000	$ 12,711,000
Aged/Disabled Total	880,829	$ 1,293.65	-2.7%	892,441	$ 1,089.64	$ 1,229.80	86.60%	97.74%	$ 1,258.25	$ 150,470,000	$ 125,085,399.85	$ 1,671,000	$ 152,141,000
Other Professional	2,546,924	$ 109.79	-24.1%	2,699,073	$ 72.96	$ 81.24	87.57%	97.50%	$ 83.32	$ 27,960,000	$ 22,333,153.64	$ 560,000	$ 28,520,000
Other PNMI/CRBH	2,546,924	$ 24.51	-16.9%	2,699,073	$ 18.39	$ 20.03	90.32%	98.38%	$ 20.36	$ 5,320,000	$ 4,427,926.56	$ 600,000	$ 5,920,000
Other Other	2,546,924	$ 25.75	35.6%	2,699,073	$ 29.66	$ 33.24	84.96%	95.21%	$ 34.92	$ 14,180,000	$ 9,662,593.13	$ 320,000	$ 14,500,000
Other Total	2,546,924	$ 160.06	-13.4%	2,699,073	$ 121.02	$ 134.51	87.31%	97.05%	$ 138.60	$ 47,460,000	$ 36,423,673.33	$ 1,480,000	$ 48,940,000
Grand Total	3,427,753	$ 451.36	-7.7%	3,591,514	$ 361.71	$ 406.68	86.78%	97.57%	$ 416.82				
Grand Total Dollars					$ 1,299,074,431	$ 1,460,583,504			$ 1,497,009,173	$ 197,930,000	$ 161,509,073	$ 3,151,000	$ 201,081,000
Remaining reserve													$ 39,571,927
Margin - 10%													$ 4,000,000
Final Reserve													$ 205,081,000

TABLE 4B

SFY2011 IBNP Development - Incurred PMPM Trend Method

	SFY2010			SFY2011									
Category	Member Months	Estimated Incurred PMPM	Implied Trend	Member Months	Paid PMPM at 6/30/11	[illegible]	Est. % Complete at 6/30/11	[illegible]	Estimated Incurred PMPM	Reserve at 6/30/11	[illegible]	Prior period reserve est.	Total reserve
Aged/Disabled Professional	880,829	$ 677.70	0.0%	892,441	$ 563.58	$ 627.81	83.16%	92.64%	$ 677.70	$ 101,850,000	$ 57,326,444.65	$ 710,000	$ 102,560,000
Aged/Disabled PNMI/CRBH	880,829	$ 206.55	23.0%	892,441	$ 219.48	$ 248.83	86.39%	97.94%	$ 254.06	$ 30,860,000	$ 26,189,056.20	$ 420,000	$ 31,280,000
Aged/Disabled Nursing Facility	880,829	$ 314.66	0.0%	892,441	$ 228.92	$ 264.13	72.75%	83.94%	$ 314.66	$ 76,520,000	$ 31,427,270.23	$ 540,000	$ 77,060,000
Aged/Disabled Other	880,829	$ 94.74	0.0%	892,441	$ 77.67	$ 89.03	81.98%	93.97%	$ 94.74	$ 15,240,000	$ 10,142,628.78	$ 1,000	$ 15,241,000
Aged/Disabled Total	880,829	$ 1,293.65	3.7%	892,441	$ 1,089.64	$ 1,229.80	81.25%	91.70%	$ 1,341.16	$ 224,470,000	$ 125,085,399.85	$ 1,671,000	$ 226,141,000
Other Professional	2,546,924	$ 109.79	0.0%	2,699,073	$ 72.96	$ 81.24	66.45%	73.99%	$ 109.79	$ 99,410,000	$ 22,333,153.64	$ 560,000	$ 99,970,000
Other PNMI/CRBH	2,546,924	$ 24.51	0.0%	2,699,073	$ 18.39	$ 20.03	75.02%	81.71%	$ 24.51	$ 16,530,000	$ 4,427,926.56	$ 600,000	$ 17,130,000
Other Other	2,546,924	$ 25.75	32.0%	2,699,073	$ 29.66	$ 33.24	87.28%	97.81%	$ 33.99	$ 11,670,000	$ 9,662,593.13	$ 320,000	$ 11,990,000
Other Total	2,546,924	$ 160.06	5.1%	2,699,073	$ 121.02	$ 134.51	71.91%	79.92%	$ 168.30	$ 127,610,000	$ 36,423,673.33	$ 1,480,000	$ 129,090,000
Grand Total	3,427,753	$ 451.36	1.9%	3,591,514	$ 361.71	$ 406.68	78.68%	88.46%	$ 459.74				
Grand Total Dollars					$ 1,299,074,431	$ 1,460,583,504			$ 1,651,151,460	$ 352,080,000	$ 161,509,073	$ 3,151,000	$ 355,231,000
Remaining reserve													$ 193,721,927
Margin - 10%													$ 19,400,000
Final Reserve													$ 374,631,000

TABLE 4C

SFY2011 IBNP Development - Midpoint

	SFY2010			SFY2011									
Category	Member Months	Estimated Incurred PMPM	Implied Trend	Member Months	Paid PMPM at 6/30/11	[illegible]	Est % complete at 6/30/11	[illegible]	Estimated Incurred PMPM	Reserve at 6/30/11	[illegible]	Prior period reserve est.	Total reserve (mid pt)
Aged/Disabled Professional	880,829	$ 677.70	-2.7%	892,441	$ 563.58	$ 627.81	85.43%	95.17%	$ 659.69	$ 85,770,000	$ 57,326,444.65	$ 710,000	$ 86,480,000
Aged/Disabled PNMI/CRBH	880,829	$ 206.55	22.3%	892,441	$ 219.48	$ 248.83	86.85%	98.47%	$ 252.70	$ 29,640,000	$ 26,189,056.20	$ 420,000	$ 30,060,000
Aged/Disabled Nursing Facility	880,829	$ 314.66	-6.6%	892,441	$ 228.92	$ 264.13	77.86%	89.84%	$ 293.99	$ 58,080,000	$ 31,427,270.23	$ 540,000	$ 58,620,000
Aged/Disabled Other	880,829	$ 94.74	-1.5%	892,441	$ 77.67	$ 89.03	83.22%	95.40%	$ 93.32	$ 13,970,000	$ 10,142,628.78	$ 1,000	$ 13,971,000
Aged/Disabled Total	880,829	$ 1,293.65	0.5%	892,441	$ 1,089.64	$ 1,229.80	83.84%	94.62%	$ 1,299.71	$ 187,460,000	$ 125,085,399.85	$ 1,671,000	$ 189,131,000
Other Professional	2,546,924	$ 109.79	-12.1%	2,699,073	$ 72.96	$ 81.24	75.56%	84.13%	$ 96.56	$ 63,690,000	$ 22,333,153.64	$ 560,000	$ 64,250,000
Other PNMI/CRBH	2,546,924	$ 24.51	-8.5%	2,699,073	$ 18.39	$ 20.03	81.96%	89.27%	$ 22.44	$ 10,920,000	$ 4,427,926.56	$ 600,000	$ 11,520,000
Other Other	2,546,924	$ 25.75	33.8%	2,699,073	$ 29.66	$ 33.24	86.10%	96.49%	$ 34.45	$ 12,930,000	$ 9,662,593.13	$ 320,000	$ 13,250,000
Other Total	2,546,924	$ 160.06	-4.1%	2,699,073	$ 121.02	$ 134.51	78.86%	87.66%	$ 153.45	$ 87,540,000	$ 36,423,673.33	$ 1,480,000	$ 89,020,000
Grand Total	3,427,753	$ 451.36	-2.9%	3,591,514	$ 361.71	$ 406.68	82.53%	92.79%	$ 438.28				
Grand Total Dollars					$ 1,299,074,431	$ 1,460,583,504			$ 1,574,080,317	$ 275,000,000	$ 161,509,073	$ 3,151,000	$ 278,151,000
Remaining reserve													$ 116,641,927
Margin - 10%													$ 11,700,000
Final Reserve													$ 289,851,000

Deloitte

ATTACHMENT - C

MaineCare Claims Adjustments

Background

The State of Maine Department of Audit conducted a review of MaineCare claims adjustments for the period of January 2005 through December 2009, and as a result issued a finding in the State Fiscal Year 2010 Single Audit Report citing the improper application and reporting of the Federal Medical Assistance Percentage (FMAP) for claims adjustments processed in the Maine Claims Management System (MeCMS). The Department of Audit identified the *known questioned costs* as indeterminable. The unofficial amount that the Department of Audit determined was billed in error to the federal government totaled $11.7M.

The Department of Health and Human Services established communications with the Centers for Medicare and Medicaid Services (CMS) soon after to address the concerns identified by the Department of Audit and gain an understanding of CMS's interpretation of the federal regulations.

The Office of Inspector General (OIG), Office of Audit Services notified the Department in late-July of their intention to conduct an audit of the "Claim Adjustments Made to the Centers for Medicare and Medicaid Services Form 64" for the period January 1, 2005 through December 31, 2009. The OIG indicated that CMS contacted them and requested that they perform this audit.

The underlying issue is that for claims adjustments that were originally paid at a different FMAP than our current FMAP, the adjustment process does not comply with federal regulations. It is important to note that claims are adjusted the same way in the new claims system, Maine Integrated Health Management System (MIHMS) as they were in MeCMS.

Historically, changes in FMAP have been fairly immaterial. However, the enhanced rate the State of Maine received from the American Recovery and Reinvestment Act of 2009 exacerbated the difference between the current process and the proposed process by the OIG and the Department of Audit.

Federal Regulation Citations

- Social Security Act, Section 1903(A)(1)
- CMS State Medicaid Manual, Section 2500.2

MaineCare Claims Adjustments

Current Claims Adjustment Process – Example

For purposes of this example, we will assume that the original claim payment was processed and paid in SFY08 and that it was a "date of service" adjustment with no impact to total claim dollars.

- Original Claim: The original $100 claim paid at 63.31% - Federal $63.31 / State $36.69.
- Adjusted Claim: An adjustment to the claim is processed in SFY09 (SFY09 FMAP: 74.35%). The system handles this adjustment as follows:
    - Reverses the claim at the original FMAP: Federal <$63.31> / State <$36.69>
    - Reprocesses the claim, correcting the dates of service, and repays the claim at the current FMAP: Federal $74.35 / State $25.65.
- Result: In this example, the federal share increased $11.04.

The OIG has explained that their interpretation of the regulation is that the original FMAP should have been applied to the reprocessed claim and that there should not be a change in the federal share of the payment.

Current Status of the OIG Review

The Department and the OIG held an entrance conference on September 27, 2011, at which time they explained what information they would be reviewing and their interpretation of the federal regulations. They estimated that the audit review would be complete by the end of the calendar year, a draft report would be issued in March or April, and a final report would be issued in mid-to-late summer.

The Department provided the OIG with the claims adjustment transactions for the audit period on September 15, 2011.

Current Impact to the General Fund

Beginning in July 2011, the enhanced ARRA FMAP was no longer available to states. Therefore, any adjustment of claims processed after July 1 that were originally processed during the ARRA period have a negative impact to the General Fund. To date in SFY12, approximately $3 million of General Fund dollars have been used for this purpose.

ATTACHMENT - D

Budget Initiative Fact Sheet

Office: MaineCare Services **Date:** 12/13/2011

Initiative #: 7462 – Non-Medicaid Elderly in a Residential Setting

Account: Z009

I. Budget Proposal Description:

This initiative eliminates state funded medical coverage for individuals who are meeting a deductible necessary to become MaineCare eligible and who reside in Private Non Medical Institutions. The state is paying 100 percent of their services (less cost of care) while the individual is meeting their deductible.

II. Financial Information:

4 Years of Spending:

	SFY'08	SFY'09	SFY'10	SFY'11
General Fund	14,603,979	12,461,288	14,562,525	13,511,246
Other Special Revenue				
Federal Funds				
Total	14,603,979	12,461,288	14,562,525	13,511,246

Other sources of funding for program, i.e. FHM? ☐ Yes x No

III. Total Members Eligible: 2,100

IV. Program Eligibility Criteria:

Individuals who reside in Private Non-Medical Institutions who do not have enough monthly income to pay the private rate of the facility. These individuals have income over 100 percent FPL ($908) and are under the asset limit of $2,000.They reside in Residential Care Facilities defined in Appendix C and F of the MaineCare Benefits Manual. Once these members spend down their income, they become eligible for MaineCare.

V. Current Budget Proposal:

1) Appropriation Increase: $ -0-

SFY'12 SFY'13

ATTACHMENT - E

FINANCIAL ORDER/EXPENDITURE SUMMARY FOR 010-Z00901

FINANCIAL ORDERS/BUDGET:	FY2008	FY2009	FY2010	FY2011	FY2012
Original Allotment	7,980,783	10,814,379	10,814,379	6,274,174	6,058,174
Transfer In - **FROM** other MaineCare Accts:	2,265,000	0	4,200,000	12,479,798	20,032,261
Transfer Out **TO** other MaineCare Accts:	(400,000)	(1,000,000)	(440,000)	(970,000)	(3,710,000)
Transfer Out Per State-Wide Resolve 2009 2009, Ch. 167, 2009 PL Ch. 522,534,569,584,615			(4,314,296)		
	9,845,783	9,814,379	10,260,083	17,783,972	22,380,435
EXPENDITURES:					
Expenditures:	15,656,885	13,443,981	16,169,948	24,823,321	18,595,717
Expenditures Transfer Out TO 010-014701 Acct:	(6,232,209)	(5,253,365)	(6,239,663)	(7,071,610)	(1,501,906)
	9,424,677	8,190,616	9,930,285	17,751,711	17,093,810
	421,106	1,623,763	329,798	32,261	5,286,625

Response to question #4 under the PNMI/R&B section from Steefanie & Nick on the "Notes from the December 13 Briefing on the DHHS Supplemental Budget" document

ATTACHMENT - F

ENROLLMENT - TOTAL MEMBERS ENROLLED

"What is the average total cost per member?" (TOTAL COST)/(TOTAL ENROLLED)

REPORT PMPM - all members

Time Period Jul 2007 - Sep 2011, all claims PAID, then sorted by SRVC DATE

NOTE: Net Payment has been GROSSED UP as if 100% of claims generated were both billed to MaineCare and paid by MaineCare

	Traditional Medicaid				CHIP Medicaid Expansion				CHIP Cub Care			
Service Month	Members	PMPM	BUMP % BILLED	Net Payment Grossed to 100%	Members	PMPM	BUMP % BILLED	Net Payment Grossed to	Members	PMPM	BUMP % BILLED	Net Payment Grossed to
Jul-07	221,522	$549.88	99.99%	$ 121,810,700	9,690	$110.25	99.99%	$ 1,068,354	4,654	$108.83	99.99%	$ 506,479.79
Aug-07	222,029	$540.97	99.99%	$ 120,110,979	9,639	$118.32	99.99%	$ 1,140,461	4,647	$146.56	99.99%	$ 681,060.58
Sep-07	222,235	$497.92	99.98%	$ 110,654,269	9,836	$117.85	99.99%	$ 1,159,220	4,566	$113.15	99.99%	$ 516,631.86
Oct-07	222,182	$585.01	99.97%	$ 129,977,655	9,789	$152.37	99.97%	$ 1,491,561	4,574	$162.22	99.98%	$ 741,984.10
Nov-07	220,962	$531.00	99.97%	$ 117,331,862	9,881	$143.82	99.97%	$ 1,421,046	4,581	$132.49	99.98%	$ 606,945.24
Dec-07	220,971	$518.85	99.96%	$ 114,651,144	9,874	$125.63	99.97%	$ 1,240,493	4,577	$114.87	99.97%	$ 525,759.22
Jan-08	222,920	$575.66	99.97%	$ 128,326,495	9,408	$143.56	99.97%	$ 1,350,581	4,714	$135.65	99.97%	$ 639,468.01
Feb-08	223,604	$515.43	99.96%	$ 115,252,143	9,218	$139.24	99.97%	$ 1,283,469	4,730	$133.16	99.97%	$ 629,862.92
Mar-08	223,599	$567.81	99.95%	$ 126,961,394	9,307	$145.86	99.95%	$ 1,357,511	4,733	$134.11	99.94%	$ 634,761.75
Apr-08	222,867	$599.82	99.96%	$ 133,680,401	9,383	$155.59	99.96%	$ 1,459,915	4,757	$131.57	99.95%	$ 625,865.18
May-08	222,716	$605.79	99.96%	$ 134,918,563	9,477	$142.32	99.97%	$ 1,348,795	4,759	$127.76	99.97%	$ 607,995.15
Jun-08	222,337	$536.47	99.96%	$ 119,276,421	9,445	$136.28	99.96%	$ 1,287,145	4,702	$117.31	99.96%	$ 551,570.46
Jul-08	222,198	$600.66	99.93%	$ 133,465,022	9,616	$144.47	99.90%	$ 1,389,212	4,673	$119.49	99.90%	$ 558,380.60
Aug-08	222,465	$585.32	99.95%	$ 130,212,954	9,736	$157.16	99.95%	$ 1,530,105	4,558	$110.44	99.95%	$ 503,406.07
Sep-08	222,450	$564.37	99.95%	$ 125,543,222	9,832	$147.52	99.96%	$ 1,450,389	4,614	$121.37	99.95%	$ 560,021.06
Oct-08	222,153	$724.82	99.95%	$ 161,020,621	9,909	$176.17	99.96%	$ 1,745,700	4,670	$147.17	99.95%	$ 687,300.16
Nov-08	222,660	$555.10	99.96%	$ 123,599,397	9,993	$151.38	99.96%	$ 1,512,734	4,605	$130.93	99.96%	$ 602,953.33
Dec-08	223,041	$408.08	99.94%	$ 91,018,997	9,955	$124.64	99.96%	$ 1,240,797	4,663	$105.17	99.95%	$ 490,427.60
Jan-09	227,820	$388.67	99.96%	$ 88,545,810	9,244	$122.99	99.96%	$ 1,136,953	4,753	$102.42	99.96%	$ 486,780.46
Feb-09	229,726	$469.10	99.97%	$ 107,764,617	9,042	$134.31	99.97%	$ 1,214,463	4,778	$168.76	99.97%	$ 806,317.58
Mar-09	230,646	$564.36	99.97%	$ 130,166,249	9,408	$170.68	99.97%	$ 1,605,740	4,816	$130.14	99.96%	$ 626,737.47
Apr-09	230,891	$573.82	99.97%	$ 132,489,360	9,790	$164.43	99.97%	$ 1,609,815	4,819	$152.55	99.97%	$ 735,139.20
May-09	231,671	$553.72	99.97%	$ 128,280,304	10,007	$171.50	99.98%	$ 1,716,230	4,892	$159.73	99.98%	$ 781,402.29
Jun-09	233,037	$545.51	99.97%	$ 127,124,723	10,290	$153.98	99.98%	$ 1,584,499	4,852	$125.31	99.98%	$ 608,026.92
Jul-09	233,899	$656.08	99.97%	$ 153,455,743	10,656	$120.30	99.98%	$ 1,281,946	4,914	$91.97	99.97%	$ 451,916.73
Aug-09	235,272	$633.30	99.97%	$ 148,997,442	10,833	$112.23	99.98%	$ 1,215,775	4,888	$89.89	99.98%	$ 439,394.08
Sep-09	236,408	$588.52	99.97%	$ 139,131,492	11,015	$138.56	99.97%	$ 1,526,196	4,900	$105.75	99.97%	$ 518,172.54
Oct-09	238,999	$595.55	99.97%	$ 142,337,041	11,335	$156.15	99.97%	$ 1,769,934	5,012	$117.39	99.97%	$ 588,383.15
Nov-09	239,542	$546.98	99.96%	$ 131,025,856	11,551	$139.75	99.97%	$ 1,614,222	5,064	$109.21	99.96%	$ 553,031.85
Dec-09	240,332	$543.25	99.96%	$ 130,559,567	11,531	$132.41	99.96%	$ 1,526,855	5,213	$126.11	99.97%	$ 657,432.39
Jan-10	241,725	$580.01	99.96%	$ 140,203,197	11,646	$141.82	99.96%	$ 1,651,688	5,186	$129.58	99.96%	$ 671,997.61
Feb-10	241,806	$526.85	99.95%	$ 127,396,447	11,957	$135.53	99.95%	$ 1,620,475	5,234	$133.94	99.95%	$ 701,035.92
Mar-10	242,763	$599.07	99.94%	$ 145,432,984	12,135	$166.46	99.95%	$ 2,020,038	5,278	$142.63	99.96%	$ 752,799.14
Apr-10	243,458	$540.16	99.94%	$ 131,505,671	12,140	$160.04	99.95%	$ 1,942,831	5,268	$139.60	99.95%	$ 735,426.43
May-10	244,084	$524.14	99.94%	$ 127,935,273	12,051	$158.47	99.94%	$ 1,909,683	5,255	$129.87	99.95%	$ 682,470.51
Jun-10	245,320	$499.10	99.93%	$ 122,438,560	11,976	$148.10	99.94%	$ 1,773,685	5,397	$122.51	99.95%	$ 661,177.26
Jul-10	242,809	$513.30	99.91%	$ 124,634,876	9,459	$110.16	99.93%	$ 1,041,983	5,381	$102.02	99.94%	$ 548,981.76
Aug-10	244,838	$488.53	99.85%	$ 119,611,508	9,530	$120.15	99.88%	$ 1,145,036	5,434	$104.38	99.90%	$ 567,178.53
Sep-10	245,903	$555.47	99.75%	$ 136,592,833	9,633	$161.72	99.77%	$ 1,557,824	5,520	$138.24	99.77%	$ 763,111.70
Oct-10	246,600	$566.94	99.53%	$ 139,806,625	9,645	$163.19	99.39%	$ 1,573,963	5,572	$139.87	99.35%	$ 779,376.61
Nov-10	247,267	$547.30	99.46%	$ 135,329,656	9,590	$148.77	99.22%	$ 1,426,702	5,641	$179.07	99.25%	$ 1,010,109.69
Dec-10	247,725	$543.05	99.29%	$ 134,527,591	9,650	$155.05	98.92%	$ 1,496,240	5,730	$129.02	98.91%	$ 739,282.09
Jan-11	248,561	$575.64	99.26%	$ 143,081,461	9,770	$153.97	98.97%	$ 1,504,249	5,800	$143.37	98.96%	$ 831,546.62
Feb-11	249,277	$504.16	99.06%	$ 125,675,111	9,616	$148.51	98.95%	$ 1,428,088	5,790	$137.96	98.88%	$ 798,797.53
Mar-11	250,522	$547.54	98.87%	$ 137,172,042	9,691	$168.99	98.73%	$ 1,637,719	5,819	$162.62	98.60%	$ 946,308.13
Apr-11	250,497	$498.64	98.65%	$ 124,907,617	9,834	$137.04	98.57%	$ 1,347,631	5,824	$129.83	98.45%	$ 756,136.55
May-11	251,361	$519.45	98.18%	$ 130,569,034	9,911	$143.98	98.13%	$ 1,427,000	5,856	$130.71	98.08%	$ 765,432.38
Jun-11	251,147	$506.99	96.91%	$ 127,328,416	10,110	$130.47	97.18%	$ 1,319,007	5,835	$122.18	97.35%	$ 712,895.56
Jul-11	251,756	$552.87	92.74%	$ 139,188,368	10,307	$129.68	93.96%	$ 1,336,649	5,854	$110.60	94.41%	$ 647,432.93
Aug-11	252,163	$531.12	64.65%	$ 133,928,414	10,434	$135.71	61.29%	$ 1,416,016	5,841	$185.13	60.52%	$ 1,081,325.33
Sep-11	250,207	$535.27	55.34%	$ 133,928,414	10,588	$147.26	58.42%	$ 1,559,222	5,834	$134.87	58.98%	$ 786,813.68
Oct-11	250,949	$534.56		$ 134,146,174	10,606	$147.40		$ 1,563,340	5,863	$135.06		$ 791,927.36
Nov-11	251,691	$533.84		$ 134,363,933	10,625	$147.53		$ 1,567,457	5,893	$135.26		$ 797,041.03
Dec-11	252,433	$533.14		$ 134,581,693	10,643	$147.67		$ 1,571,575	5,922	$135.45		$ 802,154.71
Jan-12	253,175	$532.44		$ 134,799,452	10,661	$147.80		$ 1,575,692	5,952	$135.64		$ 807,268.39
Feb-12	253,917	$531.74		$ 135,017,212	10,679	$147.93		$ 1,579,809	5,981	$135.83		$ 812,382.06
Mar-13	254,659	$531.04		$ 135,234,971	10,698	$148.06		$ 1,583,927	6,010	$136.01		$ 817,495.74
Apr-12	255,401	$530.35		$ 135,452,731	10,716	$148.20		$ 1,588,044	6,040	$136.20		$ 822,609.42
May-12	256,143	$529.67		$ 135,670,490	10,734	$148.33		$ 1,592,162	6,069	$136.38		$ 827,723.09
Jun-12	256,885	$528.99		$ 135,888,249	10,752	$148.46		$ 1,596,279	6,099	$136.56		$ 832,836.77

Measure of variance:	R Square=	0.95			R Square=	0.08			R Square=	0.91		
	very small variance in members				large variance in members				very small variance in members			
		Avg PMPM	Avg Cycle	Normalized Total:		Avg PMPM	Avg Cycle	Normalized Total:		Avg PMPM	Avg Cycle	Normalized Total:
SFY 2010 AVG		$568.88	31,546,524	$ 1,640,419,272		$143.01	381,795	$ 19,853,328		$120.33	142,562	$ 7,413,237.61
SFY 2011 AVG		$530.57	30,369,938	$ 1,579,236,770		$145.19	325,105	$ 16,905,441		$135.17	177,291	$ 9,219,157.14
SFY 2012 AVG		$533.73	31,196,156	$ 1,622,200,102		$145.40	356,349	$ 18,530,172		$137.71	188,981	$ 9,827,010.51

	Member Months	times Avg PMPM	Estimated impact from membership:	Member Months	times Avg PMPM	Estimated impact from membership:	Member Months	times Avg PMPM	Estimated impact from membership:
June 2011 Member Months	3,013,764			121,320			70,020		
Actual FY 2012 Member Months	3,039,378			127,442			71,359		
Avg Increase in Member Months	**25,614**	$533.73	$13,670,636	**6,122**	$145.40	$890,208	**1,339**	$137.71	$184,338
Increase in Avg PMPM		$3.16			$0.21			$2.54	
Jun 2011 Enrollment *		251,147			10,110			5,835	
Estimated Impact due to PMPM *		$ 9,525,356			$ 25,865			$ 177,769	

ENROLLMENT - TOTAL MEMBERS ENROLLED

"What is the average total cost per member?" (TOTAL COST)/(TOTAL ENROLLED)

REPORT **PMPM - all members**

Time Period Jul 2007 - Sep 2011, all claims PAID, then sorted by SRVC DATE

NOTE: Net Payment has been GROSSED UP as if 100% of claims generated were both billed to MaineCare and paid by MaineCare

	MEDICAID PARENT EXPANSION 101% 150% FPL				MEDICAID PARENT EXPANSION 151% 200% FPL				CHILDLESS ADULT WAIVER			
Service Month	Members	PMPM	BUMP % BILLED	Net Payment Grossed to	Members	PMPM	BUMP % BILLED	Net Payment Grossed to	Members	PMPM	BUMP % BILLED	Net Payment Grossed to
Jul-07	19,168	$72.46	99.99%	$ 1,388,963	5,693	$118.32	99.99%	$ 673,602	19,696	$98.45	99.99%	$ 1,939,031
Aug-07	19,154	$77.13	99.99%	$ 1,477,408	5,688	$58.70	99.99%	$ 333,859	20,586	$99.64	99.99%	$ 2,051,227
Sep-07	19,187	$72.26	99.99%	$ 1,386,370	5,647	$54.71	99.99%	$ 308,946	20,655	$110.41	99.99%	$ 2,280,545
Oct-07	19,179	$87.90	99.99%	$ 1,685,847	5,659	$65.93	99.99%	$ 373,115	20,585	$125.71	99.99%	$ 2,587,793
Nov-07	19,143	$75.83	99.98%	$ 1,451,600	5,670	$62.01	99.99%	$ 351,581	20,169	$117.50	99.98%	$ 2,369,862
Dec-07	19,075	$67.90	99.98%	$ 1,295,247	5,646	$53.66	99.98%	$ 302,963	19,178	$116.80	99.98%	$ 2,240,016
Jan-08	18,653	$86.89	99.98%	$ 1,620,802	5,746	$81.76	99.99%	$ 469,799	18,165	$147.37	99.98%	$ 2,677,050
Feb-08	18,288	$87.13	99.97%	$ 1,593,429	5,781	$66.85	99.98%	$ 386,472	17,252	$130.94	99.97%	$ 2,258,975
Mar-08	18,392	$86.48	99.95%	$ 1,590,590	5,760	$76.59	99.97%	$ 441,170	16,255	$144.17	99.95%	$ 2,343,456
Apr-08	18,413	$84.85	99.96%	$ 1,562,320	5,736	$95.54	99.98%	$ 548,035	15,288	$182.19	99.96%	$ 2,785,317
May-08	18,297	$78.05	99.97%	$ 1,428,015	5,715	$69.17	99.97%	$ 395,323	14,458	$168.03	99.97%	$ 2,429,394
Jun-08	18,406	$85.85	99.96%	$ 1,580,104	5,726	$72.15	99.97%	$ 413,148	13,720	$126.70	99.97%	$ 1,738,360
Jul-08	18,518	$102.47	99.93%	$ 1,897,477	5,714	$89.60	99.95%	$ 511,995	13,808	$155.00	99.94%	$ 2,140,221
Aug-08	18,576	$92.42	99.95%	$ 1,716,853	5,712	$80.72	99.97%	$ 461,082	13,307	$165.29	99.96%	$ 2,199,572
Sep-08	18,735	$100.03	99.96%	$ 1,874,155	5,666	$85.23	99.97%	$ 482,903	12,594	$166.48	99.97%	$ 2,096,706
Oct-08	18,995	$106.86	99.97%	$ 2,029,738	5,729	$118.44	99.97%	$ 678,566	11,871	$178.38	99.97%	$ 2,117,538
Nov-08	18,885	$92.99	99.97%	$ 1,756,126	5,642	$83.73	99.98%	$ 472,405	11,409	$161.14	99.97%	$ 1,838,436
Dec-08	18,777	$93.36	99.97%	$ 1,753,055	5,702	$77.01	99.98%	$ 439,121	10,979	$174.91	99.96%	$ 1,920,365
Jan-09	17,610	$101.39	99.97%	$ 1,785,529	5,747	$83.00	99.98%	$ 477,000	10,404	$260.12	99.98%	$ 2,706,308
Feb-09	17,121	$79.04	99.98%	$ 1,353,184	5,628	$70.64	99.98%	$ 397,562	10,051	$148.53	99.98%	$ 1,492,848
Mar-09	17,055	$108.45	99.98%	$ 1,849,644	5,694	$110.01	99.98%	$ 626,377	9,639	$169.65	99.98%	$ 1,635,222
Apr-09	17,029	$130.19	99.98%	$ 2,216,957	5,812	$80.08	99.98%	$ 465,407	12,006	$137.83	99.98%	$ 1,654,747
May-09	17,087	$79.36	99.98%	$ 1,355,985	5,970	$72.62	99.99%	$ 433,532	11,689	$133.38	99.99%	$ 1,559,022
Jun-09	17,223	$90.35	99.98%	$ 1,556,039	5,979	$74.36	99.99%	$ 444,625	11,519	$150.83	99.98%	$ 1,737,380
Jul-09	17,357	$84.57	99.98%	$ 1,467,881	6,070	$71.87	99.99%	$ 436,264	11,255	$152.54	99.99%	$ 1,716,881
Aug-09	17,383	$94.16	99.98%	$ 1,636,745	6,167	$68.37	99.98%	$ 421,653	10,976	$213.34	99.99%	$ 2,341,573
Sep-09	17,308	$90.40	99.98%	$ 1,564,637	6,250	$68.65	99.98%	$ 429,041	10,654	$163.66	99.99%	$ 1,743,612
Oct-09	16,933	$93.33	99.98%	$ 1,580,317	6,350	$67.80	99.98%	$ 430,536	10,571	$168.25	99.99%	$ 1,778,587
Nov-09	17,171	$84.52	99.98%	$ 1,451,377	6,396	$65.88	99.98%	$ 421,380	10,928	$148.02	99.98%	$ 1,617,521
Dec-09	17,017	$76.16	99.97%	$ 1,296,083	6,441	$79.30	99.98%	$ 510,763	10,665	$144.44	99.98%	$ 1,540,451
Jan-10	17,093	$91.16	99.97%	$ 1,558,190	6,547	$89.54	99.97%	$ 586,191	11,219	$159.72	99.98%	$ 1,791,872
Feb-10	17,311	$97.22	99.97%	$ 1,682,986	6,554	$77.33	99.97%	$ 506,840	10,912	$164.39	99.96%	$ 1,793,813
Mar-10	17,387	$114.83	99.95%	$ 1,996,517	6,661	$105.70	99.95%	$ 704,088	12,779	$182.43	99.91%	$ 2,331,302
Apr-10	17,256	$114.28	99.95%	$ 1,972,064	6,743	$85.94	99.96%	$ 579,479	13,251	$170.87	99.95%	$ 2,264,236
May-10	17,476	$98.45	99.96%	$ 1,720,561	6,757	$68.53	99.96%	$ 463,031	16,141	$139.26	99.97%	$ 2,247,762
Jun-10	17,421	$95.88	99.95%	$ 1,670,343	6,773	$75.06	99.95%	$ 508,387	15,948	$143.38	99.97%	$ 2,286,668
Jul-10	20,067	$103.33	99.93%	$ 2,073,536	6,914	$76.56	99.93%	$ 529,365	16,139	$121.67	99.94%	$ 1,963,595
Aug-10	20,116	$92.28	99.89%	$ 1,856,315	6,999	$76.25	99.88%	$ 533,654	16,706	$127.74	99.91%	$ 2,134,048
Sep-10	20,233	$140.45	99.80%	$ 2,841,755	7,027	$107.39	99.78%	$ 754,618	17,815	$173.36	99.85%	$ 3,088,469
Oct-10	20,302	$158.30	99.47%	$ 3,213,851	7,088	$112.25	99.46%	$ 795,649	17,422	$195.84	99.54%	$ 3,411,948
Nov-10	20,381	$154.03	99.40%	$ 3,139,376	7,112	$122.82	99.37%	$ 873,497	17,146	$192.81	99.46%	$ 3,306,000
Dec-10	20,503	$145.42	99.17%	$ 2,981,510	7,218	$117.72	99.18%	$ 849,723	16,832	$188.98	99.30%	$ 3,180,883
Jan-11	20,667	$163.64	99.20%	$ 3,381,972	7,373	$139.76	99.20%	$ 1,030,431	18,756	$171.56	99.35%	$ 3,217,698
Feb-11	20,548	$148.27	98.97%	$ 3,046,704	7,443	$116.04	98.94%	$ 863,719	18,373	$165.92	99.09%	$ 3,048,510
Mar-11	20,726	$146.24	98.94%	$ 3,030,951	7,612	$117.58	98.87%	$ 894,997	18,002	$166.59	99.18%	$ 2,998,917
Apr-11	20,955	$124.52	98.80%	$ 2,609,324	7,697	$92.46	98.69%	$ 711,694	17,520	$142.93	99.03%	$ 2,504,132
May-11	21,278	$122.23	98.50%	$ 2,600,777	7,709	$102.41	98.32%	$ 789,456	17,142	$147.12	98.82%	$ 2,521,899
Jun-11	21,465	$124.86	97.75%	$ 2,680,181	7,715	$102.65	97.48%	$ 791,974	16,629	$148.95	98.40%	$ 2,476,883
Jul-11	21,641	$150.77	94.60%	$ 3,262,821	7,692	$127.50	94.08%	$ 980,751	16,257	$181.30	96.10%	$ 2,947,465
Aug-11	21,809	$131.68	68.04%	$ 2,871,793	7,752	$108.20	69.35%	$ 838,765	15,853	$173.45	65.35%	$ 2,749,634
Sep-11	22,059	$125.93	48.57%	$ 2,777,925	7,713	$105.01	48.33%	$ 809,939	18,957	$138.49	47.60%	$ 2,625,432
Oct-11	22,109	$127.09		$ 2,809,691	7,761	$105.61		$ 819,652	18,607	$141.84		$ 2,639,132
Nov-11	22,158	$128.23		$ 2,841,457	7,809	$106.21		$ 829,366	18,257	$145.30		$ 2,652,832
Dec-11	22,208	$129.38		$ 2,873,224	7,857	$106.80		$ 839,079	17,907	$148.91		$ 2,666,533
Jan-12	22,258	$130.52		$ 2,904,990	7,904	$107.38		$ 848,792	17,557	$152.66		$ 2,680,233
Feb-12	22,308	$131.65		$ 2,936,757	7,952	$107.96		$ 858,506	17,207	$156.56		$ 2,693,933
Mar-13	22,357	$132.78		$ 2,968,523	8,000	$108.53		$ 868,219	16,857	$160.62		$ 2,707,633
Apr-12	22,407	$133.90		$ 3,000,290	8,048	$109.09		$ 877,933	16,507	$164.86		$ 2,721,334
May-12	22,457	$135.02		$ 3,032,056	8,096	$109.64		$ 887,646	16,157	$169.28		$ 2,735,034
Jun-12	22,506	$136.13		$ 3,063,823	8,144	$110.19		$ 897,360	15,807	$173.89		$ 2,748,734

Measure of variance:	R Square=	0.24			R Square=	0.90			R Square=	0.01		
	large variance in members				very small variance in members				very large variance			
		Avg PMPM	Avg Cycle	Normalized Total:		Avg PMPM	Avg Cycle	Normalized Total:		Avg PMPM	Avg Cycle	Normalized Total:
SFY 2010 AVG		$94.62	376,879	$ 19,597,701		$77.18	115,339	$ 5,997,651		$161.42	451,044	$ 23,454,277
SFY 2011 AVG		$135.32	643,389	$ 33,456,251		$107.14	181,130	$ 9,418,776		$162.38	651,019	$ 33,852,981
SFY 2012 AVG		$132.73	679,680	$ 35,343,349		$109.32	199,154	$ 10,356,007		$158.15	626,306	$ 32,567,930
	Member Months	times Avg PMPM	Estimated impact from membership:		Member Months	times Avg PMPM	Estimated impact from membership:		Member Months	times Avg PMPM	Estimated impact from membership:	
June 2011 Member Months	257,580				92,580				199,548			
Actual FY 2012 Member Months	266,277				94,727				205,930			
Avg Increase in Member Months	**8,697**	$132.73	$1,154,379		**2,147**	$109.32	$234,705		**6,382**	$158.15	$1,009,316	
Increase in Avg PMPM		-$2.59				$2.18				-$4.23		
Jun 2011 Enrollment *		21,465				7,715				16,629		
Estimated Impact due to PMPM *		$ (666,337)				$ 201,838				$ (843,678)		

ENROLLMENT - TOTAL MEMBERS ENROLLED

"What is the average total cost per member?" (TOTAL COST)/(TOTAL ENROLLED)

REPORT

Time Period

NOTE: Net Payment has been GROSSED UP as if 100% of claims generated were both billed to MaineCare and paid by MaineCare

	MaineCare AND DEL MeRX				Total			
Service Month	Members	PMPM	BUMP % BILLED	Net Payment Grossed to	Members	PMPM	BUMP % BILLED	Net Payment Grossed to
Jul-07	29,916	$10.15	100.00%	$ 303,729	310,339	$411.45	99.99%	127,689,502
Aug-07	30,123	$11.05	100.00%	$ 333,007	311,866	$404.42	99.99%	126,126,161
Sep-07	30,451	$10.71	100.00%	$ 326,080	312,577	$373.12	99.99%	116,630,131
Oct-07	30,672	$12.30	100.00%	$ 377,342	312,640	$438.94	99.97%	137,230,477
Nov-07	30,901	$12.25	100.00%	$ 378,564	311,307	$398.02	99.97%	123,907,326
Dec-07	31,190	$10.96	99.99%	$ 341,956	310,511	$388.37	99.97%	120,593,542
Jan-08	31,575	$23.53	100.00%	$ 742,997	311,181	$436.48	99.97%	135,823,017
Feb-08	31,798	$16.13	99.99%	$ 512,792	310,671	$392.42	99.97%	121,913,886
Mar-08	32,142	$17.96	99.99%	$ 577,233	310,188	$431.68	99.96%	133,902,059
Apr-08	32,514	$19.18	99.99%	$ 623,493	308,958	$457.28	99.96%	141,281,266
May-08	32,854	$18.55	99.99%	$ 609,479	308,276	$459.76	99.96%	141,733,088
Jun-08	33,194	$16.30	99.99%	$ 541,100	307,530	$407.71	99.96%	125,383,617
Jul-08	33,449	$18.54	99.99%	$ 620,071	307,976	$456.45	99.94%	140,576,890
Aug-08	33,795	$15.59	99.99%	$ 526,754	308,149	$445.06	99.95%	137,145,231
Sep-08	34,438	$18.07	99.99%	$ 622,329	308,329	$430.14	99.96%	132,624,335
Oct-08	34,935	$19.58	99.99%	$ 683,972	308,262	$548.09	99.96%	168,956,523
Nov-08	35,172	$17.21	99.99%	$ 605,253	308,366	$422.82	99.96%	130,382,079
Dec-08	35,435	$19.93	99.99%	$ 706,389	308,552	$316.20	99.95%	97,564,696
Jan-09	36,581	$29.52	99.99%	$ 1,079,817	312,159	$308.22	99.96%	96,215,053
Feb-09	36,887	$21.60	99.99%	$ 796,866	313,233	$363.38	99.97%	113,822,715
Mar-09	37,112	$23.38	100.00%	$ 867,505	314,370	$436.98	99.97%	137,373,709
Apr-09	37,590	$21.29	99.99%	$ 800,431	317,937	$440.24	99.97%	139,968,226
May-09	37,734	$20.12	99.99%	$ 759,196	319,050	$422.76	99.98%	134,882,218
Jun-09	37,950	$21.43	99.99%	$ 813,087	320,850	$417.22	99.97%	133,864,801
Jul-09	38,325	$19.71	99.99%	$ 755,569	322,476	$494.80	99.97%	159,561,660
Aug-09	38,952	$18.94	99.99%	$ 737,665	324,471	$480.12	99.97%	155,785,986
Sep-09	39,573	$20.27	99.99%	$ 801,952	326,108	$446.82	99.97%	145,710,878
Oct-09	39,909	$22.87	99.99%	$ 912,520	329,109	$453.93	99.97%	149,392,887
Nov-09	40,190	$21.79	99.99%	$ 875,838	330,842	$415.77	99.97%	137,554,688
Dec-09	40,221	$21.88	99.99%	$ 880,196	331,420	$413.27	99.96%	136,967,022
Jan-10	40,394	$34.55	99.98%	$ 1,395,797	333,810	$442.93	99.96%	147,854,666
Feb-10	39,858	$26.68	99.98%	$ 1,063,263	333,632	$403.92	99.96%	134,761,481
Mar-10	40,031	$28.93	99.98%	$ 1,158,246	337,034	$458.09	99.94%	154,392,293
Apr-10	40,262	$27.92	99.98%	$ 1,124,056	338,378	$414.09	99.94%	140,119,722
May-10	40,443	$25.42	99.97%	$ 1,028,218	342,207	$397.37	99.95%	135,982,213
Jun-10	40,525	$28.37	99.96%	$ 1,149,612	343,360	$380.02	99.93%	130,482,800
Jul-10	40,243	$27.09	99.95%	$ 1,090,294	341,012	$386.72	99.91%	131,876,377
Aug-10	40,265	$30.52	99.88%	$ 1,228,779	343,888	$369.51	99.86%	127,070,784
Sep-10	40,595	$68.28	99.84%	$ 2,771,626	346,726	$427.89	99.77%	148,359,129
Oct-10	40,866	$75.88	99.81%	$ 3,100,898	347,495	$439.33	99.55%	152,666,221
Nov-10	41,105	$70.16	99.78%	$ 2,883,852	348,242	$424.85	99.48%	147,952,349
Dec-10	41,473	$64.47	99.74%	$ 2,673,950	349,131	$419.40	99.32%	146,427,282
Jan-11	41,790	$93.81	99.66%	$ 3,920,171	352,717	$444.96	99.29%	156,946,158
Feb-11	42,117	$45.33	99.50%	$ 1,909,073	353,164	$387.20	99.09%	136,743,718
Mar-11	42,311	$38.18	99.25%	$ 1,615,546	354,683	$417.95	98.92%	148,240,673
Apr-11	42,600	$30.54	99.03%	$ 1,300,815	354,927	$377.77	98.70%	134,079,446
May-11	42,824	$32.95	98.64%	$ 1,410,881	356,081	$393.17	98.26%	139,998,621
Jun-11	43,090	$31.32	97.48%	$ 1,349,479	355,991	$383.46	97.07%	136,507,303
Jul-11	43,292	$57.52	91.58%	$ 2,490,066	356,799	$422.54	92.91%	150,761,757
Aug-11	43,610	$35.76	79.82%	$ 1,559,357	357,462	$394.60	66.14%	141,055,253
Sep-11	43,871	$48.97	36.41%	$ 2,148,392	359,229	$408.20	53.03%	146,635,826
Oct-11	44,152	$49.58		$ 2,188,928	360,048	$408.33		147,019,316
Nov-11	44,433	$50.18		$ 2,229,463	360,868	$408.47		147,402,805
Dec-11	44,714	$50.77		$ 2,269,998	361,687	$408.60		147,786,295
Jan-12	44,995	$51.35		$ 2,310,533	362,507	$408.74		148,169,785
Feb-12	45,276	$51.93		$ 2,351,069	363,326	$408.87		148,553,274
Mar-13	45,557	$52.50		$ 2,391,604	364,145	$409.00		148,936,764
Apr-12	45,838	$53.06		$ 2,432,139	364,965	$409.14		149,320,254
May-12	46,119	$53.61		$ 2,472,675	365,784	$409.27		149,703,744
Jun-12	46,401	$54.16		$ 2,513,210	366,603	$409.40		150,087,233

Measure of variance:	R Square= 0.96 very small variance			R Square= 0.91 very small variance		
	Avg PMPM	Avg Cycle	Normalized Total:	Avg PMPM	Avg Cycle	Normalized Total:
SFY 2010 AVG	$24.82	228,518	$ 11,882,931	$432.92	33,241,660	1,728,566,296
SFY 2011 AVG	$50.58	485,680	$ 25,255,363	$406.00	32,824,386	1,706,868,059
SFY 2012 AVG	$50.83	526,105	$ 27,357,434	$408.76	34,142,929	1,775,432,306

	Member Months	times Avg PMPM	Estimated impact from membership:	Member Months *	times Avg PMPM	Estimated impact from membership *
June 2011 Member Months	517,080			4,271,892		
Actual FY 2012 Member Months	538,260			4,343,372		
Avg Increase in Member Months	**21,180**	$50.83	$1,076,478	**71,480**	$408.76	$18,220,060
				** Adding across*		** Adding across*

Increase in Avg PMPM	$0.24		$2.76	
Jun 2011 Enrollment *	43,090		355,991	** Adding across*
Estimated Impact due to PMPM *	$ 125,153		$8,545,966	** Adding across*

ATTACHMENT - G

General Fund Appropriations for Medicare A, B or D Purposes
Fiscal Year 2005-06 through 2012-13

Biennium	PL Reference	Initiative #	Initiative Description	Initiative Justification	Account #	Account Name	Fiscal Year	
							FY 12	FY 13
2012-2013	PL 2011, c. 380	C/A/1490	Provides funding to the Medical Care - Payments to Providers program for Medicare Part B payments, which is offset by reducing funding for the Low-cost Drugs To Maine's Elderly program.	This initiative reduces funding for Medicare Part D by reducing Wellcare and AARP contracts by $250,000 each. Growth in the Qualified Medicare Beneficiary program (QMB) and Specified Low-Income Medicare Beneficiary program (SLMB) means less Medicare Part D funding is required while more is needed for Medicare Part B payments to the Centers for Medicare and Medicaid Services.	01010A014701	Medical Care Services	500,000	500,000
biennium	PL 2011, c. 380	C/A/1490	See above	See above	01010A020201	Drugs for Maine's Elderly	(500,000)	(500,000)

							FY 10	FY 11
2010-2011	PL2011, c.1	I/A/1490	Provides funding to the Medical Care - Payments to Providers program for Medicare Part B payments which is offset by reducing funding for the Low-cost Drugs To Maine's Elderly program.	This initiative reduces funding for Medicare Part D by reducing Wellcare and AARP contracts by $250,000 each. Growth in the Qualified Medicare Beneficiary program (QMB) and Specified Low-Income Medicare Beneficiary program (SLMB) means less Medicare Part D funding is required while more is needed for Medicare Part B payments to the Centers for Medicare and Medicaid Services.	01010A014701	Medical Care Services		500,000
biennium	PL2011, c.1	I/A/1490	See above	See above	01010A020201	Drugs for Maine's Elderly		(500,000)
	PL 2009, c. 571	F/A/1916	Provides funding for the increase in Medicare Part B premium payments.	The State is required to pay Medicare Part B premiums for individuals enrolled in Qualified Medicare Beneficiary (QMB) or Specified Low-income Medicare Beneficiary (SLMB) Medicare Savings Plans. The Medicare Part B premium is increasing as of January 1, 2010 from $96.40 per month to $110.50 per month.	01010A014701	Medical Care Services	1,741,141	4,165,856

	PL 2009, c. 571	F/A/1919	Provides funding for the increased cost of Medicare Part D payments.	The State of Maine participates in the Medicare Part D program with the federal government and contributes a phased-down percentage. Based on projections by the federal Centers for Medicare and Medicaid Services (CMS) and the growth of participation the department projects an increased need to fully fund the payments to CMS.	01010A014701	Medical Care Services	0	320,079
	PL 2009, c. 571	F/A/7243	Reduces funding from savings realized from the application of the enhanced Federal Medical Assistance Percentage to state Medicare Part D payments. *(Note: This was a one-time initiative in FY 10 and FY 11 only. The 2012-2013 baseline budget was adjusted to restore these amounts.)*	Reduces funding from savings realized from the application of the enhanced Federal Medical Assistance Percentage to state Medicare Part D payments.	01010A014701	Medical Care Services	(11,708,148)	(16,128,958)

							FY08	FY09
2008-2009 biennium	PL 2009, c. 1	I/A/7912	Reduces funding for the proper accounting of Medicare Part B premium payments for the qualified individual population. This initiative relates to the curtailments ordered in Financial Order 004576 F9. *(Note: this was a one-time adjustment. FY 10 and FY 11 baseline budget were not impacted by this reduction.)*	Pursuant to the state MaineCare manual (also covered under section 1902 (a)(10)(E) and 1905 (b) of the Social Security Act), Part B Premium payments made on behalf of QI members are paid with 100% federal money. These payments have been recorded correctly on the CMS 64, however, an entry was not made into the accounting system to move the state share of the paid billing to the federal account. This will be corrected on an ongoing basis.				(4,339,789)

							FY 06	FY07
2006-2007	PL 2005, c. 12	B/B/1140	Reduces funding by restructuring the low-cost drugs for the elderly and disabled program to reflect a change in drug coverage for Medicare beneficiaries when the Medicare Part D drug benefit is fully implemented in January 2006.	N/A	01010A001701	Medical Care Services	0	(5,000,000)
biennium	PL2005, c. 519	F/AAA/7612	Provides funding to pay the State share of the Medicare Part D benefit for the MaineCare dual eligibles.	N/A	01010A014701	Medical Care Services	3,057,195	16,126,300

ATTACHMENT - H

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEMORANDUM

DATE: December 1, 2011

TO: State Medicaid Agency

FROM: Peter M. Kelchner, CPA
Director, Division of Premium Billing & Collections
Accounting Management Group
Office of Financial Management

SUBJECT: Premium Rates for Medicare Part A and Part B
Effective January 1, 2012 - **INFORMATION**

The Administrator of the Centers for Medicare & Medicaid Services (CMS) announced the new Medicare Part A (Hospital Insurance) and Medicare Part B (Supplementary Medical Insurance) premium rates for the calendar year 2012, as released by the CMS, Office of the Actuary. Below are the premium rates to be paid under the State Buy-in Program by all State Medicaid Agencies.

Regular Part A - Hospital Insurance (HI) Premium Rates

Base Rate	$451.00
10% Surcharge	$496.10*

Reduced Part A - Hospital Insurance (HI) Premium Rates
(For individuals with 30-39 quarters of Social Security Coverage)

Base Rate	$248.00
10% Surcharge	$272.80*

*NOTE: The 10% surcharge is applicable only in QMB Part A Group Payer States.

Part B - Supplementary Medical Insurance (SMI) Premium Rate

Base Rate	$ 99.90

The Summary Accounting Statement for the January 2012 billing period reflects the rates listed above. If you have any questions please contact Lucia Diaz-Robinson, at (410) 786-0598 or via email at Lucia.Diaz-Robinson@cms.hhs.gov.

/s/
Peter M. Kelchner, CPA

PART A

CENTERS FOR MEDICARE & MEDICAID SERVICES

SUMMARY ACCOUNTING STATEMENT

BILLING NOTICE

HOSPITAL INSURANCE PREMIUMS

NAME OF ORGANIZATION	AGENCY CODE	BILLING PERIOD	DATE OF BILL
MAINE	S20	JAN 2012	12/15/2011

This statement contains billing for items processed through this period only. It does not include remittances or billing for items received too late for processing, or items under investigation. Such items will be included in a later billing.

1. PREVIOUS BALANCE		$37,222.00	
2. ADJUSTMENTS		$0.00	
3. CURRENT MONTH'S LIABILITY--PAYABLE BY	01/01/2012	$27,488.00	*
4. PAYMENTS RECEIVED RECEIVED 11/01/2011	$17,486.00	$17,486.00 CR	
5.			
6. TOTAL BALANCE		$47,224.00	

☐ SEE ATTACHMENT (S)

* $27,488.00 REPORT ON FORM CMS-64.9

ENTRIES ON THIS FORM ARE EXPLAINED IN THE STATE BUYIN MANUAL.
FOLLOWING ARE THE ELECTRONIC FUNDS TRANSFER METHODS AGENCIES SHOULD USE TO PAY THE MEDICARE PREMIUMS AND/OR STATE PHASED-DOWN CONTRIBUTIONS:

1. THE U.S. DEPARTMENT OF THE TREASURY'S INTERNET COLLECTIONS APPLICATION KNOWN AS PAY.GOV
2. THE U.S. DEPARTMENT OF THE TREASURY'S ELECTRONIC TRANSFER OF MONIES SYSTEM KNOWN AS THE TREASURY FINANCIAL COMMUNICATIONS SYSTEM (TFCS) OR FEDWIRE

SEE THE MANUAL NAMED ABOVE FOR COMPLETE INSTRUCTIONS.

FAILURE TO COMPLY WITH THESE INSTRUCTIONS COULD DELAY THE PROPER CREDITING OF YOUR PAYMENT.

CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MD 21244-1850

LAB LISTING FOR AGENCY CODE S20 MAINE

01/03/2012

TOTAL ITEMS PROCESSED - 44

	DEBIT			CREDIT			MISC.
	ITEMS	MONEY		ITEMS	MONEY		ITEMS
CODE 11	2	10868.00	CODE 14			CODE 20	
CODE 41	41	17070.00	CODE 15			CODE 21	
CODE 43			CODE 16	1	450.00	CODE 23	
CODE 45			CODE 17			CODE 24	
TOTAL	43	27938.00	CODE 42			CODE 25	
			CODE 44			CODE 27	
			TOTAL	1	450.00	CODE 29	
						CODE 30	
						CODE 32	
						CODE 49	
						CODE 86	
						CODE 87	
						TOTAL	

PART B

CENTERS FOR MEDICARE & MEDICAID SERVICES

SUMMARY ACCOUNTING STATEMENT

BILLING NOTICE

SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS

NAME OF ORGANIZATION	AGENCY CODE	BILLING PERIOD	DATE OF BILL
MAINE	200	JAN 2012	12/15/2011

This statement contains billing for items processed through this period only. It does not include remittances or billing for items received too late for processing, or items under investigation. Such items will be included in a later billing.

1. PREVIOUS BALANCE		$20,708,259.90
2. ADJUSTMENTS		$0.00
3. CURRENT MONTH'S LIABILITY--PAYABLE BY	01/01/2012	$9,348,220.50 *
4. PAYMENTS RECEIVED RECEIVED 11/01/2011 $10,125,266.40		$10,125,266.40 CR
5.		
6. TOTAL BALANCE		$19,931,214.00

☐ SEE ATTACHMENT (S)

* $9,348,220.50 REPORT ON FORM CMS-64.9 CASH/DEEMED CASH

ENTRIES ON THIS FORM ARE EXPLAINED IN THE STATE BUYIN MANUAL.
FOLLOWING ARE THE ELECTRONIC FUNDS TRANSFER METHODS AGENCIES SHOULD USE TO PAY THE MEDICARE PREMIUMS AND/OR STATE PHASED-DOWN CONTRIBUTIONS:

1. THE U.S. DEPARTMENT OF THE TREASURY'S INTERNET COLLECTIONS APPLICATION KNOWN AS PAY.GOV

2. THE U.S. DEPARTMENT OF THE TREASURY'S ELECTRONIC TRANSFER OF MONIES SYSTEM KNOWN AS THE TREASURY FINANCIAL COMMUNICATIONS SYSTEM (TFCS) OR FEDWIRE

SEE THE MANUAL NAMED ABOVE FOR COMPLETE INSTRUCTIONS.

FAILURE TO COMPLY WITH THESE INSTRUCTIONS COULD DELAY THE PROPER CREDITING OF YOUR PAYMENT.

CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MD 21244-1850

Truncated premium values for the State of Maine Part B, code 200
Bill Month 01/2012

Billing File Record Data (old format)

Claim Number	Surname	Gvn Name	DOB	Trans Code	Trans Date	Bill Date	Bill File Prem Amt	Correct Prem Amt
00544501lC1	RIVARD	MELISSA	122869	1167	1099	0112	1,680.80	11,680.80
00750775SC1	CURTIS	GARY	110564	1180	0194	0112	4,697.90	14,697.90
00750775SC2	CURTIS	TAMMY	110762	1180	0194	0112	4,697.90	14,697.90
00750775SC3	CURTIS	KATHERI	041255	1180	0194	0112	4,697.90	14,697.90
					debit totals:		15,774.50	55,774.50

Total amount of truncated premiums = $40,000.00 db
This is not a bill.
Full correct premium values are included in the Summary Accounting Statement.

PLEASE NOTE: THIS ATTACHMENT TO YOUR BILLING STATEMENT BECOMES OBSOLETE AS SOON AS YOUR AGENCY CONVERTS TO SENDING AND RECEIVING DATA WITH CMS IN THE NEW EXPANDED RECORD FORMATS, part of the CMS Third Party System implemented September 2003. Premium truncation is a side-effect directly related to the conversion of billing records into the old data exchange formats. For more information, contact Phyllis.Martin@cms.hhs.gov.

LAB LISTING FOR AGENCY CODE 200 MAINE

01/03/2012

TOTAL ITEMS PROCESSED - 88962

	DEBIT			CREDIT			MISC.
	ITEMS	MONEY		ITEMS	MONEY		ITEMS
CODE 11	1575	939477.30	CODE 14	36	27210.10	CODE 20	126
CODE 41	85526	8543713.20	CODE 15	8	1253.90	CODE 21	82
CODE 43			CODE 16	365	55145.70	CODE 23	66
CODE 45			CODE 17	483	85715.50	CODE 24	5
TOTAL	87101	9483190.50	CODE 42	21	5644.80	CODE 25	115
			CODE 44			CODE 27	7
			TOTAL	913	174970.00	CODE 29	
						CODE 30	6
						CODE 32	
						CODE 49	17
						CODE 86	117
						CODE 87	407
						TOTAL	948

PART D

CENTERS FOR MEDICARE & MEDICAID SERVICES

SUMMARY ACCOUNTING STATEMENT

BILLING NOTICE

STATE CONTRIBUTION FOR PRESCRIPTION DRUG BENEFIT

NAME OF ORGANIZATION	AGENCY CODE	BILLING PERIOD	DATE OF BILL
MAINE	D20	NOV 2011	12/10/2011

This statement contains billing for items processed through this period only. It does not include remittances or billing for items received too late for processing, or items under investigation. Such items will be included in a later billing.

1. PREVIOUS BALANCE	$8,155,885.06
2. ADJUSTMENTS	$0.00
3. CURRENT MONTH'S LIABILITY--PAYABLE BY 01/01/2012	$4,197,781.64 *
4. PAYMENTS RECEIVED RECEIVED 11/01/2011 $4,045,794.11 CR	$4,045,794.11 CR
5.	
6. TOTAL BALANCE	$8,307,872.59

☐ SEE ATTACHMENT (S)

* CURRENT MONTH'S LIABILITY CALCULATED USING DATA SUBMITTED IN THE NOVEMBER 2011 STATE DUAL-ELIGIBILITY FILE.

ENTRIES ON THIS FORM ARE EXPLAINED IN THE STATE PHASED-DOWN BILLING GUIDE. FOLLOWING ARE THE ELECTRONIC FUNDS TRANSFER METHODS AGENCIES SHOULD USE TO PAY THE MEDICARE PREMIUMS AND/OR STATE PHASED-DOWN CONTRIBUTIONS:

1. THE U.S. DEPARTMENT OF THE TREASURY'S INTERNET COLLECTIONS APPLICATION KNOWN AS PAY.GOV
2. THE U.S. DEPARTMENT OF THE TREASURY'S ELECTRONIC TRANSFER OF MONIES SYSTEM KNOWN AS THE TREASURY FINANCIAL COMMUNICATIONS SYSTEM (TFCS) OR FEDWIRE

SEE THE MANUAL NAMED ABOVE FOR COMPLETE INSTRUCTIONS.

FAILURE TO COMPLY WITH THESE INSTRUCTIONS COULD DELAY THE PROPER CREDITING OF YOUR PAYMENT.

CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 SECURITY BOULEVARD
BALTIMORE, MD 21244-1850

CONTRIBUTION FOR PRESCRIPTION DRUG BENEFIT
STATE ITEMIZED LIABILITY REPORT

BILL CYCLE: NOV 2011
D20 MAINE

REPORT DATE
12/02/2011

SUBTOTAL LIABILITY FROM ENROLLMENT COUNTS	$4,197,781.64
SUBTOTAL LIABILITY FROM MONTHLY RATE CHANGES	$0.00
TOTAL CURRENT LIABILITY CHARGES ON LINE 3.	$4,197,781.64

SUBTOTAL LIABILITY CHARGES BASED ON ENROLLMENT COUNTS

BILL CYCLE	ENROLLMENT COUNT	DISENROLLMENT COUNT	RATE	LIABILITY
102010	37	13	58.22	$1,397.28
112010	40	14	58.22	$1,513.72
122010	48	17	58.22	$1,804.82
012011	57	21	63.65	$2,291.40
022011	57	20	63.65	$2,355.05
032011	61	20	63.65	$2,609.65
042011	67	21	67.93	$3,124.78
052011	86	21	67.93	$4,415.45
062011	106	20	67.93	$5,841.98
072011	162	20	82.38	$11,697.96
082011	295	39	82.38	$21,089.28
092011	467	63	82.38	$33,281.52
102011	674	178	83.59	$41,460.64
112011 CURRENT	48,629	0	83.59	$4,064,898.11
SUBTOTALS:	50,786	467		$4,197,781.64

SUBTOTAL LIABILITY CHARGES FROM MONTHLY RATE CHANGES

BILL CYCLE	NET ENRLMT BILLED	OLD RATE	NEW RATE	NET CHANGE	LIABILITY
NONE					$0.00
				SUBTOTAL:	$0.00

ATTACHMENT - I

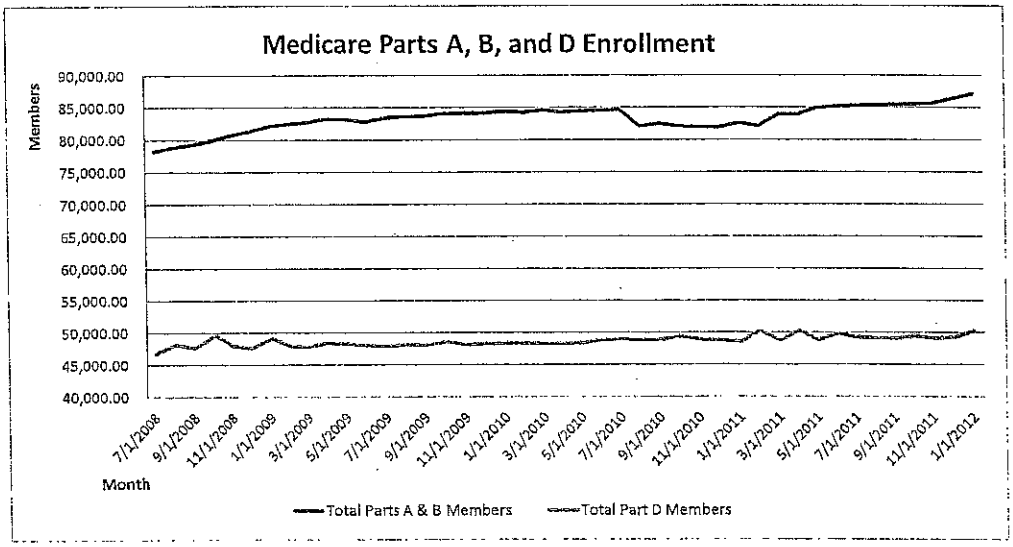
Parts A, B and D Medicaid Premiums

		Parts A & B Members					Part of Part B Total		Part D Members		
Month	Premium Rate	Code 11 Members	Code 41 Members	QI Members	Part A members	Total Parts A & B Members	SLMB Eligibles	QMB Eligibles	Total Part D Members	Part D Rate	DEL Combo Members
7/1/2008	96.40	1,145	77,025	-	12	**78,182**	5,366	25,687	**46,773**	77.19	
8/1/2008	96.40	1,114	77,735	-	12	**78,861**	5,433	26,134	**48,187**	77.19	
9/1/2008	96.40	870	78,430	-	12	**79,312**	5,570	26,666	**47,716**	77.19	
10/1/2008	96.40	1,084	78,935	-	12	**80,031**	5,698	26,977	**49,709**	77.19	
11/1/2008	96.40	1,138	79,595	2,628	12	**80,745**	5,793	27,078	**47,942**	77.19	
12/1/2008	96.40	1,095	80,261	2,733	12	**81,368**	5,880	27,187	**47,660**	74.87	
1/1/2009	96.40	1,125	80,994	2,786	14	**82,133**	5,975	27,271	**49,164**	74.87	
2/1/2009	96.40	775	81,628	2,839	17	**82,420**	6,006	27,416	**47,907**	74.87	
3/1/2009	96.40	806	81,903	2,977	19	**82,728**	6,085	27,499	**47,836**	80.23	
4/1/2009	96.40	1,002	82,245	3,086	20	**83,267**	6,131	27,661	**48,418**	80.23	
5/1/2009	96.40	899	82,288	3,137	20	**83,207**	6,128	27,710	**48,246**	80.23	
6/1/2009	96.40	882	81,926	3,218	22	**82,830**	6,194	27,769	**48,013**	80.23	
7/1/2009	96.40	985	82,403	3,292	22	**83,410**	6,319	27,958	**47,930**	80.23	
8/1/2009	96.40	903	82,711	3,339	22	**83,636**	6,384	28,182	**48,177**	80.23	
9/1/2009	96.40	775	82,910	3,412	22	**83,707**	6,514	28,613	**48,054**	80.23	
10/1/2009	96.40	990	83,075	3,492	24	**84,089**	6,572	28,903	**48,656**	80.23	
11/1/2009	96.40	826	83,311	3,607	26	**84,163**	6,596	29,120	**48,110**	80.23	
12/1/2009	96.40	804	83,283	3,676	26	**84,113**	6,673	29,356	**48,292**	78.93	
1/1/2010	110.50	1,012	83,373	3,706	26	**84,411**	6,805	29,533	**48,369**	78.93	
2/1/2010	110.50	868	83,392	3,874	29	**84,289**	6,724	29,096	**48,349**	78.93	
3/1/2010	110.50	1,040	83,538	3,887	30	**84,608**	6,754	29,261	**48,275**	81.07	
4/1/2010	110.50	911	83,369	3,788	34	**84,314**	6,802	29,404	**48,273**	58.22	
5/1/2010	110.50	902	83,502	3,781	32	**84,436**	6,842	29,511	**48,375**	58.22	
6/1/2010	110.50	865	83,675	3,798	33	**84,573**	6,910	29,579	**48,841**	58.22	
7/1/2010	110.50	994	83,622	3,844	33	**84,649**	6,982	29,776	**49,023**	58.22	4,139
8/1/2010	110.50	1,003	81,069	3,891	33	**82,105**	7,041	29,964	**48,839**	58.22	4,172
9/1/2010	110.50	1,000	81,484	3,891	34	**82,518**	7,058	30,060	**48,883**	58.22	4,230
10/1/2010	110.50	1,043	81,030	3,914	35	**82,108**	7,115	30,087	**49,449**	58.22	4,224
11/1/2010	110.50	945	81,011	3,960	34	**81,990**	7,114	30,108	**48,941**	58.22	4,209
12/1/2010	110.50	963	80,900	4,026	34	**81,897**	7,175	30,174	**48,777**	58.22	4,236
1/1/2011	115.40	1,134	81,434	4,070	36	**82,604**	7,219	30,250	**48,584**	58.22	4,294
2/1/2011	115.40	1,073	81,001	4,078	35	**82,109**	7,252	30,404	**50,325**	58.22	4,347
3/1/2011	115.40	2,859	81,034	4,151	34	**83,927**	7,271	30,242	**48,719**	63.65	4,381
4/1/2011	115.40	1,192	82,710	4,190	36	**83,938**	7,275	30,286	**50,356**	63.65	4,341
5/1/2011	115.40	1,562	83,352	4,189	36	**84,950**	7,316	30,337	**48,844**	63.65	4,340
6/1/2011	115.40	1,164	84,000	4,173	37	**85,201**	7,898	30,620	**49,851**	67.93	4,384
7/1/2011	115.40	1,035	84,221	4,183	36	**85,292**	8,358	30,692	**49,250**	67.93	4,404
8/1/2011	115.40	935	84,431	4,376	40	**85,406**	8,448	30,782	**49,217**	67.93	5,194
9/1/2011	115.40	797	84,641	4,147	40	**85,478**	8,538	30,872	**49,050**	82.38	5,194
10/1/2011	115.40	882	84,627	4,130	42	**85,551**	8,628	30,962	**49,499**	82.38	6,149
11/1/2011	115.40	883	84,722	4,134	42	**85,647**	8,718	31,052	**49,181**	82.38	6,064
12/1/2011	115.40	1,569	84,780	4,194	42	**86,391**	8,808	31,142	**49,271**	83.59	5,635
1/1/2012	99.90	1,575	85,526	4,168	43	**87,144**	8,898	31,232	**50,319**	83.59	5,647

Disclaimer! Code 11 Member, can be retroactive to any date and each member may have a different retroactive date so the totals may be deflated to some degree.

Code 41 Members are existing members

QI Members are taken from the total and are paid for 100% Federal, no state portion



ATTACHMENT - J

Plan for taking care of the elderly and disabled who will lose their homes in assisted living and residential care.

One of the primary questions raised by the proposed budget is related to the plan for people currently residing in Private Non-Medical Institutions (PNMI). While the answer to this question is vital, it is important to understand that the development of alternative funding strategies is not solely related to the DHHS budget shortfall.

PNMIs were developed in the late 1980s as a result of federal initiatives to expand Medicaid in an effort to reduce the populations in large institutions, such as AMHI and Pineland, and increase the provision of services in residential settings. These initiatives were highly successful and as a result Maine was able to leverage federal funds, move children home to Maine from out of state institutions and significantly decrease the number of people living in large institutions. Prior to these initiatives, all state funds were used to cover the cost of these services.

The Center for Medicare and Medicaid Services (CMS) expressed concern regarding Maine's use of the PNMI model beginning in 2009 with CMS citing Maine as only 1 of 2 states with this funding model in place. Most recently, CMS clearly stated in a conference call with DHHS that the PNMI model cannot continue. Their specific concerns are that Medicaid monies are paying room and board, that providers' qualifications are not consistent, there is duplication of services and consumer choice has not been fully integrated into the model.

In addition to the CMS concerns a significant shortfall in MaineCare was discovered, which necessitated the submission of a supplemental budget. Included in that budget proposal is the elimination of PNMI funding.

In 2011, DHHS began meeting with providers of PNMI services across the state in an effort to communicate and work in a collaborative fashion to develop a comprehensive plan to be certain medically necessary services are provided to those in need in full compliance with CMS regulations. The Department has also conducted regular communication with CMS to report progress and receive technical assistance. This communication will continue until resolution has been achieved.

DHHS and providers estimate that of the current population in Appendix C PNMIs, approximately 20% meet the criteria of eligibility for Nursing Facility (NF) level of care. Because this is an entitlement, these people would continue to be eligible for services under MaineCare.

With the development of PNMIs, the eligibility criteria for NF level of care was redefined. This definition remains in place today. As the PNMI model is eliminated the threshold for NF level of care needs to be re-evaluated and brought more into line with other states. This 'lowering' of the NF eligibility would result in more people currently in PNMIs being eligible for NF. While this change would necessitate an appropriation request in the change package for increased use of NFs, it also would increase the number of people eligible for supports through the Home and Community Based Services waiver (HCBS).

Included in the budget proposal is $39M budget stabilization fund. The Department would support the use of these funds to restore PNMI services.

While the Department continues its work with PNMI providers and CMS, we are also in discussion with Maine State Housing Authority (MSHA) to evaluate all current sources of funds for housing as well as any new opportunities.

While the impact of this budget proposal will affect all providers of PNMI services, some will be affected more than others. Those providers who rely primarily on MaineCare for funding will find themselves hard pressed to continue to provide services. Those providers with more diverse funding streams will still be affected, however because of the diversity built into their organizations they will continue to be able to provide most services to those in their care as the issues CMS has cited regarding PNMI are not so much related to the physical structure of PNMIs as they are the funding pattern.

DHHS will continue to work with all providers to develop and implement alternatives to the current funding pattern in PNMIs and will encourage providers to work together and within their associations to investigate creative solutions. DHHS also encourages the providers to learn from each other and work to replicate the infrastructure of those providers who will withstand these changes in the system without discontinuation of services to those in need.

In addition to this work with providers and CMS, DHHS is committed to its obligation to act as a resource to the Legislature as it debates the proposal before it and sets policy for the future. It is only through these collaborative efforts that the Department will be able to provide services to the most vulnerable and needy populations throughout our state.

ATTACHMENT - K

PNMI – July 27, 2011

Private Non-Medical Institutions Update

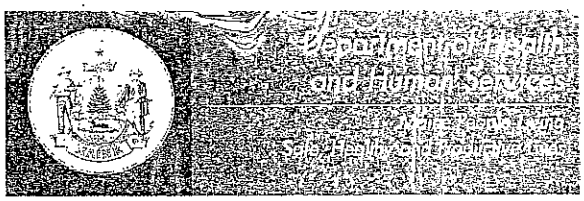
MaineCare Services is working with CMS on the processing of several state plan amendments and one is specific to PNMI services.

CMS has informed Maine that the current reimbursement methodology cannot continue. PNMI services are only permissible under a "non-risk contract" which requires paying services at cost, conduction of time studies, and cost reports that are then audited.

CMS also has concerns about whether room and board costs are being reimbursed in Maine, which is not permissible in a PNMI setting. In addition, CMS has raised concerns about comparability of the services delivered in this setting to those available in the community as well as provider qualifications and services delivered in multi-level settings that are "institution-like."

MaineCare is receiving technical assistance from a national expert in a two-day technical assistance this week, to discuss the possibility of covering some of these services in something known as "I-SPAS" which are essentially home and community based waivers.

MaineCare services will continue to work with DHHS program experts on how to cover medically necessary services through MaineCare using a different reimbursement mechanism.



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

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

TO: Providers of MaineCare Private Non-Medical Institution (PNMI) Services

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

DATE: September 1, 2011

SUBJECT: Reimbursement Changes required for PNMI to be in Federal compliance

The Department has been working with the Centers for Medicare and Medicaid Services (CMS) on compliance concerns for PNMI services. CMS has clearly communicated that significant changes must be made immediately, as these services do not meet federal compliance. As a result, DHHS is operating at financial risk by reimbursing these services. Changes must be made in the reimbursement and configuration of covered services for more than 6,000 MaineCare members served by more than 400 agencies.

CMS has indicated that some PNMI facilities appear to fit the definition of an Institution for Mental Disease (IMD) (42 CFR 435.1010), which is generally not reimbursable under Medicaid for populations between 21 and 65. DHHS has been asked to submit a list of facilities that meet this definition and to stop claiming federal match immediately.

Additionally, CMS views personal care services and rehabilitative services currently provided in a PNMI setting reimbursable *only if* they follow federal requirements. These services must be provided in the same way as they would be to a member residing in the community.

A bundled rate combining these separate services is also problematic. According to CMS, members must have free choice of providers for each component of these services that are not contingent upon remaining in that residential setting. Member eligibility and provider qualifications must also be comparable. CMS has also indicated that such services are intended to be community-based and has concerns about settings that appear to be facility-based.

To address these concerns and develop solutions, the Department is exploring other federally permissible services. These include Home and Community Based Waivers, I-SPAs and reconfiguration of existing MaineCare State Plan services. All of this must be done within the constraints of current expenditures and while anticipating significant budget shortfalls.

The Department is convening both an internal Steering Committee and a Provider Steering Committee to assure that all available expertise is utilized in this initiative. We recognize that this level of change poses significant challenges to our existing system, service providers and consumers. We are committed to working closely with all those affected by these changes to ensure we comply with CMS requirements and that everyone is kept informed of developments throughout the process.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations/Boston Regional Office

August 9, 2011

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

RE: Institution for Mental Disease Exclusion

Dear Commissioner Mayhew:

As you are aware, Maine Department of Health and Human Services (DHHS) and CMS have engaged in frequent telephone conferences for the last several months regarding the State's current operations of private non-medical institutions (PNMI). These conferences are the result of several pending State plan amendments (SPA) which MaineCare submitted in the fall of 2010. The SPAs are currently "off the clock" as CMS and MaineCare work together to reach an approvable status.

In the course of these discussions, we have learned many details about the PNMI programs, services, and operations. Based on the information that we have received from DHHS, it is our opinion that several of the PNMI facilities may meet the regulatory definition of institutions for mental diseases (IMD). Section 1905(a)(28) of the Social Security Act (the Act) generally excludes Medicaid coverage for services provided in an IMD and Federal Financial Participation is unavailable for services to IMD patients regardless of whether those services are provided within or outside the facility. Federal Medicaid regulations at 42 CFR 435.1010 define an IMD as:

> *"Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases".*

Additional guidance on the determination of whether a facility is an IMD can be found in section 4390 of the State Medicaid Manual.

However, as detailed below, there are situations in which Medicaid FFP is allowed for patients of IMDs:

a) Section 1905(a)(14) of the Act permits inpatient hospital services and nursing facility services for individuals 65 years of age or over if the IMD facility meets Medicaid survey and certification requirements and is licensed as a Medicaid facility.
b) Section 1905(a)(16) of the Act permits inpatient psychiatric services for patients who are under the age of 21 (or age 22 for those receiving such services when attaining age 21).
c) Also, for patients aged 65 and over, FFP is permitted for non-institutional services regardless of whether the IMD is licensed as an inpatient facility.

Please note that, other than the special situation noted in (b), none of these exceptions apply to IMD services for patients who are between ages 21 and 65.

Due to the above-expressed concerns, we are asking the State to identify all PNMI facilities that meet the Federal definition of an IMD and then immediately cease Medicaid claiming for services in that IMD. Please submit this list to my office within 60 days of receipt of this letter. CMS cannot guarantee that other entities with oversight responsibility of the Medicaid agency will not pursue compliance actions, within their authority, with respect to Medicaid payment to these IMDs.

Please feel free to contact me with any questions you may have regarding this letter.

Yours,

Richard R McGreal

Richard McGreal
Associate Regional Administrator

PNMI Update

As was shared in our last meeting, the Centers for Medicare and Medicaid Services (CMS) has clearly communicated its concerns about our Private Non-Medical Institution program and its lack of federal compliance. One of their most significant concerns is their belief that many of our facilities meet the definition of Institution of Mental Disease and as such, federal reimbursement would generally not be allowed for people ages 21 to 64.

The Department has been surveying all enrolled PNMI providers to ask questions posed by CMS related to this issue. The survey is attached. DHHS will complete contacting agencies and develop a list of IMDs by October 9, working in conjunction with the Attorney General's Office.

In addition, the Office of MaineCare Services (OMS) continues to receive technical assistance from Acumen, under contract with CMS to provide states with information on Individual State Plan Amendments (I-SPAs), which could provide potential resolutions for some PNMI services.

The Commissioner's Office is convening a Stakeholder group and is considering statewide listening sessions in response to the provider concerns and the overwhelming response of providers to be a part of the Stakeholder group.

Private Non-Medical Institution (PNMI) Assessment Worksheet

Name of Person Completing Form: _____ **Date:** _____

NPI + 3 Number: _____

Facility/Provider Name: _____

Facility Provider Type:

_____

Facility Provider Specialty:

_____

Address of the Facility:

_____

Contact Phone: _____ **Contact:** _____

Name and Title of Person Providing Responses:

_____

Name of Owner of the Facility: _____

Owner Address:

_____

Total Number of beds: _____|_____

Number of Beds designated for PNMI services: _____|_____

Percent of total population with a primary mental health diagnosis: _____

Description of population served (i.e. elderly, mentally ill etc.):

_____

_____

_____

_____

Does the Facility/Provider have multiple service locations: ☐ Yes ☐ No

If "YES" PLEASE BE SURE TO COMPLETE DETAIL CHART ON Page #3.

INSTRUCTIONS: REFER TO THE REFERENCE SHEET FOR A LIST OF DEFINITIONS.

SECTION 1: Please complete this section to determine if the facility should be assessed as having a separate facility/component or as a single entity:

Does the facility have more than one service location? ☐ Yes ☐ No

1. Are the components of the facility certified as different types of providers? i.e. NFs and hospitals.
   ☐ Yes ☐ No

2. Are all components controlled by one owner or one governing body?
   ☐ Yes ☐ No

3. Is one chief medical officer responsible for the medical staff activities in all components?
   ☐ Yes ☐ No

4. Does one chief executive officer control all administrative activities in all components?
   ☐ Yes ☐ No

5. Are any of the components separately licensed?
   ☐ Yes ☐ No

6. Are the components so organizationally separate that it is not feasible to operate as a single entity? ***Please answer a, b & c in response to this question***
   a. Does each component have separate administrative staff?
      ☐ Yes ☐ No

   b. Does each component have a separate Executive Director, Chief Operating Officer, Chief Executive Officer or Finance Director?
      ☐ Yes ☐ No

   c. Does each component have a separate central office building?
      ☐ Yes ☐ No

7. Are the components so geographically separate that it is not feasible to operate as a single entity? ***Please answer a & b in response to this question***
   a. Are the components located within the same county:
      ☐ Yes ☐ No

   b. Are the components more than 50 miles away from each other?
      ☐ Yes ☐ No

8. Are two or more of the components participating under the same provider category (such as NFs)?
   ☐ Yes ☐ No
   a. If **NO**, go onto next question
   b. If **YES**, can each component meet the conditions of participation independently?
      ☐ Yes ☐ No

9. Is the facility licensed as a psychiatric facility?
   ☐ Yes ☐ No

10. Is the facility accredited as a psychiatric facility?

☐ Yes ☐ No

SECTION 2: Please complete the following section if the facility has more than 16 beds and there is more than one location.

Please list each of the Service Locations and answer the questions for each:

FACILITY NAME							
Number of total beds							
Number of beds designated for PNMI							
Type of facility							
NPI + 3 if available							
11 Does this facility provide services to mentally ill persons?							
12 Is the facility under the jurisdiction of the State's mental health authority?							
13 Does the facility specialize in providing psychiatric/ psychological care and treatment?							
13a Do more than 50% of staff have specialized psychiatric/psychological training?							
13b Do more than 50% of patients receive psychopharmacological drugs?							
13c Are goals related to treating a mental health disorder included in the treatment plans?							
13d Are more than 50% of staff hours dedicated to treating a mental health disorder?							
14 Does the current need for institutionalization for more than 50% of the patients in the facility result from mental disease? **If it is not possible to make a determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the last year. Do not include a patient in the mentally ill category when no clear cut distinction is possible*							
14a Was the patient admitted to the facility because of an issue resulting from a mental disease							

14b	Does the patient's current need for institutionalization result from a mental disease?							

SECTION 3: For Nursing Facilities Only

When completing this section use the reference page for definitions relevant to this section.

15. What is the average age of the patients in this Nursing Facility? _____

16. Do more than 50% of residents in this Nursing Facility require specialized services for the treatment of serious mental illnesses? **When making this determination, please focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.**
    ☐ Yes ☐ No

SECTION 4: Substance Abuse Facilities Only

17. Does the treatment provided in the facility follow a psychiatric model? i.e. any model that focuses on psychiatric ailments and does not rely on a peer counseling model (i.e. Alcoholics Anonymous)
    ☐ Yes ☐ No

18. If yes, is this treatment provided by medically trained and licensed personnel? If no, please go to question 19.
    ☐ Yes ☐ No

19. Are services Psychological in nature? i.e. do the services provided target psychological functions and/or address psychological diagnoses?
    ☐ Yes ☐ No

20. Is the facility limited to services based on the Alcoholics Anonymous model? i.e. they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors.
    ☐ Yes ☐ No

Private Non Medical Institution (PNMI) Initiative – October 2011 Update

Overview

In early September, the Department updated all Private Non-Medical Institution (PNMI) providers and the Legislature on the work we are engaged in with the Centers for Medicare and Medicaid Services (CMS) regarding compliance issues related to PNMI services. That letter can be found online at: http://maine.gov/dhhs/oms/provider/pnmi.html.

As part of our efforts to address CMS' concerns, the Department initially sought to establish a provider Steering Committee to assure that all available expertise is utilized. Due to the overwhelming provider interest and the need to respond to CMS in a timely manner, we altered that plan.

Outreach

Statewide PNMI Forum

On October 18, the Department held a Statewide PNMI Informational Forum at the Augusta Civic Center. Over 200 people attended. Presentation topics included the current status of MaineCare PNMI services, CMS' concerns, the progress of DHHS, timelines and expectations.

Participants also had the opportunity to hear from Robin Cooper, a national expert who is the Director of Technical Assistance with the National Association of State Directors of Developmental Disabilities Services, Inc. Cooper is an expert on systems design and financing options that promote effective management practices and assure consumer choice and control. She spoke about the national perspective on community services, the Olmstead Decision and what options are available to Maine as part of this initiative.

Both presentations can be found online at: http://maine.gov/dhhs/oms/provider/pnmi.html

Regional "Work Sessions"

In November, DHHS will host six PNMI Provider "Work Sessions" which will provide the opportunity for more interactive discussions and brainstorming. It is likely that each work session will be broken up by provider type. The dates for these sessions are:

November 7	Augusta
November 8	Presque Isle
November 9	Bangor
November 10	Rockland
November 17	Lewiston
November 18	Biddeford

These sessions are scheduled from 9:00-3:00. A detailed agenda, including a registration page, will be available online soon.

Institution for Mental Disease Update

In addition to this overarching PNMI work, the Department received a letter from the Centers for Medicare and Medicaid Services on August 9, 2011, requesting the Department to identify what PNMI facilities meet the federal definition on an "Institution for Mental Disease (IMD)." These facilities are not reimbursable under the Medicaid program for members between the ages of 22-64.

The Department had several calls with CMS to clarify the request and developed an assessment that was used to call all enrolled PNMI agencies over a three-week period. The Department responded to CMS on October 12, 2011 with a list of those providers who appear to meet the federal definition (three providers, five facilities).

The Department has asked for further guidance from CMS on how to consider "scattered site" PNMI programs which are smaller facilities that fall under the umbrella of one organization. A conference call has been scheduled.

The letter to CMS and other relevant communications can be found at:
http://maine.gov/dhhs/oms/provider/pnmi.html

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

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October 12, 2011

Richard McGreal, Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Building, Government Center
Room 2275
Boston, Massachusetts 02203

Re: *CMS August 9, 2011 Letter Regarding Institution for Mental Disease Exclusion*

Dear Mr. McGreal:

Stefanie Nadeau and I very much appreciated the opportunity to speak with you yesterday to clarify your August 9, 2011, letter which asked Maine to identify all Private Non Medical Institutions (PNMI) facilities that meet the Federal regulatory definition of an Institution for Mental Disease (IMD) within 60 days. Thank you for clarifying that CMS wants a list of those PNMIs that meet the 42 U.S.C. § 1396d(a)(29) IMD exclusion criteria (individuals between the ages of 21 and 65 who reside in IMDs).

As we discussed yesterday, the issue regarding scattered sites remains unclear and we appreciate your offer to set up a call to provide further guidance. We look forward to that discussion.

Background: Maine's PNMI State Plan Program

Maine's state plan has authorized PNMI services for many years. The latest PNMI state plan was approved in 2004. *See* Maine state plan, TN No. 04-011, Attachment to 3.1-A, approved effective 9/1/04. (Attachment). The state plan approval expressly authorizes PNMI reimbursement for institutions providing substance abuse and mental health services. It authorizes:

> 1. Private non-medical institutions for substance abuse treatment, mental health services, child-care services, and services for people with mental retardation. Covered services include only detoxification, rehabilitation, extended care, extended shelter, halfway house, mental health and child-care services, provided to residents by qualified staff. . .
> *Id.*

In light of the approved plan language, the Department has never considered PNMIs to be IMDs, or to be subject to the IMD exclusion. We do not consider PNMI residents to be "patients" of these homes. Like our plan language, the regulation authorizing PNMI contracts (42 C.F.R. §434.12) makes no reference to an IMD exclusion. This is unlike the definition of inpatient hospital services and Nursing Facility services, both of which expressly incorporate the IMD exclusion. *See* 42 C.F.R. § 440.10 ("Inpatient hospital services, other than in institutions for mental diseases."); § 440.155 ("Nursing facility services, other than in institutions for mental disease.") Also note the federal definition of IMDs which

states expressly that ICF-MRs are not IMDs (42 C.F.R. § 435.1009, which states: "An institution for the mentally retarded is not an institution for mental disease.")

Below you will find the summary our analysis of PNMI services that are subject to the IMD exclusion.

The IMD Exclusion Criteria

In making a determination as to whether any of Maine's PNMIs could be considered IMDs, Maine utilized the guidelines established by CMS in its State Medicaid Manual, two emails from Robert Cruz to Patricia Dushuttle,[1] and information collected from an Assessment Worksheet developed by Maine staff and posed to Maine PNMI providers.

Maine conducted its review as a three-step analysis. The first issue to determine was whether a PNMI meets the federal regulatory definition of "institution". "Institution" is defined in 42 CFR § 435.1009 as meaning an establishment of single or multiple facilities that furnishes food and shelter and some treatment to four or more persons unrelated to the proprietor.[2]

Maine then determined whether each "institution" might be an "IMD". IMDs are defined in federal law as being institutions which have more than 16 beds, and which are primarily engaged in providing diagnosis and treatment or care of persons with mental diseases.[3] 42 CFR § 35.1010. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

CMS guidelines suggest that certain criteria be utilized in making a determination whether an institution is an IMD: (1) is the facility licensed or accredited as a psychiatric facility; (2) is the facility under the jurisdiction of the State's mental health authority; (3) does the facility specialize in providing psychiatric/psychological care and treatment; and (4) does the current need for institutionalization for more than 50% of the facility's patients result from mental disease. CMS, State Medicaid Manual, § 4390.

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[1] Robert Cruz (CMS) emails to Patricia Dushuttle (Maine DHHS) dated September 20, 2011, 4:29 PM and September 26, 2011, 4:38 PM.

[2] 42 CFR § 435.1009 defines "institution" as follows: "Institution means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor."

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The final determination is whether, if a facility is an IMD, it is subject to the Medicaid IMD exclusion[4] which essentially provides that federal financial participation is unavailable for IMDs serving populations between the ages of 21 and 65. 42 USC § 1396d(a)(14), (16) and (29).

Maine's Assessment Worksheet

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Each of these five PNMI facilities are licensed for 16 beds or over, serve a population between the ages of 21 and 65, primarily house individuals receiving treatment for persons with mental disease, and more than 50% of the patients in the facilities entered the facilities because of a need stemming from mental disease.

Per our conversation on October 11, 2011, Maine will cease requesting Medicaid reimbursement for these facilities for services rendered November 1, 2011, or later.

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(b) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental disease."

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Based on the CMS guidance we have been given to this point, and based on the information received from the PNMI facilities by the use of the recently developed Assessment Worksheet, we believe that the remaining Maine PNMIs are not "institutions", or are not "IMDs" or do not fall under the IMD exclusion regulation.

Maine's Proposed Alternatives to PNMIs

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We are and will continue to be responsive to your concerns, and we look forward to working with you as Maine works towards an appropriate alternative to the Maine PNMI program. Again, we very much appreciate our conversation yesterday, and the spirit of cooperative and collaboration as Maine finds a new way to provide necessary medical services to this very needy population.

Sincerely,

Mary C. Mayhew
Commissioner

Attachment (Maine PNMI state plan)

cc: Bonnie Smith, Deputy Commissioner of Programs
Stefanie Nadeau, Director, Office of MaineCare Services
Patricia Dushuttle, Director, Policy, Office of MaineCare Services
Pamela Easton, Director of Program and Regulatory Accountability

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Covered preventive services are limited to services provided by mental health facilities licensed by the Department of Behavioral and Developmental Services and delivered by a staff member who is a licensed practitioner of the healing arts within the scope of his/her practice under State law.

Item 13d. Rehabilitative Services

Rehabilitative Services are limited as follows:

1. Private non-medical institutions for substance abuse treatment, mental health services, child-care services, and services for people with mental retardation. Covered services include only detoxification, rehabilitation, extended care, extended shelter, halfway house, mental health and child-care services, provided to residents by qualified staff. These services may be provided by physicians, psychologists, psychological examiners, dentists, R.N.'s, L.P.N.'s, speech therapists, and other substance abuse counselors, M.S.W.'s, occupational therapists, and other qualified staff carrying out a written plan of care. Such plans of care or initial assessments of the need for services are recommended by a physician or other licensed practitioner of the healing arts. Covered Services also include administrative costs related to the provision of direct services.

2. Mental Health Services. Covered services include rehabilitation and community support services provided by staff of mental health facilities licensed or approved by the Department of Behavioral and Developmental Services. These services may be provided by physicians, psychologists, psychological examiners, MSW's, psychiatric nurses, and qualified mental health staff carrying out a plan of care. Certain crises-oriented services may be provided to individuals under age 21 as home based mental health by facilities licensed by the Department of Behavioral and Developmental Services.

3. Substance Abuse Treatment Services. Covered services include only those evaluation and clinical services provided under the direction of a physician or psychologist and delivered by qualified staff of an outpatient and/or on-residential facility certified as such by the Office of Alcoholism and Drug Abuse Prevention for the rehabilitation of substance abuse.

4. Day Health Services. Covered services are available for individuals requiring assistance with ADL's. Day health services are provided at facilities licensed by the Department at three levels, as determined by assessment using the MED tool. Level I provides for 16 hours per week, Level II allows 24 hours per week, and Level III, for those who are NF eligible, allows a cap of up to 40 hours per week.

Private Non Medical Institution (PNMI) Initiative – November 2011 Update

Overview

In early September, the Department updated all Private Non-Medical Institution (PNMI) providers and the Legislature on the work we are engaged in with the Centers for Medicare and Medicaid Services (CMS) regarding compliance issues related to PNMI services. That letter can be found online at: http://maine.gov/dhhs/oms/provider/pnmi.html.

As part of our efforts to address CMS' concerns, the Department initially sought to establish a provider Steering Committee to assure that all available expertise is utilized. Due to the overwhelming provider interest and the need to respond to CMS in a timely manner, we altered that plan.

Outreach

Statewide PNMI Forum

On October 18, the Department held a Statewide PNMI Informational Forum at the Augusta Civic Center. Over 200 people attended. Presentation topics included the current status of MaineCare PNMI services, CMS' concerns, the progress of DHHS, timelines and expectations.

Participants also had the opportunity to hear from Robin Cooper, a national expert who is the Director of Technical Assistance with the National Association of State Directors of Developmental Disabilities Services, Inc. Cooper is an expert on systems design and financing options that promote effective management practices and assure consumer choice and control. She spoke about the national perspective on community services, the Olmstead Decision and what options are available to Maine as part of this initiative.

Both presentations can be found online at: http://maine.gov/dhhs/oms/provider/pnmi.html

Regional "Work Sessions"

In November, DHHS hosted six PNMI Provider "Work Sessions" which provided the opportunity for more interactive discussions and brainstorming.

November 7	Augusta
November 8	Presque Isle
November 9	Bangor
November 10	Rockland
November 17	Lewiston
November 18	Saco

These sessions were well attended. The sessions were broken up by provider groups and facilitated by the Ofice Directors. The groups were active and productive, and common themes

became apparent. The next steps are to summarize the input from the forums, post it on the webpage, and begin using this input to formulate a plan.

A consumer fact sheet was posted on the web page and can be found here: http://maine.gov/dhhs/oms/provider/pnmi.html

Institution for Mental Disease Update

In addition to this overarching PNMI work, the Department received a letter from the Centers for Medicare and Medicaid Services on August 9, 2011, requesting the Department to identify what PNMI facilities meet the federal definition on an "Institution for Mental Disease (IMD)." These facilities are not reimbursable under the Medicaid program for members between the ages of 22-64.

The Department had several calls with CMS to clarify the request and developed an assessment that was used to call all enrolled PNMI agencies over a three-week period. The Department responded to CMS on October 12, 2011 with a list of those providers who appear to meet the federal definition (three providers, five facilities).

On November 10, 2011, The Department had a conversation with CMS seeking further clarification regarding whether PNMI beds which coexist with non-pnmi beds should be considered an IMD. During that conversation, CMS directed the Department to rescind the October 12, 2011 letter, and stated we could review our IMD decisions over the next three to six months with CMS technical assistance.

The Department has asked for further guidance from CMS on how to consider "scattered site" PNMI programs which are smaller facilities that fall under the umbrella of one organization. DHHS had a conference call with CMS, and CMS asked for an estimate of how long it would take the Department to do a thourough analysis of scattered sites. The Department determined it would take six months, with CMS technical assistance, to do this analysis.

Both letters to CMS on these points can be found on the website here: http://maine.gov/dhhs/oms/provider/pnmi.html.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations/Boston Regional Office

August 9, 2011

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

RE: Institution for Mental Disease Exclusion

Dear Commissioner Mayhew:

As you are aware, Maine Department of Health and Human Services (DHHS) and CMS have engaged in frequent telephone conferences for the last several months regarding the State's current operations of private non-medical institutions (PNMI). These conferences are the result of several pending State plan amendments (SPA) which MaineCare submitted in the fall of 2010. The SPAs are currently "off the clock" as CMS and MaineCare work together to reach an approvable status.

In the course of these discussions, we have learned many details about the PNMI programs, services, and operations. Based on the information that we have received from DHHS, it is our opinion that several of the PNMI facilities may meet the regulatory definition of institutions for mental diseases (IMD). Section 1905(a)(28) of the Social Security Act (the Act) generally excludes Medicaid coverage for services provided in an IMD and Federal Financial Participation is unavailable for services to IMD patients regardless of whether those services are provided within or outside the facility. Federal Medicaid regulations at 42 CFR 435.1010 define an IMD as:

> *"Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases".*

Additional guidance on the determination of whether a facility is an IMD can be found in section 4390 of the State Medicaid Manual.

However, as detailed below, there are situations in which Medicaid FFP is allowed for patients of IMDs:

a) Section 1905(a)(14) of the Act permits inpatient hospital services and nursing facility services for individuals 65 years of age or over if the IMD facility meets Medicaid survey and certification requirements and is licensed as a Medicaid facility.
b) Section 1905(a)(16) of the Act permits inpatient psychiatric services for patients who are under the age of 21 (or age 22 for those receiving such services when attaining age 21).
c) Also, for patients aged 65 and over, FFP is permitted for non-institutional services regardless of whether the IMD is licensed as an inpatient facility.

Please note that, other than the special situation noted in (b), none of these exceptions apply to IMD services for patients who are between ages 21 and 65.

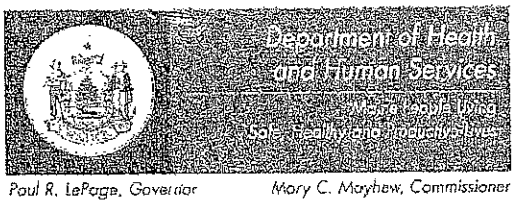
Due to the above-expressed concerns, we are asking the State to identify all PNMI facilities that meet the Federal definition of an IMD and then immediately cease Medicaid claiming for services in that IMD. Please submit this list to my office within 60 days of receipt of this letter. CMS cannot guarantee that other entities with oversight responsibility of the Medicaid agency will not pursue compliance actions, within their authority, with respect to Medicaid payment to these IMDs.

Please feel free to contact me with any questions you may have regarding this letter.

Yours,

Richard R McGreal

Richard McGreal
Associate Regional Administrator



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

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

October 12, 2011

Richard McGreal, Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Building, Government Center
Room 2275
Boston, Massachusetts 02203

Re: *CMS August 9, 2011 Letter Regarding Institution for Mental Disease Exclusion*

Dear Mr. McGreal:

Stefanie Nadeau and I very much appreciated the opportunity to speak with you yesterday to clarify your August 9, 2011, letter which asked Maine to identify all Private Non Medical Institutions (PNMI) facilities that meet the Federal regulatory definition of an Institution for Mental Disease (IMD) within 60 days. Thank you for clarifying that CMS wants a list of those PNMIs that meet the 42 U.S.C. § 1396d(a)(29) IMD exclusion criteria (individuals between the ages of 21 and 65 who reside in IMDs).

As we discussed yesterday, the issue regarding scattered sites remains unclear and we appreciate your offer to set up a call to provide further guidance. We look forward to that discussion.

Background: Maine's PNMI State Plan Program

Maine's state plan has authorized PNMI services for many years. The latest PNMI state plan was approved in 2004. *See* Maine state plan, TN No. 04-011, Attachment to 3.1-A, approved effective 9/1/04. (Attachment). The state plan approval expressly authorizes PNMI reimbursement for institutions providing substance abuse and mental health services. It authorizes:

> 1. Private non-medical institutions for substance abuse treatment, mental health services, child-care services, and services for people with mental retardation. Covered services include only detoxification, rehabilitation, extended care, extended shelter, halfway house, mental health and child-care services, provided to residents by qualified staff. . .
> *id.*

In light of the approved plan language, the Department has never considered PNMIs to be IMDs, or to be subject to the IMD exclusion. We do not consider PNMI residents to be "patients" of these homes. Like our plan language, the regulation authorizing PNMI contracts (42 C.F.R. §434.12) makes no reference to an IMD exclusion. This is unlike the definition of inpatient hospital services and Nursing Facility services, both of which expressly incorporate the IMD exclusion. *See* 42 C.F.R. § 440.10 ("Inpatient hospital services, other than in institutions for mental diseases."); § 440.155 ("Nursing facility services, other than in institutions for mental disease.") Also note the federal definition of IMDs which

states expressly that ICF-MRs are not IMDs (42 C.F.R. § 435.1009, which states: "An institution for the mentally retarded is not an institution for mental disease.")

Below you will find the summary our analysis of PNMI services that are subject to the IMD exclusion.

The IMD Exclusion Criteria

In making a determination as to whether any of Maine's PNMIs could be considered IMDs, Maine utilized the guidelines established by CMS in its State Medicaid Manual, two emails from Robert Cruz to Patricia Dushuttle,[1] and information collected from an Assessment Worksheet developed by Maine staff and posed to Maine PNMI providers.

Maine conducted its review as a three-step analysis. The first issue to determine was whether a PNMI meets the federal regulatory definition of "institution". "Institution" is defined in 42 CFR § 435.1009 as meaning an establishment of single or multiple facilities that furnishes food and shelter and some treatment to four or more persons unrelated to the proprietor.[2]

Maine then determined whether each "institution" might be an "IMD". IMDs are defined in federal law as being institutions which have more than 16 beds, and which are primarily engaged in providing diagnosis and treatment or care of persons with mental diseases.[3] 42 CFR § 35.1010. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

CMS guidelines suggest that certain criteria be utilized in making a determination whether an institution is an IMD: (1) is the facility licensed or accredited as a psychiatric facility; (2) is the facility under the jurisdiction of the State's mental health authority; (3) does the facility specialize in providing psychiatric/psychological care and treatment; and (4) does the current need for institutionalization for more than 50% of the facility's patients result from mental disease. CMS, State Medicaid Manual, § 4390.

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Sincerely,

Mary C. Mayhew
Commissioner

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cc: Bonnie Smith, Deputy Commissioner of Programs
Stefanie Nadeau, Director, Office of MaineCare Services
Patricia Dushuttle, Director, Policy, Office of MaineCare Services
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Department of Health and Human Services
Maine People Living Safer, Healthier and More Productive Lives

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

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Augusta, Maine 04333-0011
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November 8, 2011

Richard McGreal, Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Building, Government Center
Room 2275
Boston, Massachusetts 02203

Re: CMS August 9, 2011 Letter Regarding IMD Exclusion
And October 24, 2011 Telephone Conference

Dear Mr. McGreal:

Thank you for taking the time to talk with us October 24. During that phone call, you requested a timeline of how long a scattered site/IMD analysis would take the Department to complete. We estimate a comprehensive analysis would take approximately 6 months, and we would have the results to you by May 7, 2012.

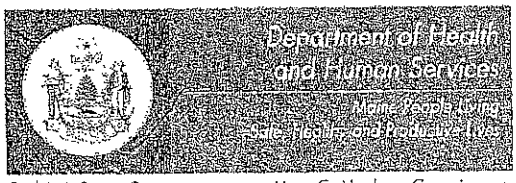
Again, thank you for your time and thoughtful consideration of our questions regarding this complicated issue. We look forward to working with you, as I expect we will have questions for you as we proceed through this process.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv

cc: Bonnie Smith, Deputy Commissioner of Programs
Stefanie Nadeau, Director, Office of MaineCare Services
Patricia Dushuttle, Director, Policy, Office of MaineCare Services
Pamela Easton, Director of Program and Regulatory Accountability



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

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November 18, 2011

Richard McGreal, Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
JFK Building, Government Center
Room 2275
Boston, Massachusetts 02203

Re: DHHS letter October 12, 2011 Letter regarding IMD identification
And November 10, 2011 Telephone Conference

Dear Mr. McGreal:

Thank you for taking the time to talk with us on November 10, 2011. Per your direction, this is a formal notification that we are rescinding our letter of October 12, 2011. Over the next three-six months we will conduct a more thorough analysis of associated non PNMI services in a PNMI setting.

We look forward to your continued technical assistance.

Sincerely,

Mary C. Mayhew

Mary Mayhew
Commissioner

MCM/klv

cc: Bonnie Smith, Deputy Commissioner of Programs
Stefanie Nadeau, director, Office of MaineCare Services
Patricia Dushuttle, Director of Policy, Office of MaineCare Services
Pamela Easton, Director of Program and Regulatory Accountability

OACPD—Adult Developmental Services
Section 21

Section 21, the Home and Community Based Comprehensive Waiver, is the primary means by which ADS authorizes services and supports to disabled adults whose needs include residential supports of one kind or another. Section 21 also provides funding for Community Support (day programs), Work Support (job coaching). It also funds some other services, but these three account for almost all funding.

According to data pulled from the EIS data system earlier this morning:

	ANNUALIZED	6 MO. PERIOD STARTING 01/01/12
Total service population	2825	
Total Section 21 authorization	$285,155,020	$142,577,510
Home Support service population	2409	
Total HS authorization	$226,484,658	$113,242,329
Group home service population*	1538	
Total group home authorization*	$199,000,000	$99,500,000
Average authorization	$129,000	

Cycle report authorization through 11/25/11 (40%) (Seed)	$43,041,600
Claims paid, same period	$42,122,151
Percentage claims vs. authorized	97.9%
Projected State expended by 06/30/12	$105,305,000

Shift staffed, group home programs account for 70% of all authorized funding in Section 21, and support roughly 54% of those served. Other residential models include Shared Living (approximately 475 programs), Family Centered Support (independent) providers, in-home supports, and other, less frequently utilized models. While it is the case that the more behaviorally and/or medically challenging individuals tend to live in group homes, we also believe that many individuals living in group homes are being over-funded and over-supported. If this is the case, a standardized assessment tool administration will demonstrate it; those over-funded individuals will have profiles similar to their peers who live in Shared Living or other models.

POTENTIAL IMPACT OF A RATE CUT ON AFFECTED RESIDENTIAL PROGRAMS

A 10% annualized cut will reduce group home funding by approximately $19.9 million, to approximately $179 million. Average member authorization will be reduced from an annualized $129,000 to $116,000.

A 4.1% reduction, commensurate with the Commissioner's figure of a $3 million reduction in the State share, will reduce group home authorizations to roughly $190.8 million, reducing average member authorizations to $124,000