1115 Waiver Application
Department of Health and Human Services
State of Maine

Contents

I. Introduction

The Maine Department of Health and Human Services (DHHS) is the single state agency that administers the Medicaid program (known as "MaineCare") for the State of Maine.

Under the current administration, DHHS is focused on managing the Medicaid program to meet not only MaineCare program objectives, but also to improve Maine's overall financial standing. At the same time, DHHS has embraced initiatives gaining momentum at the national level to address improvements in our health care delivery and payment system. This Demonstration seeks to implement a number of critical changes which will allow Maine to continue pursuing these important goals simultaneously.

First and foremost, DHHS believes that Medicaid must provide a basic medical safety net to the neediest populations in our State. To achieve this, DHHS must be able to prioritize limited resources for children, elderly, and the disabled, instead of turning Medicaid into an entitlement program for working-age, able-bodied adults. In support of this goal, DHHS will use lessons learned from the successful implementation of Supplemental Nutrition Assistance Program (SNAP) work requirements to incentivize work and work-related activities for MaineCare members. DHHS knows that employment and education are key factors to moving individuals out of poverty, and must be treated as such by all social services.

Protecting Medicaid's critical services requires flexibility to implement cost sharing, benefit design, and eligibility requirements that foster personal responsibility and financial independence. Medicaid must embrace private market policies and principles such as premiums, responsibility for missed appointments and differential cost-sharing based on setting; these are common tools used by other payers to manage utilization and costs in their programs. DHHS believes federal regulations should not prohibit Medicaid programs from responsibly employing these standard methods.

Many of these initiatives have the added benefit of transitioning MaineCare members into active consumers of healthcare who are better prepared to transition to commercial health insurance. To assist in this transition, DHHS seeks to improve transparency and information sharing to members regarding the cost incurred to the State for their health care services – individuals must have access to this information if payers are to expect more engagement and cost-conscious consumption of health care resources.

While similar 1115 waivers have been denied in the past for failure to further the objectives of the Medicaid program, DHHS believes these decisions were short sighted and drawn from incorrect assumptions. DHHS seeks to improve coverage for low-income populations by focusing resources on populations that have no other options for gaining coverage. DHHS does

not believe the Medicaid should crowd out private insurance due to rigid regulations which ignore individual assets and create a consumer environment that is vastly different from the experience of those in commercial markets. As we continue our work to maintain fiscal discipline and stability in our Medicaid program, we must have greater flexibility at the state level to manage programmatic decisions.

The three main goals of this Demonstration are:

- To preserve limited financial resources for the State's most needy individuals and ensure long-term fiscal sustainability.
- To promote financial independence and transitions to employer sponsored or other commercial health insurance.
- To encourage individual responsibility for one's health and health care costs.

II. Program Description

A. Community Engagement and Work Requirements

Employment provides not only monetary compensation, but also daily structure and a sense of pride that no government program can replicate. Currently, Medicaid eligibility rules can serve as a deterrent to work. For these reasons, and in alignment with other social service programs in our state, DHHS intends to institute a community engagement and work requirement for able-bodied adults in MaineCare similar to the requirements DHHS implemented in the SNAP program in 2014. When Maine implemented work requirements for able-bodied adults without dependents in SNAP, the earned income of those who left SNAP rose 114% in just one year. Similarly, the goal of this initiative is to increase employment and wage earnings of able-bodied adults, while subsequently focusing MaineCare funding on Maine's most needy individuals.

Maine people must receive consistent messaging on the importance of employment to Maine's economy and overall well-being. To achieve this, the Demonstration seeks to add community engagement and work requirements for working-age, able-bodied adults in coordination with similar work requirements for Temporary Assistance for Needy Families (TANF) and SNAP. The determination of who is required to comply with these requirements has been tailored to account for individual circumstances and the various types of valuable community engagement and work that may be pursued by MaineCare members. Each registrant who is referred shall be advised of the participation requirements, what constitutes noncompliance, and the consequences of noncompliance.

Members will be assessed at the point of application or reassessment to determine if they are required to meet the MaineCare work requirements. Members who are required to meet these requirements, may receive up to three months of MaineCare coverage in a thirty-six month period (beginning on the implementation date as outlined in this waiver application, and subject to adjustment based on the waiver approval date) without meeting the community engagement and work requirements. MaineCare may authorize an additional month of eligibility beyond the three months in exceptional circumstances.

Members will be notified of all applicable reporting requirements, and the MaineCare eligibility system will track countable months for members who are subject to MaineCare community engagement and work requirements. Members who fail to comply with the community engagement and work requirements will be removed from MaineCare. The start date of the disenrollment shall be the first of the month after normal procedures for closing or removal of the individual have taken place. Should a fair hearing delay the implementation, the period shall start the first of the month following the decision upholding the agency. The

disqualification period shall continue until the disqualified member complies with all registration requirements.

Requirements

There are numerous ways in which individuals may fulfill the community engagement and work requirements. An able-bodied adult must show evidence of employment, job-training, enrollment as a student, community service, receipt of unemployment benefits, and select caretaking activities when coupled with career planning. More specifically, the following activities will constitute compliance with the MaineCare work requirements:

- Working in paid employment at least 20 hours per week (averaged monthly). If self-employed, the member must be employed for 20 hours or more per week and receive weekly earnings at least equal to state or federal minimum wage, whichever is higher, multiplied by 20 hours.; or
- Participating in and complying with the requirements of a Department-approved work program for at least 20 hours per week (averaged monthly); or
- Workfare or volunteer community service 24 hours/month; or
- Enrollment as a student at least half time, as evidenced by documentation from the academic institution. The goal of the education must be to gain employment. This is based on the requirement for 20 hours/week; or
- Completing a combination of employment and education, based on achieving the threshold of 20 hours/week; or
- Receiving unemployment benefits; or
- Complying with work requirements for SNAP or TANF; or
- Providing caregiver services for a non-dependent relative or other person with a disabling health condition and planning or engaging in activities to formalize work in this area through exploration of training and certification programs.

These work requirements will apply to individuals between the ages of 19-64 in the eligibility groups described in Section IV. In addition to eligibility groups which are exempted, individuals within impacted populations may be exempted.

Individual exemptions

The following individual circumstances will exempt an individual from the requirement to comply with the proposed MaineCare work requirements:

- Residing in an institutional residential facility; or
- Residing in a residential substance abuse treatment and rehabilitation program; or

- Caring for a dependent child under age six; or
- Caring for a disabled dependent; or
- Being pregnant; or
- Being physically or mentally unable to work 20 or more hours per week. If not evident, medical certification is required. In lieu of a doctor's statement, statements from nurses, nurse practitioners, social workers, or medical personnel may be sufficient; or
- Receiving temporary or permanent disability benefits issued by governmental or private resources.

When a MaineCare member has failed to comply with the work requirements, a determination of whether or not good cause existed shall be made. All facts and circumstances shall be considered, including information submitted by the MaineCare member and the employer, when applicable.

B. Cost Sharing Initiatives

The purpose of the cost sharing mechanisms are to support a level of personal responsibility, increase member awareness of the cost of medical services, and introduce members to commercial market policies and tools. Individuals will continue to be subject to point-of-service cost sharing, which will separately be maintained consistent with Medicaid limits (no more than five percent of quarterly household income).

1. DHHS will require monthly premiums for able-bodied adults ages 18 and over in excess of applicable Medicaid limits. This requirement does not impact existing premium requirements in the MaineCare program. This provision will be limited to populations who have the ability to earn as defined by the eligibility groups described in Table 3. The same individual exemptions apply to premiums as to the community engagement and work requirements.

   Premiums will be due for each month that a member has MaineCare eligibility, unless specifically excluded from this requirement. Premiums are due on the first day of each month of coverage. The first month's premium must be paid prior to the start of benefits. Individuals will have 60 days from the date of their eligibility determination to pay the premium and have their benefits begin. Coverage will begin the first day of the month in which the premium is received. Premiums can be paid monthly, for multiple months, or they can be paid in advance for the twelve month enrollment period

In the event that a member fails to pay a required premium by the due date, the State will honor a grace period of no less than 60 days during which the member may make payment without termination from MaineCare. During the grace period, DHHS will notify the member of failure to make the required payment and may face termination from the program if the payment is not made. If the member does not make the payment after the grace period, the member will be disenrolled from MaineCare for a period of 90 days. Coverage cannot begin again until any unpaid premiums are paid. When the unpaid premiums are paid and the individual is otherwise eligible, the individual will be re-enrolled.

The MaineCare premium schedule will build in incentives to increase individual income by establishing three premium brackets, based on member income. With this design, members who move to the top of their income band are paying a lower percentage of their income toward their premium.

The premium requirements will be as follows:[1]

Table 1. Premium Requirements by Income

Income Range	Monthly Premium
0-100% FPL	$14
101% -200% FPL	$43
201% and above	$66

2. DHHS has implemented a number of operational and payment policies to address inappropriate use of the Emergency Department (ED) including, (1) the ED Collaborate which provides team-based care management to MaineCare' s highest ED utilizers, and (2) reducing payment to hospitals for non-emergency ED visits. Currently, there is not a corresponding incentive on the members' side to encourage them to seek care through primary care and other non-emergency settings. This Demonstration provides that final piece by extending cost sharing for ED use that does not result in an inpatient admission. This will be applied to all members, except for members dually eligible for Medicare and Medicaid who do not have full MaineCare. DHHS proposes to set the non-emergency use of the ED copayment at $20.

[1] Premium amounts are based off of the weighted average income of the eligibility group individuals within each tier, based on available data from the Office of Family Independence.

DHHS will identify members who have visited the ED and who were not admitted through periodic claims review. For each of these visits, DHHS will send a bill to the member for $20. This bill will include a breakdown of the costs associated with their ED visit to provide information to members regarding the cost of their care to the taxpayers of Maine.

DHHS will be responsible for collecting these payments, and this will not result in any decrease to provider payments.

3. DHHS proposes to allow providers to charge MaineCare members for missed appointments. Missed appointments are a significant problem for many MaineCare providers. When a member misses an appointment without notice, not only is the provider denied payment for the missed appointment, but other MaineCare members, who could potentially have been seen in that time slot, miss an opportunity for care. MaineCare values providers who include MaineCare members in their practice panels and believes that this allowance will offer some financial relief to providers who do make the choice to see MaineCare members.

   Providers must provide the MaineCare member prior notice regarding the standard office policy for missed appointments. Providers may only charge MaineCare members in accordance with standard office policy, except that the fee may not exceed the anticipated MaineCare reimbursement amount for the service that would have been delivered.

C. Asset Limitations

DHHS seeks to require individuals to apply personal finances and assets to their own health care costs in order to preserve MaineCare funding for the neediest members.

1. DHHS does not believe that Modified Adjustment Gross Income (MAGI)-based methodology, with its disallowance for asset or resource tests, is aligned with MaineCare's program goals. Therefore, DHHS proposes to apply a reasonable asset test to Medicaid, similar to the asset test utilized in the SNAP program. The $5,000 asset test will be applied to all MAGI households and assets that are not excluded as part of the existing State Plan will be countable in the determination of MaineCare eligibility.

   This test would be applied to all populations who do not otherwise have an asset test as part of their eligibility determinations.

2. DHHS also seeks to waive the prohibition of imposing a transfer penalty for the purchase of Medicaid-compliant annuities for long-term care coverage determinations and institute reasonable minimum pay out periods for the annuitant.

   Transfer penalties are applied when an individual who has assets that exceed the spousal asset allocation (a set amount of money the law allows a non-institutionalized spouse to retain for community living) attempts to give away the excess in order to ensure Medicaid eligibility. Under Section 1917(c)(a)(F) of the Social Security Act, an individual can purchase, for any dollar amount, what is widely known as a Medicaid-compliant annuity to avoid this penalty. Purchasing this type of annuity can effectively shelter an unlimited amount of money for a person (or the spouse of a person) applying for Medicaid long-term care coverage. For the annuity to be considered Medicaid-compliant, the state in which the individual is applying for assistance must be named as the beneficiary for the total amount of Medicaid benefits paid on behalf of the institutionalized individual. The annuity must also meet three other requirements:

   - It must be actuarially sound (meaning that the annuity is expected to pay out in full within the lifetime of the annuitant);
   - It must be irrevocable and non-assignable; and
   - It must provide for payments in equal amounts throughout the life of the annuity (no balloon payments are allowed).

   As long as an annuity meets these conditions, the purchase of the annuity is not subject to a transfer penalty. In addition, the value of the annuity is not counted toward the applicant's (and spouse's, if applicable) asset limit.

   Since 2011, twelve individuals have purchased annuities valued at $400,000 or more within two months of their spouse applying for long-term coverage in Maine. Given the requirements and the cost of a Medicaid-compliant annuity, the only reasonable explanation for purchasing one is to shelter assets and qualify for Medicaid.

   In addition to the request to apply a transfer penalty to these types of annuities, DHHS seeks to amend policies around the actuarial soundness criteria for these annuities. Specifically, DHHS would like to require that the minimum length of the payout of a Medicaid-compliant annuity equal 80% of the life expectancy of the annuitant, regardless of whether the annuitant is the institutionalized spouse or the non-institutionalized spouse.

   Under current Medicaid long-term care post-eligibility rules, the non-institutionalized spouse's income and assets are not considered when determining *ongoing* eligibility for the

long term client. As long as the annuity pays out in full sometime within the life expectancy of the annuitant, the annuity is actuarially sound within the meaning of the rule. According to the actuarial life table published by the Social Security Administration, all men and women under the age of 100 have life expectancies of over 25 months.

The shorter the length of the payout period, the more advantageous a Medicaid-compliant annuity is to a non-institutionalized spouse. As the length of the payout period grows, the probability that the State may be able to recoup some of the Medicaid cost expended on behalf of the institutionalized spouse increases.

According to records, DHHS has maintained since 2011 in regard to this type of annuity, the average annuity is paid out in full after 25 months from the date of purchase. In addition to how this annuity is used by couples, single individuals routinely use this type of annuity to privately pay for long-term care during a period of ineligibility for Medicaid coverage due to a transfer of assets (i.e., an individual intentionally transfers assets knowing a transfer penalty will be imposed and purchases this type of annuity to pay for long term care while the penalty is being served).

Requiring the length of the payout equal 80% of the life expectancy of the annuitant would make Medicaid-compliant annuities less attractive for at least two reasons:

- Although the non-institutionalized spouse could still receive 100% of his/her investment back in full, this could take several years (depending on the age of the individual at the time of purchase);
- The potential for the non-institutionalized spouse to receive his/her entire investment prior to his/her passing would decrease; and
- The payments received by the institutionalized spouse after the penalty period has expired would either be applied to his/her cost of care (if determined eligible for assistance) or would result in an ineligibility decision due to excess income.

D. Retroactive Eligibility

MaineCare coverage for an individual should begin on the first day of the month that an application for assistance is filed. Consistent with private insurance coverage, it is not the State's responsibility to pay for medical bills incurred during a time when an individual is not enrolled. Providers should determine whether or not they wish to deliver a service based on the insurance status of the individual at the time of the service and not based on potential for future retroactive insurance coverage by MaineCare.

This initiative also encourages individuals to seek coverage when they are healthy instead of waiting for medical expenses to incur before seeking coverage. This is a mindset necessary for commercial insurance coverage when enrollment is often limited to an open enrollment period. DHHS believes this will contribute positively to health outcomes, as individuals may begin receiving preventive care and establish a relationship with a primary care provider before a health crisis.

E. Presumptive Eligibility Determinations by Qualified Hospitals

In combination with the waiver of providing retroactive coverage to MaineCare members, DHHS seeks to eliminate the option for qualified hospitals to make presumptive eligibility determinations. The focus of MaineCare eligibility will be on comprehensive assessments to best determine MaineCare coverage and to set clear parameters around coverage periods. These processes will help ensure that State dollars are used only for appropriate health care coverage and they will encourage members to complete applications in a timely manner. Presumptive eligibility determinations for pregnant women will remain, in accordance with 42 CFR §435.1103.

III. Delivery System

All MaineCare members will continue to receive services through the current delivery system.

IV. Demonstration Eligibility

DHHS proposes to implement the following initiatives across all eligibility groups (with individual exemptions as described in II. Program Description):

- Charging enhanced cost sharing for use of the Emergency Department
- Using asset tests in eligibility determinations
- Applying a transfer penalty on "Medicaid-compliant annuities"
- Ceasing to provide retroactive eligibility
- Ceasing the hospital presumptive eligibility policy option

Table 3. describes the eligibility groups impacted by the proposed work requirements, and premiums. Only members over the age of 19 are included in the initiatives below. These requirements apply to all income levels within these groups.

Table 2. Demonstration Eligibility

Eligibility Group Name	Social Security Act and CFR Citations	Work Requirements	Premiums
Mandatory Categorically Needy			
Low Income Families **Parents/Caretaker Relatives**	1931 42 CFR 435.110	X	X
Transitional Medical Assistance	408(a)(11)(A) 42 CFR 435.112 1931(c)(2) 1925 1902(a)(52)	X	X (first six months)

Extended Medicaid due to Child or Spousal Support Collections	408(a)(11)(B) 42 CFR 435.115 1931(c)(1)	-	X
Former Foster Care Children	42 CFR 435.150 1902(a)(10)(A)(i)(IX)	X	X
Optional Categorically Needy			
Certain Women Needing Treatment for Breast or Cervical Cancer	1902(a)(10)(A)(ii)(XVIII) 1902(aa) 42 CFR 435.213	X	X
Individuals Eligible for Family Planning Services	1902(a)(10)(A)(ii)(XXI) 1902(ii) Clause (XVI) of 1902(a)(10)(G) 42 CFR 435.214	X	X
Reasonable classifications of individuals under age 21	1902(a)(10)(A)(ii)(I) and (IV) 42 CFR 435.222	X	X
Medically Needy Individuals Age 18 through 20	42 CFR 435.308 1902(a)(10)(C)	X	X
Medically Needy Parents and Other Caretaker Relatives	1902(a)(10)(C) 42 CFR 435.310	X	X
Special Benefits Waiver (HIV Waiver)		X	-

V. Types of Waiver Requested

A. Amount, Duration, Scope and Comparability **Section 1902(a)(10)(B)**
Section 1902(a)(17)

To the extent necessary to enable the state to vary the premiums, work requirements as described in this waiver application.

B. Reasonable Promptness and Eligibility **Section 1902(a)(10)(A) and 1902(a)(8)**

To the extent necessary to enable DHHS to not provide medical coverage until the first day of the month in which MaineCare members make their first premium payments, when applicable.

To the extent necessary to enable DHHS to make compliance with the MaineCare community engagement and work requirements and timely premium payments, a condition of eligibility for able-bodied adults.

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

To the extent necessary to enable DHHS to not provide medical coverage to MaineCare members for any time prior to the first day of the month in which the individual's application for coverage is received.

D. Cost Sharing **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable DHHS to impose mandatory cost sharing which exceed Medicaid allowable amounts for non-emergency use of the Emergency Department and for premium payments.

(Additionally 42 C.F.R. §447.15)

To the extent necessary to enable MaineCare enrolled providers to charge members directly for missed appointments.

E. Asset Tests **1902(e)(14)**

To waive the restriction on the use of asset test for Medicaid eligibility determinations as described in this waiver application.

F. Transfer Penalties **Section 1917(c)(a)(F)**
Section 1902(a)(18)

To the extent necessary to waive specific requirements of which prohibits the State from imposing a transfer penalty for the purchase of Medicaid-compliant annuities.

To the extent necessary to allow DHHS to require that the minimum length of the payout of the Medicaid-compliant annuity equals eighty percent of the life expectancy of the annuitant, regardless of whether the annuitant is the institutionalized spouse or the non-institutionalized spouse.

G. Presumptive Eligibility Determinations by Hospitals **Section 1902(a)(47)**
42 CFR 435.1110

To the extent necessary to waive the requirement to allow hospitals to serve as entities able to determine presumptive eligibility.

VI. Demonstration Area and Timeframe

DHHS seeks a five-year waiver approval period for this Demonstration. This Demonstration will operate statewide.

VII. Implementation Schedule

All initiatives, except for the premium requirements, will be implemented within six months of Demonstration approval (estimated at January 1, 2018). Premium requirements will begin July 1, 2018.

VIII. Hypotheses and Evaluation

Through this Demonstration DHHS intends to evaluate a number of hypotheses. Table 4 describes these hypotheses and how DHHS will evaluate the impact of this Demonstration.

Table 3. Evaluation Plan

#	Hypothesis	Methodology	Data Sources and Metrics
Goal 1: To preserve limited financial resources for the State's most needy individuals and ensure long-term fiscal sustainability.			
1.1	The elimination of asset tests has resulted in MaineCare eligibility for individuals who have personal assets that could be used to purchase health insurance coverage or pay for medical bills.	Examine impact on eligibility for individuals reassessed for MaineCare coverage after asset tests are reintroduced.	Eligibility files
1.2	The inability to impose restrictions and transfer penalties on Medicaid-compliant annuities has resulted in	Record the number of transfer penalties applied to applicants pre- and post – demonstration	Eligibility files

	MaineCare eligibility for individuals who have personal assets that could be used to purchase health insurance coverage or pay for medical bills.	implementation.	
Goal 2: To promote financial independence and transitions to employer sponsored or other commercial health insurance.			
2.1	Earned income of those who leave MaineCare will increase after community and engagement requirements are implemented.	Maine will conduct an analysis of the wage and employment experiences of the impacted population.	Administrative data from DHHS Wage and employment records available at the Maine Department of Labor.
Goal 3: To encourage individual responsibility for one's health and health care costs.			
3.1	Allowing providers to charge for missed appointments will result in increased provider enrollment or changes in the size of provider panels for select services (e.g. dental providers).	DHHS will monitor provider enrollment and feedback.	Provider enrollment applications Provider feedback
3.2	Allowing providers to charge for missed appointments will result in a decrease in missed appointments.	DHHS will collect provider feedback regarding this initiative through stakeholder engagement.	Stakeholder feedback
3.3	Non-emergency utilization of the Emergency Department (ED) will decrease as members are held responsible for an enhanced copayment.	DHHS will conduct a pre- and post-utilization analysis of ED use.	Claims data

IX. Demonstration Financing

The Centers for Medicare and Medicaid Services (CMS) require that all 1115 waivers demonstrate budget neutrality. This application presents information on projected expenditures with and without the implementation of this waiver. Projections on eligible member months are provided to illustrate any potential changes to eligibility. Per Member Per Month (PMPM) estimates provide the expected expenditure per MaineCare eligible member.

Projections in Table 8 (implementation of the waiver) represent all changes except ED co-payments, premiums, and missed appointments. Premium payments and ED cost sharing are

expected to result in approximately $8,104,512 - $8,269,067 in State revenue annually. This revenue is not counted as a reduction in expenditures in the Table 8.

DHHS estimates that the current trend in eligibility decline will continue regardless of this waiver implementation; however, the decline may slightly increase over the short-term with this waiver as a result of the newly proposed eligibility criteria. The impact on eligibility as a result of the waiver is expected to include able-bodied adults, which tend to have a smaller PMPM than other members. For this reason, the average PMPM is expected to increase slightly under the waiver.

These estimates are highly dependent upon assumptions utilized in the analysis including the assumed approval and implementation dates, medical trend estimates, and eligibility assumptions. As part of this demonstration, DHHS will look to evaluate these assumptions.

Note: This section reflects what was prepared and submitted for public input assuming a January 1, 2018 demonstration start date (except for premium collections, which would begin on July 1, 2018).

Table 4. Demonstration Period

Demonstration Year	DY1	DY2	DY3	DY4	DY5
Time Period	1/1/2018-12/31/2018	1/1/2019-12/31/2019	1/1/2020-12/31/2020	1/1/2021-12/31/2021	1/1/2022-12/31/2022

Table 5. Historical Data

	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Total Expenditures	$2,323,453,881	$2,256,222,980	$2,243,704,171	$2,296,672,691	$2,288,058,837
Eligible member months	3,542,635	3,403,333	3,265,058	3,104,659	2,983,647
Average PMPM	$656	$663	$687	$740	$767

Table 6. Projections (Without Waiver)

	DY1	DY2	DY3	DY4	DY5
Total Expenditures	$2,219,874,683	$2,208,775,310	$2,197,731,433	$2,197,731,433	$2,197,731,433
Eligible member	2,807,015	2,778,945	2,751,155	2,751,155	2,751,155

months					
Average PMPM	$791	$795	$799	$799	$799

Table 7. Projections (With Waiver)

	DY1	DY2	DY3	DY4	DY5
Total Expenditures	$2,219,210,886	$2,208,124,789	$2,197,087,418	$2,197,093,858	$2,197,093,858
Eligible member months	2,807,015	2,750,875	2,723,366	2,696,132	2,696,132
Average PMPM	$791	$803	$807	$815	$815

X. Public Notice

This section will be completed when noticing is completed.

XI. Demonstration Administration

Mary C. Mayhew
Commissioner
Maine Department of Health & Human Services
207-287-4223
Mary.Mayhew@Maine.gov