Deloitte.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel: 612-397-4000
Fax: 612-397-4450
www.deloitte.com

January 2, 2014

Ms. Stefanie Nadeau
Director of MaineCare Services
Maine Department of Health and Human Services
11 State House Station
Augusta, ME 04333

Subject: MaineCare Actuarial Value Benefit Assessment – MaineCare for Childless Adults

Dear Ms. Nadeau:

We appreciate the opportunity to provide actuarial services for the State of Maine's Department of Health and Human Services ("DHHS"). This memorandum summarizes the results of the analysis performed by Deloitte Consulting LLP ("Deloitte") to conduct an actuarial value benefit assessment for the MaineCare Childless Adults population ("demonstration population") covered under its Section 1115 waiver demonstration.

The State received a letter from Dianne Heffron at the Centers for Medicare & Medicaid Services ("the CMS Letter"), dated February 14, 2013, which describes the information CMS requires to determine if the State is eligible to receive an increased Federal Matching Assistance Percentage ("FMAP") on expenditures for eligible members of the demonstration population. The results of this actuarial value analysis are intended to be used by DHHS to support the response to the CMS Letter. Based on our review of the CMS Letter and discussions with the State, Deloitte understands that the key objectives for this assessment include the following:

- Develop actuarial values for the benefit packages provided to the demonstration population in effect as of December 1, 2009
- Develop actuarial values for selected "benchmark plans" in effect as of December 1, 2009
- Utilize the results of the analysis to determine whether the benefit packages offered to the demonstration population represent "full benefits," "benchmark," or "benchmark-equivalent" coverage as of December 1, 2009
- Develop an actuarial memorandum which documents the findings of our benefit assessment and includes information to assist DHHS in responding to questions outlined in Attachment A of the CMS Letter

To accomplish these objectives, Deloitte performed the following primary tasks:

- Requested and gathered data
- Reviewed and cleansed data
- Calculated actuarial values for the demonstration population and benchmark plans
- Developed this actuarial memorandum which documents the results of our benefit assessment

Deloitte will be available to participate in discussions with CMS and/or assist DHHS in drafting responses to CMS questions during the course of CMS' review.

This document includes an executive summary of our results, background on the analysis, a description of the scope of our work, data considerations, assumptions and limitations, analysis results, and conclusion.

Executive Summary

Beginning in 2014, the Patient Protection and Affordable Care Act ("PPACA") authorizes two types of increased federal Medicaid matching rates for state expenditures for low-income individuals in the new adult group [that is, the group described by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act ("the Act")]: the newly eligible FMAP and the expansion state FMAP.

It is our understanding DHHS has requested our services in reviewing the benefit requirements and calculating the actuarial values for each benefit for the demonstration population in order to help determine whether they would qualify for "newly eligible" or "expansion state" FMAP. This request includes analyzing whether the current MaineCare Medicaid benefit package for Childless Adults meets the PPACA requirements for benchmark/benchmark-equivalent coverage by comparing its actuarial value against those of the selected benchmark/benchmark-equivalent plans.

For our analysis we compared Maine's Medicaid benefit package effective December 1, 2009, otherwise known as MaineCare, for the Childless Adults population against the following benchmark plans:

- Federal Employee Health Benefit Plan ("FEHBP"): Blue Cross Blue Shield Standard PPO Option
- Maine State Employee Plan: Anthem Blue Cross Blue Shield POS Option

We received a high-level plan design summary for the largest HMO plan, Anthem Blue Choice, but the summary did not contain sufficient level of detail to include in our aggregate analysis as the benefits indicated a range of cost-sharing options by category of service. We contacted Anthem on several occasions to request a single plan design for the Blue Choice product with the largest non-Medicaid enrollment as of December 1, 2009, but we have not received the required information at the time of the release of this memorandum.

The definition of benchmark plans includes the federal employee plan, state employee plan, **or** the largest HMO insured plan. Since we are assessing the Childless Adults benefits compared to two of the plans, we believe the HMO plan is not necessary for the aggregate actuarial analysis. However, based on the information provided, we were able to determine the general coverage for adult hearing services as outlined in Appendix E and included this information in our actuarial value calculations for hearing services.

The following Table 1 provides a high-level summary of the aggregate actuarial value or plan design benefit factors for the MaineCare benefits for Childless Adults and the two benchmark plan designs based on the claims experience for Childless Adults. An actuarial value or benefit factor measures the comprehensiveness of benefits offered under a plan design, or in other words, the share of health care cost that is covered by the plan. A benefit factor of 1.00 would indicate the plan design covers 100% of the health care cost with no member cost sharing, while a benefit factor of 0.50 would reflect that the plan design covers 50% of the health care cost and 50% member cost sharing. Please refer to Appendix A for a detailed listing of benefit factors by service category.

Table 1: Aggregate Plan Design Actuarial Benefit Factors

Plan Design Actuarial Benefit Factors (Plan Responsibility)			
Service Category	**MaineCare for Childless Adults**	**FEHBP - BCBS Standard PPO**	**Maine State Employee Plan**
Aggregate Actuarial Benefit Factor	**0.984**	**0.816**	**0.926**

As shown in Table 1, based on the State of Maine's Childless Adults claims experience, we estimate that the current MaineCare benefit package for Childless Adults pays approximately 98.4% of eligible Medicaid claims, which is greater than each of the benchmark plan designs. Therefore, we have determined that the current MaineCare benefit package for Childless Adults, at an aggregate level, meets the benchmark equivalent requirement of having an actuarial value that is at least actuarially equivalent to coverage under a benchmark package.

The following Table 2 provides a summary of the plan design benefit factors for the four required service categories to meet benchmark equivalency. This analysis was performed across all four categories for the MaineCare benefit package for Childless Adults and the FEHBP and State Employee Plan. For the HMO plan, an analysis of the hearing services coverage was performed as further plan design information was not available for this benchmark plan as discussed above.

Table 2: Plan Design Actuarial Benefit Factors for Required Service Categories

Plan Design Actuarial Benefit Factors (Plan Responsibility)				
Required Service Categories	**MaineCare for Childless Adults**	**FEHBP - BCBS Standard PPO**	**Maine State Employee Plan**	**HMO Plan - Anthem Blue Choice**
Prescription Drug	0.958	0.747	0.771	N/A
Mental Health	0.996	0.865	1.000	N/A
Vision Services	0.986	0.850	0.785	N/A
Hearing Servcies	0.000	0.444	0.304	0.496

As shown in Table 2, we estimate that the actuarial values of the MaineCare benefit package for Childless Adults is at least 75% of the actuarial values of the FEHBP and State Employee Plan for prescription drug, mental health, and vision services. However, since hearing services are not a covered benefit under the demonstration population, we believe the actuarial value of hearing services under the MaineCare benefit package for Childless Adults is zero and is not at least 75% of the actuarial value of hearing services for the FEHBP, State Employee Plan, or HMO plan. Therefore, we believe the current MaineCare benefit package for Childless Adults does not meet the benchmark-equivalent requirements under PPACA as having an actuarial value of at least 75% of the actuarial values of the benchmark plans for hearing services.

In this document, we have included detailed information regarding our analysis, the adjustments and assumptions incorporated, and an overview of the results. The remainder of our letter is organized into the following sections:

- Background
- Project Scope
- Data Considerations
- Data Assumptions and Limitations
- Results
- Conclusion
- Appendices

As separate attachments, we have included a WinZip file (*MaineCare Benefit Assessment - Plan Design Documents.zip*) which contains supporting documentation regarding the benchmark plan designs, and a Microsoft Excel file (*MaineCare Benefit Assessment - Appendices.xlsx*) which contains electronic versions of appendices A-F incorporated in this memorandum.

Background

Medicaid Expansion and FMAP

On June 28th, 2012, the Supreme Court issued their decision regarding the constitutionality of the Patient Protection and Affordable Care Act ("PPACA"). Within this decision, the court provided states the opportunity to opt out from expanding current Medicaid eligibility to individuals who are age 19-64 living at up to 133% of the Federal Poverty Level ("FPL") and not previously eligible for Medicaid.

Beginning in 2014, PPACA authorizes two types of increased FMAPs for state expenditures for low-income individuals in the new adult group (that is, the group described in section 1902(a)(10)(A)(i)(VIII) of the Act) – the newly eligible FMAP and the expansion state FMAP. Under the statute, these two increased federal matching rates are only available to states that adopt the new adult group. As outlined in the CMS Letter, definitions of the two matching rates are as follows:

- **Newly Eligible FMAP:** The newly eligible FMAP is available for medical assistance expenditures on behalf of "newly eligible" individuals, who are defined (in section 1905(y)(2) of the Act) as individuals between the ages of 19 and 64 who are enrolled in the new adult group and who would not have been eligible for full benefits, benchmark coverage (described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act), or benchmark-equivalent coverage (described in section 1937(b)(2) of the Act) as of December 1, 2009. An individual may also be "newly eligible" if he or she would have been eligible but could not have been enrolled for such benefits or coverage because the applicable Medicaid waiver or demonstration had limited or capped enrollment as of December 1, 2009.

When Congress enacted PPACA, some states had already expanded coverage to adults at higher incomes. The expansion state designation under the statute provides an alternate increased FMAP to states that adopt the new adult group but where some individuals in the new group do not qualify for the newly eligible FMAP because they would have qualified for full benefits, benchmark benefits, or benchmark-equivalent benefits under the state's rules as of December 1, 2009.

- **Expansion State FMAP:** The expansion state FMAP may be available to qualifying states for expenditures for certain non-pregnant childless adults (those who are enrolled in the new adult group and who the state may require to enroll in benchmark coverage), to the extent that such individuals do not qualify for the newly eligible FMAP. A qualifying expansion state (described in section 1905(z)(3) of the Act) is a state that, as of March 23, 2010, provided "health benefits coverage" either through Medicaid or a fully state-funded program to parents and non-pregnant childless adults up to at least 100 percent of the FPL. For purposes of this statutory definition, such health benefits coverage as of March 23, 2010 must have:
    - Included inpatient hospital services
    - Not been dependent on access to employer coverage, employer contribution, or employment
    - Not been limited to premium assistance, hospital-only benefits, a high deductible health plan, or a health opportunity account [1]

[1] http://www.shadac.org/files/medicaid.gov_State-Resource-Center_FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation_Downloads_ACA-FAQ-BHP.pdf

Benchmark/Benchmark-Equivalent Benefit Packages

As stated above, the newly eligible FMAP applies to adults in the new low-income adult eligibility group who would not have been eligible for full benefits, benchmark benefits, or benchmark-equivalent benefits under the state's rules as of December 1, 2009. At the time of approval of the section 1115 demonstrations in effect as of that date, neither CMS nor states explicitly designated the coverage offered under demonstrations as "benchmark" or "benchmark-equivalent" coverage, even though the coverage offered to demonstration beneficiaries may have met such standards. Therefore, CMS is requesting that states that used section 1115 demonstrations to expand coverage to low-income adults as of December 1, 2009, to provide CMS with an analysis of the benefit package that was offered so that CMS can determine whether the benefits provided could have met a benchmark or benchmark equivalent standard, as in effect in December 2009.

As outlined in the CMS Letter, the requirements for benchmark and benchmark–equivalent coverage[2] include the following:

Benchmark Coverage:

Benchmark coverage is equal to one of the following benefit plans:

- Federal Employee Health Benefit Plan ("FEHBP"): Standard Blue Cross Blue Shield Preferred Provider Option
- State Employee Coverage: health benefits coverage that is offered and generally available to state employees ("State Employee Plan")
- Health Maintenance Organization ("HMO") plan that has the largest insured commercial, non-Medicaid enrollment in the state ("HMO Plan")
- Secretary-approved coverage

Benchmark-Equivalent Coverage:

As outlined in the CMS Letter, benchmark-equivalent coverage has an aggregate actuarial value at least as rich as coverage for one of the benchmark plans. Benchmark-equivalent coverage must include:

- Inpatient and outpatient hospital services
- Physicians' surgical and medical services
- Laboratory and X-ray services
- Emergency services

Benchmark-equivalent coverage must have an actuarial value of at least 75 percent of the actuarial value of the benchmark plan for the following additional services:

- Coverage of prescription drugs
- Mental health services
- Vision services
- Hearing services

For our analysis, since the demonstration population did not receive "full benefits" nor is the MaineCare for Childless Adults package the same as the above-outlined benchmark packages, we reviewed whether the coverage offered to the demonstration population is considered "benchmark-equivalent."

[2] http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Benchmark-Standards-12-1-09.pdf

Project Scope

Benchmark-Equivalent Plan Design Analysis

The following summarizes the project steps completed for the benchmark-equivalent plan design analysis:

1. **Gathered and uploaded claims data** – We used the latest claims and eligibility data available from the Maine Integrated Health Management System ("MIHMS") data platform. Deloitte obtained facility claims, professional claims, prescription drug claims, and eligibility data in the Structured Query Language ("SQL") server data warehouse from prior engagements with the State of Maine for the period September 1, 2010, to June 30, 2012. Additionally, we imported facility claims, professional claims, prescription drug claims, and eligibility data into the SQL server data warehouse for July 1, 2012, to March 31, 2013.

2. **Reviewed and cleansed data** – We formatted data fields and analyzed data field population to confirm credible information was available and formatted in a consistent manner for our analysis. We reviewed the financial fields and enrollment information in the warehouse data for consistency against financial reports provided by Molina Medicaid Solutions ("Molina"), Maine Medicaid's current fiscal agent.

3. **Applied service categories** – We independently applied service category indicators, which align with the benchmark requirements for our analysis, to each claim line. Details of the service category mappings are provided in Appendix C.

4. **Refined the claims data population** – We applied population restrictions and data adjustments to identify the Childless Adults population and broader MaineCare Adults population. Details of the data refinements can be found in the *Data Assumptions and Limitations* section of this letter.

5. **Calculated actuarial benefit factors for the MaineCare benefit package for Childless Adults and benchmark plan design packages** – Using Medicaid data provided, we developed a complex claim-based pricing model to review the actuarial benefit factors by service category between the MaineCare benefit package for Childless Adults and both the FEHBP and the Maine State Employee Plan, and for hearing services for the HMO plan. The model applied the appropriate cost-sharing provisions at the claim-line level based on the service category of the claim and the underlying plan design benefit. The relationship between the allowed and paid amounts was used to determine the actuarial value of the MaineCare benefits for Childless Adults. For the benchmark plan designs, the allowed amounts in the claims data along with the corresponding utilization were used to apply the cost-sharing provisions of the benchmark plans. Plan design information can be found in Appendices B and E.

6. **Compared and summarized results** – We compared benefit design differentials against The Center for Consumer Information and Insurance Oversight ("CCIIO") actuarial value calculator for reasonability. We then summarized results into a deliverable displaying the actuarial benefit differentials by service category.

7. **Actuarial Memorandum** – We summarized the results of the plan design analysis into this actuarial memorandum including the data and methodology used in the analysis.

Data Considerations

DHHS provided Deloitte the following information to aid in our analysis:

- MIHMS claims data for both paid and denied claims incurred from September 2010 to March 2013 with run-out until March 2013
- Prescription drug claims data for claims with a service date from September 2010 to March 2013 with run-out until March 2013
- Eligibility table for the demonstration population between September 2010 and March 2013
- Summary of the current MaineCare benefit package for Childless Adults and the package in effect as of December 1, 2009
- Maine FMAP letter from CMS dated February 14, 2013, from Dianne Heffron, which describes the information CMS requires to determine the increased FMAP eligibility
- Summary of the Maine State Employee plan design in effect as of December 1, 2009
- High-level information summary of benefits for the HMO plan design (Anthem Blue Choice) in effect as of December 1, 2009
- Guidance on identifying the Childless Adults population in the claims and eligibility data
- Guidance on identifying the final claim in the MIHMS claims data

Additionally, Deloitte used its internal database adjusted to be consistent with the demographics of the Childless Adults population to perform reasonableness checks of the results.

We have based our analysis on information provided by DHHS. It is common actuarial practice to perform a review of data for reasonableness and consistency, not an audit[3] of data, when performing professional actuarial services. Consistent with the requirements of Actuarial Standards of Practice ("ASOPs") Number 23 - Data Quality, we have reviewed this data against financial reports provided by Molina for consistency during the course of our work and believe it was of sufficient quality to perform the analysis. However, we have assumed without audit or verification that all data and information provided to us is complete and accurate. If the underlying data or information provided is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

We have considered the scope of the assignment and the intended use of the analysis being performed in order to determine the nature of the data needed. With the exception of hearing services, we believe the Childless Adults claims and eligibility data is credible and is a reasonable data source to be used for our analytical purposes of the benefits offered to the State of Maine's Childless Adults population. Since hearing services are not a covered benefit for the demonstration population, we utilized the hearing claims data for the broader MaineCare Adults population, with demographic adjustments to be consistent with those of the demonstration population, to calculate the actuarial values for hearing services. We believe the combination of claims and eligibility data for these two populations is credible and a reasonable data source to be used for this assessment and therefore, believe it is unnecessary to rely on external data sources for this assessment.

[3] The Actuarial Standards Board defines "audit" as follows: "To conduct a formal and systematic examination of a set of data for the purpose of testing its accuracy, using techniques commonly employed by audit professionals."

Data Assumptions and Limitations

Medicaid Data for All Services Except Hearing Services

- **Data Used:** We used calendar year 2012 data with run-out to March 2013 from the MIHMS database, which was provided by Kaleb Osgood from Molina in August 2012 and in June 2013. Maine Professional, Facility, and Prescription Drug incurred claims for the Childless Adults population served as the basis for our analysis. Given size and completeness of these datasets (more than 154,000 Childless Adult annual member months), we believe it is a reasonable source to rely upon during the course of our analysis.

- **Population Assumption:** We limited the data population to only include Childless Adults. The selected Childless Adults population is identified in the provided data as follows:
    a. For MIHMS eligibility data: claims with Recipient Aid Category (RAC) code equal to "5C" or "5C-PCCM"
    b. For MIHMS claims data (including Facility, Professional, and Prescription Drug claims): claims with RAC code equal to "5C" or "5C-PCCM" and for members who were eligible under RAC code "5C" or "5C-PCCM" when the claims were incurred

- **Monthly Enrollment:** Enrollment was based on final enrollment data provided by Kaleb Osgood from Molina in August 2012 and June 2013. The Childless Adults population was identified using RAC code equal to "5C" or "5C-PCCM". Based on this information, the Childless Adults enrollment for the period January 1, 2012, to December 31, 2012, was 154,926 member months.

Data for Hearing Benefit Analysis

Using the hearing procedure codes defined by Section 35 and Section 109 of the MaineCare Benefits Manual, we gathered all hearing-related MaineCare claims for the Childless Adults population in calendar year 2012. Given that hearing services are not a covered benefit for the demonstration population, we identified only a small number of hearing-related claims. The hearing claims identified represented $0.07 allowed PMPM and only 0.014% of the total allowed amount. When comparing these results to our Deloitte internal database, we deemed that the Childless Adults data was not a credible source for hearing claims and should not be used to determine the actuarial value of hearing services.

To develop the actuarial values for hearing services for the benchmark plans, we utilized the broader MaineCare Adults population data receiving full Medicaid benefits. This data was adjusted to be consistent with the demographics of the demonstration population as discussed below.

- **Data Used:** We used calendar year 2012 data with run-out to March 2013 from the MIHMS database, which was provided by Kaleb Osgood from Molina in August 2012 and in June 2013. The incurred hearing claims (defined by a list of procedure codes as outlined in Appendix F) for the MaineCare Adults population with ages limited to 21 to 64, served as the basis for our hearing analysis. Given size and completeness of this dataset (more than 641,000 member months), we believe it is a reasonable source to rely upon for the hearing analysis.

- **Population Assumption:** We limited the data population to only include MaineCare Adults. The selected MaineCare Adults population and hearing claims are identified in the provided data as follows:

a. For MIHMS eligibility data: claims with RAC codes indicating full traditional Medicaid benefits and with ages between 21 and 64
b. For MIHMS claims data (including Facility, Professional, and Prescription Drug claims): claims with RAC codes indicating full traditional Medicaid benefits, procedure codes related to hearing, and for members who were eligible under RAC codes indicating full traditional Medicaid benefits when the claims were incurred

Plan Design Actuarial Value Analysis

We received a high-level plan design summary for the HMO plan, Anthem Blue Choice, but this summary did not contain a sufficient level of detail to include in our aggregate actuarial analysis as the benefits indicated a range of cost-sharing options by category of service. However, based on the information provided, we were able to determine the general coverage for adult hearing services as outlined in Appendix E and included this information in our actuarial value calculations for hearing services. For further information related to the data limitations and assumptions used in our analysis, please refer to Appendix D.

Results

Benchmark/Benchmark-Equivalent Plan Design Actuarial Value Analysis

Using the provided Maine Medicaid data, we analyzed the actuarial benefit factors between the MaineCare benefit package for Childless Adults and the benchmark plan designs. To develop the benefit factors, we applied the cost sharing and benefit limitations for each of the benchmark plans to the Maine Medicaid data independently at the claim-line level to calculate the benefit factor at the service category level and in aggregate for each of the plan designs. We then used the CCIIO actuarial value calculator to compare our aggregate results for reasonableness. CCIIO oversees the implementation of the provisions related to private health insurance. The CCIIO actuarial value calculator was released by CMS and is required to be used by non-grandfathered health insurance plans offered in the individual and small group markets to determine the actuarial value of coverage and metallic tier of their products on the Health Insurance Marketplaces (formerly referred to as Exchanges). Note that the CCIIO actuarial value calculator produced results directionally consistent, but not identical to, the benefit factors as calculated under our claim-level analysis. This is reasonable as the CCIIO actuarial value calculator does not use the data specific to the State (or Childless Adults) and due to the limitations of the calculator and its simplicity, the benefits were not allowed to be applied exactly the same in the calculator as was performed in our detailed claim-level data assessment.

Table 3 which follows provides a high-level summary of the aggregate plan design benefit factors for the MaineCare benefit package for Childless Adults and the two benchmark plan designs, as well as a comparison to the plan design factors calculated using the CCIIO actuarial value calculator. An actuarial benefit factor measures the comprehensiveness of benefits offered under a plan design, or in other words, the share of health care cost that is covered by the plan. A benefit factor of 1.00 would indicate the plan design covers 100% of the health care cost, while a benefit factor of 0.50 would reflect that the plan design covers 50% of the health care cost. Please refer to Appendix A for a detailed listing of benefit factors by service category.

Table 3: Aggregate Plan Design Actuarial Benefit Factors

Plan Design Actuarial Benefit Factors (Plan Responsibility)			
Plan Design	**MaineCare for Childless Adults**	**FEHBP - BCBS Standard PPO**	**Maine State Employee Plan**
Aggregate Actuarial Benefit Factor	**0.984**	**0.816**	**0.926**
CCIIO Calculator Benefit Factor	**0.955**	**0.816**	**0.919**

As shown in Table 3, using the claims experience for the Childless Adults population, we estimate that the current MaineCare benefit package for Childless Adults pays approximately 98.4% of eligible Medicaid claims, which is greater than each of the benchmark plan designs. We note that our results are directionally consistent to the results from the CCIIO actuarial value calculator. We conducted one additional reasonability check not shown in Table 3 for which we ran a similar calculation on the broader MaineCare Adults population claims data rather than on the Childless Adults claims data. The results using the broader MaineCare Adults claims were similar to the results using the Childless Adults data, lending further confidence in the reasonableness of the actuarial values shown in Table 3 and in Appendix A.

Table 4 which follows provides a summary of the plan design benefit factors for the four required service categories to meet benchmark equivalency. This analysis was performed across all four categories for the MaineCare benefit package for Childless Adults and the FEHBP and State Employee Plan. For the HMO plan, an analysis of hearing services coverage was performed as further plan design information was not available for this benchmark plan as discussed previously.

Table 4: Plan Design Actuarial Benefit Factors for Required Service Categories

Plan Design Actuarial Benefit Factors (Plan Responsibility)				
Required Service Categories	**MaineCare for Childless Adults**	**FEHBP - BCBS Standard PPO**	**Maine State Employee Plan**	**HMO Plan - Anthem Blue Choice**
Prescription Drug	0.958	0.747	0.771	N/A
Mental Health	0.996	0.865	1.000	N/A
Vision Services	0.986	0.850	0.785	N/A
Hearing Servcies	0.000	0.444	0.304	0.496

As shown in Table 4, we estimate that the actuarial values of the MaineCare benefit package for Childless Adults is at least 75% of the actuarial values of the FEHBP and State Employee Plan for prescription drug, mental health, and vision services. However, since hearing services are not a covered benefit under the demonstration population, we believe the actuarial value of hearing services under the MaineCare benefit package for Childless Adults is zero and is not at least 75% of the actuarial value of hearing services for the FEHBP, State Employee Plan, or HMO plan.

In addition, as noted previously, in our analysis of the Childless Adults claims data we found a limited number of hearing-related claims. However, our testing indicated that the amount covered was less than 75% of the amount covered under the benchmark plans.

Conclusion

The results indicate that in aggregate, the actuarial value for the Childless Adults benefit package in effect as of December 1, 2009, is greater than the actuarial values of the FEHBP and State Employee Plan in effect as of December 1, 2009. However, due to the fact that the actuarial value for hearing services for the Childless Adults benefit package in effect as of December 1, 2009, is not at least 75% of the actuarial values for hearing services of the FEHBP, State Employee Plan, and HMO plan in effect as of December 1, 2009, we do not believe the MaineCare benefit package for Childless Adults can be considered benchmark-equivalent by CMS definition.

This memorandum and accompanying attachments (*MaineCare Benefit Assessment - Plan Design Documents.zip* and *MaineCare Benefit Assessment - Appendices.xlsx*) have been solely prepared for use by DHHS for assistance in responding to questions outlined in Attachment A of the CMS Letter. This memorandum and accompanying attachments should not be relied upon for any other purpose or by any other entity other than DHHS.

I, Tim FitzPatrick, am a Senior Manager associated with the firm Deloitte Consulting LLP. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. Actuarial methods, considerations, and analyses used in the preparation of this opinion conformed to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which form the basis for this opinion.

Again, we appreciate the opportunity to perform this analysis for you. If you have questions or concerns regarding this analysis, please contact Tim FitzPatrick at tfitzpatrick@deloitte.com or (612) 397-4650 or Tim Egan at tiegan@deloitte.com or (612) 397-4463.

Sincerely,

Tim FitzPatrick, ASA, MAAA
Senior Manager
Deloitte Consulting LLP
tfitzpatrick@deloitte.com
(612) 397-4650

Timothy J. Egan
Manager
Deloitte Consulting LLP
tiegan@deloitte.com
(612) 397-4463

Appendix A
Summary of Plan Design Benefit Factors

	Plan Design Actuarial Benefit Factors (Plan Responsibility)			
Service Category	**MaineCare for Childless Adults**	**FEHBP - BCBS Standard PPO**	**Maine State Employee Plan**	**HMO Plan - Anthem Blue Choice**
Prescription Drug	0.958	0.747	0.771	N/A
Mental Health	0.996	0.865	1.000	N/A
Vision Services	0.986	0.850	0.785	N/A
Hearing Servcies	0.000	0.444	0.304	0.496
All Services (Prior to Ded, OOP Max and Limitation)	**0.985**	**0.858**	**0.937**	N/A
After Medical Deductible/ OOP Max/ Limitation/ Adjustments	**0.984**	**0.816**	**0.926**	**N/A**
CCIIO Calculator Benefit Factor	**0.955**	**0.816**	**0.919**	**N/A**

Appendix B
Summary of Plan Design Benefits

Service Category	MaineCare for Childless Adults (2009)	State Employee Plan (Anthem POS)	FEHBP
Deductibles and Annual Maximums	None	None	Standard Option
Medical Annual Deductible	None	None	$300 per person, $600 per family (p.21)
Rx Annual Deductible	None	None	The CY deductible does not apply to Rx filled through retail or mail service program (p.80)
Out-of-Pocket Maximum	Not Applicable	Not Applicable	$5,000 if using preferred providers; $7,000 if non-preferred providers (p. 24)
Inpatient Hospital	Copay Schedule 1: MaineCare Pmt for Svc p/day — Max Mbr Copay $10.00 or less — 0.5 $10.01 - 25.00 — 1 $25.01 - 50.00 — 2 $50.01 or more — 3	100% coverage	Preferred: $200 per admission copay unlimited days Member: $300 per admission copay unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after Plan payment (p.62)
Covered Services Include:	Semi-private rooms Intensive care units Coronary care units Drugs and Biologicals Supplies, appliances, equipment Ancillary, diagnostic, and therapeutic services Swing-bed and Days Awaiting Placement Services Asthma Self Management Services Outpatient Diabetes Education and Follow-Up Services Hospital Based Physician Services Private accommodations (if required for medical reasons)	General medical and surgical care. No specific services listed	Semi-private room General nursing care Meals and special diets Operating, recovery, maternity, and other treatment rooms Diagnostic laboratory tests, pathology services, MRIs, machine diagnostic tests, X-rays Other medical supplies and equipment Anesthetics and anesthesia Acute inpatient rehabilitation
Limitations:	Max copay $3 per day for either category of hospital services provided Max $30 per calendar month for each category: inpatient or outpatient service		If admitted to Non-member facility due to a medical emergency or accidental injury, copay is $300 per admission for unlimited days and then Plan provides benefits at 100% of the Plan allowance.
Nursing Facility	100% coverage	100% coverage	100% coverage (p.67)
Covered Services Include:	Advanced Practice Registered Nursing Services		Skilled Nursing Care Extended Care
Limitations:		100 days per calendar year	

Note: This is a summary of benefits only. Please refer to the detailed plan design documents for further information

Appendix B *(continued)*
Summary of Plan Design Benefits

Service Category	MaineCare for Childless Adults (2009)	State Employee Plan (Anthem POS)	FEHBP
Hospital Outpatient	100% coverage (Except Federally Qualified Health Center Services - same copay schedule and limitations as Inpatient hospital)	100% coverage (except $50 copay for ambulatory surgical centers)	Preferred Facilities: 15% of plan allowance (ded applies) Member Facilities: 30% of plan allowance (ded applies) Non-member Facilities: 30% of Plan allowance (ded applies) (p.65)
Covered Services Include:	Ambulatory Care Clinic Services Ambulatory Surgical Center Services Federally Qualified Health Center Services Adult Family Care Services Free-standing Dialysis Services Targeted Case Management Services	Ambulatory surgery Colonoscopies	Treatment rooms Chemotherapy and radiation therapy Intravenous (IV)/infusion therapy Cardiac Rehabilitation Pulmonary Rehabilitation Anesthetics and anesthesia
Limitations:	For Adult Care Services, Skills training shall not exceed 14.25 hours annually and Care Coordination shall not exceed 18 hours annually Federally Qualified Health Center has same copay limitations as Hospital Inpatient		
Professional Services	100% coverage	Varies	Varies
Primary Care Physician, Adult	100% coverage	100% coverage	Preferred: $20 copay Participating: Member pays all NonParticipating: Member pays all
Primary Care Physician, Child	100% coverage	100% coverage	Preferred: $0 Participating: $0 NonParticipating: $0
Cancer diagnostic tests and screening / Routine immunizations	100% coverage	$0 for preferred provider, $10 for participating provider	Preferred - $20 (no ded) Participating - 30% NonParticipating - 30% of plan allowance plus any difference between allowed and billed
Maternity	100% coverage	$0 for PCP, $15 for specialist	Preferred - $0 Participating - 30% NonParticipating - 30% of plan allowance plus any difference between allowed and billed
Specialist Physician	100% coverage	$15 copay	Preferred: 15% of plan allowance Participating: 30% NonParticipating: 30% of plan allowance plus any difference between allowed and billed
Covered Services Include:	Anesthesiology Vision Laboratory Obstetrical (maternity) Psychiatric Medical Imaging Drugs Administered Other Than Oral Orthopedic Shoes CAT scans Medical Supplies & DME	Preventive care Immunizations Well woman care Office visits Maternity Colonoscopies Bariatric surgery Walk-in Center Mammogram	Preventive Care, Adult Preventive Care, Child Cancer diagnostic tests and screening Routine examinations Maternity Surgical procedures Reconstructive surgery Oral and maxillofacial surgery Organ and tissue transplants

Note: This is a summary of benefits only. Please refer to the detailed plan design documents for further information

Appendix B *(continued)*
Summary of Plan Design Benefits

Service Category	MaineCare for Childless Adults (2009)	State Employee Plan (Anthem POS)	FEHBP
	Preventive Services Physician services for children <21 Tobacco Cessation Prescriptions Consultation and referrals Immunizations Surgical Services Oral and TMJ Podiatry Private Non-Medical Institution Services Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)		
Limitations:	Limitations exist related to LOS		
Behavioral health	100% coverage (Except Section 65 - copay schedule 2)	100% coverage	Preferred/NonPreferred (p.75) Professional Services: $20 copay / 40% Inpatient Professional: 15% / 40% Outpatient Professional: 15% / 30% Inpatient Hospital: $200 copay/ $400 copay
Covered Services Include:	Behavioral Health Developmental and Behavioral Clinic Services Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders Psychiatric Hospital Intermediate Care Facility for Mental Retardation (ICF-MR)	Mental lillnesses Substance abuse	Group therapy Individual therapy Social workers Psychiatric nurses Psychological testing Inpatient professional visits Outpatient professional visits
Limitations:	30 mental health encounters per client per year unless prior auth is obtained Home Accessibility Adaptations are subject to a ten thousand dollar ($10,000.00) limit in a five (5) year period with an additional annual allowance of up to three hundred dollars ($300.00) for repairs and replacement per year Respite Services are limited to three (3) days per month Members who meet the medical eligibility criteria for admission to an ICF/MR as set forth in MaineCare Benefits Manual, Chapter II, Section 50 will be limited to $155,714 Members who meet medical eligibility criteria for admission to a Psychiatric Hospital as set forth in MaineCare Benefits Manual, Chapter II, Section 46 will be limited to $284,520 Section 65 (Behavioral Health) has copay schedule 2	Up to combined Outpatient and Office visits of 40 per calendar year	*There is also an "other" services category with a 30% coinsurance. Will take conservative assumption and bucket into one of listed behavioral coinsurances above

Note: This is a summary of benefits only. Please refer to the detailed plan design documents for further information

Appendix B *(continued)*
Summary of Plan Design Benefits

Service Category	MaineCare for Childless Adults (2009)	State Employee Plan (Anthem POS)	FEHBP
Emergency Services	Copay Schedule 1: MaineCare Pmt for Svc p/day — Max Mbr Copay $10.00 or less — 0.5 $10.01 - 25.00 — 1 $25.01 - 50.00 — 2 $50.01 or more — 3	100% coverage (Except $20 copay for emergency room visit)	Accidental Injury: $0 Medical Emergency: $20 copayment, then 15% / 30% coinsurance (preferred / participating), Ambulance: $0 (p.71)
Covered Services Include:	Transportation Emergency medical services on scene "down time"	Ambulence Ambulence care	Emergency care
Limitations:	Max copay $3 per day for either category of hospital services provided Max $30 per calendar month for each category: inpatient or outpatient service		Ambulance for non emergency: $100 copayment (see transportation service category)
Laboratory and Diagnostics	Copay Schedule 3: MaineCare Pmt for Svc p/day — Max Mbr Copay $10.00 or less — 0.5 $10.01 or more — 1	100% coverage ($50 copay for high tech diagnositics e.g., MRI, CT scans, PET scans)	Preferred: 15% coinsurance Participating: 30% coinsurance NonParticipating: 30% plus difference between allowed and billed (p.34)
Covered Services Include:	Laboratory Imaging	Imaging Laboratory X-ray CT scans MRI	Diagnostic tests X-Rays Blood tests CT scans/MRIs Lab tests Ultrasounds
Limitations:	Copayment shall not exceed $1.00 per day for services The recipient shall be responsible for copayments up to $10.00 per month whether the copayment has been paid or not.		
Family Planning	100% coverage	Not listed in benefits. Assumed maternity cost sharing with a $15 specialist copay	Preferred: 15% coinsurance Participating: 30% NonParticipating: 30% plus difference between allowed and billed (p.39)
Covered Services Include:	Early prenatal Prescription contraceptive drugs and devices Consultation Off Site delivery Pregnancy Testing Immunizations		Depo-Provera Contraceptives Voluntary sterilization
Limitations:			

Note: This is a summary of benefits only. Please refer to the detailed plan design documents for further information

Appendix B *(continued)*
Summary of Plan Design Benefits

Service Category	MaineCare for Childless Adults (2009)	State Employee Plan (Anthem POS)	FEHBP
Vision	Copay Schedule 1: MaineCare Pmt for Svc p/day — Max Mbr Copay $10.00 or less — 0.5 $10.01 - 25.00 — 1 $25.01 - 50.00 — 2 $50.01 or more — 3	$15 copay	Preferred: $20 copay / 15% coinsurance Participating: 30% coinsurance NonParticipating: 30% plus difference between allowed and billed (p.43)
Eye Exam - Specific Condition	Copay schedule 1	$15 copay	$20 copayment
Eyeglasses or Contact Lenses		Not covered unless to treat disease	15% / 30% coinsurance
Annual Eye Exam		$15 copay	$20 copayment
Covered Services Include:	Ophthalmologist Optometrist Optician	Eye exam	Pair of eye glasses Corrective lenses Treatment
Limitations:	Co-payment for members may not exceed $2.00 per day or $20.00 per month for services provided by an optician or $3.00 per day or $30.00 per month for services provided by an optometrist.	One routine eye exam per year	One corrective eyewear per year
Hearing	See Details in Appendix E	See Details in Appendix E	See Details in Appendix E
Service Category	**MaineCare for Childless Adults (2009)**	**State Employee Plan (Anthem POS)**	**FEHBP**
Non-Emergency Transportation	100% coverage	Not stated in benefits. Assume 100% coverage because ambulence is covered 100%	$100 copayment (p.69)
Covered Services Include:	Mileage reimbursement for family, volunteer, attendant Public Transportation Fare Wheelchair van service Highway tolls and parking fees Related travel expenses		Ambulance ground transportation
Limitations:			
Rehabilitation/Habilitation	100% coverage (copay schedule for chiropractic, occupational therapy, physical therapy)	$15 copay	Preferred: $20 copay Participating: 30% coinsurance NonParticipating: 30% plus difference between allowed and billed (p.75)
Chiropractic **Occupational Therapy** **Physical Therapy**	Copay Schedule 2: MaineCare Pmt for Svc p/day — Max Mbr Copay	$15 copay	

Note: This is a summary of benefits only. Please refer to the detailed plan design documents for further information

Appendix B *(continued)*
Summary of Plan Design Benefits

Service Category	MaineCare for Childless Adults (2009)	State Employee Plan (Anthem POS)	FEHBP
Covered Services Include:	Physical Occupational Chiropractic Day Habilitation Services for Persons with Mental Retardation Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations	Chiropractice Physical therapy Occupational therapy Speech therapy	Physical therapy Occupational therapy Speech therapy Cognitive rehabilitation
Limitations:	The member shall be responsible for copayments up to $20.00 per month whether the copayment has been paid or not		75 visits per calendar year
Home Health	100% coverage (copay schedule for DMS and home health services)	100% coverage (exception for Home Health services)	Preferred: 15% coinsurance Participating: 30% coinsurance NonParticipating: 30% plus difference between allowed and billed (p.47)
Home Health Services **Durable Medical Equipment**	Copay Schedule 1: MaineCare Pmt for Svc p/day — Max Mbr Copay $10.00 or less — 0.5 $10.01 - 25.00 — 1	100% coverage after $200 individual / $400 family deductible 100% coverage	
Covered Services Include:	Home Health Services Home and Community Based Benefits for the Elderly and for Adults with Disabilities Home and Community Based Services for Adults with Other Related Conditions Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder Home and Community Benefits for the Physically Disabled Adults with Intellectual Disabilities or Autistic Disorder Home Health Services Hospice Durable medical equipment Expendable medical supplies Private Duty Nursing and Personal Care Services		*No specific services listed
Limitations:	Max copayment $3.00 per day and $30 per month For Home and Community Benefits for the Physically Disabled, Personal attendant services per week max of 86.25 hours	Home health services subject to $200 individual / $400 family deductible	Home nursing care for two (2) hours per day, up to 25 visits per calendar year

Note: This is a summary of benefits only. Please refer to the detailed plan design documents for further information

Appendix B *(continued)*
Summary of Plan Design Benefits

Service Category	MaineCare for Childless Adults (2009)	State Employee Plan (Anthem POS)	FEHBP
	For Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder, members can receive services under only one Home and Community Waiver Benefit at any one time Max annual allowance for Community Support is 1,125 hours per year Home Accessibility Adaptations limited to $10,000 limit in a 5 year period with additional annual allowance up to $300 for repairs and replacement per year		
Prescription Drugs	Varies	Varies	Varies (p.82)
Retail: Generic	$3 copay	$10 copay (60 day supply)	Preferred Retail Pharmacy: 20% coinsurance Non-Preferred 45%
Retail: Formulary/Preferred Brand	$3 copay	$30 copay (60 day supply)	Preferred Retail Pharmacy: 30% coinsurance Non-Preferred: 45%
Retail: Non-Formulary/Non-Preferred Brand	$3 copay	$30 copay (60 day supply)	Preferred Retail Pharmacy: 30% coinsurance Non-Preferred: 45%
Retail: Specialty	$3 copay	$45 copay (60 day supply)	
Mail-Order: Generic	100% coverage	$10 copay (90 day supply)	$10 copay (First 4 fills per year free)
Mail-Order: Formulary/Preferred Brand	100% coverage	$30 copay (90 day supply)	$65 copayment (first 30 fills per year, then $50 copay after)
Mail-Order: Non-Formulary/Non-Preferred	100% coverage	$30 copay (90 day supply)	$65 copayment (first 30 fills per year, then $50 copay after)
Mail-Order: Specialty	100% coverage	$45 copay (90 day supply)	
Limitations:	Copay not to exceed $30 per memb per month	Infertility and impotence drugs, $50 copay	Copayments vary by non-maintenance and maintain ace drugs (longer-term, more costly)
Other Services	Varies	Varies	Varies
Allergist	100% coverage (when medically necessary)	Not listed	Preferred: 15% coinsurance Participating: 30% coinsurance NonParticipating: 30% plus difference between allowed and billed (p.40)
Allergy Injections	100% coverage (limited to 160 doses per year)	Not listed	
Allergy Testing	Not listed*	Not listed	
Chiropractic Care	Copay schedule 2 180 day limit from start of therapy 12 manipulations per year	$15 copay	Preferred: $20 copay Participating: 30% coinsurance NonParticipating: 30% plus difference between allowed and billed (p.40) 12 manipulations per year (p.47)
Orthopedics	Not listed*	Not listed	Preferred: 15% coinsurance Participating: 30% coinsurance NonParticipating: 30% plus difference between allowed and billed (p.44)
Other Services	100% coverage, except Section 12: Copay schedule 1 Section 95: Copay schedule 2	Not listed	
Limitations:	*Not listed in benefit summary - Assume additional services are covered at 100% coverage if services		

Note: This is a summary of benefits only. Please refer to the detailed plan design documents for further information

Appendix C
Benchmark Analysis Service Category Mappings

Claim Type	Deloitte Assigned Service Category in the Claims Data	Service Category in Plan Design Summary	MaineCare Benefits Sections	Chapter 10 - Section 2 (Childless Adults)
Inpatient	Acute	Inpatient	Ch. II - Section 45: Hospital Services	1 Hospital Services - Chapters II and III, Section 45
Inpatient	Acute - Medical	Inpatient	Ch. II - Section 45: Hospital Services	1 Hospital Services - Chapters II and III, Section 45
Inpatient	Acute - Surgery	Inpatient	Ch. II - Section 45: Hospital Services	1 Hospital Services - Chapters II and III, Section 45
Inpatient	Home Health	Home Health	Ch. II - Section 40: Home Health Services	*Not covered*
Inpatient	Home Health	Home Health	Ch. II - Section 91: Health Home Services	*Not covered*
Inpatient	Hospice	Home Health	Ch. II - Section 43: Hospice Services	*Not covered*
Inpatient	Maternity	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Inpatient	Mental Health	Behavioral Health	Ch. II - Section 23: Developmental and Behavioral Clinic Services	*Not covered*
Inpatient	Mental Health	Home Health	Ch. II - Section 29: Support Services for Adults with Intellectual Disabilities or Autistic Disorder	*Not covered*
Inpatient	Mental Health	Behavioral Health	Ch. II - Section 32: Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders	*Not covered*
Inpatient	Mental Health	Behavioral Health	Ch. II - Section 46: Psychiatric Hospital Services	2 Psychiatric Facility Services (inpatient) - Chapter II, Section 46.[1]
Inpatient	Mental Health	Behavioral Health	Ch. II - Section 65: Behavioral Health Services	Section 65 (Behavioral Health Services)[1]
Inpatient	Newborn - NICU	Inpatient	Ch. II - Section 45: Hospital Services	1 Hospital Services - Chapters II and III, Section 45
Inpatient	Nursing Facility	Nursing Facility	Ch. II - Section 14: Advanced Practice Registered Nursing Services	10 Advance Practice Registered Nursing Services - Chapter II, Section 14
Inpatient	Nursing Facility	Nursing Facility	Ch. II - Section 67: Nursing Facility Services	*Not covered*
Inpatient	Other	Other Services	Ch. II - Section 9: Indian Health Services	*Not covered*
Inpatient	Other	Other Services	Ch. II - Section 12: Consumer Directed Attendant Services	*Not covered*
Inpatient	Other	Other Services	Ch. II - Section 26: Day Health Services	*Not covered*
Inpatient	PNMI/CRBH	Physician Services	Ch. II - Section 97: Private Non-Medical Institution Services	8 Private Non-Medical Institution Services, substance abuse facilities only - Chapter II, Section 97 and Chapter III, Appendix B
Inpatient	Substance Abuse	Behavioral Health	Ch. II - Section 65: Behavioral Health Services	Section 65 (Behavioral Health Services)[1]
Inpatient	Well Newborn	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Abortion	Family Planning	Ch. II - Section 30: Family Planning Agency Services	9 Family Planning Agency Services - Chapters II and III, Section 30
Outpatient	Abortion	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Allergy Immunotherapy	Other Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Allergy Testing	Other Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Ambulance	Emergency	Ch. II - Section 5: Ambulance Services	19 Ambulance Services - Chapters II and III, Section 5
Outpatient	Anesthesia	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Assistant Surgeon	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Cardiovascular	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Chemotherapy	Outpatient	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Chemotherapy Administration	Outpatient	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Chiropractic	Rehabilitation/Habilitation	Ch. II - Section 15: Chiropractic Services	15 Chiropractic Services – Chapters II and III, Section 15.
Outpatient	Consults	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Critical Care Visits	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Dental	Other Services	Ch. II - Section 25: Dental Services	14 Dental Services – Chapters II and III, Section 25.
Outpatient	Diagnostic Testing	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Dialysis	Outpatient	Ch. II - Section 7: Free-standing Dialysis Services	*Not covered*
Outpatient	DME/Prosthetics	Home Health	Ch. II - Section 60: Medical Supplies and Durable Medical Equipment	17 Medical Supplies and Durable Medical Equipment, oxygen and insulin pumps and pump supplies only – Chapters II and III, Section 60
Outpatient	Emergency Room	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Extended Care Visits	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90

Appendix C *(continued)*
Benchmark Analysis Service Category Mappings

Claim Type	Deloitte Assigned Service Category in the Claims Data	Service Category in Plan Design Summary	MaineCare Benefits Sections	Chapter 10 - Section 2 (Childless Adults)
Outpatient	Hearing Aids/Services	Hearing	Ch. II - Section 35: Hearing Aids and Services	*Not covered*
Outpatient	Home Health	Home Health	Ch. II - Section 19: Home and Community Based Benefits for the Elderly and for Adults with Disabilities	*Not covered*
Outpatient	Home Health	Home Health	Ch. II - Section 20: Home and Community Based Services for Adults with Other Related Conditions	*Not covered*
Outpatient	Home Health	Home Health	Ch. II - Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder	*Not covered*
Outpatient	Home Health	Home Health	Ch. II - Section 22: Home and Community Benefits for the Physically Disabled	*Not covered*
Outpatient	Immunizations/Injections	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Inpatient Visits	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Laboratory	Laboratory and Diagnostics	Ch. II - Section 55: Laboratory Services	21 Laboratory Services, Chapter II, Section 55
Outpatient	Maternity - Cesarean Delivery	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Maternity - Non-Delivery	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Maternity - Normal Delivery	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Medical/Surgical Supplies	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Mental Health	Behavioral Health	Ch. II - Section 23: Developmental and Behavioral Clinic Services	*Not covered*
Outpatient	Mental Health	Behavioral Health	Ch. II - Section 29: Support Services for Adults with Intellectual Disabilities or Autistic Disorder	*Not covered*
Outpatient	Mental Health	Behavioral Health	Ch. II - Section 32: Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders	*Not covered*
Outpatient	Mental Health	Behavioral Health	Ch. II - Section 46: Psychiatric Hospital Services	2 Psychiatric Facility Services (outpatient) - Chapter II, Section 46.[1]
Outpatient	Mental Health	Behavioral Health	Ch. II - Section 65: Behavioral Health Services	Section 65 (Behavioral Health Services)[1]
Outpatient	Mental Health	Rehabilitation/Habilitation	Ch. II - Section 24: Day Habilitation Services for Persons with Mental Retardation (absorbed by Ch. II Section 28)	*Not covered*
Outpatient	Mental Health	Rehabilitation/Habilitation	Ch. II - Section 28: Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations	*Not covered*
Outpatient	Mental Health	Rehabilitation/Habilitation	Ch. II - Section 102: Rehabilitative Services	*Not covered*
Outpatient	MRI/CT	Laboratory and Diagnostics	Ch. II - Section 101: Medical Imaging Services	20 Medical Imaging Services – Chapter II, Section 101
Outpatient	Observation Days	Outpatient	Ch. II - Section 45: Hospital Services	1 Hospital Services - Chapters II and III, Section 45
Outpatient	Occupational Therapy	Rehabilitation/Habilitation	Ch. II - Section 68: Occupational Therapy Services	*Not covered*
Outpatient	Occupational Therapy	Behavioral Health	Ch. II - Section 50: ICF-MR Services	*Not covered*
Outpatient	Office Visits	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Other	Outpatient	Ch. II - Section 3: Ambulatory Care Clinic Services	11 Ambulatory Care Clinic Services - Chapters II and III, Section 3
Outpatient	Other	Outpatient	Ch. II - Section 4: Ambulatory Surgical Center Services (repealed)	5 Ambulatory Surgical Center Services - Chapter II, Section 4
Outpatient	Other	Outpatient	Ch. II - Section 31: Federally Qualified Health Center Services	7 Federally Qualified Health Clinic Services - Chapters II and III, Section 31
Outpatient	Other	Outpatient	Ch. II - Section 103: Rural Health Clinic Services	6 Rural Health Center Services - Chapters II and III, Section 103
Outpatient	Other	Outpatient	Ch. II - Section 2: Adult Family Care Services	*Not covered*
Outpatient	Other	Outpatient	Ch. II - Section 13: Targeted Case Management Services	*Not covered*
Outpatient	Other	Other Services	Ch. II - Section 17: Community Support Services	*Not covered*
Outpatient	Periodic Exams	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Physical Medicine	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90

Appendix C *(continued)*
Benchmark Analysis Service Category Mappings

Claim Type	Deloitte Assigned Service Category in the Claims Data	Service Category in Plan Design Summary	MaineCare Benefits Sections	Chapter 10 - Section 2 (Childless Adults)
Outpatient	Physical Therapy	Rehabilitation/Habilitation	Ch. II - Section 85: Physical Therapy Services	*Not covered*
Outpatient	Physical Therapy	Behavioral Health	Ch. II - Section 50: ICF-MR Services	*Not covered*
Outpatient	Radiology	Laboratory and Diagnostics	Ch. II - Section 101: Medical Imaging Services	20 Medical Imaging Services – Chapter II, Section 101
Outpatient	Speech Therapy	Hearing	Ch. II - Section 109: Speech and Hearing Services	*Not covered*
Outpatient	Speech Therapy	Behavioral Health	Ch. II - Section 50: ICF-MR Services	*Not covered*
Outpatient	Substance Abuse	Behavioral Health	Ch. II - Section 65: Behavioral Health Services	Section 65 (Behavioral Health Services)[1]
Outpatient	Surgery	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Outpatient	Vision Exams	Vision	Ch. II - Section 75: Vision Services	12 Vision Services (ophthalmologist and optometrist only) - Chapter II, Section 75
Outpatient	Vision glasses/ Services	Vision	Ch. II - Section 75: Vision Services	12 Vision Services (ophthalmologist and optometrist only) - Chapter II, Section 75
Outpatient	Well Baby	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Abortion	Family Planning	Ch. II - Section 30: Family Planning Agency Services	9 Family Planning Agency Services - Chapters II and III, Section 30
Professional	Abortion	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Allergy Immunotherapy	Other Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Allergy Testing	Other Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Ambulance	Emergency	Ch. II - Section 5: Ambulance Services	19 Ambulance Services - Chapters II and III, Section 5
Professional	Anesthesia	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Assistant Surgeon	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Cardiovascular	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Chemotherapy Administration	Outpatient	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Chiropractic-PCP	Rehabilitation/Habilitation	Ch. II - Section 15: Chiropractic Services	15 Chiropractic Services – Chapters II and III, Section 15.
Professional	Chiropractic-SPC	Rehabilitation/Habilitation	Ch. II - Section 15: Chiropractic Services	15 Chiropractic Services – Chapters II and III, Section 15.
Professional	Consults-PCP	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Consults-SPC	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Critical Care Visits-PCP	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Critical Care Visits-SPC	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Dental	Other Services	Ch. II - Section 25: Dental Services	14 Dental Services – Chapters II and III, Section 25.
Professional	Diagnostic Testing	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Dialysis	Outpatient	Ch. II - Section 7: Free-standing Dialysis Services	*Not covered*
Professional	DME/Prosthetics	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Emergency Room	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Extended Care Visits-PCP	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Extended Care Visits-SPC	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Family Planning	Family Planning	Ch. II - Section 30: Family Planning Agency Services	9 Family Planning Agency Services - Chapters II and III, Section 30
Professional	Hearing Aids/Services	Hearing	Ch. II - Section 35: Hearing Aids and Services	*Not covered*
Professional	Home Health-PCP	Home Health	Ch. II - Section 40: Home Health Services	*Not covered*
Professional	Home Health-PCP	Home Health	Ch. II - Section 91: Health Home Services	*Not covered*
Professional	Home Health-SPC	Home Health	Ch. II - Section 40: Home Health Services	*Not covered*
Professional	Home Health-SPC	Home Health	Ch. II - Section 91: Health Home Services	*Not covered*
Professional	Immunizations/Injections	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Injections - J Codes	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Inpatient Visits-PCP	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Inpatient Visits-SPC	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Laboratory	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90

Appendix C *(continued)*
Benchmark Analysis Service Category Mappings

Claim Type	Deloitte Assigned Service Category in the Claims Data	Service Category in Plan Design Summary	MaineCare Benefits Sections	Chapter 10 - Section 2 (Childless Adults)
Professional	Long Term Care	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Maternity - Cesarean Delivery	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Maternity - Non-Delivery	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Maternity - Normal Delivery	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Medical/Surgical Supplies	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Mental Health	Behavioral Health	Ch. II - Section 23: Developmental and Behavioral Clinic Services	*Not covered*
Professional	Mental Health	Behavioral Health	Ch. II - Section 29: Support Services for Adults with Intellectual Disabilities or Autistic Disorder	*Not covered*
Professional	Mental Health	Behavioral Health	Ch. II - Section 32: Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders	*Not covered*
Professional	Mental Health	Behavioral Health	Ch. II - Section 65: Behavioral Health Services	Section 65 (Behavioral Health Services)[1]
Professional	Mental Health	Rehabilitation/Habilitation	Ch. II - Section 24: Day Habilitation Services for Persons with Mental Retardation (absorbed by Ch. II Section 28)	*Not covered*
Professional	Mental Health	Rehabilitation/Habilitation	Ch. II - Section 28: Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations	*Not covered*
Professional	Mental Health	Rehabilitation/Habilitation	Ch. II - Section 102: Rehabilitative Services	*Not covered*
Professional	Office Visits-PCP	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Office Visits-SPC	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Optical	Vision	Ch. II - Section 75: Vision Services	12 Vision Services (ophthalmologist and optometrist only) - Chapter II, Section 75
Professional	Other	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Other	Other Services	Ch. II - Section 95: Podiatric Services_	18 Podiatric Services - Chapter II, Section 95
Professional	Other	Home Health	Ch. II - Section 96: Private Duty Nursing and Personal Care Services	*Not covered*
Professional	Periodic Exams-PCP	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Periodic Exams-PCP	Preventive Care	Ch. II - Section 94: Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	*Not covered*
Professional	Periodic Exams-SPC	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Periodic Exams-SPC	Preventive Care	Ch. II - Section 94: Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	*Not covered*
Professional	Physical Medicine-PCP	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Physical Medicine-SPC	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Radiology	Laboratory and Diagnostics	Ch. II - Section 101: Medical Imaging Services	20 Medical Imaging Services – Chapter II, Section 101
Professional	Surgery	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Therapeutic Injections	Rehabilitation/Habilitation	Ch. II - Section 85: Physical Therapy Services	*Not covered*
Professional	Transportation	Emergency	Ch. II - Section 5: Ambulance Services	19 Ambulance Services - Chapters II and III, Section 5
Professional	Transportation	Transportation	Ch. II - Section 113: Transportation Services	16 Transportation Services – Chapters II and III, Section 113
Professional	Vision Exams-PCP	Vision	Ch. II - Section 75: Vision Services	12 Vision Services (ophthalmologist and optometrist only) - Chapter II, Section 75
Professional	Vision Exams-SPC	Vision	Ch. II - Section 75: Vision Services	12 Vision Services (ophthalmologist and optometrist only) - Chapter II, Section 75
Professional	Vision glasses/ Services	Vision	Ch. II - Section 75: Vision Services	12 Vision Services (ophthalmologist and optometrist only) - Chapter II, Section 75
Professional	Well Baby-PCP	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
Professional	Well Baby-SPC	Physician Services	Ch. II - Section 90: Physician Services	3 Physician Services - Chapters II and III, Section 90
RX	Brand	Prescription Drug	Ch. II - Section 80: Pharmacy Services	4 Pharmacy Services - Chapter II, Section 80
RX	Generic	Prescription Drug	Ch. II - Section 80: Pharmacy Services	4 Pharmacy Services - Chapter II, Section 80
RX	Other	Prescription Drug	Ch. II - Section 80: Pharmacy Services	4 Pharmacy Services - Chapter II, Section 80

Appendix D

Data Limitations and Assumptions in Plan Design Analysis

1. Claims were categorized into detailed service categories and outlined in Appendix C.

2. Coinsurance cost sharing was applied to the allowed amount fields in the provided data after deductible was met, if applicable.

3. Copayment cost sharing was applied on a per admit, per encounter, or per unit basis depending on the service category. These data elements were calculated based on other data elements from the claims data. The calculation of admits, days, visits and scripts were as follows:
    a. For copayments on admits, admits were equal to the count of unique member ID, billing provider ID, and admission date
    b. For copayments on encounters, encounters were calculated as the count of unique member ID, billing provider ID, and service date
    c. For copayments on units (including the script counts), units were calculated as the sum of the quantity field by claim ID, member ID, and service category. Quantity was counted as 1 unit if the quantity field was greater than 1 and 0 units otherwise

4. Medical plan design benefit factors were first developed at the service category level, excluding the impact of the deductible and/or out-of pocket maximum. The second step in our cost-sharing calculation incorporated the impact of the deductible (if applicable) to the aggregate plan design value. The third and final step incorporated the impact of the out-of-pocket maximum, in addition to the deductible, to the aggregate plan design value.

5. The actuarial value analysis is performed on plan designs effective as of December 1, 2009, and is applied to calendar year 2012 professional, inpatient, outpatient, and drug claims and enrollment for the Childless Adults population. There are 154,926 member months at an allowed cost PMPM of $486.66.

6. The analysis compared the actuarial value for the underlying Childless Adult population for the MaineCare for Childless Adults plan design effective December 1, 2009, against the actuarial value for the Maine State Employee Plan and the FEHBP plan effective December 1, 2009.

7. The MaineCare for Childless Adults plan design effective December 1, 2009, was the benefit package utilized for the demonstration population for our analysis. The plan design information was provided to us by Lucille Weeks on April 26, 2013; however, it did not contain all benefit categories. For any missing benefit categories, we referred to Chapter X – Section 2 of the MaineCare benefits manual for non-categorical adults found online at http://www.maine.gov/sos/cec/rules/10/ch101/c10s002.doc.

8. The Blue Cross Blue Shield Standard Preferred Provider Option is the most populated FEHBP plan design and was used for the FEHBP plan design comparison.

9. The FEHBP plan has a $300 deductible for single coverage and $600 deductible for family coverage. The provided claims data did not have an indicator to differentiate single versus family coverage. Since our analysis was restricted to Childless Adults, we assumed the $300 single deductible for every beneficiary with a claim.

Appendix D *(continued)*

Data Limitations and Assumptions in Plan Design Analysis

10. The FEHBP plan has a $5,000 Out-of-Pocket Maximum ("OOPM") for preferred providers and $7,000 for non-preferred providers. The OOPM for preferred providers was used in our analysis.

11. The FEHBP plan has certain benefit limitations on vision and rehabilitation/habilitation services. Based on the population and claims data in our analysis, few claims/members would be affected by these limitations. Therefore, no adjustments were made to account for these limitations since they were deemed to have little to no impact on the result of our assessment. Any additional limitations would further decrease the benefit factor and thus continue to show that the MaineCare benefit package for Childless Adults has a greater actuarial value for these services than the FEHBP plan.

12. The FEHBP plan has either a $20 copayment or 15% coinsurance on vision services, varying by type of service. Since we were unable to identify each unique vision service in the claims data, a conservative approach was taken to apply the 15% coinsurance on all vision services so that it would yield a larger benefit factor for this service. Based on our analysis, this assumption would have little to no impact on the aggregate results of our assessment.

13. Due to the complexity of the dental plan design for the FEHBP and Maine State Employee plans and limitations in the MaineCare data for Childless Adults, we were unable to model the actual cost share for all dental services. For purposes of our analysis, we assumed 100% coverage for dental services under the FEHBP and State Employee plans. Based on our analysis, this assumption would have little to no impact on the aggregate results of our assessment.

14. The Maine State Employee plan has certain benefit limitations on vision and home health services. Based on the population and claims data in our analysis, very few claims/members would be affected by these limitations. Similar to the FEHBP plan, no adjustments were made to account for these limitations since they were deemed to have little to no impact on the results of our assessment. Any additional limitations would further decrease the benefit factor and thus continue to show that the MaineCare benefit package for Childless Adults has a greater actuarial value for these services than the Maine State Employee plan.

15. The Maine State Employee plan has an annual 40-visit limit on behavioral health services. This limitation has been taken into account in our analysis. The total allowed amount was divided by the average amount per visit for a member so that the plan paid amount would be capped at dollars attributed to 40 visits. Any allowed amounts beyond the 40-visit limit were assumed to be paid by the member.

16. The Maine State Employee plan has a $200 deductible on speech therapy services in addition to a $15 copayment on each visit. The deductible impact was reflected in the "After Medical Deductible/OOP Max/Limitation" line in Appendix A.

17. The Maine State Employee Plan has a $200 individual deductible and $400 family deductible on home health services. The provided claims data did not have an indicator to differentiate single versus family coverage. Since our analysis was restricted to Childless Adults, we assumed a $200 individual deductible for these services. The deductible impact was reflected in the "After Medical Deductible/OOP Max/ Limitation" line in Appendix A.

Appendix D *(continued)*

Data Limitations and Assumptions in Plan Design Analysis

18. The Maine State Employee Plan did not specify a benefit for allergists. For purposes of our analysis, we assumed a $15 copayment consistent with other similar specialist services.

19. We used the MIHMS claims and eligibility data for the broader MaineCare Adults population to calculate the actuarial values of the hearing benefits for the benchmark plans. These members were identified using member age and a Recipient Aid Category ("RAC") code mapping table provided by Cathy McGuire of Muskie on July 1, 2012. The broader MaineCare Adults were identified with ages between 21 and 64, and having RAC codes with indicators of "Traditional Medicaid" in the financial group field, "FULL" in the benefits field, and "adult/child" in the detailed grouping field.

20. Hearing tests for adults (ages 21-64) under the benchmark plans are a covered benefit if related to a medical condition, illness, or injury. Appendix F outlines a list of procedure codes we used to identify hearing claims in the data. We reviewed each code and identified whether it would be related to a disease, illness, or injury. Additionally, we identified codes related to hearing devices. We applied this procedure code mapping along with the benefit provisions outlined in Appendix B and E to calculate the actuarial value of the hearing benefits for the benchmark plans. For the FEHBP plan, 15% coinsurance was applied to claims with procedure codes related to disease, illness, injury, or hearing device, and claims with other procedure codes are not covered. For the Maine State Employee Plan, only claims with procedure codes related to disease, illness, or injury are covered with a $15 copayment; hearing devices are not covered. For the HMO plan, we assumed only claims with procedure codes related to disease, illness, or injury are 100% covered and hearing devices are not covered.

21. Annual chiropractic manipulation limitations were determined to be immaterial and were excluded from the cost-sharing calculations for the benchmark plan designs.

22. Generic and brand drugs were identified using the Generic Category Code field in the drug data. Claims with a Generic Category Code equal to "4" or "5" or "6" were considered generic, while claims with a Generic Category Code equal to "1" or "2" or "3" were considered brand. The remaining claims were considered "others."

23. We considered a prescription as mail-order if the days supply (Days Supply Count field) was greater than or equal to 90 days. All prescriptions with the days supply less than 90 days were considered retail.

24. There were several instances of service categories that were covered at 100% coverage under the MaineCare for Childless Adults benefit, but the data showed a small amount of cost sharing resulting in a benefit factor slightly less than 1.00. Upon review of the data we determined this to be reasonable as minor payments were denied or required to be partially covered by the member despite the coverage typically being 100%.

25. The State has either copayment limits and/or annual benefit limits on many service categories including inpatient hospital, adult care services, emergency services, etc. Upon review of the data, we believe the benefit limitations were appropriately included in the underlying allowed and paid fields in the claims data. Therefore, we did not make further adjustments to the data to account for these limitations.

Appendix E

Summary of Hearing Benefits

				State Benchmark Plan (Anthem Blue Choice)	
	MaineCare for Childless Adults	FEHBP as of December 1, 2009	State Employee Plan (Anthem POS) as of December 1, 2009	In effect as of December 1, 2009	Current State EHB Benchmark Plan
	Covered Services				
Hearing Aids	Not covered	• Hearing aids for children up to age 22, limited to $1,000 per ear per calendar year • Hearing aids for adults age 22 and over, limited to $1,000 per ear per 36-month period • Bone-anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to $1,000 per ear per calendar year. Note: Benefits for hearing aids are subject to the cost-sharing amounts Plan pays 85% Not Covered: • Routine hearing tests (except as indicated under Preventive care, children) • Testing and examinations for the prescribing or fitting of hearing aids (except as needed for covered hearing aids described on page 43)	Benefits are not provided for the prescription, fitting, or purchase of hearing aids including audiant bone conductors.	Benefits are not provided for the prescription, fitting, or purchase of hearing aids including audiant bone conductors.	Covered; Limit for 1 hearing aid per impaired ear every 36 months through age 18. Note: State of Maine requires commercial plans to provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual up to age 18 (per Title 24-A §2762, §2847-M, §4253)
	Covered Services				
Hearing Services	Not covered	Hearing tests related to illness or injury (plan pays 85%) Not covered: • Routine hearing tests (unless a part of preventive care for children) • Hearing aids (except as as described above) • Testing and examinations for the prescribing or fitting of hearing aids (except as needed for covered hearing aids listed above)	Hearing Care Benefits are not provided for hearing examinations except for screening members under the age of 19 years or when related to injury or disease. Routine hearing examinations to determine the need for hearing correction up to the end of the calendar year in which you reach age 19. Hearing examinations to diagnose a medical condition are covered.	Benefits for hearing examinations are not covered except for screening Members under the age of 19 years or when related to injury or disease.	Not Listed

Appendix F

List of Hearing Procedure Codes

Procedure Code	Modifier(s)	Description	Testing Procedure Related to Disease, Illness or Injury for an Adult?	Device Related?
92507	TF,GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual intermediate level of care (Assistant)	Yes	No
92508	TF,HQ,GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals (Assistant)	Yes	No
92551		Screening test, pure tone, air only	No	No
92552		Pure tone audiometry (threshold); air only	No	No
92553		Pure tone audiometry (threshold); air and bone	No	No
92555		Speech audiometry threshold;	No	No
92556		Speech audiometry threshold; with speech recognition	No	No
92557		Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	No	No
92561		Bekesy audiometry; diagnostic	Yes	No
92562		Loudness balance test, alternate binaural or monaural	Yes	No
92564		Short increment sensitivity index (SISI)	Yes	No
92567		Tympanometry (impedance testing)	Yes	No
92579		Visual reinforcement audiometry (VRA)	No	No
92582		Conditioning play audiometry	No	No
92583		Select picture audiometry	No	No
92585		Auditory evoked potentials for evoked response audiometry/and/or testing of the central nervous system; comprehensive	Yes	No
92587		Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion product(s)	No	No
92588		Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	Yes	No
92592		Hearing aid check; monaural (Under age 21 only)	No	No
92593		Hearing aid check; binaural (Under age 21 only)	No	No
92601		Diagnostic analysis of cochlear implant, patient younger than 7 years of age, with programming	No	No
92602		Diagnostic analysis of cochlear implant, patient younger than 7 years of age, subsequent reprogramming	No	No
92603		Diagnostic analysis of cochlear implant, age 7 years or older, with programming	No	Yes
92604		Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	No	Yes

Appendix F *(continued)*

List of Hearing Procedure Codes

Procedure Code	Modifier(s)	Description	Testing Procedure Related to Disease, Illness or Injury for an Adult?	Device Related?
92607	GN	Evaluation for prescription speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	No	Yes
92608	GN	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to 92607 for primary procedure)	No	Yes
92609	GN	Therapeutic services for the use of speech-generating device, including programming and modification	No	Yes
92620		Evaluation of central auditory function, with report; initial 60 minutes	Yes	No
92621		Evaluation of central auditory function, with report; each additional 15 minutes	Yes	No
92630	GN	Auditory rehabilitation; pre-lingual hearing loss	No	No
92630	HQ,GN	Auditory rehabilitation; pre-lingual hearing loss (Group)	No	No
92633	GN	Auditory rehabilitation; post-lingual hearing loss	Yes	No
92633	HQ,GN	Auditory rehabilitation; post-lingual hearing loss (Group)	Yes	No
96110	GN	Developmental testing; limited, (eg. Early Language Milestone Screen) with interpretation and report	No	No
92565		Stenger test, pure tone	Yes	No
92568		Acoustic reflex testing, threshold	Yes	No
92610		Evaluation of oral and pharyngeal swallowing function	No	No
V5008		Hearing screening	No	No
V5008	TF	Hearing screening (Assistant)	No	No
V5008		Hearing Screening	No	No
V5010		Assessment of hearing aid	No	Yes
V5011		Fitting/Orientation/checking of hearing aids	No	Yes
V5014		Repair/Modification of a hearing aid	No	Yes
V5020		Conformity Evaluation	No	Yes
V5030		Hearing Aid, monaural, body worn, air conduction	No	Yes
V5040		Hearing Aid, monaural, body worn, bone conduction	No	Yes
V5050		Hearing Aid, monaural, in the ear	No	Yes
V5060		Hearing Aid, monaural, behind the ear	No	Yes
V5070		Glasses, air conduction	No	Yes
V5080		Glasses, bone conduction	No	Yes
V5090		Dispensing Fee, unspecified hearing aid	No	Yes
V5100		Hearing Aid, bilateral, body worn	No	Yes
V5110		Dispensing Fee, bilateral	No	Yes
V5120		Binaural, body	No	Yes

Appendix F *(continued)*

List of Hearing Procedure Codes

Procedure Code	Modifier(s)	Description	Testing Procedure Related to Disease, Illness or Injury for an Adult?	Device Related?
V5130		Binaural, in the ear	No	Yes
V5140		Binaural, behind the ear	No	Yes
V5150		Binaural, glasses	No	Yes
V5160		Dispensing Fee, binaural	No	Yes
V5170		Hearing Aid, CROS, in the ear	No	Yes
V5180		Hearing Aid, CROS, behind the ear	No	Yes
V5190		Hearing Aid, CROS, glasses	No	Yes
V5200		Dispensing Fee, CROS	No	Yes
V5210		Hearing Aid, BICROS, in the ear	No	Yes
V5220		Hearing Aid, BICROS, behind the ear	No	Yes
V5230		Hearing Aid, BICROS, glasses	No	Yes
V5240		Dispensing Fee, BICROS	No	Yes
V5241		Dispensing Fee, monaural hearing aid, any type	No	Yes
V5242		Hearing Aid, analog, monaural, CIC (Completely in the ear canal)	No	Yes
V5243		Hearing Aid, analog, monaural, ITC (in the canal)	No	Yes
V5244		Hearing Aid, digitally programmable analog, monaural, CIC	No	Yes
V5245		Hearing Aid, digitally programmable, analog, monaural, ITC	No	Yes
V5246		Hearing Aid, digitally programmable, analog, monaural, ITE (in the ear)	No	Yes
V5247		Hearing Aid, digitally programmable, analog, monaural, BTE (behind the ear)	No	Yes
V5248		Hearing Aid, analog, binaural, CIC	No	Yes
V5249		Hearing Aid, analog, binaural, ITC	No	Yes
V5250		Hearing Aid, digitally programmable analog, binaural, CIC	No	Yes
V5251		Hearing Aid, digitally programmable, analog, binaural, ITC	No	Yes
V5252		Hearing Aid, digitally programmable, binaural, ITE	No	Yes
V5253		Hearing Aid, digitally programmable, binaural, BTE	No	Yes
V5254		Hearing Aid, digital, monaural, CIC	No	Yes
V5255		Hearing Aid, digital, monaural, ITC	No	Yes
V5256		Hearing Aid, digital, monaural, ITE	No	Yes
V5257		Hearing Aid, digital, monaural, BTE	No	Yes
V5258		Hearing Aid, digital, binaural, CIC	No	Yes
V5259		Hearing Aid, digital, binaural, ITC	No	Yes
V5260		Hearing Aid, digital, binaural, ITE	No	Yes
V5261		Hearing Aid, digital, binaural, BTE	No	Yes
V5262		Hearing Aid, disposable, any type, monaural	No	Yes
V5263		Hearing Aid, disposable, any type, binaural	No	Yes
V5264		Ear mold/insert, not disposable, any type (Under age 21 for hearing aids only)	No	Yes
V5265		Ear Mold/insert, disposable, any type	No	Yes
V5266		Battery for use in hearing device	No	Yes

Appendix F *(continued)*

List of Hearing Procedure Codes

Procedure Code	Modifier(s)	Description	Testing Procedure Related to Disease, Illness or Injury for an Adult?	Device Related?
V5267		Hearing Aid supplies/accessories	No	Yes
V5268		Assistive listening device, telephone amplifier, any type	No	Yes
V5269		Assistive listening device, alerting, any type	No	Yes
V5270		Assistive listening device, television amplifier, any type	No	Yes
V5271		Assistive listening device, television caption decoder	No	Yes
V5272		Assistive listening device, TDD	No	Yes
V5273		Assistive listening device, for use with cochlear implant	No	Yes
V5274		Assistive listening device, not otherwise specified	No	Yes
V5275		Ear Impression, each	No	Yes
V5298		Lost and Damage Cost of Replacement. Submit TAR, attach MediCal Loss and Damage Form. If the replacement is after 3-months this code can be used to bill for; if hearing aid was dispensed longer than 3-months a dispensing fee can be charged.	No	Yes
V5299		Hearing Services, miscellaneous. Determine if an alternative HCPCS Level II, Level III code or a CPT code better describes the services reported. This code should only be used if a more specific code is unavailable.	No	No
V5336		Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)	No	Yes
V5362		Speech screening (articulation)	No	No
V5362	TF	Speech screening (articulation)(Assistant)	No	No
V5363		Language screening (receptive or expressive)	No	No
V5363	TF	Language screening (receptive or expressive)(Assistant)	No	No
V5364		Dysphagia screening	No	No
V5364	TF	Dysphagia screening (Assistant)	No	No