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Department of Health and Human Services

Off Session Update to The Joint Standing Committee on Appropriations and Financial Services

August 20, 2012

Response to question from June 18th AFA Committee meeting

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1. **Can the Prescripton Monitoring Progam (PMP) be used to reduce prescription drug abuse and black market sales?**

   Response: PMP will soon begin reporting to providers how they rank compared to their peers in regards to the volume of medication per member prescribed. The goal will be for the most prolific prescribers to trend back towards what their peers are doing. The purpose is to transition from a single patient behavior review to a provider specific prescribing pattern review. To date the provider community has been receptive to this new approach.

2. **Please provide a copy of the Pain Management Protocol by Dr. Flanigan.**

   ***Response*:** See Attachment 1 (pain management policy) and Attachment 2 (pain policy concept outline)

3. **What role could the "Lock-in" program play in preventing abuse?**

   Response: Maine has a "Lock-in Program" as defined in Chapter IV of the MaineCare Benefits Manual (see Attachment 3 for language) that is designed to help prevent misuse of prescription drugs and other Medicaid benefits. The Department does not believe that it is as effective as it could be and is working to restructure the program. Our approach will likely align with Attachment 4 (letter from CMS).

4. **Does MaineCare reimburse for replacement prescriptions when the original has been lost?**

   Response: MaineCare does not pay for lost or stolen medication except in cases where a police report has been filed. Even in those cases, the history of the client is reviewed to verify that reporting stolen medication is not a general practice.

5. **Please provide financial data on Section 21 and 29 waivers for SFY '12.**

   Response: Developmental Services Waiver – 010-14A-098716

   The Developmental Services Waiver account had total expenditures of $86.9 million for SFY 2012. Expenditures exceeded the original budget of $82.9 million by $4.0 million. Of this variance, $1.7 million is attributable to prior year claims being higher than expected, resulting in a current year budget variance of $2.9 million in the General Fund.

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
Developmental Services Waiver						
010-14A-098716			**Projected**		**Actual**	
	SFY 2011	**SFYTD @ 4/30/12**	**SFY 2012**		**SFY 2012**	
Budget	59,742,364	76,471,969	82,942,700	*	86,975,327	<== Adjusted via Financial Order
Actual	59,715,557	72,957,817	87,549,380		86,897,636	
Balance	26,807	3,514,152	(4,606,680)		77,691	

Funding Breakdown of Actual and Projected Expenditures					
				SFY 2012 Actual with SFY 2011 (ARRA) Funding	**SFY 2012 vs. 2011 w/ARRA Funding**
	SFY 2011	**SFYTD @ 4/30/12**	**SFY 2012**		
General Fund	59,715,557	72,957,817	86,897,636	64,164,170	(4,448,613)
				-	
Federal Funds	140,097,889	126,380,480	150,527,599	150,534,722	(10,436,832)
				-	
ARRA	21,150,687	-	-	22,726,343	(1,575,657)
Total Expenditures	220,964,133	199,338,297	237,425,235	237,425,235	(16,461,102)

NOTE:

* The original budget was established at $82,942,700. The allotment level fluctuated during the year as this account is integrated in the set of MaineCare accounts that are managed as a group to fund all MaineCare claims.

6. In its report to the Appropriations Committee, the Department of Health and Human Services provided two pages of "Audit Status – 2012" depicting the "to do" audits, the "done" audits, and "current to do" audits. The audits appear to apply to residential facilities – nursing facilities, PNMIs, Residential care, etc.

a. Do all the audits apply to Medicaid clients and payments? If not, how many are Medicaid and how many are not Medicaid?

Response: All are Medicaid except for the group labeled Social Services.

b. What are the total dollar values of each type of audit – "To do," "done," and "current to do?"

Response: See Attachment 6.

c. What are the total dollar values of each type of audit for Medicaid Audits and for Non-Medicaid audits?

Response: We don't have the information for non-Medicaid audits. The Medicaid information is on Attachment 5.

d. How much does the State owe hospitals for MaineCare services?

Response: We estimate $474,200,672 (State and Federal).

e. How much does the State owe hospitals for MaineCare Services delivered since January 1, 2011?

f. ***Response***: Our estimate isn't broken down by date of service but instead based on the fiscal year end of the hospital. For hospital fiscal years ending in 2011 and thereafter, we estimate the amount owed is $219,132,273 ($170 million in 2011, $49 million in 2012) (State and Federal).

The estimate of amounts owed to hospitals since January 1, 2011 is for cost reporting periods ending after January 1, 2011 through June 30, 2012 as of May 2012.

Crossover claims not processed through the claims system and not previously settled for calendar years 2005 through 2010 are included in the total amount owed to hospitals (question 6d). There are no crossover settlements in 2011 forward since the MIHMS system processes them.

Settlements for fiscal periods beginning after July 1, 2012 will be relatively small. Non-acute hospitals are paid for inpatient services on a DRG basis. On the outpatient side, reimbursement is now based on the APCs with no settlement at year end. Critical Access hospitals will still be cost settled. Settlements for fiscal years ending in 2013 should be the result of "normal" changes in volume and not driven by capping PIPS.

Pain Management Policy

Proposal for a Pain Management Policy that is evidenced based where possible, consensus opinion based where possible and focused on improved pain care while reducing dependence upon opioid medications for treatment of both acute and chronic pain. There are four points of focus as delineated below.

Acute Pain (new onset)- A total of 15 days per calendar year will be allowed with 14 day PA overrides allowed. Each prescription will require a face to face visit between provider and patient. After three successive refills a patient will be determined to have developed chronic pain and requirements for management of chronic pain will be applicable.

Chronic Pain (long term in nature and patient has had an inadequate response to other treatment modalities) - Patients must participate in one or more interventions as defined by a treatment plan designed for them and they must fail to have adequate response. The patients who do then qualify for opioid treatment will be limited on total amount of opioids allowed on a daily basis.

Prior Authorization- Patients who suffer from one of the diagnoses known to have a typical poor response to opioids will require evaluation by a second physician from outside the practice of the prescribing provider before being authorized to receive an opioid prescription as part of their treatment plan. Surgeons who perform surgical procedures whose standard of care demands use of opioids for more than 15 days would be allowed to request a Prior Authorization for up to 60days without a mandatory face to face visit thereafter members still requiring management of pain will fall under the chronic pain criteria. Finally a Prior Authorization would also be allowed for end of life care, cancer pain, nursing home patients and inpatient care.

PMP- The goal is to turn this into a reporting process that sends out the data to providers showing how they compare in their treatment patterns to their peers. The intent is to allow providers 3-6 months to bring their prescribing pattern in line with other providers or have restriction placed upon them when it comes to prescribing opioids for MaineCare members.

For members who are currently receiving opioid therapy that is in excess of the policy outline above a protocol for proper, safe and effective tapering will be designed in a collaborative fashion with Pain Specialists and Addiction Medicine Specialists and then endorsed by the members of the Physician Advisory Committee.

Pain Policy Concept Outline

Acute Pain

1) A MaineCare patient may receive prescriptions for opioids without PA (Prior Authorization) for up to a total of 15 days per calendar year.
2) Through a PA process additional refills can be granted for another 14 days. After an initial 15 day prescription and three 14 day prescriptions have been filled for the same acute pain episode the member will be considered to be developing chronic pain and the chronic pain guidelines will need to be followed.
3) Face to Face encounter must occur for each and every opioid prescription written for the treatment of acute pain.

The initial 15 day total does not imply that only 15 day scripts can be written. The 15 day total can be reached by any combination of days that equals 15. For example a patient may receive two four day prescriptions through an ED on separate occasions to treat a high ankle sprain in February and a broken finger in June. This patient may then receive another prescription for seven days after an emergency appendectomy in September.

Chronic Pain

1) Base restriction on MSE (Morphine Sulfate Equivalents) total per day of 300mg.
2) Base restriction on APAP (Tylenol) max of 2grams.
3) Design coverage policy for CBT (Cognitive Behavioral Therapy) & ACT (Acceptance Commitment Therapy)
4) Design PT (Physical Therapy) policy to allow defined number of visits for treatment of chronic pain. Allow six visits with PT for treatment and implementation of HEP (Home Exercise Program).
5) OMT policy- OMT is currently a covered physician treatment. Increased use of this intervention is expected as it has been shown to be effective at improving both pain control and functional capacity in many chronic pain patients.
6) Encourage the use of Multi-disciplinary treatment program

Patients can qualify for use of opioid medications for chronic pain if they have completed a pain treatment protocol consistent with the outlined covered services and they show signs of regression after completion or if they have completed at least 50% of a pain treatment protocol and it is the providers expert opinion that adequate control will not be obtained once the care plan is completed. Patients who do not complete at least 50% of a care plan cannot receive chronic opioid medication as part of their treatment plan.

PMP

1) Generate and send reports to providers showing their ranking based on number of pills per patient compared to other specialty matched peers.
2) Semi-annual or annual report to providers on top 12-15 patients based upon MSE daily dosing.
3) Include specialty identification next to NPI on patient reports.
4) Ability to run multiple patient names at one time/generate more than one patient report at a time.
5) Generate APAP report for patients receiving more than 2g per day.

Need to be able to offer stick response for DHHS to use if these reports are ineffective in impacting prescribing patterns! Consider not authorizing opioid prescriptions for providers who do not show improvement in prescribing pattern compared to peers or require patient consultation with a second physician who is not in practice with the prescribing provider to evaluate patient and reaffirm treatment plan is within standard of care.

Dx to Require PA for Chronic Pain Treatment?

1) Back pain/Neck pain/Spine pain
2) Headache
3) FMS?
4) Complex Regional Pain Syndrome

For the diagnoses listed above only a Sub-specialist can prescribe opioids for these diagnoses without PA. PCP/General medical provider or similar long-term patient relationship medical provider can only receive an PA for these diagnoses if a consultation with a second provider has taken place and the care plan from the second provider confirms the initial treatment plan or includes opioid medications as part of the treatment. Follow-up appointments with the second provider must occur on at least an annual basis for continuation of the opioid prescription or significant changes in the care plan.

Only Surgeons can prescribe for post-op pain. After initial 15 day limit is reached by a member the Surgeon may receive a single PA for up to 60 additional days.

1.03 **DEFINITIONS (cont.)**

A. unusually frequent utilization of health care services;
B. inappropriate or excessive acquisition of drugs, especially drugs with addictive properties such as: tranquilizers, psychostimulants, narcotic analgesics, non-narcotic analgesics, sedative barbiturates and sedative non-barbiturates; and
C. duplicated services or prescriptions for the same or similar conditions.

1.03-8 **Members** are recipients of MaineCare services.

Effective 3/1/10

1.03-9 **Member Review Team ("the Team")** is the Department of Health and Human Services (DHHS) multidisciplinary team that participates in the surveillance of health care services and benefit utilization by MaineCare members and determines the existence of over-utilization and/or misuse. The Team shall consist of, at a minimum, a physician; a registered nurse or social worker; and a representative of Program Integrity. The Team may also include other consultants, such as a pharmacist and/or a representative from the Health Care Management unit of MaineCare services.

1.03-10 **Over-Utilization** is the use of health care services and benefits in excess of medical necessity, as determined by the Member Review Team.

1.03-11 **Primary Care Provider** (PCP) is a physician or other provider who practices primary care.

1.03-12 **Program Integrity Unit** is the unit responsible for conducting a federally required monitoring plan that reviews all MaineCare services and expenditures.

1.03-13 **Prescriber** is an M.D., D.O., nurse practitioner, physician assistant or resident in training who possesses a valid DEA number.

1.04 **ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN**

1.04-1 Identification of Members

A. The Program Integrity Unit will identify members who appear to be obtaining health care services that are not medically necessary. Members who are suspected of obtaining health care services that are not medically necessary may be identified by the following sources:

1. Referrals or complaints from members, providers, professional associations, health care professionals and other citizens;
2. Referrals from the Department of Health and Human Services ("DHHS"), Office of MaineCare Services, Fraud Investigation and Recovery Unit, the Department of Attorney General, Health Care Crimes Unit, third party payers, State of Maine Board of Pharmacy,

Effective 3/1/10

1.04 ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN (cont.)

Effective 3/1/10

the Health and Human Services Office of Inspector General (OIG), Center for Medicare and Medicaid Services (CMS), State and local law enforcement agencies, and any other State or Federal agency;

3. Computer generated reports that identify members who may be over-utilizing or inappropriately using health care services.

Effective 3/1/10

B. Following the identification of members who appear to utilize health care services that are not medically necessary, the Program Integrity Unit may:

1. Analyze the computer-generated profiles of the member's reimbursed health care services for the previous six (6) months, or longer if indicated;
2. Review the member's clinical records to document the medical necessity as well as the frequency of services billed, and if necessary;
3. Communicate with the key providers to determine if over-utilization is occurring.

Effective 3/1/10

C. Upon completion of the initial review process, DHHS or its Authorized Agent may contact the member who appears to have over-utilized health care services, to discuss the member's pattern of utilization of health care services. During the contact, the DHHS or its Authorized Agent shall review a summary of the member's primary care provider, pharmacy and hospitalization or other service usage and the member shall be given an opportunity to explain his or her utilization pattern. In addition to explaining the Restriction Plans, DHHS or its Authorized Agent may also provide information on how to obtain appropriate health care services or refer the member to an appropriate agency to obtain services for an identified problem.

D. DHHS or its Authorized Agent shall make notes to document the content of the contact, member responses and any referrals. DHHS or its Authorized Agent shall provide the member with a contact name and office telephone number as resources.

E. DHHS or its Authorized Agent shall refer the case to the Member Review Team for evaluation in cases where no apparent medical necessity for the health care services exists and/or over-utilization continues.

1.04-2 Member Review Team - Case Evaluation

The Member Review Team shall review cases referred under the

1.04 ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN (cont.)

preceding Section to evaluate the utilization and medical necessity of the health care services rendered to members. The Member Review Team shall summarize its findings and recommendations in writing. The Team may recommend:

A. That the member be monitored by DHHS or its Authorized Agent until more documentation and information is available.

Effective 3/1/10

B. That DHHS or its Authorized Agent contact the member to discuss, verbally or through written communication, the member's health care utilization and concerns. The DHHS or its Authorized Agent will inform the member of the benefits of proper health care utilization and assist the member, if necessary, in securing a health care provider. The Unit representative will also explain the Restriction Plans that could be implemented should the current pattern of utilization continue

C. That the member be enrolled in one or more of the four types of Lock-In of the Restriction Plan for restriction to a health care provider, pharmacy, hospital and/or other provider as necessary in order to improve the member's health care benefits usage. The Team may recommend an initial enrollment in the Restriction Plan for a period not to exceed twenty-four (24) months. Subsequent re-enrollment periods, if necessary, are limited to twelve (12) month periods.

1.04-3 Member Review Team –Plan Criteria

A. Restriction Plan Criteria

The Team may elect to enroll the member into the Restriction Plan if the member has exceeded medically necessary utilization of medical services or benefits. The Team determines over-utilization on a case-by-case basis that includes an evaluation of the member's medical condition and need for services as determined using relevant information including but not limited to the medical record, claims data and national standards for best practices. The member must retain reasonable access to MaineCare services of adequate quality, including consideration for geographic location and reasonable travel time.

Effective 3/1/10

1.04-4 Member Notification

If the Member Review Team's decision is to enroll the member in the Restriction Plan, the Program Integrity Unit shall mail a Notice of Decision to the member and provide the member with:

1. The Team's decision,
2. A summary of the evidence upon which the Team's decision Was based,

1.04 ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN (cont.)

3. The effective date of the restriction and/or enrollment into the Plan,
4. Citation of the rules supporting the Team's decision,
5. A health care provider and/or prescriber designation form, and
6. Notice of the member's right to request an administrative hearing and appeal the Team's determination in accordance with the Maine Medical Assistance Manual, Chapter I, and Chapter IV.

Effective 3/1/10

B. The member shall have thirty (30) days from the receipt of the Notice of Decision to complete the health care provider and/or prescriber designation form and return it to the Team. If the member fails to return the completed health care provider and/or prescriber designation form or otherwise notify the Program Integrity Unit of his/her designation of health care providers and/or prescriber, staff of the Program Integrity Unit shall select the member's health care providers and/or prescriber based on the member's medical needs and geographic location.

C. Selection of the health care provider(s) and/or prescriber by the Program Integrity Unit staff or through oral notice by the member shall be so documented in the member's file. Enrollment in the Restriction Plan shall not begin until after the member has had an opportunity for an administrative hearing, if requested. If a hearing is not requested by the member within thirty (30) days of the date of the Notice of Decision, then the member's enrollment in the Restriction Plan shall become effective immediately upon confirmation with the participating health care providers.

1.04-5 Provider Notification
The Program Integrity Unit will contact by telephone each health care provider and/or prescriber selected, to explain the Restriction Plan and solicit the provider's participation and cooperation. If the provider agrees to participate as the health care provider and/or prescriber for the member, a follow-up letter shall be sent by the Program Integrity Unit to the provider confirming his/her participation and the date on which the restriction shall begin.

1.05 **EMERGENCY HEALTH CARE SERVICES AND NON-PRIMARY CARE PROVIDERS**

Non-primary care providers shall be reimbursed for health care services only in the following circumstances:

Effective 3/1/10

A. When the need to stabilize an emergency medical condition (as defined in Section 1.02-4.B. & C., Chapter I of the MaineCare Benefits Manual, also refer to Chapter IV, Section 1.03-5) exists. Reimbursement is subject to the provider's later written or verbal verification of that need when requested by the Program Integrity Unit;
B. When the member has been referred by the primary care provider; and
C. When the member has received services without a referral from providers whose category of service is not covered by the restriction plan, i.e., x-ray, laboratory, and optometrists.

1.06 **PLAN MONITORING**

Effective 3/1/10

During the period of enrollment in the Restriction Plan, the Program Integrity Unit will supervise and monitor utilization patterns of restricted members and analyze computer-generated profiles of the member's health care services reimbursed under MaineCare. The member will be contacted by the Program Integrity Unit periodically to verify that his or her medical needs are being met.

The member shall receive the Program Integrity Unit's toll-free telephone number, to clarify questions regarding restriction, seek assistance if access problems arise, and report complaints.

1.07 **CHANGE IN HEALTH CARE PROVIDER**

At the time the member is notified of his/her enrollment in the Restriction Plan, the member shall be advised that he/she may change his/her health care provider for any reasonable cause at a later date, by notifying the Program Integrity Unit. Program Integrity Unit Staff shall contact the proposed health care provider and arrange his/her participation in this member's restriction plan.
If the member, or health care provider, believes a second opinion is warranted or desirable, the second opinion provider payment may be authorized by contacting the Program Integrity Unit staff in advance of the second opinion.

1.08 **CHANGE IN MEMBER STATUS IN RESTRICTION PLAN**

1.08-1 Continuation of restriction, or modification of enrollment into another Lock-In type, beyond the initial period will be recommended when subsequent annual reviews of the member's records, claims data and national standards, in accordance with the MaineCare Benefits Manual, Chapter IV, by the Member Review Team indicate one or more of the following:

A. Evidence of member's failure to comply with the recommended plan of management from the health care providers;
B. Evidence of member's continued over-utilization of services without medical necessity, which includes services where payments were denied by MaineCare because the Restriction Plan protocols were not followed; or
C. Member's voluntary request to continue the restriction.

Effective 3/1/10

1.08-2 In cases where the Member Review Team determines that the enrollment in the Restriction Plan should continue beyond the initial period, the member shall be notified in writing by a Notice of Decision.

The Notice of Decision shall include the evidence used in the determination and member's right to request an administrative hearing in accordance with the MaineCare Benefits Manual, Chapter I, and Chapter IV.

1.08 **CHANGE IN MEMBER STATUS IN RESTRICTION PLAN** (cont.)

1.8-3 When the Member Review Team determines that the member's utilization practices have significantly improved; the health care provider restriction shall be terminated on a date designated by the Member Review Team. The member shall be notified by mail of the termination of restriction and the effective date of termination. The Program Integrity Unit shall notify the member that his/her MaineCare utilization shall be monitored to insure that the improved utilization pattern is maintained. Should previously observed over-utilization practices become evident during the monitoring period, the member's case shall be reviewed in accordance with Chapter IV, Section I.

Effective 3/1/10

1.09 **MEMBER RIGHTS**

A. A member who disagrees with the determination that he/she be enrolled in the Restriction Plan, or a member who is aggrieved by an action or policy relating to his/her involvement or continued reenrollment in the Restriction Plan is entitled to oppose the action. He/she shall be informed of his/her rights to appeal. Appeals Rights are in accordance with MaineCare Benefits Manual, Chapter I.

CENTERS FOR MEDICARE & MEDICAID SERVICES

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Drug Diversion in the Medicaid Program

State Strategies for Reducing Prescription Drug Diversion in Medicaid

January 2012

Background

"Drug diversion" is best defined as the diversion of licit drugs for illicit purposes. It involves the diversion of drugs from legal and medically necessary uses towards uses that are illegal and typically not medically authorized or necessary. While drug diversion is not a new phenomenon, States are reporting a significant increase in the problem. In fact, according to the 2010 National Drug Threat Assessment report, "The threat posed by the diversion and abuse of controlled prescription drugs (CPDs), primarily pain relievers, is increasing, as evidenced by the sharp rise in the percentage (4.6 percent in 2007, 9.8 percent in 2009) of state and local law enforcement agencies reporting CPDs as the greatest drug threat in their area." Increased abuse of CPDs has led to elevated numbers of deaths related to prescription opioids, which increased 98 percent from 2002 to 2006.[1]

The National Drug Threat Assessment report further states that, "The most commonly diverted CPDs are opioid pain relievers, according to Drug Enforcement Administration (DEA) and the National Survey of Drug Use and Health (NSDUH) data."[2] Opioid pain relievers are popular among drug abusers because of the euphoria they induce. Opioid pain relievers include codeine, fentanyl (Duragesic, Actiq), hydromorphone (Dilaudid), meperidine (Demerol, which is prescribed less often because of its side effects), morphine (MS Contin), oxycodone (OxyContin), pentazocine (Talwin), dextropropoxyphene (Darvon), methadone (Dolophine), and hydrocodone combinations (Vicodin, Lortab, and Lorcet)."

In addition to opioids, it has been reported that significant diversion is occurring with high cost antipsychotic and mental health drugs, such as aripiprazole (Abilify), ziprasidone (Geodon), risperidone (Risperdal), quetiapine (Seroquel), and olanzapine (Zyprexa), as well as benzodiazepines such as alprazalam (Xanax), clonazepam (Klonopin) and lorazepam (Ativan).

The impact of drug diversion on the Medicaid program goes beyond just the cost of the prescription drugs. There are also the costs associated with doctor's visits, emergency department (ED) treatment, rehabilitation centers, and other health care needs, not to mention the human toll. In 2008, the Drug Abuse Warning Network (DAWN), operated by the Substance Abuse and Mental Health Services Administration (SAMHSA), estimated that prescription or over-the-counter drugs used non-medically were involved

[1] Figure 18 from the National Drug Threat Assessment- Number of Reported Unintentional Poisoning Deaths with Mention of Opioid Analgesics 5,547 (2002) 11,001 (2006) http://www.justice.gov/ndic/pubs38/38661/index.htm

[2] http://www.oas.samhsa.gov/nhsda.htm

in 1.0 million ED visits. Among the legal drugs, the most common drug categories involved were drugs acting on the central nervous system, especially opioid painkillers and psychotherapeutic drugs (especially sedatives and antidepressants). Opioid painkillers were associated with approximately 306,000 visits and benzodiazepines with 272,000 visits.[3] As entities jointly responsible for the Medicaid program, both CMS and State Medicaid Agencies (SMAs) must take action to make certain that the correct controls and safeguards are in place to ensure prescription drugs are used by their intended beneficiaries and purposes.

Federal Partnerships

The CMS and DEA have established key partnerships in the prevention of drug diversion. The mission of DEA's Office of Diversion Control is to prevent, detect, and investigate the diversion of controlled pharmaceuticals and listed chemicals from legitimate sources while ensuring an adequate and uninterrupted supply for legitimate medical, commercial, and scientific needs. The DEA is responsible for the Controlled Substance Registration File which is a list of 1.3 million active registrants of all entities and provider types that prescribe, administer, procure, and dispense controlled substances. This file contains identifying information of each registrant. In December 12, 2010 CMS issued an Advisory to State Program Integrity Directors on Medicaid Prescription Drug Fraud and Abuse Prevention: Access to DEA Registration File. Further, information on the DEA can be found at the following link: http://www.deadiversion.usdoj.gov.

State Partnerships

On March 25, 2010 CMS and the DEA met with both local and State officials in Ohio to discuss the growing problem of drug diversion in that state. In response to these growing concerns, the CMS Medicaid Integrity Group and the State of Ohio agreed to work collaboratively to reduce improper payments for prescription drugs.

Additionally, CMS in close collaboration with States, is providing education resources through its Education Medicaid Integrity Contractor (Education MIC) to promote best practices and will focus on providers that have been identified as having the high potential aberrant prescribing patterns for five targeted therapeutic drug classes that have also been identified as having potentially high outlier payments. Materials will focus on the importance of prescribing drugs within the dosage guidelines approved by the FDA. Although this collaboration effort is initially being piloted in only 5 States, if the results are promising, plans are in place to expand the education campaign nationally. Also, the Education MIC is developing written materials to help educate providers on areas of drug diversion, including how to identify drug seeking behavior in beneficiaries and appropriate reporting of suspicious fraudulent behavior.

Strategies for Combating Controlled Prescription Drug Diversion in Medicaid

Previous laws enacted to help safeguard against drug diversion include tamper resistant prescription pads. Effective October 1, 2007, Federal law prohibits payments for covered outpatient drugs written on non tamper-resistant pad. As part of State efforts to

[3] http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf

combat drug diversion, States should ensure that this requirement is being enforced. For more information on the tamper resistant prescription pad requirements, including Frequently Asked Questions and a State Medicaid Director Letter, see the CMS website at the following link: http://www.cms.gov/FraudAbuseforProfs/15_TRP.asp#TopOfPage."

One of the first lines of prevention in drug diversion is the ability to identify and screen high risk providers that may facilitate drug diversion. The Affordable Care Act grants States significant new authority to fight fraud and abuse in the area of drug diversion, including the ability to:

- Establish enhanced oversight for new providers,
- Establish periods of enrollment moratoria or other limits on providers identified as being high risk for fraud and abuse,
- Establish enhanced provider screening, and
- Require States to suspend payment when there is a credible allegation of fraud which may include evidence of overprescribing by doctors, overutilization by recipients, or questionable medical necessity.

In addition to these provisions in the Affordable Care Act, there are other actions States can take to prevent and detect problems with drug diversion. Elements of a robust State controlled prescription drug program include:

- Identifying problematic CPD diversion issues within the retroactive Drug Utilization Review (DUR) process. The State of Kentucky's program integrity area has access to a database of all controlled substance prescriptions filled in Kentucky. Access to the system helps identify outliers and reduce the time and cost involved in drug diversion investigations.[4]

- Establishing effective pro-active DUR screenings, such as implementing a prior approval process for high CPD doses or quantities and regularly monitoring for overutilization. The Pennsylvania Medicaid Program, with the help of the DUR board, was able to identify anomalies in utilization as the basis for refining the Medicaid program's prior authorization criteria. A Pharmacy and Therapeutics Committee developed a preferred drug list (PDL) that limits the prescribing habits of physicians to appropriate drugs in each drug class. The PDL is updated twice a year and has proven cost effective. From SFY 2005 to SFY 2007, per member per month costs in Pennsylvania decreased from $95.84 to $76.90.[5]

- Monitoring pain management clinics for evidence of overprescribing opioids. Pain management clinics are often at the center of significant drug diversion activities and in some States are unregulated. Monitoring programs should not only review opioids dispensed at pharmacies, but also those opioids that might be

[4] http://www.cms.gov/FraudAbuseforProfs/Downloads/kyfy09comppireport.pdf
[5] http://www.cms.gov/FraudAbuseforProfs/Downloads/pafy08comppifinalreport.pdf

dispensed by the provider in the pain management clinic. Oklahoma and Florida have each enacted legislation increasing monitoring of pain management clinics. For more details, refer to the section "Examples of recent State Legislation affecting Drug Diversion" on page 5 of this bulletin.

- Looking across Federal programs to expose fraudulent activities. Drug diversion impacts both Medicaid and Medicare. CMS encourages States to become involved in the Medi-Medi program. Medi-Medi contractors analyze and link data from both the Medicaid and Medicare claims processing systems. They have an established track record of exposing fraudulent provider activity that otherwise may not have been revealed through the review of State Medicaid data alone.

- Collaborating with colleagues in State agencies, bordering States, and law enforcement. Drug diversion impacts the entire healthcare systems and can occur across State lines. SMAs should share information with other State agencies responsible for mental health, substance abuse, pharmacy and medical boards to plan special projects that deal with aberrant providers and beneficiaries. SMAs should share information with bordering States when confirmed diversion links have been established. We also encourage you to reach out to law enforcement, including Medicaid Fraud Control Units (MFCUs), and State and local police. The State of Louisiana program integrity staff teamed up with mental health rehabilitation (MHR) staff from a sister agency to conduct a 100 percent review of all MHR providers. The project involved the monitoring and auditing of approximately 131 MHR providers and resulted in a number of major findings of fraud or abuse. Louisiana saved $64,797,452 through cost avoidance and made 49 overpayment recoveries that netted $585,604.54. The project also resulted in 14 referrals to the Medicaid Fraud Control Unit (MFCU).[6]

- Implementing a prescription drug monitoring program (PDMP). Practitioners and pharmacists should be encouraged to enter data and routinely access PDMPs, where available, to view patient utilization records and identify potential abusers. As of July 31, 2009, 40 States have PMDP laws, and 33 States have operational programs.[7]

- Establishing or augmenting effective recipient "lock-in" programs per 42 CFR 431.54(e) for recipients who over utilize prescription drugs. If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met.

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[6] http://www.cms.gov/FraudAbuseforProfs/Downloads/lafy09comppirev.pdf

[7] "Prescription Drug Monitoring Program: A brief overview national alliance for model state drug laws. August 2009. http://www.namsdl.org/documents/PDMPsBriefOverview7-31-09.pdf

Many States have lock-in programs, but not all include a restriction requiring beneficiaries to obtain prescriptions from a single pharmacy. In an attempt to end pharmacy-hopping, some States are requiring high users of certain drugs, including OxyContin, Xanax and Valium, to use only one pharmacy and get prescriptions for controlled substances from only one medical office. This helps to improve monitoring of the entire processes from prescription to medication utilization. The State of Iowa has a robust lock-in program with an estimated cost savings of approximately $2 million annually. Recipients abusing the program are locked into a primary care physician, pharmacy, and hospital/emergency room. The lock-in program creates a safety net approach and limits the recipient's ability to obtain drugs. The program also identifies providers who may be engaging in unsound medical practices.[8]

- Encouraging beneficiary participation in the national prescription drug "Take-Back" campaign that offers more than 4,000 sites around the nation where the public can drop off expired, unused and unwanted prescription drugs. Unused medications in the household may contribute to growing rates of prescription drug abuse among Americans. The first ever National Prescription Drug Take Back Day on Saturday, September 25, 2010, collected 121 tons of pills. Information on the "Take-Back" campaign can be found at the following link: http://www.takebacknetwork.com.

- Encouraging providers and beneficiaries to safeguard their identities. Identifiers, such as National Provider Identification (NPI) numbers, Tax Identification Numbers (TIN), U.S. Drug Enforcement Administration (DEA) numbers, and Social Security numbers (SSN) have become extremely valuable commodities. When fraudulently obtained, these identifiers can be submitted on claims to receive payment for services or items never received by patients. This kind of identity theft can have grave personal, professional and legal consequences for providers and beneficiaries. Providers and beneficiaries should be educated on appropriate steps they can take to safeguard their identities. Information on medical identity theft can be found at the following link: http://www.oig.hhs.gov/fraud/idtheft/.

Additional Resources

Below are additional resources that may be helpful in combating drug diversion.

Government Accountability Office (GAO) Report

In September 2009, GAO issued a report entitled "Fraud and Abuse Related to Controlled Substances Identified in Selected States." This report highlights strategies some States employ to combat controlled substance fraud waste and abuse. These strategies include:

[8] http://www.cms.gov/FraudAbuseforProfs/Downloads/iacompfy08pireviewfinalreport.pdf

- Checking the List of Excluded Individuals/Entities (LEIE)[9] and the Excluded Parties List System (EPLS),[10] as routine procedures in screening prescribing providers and pharmacies.
- Verifying that the pharmacy and prescribing physician are registered with the DEA for controlled substances they are prescribing or dispensing. For further information, refer to CMS' December 12, 2010 Advisory on Medicaid Prescription Drug Fraud and Abuse Prevention: Access to DEA Registration File.
- Ensuring beneficiaries are not being enrolled multiple times through pre-enrollment checks.
- Checking Social Security Administration (SSA) master death files for deceased beneficiaries and providers, and preventing payment of claims that contain deceased beneficiary or deceased provider information.

CMS recommends that States implement the GAO strategies as part of an effective drug diversion prevention program. A copy of the full report can be found at the following link: http://www.gao.gov/new.items/d09957.pdf

Center for Disease Control and Prevention (CDC) Issue Brief

In July 2010, the CDC issued a poison-issue brief entitled "Unintentional Drug Poisoning in the United States." This brief summarizes the most recent information about deaths and emergency department (ED) visits resulting from drug poisoning. The brief indicates that drug overdose death rates have increased five-fold since 1990, largely because of prescription opioid painkillers. The brief also provides recommendations to healthcare providers, pharmacy benefit managers, and States on the use and monitoring of opioid prescriptions.

A copy of the full brief can be found at the following link:
http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf

Examples of recent State Legislation affecting Drug Diversion

- In April 2010, Oklahoma (OK) enacted legislation, the Oklahoma Interventional Pain Management and Treatment Act (SB 479), which makes it unlawful to practice or offer to practice interventional pain management unless the practitioner is a licensed Doctor of Medicine (MD) or Doctor of Osteopathic (DO) Medicine. This legislation does not prohibit a nurse anesthetist from administering a lumbar intra-laminar epidural steroid injection or peripheral nerve blocks if requested by and under the supervision of a physician (MD/DO) and under conditions in which timely on-site consultation by such physician is available. This legislation prohibits nurse anesthetists from operating a freestanding pain management

[9] Maintained by the U.S. Department of Health & Human Services-Office of Inspector General
[10] Maintained by the U.S. General Services Administration

facility without direct supervision of a physician who is board-certified in interventional pain management or its equivalent.

- In May 2010, Utah (UT) enacted legislation (HB28) aimed at greater enforcement of drug laws targeted at prescription drug abuse. The new law reduces the availability of prescription drugs for abuse; increases public awareness of the negative physical and psychological effects of prescription drug abuse; provides for the legal sanctions to prosecute those who abuse them; decreases tolerance of non-medical use of prescription drugs; adds the muscle-relaxer Soma to the State's controlled substance list; makes the penalty for selling fake versions of illegal drugs the same as that for selling the real drugs; and establishes a network for disposal of unwanted prescription drugs, among other changes.

- In June 2010, Florida (FL) enacted legislation (S 2272) that gives the State greater oversight of pain-management clinics. The new law increases State regulation of the clinics, stiffens penalties the State may impose upon them, limits anyone paying cash for the prescription narcotics to a 72-hour supply for dispensation, bans advertisements for specific treatments like the opiate oxycodone and requires specific training for doctors to practice pain management.

- In August 2010, health care officials in Massachusetts approved a new detection system designed to stop "doctor shopping'' by addicted patients who try to deceive doctors into prescribing narcotics. Expanding upon an older system that reported on a limited number of drugs and did not offer direct physician access, the new process and application will require pharmacists to report prescriptions they receive for a much broader roster of medications, including steroids. The system will receive weekly updates rather than monthly.Physicians will be able to review the prescription histories of patients and be able to identify those with a history of widespread abuse. Lastly, they will also receive public health reports on their patients who are flagged by the system.

Conclusion

The CMS Medicaid Integrity Group is actively working with States and law enforcement partners on drug diversion issues and looks forward to working with all States to reduce improper payments and diversion of prescription drugs. If you have any questions or would like more information on this topic, please contact Gretchen Kane, Medicaid Integrity Specialist, CMS Medicaid Integrity Group, at 415-744-3806 or Gretchen.Kane@cms.hhs.gov .

Attachment 5

Summary of amounts owed from Medicaid Audit settlements

	Done				Current to do				Total			
	Cases	amt due State	amt due Provider	Net due	Cases	amt due State	amt due Provider	Net due	Cases	amt due State	amt due Provider	Net due
NF												
2008	112	(2,288,724.17)	2,802,302.91	513,578.74	-	-	-	-	112	(2,288,724.17)	2,802,302.91	513,578.74
2009	105	(2,274,122.56)	330,440.20	(1,943,682.36)	6	(52,966.06)	748,429.22	695,463.16	111	(2,327,088.62)	1,078,869.42	(1,248,219.20)
2010	39	(611,573.31)	1,808,872.92	1,197,299.61	70	(1,025,876.61)	3,404,169.00	2,378,292.39	109	(1,637,449.92)	5,213,041.92	3,575,592.00
2011				-					-	-	-	-
ICF-MR												
2008	23	(779,579.19)	664,847.37	(114,731.82)	-	-	-	-	23	(779,579.19)	664,847.37	(114,731.82)
2009	17	(571,132.16)	1,328,316.45	757,184.29	1	-	109,516.00	109,516.00	18	(571,132.16)	1,437,832.45	866,700.29
2010	15	(882,541.39)	778,295.61	(104,245.78)	2	(301,509.00)	201,550.00	(99,959.00)	17	(1,184,050.39)	979,845.61	(204,204.78)
2011	4	(384,897.64)	-	(384,897.64)	13	(1,290,064.28)	304,390.00	(985,674.28)	17	(1,674,961.92)	304,390.00	(1,370,571.92)
RCF												
2007	96	(1,202,463.76)	497,647.70	(704,816.06)	6	(213,981.00)	111,146.00	(102,835.00)	102	(1,416,444.76)	608,793.70	(807,651.06)
2008	85	(1,646,140.15)	542,594.33	(1,103,545.82)	14	(238,271.00)	131,716.50	(106,554.50)	99	(1,884,411.15)	674,310.83	(1,210,100.32)
2009	68	(1,611,850.33)	409,129.64	(1,202,720.69)	36	(725,950.18)	392,479.71	(333,470.47)	104	(2,337,800.51)	801,609.35	(1,536,191.16)
2010	10	(194,032.44)	23,193.33	(170,839.11)	88	(2,483,557.57)	679,801.54	(1,803,756.03)	98	(2,677,590.01)	702,994.87	(1,974,595.14)
2011				-				-	-	-	-	-
RCF - MR												
2007	33	(301,064.14)	364,018.70	62,954.56	-	-	-	-	33	(301,064.14)	364,018.70	62,954.56
2008	33	(242,596.92)	424,852.62	182,255.70	-	-	-	-	33	(242,596.92)	424,852.62	182,255.70
2009	20	(256,005.26)	214,494.34	(41,510.92)	15	(22,252.79)	205,565.13	183,312.34	35	(278,258.05)	420,059.47	141,801.42
2010	8	(123,090.93)	121,924.52	(1,166.41)	28	(226,521.57)	273,020.03	46,498.46	36	(349,612.50)	394,944.55	45,332.05
2011				-				-	-	-	-	-
PNMI												
2008	164	(6,448,280.86)	4,284,177.12	(2,164,103.74)	-	-	-	-	164	(6,448,280.86)	4,284,177.12	(2,164,103.74)
2009	141	(4,604,360.12)	3,733,754.12	(870,606.00)	19	(569,364.13)	144,114.51	(425,249.62)	160	(5,173,724.25)	3,877,868.63	(1,295,855.62)
2010	41	(262,897.72)	112,923.33	(149,974.39)	106.00	(3,093,814.73)	1,918,241.84	(1,175,572.89)	147.00	(3,356,712.45)	2,031,165.17	(1,325,547.28)
2011				-				-	-	-	-	-
Day Programs												
2007	133	(3,323,686.00)	773,270.00	(2,550,416.00)	8	(44,591.00)	8,167.00	(36,424.00)	141	(3,368,277.00)	781,437.00	(2,586,840.00)
2008	41	(3,545,948.00)	488,190.00	(3,057,758.00)	88	(974,940.84)	813,230.28	(161,710.56)	129	(4,520,888.84)	1,301,420.28	(3,219,468.56)
2009	35	(2,385,712.00)	559,935.00	(1,825,777.00)	82	(402,586.75)	613,984.85	211,398.10	117	(2,788,298.75)	1,173,919.85	(1,614,378.90)
2010	24	(1,575,996.00)	357,520.00	(1,218,476.00)	68	(186,036.55)	503,648.62	317,612.07	92	(1,762,032.55)	861,168.62	(900,863.93)

Notes:

1. Data for 2011 incomplete as cost reports for this period were not due until May 30, 2012.
2. The "done" columns reflect audit settlements while the "Current to do" reflects submitted amounts from provider cost reports.
3. The "To do" column is the sum of "Done" and "Current to do"

Attachment 5

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

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

July 13, 2012

Senator Earl McCormick, Chair
Representative Meredith Strang Burgess, Chair
Members of the Joint Standing Committee
on Health and Human Services
#100 State House Station
Augusta, Maine 04333-0100

Senator Richard W. Rosen, Chair
Representative Patrick S. A. Flood, Chair
Members of the Joint Standing Committee
on Appropriations and Financial Affairs
#100 State House Station
Augusta, ME 04333-0100

Dear Senators McCormick and Rosen, Representatives Strang Burgess and Flood, and Members of the Joint Committees on Health and Human Services and Appropriations and Financial Affairs:

As directed by PL 1746, attached is the report on MaineCare reimbursement rates for inpatient substance abuse treatment and inpatient psychiatric treatment provided by community hospitals. This report also includes a plan to correct any inequities in reimbursement between the two programs.

If you have any questions or need further information, please feel free to contact Rich Lawrence at 287-4875.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv

Attachment

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Safe, Healthy and Productive Lives
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Equalization of MaineCare Reimbursement Rates

Inpatient Substance Abuse vs. Inpatient Psychiatric Treatment

July, 2012

Submitted by the:

Maine Department of Health and Human Services
221 State Street
#11 State House Station
Augusta, ME 04333-0011

Background:

Due to the implementation of DRG reimbursement on 7/1/2011 inpatient substance abuse services are now reimbursed at a much lower rate (avg. rate of $3,211 per discharge)than inpatient psych hospitals which are paid a flat rate (typically $6,439 per discharge). As a result of this disparity PL 1746 directs the Commissioner of the Department of Health and Human Services (DHHS) to review MaineCare reimbursement rates for inpatient substance abuse treatment and inpatient psychiatric treatment provided by community hospitals. The Commissioner shall report to the Joint Standing Committee on Appropriations and Financial Affairs and to the Joint Standing Committee on Appropriations and Financial Affairs and to the Joint Standing Committee on Health and Human Services not later than July 1, 2012 on the results of the review, including findings regarding the **levels of services being provided** and the **levels of reimbursement**, and an analysis of **how the current reimbursement rates are calculated**. The report **must include a plan for correcting any inequities**.

Level of services being provided:

Inpatient Substance Abuse Services: Mercy and St. Mary's are the only two inpatient substance abuse treatment centers in the State of Maine. Specialized services include detoxification with the latest medications and comfort measures, group therapy, medical management and treatment of withdrawal symptoms, and long-term therapies designed to reduce an individual's chance of relapse. The inpatient substance abuse program will often take individuals with medical issues who are not eligible for a community based program. The average length of stay is 3.02 days.

Inpatient Psychiatric services: There are several hospitals throughout the State of Maine that have inpatient psychiatric services including Maine Medical Center, Maine General, MidCoast, Northern Maine Psych, Penobscot Bay, St. Mary's, Southern Maine Medical Center and The Aroostook Medical Center. Specialized hospitals services are offered to individuals in psychiatric crisis. Services include keeping a patient safe, monitoring the effects of medication if needed, both individual and group therapy for education on coping and life skills and developing a plan for follow-up care. The average length of stay is 5.41 days.

Current levels of reimbursement:

Inpatient Substance Abuse Services: As of July 1, 2011 the State of Maine adopted the Diagnosis Related Group (DRG) reimbursement system for inpatient hospital reimbursement. The DRG system has been implemented by Medicare and most state Medicaid Programs to provide a more rational method of payment for acute inpatient hospital services. The DRG system is designed to pay providers a similar rate for similar services. By using a predetermined rate it rewards providers that treat patients efficiently and it incentivizes the hospital to contain cost and provide efficient care. Extraordinarily costly stays receive additional payments called cost outliers. Mercy and St. Mary's are paid an average of $3,211 per discharge for inpatient substance abuse services.

Inpatient Psychiatric Services: Most inpatient psychiatric services are paid at a negotiated flat rate of $6,439 per discharge.

Current Reimbursement rate calculations:

Inpatient Substance Abuse Services: Under the DRG reimbursement system reimbursement is calculated by multiplying a state wide hospital base rate of $4,722 by a weight for each service. Reimbursement for inpatient substance abuse would be estimated at $4,722 x average weight of .68 = $3,211. These services are not reported separately on the Medicare cost report.

INPATIENT SUBSTANCE ABUSE		
DRG	Description	Weight
894	Alcohol/drug abuse or dependence, left ama	0.34
895	Alcohol/drug abuse or dependence w rehabilitation therapy	0.86
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	1.03
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.48
	TOTAL	2.72
	AVERAGE	0.68

Inpatient Psychiatric Services: Currently most providers are reimbursed at a flat rate of $6,439 per discharge. Due to the critical nature and the lack of access to these services it was determined that inpatient psychiatric services should be treated as a distinct service and reported separately on the Medicare cost report. This allowed reimbursement rates to be set based on cost.

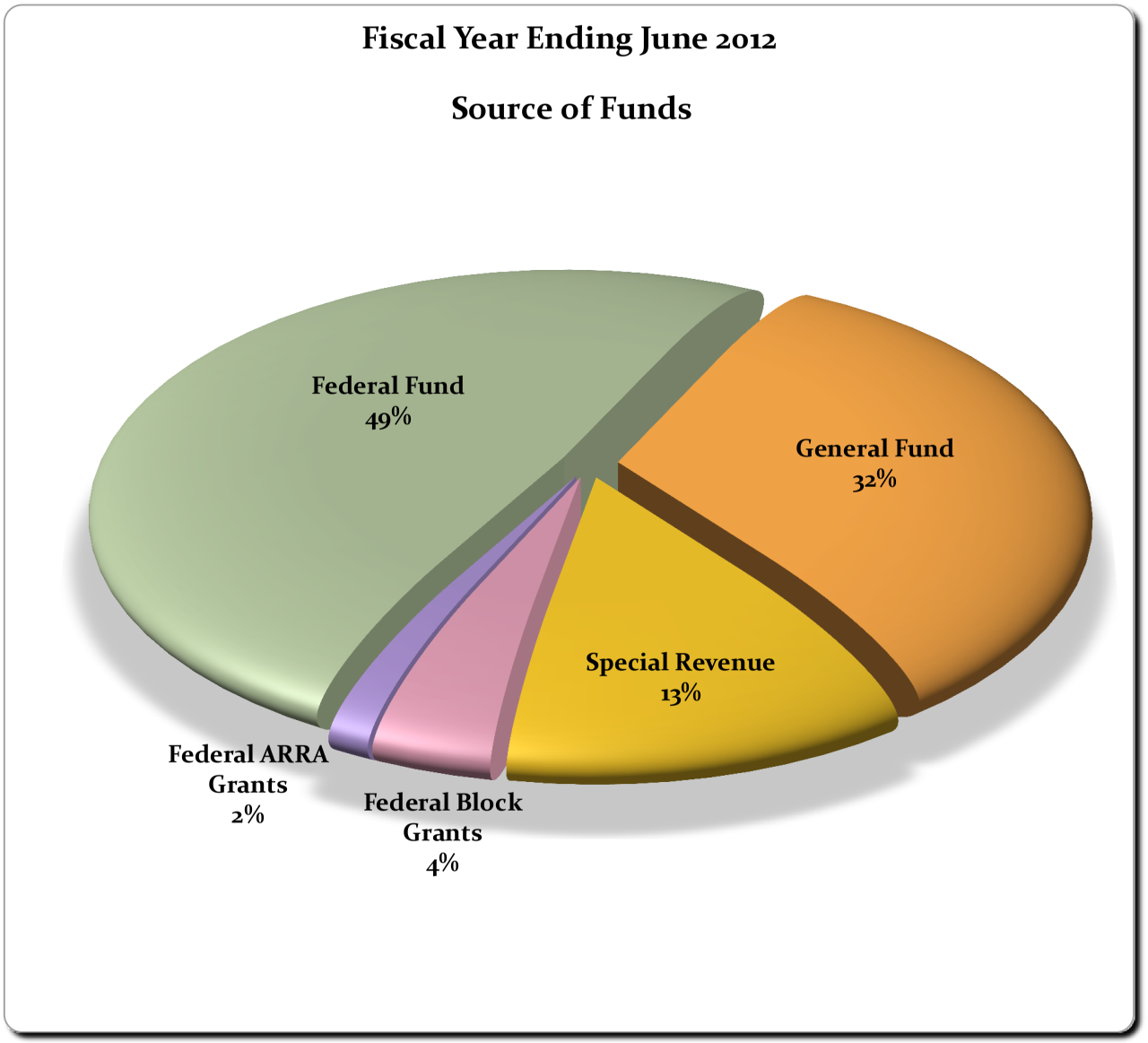
Corrective Action:

The corrective action plan has both a short term and a long term component:

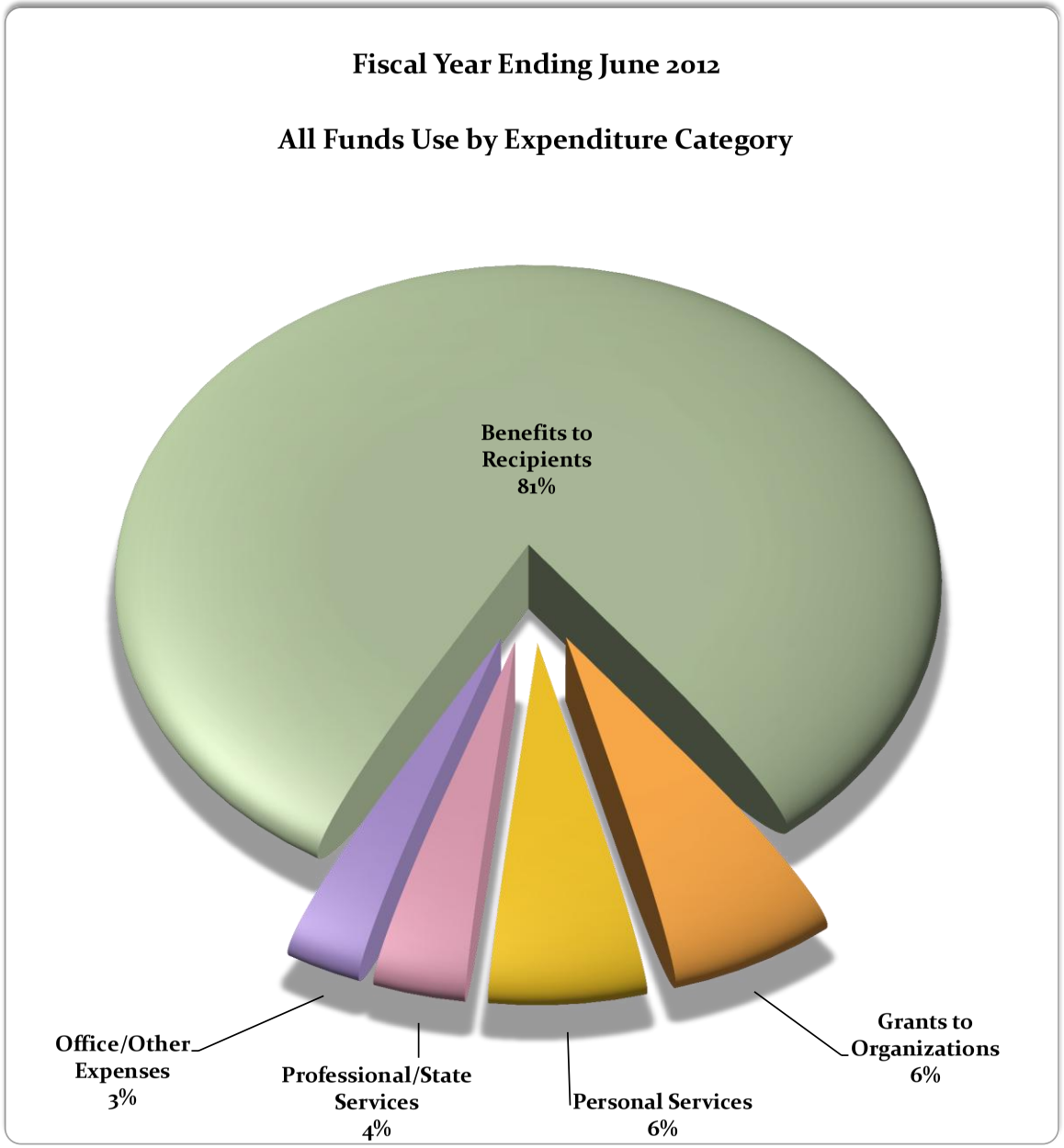
Short Term: Recalculate the inpatient substance abuse rate based on the psychiatric services rate and adjust this rate to account for the difference in average length of stay between the two programs. The average length of stay for inpatient psychiatric treatment is 5.41 days. The average inpatient substance abuse length of stay is 3.02 days or 56% (3.02/5.41). This would increase inpatient substance abuse reimbursement by $447 per case to $3,606 ($6,439 x 56%). St. Mary's and Mercy are the only two facilities who provide this type of service in Maine. These programs deal with complex populations from all over Maine. There is a large population of opiate addicts with co-occurring disorders who are not eligible for a lower level of care. Patients can be admitted on a 24/7 basis. If this change were implemented the total fiscal impact would be approximately $1.5 million annually. This temporary step is necessary in order to deal with the possible closure of Mercy's critical inpatient substance abuse center due to large operating losses. The loss of one of only two inpatient substance abuse providers would have a detrimental impact on access to these services. The provider would need to segregate the cost of inpatient substance abuse on the Medicare cost report.

Long Term: Thoroughly review inpatient DRG claims data to determine the feasibility of equalizing the inpatient psychiatric services rate and the inpatient substance abuse rate by adopting the DRG reimbursement methodology for both services. DHHS will need to determine if the DRG and outlier payments would adequately compensate the provider for inpatient substance abuse and inpatient psychiatric services. At the present time we don't have sufficient claim detail to make this determination.

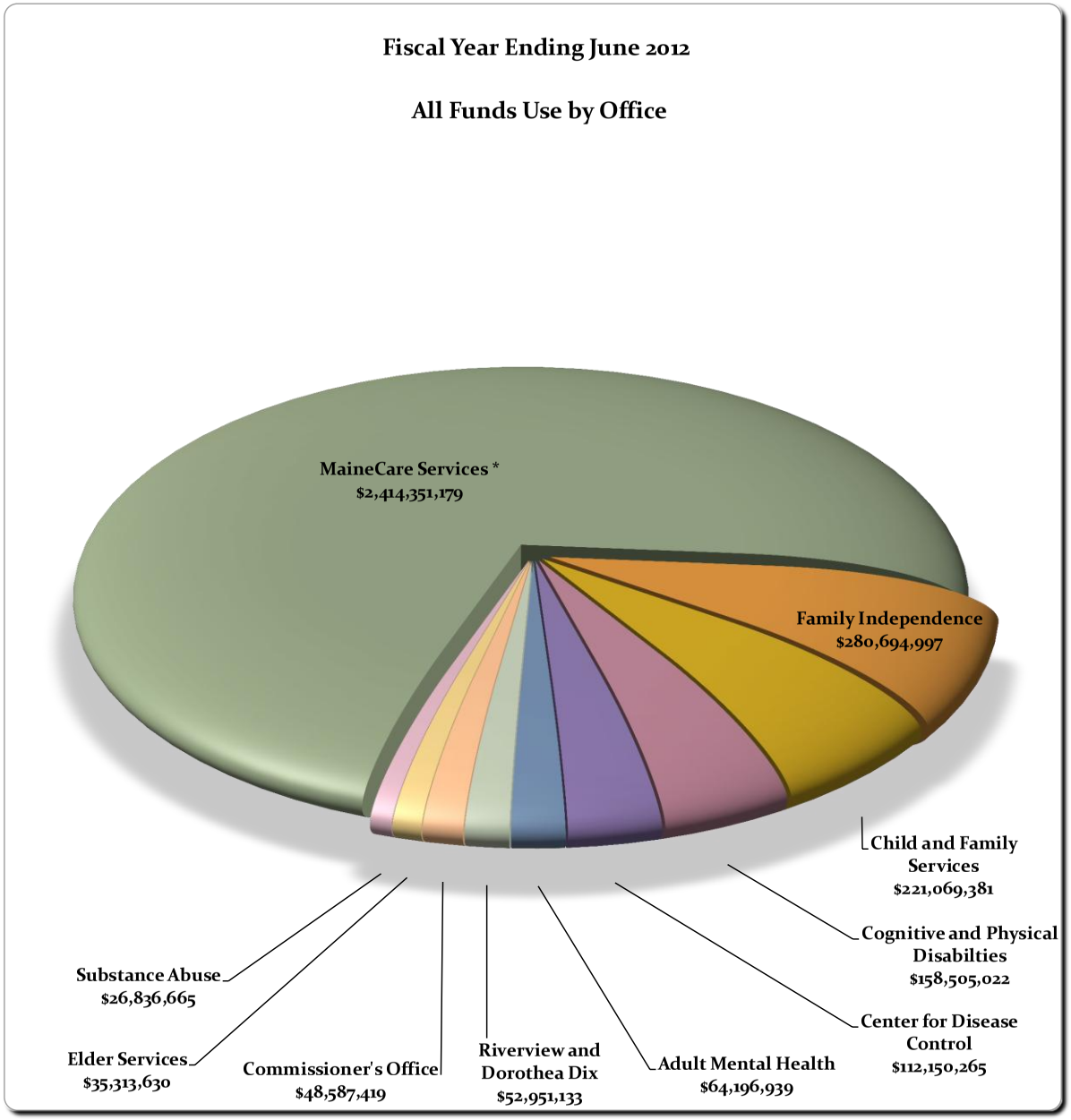
Source	Total Expenditures
Federal Fund	$ 1,666,723,761
General Fund	$ 1,105,080,317
Special Revenue	$ 457,486,009
Federal Block Grants	$ 136,356,339
Federal ARRA Grants	$ 49,010,204
TOTAL	**$3,414,656,630**



Expenditure Category	Total
Benefits to Recipients	$ 2,769,480,844
Grants to Organizations	$ 219,194,497
Personal Services	$ 205,058,051
Professional/State Services	$ 120,564,584
Office/Other Expenses	$ 100,358,654
TOTAL	**$ 3,414,656,630**

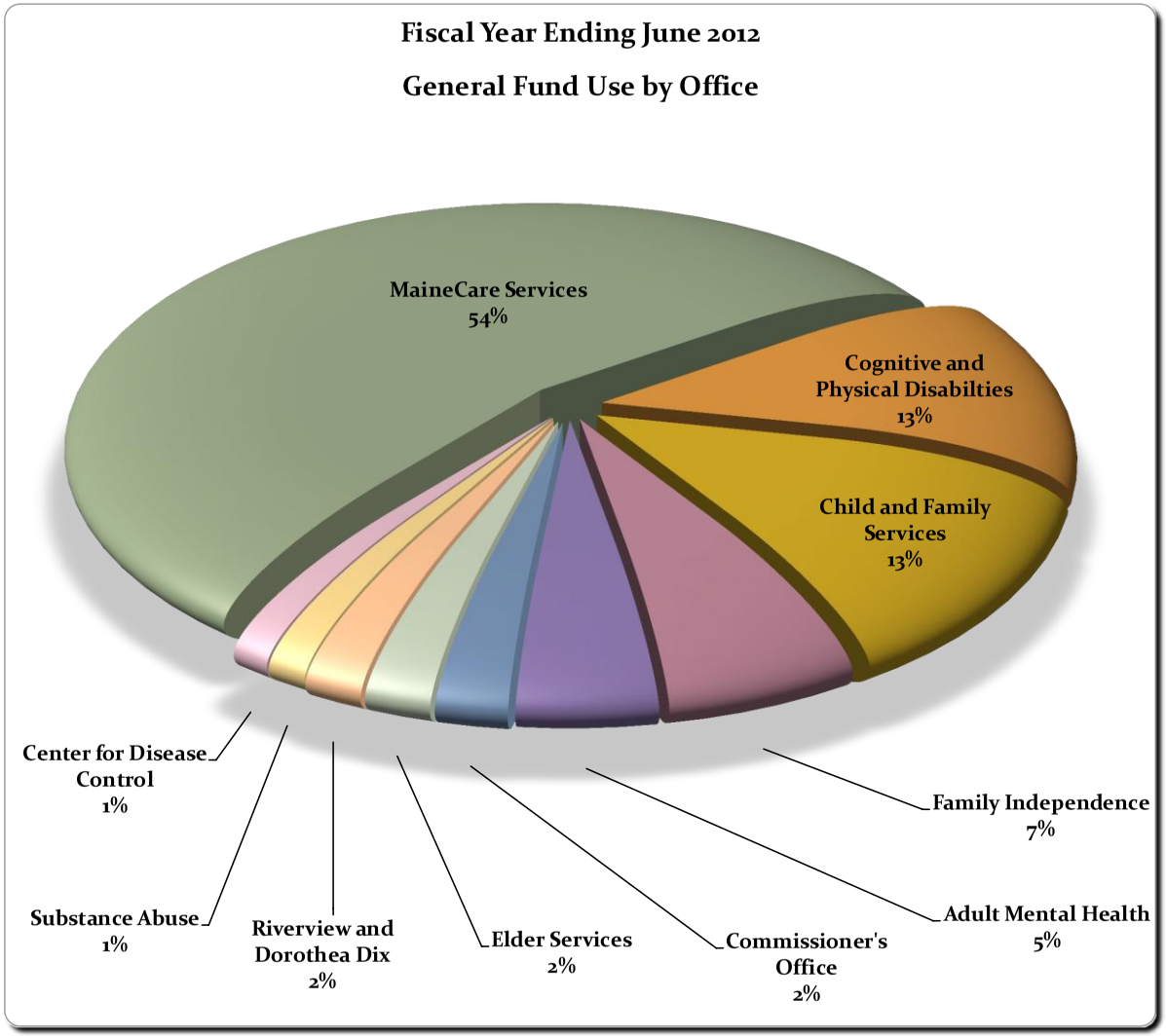


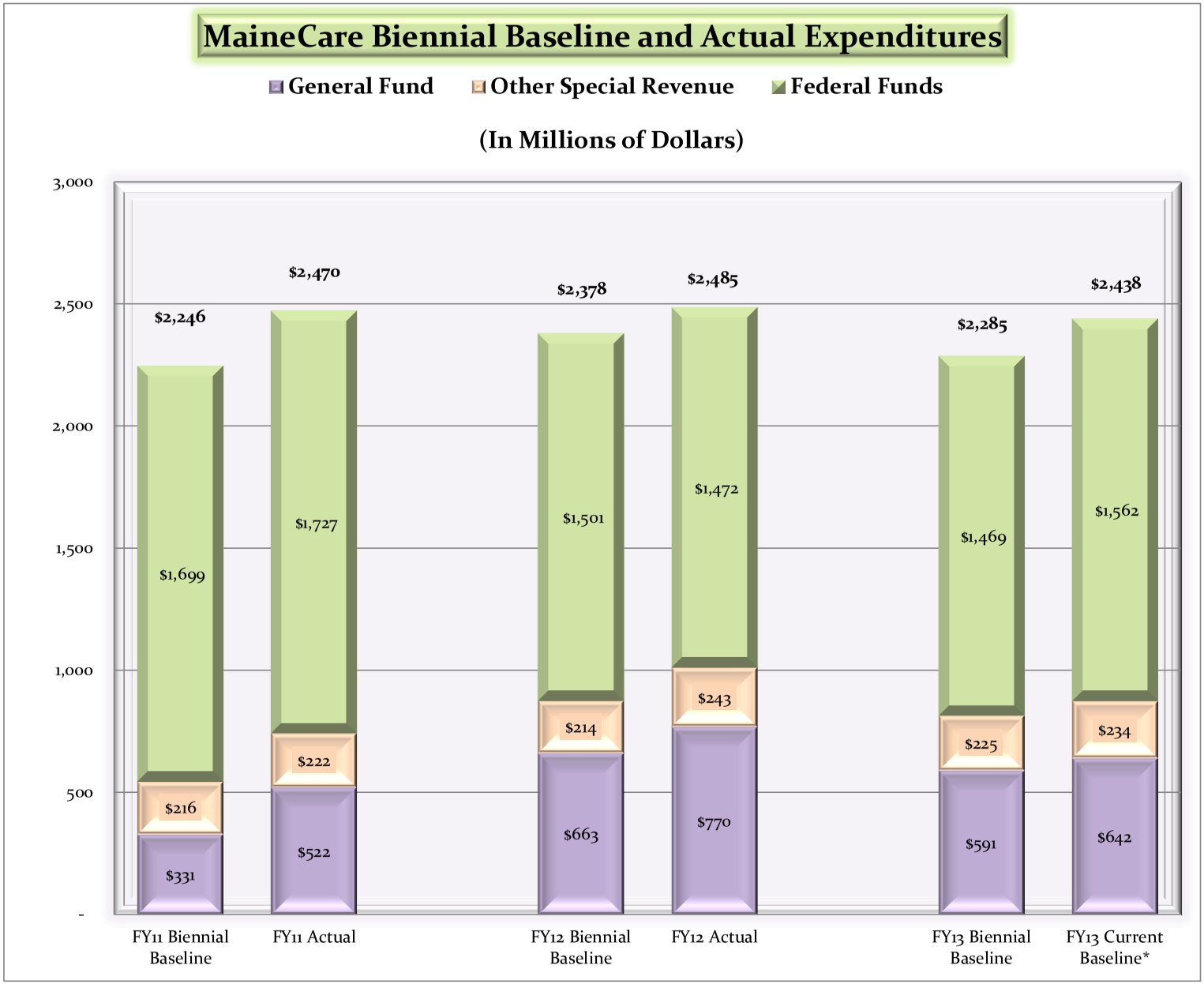
Office	Total
MaineCare Services	$ 2,414,351,179
Family Independence	$ 280,694,997
Child and Family Services	$ 221,069,381
Cognitive and Physical Disabilties	$ 158,505,022
Center for Disease Control	$ 112,150,265
Adult Mental Health	$ 64,196,939
Riverview and Dorothea Dix	$ 52,951,133
Commissioner's Office	$ 48,587,419
Elder Services	$ 35,313,630
Substance Abuse	$ 26,836,665
TOTAL	**$ 3,414,656,630**



*$222 million of Medicaid reimbursements reflected in other DHHS Offices.

Office	General Fund
MaineCare Services	$ 601,360,363
Cognitive and Physical Disabilties	$ 139,465,995
Child and Family Services	$ 138,691,135
Family Independence	$ 71,015,959
Adult Mental Health	$ 51,101,685
Commissioner's Office	$ 26,257,962
Elder Services	$ 24,468,827
Riverview and Dorothea Dix	$ 22,107,533
Substance Abuse	$ 15,505,416
Center for Disease Control	$ 15,105,442
TOTAL	**$ 1,105,080,317**





*Based on the current FMAP rate, this Federal allocation is overstated.

MaineCare Caseload, SFY 2012

Maine Department of Health and Human Services - DHHS Service Center

SFY12	Traditional Medicaid[1]	CHIP		Medicaid Expansion Parents		Childless Adult Waiver[4]	MaineCare AND DEL/ Me Rx[5]	TOTAL	% Change
		Medicaid Expansion[2]	"Cub Care"[2]	101% FPL To 150% FPL[3]	151% FPL To 200% FPL[3]				
Jul-11	251,756	10,307	5,854	21,641	7,692	16,257	43,292	356,799	0.23%
Aug-11	252,163	10,434	5,841	21,809	7,752	15,853	43,610	357,462	0.19%
Sep-11	250,207	10,588	5,834	22,059	7,713	18,957	43,871	359,229	0.49%
Oct-11	251,932	10,874	5,825	22,566	7,862	18,819	43,437	361,315	0.58%
Nov-11	252,087	10,741	5,829	21,884	7,850	18,496	43,667	360,554	-0.21%
Dec-11	253,016	10,943	5,817	21,977	7,929	18,023	43,940	361,645	0.30%
Jan-12	241,530	10,385	5,664	20,709	6,969	15,231	43,959	344,447	-4.76%
Feb-12	243,780	10,216	5,725	20,736	6,990	14,846	44,162	346,455	0.58%
Mar-12	241,720	9,912	5,668	20,471	6,932	14,308	44,174	343,185	-0.94%
Apr-12	241,764	10,106	5,608	20,854	6,867	13,888	44,202	343,289	0.03%
May-12	241,794	10,076	5,642	20,768	6,874	13,460	44,266	342,880	-0.12%
Jun-12	241,404	10,219	5,619	21,020	6,827	13,029	44,313	342,431	-0.13%

[1] Adults and Children in receipt of a financial benefit (TANF, IV-E); Aged and Disabled Persons in receipt of a financial benefit (SSI, SSI Supplement), Institutionalized Persons (NF), and Others not included below

[2] Medicaid Expansion Children (M S-CHIP) are children with family incomes above 125/133%, based on age, and up to and including 150% of the Federal Poverty Level (FPL)
"Cub Care" Children (S S-CHIP) are children with family incomes above 150% and up to and including 200% of FPL.

[3] Persons who function as the primary caretakers of dependent children and whose income is above 100% and up to and including 150% of FPL
Persons who function as the primary caretakers of dependent children and whose income is above 150% and up to and including 200% of FPL.

[4] Persons who are over 21 and under 65, not disabled, not the primary caretakers of dependent children, and whose income is not more than 125% of FPL

[5] Persons eligible for Medicaid, but not for "full benefits" (e. g., QMBY, SLMB, QI) who meet the criteria for participation in DEL and/ or Maine Rx

DEL/ ME Rx Caseload, SFY 2012

Maine Department of Health and Human Services - DHHS Service Center

SFY 2012	MaineCare Eligible				NOT MaineCare Eligible				Grand Total			
	ME Rx only	DEL and ME Rx	DEL only	TOTAL	ME Rx only	DEL and ME Rx	DEL only	TOTAL	ME Rx only	DEL and ME Rx	DEL only	TOTAL
July-11	0	43,430	0	43,430	0	51,783	0	51,783	0	95,213	0	95,213
August-11	0	43,810	0	43,810	0	52,496	0	52,496	0	96,306	0	96,306
September-11	0	43,871	0	43,871	0	51,174	0	51,174	0	95,045	0	95,045
October-11	0	43,437	0	43,437	0	52,501	0	52,501	0	95,938	0	95,938
November-11	0	43,667	0	43,667	0	53,875	0	53,875	0	97,542	0	97,542
December-11	0	43,940	0	43,940	0	54,831	0	54,831	0	98,771	0	98,771
January-12	0	43,959	0	43,959	0	50,322	0	50,322	0	94,281	0	94,281
February-12	0	44,162	0	44,162	0	51,738	0	51,738	0	95,900	0	95,900
March-12	0	44,174	0	44,174	0	50,966	0	50,966	0	95,140	0	95,140
April-12	0	44,202	0	44,202	0	50,966	0	50,966	0	95,168	0	95,168
May-12	0	44,266	0	44,266	0	51,906	0	51,906	0	96,172	0	96,172
June-12	0	44,313	0	44,313	0	52,209	0	52,209	0	96,522	0	96,522

MaineCare Cycle Summary for FY 2011

For Week **52**

WEEK #	MECMS CYCLE TOTAL	MIHMS CYCLE TOTAL	MEPOPS CYCLE TOTAL	CYCLE TOTAL
1	42,598,144.73	-	4,131,805.22	46,729,949.95
2	38,730,447.44	-	3,702,972.02	42,433,419.46
3	36,956,689.87	-	3,927,731.58	40,884,421.45
4	33,240,241.68	-	3,925,746.46	37,165,988.14
5	32,795,389.03	-	4,050,024.55	36,845,413.58
6	45,049,051.97	-	3,834,000.79	48,883,052.76
7	36,195,804.45	-	3,712,309.03	39,908,113.48
8	33,201,470.60	-	3,946,004.24	37,147,474.84
9	30,342,496.22	-	3,941,735.11	34,284,231.33
10	42,974,074.60	143,185.14	3,994,709.46	47,111,969.20
11	25,793,607.82	8,392,094.49	3,669,653.59	37,855,355.90
12	15,946,352.60	10,724,949.74	4,023,896.06	30,695,198.40
13	8,997,223.69	14,039,758.37	4,032,936.62	27,069,918.68
14	8,719,368.64	16,295,100.28	3,882,582.65	28,897,051.57
15	4,202,939.31	33,261,858.48	4,049,439.03	41,514,236.82
16	4,866,349.03	21,714,828.07	3,848,084.84	30,429,261.94
17	4,051,107.69	13,595,733.58	3,876,998.00	21,523,839.27
18	2,928,106.60	31,296,523.78	5,638,517.95	39,863,148.33
19	2,675,246.80	39,268,775.59	4,296,081.00	46,240,103.39
20	2,234,343.54	36,778,458.33	4,184,998.00	43,197,799.87
21	2,737,660.21	41,150,228.69	4,142,923.56	48,030,812.46
22	1,775,565.46	28,885,804.32	4,257,239.30	34,918,609.08
23	1,532,905.67	34,146,982.88	3,894,449.09	39,574,337.64
24	2,347,668.97	44,021,626.00	4,226,075.81	50,595,370.78
25	1,706,630.62	35,589,511.39	4,314,896.00	41,611,038.01
26	2,189,475.50	30,110,881.25	4,532,687.20	36,833,043.95
27	945,597.66	29,330,613.42	3,395,640.66	33,671,851.74
28	1,228,714.55	40,517,673.05	4,264,833.00	46,011,220.60
29	2,315,532.47	46,467,397.01	4,288,648.73	53,071,578.21
30	1,224,287.02	37,705,473.03	4,531,239.16	43,460,999.21
31	4,475,108.84	34,236,684.39	4,496,335.57	43,208,128.80
32	1,800,840.10	43,808,188.90	4,321,119.59	49,930,148.59
33	5,049,157.50	42,558,973.79	4,845,907.02	52,454,038.31
34	3,777,649.01	45,039,936.04	4,598,765.40	53,416,350.45
35	-	38,202,554.54	4,307,848.48	42,510,403.02
36	-	45,889,235.11	4,881,384.30	50,770,619.41
37	-	255,886,640.30	4,632,928.64	260,519,568.94
38	-	50,197,833.82	4,550,121.47	54,747,955.29
39	-	22,895,419.34	4,431,670.64	27,327,089.98
40	-	31,922,810.29	4,437,062.82	36,359,873.11
41	-	55,986,165.33	4,742,787.39	60,728,952.72
42	-	44,901,766.38	4,740,465.51	49,642,231.89
43	-	28,391,222.71	4,281,267.21	32,672,489.92
44	-	24,497,079.61	4,503,434.57	29,000,514.18
45	-	47,605,905.74	4,670,673.66	52,276,579.40
46	-	34,547,800.07	4,457,505.41	39,005,305.48
47	-	29,789,158.69	4,549,648.35	34,338,807.04
48	-	30,890,578.94	4,477,605.25	35,368,184.19
49	-	39,761,304.39	4,043,687.33	43,804,991.72
50	-	35,915,466.58	4,693,236.94	40,608,703.52
51	-	32,667,418.20	4,470,328.86	37,137,747.06
52	-	31,088,124.39	4,433,443.70	35,521,568.09
53	-	-	-	-
GRAND-TOTAL	485,605,249.89	1,640,117,724.44	222,086,086.82	2,347,809,061.15
AVERAGE CYCLE FOR SFY11	9,338,562.50	39,050,422.01	4,270,886.29	45,150,174.25

Average Cycle less Hospital Settlement Impact				
	MECMS	***MIHMS***	***MEPOPS***	***Total***
Total YTD (from above)	485,605,249.89	1,640,117,724.44	222,086,086.82	2,347,809,061.15
Less: Hospital Settlements	-	248,527,119.00	-	248,527,119.00
Net Total YTD Cycle Payments	485,605,249.89	1,391,590,605.44	222,086,086.82	2,099,281,942.15
Average Weekly Cycle	9,338,562.50	39,050,422.01	4,270,886.29	45,150,174.25
Avg Cycle less Hospital Settlements	14,282,507.35	26,761,357.80	4,270,886.29	40,370,806.58

MaineCare Cycle Summary for FY 2012

For Week **52**

WEEK #	MIHMS CYCLE TOTAL	MEPOPS CYCLE TOTAL	CYCLE TOTAL
1	30,019,320.79	5,189,597.77	35,208,918.56
2	46,382,984.44	3,352,652.55	49,735,636.99
3	30,134,911.81	4,533,142.51	34,668,054.32
4	35,060,143.63	4,476,661.50	39,536,805.13
5	35,528,517.89	4,309,088.39	39,837,606.28
6	55,681,875.77	4,644,198.73	60,326,074.50
7	40,699,745.69	4,392,078.11	45,091,823.80
8	39,713,798.35	4,364,771.78	44,078,570.13
9	31,936,812.14	4,214,302.98	36,151,115.12
10	44,313,066.03	4,433,422.94	48,746,488.97
11	35,009,680.72	4,251,486.91	39,261,167.63
12	40,883,494.88	4,660,049.40	45,543,544.28
13	24,917,063.90	4,580,803.68	29,497,867.58
14	32,058,932.32	4,763,713.72	36,822,646.04
15	51,594,616.58	4,635,503.87	56,230,120.45
16	42,622,023.35	4,482,032.55	47,104,055.90
17	38,024,813.59	4,600,518.86	42,625,332.45
18	36,617,040.01	4,634,538.04	41,251,578.05
19	55,911,512.03	4,653,086.40	60,564,598.43
20	42,275,267.97	4,686,746.00	46,962,013.97
21	41,058,178.08	4,652,191.70	45,710,369.78
22	32,302,096.98	4,793,469.87	37,095,566.85
23	35,971,155.20	4,421,496.82	40,392,652.02
24	54,358,473.14	4,969,133.92	59,327,607.06
25	43,809,311.05	4,719,276.50	48,528,587.55
26	32,338,562.08	4,671,412.38	37,009,974.46
27	29,842,228.75	4,268,564.06	34,110,792.81
28	52,721,438.94	4,412,657.30	57,134,096.24
29	40,417,421.75	3,899,529.11	44,316,950.86
30	33,125,137.15	5,553,241.93	38,678,379.08
31	39,134,446.13	-	39,134,446.13
32	49,890,937.25	11,031,644.69	60,922,581.94
33	47,601,984.79	6,057,755.83	53,659,740.62
34	31,826,166.42	4,966,465.44	36,792,631.86
35	34,237,326.94	4,921,977.64	39,159,304.58
36	44,064,703.57	5,489,841.21	49,554,544.78
37	38,474,431.86	5,490,266.83	43,964,698.69
38	41,728,465.63	5,204,097.25	46,932,562.88
39	30,673,054.10	4,969,776.21	35,642,830.31
40	23,331,989.39	5,204,801.96	28,536,791.35
41	56,939,739.84	4,999,010.24	61,938,750.08
42	45,741,967.25	4,792,575.96	50,534,543.21
43	39,668,444.14	4,545,779.15	44,214,223.29
44	39,950,891.86	4,642,879.08	44,593,770.94
45	51,453,028.43	4,761,134.99	56,214,163.42
46	42,492,073.91	4,762,043.78	47,254,117.69
47	44,811,585.03	4,571,146.15	49,382,731.18
48	34,939,785.33	4,943,445.98	39,883,231.31
49	30,199,896.32	4,277,958.72	34,477,855.04
50	58,310,926.67	4,783,546.47	63,094,473.14
51	40,593,470.30	4,574,528.43	45,167,998.73
52	37,830,936.75	4,656,067.14	42,487,003.89
			-
GRAND-TOTAL	2,089,225,876.92	245,866,113.43	2,335,091,990.35
AVERAGE CYCLE FOR SFY12	40,177,420.71	4,728,194.49	44,905,615.20

Average Cycle less Hospital Settlement Impact			
	MIHMS	***MEPOPS***	***Total***
Total YTD (from above)	2,089,225,876.92	245,866,113.43	2,335,091,990.35
Less: Hospital Settlements	-	-	0.00
Net Total YTD Cycle Payments	2,089,225,876.92	245,866,113.43	2,335,091,990.35

Average Weekly Cycle	40,177,420.71	4,728,194.49	44,905,615.20
Avg Cycle less Hospital Settlements	40,177,420.71	4,728,194.49	44,905,615.20

generated by DHHS Service Center

GENERAL FUND - YTD

Expenditure Object Catagories	OBJECT CODE	OBJECT_DESC	FISC_YR 2008 AMOUNT	Values % OF FY TOTAL	2009 AMOUNT	% OF FY TOTAL	% FY CHANGE	2010 AMOUNT	% OF FY TOTAL	% FY CHANGE	2011 AMOUNT	% OF FY TOTAL	% FY CHANGE	2012 AMOUNT	% OF FY TOTAL	% FY CHANGE	Total % OF FY TOTAL
HOSPITAL	**6720**	INPATIENT	14,260,167	1.72%	21,311,923	2.71%	49.5%	13,397,633	2.04%	(37.1%)	18,146,018	2.44%	35.4%	56,537,961	5.56%	211.6%	3.07%
	6721	OUTPATIENT	2,520,164	0.30%	2,898,327	0.37%	15.0%	9,793,428	1.49%	237.9%	8,122,196	1.09%	(17.1%)	9,225,311	0.91%	13.6%	0.81%
	6726	PIP	155,742,068	18.77%	144,624,658	18.40%	(7.1%)	107,435,585	16.39%	(25.7%)	98,312,536	13.23%	(8.5%)	110,111,579	10.83%	12.0%	15.28%
HOSPITAL Total			**172,522,400**	**20.80%**	**168,834,907**	**21.48%**	**(2.1%)**	**130,626,646**	**19.93%**	**(22.6%)**	**124,580,749**	**16.76%**	**(4.6%)**	**175,874,851**	**17.29%**	**41.2%**	**19.16%**
RESIDENTIAL	**6705**	BOARDING HOME CARE	4,618,108	0.56%	3,892,310	0.50%	(15.7%)	3,442,458	0.53%	(11.6%)	3,540,369	0.48%	2.8%	(6,083,401)	-0.60%	(271.8%)	0.23%
	6706	RESIDENT DIAGNO AND TREAT	84,323,255	10.16%	71,539,191	9.10%	(15.2%)	54,137,154	8.26%	(24.3%)	52,678,495	7.09%	(2.7%)	77,668,563	7.64%	47.4%	8.44%
	6725	INTR CARE FAC CARE	89,899,025	10.84%	77,978,841	9.92%	(13.3%)	62,781,737	9.58%	(19.5%)	52,802,777	7.10%	(15.9%)	81,550,804	8.02%	54.4%	9.05%
	6729	MR GROUP CARE - ICF	11,887,750	1.43%	11,047,146	1.41%	(7.1%)	9,756,163	1.49%	(11.7%)	9,911,231	1.33%	1.6%	14,946,797	1.47%	50.8%	1.43%
	6766	PERSONAL CARE SERVICES	18,539,877	2.23%	17,685,793	2.25%	(4.6%)	14,085,177	2.15%	(20.4%)	17,891,000	2.41%	27.0%	27,464,539	2.70%	53.5%	2.37%
RESIDENTIAL Total			**209,268,015**	**25.23%**	**182,143,281**	**23.17%**	**(13.0%)**	**144,202,689**	**22.00%**	**(20.8%)**	**136,823,872**	**18.41%**	**(5.1%)**	**195,547,303**	**19.23%**	**42.9%**	**21.53%**
HCBS WAIVERS	**6772**	DD WAIVER	102,428,764	12.35%	108,240,083	13.77%	5.7%	77,567,893	11.83%	(28.3%)	75,098,701	10.10%	(3.2%)	113,120,240	11.12%	50.6%	11.82%
	6778	BME(ELDERLY) WAIVER	7,037,671	0.85%	7,441,404	0.95%	5.7%	5,703,418	0.87%	(23.4%)	2,865,648	0.39%	(49.8%)	3,160,239	0.31%	10.3%	0.65%
	6786	PCA(PHYSICALLY DISABLED) WAIVER	2,213,200	0.27%	1,817,357	0.23%	(17.9%)	1,296,967	0.20%	(28.6%)	1,010,682	0.14%	(22.1%)	3,508,623	0.34%	247.2%	0.24%
HCBS WAIVERS Total			**111,679,635**	**13.46%**	**117,498,844**	**14.95%**	**5.2%**	**84,568,278**	**12.90%**	**(28.0%)**	**78,975,031**	**10.62%**	**(6.6%)**	**119,789,101**	**11.78%**	**51.7%**	**12.71%**
PHARMACY	**6780**	PRESCRIPTION DRUGS	74,233,990	8.95%	70,362,588	8.95%	(5.2%)	54,785,669	8.36%	(22.1%)	61,826,821	8.32%	12.9%	83,505,004	8.21%	35.1%	8.55%
	6781	DME SUPPLIES	6,375,160	0.77%	6,961,549	0.89%	9.2%	5,191,226	0.79%	(25.4%)	4,080,133	0.55%	(21.4%)	7,366,209	0.72%	80.5%	0.74%
PHARMACY Total			**80,609,150**	**9.72%**	**77,324,137**	**9.84%**	**(4.1%)**	**59,976,895**	**9.15%**	**(22.4%)**	**65,906,954**	**8.87%**	**9.9%**	**90,871,213**	**8.93%**	**37.9%**	**9.29%**
S S A HEALTH INSURANCE	**6602**	S S A HEALTH INSURANCE	74,520,616	8.98%	76,689,022	9.76%	2.9%	29,528,635	4.50%	(61.5%)	59,442,203	8.00%	101.3%	90,631,975	8.91%	52.5%	8.21%
S S A HEALTH INSURANCE Total			**74,520,616**	**8.98%**	**76,689,022**	**9.76%**	**2.9%**	**29,528,635**	**4.50%**	**(61.5%)**	**59,442,203**	**8.00%**	**101.3%**	**90,631,975**	**8.91%**	**52.5%**	**8.21%**
MEDICAL PROFESSIONALS	**6740**	MEDICAL DOCTOR SERVICES	28,937,912	3.49%	29,163,274	3.71%	0.8%	25,713,774	3.92%	(11.8%)	25,313,969	3.41%	(1.6%)	41,282,222	4.06%	63.1%	3.73%
	6745	NURSE PRACTITIONER	170,361	0.02%	411,065	0.05%	141.3%	461,844	0.07%	12.4%	2,797,453	0.38%	505.7%	7,554,828	0.74%	170.1%	0.28%
	6759	NURSE MIDWIFERY	40,044	0.00%	37,346	0.00%	(6.7%)	29,631	0.00%	(20.7%)	256,485	0.03%	765.6%	840,263	0.08%	227.6%	0.03%
	6765	PRIVATE DUTY NURSING	2,743,806	0.33%	2,307,431	0.29%	(15.9%)	1,678,233	0.26%	(27.3%)	3,092,958	0.42%	84.3%	4,956,187	0.49%	60.2%	0.37%
MEDICAL PROFESSIONALS Total			**31,892,124**	**3.84%**	**31,919,116**	**4.06%**	**0.1%**	**27,883,482**	**4.25%**	**(12.6%)**	**31,460,866**	**4.23%**	**12.8%**	**54,633,500**	**5.37%**	**73.7%**	**4.41%**
DED & CO-INS FOR DUALS	**6733**	PART A	3	0.00%	(6,321)	0.00%	(183303.5%)	(1,758)	0.00%	(72.2%)	4,648,057	0.63%	(264460.0%)	13,634,036	1.34%	193.3%	0.45%
	6734	PART B	194	0.00%	(23,567)	0.00%	(12239.4%)	(107)	0.00%	(99.5%)	12,777,834	1.72%	(11893095.5%)	40,398,307	3.97%	216.2%	1.32%
DED & CO-INS FOR DUALS Total			**198**	**0.00%**	**(29,888)**	**0.00%**	**(15226.2%)**	**(1,866)**	**0.00%**	**(93.8%)**	**17,425,891**	**2.34%**	**(934128.6%)**	**54,032,343**	**5.31%**	**210.1%**	**1.77%**
BEHAVIORAL HEALTH CLINICIAN	**6774**	BEHAVIORAL HEALTH CLINICIAN	28,703,152	3.46%	29,209,361	3.72%	1.8%	24,864,200	3.79%	(14.9%)	26,701,600	3.59%	7.4%	45,111,996	4.44%	68.9%	3.83%
BEHAVIORAL HEALTH CLINICIAN Total			**28,703,152**	**3.46%**	**29,209,361**	**3.72%**	**1.8%**	**24,864,200**	**3.79%**	**(14.9%)**	**26,701,600**	**3.59%**	**7.4%**	**45,111,996**	**4.44%**	**68.9%**	**3.83%**
CLINIC	**6730**	AMBULATORY AGENCY SERVICE		0.00%	15,547	0.00%		29,568	0.00%	90.2%	4,228	0.00%	(85.7%)	1,218	0.00%	(71.2%)	0.00%
	6732	MENTAL HEALTH CTR SER	4,319,465	0.52%	4,363,357	0.56%	1.0%	4,023,130	0.61%	(7.8%)	3,731,011	0.50%	(7.3%)	5,442,252	0.54%	45.9%	0.54%
	6735	FAMILY PLNG CLINICS	125,737	0.02%	137,636	0.02%	9.5%	151,680	0.02%	10.2%	(57,681)	-0.01%	(138.0%)	126	0.00%	(100.2%)	0.01%
	6737	SPEECH & HEARING CLINICS	407,064	0.05%	359,805	0.05%	(11.6%)	324,855	0.05%	(9.7%)	47,533	0.01%	(85.4%)	1,105	0.00%	(97.7%)	0.03%
	6738	RURAL HEALTH CLINICS	4,338,886	0.52%	4,345,949	0.55%	0.2%	3,333,284	0.51%	(23.3%)	3,018,217	0.41%	(9.5%)	3,775,979	0.37%	25.1%	0.47%
	6739	OTHER CLINICS	91,513	0.01%	72,535	0.01%	(20.7%)	74,008	0.01%	2.0%	109,162	0.01%	47.5%	76,033	0.01%	(30.3%)	0.01%
	6798	FEDERALLY QUALIFIED HEALTH CAR	12,312,621	1.48%	12,135,841	1.54%	(1.4%)	10,185,549	1.55%	(16.1%)	10,105,316	1.36%	(0.8%)	14,578,386	1.43%	44.3%	1.47%
	67A0	DEV & BEHAV CLINIC SERV	338,310	0.04%	250,195	0.03%	(26.0%)	225,119	0.03%	(10.0%)	5,399,618	0.73%	2298.6%	15,349,446	1.51%	184.3%	0.53%
CLINIC Total			**21,933,597**	**2.64%**	**21,680,866**	**2.76%**	**(1.2%)**	**18,347,193**	**2.80%**	**(15.4%)**	**22,357,405**	**3.01%**	**21.9%**	**39,224,546**	**3.86%**	**75.4%**	**3.06%**
REHAB SERVICES	**6717**	ADJ OR REMEDIAL TRAINING	13,745,117	1.66%	10,657,514	1.36%	(22.5%)	8,323,173	1.27%	(21.9%)	9,030,625	1.21%	8.5%	15,492,673	1.52%	71.6%	1.42%
	6747	REHABILITATIVE SERVICES	3,716,346	0.45%	3,409,715	0.43%	(8.3%)	2,955,653	0.45%	(13.3%)	1,335,297	0.18%	(54.8%)	4,307,481	0.42%	222.6%	0.39%
	6763	OCCUPATIONAL THERAPY	466,695	0.06%	484,447	0.06%	3.8%	429,471	0.07%	(11.3%)	407,855	0.05%	(5.0%)	668,362	0.07%	63.9%	0.06%
	6771	PHYSICAL THERAPY	455,856	0.05%	344,318	0.04%	(24.5%)	274,909	0.04%	(20.2%)	320,591	0.04%	16.6%	450,223	0.04%	40.4%	0.05%
	6776	SPEECH THERAPY	693,922	0.08%	723,881	0.09%	4.3%	663,225	0.10%	(8.4%)	991,128	0.13%	49.4%	1,442,672	0.14%	45.6%	0.11%
REHAB SERVICES Total			**19,077,936**	**2.30%**	**15,619,875**	**1.99%**	**(18.1%)**	**12,646,431**	**1.93%**	**(19.0%)**	**12,085,495**	**1.63%**	**(4.4%)**	**22,361,412**	**2.20%**	**85.0%**	**2.03%**
TRANSPORTATION	**6791**	AMBULANCE	2,608,623	0.31%	2,595,776	0.33%	(0.5%)	6,817,253	1.04%	162.6%	2,846,558	0.38%	(58.2%)	3,558,560	0.35%	25.0%	0.46%
	6792	OTHER TRANSPORTATION	12,715,358	1.53%	15,168,409	1.93%	19.3%	10,242,462	1.56%	(32.5%)	10,617,667	1.43%	3.7%	14,044,034	1.38%	32.3%	1.56%
TRANSPORTATION Total			**15,323,981**	**1.85%**	**17,764,184**	**2.26%**	**15.9%**	**17,059,715**	**2.60%**	**(4.0%)**	**13,464,226**	**1.81%**	**(21.1%)**	**17,602,594**	**1.73%**	**30.7%**	**2.01%**
CASE MANAGEMENT	**6748**	CASE MANAGEMENT	9,909,320	1.19%	9,799,312	1.25%	(1.1%)	8,340,949	1.27%	(14.9%)	9,071,154	1.22%	8.8%	13,511,742	1.33%	49.0%	1.26%
CASE MANAGEMENT Total			**9,909,320**	**1.19%**	**9,799,312**	**1.25%**	**(1.1%)**	**8,340,949**	**1.27%**	**(14.9%)**	**9,071,154**	**1.22%**	**8.8%**	**13,511,742**	**1.33%**	**49.0%**	**1.26%**
DENTISTRY	**6750**	GENERAL DENTISTRY	9,087,659	1.10%	9,219,833	1.17%	1.5%	8,477,956	1.29%	(8.0%)	9,105,105	1.22%	7.4%	12,303,015	1.21%	35.1%	1.20%
	6752	ORTHODONTIA	184,167	0.02%	113,585	0.01%	(38.3%)	86,935	0.01%	(23.5%)	10,617	0.00%	(87.8%)	3,336	0.00%	(68.6%)	0.01%
DENTISTRY Total			**9,271,826**	**1.12%**	**9,333,419**	**1.19%**	**0.7%**	**8,564,891**	**1.31%**	**(8.2%)**	**9,115,721**	**1.23%**	**6.4%**	**12,306,351**	**1.21%**	**35.0%**	**1.21%**
CERTIFIED SEED	**6796**	EARLY INTERVENTION SERVICES	5,891,729	0.71%	6,002,055	0.76%	1.9%	4,305,300	0.66%	(28.3%)	1,201,716	0.16%	(72.1%)	2,822,110	0.28%	134.8%	0.50%
	67A3	CERTIFIED SEED - SCHOOL REHAB		0.00%		0.00%		210,673	0.03%		11,977	0.00%	(94.3%)	3,497,098	0.34%	29099.1%	0.09%
CERTIFIED SEED Total			**5,891,729**	**0.71%**	**6,002,055**	**0.76%**	**1.9%**	**4,515,973**	**0.69%**	**(24.8%)**	**1,213,693**	**0.16%**	**(73.1%)**	**6,319,208**	**0.62%**	**420.7%**	**0.59%**
DAY TREATMENT SERVICES	**67C0**	DAY TREATMENT SERVICES	223,347	0.03%	77,127	0.01%	(65.5%)	60,190	0.01%	(22.0%)	(10,314)	0.00%	(117.1%)	5,952,194	0.59%	(57808.2%)	0.16%
DAY TREATMENT SERVICES Total			**223,347**	**0.03%**	**77,127**	**0.01%**	**(65.5%)**	**60,190**	**0.01%**	**(22.0%)**	**(10,314)**	**0.00%**	**(117.1%)**	**5,952,194**	**0.59%**	**(57808.2%)**	**0.16%**
LABORTORY SERVICES	**6790**	LABORATORY SERVICES	3,388,447	0.41%	3,715,000	0.47%	9.6%	3,361,071	0.51%	(9.5%)	3,894,411	0.52%	15.9%	5,432,649	0.53%	39.5%	0.49%
LABORTORY SERVICES Total			**3,388,447**	**0.41%**	**3,715,000**	**0.47%**	**9.6%**	**3,361,071**	**0.51%**	**(9.5%)**	**3,894,411**	**0.52%**	**15.9%**	**5,432,649**	**0.53%**	**39.5%**	**0.49%**
HOME HEALTH	**6761**	HOME HEALTH SERVICES	1,619,028	0.20%	1,554,088	0.20%	(4.0%)	1,043,917	0.16%	(32.8%)	1,977,205	0.27%	89.4%	3,574,046	0.35%	80.8%	0.24%
	6767	ATTENDANT SERVICES	1,367,034	0.16%	1,200,901	0.15%	(12.2%)	968,429	0.15%	(19.4%)	247,176	0.03%	(74.5%)	30,743	0.00%	(87.6%)	0.09%
	6788	DAY HEALTH SERVICES	211,417	0.03%	97,525	0.01%	(53.9%)	67,245	0.01%	(31.0%)	78,727	0.01%	17.1%	155,706	0.02%	97.8%	0.02%
	67F6	ASSISTED LIVING SERVICES	996,349	0.12%	913,177	0.12%	(8.3%)	107,375	0.02%	(88.2%)	21,317	0.00%	(80.1%)	7,085	0.00%	(66.8%)	0.05%
HOME HEALTH Total			**4,193,829**	**0.51%**	**3,765,690**	**0.48%**	**(10.2%)**	**2,186,966**	**0.33%**	**(41.9%)**	**2,324,425**	**0.31%**	**6.3%**	**3,767,580**	**0.37%**	**62.1%**	**0.40%**
INSURANCE	**4851**	MISC INSURANCE	555,099	0.07%	1,017,618	0.13%	83.3%	1,336,383	0.20%	31.3%	36,468	0.00%	(97.3%)	(4,397)	0.00%	(112.1%)	0.07%
	6550	HEALTH INSURANCE		0.00%		0.00%			0.00%		532,302	0.07%		611,523	0.06%	14.9%	0.03%
INSURANCE Total			**555,099**	**0.07%**	**1,017,618**	**0.13%**	**83.3%**	**1,336,383**	**0.20%**	**31.3%**	**568,769**	**0.08%**	**(57.4%)**	**607,126**	**0.06%**	**6.7%**	**0.10%**
OTHER			30,613,833	3.69%	13,734,728	1.75%	(55.1%)	77,436,850	11.81%	463.8%	127,919,176	17.21%	65.2%	63,546,713	6.25%	(50.3%)	7.77%
Grand Total			**829,578,230**	**100.00%**	**786,098,654**	**100.00%**	**(5.2%)**	**655,505,571**	**100.00%**	**(16.6%)**	**743,321,329**	**100.00%**	**13.4%**	**1,017,124,398**	**100.00%**	**36.8%**	**100.00%**

FUND	(All)
FISC_YR	2012

ALL FUNDS - MaineCare and Related Spending Year to Date FY 2012 BY QUARTER

			FISC_QTR	-										
			1		2			3			4			Total % OF QUARTER
Expenditure Object Catagories	OBJECT CODE	OBJECT_DESC	AMOUNT	% OF QUARTER TOTAL	AMOUNT	% OF QUARTER TOTAL	% OF QUARTER CHANGE	AMOUNT	% OF QUARTER TOTAL	% OF QUARTER CHANGE	AMOUNT	% OF QUARTER TOTAL	% OF QUARTER CHANGE	Total AMOUNT	TOTAL
HOSPITAL	**6720**	INPATIENT	32,978,143	5.4%	43,245,587	6.8%	31.1%	44,344,810	7.5%	2.5%	57,927,316	8.9%	30.6%	178,495,856	7.2%
	6721	OUTPATIENT	3,427,262	0.6%	4,591,173	0.7%	34.0%	4,802,347	0.8%	4.6%	8,799,775	1.4%	83.2%	21,620,557	0.9%
	6726	PIP	59,036,045	9.7%	92,968,920	14.5%	57.5%	60,056,887	10.1%	(35.4%)	88,176,103	13.6%	46.8%	300,237,954	12.1%
HOSPITAL Total			**95,441,450**	**15.7%**	**140,805,679**	**22.0%**	**47.5%**	**109,204,044**	**18.4%**	**(22.4%)**	**154,903,194**	**23.9%**	**41.8%**	**500,354,366**	**20.1%**
RESIDENTIAL	**6705**	BOARDING HOME CARE	1,084,345	0.2%	(63,962)	(0.0%)	(105.9%)	(2,481,054)	(0.4%)	3779.0%	(4,631,599)	(0.7%)	86.7%	(6,092,270)	(0.2%)
	6706	RESIDENT DIAGNO AND TREAT	50,141,115	8.3%	49,307,536	7.7%	(1.7%)	37,209,215	6.3%	(24.5%)	39,293,858	6.1%	5.6%	175,951,724	7.1%
	6725	INTR CARE FAC CARE	56,994,644	9.4%	58,440,571	9.1%	2.5%	54,913,040	9.2%	(6.0%)	51,710,188	8.0%	(5.8%)	222,058,444	8.9%
	6729	MR GROUP CARE - ICF	8,954,478	1.5%	10,874,317	1.7%	21.4%	8,503,337	1.4%	(21.8%)	7,667,088	1.2%	(9.8%)	35,999,220	1.4%
	6766	PERSONAL CARE SERVICES	17,722,597	2.9%	17,795,043	2.8%	0.4%	14,735,088	2.5%	(17.2%)	15,478,691	2.4%	5.0%	65,731,419	2.6%
RESIDENTIAL Total			**134,897,180**	**22.2%**	**136,353,505**	**21.3%**	**1.1%**	**112,879,626**	**19.0%**	**(17.2%)**	**109,518,226**	**16.9%**	**(3.0%)**	**493,648,537**	**19.8%**
HCBS WAIVERS	**6772**	DD WAIVER	76,696,269	12.6%	82,206,450	12.8%	7.2%	73,608,828	12.4%	(10.5%)	75,583,738	11.7%	2.7%	308,095,285	12.4%
	6778	BME(ELDERLY) WAIVER	1,972,689	0.3%	2,421,471	0.4%	22.7%	2,107,470	0.4%	(13.0%)	2,074,103	0.3%	(1.6%)	8,575,732	0.3%
	6786	PCA(PHYSICALLY DISABLED) WAIVER	2,544,787	0.4%	2,786,376	0.4%	9.5%	2,447,700	0.4%	(12.2%)	1,730,107	0.3%	(29.3%)	9,508,970	0.4%
HCBS WAIVERS Total			**81,213,744**	**13.4%**	**87,414,297**	**13.7%**	**7.6%**	**78,163,999**	**13.1%**	**(10.6%)**	**79,387,948**	**12.2%**	**1.6%**	**326,179,988**	**13.1%**
S S A HEALTH INSURANCE	**6602**	S S A HEALTH INSURANCE	41,509,357	6.8%	43,046,524	6.7%	3.7%	39,996,194	6.7%	(7.1%)	42,242,865	6.5%	5.6%	166,794,940	6.7%
S S A HEALTH INSURANCE Total			**41,509,357**	**6.8%**	**43,046,524**	**6.7%**	**3.7%**	**39,996,194**	**6.7%**	**(7.1%)**	**42,242,865**	**6.5%**	**5.6%**	**166,794,940**	**6.7%**
PHARMACY	**6780**	PRESCRIPTION DRUGS	37,196,895	6.1%	20,062,596	3.1%	(46.1%)	45,938,231	7.7%	129.0%	29,972,195	4.6%	(34.8%)	133,169,917	5.3%
	6781	DME SUPPLIES	3,926,017	0.6%	4,729,281	0.7%	20.5%	4,374,774	0.7%	(7.5%)	4,744,399	0.7%	8.4%	17,774,470	0.7%
PHARMACY Total			**41,122,912**	**6.8%**	**24,791,877**	**3.9%**	**(39.7%)**	**50,313,005**	**8.5%**	**102.9%**	**34,716,594**	**5.4%**	**(31.0%)**	**150,944,387**	**6.1%**
MEDICAL PROFESSIONALS	**6740**	MEDICAL DOCTOR SERVICES	27,660,478	4.6%	28,459,857	4.4%	2.9%	27,709,748	4.7%	(2.6%)	27,779,959	4.3%	0.3%	111,610,041	4.5%
	6745	NURSE PRACTITIONER	5,309,952	0.9%	5,637,493	0.9%	6.2%	5,666,845	1.0%	0.5%	4,699,069	0.7%	(17.1%)	21,313,359	0.9%
	6759	NURSE MIDWIFERY	536,192	0.1%	564,764	0.1%	5.3%	590,378	0.1%	4.5%	619,920	0.1%	5.0%	2,311,254	0.1%
	6765	PRIVATE DUTY NURSING	3,391,226	0.6%	3,775,553	0.6%	11.3%	2,669,782	0.4%	(29.3%)	3,450,322	0.5%	29.2%	13,286,884	0.5%
MEDICAL PROFESSIONALS Total			**36,897,849**	**6.1%**	**38,437,667**	**6.0%**	**4.2%**	**36,636,753**	**6.2%**	**(4.7%)**	**36,549,270**	**5.6%**	**(0.2%)**	**148,521,539**	**6.0%**
DED & CO-INS FOR DUALS	**6733**	PART A	7,253,663	1.2%	11,870,164	1.9%	63.6%	6,933,922	1.2%	(41.6%)	10,978,302	1.7%	58.3%	37,036,050	1.5%
	6734	PART B	18,538,627	3.1%	25,829,033	4.0%	39.3%	28,236,130	4.7%	9.3%	37,754,577	5.8%	33.7%	110,358,368	4.4%
DED & CO-INS FOR DUALS Total			**25,792,290**	**4.3%**	**37,699,198**	**5.9%**	**46.2%**	**35,170,052**	**5.9%**	**(6.7%)**	**48,732,879**	**7.5%**	**38.6%**	**147,394,418**	**5.9%**
BEHAVIORAL HEALTH CLINICIAN	**6774**	BEHAVIORAL HEALTH CLINICIAN	29,825,502	4.9%	32,937,622	5.1%	10.4%	29,566,565	5.0%	(10.2%)	30,357,254	4.7%	2.7%	122,686,943	4.9%
BEHAVIORAL HEALTH CLINICIAN Total			**29,825,502**	**4.9%**	**32,937,622**	**5.1%**	**10.4%**	**29,566,565**	**5.0%**	**(10.2%)**	**30,357,254**	**4.7%**	**2.7%**	**122,686,943**	**4.9%**
CLINIC	**6730**	AMBULATORY AGENCY SERVICE	50	0.0%	220	0.0%	344.6%	3,824	0.0%	1637.5%	1,272	0.0%	(66.7%)	5,366	0.0%
	6732	MENTAL HEALTH CTR SER	3,599,253	0.6%	3,849,842	0.6%	7.0%	3,721,506	0.6%	(3.3%)	3,435,900	0.5%	(7.7%)	14,606,500	0.6%
	6735	FAMILY PLNG CLINICS		0.0%	344	0.0%			0.0%	(100.0%)	-	0.0%		344	0.0%
	6737	SPEECH & HEARING CLINICS		0.0%	2,347	0.0%		111	0.0%	(95.3%)	551	0.0%	396.4%	3,010	0.0%
	6738	RURAL HEALTH CLINICS	2,964,999	0.5%	2,680,287	0.4%	(9.6%)	2,295,254	0.4%	(14.4%)	2,357,359	0.4%	2.7%	10,297,899	0.4%
	6739	OTHER CLINICS	9,881	0.0%	17,587	0.0%	78.0%	13,252	0.0%	(24.6%)	34,927	0.0%	163.6%	75,647	0.0%
	6798	FEDERALLY QUALIFIED HEALTH CAR	7,944,717	1.3%	10,897,374	1.7%	37.2%	9,523,073	1.6%	(12.6%)	10,715,415	1.7%	12.5%	39,080,578	1.6%
	67A0	DEV & BEHAV CLINIC SERV	9,416,602	1.6%	9,637,473	1.5%	2.3%	9,990,545	1.7%	3.7%	12,376,938	1.9%	23.9%	41,421,558	1.7%
CLINIC Total			**23,935,502**	**3.9%**	**27,085,474**	**4.2%**	**13.2%**	**25,547,564**	**4.3%**	**(5.7%)**	**28,922,362**	**4.5%**	**13.2%**	**105,490,902**	**4.2%**
REHAB SERVICES	**6717**	ADJ OR REMEDIAL TRAINING	10,968,652	1.8%	11,707,321	1.8%	6.7%	9,004,025	1.5%	(23.1%)	10,374,722	1.6%	15.2%	42,054,720	1.7%
	6747	REHABILITATIVE SERVICES	3,176,589	0.5%	3,160,600	0.5%	(0.5%)	2,048,697	0.3%	(35.2%)	2,791,422	0.4%	36.3%	11,177,308	0.4%
	6763	OCCUPATIONAL THERAPY	430,266	0.1%	455,387	0.1%	5.8%	432,555	0.1%	(5.0%)	536,302	0.1%	24.0%	1,854,511	0.1%
	6771	PHYSICAL THERAPY	281,431	0.0%	331,612	0.1%	17.8%	307,135	0.1%	(7.4%)	324,599	0.1%	5.7%	1,244,777	0.1%
	6776	SPEECH THERAPY	960,738	0.2%	921,582	0.1%	(4.1%)	923,368	0.2%	0.2%	1,209,414	0.2%	31.0%	4,015,101	0.2%
REHAB SERVICES Total			**15,817,677**	**2.6%**	**16,576,501**	**2.6%**	**4.8%**	**12,715,780**	**2.1%**	**(23.3%)**	**15,236,459**	**2.4%**	**19.8%**	**60,346,418**	**2.4%**
TRANSPORTATION	**6791**	AMBULANCE	2,553,063	0.4%	2,393,620	0.4%	(6.2%)	2,288,419	0.4%	(4.4%)	2,280,388	0.4%	(0.4%)	9,515,491	0.4%
	6792	OTHER TRANSPORTATION	9,377,437	1.5%	10,015,691	1.6%	6.8%	9,093,413	1.5%	(9.2%)	9,480,282	1.5%	4.3%	37,966,823	1.5%
TRANSPORTATION Total			**11,930,501**	**2.0%**	**12,409,311**	**1.9%**	**4.0%**	**11,381,832**	**1.9%**	**(8.3%)**	**11,760,670**	**1.8%**	**3.3%**	**47,482,314**	**1.9%**
CASE MANAGEMENT	**6748**	CASE MANAGEMENT	10,709,946	1.8%	10,093,087	1.6%	(5.8%)	10,136,284	1.7%	0.4%	10,700,242	1.7%	5.6%	41,639,559	1.7%
CASE MANAGEMENT Total			**10,709,946**	**1.8%**	**10,093,087**	**1.6%**	**(5.8%)**	**10,136,284**	**1.7%**	**0.4%**	**10,700,242**	**1.7%**	**5.6%**	**41,639,559**	**1.7%**
DENTISTRY	**6750**	GENERAL DENTISTRY	7,701,237	1.3%	9,020,372	1.4%	17.1%	8,332,603	1.4%	(7.6%)	9,427,481	1.5%	13.1%	34,481,693	1.4%
	6752	ORTHODONTIA	688	0.0%	1,650	0.0%	139.8%	660	0.0%	(60.0%)	338	0.0%	(48.7%)	3,336	0.0%
DENTISTRY Total			**7,701,925**	**1.3%**	**9,022,022**	**1.4%**	**17.1%**	**8,333,263**	**1.4%**	**(7.6%)**	**9,427,819**	**1.5%**	**13.1%**	**34,485,030**	**1.4%**
CERTIFIED SEED	**6796**	EARLY INTERVENTION SERVICES	2,028,683	0.3%	1,990,297	0.3%	(1.9%)	1,982,748	0.3%	(0.4%)	2,224,808	0.3%	12.2%	8,226,535	0.3%
	67A3	CERTIFIED SEED - SCHOOL REHAB	2,383,271	0.4%	1,580,951	0.2%	(33.7%)	8,759,012	1.5%	454.0%	8,713,198	1.3%	(0.5%)	21,436,432	0.9%
CERTIFIED SEED Total			**4,411,954**	**0.7%**	**3,571,248**	**0.6%**	**(19.1%)**	**10,741,760**	**1.8%**	**200.8%**	**10,938,005**	**1.7%**	**1.8%**	**29,662,967**	**1.2%**
DAY TREATMENT SERVICES	**67C0**	DAY TREATMENT SERVICES	2,154,752	0.4%	483,298	0.1%	(77.6%)	6,791,274	1.1%	1305.2%	4,157,596	0.6%	(38.8%)	13,586,920	0.5%
DAY TREATMENT SERVICES Total			**2,154,752**	**0.4%**	**483,298**	**0.1%**	**(77.6%)**	**6,791,274**	**1.1%**	**1305.2%**	**4,157,596**	**0.6%**	**(38.8%)**	**13,586,920**	**0.5%**
LABORTORY SERVICES	**6790**	LABORATORY SERVICES	2,185,643	0.4%	3,240,638	0.5%	48.3%	3,650,386	0.6%	12.6%	3,912,362	0.6%	7.2%	12,989,029	0.5%
LABORTORY SERVICES Total			**2,185,643**	**0.4%**	**3,240,638**	**0.5%**	**48.3%**	**3,650,386**	**0.6%**	**12.6%**	**3,912,362**	**0.6%**	**7.2%**	**12,989,029**	**0.5%**
HOME HEALTH	**6761**	HOME HEALTH SERVICES	1,994,955	0.3%	2,515,996	0.4%	26.1%	2,412,196	0.4%	(4.1%)	2,714,932	0.4%	12.6%	9,638,079	0.4%
	6767	ATTENDANT SERVICES	15,189	0.0%	51,311	0.0%	237.8%	7,678	0.0%	(85.0%)	8,678	0.0%	13.0%	82,856	0.0%
	6788	DAY HEALTH SERVICES	116,920	0.0%	102,420	0.0%	(12.4%)	111,640	0.0%	9.0%	93,298	0.0%	(16.4%)	424,277	0.0%
	67F6	ASSISTED LIVING SERVICES		0.0%	240,774	0.0%		(228,606)	(0.0%)	(194.9%)		0.0%	(100.0%)	12,168	0.0%
HOME HEALTH Total			**2,127,063**	**0.4%**	**2,910,501**	**0.5%**	**36.8%**	**2,302,908**	**0.4%**	**(20.9%)**	**2,816,908**	**0.4%**	**22.3%**	**10,157,381**	**0.4%**
INSURANCE	**4851**	MISC INSURANCE	131,172	0.0%	(133,434)	(0.0%)	(201.7%)	50	0.0%	(100.0%)	(7,678)	(0.0%)	(15455.1%)	(9,890)	(0.0%)
	6550	HEALTH INSURANCE	259,870	0.0%	533,677	0.1%	105.4%	438,281	0.1%	(17.9%)	445,370	0.1%	1.6%	1,677,199	0.1%
INSURANCE Total			**391,042**	**0.1%**	**400,243**	**0.1%**	**2.4%**	**438,331**	**0.1%**	**9.5%**	**437,693**	**0.1%**	**(0.1%)**	**1,667,309**	**0.1%**
OTHER			38,298,903	6.3%	12,932,226	2.0%	(66.2%)	10,513,321	1.8%	(18.7%)	13,447,610	2.1%	27.9%	75,192,060	3.0%
Grand Total			**606,365,192**	**100.0%**	**640,210,918**	**100.0%**	**5.6%**	**594,482,941**	**100.0%**	**(7.1%)**	**648,165,956**	**100.0%**	**9.0%**	**2,489,225,006**	**100.0%**

HOSPITAL-Settlement Estimate By State Year
Through June 30, 2012

			62.57%	37.43%
	Due Hospital	**Total Dollars**	**Federal Dollars**	**State Dollars**
1.	SY 2006 settlements not issued as of May 2012	3,579,941	2,239,969	1,339,972
2.	SY 2007 settlements not issued as of May 2012	2,023,342	1,266,005	757,337
3.	SY 2008 settlements not issued as of May 2012	5,899,668	3,691,422	2,208,246
4.	SY 2009 settlements not issued as of May 2012	69,574,016	43,532,462	26,041,554
5.	SY 2010 settlements not issued as of May 2012	133,396,291	83,466,060	49,930,232
6.	SY 2011 settlements not issued as of May 2012	170,114,375	106,440,564	63,673,810
7.	SY 2012 settlements not issued as of May 2012	49,017,899	30,670,499	18,347,399
8.	Appeal settlements o/s as of 02/02/09	6,242,721	3,906,070	2,336,650
9.	QMB Crossovers (through 8/31/10)	34,352,420	21,494,309	12,858,111
10.	Total Due Hospital SY 2006 through 2012	**474,200,672**	**296,707,361**	**177,493,312**

	Due State	**Total Dollars**	**Federal Dollars**	**State Dollars**
1.	SY 2006 settlements not issued as of May 2012	-	-	-
2.	SY 2007 settlements not issued as of May 2012	-	-	-
3.	SY 2008 settlements not issued as of May 2012	(5,897,298)	(3,689,939)	(2,207,359)
4.	SY 2009 settlements not issued as of May 2012	(840,012)	(525,595)	(314,416)
5.	SY 2010 settlements not issued as of May 2012	(1,486,900)	(930,353)	(556,547)
6.	SY 2011 settlements not issued as of May 2012	(5,737,973)	(3,590,250)	(2,147,723)
7.	SY 2012 settlements not issued as of May 2012	(274,262)	(171,606)	(102,656)
8.	Appeal settlements o/s as of 02/02/09	-	-	-
9.	QMB Crossovers (through 8/31/10)	-	-	-
10.	Total Due State FY 2006 through 2012	**(14,236,445)**	**(8,907,743)**	**(5,328,701)**

	Net Due Hospital / (State) through SY 2012			Estimated $$ Net Due Hospitals
1.	SY 2006 settlements not issued as of May 2012	3,579,941	2,239,969	1,339,972
2.	SY 2007 settlements not issued as of May 2012	2,023,342	1,266,005	757,337
3.	SY 2008 settlements not issued as of May 2012	2,370	1,483	887
4.	SY 2009 settlements not issued as of May 2012	68,734,004	43,006,866	25,727,138
5.	SY 2010 settlements not issued as of May 2012	131,909,391	82,535,706	49,373,685
6.	SY 2011 settlements not issued as of May 2012	164,376,401	102,850,314	61,526,087
7.	SY 2012 settlements not issued as of May 2012	48,743,637	-	18,244,743
8.	Appeal settlements o/s as of 02/02/09	6,242,721	3,906,070	2,336,650
9.	QMB Crossovers (through 8/31/10)	34,352,420	21,494,309	12,858,111
10.	Net Due Hospitals SY 2006 through 2012	**459,964,228**	**257,300,724**	**172,164,610**