MainePERS
PUBLIC EMPLOYEES RETIREMENT SYSTEM

CHIEF EXECUTIVE OFFICER
Dr. Rebecca M. Wyke

November 1, 2021

Via Hand Delivery

Senator Craig Hickman, Senate Chair
Representative Mike Sylvester, House Chair
Members, Joint Standing Committee on Labor and Housing
100 State House Station
Augusta, ME 04333-0100

Re: Program Evaluation Report for the Maine Public Employees Retirement System

Dear Senator Hickman, Representative Sylvester, and Members of the Joint Standing Committee on Labor and Housing:

I am pleased to submit the Program Evaluation Report of the Maine Public Employees Retirement System pursuant to the Committee's letters dated June 30, 2021 and September 29, 2021.

We look forward to assisting the Committee and its staff in the review of the System.

Sincerely,

Dr. Rebecca M. Wyke
Chief Executive Officer

RMW/mg

Enclosure

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Program Evaluation Report
Required by 3 M.R.S. §956
November 1, 2021

Maine Public Employees Retirement System

The Maine Public Employees Retirement System (herein “System”) provides the following Program Evaluation Report, organized by the evaluation elements specified in 3 M.R.S. §956.

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

The Maine Public Employees Retirement System is enabled by Administrative Procedures and Services, 5 M.R.S. Chapter 421 (Section 17101 in particular). The System is further enabled by Executive, 2 M.R.S. Chapter 1, Section 1-A; Legislature, 3 M.R.S. Chapter 29, Section 731 (Legislative Retirement Program); and Judiciary, 4 M.R.S. Chapter 27, Section 1231 (Judicial Retirement Program).

B. A description of each program administered by the independent agency, including priorities, goals and objectives, performance measures and assessment of performance

The Maine Public Employees Retirement System (MainePERS) is an independent public agency of the State of Maine that traces its history to 1942. By the authority granted to it by the Maine Legislature, the System administers retirement programs that cover State employees, the public school teachers, judges, legislators, and employees of the 311 municipalities and other public entities, called "participating local districts" (PLDs), that have chosen to provide retirement plans to their employees through MainePERS. The System is also responsible for the payment of retirement and survivors' benefits to former governors and their surviving spouses and to judges who retired prior to the establishment of the Judicial Retirement Program in 1984. In addition, the System administers a Group Life Insurance Program that provides life insurance benefits for active and retired System members and for the employees of a few PLDs for whom MainePERS administers only the Group Life Insurance Program. The System also administers defined contribution plans for PLD employees.

Responsibility for the operation of the Maine Public Employees Retirement System rests with the System's Board of Trustees, which is comprised of eight members. State law specifies the Board's composition. Three trustees are System members, one of whom is proposed and elected by the Maine Education Association, one of whom is proposed and elected by the Maine State Employees Association, and one of whom is a PLD member or retired member appointed by the governing body of the Maine Municipal Association. Four other trustees are appointed by the Governor. Of these, one must be selected by the Governor from a list of nominees submitted by the Maine Retired Teachers Association and one must be a MainePERS retiree selected from a list of nominees submitted by State and/or PLD retirees. The remaining two appointees are direct gubernatorial appointments, both of whom must be qualified through training or experience in investments, accounting, banking or insurance or as actuaries. All elected or appointed trustees are subject to the legislative confirmation process and required to have "a working knowledge of retirement policy and legal issues and a general knowledge and understanding of banking, finance, and investment practices." The eighth trustee is the State Treasurer, who serves *ex-officio*. All trustee terms are three years, except for the two-year term

of the State Treasurer. The Board annually elects its chair and vice chair from among its members.

The MainePERS Trustees serve as fiduciaries and Trustees of the State and Teacher, Judicial and Legislative Retirement Programs as well as for the PLD Consolidated Program and the Retiree Health Insurance Post-Employment Benefits Investment Trust. The MainePERS Trustees also oversee the MaineSTART defined contribution plans.

The Board contracts for the services of an actuary, currently Cheiron, to prepare annual valuations of the assets and liabilities of each of the retirement programs administered by the System. The actuary provides information and recommendations as to sound and appropriate actuarial assumptions, which are utilized with valuation information to determine funding requirements.

The Board manages System investments through its investment policy. The policy states the Board's underlying investment objectives, sets out the investment strategies intended to realize the objectives, and establishes guidelines and criteria for implementation of the strategies. The Board contracts with Cambridge Associates to advise it on the investment policy and on implementation of the investment program.

The Board is the final administrative decision maker in matters involving the rights, credits, and benefits of members. It has established an administrative appeals process for the making of such decisions. In this process, factual and legal determinations are recommended to the Board by independent hearing officers who serve under contract. The Board's final administrative decisions are appealable to the Maine Superior Court.

1. Defined Benefit Pension Program

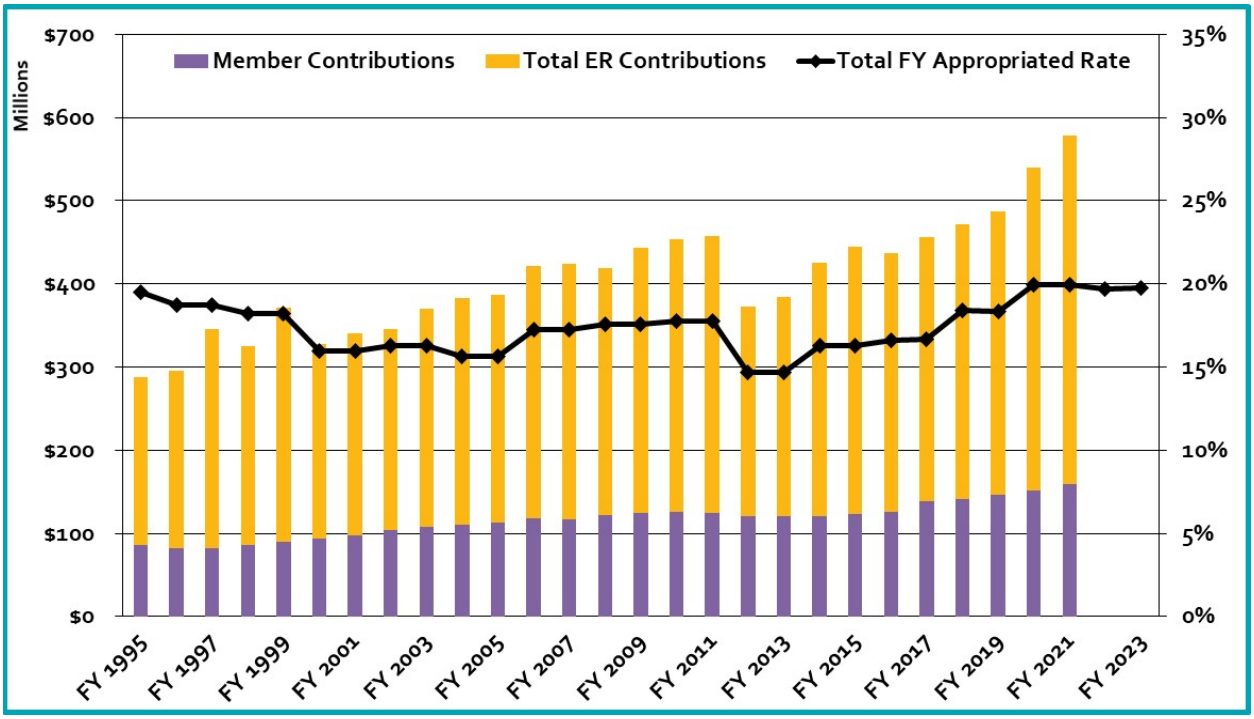
The System’s retirement program provides a specific retirement benefit based on the member’s average final compensation and years of service credit. In the plans for State employees, teachers, judges and legislators, the employer, not the employee, bears the investment risk. In the plan for PLD members, employers and employees share risk. Generally, members are eligible for retirement benefits when they have five years of service and meet other requirements that apply to their specific plan. Members who have reached normal retirement age may vest with one year of service immediately preceding retirement. Normal retirement age for State employees, teachers, judges, and legislative members is 60, 62, or 65, depending on when they entered service. For PLD Consolidated Plan members, the normal retirement age is 60 or 65. In FY 2021, the System paid $1,016,749,067 to approximately 45,000 retirees and beneficiaries.

Members in the defined benefit pension plans are entitled to have pre-retirement death benefits paid to their beneficiaries in the event that the member dies prior to receiving a refund or service retirement benefit. In FY 2021, the System paid $24,933,925 in pre-retirement death benefits to approximately 750 beneficiaries.

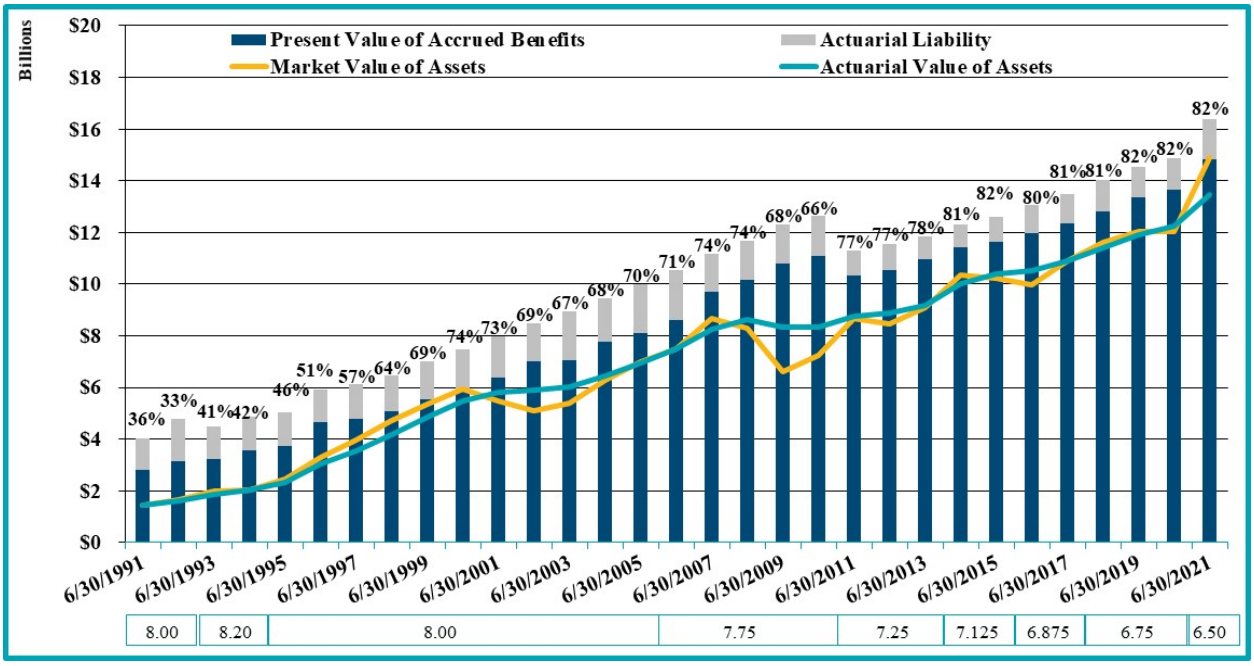
The System's defined benefit program goals are full funding for each of the defined benefit plans and maintaining contribution rate stability, while using sound actuarial assumptions and methods and taking reasonable steps to manage funding risks. The System has worked toward achieving those goals by prudently managing its investments, gradually lowering its discount rate from 8.2% in the 1990s to 6.5% today, successfully proposing and advocating for the adoption of a constitutional amendment to amortize State and Teacher Plan experience losses over a 20-year period, and implementing reforms to the PLD Consolidated Plan to strengthen its funding and future stability.

These efforts have resulted in improved funding levels for all plans. The lowering of the discount rate from 8.2% to 6.5% has slowed the growth in funding level because this also lowers projected investment returns, but this means that funding levels and contribution rates are more stable and not as negatively impacted by market corrections.

The chart below shows the remarkable stability of the State's employer contribution rate for the State and Teacher plan, which has remained between approximately 15% and 20% of payroll while the plan's funded status has significantly improved.

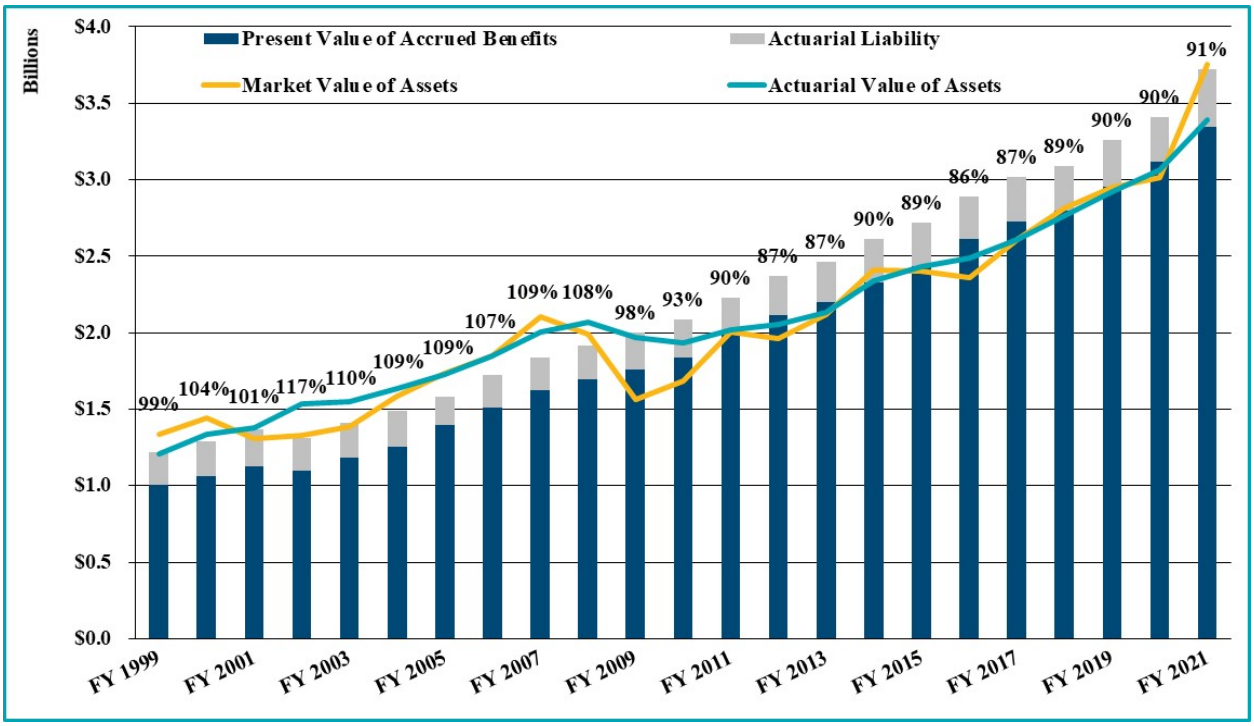


The State and Teacher Plan was funded at 82.1% as of June 30, 2021, and is projected to be fully funded by the end of FY 2028.



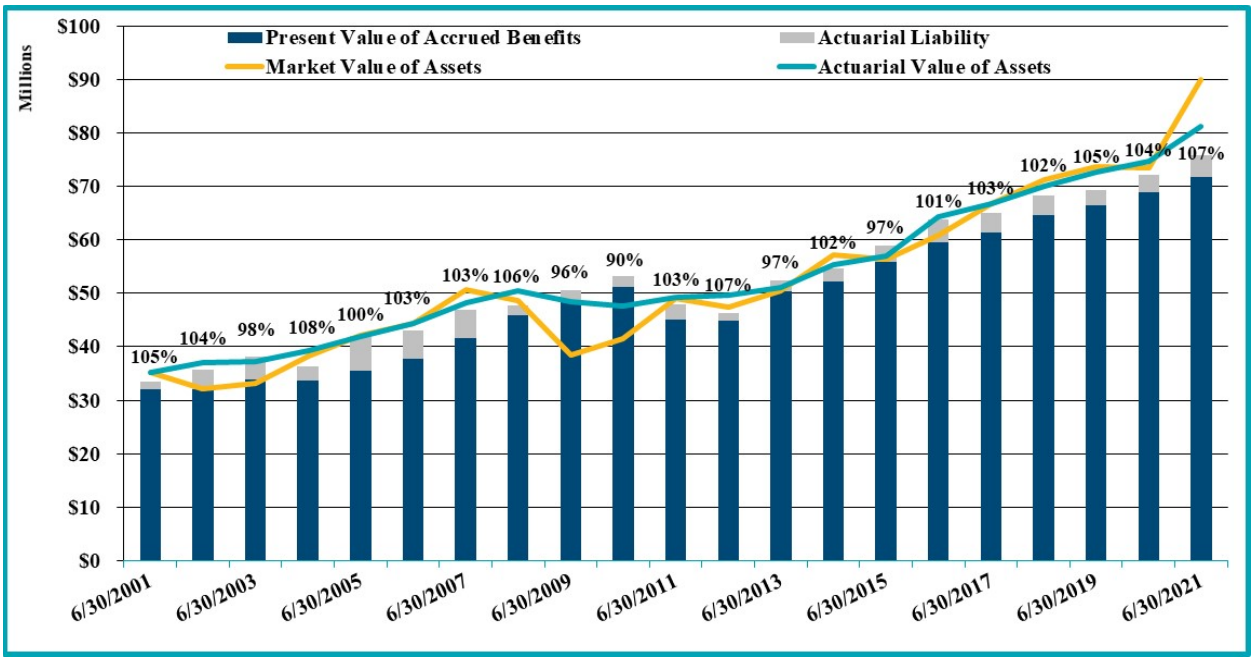
State and Teacher Plan Funding Level

The PLD Consolidated Plan was funded at 91.1% as of June 30, 2021 and is projected to be fully funded by the end of FY 2025.



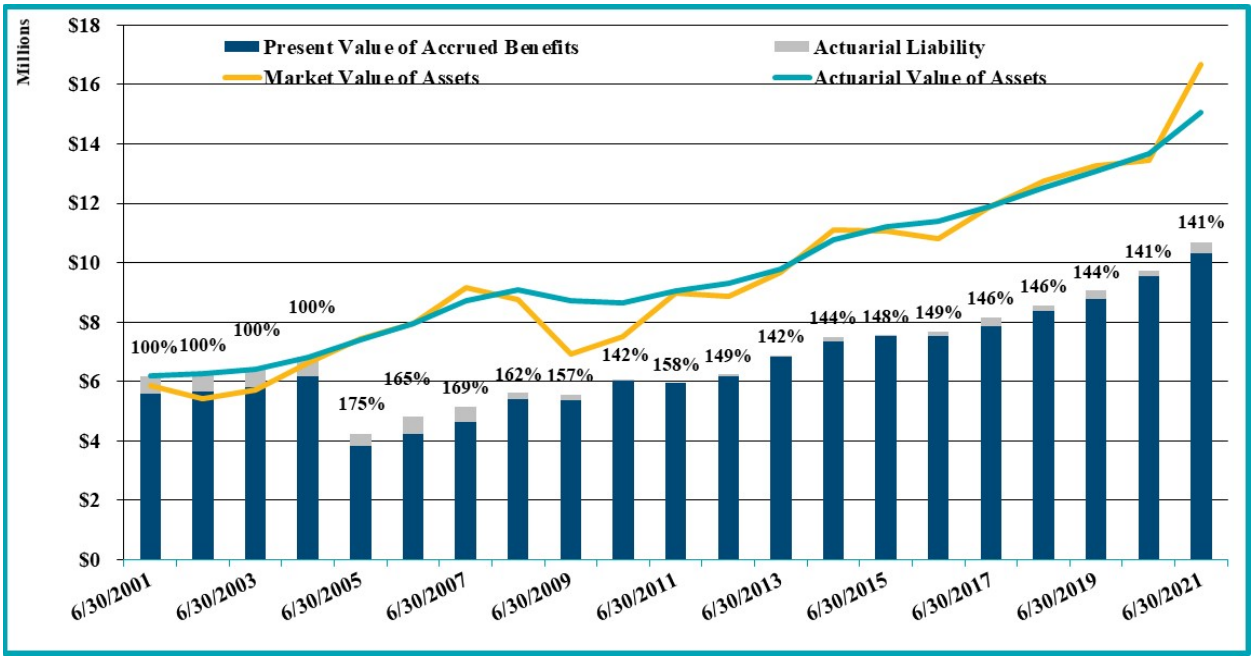
PLD Consolidated Plan Funding Level

The Judicial Retirement Plan is considered fully-funded with a funding level of 107.2% as of June 30, 2021.



Judicial Retirement Plan Funding Level

The Legislative Retirement Plan also is considered to be fully-funded. The Plan's funding level as of 6/30/21 was 140.9%.



Legislative Retirement Plan Funding Level

2. Disability Program

The System administers the disability retirement program as defined by law for eligible members who become permanently disabled while in service and are unable to perform the duties of their current position. In FY 2021, the System paid $28,922,911 in disability benefits to approximately 1,000 disability retirees.

The System's goal for the disability program is to make fair and timely determinations of eligibility for disability retirement benefits while providing applicants with the information and assistance they need. As a result of stakeholder concerns that the System was not meeting these goals, the System began process changes in 2017 to increase information flow and assistance to applicants and worked with stakeholders on consensus legislation to improve the program more broadly. This resulted in the enactment of Public Law 2021, chapter 277, which became effective October 18, 2021. In anticipation of enactment of this law, the System replaced its traditional Medical Board in 2020 with medical review services provided by the University of Massachusetts Medical School.

The table below shows disability application approval rates over the past five full calendar years.

	2016	2017	2018	2019	2020
Applications	121	86	92	84	69
Granted	39	41	56	55	59
Denied	82	45	35	29	10
Approval Rate	32%	48%	61%	66%	86%

3. Group Life Insurance Program

The System provides term group life and accidental death and dismemberment insurance to 51,400 participants and retirees through a contract with a licensed insurance company, The Hartford. The vendor performs selected plan administration functions.

The System verifies the validity of claims, determines the claim amounts, obtains necessary documents, and forwards all required material to the insurance company. The insurance company reviews the documentation and issues payment, which is forwarded by the System to the recipient. In FY 2021, the System paid $14,136,035 in life insurance proceeds and processed approximately 670 claims.

The System's goal is to assist members with understanding and maintaining insurance coverage and to make fair and timely claims determinations.

4. MaineSTART Program

The System also administers the MaineSTART defined contribution retirement plans that are established under sections 401(a), 403(b), and 457(b) of the Internal Revenue Code. These plans are presently available to employees of those employers in the PLD Consolidated Plan that have adopted one or more of the plans.

As of June 30, 2021, 6 PLD employers offered the 401(a) plan to employees. As of that date, there were 84 participants in that plan with total assets of $7,297,494.

As of June 30, 2021, 71 PLD employers offered the 457(b) plan to employees. As of that date, there were 847 participants in that plan with total assets of $36,208,876.

As of June 30, 2021, 1 PLD employer offered the 403(b) plan to employees. As of that date, there were 549 participants in that plan with total assets of $16,972,563.

The System has set a goal of expanding participation in these plans. The above figures represent 20% growth in PLD employer participation and 36% of growth in employee participation over June 30, 2018. This growth primarily is through outreach by System staff to PLDs and their employees.

The System has submitted proposed legislation that would expressly authorize the System to offer MaineSTART beyond PLDs to other employers who participate in the System's defined benefit plans.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility

Number of Positions at June 30, 2021: 112
Vacancies at June 30, 2021: 10

A functional organization chart and a list of job classifications are attached as Exhibit A.

D. REQUIREMENT REPEALED BY PL 2013, CHAPTER 307

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the last 10 years

All members of each plan contribute a percentage of their earnable compensation to the System. The amount of the member contribution is set by statute or in the case of the PLD Consolidated Retirement Plan pursuant to rule and varies according to the plan under which a member is covered and other criteria set out in the law. Each employer also contributes to the System in an amount that is a percentage of total earnable compensation paid to members who are employees of that employer.

The employer contribution has two components: (1) the normal cost contribution, which, with current member contributions, supports benefits currently being earned by active members; and (2) the unfunded actuarial liability (UAL) contribution, which is payment on the amortized debt that represents the liability for benefits in excess of the amount supported by assets of the System. The State pays the employer contribution on behalf of all State employee members, as well as on behalf of Judicial and Legislative members. The State also pays the unfunded actuarial liability contribution on behalf of teacher members. Beginning July 1, 2013, local

school units pay the employer normal cost contribution on behalf of their teacher members. PLD employers pay the employer contribution on behalf of their employees who are members. Employer contribution percentages are actuarially determined by plan and can vary from year to year.

The System's operating funds are provided by its participating employers through an assessment against the plan or program. Total operating expenses for staff and all other costs of operation, with the exception of certain investment-related expenses required by law to be paid directly from investments, are allocated among the System's plans and programs, including the defined benefit plans, the group life insurance program, and the defined contribution plans. The allocation methodology used first allocates identifiable direct costs to each plan or program. The remaining costs are then allocated across each plan or program based on the total assets under management as of June 30 of the previous fiscal year. The allocation methodology produces an annual operating cost for each plan or program based upon an operating budget annually approved by the System's trustees. Operating funds are then collected by assessment across plans and programs. The System's administrative budget is approved annually by the Board of Trustees and reported to the Legislature.

The System receives a biennial general fund appropriation for the funding of benefits payable from the Governor's Retirement Fund. Funding of benefits to retired governors and the surviving spouses of retired governors is provided on a pay-as-you-go basis. The System has received the following general fund appropriations in the past ten years, including the current biennium, for the funding of benefits under this plan.

Fiscal Year	Appropriation
2021	$ 200,768
2020	$ 196,740
2019	$ 168,036
2018	$ 164,720
2017	$ 166,044
2016	$ 163,144
2015	$ 130,580
2014	$ 115,477
2013	$ 166,975
2012	$ 163,928

The System also receives a biennial general fund appropriation for the funding of benefits from the Pre-1984 Judicial Retirement Fund, which is funded on a pay-as-you-go basis. The System has received the following general fund appropriations in the past ten years, including the current biennium, for the funding of benefits under this plan.

Fiscal Year	Appropriation
2021	$ -
2020	$ -
2019	$ 88,852
2018	$ 75,572
2017	$ 73,364
2016	$ 54,760
2015	$ 388,356
2014	$ 354,940
2013	$ 305,554
2012	$ 325,476

The System prepares an Annual Financial Report (AFR) each year with extensive information on all aspects of its operations. The following information, is excerpted from the most recently published AFR, for the fiscal year ended June 30, 2020, and earlier AFRs. Information for the fiscal year ended June 30, 2021 is from the audited financial statements for that period.

1. Summary of Investment Activity

(In Millions)

Fiscal Year	Opening Market Value	Closing Market Value	Rate of Return
2021	$ 14,720.0	$ 18,146.0	26.5%
2020	$ 14,886.0	$ 14,720.0	1.8%
2019	$ 14,344.0	$ 14,886.0	7.3%
2018	$ 13,385.0	$ 14,344.0	10.3%
2017	$ 12,283.0	$ 13,385.0	12.5%
2016	$ 12,610.0	$ 12,283.0	0.6%
2015	$ 12,732.0	$ 12,610.0	2.0%
2014	$ 11,264.0	$ 12,732.0	16.7%
2013	$ 10,470.0	$ 11,264.0	11.1%
2012	$ 10,739.0	$ 10,470.0	0.6%
10-year Period			8.7%

2. Schedule of Employers' Contributions

	(In Millions)		
Fiscal Year	Annual Required Contribution	Annual Contribution	Percent Contributed
2021	$ 487.8	$ 487.8	100.0%
2020	$ 467.2	$ 467.2	100.0%
2019	$ 413.0	$ 413.0	100.0%
2018	$ 397.1	$ 397.1	100.0%
2017	$ 365.3	$ 365.3	100.0%
2016	$ 349.9	$ 349.9	100.0%
2015	$ 343.3	$ 343.3	100.0%
2014	$ 340.5	$ 340.5	100.0%
2013	$ 294.1	$ 294.1	100.0%
2012	$ 277.9	$ 278.2	100.1%

3. Schedule of Funding Progress

		(In Millions)			*(In Millions)*	
Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability (AAL) - Entry Age	Unfunded AAL (UAAL)	Funded Ratio	Annual Covered Payroll	UAAL as a Percentage of Covered Payroll
June 30, 2021	$ 16,946	$ 20,198	$ 3,252	83.9%	$ 2,874	113.1%
June 30, 2020	$ 15,402	$ 18,357	$ 2,955	83.9%	$ 2,695	109.6%
June 30, 2019	$ 14,899	$ 17,884	$ 2,985	83.3%	$ 2,585	115.5%
June 30, 2018	$ 14,267	$ 17,198	$ 2,931	83.0%	$ 2,465	118.9%
June 30, 2017	$ 13,593	$ 16,575	$ 2,982	82.0%	$ 2,379	125.3%
June 30, 2016	$ 13,077	$ 16,031	$ 2,954	81.6%	$ 2,308	128.0%
June 30, 2015	$ 12,877	$ 15,404	$ 2,527	83.6%	$ 2,246	112.5%
June 30, 2014	$ 12,420	$ 14,992	$ 2,572	82.8%	$ 2,172	118.5%
June 30, 2013	$ 11,375	$ 14,356	$ 2,981	79.2%	$ 2,130	140.0%
June 30, 2012	$ 10,997	$ 13,975	$ 2,977	78.7%	$ 2,202	135.2%

4. Schedule of Benefits Expenses by Type, Net of Accruals

(In Millions)

		All Defined Benefit Plans						Group Life Insurance Plans
					Refunds of Contributions			
Fiscal Year	Total Benefits & Refunds Expense	Service Retiree Benefits, Including Beneficiary Benefits	Disability Benefits	Pre-Retirement Death Benefits	Refunds due to Death	Refunds due to Termination	Other Refunds	Claims Benefits
2021	$ 1,106	$ 1,017	$ 29	$ 25	$ 5	$ 16	$ -	$ 14
2020	$ 1,079	$ 984	$ 30	$ 25	$ 7	$ 20	$ -	$ 14
2019	$ 1,035	$ 944	$ 31	$ 24	$ 5	$ 21	$ -	$ 10
2018	$ 982	$ 892	$ 31	$ 23	$ 4	$ 19	$ -	$ 12
2017	$ 945	$ 854	$ 33	$ 23	$ 5	$ 18	$ -	$ 12
2016	$ 902	$ 814	$ 34	$ 22	$ 3	$ 19	$ -	$ 10
2015	$ 919	$ 783	$ 35	$ 22	$ 4	$ 21	$ 43	$ 11
2014	$ 835	$ 739	$ 36	$ 20	$ 4	$ 23	$ 2	$ 10
2013	$ 807	$ 715	$ 37	$ 21	$ 5	$ 19	$ -	$ 10
2012	$ 780	$ 671	$ 37	$ 20	$ -	$ -	$ 44	$ 8

5. Administrative Operating Expenses. The following summary has been prepared for this report.

Fiscal Year	Salaries & Wages	Employee Benefits	Other Personnel Expenses	Total Personnel Expenses	All Other Expenses	Total Administrative Operating Expenses
2021	$5,183,249	$2,762,754	$ 51,234	$7,997,237	$7,244,233	$ 15,241,470
2020	$5,039,360	$2,816,732	$ 69,338	$7,925,430	$7,846,507	$ 15,771,937
2019	$4,869,670	$2,853,869	$ 33,905	$7,757,444	$7,389,069	$ 15,146,513
2018	$5,190,668	$2,676,368	$ 18,997	$7,886,033	$6,077,580	$ 13,963,613
2017	$4,698,584	$2,561,708	$ 42,652	$7,302,945	$5,126,146	$ 12,429,091
2016	$4,158,576	$2,645,658	$ 27,642	$6,831,875	$4,790,478	$ 11,622,353
2015	$4,011,909	$2,543,172	$ 59,157	$6,614,238	$5,587,751	$ 12,201,989
2014	$3,713,392	$2,177,955	$ 37,050	$5,928,397	$4,695,955	$ 10,624,352
2013	$3,674,990	$2,091,087	$ 38,813	$5,804,890	$5,153,859	$ 10,958,749
2012	$3,768,451	$2,081,726	$ 30,113	$5,880,290	$4,146,781	$ 10,027,071

F. REQUIREMENT REPEALED BY PL 2013, CHAPTER 307

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objections and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements

The System coordinates with State agencies, including the Departments of Administration and Financial Services, State Employee Health Commission, Maine Revenue Services, Department of Education, Department of Labor, Worker's Compensation, and the Department of Health and Human Services principally to share information to foster more effective and efficient administration of benefits and services. The System also cooperates with

the Social Security Administration to educate employers, members, and retirees about both programs.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes

System constituents include members, retirees, beneficiaries, employers, and the interest groups who represent these constituencies.

I. A summary of efforts by the agency or program regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives

The System utilizes private providers in administering its programs. The Group Life Insurance Program is administered by The Hartford, and the System contracts with Newport Group to provide record keeping services for the MaineSTART plans. The System uses the University of Massachusetts Medical School for medical review services and various technology partners and other vendors for its operations.

J. Identification of emerging issues for the agency or program in the coming years

1. Preservation of the Trust Fund

As the defined benefit retirement plans approach full funding and benefit outflows increase relative to the inflow of contributions, it is important that actuarial assumptions and investment strategy be carefully adjusted to prevent adverse effects to plan funding levels and contribution rates from market downturns. The System is working with its actuary and investment consultants to prepare for the transition to full funding.

2. Design and Possible Implementation of a New Pension Plan

The System currently is leading a working group to investigate new pension plan design options that would include social security and benefits comparable to the current defined benefit plan. This System was directed to perform this study by Resolves 2021, Chapter 66.

3. Security and Integrity of Information Systems

As custodian of personal and financial information for more than 100,000 members, retirees, and beneficiaries, the System takes very seriously its obligation to protect the security and integrity of its information systems and assets. Current protections are described in part M, below, and will evolve as technology and cyber security threats evolve.

4. Cultivation of a "Member-Centric" Organization

The System is focusing on enhancing services to members, including streamlining processes, improving data accuracy, and providing new ways for accessing services and information.

5. Divestment

PL 2021, chapters 231 and 234 require the System to divest from fossil fuel and private prison investments to the extent consistent with sound investment criteria and fiduciary

obligations. The System and its investment consultants are evaluating implementation of the divestment statutes, including the extent to which alternative investments are available with comparable risk/return profiles and fees.

6. Expansion of MaineSTART Participation

As noted above, the System has set a goal of expanding participation in the MaineSTART defined contribution plans and has submitted proposed legislation that would expressly authorize offering the plans to any employers who participate in the System's defined benefit plans.

7. Long Term Disability Insurance

Pursuant to PL 2021, chapter 277, the System will convene a stakeholder group to develop an implementation plan for mandatory long-term disability insurance coverage to System members through their employers and submit the plan and any recommended legislation by January 3, 2023.

8. Development of Stakeholder Relations

Open and trusting relations with members, retirees, employers, and representatives of these stakeholders enables the System to better understand and respond to their needs.

K. Any other information specifically requested by the committee of jurisdiction

Attached as Exhibit B are the policies and practices of the MainePERS disability retirement unit.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program

The defined benefit and defined contribution programs administered by the System must maintain compliance with applicable provisions of the Internal Revenue Code in order to maintain their status as "qualified plans" under the Code. Among others, the following Internal Revenue Code requirements apply: (a) §401(a) (2) (exclusive benefit rule); (b) §414(u) (military service); (c) 415(b) & (c) (limitations on contributions and benefits) and (d) §503(b) (prohibited transactions).

M. Agency policies for collecting, managing and using personal information over the internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement

The System has established an Information Technology Oversight Council (Council) comprised of senior managers, information technology staff, and external consultants with expertise on cybersecurity and information technology infrastructure. One of the roles of the Council is to review and create security and infrastructure policies for the protection of information and electronic assets. The operating environment is managed by System staff and two vendor partners with expertise in technology security.

Sources of data include submissions of reports and information by employers, members, and beneficiaries. Collection and retention of this data is for official use only and is necessary for the System to fulfill its responsibilities. Information arrives through secure manual processes, such as the United States Postal Service, hand delivered material by individuals, and electronically using secure technologies, including encryption.

The System uses a layered approach to security. Perimeter protection includes firewalls with advanced traffic filtering and malware threat prevention technologies. The System's websites are externally hosted and protected through trusted third part vendors. The Employer Self Service (ESS) portal is accessible through a demilitarized zone (DMZ) of the network and protected with multi-factor authentication. Secure Socket Layer (SSL) encryption protects employers' transactions through the ESS portal with data storage occurring in an encrypted Oracle database. File servers, databases, and applications utilize security best practices, such as complex passwords and periodic scanning for vulnerabilities. Network device configurations are reviewed and hardened to prevent unauthorized access. A suite of Cisco security products enable protection for endpoints and provide filtering and monitoring of email and web traffic.

External remote access occurs through devices owned by the System and with leading security solutions providing both access and security protection. These devices create virtual private networks providing secure access to the computing environment. Other access is managed using multi-factor authentication into the environment for both vendors and the remote workforce.

Mobile devices such as laptops include full disk encryption and password protection. Mobile device management is in place for both iPad and iPhone products. Personal non-System owned devices are not authorized for use for storing System information or accessing the System network. Employees are restricted from the use of System owned resources for personal activities.

Continuous monitoring of network communications and interfaces occurs through multiple technology partners. Real-time managed security monitoring and alert notifications allow security partners and staff to respond when suspicious activity occurs. These incidents are escalated to senior management for serious situations. The System also uses next day security monitoring of system, event, and activity logs, providing a holistic view of network activity with daily and monthly reports.

The System uses an encrypted email solution for its members, employers, and other stakeholders needing to communicate electronically with MainePERS. The Zix portal is accessible from the System's website. Protection against e-mail vulnerabilities, such as phishing attacks is through SPAM cleansing filters and ongoing training of personnel.

To protect privacy, account-specific information is discussed with a member on the telephone only after the member's identity is verified using the LexisNexis Instant ID Q&A service.

The data center is housed within MainePERS primary location in Augusta. The physical infrastructure is fully enclosed with a hardened ceiling, restricted credential card access for authorized personnel, and video camera monitoring within the data center. Data is replicated from Augusta to the disaster recovery site in Brunswick. Additional protection is provided by a fire suppression system and redundant cooling with status alerts for temperature changes. These systems undergo preventative maintenance on a regular basis. In addition to replication,

archival and backup tapes include encryption protection and are transported and stored offsite by a professional data security vendor.

The System conducts internal and external penetration testing annually through the use of ethical hackers associated with vendor partners. Working with a vendor partner, the System conducts a Configuration and Vulnerability Assessment that examines the network and server security configurations. Risk assessments are conducted annually with patch scanning occurring monthly and annual security training for staff. The System conducts periodic information technology audits.

The System collects only information necessary to administer benefits and does not permit secondary use except as provided by statute, in which case the System provides the ability to opt-out choice. The System's web sites include privacy policy notices about the collection and use of information. Members, retirees, and beneficiaries are provided a copy of their records upon request. The System maintains and periodically tests its Incident Response Plan for responding to, reporting, and mitigating any breach of data security.

N. A list of reports, applications and other similar paperwork required to be filed with the agency by the public

A list of filing requirements and filing statistics can be found in Exhibit C.

O. A list of reports required by the legislature to be prepared or submitted by the agency or independent agency

A list of required reports can be found in Exhibit D.

P. A copy of the single-page list of organizational units and programs within each organizational unit required pursuant to Section 955, subsection 1, placed at the front of the report

A functional organization chart is attached as part of Exhibit A.

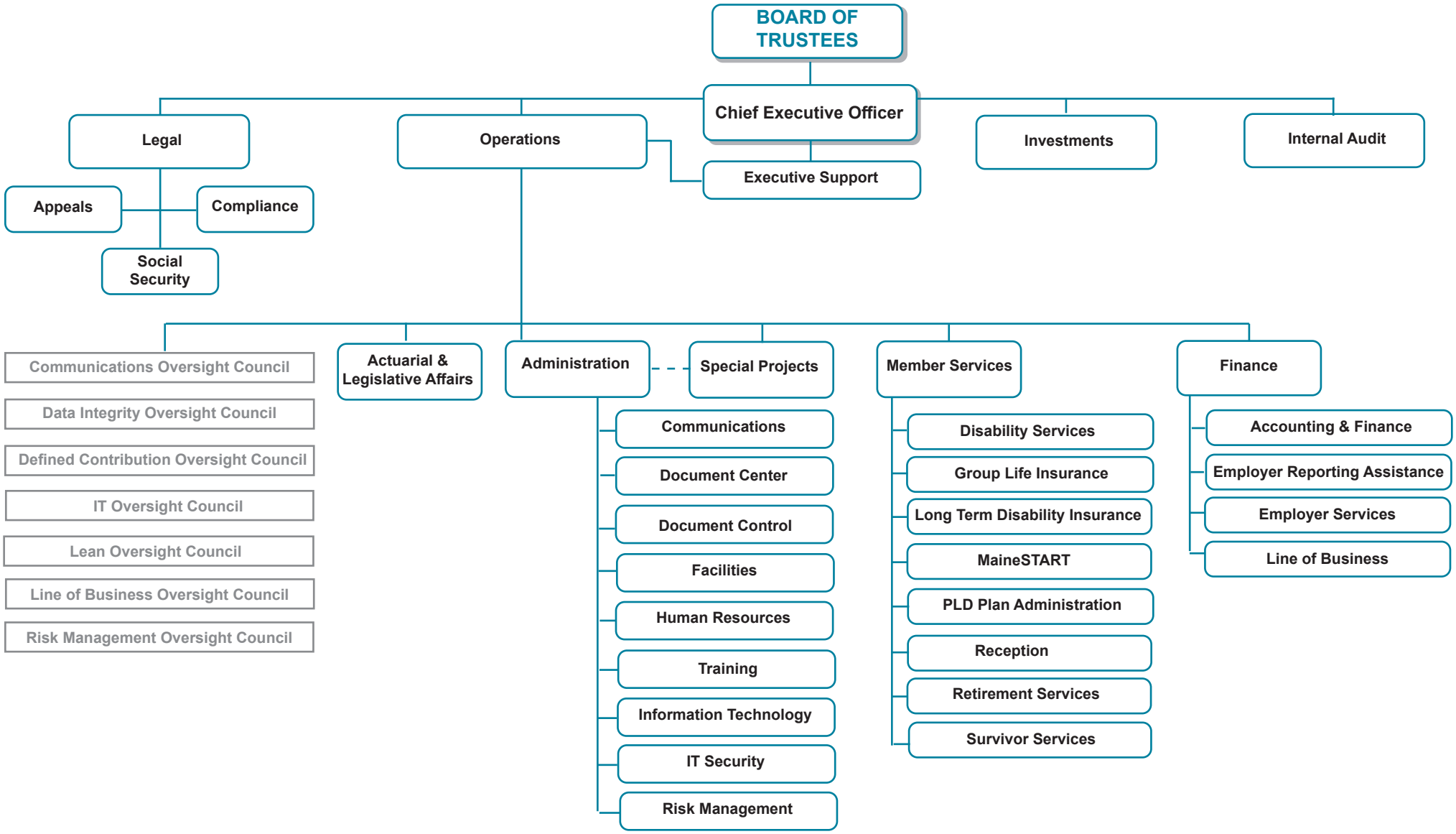
Q. Identification of provisions contained in the agency's or independent agency's enabling or authorizing statutes that may require legislative review to determine the necessity of amendment to align the statutes with federal law, other state law or decisions of the United States Supreme Court or the Supreme Judicial Court

The System continuously monitors for this purpose, proposes legislation where required for consistency with federal law, and identifies through legislative testimony any constitutional or federal legal conflicts in proposed bills.

MainePERS
PUBLIC EMPLOYEES RETIREMENT SYSTEM

EXHIBIT A

Organizational Chart by Function



JOB CLASSIFICATIONS

ACCOUNT REPRESENTATIVE
ACCOUNTANT
ACCOUNTING MANAGER
ADMINISTRATIVE SERVICES PROJECT DEVELOPER
ANALYST, INVESTMENTS
ASSET CLASS HEAD
BUSINESS ANALYST COORDINATOR
BUSINESS SYSTEM ANALYST
CHIEF EXECUTIVE OFFICER
CHIEF INVESTMENT OFFICER
CHIEF OPERATING OFFICER
COMMUNICATIONS ASSOCIATE
COMPLIANCE OFFICER
COMPUTER OPERATIONS TECHNICIAN
DC PLAN ADMINISTRATOR
DIRECTOR OF ADMINISTRATION
DIRECTOR OF FINANCE
DIRECTOR OF MEMBER SERVICES
DIRECTOR OF SPECIAL PROJECTS
DISABILITY RETIREMENT BUSINESS UNIT LEADER
DISABILITY SERVICES ASSOCIATE SPECIALIST
DISABILITY SERVICES TECHNICIAN
DISABILITY SPECIALIST
DOCUMENT CENTER SENIOR TECHNICIAN
DOCUMENT CENTER TECHNICIAN
EMPLOYER SERVICES BUSINESS UNIT LEADER
EMPLOYER SERVICES TECHNICIAN
EXECUTIVE ASSISTANT
FACILITIES MANAGER
GENERAL COUNSEL
HUMAN RESOURCES ADMINISTRATIVE ASSISTANT
HUMAN RESOURCES SPECIALIST
INFORMATION SECURITY ANALYST
INSURANCE PROGRAMS BUSINESS UNIT LEADER
INTERNAL AUDITOR
IT OPERATIONS ASSOCIATE
MANAGER, ACTUARIAL & LEGISTATIVE
MANAGER, HUMAN RESOURCES
MANAGING DIRECTOR, INVESTMENTS
MEMBER SERVICES REPRESENTATIVE
MEMBER SRVC/RETIREMENT SRVS CLERK
NETWORK & OPERATIONS SUPERVISOR
NETWORK ADMINISTRATOR
PARALEGAL
PAYROLL COMPLIANCE AUDITOR
PENSION ASSOCIATE I
PENSION ASSOCIATE II - PART-TIME
PENSION ASSOCIATE III
PENSION SERVICES TEAM ADMINISTRATOR
PLD BUSINESS UNIT LEADER & PLAN ADMINISTRATOR
QUALITY CONTROL TECHNICIAN
RETIREMENT SERVICES SENIOR TECHNICIAN
RETIREMENT SERVICES SPECIALIST
SENIOR ANALYST, INVESTMENTS
SENIOR ANALYST, OPERATIONS
SENIOR COMPUTER OPERATIONS TECHNICIAN
SENIOR FINANCIAL ANALYST
SENIOR PROGRAMMER ANALYST
SERVICE PROGRAMS ACCOUNT ASSOCIATE
SERVICES PROGRAM SPECIALIST
STATE & TEACHER BUSINESS UNIT LEADER
SUPPLEMENTAL BENEFITS TEAM ADMINISTRATOR
SURVIVOR SERVICES CLERK
SYSTEM REPRESENTATIVE
SYSTEMS DEVELOPMENT SUPERVISOR

EXHIBIT B
INFORMATION SPECIFICALLY REQUESTED
BY THE COMMITTEE OF JURISDICTION

Departmental Policy – Disability Services
2.1 – Medical Diagnosis

Summary of Policy

State law requires the Maine Public Employee's Retirement System to collect, evaluate, and make determinations that include the consideration of medical diagnosis. MainePERS established this policy to provide guidance regarding the medical evidence it is charged with evaluating.

Statutory/Legal/Board Policy Provisions

- 5 M.R.S. § 17106

Impacted Departments

- Service Programs
- Legal

Definitions

In the context of this Departmental Policy:

1. **Medical Diagnosis.** The term "medical diagnosis" refers to the process of determining which namable illness, injury or condition explains a person's symptoms. The information required for diagnosis is typically collected from an individual's personal history, physical examination(s), and tests performed by an appropriately qualified medical professional.
2. **Qualified Medical Professional.** The term "qualified medical professional" refers to an individual who, given their education and experience, is credible for the purpose of rendering a medical diagnosis.

Background and Legal Framework

1. **Background.** The foundation of a disability retirement claim is built on three medical-related components. Applicants demonstrate that a medical diagnosis exists, and the functional limitations which relate to tasks required to perform their job that are associated with one or more diagnoses, and whether any of the limitations are permanent. Meaningful determinations regarding these medical issues require the involvement and expertise of qualified medical professionals.

   Described here are standards regarding medical diagnosis that MainePERS will apply when evaluating and drawing conclusions from an applicant's medical records.

2. **Legal Framework.** Maine law describes how MainePERS must consider medical evidence when making a disability retirement application decision. Those provisions cover the scope of records to be considered, and the weight that may be given to records.

   The basic expectation is that all medical records submitted and accumulated while evaluating an application must be considered when drawing conclusions regarding the existence of a medical diagnosis and any functional limitations associated with it. While the

law prohibits MainePERS from giving "preferential weight" to any particular piece of evidence, it recognizes that, where weighting evidence is necessary and appropriate, it must at least be based on "…the expertise of the medical source, the foundation of information upon which the opinion is rendered and its consistency with other medical evidence in the record."

Interpretations of the statutory provisions that govern medical evidence have occurred from time-to-time by Maine courts, the Board of Trustees, and the executive director. To the extent that any such interpretation establishes precedent regarding the handling of medical evidence by a decision maker, it will be applied by MainePERS and, as necessary, identified and explained in a decision.

Diagnostic Considerations

1. **Challenges.** Diagnosis is often challenging because many signs and symptoms are nonspecific. For example, redness of the skin, by itself, is a sign of many disorders and thus doesn't tell an appropriately qualified medical professional what is wrong.

2. **Options.** There is not a single accepted approach to reaching a medical diagnosis. Some methods may provide a higher degree of certainty than others and some approaches may have published industry standards associated with them. Where MainePERS' medical evaluator identifies an accepted diagnostic standard, MainePERS will use it as the criteria for substantiating a medical diagnosis.

   A. *Methods*. The wide variety of approaches used for diagnosis (including but not limited to clinical, laboratory, radiology, differential, or dual) are a potentially significant factor in evaluating the sufficiency of records and weight given to a record.

   B. *Rigor*. The qualifications of a medical provider and the diagnostic methods used by them are significant factors in determining the appropriateness of the conclusions drawn in an opinion.

3. **Qualified Medical Professionals.** It is accepted in the field of medicine that the credentials acquired by individuals are hierarchical, creating a system where the opinion of an individual with extensive schooling and practice is more heavily relied on than the opinion rendered by an individual with less. Consistent with state law, all other things being equal, the weight given to a medical opinion when MainePERS makes determinations in a disability retirement matter will be greater when the opinion has been rendered by an individual with expertise and/or specialization in the relevant field.

   The standard defined in the prior paragraph does not preclude giving greater weight to a generalist medical provider's opinion based on the documentary support for the opinion in the medical records and the provider's unique qualifications, experience, and relationship with the patient.

4. **Records.** A crucial factor in all determinations is the extent to which opinions and qualifications are documented in the totality of records available for consideration regarding an application. Recognized in state law is the importance of a sufficient foundation of information and consistency within the available records. High value will be placed on the records in front of MainePERS when a determination is made. The validity of a diagnosis will typically be undermined by records that are insufficient to support offered opinions or inconsistent among providers and dates.

5. **Consistent Provider Opinions.** Deference will be given regarding diagnosis when two or more qualified medical professionals directly evaluating and providing treatment have reached consistent conclusions. Similar deference will be provided regarding the permanence of a condition when the applicant is following all the treatment recommendations of a qualified medical professional who is directly evaluating and providing treatment recommendations and their condition remains unchanged. The exception to this deference may occur when clear evidence to the contrary also exists in the record in a manner that shows it is likely the opinions are fundamentally flawed,

Ownership

This policy is owned by the Disability Services Business Unit Leader.

As adopted April 7, 2017. Approved as amended February 8, 2021.

Jim Busch
Deputy Executive Director - Service Programs

Disability Services Practice
2.3 - UMASS-DES Medical Evaluation Process

Summary of Practice

Medical information relevant to a disability retirement application is a critical component in determining eligibility for those benefits. MainePERS staff relies on the expertise of qualified medical professionals contracted through the University of Massachusetts Disability Evaluation Services (UMASS-DES) to make medical determinations that are relevant to initial and continuing eligibility. This practice details the process that will be followed regarding the interactions of MainePERS and UMASS-DES.

Statutory/Legal/Board Policy Provisions

- 5 M.R.S. §§ 17925 & 18525
- 94-411 C.M.R. 202

Background

The medical review resource for staff, the MainePERS Medical Board, was replaced when MainePERS partnered with UMASS-DES. The executed contract tasked UMASS-DES with evaluating medical evidence gathered as part of a disability retirement application and providing guidance to staff on the merits of that information. Although member specific considerations such as pre-existence of diagnoses or functional ability after reaching normal retirement age will be an occasional concern, the primary matters for review will be existence of an applied on diagnosis, resulting functional limitations and permanency of those limitations as of a member's last date in service. Collaborative work with this resource will provide MainePERS disability staff the guidance needed to give members responsive and clear feedback on the merits of the medical records in an application for disability retirement.

Process

1. **Portal.** To accomplish the transfer of information, UMASS-DES maintains an internet-based portal to facilitate the secure exchange of files, reports and correspondence between MainePERS and UMASS-DES staff. Only authorized users have access to the portal through a secure log in profile and each user is provided with instructions. Monitoring of case progression and case related communication will be accomplished through this portal.

   A. *New Cases.* When a member's application file is ready for medical evaluation, a Disability Specialist (DS) will create a record for the member in the portal by inputting identifying information such as MainePERS alternate ID number, demographic information, type of review and enter any case specific notes needed for UMASS-DES staff. A combined file will be created using the Adobe Acrobat program and uploaded to the UMASS-DES portal. A memorandum with specific information about the evaluation needed and the status of the case (initial review, post MR review, appeal, etc) as well as any member specific questions or clarification will be located at the beginning of the combined file.

B. *Case Status.* Functionality is available in the portal to query a case in the medical evaluation process. MainePERS staff will access member records to monitor status updates and notes as the case progresses through the evaluation process in order to maintain ongoing familiarity with their caseload. Information that will be available in the portal will be the UMASS-DES disability reviewer assigned to the file, the type of medical professional that will review the information (physician, psychologist or psychiatrist), status of the review, notation of any communication with the member's medical providers and notes or comments related to review activity.

C. *Document Availability.* When the medical evaluation is complete and documents are available, UMASS staff will upload the completed Medical Evaluation Form and functional limitation forms to the portal. An email to the assigned DS will serve as notification that the documents can be found in the portal.

2. Medical Review. After a medical file has been uploaded to the portal, a UMASS-DES disability assistant will receive notification of the upload and will review the file to verify that all expected information is included. The file will be assigned to a Disability Reviewer who will facilitate assignment and timely completion of the medical evaluation. The Reviewer examines the information in the file to determine what medical specialty is needed and assigns the appropriate medical professional to complete the case file review. Reviewers are particularly sensitive to matching specialties for the evaluation in situations where an applicant has been treating with a specialist.

A. *Medical Evaluation Form.* Every medical basis that a member includes in an application for consideration will be fully considered and opined on by qualified medical professionals at UMASS-DES. Medical findings that determine whether a diagnosis is supported in the available record, pertinent history, functional impacts and treatment modalities that may ameliorate limitations are discussed within the medical review forms. Those aspects of an application include:

1) APPLICATION BASIS. Medical conditions in this section are those identified by the member as needing evaluation.

2) DIAGNOSES. All medical diagnoses found to exist based on the records provided are included here. Diagnoses that the member has not identified may be included but are limited to diagnoses determined to have a material effect on the member's functioning. Non-impactful or resolved diagnoses not applied on by the member do not get listed.

3) RECORDS EVALUATED. Evaluating clinicians refer to the medical documents they found in the record and relied on in making their determinations in this section. Reference to specific objective data that documents the existence of diagnoses or limitations may also be included.

4) CLINICIAN TO CLINICIAN CONTACT. When the medical professionals completing the evaluation find information in the file that could be clarified by a member's treating provider, the clinician typically contacts that provider. Reference to that call will be recorded in this section with a more complete record of the interaction appended to the medical review document.

5) NARRATIVE. The narrative section of the report contains an analysis of the records reviewed and document evidence the reviewer found to be compelling and

supportive of the opinions expressed, including the standards relied on to reach opinions. A brief history of each medical condition listed in sections 2 and 3, including diagnostic criteria that supports or refutes existence of that diagnosis, relevant documentation indicating the effect of the diagnosis on function and history of treatment and outcomes of those efforts is discussed. Disability Reviewers evaluate the evaluation report to ensure that opinions are definitive and consistent throughout.

6) PERMANENCE. An opinion is provided in this section on likely improvement of functional limitations that would result from additional treatment efforts and discussion of any modalities that would reasonably be expected to result in improvement.

B. *Functional Limitation Forms.* Supported diagnoses are assessed for impact on specific activities and resulting functional limitations will be documented.

1) PHYSICAL FUNCTIONAL LIMITATIONS. Limitations for each identified exertional category is evaluated with a summary at the end of each section that includes the reasoning for the limitations and the diagnoses associated with the limitation. When applicable, the summary narrative on the form will contain a brief statement that describes the medical professional's opinion on how functional limitations interact to result in the assigned work capacity.

2) MENTAL HEALTH FUNCTIONAL LIMITATIONS. Limitations for each identified mental health category is evaluated with a summary at the end of the form that includes the reasoning for the limitations and the diagnoses associated with the limitations. When applicable, the summary narrative on the form will contain a brief statement that describes the medical professional's opinion on how functional limitations interact to result in the assigned work capacity.

3) NO FUNCTIONAL LIMITATIONS. When supported diagnoses do not result in functional limitations, there will be a statement in the summary narrative of the form to document that finding.

4) WHOLE PERSON APPROACH. The "whole person" approach to determining the extent to which an applicant is functionally limited is applied by UMASS in every case. As a result, there is no separate "in-combination" analysis as formerly used by MainePERS.

B. *Review Completion.* After the UMASS-DES medical professional has reviewed the assigned file and completed the appropriate forms, the Disability Reviewer completes a quality control assessment of the forms and resolve any concerns that may be apparent. The Disability Reviewer then uploads the file to the portal and sends a notification email to the assigned DS.

C. *Timeframe for Review Results.* Although reports may be available earlier, by contract the medical evaluation documents will be available to MainePERS staff 15 to 30 calendar days following upload of the file to the portal for an initial review or a reconsideration. A response to questions or clarification for an existing report will also be available within 5 days after a request is made. If a report has not been uploaded by

the expected deadline, the DS must email the UMASS Disability Reviewer assigned to the file to request an update on the timeframe.

3. Report Review and Feedback.

A. *Initial Review*. After medical evaluation forms are received from UMASS-DES staff, the assigned DS performs an initial review within 5 to 10 business days to determine whether the forms contain clear errors or omissions. Examples of these include: (1) a condition applied upon but not addressed in the forms, (2) one form that says a condition does not cause functional limitations and another on the same member that says that the condition does cause functional limitations, and (3) incorrectly identifying a provider. When a clear error or omission is discovered, the DS will inform the UMASS-DES Disability Reviewer assigned to the file via email, a phone call, or an upload to the portal. If done by phone, the DS will document the feedback. The UMASS-DES Disability Reviewer will work to address the feedback and will provide revised forms or otherwise respond within 5 days.

B. *Regular Evaluation*. The assigned DS then does their regular evaluation of the materials in light of the application record. The more complete an understanding of the diagnoses under review and the limitation findings that the reports convey, the more useful the information is to the DS and the applicant. MainePERS expects UMASS-DES to provide reports that are clear and consistent, both internally and in comparison to reports on other cases. However, MainePERS recognizes that UMASS is an independent party that is solely responsible for its opinions, analyses, findings, and conclusions. The DS should not seek revision of UMASS-DES reports other than to correct obvious errors or omissions as discussed in paragraph A of this sub-§. Concerns about the quality of UMASS-DES reports should be brought to the attention of the Business Unit Leader and management, as appropriate, to address with UMASS-DES as part of the vendor relationship.

C. *Questions or Clarifications.* It occasionally may be necessary to ask UMASS-DES a question or request a clarification because a report does not address a significant issue or because it is so unclear on a significant issue that, after making all reasonable inferences, the DS cannot determine the reviewer's findings and conclusions on that issue. After consulting with the Business Unit Leader, the DS will forward the question or request for clarification to the UMASS-DES Disability Reviewer assigned to the file either via email or an upload to the portal. Any questions or request for clarification should be submitted as soon as feasible after receiving the medical evaluation forms, consistent with other unit work priorities. The UMASS-DES Disability Reviewer will work with the medical professional who signed the Medical Evaluation Form to address any questions or requests, and a written response will be received within 5 to 10 business days unless availability of the medical professional requires adjustment of that time frame. Any question, request for clarification, and response is part of the record.

4. Communication about the role of UMASS-DES. Members applying for disability retirement entrust MainePERS with the confidential information inherent in medical records and expect safekeeping of that information. The message to members or others who express concern about an outside reviewer or the confidentiality of their medical records must be that MainePERS is fully confident that data security is a primary focus for MainePERS and UMASS-DES. Comprehensive measures are in place to maintain the

safekeeping of information shared through the secure online portal, and UMASS-DES doctors are held to the same standards of confidentiality as every other medical professional. Only staff with a role in the process have access to the information and are vigilant in adhering to information security protocols. Just as a member's own medical provider must maintain discretion and security regarding medical information, so must MainePERS and UMASS-DES.

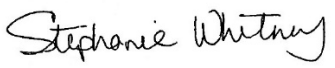
Associated Materials

- UMASS-DES Medical Evaluation form
- Physical Functional Limitations form
- Mental Health Related Functional Limitations form
- Maine Portal Instructions

Ownership

This Practice is owned by the Disability Business Unit Leader.

Adopted this 8th day of February, 2021. Approved as amended March 31, 2021.



Stephanie Whitney
Disability Business Unit Leader

Disability Services Practice
2.4 Placing an Application on Hold

Summary of Practice

This Practice details the process that will be followed when a member has requested that MainePERS temporarily stop taking action regarding her or his pending disability retirement application or it has been determined by MainePERS that recognizing a pause in processing is necessary. This period of time is referred to as a "hold" on the application, and must be requested by the member in writing or documented by MainePERS. When the conditions detailed in this practice have been met, a hold will be routinely allowed by MainePERS. A hold is designed to formally allow a member (applicant) time to determine the best course on which their application should proceed, including seeking additional medical opinions, without any undue pressure that may be perceived as a result of a less formal acknowledgment.

Statutory/Legal/Policy Provisions

5 M.R.S. §§ 17106, 17901, 17921, & 18521

Background

Members may formally request that the processing of their disability retirement application be put on hold when a significant decision must be made by them and they feel the options require time for consideration that otherwise might not be available. Also, it is important to formally recognize periods of inaction in order to accurately calculate the time it takes to process an application versus idle time spent at the direction of a member. Although there is not a set limit on the number of times an application may be placed on hold under any given scenario, MainePERS will use its judgment to determine whether multiple requests at the same stage of processing are appropriate given the circumstances.

It is likewise necessary to allow for a pause in processing where MainePERS determines that the circumstances surrounding an application make formally recognizing the pause warranted because it is in the interest of the member or a practical step that realistically reflects the situation.

Process

1. **Hold Scenarios.** The following points in the disability retirement application process may be a time when a member will request, or MainePERS will determine, that further processing of their application formally cease for a defined period of time.

    A. *Pre-Medical Review*. Before a member's file is compiled for evaluation by MainePERS' contracted medical consultant, the Disability Specialist (D.S.) assigned to processing it will have a conversation with her or him regarding the records accumulated and status of the application in the process. Questions may arise as a result of that conversation related to missing records or the member's medical condition(s) that require an extended period of time to answer

or pose challenges to a member regarding the path forward with their application that are best answered after some reflection.

B. Post-Medical Review. After the medical consultants have issued an opinion, a member will discuss the status of her or his application with the D.S. assigned to processing it. Questions existing at that point related to a member's medical condition(s) may pose challenges to a member regarding the path forward with their application that are best answered after some reflection that is not amenable to an immediate commitment to what will be the typical deadlines in the process.

C. MainePERS Determination. At any point in the application process MainePERS may determine that circumstances are such that it is in the best interest of the member to formally acknowledge a temporary pause in the processing of their application. These circumstances include situations where an extended period of inaction is anticipated but the member refuses, either through inaction or explicitly, to use the hold process documented in this practice.

2. Requests. It is essential that a member's desire to have the processing of their application temporarily cease is documented, and that they have an understanding of the duration of the hold and its impact on the process time line. The form of a request is not crucial. The member may submit a written request or the D.S. assigned to processing an application may memorialize in the record a conversation where the member requests a hold.

A. Content

1) ACKNOWLEDGEMENT. A member's hold request must be sufficiently clear and provide adequate detail so that the D.S. assigned to processing the application has understandable documentation of the situation in the file.

2) DURATION. The hold period requested by a member can be up to 90-days from the date the written communication is received by MainePERS. The initial hold period may be extended for up to an additional 90-days upon request by the member so long as the extension documentation is filed prior to the end of the previously granted hold. The maximum time period allowable without significant justification is 180-days.

B. Timing. A request that an application be put on hold will typically be received within 14-days of the D.S. assigned to processing an application communicating one of the decision points prescribed in this practice.

3. Tracking. A D.S. must record details regarding a hold in the Disability Tracking Database. The recorded information must be sufficient for the case status to be known, dates associated with the hold are clear, and other important information is clear.

4. Confirmation Correspondence. The D.S. assigned to processing an application will follow a request for application hold, or a MainePERS determination that hold is appropriate, with a confirmation letter that details the start and end dates of the time period.

5. Hold End. The D.S. will contact a member no more than 30-days or less than 14-days prior to the end of a hold period in order to remind them of the upcoming end date. The form of

this contact must be determined by the D.S. based on the situation known to exist in a case. After the hold period ends, the D.S. will again contact the member in order to have a conversation regarding the restart of the MainePERS process. This conversation may include requesting updated provider releases or updated records. If a member requests that a hold period end prior to the established end date, the request must be in writing.

6. **Member Unavailable.** In situations when contact at the end of a hold period has not been possible because the member is unavailable, processing of the application will proceed. A letter will be sent to the member to document that the application process is restarting.

Associated Materials

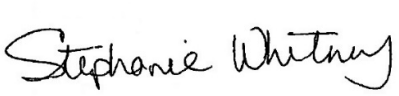
Hold End Letter Template

Application Processing Restart Letter Template

Ownership

This Practice is owned by the Disability Business Unit Leader.

Adopted this 30th day of May, 2019. Approved as amended December 2, 2020.



Stephanie Whitney
Supervisor Business Unit Leader

Disability Services Practice
2.5 Applicant Intake

Summary of Practice

From the point when a member first contacts MainePERS regarding disability retirement until their decision is made on whether to apply for the benefit, the assistance and information provided to them is crucial to informed decisions being made. The period from this first contact to the point when an application is filed is referred to as intake. This Practice details a standardized intake process that focuses on getting specific information to a member regarding their unique situation and customizing the materials supplied to them so that the consequential decisions they are making are well informed.

Statutory/Legal/Board Policy Provisions

- 5 M.R.S. §§ 17925 & 18525

Background

Members inquiring about disability retirement are either: (1) making a general inquiry; (2) have a sense of their medical situation and the program but haven't decided whether disability retirement is right for them; or (3) feel they are ready to apply, whether they are well informed about the program or not. Regardless of the circumstances under which an initial contact is made, MainePERS goal for supplying accurate and complete information is the same. With providing accurate and timely information as the goal, any member making contact with the program will then have the foundation they will need to begin serious consideration of an application. Experience has shown that even the individual who believes they understand the program typically has some misperception or inaccurate information.

Although providing some assistance and some information regarding the program is possible for all Disability Services Division employees, a conversation regarding how an individual's situation may fit within the program must be conducted by a Disability Specialist (D.S.). Although the beginning of most conversations will be similar, as the discussion develops a D.S. must apply their professional judgment to determine whether the details associated with formal intake must be covered and in what manner the information will be presented.

Process

1. **Routing.** New program inquiries will be routed to an available D.S. Effort will be made to evenly distribute new inquiries among the D.S.s because under most circumstance the relationship established in an initial inquiry will continue for the member in subsequent intake-related inquiries.

   Members who have previously contacted the program will be routed to the D.S. who previously spoke with them, if possible. Questions about whether an individual has had previous contact with the program regarding disability retirement will be answered by searching the Disability Database . The D.S. will pick up the subsequent conversation in a manner consistent with this practice.

2. **Case Assignment.** To the extent that incoming inquiries cause an imbalance in workload, the Disability Business Unit Leader will redistribute cases in an appropriate and equitable manner. Although prior contact with a member may influence a case assignment decision at the point when an application is filed, it is only one of many factors. Nothing in this practice should be construed as requiring case assignment to a particular D.S. because of their contact with the member during intake.

3. **Handling Initial Inquiries**

   A. GENERAL INQUIRIES. A member inquiring with general questions will be given a standardized program description that emphasizes the nature of the benefit being retirement and other general information about the program. This description is contained on the Intake Form. The member will also be offered written materials - brochure and F.A.Q.s - along with a summary of the conversation that will also include the D.S.'s name for any future contact.

   B. FORMAL INTAKE. A member whose inquiry is about how to apply to the program will be provided with a more specific description of the process - including the need for formal intake - and asked if they are interested in participating in an intake interview at that time. Any intake interview will be conducted in the prescribed format, which includes following the progression established on the Intake Form. The form's structure is designed to provide the member with accurate and timely information specific to their situation so they have the foundation they will need to begin serious consideration of an application.

      The D.S. will be prepared to use the resources available to them in order to: review standard requirements and definitions; verify demographic information; discuss information specific to the member; review information needed for an application; and set expectations so the member can determine whether disability retirement is the right place for them to be and now is the right time for them to apply. After the intake interview, the member will be sent the Intake Form filled in with information gathered during the conversation, Disability Program Overview F.A.Q.s, and a "Qualifying for Disability Retirement" brochure. Where the member has asked for an application, a partially pre-populated version will be included with the intake information along with partially pre-populated medical release forms.

   C. REPEAT INQUIRIES. Each separate inquiry for the same individual will typically be considered a new intake for tracking purposes, not a continuation of a previous call unless the circumstances make continuation sensible. For example, an individual who does not get far into an intake conversation, is sent materials summing up the conversation, and immediately calls to get farther into an interview may be treated as a continuation. In any case, a member will be asked if previously collected information is still current.

4. **Post-intake Communications.** Some general inquiries will be followed with written correspondence, in accordance with this practice. An inquiry that proceeds to the point of an intake conversation will be always followed with written correspondence, as detailed in this practice.

5. **Inquiry Tracking.** MainePERS maintains an electronic database known as the Disability Database for the purpose of recording information regarding disability retirement cases. In the intake context, an initial inquiry, whether general or formal, will require the opening of a case. The case established as a result of an initial inquiry will be the basis for tracking all

subsequent interactions unless and until a definitive event occurs which requires that the pending case be closed. Any practice and user manual applicable to recording information in the Disability Database. will be followed during the intake process.

Associated Materials

- Intake Form
- Disability Program F.A.Q.s
- Qualifying for Disability Retirement brochure

Ownership

This Practice is owned by the Disability Business Unit Leader.

Adopted this 30th day of May, 2019. Approved as amended December 2, 2020.

Stephanie Whitney

Stephanie Whitney
Disability Business Unit Leader

Disability Services Practice
2.6 - Changeover to Service Retirement

Summary of Practice

A disability retirement benefit transitions to a service retirement benefit at a time determined by criteria set in statute. Depending on the plan a recipient is covered by, that changeover is required to occur at the point when either the recipient reaches the age that is ten years beyond his or her normal retirement age or the point at which the recipient has accrued enough creditable service so that the service retirement benefit equals the disability retirement benefit amount. This practice outlines the role of Disability staff in the changeover process.

Statutory/Legal/Policy Provisions

Title 4 §1353
Title 5 §17907.2, 18507.2

Background

To ensure timely changeover of disability recipients to service retirement so that accrual of excess creditable service or overpayment of benefits does not occur, recipients must be identified and provided the necessary estimates and benefit option information to make an informed choice prior to the date the changeover is slated to occur. Receipt of necessary application materials must be facilitated to allow time for the changeover to be completed without an interruption in benefits. The process of identifying recipients requiring changeover and accomplishing that process primarily resides in Pension Services but the Disability Unit serves a supportive role in facilitating that process.

Process

1. **Quarterly Report.** An Associate Specialist in the Disability Unit performs the tasks outlined in this practice. At a point in each quarter of the year, the Associate Specialist queries V3 for a report of the recipients scheduled to changeover at any point within the next year. The report is reviewed for the following purposes:

    A. *Earnings Limitations*. Disability recipients are limited in the amount they can earn on an annual basis without impacting their benefit and can request to be informed of that limit. The list of recipients pending changeover is reviewed to identify those who have a history of reported earnings through the Annual Statement of Compensation process. For those recipients, because they will receive a disability benefit for only a portion of the year, a pro-rated earnings limitation is calculated and contact is made to notify her or him of the updated limit in an effort to prevent the recipient from over earning and incurring a balance due to the System. The standard letter to notify recipients of earnings limitations, which differentiates between earnings with MainePERS covered and non-covered employers, normally contains language regarding the pro-rated effect of partial year benefits and is edited to also include the recipient's changeover date and the adjusted limitation amount. If the changeover is to occur in the middle of a month, recipients are advised to retain and forward advices of deposit or other salary

documentation for the month in which they changeover to facilitate accurate earnings calculation.

B. *Medical Considerations*. The list is additionally reviewed to identify recipients with significant, debilitating medical conditions such as traumatic brain injury, dementia or advanced illness who may need additional support in negotiating the changeover process. Pension Services staff is notified of those recipients and the type of potential assistance that may be required given what was last known about their medical condition.

2. **Internal Communications.** Pension Services is responsible for providing an estimate and service retirement application to recipients scheduled to changeover, and as a function of customer service to the member, disability staff verifies whether those recipients have returned the service retirement application and any other required information. If it is within three months of the changeover date and the necessary information has not been received, Disability staff will check Call Center to verify if Pension Services staff has contacted the recipient. If contact has not been made, Disability staff will call the recipient to follow up on the necessary changeover information and document the contact in Call Center. If the recipient needs the estimate or any related forms resent, staff will email the Technician who completed the service retirement estimate or the appropriate Pension Services Specialist if the original technician is no longer available. If an estimate has not yet been completed for the recipient, the Pension Services Business Unit Leader will be notified.

Associated Materials

- Letter- EL MainePERS Covered Employment
- Letter- EL Non-Covered Employment

Ownership

This Practice is owned by Disability Retirement Unit Leader.

Adopted this 20th day of September 2018. Amended this October 15, 2019 and February 9, 2021.

Stephanie Whitney

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Stephanie Whitney
Disability Retirement Unit Leader

Disability Services Practice
2.7 - Verification of Review of Continuing Disability Documents

Summary of Practice

Disability recipients are required by statute to participate in a periodic review so MainePERS can determine continuing eligibility for a disability retirement benefit. The review process requires the exchange of confidential information via US Mail. Due diligence is necessary to ensure that confidentiality is maintained and sensitive information is not disclosed inappropriately.

Statutory/Legal/Policy Provisions

- 5 M.R.S. §§ 17907, 17929, 18507, & 18529

Background

Approximately every two years, disability recipients are required to participate in a review to determine whether eligibility for a disability retirement benefit continues. In order to meet this requirement, a recipient must demonstrate that the incapacity on which their disability benefit was approved remains and prevents the ability to engage in substantially gainful activity. Confidential information is obtained from the recipient, including current effects of the medical basis benefits were granted on and updated relevant medical care providers. Likewise, updated medical records are obtained from current treatment providers. Personally identifiable information is prepopulated in a form mailed to the recipient to assist in acquiring the medical opinions of clinicians. Competent procedures must be in place to protect against unintended disclosure of this information and guarantee that it reaches the appropriate recipient.

Process

1. **Preparing the Review Documents.** An Associate Specialist or Technician perform the duties outlined in this practice. At the time a recipient is approved for a disability retirement a future review date is identified by the specialist handling the application and that date is entered by them into Disability Tracking.

   A. *Identifying Recipients for Review*- Every month a report is generated from Disability Tracking that identifies the recipients due for review in the queried month. An Associate Specialist reviews the report and removes the names of recipients that are due to change over to service retirement within the upcoming year. The list of recipients is then forwarded to the Disability Specialists and Business Unit Leader to identify any information or concerns important to consider during the review. Within a week feedback will be provided by the specialists, the list is finalized, and a packet of information and forms to facilitate the review is prepared.

   B. *Medical Certification for Disability Retirement*- A Technician prepares a Medical Certification for Disability Retirement form to include in the review packet. A copy of the Medical Certification form is saved on the common drive for each recipient and is populated with identifying information found in V3 and the Disability Database. The following information is entered into the form: name, birthdate, last four numbers of SSN,

and the medical condition(s) the recipient is receiving a disability benefit for. It is intended that the recipient's treating clinician will complete the form and offer opinions about the status of the recipient's medical condition and resulting current functional limitations.

C. *Preparing the Packet*- A Technician assembles the forms to be mailed to the recipient (Report of Continuing Disability, the prepopulated Medical Certification for Disability Retirement form, Consent Form Authorizing the Release of Information and Consent Form Designating Authorized Representatives) and inserts them into the Review for Continuing Eligibility Booklet. The prepared Booklet is placed in an envelope and an address label is attached. The envelope is not sealed.

2. **Verification-** An Associate Specialist removes the contents of the prepared envelope to confirm the accuracy of the documents. The name and address on the envelope label are verified in V3. The Medical Certification is reviewed to confirm that the name is correct and matches the name and address on the envelope. The birthdate, last four of SSN, and medical condition(s) are also verified and the packet is inspected to be sure that a Report of Continuing Disability, Consent Form Authorizing the Release of Information and Consent Form Designating Authorized Representatives are included. Following completion of the review, the envelope is sealed and forwarded to the Document Center for mailing.

Associated Materials

- DC-0005 Report of Continuing Disability
- DC-0514 Medical Certification for Disability Retirement
- DC-0603A Consent Form Authorizing the Release of Information
- CL-0888 Consent Form Designating Authorized Representatives
- Review for Continuing Eligibility Booklet

Ownership

This Practice is owned by the Disability Retirement Business Unit Leader

Adopted this 4th day of October, 2019; Approved as amended January 7, 2021

Stephanie Whitney

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Stephanie Whitney
Disability Retirement Business Unit Leader

Disability Services Practice
2.10 Pre-Medical Review Member Contact - New Application Pending

Summary of Practice

This Practice establishes the expectations around what will happen when a Disability Specialist (D.S.) communicates with a member who has applied for disability retirement once she or he has collected all the information that appears available from the member, the member's employer, and medical providers identified by the member. Communication at this stage is designed to: (1) confirm the completeness of information discussed and received to that point in the process; (2) review the standards applying to and questions that will be considered by UMASS-DES; and (3) allow a member to know the opportunity exists to supplement the record with additional information. This approach to communication is pursued in order to present as complete a record as possible to UMASS-DES when it makes its evaluation.

Statutory/Legal/Policy Provisions

5 M.R.S §§ 853, 1353, 17106, 17901, 17921, & 18521

Background

A member seeking disability retirement works with a D.S. throughout the processing of their application. One of the most crucial aspects of those communications is the collection of information because an incomplete picture of the member's situation will result in an uninformed decision. The approach to this pre-Medical Review conversation seeks to inform members of the process and solicit additional information should they have any to offer.

Process

1. **Completeness Determination.** The D.S. assigned to process an application must use her or his judgment to determine that, to the best of their knowledge and ability, all relevant medical and employer information has been received. That determination is crucial because the context of the conversation(s) with a member at this stage is premised upon the potential that the application is ready to proceed to UMASS-DES for its evaluation.

2. **Status Review Conversation.** Once the completeness determination is made, the D.S. must attempt to contact the member. This contact will typically be via telephone in the first instance, but may also be accomplished in writing by email where a telephone call is unsuccessful. The D.S. must use her or his judgment to determine which available methods of communication are appropriate given what is known about the member and their situation.

   The primary purpose at this stage of application processing for reviewing the general content of a member's records and the standards that will be applied when UMASS-DES evaluates those records is to allow the member to be as knowledgeable as possible and make every attempt to have the records complete prior to UMASS'' doctors dedicating time to an evaluation. The essential points for discussion include: (1) confirmation of the completeness of information discussed and received to that point in the process; (2) review

of the standards applying to, and questions that will be considered by, UMASS-DES; and (3) allowing a member to know the opportunity exists to supplement the record with additional information prior to evaluation by UMASS-DES.

A. Member Contacted. When the member is reached by telephone they will be informed of the purpose of the call. At that point the member will either engage in the intended conversation or refuse the opportunity.

1) CONVERSATION CONTENT. When a member engages in a conversation at this point in the process, the D.S. will address the following:

a. Process Overview
- Brief outline of the process preceding this point in time
- Brief outline of the process from this point on

b. Medical Standards
- Overview of why UMASS-DES evaluation happens, including a review of the Medical Review FAQ reference sheet
- Discuss outcome of UMASS-DES evaluation, focusing on the report structure and content
- Make sure member understands the role of the UMASS-DES consultants that assist MainePERS
- Member understands the criteria that have to be met to qualify for disability retirement

c. Medical Providers
- Review information received including sources and dates of service
- Determine whether additional relevant providers exist; is there more medical information available from the known providers?
- Determine whether the member has an interest in seeking out any new providers
- Does the member want to supplement the record with additional medical information before the pending medical review occurs?
- If appropriate, offer to send a copy of the records to the member

2) CONVERSATION REFUSED. If the member refuses the opportunity to engage in a conversation regarding their application prior to UMASS-DES evaluation, that outcome will be documented (*see PreMR Ltr Template - Conv Refused*). Regardless of their refusal, the materials that otherwise would have been sent following a status conversation will be enclosed with the letter.

B. Member Unavailable. At this stage of the process, the D.S. will typically attempt to contact a member by telephone at least three times using the number she or he supplied on their application. A D.S. will pursue contact through other methods at an appropriate frequency when alternative means have been provided or are otherwise available and circumstances warrant it.

Unless an authorized representative has been specifically named by the member, a D.S. must avoid discussing any aspect of a member's situation with third-parties. If inadvertently contacted as a result of a telephone call or other correspondence, the D.S. can at most tell the third-party that MainePERS is attempting to contact the member. (*see* paragraph 2(B)(2) of this practice for guidance on proceeding when all attempts at contact have been unsuccessful).

1) AUTHORIZED REPRESENTATIVE. Where contact with a member has been unsuccessful and an authorized representative has been identified, the D.S. will attempt to contact that person at an appropriate frequency, and with an available method, when circumstances warrant it.

2) DOCUMENTATION. If the D.S. is unsuccessful contacting the member, or their representative, that outcome will be documented (*see PreMR Ltr Template - Member Unavailable*). The materials otherwise forwarded following a status conversation will be enclosed with the letter. The letter must specify the date on which application processing will resume, and the D.S. will organize their schedule accordingly.

3. Status Review Follow-up. Where the member has engaged in a conversation regarding the status of her or his application, regardless of the next step that results, it will be documented in a letter to the member.

A. Case Proceeding to Medical Review. A member who during their telephone conversation informs the D.S. that they are comfortable with their records being scheduled for UMASS-DES evaluation as soon as possible will be sent a letter documenting that desire (*see PreMR Ltr Template - Proceed to MR*). Enclosed with that letter will be the Provider Summary, and Frequently Asked Question reference documents regarding the program, UMASS-DES reports, and medical diagnosis standards.

B. Additional Records Sought

1) EXISTING PROVIDER. If the status review conversation reveals that a member has recently seen a provider(s) already identified as evaluating a condition relevant to the application, the records are not yet on hand at MainePERS, and the member wants those records considered, the D.S. will begin the process to request updated records before submitting the file for medical review. If the member identifies a provider not previously raised, the D.S. will send a release form to the member, and subsequently request the records.

2) NEW PROVIDER OR NEW CONDITION ADDED. If in the conversation a member expresses the desire to see an additional provider or add an additional medical condition prior to the pending UMASS-DES evaluation, the D.S. must discuss and agree on a schedule for obtaining and submitting the records the member is seeking. The D.S. must use her or his judgment in light of Disability Retirement Practice 2.4 *Placing an Application on Hold* to determine whether the time that appears necessary to obtain the records from any such provider is significant enough to warrant putting the application on hold. Regardless, the D.S. will send a letter (*see PreMR Ltr Template - New Records Wanted*) to the member in order to document decisions made during the status conversation. A release form for any new providers or an addendum for any new conditions will need to be received from the member within 15 days or the application will automatically be put on hold.

3) TIME ALLOTTED FOR SUBMITTAL. Experience demonstrates that the amount of time required to submit existing and new records will differ, largely because of the need to see additional providers where new records are involved. The time required for existing records is usually less than 45-days and new records can be up to three (3) months. In rare circumstances a member may need six (6) months from the date of the so-called *MR observation* letter and phone call. In either case, these expectations must be discussed with the member and an understanding must be

reached with them about the appropriate time period given their situation. This includes the consideration of placing an application on-hold.

For existing providers, the System will make every effort to obtain updated medical records. If a new provider is identified, the System will try to obtain records after obtaining a new release from member. If a new release is not received from member within 15 days, the D.S. will attempt to contact member. If the D.S. is unable to contact the member or release is not received within 7 days from that point, the D. S. will continue on with the process. The D.S. will send a letter (*see PreMR Ltr Template - Existing Records Needed*) to the member in order to document the decisions made regarding existing records during the status conversation.

4) ADDING NEW CONDITIONS. If a member chooses to add an additional medical condition(s) to the application prior to evaluation by UMASS-DES, she or he must submit a complete Addendum form. The D.S. will gather the relevant medical records during this time frame and the additional condition will be considered along with all the other conditions.

5) POST-RECORD PROCESS. Upon receipt of additional records, the D.S. will reinitiate contact with the member in conformance with this practice. The D.S. will use her or his judgment in determining the extent to which detailed conversation regarding all items listed in section 2(A)(1) of this practice is necessary in any subsequent conversation. The typical factors considered in this decision include the demonstrated understanding and engagement of the member, the complexity of the member's application, and the extent of the new information added to their file.

   The general expectation is that the conversation at this point in the process is to confirm that all records identified in the first pre-Medical Review discussion are now on-hand and that the file is ready for UMASS-DES evaluation. In the unusual situation where a member goes beyond this expectation and, unsolicited, asks to submit additional records, the D.S. must evaluate the request and use professional judgment to determine whether otherwise unexpected circumstances have led to this request are therefore justifiable. The process of ongoing conversation and repeated check-ins with a member to this point in the process should typically make the need to reset the process for submittal of a second round of additional records unwarranted. The receipt of the additional records that were identified in an original conversation is usually the trigger for proceeding to UMASS-DES evaluation.

4. UMASS-DES Evaluation. Once the point is reached when an application will proceed to UMASS-DES for evaluation, all practices applicable to that process will be followed.

Associated Materials

Provider Summary

UMASS-DES Medical Review F.A.Q.s

Medical Diagnosis F.A.Q.s

Disability Retirement F.A.Q.s

Specialist's Talking Points for Pre-Medical Review Conversation

PreMR Ltr Template - Conv Refused

PreMR Ltr Template - Existing Records Needed

PreMR Ltr Template - Hold Wanted

PreMR Ltr Template - Member Unavailable

PreMR Ltr Template - New Records Wanted

PreMR Ltr Template - Proceed to MB

Ownership

This Practice is owned by the Disability Retirement Business Unit Leader

Adopted this 18th day of July 2019. Approved as amended March 10, 2021

Stephanie Whitney

Stephanie Whitney
Disability Retirement Business Unit Leader

Disability Services Practice
2.11 Post-Medical Review Member Contact - New Application Pending

Summary of Practice

This Practice details the process that will be followed by a Disability Specialist (D.S.) regarding member communications at the point in time immediately after UMASS-DES has issued a review report while a new application is pending and she or he has completed an initial review of the record in light of those opinions. Communication at this stage of the process is designed to share observations made and, as needed, allow an opportunity for the member to understand and reconcile issues found in the records prior to a decision being made. Unless approval is warranted, this communication will first occur via a telephone call and then be followed in writing. Whenever possible, after the member has reviewed the documentation, a detailed conversation on the telephone or at MainePERS' office, if the member prefers to meet in person, will occur. Written communications are designed to provide the member with documentation that she or he can reference to better understand the status of their application in light of what otherwise is a technical document written by doctors. The verbal communication subsequent to documents being sent to the member is designed to answer questions and assist with the next steps in the process.

Statutory/Legal/Policy Provisions

5 M.R.S §§ 853, 1353, 17106, 17901, 17921, & 18521

Background

A member seeking disability retirement works with a D.S. throughout the processing of their application. One of the most crucial aspects of those communications is the collection of information because an incomplete picture of the member's situation will result in an uninformed decision. The approach to Post-Medical Review communications that are described in this practice are structured to inform members of the process, enhance their knowledge regarding what is being seen in their records, and solicit additional information should they have any to offer.

Process

1. **Post Medical Review Determinations.** The D.S. assigned to an application is responsible for determining whether: (1) the application can be approved based on the record existing at that point; or (2) points raised regarding the content of a member's records need to be reconciled before a favorable decision can be made.

   A. Approval. If the D.S. determines the record is sufficient to warrant approval of an application, she or he will immediately telephone the member to inform them of the decision. This call must be followed with an approval letter and payroll paperwork.

   Where the records appear to justify approval regarding some medical conditions and denial on others, a Final Decision addressing all conditions applied on and reflecting this mixed result will be issued. The member will then have the option of filing an appeal to further pursue eligibility based on any of the denied conditions. Continuing with the labor

required in the administrative process by issuing Observations regarding unsubstantiated conditions is not warranted in a mixed decision situation.

B. Records Reconciliation. The Medical Review report often raises questions regarding some aspect of a member's disability claim. The D.S. will call the member to inform her or him of these questions and then additionally provide these observations by letter. The D.S. will subsequently attempt to discuss these observations in detail on the telephone after the member has had the opportunity to review related information.

1) LETTER(S). The D.S. will send a letter (***see*** *PostMR Ltr Template - MR Observations*) immediately following issuance of the Medical Review report and a preliminary phone call. This letter is structured to provide members with information regarding the status and content of their application and let them know that the D.S. will be telephoning to discuss their application. The letter will include, as appropriate, observations regarding all aspects of what was considered by UMASS-DES, not just medical records. Enclosed in this letter will be the Provider Summary, Diagnostic Standards F.A.Q.s, and Medical Review F.A.Q.s. Under separate cover within a day or two after the *MR Observation* letter is sent, a secured email will be sent to the member, with a link providing her or him a complete set of the records considered by UMASS-DES.

2) TELEPHONE CONVERSATION. As follow-up to the so-called *MR Observation* letter, the primary purpose of a telephone call is to completely describe where the member is in the process, what UMASS-DES said regarding their records, review the standards and criteria that have been applied in that analysis, convey what the Medical Review report means and how it influences their application, and provide appropriately specific guidance regarding the member's options for providing feedback to MainePERS regarding what is being seen in the records. The D.S. should use all available guidance in preparing for and conducting this telephone conversation, including, policies, practices, sample points of discussion, frequently asked question publications, and the like. The conversation will typically be structured as follows:

a. Process Overview
   - Brief outline of this point in time in process
   - Overview of why UMASS-DES evaluation happens
   - Discussion of the outcome of UMASS-DES evaluation & observations, including a walkthrough of relevant records.

b. Frequently Asked Questions
   - Review the information provided in the FAQs sent with the *MR Observations* letter
   - Affirm member understands the role of the Medical Review consultants that assist MainePERS
   - Member understands the criteria that have to be met to qualify for disability retirement

c. Outline of questions addressed to UMASS-DES
   - Walk through structure of Medical Review report
   - Answer any questions or concerns the member has about information sought from UMASS-DES

3) CONVERSATION REFUSED. If the member refuses the opportunity to engage in a conversation at this stage regarding their application, that outcome will be documented (*see PostMR Ltr Template - Conv Refused*). Regardless of their refusal, the package of information that otherwise would have been sent following a status conversation will be enclosed with the letter. (*see* paragraph 1(B)(1) of this practice)

4) MEMBER UNAVAILABLE. At this stage of the process, the D.S. will typically attempt to contact a member by telephone at least three times using the number she or he supplied on their application. A D.S. will pursue contact through other methods at an appropriate frequency when alternative means have been provided or are otherwise available through other MainePERS maintained data, and circumstances warrant it. Where contact with a member has been unsuccessful and an authorized representative has been identified, the D.S. will typically attempt to contact that person at an appropriate frequency, and with an available method, when circumstances warrant it.

   Unless a representative has been specifically named by the member, a D.S. must avoid discussing any aspect of a member's situation with third-parties. If inadvertently contacted as a result of a telephone call or other correspondence, the D.S. can at most tell the third-party that MainePERS is attempting to contact the member.

   In the event that the member cannot subsequently be reached by telephone, the D.S. must include a date in the letter that is 14 calendar days from the point when she or he believes the letter should be received for the purpose of having the member know that processing will continue in the absence of a conversation.

C. Impossibility Determination. Where UMASS-DES has found that a disease exists, has functional limitations associated with it, and that the limitations will be permanent, the remaining determination regarding impossibility may require additional research by the D.S. Only in extraordinary situations where an extended period of time appears necessary to complete this process is there any need to contact the member. The D.S. will use her or his judgment to determine if and when contact is needed. (For example Chapter 509 determinations)

2. Record Collection. Where the member expresses an interest in supplementing the record, the D.S. will provide whatever guidance and assistance is appropriate to help with gathering it. This includes making reasonable scheduling accommodations.

A. Additional Records Sought

1) EXISTING PROVIDER. If the post-Medical Review conversation reveals that a member has recently seen a provider(s) already identified as evaluating a condition relevant to the application, the records are not yet on hand at MainePERS, and the member wants those records considered, the D.S. will begin the process to request updated records before considering or submitting the file for an additional medical review. If the member identifies a provider they have already seen but not previously mentioned, the D.S. will send a release form to the member, and subsequently request the records. The D.S. will send a letter (*see PostMR Ltr Template - Existing Records Needed*) to the member in order to document the decisions made during the status conversation regarding the collection of additional existing records. This letter will need to be modified in situations where the combination of existing records are

being sought and the member wants to see new providers; this situation must be discussed with the Disability Services Division Business Unit Leader.

2) NEW PROVIDER. If in the conversation a member expresses the desire to see an additional provider, the D.S. must discuss and agree on a schedule for obtaining and submitting the records the member is seeking. The D.S. will send a letter (*see PostMR Ltr Template - New Records Wanted*) to the member in order to document decisions made during the status conversation.

3) TIME ALLOTTED FOR RECORD SUBMITTAL. Experience in the Disability Services Division demonstrates that the amount of time required to submit existing and new records will differ, often because of the need to see additional providers where generating new records is involved. The time required for existing records is usually less than 45-days and new records can be up to three (3) months. In rare circumstances a member may need six (6) months from the date of the *MR observation* letter and phone call. In either case, these expectations must be discussed with the member and an understanding must be reached with them about the appropriate time period given their situation. This includes the consideration of placing an application on-hold.

   For existing providers, the System will make every effort to obtain updated medical records. If a new provider is identified, the System will try to obtain records after obtaining a new release from the member. If a new release is not received from the member within 15 days, the D.S. will attempt to contact the member. If the D.S. is unable to contact the member or a release is not received within 7 days from that point, the D. S. will continue on with the process.

4) CONTACT DURING RECORD GATHERING. Where the D.S. has not heard from a member and the end of the agreed upon time period for record gathering is drawing near, he or she will attempt to contact the member. This contact should typically occur approximately 14-days prior to the agreed upon end date. If the member cannot be reached by phone, a letter will be sent as a reminder to the member of the time remaining to supplement the record. Updated records from existing providers, even when the member has not identified that as a need, will be requested as applicable and at the D.S.' discretion.

4) ADDING NEW CONDITIONS. If a member chooses to add an additional medical condition(s) to the application during, or as a result of, this information gathering period, the member must submit a complete Addendum (form # DC-0003a). The D.S. will gather the relevant medical records during this time frame and the additional condition will be considered by UMASS-DES at the time it reviews the previously evaluated medical conditions.

B. Hold. The D.S. should discuss putting the member's application "on hold" if she or he proposes needing greater than the time describe in paragraph 2(A)(3) of this practice for the collection of additional records. Disability Services Practice 4.0 *Placing an Application on Hold* must be followed.

If the member has not supplied additional medical information or notified the D.S. that supplemental information exists within the hold period or within the Preliminary Finding period, the D.S. will send a letter (*see PostMR Ltr Template - Time Period Ending*) providing fourteen (14) calendar days to respond. If the member does not contact the D.S. in that time period, determinations will be issued. Where contact with a member

has been unsuccessful and an authorized representative has been identified, the D.S. will typically attempt to contact that person at an appropriate frequency, and with an available method, when circumstances warrant it.

3. **Medical Board Review.** Similar to Pre-Medical Review procedures and in conformance with any practice applicable to the process during that time period, upon receipt of additional records the D.S. and member will communicate to confirm that the application materials are ready for review by UMASS-DES. An application will typically be reviewed by UMASS-DES one time in addition to the original evaluation unless the D.S., within his/her discretion, finds further review by UMASS-DES necessary. The addition of conditions after the original Medical Review evaluation will not alone be the factor that results in multiple subsequent reviews of those conditions. If needed or wanted by the member, any additional development of the record regarding those conditions must occur as part of an appeal. Once UMASS-DES has reviewed the record as a whole in light of the supplemental information, the D.S. will make a determination of eligibility on existing conditions and any medical conditions added in this time frame, and issue the appropriate determinations. All practices applicable to issuance of determinations will be followed.

4. **Determinations.** Some members ask that their application proceed to issuance of determinations regardless of the observations made by UMASS-DES. These determinations may take the form of a "Final Decision" or "Preliminary Findings". The D.S. must attempt to discuss these two options with the member in order to determine whether she or he wants a "Final Decision" to issue regardless of their potential eligibility for Preliminary Findings. Practices applicable to issuance of a Final Decision or Preliminary Decision will be followed in these situations.

   In situations where the member was provided with an opportunity in conformance with this practice but did not submit additional records, and has not responded to phone calls and emails, a "Final Decision" or "Preliminary Findings" will be issued. Practices applicable to issuance of a "Final Decision" or "Preliminary Findings" will be followed in these situations.

Associated Materials

Provider Summary
UMASS-DES Medical Review Template (Annotated)
Medical Diagnosis F.A.Q.s
Disability Retirement F.A.Q.s
Specialist's Talking Points for Pre-Medical Review Conversation
PostMR Ltr Template - Conv Refused
PostMR Ltr Template - Existing Records Needed
PostMBR Ltr Template - Hold Wanted
PostMR Ltr Template - MB Observations
PostMR Ltr Template - Member Unavailable
PostMR Ltr Template - New Records Wanted
PostMR Ltr Template - Proceed to Determinations

Ownership

This practice is owned by the Disability Retirement Business Unit Leader

Adopted this 18th day of July 2019. Approved as amended March 10, 2021.

Stephanie Whitney

Stephanie Whitney
Disability Retirement Business Unit Leader

Disability Services Practice
2.15 – Issuing Preliminary Findings

Summary of Practice

When a new application is pending, MainePERS will evaluate the whole record and make determinations regarding a disability retirement application after medical review of the medical records has been completed. Where approval is not supported by the available records, the document that issues to the member will be the final decision or, if she or he does not yet have a last date in service at that time or the flaw in the records relates to establishing the permanency of functional limitations, may be preliminary findings if the member so chooses. Issuance of Preliminary Findings is established because it is in the best interest of the member to open a time period during which the member will be able to choose among options for how to proceed with her or his application.

Statutory/Legal/Policy Provisions

None Found

Preliminary Finding Determinations

A Disability Specialist (D.S.) will exercise her or his judgment when determining whether the next step in the application process should be issuance of a Final Decision or Preliminary Findings. The circumstances that make issuance of Preliminary Findings appropriate are limited to applications where positive findings are possible on all qualifying criteria but the permanence of functional limitation that make it impossible for the member to perform their former job or the member does not yet have a last date in service. Those two circumstances are appropriate for Preliminary Findings because there is the possibility that leaving the application pending for additional time could result in the submission of records that allow a positive finding to be made. In situations where multiple medical conditions are at issue and appear to not meet the approval criteria, and meeting the permanence standard is the shortcoming associated with at least one of the conditions, all conditions associated with the application would become part of the Preliminary Findings.

Process

1. **Final Medical Review Reports.** The D.S. will consider whether the next step in the application process should be issuance of a Final Decision or Preliminary Findings only after the medical reviewer has issued the last findings it will publish based on a member's expressed desire to not submit additional information or if additional records were submitted after the first medical review and the report is the result of a second documented review.

2. **Discussion of Options.** A primary purpose of providing Preliminary Findings is to allow an applicant the opportunity to reasonably extend the processing time of their application before a Final Decision issues so she or he has the opportunity to allow their situation to further develop to a point that could change the outcome. Whether to pursue that path is a decision the applicant must make.

A. TELEPHONE CONTACT. Should the D.S. determine that issuance of Preliminary Findings is an available option given the member's circumstances, she or he will attempt to reach the applicant by telephone.

1) *Purpose*. The potential for issuance of Preliminary Findings opens options for an applicant that are not available if the member forgoes them and chooses a Final Decision. A telephone conversation is necessary to ensure an applicant understands the stage they are at in the process and what options are available to them.

2) *Content*. At a minimum, the following subjects will be discussed with the member during a telephone conversation regarding the option for Preliminary Findings.

a) Options

1. PROCEED TO FINAL DECISION. Applicants are under no obligation to take additional time before having a Final Decision issue.

2. SUBMIT ADDITIONAL RECORDS. At this stage, achieving the positive outcome a member is seeking requires that she or he submit evidence that allows favorable findings to be made. To obtain an opportunity to submit additional records, the applicant must choose to have Preliminary Findings issue in lieu of a Final Decision. Should the applicant ask that Preliminary Findings issue in order to submit additional information, the schedule on which a member plans to produce additional records must be established. The initial phone call provides an opportunity to establish that schedule. When it is not possible to establish a schedule during this telephone call, the approach to future communication regarding the schedule must be discussed. If the schedule an applicant is proposing triggers the guidelines in MainePERS' practice regarding applications being put on hold, those provisions will be followed.

3. ABEYANCE. Given MainePERS policy regarding an applicant's ability to have processing of their application held in abeyance for a reasonable amount of time, an applicant is under no obligation to decide whether she or he will submit additional records or ask that a Final Decision issue. In situations where an applicant asks to have processing held in abeyance, the practice describing how to put an application "on hold" must be followed.

b) Timing. The additional maximum time period available to an applicant is six-months. Although an applicant should be aware of the time available to them, the D.S. must use her or his judgment when having a conversation with the member in order to provide useful input to them on how to make a decision about

their needs. It is typical that extensions will be in increments of three (3) months, and "on hold" procedures will be followed as appropriate.

3) *Written Confirmation*. A member who is eligible for Preliminary Findings but in their telephone call instead chooses to proceed to a Final Decision or put their application on hold must be immediately provided with a written summary of that conversation and a description of its consequences regarding their application. A Microsoft Word®

document template has been established, and is kept current, for the purpose of ensuring consistency in the confirmation letter that must be sent. The D.S. will use the current version of that letter template. Individuals choosing to receive Preliminary Findings will receive them in accordance with the steps detailed in Section 3 of this Practice.

B. FOLLOW-UP. In situations where questions have been left open or where milestones have been defined, the D.S. must use her or his judgment to determine when and by what means a member should be contacted to check on the status of their situation. In no situation where open questions exist should more than one-month pass between contacts. The D.S. should contact a member anytime a milestone passes without what was expected occurring, e.g. the member should be contacted if records failed to arrive on time.

C. UNABLE TO CONTACT. In situations where the D.S. has made three attempts to contact the member by phone and has been unable to contact the member, written notice will be sent to the member giving the member ten (10) days to contact MainePERS to discuss. If the member does not contact MainePERS within ten days, the D.S. will issue a Final Decision.

3. Preliminary Findings

A. FORMAT. A Microsoft Word® document template has been established, and is kept current, for the purpose of ensuring consistency when Preliminary Findings are issued regarding a disability retirement application. The D.S. will use the current version of that template.

B. CONTENT. The Preliminary Findings template is organized in a manner that provides a member with information regarding the findings that is sufficient for them to understand the basis on which the findings were made. It is the obligation of a D.S. to ensure that adequate detail is provided consistent with any applicable MainePERS policy or practice.

C. ISSUANCE. Once finalized, Preliminary Findings will be sent to the applicant, and any other representative she or he identified, via U.S. Mail Certified. A Microsoft Word® document template has been established, and is kept current, for the purpose of ensuring consistency in the Preliminary Findings letter. A D.S. will use that current cover letter template.

4. Evaluation of Additional Evidence. Practices applicable to medical review of records must be followed when additional records are submitted in an attempt to cure issues identified in a member's Preliminary Findings.

5. No Additional Evidence Submitted. When a member does not submit additional evidence during an agreed upon extension to her or his processing time period, the D.S. will proceed to issuance of a Final Decision. Although the D.S. has had, or attempted to have, a conversation when the expected submission did not arrive, written notice will be sent to the member to acknowledge that a deadline has passed and inform them that a Final Decision is under development. Practices applicable to the issuance of a Final Decision must be followed.

A Microsoft Word® document template has been established, and is kept current, for the purpose of ensuring consistency in the confirmation letter that must be sent to a member. The D.S. will use the current version of that letter template.

Ownership

This Disability Services Practice is owned by the Disability Business Unit Leader.

Adopted this 30th day of May 2019; Approved as amended January 7, 2021

Stephanie Whitney

Stephanie Whitney
Disability Business Unit Leader

Disability Services Practice
2.18 – Identifying Pre-Existing Medical Conditions

Summary of Practice

Maine law provides the framework for determining eligibility for disability. One of those guidelines requires that a period of continuous creditable service be established to allow for medical conditions that exist prior to a member's initial date of membership to be found eligible for disability retirement. This practice details the process for evaluating creditable service and clarifying periods of time in membership where contributions have not been made.

Statutory/Legal/Policy Provisions

- 5 M.R.S. §§ 17924(2); 18524(2); & 17001(13)(A)(1)
- *Family and Medical Leave Act of 1993*, 29 U.S.C. § 2601 *et seq*.

Background

A member normally does not qualify for disability retirement based on a medical condition that existed prior to their initial membership date unless the member has five years of continuous creditable service. Continuous service is defined as service time without breaks in service credit due to insufficient work hours, unpaid leaves of absence that are not federal Family Medical Leave Act (FMLA), or terminations. Payment received that is not for services rendered or is from donated or sick leave bank time also constitutes a break in continuous creditable service. However, a period of up to 30 days of unpaid leave service may be granted for acceptable leaves and could extend the period of continuous service. The exception to the pre-existence disqualification is if the medical condition was the result of or substantially aggravated by an injury or accident at work that was due to event or circumstances not typically encountered within the duties of the member's job.

Process

1. Information Gathering

A. *Verification Of Creditable Service*. An official verification of the amount of service a member is credited with must be requested from the appropriate Retirement Services business unit (State, Teacher, PLD). A Disability Specialist will create a Disability estimate workflow in V3 that includes specific questions that facilitate the analysis of continuous service, and routes it to the appropriate unit's queue. Those questions include:

1) Identifying the member's first date of membership, which may not be the first date of employment if membership was optional at the time of hire and the member elected to join at a later date.

2) Explanation of any breaks or gaps in the member's creditable service and the reason for the break.

3) Identifying the dates of any FMLA time.

4) If the member has five years of continuous creditable service, identifying the dates of that continuous service.

5) Determination of the amount of any creditable service granted for unpaid leave.

B. *Employer Information*. As part of the regular request that is made at the beginning of processing an application, a Disability Specialist will always ask an employer about the existence of any unpaid leaves, including but not limited to FMLA, administrative leave, or suspensions so the reason for unpaid time can be determined.

C. *Medical Information*. Confirming whether a medical condition was diagnosed prior to an individual's initial membership date if the member does not have five (5) years of continuous creditable service is a crucial part of the pre-existing analysis. In situations where continuous service requirements are not met, medical records must be obtained for treatment that occurred prior to the identified initial membership date with MainePERS. A Disability Specialist's conversations with the applicant will identify treatment providers and facilities that provided treatment prior to that date to the present time. Requests for information to those facilities will be made to capture relevant information.

2. Considerations

A. *FMLA*. This federally regulated benefit allows a period of continuous or intermittent twelve weeks of paid or unpaid time away from work without causing jeopardy to an employee's benefits. This protection extends to creditable service. Therefore, time off payroll due to an FMLA leave is not a break in continuous service unless the member does not return to work at the end of the leave. Any interruption in creditable service incurred as a result of unpaid FMLA leave is not a break in continuous service as long as the member returns to work at the end of the leave. If the member remains out of work beyond the end of that leave and transitions to a different type of leave such as unpaid medical leave, a break in service is created.

B. *Workers Compensation*. State law requires that members pay mandatory costs for creditable service based on Workers Compensation benefits received. Gaps in creditable service due to this type of leave may exist in a member's accounts if MainePERS has been unaware of the leave. However, once the leave is identified, creditable service is granted for that time because, since January 2004, the costs are mandatory and will be recouped either from direct payment by the member or through withheld payments prior to benefits being paid to the member. This type of leave will not constitute a break in service.

C. *Leaves of Less Than 30 Days*. A Board of Trustees decision (February 2003) determined that an unpaid leave of less than 30 days within a calendar year does result in loss of creditable service but does not disqualify a member from disability retirement based on a pre-existing medical condition. This allowed 30 days of unpaid leave would be reduced by any unpaid leave service that is granted.

3. Determinations. In situations where less than five years of continuous creditable service is found to exist, a determination must be made whether the medical condition(s) that form the basis of the application for disability retirement existed prior to the member's initial membership date. A review of medical records must occur to identify whether any of the

following situations, which will substantiate that a pre-existing medical condition existed, apply to the bases of the application for disability retirement.

A. The condition(s) was diagnosed by a health care provider prior to the member's date of initial membership.

B. The member exhibited a constellation of signs, symptoms or findings from which a health care provider reasonably should have diagnosed the medical condition(s) or should have caused that provider to request additional tests where the results would have led the provider to make the diagnosis.

C. The member's application is based on a condition(s) for which some, but not all, of the signs and symptoms needed for a diagnosis were present prior to the initial membership date and could not reasonably have been diagnosed at that time but which later fully manifested and was diagnosed.

D. The condition(s) that is the basis for the application for disability retirement was directly caused by or attributable to a condition(s) that was diagnosed, or reasonably should have been diagnosed, prior to the initial membership date.

Associated Materials

- V3 Generated "Membership Listing"

Ownership

This Practice is owned by Disability Retirement Business Unit Leader

Adopted this 22nd day of February 2019. Approved as amended December 11, 2020

Stephanie Whitney

Stephanie Whitney
Disability Retirement
Business Unit Leader

Disability Services Practices
2.21- Handling VA Individual Un-employability Findings

Summary of Practice

The presumption that a veteran who has been determined by the United States Department of Veteran's Affairs (VA) to be individually unemployable (IU) is disabled requires a Disability Specialist performing an intake and/or processing an application to consider the information used by the VA in ways that typical applications do not require. The legal presumption that an IU applicant is disabled unless certain evidence exists to the contrary creates additional decision points for the Specialist.

Statutory/Legal/Policy Provisions

- 5 M.R.S. §§ 17921, 17924, 18521, & 18524
- 38 Code of Federal Regulations, Section 4.16

Background

Effective October 1, 2018, MainePERS members who the VA has determined meet federal individual un-employability standards are presumed to also be disabled for disability retirement purposes unless evidence not considered by the VA rebuts that presumption. Also, the individual un-employability determination must be relevant regarding an applicant's last date in service and pre-existing condition standards must be met when applicable.

Process

1. Initial Contact

A. INTAKE. Just like all disability retirees, a member seeking disability retirement who also has received an individual un-employability determination from the VA must initiate contact with the Disability Unit. A Disability Specialist will conduct a Full Intake in conformance with Disability Service Practice 5.0 - Applicant Intake.

B. APPLICATION. The member will complete the remainder of the Application for Disability Retirement and any necessary release forms including VA form #3288 (Request For and Consent to Release of Information From Individual's Records) and return that information along with the determination from the Department of Veteran's Affairs that designates individual un-employability, including but not limited to form #8940(Veteran's Application For Increased Compensation Based on Un-employability) and all Rating decision(s) regarding the condition(s) applied on to MainePERS. Additional information that often is pertinent includes VA Form #21-4192 (Request for Employment Information in Connection with Claim for Disability Benefits).

2. Information Gathering

A. RECEIPT OF APPLICATION. The received application and release forms will be reviewed and verified for completeness and must meet the standards required of all applications for acceptance. These standards include valid signatures and proof of filing for social security disability or workers compensation if applicable. Once accepted, the application will be assigned to a Disability Specialist for processing.

B. NEW APPLICATION INTERVIEW. The Disability Specialist will contact the member for a complete New Application Interview. When an IU applicant is involved, discussion of all the member's medical care providers must occur to confirm and document those sources since they may have received care at the VA as well as from private doctors. History of the member's finding of IU will be reviewed with the applicant in order to fully discuss the medical basis for the finding and date the designation was awarded.

C. MEDICAL RECORDS REQUEST. A request will be made to the Veteran's Administration for, among other things, medical records; all information used to assess the member's rating status for VA purposes, and any findings or decisions granting the designation of individual un-employability. The evidence noted in the rating decision will be specifically requested using form 3288. Requests to gather records from additional providers will also be sent at this point in the application process.

D. CREDITABLE SERVICE. A workflow for a Disability Estimate will be opened in V3.10 and routed to the appropriate Pension Services Unit for completion.

E. EMPLOYER REPORT. A request will be made to the member's employer to complete the Employer's Disability Report and provide all supplemental information requested on the form. After receipt of the information, an Employer Interview will be conducted.

3. Considerations. The elements in this section are crucial aspects of determining whether an applicant's IU status is determinative.

A. PRE-EXISTING. All applicants with less than five (5) years of continuous creditable service and a medical condition that pre-existed that period of time are eligible to retire due to a disability only if the condition was substantially aggravated by something experienced on-the-job that was outside the normal course of their employment. An applicant relying in whole or in part on an IU determination as justification for being disabled must produce records that allow a pre-existing analysis and finding to occur. Determinations on whether a condition is pre-existing and the manner in which any such condition must be evaluated are made in conformance with Disability Services Practice 2.18 Identifying Pre-Existing Medical Conditions.

B. LAST DATE IN SERVICE. Whether an applicant is disabled for the purpose of receiving a retirement benefit is determined as of the point in time they were last in service in a MainePERS covered position. Employment records must be used to determine whether an applicant relying in whole or in part on an IU determination as justification for being disabled had that status with the VA as of her or his last date in service. Upon receipt of the completed Employer Report and supplemental information, the Disability Specialist will contact the Human Resources of the member's employer to verify the last date the

member received pay from either working or receiving his or her own accruals of leave time.

C. AGE-RESTRICTION. If the member is covered by a disability plan provision that includes an age-restriction, the member must have received the IU designation prior to reaching his or her normal retirement age.

4. Medical and Employment Record Evaluation

A. MEDICAL AND EMPLOYMENT RECORD CONTENT. Medical and employment records document the facts that support disability retirement determinations. Situations that involve an applicant who has seen providers at the VA and outside of that institution must have all their records gathered unless it appears more likely than not that all records were considered by the VA when the IU determination was made.

Where it appears from the intake process and VA records that more likely than not no other providers were seen regarding a medical condition at issue, a Specialist may then be able to determine that evidence that otherwise may have rebutted the VA determination does not exist. Where additional providers were seen regarding such a condition, their records must have been considered by the VA in order for a Specialist to conclude that potentially rebutting evidence does not exist. When it is unclear whether the VA considered any such records, the information must be accumulated and evaluated in order to determine if there is significant information from a qualified medical professional that appears to be at odds with the information used by the VA in support of the findings as outlined in the relevant Rating Decision.

B. MEDICAL RECORD EVALUATION. If in the judgment of the Specialist a significant omission or discrepancy is indicated between the information used by the VA and records from the member's additional providers, she or he will request any missing information and refer the matter to UMASS-DES for evaluation.

5. Approval and Benefit Processing

A. APPROVAL. Upon verification of individual un-employability and documented compliance with the additional previously noted statutory eligibility criteria, the Disability Specialist will approve the member for a disability retirement benefit based on the medical condition(s) found by the VA to meet individual un-employability. If the member's application includes additional medical bases that have not been rated as IU, the Disability Specialist will complete the full eligibility analysis and will issue a decision regarding all bases comprising the application at one time. Approval will include a call to the member for notification of the decision and a decision letter will be mailed after that conversation. The letter will include a direct deposit form as well as W-4Ps for federal and state withholding. A request will be emailed to the human resources contact at the member's employer to submit Employer Preliminary Benefit Certification Form, Vacation and Sick Leave Form and Personnel Status Change Form in Employer Self Service

B. VOCATIONAL REHABILITATION. The member will be offered the opportunity to participate in vocational rehabilitation, if appropriate. An election form will be provided to the member in order to accept or decline the offer of vocational rehabilitation. A response to this one time offer must be received within 10 days of the member's receipt of the offer. Failure to respond will be considered to be a decline of services.

C. COMPLIANCE. Members granted disability retirement based on and IU determination must comply with all requirements of a disability recipient including the Annual Statement of Compensation process, earnings limitations and Review of Continuing Eligibility.

6. **Review of Continuing Eligibility.** Disability retirees who qualify due to IU status are reviewed in the same manner as all other recipients.

Associated Materials

- Intake form and attachments
- Disability Retirement Application (DC-003)
- Consent Forms Authorizing Release of Medical Information (DC-0603)
- Consent Form Authorizing Release of Information From Employer/Government Agency (DC-0603B)
- New Application Interview form
- Employer Report (DC-0006)
- Membership Listing
- Healthcare Provider's Request- New Application (DC-0602)
- Decision Letter
- VA form #3288 (Request For and Consent to Release of Information From Individual's Records)
- VA form #8940(Veteran's Application For Increased Compensation Based on Un-employability)
- VA Form #21-4192 (Request for Employment Information in Connection with Claim for Disability Benefits)
- VA Rating Decision
- W-4P- Federal and State
- Direct Deposit Form (AC-0400)

Ownership

This Practice is owned by the Disability Retirement Business Unit Leader

Adopted this 25th day of January, 2019. As amended January 22, 2020 and February 9, 2021.

Stephanie Whitney

Stephanie Whitney
Disability Retirement Business Unit Leader

EXHIBIT C
FORMS REQUIRED TO BE FILED WITH MAINEPERS

Form	Statutory Authority	Last Revised	Frequency	Number Received (CY)*			
				2019	2020	2021	2022
Application for Membership	5 M.R.S. §17651	01/21	When becoming a member	14189	10777	14784	14800
Refund Application	5 M.R.S. §17705	02/20	When applying for refund of contributions	1600	1318	1563	1570
Application for Coverage Group Life Insurance	5 M.R.S. §§18058, 18658	01/21	Within 31 days of entering an eligible position	6300	4886	6528	6530
Cancellation/Reduction in Coverage	5 M.R.S. §§18058(2), 18658(2)	04/19	When cancelling or reducing GLI coverage	200	175	309	230
Member Statement of Death Claim	5 M.R.S. §§18057, 18657	07/21	Upon death of individual with GLI coverage	576	791	917	1000
MainePERS Employer Security Administrator Authorization Form	5 M.R.S. §17105	07/21	Upon becoming a reporting employer and upon security administrator position change	89	94	103	110
Application for Service Retirement Benefits	3 M.R.S. §851; 4 M.R.S. §1351; 5 M.R.S. §§17803, 18403	08/21	At time of retirement	2111	2168	2175	2180
Confidentiality Election Form -- Home Contact Information	5 M.R.S. §17057 sub-§3 C	12/18	At any time the member/retiree makes an election	18	14	10	10
Application for Disability Retirement Benefits	3 M.R.S. §853; 4 M.R.S. §1353; 5 M.R.S. §§1122, 17902, 17925, 18525	07/21	When applying for benefits	105	98	107	110

Form	**Statutory Authority**	**Last Revised**		**Number Received (CY)***			
			Frequency	**2019**	**2020**	**2021**	**2022**
Report of Continuing Disability	3 M.R.S. §853; 5 M.R.S. §18507, 18529; 4 M.R.S. §1353; 5 M.R.S. §17929; 5 M.R.S. §§1122	03/19	After five years and then two years thereafter. Every two years Annually for the first five years and every three years thereafter.	287	214	87	100
Annual Statement of Compensation for Disability Retirees	3 M.R.S. §853; 4 M.R.S. §1353; 5 M.R.S. §§1122, 17909, 17931, 18509, 18531	12/20	Annually	1429	1350	1380	1380
Personnel Status Change	5 M.R.S. §§17105(2), 17601(2), 18204	10/19	When a Teacher or PLD Member changes employment status	5499	4437	4387	4400
Member/Benefit Recipient Data Update	5 M.R.S. §17105(1)(F)	08/20	When a member/retiree seeks to change data including their name or address	6268	4356	3353	3250

*Calendar Year (CY) 2021 and 2022 are estimates

EXHIBIT D
REPORTS REQUIRED BY THE LEGISLATURE

Report	**Statutory Reference**	**Date Due**
Quarterly Out-of-State Travel Report	5 M.R.S. § 44-A	Within 15 days after end of each quarter
Annual Report on the Board's Environmental, Social, and Governance Policy	PL 2021, ch. 231, 319	January 1
Annual Divestment Report	P.L. 2021, ch. 231	January 1, 2023-2026
Annual Quasi-Independent State Entity Report (Procurement and Contributions)	5 M.R.S. § 12023	February 1
Annual Military Subsidy Report	5 M.R.S. § 17760(6)	February 15
Annual Operations Report	5 M.R.S. § 17103(11)	March 1
Annual RHIPEB Investment Trust Fund Report	5 M.R.S. § 17435	March 1
Report on Pension Plan Options	Resolves 2021, ch. 66	December 1, 2021 (extension being requested)
Report on Plan for Teachers to Collect Social Security	Resolves 2021, ch. 72	December 1, 2021 (extension being requested)
Report on Windfall Elimination Provision and Government Pension Offset	Resolves 2021, ch. 84	January 1, 2022
Report on Mandatory Long-Term Disability Insurance	PL 2021, ch. 277, § 43	January 1, 2023
Report on Disability Retirement	PL 2021, ch. 277, § 43	January 31, 2023