MAINE DEPARTMENT OF HUMAN SERVICES

MEDICAID PROGRAM REPORT

SFY87

John R. McKernan, Jr.
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

February 16, 1988

The Honorable Michael Pearson, Senate Chair
The Honorable Donald Carter, House Chair
Members of the Appropriations and Financial Affairs Committee

The Honorable Paul Gauvreau, Senate Chair
The Honorable Peter Manning, House Chair
Members of the Human Resources Committee
State House Station 3
Augusta, Maine 04333

Dear Senator Pearson, Representative Carter, Senator Gauvreau, Representative Manning and Members of the Committees:

I am pleased to transmit to you the third annual Department of Human Services Report on the Medicaid program. This report has been developed in accordance with 22 MRSA §3174-B as enacted by the 113th Legislature. I hope it will provide a more complete understanding to all who have an interest in this important program.

Maine's Medicaid program was successful in providing access to comprehensive health care services for approximately 136,000 low income people last year. Major credit should go to the 4900 in-state individuals, institutions and agencies who provided Medicaid services in 1987. Just as important are the 162 employees of the Department of Human Services who play a role in administering this $300 million program, the advocates who support it and, of course, the Legislature.

This report contains an overview of the Medicaid program, a summary of recent and proposed Federal changes in the program and our responses, a review of our quality assurance and cost containment activities and a summary of our annual fee and policy review. We look forward to your comments for improving the program.

Thank you for your continued interest and support.

Sincerely,

Rollin Ives
Commissioner

Foreword

The Bureau of Medical Services recognizes its responsibility for administering the Medicaid Program on behalf of the Department of Human Services. We work closely with other Bureaus, consumer and provider groups and the Department of Mental Health and Mental Retardation. The Bureau's work is also guided by a Medicaid Advisory Committee which is made up of consumers, their advocates and providers. This committee meets regularly with the Bureau director and staff and is chaired by a consumer representative, Robert Philbrook of Portland. Administration of the Program is shared with the Bureau of Income Maintenance which is responsible for determining client eligibility.

I believe this report provides a comprehensive relew of the program and our work this year. The principal coordinator of this Third Annual Medicaid Report is Victoria Burwell, Acting Director of the Division of Medicaid Policy and Programs. Ms. Burwell spent long hours, beyond those required of her day-to-day responsibilities, to prepare this report. Additional thanks go to those who assisted her, including:

Typing and Report Organization
- Beth Brann, Secretary

Coordination of Program Statistics
- Deborah Curtis, Special Assistant to the Director
- Hilary Fleming, Assistant Bureau Director
- Louis Dorogi, Director, Division of Licensing and Certification
- Margaret Ross, Director, Surveillance and Utilization Review Unit
- Sandra Bethanis, Director, Division of Medical Claims Review
- Linda Barr, Manager, Professional Claims Review Unit
- Edna Jones, Director, Preventive Health Program
- James Welton, Management Analysist
- Barbara Hamblin, Manager, Provider Relations Unit
- Judy Williams, Director, Medicaid Eligibility; Bureau of Income Maintenance
- Michael O'Donnell, Pharmacy Consultant, Bureau of Medical Services
- Evangeline Lee, Director, Consumer Services
- Michael Reid, Director, Division of Health Planning and Administration, Bureau of Health
- Jim Getchell, Director, Office of Audits

We appreciate this opportunity to reflect the accomplishments of Maine's Medicaid Program and the staff which administers it as well as to show some of the challenges which lay ahead.

Elaine Fuller

Elaine E. Fuller
Director
Bureau of Medical Services

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SUMMARY

For the size of its population, Maine has one of the most comprehensive Medicaid Programs in the country and enjoys a Federal match rate of 68.86% for Federal Fiscal Year 1987. 135,875 low-income individuals were provided a broad range of health care services in 1987. Approximately 65,600 of these individuals were under 21, the remaining 70,275 were over age 21. Over 7,000 in-state and out-of-state providers served these clients at a cost to the state of $95,637,723 and bringing in $203,885,368 in federal monies. The administrative costs account for only 3.3 percent of the total program costs.

- 89.8% of total Medicaid funds are utilized to provide reimbursement for six services plus administration: general intermediate care facilities (33.9%), intermediate care facilities for the mentally retarded (10.1%), hospitals (29.1%), prescription drugs (7.0%), physicians (4.6%), home health services (1.8%), and administration (3.3%).

- The cost of services grew 10.6 percent from SFY86 to SFY87 primarily as a result of increased hospital and ICF costs, increased utilization of services such as lab and x ray, substance abuse treatment, physical therapy services and waiver services

- Based upon the Sixth Annual Fee Review the Bureau recommends fee increases, when funds are available, for physicians, ambulance providers and podiatrists.

- The Department avoided or recouped $82,236,706 in expenditures last year through the Third Party Liability Unit and Surveillance and Utilization Review efforts.

- An average of 13,000 claims are processed each day and the average length of time for Medicaid payment is 16 days.

- The Licensing and Certification Division, with a staff of 44, conducted 573 licensing and certification surveys and resurveys last year for quality of services and investigated 301 complaints.

- The Medicaid Advisory Committee, re-activated in the past year and made up of consumers, their advocates and providers, guides and advises the Department in its administration of the Medicaid Program.

A. INTRODUCTION

The Medicaid Program was established in 1965 by an act of the United States Congress. As Title XIX of the Social Security Act, Medicaid became one of the most significant elements of the War on Poverty by creating a federal and state responsibility to provide access to comprehensive health care services for low income people. The Medicaid Program is a federal/state partnership with the federal government matching a percentage of every dollar spent by states on health care services for its eligible residents. In Maine, the program began modestly in 1966. Since that time it has grown to become one of the largest, most comprehensive, and essential programs administered by state government.

Medicaid recipients receiving federally-supported financial assistance (Supplemental Security Income or Aid to Families with Dependent Children) must receive at least the following services:

- inpatient hospital care
- ambulance
- outpatient hospital care
- rural health clinic
- physician services
- skilled nursing facility services
- family planning
- early periodic screening, diagnosis and treatment
- home health care
- independent laboratory & x-ray
- nurse midwifery services

In addition, states may also elect to expand their programs by coverage of certain optional services. At the present time, Maine offers the following optional services:

- occupational therapy
- dental, dentures
- venereal disease screening
- podiatric
- medical supplies and equipment
- speech and hearing centers
- mental health centers
- speech pathology
- optical
- chiropractic
- intermediate care facilities (ICF)
- intermediate care facilities for the mentally retarded
- waiver services for the mentally retarded
- waiver services for the elderly
- waiver services for the physically disabled
- inpatient psychiatric services for under age 22 (eff. 7/1/86)
- substance abuse treatment facilities
- prescription drugs
- optometry
- transportation
- Medicare Part A deductible and co-insurance
- Medicare Part B deductible and co-insurance
- Medicare Part B premium
- audiology
- residential treatment facility
- hearing aid dealers
- physical therapy
- personal care
- private duty nursing
- psychology
- psychological examiners
- inpatient hospital services in mental institution for age 65 or older (eff. 7/1/86)

Other optional services available, but not offered under Maine's State Plan are:

- clinic services
- inpatient Hospital for Age 65 or Older in TB Institution
- intermediate Care for Age 65 or Older in TB or Mental Institution
- hospice
- skilled nursing facility for age 65 or older in TB or mental institution
- case management

An explanation of each of these non-covered services follows.

Federal regulations require that **clinic services** be provided by or under the direction of a physician or dentist and within the clinic setting. Maine discontinued the coverage of mental health clinic services as a "clinic" service because it was found that this definition was too restrictive. Mental health clinic services are now considered to be rehabilitative services and may be furnished under the direction of a physician or psychologist and may be provided in settings appropriate to the care of the client.

Bureau of Medical Services staff continue work on policy development for **hospice** services. A request to the Health Care Financing Administration for the coverage of **case management** services has been approved and a policy for these services is in the process of implementation. Services in **TB institutions** are not covered because there are no longer any such institutions in Maine.

Within broad Federal guidelines, States have considerable flexibility in structuring their Medicaid Programs, including the determination of provider reimbursement levels. States also have the ability to develop alternative health care delivery programs through a variety of mechanisms such as freedom-of-choice waivers and home and community-based waivers. Freedom of choice waivers, while they limit client choice, allow states to implement cost-effective systems of care such as managed care. This would allow the Medicaid Program to designate primary care physicians for certain areas of the state and require that recipients see one of them for all their primary health care needs. Maine is studying managed care and plans to propose rules to institute such programs within a year. Home and community-based waivers allow states to provide community-based care as an alternative to institutionalization. The Department of Human Services currently operates three such waivers; for the mentally retarded, elderly, and physically disabled.

Medicaid coverage was provided to 135,875 Maine citizens for at least part of 1987. As illustrated in Figure 1, this is a somewhat smaller number than has been typically eligible in the years since 1975 and represents a 4.42% decline compared to the number eligible in 1986. This decrease may be tied to the improved economic climate of recent months, as there has been no tightening of eligibility requirements. The sharp drop in people eligible from 1981 through 1984 was caused by Federal budget changes which restricted eligibility. The increases for 1985 and 1986 were the result of state actions that expanded eligibility for AFDC and further Federal changes which reversed some of the previous restrictions such as the AFDC unemployed parent program effective November, 1984.

One of the conditions of eligibility is a needs test based on income and resources. All recipients must meet this needs test but children under adoption assistance or foster care payments (Title IV-E) and those recipients who are eligible by virtue of meeting the eligibility requirements for Supplemental Security Income and AFDC, are deemed automatically eligible. Resources include real or personal property, such as land, cash, life insurance, non-essential automobiles, etc. Health insurance is not considered an available resource in the determination of Medicaid eligibility. As long as an applicant, spouse and/or dependent children reside in the applicant's home, the home is not considered an available resource for purposes of determining eligibility for Medicaid.

The people eligible for Medicaid are divided into two groups, one group is classified as categorically needy, and the other is medically needy.

Categorically Needy

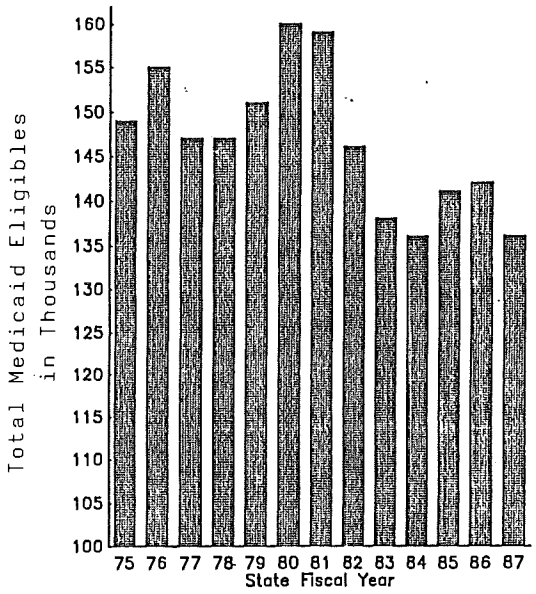
Categorically Eligible - (required by federal law)

This group includes all people who are receiving financial assistance through either Aid to Families with Dependent Children or Supplemental Security Income (SSI). (A dependent child is defined as one who is deprived of parental support and care because one or both parents is ill, absent, unemployed, or deceased. SSI deals with those persons who are aged (65+), blind, or disabled.)

Categorically Related - (includes mandatory and optional coverage groups)

This group includes people who for one reason or another are not receiving AFDC or SSI financial assistance but who do meet the financial eligibility standards of these programs.

Figure 1
Medicaid Program Eligibles
SFY 75 - 87
Number of Recipients Range From
135,717 - 160,089



Coverage was extended in October 1985 to pregnant women and newborns. Coverage continues for 60 days beyond the birth of the child. New Medicaid options related to pregnant women and infants were created under the Omnibus Budget Reconciliation Act of 1986 (OBRA-86). This federal legislation allows states to expand eligibility to pregnant women and children whose income is below the federal poverty level. Once a state acts to expand eligibility for this group, it may then cover additional elderly and disabled individuals. This is an option that Maine has not yet taken. Bureau staff are exploring the costs associated with the addition of these groups of eligibles and options for funding.

Individuals under age 21 are covered by virtue of being a dependent child whether or not in an intact family. These households must still meet eligibility standards.

At any given time, approximately 89% of the total Medicaid - eligible population are categorically eligible or categorically related individuals.

Medically Needy

States must provide assistance for categorically needy persons and may provide for the "medically needy" as a state option.

Approximately 2% of the total Medicaid eligible population is comprised of individuals classified as medically needy.

This group includes people whose income or assets initially exceed eligibility levels but who incur direct medical expenses sufficient to cause them to "spend down" their income to a level which makes them eligible. This means that individuals must spend their excess income on medical care expenses before becoming eligible for Medicaid. Approximately 33 states provide for the

"medically needy" option. Although Federal law does not require that Medically Needy recipients receive the same full range of services as other Medicaid eligible people, Maine has chosen to provide all services except psychological services to this group. Since mental health clinic services are available on a statewide basis to provide psychological services, it is believed that adequate coverage is available to maintain access to these services for this population.

Because Maine also has chosen to exercise other eligibility options such as covering individuals eligible for SSI who have yet to apply or including unemployed parents in the AFDC program, its current Medicaid coverage is notable for both the scope of service provided and the range of people included. (Some people may not apply for AFDC or SSI payments because the payments may be too small (based upon their income) and their primary interest is in receiving health care benefits.) Maine's Medicaid Program covers all possible eligibility options except two. The first exception is the six-month optional extension for AFDC recipients who return to work. Currently under AFDC, individuals receive two different types of extensions:

(1) AFDC eligible individuals working for the first four months receive a disregard from their income which is equal to $30 plus 1/3 of the remainder of their countable income. After the first four months of employment this disregard is no longer applied to income. If a client's income is over the net income standards because this disregard is no longer applicable, that previously-eligible AFDC family is eligible for 9 months of extended coverage.

(2) AFDC households receiving either an increase in earnings or an increase in hours of employment, which cause their income to exceed the allowable income standards, are entitled to a four-month extension of coverage.

The six-month extension was not added because it is believed that the current extensions adequately cover the individual's needs in the transition from receiving assistance from the state. The second exception is individuals who would be ineligible if they were not enrolled in a health maintenance organization (HMO). Since the Medicaid Program currently does not enroll any HMO providers, this option does not apply to Maine.

B. PROGRAM FINANCING

The Medicaid program is financed on a matching basis by both federal and state resources. Direct services are matched in each state at variable rates that are recalculated annually. These rates are determined on the basis of a formula which measures relative per-capita income in each State and are designed to provide relatively poor states with relatively higher rates of Federal financial commitment. Nationwide, the federal share for medical assistance payments ranges from 50% to 79%. Maine's rate for SFY 1986 and 1987 was 68.86%, and is 67.08% for SFY 88. Maine's rate for SFY89 will be 66.68%. One current exception to this service match is for family planning services, which are matched by the federal government at 90%. However, the President's budget proposes to reduce this match to states' service match level. If this occurs, Maine would lose approximately $59,850 in federal funds.

Program administration matching rates do not change from year to year. However, they do vary according to the type of administrative cost. Most costs are matched at a 50% rate, but other activities such as health profession personnel and the program's computerized information and bill-paying system, the Medicaid Management Information System (MMIS), are matched at 75%. Special program enhancements may also receive a varying match rate. For example, the development of the Department's computerized system for tracking services to children and young adults under the Preventive Health Program is matched at 90%.

The program budget is composed of three major accounts:

- Payments to Medical Care Providers
- Intermediate Care
- Administration

The Department combined the Intermediate Care and Skilled Care accounts to allow for greater flexibility in budgeting for these similar cost services in August 1987.

Although the Department has budgeted these large accounts in recent years with a relatively high degree of accuracy, it is a difficult process. The Medicaid Program must provide services to the same degree and scope to all Medicaid recipients. As new client groups become eligible, they are entitled to the same services available to others.

The State's share of funds is appropriated primarily within the three major accounts. However, major efforts in recent years to take maximum advantage of Federal matching funds has resulted in the inclusion of a number of services which have traditionally been funded through other accounts. Therefore, 100% state funds are transferred to Medicaid from accounts within the Bureau of Social Services, the Bureau of Maine's Elderly, the Office of Alcohol and Drug Abuse Prevention, the Bureau of Mental Retardation, and the Bureau of Mental Health, thereby bringing in federal funds for services such as mental health services, waiver services and ICF services for the mentally retarded.

The Bureau of Medical Services is in the process of exploring with the Bureau of Social Services and the Department of Mental Health and Mental Retardation other services presently funded with 100% State monies that could be covered under Medicaid options.

TABLE 1
Participation by Other State Agencies in Medicaid Funding

	Bureau of Social Services	Bureau of Maine's Elderly	Department of Mental Health & Mental Retardation	Bureau of Rehabilitation	Office of Alcoholism and Drug Abuse Prevention
Intermediate Care Level Services			State Facilities for ICF/MR Services, Day Treatment Services, Medicaid Waiver for the Mentally Retarded		
Medicaid Waiver Services		Waiver for the Elderly	Waiver for the Mentally Retarded	Waiver for the Physically Disabled	
Payments to Other Medicaid Providers	Mental Health Clinic Services for Child Protective and Adult Cases		Mental Health Clinic Services for BMH clients, Medicare Part A Deductible for State Hospital Inpatients		Private Non-Medical Institution Services for Substance Abuse Treatment

C. EXPENDITURES

The Maine Medicaid Program expended a total of $299,523,091 in state and federal funds for SFY 1987. This was 10.46% more than was expended in SFY 1986 for services and administrative expenses and included the cost of adding new services, increased utilization of some services, and inflation.

As illustrated in Table 2, Medicaid expenditures are charged against three accounts. Intermediate cares services (41.8%) and payments to Medicaid providers (54.9%) make up 96.7% of Medicaid expenditures. The account for payments to other Medicaid providers includes a wide range of services such as physicians, hospitals, home health care, dental and transportation. The administrative account composed 3.3% of total program expenditures. Admininstrative costs as a percentage of total program expenditures have remained relatively constant over the past several years.

The Bureau of Medical Services accounts provide most of the state funds required by Medicaid. However, as previously stated, other bureaus provide funds for the purposes outlined in Table 1.

TABLE 2
Total Medicaid Program Expenditures
By Major Activity Category and Source of Funds
SFY 87

Activity	Total State Funds*	Federal Funds	Total	Percent of Total
Administrative Services	$3,955,351	$5,986,772	$9,942,123	3.3
Intermediate Care Level Services	$38,986,126	$86,210,169	$125,196,295	41.80
Payments to Other Medicaid providers	$51,189,387	$113,195,286	$164,384,673	54.88
TOTAL	$94,130,864	$205,392,227	$299,523,091	

*This table includes state funds from all Department of Human Services and Department of Mental Health and Mental Retardation accounts that provide "seed" for the state share of certain payments under the Medicaid program.

The Maine Medicaid Program pays providers in three different ways: 1) fee for service, where a fixed fee schedule is developed for each procedure or service 2) cost-based reimbursement in which a rate of reimbursement is developed for each provider based upon allowable costs. These providers (i.e. home health agencies, nursing homes, private non-medical institutions) are subject to annual audits to verify costs which result in cost settlements. A cost settlement may mean that the provider was overpaid and owes funds to the Department or that they were underpaid and are due additional funds from the Department. 3) Prospective reimbursement provides for a pre-determined amount to be paid to the provider of services (i.e. hospitals). This method is described in more detail on page 10, Payment for Inpatient and Outpatient Hospital Services.

Table 4 provides a detailed breakdown of expenditures for payments made to Medicaid providers for SFY 87 as compared to SFY 86. A total of $289,580,969 was expended in SFY 87 for all mandatory and optional services. This amounts to 10.64% more than was expended for services only in SFY 86. Therefore, of the overall 10.46% increase in expenditures as described above, expenditures for services increased at a slightly greater rate than total expenditures for the operation of the Medicaid Program. Figure 2 below provides a graphic display of the growth in expenditures for services under the Medicaid Program.

Figure 2
Medicaid Program Service Expenditures
SFY 79 - 87
Range $124,716,908 - $289,580,969

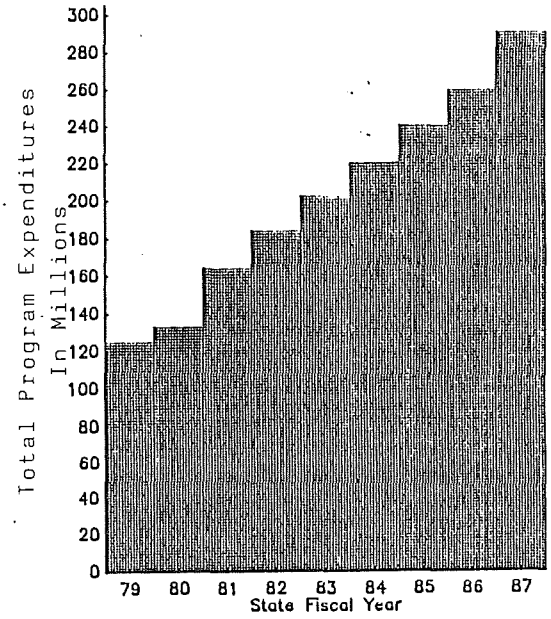


Table 3 presents the trends for utilization of in-patient hospital, intermediate care facility (ICF) and skilled nursing facility (SNF) services and compares the number of days for which Medicaid provided reimbursement in Federal Fiscal Years 1984 through 1987. Table 3a compares total Medicaid expenditures for those same services for the same periods of time.

Table 3
Trends for Utilization of In-Patient Hospital, ICF, and SNF Services by Federal Fiscal Year*

	FFY84 Days Reimbursed	FFY85 Days Reimbursed	% Change	FFY86 Days Reimbursed	% Change	FFY87 Days Reimbursed	% Change
Hospital	103,552	108,218	4.3	120,121	9.9	112,573	-6.3
ICF	2,404,270	2,415,885	.5	2,414,048	-.08	2,448,059	1.4
SNF	58,248	64,424	9.6	65,613	11.2	68,749	4.6

Table 3a
Trends in Expenditures for In-Patient Hospital, ICF, and SNF Services by Federal Fiscal Year*

	FFY84 Expenditure	FFY85 Expenditure	% Change	FFY86 Expenditure	% Change	FFY87 Expenditure	% Change
Hospital	$18,111,957	$48,575,521	62.7	$54,492,730	10.9	$67,074,629	18.8
ICF	$21,284,850	$81,278,948	73.8	$96,619,131	16.0	$101,256,535	4.6
SNF	$1,169,867	$2,834,114	58.7	$3,699,621	23.4	$3,775,723	2.0

*This information is produced for annual reports to the Health Care Financing Administration and, for that reason, is based on Federal Fiscal Years rather than for State Fiscal Years.

TABLE 4
MEDICAID EXPENDITURES - SFY86 & SFY87

MANDATORY SERVICES	Total Expenditures 7/1/85-6/30/86	Total Expenditures 7/1/86-6/30/87	% of Change + or (-)
Ambulance	$477,336	$454,718	-4.97%
Family Planning Clinics	$198,473	$151,183	-31.28%
Home Health	$8,167,017	$5,345,597	-52.78%
Independent Lab & X-ray	$184,772	$280,223	34.06%
Inpatient Hospital (7)	$54,492,730	$67,074,629	18.76%
Nurse-Midwifery	$709	$1,297	45.34%
Outpatient Hospital (7)	$14,215,053	$17,229,262	17.49%
Physician	$13,275,971	$13,387,023	0.83%
Rural Health Clinic	$679,944	$815,225	16.59%
Skilled Nursing Facility	$3,291,296	$3,484,245	5.54%
Total Mandatory Services	$94,983,301	$108,223,402	12.23%
OPTIONAL SERVICES			
Chiropractic	$123,173	$177,617	30.65%
Dental(5)	$1,952,871	$2,063,730	5.37%
HMO	$42,043	$0	N/A
ICF Community	$92,269,062	$94,010,660	1.85%
ICF State Institutions	$1,854,673	$2,078,404	10.76%
ICF/MR Community	$12,382,559	$13,185,342	6.09%
ICF/MR State Institutions	$14,068,835	$15,921,889	11.64%
Medical Supplies & Equipment (1)	$2,460,358	$2,615,665	5.94%
Medicare-Part A, Deductible & Co-Insurance	$4,170,232	$5,011,183	16.78%
Medicare-Part B, Deductible & Co-Insurance	$2,977,031	$3,995,095	25.48%
Medicare-Part B Premium	$3,093,945	$2,559,379	-20.89%
Mental Health(2)	$4,566,945	$5,192,865	12.05%
Personal Care Services	$0	$1,079,330	100.00%
Physical Therapy	$3,515	$21,976	84.01%
Podiatry	$93,794	$80,755	-16.15%
Prescribed Drugs (6)	$17,764,221	$20,361,454	12.76%
Private Duty Nursing	$0	$173,423	100.00%
Residential Treatment Facility	$329,500	$283,573	-16.20%
Speech & Hearing(3)(5)	$528,436	$652,827	19.05%
Transportation	$472,929	$1,047,731	54.86%
Vision Care (4)(5)	$503,859	$509,106	1.03%
Waiver Service - Disabled	$0	$24,913	100.00%
Waiver Service - Elderly	$770,722	$3,464,286	77.75%
Waiver Service - Mental Health	$389,398	$233,189	-66.99%
Waiver Service - Mental Retardation	$3,979,275	$5,972,316	33.37%
Unclassified	($998,321)	$640,759	255.80%
Total Optional Services	$163,799,055	$181,357,567	9.68%
TOTAL MEDICAID EXPENDITURES	$258,782,356	$289,580,969	10.64%

Footnotes:

1. Includes Orthotic/Prosthetic devices.
2. Includes Mental Health Clinics, Psychologist, Psychological Examiner and Community Support at Mental Health Clinics.
3. Includes Speech and Hearing Clinics, Audiologists, Speech Pathologists, and Hearing Aid Dealers.
4. Includes Opticians and Optometrists.
5. These Categories of Service include additional services for children under 21 as required by the EPSDT Program
6. Includes prescribed drugs for recipients living in ICFs and SNFs.
7. Hospital figures do not include year end settlements.

Source of Data: Controller's Income and Expenditure Analysis Report

Explanation of Large Percentages of Change (in Table 4)

Family Planning Services expenditures declined 31.28% in SFY87, from $198,473 in SFY86 to $151,183 in SFY87. While the number of participating providers remained the same, the number of recipients served dropped from 2,650 in SFY86 to 2,242 in SFY87. This decline coincides with an overall decline in individuals eligible for Medicaid, from 142,052 in SFY86 to 135,875.

Home Health Services expenditures decreased by 52.78%, from $8,167,017 in SFY86 to $5,345,597 in SFY87. The number of clients served remained about the same, however, the number of participating providers dropped from 26 in SFY86 to 19 in SFY87 (27%). Some of this decline can be attributed to changes in reporting of these services called the alternative long term care program which is no longer a part of Home Health Services.

Independent Lab and X-Ray Services expenditures grew substantially (34.06%) again. Expenditures increased from $184,772 in SFY86 to $280,223 in SFY87. This increase is tied to a large increase in the number of participating providers, up from 30 in SFY86 to 40 in SFY87, and in the number of recipients served, up from 5,869 in SFY86 to 7,267 in SFY87 (19.24%).

Nurse-Midwife Services showed a large percentage increase (45.34%) that, because of the low number of participating providers, amounted to an increase of $588 over SFY86's expenditure of $709. A slight increase in the number of recipients served accounts for SFY87's expenditure of $1,297.

Chiropractic Services experienced an increase of 30.65% in expenditures, up from $123,173 in SFY86 to $177,617 in SFY87. This increase resulted from a 30% increase in reimbursement rates and a 4.12% increase in the number of recipients served.

Private Duty Nursing and Personal Care Services were added during SFY87. Ten and fourteen providers cared for 37 and 229 recipients, respectively. These services are now the alternative long term care program, formerly reported under Home Health Services.

Physical Therapy Services experienced an 84% increase in expenditures due to a 47% increase in the number of providers participating (up to 15 from 8 in SFY86) and a 71% increase in the number of recipients served (217 in SFY87 compared to 63 in SFY86). The annual cap on services delivered by private practitioners was also increased from $100 to $500 in SFY87.

Transportation Services expenditures increased 54.86% over SFY86 expenditures of $472,929 as a result of a 10% increase in participating providers and an increase of 37.75% in recipients served, up from 3,099 in SFY86 to 4,978 in SFY87. Reimbursement rates for these providers also were increased through the inclusion of "By Report" reimbursement for some codes. This allows an agency to bill the cost of a service below a cap amount.

The **Waiver for the Physically Disabled** was implemented and served twenty-four recipients with one participating provider.

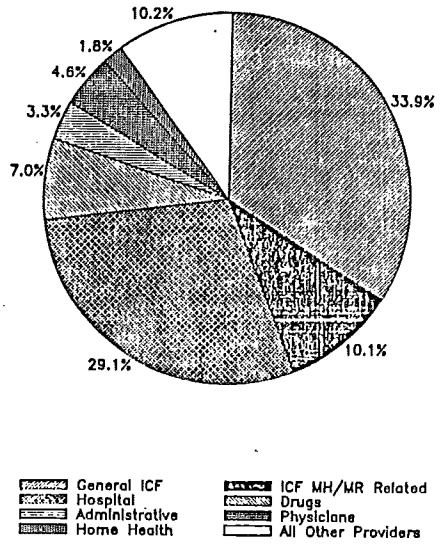
The **Waiver for the Elderly** was fully implemented in SFY87 and saw a 77.75% increase over expenditures made in SFY86, up to $3,464,286 from $770,722 in SFY86. This is tied to the dramatic 60.59% increase in recipients served, 365 in SFY86 as compared to 926 in SFY87.

Expenditures for the **Mental Health Waiver** were down 66.99% because its term of service expired on May 7, 1987. Clients served under this program continue to receive care through State-funded programs.

The **Waiver for the Mentally Retarded** saw a 33.37% increase in expenditures, rising to $5,972,316 from $3,979,275 in SFY86. This was the result of a 14.57% increase in participating providers, up from 176 in SFY86 to 206 in SFY87, and a 12.27% increase in the number of recipients served, 372 in SFY86 as compared to 424 in SFY87).

Finally, Figure 3 provides a graphic summary of the services provided by the total program expenditures of $299,523,091 in SFY 87. Data in this figure indicate that 89.8% of total Medicaid funds are utilized to provide reimbursement for the following seven services: general intermediate care facilities (33.9%), intermediate care facility services that are mental health/mental retardation related (10.1%), hospital (29.1%), prescription drugs (7.0%), physician (4.6%), home health (1.8%), and administrative services (3.3%).

Figure 3
Services Provided by Medicare
Program Expenditure
SFY 87 - Total Expenditures
$299,523,091



Payment for Inpatient and Outpatient Hospital Services

The Maine Health Care Finance Commission was created by the Legislature in 1983 to manage Maine's hospital discharge data system and implement a hospital prospective reimbursement system. The new reimbursement system was designed to:

1. Appropriately limit future increases in the cost of hospital care;

2. Protect the quality and accessibility of the hospital care available to the people of Maine by assuring the financial viability of an efficient and effective hospital system;

3. Encourage hospitals to make the most efficient use of the resources made available to them;

4. Afford those who pay hospitals a greater role in determining their reasonable financial requirements without unduly compromising the ability of those who govern and manage hospitals to decide how the resources made available to them will be used;

5. Provide predictability in payment amounts for hospitals and payors; and

6. Assure greater equity among those who pay for hospital care.

In determining the hospitals financial requirements for a given year, the hospitals submitted financial data to the Commission for a base year. Future year reimbursement takes the base year budget and adjusts it for inflation, changes in service delivery and utilization, case mix, working capital and other changes as verified by the hospital.

The prospective payment system assures that all payors (i.e., Medicaid, self-pay, Blue Cross/Blue Shield) reimburse hospitals the total cost of providing hospital services. In addition, each payor is responsible to pay for a portion of bad debt and charity care. This represents costs which were previously not paid by Medicaid. In October 1987, the Health Care Financing Administration notified the Department that it had accepted the Department's assurances that our hospital payment system meets Federal criteria, a major accomplishment.

Medicaid reimburses hospitals its fair share of total cost, plus a portion of bad debt and charity care for disproportionate share hospitals. Disproportionate share hospitals are defined as those hospitals that Medicaid charges equal or exceed fifteen percent (15%) of the hospital charges by all hospital payors. Estimates indicate that ten hospitals or approximately 23 percent (23%) of all Maine hospitals can be classified as disproportionate share hospitals.

Hospitals not classified as disproportionate share hospitals are reimbursed under a 1987 Maine Health Care Finance Commission rule change. The rule specifies that outpatient hospital services will be paid according to the Tax Equity and Fiscal Responsibility Act (TEFRA) calculation. Inpatient hospital services will be paid at the rate that is the lower amount of two calculations: the amount calculated under the Maine Health Care Finance Commission or the Tax Equity and Fiscal Responsibility Act.

Projecting these changes into future hospital payment years under the prospective payment system of the Maine Health Care Finance Commission results in estimates that the Medicaid budget for FY 88 will increase by nearly twenty percent (20%). The state share of hospital costs will exceed thirty-four million dollars ($34,000,000) for fiscal year 1988. Additionally, 1987 rule changes, such as adjustment to the hospital financial requirements to allow increases in wages to recruit and retain medical staff, will complicate projecting impacts on future state fiscal years. Based on preliminary analysis of utilization patterns and inflationary factors the Medicaid hospital budget can be expected to exceed an eight percent (8%) growth in fiscal year 1989.

Intermediate Care Facility (ICF) and Skilled Nursing Facility (SNF) Services

Maine currently has 9,023 ICF beds in 135 general intermediate care facilities. Reimbursement for ICF services averages $52 per day. The most recent available federal data (Oct. 1986) indicated that only three states in HCFA Region I have higher average per diem rates than Maine. Maine currently has 517 SNF beds in 18 facilities. Reimbursement for SNF services averages $81 per day. This makes Maine the highest in Region I for SNF reimbursement.

As noted in the Department's Long Term Care Plan, Maine's ratio of ICF (excluding ICF/MR) beds to SNF beds is 17:1. This is the third highest ratio in the nation.

A large part of the cost of general-use ICF beds is borne by the State's Medicaid budget, since at any given time, approximately 75% of ICF residents are Medicaid recipients.

With only 517 SNF beds statewide, there is a problem of access to SNF beds for Medicare beneficiaries. A study of "Skilled Nursing Facility Services in Maine: Issues, Trends and Recommendations for Promoting Access" conducted for the Department in 1986 by the Human Services Development Institute of U.S.M. found that in 1984 Medicare-covered SNF days in Maine amounted to 130 per 1,000 beneficiaries, while the national average was 295 days per 1,000 Medicare beneficiaries. If Maine's utilization rate had been at the national average an

additional $1,978,700 of Medicare revenues would have been available to help cover costs of post-hospital and long term care. Part of this additional revenue to the State could have offset some Medicaid institutional costs and also enabled the Medicaid program to fund additional long term care services in the home setting. More importantly, this Medicare coverage would have benefitted the non-Medicaid eligible person in need of this level of care who ends up in an ICF as the only option for care. These individuals often have to pay for these services out-of-pocket since no third party payors, except Medicaid, cover services in ICFs.

The Department, in conjunction with the Attorney General's Office and Legal Services for the Elderly, has developed an Advocacy for Medicare Patients (AMPs) program to address the problem of denials of Medicare coverage after care has been provided for Medicaid recipients, as well as for individuals who, although not eligible for Medicaid, may not have the resources to pay for the care. By the end of SFY87 reconsideration requests had been filed in behalf of 104 Medicaid beneficiaries. Regulations have also been adopted to permit hospitals to establish "swing beds" for SNF-level care. No hospitals have applied for "swing bed" certification.

Table 5 provides a breakdown of state and federal expenditures for ICF and SNF services under the Medicaid Program.

Table 5

Institutional Long-Term Care Expenditures
SFY82-87
(In Millions)

	SFY82	SFY83	SFY84	SFY85	SFY86	SFY87
ICF						
state	23.38	25.11	27.93	26.86	28.33	31.20
federal	51.46	53.30	58.37	62.17	63.94	66.50
SNF						
state	.95	.86	1.00	1.08	1.01	1.06
federal	2.08	1.83	2.07	2.50	2.28	2.27
Total						
state	24.33	25.97	28.93	27.94	29.34	32.26
federal	53.54	55.13	60.44	64.67	66.22	68.77

As of November 30, 1987; information reported by Maine's long-term care facilities indicates that there were 318 empty ICF and SNF beds. At the same time, there were 183 Medicaid clients in hospitals awaiting placement to a nursing home. An additional 111 individuals were at home awaiting nursing home placement. Most of these individuals require a heavier kind of care than most nursing homes are able or willing to provide. In addition, nursing homes are experiencing serious staffing shortages, as are some hospitals, home health agencies and other health care providers. Department staff are working toward a solution to this problem through current initiatives for increased wages for nursing staff and allowing the costs of training certified nurses' assistants. In November 1987 amendments to the Principles of Reimbursement for Long Term Care Facilities provided for adjustments in the per diem rate for wage increases to deal with serious problems of recruitment of nursing staff for CNA trainng costs. As of November 1987, 104 facilities had been granted increases totalling $5,042,000, of which $1,609,910 will be covered by the Medicaid program. Future plans for addressing the issue of access for heavy care patients include case-mix reimbursement, higher reimbursement levels for heavier care patients and by encouraging that new beds built serve heavy-care patients.

Table 6 ranks Maine's nursing home analysis areas from lowest to highest in terms of the number of ICF beds for every 1000 individuals over age 65.

While Maine's State Health Plan sets a goal of 60 beds for every 1000 individuals over age 65, a condition of the home and community-based waivers (see page 22) is to reduce the rate of growth of nursing home beds. As stated in the planning document submitted with two waiver requests, it is the intent of the State of Maine to continue to reduce the ratio of ICF beds to elderly population. It was projected in the requests that by 1990 the ratio of beds to 1000 population over age 65 would be 55.156. Under this plan, new beds would be approved for construction only in areas where needed to achieve a more consistent statewide ratio of beds or to replace obsolete facilities if needed to maintain the desired ratio of beds.

Table 6
Ranking of Nursing Home Analysis Areas by ICF[1] Bed to Population Aged 65+ Ratio
July 1, 1987

Nursing Home Analysis Areas	Licensed ICF Beds 6/30/87[2]	Projected Population 65+, 7/1/87	Ratio of Beds to 1000 Pop. 65+	ICF Beds Coming On Line[3]	ICF Beds Allocated 1987[4]	Existing and Planned ICF Bed/Pop. 65+ Ratio
Waldoboro	111	3,914	28.4	30	-	36.0
York	210	6,553	32.0	-	40	38.2
Belfast	126	3,140	40.1	-	-	40.1
Caribou-Presque Isle	263	5,670	46.4	-	-	46.4
Bangor[5]	471	11,944	39.4	40	45	46.6
Bucksport	143	2,923	48.9	-	-	48.9
Portland	1,182	25,806	45.8	-	100	49.7
Skowhegan	210	4,201	50.0	-	-	50.0
Camden-Rockport	312	6,202	50.3	-	-	50.3
Bridgton	179	3,529	50.7	-	-	50.7
Dover-Foxcroft	168	3,751	44.8	24	-	51.2
Rumford	112	2,895	38.7	-	40	52.5
Sanford	233	5,557	41.9	65	-	53.6
Biddeford	413	7,711	53.6	-	-	53.6
Danforth-Houlton	167	2,980	56.0	-	-	56.0
Augusta[5]	567	9,821	57.7	-	-	57.7
Eastport	142	2,458	57.8	-	-	57.8
Waterville	454	7,829	58.0	-	-	58.0
Lincoln-Millinocket	168	2,865	58.6	-	-	58.6
Jonesport	87	1,437	60.5	-	-	58.6
Farmington	291	4,741	61.4	-	-	61.4
Bath-Brunswick	481	7,511	64.0	-	-	64.0
Calais	100	1,434	69.7	-	-	69.7
Lewiston-Auburn	988	14,065	70.2	-	-	70.2
Ellsworth	335	4,417	75.8	-	-	75.8
Norway	305	3,460	88.2	-	-	88.2
Pittsfield	141	1,492	94.5	-	-	94.5
Madawaska	305	2,620	116.4	-	-	116.4
NHAA Totals, Ratios	8,664	161,522*	53.6	159	225	56.0
Statewide ICF[6]	120	N/A	N/A	-	200	N/A
State Totals, Ratios[7]	8,784	161,522*	54.4	159	425	58.0

Notes:

1 ICF = Intermediate Care Facility

2 From preliminary 6/30/87 bed count, Office of Data, Research and Vital Records (ODRVS).

3 ICF beds coming on line are beds for which certificates of need (CON) have been issued. Twenty-four of the 40 Bangor beds and the 24 Dover-Foxcroft beds have been completed as of 11/6/87.

4 ICF beds allocated are beds for which CON applications have been solicited and accepted.

5 Table does not include ICF beds in the Augusta and Bangor Mental Health Institutes.

6 Statewide ICF beds have not been included in NHAA counts. There are 120 statewide ICF beds at Maine Veterans Home in Augusta. An additional 200 statewide ICF beds were allocated in 1987; Twenty of these are general beds which may be approved as needed anywhere in the State. The remaining 180 statewide allocated beds are planned for veterans only.

7 Not included in this table are 25 ICF beds allocated in 1987 for a demonstration Continuing Care Retirement Community.

* Statewide projected population 65+ figure includes 596 people residing in unorganized territories. These people are not included in the 28 individual NHAA population figures.

Table prepared by: Maine DHS Office of Health Planning and Development, November 1987.

Intermediate Care Facilities for Persons With Mental Retardation (ICF/MR Services)

Maine provides long term care through two categories of ICF/MR services.

Nursing services are available for those individuals whose physical needs are such that general ICF-level care would be indicated if mental retardation were not present. In SFY87; 525 recipients were served in 15 facilities at an average annual cost per recipient of $39,286. The number of Medicaid recipients living in each of these facilities averaged 35 in SFY87; at an average cost of $114 per day.

Maine's Medicaid program also provides reimbursement for ICF/MR group home. In this setting, residents receive developmental training at various locations around the State. This training is reinforced by the therapeutic atmosphere of the ICF/MR. A total of 208 recipients were served in SFY87; In general, 8 Medicaid recipients lived in each of the 27 participating group homes at an average annual cost of $36,881 per person, the cost per day was $100.

Had Federal financial participation (FFP) not been available, the cost to the State for these services would have been over $28,000,000.

D. PROVIDERS AND RECIPIENTS OF SERVICE

The Medicaid Program is indebted to the more than 5,000 in-state practitioners, institutions, and agencies who provided health care services to Medicaid clients over the course of the past state fiscal year. The Bureau of Medical Services is also grateful to the provider associations and individual providers who have so generously provided their time and shared their knowledge and expertise in the development and refinement of the Medicaid Program in order to better serve Medicaid clients in Maine. As a result of their commitment, the Program continues to assure statewide access to health care for Maine's lowest income citizens.

Medicaid payments are made to participating health care professionals who provide medical services to eligible people. Medicaid recipients have the freedom to choose any enrolled Medicaid provider. The choice of providers may be limited for those clients who are under the Recipient Restriction Program (see Page 24) or if a state has a freedom-of-choice waiver from the Federal govenment. Individuals are issued a Medicaid identification card each month which lets the provider know that charges should be billed to the Medicaid Program.

Table 7 compares the number of in-state participating providers in Maine's Medicaid Program for the period SFY86-87. Table 8 provides a comparision of recipients served during that same period.

Table 7
In-State Providers by Type of Service

Type of Service	Number of Providers SFY86	Number of Providers SFY87	% of Change
Physicians	1,273	1,281	.63
Pharmacists	265	257	-3.02
Dentists	411	398	-3.17
Optometrists	134	138	2.90
Psychologists	157	174	9.78
Durable Medical Equipment	168	190	11.58
ICFs	156	146	-6.42
SNFs	17	17	0
Hospital Inpatient	45	45	0
Hospital Outpatient	197	194	-1.5
All Other	2,142	2,556	16.21
Total	4,965	5,396	7.99

Table 8
Recipients Served*

Type of Service	Number of Recipients SFY86	Number of Recipients SFY87	% of Change
Physicians	86,366	84,316	-2.38
Pharmacists	94,088	93,978	-.12
Dentists	30,293	28,211	-6.88
Optometrists	14,341	14,258	-.58
Psychologists	3,853	4,483	14.06
Durable Medical Equipment	4,787	5,405	11.44
ICFs	8,845	8,751	-1.07
SNFs	412	408	-.98
Hospital Inpatient	19,120	15,769	-17.53
Hospital Outpatient	45,716	62,290	26.6
All Other	58,941	84,314	30.00
Unduplicated # of recipients	142,148	1135,875	-4.42

*This table includes duplicated counts of clients across service categories.

E. MEDICAID FEES

The Department of Human Services must balance two important considerations in managing the Medicaid fee schedule. The fees paid must be sufficient to attract enough providers so that services are available to Medicaid recipients at least to the extent that those services are available to the general population. From this perspective, there is substantial pressure to pay fees which approach or equal going rates in order to assure complete access for Medicaid recipients. However, the Department is also responsible for assuring access to a wide range of services for recipients, for prudent management, and for assuring that limited public funds are spent carefully. This consideration leads to policies that emphasize the purchase of care at the lowest possible cost.

The Bureau of Medical Services does an annual comprehensive review of reimbursement for providers paid on a fixed fee schedule that provides an incremental system of increases based on need, access, equity, and the availability of state funds. Sometimes this incremental approach cannot be realized due to budget constraints. Sometimes providers obtain increases by going directly to the Legislature.

To assist in making these difficult decisions, the Department conducts an annual review of fees with providers. Over the course of the summer of 1987, in accordance with 22 MRSA §3173, the Sixth Annual Fee Review was conducted. As in previous reviews, legitimate concerns of several provider groups have been identified. It is clear that most groups are faced with rising costs and an increasing gap between Medicaid fees and their usual charges. However, with the relative lack of new state funds and the continuing availability of Medicaid services, across-the-board increases could not be made. Rather, the Bureau plans to continue the incremental approach to change it has been using during the past year.

Sixth Annual Fee Review
SFY 1987

The 1987 Annual Fee Review was conducted by the Bureau of Medical Services in cooperation with providers and their organizations. In August 1987, a letter was mailed to providers which asked for their input in our annual fee review. That letter included information on provider and recipient participation and expenditures for State Fiscal Year 1987 for the State's Medicaid Program for the particular provider group.

Based upon this fee review, it has become clear that the process of meeting with providers on an annual basis is an extremely valuable one, not simply for reviewing fees but also to conduct a review of policy affecting providers and the clients they serve. Henceforth, the fee review will be expanded to include an annual review of policies as well. While the Department will continue to meet with providers on a regular basis throughout the year, we believe there is merit in formalizing the review of the policy to assure a process of reconsideration and future planning. As a result of the meetings scheduled throughout August and September, a meeting was convened by Bureau of Medical Services staff on September 25, 1987. All fee-for-service providers were invited to discuss the preliminary findings and recommendations of the Bureau.

The following summary represents changes in the Medicaid fee schedule and policies for fee-for-service providers that have occurred since 1983 and includes issues discussed during the SFY87 Annual Fee Review and actions taken by the Bureau of Medical Services.

AMBULANCE

4/27/84 Increased base rate from $35 (resident) and $40 (nonresident) to $47.50. Land mileage changed to "loaded" mile at $2/mile. Expected to increase Medicaid reimbursement by 10%. (Legislative appropriation).

9/1/85 Incorporated reference to air ambulance services provided through a sole contractor, and outlined the bidding process and award of contract.

4/9/87 Implemented the second contract to provide air ambulance services to recipients through a sole supplier.

SFY87 AFR Representatives of the Maine Professional Ambulance Association stressed the urgent need for an increase in allowances to bring reimbursement in line with the cost of doing business. A specific request was made to increase the base rate from $47.50 to $90.00, the loaded mile allowance from $2.00 to $2.50, the allowance for oxygen from $6.00 to $20.00, and for a general increase in the allowance for defibrillator service. The Bureau has recommended the base rate and loaded mile allowances as they were proposed. This increase represents an 89.5% increase in the base rate and a 25.0% increase in the loaded mile allowance.

Concern was expressed for the difficulty some providers have experienced in getting claims paid. This concern was shared with the Provider Relations Unit staff.

Concern was also expressed for the inappropriate use by some recipients of ambulance services for non emergencies. An education program for recipients is being considered. The Bureau will also explore the current practice of transporting ambulatory clients by ambulance, especially from nursing homes.

Pursuant to Delta ambulance Company's request for reimbursement for the use of an isolette and specialized support equipment for transporting critically ill neonates, the Bureau plans to look into the issue of the availability of specialized transport for critically ill neonates.

CHIROPRACTIC SERVICES

7/1/86 Increased fees from $7 to $10.

DENTAL

1/1/83 4% overall increase to general dental procedures/extractions allowances.

5.38% increase for certain prophylactic/restorative services allowances.

This was the second in a 2-part increase, totalling 15% overall. These increases enhanced the overall reimbursement for general dentistry in order to relieve dissatisfaction with rates.

12/1/84 Increase in allowances for certain oral surgical procedures. Allows oral surgeons to be reimbursed a higher percentage of the cost of providing the service. Included expanded definitions for certain procedures, and several miscellaneous revisions.

DENTAL (Cont.)

9/1/85 A relative-value-scale reimbursement methodology was adopted that increased fees for orthodontia to raise the percentage of cost reimbursed by Medicaid.

9/1/86 Increased certain general dental fees to 60% of the average of fees reported for each procedure in the most recent survey published by the American Dental Association. Certain prior authorization requirements were eliminated to facilitate program administration and to expand preventive services.

SFY87 AFR Representatives expressed concern for what they believe is an inadequate fee schedule for dental services that has not kept pace with rapidly rising malpractice and overhead costs. Potential impact in the form of declining provider enrollment was a major concern. Representatives suggested that if a comprehensive fee increase is not possible, the Bureau should examine the possibility of an increase for selected dental services, e.g., fluoride treatment, preventive services, sealants, amalgams, and composits.

Representatives also stated that reimbursement for the limited number of services available to recipients over age 21 was inadequate. These are limited to extractions performed in the presense of certain surgical procedures whose outcomes could be affected by infection or severe decay. Another area of concern was the apparent lack of responsibility and cooperation shown by some Medicaid recipients evidenced by a high rate of cancellations and "no shows" among Medicaid patients.

Representatives were also concerned that some recipients were referred for orthodontic treatment in the absence of basic dental care and suggested that the Dental Services rule be revised to permit greater selectivity among patients. Providers were also concerned that reimbursement for orthodontic treatment is available only to specialists in orthodontia.

Representatives were interested in participating in the development of an education program for Medicaid recipients.

Providers expressed their desire for better communication with the Bureau and increased input in the development of rules.

The Bureau is striving for an improved atmosphere of cooperation with providers. It is seeking to provide a fee increase of approximately 30% for services in the children's program. A dental advisory committee, composed of providers, advocates, and Department of Human Services staff was formed to make recommendations concerning coverage of adult dental services to the Legislature. This committee will present a proposal to the Human Resources Committee during the second session of the 113th Legislature in 1988.

DURABLE MEDICAL EQUIPMENT & SUPPLIES

12/1/83 Billing of acquisition cost (AC) plus a gross profit ranging from 35% to 50%. Assures the provider a profit as equipment and supply acquisition costs increase.

8/1/84 Increased gross profit for any item with AC of $300 or more from 30% to 50%. Increased profit on large ticket items making reimbursement more equitable for these items. Eliminated prior authorization under certain conditions to streamline the procedure for repairing equipment owned by the Department.

6/1/85 Increased mark-up to 50% for all durable medical equipment and supplies based on adjusted acquisition costs. Diabetic testing material was added as a covered item. Freight-in and delivery charges are no longer reimbursable.

FAMILY PLANNING AGENCY SERVICES

10/3/83 Increased rate of reimbursement to cover 100% of clinic costs. No fee increase since the service was established in 1979.

SFY87 AFR As a result of several very productive meetings with Family Planning Services providers held during SFY87, the rule for these services was completely revised. In addition to more accurate definitions and descriptions, some services were expanded. Reimbursement rates were adjusted using an improved accounting formula employed by all the clinics. This adjustment resulted in an aggregate incrase of 11%, although not every clinic expreienced an increase.

HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE ELDERLY

5/1/85 New coverage - allows reimbursement to a new group of providers and expands services for certain existing providers for services to waiver clients as an alternative to institutionalization.

9/1/86 Increased the allowance for the projected annual cap for these services from 75% to 100% of the annual average cost of institutional care that waiver services supplant.

HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE MENTALLY ILL

8/17/83 New coverage - allows reimbursement to a new group of providers - move toward deinstitutionalization of the mentally ill.

5/7/87 Waiver expired; reimbursement not renewed by HCFA.

HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE MENTALLY RETARDED

11/1/83 New coverge - reimburses new group of providers and expands covered services to waiver clients - move toward deinstitutionalization of the mentally retarded.

9/1/85 Maximum allowable number of boarding home beds was increased to eight and the maximum allowable cost per resident per month was increased to $870. (These changes affected Title XIX Waiver Homes for the Mentally Retarded only.)

HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE MENTALLY RETARDED (Cont.)

7/1/86 HCFA granted program a 1 year extension.

7/22/87 Waiver approved for 3 more years. Rates for O.T. consultation, P.T. consultation, case management, and residential training Level I increased.

HMO

12/21/83 New coverage - new provider.

10/1/85 Coverage was terminated.

INDEPENDENT LAB/X-RAY

8/1/83 Added new procedures not previously coded and increased basic value of certain radiological procedures.

MENTAL HEALTH CLINICS

7/1/85

1. Increased allowances 94% for individual and family therapy services and 84% for group psychotherapy services provided by a psychiatrist.

2. Increased allowances 104% for individual and family therapy services provided by a psychologist. Group psychotherapy services were increased 100% for 3/4 of an hour, 90% for one hour and 1/2 hour, and 65% for 1/4 of an hour.

3. Increased allowances 105%-110% for individual and family therapy services provided by a psychiatric nurse or social worker and 88%-93% for group psychosocial therapy services.

4. Increased allowances 104% for all services provided by "other qualified staff".

8/6/85 Provided an increase in reimbursement rates to mental health clinics based on average costs. Eliminated most restrictions on the setting of mental health clinic services and allowed collateral contacts. Added coverage of registered substance abuse counselors (RSAC) services.

4/28/86 Expanded substance abuse coverage to all professionals within mental health centers except other qualified staff.

5/1/87 Eliminated substance abuse treatment services provision from this section of the manual.

SFY87 AFR A representative of the Maine Council of Community Mental Health Centers expressed concern that the current level of reimbursement reflects the cost of doing business three years ago. It was also noted that the greatest disparity between the level of reimbursement and cost exists for physicians and is least for other qualified staff.

MENTAL HEALTH CLINICS (Cont.)

The following suggestions are being explored by Bureau of Medical Services staff and Bureau of Mental Health staff:

- Consider qualification standards other than comprehensive licensure for mental health clinics.
- Develop standards and supervisory training for other qualified staff.
- Allow reimbursement for co-therapists, especially for sexual abuse therapy.
- Include occupational therapists on the list of Mental Health Clinic professional staff.

NURSE MIDWIFE

11/1/83 New coverage - in compliance with federal requirements.

7/1/85 The fee schedule for delivery, antepartum and post partum care was increased from $241 to $450.

OPTOMETRICAL[1]/OPHTHALMOLOGICAL[2]/RADIOLOGICAL[3]

12/22/83 1. Added: complete visual field ($8)
"other studies" reimbursement to permit optometrist to provide diagnostic services for the early detection of eye disease
refraction for Medicare eligibles ($5)

This permits optometrist to provide diagnostic services for the early detection of eye disease.

2. Increased complete visual field allowance from $5 to $8 as a result of 1st annual fee review, increased allowance for this exam which requires sophisticated and expensive equipment.

Added certain procedures to surgery of eye/retina to allow a more detailed specification of services provided by ophthalmologists.

3. Increased ocular & orbital echography or sonography basic value from 6.0 to 10.0. Increase allows reimbursement of a greater percentage of the cost of providing the service.

OPTICIAN SERVICES

4/1/87 Revised rule to provide eyewear to recipients through a sole supplier of eyeglasses and eyeglass parts.

OPTOMETRY SERVICES

1/1/87 Increased the allowance for Functional Eye Examination from $18.00 to $19.50 and changed the procedure name to Comprehensive Eye Examination.

Added the following procedures and reimbursement rates to allow greater flexibility in providing services:

OPTOMETRY SERVICES (Cont.)

Home Medical Services	
Eye Examination, Brief-Limited-Minimum	$9.50
Eye Examination, Intermediate-Extended	$14.50

Office Medical Services	
Eye Examination, Intermediate-Extended	$13.50
Intermediate Visual Field	$13.50
Extended Visual Field	$19.50

Revised the fee schedule to conform to the HCFA Common Procedures Coding System (HCPCS).

4/1/87 Revised rule to provide eyewear to recipients through a sole supplier of eyeglasses and eyeglass parts.

ORAL SURGICAL

12/1/84 Increase in allowances for certain oral surgical procedures. Allows oral surgeons to be reimbursed a higher percentage of the cost of providing the service. Included expanded definitions for certain procedures and several miscellaneous revisions.

ORTHODONTIA

8/1/85 Increased fees for orthodontia to raise the percentage of cost reimbursed by Medicaid.

PHARMACY SERVICES

7/16/86 Increased the dispensing fee from $3.20 to $3.35 (legislative appropriation).

PHYSICAL THERAPY SERVICES

7/1/86 Increased fees $6 per 1/2 hour to $12 per 1/2 hour and the annual cap from $100 to $500. Eliminated Medicare certification requirement. Expanded setting requirement.

SFY87 AFR Representatives of the Maine Chapter of the American Physical Therapy Association expressed concern that low reimbursement rates for private practitioners may result in shifting of services to higher cost hospital services. Representatives were concerned that heavy demand on hospital physical therapy departments could result in a decline in the quality of service provided. Representatives were concerned that low reimbursement rates provided no incentive for physical therapists to enroll as Medicaid providers.

Representatives were also concerned that some physicians may be billing third party payors for office visits that contain physical therapy services performed by someone other than a physical therapist.

The Bureau will review utilization data and will explore the possibility of a fee increase for Physical Therapy Services.

PHYSICIAN SERVICES

7/1/85 1. Increased allowances 72% for individual and group therapy services provided by psychiatrists.

2. The fee schedule was substantially raised for delivery, antepartum, and post partum care.

7/1/86 Developed a comprehensive screening visit for Preventive Health Progam enrollees with an enhanced reimbursement rate of $26.

8/1/86 Increase in allowances for certain surgical procedures related to dilation and curettage.

12/15/86 Policy clarification identifying both the preventive health services which are reimbursable to both participating and non-participating Preventive Health Program (PHP) providers and allowing the $26.00 screening exam fee to be billed regardless of the physician's usual and customary charges for well child care.

3/1/87 Updated Health Care Common Procedure Coding System (HCPCS).

4/1/87 (Ophthamology) - Revised rule to provide eyewear to recipients through a sole supplier of eyeglasses and eyeglass parts.

6/3/87 Rule revised to include the Department's policies concerning organ transplant procedures.

7/1/87 Updated Health Care Common Procedure Coding System (HCPCS).

SFY87 AFR In meetings with representatives from both the Maine Medical Association and the Maine Osteopathic Association the main area of concern was over reimbursement rates.

The proposed increase for physician office fees expected early in 1988 was discussed and providers expressed their desire to see an increase in all fees, rather than just office visits. The Bureau's work with the Human Services Development Institute of the University of Southern Maine on a relative value scale (RVS) was discussed. It is hoped that an RVS will reduce the disparity between Medicaid reimbursement and usual and customary fees and will prevent such a large difference from recurring in the future.

Representatives expressed their disapproval of the Bureau's proposal to eliminate reimbursement for Medicare crossover payments (the balance between the amount Medicare pays for a given procedure and the amount it would allow as a charge). Osteopathic representatives concern for individuals not eligible for Medicaid who are in need of care prompted a discussion of the Bureau's work with the Robert Wood Johnson Foundation on the development of a program that will reimburse medical care for the uninsured. A meeting was held with the Physicians Advisory Workgroup in December 1987 to review the proposed changes in the fee schedule.

PODIATRIC MEDICINE SERVICES

SFY87 AFR — In a meeting with representatives from the Maine Podiatric Medicine Association, concerns over low reimbursement rates were discussed. Representatives believe podiatric physicians should have parity with other physicians and urged the Bureau to consider implementing a tiered office visit schedule and reimbursement for mileage. Representatives also believe Medicaid monies would be saved if settings restrictions for surgical procedures were reduced or eliminated. The Bureau will explore implementing these suggestions as part of the revision of the rule for Podiatry Services now under way and will explore the possibility of a fee increase using savings resulting from the reduction of settings restrictions.

PREVENTIVE HEALTH PROGRAM

7/1/87 — Rule revised to include rural health centers as providers of services.

PRIVATE DUTY NURSING & PERSONAL CARE SERVICES

6/1/86 — Established policy for coverage of these services provided by R.N.s, L.P.N.s, C.N.A.s, H.H.A.s.

4/20/87 — Revised rule to include reimbursement for an extended level of care for clients classified at the skilled nursing facility level of care.

PRIVATE NON-MEDICAL INSTITUTIONS

1/1/85 — Expanded coverage to include substance abuse treatment facilities - new providers.

PSYCHOLOGICAL SERVICES

7/1/85 — An across-the-board fee increase of 71% to 72% was established to cover all clinical psychological services for individual and group psychotherapy treatment. The psychometric testing fee schedule was also increased 38%.

SFY87 AFR — Representatives of the Maine Psychological Association conveyed to the Bureau their belief that reimbursement rates are too low and that skills used by Ph.D. psychologists in psychological testing are the same as those used for other psychological services, thus warranting a higher reimbursement rate.

Representatives also raised several concerns over Medicaid policy. Practitioners described the dilemma with which they are faced when patients lose Medicaid coverage and are still in need of care or when patient-related contacts, for which no reimbursement is available, are needed.

Representatives expressed their frustration with having to wait for Medicaid reimbursement until after settlement by other payors is reached and with time limitations currently allowed for group therapy. The Bureau will explore reimbursement increases and expansion and simplification of policy wherever possible.

SPEECH AND HEARING SERVICES

7/1/86 Increased the fee schedule for speech and hearing services 28% - 29% for all procedures (legislative appropriation). Included policy clarifications.

12/1/86 Policy clarification updating billing instructions for the purchase of hearing aids.

SFY87 AFR Representatives from the Maine Speech and Hearing Center Directors expressed interest in the following:

- Receiving a higher level of reimbursement that would reflect the cost of doing business.
- Receiving reimbursement for services provided in a school setting that currently receive Department of Education funding.
- Adding speech and hearing services as rural health clinic covered services.
- The possibility of allowing procedure-based billing for Audiology services rather than time-based billing.
- Resolving the ongoing problem of Medicaid clients missing and cancelling appointments.

Although it is unlikely that a fee increase for speech and hearing services is possible this year, these other suggestions are currently under consideration. Specifically, Bureau staff are exploring the possibility of implementing a "no show" code in order to track missed appointments and of developing an education plan to help alleviate this problem.

SUBSTANCE ABUSE TREATMENT SERVICES

5/1/87 New policy developed for facilities certified by the Office of Alcoholism and Drug Abuse Prevention (O.A.D.A.P.).

TRANSPORTATION SERVICES

10/1/85 Allows reimbursement through Medicaid as a direct vendor payment to transportation providers to provide transportation to medically necessary Medicaid covered services.

11/1/86 Increased reimbursement for passenger miles and odometer miles to relate to the transportation agency's cost of providing service.

12/31/86 Implemented wheelchair van services provision. Added an interviewing guideline used to determine eligibility. Certain Procedure Codes were changed from $.50 to "By Report".

4/20/87 Clarification of related travel expenses policy. Inclusion of base rate for certain wheelchair van services.

TRANSPORTATION SERVICES (Cont.)

SFY87 AFR — Members of the Maine Transportation Association expressed concern for a number of issues, including differing interpretations of the Explanation of Medicaid Benefits (EOMB), liability for client fraud, and appropriate use of the Department of Transportation map.

The Association also suggested providing reimbursement for transporting preschool children to school-based therapy services.

Bureau staff is currently working closely with the Association's members on resolving these issues.

VD SCREENING CLINICS

10/3/83 — Fee increase to cover increased costs due to inflation ($10 to $15). No fee increase since established in 1978.

SUMMARY OF SIXTH ANNUAL FEE REVIEW

The Bureau of Medical Services has again identified physician, ambulance, and podiatry office visit reimbursement rates as being at levels that may threaten recipient access to these services.

While provider enrollment has again this year remained essentially the same, the Bureau of Medical Services shares the concern of providers and the consumer-based Medicaid Advisory Committee that some providers may decide to withdraw from the program if changes in fees are not made.

Due to reports of increasing problems with access to care and the impact of low Medicaid reimbursement on the recruitment of physicians in underserved areas, reimbursement for physician services continues to be the Bureau's highest priority. An increase for office and other visits is anticipated in SFY88, supported by the change in payments for Medicaid/Medicare dual eligible clients and additional state dollars totalling $1,006,000. The reimbursement rate for an intermediate level office visit, for example, is expected to rise from $13.50 to $23.25. The Bureau also plans to work with the University of Southern Maine's Human Services Development Institute on developing a relative value scale that will help prevent the wide disparity that now exists between Medicaid reimbursement rates and usual and customary fees from occurring in the future.

The Bureau also plans to increase the base rate for ambulance services from $47.50 to $90.00. It is expected that this increase will alleviate some of pressure experienced by providers as a result of sharply rising operating costs and will reduce the potential for providers withdrawing from the Medicaid program.

As identified last year, podiatric medicine office visits should follow the tiered format used for other physicians rather than the one fee per visit in current use. The Bureau is entering the final stages of examining financial data provided by the Maine Podiatric Medicine Association for the development of a tiered fee schedule. A complete revision of the rule for Podiatric Medicine Services has also been drafted and reviewed by the Association.

Where possible, the Bureau will also examine fee increases for Dental, Physical Therapy, Psychological, Speech and Hearing, and Transportation Services.

Meetings with many provider groups included discussion of providers' frustration with Medicaid recipients who frequently fail to keep or cancel appointments and the impact this behavior may have on providers' willingness to tolerate low reimbursement rates. The Bureau agrees with providers that education is an important component in changing behavior and will explore ways of improving this situation.

F. MEDICAID ADVISORY COMMITTEE

The Medicaid Advisory Committee is mandated by federal regulation to advise the state agency which administers Title XIX funds. The Committee's membership and its function were expanded in early 1987 and it has become a source of expertise and guidance for the Bureau of Medical Services. It now consists of 16 members, representing consumers, providers, and advocacy organizations. The role of the Committee is to review the initiatives of the Medicaid agency, provide input to its policy development and program administration, and make recommendations to improve access to and quality of care.

Since its first meeting in February 1987, the newly expanded Committee has addressed a wide range of concerns. It has reviewed the issues of physician access and reimbursement, hospital utilization, copayment for Medicaid consumers, pharmacy services, staff shortages for providers, and the adequacy of Title XIX dental services. Most recently, the Committee has taken an active role in advocating for Maine's adoption of the SOBRA amendments, which expand Medicaid eligibility up to 100% of poverty for pregnant women, children to age 5, and the aged and disabled.

G. STATUS OF WAIVER PROGRAMS

Since 1981, the federal government has allowed states to gain approval for waivers of certain Medicaid regulations in order to provide community-based long-term-care services to individuals who might otherwise require institutional care. Waivers require states to slow the growth of their nursing home programs. In our justification for the waivers obtained for those individuals at the intermediate level of care, we promised to build only 255 new intermediate care facility beds between 1985 and 1987.

Maine currently administers three "waiver" programs. The Bureau of Medical Services has developed and implemented these waivers in direct cooperation with the other bureaus which are responsible for serving the specific groups which benefit from the expanded service. The three waiver programs are:

Waiver Services for the Mentally Retarded

In 1983, the Departments of Human Services and Mental Health and Mental Retardation received approval for a waiver through June 1986 to provide services to mentally retarded individuals who would otherwise require institutionalization in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Services provided to clients residing in individual residences, group homes and foster homes include certain rehabilitation, residential training, case management, and respite care services. In SFY87, 424 clients were provided waiver related services by 206 providers for a cost of $5,972,316. The federal government recently approved the Department's request for a three-year renewal of this Waiver program.

Waiver Services for the Elderly

In May 1985, the Department of Human Services put into place a community based services waiver program for elderly individuals operated by the Bureau of Maine's Elderly and local area agencies on aging. Services provided to clients on a statewide basis include case management, homemaker, personal care, transportation, home health care, adult day care, mental health and emergency response system services. In SFY87, 926 clients have been provided waiver services at a cost of $3,464,286. The Department anticipates providing services to 1,680 clients over the three year period of the waiver. The waiver will generate up to $5.7 million in additional federal funds. A request to renew this waiver for another three years has been submitted to HCFA.

Waiver Services for the Physically Disabled

The Department received approval for this waiver program in July 1986. Effective October 1, 1986, case management, consumer instruction, and personal care services were available to eligible individuals with physical disabilities. This waiver, operated through the Bureau of Rehabilitation and ALPHA 1 (an independent living center for the physically disabled), served 24 clients during SFY87 at a cost of $24,913. It is projected that this waiver program will serve a total of 144 individuals over a three year period at a total cost of $511,000 in year one, $715,000 in year two, and $1,137,000 in year three.

H. SPECIAL SERVICES

1. Preventive Health Program (PHP)

Maine is required by federal law to provide Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services to all Medicaid eligible children. Effective July 1, 1986, Maine provides these services through its Preventive Health Program (PHP) The Preventive Health Program is a program of interrelated outreach, medical, dental, and other appropriate services available to Medicaid recipients under the age of twenty-one, and is administered through the Division of Medicaid Policy and Programs.

Outreach Services

When children become Medicaid recipients they are eligible for PHP services. Outreach workers contact caretakers (parents and guardians) to describe the special services available to children and young adults. At this time caretakers are asked to decide whether or not they want to enroll their children in the Preventive Health Program. The Bureau of Medical Services has written agreements with fifteen local agencies to perform outreach. In SFY87, 71 PHP staff informed 10,617 (98%) of the newly eligible and re-eligible families about the PHP through interviews or by letter. Of those families who were informed of services through interviews, 9,329 (88%) of the caretakers enrolled their children in the PHP.

PHP workers notify caretakers of participating children when examinations and immunizations are due. They also notify caretakers of three-year-old children that an initial dental examination should be obtained. In SFY87, 25,227 notifications for screening examinations and 2,862 dental notices for three-year-old recipients were sent.

Screening Services

PHP provides regularly-scheduled medical and dental examinations for children and young adults who have identified health problems as well as those who are seemingly well. Age-appropriate immunizations are given at the time of screening.

The policy and standards for preventive health screening examinations were effective July 1, 1986. Claims were paid for 15,327 medical screening examinations in SFY87. During the same time period, claims were paid for 31,652 preventive dental treatment visits.

Diagnostic and Treatment Services

Referrals for diagnosis and treatment are made if screening examinations indicate that medical or dental problems may exist. Children who are examined according to the periodic schedule are eligible to receive services not available to all Medicaid recipients. Medical services include additional vision services and eyeglasses and additional hearing services and hearing aids. Dental services include routine dental treatment and medically necessary orthodontics.

PHP Work In Progress

The Bureau of Medical Services and the Bureau of Health's Division of Maternal and Child Health (DMCH) continue to collaborate on initiatives to enhance PHP. These include formalizing the referral process between programs for services and case management. Services included in the agreement will include Maternal and Child Health, Handicapped Children's Program, the Women, Infants, and Children (WIC) program, and payment for parenting classes.

The Bureau of Medical Services is collaborating with the Ambulatory Care Coalition to develop continuing care arrangements between the Preventive Health Program and Rural Health clinics certified by Medicare. Under these agreements, Rural Health Clinics will provide a broad range of medical services and assume some outreach and follow-up services done by PHP agencies.

Bureau of Medical Services' staff participated on an advisory panel convened to examine PHP dental issues. The recommendations of the panel, aimed at enhancing dental services for children and young adults, will be incorporated into the Program's action plan.

Programming of the PHP subsystem in the Medicaid Management Information System (MMIS) by the Division of Data Processing is nearing completion. When this subsystem is fully operational, each child will have a profile of services obtained through PHP. Many of the notification and tracking activities will be done by the computer, freeing up time of the PHP outreach workers to work more intensely with families. With this enhancement, the program will be able to ensure that more children receive screening, diagnosis, and treatment in a timely manner.

2. Organ Transplant Services

In SFY87; the Medicaid Program provided reimbusement for transplant evaluations and transplant procedures for bone marrow, cornea, liver, heart, and heart-lung transplants.

The following Table 9 shows the numbers of individual transplants either approved or actually performed during SFY85, SFY86, and SFY87.

Table 9
Organ Transplant Approved/Performed

Transplant Procedure	Total Approved	Performed	Waiting List
Liver	4	3	1
Kidney	2	2	-
Heart-Lung	3	-	3
Heart	6	4	2
Cornea	1	1	-
Bone Marrow	15	7	8

Although transplant procedures have been covered under Maine's Medicaid Program, the Federal government requires states to develop policy and specific criteria for these services. Therefore, the Bureau has developed policy, included in the Physician Services section of the Maine Medical Assistance Manual, to address Maine's Medicaid requirements for organ transplants.

3. Services for Persons With Aquired-Immune Deficiency Syndrome (AIDS)

Medicaid-eligible individuals who are also persons with AIDS are eligible for as many Medicaid services as are medically necessary. To date, 18 individuals with this disease were served by the Medicaid Program. It is estimated that the Medicaid Program provided a total of $800,000 in reimbursement for services to these 18 individuals in SFY86 and SFY87. Bureau staff are exploring ways of covering additional appropriate services for AIDS patients.

I. FINANCIAL AND PROGRAM MANAGEMENT

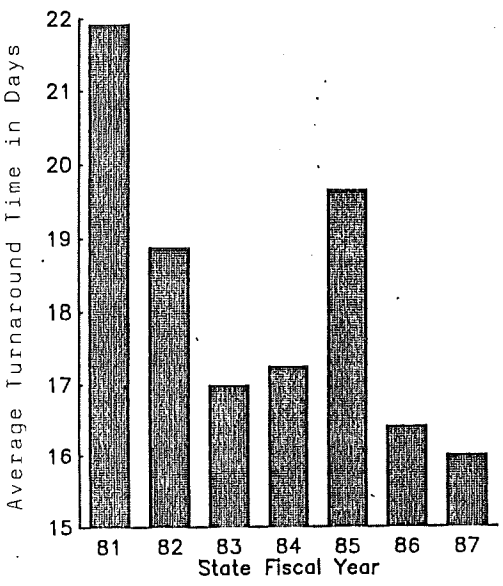
Medicaid has several special mechanisms designed to manage the program and its funds to assure that resources are directed to patient care and not spent inefficiently. Among those which make a significant contribution to the program's effectiveness are:

1. Medical Claims Review

The Division of Medical Claims Review is responsible for the Medicaid Management Information System (MMIS) computerized claims processing and reference subsystems. Before the implementation of the MMIS in 1978, the Medicaid program had an average "turnaround" time of approximately 32 days between submission of a claim and the issuance of payment. Currently, approximately 13,000 claims a day are processed by this system with an average "turnaround" time of 16 days. This represents a significant record of achievement (See Figure 4). According to the most recent Federal review, the system was operating with 99.7% accuracy.

Figure 4

Average Turnaround Time for
Processing Medicaid Claims
SFY 81 - 87
Range 16.74 - 21.91 Days



The staff of this Division maintains the extensive reference subsystem required to process claims. The reference files include a listing of 7,044 providers (including out-of-state and border providers) eligible to bill the Department for services provided to Medicaid eligible individuals.

A file of 16,500 services or procedures is also maintained, with an average of 2,000 changes annually. This file includes all procedures, the rates of reimbursement established for each, any prior authorization requirements, and limits the type of provider who may bill for a service. The MMIS system has the following special capabilities designed to prevent erroneous payments for inadvertant provider billing or attempts at fraud:

a) Computerized Editing: Each claim is examined for completeness, validity of client eligibility, provider eligibility, validity of pricing, code structure, and date of service through a computerized editing process. If there are major discrepancies, then the claim is routed for follow-up review by a staff member;

b) Explanation of Medical Benefit Reports: Each month, a random sample of recipients are sent Explanation of Medical Benefits (EOMB) Reports that list the services billed in their name. They are asked to verify to Medicaid staff that they actually received the services. This assists Medicaid staff in identifying providers who have billed for services that they have not provided;

c) Licensure Status Information: The Division of Medical Claims Review works cooperatively with several state licensing agencies to share computerized licensure-status information on providers. This helps to ensure that unlicensed providers cannot receive reimbursement for Medicaid services; and

d) Uniqueness of Provider Numbers: Each provider affiliated with an agency provider (e.g., mental health agency) is identified by an agency billing provider number and a unique servicing provider number. This reduces the opportunity for purposeful or inadvertant double-billing.

The Division of Medical Claims Review also ensures that resources are utilized appropriately by requiring that prior authorization be given for treatment which often can be provided through a less-costly alternative. Division staff received approximately 15,208 requests for prior authorization of services. Of these requests, 826 services were denied because there was a more appropriate, less costly alternative service available or the service requested was determined to be not medically necessary. These denials resulted in a total savings of approximately $1,470,121.

A total of 304 requests were deferred for more information, with savings of approximately $690,544. In addition, 1,624 claims for services already performed failed to meet prior authorization criteria, resulting in a saving of $1,280,142. The work of the Prior Authorization Unit resulted in savings of $3,440,807 for the Department.

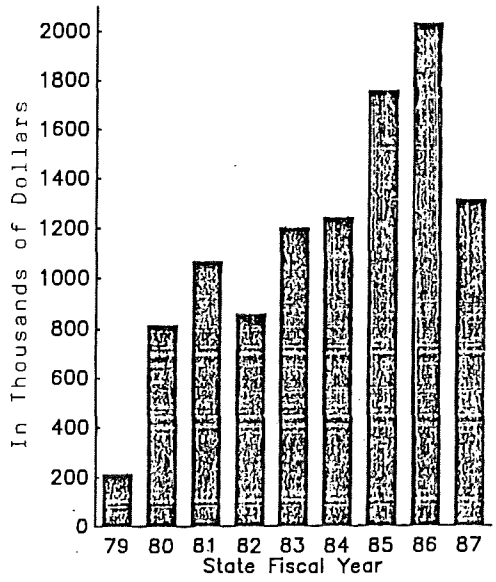
2. Third Party Liability Activities

Federal law requires that Medicaid be the payer of last resort. This means all other health care resources available to an individual must be used before the Medicaid program will pay for services. The Third Party Liability Unit (TPL) is part of the Division of Medical Claims Review and is responsible for assuring that other forms of health insurance, coverage from liability claims, or other sources of medical care payment are used to offset costs which would otherwise be assumed by Medicaid.

The Unit achieves savings through two principle means: recovery of payments already made and avoidance of payments until other coverage has been exhausted (See Figure 5) Cost avoidance allows the Department to avoid paying for medical care until all other coverage has been exhausted. Other kinds of coverage include: private health insurance, individual income of nursing home residents and Federal health care coverage (Medicare). Approximately 12% of the people eligible for Medicaid benefits also have other kinds of health care benefits available to pay for medical care. In 1987, the Department realized a savings of $80,311,006 in cost avoidance. This represents a 24.4 percent savings increase compared to SFY86.

Figure 5

Maine Medicaid Program
Third Party Liability Recoveries
SFY 79 - 87
Range $212,002 - $2,032,250



Recovery allows the staff of the TPL Unit to investigate any accident, employment-related injury, product liability, and in- or out-of-court settlements which involve Medicaid-eligible clients

for whom the Department has paid, or may be billed, for health care services. Actual recoveries by the TPL staff for SFY1987 amount to $1,313,419, a drop from $2,632,280 in SFY1986. The reason for the shift in the recoveries and costs avoided was a change in Federal regulations requiring providers to bill other third party payors before billing Medicaid, called "chase and pay". Previously providers could bill Medicaid first and then the TPL unit recovered from other third party payors, called "pay and chase".

3. **Advocacy for Medicare Patients (AMP)**

The Department believes that its third party liability system will be made even more effective through the development of the Advocacy for Medicare Patients Program to focus on assuring that Medicare recipients receive the full benefits to which they are eligible. There is growing evidence that many individuals are not currently receiving the full level of Medicare benefits to which they are entitled. The Department added two TPL specialists and one assistant attorney general who will pursue these issues on an individual basis and assure that Medicaid funds are not used to pay for skilled nursing care or home health care which Medicare should cover. Because these activities will save state funds, the additional positions were added at no net cost. In addition, $30,000 for administrative services and $9,000 for legal services were awarded by the Department to Legal Services for the Elderly, Inc., to operate a cooperating program aimed at educating providers and consumers regarding the appeals process for Medicare denials as well as for taking over some cases for appeals for beneficiaries who are both Medicare and Medicaid eligible.

4. **Division of Medicaid Policy and Programs**

The Division of Medicaid Policy and Programs, which now includes the Provider Relations Unit (described below), is responsible for the development of policies, procedures and programs to assure access of Medicaid beneficiaries to the range of Medicaid services. Services must fall within budgetary constraints and be provided in an efficient and equitable manner. In order to develop policy to cover new services or to update or revise existing services, staff of this Division regularly meet with affected providers and consumers. This Division also conducts the Annual Fee Review for fee-for-service providers in order to determine if reimbursement is adequate to maintain access to services for Medicaid clients.

Major work for the Division over the course of the next year includes:

- establishing a new rule for Neuropsychological Testing;
- development of new policy for Continuing Care;
- amendment of Medical Supplies and Durable Medical Equipment Services to provide reimbursement for augmentative communication systems;
- amendment of the rule for Podiatric Medicine;
- revision of the policy for Inpatient Psychiatric Facility Services;
- development of policy to establish Case Management Services for Persons With Severe and Disabling Mental Illness and other special client groups;

- development of policy to establish a hospice benefit;

- updating and revision of the nursing home policy for Medicaid;

- development of policy to cover certain services provided in licensed boarding care facilities;

- reviewing with the Bureau of Social Services services eligible for Medicaid coverage that are now funded wholly from State resources; and

- development of policy to provide Medicaid coverage, where possible, of services provided by the Department of Mental Health and Mental Retardation that are now funded wholly from State resources.

5. The **Provider Relations Unit** serves as a liaison between the Bureau and Medicaid providers. This unit participated in the implementation of several changes during SFY87.

   - In June 1987, Unit staff provided training to hospitals around the state in the use of HCPCS codes.

   - During the summer of 1987, Provider Relations staff conducted state-wide training for chiropractors to introduce policy and rule revisions.

   - In June 1987, rural health clinics around the State received training in the use of the Preventive Health Program and other codes that were included in the revision of the Rural Health Clinic Services rule.

   - During the fall, Provider Relations Unit staff met with eligibility workers in every Bureau of Income Maintenance office in the State to discuss BMS and Medicaid issues.

   This unit is available to respond to telephone and written inquiries from providers regarding services under the Medicaid Program. Telephone calls to the unit average one hundred per day. Provider Relations Unit staff routinely visit new providers and other providers who may need assistance in billing or interpretation of Medicaid Policy.

6. **Consumer Services**

   At the close of SFY87, the Recipient Relations Unit and the Patient Classification Unit were united to form the Division of Consumer Services.

   Staff members of the Recipient Relations Unit are frequently called upon to intervene on behalf of Medicaid clients who need assistance with problems relating to Medicaid-covered services. The staff assists clients with unpaid medical bills, in identifying available medical care providers and in the judicious use of their Medicaid benefits.

   The primary responsibility of the Patient Classification Unit is to determine if those applicants who seek care either at home or in a nursing home have needs for medical and nursing care that can only be met with the level of care provided in a nursing home. The unit is staffed with registered nurses who have clerical support services. Each nurse is responsible for a geographical section of the state and works closely with the appropriate Income Maintenance Unit to establish both the financial and medical eligibility of the applicant. Eligibility determination is done concurrently.

A medical social work consultant has also been added to the unit to assist discharge planners and families in planning appropriate placement for patients.

Programs which require classification prior to admission are:

Long Term Care - skilled nursing and intermediate care facilities;

Home and Community-Based Waiver Services for the Elderly;

Home and Community-Based Waiver Services for the Mentally Retarded;

Home and Community-Based Waiver Services for the Physically Disabled;

Inpatient Psychiatric Facility Services for those under 22 and over 65;

Home Care for certain disabled children age 18 and under; and

Private Duty Nursing and Personal Care Services.

The Patient Classification Unit receives approximately 700-800 requests for classification each month and coordinates its work with local case management systems. The case management system for the elderly is operated by the area agencies on aging who conduct home visits to assess individuals seeking nursing home admission and visit hospitalized individuals to assess needs for private duty nursing and personal care services.

7. **Surveillance and Utilization Review**

The Division of Surveillance and Utilization Review (SURS) is a federally-required post-audit system. It retrieves information from all paid claims for services. Payments to health care providers and services received by Medicaid clients are analyzed by staff of this unit to identify patterns of overuse and abuse for further investigation. Surveillance is the monitoring program activity generated by providers rendering services to recipients and is mainly concerned with the possibility of program abuse and fraud. Utilization Review is the assessment of the quality of care and frequency of services being rendered to Medicaid recipients.

In SFY87, termination from the Medicaid Program for program abuse or non-compliance with Medicaid policy, was effected for the following types of providers:

3 physicians
2 nurses
1 nurse assistant
1 pharmacist

As a result of surveillance efforts in SFY 87, $601,315 of additional potential overpayments were identified and $612,281 were actually recouped from providers. Figure 6 shows potential overpayments that have occurred over the past five years. Actual recoupment of the overpayments which have been identified is an ongoing process. Figure 7 shows the provider groups that received requests for recoupments as a percent of the total requests for SFY 87. The Department is increasing the size of the previous three-person professional staff by two additional professionals, with the expected impact being increased savings to the Medicaid Program.

Figure 6
Surveillance and Utilization Review
Actual Recoupments as a Subset
of potential overpayments
SFY83-87

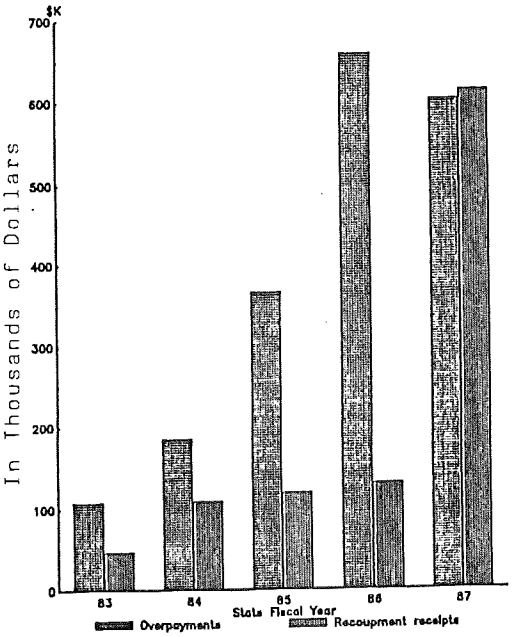
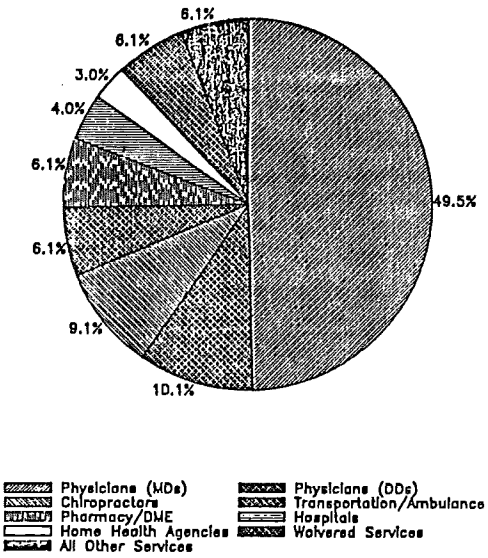


Figure 7
Surveillance and Utilization Review
Recoupment Requests
SFY87



8. Recipient Restriction Program

Education about proper use of health care is one of the most beneficial tools to reduce overutilization or abuse of services by Medicaid clients. Social workers or nurses contact Medicaid clients who appear to be misusing the health care system to provide education on its proper use. Providers are also encouraged to instruct clients in how to use services properly.

The Recipient Restriction Program, a part of the Division of Surveillance and Utilization Review, is the method of last resort to curtail misuse or abuse of benefits. After client education and referrals and resources have been presented, continued misutilization is interrupted by limiting the providers that Medicaid will reimburse for a particular client. Client may be enroled in the restriction process for up to a year.

The client selects the providers of his or her choice for the restriction period. Restricted clients are monitored and the restriction is evaluated at least once a year for continuation or modification.

Only one client was enrolled in the program during SFY 1987 and is expected to be discharged soon. Seven restricted clients enrolled in SFY86 improved their use of health care over the course of SFY87 and were released from the restriction.

9. Returned Drug Program

In 1978, Maine became the first state to develop a Returned Drug Program for Medicaid patients residing in nursing homes. Prescription drugs are often not used due to a change in the medication or the death of a patient. Many of these drugs, when packaged correctly, can be safely used by others. Arrangements have been made for nursing homes to return them directly to the dispensing pharmacy which retains 30% of the cost savings while the Department receives the remaining 70%. In SFY 87, the amount of money saved by this program was $90,000. The Consultant Pharmacist in the Bureau of Medical Services is responsible for this program.

10. Audits

The Division of Audits is part of the Office of Management and Budget and conducts fiscal audits of Medicaid participating agencies such as nursing homes, home health agencies, Preventive Health Program (PHP) agencies, and rural health clinics. The Division of Audits is also responsible for auditing all other funding programs of the Department of Human Services. These audits often result in disallowances for expenses not reimbursed by Medicaid but claimed by the provider. The audits sometimes result in the return of funds to the Department, as they were not used by the Medicaid agency. Because financial information is not submitted to the Department until 90 days or more after the close of an operating year, the most recent information available is usually two years in arrears. In State Fiscal Year 1985, Department audits recovered $3,683,875 on provider claims that either were disallowed because they did not conform to the Medicaid Principles of Reimbursement or were refunds for overpayments.

J. LICENSING AND CERTIFICATION

The Division of Licensing and Certification issues licenses to 44 hospitals, 198 long term care facilities and 62 home health care services agencies/ organizations. Forty-four professional, adminstrative and consulting staff are involved in reviewing and ensuring facility and agency compliance with State licensure regulations. As the State Survey Agency for the Health Care Financing Administration, the Division also certifies that all licensed facilities and a variety of other agencies and services comply with federal regulations for participation in Medicare and Medicaid reimbursement programs.

During State FY87, 573 licensing and certification surveys/resurveys were conducted for the programs listed below. Additionally, 301 complaints were investigated.

The Division of Licensing and Certification is responsible for the following:

Provider	Licensure	Medicare Certification	Medicaid Certification Only
Hospitals:			
42 General Hospitals	X	X	
Prospective Payment Exclusions:			
8 Alcohol Units		X	
5 Rehabilitation Units		X	
5 Psychiatric Units		X	
11 Ambulatory Care Centers	X		
2 Specialty Hospitals (Psych + Rehab)	X	X	
17 Home Health Agencies	X	X	
45 Home Health Care Services Agencies*	X		
6 Independent Laboratories		X	
23 Rural Health Centers		X	
4 Rehabilitation Agencies		X	
5 Portable X-Ray Services		X	
19 Physical Therapist In Independent Practice		X	
5 End Stage Renal Disease Facilities		X	
2 Ambulatory Surgical Centers		X	
21 Skilled Nursing Facilities	X	X	X
135 Intermediate Care Facilities	X		X
42 Intermediate Care for the Mentally Retarded Facilities	X		X
Chiropractors		X	
397 Total			

* These include Medicare-certified home health agencies who are also eligible for Medicaid participation.

A third responsibility, in addition to licensure and certification surveys, is the federally-mandated inspection of care and services in inpatient psychiatric facilities and skilled nursing and intermediate care facilities participating in the Medicaid program. Each facility is visited every six months by a team of nurses and social workers to determine whether:

- The services available in the facility are adequate to meet the needs of each recipient and promote maximum physical, mental and psychosocial functioning;
- It is necessary and desirable for the recipient to remain in the facility;
- It is feasible to meet the recipient's health needs and, in an ICF, the recipient's rehabilitative needs, through alternative institutional or noninstitutional services; and
- Each recipient in an institution for the mentally retarded or inpatient psychiatric facility is receiving active treatment.

K. RESIDENTIAL CARE

Services provided through this division are currently funded entirely with State monies. During SFY88, the Bureau will explore accessing Medicaid funds and providing some care as a Medicaid service. One hundred twenty facilities with the potential for serving 2,300 residents will be affected by this move.

L. CONCLUSION

The Medicaid Program meets its primary goal of providing comprehensive health care to more than 135,000 of Maine's poorest citizens each year at an annual cost of more than $95 million state dollars. While the care given to recipients is equal in quality to that available to all other members of society, concern exists that in some parts of the state access to providers of some types of care may become a growing problem. Maine owes a debt of gratitude to the 7000 in-state and out-of-state providers who participate in the Medicaid Program. Even though some free care or, perhaps more accurately, care that is only partially reimbursed, is still provided throughout the system, it is significant that Medicaid invested more than $299 million in public resources in Maine's health care system in 1987. This represents a substantial commitment to the health of Maine's Medicaid recipients.

M. ISSUES FOR THE FUTURE

The Bureau of Medical Services, as part of the Department's goals and objectives to establish an internal planning process, has instituted a workplan for SFY88 that will be revised annually, in consultation with the Medicaid Advisory Committee and others. The plan includes specific objectives in areas of long-term care, program efficiency and administrative reforms. Activities to meet these goals are summarized below.

- Pursue managed care initiatives by developing prepaid and managed care programs for Medicaid and assure Medicaid participation in developing HMOs.
- Implement the three-year grant from the Robert Wood Johnson Foundation to develop a pilot insurance program for Maine's uninsured. This project will include approximately 3,000 Medicaid recipients and may provide guaranteed eligibility as a benefit under this managed care demonstration.

- Develop and implement a plan including education and other incentives to change the behavior of Medicaid recipients who fail to keep or cancel appointments.

- Implement Program Liaison activities to promote cooperation, coordination, and concensus with providers and other affected parties.

- Expand the annual fee reviews with providers to include a review of the policies and long range joint initiatives to improve the Medicaid program.

- Expand Medicare participation in funding long term care by increasing the number of skilled nursing facility beds through the use of "swing beds" (beds which may be used as hospital or nursing home beds), converting excess hospital beds to long term care beds, resolving current reimbursement problems for SNFs and providing for dual certified SNF/ICF beds.

- Implement Fair Rental reimbursement for capital costs for long term care facilities.

- Complete the study of and develop criteria and procedures for case-mix reimbursement for nursing homes.

- Develop long term care resources for special needs groups.

- Expand utilization review activities for hospitals and other services including prior approvals for certain procedures, same-day surgery policies, and exploring further the benefits of a Second Surgical Opinion Program.

- Review and revise program criteria for home health agency services and transportation servies to improve access where needed and to avoid payment for unnecessary services.

- Quality of care initiatives:

  - contracting with the Human Services Development Institute of the University of Southern Maine to conduct a study to improve consumer access to licensing and certification data;

  - expansion of consumer involvement in the administration of the Medicaid program through the Medicaid Advisory Committee and other initiatives;

  - creation of a position within the Division of Licensing and Certification to provide training and technical assistance to providers to help improve staff skills, enhance status of CNA, and deal with long term care issues;

  - seeking legislation to allow fines and intermediate sanctions as penalties for providers who fail to meet standards;

  - increasing incentives for and collaboration with providers who share quality of care concerns.

- Conduct studies concerning accessing skilled nursing care facilities, improving the licensing and survey process to focus on consumer protection and quality assurance, and evaluating the in-home long term care programs funded by the Department.

- Analyze the data from the study of flat rate-reimbursed boarding homes and develop recommendations for action.

- Develop criteria and procedures for hospital payments for in- and out-patient services and for disproportionate share hospitals to comply with Federal requirements.

- Seek Medicaid coverage for case management as an optional service for various client groups.

- Develop Medicaid policy to establish Medicare/Medicaid certified hospice programs.

- Reconstitute the Residential Care Advisory group and establish eligibility criteria for boarding home placement. Access Medicaid funds for some services.

- Develop a classification process for clients of Residential Care, using criteria established by the Residential Care Advisory group, in cooperation with Consumer Services.

- Maximize Medicaid match for State-funded services provided by the Bureau of Social Services and the Department of Mental Health and Mental Retardation.

- Increase physician enrollment in the Preventive Health Program.

- Develop cost containment mechanisms, including the continuation of the vision care volume purchasing contract for eyewear and a similar proposal for certain durable medical equipment.

- Reduce the cost of drugs and durable medical equipment without reducing the quality of these products.

- With funds from the federal government, expand alcoholism and substance abuse services, mental health and state eligibility functions in rural health clinics.

- Enhance monitoring of inappropriate denials of covered services by Medicare and other third-party payors by supporting L.D. 2022, an act that would require attorneys for parties in accident and liability suits for whom Medicaid benefits relative to the suit have been paid to notify the Bureau of Medical Services of the settlement of such actions.

- Expand Surveillance and Utilization Review Services' collections by $400,000 annually.

Recent Federal Changes and Their Impact

In addition to the above initiatives, Bureau of Medical Services staff are addressing new issues as a result of federal legislation. The Omnibus Budget Reconciliation Acts of 1986 & 1987 provide new options for states which are summarized below:

1. Optional coverage of poor pregnant women and children up to age 2 with incomes up to 100% of the Federal poverty level, and effective July 1, 1988, up to 185% of the Federal poverty level and up to age 4.

2. Optional coverage of elderly and disabled poor with incomes up to 100 percent of the Federal poverty level. (States may not implement this option unless it agrees to cover the first option, above.)

3. Optional coverage of poor Medicare beneficiaries with incomes up to 100% of the Federal poverty level. Medicaid would cover the Medicare Part A premiums (if applicable), Part B premiums, and the deductibles and coinsurance amounts for Parts A and B. (States may not implement this option unless option 1, above, is also covered.)

4. Medicaid eligibility for qualified severely impaired individuals. This provision provides mandatory coverage to allow individuals who are blind or physically or mentally disabled to continue to receive Medicaid coverage if they continue to meet all requirements for SSI except for earnings.

5. Homeless individuals may continue to be Medicaid eligible regardless of whether or not the individual's residence is maintained permanently or at a fixed address.

6. Payments for aliens under Medicaid must be provided if such individuals meet the eligibility requirements for AFDC or SSI, AND have emergency medical conditions that place their health in serious jeopardy.

7. "Presumptive" eligibility for pregnant women would allow qualified providers to determine that the family income of a pregnant woman meets eligibility standards. This provision would allow pregnant women to receive ambulatory prenatal care immediately.

8. Federal regulations will require states to extend coverage to children up to age 6 and are allowed the option of covering children up to age 8.

9. Optional coverage to families with income up to 185 percent of the federal poverty level. Families whose income is above 150 percent of the federal poverty level can be charged a monthly premium up to 10 percent of their income.

10. Nursing Home Quality Improvements raise the personal needs allowance for Medicaid eligible recipients in nursing homes and other institutions from $25 to $30 per month (Maine presently supplements the $25 allowance with an additional $10.00 from State funds).

11. Federal regulations revised nursing home participation requirements, survey and certification procedures, and enforcement remedies under Medicaid.

The Bureau of Medical Services has developed a proposal for the first two options and is exploring possible funding for at least the first option. Presumptive eligibility is being tested in two sites.

The federal budget may also have an impact upon Maine's budget for the Medicaid Progam. While it is difficult to predict the outcome of the budget, the major predictable problem will be the declining federal matching rate. As noted earlier in this report, this rate is calculated on the basis of a formula which measures relative pre-capita income in the state. As Maine's economic situation improves, this federal match rate will decrease, placing more and more of the burden upon the State for financing services for Medicaid clients.

If enacted as proposed, it is expected that the following provisions will shift more costs to the states in the administration and provision of services under Medicaid.

- Modification of the Medicare Part B premium for third party payors would set the premium at 50% of program costs. Medicaid would experience a doubling of its Part B premium costs, requiring approximately $955,000 in state funds.

- Indexing the Medicare deductible to keep pace with Medicare inflation is expected to cost the State of Maine up to $50,000 over anticipated increases for this service.

- A federal cap on Medicaid Programs limited to inflationary adjustments would limit Maine's ability to expand the Medicaid Program. If growth is capped at a 5% level, Maine would need to slow the growth of its Medicaid Program by approximately $2,133,484 for SFY88.

- A decrease in the federal match rate for family planning from 90/10 to 50/50 would require an additional $59,850 in state funds to maintain this service at current levels of utilization for SFY88.

- A decrease in federal funding from 75% to 50% for the survey and certification of nursing homes would reduce the Bureau's ability to inspect nursing homes by approximately one-third. This initiative jeopardizes the health and safety of clients by diminishing the State's ability to follow up on complaints and deficiencies. This provision would cost the State an additional $139,971 in SFY88.

- Decreasing federal funding from 75% to 50% for the operation of Maines federally-approved Medicaid Management Information System would reduce the Bureau's ability to process and pay medical claims in a timely manner for services provided to Medicaid clients and require an additional $749,488 in State funds for SFY88.

- A decrease in federal funding from 75% to 50% for skilled medical personnel would cost the State an additional $279,084 for SFY88.