MEDICAID ANNUAL REPORT

STATE FISCAL YEAR 1988

PREPARED BY:

DEPARTMENT OF HUMAN SERVICES
BUREAU OF MEDICAL SERVICES

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Department of Human Services
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FOREWORD

This Annual Report is prepared as required by statute for the information of the Joint Committees on Human Resources and Appropriations and Financial Affairs.

The Bureau of Medical Services is responsible for administering the Medicaid Program on behalf of the Department of Human Services. The Bureau works closely with other Bureaus, consumer and provider groups and the Department of Mental Health and Mental Retardation and other branches of state government. It is guided in its tasks by a Medicaid Advisory Committee composed of consumers and their advocates and a variety of private and public providers of health care. Administration of the Medicaid Program is shared with the Bureau of Income Maintenance which determines client eligibility.

Medicaid is an extremely complicated program. It purchases thousands of different health care services for tens of thousands of Medicaid recipients each year. In conjunction with this essential mission, the Bureau must comply with countless federal and state procedural and financial requirements and regulations.

As you read this report, please bear in mind that it is only a brief sketch of the Bureau's activities in State Fiscal Year 1988 and its current projects and objectives. If you have need of more detailed information, please contact the Bureau by calling 289-2674.

I wish to extend my thanks to members of my staff who provided the data and text for this report.

Elaine E. Fuller
Director
Bureau of Medical Services

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1. SUMMARY

Maine has one of the most comprehensive Medicaid Programs in the country. Over 133,000 persons were eligible for services for at least part of State Fiscal Year 1988 and, on average, approximately 90,000 recipients were enrolled in Medicaid each month. They received $323,610,339 in health care services during the year. In 1980, Medicaid expenditures were $124,716,908. They have increased 259% in eight years.

* Total Medicaid health care expenditures rose 8.6% from SFY87 to SFY88

* A major study is underway to evaluate physician fees

* An initiative to provide health coverage for the uninsured is underway, co-sponsored by the Department and the Robert Wood Johnson Foundation

* An average of 16,000 Medicaid claims are now processed daily and the average length of time until payment is 17.3 days

* Licensing and Certification surveyed 373 facilities and investigated 257 complaints in SFY88

* Residential Care inspected and licensed 270 boarding homes and 356 foster homes last year

2. SFY 1988 MEDICAID RECEIPTS AND EXPENDITURES

The Medicaid Program is funded with a combination of state and federal dollars. During Fiscal Year 1988, the State's share of total expenditures was 32.48% and the federal share was 67.52%. In actual dollars, Medicaid services were purchased with $105,108,638 in state monies and $218,501,701 in federal support.

Table 1 (pp 15-16) details SFY87 AND SFY88 expenditures by category of service. Many of the substantial changes in expenditures were caused by the implementation of new policy and the transfer of certain procedures among categories of service. Other changes are now the subject of analysis which will be discussed in a separate document. A brief commentary on the changes by category of service is on pages 17 and 18. The expenditure report is followed by a breakdown of federal and state contributions (Table 2, pp 19-20). The pie chart on page 21 reveals that six categories of service accounted for 84% of total Medicaid expenditures last year. Table 3 on page 22 lists numbers of participating providers and recipients served in major categories of service during the last fiscal year.

Five other state agencies provide seed funds for specific services in the Medicaid Program. The Department of Mental Health and Mental Retardation (DMHMR) furnishes state match for state-operated ICF/MR facilities and psychiatric hospitals, and for case management and day treatment services. It also supports the Waiver Program for the Mentally Retarded and mental health clinic services for clients of the Bureau of Mental Health, and pays the Medicare Part A deductible for state hospital patients. The Bureau of Social Services seeds mental health clinic services for Child and Adult Protective cases.

Total administrative costs for the Bureau of Medical Services in SFY88 were $12,395,400, up 14.5% from $10,828,581 in SFY87. These figures include administrative costs of the Divisions of Licensing and Certification and Residential Care. Funding related specifically to the Medicaid Program was $9,180,498 in SFY88 and $8,296,627 in the previous year, a net increase of 10.7%.

The ratio of administrative costs to expenditures for health services was 2.84% in SFY88, rising slightly from 2.78% in SFY87.

3. ANNUAL FEE REVIEW

The Bureau of Medical Services invites all categories of participating providers to annual meetings to discuss policy and reimbursement issues. During the summer of 1988, staff met with the following provider associations:

Speech and Hearing
Occupational Therapy
Psychology
Family Planning
Ambulance
Physician (MD and DO)
Optometry
Transportation
Pharmacy
Nurse-Mid-Wife
Mental Health Center
Dental
Durable Medical Equipment & Supplies

Other fee-for-service providers either declined or did not respond to the Bureau's invitation to meet.

On September 29, 1988, an Annual Fee Review summary meeting was held, chaired by Bureau Director Elaine Fuller. Categories represented were both physician groups (MD and DO), speech and hearing, mental health centers and ambulance services.

4. BUREAU OF MEDICAL SERVICES ACTIVITIES

The Bureau's mission is to serve the health needs of Maine citizens by:

Purchasing cost effective, accessible, quality health and social services for low income people,

Protecting the health and welfare of people needing institutional or residential care or agency services,

And assisting eligible consumers in utilizing the health care delivery system appropriately.

The Bureau carries out this mission by:

Establishing, monitoring, and enforcing generally accepted standards,

Developing and implementing policy for coverage of health and social services,

Educating consumers and advocating in their behalf,

And assuring availability of qualified providers.

The responsibilities of the Bureau of Medical Services have grown substantially in recent years. Both across the country and in Maine, Medicaid has become the primary funding source for long term care services. Since other third party payers have not covered long term care, Medicaid is the eventual payer for citizens of all income classes. The average annual cost of intermediate facility care, about $24,000 for private pay residents, rapidly impoverishes most individuals.

Although the Maine Medical Assistance Program was initially a purchaser of basic medical care for the very poor, it has become a source of funding for an increasingly complex and diverse array of services for an expanding eligible population. Federal legislation over the last few years has created options for states to expand existing services to new populations. The 113th Legislature also voted to fund options created by the Sixth Omnibus Budget Reconciliation Act (SOBRA). One provision allows Medicaid benefits for pregnant women and children up to age one under 185% of federal poverty guidelines. Another provides coverage for children under five and the elderly and disabled up to 100% of poverty. The effort to draw down additional federal matching funds is a continuing process.

Concerning basic medical services, Medicaid expenditures for hospital services doubled between SFY80 and SFY88 to

$90,835,653. In contrast, physician services, which are covered without limitations, rose only 14% in the same period, from $12,200,000 to $13,976,000.

The largest single item in the Medicaid budget is intermediate care facilities. In 1980, $57,300,000 were expended to care for 7,806 recipients, but by 1988, costs had risen 93.2% to $110,700,000 while the number of patients had risen only 14.1%, to 8,905. Since long term care costs are projected to nearly double by 1995, the Bureau has placed high priority on long term care facility reimbursement policy. Two major changes currently underway are the development of a case-mix reimbursement system and a revised method of funding capital costs known as a "fair rental system."

Another area of concern is community-based services. Between 1980 and 1988, costs rose 457% from $1,100,000 to $5,030,000 and recipients increased 212% from 1,823 to 3,858. Since it is generally accepted that institutional services are the most expensive form of long term care, the Bureau will continue to develop policy conducive to the growth of community-based services as an alternative to institutional long term care.

Many of the services funded by Medicaid have been developed to respond to the needs of particular client groups. For example, substantial resources are used for intermediate care facilities, day habilitation and Home and Community-based Waiver services for the mentally retarded; substance abuse treatment services; mental health clinic services; and inpatient psychiatric services. Another example is the Preventive Health Program which promotes periodic examinations and appropriate immunizations for enrolled children.

Medicaid recipients received approximately 1.4 million prescription drugs in SFY88. Total pharmacy expenditures were $22,885,291, up 9.3% from the previous year. The success of a combination of state and federal initiatives to control drug costs is evident in figures for calendar year '88, when the average cost per prescription increased only $0.30, from $16.63 in 1987 to $16.93.

Initially, some categories of service were seeded by the state agencies responsible for the program, but, over time, they have been assimilated into the Bureau's "payments to providers" and "nursing care facilities" accounts. DHS now seeds ICF/MR, substance abuse, the waiver programs for the elderly and the disabled, and many transportation services.

The Bureau pays for services in many different ways. Some substance abuse services are reimbursed on a capitated basis and others, on a cost reimbursement basis. Hundreds of procedures are purchased on a fee-for-service basis. Inpatient acute care reimbursement is determined by the Maine Health

Care Finance Commission, which allocates costs among payers based on utilization. Upper limits on allowable costs permit prescription drugs to be purchased less expensively than in previous years.

Another important effort of the Bureau is to utilize federal Medicaid matching funds wherever possible. Staff have been working with consultants to the Department of Mental Health and Mental Retardation to increase institutional reimbursement both retroactively and prospectively. BMS has also introduced policy to cover case management services provided by DMHMR. Similar activities include developing policy for personal care attendant services with the Bureau of Rehabilitation and for a capitated boarding home payment system.

Although Medicaid regulations permit contracts with new types of health service delivery organizations, there has been little opportunity in Maine to take advantage of this option. One such opportunity to which the Bureau is fully committed is a project now providing health insurance for the uninsured in the Brunswick area. It will expand to the Skowhegan area early in 1989. Funded by the Department of Human Services and the Robert Wood Johnson Foundation, the initiative is staffed by the Bureau and the Human Services Development Institute. Participants are being enrolled in a health maintenance organization operated by Health Source, Inc., under a program known as MaineCare. By early January, 70 working uninsured individuals representing 32 businesses had been enrolled and widespread publicity during the week of January 9, 1989, generated a flood of new inquiries. Under a companion project, FamilyCare, AFDC recipients are being offered the opportunity to enroll in the HMO. The Bureau plans to evaluate the experience of Medicaid recipients who join the plan.

Bureau staff have developed documents outlining initiatives for the health care industry and long term care. These are two of ten "key result areas" identified by the Commissioner as priorities for 1989. Other BMS activities last year included staffing the Special Select Commission on Access to Care, initiating the development of hospice services, researching the issue of the uninsured and supporting AIDS-related activities.

MEDICAID ADVISORY COMMITTEE - It was an active year for the Medicaid Advisory Committee which was chaired by Robert Philbrook of Portland. Two of the committee's main concerns were outreach and access to care for eligible consumers. Members were particularly interested in the logistics of enrolling persons who became eligible October 1, 1988, under the SOBRA provisions described earlier. Out of their deliberations on this issue, the committee developed a series of recommendations which the Department is in the process of implementing.

PHYSICIAN ADVISORY WORK GROUP - Representatives of a variety of medical specialties advise the Bureau through the

Physician Advisory Work Group. In addition to reviewing a host of Medicaid policy issues related to medical practice, this group has devoted considerable time to an assessment of physician fees. With the Human Services Development Institute providing consulting researchers, an assessment of reimbursement to doctors is underway using both resource-based and charge-based relative value scales. The project, which is scheduled to be completed in May of 1989, will provide the basis for adjusting fees for individual procedures to levels that are intended to assure reasonable access to services for Medicaid enrollees.

CONSUMER SERVICES - During SFY87, the Bureau's Recipient Relations Unit and the Patient Classification Unit were merged to form the Division of Consumer Services. Last year, staff classified approximately 1,000 patients per month for institutional and community-based long term care. The 12,000 classifications included both initial and ongoing determinations.

The toll-free recipient information line generated approximately 300 calls per month concerning consumer problems ranging from unpaid bills to locating providers.

FINANCIAL SERVICES AND MEDICAL CLAIMS - Considerable staff resources are committed to hospital reimbursement activity, working in conjunction with the Maine Health Care Finance Commission. Acute care hospital expenditures remained almost constant between SFY87 and SFY88, declining 0.7% to $90,835,653. Further analysis of hospital expenditures will be conducted.

Other Financial Services activities included reimbursement adjustments to raise nursing salaries in long term care facilities, extensive negotiations on nursing home reimbursement policy, and continued development of fair rental and case mix reimbursement programs.

The Division of Medical Claims review processed 3,532,089 claims in SFY88, which is more than triple the number handled in 1980 (1,037,513). Average daily claims volume is currently about 16,000. The average time from the point when Medical Claims receives a claim to the date when a check is issued is 17.3 days. The inquiry staff last year received 79,488 telephone inquiries.

Eighty percent of claims are processed without a suspension for correction, rejection or additional information. Ten percent of claims are now "paperless," filed electronically over telephone lines. About 17,000 requests for prior approval of medical procedures were received in SFY88, and 824 were denied and 206 were deferred, resulting in a savings of $2,929,841.

The Third Party Liability Unit recovered a total of $1,477,991 during the last fiscal year. During the same peri-

od, cost avoidance, which is payment for services to Medicaid enrollees by other third party payers, totalled $79,500,000. The unit is currently expanding its recovery efforts by improving its ability to identify other third parties. New information resources include the Division of Motor Vehicle Registration, Worker's Compensation, the Estate Recovery Law, the AMPS Program and the Bureau of Labor Statistics.

LICENSING AND CERTIFICATION - Division staff completed 373 surveys in SFY88 which involved fifteen different types of providers. Four new facilities with a total of 83 new beds were surveyed. Two hundred and fifty-seven complaints were investigated of which 243 involved nursing homes. Adverse actions were taken in 28 cases.

POLICY AND PROGRAMS - As this report is submitted, the Division of Policy and Programs is developing, amending and researching 46 policies incorporated in the Maine Medical Assistance Manual. The Division averages 500 telephone calls per week from providers. The inquiries are handled by six (full time equivalent) provider relation specialists who also deliver on-site assistance around the State.

Revision of the policy for psychology services will be a priority on the BMS agenda for 1989. It must be made consistent with the policy for services provided in a mental health center. In addition, providers and Bureau staff will jointly develop utilization review standards.

Optometry services policy must be revised to comply with the new optometric laws. These policy changes will be initiated when staff resources become available.

In the area of rehabilitative services, staff are completing policy providing reimbursement for consumer-directed personal care attendants.

To obtain "usual and customary charge" data, a survey of dentists will be conducted and evaluated for possible changes in the dental fee schedule.

A major project of the Division is an assessment of physician fees using both charge-based and resource-based relative value scales. Consultants from the Human Services Development Institute at the University of Southern Maine are assisting the Bureau in this endeavor. The objective is to provide an accurate base for adjusting physician fees to reasonable levels and eliminating irregularities caused by "item by item" changes in the past.

Due to the increased costs of providing family planning services, a fee increase is planned. The federal matching rate for family planning services is 90%.

In the area of pharmacy services, the relationship between the Medicaid dispensing fee and current costs of filling prescriptions will be assessed.

Ambulance service providers have requested an increase in mileage reimbursement from $2.00 per loaded mile to $2.50. Payment is calculated in "loaded" miles, distances over which the vehicle actually transports a patient. Adjustments for increases in the costs of oxygen and advanced life support systems carried by ambulances are also anticipated.

Speech and hearing agencies have presented cost and employee vacancy rate data for the Bureau's assessment. The agencies report that they are experiencing difficulty in maintaining staff because of competition from hospitals for the same professionals and low Medicaid reimbursement.

Providers of transportation services are requesting reconsideration of their reimbursement rates. They are required to serve all Medicaid clients who seek their services.

The ability to provide 24-hour service at current reimbursement rates is the concern of providers of durable medical equipment and supplies. It has also been recommended that the Medicaid Program cover nasal continuous positive airway pressure equipment.

The Bureau's staff will work with the Bureau of Mental Health on the serious access problem experienced by Medicaid enrollees in obtaining mental health clinic services. A previous increase in clinic rates resulted in no increase in utilization.

The expansion of nurse midwife policy to include certain gynecological services will be considered.

Concerning occupational therapy services, increased reimbursement and coverage of occupational therapy aides have been requested.

During SFY88, Preventive Health Program outreach workers around the state informed 9,951 parents and guardians about the special PHP services available to children and young adults. The workers also notified caretakers concerning 26,177 screening examinations and 2,836 initial dental examinations (for three-year-olds). Claims were paid for 21,264 medical screenings and for 29,047 preventive dental visits. About 14% of the medical exams (2,911) identified conditions that required additional diagnosis and treatment. Outreach workers are currently receiving additional training in assisting families in obtaining needed health care services.

RESIDENTIAL CARE - Licensing activities in SFY88 involved 270 boarding homes and 356 adult foster homes. Staff investi-

gated 78 complaints about boarding homes and 28 related to foster homes. As the result of actions by the Department, four boarding homes and eight foster homes were closed. The division is actively engaged in bringing Medicaid reimbursement to the boarding home program and in implementing the Fines and Sanctions Law passed during the last legislative session.

SURVEILLANCE AND UTILIZATION REVIEW - In SFY88, the following providers were terminated from the Medicaid Program:

3 Physicians
1 Psychologist
1 Nurse.

As the result of surveillance efforts in SFY88, $242,620 in new overpayments were identified and $398,450 in existing overpayments were actually recouped from providers.

No new clients were added to the recipient restriction program last year, but 16 previously enrolled recipients remained in the program. The social worker and registered nurse assigned to the unit had almost 1,200 personal contacts with Medicaid recipients, providing education in the appropriate use of the health care system and correcting inappropriate patterns in the use of health care services.

Currently, the Division has a number of large scale reviews in progress involving home health agencies, hospital-based skilled nursing facilities (SNFs), the prescribing of the drugs Tagamet and Zantac, and other trends in drug prescription and utilization.

5. ISSUES FOR THE FUTURE

The Medicaid Program is a crucial component of any strategy to insure basic health care for Maine's citizens. Major cuts in Medicaid cannot be achieved without eliminating optional services or reducing payments to providers, which will both significantly restrict recipient access.

However, as the Bureau of Medical Services assumes responsibility for more services to greater numbers of eligibles, it is imperative that concomitant efforts be made to manage finite resources efficiently and contain the inevitable rise in health care costs.

The Bureau intends to meet the future by:

* Continuing to work with the Human Services Development Institute to develop managed care systems for certain Medicaid populations and services

* Establishing limits on length of stay for in-patient psychiatric hospital services

* Continuing analysis of data from the Medicaid Management Information System to identify services for which prior authorization and other controls should be required

* Rewriting policy for durable medical equipment

* Expanding audit capabilities to detect charges that significantly exceed the cost of providing services

* Continuing the careful management of long term care services and the promotion of community-based services

* Considering diagnosis-related group reimbursement and other strategies for containing in-patient and out-patient costs

* Continuing to refine fee schedules and cost reimbursement criteria to reflect current practice and technology

* Pursuing new sources of third party liability recoupment.

As the Bureau enters the 1990's, there are components of the delivery system where significant cost increases are anticipated:

Nursing care facilities
Community-based long term care
Coverage of the uninsured
Improvements in access to care
Expansions of services and eligible populations
Changes in the federal matching rate

The challenge facing those responsible for public policy is to address these inevitable demands recognizing the reality of limited resources.

	SFY 87	SFY 88	'PERCENT 'CHANGE
'MEDICAID EXPENDITURES - SFY87 AND SFY88			
	SFY 87	SFY 88	'PERCENT 'CHANGE
AMBULANCE	$470,996	$488,122	3.64%
AUDIOLOGY	$19,097	$12,839	-32.77%
BME WAIVER	$2,961,983	$3,231,609	9.10%
BMH WAIVER	$241,979	$38,434	-84.12%
BMR WAIVER	$5,910,743	$8,172,502	38.27%
RURAL HEALTH CLINIC	$703,987	$851,912	21.01%
CHIROPRACTOR	$186,190	$214,393	15.15%
DAY HABILITATION	$0	$1,753,386	N/A
DENTAL	$2,252,595	$2,114,158	-6.15%
DME & SUPPLIES	$2,423,466	$2,837,357	17.08%
PROSTHETIC/ORTHOTICS	$269,550	$383,180	42.16%
EPSDT	$0	$505,091	N/A
FAM. PLANNING CLINIC	$170,083	$181,227	6.55%
ACUTE HOSPITAL	$90,898,789	$90,835,653	-0.07%
HEARING AID DEALERS	$43,035	$52,699	22.46%
HOME HEALTH AGENCIES	$5,294,009	$5,030,850	-4.97%
ICF/MR (G)	$7,603,580	$7,583,802	-0.26%
ICF/MR (N)	$20,750,506	$20,677,838	-0.35%
ICF	$98,706,575	$110,720,072	12.17%
INDEPEN. LAB & X-RAY	$288,227	$530,423	84.03%
MEDICARE PART A	$5,291,536	$5,795,275	9.52%
MEDICARE PART B	$4,126,021	$3,845,499	-6.80%

	SFY 87	SFY 88	'PERCENT 'CHANGE
ACUTE PSYCHIATRIC INPATIENT HOSPITAL	$1,406,255	$4,731,636	236.47%
MENTAL HEALTH CLINIC	$3,548,143	$3,961,884	11.66%
NURSE MIDWIFE	$0	$252	N/A
OCCUPATIONAL THERAPY	$0	$3,918	N/A
OPTICAL SERVICES	$39,448	$95,846	142.97%
OPTOMETRIC	$485,021	$379,471	-21.76%
PERSONAL CARE SERVICES	$1,109,014	$1,488,633	34.23%
PHYS DISABLED WAIVER	$37,139	$380,077	923.39%
PHYSICAL THERAPY	$23,849	$34,305	43.84%
PHYSICIAN SERVICES	$14,472,539	$13,976,708	-3.43%
PODIATRY	$80,310	$103,370	28.71%
PHARMACY	$20,939,940	$22,885,291	9.29%
PRIVATE DUTY NURSE	$204,787	$296,360	44.72%
PRIV. NON-MED. INST.	$268,916	$360,652	34.11%
PSYCHOLOGICAL SERVICES	$1,885,586	$2,040,491	8.22%
SNF	$3,079,911	$4,336,102	40.79%
SPEECH & HEARING	$255,072	$264,502	3.70%
SPEECH PATHOLOGY	$482,715	$473,967	-1.81%
SUBSTANCE ABUSE	$6,295	$364,212	5685.73%
TRANSPORTATION	$1,140,073	$1,571,681	37.86%
VD SCREENING	$5,958	$4,660	-21.79%
TOTAL	$298,083,918	$323,610,339	8.56%

Comments on Changes by Category of Service

There were many variations in the levels of expenditures for individual categories of service during SFY87 and SFY88. The following text is a partial explanation of these changes. The abbreviation "RFE" is used to indicate that the change in expenditure "requires further evaluation." In categories of service where the increase approximates general growth of the Medicaid Program or where a low level of funding could cause wide variations in the percent of change, no comment has been made.

Audiology - RFE.

BMH Waiver - being phased out. Patients are being assimilated into other programs.

BMR Waiver - 100 clients added when waiver was renewed in July, 1987.

Rural Health Clinic - podiatry services added; and "well care" services increased through the Cooperative Agreement.

Chiropractor - x-rays added as billable service.

Day Habilitation - new category of service. ICF-MR client services were included in the two ICF-MR categories in 1987.

Dental - decrease in both providers and clients. RFE.

Durable medical equipment and supplies - RFE.

Prosthetic/orthotics - RFE.

EPSDT - screening costs for children reported in this category as of SFY88.

Acute Hospital - level expenditures caused in part by TEFRA restrictions. RFE.

Home Health Agencies - cost settlements from previous year. Offset by substantial increases in the Personal Care Services and Private Duty Nurse categories.

ICF/MR (Group and Nursing) - clients' day habilitation services included in SFY87, but reported separately in SFY88 (see "Day Habilitation" above).

Independent Lab and X-ray - increases in both providers and clients. RFE.

Medicare Parts A and B - billings for co-insurance and deductibles determined by enrollment and utilization of dually-eligible clients.

Acute Psychiatric Inpatient Hospital - rapid growth in Medicaid utilization at Jackson-Brook Institute. RFE.

Nurse Midwife - services billed through physician practices and hospitals. RFE.

Occupational Therapy - new service.

Optical Services and Optometric - expenditures for eyeglasses consolidated under optical services through a sole-source contract.

Personal Care Services - increase in the number of clients and in the annual limit on expenditures per client.

Physically Disabled Waiver - increase in clients and significant increase in services per client during the second year of the waiver. RFE.

Physical Therapy - elimination of annual $500 limit and addition of the Baxter School for the Deaf as provider.

Physician Services - extended period without fee increases. Note: data for first six months of SFY89 when fee changes were implemented indicate that the downward trend has been reversed.

Private Duty Nurse - increase in number of clients and in the annual limit on expenditures per client.

Private Non-Medical Institution - added "community residences for the mentally retarded." Rate increases based on "non-risk" contracts. RFE.

Skilled Nursing Facility - increase in utilization and in out-of-state facilities. RFE.

Speech Pathology - fewer clients, although more participating providers. RFE.

Substance Abuse - established as separate category in May, 1987.

Transportation - 20% increase in clients partially caused by transport to day habilitation services.

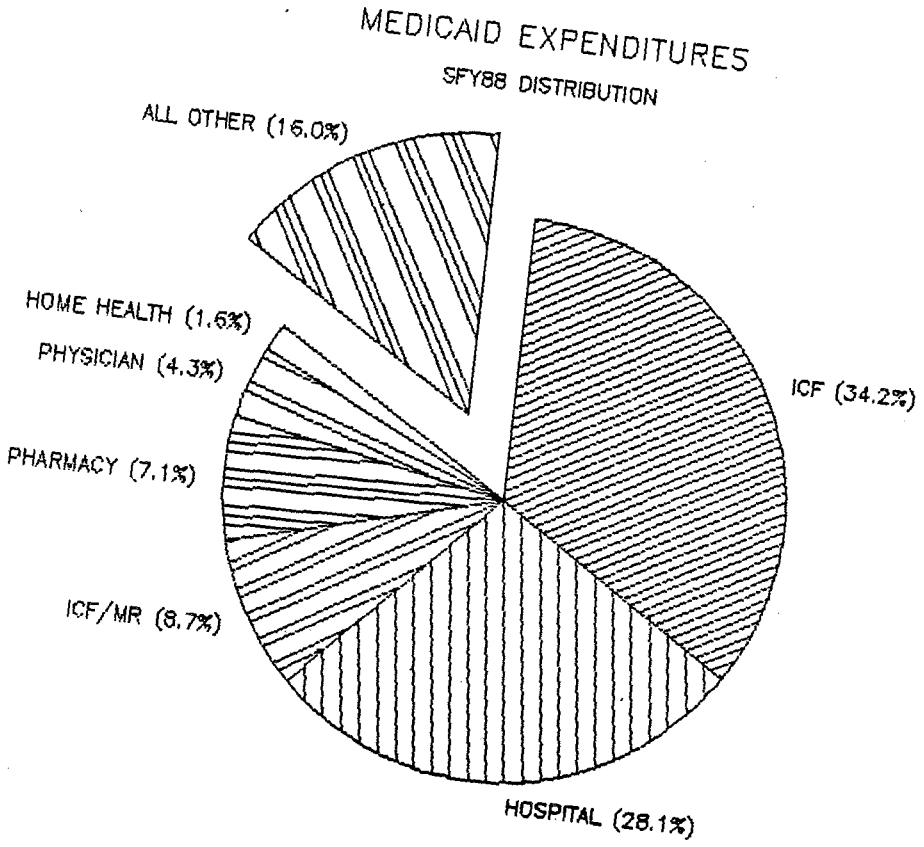
VD Screening - RFE.

'MEDICAID EXPENDITURES - SFY88
STATE, FEDERAL AND TOTAL DOLLARS

	STATE (32.48%)	FEDERAL (67.52%)	TOTAL (100%)
AMBULANCE	$158,542	$329,580	$488,122
AUDIOLOGY	$4,170	$8,669	$12,839
BME WAIVER	$1,049,627	$2,181,982	$3,231,609
BMH WAIVER	$12,483	$25,951	$38,434
BMR WAIVER	$2,654,429	$5,518,073	$8,172,502
RURAL HEALTH CLINIC	$276,701	$575,211	$851,912
CHIROPRACTOR	$69,635	$144,758	$214,393
DAY HABILITATION	$569,500	$1,183,886	$1,753,386
DENTAL	$686,679	$1,427,479	$2,114,158
DME & SUPPLIES	$921,574	$1,915,783	$2,837,357
PROSTHETIC/ORTHOTICS	$124,457	$258,723	$383,180
EPSDT	$164,054	$341,037	$505,091
FAM. PLANNING CLINIC	$18,123	$163,104	$181,227
ACUTE HOSPITAL	$29,503,420	$61,332,233	$90,835,653
HEARING AID DEALERS	$17,117	$35,582	$52,699
HOME HEALTH AGENCIES	$1,634,020	$3,396,830	$5,030,850
ICF/MR (G)	$2,463,219	$5,120,583	$7,583,802
ICF/MR (N)	$6,716,162	$13,961,676	$20,677,838
ICF	$35,961,879	$74,758,193	$110,720,072
INDEPEN. LAB & X-RAY	$172,281	$358,142	$530,423
MEDICARE PART A	$1,882,305	$3,912,970	$5,795,275
MEDICARE PART B	$1,249,018	$2,596,481	$3,845,499

ACUTE PSYCHIATRIC INPATIENT HOSPITAL	$1,536,835	$3,194,801	$4,731,636
MENTAL HEALTH CLINIC	$1,286,820	$2,675,064	$3,961,884
NURSE MIDWIFE	$82	$170	$252
OCCUPATIONAL THERAPY	$1,273	$2,645	$3,918
OPTICAL SERVICES	$31,131	$64,715	$95,846
OPTOMETRIC	$123,252	$256,219	$379,471
PERSONAL CARE SERVICES	$483,508	$1,005,125	$1,488,633
PHYS DISABLED WAIVER	$123,449	$256,628	$380,077
PHYSICAL THERAPY	$11,142	$23,163	$34,305
PHYSICIAN SERVICES	$4,539,635	$9,437,073	$13,976,708
PODIATRY	$33,575	$69,795	$103,370
PHARMACY	$7,433,143	$15,452,148	$22,885,291
PRIVATE DUTY NURSE	$96,258	$200,102	$296,360
PRIV. NON-MED. INST.	$117,140	$243,512	$360,652
PSYCHOLOGICAL SERVICES	$662,751	$1,377,740	$2,040,491
SNF	$1,408,366	$2,927,736	$4,336,102
SPEECH & HEARING	$85,910	$178,592	$264,502
SPEECH PATHOLOGY	$153,944	$320,023	$473,967
SUBSTANCE ABUSE	$118,296	$245,916	$364,212
TRANSPORTATION	$510,482	$1,061,199	$1,571,681
VD SCREENING	$1,514	$3,146	$4,660
TOTAL	$105,108,638	$218,501,701	$323,610,339

Chart 1


MEDICAID EXPENDITURES
SFY88 DISTRIBUTION
ALL OTHER (16.0%)
HOME HEALTH (1.6%)
PHYSICIAN (4.3%)
PHARMACY (7.1%)
ICF/MR (8.7%)
HOSPITAL (28.1%)
ICF (34.2%)

PARTICIPATING PROVIDERS BY TYPE OF SERVICE

Type of Service	Number of Providers		
	'SFY87	'SFY88	'% Change
Physicians	1281	1700	32.7%
Dentists	257	401	56.0%
Pharmacists	398	283	-28.9%
Optometrists	138	141	2.2%
Psychologists	174	187	7.5%
Durable Med. Equip.	190	251	32.1%
ICFs	146	146	0.0%
SNFs	17	26	52.9%
Hospital IP	45	45	0.0%
Hospital OP	194	192	-1.0%
All Other	2556	3218	25.9%
TOTAL	5396	6590	22.1%

'RECIPIENTS SERVED BY TYPE OF SERVICE

Type of Service	Number of Recipients		
	'SFY87	'SFY88	'% Change
Physicians	84,316	81,358	-4%
Dentists	93,978	25,998	-72%
Pharmacists	28,211	93,406	231%
Optometrists	14,258	13,471	-6%
Psychologists	4,483	4,969	11%
Durable Med. Equip.	5,405	6,672	23%
ICFs	8,751	8,905	2%
SNFs	408	414	1%
Hospital IP	15,769	16,155	2%
Hospital OP	62,290	60,432	-3%
All Other	84,314	97,644	16%