FIFTH ANNUAL MEDICAID REPORT

STATE FISCAL YEAR 1989

Prepared By
Maine Department of Human Services
Bureau of Medical Services

John R. McKernan, Jr.
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

January 31, 1990

The Honorable Michael D. Pearson, Senate Chair
The Honorable Donald V. Carter, House Chair
Members of Appropriations & Financial Affairs Committee

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

Dear Chairmen:

I am pleased to transmit to you the Fifth Annual Medicaid Report from the Department of Human Services. This report has been developed in accordance with 22 MRSA section 3174-B as enacted by the 112th Legislature. I hope this report will provide information that you as Legislators will find useful in framing public policy, and that we will work together to address some of the issues and unmet needs identified in this report.

Maine's Medicaid Program was successful in providing comprehensive health care services for 126,100 low-income people during State Fiscal Year 1989. The valuable service provided by the almost 5,776 in-State individuals, institutions and agencies who provided these services needs to be recognized. Just as important are the 200 employees of the Department of Human Services, Bureau of Medical Services who are responsible for administering this $400M program, the advocates who support it and of course the Legislature.

This report contains an overview of the Medicaid Program and the Bureau of Medical Services, a summary of accomplishments during the past year, work that is in progress and issues for the future. We look forward to your comments for improving the program and this report. Thank you for your continued interest and support.

Sincerely,

Rollin Ives

FOREWORD

The Bureau of Medical Services, as the agency within the Department of Human Services responsible for the services provided under the Medicaid Program, is constantly striving to improve its management of the Medicaid Program in order to utilize resources most efficiently to better serve the health care needs of Maine's poor citizens. We work closely with other Bureaus in the Department, the Department of Mental Health and Mental Retardation, and most recently the Department of Educational & Cultural Services and the Department of Corrections. We are also working with the Division of Community Services. It is a goal of the Department of Human Services to take advantage of matching Federal dollars to expand the resources available to better serve Maine's citizens. Administration of the program is shared with the Bureau of Income Maintenance, which is responsible for determining client eligibility to participate in the Medicaid Program.

The Bureau is also guided by a Medicaid Advisory Committee which is made up of consumers, their advocates and providers. This Committee has been meeting regularly since it was reactivated in 1987 and fulfills a valuable role in sharing their concerns, particularly those of the consumers. Meetings are also held regularly with representatives of various provider associations and organizations in order to have an opportunity to informally discuss issues and concerns.

I believe this report provides a comprehensive review of the Medicaid Program and our work over the past year. The principle author and coordinator of this Fifth Annual Medicaid Report was Francis T. Finnegan, Deputy Director of the Bureau of Medical Services, who received considerable support and assistance from the Division Directors and other staff of the Bureau. Mr. Finnegan spent long hours, beyond those required in his day-to-day responsibilities to prepare this report. Additional thanks go to those who assisted him.

We appreciate this opportunity to reflect the accomplishments of Maine's Medicaid Program and the staff which administers it as well as to identify some of the issues facing Maine in our health care delivery system.

Elaine E. Fuller
Director
Bureau of Medical Services

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

In State Fiscal Year 1989, the Maine Medical Assistance Program provided $383,705,427 in health care services to 126,100 Medicaid recipients. Enrollees were served by 5776 individual providers. In the course of the year, the Bureau of Medical Services processed 3,806,375 claims. To carry out this large responsibility effectively, the 200 personnel of the Bureau carried out many specialized tasks. In addition to processing 16,000 to 18,000 claim forms every working day, major revisions and additions were made to the policies and regulations under which the Bureau functions. The quality, appropriateness and cost of health care services were closely monitored. The licensing and certification of all of the health care and adult residential care facilities in the State is also the Bureau's responsibility.

Some of the highlights of SFY89 include:

Expanded Medicaid eligibility, covering obstetrical care and infants up to 185% of federal poverty guidelines. Also in October, 1988, coverage for children up to age six and the disabled and elderly was expanded to 100% of poverty.

Physician fees for certain basic services and deliveries were increased and a study was initiated to base a subsequent increase on a newly developed resource-based relative value scale.

Increased recoveries of other third party payments for services to Medicaid recipients from $1.4 million in SFY88 to $2.82 million in SFY89. Payment of an additional $10 million during the same period was avoided through refinements in the claims processing system. Requested and obtained legislation strengthening the Bureau's ability to recover monies for services to Medicaid recipients.

Implemented policies to obtain federal funding for coverage of certain services in community residences for children, substance abusers, mentally disabled and developed policies to cover cost-reimbursed boarding homes. Also provided Medicaid coverage for case management for the mentally retarded, persons with disabling mental illness and AIDS victims.

Renewed and expanded number of clients covered under waivers of certain Medicaid regulations for in-home and community services as an option to institutional care for the elderly, disabled and mentally retarded. Organized and, in October, 1989, hosted the Seventh Annual National Home and Community-based Services Conference.

Implemented an on-line error corrections system to improve claims processing.

Selected as one of four states to participate in the National Nursing Home Case Mix and Quality Demonstration Project.

I. BACKGROUND AND COMPARISONS

BACKGROUND

The Medicaid Program was established in 1965 when Congress created Title XIX of the Social Security Act to provide access to comprehensive health care services for low-income people. The Medicaid Program is a Federal/State partnership with the government matching on a percentage basis every dollar spent by states on covered services for its eligible residents. The match rate for services changes depending on economic conditions in individual states and ranges from a Federal match of 79% in poor states to a minimum Federal match of 50%. The match rate in Maine for SFY'89, the year of the report, was 67.78%. In the current fiscal year, the match rate is 65.57% and in SFY'91 the Federal share will decrease to 63.92%. The decreased Federal match rate alone accounted for a 6% increase in State funds to maintain the same services.

In recent years, Congress has passed legislation authorizing additional optional services, such as targeted case management and provisions for waivers, which permit states greater flexibility in designing programs to meet specific needs. Congress has also authorized optional expanded Medicaid eligibility which Maine implemented in the past year, referred to as the SOBRA option. Congress also mandated expanded Medicaid coverage as in the Medicare Catastrophic Coverage Act of 1988 and most recently the Omnibus Budget Reconciliation Act of 1989 in which states are required as of April 1, 1990 to provide Medicaid coverage for children born after September, 1983 and pregnant women up to 133% of the Federal poverty level. Maine already covered pregnant women and infants up to 185% of poverty and children in that age group up to 100% of poverty, under the SOBRA option.

There are certain underlying principles for services under the Medicaid Program, also known as the Medical Assistance Program. Services must be "medically necessary," as in the need for hospital, nursing home, home health care and many other services. Maine's Medicaid Program also covers many preventive and rehabilitative services, in addition to those required as part of the EPSDT Program for children. States are responsible for administering the Medicaid Program, within the constraints of Federal law and regulations. Therefore, states establish eligibility standards, eligibility options, coverage of optional services and rates to be paid. States are responsible for assuring that payment is made only on the basis of services provided--that for every claim submitted, there is documentation of the service having been provided, permitting certain capitated payments in residential settings.

Maine Compared to Other States Nationwide

There are two basic measurements of a health benefit program---the comprehensiveness of the services covered and the eligibility criteria for recipients. Evaluated under both criteria, Maine has one of the best Medicaid programs in the country.

Maine has incorporated virtually all optional services authorized by the Health Care Finance Administration. There are four services not covered. SNF and ICF level institutions for mental diseases for age 65 and over are not covered because there are no such facilities in Maine. There are general ICF units at both AMHI and BMHI which are covered by Medicaid. Emergency hospital services are not listed as a separate service, because Maine Medicaid recipients receive this care as part of their basic acute care coverage. Although hospice care is not currently covered, BMS staff have draft policy and it will be a covered service in the near future.

Maine has adopted all of the SOBRA options and qualifying income requirements are much more generous in Maine than in most other states. In fact, as of January, 1989, Maine's income standard for an AFDC family of three was 75.4% of federal poverty guidelines, the third highest in the nation. The national average was 47.1%.

Maine has and is developing case management services aggressively. The State has also used the "Private Nonmedical Institution" option creatively to cover services for children in residential settings, for substance abuse treatment in residential settings and for adults in boarding care facilities.

Concerning the Home and Community-Based Waivers, Maine has three established waiver programs serving the mentally retarded, the elderly and the disabled. A waiver program for Aids victims is also under consideration.

Maine's Medicaid budget was two-thirds of one per cent of national outlays in 1988, which meant that 34 states had larger budgets. However, in terms of cost per recipient, Maine ranked 13th, spending $2,715.18 per recipient compared to a national average of $2,126.46.

From 1985 to 1988, Maine's acute care expenditures, excluding mental health and outpatient services, grew faster than all other states except Kansas. However, Maine's 1988 average expenditure per recipient using acute care services ($2,739) was well below the national average of $3,062.

In the area of long term care, the Maine Medical Assistance Program covers three out of every four nursing home residents in the State. In 1986, Maine's ICF average reimbursement rate was 12th in the country. Although more recent comparisons are not available, changes in the Principles of Reimbursement for ICFs have provided substantial increases to nursing homes since 1987.

Maine in Comparison to Other New England States

As of October 1, 1988, Massachusetts covered more optional services than any other New England state with thirty-two. Maine, covering twenty-seven, was third ahead of Connecticut, Vermont and Rhode Island.

Maine paid a higher rate for skilled nursing facility care than all other New England states in 1986 at $78.87 per diem, but paid less ($49.94) for intermediate care than all but one of its sister states. Despite its rank in New England, Maine was still the twelfth highest in the country, It must be kept in mind that health care services in the northeast are, in general, the highest in the country.

Maine's acute care expenditures per recipient in 1988 were the lowest in New England, but between 1985 and 1988 they rose faster in Maine than in any other New England state, with an increase of 17.3%.

II. STATE FISCAL YEAR 1989 SERVICES AND EXPENDITURES

This section details the distribution of $383,705,427 on Medicaid health care expenditure during State Fiscal Year 1989. The report lists changes in expenditures and recipients for both mandatory and optional services.

In delivering a total of $383,705,427 in services, the Bureau expended $9,622,366 administering the program. The percent of administrative overhead, 2.5%, is exceptionally low.

The following tables list expenditures by category of service for state fiscal years 1988 and 1989 and the percentage change and the number of recipients receiving each service. They are derived from the Medicaid Management Information System and are based on claims data and cost settlement and adjustments. Services are listed in order of SFY89 expenditures, from the highest to the lowest.

COMPARISON OF MEDICAID EXPENDITURES- SFY88 to SFY89

	MANDATORY SERVICES	SFY88	SFY89	% CHANGE
1	HOSPITAL SERVICES	$94,545,473	$93,934,248	-0.65%
2	PHYSICIAN SERVICES	$14,482,609	$17,653,837	21.90%
3	HOME HEALTH AGENCIES	$5,030,850	$5,440,947	8.15%
4	SNF	$4,336,102	$5,020,691	15.79%
5	CERTIFIED RURAL HEALTH CLINIC	$851,912	$1,033,810	21.35%
6	INDEP. LAB. & X-RAY	$530,423	$902,456	70.14%
7	AMBULANCE	$488,122	$659,447	35.10%
8	FAMILY PLANNING CLINIC	$181,227	$436,798	141.02%
9	NURSE MIDWIFE	$252	$0	-100.00%
	TOTAL MANDATORY SERVICES	$120,446,970	$125,082,234	3.85%
	OPTIONAL SERVICES	SFY88	SFY89	% CHANGE
10	ICF	$110,720,072	$123,337,138	11.40%
11	PHARMACY	$22,885,291	$26,705,856	16.69%
12	ICF/MR (N)	$20,677,838	$23,891,861	15.54%
13	DAY HABILITATION	$1,753,386	$11,715,244	568.15%
14	BMR WAIVER	$8,172,502	$9,981,050	22.13%
15	ACUTE PSYCHIATRIC HOSPITAL	$4,731,636	$7,826,847	65.42%
16	ICF/MR (G) BOARDING	$7,583,802	$7,334,955	-3.28%
17	BOARDING HOME	$5,553,027	$7,081,345	27.52%
18	MEDICARE PART A	$5,795,275	$6,587,372	13.67%
19	MENTAL HEALTH CLINIC	$3,961,884	$4,035,292	1.85%
20	TRANSPORTATION	$1,571,681	$3,800,823	141.83%
21	DME AND SUPPLIES	$2,837,357	$3,491,867	23.07%
22	DENTAL	$2,114,158	$3,332,721	57.64%
23	MEDICARE PART B	$3,845,499	$3,312,755	-13.85%
24	BME WAIVER	$3,231,609	$2,308,413	-28.57%
25	CASE MANAGEMENT	$0	$2,278,789	N/A
	MENTAL RETARDATION	$0	$2,116,592	N/A
	MENTAL ILLNESS	$0	$162,197	N/A
26	PSYCHOLOGICAL SERVICES	$2,040,491	$1,982,261	-2.85%
27	PERSONAL CARE SERVICES	$1,488,633	$1,670,449	12.21%
28	PHYSICAL DISABLED SERVICES	$380,077	$867,495	128.24%
29	SUBSTANCE ABUSE	$364,212	$657,619	80.56%
30	PRIVATE NON-MEDICAL	$360,652	$655,413	81.73%
	DETOX	$0	$84,925	N/A
	CHILD SVCS	$0	$467,628	N/A
	RESIDENTIAL REHAB.	$0	$21,214	N/A
	MI DISABLED	$0	$81,646	N/A
31	OPTOMETRIC	$379,471	$544,477	43.48%
32	SPEECH PATHOLOGY	$473,967	$474,071	0.02%
33	PROSTHETIC/ORTHOTICS	$383,180	$443,798	15.82%
34	CHIROPRACTOR	$214,393	$236,636	10.37%
35	SPEECH AND HEARING	$264,502	$223,980	-15.32%
36	HOSPICE	$0	$184,155	N/A
37	PRIVATE DUTY NURSING	$296,360	$169,393	-42.84%

38	BOARDING HOME WAIVER	$0	$156,264	N/A
39	PODIATRY	$103,370	$128,467	24.28%
40	OPTICAL SERVICES	$95,846	$119,460	24.64%
41	PHYSICAL THERAPY	$34,305	$89,757	161.64%
42	HEARING AID DEALERS	$52,669	$60,156	14.22%
43	OCCUPATIONAL THERAPY	$3,918	$31,837	712.58%
44	AMB. CARE CLINIC	$0	$19,609	N/A
45	AUDIOLOGY	$12,839	$12,358	-3.75%
46	VD SCREENING	$4,660	$4,440	-4.72%
47	BMH WAIVER	$38,434	$0	-100.00%
	TOTAL OPTIONAL SERVICES	$212,426,996	$255,754,123	20.40%

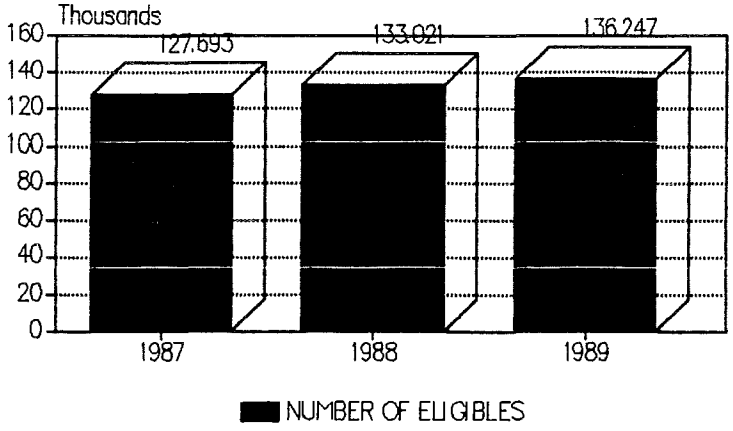
ANALYSIS OF NUMBER OF RECIPIENTS SERVED

	MANDATORY SERVICES	SFY 88	SFY 89	% CHANGE
1	HOSPITAL SERVICES	76976	79151	2.83%
2	PHYSICIAN SERVICES	81358	82208	1.04%
3	HOME HEALTH AGENCIES	3858	3788	-1.81%
4	SNF	414	439	6.04%
5	CERTIFIED RURAL HEALTH CLINIC	6542	6997	6.96%
6	INDEP. LAB. & X-RAY	11729	16213	38.23%
7	AMBULANCE	3352	3752	11.93%
8	FAMILY PLANNING CLINIC	2374	2724	14.74%
9	NURSE MIDWIFE	1		-100.00%
	TOTAL RECIPIENTS SERVED	186604	195272	4.65%

	OPTIONAL SERVICES	SFY 88	SFY 89	% CHANGE
10	ICF	8965	9060	1.06%
11	PHARMACY	93406	96519	3.33%
12	ICF/MR (N)	552	550	-0.36%
13	DAY HABILITATION	457	1594	248.80%
14	BHR WAIVER	468	529	13.03%
15	ACUTE PSYCHIATRIC HOSPITAL	252	293	16.27%
16	ICF/MR (G) BOARDING	209	204	-2.39%
17	BOARDING HOME	2105	2128	1.09%
18	MEDICARE PART A	14729	15314	3.97%
19	MENTAL HEALTH CLINIC	6505	6732	3.49%
20	TRANSPORTATION	6061	8227	35.74%
21	DME AND SUPPLIES	6117	7266	18.78%
22	DENTAL	25998	29419	13.16%
23	MEDICARE PART B	24819	25802	3.96%
24	BME WAIVER	811	792	-2.34%
25	CASE MANAGEMENT	0	1730	N/A
	MENTAL RETARDATION	0	1530	N/A
	MENTAL ILLNESS	0	200	N/A
26	PSYCHOLOGICAL SERVICES	4969	4955	-0.28%

27 PERSONAL CARE SERVICES	338	408	20.71%
28 PHYSICAL DISABLED SERVICES	85	117	37.65%
29 SUBSTANCE ABUSE	1166	1579	35.42%
30 PRIVATE NON-MEDICAL	210	359	70.95%
DETOX	0	181	N/A
CHILD SVCS	0	148	N/A
RESIDENTIAL REHAB.	0	28	N/A
MI DISABLED	0	24	N/A
31 OPTOMETRIC	13471	14429	7.11%
32 SPEECH PATHOLOGY	1144	1283	12.15%
33 PROSTHETIC/ORTHOTICS	555	590	6.31%
34 CHIROPRACTOR	2106	2300	9.21%
35 SPEECH AND HEARING	928	851	-8.30%
36 HOSPICE	34	22	-35.29%
37 PRIVATE DUTY NURSING	65	163	150.77%
38 BOARDING HOME WAIVER	30	30	0.00%
39 PODIATRY	1645	1785	8.51%
40 OPTICAL SERVICES	3943	4626	17.32%
41 PHYSICAL THERAPY	251	529	110.76%
42 HEARING AID DEALERS	173	176	1.73%
43 OCCUPATIONAL THERAPY	41	157	282.93%
44 AMB. CARE CLINIC	0	278	N/A
45 AUDIOLOGY	381	362	-4.99%
46 VD SCREENING	209	196	-6.22%
47 BMH WAIVER	11	0	-100.00%
TOTAL RECIPIENTS SERVED	223209	241354	8.13%

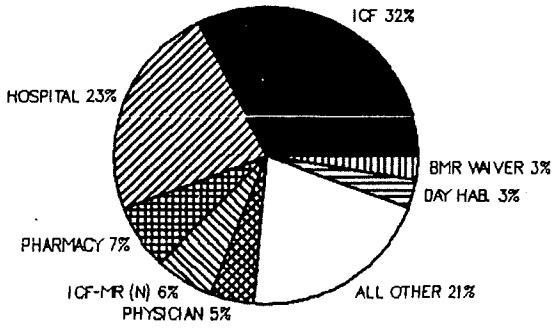
MEDICAID ELIGIBLES
1987 - 1989



The graph above shows a gradual rise in the number of Medicaid eligibles.

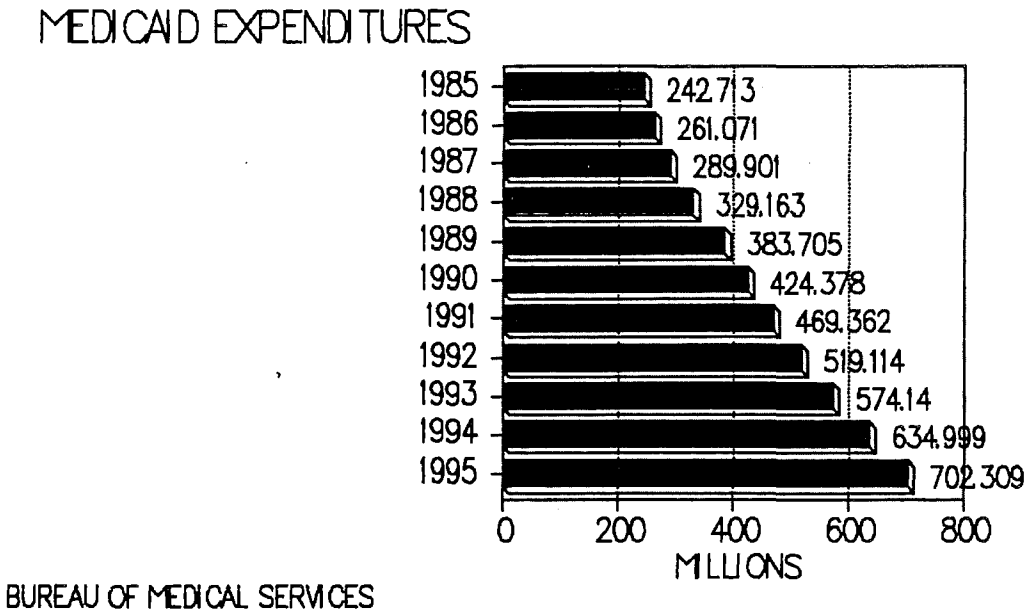
The pie chart below shows that general intermediate facility care (32%) was the largest single expenditure in SFY89, followed by hospital care and pharmacy.

MEDICAID EXPENDITURES
STATE FISCAL YEAR 1989



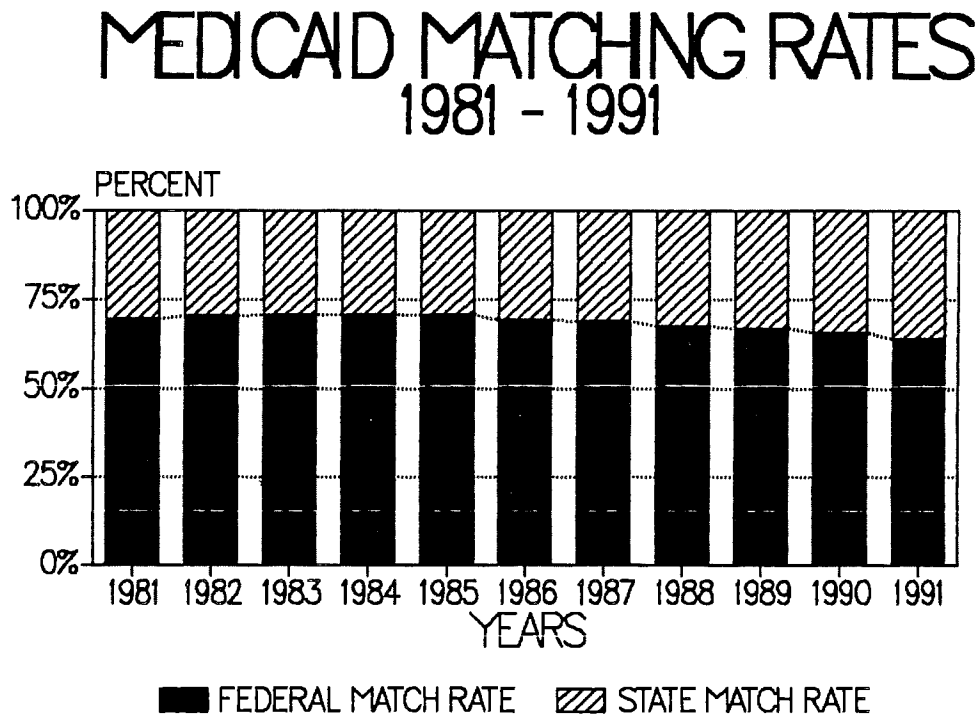
The following graph displays historical growth in Medicaid expenditures and also projects a budget of nearly $700 million in 1995.

TOTAL MEDICAID EXPENDITURES
1985-1995 WITH PROJECTIONS



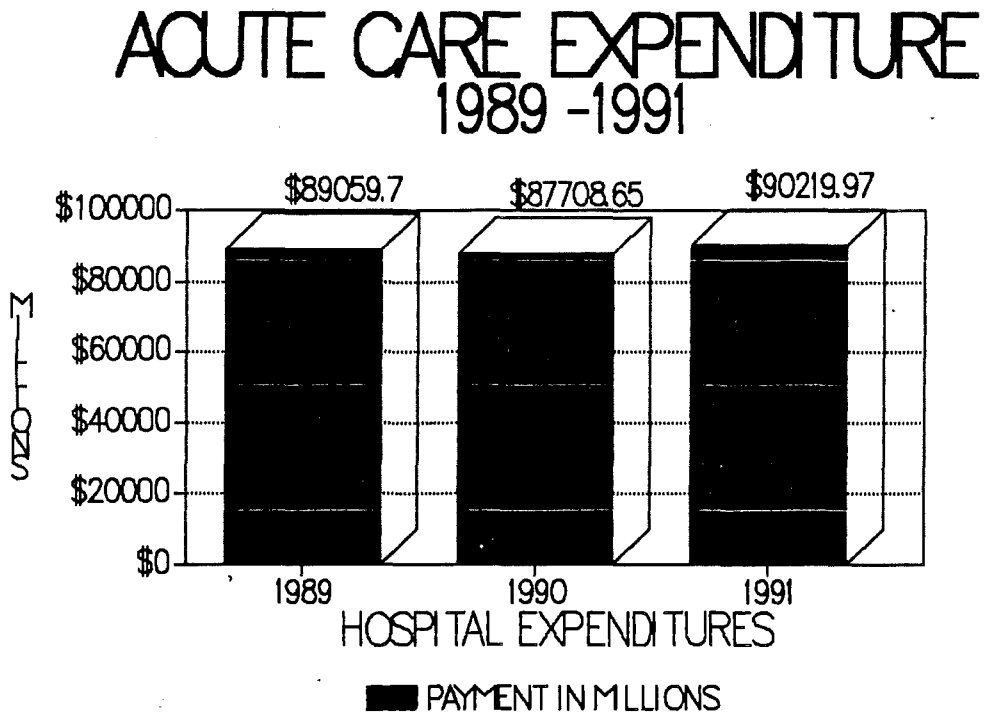
BUREAU OF MEDICAL SERVICES

The federal matching rate for Medicaid is based on a state's per capita income in comparison to that of the nation. Because Maine's per capita income has been growing faster than the national average, the State's share has been steadily increasing.



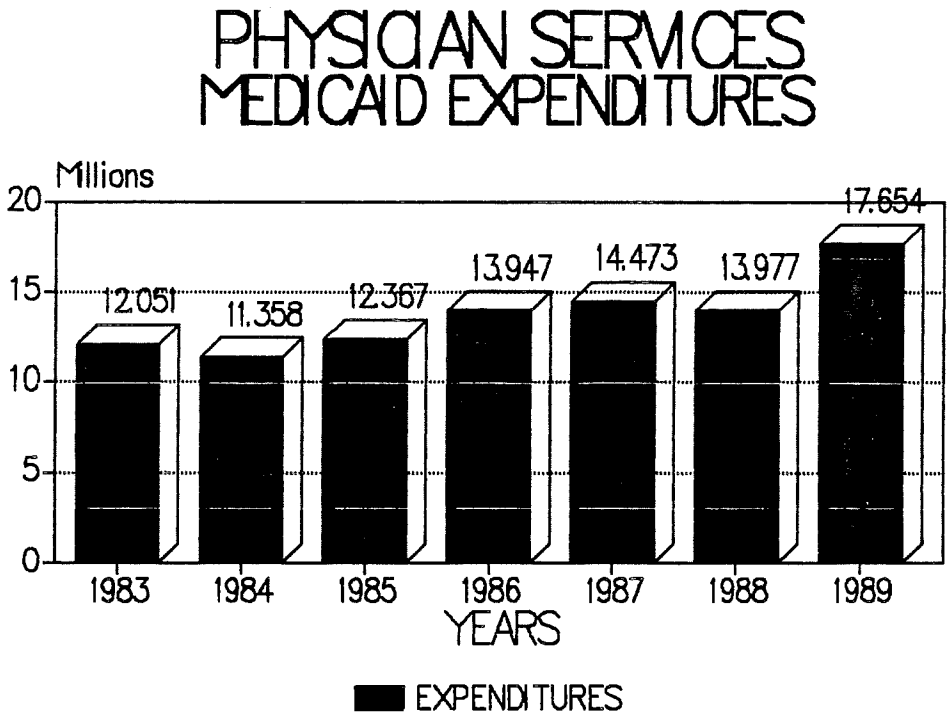
BLENDED TO STATE FISCAL YEAR

Acute care services for Medicaid recipients are projected to decline during SFY90 and then rise again in 1991.



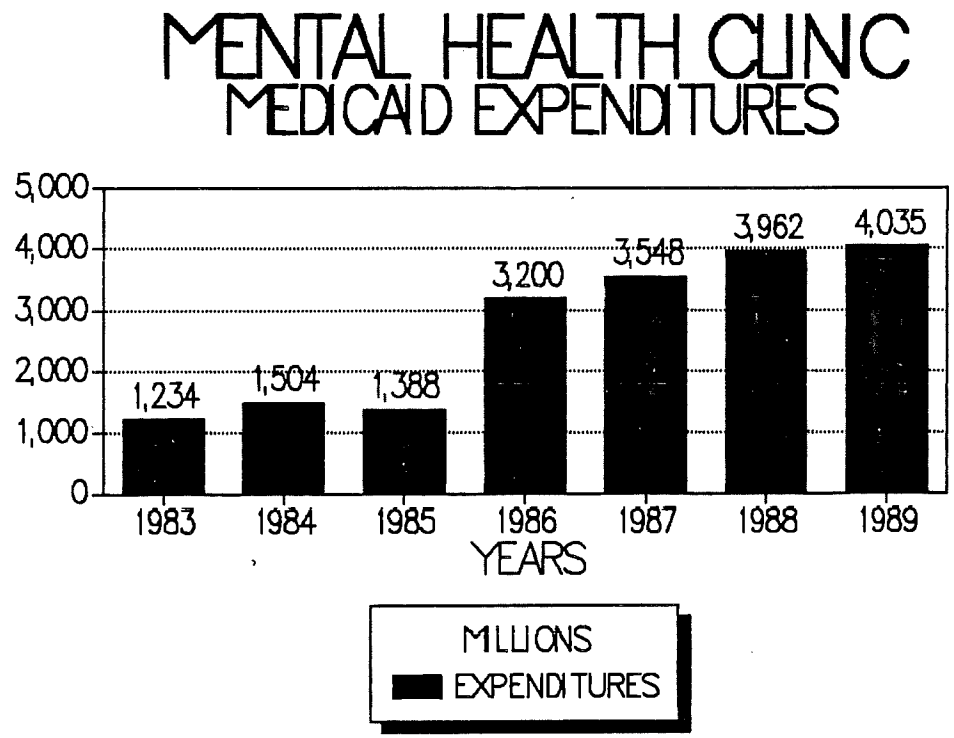
1990 & 1991 PROJECTED

Physician expenditures rose at a rate well below medical care inflation for most of the 1980's. Two-thirds of last year's increase was due to a rise in fees for a limited number of procedures and the remaining third, to increased utilization.



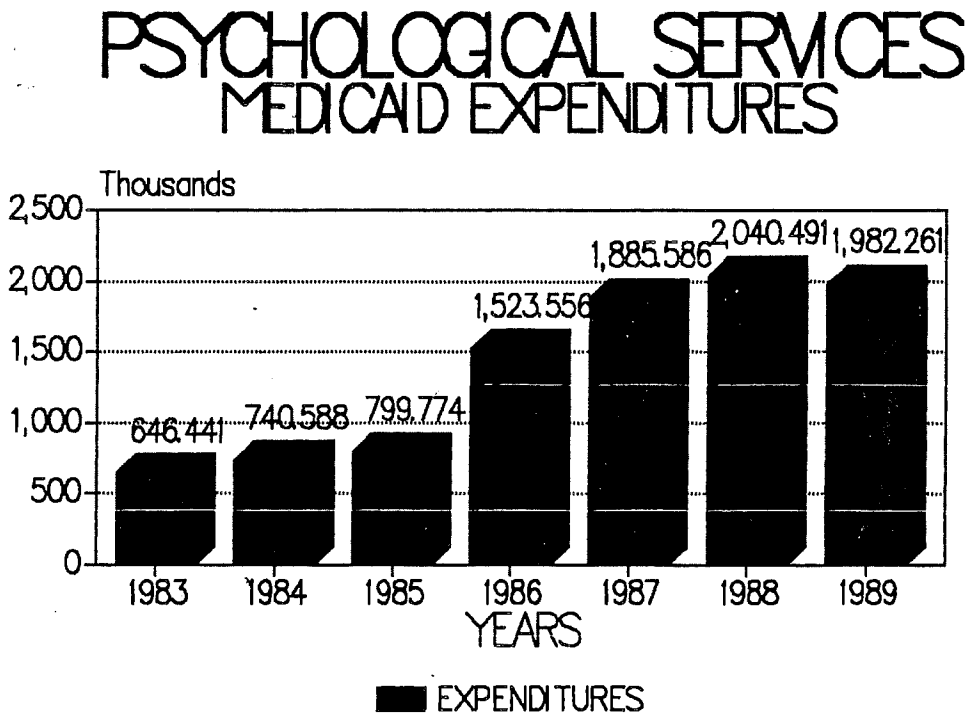
SOURCE MR-O-12

Mental health clinic expenditures levelled off in 1989 after tripling in the previous six years.



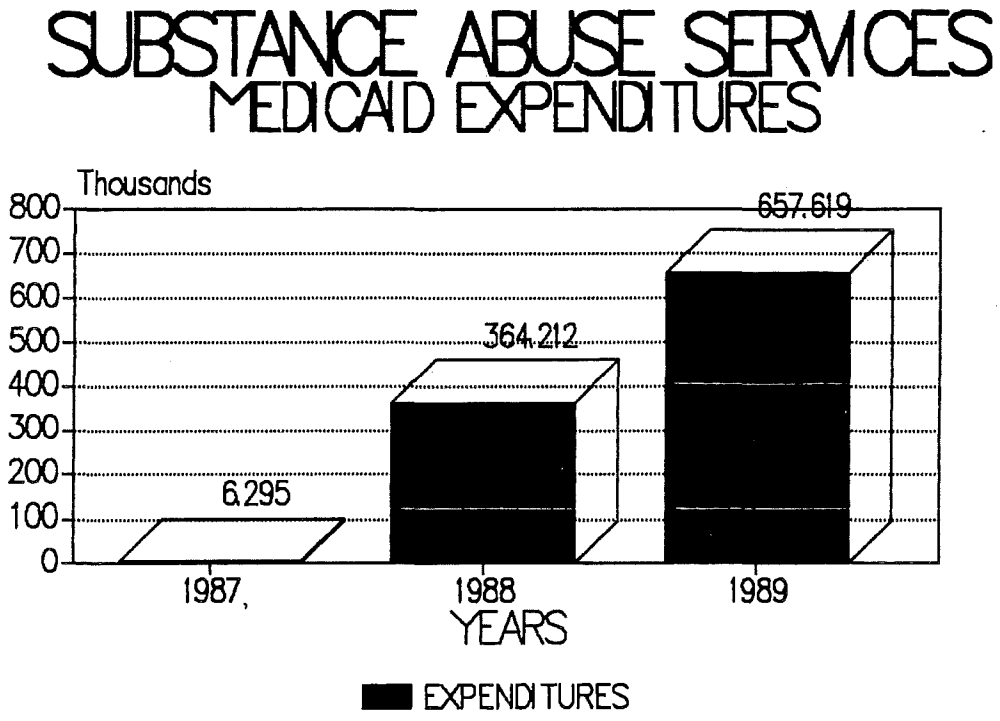
SOURCE MR-0-12

After six years of steady growth, psychological services declined in 1989.



SOURCE MR-0-12

Substance abuse expenditures have grown rapidly in the last two years.



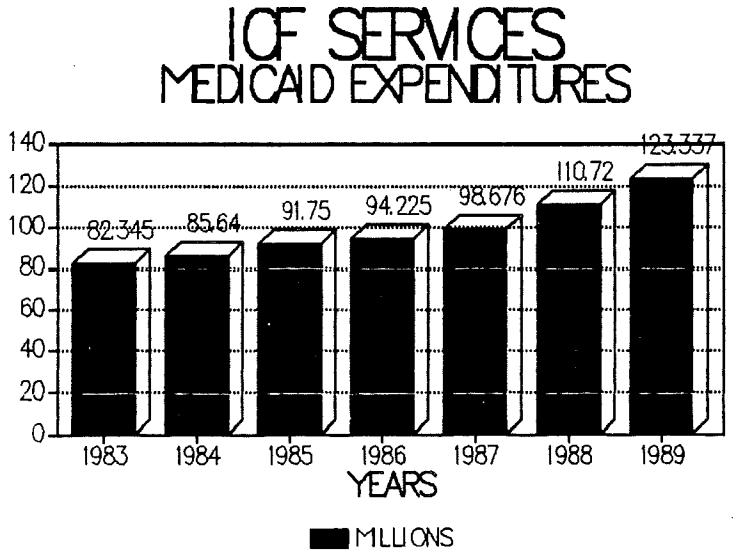
SOURCE MR-O-12

Intermediate Care and Skilled Nursing Facilities

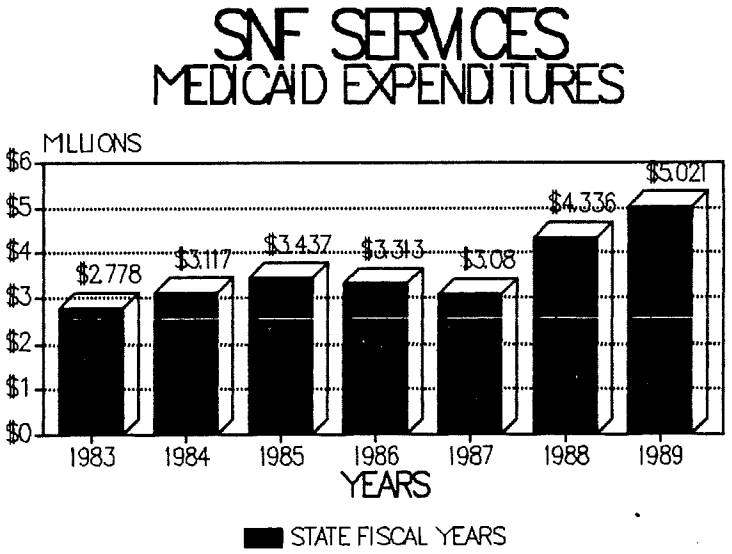
Maine currently has 9,137 ICF beds in 136 facilities. Reimbursement for ICF services averaged $66.50 per day as of December 31, 1989. Maine currently has 603 skilled beds in 25 facilities. Reimbursement for SNF services averages $84.44 per day.

Maine's ratio of ICF (excluding ICF/MR) beds is over 15:1, which is very high compared to other states. Approximately 75% of general use ICF beds are occupied by Medicaid recipients. In most states, public funds spent on SNF beds are generally Medicare dollars which involve no state matching monies. The Department is continuing to expand access to SNF-level beds through the development of dual-certified facilities and the expansion of the number of hospital swing beds.

Below are displayed the year to year trends in expenditures for ICF and SNF care.

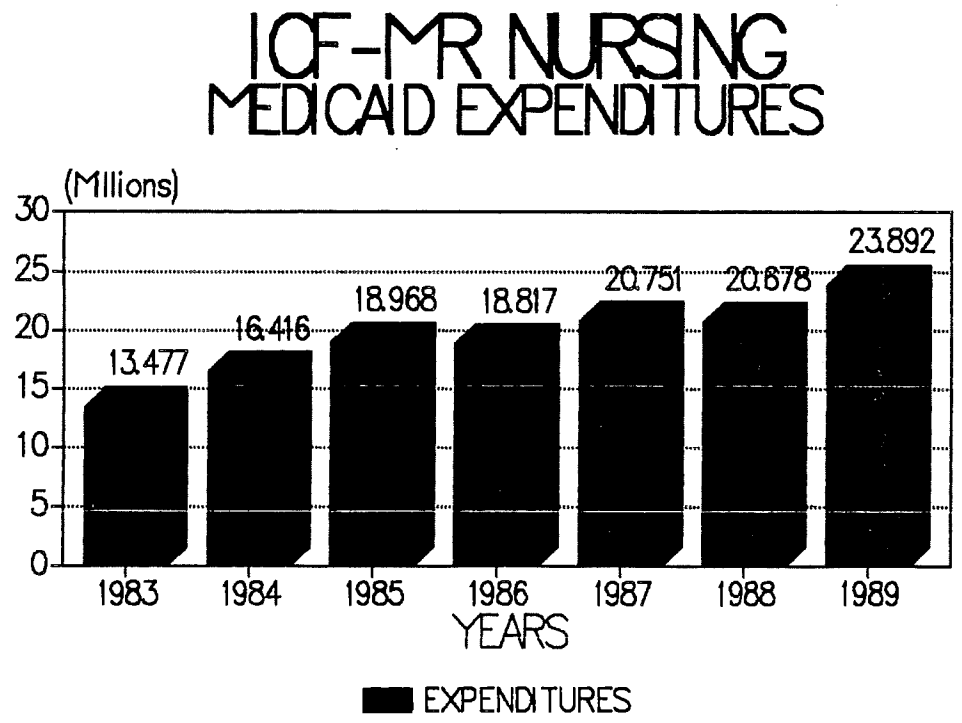


SOURCE MR-O-12 & 1990 ACT.



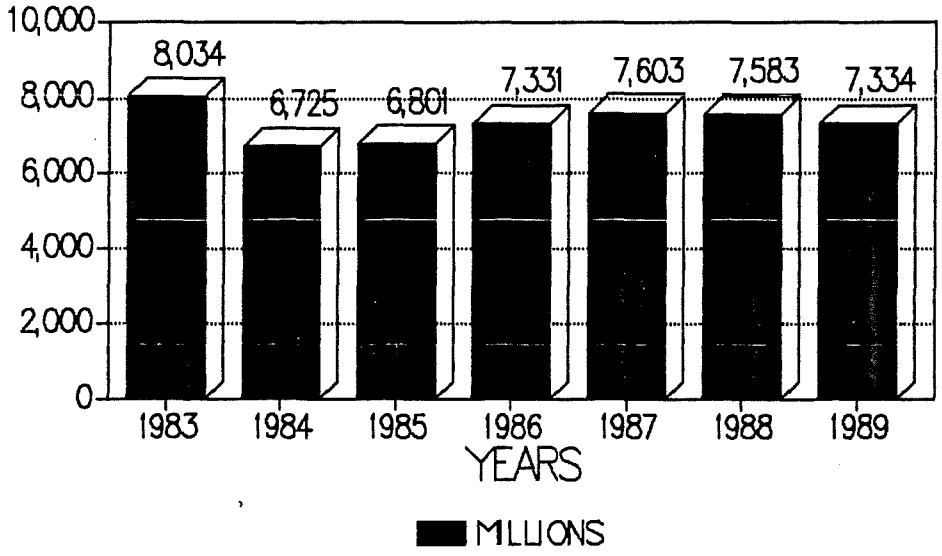
SOURCE MR-O-12 & 1990 ACT.

The following two charts display expenditures for institutional care of the mentally retarded. The impact of P.L. 829, An Act Concerning Intermediate Care Facilities for the Mentally Retarded, is not reflected in these graphs. Although reimbursement changes to substantially increase staff wages were effective April 1, 1989, most of the financial impact is on the current fiscal year (1990). As of December, 31, 1989, the state average daily rate was $137.24 and day habilitation services averaged $45.11 per day.



SOURCE MR-O-12

ICF-MR BOARDING
MEDICAID EXPENDITURES



SOURCE MR-0-12

III. 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. Nation-wide, the Federal share for medical assistance payments ranges from 50% to 79%. Maine's rate for SFY'86 was 68.85% and will be 63.92% for SFY'91. One current exception to this service match is for family planning services, which are matched by the Federal government at 90%.

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%.

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. Also, as our economy changes, it affects numbers of clients. From December, 1988 to December, 1989 the AFDC caseload increased 11% which will result in a commensurate increase in Medicaid expenditures for that group of eligible recipients.

The State's share of funds is appropriated primarily within 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 utilized to seed Medicaid from accounts within the Bureau of Child and Family Services, the Bureau of Elder & Adult Services, 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, day habilitation and ICF services for the mentally retarded in State institutions.

The Bureau of Child & Family Services provides seed money for mental health clinic services for child protective cases. The Bureau of Elder & Adult Services provides seed money for the waiver for the elderly and for mental health services for adult protective cases. The Department of Mental Health and Mental Retardation provides seed money for State facilities for ICF/MR services, day treatment services, Medicaid waiver for the mentally retarded and mental health clinic services for BMH clients. The Office of Alcoholism and Drug Abuse Prevention provides some seed money for private non-medical institution services for substance abuse treatment.

We have recently received approval to use funds from the City of Portland to seed services provided by their Health Department. This is the first time this has been done in Maine, and it is possible other local revenues could be used as State match.

IV. ANNUAL FEE REVIEW

The Bureau of Medical Services invited all associations or representatives for each category of fee-for-service provider to meet to discuss policy and reimbursement issues. Over the course of the summer of 1989, staff of the Division of Medicaid Policy and Programs met with the following provider groups:

Speech and hearing
Ambulance
Family Planning
Occupational therapy
Transportation
Dental
Physician (MD, DO)
Chiropratic

Other fee-for-service providers either declined or did not respond to the Bureau's invitation to meet. A number of provider groups noted that they felt it was unnecessary to meet since changes in Medicaid policy had been put in place over the course of the last year.

On September 13, 1989, the Annual Fee Review summary meeting was held, chaired by Elaine Fuller, Bureau Director. Categories of providers represented included both physician groups as well as state agency staff.

This group considered the question of the usefulness of going through the Annual Fee Review. It was noted that the Bureau of Medical Services has been very responsive to provider groups and need not be "forced" to meet annually. It was thought that perhaps the invitation to meet annually could be maintained but that the statutory requirements be dropped in order to ease the paperwork burden on BMS staff, thus giving them more time to work with providers or on issues relating to providers.

V. 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 average attendance has been ten people with the consumers and advocates attending most regularly. The Chair of the Medicaid Advisory Committee is Robert Philbrook, a consumer representing MAIN. 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. During SFY'89 the major issues discussed were access, particularly to physician and dental services and transportation.

VI. BUREAU OF MEDICAL SERVICES OPERATIONS

The mission of the Bureau of Medical Services is to

serve the health care needs of Maine citizens.....

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

Protect eligible consumers in utilizing the health care delivery system appropriately.

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.

Assuring availability of qualified providers.

This section addresses how the seven divisions of the Bureau carried out this mission during State Fiscal Year 1989.

1. Division of Policy and Programs

Policy Unit

Although the Policy Unit of the Division of Medicaid Policy and Programs experienced considerable staff turnover during the course of the last state fiscal year, a number of policy amendments were made to the Maine Medical Assistance Manual. Among the sections amended were the following:

Ambulance Services - increased base rate from $47.50 to $95.00 and instituted reimbursement for specialized neonatal transport services. (Eff. 10/1/88)

Dental Services - increased reimbursement rates to approximately 70% of usual and customary charges (based on a fee survey published by ADA in May, 1987). (Eff. 7/1/88)

Pharmacy Services - implemented a mechanism for effecting drug price changes with 30 days notice to providers, changes in drug pricing required by Federal regulations, addressed coverage of certain over-the-counter drugs and drugs for recipients with quadriplegia, paraplegia, and those in need of dialysis. (Eff. 2/1/89)

Home and Community-Based Waiver Services for the Elderly - increased reimbursement rates for home health aides and CNAs as well as case management and adult day health. (Eff 4/1/89)

Home and Community-Based Waiver Services for the Physically Disabled-allows evaluations to be conducted by either an OT or RN rather than requiring both to do the evaluations, increased the reimbursement rates for attendant services from $5.00 to $5.25. (Eff. 7/1/88)

Home and Community-Based Waiver Services for the Mentally Retarded-allowed for a 3% cost-of living increase for residential training foster care, levels 1, 11, and 111. (Eff.12/1/88)

Hospital Services - changed definition of a Swing-bed Hospital from an acute care hospital consisting of less than 50 beds to less than 100 beds. (Eff 10/9/88)

Inpatient Psychiatric Hospital Services - deletes the involvement of the Division of Consumer Services in authorizing acute care needs. (Eff 1/1/89)

ICF, ICF-MR, SNF Services - implemented on an emergency basis the federally required Pre-admission screening program for people with mental illness or mental retardation. (Eff 1/1/89)

Nurse Midwife Services - implemented a fee increase to 90% of the physician services rate for pre-natal, delivery, and antepartum call services. (Eff 7/1/88)

Occupational Therapy Services - allows agencies that hire OTs to be reimbursed for providing occupational therapy services. (Eff 4/1/89)

Optical/Optometry/Ophthalmology Services - expands the coverage of eyeglasses from only those who have had cataract surgery to those who require eyeglasses when the power is equal to or greater than 10.00 diopters. (Eff. 7/1/88)

Physician Services - substantially increased reimbursement for visits in the office, home, hospital, and nursing home, allows the billing of the surgical admit visit, increases the OB global fee and delivery fees. (Eff 7/1/88)

Preventive Health Program - increased rates of reimbursement for PHP visits. (Eff 7/1/88)

Psychological Services - allows Medicaid eligible individuals at the Medically Needy category to receive services from a psychologist. (Eff 12/1/88)

Transportation Services - allows the coverage of wheelchair van services. (Eff 12/1/88)

New Policies

Ambulatory Care Clinic Services	Effective 7/1/88
Case Management of Individuals with HIV Infection	Effective 7/1/89
Day Habilitation	Effective 8/1/88
Health Occupation Training Program	Effective 12/1/89
Health Maintenance Organizations	Effective 1/1/89

Provider Relations

The Provider Relations Unit has undergone many changes from SFY July, 1988 to June, 1989. The Unit continues to have a very high turnover rate among its eight provider relations specialists. One of the key factors in this turnover is the low pay range assigned to this responsible, broad-based, yet detailed, position and the stress associated with often dealing with angry, verbally abusive providers. Many other positions within the State system offer a higher level of pay for a lesser amount of responsibility and stress, making these kinds of positions attractive for Unit staff.

Inability to keep personnel once they are adequately trained results in slower response time to provider telephone and mail inquiries because staff is not as familiar with the material. This is, of course, something that is achieved by employment in this position for an extended period of time. This problem causes a delay in requested and new provider visits and our overall ability to be accessible to health care providers participating in Medicaid. Because we are constantly training new employees, and it takes six months to a year to be comfortable with the material, we are not as likely to provide group training for providers as frequently as it would take to begin lessening the numbers of phone calls we receive and to cut down on the suspense rate for claims processing. Our inability to retain personnel also contributes to our access problem because providers are frustrated at the "Bureaucracy" and the paperwork when they cannot obtain the support they need to submit accurate claims and receive prompt payment.

2. Consumer Services

Considerable staff resources are committed to medical eligibility determinations for institutional nursing facility placement and community based waiver services. All Medicaid clients are classified prior to accessing long term care services. Last year, the Division of Consumer Services classified approximately 1000 clients per month for institutional and community based long term care services. The annual total includes approximately 9000 clients actually accessing services over the past year. The remaining figures include classifications of clients who expired prior to an actual nursing home placement, as well as clients who get to not access services after they are classified as medically eligible. On average, 150 clients/month await admission to a nursing home in a hospital setting. Another 100/month await placement from home.

Two hundred applicants in the last year were denied long term care services, mostly due to medical ineligibility. No data is kept of the number of classifications which were not completed due to financial ineligibility. Also no figures were kept on the numerous consultations provided on behalf of Title XIX eligible clients wishing admission to a nursing facility.

The number of out-of-state Skilled Nursing Home placements for Traumatic Brain Injury clients remains an average of 24 clients in any given month. Ongoing out-of-state classification is a very time consuming process.

Staff have identified gaps in the resource continuum for Head Injured clients. Out-of-state SNF placements are prolonged primarily because less intensive services are as unavailable in Maine as are the specialized rehabilitation services which necessitates the out-of-state placement to begin rehabilitation.

In addition to the unavailable in-state resources for the Head Injured, other client populations with unmet needs have also been identified this past year. Some Medicaid clients have been waiting admission to a nursing facility from a hospital for over 2 years. The division is working with other DHS staff and various departments throughout the State to identify unmet needs, to address the needed transfer of misplaced clients and to create resources to meet the needs of these populations.

Bed Hold authorizations for clients temporarily hospitalized from a nursing home setting were tallied for the first time this past year. Over 1700 Bed Hold authorizations were granted with an average of 33 a week.

In addition to the medical eligibility classifications, the Division newly assumed the federally mandated responsibility of screening all nursing facility applicants throughout the state, regardless of payment source, for Mental Illness/Mental Retardation needs prior to admission to a nursing facility. Over 10,000 screens were performed over a 12 month period, averaging well over 800 screenings per month.

In spite of the 114th Legislature signing into law P.L. 495 granting the State the authority to classify private pay clients who are within 180 days of financial eligibility for Medicaid, the limits on staffing resources have prevented the Division of Consumer Services from instituting this service.

Another program adversely affected by the inability to fill newly authorized positions was the prior authorization of high utilization "maintenance level" home health clients. This program is intended to identify patients who use extraordinary amounts of service in a 60-day period and subsequently evaluate actual service need and prior authorize continuing services. Projected cost savings could not be realized due to the delayed implementation of this policy.

In addition to medical eligibility classifications, the Division of Consumer Services provides information and referral services to Medicaid clients calling on a toll free recipient-specific line. Approximately 500 calls are received per month, a 60% increase over last year. The majority of the 6000 calls were regarding billing problems. A growing problem area is access to medical services. Some preventive education and information may forestall the problems currently facing many Medicaid recipients.

Finally, the lack of computer and other technical resources, combined with limited staffing resources contribute to delayed implementation of more sophisticated procedures. Personnel resources could better be utilized in provider/client contacts regarding program eligibility and access to services.

3. Division of Surveillance and Utilization Review

In SFY 89 the following providers and/or employees of providers were terminated from participating in the Medicaid Program:

2 Nurses
2 BMR Waiver Foster Parents
1 Physician
1 Rural Health Clinic
1 Psychologist

As the result of surveillance efforts in SFY 89, $308,835 in new overpayments were identified and a total of $260,414 was actually recouped from providers. The Division opened 171 provider cases for review and completed 208 cases. A first for the Division involved one case that resulted in the State receiving a share of Civil Monetary Penalties ($33,358). These penalties are applied by the United States Office of Inspector General and until recently were not shared with the states.

The large scale reviews of 21 home health agencies involving 378 patient records are near completion. As of November 1989, the overpayment amount totaled $136,738. The major issues identified were: no documentation of services billed; billing of services not covered by Medicaid; and exceeding authorized number of service hours.

The Division has also actively participated in educating Medicaid providers of the importance and necessity of documenting the health care service delivered. Staff continues to conduct six month utilization review of inpatients at psychiatric hospitals, as required by federal regulation.

In SFY 89 the Division's recipient unit opened 241 new cases to review possible misutilization of the health care system. Four recipients were added to the restriction program which currently enrolls 20 clients. This unit continues to provide referrals and information to the three Drug Utilization Review Committees that address physician over-prescribing patterns of habit forming drugs.

Presently, the Division is actively pursuing information on a new SUR subsystem to replace the existing mid- 1970 SURS II software, and developing the use of personal computers, for reviews and reports which are currently unavailable.

Drug Utilization Review Committees have intensified efforts, to combat prescription drug diversion as well as patterns of over prescribing by "enabling physicians".

4. Financial Services Unit

The responsibilities of the Financial Services Unit encompass a range of activities involving monitoring the administrative and service expenditures for all programs of the Bureau of Medical Services.

There were significant changes made to the Principles of Reimbursement for Intermediate Care Facilities (ICF) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) during FY'89. These changes were in response to the inability of facilities to recruit and retain staff because of sudden rise in wages and salaries in Maine's market place and also due to the instability of Workers Compensation costs in Maine. These changes took the costs of wages and salaries, workers compensation and liability insurance from the prospective reimbursement rate of ICF's and ICF's/MR, where those costs were inflated by a percentage rate each year, and included the actual costs of these services as allowable costs. The effect of this change increased Medicaid reimbursement to ICF and ICF's/MR by $15.6 million between SFY88 and SFY89.

The Unit is responsible for determining Medicaid reimbursement to acute care hospitals and acute psychiatric hospitals. There were in excess of 200 active cases the Unit staff addressed with the Maine Health Care Finance Commission and the Maine hospitals and other payers. These cases include the calculation of the gross patient service revenue limits, adjustments for increases to hospital financial requirements for wage and salary increases, new drugs and technology not addressed through the certificate of need process and the treatment of debt financing.

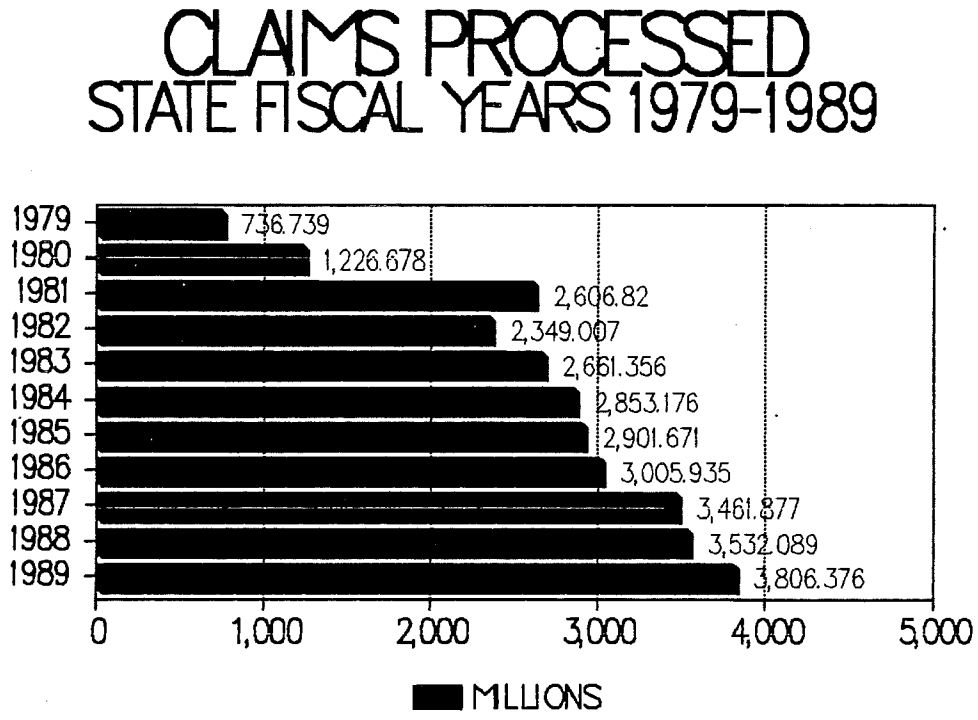
The Unit responded to requests for informal reviews from five hospitals. The issues under review included untimely submission of claims and undercharging by the hospital for services provided to Medicaid clients waiting placement in a long-term care facility, and the effects on the calculation of Medicaid payments. Additional reviews were requested for determining Medicaid treatment of third party liability and the effect of a change in discharge rates at hospitals on the computation of Medicaid payments.

There were two Medicaid providers who filed for bankruptcy during FY'89. One was a long-term care facility and the other, a hospital. Neither case has been finalized. In addition two hospitals gave up their license to operate as an acute care facility during the year. One is operating as a physician service and the other is providing outpatient services as an arm of a larger hospital in the area.

5. Division of Medical Claims Review

Data Control & Inquiry Unit

Mail room staff sorted between 14,000 and 18,000 claims daily in SFY89 and mailed out a total of 2.4 million claims to providers for future billing. Approximately 3,000 checks were sent to providers weekly.



The Inquiry Unit answered 10,000 phone calls monthly with a staff of 5 people. A federally-required Advanced Planning Document is being prepared to obtain a Voice Response System which will accommodate 50% of provider calls 24 hours a day.

Error Corrections/Adjustments/Provider File

The Error Corrections Unit evaluates suspended claims determining if they should be paid, partially paid or completely denied. A computerized on-line error correction system was implemented during this year. Over one million claims were evaluated last year.

All Buy-In tapes from Social Security indicating any exceptions to the State Buy-in system, are resolved. Claims for programs other than Title 19 are evaluated to assure all State agencies reimburse at a standard rate. Medicare/Medicaid claims are processed on the Medicare cross-over system to calculate co-insurance and/or deductibles.

The Adjustment Unit accounts for all monies taken in or paid out through the financial subsystem. These include specific financial transactions within the internal accounting system for providers; all monies recouped by the Third Party Liability Unit; all recoupments initiated by SURS; and cost settlements initiated in the Adjustment Unit. Claims previously paid are also adjusted either to recoup or reimburse at lower rates.

Provider file staff are responsible for enrollment of all providers into the Medicaid system and for assuring that providers meet all State & Federal requirements for participation in Medicaid. They also control all batches of claims rejected by the computerized system, distribute work to Error Corrections and Adjustments via computerized system and mail all manuals and instructions to providers.

Third Party Liability Unit

A major function of this unit is to seek payment from other sources, since Medicaid is, by law, the payor of last resort. Other sources include other health insurance companies and workers compensation and accident liability awards. This function is referred to as "cost avoidance" in Medicaid parlance. It is done in cooperation with the regional offices of the Bureau of Income Maintenance which identify other coverage in the initial application process. The result last year was a cost avoidance of $89.2 million. This figure includes health insurance, Medicare, nursing home assessments, and spend down amounts.

Staff also recoups monies already spent by the Medicaid Program which are later identified as the responsibility of another third party. This includes Medicare denials and litigation. Last year a total of $2.8 million was recouped, an average of over $300,000 for each person in these positions.

Professional Claims Review Unit

The Professional Claims Review Unit inputs, monitors, deletes and maintains data base for the on-line subsystems of the Medicaid Management Information System. Their work encompasses all of the diagnostic and procedure codes used to identify and pay for Medicaid services, as well as special edits restricting certain services and/or requiring prior approval. Approximately 2,500 procedures with no fixed fee are evaluated annually. This unit is also responsible for granting or denying prior approvals for certain services. Requests totaling $3.6 million were denied.

6. Division of Health Insurance and Special Projects

The Bureau of Medical Services created a new Division of Health Insurance and Special Projects in 1989. This division is responsible for administering the Maine Health Program, the Maine Managed Care Insurance Demonstration Program, the Medicaid Buy-in for the Disabled, and providing staff support to the Maine High Risk Insurance Organization.

7. Division of Licensing and Certification

Division staff completed 269 surveys during SFY 88 and conducted 299 follow-up surveys involving sixteen different types of providers. Twelve new providers were surveyed. Three hundred and ninety complaints were investigation, of which 373 involved nursing homes. Adverse Actions were taken in 93 cases. There was a twenty per cent turnover of Division staff, primarily registered nurses, during the year.

The legislature passed new legislation mandating licensure of state-operated health care facilities. This added two hospitals, three nursing homes and five intermediate care facilities for the mentally retarded. Additionally, the legislature required licensure of all ambulatory surgical facilities by January 1, 1990. Six facilities are added under this requirement.

The Division is implementing many of the changes mandated by the Nursing Home Reform Act included in OBRA-87. One of the federal expectations is that there will be a 40% increase in long term care surveyor staff. Given the State revenue situation, hiring additional staff may not be a priority which could possibly create compliance problems.

The Division is also working with BMR and ICF/MR providers on a revision of the licensing regulations for these facilities. As part of this task, a review is underway for a more effective staffing basis for intermediate care facilities for the mentally retarded. The Division receives many requests for "one-on-one" staffing, creating additional costs for these facilities. There are also issues concerning day habilitation services which are being addressed cooperatively with providers and BMR staff.

8. Division of Residential Care

Licensing activity in SFY 89 involved 239 boarding homes (representing 3,160 beds) and 337 adult foster homes (representing 879 beds). Staff investigated 85 complaints about boarding homes and 31 complaints about foster homes. Two conditional licenses were issued to boarding homes and one was issued to a foster home. Appeals of Departmental actions have resulted in a considerable increase of time in litigation.

VII. WORK IN PROGRESS

In all of the Divisions and special units of the Bureau of Medical Services, there are major initiatives to improve both the quality of medical services received by Medicaid recipients and the cost effectiveness of the financial resources used to purchase services.

The Division of Policy and Programs is investigating a number of high-priority areas in the current year for changes to the Maine Medical Assistance Manual. Many of those changes will enable the State to draw down additional federal dollars.

Physician Services - Meetings with the Physician's Advisory Workgroup were held over the course of the last year in order to put in place a resource-based relative value scale for the physician fee schedule. Funds have been appropriated for physician fee increases and will be applied to the physician fee schedule early in 1990.

Case Management Services for Children Birth Through Age Five With or at Risk of Developmental Delays - This is a new policy which will make case management services available to this Medicaid population of children. Staff of the Division has been working with staff of the Bureau of Children with Special Needs to develop this policy and will be having further discussions with them and staff of the Bureau of Health. Target date for implementation is 7/1/90.

Case Management for Children in Custody or Care of DHS - Rules have been drafted and an action plan is being implemented. Completion is dependent on additional staff time.

Case Management for Children Who Are Abused or Neglected - rules drafted, but implementation is dependent on adequate staffing.

ICF, SNF, and ICF/MR Services - This section is very outdated and will be undergoing major revisions to reflect current practice as well as to implement requirements of the Omnibus Budget Reconciliation Act of 1987. A new section is being added to cover traumatic brain injury services in long term care facilities.

Rehabilitation Services - Funds have been appropriated to provide specialized rehabilitation services to individuals with a traumatic brain injury. A new policy will be implemented in order to put together a package of services for this population.

Optometry Services - Changes in the licensing law for optometrists has made it necessary for us to amend policy in order to allow optometrists to perform minor surgical procedures.

Psychological Services - In a cooperative effort with the Bureau of Mental Health, this policy has been substantially revised and the target for implementation 7/1/90.

Psychiatric Hospital Services - This policy will be amended to include outpatient service coverage as well as partial hospitalization. The target for implementation is 7/1/90.

Day Habilitation for Persons with Mental Retardation - rules have been drafted and the target date is 4/1/90.

Home-Based Mental Health - rules have been drafted and the target date is 6/1/90.

Children's Mental Health Services in Residential Treatment Centers - rules drafted, but implementation dependent on obtaining state seed and adequate staff time.

Reimbursement for School-Based Services - rules have been drafted and the target date is 8/1/90.

Increased Reimbursement for Private Nonmedical Institutions (Residential Treatment Centers) - rules drafted, but implementation dependent on adequate staff time.

Personal Care Attendants - policy has been drafted and is under review, but implementation is dependent on an appropriation to seed these services.

To increase Medicaid savings, staff of the Third Party Liability Unit will initiate a review of insured absent parents, in close cooperation with the Support Enforcement Location Unit. Tape matching activity will be expanded to include the Bureau of Labor for employee insurance, the Division of Motor Vehicles for possible accident insurance and Worker's Compensation cases.

Also under consideration is the development of new legislation related to the recoupment from estates of ineligible clients and to require public and private agencies to cooperate in giving information relevant to the recoupment of funds due to the State.

The Maine Managed Care Insurance Demonstration Program is a project funded by the Robert Wood Johnson Foundation and the State of Maine to develop health insurance and managed care products for small business groups, the self-employed and AFDC recipients. The aim of the program is to test the possibilities of public-private partnerships among employers, the insurance industry, and the state in making affordable health insurance available to previously uninsured groups and individuals

The program, known as MaineCare, has been operational at one site, in the Bath-Brunswick area since December 1988. As of September, 1989 it had enrolled 158 small businesses with 547 enrollees. State subsidies are available for persons under 200% of the federal poverty level, as long as participating employers and employees each pay a portion of single and family premiums. Premiums for persons below 100% of the poverty level are fully subsidized. A comprehensive benefits package is provided through a contract with an independent physician network HMO. The Division of Health Insurance and Special Projects is developing a second site in Somerset County which is due to be operational in early 1990. Staff are also developing a new insurance plan called FamilyCare that would provide managed care Medicaid benefits to AFDC recipients residing in the targeted sites.

The Maine High Risk Insurance Organization is a statewide pilot program of health insurance for those individuals who are unable to obtain adequate protection due to existing health conditions. The plan is administered by the Mutual Insurance Company of Nebraska, and is funded by a combination of individual premiums, an assessment on hospitals, and for those enrollees meeting certain income quidelines, premium subsidies from the general fund. Enrollment in the pool is capped at 300, and the program is due to sunset in 1991, unless continued by the Legislature.

The Medicaid Buy-In Program for persons with disabilities was passed by the State legislature in 1988. This program is to ensure that persons with disabilities have access to affordable health insurance regardless of their preexisting conditions. Program design guidelines and criteria are currently being developed. The program may be implemented in 1990.

A 40% increase in Long Term Care surveyor staff is anticipated by the Division of Licensing and Certification to comply with new federal requirements. The Division will also implement new outcome-oriented Federal surveys and a Fines and Sanctions Program for nursing homes.

Inspection of Care for Title XIX recipients will end on October 1, 1990. Revision of both the Nursing Home and ICF/MR regulations is underway, as is implementation of Nurse Aide testing and the establishment of a Nurse Aide Registry.

Major projects underway in the Division of Residential Care include policies and rules utilizing Medicaid to reimburse for part of the services in boarding homes. The target date for implementation is March, 1990. Regulations have also been drafted to enforce the fines and sanctions law passed in the State legislature. Rulemaking will begin 3/1/90.

Pre-admission assessment procedures for residents applying for admission to cost-reimbursed homes will be implemented during the coming year. The Division will be involved in determining if residents need services in a boarding home in order to be able to draw down Medicaid funding and plans to hire one staff authorized by the last legislative session to implement this program.

The Division will also begin to use a computer for information management. Along with H.S.D.I. and members of the Residential Care Advisory Committee, the Division will develop and conduct a survey of boarding home residents focusing on resident satisfaction. The Division will be concentrating on methods to ensure that boarding home staff are qualified and competent to provide services.

VIII. SPECIAL PROGRAMS

Waiver Programs

The Bureau of Medical Services administers three Home and Community-Based Waiver Programs. These programs provide a package of services that help to deinstitutionalize or divert individuals from nursing homes. The three programs are described below:

Home and Community-Based Waiver for the Mentally Retarded

This program has been in place since its approval in July of 1983. It offers case management, habilitation, respite, transportation, consultation and residential training services to those eligible recipients. In State Fiscal Year '89 this program served 529 individuals at a total cost of $9,974,512. This waiver is up for renewal in 1990.

Home and Community-Based Waiver for the Elderly

The State's second waiver program was approved in May of 1985 and was renewed in 1988 for another five years. Recipients of this program may receive case management, day health, personal care, homemaker, home health, transportation, emergency response systems, and mental health services. 792 people received services in SFY'89 at a total cost of $2,229,013.

Home and Community-Based Waiver for the Physically Disabled

This waiver program, approved in July of 1986, was up for renewal this year. A number of extensions of the program were granted in order to give the State and HCFA time to respond to questions and additional information. Approval from HCFA to continue this program for another five year period is expected shortly. This waiver allows eligible individuals to receive case management, consumer instruction and personal care services. During SFY'89, 117 people were served at a total cost of $871,820.

Maine Health Program

This health benefit program was created by statute in 1989 (PL 588) to expand basic health services to the citizens in Maine. The law mandates that, beginning July 1, 1990, all children under 18 years of age residing in households with incomes at or less than 125% of the federal poverty level are eligible to receive a comprehensive set of health care benefits. Similarly, all adults whose household income is at or below 95% of federal poverty guidelines are eligible to receive program benefits. The program will rely largely on the current infrastructure of the Medicaid program to conduct eligibility determination, process claims, monitor program performance and for other administrative functions.

Funds for the program in the amount of $10 million have been appropriated from the general fund for this biennium to meet the cost of covering an estimated 13,000 individuals in the first year of program operation. A 12 member advisory committee, appointed by the Governor and by legislative leadership, advises the Bureau on program policy and development.

Preventive Health Program

Early, Periodic, Screening, Diagnosis and Treatment Services, which in Maine is called the Medicaid Preventive Health Program, make available regularly scheduled medical and dental screening examinations to children and young adults up to the age of 21. An average of 43,504 children were eligible for PHP services in SFY 89 (a decrease of 2% from SFY88).

Outreach workers, employed by 15 local community agencies, inform families about the services available to children and young adults through the PHP.

In SFY 89 there were 12,842 new and re-eligible families to be informed of PHP services. The results of the outreach workers' efforts are as follows:

Informed face-to-face	10,585	82.43%
Close out letter sent	971	7.56%
Could not be located	122	0.95%
Off Medicaid < 60 days	1,164	9.06%

Of the 10,585 families informed in a face-to-face interview, 82% enrolled children in the PHP, 14% requested initial screening and 4% declined or were undecided. The cost of outreach services for SFY 89 was $2,281,401.

Children may obtain medical screening examinations when they become Medicaid recipients and according to the Department's periodic schedule. Outreach workers reminded parents that 27,988 screenings were due and tracked individual children for 180 days to ensure timely screening and diagnosis or treatment when needed.

The PHP recommends that children obtain their first dental exams at age three and then twice a year after that. Outreach workers notified the parents of 2,807 three year old children that their first dental exams were due. Of the $2.67 million spent for dental services for children, 38% was for preventive care, 40% for restorative are and 22% for orthodontic care.

In addition to screening services, children are covered for vision care including eyeglasses, hearing services including hearing aids, and immunization services. Bureau staff met with representatives of the agencies providing outreach services, dental providers and orthodontists to identify problem areas and develop plans to enhance the PHP. The common issues identified by these group were the following:

* Access to PHP screening in specific geographic areas.

* Access to dental services, particularly specialty services such as orthodontics.

* Family/child knowledge of health services and the appropriate use of resources and the family's/child's attitude toward health care in general and preventive care in particular.

* Need to decrease the number of broken appointments and "no shows."

* Need to continue to improve coordination with other child-serving programs.

Skilled Nursing Facility Services

One of the long standing issues concerning SNF level care is the availability of beds certified as skilled nursing facility level throughout the state. Out of the total of 9,740 long term care facility beds in the state, only 603 are SNF level. This is an increase of 66 beds over the number of SNF beds available in December of 1986. Part of this increase is the result of some hospitals applying for "swing beds" that can be used for SNF level of care. The other increase is the result of incentives built into the CON process for SNF beds to be included in proposals for new construction. The significance of this issue is that private pay and Medicaid eligible clients do not have access to the Medicare benefit for this service. Medicaid patients fare somewhat better than private pay, since their care will be covered under the Medicaid program. However, for the 90% of the elderly population who are not Medicaid eligible, if they need post hospital care in a long term care facility they have to pay for that care out of their private funds rather than be covered under Medicare as is intended in their health insurance benefit. The Bureau has proposed that Intermediate Care Facilities become "dual certified", whereby all of the beds would be eligible for both SNF and ICF level reimbursement, with the provision that the facility would apply for Medicare certification. Due to the inability to resolve the Medicare reimbursement issue and the reluctance of Nursing Homes to become involved in the Medicare program, this initiative has not moved forward as intended.

The other significant issue concerning Skilled Nursing Facility care is the lack of appropriate skilled level placements for persons with special needs. Earlier in this report it is noted that there are generally 12 out of state placements in skilled nursing facilities for persons with head injuries. In addition, there are some young adults with other diagnoses who continue to be placed in out of state facilities because of the lack of resources in the state of Maine.

Case Mix Reimbursement and Quality Assurance Demonstration Project

Maine is one of four states chosen by the Health Care Financing Administration (HCFA) to participate in a case mix reimbursement and quality assurance demonstration project. The staff of the Financial Services Unit is working with the Human Services Development Institute (HSDI) at the University of Southern Maine, the nursing home industry and HCFA to develop a reimbursement system which will increase access to nursing homes for people who no longer need hospital services but continue to need a substantial amount of medical intervention. The project goals are to develop a more equitable payment system which will reimburse based on resident's characteristics and services needed and to incorporate a mechanism for monitoring and improving the quality of care provided in the facilities.

Drug Utilization Review Committees

Drug Utilization Review Committees have intensified efforts to combat prescription drug diversion, as well as patterns of over prescribing by "enabling physicians." SURS has currently identified recipients who use at least 4,800 analgesic/tranquilizer pills in one day (an average of more than 13 pills per day). Drug Utilization Review Committees are the means for determining the medical necessity and controlling excessive drug use through direct education and/or support contacts with their peers, the over-prescribing physicians.

Organ Transplants

During SFY89, prior authorization was granted for three bone marrow transplants, one heart transplant evaluation, one cornea transplant and one kidney transplant.

AIDS

Approximately 59 Medicaid recipients were treated for AIDS during SFY89 at a cost of $826,857, or $14,000 per patient. This data is derived from the SURS subsystem of MMIS and is a projected estimate.

IX. SERVICES NOT COVERED

Several specific services are not presently covered by Maine Medicaid, although discussions have taken place concerning coverage of these services:

Continuous positive airway pressure devices
Augmentative communication systems
Independently practicing social workers
Nurse practitioners (OBRA of 89 makes mandatory the coverage of certified pediatric and family nurse practitioners)

In addition to these items, the following services relating to children have been identified as necessary services but have either not been funded or the staff time has not been available to proceed with the work necessary to develop policy:

1. Case Management for Adolescents

2. Improved Diagnostic Assessment and Evaluation for Abused Children

3. Therapeutic Foster Homes

The Bureau will be proceeding on developing policy for the additional services.

X. ISSUES FOR THE FUTURE

There are a number of issues in our society today which will have significant impact on the Medicaid Program of the future.

. The Medicaid Program with an annual expenditure of $400M of State and Federal money is one of the largest single programs for the low-income citizens of Maine. Not only is the cost of health care increasing at a rate higher than the consumer price index, but as the overall population ages, increasing the number of elderly people within the Medicaid eligible population, the costs of the Medicaid Program will rise even more. The average cost per elderly client in the Medicaid Program is $4,948 compared to $2,678 per recipient under the age of 65. Significant also is the fact that persons over the age of 85 will be increasing at a higher percentage than the "young old." This is the group that uses all health services to a greater extent, and particularly, long-term care services. Although Maine has stated a public policy of "balanced growth" between institutional and community-based in-home services, the amount of resources available to meet the need for in-home services for persons at risk of nursing home placement does not begin to meet the demand. Therefore, we continue to experience a shortage of nursing home beds, as evidenced by the patients waiting for placement in hospitals and at home.

. The economy will also have a significant impact on State expenditures for the Medicaid Program. As noted earlier in this report, the AFDC caseload has increased 11% from December, 1988 to December, 1989. If this trend continues, there obviously will be more clients whose health care needs are covered under the Medicaid Program. This trend should have an effect on the matching Federal rate for the Medicaid Program. However, if the economy begins to improve again, as we hope will happen, the Federal match rate for the Medicaid Program will undoubtedly continue to decline, requiring greater investment of State resources to maintain the same level of services.

. All agencies of State government, under the leadership of the Department of Human Services, must continue to explore the possibilities for covering under the Medicaid Program services presently funded totally out of State revenues. Substantial gains have been made in recent years in providing Medicaid coverage for services to the mentally retarded, children in residential treatment centers, the elderly in boarding homes, and the mentally ill. Work is continuing on developing and implementing policy for coverage of case management services for a variety of targeted client groups. The Children's Policy Committee of the Interdepartmental Council has been working closely with representatives from the Bureau of Medical Services since December, 1988. The following areas have been identified for the potential draw down of Federal match:

-Use of model waivers to develop special services under P.L. 99-457, Part H, for families with children at risk of developmental disabilities

-Case management for homeless children and families

-Case management for juvenile justice clients

-Expanded perinatal services to improve pregnancy outcomes

-Coverage for services related to Headstart programs

-Expanding the number of sites in Maine where women can be presumptively determined to be eligible for Medicaid, thereby gaining immediate access to ambulatory prenatal care

. The intent of all of these initiatives is to fund existing services, not necessarily create new services, utilizing existing State resources. With the additional Federal funds that would be brought into Maine, services could be expanded, such as in the area of perinatal care, and funds freed up by using Federal Medicaid dollars for existing services could be utilized to meet other priority needs.

. The three largest services funded under the Medicaid Program are reimbursed on a cost basis. Those are hospital services, nursing home services and the prescription drug program. There are a few other smaller services reimbursed on cost, such as rural health clinics, but the majority of services are on a negotiated fee basis. There is no provision for automatic increases in these fees, and the Bureau is under constant pressure from providers to increase fees. Until the summer of 1988, physicians had not received an increase in fees for 11 years. Mental health centers and home health agencies are currently meeting with Bureau staff concerning the need for a fee increase. Routine home health agency services are based on the costs as determined by the Medicare Program, but the private duty nursing and personal care services provided by home health agencies are on an hourly fee basis. Although the fees for providers in group settings are determined based on cost information that is submitted, there are no standards or principles under which allowable costs are determined for such things as administrative costs. These are fairly significant services and therefore any fee increases do have a significant impact on the amount of State funds needed to cover the increase.

The fees paid by the Medicaid Program do have impact on the issue of access to health care. In addition to the ongoing inflationary increases in costs, health care providers are faced with increasing workers compensation costs and rapidly rising malpractice insurance rates. The issue of providing fee increases for providers needs to be dealt with much more equitably than it has in the past if we are to continue to assure reasonable access to services for Medicaid recipients.

. Coverage for prescription drugs is an optional service that Maine has chosen to include as a Medicaid benefit. Due to the increasing costs of the wholesale price of drugs, new drugs coming on the market, some at extremely high costs, the Bureau is taking action to control the costs of this benefit. A committee of pharmacists is working with Bureau staff to make recommendations concerning the prescription drug program. The report of this committee will be presented to the Legislature by February 15, 1990, the date the report is due. Many of the concerns with the prescription drug benefit could be addressed much more effectively if we had the capability of "point of sale" equipment in pharmacies throughout the State. The cost effectiveness of this investment is being explored by the committee.

. As noted earlier in the report, there are several services that are not presently covered under the Medicaid Program, and resources are not available for meeting the needs of certain special populations. Particularly outstanding is the need for both residential and community-based rehabilitation services for persons with traumatic brain injury, and the need for alternative placements for children who have been treated in an acute psychiatric hospital, such as Jackson Brook Institute. The other group whose needs have never been well met is adults with seriously handicapping neurological and muscular disorders, such as cerebral palsy and multiple sclerosis. These are all relatively small groups of clients, but the resources needed to meet their needs are substantial. Initiatives for addressing some of these needs are being explored, but without adequate resources it will be difficult to implement new services.

. Given the needs identified, the limited resources available and the ever changing medical technology, the

Department is proposing to establish a committee to prioritize the services that have the greatest benefit in relation to the resources needed. The work of this committee would be patterned on Oregon's plan to "prioritize" Medicaid services using a cost benefit analysis framework. The intent would be to establish a system under Medicaid, which then becomes the basis for the Maine Health Program, to prioritize services and provide the essential services to all residents with incomes below an established Federal poverty line. Such a committee would be made up of legislators, providers, consumers, advocates and State agency representatives. Such a committee will require considerable staff support, and the Bureau will be exploring options for providing this staff support.

. As the Medicaid Program continues to expand as well as other State funded health programs whose claims go through the medical claims processing system of the Bureau, the capability of the claims system to continue to expand needs to be enhanced. About 10% of claims are now being submitted electronically, primarily from hospitals and pharmacies, and this capability needs to be expanded to include the return of reimbursement information to providers. The Department is presently meeting with New Hampshire and Vermont to do a tri-State proposal for an automated recipient eligibility verification system which could also be used for submitting claims from providers and transferring funds to both providers and recipients electronically. Such a system would be similar to a credit card system, in that Medicaid recipients would have plastic cards that would be run through a machine which would then feed back a variety of information to the provider. The present monthly mailing of Medicaid eligibility letters is an inefficient, outdated system and needs to be replaced. These changes will require an initial investment for which a 90% Federal match may be available if the advanced planning document is approved by the Health Care Financing Administration for the investment in the hardware. The Department has been encouraged by the Regional Office to pursue such an initiative. In addition to these enhancements to the claims processing system, which would enable more claims to be submitted faster, the State needs the capability to include more claims in a pay cycle. On occasion, we have reached a ceiling on the number of claims that could be submitted in a pay cycle, thereby delaying payments to the next pay cycle. This problem also needs to be addressed.

. The Bureau is constantly being asked to produce data concerning the services provided under Medicaid, costs, trends, breakdowns by age group and geographic area, and other information which is in the system but difficult to retrieve. Although the Division of Surveillance and Utilization Review subsystems identify both providers and recipients who abuse the system, there is a need for greater capability within the Bureau to analyze data for budgetary and planning purposes. The administrative costs in Maine's Medicaid Program have been held down very effectively to 2.5% but this has limited the ability of the Bureau to manage the program as efficiently as would be desirable. With increased data analysis capability on an ongoing basis, areas could be targeted for policy changes that would ultimately save the State some unnecessary expenditures.

Although the Medicaid Program met its primary goal of providing comprehensive health care to 126,100 of Maine's poorest citizens during Fiscal Year 1989, there are clearly other needs that are not being met. However, with an investment of $127,466,943 in State resources, participants received an array of services exceeding that provided in any privately funded health insurance program. This is a remarkable achievement considering that 25 years ago this care was available only as a result of charity through hospitals, physicians and other medical providers. This success is achieved through the 5,776 in-State and out-of-State providers who participate in the Medicaid Program. Even though some "free care" or, perhaps more accurately care which is only partially reimbursed is still provided throughout the system, it is most significant that Maine invested $383,705,427 in state and federal resources in the Medicaid Program in 1989. This represents a substantial commitment to both recipients and providers.