ANNUAL MEDICAID REPORT

STATE FISCAL YEAR 1990

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

April 1, 1991

The Honorable Michael Pearson, Senate Chair
The Honorable Lorraine Chonko, House Chair
Members of Appropriations & Financial Affairs Committee

The Honorable Gerard Conley, Jr., Senate Chair
The Honorable Peter Manning, House Chair
Members of Human Resources Committee
State House
Augusta, Maine 04333

Dear Chairpersons:

I am pleased to transmit to you the Annual Medicaid Report for 1990 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. This report provides information that you as Legislators should find useful in framing public policy in these times of decreasing resources. I urge you to refer to this report as we face the difficult decisions ahead.

Maine's Medicaid Program was successful in providing comprehensive health care services for 133,020 low-income people during State fiscal year 1990. The valuable service provided by the almost 6,317 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 and a summary of accomplishments during the past year. We look forward to your comments for improving the program and this report. Thank you for your continued interest and support.

Sincerely,

Rollin Ives
Commissioner

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, the Department of Education and cooperative efforts with the Department of Corrections are being initiated. We are also working closely with Child Development Services in developing policy for children served by a variety of State agencies. 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. In addition to the Annual Fee Review, meetings are also held 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. We appreciate this opportunity to reflect the accomplishments of Maine's Medicaid Program and the staff which administers it.

Elaine E. Fuller
Director
Bureau of Medical Services

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I. HIGHLIGHTS OF 1990 MEDICAID PROGRAM

In State Fiscal Year 1990, the Maine Medical Assistance Program spent $417,451,548 for health care services to 133,020 Medicaid recipients from 6,317 institutions, agencies or individual providers. In the course of the year, the Bureau of Medical Services processed 4,111,935 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 23,000 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 Medicare/Medicaid certification of all of the health care institutions and agencies and adult residential care facilities in the State are also the Bureau's responsibility.

Some of the highlights of SFY90 include:

The study to implement a fee increase for physicians based on a newly developed resource-based relative value scale was carried out with a Physicians Advisory Workgroup and prepared for implementation in October, 1990.

Increased recoveries of other third party payments for services to Medicaid recipients from $2.8 million in SFY89 to $4.34 million in SFY90. Payment of an additional $9.2 million, for a total of $98.4 million during the same period was avoided through refinements in the claims processing system.

Implemented policies to obtain federal funding for coverage of certain services in community residences for children, substance abusers, mentally disabled and cost-reimbursed boarding homes.

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.

As one of four states participating in the National Nursing Home Case Mix and Quality Demonstration Project, worked closely with the nursing home industry, the Health Care Financing Administration Office of Research and Demonstrations, the contractors for this project and the other four states in developing criteria, protocols, and time studies leading to Case Mix Reimbursement.

In spite of cutbacks in staff, scored 98.4% out of a possible 100% in annual Federal Systems Performance Review of the claims processing system, enabling Maine to continue to receive 75% Federal matching funds for this activity.

Submitted a proposal for and was awarded a demonstration grant expanding Medicaid coverage to children up to 125% of poverty. A major component of this demonstration is the buy-in to private group health insurance when cost-effective.

An on-line adjustment screen was designed and implemented to reduce manual processing of adjustments in claims. Electronic claims submissions increased from 10% to 17% with the addition of nursing homes, boarding homes and more pharmacies.

Implemented Federal Nursing Home Reform Act (OBRA-87) requirements for Pre-Admission Screening and Annual Resident Review (PASARR) and Nurse Aide Registry and Competency Testing.

II. 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'90, the year of the report, was 67.78%. In the current fiscal year, the match rate is 65.57% and in SFY'92 the Federal share will decrease to 63.92%.

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 also authorized optional expanded Medicaid eligibility which Maine implemented in the previous fiscal year, referred to as the SOBRA option. Congress also has mandated a variety of expanded groups in both coverage and eligibility in the Medicare Catastrophic Coverage Act of 1988 and 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 in families under 100% of poverty 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 ages 1 to 6 in families up to 100% of poverty, under the SOBRA option. States are also mandated to cover any medically necessary services for children under the age of 21, provided the service is eligible as an optional service under Federal regulations, whether or not the service is otherwise included under the State Medicaid Plan. States are also mandated to pay the Part A and B premiums, copayments and deductibles for elderly under 100% of poverty.

There are certain underlying principles for services under the Medicaid Program, also known as the Medical Assistance Program. The Federal government mandates certain services which must be covered. 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 most generous Medicaid programs in the country.

Maine has incorporated virtually all optional services authorized by the Health Care Financing 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. Hospice care is not currently covered, although draft policy has been prepared and a Hospice Task Force is being convened.

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, 1990, 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 47.4%.

Maine has developed case management services aggressively, with several new targeted case management services covered effective July 1, 1990. 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.

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 per recipient compared to a national average of $2,126. 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 1989, Maine's average reimbursement rate for nursing home care was 10th in the country. Changes in the Principles of Reimbursement for ICFs have provided substantial increases to nursing homes in recent years.

Maine in Comparison to Other New England States

As of October 1,1990, Massachusetts covered 28 optional services while Maine covered 27 optional services. Rhode Island covers only 16 optional services, with the other states in-between.

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%.

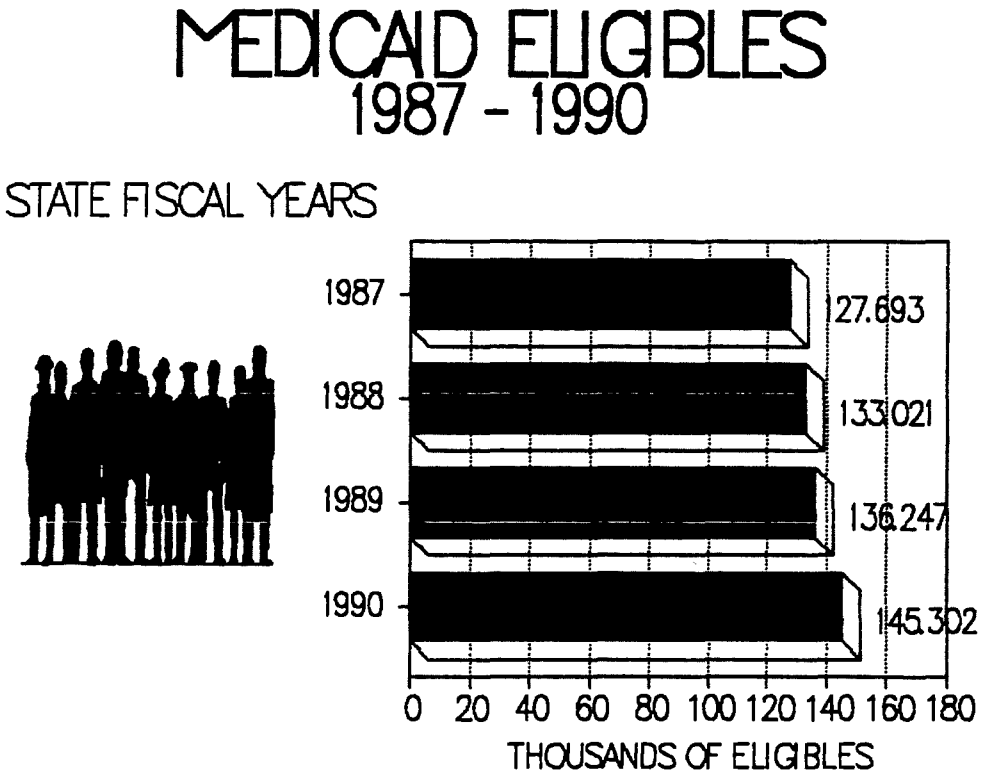
The table below shows some comparisons with other New England states in several areas:

State	1989 Est Pop In T's	1989 Per Cap Income	#Med. Recips.	# Per 1000	Cost Per Recips. Incl. LTC	Cost Per Recips. Less LTC	Total Expend.	Match Rate	LTC Fac. Costs	%LTC Costs	Cost Less LTC
Maine	1,222	$16,310	128,000	104.7	$3,231	$1,814	$413,575,914	65.20%	$181,447,907	43%	$232,128,017
New Hamp.	1,107	$20,251	45,703	41.3	$4,555	$2,008	$208,175,439	50.00%	$116,404,434	56%	$91,771,005
Vermont	567	$16,399	59,845	105.5	$2,554	$1,486	$152,815,831	62.77%	$63,908,348	41%	$88,907,483
Mass.	5,913	$22,196	570,000	96.4	$3,719	$2,421	$2,200,000,000	50.00%	$740,000,000	35%	$1,380,000,000
R.I.	998	$18,061	82,907	83.1	$5,119	$2,969	$424,413,810	55.15%	$178,247,276	42%	$246,166,534
Conn.	3,239	$24,604	217,541 (9/90 only)	67	$5,143	$2,622	$1,118,729,848	50.00%	$548,360,000	49%	$570,370,000

Figures for Connecticut include only number of eligibles in one month.
Twelve month figure for eligibles would be higher resulting in lower cost/recipient.

III. MEDICAID RECIPIENTS

Medicaid is available for certain categories of people specified by law, based on financial (income and resources) criteria. During recent years Congress has mandated expansions of the Medicaid elgibility pool in order to cover more children and to cover certain costs for the elderly. The graph below shows the increase in Medicaid eligibles since 1987.



Maine's Medicaid Program has two main components, a "categorically needy" program and a "medically needy" program.

. **Categorically Needy.** The categorically needy group consists of people who receive or are eligible to receive cash assistance payments under other assistance programs or are specially authorized by law. These include:

- recipients of Aid to Families with Dependent Children (AFDC) payments, foster care and adoption assistance (Title IV-E) payments;
- pregnant women and infants up to age one;
- children up through age 21; and
- recipients of SSI.

With respect to the aged, blind and disabled groups, Federal regulations permit states to either accept as categorically needy all persons found eligible for the Federal Supplemental Security Income (SSI) program or to set categorically needy eligibility criteria which are more restrictive than SSI standards. Maine elected to accept as categorically needy all persons found eligible for SSI.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) expanded Medicaid for individuals who are entitled to Medicare Part A, the hospital insurance part of the program. As noted previously, Medicaid coverage is in the form of payment for out-of-pocket expenses for both Part A and Part B Medicare-covered services, such as premiums, deductibles and coinsurance. The income and resource limits that must be met to qualify for Qualified Medicare Beneficiary are more generous than those necessary to receive full Medicaid coverage. (See "Eligibility Income Levels" and "Eligibility Resources Limits", Qualified Medicare column.)

Another provision of the Medicare Catastrophic Coverage Act protects a portion of the income and resources of a married couple for the spouse living in the community when the other spouse requires long term care. This allows the institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. These provisions were effective October 1, 1989.

Persons in the categories listed above must have income and resources (such as savings, automobiles) below a certain level to qualify for Medicaid.

. **Medically Needy.** The medically needy meet the same general requirements as the categorically needy but do not receive cash assistance payments, generally because their income is higher than state standards allow. If the medically needy individual's income is higher than the allowable level, he or she must spend the excess income on medical care before becoming eligible. This is known as the Medicaid deductible (or "spenddown").

Medicaid counts the population it serves in two ways: "eligibles" and "recipients". "Eligibles" are those who meet Medicaid's categorical and financial criteria and qualify for Medicaid to pay for medical care on their behalf. Categorical eligibility extends only to families with children, the blind, disabled, elderly and pregnant women. Single adults with no children are not categorically eligible for Medicaid. Most eligibles use services and are called "recipients". In SFY 1990, Medicaid paid for 133,020 recipients. Some eligibles, however, do not use services during the year. These are persons who automatically qualified for Medicaid because they qualified for cash assistance programs, but did not need health care during the

year, or used care for which Medicaid did not pay. During 1990, approximately 12,000 eligibles did not use a service.

In SFY 1990, 145,302 persons were eligible for Medicaid at some time during the year. This represents an increase of almost 10,000 eligibles over the prior year. The largest portion of the increase is due to eligibility expansions that began in 1989, including the SOBRA options providing coverage of greater numbers of pregnant women and children, elderly and disabled. Also, as our economy changes, it affects numbers of clients. From 1989 to 1990 the AFDC caseload increased 13.8% which results in a commensurate increase in Medicaid expenditures for that group of eligible clients.

"Recipients" are counted in two ways in relation to their use of services: "unduplicated" and "duplicated." Total recipients is an unduplicated count, enumerating all those individuals who have used one or more types of service. The recipient count for types of service is a duplicated count, meaning that a recipient using two or more different types of service would be counted once in each service category. As a result, the sum of all recipients across service categories does not equal the total unduplicated recipient.

ELIGIBILITY INCOME LEVELS (ANNUAL)

FAMILY SIZE	CATEGORICALLY NEEDY	MEDICALLY NEEDY	100% OF POVERTY AGED, BLIND DISABLED CHILDREN 6-8
1	3,696	4,992	6,620
2	5,820	5,400	8,880
3	7,824	7,296	11,140
4	9,828	9,096	13,400
5	11,832	10,992	15,660

FAMILY SIZE	133% OF POVERTY AGE 1 - 6	185% OF POVERTY PREGNANT WOMAN INFANT	100% OF POVERTY QUALIFIED MEDICARE BENEFICIARY
1	8,804	12,247	6,620
2	11,810	16,428	8,880
3	14,816	20,609	
4	17,822	24,790	
5	20,827	28,971	

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ELIGIBILITY RESOURCES LIMITS (ANNUAL)

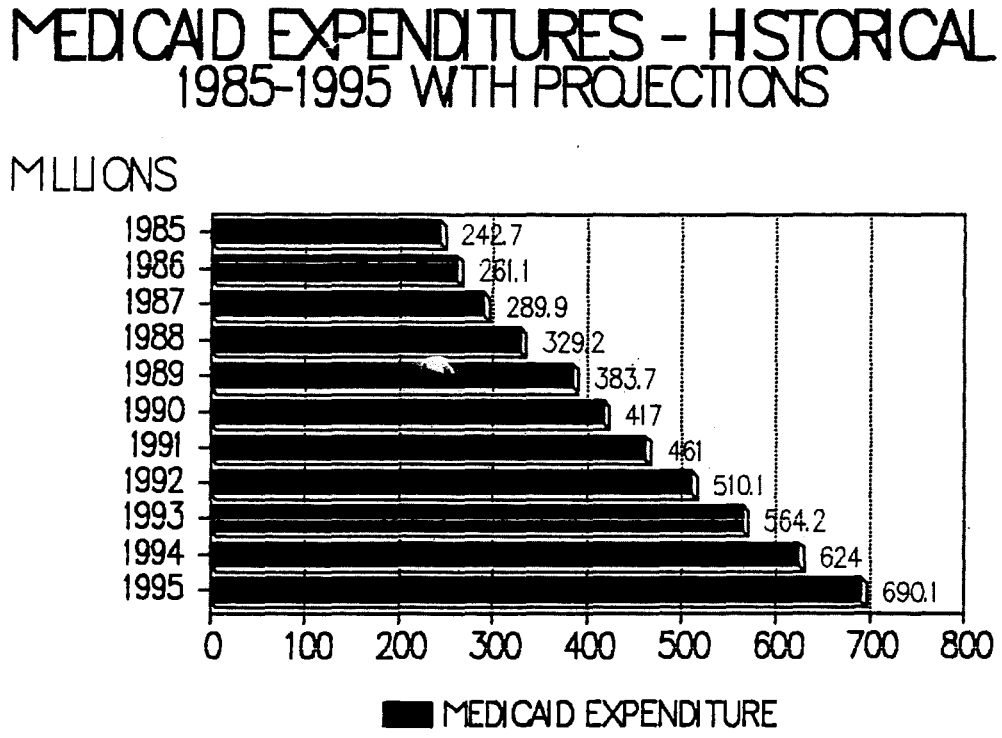
FAMILY SIZE	CATEGORICALLY NEEDY	MEDICALLY NEEDY	100% OF POVERTY AGED, BLIND DISABLED CHILDREN 6 – 8
1	$1,000	2,000	2,000
2	NO INCREMENT	3,000	3,000
3	FOR FAMILY	3,100	N/A
4	SIZE	3,200	N/A
5		3,300	N/A

FAMILY SIZE	133% OF POVERTY AGE 1 – 6	185% OF POVERTY PREGNANT WOMAN INFANTS	QUALIFIED MEDICARE BENEFICIARY
1	NO RESOURCES	NO RESOURCES	4,000
2	TEST APPLIED	TEST APPLIED	6,000
3			
4			
5			

MEDICAID

IV. SERVICES AND EXPENDITURES

This section details the distribution of $417,451,548 on Medicaid health care expenditure during State Fiscal Year 1990. The following graph displays historical growth in Medicaid expenditures and also projects a budget of nearly $700 million in 1995.



BUREAU OF MEDICAL SERVICES

The following table lists expenditures by category of mandatory and optional services for state fiscal years 1988, 1989 and 1990 and the percentage change for each service.

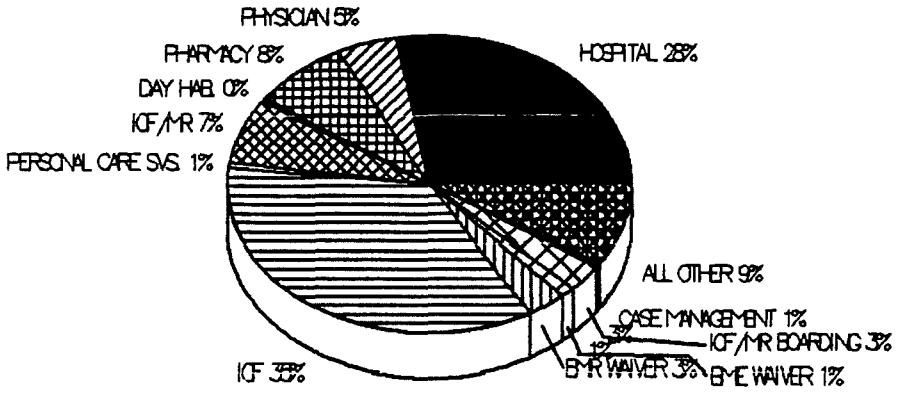
COMPARISON OF MEDICAID EXPENDITURES - SFY 88 TO SFY 90

MANDATORY SERVICES	SFY 88	SFY 89	PERCENT CHANGE	SFY 90	PERCENT CHANGE
HOSPITAL SERVICES	$94,545,473	$93,934,248	-0.65%	$99,765,007	6.21%
PHYSICIAN SERVICES	$14,482,609	$17,653,837	21.90%	$19,613,181	11.10%
HOME HEALTH AGENCIES	$5,030,850	$5,440,947	8.15%	$6,259,113	15.04%
SNF	$4,366,102	$5,020,691	14.99%	$7,380,560	47.00%
RURAL HEALTH AGENCIES	$851,912	$1,033,810	21.35%	$1,240,510	19.99%
INDEP. LAB. & X-RAY	$530,423	$902,456	70.14%	$1,126,841	24.86%
AMBULANCE	$488,122	$659,447	35.10%	$996,296	51.08%
FAMILY PLANNING CLINIC	$181,227	$436,798	141.02%	$513,154	17.48%
ICF	$110,720,072	$123,337,138	11.40%	$140,072,090	13.57%
ICF/MR	$20,677,838	$23,891,861	15.54%	$28,311,791	18.50%
MEDICARE PART A	$5,795,275	$6,587,372	13.67%	$5,931,394	-9.96%
MEDICARE PART B	$3,845,499	$3,312,755	-13.85%	$5,139,961	55.16%
TRANSPORTATION	$1,571,681	$3,800,823	141.83%	$3,273,351	-13.88%
TOTAL MANDATORY SERVICES	$263,087,083	$286,012,183	8.71%	$319,623,249	11.75%
OPTIONAL SERVICES					
PHARMACY	$22,885,291	$26,705,856	16.69%	$30,582,766	14.52%
DAY HABILITATION	$1,753,386	$11,715,244	568.15%	$1,641,148	-85.99%
BMR WAIVER	$8,172,502	$9,981,050	22.13%	$12,554,664	25.79%
ACUTE PSYCHIATRIC	$4,731,636	$7,826,847	65.42%	$10,818,691	38.23%
ICF/MR (G) BOARDING	$7,583,802	$7,334,955	-3.28%	$11,487,120	56.61%
MENTAL HEALTH CLINIC	$3,961,884	$4,035,292	1.85%	$4,818,812	19.42%
DME AND SUPPLIES	$2,837,357	$3,491,867	23.07%	$4,208,330	20.52%
DENTAL	$2,114,158	$3,332,721	57.64%	$4,751,809	42.58%
BME WAIVER	$3,231,609	$2,308,413	-28.57%	$4,803,197	108.07%
CASE MANAGEMENT	$0	$2,278,789	NA	$1,066,858	-53.18%
MENTAL RETARDATION	$0	$2,113,592	NA	$609,238	-71.18%
MENTAL ILLNESS	$0	$162,197	NA	$450,301	177.63%
PSYCHOLOGICAL SVCS.	$2,040,491	$1,982,261	-2.85%	$2,145,248	8.22%
PERSONAL CARE SVS.	$1,488,633	$1,670,449	12.21%	$2,267,130	35.72%
PHYSICAL DISABLED	$380,077	$867,495	128.24%	$1,150,346	32.61%
SUBSTANCE ABUSE	$364,212	$657,619	80.56%	$797,858	21.33%
PRIVATE NON-MEDICAL	$360,652	$655,413	81.73%	$1,051,553	60.44%
DETOX	$0	$84,925	NA	$65,039	-23.42%
CHILD SVCS.	$0	$467,628	NA	$521,555	11.53%
RESIDENTIAL REHAB.	$0	$21,214	NA	$25,398	19.72%
MI DISABLED	$0	$81,646	NA	$150,660	84.53%
MEDICAL/REMEDIAL	$0	$0	NA	$287,997	NA
OPTOMETRIC	$379,471	$544,477	43.48%	$686,566	26.10%
SPEECH PATHOLOGY	$473,967	$474,071	0.02%	$455,517	-3.91%
PROSTHETIC/ORTHOTICS	$383,180	$443,798	15.82%	$549,123	23.73%
CHIROPRACTOR	$214,393	$236,636	10.37%	$253,843	7.27%
SPEECH AND HEARING	$264,502	$223,980	-15.32%	$207,644	-7.29%
HOSPICE	$0	$184,155	NA	$146,699	-20.34%
PRIVATE DUTY NURSING	$296,360	$169,393	-42.84%	$476,429	181.26%
BOARDING HOME WAIVER	$0	$156,264	NA	$267,402	71.12%
PODIATRY	$103,370	$128,467	24.28%	$177,627	38.27%
OPTICAL SERVICES	$95,846	$119,460	24.64%	$134,362	12.47%
PHYSICAL THERAPY	$34,305	$89,757	161.64%	$163,489	82.15%
HEARING AID DEALERS	$52,669	$60,156	14.22%	$49,568	-17.60%

OCCUPATIONAL THERAPY	$3,918	$31,837	712.58%	$69,553	118.47%
AMB. CARE CLINIC	$0	$19,609	NA	$27,597	40.74%
AUDIOLOGY	$12,839	$12,358	-3.75%	$11,491	-7.02%
VD SCREENING	$4,660	$4,440	-4.72%	$5,820	31.08%
BME WAIVER	$38,434	$0	-100.00%	$0	NA
TOTAL OPTIONAL SERVICES	$64,263,604	$90,674,331	41.10%	$99,938,448	10.22%
TOTAL ALL SERVICES	$327,350,687	$376,686,514	15.07%	$419,561,697	11.38%

The pie chart below displays the major expenditures, with long term care services grouped together showing that 51% of the expenditures were for long term care services. The Medicaid Program was created in 1966 to provide health care primarily to long term care services has increased substantially, making Medicaid the major source of funding for nursing home care, as well as in-home long term care services.

MEDICAID EXPENDITURES
STATE FISCAL YEAR 1990



BUREAU OF MEDICAL SERVICES

In order to better understand the uses of Medicaid funds, the table below shows the expenditures by type of service and recipients of those services.

STATE FISCAL YEAR 1990
USE OF MEDICAID FUNDS

TYPE OF SERVICE	TOTAL EXPENDITURES	PERCENT OF SERVICE DOLLARS	USERS OF SERVICES*	COST PER SERVICE USER
ICF	$ 142,437,273	34.9%	9,068	$ 15,708
INPATIENT HOSPITAL	67,085,705	16.5%	17,973	3,733
ICF-MR	42,802,977	10.5%	751	56,995
PHARMACY	30,547,442	7.5%	102,417	298
OUTPATIENT HOSPITAL**	22,981,358	5.6%	65,153	353
PHYSICIAN	19,883,684	4.9%	86,327	230
MEDICARE PART A/PART B	11,071,355	2.7%	42,960	258
SNF	7,231,108	1.8%	530	13,644
HOME HEALTH	6,423,510	1.6%	4,021	1,597
PSYCHIATRIC HOSPITAL	4,920,142	1.2%	452	10,885
MENTAL HEALTH CLINICS	4,818,128	1.2%	7,574	636
DENTAL	4,749,715	1.2%	35,301	135
TRANSPORTATION	3,390,501	0.8%	9,739	348
PRIVATE DUTY NURSING/PERSONAL CARE	2,743,559	0.7%	552	4,970
DAY HABILITATION	1,245,027	0.3%	1,367	911
HOME- & COMMUNITY-BASED WAIVERS				
BMR WAIVER	12,999,554	3.2%	545	23,852
BME WAIVER	4,722,969	1.2%	866	5,454
PHYSICAL DISABLED	1,163,976	0.3%	136	8,559
OTHER	16,542,986	4.1%	83,351	198
GRAND TOTAL EXPENDITURES	$ 407,760,969	100.0%		
TOTAL RECIPIENTS***			133,020	
SERVICE EXPENDITURES PER RECIPIENT				$ 3,065

*"USERS OF SERVICES" IS A DUPLICATED COUNT OF RECIPIENTS. A RECIPIENT WHO USES ONE OR MORE SERVICES IS COUNTED IN EACH SERVICE CATEGORY.

**TOTAL EXPENDITURES FOR OUTPATIENT HOSPITAL SERVICES ESTIMATED USING A RATIO FROM TOTAL PAYMENT YEAR 4 DATA.

***"TOTAL RECIPIENTS" IS AN UNDUPLICATED COUNT, AND COUNTS RECIPIENTS ONLY ONCE DURING THE YEAR REGARDLESS OF THE NUMBER AND TYPE OF SERVICES THEY USE. TOTAL RECIPIENTS FOR FFY 1990 USED AS A PROXY FOR TOTAL RECIPIENTS DURING SFY 1990.

NOTE:PERCENTS MAY NOT ADD DUE TO ROUNDING.

HOSPITAL SERVICES

During SFY90, 17,973 Medicaid eligible people utilized inpatient hospital services. This represents an increase over SFY89 of 8.3%. During this same time period, 65,153 people utilized outpatient hospital services which represents a 4.8% increase from the previous fiscal year.

Medicaid reimburses hospitals for inpatient hospital services at a rate per discharge. During the period from 10/88 thru 9/89, the hospitals 5th payment year established by the Maine Health Care Finance Commission, Medicaid discharges rose to 21,801 which represented a 9.08% increase from the previous payment year. With data being collected currently for the 6th payment year (those hospitals whose payment year began 10/1/89, the data representing 21% of the hospitals, including our large facilities), the discharge data indicates an increase of 12.6% from the 5th payment year to the 6th payment year.

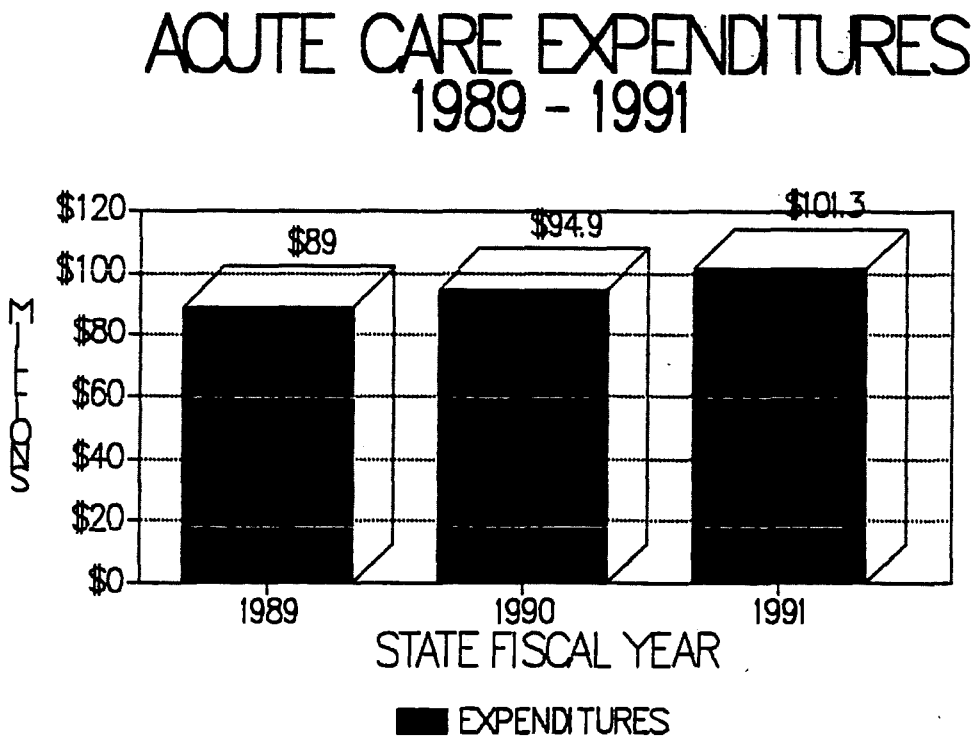
Average length of stay for Medicaid clients is 6.3 days compared to all payers of 6.8 days. Included in this Medicaid data is an average length of stay of 54.73 days at Jackson Brook Institute, the psychiatric hospital in South Portland. This is primarily care for children as Medicaid does not cover anyone between the ages of 21 and 65 in a psychiatric hospital.

Medicaid is required by regulation to identify hospitals which serve a disproportionate share of low income people and provide additional funds to reimburse for their care. The determination is based on a facility's Medicaid utilization. The inpatient utilization rate must be at least one standard deviation above the Medicaid inpatient utilization of all hospitals receiving Medicaid payments or have a low income inpatient utilization rate exceeding 25%. Maine also defines a disproportionate share hospital as one that has a Medicaid utilization rate equal to 15% or greater based on Medicaid charges. The hospital must also have at least two obstetricians with staff privileges or in rural areas any two physicians with staff privileges who have agreed to provide obstetric services to individuals entitled to such services under Medicaid.

As the Bureau finalizes PY5 (10/1/88-8/30/90), there are nine hospitals that are identified as disproportionate share facilities which have incurred an additional Medicaid obligation of $3,246,577.

Days waiting placement to subacute care either provided at home or in a long term care facility have declined from 42,886 reported in 1987-1988 to 39,931 days in PY5. Days waiting placement are reimbursed at the state-wide average rate for either SNF or ICF level care until 10/1/90, and then at a "blended" statewide nursing facility rate.

The bar chart below demonstrates the rate of growth in acute care expenditures for the period 1989 to 1991.



1991 DATA IS PROJECTED

INTERMEDIATE CARE AND SKILLED NURSING FACILITIES

Maine currently has 9,345 ICF beds in 137 facilities. The per diem rate for ICF services averages $62.98 per day as of December 31, 1990. Maine currently has 546 skilled beds in 24 facilities. This is a decrease of 57 beds from December, 1989. In addition, there are 185 Nursing Facility (NF) "swing beds" in three hospitals. The per diem rate for SNF services averages $89.00 per day. As of 10/1/90, as a result of the Federal Nursing Home Reform Act, all facilities are called Nursing Facilities and meet the same standards. However, there will still be different levels of care at different rates of payment.

Maine's ratio of ICF (excluding ICF/MR) beds to SNF 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 advocate for expanded access to SNF-level beds through the development of

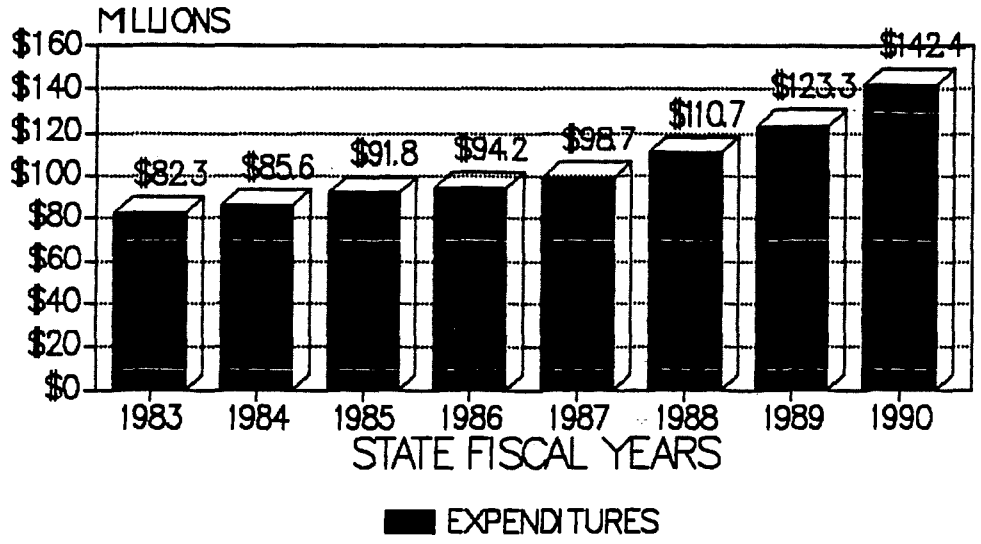
dual-certified facilities and the expansion of the number of hospital swing beds. The Department is working with the nursing home industry to promote the wide-spread availability of Medicare-certified beds. Many of the Medicaid-eligible residents in our general ICF's would be eligible for Medicare payments either on admission or when returning to a nursing home after we have paid to hold a bed. If more facilities were participating in the Medicare Program we could draw down more Federal payments to offset Medicaid costs. The lack of Medicare-certified beds also denies access to skilled nursing facility care covered under Medicare for many elderly who pay privately for a benefit to which they are entitled.

Significant changes were made to the Principles of Reimbursement for Long Term Care Facilities as a result of Public Law 567, An Act to Provide Reasonable Cost of Wages Paid to Employees of Long Term Care Facilities. The changes reinstate the prospective rate based payment system for variable costs to include employee salary, wages and benefits using a base year of the preceding fiscal year; the elimination of the routine service cost limit (223 limit); and the development of the Maine Health Care Facility Economic Trend Factor. Rules were also promulgated for intensive rehabilitative skilled nursing care services for individuals with traumatic brain injuries. Several lengthy State Plan Amendments had to be submitted to the Health Care Financing Administration (HCFA) for approval to support the changes required in the long term care principles of reimbursement and to incorporate the Omnibus Budget Reconciliation Act (OBRA) of 1987 requirements for long term care facility services. The OBRA changes collapse the current two levels of care (intermediate and skilled) into a single category of care entitled nursing facility (NF).

There have been several changes in the Principles of Reimbursement in the past two years to deal with staffing shortages as well as extraordinary increases in certain other costs. Passage of Public Law 567 during the 114th Legislature also contributed significantly to increased costs for nursing homes. According to 1989 data, nursing home rates (ICF) in Maine are the 8th highest nationally, and the SNF rates are the 10th highest. Expenditures for long term institutional care increased 14.9% from SFY89 to SFY90. Nursing facility (not including ICF/MR) expenditures accounted for 35.3% of all Medicaid expenditures in SFY90. With ICF/MR expenditures, long term care accounted for 45% of all Medicaid expenditures.

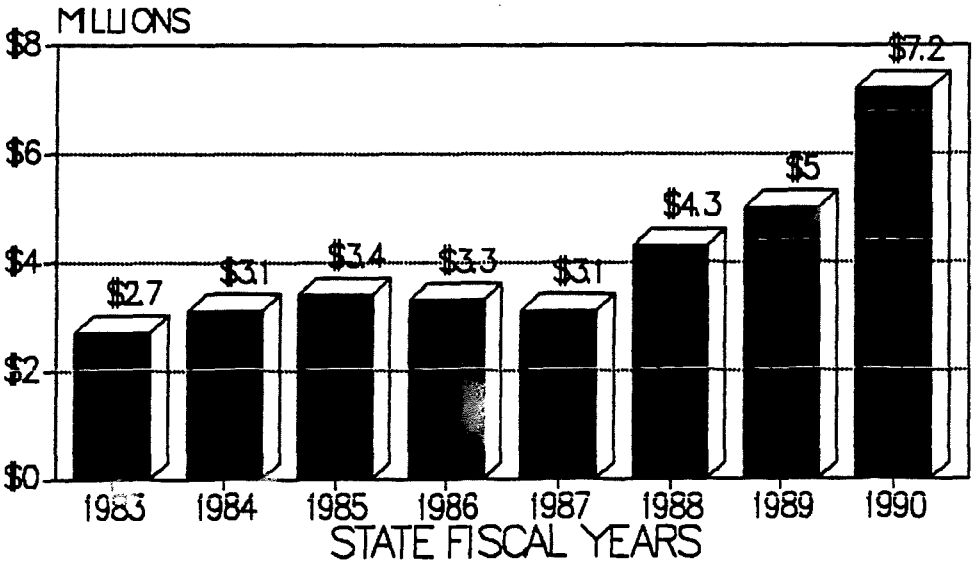
The year to year trends in expenditures for ICF and SNF care are displayed below.

ICF SERVICES
MEDICAID EXPENDITURES



SOURCE MR-O-12 & 1990 ACT.

SNF SERVICES
MEDICAID EXPENDITURES

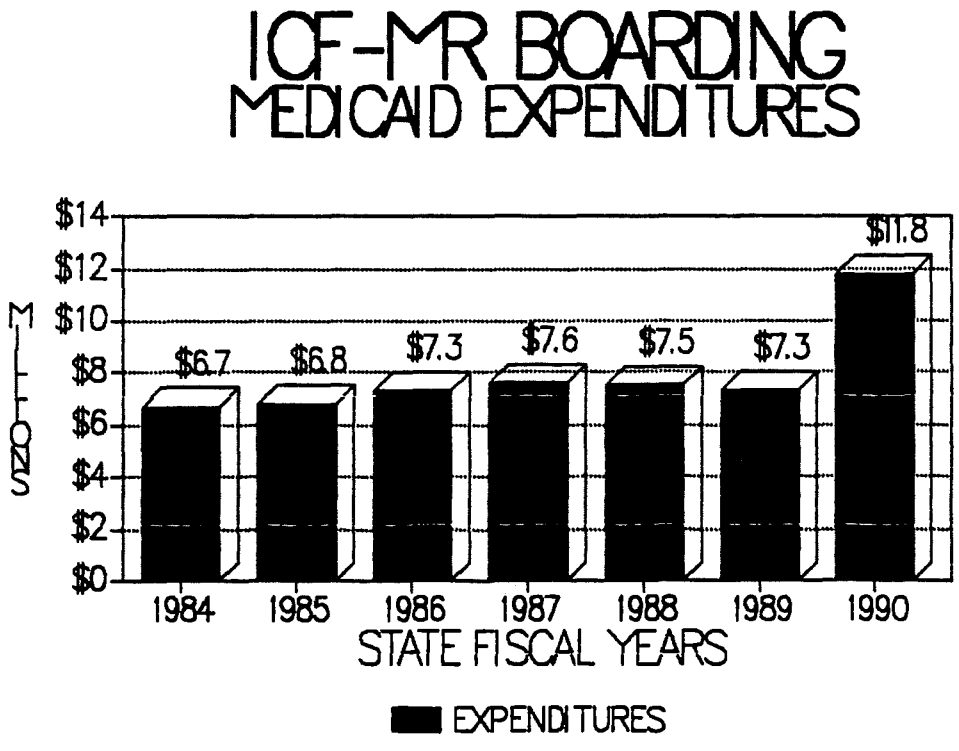


SOURCE MR-O-12 & 1990 ACT.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES

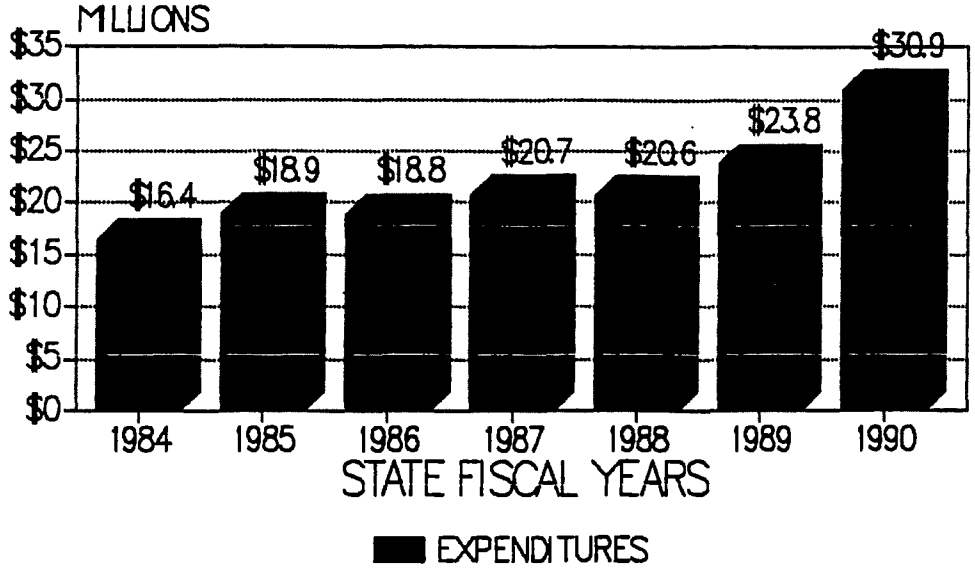
During 1990 there were 13 ICF/MR nursing facilities with 217 beds and 30 ICF/MR group homes with 219 beds. In addition, there are 219 nursing and 76 group beds at the Pineland Center. During the 114th Legislature, the "parity" bill was passed which required the Department to implement the recommendations of the Staff Retention Advisory Committee. This required a career ladder for employees of ICF/MR facilities compared to State job classifications and comparable wages. As a result of this legislation, per diem rates to Intermediate Care Facilities for the Mentally Retarded have increased an average of $50.52 per day. Expenditures in SFY90 increased by 27.5% over SFY89 costs, primarily as a result of the "Parity Bill." In addition to the costs of ICF/MR services, residents of these facilities also attend day habilitation programs at a cost of $53.60 per day of attendance.

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 evident in these graphs.



SOURCE MR-0-12 & 1990

ICF-MR NURSING
MEDICAID EXPENDITURES



SOURCE MR-0-12 & 1990

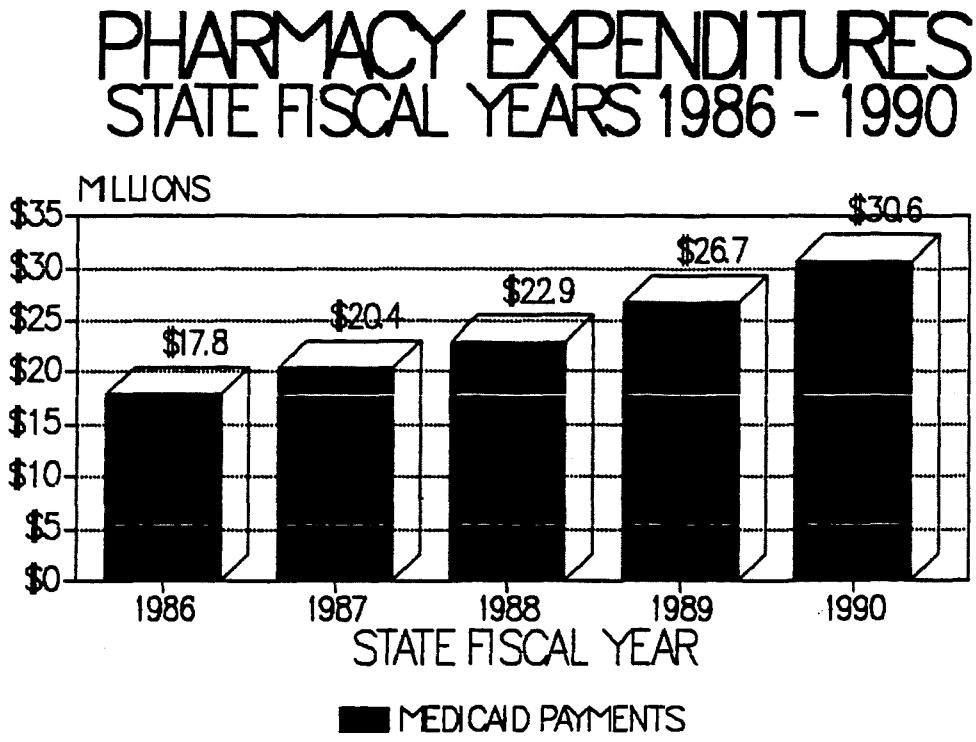
PHARMACY SERVICES

The largest expenditure for non-institutional services is for prescription drugs. Although only about 10,000 recipients or 8% of total recipients, utilize nursing home services (including skilled nursing and facilities for the mentally retarded), 28% of pharmacy expenditures are for residents of these facilities. Pharmacy services are not billed separately for hospital care, so those costs are not included in these expenditures.

There are three regional drug utilization review committees which meet regularly to review data on drug claims and printouts from the surveillance and utilization review system. Special studies have been done with letters to physicians which resulted in significant reductions in prescribing certain medications. With the loss of the full-time pharmacist who retired, and a pharmacist consultant only one day a week, these activities have been somewhat curtailed.

The 114th Legislature authorized the establishment of a formulary committee to develop policy on limiting certain prescription drugs. The intent was to limit access to later generations of drugs with no therapeutic benefit over existing products, but as sole source new products very costly. However, Congress passed a Drug Rebate bill in October, 1990 that prohibits Medicaid programs from having restricted formularies and from placing any limits on prior authorization requirements for the first six months from the time a new drug receives FDA aproval. In return, the pharmaceutical companies must give rebates to states to equal the "best price" they give to large purchases, such as the Veterans Administration and large HMO's. Pharmaceutical Manufactures have not entered into an agreement with the Secretary of Health and Human Services for rebates, any drug claims for that manufacturers product will not be eligible for Federal match. The drug rebate program was implemented January 1, 1991 and the Congressional Budget Office predicts significant savings. However, prices of drugs have increased significantly.

The chart below shows the growth in pharmacy expenditures.



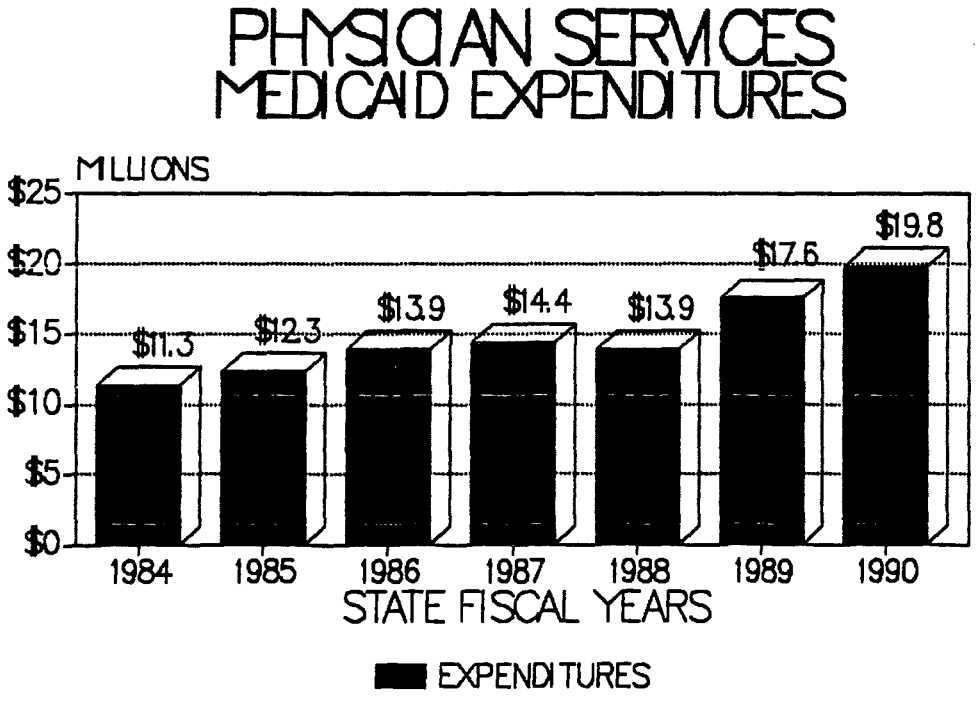
BUREAU OF MEDICAL SERVICES

PHYSICIAN SERVICES

Physician expenditures rose at a rate well below medical care inflation for most of the 1980's. The Bureau continued to meet with the Physician Advisory Workgroup and the Human Services Development Institute of the University of Southern Maine to develop the Resource Based Relative Value Scale (RBRVS) fee schedule, which was implemented October 1, 1990. The goals of the RBRVS are to 1) increase Medicaid physician payments; 2) achieve greater equity in Medicaid physician fees by reducing unjustified differences in fees among and within medical specialities; and 3) increase access to medical care for Medicaid recipients.

Although much work has been accomplished by this project, the fee increase is seen as the first in a systematic revision of the physician fee schedule. Fees for anesthesiology, radiology and laboratory services also need revision. An agenda must be developed to address these services as well as to further improve the equity of physician fees under Medicaid as additional funds become available and as refinements are made in the Harvard RBRVS.

The bar graph below shows the trend in physician expenditures from 1984 to 1990 for the Medicaid program.

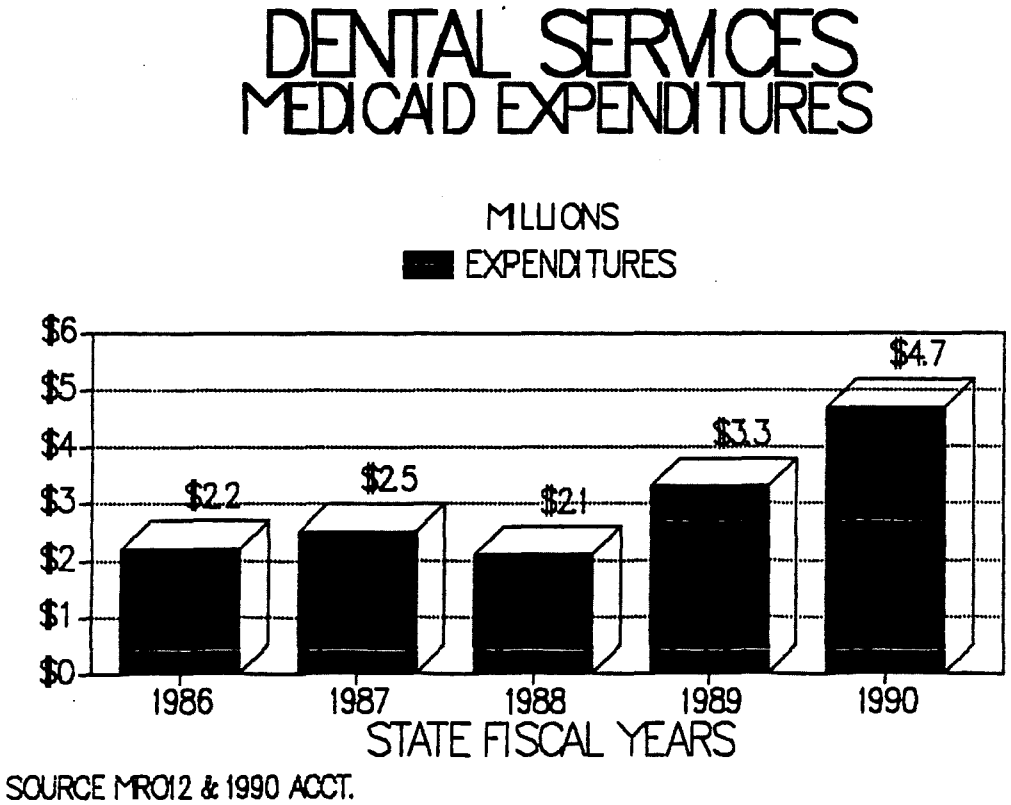


DENTAL SERVICES

Comprehensive dental services have been covered for children for many years, as required under the Federal EPSDT (Early Periodic Screening, Diagnosis and Treatment) regulations. Orthodontia services must be prior authorized, using a scale to rate the severity of the malocclusion or displacement of teeth. Once orthodontia treatment is initiated, coverage continues until the course of treatment is completed. If Medicaid eligibility is lost during this time, the cost is paid from all State funds. During SFY90 $136,389 was spent for orthodontia for children no longer eligible for Medicaid coverage.

SFY90 was the first full year of coverage for adult dental care. Approximately 23.85% (9,300) of the total number of recipients receiving dental services (39,000) were 21 or older. They accounted for 40.42% ($1,848,834) of all Medicaid dental expenditures ($4,573,994). Almost 56% ($1,033,695) of all dental payments for adults were made for dentures.

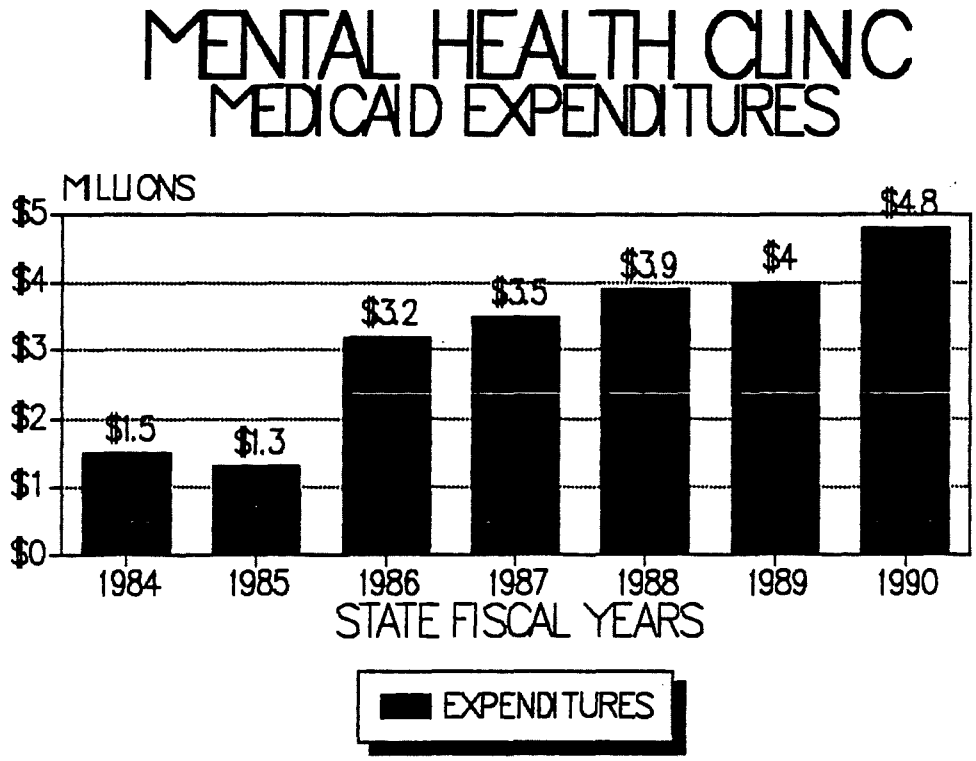
The graph below shows expenditures for dental services from 1986 to 1990.



SOURCE MRO12 & 1990 ACCT.

MENTAL HEALTH CLINICS

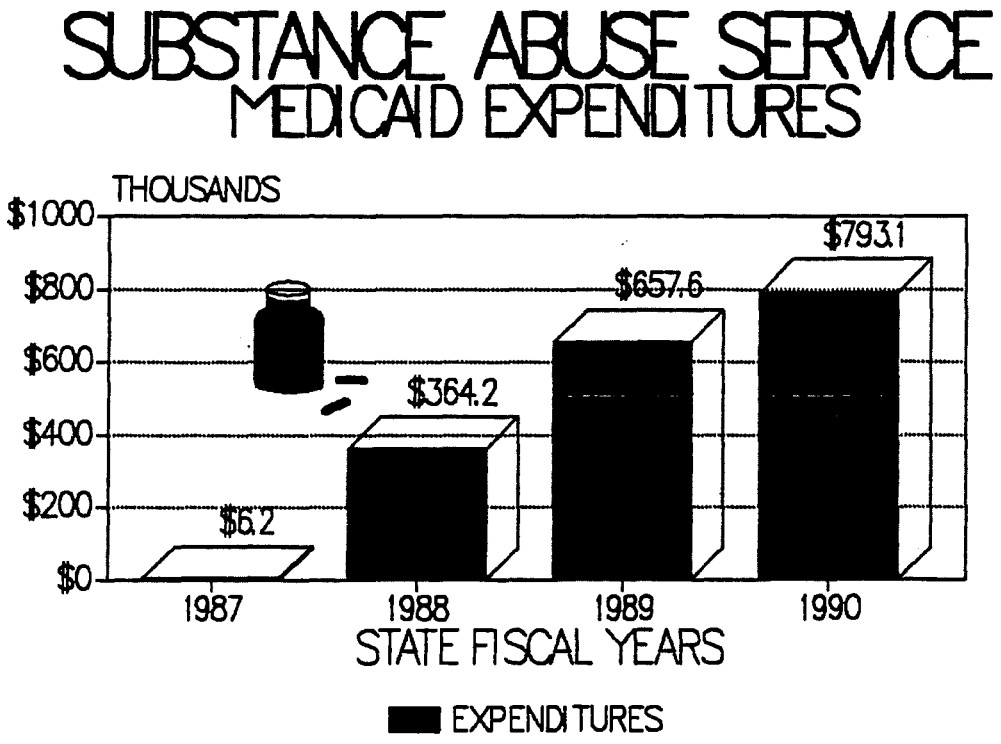
The rate of increase in mental health clinic expenditures decreased in 1989 after tripling in the previous six years but then increased by 20% in SFY90. The expenditures for mental health clinic services continue to increase significantly, and increases can be expected to continue as the Augusta Mental Health Institute Consent Decree is implemented. There are presently 11 mental health centers in Maine, and another ten on the border, eligible for Medicaid reimbursement. The Bureau of Medical Services is working with the Bureau of Mental Health in the Department of Mental Health/Mental Retardation to explore expansions of eligible providers and in promoting cost efficiencies.



SOURCE MR-O-12 & 1990

SUBSTANCE ABUSE SERVICES

Substance abuse expenditures in the Medicaid Program have grown rapidly in the last three years, as the Department developed policy to draw down Federal match for these services and made policy revisions to cover more of the programs once funded by total State dollars.



SOURCE MR-0-12 & 1990

V. ANNUAL FEE REVIEW

The Bureau of Medical Services held a meeting of representatives of fee-for-service provider associations and the Medicaid Advisory Committee on August 21, 1990. All of the fee-for-service categories of providers were invited to come together in order to foster an understanding of the problems or concerns of other providers as well as to become more aware of the demands placed on the Bureau of Medical Services in prioritizing the services targeted for fee increases in light of competing requests and in an environment of fiscal constraint.

There were common themes across the provider types:

- Because Medicaid fee-for-service rates remain frozen at current levels, providers are forced to cut services to Medicaid clients in order to maintain a certain level of income.

- Record-keeping requirements should be reviewed to determine if they could be lessened, enabling providers to cut costs in that area.

- Medicaid is currently paying for services in higher-cost institutional settings or provided by cost-reimbursed providers because private practitioners cannot recover the cost of providing services to Medicaid clients. Support for community-based services could reduce overall expenditures.

- Preventive care was seen as an important part of the provision of service. By keeping people at home in the least restrictive environment and functioning at their best level, an investment is being made in keeping people out of the high-cost settings.

- When fee increases are approved, the time lag in implementing them often makes them outdated.

Other provider specific concerns were raised which also deserve consideration:

- Dentistry - The use of co-payments was urged in order to instill a sense of responsibility in clients. It was recommended that tax incentives for free care be sought.

- Nurse Midwives - The services provided by nurse midwives should be reimbursed at the same level as physicians. Policy changes already drafted in this area, as well as to allow reimbursement of their ob/gyn services should proceed.

- Ambulatory Care Clinics - Services provided by these clinics should also be reimbursed at the same level as physicians. It was noted that a certified nurse practitioner in this setting receives a lower reimbursement rate than a private practitioner.

- Family Planning - While reimbursement rates have been good in this area, largely due to the 90% federal match, the services of family planning agencies are underused.

- Ambulance - The current level of reimbursement is not enough to reimburse the full cost of transferring patients. This has become more troublesome as costs have increased in workers' compensation, liability and malpractice insurance, sophisticated training and certification requirements and medical supplies and equipment.

- Physicians - The physicians would rather use equitable reimbursement rather than a tax incentive.

- Transportation - Much money is being spent on transporting children to an orthodontist because of the unavailability of these providers in some areas. It was recommended that the Bureau explore the option of paying an orthodontist to travel to these areas rather than transporting the clients.

Work has been done over the course of the year in a move toward more equitable rates of reimbursement:

- Mental Health Clinics - A fee increase effective July 1, 1990 was implemented for the services of social workers and other qualified staff.

- Certified Family and Certified Pediatric Nurse Practitioners - This service, mandated by OBRA'90, was implemented effective April 1, 1990. Reimbursement rates are at the same level as physicians.

- Physicians - A fee increase was implemented October 1, 1990. This put in place the work of HSDI on a resource-based relative value scale. This fee increase is the first step in the plan for more equitable reimbursement for physician services.

As a result of this year's Annual Fee Review, it is recommended that the following areas receive priority status in targeting fee increases:

- physician services
- therapy services - physical, occupational, speech/language

- private duty nursing and personal care services
- ambulance services

It is our belief that by investing in keeping people at home, overall expenses will be reduced. Ambulance services are included because of the nature of this business. These providers cannot refuse to transport a client based on their payment source while other providers are able to cut services or set "quotas."

VI. ADVISORY COMMITTEES

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 in 1990. It now consists of 21 members, representing consumers, providers, and advocacy organizations; representatives of mental health consumers and providers were added, pursuant to State legislation . 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. Staff from the Bureau of Income Maintenance and the Recipient Relations Unit in BMS also attend these meetings, which are scheduled every four to six weeks.

Since its first meeting in February, 1987, the Committee has addressed a wide range of concerns. During SFY'90 the major issues discussed were access, particularly to physician and dental services and transportation, co-payments for prescription drugs and proposed policy concerning the role of the Medicaid Advisory Committee.

HOME HEALTH ADVISORY COMMITTEE

As a result of legislation passed in the 114th Legislature, an advisory committee of nine providers, consumers and legislators met for the first time in December, 1989. This Committee has reviewed policies for Medicaid coverage, the regulations for licensure of Home Health Agencies, the Federal requirements for Medicare/Medicaid certification and utilization data. A report of the activities of this Advisory Committee has been submitted to the Joint Committee on Human Resources. The assistance provided by Louise Gamache, the Chair of this Committee, in preparing minutes, reports and notices was greatly appreciated.

PHYSICIANS ADVISORY WORKGROUP

One of the initiatives included in the Medicaid policy contract with the University of Southern Maine, Human Services Development Institute, (HSDI) has been to develop a Resource Based Relative Value Scale for setting physician fees. Although increases in payment for visits in various settings and for obstetrical care have been granted, there have been no increases in fees for surgical and other specific procedures for eleven years.

In order to reimburse physicians more equitably, eliminate some of the differences in fees among specialties and among procedures within specialties, and to assure responsible access to services for Medicaid recipients, a first step was taken to systematically increase physician fees.

In June, 1989 the Legislature appropriated $833,000 to increase Medicaid provider fees. These funds were used to revise the physician fee schedule by applying that portion of the Harvard RBRVS judged valid and reliable by external evaluators--the work component rates--to current Medicaid charges to develop relative value-based weights and converted to revised fees.

The Physicians Advisory Workgroup was consulted throughout this process over the course of the year to review preliminary fee schedules and recommend further work and changes. The result was a revised fee schedule implemented October 1, 1990 in which two-thirds of the funds were used to increase medicine care procedures and one-third to surgical procedures.

PREVENTIVE HEALTH PROGRAM PHYSICIANS ADVISORY WORKGROUP

There is another group of physicians that meets periodically to provide advice and guidance concerning the Preventive Health Program, the Early Periodic Screening, Diagnosis and Treatment Program for Children, mandated by Federal statute. The Bureau has sought input concerning policies in order to increase physician participation in the program. Of particular concern has been the standards for screening and the periodicity schedule.

DENTAL ADVISORY WORKGROUP

One of the recommendations made in the report of the first year of experience of the adult dental program was that an advisory committee be established to assist the Department's Dental Consultant and to provide an effective liaison to the dental professions. The first meeting was held in February of this year, with another meeting scheduled in April. One of the primary tasks of this workgroup will be to review and make recommendations concerning current policy related to the standards and criteria set forth in the Medical Assistance Manual, as well as the current fee schedule, related to dental services. The main issues identified were access, denture policy and high incidence of full mouth extractions, and orthodontia criteria.

VII. PROGRAM FINANCING AND ADMINISTRATION

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 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 68.86%. The Federal share has dropped to 65.57 for SFY90 and is 63.49% for SFY'91. One exception to this service match is for family planning services, which are matched by the Federal government at 90%. Although total expenditures increased 9% from SFY89 to SFY90, because of the decrease in the Federal share, the increased cost to the General Fund was substantially greater.

In delivering a total of $419 million in services, the Bureau expended $10.5 million administering the program. The percent of administrative overhead, 2.5% , is exceptionally low.

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.

The State's share of funds is appropriated primarily within the three major accounts. However, major efforts in recent years to take maximum advantage of Federal matching funds has resulted in the inclusion of a number of services which have traditionally been funded through other accounts. Therefore, 100% State funds are 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, the Bureau of Children with Special Needs and the Bureau of Mental Health, thereby bringing in Federal funds for services such as case management, mental health services, waiver services, day habilitation and ICF services for people with mental retardation 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 mental health services for adult protective cases. The Department of Mental Health and Mental Retardation provides seed money for any Medicaid-covered services in State facilities such as the nursing home units at AMHI and BMHI and for ICF/MR services; day treatment services; Medicaid waiver for people with mental retardation; 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.

The Department has had ongoing policy development to maximize Federal funding of services provided by other State agencies. In addition, a major initiative to expand Medicaid services to children and families and draw down Federal matching funds was implemented in 1990. Funds were appropriated by the Legislature and the Bureau of Medical Services was charged with the responsibility for the development and implementation of the Medicaid Plan for Children and Families, to be coordinated by the Interdepartmental Council. A contract was awarded to the Institute for Human Services Management of Bethesda, Maryland who is subcontracting with CARES, Inc. of Augusta, Maine, to pursue all possible options for enhancing funding and services to families and children. The results of this initiative are being reported to the Legislature directly through quarterly reports and a series of plans culminating in the final plan due by December 31, 1991.

The Financial Services Unit, a part of the Bureau Administration Office, is responsible for monitoring administrative and service expenditures of the Bureau of Medical Services and the supervision of the Division of Medical Claims Review. This unit is also responsible for analyzing hospital expenditure data, developing new policies and principles of reimbursement for both long term and acute care services.

The Unit submitted a State Plan Amendment to HCFA related to the definition and treatment of disproportionate share hospitals. The Maine Medical Assistance Manual was also changed to reflect the disproportionate share computations. The Unit worked with industry, HCFA and Departmental staff in effecting these changes to the State Plan, Principles of Reimbursement and Maine Medical Assistance Manual. This unit also submitted the nursing home reimbursement changes to HCFA, after a similar lengthy process with the nursing home industry.

Amidst these many policy changes the daily activities of the Unit continued unabated. The staff continued to provide monthly budget reports with projections for over and under expenditures.

The computation of the monthly charge data, and the TEFRA calculations were completed to allow hospitals to comply with Federal, State and Maine Health Care Finance Commission rules. The Unit staff participated in the review and comment on new rules drafted by the Maine Health Care Finance Commission. The Unit actively intervened and has participated in informal negotiations in over 200 cases with the Maine Health Care Finance Commission and hospitals throughout the State.

Additionally, the staff have completed several activities including analyzing costs of new licensing requirements for ICF/MR's, providing fiscal estimates of costs associated with new legislative initiatives, analysis of the financial status of institutions considered fiscally borderline, assisting in the review of staffing patterns for ICF's undergoing the certificate of need process, analyzing hospital appeals on cases regarding the calculation of the Target Amount Computations, treatment as a disproportionate share hospital, payment arrangements, claims processing issues and treatment of third party liability amounts.

This Unit has had the lead responsibility in the development, training, organization and field testing of the Multi-State Nursing Home Case Mix Payment and Quality Demonstration Project. Funding for this demonstration project was granted by HCFA, and the demonstration is being carried out in conjunction with the Human Services Development Institute of the University of Southern Maine. The staff have also provided technical assistance to the Maine Health Program and the MaineCare Program.

VIII. BUREAU OF MEDICAL SERVICES OPERATIONS

The mission of the Bureau of Medical Services is to

serve 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 1990.

1. Division of Policy and Programs

This Division is made up of two units: the Policy Unit and the Provider Relations Unit, which are described below. In addition to these two major units of responsibility, this division is responsible for the overall administration of three Medicaid Home and Community-Based Waivers. This includes renewing these Waiver Programs, completing the annual reports for HCFA, amending the Waivers as necessary and assuring that other reports and assessments are completed within certain timeframes. During this past State fiscal year we received Federal approval of the five-year renewal request for the Home and Community-Based Waiver for the Physically Disabled. The five-year renewal of the Waiver for Individuals with Mental Retardation was also approved effective July 22, 1990, while the Waiver for the Elderly is not due for renewal until 1993.

The Division of Medicaid Policy and Programs was involved in planning and hosting the Seventh Annual National Home and Community-Based Services Conference this fiscal year. Every state was represented as was the Health Care Financing Administration. Over 200 individuals participated in this successful conference that explored topics such as ethical issues in long term care, case management, quality of in-home services, waiver renewals and reporting, and training.

Policy Unit

The impact of funding cutbacks and reduced staffing has weighed heavily on this unit. Because of the reduced funding, the unit has launched a major rulemaking campaign to implement services to maximize Medicaid reimbursement for services currently provided with total State dollars. Staff turnover in this unit has made this effort more difficult and time-consuming. However, the activity in this unit remains at a high level. Many revisions and additions to the Maine Medical Assistance Manual were made or initiated during SFY90. The following listing outlines these amendments:

New Coverage Policy

. Ambulatory Surgical Center Services	Effective 4/1/90
. Day Health	Effective 6/15/90
. Home Based Mental Health	Effective 8/1/90
. Certified Family and Pediatric Nurse Practitioners	Effective 4/1/90
. Private Non-Medical Institutions for Medical and Remedial Services	Effective 3/1/90
. Rehabilitation Services	Effective 8/1/90
. Case Management for Children Birth thru 5, with or at Risk of Developmental Delays	Effective 7/1/90
. Case Management for Adults in Need of Protective Services	Effective 7/1/90
. Case Management for Children at risk of or Having been Abused or Neglected	Effective 7/1/90
. Case Management for Children in the Care or Custody of the Department of Human Services	Effective 7/1/90

Policy Amendments

. Ambulatory Care Services - changed to allow the provision of services to individuals age 21 or older. (Effective 11/1/89)

. Case Management for People with Mental Retardation - increased reimbursement to reflect the cost of providing the service and from a weekly to a monthly rate. (Effective 5/1/90)

- Day Habilitation Services - reinstated coverage of "freestanding" day hab retroactive to 7/1/89. (Effective 5/1/90)

- Home and Community-Based Waiver for the Physically Disabled - amendments allow evaluations to be performed by either an OT or an RN and gives the consumer the primary authority for supervision of personal care attendants. (Effective 9/1/89)

- Home and Community-Based Waiver for People with Mental Retardation - established timeframes for the submission of client assessment forms to the Bureau, increased reimbursement for foster care services, and case management as well as changing the unit of case management services from weekly to monthly. (Effective 5/1/90)

- Dental Services - clarified criteria for prior authorization of orthodontia and allowed reimbursement of the hospital admission visit prior to surgery. (Effective 10/1/89)

- General Administrative Policies and Procedures (Chapter I) - implemented certain sanctions for nursing homes. (Effective 11/15/89)

- Home Health Services - redefined covered and non-covered services and levels of care provided to individuals at home and clarified record-keeping requirements. (Effective 8/1/90)

- SNF/ICF/ICF-MR Services - defines service coverage for individuals with traumatic brain injury residing in a SNF or a dual-licensed nursing facility. (Effective 9/1/89)

- Physician Services - clarified sterilization procedures and provided a fee increase for certain medical and surgical services (Effective 10/1/90), added coverage of the potential acuity meter (Effective 9/1/90) and redefined coverage of group psychotherapy (Effective 11/1/90).

- Optometry Services - added coverage of certain non-surgical procedures and clarified reimbursement for eyeglasses for adults. (Effective 7/1/90)

- Optician - clarified reimbursement for eyeglasses for adults. (Effective 7/1/90)

- Pharmacy Services - changed drug prices under the Federal Upper Limits Program and MMAC guidelines and increased the co-payment from $.50 to $.75. (Effective 12/1/89)

- Podiatry Services - expanded covered services and allowed certain surgical procedures to be provided in an office setting. (Effective 7/29/89)

- Preventive Health Program - allowed ambulatory care centers to be PHP providers. (Effective 8/1/89)

- Private Duty Nursing/Personal Care Services - redefined family members and requirements for home health aides. (Effective 10/1/89)

- Rural Health Clinic Services - clarifies criteria for services provided in an individual's home by an RN. (Effective 11/1/89)

- Substance Abuse Treatment Services - expanded reimbursement options for non-residential rehabilitation and expanded the definition of other qualified staff to include associate substance abuse counselors. (Effective 11/1/90)

- Transportation - reinstated coverage for transportation to day hab services. (Effective 7/1/90)

- Psychiatric Facility Services - changed the name of this policy from "Inpatient Psychiatric Facility Services" and added coverage of outpatient services and partial hospitalization. (Effective 11/1/90)

- Mental Health Clinic Services - provided fee increases for social worker and other qualified staff services, redefined limits for psychotherapy and psychometric testing as well as allowing intervention and collateral services by psychological examiners. (Effective 11/1/90)

- Psychological Services - redefined limits on psychotherapy services and psychometric testing, added collateral contacts for psychologists and psychological examiners as well as intervention services for psych. examiners. (Effective 11/1/90)

This Division is heavily involved in the development of a Medicaid Plan for Children and Families as a result of Chapter 103 Resolves. A project director has been hired to coordinate the activities of the contractor, Institute for Human Services Management, and liaisons and other staff in the Departments of Education, Mental Health/Mental Retardation, Human Services, and Corrections. This plan is expected to identify services in each of the four departments that are currently supported with total State dollars that can be brought under the Medicaid Program. In addition, this Plan is to identify gaps in service and put together a plan for securing the funding for these services.

It is hoped that computer technology can be obtained for staff in this division. Most all of the work performed here would lend itself well to computerization, thus decreasing the demands on an overworked, short-staffed clerical unit and allowing more efficient use of each person's time.

Provider Relations Unit

The Provider Relations Unit continues to be understaffed in FY July 1989-June 1990 partly due to the excellent background staff members receive on the job which then enhances their chances of promotional opportunities. In addition, the hiring freeze this year has made it difficult to fill positions when they are vacated and two positions were lost to layoffs, and two other positions turned over due to "bumping". Despite these difficulties, dedicated staff in the unit have managed several state-wide group education sessions introducing new Medicaid policy pertaining to Podiatry Services, Ambulatory Surgical Centers, Private Non-Medical Institutions for Medical and Remedial Services, Case Management for Children Aged 0-5 Who Have or Are at Risk for Developmental Delays, Case Management for Adults in Need of Protective Services, Certified Nurse Practitioners and for providers participating in the Social Services Program. Numerous other educational opportunities have been provided for many different provider types in smaller groups and one-on-one throughout the State. Unfortunately, our efforts to provide group education in the field have limited the availability of staff to provide telephone coverage for provider calls.

The Provider Relations Unit has become more heavily taxed as a result of the decreased staffing levels and increasing workload. Because of the volume of phone calls (over 400 incoming calls per week) and correspondence received by this unit and the staff shortages, these staff members are unable to keep pace with the workload. They find themselves dealing with a provider community that is becoming increasingly frustrated with their inability to access the assistance of a provider relations specialist.

Our future goals will concentrate on a much deserved reclassification of a very responsible position, the addition of computer terminals for each staff member to accomplish a more efficient use of time, and an effort to fully staff the Provider Relations Unit so that we can be more accessible to Medicaid providers, thus improving access to heath care for the ever increasing Medicaid consumer population.

2. Division of Consumer Services

Considerable staff resources are committed to medical eligibility determinations for institutional nursing facility placement and community based long term care 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 do 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.

Approximately 200 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. An average of 50 consultations per month were provided to hospitals and nursing facilities on behalf of Medicaid eligible clients seeking admission to a nursing facility.

The number of out-of-state Skilled Nursing Home (SNF) placements for Traumatic Brain Injury (TBI) clients remains an average of 24 clients in any given month. The number of applicants this past fiscal year, however, has dramatically declined to 8. The newly developed in-state SNF with TBI beds has contributed to the decline in applicants for out-of-state services. The majority of out-of-state TBI clients have an average length of stay exceeding 18 months. Gaps in the continuum of TBI resources are prolonging out-of-state SNF placements. The development of more TBI specialized SNF services currently in progress will continue to keep more TBI clients in-state and the numbers of out-of-state clients is expected to decline even further. Staff are working with various organizations in addressing the need for a variety of TBI services beyond SNF care.

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. Some of these unmet needs include psychiatric services for bed-bound geriatric clients in nursing facilities.

Bed Hold authorizations for clients temporarily hospitalized from a nursing home setting were again tallied this past year. 2,489 Bed Hold authorizations were granted with an average of 48 a week. This is a 68% increase over the last fiscal year. Clients are living longer and have more complex medical needs.

In spite of the 114th Legislature authorizing two nurse positions and one clerical position, no additional staffing was approved for this Division. One clerical position was vacated and remained vacant with no prospect for filling the position. With Maine becoming a Case Mix Demonstration state, one nurse participated in state-wide training in the initial year of this project. The lack of personnel resources has resulted in the curtailment of consultation services and the discontinuation of on-site provider training.

In addition to the 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 575 calls are received per month. The majority of the 700 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.

3. Division of Surveillance and Utilization Review

As the result of surveillance efforts in SFY 90, $278,258 in new overpayments were identified and a total of $239,994 was actually recouped from providers. The Division opened 191 provider cases for review and completed 183 cases.

The large scale reviews of 24 home health agencies are near completion. As of March, 1991 overpayment amount totaled $115,811. 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 90 the Division's recipient unit opened 193 new cases to review possible misutilization of the health care system. Seven recipients were added to the restriction program which currently enrolls 24 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. At any given time, 214 individuals are being monitored by the staff in this unit.

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. As the number of claims increases, it is increasingly difficult to maintain an effective surveillance and utilization review program with existing systems.

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

4. Division of Medical Claims Review

Maine is one of 14 states that does not contract with a fiscal intermediary, although we do contract for keypunching. During SFY90, 4.1 million claims were processed. Electronic claims has increased from 10% to 17% with the addition of nursing homes, boarding homes and pharmacies. The average number of days from receipt of claim to pay order date is 18 days in SFY90. The average cost per claim was one of the lowest in the nation.

Data Control & Inquiry Unit

Mail room staff sorted, dated and I.D. stamped and photographed between 14,000 and 23,000 claims daily in SFY90 and mailed out a total of 2.4 million claims to providers for future billing. Approximately 3,000 checks were sent to providers weekly.

Error Corrections/Adjustments/Provider File

The Error Corrections Unit evaluates suspended claims determining if they should be paid, partially paid or completely denied.

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.

A new online adjustment screen to eliminate manual processing has been designed and implemented. 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.

The Error Corrections Unit is now short four claims evaluators and two Clerk II's. This shortage of staff will delay the resolution of rejected claims, increase the suspension rate and delay payment 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 $98.4 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 $4.4 million was recouped, an average of over $351,000 for each staff person in these positions.

These recoupments were from sources such as health insurance companies, Medicare denials, and accident awards.

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 21,714 prior approvals for certain services. Requests totaling $6.2 million were either denied or deferred for more information.

Organ transplant approvals - July, 1989 - June, 1990:

. Bone marrow	14
. Heart	4
. Heart-lung	3
. Kidney	2
. Liver	3
. Lung	2

Total expenditures for clients with AIDS from January, 1989 to March, 1990 was $1,110,259 for 97 recipients.

Financial Data Control

This unit is responsible for all checks which come into the Division plus the verification of our weekly claims and financial reports. They received 6,575 checks for fiscal year ending June 30, 1990 which totaled $11,052,483. There are currently collectible accounts receivable of $3,517,284. Without additional legislation being requested, an additional $1 million is deemed uncollectible.

5. Division of Health Insurance and Special Projects

The Division of Health Insurance and Special Projects, within the Bureau of Medical Services, is responsible for administering several health care initiatives which target the uninsured population in Maine. These programs include the Maine Health Program, the demonstration grant from the Health Care Financing Administration, and the MaineCare Program. In addition, the Division provides staff support to the Board of the Maine High Risk Insurance Organization.

The Maine Health Program is a new initiative, designed to provide Medicaid-like benefits to low income citizens who meet certain eligibility criteria. It was authorized by statute in 1989 (Public Law 588). Subsequent amendments to the enabling legislation, in 1991, mandated an implementation date of October 1, 1990. Program administration relies largely on the current infrastructure of the Medicaid Program to conduct eligibility determination, process claims, monitor program performance and for other administrative functions. A 12 member advisory committee, appointed by the Governor and by legislative leadership, advises the Department on program policy and development.

Under the Maine Health Program, eligibility for Medicaid-like services is extended to all adults with incomes 95% or less of the Federal poverty level and to Maine children and adolescents through age 17, who are not otherwise covered by Maine's existing Medicaid Program and who are in families with incomes 125% or less of the Federal poverty level. Eligibility for coverage is determined using a formula for countable

household income. Because Medicaid eligibility is based on categorical eligibility, it is expected that many of the prospective enrollees of the Maine Health Program are those people who do not fit Medicaid's categorical requirements: single individuals, and intact families with slightly more income than Medicaid's limits.

In order to maintain enrollees' coverage for a period of time after their income exceeds program guidelines, a transition period is allowed. Enrollees whose family income increases up to 50% beyond the eligibility criteria may continue enrollment in the program, provided they pay a premium. The premium contribution will increase incrementally, as their income rises. They may continue enrollment for a period of two years, provided their income does not exceed the transition income criteria.

All benefits available under the Maine Medicaid Program are available to program enrollees with certain exceptions. Any female who becomes pregnant while enrolled in the program will receive pregnancy related benefits under the "SOBRA" component of Maine's Medicaid Program. Long term care services are not covered by the Maine Health Program nor are case management services as they have been defined by the Maine Medicaid Program.

Enrollees in the program are either covered in total by the Maine Health Program or they are enrolled in employer-sponsored private coverage, with wraparound for the Medicaid benefit not available through the private plan.

Upon application to the program, it is determined whether or not private insurance, through an employer plan is available to the eligible applicant. If not, the individual is enrolled in the extended coverage through the Maine Health Program. If there is coverage available, a series of screens will take place to determine whether it is beneficial and cost-effective for the Department to enroll the individual in the private plan.

Program activities in SFY90 centered on the design of the initiative and its interface with the existing Medicaid Program, and the development and promulgation of program rules. Guidelines were established for the determination of eligibility, the review of employer-supported health plans to determine cost-effectiveness, and the procedures for payment of enrollee premiums for third party coverage. Maine Health Program staff worked with both the Advisory Committee and other Department staff to resolve all design and operational issues prior to the implementation date of October 1, 1990. As a result of budget negotiations in the 1990 legislative session, the program's funding level was reduced to an appropriation of $2,885,716 for SFY91. It was expected that these funds would be sufficient to pay for the nine months of service delivery in that fiscal year.

In addition to the development of the Maine Health Program, Division staff prepared an application to the Health Care Financing Administration in response to a solicitation for proposals to expand health insurance coverage through an extension of Medicaid eligibility to targeted populations. The application requested funding for a demonstration project which would extend Medicaid eligibility to the children and adolescents to be covered under the Maine Health Program. The emphasis of the demonstration was the comparison of costs and utilization between those enrolled in traditional Medicaid coverage, and those enrolled in private coverage through an employer-supported plan. HCFA approved the Department's proposed demonstration in September, 1990; Federal funding of services under the demonstration is due to begin after April, 1991.

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 October, 1990 it had enrolled 279 small businesses with 863 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 became operational in February, 1991.

The Maine High Risk Insurance Organization is a state-wide 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 of Omaha Insurance Company of Nebraska, and is funded by a combination of individual premiums, an assessment on hospitals, and for those enrollees meeting certain income guidelines, premium subsidies from the general fund. Enrollment in the pool is capped at 600, and the program's sunset date is June, 1992.

The Medicaid Buy-In Program for Persons with Disabilities was passed by the State Legislature in 1988. This program is to ensure that working persons with disabilities have access to affordable health insurance regardless of their preexisting conditions. Program design guidelines and criteria were developed.

6. Division of Licensing and Certification

Division staff completed 277 certification surveys during SFY 90 and conducted 454 follow-up surveys involving sixteen different types of providers. Nineteen new providers were surveyed. Four hundred and twenty-four complaints were received of which 362 involved nursing homes. There were two hundred and forty-seven complaints investigated.

Based on staff turnover, the State mandated hiring freeze, voluntary cost savings program participation and extended illnesses, the Division operated for a significant period of time with a 20%+ personnel shortage. This resulted in a backlog of complaint investigations and surveys of Intermediate Care Facilities for the Mentally Retarded.

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 working on revisions to regulations for nursing homes, hospitals, ambulatory surgical centers and Intermediate Care Facilities for the Mentally Retarded. Representatives of the affected providers are included in the development of revised regulations.

7. Division of Residential Care

Licensing activity in SFY 90 involved 217 boarding homes (representing 3,192 beds) and 294 adult foster homes (representing 886 beds). Staff (reduced from previous SFY89) investigated 138 complaints about boarding homes and foster homes. Four conditional licenses were issued to boarding homes and five were issued to foster homes. Appeals of Departmental actions have resulted in a considerable increase of time in litigation. Due to staffing shortages and a backlog in the Fire Marshal's office, 13% of boarding home and 20% of adult foster home licenses had expired with no new license being issued. Sixteen cost reimbursed adult boarding homes were enrolled as Private Non-Medical Institutions under Medicaid, representing approximately 362 recipients. The speed with which this program has been implemented has been hampered by the hiring freeze.

The Division has developed new principles for reimbursement and made changes in the Maine Medical Assistance Manual in order to draw down Title XIX Medicaid funds for the Private Non-Medical Institution program which provides funding for medical and remedial services in some boarding homes.

The Resident Satisfaction Survey, one method the Division is using to evaluate overall program impact on residents, has been developed under the Medicaid Policy Contract with HSDI and administered in the field for the first year. Although the final report and recommendations have not been received, the data collected and resident responsiveness to this project has been extremely positive. Many unforeseen benefits have surfaced since development of this project began in March, 1989. Demographic data, previously unavailable, has been obtained which makes the accountable use of limited resources more possible.