Maine Department of Human Services
Bureau of Medical Services

Annual Report to the State Legislature

Medicaid in Maine

SFY 1999

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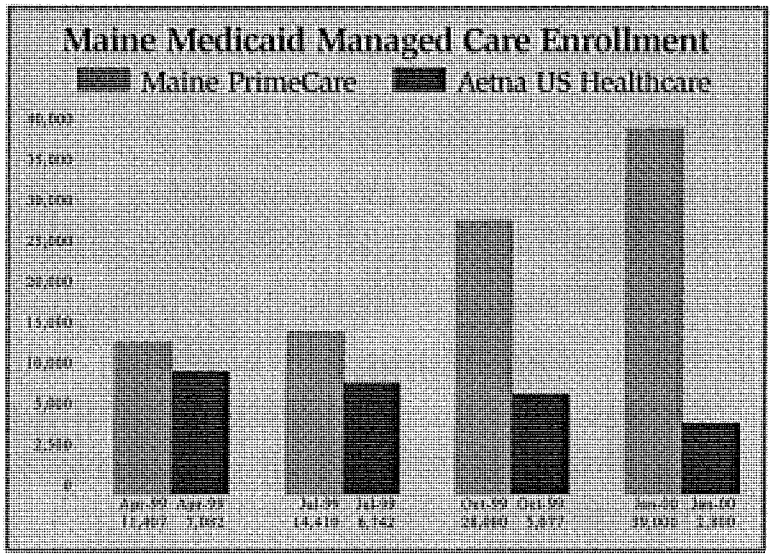
Highlights of SFY 1999

Maine PrimeCare—A New Name and New Locations

Maine PrimeCare is a Primary Care Case Management (PCCM) program operated by the Bureau of Medical Services. Enrollment into the program provides Medicaid beneficiaries with a choice of a primary care provider, establishing a medical home with medical coverage 24 hours a day, 7 days a week. Enrollment has been mandatory in Aroostook, Piscataquis, and Washington counties, Maine's most rural counties, since December of 1996, and has resulted in 8.5% cost savings in managed services from decreases in unnecessary utilization. The program emphasizes the importance of preventive services and provides an environment where those services can be obtained in a timely fashion.



In May of 1999, the Department began to phase in mandatory enrollment beginning in Androscoggin County. Cumberland, York and Somerset Counties are now being phased in. Currently, there are over 35,000 enrollees in seven counties. Completion of Statewide enrollment for beneficiaries receiving Medicaid under TANF, TANF related, and foster care is anticipated around the end of the year 2000. Maine PrimeCare will be offered as a choice to individuals when the mandatory HMO program is implemented in the next year. Once the Statewide phase in is completed, the Bureau will expand Maine PrimeCare to serve the high needs populations, the elderly and disabled.

Cub Care and Medicaid Expansion Enrollment Climbs

The Balanced Budget Act of 1997 established the *Children's Health Insurance Program* (CHIP) under Title XXI of the Social Security Act. Title XXI enables states to provide health insurance coverage for children by expanding Medicaid and/or creating new state programs.

In Maine, the 118th Maine Legislature established the Maine Commission on Children's Health Care to consider the problem of uninsured children in Maine and to review options for providing health insurance under Title XXI.

The Commission recommended that the State (1) expand Medicaid, (2) create a separate program called Cub Care, and (3) provide Medicaid and Cub Care enrollees who lose eligibility due to changes in income an option to purchase coverage. Legislation to implement the recommendations was passed and signed into law in April, 1998.

The *Medicaid Expansion* was implemented July 1, 1998. It provides coverage to children ages 1 through 18 living in families with income up to and including 150% 0f the federal poverty guidelines. As of November, 1999, 5,451 children were enrolled in Medicaid as a result of the expansion.

Cub Care was implemented August 1, 1998. It provides coverage to children ages 1 through 18 living in families with income up to and including 200% of the federal poverty guidelines (up from 185% effective 10/1/99). Cub Care participants must pay a monthly premium based on family size and income. Cub Care benefits are the same as those for Medicaid. As of November 1999, 2,430 children were enrolled in Cub Care.

Through the *Health Insurance Purchase Option* families may purchase coverage for their children who lose Medicaid or Cub Care eligibility due to changes in income. Families may purchase coverage for up to 18 months after the last month of Medicaid or Cub Care eligibility. As of September 1999, the premium was $1200 per child per year and 2 children were enrolled in the program.

The Department will be evaluating CHIP and expects to have a report available by the summer of 2000. The evaluation will look at the impact of this new coverage on the number of uninsured children in Maine and consumer utilization and satisfaction.

Immunizations—Not Just for Kids Anymore

In 1998 the Bureau began assessing the status of adult immunizations. In 1998, influenza and pneumonia, both largely avoidable illnesses with immunization, accounted for 438 deaths in the Medicaid population. In fiscal year 1999, the Bureau began investigating ways of decreasing the death rate and illness rates of its Medicaid population. In conjunction with the Bureau of Health, the Medicaid Program now makes pneumonia and influenza vaccines more available and less costly to providers. Medicaid's nursing facility policy also requires NFs, on an annual basis, to offer vaccinations and educate residents as to their importance. In fiscal year 2000, nursing facilities and physicians will receive from BMS, a list of all recipients who have not been immunized, in an attempt to increase the number of immunizations. At the end of the cold and flu season, the effectiveness of this effort will be re-assessed and any associated cost savings will be calculated.

How Well Is Maine Immunizing Children?

Children's immunization rates for the State of Maine have been consistently high for several years. Recent information indicates that for all Maine children, regardless of payer source, Maine ranks second in the nation. It has not been as easy, however, to measure immunization rates specifically for Medicaid children. Primarily this is because rates for Medicaid children come from claims. Claims data is generally not reliable in developing statistics for a number of reasons including:

1. Most vaccine is supplied by the State so that a provider is paid only for the administration of the vaccine. Many provider offices do not bill for the administration fee.
2. In addition, Federally Qualified Health Centers and Rural Health Centers are paid on a cost basis rather than by fee for service and, therefore, there is no incentive for these providers to report the administration of a vaccine.This is why the Bureau was particularly excited when asked by the Health Care Financing Administration (HCFA) last year to be one of its first pilot sites to measure rates effectively and work to improve those rates once a more accurate rate is identified. This pilot project has given Maine an opportunity to collaborate with nine other States in the Government Performance and Results Act (GPRA). At a site visit this spring HCFA discussed our measurement methodology. The Bureau's computer applications and ability to analyze that data were important factors in these discussions. In the early summer, and again this fall, the Bureau was asked to make a presentation to a national audience on current methodology and plans to improve upon future measurements. This information was presented to the pilot sites selected last year, as well as to a new group of states selected for the year two demonstration. It is expected that continued collaboration with neighboring states, the Federal Government and the Maine Bureau of Health will yield better results in both the measurement tool and the interventions that will occur to improve immunization rates for Maine Medicaid children.

Medicaid Implements the Primary Care Provider Incentive Program

The Primary Care Physician Incentive Program (PCPIP) is a system to reward physicians who have provided quality primary care to Medicaid clients. Physicians receive scores in various categories such as the number of Medicaid patients, emergency room utilization and prevention/quality. Each physician is compared to other physicians in his/her primary care specialty and is then given an overall ranking. Physicians ranking above the 20th percentile will receive a monetary share of their specialty pool, based on percentile. The 20th percentile and below do not receive a monetary share of their specialty pool. The following table provides an example of the possible payments for the pediatric specialty pool.

Primary Specialty: Pediatrics Pool: $274,942.31 # Of Providers: 169

Percentile	# of Providers	% of Pool	$ per Decile	$ per Provider
90-100	17	25	$ 68,735.58	$4,043.27
80-89	17	20	$ 54,988.46	$3,234.62
70-79	17	15	$ 41,241.35	$2,425.96
60-69	17	13	$ 34,367.79	$2,021.63
50-59	17	10	$ 27,494.23	$1,617.31
40-49	17	8	$ 20,620.67	$1,212.98
30-39	17	6	$ 16,496.54	$ 970.38
20-29	17	4	$ 10,997.69	$ 646.97
10-19	17	0	$ 0.00	$ 0.00
0-9	16	0	$ 0.00	$ 0.00
	169		**$274,943.31**	

The Primary Care Physician Incentive Program will be expanded to include the drug management of specific illnesses when there are widely accepted clinical practice guidelines available and when evidence supports the need to implement them. To achieve this enhancement, the automated drug management system will be further utilized to most efficiently collect and process the necessary clinical data. This should substantially reduce the paperwork for providers and at the same time accelerate the initiation of appropriate drug therapy for the patient.

Service Coverage for People with HIV/AIDS

In October 1998, the Bureau of Medical Services submitted an application to HCFA for an HIV/AIDS demonstration project. Approval of this application would grant the State of Maine a waiver of certain portions of Title XIX of the Social Security Act (the Act). This would be accomplished under authority of Section 1115(a)(2) of the Act. The Bureau has requested waivers permitting the Secretary to regard as federally matchable those expenditures that would not otherwise be included as matchable expenditures under Section 1903 of the Act.

The waivers would allow persons diagnosed with HIV disease, or people living with AIDS to have expanded income eligibility up to 300% of the federal poverty level. The demonstration project would allow for a limited benefit package of essential services; such as pharmaceuticals, office visits, laboratory services, inpatient hospital services, and case management services. Maine has also requested a program cap that would limit the number of enrollees to a maximum of 300 people at any point in time.

This demonstration project is designed to delay, prevent or even reverse the progress of this deadly disease, and to be cost neutral to the Medicaid program within 5 years.

Maine's Drugs for the Elderly and Uninsured Expands

On August 1, 1999 *Maine's Drugs for the Elderly Program* expanded. There are now two components to the program: *Basic* and *Supplemental*. The *Basic* component continues to cover prescriptions for drugs from participating manufacturers for particular conditions and illnesses with a $2 or 20% copayment (whichever is greater) by the consumer. The *Supplemental* component allows eligible program members to purchase all drugs from participating manufacturers under the Medicaid Program at the Medicaid price, minus a $2 payment by the State. In addition to this expansion, eligibility requirements were broadened to consider higher income thresholds and also the disability status of the applicant. Income eligibility was increased from 131% of the FPL to 185% resulting in an increase in enrollment from 22,000 to 40,000.

The Basic Program covers 80% of the cost for chronic medications to treat:

Diabetes
Cardiac conditions
High blood pressure
Arthritis
Anticoagulation
Chronic obstructive lung disease
Hyperlipidemia
Osteoporosis
Incontinence
Thyroid diseases
Glaucoma
Parkinson's Disease
Multiple sclerosis
Amytrophic lateral sclerosis

The Bureau will be promulgating rules to create *Maine's Reduced Cost Drugs for the Uninsured Program.* This coverage will be available to legal residents of Maine who have no other prescription drug benefit. Coverage and reimbursement under the program will be made for drugs from manufacturers or labelers with a signed agreement with the Department for rebates. Consumers will be charged the pharmacy's usual and customary charge for the drug, minus the amount paid by the Bureau as a "State Refund."

Vice President of the National Association of Surveillance Officials

A Maine Surveillance and Utilization Review staff member was elected to the office of Vice President of the National Association of Surveillance Officials (NASO). The Association's primary purpose is to provide a mechanism for its members to enhance, develop, and disseminate collective information by exposing its members to new techniques and technology in combating health care fraud, abuse, and waste in the Medicaid Program. Marc Fecteau was elected from a field encompassing all fifty states, Puerto Rico, Guam, and the U.S. Virgin Islands. He will assume the office of President of NASO in July of 2000.

The Case Mix Classification System

The *Case Mix Unit* staff who are responsible for the implementation of the combined Medicaid/Medicare reimbursement and quality assurance system throughout Maine continue to make progress. In SFY 1999, 226 nursing facilities were visited by the Case Mix Nurse Auditors who reviewed over 10,000 Multiple Data Set (MDS) 2.0 items for the purpose of monitoring and evaluating the accuracy of the assessment data. The MDS 2.0 is HCFA's mandated, standardized, assessment tool used to determine the overall payment level for the nursing facility. Sanctions for inaccurate reporting by nursing facilities were restarted effective April 1, 1999 after giving facilities time to become accustomed to this system. Only two facilities have been sanctioned since April.

The case mix system is being implemented in residential care facilities (RCFs). The case mix nurse consultants visited 76 Level II residential care facilities. They reviewed 2,597 assessment records for accuracy. Staff revised the MDS RCA manual and assessment tool for the time study, held in October. 32 residential care facilities will be participating in the time study.

Staff in this unit also held statewide training for nursing facilities and residential care facilities (RCF) regarding Quality Indicators. Ninety-eight percent of the NFs and RCFs were represented. Case mix nurse auditors gave monthly MDS 2.0 training sessions to nursing facilities and MDS-RCA training sessions to the RCFs in each of their geographic districts. Thirty training sessions were held with over 400 people attending.

Initiatives for 2000 and Beyond

Health Insurance for All Maine Children

The Bureau of Medical Services will be working toward the Governor's Initiative to reduce the number of uninsured children in Maine to the lowest number possible. Despite a potential enrollment in the current CubCare Program of 10,000 and an additional 2,000 from moving to cover children in families with incomes up to 200% of the federal poverty level (effective October 1, 1999), another 8,000 lack access to coverage and another 10,000 are eligible for Medicaid, but do not enroll. The high cost of health insurance and reductions in employer-paid coverage are the main causes for the continuation of this problem.

Eliminate Placement of Children in Out-of-State Psychiatric Facilities

Since the early 1990's, an increasing number of children have been sent out of State for psychiatric treatment services. Maine has not instituted an across-the-board policy requiring all children to be served in Maine. The State has already made significant headway in reducing the number of children in out-of-State placements by building the capacity to service them in Maine. The Bureau of Medical Services and other Department staff will work with the Department of Mental Health, Mental Retardation, and Substance Abuse Services toward the goal of reducing the number of children in out-of-State facilities as near to zero as possible.

Medicaid Recipients Receive Coverage from an HMO

The Department currently contracts with one Health Maintenance Organization (HMO) to provide managed care services on a *voluntary* basis for individuals in the TANF (Temporary Assistance to Needy Families, the program which replaced Aid to Families with Dependent Children) or TANF-related categories of eligibility, as well as for foster children. There are approximately 5,000 individuals enrolled in this voluntary managed care program in the counties of Androscoggin, Cumberland, Sagadahoc, York, and Kennebec

The benefit package included in this program includes most of the services covered by Medicaid with the exception of drugs, transportation, behavioral health services and long term care services. Within the next year, this program is expected to become mandatory. Individuals in these counties and others will be allowed to have either HMO coverage or Maine PrimeCare as their choice of managed care coverage.

Access to Dental Services for Children

Dental access for Medicaid recipients continues to be a concern not only for Maine but also for many states across the country.

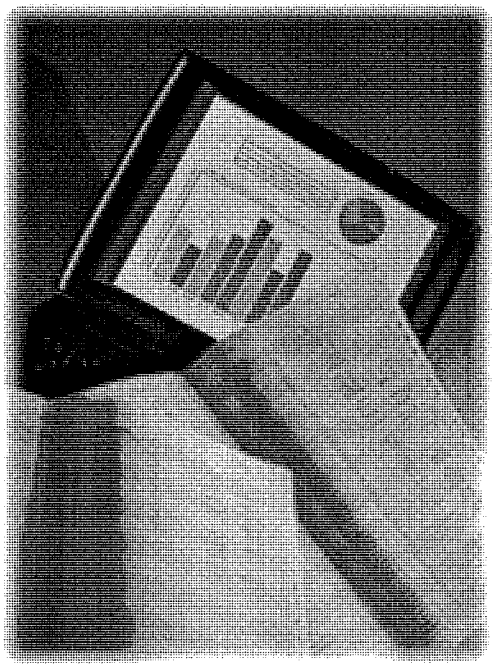
The Maine Medicaid Program and its EPSDT partners, the Bureau of Health Immunization Program (BOHIP) and the Health Benefits Advisor, have embarked on a number of initiatives in the past few years to work to increase dental access for Medicaid recipients.

- In addition to informing Medicaid families regularly that dental services are available under Medicaid and when they should schedule their preventive dental appointments, we offer Medicaid dental providers the opportunity to tell us if they have patients who require additional education on how to use the services appropriately. In turn, the family is contacted by BOHIP and given the appropriate intervention based on the need identified by the dental provider. BOHIP and the Health Benefits Advisor assist all patients who request assistance with finding a provider and obtaining transportation to their appointments.
- In order to provide the best information to recipients about which providers are available to provide dental services, a resource guide is maintained by the Health Benefits Advisor. The resource guide is very closely maintained by:
  –checking the availability of providers identified as accepting new or established patients every 45 days to update their participation,
  –contacting all Medicaid dental providers (not currently accepting Medicaid patients) every three months to update them on new information and try to gain participation, and
  –contacting, once a year, all licensed dental providers not currently participating in Medicaid, to give them new information to try to spark interest in enrolling with Medicaid as a provider of services.
- In addition, the Medicaid Program has reached out to dental providers in a variety of different ways including:
  –the transition to a claim form requested by the dental providers,
  –an increase in fees for services provided, and
  –training to increase awareness of policy and procedures and reduce the frustration that often accompanies the reimbursement process.

In spite of these efforts, access to dental care has increased only for a small number. In the coming year, Maine Medicaid will be working with a coalition of other states to find solutions to this problem. We are very excited about the prospect of gaining new insight and ideas through discussion with our neighbors in other parts of the country. Staff are working with the *Dental Advisory Committee* and will be involved in studying the potential for another increase in rates to bring Medicaid payments for dental services to a higher percentage of provider usual, customary and reasonable charges. The Bureau of Medical Services will also be working with the Bureau of Health to consider the feasibility of dental clinics as an alternative delivery mechanism for some areas of the State.

Replacement of the Medicaid Claims Payment System

The existing *Medicaid Management Information System* (MMIS) will be replaced in the next two years by a new *Claims Management System* (CMS). The existing MMIS is a mainframe, batch processing system, written in COBOL. It was installed in 1978 and was upgraded twice in the early 80's. It is currently unable to provide adequate management information, support changing Medicaid program needs, or integrate effectively with other data systems. The new CMS will break up the functionality of the MMIS into sub-systems that are being built as interconnecting modules. The modular approach will make the CMS flexible in three ways: business functionality, upgrades, and integration with other systems. The CMS project will build a system able to deal with the increased complexity of the Medicaid delivery and billing systems, provide better fiscal and business management tools, and create better information delivery systems.



The first phase of the CMS project started in 1995 with the building of the Bureau's five other systems: MECAPS, MMDSS, MECARE, IMMPACT, and MEPOPS. From this point onward CMS will be a 3-year project. The project will be broken up into three parts. The first step will be the replacement of the MMIS and the building of a separate, but integrated financial system. That work is scheduled to be completed in the middle of 2001. The next step will be systems integration and the Surveillance and Utilization Review (SURS) system. The existing modules and a new SURS piece will be more fully integrated with each other and with the claims processing and financial systems being built. Integration will be started concurrently with portions of the claims processing and financial pieces. It should be completed in the latter half of 2002. The last step constructs a work flow management capability. This will allow workers and management to better access electronic records from across systems and groups. This step, too, will be started concurrently with other CMS work and is expected to be completed in the latter half of 2002. Another component will be an Internet-based electronic network among the Bureau and its 15,000+ providers.

The final result of the CMS work will be a system that is able to handle the present demands of the Medicaid program. Its modular approach will make it adaptable to future Medicaid program changes as well as allowing upgrading to be by component rather than system wide. CMS will provide a solid foundation for Maine's Medicaid Information Systems.

Maine Medicaid Explores Provider Credentialing

At the start of fiscal year 1999, the QM Unit began reviewing the need for a credentialing program for Maine Medicaid providers. This process would allow Maine Medicaid to better screen its providers, thus protecting recipients from fraudulent or incompetent providers. It has determined that several Maine Medicaid providers have had adverse actions taken against them by the Board of Medicine. Because these actions have not resulted in the physician's loss of license, BMS Medicaid staff are developing a method of determining baseline standards and Medicaid policy changes for participation in the Maine Medicaid program as well as a system for tracking providers.

Other Quality Initiatives

Through a study of *emergency room use,* staff of the Bureau's Quality Improvement Division found that 85% of all emergency room visits were for conditions that are more appropriately treated in the physician office setting. In January of 1999, the Division researched and developed an informational fact sheet on the five most common illnesses with which individuals present in an emergency room. These illnesses included nausea, vomiting, diarrhea, common cold, earache and sore throat. A mailing was sent to Maine Medicaid recipients who were seen in the ER with these illnesses in four counties. Staff will spend the next fiscal year reviewing claims to determine if the survey and educational form have decreased the number of emergency room visits for non-emergency reasons and the associated cost savings.

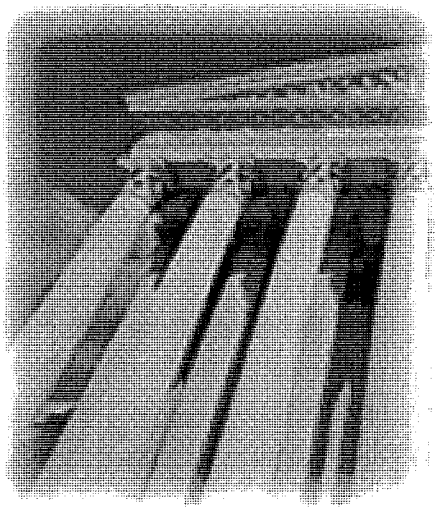
At the start of the 1999 fiscal year, the Bureau began reviewing claims surrounding *smoking related illness.* 64% of all the Medicaid clients over 17 years of age attempted to stop smoking with the assistance of medication. A prior Medicaid survey showed that nearly 50% of adult Medicaid recipients were smokers. Therefore, approximately 12-13% of the Medicaid smokers tries to quit smoking with prescription medications each year, with a 27% success rate measured by survey 9 to 12 months later. Division staff will begin educating providers and recipients on techniques/interventions that have been most effective in smoking cessation. It is the QI Division's goal to increase the non-smoking population by 10% and decrease the cost of smoking related illness by 10% over the next fiscal year.

In late fiscal year 1999, the QI Division began a project to assess the *effectiveness of care and services received by people with diabetes.* A survey of Maine Medicaid diabetic recipients was conducted in the spring of 1999. The preliminary results of this survey reflect that 55% of the population has nerve or circulation problems in their lower extremities, 74% of the recipients surveyed stated they were at risk for foot complications/ infections. The preliminary survey results also reflected that 50% of the providers do not address proper footwear with recipients and 77% fail to address how to prevent foot trauma.

Legislative Corner

During the First Regular Session of the 119th Maine Legislature the Bureau initiated the following 3 bills:

- ❑ LD 1525 **An Act to Improve Medical Support for Children.**
- ❑ LD 2015 **An Act to Amend the Health Care Receivership Laws.**
- ❑ HMO **Sanctions.**



LD 1525 was indefinitely postponed. LD 2015 was passed, approved by the Governor as 1999 PL Chapter 284. The HMO sanctions bill was deferred.

The following are bills that were initiated by parties outside of the Department and eventually passed by the Legislature and approved by the Governor.
In general the legislation listed below requires the Bureau to perform a variety of functions such as participating in study commissions, performing fee reviews and creating new programs:

✓ LD 206 **Resolve, to Establish the Commission to Study Bulk Purchasing of Prescription Drugs and Medical Supplies.** RESOLVE 75. Bureau action: BMS Director or designee participation in study Commission.

✓ LD 442 **Resolve, to Create a Study Group to Prepare Pharmaceutical Guidelines for Geriatric Residents in Long-term Care Settings.** RESOLVE 3. Bureau action: DHS to appoint study group, BMS to provide staffing to study group with report due to Health and Human Services Committee by March 1, 2000.

✓ LD 610 **Resolve, to Increase Access to Medicaid for People who Need Psychological Services.** RESOLVE 73. Bureau action: Rulemaking, psychological services fee increase by 10/1/2000.

✓ LD 845 **Resolve, Directing the Department of Human Services to Study Methods to Increase Access to Health Care for Low-income Maine People.** RESOLVE 29. Bureau action: Department to prepare eligibility study for report to Health and Human Services Committee by 12/31/99.

✓ LD 1012 **Resolve, to Increase Public Trust in Medical Care.** RESOLVE 12. Bureau action: Rulemaking by 1/1/2000, wearing of ID badges by persons providing health care services.

✓ LD 1598 **An Act Regarding Hospital Cooperation.** PL 306. No Bureau action needed.

✓ LD 1687 **An Act Relating to Medicaid Liens.** PL 483. No Bureau action needed.

✓ LD 1755 **An Act to Improve Access to Dental Care for Children.** PL 301. Bureau action: Annual Fee Review and coordination with BoH on mobile van and residency program feasibility. Report to Health and Human Services Committee due by 12/31/99.

✓ LD 1809 **An Act to Increase Access to Cub Care for Children.** PL 522. Bureau action: New BMS program, requires drug rebate agreement with each drug manufacturer to mirror federal rebate program. Effective date 10/1/99.

✓ LD 1896 **Resolve, to Increase Certain Reimbursement Rates under the Medicaid Program.** RESOLVE 76. Bureau action: Rulemaking; Chiropractic fee increase by 1/1/2000 and Speech and Hearing Center Services fee increase by 11/1/99.

✓ LD 2015 **An Act to Amend the Health Care Receivership Laws.** PL 384. Bureau action: Rulemaking, specialty hospitals, critical access hospitals, ambulatory surgical centers, hospice agencies and end stage renal disease units and other miscellaneous.

✓ LD 2082 **An Act to Reduce the Cost of Prescription Drugs to Qualifying Residents of the State.** PL 431. Bureau action: Major program design, implementation and evaluation with annual summary report. Initial program operational start-up 1/1/2000.

✓ LD 2113 **Resolve, Directing the Department of Human Services to Conduct a Review of Certain Reimbursement Rates under the Medicaid Program.** RESOLVE 28. Bureau action: Fee Review and report to Health and Human Services Committee by 12/31/99

The following items are from the Part I (Chapter 16) and Part II (LD 617, Chapter 401) Budget Bills and represent budget items requiring BMS action:

Part I – Chapter 16 – page 202-2933 (13).

✓ Deappropriation to limit prescription drugs growth.

✓ Deappropriation to limit boarding home growth.

✓ Deappropriation to limit growth in Private Non-Medical Institutions.

✓ Deappropriation to reduce payments on Medicare crossover claims to hospitals.

✓ Deappropriation of funds by reducing Part B crossover payments to non-physician Part B providers, excluding federally qualified health centers, rural health centers and Indian health centers.

Part II – Chapter 401

✓ Part MM. Pages 228-2935 (21) through 233-2935 (21). Provides funding and legislation to establish Dental Services for low-income citizens.

✓ Part NN. Pages 233-2935 (21) through 240-2935 (21). Provides funding and legislation to establish a Maine Dental Education Loan Program.

✓ Part QQ. Pages 241-2935 (21) through 242-2935 (21). Provides funding to expand Cub Care.

✓ Part KKK. Pages 275-2935 (21) through 282-2935 (21). Provides funding to greatly expand DEL eligibility, covered drugs, and oversight with an effective date of 8/1/99. Requires HCFA waiver application effective 1/1/2000 to cover drugs for disabled and elderly, waiver status report to Health and Human Services Committee by 10/1/99. (see LD 2255/PL 531 for date corrections reflected here)

✓ Part SSS. Pages 298-2935 (21) through 299-2935 (21). Provides funds to increase reimbursement rates for consumer-directed personal care attendants effective 10/1/99, requires fee review due 1/1/02 and every 2 years thereafter.

During the Second Regular Session of the 119th Maine Legislature, the Bureau is considering the drafting of legislation in the areas of third party liability, licensing of Birthing Centers, Certified Nurse Assistants Registry requirements for CNAs working in Hospitals or Hospice programs and statutory changes in the CubCare Program.

Overview of the Maine Medicaid Program

Medicaid is a program funded jointly by the federal government (the Health Care Financing Administration) and the states and administered by the states in compliance with federal laws and regulations. Since 1965, through Title XIX of the Social Security Act, Medicaid has been provided for Maine's citizens of low income.

Each state's program varies in eligibility criteria, services covered, limitations on services and reimbursement levels. Medicaid services are funded by a federally determined formula that combines state and federal revenues at an approximate 34% State and 66% Federal dollar split.

Maine Medicaid
Federal Financial Participation Rates

	Federal	State
1994	61.96%	38.04%
1995	63.30%	36.70%
1996	63.32%	36.68%
1997	63.72%	36.28%
1998	66.04%	33.96%
1999	66.40%	33.60%

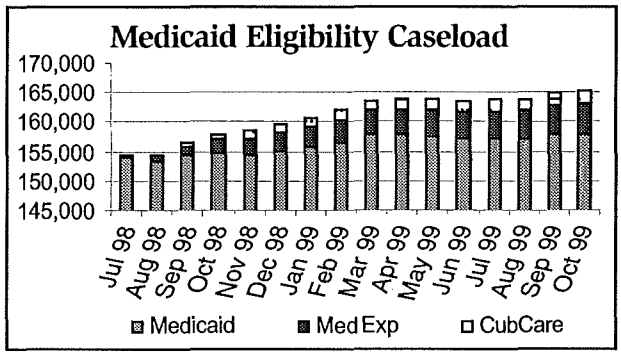
Who is Covered?

Medicaid was created to provide health care to certain low-income individuals. State Medicaid programs are required by HCFA to cover certain groups, while other groups are covered at the option of the State. To be eligible for Medicaid, a person must belong to one of the groups described below and meet certain financial criteria.

- **Under age 19.** There is no asset limit for this group. Income must be under 150% of the Federal Poverty Level (FPL) (200% for CubCare.) For children under age 1, the income limit is 185% of the FPL.
- **Age 19, 20.** Asset limit is $2,000 with income under 100% of the FPL.
- **Age 21 – 64.** Unless the criteria for "Disabled" or "Blind"(below) is met, the individual must be caring for a child under age 18 and be a single parent. If there are two parents living in the household, one parent must be employed less than 130 hours per month or unable to work for 30 days. The income limit for this group is 100% of the FPL and the asset limit is $2,000.
- **Disabled/Blind.** The definition of "blind" and "disabled" is the same definition used by the Social Security Administration. To be considered to have a disability, the individual must have a physical or mental impairment that substantially impairs his or her ability to perform work (substantial gainful activity). This condition must have existed or must be expected to continue to exist for one year. The income limit for an individual in this group is 100% of the FPL and the asset limit is $2,000.

If an individual with a disabling condition (in any age group) has earnings he or she has a more liberal asset limit of $8,000. The income limit is 250% of the FPL as long as income from pensions, retirement, etc., is under 100% of the FPL.

- **Age 65 and over.** The income limit for an individual in this group is 100% of the FPL. The asset limit is $2,000.
- **Special Coverage Groups.** Pregnant women are eligible without regard to assets as long as income is under 185% of the FPL. Coverage continues for three months after the end of pregnancy.
- If a **child under age 19 has a severely disabling condition** requiring a high level of medical services that would otherwise require that the child reside in an institution, the child may be eligible regardless of parental income. This is referred to as the Katie Beckett eligibility option.
- Any individual who is **entitled to Medicare Part A** may be eligible for Medicaid to pay their Medicare Part B premium. The income limit for this benefit is 135% of the FPL. The asset limit for an individual is $4,000.



Other special eligibility rules apply for those who reside in a nursing facility or some residential care facilities.

Medicaid also authorizes a monthly State Supplement benefit for certain individuals, most of whom are SSI recipients and a monthly income supplement to the low-income individuals whose spouse is a Medicaid covered resident of a cost reimbursed boarding home.

What is Covered?

Medicaid services fall under two general categories: *Mandatory* and *Optional.* Mandatory services are services that the federal government requires as a condition of participation. Optional services are services the state can choose to cover. Maine has a substantial optional program to provide broad medical coverage to Medicaid recipients.

Mandatory Services:

- Early and periodic screening, diagnosis and treatment for those under age 21
- Family planning services and supplies
- Inpatient hospital services
- Laboratory and x-ray services
- Nurse-midwife and nurse practitioner services
- Nursing facility and home health services for those age 21 and over
- Outpatient hospital services
- Physician services and medical and surgical services of a dentist
- Rural health clinic and federally qualified health center services

Optional Services:

- Ambulance services
- Case management services
- Chiropractic services
- Clinic services, including ambulatory care clinic services
- Dental Services
- Diagnostic, screening, preventive, and rehabilitative services, which include: *mental health services, private non-medical institutions, early intervention services, school-based rehab services, home-based mental health, community support, day habilitation, day health, substance abuse treatment, developmental and behavioral evaluation clinic services*
- Emergency hospital services
- Eyeglasses
- Inpatient hospital services for those above age 65 in institutions for mental diseases
- Inpatient psychiatric services for those under age 21
- ICF/MR services
- Medical social worker services
- Medical supplies and durable medical equipment
- Nursing facility services for individuals under age 21
- Occupational therapy
- Orthotic and prosthetic devices
- Optician services
- Optometry services
- Personal care services
- Physical therapy
- Podiatry services
- Prescribed drugs
- Private duty nursing services
- Psychological services
- Speech, hearing and language disorder services
- STD screening services
- Swing bed services

The Medicaid program also covers transportation services to enable individuals to obtain medical services and treatment. The State of Maine has opted to provide transportation services through provider agreements with full-service transportation providers located across the State.

Maine Medicaid has also chosen to provide home and community-based service waivers for individuals who would otherwise be eligible to receive care in a nursing facility or ICF/MR. Maine currently operates four Waiver programs, which have been approved by HCFA:

- HCBS Waiver for People with Mental Retardation
- HCBS Waiver for the Elderly
- HCBS Waiver for People with Physical Disabilities
- HCBS Waiver for Adults with Disabilities

What Does the Program Cost?

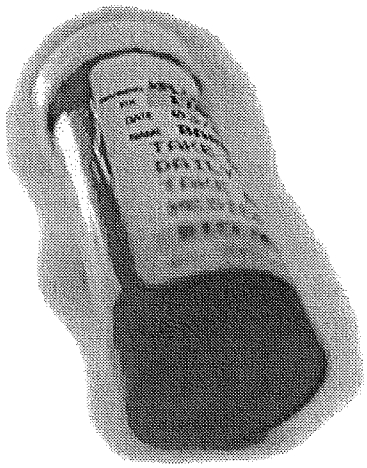
Medicaid Services. Medicaid is a major budgetary commitment for the State of Maine, consuming approximately 14% of the State's general fund budget in FY 1999. Total expenditures for this State fiscal year were $1,117,549,639. Of the 196,808 individuals determined eligible for services under the program for some portion of SFY99, 174,166 received services.

Medicaid Drug Benefits continue under the requirements of Federal mandates, specifically OBRA90 and OBRA93. Accordingly, Maine Medicaid, as for all Medicaid programs, is required to cover new drugs as the Food and Drug Administration approves them. The only requirement Medicaid agencies can have for guidelines for coverage are: a) the drug manufacturer must have a contract with the Federal Government for Medicaid coverage and b) the drug is medically necessary and is used for a covered service. Under Federal requirements, the only recourse States have available to control or influence drug utilization and drug costs is by utilizing a prior authorization program.

Medicaid Outpatient Prescription Drug Spending

	SFY 97	SFY 98	Change	SFY 99	Change
Total Expenditures	$98,964,628	$109,697,688	10.8%	$135,493,928	23.5%
Drug Rebates	-$17,206,484	-$20,206,046	17.4%	-$27,957,863	38.4%
Drug Rebate Percentage	17.4%	18.4%		20.6%	
Net Expenditures	$81,758,144	$89,491,642	9.5%	$107,536,065	20.2%
Number of Drug Recipients	141,220	144,205	2.1%	150,933	4.7%
Total Expenditures Per Recipient	$700.78	$760.71	8.6%	$897.71	18.0%
Net Expenditures Per Recipient	$578.94	$620.59	7.2%	$712.48	14.8%
Number of Prescriptions	2,793,666	2,870,422	2.7%	3,114,155	8.5%
Prescriptions per Recipient	19.8	19.9	0.6%	20.6	3.7%
Expenditures per Prescription	$35.42	$38.22	7.9%	$43.51	13.8%

While there have been many significant advances in drug therapy in the last several years, and more are released each month, the cost for these newer medications is significant. Many of these new drugs avoid or help to avoid other more costly methods of treatment, such as hospitalization, surgery, etc. However it is impossible to determine the overall savings to the Medicaid program because of both the lack of history of these newer drugs and, oftentimes their multiple uses. Additionally, some newer drugs have a higher safety profile and physicians, therefore, feel freer to use them. There is no disagreement in the health care industry about the potential cost effectiveness of both these newer drugs as well as new uses for older drugs. However, no one, including the drug industry itself, has been able to definitively describe programmatic cost savings.



Further, there have been a number of very significant changes in the way drugs are marketed, with Direct-To-Consumer (DTC) advertising by the manufacturers creating an unprecedented demand for prescription drugs. Until recently, FDA prohibited these DTC ads. DTC advertising is prevalent on nightly television, in most magazines and periodicals such as Time, Newsweek, Reader's Digest, etc.. The effect of these ads is to significantly increase consumer demand. This demand raises Medicaid drug costs disproportionally as these ads are for expensive brand name drugs.

Some common examples of recent or new drugs include:

1. Zoloft, Zyprexia etc. The drug cost to Medicaid for last 12 months alone for this class of drugs for behavioral health conditions was over $12 million. However, they are much safer and have much fewer side effects than the older, more traditional drugs used to treat some illnesses.

2. Risperidal, Clozaril etc. The drug cost to Medicaid for the last 12 months alone for this class of drugs was $10 million - not counting ancillary costs such as lab work for people receiving Clozaril for schizophrenia.

Obviously, there is a significant offset to mental health institutional and outpatient costs from the use of both these classes of drugs, but it is very hard to quantify. The private sector is also unable to resolve the mental health cost quantification issue. These issues are being continually discussed by many practitioners and drug benefit programs, but it is also a very difficult issue.

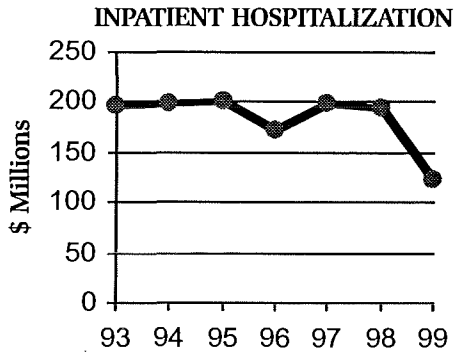
3. Anti-fungal agents (ex. TV ads for nice looking toe nails). Traditional antifungal drug treatment was long term and had potential for a number of serious complications. Now relatively safe anti-fungals are available, but are costly ($400 for a course of therapy is not unusual).

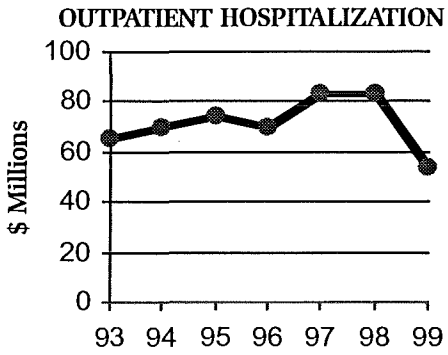
4. Claritin, Zyrtec for allergies, cost for last 12 months was $2 million

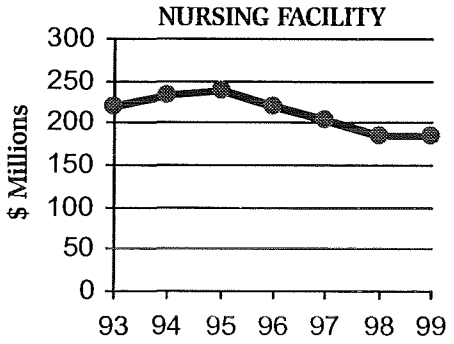
Also significantly impacting the Medicaid drug program is the issue of drugs used for lifestyle enhancing purposes. In addition to the Viagra type drugs, the 'antiulcer' type medications (Tagamet-Pepcid-Zantac-Prilosec-Prevacid type drugs) need to be considered. One of these drugs (Prilosec) is the most prescribed drug in the Medicaid program as well as in all private prescription drug programs. The cost to Maine Medicaid last year for this single drug alone was well over $8 million. These types of 'antiulcer' medications are often used instead of beneficial life-style modification. However, on the flip side, providing these drugs when they are 'medically necessary' clearly prevents serious complications. The dilemma for Medicaid (and all prescription drug benefit programs) is how to provide medications for the 'medically necessary' cases, while avoiding the unnecessary costs of lifestyle enhancing utilization. We are working with private drug benefit programs to help resolve this extremely complicated problem. With the Bureau's retrospective drug utilization program, we were able to show savings of over $1 million in this class of drugs last year from reduction in non-medically necessary utilization.

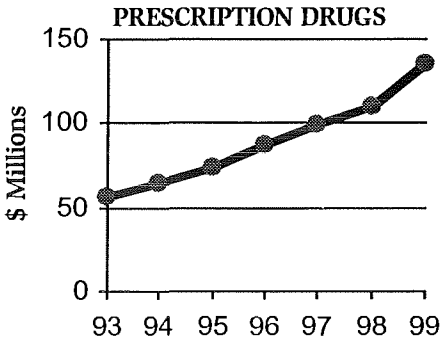
The costs of generic drugs are escalating. States have little or no control over these issues. Examples include the cost of a very popular drug, Lorazepam, going from $1.73 per hundred tablets in 1997 to over $58.00 per hundred in 1998. Another very popular sleeping pill, Temazepam went from $3.15 per 100 capsules in 1997 to over $72.00 per hundred capsules in 1998. Any action by the Federal government on these pricing issues will take significant time, probably years, before it is resolved.

Selected Major Service Categories

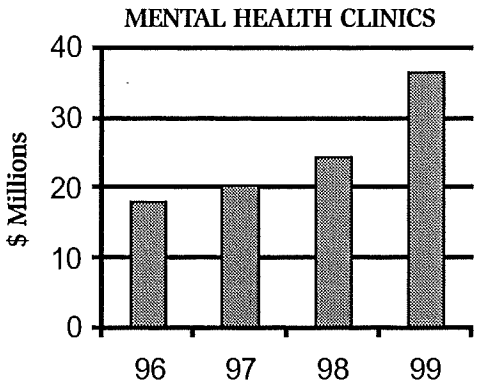


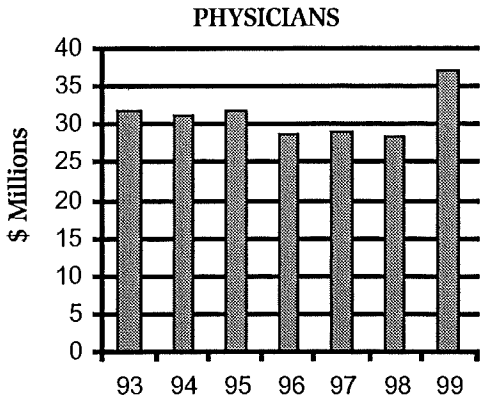


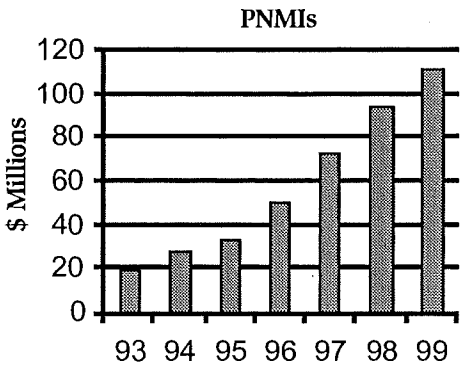


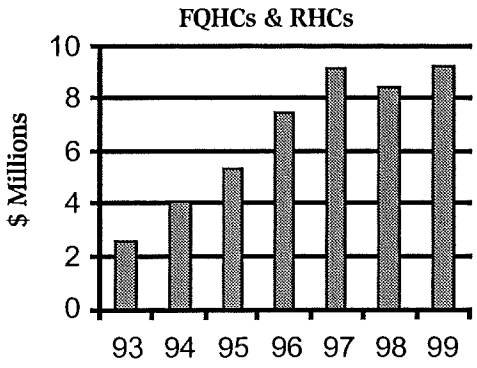


Selected Other Service Categories





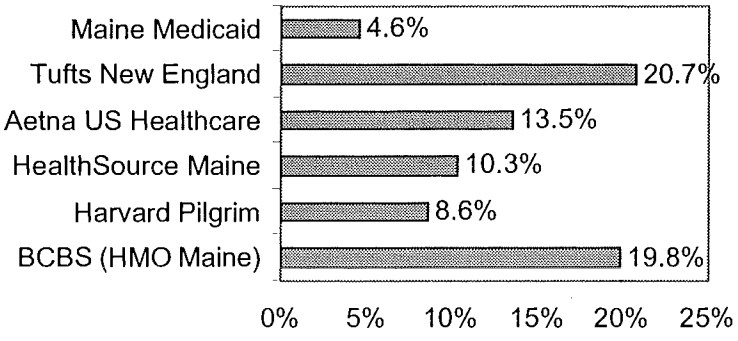




Medicaid Administration

In addition to expenditures of $1.1 billion for health care services, $53 million was expended in SFY 1999 to administer the Maine Medicaid Program. This represents less than 5% of total Medicaid spending. This percentage of administrative spending is considerably less than the percentage of administrative costs for other health care insurers in Maine.

Administrative Cost Percentage



1999 Medicaid Costs Program vs AdministrativeExpenditures

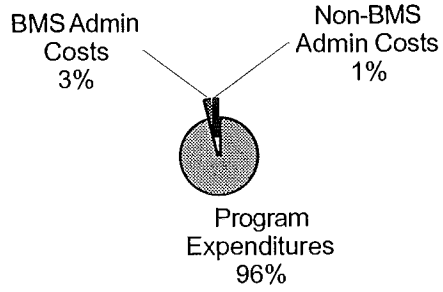


TABLE A-1. MEDICAID EXPENDITURES BY CATEGORY OF SERVICE

CATEGORY OF SERVICE	EXPENDITURES SFY 1997	EXPENDITURES SFY 1998	Percent Change	EXPENDITURES SFY 1999	Percent Change
01 GENERAL INPATIENT	$197,831,519	$193,335,727	-2.3%	$123,427,502	-36.2%
02 PSYCH FACILITY SVC	$40,492,454	$39,607,953	-2.2%	$41,012,842	3.5%
03 NURSING FACILITY	$202,292,500	$185,581,203	-8.3%	$184,099,858	-0.8%
04 GENERAL OUTPATIENT	$83,018,482	$83,361,344	0.4%	$53,683,008	-35.6%
06 PHYSICIAN	$29,195,225	$28,328,585	-3.0%	$37,185,517	31.3%
07 PODIATRIC	$346,478	$335,704	-3.1%	$430,451	28.2%
08 PHP AGENCY	$616,496	$37,360	-93.9%	$0	-100.0%
09 DENTAL	$5,003,898	$6,641,320	32.7%	$9,567,559	44.1%
10 PRESCRIBED DRUGS	$98,964,628	$109,697,688	10.8%	$135,493,928	23.5%
11 HOME HEALTH SERVICES	$14,434,836	$15,415,570	6.8%	$15,704,936	1.9%
12 COMMUNITY SUPPORT SV*	$16,282,496	$24,854,070	52.6%	$28,090,746	13.0%
13 SOCIAL WORKER SERVS*	$204,635	$305,307	49.2%	$299,345	-2.0%
14 LAB & X-RAY-INDEP.	$3,890,376	$3,660,550	-5.9%	$4,099,497	12.0%
15 TRANSPORTATION	$10,594,069	$11,618,120	9.7%	$12,775,808	10.0%
16 SUPPLIES AND DME	$6,220,888	$6,905,975	11.0%	$7,288,240	5.5%
17 PROSTHETIC, ORTHOTIC	$1,045,508	$1,077,379	3.0%	$1,193,656	10.8%
18 AMBULATORY SURG CENT	$175,794	$234,242	33.2%	$221,865	-5.3%
19 CLOZARILL MONITORING*	$627,675	$504,990	-19.5%	$23,402	-95.4%
22 PHY. DISABLED WAIVER	$5,062,143	$5,552,487	9.7%	$6,185,082	11.4%
23 SWING BED.*	$3,778	$19,183	407.8%	$75,101	291.5%
24 CASE MANAGEMENT	$25,008,878	$28,819,565	15.2%	$33,503,742	16.3%
25 FAMILY PLAN-CLINIC	$890,819	$822,353	-7.7%	$751,575	-8.6%
26 BMR WAIVER	$61,729,335	$75,452,653	22.2%	$93,074,043	23.4%
27 SPEECH AND HEARING	$524,854	$540,848	3.0%	$525,013	-2.9%
28 MENTAL HEALTH	$20,224,896	$24,671,605	22.0%	$36,570,004	48.2%
29 AMBULANCE	$1,491,838	$1,673,802	12.2%	$1,859,966	11.1%
30 AMBUL. CARE CLINIC	$40,484	$29,414	-27.3%	$337,100	1046.1%
31 PHYSICAL THERAPY	$1,057,853	$1,031,192	-2.5%	$960,558	-6.8%
32 CHIROPRACTIC	$340,814	$292,033	-14.3%	$295,922	1.3%
33 OCCUPATIONAL THERAPY	$700,675	$728,109	3.9%	$579,181	-20.5%
35 DAY HABILITATION	$7,890,758	$9,035,340	14.5%	$10,958,898	21.3%
36 DAY HEALTH	$424,492	$577,618	36.1%	$592,650	2.6%
37 OPTOMETRIC SERVICES	$1,119,039	$1,062,392	-5.1%	$1,409,182	32.6%
38 PSYCHOLOGICAL SVCS	$3,123,315	$2,659,538	-14.8%	$2,572,509	-3.3%
39 PRIVATE NONMD. INST. (Medicaid)	$70,207,743	$90,272,883	28.6%	$106,710,903	18.2%
40 ICF/MR (BOARDING)	$37,362,292	$32,739,328	-12.4%	$31,140,953	-4.9%
41 MEDICARE CROSSOVER-A	$3,745,538	$3,898,140	4.1%	$3,078,456	-21.0%
42 OPTICAL SERVICES	$299,594	$253,611	-15.3%	$150,582	-40.6%
43 CERT. RURAL HLT. CL.	$3,400,260	$3,247,459	-4.5%	$3,769,942	16.1%
44 VD SCREENING	$12,665	$9,815	-22.5%	$7,765	-20.9%
45 HEARING AID DEALERS	$51,386	$51,497	0.2%	$43,786	-15.0%
46 AUDIOLOGY SERVICES	$35,726	$31,262	-12.5%	$44,888	43.6%
47 SPEECH PATH. SERV.	$2,415,729	$2,383,957	-1.3%	$2,439,067	2.3%
48 SUBSTANCE ABUSE	$3,698,232	$3,865,319	4.5%	$3,913,548	1.2%
50 MEDICARE CROSSOVER-B	$8,588,909	$13,684,625	59.3%	$15,567,929	13.8%
52 HMO PAYMENTS	$3,810	$3,503,272	91849.4%	$6,843,139	95.3%
53 NURSE/MIDWIFE	$162,177	$70,507	-56.5%	$54,473	-22.7%
55 ATTENDANT SERVICES	$2,123,423	$3,068,619	44.5%	$3,495,101	13.9%
57 BME WAIVER	$10,272,214	$14,604,975	42.2%	$21,521,767	47.4%
58 PRIVATE DUTY NURS	$2,699,210	$2,387,610	-11.5%	$3,182,176	33.3%
59 PERSONAL CARE SER	$2,100,367	$3,362,683	60.1%	$4,220,115	25.5%
60 NURSE PRACTITIONER	$47,686	$52,300	9.7%	$103,741	98.4%
61 REHABILITATIVE SVCS	$5,023,575	$6,442,685	28.2%	$8,487,654	31.7%
62 HOME BASED M-H	$1,828,123	$1,826,316	-0.1%	$1,878,774	2.9%
63 FED. QUAL. HLTH CTR	$5,763,630	$5,195,679	-9.9%	$5,493,315	5.7%
65 EARLY INTERVENTION	$5,056,397	$4,953,032	-2.0%	$5,896,210	19.0%
66 DEVLOP/BEHAV CLIN SV	$599,674	$524,025	-12.6%	$526,950	0.6%
67 NON-TRADITIONAL PHP*	$2,791,715	$14,164,538	407.4%	$27,777,162	96.1%
CAT. OF SERVICE TOTALS	**$1,009,162,003**	**$1,075,065,356**	**6.5%**	**$1,101,197,082**	**2.4%**
OTHER MEDICAID					
CHILD HEALTH INSURANCE PROG	$0	$0	0.0%	$5,464,154	0.0%
MEDICARE "BUY-IN" PREMIUM	$15,582,696	$8,899,871	-42.9%	$18,543,971	108.4%
DRUG REBATES	-$17,206,484	-$20,206,046	17.4%	-$27,957,863	38.4%
TPL RECOVERY -- CREDITS	-$9,806,445	-$11,956,890	21.9%	-$11,773,040	-1.5%
AMHI/BMHI DSH PAYMENTS	$51,680,711	$50,345,541	-2.6%	$32,075,335	-36.3%
SUBTOTAL OTHER MEDICAID	$40,250,478	$27,082,476		$16,352,557	-39.6%
TOTAL MEDICAID	**$1,049,412,481**	**$1,102,147,832**	**5.0%**	**$1,117,549,639**	**1.4%**
Adjusted for the Elim. of DSH in 1998		$1,008,368,999		$1,117,549,639	10.8%
MEDICAID RELATED:					
05 SOCIAL SERVICES	$1,304,754	$1,288,744	-1.2%	$1,488,817	15.5%
54 CHILD HEALTH	$5,695	$36,820	546.5%	$57,445	56.0%
56 WAIVERED BOARD HM	$393,211	$314,537	-20.0%	$392,173	24.7%
STATE BOARDING HOME PAYMENTS	$9,872,349	$13,764,437	39.4%	$16,278,274	18.3%
NON-MEDICAID MAP SPENDING	$2,574,481	$3,640,160	41.4%	$3,593,080	-1.3%
FIN. DISTRESSED HOSP's	$8,259,313	$0	-100.0%	$0	0.0%
SUBTOTAL MEDICAID RELATED	$22,409,803	$19,044,698	-15.0%	$21,809,789	14.5%
TOTAL MEDICAID AND RELATED	**$1,071,822,284**	**$1,121,192,530**	**4.6%**	**$1,139,359,428**	**1.6%**
Adjusted for the Elim. of DSH in 1998		$1,027,413,697		$1,139,359,428	10.9%

SOURCES: MR-0-12 AND "1990 ACCOUNT" REPORTS, MMIS WEEKLY REPORTS AND MFASIS MONTHLY CASH REPORTS.

TABLE A-2. MEDICAID RECIPIENTS BY CATEGORY OF SERVICE

CATEGORY OF SERVICE	RECIPIENTS SFY 1997	Percent Change	RECIPIENTS SFY 1998	Percent Change	RECIPIENTS SFY 1999	Percent Change
01 GENERAL INPATIENT	20,592	-0.5%	18,869	-8.4%	18,046	-4.4%
02 PSYCH FACILITY SVC	1,334	-3.5%	1,217	-8.8%	2,683	120.5%
03 NURSING FACILITY	8,963	-2.0%	8,649	-3.5%	8,624	-0.3%
04 GENERAL OUTPATIENT	93,731	-2.1%	86,452	-7.8%	84,387	-2.4%
06 PHYSICIAN	106,419	-2.9%	99,046	-6.9%	101,377	2.4%
07 PODIATRIC	4,543	-7.6%	4,078	-10.2%	4,148	1.7%
08 PHP AGENCY	14	0.0%	1	-92.9%	0	-100.0%
09 DENTAL	43,574	-2.2%	41,125	-5.6%	42,827	4.1%
10 PRESCRIBED DRUGS	141,220	-0.1%	144,205	2.1%	150,933	4.7%
11 HOME HEALTH SERVICES	6,975	2.5%	7,174	2.9%	6,947	-3.2%
12 COMMUNITY SUPPORT SV*	5,362	14.8%	6,414	19.6%	7,305	13.9%
13 SOCIAL WORKER SERVS*	297	249.4%	362	21.9%	414	14.4%
14 LAB & X-RAY-INDEP.	45,261	0.4%	41,310	-8.7%	41,845	1.3%
15 TRANSPORTATION	24,275	-7.2%	22,711	-6.4%	22,632	-0.3%
16 SUPPLIES AND DME	13,926	-0.6%	14,751	5.9%	15,214	3.1%
17 PROSTHETIC, ORTHOTIC	1,280	11.6%	1,338	4.5%	1,479	10.5%
18 AMBULATORY SURG CENT	251	5.9%	345	37.5%	311	-9.9%
19 CLOZARILL MONITORING*	599	2.6%	463	-22.7%	187	-59.6%
22 PHY. DISABLED WAIVER	269	23.4%	283	5.2%	305	7.8%
23 SWING BED.*	1	0.0%	4	300.0%	21	425.0%
24 CASE MANAGEMENT	15,756	6.0%	13,910	-11.7%	16,861	21.2%
25 FAMILY PLAN-CLINIC	5,221	-1.6%	4,861	-6.9%	4,376	-10.0%
26 BMR WAIVER	1,135	13.0%	1,349	18.9%	1,610	19.3%
27 SPEECH AND HEARING	771	-23.6%	914	18.5%	808	-11.6%
28 MENTAL HEALTH	14,165	10.8%	16,440	16.1%	19,137	16.4%
29 AMBULANCE	8,591	3.7%	9,656	12.4%	10,717	11.0%
30 AMBUL. CARE CLINIC	650	-14.4%	612	-5.8%	1,202	96.4%
31 PHYSICAL THERAPY	2,282	5.3%	2,291	0.4%	2,190	-4.4%
32 CHIROPRACTIC	3,884	-3.9%	3,364	-13.4%	3,502	4.1%
33 OCCUPATIONAL THERAPY	1,655	58.8%	1,714	3.6%	1,087	-36.6%
35 DAY HABILITATION	892	2.2%	975	9.3%	1,084	11.2%
36 DAY HEALTH	122	41.9%	147	20.5%	135	-8.2%
37 OPTOMETRIC SERVICES	28,099	-0.5%	26,057	-7.3%	28,471	9.3%
38 PSYCHOLOGICAL SVCS	6,599	1.4%	6,110	-7.4%	4,839	-20.8%
39 PRIVATE NONMD. INST.	5,786	23.4%	6,431	11.1%	7,359	14.4%
40 ICF/MR (BOARDING)	415	-14.4%	396	-4.6%	320	-19.2%
41 MEDICARE CROSSOVER-A	25,023	7.9%	25,382	1.4%	26,567	4.7%
42 OPTICAL SERVICES	10,682	-2.0%	9,421	-11.8%	9,746	3.4%
43 CERT. RURAL HLT. CL.	14,084	32.5%	14,097	0.1%	15,250	8.2%
44 VD SCREENING	529	-19.8%	412	-22.1%	328	-20.4%
45 HEARING AID DEALERS	190	5.0%	195	2.6%	201	3.1%
46 AUDIOLOGY SERVICES	572	37.2%	453	-20.8%	644	42.2%
47 SPEECH PATH. SERV.	3,381	18.4%	3,370	-0.3%	2,544	-24.5%
48 SUBSTANCE ABUSE	4,872	-4.3%	4,605	-5.5%	4,620	0.3%
50 MEDICARE CROSSOVER-B	32,991	4.5%	35,117	6.4%	36,630	4.3%
52 HMO PAYMENTS	na	na	na	na	na	na
53 NURSE/MIDWIFE	743	0.1%	421	-43.3%	148	-64.8%
55 ATTENDANT SERVICES	216	54.3%	288	33.3%	297	3.1%
57 BME WAIVER	1,343	19.1%	1,618	20.5%	1,904	17.7%
58 PRIVATE DUTY NURS	223	39.4%	455	104.0%	610	34.1%
59 PERSONAL CARE SER	478	76.4%	796	66.5%	1,092	37.2%
60 NURSE PRACTITIONER	425	72.1%	392	-7.8%	524	33.7%
61 REHABILITATIVE SVCS	277	58.3%	314	13.4%	298	-5.1%
62 HOME BASED M-H	512	12.3%	539	5.3%	579	7.4%
63 FED. QUAL. HLTH CTR	13,868	-3.1%	13,024	-6.1%	13,120	0.7%
65 EARLY INTERVENTION	1,548	1.0%	1,522	-1.7%	1,474	-3.2%
66 DEVLOP/BEHAV CLIN SV	551	26.1%	466	-15.4%	460	-1.3%
67 NON-TRADITIONAL PHP*	36	100.0%	8,689	24036.1%	14,585	67.9%
CAT OF SERV. RECIP'T TOTALS	**171,138**	**-2.2%**	**166,124**	**-2.9%**	**168,861**	**1.6%**
OTHER MEDICAID						
CHILD HEALTH INSURANCE PROG	na	na	na	na	5,305	na
MEDICARE "BUY-IN" PREMIUM	na	na	na	na	na	na
DRUG REBATES	na	na	na	na	na	na
TPL RECOVERY -- CREDITS	na	na	na	na	na	na
AMHI/BMHI DSH PAYMENTS	na	na	na	na	na	na
SUBTOTAL OTHER MEDICAID	0	0.0%	0	0.0%	5,305	0.0%
TOTAL MEDICAID (unduplicated)	**171,138**	**-2.2%**	**166,124**	**-2.9%**	**174,166**	**4.8%**
MEDICAID RELATED:						
05 SOCIAL SERVICES	1,509	0.0%	1,411	-6.49%	1,449	2.69%
54 CHILD HEALTH	12	50.0%	51	325.00%	41	-19.61%
56 WAIVERED BOARD HM	27	-6.9%	25	-7.41%	26	4.00%
STATE BOARDING HOME PMTS	na	na	na	na	na	na
NON-MEDICAID MAP SPENDING	na	na	na	na	na	na
FIN. DISTRESSED HOSP's	na	na	na	na	na	na
SUBTOTAL MEDICAID RELATED	na	na	na	na	na	na

SOURCES: MR-0-12 AND "1990 ACCOUNT" REPORTS, MMIS WEEKLY REPORTS AND MFASIS MONTHLY CASH REPORTS.

TABLE A-3. MEDICAID SPENDING PER RECIPIENT BY CATEGORY OF SERVICE

CATEGORY OF SERVICE	SPENDING/ RECIPIENT SFY 1997	SPENDING/ RECIPIENT SFY 1998	Percent Change	SPENDING/ RECIPIENT SFY 1999	Percent % Change
01 GENERAL INPATIENT	$9,607	$10,246	6.7%	$6,840	-33.2%
02 PSYCH FACILITY SVC	$30,354	$32,546	7.2%	$15,286	-53.0%
03 NURSING FACILITY	$22,570	$21,457	-4.9%	$21,347	-0.5%
04 GENERAL OUTPATIENT	$886	$964	8.9%	$636	-34.0%
06 PHYSICIAN	$274	$286	4.3%	$367	28.2%
07 PODIATRIC	$76	$82	7.9%	$104	26.1%
08 PHP AGENCY	$44,035	$37,360	-15.2%	$0	-100.0%
09 DENTAL	$115	$161	40.6%	$223	38.3%
10 PRESCRIBED DRUGS	$701	$761	8.6%	$898	18.0%
11 HOME HEALTH SERVICES	$2,070	$2,149	3.8%	$2,261	5.2%
12 COMMUNITY SUPPORT SV*	$3,037	$3,875	27.6%	$3,845	-0.8%
13 SOCIAL WORKER SERVS*	$689	$843	22.4%	$723	-14.3%
14 LAB & X-RAY-INDEP.	$86	$89	3.1%	$98	10.6%
15 TRANSPORTATION	$436	$512	17.2%	$565	10.3%
16 SUPPLIES AND DME	$447	$468	4.8%	$479	2.3%
17 PROSTHETIC, ORTHOTIC	$817	$805	-1.4%	$807	0.2%
18 AMBULATORY SURG CENT	$700	$679	-3.1%	$713	5.1%
19 CLOZARILL MONITORING*	$1,048	$1,091	4.1%	$125	-88.5%
22 PHY. DISABLED WAIVER	$18,818	$19,620	4.3%	$20,279	3.4%
23 SWING BED.*	$3,778	$4,796	26.9%	$3,576	-25.4%
24 CASE MANAGEMENT	$1,587	$2,072	30.5%	$1,987	-4.1%
25 FAMILY PLAN-CLINIC	$171	$169	-0.8%	$172	1.5%
26 BMR WAIVER	$54,387	$55,932	2.8%	$57,810	3.4%
27 SPEECH AND HEARING	$681	$592	-13.1%	$650	9.8%
28 MENTAL HEALTH	$1,428	$1,501	5.1%	$1,911	27.3%
29 AMBULANCE	$174	$173	-0.2%	$174	0.1%
30 AMBUL. CARE CLINIC	$62	$48	-22.8%	$280	483.5%
31 PHYSICAL THERAPY	$464	$450	-2.9%	$439	-2.6%
32 CHIROPRACTIC	$88	$87	-1.1%	$85	-2.7%
33 OCCUPATIONAL THERAPY	$423	$425	0.3%	$533	25.4%
35 DAY HABILITATION	$8,846	$9,267	4.8%	$10,110	9.1%
36 DAY HEALTH	$3,479	$3,929	12.9%	$4,390	11.7%
37 OPTOMETRIC SERVICES	$40	$41	2.4%	$49	21.4%
38 PSYCHOLOGICAL SVCS	$473	$435	-8.0%	$532	22.1%
39 PRIVATE NONMD. INST.	$12,134	$14,037	15.7%	$14,501	3.3%
40 ICF/MR (BOARDING)	$90,030	$82,675	-8.2%	$97,315	17.7%
41 MEDICARE CROSSOVER-A	$150	$154	2.6%	$116	-24.6%
42 OPTICAL SERVICES	$28	$27	-4.0%	$15	-42.6%
43 CERT. RURAL HLT. CL.	$241	$230	-4.6%	$247	7.3%
44 VD SCREENING	$24	$24	-0.5%	$24	-0.6%
45 HEARING AID DEALERS	$270	$264	-2.4%	$218	-17.5%
46 AUDIOLOGY SERVICES	$62	$69	10.5%	$70	1.0%
47 SPEECH PATH. SERV.	$715	$707	-1.0%	$959	35.5%
48 SUBSTANCE ABUSE	$759	$839	10.6%	$847	0.9%
50 MEDICARE CROSSOVER-B	$260	$390	49.7%	$425	9.1%
52 HMO PAYMENTS	na	na	na	na	na
53 NURSE/MIDWIFE	$218	$167	-23.3%	$368	119.8%
55 ATTENDANT SERVICES	$9,831	$10,655	8.4%	$11,768	10.4%
57 BME WAIVER	$7,649	$9,027	18.0%	$11,303	25.2%
58 PRIVATE DUTY NURS	$12,104	$5,247	-56.6%	$5,217	-0.6%
59 PERSONAL CARE SER	$4,394	$4,224	-3.9%	$3,865	-8.5%
60 NURSE PRACTITIONER	$112	$133	18.9%	$198	48.4%
61 REHABILITATIVE SVCS	$18,136	$20,518	13.1%	$28,482	38.8%
62 HOME BASED M-H	$3,571	$3,388	-5.1%	$3,245	-4.2%
63 FED. QUAL. HLTH CTR	$416	$399	-4.0%	$419	5.0%
65 EARLY INTERVENTION	$3,266	$3,254	-0.4%	$4,000	22.9%
66 DEVLOP/BEHAV CLIN SV	$1,088	$1,125	3.3%	$1,146	1.9%
67 NON-TRADITIONAL PHP*	$77,548	$1,630	-97.9%	$1,905	16.8%
CAT OF SERV. RECIPIENT TOTALS	**$5,897**	**$6,471**	**9.7%**	**$6,521**	**0.8%**
OTHER MEDICAID					
CHILD HEALTH INSURANCE PROGRAM	na	na	na	na	na
MEDICARE "BUY-IN" PREMIUM	na	na	na	na	na
DRUG REBATES	na	na	na	na	na
TPL RECOVERY -- CREDITS	na	na	na	na	na
AMHI/BMHI DSH PAYMENTS	na	na	na	na	na
SUBTOTAL OTHER MEDICAID	$0	$0	0.0%	$0	0.0%
TOTAL MEDICAID	**$6,132**	**$6,634**	**8.2%**	**$6,417**	**-3.3%**
Adjusted for the Elim. of DSH in 1998	$6,070	$6,417	5.7%		
MEDICAID RELATED:					
05 SOCIAL SERVICES	$865	$913	5.63%	$1,027	12.50%
54 CHILD HEALTH	$475	$722	52.13%	$1,401	94.07%
56 WAIVERED BOARD HM	$14,563	$12,581	-13.61%	$15,084	19.89%
STATE BOARDING HOME PAYMENTS	na	na	na	na	na
NON-MEDICAID MAP SPENDING	na	na	na	na	na
FIN. DISTRESSED HOSP's	na	na	na	na	na
SUBTOTAL MEDICAID RELATED	na	na	na	na	na

SOURCES: MR-0-12 AND "1990 ACCOUNT" REPORTS, MMIS WEEKLY REPORTS AND MFASIS MONTHLY CASH REPORTS.

The Bureau of Medical Services

Bureau of Medical Services Mission Statement

The Mission of the Bureau of Medical Services is to
Serve the Health Care Needs of Maine Citizens.
To purchase cost effective, accessible,
quality health and social services for low-income people.
To protect the health and welfare of people needing institutional or
residential care or agency health services.
To assist 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 on their behalf;
Assuring availability of qualified providers.

Organization

The *Bureau of Medical Services* is one of five Bureaus within the Department of Human Services (DHS). The Department of Human Services is the single State agency responsible for administering the Maine Medicaid Program. The Bureau of Medical Services has five overall functional divisions:

Policy and Programs

The *Division of Policy and Programs* is responsible for research and developing coverage for and access to a comprehensive array of health and social services for Medicaid recipients and other individuals of low income.

The *Information and Research Unit* provides general Medicaid information and research assistance to all callers to the Bureau of Medical Services. They also provide assistance to staff within the Provider and Consumer Relations Unit. The *Provider and Consumer Relations Unit* is responsible for providing information, education and assistance to providers and consumers relative to Medicaid and other State health care coverage policy. The *Provider File Group* enrolls new providers, updates provider enrollment records and maintains provider files. In recent years the number of providers, the complexity of the coverage, and reimbursement rules to which they must adhere have grown tremendously. To ensure appropriate technical assistance for providers and consumers the work of the Provider and Consumer Relations and Information and Research Units the Bureau is seeking ways to supplement these resources. The

Bureau may seek a contract to provide additional customer support. This will allow staff to focus additional efforts on training providers.

The *Policy Development Unit* is responsible for the development of Medicaid rules, requests for proposals for securing specialized service providers as well as for the services of consultants. This Unit also provides the contract management for the HMO contracted to provide services for the Department's *Medicaid Managed Care Initiative.* Much of the staff's time is devoted to adding, updating and modifying rules when necessary for appropriate access to services for consumers and reimbursement for providers. This Unit is also responsible for developing the managed care and home and community based service waivers which allow the Department to implement innovative services and service delivery models that require special permission from the federal government.

The Unit is now also overseeing, in conjunction with the Quality Improvement Division and the Bureau of Insurance, the implementation of a program to monitor the quality of services provided by commercial HMOs operating within the State. As enrollment in commercial managed care plans increases, it has become increasingly important for the State to take an active role in ensuring the quality of care provided under their auspices.

Acting under the authority of the HMO Act, the Bureau of Insurance and the Bureau of Medical Services have formed the Inter-Agency Task Force to coordinate the regulatory roles of each Department and to develop a plan for improving the quality of care oversight for Maine's HMOs. BMS has released a proposed rule based on this plan which calls for documentation and onsite reviews of each HMO at least once every three years and coordination with reviews conducted and standards established by NCQA where possible. The National Committee for Quality Assurance is a voluntary accreditation body, which is widely regarded as the national leader in establishing quality standards for HMOs. Annual reporting will also be required. The first review is expected to be conducted in the fall of 1999.

The *Cub Care Unit* provides the coordination for the Department's Cub Care Program. This program was implemented in August of 1998 and is a cooperative effort between the Bureau of Health, the Bureau of Family Independence and the Bureau of Medical Services. The program provides health care coverage to children through age 18 who meet certain income guidelines as described previously in this report.

Quality Improvement

The *Quality Improvement Division*, which began operation in 1999, brings together the Bureau's clinical and quality management expertise. The Division brings together established units within the Bureau, to take the lead in determining and tracking quality indicators to ensure services by the Bureau meet established standards of medical necessity and are beneficial to the recipient. The Division also reviews services that require authorization and operates the Case Mix Program, which determines the nursing facility reimbursement based on clinical criteria.

The *Quality Management Unit* within this Division has been designed to scrutinize the quality of services/care purchased by BMS for Maine Medicaid recipients. The Unit focus is on the current trends within health care. In SFY 1999, the unit had underway several projects directed at cost savings and improved services/care. In addition to a number of quality initiatives described earlier in this report, this Unit has developed Maine Medicaid HEDIS measures designed to help the QI staff track and trend care and services provided to Medicaid recipients. These measures help to identify areas of low or poor quality services that directly relate to high costs in medical care.

The *Case Mix/ Classification Review Unit* is responsible for the design, development, implementation, and evaluation of a combined Medicaid /Medicare reimbursement and Quality Assurance System throughout the State of Maine. The Unit utilizes a HCFA mandated, standardized, universal assessment tool (MDS 2.0) for all nursing facility residents. The Case Mix Unit analyzes and audits specific assessment data documenting acuity of care in order to monitor and manage the integrity of the Case Mix Classification System which is the payment basis for nursing facility residents under Medicaid.

The Classification Unit serves as the *Help Desk* for all the nursing facilities and home health agencies. They are the direct lines of communication for problem solving and assistance for all facets of the data submission process. Help Desk staff assisted with over 4000 calls. Staff generate all rosters for facilities and problem solve for the submission and correction process.

The Case Mix Unit is also responsible for the ongoing development, implementation, education, and evaluation of a case mix system for Level II Cost Reimbursed Assisted Living Facilities.

This Unit oversees the contracting agency determining medical eligibility for children applying for the Katie Beckett eligibility option. The Unit tracks medical eligibility for many different Medicaid programs e.g., Home and Community Based Waiver (HCBW) for the Elderly, HCBW for the Physically Disabled, and the HCBW for Adults with Disabilities and the Elderly Waiver, nursing facility level of care and at risk level for Private Duty Nursing.

The *Professional Claims Review Unit* reviews all medical service requests for Medicaid services that need prior authorization. These include: all out-of-State services, in-State inpatient psychiatric services, certain items of durable medical equipment, some dental care and eye care, certain hearing services, out-of-State or unusual requests for transportation, organ transplants, Optional Preventive Health Program services, some surgical procedures, and sterilizations.

This Unit administers the *Medical Eye Care Program.* The original Medical Eye Care Program was eliminated during the recession of 1990/1991. The Program was reinstated by the 116th Maine Legislature beginning July 1, 1994. The Medical Eye Care Program is entirely State funded and covers eye care services for people of all ages whose gross annual income is equal to or less than 80% of the State's median income adjusted for family size. Coverage is limited to the treatment of eye conditions that would progress to blindness if left untreated (glaucoma, diabetic retinopathy, and cataracts). During State fiscal year 1999 there were 621 individuals that received services under the Program at a cost totaling $223,711.

In SFY99 the Unit developed a new access data base for tracking its prior authorization records . It is already proving to be a very flexible and valuable tool. More phases will be implemented in SFY2000 to enhance the capabilities, make the decision process faster and more accurate. The Unit is looking into moving to an all-electronic record system that will be linked to this data base. Future plans also include the posting of a modified version of the Medicaid fee schedule on the Web with a section for posting codes additions and changes.

The *Surveillance and Utilization Review Unit* (SURS) is responsible for monitoring provider and recipient compliance with Maine Medicaid policies and regulations. Reviews are performed to fulfill the requirements set forth in Section 42 of the Code of Federal Regulations.

In SFY 1999, the unit identified over $4M of overpayments due to fraud, abuse, and waste. In addition, the unit took action on 11 providers and/or employees of providers by terminating their privileges to participate in the Medicaid Program.

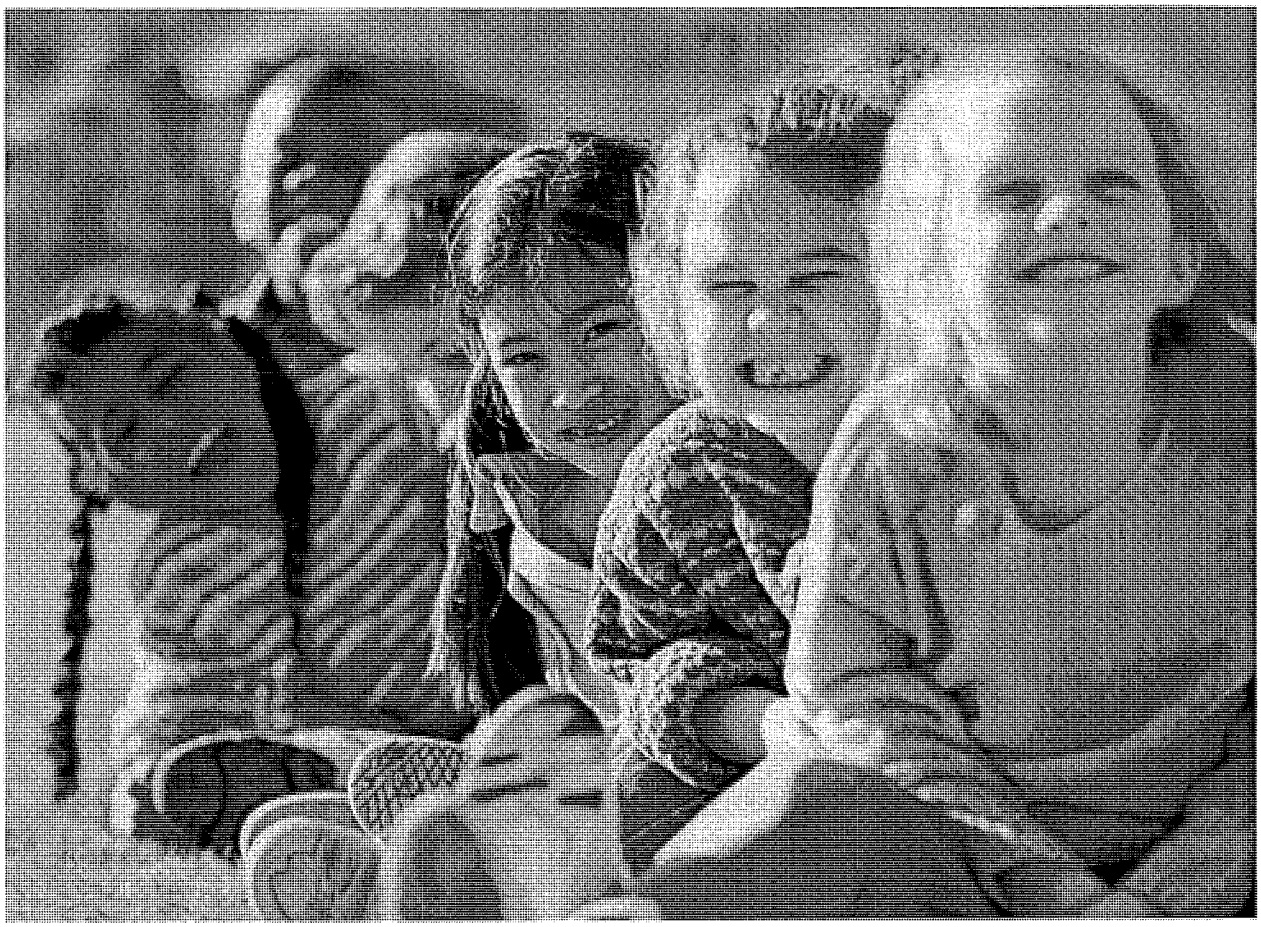
In 1999 the cost benefit of SURS fraud/abuse/waste activities was calculated at an estimated cost savings benefit of over 20:1. For each dollar expended, the Unit recovered and/or saved $20.00 of Medicaid funding for this activity.

SURS staff continues to develop joint cases with the Medicaid Fraud Control Unit (MFCU) of the Maine Attorney General's Office, the U.S. Attorney's Office, and the U.S. Department of Health and Human Services' Office of Inspector General. Seven new cases were referred to the MFCU in SFY99 involving over $500K of alleged fraudulent billings. The U.S. Attorney's Office and the MFCU have recently settled a DME case involving both Medicaid and Medicare. SURS staff were instrumental in developing the case. The negotiated settlement will net $149K of Medicaid funds. A recipient fraud scheme involving transportation payments of over $50,000 may be close to settlement. This case was originally identified by SURS staff and referred to the OIG.

Administratively, the Unit continues to identify and recover Medicaid funds that were inappropriately paid due to various billing errors, poor record keeping or lack of records, and failure to follow Medicaid policies and procedures. The Unit successfully settled a $500K pharmacy case involving one of the State's largest pharmacy chains. The large recovery was the result of that pharmacy's failure to reimburse the Medicaid Program for returned drugs over a three-year period.

In addition to fraud and abuse cases, the unit monitors recipient utilization of health care services. Although this activity has been hampered in the last several years by the lack of a computer system to identify cases, the process continues through referrals. Health care providers contact the Unit to refer clients that they believe are overutilizing services. A nurse contacts the client and his/her health care providers and assists in coordinating proper health care services. This nurse is currently coordinating/monitoring approximately 350 cases.

The *Maine PrimeCare and EPSDT Unit* is also included in this Division. PrimeCare is the Bureau's primary care case management program for TANF and TANF related clients (See Highlights section for a further description.) To assist Bureau staff in implementing this Program, BMS has contracted with Public Consulting Group of Boston, Massachusetts to provide Health Benefits Advisor Services. Their services include beneficiary education and enrollment into Medicaid managed care programs, PCP recruitment for Maine PrimeCare and providing member services for Maine PrimeCare enrollees. They also provide assistance to Medicaid beneficiaries to eliminate barriers to receiving care under Early, Periodic, Diagnosis, and Treatment Services (EPSDT) in partnership with the Bureau of Health Immunization Program (BOHIP).



In order to provide EPSDT Services to eligible beneficiaries under the age of 21, the Bureau of Medical Services has formed a partnership with the Bureau of Health and Public Consulting Group, the Bureau's Health Benefits Advisor. Services include:

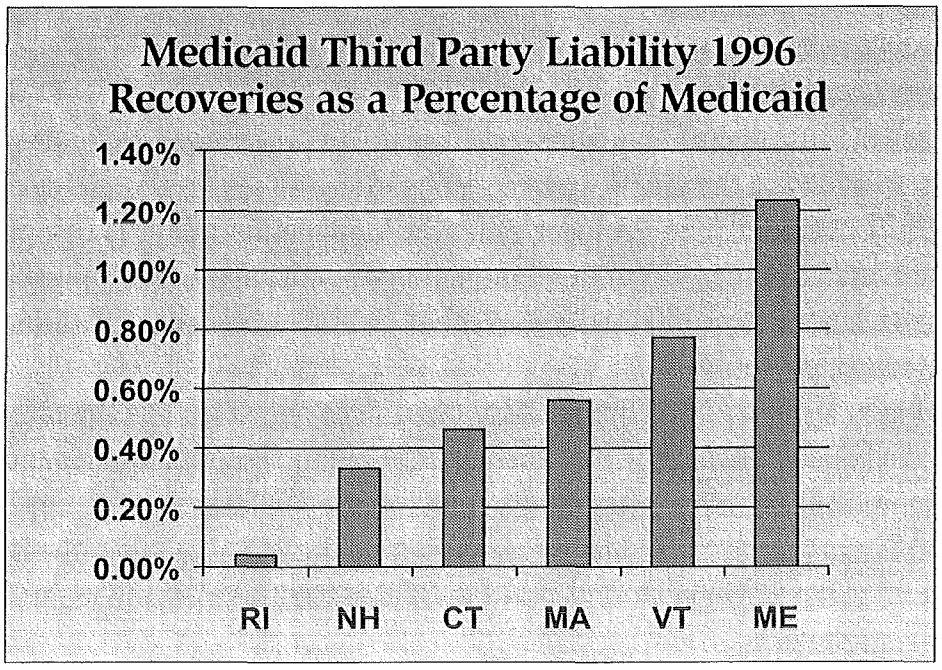
- Informing newly eligible Medicaid beneficiaries about medical services available to them, emphasizing the importance of preventive services. (The Maine Medicaid Program has adopted the Bright Futures periodic schedule and health guidelines.)
- Sending reminders to beneficiaries who are due for preventive visits in accordance with the periodicity schedule.
- Assisting Medicaid beneficiaries in finding Medicaid providers for medical and social services.
- Making referrals to medical and social services as needed.
- Assisting Medicaid beneficiaries to make and keep appointments with Medicaid providers by assisting them with making appointments and arranging transportation.
- Assisting Medicaid providers in the education of beneficiaries about the importance of preventive services and keeping medical appointments.

Financial Services

The Division of Financial Services has primary responsibility for managing the financial functions of the Bureau. In recent years, the Division has seen the scope of its responsibilities increase dramatically. This has partially been a reflection of the increased role of budget and financial considerations in health care policy, but also reflects an effort by the Bureau to better coordinate its financial functions within one Division. With the addition of the Third Party Liability (TPL) Units more than five years ago, the Acute Care Certificate of Need (CON) Unit two years ago, and the recent return of the Claim Processing Units, the Division now includes a staff of more than 80 people.

The Division's *Acute Care and Long-Term Care Financing Units* are responsible for preparing and managing the more than $1.1 billion Medicaid budget. This includes: setting and analyzing provider reimbursement rates and contracts, reconciling provider payments with audits and adjustments; analyzing the financial impact of legislation and policy changes; and projecting trends in Medicaid spending. These units have evolved over the years from primarily focusing on institutional providers (i.e., hospitals and nursing homes) to a more broad focus including all provider groups and managed care organizations.

The Division's *Third Party Liability (TPL) Units* are responsible for enforcing State and federal third party liability rules designed to ensure Medicaid is the payer of last resort. These Units recover some $12 million per year from third party insurers who should have paid a bill that Medicaid initially paid. Once these insurers are identified, savings to Medicaid from avoiding future costs are even greater.



Specific responsibilities of the TPL Units include: identifying third party payers; recovering from these payers and avoiding future costs; casualty and estate recoveries; and analysis of the cost effectiveness of paying Medicaid recipient third party insurance premiums. These units have also taken on primary responsibility for managing the Medicaid drug rebate program that ensures Medicaid pays the lowest price possible for prescription drugs. In SFY 1999 alone, the Unit collected some $28 million in drug rebates, after returning the federal portion, the state share of these collections was almost $10 million.

The Division's *Claims Processing Units* are responsible for ensuring claims are processed accurately and in a timely fashion. The Data Control Unit is the first to receive Medicaid claims in the processing cycle. This Unit is responsible for the screening of all claims that go into the system. It also prepares all claims that go to the keying contractor and are responsible for the paper claims until adjudication. In addition, this Unit is responsible for the final step in the process, the mailing of weekly remittance statements and checks to providers. The *Data Capture Unit* receives all claims for microfilming and scanning. This Unit films all claims and assigns the transaction control number. Claims that are scanned through the Optical Character Recognition System are corrected through a keypunch process within the Unit prior to being sent to the mainframe.

The *Data Resolution Unit* is responsible for most claims that suspend during the processing cycle. Its primary function is to evaluate the claim, correct, price, deny or return the claim depending on the claim's problem. The Provider Account Management Unit is responsible for adjusting claims paid inappropriately, rate changes, cost settlement payables/receivables, physician incentive payments and other financial transactions that are needed to correct/adjust payments.

The Division's *Acute Care Certificate of Need (CON) Unit* is responsible for administering Maine's Certificate of Need Act. Specific responsibilities include: analyzing the need for new or expanded health care facilities and/or health-related services of all types – not just Medicaid; providing technical assistance for the development of these projects; and making final recommendations regarding the need for these projects.

Program Evaluation

The *Division of Program Evaluation* supports the Bureau's efforts in evaluating the health care services and programs offered to those eligible, and assists the divisions and units in improving processes for better workflow and efficiency. This Division performs the long-range technical planning for the Bureau, coordinates the Bureau's research and training initiatives and acts as a liaison with the Department's information services staff. Staff in this Division work to ensure that the Bureau's information services needs are met. This is done by enhancing the information systems as needed and helping the Bureau have access to current, in-depth, reliable information in a timely manner.

Oversight of the Bureau's computer systems resides in this Division. The *Maine Medicaid Decision Support System* (MMDSS) is used to assist Bureau staff to monitor, control and direct Medicaid services and expenditures. MMDSS identifies and consolidates data in a flexible, efficient and cost-effective system to support program, policy and administrative decisions resulting in improved services, quality and outcomes for Medicaid and other consumers of State health programs. Accordingly, the system provides better data access with tools to perform sophisticated information analysis to identify trends, obstacles and opportunities and to act on those analyses in order to better serve those for whom the Bureau purchases services.

In 1996 the Bureau implemented the *Maine Enrollment and Capitation System* (MECAPS). This system was designed to facilitate efficient communication between existing data sources, including the Bureau of Medical Services, the MMIS, the Bureau of Family Independence, the Health Benefits Advisor, and the managed care organizations. MECAPS has management information capabilities such as administrative and management analysis and access to standardized data across units. It allows the Bureau and its HBA to enroll individuals in the Bureau's managed care programs. It also calculates the capitation payments due to managed care organizations.

The *Medicaid Point of Purchase System* (MEPOPS) was installed in 1996 in all of Maine's pharmacies. This system captures over 3 million claims per year. Averaging 8,000 transactions per day, the system checks client eligibility, reviews the prescription for duplication/early refill, reviews for contraindications to health, and processes the transaction for payment.

MECARE is the Department's automated version of the *Medical Eligibility Determination* form. This system is used to determine if a client meets the medical eligibility criteria for the Department's long-term care programs. This software is installed on the laptop computers of nurses who do the assessments. The nurses travel to the consumer's residence, connect to MECARE by modem, and collect the demographic and clinical information necessary to make the determination. MECARE makes the eligibility determination instantly, enabling the nurse to inform the consumer of all the programs and benefits for which they are eligible.

ImmPact, Maine and New Hampshire's Immunization Information System, fundamentally changed the way immunization information is gathered, stored, tracked and shared. For the very first time, two states have been participating jointly in the design, development and support of such a system.

This valuable tool represents the first multi-state immunization information and well-child planning system which tracks the types and dates of patients' vaccines, due dates for their next boosters, well-child checkups and the names of the vaccine providers.

ImmPact leverages existing Medicaid and birth certificate information, there is no need for redundant data entry or maintenance.

ImmPact is a key data resource to provide the information needed for improving and sustaining high levels of immunization coverage. ImmPact fills the information gap by:

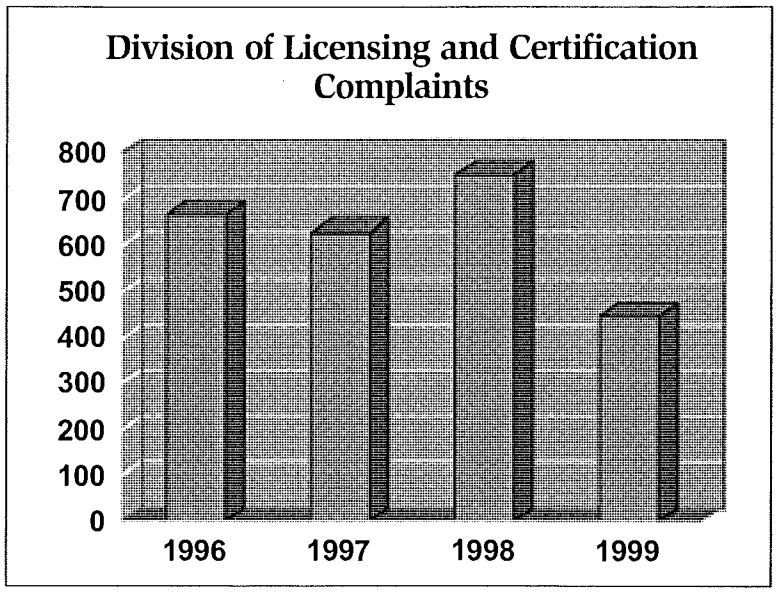
1. Maintaining databases that enroll children at birth and store information on each and every immunization encounter;
2. Consolidating records that are scattered across providers, enabling an immunization needs assessment of each patient based on complete and accurate data;
3. Promoting automated and aggressive recall of under-immunized children;
4. Providing practice- and community-based immunization coverage assessments to promote immunization at every opportunity, and to identify and target interventions in area of need.

Licensing and Certification

The *Division of Licensing and Certification* is somewhat unique in that it was one of the first survey and certification agencies to be part of the Title XIX or Medicaid Agency in a State. Usually, the agency or its equivalent is found in the Department of Health.

The Division of Licensing and Certification appears to be a growth industry. New licensure and Medicare/Medicaid programs have resulted in its rapid expansion from a modest 455 facilities in 1990 to 1,946 facilities in 1994, when the former Division of Residential Care was integrated into the Division of Licensing and Certification, bringing with it over 800 new facilities. Currently, the Division licenses and/or certifies over 2,300 facilities. These additions included State licensure programs for ambulatory surgical centers, hospices, assisted living programs, State facilities such as AMHI and BMHI and Federal Medicare/Medicaid certification programs for rehabilitation agencies, mammography units, End Stage Renal Disease facilities, and the Comprehensive Laboratory Improvement Amendments (CLIA).

Correspondingly, the Division's complaint investigation workload shot up from 422 in 1994 to over 975 currently. In 1990, the Division became responsible for operation of the Maine Registry of Certified Nursing Assistants. From 2,400 CNAs, it now handles more than 33,000. The paralegal support for the Division handles over 60 administrative hearings per year.



The Division has overall responsibility for the Minimum Data Set 2.0. Using Quality Indicators, it has successfully targeted resident populations in nursing facilities to best utilize its survey resources. On July 1, 1999, the Division implemented the expanded survey requirements of the Federal Nursing Home Initiatives, which include staggered surveys, review of abuse protocols and increased focus on nutrition, hydration, pressure sores and fecal impaction in nursing facilities.

The Division has also implemented use of the Federal Outcome and Assessment Information Set (OASIS) for Maine's home health agencies. It has written regulations and implemented oversight for the Critical Access Hospitals and licensure of End Stage Renal Disease facilities.

During the year 2000, it hopes to establish an updated licensure database and secure adequate computer support.