Maine Department of Human Services
Bureau of Medical Services

Annual Report to the State Legislature

Medicaid in Maine

SFY 2000

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Annual Report–SFY 2000

TABLE OF CONTENTS

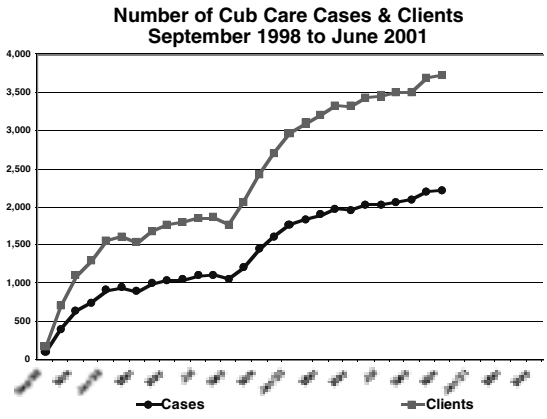
Highlights of SFY 2000

Expansion of Coverage for Children

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP) 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. The Maine Commission on Children's Health Care, established by the One Hundred and Eighteenth Maine Legislature to consider the problem of uninsured children in Maine and review options for providing health coverage under Title XXI, recommended that the State (1) expand Medicaid, (2) create a separate program called Cub Care, and (3) allow Medicaid and Cub Care participants who lose eligibility due to changes in income an opportunity to purchase coverage for up to eighteen months.

The Medicaid expansion initiative was implemented July 1, 1998. It provided coverage to children ages 1 through 18 living in families with income up to and including 150% of the federal poverty guidelines. According to data from the Bureau of Family Independence, as of July, 2000, 5,913 children were enrolled in Medicaid as a result of the expansion. Between July 1999 and 2000, enrollment increased by 22.8%.

Cub Care was implemented August 1, 1998. Originally, Cub Care provided coverage only to children age 1 through 18 living in families with income between 150% and 185% of the federal poverty guidelines. Subsequent changes to the State statute increased the maximum income level to 200% and authorized coverage for children under one. The change in the maximum income level was implemented October 1, 1999 and the new age criterion was implemented September 1, 2000. Cub Care benefits are the same as those offered under Medicaid but Cub Care participants pay a monthly premium based on family size and income. As of July 25, 2000, 3,452 children were enrolled in Cub Care.



Between July 1999 and 2000, enrollment increased from 1,864 to 3,452, an 85.2% increase.

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. The current premium is $1200 per child per year. As of October 2000, 55 children were enrolled in this option. This is up from 4 children one year ago.

Numbers of Uninsured Children Down in Maine

The Bureau of Medical Services (BMS) sponsored a random household survey in 1997 to determine the number of uninsured and insured children in low-income families. The Bureau sponsored another random household survey in 1999/2000. The new survey used the same survey methodology, instrument, and weighting methodology; however, a smaller sample was used due to cost constraints. The final results are as follows:

Percentage of Federal Poverty Level	# Uninsured (or Unknown) Children 1997 Survey	# Uninsured Children 2000 Survey
< 125%	7,658	5,554
125%-185%	11,357	4,895
186%-200%	2,338	687
> 200%	6,557	6,269
No income information	4,071	1,545
Total	**31,981**	**18,950**

The random household survey is the primary source of information available to estimate the progress made in decreasing the number of uninsured children in the State. While the health care environment has changed and the Medicaid Expansion and Cub Care initiatives have been operational only for a short period, the data would seem to suggest that the SCHIP is having a positive impact on increasing the number of low-income children in the State with creditable health coverage.

Expansion of Coverage: Parents

As a result of legislation passed by the One Hundred and Nineteenth Maine Legislature, parents of children age 18 and under enrolled in Medicaid also are eligible for Medicaid. Coverage will be available to parents with family income equal to or less than 150% of the federal poverty guidelines and assets less than $2000. Effective September 1, 2000, the Department of Human Services implemented this coverage option.

Further Expansion of Pharmacy Programs

On August 1, 2000 Maine's Drugs for the Elderly or Disabled (DEL) Program was once again expanded. The Program has been expanded to cover 80% of the cost of prescription drugs from participating manufacturers for all generic drugs. This is in addition to the disease states already covered under the Basic component. An annual catastrophic spending limit was also established for the DEL Program. After the DEL Participant has

spent $1000 for prescription drugs in the Program, the State will then pay 80% of the cost of all prescription drugs. However, if DEL participants have another prescription drug coverage plan, they must first use that plan's coverage since the DEL Program is the payor of last resort.

In early January, 2001, Maine expects to implement the Maine Rx Program. This Program was established to make prescription drugs available at affordable prices for those without a public or private prescription drug coverage plan. It is estimated at full capacity, this new Program could benefit up to 325,000 Maine residents.

Medicaid Managed Care

Maine PrimeCare is a primary care case management (PCCM) program operated by the Department of Human Services. Enrollment into the program provides Medicaid and Cub Care 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. To date, this program has resulted in an 8% savings of managed services due to a reduction 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 a county-by-county phase in of mandatory enrollment beginning in Androscoggin county. Completion of Statewide enrollment for beneficiaries receiving Medicaid and Cub Care under TANF, TANF related, and foster care will be completed the end of the year 2000. It is anticipated that enrollment will rise to approximately 80,000 recipients. In SFY 2001 the Bureau of Medical Services phased out the small voluntary HMO program with Aetna US HealthCare which was operating in seven counties.

Survey of Recipients About Their Primary Care

In the spring of 2000, the Quality Improvement Division began working in conjunction with the Foundation for Health Care Accountability (FACCT) on a project to review Medicaid and Cub Care recipients opinions of the services recipients ages 0-4 receive from their primary care providers. This survey had 3 specific objectives that included:

1. **evaluating the quality of care for low-income children;**
2. **correlating parents' perceptions of well child visits with provider documentation of care provided during such encounters;**
3. **developing a report on policy implications and strategies for deployment includ-**

ing consumer reporting and feedback.

The survey was mailed to 3,914 Maine Medicaid and Cub Care recipients. Survey responses were entered into a database and submitted to FACCT for analysis. As of July 20, 2000, Maine Medicaid had received a survey response rate of 59.9%. The Foundation for Health Care Accountability has stated that they have performed this survey in several other states for Commercial, Medicare and Medicaid plans and this has been the highest response rate to date.

The Bureau intends to perform an adolescent survey in conjunction with the Foundation for Health Care Accountably in 2001. This survey will be useful in determining what educational and preventative services need to be provided to improve the health care for adolescents who have Maine Medicaid coverage.

Lead Testing

During the last year the Bureau has been monitoring the lead testing rates of 1- and 2-year-old Medicaid and Cub Care recipients. The Division of Quality Improvement is presently creating a baseline to determine if providers are testing recipients for lead poisoning. In 1990, the Centers for Disease Control (CDC) determined that 4.4% of the children in the US have been diagnosed with elevated lead levels. CDC estimated that 890,000 US children ages 1-5 have elevated blood lead levels and more that one-fifth of African-American children living in housing built before 1946 have elevated blood lead levels. The major sources of lead exposure are deteriorated paint in older housing, dust and soil that are contaminated with lead from paint and from past emissions of leaded gasoline.

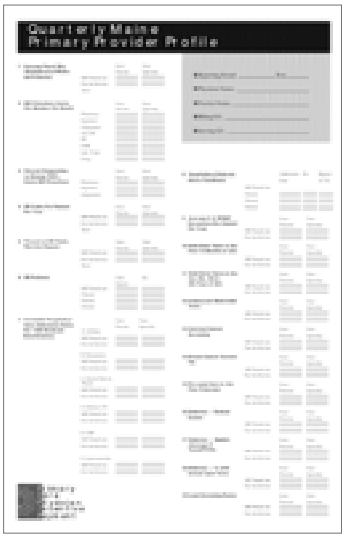
Lead poisoning can cause learning disabilities, behavioral problems and at very high levels seizures, comas and even death. Children between 12 and 36 months of age have a lot of hand-to-mouth activity, so if there is lead in their homes, they are more likely to ingest lead particles than are older children. Lead poisoning affects virtually every system in the body and often occurs with no distinctive symptoms. Lead can damage a child's central nervous system, kidneys, and reproductive system. Even low levels of lead are harmful and are associated with decreased intelligence, impaired neurobehavioral development, decreased stature and growth and impaired hearing acuity.

The goal for lead screening in the 1-year-old population is 100%. In actuality, the screening rate has been very poor, with the baseline being 8%. Initial efforts have resulted in only nudging the rate up to 14%.

The Bureau will need to develop and employ multiple interventions in a sustained, concerted effort to continue to make progress. In an attempt to increase physician awareness of the need for lead testing and to improve lead-testing rates, lead-testing rates are now included in the Primary Care Provider Incentive Program (PC-PIP) report. Primary care providers receive a report that outlines the current number of recipients ages 1 to 2 in their panel and indicates the percent that had lead screening. BMS will continue to collaborate and support joint interventions with the Bureau of Health and clinical researchers.

Primary Care Provider Incentive Program (PC-PIP)

A PC-PIP report is mailed to approximately 1,000 providers on a quarterly basis. This report provides the primary care provider with data reflective of utilization patterns and preventative services as compared to other practitioners of his/ her specialty. There are approximately 32 HEDIS (Healthplan Employer Data Information Set) or HEDIS-like measures that have been developed over the last 3 years. HEDIS measures are standards that are used as measures of quality to track health outcomes for Medicaid and Cub Care recipients. These measures include: lead testing rates in children ages 1 and 2, the number of Early, Periodic Screening, Diagnosis and Treatment (EPSDT) preventive visits made by recipients assigned to a specific provider, diabetic (Hgb A1C) testing rates as well as breast and cervical cancer screening rates. This program distributed an average of approximately $3,000.00 per provider, based on performance, over this past fiscal year.


Quarterly Maine
Primary Provider Profile

Since the formalization of the PC-PIP, providers have frequently called to request information specific to their practices. As a result of these requests individual reports have been sent to providers in areas of lead testing rates and EPSDT visits.

Starting in calendar year 2000, a quarterly newsletter was mailed in conjunction with the PC-PIP report. This newsletter updates providers on changes made to the Program as well as projects/ studies being conducted by the Bureau's Quality Improvement Division.

The Bureau received requests for this newsletter from other types of providers. As a result, the newsletter now includes such information as billing change information, commonly-occurring errors in billing, Bureau projects and studies as well as updates on Maine PrimeCare and articles of interest to nursing facility providers. The expansion of the newsletter is in direct response to the requests from providers.

Year 2 of the Adult Immunization Project

The project was designed to promote the use of pneumonia and influenza vaccine in nursing facilities. In 1999, the Maine Medicaid policy for nursing facilities was changed to require annual offering and determination of immunization status of both nursing home residents and staff. Maine Medicaid also made arrangements with the Bureau of Health to provide vaccine to all provider types. This was determined to be a cost neutral project. Providers are now able to order Pneumovax and Influenza through the Bureau of Health.

National nursing home standards published in 1995 reflected an influenza immunization rate of 63%, and pneumonia immunization rate of 22%. The Maine Medicaid nursing home influenza immunization rate during flu season 1998-1999 was 81.6%. For the 1999-2000 season, pneumonia vaccine rates increased from 27% to 63.4%, while influenza rates held about steady from 81.6% to 80.8%. Many of the nursing facilities reported difficulty in obtaining influenza vaccine during the 1999-2000 flu season, which may explain the small decline in influenza rates.

The specific goals for this next year is to raise pneumonia vaccination 10%, from 63% to 70% and influenza immunization from 82 to 84%. Newsletter articles were published in the fall, and nursing homes were required to report the immunization status of Medicaid recipients within the facility.

HIV/AIDS Demonstration Waiver Approved

Last spring Maine DHS received approval of its application to the Health Care Financing Administration (HCFA) to run an HIV/AIDS demonstration project. Although other states are considering, or have applied for such waivers, Maine was the first in the nation to receive approval. Approval of this application granted the State a waiver of certain portions of the Social Security Act.

The waiver will allow people 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 allows for a limited benefit package of essential services; including pharmaceuticals, office visits, laboratory services, inpatient hospital services and casemanagement services. The program will be capped at approximately 300 people at any point in time.

Without the provisions of this waiver, individuals with HIV disease who are over the income limits would have to wait to become disabled before attaining Medicaid eligibility. This demonstration project is designed to delay, prevent or even reverse the progress of this deadly disease. It is also designed to be cost neutral to the Medicaid program within five years.

The waiver will be run by the Bureaus of Medical Services, Family Independence and Health within the Department of Human Services. A team representing these Bureaus, a consulting team from the University of Maine at Farmington and health care and social service providers has been working together to develop operational protocols for this groundbreaking waiver.

Planning Grant Awarded for Community-Based Long Term Care

The Center for Health Care Strategies (CHCS), in a major initiative tied to the U.S. Supreme Court's decision in the 1999 *Olmstead v L.C.* case, awarded planning grants to seven states to improve their community-based long-term care services. These grants were funded by CHCS under the Robert Wood Johnson Foundation's Medicaid Managed Care Program. Maine was one of the seven states awarded a grant.

In June 1999, the U.S. Supreme Court ruled in *Olmstead* that states must develop a "comprehensive, effectively working plan" to provide medically appropriate community-based care to eligible populations within given budget constraints. The ruling resolved a lawsuit brought by two institutionalized women against the State of Georgia, in which they requested that appropriate community-based settings be provided to meet their ongoing treatment needs.

There are four parts to Maine's grant:

1. **Focus groups with consumers to discuss coordination and delivery of services to children and adults;**
2. **Case studies of individuals with complex issues or with particular difficulty accessing services with multiple agencies are involved;**
3. **Analysis of data systems to determine a set of key data elements consistent across State agencies, as well as recommendations for making systems more compatible for tracking and monitoring; and**
4. **Organizational analysis to develop new models for interagency coordination.**

This grant complements the work of the Plan Development Work Group for Community-Based Living that includes consumer representation from among a broad range of disability organizations, as well as representation from five State Agencies (Departments of Human Services, Mental Health Mental Retardation and Substance Abuse Services, Education, Corrections and Labor.) This Workgroup is developing the working plan; inventorying and summarizing existing initiatives that parallel the goals and objectives of *Olmstead* to incorporate into the working plan and to disseminate through the website developed for this effort and other media.

Medicaid Coverage for People with Disabilities

Maine had a new coverage option as of August 1, 1999 that allows someone with a disability to increase their earnings and still get Medicaid coverage.

Individuals are potentially eligible if :

- **They meet the Social Security criteria for disability. If someone is not getting a Social Security payment, the Department will determine if those criteria are met.**
- **Their unearned income (such as Social Security and other pensions) is below 100 percent of the Federal Poverty Level (FPL) and both earned and unearned income combined is below 250 percent of the FPL.**
- **Assets are under $8,000 for an individual and $12,000 for a couple.**

Some people must pay a monthly premium. The premium amount is $10 per month for individuals with income between 150 percent and 200 percent of the FPL and $20 per month for individuals whose income is between 200 and 250 percent of the FPL. There is no premium due for people whose income is below 150 percent of the FPL or persons paying a Medicare Part B premium.

New Resources for Children

Department of Human Services staff, along with the Department of Mental Health, Mental Retardation and Substance Abuse Services have reduced the numbers of children in out-of-state placements from approximately 260 to 112 through a major resource development effort. The Departments plan to continue that process until there are no children placed out of State for services. Approximately 300 new options for children have been developed, and another 117 are in various stages of development.

Efforts continue to maximize use of children's psychiatric hospital beds in Maine:

A multi departmental effort is underway to focus on assuring that Maine children are treated in Maine hospitals and then discharged in a timely manner. The Departments will be stepping up efforts for more aggressive discharge planning for children with the belief that shorter lengths of stay are more effective for the child and family. This effort will require increased reliance on crisis units and transitional programs for children who are able to safely move from the hospital. There are also efforts to enhance Maine's crisis services in order to assure that children are appropriately triaged and treated in the most integrated settings possible. This has involved the addition of a dozen new crisis beds along with adding to the community-based diagnostic capacity. The Departments are also exploring ways to better utilize out patient services to decrease reliance on in patient diagnostic services

Enhanced, integrated substance abuse/mental health treatment resources for children:

Currently Maine has no community-based resources that for children who have a diagnosed mental health condition, are on psychotropic medications, and need substance abuse treatment. This is considered the highest priorities among all child-serving State agencies. The Department is developing one new community based residential program for each of the three DHS regions. This would mean an additional twelve beds to add to six already in the development now.

Enhanced services for children coming into DHS custody, who are at risk of going out of State:

Currently there are approximately 3,100 children in DHS custody. The needs of these children are widely varied. The Department needs to continue to develop new resources to serve children as they come into care. Department staff are currently doing a needs assessment in each of the local offices to quantify the types of services needed. The results of this assessment will determine the configuration of new resources developed. It is already known that the State needs more bridge homes, regular foster care, and therapeutic foster care. The array of community-based services that will better enable children to remain in their community needs to be enhanced.

Enhanced services for homeless youth:

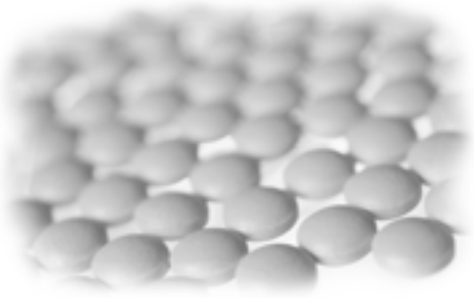
There are two major task forces to address services for homeless youth; one in Portland and Bangor. They have had broad participation from a wide range of community providers and leaders, along with all child-serving State departments. These groups identified a number of initiatives that could reduce the number of children who are homeless. It is recommended that programs be developed that would help teens become engaged in both educational and vocational resources, along with better residential alternatives.

Initiatives Beyond the Year 2000

Prescription Drug Costs

Outpatient pharmaceutical spending for the Medicaid Program has been accelerating at a rate in excess of 20 percent for the past two years. Program costs for SFY 2000 were in excess of $160 million. Estimates from all sources expect this 15-20 percent annual increase to continue for at least several more years. The Bureau of Medical Services recognizes that the potential long-term impact of increased spending for pharmaceuticals is to control or prevent disease. This ultimately results in a reduction in overall health system spending with the potential for higher quality care. However, the Bureau needs to ensure that patients are receiving appropriate therapy with pharmaceuticals in the most cost-effective manner possible.

As a result, the Bureau has developed a new and innovative voluntary program implemented in cooperation with physicians and other prescribers. This program is the Physician Directed Drug Initiative. This physician directed initiative is aimed at cost-effective rational drug therapy, which will more effectively manage prescription drug costs. This program will encourage medication use in some conditions that pose a high risk to patient health, while encouraging increased use of appropriate lower-cost medication alternatives.



This program provides for progressive compensation to reward physicians whose efforts result in a positive shift toward the goals and objectives of the program. Some of the objectives of the program are:

- promote increased utilization of ACE inhibitors for high-risk patients with congestive heart failure;
- increase utilization of anti-coagulants in patients with atrial fibrillation;
- increase utilization of anti-inflammatory medications for patients with asthma;
- minimize use of antibiotics in viral-based upper respiratory illnesses;
- encourage appropriate, cost-effective therapy for patients with acid-peptic related disease; and
- maximize the use of lower cost generic medications where appropriate.

The Bureau intends to update this program continuously, to monitor current initiatives and identify new areas for improvement in outcomes and drug therapy. The overall goal is to enhance the quality of care while achieving overall cost savings to Medicaid. Additionally, the Bureau will exert considerable effort to identify any additional drugs suitable for prior authorization, including the consideration of dose/strength and quantity limitations.

Tri-State Initiative

The Governors of three New England states—Maine, New Hampshire and Vermont—met in early 2000 to share and discuss their common concerns about rising prescription drug prices. They are concerned about rising prescription drug costs and the burdens placed upon their citizens in general because of escalating prescription costs. The three Governors have considered a number of options to help their citizens save money on prescription costs.

The Governors felt that it would be productive for the three states to form a Coalition to see if concerted action among the states could significantly impact prescription drug expenditures in the states' public programs, including Medicaid. The Governors wanted to join together due to their states' similar socioeconomic and geographic characteristics.

The Governors also realized that such a Coalition might be able to lower prescription costs for other state populations as well, who would participate on a voluntary basis. In addition, these states have a variety of initiatives underway to lower or subsidize prescription drug costs for the uninsured, elderly, and lower income residents that do not qualify for Medicaid.

Accordingly, the Governors appointed a working group of Cabinet members and other senior officials from the three states. This working group studied whether aggregating pharmaceutical purchasing could lower overall prescription drug costs for the various state-funded programs, the uninsured and other groups in the three states.

After intensive study during the spring and summer, the working group reported back to the Governors its finding that aggregate purchasing by the states could be beneficial. In general, the conclusion is that drug expenditures for some or all of the following populations could be combined in a multi-state effort.

- Individuals without access to pharmacy benefit coverage
- Medicaid beneficiaries
- Medicare beneficiaries
- State employees, retirees and dependents
- College and university employees, retirees and dependents

The working group recommended to the Governors that the most effective strategy to implement a multi-state purchasing alliance would be to recruit a pharmacy benefit manager (PBM). To this end, the three states have released a Request for Proposals for a Pharmacy Benefit Manager.

The Coalition believes that the pharmacy benefit management industry may be able to help control escalating state drug expenditures through the use of techniques developed for the private sector. While Medicaid drug programs differ in some ways from pharmacy benefit management programs in the commercial market, they also have much in common. Until now the PBMs that manage pharmacy benefits for the private sector have not been a major factor in providing these services to state Medicaid programs. These same

techniques and procedures can work to the benefit of the other groups that will be included in this initiative. The RFP issued by the three states is intended to invite innovative cost reduction proposals for the populations identified above utilizing pharmacy benefit management principles and expertise.

Ticket to Work

Maine requested funding from the Health Care Financing Administration and received a grant in the amount of $582,000 for a period of four years for its CHOICES Program (Continuing Health Options and Incentives via Coordinated Employment Supports). This is an infrastructure grant project that builds on the strength of Maine's current Medicaid Buy-In Program. The goals of this program development and partnership-building initiative are to:

- improve access to competitive employment for people with disabilities;
- advance technical understanding of how Medicaid-funded services specifically support the competitive employment of people with disabilities, and to devise equitable and effective methods for targeting Medicaid resources to that end;
- improve the coordination of multiple policies and programs available to support competitive employment among people with disabilities; and
- increase collaborative efforts with other states to promote employment of people with disabilities.

The Maine CHOICES project will undertake a significant research and program development agenda through a partnership of State and federal agencies, consumers, disability organizations, service providers and researchers. Using a combination of methods that will include consumer surveys, focus groups, analysis of current program utilization and key informant interviews, the project will collect and analyze data regarding people with disabilities in Maine and use the knowledge gained to improve the current Medicaid Buy-In program, increase access to coordinated employment supports, and make changes to Maine's health systems. Through state-to-state technical assistance collaboration, it will share its progress, and also learn about the best program features that can be considered for adaptation and use in Maine.

Replacement of the Medicaid Claims Payment System

The existing MMIS module for Medicaid claims processing was developed and installed in 1978. While the system continues to support the minimal operational needs of claims processing and federal reporting, it is deficient in its ability to provide management information and to support the changing needs and ever-increasing complexity of the Medicaid program. The Maine Medicaid program is funded to replace this system with the Claims Management System (CMS.) CMS will include: automated claims processing; financial analysis; administrative and information queries and reports. It also segments the functionality of the MMIS claims processing system into interconnecting

modules which makes the CMS flexible from a business functionality, upgrades, and system integration perspective. The project has commenced with development and approval of an Advanced Planning Document (APD) for the Health Care Financing Administration (HCFA). BMS has partnered with the Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) due to the growing number of Maine citizens receiving services from this Department which are funded via the Maine Medicaid Program. HCFA has embraced this partnership and recognizes DMHMRS as an integral part of the Maine Medicaid Program and eligible for federal matching funding. BMS anticipates the system will be operational in 2002.

Quality Improvement for Health Care Facilities

The Health Care Financing Administration (HCFA) is in the process of implementing its major Quality Improvement and Evaluation System (QIES). The system goes well beyond providing the State Survey Agency the ability to collect assessment data from providers and transmit the data for analysis and support of the prospective payment system. This system was intended to provide applications/tools to use performance information to bolster on-site survey activities, monitor ongoing quality efforts, and facilitate the providers' continuous quality improvement process.

The next phase in implementing this system is the interfacing of the ASPEN, OSCAR and ODIE systems. These subsystems support the licensing and certification process of health care facilities. There are expected to be some Maine-specific system refinements in this system, including the addition of State-licensed-only facilities, training and technical interfacing with Core operations. Additionally, the existing MDS/OASIS systems will be extended to include new provider types in the future (e.g. end-state renal dialysis facilities, ICFs/MR, rehabilitation facilities.) QIES will provide the infrastructure for all future HCFA quality data development. It will provide the opportunity to expand the use and understanding of health care quality data.

During the period from November of 2000 through January of 2002, HCFA will begin the many phases of QIES implementation starting with conversion of the OASIS data from home health agencies.

Home Health Assessment Tool

HCFA has implemented the Outcome and Assessment Information Set (OASIS) since 1999. Federal regulations require that those home health agencies participating in Medicare complete on each patient a patient-specific, comprehensive assessment using a standard, federally designed care assessment set. The federal regulations require that OASIS data be electronically submitted to the State Survey Agency, which in turn reviews and forwards the data to HCFA.

After the initial startup, home health agencies will use this assessment tool for clinical assessment. HCFA will use the data for design and implementation of a prospective payment system (PPS) to pay home health agencies. By July 2001, HCFA expects to use its national OASIS database to produce Outcomes Based Quality Improvement reports (OBQIs) and a Medicare PPS based on these data. Bureau of Medical Services' Division of Licensing and Certification, assisted by staff of the Edmund S. Muskie Institute of the University of Southern Maine, has provided the technical support for systems implementation, ongoing changes from HCFA, and training on the use of the system.

Quality Oversight of Commercial HMOs

The Department has proposed rules that will establish standards for assuring the quality of care delivered by commercial health maintenance organizations. This rule provides for a periodic examination of the HMO no less frequently than once every three years. This periodic examination may be coordinated with a DHS approved national accrediting organization in order to streamline this process. The first onsite review will be coordinated with NCQA and will take place in December 2000 at Aetna U.S. Healthcare.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA legislation establishes standards for electronic transactions, code sets, various national identifiers, security, and privacy for the health care industry. These standards are to be implemented within 26 months of the publication of the final rule for each set of standards. The first final rule for electronic Transactions and Code Sets was adopted in August of 2000 with an implementation date of October 16, 2002. HCFA has no projected dates for publication of the final rules for the remaining standards for national identifiers, claim attachments, enforcement, privacy, and security. However, these are expected to be published in staggered fashion and there will be overlapping implementation dates of various standards ongoing over the next few years.

Maine Medicaid staff are working to determine the business impacts of HIPAA. The new Claims Management System must be compliant with any final rules in regard to HIPAA. Informational sessions will be held with State agencies in order to increase the awareness of the far-reaching impact of HIPAA and to assist them in planning for program and system changes.

Plastic ID Cards

A new Medical Assistance identification card is in the development stage. This card will be the new eligibility identifier for all Medicaid and Cub Care recipients. Currently the Bureau of Medical Services mails eligibility cards on a monthly basis. It is a substantial investment of staff resources and dollars to print and mail these cards over the course of a year. These forms, on 8.5 X 11 paper, contain the basic eligibility for a client and could potentially be out of date shortly after the card is issued because of eligibility changes. As a result, providers must verify eligibility by using the Department's voice response system whether or not the client's ID card indicates eligibility.

The new plastic card will have a magnetized stripe and will replace the monthly paper card. The cards would be used to verify Medicaid eligibility through point of service (POS) card readers located at the health care provider's place of business. All pertinent eligibility information would be accessed real time by the provider through this system. Those providers who choose not to have a POS system could choose to have faxed information or choose to continue to call the Bureau for the Medicaid eligibility data using the voice response system.

The Department will be issuing an RFP for the swipe card in early 2001. Vendors will be providing information to health care providers in regard to the point of service card readers. Providers will choose between purchasing the services provided by these vendors or continuing to verify eligibility through the voice response system.

Legislative Corner

During the Second Regular Session of the 119th Legislature 434 legislative documents were considered, along with a number of carry over bills. Of the total, Bureau staff followed 33 bills and prepared written testimony and/or letters on 11 bills.

The Bureau initiated the following Department bill:

✔ LD 2269. **An Act to Make Changes to the Cub Care Program.**

The purpose of the bill was to allow the program to serve children who have not attained one year of age and set premiums for families with incomes between 185% and 200% of the poverty guideline. This provision was revised and made part of the Supplemental Budget (PL Chapter 731 (Page 210).

The following are bills that were initiated, for the most part, by parties outside of the Department and passed by the Legislature and signed by the Governor, for which there is an impact on the Bureau:

✔ LD 114. **An Act Regarding Medicaid Managed Care Ombudsman Services.** This carryover bill from the 1st Session provides parameters to be used in contracting ombudsman services.

✔ LD 2046. **An Act to Amend the Powers of Hospital Administrative District No. 1.** The bill amends the powers of the board of directors.

✔ LD 2510. **An Act to Amend the Elderly Low-Cost Drug Program.** Retains eligibility for household members that were eligible during the year prior to the low-cost drug program expansion.

✔ LD 2599. **An Act to Establish Fairer Pricing for Prescription Drugs.** Establishes the Maine Rx Program.

✔ LD 2644. **An Act Relating to Eligibility for the Elderly Low-cost Drug Program.** Clarifies eligibility so that Medicaid eligibles without a pharmacy benefit may otherwise qualify for the Elderly Low-Cost Drug Program.

The following are highlights from the Supplemental Budget (LD 2510). (PL Chapter 731)

✔ Page 41. Appropriates State funds of $29,915,129 in 2000 and $28,456,139 in 2001 to cover the Medicaid shortfall.

✔ Page 41. ($132,000) Deappropriates State funds to cover the 97/98 AMHI and BMHI hospital tax.

✔ Page 42. Provides State funds for one pharmacist for the Low Cost Drugs and Medicaid Programs.

- ✔ Page 43. Provides State funds for Claims Management System development.
- ✔ Page 92. Appropriates Federal funds of $58,748,561 in 2000 and $55,596,849 in 2001 to cover the Medicaid shortfall.
- ✔ Page 92. Provides Federal funds to establish three Senior Medical Claims Evaluator positions to provide improved customer services within the Provider Relations Unit.
- ✔ Page 94. Provides Federal funds for Claims Management System development.
- ✔ Page 115. Provides Federal funds of $2,761,000 to cover a shortfall in the Medicaid Administration account.
- ✔ Page 116. Appropriates Federal funds, $132,659, to cover the AMHI/BMHI hospital tax.
- ✔ Page 140. Appropriates State funds, $17,435 for reclassifications.
- ✔ Page 208. Appropriates Special Revenue from the Healthy Maine fund for the State share of a Management Analyst II to aid in managing Medicaid coverage.
- ✔ Page 209. Appropriates Special Revenue from the Healthy Maine fund of $3,645,925 for expanded Medicaid coverage.
- ✔ Page 209. Appropriates federal funds for the federal share of a Management Analyst II position.
- ✔ Page 209. Appropriates Federal funds of $7,146,021 for expanded Medicaid coverage.
- ✔ Page 210. Appropriates Federal funds of $1,164,449 to cover the costs to provide Medicaid access to pregnant women.
- ✔ Page 210. Appropriates Special Revenue from the Healthy Maine fund of $596,000 for the costs to provide access to Medicaid for pregnant women.
- ✔ Page 210, Part PP. Provides language and funds to expand Cub Care and Medicaid coverage.
- ✔ Page 216, Part TT. Expands TPL law to include Low Cost Drugs for the Elderly.
- ✔ Page 222, Part UU. Provides $1,800,000 in Special Revenue funds from the Fund for a Healthy Maine to improve access to tobacco-related chronic disease prevention services.
- ✔ Page 223, Part UU. Provides federal share funds, $3,516,792 to improve access to tobacco-related chronic disease prevention services.
- ✔ Page 296, Part BBBB. Language, State and Federal funding to streamline and study the long term care system.

The following are from the Emergency Appropriation for SFY 2000 (LD 2692). (PL Ch.732):

- ✔ Page 4. Provides $29,915,129 in State funds to cover the budget shortfall.
- ✔ Page 5. Provides a deappropriation of ($132,659) to cover the 97/98 hospital tax for AMHI/BMHI.
- ✔ Page 12. Provides $2,761,000 in Special Revenue funds to cover the shortfall in the Medical Care Administration account.
- ✔ Page 13. Provides $132,659 in Special Revenue funds to cover the hospital tax for AMHI/BMHI in tax years 97/98.
- ✔ Page 20. Provides $79,880 in federal funds to cover reclassifications and range changes within the Bureau.

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	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%	76.48%	23.52%
2000	66.22%	33.78%	76.36%	23.64%
2001	66.12%	33.88%	76.28%	23.72%
2002	66.58%	33.42%	76.61%	23.39%

Who is Covered?

State Medicaid programs are required by HCFA to cover certain groups, while other groups are covered at the option of the State. In Maine, a person must belong to one of the groups described below and meet certain financial criteria in order to get coverage.

- **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.) If a child becomes ineligible for coverage due to an increase in family income, coverage can be purchased for up to 18 additional months at the cost of $100/child per month. This is the Health Insurance Purchase Option. This option provides the same services as Medicaid.
- **Age 19, 20.** Asset limit is $2,000 with income under 150% 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 indiviual with a disabling condition (in any age group) has earnings, he or she has a more liberal asset limit of $8000. The income limit is 250% of the FPL as long as income from pensions, retirement, etc. is under 100% of the FPL.

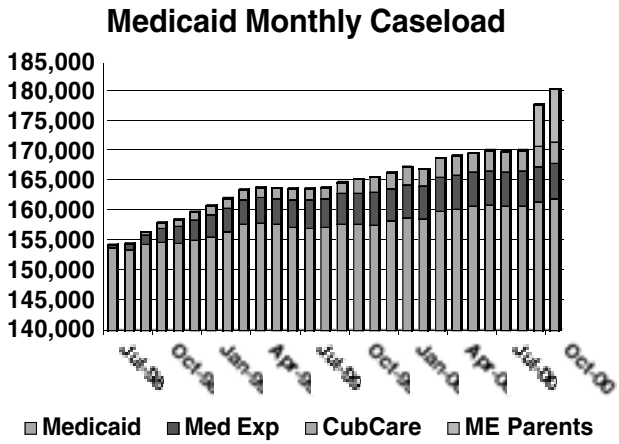
- **Age 65 and over.** The income limit for an individual in this group is 100% of the FPL. The asset limit is $2,000.
- **Special Coverage Groups.** Pregnant women are eligible without regard to assets as long as income is under 200% of the FPL. Coverage continues for 60 days after the end of pregnancy.

  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. If income is over this amount but under 175% of the FPL, the individual may be eligible instead for one annual payment of $37.08. 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 services
- Nurse practitioner services
- Nursing facility and home health services for those 21 & 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
- Hospice (To be covered in early 2001)
- 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

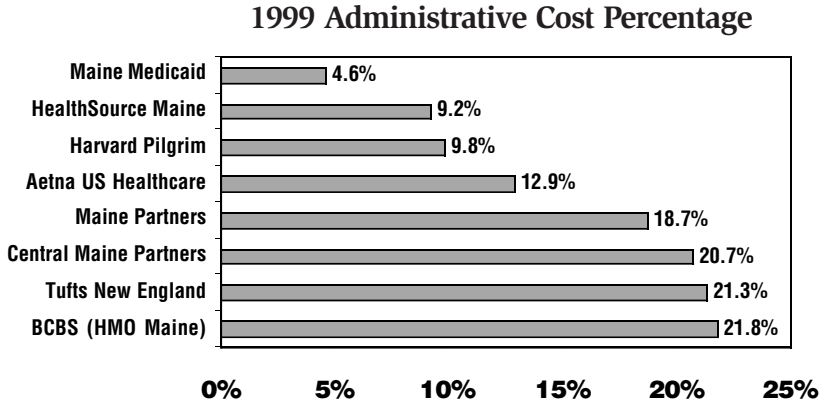
What Does the Program Cost?

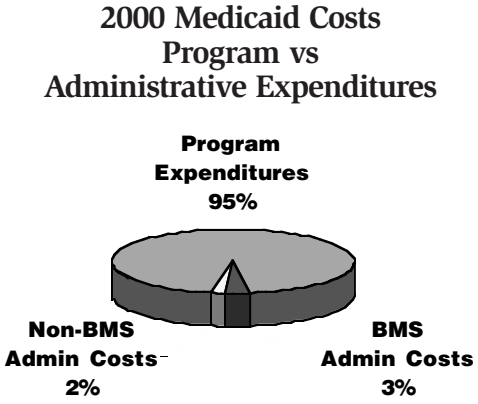
Medicaid Services—Medicaid is a major budgetary commitment for the State of Maine, consuming approximately 14% of the State's general fund budget in FY 1999. Total expenditures for this State fiscal year were $1,117,549,639. Of the 196,808 individuals determined eligible for services under the program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

Medicaid Outpatient Prescription Drug Spending

	SFY 1998	SFY 1999	Change	SFY 2000	Change
Total Expenditures	$109,697,688	$136,033,928	24.0%	$169,033,986	24.3%
Drug Rebates	-$20,206,046	-$27,957,863	38.4%	-$35,978,026	28.7%
Drug Rebate Percentage	18.4%	20.6%		21.3%	
Net Expenditures	$89,491,642	$108,076,065	20.8%	$133,055,960	23.1%
Number of Drug Recipients	144,205	150,933	4.7%	149,714	-0.8%
Total Expenditures Per Recipient	$760.71	$901.29	18.5%	$1,129.05	25.3%
Net Expenditures Per Recipient	$620.59	$716.05	15.4%	$888.73	24.1%
Number of Prescriptions	2,870,422	3,114,155	8.5%	3,381,970	8.6%
Prescriptions per Recipient	19.9	20.6	3.7%	22.6	9.5%
Expenditures per Prescription	$38.22	$43.68	14.3%	$49.98	14.4%

Medicaid Administration—In addition to expenditures of $1,249,858,552 for health care services, $44,040,157 was expended in SFY 2000 to administer the Maine Medicaid Program. This represents 3.35% of total Medicaid spending. Spending the administration of non-Medicaid programs This percentage of administrative spending is considerably less than the percentage of administrative costs for other health care insurers in Maine.





Medicaid Advisory Committee

Did you know that federal and State laws and regulations require the establishment of a medical care advisory committee to advise the Medicaid agency director about health and medical care services? In Maine we meet this requirement through the Medicaid Advisory Committee (MAC). Currently, the MAC is comprised of representatives from the following consumer and provider organizations:

CONSUMER REPRESENTATIVES

Joe Ditre, Consumers for Affordable Health Care
Michelle Tarr, Houlton Band of Maliseet
Christine Hastedt, Maine Equal Justice Project
Barbara Ginley, Women's Lobby
Helen Bailey, Maine Advocacy Services
Carol Carothers, Alliance for the Mentally Ill
Paula Valente, Maine Health Care Association
Pam LaBourdais, AFDC Advisory Council
Bob Philbrook, Maine Association of Interdependent Neighborhoods
Hilton Power, American Association of Retired Persons
Ellie Goldberg, Maine Children's Alliance

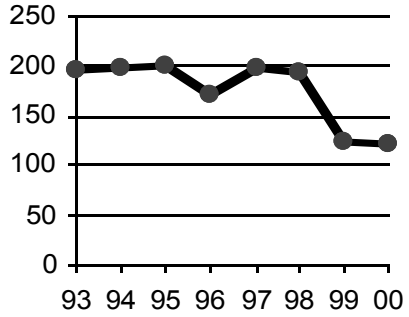
PROVIDER REPRESENTATIVES

Kristina E. Lunner, Maine Medical Association
Kevin C. Behre, Maine Hospital Association
Bonnie Post, Maine Ambulatory Care Coalition
Kellie Miller, Maine Osteopathic Association
Vicki Purgavie, Home Care Alliance of Maine
Ron Welch, Maine Association of Mental Health Services
Becky Brush, R.Ph., Maine Pharmacy Association

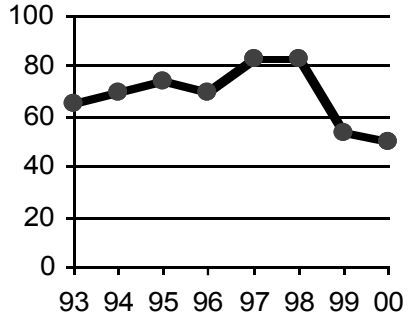
The Chairperson for the MAC is Barbara Ginley. Currently, Barbara is the Executive Director of the Maine Migrant Health Program. The MAC meets on the First Tuesday of the month at DHS offices located at 35 Anthony Avenue, Augusta.

Selected Major Service Categories

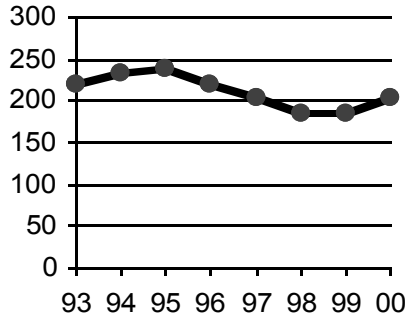
INPATIENT HOSPITALIZATION



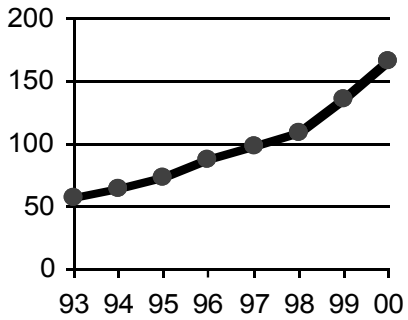
OUTPATIENT HOSPITALIZATION



NURSING FACILITY

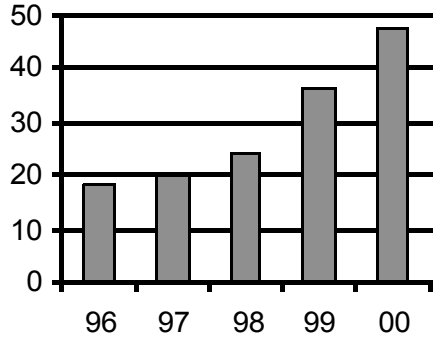


PRESCRIPTION DRUGS

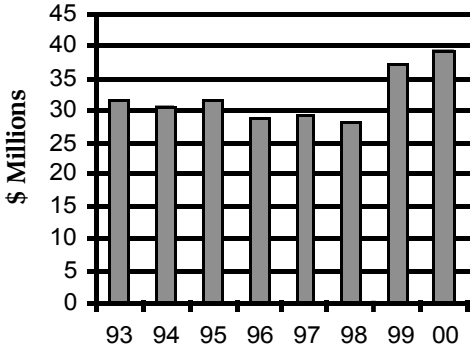


Selected Other Service Categories

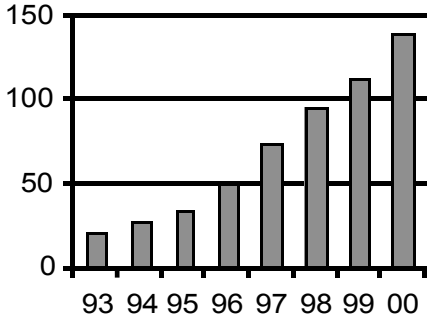
MENTAL HEALTH CLINICS



PHYSICIANS



PNMIs



FQHCs & RHCs

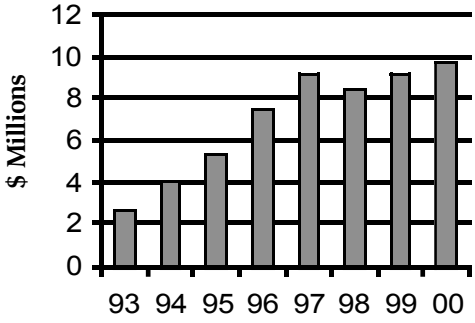


TABLE A-1. MEDICAID EXPENDITURES BY CATEGORY OF SERVICE

CATEGORY OF SERVICE	EXPENDITURES SFY 1998	EXPENDITURES SFY 1999	Percent Change	EXPENDITURES SFY 2000	Percent Change
01 GENERAL INPATIENT	$193,335,727	$123,427,502	-36.2%	$118,895,717	-3.7%
02 PSYCH FACILITY SVC	$39,607,953	$41,012,842	3.5%	$41,350,658	0.8%
03 NURSING FACILITY	$185,581,203	$184,099,858	-0.8%	$200,535,349	8.9%
04 GENERAL OUTPATIENT	$83,361,344	$53,683,008	-35.6%	$49,182,435	-8.4%
06 PHYSICIAN	$28,328,585	$37,185,517	31.3%	$39,549,180	6.4%
07 PODIATRIC	$335,704	$430,451	28.2%	$437,114	1.5%
08 PHP AGENCY	$37,360	$0	-100.0%	-$5,316	na
09 DENTAL	$6,641,320	$9,567,559	44.1%	$9,863,575	3.1%
10 PRESCRIBED DRUGS	$109,697,688	$135,493,928	23.5%	$167,633,986	23.7%
11 HOME HEALTH SERVICES	$15,415,570	$15,704,936	1.9%	$10,731,156	-31.7%
12 COMMUNITY SUPPORT SV*	$24,854,070	$28,090,746	13.0%	$35,588,765	26.7%
13 SOCIAL WORKER SERVS*	$305,307	$299,345	-2.0%	$321,551	7.4%
14 LAB & X-RAY-INDEP.	$3,660,550	$4,099,497	12.0%	$4,914,966	19.9%
15 TRANSPORTATION	$11,618,120	$12,775,808	10.0%	$13,954,365	9.2%
16 SUPPLIES AND DME	$6,905,975	$7,288,240	5.5%	$7,688,958	5.5%
17 PROSTHETIC, ORTHOTIC	$1,077,379	$1,193,656	10.8%	$1,290,186	8.1%
18 AMBULATORY SURG CENT	$234,242	$221,865	-5.3%	$241,773	9.0%
19 CLOZARILL MONITORING*	$504,990	$23,402	-95.4%	$0	-100.0%
22 PHY. DISABLED WAIVER	$5,552,487	$6,185,082	11.4%	$7,246,772	17.2%
23 SWING BED.*	$19,183	$75,101	291.5%	$56,561	-24.7%
24 CASE MANAGEMENT	$28,819,565	$33,503,742	16.3%	$46,561,928	39.0%
25 FAMILY PLAN-CLINIC	$822,353	$751,575	-8.6%	$710,478	-5.5%
26 BMR WAIVER	$75,452,653	$93,074,043	23.4%	$111,561,976	19.9%
27 SPEECH AND HEARING	$540,848	$525,013	-2.9%	$717,542	36.7%
28 MENTAL HEALTH	$24,671,605	$36,570,004	48.2%	$47,261,888	29.2%
29 AMBULANCE	$1,673,802	$1,859,966	11.1%	$2,005,852	7.8%
30 AMBUL. CARE CLINIC	$29,414	$337,100	1046.1%	$1,011,219	200.0%
31 PHYSICAL THERAPY	$1,031,192	$960,558	-6.8%	$1,051,314	9.4%
32 CHIROPRACTIC	$292,033	$295,922	1.3%	$268,093	-9.4%
33 OCCUPATIONAL THERAPY	$728,109	$579,181	-20.5%	$778,426	34.4%
35 DAY HABILITATION	$9,035,340	$10,958,898	21.3%	$13,672,001	24.8%
36 DAY HEALTH	$577,618	$592,650	2.6%	$711,217	20.0%
37 OPTOMETRIC SERVICES	$1,062,392	$1,409,182	32.6%	$1,345,890	-4.5%
38 PSYCHOLOGICAL SVCS	$2,659,538	$2,572,509	-3.3%	$2,638,931	2.6%
39 PRIVATE NONMD. INST. (Medicaid)	$90,272,883	$106,710,903	18.2%	$132,139,973	23.8%
40 ICF/MR (BOARDING)	$32,739,328	$31,140,953	-4.9%	$32,433,990	4.2%
41 MEDICARE CROSSOVER-A	$3,898,140	$3,078,456	-21.0%	$4,337,161	40.9%
42 OPTICAL SERVICES	$253,611	$150,582	-40.6%	$181,727	20.7%
43 CERT. RURAL HLT. CL.	$3,247,459	$3,769,942	16.1%	$4,160,184	10.4%
44 VD SCREENING	$9,815	$7,765	-20.9%	$7,510	-3.3%
45 HEARING AID DEALERS	$51,497	$43,786	-15.0%	$62,948	43.8%
46 AUDIOLOGY SERVICES	$31,262	$44,888	43.6%	$42,779	-4.7%
47 SPEECH PATH. SERV.	$2,383,957	$2,439,067	2.3%	$2,720,312	11.5%
48 SUBSTANCE ABUSE	$3,865,319	$3,913,548	1.2%	$3,843,111	-1.8%
50 MEDICARE CROSSOVER-B	$13,684,625	$15,567,929	13.8%	$17,493,350	12.4%
52 HMO PAYMENTS	$3,503,272	$6,843,139	95.3%	$3,295,933	-51.8%
53 NURSE/MIDWIFE	$70,507	$54,473	-22.7%	$59,404	9.1%
55 ATTENDANT SERVICES	$3,068,619	$3,495,101	13.9%	$3,314,388	-5.2%
57 BME WAIVER	$14,604,975	$21,521,767	47.4%	$21,190,181	-1.5%
58 PRIVATE DUTY NURS	$2,387,610	$3,182,176	33.3%	$3,940,491	23.8%
59 PERSONAL CARE SER	$3,362,683	$4,220,115	25.5%	$4,913,640	16.4%
60 NURSE PRACTITIONER	$52,300	$103,741	98.4%	$115,412	11.3%
61 REHABILITATIVE SVCS	$6,442,685	$8,487,654	31.7%	$10,525,190	24.0%
62 HOME BASED M-H	$1,826,316	$1,878,774	2.9%	$2,378,028	26.6%
63 FED. QUAL. HLTH CTR	$5,195,679	$5,493,315	5.7%	$5,613,119	2.2%
65 EARLY INTERVENTION	$4,953,032	$5,896,210	19.0%	$6,876,410	16.6%
66 DEVLOP/BEHAV CLIN SV	$524,025	$526,950	0.6%	$506,000	-4.0%
67 NON-TRADITIONAL PHP*	$14,164,538	$27,777,162	96.1%	$27,804,709	0.1%
CAT. OF SERVICE TOTALS	**$1,075,065,356**	**$1,101,197,082**	**2.4%**	**$1,227,730,456**	**11.5%**
Adjusted for Elim. of DSH in 1998	$981,286,523	$1,101,197,082	12.2%	$1,227,730,456	11.5%
OTHER MEDICAID					
CHILD HEALTH INSURANCE PROGRAM	$0	$5,464,154	0.0%	$12,375,555	126.5%
MEDICARE "BUY-IN" PREMIUM	$8,899,871	$18,543,971	108.4%	$19,391,567	4.6%
DRUG REBATES	-$20,206,046	-$27,957,863	38.4%	-$35,978,026	28.7%
TPL RECOVERY -- CREDITS	-$11,956,890	-$11,773,040	-1.5%	-$10,930,428	-7.2%
AMHI/BMHI DSH PAYMENTS	$50,345,541	$32,075,335	-36.3%	$37,269,428	16.2%
SUBTOTAL OTHER MEDICAID	$27,082,476	$16,352,557	-39.6%	$22,128,096	35.3%
TOTAL MEDICAID	**$1,102,147,832**	**$1,117,549,639**	**1.4%**	**$1,249,858,552**	**11.8%**
Adjusted for the Elim. of DSH in 1998	$1,008,368,999	$1,117,549,639	10.8%	$1,249,858,552	11.8%
MEDICAID RELATED:					
05 SOCIAL SERVICES	$1,288,744	$1,488,817	15.5%	$1,383,089	-7.1%
54 CHILD HEALTH	$36,820	$57,445	56.0%	$19,450	-66.1%
STATE BOARDING HOME PAYMENTS	$13,764,437	$16,278,274	18.3%	$22,602,073	38.8%
NON-MEDICAID MAP SPENDING	$3,640,160	$3,593,080	-1.3%	$4,179,985	16.3%
FIN. DISTRESSED HOSP's	$0	$0	0.0%	$1,600,000	na
SUBTOTAL MEDICAID RELATED	$18,730,161	$21,417,616	14.3%	$29,784,597	39.1%
TOTAL MEDICAID AND RELATED	**$1,120,877,993**	**$1,138,967,255**	**1.6%**	**$1,279,643,149**	**12.4%**
Adjusted for the Elim. of DSH in 1998	$1,027,099,160	$1,138,967,255	10.9%	$1,279,643,149	12.4%

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 1998	RECIPIENTS SFY 19988	Percent Change	RECIPIENTS SFY 2000	Percent Change
01 GENERAL INPATIENT	18,869	18,046	-4.4%	18,652	3.4%
02 PSYCH FACILITY SVC	1,217	2,683	120.5%	2,742	2.2%
03 NURSING FACILITY	8,649	8,624	-0.3%	8,504	-1.4%
04 GENERAL OUTPATIENT	86,452	84,387	-2.4%	88,135	4.4%
06 PHYSICIAN	99,046	101,377	2.4%	101,878	0.5%
07 PODIATRIC	4,078	4,148	1.7%	4,207	1.4%
08 PHP AGENCY	1	0	-100.0%	0	na
09 DENTAL	41,125	42,827	4.1%	43,136	0.7%
10 PRESCRIBED DRUGS	144,205	150,933	4.7%	149,714	-0.8%
11 HOME HEALTH SERVICES	7,174	6,947	-3.2%	5,515	-20.6%
12 COMMUNITY SUPPORT SV*	6,414	7,305	13.9%	7,794	6.7%
13 SOCIAL WORKER SERVS*	362	414	14.4%	408	-1.4%
14 LAB & X-RAY-INDEP.	41,310	41,845	1.3%	44,170	5.6%
15 TRANSPORTATION	22,711	22,632	-0.3%	24,561	8.5%
16 SUPPLIES AND DME	14,751	15,214	3.1%	16,174	6.3%
17 PROSTHETIC, ORTHOTIC	1,338	1,479	10.5%	1,451	-1.9%
18 AMBULATORY SURG CENT	345	311	-9.9%	341	9.6%
19 CLOZARILL MONITORING*	463	187	-59.6%	0	-100.0%
22 PHY. DISABLED WAIVER	283	305	7.8%	336	10.2%
23 SWING BED.*	4	21	425.0%	19	-9.5%
24 CASE MANAGEMENT	13,910	16,861	21.2%	20,198	19.8%
25 FAMILY PLAN-CLINIC	4,861	4,376	-10.0%	4,329	-1.1%
26 BMR WAIVER	1,349	1,610	19.3%	1,825	13.4%
27 SPEECH AND HEARING	914	808	-11.6%	981	21.4%
28 MENTAL HEALTH	16,440	19,137	16.4%	21,294	11.3%
29 AMBULANCE	9,656	10,717	11.0%	11,554	7.8%
30 AMBUL. CARE CLINIC	612	1,202	96.4%	1,332	10.8%
31 PHYSICAL THERAPY	2,291	2,190	-4.4%	2,524	15.3%
32 CHIROPRACTIC	3,364	3,502	4.1%	3,156	-9.9%
33 OCCUPATIONAL THERAPY	1,714	1,087	-36.6%	1,350	24.2%
35 DAY HABILITATION	975	1,084	11.2%	1,191	9.9%
36 DAY HEALTH	147	135	-8.2%	156	15.6%
37 OPTOMETRIC SERVICES	26,057	28,471	9.3%	27,872	-2.1%
38 PSYCHOLOGICAL SVCS	6,110	4,839	-20.8%	4,856	0.4%
39 PRIVATE NONMD. INST.	6,431	7,359	14.4%	8,047	9.3%
40 ICF/MR (BOARDING)	396	320	-19.2%	303	-5.3%
41 MEDICARE CROSSOVER-A	25,382	26,567	4.7%	28,685	8.0%
42 OPTICAL SERVICES	9,421	9,746	3.4%	9,905	1.6%
43 CERT. RURAL HLT. CL.	14,097	15,250	8.2%	16,247	6.5%
44 VD SCREENING	412	328	-20.4%	252	-23.2%
45 HEARING AID DEALERS	195	201	3.1%	215	7.0%
46 AUDIOLOGY SERVICES	453	644	42.2%	674	4.7%
47 SPEECH PATH. SERV.	3,370	2,544	-24.5%	2,677	5.2%
48 SUBSTANCE ABUSE	4,605	4,620	0.3%	4,465	-3.4%
50 MEDICARE CROSSOVER-B	35,117	36,630	4.3%	36,985	1.0%
52 HMO PAYMENTS	na	na	na	na	na
53 NURSE/MIDWIFE	421	148	-64.8%	118	-20.3%
55 ATTENDANT SERVICES	288	297	3.1%	303	2.0%
57 BME WAIVER	1,618	1,904	17.7%	1,776	-6.7%
58 PRIVATE DUTY NURS	455	610	34.1%	983	61.1%
59 PERSONAL CARE SER	796	1,092	37.2%	1,289	18.0%
60 NURSE PRACTITIONER	392	524	33.7%	525	0.2%
61 REHABILITATIVE SVCS	314	298	-5.1%	380	27.5%
62 HOME BASED M-H	539	579	7.4%	719	24.2%
63 FED. QUAL. HLTH CTR	13,024	13,120	0.7%	12,844	-2.1%
65 EARLY INTERVENTION	1,522	1,474	-3.2%	1,462	-0.8%
66 DEVLOP/BEHAV CLIN SV	466	460	-1.3%	434	-5.7%
67 NON-TRADITIONAL PHP*	8,689	14,585	67.9%	14,532	-0.4%
CAT OF SERV. RECIPIENT TOTALS	**166,124**	**168,861**	**1.6%**	**170,996**	**1.3%**
OTHER MEDICAID					
CHILD HEALTH INSURANCE PROGRAM	na	5,305	na	10,472	97.4%
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	5,305	0.0%	10,472	97.4%
TOTAL MEDICAID (unduplicated)	**166,124**	**174,166**	**4.8%**	**181,468**	**4.2%**
MEDICAID RELATED:					
05 SOCIAL SERVICES	1,411	1,449	2.69%	1,380	-4.76%
54 CHILD HEALTH	51	41	-19.61%	40	-2.44%
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.

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

CATEGORY OF SERVICE	SPENDING/ RECIPIENT SFY 1998	SPENDING/ RECIPIENT SFY 1999	Percent Change	SPENDING/ RECIPIENT SFY 2000	Percent Change
01 GENERAL INPATIENT	$10,246	$6,840	-33.2%	$6,374	-6.8%
02 PSYCH FACILITY SVC	$32,546	$15,286	-53.0%	$15,080	-1.3%
03 NURSING FACILITY	$21,457	$21,347	-0.5%	$23,581	10.5%
04 GENERAL OUTPATIENT	$964	$636	-34.0%	$558	-12.3%
06 PHYSICIAN	$286	$367	28.2%	$388	5.8%
07 PODIATRIC	$82	$104	26.1%	$104	0.1%
08 PHP AGENCY	$37,360	$0	-100.0%	$0	na
09 DENTAL	$161	$223	38.3%	$229	2.4%
10 PRESCRIBED DRUGS	$761	$898	18.0%	$1,120	24.7%
11 HOME HEALTH SERVICES	$2,149	$2,261	5.2%	$1,946	-13.9%
12 COMMUNITY SUPPORT SV*	$3,875	$3,845	-0.8%	$4,566	18.7%
13 SOCIAL WORKER SERVS*	$843	$723	-14.3%	$788	9.0%
14 LAB & X-RAY-INDEP.	$89	$98	10.6%	$111	13.6%
15 TRANSPORTATION	$512	$565	10.3%	$568	0.6%
16 SUPPLIES AND DME	$468	$479	2.3%	$475	-0.8%
17 PROSTHETIC, ORTHOTIC	$805	$807	0.2%	$889	10.2%
18 AMBULATORY SURG CENT	$679	$713	5.1%	$709	-0.6%
19 CLOZARILL MONITORING*	$1,091	$125	-88.5%	$0	-100.0%
22 PHY. DISABLED WAIVER	$19,620	$20,279	3.4%	$21,568	6.4%
23 SWING BED.*	$4,796	$3,576	-25.4%	$2,977	-16.8%
24 CASE MANAGEMENT	$2,072	$1,987	-4.1%	$2,305	16.0%
25 FAMILY PLAN-CLINIC	$169	$172	1.5%	$164	-4.4%
26 BMR WAIVER	$55,932	$57,810	3.4%	$61,130	5.7%
27 SPEECH AND HEARING	$592	$650	9.8%	$731	12.6%
28 MENTAL HEALTH	$1,501	$1,911	27.3%	$2,219	16.1%
29 AMBULANCE	$173	$174	0.1%	$174	0.0%
30 AMBUL. CARE CLINIC	$48	$280	483.5%		-100.0%
31 PHYSICAL THERAPY	$450	$439	-2.6%	$417	-5.0%
32 CHIROPRACTIC	$87	$85	-2.7%	$85	0.5%
33 OCCUPATIONAL THERAPY	$425	$533	25.4%	$577	8.2%
35 DAY HABILITATION	$9,267	$10,110	9.1%	$11,479	13.5%
36 DAY HEALTH	$3,929	$4,390	11.7%	$4,559	3.9%
37 OPTOMETRIC SERVICES	$41	$49	21.4%	$48	-2.4%
38 PSYCHOLOGICAL SVCS	$435	$532	22.1%	$543	2.2%
39 PRIVATE NONMD. INST.	$14,037	$14,501	3.3%	$16,421	13.2%
40 ICF/MR (BOARDING)	$82,675	$97,315	17.7%	$107,043	10.0%
41 MEDICARE CROSSOVER-A	$154	$116	-24.6%	$151	30.5%
42 OPTICAL SERVICES	$27	$15	-42.6%	$18	18.7%
43 CERT. RURAL HLT. CL.	$230	$247	7.3%	$256	3.6%
44 VD SCREENING	$24	$24	-0.6%	$30	25.9%
45 HEARING AID DEALERS	$264	$218	-17.5%	$293	34.4%
46 AUDIOLOGY SERVICES	$69	$70	1.0%	$63	-8.9%
47 SPEECH PATH. SERV.	$707	$959	35.5%	$1,016	6.0%
48 SUBSTANCE ABUSE	$839	$847	0.9%	$861	1.6%
50 MEDICARE CROSSOVER-B	$390	$425	9.1%	$473	11.3%
52 HMO PAYMENTS	na	na	na	na	na
53 NURSE/MIDWIFE	$167	$368	119.8%	$503	36.8%
55 ATTENDANT SERVICES	$10,655	$11,768	10.4%	$10,939	-7.0%
57 BME WAIVER	$9,027	$11,303	25.2%	$11,931	5.6%
58 PRIVATE DUTY NURS	$5,247	$5,217	-0.6%	$4,009	-23.2%
59 PERSONAL CARE SER	$4,224	$3,865	-8.5%	$3,812	-1.4%
60 NURSE PRACTITIONER	$133	$198	48.4%	$220	11.0%
61 REHABILITATIVE SVCS	$20,518	$28,482	38.8%	$27,698	-2.8%
62 HOME BASED M-H	$3,388	$3,245	-4.2%	$3,307	1.9%
63 FED. QUAL. HLTH CTR	$399	$419	5.0%	$437	4.4%
65 EARLY INTERVENTION	$3,254	$4,000	22.9%	$4,703	17.6%
66 DEVLOP/BEHAV CLIN SV	$1,125	$1,146	1.9%	$1,166	1.8%
67 NON-TRADITIONAL PHP*	$1,630	$1,905	16.8%	$1,913	0.5%
CAT OF SERV. RECIPIENT TOTALS	**$6,471**	**$6,521**	**0.8%**	**$7,180**	**10.1%**
Adjusted for the Elim. of DSH in 1998	$5,907	$6,521	10.4%	$7,180	10.1%
OTHER MEDICAID					
CHILD HEALTH INSURANCE PROGRAM	na	$1,030	na	$1,182	14.7%
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**	**$1,030**	**0.0%**	**$1,182**	**14.7%**
TOTAL MEDICAID	**$6,634**	**$6,417**	**-3.3%**	**$6,887**	**7.3%**
Adjusted for the Elim. of DSH in 1998	$6,070	$6,417	5.7%	$6,887	7.3%
MEDICAID RELATED:					
05 SOCIAL SERVICES	$913	$1,027	12.50%	$1,002	-2.46%
54 CHILD HEALTH	$722	$1,401	94.07%	$486	-65.30%
STATE BOARDING HOME PAYMENTS	na	na	na	na	na
NON-MEDICAID MAP SPENDING	na	na	na	na	na
FIN. DISTRESSED HOSPITALS	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
orresidential 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 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:

Division of 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 Bureau will be expanding the provider assistance team. 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 provided 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 CubCare Unit provides the coordination for the Department's CubCare 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.

Division of Quality Improvement

The Quality Improvement Division 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 covered 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 2000, in addition to the quality initiatives described in the Highlights Section the Unit continued to track and trend emergency room usage for non-emergency reasons.

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 Pharmacy Programs Unit manages the pharmacy benefits administered by the Bureau of Medical Services. This includes the Medicaid pharmacy benefit as well as the Drugs for the Elderly or Disabled. This unit is also working to implement the Maine Rx Program.

The Professional Claims Review Unit reviews all medical service requests for Medicaid services that need prior authorization. These include: all out-of-State 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 Early Periodic Screening, Diagnosis, and Treatment 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 2000 there were 1,077 individuals who received services under the Program at a cost totaling $590,031.

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 2000, the unit identified over $3.5M of overpayments due to fraud, abuse, and waste. In addition, the unit took action on 22 providers and/or employees of providers by terminating their privileges to participate in the Medicaid Program.

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 (OIG). The unit referred 17 cases to the MFCU in the past year and several cases to the OIG. In addition to the referrals, the SURS recipient unit has assisted the OIG in its investigation of illegal-

ly acquired prescription drugs; specifically, the drug oxycontin. To date, approximately $50,000 of Medicaid funds has been identified as the primary source for the purchase of these illegally acquired prescriptions. There have been several convictions, to date, with orders of restitution to the Maine Medicaid Program.

The SURS Unit also initiated a pro-active approach to recover Medicaid overpayments. In June of SFY 2000 the unit contacted all Maine Medicaid providers to inform them of the Bureau's intention to increase its efforts to combat fraud, abuse, and waste. The letter reminded providers of their obligation to comply with Medicaid rules and regulations and promptly return any overpayments they may have received.

During SFY 2000, Marc Fecteau of the Maine SURS staff was named President of the National Association of Surveillance Officials (NASO). NASO is comprised of state and federal officials responsible for combating health care fraud, abuse, and waste in the Medicaid Program. In November 1999, Mr. Fecteau, in his capacity as President of NASO, testified at a Hearing before the House Subcommittee on Oversight and Investigations of the Committee on Commerce. His testimony advocated for increased federal funding in combating Medicaid fraud and abuse including innovative funding solutions for the acquisition of technological tools. He also testified on the inequity of a current HCFA regulation that requires states to return the federal portion of identified overpayments within 60 days of discovery. It was recently learned that this ruling will be addressed in the next congressional session.

The Maine PrimeCare and EPSDT Unit is also included in this Division. Maine PrimeCare is the Bureau's primary care case management program for TANF and TANF related clients. To assist Bureau staff in implementing this Program, BMS is in its third contract year 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, primary care provider 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.

Division of 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 its size and 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 inclusion of the Third Party Liability (TPL) Unit, the Acute Care Certificate of Need (CON) Unit, and the recent return of the Claim Processing Unit, the Division now includes a staff of some 80 people.

The Division's Acute and Long-Term Care Financing Unit is responsible for preparing and managing the more than $1.2 billion Medicaid budget. This includes: analyzing and setting provider reimbursement rates; contract review and reimbursement determination; reconciling provider payments with audits and adjustments; analyzing the financial impact of legislation and policy changes; and projecting trends in Medicaid spending. The Unit has evolved over the years from a primary focus of hospital and nursing home reimbursement to a more broad focus that now includes the financial oversight of more than 60 Medicaid policy areas contained in the Maine Medical Assistance Manual.

In addition to its ongoing functions, the Unit spent considerable time over the last year providing financial technical assistance for major policy initiatives. These initiatives include expanding prescription drug coverage through the Drugs for the Elderly and Disabled program and the new Maine RX program, as well as expanded access for children and their parents under Medicaid and CubCare. The Unit also continued its role of providing financial technical assistance to the Department of Mental Health, Mental Retardation, and Substance Abuse (DMHMRSAS) in administering its programs that are reimbursed through Medicaid.

The Division's Third Party Liability (TPL) Unit is responsible for enforcing state and federal third party liability rules designed to ensure Medicaid is the payor of last resort. The Unit recovers 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. Maine's TPL program is consistently ranked nationally as one of the top performers in recovering third party payments.

The primary focus of the TPL Unit is to maintain Medicaid as the payor of last resort. This is accomplished through the verification of other health coverage available to a Medicaid recipient. This information is incorporated into the claims processing system

and prevents Medicaid paying as the primary insurer. This past fiscal year costs avoided by denying a submitted claim to bill the primary payer or claims noting an initial third party payment totaled $139 million.

TPL staff is also responsible for managing the Medicaid Drug Rebate program. This program ensures Medicaid pays the lowest price possible for prescription drugs. This past year alone the Unit collected $35 million in drug rebates, after returning the federal portion the state share of these collections was almost $13 million.

In addition, TPL staff administer the Premium Payment assistance (PHIPPs) and Health Insurance Purchase Option (HIPO) programs. The PHIPPs program provides financial assistance to Medicaid clients seeking to retain or obtain private coverage when cost effective. The HIPO program allows clients who have lost Medicaid eligibility to purchase continued Medicaid coverage.

As an extension of their recovery responsibilities, TPL Unit accounting staff also process all checks received in the Bureau of Medical Services. Over $66 million in checks were processed this past fiscal year. The audit protocols established by the Unit were instrumental in recovering over $750,000 in mishandled checks.

The Division's Claims Processing Unit is responsible for ensuring claims are processed accurately and timely. Data Control staff are the first to receive Medicaid claims in the processing cycle. They are responsible for the screening of all claims that go into the system, either paper claims or those claims forwarded to the keying contractor until adjudication. In addition, Data Control staff is responsible for the final step in the claims adjudication process, the distribution of payments and remittance statements to providers.

Data Capture staff receive all claims for microfilming and scanning. Here all claims are filmed and assigned a unique transaction control number (TCN) for audit purposes. Claims scanned through the Optical Character Recognition System are corrected through a keypunch process prior to being sent to the mainframe.

Data Resolution staff is responsible for claims that suspend during the adjudication process. The primary function is to evaluate the claim and make corrections, price, deny or return the claim as warranted. Provider Account Management staff is responsible for adjusting paid claims. Inappropriate payments, rate changes, cost settlements, payables/receivables, physician incentive payments and other financial transactions that require correction or adjustment may necessitate the adjustments.

The Division's Acute Care Certificate of Need (CON) Unit is responsible for administering Maine's Certificate of Need Act - 22MRSA Sec. 301, et.seq. The Unit is responsible for analyzing the need for new or expanded health care facilities and/or health-related services of all types. Staff provide technical assistance for the development of these projects; and make final recommendations regarding the need for the projects and services. The Unit's work is not limited to Medicaid, but must also consider the fiscal impact of projects on private and other public payers including Medicare.

Division of Program Evaluation

The Division of Program Evaluation supports the Bureau's efforts in evaluating and enhancing the health care services and programs offered to those that are eligible. This Division also acts as a liaison with the Department's information services staff and assists with the electronic billing used by close to 2,000 providers on a daily basis.

The Resource Development Unit, within the Division of Program Evaluation, works toward increasing the efficiency and effectiveness of the Medical Assistance programs administered by the Bureau. This is accomplished by facilitating group processes for the other divisions and units within the Bureau, data warehouse user training and support, Web site development and management, information research and reporting, involvement in claims management system design, coordinating the Bureau's internship opportunities and helping to define the Bureau's information technologies training. All this adds up to improving processes for better workflow, efficiency and capability.

This unit created and manages the Bureau's Web site. The Bureau receives many inquiries through this site, which serves as a hub for all Bureau information. The unit also works with other branches of government by researching requests for information through intensive interaction with the Bureau's data warehouse.

Staff within this unit were key to the design and development of some of the Bureau's systems, including the Professional Claims Review Unit (PCRU) System. The PCRU system is a database to track all the prior authorization history and to be able to improve customer service. It will be used as a management tool to monitor workflow, produce statistics/reports and to produce tailored letters to providers and recipients.

They are currently working with IT staff to complete work on the Complaint, Grievance and Info Tracking (CGI) System. The CGI System is a one-place data system to record and organize complaints, grievances and other information that the Bureau needs to track. Both systems increase our ability to improve our services to the recipient as well as minimize staff time by increasing efficiency and enhancing quality assurance.

The future goals of this Division are to help the Bureau develop more efficient means to access system data and to be more effective with technology tools to enable the Bureau to enhance its ability to serve providers and recipients.

The Department's information services staff provides technical support for the Bureau's Medicaid Management Information System (MMIS) modules and computer infrastructure. Existing MMIS modules are updated regularly to support federal and State mandated changes to the Medicaid program. In addition, as noted earlier, the major MMIS module used for processing all Medicaid claims was recently funded for replacement over the next two years.

The Maine Point of Purchase System (MEPOPS) is a contracted, real-time, on-line adjudication system that processes pharmacy claims for the Maine Medicaid Program. MEPOPS provides pharmacies with immediate notification of eligibility, drug coverage,

and reimbursement rates. The system processes over 10,000 claims daily from over 300 pharmacies throughout Maine. MEPOPS provides critical data and reporting to support federal and State requirements as well as support many drug initiatives introduced over the last two years.

The Maine Enrollment and Capitation System (MECAPS) determines eligibility for managed care based on clients' Medicaid eligibility and geographic residence in the State, and calculates managed care payment rates based on Medicaid aid category group, age, sex and geographic location. The system currently has over 60,000 Medicaid clients enrolled in managed care and has improved overall access to health care. Recent enhancements to the system include the ability to auto-assign a client to managed care as well as retroactively assign if necessary.

The Maine Medicaid Decision Support System (MMDSS) is a large data warehouse with user-friendly screen displays designed for the average computer user. The database contains over 5 years of Medicaid claims and client eligibility information extracted from other systems in DHS to provide a common data environment. This important system provides the Medicaid Program an effective tool to analyze Medicaid utilization, excessive levels of care, fraud, and costs. The system is scheduled for a technical and functional upgrade in 2001.

Maine Long-Term Care Eligibility System (MECARE) is an automated system for determining the medical eligibility of recipients for entrance into the long-term care system. The system facilitates the capture of demographic information, clinical information, and the development of a care plan including the determination of outcome and information dissemination. All referrals for clinical assessments are entered into the system by central office staff and downloaded daily to 75 nurse assessors via modem to laptop computers from the central server. The assessments are completed directly with recipients throughout Maine and uploaded to the central server upon completion though the same method. This on-site assessment process has dramatically improved the accuracy of eligibility determinations as well as the care plans assigned. MECARE was recently enhanced with new functions to support home health services and will have added improvements in 2000 for overall performance of the system.

The existing MMIS module for Medicaid Claims Processing was developed and installed in 1978. The system continues to support the minimal operational needs of claims processing and federal reporting. As noted above, this module is slated for replacement with a new Claims Management System.

Division of Licensing and Certification

The Division of Licensing and Certification enforces State licensing standards as well as serves as the State Survey Agency for the Health Care Financing Administration. In this capacity, the Division is responsible for determining whether participating providers/suppliers meet the requirements of Medicaid and /or Medicare. Currently, the

Division licenses and/or certifies over 2300 providers/suppliers. Of these providers, most participate in Medicare and/or Medicaid. There are over 100 new providers added annually.

The Division is responsible for 26 licensing/certification programs that include a wide spectrum of health care providers, including hospitals, home health agencies, end stage renal disease (ESRD) facilities, rural health clinics, nursing homes and assisted living facilities. The Division operates the Maine Registry for Certified Nursing Assistants, listing over 36,000 CNAs and certifies 922 laboratories under the Comprehensive Laboratory Improvement Amendments of 1988 (CLIA). The paralegal support for the Divisions handles over 60 hearings per year. Additionally, the unit furnishes consultative services for behavioral management to nursing and assisted living facilities.

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. It has also implemented use of the Federal Outcome and Assessment Information Set (OASIS) for Maine's home health agencies. It has begun to implement the newest revisions to the Federal Automated Survey Processing Environment (ASPEN) facility and survey management systems in order to integrate the survey database with other State and federal databases.

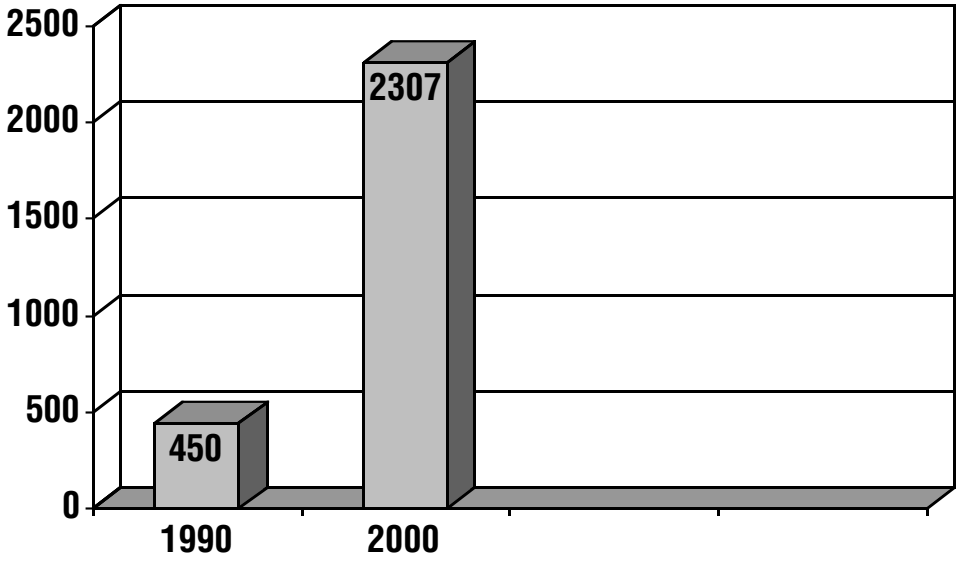
In SFY 2000 the Division conducted over 690 licensing and certification surveys, 373 follow-ups and 700 complaint investigations. It implemented the expanded survey requirements of the Nursing Home Initiative, which included staggered surveys, review of abuse protocols, increased focus on nutrition, hydration, pressure sores and medication administration. It updated and revised hospital, hospice, ambulatory surgical center, home health care services, nursing home and ESRD licensing regulations during this past year.

The Division handles an increased complaint investigation workload due to Federal requirements, which now mandate a 2-day investigation cycle for immediate jeopardy and 10 days for alleged or actual harm. This Unit handles over 1,000 complaints per year.

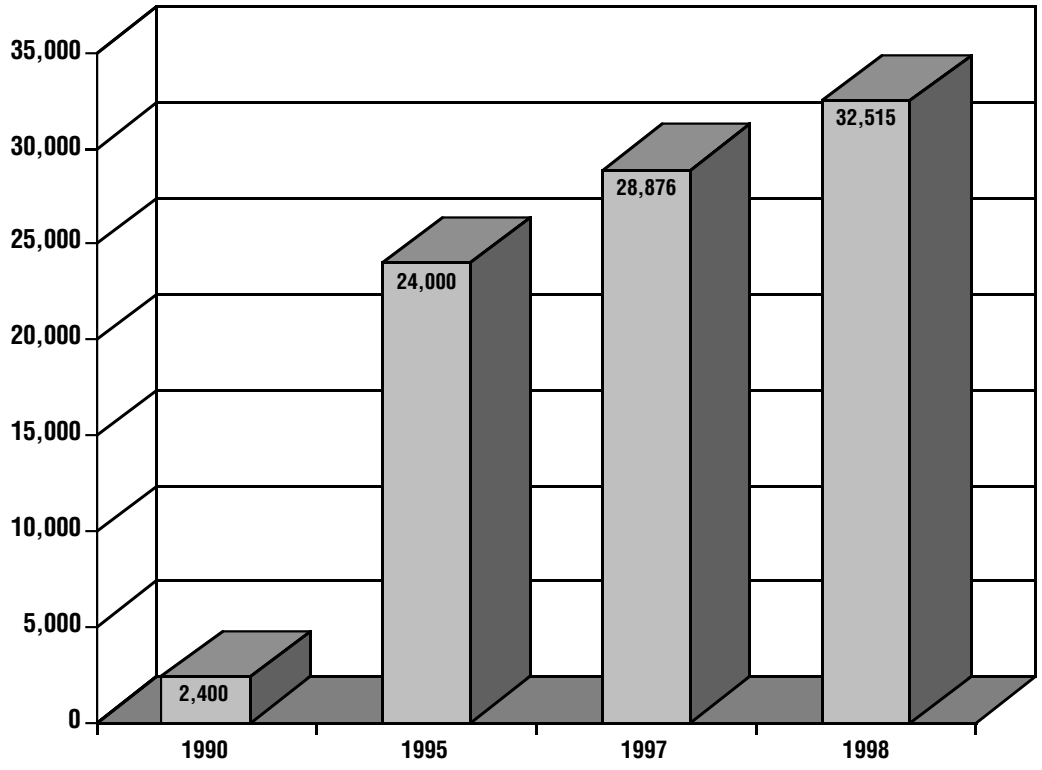
The Maine Registry of Certified Nursing Assistants now handles over 34,000 certified nursing assistants (CNAs). It has upgraded its computer system to handle the increasing volume of additional CNAs and to begin a long overdue annual recertification process. The paralegal support for the Division handles over sixty hearings per year.

Given the Division's rapid growth from 450 providers/facilities in 1990 to over 2,300 in SFY 2000, compounded by the increasing Federal Survey requirements and the doubling of assisted living facilities, the Division's staffing is inadequate and requires additional staffing to accomplish its large workload.

Increasing Numbers of Facilities and Providers Licensed by the Division of Licensing and Certification



Complaints Registered with The Division of Licensing and Certification



Annual Fee Review

This section of the Annual Report is to comply with the requirement for an annual review of the adequacy of reimbursement rates for Medicaid services paid on a fee for service basis. In this report, the Bureau of Medical Services uses the best available information on provider Usual Customary and Reasonable (UCR) rates to analyze the adequacy of Medicaid rates and the costs of bringing these rates up to 70% of the UCR rates.

The Bureau of Medical Services (BMS) has the responsibility to oversee and maintain the quality of services provided to Medicaid beneficiaries. The Bureau exercises this authority through decisions with respect to program development, provider contracting and payment, data reporting and analysis, and the design of tools and practices to enhance service delivery and accessibility.

To perform an analysis of the adequacy of Maine Medicaid Dental rates a survey was sent to all licensed Maine dentists. A total of six hundred sixteen (616) surveys were sent with two hundred ninety (290) completed and returned for a response rate of forty-seven percent (47%). To see the complete survey refer to the Medicaid Reimbursement for Dental Services (A report required by Title 22 MRSA Section 3174-u (Maine Public Laws 1999 Chapter 301).

To perform an analysis of the adequacy of occupational therapy services the Occupational Therapy Association of Maine surveyed five hundred fifty-two (552) occupational therapists for their UCR rates for one hour of occupational therapy. Forty (40) occupational therapists responded for a return rate of seven percent (7%). The UCR rate for one hour of occupational therapy was $97.00 -- Medicaid reimburses $40.00 or 41% of this UCR rate.

To perform an analysis of the adequacy of physical therapy services the Maine American Physical Therapy Association surveyed forty (40) physical therapists for their UCR rates for one hour of physical therapy. Twelve (12) physical therapists responded for a return rate of thirty percent (30%). The therapists provided information on the three most common types of services provided. An analysis of the UCR rates indicated that the average UCR for the three services was $111 for one unit of physical therapy and Medicaid reimbursement is $36.67 or thirty three percent (33%) of the UCR.

To perform an analysis of the adequacy of the speech and hearing service the Maine Speech and Hearing Association surveyed six-hundred sixty-eight (668) speech and hearing agencies for their UCR rates for speech and hearing services. One-hundred thirty-eight (138) therapists responded for a return rate of twenty one percent (21%). An analysis of the UCR indicates that the average UCR rate for the four most common types of services provided was $53.00 for one unit of service -- Medicaid reimburses $23.50 or 44% of the UCR rate.

Using this and other information, the BMS estimates the total annual cost (in SFY 2000 dollars) of increasing fee-for-service provider rates under three scenarios -- 50%, 60% and 70% of their UCR rates. The cost impacts would range from a total of $1.5 million (just under $500,000 state share) to bring all providers up to 50% of their UCR rates, to more than $9 million (more than $3 million state share) to increase provider rates to 70% of UCR.

Medicaid Fee-for-Service Rates -- SFY 2000 Data

	Providers Participating	Recipients Served	Total Payments	Avg Payment / Recipient	Avg Payment / Provider	Units of Service	Avg Units/ Recipient	Avg Units / Provider	Avg Payment Unit	Payment as % of UCR 1/	Typical Rate
Physicians	1,372	101,878	$39,549,180	$388.20	$28,825.93	664,366	6.52	484.23	$59.53	60%-70%	$42.50
Ambulatory Care Clinics	9	1,332	$1,011,219	$759.17	$112,357.67	6,913	5.19	768.11	$146.28	60%-65%	$45.43
Nurse Midwife	6	118	$59,404	$503.42	$9,900.67	958	8.12	159.67	$62.01	61.59%	$42.50
Optometry	141	27,872	$1,345,890	$48.29	$9,545.32	62,912	2.26	446.18	$21.39	51.15%	$40.80
Optician	14	9,905	$181,727	$18.35	$12,980.50	20,922	2.11	1,494.43	$8.69	2/	2/
Podiatry	53	4,207	$437,114	$103.90	$8,247.43	11,334	2.69	213.85	$38.57	46.50%	$42.50
Family Planning	12	4,329	$710,478	$164.12	$59,206.50	8,368	1.93	697.33	$84.90	100.00%	
Psychology 3/	233	4,856	$2,638,931	$543.44	$11,325.88	37,719	7.77	161.88	$69.96	60.57%	$44.65
Mental Health Clinics	81	21,294	$47,261,888	$2,219.49	$583,480.10	353,441	16.60	4,363.47	$133.72	90%-100%	
Substance Abuse Treatment	66	4,465	$3,843,111	$860.72	$58,228.95	64,544	14.46	977.94	$59.54	90%-100%	$52.00
Speech Pathology	130	2,677	$2,720,312	$1,016.18	$20,925.48	65,851	24.60	506.55	$41.31	44.38%	$47.00
Speech & Hearing Ctrs.	28	981	$717,542	$731.44	$25,626.50	15,293	15.59	546.18	$46.92	58.71%	$55.46
Audiology	12	674	$42,779	$63.47	$3,564.92	903	1.34	75.25	$47.37	39.17%	$47.00
Physical Therapy	148	2,524	$1,051,314	$416.53	$7,103.47	25,594	10.14	172.93	$41.08	32.98%	$40.00
Occupational Therapy	99	1,350	$778,426	$576.61	$7,862.89	40,168	29.75	405.74	$19.38	41.22%	$40.00
Dental	317	43,136	$9,863,575	$228.66	$31,115.38	105,464	2.44	332.69	$93.53	70.59%	$22.50
Chiropractic 4/	118	3,156	$268,093	$84.95	$2,271.97	28,396	9.00	240.64	$9.44	25.71%	$9.00
Private Duty Nursing	24	983	$3,940,491	$4,008.64	$164,187.13	18,528	18.85	772.00	$212.68	75.00%	$30.00
Personal Care	41	1,289	$4,913,640	$3,811.98	$119,844.88	244,756	189.88	5,969.66	$20.08	75.00%	$14.56
Ambulance 5/	115	11,554	$2,005,852	$173.61	$17,442.19	241,164	20.87	2,097.08	$8.32	47.50%	$95.00
Medical Supplies & DME	334	16,174	$7,688,958	$475.39	$23,020.83	6,075,022	375.60	18,188.69	$1.27	6/	
LCPC/ LCSW	99	408	$321,551	$788.12	$3,247.99	107,038	262.35	1,081.19	$3.00	60.57%	$42.40
Day Health	28	156	$711,217	$4,559.08	$25,400.61	118,511	759.69	4,232.54	$6.00	69.86%	$7.20
Nurse Practitioner	8	525	$115,412	$219.83	$14,426.50	5,986	11.40	748.25	$19.28	60%-65%	$42.50
Attendant Services	1	303	$3,314,388	$10,938.57	$3,314,388.00	348,500	1,150.17	348,500.00	$9.51	71.80%	$8.25

1/ UCR (usual, customary and reasonable) information based on best available survey data.
2/ Sole source contract for eyeglasses.
3/ Does not reflect the rate increase effective 10/1/00 -- 25% rate increase.
4/ Does not reflect the rate increase effective 10/1/00 - rate increased from $9.00 to $20.00 per hour.
5/ Stated percentage is a result of comparison of Base Rates.
6/ Reimbursement based upon "cost +" formula.

Rate Increase Scenarios -- Medicaid Impact

	Est. Total Cost To 50% UCR SFY 2000	Est. State Cost To 50% UCR SFY 2000	Est. Total Cost To 60% UCR SFY 2000	Est. State Cost To 60% UCR SFY 2000	Est. Total Cost To 70% UCR SFY 2000	Est. State Cost To 70% UCR SFY 2000
Physicians	$0	$0	$0	$0	$3,042,245	$1,026,453
Ambulatory Care Clinics	$0	$0	$0	$0	$121,346	$40,942
Nurse Midwife	$0	$0	$0	$0	$7,128	$2,405
Optometry	$0	$0	$232,867	$78,569	$495,993	$167,348
Optician	2/	2/	2/	2/	2/	2/
Podiatry	$32,901	$11,101	$126,904	$42,817	$220,907	$74,534
Family Planning	$0	$0	$0	$0	$0	$0
Psychology 3/	$0	$0	$0	$0	$410,777	$138,596
Mental Health Clinics	$0	$0	$0	$0	$0	$0
Substance Abuse Treatment	$0	$0	$0	$0	$0	$0
Speech Pathology	$344,380	$116,194	$957,318	$322,999	$1,570,257	$529,805
Speech & Hearing Ctrs.	$0	$0	$15,766	$5,319	$137,984	$46,556
Audiology	$11,828	$3,991	$22,749	$7,676	$33,671	$11,360
Physical Therapy	$542,552	$183,057	$861,325	$290,611	$1,180,098	$398,165
Occupational Therapy	$165,807	$55,943	$354,654	$119,660	$543,501	$183,377
Dental	$0	$0	$0	$0	$0	$0
Chiropractic 4/	$253,286	$85,459	$357,562	$120,641	$461,837	$155,824
Private Duty Nursing	$0	$0	$0	$0	$0	$0
Personal Care	$0	$0	$0	$0	$0	$0
Ambulance 5/	$105,571	$35,620	$527,856	$178,099	$950,140	$320,577
Medical Supplies & DME	6/	6/	6/	6/	6/	6/
LCPC/ LCSW	$0	$0	$0	$0	$50,053	$16,888
Day Health	$0	$0	$0	$0	$1,425	$481
Nurse Practitioner	$0	$0	$0	$0	$13,849	$4,673
Attendant Services	$0	$0	$0	$0	$0	$0
	$1,456,325	$491,364	$3,457,001	$1,166,392	$9,241,212	$3,117,985

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Maine Department of Human Services
Bureau of Medical Services