MAINE STATE LEGISLATURE

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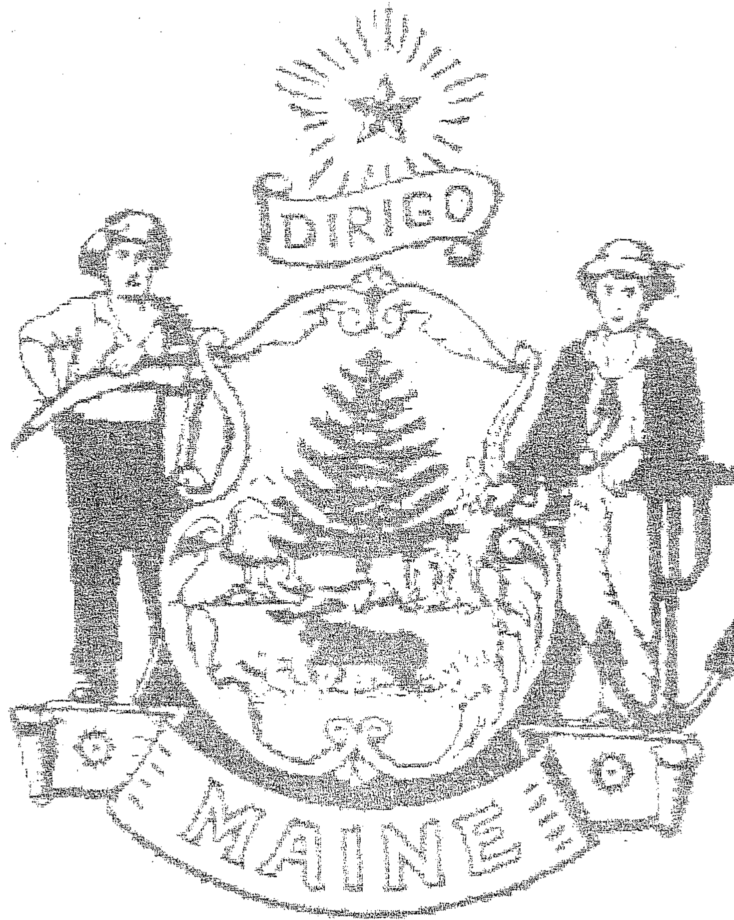
Bureau of Medical Services



Annual Report to the State Legislature

SFY 2001

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Kevin W. Concannon, Commissioner

Bureau of Medical Services
Eugene I. Gessow, Director

Deputy Director
Christine Zukas-Lessard

Director, Licensing and Certification Division
Louis Dorogi

- Hospital Licensing
  - CNA Registry
  - CLIA
  - OASIS
- Long Term Care Licensing
- Assisted Living

Director, Policy and Provider Services Division
Marianne Ringel

- Medicaid Information and Research Unit
- Provider and Consumer Relations Unit
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Financial Services Division
Director, David Winslow

- Acute & Long Term Care Financing
- Third Party Liability and Recovery
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Jude Walsh

- Surveillance and Utilization Review
- Case Mix / Medical Eligibility
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- Quality Management
- EPSDT and Maine PrimeCare
- Pharmacy Programs
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Director, Program Evaluation Division
Mark Greenfield

- Resource Unit
- Resource Development Unit

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Overview of MaineCare

MaineCare, formerly called Maine Medicaid, is a program funded jointly by the federal government (the Centers for Medicare and Medicaid Services (CMS formerly HCFA) 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.

The Department of Human Services is the single State agency for the state's Medicaid Program. However, the Department of Behavioral and Developmental Services shares in this responsibility by administering the behavioral health benefits covered by MaineCare.

Enrollment

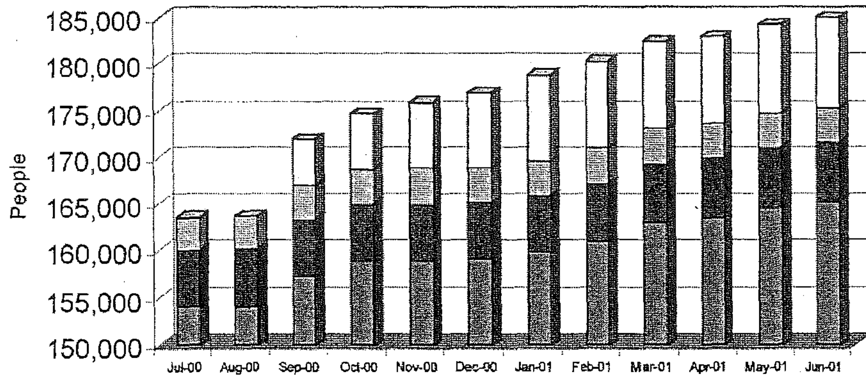
Enrollment in MaineCare has been increasing steadily since 1998 after a drop in the total number of members in 1996 and 1997. This increased enrollment is as a result of the efforts of the Legislature and the Department to cover new categories of members in order to reduce the number of people in Maine without health insurance. The SFY01 increase in the number of members served by MaineCare is the largest increase since 1991 when the number of members increased by 7.84%, from 159,678 members in SFY1990 to 172,190 in SFY1991. The reason for the significant increase this past fiscal year is due to the addition of new members obtaining pharmacy benefits through the Healthy Maine Prescription benefit.

Year	SFY 94	SFY 95	SFY 96	SFY 97	SFY 98	SFY 99	SFY 00	SFY01
Undup Eligibles	190,453	188,045	185,043	182,081	188,686	195,908	204,058	264,761
% Change	-0.60%	-1.26%	-1.60%	-1.60%	3.63%	3.83%	4.16%	29.75%

Individuals may apply for MaineCare by mail or at a Department of Human Services regional office. The Department has several application forms, including a one-page application for families with children and pregnant women and a single TANF/MaineCare application. The one-page application has been translated into 11 foreign languages.

Effective October 1, 2001 the Department provided 12 months of continuous eligibility for children regardless of any changes in family circumstances, such as income.

Medicaid Monthly Caseload SFY 2001



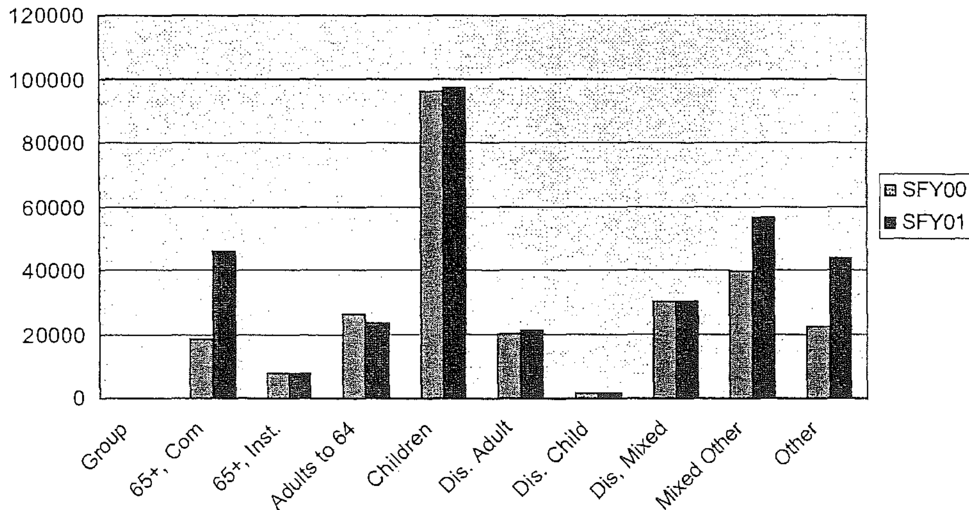
	Jul-00	Aug-00	Sep-00	Oct-00	Nov-00	Dec-00	Jan-01	Feb-01	Mar-01	Apr-01	May-01	Jun-01
CHIPS ME Parents	0	0	4933	5974	7064	7978	9173	9222	9299	9362	9462	9562
CHIPS CC	3480	3509	3544	3643	3770	3727	3758	3836	3772	3687	3639	3664
CHIPS ME	6042	6215	6195	6124	6055	5983	5986	6114	6292	6340	6374	6407
Base Medicaid	154112	154055	157321	158966	159055	159265	159951	161128	163052	163627	164805	165355

Note: Does not include the 45,000 individuals receiving Healthy Maine Prescription benefit that began on 6/1/01

Please see Chart I for a description of who is eligible for MaineCare benefits.

The following chart shows the comparative numbers of members eligible in SFY 2000 and 2001 by some major categories of coverage.

MaineCare Members
SFT 2000 & 2001



Increasing Access to Health Care

State Children's Health Insurance Program (SCHIP)

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. In the summer of 1998, the State expanded Medicaid coverage for children and created a separate program that had been called Cub Care. Benefits for this group are the same as MaineCare. Cub Care members pay a monthly premium based on family size and income. As of September 2001, there were 6,593 children enrolled in the MaineCare expansion option and 3,907 children enrolled in Cub Care.

Maine's SCHIP initiative has been very successful. Maine was one of only ten states to spend the total amount allotted to the State for FFY 98. Maine also spent its entire FFY 99 allotment. As a result, Maine received redistributed dollars from those states that under spent the amounts allotted to them for FFY 98 and 99. Maine is among the most successful states in increasing enrollment into health care coverage. According to the Children's Defense Fund report, *All Over the Map* published in July 2000, Maine ranked fifth in SCHIP enrollment.

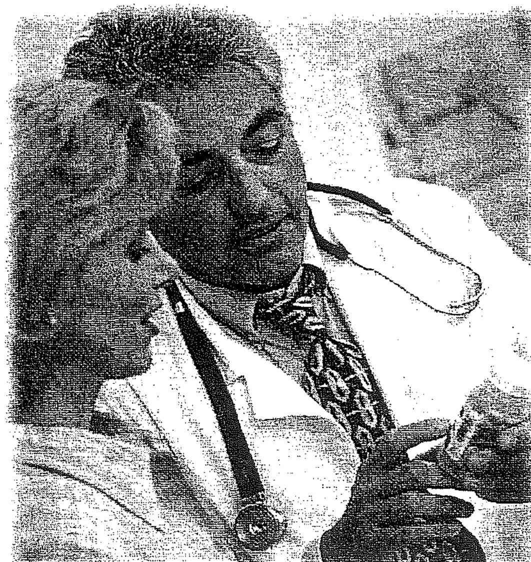
Outreach Efforts

The Bureau of Medical Services contracted with the Maine Ambulatory Care Coalition to implement a statewide outreach campaign to identify and enroll eligible children and their parents in MaineCare. Outreach activities included the following:

- technical training sessions on MaineCare eligibility policies and the application process for staff of community-based agencies serving individuals and families who might be eligible;
- general training sessions on the availability of Maine coverage for community service organizations; and
- a hospital sign-up day conducted in collaboration with the Maine Hospital Association.

Expansion of Prescription Drug Benefits

Over the past year, prescription drug benefits have been expanded in an effort to improve access to prescription drugs and the quality of life for MaineCare members. More over-the-counter drugs are now covered to help relieve symptoms of common illnesses such as coughs, colds, and allergies. Rules were adopted to implement prior authorization for certain prescription drugs. This initiative is aimed at assuring members receive drugs that are clinically appropriate and meet healthcare guidelines.



To assist prescribers to better serve MaineCare members, a Pharmacy Resource Guide was developed and mailed to all prescribers in the State. This guide provides information on covered benefits. It also provides information on drugs requiring prior authorization and alternative drugs that are beneficial and also cost effective.

In January of 2001 the Centers for Medicare and Medicaid Services approved a waiver that extends access to discount prescription drugs for over 100,000 people. This expansion offers a 25% discount on prescription drug prices, allowing members the ability to purchase prescriptions they may have not have previously filled due to the cost. Additionally, integration of the low cost drug benefit into the waiver has allowed member's access to a fuller, more robust array of medications than were previously covered. The Bureau of Medical Services is surveying 50,000 recipients of this new drug benefit regarding their current health status. These same members will be resurveyed in one year regarding any changes in health. It is hopeful that over time Maine will see a healthier population because of an improved ability to purchase necessary drugs.

Breast and Cervical Health

The Breast and Cervical Cancer Prevention Treatment Act of 2000 (Public Law 106-354) amended Title XIX of the Social Security Act to allow states to provide Medicaid coverage to uninsured women screened through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast or cervical cancer.

The Department of Human Services began providing coverage to these eligible women effective October 2001. A woman whose eligibility is based on this new option is entitled to full MaineCare benefits as long as she is in treatment for breast or cervical cancer. The Bureau of Health administers the Maine Breast and Cervical Health Program (MBCHP) and has worked in partnership with the Bureau of Medical Services and the Bureau of Family Indepen-dence to implement this MaineCare eligibility option.

Waiver to Provide Coverage for Childless Adults

The Maine legislature required the Bureau to apply for a waiver to the Center for Medicare and Medicaid Services to provide coverage for childless adults whose income is up to 125% of the Federal Poverty Level (FPL). These individuals, sometimes referred to as "noncategoricals," are not included in any of the categories of people who can be covered by Medicaid without a waiver; primarily children and their parents, the elderly or disabled. This innovative waiver will be scrutinized closely by CMS, and this expansion beyond the current Medicaid eligibility categories will not automatically be approved. If approved, the coverage will initially be for those whose income is less than 100% of the FPL. If funds allow, coverage can be expanded to include those whose income is up to 125% of the Federal Poverty Level.

Covered Services, the Cost of Care and the Providers of Service

The Social Security Act specifies a set of mandatory benefits that state Medicaid programs must cover, and a set of optional benefits that states may choose to cover. As long as these are provided in accordance with federal regulations, federal financial participation is available for reimbursement.

A very important exception is made in federal statute. Any federally defined Medicaid service determined by the state to be a medically necessary service must be provided to children. This is true regardless of whether the service has been included in the State Plan.

Maine has a substantial program to provide broad medical coverage to MaineCare Members.

Acute Care

- Inpatient and outpatient hospital services
- Laboratory and x-ray services
- Physician and nurse practitioner services
- Dental Services
  (also those services provided in rural health
- Chiropractic services
  clinics and federally qualified health centers)
- Ambulance services
- Podiatry services
- Occupational therapy
- Optometry services
- Physical therapy
- Speech, hearing and language disorder services

Long Term Care

- Institutional: Nursing facility and assisted living
- Community based: Private duty nursing, personal care, hospice, adult day health

Pharmacy

Behavioral Health

- Institutional: Inpatient psychiatric services,
- Intermediate Care Facilities for People with Mental Retardation
- Community based: Medical social worker services, psychological services, day habilitation, home and community based waiver services for people with mental retardation, community support, substance abuse treatment

Preventive

- Early intervention (birth through age 5), smoking cessation, asthma and diabetes education
- Family planning services and supplies

Transportation (non emergency)

Medical supplies and durable medical equipment, eyeglasses and orthotic and prosthetic devices

Part B Premium Payments (Medicare members)

The federal government pays a portion of every dollar spent on MaineCare covered services. The following table shows the percentages provided by the federal government and Maine state government over the past eight years and the rates expected for 2002 and 2003.

TABLE A-1. MEDICAID EXPENDITURES BY CATEGORY OF SERVICE

CATEGORY OF SERVICE	EXPENDITURES SFY 1999	EXPENDITURES SFY 2000	% Change	EXPENDITURES SFY 2001	% Change
HOSPITAL SPENDING					
01 GENERAL INPATIENT	$123,427,502	$118,895,717	-3.7%	$113,094,479	-4.9%
02 PSYCH FACILITY SVC	$41,139,426	$41,350,658	0.5%	$39,328,116	-4.9%
04 GENERAL OUTPATIENT	$53,683,008	$49,182,435	-8.4%	$50,500,997	2.7%
SUBTOTAL HOSPITAL	*$218,249,936*	*$209,428,810*	*-4.0%*	*$202,923,592*	*-3.1%*
PHYSICIAN & RELATED PRACTITIONERS					
06 PHYSICIAN	$37,185,517	$39,549,180	6.4%	$42,894,163	8.5%
18 AMBULATORY SURG CENT	$221,865	$241,773	9.0%	$269,547	11.5%
30 AMBUL. CARE CLINIC	$337,100	$1,011,219	200.0%	$1,176,451	16.3%
43 CERT. RURAL HLT. CL.	$3,769,942	$4,160,184	10.4%	$4,928,577	18.5%
08 PHP AGENCY	$0	-$5,316	0.0%	$0	0.0%
53 NURSE/MIDWIFE	$54,473	$59,404	9.1%	$53,732	-9.5%
60 NURSE PRACTITIONER	$103,741	$115,412	11.3%	$129,485	12.2%
63 FED. QUAL. HLTH CTR	$5,493,315	$5,613,119	2.2%	$7,618,128	35.7%
09 DENTAL	$9,567,559	$9,863,575	3.1%	$10,578,425	7.2%
07 PODIATRIC	$430,451	$437,114	1.5%	$494,641	13.2%
31 PHYSICAL THERAPY	$960,558	$1,051,314	9.4%	$1,071,506	1.9%
33 OCCUPATIONAL THERAPY	$579,181	$778,426	34.4%	$851,891	9.4%
37 OPTOMETRIC SERVICES	$1,409,182	$1,345,890	-4.5%	$1,498,115	11.3%
42 OPTICAL SERVICES	$150,582	$181,727	20.7%	$212,003	16.7%
27 SPEECH AND HEARING	$525,013	$717,542	36.7%	$1,665,446	132.1%
46 AUDIOLOGY SERVICES	$44,888	$42,779	-4.7%	$52,610	23.0%
47 SPEECH PATH. SERV.	$2,439,067	$2,720,312	11.5%	$1,778,577	-34.6%
13 SOCIAL WORKER SERVS*	$299,345	$321,551	7.4%	$422,543	31.4%
SUBTOTAL PHYSICIAN AND RELATED	*$63,867,701*	*$68,473,298*	*7.2%*	*$76,138,199*	*11.2%*
PRESCRIPTION DRUGS & RELATED					
10 PRESCRIBED DRUGS	$135,461,600	$167,633,986	23.8%	$186,599,427	11.3%
10.2 HMP WAIVER (MEDICAID)	$0	$0	0.0%	$247,362	0.0%
XX DRUG REBATES	-$27,957,863	-$35,978,026	28.7%	-$34,584,426	-3.9%
14 LAB & X-RAY-INDEP.	$4,099,497	$4,914,966	19.9%	$4,086,116	-16.9%
16 SUPPLIES AND DME	$7,288,240	$7,688,958	5.5%	$9,445,253	22.8%
17 PROSTHETIC, ORTHOTIC	$1,193,656	$1,290,186	8.1%	$1,214,158	-5.9%
45 HEARING AID DEALERS	$43,786	$62,948	43.8%	$55,103	-12.5%
SUBTOTAL PRESC. DRUGS & RELATED	*$120,128,916*	*$145,613,018*	*21.2%*	*$167,062,993*	*14.7%*
LONG-TERM CARE & RELATED					
03 NURSING FACILITY	$184,099,858	$200,535,349	8.9%	$202,697,747	1.1%
39 PRIVATE NONMD. INST. (Medicaid)	$106,710,903	$132,139,973	23.8%	$147,547,998	11.7%
56 WAIVERED BOARD HM	$392,173	$440,912	12.4%	$295,558	-33.0%
61 REHABILITATIVE SVCS	$8,487,654	$10,525,190	24.0%	$13,027,224	23.8%
11 HOME HEALTH SERVICES	$15,704,936	$10,731,156	-31.7%	$6,883,316	-35.9%
55 ATTENDANT SERVICES	$3,495,101	$3,314,388	-5.2%	$3,765,039	13.6%
58 PRIVATE DUTY NURS	$3,182,176	$3,940,491	23.8%	$4,283,930	8.7%
21 HOSPICE	$0	$0	0.0%	$0	0.0%
23 SWING BED	$75,101	$56,561	-24.7%	$19,808	-65.0%
36 DAY HEALTH	$592,650	$711,217	20.0%	$787,015	10.7%
22 PHY. DISABLED WAIVER	$6,185,082	$7,246,772	17.2%	$7,261,920	0.2%
57 BME WAIVER	$21,521,767	$21,190,181	-1.5%	$19,096,433	-9.9%
41 MEDICARE CROSSOVER-A	$3,078,456	$4,337,161	40.9%	$3,761,837	-13.3%
50 MEDICARE CROSSOVER-B	$15,567,929	$17,493,350	12.4%	$16,001,833	-8.5%
SUBTOTAL LONG-TERM CARE & RELATED	*$373,310,081*	*$417,576,341*	*11.9%*	*$430,472,032*	*3.1%*
BEHAVIORAL HEALTH SERVICES					
12 COMMUNITY SUPPORT SERVICES	$28,090,746	$35,588,765	26.7%	$42,018,181	18.1%
26 BMR WAIVER	$93,074,043	$111,561,976	19.9%	$126,391,963	13.3%
28 MENTAL HEALTH	$36,570,004	$47,261,888	29.2%	$57,820,300	22.3%
35 DAY HABILITATION	$10,958,898	$13,672,001	24.8%	$16,703,571	22.2%
38 PSYCHOLOGICAL SVCS	$2,572,509	$2,638,931	2.6%	$2,816,446	6.7%
40 ICF/MR (BOARDING)	$31,140,953	$32,433,990	4.2%	$32,702,942	0.8%
48 SUBSTANCE ABUSE	$3,913,548	$3,843,111	-1.8%	$4,238,879	10.3%
62 HOME BASED M-H	$1,878,774	$2,378,028	26.6%	$2,351,445	-1.1%
66 DEVLOP/BEHAV CLIN SV	$526,950	$506,000	-4.0%	$600,222	18.6%
XX AMHI/ BMHI DSH	$32,075,335	$37,269,428	16.2%	$38,516,939	3.3%
SUBTOTAL BEHAVIORAL HEALTH SERVICES	*$240,801,760*	*$287,154,118*	*19.2%*	*$324,160,888*	*12.9%*
OTHER MEDICAID SERVICE CATEGORIES					
15 TRANSPORTATION	$12,775,808	$13,954,365	9.2%	$14,473,000	3.7%
29 AMBULANCE	$1,859,966	$2,005,852	7.8%	$2,109,623	5.2%
24 CASE MANAGEMENT	$33,503,742	$46,561,928	39.0%	$66,232,853	42.2%
25 FAMILY PLAN-CLINIC	$751,575	$710,478	-5.5%	$740,573	4.2%
44 VD SCREENING	$7,765	$7,510	-3.3%	$7,920	5.5%
65 EARLY INTERVENTION	$5,896,210	$6,876,410	16.6%	$7,035,064	2.3%
67 NON-TRADITIONAL PHP\SCHOOL REHAB	$27,777,162	$27,804,709	0.1%	$22,878,970	-17.7%
52 HMO WAIVER	$6,843,139	$3,295,933	-51.8%	$233,870	-92.9%
SUBTOTAL OTHER MEDICAID SERVICES	*$89,415,367*	*$101,217,185*	*13.2%*	*$113,711,873*	*12.3%*
OTHER MEDICAID					
MEDICARE "PART B BUY-IN" PREMIUMS	$18,543,971	$8,698,066	-53.1%	$17,110,586	96.7%
THIRD PARTY (TPL) RECOVERIES	-$11,773,040	-$10,930,428	-7.2%	-$12,381,830	13.3%
"CHIPs" MEDICAID EXPANSIONS	$5,337,570	$12,391,229	132.2%	$17,747,683	43.2%
TOTAL MEDICAID	*$1,117,882,262*	*$1,239,621,637*	*10.9%*	*$1,336,946,016*	*7.9%*
MEDICAID-RELATED STATE-ONLY PAYMENTS					
HMP\DEL PAYMENTS	$0	$0	0.0%	$1,117,880	1.0%
STATE BOARDING HOME PAYMENTS	$16,278,274	$22,602,073	38.8%	$26,018,669	15.1%
FIN. DISTRESSED HOSPITAL PAYMENTS	$0	$1,600,000	0.0%	$1,600,000	0.0%
05 SOCIAL SERVICES	$1,488,817	$1,383,089	-7.1%	$1,237,114	-10.6%
54 CHILD HEALTH	$57,445	$19,450	-66.1%	$30,335	56.0%
OTHER CHILD HEALTH PROGRAMS	$3,063,840	$3,408,641	11.3%	$4,313,084	26.5%
MEDICAL EYE CARE PROGRAM	$223,711	$461,355	106.2%	$421,016	-8.7%
TUBERCULOSIS GRANTS	$199,594	$183,648	-8.0%	$310,730	69.2%
OTHER STATE ONLY PAYMENTS	$124,893	$126,341	1.2%	$146,596	16.0%
SUBTOTAL STATE-ONLY PAYMENTS	*$21,436,574*	*$29,784,597*	*38.9%*	*$35,195,424*	*18.2%*
TOTAL MEDICAID & RELATED EXPENDITURES	**$1,139,318,836**	**$1,269,406,234**	**11.4%**	**$1,372,141,440**	**8.1%**

TABLE A-2. MEDICAID RECIPIENTS BY CATEGORY OF SERVICE

CATEGORY OF SERVICE	RECIPIENTS SFY 1999	RECIPIENTS SFY 2000	% Change	RECIPIENTS SFY 2001	% Change
HOSPITAL SPENDING					
01 GENERAL INPATIENT	18,046	18,652	3.4%	19,162	2.7%
02 PSYCH FACILITY SVC	2,683	2,742	2.2%	2,826	3.1%
04 GENERAL OUTPATIENT	84,387	88,135	4.4%	95,605	8.5%
PHYSICIAN & RELATED PRACTITIONERS					
06 PHYSICIAN	101,377	101,878	0.5%	111,450	9.4%
18 AMBULATORY SURG CENT	311	341	9.6%	403	18.2%
30 AMBUL. CARE CLINIC	1,202	1,332	10.8%	1,459	9.5%
43 CERT. RURAL HLT. CL.	15,250	16,247	6.5%	18,026	10.9%
08 PHP AGENCY	0	0	0.0%	0	0.0%
53 NURSE/MIDWIFE	148	118	-20.3%	95	-19.5%
60 NURSE PRACTITIONER	524	525	0.2%	466	-11.2%
63 FED. QUAL. HLTH CTR	13,120	12,844	-2.1%	16,546	28.8%
09 DENTAL	42,827	43,136	0.7%	44,097	2.2%
07 PODIATRIC	4,148	4,207	1.4%	5,102	21.3%
31 PHYSICAL THERAPY	2,190	2,524	15.3%	2,540	0.6%
33 OCCUPATIONAL THERAPY	1,087	1,350	24.2%	1,457	7.9%
37 OPTOMETRIC SERVICES	28,471	27,872	-2.1%	30,811	10.5%
42 OPTICAL SERVICES	9,746	9,905	1.6%	10,828	9.3%
27 SPEECH AND HEARING	808	981	21.4%	1,717	75.0%
46 AUDIOLOGY SERVICES	644	674	4.7%	752	11.6%
47 SPEECH PATH. SERV.	2,544	2,677	5.2%	2,189	-18.2%
13 SOCIAL WORKER SERVS*	414	408	-1.4%	517	26.7%
PRESCRIPTION DRUGS & RELATED					
10 PRESCRIBED DRUGS	150,933	149,714	-0.8%	148,003	-1.1%
10.2 HMP WAIVER (MEDICAID)	0	0	0.0%	0	0.0%
XX DRUG REBATES	na	na	na	na	na
14 LAB & X-RAY-INDEP.	41,845	44,170	5.6%	36,418	-17.6%
16 SUPPLIES AND DME	15,214	16,174	6.3%	17,726	9.6%
17 PROSTHETIC, ORTHOTIC	1,479	1,451	-1.9%	1,765	21.6%
45 HEARING AID DEALERS	201	215	7.0%	169	-21.4%
LONG-TERM CARE & RELATED					
03 NURSING FACILITY	8,624	8,504	-1.4%	8,275	-2.7%
39 PRIVATE NONMD. INST. (Medicaid)	7,359	8,047	9.3%	8,527	6.0%
56 WAIVERED BOARD HM	26	24	-7.7%	25	4.2%
61 REHABILITATIVE SVCS	298	380	27.5%	460	21.1%
11 HOME HEALTH SERVICES	6,947	5,515	-20.6%	3,234	-41.4%
55 ATTENDANT SERVICES	297	303	2.0%	348	14.9%
58 PRIVATE DUTY NURS	610	983	61.1%	1,188	20.9%
21 HOSPICE	0	0	0.0%	0	0.0%
23 SWING BED	21	19	-9.5%	12	-36.8%
36 DAY HEALTH	135	156	15.6%	173	10.9%
22 PHY. DISABLED WAIVER	305	336	10.2%	303	-9.8%
57 BME WAIVER	1,904	1,776	-6.7%	1,589	-10.5%
41 MEDICARE CROSSOVER-A	26,567	28,685	8.0%	28,266	-1.5%
50 MEDICARE CROSSOVER-B	36,630	36,985	1.0%	37,253	0.7%
BEHAVIORAL HEALTH SERVICES					
12 COMMUNITY SUPPORT SERVICES	7,305	7,794	6.7%	8,197	5.2%
26 BMR WAIVER	1,610	1,825	13.4%	2,028	11.1%
28 MENTAL HEALTH	19,137	21,294	11.3%	23,195	8.9%
35 DAY HABILITATION	1,084	1,191	9.9%	1,383	16.1%
38 PSYCHOLOGICAL SVCS	4,839	4,856	0.4%	4,791	-1.3%
40 ICF/MR (BOARDING)	320	303	-5.3%	289	-4.6%
48 SUBSTANCE ABUSE	4,620	4,465	-3.4%	4,726	5.8%
62 HOME BASED M-H	579	719	24.2%	677	-5.8%
66 DEVLOP/BEHAV CLIN SV	460	434	-5.7%	440	1.4%
XX AMHI/ BMHI DSH	na	na	na	na	na
OTHER MEDICAID SERVICE CATEGORIES					
15 TRANSPORTATION	22,632	24,561	8.5%	25,075	2.1%
29 AMBULANCE	10,717	11,554	7.8%	12,162	5.3%
24 CASE MANAGEMENT	16,861	20,198	19.8%	24,615	21.9%
25 FAMILY PLAN-CLINIC	4,376	4,329	-1.1%	4,405	1.8%
44 VD SCREENING	328	252	-23.2%	274	8.7%
65 EARLY INTERVENTION	1,474	1,462	-0.8%	1,444	-1.2%
67 NON-TRADITIONAL PHP\SCHOOL REHAB	14,585	14,532	-0.4%	13,936	-4.1%
52 HMO WAIVER	na	na	na	na	na
OTHER MEDICAID					
MEDICARE "PART B BUY-IN" PREMIUMS	na	na	na	na	na
THIRD PARTY (TPL) RECOVERIES	na	na	na	na	na
"CHIPs" MEDICAID EXPANSIONS	5,305	10,472	97.4%	12,199	16.5%
TOTAL MEDICAID	**174,166**	**181,468**	**4.2%**	**193,519**	**6.6%**

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

CATEGORY OF SERVICE	SPENDING/ RECIPIENT SFY 1999	SPENDING/ RECIPIENT SFY 2000	% Change	SPENDING/ RECIPIENT SFY 2001	% Change
HOSPITAL SPENDING					
01 GENERAL INPATIENT	$6,840	$6,374	-6.8%	$5,902	-7.4%
02 PSYCH FACILITY SVC	$15,333	$15,080	-1.6%	$13,917	-7.7%
04 GENERAL OUTPATIENT	$636	$558	-12.3%	$528	-5.3%
PHYSICIAN & RELATED PRACTITIONERS					
06 PHYSICIAN	$367	$388	5.8%	$385	-0.9%
18 AMBULATORY SURG CENT	$713	$709	-0.6%	$669	-5.7%
30 AMBUL. CARE CLINIC	$280	$759	170.7%	$806	6.2%
43 CERT. RURAL HLT. CL.	$247	$256	3.6%	$273	6.8%
08 PHP AGENCY	$0	$0	0.0%	$0	0.0%
53 NURSE/MIDWIFE	$368	$503	36.8%	$566	12.4%
60 NURSE PRACTITIONER	$198	$220	11.0%	$278	26.4%
63 FED. QUAL. HLTH CTR	$419	$437	4.4%	$460	5.4%
09 DENTAL	$223	$229	2.4%	$240	4.9%
07 PODIATRIC	$104	$104	0.1%	$97	-6.7%
32 CHIROPRACTIC	$85	$85	0.5%	$143	68.4%
33 OCCUPATIONAL THERAPY	$533	$577	8.2%	$585	1.4%
37 OPTOMETRIC SERVICES	$49	$48	-2.4%	$49	0.7%
42 OPTICAL SERVICES	$15	$18	18.7%	$20	6.7%
27 SPEECH AND HEARING	$650	$731	12.6%	$9703	2.6%
46 AUDIOLOGY SERVICES	$70	$63	-8.9%	$70	10.2%
47 SPEECH PATH. SERV.	$959	$1,016	6.0%	$813	-20.0%
13 SOCIAL WORKER SERVS*	$723	$788	9.0%	$817	3.7%
PRESCRIPTION DRUGS & RELATED					
10 PRESCRIBED DRUGS	$897	$1,120	24.8%	$1,261	12.6%
10.2 HMP WAIVER (MEDICAID)	$0	$0	na	$0	na
14 LAB & X-RAY-INDEP.	$98	$111	13.6%	$112	0.8%
16 SUPPLIES AND DME	$479	$475	-0.8%	$533	12.1%
17 PROSTHETIC, ORTHOTIC	$807	$889	10.2%	$688	-22.6%
45 HEARING AID DEALERS	$218	$293	34.4%	$326	11.4%
LONG-TERM CARE & RELATED					
03 NURSING FACILITY	$21,347	$23,581	10.5%	$24,495	3.9%
39 PRIVATE NONMD. INST. (Medicaid)	$14,501	$16,421	13.2%	$17,304	5.4%
56 WAIVERED BOARD HM	$15,084	$18,371	21.8%	$11,822	-35.6%
61 REHABILITATIVE SVCS	$28,482	$27,698	-2.8%	$28,320	2.2%
11 HOME HEALTH SERVICES	$2,261	$1,946	-13.9%	$2,128	9.4%
55 ATTENDANT SERVICES	$11,768	$10,939	-7.0%	$10,819	-1.1%
58 PRIVATE DUTY NURS	$5,217	$4,009	-23.2%	$3,606	-10.0%
59 PERSONAL CARE SER	$3,861	$3,812	-1.3%	$3,633	-4.7%
23 SWING BED	$3,576	$2,977	na	$1,651	-44.6%
36 DAY HEALTH	$4,390	$4,559	3.9%	$4,549	-0.2%
22 PHY. DISABLED WAIVER	$20,279	$21,568	6.4%	$23,967	11.1%
57 BME WAIVER	$11,303	$11,931	5.6%	$12,018	0.7%
41 MEDICARE CROSSOVER-A	$116	$151	30.5%	$133	-12.0%
50 MEDICARE CROSSOVER-B	$425	$473	11.3%	$430	-9.2%
BEHAVIORAL HEALTH SERVICES					
12 COMMUNITY SUPPORT SERVICES	$3,845	$4,566	18.7%	$5,126	12.3%
26 BMR WAIVER	$57,810	$61,130	5.7%	$62,323	2.0%
28 MENTAL HEALTH	$1,911	$2,219	16.1%	$2,493	12.3%
35 DAY HABILITATION	$10,110	$11,479	13.5%	$12,078	5.2%
38 PSYCHOLOGICAL SVCS	$532	$543	2.2%	$588	8.2%
40 ICF/MR (BOARDING)	$97,315	$107,043	10.0%	$113,159	5.7%
48 SUBSTANCE ABUSE	$847	$861	1.6%	$897	4.2%
62 HOME BASED M-H	$3,245	$3,307	1.9%	$3,473	5.0%
66 DEVLOP/BEHAV CLIN SV	$1,146	$1,166	1.8%	$1,364	17.0%
XX AMHI/ BMHI DSH	na	na	na	na	na
OTHER MEDICAID SERVICE CATEGORIES					
15 TRANSPORTATION	$565	$568	0.6%	$577	1.6%
29 AMBULANCE	$174	$174	0.0%	$173	-0.1%
24 CASE MANAGEMENT	$1,987	$2,305	16.0%	$2,691	16.7%
25 FAMILY PLAN-CLINIC	$172	$164	-4.4%	$168	2.4%
44 VD SCREENING	$24	$30	25.9%	$29	-3.0%
65 EARLY INTERVENTION	$4,000	$4,703	17.6%	$4,872	3.6%
67 NON-TRADITIONAL PHP\SCHOOL REHAB	$1,905	$1,913	0.5%	$1,642	-14.2%
52 HMO WAIVER	na	na	na	na	na
OTHER MEDICAID					
MEDICARE "PART B BUY-IN" PREMIUMS	na	na	na	na	na
THIRD PARTY (TPL) RECOVERIES	na	na	na	na	na
"CHIPs" MEDICAID EXPANSIONS	$1,006	$1,183	17.6%	$1,455	23.0%
TOTAL MEDICAID	**$6,418**	**$6,831**	6.4%	**$6,909**	1.1%

MaineCare Financial Participation Rates

	Medicaid		SCHIP	
	Federal	State	Federal	State
SFY 1994	61.96%	38.04%		
SFY 1995	63.30%	36.70%		
SFY 1996	63.32%	36.68%		
SFY 1997	63.72%	36.28%		
SFY 1998	66.04%	33.96%		
SFY 1999	66.40%	33.60%	76.48%	23.52%
SFY 2000	66.22%	33.78%	76.36%	23.64%
SFY 2001	66.12%	33.88%	76.28%	23.72%
SFY 2002	66.58%	33.42%	76.61%	23.39%
SFY 2003	66.22%	33.78%	76.35%	23.65%

Provider Participation

MaineCare enjoys a high participation rate among most of the provider types in the State. All of the 37 acute care hospitals in Maine participate in the MaineCare Program. Of these, 6 hospitals have elected to participate as a Critical Access Hospital. All but one Maine pharmacy provides services to MaineCare members.

Staff at the Bureau of Medical Services continues to recruit primary care providers (PCP) to provide services under the managed care benefit. Participation by PCPs continues to be good.

The Department employs a number of strategies to continue the participation rate it has enjoyed.

Providers may call the MaineCare Provider Inquiry Line and the Provider Relations Unit for policy interpretation with billing problems. Providers may also call the automated Voice Response system to verify eligibility, third party coverage and status of claims.

A variety of provider education sessions are hosted over the course of the year, including individual provider office meetings and group sessions to explain new policies and policy changes.

The Department is developing a claims processing system that will allow Web-based access for the submission of claims, verification of eligibility and status of claims.

More than Just Paying the Bills

The Bureau of Medical Services has recognized that it must employ strategies to make improvements in quality, access and cost. The MaineCare Program in Maine, like others across the nation, once simply a payer of claims, has shifted its focus to ensure that MaineCare members receive quality care and that funds are spent effectively. This section highlights those strategies.

Members utilizing Maine MaineCare represent a broad spectrum of individuals with many diverse health care needs. These needs vary tremendously from routine preventative services to the most highly complex medical and surgical procedures. Maine MaineCare covers a significant portion of the State's population, including those groups most at risk for receiving inadequate medical care; whether due to physical, financial, educational, cultural, or geographic barriers.

It is incumbent upon the Bureau of Medical Services to assess and maintain the "wellness" of the member population where able, and to ensure timely and appropriate medical care. Quality projects are the keystone of the ongoing efforts of the Bureau to do more than "just pay the bills." The many benefits administered by the Bureau emphasize the goal to improve the health and welfare of members by providing the medically and fiscally appropriate education, service or medication in a timely basis to those in need.

BMS also recognizes that availability of a service by itself is not enough to ensure proper utilization. Both over- and under-utilization can be an issue. The Bureau engages in outreach efforts to both providers and members to encourage appropriate utilization. Educational outreach, targeted restrictions, payment incentives, disease education and management programs, and utilization reviews all contribute to the ultimate goal of ensuring that Maine citizens receive the highest quality and most cost-effective medical care available.

Primary Care Case Management

MaineCare managed care is a primary care case management (PCCM) benefit operated by the Bureau of Medical Services. Enrollment into the program provides MaineCare members with a choice of a primary care provider, establishing a medical home with medical coverage 24 hours a day, 7 days a week. This benefit emphasizes the importance of preventive services and provides an environment where those services can be obtained in a timely fashion. The goals of this benefit are to:

- ✓ Increase access to primary care
- ✓ Increase access to preventive care
- ✓ Establish a medical home
- ✓ Provide continuity of care
- ✓ Strengthen patient/provider relationships
- ✓ Provide a climate that encourages appropriate utilization of services
- ✓ Reduce emergency room visits for non-emergent care
- ✓ Reduce avoidable hospital admissions

Enrollment has been mandatory in Aroostook, Piscataquis, and Washington counties, Maine's most rural counties, since December of 1996. In May of 1999, the Department began a county-by-county phase in of mandatory enrollment. Statewide enrollment for beneficiaries receiving MaineCare under TANF, Families with Children (previously known as TANF related), and Cub Care beneficiaries, was completed as scheduled in January of 2001. Enrollment into the program currently totals over 96,000 members.

Providers who become primary care providers (PCPs) in MaineCare managed care agree to provide comprehensive primary care, patient program education, authorization for managed services, and provide or arrange 24-hour coverage. Providers' plans for providing or arranging coverage as part of a provider's eligibility to serve as a PCP must be approved by the Bureau. In return for agreeing to provide these services, the provider is paid three dollars per member per month in addition to payment for any direct services provided.

Twenty-four hour coverage is a critical component of reducing the inappropriate use of more expensive medical services, such as emergency rooms. Random phone calls are made to providers on a quarterly basis to verify coverage during normal working hours, evenings, nights, weekends, and holidays. This process ensures that MaineCare members have a medical home where they are assured of improved continuity of care and the appropriate emergency rooms.

We have help in providing the MaineCare managed care benefit. The Bureau of Medical Services is contracting for the fourth year with Public Consulting Group of Boston, Massachusetts, to provide Health Benefits Advisor Services. The contracted services include beneficiary education and enrollment into MaineCare managed care, PCP recruitment and retention for MaineCare managed care, member services for MaineCare managed care members, and assistance to MaineCare members to eliminate barriers to receiving care under Early, Periodic, Diagnosis, and Treatment Services (EPSDT.) The Health Benefits Advisor has also agreed to expand the role of member services for all MaineCare members.

Incentive Payments

The Primary Care Provider Incentive Payment (PC-PIP) was designed to give feedback to providers on their utilization patterns in preventive health services as well as in the treatment of chronic diseases. Good outcomes are rewarded with a payment over and above the fee-for-service rate.

Each quarter, primary care providers receive a utilization profile that is specific to their individual practice. It identifies the utilization patterns of both the MaineCare managed care population and the fee-for-service population. Outcomes being measured include: lead testing rates for one and two year olds, preventive health visit rates for children, diabetic testing rates, cervical cancer screening rates, and emergency room visit rates.

Since 1998, the PC-PIP has distributed $3 million per year, or about an average of $4,000.00 per provider.

Assistance to Members and Providers

The Primary Care Newsletter is mailed in conjunction with the PC-PIP profiles. The newsletter contains information on changes made to the PC-PIP and updates on the projects and studies being conducted by staff of the Bureau of Medical Services. The audience for this newsletter has recently expanded to providers of nursing facility services as well as to other private and State agencies.

MaineCare provides Early Periodic Screening, Diagnosis and Treatment services to eligible members under the age of 21, these services include:

- Informing newly eligible MaineCare members about medical services available to them emphasizing the importance of preventive services.
- Sending reminders to members who are due for preventive visits in accordance with the periodicity schedule.
- Assisting members in finding providers for medical and social services.
- Making referrals to medical and social services as needed.
- Assisting members in making and keeping appointments by assisting them with appointment scheduling and arranging transportation.
- Assisting providers in the education of members about the importance of preventive services and keeping medical appointments.

Lead testing has been a focus of work over the last year. EPSDT staff provides follow up with families and providers regarding lead testing. Children at the ages of one and two are required to have lead tests. Providers receive a contact from Bureau staff when comprehensive physical exams do not indicate that lead testing has occurred. Staff also provides follow-up letters for abnormal findings.

Since 1998, Bright Futures assessment forms have has been submitted to the Bureau by primary care providers for all MaineCare members under the age of 21. These forms allow providers to request the Bureau to provide follow up assistance in meeting member health care needs or to talk with members who have failed to attend scheduled appointments.

Disease Education and Management

Disease Management has become a priority in providing quality care to members with high costs of care. Medicine today is primarily based on an "episodic" approach. This means that the focus

of most healthcare systems is on the "ill" individual during each acute episode of illness. Prevention and management of the illness between these episodes is de-emphasized by the current structure of billing, payments, and quality review.

It is a goal of BMS in the coming year to focus more resources on identifying those illnesses, for which the medical and fiscal burden could be limited by innovative interventions to try to maintain health, rather than simply reacting to and treating illness. "Disease Management" is the use of various tools to try to limit the impact of many (usually chronic) illnesses such as diabetes, chronic obstructive pulmonary disease, coronary artery disease, depression, and congestive heart failure.

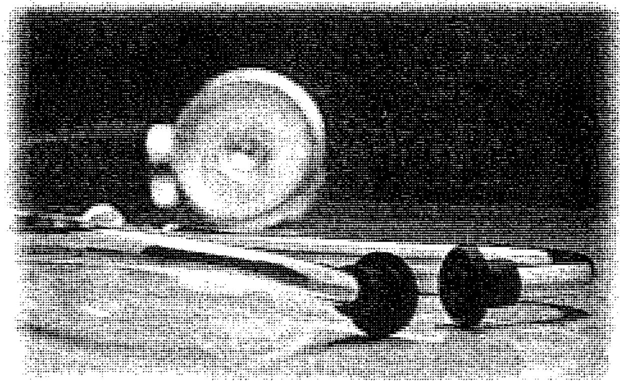
Information systems can be used to identify members at risk for disease or for complications of their current disease. Once these members are identified, there are many potential strategies to try to improve their medical care. Barriers to the most effective care can be identified-whether social (e.g. no transportation or lack of childcare) or medical (e.g. a provider may not be aware of a member's risk factors or may not be aware of the latest guidelines) or logistical (a certain type or level of expertise is not available in a rural area). Often reinforcement and support of members with complex treatment regimens can enhance compliance and outcomes, which may reduce complications and hospitalizations, while improving quality of life. The education of physicians and members as to current recommendations for care, outreach activities to try to identify why members aren't taking advantage of or aren't compliant with available services, and targeted interventions to help both physician and member manage complex illnesses are just a few potential strategies.

BMS will be implementing several Disease Management efforts in the coming year and, thereby, begin to evaluate systems of care that can reduce the burden of illness for those members with chronic disease.

Quality Efforts

A Young Adult Lifestyle Survey is being developed in conjunction with the Foundation for Health Care Accountability. This survey will be designed to evaluate the health care services and lifestyle needs of MaineCare members between the ages of 14 and 18. The Bureau will use this information to improve services geared for this population.

The Emergency Room Project began in late fall of 1999. Staff of the Bureau's Quality Improvement Division began monitoring emergency room utilization patterns among MaineCare members. Through this review it was determined that MaineCare members had high numbers of claims for ear aches, sore throats, common colds and coughs. In the spring of 2000, staff began tracking and trending the number of members who used the emergency room for one of the above diagnoses over the previous three months. Educational materials were also developed and were mailed to members identified as using the emergency room with these diagnoses.



During this fiscal year, staff concentrated on those members who continued to use the emergency room for these diagnoses despite the educational mailing. These members now receive a phone call that provides education to the member and assistance in obtaining a primary care provider. Staff also try to determine if there are issues that needed to be followed up with the provider.

Providers may also ask for the Bureau's assistance in supporting their patients, who may be overusing the emergency room, by making a referral to Bureau staff or to the Department's Health Benefits Advisor.

Adult Immunizations

Adult Immunizations have been a focus of MaineCare for three years now. The project was designed to promote the use of pneumonia and influenza vaccine in nursing facilities. In 1999, MaineCare adopted rules requiring nursing facilities to determine, on an annual basis, the immunization status of both nursing home residents and staff and to offer these immunizations.

The goal of this effort was to increase immunizations in the nursing homes by 10% and achieve cost savings by preventing illness. National Nursing Home Standards published in 1995 reflected influenza immunization rate of 22.0%, and pneumonia immunization rate of 63.0%.

MaineCare nursing home influenza immunization rate during flu season 1998-1999 was 81.6%. As a result of this effort, immunization rates for MaineCare members increased during the 1999-2000 influenza season. In addition, we saw pneumonia vaccine rates increase from 28% in the 1997-98 season to 77% in the 2000-2001 season.

Pain Management

Chronic Pain Management benefits are available to members on a voluntary basis. This benefit was developed after a review of narcotic utilization patterns among MaineCare members. This review indicated that over 1,000 members in any given quarter were obtaining narcotic prescriptions from 3 or more different prescribers. These prescriptions could have been filled at multiple pharmacies and could include narcotic prescriptions obtained from multiple emergency room visits.

Based on concerns for the risks to the health of the members, a voluntary benefit was developed. Under this benefit, the member selects a primary prescriber, preferably a primary care provider who will manage the member's medical condition. Staff assists the member with selecting a primary care provider and obtaining the needed services to evaluate the member's chronic pain. These services may include obtaining a specialist evaluation on chronic pain, receiving needed durable medical equipment to help relieve or control pain and educational services on the appropriate use of pain medication.

There are currently 193 members who have decided that this benefit was right for them and have chosen this option.

Case Mix

Case Mix is the Medicaid/Medicare Reimbursement and Quality Assurance System. The Centers for Medicare and Medicaid Services mandates the use of a standardized, universal assessment tool —the Minimum Data Set 2.0 (MDS) for all long-term care nursing facility residents. The MDS is the basis for case mix payment, quality indicators and the care planning process.

The Case Mix Unit Nurses of the Bureau of Medical Services review the MDS in nursing and Level II assisted living facilities for accuracy of the assessments. If errors are found on the assessment, the errors can and do impact the care planning process, the case mix payment and/or the quality indicators. This can impact the quality of services provided to the residents.

The Division of Licensing and Certification uses quality indicators, to successfully identify resident populations in nursing facilities in order 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 since 1999. Federal regulations require that those home health agencies participating in Medicare complete on each patient and 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 The Centers for Medicare and Medicaid Services.

After the initial startup, home health agencies will use this assessment tool for clinical assessment. The Centers for Medicare and Medicaid Services will use data for design and implementa-

tion of a Prospective Payment System (PPS) to pay home health agencies. The Centers for Medicare and Medicaid Services will use its national OASIS database to produce Outcomes Based Quality Improvement Reports (OBQIs) and Medicare PPS based on this data. The Division of Licensing and Certification, assisted by a cooperative agreement with the Edmund S. Muskie School of Public Services at the University of Southern Maine, has provided the technical support for systems implementation, ongoing changes from CMS, and training on the use of the system. 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. Additional data modules are being added to ASPEN by CMS. A Long Term Care data module will be added, followed by a Complaints module in January 2002 and an Enforcement module in May 2002.

Quality in Long Term Care Facilities

The quality of the care in the State's long-term care facilities has long been a focus of the Bureau of Medical Services. The Division of Licensing and Certification has implemented a number of initiatives to promote quality care in health care facilities across the State of Maine. They have sponsored forums for Best Practice Initiatives for providers and survey staff. In April 2001, over 200 people attended a forum for "Nutrition and Hydration Care" in Portland and Bangor for nursing facilities and assisted living facilities. The Division is sponsoring "Best Friends" Training to nine nursing facilities. This training provides suggested guidelines for caregivers who serve people with Alzheimer's and dementia. The Division has also provided training to health care providers and survey staff for abuse and neglect, detection and prevention. The intent of the training is to provide guidelines for a provider's approach to program assessment, planning, implementation, monitoring, and quality improvement for the detection and prevention of abuse and neglect.

In July 2000, the Centers for Medicare/Medicaid Services released a program memorandum listing specific performance standards to be used to evaluate State performance on nursing facility surveys after October 2000. The Division has had federal monitoring surveys over the past year, and received a rating equivalent to 95% in it compliance with the performance standards.

Other health care facilities are also monitored in relation to their quality outcomes. Home health agencies have outcome indicators that are monitored through the Division as well as through provider reports for adverse outcomes. Also, as part of the survey process in hospital, end-stage renal dialysis units, home health agencies, and patients are interviewed to gain information directly about their concerns. Facilities with a CLIA certification are monitored for quality of laboratory testing through enrollment of approved proficiency testing programs. All licensed and certified facilities are required to develop and maintain quality programs related to all aspects of patient care. During the survey process, the Division reviews the facility's quality program for appropriateness and effectiveness.

Quality Oversight of Commercial HMOs

Quality Oversight of Commercial HMOs began in 1998 with the Bureau of Medical Services collaborating with the Bureau of Insurance to develop a tool to assist in the evaluation of commercial health maintenance organizations for compliance with insurance Rules 850 and 56A. In the fall of 2000, the data collection tool was finalized and construction of a database began. The database will produce reports that allow for the comparison of HMOs between each review and among each other. These reports are targeted for completion on the fall of 2002.

In December of 2000, the Oversight Team, consisting of staff from both Bureaus, began the process of review on a health plan. A State specific survey was conducted in June of 2001, which reviewed the plan for standards or elements specific to the State of Maine. Additional surveys are planned for October of 2001 and February of 2002.

What's in the Future

MaineCare

The 120th Maine Legislature passed legislation changing the names of the Medicaid and Cub Care programs to MaineCare effective July 2002. By the July 2002 deadline, the transition to MaineCare will be complete. Prior to July 2002, the Department will use MaineCare as it prints new materials. Materials referencing Medicaid and Cub Care will still be seen as the Department uses up existing forms and brochures.

In the fall of 2001, the Department began notifying members, providers and other interested parties of the name change. Advance notice was sent to members along with their monthly ID card. A special mailing was sent to providers and community based agencies.

Along with the change in our name, the Bureau is working to consolidate its member services functions in order to provide better service to both members and providers. A first step in that direction will be to consolidate the many toll free numbers into one number for members and one for providers.

A Claims Processing System for the 21st Century

The Bureau of Medical Services has awarded a contract to develop a replacement Medicaid claims processing system. The contractor, Client Network Services, Inc., is on a very aggressive schedule to implement MeCMS (Maine Claims Management System) throughout Maine by early 2003.

There are significant functional and technical deficiencies and limitations of the existing claims processing system. Although the existing system processes claims correctly, it must be replaced in order to handle increased complexity and provide enhanced functionality.

The new system will include: automated and enhanced claims processing; financial analysis and processing; administrative and information reports; and provider file and other reference information management. MeCMS must pass a federal certification process by the Center for Medicare and Medicaid Services, plus meet requirements of the upcoming Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires BMS and all health providers throughout Maine to conform to standards of electronic data interchange, privacy, and security. Compliance with the first HIPAA rule has been extended to October 2003.

The new system will enhance the BMS capability to manage the MaineCare Program and substantially improve claims processing for providers. MeCMS will offer web-based access for providers to submit claims, check member eligibility, and rapid access to claim status. This implementation approach requires no additional software for the provider, simply access to an Explorer web browser. The system will continue to work with existing provider systems similar to the current system. Obvious benefits of the system will be a reduction in paper claims processing and expedited payment of electronically processed claims.

HIPAA

The Health Insurance Portability & Accountability Act of 1996 (August 21), Public Law 104-191, which amends the Internal Revenue Service Code of 1986. Also known as the Kennedy-Kassebaum Act.

The Administrative Simplification section requires:

1. Improved efficiency in healthcare delivery by standardizing electronic data interchange, and
2. Protection of confidentiality and security of health data through setting and enforcing standards.

More specifically, HIPAA calls for:

1. Standardization of electronic patient health, administrative and financial data.
2. Unique health identifiers for individuals, employers, health plans and health care providers.
3. Security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

The bottom line is that we will see sweeping changes in most healthcare transaction and administrative information systems.

All healthcare organizations are affected. This includes all health care providers, even one-physician offices, health plans, employers, public health authorities, life insurers, clearinghouses, billing agencies, information systems vendors, service organizations, and universities.

HIPAA calls for severe civil and criminal penalties for noncompliance, including: fines up to $25K for multiple violations of the same standard in a calendar year and fines up to $250K and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information

Most entities have 24 months from the effective date of the final rules to achieve compliance. Normally, the effective date is 60 days after a rule is published. The Transactions Rule was published on August 17, 2000. So the compliance date for that rule is October 16, 2002 which was recently extended to October of 2003. The Privacy Rule was published on December 28, 2000, but due to minor glitch didn't become effective until April 14, 2001. Compliance is required for the Privacy Rule on April 14, 2003.

Emerging Issues

- Encouraging members to stay healthy and to get healthy
- Access to dental services
- Managing costs in a largely rural state; especially hospital services
- Managing costs without a great deal of competition in the Maine health care marketplace
- Shifting from cost-based to value-based purchasing strategies
- Long Term:
    - Demographics – Anticipated increases in elderly and disabled members with rising expectations among both groups as to the scope of services that should be available
    - Continuing access to affordable commercial insurance products for businesses and families
    - Advances in medical technology may increase and/or decrease costs (e.g. Alzheimer's treatment), including, but not limited to pharmaceuticals.
    - Health care provider shortages (especially direct care workers for the elderly and disabled in both institutional and community settings.)
    - Coherent strategy for Medicare/Medicaid eligibles.

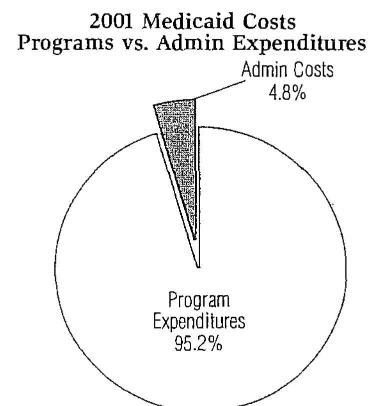
Operations and Organization

Just over 190 employees comprise the MaineCare operations staff of the Bureau of Medical Services staff. The Division of Licensing and Certification employs an additional 56 staff.

A sample of activity in FY 2001:

- The Inquiry Unit, the first point of contact for most members and providers responded to approximately 50,000 phone, e mail, mail and fax inquiries.
- The Provider Relations Unit staff visited 144 providers and hosted several group policy education and billing sessions.
- The MaineCare Program processed a total of 5,415,753 claims. Of this number 2,262,386 were non-pharmacy paper claims; 2,371,356 were electronic claims and 782,011 represented Medicaid reimbursement after Medicare payment. In addition to the claims processed by DHS, the Department's contractor for pharmacy claims processed an additional 3,098,131 pharmacy claims.
- The Provider File Unit sent out approximately 760 new provider enrollment packets.
- The Surveillance and Utilization Review (SUR) Unit identified over $2.9M of overpayments due to the Medicaid Program.
- The SUR Unit assisted the Office of the Inspector General in over 50 cases of illegally acquired prescription drug cases related to oxycontin.
- The Third Party Liability Unit recovered approximately $11 million from third party insurers who should have paid a bill that MaineCare initially paid.
- Costs avoided by denying a submitted claim to bill the primary payer or claims noting an initial third party payment totaled $43 million for SFY 01.
- The Third Party Liability Unit collected $34.6 million in drug rebates. After returning the federal portion, the State share of these collections was almost $11.4 million.
- Each year, the Division of Licensing and Certification reviews over 100 new providers.
- The CNA Registry lists over 33,000 certified nursing assistants.
- During the past year the Division of Licensing and Certification conducted over 1,037 licensing and certification surveys, 300 follow ups and investigation of over 750 complaints.
- In FY 2001 The Case Mix Unit held a number of training sessions:
  - 33 MDS 2.0 training sessions were held (313 people were in attendance.)
  - 34 MDS-RCA training sessions were held (336 attended.)
  - 391 nursing facilities were visited. The average error rate (inaccurate MDS) was 10.75%, an improvement over last year's 10.85%.
  - 259 residential care facilities were visited and the average error rate (inaccurate MDS-RCA) was 18.72%. (First year)

2001 Medicaid Costs
Programs vs. Admin Expenditures



In addition to the expenditures for health care services, $67,805,912 was expended in SFY 2001 to administer the MaineCare Program. This represents 4.48% of total Medicaid spending.

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 Care Program. The *Bureau of Medical Services* has five overall functional divisions:

Division of Policy and Provider Services

The Division of Policy and Provider Services is responsible for research and developing coverage for, and access to, a comprehensive array of health and social services for MaineCare members and other individuals of low income. It provides general MaineCare information and research assistance to all callers to the Bureau of Medical Services. It also is responsible for enrolling providers and for providing information, education and assistance to providers and con-

sumers relative to MaineCare and other State health care coverage policy.

Division of Quality Improvement

The Quality Improvement Division takes the lead in determining and tracking quality indicators to ensure services and benefits meet established standards of medical necessity and are beneficial to the member. This division is responsible for Maine's Case Mix system and for the medical eligibility of certain MaineCare members. The MaineCare managed care benefit and the Department's pharmacy benefits are managed by this Division, as is the Medical Eye Care benefit. This Division handles prior authorizations for certain medical services and items of durable equipment, as well as services provided out of state. The Division is also responsible for monitoring provider and recipient compliance with MaineCare policies and regulations

Division of Financial Services

The Division of Financial Services has primary responsibility for managing the financial functions of the Bureau and is responsible for preparing and managing the MaineCare budget. This Division is responsible for enforcing state and federal third party liability rules designed to ensure MaineCare is the payor of last resort and it is responsible for managing the drug rebates. The Division ensures that claims are processed accurately and timely which includes: microfilming and scanning claims, resolving suspended claims and adjusting paid claims. This Division is also responsible for administering Maine's Certificate of Need Act .

Division of Research and Resource Development

The Division of Research and Resource Development coordinates the Bureau's research and training initiatives and assists with special projects. It performs the research, analysis and reports from information extracted from the Bureau's data warehouse in order to assist in evaluating the effectiveness of the Programs and services the Bureau provides. The Division is also responsible for training BMS staff and other agency staff in how to retrieve data from the MaineCare Decision Support System, for coordinating the Bureau's interns and notifying Bureau staff of training opportunities offered in house and by other agencies and organizations across the State.

The Division of Licensing and Certification

The Division of Licensing and Certification is responsible for enforcing State licensure standards and Federal Medicare/Medicaid certification requirements for over 2,400 providers/suppliers. It registers complaints in regard to the facilities and agencies it licenses. The Division also operates the Maine Registry of Certified Nursing Assistants and certifies laboratories under the Comprehensive Laboratory Improvement Amendments of 1988 (CLIA).

The Medicaid Advisory Committee (MAC)

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.

During SFY 2001, the MAC was comprised of representatives from the following consumer and and provider organizations:provider organizations:

Consumer Representatives

Joe Ditre, Consumers for Affordable Health Care
Cynthia Sudheimer, Plan Development Work
Christine Hastedt, Maine Equal Justice Project
Barbara Ginley, Women's Lobby
Helen Bailey, Maine Advocacy Services
Carol Carothers, Alliance for the Mentally Ill
Pam LaBourdais, AFDC Advisory Councill
Bob Philbrook, Maine Association of Interdependent Neighborhoods
Hilton Power, American Association of Retired Persons
Ellie Goldberg, Maine Children's Alliance

Provider Representatives

Gordon Smith, Maine Medical Association
Mary Meyhew, Maine Hospital Association
Group for Community Based Living
Bonnie Post, Maine Ambulatory Care Coalition
Kellie Miller, Maine Osteopathic Association
Vicki Purgavie, Home Care Alliance of Maine
Paula Valente, Maine Health Care Association
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 in Augusta.