Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor
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January 18, 2012

To: Senator Richard Rosen, Senate Chair
Representative Patrick Flood, House Chair,
Members of the Joint Standing Committee on Appropriations and Financial Affairs

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: Information provided by the Department of Health and Human Services in response to questions asked at the January 11, 2012 Work Session

Optional Services

1. Sen. Rosen: Two General Questions: Comparison to typical commercial plan for these optional services.

2. Are any optional services mandated by state for private carriers?

   Response for questions 1 and 2: DHHS will provide a response in the next packet of responses.

3. Rep. Martin: What are the demographics of those receiving each of the optional services (age, employment status etc.).

   Response: Please refer to updated fact sheets.

4. Rep. Flood: Can optional services be redesigned for stricter eligibility? Can the eligibility be restricted by diagnosis, age, employment eligibility etc.?

   Response: Based on Federal guidelines, we are not able to restrict services based on diagnosis, age or employment eligibility. We can limit the benefits provided within each of the various optional services.

Ambulatory Surgical Center

5. Rep. Chase: from FY10-FY11 a substantial drop. What was the cause? MIHMS is the probable cause. Would we not be seeing savings in the range of the historic expenses?

   Response: This difference in the spending is directly related to the implementation of MIHMS and the problems with claims processing in SFY11.

6. Rep. Webster: What are the procedures? Who would lose services and what would the cost be for substitute services such as hospitalization?

   Response: Please refer to the updated fact sheets for the procedures performed. In regards to the difference in reimbursement methodologies of the ASC's and Hospitals, please see below:

   - ASC reimbursement is the lower of: A) the lowest amount allowed by Maine Medicare Part B carrier based on current Medicare rates; or B) the provider's usual and customary facility charge.

   - Acute Care Non-Critical Access hospital setting is either DRG-based for inpatient or the lower of 83.8% of MaineCare outpatient costs or charges

Chiropractic

7. Rep. Webster: Who received care, type of procedures and consequences of not providing the service? This is a less expensive form of treatment than surgery. Is there a projected cost of hospitalization.

   Response: please see updated fact sheet for procedures performed. Based on the services provided, some of these services are provided by other providers who will remain eligible for MaineCare reimbursement. In terms of the cost of hospitalization for back surgeries as an example, the average MaineCare reimbursement is: In regards to reimbursement we pay a per discharge amount, therefore it is not a comparison that we can make. Please include the amount we would reimburse for back surgery on average based on the DRG.

8. Rep. Rotundo: What happens to the unmet needs? Will it result in more expensive care elsewhere?

   Response: The budget proposal seeks to eliminate the service provider type of chiropractors. Other providers who will remain eligible for MaineCare may provide similar services. Chiropractors are reimbursed under Chapter III rates (53% of Medicare), whereas qualified physicians are reimbursed 70% of the lowest 2009 Medicare fee schedule rates.

Vision

9. Rep, Martin: It appears that the costs increased sharply between FY10 and FY11. What is the cause of that?

   Response: The difference is directly related to the implementation of MIHMS. The SFY '11 data reflects services provided in a physician's office where as that was not reflected in the SFY '10 data.

10. Rep. Rotundo: If none of the services listed no matter who performs them, what would be the cost of doing away with preventative services?

    Response: We cannot predict the rate of utilization of other services in the absence of these services. These services may increase utilization of higher cost facility-based services.

11. Rep. Webster: Studies of the consequences of a lack of screening for eye disorders and the associated costs.

    Response: This is a proposal in response to a budget challenge, savings identified because this is an optional service as defined by the Federal Government. These are clearly valuable services, however the Department can no longer afford within its existing budget to fund optional services.

12. Rep. Flood: Current services regarding eye glasses? Confirm the last bullet of services?

    Response: Current policy for eyeglass coverage for adults is limited to one per lifetime for 10 diopters or more.

13. Rep. Stevens: What are the vision services provided by physicians that are mandatory under the Medicaid program?

    Response: All medically necessary physician services are mandatory. So all services related to medical conditions and diseases of the eye would continue to be covered. There are multiple CPT codes that cover these procedures, and a physician, using his/her clinical judgment and working within his/her scope of licensure would make those determinations.

14. Sen. Hill: Any chance that the user numbers are suspect given that they are from FY11 which has proven problematic due to the transition from MECMS?

    Response: See updated fact sheet.

15. Rep. Martin: Is there a way the services can be provided at a cheaper price?

    Response: The Legislature can review rates of reimbursement for the providers of these services; currently MaineCare reimburses qualified providers billing under vision policy at the lowest of A) 53% of the current Medicare fee schedule, B) what Medicare B will pay, C) amount allowed under Section 90 (physician policy), or D) the usual and customary charge.

16. Rep. Rotundo: Given that physicians performing the services would be paid for, would a referral to an optometrist be covered?

    Response: No, a service referred to an optometrist will no longer be covered.

Dental

17. Rep. Martin: Would adults in waiver homes be eligible for dental services under this proposal and are they eligible now?

    Response: Dental services are not currently covered for those individuals that reside in a waiver home.

18. Rep. Webster: Will those in waiver homes want to move to the more expensive ICF-MR in order to access dental care?

    Response: There was a choice made to move into the Waiver by or for the waiver members, so they could be removed from an institutional setting and live in a smaller home-like environment. The choice to move back into an ICF-MR setting would be theirs, but would not be ideal, as they already chose to get out of the institutional environment for a better living situation.

19. Rep. Webster / Rep. Rotundo: What would be the cost consequence of the increase in emergency room care for dental issues?

    Response: We cannot determine at this time if there will be additional costs due to emergency room use. This is a valuable service, however, due to current budget challenges the Department cannot afford to fund these optional services without a provision for alternative funding.

Occupational Therapy

20. Rep. Rotundo: Savings numbers net of costs of institutionalization (see last bullet in fact sheet)? Since the answer was no, what would be the additional cost.

    Response: We cannot determine at this time if there will be additional costs due to institutionalization.

21. Rep. Webster: What are the demographics (age and sex) of people getting this service? How many receive it in order to go back to work or school?

    Response: Please refer to updated fact sheet.

Physical Therapy

22. Rep. Webster: Fifth item on fact sheet can you give an estimate of the number of people who would have to go to a higher level of care and how much would that cost?

    Response: We cannot determine at this time if there will be additional costs due to institutionalization.

23. Rep. Rotundo: Is this a service that helps to control costs in the long run?

Response: While it is difficult to respond to this question given the variety of physical therapy services provided, for some individuals this service may clearly help to restore mobility and reduce the need for more expensive interventions.

24. Sen. Rosen: Again it looks like a sharp increase in FY11? The answer may be the implementation of MIHMS but Stephanie will confirm.

Response: With the implementation of MIHMS the state had to transition to HIPAA compliant billing codes. In the previous claims processing system we used "local" codes which allowed us to identify procedures and place of service separetly. In MIHMS we are extracting data at a procedure code level therefore reflecting all services rendered.

Podiatry

25. Rep. Webster: In addition to diabetics, there are others with muscular-selector issues with mobility issues that are treated under podiatry services, what are the estimates of additional expenses for those?

Response: We cannot determine at this time if there will be additional costs due to treatment by other providers.

STD Clinics

26. Rep. Rotundo: How many clinics would be impacted? Would the clinics continue to exist (i.e. other funding sources?

Response: There are currently 3 clinics enrolled. One in each of these cities – Portland, Bangor and Lewiston.

27. Rep. Rotundo: What would be the impact on public health?

Response: Over all, STD Clinics and Family Planning partners in Maine report 32% of all Chlamydia cases, 40% of all gonorrhea, 60% of all syphilis, and 21% of all HIV. It is possible services may be reduced and follow-up on reported cases may be impacted if clinic hours are reduced. The effect will depend on the management responses of the affected clinics.

Total reported cases in 2011 (rough data):
Chlamydia – 3102
Gonorrhea – 273
Syphilis – 20
HIV – 54

STD Clinic reported cases:
Chlamydia – 136 (4%)
Gonorrhea – 53 (19%)
Syphilis – 12 (60%)
HIV – 8 (15%)

Family Planning reported cases:
Chlamydia – 860 (28%)
Gonorrhea – 56 (21%)
Syphilis – 0
HIV – 3 (6%)

28. Rep. Clark: Please clarify the financial information on page 1 of the fact sheet. 08 spending vs 11?

Response: With the implementation of MIHMS the state had to transition to HIPAA compliant billing codes. In the previous claims processing system we used "local" codes which allowed us to identify procedures and place of service separetly. In MIHMS we are extracting data at a procedure code level therefore reflecting all services rendered.

Smoking Cessation

29. Rep. Rotundo: She understands that the initiative would yield the savings listed. How many people take advantage of these services?

Response: Please see fact sheet for total number of users.

30. Stephanie volunteered to get information on other funding sources for these types of programs.

Response: Smoking cessation is supported through the Maine CDC's Partnership For a Tobacco-Free Maine (PTM). The program supports:

- Tobacco HelpLine - confidential, free telephone counseling for any Maine resident who wants to quit using tobacco.
- Nicotine Replacement Therapy (medication to quit) - Interested and committed participants who are over 18 years old can receive up to three months of Nicotine Replacement Therapy (NRT) at no cost provided they do not have insurance or pharmacy benefits that cover NRT, pass a medical screen, and are enrolled in the counseling program.
- NRT Medications for MaineCare members are being paid by Office of MaineCare Services at this time. Present PTM funding levels for NRT would not support the additional demand for services of MaineCare members. There are no other known funding sources.

31. Sen. Rosen: Are the products OTC or prescription only?

Response: Prescription only.

32. Rep. Chase: What is the success rate of these programs?

Response: It is difficult to determine all of the factors involved, but Maine has experienced a drop in smoking rates over the past decade:

- Adult smoking rates dropped from 24% in 1999 to 18% in 2010.
- Youth smoking rates for High School dropped from 39% in 1997 to 18% in 2009.
- Cigarette consumption (packs of cigarettes sold per capita annually) has dropped from a 1977 high of 156 packs per capita sold annually to 53 packs per capita sold annually in 2010.
- Maine sold 106 packs per capita in 1999 and 53 packs per capita in 2010 – cutting consumption in half in the years the current tobacco program has been in existence, the years since the Master Settlement Agreement.

Rates of smoking – Current smoker:

Year	Statewide Adults 18-64 years	MaineCare Adults 18-64 years
2005	24.3%	43.7%
2006	24.2	41.0
2007	23.2	47.4
2008	20.6	44.5
2009	19.9	43.7
2010	20.6	40.4

*Above results are from the Maine Behavioral Risk Factor Surveillance Survey

*Note:
First bullet above is Maine Behavioral Risk Factor Surveillance Survey results for all Maine adults 18 years and older.
Second bullet above is Maine Youth Risk Behavioral Health Survey for high school students.
Table above is citing Maine adults aged 18-64 years; this best represents the population of MaineCare members.

Cc: Joint Standing Committee on Health and Human Services
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Katrin Teel, Senior Health Policy Advisor, Governor's Office
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