PROP #	THEME	Proposal Description	Time Frame	Concerns
14d	Changes in eligibility	Offer 12 month continuous eligibility for populations	LT	Ongoing health care ensures appropriate preventive care, but costs money in short-term
19a	Changes in eligibility	Reduce frequency of redeterminations	LT	Programming changes to CARES; Might increase costs due to non-reporting of financial changes
71f	Changes in eligibility	Tighten eligibility criteria	n/a	Violates federal maintenance of effort
67c	Coordination of benefits	More active enrollment of Medicaid beneficiaries into Medicare	FY 13	Implementing process
48	Coordination of benefits	Do not pay for services that should be covered by Veterans Administration	FY 13 -FY 14	Need to analyze further
47	Coordination of benefits	Do not pay Medicare Part B coinsurance	n/a	Federal rules require us to pay
46	Coordination of benefits	Do not pay for services denied under Medicare Advantage	ST	Need to analyze further
82h	Coordination of care	Supportive of patient centered medical home (PCMH) program development; expansion of program could increase savings	FY 13	Medicaid funding level does not fully support current enrollment numbers (MHCC program); Need to develop proposal to implement chronic health home option under ACA; savings not guaranteed
29a	Coordination of care	Develop behavioral health home; increase care coordination; use family physician as one stop shop and to manage ER admissions	FY 13	Need to develop proposal and submit plan to CMS; 10 percent general funds are needed; savings not guaranteed
8	Coordination of care	Develop behavioral health home; increase care coordination; use family physician as one stop shop and to manage ER admissions	FY 13	Need to develop proposal and submit plan to CMS; 10 percent general funds are needed; savings not guaranteed
62b	Coordination of care	Mandate MCOs to identify high cost users and provide intensive case management	FY 13	Analyzing the ACA chronic health home option for individuals with substance use and mental illness; savings not guaranteed
36	Coordination of care	Bar MCOs from assigning hospital outpatient departments as their enrollee's primary care provider	FY 13	Might cause network adequacy issues for PCPs in certain parts of the State

PROP #	THEME	Proposal Description	Time Frame	Concerns
14a	Coordination of care	Implement behavioral health home under the ACA	FY 13	Need to develop proposal and submit plan to CMS; 10 percent general funds are needed; savings not guaranteed
20a	Coordination of care	Expand the MHCC all payer medical home to more people	FY 13	Medicaid funding level does not fully support current enrollment numbers; savings not guaranteed
53d	Coordination of care	Improve oversight of foster care system	FY 13	Requires accurate and timely data sharing by DSS social workers; savings not guaranteed
24a	Coordination of care	Implement care management for high cost Medicaid managed care enrollees with co-occurring medical and substance use disorders; Provide case management to individuals with substance use disorders	FY 13	Need to develop proposal for ACA chronic health home and submit plan to CMS; 10 percent general funds are needed; savings not guaranteed
24b	Coordination of care	Develop integrated primary care models to coordinate substance use disorders and promote SBIRT in all hospitals ED facilities	FY 13	Medicaid already covers SBIRT; Analyzing the ACA chronic health home option for individuals with substance use and mental illness; savings not guaranteed
52	Coordination of care	Pay pharmacists for medication therapy management	LT	Significant system changes required; Savings difficult to quantify
9d	Coordination of care	Begin transition planning sessions with providers (e.g., United Health Care and Kaiser) to develop partnerships with primary health care organizations which will serve as key bridge to ACA	LT	Need more details about proposal
18	Coordination of care	Provide case management services to high cost enrollees	LT	Certain high cost fee-for-service enrollees already receive care coordination, e.g., REM; savings not guaranteed
26a	Coordination of care	Managed care for high-cost users	LT	Many high cost users already are under managed care or have a case manager assigned under FFS program; savings not guaranteed

PROP #	THEME	Proposal Description	Time Frame	Concerns
57c	Coordination of care	Reduce hospital readmissions (partnership with office of genetics) for REM children and adults	n/a	Already provide case management for REM enrollees; savings not guaranteed
81b	Coordination of care	We support efforts to actively examine system changes, such as patient centered medical homes	n/a	Comment
76b	Coordination of care	Care coordination works - improves outcomes and cost savings	n/a	Comment
17b	Coordination of care	Improve access and medication management issues	n/a	Need more details about proposal
20b	Coordination of care	Reduce unnecessary hospital readmissions (take advantage of savings from HSCRC initiatives)	n/a	Program does not produce savings in short-term; Hospitals are able to retain savings in short-term
30	Coordination of care	Allow LHD ACCU staff to provide more coordination and have MCO provide case management	n/a	Already doing this
53c	Coordination of care	Improve reporting of mental health services to MCOs	n/a	Mental health claims data is not real-time, Need to consult attorneys concerning confidentiality issues
56c	Coordination of care	Count savings generated by HSCRC initiatives, e.g., reduce unnecessary hospital readmissions	n/a	Programs do not produce savings in short-term; Hospitals are able to retain savings in short-term
83b	Coordination of care	Provide intensive care coordination during first 30 days following a hospital discharge for targeted pediatric populations	ST	Need to develop proposal
77b	Coordination of care	Put MCOs in charge of care coordination, especially for mental health	ST	Department is currently working with a consultant to review how best to integrate mental health, substance abuse and somatic services
14c	Coordination of care	Improve coordination of care, using ACA options - health home, accountable care organizations -- and other models for care integration	ST	Need to develop proposal
21c	Coordination of care	Improve coordination of care, using ACA options - health home, accountable care organizations -- and other models for care integration	ST	Need to develop proposal

PROP #	THEME	Proposal Description	Time Frame	Concerns
25i	Coordination of care	Increase use of ambulatory outpatient surgery compared to surgeries in hospital and hospitalist services	ST	Need to further research hospitalist suggestion; create prior-authorization for surgeries in hospital versus ambulatory surgery centers
62a	Coordination of care	Provide incentives to mandate primary care providers to screen for substance use disorders; promote SBIRT by providers	ST	Medicaid already covers SBIRT and PCPs are required to screen enrollees under HealthChoice (although many do not do so); savings not guaranteed
26b	Coordination of care	Develop wrap-around supports for high-cost users	ST	Need to analyze further
25b	Coordination of care	Integrate behavioral health and somatic care	ST/LT	The Deputy Secretary for Behavioral Health is reviewing integration; Analyzing the ACA chronic health home; savings not guaranteed
60	Eliminate fraud and abuse	Medical day care centers are providing false information to guide seniors to become Medicaid eligible and eligible for medical day services	n/a	Comment - will refer to Office of the Inspector General
21b	Health IT	Implement Federal EHR incentive program	FY 12	Already doing this; savings more long-term
21a	Health IT	Replace MMIS	LT	Already doing this
82b	HealthChoice Contracting	Do not move toward a selective contracting model in HealthChoice	n/a	Comment - not cost containment
68	Improve administration	Modify PAC application process to permit applicants to select MCO	FY 13	Need to analyze further to determine if there are potential cost savings
19b	Improve administration	Improve efficiency of eligibility staff	FY13	Need more details; new eligibility systems already being planned
59e	Improve administration	Reorganize Medicaid services to eliminate wasteful bureaucracy	LT	Need to analyze further
70	Improve administration	Simplify the number of programs, e.g., son enrolled in REM, DDA's new direction waiver, Maryland attendant care program; Pay for DME and Rx that are medically necessary	n/a	Will discuss with LTC Reform Workgroup - Already pay for medically necessary DME and Rx.
25j	Improve claim payment	Implement pre-payment claim unbundling detection software	n/a	Already doing with plans for new MMIS
25f	Improve claim payment	Outsource claims expense recovery services	ST	Already hire TPL contractor; might be opportunities to add initiatives

PROP #	THEME	Proposal Description	Time Frame	Concerns
26d	Improve mental health system	Incent crisis stabilization programs for individuals with co-occurring mental health/substance abuse issues	n/a	Referred to the Deputy Secretary for Behavioral Health
78f	Improve mental health system	Expand cost effective programs for high utilizers; develop crisis program statewide; ensure access to crisis programs; use medical homes under ACA; develop recovery oriented acute care systems; ensure Lorraine Sheehan revenue continued commitment of dedicated revenues from Lorraine Sheehan alcohol tax	n/a	Referred to the Deputy Secretary for Behavioral Health
26e	Improve mental health system (and Addictions Treatment)	End moratorium on the development of affordable housing by mental health providers; Expand residential opportunities for individuals with substance use disorders	n/a	Referred to the Deputy Secretary for Behavioral Health
26k	Improve mental health system (and Addictions Treatment)	Consolidate Mental Hygiene Adm and ADAA	n/a	Referred to the Deputy Secretary for Behavioral Health
26g	Improve mental health system (and Addictions Treatment, and Developmental Disabilities)	Implement self-directed disease management programs in substance abuse treatment programs, CRPs, PRPs, and for individuals with developmental disabilities	n/a	Referred to the Deputy Secretary for Behavioral Health
26h	Improve mental health system (and Addictions Treatment, and Developmental disabilities)	Create specialized community programs for aging individuals with substance use disorders, mental illness, or developmental disabilities	n/a	Referred to the Deputy Secretary for Behavioral Health
78e	Improve quality of care	Use Medicaid more creatively to support people on the developmental disabilities' waiting list; serve more individuals on waivers; ensure continued commitment of dedicated revenues from Lorraine Sheehan alcohol tax	FY 13	Need to analyze further
58	Improve quality of care	Encourage use of end of life planning tools, like advanced directives	FY13	Department supports this initiative - needs to determine if more can be done

PROP #	THEME	Proposal Description	Time Frame	Concerns
14e	Improve quality of care	Develop quality monitoring and reporting tools for all Medicaid services	LT	Need to develop measures and hire contractors to measure
26m	Improve quality of care	Implement pay-for -performance programs across providers	LT	Already have pay for performance programs for nursing homes and MCOs - harder to implement such programs with smaller providers - administrative costs may offset any potential savings
78c	Improve quality of care	Improve access to community-based services for children and adults with developmental disabilities under Medicaid; expand access to home services; change rate structure for personal care; develop behavioral supports	LT	Need to analyze further
78d	Improve quality of care	Comply with legal and professional standards regarding institutional care for persons with disabilities who are alleged to have committed delinquent or criminal offenses; Develop more integrated, coordinated system for this population; Determine if DHMH not courts can make commitment decisions; provide community based care under 1915(i); dedicated legal counsel for forensic service issues within DHMH	LT	Need further review; but results in increased costs in short-term
9c	Improve quality of care	Provide services through school to all Medicaid children, not just those who have an IEP and IFSP	n/a	Not a cost containment; service expansion
11	Improve quality of care	Physician should signoff on service need; unannounced visits to centers; make clear about consequences of falsifying information	n/a	Already doing this
20c	Improve quality of care	Quantify savings from HSCRC hospital-acquired conditions policy	n/a	Already doing this
26j	Improve quality of care	Consider mandating accreditation by CARF/JCAHO	n/a	Referred to Office of Health Care Quality
26p	Improve quality of care	Set core minimum performance standards for state purchased behavioral health services	n/a	Referred to the Deputy Secretary for Behavioral Health

PROP #	THEME	Proposal Description	Time Frame	Concerns
26q	Improve quality of care	Move to performance-based provider eligibility	n/a	Should be analyzed when reviewing pay-for-performance opportunities
56d	Improve quality of care	Deal with sustainable long-term program changes	n/a	Comment
62c	Improve quality of care	Ensure Medicaid covers all medications for substance abuse treatment	n/a	All MCOs have approved formularies in which they must cover necessary medications. But they do not need to be the same
82e	Improve quality of care	Supportive of HSCRC bundled payment structures	n/a	Comment
82f	Improve quality of care	Supportive of HSCRC quality-based pay for performance measures	n/a	Comment
82g	Improve quality of care	Supportive of HSCRC admission-readmission revenue episode payment structure	n/a	Comment
72	Improve quality of care	Re-examine the cost-benefit ratio for extended part C in Infant and Toddler Program		Referred to Maryland State Department of Education
78b	Improve quality of care	Make Medicaid community-based mental health services array more robust and contain Medicaid spending on more		Referred to the Deputy Secretary for Behavioral Health
26i	Improve quality of care	Repeal unnecessary or harmful regulations and standardize regulations	n/a	Not a cost containment idea
15b	Maximize fed. match rates	Ensure program is maximizing federal matching rates	FY 12	
44	Maximize fed. match rates	Transfer eligible children from Title XIX to CHIP	FY 12	Requires CARES programming
26l	Maximize fed. match rates	Utilize a blended funding model	n/a	Need more information on proposal
26n	Maximize fed. match rates	Create community incentive pools. States have created centralized match pools	n/a	Need more information on proposal
26o	Maximize fed. match rates	Turn the state budget for funded behavioral health issues into a population based budget	n/a	Referred to the Deputy Secretary for Behavioral Health

PROP #	THEME	Proposal Description	Time Frame	Concerns
67a	Maximize fed. match rates	Maximize federal match on state expenditures by DJS and local DSS	n/a	CMS denied proposal to pay targeted care management to DJS and DHR staff
56a	Maximize fed. match rates	Cutting Medicaid means a lose of federal monies	n/a	Comment
67b	Maximize fed. match rates	Maximize federal match on safety net provider expenditures regarding Medicaid outreach and enrollment	ST	Need to determine how many outreach activities are occurring that are matchable; need to be able to transfer general fund dollars
45	Maximize fed. match rates	Review cost allocation plan related to Title XIX and Title XXI	ST	Currently reviewing
12	Rebalancing LTC	Nursing facilities should have a bed hold longer than 15 days; allow categorical eligible Medicaid enrollees to apply simultaneously to institutional eligibility and HCBS waivers	FY 12	First recommendation is not a cost containment initiative; Requires some coordination with CARES process
31	Rebalancing LTC	Allow categorically eligible Medicaid enrollees to apply simultaneously to institutional eligibility and HCBS waivers	FY 12	Requires some coordination with CARES process
37	Rebalancing LTC	Reduce paid days in Nursing facility bedhold policy	FY 12	Access to the facility could be delayed or denied if facility 100 percent occupied
55b	Rebalancing LTC	Apply for community first choice	FY 13	Maryland is analyzing and reviewing; may apply in FY 12 but savings would not occur in later years
59b	Rebalancing LTC	Demedicalize services - use more personal care attendants	FY 13	Maryland is analyzing and reviewing Community First Choice; May apply in FY 12 but savings would not occur in later years
2a	Rebalancing LTC	Rebalancing will cost money due to the woodwork effect	n/a	Comment
61d	Rebalancing LTC	Require some LTC Waiver participants to move to ALFs	n/a	Not permissible according to federal rules
61e	Rebalancing LTC	Include a cost of care calculation in Older Adults Waiver care plans	n/a	Already doing this

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73a	Rebalancing LTC	Rebalance long-term care without cutting funds to providers or assessing provider taxes (e.g, medical day care)	n/a	Comment
75a	Rebalancing LTC	Institutionalized individuals receiving SSI should be diverted to waiver program	n/a	LTC rebalance top priority; Maryland already has Money Follows the Person and Individual programs
81a	Rebalancing LTC	We support renewed efforts to redesign LTC system	n/a	Comment
59a	Rebalancing LTC	Expand the use of community-based services; apply for Community First Choice	ST	LTC rebalance top priority; need to be consider in LTC workgroup; Maryland is analyzing and reviewing Community First Choice; May apply in FY 12 but savings would not occur in later years
19c	Rebalancing LTC	Increase funding for Older Adults Waiver	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
53a	Rebalancing LTC	Support increasing supports and services to remain in the community; take advantage of dual eligible federal demonstrations (CMS innovations center)	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup; CMS demonstration need to be considered this Fall
55a	Rebalancing LTC	Open independent living waivers	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
1	Rebalancing LTC	Transition 1,000 nursing home residents into the community; Get federal grant funds to bring in additional ombudsman	ST/LT	Difficult to increase nursing home transitions beyond MFP targets in short-term
14b	Rebalancing LTC	Partner with HUD and other supportive housing programs to target Medicaid population	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
13	Rebalancing LTC	Expand consumer directed service options and reorganize Medicaid services based on functional need	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
15a	Rebalancing LTC	Move to community-based services	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
17c	Rebalancing LTC	Expedite ways for people to get out of nursing facilities and into community-based services	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup

PROP #	THEME	Proposal Description	Time Frame	Concerns
25c	Rebalancing LTC	Expand LT managed care	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup; Need to ensure community options exist
26f	Rebalancing LTC	Expand use of in-home personal assistants	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup; Need to ensure community options exist
54	Rebalancing LTC	Transfer individuals to their homes when they are released from hospitals	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
56e	Rebalancing LTC	Apply for CMS dual eligible demonstration (CMS Innovations Center)	ST/LT	CMS demonstration need to be considered this Fall; Savings would be more longer term
56f	Rebalancing LTC	Improve Maryland's home and community based services	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
57a	Rebalancing LTC	Look into housing opportunities	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
57b	Rebalancing LTC	Implement cash and counseling	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
59c	Rebalancing LTC	Expand consumer directed service options	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
59d	Rebalancing LTC	Increase coordination for dual eligibles	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
61b	Rebalancing LTC	Increase emphasis on nursing home diversion	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
61c	Rebalancing LTC	Slow the rate of nursing home admissions by improving in-home services	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
76a	Rebalancing LTC	Serve more individuals in the community	ST/LT	LTC workgroup
78a	Rebalancing LTC	Make community waiver services more accessible and flexible, and community Medicaid services more robust	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
82i	Rebalancing LTC	Apply for federal demonstrations for duals	ST/LT	CMS demonstration needs to be considered this Fall; Savings would be more longer term

PROP #	THEME	Proposal Description	Time Frame	Concerns
67g	Rebalancing LTC	Institute higher level of care coordination for dual eligibles	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup; CMS demonstration need to be considered this Fall (Innovations Center), but savings more longer term
80	Rebalancing LTC	Invest in home and community-based services instead of cutting services for people with disabilities; increase funding for Bridge Subsidy program; increase number served under waivers; stop backfilling nursing home beds	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
22	Rebalancing LTC	Accelerate rebalancing LTC supports and services; Develop plan for 1,333 nursing residents; discontinue retrospective nursing home cost settlements and freeze nursing home rates	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
53b	Rebalancing LTC	Allow aged MCO members to stay in managed care	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
83a	Rebalancing LTC	Work with MCOs to identify individuals meeting nursing home level of care at the earliest possible time if they might benefit from waivers (Proposal provides recommendations on new processes)	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
7	Reduce benefits	Purchase employer-sponsored insurance under the Medicaid HIPP provision	LT	Need to analyze further
9a	Reduce benefits	Restructure benefits, such as using intermediate care facilities rather than urgent care facilities	ST/LT	Need more details - proposal is not clear
25h	Reduce ER use	Create a discharge advocacy program in hospital	FY 13	Need to further develop proposal
19d	Reduce ER use	Train young mothers to reduce ER usage; Encourage people with insurance to not use ER; Create a discharge advocacy program in hospital	FY 13	Need to further develop proposal
4a	Reduce ER use	Require patients to use patient first facilities before going to the hospital	LT	Requirement would be difficult to implement and verify/ might also conflict with EMTALA law
16	Reduce ER use	Do not implement $50 copay for non-emergency ER services	n/a	Comment

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17a	Reduce ER use	Do not implement $50 copay for non-emergency ER services	n/a	Comment
40	Reduce ER use	Require $50 copays for non-emergency visits	n/a	Non-emergency services are being retracted through bill audits
81c	Reduce ER use	We are encouraged by HSCRC efforts to reduce unwarranted readmissions; Further encourage HSCRC to examine ways to change rate system to lower use of ER	n/a	Comment (refer to HSCRC)
23	Reduce ER use	Implement a Dental ER pilot for adults	n/a	This is not a cost containment project because Medicaid doesn't cover dental services for adults
67d	Reduce ER use	Review ER claims to see if services could be provided in ambulatory setting; might need to consider revising EMTALA system	ST	Already doing this
26c	Reduce ER Use	Provide incentives to use medical day care to divert ER and inpatient days	ST/LT	Individuals need to meet nursing home level of care to qualify for medical day care services
6	Reduce fraud and abuse	Hire more fraud investigators; penalties should fit the crime; technologies should be in place for eligibility workers to check income, assets and citizenship	FY 13	Refer to Office of the Inspector General;
3	Reduce fraud and abuse	Make people prove citizenship and apply an asset requirement	n/a	Already review citizenship; Violates federal maintenance of effort
67f	Reduce fraud and abuse	Increase recoveries from fraud, waste, and abuse; one potential area is DME	ST	Referred to Office of Inspector General; Department pursuing Asset Verification System implementation
69	Reduce pharmacy costs	Since federal government is phasing out the "donut hole" there may be pharmacy savings for kidney disease program	FY 12	Difficult to analyze savings; Medicaid will receive the savings without having to make changes
27	Reduce pharmacy costs	Implement $5 pharmacy copays	LT	Already have copays for brand-name ($3) and generic drugs ($1); Could change copays but not as high as $5; copays cannot exceed 5 percent of income. Need new MMIS to track copays

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43	Reduce pharmacy costs	Corrective managed care and pharmacy lock-in	LT	Due to system limitations, the cost of operating program most likely will exceed service costs on FFS side
9b	Reduce pharmacy costs	Use more generic drugs	n/a	Already doing this - generic mandatory policy in place
14f	Reduce pharmacy costs	Increase use of generic drugs	n/a	Already doing this - generic mandatory policy in place
25d	Reduce pharmacy costs	Increase generic drug utilization	n/a	Already doing this - generic mandatory policy in place
67e	Reduce pharmacy costs	Savings from reducing scope of contract for its preferred drug list since DHMH is a member of Drug Effectiveness Review Project	n/a	Effective July 1, 2011 DHMH no longer a member of Drug Effectiveness Review Project
84	Reducing eligibility levels	Capping enrollment for the Primary Adult Care Program	FY 12	federal maintenance of effort does not apply to PAC. Negatively impacts recent efforts to improve access to substance abuse services; Individuals would lose coverage
29b	Reducing eligibility levels	Sliding scale eligibility; Increase cost sharing based on income	LT	Violates federal maintenance of effort; Other copay suggestions are being reviewed for FY 12
55c	Reimbursement	Decrease reimbursement rates for durable medical equipment and supplies	FY 12	More consistent with rates paid by neighboring states
38	Reimbursement	Reduce reimbursement rates for DME, DMS, and oxygen	FY 12	More consistent with rates paid by neighboring states
73b	Reimbursement	Forgo additional claims under the Smith v. Colmers lawsuit	FY 12	All parties need to agree and Courts need to approve
73c	Reimbursement	Eliminate the communicable disease care reimbursement category	FY 12	There is evidence to suggest the add-on is not justified.
85	Reimbursement	Patients requiring observation care but not inpatient care - only reimburse hospitals for services provided within 23 or 24 hours	FY 13	Need to analyze further

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39	Reimbursement	Decrease providers who have not received a cut in payments - Orthopedics, Neurosurgeons, Emergency Medicine	FY 13	Providers might discontinue seeing Medicaid patients - also goes against legislative intent to protect these provider types
49	Reimbursement	Implement additional provider assessments, e.g., assessments on Medicaid day care providers	FY 13	Need to analyze further impact on providers and costs to implement
51	Reimbursement	Implement surcharge on providers for surgery and radiology services	FY 13	Need to analyze further impact on providers and costs to implement
82c	Reimbursement	Enforce that HealthChoice MCO must spend 85% of revenues on medical care	FY 13	Regulations phase-in requirement; Need to review if it can be enforced sooner
25a	Reimbursement	Enforce that HealthChoice MCO must spend 85% of revenues on medical care	FY 13	Regulations phase-in requirement; Need to review how to enforce sooner
20d	Reimbursement	Increase the Medicaid discount on HSCRC regulated services	LT	Not likely viable, since discount would apply to Medicare services as well and creates a significant shift to the private insurers
25e	Reimbursement	Increase the Medicaid discount on HSCRC regulated services	LT	Not likely viable, since discount would apply to Medicare services as well and creates a significant shift to the private insurers
63	Reimbursement	Improve estate recovery by barring tax sales on homes where Medicaid has a lien	LT	Need to analyze further
56b	Reimbursement	Cutting provider rates destabilizes provider networks	n/a	Comment
61a	Reimbursement	Make sure DHMH is collecting fraud fines	n/a	Handled by the courts
61f	Reimbursement	Adjust "room and board" amount annually for assisted living residents under Waivers	n/a	No Medicaid savings - higher room and board costs result in lower contribution of care
71h	Reimbursement	Cost sharing with nursing facility residents; families should contribute	n/a	Nursing home residents contribute all of their income other than a small personal needs allowance; current rules don't allow Medicaid to require families to pay for care
75b	Reimbursement	Seek federal reimbursement for Medicaid coverage of Medicare-eligibles that were misclassified	n/a	Requires action by Congress
82a	Reimbursement	Do not increase Medicaid's reliance on hospital assessments	n/a	Comment

PROP #	THEME	Proposal Description	Time Frame	Concerns
64	Reimbursement	Pursue manufacturer rebates on non-prescription purchases	n/a	Need to analyze further
50	Reimbursement	Expand definition of "estate" to include assets that bypass probate	ST/LT	Need to analyze further
5	Reimbursement	Primary care providers should not take the full hit	n/a	Comment
4b	Reimbursement	Only reimburse transportation services after reviewed	n/a	Already doing this
77c	Reimbursement	Limit reimbursement for hospitals to triage fee and screening and diagnostics for non-ER visits; Adjust out of state hospital payments to more closely align with VA; Reduce one day hospital stays; Disallow payment for inefficient provision of services in hospital	n/a	HSCRC is doing a number of initiatives to reduce one day hospital stays ; Department already only pays triage fee and the ancillaries to determine that it is not an emergency
10	Service limits	Make changes to medical day care program - cut funding; charge copays; and conduct inspections	FY 12	Cuts to medical day care reduce a low cost community option for enrollees; Consider more support in senior activities in LTC rebalancing workgroup; Could reduce community infrastructure
28	Service limits	Make changes to medical day care program - cut funding; charge copays; conduct inspections; Support more non-profit organizations to provide senior activities	FY 12	Cuts to medical day care reduce a low cost community option for enrollees; Consider more support in senior activities in LTC rebalancing workgroup; Could reduce community infrastructure
71c	Service limits	Reduce adult day care to 3 days per week	FY 12	Cuts to medical day care reduce a low cost community option for enrollees; Consider more support in senior activities in LTC rebalancing workgroup; Could reduce community infrastructure
82d	Service limits	Examine current benefit structure and determine whether adjustments in coverage can be made without negatively impacting quality of care	FY 12	Options for FY 12 consider benefit changes
42	Service limits	Do not pay for elective (not medically necessary) cesarean deliveries	FY 12	Most deliveries are paid for by MCOs - Need to further analyze potential savings

PROP #	THEME	Proposal Description	Time Frame	Concerns
35	Service limits	Tighten criteria for orthodontia program	FY 12	Most deliveries are paid for by MCOs - Need to further analyze potential savings
32	Service limits	Place limits on non-ER outpatient hospital visits; The limit is on hospital facility visits not physician visits (physicians bill separately from the hospital)	FY 12	Hospitals would not know when enrollees reach the visit limit. Unpaid visits would be built into hospital rates as uncompensated care which would be paid by payers
33	Service limits	Eliminate the podiatry program	FY 12	Medically necessary services would shift to other providers, e.g., providers.
74	Service limits	Do not cover elective abortions	FY 13	Not a cost containment idea since cost of birth exceeds cost of abortion
41	Service limits	Reduce length of stay at chronic hospitals for children	FY 13	Need assistance of an utilization control agent
53e	Service limits	Require prior authorizations for radiology services	FY 13	Prior authorizations would increase contractor costs and may decrease provider satisfaction - but should be examined for high cost procedures
66	Service limits	Do not cover neonatal circumcision	FY 13	Controversial policy issue
20e	Service limits	Cut optional services and increase use of prior authorization	FY 13	Cutting certain optional services would increase higher cost mandatory services; Medicaid program doesn't provide certain optional services for adults, such as dental
34	Service limits	Eliminate the kidney disease program	LT	Need change in State law
71d	Service limits	Implement co-pays	LT	Federal rules allow copays; however, copays cannot exceed 5 percent of income. Need new MMIS to track copays
71a	Service limits	Cut each program by 50 percent	n/a	Not viable
71b	Service limits	Do not pay for services that should be covered by SSI cash benefit, transportation	n/a	Federal rules require us to pay transportation
71e	Service limits	Eliminate prescription drug, dental, vision, walker, and cane assistance programs	n/a	Federal rules allow states to not cover optional services for adults; Medicaid doesn't cover adult dental and eyeglasses. Cutting pharmacy services would result in higher costs for hospital and other services

PROP #	THEME	Proposal Description	Time Frame	Concerns
71g	Service limits	Limit cleaning, cooking assistant services to only blind and wheelchair persons	n/a	Services are not currently covered
79	Service limits	Do not eliminate podiatry program	n/a	Comment
2b	Service limits	Cease money on expensing, life-extending treatment	n/a	Not viable without federal law changes
65	Service limits	Adopt benchmark coverage in Medicaid for eligible beneficiaries	ST	The Department will be analyzing this option as it prepares for Health Care Reform under the ACA
77a	Service limits	Require preauthorization of certain specialty services that don't require anesthesia to encourage lower cost settings; also more broadly using pre-authorization to limit use of more costly settings	ST	Should be examined further
25g	Service limits	Require prior authorizations for ancillary (lab, radiology services) in costly settings; Require prior-authorizations for PCP services in costly settings, e.g., HSCRC outpatient facility practices servicing as PCPs	ST/LT	Might cause network adequacy issues for PCPs in certain parts of the State; prior authorizations would increase contractor costs and may decrease provider satisfaction but should be examined for high cost procedures