**Proposal Number:**  21b

**Theme:** Health IT

**Viable?:** Yes, but complex

**Implementation Timeline:** Implementing now, but savings are more long term

**Required Approvals: Regulatory Change:**  No **Statutory Change:**  No

**State Plan Amendment:**  No  **Federal Waiver:**  No

**Proposal Description:**

Health IT: Establish the necessary administrative framework for Maryland Medicaid physicians to apply for HIT incentives.

**Financial Impact:**

Unknown

**Benefits of Proposal:**

Establishing the appropriate administrative framework for delivering Health IT-related incentives will improve the easy of and speed by which eligible providers will receive incentive payments. In turn, the adoption of Health IT may reduce costs by lowering administrative overhead and the frequency of duplicative and unnecessary procedures. Over time, historical records of treatment can be used to improve health care quality and disease prevention.

**Concerns with Proposal:**

Maryland plans to implement the EHR incentive program in the fall of 2011 and foresees no barriers in registering and paying providers for participation.

**Impacted Stakeholders:**

Medicaid providers eligible for incentives, DHMH Systems and Planning staff, and the Chesapeake Regional Information System for our Patients – Maryland’s Health Information Exchange.

**System Implications:**

Maryland is in the process of creating a new registration and attestation system to administer the program. Necessary MMIS modifications will be made to ensure payment.

**Proposal Number:**  15b (see Proposal Number 44)

**Theme:** Maximize match rates

**Viable?:** Yes, but complex

**Implementation Timeline:** Depends on ability to make changes to CARES system

**Required Approvals: Regulatory Change:** No **Statutory Change:** No

**State Plan Amendment:** No  **Federal Waiver:** No

**Proposal Description:**

Maximize match rates

**Financial Impact:**

Unknown

**Benefits of Proposal:**

The Department is analyzing this proposal for the FY12 and FY13 budgets. For example, we

want to make sure the higher CHIP match (65% FMAP) applies for the appropriate children.The

Department may identify other administrative functions that could be recategorized into higher federal matching categories.

**Concerns with Proposal:**

This proposal would require staff effort to review all of our cost allocation plans and allocation

of eligibility categories to appropriate federal match categories.

**Impacted Stakeholders:**

None

**System Implications:**

CARES/MMIS changes may be necessary to achieve a higher CHIP match.

**Proposal Number:**  44 (See Proposal Number 15b)

**Theme:** Maximizing Match Rates -Transfer eligible children from Title XIX to CHIP

**Viable?:** Yes, but complex

**Implementation Timeline:** FY12 (potentially by April 1, 2012)

**Required Approvals: Regulatory Change:** No **Statutory Change:** No

**State Plan Amendment:** No  **Federal Waiver:** No

**Proposal Description:**

Make sure eligible children between 100-116% federal poverty line receive services under the Children’s Health Program (CHIP) instead of under Title XIX, Families and Children (FAC).

**Financial Impact:**

15% higher federal match for appropriate kids, approximately $3 million

would be saved annually, or $750,000 if implemented by April 1, 2012.

**Benefits of Proposal:**

Increased federal funds

**Concerns with Proposal:**

Requires significant systems changes in CARES and MMIS to identify

these children based on their income levels. DHR controls the CARES system, so any changes

would require coordination with DHR. CARES changes can take a long time to implement.

**Impacted Stakeholders:**

None

**System Implications:**

CARES, and possible MMIS changes would be required.

**Proposal Number:**  12 (see Proposal Number 31)

**Theme:** Rebalancing LTC

**Viable?:** Yes, but it will take time to implement a new process.

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** No  **Federal Waiver:** No

**Proposal Description:**

- Allow institutionalized categorically eligible Medicaid beneficiaries to apply for HCBS without a long term care financial eligibility determination process

-Service limits: Nursing facilities should have a bed hold longer than 15 days

**Financial Impact:**

-Allowing waiver applications before LTC MA is determined could facilitate increased transitions

to the community each year if the person is able to maintain community housing by avoiding

eligibility delays. It is estimated to save $1.2 million in FY 2012. To achieve cost savings, OES

will require approval for 5 FTEs to establish an expedited LTC unit within DHMH DEWS unit. This

assumption is based on a 6 month implementation of the unit and an increase of enrollment of 146 recipients. Staff costs would offset savings.

-Increasing bed hold days requires that we pay for more bed days while the person is not in the facility and is likely receiving other Medicaid-funded services. This would increase rather than decrease costs.

**Benefits of Proposal:**

**-**Less expensive sites of service that allows recipients to age in place

-Expedited transition of recipients from long-term care to the community

**Concerns with Proposal:**

Increased cost for bed hold days.

Staffing is needed.

Will need expedited Health Treatment Plans from AAAs.

**Impacted Stakeholders:**

NF providers, HCBS providers, disability advocates, NF residents

**System Implications:**

Policy change for DEWS to accept applications from NF residents who do not have LTC MA.

Increased applications for HCBS.

**Proposal Number:**  31 (see Proposal Number 12)

**Theme:** Rebalancing LTC - Allow beneficiaries to apply for HCBS without a LTC eligibility determination process

**Viable?:** Yes, but it will take time to implement a new process.

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** No **Federal Waiver:** Yes

**Proposal Description:**

-If cost effective, allow institutionalized categorically eligible Medicaid beneficiaries to apply for HCBS without a LTC financial eligibility determination process (a functional eligibility test still would be required to screen against brief rehab NF stays).

**Financial Impact:**

Allowing waiver applications before LTC MA is determined could facilitate increased transitions

to the community each year if the person is able to maintain community housing by avoiding

eligibility delays. It is estimated to save $1.2 million in FY 2012. To achieve cost savings, OES

will require approval for 5 FTEs to establish an expedited LTC unit within DHMH DEWS unit. This

assumption is based on a 6 month implementation of the unit and an increase of enrollment of 146 recipients. Staff costs will offset savings.

**Benefits of Proposal:**

**-**Less expensive sites of service that allows recipients to age in place

-Expedited transition of recipients from long-term care to the community

**Concerns with Proposal:**

-Staffing is needed

-Expedited Health Treatment Plans from AAAs

**Impacted Stakeholders:**

NF providers, HCBS providers, disability advocates, NF residents

**System Implications:**

Policy change for DEWS to accept applications from NF residents who do not have LTC MA.

Increased applications for HCBS.

**Proposal Number:**  37

**Theme:** Rebalancing LTC - Reduce paid days in Nursing facility bedhold policy

**Viable?:** Yes

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** Yes **Federal Waiver:** No

**Proposal Description:**

Reduce paid days in nursing facility bedhold policy

**Financial Impact:**

Based on current annual expenditures of $4.6 million total funds for bed holds, $2.3 million in

savings could be realized in FY 2012 if bed-holds for hospitalization were eliminated effective

January 1, 2012, or a portion of this amount could be saved if the number of days allowed were

reduced.

**Benefits of Proposal:**

Unnecessary hospitalizations would be reduced.

**Concerns with Proposal:**

Access to the facility could be delayed or denied for a resident returning from a hospital stay if

the nursing facility is 100% occupied.

**Impacted Stakeholders:**

NFs (HFAM, LifeSpan), NF residents.

**System Implications:**

There would be administrative and systems issues if a resident needed to be discharged from a

facility and the nursing home span closed whenever there is a hospitalization.

**Proposal Number:**  69

**Theme:** Reduce Pharmacy Costs - Recalculating cost of pharmacy payments under Kidney Disease Program

**Viable?:** Unknown

**Implementation Timeline:** FY2013

**Required Approvals: Regulatory Change:** No **Statutory Change:** No

**State Plan Amendment:** No  **Federal Waiver:** No

**Proposal Description:**

-The KDP pays approximately $3.6 million annually for medications that are not covered by Medicare Part D. Under the Affordable Care Act, the doughnut hole is being closed over 10 years beginning this year. On January 1, 2011, Medicare began picking up half the cost of brand name medications in the doughnut hole.

-We don’t know what the FY2012 savings might be from this partial closure of the doughnut hole. If DHMH saves a portion of the $3.6 million it had budgeted for, there would be some savings. Currently KDP is not funded out of general funds, but, instead, by the Care First fund. Nonetheless, there may be a way for Medicaid to get credit for the savings to the KDP from lower pharmacy costs for Medicare beneficiaries.

**Financial Impact:**

The Department cannot estimate savings at this time. If recipients start hitting the donut hole

this year, we will be better able to access impact.

**Benefits of Proposal:**

We will achieve the savings without impacting consumers or implementing system changes.

**Concerns with Proposal:**

None

**Impacted Stakeholders:**

KDP recipients

**System Implications:**

Unknown

**Proposal Number:**  84

**Theme:** Reducing Eligibility Levels - Capping the Primary Adult Care Program

**Viable?:** Yes

**Implementation Timeline:** FY 2012 – January 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** No  **Federal Waiver:** No

**Proposal Description:**

Cap enrollment for the Primary Adult Care Program.

Maryland has the authority to cap enrollment for the Primary Adult Care Program. The terms and conditions of the cap are as follows:

In cases where the State determines, based on advance budget projections that it cannot continue to enroll PAC applicants without exceeding the funding available for the program the State can establish an enrollment cap for the PAC program.

* Notice - before affirmatively implementing the caps authorized, the State must notify CMS at least 60 days in advance. This notice must also include the impact on budget neutrality.
* Implementing the Limit - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the Demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
* Outreach for those on the Wait Lists - the State will conduct outreach for those individuals who are on the PAC wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid or the MHIP programs at any time.
* Removing the Limit – the State must notify CMS in writing at least 30 days in advance when removing the limit.

**Financial Impact:**

There are approximately 56,000 individuals enrolled under the PAC program**.** Roughly 1,900 individuals lose PAC enrollment every month. (Enrollment grows every month because more people are enrolled every month than are disenrolled.) The Department is projected to spend around $3,000 (TFs) a year on a PAC recipient. The savings would depend where the Department set the enrollment cap and when it started the cap. For example, if the PAC program were capped at 50,000 enrollees, approximately $5.8 million would be saved.

|  |  |  |  |
| --- | --- | --- | --- |
| **PAC Enrollment** | | | |
|  | Monthly PAC Enrollment | Cumulative Enrollment Decline | Savings (Enrollment Decline x $250 PMPM) |
| January 2012 | 56,000 | - | - |
| February 2012 | 54,100 | 1,900 | $475,000 |
| March 2012 | 52,200 | 3,800 | $950,000 |
| April 2012 | 50,300 | 5,700 | $1,425,000 |
| May 2012 | 50,000 | 6,000 | $1,500,000 |
| June 2012 | 50,000 | 6,000 | $1,500,000 |
|  |  | **Total Savings** | **$5,850,000** |

**Benefits of Proposal:**

It will result in savings during FY 12. Federal maintenance of effort does not apply to PAC.

**Concerns with Proposal:**

A number of low-income childless adults would become uninsured and would forgo services

covered under the limited primary adult care benefit package. This would negatively impact

recent efforts to improve access to substance abuse services. This is exactly the population we

would be required to enroll with the Medicaid expansion anticipated by the Affordable Care Act.

**Impacted Stakeholders:**

Low-income Primary Adult Care (PAC) enrollees.

**System Implications:**

The Department will need to develop a waiting list.

**Proposal Number:**  55c (see Proposal Number 38)

**Theme:** Reimbursement - Decrease cost (or reimbursement of) durable medical equipment

**Viable?:** Yes

**Implementation Timeline:** FY 2012 - January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** Yes **Federal Waiver:** No

**Proposal Description:**

Cost of medical equipment is too high. Servicing equipment is expensive. Example: A wheelchair costs $20,000.

**Financial Impact:**

Reducing the current payment for DME/DMS/Oxygen would result in a $2,012,578 savings to

the State annually. If implemented 1/1/2012, just over $1 million would be saved.

**Benefits of Proposal:**

Reducing reimbursement rates for medical equipment and supply providers would be more

consistent with rates paid in neighboring states.

**Concerns with Proposal:**

It is possible that some providers may decide not to accept Medicaid.

**Impacted Stakeholders:**

Medical equipment and supply providers

**System Implications:**

Not significant.

**Proposal Number:**  38 (See Proposal Number 55c)

**Theme:** Reimbursement - Durable medical equipment (DME) reimbursement

**Viable?:** Yes

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** No  **Federal Waiver:** No

**Proposal Description:**

Decrease reimbursement for DME from 98% of Medicare rates to 90%

**Financial Impact:**

Reducing the current payment for DME/DMS/Oxygen would result in a $2,012,578 savings to

the State annually. If implemented 1/1/2012, just over $1 million would be saved.

**Benefits of Proposal:**

Reducing reimbursement rates for medical equipment and supply providers would be more

consistent with rates paid in neighboring states.

**Concerns with Proposal:**

It is possible that some providers may decide not to accept Medicaid.

**Impacted Stakeholders:**

Medical equipment and supply providers

**System Implications:**

Not significant.

**Proposal Number:**  73b

**Theme:** Reimbursement - Forgo additional claims under the Smith v. Colmers lawsuit

**Viable?:** Yes, pending consent from facilities and courts

**Implementation Timeline:** FY 2012

**Required Approvals: Regulatory Change:** No **Statutory Change:** No

**State Plan Amendment:** No  **Federal Waiver:** No

**Proposal Description:**

Earlier this month, the State informed the industry of a 20%-25% disallowance in paid claims under the Smith v. Colmers lawsuit. Therefore, each provider receiving funds from the Smith v. Colmers [resolution] now has a payback. This [resolution], however, allows for additional claims to be considered, which would require the same process to be followed with the escrow accounts, audits, paybacks, etc. The State has inquired as to whether the industry would like to have these additional claims considered, which may total between $1-2 million. Given the administrative burdens for both providers and the Department, LifeSpan is willing to forgo these claims from being considered provided that the $1-2 million is credited to the nursing homes and used to offset the $40 million needed in Medicaid reductions.

**Financial Impact:**

$2 million TF. Nursing facilities would forgo $2 million of the Smith v. Colmers resolution.

**Benefits of Proposal:**

-Saving budgeted dollars

**Concerns with Proposal:**

-Need court approval

-Need buy-in from plaintiff’s counsel and other non-LifeSpan nursing facilities

**Impacted Stakeholders:**

Nursing facilities

**System Implications:**

None

**Proposal Number:**  73c

**Theme:** Reimbursement - Eliminate the communicable disease care reimbursement category

**Viable?:** Yes

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes  **Statutory Change:** No

**State Plan Amendment:** Yes  **Federal Waiver:** No

**Proposal Description:**

-LifeSpan believes that the State can no longer justify the communicable disease care ("CDC") reimbursement category. In 1988, the State created a nursing cost center reimbursement category for CDC services for Medicaid recipients with a communicable disease requiring nursing facility services. In doing so, facilities providing CDC services were reimbursed for nursing services at the customary level of care amount plus an additional 3.35 hours of nursing care per resident plus an additional "add-on" rate of between $40.84 to $50.43 for each CDC resident depending on the location of the facility. This "add on" was to cover additional costs in the other cost centers - other patient care, routine and administrative and capital - and equated to 40% of the labor component.

-LifeSpan now questions whether the CDC category is necessary and/or reasonable. With regard to the assertion that additional nursing care is needed, since the additional nursing hours were built into the system in 1988, the State has performed two work measurement studies. During the 1994 work measurement study, it was determined that the CDC service required an additional 1.3515 hours of nursing care, significantly less than the 3.35 hours for which facilities were paid. However, the 2005 work measurement study performed by the UMBC Center for Health Program Development and Management found that no additional nursing care was required to care for these residents. This is most likely due to the use of mandatory universal precautions for all residents regardless of CDC diagnosis and to the tremendous advances in CDC disease management. Despite these studies, the State continues to pay facilities an additional 2.52 hours of nursing time, plus an additional “add-on” of between $27 to $31 per day, equating to 40% of labor costs. Taken together, this rate adjusts to roughly an additional $100 to $110 in reimbursement per CDC resident per day.

-More importantly, while some providers have argued that CDC residents require the hiring of nurse practitioners and infection control nurses as well as the need for increased nursing salaries, a further review of the most recent cost reports available to the industry demonstrates that many facilities are already being reimbursed their full costs. As a point of information, under the nursing cost center, providers are reimbursed their full nursing cost up to a certain ceiling. Providers that remain under the ceiling are required to issue a payback to the State for the unused portion of reimbursement minus an allowable "profit." According to our review of recent cost reports, approximately 65% of the top twenty facilities delivering CDC services have a nursing payback. This means that these providers are currently not spending all the money allocated under the nursing cost center, meaning their full nursing costs are fully covered even before the additional CDC nursing payment.

-Perhaps even more troubling is the continued assertion that the nursing facility reimbursement system fails to take into account the "non-direct care costs" associated with this population. Based on a 2008 study performed by Clifton Gunderson, examples of such indirect costs, which are allowable expenses under the remaining three cost centers, include maintenance - "destruction of property issues caused by residents who require CDC leads to increased need for additional maintenance staff and supply/repair costs"; higher professional/general liability insurance and workers compensation insurance; and higher auto expense/depreciation due to greater need for outside visits such as to the HIV clinic.

-Again, according to the most recent cost reports available to the industry, a review of the top twenty facilities providing CDC services reveals that 95% are fully reimbursed under the routine and administrative cost centers and 100% are reimbursed their full costs under the other patient care center. In each category, those facilities that are fully reimbursed also earn efficiency payments, meaning that they receive an additional payment for not spending their full allotment. In essence, these providers are not only having all of their costs of care reimbursed but they are also receiving additional CDC “add-on” payments for these same expenses – clearly "double-dipping."

-Equally important, we believe that many of these costs further contribute to the stigmatization of this population and are not directly related to the disease but possibly other factors, which are not attributable solely to individuals with CDC diagnosis but may include other residents as well. Therefore, LifeSpan believes that this State should consider eliminating or, at a minimum, reducing the CDC reimbursement category. While it is more difficult to determine the cost savings by reducing the nursing hours, the State will save approximately $4.5 million by eliminating the "add-on" payment. As illustrated above, while it was necessary in 1988, it is no longer necessary and the data no longer supports its need. It is important to emphasize that by eliminating or reducing this category we are not advocating for the reduction to services for individuals with communicable disease. On the contrary, we are simply correcting an overpayment in the system that has been allowed to continue without just cause that continues to unjustly stigmatize a certain population of residents and has required all nursing facilities to share a greater burden of the cuts in recent years.

**Financial Impact:**

Up to $10 million total funds annually if payment is eliminated, or $5 million if implemented

January 1, 2012. (Savings would probably be temporary until the next time nursing services is

recalibrated – payment for actual nursing hours would be redistributed more accurately to

other services – or until RUGs is adopted.)

**Benefits of Proposal:**

Nursing funds would not be inappropriately distributed to providers not actually incurring costs

for nursing services. There is evidence to suggest the add-on is not justified.

**Concerns with Proposal:**

Controversial.

**Impacted Stakeholders:**

Nursing home providers, LifeSpan, HFAM

**System Implications:**

None

**Proposal Number:**  10 (See Proposal Number 28)

**Theme:** Service Limits - Reduce fraud and abuse in the Medical Day Care program

**Viable?:** No

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** No **Federal Waiver:** Yes

**Proposal Description:**

Reduce fraud in the Adult Day Care program by:

* + Conducting impromptu inspections of facilities, reviewing the qualifications of the participants, and retaining only the qualified seniors in the program
  + Limiting the number of recipients on Medicaid for Adult Day per site
  + Cut the funding for each qualified participant from $71 to $50
  + Charge a $5 a day co-payment per participant
  + Cut all funding for the Adult Day Care program

**Financial Impact:**

Cutting funding from $71 to $50 will result in a net savings of $15.66 million total funds in FY 2012 if implemented January 1, 2011. This is a drastic change in funding and it is likely that a number of medical day care centers would go out of business. If there insufficient centers, some individuals would need to enter nursing homes. The projected savings would be to be adjusted downward to reflect the higher cost of individuals entering nursing home.

**Benefits of Proposal:**

Would result in savings in FY 2012.

**Concerns with Proposal:**

-Continued stay reviews are currently completed annually; only qualified participants are allowed to continue their stay. Impromptu inspections of participants will create an administrative burden for the UCA and provider.

-Each center has a licensed capacity and the 1915(c) waiver caps the number of participants. Limiting the number of Medicaid participants per center would violate Medicaid participants’ ability to choose providers.

-Cutting funding from $71 to $50 without a cost analysis to determine impact on the industry and access to care is not recommended. Cuts to medical day care reduce a low cost community option for enrollees. The LTC rebalancing workgroup is instead considering more support for populations at risk of entering nursing facilities.

**Impacted Stakeholders:**

MAADS, HFAM, Disabled Population, Elderly Population, Adult Day Care providers

**System Implications:**

Copayments cannot be implemented because participants cannot be required to pay above 5% of income. Allowed amounts would have to be determined on a participant-specific basis; individual amounts could not be accommodated by the system.

**Proposal Number:**  28 (see Proposal #10)

**Theme:** Service Limits - Reduce fraud and abuse in Adult Day Care Centers

**Viable?: No**

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** No **Federal Waiver:** Yes

**Proposal Description:**

-Review the participants and retain only the qualified seniors in this program.

-Cut the funding for each qualified participant.

-Charge a co-pay for participant.

-Support Non-Profit organizations to provide more senior activity centers for healthy seniors.

-Support more Assisted Living and group homes to provide a service to those in serious need (someone estimated it’s 20% of current day care members). It may save money and be more helpful for members.

**Financial Impact:**

-None for first recommendation, utilization reviews are currently being conducted

-See Proposal #10 for reimbursement reduction analysis.

**Benefits of Proposal**:

None for first recommendation, utilization reviews are currently being conducted.

**Concerns with Proposal:**

**-**Utilization reviews are conducted by UCA. Only qualified participants are allowed to

continue their stay.

-Cutting the funding without a cost analysis determining the impact on the industry’s ability to provide the service.

- Funding senior centers, assisted living facilities and group homes will cost the State.

**Impacted Stakeholders:**

N/A

**System Implications:**

N/A

**Proposal Number:**  71c

**Theme:** Service Limits - Reduce Adult Day Care to 3 days per week

**Viable?:** No

**Implementation Timeline:** Long Term

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** Yes

**State Plan Amendment:** Yes  **Federal Waiver:** Yes

**Proposal Description:**

-Instead going to Adult Day Health Care Ctr 5 or 6 days a week, seniors in the program to be allowed going to the Ctr 3 days only. With their children, relatives, friends around and some have money allocated to their children, they can find ways to live without going to Adult Day Care Ctr everyday which use up big part of Medicaid money.

**Financial Impact:**

$9.8 million could be saved if implemented January 1, 2012. Savings would be

offset by any increased cost of individuals entering nursing homes or costly waivers.

**Benefits of Proposal:**

It is estimated that this would reduce payments to medical day care centers by $9.8 million if

implemented beginning 1/1/12.

**Concerns with Proposal:**

Many individuals and their families depend on these centers to care for family member so that

they can work. If families cannot use the centers during working hours, then individuals

currently receiving services may have to enter more costly nursing homes or in the case of some

of the other waivers, may need to receive more costly waiver services. May result in more

institutionalization at a time when Maryland is seeking to rebalance its long term care system.

**Impacted Stakeholders:**

MAADS, HFAM, Disabled Population, Elderly Population, Adult Day Care providers

**System Implications:**

None

**Proposal Number:**  82d

**Theme:** Service Limits - Medicaid Program Benefit Structure

**Viable?:** Yes, but longer term.

**Implementation Timeline:** Long Term

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** Yes

**State Plan Amendment:** Yes **Federal Waiver:** Yes

**Proposal Description:**

-The current benefit structure for the existing Medicaid population should be re-examined to identify potential adjustments in coverage that will reduce medical expenses without negatively impacting quality of care.

-The State should consider implementing a benefit package that is more consistent with commercial benefits in terms of cost sharing, copayments, and benefit limitations for any expansion population as well as potentially the MD CHIP population at higher income levels.

**Financial Impact:**

Not clear.

**Benefits of Proposal:**

This should be examined as part of preparing for health reform.

**Concerns with Proposal:**

The Department needs additional time to analyze and implement changes.

**Impacted Stakeholders:**

Medicaid enrollees, providers

**System Implications:**

None

**Proposal Number:**  42

**Theme:** Service Limits - Elective cesarean deliveries

**Program Area:** Utilization

**Viable?:** Yes, but long term

**Implementation Timeline:** FY 13

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** Yes  **Federal Waiver:** No

**Proposal Description:**

-Do not pay for elective cesarean deliveries under 39 weeks

**Financial Impact:**

Unclear at this time. Most deliveries are paid for by MCOs, so the Department needs to further analyze any potential savings.

**Benefits of Proposal:**

Possibly fewer low birth weight babies.

**Concerns with Proposal:**

Medicaid can match administrative data to birth certificate information for gestational age

which will flag cases that might be a problem. Medicaid can pull records and have the utilization

control agent complete a medical record review to determine if it was a true elective/non-

emergency delivery.

-There were only 560 FFS cesareans in FY 10. The Department cannot determine which ones would have been elective.

-If UCA has to wait for birth certificate to perform normal post discharge record review, payment to the hospitals will be greatly delayed.

-UCA does not currently review cesarean stays ≤5 days. Having all cesarean stays reviewed will require UCA contract modification and additional funding.

-Some hospitals already have programs in place to watch for this.

-Additional pre-auth requirements or post payment retractions will cause dissatisfaction in ob/gyn community which will further weaken the network.

-Information gathered from MCOs indicates that ob records always support medical necessity. Finding ones that don’t will be minimal, at best.

**Impacted Stakeholders:** Pregnant women, obstetricians, hospitals

**System Implications:** N/A

**Proposal Number:**  35

**Theme:** Service Limits - Tighten criteria for orthodontia program

**Viable?:** Yes

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** No **Statutory Change:** No

**State Plan Amendment:** No  **Federal Waiver:** No

**Proposal Description:**

Tighten criteria for orthodontia program

**Financial Impact:**

$1M

**Benefits of Proposal:**

Changing the orthodontia criteria would be more consistent with other state Medicaid

programs.

**Concerns with Proposal:**

Would result in increased appeal hearings and complaints.

**Impacted Stakeholders:**

Parents and advocates will protest this action; orthodontists will be unhappy with loss of

revenue.

**System Implications:**

None

**Proposal Number:**  32

**Theme:** Service Limits - Place limits on outpatient hospital visits

**Viable?:** Yes, but would be complex to implement

**Implementation Timeline:** FY 2012 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** Yes  **Federal Waiver:** No

**Proposal Description:**

Limit outpatient hospital visits per year to eleven (done in some states). For mandatory services, states may limit coverage only to the extent that no more than 10 percent of beneficiaries are not fully covered for that particular service (CMS, 2010).

**Financial Impact:**

In 2010, the Department analyzed the potential savings. The analysis for limiting hospital outpatient visits is outlined below. This analysis only includes the amount for the hospital facility fee. The professional fee would continue to be paid even after the limit was reached.

|  |  |  |
| --- | --- | --- |
| **Non-ED Outpatient Hospital Visits** | **FFS** | **MCO** |
| 90% Threshold Visit Limit | 11 | |
| Number of Enrollees with a Visit | 67,503 | 72,797 |
| Number of Visits | 316,331 | 306,739 |
| Number of Enrollees above the 90% Threshold | 6,149 | 5,005 |
| Number of Visits for Enrollees above the 90% Threshold | 78,727 | 56,753 |
| Average Cost per Visit | $664 | |
| Total Savings (Federal and State) | $52,274,728 | $37,683,992 |
| State Share | $26,137,364 | $18,841,996 |

**Benefits of Proposal:**

Limiting hospital outpatient hospital visits may encourage enrollees to seek treatment in less costly settings, such as physician offices.

**Concerns with Proposal:**

Hospitals’ uncompensated care would increase. The Health Services Cost Review Commission would need to determine whether or not to prospectively build in higher uncompensated care percentages into the hospital rates, which would be passed along to payers.

DHMH’s systems would be unable to alert providers on whether or not enrollees already met the service limit requirements. This will make it difficult to build the increase in uncompensated care prospectively into rates.

**Impacted Stakeholders:**

-Adults only

-Hospitals, payers

**System Implications:**

Would be difficult to inform providers ahead of time if the patient had reached his/her yearly quota and, therefore, the provider would not get reimbursed for the service.

**Proposal Number:**  33

**Theme:** Service Limits - Eliminate the Podiatry Program

**Viable?:** Yes

**Implementation Timeline:** FY 12 – January 1, 2012

**Required Approvals: Regulatory Change:** Yes **Statutory Change:** No

**State Plan Amendment:** Yes **Federal Waiver:** No

**Proposal Description:**

Eliminate the Podiatry coverage for all Recipients other than Dual Eligible Recipients

**Financial Impact:**

-Total yearly Medicaid payments for Podiatry = $1,856,170

-Non Medicare Crossover payments = $687,642

-FY 12 savings would be for ½ year = $343,821

**Benefits of Proposal:**

Would result in cost savings.

**Concerns with Proposal:**

Recipients without podiatry coverage may seek services through other mechanisms including

physicians and ERs.

**Impacted Stakeholders:**

Podiatrists and Non-Medicare recipients

**System Implications:**

None