MaineCare Redesign Task Force

Recommendation Report

December 15, 2012

Contents

Overview

The MaineCare Redesign Task Force was established in 2012 by legislative mandate to "provide detailed information that will maintain high-quality, cost-effective services to populations in need of health care coverage, comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010 for state Medicaid programs and realize General Fund savings in fiscal year 2012-13 of $5,250,000" (Public Law, Chapter 657, LD 1746, 125th Maine State Legislature). This report provides an overview of the Task Force findings and recommendations for MaineCare reform and cost containment strategies.

Background

Task Force membership was established pursuant to PL 2011, Chapter 657, Part T. Mary Mayhew, the Commissioner of Health & Human Services served as the chair of the task force. Eight additional members were appointed to represent MaineCare members and providers and to provide expertise in public health, financing, state fiscal and economic policy. The Task Force convened nine times between September and December, 2012. All meetings were open to the public and provided an opportunity for public input and comment. Additionally, the Department of Health and Human Services contracted with SVC, Inc. and Milliman to staff the Task Force and provide a national perspective and expertise on healthcare reform and Medicaid cost containment strategies. Meeting minutes are available in Appendix 2.

Table 1: Task Force Membership

Member	Role
Mary Mayhew	Commissioner, DHHS
Ana Hicks	Represents MaineCare members
Rose Strout	Represents MaineCare members
Mary Lou Dyer	Represents providers of MaineCare services
David Winslow	Represents providers of MaineCare services
Scott E. Kemmerer	Member of the public who has expertise in public health policy
Frank Johnson	Member of the public who has expertise in public health care financing
Jim Clair	Member of the public who has expertise in state fiscal policy
Ryan Low	Member of the public who has expertise in economic policy

Table 2: Task Force Meetings

Meeting Date	Agenda Items
August 28, 2012	• Welcome & Introductions • Guiding Principles • Review of Governing Statute • Meeting Framework • Medicaid Overview • Value-Based Purchasing Overview • Review of Statutory Duties • Future Topics/Agendas • Public Comment
September 12, 2012	• Welcome & Introductions • Review of Requested MaineCare Data • Presentation by Michael DeLorenzo, PhD, MaineHealth Management Coalition: Health Care Costs in Maine • Presentation by Elizabeth Mitchell, Executive Director, MaineHealth Management Coalition: Efforts to Impact Healthcare Costs and Performance • Presentation by Dr. Flanigan: MaineCare by the Numbers • Review and Finalize Guiding Principles – Suggested Principles • Future Topics/Agendas • Public Comment
September 25, 2012	• MaineCare by the Numbers Part 2 – Dr. Kevin Flanigan o Analysis of the top 5% of expenditures by services delivered o Deeper drill down of services that drive top 5% of expenditures o Further look at where services are being delivered and how dollars are distributed • Introduction of Consultant hired to staff Task Force • Presentation by Seema Verma, SVC Inc. & Rob Damler, Milliman o What are peer/like states doing to contain costs in the Medicaid program? o How are other states managing high cost utilizers?

Meeting Date	Agenda Items

October 9, 2012	• Introductions
	• Re-Cap/Status of Prior Requests
	• Presentation by Seema Verma, SVC Inc. & Rob Damler, Milliman
	  o Short-Term Savings – Compare to Other States
	  ▪ Mandatory Benefits
	  ▪ Optional Benefits
	  o Mid-Term Savings
	  ▪ Pharmacy
	  ▪ Program Integrity
	  ▪ Impact of Medicaid Managed Care in Other States
	  o Long-Term Savings
	• Develop Specific Categories for Recommendations Based on Data and Options
	• Public Comment

October 23, 2012	• Introductions • Review Outstanding Questions and Follow Up From Last Meeting • Changes to Meeting Schedule and Report Back to Legislature • Presentation by Seema Verma, SVC Inc. and Rob Damler, Milliman o Long-Term Savings Initiatives for Consideration in the MaineCare Program • Task Force Input and Decisions – Discuss Merits and Vote on Next Steps for the Long-Term Initiatives • Public Comment • Adjourn
November 6, 2012	• Introductions • Review Outstanding Questions and Follow up From Last Meeting • Presentation by Seema Verma, SVC Inc. & Rob Damler, Milliman – Matrix of Savings Initiatives • Task Force Input and Decisions – Discuss Merits and Vote on Next Steps for the Initiatives • Public Comment • Adjourn
November 14, 2012	•
December 11, 2012	•

Process

To begin, the Task Force undertook a comprehensive review of the MaineCare program. Current eligibility categories, benefits, cost-sharing requirements, enrollment, and expenditures were reviewed. This review included an in-depth analysis of high-cost members by provider type, eligibility level, and funding source. Current MaineCare initiatives such as the transportation broker procurement and value-

based purchasing strategies were also reviewed. MaineCare features were reviewed, with consideration of overall service utilization and spending trends in Maine and nationwide.

The Task Force also focused considerable attention to initiatives being used by Medicaid agencies across the nation to deliver cost-effective, high quality services. In addition to research on general nationwide trends, nine states were reviewed in depth to identify recent cost-cutting strategies, innovative solutions, and budget impacts. These states included Arizona, Arkansas, Florida, Idaho, Iowa, Louisiana, Maryland, Minnesota and Wisconsin.

Finally, short-term, mid-term, and long-term strategies for MaineCare reform were developed with public input received and incorporated. Short-term and mid-term strategies were reviewed in the context of the overall vision and long-term strategies of MaineCare. This focus was to ensure all cost-containment strategies and recommendations were aligned and that short-term strategies did not undermine the State's long-term vision for delivering high quality cost-effective services to MaineCare enrollees. All strategies were considered with the long range goals of investing in primary care, producing coordinated, quality services for Maine's must vulnerable citizens, and fostering effective and efficient use of services. The Task Force developed the following list of guiding principles to inform decision making and frame evaluation of proposed initiatives:

- Cost effective
- High quality
- Patient/consumer centered
- Program Sustainability
- Holistic and individualized approach based on unique needs
- Flexibility (not one size fits all)
- Evidence based
- Innovation/technical approach
- Data analytics
- Collaboration
- Payor alignment
- Medical necessity

Findings

Current Eligibility Levels, Options for Eligibility Levels and Changes

The Task Force reviewed the current eligibility categories in the MaineCare program. In addition to the federally-mandated eligibility categories, MaineCare currently provides coverage to the optional categories outlined in Table 3. Recent budget initiatives have addressed eligibility changes, including reducing the income level for parents and caretaker relatives from 200% FPL to 100% FPL and reducing Medicare Savings Programs by 10%. Additionally, the use of State funds has been eliminated for the elderly with incomes above 100% FPL residing in a residential setting. The childless adults waiver has

been capped at 40 million, and eligibility for 19 and 20 year olds has been repealed. The Task Force is not recommending any further changes to the eligibility categories.

Table 3: MaineCare Coverage of Optional Categories[i]

Eligibility Group	Details	# Enrolled Individuals
Pregnant Women to 200% FPL	Mandatory but covered at an optional higher income level	1,813
Children Under Age 1 to 200% FPL	Mandatory but covered at an optional higher income level	688
Children Under 18 to 200% FPL	Mandatory but covered at an optional higher income level	110,292
Parents & Caretaker Relatives	Mandatory but covered at an optional higher income level	79,793
Children under a State Adoption Assistance Program	Optional Category	281
Non-SSI Aged & Disabled to 100% FPL	Optional Category	25,246
Residents of nursing homes with income < the private rate	Optional Category	3,407
Medically Needy	Optional Category	-
Katie Beckett Coverage	Optional Category	911
HCBS for the Elderly, Disabled, Adults with Physical Disabilities & MR ≤300% SSI Federal Benefit Rate	Optional Category	-
Individuals who are HIV Positive ≤250% FPL	Optional Category	417
Breast & Cervical Cancer Program ≤250% FPL	Optional Category	214
Working Disabled ≤250% FPL	Optional Category	887
TOTAL Optional MaineCare Clients		**223,062**

Current Benefits, Options for Benefits & Changes

The Task Force reviewed the current benefits provided under the MaineCare program. Coverage limitations and prior authorization requirements were compared against the practices of Medicaid agencies across the nation. Additionally, current MaineCare coverage was reviewed against federal requirements for coverage of optional and mandatory benefits.

Prior authorization is currently required by MaineCare for the following services:

- All out-of-state services
  - Including ambulance & air medical transport
- Optional treatment services for members under age 21
- Transportation for continuous treatments in hospital outpatient setting
- Dental services
  - Dentures

  - Orthodontia
  - TMJ surgery
- Hearing aids
- Certain medical supplies & DME
  - DME costing more than $699
  - Apnea monitor
  - Hospital beds
  - Infusion pump
  - Wheelchairs
  - Oxygen, etc
- Vision services
  - Eyewear
  - Non-MaineCare frames
  - Low vision aids
  - Orthoptic therapy/visual training
- Certain physician services
  - Breast reconstruction & reduction
  - Gastric bypass
  - Mastopexy
  - Organ transplant, etc.

MaineCare has recently undertaken a variety of benefit changes as outlined in Table 4. As a result of the comprehensive review undertaken by the Task Force, additional benefit changes and prior authorization requirements are being recommended as outlined in the Recommendations section.

Table 4: MaineCare Benefit Changes Prior to 9/12

Service	Detail
Smoking cessation products	Eliminated except for pregnant women
Ambulatory surgical center reimbursement	Eliminated
STD screening clinic reimbursement	Eliminated
Optometry visits for adults	Limited to 1 every 3 years
Chiropractic visits	Limited to 12 per year
Case management for the homeless	Added medical eligibility criteria
Physical therapy	Limited to 2 hours per day
Occupational therapy	Limited to 2 hours per day & 1 visit per year for palliative or maintenance care

Current Cost-Sharing for MaineCare Participants

The Task Force reviewed the current cost-sharing requirements under MaineCare against federal requirements. The maximum allowable cost-sharing is not currently imposed. Children are exempt from co-pays and for adults the federally allowable amount is higher than that implemented by MaineCare as illustrated in Table 5. However, the Task Force is not recommending imposing cost sharing for children or imposing higher co-pays for adults. This is due to the concern that increased cost-sharing may reduce utilization especially for primary care and preventive services. Additionally, Medicaid savings may not be realized through the imposition of cost-sharing as care may shift to higher-cost hospital services if

patients avoid necessary care. Finally, the burden may be shifted to providers if enrollees fail to pay their required cost-sharing, resulting in reduced reimbursement to the provider.[ii]

Table 5: MaineCare Adult Co-Pays vs. Federal Allowable Amounts

State Payment For Service	Federally Allowable Nominal Amount	MaineCare Co-Pay
$10.00 or less	$0.65	$0.50
$10.01 - $25.00	$1.30	$1.00
$25.01 - $50.00	$2.55	$2.00
≥$50.01	$3.80	$3.00

Increases to the premiums imposed on children are not allowable until 2019 with the expiration of the Affordable Care Act Maintenance of Effort.

Spending Analysis

The Task Force reviewed current MaineCare spending and utilization trends. Spending analysis included review by such factors as funding source, provider type, enrollee eligibility, and diagnosis. This analysis resulted in identifying that the top 5% of the MaineCare population generates 54% of the overall spending. This information was used to identify potential management and administrative strategies for reform and to inform the development of recommendations targeted both to the entire MaineCare population and to specific sub-populations where appropriate.

Federal funding is the primary source of funding for MaineCare programs. However, the federal share has declined since 2012 and will drop again in 2014 as illustrated in Table 6. Therefore, even if no other factors change from FFY 2012-13, Medicaid expenditures from the State's perspective will increase.

Chart 1: MaineCare Sources of Funds by SFY[iii]

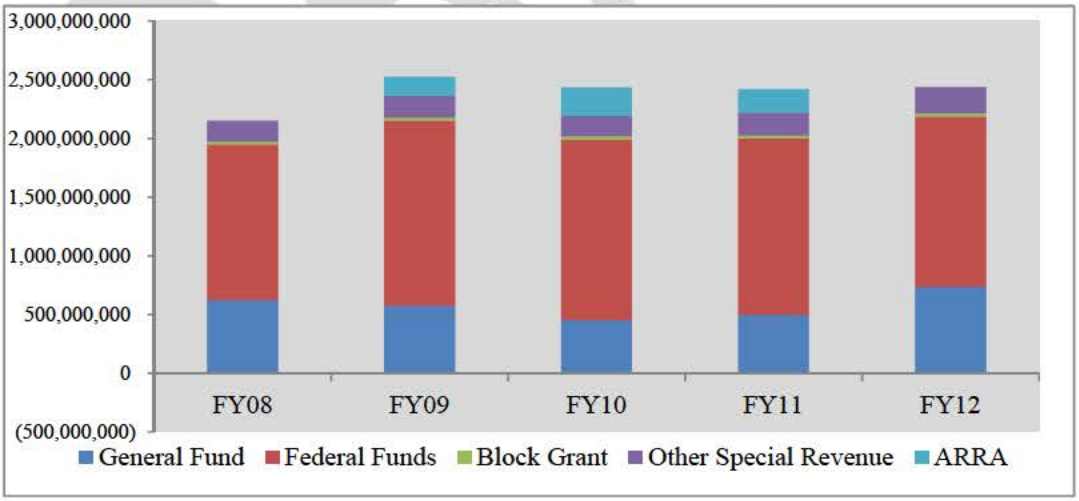

Table 6: Federal Medical Assistance Percentage
Impact of Updated Rates

FFY	Federal Share	State Share	State Budget Impact
2012	63.27%	36.73%	
2013	62.57%	37.43%	1.9%
2014	61.55%	38.45%	2.7%

Aligned with nationwide Medicaid trends, as illustrated in Chart 4, 54% of MaineCare expenditures are attributed to 5% of enrollees. This top 5% has significantly higher per member costs than other members, as demonstrated in Chart 5 and Table 7. The top 5% are primarily between the ages of 18 to 44, in the SSI disability category with a diagnosis of developmental disability. The highest spend for this group is for waiver services. The next 5% of enrollees are also primarily between the ages of 18 and 44 in the SSI disability category. Their primary diagnoses are mental health related with significant spending in waiver services and private non-medical institutions (PNMI).

Chart 2: Expenses by Eligibility Category[iv]

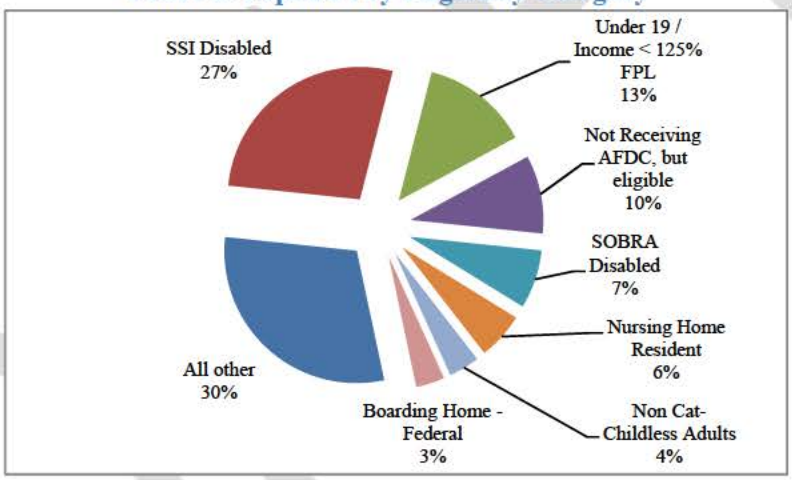

Chart 3: Expenses by Provider Type[v]

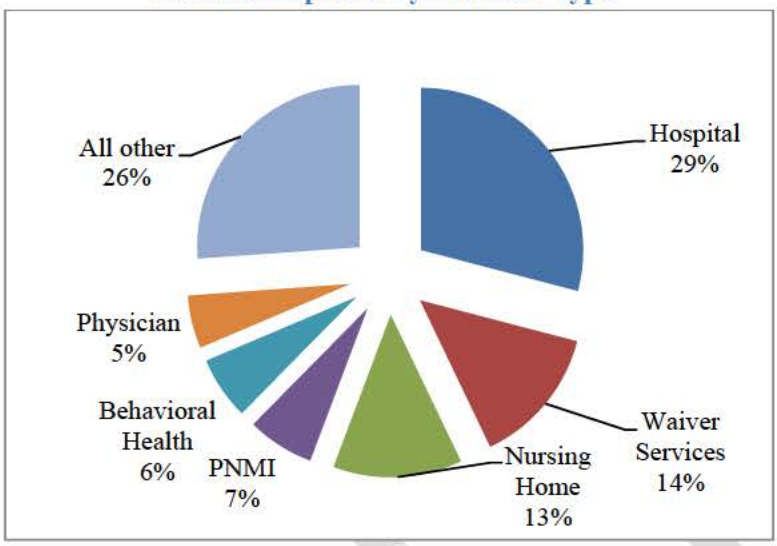

Chart 4: Expense by Cost Distribution FY 2011[vi]

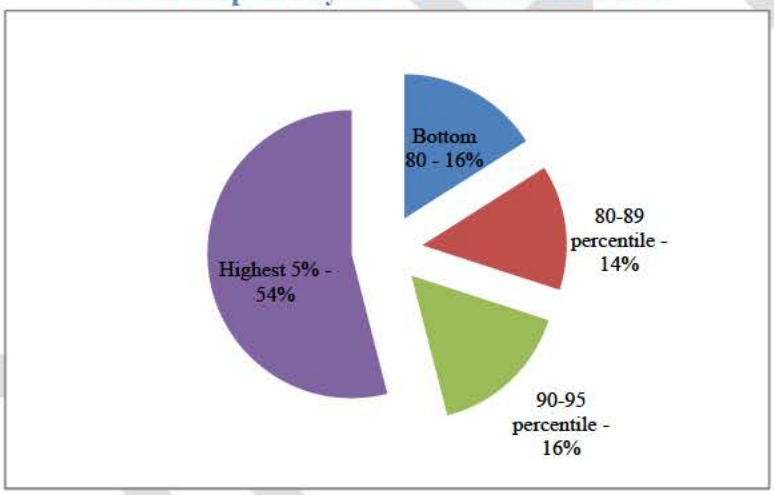

Chart 5: Annual Cost Per Member[vii]

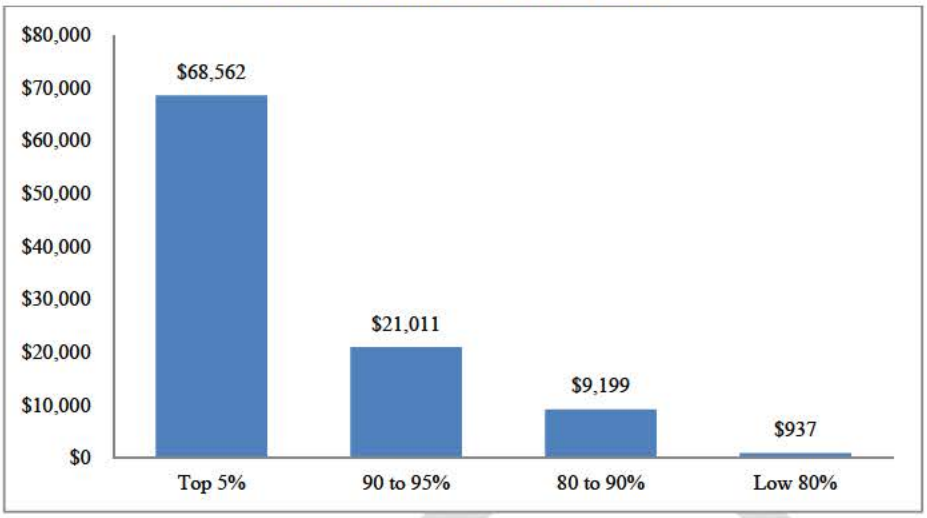

Table 7: Cost PMPM[viii]

Top 5%	90 to 95%	80 to 90%	Low 80%
$5,713	$1,750	$766	$78

Table 8: Cost Distribution – High 5% (Non-Dual)[ix]

State & Federal Expenditures – SFY 2010
Expenditures in Millions

	Adult/Child	Disabled	Other
Hospital	$ 120.5	$ 142.8	$ 11.5
Mental health	$105.9	$ 68.2	$ 3.0
LTSS/Other	$ 29.1	$209.2	$ 22.6
Physician	$ 12.2	$ 14.9	$ 1.1
Pharmacy	$ 18.7	$36.3	$ 1.8
All other	$ 3.7	$ 9.2	$ 0.3
TOTAL	**$ 290.2**	**$ 480.6**	**$ 40.4**

Table 9: Cost Distribution – Next 15% (Non-Dual)[x]

State & Federal Expenditures – SFY 2010
Expenditures in Millions

	Adult/Child	Disabled	Other
Hospital	$144.3	$ 31.2	$ 4.6
Mental health	$55.6	$ 23.0	$ 1.7
LTSS/Other	$26.4	$19.9	$ 3.8

Physician	$32.2	$ 8.7	$ 1.2
Pharmacy	$40.0	$26.8	$ 1.6
All other	$11.2	$ 3.8	$ 0.3
TOTAL	**$309.8**	**$ 113.4**	**$ 13.2**

Table 10: Cost Distribution for Low 80%[xi]

State & Federal Expenditures – SFY 2010

Expenditures in Millions

	Adult/Child	**Disabled**	**Other**
Hospital	$ 88.9	$ 7.7	$ 2.6
Mental health	$30.6	$ 10.9	$ 1.5
LTSS/Other	$ 29.8	$7.7	$ 9.1
Physician	$ 51.9	$ 8.5	$ 9.3
Pharmacy	$ 38.8	$9.2	$ 1.8
All other	$ 22.3	$ 3.9	$ 1.1
TOTAL	**$ 262.4**	**$ 47.9**	**$ 25.3**
Lives	191,916	28,857	37,390

Table 11: Consumer Characteristics[xii]

	Top 5%	**2nd 5%**	**80-89%**	**<80%**
Age group	18-44	18-44	18-44	Under age 18
RAC	SSI disabled	SSI disabled	Not receiving AFDC, but eligible (parents/ caregivers)	Under 19, income <125% FPL
Clinical condition	Developmental disability	Mental health: neuroses	Pregnancy with complications	Preventive/ Admin encounters
Provider type	Waiver services	PNMI/Waiver services	Physician/ Hospital	Physician/ Hospital

As illustrated in Table 12, Maine's spending on developmental disability waiver services is above the national average and represents an area for potential cost savings through enhanced management strategies as discussed further in the Recommendations section.

Table 12: Intellectual Disability & Development Disability HCBS Waiver[xiii]

Rank	Average Expenditures per Waiver Recipient in FY 2009 (State and Federal Expenditures)
25th percentile	$ 31,161
50th percentile	$ 42,155
US average	$42,896
75th percentile	$ 51,199
90th percentile	$ 68,478
Maine average	$77,736

Current DHHS Management & Administrative Strategies & Options

Current MaineCare management and administrative strategies were reviewed by the Task Force. These current initiatives were reviewed against nationwide trends for managing Medicaid populations. The Task Force examined multiple options for MaineCare's long-term management strategies. Management options were considered based on the analysis of spending patterns in the MaineCare program, separated by eligibility group and clinical diagnoses to determine the appropriate management strategy by population.

Recent MaineCare initiatives have centered on value based purchasing strategies. Under value based purchasing, payers reimburse for outcomes and quality versus volume-based reimbursement under traditional fee-for-service arrangements. Additionally, consumers have incentive to become active participants in their healthcare consumption and benefits are designed to provide appropriate intensity and levels of care. Under such strategies, the goal is for providers to better coordinate total care resulting in better outcomes at lower costs. MaineCare value based purchasing initiatives include an Accountable Communities Program, Patient Centered Medical Homes, and a Primary Care Provider Incentive Program. Additionally, MaineCare collaborates with ER departments to identify high utilizers and drivers of utilization and to encourage members to seek care in appropriate treatment settings.

The Accountable Care Organization (ACO) model was reviewed by the Task Force. ACOs are provider-run organizations under which there is shared responsibility among providers for enrollees' care. In an ACO model providers have an opportunity to reap the benefits of shared savings. Medicaid ACOs are still in their infancy but a growing number of States are examining this model as a potential management strategy. [xiv]

Review of Initiatives Being Used in Other States' Medicaid Programs

Medicaid agencies around the country are experiencing significant budget constraints. Immediate savings have been realized through traditional strategies aimed at decreasing utilization and restricting reimbursement. Such strategies were reviewed by the Task Force in the context of long-term impact on access to care and cost shifting. Nationwide, longer-term strategies continue to be explored to transform the delivery of care to both improve quality outcomes and realize cost savings. Table 13 provides a summary of recent cost-cutting and quality initiatives being implemented by State Medicaid agencies.

Table 13: Nationwide Cost-Containment Trends

Strategy	Nationwide Trends	Recent MaineCare Initiatives
Increased cost-sharing	• FY 2012: 14 states adopted	N/A

Benefit reductions & limitations	• FY 2012:
	  ○ 17 states imposed limits
	  ○ 7 states eliminated
	• Use of Prior Authorization
	• Concurrent review
	• Targeting high cost imaging & radiology
	• Common benefits targeted:
	  ○ Home health & personal care
	  ○ Dental
	  ○ Physical, Speech & Occupational Therapy
	  ○ Vision
		• Eliminate - Smoking cessation products (except for pregnant women): 10/1/12 (pending)
		• Eliminate - Ambulatory surgical center services: 9/1/12 (pending)
		• Eliminate - STD screening clinic services
		• Limit - Optometry visits for adults (1/3 years)
		• Limit - Chiropractic visits (12/year)
		• Limit - Added medical eligibility criteria for Case Management for homeless
		• Limit - Physical therapy (2 hr./day)
		• Limit - Occupational therapy (2 hr./day & 1 visit/year for palliative or maintenance care
		• PA currently required for a multitude of services

Rate reductions	FY 2012: • 9 States reduced primary care reimbursement • 14 States reduced specialist reimbursement • 13 states reduced dental reimbursement	• Support services for adults with intellectual disabilities: 2010 • Nursing facilities: 7/1/10 • Rehab & community support services for children with cognitive impairments/physical limitations: 6/1/11 retro to 9/1/10 • Developmental & behavioral clinic services: 7/1/10 • Behavioral health services: 7/1/10 • Transportation: 8/1/10 • Occupational & physical therapy: 4/1/12 (pending) • Podiatrist: 4/1/12 • Private non-medical services: 10/1/10 • Family planning: 7/1/11 • Community support services: 7/1/10 • Behavioral Health (Methadone): 4/1/12, 1/1/13 (pending) • Group homes: 7/1/12

Strategy	Nationwide Trends	Recent MaineCare Initiatives
Pharmacy targeted reforms	• PDLs & PA • MAC Rates – Blood Factor pricing • Supplemental rebates • Changes to ingredient cost & dispending fee reimbursement • Increased use of generics & mail-order • Enhanced management for high cost & overprescribed drugs • HIT to encourage appropriate prescribing • Cost sharing incentives • 340b payment at cost • Specialty drug vendors • Monitoring use of anti-psychotics • Pharmacy TPL – cost avoidance	• Rebates for crossover claims • Supplemental rebate agreements • Restrictions on narcotics use to begin 1/1/2013 • PAs for more costly drugs to begin 1/1/2013 o Tried & failed requirements o Additional step therapy • Restrictions on scripts to begin 1/1/2013 • Suboxone 2 year limit to begin 1/1/2013 • Average Wholesale Price – 16%: 4/1/12 (pending) • Mandatory generic substitution (pending) • Smoking cessation 50% reduction (pending) • Medication Management Initiative • No coverage for: o Anorexic or certain weight loss drugs o Most vitamins and herbal products o Hexachlorophene (for nursing facility patients) o Products listed as part of the per diem rate of reimbursement for Nursing Facility Services o Discontinued or recalled drugs o Less than Effective Drugs (defined by FDA) o TB drugs o OTC drugs (unless designated otherwise) o Fertility drugs Etc. (listed in MaineCare manual)
Eligibility Changes	• Review of eligibility categories to determine potential duplication with eligibility for tax credits beginning in 2014 • Increased asset tests • Reduced eligibility periods for spend-down	• SPA to reduce income eligibility for Medicare Savings Program to federal minimum • SPA to eliminate coverage for 19 & 20 year olds • SPA to reduce eligibility for parents from 200% to 100% FPL
Program integrity initiatives	• Oversight through audit, data review, survey & certification • Increased claims level analysis • Contracts with program integrity vendors	• Utilization of Recovery Audit Contractors • Centralized provider enrollment process • Centralized program integrity training across all pertinent agencies • Annual audit review by external agency or contractor • Ongoing review of Medicaid policy and procedure • Federal partnership best practice implementation (except CMS best practice annual summary report) • Review of repayments due upon TPL payment

Strategy	Nationwide Trends	Recent MaineCare Initiatives
Reimbursement reforms	• Expansion of list of hospital acquired conditions (HAC) for which reimbursement is barred beyond CMS required minimum • Not reimbursing for potentially preventable readmissions • No reimbursement for elective C-Section before 39 weeks • Provider taxes • Bundled payments	• Implements federal minimum requirement for HAC • MaineCare does not reimburse for readmits within 72 hours
Value Based Purchasing	• Measuring and reporting comparative performance • Paying providers differentially based on performance • Designing health benefit strategies & incentives to encourage individuals to select high value services and providers and better managed their health care	• Patient Centered Medical Homes • Accountable Communities • Primary Care Provider Incentive Program
Purchasing Strategies	• Managed Care • Health Homes • ACOs	• PCCM
HIT	• Electronic health records • Health information exchanges	• Current MaineCare initiative
Managing Duals	• Special Needs Plans (SNPs) • Program of All-Inclusive Care of the Elderly (PACE)	

Strategy	Nationwide Trends	Recent MaineCare Initiatives

Managing long-term care & high cost populations	• Changes to institutional reimbursement
	  ○ Reductions in payments for bed-holds
	  ○ Stricter nursing home LOC
	• Long-Term Care Partnership Programs
	• ACA provisions targeted at shifting long-term care to community settings
	  ○ State Balancing Incentives Program
	  ○ Community First Choice
	  ○ Money Follows the Person Rebalancing Demonstration
	• Risk-based managed care
	• Behavioral & physical health integration strategies
		• Money Follows the Person Rebalancing Demonstration
		• Plan to implement Care Coordination teams in 2013

Member Incentive Programs	• Some states have begun experimenting with member incentive programs to encourage healthy behaviors	• N/A
Managing Radiology	• Radiology benefits managers • Clinical decision support • Online interactive PA	• PA requirements

The Task Force reviewed other State designs in terms of benefits included in the managed care arrangements and covered populations. Overall, nationwide the majority of Medicaid children are enrolled in some form of managed care. The use of managed care is less prevalent among non-disabled adults, though still widespread and growing across the country. Additionally, aged and disabled Medicaid enrollees are less likely to be enrolled in managed care, though States are increasingly moving toward expansion of mandatory managed care for individuals with special healthcare needs[xv]. The implications of a MCO model in rural settings were reviewed by the Task Force as well as review of States that have moved away from MCO models.

Nationwide trends for managing Medicaid enrollees' care include extensive use of Primary Care Case Management (PCCM) and Managed Care Organizations (MCOs). Under PCCM models, as used in MaineCare, the State contracts directly with providers who are responsible for management of the beneficiaries assigned to their panel. Typically, providers receive a small per member per month fee in addition to the fee-for-services payments for services rendered. Under an MCO arrangement, states contract with an entity which receives a per member per month capitation. In turn, the MCO is responsible for managing all covered benefits for the assigned population.

Across the nation, States are increasingly exploring managing long-term services and supports through MCO capitation versus fee-for-service arrangements (MLTSS). As of 2012, there were 16 States with MLTSS programs - double the number of programs in 2004. Of these states, eight currently enroll adults with intellectual and developmental disabilities in their MLTSS program[xvi].

Other management models reviewed included strategies targeted at duals (individuals enrolled in both Medicare and Medicaid). Dual management strategies currently being used by other States include Program of All-Inclusive Care of the Elderly (PACE) and contracting with Special Needs Plans (SNPs). The PACE program, offered in 29 states, provides multidisciplinary home- and community-based services to duals. PACE organizations receive prospective monthly Medicare and Medicaid capitation payments for each enrollee and assume full financial risk for all needed healthcare services. SNPs are a category of Medicare Advantage Plans targeting enrollees with special needs such as duals.

Recommendations:

Based on the review of other state initiatives and cost-cutting strategies, the Task Force began to identify potential areas for consideration and identified data needs to evaluate potential strategies. Initiatives were considered along three main tracks: short-, mid-, and long-term strategies. The short- and mid-term strategies were intended to address the immediate budget concerns and to address the $5.25M/$14M (state/state & federal) shortfall. The longer-term strategies reflected the Task Force's intention to re-design the MaineCare program, setting the stage for a program that has improved quality and outcomes, and creating the foundation for long-term effective and efficient fiscal management of the program.

The Task Force was provided with information on previous DHHS cost-containment efforts, current policies and initiatives, and potential and estimated savings for each of the initiatives. A matrix (Appendix 3) was developed that contained the aforementioned data, in addition to the impact of each initiative, with the benefits and limitations of each strategy. Each potential initiative was also evaluated for its impact on the long-term strategy and the implementation requirements. Implementation requirements could include a need for State legislation, federal approval, system changes, provider and member communication needs. Some ideas were eliminated if the implementation in terms of time, effort, and cost outweighed the savings. The committee also entertained ideas that could create costs in the short term by adding benefits but may avoid costs in the long-term, such as providing coverage for member incentive programs that promote healthy behaviors or smoking cessation services. After discussing each potential recommendation, Task Force members were each asked to rate their interest in potentially pursuing the recommendation on a scale of one to five, with five representing a high level of interest and one representing a low level of preference. Their scores were then used to calculate an average score for each potential recommendation. Recommendations were considered for any option that received an average score of 3.5 or higher. Task Force members were also asked to provide feedback on any specific concerns or modifications that they would like to see to the original recommendations.

Short-Term:

Short-term savings were defined as those that could be implemented within 3-6 months and that would impact the budget in SFY 2013. The Task Force was charged with identifying $5M in state savings or

$15M in federal savings that must be counted in SFY 2013. Given the fact that the committee started meeting in August 2012 – the end of the first quarter of the fiscal year – all the savings to achieve this goal had to be short-term. Also, the 3-6 month timeframe could be ambitious, as some short-term savings could require federal approval, making the implementation timeframe uncertain. Also, limiting the options is that after the savings are implemented, there is additional time needed for the savings to be gained, due to claims lag time and other factors. Most States that have attempted such short-term savings are successful to the degree that they have been able to implement changes around eligibility, benefits, increased cost-sharing or rate reductions. While producing savings in the short-term, the Task Force noted that these savings may create unintended consequences in other areas. For example, rate reductions may create access issues for members. Cuts in benefits may produce utilization increases in other areas and increased cost-sharing may contribute to members avoiding or delaying necessary treatment.

In considering short-term initiatives, the Task Force members eliminated some areas from consideration. The committee did not recommend any changes to participant cost-sharing, citing concerns that it could create barriers to care and could amount to provider cuts. Eligibility changes were also not recommended, although there was discussion that MaineCare coverage may overlap with coverage offered through Exchange-based tax credits available through the Affordable Care Act in 2014; but the group did recommend that this be examined in the future. Additionally, rate reductions of ten percent were considered for a variety of categories, including medical equipment & supplies, home health, outpatient hospital services, dental services, physician services, and others. While this would provide immediate cost savings, this option was not recommended because the Task Force feared that this strategy could ultimately undermine long-term strategies. By reducing provider reimbursement, the committee acknowledged an additional burden on providers that could ultimately result in greater access issues for MaineCare members. The committee also sought new avenues for short-term savings that did not duplicate recent efforts made to the prior year's budget.

Mid-Term:

Mid-term strategies were projects that would likely take beyond six months to implement due to their complexity, while savings could be gleaned within the first year and beyond. It is possible that some of the mid-term strategies could be short-term initiatives depending on the implementation and priority given to some of the suggested projects. Most of the mid-term projects involved enhancements to the pharmacy program. In the cursory review conducted by SVC Inc., Maine's pharmacy program was one of the best in the country in terms of its overall management and ability to glean rebates from manufacturers, as well as its use of generic drugs. The strategies that were recommended were due to changes in the market due to higher use and growing use of specialty drugs, many new drugs moving to generic and other market changes. Mid-term changes may also require DHHS to obtain CMS approval and may require using new and different vendors; therefore time for procurement (developing RFP and evaluating RFP responses) was calculated.

Long-Term:

The Task Force devoted an entire meeting to the discussion around long-term strategies. Throughout the discussion of the short- and mid-term changes, the Task Force noted that many of the strategies had been utilized in the past and yet there was continual need to address Medicaid budget shortfalls. This

sharpened the committee's focus on the longer term strategy and re-design of MaineCare. In particular, the committee spent time reviewing managed care strategies of other States that involved both primary care case management (PCCM) and risk-based managed care (RBMC). They reviewed the success, including cost savings as well as challenges of other States and mitigation strategies to address key challenges. The committee was particularly interested in the DHHS recent efforts around Value-Based Purchasing. Members expressed desire to build upon those strategies, rather than re-creating a different approach that duplicated or eliminated the promising approaches in which DHHS has invested with community partners.

The data developed and presented by Dr. Flanigan was a critical component of shaping the Task Force's long-term strategy. In particular, the data that showed the high cost of the top 20% of MaineCare participants and in particular the top 5%. Among the top 5% of high-cost enrollees, the primary eligibility category was SSI recipients ages 18 to 44 with developmental disabilities. The largest spend by provider type for this top 5% was for waiver services. Additionally, among the next 5% of enrollees by cost, mental health diagnoses were prevalent with spending primarily for private non-medical institutions and waiver services.

Finally, other data presented by Milliman also outlined areas where Maine was an outlier as compared to other States. First, as illustrated in Table 14, there is a high incidence of neonates among the MaineCare population. Forty six percent of deliveries are neonates versus 17% in Indiana and 27% in Michigan. Therefore, targeted initiatives to increase the incidence of normal deliveries have the potential for significant cost savings.

Table 14: Potential Savings (State & Federal) for Reducing Number of Neonates[xvii]

	Base Admits	Base Spending		Redistributed Admits	Redistributed Spending
Normal newborns	3,316	$ 3,750,451		3,887	$ 4,396,035
Neonate	2,854	$21,620,671		2,283	$ 17,296,537
TOTAL	**6,170**	**$ 25,371,121**		**6,170**	**$ 21,692,571**
Neonate %	46%			37%	
Savings from redistribution					**$3,678,550**

Second, as illustrated in Table 15, MaineCare's hospital readmission rate within 30 days is higher than the national average. The MaineCare average is 17.7% versus a national average of 9.4%.

Table 15: Maine Hospital Readmissions within 30 days[xviii]

	Maine Readmit Rate	US Readmit Rate
Pregnancy, Childbirth	7.0%	3.8%
Mental Health	21.5%	11.8%
Circulatory	21.5%	10.4%
Respiratory	22.4%	11.4%
Digestive	22.6%	10.3%
Alcohol/Drug Use	21.1%	13.0%
Musculoskeletal	10.8%	8.3%
Nervous	17.1%	9.5%
Liver, Pancreas	25.5%	12.3%
Metabolic	20.2%	10.7%
Skin, Breast	17.4%	8.0%
Infections	27.4%	11.5%
Kidney	23.9%	12.4%
Injuries, Poisonings	16.8%	8.4%
Health Status	18.6%	9.9%
Female Reproductive	6.4%	6.4%
Ear, Nose, Mouth & Throat	12.6%	7.2%
Myeloproliferative Diseases	49.7%	37.4%
Blood	36.4%	14.1%
Male Reproductive	12.8%	7.2%
HIV Infections	24.4%	17.2%
Multiple Trauma	10.5%	7.9%
Eye	40.9%	6.9%
Burns	5.9%	6.1%
TOTAL	17.7%	9.4%

Third, as illustrated in Table 16, Maine's spending on developmental disability waiver services is above the 90th percentile of nationwide spending.

Table 16: Intellectual Disability & Development Disability HCBS Waiver[xix]

Rank	Average Expenditures per Waiver Recipient in FY 2009 (State and Federal Expenditures)
25th percentile	$ 31,161
50th percentile	$ 42,155
US average	$42,896
75th percentile	$ 51,199
90th percentile	$ 68,478
Maine average	$77,736

Final Short-Term Strategy Recommendations

Prior Authorization

Prior authorization (PA) policies are used by State Medicaid agencies and other payers to apply medical necessity criteria to ensure the appropriate delivery of services and reduce overutilization. As outlined in the Findings section, MaineCare currently requires prior authorization for a variety of services. However, analysis identified where MaineCare does not currently require PA where other States do. Some of these services include psychiatric services for individuals under 21, elective surgeries, and various high cost imaging and radiology services. The Task Force recommended implementation of prior authorization policies for these services as outlined in Table 17.

Table 17: Prior Authorization Recommendations

Service	Task Force Score	Estimated State & Federal Savings	Estimated State Savings
Individuals under 21: Concurrent review for inpatient psychiatric services & PA for outpatient.	4.7	$90K	$34K
Elective Services	5.0	$0.8M	$0.3M
High Cost Imaging & Radiology	4.7	$2.5M	$0.9M
TOTAL		$3.39M	$1.234M

Hospital-Acquired Conditions

Per federal regulations, State Medicaid programs are not permitted to reimburse hospitals for certain hospital-acquired conditions. Examples of prohibited reimbursement include a foreign object retained after surgery and surgical site infections. With federal approval through a State Plan Amendment process, States can identify additional conditions for which Medicaid reimbursement will not be provided. Maine currently utilizes the federal minimum requirement. In 2009, Maryland expanded the list of hospital-acquired conditions for which reimbursement would not be provided to a total of 49 conditions. Hospitals with a higher-than-average complication rate receive an overall decrease in payment.[xx] The Task Force recommends mirroring Maryland's strategy. **This short-term strategy received an average score of 3.9 from Task Force members. Estimated savings include $1.75 million in State & Federal expenditures or $0.7M in State expenditures.**

Readmissions

As previously discussed, Maine's readmission rate within 30 days is higher than the national average (17.7% vs. 9.4%). MaineCare does not currently reimburse for readmissions within 72 hours. States have explored additional strategies for reducing potentially preventable readmissions. For example, in New York hospitals that have excess readmissions within 14 days receive payment reductions for all non-behavioral health-related Medicaid discharges[xxi]. In Massachusetts, hospitals above the set threshold for readmissions receive a 2.2% reduction in their standard payment amount per discharge[xxii]. Under the Affordable Care Act, Medicare has also implemented policies related to preventable readmissions. With

penalty amounts increasing annually, hospital reimbursement is reduced for excess readmissions rates for certain clinical conditions (acute myocardial infarction, heart failure and pneumonia).

The Task Force is recommending modifying the current readmissions policy and scored such a strategy at 4.7. In place of the current policy of not reimbursing for readmissions within 72 hours, the Task Force recommended either increasing the time span to 14 days and lowering the overall reimbursement rates a hospital receives, or implementing the Medicare policy. DHHS should evaluate both options and MaineCare-specific data to determine the appropriate strategy. The committee noted that hospitals that did not have the first admission and discharge would not be penalized for the readmission; that is, if an individual readmitted to a different hospital the second admitting hospital would not lose reimbursement. **Estimated savings for implementing this strategy include $15 million in State and Federal expenditures or $5.6 million in State expenditures. A State Plan Amendment would be required.**

Reimbursement for Leave Days

Currently, MaineCare reimburses for hospital and therapeutic leave days as outlined in Table 18. Under this policy, facilities receive payment for days when the Medicaid enrollee is not present in the institution and receiving care. Other States do not provide Medicaid reimbursement for such leave days. For example, seven states do not reimburse for any leave days for IMD facilities and three states do not reimburse for any leave days for ICFMRs.[xxiii]

Table 18: MaineCare Leave Days

Facility Type	Current MaineCare Reimbursement Policy
Nursing Facility	10 hospital leave days 36 therapeutic leave days
IMD	10 hospital leave days 36 therapeutic leave days
ICFMR	25 hospital leave days 52 therapeutic leave days

The Task Force is recommending eliminating reimbursement for these leave days and scored this initiative at 3.5. Savings are estimated at $1.7 million in State and Federal expenditures or $0.6 million in State expenditures. One Task Force member did caution that depending on the supply of beds, patients may not have a place to return to or may have to transfer to another facility. This raises the concern that complete elimination of reimbursement could cause longer inpatient hospitalizations. A potential alternative to mitigate this risk is reimbursement reduction versus complete elimination. A State Plan Amendment would be required to implement this change.

Final Mid-Term Strategy Recommendations

Pharmacy

Competitive Bid for Specialty Pharmacy

To address the high cost of specialty pharmacy drugs, the Task Force is recommending a competitive bid for a specialty pharmacy vendor. Under this approach enrollees would be required to receive their specialty drugs from the contracted vendor. Typically, in addition to dispensing drugs, specialty pharmacy vendors conduct clinical outreach to doctors and enrollees to ensure proper prescribing patterns and medication use. These vendors offer the advantage of aggressive pricing discounts due to volume purchasing.

This approach received an average score of 4.7 from the Task Force. Associated savings are estimated at $2.1 million in State and Federal Expenditures or $0.8 million in State expenditures. This figure is anticipated to grow annually as specialty drug spending is expected to comprise around 40% of the total pharmacy spend by 2015.

Expand Medicaid Management Initiative

Currently MaineCare utilizes the Goold Med-Management tool, a health informatics tool to facilitate case management activities. This is a web-based tool available to clinicians and support staff to support "Intensive Benefits Management, Medication Therapy Management Program (MTMP), therapy compliance, and other programs requiring case management.[xxiv]" **The Task Force is recommending expansion of this program and scored this initiative at 5.0.** Further research is needed to develop estimated savings related to this recommendation.

Monitor Use of Anti-Psychotic Medications

With the steady increase of prescribed anti-psychotic medications, particularly among children, States have targeted monitoring their use among Medicaid enrollees both to ensure appropriate clinical outcomes and cost-effectiveness. For example, Maryland launched the Anti-psychotic Medication Initiative in which a peer review program was implemented and prior authorization required for anti-psychotic prescriptions for children under age 10. Additionally, prior authorization is required for Tier 2 and non-preferred anti-psychotic medications for patients' age 10 years and up.[xxv]

The Task Force is recommending implementation of such a program for MaineCare enrollees. Prior authorization would be required for use among children, adults, and seniors. **This initiative scored at 4.8. Associated savings are estimated at $0.7 million in State and Federal expenditures or $0.3 million in State expenditures.**

Restore Smoking Cessation Services

Smoking cessation services were eliminated effective October 1, 2012 for all MaineCare enrollees except pregnant women. Due to the significant health impact and costs associated with smoking, the Task Force is recommending reinstatement of these benefits. While covering smoking cessation benefits would cost the State in the short-term, the Task Force strongly believes that the short-term costs will be far outweighed by the mid- and long-term savings benefits. By providing MaineCare members with access

to the counseling and products they need to break their smoking addiction, they can eliminate the personal costs associated with the addiction, as well as prevent future health costs for the MaineCare system.

This strategy received an average score of 3.7. Additional research is necessary to develop estimated cost savings.

Program Integrity

Medicaid agencies are utilizing a variety of program integrity initiatives to combat fraud, waste, and abuse. MaineCare currently utilizes Recovery Audit Contractors, has a centralized provider enrollment process and provides program integrity training across all pertinent agencies. Additionally, an annual audit is conducted by an external agency and there is ongoing review of Medicaid policies and procedures to ensure appropriate controls are in place. Finally, MaineCare has implemented the Federal Partnership Best Practices with minor exceptions.

The Task Force is recommending increased initiatives surrounding program integrity including the development of operational policies and procedures to handle Medicaid discretionary functions. Additionally, the Task Force is recommending undertaking an internal review of data collected, utilizing the CMS Best Practice Annual Summary Report and developing policies, procedures and mechanisms to report to the Medicaid and CHIP Payment and Access Commission. **These initiatives were given an average score of 4.4 by the Task Force. Finally, tracking patients and not allowing patients to use cash to pay for controlled substances is also recommended and received an average score of 4.8 by the Task Force. Such program integrity initiatives are anticipated to provide savings of $6.5 million in State and Federal expenditures or $2.4 million in State expenditures.**

Final Long-Term Strategy Recommendations:

The final recommendations were built around a strategy of targeted initiatives by population and/or category. There was recognition that different approaches were needed to account for the complexity of different populations, but the goal for both is to manage, coordinate, and prevent disease progression. The committee developed two approaches, one for 80% of the MaineCare population designed for less complex disease, which centers on strong primary care management and community partners to manage and coordinate care. Another approach was recommended for the highest cost populations - the top 20% of MaineCare. This population is likely to be disabled, either physically or mentally, receiving waiver services and has significant co-morbidities, often mental health issues. This population requires medical care as well as long-term care support services, including institutional and home- and community-based care. The top 5% of the population is the most expensive, and the long-term strategy is to prevent population just below the 5% - the next 15% - from becoming the top 5%, where costs are difficult to control.

Value-Based Purchasing

MaineCare has been working toward implementing a variety of value-based purchasing initiatives. Under these strategies, providers are reimbursed for outcomes and quality versus volume-based reimbursement under traditional fee-for-service arrangements. The goal is for providers to better coordinate total care resulting in better outcomes at lower costs. MaineCare value-based purchasing initiatives include an Accountable Communities Program, Patient Centered Medical Homes, and a Primary Care Provider

Incentive Program. The approach continues the primary care case management program that has been in place, but adds community care coordinators to augment the medical home care coordination activities. Under these initiatives, Community Care Teams will provide wrap-around support to physician practices to deliver intensive care management to the highest need members. Additionally, Community Care Teams with expertise in behavioral health will partner with practices to serve members with serious mental illness. The Primary Care Provider Incentive Program is an incentive program to reward practitioners that provide high quality care to MaineCare members. The goals of the program are to reduce disincentives to having higher Medicaid patient panels, reduce inappropriate ER utilization and increase the utilization of preventive and high quality services. Providers receive a monetary payment based on their ranking for select quality measures. Additionally, MaineCare collaborates with ER departments to identify high utilizers and drivers of utilization and to encourage members to seek care in appropriate treatment settings.

Following analysis of the cost distribution and enrollment of the entire MaineCare population, the Task Force identified these current strategies as effective management techniques for the low-risk and low-cost enrollees. That is, the bottom 80% of enrollees by cost comprised primarily of non-disabled, pregnant women and children whose needs center primarily on primary care. The Task Force is recommending increased promotion of targeted initiatives aimed at emergency room utilization, maternal and child health, care coordination and provider incentive programs. **The Task Force scored these initiatives at 5.0. These management activities are anticipated to provide savings of $5.2 million in State and Federal expenditures or $2.0 million in State expenditures.**

Value-Based Purchasing with Care Management Organization

The Task Force reviewed other States' use of contracted entities known as Care Management Organizations (CMO) in collaboration with value based purchasing initiatives. For example, in Louisiana, an enhanced PCCM model is used. The State contracts with two entities to provide care management and oversee the network of primary care providers. Savings targets are established by the State and any savings attained must be shared with providers. If savings are not achieved, the entity is at risk and must return up to fifty percent of the monthly care management fee received.[xxvi]

Contracting with a CMO provides an opportunity to build upon MaineCare's value-based purchasing initiatives. As MaineCare is currently implementing a variety of strategies, a CMO could oversee and coordinate all programming and provide technical assistance, expertise and management. Claims would continue to be paid by the State while the CMO would monitor the provider network including patient-centered medical homes and accountable care communities. The entity would also undertake additional care management initiatives. Additionally, as there is no absolute guarantee of savings under value-based purchasing initiatives, contracting with a CMO and tying in savings guarantees reduces financial risk to the State.

The Task Force strongly supported the use of a CMO as an additional layer to the current value based purchasing initiatives and scored this at 5.0. Estimated State and Federal savings are $1.8 million or $0.7 million in State expenditures. A State Plan Amendment or waiver would be necessary to implement this model.

Strategies to Reduce Neonates & Increase Normal Births

As previously discussed and illustrated in Table 19, MaineCare has a high incidence of neonates. The Task Force is recommending targeted initiatives to increase the incidence of normal deliveries and healthy newborns. This could be developed as either a separate initiative or as a responsibility of the CMO. **This initiative has strong support from the Task Force with an average score of 4.7. By reducing the percentage of neonates from 46% to 37%, State and Federal savings of $3.7 million is anticipated or $1.4 million in State expenditures.**

Table 19: Savings (State & Federal) for Reducing Number of Neonates[xxvii]

	Base Admits	Base Spending		Redistributed Admits	Redistributed Spending
Normal newborns	3,316	$ 3,750,451		3,887	$ 4,396,035
Neonate	2,854	$21,620,671		2,283	$ 17,296,537
TOTAL	**6,170**	**$ 25,371,121**		**6,170**	**$ 21,692,571**
Neonate %	46%			37%	
Savings from redistribution					**$3,678,550**

Dental Benefits for Emergency Department Utilizers

Currently MaineCare provides limited dental services for adults. Extraction is available for severely decayed teeth which pose a threat of infection during a surgical procedure of the cardiovascular or skeletal system or during radiation treatment for a tumor. Treatment is covered to relieve pain or eliminate infection. Other dental services are covered if found to be medically necessary to correct an underlying medical condition or if they are determined cost-effective in comparison to the provision of other covered services for the treatment of that condition.

Due to the concern that dental pain is a driver of emergency room utilization, and therefore cost shifting to a more expensive treatment setting, the Task Force is recommending allowing dental benefits for individuals who utilize the emergency room for dental services. **The Task Force gave this initiative an average score of 4.2. Estimated costs associated with implementing this benefit are $8.4 million in State and Federal expenditures or $3.2 million in State expenditures.**

Capitation for Top 20%

As previously discussed, the service costs for the top 5% of MaineCare enrollees represent 54% of total spending. These populations are primarily disabled, waiver enrollees and those living in residential facilities. States are increasingly exploring managing long-term services and supports through MCO capitation versus fee-for-service arrangements (MLTSS). As of 2012, there were 16 States with MLTSS programs, double the number of programs existing in 2004, and at least half of states are planning for this type of initiative.[xxviii]

The Task Force is recommending implementation of a capitated managed care program for these vulnerable populations. Enrollees would include not only those in the top 5% of spending but also the next 15% to prevent them from becoming the top 5%. An MCO model for this population would provide aggressive case and disease management to prevent disease progression and avoid hospitalization and

institutionalization. Home- and community-based care would be promoted over institutional care, with enrollees continually re-evaluated to ensure the appropriate level of services are being delivered. Contracting strategies such as performance bonuses and withholds tied to quality outcomes would be utilized to assure the delivery of high quality care and outcomes. At least one committee member stressed a phased in approach of this strategy, starting with the highest risk first and then gradually expanding the use of managed care.

The Task Force provided an average score of 3.6 for this recommendation. Estimated State & Federal savings are $45.9 million or $17.2 million in State savings. A State Plan Amendment or waiver would be necessary to implement this initiative.

Hard Stop to Elective Inductions Prior to 39 Weeks

Elective inductions prior to 39 weeks are associated with longer labors, increased c-section rates and reduced birth outcomes. Other States such as Ohio and Utah have stopped reimbursing for elective inductions prior to 39 weeks. The Task Force is recommending implementing this policy, with a prior authorization process for exception cases. **This recommended initiative received an average score of 4.0 from the Task Force. Associated estimated State and Federal savings are $0.85 million or $0.32 million in State savings.**

Radiology Benefits Manager

To contain costs and ensure the appropriate delivery of radiology services, State strategies have included contracting with Radiology Benefit Managers (RBM). For example, North Carolina implemented an RBM in 2009. All prior authorizations for radiology are handled by the RBM.

The Task Force is recommending contracting with a RBM for the MaineCare program and scored this contracting strategy at 4.4. Estimated State and Federal savings are $2.5 million or $0.9 million in State savings.

Care Coordination for Long Term Services and Supports

MaineCare is scheduled to implement care coordination teams in 2013 for individuals receiving long-term services and supports. The Task Force was in support of this initiative and recommended continued implementation. **An average score of 5.0 was provided for this initiative.**

Conclusion

The Task Force is recommending a comprehensive package of short-term, mid-term, and long-term strategies to reform MaineCare to ensure long-term sustainability and the delivery of high-quality, cost-effective care. Together these strategies are projected to save the State $30.9 million as outlined in Table 20.

Table 20: Summary of Task Force Recommendations

	Proposed Change : Short-term Strategy	Rank Low = 1 High = 5	Predicted Savings	
			State & Federal	State[xxix]
Prior	• Implement concurrent review for inpatient psychiatric services	4.7	$90K	$34K

Authorization	for individuals under 21			
	• Elective surgeries	5.0	$0.8M	$0.3M
	• High cost imaging & Radiology	4.7	$2.5M	$0.9M
Hospital-Acquired Conditions (HACs)	• Expand list to include all of those listed for the State of MD and • Payment adjustments made annually based on HACs	3.9	$1.75M	$0.7M
Readmissions	• Increase time span for which readmissions are not reimbursed	4.7	$15M	$5.6M
Leave Days o Nursing Facility o IMD o ICFMR	• Eliminate reimbursement for hospital leave & therapeutic leave days	3.5	$1.7M	$0.6M
Total savings from Short-term strategies			$21.8M	$8.1M
	Proposed Change : Mid-term Strategy	**Rank** Low = 1 High = 5	**Predicted Savings** **State & Federal**	**State**[xxx]
Pharmacy	• Competitive bid for specialty pharmacy	4.7	$2.1M	$0.8M
	• Expand Medication Management Initiative[xxxi]	5.0	Addtl. research needed	Addtl. research needed
	• Monitor use of Anti-Psychotics in Children and Adults and Seniors o PA required	4.8	$0.7M	$0.3M
	• Restore smoking cessation services	3.7	Addtl. research needed	Addtl. research needed
Program Integrity	• Develop operational policy and procedure to handle day to day Medicaid discretionary functions and • Internal review of data collected • Utilize CMS's best practice annual summary report • Develop policy/procedure and mechanisms for reporting to the Medicaid and CHIP Payment and Access Commission	4.4	$6.5M	$2.4M
	• No cash for controlled substances	4.8	Addtl. research needed	Addtl. research needed
Total savings for Mid-term strategies			$9.3M	$3.5M
	Proposed Change : Long-term Strategy	**Rank** Low = 1 High = 5	**Predicted Savings** **State & Federal**	**State**[xxxii]
Value-based purchasing	• Increase promotion of targeted initiatives o ED o Maternal & child health o Care Coordination to assist transition o Provider incentive program	5.0	$5.2M	$2.0M

Value-based purchasing with Care Management Organization (CMO)	• Care Management Organization	5.0	$1.8M	$0.7M
Reduce neonates & increase normal births	• Healthy Babies Initiative/Also combines with Care Management Organization	4.7	$3.7M	$1.4M
ER utilization	• Allow dental benefits for individuals using the ED for dental services[1]	4.2	($8.4M)	($3.2M)
Capitation for top 20%	• Aggressive case & disease management • Home & community-based care • Continually & periodically re-evaluate clients to assure appropriate level of care • Carve outs • Reduce waitlist • Risk adjustment • Performance bonus for meeting quality incentives • Withhold to assure that process measures achieved	3.6	$45.9M	$17.2M
Elective inductions prior to 39 weeks[xxxiii]	• Put "hard stop" to elective inductions prior to 39 weeks gestation	4.0	$0.85M	$0.32M
Radiology Benefits Manager (RBM)[xxxiv]	• Implement Radiology Benefits Manager Require PA • Utilize clinical decision support (CDS) – no PA • Implement real-time online interactive PA	4.4	$2.5M	$0.9M
Care Coordination for LTSS	• N/A	5.0	N/A	N/A
Total savings for Long-term strategies			**$51.6M**	**$19.3M**

Appendix 1 – Presentations

All Task Force presentations, research, and supporting documentation can be found at http://www.maine.gov/dhhs/mainecare-task-force/index.shtml

Appendix 2 – Meeting Minutes

Department of Health and Human Services Maine People Living Safe, Healthy and Productive Lives Paul R. LePage, Governor Mary C. Mayhew, Commissioner	**Department of Health and Human Services** **MaineCare Redesign Task Force Minutes** **8/28/2012**

Attendance:

Mary C. Mayhew, Commissioner, DHHS
Rose Strout, Member of the MaineCare Advisory Committee representing MaineCare Members
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Jim Clair, Member of the public who has expertise in public health financing
Ryan Low, Member of the public who has expertise in economic policy
Frank Johnson, Member of the public who has expertise in public health care financing
David Winslow, Member of MaineCare Advisory Committee representing providers of MaineCare Services
Scott E. Kemmerer (via the internet), Member of the public who has expertise in public health care policy
Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members
Nick Adolphsen, DHHS, staff
Stefanie Nadeau, DHHS/MaineCare staff
Michelle Probert, DHHS/MaineCare staff
Kevin Flanigan, DHHS/MaineCare staff
Jim Leonard, DHHS/MaineCare Staff
Denise Gilbert, DHHS, staff

Agenda	Discussion	Next Steps
Welcome and Introductions	Introductions were made and the Commissioner provided an overview of the meeting agenda	
Housekeeping	Commissioner informed members that handouts/materials discussed at the meetings will be posted on the DHHS web site at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Minutes will be published on-line and e-mailed to all interested parties. General Public members were encouraged to sign in if they wished to be added to the MaineCare interested parties distribution list.	

Agenda	Discussion	Next Steps
	DHHS staff members available in support of the MaineCare Redesign Task Force are: Stefanie Nadeau, Jim Leonard, Nick Adolphsen, and Denise Gilbert. Questions should be forwarded to Nick at Nick.Adolphsen@maine.gov	
Review of Governing Statute	There was a brief review of the Governing Statute – Public Law 2011, Chapter 657, Part T (attached), noting the duties. Members discussed the possibility of working with a facilitator/consultant who has a national health policy perspective. The deadline for the report to the Joint Standing Committees of Appropriations and Financial Affairs and the Health and Human Services is 11/15/12. A draft report should be completed and sent to the DHHS Commissioner's office by 11/6/12 for review.	
Medicaid Overview	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Stefanie Nadeau presented "An Overview of the MaineCare Program". This outlined MaineCare's contractual relationship with CMS, identified the basic requirements of Medicaid, defined the MaineCare Waiver Populations, numbered MaineCare Enrollment, and provided a brief history of MaineCare Expenditures. Members requested additional information/data: • Section 32 regarding Children • Current caseload information • Chart similar to the "High 5% Service Types – by Net Payments" (Page 22 of the handout) for all populations • Information on co-payment limitations • SPA Waivers: what's available and what are the requirements	The Office of MaineCare Services will provide the requested information at the meeting scheduled on September 12th.
High Cost User Overview	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Dr. Kevin Flanigan presented an overview of "The Top 5%" high cost user. The data indicates that the majority of the cost (approximately 74%) is for non-medical	

Agenda	Discussion	Next Steps
	services and a majority of that (approximately 55%) is expended on long term care. An internal committee has been convened to identify and study the high cost user, by doing so the Department hopes to improve the quality of services, eliminate duplication by better coordination of care, thereby cutting costs. The current thinking is for the DHHS to act as its own "Accountable Care Organization" (ACO), across all DHHS programs and clients, matching services (departmental and community based) with identified needs. Questions discussed and additional information requested: • Deeper breakdown of the top 5%, such as age, waiver, etc. • Identify any budget barriers/issues • Criteria used to measure client stability • Define "Care Management" versus "Case Management" • Review of historical patterns by major categories such as pharmacies	The Office of MaineCare Services will provide additional information at the meeting scheduled on September 12th.
Value Based Purchasing Overview	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Next Michelle Probert presented on DHHS' current initiatives: **MaineCare Value-based Purchasing Strategy.** "In August 2011, Maine DHHS moved away from Managed Care focused principally on cost-containment to leverage on-the-ground initiatives the right care for the right cost". Creating Accountable Communities (ACO) and Health Homes to "improve transitions of care" and "strengthen primary care". The handout identifies the current list of CMS approved conditions for coverage and the newly proposed conditions awaiting CMS approval. Development of the Health Homes is a two stage process. Stage "A" will help individuals with chronic conditions. Timeline for implementation of stage "A" is: 6/12 select eligible health home practices; 7/12 Community Care Team application issued; 9/12 submit state plan amendment; 10/12 Community Care Team selected; 1/13 Stage "A" implemented. Stage "B" will help individuals with SPMI and/or SED. Stage "B" implementation timeline is: 9/12 issue request for information; late Fall 12 initiate discussion with	

Agenda	Discussion	Next Steps
	CMS/SAMHSA; Early Winter submit state plan amendment; Spring/Summer implement. It was noted that these initiatives are only financed for 24 months beginning from the date of implementation for each stage. **Emergency Department (Ed) Collaborative Care Management Project.** Objectives are: "to reduce avoidable ED use and improve health outcomes for high needs, high utilizers of the ED through statewide care management efforts by leveraging care management resources in the community" and "identifying and filling gaps where no care management capacity exists" and "increase availability of ED for true emergency situations" building on the successful pilot with MaineGeneral. Suggestions/ideas discussed: - Look at pharmacy model - No need for DHHS Care Managers, providers see DHHS/MaineCare as the information source - This initiative has booked savings of approximately $5.4 million in state and federal funds for previous budgets **Accountable Communities Initiative (ACO).** According to the DHHS definition and ACO is an entity responsible for population's health and health costs that is "provider-owned and driven", "a structure with strong consumer component and community collaboration" and "includes shared accountability for both cost and quality" featuring two models: Shared Saving Only: minimum 1,000 patients - Share in a maximum of 50% of savings, based on quality performance - Not accountable for any downside risk - Subject to lower per patient cap	Office of MaineCare Services will review pharmacy model and provide information.

Agenda	Discussion	Next Steps
	Shared Savings & Losses: minimum 2,000 patients - Share in a maximum of 60% savings, based on quality performance - Not accountable for any downside risk in the first performance year - In year 2, accountable for up to 5% of any losses - In year 3, accountable for up to 10% of any losses - Must demonstrate capacity for risk sharing Accountable Communities must include all costs for DHHS identified "core" services. Timeline for implementation is: 8/12 start discussions with CMS about State Plan Amendment; 9/12 issue the application; 11/12 send state plan amendment to CMS; 12/12 select accountable communities and 4/13 start the ACOs. Suggestions/Ideas discussed: - Need additional information/follow-up on Section 65 and 28. - Need to discuss global waiver Questions: • Can the savings from DHHS's current initiatives be counted in meeting the goal of the $5 million? No, the savings associated with current initiatives have already been budgeted.	Discuss global waiver at future meeting.
Guiding Principles	Principles suggested by members: • Cost effective • High quality • Patient/consumer centered • Program Sustainability • Holistic and individualized approach based on unique needs • Flexibility (not one size fits all)	Members can send additional principle suggestions to Nick at Nick.Adolphsen@maine.gov for inclusion. A draft of the principles will be

Agenda	Discussion	Next Steps
	• Evidence based • Innovation/technical approach • Data analytics • Collaboration • Payor alignment • Medical necessity	distributed to the task force.
Future Topics/Agendas	Suggestions: • GAP analysis • Review state and private initiatives • Further review of data presented (High Cost, Value based Purchasing) • Limitations by federal regarding incentive and benefit design for flexibility regarding waivers • DRGs	Members will send additional agenda items to Nick. UPCOMING MEETINGS – 1 -4 pm, Rm 228 State House September 12 September 25 October 9 October 23 November 6
Public Comment	Dale Hamilton CHCS asked if the $5 million was per quarter or annually. The $5 million is annual. During the first year the $5 million will have to be absorbed in the last quarter due to the timing of the task force work. Vanessa Santarelli, Maine Primary Care Association, offered to provide any information the Task Force would find helpful. She requested that members be mindful of dental care during the development of health homes. She expressed concern regarding the formal process for public input. Richard Kellogg, TSG spoke about the Independent Home and Community Based services model and offered to provide information to the task force.	Task Force will consider a formal public input process at a future meeting.

Department of Health and Human Services Maine People Living Safe, Healthy and Productive Lives Paul R. LePage, Governor Mary C. Mayhew, Commissioner	**Department of Health and Human Services MaineCare Redesign Task Force Minutes 9/25/2012**

Attendance:

Mary C. Mayhew, Commissioner, DHHS
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Jim Clair, Member of the public who has expertise in public health financing
Ryan Low, Member of the public who has expertise in economic policy
David Winslow, Member of MaineCare Advisory Committee representing providers of MaineCare Services
Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members
Nick Adolphsen, DHHS, staff
Stefanie Nadeau, DHHS/MaineCare staff
Kevin Flanigan, DHHS/MaineCare staff
Jim Leonard, DHHS/MaineCare staff
Denise E. Gilbert, DHHS staff
Seema Verma, SVC, Consultant
Rob Damler, SVC, Consultant

Agenda	Discussion	Next Steps
Welcome and Introductions	Introductions were made. Following introductions Commissioner quickly reviewed agenda and asked members if additional items needed to be provided and/or discussed at a future date.	Need to discuss the Global Waiver Additional information regarding peer states may be needed
MaineCare by the Numbers Part II	Handouts/materials discussed at the meetings will be posted on the DHHS web site at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Dr. Flanigan presented "MaineCare by the Numbers, Part II" which provided a deeper review of claims data for the top 8 clinical conditions (*1. Mental Health; 2. Signs/Symptoms/Oth Cond, NEC; 3. Neurological Disorders, NEC; 4. Diabetes; 5. Dementia, Primary Degenerative; 6. Prevent/Admin Hlth Encounters; 7. Pregnancy with and without complications; 8. Infections – ENT EX Otitis Med*); provider type , payments, procedure codes for waiver service providers, etc., Concerns/Issues/data requests: 1. Concern was expressed that some of the information shared was confusing. Suggestion was made to review mental health procedure codes, particularly for those under 18.	MaineCare staff will provide requested information

Agenda	Discussion	Next Steps
	2. What is considered a waiver service? Staff providing residential support for individuals living in a community setting (not institutionalized) 3. Members expressed interest in additional information regarding the "churn" rate for the top 5 to 20% of claims.	
Introduction of Consultant hired to staff Task Force – Seema Verma and Rob Damler	Jim Leonard introduced the two consultants Seema Verma and Rob Damler from SVC based in Indiana who will work with the Task Force to provide a national perspective on what other states are doing to improve quality, reduce costs, and restructure Medicaid services.	
Medicaid Cost Containment Strategies Presentation – Seema Verma and Rob Damler, SVC	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Seema Verma and Rob Damler presented an overview of cost containment strategies being considered or used around the country. The three categories discussed, which members felt all should be on the table, were: a. short-term strategies (6-12 mos.) most times needing a CMS state plan amendment; • increased cost-sharing – which include co-pays, premiums, and deductibles – concern was expressed that this may limit access; that providers would incur the loss as most times it does not make business sense to collect a minimal co-payment, but it was thought that payments to incentivize for the use of preventative healthy living would be an agreeable option as opposed to punitive measures, members were also encouraged to consider the mid-term and long-term strategies for implementing systems change so Maine is not repeating this process every couple of years • Benefit reductions & limitations – limiting some of the mandatory benefits such as the number of inpatient and outpatient visits, elimination or reduction of optional services such as physical therapy, occupational therapy, dental services, etc. Members were reminded to consider the long term impact of implementing some of the short-term strategies. Sometimes limiting services in one area may increase cost in another.	Seema, Rob and DHHS staff will provide information for discussion at the meeting scheduled for October 9, Room 228, State House

Agenda	Discussion	Next Steps
Medicaid Cost Containment Strategies Presentation – Seema Verma and Rob Damler, SVC cont.	• rate reductions – which have been one of the most common cost-containment strategy among states, include rate reimbursement for medical equipment, medical supplies, ambulance, home health, mental health, outpatient hospital, chiropractor, non-emergency transportation, HCBS, podiatry, and C-section - it was suggested that DHHS develop a list of all changes Maine has implemented regarding Medicaid over the last few years so members would have a better idea of what other options would be available. b. mid-term strategies (1-3 years) • Pharmacy targeted reforms - which could include prior authorization, increased use of generics, cost sharing incentives, etc. • Reducing prescription drug abuse • Eligibility changes – asset tests, reducing or eliminating outreach activities; reporting changes, etc. • Quality Initiatives – Complex case management, outreach programs, care management, reducing fraud and abuse. • Managing high cost enrollees • Program integrity initiatives – such as with Maine's Medicaid Fraud Recovery Unit • Reimbursement reforms – such as limiting reimbursement for potentially preventable events, C-section reimbursement, provider taxes, etc. c. long-term strategies (3-5 years) • Value based purchasing – managed care, health homes, accountable care organizations – additional information was requested regarding which states have been successful in implementing managed care systems (are they rural or more urban, impact of managed care in other states? • Health Information Technology – allows better coordination, reduction in duplication of services and additional funding made available to states through ARRA for initiatives such as payment incentives for implementation of electronic health records • Managing duals – better coordination between Medicaid and Medicare • Managing long-term and high cost populations by integration with	

Agenda	Discussion	Next Steps
Medicaid Cost Containment Strategies Presentation – Seema Verma and Rob Damler, SVC cont.	Medicare Following the discussion a worksheet was distributed "Maine Medicaid Cost Containment Strategy Summary" with the intent to help members prioritize/narrow Maine's focus. Members felt additional information and discussion was needed prior to this exercise. Items discussed/information requested: • Enhanced management of developmental disabilities – more information regarding Maryland's Children's anti-psychotic medications • More discussion regarding mid-term strategies such as preventative programs around high risk pregnancies implemented in North Carolina and Indiana • Both consultants felt risk was essential in for-profit markets and reward incentives could drive provider and health plans to improve/provide services • It was felt perverse incentives drive higher use of services • Has DHHS, through the Cost Work Group, assessed costs, developed strategies, projected savings, implemented interventions/initiatives they could share? • Additional information on how Maine's high cost user (top 5%) compares to other states • Need to include groups such as diabetes, behavioral, high cost, and developmental • Mary Lou Dyer distributed two handouts from the Maine Association for Community Service Providers "Analysis of High Cost Data Pertaining to Intellectual Disabilities (global waiver)	Seema, Rob and DHHS staff will provide information for discussion at the meeting scheduled for October 9, Room 228, State House
Public Comment	Megan Hannah, Planned Parenthood, agreed that Maine is getting the federal 90/10 match for high risk pregnancies but mentioned that Maine could realize an additional $4 million in savings if DHHS took advantage of all 90/10 match programs available. Hilary Schneider, American Cancer Society Cancer Action Network distributed	Ms. Hannah will provide her comments in writing Ms. Schneider will provide sources for

Agenda	Discussion	Next Steps
	materials regarding potential MaineCare Savings Initiative that Improve Cancer Prevention and Treatment such as: Tobacco Cessation Coverage and Palliative Care Programs Dawn Croteau mentioned that public service announcements regarding how to read nutritional labels would help reduce MaineCare costs related to obesity and diabetes	information provided
		UPCOMING MEETINGS – 1 -4 pm, Rm 228 State House; October 9, October 23, and November 6

Department of Health and Human Services Maine People Living Safe, Healthy and Productive Lives Paul R. LePage, Governor Mary C. Mayhew, Commissioner	**Department of Health and Human Services** **MaineCare Redesign Task Force Minutes** **10/9/12**

Attendance:

Mary C. Mayhew, Commissioner, DHHS
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Jim Clair, Member of the public who has expertise in public health financing
Ryan Low, Member of the public who has expertise in economic policy
David Winslow, Member of MaineCare Advisory Committee representing providers of MaineCare Services
Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members
Frank Johnson, Member of the public who has expertise in public health care financing
Rose Strout, Member of the MaineCare Advisory Committee representing MaineCare Members
Scott E. Kemmerer, Member of the public who has expertise in public health care policy

Nick Adolphsen, DHHS staff
Kevin Flanigan, DHHS/MaineCare staff
Jim Leonard, DHHS/MaineCare staff
Denise E. Gilbert, DHHS staff
Seema Verma, SVC, Consultant
Rob Damler, Milliman, Consultant

Agenda	Discussion	Next Steps
Welcome and Introductions	Introductions were made. Commissioner opened the floor for suggestions/ additions to the agenda. Suggestions/Comments: Keep in mind the need for dental/oral health Interested in more information regarding any high cost management programs Additional guidance needed to focus ideas and initiatives Need background/historical perspective of priorities Discuss Global Waiver How the initiative fit/connectivity These meetings are an opportunity for task force to "flesh out specifics"	MaineCare/DHHS will develop a matrix of Maine initiatives defining their connectivity.
Re-Cap/Status of Prior Requests	Jim Leonard provided an update on outstanding items/questions/data requests:	

Agenda	Discussion	Next Steps
Re-Cap/Status of Prior Requests cont.	1. Information regarding pharmacies and pharmaceuticals – will be presented today 2. Care Management versus Case Management – care management is a technique to manage cost and case management is support staff managing Medicaid covered services 3. Measuring client stability – MaineCare measures stability over an 11 month period 4. Identify budget issues/barriers – will be covered in today presentation 5. Deeper breakdown of top 5% - provided in MaineCare by the Numbers – Part II 6. SPA Waivers – will be covered in today's presentation 7. Cost data – MaineCare staff currently working on this 8. Current Caseload data – MaineCare staff currently working on this *9.* Implementation of Section 32 (children) – approximately Nov. 21 It was mentioned that these meetings provide the opportunity to "flesh out specifics" for MaineCare redesign and interaction during the presentations was encouraged.	Cost data and current caseload information will be provided.
Presentation by Seema Verma and Rob Damler	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml The presentation provided a comparison of Maine's costs to other states regarding short term savings for mandatory and options benefits, med term savings for pharmacy and program integrity, outlined the impact of Medicaid managed care in other states, presented long term savings options. Discussion: The federal medical assistance percentage will drop by 1.9% in FY '13 and could possibly drop 2.7% in FY '14. The FY '14 rate will be finalized in the spring of '13 and could change.	

Agenda	Discussion	Next Steps
Presentation by Seema Verma and Rob Damler cont.	Maine is below the national average in Medicaid per enrollee for the aged and adult populations. This presentation does not consider all state funding. More information is needed to clarify amount spent for each population. Maine is far above average for spending in disabled and children populations. Task force members requested additional information regarding the "high cost kids", the severity, Maine's rate of disability, and information regarding policy decisions that may have driven up the cost. States that are limiting ED visits are being challenged in the courts. This is shifting costs to the hospitals, may want to consider restrictive Medicaid cards as an option. Maine currently is piloting a project using restrictive care and urgent care options which is producing significant savings. Members asked if this program could expand. It was suggested that the matrix mentioned previously include **information on prior authorization; individual assessment; rate reduction; utilization management; payment reform; care management ; what is on-going; overlapping concerns; and what savings have been booked and what additional savings are expected.** *BELOW IS THE LIST OF INITITIVES MEMBERS HAD INTEREST IN RESEARCHING:* **Short-term: Changes to Mandatory Benefits** **Inpatient hospital** – PA for all non-emergency admissions except maternity PA for all elective admissions Consolidate payment for readmit within so many days Potentially avoidable complications **Outpatient hospital** - coverage limits for cardiac rehab **Nursing facility** – review bed hold days **Physician services** – require PA for specified procedures and services **FQHC services** – wrap around managed care **Lab & X-ray** – focusing on high cost **Freestanding Birth Center services** – look at reimbursement models	DHHS staff and consultants will meet to coordinate responses regarding information requests.

Agenda	Discussion	Next Steps
Presentation by Seema Verma and Rob Damler cont.	**Transportation to medical care** – Michelle Probert to provide additional information regarding Maine program **Short-term: Changes to Optional Benefits** **Self-Directed personal assistance services** – what might the consultants recommend **Inpatient psychiatric services for individuals under 21** – require periodic re-authorization **Out-of-state services** – provide any information on Medicaid services Maine pays for any out-of-state services. **Rehab Services (BH $ Substance Abuse)** – Med Management, further define "up to 1 hr." Is it annual? Weekly? More detail needed on Maine trends versus other states **Dental** – research studies regarding cost avoidance and provide list of states that contract services out **Chiropractic** – further limiting or elimination **Private duty nursing** – budget number by age group **Personal care** – budget numbers **Case Management** – provide list of groups eliminated **Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)** **Mid-Term Strategy: Eligibility Changes** Review spend down eligibility and current medical expenses considered for spend-down eligibility. **Increased use of generics** – need to explore **Rebates** - cross over pharmacy claims and specialty pharmacy costs in Maine compared to other states **HIT** – explore restricted card program **Mid-Term Strategy: Program Integrity**	

Agenda	Discussion	Next Steps
	Need to review contracts for program integrity language **Overview: PCCM vs. MCO Model** Members felt additional information on the successful components of managed care When caring for the high cost user how do medical homes versus managed care work An idea discussed was the possibility of tailoring the solutions by specific population i.e. Managed care for high cost user Additional information needed on PACE Need to consider the effect of any initiatives that will affect Maine's current initiatives (long range plans) of health homes and ACO	Members will forward any additional initiatives they feel worth discussion to Nick for distribution to Task Force prior to the next meeting.
Presentation by Seema Verma and Rob Damler cont.	There was a brief discussion regarding next steps in the drafting of the final report.	Draft of MaineCare Redesign Task Force Report will be presented at the November 6th meeting for public comments prior to finalizing. Nick will schedule an additional meeting in November to finalize report.
Public Comment	Vanessa Santarelli. CEO, Maine Primary Care – offered to provide information regarding the good work FQHAs are providing in Maine. She also invited members to visit any of the programs. Richard Kellogg, TSG suggested 4 models to consider in the interim/transition to	Vanessa will forward additional information to Nick for distribution to the MaineCare Redesign Task Force Richard Kellogg will forward

Agenda	Discussion	Next Steps
	ACO and Health Homes	information to be distributed.

Appendix 3 - Matrix

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
Short-Term							
• Prior Authorization	• PA currently required for: o All out-of-state services (including ambulance & air medical transport) o Optional treatment services for members under age 21 o Transportation for continuous treatments in hospital outpatient setting o Dental services (i.e. dentures, orthodontia, TMJ surgery, dental services) o Hearing aids o Certain medical supplies & DME, i.e. DME costing more than $699, apnea monitor, hospital beds, infusion pump, wheelchairs, oxygen, etc.)	• Implement concurrent review for inpatient psychiatric services for individuals under 21	$90K	$34K	**Pros:** • Applies medical necessity criteria to ensure appropriate delivery of services & reduces overutilization **Cons:** • Increased administrative responsibility for providers • Increased State administrative responsibility	May need to be modified with Enhanced PCCM model & for the managed care for LTSS, as those companies will likely establish their own PA Also overlaps with pharmacy initiatives	• Implementation Timeline: 3-6 mo. • Savings Realization Timeline: 6-12 mo. • Changes: Systems • Communication: Providers
		• Elective surgeries	$0.8M	$0.3M	See above	May need to be modified with Enhanced PCCM model & for the managed care for LTSS, as those companies will likely establish their own PA	See above
		• Elective inductions <39 weeks	$0.85M	$0.32M	**Pros:** • Reduced C-section rate • Better birth outcomes • Shorter labors **Cons:**	May need to be modified with Enhanced PCCM model, as those companies will likely establish their own	See above

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• Prior Authorization (cont.)	○ Vision services (i.e. eyewear, non-MaineCare frames, low vision aids, orthoptic therapy/visual training) ○ Certain physician services (i.e. breast reconstruction & reduction, gastric bypass, mastopexy, organ transplant, etc.) • PA currently under consideration for: ○ Prosthetics				• Challenge on how to implement • Administrative responsibilities for provider and State Less savings than "hard stop" option	PA	
		• High cost imaging & Radiology	$2.5M	$0.9M	**Pros:** • Applies medical necessity criteria to ensure appropriate delivery of services & reduces overutilization **Cons:** • Increased administrative responsibility for providers • Increased State administrative responsibility	May need to be modified with Enhanced PCCM model & for the managed care for LTSS, as those companies will likely establish their own PA	See above
• Rate reductions	• Support services for adults with intellectual disabilities: 2010 • Nursing facilities: 7/1/10 • Rehab & community support services for children with cognitive impairments/physical limitations: 6/1/11 retro to 9/1/10 • Developmental & behavioral clinic services: 7/1/10	• 10% reduction - Medical Equipment & supplies	$2.4M	$0.9M	**Pros:** • Immediate savings **Cons:** • The impact on providers increases over the years as costs rise & reimbursement does not • Providers may leave the market creating access issues for recipients	May impact savings potential for long-term initiatives.	See above
		• 10% reduction - Home health	$1.7M	$0.6M	See above	See above	See above
		• 10% reduction - Outpatient hospital	$13.0M	$4.9M	See above	See above	See above
		• 10% reduction -	$3.5M	$1.3M	See above	See above	See above

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• Rate reductions (cont.)	• Behavioral health services: 7/1/10 • Transportation: 8/1/10 • Occupational & physical therapy: 4/1/12 (pending) • Podiatrist: 4/1/12 • Private non-medical services: 10/1/10 • Family planning: 7/1/11 • Community support services: 7/1/10 • Behavioral Health (Methadone): 4/1/12, 1/1/13 (pending) • Group homes: 7/1/12	Dental					
		• 10% reduction – Physician	$12.4M	$4.7M	See above	See above	See above
		• 10% reduction – Lab & X-ray	$2.4M	$0.9M	See above	See above	See above
		• 10% reduction - Optometry, Optician, Ophthalmology	$1.4M	$0.5M	See above	See above	See above
		• 10% reduction - Private duty nursing	$1.3M	$0.5M	See above	See above	See above
		• 10% reduction – Hospice	$0.2M	$75K	See above	See above	See above
		• 10% reduction - Targeted Case Management	$4.7M	$1.8M	See above	See above	See above
		• 10% reduction - IMD/ICFMR	$4.4M	$1.7M	See above	See above	See above
• Benefit changes	• Eliminate - Smoking cessation products (except for pregnant women): 10/1/12 (pending) • Eliminate - Ambulatory surgical center services: 9/1/12 (pending) • Eliminate - STD screening clinic services • Limit - Optometry visits for adults (1/3 years)	• Elimination - Chiropractic care	$0.7M	$0.3M	**Pros:** • Immediate savings **Cons:** • Could adversely impact chiropractors	May reduce savings for long term initiatives, cost-shifting	• Implementation Timeline: 6-12 mo. • Savings Realization Timeline: 12 mo.+ • Changes: Systems • Communication: Providers • Document: SPA

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• Benefit changes (cont.)	• Limit - Chiropractic visits (12/year) • Limit - Added medical eligibility criteria for Case Management for homeless • Limit - Physical therapy (2 hr./day) • Limit - Occupational therapy (2 hr./day & 1 visit/year for palliative or maintenance care)						
• Hospital-Acquired Conditions (HACs)	• MaineCare implementing federal minimum requirement	• Expand list to include all of those listed for the State of MD and • Payment adjustments made annually based on HACs	$1.75M	$0.7M	**Pros:** • Promotes quality • Reduces reimbursement to hospitals for poor health outcomes	N/A	• Savings realization – 6-12 mo.
• Readmissions	• MaineCare does not reimburse for readmits within 72 hours	• Increase time span for which readmissions are not reimbursed	$15M	$5.6M	**Pros:** • Promotes quality **Cons:** • Results in reduction in hospital reimbursement	Managed care and PCCM will likely focus on this area, so may reduce savings attributed to the long term strategies	• Implementation Timeline: 3-6 mo. • Savings Realization Timeline: 6-12 mo. • Changes: Systems • Communication: Providers • Document: SPA
• Leave Days o Nursing Facility o IMD o ICFMR	• Current limits: o Nursing Facility: 10 hospital leave days & 36 therapeutic leave	• Eliminate reimbursement for hospital leave & therapeutic leave	$1.7M	$0.6M	**Pros:** • Focus on eliminating waste **Cons:** • Depending on supply of beds, patient	N/A	• Implementation Timeline: 3-6 mo. • Savings Realization Timeline: 6-12 mo.

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• Leave Days (cont.)	days ○ IMD: 10 hospital leave days & 36 therapeutic leave days ○ ICFMR: 25 hospital leave days & 52 therapeutic leave days	days • Eliminate - Nursing Facility: 10 hospital leave days & 36 therapeutic leave days • Eliminate - IMD: 10 hospital leave days & 36 therapeutic leave days • Eliminate - ICFMR: 25 hospital leave days & 52 therapeutic leave days			may not have a place to return to, or have to go to another facility		• Changes: Systems • Communication: Providers • Document: SPA
TOTAL SAVINGS for Short-term strategies			**$70.8M**	**$26.6M**			
Mid-Term							
• Pharmacy	• Rebates for crossover claims • Supplemental rebate agreements • Restrictions on narcotics use to begin 1/1/2013 • PAs for more costly drugs to begin 1/1/2013 ○ Tried & failed requirements ○ Additional step therapy • Restrictions on scripts to begin 1/1/2013	• Competitive bid for specialty pharmacy	$2.1M [xxxvi]	$0.8M	**Pros:** • Aggressive pricing discounts (due to volume purchasing) • Additional benefits (i.e. clinical outreach to providers & members to ensure proper medication use)	May duplicate care management organization efforts	• Implementation Timeline: 12+ mo. • Savings Realization Timeline: 12-18 mo. • Changes: Systems (potential) • Communication: Providers, Members • CMS waiver approval • Document: RFP process, Contract development, Potential 1115 waiver
		• Increase generic	$3.6M	$1.4M	**Pros:**	N/A	• Implementation Timeline:

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• Pharmacy (cont.)	• (Behavioral Health) Suboxone 2 year limit to begin 1/1/2013 • Average Wholesale Price – 16%: 4/1/12 (pending) • Mandatory generic substitution (pending) • Smoking cessation 50% reduction (pending) • Medication Management Initiative • No coverage for: o Anorexic or certain weight loss drugs o Most vitamins and herbal products o Hexachlorophene (for nursing facility patients) o Products listed as part of the per diem rate of reimbursement for Nursing Facility Services o Discontinued or recalled drugs o Less than Effective Drugs (defined by FDA) o TB drugs o OTC drugs (unless	dispensing rate by 1%, Reduce use of specialty drugs			• Reduce costs from brand name prescriptions		3-6 mo. • Savings Realization Timeline: 12-18 mo. • Communication: Providers, Pharmacy
		• Expand Medication Management Initiative[xxxvii]	Addtl. research needed	Addtl. research needed	**Pros:** • Enhanced care management	Could be a part of the Care Management Organization; Timeline may overlap	Current Vendor-?
		• Monitor use of Anti-Psychotics in Children and Adults and Seniors[2] o PA required	$0.7M	$0.3M	**Pros:** • Ensures appropriate medication **Cons:** • Additional administrative requirements for providers	See above	• Implementation Timeline: 6-12 mo. • Savings Realization Timeline: 12-18 mo. • Changes: Systems • Communication: Providers • Document: Develop criteria

[2] Submitted by Ana Hicks, Taskforce member

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• Pharmacy (cont.)	designated otherwise) ○ Fertility drugs • Etc. (listed in MaineCare manual)						
• Transportation	• Broker Procurement in progress	• N/A	N/A	N/A	N/A	N/A	N/A
• Program Integrity	• Utilization of Recovery Audit Contractors • Centralized provider enrollment process • Centralized program integrity training across all pertinent agencies • Annual audit review by external agency or contractor • Ongoing review of Medicaid policy and procedure • Federal partnership best practice implementation (except CMS best practice annual summary report)	• Develop operational policy and procedure to handle day to day Medicaid discretionary functions and • Internal review of data collected • Utilize CMS's best practice annual summary report • Develop policy/procedure and mechanisms for reporting to the Medicaid and CHIP Payment and Access Commission	$6.5M	$2.4M	**Pros:** • Internal safeguard against fraud, abuse, and waste • Promoting uniform standards • Understanding of current fiscal enrollment status • Improve accuracy of strategic forecasts • Stronger basis for federal reimbursement • Provide state with safeguards in disputes with the federal government	N/A	• Implementation Timeline: 6-12 mo. • Savings Realization Timeline: 12+ mo. • Changes: Systems, Human resource expansion or redirect • Communication: Data review team, Internal policy team • Document: Develop criteria
TOTAL SAVINGS for Mid-term strategies			**$16.5M**	**$6.3M**			
Long-Term – Investment in Primary Care							
• Value-based purchasing	• Patient Centered Medical Homes • Accountable Communities	• Increase promotion of targeted initiatives	$5.2M	$2.0M	**Pros:** • Encourage appropriate level of care in appropriate care setting	N/A	• Implementation Timeline: 18-24 mo. • Savings Realization Timeline:

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
	• Primary Care Provider Incentive Program	○ ED ○ Maternal & child health ○ Care Coordination to assist transition ○ Provider incentive program			• Better health outcomes **Cons:** • Costs associated with oversight & monitoring		1-3 years • Changes: Systems (possibly) • Communications: Providers, Members
		• Member Incentive program	($7.5M)	($2.8M)	**Pros:** • Pay for outcomes and quality (not just quantity of services) **Cons:** • Not much research done on long-term health outcomes	N/A	• Implementation Timeline: 1-3 years • Changes: Systems • Communication: Providers • Document: Incentive criteria & benefits
• Value-based purchasing with Care Management Organization (CMO)	• N/A	• Care Management Organization	$1.8M	$0.7M	**Pros:** • Tie in savings guarantee (funding goes back to state if savings not met) • Technical expertise, specialized knowledge • Brings together all initiatives under 1 responsible entity **Cons:** • Perception of duplication with services provided in medical home (can be overcome with contracting strategies) • State needs resources to monitor CMO • Less potential savings than Capitation	May overlap with short- and mid-term strategies	• Implementation Timeline: 18-24 mo. • Savings Realization Timeline: 2-4 years • Changes: Systems (IT) • Communication: Providers, Members • Document: RFP process, Contract development, CMO readiness review

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
					model (softer model) • Concern that takes away some local control at patient/doctor level		
• Reduce neonates & increase normal births	• N/A	• Healthy Babies Initiative/Also combines with Care Management Organization	$3.7M	$1.4M	**Pros:** • Better health outcomes • Long-term savings (by having babies healthier)	Could be tied into CMO; Could be a CMO-driven initiative	• Implementation Timeline: 12-18 mo. • Savings Realization Timeline: 2-4 years • Changes: Systems (possibly) • Communication: Providers, Members
• ER utilization	• Working with ER departments to identify high utilizers, identify drivers of high utilization, & encourage appropriate treatment settings • Adult (non-ICF-MR) dental covers: o Acute surgical care following traumatic accident o Oral surgical procedures not involving dentition & gingiva o Tooth extraction if posing a serious health threat or during radiation therapy o Treatment to relieve	• Allow dental benefits for individuals using the ED for dental services	($8.4M)	($3.2M)	**Pros:** • Address dental needs to prevent future costs • Better health outcomes **Cons:** • Initial costs	Could be tied into CMO; Could be a CMO-driven initiative	• Implementation Timeline: 12-18 mo. • Changes: Systems Communication: Providers, Members
		• Expand on current initiatives and use findings to identify and mitigate high utilizers	N/A	N/A	**Pros:** • Ensure delivery of services in appropriate setting • Reduce hospital ER costs	See above	• Implementation Timeline: Current • Changes: Systems • Communication: Providers, Members

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	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• ER utilization (cont.)	pain, eliminate infection, or prevent imminent tooth loss ○ Other dental services (i.e. full & partial dentures, medically necessary, services that would be more cost-effective than alternative treatment for same condition)						
Long Term – Coordinated, quality services for Maine's most vulnerable citizens							
• Capitation for top 20%	• N/A	• Aggressive case & disease management • Home & community-based care • Continually & periodically re-evaluate clients to assure appropriate level of care • Carve outs • Reduce waitlist • Risk adjustment • Performance bonus for meeting quality incentives • Withhold to assure	$45.9M	$17.2M	**Pros:** • Increased coordination • Contracting strategies to improve performance • Prevent disease progression, avoid hospitalization & institutionalization • Members able to stay in their home/community • Cost savings • Ensure that members receiving appropriate level of care • Specialty care provided by experienced providers • MCOs/HMOs will not be penalized for taking higher-risk members (for Risk adjustment) • Incentive for providers to provide quality care (for Performance bonus)	Could be tied into HMO/MCO; Could be a HMO/MCO-driven initiative May have some challenges coordinating care with MCO/HMO (for Carve outs)	• Implementation Timeline: 18-24 mo. • Savings Realization Timeline: 1-3 years • Changes: Systems • Communication: Providers, Members • Document: RFP process, Contract development, HMO/MCO readiness review, Quality measures, Determine bonus (for Performance bonus)

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• Capitation for top 20% (cont.)		that process measures achieved			**Cons:** • State resources required for oversight • Some studies have not shown cost savings • Potentially fragmented care (Carve outs) • May require administrative/actuarial assessment & modifications (for Risk adjustment) • Financial & administrative burden (for Performance bonus)		
Long Term – Effective & efficient use of services							
• Elective inductions prior to 39 weeks[xxxviii]	• N/A	• Put "hard stop" to elective inductions prior to 39 weeks gestation	$0.85M	$0.32M	**Pros:** • Reduced C-section rate • Better birth outcomes • Shorter labors **Cons:** • Challenge on how to implement	N/A	• Implementation Timeline: 3-6 mo. • Savings Realization Timeline: 6-12 mo. • Changes: Systems • Communication: Providers • Document: SPA
• Radiology Benefits Manager (RBM)[xxxix]	• (*PA requirements link from MaineCare manual broken*)	• Implement Radiology Benefits Manager Require PA • Utilize clinical decision support (CDS) – no PA • Implement real-time online interactive PA	$2.5M	$0.9M	**Pros for RMB:** • More effective management of radiology services • Reduce incidence of medically unnecessary services • Cost savings from prevented services **Cons for RBM:** • Costs shifted to providers • Administrative burden on providers for PAs **Pros for CDS:**	May overlap with CMO and MCO models, and short-term PA	• Implementation Timeline: 18-24 mo. • Savings Realization Timeline: 2-4 years • Changes: Systems • Communication: Providers, Members • Document for RBM: RFP process, Contract development • Document for CDS and

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
• RBM (cont.)					• Reduce incidence of medically unnecessary services • Can integrate into EHRs or access via the Web **Cons for CDS:** • Administrative burden on providers to go through CDS • May have lower savings than RBM **Pros for online interactive PA:** • Reduce incidence of medically unnecessary services • Requests meeting criteria automatically approved in real time		online interactive PA: Develop criteria, (If vendor) RFP process, Contract development
• Care Coordination for LTSS	• Plan to implement Care Coordination teams in 2013	• N/A	N/A	N/A	N/A	May be duplication of PCCM/MCO services	N/A
• Cost barrier reduction	• N/A	• Eliminate co-pays	($9.2M)	($3.5M)	**Pros:** • Encourage primary care utilization		
TOTAL SAVINGS for Long-term strategies			**$34.9M**	**$13.0M**			
Additional Task Force Strategy Recommendations							
• Program Integrity	• N/A	• No cash for controlled substances	Addtl. research needed	Addtl. research needed	**Pros:** • Discourage improper use of controlled substances **Cons:** • Potential administrative burden for pharmacies		• Implementation Timeline: 6-12 mo. • Savings Realization Timeline: 12+ mo. • Changes: Systems, Human resource expansion or redirect • Communication: Data review team, Internal policy team

	Previous Initiatives	Proposed Changes	Predicted Savings		Impact	Impact on Long-Term Strategies	Implementation Requirements
			State & Federal	State[xxxv]			
							• Document: Develop criteria
• Pharmacy • Pharmacy (cont.)	• Eliminate smoking cessation benefits	• Reinstate smoking cessation benefits	Addtl. research needed	Addtl. research needed	**Pros:** • Long-term cost savings likely • Improved health **Cons:** • Short-term cost		• Implementation Timeline: 6-12 mo. • Savings Realization Timeline: 12+ mo. • Changes: Systems • Communication: Providers, Members • Document: Develop criteria, SPA
TOTAL SAVINGS for Additional Task Force Strategy Recommendations			Addtl. research needed	Addtl. research needed			
TOTAL SAVINGS for Short-, Mid-, and Long-term strategies combined[xl], [xli]			***$122.2 M***	***$45.9M***			

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[xvi] Truven Health Analytics, The Growth of Managed Long-Term Services & Supports (MLTSS) Programs: A 2012 Update. July 2012.
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[xxix] State share estimated at 37.5% of State and Federal savings projections
[xxx] State share estimated at 37.5% of State and Federal savings projections
[xxxi] Data is not available to estimate potential savings.
[xxxii] State share estimated at 37.5% of State and Federal savings projections
[xxxiii] Elective induction strategy may overlap with short-term savings.
[xxxiv] Radiology strategy may overlap with short-term savings.
[xxxv] State share estimated at 37.5% of State and Federal savings projections
[xxxvi] This figure would grow annually as specialty drug spend is expected to comprise around 40% of total pharmacy spend by 2015.
[xxxvii] Data is not available to estimate potential savings.
[xxxviii] Elective induction strategy may overlap with short-term savings.
[xxxix] Radiology strategy may overlap with short-term savings.

[xl] As strategies may overlap, savings may also overlap

[xli] Limitations: Savings estimates are based on preliminary information, and actual savings may vary based on final policy and implementation.