Idaho Medicaid Managed Care Updates
Department of Health and Welfare
HB0777, Regular Legislative Session 2022
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INTRODUCTION

This report provides updates to the Legislative Services Office and the Division of Financial Management on Medicaid's progress toward integrating managed care approaches into the state Medicaid system as required by HOUSE BILL NO. 777 of the 2022 Idaho legislative session.

Over State Fiscal Year 2022, the Division of Medicaid has been focused on improved contract oversight with current managed care contracts; procurement activities; and looking towards the future of the Medicaid delivery system to ensure a robust array of available services and providers while promoting efficient administration. This report outlines updates for each current Medicaid managed care products, including other at-risk programs, administered by the Division of Medicaid. Going into SFY23, the Division has begun an evaluation of delivery system changes, to include a potential enhancement of the current managed care footprint within Idaho. This evaluation will include an assessment of impacts to overall cost effectiveness; Medicaid provider impacts; internal organizational changes; and necessary federal authorities.

INTEGRATED MANAGED CARE FOR DUAL ELIGIBLES

Idaho has two at-risk managed care programs that provide coordinated care for members dually eligible for Medicare and Medicaid. As of November 2022, there are 26,029 dual eligible members enrolled in a managed care program, representing 80.7 percent of dual eligible members statewide.

Medicare-Medicaid Coordinated Plan (MMCP)

The MMCP is an integrated healthcare plan exclusively for Idaho dually eligible individuals. The plan includes most Medicaid benefits along with Medicare benefits and an integral care management component. 12,725 members are voluntarily enrolled with the MMCP as of November 2022, reflecting a 12 percent increase from November 2021. Two plans, Blue Cross of Idaho and Molina Healthcare of Idaho, currently participate in the program. As of January 1, 2022, the MMCP is available from both participating vendors in 21 Idaho counties. One vendor, Blue Cross of Idaho administers the MMCP in three additional counties.

Idaho Medicaid Plus (IMPlus)

IMPlus, a managed care program for dual-eligible participants for whom the more integrated MMCP may not be the best fit. IMPlus was successfully launched over the course of 2018-2019 using a phased-in approach. Under this program, all Medicaid benefits for dual eligible participants are provided through a managed care plan. IMPlus also includes care management benefits to help people with Medicare and Medicaid eligibility effectively manage their health needs.

Enrollment into IMPlus is mandatory for most dual eligible participants who have not enrolled in the more integrated MMCP. Mandatory enrollment means the participant must choose one of the two participating Health Plans to administer their Medicaid coverage (their choice of Medicare coverage is not affected). Participants that do not actively select a plan are automatically enrolled with one of the two participating plans. IMPlus serves 13,304 members statewide as of November 2022.

Opportunities for Further Integration and Transparency

Idaho Medicaid notified the Centers for Medicare and Medicaid Services (CMS) and participating duals' plan vendors of its intent to take advantage of new federal regulations and guidance announced in August 2022. These regulation changes allow the state to work together with CMS and participating vendors on development and approval of integrated materials for enrollees, including annual Summary of Benefits documents, prescription drug formulary, and a combined provider and pharmacy directory. While these materials will not launch until the 2024 contract year, the Medicaid team will be working with the vendors and CMS over the course of 2023 towards this goal. With this commitment, Idaho will be granted access to the CMS Health Plan Management System, which houses Medicare data on vendor quality and performance metrics. This initiative will make it easier for participants to understand and navigate the full scope of the benefits available under the integrated program, in addition to enhancing transparency on performance across both the Medicare and Medicaid components of the program.

Preparing for Changes to Contracting Approach

In July 2022, Medicaid coordinated with the Division of Purchasing to publish a Request for Information to gather input from potential vendors on a change to the program's historical contracting approach. Since the inception of the duals' programs, Medicaid adopted an any-willing and qualified contracting approach such that any carrier that demonstrated the ability to administer the programs, met statutory requirements and obligations, and successfully complete operational readiness review for the state could enter the market. The purpose of a shift to a competitively procured model is intended to further enhance the efficiency and effectiveness of the duals' programs and build upon lessons learned from the original model. Medicaid continues to work through this procurement.

IDAHO BEHAVIORAL HEALTH PLAN (IBHP)

Idaho Medicaid has operated a risk-based outpatient behavioral health managed care program since late 2013. Coverage includes outpatient mental health and substance use disorder services as well as coordination of care and transitions between outpatient and inpatient services. All Medicaid members are automatically enrolled in the plan, except those who receive comprehensive services under managed care plans for dually eligible individuals. Services delivered under the IBHP are based on evidence-based practices and promote integrated physical and behavioral healthcare and individualized person-centered service plans. The current IBHP managed care contractor is Optum Idaho. Program highlights for this reporting period include the following areas.

Youth Empowerment Services Initiative

The Department of Health and Welfare's divisions of Medicaid and Behavioral Health continue to work toward improvements to the system of care for children's mental health in partnership with stakeholders. The new system of care for children's mental health is an outcome of a class action lawsuit and the resulting settlement agreement. This work is organized within the on-going Youth Empowerment Services (YES) initiative. The YES framework uses a youth and family-centered, team-based, and strengths-focused approach for early identification, treatment planning, and implementation of mental health care.

Substance Use Disorder Services
Medicaid and Optum Idaho continue to work to further integrate Substance Use Disorder (SUD) and Mental Health services through improved care coordination, supports, and additional SUD services provided under the authority of the Idaho Behavioral Health Transformation Waiver.

Procurement Initiative
The Division of Medicaid is working in partnership with the Division of Behavioral Health (DBH) and the Idaho Department of Juvenile Corrections (IDJC) to develop a new and innovative approach to enhance the quality and availability of behavioral healthcare services across Idaho. Much of this work will be effectuated through the new Idaho Behavioral Health Plan contract following an extensive and thorough re-procurement process. The new contract will encompass both Medicaid and non-Medicaid services currently provided by Medicaid, DBH or IDJC, including the integration of inpatient, outpatient, and SUD behavioral health services within a managed care delivery model. The Department is currently working through the procurement process to award this contract.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)
Idaho Medicaid operates a statewide risk-based Non-Emergency Medical Transportation (NEMT) program through a brokerage contract with Medical Transportation Management (MTM). The Idaho NEMT program covers transportation to and from healthcare services for Medicaid-eligible members who have no other means of transportation. Updates for the NEMT program include the following.

Customer Service Enhancements
NEMT continues to improve customer service experience by addressing participant and program inquiries on the phonelines and group email box and by providing information, education, and outreach to related internal and external teams and organizations. Additionally, Medicaid works daily with MTM to assist with booking trips, ensuring complaints are thoroughly investigated, and improving stakeholder communication. Medicaid has been working to stay abreast of transportation trends and is collaborating with MTM towards a enhancing every participant's experience in securing reliable and safe transportation.

Program Quality
Medicaid continues to improve upon oversight of the daily operations and performance of the NEMT contract. The improved oversight has resulted in more frequent and effective communication between Medicaid, participants, stakeholders, and advocates. Improved communication has ensured rapid and thorough responses to reports of incidents and complaints, allowing for quick response to situations and prevention of such situations to become widespread. Enhanced oversight of the contract performance permits Medicaid to closely monitor trend data and quality reports to analyze utilization of various modes of transport including NEMT provider network, mileage reimbursement, and use of other transportation networks (where available, appropriate to condition, and efficient use of resources) in regions around the state. Medicaid conducts quality monitoring on a regular basis to continue to identify areas for improvement to mitigate obstacles for participant transportation.

Procurement

This past year Medicaid has worked towards awarding a new NEMT contract. Stakeholder feedback has driven focus on contractor responsiveness, reliability, and overall quality of the NEMT program. The contract will provide the structure for the contractor to exercise prompt and effective coordination with participants, regulate a safe, trained, and professional network of transportation providers, and a reliable system to support trip requests, trip scheduling, and accurately report trip data. These enhanced areas of contract oversight are aimed to ensure safety, reliability, efficiency, and veracity of data reporting. The Department is currently working towards contract award.

IDAHO SMILES DENTAL PROGRAM

Idaho Medicaid has operated a statewide risk-based dental program since 2015. Coverage includes preventive, diagnostic and therapeutic benefits. Idaho Medicaid's goal for the dental program is to provide for members' dental needs while ensuring quality service, maintaining consistency of care, maximizing use of technology, providing timely and dependable service delivery. The Idaho Smiles Dental program continues to be administered by MCNA Dental. The Division of Medicaid and Division of Purchasing are currently working through procurement development activities for this program. The contract with MCNA is expected to be extended into calendar year 2025. Program highlights for this reporting period include the following.

Open Provider Network Approach

MCNA Dental continues to operate an open provider network continually inviting eligible dental providers to join the 664 providers currently serving the Medicaid population in Idaho.

Dental Provider Outreach

MCNA continues to conduct in-person and telephone outreach to dental providers not already accepting Medicaid members to increase access for adult members. This is especially important as the number of adult participants and demand for dental services grew with Medicaid Expansion in January 2020. However, Idaho continues to have provider capacity challenges for specialty dental care such as oral surgery and endodontist services for both children and adults. In-person and telephone outreach efforts continue to improve access needs. Additional reporting on this activity from July to September 2022 was conducted with 203 non-network providers; providers were contacted to participate in Idaho Medicaid's dental network, 95 percent of these providers cited reimbursement rates being too low to consider enrolling in the plan.

Dental Benefits Utilization

For Federal Fiscal Year 21, approximately 52 percent of enrolled children ages 0-20 and 13 percent of individuals 21 and older received a preventive dental service. The rate of individuals receiving preventive dental care has stayed steady for children over time and has increased by approximately two percentage points for adults. MCNA is currently operating multiple provider and member focused activities to increase utilization of preventive services. Member focused activities include patient reminder calls and text messages when a member is overdue for a dental service.

VALUE CARE ORGANIZATIONS AND HEALTHY CONNECTIONS VALUE CARE (HCVC)

The HCVC program was developed in collaboration with Medicaid providers to move away from a fee-for-service payment model to a value-based payment model that rewards providers for improving the quality of care they give to Medicaid members and controlling Medicaid costs. Under HCVC, value care organizations (VCOs), comprised of primary care providers and hospital systems, are held accountable for meeting a total cost of care target and making incremental improvements on six quality measures.

HCVC was intended to implement on July 1, 2020; however, the implementation was postponed until January 1, 2022 due to the COVID-19 pandemic. During Performance Year 1 (Calendar Year 2022), HCVC covered approximately 250,000 member lives. The program excluded the Medicaid expansion and dual eligible populations. In Performance Year 2 (Calendar Year 2023), the program will include the expansion population. During the first two performance years, VCOs have the option to select upside gain share only (maximum 5% savings) or symmetrical savings and loss risk sharing up to 80%. VCOs that select symmetrical savings and loss risk sharing will share in savings when cost and quality targets are met or share in losses when the cost target has not been met. The goal is to have all VCOs participating under a risk-sharing agreement in Performance Year 3.

Medicaid collaborates with VCOs and hosts monthly meetings with VCO leaders and quality experts to monitor the program's performance, share best practices and make recommendations for future changes to the program. The program is planning to do a full evaluation of Performance Year 1 in the fall of 2023, once data are complete after a six-month claim runout period.