Idaho Medicaid Managed Care Updates
Department of Health and Welfare
HB0369, Regular Legislative Session 2023
December 1, 2023

INTRODUCTION

This report provides updates to the Legislative Services Office and the Division of Financial Management on Medicaid's progress toward integrating and sustaining managed care approaches into the state Medicaid system as required by HOUSE BILL NO. 369 of the 2023 Idaho legislative session.

Over the past year, the Division of Medicaid has continued to focus 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 and quality services. The Division also worked closely with our managed care partners though the Public Health Emergency unwinding to promote continued access to medically necessary services across Idaho. In addition to this, the Division supported the Medicaid Managed Care Task Force enacted through House Concurrent Resolution 9 of the 2023 Legislative Session and further direction in the 2024 legislative session.

INTEGRATED MANAGED CARE FOR DUAL ELIGIBLES

Idaho has two risk-based managed care programs that provide coordinated care for members dually eligible for Medicare and Medicaid. As of November 2023, there are 23,610 dual eligible members enrolled in a managed care program and over 3,000 members served by Medicaid's fee-for-service network who mostly reside in Idaho's remote counties.

During the 2023 contract period for both programs, Medicaid bolstered minimum outcome measures in addition to minimum face-to-face care coordination visits for individuals residing in Skilled Nursing Facilities to support transition to the community when appropriate. Moving into 2024, both program's contracts will contain risk mitigation strategies because of the continued fluctuation in program membership. Medicaid intends to move both managed care products to full risk-based programs in 2025.

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. As of November 2023, roughly fourteen thousand members are voluntarily enrolled with the MMCP.

Two plans, Blue Cross of Idaho and Molina Healthcare of Idaho, currently participate in the program. The MMCP is available from both participating vendors in twenty-one (21) Idaho counties. One vendor, Blue Cross of Idaho administers the MMCP in twelve (12) 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. As of November 2023, IMPlus serves close to ten thousand members statewide.

Opportunities for Further Integration and Transparency - MMCP

Idaho Medicaid notified the Centers for Medicare and Medicaid Services (CMS) and participating duals' plan vendors of our 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. These materials will not launch until the 2024 contract year, the Medicaid team has continued to work towards this goal with CMS. This commitment allows Idaho 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.

Procurement Preparation and Development – MMCP and IMPlus

Medicaid has worked closely with national experts to assist with the preparation and development of an upcoming procurement for these programs; this will be the first time these contracts will be competitively procured to ensure the best value for eligible participants and Idaho Medicaid. The solicitation will take lessons learned and best practices in operating the duals program over the past decade and look to make enhancements to several areas to drive participant health outcomes and better contain program cost. As part of procurement development, the Division focused intently on stakeholder engagement and feedback to ensure we are responsive to the needs of those being served and providers rendering services. The Division of Medicaid sent out flyers to participants, providers, and various stakeholders with links to an online survey and held multiple virtual stakeholder engagement sessions in August and September of 2023. It is anticipated that the Request for Proposal (RFP) for both MMCP and IMPlus will be released in early 2024.

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. Care coordination and service delivery of SUD services will also continue to improve through the implementation of the recently procured new IBHP contract which includes consolidation of utilization management activities, expanded crisis system of care, and a more robust care coordination system.

IBHP Procurement
The Division of Medicaid is working in partnership with the Division of Behavioral Health (DBH) and the Idaho Department of Juvenile Corrections (IDJC) to implement a new and innovative approach to enhance the quality and availability of publicly funded behavioral healthcare services across Idaho through a new IBHP prepaid inpatient health plan (PIHP). The new contract encompasses both Medicaid and non-Medicaid services currently provided by Medicaid, DBH or IDJC, including the integration of behavioral health inpatient, outpatient, and substance use disorder residential services within a managed care delivery model. Following an extensive and thorough re-procurement process, the contract was awarded to Magellan Health in June of 2023 and the department along with the IDJC are working through implementation activities with an anticipated go-live date in 2024.

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. A new contract was awarded in January 2023 with service go-live September 1, 2023. 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 program email 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 resolved, and improving stakeholder communication. Medicaid has been working to stay abreast of transportation trends and is collaborating with MTM towards enhancing every participant's experience in securing reliable and safe transportation. During implementation of the new contract this past year, Medicaid worked with MTM to implement a team of dedicated, multifaceted customer service personnel that can thoroughly assist members, facilities, and other stakeholders with urgent or complex matters on a local level.

Program Quality
Medicaid continues to improve upon oversight of 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 incident reports and complaints, allowing for quick responses to situations and prevention of such situations to become escalated or 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. During the past year, NEMT has experienced significant improvements in reliability of members ability to book and complete trips successfully as well as reductions in complaints related to service delivery. The program works continuously to monitor and mitigate risks of fraud, waste, and abuse while also ensuring that participants are set with the most reliable transportation for their medical needs.

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, and providing timely and dependable service delivery. The Idaho Smiles Dental program continues to be administered by Managed Care of North America (MCNA) Dental. The Division of Medicaid and Division of Purchasing are currently working through procurement development activities for this program. The contract with MCNA was recently extended to October 2025. Program highlights for this reporting period include the following.

Open Provider Network Approach

MCNA Dental continues to operate an open provider network encouraging additional eligible dental providers to join the 664 providers at 523 facilities who currently serve the Medicaid population in Idaho. MCNA conducts outreach continuously to recruit and onboard providers in various specialties to provide covered services as network providers.

Dental Improving Provider Participation

In Spring 2023, using funds budgeted in the contract, fees for 16 of the most frequently utilized services for adults and children were increased by MCNA, in efforts to encourage access in the most frequently utilized services. In addition to this effort, the program and its contractor continue to look for ways to streamline processes related to the administrative burdens associated with prior authorizations, case reviews and claims submission and payment. Monthly the contractor conducts outreach efforts consisting of in person and phone efforts, to recruit providers in the various disciplines into the network, and to collect information as to why providers may not be interested in participating in the Medicaid network.

Dental Benefits Utilization

For Federal Fiscal Year 2022, approximately 51 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. One such initiative is helping members identify a dental office that participates in the plan and is within appropriate distance to the member that can serve as the member's dental home; through this outreach effort 319,000 members were assigned to a dental home in 2023. Additional member focused activities include patient reminder calls and text messages when a member is overdue for a dental service, as well as staff that can assist members find care in challenging or difficult circumstances.

Dental Procurement

In preparation for procurement development, the Division of Medicaid engaged in extensive stakeholder outreach to understand areas of opportunity to improve through the next contract. During Fall 2023, Medicaid conducted three virtual stakeholder engagement sessions open to providers, participants and interested stakeholders. The Division also sent out an engagement survey to a sample of participants and providers. Information acquired from these engagement initiatives will influence the upcoming Request for Proposal (RFP), expected to be posted in early 2024. To accommodate for this procurement timeline, the current dental contract was extended to October 2025, when the new contract and awarded vendor is anticipated to go live.

VALUE CARE ORGANIZATIONS AND HEALTHY CONNECTIONS VALUE CARE

The Healthy Connections Value Care (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 costs to Medicaid. 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 quality measures.

HCVC was implemented on January 1, 2022. During Performance Year 1 (Calendar Year 2022), the program excluded the Medicaid expansion and dual eligible populations and covered approximately 250,000 member lives. In Performance Year 2 (Calendar Year 2023), the Medicaid expansion population was added; the program continued to cover approximately 260,000 member lives after the public health emergency unwinding process. During the first two performance years, VCOs had 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. In performance year 3, all VCOs will participate under a symmetrical risk-based agreement with a minimum risk share of 15%. Additionally, the quality performance program will be expanded. HCVC will monitor additional measures and VCOs will have the option to select optional measures for which they are held accountable.

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. In Performance Year 1, ten VCOs were able to share in savings by beating their individual gross target costs and quality measure targets. After nearly $11 million in net distributable savings to the VCOs, the Department retained nearly $50 million in settlement savings*. All VCOs were held accountable for 3 or 6 quality measures. Across all VCOs, 67% of quality measures saw improvement and 45% of all quality targets were achieved.

The HCVC program is currently preparing a full evaluation of Performance Year 1 and will continue to monitor the program's performance and intents to make changes to optimize cost control and improve health outcomes.

*Retained settlement savings is based on PMPM level calculations of Gross Target Cost. Gross Target Cost is built from the 2019 base year and the application of a negotiated Program Change Factor. The negotiated Program Change Factor might not reflect best estimated financial projections due to being a negotiated assumption for the settlement calculation.