Idaho Medicaid Delivery System Overview

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Medicaid Delivery Systems Overview

Medicaid Delivery Systems

There are two delivery system models used to administer the Medicaid program nationally

- Fee-for-Service
- Managed Care

Fee-for-Service

The State Medicaid Agency contracts directly with providers and reimburses for delivery of services at a fixed rate.

State takes on responsibility to administer all functions of the program via state staff and contractors including but not limited to:

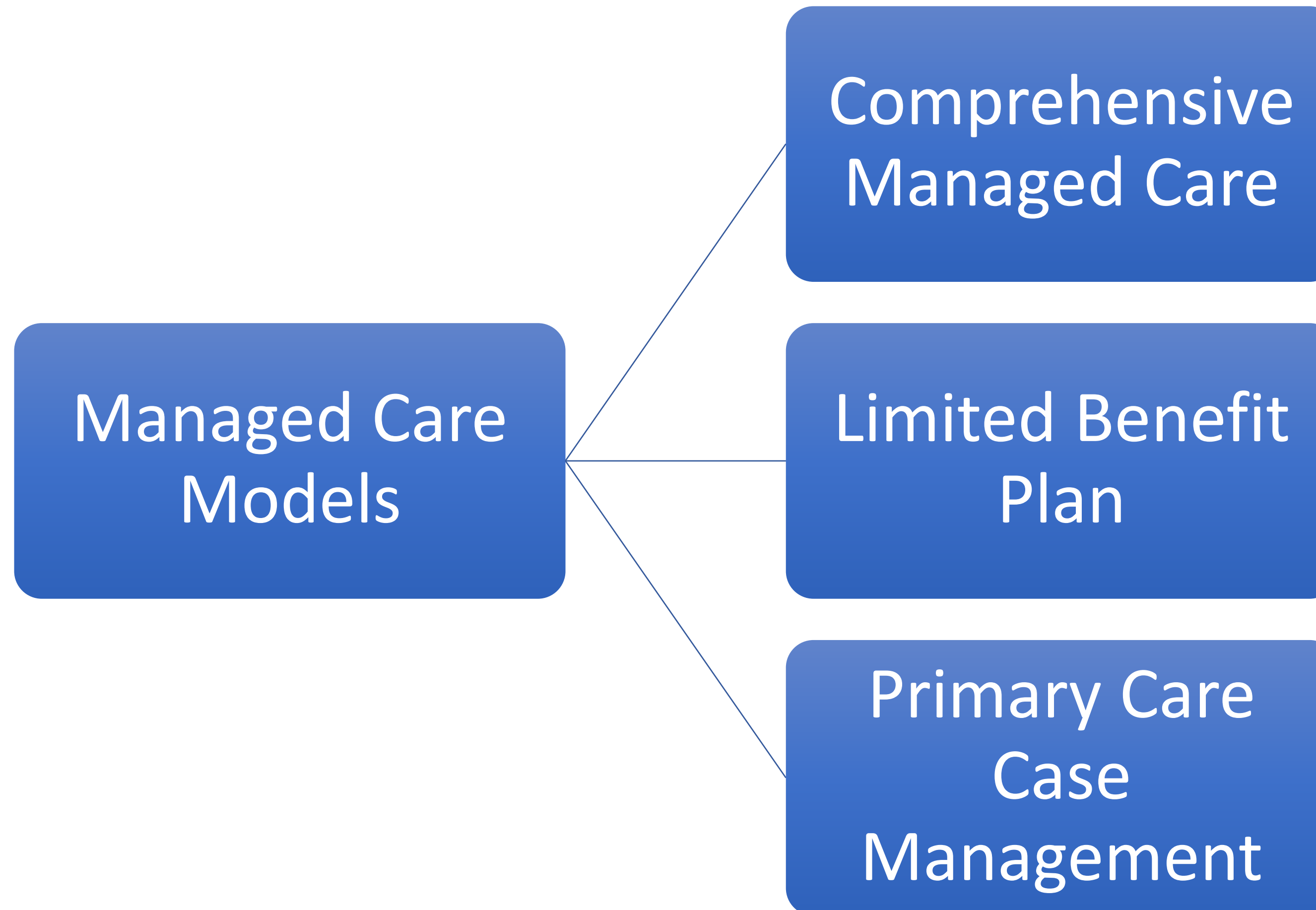
- Provider network management and provider reimbursement
- Utilization management
- Care coordination and case management
- Quality reporting and quality improvement initiatives
- Data analytics
- Policy work- following state and federal guidance and updates, managing federal authorities, required reporting, updating rules, updating guidance document

Fee-for-Service Considerations

- Contracts directly between state and providers although many functions are contracted out (e.g. claims payment)
- Providers can directly take on risk in value-based contract arrangements with the state
- Lesser degree of budget certainty (not a capitated model with a set rate)
- Limitations to care coordination and case management (within current model)
- Hospitals and nursing facilities have rates supplemented through the Upper Payment Limit payment
- Regardless of delivery system design, the state will always need infrastructure for fee-for-service
  - Some populations are not required to move to managed care (tribal members)
  - Home and community-based services may be better suited to stay within a FFS structure

Managed Care

There are multiple managed care models



Comprehensive Managed Care

State contracts with Medicaid managed care plan(s) to cover all or most services for Medicaid beneficiaries

The plan is paid a set capitated amount (Per Member Per Month)

The plan takes on the financial risk within the established capitation payment

Comprehensive Managed Care Cont

- Most managed care plans provide integrated care (physical and behavioral health) unless the state has carved specific services out.
- Typically a full risk arrangement but can have some risk mitigation contract elements as the contract is starting or if there is an uncertain event that may change utilization in an unpredictable manner (e.g. COVID-19)
- Capitation payment may result in profit or losses for the plan based on management of the population

Limited Benefit Plan

State contracts with Medicaid managed care plan(s) to cover specific services or populations (e.g. dental)

The plan is paid a set capitated amount (Per Member Per Month)

The plan takes on the financial risk within the established capitation payment

Primary Care Case Management

Case Management Fee	• Medicaid beneficiaries are assigned a primary care provider who is paid a fixed case management fee to support management of the patient's care
Financial Risk	• No financial risk for the provider unless established through a value-based contract
Reimbursement	• Provider continues to be reimbursed via fee-for-service with the additional case management fee

Idaho Medicaid Healthy Connections Value Care Program leverages PCCM as the foundation of the program. Providers are in a value-based contract where they can gain or lose funds based on performance while receiving base reimbursement via fee-for-service and a primary care case management fee.

Managed Care Considerations

- Intermediary contracts vs. state contracting directly with providers
    - Plan may profit or lose based on their management of the population
- Value-based contracts can be required with providers through contract terms to further control costs and promote value
- Care coordination is required in contracts and plans hire care coordinators/case managers to manage utilization of services and ensure appropriate delivery of care
- Additional plan resources may allow for state to be more agile in implementation of new initiatives and quality efforts via contract
- Potential for greater degree of budget certainty with set capitation rate
    - Will increase with utilization and cost

Managed Care Considerations Continued

- Still requires state resources to appropriately oversee managed care contracts
- Competitive procurement process
  - Best value to the state
  - Multi-year process
  - Large contracts
- Upper Payment Limit supplemental payments with providers are no longer available per federal regulation
  - UPL is based on fee-for-service reimbursement structure
  - These are converted to directed payments through managed care plans with required quality measures
- 41 states have moved to Medicaid managed care

Capitation Payment Overview

Per Member Per Month x Total Members = Capitation Payment

Capitation payment is federally required to be actuarily certified annually. Rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract.

Capitation Payment Assumptions

- Emerging claims/utilization experience from prior period
- New services or service changes
- New populations or changes in risk pool
- Program financial risk
- Administrative costs

Provider contracts and rates are between the managed care plan and the provider but must remain within the capitation payment

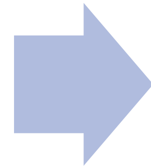
Regular review of Medical Loss Ratio= Ratio of medical spend vs. administrative spend (target 85/15)

Current Idaho Medicaid Delivery System

Legislation History

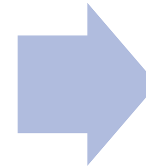
H221 (2011)

- Idaho Code 56-263 and 56-265
- Established managed care requirements
- Duals plan
- Executive Order 2011-01 Establishing the Behavioral Health Interagency Cooperative
- Idaho Behavioral Health Plan



H128 (2017)

- Value-based arrangements with providers outlined in 56-265



H351 (2020)

- Value-based arrangements with hospitals for inpatient and outpatient services

What Models Does Idaho Medicaid Use?

Comprehensive-risk managed care

- Contracts for dually eligible (Medicare and Medicaid beneficiaries)
- Increasing risk in the contract (removing risk mitigation strategies in CY24)

Limited benefit managed care

- Idaho Behavioral Health Plan
- MCNA Dental Plan
- MTM for non-emergency medical transportation

Primary Care Case Management

- Health Connections Value Care
- Providers base reimbursement is still fee-for-service
- Paid monthly case management fee
  - Tier 1: $3 PMPM (basic primary care)
  - Tier 2: $7 PMPM (care coordination)
  - Tier 3: $9.50 PMPM (PCMH, extended hours)
- Opportunity to gain or lose based on selected risk

Traditional Fee-for-Service

- Physical health services for all non-dual populations
- Inpatient behavioral health services
- Pharmacy
- Home and Community Based Services

Healthy Connections Value Care

First performance year 2022

- Final data available from year 1 later this summer

Primary Case Management is the foundation of the model

- Primary care providers paid a monthly case management fee for managing the care of attributed participants

Value-based contract creates opportunity to earn additional savings through meeting a cost target and meeting quality measures; also possibility of loss

Providers select level of upside/downside risk

- Option to select zero risk in years 1 and 2 due to pandemic and introduction of Expansion population
- Up to 80 percent upside/downside risk
- Not all services included in the model (e.g. pharmacy, long-term care not included)

Areas of Opportunity

- Overseeing multiple delivery models is very challenging with limited staff resources
  - Prioritization of oversight in a primary delivery model
- Difficult to implement cost containment activities within current system and with multiple models
- Utilization management, care coordination, case management
  - Within given delivery system
  - Contracted state or health plan resources
- Capitated model to promote greater budget certainty
  - Providers or health plans