



State of Idaho, Division of Purchasing, Medicaid Cost Containment

FINAL REPORT

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Executive Summary

The Idaho Medicaid program is operationally sound and benefits from a strong, dedicated, and lean administrative team. The program as currently operated and constructed could likely continue in the near term with minimal disruption. However, the financial pressures and overall program structure create longer term instability and risk. Therefore, the State of Idaho issued a Request for Proposals (RFP) seeking cost containment and revenue maximization recommendations for Medicaid, to be articulated in two separate reports addressing both short-term and long-term.

Evaluation Overview

The evaluation leveraged a substantial commitment by the Idaho’s Executive Office of the Governor’s Division of Financial Management (DFM) and the Idaho Department of Health and Welfare’s Division of Medicaid (IDHW) to understand the current Idaho health delivery system from a beneficiary, provider, payor, and regulator point-of-view. The staff from these two state agencies provided invaluable insight into the nuances of Idaho’s publicly funded healthcare system. As part of this review, staff described past cost containment efforts, the challenges facing Idaho’s Medicaid program, such as the rural and frontier nature of the state, and other advantages that can be used as a foundation for future recommendations.

The findings and recommendations were developed by assessing the totality of information collected including an in-depth review of IDHW programs, policies, and procedures, and an analysis of targeted data reports. Given the short turnaround time for this report, further interviews with stakeholders were not possible. However, IDHW should engage with specific stakeholder groups, including consumers, families, caregivers, and providers prior to implementing any of the recommendations contained within this report. These stakeholders will have valuable perspectives regarding their experiences with the current system and potential reforms.

As described in this report, demand for long-term systemic savings continues to be a focus of the Idaho Legislature and will likely remain so until Idaho implements a comprehensive approach to addressing rising Medicaid costs. Although this is the culmination of this scope of work, this report can serve as a starting point as IDHW broadens its work to assess how changes to current programs and policy can impact these costs.

Figure 1: Idaho Project Timeline



Summary of Findings and Recommendations

In December 2022, the Interim Report was submitted, providing specific, short-term (one year or less) initiatives to achieve at least \$41.5 million in General Fund savings for the Medicaid program. The research conducted for that report and further analysis produced longer-term options (one to three years) for the program presented in this Final Report.

This is an important distinction: as required in the RFP, the recommendations in this report purposefully take the longer view, rather than the more immediate and limited scope of the Interim Report. Legislators noted this dynamic in committee hearings in February, expressing concerns regarding potential unintended impacts of policy decisions limited to the short term. While longer term reforms will also have impacts, they inherently allow for a more deliberative and holistic approach.

Overall, the Idaho Medicaid program is at a crossroads, with multiple care delivery and financing systems established incrementally over many years. The recommendations summarized below and described in further detail in the body of this report are designed to bring cohesion to the overall program structure while recognizing certain areas present greater opportunity, and risk, than others.

Table 1: Summary of Recommendations

Program Area	Proposed Recommendation(s)	Action (Legislative or Administrative)	CMS Approval Needed?
Program Integrity	• Monitor and evaluate performance of the data warehouse	Administrative	No
	• Review MCO Fraud, Waste, and Abuse mitigation activities	Administrative	No
	• Utilize third-party vendors to conduct regular reviews of fee-for-service (FFS) program and provider activities	Administrative	No
	• Retain functional independence of the Program Integrity Unit	Administrative	No
Pharmacy	• Engage a Request for Information (RFI) process to provide the State with additional information and insight into pharmacy benefit administration	Administrative	No
	• Seek CMS approval of a SPA to enable value-based purchasing	Administrative	Yes
	• Retain a strong in-house pharmacy benefit administration program	Administrative	No
Developmental Disabilities Services	• Coordinate school-based services (SBS) claims with members' primary care providers	Administrative	No
	• Ensure sufficient community providers in areas where the local education agencies (LEAs) are not participating in the state's SBS program	Administrative	No
	• Introduce upside-focused value-based payment arrangements	Both	Yes
	• Conduct an audit of "Pass-through" requirements to ensure direct care workers receive intended wage increases	Administrative	No

Long-Term Services and Supports	<ul style="list-style-type: none"> • Increase the quality thresholds to award additional dollars under the Nursing Home Quality Payment Program 	Administrative	Yes
	<ul style="list-style-type: none"> • Review and amend the percentage of dollars earned for each reward tier 	Administrative	Yes
	<ul style="list-style-type: none"> • Transitioning HCBS services to a managed long-term care delivery system 	Both	Yes
School-Based Services (SBS)	<ul style="list-style-type: none"> • Implement a withhold of SBS claims to cover state operating and program improvement costs 	Administrative	No
	<ul style="list-style-type: none"> • Monitor California and other states as they consider and prepare for managed care for SBS. 	Administrative	No
Revenue Maximization	<ul style="list-style-type: none"> • Increase hospital assessment in accordance with upper payment limit and related initiatives and limits 	Both	Yes
	<ul style="list-style-type: none"> • Increase nursing home assessment up to (or just under) the federal 6% maximum 	Both	Yes
	<ul style="list-style-type: none"> • Evaluate directed payment program (DPP) opportunity to increase current hospital and nursing home provider reimbursement to the average commercial rate 	Both	Yes
	<ul style="list-style-type: none"> • Conduct high level analysis of a new MCO assessment opportunity 	Both	Yes
	<ul style="list-style-type: none"> • Evaluate ground ambulance provider assessment for private providers 	Both	Yes
Expanded Managed Care	<ul style="list-style-type: none"> • Following comprehensive stakeholder process, plan for and transition most of the remaining FFS populations and services (expansion, adult, and child) to comprehensive managed care, excluding <i>services for individuals with developmental disabilities or school-based services</i> 	Both	Yes

Some of these recommendations may require further initial investment before substantive savings are realized. Prioritization of these recommendations will ultimately be determined by state policy makers. However, if the recommendation to implement comprehensive managed care is considered, the impact of that policy choice on other recommendations should be reviewed to ensure alignment with any other selected initiatives.

Introduction

Sellers Dorsey, in collaboration with the State of Idaho’s Executive Office of the Governor’s Division of Financial Management (DFM) and Department of Health and Welfare’s (IDHW) Division of Medicaid, undertook an in-depth review of the State’s Medicaid program. This project was specifically designed to address concerns regarding substantial increases in General Fund spending necessary to maintain the Medicaid program by providing recommendations for cost containment, revenue maximization, and key investments.

The Request for Proposals (RFPs) issued by the State required two reports, the Interim Report and the Final Report, to be produced and delivered to DFM.

Sellers Dorsey was asked by DFM to appear before the Idaho State Legislature’s Health and Welfare committees in each House to formally present the high-level findings of the report and to answer questions posed by the committee.

The Interim Report¹ stressed that achieving the savings target in the short-term would require difficult choices primarily related to provider reimbursement and member benefits. Additionally, recommendations in the Interim Report may have unintended consequences related to member access, provider participation, and longer-term financial implications. Additional analysis to determine the impacts on access, reimbursement, eligibility, and coverage, was not conducted in the Interim Report primarily because it was outside of the scope of the RFP parameters. However, the Interim Report noted that additional analysis would need to be conducted before action on these recommendations could be taken.

The initial report deemed the “Interim Report”, specifically required Sellers Dorsey to provide short-term (one year or less) cost containment and revenue maximization initiatives to achieve at least a \$41.5 million reduction in annual General Fund spending in Medicaid. Sellers Dorsey conducted an in-depth analysis of various programmatic areas, conducted formal interviews, participated in follow-up, and informal exchanges with the State teams in production of the report. The Interim Report was initially delivered to DFM (formally the client of the RFP) on December 5th, 2022 and shared with the Legislature and other stakeholders shortly thereafter.

Both legislative committees recognized a need to balance the short-term and long-term recommendations while still managing the cost trend. The committees also expressed strong interest in the Final Report including a specific focus on the discussion of the role and scope of managed care.

The second report, deemed the “Final Report” and presented here, required cost containment and revenue maximization recommendations for the Medicaid program over the long-term (three years), with no specific financial or budgetary goal. These two elements are specifically articulated in the RFP:

Section 9.3 - The Contractor must conduct an evaluation and study of ongoing cost containment strategies for the IDHW’s Division of Medicaid. The strategies must address Medicaid growth in a way that supports the mission of IDHW. The Contractor must identify opportunities to assist DFM and IDHW with the implementation of policies that lead to practical and expeditious cost containment strategies for Idaho Medicaid;

¹ Michael Heifetz, “State of Idaho, Division of Purchasing Medicaid Cost Containment Interim Report,” Sellers Dorsey, December, 2022, <https://bloximages.chicago2.vip.townnews.com/idahopress.com/content/tncms/assets/v3/editorial/b/17/b171adae-a6fe-11ed-a0de-b74c6f00a753/63e2729e3fd25.pdf.pdf>

Section 9.3.5 - Advise on federal revenue optimization strategies for the State that exist under federal statutes, regulations, and/or policies Sellers Dorsey approached the Idaho Medicaid program at a high level, reviewing and assessing program functionality, stability, current and anticipated programmatic pressures, and other elements.

In addition, the RFP refers to managed care, noting “...while Idaho Medicaid has made some significant progress moving from volume and cost-based reimbursement to value-based payments and bolstering oversight processes of their managed care organizations (MCOs), the division recognizes the need to identify impactful cost-containment strategies to promote long-term budget sustainability.”

Report Overview

This evaluation leveraged a substantial commitment from Idaho DFM and IDHW to assist in understanding the current Idaho health delivery system from a beneficiary, provider, payor, and regulator point-of-view. Staff from DFM and IDHW provided invaluable insight into the nuances of Idaho’s publicly funded healthcare system. As part of this review, staff described past cost containment efforts, the challenges facing Idaho’s Medicaid program (such as the rural and frontier nature of the state), and other advantages that can be used as a foundation for future recommendations. These conversations, frequent correspondence, targeted data reports, and additional publicly available reports contributed to a firm understanding of the complex challenges faced by members, providers, and other stakeholders.

Figure 2: Report Development: Summary of Major Milestones

- An in-depth environmental scan of IDHW programs, policies, and procedures, including state budget document reviews and corroborating staff interviews, to determine whom each program serves, how services are provided, and the incentives and disincentives built into the existing delivery system framework.
- An analysis of program specific administrative data used by the Medicaid programs, with a special focus on enrollment patterns and service use within the Medicaid program from 2017 through 2021, the most recent years with complete service use data available for our analysis (in some cases more recent data was available and is noted within the paper). An initial list of additional data requests was developed and discussed at the kick-off meeting, and further refined throughout the duration of the project.
- Substantial input and collaboration from DFM and IDHW staff and subject matter experts, about their experiences with the system and their recommendations about needed system reforms.

The final set of findings and recommendations presented in this report were developed by comprehensively assessing the information and perspectives collected through the evaluation process. In consultation with IDHW, the initial assessment focused on short-term savings opportunities that could be realized through changes to the Medicaid program and policies. Idaho currently has several different reimbursement structures and delivery systems, including fee-for-service, managed care, and a value-based model. Like many other states, Idaho faces critical workforce and access challenges across the care continuum. This report identifies recommendations to address the rising cost of Medicaid services.

Report Format and Outline

As described in the RFP, this report focuses on a discrete set of recommendations DFM and IDHW may consider to bend the cost curve for overall Medicaid General Fund Expenditures. These recommendations are grouped into three areas of focus: (1) Specific Programmatic Area Opportunities; (2) Revenue Maximization and Supplemental Payment Program opportunities; and (3) Comprehensive Managed Care.

This report further addresses potential risks to the recommendations and presents supporting data regarding the current healthcare landscape, delivery system, provider payment initiatives, and managed care environment.

The report also includes multiple references to stakeholders and the need to engage such groups as any reforms are undertaken. A collaborative environment will improve both the substance of reforms and the success of those reforms as the State strives to achieve long-term savings and further the goals of the health care quadruple aim noted in Figure 3.

Limitations

The recommendations included in this final report are based on information and data from the State of Idaho, both publicly available resources and more customized information and data. Data that informs this report was derived from the State's Medicaid Management Information System (MMIS) and other State of Idaho and publicly available resources. Therefore, the analyses and recommendations may be impacted by any limitations, gaps, or errors in such information. The Sellers Dorsey project team encourages Idaho to carefully review these findings and conduct additional analysis to determine the overall viability and impact to the Idaho health care delivery system.

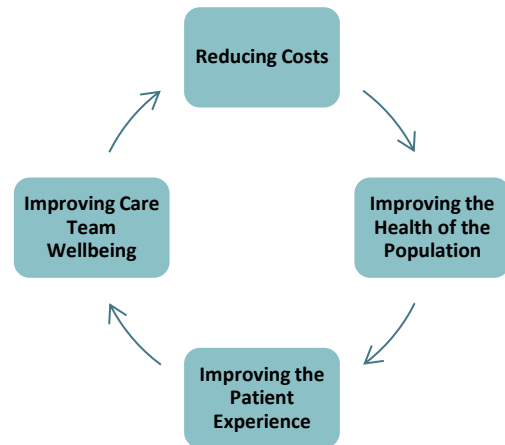
The recommendations and initiatives suggested in this final report may be implemented at the discretion of the State of Idaho pursuant to executive branch authority, legislative direction, statutory authority, and federal laws, regulations, and guidelines. The success and timing of operational components are subject to any limitations within the Idaho Medicaid program, including internal and/or external resources required to implement.

Overview of Idaho Medicaid

A thorough review and analysis of the Idaho Medicaid program found both successes and opportunities as policy makers look towards long-term challenges.

On the positive side, the Medicaid program is operationally stable and meeting the needs of its members while largely addressing provider concerns. In the areas of services for individuals with developmental disabilities and school-based services, Idaho Medicaid is a national leader. Furthermore, the Idaho Medicaid team is strong despite its lean nature. These are just a few examples of the strengths of the program.

Figure 3: The Quadruple Aim

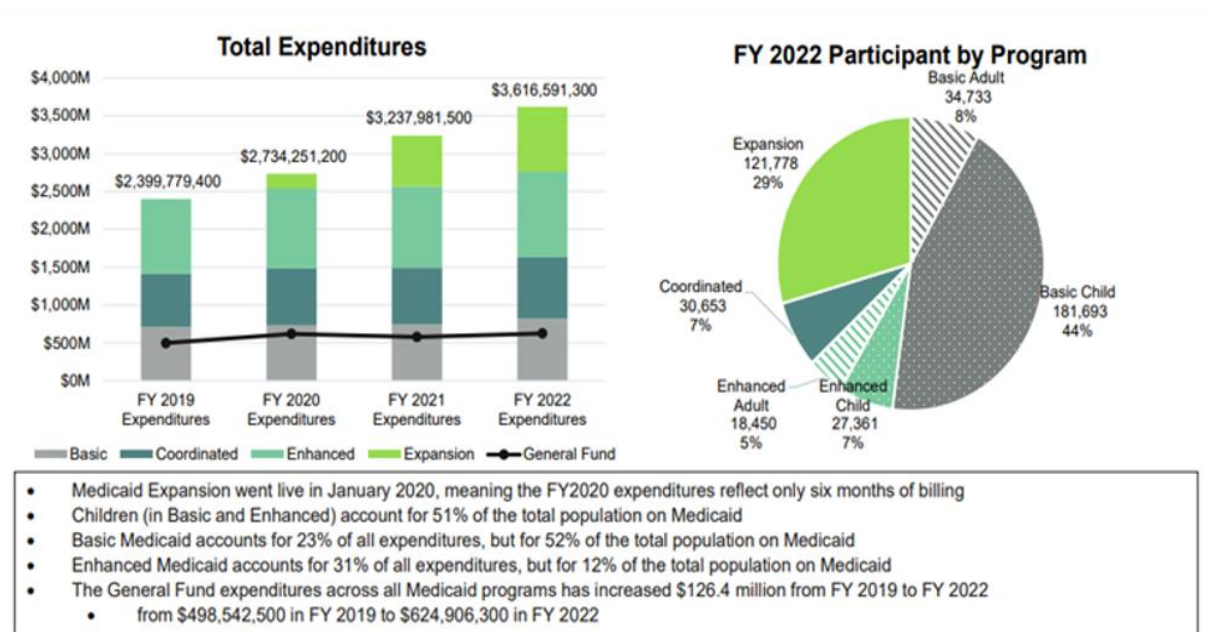


A significant challenge lies at the heart of the Idaho Medicaid program, which currently operates three care delivery and financing systems: fee for service, managed care, and value-based systems. Managing multiple delivery and financing models contributes to challenges and opportunities described in this report, including administrative and management complexities and inefficiencies.

In addition, the Idaho Legislature’s Office of Performance of Evaluation conducted a review of the rate-setting and related processes and published its report in March 2022. This report noted that the Medicaid budget had doubled in the last ten years, while the Medicaid team operates with fewer staff than in 2009. These factors should be considered as this Final Report is reviewed and the recommendations therein are considered.

The Idaho Medicaid program covers approximately 415,000 members, as illustrated on the right side of Figure 4 below:

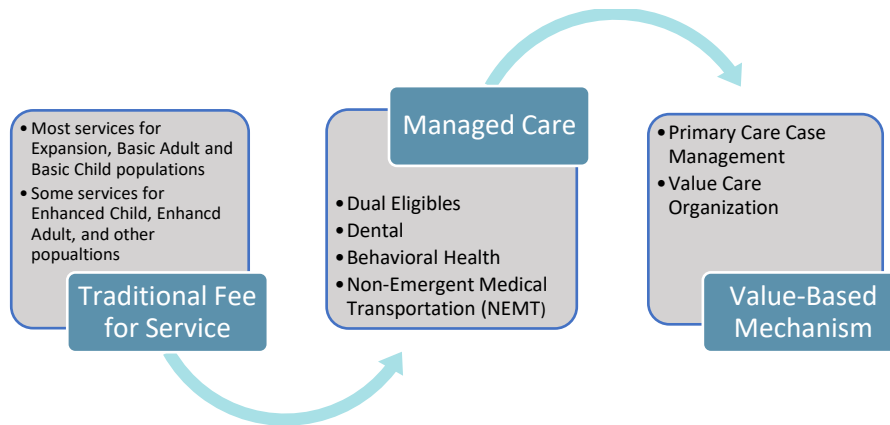
Figure 4: Division of Medicaid, Agency Review: by Expenditures and Participants, FY 2022



As noted in the Total Expenditures graph in Figure 4, increasing expenditures are being driven largely by the enhanced and expansion populations. This is to be expected due to the greater need for services typical of these populations. This may eventually stabilize for the expansion population, although this may not be known for a few more years. This is also an important component of the redetermination process (which populations will be impacted the most, and the corresponding budgetary and programmatic impacts, remain unknown). As noted, Idaho’s Medicaid program manages three separate models of care delivery and financing:

² Legislative Services Office. Division of Medicaid, n.d., <https://legislature.idaho.gov/iso/bpa/budgetinformation/agency/>

Figure 5: Idaho Models of Care Delivery and Financing



This is further stratified in Tables 1 and 2 below. These tables illustrate certain services covered through managed care are available to most Medicaid members, even if most of the members – and most clinical services - are categorized under FFS.

Table 2: Current Managed Care Populations and Services in Idaho (2023)

Population/Service	Members	Notes
Dual Eligibles (Medicare and Medicaid)	27,000	This contract is not competitively procured; it is reviewed on an annual basis
Behavioral Health	427,800	Current contract ends in 2025
Dental	455,100	This procurement has not been finalized.
Healthy Connections (PCCM and VCO Initiatives)	403,700	

Table 3: Current Predominantly Fee for Service Populations in Idaho

Population	Members	Notes
Expansion	121,800	
Children	209,100	Includes “Basic” and “Enhanced”; excludes waiver services
Adults	53,200	Includes “Basic” and “Enhanced”; excludes waiver services

The above data, and the conceptual nuance of Idaho utilizing managed care for a narrow set of services, can create the impression that much of the Idaho Medicaid program is largely administered through managed care. However, Table 4 illustrates where Idaho stands compared to other states in adoption of managed care:

Table 4: Medicaid MCO Expenditures as a Percent of Total Medicaid Expenditures, FFY 2016-2020

Rank	State	MLTSS	2016	2017	2018	2019	2020	Rank	State	MLTSS	2016	2017	2018	2019	2020
1	Iowa	Yes	13.4%	92.2%	91.8%	92.1%	96.7%	29	Nevada	No	42.0%	45.6%	46.6%	45.7%	49.1%
2	Hawaii	Yes	88.4%	94.7%	94.7%	94.7%	95.2%	30	Utah	No	49.3%	50.8%	47.1%	47.0%	47.3%
3	Kansas	Yes	94.3%	93.5%	91.0%	93.9%	93.6%	31	California	Yes	46.4%	52.8%	46.7%	48.4%	46.7%
4	Delaware	Yes	81.0%	83.0%	85.1%	84.3%	88.1%	32	Indiana	No	27.3%	43.2%	47.1%	45.1%	46.5%
5	Puerto Rico	Yes	99.3%	98.6%	90.0%	98.6%	87.2%	33	New Hampshire	No	43.5%	42.8%	42.2%	39.5%	45.7%
6	Arizona	Yes	85.1%	86.3%	86.1%	86.0%	85.7%	34	West Virginia	No	17.9%	44.9%	43.6%	42.4%	44.0%
7	Washington	No	49.8%	55.0%	51.2%	67.0%	84.4%	35	Massachusetts	Yes	38.3%	39.6%	38.4%	40.8%	42.6%
8	New Mexico	Yes	84.1%	79.3%	80.5%	80.7%	83.6%	36	Georgia	No	35.6%	38.5%	29.8%	29.6%	36.0%
9	Pennsylvania	Yes	54.8%	58.5%	58.8%	66.8%	78.5%	37	District of Columbia	No	38.5%	36.9%	36.5%	33.3%	31.0%
10	Tennessee	Yes	67.1%	63.7%	69.7%	70.8%	72.4%	38	North Dakota	No	17.0%	24.8%	25.1%	23.5%	22.7%
11	Louisiana	Yes	39.9%	64.6%	74.0%	59.3%	70.8%	39	North Carolina	No	28.2%	22.7%	26.6%	28.4%	28.6%
12	Illinois	Yes	30.7%	44.3%	59.6%	63.4%	70.5%	40	Idaho	No	10.5%	9.8%	6.1%	13.7%	20.7%
13	Florida	Yes	64.8%	74.6%	71.0%	71.4%	70.1%	41	Mississippi	No	0.0%	0.0%	0.0%	0.0%	0.0%
14	Kentucky	Yes	71.9%	71.9%	73.2%	71.5%	70.0%	42	Arkansas	No	0.0%	0.0%	1.4%	14.9%	17.9%
15	Ohio	Yes	54.1%	57.1%	63.7%	63.2%	68.5%	43	Colorado	No	12.8%	15.9%	16.2%	7.3%	9.1%
16	Michigan	Yes	61.6%	64.3%	65.3%	65.3%	65.1%	44	Oklahoma	No	0.8%	1.3%	1.2%	1.2%	0.9%
17	Virginia	Yes	39.4%	39.9%	52.5%	62.9%	64.9%	45	Wyoming	No	0.0%	1.2%	0.6%	-0.1%	0.3%
18	New Jersey	Yes	56.0%	63.1%	64.1%	62.6%	63.6%	46	Alabama	No	0.0%	0.8%	0.8%	0.7%	0.1%
19	Texas	Yes	50.4%	60.1%	62.3%	60.5%	63.3%	47	Alaska	No	0.0%	0.0%	0.0%	0.0%	0.0%
20	Oregon	No	60.9%	57.0%	58.3%	59.4%	60.5%	48	Amer. Samoa	No	0.0%	0.0%	0.0%	0.0%	0.0%
21	New York	Yes	48.7%	59.6%	59.8%	59.6%	60.3%	49	Connecticut	No	0.0%	0.0%	0.0%	0.0%	0.0%
22	Rhode Island	Yes	57.1%	64.6%	62.6%	55.2%	59.7%	50	Guam	No	0.0%	0.0%	0.0%	0.0%	0.0%
23	Nebraska	No	34.1%	51.4%	57.2%	56.7%	55.3%	51	Maine	No	0.0%	0.0%	0.0%	0.0%	0.0%
24	Mississippi	No	22.8%	50.9%	49.9%	50.5%	52.3%	52	Montana	No	-0.8%	0.0%	0.0%	0.0%	0.0%
25	Maryland	No	45.1%	46.3%	47.9%	46.8%	50.8%	53	N. Mariana Islands	No	0.0%	0.0%	0.0%	0.0%	0.0%
26	Wisconsin	Yes	45.2%	46.8%	46.3%	47.5%	50.2%	54	South Dakota	No	0.0%	0.0%	0.0%	0.0%	0.0%
27	Minnesota	Yes	50.1%	48.7%	49.6%	47.7%	49.9%	55	Vermont	No	0.0%	0.0%	0.0%	0.0%	0.0%
28	South Carolina	Yes	46.1%	48.6%	48.8%	47.0%	49.7%	56	Virgin Islands	No	0.0%	0.0%	0.0%	0.0%	0.0%

The lack of a comprehensive service delivery structure is a significant contributing factor to the cost trend and presents opportunities to improve cost containment and further maximize revenue.

Public Health Emergency

The public health emergency (PHE) was issued by the Federal Department of Health and Human Services (DHHS) on January 31, 2020. States were required to provide continuous coverage and keep beneficiaries enrolled for the duration of the PHE as a condition of receiving an increased Federal Medical Assistance Percentage (FMAP) of 6.2 percentage points.⁴

As a condition of receiving the enhanced FMAP, all states have paused eligibility redeterminations during the PHE. States have been planning for the end of the PHE and the resumption of the standard redetermination process and working to prevent unnecessary coverage losses. Nationally, it is estimated that between 5.3 million to 14.2 million enrollees could lose coverage because of the end of the continuous coverage requirements.⁵ However, in Idaho and elsewhere, this is very difficult to predict. Per the federal Consolidated Appropriations Act of 2023, the enhanced FMAP will be “phased down” on a quarterly basis over the course of calendar 2023. In addition, states may initiate redeterminations beginning on April 1, 2023; Idaho has indicated plans to begin this process in April.

³ “Medicaid Managed Care Spending in 2020,” Health Management Associates, February 25, 2021, <https://www.healthmanagement.com/blog/medicaid-managed-care-spending-in-2020>

⁴ Elizabeth Williams, Robin Rudowitz, and Bradley Corallo, “Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends,” Kaiser Family Foundation, May 10, 2022, <https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuous-coverage-requirement-during-and-after-the-phe-ends/>

⁵ Jennifer Tolbert and Meghana Ammula, “10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Requirement,” Kaiser Family Foundation, February 22, 2023, <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

Pursuant to DFM direction and project scope, this report does not evaluate any potential changes in enrollment, utilization, expenditures, or policy considerations associated with the end of the PHE, or the Consolidated Appropriations Act of 2023.

In addition, the PHE has introduced numerous irregularities in what are considered “normal” data elements within Medicaid specifically and health care broadly. These include trends in utilization, costs for certain services, and enrollment. Therefore, discerning long-term impacts based on the three years of the PHE has inherent risks.

Programmatic Areas

In addition to the short-term recommendations included in the Interim Report, the State of Idaho has opportunities to improve operations and cost containment in certain programmatic areas, including program integrity, pharmacy, and long-term care/skilled nursing facilities. There are two other programmatic areas – intellectual and developmental disabilities services and school-based services, that are functioning at a high level. Therefore, both areas should be approached cautiously as possible reforms are considered.

Program Integrity

Background

Effective program integrity systems benefit states, the federal government, Medicaid members, and providers. Program integrity can be a key component of maintaining public confidence in Medicaid programs.

Overall, program integrity activities include pre-and post-payment program integrity audits, clinical reviews of payments within fee-for-service and organized delivery systems, education and outreach to providers relating to program integrity, and referrals in cases of fraud allegations. Payment error rates, recoveries, and other key performance indicators are tracked and reported.

The Interim Report recommended additional resources and refined use of third-party vendors to enhance program integrity activities and appropriately generate savings for the General Fund. This recommendation was derived from state reports, IDHW Medicaid Program Integrity Unit SFY 2021 Closed Cases and the same report for SFY 2022 July through December, indicating lower than expected cases, audits, and civil monetary penalties in areas that typically draw greater scrutiny (such as durable medical equipment, independent lab services, and home health). It is important to note, however, that recent data may be skewed due to the pandemic, which prevented on-site visits and other limitations on audit functionality.

The existing program integrity group is progressing by increasing its scope to include reviews of claims for dental and behavioral health-managed delivery systems. In addition, a new data warehouse has been launched that will provide additional levels of insight into the program and help target future program integrity efforts.

Considerations

For program integrity to remain effective, it must be adequately funded, have clear objectives, and appropriately use technology, such as the data warehouse and third-party vendors. It must also be

flexible, as changes to federal regulations will likely require additional investment in program integrity even in a static environment. In addition, the efforts and sophistication of those who may intentionally seek to commit fraud continues to advance, requiring the program integrity team to similarly modify its analytical capabilities.

Structural changes to Idaho's Medicaid delivery system, such as a transition to comprehensive managed care, will inherently require revisions and enhancements to the functions and structure of the program integrity team. While a FFS component would still likely remain, many of the responsibilities of the program integrity group would shift to oversight and close review of MCO program integrity functions and contractual compliance with state requirements.

Recommendations

- 1) **Monitor and evaluate performance of the data warehouse.** Monitor and evaluate performance of the data warehouse to ensure its functionality is efficiently utilized. Outliers should be identified through data mining, and expanded data sets, including all managed care claims, should be in-scope of the data analytics program. Moreover, this function should be expanded if additional managed care or value-based initiatives are implemented.
- 2) **Review MCO (Fraud, Waste, and Abuse) FWA mitigation activities.** Provide resources to review fraud, waste, and abuse activities of the current MCOs. This may require additional expertise and resources at the Medicaid Program Integrity Unit, which is appropriately distinct from Medicaid program operations.
- 3) **Maximize MCO analysis and accountability vendor.** Further maximize analysis of all MCO financial and clinical activities including payments made to providers, outside of complaint-driven or outlier situations.
- 4) **Retain functional independence.** Retain independence from the management of MCO, pharmacy, behavioral health, and fee-for-service administration contracts. This may become more important if the State makes additional transitions to managed care.

Pharmacy

Background

States face difficult decisions regarding management of the Medicaid prescription drug benefit. While national Medicaid pharmacy expenditures remained stable from 2015 to 2019, according to the Kaiser Family Foundation, prices began rising in 2020 despite a drop in utilization. Relatedly, Idaho Medicaid pharmacy expenditures increased 24% between FY 2021 and FY 2022, as Medicaid Expansion was implemented, and additional high-cost drugs reached the market.

Medicaid programs are required under the Medicaid drug rebate program to cover all FDA-approved drugs that participate in a federal rebate agreement. Since states cannot limit the scope of covered drugs to control drug costs, states have used a variety of payment strategies and utilization controls to manage expenditures, see Table 5. Many states employ a pharmacy benefit manager, (PBM) and a preferred drug list (PDL) to reduce expenditures. States have also relied on the Medicaid rebate program to reduce their costs, with most states, including Idaho, participating in a multistate pool to maximize supplemental rebates.

Table 5: Pharmacy Program Design Options

Pharmacy Program Design	Description
Carve-Out	All pharmacy services are administered directly by the state Medicaid agency
Carve-In	Contracted MCOs or their PBMs are responsible for the pharmacy benefit within the confines established by the state Medicaid program
State-Mandated Pharmacy Reimbursement	MCOs must pay the pharmacies using the same methodology as the fee-for-service (FFS) program
Mandated Single PBM	The state selects a single PBM and requires all contracted MCOs to contract with the PBM. The MCOs are at risk for the cost of drugs
Non-Risk Managed Care Model	MCOs administer the drug benefit but are not at risk for the cost of outpatient drugs. MCOs remain at risk for most physician-administered drugs
Single PBM as a Prepaid Ambulatory Health Plan (PAHP)	The state hires a single PBM to manage the pharmacy benefit for all enrollees. The state is at risk for the cost of the drugs. Single PBM can be structured as a PAHP

States are also pursuing value-based purchasing agreements (also referred to as “outcomes-based arrangements”) for very high-cost (in some cases, over \$1 million) drugs being approved at a more rapid pace by the federal Food and Drug Administration (FDA). Such arrangements require CMS approval of a Medicaid State Plan Amendment (SPA). Since 2018, sixteen states have received such approvals, and the Idaho team is evaluating such options.

Idaho presently contracts directly for pharmacy benefit administration, referred to as “carving out” the pharmacy benefit away from the MCOs (even in Idaho's current environment of limited managed care). Under this model, the State performs many of the pharmacy contracting functions and establishes the reimbursement methodology. Magellan Health, an outside vendor, performs day-to-day claims administration and assists with Preferred Drug List (PDL) maintenance. As such, Magellan acts as a pharmacy benefit administrator (PBA). According to staff, it is not performing some of the standard PBM functions, including provider (pharmacy) network management and formulary development.

Considerations

Please note these considerations and subsequent recommendations are limited in scope and impact due to Idaho operating its Medicaid program largely under a FFS model. Should the State transition to comprehensive managed care (discussed under the **Comprehensive Managed Care** section), the impacts of reforms to pharmacy benefit administration will significantly rise in magnitude.

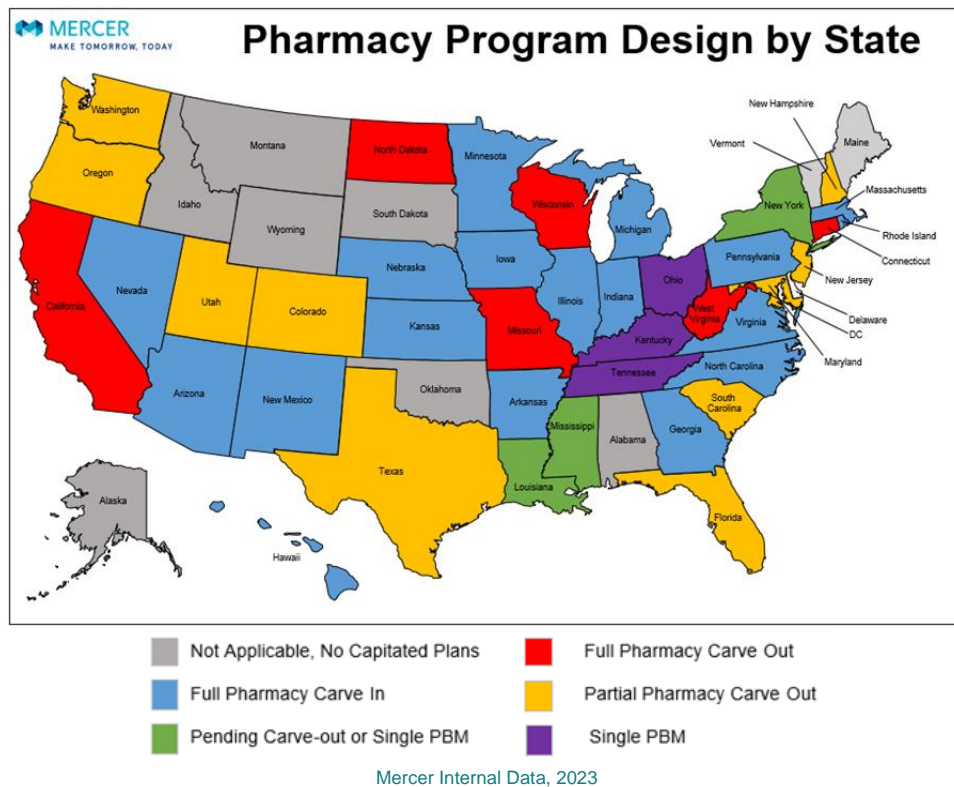
The current carve-out model is generally performing well for the Idaho Medicaid program. It provides transparency regarding pricing and pharmacy reimbursement, maintains a wide provider (pharmacy) network and member access, and processes claims efficiently. These elements may be approached differently in a carve-in model.

Conversely, there are potential drawbacks to carving out PBM services. These include challenges in care coordination and measuring quality of service, and limitations on cost containment mechanisms applied

to drug purchasing, network management, and pharmacy reimbursement. In a carved-out environment, these responsibilities are borne by the State. In a carved-in environment, the MCOs manage these aspects in accordance with contractual requirements and State oversight, while also being responsible for the entirety of care for the members.

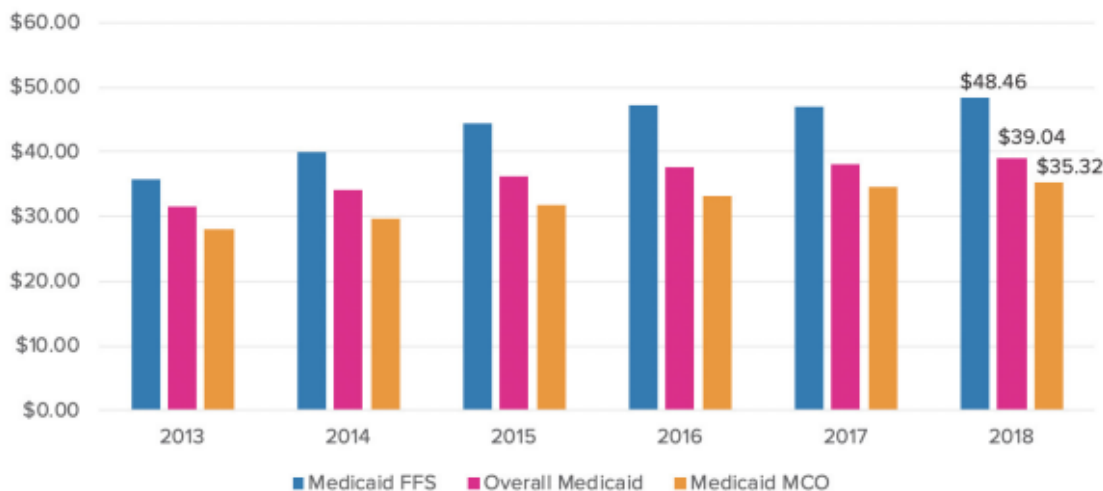
As presented below, 34 states carve the pharmacy benefit into managed care, although there has been a recent trend to move away from this model in certain larger states. Sixteen of these states also participate in multi-state purchasing pools, including Idaho.

Figure 6: MCO States Carved in Pharmacy Benefits to MCO Contracts as of July 2022



The Idaho Medicaid program may benefit from adopting the carve-in model, even with the currently limited managed care populations and services. Inclusion of the pharmacy benefit may attract greater competition, and the carve-in model has demonstrated cost containment, achieving 13% better control over the rate of increases in prescription drug expenditures than fee-for-service programs, according to the Menges Group and referenced in Figure 7. This model also shifts some of the administrative burden to the MCOs.

Figure 7: Medicaid FFS, Overall & MCO Net Costs per Prescription, all drugs 2013–2018



Source: Menges Group analysis of CMS 64 reports; national Medicaid FFS, overall and MCO post-rebate cost per prescription, all drugs for FFY 2013 – 2018.

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However, a carve-in strategy also poses risks, particularly related to provider (pharmacy) network management, reimbursement, and price transparency. Pharmacies, particularly in some locations, may be reluctant to contract with traditional PBMs utilizing certain network and reimbursement strategies. Notably, Ohio is shifting to a “single PBM” model, in part to prevent reimbursement and pricing irregularities. Idaho is in a good position to thoughtfully address these issues, as Idaho has specific language directing the Medicaid program to consult with pharmacies as it considers changes to its pharmacy program.

Whether the pharmacy benefit is carved in or separately managed by the State, a transparent process with stakeholders should be utilized. This process should emphasize financial accountability for the cost of a prescription drug as well as local pharmacy reimbursement. Certain states have discovered PBMs have been utilizing “spread pricing” as a mechanism to generate additional profit, leading fourteen states to place restrictions on the process.⁷ This simply refers to the practice of the PBM reimbursing the pharmacy less than the cost for the drug, and retaining the difference (the “spread”).

Recommendations

- 1) **Engage a Request for Information (RFI) process to provide the State with additional information and insight into pharmacy benefit administration.** This recommendation would provide policy makers with additional information upon which to base a decision. Due to Idaho’s relatively small Medicaid membership, carving the pharmacy benefit into the MCO contracts may ultimately present the best opportunity for cost containment. However, the state may choose to retain control of the PDL and ensure pricing integrity, as cost containment is one of several important elements of a strong pharmacy benefit program.

⁶ “The Value of Medicaid Managed Care,” AHIP, n.d. <https://www.ahip.org/resources/the-value-of-medicaid-managed-care>

⁷ Kathleen Gifford et al., “How State Medicaid Programs are Managing Prescription Drug Costs,” Kaiser Family Foundation, April 2020, <https://files.kff.org/attachment/How-State-Medicaid-Programs-are-Managing-Prescription-Drug-Costs.pdf>

- 2) **Seek CMS approval of a SPA to enable value-based purchasing.** This initiative would allow, but not require, Idaho to pursue value-based contracts for high-cost drugs and therapies. This creative approach will help address member access and budgetary challenges as more of these are approved by the FDA.
- 3) **Retain and continue a strong in-house pharmacy benefit administration program.** Under managed care or FFS, a robust in-house program is needed to conduct oversight of third-party vendors, the PDL and rebate programs, and pharmacy-related policy. This will ensure an accountable and adaptable program, while providing transparency, stability, and member access in small, rural, and potentially underserved communities.

Intellectual and Developmental Disabilities Services

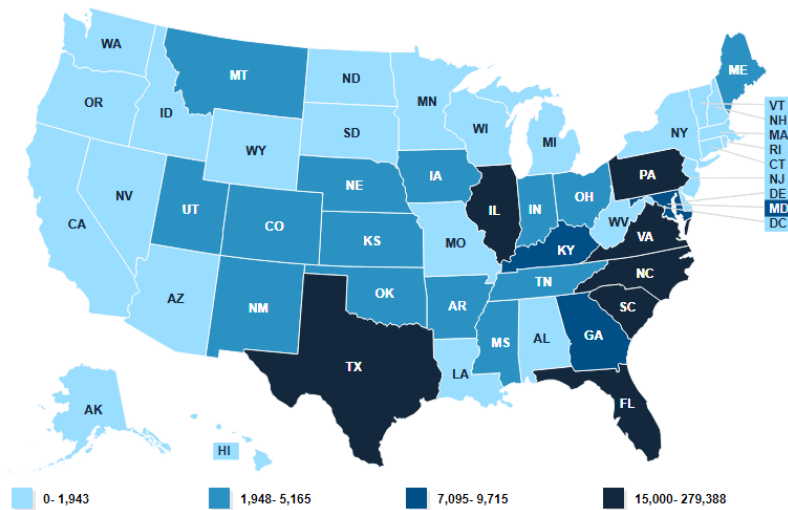
Background

All services provided to Medicaid members with intellectual and developmental disabilities (IDD), including those services provided under the state's Katie Beckett program, are provided in a fee-for-service environment and are overseen by a separate disability-related state agency (along with the Medicaid program). Idaho has earned the reputation as a regional leader in both the number of individuals served by these programs as well as the comprehensiveness of services covered for these populations. Idaho does not currently have a waiting list, positively distinguishing Idaho from many other states as illustrated in Figure 8.

Given the importance of continuing to serve these members (and, where applicable, their families), there are three specific, long-term policy recommendations presented below. It should be noted that the State is not considering carving these disability-related services into managed care, nor is that concept recommended here. This is due to the complexities of such an endeavor interrupting the stability of the program and the risk of potentially disrupting care for vulnerable members. In addition, structural modifications to the program may have implications regarding the KW lawsuit settlement agreement, relating to how individual service needs are determined and budgeted by the Division of Medicaid, and member rights in this regard.

IDD services provided to children enrolled in Medicaid in a school setting are funded through a special relationship between the state and the local education agencies (LEAs). Through an intergovernmental transfer (IGT) process, the LEAs fund the state share of Medicaid-reimbursable services. As claims are submitted to the state, the state withdraws the appropriate schools' state share, draws down the associated federal share, and pays the claims to the LEAs. This LEA self-funded program not only appears to be working well in serving the members who need these services, it also creates a sustainable funding source that should rise with growth in demand for services in the future.

Figure 8: Medicaid Intellectual and Developmental Disabilities Waiver Waiting List Enrollment



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Considerations

Based on a review of the Expenditure Detail October 2022 provided by the State, the average weekly members receiving IDD services in SFY17 was 6,774, compared to 6,762 in SFY22. However, the expenditures for approximately the same number of members increased by more than 50%, from \$266m in SFY17 to \$408M in SFY22. This may be largely due to the KW lawsuit settlement. Nevertheless, this large increase in expenditures in serving approximately the same number of individuals suggests that Idaho may find itself facing some financial and operational challenges in the coming years. Additionally, the state team indicated it anticipates needing to add services and/or providers in the future to ensure continuity in the array of services offered to this population. As those services and providers are added, the State further anticipates challenges of maintaining sustainable funding over the long-term.

Similarly, but on a narrower scale, the Katie Beckett Medical Utilization information demonstrates a growth in expenditures from \$2.6 million in Q2 of SFY19 to \$3.41 million in Q2 of SFY22 of disability service delivered in a school setting. During the same period, there was an increase in the number of individuals receiving Katie Beckett services in a school setting from 2,735 in Q2 of SFY19 to 3,773 in Q2 of SFY22. Given the 31% increase in expenditures and 38% increase in members served in just three years, it appears Idaho is leveraging schools as a critical component of its care delivery platform for disability services.

However, limited oversight, reconciliation, and review of the reimbursement structure for community-based providers of IDD services was also observed. For example, Intermediate Care Facilities (ICFs) are the only provider type serving this population that must submit annual cost reports that are then audited by Myers & Stauffer; the non-ICF providers are not subject to this requirement. Applying this requirement equitably may enhance the reimbursement-to-cost correlation, further enabling the State

⁸ “Medicaid HCBS Waiver Waiting List Enrollment by Target Population and Whether States Screen for Eligibility,” Kaiser Family Foundation, 2021, <https://www.kff.org/medicaid/state-indicator/medicaid-hcbs-waiver-waiting-list-enrollment-by-target-population-and-whether-states-screen-for-eligibility>

to continue driving high quality and introducing value-based payment arrangements without disrupting care delivery to these important Idahoans.

For example, the State could implement a value-based reimbursement methodology whereby a portion of the total annual rate (e.g., 5%) paid to ICF and DD HCBS providers is withheld from up-front payment for services. These withheld funds would then be earned back by meeting state-defined quality metrics. Initial metrics should be both cost-effective and administratively simple. Examples could include: (i) timely submission of cost reporting data; (ii) member and member's family's satisfaction survey data regarding member involvement in the annual care plan and service options; and (iii) service delivery metrics (such as the number of missed shifts by providers per month or quarter per member).

With easy-to-accomplish metrics in the early years of these arrangements, the state may balance the need for provider accountability with a realistic path to increase the weight of these quality metrics with respect to total (and potentially higher) reimbursement over time.

The recommendations below consider the importance of Idaho maintaining a strong program and upholding its position as a national leader in this regard. Therefore, the State may need to consider additional investments in the program to ensure longer-term stability.

Recommendations

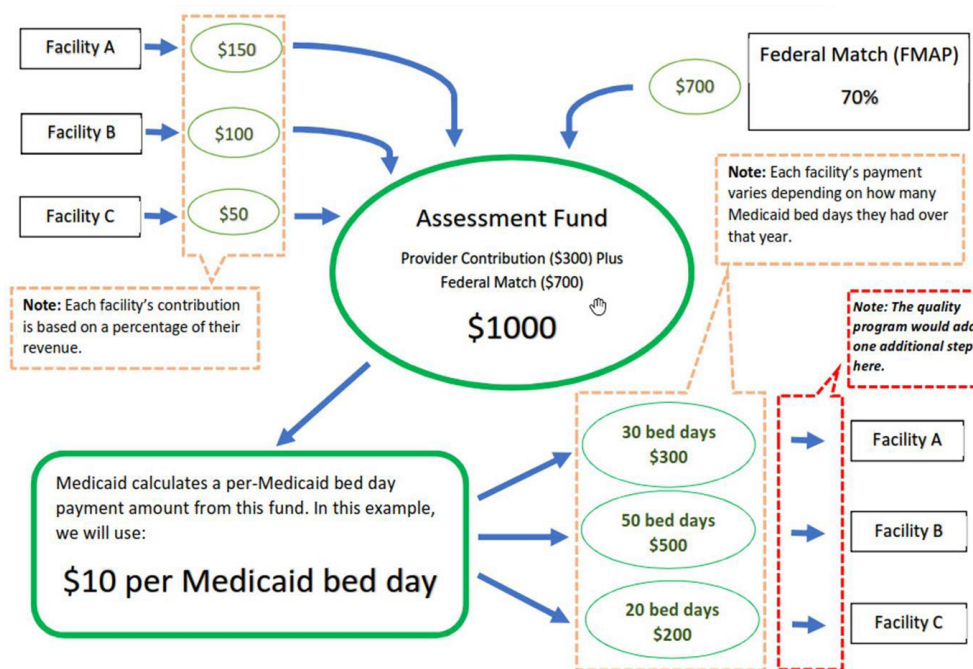
- 1) **Coordinate school-based services (SBS) claims with members' primary care providers.** To improve care coordination and corresponding outcomes, as well as reduce potential service duplication, the State should implement a system in which each child's claims for services provided in a school setting are shared with their assigned Medicaid-enrolled primary care provider.
- 2) **Ensure sufficient community providers in areas where the LEAs are not participating in the state's SBS program.** The State should remain vigilant in assessing network adequacy in communities with limited LEA participation as Medicaid provider of SBS. This may include loosening telehealth restrictions and/or increasing telehealth reimbursement and revising fee schedules upward in areas with lower provider density and lower LEA participation in the Medicaid SBS program.
- 3) **Introduce upside-focused value-based payment arrangements.** To both incentivize high quality care and member outcomes, as well as to plan adequately for future growth in services, the State should consider implementing quality-based payment arrangements for the IDD service providers in the State. This recommendation would include broad engagement and collaboration with the IDD community.
- 4) **Conduct an audit of "Pass-through" requirements to ensure direct care workers receive the funding as intended.** This item was included in the Interim Report and remains an important source of accountability aligned with important legislative and industry efforts to attract and maintain a stable care delivery workforce.

Long-Term Services and Supports, Nursing Facilities

Background

The use of pay for performance or other value-based quality incentive programs can be an effective tool to incentivize providers to focus on specific priority areas and state policy goals. Idaho's current Nursing Facility (NF) Quality Payment Program was developed in collaboration with NF stakeholders, including state, county-owned and private nursing homes, and was approved by CMS on July 1, 2020. The NF quality payment was created as a mechanism to continue UPL supplemental payments to nursing facilities based on the quality of care provided by the facility using nationally recognized quality metrics.⁹ At a high-level, the program is based on each NF current assessment and UPL distribution, with the quality program base built off each facilities resulting calculated payment (See Figure 9).

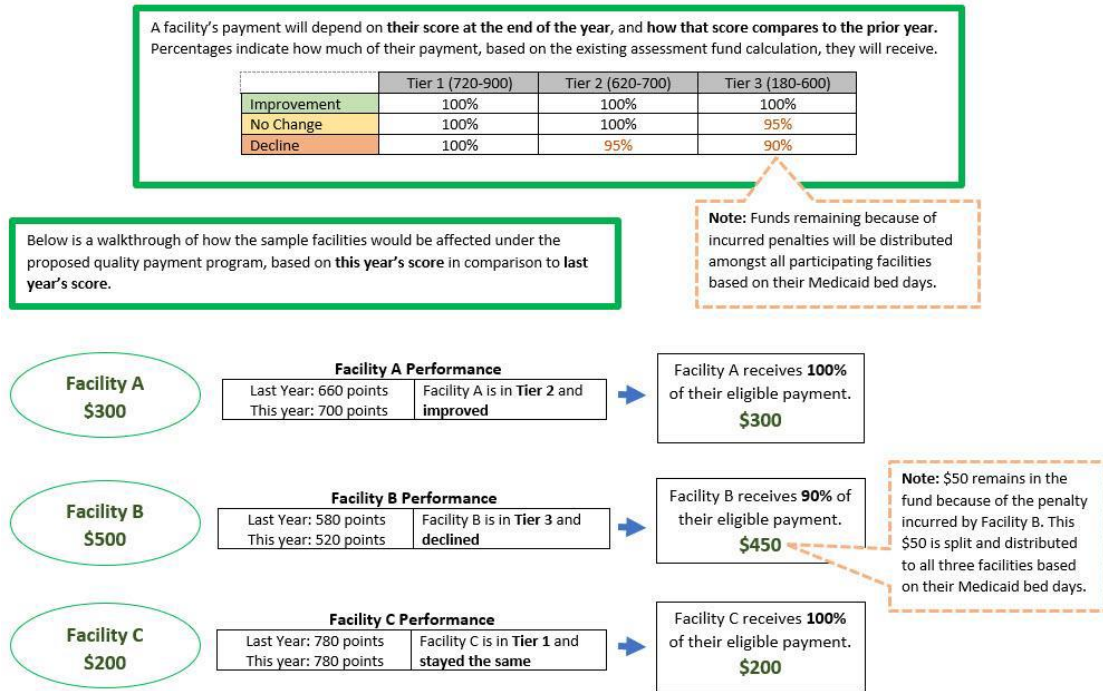
Figure 9: Illustration of Current Nursing Facility Assessment and UPL Distribution



For the quality payment program measure component, facilities report on nine measures and are awarded between 20-100 points per measure with the totals for all measures being tied to one specific payment tier with facilities in Tier 1 achieving between 720-900 points, Tier 2, 620-700, and Tier 3, 180-600 points. Payments are tied to the tiers and the associated change in quality measures for the previous year (see Figure 10).

⁹ "State Plan Amendment," Medicaid.gov, November 9, 2020, <https://www.medicaid.gov/Medicaid/spa/downloads/ID-20-0002.pdf>

Figure 10: Illustration of Current Nursing Facility Quality Payment Program Distribution Methodology



Considerations

Several state NF programs (New Jersey, Georgia, Missouri, New York, Minnesota, Ohio, and Texas) have similar scoring approaches to the one described above that award improvement over baseline and maintenance, while penalizing declining scores. A handful of other states utilize more of an “all or nothing” approach: if the NF’s performance was maintained or improved, they earned a quality payment, but if the performance declined, they earned no additional payment.

A review of the most current NF Quality Payment Program information available¹⁰ indicates there is opportunity to modify the current FFS reimbursement model to further ensure continued improvement by the participating providers.

Successful pay for performance programs strike the right balance and payment structure to incentivize a change in behavior. This balance can be adjusted over time based on experience or performance. During discovery sessions, the State articulated the intent to continue efforts to pursue meaningful pay for performance programs through the care delivery system. The recommendations below support this goal and consider the maturity of the NF Quality Payment Program.

Recommendations

- 1) **Increase the quality thresholds to award additional dollars under the NF quality payment program.** Consistent with the state’s long-term policy goal of maintaining a well-designed pay for performance quality program and the best health outcomes for all its members, the state should consider narrowing the range of the elements equal to or greater than ± 20 points”, rather than “equal to or greater than ± 40 points” as it is currently operated. This change will further

¹⁰ Alexandria Childers-Scott, n.d.

incentivize providers to improve care delivery, and to ensure appropriate monitoring and documentation of those services to be rewarded with additional payment. Any potential penalties eventually generated by this initiative could be used to address workforce, access, and housing issues, in alignment with increasing opportunities to move individuals out of institutions and into the community.

- 2) **Review and amend the percentage of dollars earned for each reward tier.** The current program payment tiers permit NFs to earn at least 95% if there is no change in performance, and 90% if there is a decline. To incentivize high quality care and improve member outcomes, as well as to plan adequately for future growth in services, more rigorous tiers should be considered, consistent with the State's overall programmatic direction. Specifically, the 90% reimbursement level for failure to improve performance should be reduced to 75%. This more demanding approach requires NFs to improve for full payment and correspondingly penalizes those that fail to make such improvements. Alternatively, and at a minimum, DHW should consider modifying the percentages so NFs that had no change receive a smaller pool than 95% and those that decline receive a smaller pool than 90%. Given those suggestions and the programs maturity, it is reasonable to define the payment earned for no change as ~85-90% and payment earned for decline as ~75-84%.

These recommendations may be met with resistance from the NF industry and other stakeholders. To maintain collaboration and transparency, these stakeholders should be engaged throughout the process of modifying the current program, if such modifications are considered.

Long-Term Services and Supports, Home and Community-Based Support Services

While this report includes a more comprehensive recommendation regarding managed care, a separate recommendation (independent of comprehensive managed care) to specifically transition home and community based (HCBS) long-term services and supports to a managed long-term service and supports program (MLTSS) is presented here.

Background

In addition to achieving the LTSS programmatic policy goals of rebalancing community-based care, increasing access, and improving satisfaction for beneficiaries, there is also a financial component to consider. LTSS expenditures for 2019 (the most recent data that excludes PHE irregularities) shows these services are consuming over 37% of the total Medicaid budget.

Table 6: Medicaid LTSS Expenditures*, Fiscal Year 2019¹¹

FY 2019 Expenditures: Total Institutional	FY 2019 Expenditures: Total HCBS	FY 2019 Expenditures: Total LTSS	FY 2019 Expenditures: Total Medicaid
\$337,741,784	\$475,289,291	\$813,031,075	\$2,143,001,207

*May include ID/DD service expenditures.

¹¹ "Medicaid Long Term Services and Supports Annual Expenditures Report," Medicaid.gov, December 9, 2021, <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>

Table 7: Total Expenditures*, FY 2017-2019

	FY 2019 Expenditures Per State Resident	FY 2017 Expenditures	FY 2018 Expenditures	FY 2018 % Change	FY 2019 Expenditures	FY 2019 % Change
Institutional	\$188.99	\$309,696,043	\$295,976,962	-4.4	\$337,741,784	14.1
HCBS	\$265.96	\$398,305,048	\$444,333,232	11.6	\$475,289,291	7.0
LTSS	\$454.95	\$708,001,091	\$740,310,194	4.6	\$813,031,075	9.8
MLTSS	\$39.73	\$18,993,073	\$27,855,345	46.7	\$70,999,142	154.9

*May include ID/DD service expenditures.

Considerations

By moving to a MLTSS delivery system for HCBS services, Idaho can further its rebalancing efforts while creating additional opportunities to control the cost curve of long-term care. Idaho already covers the dual eligible population under a managed care delivery system and has recognized some limited financial value from that endeavor. Further, a transition to MLTSS would increase the number of covered lives, and premium tax associated with those additional lives, in any future procurement offerings. In turn, this may attract additional MCOs to the market, create a more competitive bid process, and improve the financial outcome for the State. It can also achieve other policy and programmatic goals such as effective use of LTSS to avoid unnecessary acute care utilization, better coordinated whole person care.

The State should consider this recommendation carefully and include stakeholders early in the planning, development, and implementation of any such initiatives. The State should also carefully review the CMS guidance related to MLTSS on their website, which includes a timeline for transition and key elements of a well-designed MLTSS program.¹²¹³

Recommendation

- 3) **Transition HCBS services to a managed long-term care delivery system.** While it is difficult to estimate cost savings associated with a move to MLTSS, there is a degree of budget predictability that would be realized, as well as cost avoidance associated with keeping an individual in the community and out of an institution. Better coordination of care can also impact costs associated with avoidable acute care utilization.

School Based Services

Background

Idaho’s school-based services (SBS) program is structured as a traditional fee-for-service (FFS) model wherein local educational agencies (LEAs), or school districts, enroll as Medicaid providers and bill the State for services according to the State’s fee schedule. School-based practitioners submit claims under their LEAs’ organizational national provider identifier (NPI) and are not required to enroll in Medicaid as individual providers. The State does not participate in the Medicaid Administrative Claiming program.

¹² “Managed Long Term Services and Supports,” Medicaid.gov, n.d., <https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html>

¹³ “Timeline for Developing a Managed Long-Term Services and Supports (MLTSS) program,” CMS, May, 2013, <https://www.medicaid.gov/Medicaid/downloads/mltss-timeline.pdf>

In SFY 20-21, 74% of Idaho’s public and charter schools were participating in the SBS program.¹⁴ The rate is relatively stable with nominal fluctuation over the prior two fiscal years. It should be noted that SBS participation rates commonly fall well below 100% and vary widely based on the demographic makeup of LEAs in each State.

Idaho’s SBS program benefits from an MOU and close partnership between IDHW and the Idaho Department of Education (IDOE). Under this agreement, IDHW and IDOE jointly convene a Medicaid Advisory Committee and the IDOE provides all SBS program training and facilitates the Medicaid enrollment process for schools and the two departments work closely to provide coordinated program and technical assistance to participating LEAs.

Considerations

Idaho LEAs submit claims for physical and mental health services based on the State’s Medicaid Fee Schedule, including for the full range of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. To be eligible for payment, services must be included in a student’s Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), or other service plan (SP), and be provided by a qualifying practitioner.

Until recently, SBS billing was largely limited to services outlined in an IEP or IFSP due to a CMS interpretation of policy that Medicaid payment was not allowable for services that were provided without charge—so-called ‘free care’—to the beneficiary. The rescission by CMS of this policy in 2014 represented one of the largest opportunities for states to expand billing under their SBS program. The inclusion of health services outlined in a student’s SP allows Idaho LEAs to bill for services provided to the entire Medicaid student population without limitation to services included in a student IEP or IFSP.

In terms of financing, Idaho funds the SBS program through an Intergovernmental Transfer (IGT) wherein LEAs provide the entire non-federal share, transferring roughly 30% of their anticipated SBS expenditures to the state which holds funds in account until claims are processed. Payment to the LEAs includes both federal and non-federal share, with no administrative percentage or fee withheld by the state to cover operating or improvement costs. While most states finance their SBS programs using Certified Public Expenditure (CPE), this method entails complex and administratively burdensome processes which can increase state operational costs and require significant staffing resources and outside vendors at both the state and LEA-level. CMS has recently expressly encouraged States to consider financing their SBS programs through IGT citing the reduced administrative burden of this financing method for participating LEAs.¹⁵

As previously noted, Idaho does not participate in the federal Medicaid Administrative Claiming (MAC) program, which provides federal match to LEAs for administrative activities performed in service of the Medicaid program. Reimbursable MAC activities include Medicaid outreach and enrollment assistance, as well as care coordination and eligible transportation to access services. In December 2019, IDHW conducted a state-organized discussion and survey of 47 LEAs to assess the viability, interest, and merits of initiating a statewide MAC program.¹⁶ After a review of MAC program requirements and reimbursable

¹⁴“Medicaid Administrative Claiming Webinar and Poll Summary (MAC Webinar),” Idaho Department of Health and Welfare, December 5, 2019.

¹⁵ Daniel Tsai, “Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services,” Centers for Medicare and Medicaid Services, August 18, 2022, <https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf>

¹⁶ “MAC Webinar,” 2019

activities, 76% of total respondents stated the costs of participation outweighed the benefits, with 85% indicating that less than one-quarter of staff would be eligible to participate and 80% reporting low to no capacity for the processes required to identify, measure, and allocate staff time related to MAC activities (e.g., administering the program).

A review of the opportunity cost of implementing a MAC program supports the Department's decision, as expenditures for infrastructure development, software, and additional IDHW staff to monitor and audit a MAC program could be significant. A 2018 report of SBS and MAC program participation by state showed 70% of states operating a SBS program also participated in MAC, with MAC reimbursements averaging 31% as a percentage of total claims.¹⁷ Analysis of more recent fiscal years presents challenges due to modified reporting structure on the CMS-64; this figure is likely inflated when considering the states that have not yet expanded their SBS programs to allow for reimbursement of Medicaid services outside of an IEP or IFSP. We estimate a range of \$4.5-\$18.5 million in total state and federal share through the MAC program for Idaho, offset by significant costs for implementation, operations, and maintenance.

Given the high performance of SBS, low level of interest and capacity reported by LEAs, uncertain financial gain, and administrative complexity, implementation of a MAC program is not recommended at this time.

Recommendations

- 1) **Implement a withhold of SBS claims to cover state operating and program improvement costs.** As proposed in our Interim Report, the State should continue to strengthen and support the SBS program through the implementation of a withhold on SBS claims to cover state operating and program improvement costs.
- 2) **Monitor California and other states.** To give Idaho maximum flexibility in the mid and longer terms, the State should monitor California and other states as they develop requirements and infrastructure to integrate school-based providers and services into the managed care delivery system. Robust stakeholder engagement, and the productive partnerships between IDHW and IDOE will be key elements of any consideration of such a change.

Potential Risks

The preceding recommendations in each programmatic area have differing levels of risk, correlating with the depth of reform being proposed. For example, LTSS and IDD Services contain recommendations related to initiating and/or enhancing value-based payments. Conversely, SBS recommendations are more reflective of the status quo. Generally, the risks fall into three categories:

Administrative/Operational

Enhancing internal oversight, auditing, and compliance capabilities may require additional resources (third-party vendor or State staff) and expertise. This is particularly relevant in the Pharmacy and Program Integrity areas, where potential reforms may necessitate a reallocation and reprioritization of responsibilities. For LTSS and IDD, value-based care initiatives will eventually confront providers with

¹⁷"Medicaid in Schools," MACPAC, April, 2018, <https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf>

greater risk. This will bring additional scrutiny to the Medicaid team and a corresponding need to validate program metrics and the requisite process for determining “winners” under such models.

Implementation

All these initiatives are designed to improve cost containment in the longer term. As such, these reforms must be thoroughly planned, and any system and technical changes should be thoroughly tested prior to implementation to avoid unanticipated impacts on members and providers. Mechanisms should also be added to accurately and transparently measure the effectiveness of such reforms and the impacts on members and providers.

Communication

Even modest reforms can be viewed with trepidation by stakeholders, especially in programs serving members with the most complex clinical needs. With certain Idaho Medicaid programs performing as national leaders, the need to make modifications to meet future challenges could be difficult to articulate. A robust engagement process with stakeholders is crucial to successfully planning and implementing even seemingly minor reforms.

Revenue Maximization

This section describes potential opportunities for Medicaid revenue maximization. Generally, these opportunities revolve around provider assessments being utilized as the required “state share” (or state match) of Medicaid expenditures. In turn, the funds derived from these assessments may be utilized to draw down additional federal matching funds.

The uses of such funds ultimately are determined by state policy makers, within the guardrails established by federal laws and regulations. As discussed earlier, the recommendations below are not to be regarded as cumulative. While there may be opportunities to implement such initiatives in various combinations, federal regulations will determine the allowable and appropriate interplay among the initiatives and the corresponding viability.

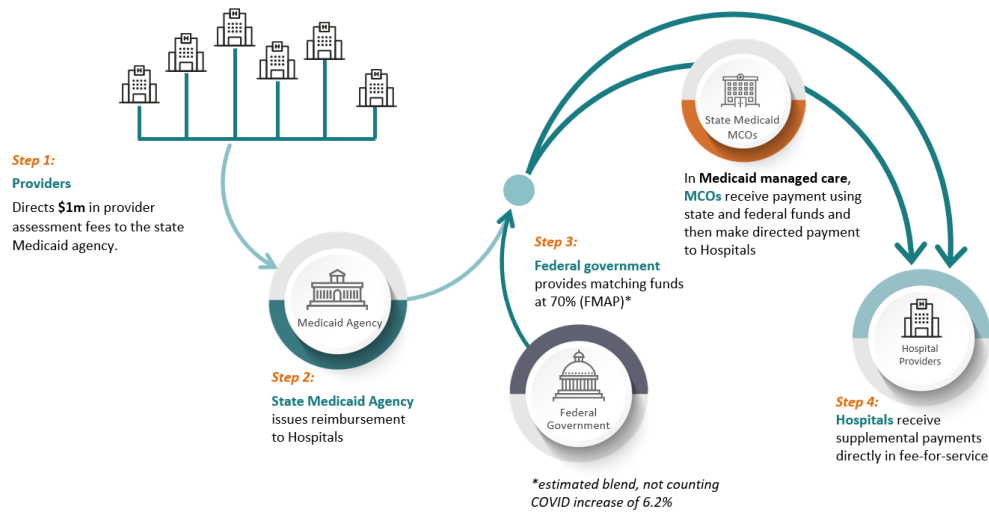
Supplemental and Directed Payment Programs

In both FFS and managed care environments, there are widely utilized methods to maximize federal revenue for the Medicaid program. Referred to broadly as Supplemental Payment Programs (SPPs) and as Directed Payment Programs (DPPs) specifically in managed care environments, these mechanisms allow states to use various sources of state share – inclusive or exclusive of additional General Fund expenditures – to draw down federal revenue for the specific purpose of increasing provider reimbursement.

For private (non-governmental) providers, a provider assessment is the typical source of state share. For public providers, such as academic health centers and hospitals, the source of state share is often an intergovernmental transfer (IGT)

Figure 11 describes the typical flow of funds for payment programs for the provider assessment model. The process is similar for the IGT model.

Figure 11: Funding Flow

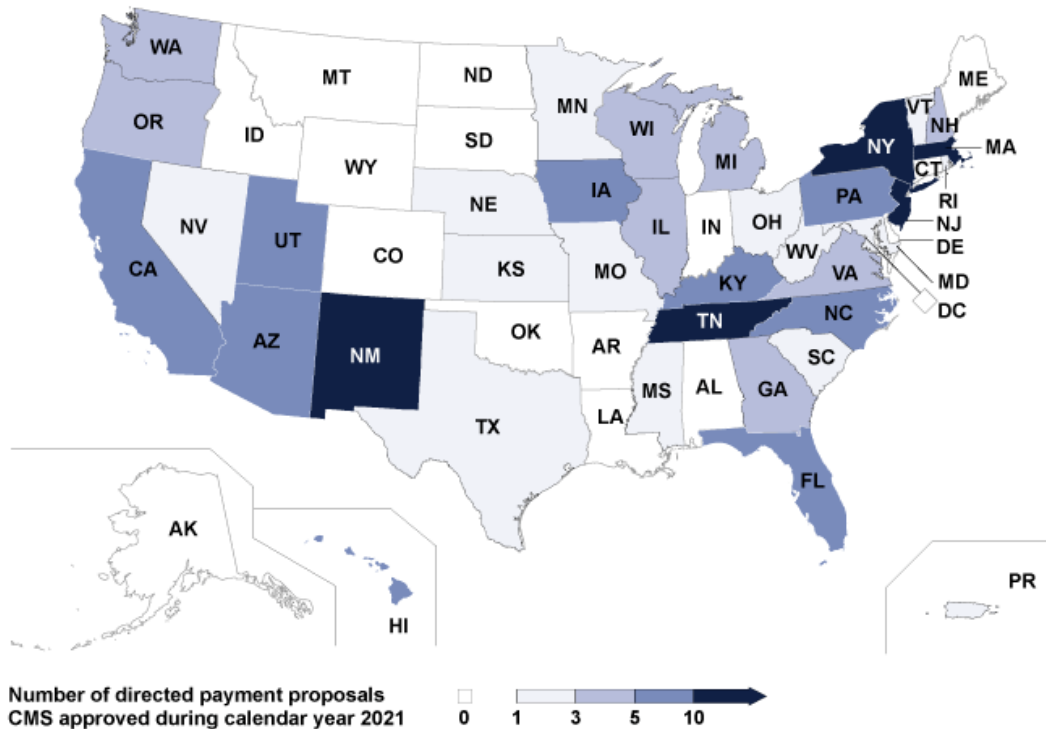


In general, SPP administered through traditional, FFS Medicaid limit provider reimbursement to the provider’s cost, or to the Medicare equivalent as part of Upper Payment Limit (UPL) demonstrations. Under managed care, states have increased flexibility to develop payment programs that can mirror the FFS environment or exceed it by reimbursing providers up to the average commercial rate (ACR). The ACR is often considered the maximum permissible payment amount, as managed care rates are evaluated for actuarial soundness.

Since 2017, DPPs have been used in a majority of states to improve overall Medicaid reimbursement for providers.¹⁸ In 2021, 79 DPPs were approved, as depicted in Figure 12.

¹⁸ “Medicaid: State Directed Payments in Managed Care,” U.S. Government Accountability Office, June 28, 2022, <https://www.gao.gov/products/gao-22-105731>

Figure 12: State Directed Payments Approved in 2021



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-22-105731

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Idaho already utilizes such financing mechanisms within the hospital and NF institutional categories, and for public ambulance service providers. These are referenced below, as well as additional opportunities.

While such mechanisms are quite common across the country, federal law requires states to maintain a minimum level of funding for its Medicaid program as articulated in Sec. 1902.[42 USC 1396a] (a)²⁰:

“A State plan for medical assistance must—
(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;
(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan...”

This means that while states utilize provider assessments (and in some states even local provider assessments) to provide a portion of the non-federal share, there is a federally mandated “floor” on the extent to which these mechanisms may be utilized overall.

More specific categories of revenue maximization opportunities are referenced below. Conceptually and practically, these categories should not be viewed as cumulative, as it would be difficult to maximize every theoretical opportunity and maintain compliance with federal regulations. Political and

¹⁹ “Medicaid: State Directed Payments in Managed Care,” U.S. Government Accountability Office, June 28, 2022, <https://www.gao.gov/products/gao-22-105731>

²⁰ “42 U.S. Code 1396a- State Plans for Medical Assistance,” Legal Information Institute, n.d. <https://www.law.cornell.edu/uscode/text/42/1396a>

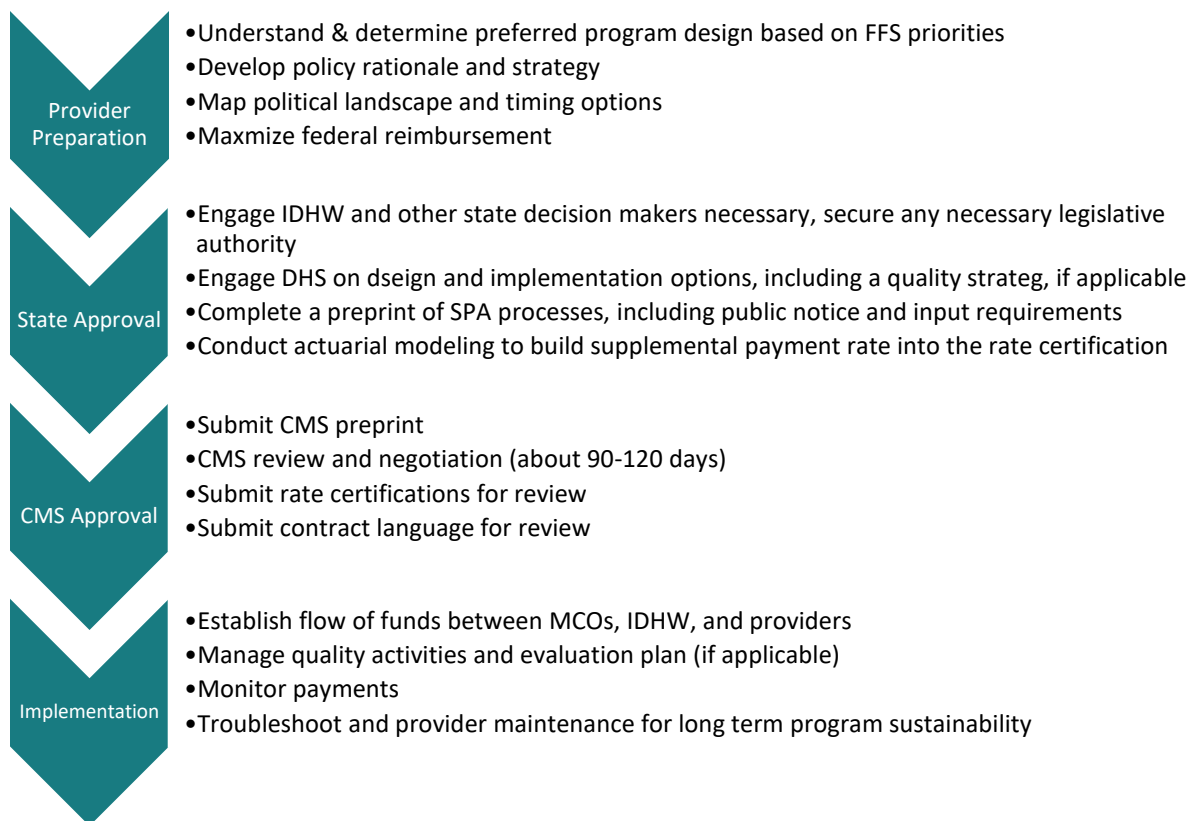
stakeholder response likely also limits the extent to which such mechanisms can be used, although these are more subjective standards.

In addition, financial estimates for each category are not calculated because of multiple, interrelated factors that require numerous policy decisions, including:

- The number of additional members to be covered under managed care (if any), and the corresponding financial resources and clinical composition of those populations;
- The source of state share and corresponding federal regulations;
- The goals of any DPPs, including quality components;
- The degree of provider engagement;
- The timing of any new populations under managed care and DPP implementation;
- The computations of FMAP for the various populations, and the expiring PHE;

The designs of such programs are complex and require full stakeholder engagement in what can be a lengthy process that includes both formal materials submitted to CMS (such as “Preprint” forms that explain the financial, operational, and quality-related components of the initiative), and CMS review and negotiations. Figure 13 illustrates the phases and elements of SPPs from concept through implementation and the categories of providers generally subject to assessments. Selected examples are provided at the end of this section, drawn from western states which share certain geographic and demographic features with Idaho.

Figure 13: SPPs from Concept through Implementation



Hospitals

Idaho currently has a hospital assessment that provides the state share of funding for the Disproportionate Hospital Share (DSH) program, and to ensure adequate funding for the private hospitals to be reimbursed at the Upper Payment Level (UPL) as permitted by federal regulations. Senate Bill 1350, enacted last year, removed the statutory assessment limit of 2.5% of net patient revenues and, alternatively, established the federal limit (6%) as the maximum.

The effective assessment rate for 2024 is anticipated to be approximately 2.27% (equal to \$68 million). There is significant room, therefore, to increase assessment revenues to support the Medicaid program. This could be approached under the current FFS and limited managed care system or under comprehensive managed care.

Recommendations

- 1) **Increase hospital assessment.** Given the current hospital assessment rate, this assessment can be increased to offer additional support to the Medicaid program.
- 2) **Evaluate DPP opportunity to increase current hospital reimbursement to the average commercial rate.** If comprehensive managed care is considered, an analysis of additional provider reimbursement, up to the average commercial rate, should be conducted. Enhancing hospital reimbursement through increases in the existing provider assessments can help mitigate provider concerns regarding the implementation of additional managed care.

Skilled Nursing Facilities

Idaho currently has an NF assessment applied prospectively on a per-resident-day basis. While not enumerated in this manner, this translates to a rate of 2.37%. House Bill 351, enacted in 2020, increased the NF assessment to achieve a total of \$6.79 million in General Fund relief for state fiscal years 2020 and 2021 while holding the nursing facilities harmless. Further, House Bill 351 specifically prohibited carrying forward any rate adjustments made as a component of this initiative.

Since that time, these providers have not had a reimbursement increase. This may be sustainable (if not desirable) in the near term. However, in the longer term this will result in effectively reduced reimbursement due to continued labor cost increases and other pressures.

Recommendations

- 1) **Increase nursing facility assessment.** As referenced in the Interim Report, there is room to increase the NF assessment as part of a DPP in alignment with comprehensive managed care or in the current environment.
- 2) **Evaluate DPP opportunity to increase current NF provider reimbursement to the average commercial rate.** If comprehensive managed care is considered, an analysis of additional provider reimbursement, up to the average commercial rate, should be conducted.

Managed Care Organizations

Typically implemented in states with greater utilization of Medicaid managed care, MCO assessments can serve the same purpose as any other provider assessment. In addition, as Idaho considers expanding managed care to include additional populations, an MCO assessment could offer the state assistance in

funding the transition by providing a source of funding for implementation, and ongoing administration, of an expanded managed care effort.

As with any assessment, the impact on the industry overall must be weighed alongside the financial opportunities created. Managed care penetration beyond the Medicaid program will be a factor in an evaluation of the potential viability for an MCO assessment in Idaho, as federal laws and regulations require an MCO assessment to be applied broadly to the insurance carriers' revenue base. In addition, CMS will ultimately review managed care rates for actuarial soundness. Currently, 18 states impose MCO assessments.

Recommendation

- 1) **Conduct high level evaluation of new MCO assessment opportunity.** This could be evaluated within the current managed care environment for dual-eligibles, behavioral health, dental, and NEMT. Consideration must be given to potential impacts on the commercial insurance lines of the current carriers, as applicable. If further managed care is considered, a similar analysis should be conducted.

Ambulance Services

Idaho already has passed legislation to create a program for public providers using a certified public expenditure model. For private providers, a provider assessment like those applicable to other classes of providers may be a viable option. Such programs are currently operational in about a dozen states and under consideration in others.

Recommendation

- 1) **Evaluate ground ambulance provider assessment for private providers.** Given the need to ensure access to ambulance services, particularly in rural and frontier areas, a provider assessment program should be evaluated for its ability to achieve this goal without additional burden to the General Fund.

DPP Examples

Below are three examples of DPPs, as articulated by the respective states in materials submitted to CMS. The first two (Oregon and Utah) are hospital programs, with one using an IGT for the source of non-federal share and the second employing a provider assessment model. The third example (Washington State) is a physician program also using an IGT.

State of Oregon: Hospital IGT Program to ACR

State	Oregon
Amount	Total: \$530,000,000 Federal: \$390,398,000 State: \$139,602,000
Type of DPP	Public Academic Medical Center(s) will receive qualified directed payments for each inpatient discharge and outpatient visit of an Oregon Health Plan (Medicaid and CHIP) member enrolled in a Coordinated Care Organization.
Development	<p>Qualified directed payments from the PAMC hospital services quality and access pool are tied to actual hospital services provided: the number of inpatient discharges and outpatient visits reported by PAMC hospital(s) to Coordinated Care Organizations (CCOs). Payment amounts are a uniform dollar increase initially determined by dividing the projected quality and access pool by the number of projected inpatient discharges and outpatient visits for calendar year 2022. The quality and access pool is sized such that payments for inpatient discharges and outpatient visits should equal the Average Commercial Rate. The uniform dollar amount for the qualified directed payments will target an even IP/OP split, distributing approximately 50% of the pool for inpatient discharges and 50% of the pool for outpatient visits. Projected hospital services are based on historical and available 2020 utilization. Payment amounts are adjusted periodically based on actual utilization to ensure the PAMC hospital services quality and access pool is fully distributed.</p> <p>The payment arrangement was developed in collaboration with hospital stakeholders, the 2017 Oregon Legislature, and Coordinated Care Organizations.</p>
Fee Schedule Requirement	Uniform Dollar or Percentage Increase
Class	Hospital inpatient and outpatient services
Class Defined	<p>Public Academic Health Center(s) receive qualified directed payments if they meet the definition of a Public Academic Medical Center, as outlined in the State Plan:</p> <p>Definition:</p> <p>“(1) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services; and (2) The hospital must be located within the State of Oregon (border hospitals are excluded); and (3) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.”</p>
Funding for the Non-Federal Share	Intergovernmental transfers (IGTs) from a State or local government entity

State of Utah: Private Hospital Outpatient Tax Program to Medicare Rates

State	Utah
Amount	Total: \$29,661,792 Federal: \$19,873,400 State: \$9,788,391
Type of DPP	<p>The state of Utah is proposing to restructure current payments to hospitals made by Medicaid Accountable Care Organizations (ACO) for the purpose of improving access to care for all Medicaid members and more transparently complying with §438.6(c)(1)(iii)(B). Section 26-36d-205 requires the Utah Department of Health to,</p> <p>“...for accountable care organization rates... incorporate into the accountable care organization rate structure calculation consistent with the certified actuarial rate range...an amount equal to the difference between payments made to hospitals by accountable care organizations for the Medicaid eligibility categories covered in Utah before January 1, 2019, based on submitted encounter data and the maximum amount that could be paid for those services using Medicare payment principles to be used for directed payments to hospitals for outpatient services.”</p> <p>These payments encourage all Utah hospitals to contract with at least one and possibly multiple Medicaid ACOs. These additional payments allow access to a greater number of hospitals and all types of hospitals for Medicaid enrollees. They allow access to all types of hospital services statewide and maintain and increase quality of care for all Medicaid members. This is particularly important for more rural areas of the state. They also encourage Utah hospitals not in the service areas of the ACOs to accept patients who happen to be outside their service area when they need care. In addition, they will improve the quality of care rendered in hospitals. Finally, this will also improve access to inpatient and outpatient services for Medicaid members when they are not enrolled in an ACO.</p> <p>Utah proposes to continue adding these supplemental amounts to the ACO rates for the period specified previously. The Utah ACOs will be directed on how to make these payments to the hospitals through their managed care contracts with the State of Utah for Medicaid.</p> <p>The State intends to evaluate the benefits of these payments each year to determine whether to request approval to continue these payments.</p> <p>This program targets all ACO Medicaid enrollees covered under the contract. All populations that are required to enroll in managed care in accordance with Utah’s 1915(b) Choice of Health Care Delivery Program Waiver in 13 of the 29 counties in Utah will be directly impacted by this proposal. The state expects the hospitals to provide equal access to care and quality of care to Utah Medicaid fee for service members or ACO enrollees who may require services in a hospital in any location in the state.</p>

Development	[response to 19D mirrors 8]
Fee Schedule Requirement	Uniform Dollar or Percentage Increase
Class	Hospital outpatient services
Class Defined	Privately owned outpatient hospitals
Funding for the Non-Federal Share	Health Care-Related Provider tax(es) / assessment(s)

State of Washington: Physician IGT Program to ACR

State	Washington
Amount	Total: \$90,000,000 Federal: \$65,000,000 State: \$25,000,000
Type of DPP	On a quarterly basis, the state will do a retrospective review of the providers' accepted professional encounter data to compare managed care payments versus the ACR at the service line level. The state will aggregate, by provider, the total difference between the managed care payment and the ACR. The agency will pay the total amount for all their contracted eligible providers to the managed care plans. The managed care plans, at that point, will disburse the funds to the participating providers, based on their individual utilization.
Development	The increase is calculated as the difference between the Average Commercial Rate. and the paid amount. The amount is appropriate as it provides the funding needed to providers, so that they can continue to provide care to under-served communities.
Fee Schedule Requirement	Uniform Dollar or Percentage Increase
Class	Professional services at an academic medical center
Class Defined	Qualified Licensed Professionals who are eligible to receive payment for professional services under the state's approved Medicaid program and are: <ul style="list-style-type: none"> 1. Licensed by the State of Washington, where applicable; 2. Enrolled as a State of Washington Medicaid provider; and 3. Either: <ul style="list-style-type: none"> a. Employed by the University of Washington and/or a member of its affiliated physician practice plans; or b. Employed by a public hospital or other public entity, when the public entity elects to participate. <p>It is not required for these professionals to provide services in an academic setting</p>
Funding for the Non-Federal Share	Intergovernmental transfers (IGTs) from a State or local government entity

Potential Risks

All these provider assessment mechanisms have inherent risks. The State has likely already confronted some of these risks with the hospital and NF assessments already in place, and the subsequent adjustments made legislatively and regulatorily. These fall into three broad categories:

Stakeholder

The Interim Report and multiple sections herein reference the importance of stakeholders as policy modifications are considered and, in some cases, eventually implemented. Provider assessments are no exception. The complexities of program design, enabling legislation at the state level, the CMS approval process, and implementation require “buy-in” from all stakeholders, even as their perspectives may be quite different. Therefore, a collaborative, transparent stakeholder engagement process should be constructed to reduce the risk of miscommunication and stakeholder opposition that may slow or derail such initiatives.

Legislative

Based on the current regulatory and legislative structure of the provider assessments, legislative approval will likely be required to implement the revenue maximization recommendations discussed in this report. This extends further to the flow of funds and budgetary impact. Therefore, legislative engagement and statutory enactment will be key elements of successfully implementing any of the initiatives in this section of the report.

Federal

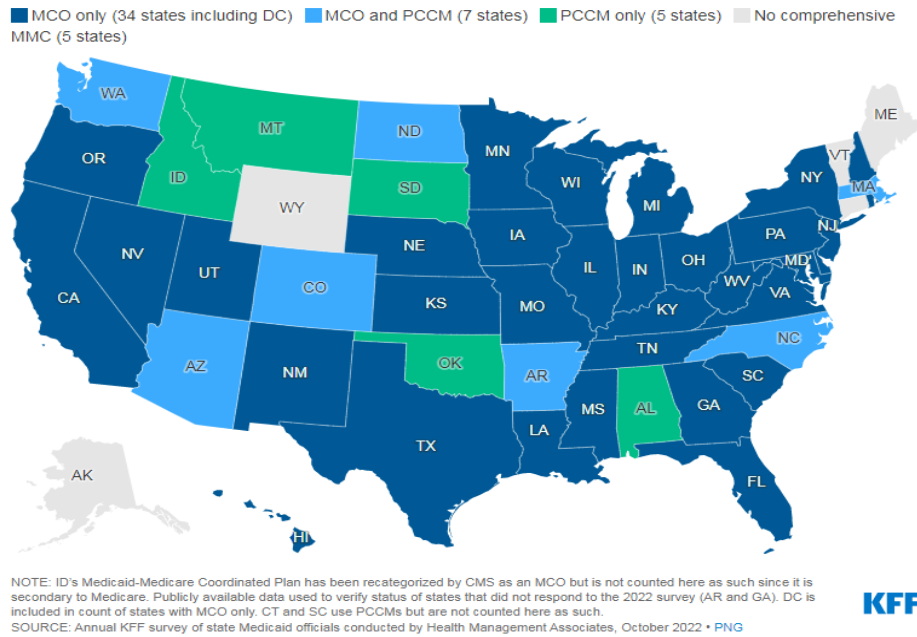
Any changes to reimbursement methodologies may require federal approval of a State Plan Amendment (SPA) or of a managed care contract change involving submission of the “preprint” form referenced earlier. CMS review of these mechanisms and the supporting policy goals can be time-consuming, resource intensive, and unpredictable.

Comprehensive Managed Care

As noted in the Executive Summary, this report includes a recommendation to implement comprehensive managed care to fully include the Expansion, Basic Adults, and Basic Child populations and services. This represents a conservative total of over 300,000 additional lives and applicable services (based on 2022 Legislative Service Organization data; excludes waiver services). This section includes numerous elements of comprehensive managed care for the State’s consideration (beginning with “Federal Authority” below), and recommendations for each.

This overall recommendation is partially based on a notable difference from other states: Idaho largely utilizes the FFS system for the typically less complex populations (Expansion, Basic Child, and Basic Adult, for example), while utilizing managed care for the more challenging populations and related services (dual eligibles and behavioral health services, for example). This means there is a significant opportunity to apply comprehensive managed care to the Idaho Medicaid program to achieve sustainable cost containment.

Figure 14: Prevalence of Medicaid managed care models across the country, as of July 2022.



Cost Containment and Budget Stability

While managed care typically does not (at least, not initially) reduce costs to the State, it can bring budget stability and predictability through the rate setting process and the transition of financial risk to the managed care entities. The state actuaries would compute the costs in the per member per month (PMPM) model, based on specific actuarial and clinical experience of the populations. The State is then able to utilize that information in its budgeting process, having insight into cost pressures and financial trends for future years. This allows for more predictability and a degree of longer-term budget forecasting, within certain margins of error.

This forecasting can be done for both the near term and long term, enabling the legislative and executive branch budgeting authorities to plan for reasonable increases in the PMPM rates and the overall Medicaid budget. Such data can be combined with demographic information and projections to provide a picture of the Medicaid population in the future (five years, ten years, etc.). In some states, (such as Wisconsin), this means the population will be older - particularly in rural areas - and, therefore, will statistically have more medical needs, including nursing facility care and other more expensive needs. In other states that attract more younger, working-age populations, these projections may be more favorable.

While the State would still be the payer for Medicaid members, the State would not be directly and immediately at risk for unanticipated cost increases, such as the unexpected prevalence of more serious and expensive conditions, or poor management of chronic conditions, such as diabetes, that lead to avoidable medical services. Instead, these clinical and financial risks would fall on the MCOs.

²¹ Tolbert and Ammula, n.d.

Cost Containment Analysis and Results

Determining the level of cost containment and projected savings requires a thorough actuarial analysis with transparent and realistic assumptions based on historical clinical and financial data, anticipated cost and member acuity trends, and MCO performance. In Texas, such an analysis was conducted on a retrospective basis. This study concluded that managed care saved between 5.0% and 10.7% when compared to estimated FFS expenditures.²² However, these savings took time to materialize and overhead (administrative) costs increased in order to manage the program effectively.

Separately, a study conducted by Emory University in 2020 reviewed 32 previous studies regarding the financial and care delivery results derived from managed care.²³ It was concluded that managed care may contain or even reduce cost, improve quality and access, and address specific issues associated with unique populations. However, such results were anecdotal and state specific. For example, managed care was shown to achieve a reduction in drug spending, and to reduce hospital readmissions for children with Type 1 diabetes. Notwithstanding, these results were not uniform, and in some instances the desired results were not achieved.

These retrospective studies illustrate the complexities of prospectively projecting savings or cost containment. They also illustrate the need to leverage lessons from other states, determine an appropriate managed care structure for Idaho, provide that structure with appropriate resources, conduct a thorough actuarial analysis as referenced above, and ensure that stakeholders, members, and providers are at the forefront of any reforms.

Below are key elements and recommendations to consider should the State choose to further evaluate a possible transition to comprehensive managed care.

Federal Authority

The Federal Centers for Medicare and Medicaid Services (CMS) must authorize any state/territory to utilize Medicaid managed care. CMS offers multiple mechanisms for such approval, including the State Plan Amendment (SPA) process, 1915 and 1115 waivers, and potential consolidation of any current state waivers into a single, comprehensive 1115 waiver. Figure 15 indicates the key elements of each, as referenced in a recent MACPAC report²⁴:

²² Susan Hart and Darin Muse, "Texas Medicaid Managed Care Cost Impact Study," Milliman, February 17, 2015, <https://www.arkleg.state.ar.us/Calendars/Attachment?committee=836&agenda=114185&file=Milliman-Texas-Medicaid-Managed-Care-Cost-Impact-Study-20150211-2.pdf>

²³ Daniele Franco Montoya, Puneet Kaur Chehal, and E. Kathleen Adams, "Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update," Annual Review of Public Health, 2020, <https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-040119-094345>

²⁴ "Features of Federal Medicaid Managed Care Authorities," MACPAC, n.d., <https://www.macpac.gov/features-of-federal-medicaid-managed-care-authorities>

Figure 15: Key Elements of SPA, 1915, and 1115 Waivers

	1932(a) State plan amendments (SPAs)	Section 1915(b) program waivers	Section 1115 research and demonstration waivers
General Authority	Exempts states from state plan requirements for statewideness,[1] comparability,[2] and freedom of choice. Provides states with a time-limited waiver from state plan requirements for statewideness, comparability, and freedom of choice. May be used to provide additional services that are not provided to enrollees who are not covered by the waiver, as well as limit the number of service providers.	Broad authority permitting all of the flexibility allowed under 1915(b) waivers as well as waiver of other federal Medicaid requirements contained in Section 1902 of the Social Security Act. The Secretary of the U.S. Department of Health and Human Services (The Secretary) also may provide federal matching funds for services, activities, or costs not otherwise matchable.	Not Applicable
Approval Period	Indefinite	Initially Approved for Two Years	Initially approved for five years, although the HHS may approve shorter or longer periods.
Populations States May Require to Enroll	All state plan populations except certain children with special needs, Medicare beneficiaries, and American Indians.	All state plan populations.	All state plan populations, as well as any individuals not otherwise eligible for Medicaid (authorized through costs not otherwise matchable).
Application Requirements	Completion of mandatory Centers for Medicare and Medicaid Services (CMS) state plan preprint.	Completion of CMS application template.	No CMS standard preprint form or template available, but must submit proposal describing design features of program (e.g., populations covered, design of Medicaid managed care program)
Federal Budget Requirements	No required budget or cost analysis.	Demonstrate cost effectiveness and efficiency of program (actual expenditures cannot exceed projected expenditures for approval period).	Demonstrate budget neutrality (federal expenditures cannot be greater during the approval period with the waiver than without the waiver).
CMS Review Time Frame	Approved within 90 days of CMS receipt unless written disapproval or request for additional information. If additional information requested, 90-day period begins again on day CMS receives additional information.	Same as SPA time frame.	No required time frame for CMS review or approval, but CMS will not make a final decision on a demonstration until at least 45 days after submission.
Renewal Period	No renewal needed	Customarily up to two years; CMS has discretion to approve for five years if the waiver covers dually eligible enrollees.	Customarily up to three years; CMS has the discretion to approve for five years if the waiver covers dually eligible enrollees.
Program Demonstration	Contained within overall CMS state plan preprint	Contained within CMS application template.	Special terms and conditions negotiated between CMS and states and documented.
Monitoring and Evaluation	CMS monitors implementation of SPA to ensure requirements are met; state conducts separate evaluation of managed care entities.	Same as SPA	CMS monitors implementation of waiver to ensure requirements are met; required periodic evaluation of the project (often conducted by the state).

Idaho already has multiple waivers in place, including 1915(b), allowing for managed care of certain populations (such as dual eligibles) and services (home and community-based services) not otherwise allowed under the standard state plan. Some states have multiple waivers already in place and may choose to consolidate them to construct new programs with new services and financing mechanisms. California most recently pursued this method. While an option, this appears unnecessary for Idaho.

Recommendation

- 1) **Utilize the waivers in place to allow for greater managed care.** The current Idaho state plan and existing waiver authority should allow for greater managed care as described in this paper. However, a thorough review and confirmation with CMS is recommended to ensure an efficient process.

Geography

Idaho is geographically diverse, ranging from a major urban area to remote, rural and frontier areas. This presents challenges to ensure Medicaid member access to care and adequate MCO provider networks. However, many MCOs have national reach that can be leveraged, as well as telehealth, and the use of out-of-state providers in certain situations (the use of out-of-state providers presents different risks, as discussed in the Interim Report under “Single Case Agreements”).

Other states face similar situations, and there are various geographic models for implementing managed care. These are state-specific and often are based on logistics, history, and other factors. California and Pennsylvania, for example, utilize county-based systems. Alternatively, Wisconsin and Texas utilize regional approaches. Many states take a statewide approach. However, regardless of the model, states and their MCOs must still meet CMS requirements for network adequacy and access to care, and any applicable state laws and regulations.

Recommendation

- 1) **Apply a statewide approach.** Given the diverse geography, a statewide approach is more likely to ensure the rural and frontier areas are sufficiently addressed by preventing MCOs from bidding only on the more populous counties or regions.

Number of MCOs

Similarly, the number of MCOs is an important decision, particularly given the relatively small Medicaid population. States generally prefer multiple MCOs, whether regionally or statewide. Multiple MCOs offer members a choice in networks and providers, as well as customer service. Some MCOs may provide better care for certain conditions, and/or have access to specific providers for more complex medical situations requiring skilled specialists.

In addition to offering member choice, multiple MCOs can also protect states if a particular MCO falls out of compliance with state and federal requirements or faces severe financial difficulty. While such situations are rare, they could be devastating to the stability of a Medicaid program and jeopardize patient care.

The number of MCOs is also influenced by the number of covered lives in a Medicaid program. Relatively larger state Medicaid programs may utilize more MCOs, such as Illinois, which utilizes seven.

Alternatively, smaller states may have fewer. For example, Nebraska utilizes three MCOs, all on a statewide basis. Nebraska is an excellent state to consider, as it resembles Idaho in the dynamics of population distribution and geography, utilizes comprehensive managed care, and has a relatively small Medicaid population of approximately 365,000. In addition, Nebraska also expanded Medicaid through a ballot initiative. Prior to expansion, each of the three MCOs covered approximately 80,000 members. After expansion, each covers approximately 122,000 members.

Recommendation

- 1) **Contract with a maximum of three MCOs.** Idaho, with approximately 415,000 Medicaid members, could follow the Nebraska model and contract a maximum of three MCOs (and a minimum of two). Although the redetermination process may ultimately change the number of members, this should not substantively impact this recommendation.

Types of MCOs

Idaho already employs limited managed care and, therefore, is familiar with the large, national MCOs, including Optum (Idaho Behavioral Health Plan), MCNA (Idaho Smiles Dental Plan), and Molina (Molina Healthcare of Idaho for dual eligible members). Other national players may be expected to respond if Idaho issues an RFP seeking MCOs for comprehensive Medicaid managed care.

However, some states have a requirement to include a local, “home grown” MCO in their Medicaid programs as an option for members. Typically, such MCOs are provider-owned or provider-sponsored. North Carolina has such a requirement, although it allows for a partnership between local providers and a national MCO to fulfill this requirement. Interestingly, Alabama considered such an approach while pursuing a Medicaid managed care initiative, although Alabama eventually abandoned the larger managed care initiative.

Recommendation

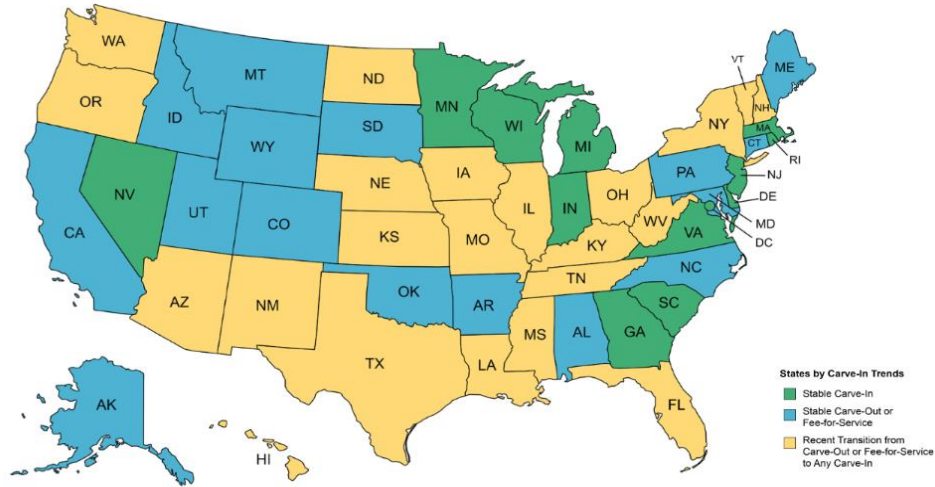
- 1) **To be determined through stakeholder engagement and administrative review.** The impacts on member access to care, cost containment, and local insurers and providers from this element requires further review.

Services Covered Under Managed Care (“Carved-In”)

States with Medicaid managed must also determine which services are to be covered by the MCOs. Such decisions can impact the level of cost containment that may be achieved: MCOs generally are able to manage care more efficiently if they are responsible for most, if not all, clinical aspects of the member’s care, allowing for greater care coordination and a team approach for members with multiple and/or complex conditions.

For example, Idaho currently covers behavioral health through a single MCO, with other member services administered through a FFS structure or a separate MCO. This is both member and service dependent, and therefore, may not be the most advantageous model in the longer term. With a broader recommendation to expand managed care, the State may choose to “carve in” behavioral health benefits into future managed care contracts. Figure 16 illustrates which states follow such a model. While this data is slightly dated, the trend has been towards the carve-in.

Figure 167 Map of States by Medicaid Behavioral Health Payer Carve-In or Carve-Out Status from 2010-2018



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Similarly, the State may elect to carve in the pharmacy benefit into the managed care contracts. This is the prevailing model nationally, with 34 states (including Washington, DC) utilizing this practice. However, California carved out the pharmacy benefit as of July 2022, New York and Ohio have plans to do so this year or later, and a handful of other states are maintaining a carved-out model. Some states carve out only certain prescription drugs, such as specialty and/or high-cost drugs and treatments.

Recommendation

- 1) **Carve in behavioral health, pharmacy, dental, LTSS and other services.** This is driven by the need to attract a competitive number of managed care RFP respondents, as well as achieve a comprehensive approach to managed care. Overall, the more comprehensive the benefits that are carved in, the more attractive the program will be to prospective managed care RFP respondents, and the greater opportunity for care coordination. In turn, the MCOs may offer additional savings or cost containment.

Value-Based Payments

The Idaho Medicaid program has utilized multiple iterations of value-based care since the 1990s. The PCCM, and the more recent Value Care Organization (VCO) program, are two examples. While these programs are well-intended and the commitments from the Medicaid program and the providers have been substantial, the cost containment and quality results have been uncertain. This is in part due to data limitations as noted in the Interim Report.

A transition to comprehensive managed care provides a rare opportunity to establish value-based elements without a large state infrastructure to manage those elements. MCOs routinely engage with providers to construct value-based elements in their contracts. These elements can be more aggressive, with providers assuming financial (“downside”) risk if they do not meet certain patient care metrics. Alternatively, these elements can be more modest, such as creating incentives for reporting various clinical and provider data, as well as for certain clinical practices (such as management of members with

²⁵ Marcela Horvitz Lennon et. al., “Is Carve-In Financing of Medicaid Behavioral Health Services Better Than Carve-Out?,” Health Affairs, February 7, 2023, <https://www.healthaffairs.org/content/forefront/carve-financing-medicaid-behavioral-health-services-better-than-carve-out>

chronic conditions). The choice lies primarily with the State, and these elements may be included in the RFP process to foster competition and ultimately incorporated into the managed care contracts. At least 21 states have such elements in their MCO contracts. (KFF, “A View from The States...”, 10/18/19).

Directed payment programs can also be used to drive quality improvement. In the 2016 “Mega Rule,” CMS created a new option for states to direct payments to providers that met the following conditions: 1) the payments were tied to utilization and delivery of services under the managed care contract; 2) the payments were distributed equally to specified providers; 3) the payments advanced at least one goal in the state’s MC quality strategy; and 4) the payments were not conditioned on provider participation in intergovernmental transfer (IGT) agreements (42 CFR §438.6(c)). Therefore, while MCOs generally have the flexibility to negotiate rates with providers, the directed payment option provides states with more control over the rates and methods used by MCOs to pay network providers.

Recommendation

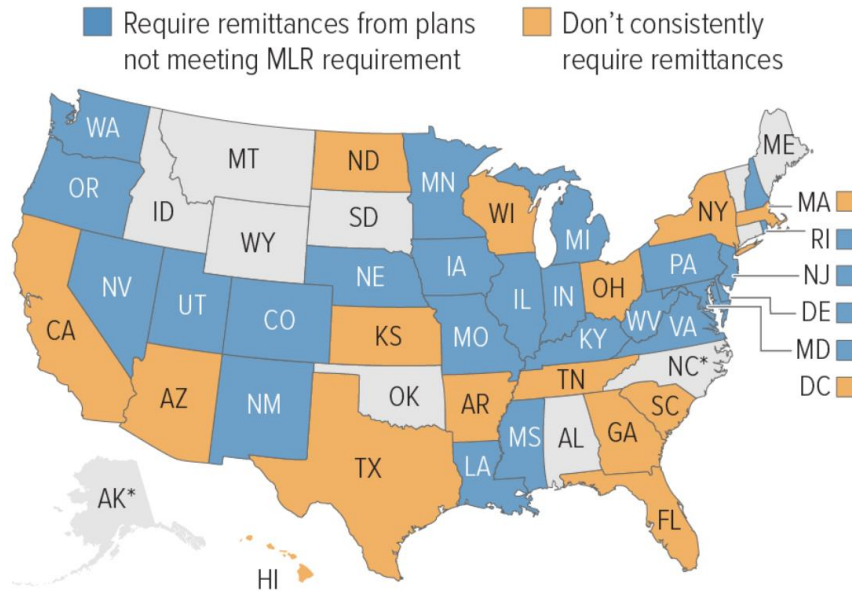
- 1) **Require aggressive quality reporting and achievements in MCO contracts; align this initiative with federal rules regarding DPPs in managed care.** In collaboration with stakeholders, determine the metrics, reporting timelines, potential rewards and penalties, and implementation process.

Medical Loss Ratio

While the Medical Loss Ratio (MLR) concept is optional, the federal regulatory structure can guide much of this process. However, if utilized by a state Medicaid program, MCOs must spend at least 85% of revenue on medical costs for the members. If the MLR falls below 85%, the MCO must rebate funds back to the State. Idaho already utilizes this with its current MCOs. The map in Figure 17 illustrates the spread of this mechanism and indicates the 25 states that utilize this tool, which represents more than half of the states that utilize comprehensive Medicaid managed care.²⁶ This map and corresponding resource does not categorize Idaho as a managed care state.

²⁶ “Only 25 States Require Medicaid Managed Care Plans to Reimburse Them if They Don't Meet Medical Loss Ratio (MLR) Requirement,” Center on Budget and Policy Priorities, n.d., <https://www.cbpp.org/only-25-states-require-medicaid-managed-care-plans-to-reimburse-them-if-they-dont-meet-medical-loss>

Figure 17: 25 States that Require Medicaid Managed Care Plans to Reimburse them if they don't meet the Medical Loss Ratio (MLR)



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Recommendation

- 1) **Maintain the MLR mechanism in the MCO contracts.** This mechanism can protect the Medicaid program from unanticipated financial impacts and add a layer of accountability. In addition, new regulations are expected very soon from CMS that may change this from a state option to a requirement.

Potential Risks

As discussed throughout this report, there are many moving parts and decisions that combine to, ideally, ensure timely access to evidence-based, high-quality care to Medicaid members.

Moving from a recommendation in a report to full implementation of comprehensive managed care understandably carries practical risks, some of which have been referenced both directly and indirectly in previous sections.

These risks fall into several categories: including the Request for Proposal (RFP) process, readiness and implementation, Medicaid program oversight, policy and political, financial, operational, and timing.

Request for Proposals (RFP) Process

Attracting a competitive cohort of MCOs to the RFP process is a key component of success, and many of the elements to achieve this were previously discussed. The components, clarity, and scoring metrics of the RFP are also important. There are numerous examples of RFP awards being contested, resulting in unproductive and expensive delays in finalizing the RFP awards and ultimate implementation. In some

²⁷ "Only 25 States Require Medicaid Managed Care Plans to Reimburse Them if They Don't Meet Medical Loss Ratio (MLR) Requirement," n.d.

cases, RFPs have been cancelled and relaunched, adding months and even years to the process. Texas, Oklahoma, North Carolina, and, most recently, New Mexico, canceled or declined to award their RFPs. Alabama, referenced earlier, abandoned efforts to move towards managed care, even after receiving federal waiver approval.

Readiness and Implementation

Even if the process advances smoothly prior to implementation, the MCOs, the Medicaid program, and/or stakeholders may not be fully prepared for the launch. Since 2016, CMS requires states to conduct pre-implementation readiness reviews to ensure that MCOs are prepared to comply with program and contract requirements and ready to deliver services to enrollees prior to enrollment.

Readiness reviews assess the ability and capacity of the MCO to perform satisfactorily in all major operational areas, including:²⁸

- Oversight of subcontractors
- Enrollee and provider communications
- Grievance and appeal procedures
- Member services and outreach
- Provider network management
- Program integrity and compliance
- Case management
- Utilization review
- Quality improvement
- Financial management
- Claims processing, reporting, and encounter data

Readiness reviews can include a desk review of documents and an on-site review, including interviews with MCO staff. Readiness assessments are also typically conducted internally by the MCOs.

Medicaid Program Oversight

Oversight of Medicaid managed care is governed by CMS. The Division of Medicaid already has oversight mechanisms in place for its current FFS and managed care programs. The transition to comprehensive Medicaid managed care will require refinement of this oversight role.

Some areas may require new expertise, additional staff, and/or outside vendors targeted towards MCO oversight and contract compliance rather than current responsibilities that often focus on direct provider and member engagement more typical of a FFS system. This is discussed further in the Medicaid Program Administration Impacts section below.

In addition, this initiative may impact other departments and agencies outside of IDHW. Ensuring these agencies, such as the Department of Insurance, are included in the planning process will help avoid bureaucratic hurdles and potential delays.

²⁸ “Key Federal program Accountability Requirements in Medicaid Managed Care,” MACPAC, n.d.
<https://www.macpac.gov/subtopic/key-federal-program-accountability-requirements-in-medicaid-managed-care/>

Policy and Political

With the numerous issues that contribute to a member-focused, accountable managed care program, policy and political dynamics can either support or inhibit the desired performance. For example, policy decisions made at the administrative or legislative level that restrict the standard tools utilized by MCOs to manage care and contain costs would likely reduce the cost-effectiveness of the program. Some examples include restrictions on prior authorization, mandatory coverage of otherwise optional benefits, modifications to pharmacy benefit administration, mandatory network contract requirements for service providers, and standardized credentialing requirements. These may be more manageable if included at the outset of program administration.

Financial

The rate-setting process and member MCO assignment are key pieces of the financial puzzle for both taxpayers (the State) and the contracted MCOs. Strong actuarial and data analyses are needed to ensure the rate setting process is accurate and reflects the clinical and demographic composition of the Medicaid population. Regardless, the initial rates may not accurately match the impact of the new populations in managed care. This impact could be positive or negative for the State, or for the MCOs (or even a single MCO). This process should be transparent to the MCOs and taxpayers. Insufficiencies in this process may undermine program performance and reduce the budgetary and care management benefits to be realized from comprehensive managed care.

Immediate financial benefits may also be limited due to the upfront costs that may be required for the transition, such as additional staff and or third-party vendors to assist in any of the structural components already discussed. DFM should participate in the development and implementation conversations to distinguish the short term and long-term financial implications.

Operational

In some states, the initial transition to managed care has been a challenging experience. Some of these challenges include delayed and/or inaccurate provider payments, MCO member enrollment delays and errors, and potential imbalances among the number, and health, of members allocated to the MCOs (if one MCO draws a disproportionate share of members with greater clinical needs, this will drive higher costs and care management needs for that MCO). A thorough implementation plan and timeline, developed with significant stakeholder input (addressed below), are critical to avoiding negative outcomes and building a flexible program that serves the members for the long term.

Timing

The most effective managed care transitions are the result of a thoughtful and deliberative planning process that includes time to develop a clear roadmap or strategy document to articulate the state's reasoning, goals, and vision for the proposed move. A thorough planning process incorporates several critical steps including: 1) stakeholder input; 2) education of program participants; 3) assessment of readiness at both the state and MCO levels; and 4) development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing management of the program.

Impacts of Comprehensive Managed Care and Cost Containment Mechanisms

Member Impacts

Medicaid members will inevitably experience some impacts in the transition from FFS to managed care, including three of greater significance (this not an exhaustive list):

- 1) As part of implementation, members will be presented with a choice of MCOs and corresponding provider networks. Depending on the medical needs of a family or individual member, this decision may impact the choice of providers, even in more challenging clinical situations. In addition, many Medicaid members do not actively select an MCO. As a result, the State assigns members through an algorithm. These members may not know who their MCO or providers are until facing a clinical need and may not be engaged in their own care. This increases medical and financial risk, particularly with chronic and complex conditions.
- 2) Members may face delays in care delivery when a service is unnecessarily subjected to prior authorization or other MCO approval process.
- 3) Members will likely be required to utilize the MCO dispute resolution process if care is denied or delayed as referenced in 2, or if a desired provider is out of network. While there will also be further appeals processes, these can be difficult to navigate without prior experience or an advocate to assist them through such processes.

Provider Impacts

Providers will likely face similar impacts as members, with four significant (but not exclusive) elements impacting providers and their interactions with patients (please note the term “providers” includes traditional providers, such as physicians, specialists, and allied health professionals, as well as pharmacies, durable medical equipment vendors, lab service providers, and others):

- 1) MCOs may seek to reduce reimbursement from what providers receive in a FFS environment. The State’s Medicaid Fee Schedule can be a guide for MCOs to establish provider reimbursement rates, often utilizing percentages of that Medicaid Fee Schedule. States may require that MCOs use the fee schedule as a minimum level of reimbursement for certain procedures and or providers to establish a floor on provider reimbursement.

Revenue maximization strategies discussed earlier in this report are often used in tandem with comprehensive managed care to address the provider reimbursement component and enhance quality improvement initiatives.

- 2) To be in an MCO network, providers may be subject to certain care delivery terms and be subject to utilization review of their practices. Beyond professional disagreements, this can impact provider reimbursement if the insurer deems such care to be medically unnecessary or clinically inappropriate.
- 3) Providers may experience an increase in non-clinical work due to the contracting and credentialing, prior authorization, claims process and other MCO review processes. This can increase provider costs and potentially impact member access downstream as providers may exit the Medicaid program if this issue becomes acute. Any expansion of managed care should

include a goal for reducing provider administrative burden.

- 4) Providers may be required to engage in value-based contracting that carries direct financial risk or other requirements, and may vary from MCO to MCO, although this element will primarily be driven by policy decisions made by the State.

Medicaid Program Administration Impacts

While thematically different than the impacts on members and providers, The Division of Medicaid would also face impacts from a comprehensive managed care initiative:

1. A transition to comprehensive managed care may modify the operational responsibilities of the Division of Medicaid. For example, some responsibilities may diminish, including claims processing, certain performance reviews, data analyses, certain audits, and some member-facing and provider-facing activities. Stakeholders from multiple and competing perspectives may still expect the State to regularly intervene on such issues. However, State intervention would typically be limited to evaluating alleged contractual violations; fraud, waste, and abuse; overall program oversight; and outlier situations.
2. Correspondingly, a transition to comprehensive managed care would task the Division of Medicaid with new oversight responsibilities to ensure MCO accountability. These include compliance with CMS guidelines and regulations, and any additional requirements overlaid by the State. This shift will likely require additional resources, particularly due to the lean nature of the current Medicaid administrative team.

In addition to the more routine functions, the current operational landscape includes managing significant issues, such as the redetermination process, the KW lawsuit settlement agreement, and the instability of an unprecedented PHE. This should be given careful consideration, as the Medicaid team has indicated some difficulty in attracting and retaining staff. This dilemma is not unique to Idaho.

Stakeholder Concerns and Engagement

As with any component of Medicaid, there are numerous stakeholders with diverse perspectives on the program. Table 8 displays the long list of stakeholders from which a transition to comprehensive managed care will draw interest and advocacy, with areas of concern associated with those stakeholders. Please note this is not intended to be exhaustive and there are subjective elements utilized for illustrative purposes.

Table 8: Stakeholders & Primary Areas of Concern with Transition to Comprehensive Managed Care

Areas of Concern	Stakeholders								
	Members & Member/ Consumer Advocacy Organizations	Disease-Specific Advocacy Organizations	Providers	Health Insurers/ MCOs	Pharmaceutical Manufacturers	Pharmacy Benefit Managers	Elected Officials	Medicaid Staff	Federal Officials
Provider Choice & Access	•	•					•	•	•
Timeliness of Care	•	•					•	•	
Prior Authorization Processes	•	•	•		•	•	•	•	
MCO Member Selection, Enrollment, & Administrative Burden	•	•					•	•	
Member Access to Providers and Pharmaceutical Products/Treatments	•	•			•		•	•	
Pharmacy Benefit Administration		•		•	•	•	•	•	
Value-Based Care Elements & Metrics			•				•	•	•
Timely & Accurate Provider Payment			•				•	•	
Sufficiency of Membership (# of covered lives)				•			•	•	
Rate-Setting Process			•	•			•	•	
Member Clinical Acuity (overall health status of members)				•			•	•	
Flexibility to Implement Managed Care Tools				•			•	•	
RFP & Contracting Processes				•			•	•	•
Compliance Requirements/MCO Oversight				•			•	•	
Prescription Drug Formularies				•	•	•	•	•	
Legislative Oversight Role	•						•	•	
Ensure Service Delivery to Members	•							•	
Transition to Oversight Responsibilities			•	•				•	
Vehicle for Managed Care (e.g., waiver, SPA)							•		•
Readiness Assessment								•	•
Program Oversight							•	•	•

Initial responses to the recommendations in this report are likely to stretch across the spectrum. Any decision to implement comprehensive Medicaid managed care should bring stakeholders to the table. While groups and individuals may be opposed for various reasons, understanding those concerns, and incorporating them into the implementation planning process, is a key to a smooth rollout. Similarly, there is value in the perspectives of groups and individuals that support such an initiative.

Stakeholders should be engaged early, often, and in structured settings. The State team knows these stakeholders well and will have valuable recommendations on how to engage, which may include third parties. Standard mechanisms include listening sessions, focus groups, and public email boxes, among others. Again, the State team will have suggestions based on previous Medicaid program initiatives and ensuring concerned residents and groups across the entire state have opportunities to provide meaningful input.

Conclusion and Next Steps

While the research and recommendations contained in this report serve as the final component in support of Idaho's commitment to identifying cost savings and revenue maximization strategies for its Medicaid program, the long-term concepts presented in this report are the initial steps to a more holistic look at potential reforms. A more in-depth evaluation would include additional actuarial analysis, engagement with different stakeholder groups, adjustments to the Medicaid administrative team to a more oversight and monitoring role, and development of a detailed timeline for implementation.

Leveraging lessons learned and emerging best practices to generate long-term savings and budget predictability to Medicaid, Idaho is poised to utilize comprehensive managed care to ensure high quality and access for members, reasonable reimbursement and administrative structures for providers, and cost containment and accountability for taxpayers. Idaho is further positioned to combine a shift to comprehensive managed care with commonly approved financing mechanisms to further bend the cost curve and improve care delivery, in collaboration with the provider community.