Idaho Medicaid Cost Containment: Final Report

Medicaid Managed Care Task Force

July 10, 2023

Executive Summary

- This project was specifically designed to address concerns regarding substantial increases in Medicaid General Fund spending by providing recommendations for cost containment and revenue maximization.

- In collaboration with the State of Idaho's Executive Office of the Governor's Division of Financial Management (DFM) and the Department of Health and Welfare's (IDHW) Division of Medicaid, an in-depth review of the State's Medicaid program was conducted.

- Recommendations are based on:
  - An in-depth environmental scan
  - An analysis of program specific administrative data used by the Medicaid programs
  - Substantial input and collaboration from DFM and IDHW staff and subject matter experts (SMEs)

Idaho Medicaid Cost Containment

Project Elements

- Programmatic Areas
- Revenue Maximization
- Comprehensive Managed Care

Idaho Medicaid Cost Containment

Project Phases

- Conduct an evaluation of ongoing cost containment strategies for the Division of Medicaid.
- Advise on federal revenue optimization strategies for the State.
- Complete an environmental scan to summarize opportunities for reduction and containment of program expenditures while preserving delivery of high-quality care and services.
- Make recommendations for new or changes to current strategies based on expert knowledge, long-term sustainability, and viability.

Overview of Idaho Medicaid

- The Idaho Medicaid program is operationally stable and is a national leader for individuals with developmental disabilities and in the area of school-based services.

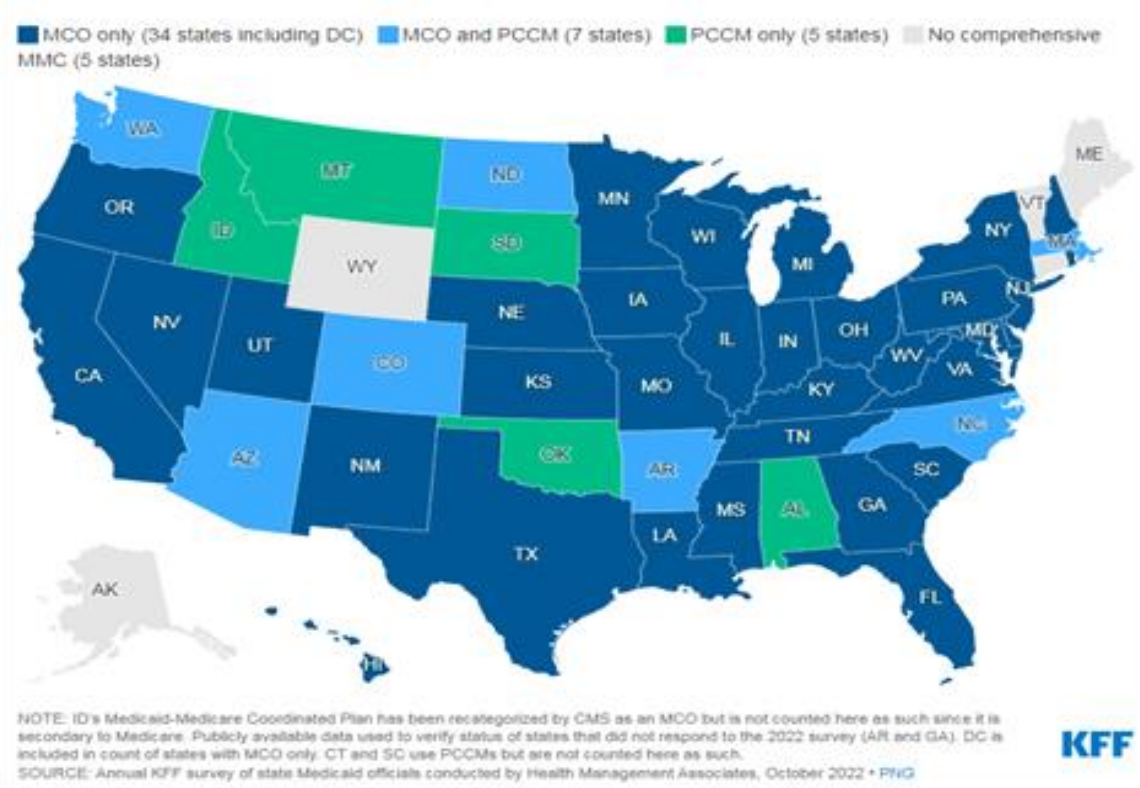
- However, the current Idaho Medicaid program is fragmented into three-care delivery and financing systems; fee-for-service, limited managed care, and value-based systems.

Idaho Medicaid Cost Containment

Medicaid Managed Care Nationwide

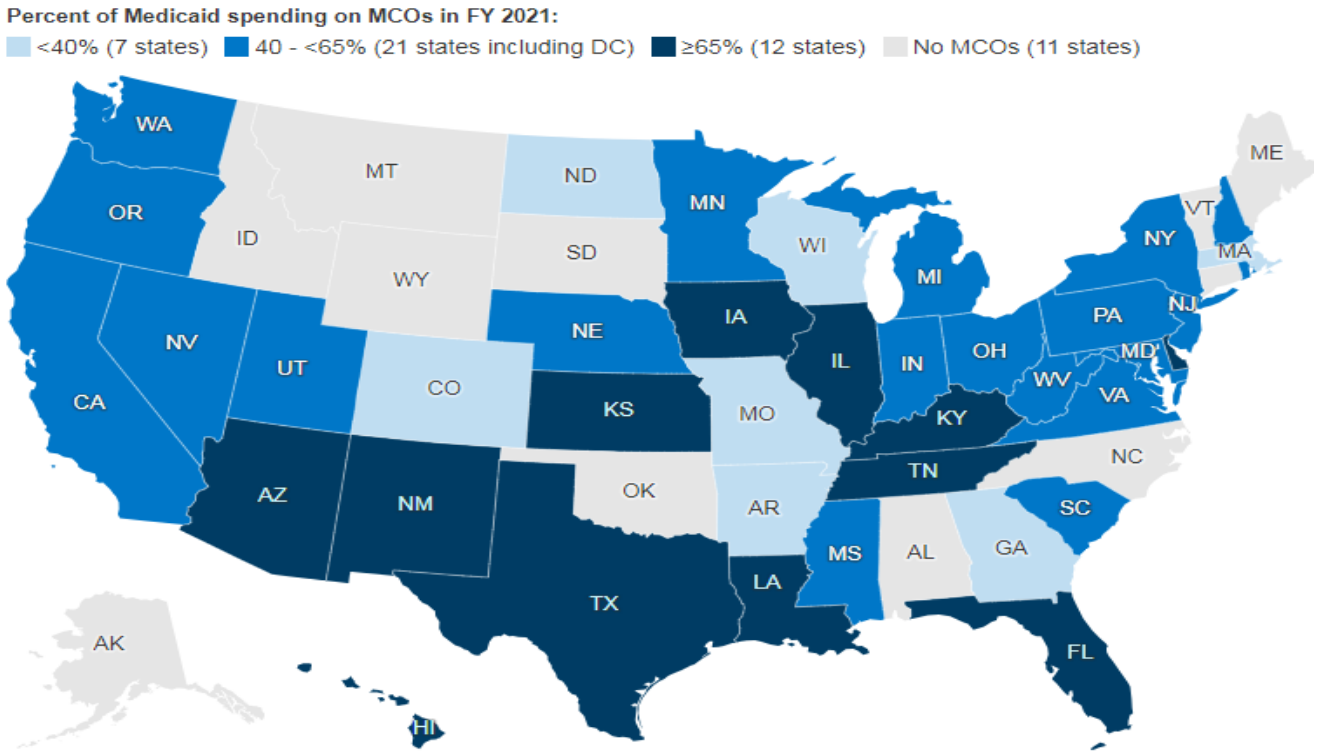
- Managed care is the main care delivery and financing system in over 40 states.

- In contrast, the current Idaho Medicaid program is fragmented into three-care delivery and financing systems: fee-for-service, limited managed care, and value-based systems.



Medicaid Managed Care Nationwide

- In most managed care states, spending on MCOs comprises at least 40% of total Medicaid spending.
- This percentage can vary depending on certain benefits/populations being “carved in” or “carved out”.



NOTE: ID's Medicaid-Medicare Coordinated Plan has been recategorized by CMS as an MCO but is not counted here as such since it is secondary to Medicare. DC is included in the count of states with 40 - <65% of Medicaid spending on MCOs. Spending is for FY 2021, which refers to the Federal Fiscal Year period of October 1, 2020, through September 30, 2021.
SOURCE: KFF analysis of Urban Institute estimates based on data from CMS (Form 64), as of August 2022. • PNG

KFF

Idaho Medicaid Cost Containment

Medicaid Managed Care Nationwide

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

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

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

COMPREHENSIVE MANAGED CARE: Considerations

COMPREHENSIVE MANAGED CARE

Federal Authority

RECOMMENDATION: 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 report.
- However, a thorough review and confirmation with CMS is recommended to ensure an efficient process.

COMPREHENSIVE MANAGED CARE

Geography

RECOMMENDATION: 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.
- Alternatively, some states utilize a regional approach, with mechanisms designed to ensure adequate MCO participation across the regions.
- Financial viability is a key driver of this element.

COMPREHENSIVE MANAGED CARE

Number & Type of MCOs

RECOMMENDATION: Contract with a maximum of three MCOs

- Idaho, with approximately 415,000 Medicaid members, could follow the Nebraska model and contract with a maximum of three MCOs (and a minimum of two).

- Some states address “type” of MCO through the procurement process, such as requiring a local or “home-grown” insurer, or MCO partnership with a local provider group.

COMPREHENSIVE MANAGED CARE

Services Covered Under Managed Care ("Carved-In")

RECOMMENDATION: Carve in behavioral health, dental, LTSS and other services; explore pharmacy

- 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 containment of the cost trend.
- Should be balanced with MCO accountability, specific state dynamics, and operational components.

COMPREHENSIVE MANAGED CARE

Value-Based Payments

RECOMMENDATION: 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.
- Federal regulations are addressing quality issues more aggressively; this is likely a long-term trend.

COMPREHENSIVE MANAGED CARE

Medical Loss Ratio

RECOMMENDATION: Implement a 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, newly proposed federal regulations ("Managed Care Access, Finance and Quality") would modify this from a state option to a requirement.

Potential Risks

- **Request for Proposals Process**
  - RFP awards have been formally appealed, resulting in delays in RFP awards and implementation.
  - In some cases, RFPs have been cancelled and relaunched over the course of years.
- **Readiness and Implementation**
  - MCOs, the Medicaid Program, and/or stakeholders may not be fully prepared for the launch.
- **Medicaid Program Oversight**
  - The transition to comprehensive Medicaid managed care will require refinement of the oversight role performed by the Idaho Medicaid team.
  - A transition to comprehensive managed care may require new “in house” expertise and/or outside vendors to implement the RFP process, MCO oversight, and/or other program elements.
  - Stakeholders from multiple and competing perspectives may continue to expect the State to intervene on various issues, even as the program oversight role may evolve.

COMPREHENSIVE MANAGED CARE

Potential Risks

- **Policy and Political**
  - Policy and political dynamics could either support or inhibit the desired performance.
    - e.g. Administrative or legislative policy decisions to limit MCO mechanisms to contain cost and manage care may impact the cost-effectiveness and quality of the program.
- **Financial**
  - 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.
  - 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.

COMPREHENSIVE MANAGED CARE

Member Impacts

- Medicaid members will experience some impacts in the transition from FFS to managed care, including:

1. Members will be presented with a choice of MCOs and corresponding provider networks.

2. Members may face delays in care delivery when a service is subject to prior authorization or other MCO approval process. However, this can also occur in FFS environments.

3. Members will likely be required to utilize the MCO dispute resolution process if care is denied or delayed, or if a desired provider is out of network.

COMPREHENSIVE MANAGED CARE

Provider Impacts

- Providers will also likely face impacts in their interactions with patients and in the “back office”, including:

  1. MCOs may seek to modify current FFS reimbursement.

  2. To be in an MCO network, providers may be subject to certain care delivery terms and utilization review of their practices. This may also occur in FFS environments.

  3. Providers may experience modifications in non-clinical work due to the prior authorization process and other MCO review processes.

  4. Providers may be required to engage in value-based contracting that carries financial risk and/or other requirements. This element can primarily be driven by State policy decisions.

COMPREHENSIVE MANAGED CARE

Stakeholder Advocacy and Engagement

	Stakeholders								
Areas of Concern	**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, & "Bureaucracy"	●	●					●	●	
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 (waiver, SPA)							●	●	●
Readiness Assessment								●	●
Program Oversight							●	●	●

Q & A

Thank you!