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State of Idaho, Division of Purchasing Medicaid Cost Containment

INTERIM REPORT

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Executive Summary

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, is undertaking an in-depth review of the State's Medicaid program. This comprehensive project is 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, cost avoidance, and key investments.

This interim report contains items that can be implemented in the short term, meaning within one-year or less, in relation to some of the Medicaid-specific programmatic areas agreed upon by DFM, IDHW and Sellers Dorsey listed in the table below, and which broadly align with the State of Idaho budget documents. In some programmatic areas, the Discovery Sessions identified potential longer-term recommendations. These will be included in the April 2023 Final Report, and such areas are not included in this Interim Report.

Notably, further transitions from fee-for-service (FFS) to managed care fall in this longer-term category. Therefore, no assumptions are made or included regarding additional resources and programmatic changes necessary for such transitions.

The target amount of savings and/or revenue maximization for this project equals five percent of the General Fund expenditures, per the Request for Proposals (RFP). This corresponds to $41.5 million of General Fund expenditures.

The FMAP percentage for the purpose of calculating the State share of expenditures and General Fund savings is 24.5139%. This was provided by IDHW staff and represents the State share inclusive of the extra 6.2% in federal share per the federal Families First Coronavirus Response Act signed into law in March 2020.

Below is a brief Summary Table of Recommendations and Annual Savings, assuming effective dates of 7/01/23, the start of the new State Fiscal Year (SFY):

Summary Table of Recommendations and Savings:

Recommendation	Annual Savings
Value-Based Care - PCCM Reform	(6.7m)
Hospital - Inpatient Rates	(6.0m)
Hospital - Outpatient Rates	(8.7m)
Hospital - SCAs Reform	(2.1m)
NEMT - PMPM Reductions	(1.2m)
Transportation - Rate Reform	(0.5m)
School Based Services - Federal Withhold	(3.1m)
DD/IDD - "Pass-through" payments	(0.05m)
DD/IDD - Standardize Rate Review	(7.2m)
LTSS - Provider Assessment	(2.4m)
Dental - Eliminate Adult Benefit	(5.8m)
Program Integrity - External Recovery Audit Contractor	(0.2m)
Program Integrity - Enhanced Program Integrity	(0.6m)
Professional Services - 7.5% Rate Reduction	(21m)
Total Savings:	**(65.7m)**

Process

The Sellers Dorsey Project Team began the project with a comprehensive environmental scan of the Idaho Medicaid program. As part of the environmental scan, the team reviewed publicly available state budget documents, reports, and Waivers. An initial list of additional data requests was developed and discussed at the initial kick-off meeting on September 19, 2022, and further refined after that discussion and shared with IDHW.

Upon completion of the kick-off, the Sellers Dorsey project team collaborated with identified Idaho Medicaid Subject Matter Experts (SMEs) to conduct a series of Discovery Sessions. Topic specific questions were developed by each Sellers Dorsey SME and shared with the identified IDHW SME prior to each discovery session Each session was scheduled for sixty minutes and covered a wide range of topics and issues specific to each topic area. Additional data needs were identified during these calls and IDHW worked with the Sellers Dorsey project team to ensure follow-up materials were shared.

The Sellers Dorsey Project Team then used the information gleaned during the discovery sessions, requested data, and follow-up questions to identify potential recommendations, with an initial focus on short-term items.

"SMART" Rubric

The full budget scorecard (found in Appendix A) contains various elements for consideration and is structured to prioritize the individual recommendations by "difficulty of implementation" ("least difficult" are listed first, followed by "medium"). However, the scorecard could be reconfigured to illustrate different rubrics.

The recommendations in this Interim Report each meet the five criteria below:

- Specific – Each item is a distinct action related to a *single* programmatic area. This means each recommendation can be selected in isolation, independent of other initiatives (no "waterfall").
- Measurable – Each item has a specific dollar amount. Certain initiatives that did not meet this standard have been excluded, although they *may* be included in the final April 2023 report.
- Achievable – Each item can be achieved while recognizing key factors, such as: difficulty of implementation, speed to dollars, implementation action requirements, and stakeholder engagement
- Relevant – Each item is related to one of the core areas for evaluation as agreed upon between Sellers Dorsey and the State.
- Time-Bound – Each item must have a realistic 12-month timeframe. Items that fall outside of that timeframe *may* be included in the final report.

Limitations

The information and recommendations included in this interim report are based on information and data from the State of Idaho, both publicly available resources and more customized information and data 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 recommendations and initiatives suggested in this interim report may be implemented at the discretion of the State of Idaho pursuant to executive branch authority, legislative requirements, 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 contractual processes, procurement processes, vendor engagement, and/or external resources necessary for implementation.

Estimates of potential savings and revenue maximization included in this interim report are based on data available during the period beginning with the kickoff meeting. While there has been consistent follow-up and dialogue with staff, some elements may not have been included due to the brief timeline of this interim report.

Factors to Consider

Administrative Capacity

Although Medicaid administration staff are dedicated and performing at high levels, an overarching theme across each discovery session was limited administrative capacity. The teams in the DFW and the Division of Medicaid are lean, which presents multiple risks such as staff burnout and turnover, overdependence on individual team members (limited backup capabilities when such staff is away from the office or changes jobs), and limited management and oversight of contracted vendors in various functions. Examples of such concerns include nonemergency medical transportation (NEMT), pharmacy benefit management, and program integrity. Some of the recommendations modify current practices, adjust certain programs, and/or require greater oversight be performed by the staff to achieve savings, generate revenue, and ensure accountability of providers, vendors,

and other Medicaid stakeholders. As these recommendations are considered, operational and administrative capacity may need to be addressed.

Additional detailed recommendations will be included in the April 2023 long term recommendations report. Such recommendations are anticipated to include broader structural changes to the Medicaid program and may require additional resources and different capabilities than the current program.

Public Health Emergency

The public health emergency (PHE) was issued by the Federal Department of Health and Human Services (DHSS) on January 31, 2020. States were required to keep beneficiaries enrolled for the duration of the PHE as a condition to receive an increased Federal Medical Assistance Percentage (FMAP) of 6.2 percentage points.[1]

As a condition of receiving the enhanced FMAP, all states have paused redeterminations during the PHE. Similarly, states have been planning for the end of the PHE and the redetermination process. Nationally, between 5.3 million to 14.2 million enrollees could lose coverage as a result of the redetermination process.[2] In Idaho, this could translate to 80,000 enrollees. Pursuant to 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. This legislation contains other provisions, and further guidance from DHHS is expected in the coming weeks.

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 eventual formal end of the PHE, or the Consolidated Appropriations Act of 2023.

Interim Recommendations

The recommendations in this interim report are organized by Medicaid programmatic areas in the following format:

- Brief description of the programmatic area
- Recommendations for cost savings/revenue maximization
- Assumptions utilized to determine financial impact
- Benefits of each recommendation
- Challenges of each recommendation
- Stakeholder Impact

Each section of the report contains a table indicating the financial impact of each recommendation. As noted, the minimum amount of savings and/or new revenue generated by the recommendations must total $41.5 million. The recommendations presented in this interim report total approximately $65 million.

Value-Based Purchasing Initiatives

Description: The Idaho Medicaid program has a long history of integrating value-based care, beginning in 1993 with the Primary Care Case Management Program (PCCM). The PCCM program was intended to reduce emergency department utilization, reduce duplication of services, and improve primary care access. The program has

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[1] Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends | KFF
[2] 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Requirement| KFF

undergone multiple structural changes and expansions, from the transition to the Patient Centered Medical Home ("Idaho Medical Home Collaborative"), to "Value Care Organizations" (VCO)

Key Elements:

- While some data indicate reduced costs through these VBP initiatives, other data does not indicate broad success.
- Multiple iterations, sometimes because of legislation, suggest value-based care programs are being utilized as an alternative to standard rate increases for providers.
- There is a lack of comprehensive third-party evaluations of the program providing a clear picture of successes and opportunities to improve these efforts.
- Idaho staff indicated that such programs are administratively challenging to oversee, including management of underperforming providers.
- The current PCCM program has considerable overlap and duplication of efforts with the newly created VCO program.

Recommendations:

Recommendation #1: Eliminate or suspend the PCCM program (25% state share)

- **Assumptions:** The savings were derived from reported SFY2022 program expenditures. The multiple iterations of this program, relative lack of regular reporting and analytics, and new federal emphasis on quality and at-risk VBP suggest the program be revisited prior to continued investment.

- **Benefits of Recommendation:** The programs are challenging to administer and there is a lack of evidence to demonstrate the level of improvement. Eliminating the PCCM program allows a reset to improve upon past challenges and create a sustainable, long-term vision in collaboration with providers, members, and the Medicaid administration.

- **Challenges of Recommendation:** There has already been significant investment in this program by the State and providers.

- **Stakeholder Impact:** There is a potential for the provider community to consider this a reimbursement cut, and some may have made investments to achieve various goals of these programs.

Summary Table of Value-Based Purchasing Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
PCCM Elimination	7/1/2023	Administrative	(6.7m)	(6.7m)
Value-Based Purchasing Subtotal			(6.7m)	(6.7m)

Hospital Reimbursement

Description: Inpatient hospital payments are mostly made through DRG. Until recently, Idaho used interim payments with settlement done in a future fiscal year. Starting in SFY2022, Idaho implemented a DRG rate-setting process with the first update and initial modeling in the second quarter of that year (10/1/22). State-owned hospitals, including five institutions for Mental Disease (IMDs), critical access hospitals, and most out-of-state hospitals are excluded from the DRG payment system.

Key Elements:

- Cost data from 2019 was used for the hospitals in the model as the budget target.
- In-state hospital payments were set at 100% of hospital costs.
- Out-of-state hospitals were set at 87% (per state statutes).
- For outpatient services, Idaho is moving to the Ambulatory Payment Classification (APC) prospective payment system.
- Medicaid payments to Idaho hospitals also includes payment for Graduate Medical Education (GME).

Recommendations:

Recommendation #1: Inpatient - Reduce in-state pay-to-cost ratio to 90% (or 95% for a reduced financial impact)

- **Assumptions:** The savings were derived from reported SFY2022 program expenditures. The estimate is based upon the newly implemented APR DRG reimbursement methodology and only reflects providers paid under the new approach. Further, the proposed reductions are for instate providers only as out of state providers already reflected a markedly lower pay-to-cost ratio (which aligns with other state Medicaid agency practices). Further, only claims and costs included in modeling were considered (i.e. claims excluded by the rate setting vendor were also excluded for cost containment estimation purposes).

- **Benefits of Recommendation:** Aligns cost coverage percentage more closely with other Medicaid programs and resets the base at a more sustainable level. However, the funding “reduction” should be restored through the hospital assessment methodology articulated in Regular Session 2022 Senate Bill 1350.

- **Challenges of Recommendation:** Because rates were frozen at 2019 levels (even at 100% of cost), inflationary pressures have reduced the overall cost coverage over time. This has the potential to exacerbate that dynamic.

- **Stakeholder Impact:** Providers are likely to interpret this as a significant reimbursement reduction and the State reversing an assumed commitment to maintain 100% cost coverage.

Recommendation #2: Outpatient – Reduce expenses by 10% (or 5% for reduced financial impact)

- **Assumption:** The savings were derived from reported SFY2022 program expenditures and includes both in and out of state providers.

- **Benefits of Recommendation:** Aligns outpatient reimbursement more closely with other Medicaid programs and resets the base at a more sustainable level.

- **Challenges of Recommendation:** The state has embarked on a multi-year effort to transition to APCs. Any changes to existing payments or policies could be viewed as a disruption to the roadmap.

- **Stakeholder Impact:** Providers are likely to interpret this as a significant reimbursement reduction.

Recommendation #3: Reduce Single Case Agreement (SCA) Expenditures to 2019 (pre-pandemic) levels

- **Assumptions:** SCAs are tracked and administered outside of the MMIS system through relatively informal means. Available data indicates year-over-growth in SCA expenditures of approximately $2.1 million since 2017, an atypical trend. To fully understand this dynamic, a very thorough financial and clinical review of the individual cases would be required, similar to that which a managed care organization would undertake to manage such complex and costly services.

- **Benefits of Recommendation:** Address the increasing trend, and cost, of reliance on SCAs from out-of-state providers for various services. In addition, while some SCAs may be necessary in a given year, improved oversight of the process (and providers) likely reduces costs. 2019 is used as the benchmark to remove potential pandemic-related irregularities.

- **Challenges of Recommendation:** Staff indicate there is very limited capacity to apply clinical and financial oversight of the SCAs. Therefore, instituting such processes may require additional resources (state staff and/or vendors). In addition, although a return to 2019 levels is reasonable, there is a degree of unpredictability in the need for rare clinical services.

- **Stakeholder Impact:** Members with very specialized clinical needs may face additional steps before being sent out-of-state for care. Out-of-state providers may resist clinical review and more aggressive financial negotiations.

Summary Table of Hospital Reimbursement Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
Inpatient Rates	7/1/2023	Both	(6.0m)	(6.0m)
Outpatient Rates	7/1/2023	Both	(8.7m)	(8.7m)
SCAs Reform	7/1/2023	Administrative	(2.1m)	(2.1m)
Hospital Reimbursement Subtotal			(16.8m)	(16.8m)

Transportation

Description: Idaho pays for and manages the Medicaid transportation benefit in two ways. Ambulance Services providers are paid on a fee-for-service basis. Non-Emergency Medical Transportation (NEMT) services are contracted with a brokerage vendor. Ambulance services are managed primarily by one DHW staff person. Approximately 80% of ambulance providers are public/municipal and the other 20% are private. Senate Bill 1283, enacted earlier this year, authorizes a Certified Public Expenditure program for ground emergency medical transportation (GEMT) providers. This program will enhance the federal component of reimbursement for public ambulance service providers. As of the date of this report, this program has not yet been implemented.

Key Elements:

- For FY22, total payments for ambulance services providers were approximately $9 million.
- For FY22, the total payments made to the NEMT vendor were just over $47 million.
- Ground ambulances provided nearly 22,000 transports in the last fiscal year at a cost of $7.8 million.
- There were 239 air ambulance transports at a total cost of about $1 million.
- Compared to other states, Idaho Medicaid pays relatively high rates for ambulance services.
- For FY22 total payments from DHW to MTM were $47.1 million. Total claims incurred were $25.9 million. This leads to an MLR of about 55%.

Recommendations:

Recommendation #1: Reduce PMPM rates paid to NEMT vendor (to cover claims, admin, and 80% MLR)

- **Assumption:** The state should work with its actuaries to develop an actuarily sound, but lower, PMPM rate.
- **Benefits of Recommendation:** The State would save nearly $5 million total if it had been implemented in SFY2022.
- **Challenges of Recommendation:** These rate changes may cause a reduction in access to services. While a GEMT has been authorized by SB 1283 that would provide relief to public providers, a similar program for private providers has not been authorized. However, a similar mechanism could be created for private providers.
- **Stakeholder Impact:** NEMT vendors will likely oppose the rate changes.

Recommendation #2: Reduce ambulance services rates to national average

- **Assumption:** While rates paid for ambulance services (basic life support, advanced life support, ground and air) are below Medicare, they are at the higher end of what state Medicaid agencies pay for these services.
- **Benefits of Recommendation:** Reducing rates by 20% (to roughly the national Medicaid average, according to data provided by the American Ambulance Association) would save approximately $2 million in total dollars and $500,000 in state funds.

- **Challenges of Recommendation:** These rate changes may cause a reduction in access to services. While a GEMT has been authorized by SB 1283 that would provide relief to public providers, a similar program for private providers has not been authorized. However, a similar mechanism could be created for private providers.

- **Stakeholder Impact:** Providers will likely oppose the rate changes.

Summary Table of Transportation Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
PMPM Reductions	7/1/2023	Administrative	(1.2m)	(1.2m)
Rate Reform	7/1/2023	Administrative	(0.5m)	(0.5m)
Transportation Subtotal			(1.7m)	(1.7m)

School Based Services

Description: Idaho's School Based Services (SBS) program is a traditional FFS model where local education agencies (LEAs), or school districts, enroll as Medicaid providers and bill the State for services per the State's fee schedule. School-based practitioners submit claims under their LEAs' organizational national provider identifier (NPI) and are not required to enroll as Medicaid providers. The State does not participate in the Medicaid Administrative Claiming program. The program has an MOU with the Idaho Department of Education that provides all SBS program training and facilitates the Medicaid enrollment process for schools.

Key Elements:

- As of 2020, there were 220 total LEAs in Idaho and 126 participating in the SBS program.
- Idaho's SBS program is financed via intergovernmental transfer (IGT). LEAs provide the entire non-federal share claims, transferring roughly 30% of their anticipated SBS expenditures to the state which holds funds in account until claims are processed.
- 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.
- A recent survey of LEAs by IDHW showed low levels of interest in implementing a MAC program.

Recommendations:

Recommendation #1: Implement an SBS claims withhold to cover state operating costs and/or program improvement expenses.

- **Methodology:** Assume 10% skim estimate from federal match excluding COVID dollars (10% of total federal match including COVID dollars for SBS for FY21 per the CMS-64 would be $3.1M).

- **Benefits of Recommendation:** This is a common mechanism through which State operating costs for SBS are covered with federal funds. There will likely be additional revenue beyond operating costs that could be used to assist the State and/or local school districts to maximize SBS through improved claims processes and other mechanisms.

- **Challenges of Recommendation:** There may be accounting and administrative efforts required, in addition to current responsibilities.

- **Stakeholder Impact:** School districts are likely to oppose this reduction in funding for SBS, which may reduce access to services. This dynamic would differ by district, as the use of these funds varies.

Summary Table of School Based Services Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
Federal Withhold	7/1/2023	Administrative	(3.1m)	(3.1m)
School Based Services Subtotal			(3.1m)	(3.1m)

Developmental Disabilities Services

Description: Idaho Medicaid provides intervention services through its State Plan, including Katie Beckett services for children. Supportive services, including respite, are offered under a 1915(i) waiver, and supportive employment services are offered under a 1915(c) waiver. One-half of the children receiving such services are under the state's Katie Beckett program, with the other half receiving intervention services under its State Plan.

As is the case across the country, one of the prevailing structural/policy challenges is the tightening labor market for the direct care workers on whom the state's programs depend on adequately meeting each individual member's and families' needs. To help address these challenges the state has authorized funding aimed specifically at those workers employed by home and community-based services (HCBS) providers. These funds are expected to be "passed through" to the agencies employing the workers in the form of higher wages.

Key Elements:

- 282 provider types are delivering all Medicaid services across programs.
- These providers fall within both Managed Care and FFS environments.
- In SFY17, the average weekly members served was 6,774, compared to 6,762 in SFY22. However, the expenditures for this relatively stable population increased by more than 50%, from $266M in SFY17 to $408M in SFY22.
- Intermediate Care Facilities are the only provider type serving members with intellectual and developmental disabilities that must submit updated annual cost reports that are also then audited by Myers & Stauffer.
- A new priority in the cost reports audits is for Myers & Stauffer to ensure the annual $2 Million direct are worker pay rate enhancement "passed through" to the workforce as intended.

Recommendations:

Recommendation #1: Ensure the Intermediate Care Facilities are complying with pass-through requirements intended to increase wages for direct care workers and recoup these dollars from noncompliant providers. In addition, consider excluding those who fail audit requirements from participating in future pass-through payment enhancement pools.

- **Assumptions:** The current pool totals $2M, and this recommendation assumes 10% of total pool dollars would not be "passed through" to direct care workers. This may be a conservative estimate, as more aggressive compliance activities could be implemented.

- **Benefits of Recommendation:** Inappropriate payments should be curbed and addressed quickly and efficiently. Providers will see an increase in auditing and oversight from the federal level in the coming years. As the State enhances efforts to hold providers accountable, compliance is expected to increase accordingly. Ultimately, this will benefit the members being served and the State.

- **Challenges of Recommendation:** Additional resources are needed for support, either through a vendor or state staff. Additionally, excluding non-compliant providers may reduce provider capacity.

- **Stakeholder Impact:** There is a potential for stakeholders to resist recoupment of any reimbursement.

Recommendation #2: Standardize the rate review/rate setting process for all HCBS providers (not limited to the Intermediate Care Facilities) who are not required to have an audited cost report.

- **Assumptions:** Adding more rigor around the rate setting process for providers currently excluded from such measures is anticipated to illustrate that rates in recent years grew at a rate that outpaced costs (and necessary overhead and margin) for these providers. The table below assumes a 7.5% reduction in costs as rates are "rightsized". Higher or lower estimates could alternatively be applied, with the dollars adjusted accordingly. Finally, such efforts typically achieve greater savings in the first year. The table below shows reduced savings in the second year, as stakeholders adjust to new policies and procedures.

- **Benefits of Recommendation:** Annual submissions of such information for a formal cost-to-rate reconciliation will help ensure rates are not growing faster than provider costs and provide improved budget predictability. The quality withhold recommendation for providers to submit this information timely and accurately to the state will help ensure both a comprehensive and timely rate review. In addition, this will bring new insight regarding potential modifications to the benefit structure while managing costs.

- **Challenges of Recommendation:** Additional resources are needed to operationally build and support this functionality, either through a vendor or state staff. Any potential rate reductions could cause reductions in access to certain services.

- **Stakeholder Impact:** Stakeholders will likely seek input into any modification to the rate setting process. Additionally, providers may interpret this recommendation as a mechanism to reduce reimbursement.

Summary Table of Developmental Disabilities Services Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
"Pass-through" Payments	7/1/2023	Administrative	(0.05m)	(0.05m)

Standardize Rate Review	7/1/2023	Administrative	(7.2m)	(4.8m)
Developmental Disabilities Services Subtotal			(7.2m)	(4.8m)

Long Term Care/Nursing Facilities

Description: Idaho Medicaid reimburses nursing facilities claims on a fee-for-service basis, using a per diem rate at the lower of the Medicaid allowed amount. For dual eligible individuals receiving services through Idaho's Medicaid Plus (IMPlus) or Idaho's Medicare-Medicaid Coordinated Plan (MMCP) nursing facility services are provided through managed care. State law authorizes the Department to levy a nursing faciality assessment, not to exceed the maximum percentage per federal law. Nursing facilities were subjected to an assessment in 2020 and 2021.

Key Elements:

- Idaho operates sixty-seven nursing facilities and contracts with facilities in Utah for specialized care and rural access.
- State and county owned, and operated facilities are exempt from this assessment.
- Myers & Stauffer is currently researching potential changes to the SNF tax program, and this work may impact the savings associated with the recommendation noted below. This analysis may also clarify any statutory or administrative code changes necessary to implement this recommendation.

Recommendations:

Recommendation #1: Increase Provider Assessment for Skilled Nursing Facilities to six percent.

- **Assumptions:** Increase the assessment to 6% tax on total revenue of nursing facilities only. The points below may be impacted by the Meyers & Stauffer analysis referenced above. In addition, no assumption is made regarding utilizing an increased assessment to leverage federal resources towards a provider reimbursement increase.

- **Benefits of Recommendation:** This is a standard mechanism used widely in Medicaid programs that quickly generates additional federal revenue to offset state general fund expenditures: 44 states have implemented such an assessment, at varying degrees up to the federal maximum of six percent. Six states are currently at the six percent ceiling: AR, CA, MI, NJ, NM, OK[1].

- **Challenges of Recommendation:** This provider group no longer receives automatic reimbursement increases, as of July 1st, 2021; levying such an assessment may exacerbate access issues for certain services, depending on federal revenue ramifications.

- **Stakeholder Impact:** There is likely to be significant pushback from interested stakeholders.

[1]Kaiser Family Foundation Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2017

Summary Table of Long-Term Care Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
Provider Assessment	7/1/2023	Legislative	(2.4m)	(2.4m)
Long Term Care Subtotal			(2.4m)	(2.4m)

Dental

Description: Idaho Medicaid generally provides broad benefits for both children (covered under Medicaid or CHIP) and adult populations, although there is no minimum requirement for adult dental services under Medicaid. As in many states, Medicaid dental access is a consistent challenge.

Key Elements:

- In FY20 there were $57 million (all funds) in dental expenditures.
- The adult dental benefit is technically discretionary spending.
- Program integrity efforts within the dental spend are limited.

Recommendations:

Recommendation #1: Eliminate the adult dental benefit

- **Assumptions:** Calculation based on state-provided summary report by aide category and procedure code ranges for SFY2021. State specified aide codes are used to identify adult and expansion populations. Recommendations utilize either all adult-related aide codes or the adult expansion population subset

- **Benefits of Recommendation:** Cost reduction. This benefit is not required.

- **Challenges of Recommendation:** Eliminating the adult dental benefit could lead to more utilization and expenses due to dental problems becoming more severe and requiring emergency department treatment or other provider services.

- **Stakeholder Impact:** Members and advocates will likely oppose this recommendation, due to the existing dental access challenge in some areas, and the potential clinical impacts noted above.

Summary Table of Dental Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
Eliminate Adult Benefit	7/1/2023	Administrative	(5.8m)	(5.8m)
Dental Subtotal			(5.8m)	(5.8m)

Program Integrity

Description: The Idaho Medicaid Program Integrity team focuses primarily on fee-for-service claims from providers. The source of this information is typically drawn from the claims system. The Program Integrity team also contracts with IBM to assist in targeting

Key Elements:

- Idaho staff have identified deficiencies in the claims payment system that inhibit greater effectiveness within the program integrity functions, such as providers being able to adjust the volume of services that are originally filed in their claims.
- Program Integrity efforts are hampered by a lack of inclusion of managed care data. However, this may be at least partially alleviated by inclusion of managed care/MMCP data in the Medicaid data warehouse early in 2023.
- The utilization of IBM Watson is constructive and there may be opportunities to further utilize this tool.
- While TPL performs reasonably well, it is not fully integrated with Gainwell functionality.

Recommendations:

Recommendation #1: Solicit external recovery audit contractor

- **Assumptions:** Comparable states recovered between $700k and $500K after 10% fee amount listed is State share only. A formal procurement process may be required, with a sole source contract being a faster option, if permitted by State procurement laws and regulations.

- **Benefits of Recommendation:** Reduces the risk of duplicate billing across programs and unintentional waste (or intentional fraud) by providers serving clients in both managed care and fee-for-service environments. The data warehouse referenced above may also be constructive in this regard.

- **Challenges of Recommendation:** There is a degree of uncertainty that the Recovery Audit Contractor market will respond to an RFP or other procurement mechanism.

- **Stakeholder Impact:** Recovery Audit Contractors routinely meet significant stakeholder resistance.

Recommendation #2: Increase utilization of external data contractor for fraud detection

- **Assumptions:** With an aggregate return of $3.36 for every $1 spent on FWA activities, Studies[2] the expected return for a well-functioning program would be approximately $4.9 million for the $1.5 million expended in Idaho. The *State of Idaho Department of Health and Welfare Medicaid Program Integrity Unit SFY 2022 Closed Cases* report used a State match rate of approximately 25%, producing an additional $653,500 annually. Projected savings are based on FY2022 reported activity of approximately $2.2 million. The three-year average activity is higher at approximately $2.9 million per year.

- **Benefits of Recommendation:** Enhanced FWA activities have been shown nationwide to reliably improve compliance and generate savings, in the ratio referenced above. Such enhanced efforts ensure greater program accountability without impacting members.

- **Challenges of Recommendation:** Additional state resources will likely be required for a relatively modest return in relation to aggregate Medicaid General Fund expenditures.

- **Stakeholder Impact:** Providers and other stakeholders will likely resist additional program integrity initiatives.

Summary Table of Program Integrity Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
External Recovery Audit Contractor	7/1/2023	Administrative	(0.2m)	(0.2m)
Enhanced Program Integrity	7/1/2023	Administrative	(0.6m)	(06m)
Program Integrity Subtotal			(0.8m)	(0.8m)

Professional Services

Description: Idaho Medicaid professional services are primarily traditional fee-for-service (FFS). Professional services include a wide array of services including those performed by a practitioner, physician administered drugs, and durable medical equipment. Ambulatory Surgical Centers (ASC) are also considered professional services and include all professional codes for billing as traditional FFS in an outpatient setting. Idaho Medicaid bases reimbursement for professional services on Medicare fee schedules.

Key Elements:

- For SFY22, Idaho reimbursed approximately $1.23 billion for non-ASC professional services and $11.1 million for ASC professional services.
- Non-ASC professional medical services are meant to reflect 90% of Medicaid Physician Fee Schedule (MPFS).
- Analyses are performed annually to maintain alignment with a prescribed % of MPFS, although there is not an automatic process for rate updates.
- Physician Administered Drugs (PAD) are reimbursed at the Medicare Average Sale Price (ASP) plus 6%.
- ASCs are reimbursed at 90% of the Medicare fee schedule upon a code becoming covered.

Recommendations:

Recommendation #1: Implement across the board (ATB) rate decrease of 7.5%.

- **Assumptions:** CPT codes that do not have an Idaho rate are not included in this reduction.

- **Benefits of Recommendation:** Cost reduction.

- **Challenges of Recommendation:** The magnitude of the reduction could exacerbate member access challenges for certain services.

- **Stakeholder Impact:** Providers can be expected to oppose this reduction, although opposition may vary based on Medicaid volume.

Summary Table of Professional Services Recommendations:

Recommendation	Implementation Date	Legislative / Administrative	SFY 2024	SFY 2025
7.5% Decrease	7/1/2023	Both	(21m)	(21m)
Professional Subtotal			(21m)	(21m)

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Appendix

Appendix A: Budget Scorecard

	FMAP	24.51%				
Budget Action Recommendation	**Annual Impact (State Share)**	**Difficulty of implementation (1 least, 3 most)**	**speed to dollars (1 fast, 3 delayed)**	**Action (Legislative or Administrative)**	**Stakeholder Engagement (1 light, 3 heavy)**	**CMS Approval needed?**
Least Difficult Recommendations to Implement						
Professional Services - Implement across the board (ATB) rate decrease of 7.5%.	$ 21,009,000	1	1	Both	2	Yes
Value-Based Care - Eliminate PCCM Program.	$ 6,722,000	1	1	Administrative	3	No
Dental - Eliminate adult benefit.	$ 5,766,000	1	1	Administrative	2	Yes
School-Based Services - Implement administrative fee of 10% levied against paid SBS claims to cover state operating costs and program enhancement activities.	$ 3,100,000	1	1	Administrative	2	TBD
Transportation - Reduce FFS ambulance services rates to national average.	$ 547,000	1	1	Administrative	2	No
TOTAL OF "LEAST DIFFICULT" IMPLEMENTATION RECOMMENDATIONS	***$ 37,144,000***					
Medium Implementation Difficulty Recommendations						
Hospital Outpatient - implement a 10% reduction in expenses.	$ 8,672,000	2	1	Both	3	TBD
LTSS - Provider Assessment (NF, LTCH, ICF/ID - Increase of 3% tax above current level (6% max.).	$ 2,449,000	2	2	Both	2	Yes
DD/IDD - Standardize rate review/rate setting for all HCBS providers and require annual submissions of cost-to-rate reconciliation.	$ 7,249,000	2	2	Administrative	2	No
Hospital Inpatient - Reduce in-state pay-to-cost ratio to 90%.	$ 6,040,000	2	1	Both	3	TBD
NEMT - Reduce PMPM rates paid to NEMT vendor (to cover claims, admin, and 80% MLR).	$ 1,196,000	2	2	Administrative	2	TBD
Program Integrity - Increase utilization of external data contractor for fraud detection.	$ 600,000	2	1	Administrative	2	No
Hospital - Reduce single case agreements to 2019 levels.	$ 2,086,000	2	2	Administrative	1	No

DD/IDD - Ensure the ICFs are using "pass-through" payments for direct care workers salaries, as required.	$ 47,000	2	2	Administrative	1	No
Program Integrity - Solicit external recovery audit contractor.	$ 207,000	2	2	Administrative	1	No
TOTAL OF "MEDIUM" IMPLEMENTATION RECOMMENDATIONS	***$ 28,546,000***					
TOTAL OF RECOMMENDATIONS	**$ 65,690,000**					