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State/Territory Name: ID

State Plan Amendment (SPA) ID: 21-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

December 18, 2024

Matt Wimmer, Administrator
Idaho Department of Health and Welfare Division of Medicaid
PO Box 83720
Boise ID 83720-0009

RE: TN ID-21-0002

Dear Administrator Wimmer:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Idaho state plan amendment (SPA) to Attachment 4.19-B ID -21-0002, which was submitted to CMS on June 10, 2021. This plan amendment modifies the reimbursement for the Primary Care Case Management Program and aligns it with the Healthy Connections Value Care Program.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact LaJoshica Smith at 214-670-4182 or via email at lajoshica.smith@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **ID-21-0002**

2. STATE **IDAHO**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07-01-2021

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1905(t) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
FFY2020 $ 0.00
FFY2021 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B pages 13-17a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B pages 13-17b

10. SUBJECT OF AMENDMENT:
Amendment to the State Plan to modify the reimbursement and structure for the Primary Care Case Management Program, known as Connections, and align it with the Healthy Connections Value Care Program.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MATT WIMMER

14. TITLE:
Administrator

15. DATE SUBMITTED:
06-10-2021

16. RETURN TO:

Matt Wimmer, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 06/10/2021

18. DATE APPROVED:
December 18, 2024

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/2021

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Todd McMillion

22. TITLE:
Director, Division of Reimbursement Review

23. REMARKS:

F. Payment to a Medicaid provider shall be:

I. Where there is an equivalent the payment to a Medicaid provider for primary care procedure codes, as defined by the Centers for Medicare and Medicaid Services, payment will not exceed one hundred percent (100%) of the Medicare rate; and payment will be ninety percent (90%) of the Medicare rate for all other procedure codes.

1. Where there is no Medicare equivalent, payment will be prescribed by use of approved pricing documentation, which may include but is not limited to invoices that list the manufacturer's suggested retail pricing (MSRP), Average Wholesale Price (AWP), and/or Wholesale Acquisition Cost (WAC).

2. The fee schedule for these services is published at: http://www.healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers, effective for the dates noted on the published version.

G. The Medicaid payment for primary care case management under Idaho's Primary Care Case Management (PCCM) program is paid in addition to fee-for-service (FFS) to physicians and non-physician practitioners who are enrolled as providers in the PCCM program. The structure is based on the primary care provider's ability to meet those needs. The case management fee is:

I. TIER 1 – HEALTHY CONNECTIONS.

1. Three dollars ($3.00) per member per month (PMPM) for all individuals enrolled in the Healthy Connections Tier with the PCCM provider.

II. TIER 2 – HEALTHY CONNECTIONS CARE MANAGEMENT.

1. Seven dollars ($7.00) PMPM for all individuals enrolled in the Healthy Connections Care Management Tier with the PCCM provider.

III. TIER 3 – HEALTHY CONNECTIONS MEDICAL HOME.

1. Nine dollars fifty cents ($9.50) PMPM for all individuals enrolled in the Healthy Connections Medical Home Tier with the PCCM provider.

H. HEALTHY CONNECTIONS VALUE CARE (HCVC) PROGRAM.

Providers under this provision are being paid for their role as part of a Primary Care Case Management (PCCM) arrangement to perform certain PCCM functions on behalf of an entity with a PCCM contract, and these payments would otherwise go to the PCCM.

The State Medicaid Agency may enter into agreements with providers to pay for services based on their value in terms of measurable health care quality and positive impacts to participant health; any such agreement shall be designed to be cost-neutral or cost-saving compared to other payment methodologies. Building on the existing Section 1932(a) PCCM Program, the State Medicaid Agency has established an approach for value-based purchasing known as the Healthy Connections Value Care (HCVC) program. New providers participating in the PCCM program are required to enroll with a Value Care Organization (VCO) during the open enrollment period from June-August to participate in the following performance year of the HCVC program.

All providers will continue to receive fee-for-service (FFS) reimbursement for the Medicaid services they provide to Medicaid participants in accordance with applicable reimbursement methodology. Those providers who voluntarily choose to form a VCO and participate in the HCVC program may also receive quality incentive payments utilizing a savings and risk approach as described below in accordance with the HCVC contract, addendums, and additional terms as applicable.

I. Definitions.

1. Value Care Organization (VCO) Entities. Primary care clinic(s) enrolled in Healthy Connections, or an organization consisting of a collaboration of independent primary care clinics, or a provider network such as an Independent Practice Association (IPA), or a Physician Hospital Organization (PHO) serving at least 2,000 Medicaid participants attributed to the participating VCO's primary care clinic(s).

2. Base Year. A twelve (12) month period of time aligned with the State of Idaho's Fiscal Year, initially beginning with State Fiscal Year 2019. Thereafter, the base year will be updated annually, the base year will be the State Fiscal Year starting two point five (2.5) years prior to the performance year. State Fiscal Year begins July 1 and ends June 30.

3. Performance Year. The twelve (12) month period of participation in the HCVC program by a VCO. The first performance year will start on January 1, 2022 and end on December 31, 2022; subsequent performance years will initiate annually on January 1 thereafter. A VCO's first Performance Year begins on January 1 immediately following their enrollment as a VCO.

4. Actual Cost of Care. Sum of all services in II.(4) Included Costs, adjusted for Stop Loss, for participants attributed for a minimum of seven (7) months to the Healthy Connections Program during the Base Year and attributed to a VCO during the Performance Year.

5. Stop Loss. For purposes of calculating Actual Cost, during the Base Year and each Performance Year, a stop-loss threshold shall apply to any Participant for whom annual aggregate Included Costs exceeds $100,000. Only twenty percent (20%) of the annual aggregate Included Costs for a Participant in excess of $100,000 and below $500,000 will be counted in determining the VCO's Actual Cost.

II. Total Cost of Care (TCOC).

1. Calculation. Annually for each Performance Year, the State Medicaid Agency will compare the statewide Actual Cost of care provided to VCO attributed participants during each Performance Year to the statewide Actual Cost of care provided to attributed

participants in the Base Year. The Total Cost of Care (TCOC) formula includes adjustments to trend statewide costs forward to account for the change in statewide costs between the Base Year and the Performance Year.

The TCOC will be calculated on a Per Member Per Month (PMPM) basis, which is the total statewide Actual Cost of care, adjusted for Stop Loss cases, divided by the total Member Months of participants attributed to the Value Care Organization (VCO). The TCOC is calculated as described in the steps below:

Step 1: Base Year Statewide PMPM divided by Base Year Statewide Risk Score equals Statewide Standardized PMPM. In rare circumstances, including, but not limited to, a public health emergency, the State Medicaid Agency and the VCOs may negotiate the Statewide Standardized PMPM.

Step 2: Statewide Standardized PMPM multiplied by VCO Performance Year Risk Score multiplied by Annual Program Change Factor equals VCO Performance Year Gross Target PMPM

Step 3: VCO Performance Year Gross Target PMPM minus VCO Performance Year Actual Cost PMPM equals VCO TCOC Savings or Loss

2. Risk Scores. For the Base Year and the Performance Year, the State Medicaid Agency will determine each Medicaid participant's risk score utilizing the proprietary Milliman Advanced Risk Adjustors (MARA) risk scoring model to standardize the target. For the Performance Year, the State Medicaid Agency will determine each Medicaid participant's risk score using the MARA risk scoring model to set the target specifically for the VCO. The MARA risk scoring model takes a variety of inputs from detailed claims data for attributed participants, including diagnosis code and prescription drug codes.

3. Participant Attribution. For a participant's cost and member months to be included in the VCO's Performance Year calculation, the participant must be Attributed to the VCO a minimum of seven (7) months. For a participant's cost and member months to be included in the Base Year calculation, a participant must be enrolled in Healthy Connections for a minimum of seven (7) months. If no Healthy Connections service location served the participant for a minimum of seven (7) months, all associated costs for that participant will be excluded from the Total Cost of Care calculation.

4. Included Costs. The following costs shall be included when calculating Target PMPM and Actual PMPM Cost:

i. Diagnostic services (lab tests, imaging, etc.)

ii. Durable medical equipment

iii. Emergency medical transport

iv. Hospice Care

v. Home Health Services

vi. Inpatient Hospital services

vii. Outpatient Hospital services

viii. Inpatient behavioral health through June 30, 2024.

ix. Outpatient facilities including ambulatory surgery centers

x. Professional services (primary care, specialty care, physical therapy, speech therapy, etc.)

5. Excluded Costs. The following costs shall be excluded when calculating Target PMPM and Actual PMPM Cost:

i. Behavioral health services not reimbursed through the fee-for-service network

ii. Dental services not reimbursed through the fee-for-service network

iii. Home and Community-Based Waiver Services (e.g. services provided to participants in their home or community rather than institutions, such as personal care services or meals)

iv. Long-term Supports & Services

v. Non-emergency medical transportation services not reimbursed through the fee-for-service network

vi. Nursing Home or Intermediate Care Facilities

vii. Pharmacy

viii. Skilled Nursing

ix. Behavioral Health Serivices covered by the behavioral health managed care plan starting July1, 2024.

6. Stop Loss. The State Medicaid Agency will establish a stop loss program to help mitigate the financial impact of certain high-cost participants within the Value Care Organization (VCO) program. For the Base Year and each Performance Year, the State Medicaid Agency will establish a $100,000 per participant threshold. Twenty percent (20%) of the costs between the $100,000 threshold and a $500,000 cap will be included in the Total Cost of Care (TCOC) calculation. All costs above the $500,000 cap will be excluded from the calculation.

III. Shared Risk Selection.

The level of risk share shall be selected by the VCO thirty (30) days prior to the start of each Performance Year. The level of risk sharing selected must be the minimum yearly requirement up to eighty percent (80%), set forth below. During performance year 1 there are two (2) Risk Sharing options as stated below:

1. Option 1 – Symmetrical Savings and Loss Risk Sharing.

Minimum Risk Share Year 1 – Twenty-five percent (25%)

Minimum Risk Share Year 2 – Fifty percent (50%)

Minimum Risk Share Year 3 – Fifty percent (50%)

Maximum Risk Share each year – Eighty percent (80%)

2. Option 2 – Upside Only Gain Share (Year 1); Symmetrical Savings and Loss Risk Sharing Future Years.

Upside Only Gain Share Year 1 – Five percent (5%)

Minimum Risk Share Year 2 – Twenty-five percent (25%)

Minimum Risk Share Year 3 – Fifty percent (50%)

Maximum Risk Share Year 2 and 3 – Eighty percent (80%)

3. Option 3: In performance year 2 and beyond there is only one option. Symmetrical savings and loss Risk Sharing options as stated below:

Upside Only Gain Share Year 1 and 2 – Five percent (5%)

Minimum Risk Share Year 3 and beyond – Fifteen percent (15%)

Maximum Risk Share– Eighty percent (80%)

IV. Quality Incentive Payments.

The Value Care Organization's (VCO's) individual performance for each Performance Year will be compared to a Statewide Total Cost of Care (TCOC) Target adjusted for an annual program change factor and VCO performance year risk score. For the initial year, the Statewide Target will be based on the Actual Costs - Program for State Fiscal Year 2019 (July 1, 2018 – June 30, 2019).

A Statewide Annual Program Change Factor shall be set prospectively by taking the average of the PMPM change for three fiscal years preceding the Performance Year, or as negotiated by the Department and the VCOs.

1. Negative Incentive Payment.

i. If the TCOC paid claims PMPM amount exceeds the VCO target PMPM amount by more than one percent (1%) for the performance year, the VCO shall remit to the State Medicaid Agency the difference between the target PMPM and the actual PMPM multiplied by the shared risk percentage selected by the VCO. In the event that amount would exceed fifteen percent (15%) of the VCO's target PMPM for attributed participants, the VCO shall remit that lesser amount to the State Medicaid Agency.

2. Positive Incentive Payment.

i. If the TCOC paid claims PMPM amount is less than the VCO target PMPM amount by at least one percent (1%) for the performance year, and the VCO has met the clinical quality measurement requirements in effect January 1, 2022 for the 2022 Performance Year and following performance years as outlined at: https://healthyconnections.idaho.gov, then, for those choosing:

a. Risk Options 1-3: the Value Care Organization (VCO) shall be eligible to receive that amount, multiplied by the shared risk percentage selected by the VCO, as incentive payment. The incentive payment amount will be paid on an incremental basis, by the number of clinical quality measure targets achieved by the VCO. In the event the total amount would exceed fifteen percent (15%) of the VCO's total cost of care target PMPM for attributed participants, the VCO shall be eligible to receive the lesser amount as incentive payment.

b. Limit payments to amounts available in the VCO settlement pool.

Any settlement pool funds available after settlements are completed for VCOs selecting two-sided risk will be used to pay VCOs in year 1 of option 2 and option 3 under upside gain only, such that if the amount available is insufficient to pay the full upside only gain only PIP, VCOs will receive payment proportional to the percent that their TCOC paid claims PMPM amount is less than the VCO target PMPM amount.

c. Incentive payments for VCOs meeting quality measure improvement targets during performance year 1 and 2 will be calculated as follows:

Number of Targets Met	Quality Incentive Payment Percentage
6	One hundred percent (100%)
5	One hundred percent (100%)
4	One hundred percent (100%)
3	Seventy-five percent (75%)
2	Fifty percent (50%)
1	Twenty-five percent (25%)
0	Zero percent (0%)

d. Incentive payments for VCOs meeting quality measure improvement targets during performance year 3 and beyond will be based on points. VCOs select a number of quality measures worth five (5) or ten (10) points. Incentive payments will be calculated as follows:

Applicable Points	Savings Payout
50+	One hundred percent (100%)
40-45	Seventy-five percent (75%)
30-35	Fifty percent (50%)
20-25	Twenty-five percent (25%)
10-15	Ten percent (10%)
0-5	Zero percent (0%)

3. Incentive Payment Collection and Distribution. The State Medicaid Agency will administer an annual settlement process for each Performance Year. Final payments/recoveries will be made no more than eighteen (18) months after all necessary data is received in final form.

V. Dispute Resolution.

The Parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement prior to initiating legal proceedings. To the extent the Parties are unable to resolve the dispute through informal, good-faith negotiations, senior executives of both Parties shall meet in person to resolve the dispute. If further negotiations are unsuccessful, the Parties shall participate in non-binding mediation prior to initiating legal action.

VI. Monitoring and Reporting.

The State Medicaid Agency will monitor and review the Healthy Connections Value Care (HCVC) program performance data, improvement over baseline, and distribution of the payment pools to determine if the initial incentive measures selected were the right combination of measures to incentivize improvement in quality, access, and total cost of care for the Idaho Medicaid population. In addition, to ensure that quality and access to care are not impacted adversely, the State Medicaid Agency will monitor Healthy Connections enrollment/disenrollment reports and cost/utilization patterns of Medicaid participants attributed to a Value Care Organization (VCO) provider as compared to the overall Idaho Medicaid population.

The State Medicaid Agency will:

- Provide CMS, upon request, with data and reports supporting achievements in the goals of improving health, increasing quality, and lowering the growth of health care costs.
- Publish updates, as conducted, to the state's quality measures on the State Medicaid Agency's website at https://healthandwelfare.idaho.gov/.
- Review, at least annually, the payment methodology and the data and analyses used to establish trends, baselines, benchmarks, risk adjustments, and other inputs used to establish the payments and make any necessary adjustments to ensure that rates are economic and efficient as required by section 1902(a)(30)(A) of the Social Security Act.