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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 19-0010

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
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

July 14, 2020

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

RE: TN 19-0010

Dear Mr. Wimmer:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Idaho's State Plan Amendment (SPA) #19-0010, which was submitted on September 30, 2019. The purpose of SPA #19-0010 is to modify the state's primary care case management (PCCM) program, known as Healthy Connections, to allow for the state's new value-based model of care. The SPA builds upon the state's already approved section 1932(a) authorities of the Social Security Act, which are utilized for the state's existing Healthy Connections PCCM program.

Idaho's SPA #19-0010 has an approved effective date of January 1, 2021. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Idaho state plan.

If you have any questions about this letter or require any further assistance, please contact Tom Couch at Thomas.Couch@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

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-19-0010**

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
~~01-01-2020~~ **01/01/2021**

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~~
1932 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
FFY2020 $0
FFY2021 $0 **FFY 2022 $0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Attachment 3.1-A page 10~~ and 11
Attachment 4.19-B pages 13-17.b.
Pages 17.a. &
17.b. are new.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Attachment 3.1-A page 10 (new page) and 11~~
Attachment 4.19-B page 13-17 (amended)

10. SUBJECT OF AMENDMENT:
Amendment to the State Plan to modify the Healthy Connections (primary care case management) enrollment process to a fixed enrollment process and to adopt the new managed care template.

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: 9/30/19

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:

18. DATE APPROVED: 7/13/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/21

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Karen Shields

22. TITLE: Acting Group Director, FMG

23. REMARKS:

10/9/19-State authorized a P&I change to block #8.

10/1019-State authorized a P&I change to blocks #8 and #9.

4/17/2020 - State authorized a P&I change to blocks #4, #8, and #9.
07/07/2020 - State authorized a P& I change to #6,#7, and 8

F. Pursuant to Idaho Code, Chapter 2, Title 56, Section 265 (version effective as of July 1, 2011) where there is an equivalent the payment to a Medicaid provider will not exceed 100% of the 01/01/2011 Medicare rate for primary care procedure codes as defined by the Centers for Medicare and Medicaid service; and will be ninety percent (90%) of the 01/01/2011 Medicare rate for all other procedure codes.

I. Where there is no Medicare equivalent, the payment rate to Medicaid providers will be prescribed by rule.

II. The fee schedule for these services and any annual/periodic adjustments to the fee schedule are published at: http://www.healthandwelfare.idaho.gov

III. The fee schedule was last updated on 07/01/2011 to be effective for services on or after 07/01/2011.

G. The Medicaid payment for primary care case management under Idaho's Primary Care Case Management program is paid in addition to FFS to physicians and mid-level providers who are enrolled as providers in the PCCM program. The structure is based on complexity of the participant's healthcare needs and the primary care physician's ability to meet those needs. The case management fee is:

I. TIER 1 – HEALTHY CONNECTIONS.

1) $2.50 per member per month for all individuals enrolled in the Healthy Connections Basic plan and with the PCCM provider.
2) $3.00 per member per month for all individuals enrolled in the Healthy Connections Enhanced plan and with the PCCM provider.

II. TIER 2 – HEALTHY CONNECTIONS ACCESS PLUS.

1) $3.00 per member per month for all individuals enrolled in the Healthy Connections Access Plus Basic plan and with the PCCM provider.
2) $3.50 per member per month for all individuals enrolled in the Healthy Connections Access Plus Enhanced plan and with the PCCM provider.

III. TIER 3 – HEALTHY CONNECTIONS CARE MANAGEMENT.

1) $7.00 per member per month for all individuals enrolled in the Healthy Connections Care Management Basic plan and with the PCCM provider.
2) $7.50 per member per month for all individuals enrolled in the Healthy Connections Care Management Enhanced plan and with the PCCM provider.

IV. TIER 4 – HEALTHY CONNECTIONS MEDICAL HOME.

1) $9.50 per member per month for all individuals enrolled in the Healthy Connections Care Management Basic plan and with the PCCM provider.
2) $10.00 per member per month for all individuals enrolled in the Healthy Connections Care Management Enhanced plan and 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 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.

Pursuant to Idaho Code 56-265(5), the Department 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) Primary Care Case Management (PCCM) Program, the Department has established an approach for value-based purchasing known as the Healthy Connections Value Care (HCVC) program.

All providers will continue to receive fee-for-service reimbursement for the Medicaid services they provide to Medicaid participants in accordance with applicable reimbursement methodology as outlined in existing SPAs and State rules. Those providers who voluntarily choose to form a Value Care Organization (VCO) and participate in the HCVC program may also receive quality incentive payments utilizing a shared savings and risk approach as described below in accordance with the HCVC contract, addendums and additional terms as applicable. Participating hospitals must agree in advance to forgo cost settlement for the Medicaid members they are serving under the VCO model.

I. Definitions.

1) Value Care Organization (VCO) Entities. A VCO participating in the HCVC program will be categorized as one of the following:

a. Accountable Primary Care Organizations (APCO): Primary care clinic(s) enrolled as Healthy Connections providers and serving at least 1,000 Medicaid participants attributed to the participating VCO's primary care clinic(s).

b. Accountable Hospital Care Organizations (AHCO): An integrated network of primary care clinic(s), enrolled as Healthy Connections providers, serving at least 10,000 Medicaid participants attributed to the participating VCO's primary care clinic(s), and at least one participating acute care hospital.

2) Base Year. State Fiscal Year 2019 (July 1, 2018 – June 30, 2019). The Base Year remains unchanged for the duration of the HCVC program.

3) Performance Year. The twelve-month period of participation in the HCVC by a VCO. A VCO's first Performance Year begins on July 1 immediately following their enrollment as a VCO.

4) Actual Cost of Care. Sum of all Included PMPM Costs, adjusted for Stop Loss, for participants attributed to the VCO during the Base Year and each Performance Year.

II. Total Cost of Care (TCOC).

1) Calculation. Annually for each Performance Year, the Department will compare the Actual Cost of care provided to VCO Attributed Participants during each Performance Year to the Actual Cost of care provided to VCO Attributed

Participants in the Base Year. The TCOC formula includes adjustments for inflation trend using the Milliman Medical Index (MMI), limiting the increase or decrease from the previous year to +/- 1%, and for participant health risk (Risk Score Adjustment).

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

Step 1:
Base Year Actual Cost PMPM / Base Year Ave. Risk Score = Risk Standardized PMPM

Step 2:
Risk Standardized PMPM * Inflation Trend* Performance Year Ave. Risk Score = Performance Year Gross Target PMPM

Step 3:
Performance Year Gross Target PMPM – Performance Year Actual Cost PMPM = VCO TCOC Savings or Loss

2) Risk Scores. For both the benchmark year and the performance year, the Department will determine each Medicaid participant's risk score utilizing the proprietary Milliman Advanced Risk Adjustors (MARA) risk scoring model. The MARA risk scoring model takes a variety of inputs off of the detailed claim data including diagnosis code and prescription drug codes. The participant risk scores will be averaged across the populations based upon the number of eligible member months each participant had in the program. The performance year target PMPM cost will be adjusted based on the increase or decrease in the risk of the attributed population during the base year and performance year for each VCO.

3) Participant Attribution. For purposes of calculating the Total Cost of Care, Medicaid participants will be attributed to their primary care clinics in accordance with the existing Healthy Connections PCCM program as outlined in this Attachment. In the event that a participant changes HC service location during the performance year, the participant will be assigned to the HC service location that managed the participant for at least seven months in the year. If no HC service location served the participant for a minimum of seven months, all associated costs for that participant will be excluded from the Total Cost of Care calculation.

4) Included and Excluded PMPM Costs.

   a. 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
ix. Outpatient facilities including ambulatory surgery
x. Professional services (primary care, specialty care, physical therapy, speech therapy, etc.)

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

i. Behavioral health services administered through a managed-care contract
ii. Dental services administered through a managed-care contract
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-emergent medical transportation services administered through a managed-care contract
vi. Nursing Home or Intermediate Care Facilities
vii. Pharmacy
viii. Skilled Nursing

5) Stop Loss. The Department will establish a stop loss program to help mitigate the financial impact of certain high-cost participants within the VCO program. For the base year and each performance year, the Department 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 calculation. All costs above the $500,000 cap will be excluded from the calculation.

III. Shared Risk Selection. Prior to each performance year, VCOs will select the percentage amount of savings or loss for which they will be held accountable.

1) Symmetrical Risk. Under this option, VCOs will select a symmetrical percentage for savings and loss as compared to the performance year target PMPM. For years 2 and 3, VCOs must identify a risk percentage that meets or exceeds the minimum percentage listed below and their percentage selection from the previous year.

a. Accountable Primary Care Organization (APCO):

i. Year 1: 10% minimum – 80% maximum savings or loss
ii. Year 2: 15% minimum – 80% maximum savings or loss
iii. Year 3: 25% minimum – 80% maximum savings or loss

b. Accountable Hospital Care Organization (AHCO):

i. Year 1: 10% minimum – 80% maximum savings or loss
ii. Year 2: 25% minimum – 80% maximum savings or loss
iii. Year 3: 50% minimum – 80% maximum savings or loss

2) Asymmetrical Risk. Under this option, VCOs, both APCOs and AHCOs, will

select the following asymmetrical percentage for savings and loss as compared to the performance year target PMPM:

a. Year 1: 40% savings – 20% loss
b. Year 2: 40% savings – 20% loss
c. Year 3: Must move to Symmetrical Risk as outlined above.

IV. Quality and Efficiency Incentive Payments. When savings have been achieved, the Department will make incentive payments to VCOs that maintain and improve on quality metrics. All organizations start from where they are at baseline with annual individual improvement targets from baseline to the statewide goal. Each VCO's quality measure improvement targets will be published by the Department prior to the beginning of each performance year.

1) Negative Incentive Payment.

a. Accountable Primary Care Organization (APCO): If the total cost of care paid claims PMPM amount exceeds the VCO target PMPM amount by more than 1% for the performance year, the VCO shall remit to the Department 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 50% of the VCO's gross Healthy Connections management fee payments for attributed participants, the VCO shall remit that lesser amount to the Department.

b. Accountable Hospital Care Organization (AHCO): If the total cost of care paid claims PMPM amount exceeds the VCO target PMPM amount by more than 1% for the performance year, the VCO shall remit to the Department 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 15% of the VCO's target PMPM for attributed participants, the VCO shall remit that lesser amount to the Department.

2) Positive Incentive Payment.

a. Accountable Primary Care Organization (APCO): If the total cost of care paid claims PMPM amount is less than the VCO target PMPM amount by at least 1% for the performance year, and the VCO has met the clinical quality measurement requirements in effect July 1, 2021 for the 2021 and following performance years as outlined at: www.healthyconnections.idaho.gov, the VCO shall be eligible to receive that amount, multiplied by the shared risk percentage selected by the VCO, as incentive payments. Half of the total available incentive payment amount will be paid when the VCO has met efficiency requirements and the other half will be paid, on an incremental basis, by the number of clinical quality measure targets achieved by the VCO. In the event that total amount would exceed 50% of the VCO's gross Healthy Connections management fee payments for attributed participants, the VCO

shall be eligible to receive that lesser amount as incentive payments.

i. Efficiency Incentive Payment. An APCO that maintains their baseline score on at least 5 of the 7 APCO quality measures will receive 100% of their efficiency pool. To ensure quality of care is at least maintained as costs are lowered, no efficiency payment will be paid to an APCO that maintains baseline on fewer than 5 measures.

ii. Quality Incentive Payment. An APCO that meets their quality measure improvement targets will receive incremental incentive payments from their quality pool as follows:

Number of Targets Met	Quality Incentive Payment Percentage
5 or more	100%
4	80%
3	60%
2	40%
1	20%
0	0%

b. Accountable Hospital Care Organization (AHCO): If the total cost of care paid claims PMPM amount is less than the VCO target PMPM amount by at least 1% for the performance year, and the VCO has met the clinical quality measurement requirements in effect July 1, 2021 for the 2021 and following performance years as outlined at: www.healthyconnections.idaho.gov, the VCO shall be eligible to receive that amount, multiplied by the shared risk percentage selected by the VCO, as incentive payments. Half of the total available incentive payment amount will be paid when the VCO has met efficiency requirements and the other half will be paid, on an incremental basis, by the number of clinical quality measure targets achieved by the VCO. In the event that total amount would exceed 15% of the VCO's total cost of care target PMPM for attributed participants, the VCO shall be eligible to receive that lesser amount as incentive payments.

i. Efficiency Incentive Payment. An AHCO that maintains their baseline score on at least 7 of the 10 AHCO quality measures will receive 100% of their efficiency pool. To ensure quality of care is at least maintained as costs are lowered, no efficiency payment will be paid to an AHCO that maintains baseline on fewer than 7 measures.

ii. Quality Incentive Payment. An AHCO that meets their quality measure improvement targets will receive incremental incentive payments from their quality pool as follows:

Number of Targets Met	Quality Incentive Payment Percentage
7 or more	100%
6	86%

5	71%
4	57%
3	43%
2	29%
1	14%
0	0%

3) Incentive Payment Collection and Distribution. The Department will administer an annual settlement process for each performance year. Final payments/recoveries will be made no more than 15 months after all necessary data is received in final form.

V. Monitoring and Reporting. The Department will monitor and review the 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 incent 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 Department will monitor Healthy Connections enrollment/disenrollment reports and cost/utilization patterns of Medicaid participants attributed to a VCO provider as compared to the overall Idaho Medicaid population.

The Department will:

1) Provide CMS, at least annually, with data and reports supporting achievements in the goals of improving health, increasing quality and lowering the growth of health care costs.

2) Provide CMS with updates, as conducted, to the state's quality measures.

Review, at least annually, the shared savings payment methodology and the data and analyses used to establish trends, baselines, benchmarks, risk adjustments and other inputs used to establish the shared savings 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.