MINUTES

HOUSE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 13, 2024

TIME: 9:00 A.M.

PLACE: Room EW20

MEMBERS: Chairman Vander Woude, Vice Chairman Erickson, Representatives Blanksma, Kingsley, Mitchell, Dixon(24), Gallagher, Healey, Redman, Wheeler, Chew (Wilson), Rubel, Roberts

ABSENT/ EXCUSED: None

GUESTS: The sign-in sheet will be retained in the committee secretary's office; following the end of session the sign-in sheet will be filed with the minutes in the Legislative Library.

Chairman Vander Woude called the meeting to order at 9:00 a.m.

Rhys Jones, Vice President, Medicaid Policy, American Health Insurance Plans (AHIP), shared information on the value of Medicaid managed care.

Medicaid managed care is a partnership with managed care organizations (MCO's) who handle the administrative operations, thereby shifting the state's focus to oversight. For the forty-two states using managed care for Medicaid, federal regulations provide them with flexibility in customization, design, and implementation of their programs.

Medicaid MCOs engage and contract with providers. They also provide enrollee outreach through avenues such as care management, education, and appointment reminders. Financial management and reporting includes medical loss ratios (MLRs), fraud waste, and abuse detection.

Using MCOs provides better budget predictability, improved care coordination, experiences from other states, tailored enrollee care, varied business models, varied capabilities for infrastructure models, and assistance to advance Medicaid initiatives.

The care and services plan includes assessment which is very helpful for enrollees with chronic and predisposing medical behavioral, functional, and social needs. Care managers with special training provide the assessments, work with providers, and work with community organizations.

The lengthy process to move to managed care has proven successful in other states when done on a graduated basis from the less complex to the more complex enrollee populations. The state sets the quality, contract, and payment rate floors as the managed care program is implemented. Capitation rates must be developed to be actuarially sound and include an MLR requirement.

MCOs meet both federal and state adequacy standards to provide the required scope of specialties, which may include telehealth. The provider and MCO agree on rates, although the state determines the rate basis.

Innovations through managed care MCO experiences in other states have increased the effectiveness and need for long-term health services. Some examples include various forms of telehealth, health related social needs, home environment modifications, and provider support.

A 2023 Medicaid managed care report shows MCOs spent 85.8% of capitation revenues on health care services and quality. AHIP administration capitation revenues were 8.1%, taxes and fees were 2.8%, and the net margin was 3.3%.

As of January 2024, 236 of the 292 MCOs are accredited by the NCQA. Medicaid MCOs improve the quality of care through routine monitoring and reporting with standardized measuring methods. Provider incentives include bonus payments in 24 states, capitation withholding of one to two percent in 25 states, and eight states make preferential auto-assignment of enrollees based on quality metrics.

Idahoans will benefit from managed care's one-stop source of Medicaid coverage information, personalized care coordination, help choosing or connecting with providers, appointment or medication reminders, and telehealth access. They will also receive health education along with access to social benefits and supports. Services not normally covered are included as in-lieu-of services because they are cost effective and reduce the need for covered services. This could be purchase of a refrigerator so the medication is properly stored. Another benefit is the coordinated assistance for programs with community organizations.

Budgetary benefits of Medicaid managed care include improved budget predictability, reallocation of staff resources, improved expenditure effectiveness, and improved access to quality care and services for Idahoans.

Mr. Jones emphasized the need to allow plenty of time for planning, design, stakeholder engagement, implementation, and refinement. He also stressed the importance of seeking assistance from the Medicaid leaders with managed care experience and success in other states. Engaging Medicaid MCOs and providers as partners will help identify issues, develop solutions, and solve problems.

In response to committee questions, **Mr. Jones** explained Medicaid providers are currently paid less than Medicare or commercial insurance carrier plans. MCOs negotiate with providers to offer more than the fee-for-service rates. The MCOs use of their own administrative staff will impact the Department of Health and Welfare staffing needs. The subcapitated provider contracts can include fee schedules, per diems, or bonus payments as part of the performance metrics.

He said the MLR requirement of capitation expenses has to go to providers. Plans must meet a network adequacy requirement. Idaho could offer or invite capitated rates. Offering rates has proved a better decision with cases of invited rates resulting in initial plans becoming insolvent. Most states begin eligibility with low acuity populations and add greater levels of care populations after the program has been in place a number of years. Enrollees need to have a choice of plans. The MCO's carry the risk, providing the state with budget predictability when rate adjustments occur.

Russ Elbel, Assistant Vice President, Select Health, Medicaid Program, came before the committee to present information on the Select Health MCO program in Salt Lake City, Utah. The program encourages value over volume and maintains a rainy day fund based on program savings. The program began in rural counties in 2015 and expanded fully in 2020. The five largest counties integrated BH enrollees in 2020.

NCQA accreditation assures a certain standard within the health plan.

There are several features to value based payments. The integrated system shares risk and savings while driving engagement and innovation. Pay for performance addresses the total cost of care, gaps in care, and care coordination. Incentives improve service, care, engagement, and quality.

Primary care groups are held to the risk adjusted total cost of care (TCOC) target which is measured and impacted throughout the year. Annual savings are shared with the provider community.

The medical and behavioral health (BH) homes program closes care gaps through bonus payments to clinics serving primary Medicaid enrollees, adding funds to build the clinics' infrastructures.

The Medicaid restricted program for high risk, high cost enrollees provides care management. Outcomes show 50% of the members graduate out of the program in twelve months as a result of better care in the right place and a primary care physician relationship. Although an administrative time consuming process, a 50% reduction in cost is seen and lives are changed. An additional per member per month (PMPM) payment is given to providers who take these individuals into their clinics. The primary care coordinator is pivotal to obtain participants.

BH access has been improved through value based payments, home visits, telehealth, bundled payments, navigators or care managers embedded in acute settings, appointment advocates, better enrollment data, expanded networks, and claims review meetings.

Accountable Care Organizations (ACOs) invest in communities with scholarships, monetary awards, incentives programs, and grants. During the pandemic members remained engaged with community health workers and telehealth.

Answering a question, **Mr. Elbel** said incentives can be aligned to reach the state's goals.

ADJOURN: There being no further business to come before the committee, the meeting adjourned at 10:42 a.m.

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Representative Vander Woude
Chair

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Irene Moore
Secretary