Idaho Medicaid
Benchmark Plans

NGA March 2008
Leslie M. Clement
Administrator, Idaho Medicaid
Background: Initiated Reform in 2005

Governor Kempthorne initiated Medicaid reform:

Problem
   Medicaid unsustainable in its current form
   “One size fits all” approach not working

Broad goals
   Modernize Medicaid
   Align benefits with health needs
   Balance quality, access and costs
   Emphasize prevention & wellness
   Encourage personal responsibility
State Authority Process

- Prior to 2006 legislative session:
  - Medicaid wrote draft reform plan
  - Sought early input from CMS
  - Sought feedback from stakeholders

- During 2006 session:
  - Medicaid and legislators drafted bills together
  - Stakeholders supported in committee
  - State statutes amended to reflect new health plans and concurrent resolutions passed to encourage the adoption of new management tools
Federal Authority Process

Medicaid and State Legislature envisioned 1115 waiver.
- Concurrent to legislative process, DRA passed.
- Idaho submitted 1115 waiver application.
- CMS suggests that reform could be better accomplished using new DRA authority.
- Twenty-one Medicaid state plan amendments submitted and approved.
- Two CHIP state plan amendments submitted and approved to align with Medicaid benchmark plans.
Deficit Reduction Act
Section 6044

- Flexibility to offer other benefits than the standard benefit package
- Encourages innovative health coverage plans
- Meets needs while maintaining sustainability
- Offer to all populations, but can’t require certain protected populations

Approved benchmarks include:
  - Equivalent of Federal Employees Health Benefit Plan
  - Equivalent of State Employees Coverage
  - Equivalent of HMO (largest commercial insurer in the state) or
  - Secretary-approved coverage
Benchmark Plans: Foundation for Reform

- Broke apart the “one-size fits all” model
- Replaced with three secretary-approved “benchmark” benefit plans:
  - Basic Plan for low-income children and adults of average health
  - Enhanced Plan for individuals with disabilities and special needs
  - Coordinated Plan for dual eligible adults
- Basic Plan and Enhanced Plan implemented July 2006.
### Secretary-approved Benchmark Plans:

<table>
<thead>
<tr>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
<th>Coordinated Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>✷ Major Medical</td>
<td>✷ Basic Plan plus:</td>
<td>✷ Medical direct through Advantage Plan</td>
</tr>
<tr>
<td>✷ Dental</td>
<td>✷ Developmental Disability services</td>
<td>✷ Integrated through capitated payment</td>
</tr>
<tr>
<td>✷ Vision</td>
<td>✷ Enhanced Mental Health services</td>
<td>✷ Traditional Medicaid through wrap-around</td>
</tr>
<tr>
<td>✷ Mental Health</td>
<td>✷ Long-term Care services</td>
<td></td>
</tr>
<tr>
<td>✷ Therapies</td>
<td>✷ Home &amp; community-based waiver services</td>
<td></td>
</tr>
<tr>
<td>✷ Transportation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Enrollment into Plans

- Benchmark Plans offered through application process
- Choice is between a benchmark and standard – not between benchmark plans
- If no special medical needs identified, Basic Plan is preferred choice
- Application process identifies medical need for enrollment into Enhanced Plan (e.g. accessed children’s mental health services or developmental disability services or is in LTC)
- Once enrolled in the Basic Plan there are “triggers” identified for appropriate changes. (e.g. 3+ day psychiatric hospitalization would move individual into Enhanced Plan)
Connecting to Values

- Benefits now connected to health needs; population-based plans.
- Benchmarks manage inappropriate service utilization.
  - Participants only get the benefits they need.
- New tools available to support improved management practices.
  - Selective contracting
- All benchmarks emphasize prevention, wellness.
  - Opportunities to manage weight & quit smoking.
- Responsibility also emphasized.
  - Co-payments for inappropriate use of services.
  - Premiums applied to all CHIP participants.
New Prevention & Wellness Coverage

- PHA = Preventive Health Assistance benefits.
- Medicaid identifies Behavior PHA participants through Health Questionnaire.
- “Behavior” PHA:
  - Generates points participants can spend on tobacco cessation or weight management
- “Wellness” PHA:
  - Points for up-to-date well child checks that participants can use to offset premiums
  - Allows individuals to retain coverage by making good health choices.
Connecting and Supporting Wellness in Other Environments

- Grants provided to school districts for preventive services provided by nurses.
  - Districts must be low-income (below 185% FPL)
  - Must have low nurse : student ratio
- Uses CHIP administrative funding. (<10% cap)
  - Health Services Initiatives non-primary expenditure allows population-based services
- Contract with State Department of Education specifies certain preventive care.
- Department of Education chooses school districts, awards grants.
Supports State flexibility and innovation

- Within benchmarks, Medicaid may “waive” traditional requirements.
  - Benefit scope & comparability
  - State-wideness
  - Freedom of choice
- Benchmarks therefore enable management innovations.
  - Disease management/P4P pilot
  - Selective contracting: dental and supplies
  - Managed Care approaches
Mandatory Medical Homes

- Idaho previously relied on 1915 (b) waiver of freedom of choice to establish primary care case management.
- New DRA authority allows waiver of freedom of choice within benchmark plans.
- All Idaho benchmark plans mandate a “medical home” for each participant, with some exceptions.
- Reduces administrative costs associated with managing a separate waiver program.
- Builds framework for expanding the role of the medical home to link with chronic disease management programs.
Disease Management

- Partnering with Family Medicine Residency Programs and Federally-Qualified Health Centers on pay-for-performance program. Limited providers and limited geographic area until determined an effective tool.
- Focuses on chronic diseases management.
  - Uses selected national indicators on diabetes care.
  - Next steps move to co-occurring disorders.
- Participation increases from three providers to thirteen.
- Reimbursement rewards for registering patients and recording that tests and visits are complete.
- Idaho participates in Center for Health Care Strategies and tested “Return on Investment” tool.
Selective Contracting: Dental Outsourcing & Supplies

- Selective Contract with Dental Plan established for Basic Plan participants.
  - Approach intended to achieve the following outcomes: Improve Access, Ensure Quality, Budget Neutral
  - Early outcomes: Expertise in dental plan management & increased % of participating dentists
- Request for Bids posted for adult incontinent supplies, nutritional supplements and diabetic supplies.
  - Projecting savings while maintaining quality
  - Some statewide push-back by small retailers
Managed Care Initiative: Medicare Advantage Plan Options

- Coordinated Benchmark Plan offers opt-in and opt-out
- Idaho’s first Medicaid managed care contract
- Medicaid wraps-around with traditional Medicaid benefits
- Pays capitated rate for paying premiums and integrated benefits such as supplies and non-Medicare drugs.
- Two Medicare Advantage Plan choices
- Different geographic areas
- Year-one goal: 10% of duals select this option
- Actual: 9% eligible participants
Idaho’s Unique Approach

- DRA requires retention of standard Title XIX plan.

<table>
<thead>
<tr>
<th>Standard Title XIX State Plan</th>
<th>Benchmark Plans as alternative to Standard State Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>No optional Medicaid services. Only mandatory Medicaid services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAID AS ENVISIONED BY LEGISLATURE</th>
<th>Benefit Plans Based on Health Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Plan for Low-Income Children and Working-Age Adults</td>
<td>Benefit Plan for Individuals with Disabilities and/or Special Needs</td>
</tr>
<tr>
<td>Benefit Plan for Elders or Individuals Dually Eligible for Medicare and Medicaid</td>
<td></td>
</tr>
</tbody>
</table>
100% Enrollment into Benchmarks

- **Basic Plan** for those of average health
  - 138,000 enrollees (90% children)
  - Average monthly cost = $235

- **Enhanced Plan** for those with disabilities
  - 32,000 enrollees (50/50, children/adults)
  - Average monthly cost = $1465

- **Coordinated Plan** for dual eligibles
  - 14,000 enrollees (all adults)
  - Average monthly cost = $1423
Building on Early Efforts

- Based on performance of Dental Contract, may determine to add Enhanced Plan participants.
- Determine how to connect the P4P program with Preventive Health Benefits.
- Evaluate the value of integrating other benefits with Medicare Advantage Plans.
- Explore opportunities to enhance “medical home”.
  - Evaluate reimbursement models to better support primary care providers.
  - Evaluate tools for improved communication about Emergency Room over-use and Missed Appointments.
Under Development: Basic Plan Participants

- Enhance Public/Private Partnership through Premium Assistance Plan improvements
  - Current HIFA Waiver not well utilized
  - Policy changes include making option available to employers of all sizes and extend option to Medicaid
  - Challenges include cost-sharing & EPSDT regulations
  - Opportunities may include expanding eligibility if option can be restricted to Premium Assistance
Under Development: Enhanced Plan participants

1. Current participants can only access Self-Directed developmental disability benefits through a 1915 (c) waiver.
   - Idaho is developing new Family-directed option
   - Opportunity: use new state plan authority to add home and community-based benefits and reduce administrative burden of maintaining waivers.

2. Current participants access transportation through disconnected providers throughout the state.
   - Idaho is in process of procuring a transportation broker.
   - Opportunity: improve coordination, quality, and contain costs.
Under Development: Systems

- New Medicaid Management Information System built on MITA standards.
  - Purchased MMIS based on off-the-shelf products from three vendors.
  - Easily customized and flexible to change according to program needs.
- Idaho Health Data Exchange. (EMR & E-prescribing)
  - Statewide IT system to exchange critical health information among health providers and health plans.
  - Improves patient care and health plan’s ability to access data for disease management.
Thank you!

Contact Info:
Leslie M. Clement
clementl@dhw.idaho.gov
(208) 334-5747