

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

g. Primary Care Case Management

/X/ Provided _____ / / Not provided

h. Integrated Care Models

_____ /X/ Provided _____ / / Not provided

Healthy Connections Value Care Organizations

Under authority of 1905(t) of the Social Security Act, the Healthy Connections Value Care program allows the use of an overarching population-focused structure to incentivize health care providers and others to work toward improved care at a lower cost for Medicaid participants. It incorporates the existing Healthy Connections patient-centered medical home program into clinically integrated networks that have the opportunity to receive positive incentive payments through shared savings when they deliver high quality, cost-effective care while also holding those participating entities accountable, through negative incentive payments, when they do not. Additional detail on incentive payments is outlined in Attachment 4.19b.

With this program, all providers, both participating and non-participating, are required to continue to meet all current Medicaid program requirements in place including covered health benefits, provider network standards, authorization processes, Healthy Connections provider assignment and management payments, and physician and hospital fee schedules. Providers who choose to participate in the program as Value Care Organizations (VCOs) are eligible to receive incentive payments (both positive and negative) when they maintain and improve health quality outcomes while lowering the total cost of care.

VCOs are required to enter into a contract with the Department prior to initiating with the program under one of the following two categories:

- **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).
- **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.

All VCOs must have an organizational structure and program designed to coordinate care between providers, improve systems of care, promote evidence-based approaches, and yield improved clinical outcomes by demonstrating the following:

1. Establishing effective data exchange with the Department to allow for efficient operations for participant enrollment verification, claims validation, risk score determination, and clinical quality measurement.
2. Implementing provider network education and outreach processes to improve clinical quality.
3. Monitoring provider network for execution of the VCO's clinically integrated network model, rewarding clinical improvement, and holding non-performing VCO network providers accountable.
4. Working collaboratively with local and regional groups identified by the Department as the Community Health Outcomes Improvement Coalition (CHOICE) entities by providing professional staff as representatives on CHOICE and providing support and sharing data to identify physical and social determinants of health care needs and identify opportunities and strategies to improve quality, cost, and utilization patterns.

Attribution

Medicaid participants (except those who are dual Medicare/Medicaid eligible or newly eligible Medicaid expansion population) receiving services through a participating VCO network provider, and subject to Healthy Connections program enrollment, as specified in Attachment 3.1-F of this State Plan, are considered attributed lives to the respective VCO. Being attributed to a particular VCO is for the purpose of performance measurement and incentive payment calculation only and has no impact on a participant's ability to receive Medicaid services or make changes to their Healthy Connections provider selection.

Quality Metrics

The Department will measure each VCO's performance based on a set of quality metrics that includes individual VCO improvement targets and statewide benchmarks. Quality metrics are in effect January 1, 2020 for the 2020 and following performance years as outlined on the Department's website at: www.healthyconnections.idaho.gov.

Assurances

In administering the VCO program, the Department provides participant protections as required by Section 1905(t) of the Act. Specifically, assuring that primary care case managers:

- 1905(t)(3)(A): provide reasonable and adequate hours of operation including 24-hour availability of information, referral and treatment for medical emergencies.
- 1905(t)(3)(B): restrict enrollment to individuals residing sufficiently near a service delivery site to be able to reach that site within a reasonable amount of time.
- 1905(t)(3)(C): provide sufficient availability of health care professionals to provide quality care in a prompt manner.
- 1905(t)(3)(D): prohibit discrimination in enrollment, disenrollment, or reenrollment on the basis of health status or need for health care services.
- 1905(t)(3)(E): provide opportunity for participant to terminate enrollment.

- 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.

- ~~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.

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. Utilizing authority under Section 1905(t) of the Act, the Department has established an Integrated Care Model (ICM) 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 calendar year of participation in the HCVC by a VCO. A VCO's first performance year begins January 1 of the year 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 a participant changes HC service locations during the performance year, the majority rule will apply, and the participant will be assigned to the HC service location that managed the participant the majority of the months in the year. If a participant was served at more than one HC service location for an equal number of months, the participant will be assigned to the most recent service location.
- 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 (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 (June 30, 2019) 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 2% 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 2% 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 2% for the performance year, and the VCO has met the clinical quality measurement requirements in effect January 1, 2020 for the 2020 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:

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

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 2% for the performance year, and the VCO has met the clinical quality measurement requirements in effect January 1, 2020 for the 2020 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:

<u>Number of Targets Met</u>	<u>Quality Incentive Payment Percentage</u>
<u>7 or more</u>	<u>100%</u>
<u>6</u>	<u>86%</u>
<u>5</u>	<u>71%</u>
<u>4</u>	<u>57%</u>
<u>3</u>	<u>43%</u>
<u>2</u>	<u>29%</u>
<u>1</u>	<u>14%</u>
<u>0</u>	<u>0%</u>

- 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.