



# **Medicaid Review Panel**

**July 29, 2025**

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IDAHO DEPARTMENT OF  
HEALTH & WELFARE



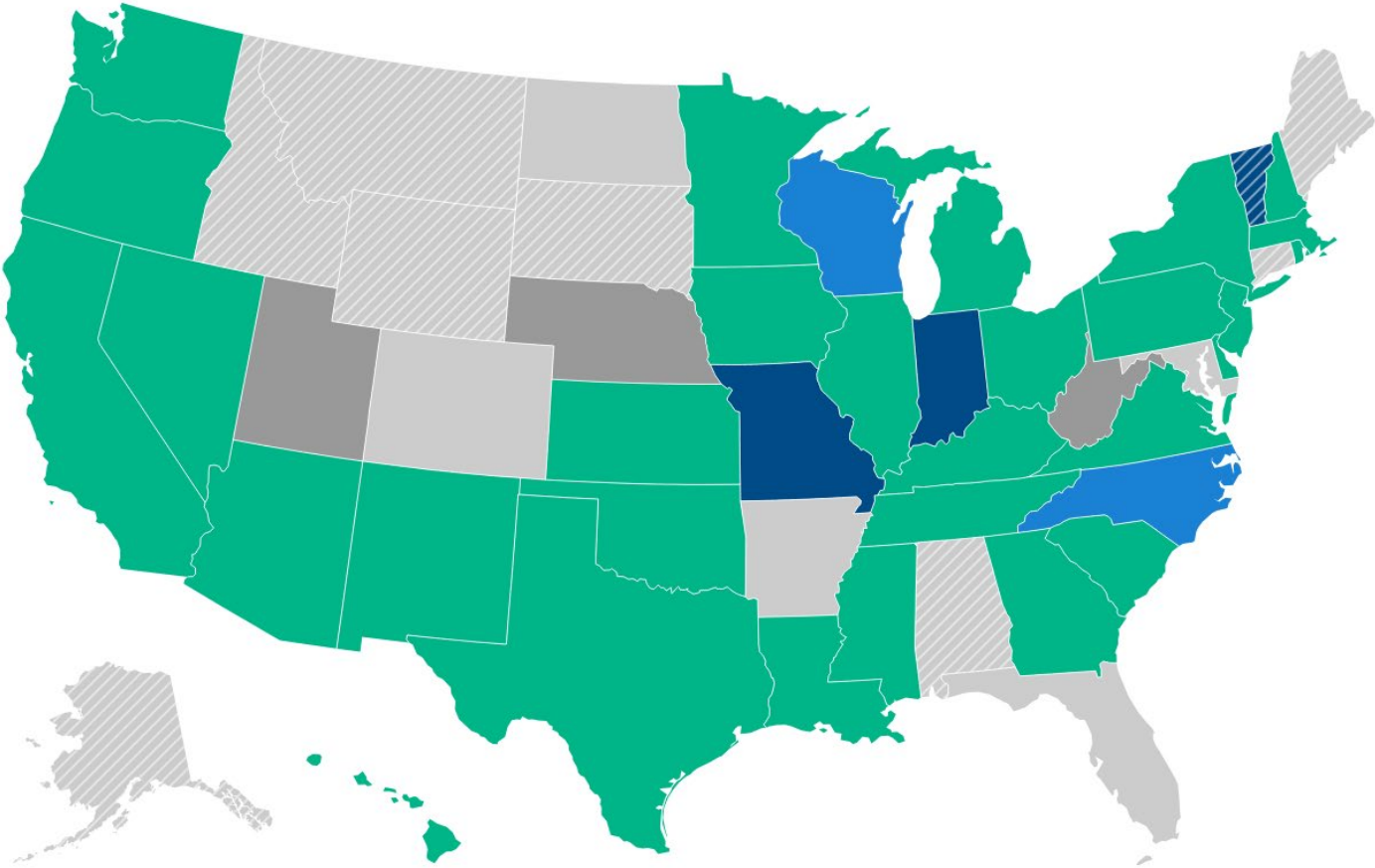
# One Big Beautiful Bill Act



- Eligibility re-determinations every 6 months for expansion population
  - Aligns with H345 but still determining the extent we are required to use all available information to determine eligibility (ex-parte)
- Work and community engagement requirements
  - Effective December 31, 2026
  - Aligns with H345 with slight differences in excluded populations including veterans, inmates of public institutions, parents/caregivers of older children aged 6 through 13.
  - \$200 million in implementation for states to be distributed by CMS
- Cost sharing
  - Aligns with H345 and effective October 1, 2028
  - Specific to expansion population only
  - Additional carve outs for behavioral health services
  - Providers able to not render services, but payment not tied to eligibility



- Hospital provider tax limitations decrease to 3.5% of net patient revenue.
  - No impact from status quo as Idaho at 2.7% for hospitals, 6% for SNFs, and 4.8% for ICFs in FY 2025.
  - SNFs and ICFs exempt from phase down.
- Cap on state directed payments decrease from ACR to 100% Medicare.
  - No impact from status quo as Idaho does not have state directed payments (only in managed care).
  - We use the FFS equivalent (upper payment limit), which has already been capped at 100% Medicare.
  - Decreases the amount of federal funding that the Idaho Legislature could have pursued in the future if policymakers wanted to align with ACR.



### Senate Reconciliation Bill Likely to Reduce Hospital and Nursing Facility Payments in Most States

States with state-directed payments (SDPs) that would have to be reduced under new Senate Finance Committee requirement

- █ Likely affected (29 states)
- █ Possibly affected (2 states)
- █ Likely unaffected (3 states)
- █ No SDPs targeting hospitals or nursing facilities (3 states)
- █ No SDPs to any providers (13 states + DC)
- ▨ No managed care (9 states)

Source: KFF analysis of Medicaid Approved State-Directed Payment Preprints; RAND Price Transparency Study, Round 5.1; KFF Status of State Medicaid Expansion Decisions.





- Prohibits federal match for any items and services provided by certain entities, such as Planned Parenthood, meeting specific definitions.
- Limits retroactive coverage after January 1, 2027 from 3 months to
  - Expansion – 1 month
  - Other Medicaid categories and CHIP - 2 months
- HHS developing a new system to notify states of duplicate enrollment
- New HCBS waiver option that does not require institutional level of care
- Rural Health Transformation Program



## \$50 billion

- FY2026 - FY2030
- States must submit plan, then HHS will award by December 31, 2025
- At least 3 areas of focus

Supporting access to OUD, SUD, and mental health services.

Provide payments to health care providers for the provision of health care items or services

Promote consumer-facing, technology-driven solutions for the prevention and management of chronic diseases

Provide training and TA for the development and adoption of technology enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, AI, etc.

Developing projects that support innovative models of care, including VBP and APMs

Providing TA, software, and hardware for significant information technology advances

Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines

Promote evidence-based interventions to improve prevention and chronic disease management

Recruiting and retaining clinical workforce talent to rural areas

# H345 Implementation Updates

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Requirement	SPA or Waiver	Deadline	Status
Rural hospital designation	SPA	Unspecified	On track to submit by the end of 2025. Following CMS approval, rule development will be needed with Licensing and Certification.
Cost sharing	SPA	July 1, 2026	<ul style="list-style-type: none"><li>-OBBBA requires increased cost sharing for expansion population in 2028, except behavioral health services.</li><li>-OBBBA did not change federal law to allow payment of cost sharing as a condition of eligibility.</li><li>-On track for submission by July 1, 2026. All allowable services other than behavioral health (to align with OBBBA).</li><li>-Requested cost estimates for system to track income and remain under 5% monthly or quarterly.</li></ul>
Work requirements	SPA will be quickest and most straightforward path.	July 1, 2026	Following passage of OBBBA, anticipating guidance from CMS in the coming months on SPA template submission. DHW recommends moving forward with the SPA as the quickest, most straightforward implementation option. A waiver could be pursued for the very limited differences between OBBBA and H345.

# H345 Implementation Updates

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Requirement	SPA or Waiver	Deadline	Status
Eligibility determination updates	SPA	July 1, 2026	Alignment with OBBBA. Anticipating CMS guidance for State Plan updates.
Choice waiver	Waiver	July 1, 2026	DOI to lead with DHW support and collaboration. Reviewing any impacts from OBBBA and continuing CMS discussions regarding options to implement.
Practice authority protections	SPA	July 1, 2025	Idaho Medicaid State Plan Amendments ID-25-0007 (coverage) and ID-25-0008 (reimbursement) were submitted to CMS June 9 following public comment period. Pending CMS approval.
Site neutral payments	SPA	July 1, 2026	Drafting SPA for submission in 2025. Identifying system, handbook, and information release updates.



Requirement	SPA or Waiver	Deadline	Status
Directed payments	Waiver, preprint	July 1, 2027	Will transition UPL to SDPs; will need support from actuarial services contract.. Actuary services contract will support directed payment design. New actuary contractor will be in place by beginning of calendar year.
Discontinue Healthy Connections Value Care (HCVC) and Primary Care Case Management	SPA	January 1, 2026	State Plan public and tribal notice posted 6/30. Prepared Healthy Connections communications and FAQs to inform providers about the transition and resources over the coming months.
FQHC no risk in HCVC	SPA	2024 performance period forward	Complete. Amendment to remove risk signed by DHW and FQHCs.
Administrative rule repeals	N/A	July 1, 2025	Consolidated three chapters of rule and posted temporary rules IDAPA 16.03.26 Medicaid Plan Benefits effective July 1, 2025.

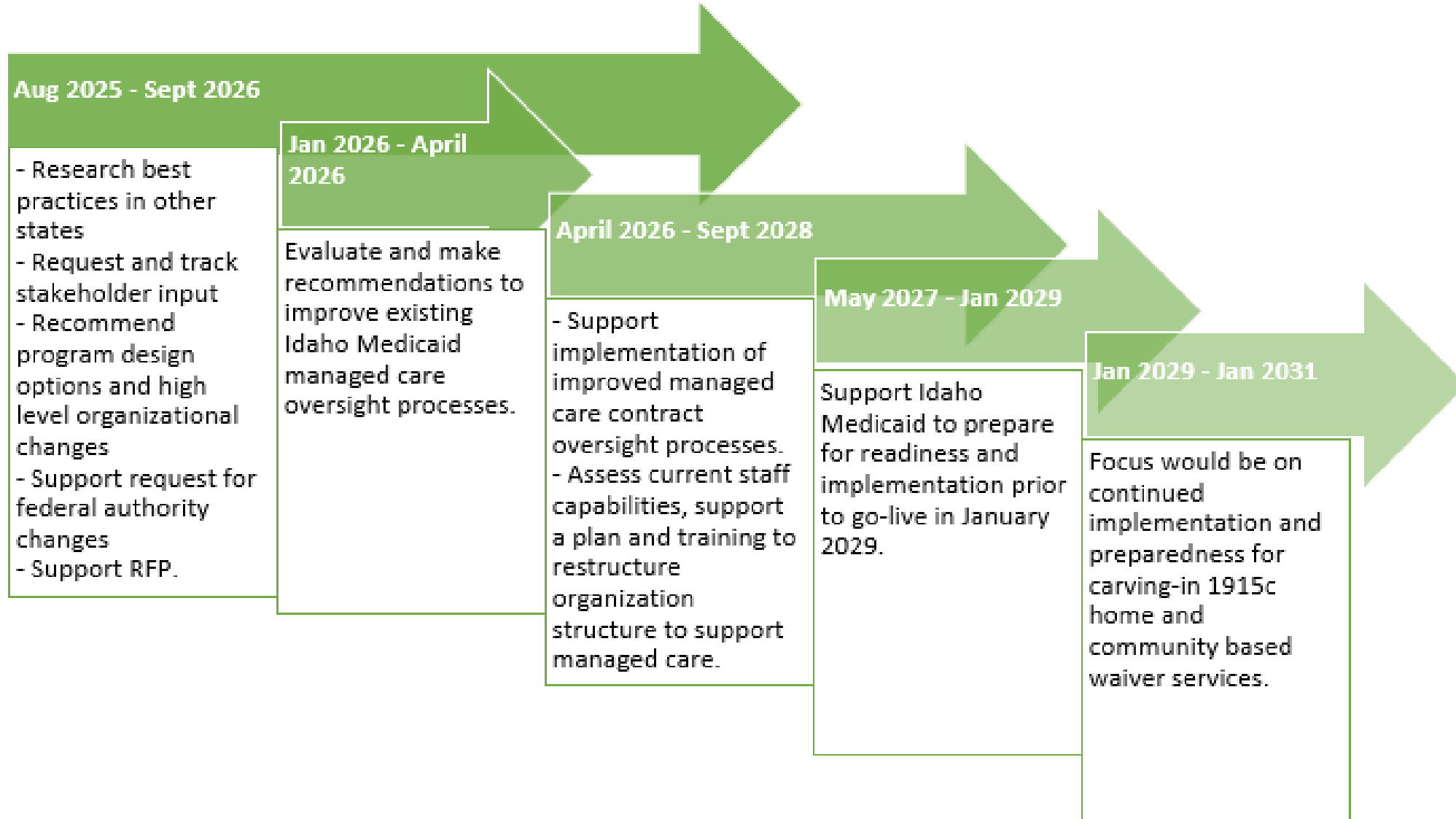


- Goals

- Support the transition to comprehensive managed care directed by H 345.
- Legislature's primary goal of cost containment.
- Also aim to streamline services, improve quality of care, and enhance care coordination.

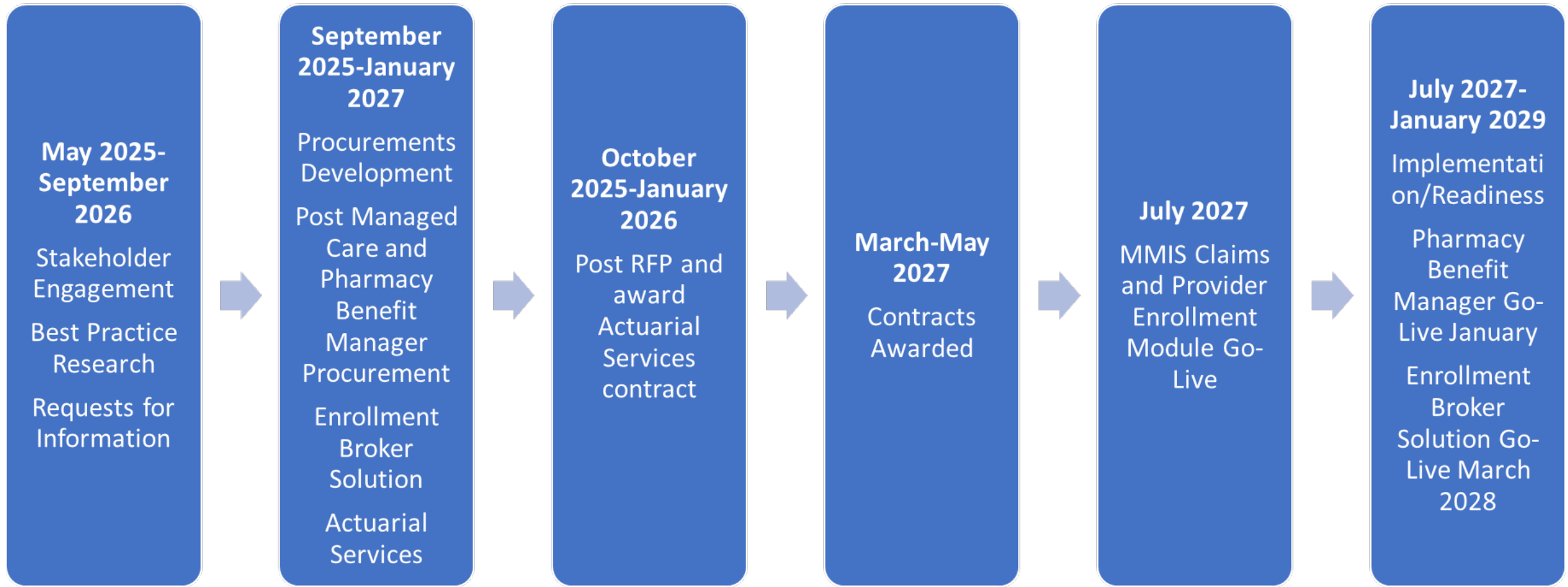
- Timeline

- June – Wrote and posted the RFP
- July – Responded to questions and evaluated 7 qualified proposals
- Next – Demonstrations, interviews, and award mid-August





# Review of Comprehensive Managed Care Timeline





- DHW fully evaluated feasibility to go-live in 2027 or 2028
- Implementing earlier than 2029 presents several important considerations
  - Adequate time to reprocure actuarial services contract; MMIS implementation; enrollment broker solution; and pharmacy benefit manager procurement
  - Appropriate time taken to evaluate other state contracts, best practices, and oversight tools
  - Stakeholder engagement across the state and the ability to respond to feedback
  - Fully developed cost projections with time to adjust to contain costs
  - Ample readiness time to test, prepare, and resolve any issues (for state, MCOs, and providers)
  - Incorporating work requirements and cost sharing
  - Internal organizational changes to meet evolving business needs

**We want this transition to be successful for Idaho and to do it right from the beginning. This will take some time and careful planning.**



# Idaho Behavioral Health Plan & Duals Contract Status Background



## Intensive Care Coordination


- Supporting 150 adults with hospital engagement & Transition of Care specialists
- Supporting 1,250 youth and their families navigate residential care and intensive home and community based services
  - As Magellan stabilizes, the state is seeing fewer Quick Response Teams needed for children at risk of entering the foster system due to behavioral health challenges.

## Fraud Waste and Abuse

- Receiving positive feedback from AG's MFCU and Medicaid MPIU about Magellan's robust collaboration on FWA
- Idaho based SIU with extensive local experience
- 37 cases in year 1

## Crisis Response


- 988 and expanded mobile crisis linked through Magellan's contract for dispatch and information sharing



## DHW Receives and Analyzes Information

- Dozens of weekly, monthly, quarterly, and annual contractually required reports
- Formal and informal stakeholder meetings
- Concerns or complaints

## DHW Provides Feedback to Magellan for Improvement

- DHW & Magellan meetings
  - Monthly contract monitoring reports
  - Management letters
  - Liquidated damages
  - Corrective action plans
- 



Liquidated damages-issued \$100,000 in January 2025 and \$5,000 in May 2025 for

- Claims payment – Resolved
- Encounter data
- Amounts not aligned with impact (goal to revise for comprehensive managed care contract).

Corrective Action Plan – Under review by DOP

- Encounter data
- Weekly, monthly, quarterly & annual Reporting
- Child and Adolescent Needs & Strengths (CANS) access

Monthly contract monitoring reports and 8 management letters for all the above plus

- Intensive Care Coordination program
- Incorrect invoicing for other state funding



## Idahoans should be served in their communities whenever possible.

- While sometimes necessary, leaving home for residential treatment
  - disconnects people from their families,
  - can lead to traumatic experiences,
  - is difficult to oversee, and
  - often does not fully address root causes of BH symptoms – which are generally complex and affect the whole family.

## Clinical reviews

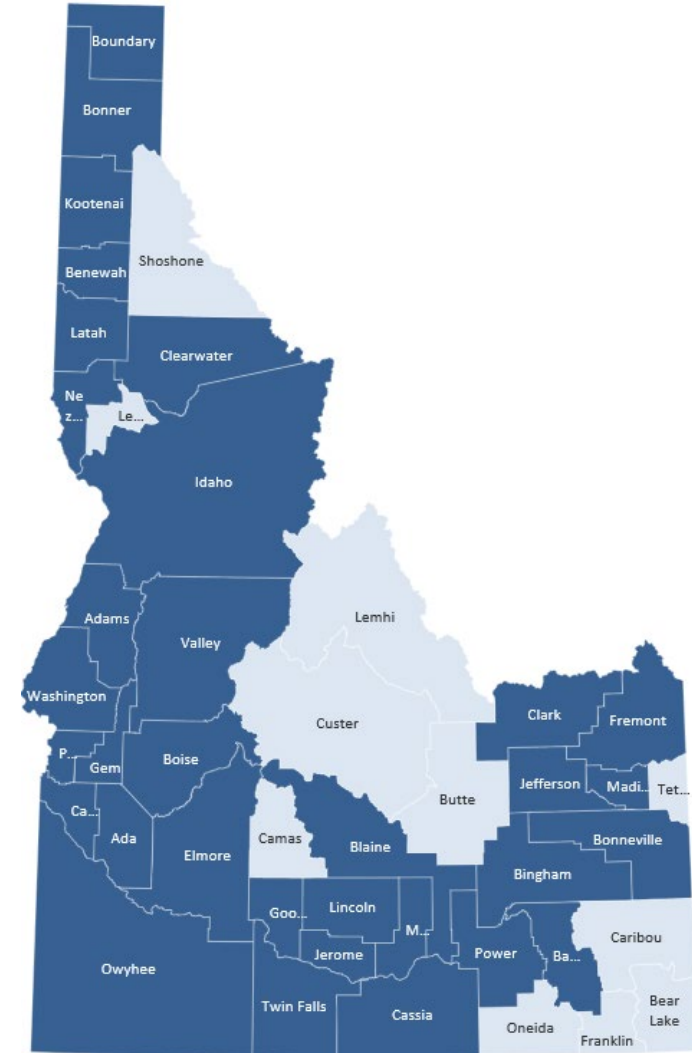
- DHW clinical staff monitoring trends and reviewing supporting documentation for approvals and denials of residential treatment
- Providing clinical feedback to Magellan based on findings and encouraging further development of intensive home and community-based services where people can be served with outpatient treatment while living at home
- Emphasizing development of intensive home and community-based services in Magellan's Annual Network Development and Maintenance Plan



# Duals Roll Out Update



- Managed care mandatory for duals in counties with at least 2 MCOs
- Previously any willing MCO
- **First competitive procurement** for the duals contracts awarded to Molina and UnitedHealthcare this year.
  - Quality payment withhold for less institutionalization, more provider follow up on chronic conditions and after hospitalization
  - Care management expanded to include Medicare services with IMPlus, more requirements to prove MCO engagement with members
- Blue Cross of Idaho contract ended early in June 2025. UnitedHealthcare came in with IMPlus in June 2025.
  - UnitedHealthcare MMCP will be offered in January 2026 due to Medicare timelines.



Counties offering MMCP/IMPlus



- 40 in-person roadshow meetings across multiple regions
- 10 virtual stakeholder sessions, reaching a broad audience
- Over 210 organizations, agencies, and stakeholders engaged
- Frequent communication to providers and participants through newsletters, postcards, and direct outreach
- Multiple emails sent to stakeholders for continued updates
- Over 750 documents reviewed to ensure clarity and compliance
  - In depth review of state and federal regulations, and contract language
- FAQs regularly updated on the website to address emerging concerns
- QA logs and issue mitigation strategies readily available



## Accelerated timeline would not have been possible without

Small scale transition compared to comprehensive managed care

- 15,000 managed care duals out of 350,000 members
- Already in managed care, with a team that knows the existing contract
- Only one of the two MCOs changing

UnitedHealthcare of Idaho's

- Nationally experienced and responsive leadership, with local staff who previously worked with Idaho Medicaid
- strong technical team
- existing network with many providers

All hands-on deck approach from DHW team to ensure readiness review completed within condensed timeframe

## Opportunities for the Future

Sufficient resources to complete readiness work in addition to day-to-day administration of program

- Consultant resources will mitigate this risk.

Rushed work to complete federal authority and contract updates

- Obtaining timely 1915b, c, and SPA authority approvals and executing necessary MCO contracts with all necessary updates.

Coordination between outgoing and incoming MCOs

- Clear expectations and timelines around data sharing and coordination leading up to any transition.
- Clear expectations around access to participant and billing data between MCOs to ensure continuity of care.



# Medicaid Expenditures and Opportunities for Managed Care Approach



	Service	FY2025 Expenditures
1	HOSPITAL	\$ 879,135,538
2	DEVELOPMENTAL DISABILITIES	\$ 671,928,894
3	PRESCRIBED DRUGS	\$ 639,442,140
4	BEHAVIORAL HEALTH MCO	\$ 467,793,733
5	DUALS MCOs	\$ 427,526,611
6	PHYSICIAN SERVICES	\$ 191,767,858
7	PERSONAL CARE SERVICES	\$ 151,970,227
8	MEDICARE PART B PREMIUMS	\$ 100,858,552
9	NURSING FACILITY SERVICES	\$ 84,967,858
10	SCHOOL DISTRICT SERVICES	\$ 73,821,229

- Hospital, developmental disability services, and pharmacy consistently the highest expenditures
- Pharmacy expenditures are reduced by approximately 50% through rebates



**Functions in place today to ensure Idaho Medicaid is covering only medically necessary services.**

**1. Nurse case management for any Medicaid participant (via contractor Telligen)**

- Coordinate care between providers
- Follow treatment plans

**2. Prior authorization of certain services (DHW staff, Telligen, and Prime)**

- Contracted team of clinicians (physicians, nurses, specialists) to support review of services on behalf of DHW.
- Peer to peer consultation with Idaho providers as needed.
- Pharmacy prior authorization criteria established for a number drugs to support health and safety and cost containment.

**3. Retrospective audits for appropriate billing (DHW staff, Telligen, and Prime)**

- Review a sample of clinical documentation to confirm it supports the billed amount and prior authorization requests.
- Support DHW with necessary data through cost recovery process.



- **More resources with MCOs for care coordination and case management**
  - Supports directing Medicaid participants to the lowest (but most appropriate) level of care.
  - Coordination across services and pharmacy benefit to ensure appropriate utilization.
  - More opportunities for participant engagement, outreach, and follow up.
- **More resources to conduct pre and post-pay claims reviews to ensure appropriate billing.**
  - Across services and routine processes in place to review claims.
  - Potential fraud, waste, and abuse mitigation.
- **Team of MCO staff to support provider contracts.**
  - Support value-based, outcome driven contract models to drive quality of care and reduce cost.
  - Support providers who are willing to take on risk-based models.
  - Support providers with billing education to ensure appropriate claims submissions and timely payment.



- **Single Pharmacy Benefit Manager (SPBM)**
  - State selects and contracts with Pharmacy Benefit Manager
  - MCOs are required to contract with the same Pharmacy Benefit Manager
- **State maintains control over**
  - Preferred Drug List (maximizing rebates to reduce cost to state)
  - Drug rebates
  - Call center for providers and participants
  - Drug utilization criteria
- **MCO engagement**
  - Coordination of services and multiple prescriptions
  - SPBM shares trend and utilization information with MCOs to improve utilization management and drive down costs
  - Work with state on drug utilization criteria
- **Other states have successfully adopted this model (Ohio and Kentucky) and many others are considering adoption given the results**
  - Mitigate spread pricing between MCOs and their company owned PBMs
  - Mitigate limited access to pharmacies and patient steering based on arrangements only favorable to the MCO.
  - Single PBM allows the state to limit pharmacy administration costs as compared to a model where each MCO has their own PBM (and is paid for it)
  - Reduced provider burden for prescribers and pharmacies filling medications.



Additional Slides if Needed for Questions



HEALTHY CONNECTIONS	Tier 1 \$3.00 PMPM*	Tier 2 \$7.00 PMPM*	Tier 3 \$9.50 PMPM*
Provide primary care including monitoring and coordinating patient care	✓	✓	✓
Provide timely referrals to medically necessary services	✓	✓	✓
Provide 24 hour, 7 days a week availability of information, referral, and treatment for emergency medical conditions	✓	✓	✓
Provide additional access to care, such as: <ul style="list-style-type: none"> <li>• Being open 46 hours or more each week</li> <li>• Having a patient portal</li> <li>• Offering telehealth</li> </ul>		✓	✓
Provide patient outreach and education activities		✓	✓
Provide quality improvement activities		✓	✓
Provide care coordination		✓	✓
Track and follow-up on referrals		✓	✓
Exchange patient-level information with other healthcare systems		✓	✓
Be nationally recognized as a Patient-Centered Medical Home			✓

\*PMPM= Per member per month reimbursement for each member enrolled to the Healthy Connections clinic



## **Have any providers left the Healthy Connections program due to the most recent legislation to sunset the Healthy Connections program?**

- Idaho Medicaid has not had any providers disenroll. We are aware that providers are concerned about impacts to their staffing and ability to offer additional care coordination services to patients absent this additional program funding.
- DHW has started to relax some of the Healthy Connections requirements in anticipation of the sunseting of the program. We are starting to see providers start to unwind their participation in the program and the additional care coordination functions they have performed.

## **How does the Healthy Connections program ending impact patients and providers?**

- Providers will discontinue Healthy Connections care coordination functions but continue to receive 100% of Medicare for primary care services.
- DHW will continue to provide access to case management services via an existing vendor contract. This will be targeted for Medicaid participants with complex conditions and identified as needing care coordination support to reduce unnecessary ED visits or higher levels of care (when possible).
- DHW will monitor for any impacts to primary care access across the state. If patients can no longer be seen by their original provider, DHW will assist to identify a new provider.