



Medicaid Review Panel

September 24, 2026

Sasha O'Connell

**DHW Deputy Director &
State Medicaid Director**



IDAHO DEPARTMENT OF
HEALTH & WELFARE



House Bill 345 calls for regular engagement with the Medicaid Review Panel:

not increase any net cost to the state. The department of health and welfare shall provide regular updates to the medicaid legislative review panel on a schedule determined by the cochairs and shall seek input from the medicaid legislative review panel to design any waivers submitted to the centers for medicare and medicaid services on behalf of the state.

Including today committee members have met **11 times** since the bill's passage last year to receive updates and provide input on implementation

- March 28, 2025
- May 23, 2025
- July 29, 2025
- September 3, 2025
- December 15, 2025
- February 17, 2026
- February 27, 2026
- March 4, 2026
- March 12, 2026
- March 26, 2026
- September 24, 2026

...not including the additional bi-weekly cochair meetings, individual meetings with members, and 8 additional review panel work groups this summer.



- ✓ Site neutral payments
- ✓ Rural emergency hospital designation
- ✓ Practice authority protections
- ✓ Administrative rule repeals
- ✓ Discontinue Healthy Connections Value Care (HCVC) and Primary Care Case Management
- ✓ FQHC no risk in HCVC (\$2.1 million)
- ✓ Eligibility determination updates (pre-populated forms and ex parte)
- ✓ Choice waiver
- ✓ Prepopulated forms and ex parte



- Submitted but not yet approved
 - Site neutral payments
 - Rural emergency hospitals
 - Prepopulated forms and ex parte
 - Choice waiver
- References to rule are updated in letters of decision and everywhere else
- Managed care authority submission delayed through JFAC action due to MMIS litigation, transition from UPL to SDPs will need to be as well this session
- HR1 (OBBBA) made Idaho's eligibility goals go live January 1, 2027, but the state plan amendment templates were only recently posted and will require public comment before the end of the year
 - Work requirements and community engagement for expansion
 - From 12 month to 6 month redeterminations for expansion
 - From 3 month retroactive coverage to 1 month for expansion and 2 months for everyone else



- Rate reductions still not approved
 - Several rounds of CMS question - state response (SPA is on RAI)
 - Access monitoring
- Youth reentry
 - Bill held in committee last year for SPA authority to conform with 2023 Consolidated Appropriations Act requirements, requested delay from CMS
- 1915(i) to state plan
 - [Idaho Code § 56-254 Eligibility For Medical Assistance](#) created the YES Medicaid group. Change to State Plan will make it administratively cleaner and not tie use of respite service to eligibility.
- 1115 demonstration waiver renewal
 - Encounter data challenges with current system not having appropriate edits and standards



Posted the RFI November 15 through December 31, 2025.

Outreach included

- Issuing a press release
- Posting on our main department website and social media accounts
- Sharing with key groups such as
 - Department's monthly lobbyist and stakeholder call
 - Medicaid Advisory Committee and Beneficiary Advisory Committee
 - National managed care associations



Legislative Engagement

- ✓ Sent draft RFI to all review panel committee members for feedback
- ✓ Reviewed and incorporated committee feedback with chairs on November 7 before posting

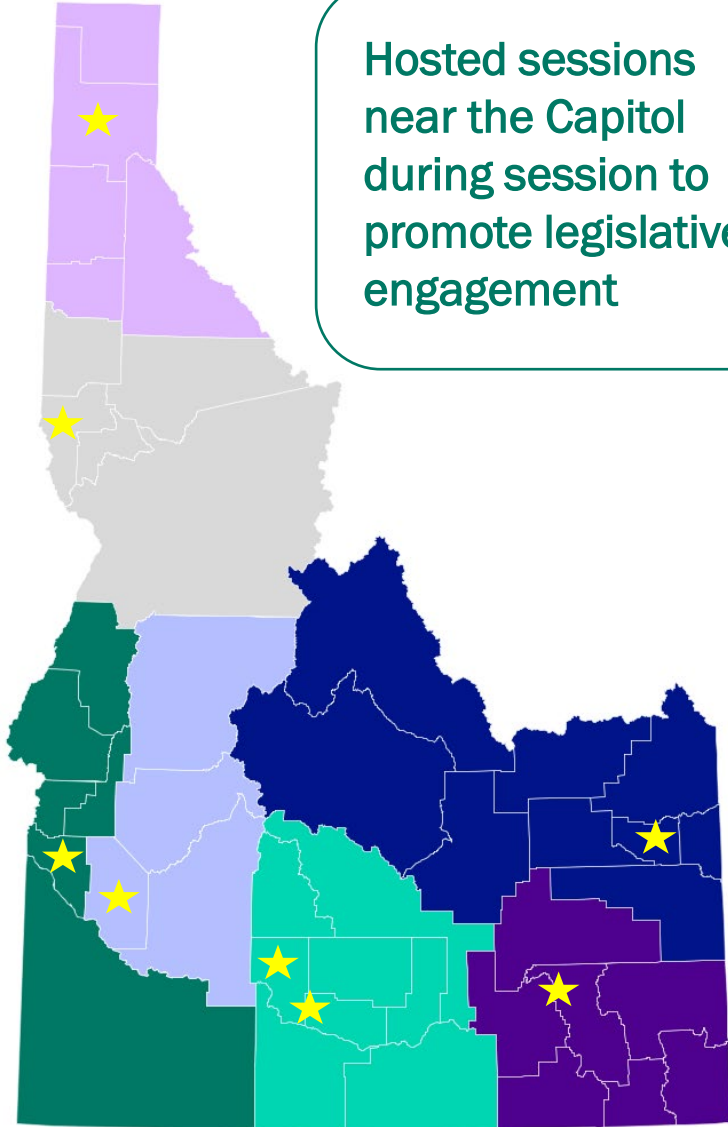
23 MCO responses

80 participant responses

88 provider responses

Medicaid Held 18 Listening Sessions

7



Hosted sessions
near the Capitol
during session to
promote legislative
engagement



September 3, 2025

Twin Falls

Region 5

November 10, 2025

Pocatello

Region 6

December 15, 2025

Rexburg

Region 7

January 6, 2026

Caldwell

Region 3

February 3, 2026

Virtual Only

All

February 25, 2026

Tribal Session

Region 4

March 10, 2026

Gooding

Region 5

April 7, 2026

Boise

Region 4

May 26, 2026

Coeur d'Alene

Region 1

May 28, 2026

Lewiston

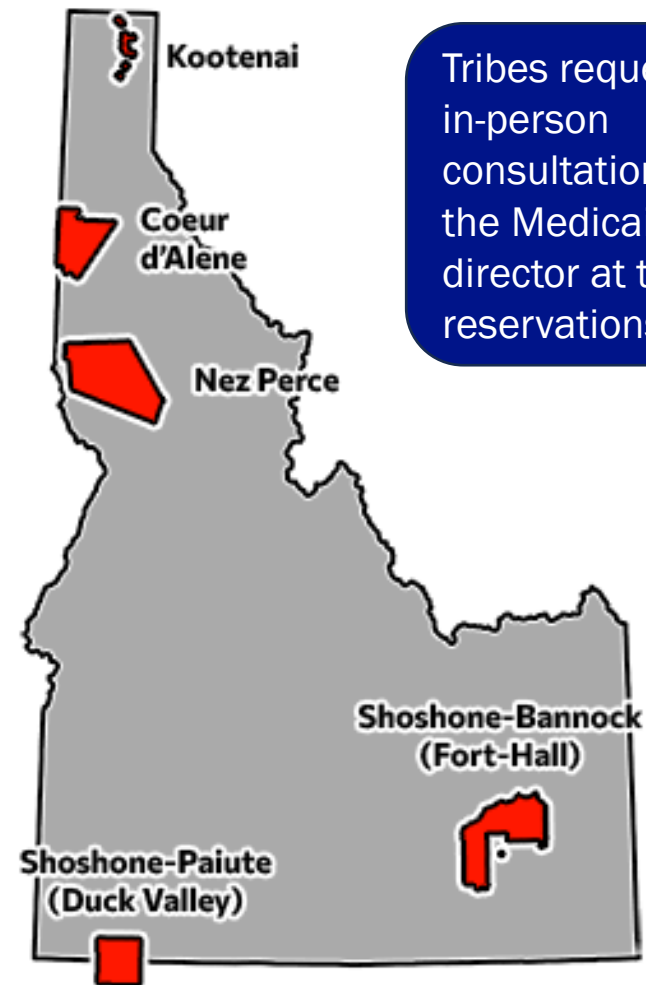
Region 2



All five tribes in Idaho have the right to a government-to-government relationship with certain protections in Medicaid.

Federal law and regulations provide American Indian/ Alaska Native members the option to opt out of managed care, develop their own tribal managed care organization, and protections to federally set payment rates.

Required consultation has occurred with 2 out of the 5 tribal councils. Remaining consultations will be scheduled before December 1.



Tribes requested in-person consultation with the Medicaid director at the 5 reservations.

Summer Legislative Work Groups

9



Group 1 - Provider Experience, MCO Operations, Administrative Burden

Senator Cook, Representative Redman, Representative Rubel, Representative Wheeler, Senator Van Orden

May 5

- Rate floors
- Provider protections (vulnerable provider types)
- Provider payments during transition to managed care
- Timely payments

June 2

- Provider engagement and communications
- Provider performance monitoring
- Data collection and management
- Data analysis and reporting

June 23

- Methods to decrease redundancy and administrative burden
- Claims warehouse
- Centralized credentialing
- Utilization management standards

July 14

- Subcontractor management
- Artificial Intelligence
- Local economic investment and workforce opportunities (“Idaho First” values)
- Plan operational standards

Group 2 - Member Experience, Quality, Cost Containment

Senator Bjerke, Senator Harris, Representative Tanner, Senator Wintrow, Representative VanderWoude

May 12

- Compliance and regulatory oversight (sanctions, penalties)
- Financial controls and risk-sharing arrangements
- Methods to improve cost containment and program efficiency
- Value-based care strategies (e.g., withholds and incentives)

June 9

- Opt-in/opt-out enrollment
- Use of auto-enrollment (provider assignment)
- Relationship to health insurance marketplace
- NEMT (Non-Emergency Medical Transportation)

June 30

- Comprehensive quality strategy
- Performance improvement plans process
- Required MCO deliverables and reporting
- Network development standards

July 21

- Care coordination and case management standards
- Plan performance standards
- Value-added benefits



- Idaho will require providers to at least **match the fee-for-service rate** for a period following the transition. The state will reassess to what extent flexibility in rate setting is appropriate for certain or all services following stabilization.
- Idaho will pursue provisions for **interest or penalties** for appropriately submitted claims that are not paid timely. The state will also **continue to have liquidated damages** for systemic late payment.



- Federal rules do not allow managed care organizations to have utilization management standards that are more restrictive than the state fee-for-service policies. The state will need to continue to **maintain our own policies**, have clinicians available to weigh in on the appropriateness of managed care policies, and also respond to concerns raised by providers and participants. The state plans to work with managed care organizations to identify **key services** that would benefit from standard prior authorization policies.
- The state expects **standardized reporting formats, core workflows, and artifacts for utilization management** across all three managed care organizations to improve provider experience.



- The state aims to have a state operated **publicly posted dashboard** with information about managed care plan performance, such as prior authorization approval rates and denial reasons, timely payment metrics, and network adequacy measures. The purpose of sharing information publicly is to give participants more information when selecting a plan and providers more information when contracting with plans.



- Idaho plans to promote fair competition across all potential bidders, while requiring a local presence to promote job opportunities and ensure relationship building with members and providers. Managed care organizations **will be required to hire certain positions in Idaho** but will not be expected to have staffing before the RFP is posted as this would advantage some bidders over others.



- Throughout listening sessions, members raised concerns about insufficient care coordination in Idaho today. The state plans to specify **detailed requirements for caseloads and contact frequency**. We also aim to learn from other states in setting **care manager qualification and documentation expectations**. Idaho will also review other state contracts to see whether there are strong performance measures that are outcome focused.



Key program design decisions have been posted on our website as they have been finalized over the last year: healthandwelfare.idaho.gov/managedcare

After work groups ended, on August 1 Medicaid solicited any recommendations that individual committee members may have above and beyond the high-level direction we agreed upon.

Medicaid Review Panel's consultant

- reached out to individual members
- pulled together their remaining questions and concerns
- will present to the group on how she believes decisions thus far address those topics, and potential recommendations if the committee would like to vote to go above and beyond the program design decisions already made.



- Comprehensive managed care contingent on MMIS go-live after procurement
 - Litigation still underway for claims and provider modules
 - Installation, development, configuration and testing will take two years after work is allowed to start, then the system will take an additional 6 months for CMS certification
 - If there is not a certain path in litigation before December 1, the state will need to delay the RFP and blackout again
- Blackout still planned for December 1
 - NDAs for Medicaid leadership and staff
 - No discussion of the contract until RFP posting