

Idaho Medicaid Managed Care Review Panel



Jennifer Strohecker, Legislative Consultant
September 24, 2026

Question 1: Consistency among MCOs

Providers should not have to navigate three entirely different prior-authorization and claims processes. If each MCO has its own requirements, a provider may need one employee who understands MCO A, another who understands MCO B, and another who understands MCO C.

The state should establish consistent processes, definitions, reporting requirements, and timelines across all MCOs wherever possible. This would reduce unnecessary administrative costs and allow providers to spend more time caring for patients.

Submitted by: Senator Cook

Response Question 1: Consistency among MCOs

Development of contractual language to directly address provider burden has been a topic of discussion and agreement among working group parties. The bullets below are from the KEY DECISION LOG.

1. Federal rules require that all providers enroll directly with the state Medicaid agency. We intend to work with managed care organizations to ensure our credentialing process is sufficient to meet their needs. This may entail adding additional questions to meet NCQA accreditation standards.
2. 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.
3. The state expects standardized reporting formats, core workflows, and artifacts for utilization management across all three managed care organizations to improve provider experience.

Question 2: Prompt payment requirements

Prompt payment is critical. When an MCO delays payment, the money remains in the MCO's account while the provider struggles with cash flow and, in some cases, making payroll.

The contracts need clear payment deadlines, meaningful enforcement provisions, and consequences when clean claims are not paid on time.

Submitted by: Senator Cook

Response Question 2: Prompt Payment Requirements

MCO contracts will require the following:

Federal regulation requires MCOs to pay 90% of clean claims to the providers within 30 days and 99% of payment within 90 days.

The KEY DECISION LOG states:

Within 30 days of provider submission to the MCO, the MCO is required to pay the provider for properly submitted claims.

Failure to pay the provider promptly will result in the “pursuit of interest or penalties for appropriately submitted claims that are not paid timely”.

- The contract language will require that interest will be paid directly to the provider from the MCO
 - Systemic late payment will result in additional liquidated damages

Submitted by: Senator Cook

Question 3: Consequences for improper denials and payment changes

I want the contracts to include liquidated damages or another meaningful financial remedy when an MCO:

- Wrongfully denies a claim or prior-authorization request;
- Reverses a prior authorization after the service has been provided; or
- Reduces the approved reimbursement amount after the provider has delivered the service in reliance on that approval.

Most of the financial remedy should be paid directly to the affected provider. If the department needs to retain a portion to cover its enforcement costs, I understand that, but I believe the department's portion should be less than 10% of the total.

The remedy must be large enough to discourage this behavior. Otherwise, it may simply become a cost of doing business.

Submitted by: Senator Cook

Response Question 3: Consequences for improper denials and payment changes

FROM KEY DECISION LOG:

As a general approach, Idaho will have enhanced provider protections with escalation mechanisms to support a stable transition. We are exploring contract language that has explicit financial remedies, interest on late payments, and expedited state mediation processes.

It was already agreed upon that the state would pursue liquidated damages in the following format: "The state will have a matrix of liquidated damages for high impact contract failures, such as noticing requirements, provider directory accuracy, and call center performance"

Also: Idaho's contract will require standardized engagement with bidirectional feedback loops. Managed care organizations will have dedicated provider relations staff in Idaho, training and education, provider manuals, and expectations in relation to training cadence, advisory committees with state attendance, and frequency of communication in some situations.

Potential Recommendation Based on Other States Language

Strengthening Provider Oversight & Service Quality in Medicaid MCOs

SUMMARY OF BEST PRACTICES:

States like TN, TX, NC, and OH establish direct MCO contract SLAs and financial penalties to reduce administrative burden and protect healthcare providers.

PROPOSED LEGISLATIVE DIRECTION:

Direct the Department of Health and Welfare (DHW) to benchmark provider-protection best practices from leading states and incorporate explicit MCO performance metrics into upcoming managed care contracts, including:

1. Customer Service SLAs - Max 30-second average speed to answer; < 3% call abandonment rate.
2. Complaint & Appeal Resolution - Mandatory resolution of provider disputes within 30 days; financial remedies for unresolved claims beyond 60 days.
3. Claim Denial & Payment Transparency - Minimum 95% clean claim prompt-payment requirement; monthly MCO reporting on top claim denial codes.

Question 4: Correct and Timely Provider Payment

I need to understand how the state will independently know whether providers are being paid correctly and on time—before a legislator receives a call from a provider who has gone months without payment.

The state should not have to rely on an MCO to prepare a special report each time a concern is raised. It should have direct access to timely data and the ability to identify problems, verify performance, and enforce the contract.

Submitted by: Senator Cook

Response Question 4: Correct and Timely Provider Payment

Response: See item #2 above.

Encounter claim submission (MCO to the state) is a regular reporting item the contract will require. Tied to timely encounter submission to DHW will be a requirement for the MCOs to also be paid timely. Failure to pay timely (within 30 days of submission for clean claims) will result in automatic daily interest % to be applied to the provider payment (MCO will pay the provider directly).

Question 5: State Ownership and Access to Data

The contracts should clearly establish that all data generated while administering Idaho's Medicaid program belongs to the state.

At a minimum, the contracts should require:

- Direct and timely state access to the data;
- Delivery in a complete, usable, and state-specified format;
- Firm deadlines for providing requested information;
- A prohibition against withholding state data for internal legal or corporate review;
- The right for the state to independently audit and analyze the data;
- Continued state access to historical data after a contract ends; and
- Meaningful consequences for failing to provide complete and timely data.

The state should not have to negotiate for access to its own information after the contract has been signed.

Submitted by: Senator Cook

Response Question 5: State Ownership and Access to Data

The MCO contracts will contain clear, specific language around data sharing requirements as outlined in Federal statute around subcontractor relationships and delegation.

Potential Recommendation Based on Other States Language

Federal Medicaid rules (42 CFR § 438.230 & § 438.8) authorize states to enforce strict data transparency on MCO subcontractors (e.g., PBMs, dental, behavioral) to eliminate hidden administrative spreads, profit shifting, and opaque reporting.

Potential LEGISLATIVE DIRECTION:

Direct the Department of Health and Welfare (DHW) to incorporate mandatory subcontractor data transparency, direct state audit rights, and clear financial reporting rules into all Medicaid managed care contracts, including:

1. Mandatory "Flow-Down" & Direct Audit Rights (42 CFR § 438.230) - Unrestricted state/CMS right to audit subcontractor records, claims, and financial systems without prior notice; records retained for 10 years.
2. "Look-Through" Accounting Rules - Bars MCOs from reporting flat vendor capitation fees as clinical claims; forces reporting of actual dollars paid to end-treating providers.
3. State Data Ownership & Unrestricted Access - Establishes that all encounter data, drug pricing, and manufacturer rebates are State property, overriding vendor "trade secret" claims.
4. Performance Remedies & Data Withholds - Financial penalties (up to 2% capitation withhold) for MCOs if sub- contractors fail to deliver timely, fully validated transactional data.
5. Structured Data Sharing Schedules - Proactive (Routine): Monthly encounter data & quarterly rebate/spread files. - Targeted (On-Demand): Full subcontractor contracts & CPA financial audits.

Question 6: MCO Weekly Claim Data Feed

The state should receive a weekly, denormalized data feed from every MCO. The feed should contain enough detail for the state to independently answer the following questions without requiring the MCO to compile or interpret the information.

For each MCO and reporting period, the state should be able to determine

Claims received and processed

- Total claims received;
- Total claim lines received;
- Number and percentage paid in full;
- Number and percentage partially paid;
- Number and percentage denied in full; and
- Submitted charges, allowed amounts, amounts paid, and amounts denied.

The contracts should clearly state whether each percentage is calculated by claim, claim line, member, or dollar amount.

Reasons for claim denials

Submitted by: Senator Cook

Question 6: MCO Weekly Claim Data Feed, cont

The data should show the number and percentage of denials involving:

- Services not covered or specifically excluded;
- Lack of prior authorization;
- Medical-necessity determinations;
- Member eligibility;
- Out-of-network or provider-contracting issues;
- Duplicate claims;
- Missing or incorrect information;
- Coding or billing issues;
- Coordination of benefits; and
- Other reasons.

Prior-authorization decisions

For both medical and pharmacy requests, the state should be able to determine:

- Total requests;
- Approved requests;
- Denied requests;
- Partially approved requests;
- Requests withdrawn or administratively closed;
- Average and median decision times; and
- Number exceeding the applicable decision-time requirement.

Approval and denial rates should use all completed prior-authorization decisions as the denominator.

Appeals and overturned decisions

Question 6: MCO Weekly Claim Data Feed, cont

The state should receive data showing:

- Number of denied claims and prior-authorization requests appealed;
- Number and percentage approved or overturned on appeal;
- Number and percentage upheld;
- Number still pending; and
- Average and median time required to resolve an appeal.

When available, the data should also identify why decisions were overturned—for example, additional information was received, the original claim was processed incorrectly, or the medical-necessity determination changed.

Timeliness and unpaid claims

The state should be able to determine:

- Number and dollar amount of clean claims paid within 15, 30, 45, and more than 45 days;
- Number and dollar amount of claims that remain unpaid or pending;
- Aging of unpaid claims: 0–30, 31–60, 61–90, 91–120, and more than 120 days;
- Number and dollar amount of claims suspended or pended for additional information;
- Interest or prompt-payment penalties paid because of late payment; and
- Number of substantiated provider complaints involving delayed, incorrect, or missing payments.

Response and Potential Recommendation Question 6: MCO Weekly Data Feed

Response: We appreciate the level of detail requested for claims data reporting. Some level of detail is spot on and can be requested. Other parts may need to be further evaluated.

Would you like to propose this as a recommendation to the Committee / DHW for discussion and then inclusion as part of the contractual requirements??

Question and Response 7: Customer Service Requirements

Hiring customer service teams in state vs. large call centers out of state

Response from Key Decision Log:

Idaho's contract will require standardized engagement with bidirectional feedback loops.

Managed care organizations will have dedicated provider relations staff in Idaho, training and education, provider manuals, and expectations in relation to training cadence, advisory committees with state attendance, and frequency of communication in some situations.

Submitted by Senator Wintrow

Question and Response 8: Customer Service Requirements

Customer service: Being able to talk to a person on the phone who is a good problem solver and doesn't just "pass the buck"

Response from Key Decision Log:

Managed care organizations will have dedicated provider relations staff in Idaho, training and education, provider manuals, and expectations in relation to training cadence, advisory committees with state attendance, and frequency of communication in some situations.

Submitted by Senator Wintrow

Question and Response 9: Care Management Quality and Ratios

Outstanding care coordination and a good ratio of care coordinators to clients, especially those with complex needs

Response from Key Decision Log:

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.

Submitted by Senator Wintrow

Question and Response 10: DHW Staffing for MCO Oversight

Appropriate staffing for the department to monitor contracts and intervene and regularly problem solve and process innovate: monitoring progress, metrics, complaints, and consistency

Response and Potential Recommendation:

Is this something you would like Deloitte to review: To consider current DHW org structure and consider current / future workload : staffing ratios to ensure sufficient staffing?

Would you like to propose a recommendation to the committee for DHW to have a certain number of additional staff?

Submitted by Senator Wintrow

Question 11: Standardized Approach for Providers

System consistency to support providers; it is not helpful to have too many forms and systems that make it harder on providers; ensure that systems are easy, quick to enter data, and not adding too much additional work to providers. They need to spend 90% of their time caring for people not filling out forms or being denied without reason

Submitted by Senator Wintrow

Response Question 11: Standardized Approach for Providers

We have had extensive discussion about how to reduce provider administrative burden and have had the following recommendations from the KEY DECISION LOG:

- Uniform credentialing standards
- Use of standardized templates for targeted areas like utilization management and standardized reporting requirements.
- 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."
- While states with more experience in managed care may set high level operational outcomes, Idaho recognizes that this change will be a significant transition for providers and members. The state plans to establish clear minimum operational standards with formal readiness reviews and demonstrations. We will also solicit feedback from providers and enforce robust claims testing before go-live.

Question and Response 12: Provider Training and Standardized Tools

Establish clear, easy billing codes and training and system to access to ensure that fraud is being controlled and that providers have a good understanding up front of what is covered and how

Response and Proposal for Recommendation:

The key decision log states that ID contract will require standardized engagement with bidirectional feedback loops. MCOs will have dedicated provider relations staff in Idaho, training and education, provider manuals and expectations in relation to training cadence, advisory committees with state attendance and frequency of communication in some situations.

Is there an additional recommendation you would like to propose?

Submitted by Senator Wintrow

Question 13: MCO Prior Authorization Data Reporting

Metrics about denials; I met with “a plan” in the last month due to concerns that their denial rate for claims was over 50%. There's something wrong there. In these cases, there needs to be enough qualified and appropriate DHW staff that can step in and intervene and check on these things. It shouldn't take a call to a State Senator to get things done.

Response from KEY DECISION LOG:

The state will have a 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.

Submitted by Senator Wintrow

Question and Response 14: Liquidated Damages

Appropriate liquidated damages for not meeting expectations or metrics established in contract

KEY DECISION LOG:

As a general approach, Idaho will have enhanced provider protections with escalation mechanisms to support a stable transition. We are exploring contract language that has explicit financial remedies, interest on late payments, and expedited state mediation processes.

The state will pursue liquidated damages in the following format: “The state will have a matrix of liquidated damages for high impact contract failures, such as noticing requirements, provider directory accuracy, and call center performance”

Submitted by Senator Wintrow

Question and Response 15: Preventive Care Incentives

Provide incentives for providers and patients that are meeting health care outcomes that are more in line with prevention work

RESPONSE:

The DHW would be able to create incentives tied to a quality or performance withhold with prevention work highlighted as a key objective for. Two mechanisms to do this are through performance improvement plans and quality withhold incentives.

KEY DECISION LOG:

- Managed care organizations are required to maintain performance improvement plans. The state plans to designate priority areas for a small number of plans and allow plans to select additional plans independently.
- States are required to maintain and update a quality strategy. Idaho plans to work with managed care organizations to ensure align payment withholds and other performance expectations with the quality strategy.

Submitted by Senator Wintrow

Question and Response 16: Appeals and Grievances

A clear and easy pathway for providers or clients to make a complaint or grievance; this needs to be monitored transparently by department, and formal complaints and grievance cannot be handled by the company being grieved.

RESPONSE and POTENTIAL RECOMMENDATION:

- CMS enforces extensive, highly rigid legal requirements governing how managed care plans handle appeals and grievances. These federal standards ensure beneficiaries are protected from arbitrary care denials or poor service.
- Federal guidelines requires that appeals and grievances cannot be subcontracted out to a third party and are required to be operated in house with the MCO.

It could be proposed that DHW research best practices from other states and apply it in contracts.

Submitted by Senator Wintrow

Proposal: Subcontractor Oversight and Best Practices

Managed care organizations often subcontract a portion of their obligations under state contracts to another vendor. Idaho has historically required review and pre-approval of those contracts and will do so in the future. The state will also research other state contracts and determine whether we will not permit subcontracting of certain responsibilities.

****This is existing language****

Consider Potential Recommendation based on other state work:

Recommend that DHW research other state approaches and identify best practices for financial transparency (such as pass through MLR reporting), operational accountability, and timely data collection sharing of subcontractors.

Thank you.