House Bill 345 & Managed Care Update

February 26, 2026

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State Medicaid Administrator & DHW Deputy Director

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Legislative Medicaid Review Panel

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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.

Committee members met 6 times since the bill's passage 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

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H345 Implementation Updates

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Requirement	SPA or Waiver	Deadline	Status
Rural hospital designation	SPA	Unspecified	On track. Draft SPA out for public notice, with submission to CMS planned for Q1 2026 (effective date July 1, 2026).
Cost sharing	SPA	July 1, 2026	On track. All allowable services other than behavioral health (to align with OBBBA in 2028). Will share more detail in coming slides.
Work requirements	SPA	January 1, 2027 to align with OBBBA for fastest implementation	Following passage of OBBBA, anticipating guidance from CMS this spring on SPA template submission. SR working towards new contract to manage all programs with work requirements. Analyzing potential to meet advanced noticing requirements for early go live before CMS guidance.

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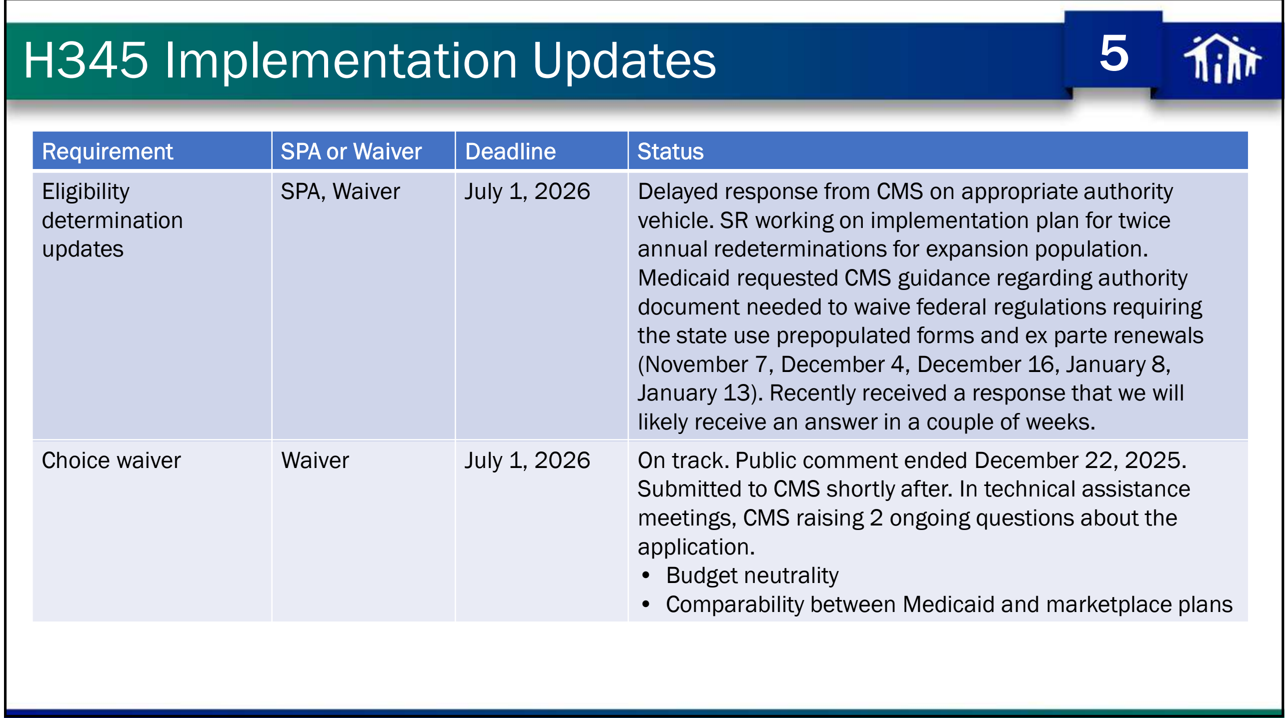

H345 Implementation Updates

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Requirement	SPA or Waiver	Deadline	Status
Eligibility determination updates	SPA, Waiver	July 1, 2026	Delayed response from CMS on appropriate authority vehicle. SR working on implementation plan for twice annual redeterminations for expansion population. Medicaid requested CMS guidance regarding authority document needed to waive federal regulations requiring the state use prepopulated forms and ex parte renewals (November 7, December 4, December 16, January 8, January 13). Recently received a response that we will likely receive an answer in a couple of weeks.
Choice waiver	Waiver	July 1, 2026	On track. Public comment ended December 22, 2025. Submitted to CMS shortly after. In technical assistance meetings, CMS raising 2 ongoing questions about the application. • Budget neutrality • Comparability between Medicaid and marketplace plans

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H345 Implementation Updates

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Requirement	SPA or Waiver	Deadline	Status
Directed payments	Waiver, preprint	July 1, 2027	On track. Will transition UPL to SDPs; will need support from actuarial services contract. Actuary services contract will support directed payment design. New actuary contract being procured in coming weeks.
Discontinue Healthy Connections Value Care (HCVC) and Primary Care Case Management	SPA	January 1, 2026	Complete. Associated guidance, rules, and FAQs have been updated for several months. Enrollment in Healthy Connections ceased. System changes to stop PCCM payments successful last month.
FQHC no risk in HCVC	SPA	2024 performance period forward	Complete. Amendment to remove risk signed by DHW and FQHCs.

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H345 Implementation Updates

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Requirement	SPA or Waiver	Deadline	Status
Site neutral payments	SPA	July 1, 2026	On track. Draft SPA out for public notice, with submission to CMS planned for Q1 2026 (effective date July 1, 2026).
Practice authority protections	SPA	July 1, 2025	Complete. CMS directed us to withdraw SPA and pursue through handbook changes. Letter drafting for 22 health care-related boards requesting review and recommendations on any services under scope of practice but not currently billable to Idaho Medicaid.
Administrative rule repeals	N/A	July 1, 2025	Complete. Consolidated three chapters of rule and posted temporary rules IDAPA 16.03.26 Medicaid Plan Benefits effective July 1, 2025. One chapter was not repealed in H345 (Consumer-Directed Services). Legislature will vote on removing that leftover chapter and replacing with consolidated chapter.

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Cost Sharing

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Idaho Code § 56-2203 Legislative Approval – Medicaid Cost-Sharing.

(1) The department of health and welfare is authorized to and shall submit a state plan amendment to the centers for medicare and medicaid services to include participant cost-sharing as a condition of participation in a medical assistance program, to the extent allowed under federal law, that is at least to the levels developed by other states and up to the maximum charged by other states.

(2) The department of health and welfare shall:

(a) Take such actions as are necessary to implement the provisions of this section;

(b) Begin the application process for federal approval of the state plan amendment required by this section no later than July 1, 2026; and

(c) Continue any existing cost-sharing under the medicaid state plan in effect at the time of the passage of this act until supplanted by the new state plan amendment required by this section.

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Cost Sharing

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- Increase Medicaid member copays from $3.65 to $4.00 on benefits already subject to a copay for applicable members and **add benefits** that will be subject to a copay.
- Add copays on preferred and non-preferred drugs. Preferred drugs will have a $4 co-pay, and non-preferred drugs will have an $8 copay.
- System changes must be made to track income and remain under 5% monthly or quarterly → would require supplemental to move forward now and pay twice or move forward in 2027 with smaller or no system cost.
- OBBBA did not change federal law to allow payment of cost sharing as a condition of eligibility.

— *Accessing Emergency Transportation Services For Non-Emergency Medical Condition*
— *Accessing Hospital Emergency Dept Services For Non-Emergency Medical Condition*
— ***Ambulatory Surgical Center Services***
— ***Chemotherapy and Radiation Therapy Services***
— *Chiropractic Services*
— ***Dental Services***
— ***Diagnostic X-Ray Services***
— ***Durable Medical Equipment***
— ***Federally Qualified Health Center (FQHC) Services***
— ***Home Health Services***
— ***Inpatient Hospital Services***
— ***Laboratory Services***
— *Occupational Therapy Services*
— *Optometric Services*
— *Outpatient Hospital Services*
— *Physical Therapy Services*
— *Physician Office Visits*
— *Podiatry Services*
— ***Rural Health Clinic (RHC) Services***
— *Speech Therapy Services*
— ***Urgent Care Center Services***

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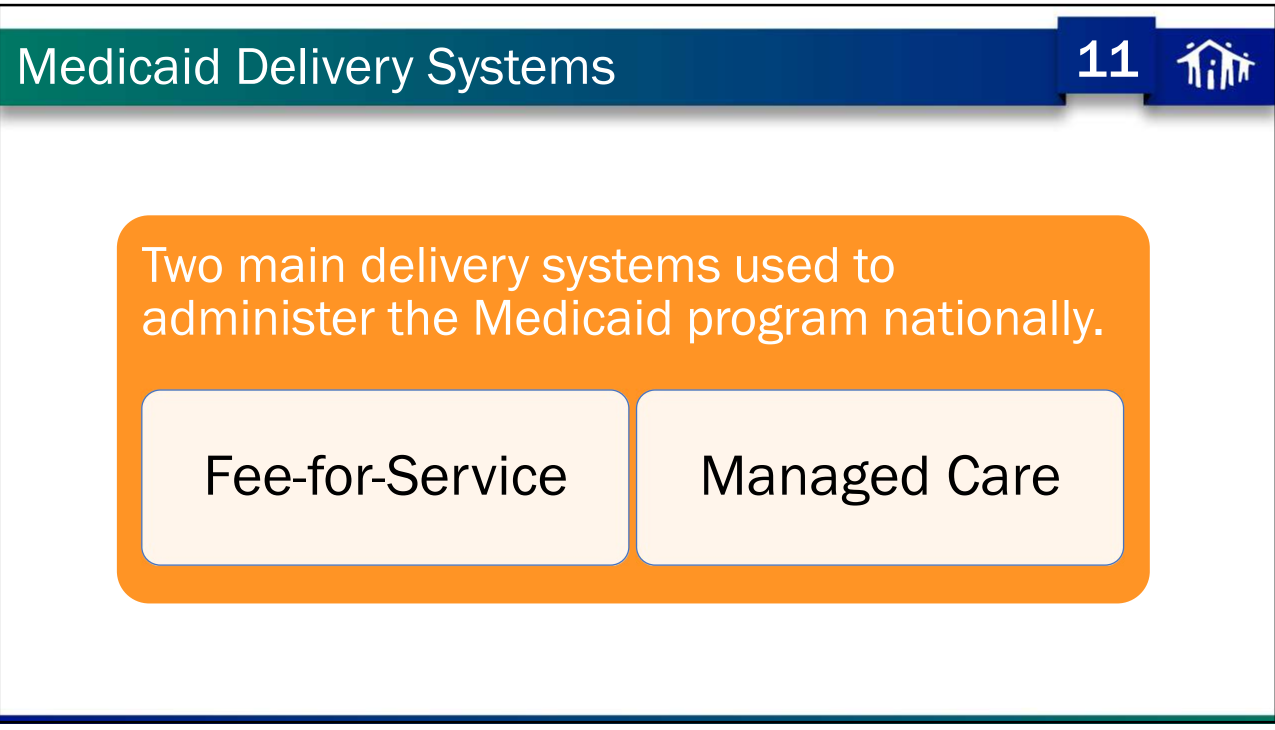

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Fee-for-Service

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The State Medicaid Agency contracts directly with providers and pays them a fixed rate per service rendered.

State administers all functions of the program with staff and contractors

- Provider network management and provider reimbursement
- Utilization management and prior authorization
- Care coordination and case management
- Quality reporting and quality improvement initiatives
- Data analytics
- Compliance and authority work
- Fraud, waste, and abuse investigations

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Managed Care Models

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- State maintains some responsibilities, but transitions to an oversight role.
- The MCO is paid a set capitated amount and takes on financial risk within the PMPM.
- Several models
  - Primary care case management
  - Limited benefit plans
  - Comprehensive managed care

Last year DHW was operating all three of these models, a fee-for-service program and a value-based payment arrangement.

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Idaho Often Isn't on the Map for Managed Care

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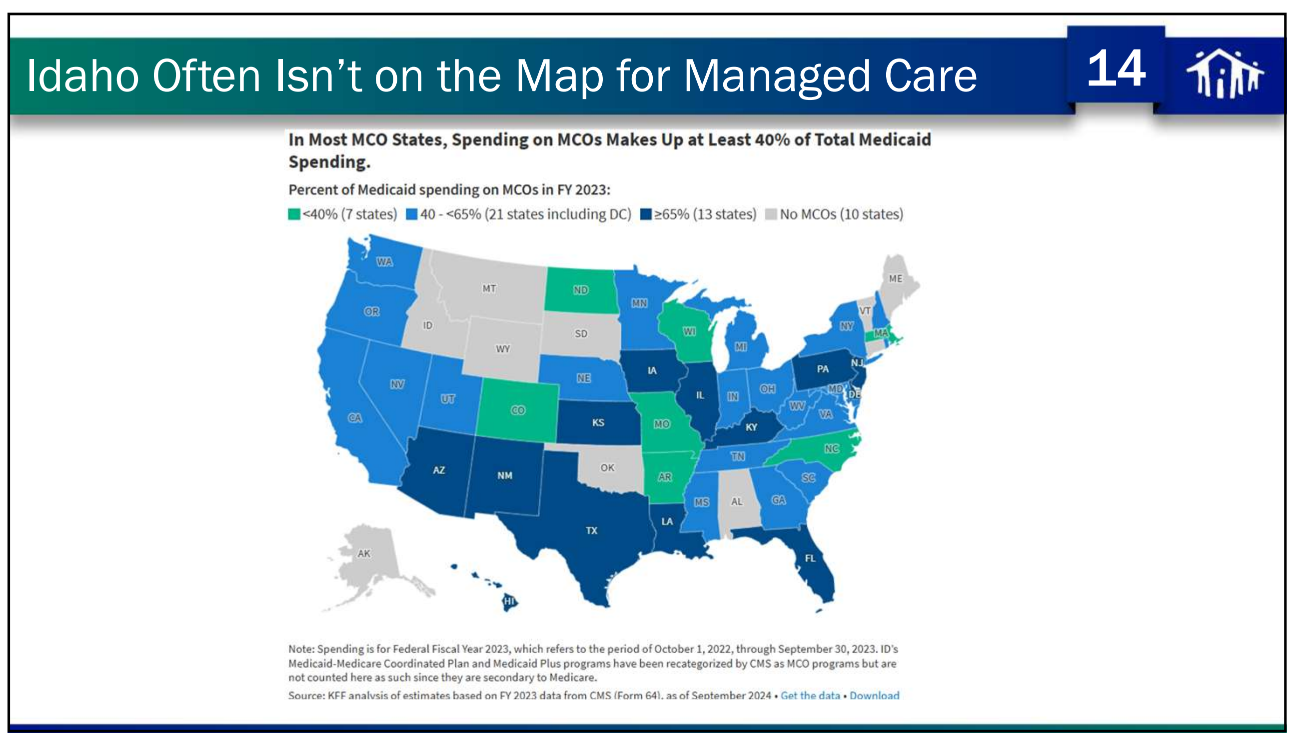

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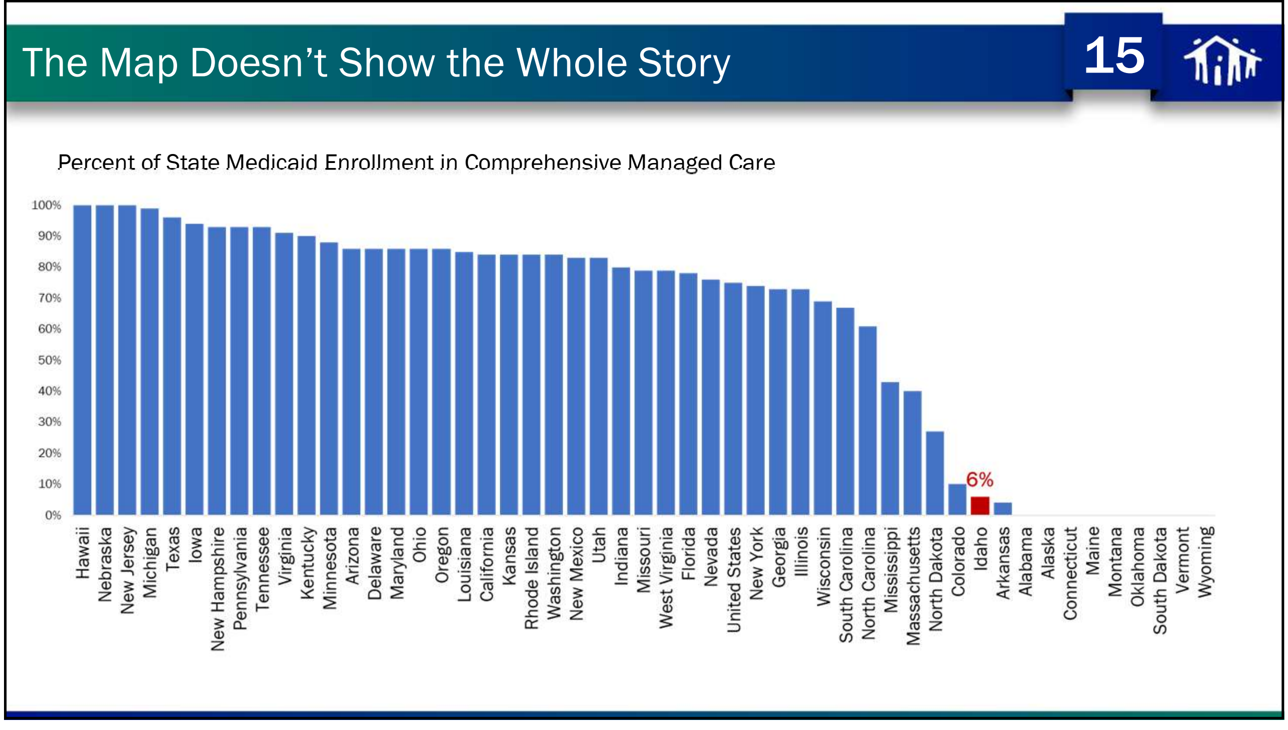

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Managed Care in Idaho

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- Today, Idaho uses managed care for certain Medicaid services, including dental services, behavioral health services, non-emergency transportation, and the Duals program for members who qualify for both Medicaid and Medicare.
- Only a small percentage of Idaho's Medicaid members, however, are in comprehensive managed care.
- When Idaho transitions to comprehensive managed care, nearly all Medicaid services, like doctor visits, prescriptions, and hospital care will be coordinated under one health plan for each member enrolled in the managed care program.
- This change is intended to **improve coordination, simplify access**, and **help members get the full range of care** without gaps.
- Idaho will be the 43rd state to use comprehensive managed care for Medicaid.

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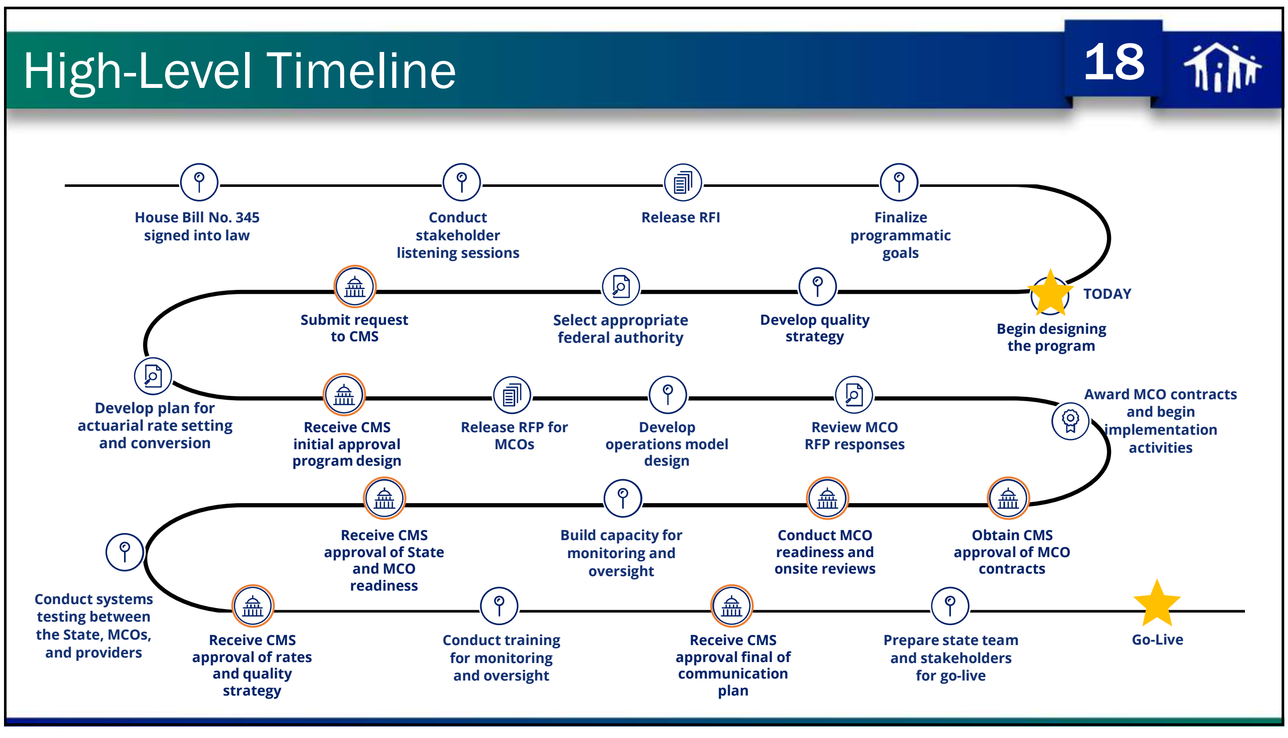

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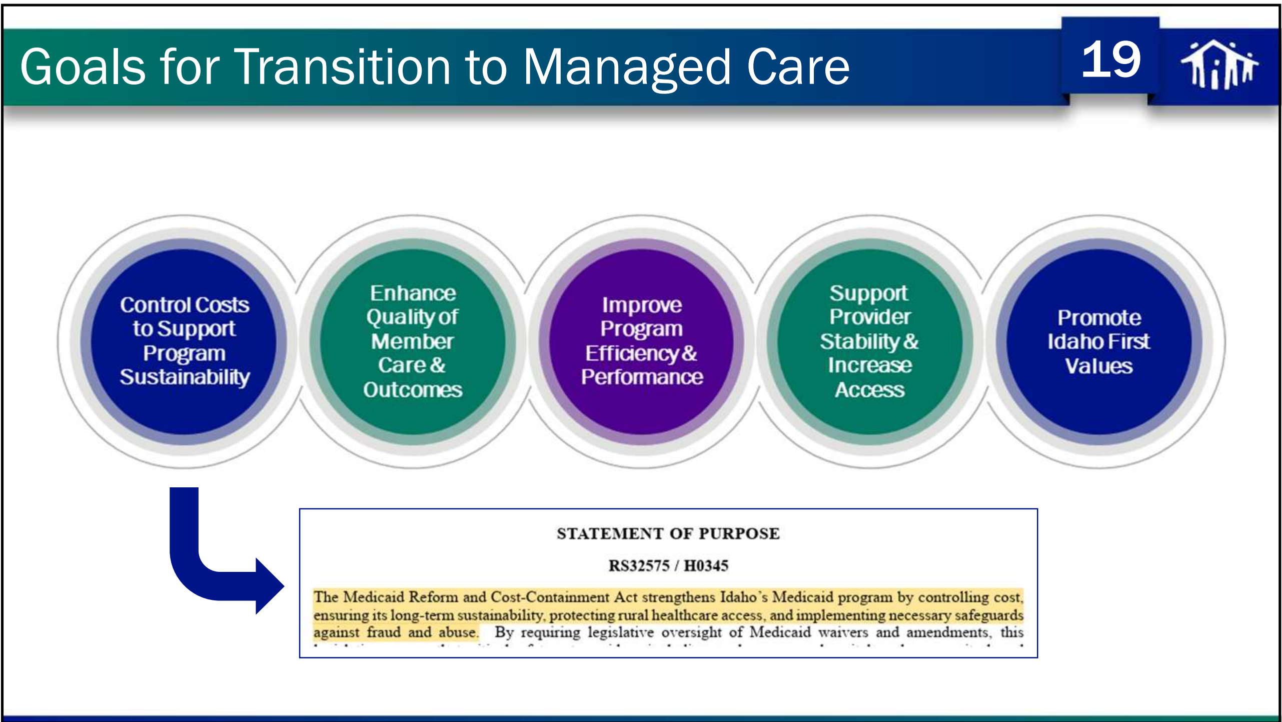

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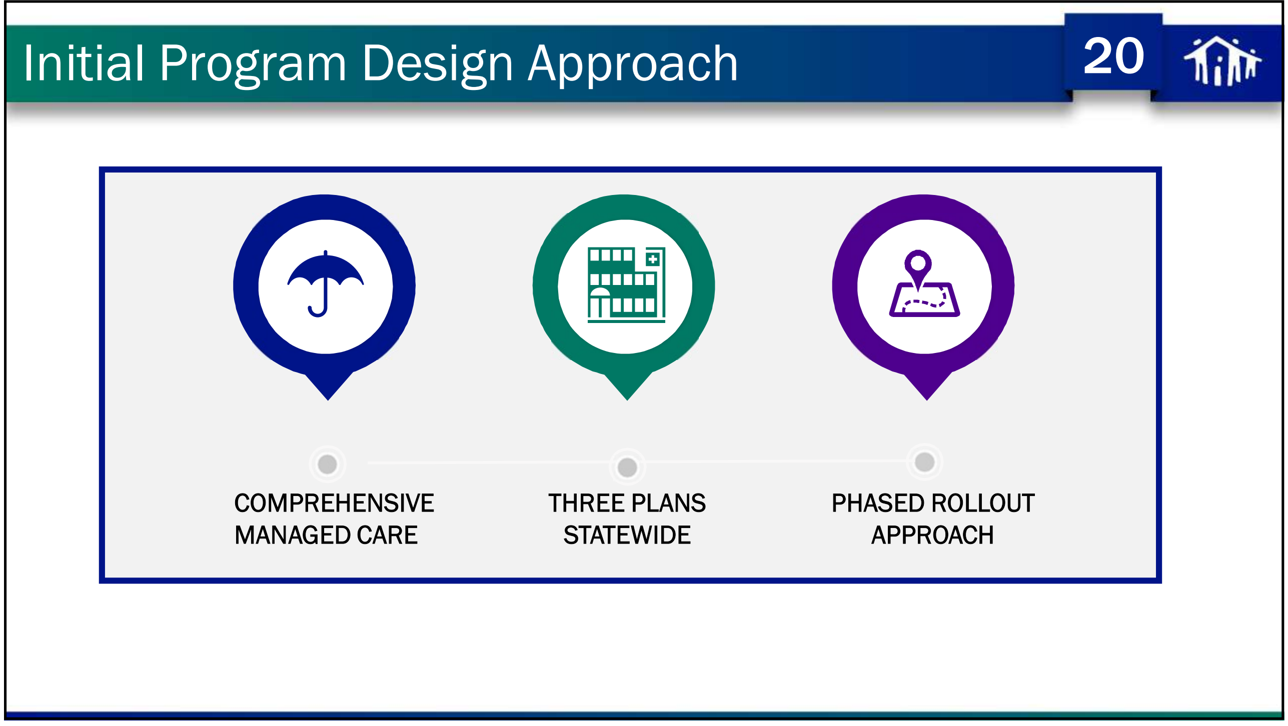

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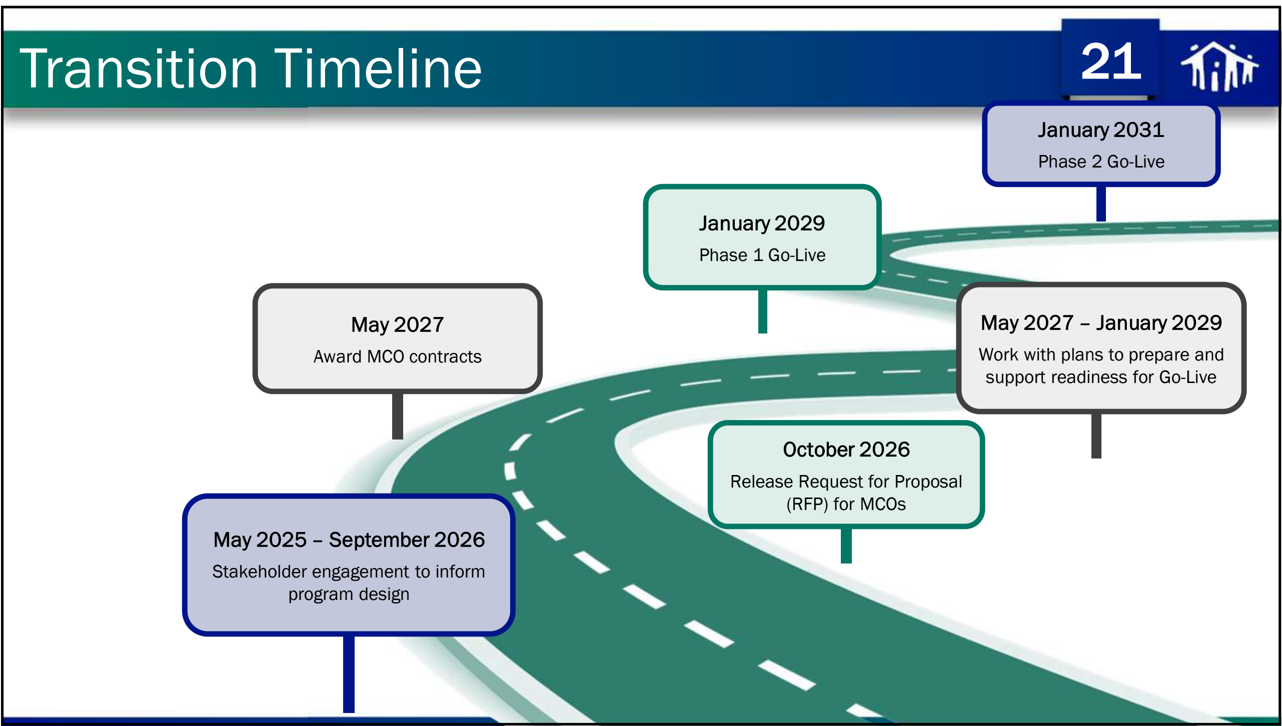

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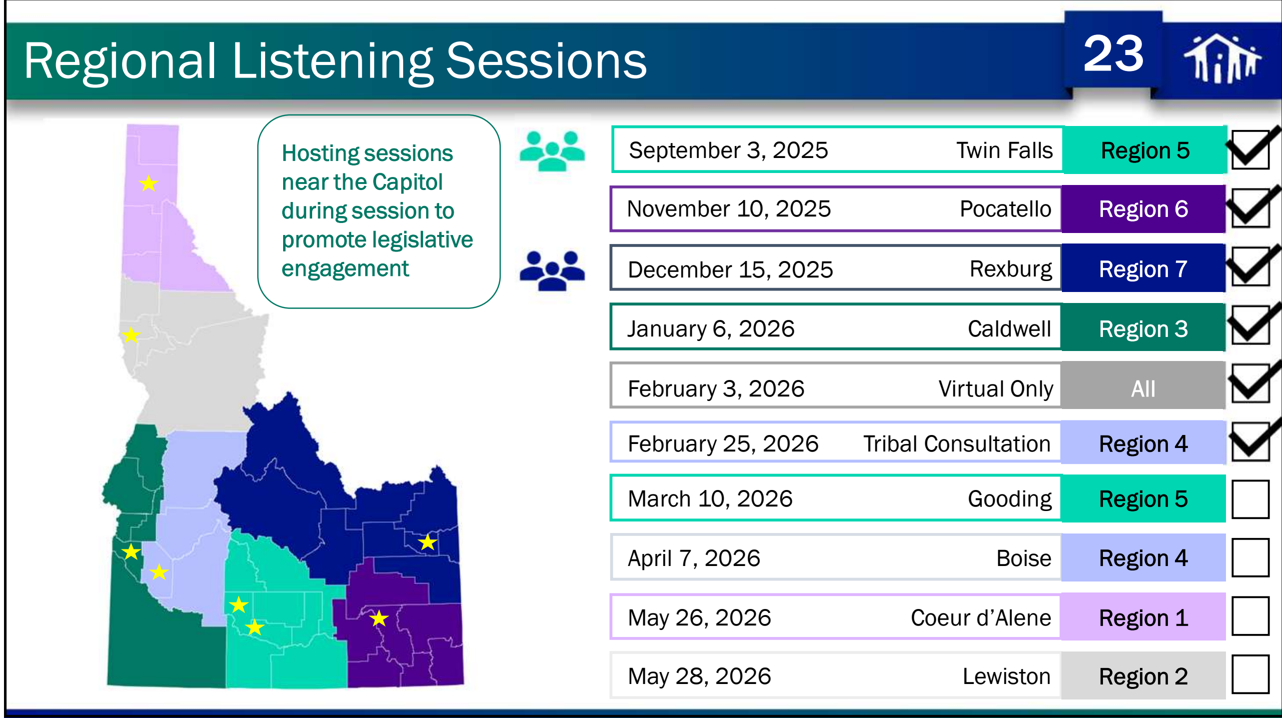

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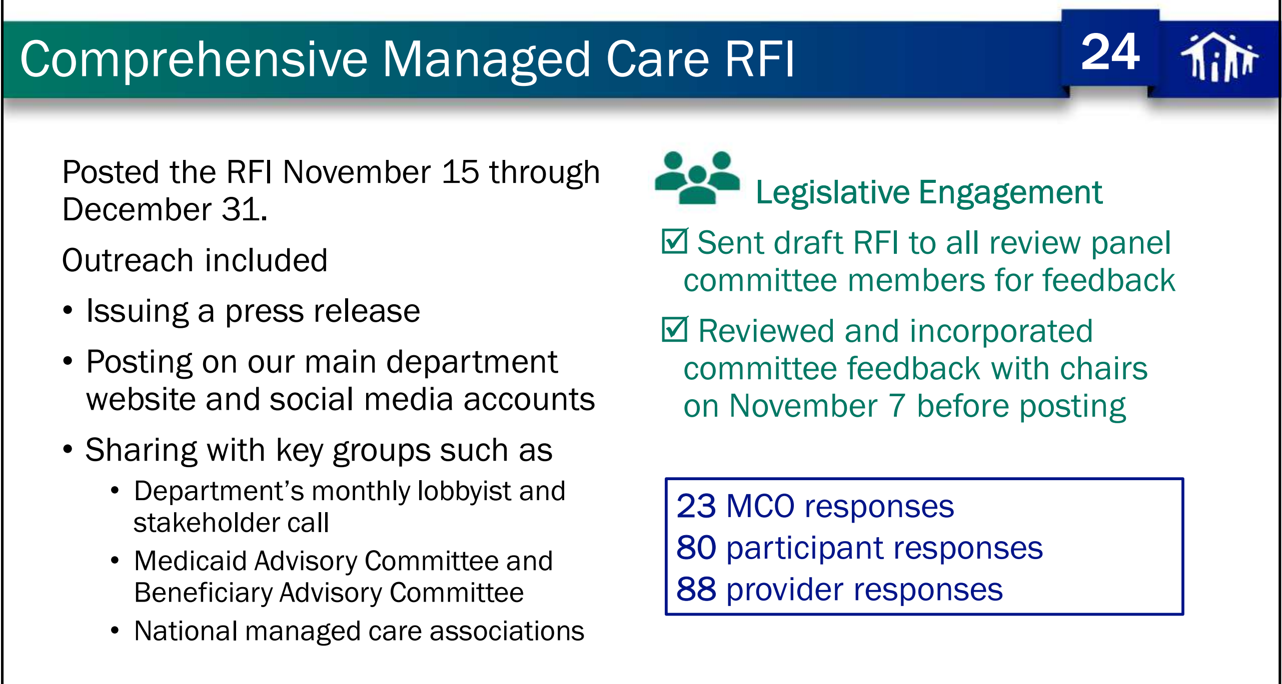

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How Findings Can Inform the State's Approach

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Transition Timing, Sequencing, and Concerns

Respondents expressed **concern that compressed or poorly phased timelines could exacerbate payment delays, administrative errors, or service disruptions, particularly for smaller and rural providers with limited capacity to absorb additional risk.** Members' concerns are transition-specific, **focused on what could go wrong during implementation rather than on the transition** to managed care itself.

Network Adequacy Standards

Importance of **how standards are defined, monitored, and enforced.** Respondents emphasized that **network adequacy is meaningful only insofar as it translates into real-world access, including provider availability, reasonable travel distances, and appointment timeliness.** Standards not paired with active oversight could fail to prevent access gaps, especially in rural and specialty care markets.

BH, DD, and Waiver Services

Respondents emphasized **sensitivity around changes to service authorization processes, continuity of existing providers, and the transitions' impacts on individuals with complex or long-term needs.** Even temporary disruptions in these areas were described as having disproportionate consequences for members and families, with limited ability to handle gaps in care.

Care Coordination

Care coordination should **decrease the navigation burden on families, with clear accountability for managing services** across medical, behavioral, developmental, and educational settings. Care coordination design should **avoid duplication with existing coordination roles** where possible and focus on **timely follow-up and navigation, confirming patients can access primary care, behavioral health, and preventive services** before conditions escalate.

Process Streamlining and Simplification

Members' emphasize simplification and recommend **prioritizing streamlining processes rather than layering additional requirements** onto an already complex system. **Medical necessity definitions, authorization criteria, and review processes should be clear, consistent, and clinically appropriate.** Improvements to communication—such as **plain-language explanations of coverage decisions and predictable timelines**—can address many challenges.

Pre-Launch Preparation and Activities

Pre-go-live activities should include **parallel claims testing, authorization workflow testing, and directory validation to identify issues before live operations.** Clear, consistent **communication and provider education should begin well before go-live and continue through stabilization.** Transition timelines should be realistic and phased, allowing **time to resolve issues before expanding scope or increasing performance expectations.**

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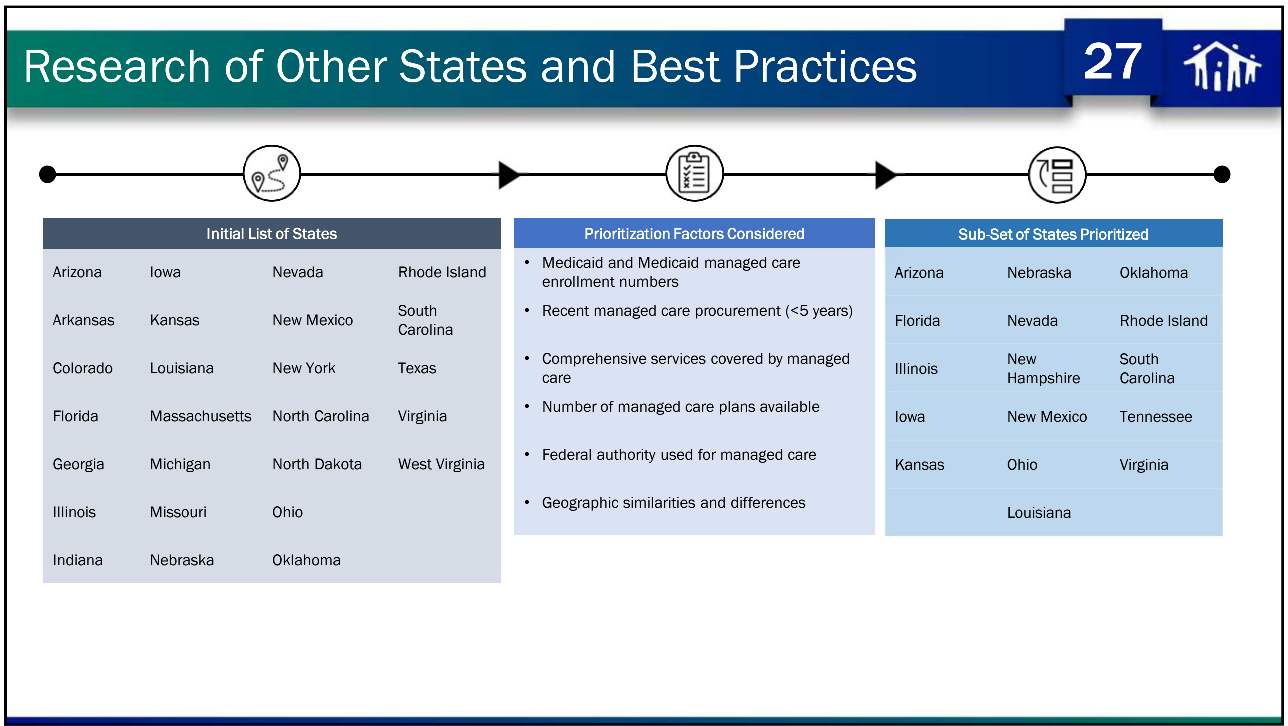

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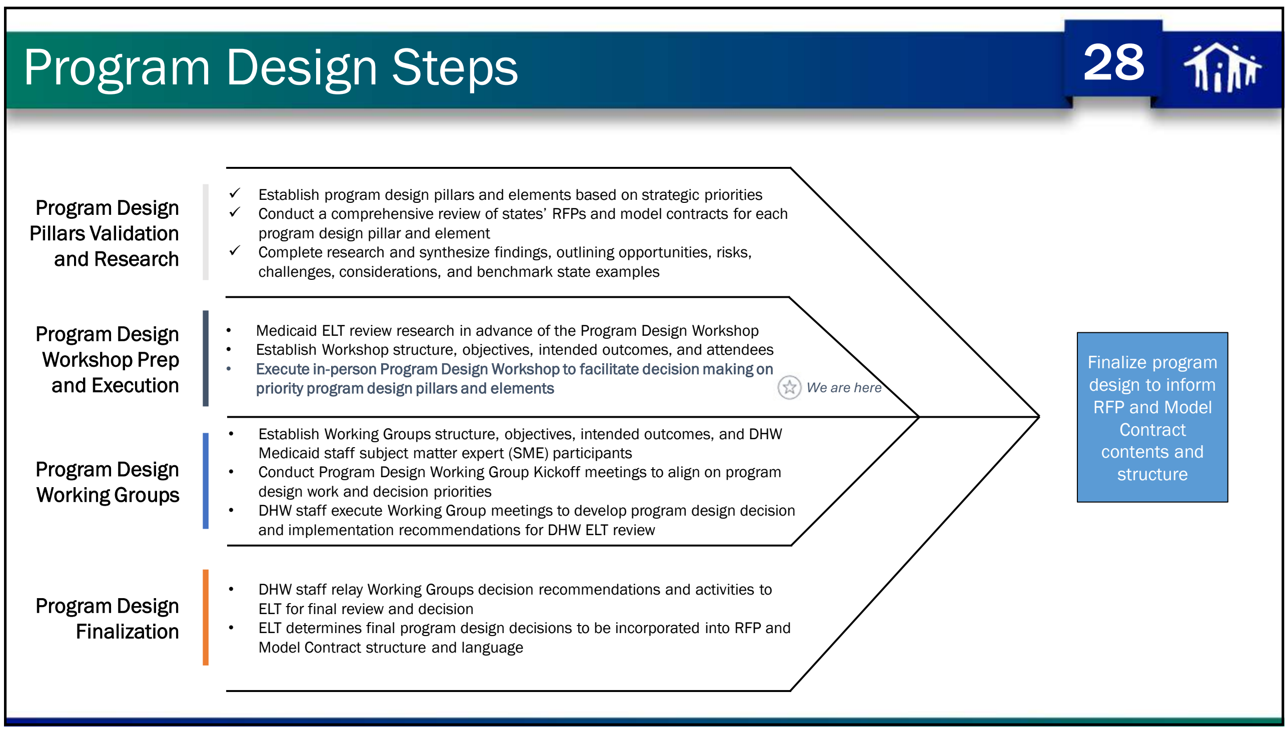

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Program Design Pillars

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Program Structure and Governance

- Number of managed care plans
- Plan governance model
- Plan geographic coverage
- DHW in-house staffing vs. outsourcing
- Local economic investment and workforce opportunities (e.g., "Idaho First" values)
- Carve-ins and carve-outs
- Relationship to marketplace

Member Enrollment and Engagement

- Member plan assignments
- Populations (i.e., ID/DD)
- Member engagement and communications
- Work requirements
- Member protections
- Cost-sharing
- Opt-in/opt-out enrollment
- Open enrollment timeframes

Benefit Design and Services

- Benefit design (including special focus areas: BH, primary care access, children in state custody)
- Care coordination and case management standards
- Transitions of care
- Value-added benefits
- HCBS (Home and Community-Based Services)
- NEMT (Non-Emergency Medical Transportation)
- Rural Health Transformation Plan

Provider Network and Operations

- Network development standards
- Provider protections (e.g., vulnerable provider types)
- Provider payments during transition to managed care
- Timely payments
- Centralized credentialling
- Rate floors
- Provider performance monitoring
- Provider engagement and communications
- Use of auto-enrollment

Plan Operations and Administration

- Plan operational standards
- Utilization management standards
- Data collection and management
- Methods to decrease redundancy and administrative burden
- Methods to improve cost containment and program efficiency
- Pharmacy operations
- Artificial Intelligence (AI) (e.g., to improve member experience and protect data)
- Subcontractor management

Oversight, Quality and Performance Management

- Plan performance standards
- Value-based care strategies (e.g., withholds and incentives)
- Required MCO deliverables and reporting
- Compliance and regulatory oversight (e.g., sanctions, penalties, liquidated damages)
- Financial controls and risk-sharing arrangements
- Data analysis and reporting
- Quality management
- Oversight committee
- Claims warehouse
- Performance improvement plans process
- Comprehensive quality strategy

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Care Coordination and Case Management

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Example Approach	Example Approach 1: Prescribed Core Functions with Mandatory Populations	Example Approach 2: Highly Prescriptive Care Management Model	Example Approach 3: Outcomes-Focused Coordination with Limited Process Specification
Example Approach Summary	Idaho establishes required care coordination functions, including assessment, risk stratification, care planning, and transitions management, and mandates enhanced case management for designated high-need populations, while allowing MCOs flexibility in how they staff and operationalize.	Idaho specifies detailed requirements for care manager qualifications, maximum caseloads, contact frequency standards, and documentation protocols, creating a uniform statewide model that all MCOs must implement consistently.	Idaho sets outcome expectations and requires reporting on coordination results but leaves most decisions about care management design, staffing, workflows, and member engagement strategies to MCO discretion.
Benefits & Opportunities	• Establishes **consistent minimum standards across all MCOs**, ensuring every member receives a baseline level of support regardless of which plan they join. • Enables **meaningful oversight and performance comparison** by standardizing core activities while avoiding operational micromanagement. • **Allows MCOs to design staffing models and workflows** that complement existing provider-led care efforts in small communities.	• **Reduces variation across plans**, making it easier for members and providers to understand what to expect from care management. • **Simplifies compliance monitoring and creates day-to-day coordination activities transparent** by establishing clear, standardized, and auditable process and documentation standards that can be measured objectively. • Provides **explicit guidance that can accelerate MCO implementation** during the transition period.	• **Maximizes MCO flexibility and innovation** to design care models that fit local market conditions and leverage existing community relationships. • **Reduces state administrative burden during procurement and initial implementation** by avoiding detailed process specifications. • Allows plans to **align care coordination with their broader network and quality strategies** without artificial constraints.
Risks & Challenges	• Requires Idaho to **invest significant effort in defining population criteria and developing monitoring systems** before procurement. • Creates **potential for wide variation in execution quality across MCOs** despite common requirements, demanding active state oversight. • **Demands ongoing refinement of population definitions and functional requirements** as the program matures and circumstances change. • May **generate disputes over interpretation of requirements** if core functions are not sufficiently detailed in contract.	• **Risks misalignment with how providers currently manage patients**, potentially duplicating existing care coordination efforts. • **Discourages MCO innovation in care delivery models** that might better serve Idaho's diverse geographic and population needs. • **Increases administrative burden on plans** through rigid documentation requirements. • Demands **substantial state resources to define, monitor, and enforce** detailed specifications across multiple compliance dimensions.	• Creates **high risk of inconsistent implementation across plans,** with some members receiving robust support while others receive minimal coordination. • **Challenges Idaho's ability to provide meaningful oversight during the critical transition** period when problems are most likely to emerge and proactively address problems by limiting day-to-day transparency. • **May result in lowest-common-denominator approaches** if MCOs interpret flexibility as permission to minimize investment in coordination infrastructure.

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Stay Engaged With Us

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- ➢Feel free to reach out with any questions or set up a time to meet.
- ➢The full body is of course welcome to attend the Medicaid Review Panel meetings during session and outside of session.
- ➢The department created a new website that posts information on the managed care transition: healthandwelfare.idaho.gov/managedcare
  - Prior presentations
  - Summary of findings from the Request for Information
  - Comment and concern form
  - Flyers and dates for next listening sessions
  - Notes and analysis of listening sessions thus far

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