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Public Request for Information Regarding Idaho Medicaid Managed Care

The Idaho Department of Health and Welfare (IDHW) was seeking input from members, providers, managed care organizations, and pharmacy benefit managers regarding what they would like to see in a comprehensive managed care plan. The RFI opened on November 15th and closed on December 31st. Comments from the National MLTSS Health Plan Association were submitted on December 31st.

Please note that comments were submitted via an online form, and responses had to be shortened to meet character limits. Additionally the online form had limitations with regard to including external links and maintaining formatting (e.g., bullets).

What innovative ideas and best practices to achieve cost savings could be implemented through a comprehensive managed care program?

First and foremost, the managed care model provides states with budget predictability and a more sustainable financial model. Through capitated payment arrangements, states can manage expenditures more effectively while ensuring compliance with federal requirements.

The initial implementation of managed care often requires significant state investments in modernizing infrastructure and technology, in addition to building new oversight capabilities with the state's workforce. Over the long term, comprehensive managed care programs, particularly those that carve in all benefits including LTSS and behavioral health, offer innovative approaches to control costs while improving care for older adults and individuals with complex needs, who typically incur high costs. As of 2021, Managed LTSS plans serve over 60% of Medicaid LTSS users but account for only 38% of Medicaid LTSS expenditures, demonstrating managed care's ability to deliver care more efficiently and cost-effectively compared to fee-for-service (FFS) models.

By shifting care from institutional settings to HCBS, Managed LTSS programs not only reduce reliance on expensive nursing home care but also enhance care coordination for high-need populations. Nursing home care costs about 1.7 times more than receiving care at home, and by 2029 more than half of the aging population is projected to be unable to afford it. However, a study found that the number of nursing home residents per capita decreased at a faster rate in MLTSS states than in FFS LTSS states for all 65 and over age groups, due to MLTSS health plans' focus on providing care to members in their preferred

setting. These innovations can lead to significant cost savings, as the median cost for in-home care is $90,245 less than nursing home facility care.

In what ways can managed care programs support increased primary and preventive care access to decrease dependence on higher levels of care like emergency rooms?

Managed care can make primary care easier to access, more convenient, and more coordinated for members. Managed care can expand access to care through telehealth, virtual urgent care, and home-based visits, as well as by proactively connecting members with primary care providers, assisting with appointment scheduling, and using care managers to coordinate services (particularly for high-risk individuals). Managed care plans can also address barriers to care, such as transportation or language access, to help ensure members can consistently attend preventive and routine visits.

Managed care plans contract with critical access hospitals (CAHs), federally qualified health centers (FQHCs), rural health clinics, and school-based clinics, all of which play a pivotal role in reducing unnecessary ER utilization by providing accessible, comprehensive primary and preventive care in underserved communities. These clinics provide a broad spectrum of services, including medical, behavioral, dental, and more, and can address needs before they escalate. Local health clinics also build trusted relationships with community members, increasing adherence to treatment, which has been proven to lower ER visits. MCOs are close partners with CAHs, FQHCs, and other community clinics, providing financial and operational support to ensure availability of critical programs and services. Many MCOs collaborate with FQHCs to implement value-based arrangements that reward quality and efficiency as well as incent the use of provider extenders such as community health workers (CHWs) to improve health directly in the community.

Through their focus on rebalancing, our MLTSS Association's member health plans help more individuals to remain and receive care in their homes and communities. High-quality home and community-based services support effective transitions from hospital to home, provide stabilization and support to individuals to remain in their homes, and may reduce the need for costly readmissions or emergency care.

What are innovative ideas and best practices to maximize home and community-based services in lieu of reliance on institutional settings?

With the right supports in place, individuals with LTSS needs can live in the most integrated setting of their choosing. Recognizing this, many states partner with MCOs to maximize access to HCBS and divert individuals from unnecessary institutional placements. This

approach, commonly referred to as rebalancing, has proven to improve health outcomes, enhance quality of life, and increase member satisfaction. Progress has been made nationally: in 2023, HCBS users comprised 87.1% of total Medicaid LTSS users, which is very comparable to Idaho's current rate of 87.4%. We applaud Idaho's significant efforts that have moved the needle on rebalancing.

Opportunities remain to further delay or avoid institutional placement and to leverage the broader HCBS benefit package to build capacity and serve more individuals. MCOs are uniquely positioned to help states achieve rebalancing goals. By design, MLTSS expands access to HCBS, promotes efficiency, and ensures that members receive the right care in the right setting. Because HCBS is often less costly than institutional care, such as nursing facilities, states can serve a greater number of individuals while also honoring member preferences.

A study by Milliman found that the number of nursing home residents per capita decreased at a faster rate in MLTSS states than in fee-for-service LTSS states for all 65 and over age groups, due to MLTSS health plans' focus on providing care to members in their preferred setting. Several MLTSS states surveyed by ADvancing States reported that MCOs significantly contributed to their success in rebalancing. After 25 years of incrementally adjusting HCBS targets, Arizona reported that 86% of its MLTSS consumers are in community settings and 68% are living in their own homes. New Jersey has seen a significant shift in its ratio of consumers receiving institutional care versus those receiving community-based care since it started its program in 2014, from a 70/30 ratio (institutional vs. community) to 36/64 ratio in 2021. Moreover, even with an increase in total MLTSS population of 53%, the state has seen a 20% absolute decrease in the number of individuals residing in nursing facilities.

Key ways in which MLTSS supports at-home services are:

Facilitating successful transitions from institutions to home and community settings. MLTSS programs provide extensive care coordination and often value-added benefits to ensure members maintain the right level of care from institutions to home.

Establishing accountability for shifting members to HCBS. MLTSS plans can partner with states to provide unique insights through data and progress tracking to help measure and achieve rebalancing goals.

Supporting holistic and coordinated person-centered care. Having a comprehensive view of a beneficiary's needs and care ensures that each beneficiary receives the right level of care in the setting of their choice, with the right supports in place.

MCOs support access to existing state benefits and resources (e.g., via Money Follows the Person) and have developed their own strategies to maximize access to HCBS. MCOs have partnered with states to develop rate structures that align incentives with rebalancing goals. Additionally, MLTSS plans actively partner with states on direct care workforce, housing, provider infrastructure, and value-based payment programs that build capacity in the HCBS system. The MLTSS Association's member plans have created numerous innovative value-added benefits and value-based payment arrangements. For example, MCOs in Kansas have offered items such as transition funds, home safety items, internet access, and caregiver supports all with the goal of helping people remain in the most integrated setting. With the flexibility of the managed care delivery model, MCOs can creatively address local barriers and augment Idaho's existing resources.

What are innovative ideas and best practices to maximize home and community-based behavioral health services in lieu of reliance on acute or residential treatment settings?

Medicaid plays a key role in financing behavioral health (BH) care nationwide – as of 2023, 44% of adults who receive Medicaid had experienced mental illness or substance use disorder in the previous 12 months. To maximize home- and community-based BH services and reduce reliance on acute or residential settings, states and MCOs can integrate BH with LTSS through their managed care contracts. Including requirements for mandating interdisciplinary care teams, incentivizing care coordination, and braiding BH and LTSS funding within MCO contracts can reduce costs associated with hospitalization and nursing facility stays, leading to lower costs for state Medicaid programs and better outcomes for individuals.

MLTSS plans also provide innovative workforce solutions to improve access to community-based behavioral health supports. For example, New Hampshire Healthy Families (Centene Corporation) invested $500,000 with New England College to expand the Community Mental Health Center workforce through 10 four-year scholarships to incentivize aspiring behavioral health clinician placement at these critical access points.

Describe an outreach and education strategy to help members navigate managed care, understand their benefits, and access needed services.

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In our MLTSS member plans' experience, a high level of stakeholder engagement in the transition to a new managed care program is an effective mechanism for building trust with the community, beneficiaries, and their families. MLTSS Association member health plans have noted several successes with establishing member and multistakeholder advisory committees to collect robust feedback that is used to shape MLTSS programs. For example, our member health plans have developed programs that bring beneficiaries together via focus groups, surveys, workshops, online communities, and advisory group meetings to share their experiences about the care they receive. The input is subsequently used to drive initiatives that are most effective for meeting beneficiary needs, improving those aspects of member experience that are difficult and preserving those that add the most value.

Some states also established statewide stakeholder councils that participated in the planning and implementation of an MLTSS program. Massachusetts convened an Implementation Council with more than 50 percent of its membership comprised of consumers and consumer advocates. Washington created a Health Home Advisory Team (HAT) for its Health Home project that included a mix of providers, consumers, consumer advocates, state and local agencies, and the domestic workers union. Pennsylvania also convened an MLTSS subcommittee that was instrumental in the transition to managed LTSS with the establishment of Community Health Choices. MLTSS health plans are happy to participate in such state-level committee structures, and are often invited to present updates and answer questions from stakeholders.

Additionally, the development of educational materials and review of plan materials could ensure consistency across the state, reducing confusion among both beneficiaries and providers. Moreover, it is valuable for states to take an active role in engaging with a range of advocacy and stakeholder groups (e.g., primary care physicians, specialists serving the target population, area agencies on aging, and other community-based organizations) well in advance of the first enrollment period to gain buy-in to MLTSS offerings from beneficiaries and providers, ease concerns about disruptions in services, and explain the added value of choosing integrated care options.

Please provide ideas on ways to improve quality and outcomes through financial arrangements including value-based payment design. *Provide examples, including how you would engage rural providers, as well as ideas for a reasonable implementation glide path*.

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States have broad authority to define quality measurement and payment structures within their Medicaid programs. States must balance sufficient standardization while not limiting innovation. Many states have partnered with MCOs to implement payment systems in which providers of all sizes can participate and gradually move to higher levels of risk over time.

Historically, LTSS providers (including those that serve small volumes of consumers and/or operate in rural areas) were often excluded from state value-based care (VBC) initiatives. MLTSS programs and the MLTSS population both require a different approach to value measurement and VBC to achieve success. States and MCOs, in collaboration with LTSS beneficiaries and providers, must navigate these complexities to develop VBC models that are truly reflective of the unique needs of LTSS beneficiaries and the unique LTSS programs they utilize. The MLTSS Association's plans are actively advancing a thoughtful and gradual adoption of VBC by LTSS providers (e.g., homecare agencies, nursing facilities). Our plans have extensive experience in supporting providers to modernize work processes and systems while on a glide-path toward VBC. Success in these arrangements takes time and relationship building.

For example, when Elevance enters a market that previously relied solely on a fee-for-service (FFS) delivery system, they prefer to hold off on prematurely introducing pay-for-performance (P4P) arrangements. Instead, they choose to build provider relationships and assess the broader environment's readiness for more sophisticated contracting approaches. Instead of immediate performance and outcomes agreements, Elevance chooses to create arrangements that foster the development of provider capacity, capability, and trust. As those elements grow, Elevance models for providers new to managed care what reimbursement under a more sophisticated value-based arrangement would look like as compared to the FFS model the providers were used to.

In mature markets, our member plans have implemented VBC (primarily P4P) with LTSS providers. For example, VNS Health engaged with Licensed Home Care Service Agencies (LHCSAs) to develop a P4P initiative in New York. VNS Health used a consistent set of metrics and methodology across all LHCSAs, with metrics including flu vaccinations, falls, ER visits, hospitalizations, and management of pain and urinary continence. To support provider success, VNS Health shared data dashboards highlighting things like falls risk lists and hospitalization risk lists. They held monthly meetings to review performance, discuss interventions, educate leadership and clinical teams on the various metrics, and address training for aides on how to impact specific measures in delivering home care services.

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In 2025, the MLTSS Association published recommendations to accelerate strategic adoption of VBC in MLTSS, drawing on lessons from health plans leading in this space (available at mltss.org). In this report, the MLTSS Association recommends that states:

Structure VBC-related requirements and overall quality strategy in a well-informed manner, balancing standardization with flexibility to encourage innovation.

Evaluate trade-offs in decision-making to establish a VBC program that alleviates common hurdles (e.g., data sharing) while enabling provider-driven innovation.

Provide broad guidelines that connect to an overall quality strategy, offering clear parameters while trusting that health plans and providers will rise to meet the challenge based on their on-the-ground knowledge and shared understanding of the value gaps/needs.

Ensure quality metrics closely align with the desired outcomes.

Develop robust measurement strategies to assess the impact of VBC initiatives and encourage innovative approaches to VBC.

Prioritize engaging stakeholders early in the development of guidelines, standards, and policies.

What are some areas where managed care could fill gaps in the current delivery system? (e.g., maternity care).

Managed LTSS plans help states like Idaho fill important system gaps by building connections between the health care delivery system and community-based organizations, supporting individuals as they transition out of institutional settings and back into the community, and connecting members to in lieu of services (ILOS) that address unmet social and functional needs. Plans can offer value-added benefits that supplement Medicaid-covered services, such as enhanced care coordination supports or non-clinical services that promote independence and stability. Together, these strategies reduce care fragmentation, improve outcomes, and enhance quality of life for members.

As previously mentioned, community investments are also an important way that managed care plans address local gaps in the delivery system and fill workforce shortages. For example:

Under Ohio's NextGen Medicaid program, participating MCOs committed $6.9 million in grants to local organizations to expand services such as doula training, food-prescription programs for rural areas, and behavioral-health supports in underserved neighborhoods.

In Illinois, UnitedHealthcare provided grants to fund ten $2,500 scholarships for nursing students, with a specific focus on strengthening the workforce in rural Illinois.

Managed care plans are engaged in innovative ways to close system gaps outside of traditional fee-for-service arrangements, reflecting their position at the intersection of financing, care coordination, and community-based services. MLTSS health plans utilize value-based contracts with providers that reward high-quality care instead of high-volume care – leading to lower costs for states and better care for the members they serve. By tying payments to outcomes, MLTSS health plans can incentivize shared accountability across providers to prevent institutionalization and allow individuals to safely remain in their homes and communities.

Managed care plans are also deeply invested in augmenting the direct care workforce, as nationwide shortages can make it difficult for individuals to access the care they need. MLTSS plans fund and deploy enabling technologies that can support or reduce the need for in-person support, while supporting members' independence and autonomy. MLTSS health plans also encourage the growth of robust provider networks by supporting members who wish to self-direct their care. Managed care plans provide care management services that ensure that members have the support needed to identify and manage their providers while also adhering to strict program integrity requirements. Together, these investments demonstrate how managed care goes beyond financing services to strengthen the care delivery system, expand access to care, and support person-centered outcomes.

What are innovative ideas and best practices to leverage the managed care delivery system to promote sustainable financial self-sufficiency among members in the short and long term?

The managed care delivery system can be leveraged to promote sustainable financial self-sufficiency by integrating economic and social stability supports directly into managed care programs, as seen in states like Tennessee. Through initiatives such as TennCare's Employment and Community First CHOICES program, managed care organizations provide employment exploration, skills development, and job coaching to help individuals with disabilities gain and maintain competitive work, demonstrating how managed care can be used to advance long-term economic independence. TennCare also leverages managed

care to deliver HCBS supports and transition services through CHOICES and Money Follows the Person, enabling members to live more independently in the community, which can reduce institutional dependence and support greater autonomy.

Through authorities such as value-added benefits, MCOs can support members in accessing educational materials or classes, obtaining scholarships, and through other local or regional partnerships gain access to supports to develop marketable skills. These types of supports promote short and long-term self-sufficiency by both connecting individuals with an immediate need to employment support and helping individuals to gain education and experience that will allow them to develop in their career. Such approaches illustrate how MCOs can coordinate health, LTSS, employment supports, and social services to help members achieve both immediate stability and lasting financial self-sufficiency.

The MLTSS Association's member plans actively promote equal employment opportunities for people with disabilities, which has been shown to improve their members' health while strengthening communities. Examples include:

In 2022, Wellpoint (Elevance Health) in Texas sponsored an Employment First Initiative in partnership with the national APSE and the Texas APSE chapter to enhance the capacity of providers to deliver supportive employment services. The Employment First Initiative supported 33 individuals from provider organizations to participate in an 8-week workshop series to learn about Employment First and competitive integrated employment (CIE), access a stipend for participating in the collaborations, and registration for the Credentialed Employment Support Professional exam.

As mentioned above, Tennessee's ECF CHOICES program helps people with disabilities find jobs and live on their own. While the national employment rate for individuals with I/DD ages 22 to 62 is around 14%, UnitedHealthcare's targeted efforts in Tennessee helped individuals achieve a 27% employment rate. Participants received an average rate of pay above minimum wage and worked 16.71 hours, on average, during the week.

Sunflower Health Plan (Centene Corporation) is the statewide manager for Project SEARCH in Kansas, which has a 73% success rate of its students achieving CIE upon graduation. Project SEARCH is a nationwide initiative that attempts to provide structured learning and internships for students with disabilities in their last year of high school or when finishing a transition program.

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CareSource, a national nonprofit health plan, has administered an employment readiness program for its members since 2014. Members who participate in CareSource's JobConnect program experience a 19% decrease in inpatient admissions and an 8% reduction in avoidable emergency department visits—evidence that economic stability drives better health outcomes. A third-party evaluator recently reported that CareSource JobConnect participants who found employment and transitioned off Medicaid ranged from 57-75% across CareSource's three largest markets. Economic impacts range from $2.7-$15.5 million in these states.

How could IDHW measure the performance of the managed care program and managed care organizations (MCOs) regarding both processes and outcomes? In your response, please emphasize measures that can help the state gauge performance in real time, or using very recent data.

The MLTSS Association believes the following criteria are the most important to be considered and weighed in terms of developing a specific set of measures:

Feasibility. MLTSS plans should be able to implement and report on measures within reasonable efforts to do so.

Use/Usability. Plans must apply and use the measures to inform changes to service provision and internal priorities for spurring system change.

Scientific Applicability. Even if a measure has been widely adopted and is being applied consistently across the country if there is no assurance that the measure has been rigorously tested for validity and reliability, then the measure may not be effectively measuring is it supposed to be and thus misleading both plans and states.

Alignment with Value-Based Payment Principles. The alignment of a measure to value-based purchasing principles should be considered an additional selection criterion to ensure that there is some measure of payment for quality.

Beneficiary Check. This criterion is to ensure that the measures adopted by the state align with what HCBS beneficiaries themselves feel are important indicators of quality HCBS. It is important to explore measures that provide a person-centered holistic view of quality while also considering beneficiaries' experience of care and social determinants of health.

Promoting Innovation. Measures should represent a meaningful balance between burden and innovation, minimizing data collection and reporting burden and appropriately risk-adjusted to account for factors beyond the control of health insurance providers.

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Managed care programs represent a public-private partnership model that advances high-quality care delivery while ensuring fiscal responsibility. These programs combine private-sector innovation with state-led oversight and accountability. Through contractual requirements, performance monitoring, and quality reporting, states are able to hold managed LTSS organizations accountable for delivering person-centered services, improving outcomes, and supporting individuals' ability to remain in their homes and communities.

States can further assess and drive improvements in MCO performance by embedding expectations into contracts and oversight processes. This provides states with additional levers to monitor how well MCOs deliver services and meet program goals. These requirements give states the opportunity to incorporate a broad set of quality and performance standards into their oversight framework. States can also use the quality review process to evaluate MCO performance on key administrative functions, such as the timeliness of prior authorizations and claims processing. For example, Iowa's 2019 Managed Care Annual Performance Report illustrates this by detailing how contracted MCOs performed across a range of administrative and operational measures.

In what ways can the managed care program improve measurement and reporting, and ultimately improve quality and outcomes?

To improve quality and outcomes, clarity and consistency in measurement standards are essential. When metrics are defined differently across MCOs, comparisons become unreliable and improvement efforts lose focus. In its transition to managed care, IDHW should adopt standardized methodologies for all MCOs, ensuring that calculations are uniform and transparent. Ideally, these standards should align with nationally recognized benchmarks, such as the National Committee for Quality Assurance (NCQA), so Idaho can understand how its performance compares to other states. The Association also recommends a common, core set of items to assess functional capabilities and limitations that would be included in all assessment instruments used by MCOs, which would allow stakeholders to collect a standard set of data elements that would inform comparable quality measures to evaluate the quality of LTSS.

Many MLTSS plans have integrated disability advisory councils and regularly engage with local advocacy and stakeholder groups. MLTSS plans are required to report data to CMS and to their respective states related to beneficiary satisfaction and plan performance. While each state designs their own MLTSS program, as of 2016, all states that contract with managed care plans to provide LTSS must measure plan performance in three areas:

quality of life, community integration, and rebalancing toward HCBS. This is to ensure that resources are being used effectively and providing maximum benefit to enrollees.

For managed care more broadly, states that contract with MCOs are federally required to implement quality oversight activities, including developing and updating a State Quality Strategy (QS), maintaining an ongoing Quality Assessment and Performance Improvement (QAPI) program, and conducting External Quality Review (EQR). These requirements give states the opportunity to incorporate a broad set of quality and performance standards into their oversight framework.

Through the managed care model, health plans are held to high standards at both the federal and state level and work closely with their State Medicaid partners to achieve quality health outcomes for those they serve. States can also strengthen quality and outcomes by tying preferential auto-assignment to demonstrated performance—directing new or passive enrollments to MCOs with stronger quality scores, improved outcomes, and higher provider performance. This approach reinforces accountability, rewards high-value plans, and creates a clear incentive for all MCOs to continuously improve measurement, reporting, and care delivery.

What are the obstacles to improving measurement and reporting?

Efforts to improve measurement and reporting are often hindered by fragmented data systems, limited interoperability, and inconsistent use of standardized tools and definitions across plans and providers. Reporting requirements vary by entity, adding administrative burden, especially for smaller providers and community-based organizations (CBOs). These challenges are even greater for dually eligible individuals, where lack of timely access to Medicare data makes it difficult to assess outcomes across programs or track avoidable utilization. Measurement of social needs and functional status is also limited by inconsistent data capture and siloed documentation outside of clinical systems.

Addressing these issues requires more unified infrastructure and alignment in practice. Investments in shared HIE/IT systems and stronger data-sharing arrangements, including access to Medicare data, would make reporting more complete and actionable. In Minnesota, LTSS data has even been integrated into the state's HIE, which helps streamline care coordination and supports performance tracking.

Standardizing assessments, screening tools, and core quality measures across plans and providers would reduce burden while improving comparability. Integrating social and functional needs data, supported by technical and financial assistance for organizations

with limited capacity, would ensure reporting reflects the full spectrum of factors shaping quality and outcomes.

Intra-agency coordination is another critical component in developing standards for data collection and definitions of measures. Collaboration between various state agencies is necessary to ensure that data collection methods and measure definitions are consistent and aligned with the quality goals across state programs. This coordination helps to eliminate discrepancies and redundancies in data reporting by providers and plans, leading to more accurate and meaningful evaluations of performance.

The MLTSS Association believes the following criteria are the most important to be considered and weighed in terms of developing a specific set of measures:

Feasibility. MLTSS plans should be able to implement and report on measures within reasonable efforts to do so.

Use/Usability. Plans must apply and use the measures to inform changes to service provision and internal priorities for spurring system change.

Scientific Applicability. Even if a measure has been widely adopted and is being applied consistently across the country if there is no assurance that the measure has been rigorously tested for validity and reliability, then the measure may not be effectively measuring is it supposed to be and thus misleading both plans and states.

Alignment with Value-Based Payment Principles. The alignment of a measure to value-based purchasing principles should be considered an additional selection criterion to ensure that there is some measure of payment for quality.

Beneficiary Check. This criterion is to ensure that the measures adopted by the state align with what HCBS beneficiaries themselves feel are important indicators of quality HCBS. It is important to explore measures that provide a person-centered holistic view of quality while also considering beneficiaries' experience of care and social determinants of health.

Promoting Innovation. Measures should represent a meaningful balance between burden and innovation, minimizing data collection and reporting burden and appropriately risk-adjusted to account for factors beyond the control of health insurance providers.

Measures should provide meaningful information to all stakeholders while using the most efficient and parsimonious number of measures. The measures selected should be person-centered and conceptually important to LTSS beneficiaries.

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How can these obstacles be addressed?

Please see previous response.

How can plans support IDHW to comply with federal and state regulations, including fraud, waste, and abuse prevention?

MLTSS Association member health plans have supported states with implementing a variety of federal programs and regulatory requirements, such as state initiatives funded by ARPA and state implementation of the HCBS Settings Rule. The MLTSS Association also provides state-specific resources to help ensure state compliance with federal regulations that pertain to MLTSS and integrated care.

New federal requirements will condition Medicaid eligibility on work and community involvement for specific populations. MCOs can help states meet these requirements through various member engagement strategies. While the imposition and assessment of community engagement compliance are functions that should be managed by IDHW, MCOs are well-positioned and proven to be well equipped to educate, screen, and connect consumers to community resources, including employment supports, educational resources, and volunteer opportunities.

Health plans could support IDHW in fraud, waste, and abuse prevention by implementing compliance, audit, and program-integrity structures that integrate with state oversight. Plans could also provide regular training for providers and staff, collaborate on joint investigations when needed, ensure timely communication to help the state maintain full alignment with CMS and state regulatory expectations, and alert the state to non-compliance. MCOs should also continuously support member rights, dignity, access, and non-discrimination requirements through established policies and procedures to comply with any applicable federal and state laws pertaining to member rights and obligations from a plan's employees, subcontractors, and contracted providers to observe and protect those rights.

What innovations have you implemented in other states to ease provider administrative burden as they contract with your plan? *Please provide examples of strategies to streamline administrative processes and control administrative costs and overhead*.

Our MLTSS Association member health plans frequently collaborate with state agencies and each other to identify opportunities to ease administrative burden for providers who

work across multiple managed care plans, particularly during the initial transition from a fee-for-service system to managed care.

Examples of innovations that could be implemented to ease provider administrative burden include a single, unified credentialing process across plans, allowing providers to complete onboarding once instead of navigating multiple plan-specific requirements. Standardized prior authorization procedures have also been introduced to reduce repetitive paperwork and expedite approvals, minimizing delays for both providers and members. These approaches streamline administrative workflows, reduce overhead, and help control administrative costs, enabling providers to focus more on patient care rather than administrative tasks.

Many of our Association's member plans also have extensive experience implementing a variety of frameworks for electronic visit verification (EVV) and financial management systems for self-direction that minimize provider administrative burden. In some cases, plans have collaborated to choose a single vendor so that providers can implement the same processes and technology across MCOs. In other cases, MCOs have worked together and with State Medicaid Agencies to leverage aggregators which allow providers to maintain their current technology and systems while ensuring that MCOs have sufficient information and documentation to verify claims and process payment.

Lastly, as IDHW knows, when it comes to dually-eligible individuals there are opportunities to use the integrated FIDE-SNP model to simplify duplicative or conflicting processes across Medicaid and Medicare, which benefits providers as well as enrollees. States that promote alignment of dually-eligible individuals under a single MCO for Medicaid and Medicare can reduce provider burden by eliminating duplicative authorizations, billing rules, and reporting requirements. Providers benefit from one set of processes, one point of contact, and faster, more predictable payment—freeing them time to focus on care instead of administration.

What can IDHW require of plans to ease provider administrative burdens for providers contracting across multiple plans?

As mentioned in other responses, our member health plans and their network providers have found it very helpful to hold many provider forums through different areas and formats (in person, virtual) and targeting different provider types. These provide an opportunity to deliver consistent messages across plans and IDHW, and also for individual plans to respond to provider questions on an individual and group level.

Additionally, MCOs can work collaboratively with IDHW to develop a consistent framework and/or process for provider credentialing to reduce duplicative administrative tasks for providers that are contracting across multiple plans.

Provide recommendations to support provider recruitment and training, particularly in underserved regions.

As mentioned in a different response, MLTSS plans have a long history of investing to support the direct care workforce, which is critical to providing access to high-quality home and community-based services, particularly in underserved regions. In 2023, the MLTSS Association published a report highlighting promising practices MLTSS plans and providers are leveraging to address persistent workforce shortages and expand the network of direct care workers in their communities (available at https://www.mltss.org/post/report-on-strengthening-the-direct-care-workforce).

How can plans best support providers in coordinating member care across multiple providers?

Managed care plans can support providers in coordinating member care across multiple providers by giving providers the tools, information, and resources needed to work together and with plan staff as a unified team. Health plan care coordinators facilitate communication across providers, allowing providers to connect quickly and align care. MCOs can also leverage software that integrates with systems that support provider practices and provides real-time connectivity with the rest of the care team. Software that supplies data such as admission and discharge alerts, updated medication lists, summaries of care, and shared care plans can help each participating provider understand what is happening with the member across the system and reduce gaps in care.

MLTSS plans implement person-centered planning approaches that actively engage high-risk members, their caregivers, and the providers of the member's choosing in the care and service planning process. Through structured assessments, care team consultations, and ongoing communication, plans ensure that all participants have a shared understanding of members' unique needs, preferences, and goals. This collaborative approach promotes alignment across medical, behavioral, and long-term supports, supports informed decision-making by the member, and allows care plans to evolve as circumstances change—ultimately improving care coordination, satisfaction, and outcomes.

MLTSS plans support the coordination of member care across multiple providers by reducing administrative burden, enabling clear roles within the care team, and investing in

interoperable care coordination infrastructure. Plans can provide flexible approaches to incorporate providers into the interdisciplinary care team. For example, plans can support primary care practices that serve high-needs members by encouraging or funding dedicated care coordinators who focus on non-medical and cross-sector needs and serve as the primary point of contact with plan care managers. Plans can also deploy or support technology platforms that integrate with primary care and community-based organization systems to enable real-time information sharing, care updates, closed-loop referrals, and task management without requiring providers to adopt duplicative tools.

What are some best practices or processes that could be implemented either by IDHW or the managed care plans that would make the transition to managed care easier on providers in the six months leading up to and immediately following go-live?

The MLTSS Association's member health plans have extensive experience with managed care implementations from other states. Our health plans understand that providers are moving from one familiar process to needing to contract, get credentialed, learn how to submit claims, and understand all of the requirements of a new system across multiple health plans. As mentioned previously, there are processes such as a common credentialing framework across plans, which can be used to manage the administrative burden on providers, particularly around go-live. Additionally, our member plans will bring to Idaho their experience with setting up Network and Provider Services teams that have knowledge of the local environment, developing provider-facing materials and tools, and offering provider training and support through a variety of channels and formats.

To make the transition easier specifically in the months leading up to and following "go-live," our member plans recommend engaging with provider associations and advisory groups and/or offering regional provider town halls (in person and virtual) scheduled and facilitated by IDHW where each MCO can present about their processes and take questions. These types of meetings should continue through go-live to offer a forum for troubleshooting with any common issues that arise (in addition to offering individual provider support). For example, during the implementation of managed LTSS through Pennsylvania's Community HealthChoices program and Indiana's PathWays for Aging programs, numerous local and regional provider forums and trainings were held with participation from all MCOs.

One of the most effective strategies is early and transparent communication with providers. IDHW should prioritize accessible, consistent messaging developed jointly by the state and its MCO partners, creating a unified communication plan that includes FAQs,

timelines, education and training resources. Regular updates through webinars, newsletters, and provider forums help reduce uncertainty and build trust. Allowing MCOs to engage providers before go-live ensures questions are addressed early and minimizes disruption.

Additionally, our Association's member health plans have experience with providing continuity of care and maintaining current beneficiary/provider relationships for a state-specified period of time after go-live, even if those providers do not enroll in the MCO's network. Specifically, for LTSS providers, the MLTSS Association recommends that IDHW provide the MCOs with access to beneficiaries' current care/service plans and authorizations in advance of go-live to facilitate continuity of services during these critical months.

Describe a recommended approach to building collaborative relationships with providers to improve care coordination and member outcomes.

MCOs collaborate with providers by creating a framework that emphasizes shared goals, transparent communication, technology enablement, and aligned incentives. An approach with these tenets fosters trust, reduces administrative burden and provider abrasion, and drives measurable improvements in member outcomes. Collaboration begins with alignment on common objectives such as improving preventive care, reducing hospital readmissions, and/or enhancing member satisfaction. These goals should be tied to measurable outcomes and quality metrics. In addition, linking these objectives to value-based care incentives can further accountability and shared success.

For example, CareSource's partnership with Comprehensive Post Acute Network (CPAN), one of Ohio's largest nursing facilities, rewards higher-performing nursing facilities for quality outcomes and incentivizes other facilities to raise their standard of care. The arrangement supports an accelerated admission program to expedite MyCare Ohio members into over 70 CPAN facilities without prior authorization. It also awards quality outcomes by monitoring performance for the average length of stay, CMS Star ratings, rebalancing/successful transition to the community, decreased preventable emergency department (ED) utilization, and reduced avoidable hospital admissions.

Idaho could explore working with providers on the implementation of technology, and training providers on the use of new technology. Providing provider trainings would strengthen the plan-provider relationship, while also alleviating the pressure on the workforce. With technology in place to minimize administrative burdens, providers can

coordinate benefits more effectively and deliver more responsive care, which directly improves outcomes for members. These efforts can be reinforced through value-based strategies that align incentives across the state, plans, and providers, ensuring all parties are working toward shared goals of improved coordination, better outcomes, and enhanced member experience.

Humana's Family Care program engaged supported employment providers around the benefits of moving from FFS to an outcome-based reimbursement model. To ensure its providers could fully participate in developing this value-based arrangement, Inclusa awarded high-performing providers who were committed to participating in the model a grant to support their leadership and program staff involvement in a workgroup and to support the providers collecting and reporting additional performance-based data that was needed to support the creation of the new reimbursement model.

Collaboration is particularly important when it comes to populations with complex needs. Some states provide LTSS to children and youth with special health care needs (CYSHCN) through managed care. States have the ability to design specialized MLTSS programs for CYSHCN and identify the MCOs that are best equipped to serve this population. States can also institute quality and reporting requirements for this population, as well as requirements that MCOs coordinate with state and community-based agencies to coordinate care across programs and ensure quality and continuity of LTSS services.

There are also states that have had success integrating individuals with I/DD into their managed care programs. In Arizona, the state has eliminated their waitlist for services and reported high client satisfaction and strong performance on health, welfare, and consumer experience metrics. Several of the MLTSS Association's member health plans have deep experience working with these populations and collaborating with specialized providers in states like Iowa and Kansas where all Medicaid populations are included in the managed care program.

What are some best practices or strategies in developing provider requirements and network adequacy standards in managed care that have been effective in other states with respect to meeting the unique health care needs of rural communities?

The National MLTSS Health Plan Association understands that standards used to assess network adequacy for traditional health care services (for which consumers travel to providers) are typically established for a specified geographic service area and create either: 1) a maximum time and/or distance an individual may be required to travel to reach

the nearest in-network provider of a given type of service; and/or 2) a minimum ratio of providers to consumers for a given provider type. However, the nature of the services provided as well as the location in which they are provided in LTSS fundamentally differs from traditional health care settings. A significant number of LTSS services involve a service provider traveling to the LTSS consumer rather than the other way around. In such instances LTSS providers travel to where consumers are located to "provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping)."

The National MLTSS Association recommends states adopt network adequacy standards for LTSS that are based upon time to placement and that acknowledge and account for differences between urban and rural areas as well as agency directed and self-directed attendant services. In 2017, the Association published recommendations for states which can be accessed at https://www.mltss.org/post/model-ltss-performance-measurement-and-network-adequacy-standards-for-states

The MLTSS Association is happy to support IDHW with developing meaningful standards for these provider types.

What recommendations do you have for identifying gaps in the behavioral health service continuum?

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Please describe your ability to provide region specific services, such as working with healthcare systems in the Pacific Northwest to provide access to cell and gene therapies, as well as regional and independent community pharmacies to ensure network access.

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Please describe ways in which plans can demonstrate commitment to Idaho First values, including ideas for economic investment in the state and providing employment opportunities for Idahoans.

Managed Care Organizations (MCOs) support economic development in the communities where their members live through a diverse range of initiatives to address local needs and work in partnership with local organizations. MCOs have provided relief during natural disasters, distributed food and essential household items, run holiday toy drives, organized

community health fairs and job fairs, and offered job training and scholarship opportunities. Examples of plan investments in other states include:

Under Ohio's NextGen Medicaid program, participating MCOs committed $6.9 million in grants to local organizations to expand services such as doula training, food-prescription programs for rural areas, and behavioral-health supports in underserved neighborhoods. These initiatives help strengthen community-based services and create jobs, simultaneously boosting local economic investment and improving care capacity.

Just this month, the MolinaCares Accord, in collaboration with Molina Healthcare of Nevada, provided grants to two local food banks to help address rising food insecurity across the state. The donations, totaling $187,000, were given to Three Square Food Bank serving Southern Nevada and Food Bank of Northern Nevada.

AmeriHealth Caritas supports members' career and personal development through programs like Pathways to Work, a 12-week internship that includes mentoring, coaching, workshops, and skills training to enhance job readiness, and Mission GED, which provides tools and support for members to earn their GEDs and pursue further education.

These examples represent only a very small subset of the community reinvestment and workforce development initiatives our MLTSS Association member health plans have undertaken nationwide. MLTSS plans have a long history of investing to support the direct care workforce, which is critical to providing access to high-quality home and community-based services. In 2023, the MLTSS Association published a report highlighting promising practices MLTSS plans and providers are leveraging to address persistent workforce shortages and expand the network of direct care workers in their communities (available at https://www.mltss.org/post/report-on-strengthening-the-direct-care-workforce).

For example, UPMC Health Plan launched its Certified Nursing Assistant (CNA) Apprenticeship program in the UPMC Senior Communities, comprised of 14 skilled nursing and rehabilitation centers in Pennsylvania. The program provides a robust career path for CNAs, and its extensive network of facilities provides ample opportunities for apprentices to gain valuable hands-on experience within the UPMC Health System. The curriculum, approved by the Pennsylvania Department of Education, includes learning pathway modules designed to enhance clinical expertise and leadership qualities. Apprentices who successfully complete the program's goals and objectives will receive recognition and compensation for their accomplishments, as well as continued growth opportunities through a tuition assistance program.

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Other examples of managed care investments into the LTSS infrastructure include collaborations with community colleges to improve recruitment, skills development, retention, and career advancement for students and existing direct care workers; career and technical education programs to expand the pipeline of trained professionals; and multi-plan collaboration to streamline recruitment efforts, such as hiring a single worker who can serve across multiple MCOs. These initiatives strengthen provider infrastructure, improve retention, and build resilience across the LTSS workforce by focusing on retraining, redeployment, and skills enhancement. IDHW should maintain inclusion of the community reinvestment requirement within its future managed care contracts with the mandate that MCOs reinvest a portion of revenue into workforce development initiatives to increase employment opportunities or SDOH interventions that improve health outcomes for Idahoans.

NOTE: The MLTSS Association declined to answer all of the additional questions related to the pharmacy benefit