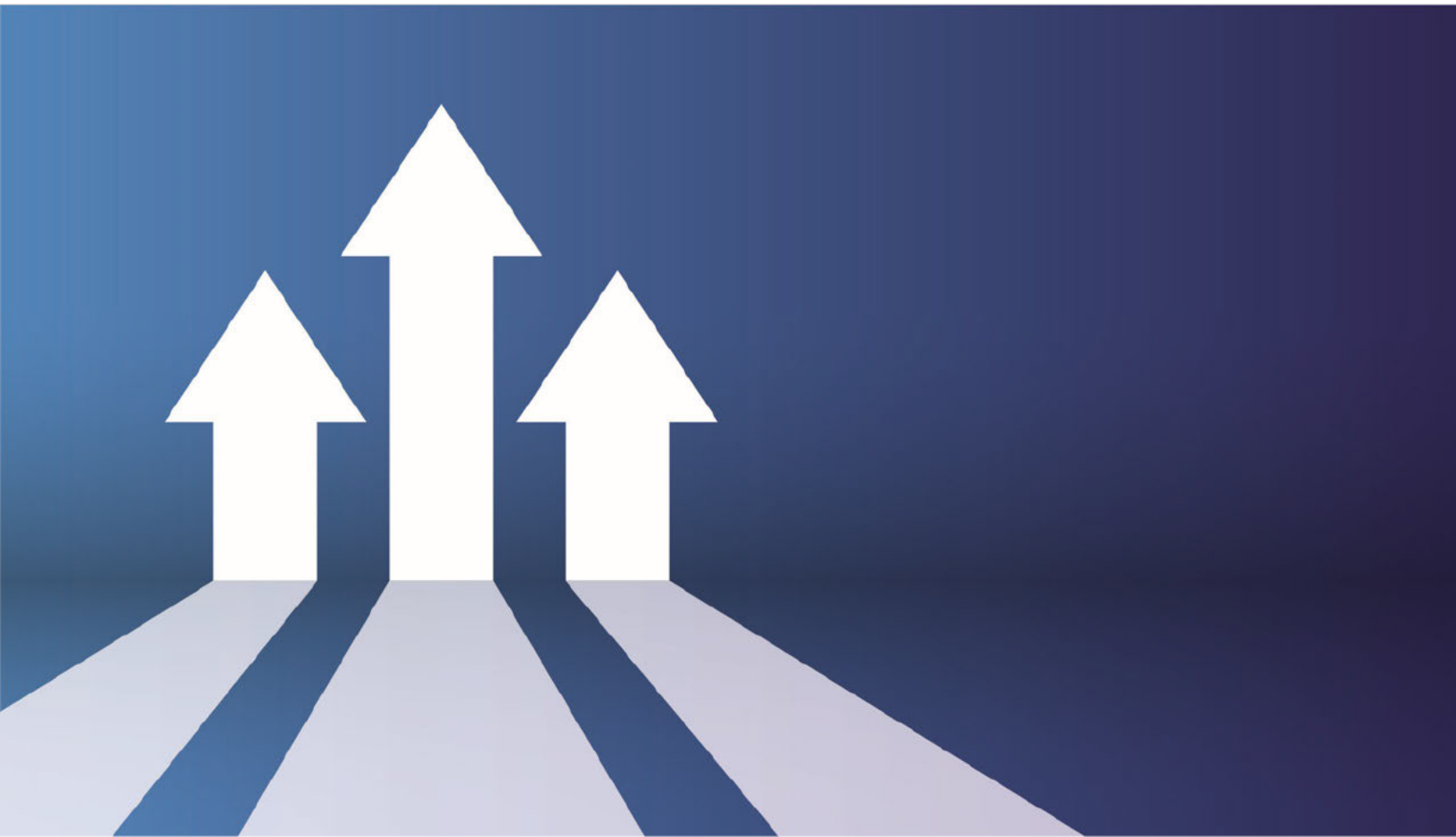
Mid-point Assessment Report for Idaho's 1115 Behavioral Health Transformation Waiver

April 30, 2024	Evidence-to-Impact Collaborative

Prepared for: Idaho Department of Health and Welfare



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About Us:

The Evidence-to-Impact Collaborative's (EIC) mission is to increase the societal benefit of science through improving the relevance, value, and use of scientific insights by decision makers within government, industry, and practice communities. Within our work, we define impact broadly as the benefits achieved by using scientific evidence to improve public health, economic functioning, and human flourishing. In this context the EIC serves as the central hub for impact science at Penn State—working across disciplines, colleges, and institutes.

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Executive Summary

Overview

In 2020, the "Idaho 1115 Behavioral Health Transformation" Waiver was approved by the Centers for Medicaid and Medicare Services (CMS) (from this point forward, referred to as the Idaho BHT Waiver). This waiver allows Idaho to leverage federal financial participation (FFP) for services provided by an Institution of Mental Diseases (IMD) and to improve transitions of care for individuals experiencing substance use disorder (SUD) and serious mental illness/serious emotional disturbance (SMI/SED). Funding is contingent upon progress toward a defined set of milestones and metrics.

The Idaho Department of Health and Welfare (IDHW) is leading the implementation of the Idaho BHT Waiver and contracted with the Pennsylvania State University (Penn State) to conduct an independent evaluation of the implementation. As part of this agreement, faculty and researchers affiliated with Penn State's Evidence-to-Impact Collaborative have compiled this report.

Summary of Findings

The evaluation conducted for the period of April 17, 2020 - March 31, 2022, suggests Idaho is making sufficient progress toward SUD milestones – either showing increases in emergency department (ED) visit follow-up and medication adherence or largely maintaining baseline rates of readmissions and preventive care utilization. Progress toward meeting SMI/SED milestones is less clear although data limitations may be masking progress.

IDHW has made significant progress toward completing the actions outlined in its Implementation Plan. We anticipate that the execution of the upcoming Idaho Behavioral Health Plan (IBHP) contract reprocurement will result in the completion of multiple milestones within the SUD and SMI/SED plans. A variety of SUD and SMI/SED measures, assessed using administrative data, appear to show promising increases in medication-assisted treatment (MAT) utilization. Although declines in adherence are worth noting and monitoring, these declines may stem in part from newly initiated patients as well as from COVID-19 related disruptions in care. The increase in MAT re-engagements further suggests that MAT utilization is making progress. Importantly, Idaho's behavioral health workforce is maintaining and, in some cases, growing despite national trends of worker loss connected to the COVID-19 pandemic.

Recommendations

Based on data and findings from this report, the following actions may improve the potential for IDHW to meet its waiver goals:

- Dedicate additional staff and data resources to support the complexity of this undertaking, particularly related to the tracking and measuring of progress on all metrics.
- Broaden stakeholder engagement to include key groups such as the Hospital Association, law enforcement, and schools.
- Sustain advances in telehealth that were catalyzed by COVID-19.

Report Roadmap

Chapter 1

- Introduction
- Describe Idaho BHT Waiver Background
- Provide overview of mid-point assessment (MPA) report
- Describe Methodology

Chapter 2

- State Action to Implement Milestones
- Describe state actions toward meeting milestones from April 2020 – March 2022

Chapter 3

- Idaho's Progress on Milestones and Metrics
- Present outcomes to date using qualitative and quantitative data

Chapter 4

- Findings and Recommendations
- Outline high-level summary findings
- Present recommendations to promote future progress on milestones

Appendices

- Technical details on methods and data sources

CHAPTER 1

Introduction

Medicaid Expansion

Two important factors prompted the application for the Idaho BHT Waiver -- (1) the significant impact of the opioid epidemic and (2) Idaho's expansion of Medicaid eligibility on January 1, 2020. The journey leading to Medicaid expansion began with a citizen-initiated ballot measure. This measure, Idaho Proposition 2, Medicaid expansion Initiative, was included on the 2018 general election ballot and passed on November 6, 2018. This proposition mandated that Idaho expand Medicaid eligibility criteria to include all individuals under age 65 whose modified adjusted gross income is less than or equal to 133% of the federal poverty guidelines who were not otherwise eligible for Medicaid coverage.[1-4]

Following the passage of Proposition 2, the Idaho Legislature passed Senate Bill 1204 on April 5, 2019 to outline the requirements for implementation of Medicaid expansion. This bill mandated that IDHW

"research options and apply for federal waivers to enable cost-efficient use of Medicaid funds to pay for substance abuse and/or mental health services in institutions for mental disease."[5] Thus, necessitating the application for Section 1115 Waiver funding. Idaho expanded Medicaid and IDHW applied for the 1115 BHT waiver in January 2020. Medicaid expansion was expected to significantly increase the number of Medicaid enrollees with SMI, SED, and/or SUD because of increased coverage rates and increased likelihood of diagnosis. IDHW initially expected total enrollment to reach 91,000[6] but the COVID-19 pandemic boosted the increase to approximately 121,000 by March 2022.[7] In 2020, there were 20,090 Medicaid enrollees with an SUD diagnosis and 20,973 Medicaid enrollees with an SMI/SED diagnosis. In 2021, the latest year for which we have data, there were 24,402 Medicaid enrollees with an SUD diagnosis and 23,520 Medicaid enrollees with an SMI/SED diagnosis.

Idaho 1115 Behavioral Health Transformation Waiver and IDHW

IDHW serves under the leadership of Idaho's Governor and is a leader in the integration of health and human services for the state.[8] A Director oversees the operations of IDHW and is advised by a Board while also being governed by the Idaho State Legislature and CMS.

Core functions of IDHW include:

- Administering state and federal public assistance and health coverage programs, which includes Medicaid and Supplemental Nutrition Assistance Program
- Providing direct-care services for certain disadvantaged or underserved populations
- Protecting children and vulnerable adults
- Licensing various types of care facilities
- Promoting healthy lifestyles
- Identifying and reducing public health risks

The "Idaho 1115 Behavioral Health Transformation" (Project Number 11-w-00339/10) was approved by the CMS on April 17, 2020, with an end date of March 31, 2025. As noted in the Executive Summary, Idaho's BHT Waiver allows IDHW to leverage FFP for services provided to Medicaid recipients receiving SUD and/or SMI/SED care in an IMD and to improve transitions of care for this population of Medicaid beneficiaries. Funding is contingent on progress toward a defined set of milestones. Success is evaluated based on IDHW's ability to carry out its Implementation Plan as well as progress toward meeting a set of performance targets as defined in the IDHW Monitoring Protocol.

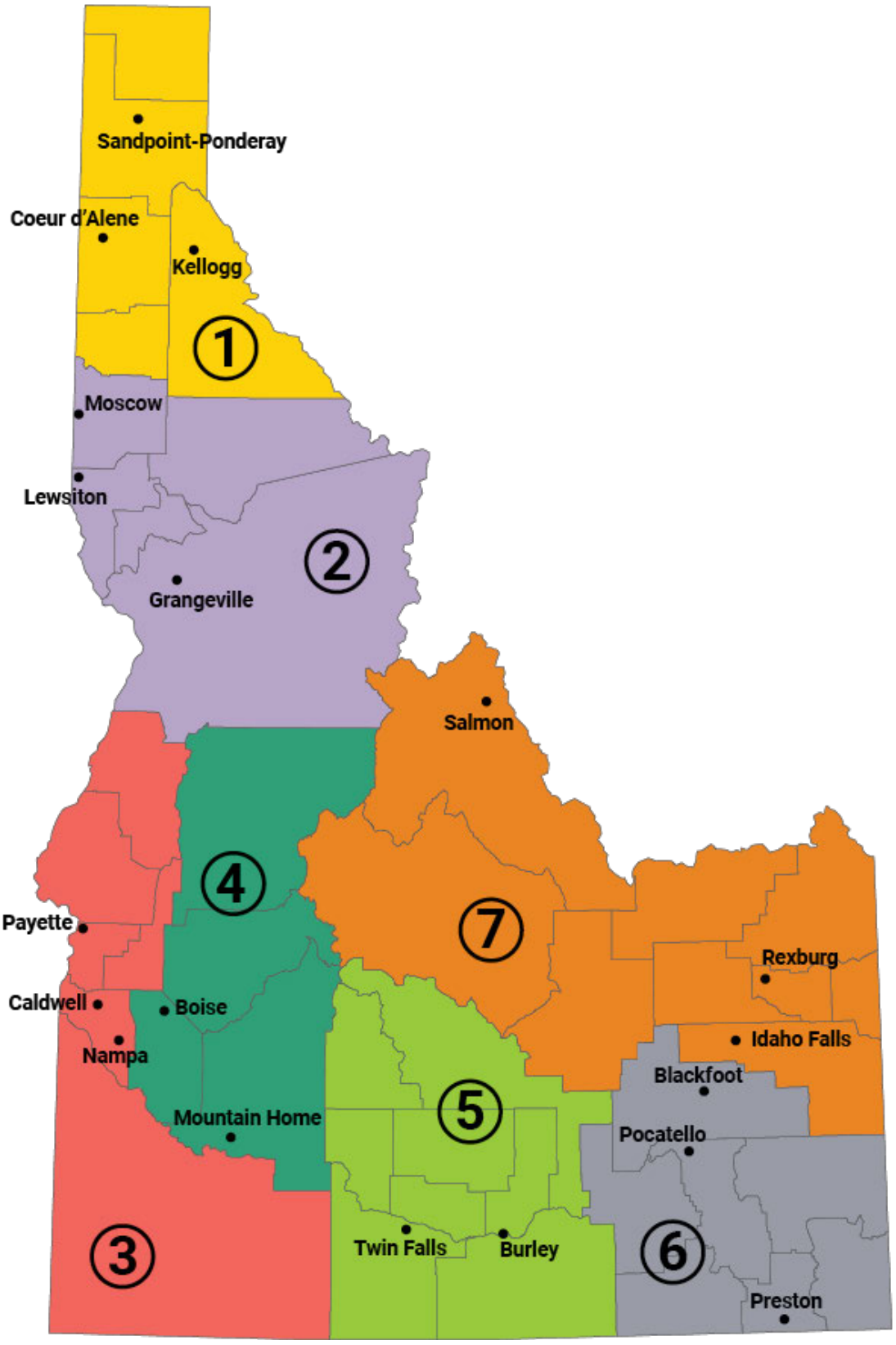
Idaho's Healthcare System

Like much of the United States, Idaho's healthcare system has been historically fragmented and reliant upon partnerships between agencies, provider organizations, and the community. Fragmentation, combined with access issues created by Idaho's rural geography (most of Idaho is designated as a Health Professional Shortage Area (HPSA)), have resulted in the need to improve the health of Idahoans. Notably, Idaho ranks 50th out of 50 states for number of active physicians per capita making healthcare access,[9] especially access to community-based services, and health professional workforce retention very challenging.

Pertaining to behavioral healthcare delivery, there are three psychiatric hospitals in Idaho serving the adult population: 1) Cottonwood Creek Behavioral Hospital; 2) Intermountain Hospital; and 3) State Hospital South. Cottonwood Creek Behavioral Hospital, State Hospital South, and Intermountain Hospital are classified IMDs for the purpose of this report, i.e., psychiatric hospitals or other residential treatment facilities that have more than 16 beds. State Hospital South differs from the other two IMDs as it is one

of the state psychiatric hospitals in Idaho administered by the Division of Behavioral Health within the Idaho Department of Health and Welfare. It also maintains a statewide program to restore the competency of criminal justice patients.

Figure 1.1 IDHW Regional Map: Medicaid



Description of Idaho BHT Waiver's Policy Goals

The Idaho BHT Waiver provides IDHW the opportunity to receive federal Medicaid match funding for inpatient and residential care received at IMDs. This is part of a broader strategy to improve access to and coordinate high quality, clinically appropriate behavioral healthcare for Medicaid beneficiaries aged 21-64 with a diagnosis of SMI/SED and/or SUD. It also supports efforts by IDHW to expand access to a continuum of evidence-based care at varied levels of intensity. The overarching goal of the waiver is to ensure that Medicaid enrollees aged 21-64 in Idaho can access necessary behavioral healthcare when they need it.

To achieve this goal, IDHW is implementing three broad, overarching aims:

Aim 1. Expand coverage of Medicaid reimbursable services for individuals with SUD and/or SMI/SED

Aim 2. Expand availability and access to services across the state (particularly in rural and frontier areas)

Aim 3. Improve coordination of care including transitions of care for Medicaid beneficiaries

To help IDHW achieve these aims, CMS created metrics and milestones as markers of success. See the milestones for SUD and SMI/SED listed below and metrics throughout this report.

SUD Milestones:

Milestone 1: Access to critical levels of care for OUD and other SUDs
Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria
Milestone 3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications
Milestone 4: Sufficient provider capacity at each level of care, including MAT
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
Milestone 6: Improved care coordination and transitions between levels of care

SMI/SED Milestones:

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
Milestone 2: Improving Care Coordination and Transitioning to Community-based Care
Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
Milestone 4: Earlier Identification and Engagement in Treatment, including through increased integration

Overview of Mid-Point Assessment (MPA)

The final draft of this MPA is required to be submitted to CMS by April 30, 2024.

CMS requires that a mid-point assessment (MPA) be conducted by an independent evaluator to assess progress toward meeting the milestones included in the approved Idaho BHT Waiver. As noted in the Executive Summary, IDHW contracted with the Pennsylvania State University (Penn State) to conduct an independent assessment of the Idaho BHT Waiver implementation. As part of this agreement, faculty and researchers affiliated with Penn State's Evidence-to-Impact Collaborative (EIC) have compiled this report. This work includes completion of this mid-point assessment. This report presents the EIC's findings.

For evaluation purposes, the MPA focuses on comparing changes in outcomes from the baseline period through the early demonstration period which ended March 2022. Subsequent reports will evaluate final outcomes through the end of the demonstration period in March 2025. The MPA is further divided into outcomes focused on SUD and SMI/SED.

The required elements of the MPA, per IDHW's approved Special Terms and Conditions (STC), include:

- Presentation of demonstration monitoring metrics as evidence of IDHW's progress towards demonstration milestones
- Description of IDHW's progress toward completion of action items as defined in the IDHW implementation plan including feedback from key stakeholders and other relevant Idahospecific data
- Status update on budget neutrality requirements
- Description of internal and external factors that impacted early implementation noting facilitators and barriers to progress
- Assessment of Idaho's risk of not achieving each milestone and recommendations for improvement

Data sources encompassed feedback from key stakeholders as well as input and information from IDHW staff including data, technical documentation, policy documents, and reporting documents. The Penn State team met twice each month with IDHW staff to provide updates, clarify expectations, and request data.

The Penn State team completed this assessment through a variety of activities:

- Conducting interviews with key stakeholders
- Assessing progress toward each milestone in the Implementation Plan
- Conducting cost analysis based on budget neutrality documentation
- Determining factors affecting performance and progress and assessing risk of milestones not being met
- Providing IDHW narrative summaries throughout report development

Methodology

Data Sources

The MPA utilizes data from three primary sources. First, IDHW collected data about the number and types of behavioral health providers in Idaho as part of the annual Mental Health Availability Assessment (MHAA). The MHAA is based on data collected from providers, licensing boards, and other associations to obtain information regarding staff counts and facility characteristics.

Second, the remaining quantitative outcomes are assessed using Medicaid claims data reports. Broadly, as claims are adjudicated, they are warehoused in the IBM Cognos database system. IDHW team members can query the database to run reports. The IDHW team regularly runs reports for many of the outcomes described in the tables throughout this MPA as part of quality reporting. These reports are then securely provided to the Penn State team and served as the basis for much of the data reported in this MPA. These outcomes were reported at the annual or quarter level (see Appendix A), with some cases of enrollee level reports.

Finally, we supplemented the quantitative data with a qualitative data analysis approach that used both key informant interviews and primary document review including the quarterly SUD and SMI Monitoring Reports. (Please refer to Appendix B for more detail on key informant interviews).

After reviewing secondary documents provided by IDHW, Penn State developed a logic model (see Appendix C). The goal of the logic model was to organize and describe the theory of change of the Idaho BHT Waiver and its intended short-and longer-term impacts. The benefit of such a model is to organize what changes are being made and how they might be expected to impact the metrics being targeted. It can also help to contextualize findings and identify explanatory targets for any ultimate results. Penn State shared the logic model with IDHW who provided feedback before finalizing.

There are two important notes about data limitations:

1. We are not yet able to assess outcomes related to mortality as we have not received Vital Statistics data that we can merge with Medicaid enrollment status. The major delay has been getting approval and then actually receiving the data with sufficient detail to allow the merge with Medicaid status (i.e. whether the person is enrolled in Medicaid). The application has been approved by the Bureau of Vital Records and Health Statistics that manages these data and Penn State is awaiting the receipt of this data. This data will be included in future analyses.

2. For most outcomes, the data reports provided by IDHW are aggregated at the annual or quarterly level. The analytic issue this poses is that without individual-level information about whether the person was eligible for Medicaid under the original criteria or the expansion criteria, we see large changes between 2018-2019 and 2020. It is currently impossible to fully disentangle whether these changes are a result of Medicaid expansion or the Idaho BHT Waiver demonstration. IDHW is currently working with their IBM (International Business Machines Corporation) data vendor to provide beneficiary-level data reports that will likely provide more granular information about individuals' eligibility. While the Penn State team has pushed for more granular data since the beginning of the evaluation, we are only recently starting to get this level of data. We will continue to work to obtain these data for outcomes.

MPA Methodology for Assessing Progress

To evaluate the progress of the Idaho BHT Waiver the Penn State team used a triangulation mixed methods approach combining both quantitative and qualitative analyses.[10-12] The quantitative approach aimed to assess changes in the performance metrics between the baseline and demonstration periods. The qualitative analysis approach was based on document review and series of interviews with key stakeholders across Idaho (refer to Appendix B for more detail on stakeholder interviews) to better understand the history of how the Idaho BHT Waiver came about, the theorized model of change, what had been accomplished to date, fidelity to the proposed implementation plan, barriers and facilitators to success, and important next steps.

Quantitative Methods Approach

Broadly, the quantitative approach entailed a pre-post design.[10] We compared changes in each SUD and SMI/SED outcome, for which we had sufficient data, between the baseline and demonstration periods.

Definition of Baseline and demonstration periods:

- Baseline Period: Depending on the outcome (i.e., whether it is reported at the quarter or year level), we define the baseline period slightly differently:
    - Data collected annually: Average in 2018 and 2019
    - Data collected quarterly: quarter 1 of 2020 (i.e., January – March)
- Demonstration Year 1 (DY1): April 2020 through March 2021
- Demonstration Year 2 (DY2): April 2021 through March 2022

For each outcome we estimated two mean differences:

Change in Demonstration Year 1 (DY1) = $Y_{(DY1)} - Y_{(Baseline)}$ and;

Change in Demonstration Year 2 (DY2) = $Y_{(DY2)} - Y_{(Baseline)}$

We report these as both absolute changes and percentage changes. The reason for including both years separately is twofold. First, it accounts for the fact that the Idaho BHT Waiver may take time to be implemented so the impact may not be fully realized in the first year. Second, the COVID-19 pandemic is a major, unanticipated event that occurs immediately around the beginning of the demonstration period. Thus, there was little time between the Idaho BHT Waiver beginning without an impact of the pandemic. Following CMS guidance,[13] we will attempt to account for this in all analyses. One way is to separately estimate changes in outcomes in both DY1 and DY2 to account for the changing nature of the pandemic between 2020, 2021, and the beginning of 2022.

With the exception of annual data, data in the demonstration years are then divided by 4 to account for the fact that our baseline is only a single quarter (by dividing by 4 we get average quarterly data). We do this to properly account for Medicaid expansion. Because we do not currently have individual level data that accounts for whether a person was eligible according to criteria prior to expansion or only after expansion, we cannot disentangle effects of the expansion compared to the Idaho BHT Waiver itself. Empirically, we found that when examining outcomes using a 2018-2019 baseline period, we saw very large increases in DY1 that are likely driven largely by Medicaid expansion. Even if using rates (instead of counts), we observe large changes that are likely driven by Medicaid expansion. As an example of this,

we observed outpatient utilization for SUD drastically change from 1,392 patients (or a 31.6% rate for enrollees diagnosed with SUD) in quarter 4 of calendar year (CY) 2019 to 3,427 (46.6%) quarter 1 of 2020. Given the large increase, we were worried using a baseline period of 2019, in many cases, would mean overstating increases resulting from Medicaid expansion. Although we can rectify this more clearly when we have individual level data, we chose to use a narrower baseline period of Q1 of CY 2020 when quarterly data were available in order to better account for Medicaid expansion. While not optimal to have such a short baseline period, using the first quarter of 2020 provides the best chance of isolating changes resulting from the Idaho BHT Waiver rather than Medicaid expansion.

As mentioned previously, future deliverables will include more granular, individual-level data that will afford us the opportunity to use more nuanced approaches to better isolate the impact of the Idaho BHT Waiver on each of the outcomes. These two approaches are as follows:

1. First, as outlined above, we will estimate changes in outcomes for those who would have been eligible under the pre-expansion criteria. This allows us to isolate changes due to the demonstration rather than expansion. More granular data will also allow us to control for other individual-level demographics and risk factors.
2. For the second approach, we compare changes in each of the outcomes to changes in utilization of non-behavioral healthcare. This approach has the advantage in that it allows us to include all Medicaid enrollees (noting that childless adults and others who become eligible under expansion are an essential group to include in future assessments). This helps to control for the COVID-19 pandemic, specifically COVID-19 related declines in care.[13] A potential limitation is that this may be imperfect if non-behavioral healthcare responded differently. However, it will help to account for changes in Medicaid enrollees that occurred following Medicaid expansion.

Finally, future analyses will also attempt to include control states in collaboration with CMS to further control for both Medicaid expansion in Idaho and the COVID-19 pandemic.

Qualitative Methods Approach

The qualitative approach includes both secondary document review (e.g., review of Idaho's BHT Waiver application, all reports to CMS to date, and other demonstration related documents) as well as key informant interviews. The goals were to:

a. Better understand the history of how the demonstration came about
b. Create a theorized model of Idaho's BHT Waiver demonstration
c. Describe what Idaho BHT Waiver demonstration steps have been implemented to date
d. Describe fidelity to the proposed plan
e. Identify barriers and facilitators to success, and
f. Describe successes as well as important next steps

Between February and May 2022, Penn State engaged in semi-structured interviews of 12 key informants. Informants included DHW employees (Idaho Medicaid, Division of Behavioral Health) and providers. All interviews were recorded with consent and then transcribed for analysis.

These semi-structured interviews included questions related to:

- Professional role

- Experience of the background and history of behavioral health in Idaho
- Understanding of the development and design of the Idaho BHT Waiver
- Experience with the Idaho BHT Waiver to date
- Feedback to help guide ongoing Idaho BHT Waiver efforts

One team member did an initial reading of the full interview transcripts and organized the data based on the logic model, interview protocol, and emergent themes and concepts.
This team member then drafted a report that included the following primary sections:

- Background & History of Behavioral Health in Idaho
- Medicaid expansion and Idaho's BHT Waiver Mandate
- Development & Design of Idaho's BHT Waiver/Demonstration
- Implementation
- Challenges/Barriers to Implementation
- Feedback and Advice from Demonstration Stakeholders

The research team members who conducted the key informant interviews reviewed the report and provided feedback for clarifications and additions using an iterative approach; the report was then shared with the full research team for their review.

Interview data was combined with a systematic document analysis and inventory procedures. Hundreds of documents were either provided by IDHW, collected from public document archives, or gathered from national and Idaho news outlets. This approach sought to provide context for understanding the complexities and experiences of obtaining and implementing the Idaho BHT waiver.

In the following chapter, we detail IDHW actions to implement milestones described in the sections above.

CHAPTER 2

State Actions to Implement Milestones

Idaho Behavioral Health Plan
To meet the goals of the Idaho BHT Waiver, IDHW agreed to implement recommended milestones outlined by CMS for SMI/SED and SUD demonstrations. The following sections discuss progress made on state actions toward achieving those milestones from April 17, 2020 to March 31, 2022. Future progress will be assessed in upcoming evaluation deliverables. To assess progress, we referenced CMSapproved quarterly progress reports and weekly IMD status reports provided to Penn State from IDHW to determine the status of each action to address milestones and related criteria. In this Chapter, we also summarize future work planned by IDHW, where applicable. This information was compiled in Table E.23 in Appendix D and discussed below.

Within this discussion, we would be remiss to not note the impact of delays in the IBHP contract procurement. IDHW is currently contracted with Optum, a subsidiary of United Behavioral Health, to

cover Idaho Medicaid outpatient behavioral health services only. Managed Care Organization contracts are required to be procured every 8 years. This procurement is an opportunity to contract for up-to-date behavioral health service needs. The current contract with Optum has been extended until the execution of the new IBHP contract.[14,15] The IBHP contract solicitation was released on December 30, 2021 in an invitation to negotiate (ITN) format. This procurement, at an estimated value of $2 billion over 4 years, will be the largest contract IDHW has awarded to date. The original expected contract award date was October 2022; at this time the expected date of contract award is sometime in 2023 with services start date likely not until Spring 2024. Delays throughout the procurement process are resulting in delays in state actions to implement milestones.

As mentioned above, the current contract with Optum includes Medicaid outpatient behavioral health services only, whereas the contract procurement will also include behavioral health inpatient, emergency department, and SUD residential services. The upcoming IBHP contract will also outline specific incentives for behavioral health professionals who operate within primary care settings, will require MAT for OUD to be available in all regions of Idaho, and will outline specific access metrics that pertain to increased use of telehealth services in Idaho.

The IBHP contract procurement is a key component of the Idaho BHT Waiver implementation. Interview respondents who were familiar with the Idaho BHT Waiver spoke generally about implementation, in large part, because the focus has been on the ongoing contract procurement process:

> *"There's a lot of areas in our implementation plan that we put—we're dependent on the procurement. Some of that is specific to some of the metrics and some of the other things that we would expect the provider network to help us accomplish…. I think a lot of that is [care coordination] going to come with the re-bid [procurement]"*

Specific impacts of this contract delay will be discussed within relevant milestones below. More information on this contract procurement and implementation will be covered in future reports.

Findings on SUD Milestone Implementation

Milestone 1: Access to Critical Levels of Care for Opioid Use Disorder (OUD) and Other SUDs

To satisfy SUD milestone 1, the IDHW Implementation Plan included the following criteria:

A. Coverage of outpatient services
B. Coverage of intensive outpatient services
C. Coverage of medication assisted treatment (medications as well as counseling and other services)
D. Coverage of intensive levels of care in residential and inpatient settings
E. Coverage of medically supervised withdrawal management

Summary of SUD Implementation Plan Activities:

For Milestone 1, much groundwork has been achieved to set IDHW up for success in addressing coverage gaps for outpatient and intensive outpatient services. Part of the work to address coverage gaps included IDHW residential service definitions aligned with American Society for Addiction Medicine (ASAM)

criteria and reimbursement methodology. IDHW also developed regulations, rules, and standards to establish qualifications for inpatient and residential treatment providers that align with ASAM standards for types of services, hours of clinical care, and staff credentials. Optum is contractually obligated to follow ASAM standards and ASAM compliance was added to the ITN for the IBHP contract procurement that is in process.

Provider enrollment

A large part of IDHW achieving access to critical levels of care through expanded outpatient coverage is provider enrollment within its Medicaid Enterprise Systems. Further, IDHW initiated the process for enrollment of SUD inpatient and residential treatment facilities to provide ASAM 3.5 and 3.7 (clinically managed high-intensity residential services) level care beginning in 2020 shortly after the Idaho BHT waiver approval. This work consisted of initially engaging with providers IDHW knew would be most likely to enroll in Medicaid to elicit feedback on rate setting and Commission on Accreditation of Rehabilitation Facilities (CARF) certification requirements. Implementation of this enrollment process has been delayed due to competing priorities and timeline delays for other programs. The upcoming IBHP contract will assist in providing an avenue for residential treatment providers to enroll as Idaho Medicaid providers. Leading up to implementation of the upcoming IBHP contract, coverage of residential services equivalent to ASAM 3.5 and 3.7 will be added to the Medicaid-covered services. The start date for coverage is dependent on the completion of the provider enrollment and certification process.

Outpatient Coverage

Efforts to expand outpatient coverage and access to mental health services have included the addition of Recovery Coaching to the state Medicaid plan and the upcoming IBHP contract. Withdrawal management was also added to the state Medicaid plan. Idaho's governor supported two efforts to increase access to mental health services for Medicaid beneficiaries. These efforts included signing an executive order making several emergency telehealth rules permanent (many focusing on expanding connected health platforms to improve access to care) as well as the Governor recommending (and the Idaho legislature approving) funding for a Certified Community Behavioral Health Clinic (CCBCH) pilot. There is ongoing work to enroll new partial hospitalization providers and expand coverage of MAT. Partial hospitalization is already covered by the Medicaid state plan and was added as an IBHP service in early 2020. IDHW and the IBHP contractor will continue to support this service by enrolling new partial hospitalization providers throughout the Idaho BHT Waiver demonstration period. Work has included the following:

- In January 2021, IDHW developed coverage policy for provision of MAT at Opioid Treatment Programs (OTPs) which was added as a Medicaid- covered service and restructured reimbursement in the form of weekly bundle as of January 1, 2021. An example of expanded coverage of MAT included the openings of two medication for opioid use disorder clinics in the state in December 2021.
- By April 2021, modifications to the state Medicaid Plan and 1915(b) Medicaid Plus Waiver authority allowed IDHW to address coverage of MAT services.

Summary:

Based on the actions described above, we consider Milestone 1 in progress pending the execution of the upcoming IBHP contract.

Work accomplished after Midpoint assessment timeframe of April 2020 to March 2022: Post-March 2022, we were aware of advances in progress for the enrollment of SUD residential treatment providers as Idaho Medicaid providers delivering ASAM 3.5. Much of the progress with this work was achieved by July 2022. Providers were given information about this enrollment including requirement and approved rates for service in June 2022. The enrollment process went live, reimbursement for ASAM 3.5 & 3.7 in residential settings began, and provider handbook updates were in the process of being completed. Additionally, IDHW restructured MAT reimbursement following the completion of the CMS MAT Affinity TA (Technical Assistance) Group in April 2022.

Work to be pursued by IDHW in the future:
IDHW will pursue enrolling qualified SUD inpatient and residential treatment providers as Idaho Medicaid providers delivering ASAM 3.5 and 3.7 throughout the state as well as continuing their work enrolling partial hospitalization providers and continuing to ensure access to MAT treatment for OUD.

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

To satisfy SUD milestone 2, the IDHW Implementation Plan identified the following criteria:

A. Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence- based clinical treatment guidelines
B. Implementation of a utilization management approach such that
    i. beneficiaries have access to SUD services at the appropriate level of care,
    ii. interventions are appropriate for the diagnosis and level of care, and
    iii. there is an independent process for reviewing placement in residential treatment settings

Summary of SUD Implementation Plan Activities:
As a foundation to milestone 2, Idaho Medicaid assessed 18 existing SUD placement strategies to ensure evidence-based placement criteria were being utilized. In partnership with Optum Idaho Medicaid Idaho Medicaid aligned provider agreements and provider manual with ASAM criteria to ensure access to appropriate levels of care and oversight on lengths of stay including placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions in early 2020. Additionally, an independent utilization management (UM) process was established to ensure beneficiaries have access to SUD services at the appropriate level of care with the appropriate interventions based on ASAM Criteria.

Status of SUD Milestone Implementation:
Based on the actions described above, we consider Milestone 2 in progress pending the execution of the upcoming IBHP contract.

Work to be pursued by IDHW in the future:
Building upon the foundation described above, IDHW will require inclusion of a full psychosocial assessment covering six dimensions in accordance with the ASAM criteria as well as language regarding the implementation of the above-mentioned access and care items in the upcoming IBHP contract. Rules and standards for assessments will be discussed with the contract holder. IDHW will focus on the award and implementation of the upcoming IBHP contract to further these milestone activities.

Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

To satisfy SUD milestone 3, the IDHW Implementation Plan identified the following criteria:

A. Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD- specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings
B. Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards
C. Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off-site

Summary of SUD Implementation Plan Activities

As a foundation to milestone 3, IDHW worked to ensure residential provider qualifications and residential treatment facilities met nationally recognized SUD-specific program standards. To accomplish this, IDHW 1) updated provider guidance, revised Medicaid enrollment, and made changes within the upcoming IBHP contract and 2) internally updated the Medicaid provider handbook with guidance regarding residential treatment provider qualifications, requirements regarding ASAM criteria, and other program standards. IDHW is waiting for these provider handbook changes to be finalized and published publicly.

IDHW requires Substance Abuse Rehabilitation Facilities (SARFs) to be nationally accredited in behavioral health services and hold a CARF ASAM certification. SUD residential treatment programs enrolled with Medicaid and created an ongoing process to periodically reevaluate existing publicly funded SUD residential treatment programs to ensure residential treatment providers adhere to statedeveloped standards. To assist with compliance, CARF offers the state access to its portal and public website posts that contain information indicating those providers and facilities that are in compliance with qualifications. IDHW also revised Medicaid enrollment policies, regulations, and standards to require all Medicaid enrolled SUD residential treatment providers offer at least two forms of MAT.

Status of SUD Milestone Implementation:

Based on the actions described above, we consider Milestone 3 in progress pending the execution of the upcoming IBHP contract.

Work accomplished after Midpoint assessment timeframe of April 2020 to March 2022:

IDHW is adding a requirement for residential facilities providing care at ASAM levels 3.5 and 3.7 to be CARF ASAM certified. This will be in place for all residential facilities providing these levels of ASAM by the beginning July 1, 2022.

Work to be pursued by IDHW in the future:

IDHW will pursue enrolling qualified SUD residential and inpatient treatment providers as Idaho Medicaid providers delivering ASAM 3.5 and 3.7 throughout the state. Regarding the upcoming IBHP contract, residential service coverage will be incorporated into the new contract, including the

requirement that all providers enrolled in the IBHP network must adhere to these minimum provider qualification standards and the requirement for the IBHP contractor to ensure all network inpatient and residential treatment providers comply with MAT policy requirements.

IDHW will focus on the award and implementation of the upcoming IBHP contract to further these milestone activities.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for MAT for OUD

To satisfy SUD milestone 4, the IDHW Implementation Plan identified the following criteria:

A. Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT:
   (i) Outpatient Services
   (ii) Intensive Outpatient Services
   (iii) Medication Assisted Treatment (medications as well as counseling and other services)
   (iv) Intensive Care in Residential and Inpatient Settings
   (v) Medically Supervised Withdrawal Management

Summary of SUD Implementation Plan Activities

For milestone 4, IDHW assessed the availability of providers enrolled in Medicaid and providers accepting new patients in critical levels of care including those that offer MAT through the process of the Mental Health Availability Assessment (MHAA). IDHW implements an annual assessment of the availability of behavioral health providers focused on the number and types of behavioral health providers in Idaho. The MHAA is based on data collected from Optum, providers, licensing boards, and other associations to obtain information regarding staff counts and facility characteristics. IDHW has completed two MHAAs including in 2019 (baseline) and in 2020 and will continue to assess provider capacity throughout the demonstration period to monitor the effect of new policies to expand capacity. In relation to the availability of providers in critical levels of care, Medicaid now funds services in 24hour crisis centers in each region of Idaho and the state will leverage the new Non-Emergency Medication Transportation (NEMT) contract to continue to strengthen the NEMT provider network in Idaho in order to try to improve access to care. The new NEMT contract will require the contractor to meet specific criteria regarding availability of NEMT services across Idaho.

Status of SUD Milestone Implementation

Based on the actions described above we consider this milestone to be in progress pending the execution of the upcoming IBHP and NEMT contracts.

Work accomplished after Midpoint assessment timeframe of April 2020 to March 2022:

A community resource, the Crisis and Suicide Hotline (988), went into effect on July 16, 2022. This hotline saw an increase of 39.5% in call volume from July 16, 2022 to September 12, 2022. Work with this hotline will continue throughout the waiver.

Work to be pursued by IDHW in the future:

IDHW will continue to assess provider capacity throughout the demonstration period to monitor the effect of new policies to expand capacity and will focus on the award and implementation of the upcoming IBHP and NEMT contracts to further these milestone activities. While the DBH intends to

expand inpatient and crisis bed registry as a first responder community resource over the course of the Idaho BHT Waiver, this is currently delayed.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

To satisfy SUD milestone 5, the IDHW Implementation Plan identified the following criteria:

A. Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse
B. Expanded coverage of, and access to, naloxone for overdose reversal
C. Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs
D. Other

Summary of SUD Implementation Plan Activities

For Milestone 5, IDHW laid groundwork for implementing comprehensive treatment and prevention strategies to address opioid abuse and opioid use disorder. A new pharmacy Prior Authorization form for analgesics-Opioid non preferred and/or Morphine Milligram Equivalents (MME) over 90 was implemented in August 2020 along with other interventions to prevent OUD. This prior authorization form includes a required attestation by providers indicating they are "providing safe, long-term opioid treatment for chronic pain, including among other things co-prescribing naloxone, obtaining annual treatment agreements, and performing regular drug screens."[16] IDHW worked with Optum to get the Opioid Treatment Program (OTP) coverage policy finalized during year one, so that MAT at OTPs was covered beginning January 2021.

Work to increase utilization and improve functionality of prescription drug monitoring programs (PDMP) involved a new law that was passed in October 2020. More information on this law will be discussed in the Health IT Plan/PDMP section. In addition, Governor Little signed Executive Order 2019-09 on June 13, 2019, creating the Opioid and Substance Use Disorder Advisory Group chaired by the Administrator of the Office of Drug Policy. The Advisory Group met regularly and sent recommendations to the Governor in October 2020. The Office of Drug Policy also chaired an Opioid Strategic Plan group that broke out into goal groups to discuss metrics and strategy which produced several outputs. IDHW holds Opioid Check-In Meetings twice a month to discuss current issues, concerns, strategies, decisions, and policies. During the 2020 legislative session, a new law was passed requiring prescribers to check the PDMP database prior to prescribing any opioid or benzodiazepine. This law went into effect on October 1, 2020.[17]

Programs within IDHW, including the Maternal Health Program, the Drug Overdose Prevention Program, and the DBH, have worked collaboratively surrounding SUD and mental health supports for pregnant and parenting women in response to Idaho's maternal mortality rate. During the past three years the majority of Idaho's maternal deaths were among Medicaid participants and just under half were attributed to SUD.[18,19]

IDHW has also started a collaboration with addiction medicine fellowships in the Boise area. Three fellows volunteered with Idaho Medicaid beginning in DY2Q3 (October – December 2021) and DY2Q4 (January 2022- March 2022) to work with the pharmacy team on safe opioid prescribing and access to medications for opioid use disorder. The fellows will also help Medicaid, the Drug Overdose Prevention

Program, the Maternal Health Program, and DBH to design an intervention to help engage pregnant and parenting women with SMI and/or SUD in care.

Status of SUD Milestone Implementation

Based on the actions described above we consider this milestone to be in progress pending the execution of the upcoming IBHP contract.

Work to be pursued by IDHW in the future:

IDHW intends to further expand coverage and access to naloxone for overdose reversal by 1) developing and utilizing an integrated acquisition and tracking platform for naloxone distribution; 2) identifying and partnering with critical stakeholders to expand naloxone distribution; and 3) standardizing training content across stakeholders and platforms over the course of the demo. IDHW also plans to begin tracking naloxone usage by first responders statewide.

Additionally, work to enhance PDMP functionality, interoperability, ease of use, and patient matching capabilities upon CMS approval of the Implementation Advanced Planning Document (IAPD) Health Information Technology for Economic and Clinical Health (HITECH) Act application will continue into the next period.

Milestone 6: Improved Care Coordination and Transitions between Levels of Care

To satisfy SUD milestone 6, the IDHW Implementation Plan identified the following criteria:

A. Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community- based services and supports following stays in these facilities

Summary of SUD Implementation Plan Activities

Groundwork has been established to set IDHW up for success including the development of transition of care standards and development of coordination of care standards. These transition of care standards, IBHP provider agreements and additional Healthcare Effectiveness Data and Information Sets for FollowUp after Hospitalization for Mental Illness (HEDIS FUH) performance will be included in the upcoming IBHP contract.

Status of SUD Milestone Implementation

Based on the actions described above we consider this milestone to be in progress pending the execution of the upcoming IBHP contract.

Work accomplished after Midpoint assessment timeframe of April 2020 to March 2022:

Residential treatment providers were notified of care coordination and transitions between levels of care requirements in April 2022. Case Management and Targeted Care Coordination services became billable services in May 2022. These services assist members in setting up and coordinating postdischarge services and can be provided up to 180 days prior to the member being discharged out of the hospital or Residential Setting. More on this work will be included in future reports.

Work to be pursued by IDHW in the future:

As envisioned, the upcoming IBHP contract will require the selected managed care organization (MCO) to embed performance standards within community provider and inpatient/residential provider agreements. The selected entity will employ a team of clinicians that perform direct interventions to high-risk Idaho Medicaid members. This team will directly interface with community providers and residential/inpatient discharge coordinators. IDHW will focus on the award and implementation of the upcoming IBHP contract to further these milestone activities.

Findings on SMI/SED Milestone Implementation

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

To satisfy SMI/SED milestone 1, the IDHW Implementation Plan identified the following criteria:

A. Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid
B. Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements
C. Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay
D. Compliance with program integrity requirements and state compliance assurance process
E. The state requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions
F. The state expects to make other program changes that may affect metrics related to Milestone 1.

Summary of SMI/SED Implementation Plan Activities

For milestone 1, the IDHW's Division of Licensing and Certification has established licensing and certification requirements for psychiatric hospitals to ensure participating hospitals and residential settings meet state's licensing, certification, and nationally recognized accreditation requirements prior to participating in Medicaid to provide mental health treatment. The Division of Licensing and Certification uses the CMS State Operations Manual survey guidelines for psychiatric hospitals and Division staff may conduct on-site surveys at any time (or at a minimum annually) to ensure compliance with 42 Code of Federal Regulations (CFR) part 482 regulations.[20,21]

Prior to the release of the IBHP contract solicitation, the Divisions of Medicaid and Behavioral Health collaborated to define UM Standards that will be utilized in the IBHP contract and provider agreements. The IDHW program integrity rules and compliance assurance process establish provider requirements to assure program integrity and quality compliance. This includes fraud detection and investigation, the prevention of improper payments, and provider participation. During provider enrollment and reenrollment, the Division of Medicaid verifies that providers meet federal program integrity requirements.

Idaho Medicaid implemented Value Based Payment (VBP) arrangements for specific medical services beginning July 1, 2021 by contracting with eleven Value Care Organizations (VCOs), including five hospital networks, three primary care provider groups, and three independent primary care providers. Idaho Medicaid anticipates that moving to value-based care will incentivize providers to focus on quality and outcomes, rather than just provision of services. However, we were not provided with sufficient detail to determine what the specific impacts are expected to be on behavioral health.

Status of SMI/SED Milestone Implementation

Based on the actions described above, we consider Milestone 2 in progress pending the procurement of the upcoming IBHP contract.

Work to be pursued by IDHW in the future:

The upcoming IBHP contract will consolidate utilization management activities for all behavioral health services (inpatient and outpatient).

Additionally, there will be a contractual requirement that psychiatric hospitals and residential settings screen and facilitate access to treatment for beneficiaries experiencing co-morbid physical health conditions, SUDs, and suicidal ideation if these organizations become part of the new IBHP provider network. IDHW expects to report screening data based on claims submission for DY1 and DY2 and to phase in additional medical records review reporting through the upcoming IBHP contract.

Milestone 2: Improving Care Coordination and Transitioning to Community-based Care

To satisfy SMI/SED milestone 2, the IDHW Implementation Plan identified the following criteria:

A. Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions
B. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available
C. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community- based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge
D. Strategies to prevent or decrease lengths of stay in EDs

Summary of SMI/SED Implementation Plan Activities

For Milestone 2, Idaho Medicaid will require that all psychiatric hospitals participating in the Idaho BHT Waiver assess beneficiary housing situations and coordinate with housing services providers under the upcoming IBHP contract. The Medicaid State Plan already includes service definitions for Crisis Response and Crisis Intervention, which are delivered through the IBHP provider network.

IDHW has participated in other efforts to improve care coordination and connection to communitybased care. These include:

- Medicaid's Medical Director, Magni Hamso, MD, MPH, FACP, FASAM, joined the Maternal Mortality Review Committee (MMRC), a multidisciplinary state-level committee that meets at least annually to evaluate abstracted cases to identify, review, and analyze maternal deaths (pregnancy-associated and pregnancy-related) in the state of Idaho.

- The Idaho Council on Developmental Disabilities is continuing to work to integrate personcentered planning initiatives for adults with disabilities and families of children with disabilities. This work aims to allow these individuals and their families to have maximum flexibility and control over their services and supports, to recognize the importance of natural supports, and to embed person-centered planning in state regulations and policies. A model was developed as part of the person-centered planning initiative. This model will adhere to best practice guidelines and include input from individuals with developmental disabilities and their families.

Status of SMI/SED Milestone Implementation

Based on the actions described above, we consider Milestone 2 in progress pending the procurement of the upcoming IBHP contract.

Work accomplished after Midpoint assessment timeframe of April 2020 to March 2022:

Although beyond this timeframe, IDHW made provider handbook changes in July 2022 that are awaiting final approval. State-specific metrics were added including a metric to the monitoring protocols which will help monitor the MCO beneficiaries' housing situations as well as a metric to the monitoring protocols which will help monitor timeliness of post-discharge MCO beneficiary follow up.

Work to be pursued by IDHW in the future:

The upcoming IBHP contract will include inpatient services, allowing for improved quality assurance of follow-up contacts with Medicaid members post discharge. Specifically, the new contract will require IMDs that are IBHP network providers to contact beneficiaries and community-based providers within 72 hours post-discharge. The transition planning services and state standards to be embedded in the upcoming IBHP contract will assist in ensuring beneficiaries are appropriately transitioned to community providers. In addition, the managed care contract will include enhanced case management requirements for all hospitalizations related to SMI/SED and SUD, regardless of the duration or type of hospitalization (acute inpatient at psychiatric hospitals, residential treatment in an IMD, or an emergency department visit). IBHP contractor staff will be required to work directly with the member through at least 30 days post-discharge.

Milestone 3: Increasing Access to Continuum of Care, Including Stabilization Services

To satisfy SMI/SED milestone 3, the IDHW Implementation Plan identified the following criteria:

A. The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The

content of annual assessments should be reported in the state's annual demonstration monitoring reports. These reports should include which providers have waitlists and what are average wait times to get an appointment.

B. Financing Plan (will be discussed in section below)
C. Strategies to improve state tracking of availability of inpatient and crisis stabilization beds
D. State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay
E. Other state requirements/policies to improve access to a full continuum of care including crisis stabilization

Summary of SMI/SED Implementation Plan Activities

Availability and access to mental health services

IDHW created plans to improve availability of and increase access to mental health services. These plans will change reimbursement and financing policies to address gaps in access to community-based providers identified in IDHW's initial MHAA. As mentioned in SUD Milestone 4, Baseline (2019) and DY1 (April 2020 – March 2021) MHAA reports have been completed.

Increasing availability of on-going community-based services specifically involving outpatient, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model will be part of the upcoming IBHP contract. Crisis center services reimbursement and Partial Hospitalization Program payment began in January 2020 through the Optum IBHP contract.

Crisis services

Additionally, under DBH authority the availability of non-hospital, non-residential crisis stabilization services will increase. This specifically includes services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders. In DY2Q3 (October-December 2021) and Q4 (January – March 2022), in response to IDHW's request for funding to support a comprehensive crisis system, the Idaho legislature approved financial appropriations to IDHW to support several behavioral health initiatives. A portion of the money will be used to expand the 988 National Suicide Prevention Lifeline in Idaho. Additionally, $15 million dollars in state general funds were appropriated for establishing three psychiatric residential treatment facilities across Idaho supporting community-based services and preventing patients, specifically children and youth, from being sent out of state for treatment. Idaho will also use $12 million of these funds to explore the CCBHC model to expand the state's capacity to address the overdose crisis and establish innovative partnerships with law enforcement, schools, and hospitals to improve care, reduce recidivism, and prevent hospital readmissions. The goal of the CCBCH pilot will be to improve access and the quality of behavioral health services in Idaho. Other community-based service actions include expanding access to Assertive Community Treatment (ACT) services and promoting the growth of the IBHP provider network to expand the number of providers who offer telehealth services. Overall, actions to support communitybased services remain largely in progress dependent on the procurement of the upcoming IBHP contract.

State reported metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3, will be discussed in Chapter 3.

Status of SMI/SED Milestone Implementation

Based on the actions described above, we consider Milestone 3 in progress pending the execution of the upcoming IBHP contract.

Work accomplished after Midpoint assessment timeframe of April 2020 to March 2022:

Although just outside the above referenced time period, IDHW continued to prepare to implement the 988 National Suicide hotline that went live on July 16, 2022. The Idaho Behavioral Health Council drafted their Idaho Behavioral Health Workforce Plan 2022-2024 to help address the shortage of healthcare professionals. This plan will be released July 1, 2022.

Work to be pursued by IDHW in the future:

- Additional language has been added to the upcoming IBHP contract to include crisis service requirements and community training requirements as well as language requiring the IBHP contractor to support Idaho's crisis vision by offering the crisis service array. This array includes Crisis Response, Crisis Intervention, and Member Crisis Line. Language that supports the growth and sustainability of Certified Behavioral Health Clinic Models within the IBHP network has also been included in the upcoming IBHP contract. This upcoming contract will also include outpatient levels of care provider access requirements.

- The Divisions of Medicaid and Behavioral Health have collaborated to identify state-approved clinical domain assessment requirements which will be reflected in the Medicaid Provider Handbook once the upcoming IBHP contract goes into effect. IDHW intends to develop and implement requirements and/or standards to ensure Comprehensive Diagnostic Assessments are conducted to determine appropriate levels of care and length of stay within the upcoming IBHP contract and future provider agreements. Additionally, DBH houses the crisis bed registry known as the Idaho Psychiatric Bed and Seat Registry (IPBSR) platform. Idaho Medicaid and DBH will train community stakeholders in the use of the IPBSR platform. The upcoming IBHP contract will also contain a requirement for the contractor to create a program amongst the state's crisis centers and other providers to work with the IPBSR to connect individuals with needed resources.

The Divisions of Behavioral Health and Medicaid will work directly with the IBHP contractor to promote improved communication in relation to crisis services between first responders and treatment providers. Ongoing training opportunities will be offered to community providers and first responders on crisis services throughout the state. To support this work, IDHW must update the 1915(b) managed care waiver to include inpatient and residential services.

Milestone 4: Earlier Identification and Engagement in Treatment, Including through Increased Integration

To satisfy SMI/SED milestone 4, the IDHW Implementation Plan identified the following criteria:

A. Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, including through supported employment and supported education programs
B. Plan for increasing integration of behavioral healthcare in non-specialty settings to improve early identification of SED/SMI and linkages to treatment

C. Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI
D. Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people

Summary of SMI/SED Implementation Plan Activities

IDHW will outline the requirement for the IBHP contractor to implement strategies for identifying and engaging beneficiaries with, or at risk of, SMI/SED into treatment sooner, including through supported employment and supported education programs, as well as coordination with the Healthy Connections primary care network. This requirement was included in the IBHP contract language and the IBHP contractor will be required to have policies that support these efforts.

Status of SMI/SED Milestone Implementation

We consider Milestone 4 in progress pending the execution of the upcoming IBHP contract.

Work accomplished after Midpoint assessment timeframe of April 2020 to March 2022:

DBH continues to work with community partners to expand Emergency Department Psychiatric Triage Centers (ED-PTC) services to areas in Idaho that have been seriously impacted by COVID-19.

Work to be pursued by IDHW in the next period:

IDHW is revising standards about early identification and engagement of participants with or at risk of SMI/SED. These standards will be included in the upcoming IBHP contract. The contractor will develop strategies to identify participants who are at risk of SMI/SED and the contractor will have policies and procedures in place that outline these strategies and track the efforts and outcomes. Additionally, the Idaho Department of Juvenile Corrections (IDJC) and the IDHW plan to establish a framework for youth crisis centers in Idaho. Youth can stay at one of the centers for up to 23 hours and 59 minutes and receive a place to rest, food, and access services from mental health professionals to stabilize, develop a plan of care, and receive provider referrals to resources.

Findings on State Health IT Plan/PDMP Assessment & Plan

There is important statewide infrastructure in place to support IDHW's implementation of SUD and SMI/SME health IT activities. This infrastructure includes (1) the Idaho Health Data Exchange (IHDE) - a sole source statewide health data exchange; (2) Bamboo Health[22] - the sole vendor of Idaho's prescription drug monitoring program (PDMP); and (3) a high adoption rate of electronic health records (EHR) and prescription dispensing software systems among providers and pharmacies across Idaho.

The IHDE participates in the Patient Centered Data Home initiative, which seeks to improve exchange of patient information among Health Information Exchanges (HIEs) across the country. The IHDE has connected to the Utah Health Information Exchange, which is in turn connected to HIEs in Alaska, Arizona, California, Colorado, Hawaii, Iowa, Nebraska, North Dakota, Oregon, and Wyoming; thus, increasing Idaho providers' access to health information. IDHW also realized additional opportunities for health IT through collaboration with companies such as Collective Medical Technologies, Inc. Collective Medical operates a nationwide admission, discharge and/or transfer-based care collaboration network in over 40 states and is connected to multiple Idaho facilities, networks, and health plans.

The IHDE is a key partner in IDHW's implementation of health IT activities. While progress has been made, IDHW has reported delays which may impact IDHW's ability to meet its health IT implementation goals. According to one respondent:

> *"The HIE has struggled. They're at a point where the legislature was not convinced that the HIE was a good long-term investment, so it's really not state-funded anymore, except in maybe a trivial kind of way. I think if we had had—if we'd been thinking more along the lines of how you would do this, not assuming the HIE is going to play a big role, but it would've served us better. That part, I think, is one of the hardest problems. That's one of the hardest pieces of the 1115. Is really how are you going to synchronize data? How are you going to share data? How are you going to do it in a way that respects patient rights and all that? That's the hard part."*

SUD

To satisfy SUD HIT, the IDHW Implementation Plan identified the following criteria:

A. Enhanced interstate data sharing in order to better track patient specific prescription data
B. Enhanced ease of use for prescribers and other state and federal stakeholders
C. Enhanced connectivity between the state's PDMP and any statewide, regional, or local HIE
D. Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns
E. Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP
F. Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery
G. Develop enhanced provider workflow/ business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow
H. Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP-prior to the issuance of an opioid prescription
I. Leverage the above functionalities/ capabilities/supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing— and to ensure that Medicaid does not inappropriately pay for opioids

Summary of Health IT Plan Implementation Activities

IDHW works closely with the Opioid and Substance Use Disorder Advisory Group, meeting at least twice per month to discuss current issues, concerns, strategies, decisions, and policies. Further, they continue to monitor progress of the law requiring prescribers to check the PDMP database prior to prescribing any opioid or benzodiazepine, which went into effect on October 1, 2020.

IHDE and the Idaho PDMP participate in nationwide data sharing efforts. IHDE participates in Civitas Networks for Health (formerly the Strategic Health Information Exchange Collaboration (SHIEC))[23,24] with 74 other health information exchanges. The PDMP shares data through PMP Interconnect which facilitates the transfer of PMP data across state lines.

While there have been delays, progress has been made in enhancing data sharing and connectivity to the state's PDMP. In April and May 2020, IHDE 1) revised its participant agreement to include prescription

drug and substance use disorder data although concerns remain about how it can be shared and utilized beyond the individual health care provider; 2) further defined its business and data needs, priorities and connection types in order to better serve Idaho's healthcare landscape; and 3) began cleanup of its master patient index to ensure complete and consistent data, which is necessary to properly identify patient medical records and to link records across disparate databases and healthcare organizations.

In June 2020, the Idaho Board of Pharmacy announced a statewide initiative to integrate Idaho PDMP data into approved electronic health records (EHR) and pharmacy systems throughout the state, using Appriss Health's (now rebranded as Bamboo Health) PMP Gateway solution. This integration at the point of care increases the ease of access and use of prescription information and helps providers make critical clinical decisions, including the prescribing and dispensing of controlled substances, as well as informed decisions around patient care and safety. Prior to this integration initiative, Idaho prescribers and pharmacists had to log in to a separate system to query patient information. With the integration, providers and pharmacists can initiate a patient query through an EHR or pharmacy system to return the patient's controlled substance prescription records directly within the clinical workflow inside the EHR. The Board of Pharmacy worked to enhance the inclusion of all long-term opioids within the controlled substance information in the PDMP.

By August 2020, IDHW included parameters related to the frequency of reports, data, and prescriber and dispenser information written into its new reporting structure. In September 2020, IHDE built Application Programing Interface (API) connections to the PDMP and went live with view-only clinical portal access in September 2020. IDHW contracted with an outside vendor to assist in cleanup of the master patient index. By fall of 2020, IDHW was finding enhanced match rates of the master patient index with active exchange with two MPI vendors within the data exchange.

As mentioned previously, the statute mandating PDMP checks prior to prescribing/dispensing opioids went live October 1, 2020. Idaho Board of Pharmacy purchased a statewide PMP Gateway license in September 2020 which makes PDMP link available in select dispensing and EHR workflows.

The Board of Pharmacy continues to train prescribers and pharmacists. IDHW and the IHDE continue conversations regarding the feasibility of integrating Medicaid and Medicare claims data-enhancing information to match patient records.

Project ECHO (Extension for Community Health Outcomes) includes provider training for opioid alternative practices. Based at the University of Idaho, ECHO Idaho connects providers (typically in underserved areas) with subject matter experts who provide education, case consultation, resource sharing, and discussion through a virtual platform.[25]

SMI/SED

To satisfy SMI/SED HIT, the IDHW Implementation Plan identified the following criteria:

A. Closed loop referrals and e- referrals from physician/mental health provider to physician/ mental health provider
B. Closed loop referrals and e- referrals from institution/ hospital/clinic to physician/ mental health provider
C. Closed loop referrals and e- referrals from physician/mental health provider to community-based supports
D. The state and its providers can create and use an electronic care plan

E. E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers
F. Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications
G. Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications
H. Transitions of care and other community supports are accessed and supported through electronic communications
I. Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive healthcare information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)
J. Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem
K. Telehealth technologies support collaborative care by facilitating broader availability of integrated mental healthcare and primary care
L. The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment
M. Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis
N. As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records
O. Electronic medical records capture all episodes of care, and are linked to the correct patient

Idaho has made strategic program and reimbursement design decisions that promote care coordination, closed loop referrals and e-referrals, and incentivize primary care providers for enhanced care coordination capabilities. Idaho's Primary Care Case Management (PCCM) program, Healthy Connections, operates as a managed fee-for-service model in which a network of primary care physicians and healthcare providers serve as the patient-centered medical home (PCMH) for Medicaid members. Under this arrangement, the primary care provider is responsible for monitoring and managing members' care, providing primary care services, and making timely referrals to other providers to ensure medically necessary services are provided promptly without compromising quality of care. IDHW included requirements to promote the use of closed loop and e-referrals in the upcoming behavioral health managed care contract. Use of e-referrals for community-based services and resources remains limited, as competing Department priorities have been budgeted ahead of this project. In 2021, IHDE connected the Utah Health Information Exchange, Ada County EMS and two Behavioral Health clinics. The IHDE has implemented enhancements to support behavioral health provider needs by expanding use of admission, discharge, and transfer (ADT), Consolidated Clinical Document Architecture (CCDA) interface capabilities, and Direct Messaging communications in two behavioral health clinics.

As of the end of DY2, twenty-one hospitals in Idaho contracted with Collective Medical, a real-time collaboration platform that allows for a flow of patient information going to and from the hospitals. In July 2021, Collective Medical's work to facilitate seamless sharing of sensitive information while also segregating and protecting highly sensitive records met this capacity for Idaho.

Beginning in August 2020, the IDHE increased its ability to impact social determinants of health by contracting with Aunt Bertha, a social service search and referral platform. By early 2021, IHDE

contracted with consent management platforms which will enable IHDE to expand its network and services to behavioral health providers, facilitate sharing of mental health and SUD information with patient approval, and improve coordination across the continuum of care.

Starting in July 2020, comprehensive analytics services are being expanded through a new IHDE partnership with KPI Ninja. This platform will help maximize the usability of Idaho's health IT infrastructure by turning data into information and insights that providers, payers, and other stakeholders can use to improve health services.

The Division of Public Health contracted with Stonewall Analytics to complete a "Telehealth Environmental Scan." Final reporting was presented on September 25, 2020. Recommendations were passed on to the state's Telehealth Task Force which researched and explored rates of adoption, various uses, innovations, and challenges associated with integrating telehealth services into patient care. In December 2020, telehealth and remote patient monitoring were integrated with IHDE to help increase remote access to essential healthcare services.

IDHW leaders were already planning to invest in telehealth for patients with behavioral health needs, but when the COVID-19 pandemic began, CMS changed the rules for telehealth, and this plan materialized very quickly:

> *"For telehealth, the pandemic just sort of came—the waiver got approved right in the middle of the pandemic. We were like, "Yeah, take the lid off of telehealth, anyway." I think it's remaining off. That part became more aggressively resolved than we'd anticipated, just as a COVID response."*

Providers are not always supportive of telehealth services particularly for patients with SUDs, especially in the group therapy setting, and for patients with psychiatric disease:

> *"I've always found .,.. problems with being able to hear, connect, see the person you're talking to and actually just develop a good rapport with your provider, which is important in psychiatric care and counseling and therapy and things like that."*

However, Idaho's governor signed an executive order in June 2020, making more than 150 emergency telehealth rules (initiated to respond to the COVID-19 pandemic) permanent. Many of these rules focus on expanding connected health platforms to improve access to care. In March 2021, IDHW saw utilization increases outside of telehealth which correlated with pandemic restrictions lifting and with vaccination availability to Idahoans.

Work accomplished after Midpoint assessment timeframe of April 2020 to March 2022:

The new IBHP contract will require behavioral health providers to utilize software for care coordination. Idaho's 1115 BHT Team was notified that the State's Medicaid Health Information Technology (HIT) Plan had been submitted to CMS in March 2022.

In August 2022, the IDHE filed for Chapter 11 bankruptcy protection in response to a lawsuit filed by an out-of-state contractor. According to the IDHE, this filing allows IDHE to continue operations and to resolve any outstanding contract disputes. The full impact of this on health IT is being assessed by the IDHW and will be reported in the interim report.

Work to be pursued by IDHW in the future:
Continued expansion of HIE and services to behavioral health providers, sharing of mental health and substance use disorder information with patient approval, and coordination across the continuum of care is delayed due to the previously mentioned bankruptcy of the IHDE. There is lack of a strategic vision regarding HIT and data, and it is unclear how this will proceed. Progress will be reported in future reports.

CHAPTER 3

Idaho's Progress on Milestones and Metrics

In this chapter we assess Idaho's progress in meeting the milestones in the CMS approved evaluation plan. As described in Chapter 1, we undertake a mixed-methods approach that combines both quantitative and qualitative research methods.

We assess progress on each milestone separately. First, using data provided by IDHW, we assess changes associated with each metric. We then incorporate findings on milestone progress from key informant interviews by highlighting factors that could affect performance on specific milestones and metrics.

MPA Methodology for Assessing Progress

Performance Measures

The evaluation plan developed by Penn State in consultation with IDHW and approved by CMS specifies each of the SUD and SMI/SED performance metrics to be tracked throughout the demonstration period. The metrics are based on the goals and milestones laid out in the approved Idaho BHT Waiver. Three tables below summarize the metrics:

- Table 3.1: SUD care metrics
- Table 3.2: SMI/SED care metrics
- Table 3.3: cost analysis metrics

For each metric we describe the goal and milestone, the research question that the metric corresponds, the level of data to be used, and the hypothesized direction of the targeted change (i.e., hypothesized increase or decrease in demonstration period relative to baseline period).

Quantitative Results SUD Milestones

All tables referenced in this section can be found in Appendix D. Based on data provided, we include the terms substance use disorder (SUD), alcohol use disorder (AUD), opioid use disorder (OUD), and alcohol and other drug use disorder (AOD). While there can be some overlap conceptually between SUD and AOD, we note here that SUD tends to be defined as it is in the HEDIS measures and AOD tends to be defined as the following HCPCS codes H0020, H0033, J0570-J0575, J2315, Q9991, Q9992, and S0109.

SUD Milestone 1: Access to critical levels of care for OUD and other SUDs

Results (Table E.1)
We note a relatively short baseline period of Q1 2020 as it is the only quarter that includes Medicaid expansion but not the Idaho BHT Waiver. As described above, when more granular, individual-level data become available, we intend to expand the baseline period for the population that was eligible prior to Medicaid expansion in January 2020.

We examined changes in the number of beneficiaries initiating SUD treatment, which we defined as the number of beneficiaries receiving MAT or SUD-related treatment services during the measurement period but not in the preceding three months. The three-month washout period is used to focus on treatment initiation. We observed an initial, large decrease in SUD treatment initiation from 1,446 beneficiaries in the baseline period to 944 beneficiaries in DY1 (-34.7% from baseline) and 1,103 beneficiaries in DY2 (-23.7% from baseline). Although not a metric required by CMS, we included this measure as an important dimension of measuring treatment engagement since total treatment includes both ongoing and new patients. Thus, beneficiaries initiating SUD treatment captures outreach and engagement with new patients.

We believe two factors may explain this result. The first is a mechanical issue – the large number of beneficiaries initiating SUD treatment between January and March 2020 is likely a result of Medicaid expansion. Because these individuals were not in Medicaid prior to 2020, they would be classified as initiating treatment even if they had been undergoing treatment previously but were not covered by Medicaid. This would effectively inflate the treatment initiation numbers in the baseline period (given the definition of initiation). As a result, the number initiated would be likely to fall in subsequent periods once patients are in treatment covered by Medicaid (i.e. it becomes treatment, not initiation). Unfortunately, with the data available we were not able to determine the extent of this issue, but we will be able to do so in future analyses using individual-level data. The second potential issue is the COVID-19 pandemic that may have made it more difficult to initiate treatment.

For several of the other categories of care, we see a different pattern. For outpatient services, intensive outpatient and partial hospitalization services, and residential and inpatient services we observed increases from baseline to DY1 and DY2. Outpatient and intensive outpatient/partial hospitalizations continued to increase from DY1 to DY2. However, residential and inpatient services dropped significantly between DY1 and DY2, although remaining higher relative to baseline. Part of this may have been due to a dispute over the interpretation of ASAM levels of care and approved lengths of stay, which led to a period where two IMDs did not admit Medicaid beneficiaries.

Relative to the baseline period of Q1 2020, we observed consistent increases in the number of beneficiaries receiving MAT. Specifically, relative to baseline, numbers increased by 62.6% in DY1 and 137.3% in DY2. Some part of this is likely explained by gradual engagement of newly enrolled SUD beneficiaries who became eligible after Medicaid expansion. Despite an increase in beneficiaries receiving MAT, we observed a decline in adherence (i.e., % of adults with MAT with at least 80% medication possession ratio (MPR, a commonly used measure of medication adherence) or 80% of days after initiation for which the patient had received MAT). We note this is a slight departure from the original metric which was adults with at least 180 days of continuous treatment. We changed the metric because in the data we received, we observed no patients with 180 days of continuous MAT--while part of this may have been a data reporting issue, the concern was the metric was not sensitive enough to observe any changes.

While it is concerning that MAT adherence (continuity of pharmacotherapy) declined, we did observe increased rates of MAT re-engagement (defined as beneficiaries with a gap of at least 30 days of MAT that then have a subsequent MAT fill, illustrated in Figure E.2) as well as increases in MAT utilization. Additional individual-level data will help to determine what might be driving these findings. For example, we will be able to better determine whether declines in adherence might be related to the pandemic and whether the increases in re-engagements and broader MAT utilization where related to Medicaid expansion or more directly tied to changes resulting from the Idaho BHT Waiver.

Finally, because early intervention services were not up and running at this point, we do not see any utilization of early intervention services in this time period.

It is not clear how much the COVID-19 pandemic and the associated isolation may have played a role in the exacerbation of treatment needs for Medicaid enrollees with SUD. Results are suggestive that those already receiving treatment and with a connection to the behavioral health treatment system may not have experienced the same drop in care as those trying to initiate SUD treatment. Further, while treatment initiation lagged (also likely in part due to a definitional issue described above), it did start to rebound and increase slightly at the beginning of 2022 relative to the baseline. For the MPA, we believe Idaho is on track with SUD treatment initiation and utilization, especially as COVID-19 related declines in SUD treatment initiation appear to be moving in the right direction.

SUD Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria

Results (Table E.2)
Medicaid beneficiaries treated for SUD in an IMD dropped from 668 in DY1 to 364 in DY2 (note: because IMD care is not covered by Medicaid prior to the Waiver we do not have Medicaid claims data for the baseline period). Second, average length of stay (ALOS) for SUD care in an IMD dropped from 7.0 days in DY1 to 4.6 days in DY2. Although promising and possibly consistent with patients receiving care in the appropriate setting, we were not provided with sufficiently detailed data to follow individual care trajectories.

SUD Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Since there are no metrics assigned to SUD Milestone #3, there are no results to report.

SUD Milestone 4: Sufficient Provider Capacity at Each Level of Care, Including MAT

Results (Table E.4)
We observed noticeable increases in each of the available measures of SUD provider availability. The number of providers registered with Medicaid to provide SUD treatment increased from 1,620 providers in the baseline period (2018-2019 since only annual data were available) to 2,655 in DY1, and then down slightly to 2,509 in DY2 (although still significantly above baseline). Similarly, we observed increases in Medicaid-enrolled SUD service providers who have met MAT prescribing standards from 204 at baseline to 586 in DY1 and 595 in DY2. The number of community-based SUD service providers increased from 207 at baseline (i.e., Q1 2020 since quarterly data are available) to 250 in DY1 then down slightly to 243 in DY2. Patient satisfaction increased 17-20% relative to the baseline period of Q1 2020.

Overall, Idaho appears to be making positive progress in ensuring there are sufficient providers available to treat the growing number of Medicaid enrollees with SUD. For each category of provider for which data were available, we observed increases in the number of providers. Given the difficulties in recruiting and retaining providers who can treat SUD patients, this is a promising direction. It is not clear what is driving the increase – more providers moving to the area, more existing providers able to treat SUD patients, or more existing providers enrolling in Medicaid, etc. That patient satisfaction was maintained if not slightly increased also shows sufficient progress in that new providers appear to be meeting patient satisfaction.

SUD Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Addiction and OUD

Results (Table E.5)
We observed promising declines in rates of risky opioid prescribing (i.e., ≥90 MME), opioid prescriptions from multiple providers (i.e. from at least 4 providers and pharmacies). Specifically, from the baseline in 2018-2019, we observed declines for both DY1 and DY2 for rates of high dosage opioid prescriptions filled, high dosage prescriptions from multiple providers, and concurrent prescriptions for opioids and benzodiazepines, which have a high risk for overdose.[31] It remains to be seen how much of this is due to the demonstration itself vs. broader national trends towards less risky prescribing. However, the declining rates appear to show evidence of sufficient progress for meeting this milestone. Data on

overdose death rates were not available to the evaluation team at the time of this report. So, while data exist and will be included in subsequent reports, we are not able to report on this outcome here.

Finally, ED visits for SUD have increased 25.6% in DY1 compared to baseline and 57.5% in DY2 compared to baseline. Given the short baseline period, one methodological concern is that we are not able to capture seasonal variation in ED visits. With more granular data we expect to obtain more precise estimates. However, the increase in SUD ED visits is also consistent with broader national trends showing increases in overdose rates during the pandemic. Overall, this remains a target of concern, as it does throughout the US,[26-28] but we believe it is unlikely that this increase is a result of Idaho's BHT Waiver demonstration. Further, the increase in treatment rates suggests a promising pattern that hopefully continues with impacts on future ED visit rates.

SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care

Results (Table E.6)

We find consistent increases in both alcohol and opioid treatment initiation and engagement, both of which are positive findings. Treatment initiation is defined as the percentage of beneficiaries who initiate treatment within 14 days of an initial diagnosis; whereas engagement is defined as the percentage of beneficiaries still engaged in care within 34 days of the initiation visit. Relative to baseline, we observe 15-20% increases in alcohol treatment initiation, 25-36% increases in alcohol treatment engagement, 21-23% increases in opioid treatment initiation, 39-61% increases in opioid treatment engagement. We estimate more mixed results for other drug treatment initiation or engagement. Relative to baseline, we see increases in DY1, 13.9% for initiation and 17.8% for engagement. But then slight decreases in DY2 - 2.5% lower initiation and 1.5% lower engagement relative to baseline.

We see increases in rates of SUD treatment follow-up following an ED visit (14-18% within 7 days and 16-20% within 30 days), but not for follow-up after a mental illness ED visit. We see few changes in readmission rates for SUD beneficiaries. While there is an initial decline of 5.1% in DY1 relative to baseline, rates rise 1.5% in DY2 relative to baseline.

Although it does not address a research question, we note two additional outcomes listed as critical metrics by CMS. First, we find that initiation for alcohol, opioid, and other drug dependence treatment (i.e., any treatment for a new AOD episode) goes from 52.1% in CY 2020 to 47% in CY 2021; and treatment engagement (i.e., any treatment within 34 days of the initiation visit) goes from 31% in CY 2020 to 28% in CY 2021. Due to data limitations, we only have CY measures so note that CY 2020 includes both pre- and post-BHT Waiver demonstration periods.

Key Takeaways:

The demonstration appears to show promising increases in MAT utilization. Although declines in adherence are worth noting and monitoring, the declines may stem in part from newly initiated patients as well as COVID-related disruptions in care. The increase in MAT re-engagements further suggests that MAT utilization is making progress.

Overall, Idaho appears to be making sufficient progress for these milestones – either showing increases in ED visit follow-up and medication adherence or largely maintaining baseline rates of readmissions and preventive care utilization.

SUD Performance Metrics

Table 3.1 SUD Performance Research Questions included in Mid-Point Assessment

Milestone	Research Question	Metric/Outcome	Target Trend Hypothesized	Data Availability
Milestone 1: Access to critical levels of care for OUD and other SUDs	1.1 Did early intervention services for SUD increase during the demonstration period?	Number of beneficiaries who used early intervention services for SUD during the measurement period.	Increase	Quarterly
	1.2: Did outpatient services increase during the demonstration period?	Number of beneficiaries who used outpatient services for SUD during the measurement period	Increase	Quarterly

	1.3: Did intensive outpatient and partial hospitalization services increase during the demonstration period?	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD during the measurement period	Increase	Quarterly
	1.4: Did residential and inpatient services increase during the demonstration period?	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Increase	Quarterly
	1.5: Did MAT services increase during the demonstration period?	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Increase	Quarterly
	1.6: Did continuity of pharmacotherapy for OUD increase during the demonstration period?	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment.	Increase	Quarterly
Milestone 2: Widespread use of evidencebased, SUDspecific patient placement criteria	2.1: Did Medicaid beneficiaries treated in an IMD for SUD decrease during the demonstration period?	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period	Decrease	Annual
	2.2: Did average length of stay (ALOS) in IMDs decrease during the demonstration period?	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD	Decrease	Annual
Milestone 4: Sufficient provider capacity at each level of care, including MAT	4.1: Did SUD provider availability increase during the demonstration period?	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Increase	Annual
	4.2: Did SUD provider availability for MAT increase during the demonstration period?	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Increase	Annual

Milestone	Research Question	Metric/Outcome	Target Trend Hypothesized	Data Availability

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid addiction and OUD	5.1: Did use of opioids at high dosage in persons without cancer (OHD-AD) decrease during the demonstration period?	The percentage of beneficiaries aged 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Decrease	Annual
	5.2: Did use of opioids from multiple providers in persons without cancer (OMP) decrease during the demonstration period?	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Decrease	Annual
	5.3: Did use of opioids at high dosage and from multiple providers in persons without cancer (OHDMP)decrease during the demonstration period?	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Decrease	Annual
	5.4: Did concurrent use of opioids and benzodiazepines (COB-AD) decrease during the demonstration period?	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Decrease	Annual
	5.5: Did emergency department utilization for SUD per 1,000 Medicaid beneficiaries decrease during the demonstration period?	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period.	Decrease	Quarterly
	5.6: Did overdose death rates decrease during the demonstration period?	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration.	Decrease	Not Available
Milestone	Research Question	Metric/Outcome	Target Trend Hypothesized	Data Availability

Milestone 6: Improved care coordination and transitions between levels of care	6.1: Did initiation and engagement of alcohol and other drug dependence treatment (IET-AD) increase during the demonstration period?	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit	Increase	Annual
	6.2: Did follow-up after emergency department visit for alcohol and other drug abuse or dependence: age 18 and older (FUA-AD) increase during the demonstration period?	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence.	Increase	Annual
	6.3 Did follow-up after emergency department visits for mental illness: age 18 and older (FUMAD) increase during the demonstration period?	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) addiction or dependence who had a follow-up visit for AOD addiction or dependence.	Increase	Annual
	6.4: Did readmissions among beneficiaries with SUD decrease during the demonstration period?	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.	Decrease	Annual

SMI/SED Milestones

All tables referenced in this section can be found in Appendix D.

SMI/SED Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

Results (Table E.7)
We observed increases in the quarterly average number of patients with a SMI/SED diagnosis who received any behavioral health care. Relative to the baseline period of Q1 2020, we observed a 5.6% increase in DY1 and a 14.7% increase in DY2. It is difficult to determine how much this results from the Idaho BHT Waiver and how much from the COVID-19 pandemic that had clear impacts on mental health and related care.[32] While use of first-line psychosocial care for children and adolescents on antipsychotics is a critical metric as defined by CMS, we did not receive data to assess this outcome and since an amendment for adding the under 21 population is under consideration we are holding off on outcomes related to this population.

SMI/SED Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

Results (Table E.8)
Promisingly, we observed declines in 30-day all-cause unplanned readmissions for patients discharged from a SMI/SED inpatient stay from baseline (2018-2019) to both DY1 and DY2. The decline was 8.4% relative to baseline in DY1 and while the readmission rate ticked back up slightly in DY2, it remained 6.5% lower than baseline. While some part of this might be explained by changing patterns of patients following Medicaid expansion (i.e. patients treated for SUD[33-35] under Medicaid expansion may have different patterns than those eligible for Medicaid prior to 2020), it appears Idaho is making sufficient progress on this milestone.

In addition to these outcomes, we report several critical metrics listed by CMS. The first is follow-up rates after hospitalization for SMI/SED. We found the 7-day follow-up rates increased from 31% in CY 2020 to 32% in CY 2021. Similarly, 30-day follow-up rates increased slightly from 48% in CY 2020 to 49% in CY 2021. Follow-up within 7 days after emergency department visits for AOD went from 32% in CY 2020 to 31% in CY 2021; while 30-day follow-up rates remained the same at 39% in CY 2020 and CY 2021. Follow-up visits after emergency department visits for SMI went from 60% in CY 2020 to 62% in CY 2021 for 7-day follow-up; and 72% in CY 2020 to 74% in CY 2021 for 30-day follow-up. These results appear promising.

We again were limited by data we received to only be able to look at these rates by calendar year, so CY 2020 includes both pre- and post-BHT Waiver periods.

SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Results (Table E.9)
From baseline to DY1 and DY2 we observed increases in mental health services utilization-inpatient and intensive outpatient/partial hospitalization SMI/SED care but declines in mental health services utilization-ED, outpatient rehabilitation care for SMI/SED, and crisis services utilization. Inpatient and ED care for SMI/SED are in the hypothesized direction, but outpatient rehabilitation is not. It is difficult to determine without more detailed data what might have driven the somewhat unexpected drop in crisis

services – e.g., whether it is a drop in need or potential issues with access. Moving forward 988 services might be important, but those did not go into effect until 2022 so unlikely to explain the drops in both DY1 and DY2. More broadly, as Idaho reprocures the IBHP contract there is the hope that SMI/SED care will continue to shift towards outpatient options as appropriate (since one goal of the new managed care contract is to fold in inpatient care to further incentivize coordination of care and having patients receive care in the most appropriate but also least intensive location). We also note part of the increase in mental health services utilization-inpatient and intensive outpatient/partial hospitalization care for SMI/SED may have stemmed from COVID-related issues.

Similar to SUD, we also report average length of stay in an IMD, which is a critical metric but not one of our research questions. We find average length of stay declined from 8.7 days in DY1 to 7.3 days in DY2. Again, we do not have data for the baseline period as Medicaid claims data are not available for IMD stays.

SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Results (Table E.10)
We had limited data available to assess progress on these metrics—we only had data available for about half of the metrics included for assessment in the original evaluation plan. Our assessment focused only on availability of community-based behavioral health services (i.e., community-based rehabilitation services, which is an internal metric defined within the Optum database), availability of crisis care, and availability of behavioral health services at federally qualified health centers (FQHCs). All these outcomes appear to be positive – we observed increases in community-based behavioral health services in DY1 and DY2 compared to baseline; and relatively constant rates of crisis services and behavioral care at FQHCs in DY1 compared to baseline (we did not have data for DY2). While we did not have data on the number of providers who make virtual visits available, we did find that the number of beneficiaries who had a virtual visit (for behavioral health services) went from 575 (baseline) to 2,968 (+416.2 % in DY1) back down to 2,233 (+288.3 % in DY2). This is suggestive of increased availability of telehealth services, although much of this increase is likely due to the rule changes brought on by the COVID-19 pandemic. Although the metric is intended to be the number of providers, this was not available. The next best approach, we believe, is to examine utilization.

One limitation is that Optum provides estimates of community-based rehab services, which they define as “services provided to you by a behavioral health professional in your home or community to help you learn and practice the skills you need to support your overall wellness and independent living abilities." However, it is not clear how they have operationalized this definition, which can make it difficult to replicate or verify these estimates. This is particularly important when we move from aggregate data to our preferred, future analyses using individual-level data.

SMI/SED Milestone 4: Earlier Identification and Engagement in Treatment, Including through Increased Integration

Results (Table E.11)
Currently, the data to assess progress on this metric are not available. These data are expected to become available in the next reporting period.

In terms of outcomes that are CMS-defined critical metrics but not research questions (so not in Table E.11), data show that over 99% of patients had a preventive or ambulatory care visit within the year for Medicaid beneficiaries with SMI in both CY 2020 and 2021. This level of contact with the health care system is good but provides limited details on the types of care received. We also found steady rates of follow-up care for adult Medicaid beneficiaries newly prescribed an antipsychotic medication – rates of 68% in CY 2020 and 69% in CY 2021.

Key Takeaways:

Idaho appears to be making sufficient progress toward meeting milestones 1 and 2. Progress toward meeting milestone 3 appears less clear. We were unable to determine progress on Milestone 4 due to a lack of data.

SMI/SED Performance Metrics

Table 3.2 SMI/SED Performance Research Questions included in Mid-Point Assessment

Milestone	Research Question	Metric/Outcome	Target Trend Hypothesized	Data Availability
Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	7.1: Did utilization of behavioral health treatment services increase during the demonstration period?	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.	Increase	Quarterly
Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	8.1 Did the number of enrollees receiving care from co-located physical and behavioral health facilities increase during the demonstration period?	The number of enrollees receiving care from co-located physical and behavioral health facilities	Increase	Not Available
Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	9.1: Did mental health services utilization increase in inpatient settings during the demonstration period?	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.	Increase[1]	Quarterly
	9.2: Did mental health services utilization increase in intensive outpatient and partial hospitalization settings during the demonstration period?	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.	Increase[2]	Quarterly
	9.3: Did mental health services utilization increase in ED settings during the demonstration period?	Number of beneficiaries in the demonstration population who utilized ED services for mental health during the measurement period.	Decrease	Quarterly

	9.4: Did crisis service utilization increase during the demonstration period?	Number of crisis calls related to SMI/SED services.	Decrease	Quarterly
	9.5: Did outpatient rehabilitation increase during the demonstration period?	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period.	Increase	Quarterly
	9.6: Did case management increase during the demonstration period?	Cannot break down from any service.	Increase	Not Available
	9.7: Did home and community services increase during the demonstration period?	See 9.6	Increase	Not Available
Milestone	Research Question	Metric/Outcome	Target Trend Hypothesized	Data Availability
	9.8: Did long-term services/supports increase during the demonstration period?	See 9.6	Increase	Not Available
Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	10.1: Did availability of community-based behavioral health services (overall, outpatient, inpatient/residential, officebased) increase during the demonstration period?	The number of community-based behavioral health services (overall, outpatient, inpatient/residential, office-based) per 1000 members	Increase	Quarterly
	10.2: Did suicide rates decrease during the demonstration 2022 period?	Suicide or Overdose Death Within 7 and 30 Days of Discharge from an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries with SMI or SED (count/rate)	Decrease	Not Available
	10.3: Did availability of virtual visits increase during the demonstration period?	The number of providers delivering telehealth services per 1000 members	Increase	Not Available
	10.4: Did availability of clinics with co-located physical and behavioral health providers increase during the demonstration period?	The number of clinics with co-located physical and behavioral health providers per 1000 members	Increase	Not Available
	10.5: Did availability of crisis care (overall; crisis call centers; mobile crisis units; crisis assessment centers; coordinated community response teams) increase during the demonstration period?	The number of crisis care service facilities per 1000 members?	Increase	Annual
	10.6: Did availability of behavioral health in FQHCs increase during the demonstration period?	Number of FQHCs with behavioral health services available	Increase	Annual

	10.7: Did per capita availability of outpatient mental health professionals, by type (e.g., psychologists, social workers) increase during the demonstration period?	The ratio of the number of outpatient mental health professionals and the number of members.	Increase	Not Available*
Milestone 2: Improving Care Coordination and Transitioning to CommunityBased Care	11.1: Did 30-day readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF) increase during the demonstration period?	The number of 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	Decrease	Annual

[1] Increase due to access while acknowledging issue that longer run not clear an increase is desirable.
[2] Particularly relative to those receiving care in the inpatient/ residential setting.
*10.7 See limitations, baseline data cannot be defined with available data.

Budget Neutrality Metrics

Results of Performance on Budget Neutrality

One important stipulation of the Idaho BHT Waiver is that behavioral health spending (i.e., SUD and SMI/SED) not exceed hypothetical, projected spending. In other words, the Idaho BHT Waiver is expected to meet budget neutrality expectations. In this section, we review the Budget Neutrality Workbooks reported to CMS (specifically the most recent report from Year 2, Quarter 3–retrieved February 2022).

Separately for SUD and SMI/SED spending, the tables below report spending both under the Waiver as observed as well as hypothetical, projected spending "without waiver". Because a major component of the Idaho BHT Waiver is to allow Medicaid funds to cover IMD care, the "without waiver" spending projects what spending would have been without the waiver but allowing for IMD care to be covered. Below we present three sets of tables from the latest Budget Neutrality Report: (a) Projected Expenditures Without the Waiver for SUD and SMI/SED [Table E.19a]; (b) Expenditures with the Waiver for SUD and SMI/SED [Table E.19b]; and (c) an initial budget neutrality test [Table E.19c].

For the budget neutrality test, project spending without the waiver is compared to actual spending for DY1 and DY2 and projected for the remaining years. As the tables show, spending appears substantially lower with the waiver compared to projections without the waiver. Idaho appears to be hitting their budget neutrality targets – here defined as the cumulative target percentage (CTP) multiplied by the total "without waiver" spending for SUD and SMI/SED. While the target is supposed to have actual spending move towards projected "without waiver" spending, Idaho appears to already be well below this target. The large difference is likely in part due to different spending patterns for those eligible for Medicaid prior to expansion vs. after expansion.

Budget Neutrality Performance Measures

Table 3.3 Budget Neutrality Research Questions included in Mid-Point Assessment

Category	Research Question	Metric/Outcome	Trend	Data Availability

SUD	13.1: Has total spending for SUDrelated care changed over the 1115 waiver demonstration period?	Total spending for SUDrelated care	Decrease per capita	Annual
SMI/SED	13.2: Has total spending for SMI/SED-related care changed over the 1115 waiver demonstration period?	Total spending for SMI/SEDrelated care	Increase	Not available
SUD	13.3: Has total spending by site of care for SUD-related care changed over the 1115 waiver demonstration period?	Total spending for SUDrelated care by inpatient/residential, outpatient, prescription drug	Shift away from inpatient/residential	Not available
SMI-SED	13.4: Has total spending by site of care for SMI/SED-related care changed over the 1115 waiver demonstration period?	Total spending for SMI/SEDrelated care by inpatient/residential, outpatient, prescription drug	Shift away from inpatient/residential	Not available
SMI/SED	13.5: Has total federal spending changed over the 1115 waiver demonstration period (including both FMAP for SUD and SMI/SED care as well as additional administrative costs)?	Total federal spending (including both FMAP for SUD and SMI/SED care)	Stable	Annual

Provider Availability Assessment

Generally, Idaho appears to be maintaining provider availability. The number of hospitals, mobile units, and crisis units have held constant, although we also observed a small decline in the number of inpatient psychiatric hospital beds. The number of FQHCs increased slightly. We observed slight increases in the number of Medicaid-enrolled psychiatrists, although drops in overall psychiatrists. More promising, we saw significant increases in the number of Medicaid-enrolled providers offering intensive outpatient services and "other" (i.e., non-psychiatrist) behavioral health providers.

Overall, we believe Idaho is making sufficient progress, especially as states nationwide face behavioral health provider crises. Maintaining availability for some types of care while increasing some is promising. However, there are two lingering concerns. First, inpatient care, crisis services, and community-based care are all dimensions that Idaho is still focusing on increasing availability. Second, there are still large concerns about availability of care in the rural and frontier areas. We note in the key informant interviews that a significant amount of attention was paid to both the IBHP managed care contract and managing COVID-19 related difficulties. As the managed care contract becomes finalized, Idaho can continue to refocus attention on the goal of increasing provider availability, which we certainly acknowledge is an issue facing many states.

Results of Performance on Availability of Practitioners Metrics (Table E.12)

Although we observed an overall decrease in the number of psychiatrists in the state (from 115 in 2019 to 93 in DY1), we observed a slight increase in the number of psychiatrists enrolled in Medicaid (an increase from 80 to 84). This is despite broader national trends of fewer psychiatrists accepting Medicaid[29] and psychiatrists being the specialty with the lowest Medicaid enrollment rates.[30]

In addition, there was a 7.5% increase in the overall number of other behavioral health practitioners and a larger 17.6% increase in Medicaid enrolled other behavioral health practitioners. Although this increase

is promising, only 27% (i.e. 1,927 of 7,099) of these other behavioral health practitioners appear to be enrolled in Medicaid.[29,30]

Not shown here, but there were no community mental health centers in Idaho within the timeline of this report, April 17, 2020 through March 31, 2022 although our understanding is that this is in progress.

Results of Performance on Availability of Intensive Outpatient, Residential, IMD, and Outpatient Treatment Metrics (Tables E.13, E.14, and E.15)
We observed sizeable increases in the number of provider locations offering intensive outpatient and partial hospitalization providers, which went from 14 in 2019 to 38 in DY1. We observed no changes in the number of residential mental health treatment facilities or beds between 2019 and 2020. Similarly, we observed no changes in the number of IMDs with the same three available at both baseline and DY1. Given the capital intensity of expanding these services (i.e., it takes significant financial investment to expand or build new facilities), it is not surprising no change was observed in one year, especially the first year of the COVID-19 pandemic. Therefore, Idaho appears to be meeting progress milestones.

Results of Performance on Availability of Inpatient Services Metrics (Table E.16)
We observed no change in the availability of inpatient behavioral health services. This included no change in the number of hospitals, the number of licensed psychiatric hospital beds, and the number of Medicaid enrolled licensed psychiatric hospital beds.

Results of Performance on Availability of Crisis Stabilization Services Metrics (Table E.17)
We observed no change in crisis stabilization services between baseline and DY1. In both years, there were 16 crisis call centers, 7 mobile crisis units, 9 crisis observation/assessment centers, but no crisis stabilization units or coordinated community crisis response teams. We expect these numbers to increase in future years as Idaho continues the push to expand crisis care and community crisis response teams.

Results of Performance on Availability of Federally Qualified Health Centers (FQHC) Metrics (Table E.18)
We observed a small increase in the number of FQHC service locations, which increased from 46 in 2019 to 47 in DY1. This appears to be in line with progress towards this milestone.

Key Takeaways
Overall, Idaho appears to be either maintaining or growing its behavioral health workforce and thus making sufficient progress for this milestone.

Key Informant Interview Findings – Stakeholder Input

To complement the findings from the quantitative analyses, we present findings from a secondary document review and key informant interviews.

Between February and May of 2022, Penn State engaged in 12 key informant interviews. More details on the approach are above in the Qualitative Methods Approach section in Chapter 1. Below we summarize the emerging themes that were identified during qualitative analysis and incorporate representative, de-identified quotes from the interviews. The key themes are: (1) the Idaho behavioral health managed care plan and ongoing procurement process; (2) the importance of Medicaid expansion in the Idaho BHT

Waiver process; (3) development/design of Idaho's BHT Waiver demonstration; (4) implementation of Idaho's BHT Waiver demonstration; (5) challenges and barriers to implementation; (6) the impact of the COVID-19 pandemic; and (7) initial lessons learned.

(1) Idaho Behavioral Health Managed Care Plan and Ongoing Procurement Process

One important area highlighted by both the secondary documents and key informant interviews was the intended changes to the IBHP. Many of the goals of the Idaho BHT Waiver (e.g., improved coordination of care, patients receiving care in the most appropriate setting, providing cost-effective care, etc.) are, in part, contingent on these goals being directly incorporated into the managed care contract, itself.

A respondent reported that the contract for the IBHP needs to be in place to accomplish the BHT goals: "There's a lot of areas in our implementation plan that we put—we're dependent on the procurement." Negotiations are in progress and the new IBHP is intended to "make major changes to the state's behavioral health service delivery system," specifically, the new contract will expand to include inpatient care delivery and the "inpatient hospitals…will be part of the provider network." The goal of covering inpatient services is to focus on care coordination, i.e., helping a patient "transition through certain levels of care or come from an inpatient setting down into the community provider network." Most recently, while the plan was to have the contract awarded by the end of the 2022 calendar year, several legal hurdles have delayed finalization of the contract.

(2) Medicaid Expansion and the Idaho BHT Waiver

Medicaid expansion in Idaho went into effect on January 1, 2020. Although enrollment began on November 1, 2019, coverage did not begin until the beginning of 2020. This was described as "fairly late in terms of Medicaid expansion" by one respondent. One factor contributing to the delay was the lack of support from the legislature, which meant supporters of expansion focused instead on a ballot initiative advanced by a citizen group that took several years to pass. As one respondent described the process:

> *"[Medicaid expansion] was really a grassroots [effort]. It was voted on the ballot, and it wasn't something that came down from leadership. It took two years to get it through… it definitely was a movement of the people, I would say, to get Medicaid expansion put in place…"*
> *"Reclaim Idaho" really did a grassroots effort funded by… [b]ig group that works on Medicaid expansion nationwide. We're successful in getting a ballot initiative the same year that Governor Little got elected in 2018…. The Idaho Hospital Association was a key funder. The Medical Association was also a supporter of it. The Hospital Association was out in front, and they really caught a lot of flak for it. The legislature was not happy with that ballot initiative. It passed by such a wide margin."*

Once passed, the expansion meant Medicaid was the primary payor for thousands of newly eligible residents, and as a respondent pointed out: "One of the recognized populations that that impacted the greatest was the behavioral health population, people with [severe] mental illness and addiction." The state initially expected total enrollment to cap at 91,000[6] but the COVID-19 pandemic boosted the increase to approximately 121,000[7] by March 2022. While DBH provided some behavioral health services prior to Medicaid expansion, expansion meant those newly eligible for Medicaid would have these services covered by Medicaid. So a realistic question emerged as described by one respondent, "…how do you find the resources to pay for that…?":

"[The waiver] makes the services delivered in IMDs, Medicaid reimbursable. The waiver itself fostered an opportunity, kind of gave us the direction, and probably some resources with the savings to be able to create a more comprehensive array or continuum of care to include like partial hospitalization … and intensive outpatient services, those kind of things."

Again, another respondent echoed that Medicaid expansion "did add a significant amount of individuals to our program" and went on to explain the implications and plans for the Idaho BHT Waiver:

"When we expanded Medicaid, we knew that there were a lot of adults that were probably underserved. The ability for us to treat them effectively in the community, already being a professional health shortage area in behavioral health, we understood that there is most likely going to be a magnification on that shortage area, really, because you've got a significant amount of individuals becoming eligible for Medicaid services…. We didn't understand what that would look like. We knew that we had limited hospital space for psychiatric admissions, ER admissions, so looking at the IMD, and the SUD and SED side of it—or, excuse me, SMI, we thought that it would really help us drive, one, building out a good continuum of care for both SUD and mental health. Two, it would open up some additional opportunities for us to treat individuals in a more appropriate setting at a lower cost. Instead of having individuals show up at an ER, be admitted into a hospital setting for the psychiatric unit and us paying over $1,000 a day for that admission, if these individuals could be admitted to an IMD, then we could treat them more effectively with more focus on their SUD or mental health disorder and do that at a lower cost. Again, back to that least restrictive setting, and again, also the lower cost perspective is really important there as well."

A respondent on the provider side emphasized that the Medicaid expansion and Idaho BHT Waiver increased the ability to bill for more services. Prior to the waiver, if a patient did not have resources to pay, the State's general funds and consequently the State Hospital's funding would be impacted: "… definitely, with the IMD waiver and stuff that one thing that helped for us was being able to bill for those services…. All of it was funded through the state general fund dollars. If the patient didn't have the resource, and things would have to write it off, and then it would end up happening the hospital was funded through state general funds." Now the Idaho BHT Waiver changes where the reimbursement comes from—i.e., rather than the state's general fund, the State Hospital can now bill Medicaid. Most notably, for the first time since 1965, Idaho's BHT Waiver provides federal matching dollars for IMD stays, with certain requirements as outlined in this CMS communication of 2018.[36]

(3) Development and Design of the Idaho BHT Waiver

Primary Benefit of the waiver from IMD perspective: How to Best Care for and Pay for IMD Care with More Individuals Eligible for Medicaid

One respondent stated that from the vantage point of the IMD, because of the Idaho BHT Waiver and the increased number of Idahoans eligible under Medicaid could be admitted to an IMD because of the ability to access federal matching dollars:

"…the primary benefit [of the 1115 waiver] is that we're here to take care of people. We're here to take care of patients. The majority of people who are adults who are falling under this umbrella are people that otherwise would not have been able to access care.

There's a minor financial benefit, but nobody's making money off of Medicaid, let's be honest. When you have lower income population, which Idaho is, it's still a very rural state, very low income. Then you also have the opioid epidemic, then you have the methamphetamine epidemic, even though it has not been declared as such it is. You have roughly 150,000 people here in Idaho who desperately needed care, desperately needed help and were not eligible for it, so that was the main motivator behind really getting this waiver going. Was that we're missing a giant segment of the population that does need services, and there's just no way they're going to be able to afford them."

Another respondent reported that although the IMD facilities have the resources and are designed to provide tremendously needed behavioral health treatment, it is not a sustainable business model to have a high census of Medicaid patients: "Medicaid is still our lowest payor. The state, even within the last year, has cut that another eight percent… It was already a very low Medicaid rate. From a business model, it's not a sustainable model for us to have a full occupancy of Medicaid patients."

This respondent expressed a very favorable view of the waiver: "…to have the ability to treat the Medicaid patients within our facilities is a wonderful thing just because there's no other place for these individuals to get care," while simultaneously acknowledging the importance of building "solid outpatient programs" and citing the hospital's commitment to helping establish outpatient continuum of care programs. The respondent said specifically that the waiver "has significantly … expand[ed] IMD access to care for Medicaid enrollees aged 21-64 (adolescent Medicaid patients were already covered for treatment in the IMD setting). For example, because of the waiver, the Medicaid patient population at one IMD has increased to about 47%. Before the waiver, the IMD could only provide treatment to the most acute (Medicaid) cases because the care was uncompensated. In addition to the IMD being committed to helping build up the outpatient network to improve and facilitate care, there is a financial motivation as well – patients need to be transitioned into an outpatient provider's care within seven days of discharge or the IMD faces a reimbursement reduction:

"…we are incentivized, or decentivized [sic], however you want to look at that, to make sure that a patient gets into an outpatient provider within seven days. Well, most of the providers don't have appointments available because they're overwhelmed with the patients that they have. There's just not enough clinics out there. There's not enough access. We have to be creative in partnering with certain programs and encouraging people to make sure that they see our patients within seven days. That becomes challenging. We've been successful with a couple clinics, but it's not always the case."

Medicaid Behavioral Health Primary Treatment Goal: Least Restrictive Level of Care

A respondent stated that Medicaid's primary goal "is to always treat individuals in the least restrictive level of care possible, which would be, our hope, to do so in their homes." The respondent went on to reiterate that while the "rural and frontier" nature of Idaho makes it difficult to have sufficient availability of appropriate providers to care for patients with complex behavioral health needs in the community, "…we are really trying to focus our efforts around building out our … intensive communitybased services such as partial hospitalization programs, intensive outpatient programs, and then the supportive services as well." While the Idaho BHT Waiver allows for Medicaid coverage of IMD services, the broader goal is to ensure patients have access to care at the most appropriate level.

Community-Based Care/Care Transition/Care Coordination

In keeping with Medicaid's "least restrictive level of care" principle to avoid IMD admissions whenever possible, all respondents emphasized and articulated in one way or another that redesigning Idaho's behavioral health care delivery system hopefully will result in the ability and capacity to appropriately and intensively, which is also a CMS requirement to provide care in the least restrictive setting possible:

> *"…treat folks in their community and keep them in their homes, those that are able to sustain a healthy lifestyle in the community….It's something that we are really trying to focus our efforts around building out our intensive … community-based services such as partial hospitalization programs, intensive outpatient programs, and then the supportive services as well…….in the event that someone goes into a really acute psychiatric facility, that there's got to be things in place to transition those participants back to the community. I think that that's what, really, this waiver tries to do…"*

Sometimes inpatient stays are unavoidable and/or necessary; as mentioned, both the new IBHP and Idaho BHT Waiver are centered on care coordination and care transition.

> *"We often, unfairly, force patients and members...to coordinate their own care. I think one of the things that we did through the IMD waiver was to take a second look at that and recognize how the systems need to come together to coordinate that care on behalf of and for the benefit of patients as opposed to forcing them to do it themselves, which creates—it's just a real challenge navigating systems."*

> *"I think a lot of that is going to come with the re-bid [IBHP procurement]. There's a big push towards increased care coordination… We've had conversations with providers around that. There's a big push towards an increased role in the plan in care coordination. I think that makes a lot of sense because care coordination right now is done through a provider network, and it's very haphazard."*

Crisis Centers

One provider attributed funds from the Waiver with enabling the establishment of crisis centers and the coordination of a patient's care between a crisis center and a hospital; the respondent's understanding was "… that was part of the plan is get these crisis centers and that has a lot to do with getting funds in, matched dollars around from the feds and so absolutely could afford and moving into the crisis centers. That has [happened] many times over the last couple of years; individuals have been able to go right from the crisis center to right to one of the hospitals. That's an important impact – positive." While it is not accurate to say that federal matching funds are what allowed funding the establishment of crisis centers, we believe this further highlights some of the disconnect between details of the Waiver and how providers perceived these details.

As noted in Table E.10 of this report, the number of crisis service centers did not change, although it is a target of future availability expansion. The same administrator highlighted the potential benefits of a crisis center as a place for people to get help; a way to decrease emergency room utilization, particularly with the help of law enforcement; 24/7 access to psychiatric providers; and avoid hospitalization if a crisis center would be the appropriate treatment setting with a discharge to an outpatient program.

Law Enforcement Collaboration

A provider respondent shared that discussions and planning on the issues of workforce recruitment/retention, cost reduction, and sustainability related to improving quality of care on the outpatient side are on the right track and added that including the law enforcement perspective is vital. They noted that law enforcement plays an important part on the continuum of care, especially in their role helping individuals who are in crisis and/or visit a crisis center gain access to treatment.

Criminal Justice System and Reentry Centers/Treatment Courts/Medicaid Expansion's Impact on Courts' Budget

One provider respondent complained that the criminal justice system needs to provide increased oversight for the treatment of patients with SUDs – the provider noted that the majority of their patient population is on probation. It seemed to this respondent that many SUD patients lost out with the Medicaid expansion and that the criminal justice system "lost interest in [their] treatment." This provider's opinion is that there is less oversight and fewer referrals to outpatient SUD/Behavioral health providers for parolees with SUDs since reportedly, money from the expansion was invested by the Idaho Department of Correction (IDOC) to open non-residential parolee "reentry centers" – called Connection and Intervention Stations – in Boise, Coeur d'Alene, Twin Falls and Idaho Falls. In 2020, IDOC signed a "three-year, $4.5 million contract with the GEO Group's Reentry Services division.[37] The GEO Group is a real estate trust that invests in private prisons and mental health facilities.

Another respondent said that Idaho is still "very criminal justice focused with our approach to drugs" and that "mental health and substance use issues really permeate so much of what [the courts] do." Idaho has several treatment courts, including mental health and drug courts. An individual who has committed a felony can apply for the appropriate treatment court program which provides services for typically about 1 ½ to 2 years to help the person "get on a good path" – including a provider for behavioral health and SUD treatment. The programs typically accept the applicants most at risk for going to prison (i.e. "This is a last shot of not going to prison to get them in a much better place and back on their feet"). The participants must meet several requirements to successfully complete the program.

A respondent reported that their facility continues to see an increase in patients coming from the criminal justice system rather than because of Medicaid expansion or the Idaho BHT Waiver:

> *"From our perspective, I don't know that we've seen an increase in patients necessarily, due to IMD [Sec 1115 waiver]. I think that we've seen an increase in the number of patients we take that are coming here for the criminal commitment or for the competency… I think that was driven more through the court system [not as a result of the Medicaid expansion], just defense attorneys requesting that more, but not for sure."*

(4) Implementation of the Idaho BHT Waiver

Multiple respondents reported not being aware of the Idaho BHT Waiver or knowing few details; "like none," said one provider respondent who also did not know what IMD stood for. The same respondent continued: "I'm on the executive board of the behavioral health board here locally and I haven't heard of 1115 at all. Health and welfare is a very closed system. They might know all about it, but they don't share that with anybody else."

Another respondent explained their limited understanding of the waiver:

> *"I'll be honest. I know very little. I know that we got a waiver so that there could be standalone mental health hospitals that would be Medicaid eligible. Essentially, we can put folks that are being paid by Medicaid into some standalone hospitals. That I know that we got the waiver. We were approved for it. I know you're researching it. That truly is about as much as I know because I just—that's not a level that I get into."*

The respondents who were familiar with the Idaho BHT Waiver have spoken generally when asked about implementation, in large part, because the focus has been on the ongoing procurement process (i.e., awarding the contract to the next contractor of the IBHP), and to a lesser degree, because of the timing of the pandemic.

One respondent described the initial launch as a very positive experience, noting that the State was helpful and supportive. One respondent was complimentary of the collaboration with IDHW and the Division of Medicaid; they reported meeting regularly with both IDHW and Medicaid leadership and staff who are "very deeply involved," "very open to dialogue from the IMDs and from the hospitals," and

> *"working hard and they're figuring it out as they go" because IDHW's "been given directions by the legislature and now they have to figure out how to implement [the waiver]…. ways to follow legislative guidance and then just working with us and our major competitor—with whom we have a very collegial relationship—to establish some guidelines and to establish some best practices."*

When asked for their perspective on how the Idaho BHT Demonstration is going overall, a respondent said that the waiver is a lifesaver:

> *"I just feel like it's gone really well just because we've seen a lot of people receive services that wouldn't have, historically, been able to receive services. From my vantage point, I feel like it's created access. That's what behavioral health treatment is about is reducing a stigma, encouraging people to get treatment for the illnesses that they suffer from, and getting them to people that can get them started in that process and help them along the way. Helping people understand that mental illness is a real thing. With the pandemic, we've seen an increase in the number of people that are suffering from mental health problems and issues. Getting treatment and help is lifesaving. I feel like this waiver has saved countless lives."*

Reportedly the IMDs "don't do a whole lot of coordination together as far as driving policy changes within the state" and are not collaborating to any notable degree. During meetings focused on providing care at the height of the pandemic, there was some discussion "about impacts with Medicaid and reimbursement and structure of that."

(5) Challenges and Barriers

SUD Treatment Facility Provider Certification/Enrollment Delays

Respondents reported several challenges related to the implementation of the SUD treatment goals:

"…there have been some challenges too. I mean, obviously, like you said, there's always challenges. I think we've experienced some challenges in bringing up some of the services, which I don't know if we touched too much on the substance use disorder piece of an inpatient community-based residential center. Underneath the waiver, you're able to pay for a community-based IMD, which is not a credentialed hospital. I think that's one of the key components. It's kind of like your 28-day program. I think that's the best way to reference it, even though it's probably not the perfect way, but I think that everybody's able to understand that type of a program, where you've got a substance use disorder individual who needs an alternative residential placement. They would receive services while they're in that program. This waiver allows us to use Medicaid funds to pay for those services. We've really been struggling bringing up this new provider type because there's a couple things that have been a challenge, one being building the new provider type in our system. We've got a lot of other initiatives, competing priorities that have delayed it. Also, there are some strings attached with bringing this service up, such as providers becoming certified, ASAM certified…."

"…the SUD residential treatment facility or provider enrollment, I was promised that that would be completed October of last year. Now, I'm getting told it can be started in January 2022, so should be completed maybe by June. Getting providers informed because the expectation is that they have CARF certification for ASAM, which is a big lift for providers. I don't even know that with the rate setting that we have, being fairly competitive, if it's going to—I think one of the biggest arguments is, is it worth it for the provider to become certified and pay because we're not reimbursing them for that certification payment or process? Is it worth it for them to become certified so that they can receive Medicaid funding for that—for those services?

That's one thing providers have been supportive of, but I'm still a little bit nervous if something gets delayed any further what that will mean…. just making sure the providers are taken care of, really, because we're not going to be successful with this waiver unless we get that provider support. That's what I think about the most. I don't want this to be hard for them. I don't want it to be something that is challenging for them to become a Medicaid provider or to enroll folks or to be able to provide any of these said residential services like we're expecting."

Insufficient Resources for Demonstration Program

A respondent reported concerns about whether there are sufficient resources dedicated to the Idaho BHT Waiver:

"…on the state side too, we really haven't gotten more resources to operationalize this project. It's been challenging taking this on with our day-to-day operations, interactions with CMS. Operating a demonstration program is not something that's, I guess, relatively easy to do. There's a lot of strings attached, administrative responsibilities."

Access to Care/Provider Shortage

As previously noted, the state of Idaho has a large number of rural areas and this has presented challenges according to respondents:

"…being in a rural and frontier area here in Idaho, it's, again, challenging to find the appropriate providers to complement therapeutic services that can address the needs of individuals with complex behavioral health needs in the community. We do end up seeing, for instance, children

being placed out of state and in residential treatment facilities, or individuals going to our institutions for mental disease."

Another problem that the provider shortage underscores is that "per capita, there's just not a lot of psychiatrists that are willing to do even outpatient treatment. Those that are doing outpatient treatment aren't doing Medicaid treatment. They're doing commercial treatment."

Need to Amend Waiver

As one respondent noted, the under 21 population cannot be reached under the current structure of Idaho's BHT Waiver:

"…the community-based service, the way that we structured the waiver, individuals between the ages of 21 and 64 are the only—is the population that we're going to be able to serve in those settings. We are going to be pursuing an amendment to the waiver to include the under-21 population. As I previously mentioned, the under-21 population can access services in an IMD if it's a specific facility type, being a Medicare/Medicaid credentialed hospital or a psychiatric residential treatment facility. When you have the substance use disorder community-based IMDs that are not certified as a hospital, we don't have the authority to treat those individuals underneath the waiver or underneath our general state plan. There's the need to amend the waiver to include the under-21 population for substance use disorder services in those community-based residential centers. I wish we had done that when we originally implemented the waiver. I think that that has created some—or is going to create some challenges for us until we get it amended."

Data Component

According to respondents, the data component of the Idaho BHT Waiver has proved challenging:

"There's a big data component in all these 1115 SUD mental health waivers. When we were putting it together, we were working with our health information exchange to try and leverage their capabilities to do that. …That's one of the hardest pieces of the 1115. Is really how are you going to synchronize data? How are you going to share data? How are you going to do it in a way that respects patient rights and all that? That's the hard part."

Resistance to the Demonstration at the County-level and from Idahoans

A respondent reported that they have received some resistance to the Demonstration from the Idaho Association of Counties mostly because of the perceived cost burden to counties and from Idaho residents who are strongly protective of individual rights and autonomy (although we note that we do not have county-level data on this topic):

"We've gotten… some pushback from the Idaho Association of Counties. They've worked in tandem with some of the representatives that are against it. That's usually coming from a governmental spending perspective. Ada County, which is the county that [Boise] is in, as you might imagine, carries a line share of costs when it comes to the county association, and so they're the ones who are most concerned about the impact on their county budget. We've seen a little bit of, also, citizen pushback.

(6) Impact of the COVID-19 Pandemic

The COVID-19 pandemic has caused challenges for a variety of reasons. On the administrative side this included impacts on timeline, challenges with reconciling COVID-impacts from a budget perspective, and a broad need for various state entities to address the pandemic. On the care side, the pandemic included a shift to telehealth in many cases, which providers noted impacted their ability to provide care in the way they are used to doing (especially group sessions) as well as broader impacts on care availability and behavioral health more generally (i.e., the COVID-19 pandemic negatively impacted residents behavioral health).

Timeline

> *"Some of it was that CMS's expectations, even when we were applying, was that we would accomplish things by—they gave us two years to implement, so we really thought about what could we do within two years. Some of it, yes, was too much, of course. Then obviously when you're approved a month after COVID—COVID hit Idaho March 2020. We got approved a month after that. When a lot of Medicaid staff—well, quite frankly, all department staff just moved roles into addressing COVID. Things changed and priorities changed."*

Budget

> *"…. Our actuaries were still trying to figure out some of the COVID impacts to see if some of what was showing was due to COVID."*

Telehealth

IDHW leaders were already planning to invest in telehealth for patients with behavioral health needs, but when COVID came into play and CMS changed the rules for telehealth, this plan materialized very quickly:

> *"For telehealth, the pandemic just sort of came—the waiver got approved right in the middle of the pandemic. We were like, "Yeah, take the lid off of telehealth, anyway." I think it's remaining off. That part became more aggressively resolved than we'd anticipated, just as a COVID response."*

Providers are not always supportive of telehealth services particularly for patients with SUD, especially in the group therapy setting, and for patients with psychiatric disease:

> *"I've always found .,.. problems with being able to hear, connect, see the person you're talking to and actually just develop a good rapport with your provider, which is important in psychiatric care and counseling and therapy and things like that."*

(7) Initial Lessons Learned

Increase Access to Care

One respondent reiterated that creating more outpatient care capacity and increasing access is very important overall. But specifically, the respondent added that even more access to care is needed within the school system: "…that's certainly needed, and people are suffering at a younger age now than we've seen in years past. Getting ahead of that and being open for counseling and help and medication management at earlier ages is better…"

Demonstration Successes: Lessons Learned for Federal/State Legislature

A respondent cited cost savings and the reduction of opioid-related deaths as one of the main successes of the demonstration and a selling point to the Federal and State Government to continue to provide funds and legislative support:

> *"…one of the primary things I think that they're able to point to is the cost savings and then the reduction in opioid related death. One of our discussion points—when I say our, I'm referring to my facility and then some of the outpatient providers, with the legislature it's focused around that. If you as a legislature is able to show that you've reduced opioid deaths while saving the state's money, saving the taxpayers money, they'll re-elect you until you die. That's one of the successes that we've pushed towards/pointed towards. I think the legislature will take that up, the governor will take that and use that as a talking point to the federal government as to what they've been able to accomplish."*

Advice for Other States Considering a Similar Program

When asked for advice to leaders in other states who are considering implementing a similar program, a respondent said:

> *"I would definitely advise them to be very involved in the standards of care and also the criteria, because those are two areas where there's still a disconnect with the government. So, if they're looking at working with their Department of Health and Welfare, whatever they call it in that state, I would say that you need to be at the table when they're discussing what those criteria are going to be. Because often times, we'll run into a situation where what we are looking at as criteria is not the same as what the state is looking at."*

Stakeholder Involvement Needed: The Hospital Association

A respondent described needing more collaboration and interaction with the Hospital Association and for the Hospital Association to place more emphasis on Mental Health.

Limitations

We acknowledge several important limitations in the MPA. First, we faced major delays in obtaining access to individual level data, necessary for evaluating a majority of the metrics. Although our approved Evaluation Plan specified the data required to implement our evaluation, we experienced multiple delays in gaining the requisite approvals for data access. Once approvals were secured, we've continued to work through challenges related to data acquisition and clarifications. this is not surprising as the evaluation represents an important shift from the usual metrics (which are often reported using aggregated reports) to the data needs of this and future assessments. However, there have been significant delays and the Penn State team is only just now beginning to receive some of the necessary data. While we hope this will be completed for the Interim Report, it was a major limitation for this midpoint assessment.

The reason individual data are critical to the evaluation is multi-fold. First, it will allow us to control for individual characteristics such as demographics and other risk factors (e.g., comorbid conditions). Second, because the Idaho BHT Waiver occurs a few months after Medicaid expansion, one analytic difficulty is disentangling expansion effects from Waiver effects. Individual-level data will allow us to

estimate results limited to those eligible under pre-expansion criteria as well as use non-behavioral healthcare utilization as a further control, especially for those eligible via expansion. An important note is that the current MPA does the best with the aggregate data but with the aforementioned limitations. As a result, future results might change.

Individual-level data is also critical for being able to account for the COVID-19 pandemic, which CMS has noted as being an area of difficulty in all assessments.[13] The pandemic impacted all types of care. For behavioral healthcare, it impacted where and how care was provided (e.g., an increase in telehealth), patients' access to care, and important direct impacts on patients' mental health and wellbeing due to isolation and other social challenges caused by the pandemic. One of our proposed strategies is like that described above – using non-behavioral healthcare as a control to account for across-the-board drops in care, at least in the periods directly surrounding the most acute parts of the pandemic (which also happens to be the beginning of the Idaho BHT Waiver period). Impacts on enrollees' mental health are more difficult to disentangle in our estimates but we plan to use estimates from other states to account for this factor.

Another limitation to note is that we have several metrics for which we did not have data. We anticipate some of this will be rectified with the move to more granular, individual-level data. Some metrics might have to be altered or dropped if sufficient data are not available for assessment.

Assessment of Overall Risk of Not Meeting Milestones (Table E.21 in Appendix D) Overall, we find the risk of not meeting the critical metrics to be low to medium. For the metrics, for which we have data, Idaho appears to be at low risk of not meeting milestones. However, we have noted some methodological difficulties in precisely determining this. Additionally, since we are missing data on a number of metrics, we are more circumspect in our assessment and thus list as low to medium risk.

Currently, we would assess the risk of not meeting the implementation plan action items as low to medium. A major implementation item is the forthcoming IBHP contract. As this has been sent out for bid but is currently delayed, it is difficult to know when this will be complete. Initially, the contract was to have been finalized by the end of the 2022 calendar year, but a variety of issues leave this in flux. When finalized, this will likely go a long way in supporting implementation goals. Again, based on key informant interviews, we believe the outstanding items can then be targeted. There remain some concerns about sufficient provider availability, especially in rural and frontier areas.

Most key stakeholders viewed progress as positive, especially considering the scope of the behavioral health issues in Idaho and the concomitant COVID-19 pandemic. Broader awareness across providers in the state and closer collaboration with the criminal justice system were two items mentioned as possible limitations.

Finally, we would assess that provider availability is at low to medium risk. There are promising developments in terms of additional non-psychiatrist providers and intensive outpatient providers. But other care types have remained fairly constant. However, we have noted throughout that this must also be assessed in light of broader, nationwide declines in the behavioral health workforce.

Conclusions

Overall, we find that the state is making sufficient progress in meeting the milestones for the Idaho BHT Waiver. Notably, the number of providers is either holding constant (even when elsewhere behavioral health provider shortages are being noted) or increasing. In addition, most of the milestones we examined are trending in the right direction (albeit with the important caveats noted in terms of data limitations).

Some of those that are not, are likely impacted by the COVID-19 pandemic, which has been shown to have large impacts on behavioral healthcare across the US – for both SUD and SMI/SED. Additional years of data and the shift towards individual-level to assess the demonstration may help to illuminate how much of changes were due to the pandemic compared to the Idaho BHT Waiver. Although an ongoing challenge is obviously that the pandemic, even as it has evolved, is likely to have long-lasting effects.

Summary of Findings and Recommendations

Broadly, we see significant progress throughout the course of implementation. Quantitative and qualitative findings tell a generally positive story, and these mid-point analyses indicate the Idaho BHT Waiver demonstration may have played a key role in stabilizing and maintaining access to SMI and SUD services during the COVID-19 pandemic—when many states were dealing with profound disruptions of care. Our assessment points to significant success towards meeting progress milestones (i.e., implementation actions planned and executed) and despite some delays toward achieving performance milestones (i.e., metrics included in Tables 3.1, 3.2, and 3.3). The major remaining hurdle relates to the execution of the state's new IBHP, which is highly likely to accelerate the state's ability to achieve waiver outcomes, especially as related to progress milestones. Our interviews with key informants highlighted specific challenges the state is facing as it moves into this next phase of its BHT Waiver implementation. Below we summarize ongoing opportunities and potential challenges to improve waiver outcomes and offer recommendations.

Challenges

Despite its general progress, as noted above, implementation has been affected by significant events such as Medicaid expansion (just prior to the Idaho BHT waiver demonstration and a major catalyst for the Waiver application), COVID-19, and delays in procurement of a IBHP contract. Along with these factors, key informant interviews offered valuable insight into contextual events that have co-occurred and likely influenced implementation of the Idaho BHT Waiver. These include the lack of providers, patient access issues, and resistance from local entities and some citizens. Additional internal challenges included scarcity of resources to support implementation and data complexities. One other internal concern was ensuring access to behavioral health care for the under age 21 population. Thus, there has been interest in altering the Waiver to include this population.

Medicaid Expansion

One of the key challenges was the near overlapping between Medicaid expansion that immediately preceded Idaho's BHT Waiver demonstration (and was a major impetus for the Waiver itself). The expansion of Medicaid placed numerous logistical impacts on providers as well as the state. Initial estimates indicated that expansion would lead to about 91,000[6] people becoming eligible. Ultimately, this has led to about 121,000[7] Idahoans enrolling in coverage. Medicaid expansion also significantly complicated aspects of the analytic approach given the close proximity to the 1115 waiver demonstration itself—a meta factor in the data challenges described above.

COVID-19 Pandemic

As was true throughout the United States, the COVID-19 pandemic widely disrupted health care. In addition to care disruptions, there were numerous deleterious effects on population mental health. Thus, the COVID-19 pandemic had clear and wide-ranging impacts on the Idaho BHT waiver demonstration. This included various delays in implementation as well as the aforementioned care disruptions and mental health impacts.[38-41] While there are likely to be lingering impacts on mental health, implementation activities have successfully progressed.

Moving forward, one major consideration is the national COVID-19 Public Health Emergency declaration that provides continued Medicaid coverage to Idahoans even if they may have otherwise become ineligible. It was first declared in January 2020 and was most recently estimated to impact over 130,000 Idahoans or more than a fourth of the total Medicaid population.[42] A notice was sent to Medicaid enrollees starting February 1, 2023.[43] At this time a massive logistical task of verifying eligibility and removing ineligible individuals will occur. Enrollees deemed ineligible have 60 days to respond before they are removed. If enrollees respond within that timeframe, they will have their Medicaid eligibility reevaluated; if they do not qualify, they have the ability to discuss other health care options with Your Health Idaho (YHI). We expect this to be highly disruptive to Idaho BHT waiver implementation—impacting both state capacity as well as access to care for many using SMI/SED and SUD services made possible by the waiver. In particular, we expect it to lead both to the loss of SMI and/or SUD services as well as contribute to volatility in enrollment eligibility—which could contribute to intermittent access to care for those cycling between eligible and ineligible status depending on local labor markets.

Access to Care in Rural and Frontier Areas

Mentioned as an issue by numerous key informants, access to care in rural and frontier areas of the state remains a lingering concern. There are significant difficulties in recruiting a behavioral health care workforce in Idaho, but the issue is particularly acute in rural and frontier areas. While the uptake in telehealth has helped to connect patients with behavioral health care, in cases with limited in-person providers, significant gaps persist. This challenge remains an important one to address, while noting that access to behavioral health care in rural areas is an issue throughout the United States.

Managed Care Contract and Coordination of Care

Delays impeded progress in designing and implementing a new behavioral health managed care contract. The importance of the contract is that, in part, it would incorporate inpatient care in order to better align incentives to coordinate care and ensure patients are receiving care in the appropriate setting. Finalizing the managed care contract will ease constraints in addressing other issues related to care coordination and availability of providers, which were challenges noted by several key informants during interviews.

Community Based Care and Credentialing Providers

One challenge identified was state provider capacity in terms of who can deliver behavioral health care across the continuum of intensity (i.e., from residential to intensive outpatient to community settings). Community-based care alternatives, including more intensive outpatient or residential care, are critical to ensuring access to appropriate behavioral health care.

Resource Constraints

Given the effort involved in undertaking and implementing the Idaho BHT waiver demonstration, one challenge has been ensuring sufficient resources from the state. Given the initial state-level tension surrounding Medicaid expansion, especially within the legislature, resource availability remains a challenge. This is part of a broader historical pattern of under-resourcing behavioral health needs for low-income populations in Idaho and across the country. One related issue has been the significant data needs for the demonstration, which have been complicated by resource challenges. While the state has continuously sought to improve data systems prior to and throughout the waiver period, staffing and internal turnover has limited capacity, while external contractors supporting the data management and analysis have at times had difficulty efficiently providing the needed data and/or metrics for internal and external reporting (even impacting data access for this report).

Collaboration with the Criminal Justice System

One potentially unintended consequence of Medicaid expansion was that counterparts working in Idaho's criminal justice system began to see SUD treatment as more of a Medicaid issue than an issue formerly viewed through a collaborative lens. While recognizing the healthcare needs of those experiencing SUD is generally a positive development for treatment outcomes, it did give rise to some difficulties. Specifically, given that many SUD patients are involved in the criminal justice system, some healthcare providers reported new challenges in coordination with the criminal justice system.

Gap in Meeting SUD and SMI Needs of Youth and Young Adults

One challenge that arose was the needs of the under-21 Medicaid population with behavioral health needs. The majority of substance misuse is initiated in adolescence.[44] The lifetime harms to health and public costs are staggering and treating SUD early can reduce harm and lead to significantly better treatment outcomes. To ensure similar access to care in the appropriate setting, there is likely a need to explore expanding the Idaho BHT Waiver to the youngest of the Medicaid population.

Assessment of State's Capacity to Provide SUD and SMI/SED Services

During the initial waiver period, the state was able to largely maintain capacity for SUD and SMI services despite unprecedented need during the pandemic and reductions to the healthcare workforce. We note this in the context of national trends of health workers exiting the workforce —particularly in behavioral health fields.[45] While this stability is quite notable, it is also within the context of an historically underserved state. Therefore, this stability should not be equated to maintaining an adequate capacity of services, but the ability to prevent losses is important to recognize.

Although the number of psychiatrists in the state decreased between 2019 and 2020, the number of Medicaid-enrolled psychiatrists saw a small increase and the number of practitioners treating mental illness increased overall and within the Medicaid program. Both outpatient and residential capacity for treating mental illness increased, while the IMD capacity within the state remained unchanged. Inpatient services largely remained unchanged, although the number of licensed psychiatric hospital beds within the state (both overall and Medicaid-enrolled) decreased. Stabilization services and FQHCs remained stable. Given key informant feedback as well as Idaho's BHT Waiver goals, we would expect to see future increases in the number and types of crisis stabilization services offered in Idaho.

Once executed, the new IBHP will be the largest contract ever implemented in the state of Idaho. Given the size and complexity of the contract and its implementation, it is notable that the staff size of IDHW's Medicaid office has reduced since the beginning of Idaho's BHT Waiver implementation began.

Recommendations

Findings at the time of the MPA have offered a number of insights about the progress of the Idaho BHT Waiver, the diligence and impact of the staff in charge of waiver implementation as well as challenges and opportunities that are likely to influence the remainder of the waiver period. In this context, we offer the following recommendations:

Prepare for Expiration of the COVID-19 Public Health Emergency Declaration

Expiration of the COVID-19 Public Health Emergency Declaration will have significant impacts on the current Medicaid population as well as cause significant strain on the state and providers. Preparations for how to mitigate the short and long-term impacts of this expiration on both Idahoans as well as the government and healthcare systems that serve them is essential. We recommend taking stock now of how loss of coverage will affect providers' ability to sustain existing SUD and SMI services.

Build Coalitions Outside Healthcare

Broaden stakeholder input by engaging relevant medical professional organizations, law enforcement and schools. Both SUD and SMI/SED impact individuals and communities on multiple levels. There are multiple points in which the state can support those suffering from these health problems and groups such as these can be valuable partners. A broad coalition may help the State identify additional opportunities to reach these populations. Other states have, for instance, sought to facilitate internal data sharing, allowing for coordination of care across systems. These integrated data systems provide the opportunity to have a system-wide understanding of how SUD and SMI are impacting their population and provide opportunities to benchmark outcomes in a more holistic manner.

Continue to Build Telehealth Capacity

Time and attention should be dedicated to ensuring advances made to date are sustained. In particular, the COVID-19 pandemic catalyzed telehealth within the state. Given the rural and underserved nature of many Idahoans, the state would be wise to sustain this progress regardless of the BHT Waiver.

Actively Plan for Personnel Needs Related to Waiver Implementation

We would offer that other states seeking to implement an 1115 Waiver program recognize the importance of fully supporting the undertaking. Key components of implementing initiatives of this size and complexity include ensuring that those entities responsible for implementing the program have the authority to convene relevant parties together, have sufficient staff and can replace and retrain staff when there is turnover, have sufficient time to implement large initiatives, and are resourced with relevant experts.

Invest in State Data Systems

We would recommend that states undertaking this work fully explore the data landscape within their states and government agencies and departments. Determining the success of these waiver programs hinges upon gathering large amounts of data and having the flexibility to analyze that data in a variety of ways is key. Understanding what is possible within a given state's systems is an essential component of successfully implementing an 1115 waiver program.

Next Steps

The Penn State Evaluation team will be undertaking the next phase of data collection and evaluation, as planned, which includes delivery of beneficiary-level data. We expect to begin receiving beneficiary-level data underlying key metrics calculated by the states data vendor (IBM) that will allow us to complete detailed outcome evaluations as proposed. The qualitative evaluation team will continue monitoring, ingesting, and analyzing documents, media, and public statements related to the waiver project. Further, they will be conducting key stakeholder interviews—particularly surrounding implementation of the behavioral health contract.

Appendices Overview

A. Evaluation Timeline
B. Interview Guide
C. Logic Model
D. Data Tables and Graphics
    - SUD Performance on Milestones
    - SMI/SED Performance on Milestones
    - Provider Availability Performance
    - Budget Neutrality
    - State Actions to Implement Milestones
    - Midpoint Assessment of Risk of Not Achieving Milestones
E. Acronyms
F. Independent Assessor Description
G. Conflict of Interest Statement

Appendix A. Evaluation Timeline

Project Period	Dates
Contract Fully Executed	April 9, 2021
Contract End	January 19, 2027

Evaluation Period	Dates
Baseline Period	January 2018 - March 2020
Early Demonstration Period	April 17, 2020 – December 2022
Late Demonstration Period	January 2023 – March 31, 2025

Demonstration Years		
Demonstration Year 1	April 17, 2020 to March 31, 2021	12 months
Demonstration Year 2	April 1, 2021 to March 31, 2022	12 months
Demonstration Year 3	April 1, 2022 to March 31, 2023	12 months
Demonstration Year 4	April 1, 2023 to March 31, 2024	12 months
Demonstration Year 5	April 1, 2024 to March 31, 2025	12 months

Appendix B. Interview Guide

Idaho Behavioral Health Transformation Waiver Interview Protocol, Round 1
This transcript below outlines specific topic modules and associated questions we explore with interview participants.

PROTOCOL START

Introduction & Consent
[Note: The implied consent form is sent to interview participants when the call is scheduled.]

Thank you for talking with me today. This interview is part of the evaluation of the Idaho Section 1115 behavioral health transformation demonstration waiver (referred to as the demonstration waiver throughout the interview). Penn State is contracted as an independent evaluator of the demonstration. We will be analyzing what we learn across all interviews; nothing that we report to the Idaho Department of Health and Welfare or CMS will be attributed directly to you or your organization.

You should have received a copy of the research consent form via email when this was scheduled. This study is approved by Penn State's Institutional Review Board (IRB) and everything you say will be kept confidential. [Note: If respondent did not receive the consent form or is unsure, pause to email it to the respondent.]

I look forward to hearing your insights on the Idaho Behavioral Health Transformation Waiver during our discussion today. Please let me know if I ask you anything today about which your involvement or knowledge is limited. We can discuss who would be a good a person for us to follow-up with, as needed. [Note: If there are multiple interviewees, please thank them all and say all of their perspectives are important and that you'd like to hear from everyone during the interview.]

Do you have any questions for me before we begin? Do I have your permission to record this interview?

Note for interviewer: Again, as a reminder, I'll be using the term "demonstration waiver" throughout the interview to refer to the Idaho Section 1115 behavioral health transformation demonstration waiver.

Module 1: Introduction

Before we get started, can you please confirm that your current position is [*position title*]? Can you provide a high-level overview of your role?
For context, can you give us a high-level overview of your organization?

Module 2: Background & History of Behavioral Health in Idaho

I'd like to start with some general background and context around behavioral health in Idaho, including Severe Mental Illness and Substance Use Disorder. Can you provide a brief summary of your understanding of the context around behavioral health in Idaho?
What has been your role in the area of behavioral health?
Is there anything else critical for us to understand around behavioral health in Idaho?

Module 3: Development/Design of Demonstration Waiver

We'd like to start out by talking about what motivated the development of the demonstration waiver.

At a high level, please describe your role(s) in planning for and implementing the demonstration waiver.
1. What stakeholder groups were involved in these discussions? 2. What stakeholder groups advocated for the demonstration waiver? What did they hope to get out of it? 3. Which, if any, stakeholder groups opposed the demonstration waiver? What were their concerns or rationale?
1. What did you identify as the short-term goals? 2. What did you identify as the long-term goals identified? 1. *Expand coverage of Medicaid reimbursable services for individuals with SMI/SED and/or SUD;* 2. *Increase access and availability of behavioral health services across the state, particularly in rural and frontier areas; and* 3. *Improve coordination of care, including transitions of care, for Medicaid beneficiaries.*
How, if at all, was the development or design of the demonstration waiver influenced by previous work in Idaho? In other states?
Were there initial barriers that needed to be overcome to implement the demonstration waiver?

Module 4: Implementation

Note to interviewers: details on implementation milestones will be provided with background materials.

We'd like to now talk with you about the implementation of the demonstration waiver.

	From your understanding and knowledge, once the demonstration waiver was passed, could you describe what implementation was supposed to look like? What was the implementation plan? What were the major milestones to be reached?

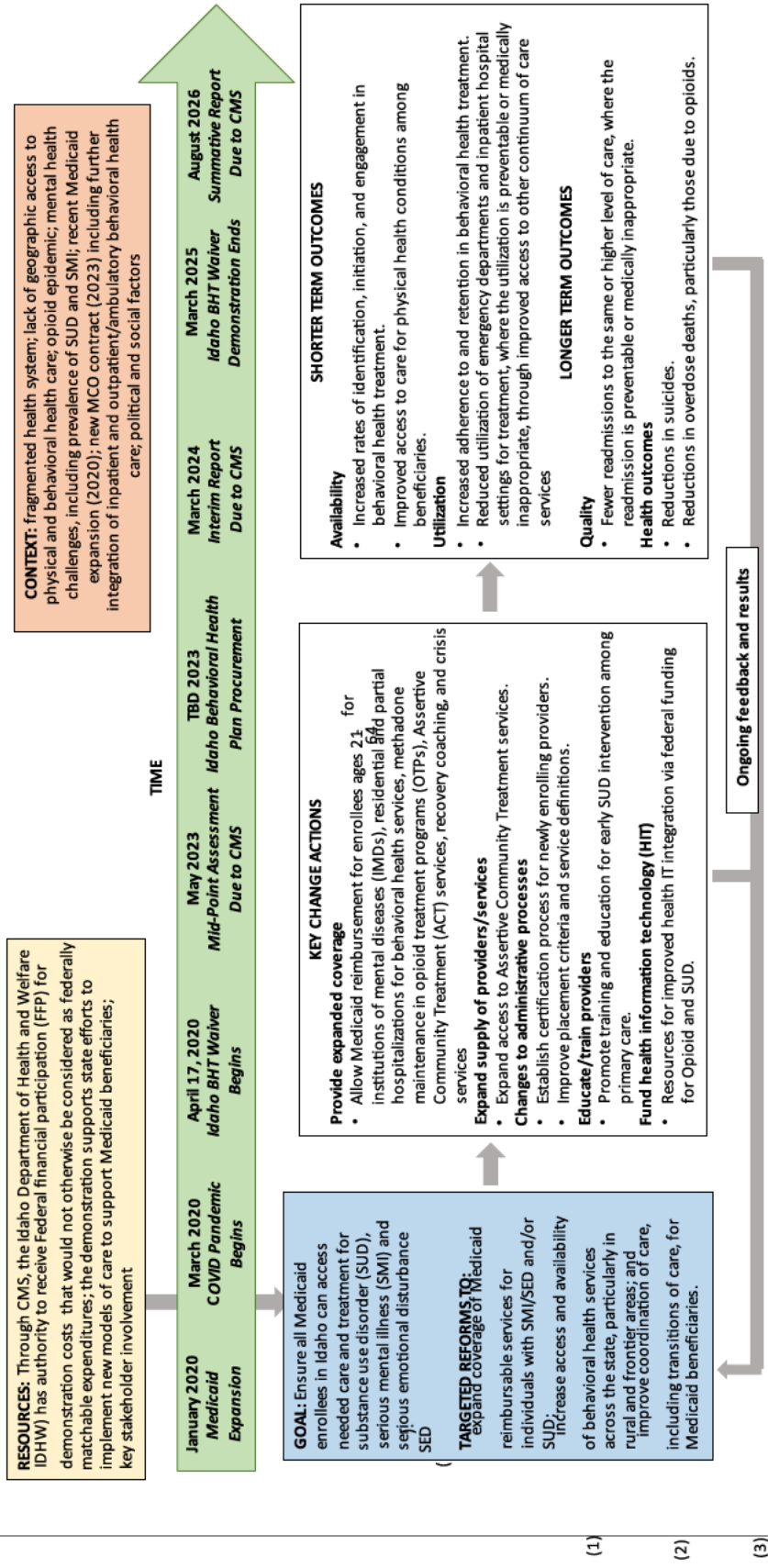
	Please describe the logistics of the implementation of the demonstration waiver thus far. What has been challenging? Have there been delays? If so, what have those delays been? *[Probe: if not mentioned, discuss delays in managed care contract process and HIT]* *Probe the following for each major goal of the demonstration waiver: logistics and process, who is involved, challenges, what is facilitating successes, etc.* 1. *Expand coverage of Medicaid reimbursable services for individuals with SMI/SED and/or SUD;* 2. *Increase access and availability of behavioral health services across the state, particularly in rural and frontier areas; and* 3. *Improve coordination of care, including transitions of care, for Medicaid beneficiaries.*
	Now in implementation phase, what do stakeholders think about the likelihood that the demonstration waiver will have its intended impact?
	Are there unique characteristics about Idaho that make the demonstration waiver more or less challenging to implement?
	If a counterpart in another state was looking to replicate the demonstration waiver, what advice would you give them?
	Looking back from your current vantage point, what – if anything – do you think that the Idaho Department of Health and Welfare should have done differently with regard to planning, set-up or early implementation of the demonstration waiver?
	Looking forward, what challenges, if any, do you anticipate the Idaho Department of Health and Welfare will have related to the demonstration waiver?

Thank you for your time and for sharing your thoughts. Your input will be valuable to the ongoing implementation of the demonstration waiver as well as helping understand lessons learned. May we follow-up with you via email if we have any additional questions?

PROTOCOL END

LOGIC MODEL

Appendix C: Logic Model



Appendix D: Data Tables and Graphics

SUD Tables and Graphics

Table E.1: Performance on Milestone 1 Metrics

		Value	Absolute change	Percent change %
Number of beneficiaries who used early intervention services[1a](SUD #7)	Baseline (Jan.-Mar. 2020)	0	-	-
	DY1 (Apr. 2020-Mar. 2021)	0	0	0
	DY2 (Apr. 2021-Mar. 2022)	0	0	0

Number of beneficiaries using outpatient services[1b] (SUD #8)	Baseline (Jan.-Mar. 2020)	3,477	-	-
	DY1 (Apr. 2020-Mar. 2021)	4,125	725	21.2%
	DY2 (Apr. 2021-Mar. 2022	4,700	1,273	37.1%
Number of beneficiaries with intensive outpatient and partial hospitalization services[1c](SUD #9)	Baseline (Jan.-Mar. 2020)	211	-	-
	DY1 (Apr. 2020-Mar. 2021)	283	72	34.1%
	DY2 (Apr. 2021-Mar. 2022)	363	152	71.8%
Number of beneficiaries with residential and inpatient services[1d](SUD #10)	Baseline (Jan.-Mar. 2020)	85	-	-
	DY1 (Apr. 2020-Mar. 2021)	135	50	59.2%
	DY2 (Apr. 2021-Mar. 2022)	92	7	8.2%
MAT utilization [1e] (SUD #12)	Baseline (Jan.-Mar. 2020)	1,096	-	-
	DY1 (Apr. 2020-Mar. 2021)	1,783	687	62.6%
	DY2 (Apr. 2021-Mar. 2022)	2,601	1,505	137.3%
Adherence to MAT[2f] (Continuity of pharmacotherapy) (SUD #22)	Baseline (2018-2019)	53.1	-	-
	DY1 (Apr. 2020-Mar. 2021)	47.9	-5.2	-9.8%
	DY2 (Apr. 2021-Mar. 2022)	24.4	-28.7	-54.1%

Note: SUD Milestone 1: Access to critical levels of care for OUD and other SUDs.

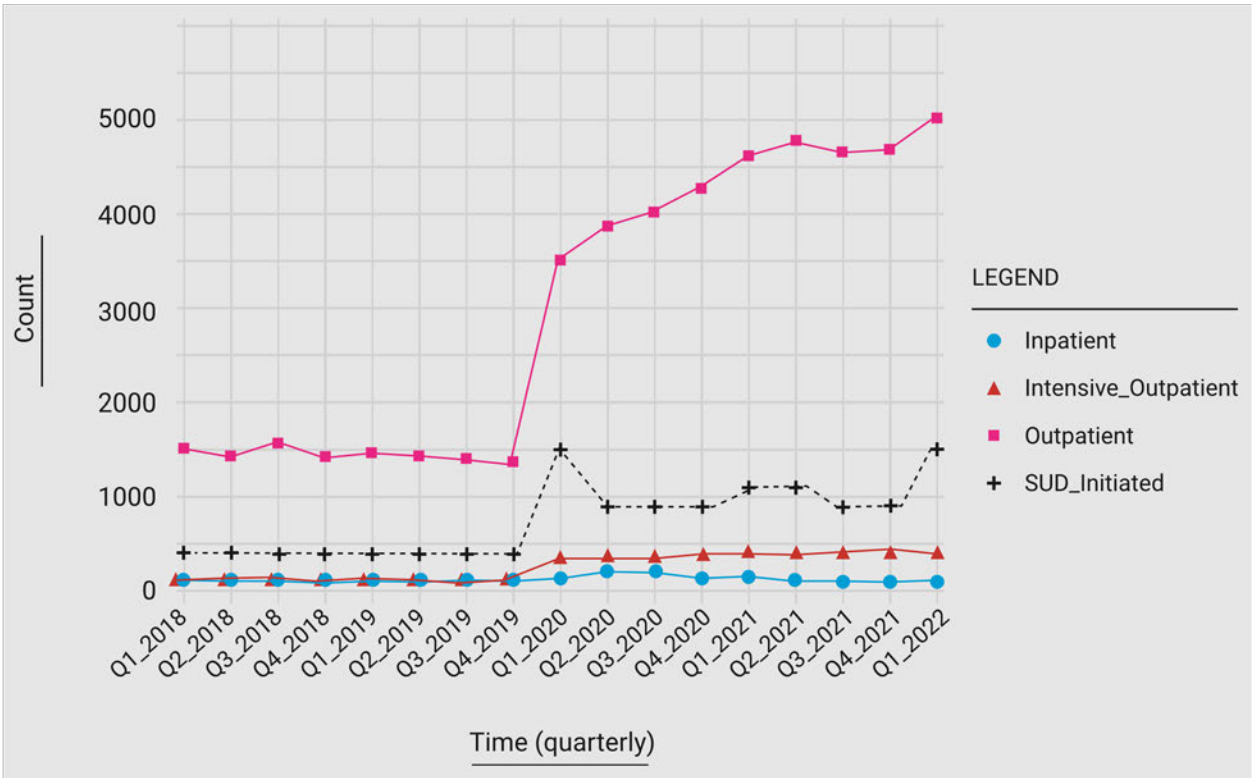
*[1], Quarterly data; [2], Annual data. SUD: substance use disorder. OUD: Opioid use disorder. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

The current adherence of MAT numbers is now using MPR (80% as the cut-off to determine if a member is adherent). The basic trend is the same as compared with using SUD #22. Note that the values of DY2 could be impacted by incomplete data, e.g., the claims in the last a few months don't have 180 days period to check.

a: Early intervention: Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.
b: Intensive_Outpatient: Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD during the measurement period. c: Inpatient: Number of

beneficiaries who use residential and/or inpatient services for SUD during the measurement period. d: Outpatient: Number of beneficiaries who used outpatient services for SUD during the measurement period. e: Number of beneficiaries who have a claim for MAT for SUD during the measurement period. f: Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have medication procession ratio (MPR) no less than 80% within 180 days after the initial MAT treatment.

Figure E.1 SUD Metrics #2, #8, #9, #10, quarterly (Counts)



Intensive Outpatient (SUD #9): Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD during the measurement period.

Inpatient (SUD #10): Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.

Outpatient (SUD #8): Number of beneficiaries who used outpatient services for SUD during the measurement period.

SUD Initiated (SUD #2): Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period.

Table E.2: Performance on Milestone 2 Metrics

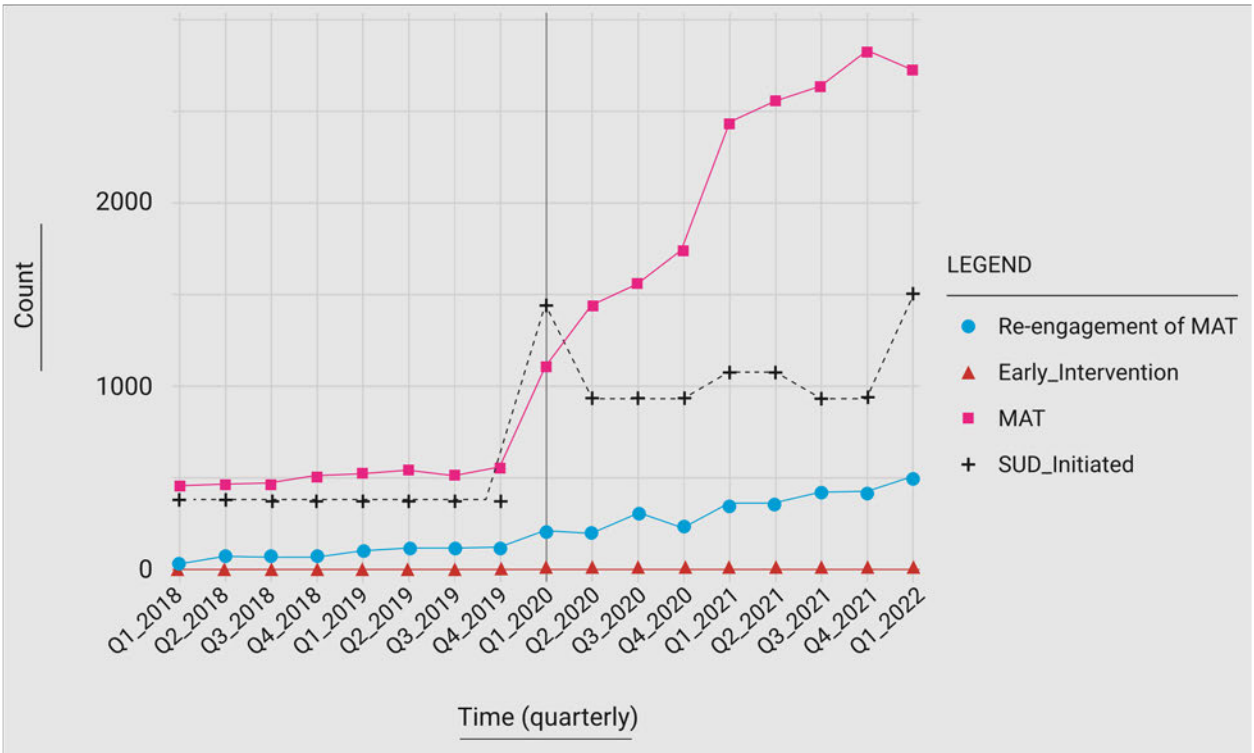
		Value	Absolute change	Percent change %
Medicaid Beneficiaries Treated in an IMD for SUD[a] (SUD #5)	Baseline (Jan.-Mar. 2020)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	668	-	-
	DY2 (Apr. 2021-Mar. 2022)	364	-	-
Average Length of Stay for SUD in IMD[b] (SUD #36)	Baseline (Jan.-Mar. 2020)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	7.0	-	-
	DY2 (Apr. 2021-Mar. 2022)	4.6	-	-

Note: SUD Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria.

*SUD, substance use disorder. IMD, institution for mental diseases. Absolute change= value of metric at mid-point – value of metric at baseline. Percent change= (value of metric at demonstration period x – Value of metric at baseline)/value of metric at baseline*100.*

a: SUD Metric #5, Number of beneficiaries who were treated in an IMD for SUD during the measurement period. b: SUD Metric #36, The average length of stay (days) for beneficiaries who were treated in an IMD for SUD during the measurement period.

Figure E.2 SUD Metrics #2, #7, and #12, quarterly (Counts)



Note: Early-intervention (SUD Metric #7): Number of beneficiaries receiving SUD screenings MAT: Number of beneficiaries who have a claim for MAT for SUD during the measurement period (all zeros).

SUD Initiated (SUD Metric #2): Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period.

Re-engagement of MAT: Number of beneficiaries who have MAT (and OUD) and have a gap of at least 30 days between fills (i.e., have a 30-day period with no MAT), then identify % that re-engage.

Table E.4: Performance on Milestone 4 Metrics

	Value	Absolute change	Percent change %

Number of providers enrolled in Medicaid qualified to treat SUD provider[2]a (SUD #13)	Baseline (2018-2019)	1,620	-	-
	DY1 (Apr. 2020-Mar. 2021)	2,655	1,035	63.8%
	DY2 (Apr. 2021-Mar. 2022)	2,509	899	54.8%
Number of providers enrolled in Medicaid and able to prescribe MAT [2b] (SUD #14)	Baseline (2018-2019)	204	-	-
	DY1 (Apr. 2020-Mar. 2021)	586	382	188%
	DY2 (Apr. 2021-Mar. 2022)	595	391	192.4%
Number of sites enrolled in Medicaid that are able to provide MAT[1c]	Baseline (Jan.-Mar. 2020)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	4	-	-
	DY2 (Apr. 2021-Mar. 2022)	6	-	-
Number of sites that provide methadone[1d]	Baseline (Jan.-Mar. 2020)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	8	-	-
	DY2 (Apr. 2021-Mar. 2022)	14	-	-
Number of community mental health centers[1e]	Baseline (Jan.-Mar. 2020)	207	-	-
	DY1 (Apr. 2020-Mar. 2021)	250	43	20.9%
	DY2 (Apr. 2021-Mar. 2022)	243	36	17.2%
Patient satisfaction[1f] (MCO survey)	Baseline (Jan.-Mar. 2020)	85.1	-	-
	DY1 (Apr. 2020-Mar. 2021)	90	4.9	5.8%
	DY2 (Apr. 2021-Mar. 2022)	94.3	9.2	10.8%

Note: SUD Milestone 4: Sufficient Provider Capacity at Each Level of Care, Including MAT.

Figure E.3a Milestone 4 Metrics, quarterly (Counts)

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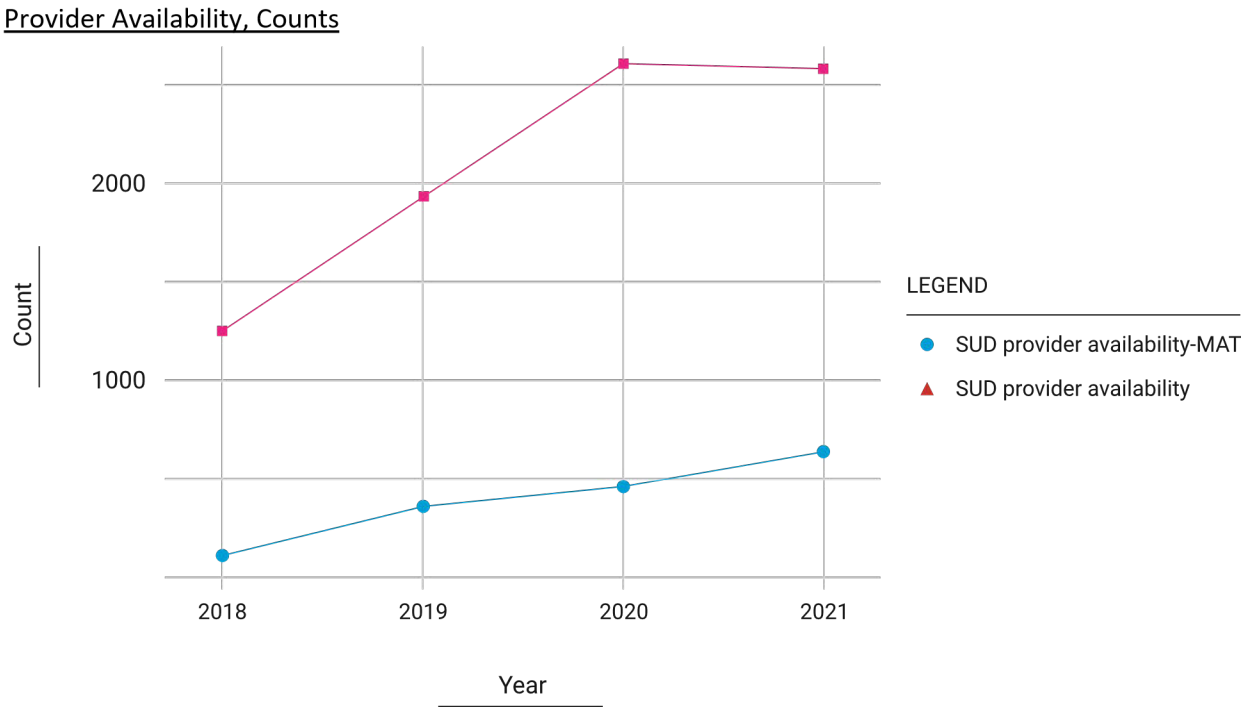
[1], *Quarterly data;* [2], *Annual data. SUD: substance use disorder. OUD: Opioid use disorder.*

*Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100. a: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period. b: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT. c: The number of Medicaid site locations delivering MAT services. d: The annual number of Medicaid site locations delivering methadone services. e: The number of community-based mental health services. f. Satisfaction rate of SUD utilization services.*



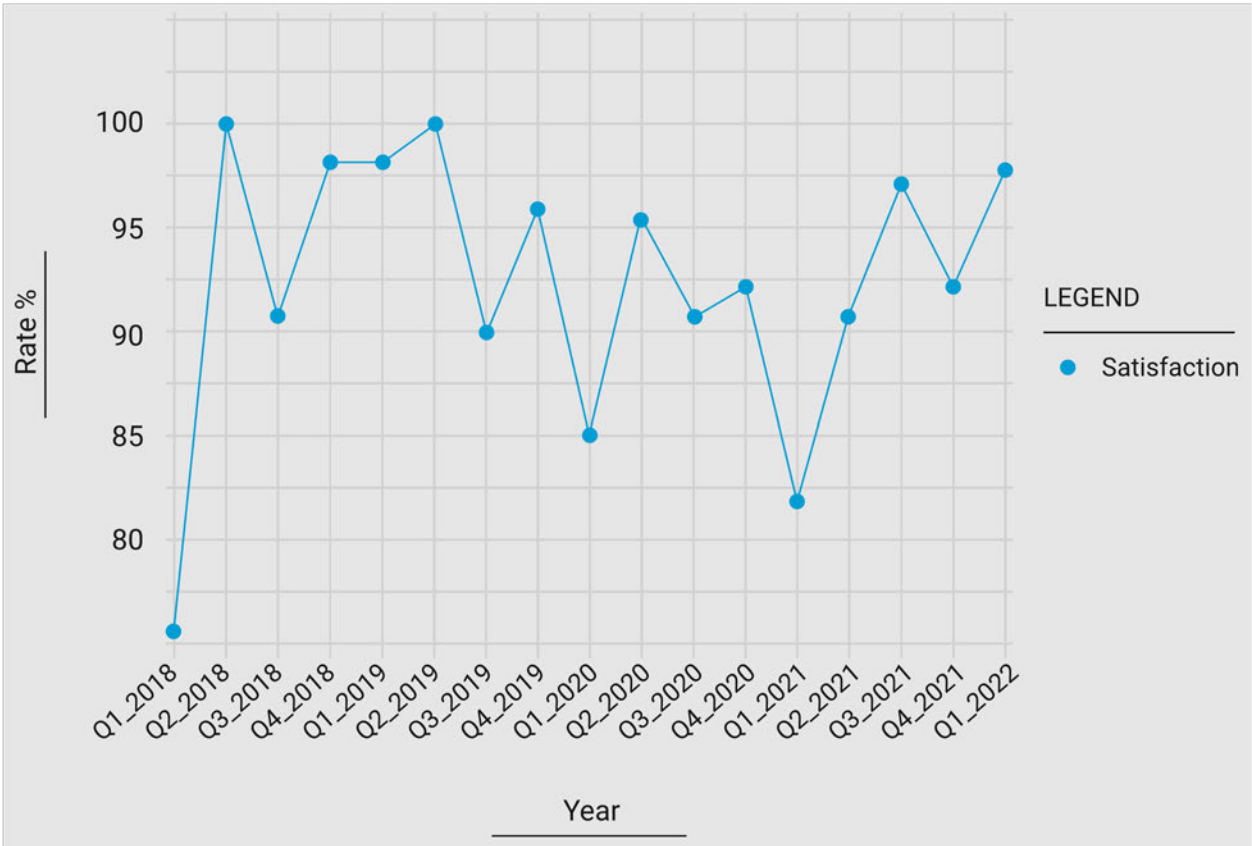
Note: SUD: substance use disorder. MAT: medication assistance treatment.

SUD provider availability (SUD #13): The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.

SUD provider availability-MAT (SUD #14): The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.

Figure E.3b Milestone 4 Metrics, Patient satisfaction, quarterly (Rates)

Satisfaction, Rates



Note: Satisfaction rate of SUD utilization services

Table E.5: Performance on Milestone 5 Metrics

	Value	Absolute change	Percent change %

Percent of adults prescribed opioids at high dosage [1a] (SUD #18)	Baseline (2018-2019)	5.5	-	-
	DY1 (Apr. 2020-Mar. 2021)	4.3	-1.2	-22%
	DY2 (Apr. 2021-Mar. 2022)	4	-1.5	-27.4%
Percent of adults with opioid prescriptions from multiple providers [1b] (SUD #19)	Baseline (2018-2019)	1.8	-	-
	DY1 (Apr. 2020-Mar. 2021)	0.7	-1.1	-60.2%
	DY2 (Apr. 2021-Mar. 2022)	0.8	-1	-54.5%
Percent of adults with high dosage opioids prescriptions or from multiple providers [1c] (SUD #20)	Baseline (2018-2019)	0.1	-	-
	DY1 (Apr. 2020-Mar. 2021)	0	-0.1	-100%
	DY2 (Apr. 2021-Mar. 2022)	0	-0.1	-100%
Percent of adults with concurrent prescription of opioids and benzodiazepines [1d] (SUD #21)	Baseline (2018-2019)	21.2	-	-
	DY1 (Apr. 2020-Mar. 2021)	15.8	-5.4	-25.6%
	DY2 (Apr. 2021-Mar. 2022)	14.5	-6.7	-31.7%
ED visits for SUD [2e] (SUD #23)	Baseline (Jan.-Mar. 2020)	990	-	-
	DY1 (Apr. 2020-Mar. 2021)	1,243	253	25.6%
	DY2 (Apr. 2021-Mar. 2022)	1,560	570	57.5%
Overdose death for SUD [2f] (SUD #27)	Baseline (Jan.-Mar. 2020)	ND	-	-
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND

Note: SUD Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Addiction and OUD.

*1.Annual data. 2.Quarterly data. SUD: substance use disorder. OUD: Opioid use disorder. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

a: The percentage of individuals ⩾18 years of age who received prescriptions for opioids with an average daily dosage of ⩾90 morphine milligram equivalents (MME) over a period of 90 days or more. b: The percentage of individuals ⩾18 years of age who received prescriptions for opioids from ⩾4 prescribers AND ⩾4 pharmacies within 180 days. c: The percentage of individuals ⩾18 years of age who received prescriptions for opioids with an average daily dosage of ⩾90 morphine milligram

equivalents (MME) AND who received prescriptions for opioids from ⩾4 prescribers AND ⩾4 pharmacies.

d: The percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded. e: Number of ED visits for SUD during the measurement period. f: Rate of overdose deaths for SUD during the measurement period.

Figure E. SUD

4a Metrics #18, #19, #20, and #21, annual (Counts)

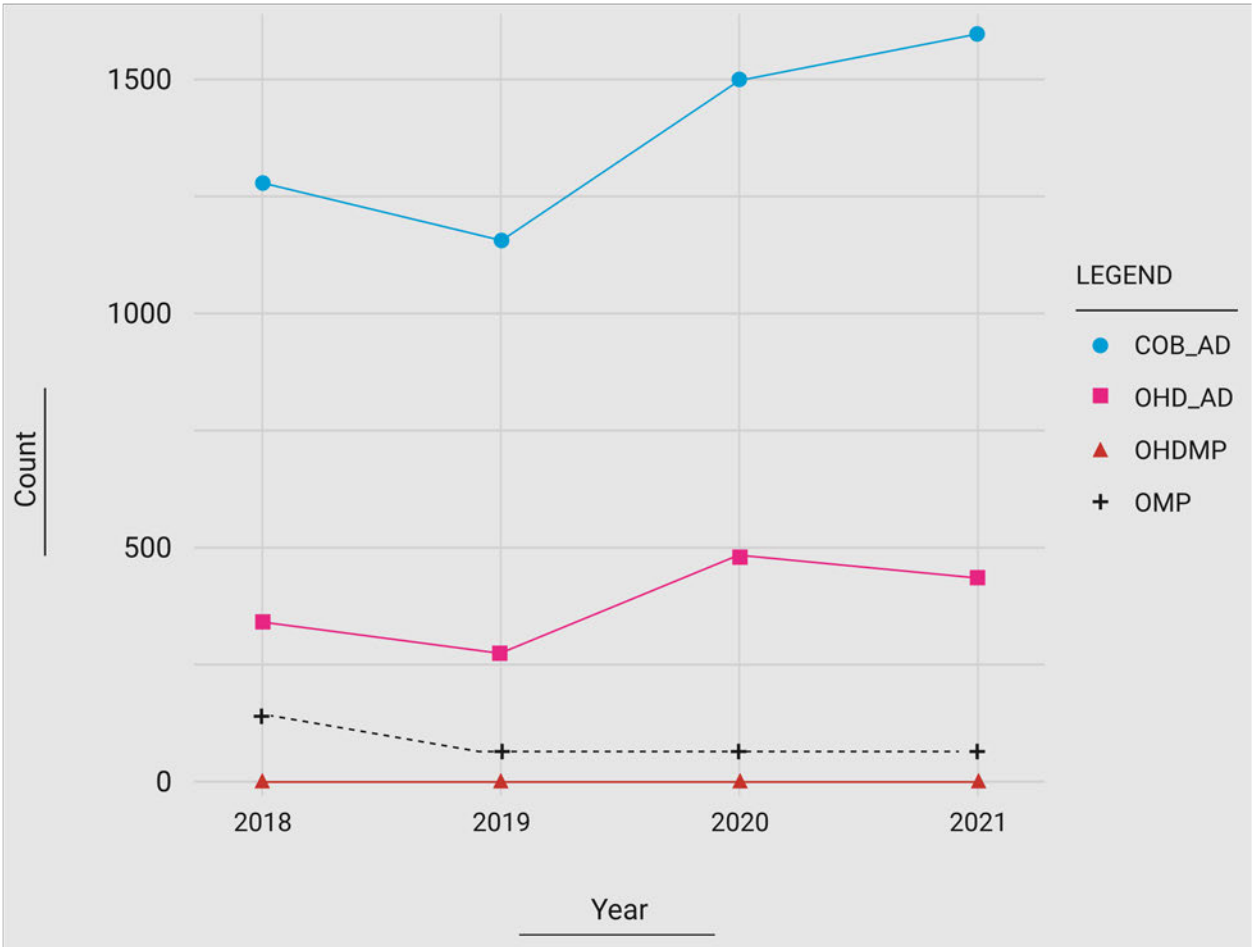


Figure E. SUD

Note: COB_AD: Concurrent Use of Opioids and Benzodiazepines. OHD_AD: Use of Opioids at High Dosage in Persons Without Cancer. OHDMP: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer. OMP: Use of Opioids from Multiple Providers in Persons without Cancer.

4b Metrics #18, #19, #20, and #21, annual (Rates)

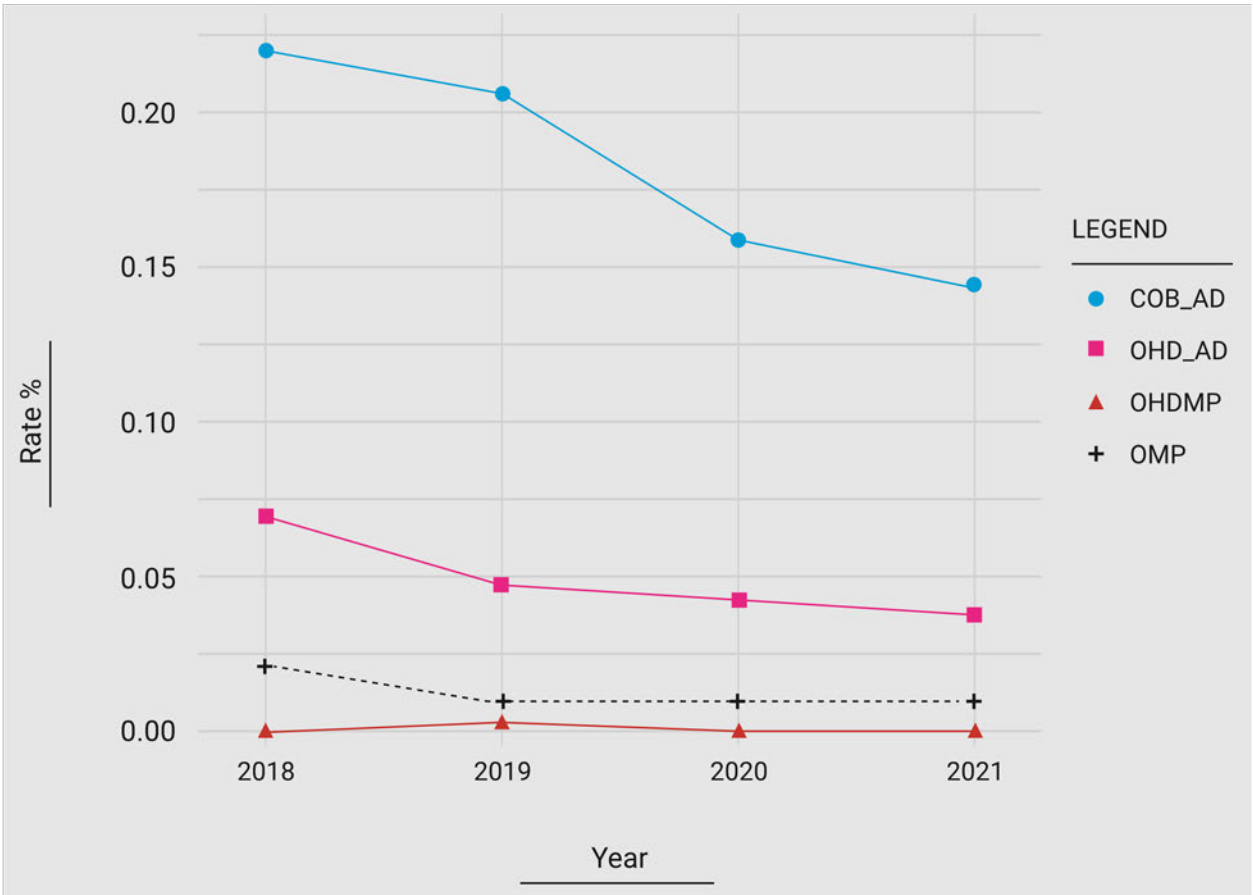


Figure E. SUD

Note: COB_AD: Concurrent Use of Opioids and Benzodiazepines. OHD_AD: Use of Opioids at High Dosage in Persons Without Cancer. OHDMP: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer. OMP: Use of Opioids from Multiple Providers in Persons without Cancer.

4c Metric #23, quarterly (Counts)

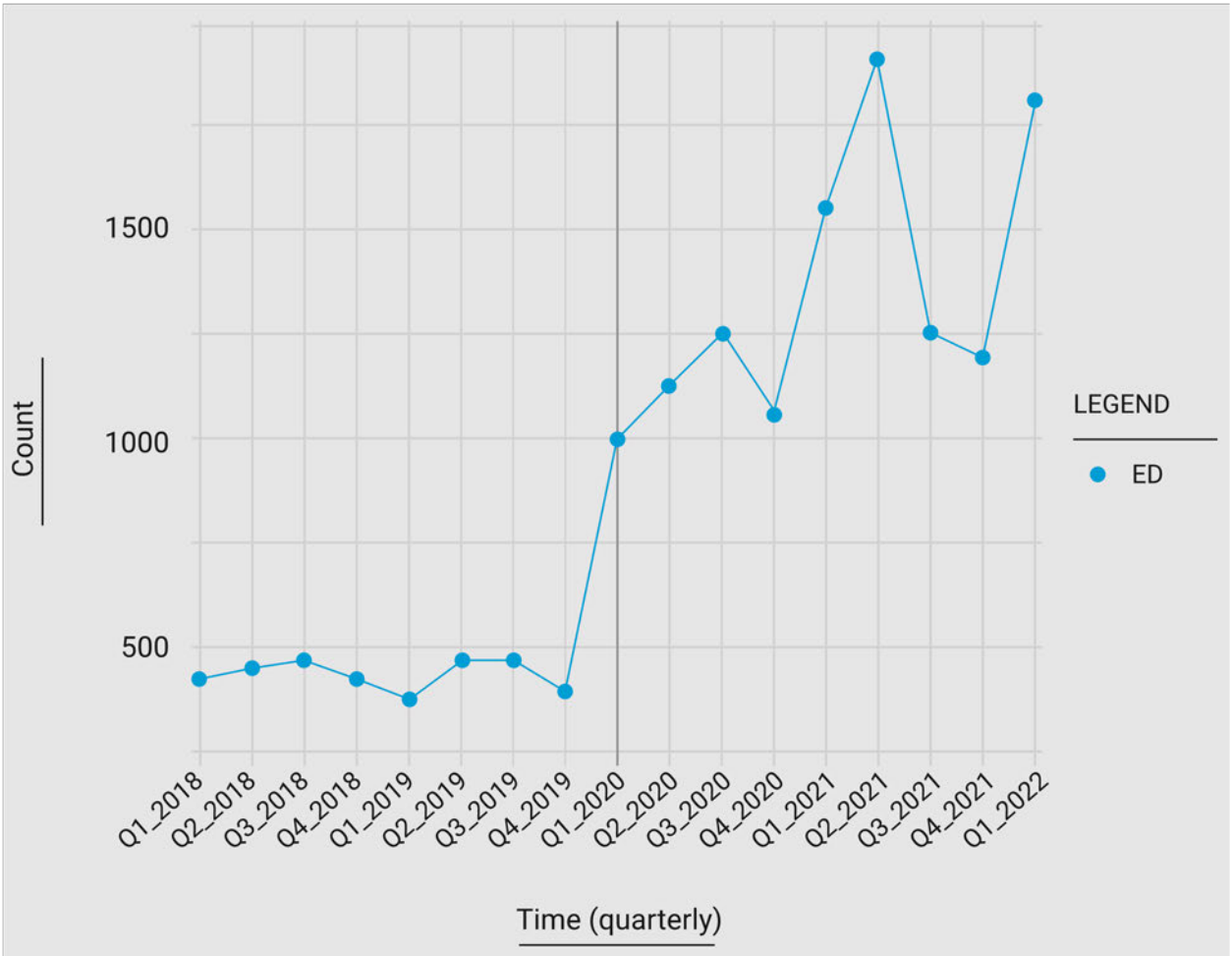


Figure E. SUD

Note: ED: emergency department. The number of ED visits for SUD.

Table E.6: Performance on Milestone 6 Metrics

		Value	Absolute change	Percent change %
IET-AD Alcohol Initiation[a] (SUD #15)	Baseline (2018-2019)	39.9	-	-
	DY1 (Apr. 2020-Mar. 2021)	48.4	8.5	21.4%
	DY2 (Apr. 2021-Mar. 2022)	46.2	6.3	15.8%

IET-AD Alcohol Engagement[b] (SUD #15)	Baseline (2018-2019)	18.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	25.5	6.8	36.1%
	DY2 (Apr. 2021-Mar. 2022)	23.5	4.8	25.5%
IET-AD Opioid Initiation[c] (SUD #15)	Baseline (2018-2019)	46.2	-	-
	DY1 (Apr. 2020-Mar. 2021)	57.2	11	23.7%
	DY2 (Apr. 2021-Mar. 2022)	56.1	9.9	21.3%
IET-AD Opioid Engagement [d] (SUD #15)	Baseline (2018-2019)	23.4	-	-
	DY1 (Apr. 2020-Mar. 2021)	32.6	9.2	39.4%
	DY2 (Apr. 2021-Mar. 2022)	37.7	14.3	61.3%
IET-AD Other Initiation[e] (SUD #15)	Baseline (2018-2019)	46.3	-	-
	DY1 (Apr. 2020-Mar. 2021)	52.7	6.4	13.9%
	DY2 (Apr. 2021-Mar. 2022)	45.1	-1.2	-2.5%
IET-AD Other Engagement[f] (SUD #15)	Baseline (2018-2019)	29	-	-
	DY1 (Apr. 2020-Mar. 2021)	34.2	5.2	17.8%
	DY2 (Apr. 2021-Mar. 2022)	28.6	-0.4	-1.5%
IET-AD Total Initiation[g] (SUD #15)	Baseline (2018-2019)	13.8	-	-
	DY1 (Apr. 2020-Mar. 2021)	52.1	38.3	278.5%
	DY2 (Apr. 2021-Mar. 2022)	47.2	33.4	242.9%
IET-AD Total Engagement[h] (SUD #15)	Baseline (2018-2019)	24.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	31	6.3	25.3%
	DY2 (Apr. 2021-Mar. 2022)	28.3	3.6	14.4%
	Baseline (2018-2019)	27.5	-	-
	DY1 (Apr. 2020-Mar. 2021)	32.5	5	18.1%
	DY2 (Apr. 2021-Mar. 2022)	31.4	3.9	14.1%
	Baseline (2018-2019)	33.9	-	-

7-day follow-up after SUD emergency department visits[i](SUD #17(1))	DY1 (Apr. 2020-Mar. 2021)	40.9	7	20.6%
	DY2 (Apr. 2021-Mar. 2022	39.3	5.4	15.9%
30-day follow-up after SUD emergency department visits[j] (SUD #17(1))	Baseline (2018-2019)	61.9	-	-
	DY1 (Apr. 2020-Mar. 2021)	59.4	-2.5	-4.0%
	DY2 (Apr. 2021-Mar. 2022	62	0.1	0.20%
7-day follow-up after mental illness emergency department visits[k] (SUD #17(2))	Baseline (2018-2019)	77	-	-
	DY1 (Apr. 2020-Mar. 2021)	72.4	-4.6	-6.0%
	DY2 (Apr. 2021-Mar. 2022	74.2	-2.8	-3.6%
30-day follow-up after mental illness emergency department visits[l] (SUD #17(2))	Baseline (2018-2019)	19.5	-	-
	DY1 (Apr. 2020-Mar. 2021)	18.5	-1	-5.1%
	DY2 (Apr. 2021-Mar. 2022)	19.8	0.3	1.5%
*Readmissions among beneficiaries with SUD[m] * (SUD #25)*				

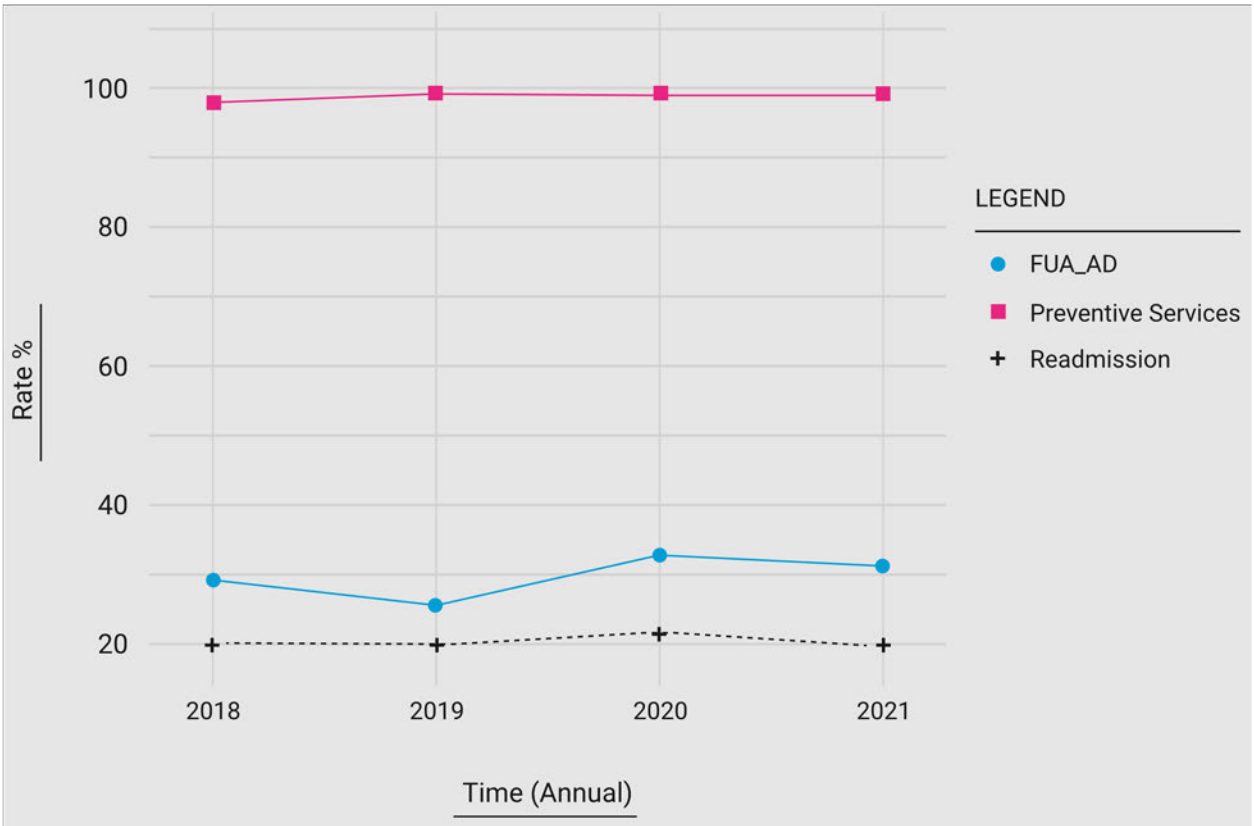
Note: SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care.

*SUD: substance use disorder. AOD: Alcohol or other drug abuse or dependence. OUD: Opioid use disorder. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

IET-AD (SUD #15): Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation (Init) or engagement (Engage) of AOD treatment:
**Initiation: Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.*
**Engagement: Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. a&b: IED-AD for Alcohol abuse or dependence. c&d: IED-AD for Opioid abuse or dependence. e&f: IED-AD for Other drug abuse or dependence. g&h: IED-AD for Total AOD abuse or dependence.*

i: Percentage of ED visits for beneficiaries age 18-64 with a principal diagnosis of AOD addiction or dependence who had a follow-up visit for AOD addiction or dependence within 7 days of the ED visit (8 total days). j: Percentage of ED visits for beneficiaries age 18-64 with a principal diagnosis of AOD addiction or dependence who had a follow-up visit for AOD addiction or dependence within 30 days of the ED visit (31 total days).. k: Percentage of ED visits for beneficiaries age 18-64 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for AOD addiction or dependence within 7 days of the ED visit (8 total days).
l: Percentage of ED visits for beneficiaries age 18-64 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for AOD addiction or dependence within 30 days of the ED visit (31 total days).
m: Rate of all-cause readmissions during the measurement period among beneficiaries with SUD. The count of 30-day readmissions: at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Figure E.5a Follow-up after ED visits for AOD, preventive service, and readmission metrics, annual (Rates)



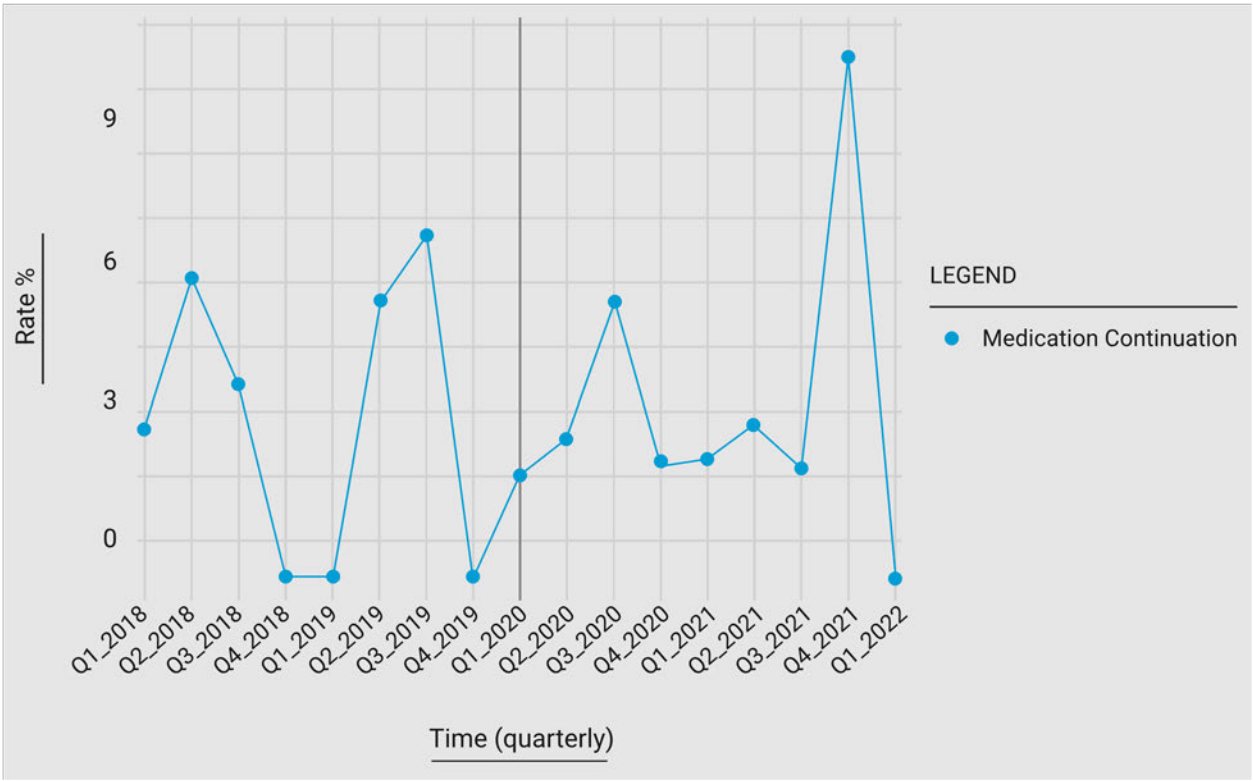
Note: FUA_AD: Percentage of ED visits for beneficiaries age 18-64 with a principal diagnosis of AOD addiction or dependence who had a follow-up visit for AOD addiction or dependence within 7 days of the ED visit (8 total days).

Preventive Services: Percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.

Readmission: Rate of all-cause readmissions during the measurement period among beneficiaries with SUD. The count of 30-day readmissions: at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Figure E.

5b Medication Continuation, quarterly (Rates)



Note: Medication Continuation: Calculated using individual level data, percentage of Medicaid beneficiaries with pharmacotherapy for SUD who have medication procession ratio (MPR) no less than 50% within 180 days after inpatient discharges for SUD.

SMI/SED Tables and Graphics

Table E.7: Performance on Milestone 1 Metrics

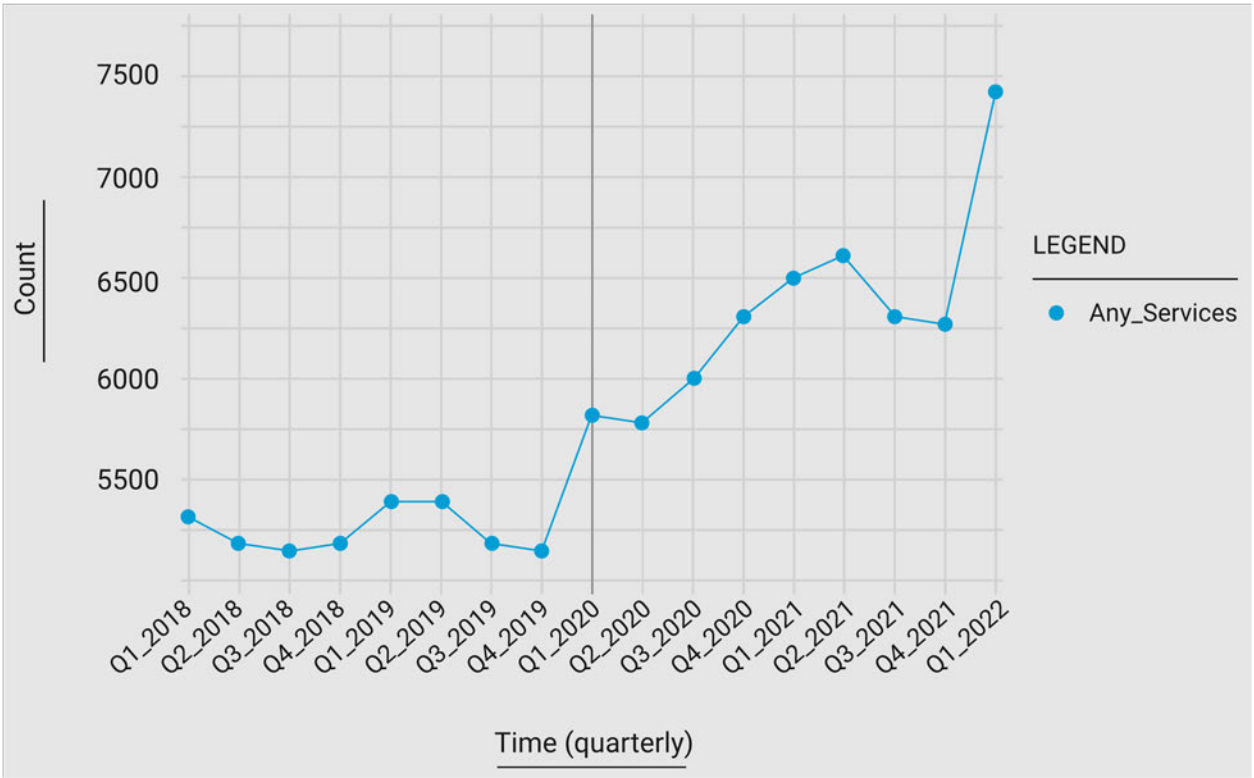
		Count	Absolute change	Percent change %
Utilization of behavioral health treatment services[a] (SMI #18)	Baseline (Jan.-Mar. 2020)	5,817	-	-
	DY1 (Apr. 2020-Mar. 2021)	6,145	328	5.6%
	DY2 (Apr. 2021-Mar. 2022)	6,673	857	14.7%

*Note: SMI/SED Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings. SUD, substance use disorder. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

Figure E.

a: Number of beneficiaries in the SMI/SED demonstration population who used any services related to mental health during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period.

6 Milestone 1 Metrics, annual (Rates)



Note: Any_Services: The number of beneficiaries in the SMI/SED demonstration population who used any services related to mental health during the measurement period.

Table E.8: Performance on Milestone 2 Metrics

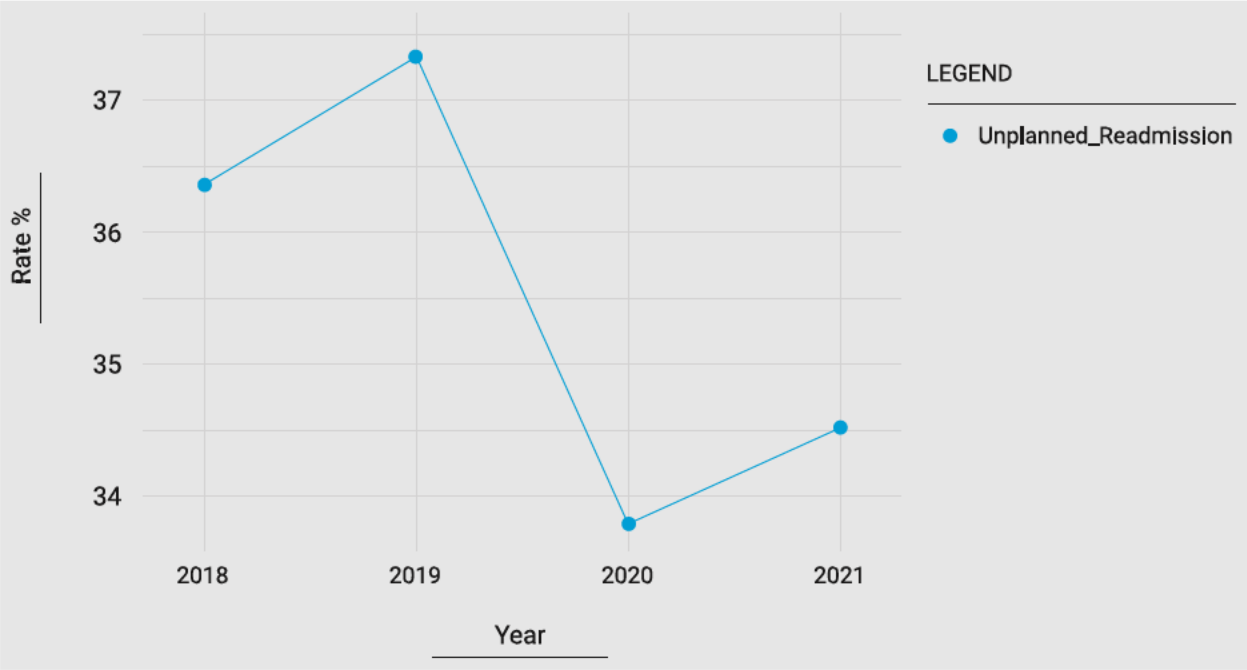
		Rate	Absolute change	Percent change %
30-day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an	*Inpatient Psychiatric Facility (IPF) (SMI #4)* Baseline (2018-2019)	36.9	-	-
	DY1 (Apr. 2020-Mar. 2021)	33.8	-3.1	-8.4%
	DY2 (Apr. 2021-Mar. 2022)	34.5	-2.4	-6.5%

Note: SMI/SED Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care.

30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF): The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.

Figure E.

7 Milestone 2 Metrics, annually (Rates)



Note: Unplanned Readmission: The percentage of All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Healthcare (PMH-20). Unplanned Readmission: The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.

Table E.9: Performance on Milestone 3 Metrics

		Count	Absolute change	Percent change %
Mental Health Services Utilization – Inpatient [a] (SMI #13)	Baseline (Jan.-Mar. 2020)	402	-	-
	DY1 (Apr. 2020-Mar. 2021)	518	116	28.7%
	DY2 (Apr. 2021-Mar. 2022)	534	132	32.8%

Figure E.

Mental health Services Utilization – Intensive Outpatient and Partial Hospitalization [b] (SMI #14)	Baseline (Jan.-Mar. 2020)	88	-	-
	DY1 (Apr. 2020-Mar. 2021)	111	23	26.3%
	DY2 (Apr. 2021-Mar. 2022	148	60	68.1%
Mental Health Services Utilization – ED [c] (SMI #16)	Baseline (Jan.-Mar. 2020)	32	-	-
	DY1 (Apr. 2020-Mar. 2021)	24	-8	-24.2%
	DY2 (Apr. 2021-Mar. 2022)	26	-6	-18%
Crisis service utilization[d]	Baseline (Jan.-Mar. 2020)	203	-	-
	DY1 (Apr. 2020-Mar. 2021)	166	-36	-18%
	DY2 (Apr. 2021-Mar. 2022)	141	-62	-30.5%
Number of beneficiaries who used outpatient rehabilitation services related to SMI/SED [e]	Baseline (Jan.-Mar. 2020	5,501	-	-
	DY1 (Apr. 2020-Mar. 2021)	4,097	-1,405	-25.5%
	DY2 (Apr. 2021-Mar. 2022	4,762	-739	-13.4%
Case management	Baseline (Jan.-Mar. 2020)	ND	ND	ND
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND
Home and community services	Baseline (Jan.-Mar. 2020)	ND	ND	ND
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND
Long-term services/supports	Baseline (Jan.-Mar. 2020)	ND	ND	ND
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND

*Average Length of Stay in IMDs[f] * (SMI #19a)*	Baseline (2018-2019)	ND	-	-
	DY1 (Apr. 2020-Mar. 2021)	8.7	-	-
	DY2 (Apr. 2021-Mar. 2022)	7.3	-	-

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services. Goal 3: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.

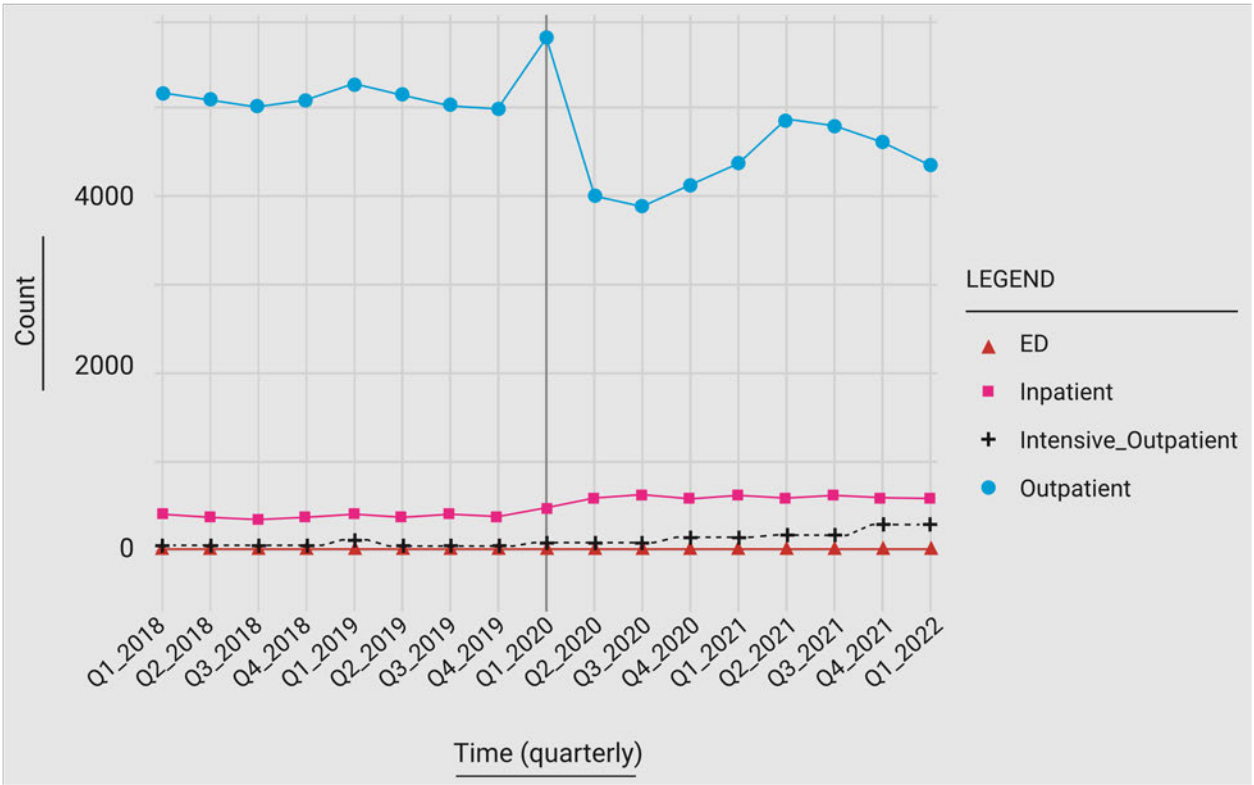
*ED: emergence department. SMI: severe mental illness. SED: severe emotion disturbance. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100. ND – no data available. Availability refers to the counts of providers.*

DY1 and DY2 values are average quarterly values.

a: Number of beneficiaries in the demonstration population who use inpatient services related to mental health. b: Number of beneficiaries in the demonstration population who use intensive outpatient and/or partial hospitalization services related to mental health c: Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period. d: Number of in-crisis calls made for SMI/SED. e: Number of beneficiaries who used outpatient rehabilitation services related to SMI/SED. f: The average length of stay (ALOS) for beneficiaries in the demonstration discharged from an inpatient or residential stay in an IMD.

**Not used for answering research questions but present here as a critical metric listed by CMS to be included in MPA.*

Figure E.8a Milestone 3 Metrics, quarterly (Counts)



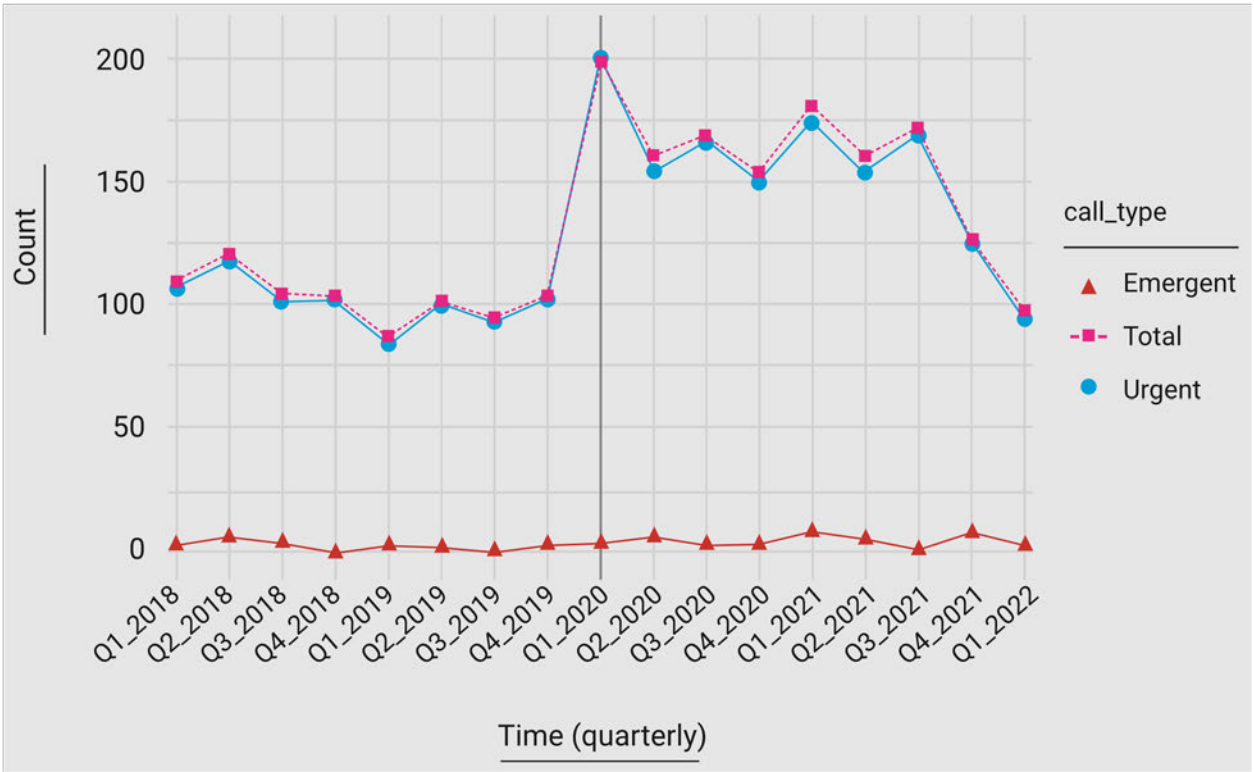
Note: Inpatient: Number of beneficiaries who use inpatient services related to SMI/SED.

Intensive Outpatient: Number of beneficiaries in the demonstration population who use intensive outpatient and/or partial hospitalization services related to mental health.

ED: Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.

Outpatient: Number of beneficiaries who used outpatient rehabilitation services related to SMI/SED.

Figure E.8b Milestone 3 Metrics, Crisis service utilization, quarterly (Counts)



Note: Only numbers of total crisis calls are reported in Table E.9. The numbers of urgent calls were very similar to the one of total calls. Emergent calls were very uncommon.

Table E.10: Performance on Milestone 3 Metrics

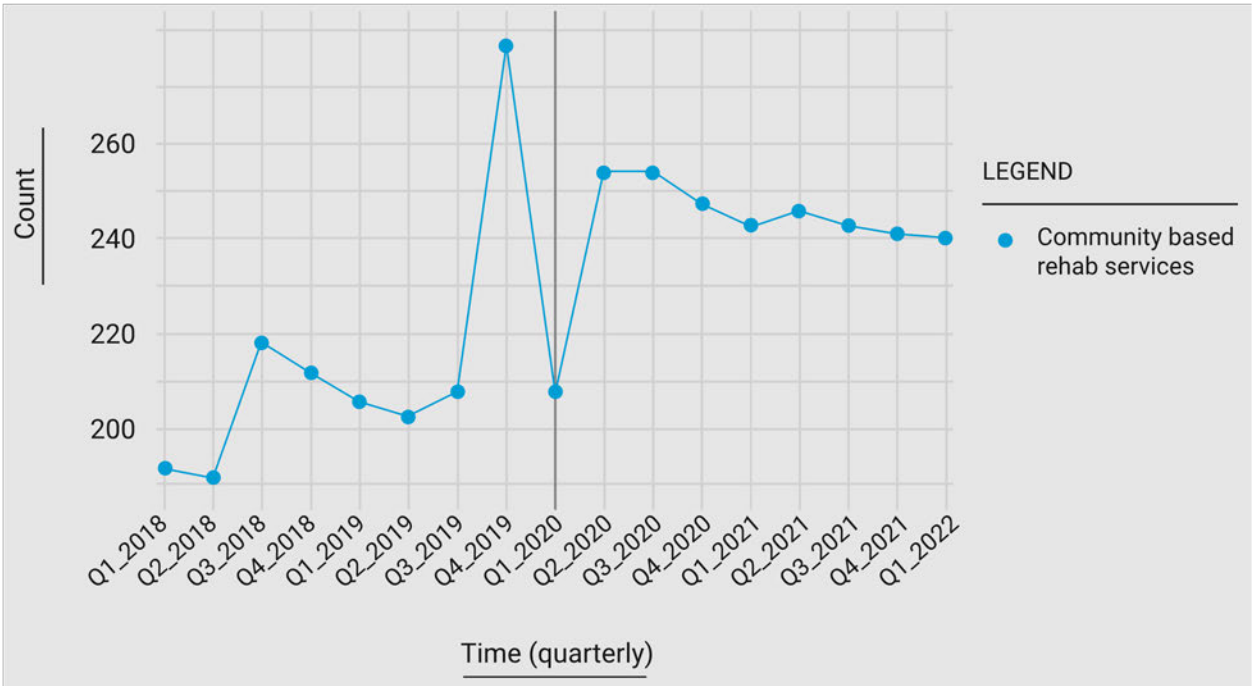
	Count	Absolute change	Percent change %

Availability of communitybased behavioral health services	Baseline (Jan.-Mar. 2020)	207	-	-
	DY1 (Apr. 2020-Mar. 2021)	250	43	20.9%
	DY2 (Apr. 2021-Mar. 2022)	243	36	17.2%
Suicide rates	Baseline (Jan.-Mar. 2020)	ND	ND	ND
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022	ND	ND	ND
Availability of virtual visits	Baseline (Jan.-Mar. 2020)	ND	ND	ND
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND
Availability of clinics with co-located physical and behavioral health providers	Baseline (Jan.-Mar. 2020)	ND	ND	ND
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND
Availability of crisis care (overall; crisis call centers; mobile crisis units; crisis assessment centers; coordinated community response teams)	Baseline (Jan.-Mar. 2020)	32	0	0
	DY1 (Apr. 2020-Mar. 2021)	32	0	0
	DY2 (Apr. 2021-Mar. 2022	ND	ND	ND
Availability of FQHCs offering *behavioral health services*	Baseline (Jan.-Mar. 2020)	46	-	-
	DY1 (Apr. 2020-Mar. 2021)	47	1	2.2%
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND
Per capita availability of outpatient mental health professionals, by type	Baseline (Jan.-Mar. 2020)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	7.4%	-	-
	DY2 (Apr. 2021-Mar. 2022)	7.0%	-	-

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services. Goal 4: Improved access to community-based services to address the chronic mental healthcare needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral healthcare.
Annual data.

*Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100. FQHC: Federal qualified health center. ND – no data available. Availability refers to the counts of providers.*

Figure E.9 Milestone 3 Metrics, quarterly (Counts)



Note: The total number of community-based rehab service providers in all Idaho counties per quarter.

Table E.11: Performance on Milestone 4 Metrics

			Count	Absolute change	Percent change
% The number of enrollees co-located physical and behavioral health facilities	Baseline (Jan.-Mar. 2020)	ND	ND	ND	*receiving care from*
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	
	(FQHC colocation report)				

Note: SMI/SED Milestone 4: Earlier Identification and Engagement in Treatment, Including through Increased Integration.

*Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

Provider Availability Tables and Graphics

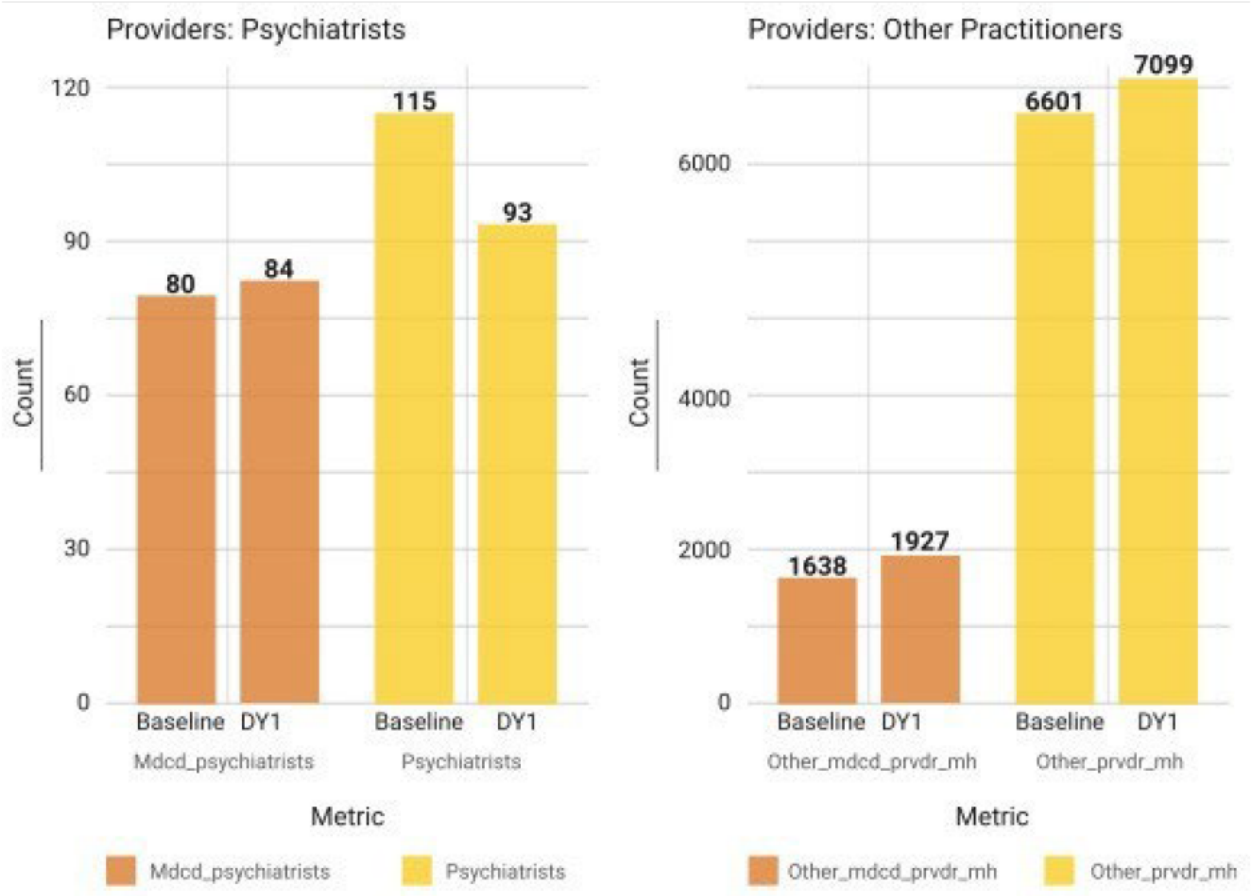
Table E.12: Availability of Practitioners

			Value	Absolute change	Percent change %
Practitioners	*Psychiatrists*[a]	Baseline (2019)	115	-	-
		DY1	93	-22	-19.1%
	Medicaid enrolled psychiatrists[b]	Baseline (2019)	80	-	-
		DY1	84	4	5.0%
	Other practitioners for treating mental illness[c]	Baseline (2019)	6,601	-	-
		DY1	7,099	498	7.5%
	Medicaid enrolled other practitioners for treating mental illness[d]	Baseline (2019)	1,638	-	-
		DY1	1,927	289	17.6%

*Note: Annual data. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

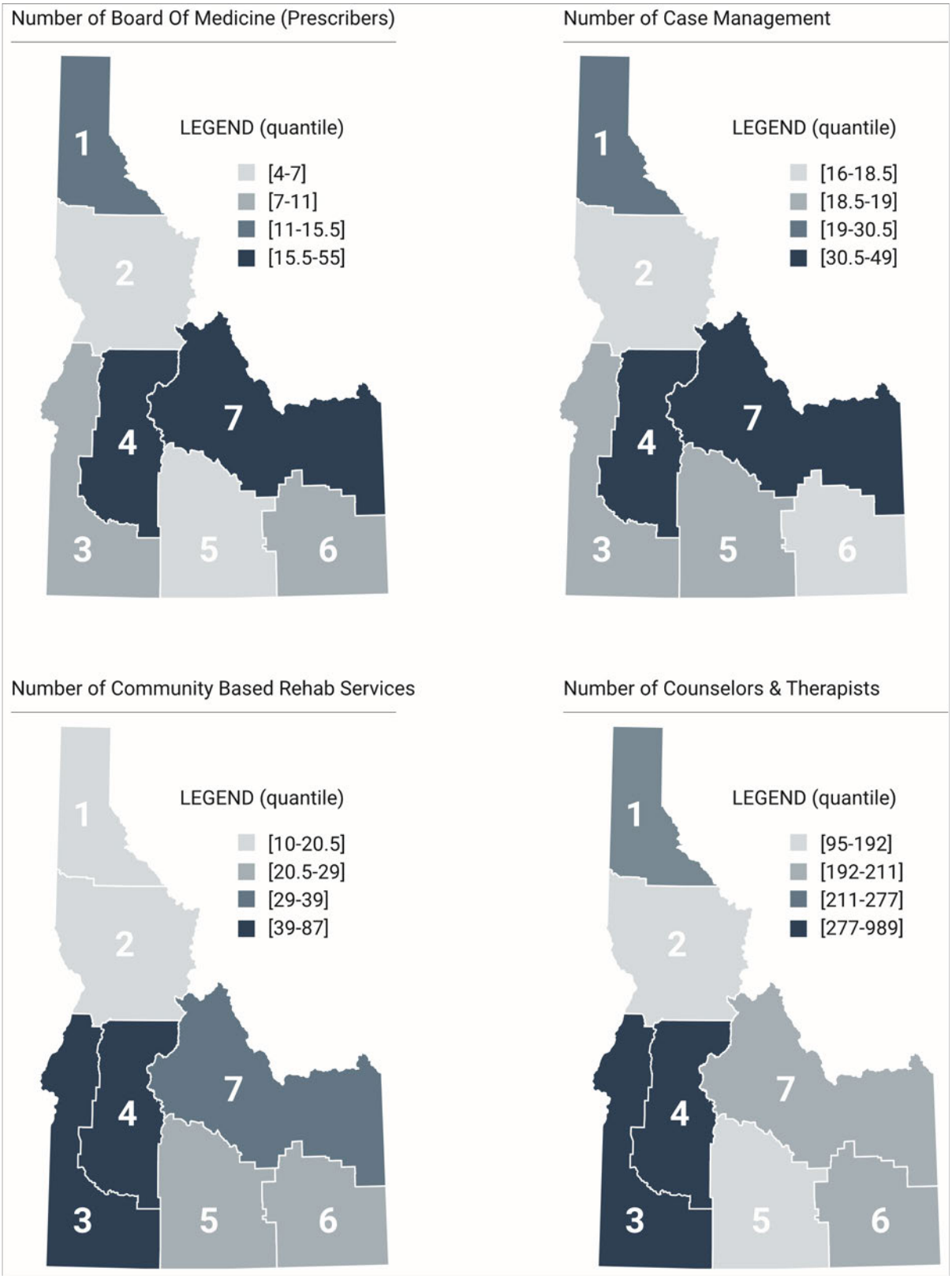
a: The number of psychiatrists or other practitioners who are authorized to prescribe psychiatric medications during the measurement period. b: The number of Medicaid-enrolled psychiatrists or other practitioners who are authorized to prescribe psychiatric medications during the measurement period.
c: The number of other practitioners certified or licensed to independently treat mental illness medications during the measurement period.
d: The number of Medicaid-enrolled other practitioners certified or licensed to independently treat mental illness during the measurement period.

Figure E.10a Availability of Practitioners

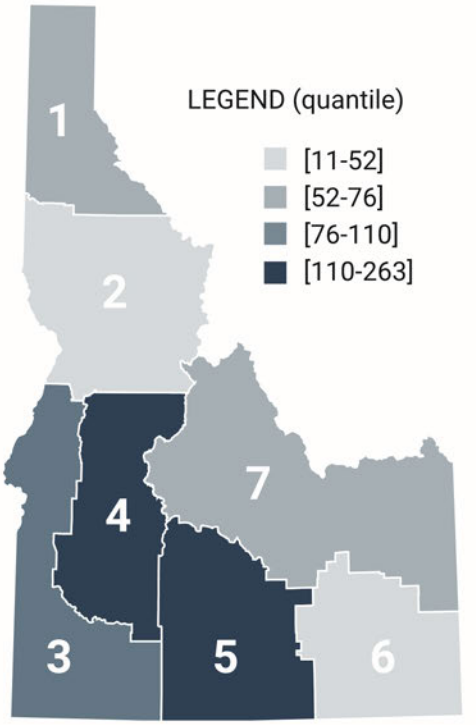


Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020. Mdcd_psychiatrists: Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications, Psychiatrists: Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications, Other_mdcd_prvdr_mh: Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness, Other_prvdr_mh: Other Practitioners Certified or Licensed to Independently Treat Mental Illness.

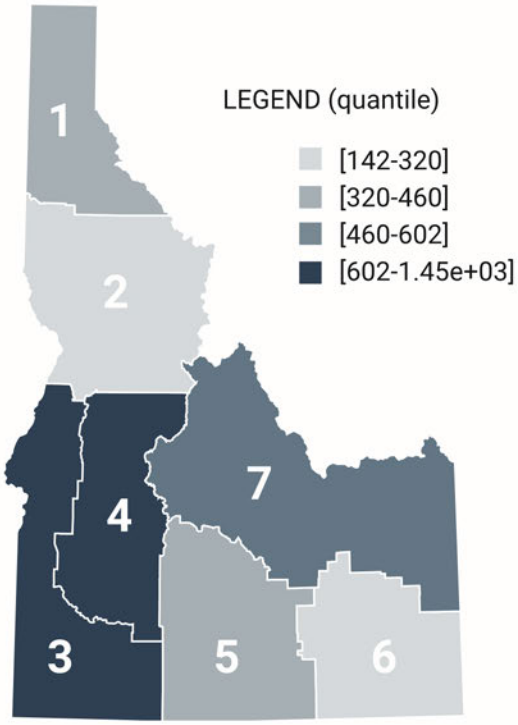
Figure E.10b Spatial distribution of providers in each region, May 2021



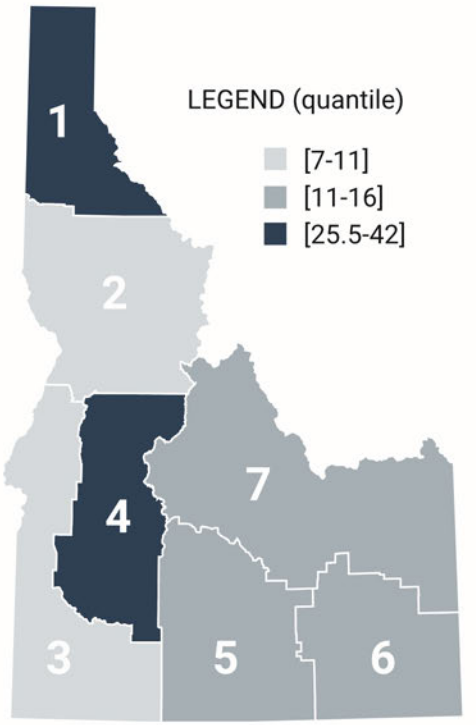
Number of MD_NP_PA_PHD



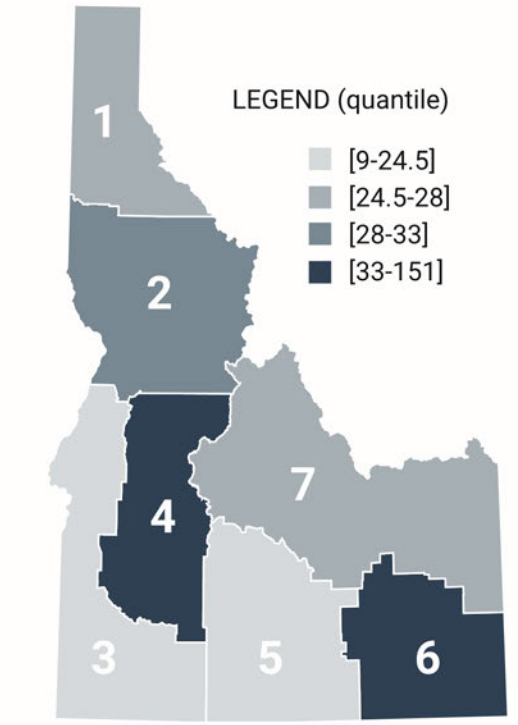
Number of MHClinicians



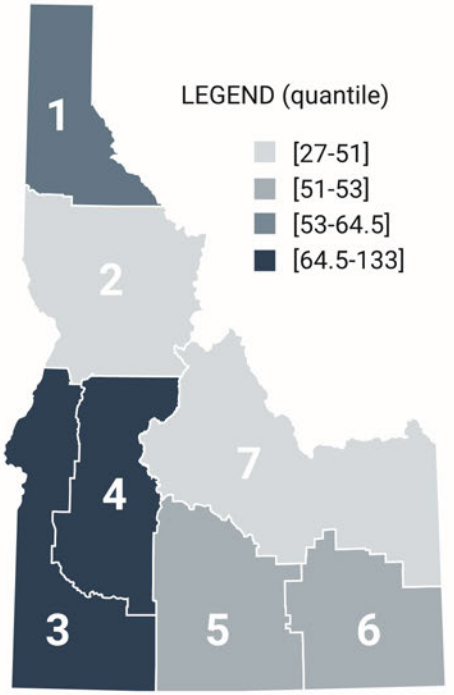
Number of MMIS Medicaid Providers



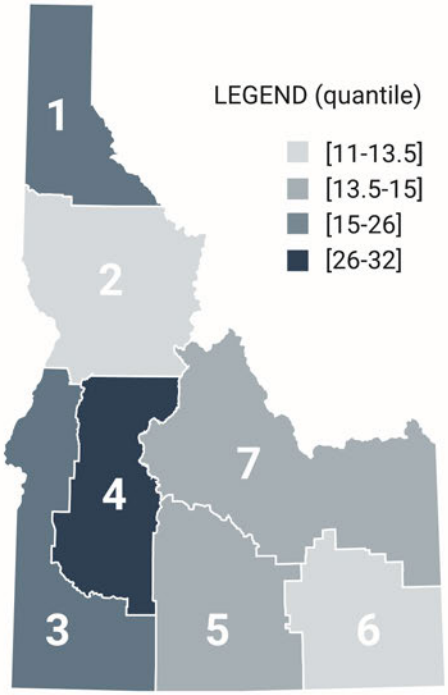
Number of Psychologists



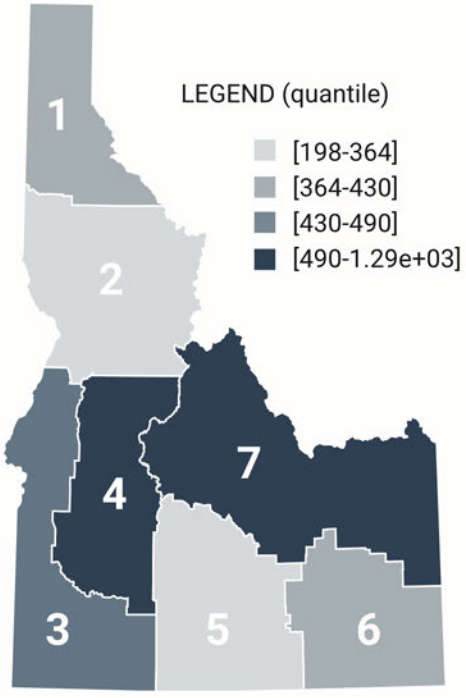
Number of Residential Care



Number of SAGroups



Number of Social Workers



Note: MD, Medical doctor. NP, Nurse practitioner. PA, Physician assistant. PHD, Philosophy doctor. MMIS, Medicaid Management Information System

Table E. : 13 Availability of Intensive Outpatient Services

			Value	Absolute change	Percent change %
Intensive outpatient services	*Providers offering intensive outpatient services*[a]	Baseline (2019)	14	-	-
		DY1	38	24	171.4%
	Medicaid-enrolled providers offering intensive outpatient services[b]	Baseline (2019)	14	-	-
		DY1	38	4	171.4%

*Note: Annual data. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

a: The number of providers offering intensive outpatient services during the measurement period. b: The number of Medicaid-enrolled providers offering intensive outpatient services during the measurement period.

In both baseline and DY1all providers offering intensive outpatient services were enrolled in Medicaid (i.e., able to be reimbursed for seeing Medicaid patients). We observed a large increase from 14 to 38

providers from baseline to DY1. Again, the growth in Medicaid-enrolled intensive outpatient providers indicates progress on this milestone.

Figure E.11 Availability of Intensive Outpatient Services

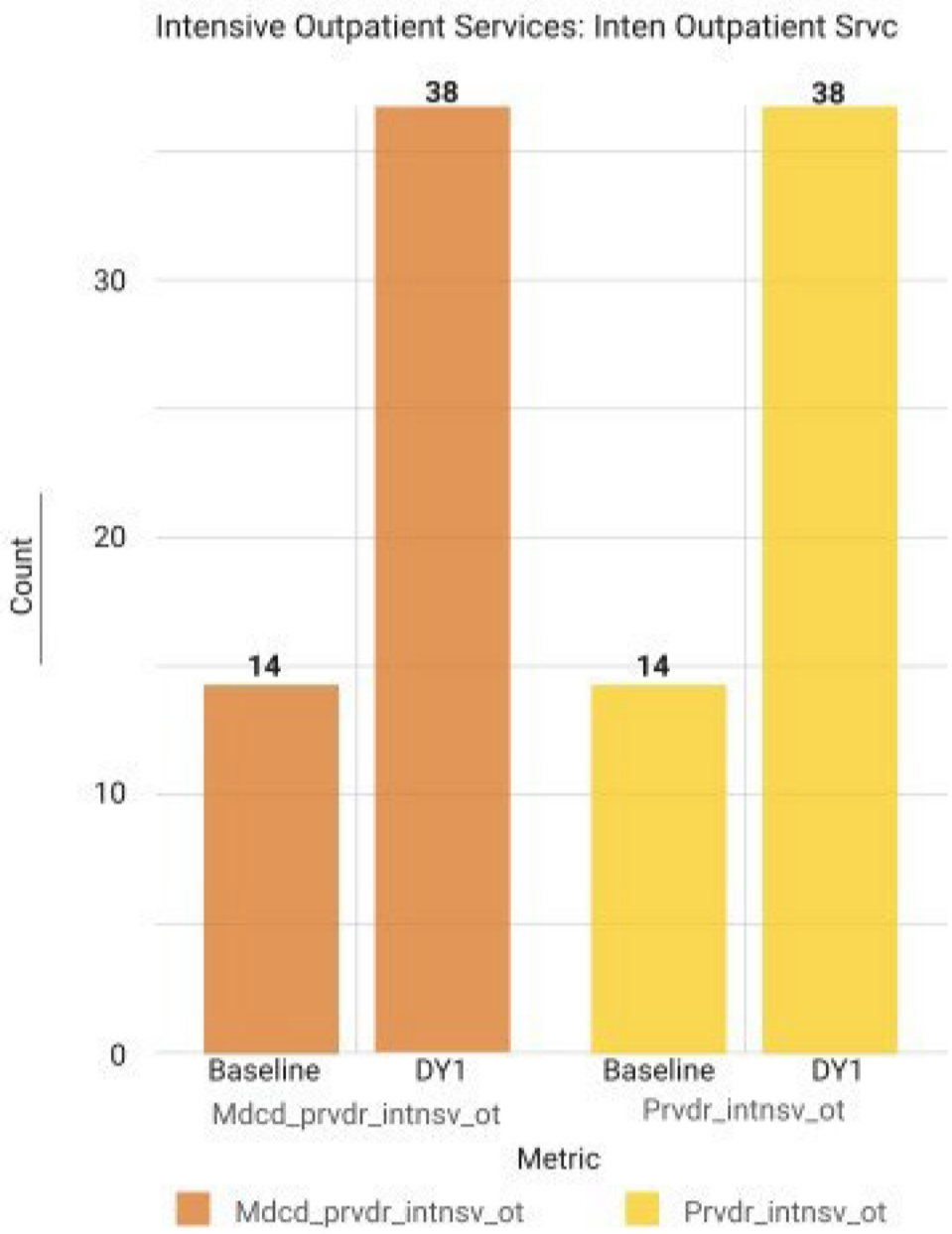


Table E. :

Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020. Mdcd_prvdr_intnsv_ot: Medicaid-Enrolled Providers Offering Intensive Outpatient Services, Prvdr_intnsv_ot: Providers Offering Intensive Outpatient Services.

14 Availability of Residential Mental Health Treatment Facilities

			Value	Absolute change	Percent change %
Residential mental health treatment facilities	*Residential mental health treatment facilities (Adult)[a]*	Baseline (2019)	4	-	-
		DY1	4	0	0
	Medicaid-enrolled residential mental health treatment facilities (Adult)[b]	Baseline (2019)	4	-	-
		DY1	4	0	0
	Residential mental health treatment facility beds (Adult)[c]	Baseline (2019)	56	-	-
		DY1	56	0	0
	Medicaid-enrolled residential mental health treatment beds (Adult)[d]	Baseline (2019)	56	-	-
		DY1	56	0	0
Psychiatric residential treatment facilities	*Psychiatric residential treatment facilities (PRTF)[e]*	Baseline (2019)	1	-	-
		DY1	1	0	0
	Medicaid-enrolled PRTFs[f]	Baseline (2019)	1	-	-
		DY1	1	0	0
	PRTF beds[g]	Baseline (2019)	12	-	-
		DY1	12	0	0
	Medicaid-enrolled PRTF beds[h]	Baseline (2019)	12	-	-
		DY1	12		

*Note: Annual data. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

a: The number of residential mental health treatment facilities (Adult) during the measurement period. b: The number of Medicaid-enrolled residential mental health treatment facilities (Adult) during the measurement period.
c: The number of residential mental health treatment facility beds (Adult) during the measurement period. d: The number of Medicaid-enrolled residential mental health treatment beds (Adult) during the measurement period. e: The number of psychiatric residential treatment facilities (PRTF) during the measurement period. f: The number of Medicaid-enrolled PRTFs during the measurement period. g: The number of PRTF beds during the measurement period. h: The number of Medicaid-enrolled PRTF beds during the measurement period.

Table E. : 15 Availability of Institutions for Mental Diseases (IMD)

			Value	Absolute change	Percent change %
Institutions for mental diseases	*Residential mental health treatment facilities (adult) that qualify as IMDs*[a]	Baseline (2019)	0	-	-
		DY1	0	0	0
	Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs[b]	Baseline (2019)	0	-	-
		DY1	0	0	0
	Psychiatric Hospitals that Qualify as IMDs[c]	Baseline (2019)	3	-	-
		DY1	3	0	0

*Note: Annual data. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

IMD: Institution for mental diseases.

a: The number of residential mental health treatment facilities (adult) that qualify as IMDs during the measurement period.
b: The number of Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs during the measurement period.
c: The number of psychiatric hospitals that qualify as IMDs during the measurement period.

Table E.16: Availability of Inpatient Services

			Value	Absolute change	Percent change %
Public and private hospitals	*Public and private hospitals* [a]	Baseline (2019)	5	-	-
		DY1	5	0	0
	Medicaid-enrolled public and private hospitals[b]	Baseline (2019)	4	-	-
		DY1	4	0	0
	Psychiatric Hospitals that	Baseline (2019)	3	-	-
		DY1	3	0	0

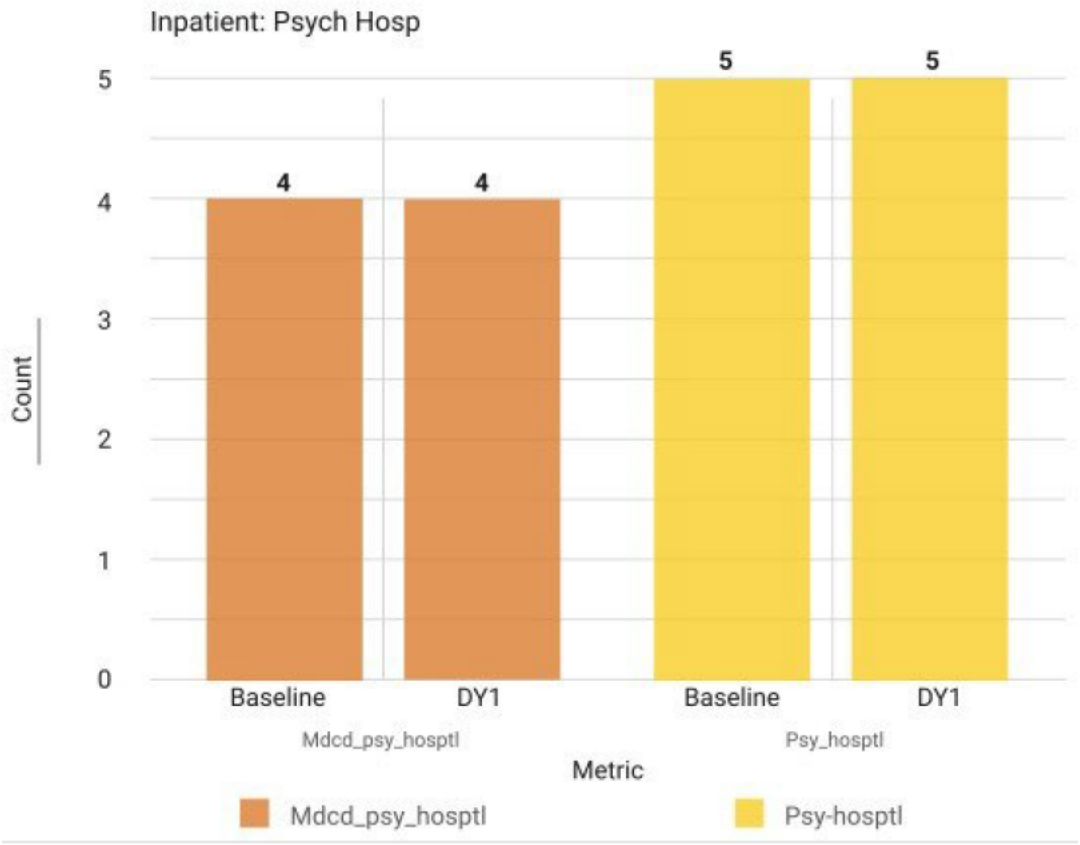
	Qualify as IMDs[c]				
Psychiatric units	*Psychiatric units in acute care hospitals[c]*	Baseline (2019)	9	-	-
		DY1	9	0	0
	Psychiatric units in critical access hospitals (CAHs)[d]	Baseline (2019)	1	-	-
		DY1	1	0	0
	Medicaid-enrolled psychiatric units in acute care hospitals[e]	Baseline (2019)	9	-	-
		DY1	9	0	0
	Medicaid-enrolled psychiatric units in CAHs[f]	Baseline (2019)	115	1	-
		DY1	93	1	0
Psychiatric beds	*Licensed psychiatric hospital beds[g]*	Baseline (2019)	806	-	-
		DY1	806	0	0
	Medicaid-enrolled licensed psychiatric hospital beds[h]	Baseline (2019)	730	-	-
		DY1	730	0	0

*Note: Annual data. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

a: The number of public and private psychiatric hospitals during the measurement period. (Note: an issue in the original MHAA suggested 5 hospitals at baseline but this was revised to be 3, thus indicating no change in hospitals).
b: The number of public and private psychiatric hospitals available to Medicaid patients during the measurement period. c: The number of psychiatric units in acute care hospitals during the measurement period. d: The number of psychiatric units in critical access hospitals (CAHs) during the measurement period. e: The number of Medicaid-enrolled psychiatric units in acute care hospitals during the measurement period. f: The number of Medicaid-enrolled psychiatric units in CAHs during the measurement period. g: The number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) during the measurement period.
h: The number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) available to Medicaid patients during the measurement period.

Figure E.

12a Availability of Inpatient Services: Psychiatric Hospitals



Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020. Mdcd_psy_hosptl: Public and Private Psychiatric Hospitals Available to Medicaid Patients, Psy_hosptl: Public and Private Psychiatric Hospitals

Figure E.12b Availability of Inpatient Services: Psychiatric Units

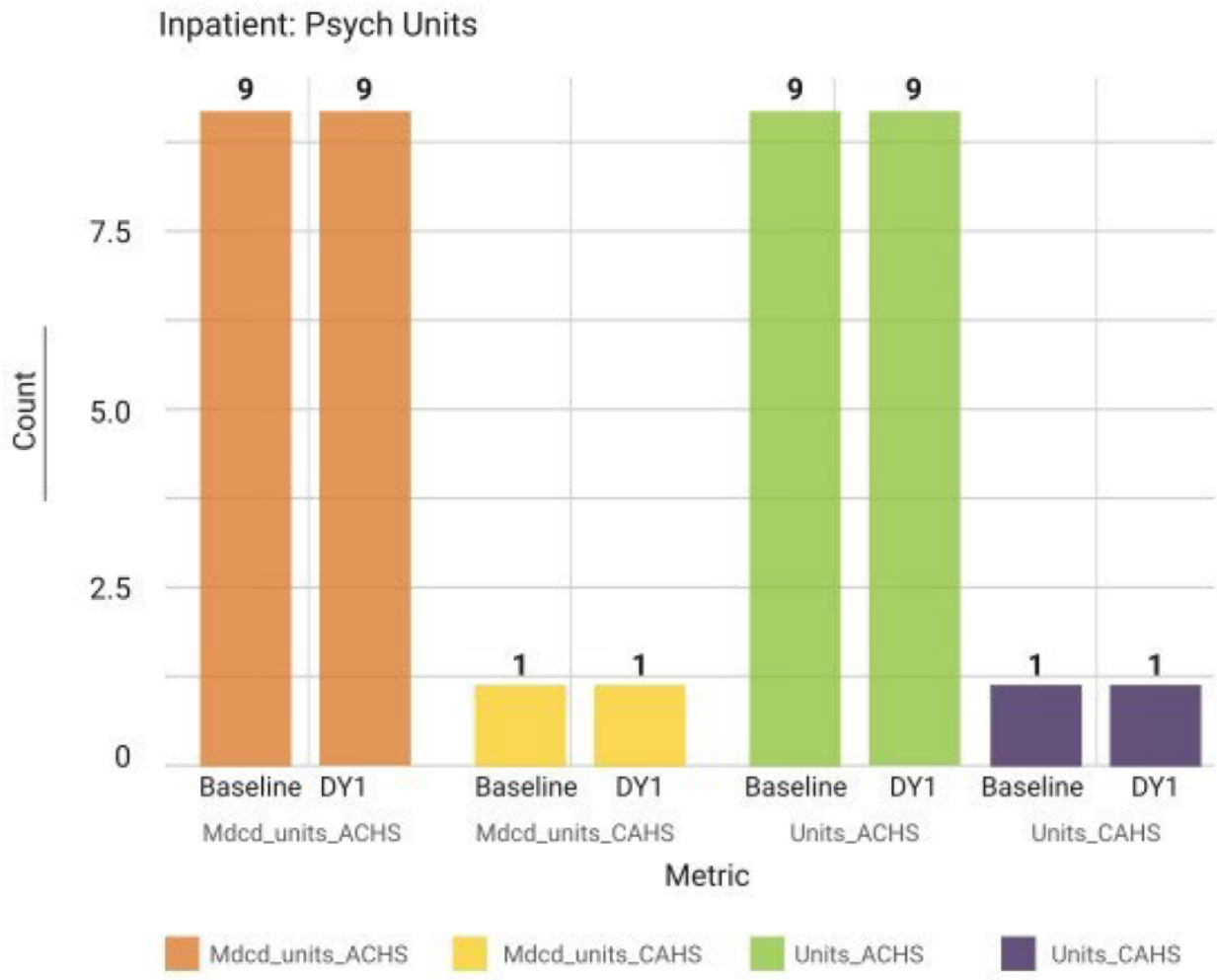
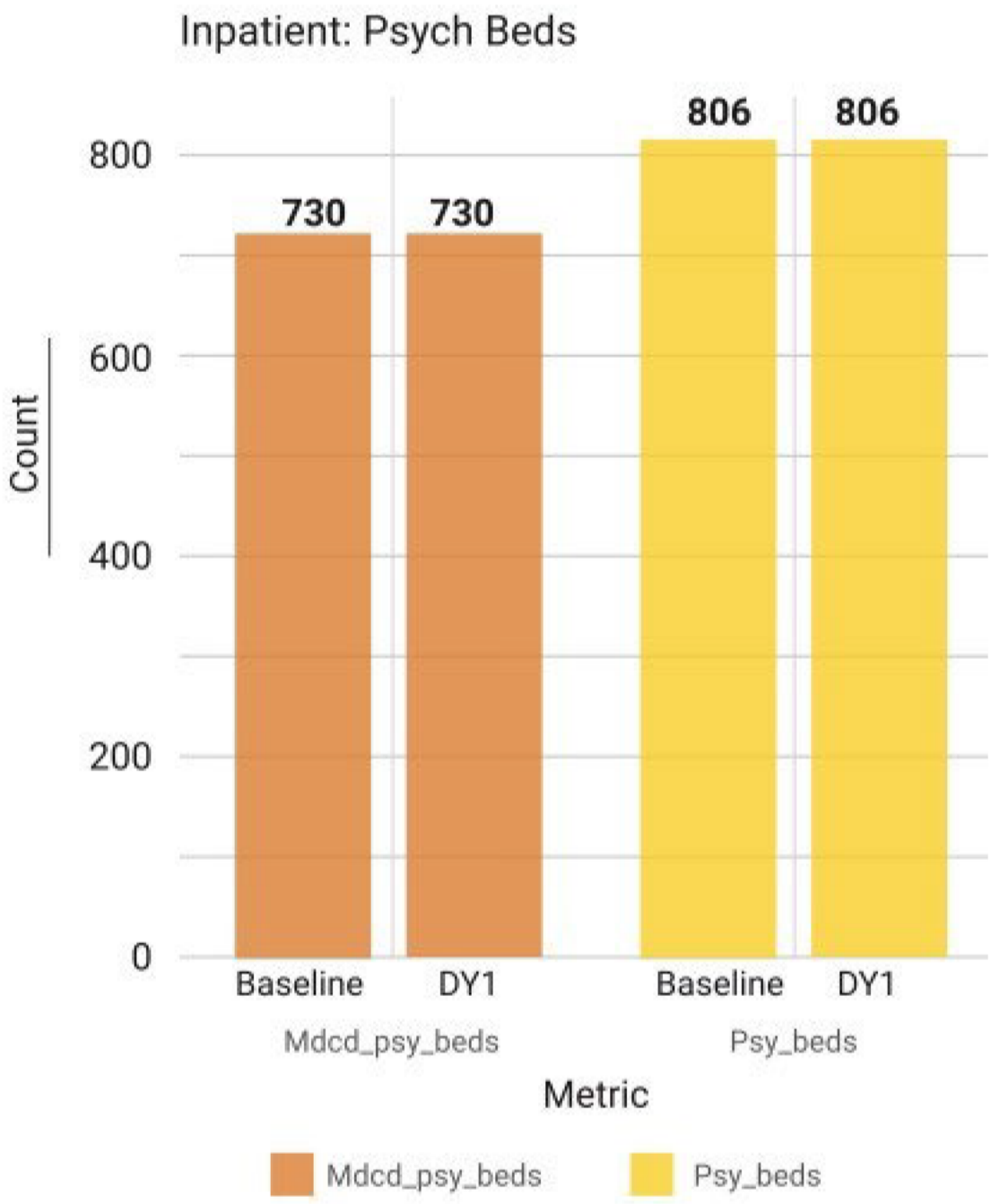


Figure E.

Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020. Mdcd_units_ACHS: Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals, Mdcd_units_CAHS: Medicaid-Enrolled Psychiatric Units in CAHs, Units_ACHS: Psychiatric Units in Acute Care Hospitals, Units_CAHS: Psychiatric Units in Critical Access Hospitals (CAHs)

12c Availability of Inpatient Services: Psychiatric Beds



Note: Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020. Psy_beds: number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units). Mdcd_psy_beds: number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) available to Medicaid patients

Figure E.

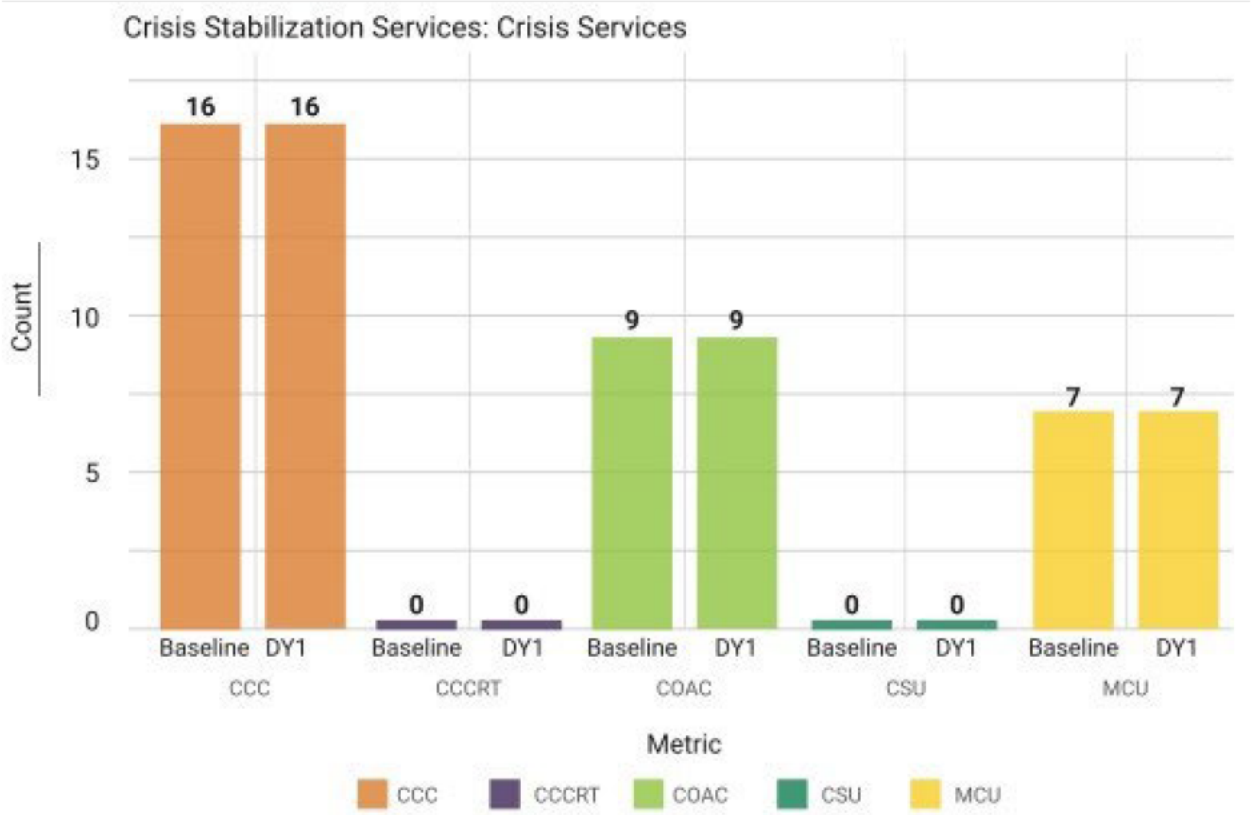
Table E.17: Availability of Crisis Stabilization Services

			Value	Absolute change	Percent change %
Crisis Stabilization Services	*Crisis Call Centers*[a]	Baseline (2019)	16	-	-
		DY1	16	0	0
	Mobile Crisis Units[b]	Baseline (2019)	7	-	-
		DY1	7	0	0
	Crisis Observation/Assessment Centers[c]	Baseline (2019)	9	-	-
		DY1	9	0	0
	Crisis Stabilization Units[d]	Baseline (2019)	0	-	-
		DY1	0	0	0
	Coordinated Community Crisis Response Teams[e]	Baseline (2019)	0	-	-
		DY1	0	0	0

*Note: Annual data. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

a: The number of crisis call centers during the measurement period. b: The number of mobile crisis units during the measurement period. c: The number of crisis observation/assessment

centers during the measurement period. d: The number of crisis stabilization units during the measurement period. e: The number of coordinated community crisis response teams during the measurement period. **13 Availability of Crisis Stabilization Services**



Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020. CCC: Crisis Call Centers, CCCRT: Coordinated

Figure E.

Community Crisis Response Teams, COAC: Crisis Observation/Assessment Centers, CSU: Crisis Stabilization Units, MCU: Mobile Crisis Units

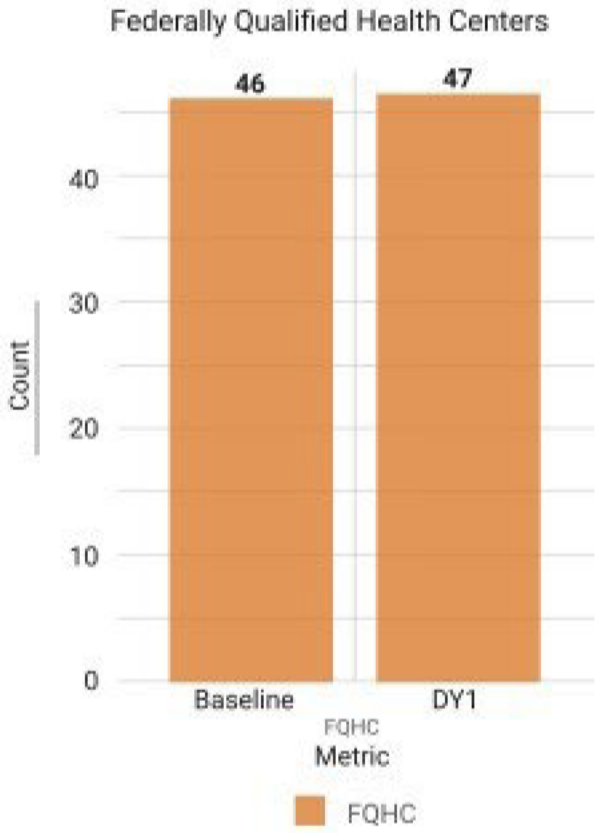
Table E.18: Availability of Federally Qualified Health Centers (FQHC)

			Value	Absolute change	Percent change %
FQHCs	*FQHCs[a]*	Baseline (2019)	46	-	-
		DY1	47	1	2.2%

*Note: Annual data. Baseline: Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.*

a: The number of federally qualified health centers (FQHC) during the measurement period.

14 Availability of Federally Qualified Health Centers (FQHC)



Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020. FQHC: Federally qualified health center.

Budget Neutrality Tables

Table E.19a Without Waiver Expenditures for SMI/SED and SUD Services

Figure E.

Expenditure		DY1	DY2	DY3	DY4	DY5
FFS-SMI/SED	Total	$20,916,650	$24,020,788	$27,586,675	$31,680,628	$36,381,677
	PMPM	$8,590.00	$8,968.00	$9,363.00	$9,775.00	$10,205.00
	MemberMonths	2,435	2,679	2,946	3,241	3,565
FFS-SUD	Total	$4,718,965	$5,419,926	$6,223,835	$7,147,091	$8,207,803
	PMPM	$6,889.00	$7,193.00	$7,509.00	$7,839.00	$8,184.00
	Member Months	685	754	829	912	1,003

Source: Idaho Behavioral Health Transformation Year 2 Quarter 3 Budget Report.

Table E.19b With Waiver Expenditures SMI/SED and SUD Services

Expenditure		DY1	DY2	DY3	DY4	DY5
FFS-SMI/SED	Total	$12,983,598	$17,367,300	$27,586,675	$31,680,628	$36,381,677
FFS-SUD	Total	$3,194,506	$4,324,117	$6,223,835	$7,147,091	$8,207,803

Source: Idaho Behavioral Health Transformation Year 2 Quarter 3 Budget Report.

Table E.19c Hypothetical Budget Neutrality Test 1

	DY1	DY2	DY3	DY4	DY5
Cumulative Target Percentage (CTP)	2.0%	1.5%	1.0%	0.5%	
Cumulative Budget Neutrality Limit (CBNL)	$25,635,615	$55,076,329	$88,886,838	$127,714,557	$172,304,038
Allowed Cumulative Variance (= CTP X CBNL)	$512,712	$826,145	$888,868	$638,573	$-
Actual Cumulative Variance (Positive = Overspending)	$(9,457,511)	$(17,206,807)	$(17,206,807)	$(17,206,807)	$(17,206,807)

Source: Idaho Behavioral Health Transformation Year 2 Quarter 3 Budget Report.

Tables E.20. Findings from Mid-Point Assessment of Implementation Plan Action Items (as of March 2022)

Status of action items as of March 31, 2022. Items are marked open if in progress and suspended if postponed with no progress. Status terminology (Completed, Open, Suspended) was sourced from CMS Mid-Point Assessment Technical Assistance document and status of milestone actions were sourced from IDHW internal project plan tracking sheet. Milestones that have overlapping action items are indicated. These duplicate action items are not listed out individually in tables E.20 but are accounted for when calculating the percentage of completed action items in table E.21.

Table E.20a. SUD Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
1a.	Amend State Plan to include new recovery coaching services.	December 31, 2021	Completed
1a.	Add recovery coaching to 1915(b).	April 16, 2021	Completed
1a.	Add recovery coaching to IBHP contract.	April 16, 2021	Completed
1a.	Review of all outpatient service definitions and staff qualifications to ensure alignment with ASAM.	March 1, 2021	Completed
1b.	Over the demonstration period, Idaho Medicaid and IBHP contractor will continue to enroll new Partial Hospitalization providers.	Over the course of the Demonstration Period by April 17, 2025	Open
1c.	Align Idaho service definition with ASAM criteria.	March 1, 2021	Completed
1c.	Modify existing State Plan language and 1915(b) authorities to ensure coverage of methadone maintenance.	April 16, 2021	Completed
1.c	Develop new policies and rules for provision of MAT at OTPs.	January 1, 2021	Completed
1.c	Restructure reimbursement following completion of CMS MAT Affinity TA Group.	January 1, 2021	Completed
1.d	Align Idaho service definition with ASAM criteria.	March 1, 2021	Completed
1.d	Provide avenue for residential providers to enroll as Idaho Medicaid providers.	April 29, 2022	Open
1.d	Add coverage of residential services equivalent to ASAM 3.5.	April 29, 2022	Open

1.d	Define reimbursement methodology for residential services and make necessary revisions to MMIS to reflect changes to provider enrollment and reimbursement for these services.	June 30, 2022	Open
1.d	Develop regulations, rules and/or standards to establish provider qualifications and service definitions for residential treatment providers that align with ASAM standards for types of services, hours of clinical care and credentials of staff.	June 30, 2022	Open
1.d	Add residential and inpatient services to the future IBHP contract rebid.	December 31, 2021	Completed
1e.	Align Idaho service definition with ASAM criteria.	March 1, 2021	Completed
1.e	Add withdrawal management to Medicaid State Plan.	October 15, 2021	Completed
1.e	Develop regulations to establish provider qualifications and service definitions for residential treatment providers that align with ASAM standards for types of services, hours of clinical care and credentials of staff.	June 30, 2022	Open

Table E.20b: SUD Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
2a.	Amend IBHP contract to require inclusion of a full psychosocial assessment covering the six dimensions in accordance with The ASAM Criteria.	December 17, 2021	Completed
2a.	Develop and implement criteria via IDAPA rules and/or standards to ensure beneficiaries' treatment needs are assessed based on SUD-specific, multidimensional assessment tools that reflect evidence-based clinical treatment guidelines.	December 31, 2021	Completed
2a.	Discuss standards with new contract holder.	July 3, 2023	Suspended
2b.	Establish necessary administrative rules, regulations or statutes, to ensure access to the appropriate levels of care and oversight on lengths of stay.	September 15, 2020	Open
2b.	Establish an independent UM process used to ensure beneficiaries have access to SUD services at the appropriate level of care with the appropriate interventions based on The ASAM Criteria.	December 31, 2021	Completed
2b.	Incorporate requirements into IBHP rebid to include additional quality measures related to UM and outcomes, and to establish minimum processes for reviewing and approving placements in inpatient and residential treatment settings in accordance to The ASAM Criteria. This UM process will promote the appropriate placement in level of care and ensure interventions are appropriate for the presenting diagnosis and level of care.	December 31, 2021	Completed

Table E.20c: SUD Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)

3a.	Update Medicaid provider handbook with guidance regarding residential treatment provider qualifications, requirements regarding ASAM criteria and other program standards.	December 30, 2022	Open
3a.	Establish statute, licensure IDAPA rules, and/or other standards for SUD residential treatment programs providing publicly funded services enrolled with Medicaid.	June 30, 2022	Open
3a.	Incorporate residential services in IBHP contract rebid, including requirement that all providers enrolled in the IBHP network must adhere to these minimum provider qualification standards.	December 31, 2021	Completed
3b.	Establish a state certification process for all SUD residential treatment programs enrolled with Medicaid.	June 30, 2022	Open
3b.	Establish an ongoing process to periodically reevaluate existing publicly funded SUD residential treatment programs to ensure residential treatment providers adhere to state- developed standards.	April 15, 2021	Open
3c.	Revise Medicaid enrollment policies, regulations and standards to require all Medicaid enrolled SUD residential treatment providers to offer at least two forms of MAT.	April 16, 2021	Completed
3.c	In 2021 rebid, include a new requirement for the IBHP contractor to ensure all network inpatient and residential treatment providers comply with MAT policy requirements.	December 31, 2021	Completed

Table E.20d. SUD Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for MAT for OUD

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
4a.	Medicaid will fund services in 24-hour crisis centers in each region of Idaho.	April 16, 2021	Completed
4a.	DBH will expand inpatient and crisis bed registry as a first responder community resource over the course of the demo.	Over the course of the Demonstration Period by March 31, 2025	Open

4a.	Continue to strengthen the NEMT provider network in Idaho. The new NEMT contract will have specific requirements the contractor will have to meet regarding availability of NEMT services across Idaho.	June 30, 2021	Completed
4a.	The IBHP rebid contract will outline specific incentives for behavioral health professionals who operate within primary care settings.	December 31, 2021	Completed
4a.	The new IBHP contract will outline specific access metrics that pertain to increased use of telehealth services in Idaho.	December 31, 2021	Completed
4a.	The new IBHP contract will outline specific real-time dashboard requirements regarding network specialties, levels of care, provider types and accepting new patients.	March 31, 2025	Suspended
4a.	The IBHP contract will require MAT for OUD to be available in all regions of Idaho.	December 31, 2021	Completed

Table E.20e. SUD Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Addiction and OUD

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
5a.	Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse.	N/A	No Action Needed
5b.	Develop and use an integrated acquisition and tracking platform for naloxone distribution.	Over the course of the Demonstration Period by March 31, 2025	Suspended
5b.	Identify and partner with critical stakeholders to expand naloxone distribution.	Over the course of the Demonstration Period by March 31, 2025	Suspended
5b.	Standardize training content across stakeholders and platforms over the course of the demo.	Over the course of the Demonstration Period by March 31, 2025	Suspended
5c.	Access CMS HITECH funding.	April 16, 2021	Completed

5c.	The new IBHP contract will outline specific real-time dashboard requirements regarding network specialties, levels of care, provider types and accepting new patients.	April 16, 2021	Completed

Table E.20f. SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
6a.	Develop transition of care standards.	September 30, 2023	Open
6a.	Notify residential treatment providers of requirements.	September 30, 2023	Open
6a.	Implement the new IBHP contract.	September 30, 2023	Open
6a.	Include Idaho Transition of care standards in the new IBHP contract.	September 30, 2023	Open
6a.	Include transition of care standards in IBHP provider agreements.	September 30, 2023	Open
6a.	Include additional HEDIS FUH measures tied to performance in IBHP contract.	December 31, 2021	Completed
6b.	DBH develop standards for coordination of care for cooccurring physical and mental health conditions.	September 30, 2023	Open
6b.	Notify providers of standards.	September 30, 2023	Open
6b.	Execution of the new IBHP contract.	September 30, 2023	Open
6b.	New IBHP contract outlines Idaho standards	September 30, 2023	Open
6b.	IBHP provider agreements outline transition of care standards.	September 30, 2023	Open

Table E.20g. SMI/SED Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
1a.	Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid.	N/A	No Actions Needed
1b.	Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements.	N/A	No Actions Needed
1c.	Prior to the release of the RFP, the Divisions of Medicaid and Behavioral Health will collaborate to define UM standards that will be utilized in the IBHP contract and provider agreements.	December 31, 2020	Completed
1c.	The Division of Behavioral Health will determine whether the developed standards will also need to be formalized and established in administrative rules and/or state statutes.	September 30, 2023	Completed
1c.	Idaho Medicaid will rebid the Idaho Behavioral Health Plan (IBHP) contract, which will consolidate utilization management activities for all behavioral health services (inpatient and outpatient).	December 31, 2020	Completed
1d.	Compliance with program integrity requirements and state compliance assurance process.	N/A	No Actions Needed
1e.	The Divisions of Medicaid and Behavioral Health will develop and implement screening standards. These standards will be incorporated into IDAPA rules that all Medicaid-enrolled psychiatric hospitals will be required to use during intake. These state standards will specifically outline screening for suicidal ideation and co-morbid physical health conditions by a licensed medical professional and utilization of ASAM Criteria for SUD screening.	December 31, 2021	Open
1e.	Divisions of Medicaid and Behavioral Health will develop and implement IDAPA rules and/or standards to ensure access to treatment for co-morbid physical health conditions, suicidal ideation and SUDs.	April 15, 2022	Open

1e.	These standards will need to be incorporated into the IBHP contract to ensure the provider network is utilizing the state standards.	April 15, 2022	Open
1e.	The IBHP contractor will establish provider network agreements that require these standards.	December 31, 2021	Open

Table E.20h. SMI/SED Milestone 2: Improving Care Coordination and Transitioning to Communitybased Care

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
2a.	The divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards to ensure intensive predischarge planning is conducted, including collaboration with community-based providers during transitions.	December 31, 2021	Open
2a.	The divisions of Medicaid and Behavioral Health will also collaborate to develop and implement criteria via IDAPA rules and/or standards for the new transition planning service.	April 15, 2022	Open
2a.	Add necessary State Plan language for transition planning services.	October 31, 2023	Open
2a.	Update 1915(b) managed care waiver to reflect transition planning services.	October 31, 2023	Open
2a.	Update IBHP contract language to include discharge and transition standards.	December 31, 2020	Completed
2b.	The Division of Medicaid will update the Medicaid Provider Handbook with requirements for hospitals to assess beneficiaries' housing situations and coordinate services when discharging Medicaid members.	January 31, 2023	Open
2b.	The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards to ensure beneficiaries' housing situations are assessed and that housing services providers are included in discharge planning, when appropriate.	January 31, 2023	Open
2b.	The Divisions of Medicaid and Behavioral Health will also collaborate to develop and implement criteria via IDAPA rules and/or standards for the new transition planning service.	January 31, 2023	Open
2b.	The Division of Medicaid will update IBHP contract language to ensure compliance by the contractor and provider network with the developed standards.	December 31, 2021	Completed

2b.	Add language to IBHP provider network agreements covering this requirement.	February 1, 2024	Open
2c.	The Divisions of Medicaid and Behavioral Health will collaborate to develop contact requirements within 72 hours of discharge from a psychiatric hospital and/or residential treatment settings.	December 31, 2021	Completed
2c.	The Divisions of Medicaid and Behavioral Health will collaborate to develop standards for the new transition planning service.	February 1, 2024	Open
2c.	Formalize IDAPA rules and/or standards regarding contact requirements within 72 hours of discharge from a psychiatric hospital and/or residential treatment settings.	December 31, 2021	Completed
2c.	Formalize IDAPA rules and/or standards regarding standards for the new transition planning service.	February 1, 2024	Open
2c.	The Division of Medicaid will update IBHP contract language to ensure compliance by the contractor and provider network with the developed standards.	December 31, 2021	Completed
2c.	Add language to IBHP provider network agreements covering this requirement.	February 1, 2024	Open
2d.	The Division of Medicaid will incorporate language within the new IBHP contract that outlines support and compliance with the Idaho crisis system to include substantial access to identified crisis services across all of Idaho.	December 31, 2021	Completed

Table E.20i. SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
3a.	The Division of Medicaid will execute a contract with OHSU's Center for Healthcare Effectiveness outlining the demonstration environmental scan requirements.	October 16, 2020	Completed
3a.	Submit a legislative budget request to fund this contract.	October 16, 2020	Completed
3a.	Evaluator will perform ongoing environmental scan activities. **This item was removed from final Penn State contract and is now an internal Idaho Medicaid deliverable**	Over the course of the Demonstration Period by June 30, 2025	Open
3b.	Financing plan – See Table E.20k	-	-
3c.	Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	N/A	No Actions Needed
3d.	The Divisions of Medicaid and Behavioral Health will collaborate to identify clinical domain assessment requirements.	December 31, 2021	Completed
3d.	The Division of Medicaid will update the Medicaid Provider Handbook to reflect these state-approved requirements.	January 31, 2023	Open
3d.	Develop and implement requirements in IDAPA rules and/or standards to ensure Comprehensive Diagnostic Assessments are conducted to determine appropriate levels of care and length of stay.	December 31, 2021	Completed
3d.	The Division of Medicaid will add contract language to the IBHP contract regarding clinical domain assessment requirements.	December 31, 2021	Completed

Table E.20j. SMI/SED Milestone 4: Earlier Identification and Engagement in Treatment, Including through Increased Integration

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
4a.	The Division of Behavioral Health will continue with STAR expansion efforts.	Over the course of the Demonstration Period by March 31, 2025	Open
4a.	The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards regarding early identification and engagement of beneficiaries with or at risk of SMI or SED.	January 25, 2022	Completed
4a.	The Division of Medicaid will outline the requirement for the IBHP contractor to implement strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, including through supported employment and supported education programs, as well as coordination with the Healthy Connections primary care network. This requirement will be included in the IBHP contract language and the IBHP contractor will be required to have a policy that supports these efforts.	December 31, 2021	Completed
4a.	Leverage the Medicaid primary care case management program, Healthy Connections, to promote training and education for early identification at the primary care level through the implementation of a standardized evidence-based assessment process.	January 31, 2023	Suspended
4b.	Idaho Medicaid will update the IBHP contract language to cover the following: 1. Requirements to push health information to IHDE 2. Incentives for co-location or integration with primary care 3. Trainings to primary care providers on integration of behavioral health and best practices on care coordination. 4. Requirements for the IBHP provider network to work with Idaho Medicaid's Healthy Connections providers on ways to Support behavioral health integration	December 31, 2021	Completed

	*Note the action items listed are counted individually for progress on milestone action items		
4b.	Idaho Medicaid will seek to implement billing simplifications to encourage more primary care providers to provide mental health services in the primary care setting.	January 31, 2023	Suspended
4c.	The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards establishing specialized settings and services for young people experiencing SED/SMI, including crisis stabilization.	December 31, 2021	Completed
4c.	The Division of Medicaid will incorporate IBHP contract language that outlines state requirements around services for young people experiencing SMI/SED.	December 31, 2021	Completed
4c.	The Division of Medicaid will incorporate IBHP contract language that outlines state requirements for telephonic and face-to-face crisis stabilization services for young people experiencing SMI/SED.	December 31, 2021	Completed

Table E.20k. Financing Plan

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
5a.	Incorporate crisis service requirements and community training requirements into the IBHP contract.	December 31, 2021	Completed
5a.	As part of the budget request for including inpatient behavioral health services into the IBHP, the Division of Medicaid will be able to support a comprehensive crisis system and additional community-based services to include the enhanced 24-hour crisis line.	January 17, 2023	Open
5a.	Update 1915(b) managed care waiver to include inpatient and residential services.	September 30, 2023	Open
5a.	The Division of Medicaid will add contract language to the upcoming IBHP request for proposal and new contract language requiring the IBHP contractor to support Idaho's crisis vision by offering the crisis service array listed above.	December 31, 2021	Completed
5b.	The Division of Medicaid will request funding to support a comprehensive crisis system.	January 17, 2023	Open
5b.	Expand access to Assertive Community Treatment (ACT) services.	February 1, 2024	Open
5b.	Draft IBHP request for proposal requirements that support the state's plans to increase availability of ongoing community-based services.	December 31, 2021	Completed
5b.	Incorporate outpatient levels of care provider access requirements into the IBHP contract.	December 31, 2021	Completed
5b.	Promote growth of the IBHP provider network to expand the number of providers who offer telehealth services.	June 30, 2020	Completed
5b.	Implement IBHP contract language that supports the growth and sustainability of Certified Behavioral Health Clinic Models within the IBHP network.	Over the course of the Demonstration Period by March 31, 2025	Suspended

Table E.20l. Health IT Plan SUD

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
SUD	Increase and enhance terminology services within the data exchange's data warehouse. Increase and enhance the storage capacity of data exchange's data warehouse.	September 30, 2020	Completed
SUD	Build a data lake within the data exchange supported by FHIR APIs. Refine data exchange's data extraction engine solutions for PDMP data reporting enhancements.	September 30, 2020	Completed
SUD	Connect Utah and eastern Oregon's health exchange networks to Idaho Health Data Exchange.	September 30, 2020	Completed
SUD	Roll out new interface connection onboarding specifications, documentation, and training to new participants.	September 30, 2020	Completed
SUD	Connect contiguous states' health information exchanges to Idaho Health Data Exchange. Idaho Board of Pharmacy to purchase statewide PMP Gateway License. PMP Gateway available in established EHR workflow. Prescriber and dispenser trainings are available during this period.	December 31, 2021	Completed
SUD	Idaho Health Data Exchange to build API connection to PDMP. Idaho Health Data Exchange to build and test authentication process for PDMP access. Idaho Health Data Exchange to conduct readiness assessment with at least one EHR vendor and clinician/organization. Go live with data exchange's view-only access to PDMP.	August 31, 2020	Completed
SUD	Idaho Health Data Exchange and Idaho Board of Pharmacy convene meeting to establish infrastructure scope for connection data exchange to PDMP.	August 31, 2020	Completed
SUD	Idaho Health Data Exchange and Idaho Board of Pharmacy convene meeting to establish infrastructure scope for connection data exchange to PDMP.	April 29, 2020	Completed
SUD	Idaho Health Data Exchange to build API connection to PDMP and go live with view-only clinical portal access.	August 31, 2020	Completed

SUD	Board of Pharmacy to add appropriate DEA Schedule I controlled substances into the Idaho's Uniform Controlled Substance information.	July 1, 2020	Completed
SUD	Develop terminology services/data quality program to identify all long-term opioids within the controlled substance information in the PDMP.	August 31, 2020	Completed
SUD	Identify the report parameters including the frequency of reports, data, and prescriber and dispenser information to write into new reporting structure.	August 31, 2020	Completed
SUD	Either (1) build a report through Appriss Health for identification of required report information; or (2) have IHDE build a report with the information above and in the SUPPORT Act applicable sections.	December 31, 2021	Completed
SUD	Idaho Medicaid to align covered providers daily limits with SUPPORT Act sections when required (e.g., daily MME for covered patients).	October 30, 2020	Completed
SUD	Develop, convene, and report on stakeholder meetings and focus groups with state agencies and prescribers to establish recommendation on measures to address prescribing pattern issues.	June 30, 2021	Completed
SUD	Idaho Health Data Exchange to use an outside vendor to assist in cleanup of master patient index.	May 11, 2020	Completed
SUD	Enhance match rates of master patient index with an active/active exchange with two MPI vendors within the data exchange. One MPI will be embedded in technology stack, one MPI will be outside stack to enhance match rate.	September 30, 2020	Completed
SUD	Two MPIs will transition from active/active to master/slave to continue the matching capabilities to produce proper matching.	December 31, 2020	Completed
SUD	Explore feasibility of HIE integration of Medicaid claims data and Medicare claims data- enhancing the information to match with patient records.	Over the course of the Demonstration Period by March 31, 2025	Suspended
SUD	The Idaho Board of Pharmacy may establish a time frame, education, and training around prescription information matching.	Over the course of the Demonstration Period by March 31, 2025	Open

SUD	Engage prescribers and dispensers on current workflow, including access to PDMP prior to prescribing an opioid or other controlled substance. **See Above (SUD HIT 1.b) for details**	September 30, 2020	Completed
SUD	Project ECHO work on provider trainings for opioid alternative practices. **See Above (SUD HIT 1.b) for details**	June 30, 2020	Completed
SUD	Increase and enhance terminology services withing the data exchange's data warehouse. Increase and enhance storage capacity of data exchange's data warehouse. SUD data will be siloed, and user access authenticated. **See Above (SUD HIT 2.a) for details**	September 30, 2020	Completed
SUD	Medicaid may access reports or request reports on Medicaid prescriber checks to the PDMP prior to issuing a schedule II, III, IV prescription as mandated by state law.	Over the course of the Demonstration Period by March 31, 2025	Open
SUD	If a prescriber is unable to check PDMP, Medicaid shall request the documentation of good faith effort and why a check was unable to be performed.	Over the course of the Demonstration Period by March 31, 2025	Suspended
SUD	Medicaid prescribers who are unable to check the PDMP will submit a working plan to Medicaid detailing steps the prescriber or entity shall take to comply with the mandatory state law, including a timeframe for compliance with regular reports updating its progress on compliance.	Over the course of the Demonstration Period by March 31, 2025	Suspended
SUD	Develop, convene, and report on stakeholder meetings and focus groups with state agencies and prescribers to establish recommendation on measures to address inability to check PDMP.	Over the course of the Demonstration Period by March 31, 2025	Suspended
SUD	Idaho Health Data Exchange to build PDMP infrastructure before integrating claims data.	Over the course of the Demonstration Period by March 31, 2025	Suspended

Table E.20m. Health IT Plan SMI/SED

Action item #	Action item description	Date to be completed	Current status (Completed, Open, Suspended)
HIT SMI/SED 1.1	The state Medicaid HIT team will convene a stakeholder workgroup charged with identifying barriers and options for increasing use of closed loop and e-referrals.	Over the course of the Demonstration Period by March 31, 2025	Suspended
HIT SMI/SED 1.1	The state Medicaid HIT team will conduct a survey to assess use of referral technology and related business practices used by providers.	Over the course of the Demonstration Period by March 31, 2025	Suspended
HIT SMI/SED 1.1	The state Medicaid HIT team will use survey data to develop a baseline of current activity and for tracking on-going use of closed loop and e-referrals.	Over the course of the Demonstration Period by March 31, 2025	Suspended
HIT SMI/SED 1.1	The state Medicaid HIT team will include requirements to promote use of closed loop and ereferrals in the upcoming behavioral health managed care contract.	Over the course of the Demonstration Period by March 31, 2025	Suspended
SMI/SED 1.2	The state HIE will identify strategies for expanding behavioral health provider adoption of EHR and HIE.	December 31, 2020	Completed
SMI/SED 1.2	The state HIE will implement IHDE enhancements to support behavioral health provider needs by expanding used of ADT< CCDA interface capabilities and Direct Messaging communications.	January 29, 2021	Completed
SMI/SED 1.2	The state HIE will contract with technology partners for establishing new interface connection builds.	November 30, 2021	Completed
SMI/SED 1.3, 2.5	Contract with consultant (Julota) to assess government agencies for workflow gaps and service opportunities	December 31, 2021	Completed
SMI/SED 1.3, 2.5	Contract with consultant (Julota) to conduct environmental scan for interested regions, communities, and resources- medical, community, etc.	December 31, 2021	Completed

SMI/SED 2.1, 2.2, 2.3	The state HIE (IHDE) will identify and classify facilities by type, location, and contact information.	April 1, 2020	Completed
SMI/SED 2.1, 2.2, 2.3	The state HIE (IHDE) will engage for business needs, data needs	Over the course of the Demonstration Period by March 31, 2025	Suspended
SMI/SED 2.4	The state Medicaid team will include requirements for supporting electronic care plans in the upcoming behavioral health managed care contract.	December 31, 2021	Completed
SMI/SED 3.1	The state HIE (IHDE) will revise the current master participant agreement and Qualified Service Organization Agreement (QSOA) to include prescription drug and 42 Part 2 data.	April 13, 2020	Completed
SMI/SED 3.1	The state HIE (IHDE) will enhance user roles and audit reporting functionality in portal with vendor, Orion Health.	June 30, 2021	Completed
SMI/SED 3.1	The state HIE (IHDE) will enhance data warehouse capabilities to support 42 Part 2 data.	September 30, 2020	Completed
SMI/SED 4.1	The state Medicaid team will include requirements for transitioning standardized assessments into structured data capture processes to improve interoperability in the upcoming behavioral health managed care contract.	December 31, 2021	Completed
SMI/SED 5.1	The state will use Support Act funds for a telehealth environmental scan of current use, barriers, and future state of telehealth and telehealth services. The environmental scan will be conducted by a vendor, Stonewall Analytics.	September 30, 2020	Completed
SMI/SED 6.1	The state Medicaid team and Optum Idaho (current managed care contractor) will conduct evaluation of current Alert workflow.	December 31, 2021	Completed
SMI/SED 6.1	The state Medicaid team will include requirements for HIT capabilities for identifying patients at risk for discontinuing treatment in the upcoming behavioral health managed care contract.	December 31, 2021	Completed
SMI/SED 6.2	The state HIE (IHDE) will define business needs, data needs, priorities, connection types.	May 20, 2020	Completed

SMI/SED 6.2	The state HIE (IHDE) will conduct readiness assessment for bi-directional interfaces.	September 30, 2020	Completed
SMI/SED 7.1	The Medicaid HIT team will identify subject matter expertise needed to perform analysis, engage stakeholders, document results, present findings to state leadership.	Over the course of the Demonstration Period by March 31, 2025	Suspended
SMI/SED 7.2	The state HIE (IHDE) will develop standard operating procedures for monitoring and remediating MPI exceptions.	February 8, 2021	Completed
SMI/SED 7.2	IHDE Staff training	March 31, 2021	Completed
SMI/SED 7.2	IHDE Compliance audits	Over the course of the Demonstration Period by March 31, 2025	Suspended

Table E.21: Summary of mid-point assessment of overall risk of not achieving demonstration milestones

Milestone	% fully completed action items[a]	% monitoring metric goals met[b]	Key themes from stakeholder feedback	Risk level[c]	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
SUD Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs	67%	67%	N/A	Low		Idaho completed all remaining action items for SUD Milestone 1 in July 2022

SUD Milestone 2: Use of Evidencebased, SUDspecific Patient Placement Criteria	67%	100%	N/A	Low		The IDHW Divisions of Behavioral Health and Medicaid worked closely prior to the release of the IBHP procurement to determine which state standards needed to be created or updated in relation to the needs of the services under the new contract. The contract is expected to be executed in Summer 2023 and the contractor will provide utilization management activities for all inpatient, residential and outpatient behavioral health services.

SUD Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	43%	-	N/A	Medium	No associated metrics, but rating based on completion of action items. Recommend to continue to complete action items.	Idaho's Governor issued executive orders in 2019 and 2020 aimed at scaling back regulations and directed state agencies to find efficiencies in the rules they administer. This added complexity to the attempt to create a state certification process for SUD residential treatment facility enrollment. Given the limitations in timeline to create a certification process and rule, Idaho Medicaid chose to align with the CARF ASAM certification for SUD residential treatment facilities and has implemented this as an enrollment requirement for these facilities. Idaho Medicaid is finalizing changes to the Medicaid

						Provider Handbook to reflect residential treatment provider qualifications, requirements regarding ASAM criteria and other program standards.
SUD Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for MAT for OUD	71%	100%	As a HPSA, provider capacity remains a concern in Idaho.	Low		The inpatient and crisis bed registry expansion has stalled due to multiple competing priorities including COVID-related tasks and the implementation of 988 in Idaho. The registry, along with identifying real-time dashboard requirements will be identified as areas still in need of targeted efforts and the Idaho 1115 BHT team is working with internal leadership on developing strategies to fully complete these goals by the end of the waiver demonstration period.
SUD Milestone 5: Implementatio	40%	67%	N/A	Medium	Continue to work with key stakeholders.	The IDHW Divisions of Behavioral

n of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD					IHRP includes important updates.	Health (DBH) and Public Health (DPH) manage and fund naloxone distribution via a third-party contractor (the Idaho Harm Reduction Project - IHRP). IHRP orders naloxone kits and distributes them to organizations across the state in a timely manner. This naloxone is provided at no cost to the consumer. Aside from grant funding through DBH and Bureau of Justice (BOJ) funds through DPH, there are no other funding sources contributing to this naloxone distribution effort and no other freenaloxone distribution services in Idaho. The IHRP plans to increase data collection in 2023 by including a QR code with every distributed kit and implement more accessible ways to dispense

						kits, including a newspaper style dispenser for access at all hours. One major complication to this distribution plan was the passing of HB 350 in the 2023 Legislative session requiring the State Opioid Response (SOR) grant funds through DBH funds available for naloxone and needles be available only to first responders in the State of Idaho. As IDHW addresses these limitations, there will be continued updates and strategies outlined in forthcoming quarterly and annual reports.
SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care	9%	50%	Informants noted that this work will be incorporated via the IBHP.	Medium	Continue to work on finalizing IBHP contract.	The IDHW Divisions of Behavioral Health and Medicaid worked closely prior to the release of the IBHP procurement to determine which state standards needed to be created or

						updated in relation to the needs of the services under the new contract. The IDHW has elected to wait until the contract is in place to work with the contractor in either developing standards or completing this milestone within the realm of provider agreements. The contract is expected to be executed in Summer 2023.
SMI/SED Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	43%	0%	N/A	High	Continue to work on finalizing IBHP contract	The IDHW Divisions of Behavioral Health and Medicaid worked closely prior to the release of the IBHP procurement to determine which state standards needed to be created or updated in relation to the needs of the services under the new contract. The contract is expected to be executed in Summer 2023 and the contractor will provide

						utilization management activities for all inpatient, residential and outpatient behavioral health services.
SMI/SED Milestone 2: Improving Care Coordination and Transitioning to Communitybased Care	35%	100%	Informants noted that this work will be incorporated via the IBHP.	Low		The IDHW Divisions of Behavioral Health and Medicaid worked closely prior to the release of the IBHP procurement to determine which state standards needed to be created or updated in relation to the needs of the services under the new contract. The contract is expected to be executed in Summer 2023 and the contractor will ensure care coordination and transitions of care activities are included in provider agreements for all inpatient, residential and outpatient behavioral health service providers.
SMI/SED Milestone 3: Increasing Access to Continuum of	71%	0%	N/A	High	Continue to work on finalizing IBHP contract	The IDHW Divisions of Behavioral Health and Medicaid

Care, Including Stabilization Services						worked closely prior to the release of the IBHP procurement to determine which state standards needed to be created or updated in relation to the needs of the services under the new contract. The IDHW has elected to wait until the contract is in place to work with the contractor in either developing standards or completing this milestone within the realm of provider agreements. The contract is expected to be executed in Summer 2023.
SMI/SED Milestone 4: Earlier Identification and Engagement in Treatment, Including through Increased Integration	75%	33%	One informant noted that increasing access in schools is an integral, missing piece of early identification .	Medium	Continue to work on finalizing IBHP contract	Many of Idaho's key action items for improving care for individuals with SMI or SED, including earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in

						treatment sooner, are dependent on the implementatio n of the new IBHP contract. The contract is expected to be executed in Summer 2023.
Financing Plan	50%	N/A	N/A	N/A		Much of Idaho's strategy to increase access to communitybased mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies to address gaps in access to communitybased providers identified in the waiver implementatio n plan are dependent on the implementatio n of the new IBHP contract. The contract is expected to be executed in Summer 2023
SUD HIT	80%	N/A	Informants noted the data component of the Idaho BHT Waiver has proved challenging.	N/A		The remaining action items within the HIT Plan have not been completed due to the ending of the

			Future visioning around HIT is planned.			contractual relationship between IDHW and the state's HIE. The HIE has since filed for bankruptcy, further disrupting Idaho's ability to complete these items. Idaho Medicaid has identified the areas still in need of targeted efforts and is working with internal leadership on developing strategies to fully complete these goals by the end of the waiver demonstration period.
SMI/SED HIT	71%	N/A		N/A		The remaining action items within the HIT Plan have not been completed due to the ending of the contractual relationship between IDHW and the state's HIE. The HIE has since filed for bankruptcy, further disrupting Idaho's ability to complete these items. Idaho Medicaid has identified the areas still in need of targeted

						efforts and is working with internal leadership on developing strategies to fully complete these goals by the end of the waiver demonstration period.

[a]*The calculation of the percentage of fully completed action items may include only the action items that the state expected to be completed by the mid-point.*

[b]*The calculation of monitoring metric goals achieved should include all of the critical metrics, but the state may choose to include other monitoring metrics.*

[c]*<u>Risk level categories</u>:*
Low- For nearly all of the critical metrics (e.g., 75 percent or more), the state is moving in the direction expected according to its annual goals and overall demonstration targets. The state has fully completed most/all associated action items as scheduled to date. Few stakeholders identified risks related to meeting the milestone, and the risks identified can easily be addressed within the planned timeframe. If the state decides to submit availability assessment data, the state is moving in the expected direction for all or nearly all (e.g., 75 percent or more) of the data.

Medium- The state is moving in the expected direction relative to its annual goals and overall demonstration targets for some (e.g., 25-75 percent) of the critical metrics and additional monitoring metrics that the state reported for additional context. The state fully completed some of the associated action items as scheduled. Multiple stakeholders identified risks that could cause challenges in meeting the milestone. If the state decides to submit availability assessment data, the state is moving in the expected direction for some (e.g., 25-75 percent) of the data.

High- The state is moving in the expected direction relative to its annual goals and overall demonstration targets for few (e.g., less than 25 percent) of the critical metrics and additional monitoring metrics that the state reported for additional context. The state fully completed few or none of the associated action items as scheduled. Stakeholders identified significant risks to meeting the milestone. If the state decides to submit availability assessment data, the state is moving in the expected direction for few (e.g., less than 25 percent) of the data.

N/A- Data is not available.

ACRONYMS

Appendix E: Acronyms

ACT- Assertive Community Treatment

ADT- Admission, Discharge, and/or Transfer-based

AOD- Alcohol or Other Drug

API- Application Programming Interface

ASAM- American Society for Addiction Medicine

BHT Waiver- Behavioral Health Transformation Waiver

CARF- Commission on Accreditation of Rehabilitation Facilities

CCBCH- Certified Community Behavioral Health Clinic

CFR- Code of Federal Regulations

CMS- Center for Medicare and Medicaid Services

COB-AD – Concurrent Use of Opioids and Benzodiazepines

CTP – Cumulative Target Percentage

CY- Calendar Year

DBH- Division of Behavioral Health

DEA- Drug Enforcement Administration

DY1 – Demonstration Year 1

DY2- Demonstration Year 2

ED- Emergency Department

ED-PTC- Emergency Department Psychiatric Triage Centers

EHR – Electronic Health Record

EIC- Evidence to Impact Collaborative

FEMA- Federal Emergency Management Agency

FFP- Federal Financial Participation
FMAP- Federal Medical Assistance Percentage

FQHC- Federally Qualified Health Centers

FUM-AD – Follow-Up After Emergency Department Visits for Mental Illness

HEDIS FUH- Healthcare Effectiveness Data and Information Sets for Follow-Up after Hospitalization for Mental Illness

HIE- Health Information Exchange

HIPAA – Health Insurance Portability and Accountability Act

HPSA- Health Professional Shortage Area

HIT- Health Information Technology

IAPD HITECH- Implementation Advanced Planning Document Health Information Technology for Economic and Clinical Health Act

IBHC- Idaho Behavioral Health Council

IBHP- Idaho Behavioral Health Plan

IBM- International Business Machines Corporation

IDAPA- Idaho Administrative Procedures Act

IDHW- Idaho Department of Health and Welfare

IDJC - Idaho Department of Juvenile Corrections

IDOC - Idaho Department of Corrections

ID PDMP- Idaho Prescription Drug Monitoring Program

IHDE- Idaho Health Data Exchange

IMD - Institution for Mental Diseases

IOP- Intensive Outpatient Programs

IPBSR - Idaho Psychiatric Bed and Seat Registry

IPF- Inpatient Psychiatric Facility

ITN- Invitation to Negotiate
MAT- Medication Assisted Treatment

MCO- Managed Care Organization

MHAA- Mental Health Availability Assessment

MME- Morphine Milligram Equivalents

MMRC - Maternal Mortality Review Committee

MPA- Mid-Point Assessment

MPI- Master Patient Index

NEMT- Non-Emergency Medical Transportation

NIDA – National Institute on Drug Abuse

OHDMP – Opioids at High Dosage and From Multiple Providers

OHSU – Oregon Health and Science University

OMP – Opioids from Multiple Providers

OTP- Opioid Treatment Programs

OUD- Opioid Use Disorder

PCCM- Primary Care Case Management

PCMH- Patient-Centered Medical Home

PCORI- Patient-Centered Outcomes Research Institute

PDMP – Prescription Drug Monitoring Program

PHP- Partial Hospitalization Programs

Project ECHO- Extension for Community Health Outcomes

PSU- The Pennsylvania State University

RPM- Remote Patient Monitoring

SAMHSA- Substance Abuse and Mental Health Services Administration

SARF- Substance Abuse Rehabilitation Facility
SNAP- Supplemental Nutrition Assistance Program

SPARC - Suicide Prevention Among Recipients of Care

STAR CSC- Strength Through Active Recovery Crisis Standards of Care

STC- Special Terms and Conditions

SUD- Substance Use Disorder

SED- Serious Emotional Disturbance

SMI- Serious Mental Illness

TA- Technical Assistance

UM- Utilization Management

VBP- Value Based Payment

VCOs- Value Care Organizations

YHI- Your Health Idaho

Appendix F. Independent Assessor Description

The Idaho Department of Health and Welfare (IDHW) contracted with an independent assessor, Penn State Evidence-to-Impact Collaborative (EIC) to conduct an independent evaluation of the Section 1115 waiver demonstration including the Mid-Point Assessment. The EIC and it's affiliate researchers have conducted extensive studies and evaluation of behavioral health and healthcare policies and interventions. This has included evaluations and studies of healthcare systems, policies, and solutions funded by the National Institutes of Health, National Science Foundation, Substance Abuse and Mental Health Administration, Pennsylvania Department of Health, Centers for Medicare and Medicaid Services, and Department of Defense.

The EIC conducted a fair and impartial demonstration evaluation in accordance with the Special Terms and Conditions and the evaluation plan approved by CMS. To mitigate potential conflicts of interest with IDHW, EIC assumed responsibility for analysis of aggregate data collected for monitoring purposes, benchmarking and evaluation of change over time as well as interpretation of results and production of deliverables. IDHW provided pre-calculated metrics that included numerators, denominators, and rates to conduct the assessment in adherence to the approved evaluation plan. These data were not independently verified by EIC due to raw data not being available at the time of analysis for the MPA but this is being addressed for subsequent reports. IDHW has confirmed no conflicts of interest for the EIC team and EIC confirms they will continue to have no conflicts of interest that would interfere with their evaluation for the remainder of the project period.

Appendix G. Conflict of Interest Statements

PennState

Office for Research Protections
Senior Vice President for Research
The Pennsylvania State University
101 Technology Center
University Park, PA 16802

814-865-1775
orp@psu.edu
research.psu.edu/orp

Date: May 22, 2023
From: Penn State University, Office for Research Protections, Conflict of Interest Program
Re: Idaho Dept of Health and Welfare, "Evaluation of Idaho's Medicaid..." award, COI review of Investigators

To whom it may concern:

Penn State Office for Research Protections Conflict of Interest Program reviews university researchers for Conflict of interest concerns in accordance with Penn State Policy RP06 Disclosure and Management of Significant Financial Interests (https://policy.psu.edu/policies/rp06).

The following personnel are named on the Idaho Department of Health and Welfare award:
Daniel Max Crowley
Joel E Segel
Xueyi Xing

A review of their required annual COI disclosure concludes that none have reported significant financial interests, so they have no conflicts of interest to report, and no further COI review was required.

Please reach out to coinsadmins@psu.edu to contact our office with any questions.

Sincerely,

[redacted]

Jessica R. Hoffman, M.Ed
COI Program

cc:
Daniel Max Crowley
Joel E Segel
Jessica Wolfe Connor
Xueyi Xing
coinsadmin@psu.edu

PennState

Edna Bennett Pierce Prevention Research Center
College of Health and Human Development
The Pennsylvania State University
314 Biobehavioral Health Building
University Park, PA 16802-6505

814-865-1971
Fax: 814-865-2530

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 2124

Centers for Medicare and Medicaid Services:

This letter is to declare that the independent evaluator for the Idaho 1115 Waiver Demonstration has no existing or foreseen conflicts of interest that would influence the evaluation responsibilities or the production of evaluation materials. This includes the Pennsylvania State University's Evidence-to-Impact collaborative and its employees currently have no financial or other interest in the outcome of the evaluation.

Sincerely,

Daniel Max Crowley PhD
Penn State University
Associate Professor of Human Development & Family Studies
Director, Evidence-to-Impact Collaborative

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