Governor Brad Little
State Capitol :: Boise, Idaho 83720
(208) 334-2100 :: gov.idaho.gov

March 12, 2025

Secretary Robert F. Kennedy, Jr.
U.S. Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Dear Secretary Kennedy,

The State of Idaho is requesting an extension to the Medicaid 11-W-00339/10: 1115 IMD Behavioral Health Transformation Demonstration for another five (5) years.

This amendment request aligns with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

Idaho seeks to continue this demonstration authority to provide a full continuum of care to those seeking behavioral health services in our state. Over the last five years under the current demonstration, we have seen significant improvements in access to needed inpatient behavioral health services to include substance use disorder treatment. It is imperative for the health of our state that we continue to enhance the availability of behavioral health services and ensure higher levels of care and treatment are readily available.

The Idaho State Medicaid Agency requests an effective date of April 1, 2025. Idaho appreciates your review of this extension request and anticipates CMS approval.

Sincerely,

[redacted]

Brad Little
Governor of Idaho

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

JULIET CHARRON – Deputy Director
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

March 12, 2025

Alex Desatoff
Demonstration Project Officer
Center for Medicaid and CHIP Services (CMCS)

Dear Alex Desatoff:

Idaho Medicaid is requesting to extend the State's 11-W-00339/10: 1115 IMD Behavioral Health Transformation Demonstration for another five (5) years.

The State Medicaid Agency has observed improved access to medically necessary services to include residential facilities serving those with mental health and/or substance use service needs and intensive outpatient services. Other key observed impacts include improved treatment coordination for Opioid Use Disorder and decreases in inappropriate opioid prescribing (albeit likely more due to changing national provider norms). While access to these services has improved under the waiver, the State Medicaid Agency continues to meet budget neutrality requirements.

Renewal of this waiver will allow the State Medicaid Agency to continue to make progress on the goals set forth in the demonstration. The next five (5) years ahead are of particular importance as the State Medicaid Agency has recently implemented a new stand-alone behavioral health managed care contract to partner with the agency to further improve behavioral health workforce and capacity; access to medically necessary services; and coordination of these services for both youth and adults. The State Medicaid Agency is optimistic that Idaho will see even further progress towards these goals in the years ahead.

The State Medicaid Agency will also be requesting to adjust its authority structure for a particular eligibility group and move from the approved 1915(i) authority to the 1115 authority by adding the following expenditure authority.

> **Youth Empowerment Services (YES) Group.** Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

SUD Demonstration Goals:

1. Increased rates of identification, initiation, and engagement in behavioral health treatment.

2. Increased adherence to and retention in behavioral health treatment.

3. Reductions in overdose deaths, particularly those due to opioids.

4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate.

6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Demonstration Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

2. Reduced preventable readmissions to acute care hospitals and residential settings.

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.

4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.

5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

This extension request aligns with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

The State Medicaid Agency requests an effective date of April 1, 2025.

Tribal solicitation and public notice were completed by providing a thirty (30) day public notice and comment period and by scheduling two (2) public hearings, each one (1) hour

long. At these hearings the most recent working proposal was described and made available to the public, and time provided during which comments were received.

Tribal solicitation was also completed by sending a Dear Tribal Leader Letter to Tribal representatives.

An amendment to the existing demonstration was submitted to CMS on December 20, 2024, regarding the following existing expenditure authority (see Appendix C of this application, per CMS request), and the extension application does not include this authority:

- *Use of Legally Responsible Individuals to Render Personal Care Services (PCS).*

Idaho appreciates your review of this extension request and anticipates CMS approval. Please direct any questions to Charles Beal, Medicaid Policy Director, at charles.beal@dhw.idaho.gov.

Sincerely,

JULIET CHARRON
Deputy Director

JC/cb

cc: Courtenay Savage, Julie Sharp

Idaho Department of Health and Welfare

Section 1115 Medicaid Demonstration Extension Application

March 12, 2025

Table of Contents

Section I. Background and Overview

Background

Idaho's health care system has been historically fragmented and reliant upon partnerships among agencies, provider organizations, and the community. Health Professional Shortage Areas (HPSA) are designated in 98.2% of the state for primary care, 95% for dental health, and 100% for mental health ((HRSA Health Professional Shortage Area Designation).

Idaho Proposition 2, a Medicaid expansion initiative, was approved on the 2018 general election ballot. This measure 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 138% of the federal poverty guidelines and not otherwise eligible for Medicaid coverage.

Subsequently, Idaho Senate Bill S1204 Medicaid (2019) was signed into law April 9, 2019, outlining requirements for implementation of Medicaid expansion. For example, this law states *"the director is hereby encouraged and empowered to obtain federal approval in order that Idaho design and implement changes to it's Medicaid program that advance the quality of services to participants while allowing access to needed services and containing excess cost"*. The law necessitated the application for Section 1115 Waiver funding. Idaho expanded Medicaid and the State Medicaid Agency applied for the 1115 BHT waiver in January 2020.

The "Idaho 1115 Behavioral Health Transformation" (Project Number 11-w-00339/10) was approved by CMS April 17, 2020, with an end date of March 31, 2025.

Additional relevant background includes:

MAT Waiver. On December 29, 2022, the President signed into law the Consolidated Appropriations Act, 2023 effectively eliminating the "Drug Addiction Treatment Act (DATA)-Waiver Program" also known as the Medication-Assisted Treatment (MAT) Waiver or X-Waiver Program. This act changed provider requirements, eliminated discipline restrictions and limits to prescription medications to treat opioid use disorder (OUD), and changed certification related to providing counseling.

Idaho's Behavioral Health Plan Governance Bureau. In January 2023, a new State Medicaid Agency Idaho Behavioral Health Plan Governance Bureau was formed as to resource and manage the oversight of quality, performance, and innovation in the IBHP.

COVID-19 Public Health Emergency and Medicaid Unenrollment. In response to the COVID-19 outbreak, on January 31, 2020, a public health emergency (PHE) under section 319 of the Public Health Service Act (42 U.S.C. 277d) was declared by the Secretary of Health and Human Services. This declaration enabled the Secretary to "temporarily waive or modify certain requirements of the Medicare, Medicaid, and

State Children's Health Insurance programs and of the Health Insurance Portability and Accountability Act Privacy Rule throughout the duration of the public health emergency declared in response to the COVID-19 outbreak".

The Consolidated Appropriations Act, 2023 was signed into law on December 29, 2022, unlinking the continuous coverage requirement from the PHE while creating a new requirement for states. This new requirement dictates that state must provide 12 months of continuous eligibility for enrollees under the age of 19 in both Medicaid and CHIP (Children's Health Insurance Plan) beginning January 2024 as well as makes permanent the state plan option to provide 12 months of postpartum coverage in Medicaid and CHIP. Continuous coverage meant that no state could remove anyone from Medicaid unless they were determined to have relocated out of state, requested to be removed, or passed away. When the COVID-19 Public Health Emergency (PHE) expired May 11, 2023, Idaho began unwinding enrollment for those enrolled in Medicaid who were no longer eligible for Medicaid benefits.

These eligibility and enrollment changes affected data, reporting, and metrics on the demonstration.

Overview

In 2020, the "Idaho 1115 Behavioral Health Transformation" was approved by the Centers for Medicaid and Medicare Services (CMS). This demonstration allows the State Medicaid Agency 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/or serious mental illness/serious emotional disturbance (SMI/SED).

SMI/SED and SUD Program Benefits. Under this demonstration, beneficiaries have access to high quality, evidence-based SMI/SED and OUD/SUD treatment and withdrawal management services, ranging from medically supervised withdrawal management for SUDs and short-term acute care in inpatient and residential settings for SMI to ongoing chronic care for these conditions in cost-effective community-based settings. The State Medicaid Agency continues to work to improve care coordination and care for cooccurring physical and behavioral health conditions.

The coverage of SMI/SED and SUD treatment services during short term residential and inpatient stays in IMDs expands Idaho's current SMI/SED and/or SUD benefit package available to all Idaho Medicaid beneficiaries. It also supports State Medicaid Agency efforts to implement models of care focused on increasing support for individuals in the community and home, outside of institutions, and improve access to a continuum of SMI/SED and/or SUD evidence-based services at varied levels of intensity.

The state continues to make progress on the following goals:

SUD Demonstration Goals:

1. Increased rates of identification, initiation, and engagement in behavioral health treatment.

2. Increased adherence to and retention in behavioral health treatment.

3. Reductions in overdose deaths, particularly those due to opioids.

4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate.

6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Demonstration Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

2. Reduced preventable readmissions to acute care hospitals and residential settings.

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.

4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.

5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Section II: Description of the Extension Request

The Idaho BHT Waiver focuses on Medicaid enrollees with SUD and/or SMI/SED. 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.

An amendment was submitted to CMS on December 20, 2024, regarding the following existing expenditure authority (included in Appendix C per CMS request), and the extension application does not include this authority:

- *Use of Legally Responsible Individuals to Render Personal Care Services (PCS). Expenditures for the state to provide payment for personal care services rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers), following a reasonable assessment by the state that the caregiver is capable of rendering the services, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.*

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 health care 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 health care when and where they need it.

To achieve this goal, the State Medicaid Agency implements three (3) broad 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.

The State Medicaid Agency has generally seen increased utilization, increased capacity including residential mental health facilities, intensive outpatient services, and residential mental health facilities and beds. Other key impacts include improved treatment coordination for OUD and decreases in risky opioid prescribing (albeit likely

more due to changing national provider norms). The State Medicaid Agency continues to meet budget neutrality targets.

Youth Empowerment Services (YES) Population Up to Three Hundred Percent (300%) FPL Addition

Idaho House Bill H0043 Medical Assistance (2017) amended Idaho Code § 56-254 Eligibility For Medical Assistance to add the following language:

> *(i) Effective January 1, 2018, children under age eighteen (18) years with serious emotional disturbance, as defined in section 16-2403, Idaho Code, in families whose income does not exceed three hundred percent (300%) of the federal poverty guideline and who meet other eligibility standards in accordance with department rule.*

Pursuant to this, Idaho submitted and CMS approved in 2018 a 1915(i) Home and Community-Based Services (HCBS) SED Medicaid State Plan Authority (renewed in 2022). This authority allowed Idaho Medicaid to serve youth under age eighteen (18), diagnosed with SED, and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG), and in need of respite services.

CMS requirements under the 1915(i) include:

- Completion of an Independent Assessment to determine SED initially and annually within three hundred and sixty-four (364) days of the previous assessment.
- Completion of a Person-Centered Service Plan (PCSP) that meets C.F.R. requirements within ninety (90) days of becoming enrolled in the YES Program and annually within three hundred and sixty-four (364) days of the previous PCSP. PCSP also to be updated as needed and/or at the request of the participant.
    - A Targeted Care Coordinator conducts PCSPs within the IBHP network, but a Children's Developmental Disability (DD) case worker or a Division of Behavioral Health (DBH) clinician can also complete them in certain situations.
- Utilization of Respite, the only 1915(i) SPA for SED service, at least one (1) time annually.

The State Medicaid Agency has encountered ongoing challenges with complying with the above requirements, particularly during the COVID-19 Public Health Emergency. In order to best serve this population and comply with CMS expectations, the State Medicaid Agency is requesting to add a new eligibility group to this demonstration (below). By moving away from eligibility conditioned on compliance with 1915(i) HCBS federal requirements, the state feels it can more effectively serve this population.

Youth Empowerment Services (YES) Group. Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed

with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

The goal is to ensure access to a system of care for children with serious mental health needs and their families.

A. Proposed Cost Sharing Requirements under the Demonstration as Extended:

Participants under this demonstration would be subject to the following cost-sharing:

All participants with family income above one hundred eighty-five percent (185%) of the FPG will be subject to a monthly premium of fifteen dollars ($15) per youth per month.

Copayments will be applicable to all participants as already defined under the state's current and approved Medicaid State Plan and waivers.

B. Proposed Changes to the Delivery System under the Demonstration as Extended:

The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as the existing demonstration.

C. Proposed Changes to Benefit Coverage under the Demonstration as Extended:

The benefit coverage will be the same manner as under the state's current and approved Medicaid State Plan.

D. Proposed Changes to Eligibility Requirements as Extended:

All eligibility requirements will continue to be met through an initial and annual application, review process, and ongoing oversight, except as noted below.

This would extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a SED, and with a family income up to three hundred percent (300%) of FPG.

An independent, needs-based evaluation or reevaluation would be required at least once every three-hundred sixty-five (365) days. The independent evaluation is performed by an agent that is independent and qualified. Independent Assessors are state-licensed, master's-level clinicians or higher. Independent Assessors receive specialized training in how to conduct the functional assessment and hold certification in a State Medicaid Agency approved tool for assessing children.

The initial assessment process also includes:

a. Evaluation of the child's current behavioral health, living situation, relationships, and family functioning;
b. Contacts, as necessary, with significant individuals such as family and teachers; and
c. A review of information regarding the child's clinical, educational, social, behavioral health, and juvenile/criminal justice history.

Section III: Expenditure Authority

Under the authority of Section 1115(a)(2) of the Act, Demonstration Projects, expenditures made by the State Medicaid Agency for the items identified below, which are not otherwise included as expenditures under Section 1903 of the Act, Payment to States, shall, for the period from April 1, 2025, through March 31, 2030, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable the State Medicaid Agency to operate the above-identified section 1115(a) demonstration.

1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) and/or Serious Mental Illness (SMI). Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) and/or a serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

2. Youth Empowerment Services (YES) Group. Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

Section IV: Demonstration Financing and Budget Neutrality

The State Medicaid Agency posts its quarterly budget neutrality worksheets on a state website at the following link:

https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=29265&dbid=0&repo=PUBLIC-DOCUMENTS

This is consistent with the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration and with State Medicaid Director Letter #24-003 RE: Budget Neutrality for Section 1115(a) Medicaid Demonstration Projects. This will allow CMS to use historical expenditures and trend rate to facilitate calculation of the demonstration's budget neutrality.

Allowable Expenditures. This demonstration project includes only allowable expenditures applicable to services rendered during the demonstration approval period designated by CMS.

Unallowable Expenditures. This demonstration project does not include expenditures for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration.

Sources of Non-Federal Share. The State Medicaid Agency certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The State Medicaid Agency further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The State Medicaid Agency acknowledges that CMS has authority to review the sources of the non- federal share of funding for the demonstration at any time. The State Medicaid Agency agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. The State Medicaid Agency acknowledges that any amendments that impact the financial status of the demonstration must require the State Medicaid Agency to provide information to CMS regarding all sources of the non-federal share of funding.

Program Integrity. The State Medicaid Agency has processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The State Medicaid Agency ensures that the State Medicaid Agency and any of its contractors follow standard program integrity principles and practices including retention of data.

Section V: Demonstration Evaluation and Monitoring

Independent Evaluator. The State Medicaid Agency will continue to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The State Medicaid Agency has contracted with an independent evaluator for the initial five years of the demonstration and completed all required evaluation reports timely.

Monitoring Reports. The State Medicaid Agency will submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY.

Goals and milestones for SUD and SMI/SED listed below.

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 misuse 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.

Section VI: Public Notice Process and Input Summary

Pursuant to the terms and conditions that govern Idaho's Demonstration, Idaho must provide documentation of its compliance with the state notice procedures set forth in 42 C.F.R. § 431.408 State public notice process. The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act as amended by Section 5006(e) American Recovery and Reinvestment Act of 2009, 42 C.F.R. § 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan.

Tribal solicitation and public notice were completed by providing a thirty (30) day public notice and comment period and by scheduling two (2) public hearings, each one (1) hour long. These were held on December 18 and 20, 2024. At these hearings the most recent working proposal was described and made available to the public, and time was provided during which comments were received.

Tribal solicitation was also completed by sending a Dear Tribal Leader Letter to Tribal representatives.

A summary of all comments received and responses have been included in this application.

VII. Demonstration Contact

STATE CONTACT

State Medicaid Director Name: Juliet Charron
Telephone Number: (208) 364-1831
E-mail Address: Juliet.Charron@dhw.idaho.gov

State Lead Contact for Demonstration Application: Charles Beal
Telephone Number: (208) 364-1887
E-mail Address: Charles.Beal@dhw.idaho.gov

Idaho Department of Health and Welfare

APPENDIX A

Public Comments and Responses

Idaho 1115 Demonstration Extension Public Comment

Comment Period: December 11, 2024 - February 28, 2025

Comments Received And State Medicaid Agency Responses

Comment	State Medicaid Agency Response
Many commenters shared personal stories concerning their family situations and the extent for which they provide care for their child or spouse.	The Department thanks the commenters for sharing their experiences.
Many commenters expressed support for continuation of the 1115 waiver for family personal care services.	The Department thanks the commenters for providing input.
Several commenters expressed concern regarding the inability to find a competent caretaker due the direct care worker shortage if FPCS is terminated.	The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the past two years and has observed at least a 10% growth in non-legally responsible caregivers. The Department also reminds families who have been caretakers that they are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their loved ones for Medicaid reimbursement. The Department will be available to work with families to find available direct care staff.
Many commenters expressed concerns that terminating the FPCS program will have a negative impact on their child or spouse/participants served.	Personal Care Services (PCS) will continue to be a benefit for Idaho Medicaid participants. All direct care workers must meet minimum standards intended to provide quality care to participants. Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity. The Department successfully administered the PCS benefit prior to the COVID 19 pandemic absent LRIs being reimbursed for PCS; this change is reverting back to the pre-pandemic provider qualifications.

Comment	State Medicaid Agency Response
Many commenters expressed removing FPCS would not suport Idaho's most vulnerable residents.	The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the past two years and has observed at least a 10% growth in non-legally responsible caregivers. The Department also reminds families who have been caretakers that they are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their children and spouses for Medicaid reimbursement. The Department will be available to work with families to find available direct care staff.
Many commenters expressed the numerous benefits they have received from this program.	The purpose of the Medicaid program is to provide coverage for medically necessary services to the Medicaid participant.
Some commenters expressed the need for more support for families.	The Department will share options for the families to provide care for their loved ones.
Many commenters expressed the concern of trusting a caretaker outside of the home.	If households have concerns about the professionalism of direct care staff, they should contact their provider agency. If a household has concerns about the training or skills of a direct care staff, they may problem-solve with the agency or report an issue to the Department at http://medicaidcomplaints.dhw.idaho.gov.
Some commenters stated that there are more families using the program appropriately than those committing fraud.	The Department has insufficient resources to ensure health and safety and operational integrity for this program due to its exponential growth.
A few commenters stated parents know what's best for their children and should be their caregiver.	The Department thanks the commenters for their comment.
A few commenters expressed concerns that this program was being terminated for cost savings.	Termination of this program is not due to cost savings for the state. This provider qualification flexibility is ending due to suspected and confirmed health and safety concerns and fraud and abuse since this flexibility has been in place. Further, the Department does not currently have the requisite resources to provide the appropriate level of oversight.

Idaho Department of Health and Welfare

APPENDIX B

Demonstration Extension Public Notice

Section 1115 Medicaid Demonstration Extension Application

Posted Public Notice Materials

IDAHO DEPARTMENT OF HEALTH & WELFARE

Title:

Division of Medicaid Public Comment Period: 1115 IMD BHT Extension Application

Entity:

Department of Health and Welfare

Date/Time:

Dec 18 2024 11:00AM

Category:

Public Hearing

Status:

Published

Add to Calendar

Additional Meeting Information

Description

December 18, 2024, 11:00am MST
Conference Room 6A, 450 W State Street, Boise, Idaho

Virtual Location

https://idhw.webex.com/idhw/j.php?MTID=md4ca186ee57ad8db2c1ff517d816f2ca
Meeting number (access code): 2826 738 4533
Meeting password: v8X7neJ2EDt (88976352 when dialing from a phone or video system)
+1-415-527-5035 United States Toll

Contact Information

Idaho Medicaid Program
(888) 528-5861
MCPT@dhw.idaho.gov
https://healthandwelfare.idaho.gov/about-dhw/public-meetings

Physical Location

PTC Building 6A
450 W. State St.
6th Floor Conference Room A
Boise, ID 83720

Google Maps

Documents

12/11/2024 Notice

Recordings

History

12/11/2024 Published

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IN PARTNERSHIP WITH:

SCO
STATE OF IDAHO
CONTROLLER'S OFFICE
BRANDON D WOOLF

Technical Support:
Phone: (208) 334-3100 opt. 0
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Privacy Policy

IDAHO DEPARTMENT OF HEALTH & WELFARE

Title:

Division of Medicaid Public Comment Period: 1115 IMD BHT Extension Application

Entity:

Department of Health and Welfare

Date/Time:

Dec 20 2024 10:00AM

Category:

Public Hearing

Status:

Published

Add to Calendar

Additional Meeting Information

Description

Meeting number (access code): 2830 571 3964
Meeting password: wQWinupe244 (97946873 when dialing from a phone or video system)
+1-415-527-5035 United States Toll

Virtual Location

https://idhw.webex.com/idhw/j.php?MTID=me64fd5f91e2178a4f20da31aeaa296e9
Meeting number (access code): 2830 571 3964
Meeting password: wQWinupe244 (97946873 when dialing from a phone or video system)
+1-415-527-5035 United States Toll

Contact Information

Idaho Medicaid Program
(888) 528-5861
MCPT@dhw.idaho.gov
https://healthandwelfare.idaho.gov/about-dhw/public-meetings

Physical Location

PTC Building 6A
450 W. State St.
6th Floor Conference
Room A
Boise, ID 83720

Google Maps

Documents

12/11/2024 Notice

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History

12/11/2024 Published

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Privacy Policy

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

JULIET CHARRON – Deputy Director
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December 3, 2024

Alex Desatoff
Demonstration Project Officer
Center for Medicaid and CHIP Services (CMCS)

Dear Alex Desatoff:

Idaho Medicaid is requesting to extend the State's 11-W-00339/10: 1115 IMD Behavioral Health Transformation Demonstration for another five (5) years.

The State Medicaid Agency has observed improved access to medically necessary services to include residential facilities serving those with mental health and/or substance use service needs and intensive outpatient services. Other key observed impacts include improved treatment coordination for Opioid Use Disorder and decreases in inappropriate opioid prescribing (albeit likely more due to changing national provider norms). While access to these services has improved under the waiver, the State Medicaid Agency continues to meet budget neutrality requirements.

Renewal of this waiver will allow the State Medicaid Agency to continue to make progress on the goals set forth in the demonstration. The next five (5) years ahead are of particular importance as the State Medicaid Agency has recently implemented a new stand-alone behavioral health managed care contract to partner with the agency to further improve behavioral health workforce and capacity; access to medically necessary services; and coordination of these services for both youth and adults. The State Medicaid Agency is optimistic that Idaho will see even further progress towards these goals in the years ahead.

The State Medicaid Agency will also be requesting to adjust its authority structure for a particular eligibility group and move from the approved 1915(i) authority to the 1115 authority by adding the following expenditure authority.

> **Youth Empowerment Services (YES) Group.** Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

SUD Demonstration Goals:

1. Increased rates of identification, initiation, and engagement in behavioral health treatment.

2. Increased adherence to and retention in behavioral health treatment.

3. Reductions in overdose deaths, particularly those due to opioids.

4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate.

6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Demonstration Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

2. Reduced preventable readmissions to acute care hospitals and residential settings.

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.

4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.

5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

This extension request aligns with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

The State Medicaid Agency requests an effective date of April 1, 2025.

The State Medicaid Agency is diligently preparing to start the public comment process this month. Tribal solicitation and public notice will be completed by providing a thirty (30) day

public notice and comment period and by scheduling two (2) public hearings, each one (1) hour long. At these hearings the most recent working proposal will be described and made available to the public, and time will be provided during which comments were received.

Tribal solicitation will also be completed by sending a Dear Tribal Leader Letter to Tribal representatives.

Idaho anticipates submitting the 1115 Demonstration renewal application no later than the very beginning of 2025. Idaho appreciates your review of this extension request and anticipates CMS approval. Please direct any questions to Charles Beal, Medicaid Policy Director, at charles.beal@dhw.idaho.gov.

Sincerely,

JULIET CHARRON
Deputy Director

JC/ah

cc: Courtenay Savage, Julie Sharp

Idaho Department of Health and Welfare

Section 1115 Medicaid Demonstration Extension Application

January 15, 2025

Table of Contents

Section I. Background and Overview

Background

Idaho's health care system has been historically fragmented and reliant upon partnerships among agencies, provider organizations, and the community. Health Professional Shortage Areas (HPSA) are designated in 98.7% of the state for primary care, 95.7% for dental health, and 100% for mental health.

Idaho Proposition 2, a Medicaid expansion initiative, was approved on the 2018 general election ballot. This measure 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 138% of the federal poverty guidelines and not otherwise eligible for Medicaid coverage.

Subsequently, Idaho Senate Bill S1204 Medicaid (2019) was signed into law April 9, 2019, outlining requirements for implementation of Medicaid expansion. For example, this law states *"the director is hereby encouraged and empowered to obtain federal approval in order that Idaho design and implement changes to it's Medicaid program that advance the quality of services to participants while allowing access to needed services and containing excess cost"*. The law necessitated the application for Section 1115 Waiver funding. Idaho expanded Medicaid and the State Medicaid Agency applied for the 1115 BHT waiver in January 2020.

The "Idaho 1115 Behavioral Health Transformation" (Project Number 11-w-00339/10) was approved by CMS April 17, 2020, with an end date of March 31, 2025.

Additional relevant background includes:

MAT Waiver. On December 29, 2022, the President signed into law the Consolidated Appropriations Act, 2023 effectively eliminating the "Drug Addiction Treatment Act (DATA)-Waiver Program" also known as the Medication-Assisted Treatment (MAT) Waiver or X-Waiver Program. This act changed provider requirements, eliminated discipline restrictions and limits to prescription medications to treat opioid use disorder (OUD), and changed certification related to providing counseling.

Idaho's Behavioral Health Plan Governance Bureau. In January 2023, a new State Medicaid Agency Idaho Behavioral Health Plan Governance Bureau was formed as to resource and manage the oversight of quality, performance, and innovation in the IBHP.

COVID-19 Public Health Emergency and Medicaid Unenrollment. In response to the COVID-19 outbreak, on January 31, 2020, a public health emergency (PHE) under section 319 of the Public Health Service Act (42 U.S.C. 277d) was declared by the Secretary of Health and Human Services. This declaration enabled the Secretary to "temporarily waive or modify certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs and of the Health Insurance Portability

and Accountability Act Privacy Rule throughout the duration of the public health emergency declared in response to the COVID-19 outbreak".

The Consolidated Appropriations Act, 2023 was signed into law on December 29, 2022, unlinking the continuous coverage requirement from the PHE while creating a new requirement for states. This new requirement dictates that state must provide 12 months of continuous eligibility for enrollees under the age of 19 in both Medicaid and CHIP (Children's Health Insurance Plan) beginning January 2024 as well as makes permanent the state plan option to provide 12 months of postpartum coverage in Medicaid and CHIP. Continuous coverage meant that no state could remove anyone from Medicaid unless they were determined to have relocated out of state, requested to be removed, or passed away. When the COVID-19 Public Health Emergency (PHE) expired May 11, 2023, Idaho began identifying those enrolled in Medicaid who were no longer eligible for Medicaid benefits.

These eligibility and enrollment changes affected data, reporting, and metrics on the demonstration.

Overview

In 2020, the "Idaho 1115 Behavioral Health Transformation" was approved by the Centers for Medicaid and Medicare Services (CMS). This demonstration allows the State Medicaid Agency 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/or serious mental illness/serious emotional disturbance (SMI/SED).

SMI/SED and SUD Program Benefits. Under this demonstration, beneficiaries have access to high quality, evidence-based SMI/SED and OUD/SUD treatment and withdrawal management services, ranging from medically supervised withdrawal management for SUDs and short-term acute care in inpatient and residential settings for SMI to ongoing chronic care for these conditions in cost-effective community-based settings. The State Medicaid Agency continues to work to improve care coordination and care for cooccurring physical and behavioral health conditions.

The coverage of SMI/SED and SUD treatment services during short term residential and inpatient stays in IMDs expands Idaho's current SMI/SED and/or SUD benefit package available to all Idaho Medicaid beneficiaries. It also supports State Medicaid Agency efforts to implement models of care focused on increasing support for individuals in the community and home, outside of institutions, and improve access to a continuum of SMI/SED and/or SUD evidence-based services at varied levels of intensity.

The state continues to make progress on the following goals:

SUD Demonstration Goals:

1. Increased rates of identification, initiation, and engagement in behavioral health treatment.

2. Increased adherence to and retention in behavioral health treatment.

3. Reductions in overdose deaths, particularly those due to opioids.

4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate.

6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Demonstration Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

2. Reduced preventable readmissions to acute care hospitals and residential settings.

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.

4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.

5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Section II: Description of the Extension Request

The Idaho BHT Waiver focuses on Medicaid enrollees with SUD and/or SMI/SED. 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.

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 health care 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 health care when and where they need it.

To achieve this goal, the State Medicaid Agency implements three (3) broad 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.

The State Medicaid Agency has generally seen increased utilization, increased capacity including residential mental health facilities, intensive outpatient services, and residential mental health facilities and beds. Other key impacts include improved treatment coordination for OUD and decreases in risky opioid prescribing (albeit likely more due to changing national provider norms). The State Medicaid Agency continues to meet budget neutrality targets.

Youth Empowerment Services (YES) Population Up to Three Hundred Percent (300%) FPL Addition

Idaho House Bill H0043 Medical Assistance (2017) amended Idaho Code § 56-254 Eligibility For Medical Assistance to add the following language:

> *(i) Effective January 1, 2018, children under age eighteen (18) years with serious emotional disturbance, as defined in section 16-2403, Idaho Code, in families whose income does not exceed three hundred percent (300%) of the federal poverty guideline and who meet other eligibility standards in accordance with department rule.*

Pursuant to this, Idaho submitted and CMS approved in 2018 a 1915(i) Home and Community-Based Services (HCBS) SED Medicaid State Plan Authority (renewed in 2022). This authority allowed Idaho Medicaid to serve youth under age eighteen (18), diagnosed with SED, and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG), and in need of respite services.

CMS requirements under the 1915(i) include:

- Completion of an Independent Assessment to determine SED initially and annually within three hundred and sixty-four (364) days of the previous assessment.
- Completion of a Person-Centered Service Plan (PCSP) that meets C.F.R. requirements within ninety (90) days of becoming enrolled in the YES Program and annually within three hundred and sixty-four (364) days of the previous PCSP. PCSP also to be updated as needed and/or at the request of the participant.
    - A Targeted Care Coordinator conducts PCSPs within the IBHP network, but a Children's Developmental Disability (DD) case worker or a Division of Behavioral Health (DBH) clinician can also complete them in certain situations.
- Utilization of Respite, the only 1915(i) SPA for SED service, at least one (1) time annually.

The State Medicaid Agency has encountered ongoing challenges with complying with all of the above requirements, particularly during the COVID-19 Public Health Emergency. In order to best serve this population and comply with CMS expectations, the State Medicaid Agency is requesting to add a new eligibility group to this demonstration.

Youth Empowerment Services (YES) Group. Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

The goal is to ensure access to a system of care for children with serious mental health needs and their families.

Challenges

Provider Shortages. Idaho, like many other states, continues to have a provider shortage at all levels of behavioral health care. The provider shortage was a major barrier to the rollout of the Idaho BHT Waiver and the new IBHP MCO.

A. Proposed Cost Sharing Requirements under the Demonstration as Extended:

Participants under this demonstration would be subject to the following cost-sharing:

All participants with family income above one hundred eighty-five percent (185%) of the FPG will be subject to a monthly premium of fifteen dollars ($15) per youth per month.

Copayments will be applicable to all participants as already defined under the state's current and approved Medicaid State Plan and waivers.

B. Proposed Changes to the Delivery System under the Demonstration as Extended:

The health care delivery system for the provision of services under this demonstration will be implemented in the same manner the existing demonstration.

C. Proposed Changes to Benefit Coverage under the Demonstration as Extended:

The benefit coverage will be the same manner as under the state's current and approved Medicaid State Plan.

D. Proposed Changes to Eligibility Requirements as Extended:

All eligibility requirements will continue to be met through an initial and annual application, review process, and ongoing oversight, except as noted below.

This would extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a SED, and with a family income up to three hundred percent (300%) of FPG.

An independent, needs-based evaluation or reevaluation would be required at least once every three-hundred sixty-five (365) days. The independent evaluation is performed by an agent that is independent and qualified. Independent Assessors are state-licensed, master's-level clinicians or higher. Independent Assessors receive specialized training in how to conduct the functional assessment and hold certification in a State Medicaid Agency approved tool for assessing children.

The initial assessment process also includes:

a. Evaluation of the child's current behavioral health, living situation, relationships, and family functioning;
b. Contacts, as necessary, with significant individuals such as family and teachers; and
c. A review of information regarding the child's clinical, educational, social, behavioral health, and juvenile/criminal justice history.

Section III: Expenditure Authority

Under the authority of Section 1115(a)(2) of the Act, Demonstration Projects, expenditures made by the State Medicaid Agency for the items identified below, which are not otherwise included as expenditures under Section 1903 of the Act, Payment to States, shall, for the period from April 1, 2025, through March 31, 2030, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable the State Medicaid Agency to operate the above-identified section 1115(a) demonstration.

1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) and/or Serious Mental Illness (SMI). Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) and/or a serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

2. Youth Empowerment Services (YES) Group. Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

Section IV: Demonstration Financing and Budget Neutrality

Allowable Expenditures. This demonstration project includes only allowable expenditures applicable to services rendered during the demonstration approval period designated by CMS.

Unallowable Expenditures. This demonstration project does not include expenditures for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration.

Sources of Non-Federal Share. The State Medicaid Agency certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The State Medicaid Agency further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The State Medicaid Agency acknowledges that CMS has authority to review the sources of the non- federal share of funding for the demonstration at any time. The State Medicaid Agency agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. The State Medicaid Agency acknowledges that any amendments that impact the financial status of the demonstration must require the State Medicaid Agency to provide information to CMS regarding all sources of the non-federal share of funding.

Program Integrity. The State Medicaid Agency has processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The State Medicaid Agency ensures that the State Medicaid Agency and any of its contractors follow standard program integrity principles and practices including retention of data.

Section V: Demonstration Evaluation and Monitoring

Independent Evaluator. The State Medicaid Agency will continue to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The State Medicaid Agency has contracted with an independent evaluator for the initial five years of the demonstration and completed all required evaluation reports timely.

Monitoring Reports. The State Medicaid Agency will submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY.

Goals and milestones for SUD and SMI/SED listed below.

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 misuse 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.

Section VI: Public Notice Process and Input Summary

Pursuant to the terms and conditions that govern Idaho's Demonstration, Idaho must provide documentation of its compliance with the state notice procedures set forth in 42 C.F.R. § 431.408 State public notice process. The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act as amended by Section 5006(e) American Recovery and Reinvestment Act of 2009, 42 C.F.R. § 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan.

Tribal solicitation and public notice were completed by providing a thirty (30) day public notice and comment period and by scheduling two (2) public hearings, each one (1) hour long. These were held on December 18 and 20, 2024. At these hearings the most recent working proposal was described and made available to the public, and time was provided during which comments were received.

Tribal solicitation was also completed by sending a Dear Tribal Leader Letter to Tribal representatives.

A summary of all comments received and responses have been included in this application.

VII. Demonstration Contact

STATE CONTACT

State Medicaid Director Name: Juliet Charron
Telephone Number: (208) 364-1831
E-mail Address: Juliet.Charron@dhw.idaho.gov

State Lead Contact for Demonstration Application: Charles Beal
Telephone Number: (208) 364-1887
E-mail Address: Charles.Beal@dhw.idaho.gov

Appendix A: Public Comment Summary

An estimated _____ people commented during Idaho's public comment period for this amendment. The following is a summary of those comments:

1115 Demonstration Renewal Comment and Response Document	
Comments/Questions	Responses
One commenter noted	

Section 1115 Medicaid Demonstration Extension Application

Posted Tribal Notice Materials

IDAHO DEPARTMENT OF HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

JULIET CHARRON – Deputy Director
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 11, 2024

Dear Tribal Representative:

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid or CHIP State Plan Amendment (SPA) or waiver application or amendment likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Idaho Department of Health and Welfare (IDHW) Division of Medicaid (Idaho Medicaid) provides notice on the following matter.

Purpose

Idaho Medicaid has submitted to the Centers for Medicare and Medicaid Services (CMS) a request to extend the state's 11-W-00339/10: 1115 IMD Behavioral Health Transformation Demonstration for another five (5) years.

The State Medicaid Agency has generally seen increased utilization, and increased capacity including residential mental health facilities, intensive outpatient services, and residential mental health facilities and beds. Other key impacts include improved treatment coordination for OUD and decreases in risky opioid prescribing (albeit likely more due to changing national provider norms). The State Medicaid Agency continues to meet budget neutrality targets.

An extension will allow the State Medicaid Agency to continue to make progress on identified goals.

The extension will also add the following expenditure authority.

> **1. Youth Empowerment Services (YES) Group.** Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

This extension request aligns with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

Proposed Effective Date
The Department is requesting an effective date of April 1, 2025.

Anticipated Impact on Indians/Indian Health Program/Urban Indian Organizations
A. Does this change directly affect American Indians / Alaska Natives (AI/AN) or Indian Health Care Providers (IHCPs) but is federally or statutorily mandated?

Idaho Senate Bill S1204 Medicaid (2019) was signed into law April 9, 2019, outlining requirements for implementation of Medicaid expansion. For example, this law states *"the director is hereby encouraged and empowered to obtain federal approval in order that Idaho design and implement changes to it's Medicaid program that advance the quality of services to participants while allowing access to needed services and containing excess cost"*. The law necessitated the application for Section 1115 Waiver funding. Idaho expanded Medicaid and the State Medicaid Agency applied for the 1115 BHT waiver in January 2020.

The "Idaho 1115 Behavioral Health Transformation" (Project Number 11-w-00339/10) was approved by CMS April 17, 2020, with an end date of March 31, 2025.

Idaho House Bill H0043 Medical Assistance (2017) amended Idaho Code § 56-254 Eligibility For Medical Assistance to add the following language:

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Pursuant to this, Idaho submitted and CMS approved in 2018 a 1915(i) Home and Community-Based Services (HCBS) Serious Emotional Disturbance (SED) Medicaid State Plan Authority (renewed in 2022). This authority allowed Idaho Medicaid to serve youth under age eighteen (18), diagnosed with Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines.

B. Does the change impact services or access to services provided, or contracted for, by Indian Health Care Providers (IHCPs) including but not limited to:
- *Decrease/increase in services*
- *Change in provider qualifications/requirements*
- *Change service eligibility requirements (i.e. prior authorization)*
- *Place compliance costs on Indian Health Care Providers (IHCPs)*
- *Change in reimbursement rate or methodology*

The extension application and the proposed change do not increase or decrease available services under IHCPs. It does not change provider qualifications / requirements or service eligibility requirements (i.e. prior authorizations). It does not

change reimbursement rates or methodology, and does not place compliance costs on IHCPs.

C. Does the change negatively impact or change the eligibility for, or access to, American Indians / Alaska Natives (AI/AN) Medicaid?

The extension application and proposed changes should not affect Medicaid eligibility or enrollment of American Indians / Alaska Natives (AI/AN).

Availability for Review

The current demonstration is available at **11-W-00339/10: 1115 IMD Behavioral Health Transformation Demonstration**.

The draft amendment is posted on the IDHW website at https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers (under "Waivers library", PUBLIC-DOCUMENTS > For Providers > Medicaid > Waivers > Idaho 1115 Family personal Care Services Waiver). The draft amendment is also attached to this letter.

Comments, Input, and Tribal Concerns

Idaho Medicaid appreciates any input or concerns that Tribal representatives wish to share regarding this extension request. Please submit any comments prior to **January 11, 2025,** by email addressed to MCPT@dhw.idaho.gov. This will also be reviewed as part of the Policy Update at the next Quarterly Tribal meeting.

Public Hearing: 1115 IMD BHT Extension Application
December 18, 2024
11:00am MST

Conference Room 6A, 450 W State Street, Boise, Idaho

Join from the meeting link
https://idhw.webex.com/idhw/j.php?MTID=md4ca186ee57ad8db2c1ff517d816f2ca

Meeting number (access code): 2826 738 4533
Meeting password: v8X7neJ2EDt (88976352 when dialing from a phone or video system)

Join by phone
+1-415-527-5035 United States Toll

Public Hearing: 1115 IMD BHT Extension Application
December 20, 2024
10:00am MST

Conference Room 6A, 450 W State Street, Boise, Idaho

Join from the meeting link
https://idhw.webex.com/idhw/j.php?MTID=me64fd5f91e2178a4f20da31aeaa296e9

Meeting number (access code): 2830 571 3964
Meeting password: wQWinupe244 (97946873 when dialing from a phone or video system)

Join by phone
+1-415-527-5035 United States Toll

Sincerely,

Juliet Charron
Deputy Director

JC/ah

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

JULIET CHARRON – Deputy Director
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 3, 2024

Alex Desatoff
Demonstration Project Officer
Center for Medicaid and CHIP Services (CMCS)

Dear Alex Desatoff:

Idaho Medicaid is requesting to extend the State's 11-W-00339/10: 1115 IMD Behavioral Health Transformation Demonstration for another five (5) years.

The State Medicaid Agency has observed improved access to medically necessary services to include residential facilities serving those with mental health and/or substance use service needs and intensive outpatient services. Other key observed impacts include improved treatment coordination for Opioid Use Disorder and decreases in inappropriate opioid prescribing (albeit likely more due to changing national provider norms). While access to these services has improved under the waiver, the State Medicaid Agency continues to meet budget neutrality requirements.

Renewal of this waiver will allow the State Medicaid Agency to continue to make progress on the goals set forth in the demonstration. The next five (5) years ahead are of particular importance as the State Medicaid Agency has recently implemented a new stand-alone behavioral health managed care contract to partner with the agency to further improve behavioral health workforce and capacity; access to medically necessary services; and coordination of these services for both youth and adults. The State Medicaid Agency is optimistic that Idaho will see even further progress towards these goals in the years ahead.

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1. Increased rates of identification, initiation, and engagement in behavioral health treatment.

2. Increased adherence to and retention in behavioral health treatment.

3. Reductions in overdose deaths, particularly those due to opioids.

4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate.

6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Demonstration Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

2. Reduced preventable readmissions to acute care hospitals and residential settings.

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.

4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.

5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

This extension request aligns with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

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public notice and comment period and by scheduling two (2) public hearings, each one (1) hour long. At these hearings the most recent working proposal will be described and made available to the public, and time will be provided during which comments were received.

Tribal solicitation will also be completed by sending a Dear Tribal Leader Letter to Tribal representatives.

Idaho anticipates submitting the 1115 Demonstration renewal application no later than the very beginning of 2025. Idaho appreciates your review of this extension request and anticipates CMS approval. Please direct any questions to Charles Beal, Medicaid Policy Director, at charles.beal@dhw.idaho.gov.

Sincerely,

JULIET CHARRON
Deputy Director

JC/ah

cc: Courtenay Savage, Julie Sharp

Idaho Department of Health and Welfare

Section 1115 Medicaid Demonstration Extension Application

January 15, 2025

Table of Contents

Section I. Background and Overview

Background

Idaho's health care system has been historically fragmented and reliant upon partnerships among agencies, provider organizations, and the community. Health Professional Shortage Areas (HPSA) are designated in 98.7% of the state for primary care, 95.7% for dental health, and 100% for mental health.

Idaho Proposition 2, a Medicaid expansion initiative, was approved on the 2018 general election ballot. This measure 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 138% of the federal poverty guidelines and not otherwise eligible for Medicaid coverage.

Subsequently, Idaho Senate Bill S1204 Medicaid (2019) was signed into law April 9, 2019, outlining requirements for implementation of Medicaid expansion. For example, this law states *"the director is hereby encouraged and empowered to obtain federal approval in order that Idaho design and implement changes to it's Medicaid program that advance the quality of services to participants while allowing access to needed services and containing excess cost"*. The law necessitated the application for Section 1115 Waiver funding. Idaho expanded Medicaid and the State Medicaid Agency applied for the 1115 BHT waiver in January 2020.

The "Idaho 1115 Behavioral Health Transformation" (Project Number 11-w-00339/10) was approved by CMS April 17, 2020, with an end date of March 31, 2025.

Additional relevant background includes:

MAT Waiver. On December 29, 2022, the President signed into law the Consolidated Appropriations Act, 2023 effectively eliminating the "Drug Addiction Treatment Act (DATA)-Waiver Program" also known as the Medication-Assisted Treatment (MAT) Waiver or X-Waiver Program. This act changed provider requirements, eliminated discipline restrictions and limits to prescription medications to treat opioid use disorder (OUD), and changed certification related to providing counseling.

Idaho's Behavioral Health Plan Governance Bureau. In January 2023, a new State Medicaid Agency Idaho Behavioral Health Plan Governance Bureau was formed as to resource and manage the oversight of quality, performance, and innovation in the IBHP.

COVID-19 Public Health Emergency and Medicaid Unenrollment. In response to the COVID-19 outbreak, on January 31, 2020, a public health emergency (PHE) under section 319 of the Public Health Service Act (42 U.S.C. 277d) was declared by the Secretary of Health and Human Services. This declaration enabled the Secretary to "temporarily waive or modify certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs and of the Health Insurance Portability

and Accountability Act Privacy Rule throughout the duration of the public health emergency declared in response to the COVID-19 outbreak".

The Consolidated Appropriations Act, 2023 was signed into law on December 29, 2022, unlinking the continuous coverage requirement from the PHE while creating a new requirement for states. This new requirement dictates that state must provide 12 months of continuous eligibility for enrollees under the age of 19 in both Medicaid and CHIP (Children's Health Insurance Plan) beginning January 2024 as well as makes permanent the state plan option to provide 12 months of postpartum coverage in Medicaid and CHIP. Continuous coverage meant that no state could remove anyone from Medicaid unless they were determined to have relocated out of state, requested to be removed, or passed away. When the COVID-19 Public Health Emergency (PHE) expired May 11, 2023, Idaho began identifying those enrolled in Medicaid who were no longer eligible for Medicaid benefits.

These eligibility and enrollment changes affected data, reporting, and metrics on the demonstration.

Overview

In 2020, the "Idaho 1115 Behavioral Health Transformation" was approved by the Centers for Medicaid and Medicare Services (CMS). This demonstration allows the State Medicaid Agency 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/or serious mental illness/serious emotional disturbance (SMI/SED).

SMI/SED and SUD Program Benefits. Under this demonstration, beneficiaries have access to high quality, evidence-based SMI/SED and OUD/SUD treatment and withdrawal management services, ranging from medically supervised withdrawal management for SUDs and short-term acute care in inpatient and residential settings for SMI to ongoing chronic care for these conditions in cost-effective community-based settings. The State Medicaid Agency continues to work to improve care coordination and care for cooccurring physical and behavioral health conditions.

The coverage of SMI/SED and SUD treatment services during short term residential and inpatient stays in IMDs expands Idaho's current SMI/SED and/or SUD benefit package available to all Idaho Medicaid beneficiaries. It also supports State Medicaid Agency efforts to implement models of care focused on increasing support for individuals in the community and home, outside of institutions, and improve access to a continuum of SMI/SED and/or SUD evidence-based services at varied levels of intensity.

The state continues to make progress on the following goals:

SUD Demonstration Goals:

1. Increased rates of identification, initiation, and engagement in behavioral health treatment.

2. Increased adherence to and retention in behavioral health treatment.

3. Reductions in overdose deaths, particularly those due to opioids.

4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate.

6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Demonstration Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

2. Reduced preventable readmissions to acute care hospitals and residential settings.

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.

4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.

5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Section II: Description of the Extension Request

The Idaho BHT Waiver focuses on Medicaid enrollees with SUD and/or SMI/SED. 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.

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 health care 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 health care when and where they need it.

To achieve this goal, the State Medicaid Agency implements three (3) broad 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.

The State Medicaid Agency has generally seen increased utilization, increased capacity including residential mental health facilities, intensive outpatient services, and residential mental health facilities and beds. Other key impacts include improved treatment coordination for OUD and decreases in risky opioid prescribing (albeit likely more due to changing national provider norms). The State Medicaid Agency continues to meet budget neutrality targets.

Youth Empowerment Services (YES) Population Up to Three Hundred Percent (300%) FPL Addition

Idaho House Bill H0043 Medical Assistance (2017) amended Idaho Code § 56-254 Eligibility For Medical Assistance to add the following language:

> *(i) Effective January 1, 2018, children under age eighteen (18) years with serious emotional disturbance, as defined in section 16-2403, Idaho Code, in families whose income does not exceed three hundred percent (300%) of the federal poverty guideline and who meet other eligibility standards in accordance with department rule.*

Pursuant to this, Idaho submitted and CMS approved in 2018 a 1915(i) Home and Community-Based Services (HCBS) SED Medicaid State Plan Authority (renewed in 2022). This authority allowed Idaho Medicaid to serve youth under age eighteen (18), diagnosed with SED, and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG), and in need of respite services.

CMS requirements under the 1915(i) include:

- Completion of an Independent Assessment to determine SED initially and annually within three hundred and sixty-four (364) days of the previous assessment.
- Completion of a Person-Centered Service Plan (PCSP) that meets C.F.R. requirements within ninety (90) days of becoming enrolled in the YES Program and annually within three hundred and sixty-four (364) days of the previous PCSP. PCSP also to be updated as needed and/or at the request of the participant.
    - A Targeted Care Coordinator conducts PCSPs within the IBHP network, but a Children's Developmental Disability (DD) case worker or a Division of Behavioral Health (DBH) clinician can also complete them in certain situations.
- Utilization of Respite, the only 1915(i) SPA for SED service, at least one (1) time annually.

The State Medicaid Agency has encountered ongoing challenges with complying with all of the above requirements, particularly during the COVID-19 Public Health Emergency. In order to best serve this population and comply with CMS expectations, the State Medicaid Agency is requesting to add a new eligibility group to this demonstration.

Youth Empowerment Services (YES) Group. Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

The goal is to ensure access to a system of care for children with serious mental health needs and their families.

Challenges

Provider Shortages. Idaho, like many other states, continues to have a provider shortage at all levels of behavioral health care. The provider shortage was a major barrier to the rollout of the Idaho BHT Waiver and the new IBHP MCO.

A. Proposed Cost Sharing Requirements under the Demonstration as Extended:

Participants under this demonstration would be subject to the following cost-sharing:

All participants with family income above one hundred eighty-five percent (185%) of the FPG will be subject to a monthly premium of fifteen dollars ($15) per youth per month.

Copayments will be applicable to all participants as already defined under the state's current and approved Medicaid State Plan and waivers.

B. Proposed Changes to the Delivery System under the Demonstration as Extended:

The health care delivery system for the provision of services under this demonstration will be implemented in the same manner the existing demonstration.

C. Proposed Changes to Benefit Coverage under the Demonstration as Extended:

The benefit coverage will be the same manner as under the state's current and approved Medicaid State Plan.

D. Proposed Changes to Eligibility Requirements as Extended:

All eligibility requirements will continue to be met through an initial and annual application, review process, and ongoing oversight, except as noted below.

This would extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a SED, and with a family income up to three hundred percent (300%) of FPG.

An independent, needs-based evaluation or reevaluation would be required at least once every three-hundred sixty-five (365) days. The independent evaluation is performed by an agent that is independent and qualified. Independent Assessors are state-licensed, master's-level clinicians or higher. Independent Assessors receive specialized training in how to conduct the functional assessment and hold certification in a State Medicaid Agency approved tool for assessing children.

The initial assessment process also includes:

a. Evaluation of the child's current behavioral health, living situation, relationships, and family functioning;
b. Contacts, as necessary, with significant individuals such as family and teachers; and
c. A review of information regarding the child's clinical, educational, social, behavioral health, and juvenile/criminal justice history.

Section III: Expenditure Authority

Under the authority of Section 1115(a)(2) of the Act, Demonstration Projects, expenditures made by the State Medicaid Agency for the items identified below, which are not otherwise included as expenditures under Section 1903 of the Act, Payment to States, shall, for the period from April 1, 2025, through March 31, 2030, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable the State Medicaid Agency to operate the above-identified section 1115(a) demonstration.

1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) and/or Serious Mental Illness (SMI). Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) and/or a serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

2. Youth Empowerment Services (YES) Group. Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).

Section IV: Demonstration Financing and Budget Neutrality

Allowable Expenditures. This demonstration project includes only allowable expenditures applicable to services rendered during the demonstration approval period designated by CMS.

Unallowable Expenditures. This demonstration project does not include expenditures for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration.

Sources of Non-Federal Share. The State Medicaid Agency certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The State Medicaid Agency further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The State Medicaid Agency acknowledges that CMS has authority to review the sources of the non- federal share of funding for the demonstration at any time. The State Medicaid Agency agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. The State Medicaid Agency acknowledges that any amendments that impact the financial status of the demonstration must require the State Medicaid Agency to provide information to CMS regarding all sources of the non-federal share of funding.

Program Integrity. The State Medicaid Agency has processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The State Medicaid Agency ensures that the State Medicaid Agency and any of its contractors follow standard program integrity principles and practices including retention of data.

Section V: Demonstration Evaluation and Monitoring

Independent Evaluator. The State Medicaid Agency will continue to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The State Medicaid Agency has contracted with an independent evaluator for the initial five years of the demonstration and completed all required evaluation reports timely.

Monitoring Reports. The State Medicaid Agency will submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY.

Goals and milestones for SUD and SMI/SED listed below.

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 misuse 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.

Section VI: Public Notice Process and Input Summary

Pursuant to the terms and conditions that govern Idaho's Demonstration, Idaho must provide documentation of its compliance with the state notice procedures set forth in 42 C.F.R. § 431.408 State public notice process. The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act as amended by Section 5006(e) American Recovery and Reinvestment Act of 2009, 42 C.F.R. § 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan.

Tribal solicitation and public notice were completed by providing a thirty (30) day public notice and comment period and by scheduling two (2) public hearings, each one (1) hour long. These were held on December 18 and 20, 2024. At these hearings the most recent working proposal was described and made available to the public, and time was provided during which comments were received.

Tribal solicitation was also completed by sending a Dear Tribal Leader Letter to Tribal representatives.

A summary of all comments received and responses have been included in this application.

VII. Demonstration Contact

STATE CONTACT

State Medicaid Director Name: Juliet Charron
Telephone Number: (208) 364-1831
E-mail Address: Juliet.Charron@dhw.idaho.gov

State Lead Contact for Demonstration Application: Charles Beal
Telephone Number: (208) 364-1887
E-mail Address: Charles.Beal@dhw.idaho.gov

Appendix A: Public Comment Summary

An estimated _____ people commented during Idaho's public comment period for this amendment. The following is a summary of those comments:

1115 Demonstration Renewal Comment and Response Document	
Comments/Questions	Responses
One commenter noted	

Section 1115 Medicaid Demonstration Extension Application

Public Hearing Materials

1115 IMD Behavioral Health Transformation Extension

December 18, 2024

DHW Division of Medicaid

IDAHO DEPARTMENT OF HEALTH & WELFARE

Housekeeping

The presentation is being recorded. If you do not wish to be recorded, please exit the meeting.

WebEx attendees will be muted. After the presentation, we will provide an opportunity to provide verbal public comment. If you intend to provide verbal comment, you may indicate by:

- Using the “raise hand” option located  enter of your screen.
- Written comments may also be posted into the chat window at the bottom right of your screen.
- For those joining the presentation via phone only, we will provide an opportunity to provide comment after the WebEx comments.

Objective

The Idaho Department of Health and Welfare Division of Medicaid is submitting to the Centers of Medicare and Medicaid Services (CMS) an extension application to the 1115 Research & Demonstration Waiver, Project Number 11-W-00339/10.

This meeting is for public comment regarding this extension.

1115 Demonstration Authority: Key Points

- The extension is for the following expenditure authorities:
  - 1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) and/or Serious Mental Illness (SMI). *Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) and/or a serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).*
  - 2. Youth Empowerment Services (YES) Group. *Expenditures to extend eligibility for full Medicaid state plan benefits to youth under age eighteen (18), diagnosed with a Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines (FPG).*
- The requested effective date is April 1, 2025.

1115 Demonstration Authority: Key Points

- Renewal of this waiver will allow the State Medicaid Agency to continue to make progress on the goals set forth in the demonstration. The next five (5) years ahead are of particular importance as the State Medicaid Agency has recently implemented a new stand-alone behavioral health managed care contract to partner with the agency to further improve behavioral health workforce and capacity; access to medically necessary services; and coordination of these services for both youth and adults.

1115 Demonstration Authority: Key Points

- An amendment is currently being submitted to CMS regarding the following existing expenditure authority, and the extension application does not include this authority:
  - Use of Legally Responsible Individuals to Render Personal Care Services (PCS). *Expenditures for the state to provide payment for personal care services rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers), following a reasonable assessment by the state that the caregiver is capable of rendering the services, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.*

Relevant Background: YES Group

- Idaho House Bill H0043 Medical Assistance (2017) amended Idaho Code § 56-254 Eligibility For Medical Assistance to add the following language:
  - *(i) Effective January 1, 2018, children under age eighteen (18) years with serious emotional disturbance, as defined in section 16-2403, Idaho Code, in families whose income does not exceed three hundred percent (300%) of the federal poverty guideline and who meet other eligibility standards in accordance with department rule.*
- Pursuant to this, Idaho submitted and CMS approved in 2018 a 1915(i) Home and Community-Based Services (HCBS) Serious Emotional Disturbance (SED) Medicaid State Plan Authority (renewed in 2022). This authority allowed Idaho Medicaid to serve youth under age eighteen (18), diagnosed with Serious Emotional Disturbance (SED), and with a family income up to three hundred percent (300%) of the Federal Poverty Guidelines.

Expected Impact on Budget Neutrality

- Idaho projects that the total aggregate expenditures under this 1115 Research and Demonstration Waiver extension will increase by a trend factor currently being developed.
  - No services are being added or deleted to the state Medicaid Program.
  - No premiums or premium criteria are changing.
- **Idaho expects these expenditures will reflect participants and healthcare costs already enrolled with Idaho Medicaid.**

Viewing The Draft Amendment

- The draft amendment is posted here:
- https://townhall.idaho.gov/PublicMeeting?MeetingID=5608
- https://townhall.idaho.gov/PublicMeeting?MeetingID=5609
- https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=32093&dbid=0&repo=PUBLIC-DOCUMENTS

Verbal Public Comments

- Comments will initially be kept to approximately five (5) minutes to allow other attendees a chance to speak.
- Raise hand on WebEx to comment; or 
- Type your comment in the chat feature.
- Identify yourself prior to comment with your name, city and state.
- Telephone comments will be taken after the WebEx comments.
  - When telephone comments are requested, press *6 to unmute yourself.
- **Any comments or questions will be responded to by DHW as part of the federal submission.**

Written Public Comments

Accepting written comments post marked by
January 11, 2025

Email:
MCPT@dhw.Idaho.gov
Mail:
Department of Health and Welfare
ATTN: Medicaid Policy
PO Box 83720
Boise, ID 83720

Idaho Department of Health and Welfare

APPENDIX C

December 20, 2024, Section 1115 Medicaid Demonstration
Amendment Request:
Removal of Expenditure Authority For
Use of Legally Responsible Individuals
to Render Personal Care Services (PCS)

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

JULIET CHARRON – Deputy Director
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 20, 2024

Alex Desatoff
Demonstration Project Officer
Center for Medicaid and CHIP Services (CMCS)

Dear Alex Desatoff:

The Idaho State Medicaid Agency is requesting an amendment to the 11-W-00339/10: 1115 IMD Behavioral Health Transformation Demonstration to remove an approved expenditure authority.

The State Medicaid Agency requests that the language below be removed from Idaho's 1115 demonstration waiver authority.

> *2. **Use of Legally Responsible Individuals (LRI) to Render Personal Care Services (PCS).** The state will provide payment for PCS rendered by an LRI, which could be inclusive of legally responsible family caregivers, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements. The requested LRI must meet all qualifications to become a direct care worker to provide PCS as authorized in the Medicaid state plan, including abiding by all oversight requirements from the hiring agency and the Idaho Department of Health and Welfare. A beneficiary can receive PCS from a non-LRI beyond the hours provided by an LRI in accordance with a beneficiary's assessed need and the plan of care. The state shall implement a phased-in approach, which will be detailed in the monitoring reports and must be submitted to CMS at least sixty (60) days in advance of implementation, for the following conditions that must be met for a beneficiary to receive PCS from an LRI:*
> *a. **Extraordinary Circumstance.** A beneficiary must demonstrate their care needs meet an extraordinary circumstance to allow for an LRI to provide PCS. An extraordinary circumstance is defined as no other caregiver being available to meet all of the beneficiary's allocated hours.*
> *b. **Application Requirement.** The beneficiary must have attempted to arrange for a non-LRI direct care worker to provide needed PCS. The beneficiary must demonstrate a minimum of two unsuccessful attempts to obtain PCS from providers that are not an LRI.*

The current structure of this expenditure authority has led to unanticipated and unsustainable growth in the program that cannot be appropriately managed and overseen within the State Medicaid Agency's current resources. Further, the State Medicaid Agency has identified a concerning volume of incidents of suspected and confirmed fraud and abuse and healthy and safety concerns that the State Medicaid Agency cannot resolve within the program's current parameters and staff capacity.

This amendment request aligns with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

The State Medicaid Agency requests an effective date of January 31, 2025.

Idaho appreciates your review of this amendment request and anticipates CMS approval. Please direct any questions to Charles Beal, Medicaid Policy Director, at charles.beal@dhw.idaho.gov.

Sincerely,

[redacted]

JULIET CHARRON
Deputy Director

JC/ah

cc: Courtenay Savage, Julie Sharp

Idaho Department of Health and Welfare

Section 1115 Medicaid Demonstration Amendment Request:

Removal of Expenditure Authority For
Use of Legally Responsible Individuals
to Render Personal Care Services (PCS)

December 20, 2024

Table of Contents

Section I. Background and Overview

A. Background

During the COVID-19 public health emergency, the federal Centers for Medicare and Medicaid Services (CMS) allowed a temporary flexibility to decrease the need for direct care workers in people's homes to prevent the spread of COVID-19.

Specifically, CMS allowed Family Personal Care Services (FPCS), the paid employment of legally responsible parents and spouses by direct care staffing agencies while providing care in their own homes for their loved ones who are Medicaid participants with disabilities. Prior to this temporary change, legally responsible individuals were expressly prohibited by both federal and state regulation from being paid personal care aides.

With the end of the federally declared public health emergency in 2023, the State Medicaid Agency faced the decision whether to terminate or continue this policy flexibility. The continuing direct care workforce shortage and concern expressed by stakeholders led the State Medicaid Agency to request and secure CMS approval to extend this flexibility through March 21, 2025, with limited safeguards given current staff capacity to oversee the program. The State Medicaid Agency had extensive technical assistance with CMS during this time. In early 2024 the Department started a stakeholder workgroup to discuss future changes to the benefit with the intent to possibly amend requirements with the March 2025 renewal.

Stakeholders are aware that the current authority supporting FPCS will end in March 2025, unless the State Medicaid Agency is authorized and funded to continue it in some form. To date, the stakeholder group has asked the State Medicaid Agency to further loosen the program's few restrictions.

Stakeholders requested less frequent in-home health and safety visits and an expanded scope of responsibilities for parents to take on and be paid for beyond what is currently authorized. To date, the State Medicaid Agency has responded that the program is under review and those recommendations will be taken into consideration.

The State Medicaid Agency is not currently resourced to continue to support this program and ensure health and safety as well as operational integrity, given its exponential growth and number of concerning trends identified of fraud, waste, and abuse.

B. Overview

The current structure of this expenditure authority has led to unanticipated and unsustainable growth in the program that cannot be appropriately managed and overseen within the State Medicaid Agency's current resources. Further, the State Medicaid Agency has identified a concerning volume of incidents of suspected and

confirmed fraud and abuse and healthy and safety concerns that the State Medicaid Agency cannot resolve within the program's current parameters and staff capacity.

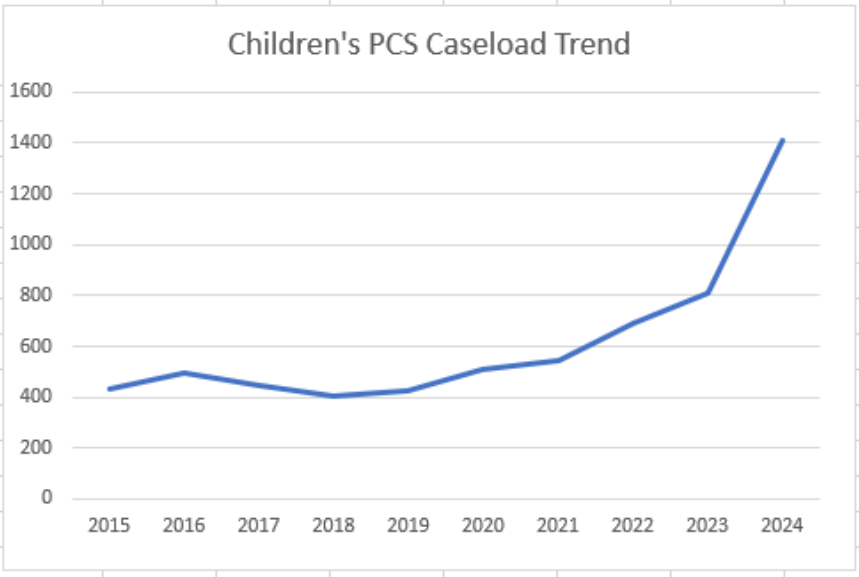
In the role as stewards of taxpayer dollars and oversight of this program serving vulnerable children and adults, the State Medicaid Agency has determined the most appropriate action is to move to terminate this expenditure authority allowing Legally Responsible Individuals to be reimbursed as PCS providers effective January 31, 2024.

This action will not remove Personal Care Services (PCS) as a State Plan Benefit, which will remain available as it has prior to COVID-19 and staffed by direct care professionals through provider agencies.

Historically across successive fiscal years dating as far back as 2015, there were roughly five hundred (500) participants in children's personal care and private duty nursing services. Enrollment jumped to five hundred forty-six (546) in 2021, and significantly increased in each subsequent year. In October 2024, the State Medicaid Agency had one thousand one hundred seventy-eight (1,178) participants in the program, and projected enrollment at one thousand four hundred thirteen (1,413) by the end of calendar year 2024.

This represents a seventy-five percent (75%) increase in enrollment since 2023 when the public health emergency ended. The growth in enrollment at this rate was not projected and is not sustainable within the State Medicaid Agency's budget if this continues. While expenditures are based on authorized hours of services that are approved by clinical staff, the State Medicaid Agency is aware of many inappropriate attempts to increase the number of authorized hours by families which are further described below.

Year	Children's PCS Caseload Trend
2015	434
2016	493
2017	446
2018	402
2019	426
2020	507
2021	546
2022	688
2023	809
2024	1413
	*1,178 as of 10/29/24



This ongoing enrollment surge is due in part to suspected program abuse. The State Medicaid Agency has observed that some parents, spouses, and provider agencies are trading tips on how to seemingly exploit this program. This includes:

- Sharing information on how to manipulate and respond to the medical assessment to maximize authorized hours of service.
- Photocopying and sharing eligibility paperwork rather than obtaining independent confirmation from two (2) direct care staffing agencies that they have insufficient staff to serve the child/spouse (as required by the program).
- Recruiting families outside Idaho to move to Idaho to be paid for these services.
- Advertising to employ parents to care for their child(ren) with special needs, saying there is, "No need to work away from home." This incentivizes parents who never previously had a need or interest in these services to apply.
- Communicating the starting pay rates for area provider agencies, resulting in participants switching agencies *not* due to a quality-of-care concern, but exclusively to maximize the household's income.

Other suspected fraudulent and concerning activities include:

- Claiming to care for children but performing other activities at the same time (i.e., driving for a ride share company).
- Inappropriately double- and triple-billing by caring and billing for multiple children simultaneously (the program only allows a provider to care for one (1) individual at a time). This also presents serious questions of quality and adequacy of care when the child has been identified to need a specific number of hours of care, but it is physically impossible for the parent to serve multiple children for those hours. This includes parents logging more than twenty-four (24) hours in a day as confirmed by electronic visit verification (EVV).
- Using Medicaid as supplemental household income by determining the needs of the child(ren) on the income received. To quote one parent, "I want PCS for four of my kids. When I find out what my income will be, I might get PCS for [the others]."
- Repeatedly calling State Medicaid Agency staff to inquire about the status of assessments and actively encouraging others to do the same, taking time away from employees completing those assessments and work for the other Medicaid participants.
- Households that have had continuous Medicaid coverage in the past, but never requested or identified a need for a child (or children) in the household to receive PCS until this flexibility was implemented, with no discernible change in the child's condition that would warrant said request.

- Instances in which one individual is clocking in and out of services for multiple participants in multiple households that appear to be efforts to avoid detection by quality assurance monitoring of EVV data. In the last calendar quarter, one individual clocked in and out with overlapping visit segments (which is prohibited) for twenty-one (21) FPCS participants.
- Households selectively providing service hours to attempt to control income that would affect eligibility for other public benefits, which suggests that the child did not medically require the total number of hours authorized.

The State Medicaid Agency can supply copies of evidence and support of all of these instances and others upon request.

Not only has enrollment increased, but costs have also nearly quadrupled since 2022 and are not sustainable within the current appropriation if this growth trend continues.

As stewards of public funds and in the role of oversight of this entitlement program serving vulnerable children and adults, the State Medicaid Agency cannot continue to operate a program with such high rates of suspected and known fraud and abuse and potential health and safety issues for participants.

Many of these cases have come to the State Medicaid Agency's attention through complaints or observed and experienced interactions with families, content posted on social media, referrals from other state agencies that serve the same population, and referrals by word of mouth from community partners and individuals. While several of these cases have been referred to the Medicaid Program Integrity Unit, the State Medicaid Agency does not have the infrastructure to administratively identify all cases needing additional inquiry and pursuing recovery. Moreover, if a household / family is perpetrating fraud, any recovery of funds would be from the agency that technically employs the parent / spouse, thereby weakening Idaho's already tenuous network of direct care agencies.

The State Medicaid Agency recognizes that there are still many families who use this benefit and program appropriately, legitimately need support, and cannot find direct care workers to provide services to their children. The State Medicaid Agency has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the last two (2) years and has observed an approximately ten percent (10%) growth in the number of unduplicated direct care workers, not including parents and spouses, as identified in the State Medicaid Agency's Electronic Visit Verification data. The State Medicaid Agency will share options through external communications to agencies and families during this transition. State Medicaid Agency staff are always available to families and provider agencies to discuss options.

At the same time, it is evident over the last year alone of operationalizing this flexibility that the State Medicaid Agency does not currently have the resources to

build an infrastructure to determine what is acceptable and then meaningfully monitor and enforce those standards to promote healthy and safety and appropriate use of public funds.

The State Medicaid Agency team responsible for administration and oversight of the FPCS program will be implementing additional safeguards and operational processes to provide as much oversight as possible during the remaining months of the FPCS flexibility. These activities will include:

- Processing timeframes for new requests will be moved to thirty (30) days. The current timeframe is fourteen (14) days. The team is unable to maintain fourteen (14) days without detrimental impact to other programs and services administered by these staff.
- Quarterly supervisory oversight forms submitted by provider agencies will require a narrative to validate that each visit did, in fact, occur and is reflective of adequate clinical oversight.
- Functional assessments for whom the primary respondent is also the direct care worker (including parents and spouses) will be subject to post-processing internal review by the Medical Director to validate that PCS are medically necessary. Additional medical documentation to substantiate the participant's ongoing need for services may be requested.

In addition, the Medicaid Program Integrity Unit is actively pursuing recoupments and assessing penalties as appropriate and will refer all credible allegations of fraud to the Medicaid Fraud and Control Unit.

Section II: Description of the Amendment

Effective January 31, 2025, the State Medicaid Agency is requesting an amendment to the 1115 Research and Demonstration Waiver, Project Number 11-W-00339/10, to remove an approved expenditure authority.

This requested amendment does not remove Personal Care Services as an available benefit for those served by Idaho Medicaid, which will continue to be available as a State Plan benefit.

Rather, the State Medicaid Agency seeks to amend who can qualify as a provider and can render the service for Medicaid reimbursement. The State Medicaid Agency will revert back to the same criteria and qualifying providers as existed pre-COVID-19. With concerted efforts and rate increases to bolster the direct care workforce, PCS provider agencies have reported a ten percent (10%) increase in the number of staff hired and who will be available to serve participants receiving PCS services. Please note, the State Medicaid Agency continues to work on several concerted efforts to support the direct care workforce beyond what has been done to date.

The State Medicaid Agency requests that the language below be removed from Idaho's 1115 demonstration waiver authority.

> ***2. Use of Legally Responsible Individuals (LRI) to Render Personal Care Services (PCS).*** *The state will provide payment for PCS rendered by an LRI, which could be inclusive of legally responsible family caregivers, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements. The requested LRI must meet all qualifications to become a direct care worker to provide PCS as authorized in the Medicaid state plan, including abiding by all oversight requirements from the hiring agency and the Idaho Department of Health and Welfare. A beneficiary can receive PCS from a non-LRI beyond the hours provided by an LRI in accordance with a beneficiary's assessed need and the plan of care. The state shall implement a phased-in approach, which will be detailed in the monitoring reports and must be submitted to CMS at least sixty (60) days in advance of implementation, for the following conditions that must be met for a beneficiary to receive PCS from an LRI:*
> *a.* ***Extraordinary Circumstance.*** *A beneficiary must demonstrate their care needs meet an extraordinary circumstance to allow for an LRI to provide PCS. An extraordinary circumstance is defined as no other caregiver being available to meet all of the beneficiary's allocated hours.*
> *b.* ***Application Requirement.*** *The beneficiary must have attempted to arrange for a non-LRI direct care worker to provide needed PCS. The beneficiary must demonstrate a minimum of two unsuccessful attempts to obtain PCS from providers that are not an LRI.*

A. Proposed Cost Sharing Requirements under the Demonstration as Amended:

This amendment would not change cost sharing requirements. Prior to and after this amendment, there are no premium, enrollment fee, or similar charge, or cost-sharing (including copayments and deductibles) required of individuals enrolled in this demonstration that varies from the State Medicaid Agency's current Medicaid State Plan.

B. Proposed Changes to the Delivery System under the Demonstration as Amended:

The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as under the State Medicaid Agency's current and approved Medicaid State Plan and waivers.

C. Proposed Changes to Benefit Coverage under the Demonstration as Amended:

The benefit coverage will be the same manner as under the State Medicaid Agency's current and approved Medicaid State Plan. Specifically, the coverage criteria and requirements for Personal Care Service (PCS) will continue as they are in State Medicaid Agency's approved State Plan Alternative Benefit Plan (ABP).

D. Proposed Changes to Eligibility Requirements as Amended:

This amendment would not change eligibility requirements. All eligibility requirements will continue to be met through an initial and annual application, review process, and ongoing oversight.

Section III: Expenditure Authority

The State Medicaid Agency is requesting remove the following approved expenditure authority from the demonstration.

2. Use of Legally Responsible Individuals to Render Personal Care Services (PCS). *Expenditures for the state to provide payment for personal care services rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers), following a reasonable assessment by the state that the caregiver is capable of rendering the services, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.*

Section IV: Expected Impact on Budget Neutrality

A. Expenditure Projection:

The State Medicaid Agency projects that the total aggregate expenditures under this 1115 Research and Demonstration Waiver demonstration amendment will decrease.

- Services are not being added or deleted to the state Medicaid Program.
- Cost sharing is not changing.
- A provider qualification flexibility is being removed.

Failing to execute the requested amendment will have a material negative impact on the State Medicaid Agency's budget neutrality model for demonstration number 11-W-00339/10.

B. Enrollment Impact:

This amendment should not have an impact on the eligibility or enrollment of Medicaid beneficiaries.

Section V: Evaluation Design

Idaho's 1115 Waiver Evaluation design will not include the removed expenditure authority.

Section VI: Public Notice Process and Input Summary

Pursuant to the terms and conditions that govern Idaho's Demonstration, Idaho must provide documentation of its compliance with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State Medicaid Agency must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act as amended by Section 5006(e) American Recovery and Reinvestment Act of 2009, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan.

Tribal solicitation and public notice were completed by publishing notice and the draft amendment at https://townhall.idaho.gov/. This is an established and well-publicized meeting and information site, created by the Idaho Governor to increase transparency and public involvement.

Tribal solicitation was also completed by sending a Dear Tribal Leader Letter to Tribal representatives.

A summary of all comments received and State Medicaid Agency responses have been included in this application in Appendix A.

STATE MEDICAID AGENCY CONTACT

State Medicaid Director Name: Juliet Charron
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E-mail Address: Juliet.Charron@dhw.idaho.gov

State Lead Contact for Demonstration Application: Charles Beal
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Idaho Department of Health and Welfare

APPENDIX A

Public Comments and Responses

Idaho 1115 Demonstration Amendment - FPCS Early Termination Public Comment

Comment Period: November 5th, 2024-December 4th, 2024

220 Total Comments Received

Comment	Idaho Department Health and Welfare Response
Many commenters shared personal stories concerning their family situations and the extent for which they provide care for their child or spouse.	The Department thanks the commenters for sharing their experiences.
220 commenters expressed support for continuation of the 1115 waiver for family personal care services.	The Department thanks the commenters for providing input.
100 commenters expressed concerns regarding the loss of household income or the financial impact the early termination of FPCS will have on their family.	While the Department appreciates the circumstances families find themselves in this service no longer being available, the Medicaid program is not designed to supplement household income or to ensure employment for household members. The purpose of the Medicaid program is to provide coverage for medically necessary services to the Medicaid participant. The Department does not have authority to consider employment needs when making decisions for this program.
156 commenters expressed concern regarding the inability to find a competent caretaker due the direct care worker shortage if FPCS is terminated early.	The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the past two years and has observed at least a 10% growth in non-legally responsible caregivers. The Department also reminds families who have been caretakers that they are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their loved ones for Medicaid reimbursement. The Department will be available to work with families to find available direct care staff throughout the transition and ongoing.

Comment	Idaho Department Health and Welfare Response
130 commenters expressed concerns that terminating the FPCS program will have a negative impact on their child or spouse/participants served.	Personal Care Services (PCS) will continue to be a benefit for Idaho Medicaid participants. All direct care workers must meet minimum standards intended to provide quality care to participants. Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity. The Department successfully administered the PCS benefit prior to the COVID 19 pandemic absent LRIs being reimbursed for PCS; this change is reverting back to the pre-pandemic provider qualifications.
127 commenters expressed concerns regarding quality of care and termination of this program. Feedback shared noted that FPCS provides a high quality of patient centered care that is often not received through outside agencies.	All direct care workers must be trained according to minimum standards established by the state. This includes special endorsements, such as using a hoyer lift or other specialized care. If a household has concerns about the training or skills of a direct care staff, they may problem-solve with the agency or report an issue to the Department at http://medicaidcomplaints.dhw.idaho.gov.
123 commenters expressed concerns that the termination of this program will result in their child or spouse having to be institutionalized.	The Department does not expect to see an increase in institutionalization as participants were living in the community before LRIs were reimbursed for providing PCS. The Department will continue to closely monitor trends between institutionalization and community-based services.
118 commenters expressed the program's savings to state costs and increased tax revenue.	Since the program's implementation the Department has seen a 75% increase in participants accessing PCS. Costs have quadrupled and are unsustainable under current appropriations. For the 2025 fiscal year (July through June 2025), $4.2 million was allocated for the program by the legislature. The program costs were $8 million within the first quarter.

Comment	Idaho Department Health and Welfare Response
115 commenters expressed removing FPCS would not suport Idaho's most vulnerable residents.	The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the past two years and has observed at least a 10% growth in non-legally responsible caregivers. The Department also reminds families who have been caretakers that they are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their children and spouses for Medicaid reimbursement. The Department will be available to work with families to find available direct care staff throughout the transition and ongoing.
15 commenters expressed concerns about strangers providing intimate personal care tasks.	Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity.
51 commenters expressed that the reason for increase enrollment was due to increased awareness and need. Additionally, the Department should not have authorized any unnecessary enrollment.	Increased enrollment can be attributed to a variety of factors, however, the Department observed parents, spouses, and provider agencies trading tips to exploit the program including: How to maximize authorized hours by manipulating medical assessments; photocopying eligibility paperwork instead of looking for direct care staff; recruiting families outside of Idaho to relocate for services; and advertising the program as a way to make income for families that previously did not need the service. Current Department staff capacity is not sufficient to provide the level of necessary oversight to appropriately mitigate inappropriate service utilization.
30 commenters expressed the numerous benefits they have received from this program.	The purpose of the Medicaid program is to provide coverage for medically necessary services to the Medicaid participant.
12 commenters expressed the need for more support for families.	The Department will share options for the families to provide care for their loved ones.
72 commenters expressed concerns that fraud and abuse could be resolved by adding more robust quality assurance measures and/or stricter eligibility criteria.	The Department has insufficient resources to ensure health and safety and operational integrity for this program due to its exponential growth.

Comment	Idaho Department Health and Welfare Response
16 commenters expressed concerns with finding a caretaker due to being in a rural area.	Families who have been caretakers are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their loved ones for Medicaid reimbursement. Two families in a similiar situtation may provide services for each other. The Department will be available to work with families to find available direct care staff throughout the transition and ongoing.
59 commenters expressed concerns regarding the Department's lack of transparency regarding the FPCS program.	The Department instituted a workgroup in January of 2024 that included advocates, families, and providers. Current information was shared with members for dissemination to their stakeholders. Minutes and agendas were posted to the Department's website for public review.
22 commenters expressed the concern of trusting a caretaker outside of the home.	If households have concerns about the professionalism of direct care staff, they should contact their provider agency. If a household has concerns about the training or skills of a direct care staff, they may problem-solve with the agency or report an issue to the Department at http://medicaidcomplaints.dhw.idaho.gov.
21 commenters expressed concerns that early termination of the FPCS program with result in of disruption to routines, will impact consistency, and have concerns with maintaining stability.	Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity.
8 commenters expressed that only families/agencies with fraud and abuse should be removed from the program.	The Department has insufficient resources to ensure health and safety and operational integrity for this program due to its exponential growth.
56 commenters stated that there are more families using the program appropriately than those committing fraud.	The Department has insufficient resources to ensure health and safety and operational integrity for this program due to its exponential growth.
7 commenters stated that child was a danger to self and others, and a direct caregiver would not care for them.	The Department will share options for the families to provide care for their loved ones. All direct care workers must be trained according to minimum standards established by the state. This includes special endorsements, such as using a hoyer lift or other specialized care. If a household has concerns about the training or skills of a direct care staff, they may problem-solve with the agency or report an issue to the Department at http://medicaidcomplaints.dhw.idaho.gov.

Comment	Idaho Department Health and Welfare Response
4 commenters expressed they had seen questionable actions by provider agencies and families for FPCS, but the program should be refined and not terminated.	The Department thanks the commenters for their comment.
4 commenters stated their family needs are 24 hours a day, and any other person who worked these types of hours would be paid a fair salary. The families who provide this care for their loved ones deserve some compensation for their hard work.	The Medicaid program is not designed to supplement household income or to ensure employment for household members. The purpose of the Medicaid program is to provide coverage for medically necessary services to the Medicaid participant. The Department does not have authority to consider employment needs when making decisions for this program.
13 commenters stated parents know what's best for their children and should be their caregiver.	The Department thanks the commenters for their comment.
Two commenters suggested the state lower wages or hours for family personal caregivers.	The Department thanks the commenter for their comment.
Two commenters requested fewer hoops for receiving reimbursement.	As a steward of taxpayer funds, the Department must ensure that services are provided with appropriate oversight to ensure quality of care, and the safety of participants.
One commenter expressed distrust in the Department's statistics and analysis and demanded an independent analysis.	The Department thanks the commenter for their comment.
One commenter expressed dissatisfaction that a stepparent will continue to be allowed to provided personal care services but a biological or adopted parent cannot.	Stepparents are not considered legally responsible for their stepchildren. There is no prohibition in 42 CFR 440.167 Personal Care Services on stepparents providing services.
One commenter expressed concerns regarding Idaho discontinuing the Certified Family Home programs.	This amendment is for the 1115 Demonstration regarding Personal Care Services by Legally Responsible Individuals and will have no impact to Certified Family Homes.
Two commenters requests that CMS reject IDHW request to remove FCPS program.	The Department thanks commenters for providing input.
One commenter expressed concerns that removing this program removes participant choice.	Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity. The prohibition on parents and spouses providing services are in federal regulations at 42 CFR 440.167 Personal Care Services.

Comment	Idaho Department Health and Welfare Response
Two commenters expressed concerns that this program was being terminated for cost savings.	Termination of this program is not due to cost savings for the state. This provider qualification flexibility is ending due to suspected and confirmed health and safety concerns and fraud and abuse since this flexibility has been in place. Further, the Department does not currently have the requisite resources to provide the appropriate level of oversight.
One commenter stated that the state will not see cost savings from terminating this program because the need for care will remain regardless of who provides the services.	Termination of this program is not due to cost savings for the state. This provider qualification flexibility is ending due to suspected and confirmed health and safety concerns and fraud and abuse since this flexibility has been in place. The Department does not currently have the requisite resources to provide the appropriate level of oversight.
Two commenters expressed that amendment fails to identify how it will continue to meet its federal obligations to provide "EPSDT services" and "arrange for" PCS services needed by Idaho Medicaid children after the termination of this program.	The Department is not making any changes to the availability of PCS as required under the EPSDT benefit.
Two commenters expressed that the amendment fails to provide sufficient assurances on how Idaho Medicaid will meet its federal obligation to assist families impacted by this program change and ensure a full continuum of care.	The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the past two years and has observed at least a 10% growth in non-legally responsible caregivers. The Department also reminds families who have been caretakers that they are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their loved ones for Medicaid reimbursement. The Department will be available to work with families to find available direct care staff throughout the transition and ongoing.
Two commenters expressed that the Amendment Request serves as another example of the Idaho Medicaid's failure to implement a program or service funded by state and federal tax dollars with adequate oversight, staff, and training.	The Department thanks commenters for their comment.
Two commenters expressed concerns that IDHW has demonstrated a pattern or practice of inappropriate program management, oversight, and training which places Idahoans with disabilities, especially children, at risk for inadequate care and treatment, resulting in abuse, neglect, and exploitation.	The Department thanks commenters for their comments and would appreciate additional details regarding these concerns so we may review and follow up.

Idaho Department of Health and Welfare

APPENDIX B

Demonstration Amendment Public Notice

IDAHO DEPARTMENT OF HEALTH & WELFARE

Title:
Division of Medicaid Public Comment Period

Entity:
Department of Health and Welfare

Date/Time:
Nov 5 2024 10:30AM

Category:
Public Hearing

Status:
Published

Add to Calendar

Description
Public Comment Period: 1115 Amendment For Personal Care Services By Legally Responsible Individuals
November 5, 2024, through December 4, 2024.
The draft amendment is posted on the IDHW website at https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers (under "Waivers library", PUBLIC-DOCUMENTS > For Providers > Medicaid > Waivers > Idaho 1115 Family personal Care Services Waiver).

It's also attached here.

Virtual Location

Contact Information
Charles Beal
(208) 364-1887
charles.beal@dhw.idaho.gov
https://healthandwelfare.idaho.gov/about-dhw/public-meetings

Physical Location
Entity Main Contact
450 W. State St.
Boise, ID 83702

Google Maps

Documents
11/05/2024 Notice

Recordings

History
11/5/2024 Published

PRESENTED BY: GOVERNOR BRAD LITTLE

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Privacy Policy

IDAHO DEPARTMENT OF HEALTH & WELFARE

BRAD LITTLE – Governor
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DIVISION OF MEDICAID
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November 5, 2024

Dear Tribal Representative:

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid or CHIP State Plan Amendment (SPA) or waiver application or amendment likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Idaho Department of Health and Welfare (IDHW) Division of Medicaid (Idaho Medicaid) provides notice on the following matter.

Purpose

Idaho Medicaid intends to submit an 1115 demonstration amendment to the Centers for Medicare and Medicaid Services (CMS) to remove the following expenditure authority.

> ***2. Use of Legally Responsible Individuals to Render Personal Care Services (PCS).*** *Expenditures for the state to provide payment for personal care services rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers), following a reasonable assessment by the state that the caregiver is capable of rendering the services, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.*

These changes are in compliance with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

Proposed Effective Date

The Department intends to submit this amendment to CMS with a requested effective date of January 31, 2025.

Anticipated Impact on Indians/Indian Health Program/Urban Indian Organizations

A. Does this change directly affect American Indians / Alaska Natives (AI/AN) or Indian Health Care Providers (IHCPs) but is federally or statutorily mandated?

This change could affect AI/AN or IHCPs, but is required under federal and state rules regarding safeguarding participants and public monies against fraud, waste, and abuse.

B. Does the change impact services or access to services provided, or contracted for, by Indian Health Care Providers (IHCPs) including but not limited to:
- *Decrease/increase in services*
- *Change in provider qualifications/requirements*
- *Change service eligibility requirements (i.e. prior authorization)*
- *Place compliance costs on Indian Health Care Providers (IHCPs)*
- *Change in reimbursement rate or methodology*

Under IHCPs that are Personal Assistance Agencies, the proposed change adjusts provider qualifications by limiting the ability of certain family members to get paid by Medicaid for providing personal care services to someone they are legally responsible for.

Participants would continue to be eligible for these services, which could continue to be rendered by providers who are not their legally responsible individual. Legally responsible individuals who are now employed by Personal Assistance Agencies may also continue to provide services to participants they are not legally responsible for.

This does not change participant requirements or service eligibility requirements (i.e. prior authorizations). It does not change reimbursement rates or methodology and does not place compliance costs on IHCPs.

C. Does the change negatively impact or change the eligibility for, or access to, American Indians / Alaska Natives (AI/AN) Medicaid?

The proposed changes should not affect Medicaid eligibility or enrollment of American Indians / Alaska Natives (AI/AN).

Availability for Review

The draft amendment will be posted on the IDHW website at https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers (under "Waivers library", PUBLIC-DOCUMENTS > For Providers > Medicaid > Waivers > Idaho 1115 Family personal Care Services Waiver). The draft amendment is also attached to this letter.

Comments, Input, and Tribal Concerns

Idaho Medicaid appreciates any input or concerns that Tribal representatives wish to share regarding these changes. Please submit any comments prior to **December 4, 2024,** by email addressed to MCPT@dhw.idaho.gov. This proposed amendment will also be reviewed as part of the Policy Update at the next Quarterly Tribal meeting.

Sincerely,

Juliet Charron
Deputy Director

JC/ah

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

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November 6, 2024

MEDICAID INFORMATION RELEASE MA24-28

To: Personal Assistance Agencies

From: Juliet Charron, Deputy Director [redacted]

Subject: Changes To The Family Personal Care Services (FPCS) Program

Due to concerning trends of suspected and confirmed fraud and abuse; significant program growth beyond budget projections; and insufficient staff resources to conduct appropriate oversight, DHW will be terminating the Family Personal Care Services effective January 31, 2025.

The Personal Care Services (PCS) benefit will continue to be available for both children and adults. Qualifying providers will revert to requirements in place prior to the pandemic and legally responsible individuals (parents and spouses) will no longer be able to provide PCS for their family members.

Background

During the public health emergency, CMS allowed a temporary flexibility to decrease the need for direct care workers in people's homes and therefore prevent the spread of COVID-19. The department implemented a temporary flexibility to allow legally responsible parents and spouses to be paid caregivers to their own loved ones who are Medicaid participants with disabilities. This is known as Family Personal Care Services (FPCS). Prior to this flexibility, legally responsible individuals were expressly prohibited in federal and state regulation from being paid personal care aides. Thus, this temporary allowance permitted parents and spouses to be employed by direct care staffing agencies and be paid to work in their homes caring for their loved ones.

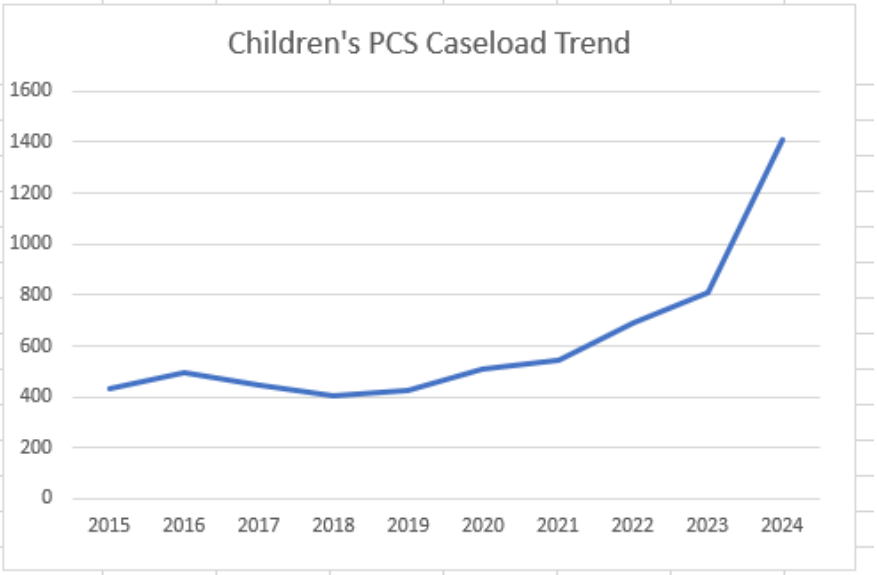
The department extended this flexibility through March 21, 2025, with limited parameters given current staff capacity to oversee the program.

Status

The department has insufficient staff and funding to support this program and its exponential growth and ensure the program's operational integrity.

For many years, there were roughly 500 participants in in children's personal care and private duty nursing services. Enrollment jumped to 546 in 2021, and significantly increased in each subsequent year. We had 1,178 participants in the program in October 2024 and project enrollment at 1,413 by the end of this calendar year, a 75% increase in enrollment since 2023 when the public health emergency ended.

Year	Children's PCS Caseload Trend
2015	434
2016	493
2017	446
2018	402
2019	426
2020	507
2021	546
2022	688
2023	809
2024	1413
	*1,178 as of 10/29/24



This ongoing enrollment surge is due in part to program abuse. We have observed that some parents, spouses, and provider agencies are trading tips on how to seemingly exploit this program, such as:

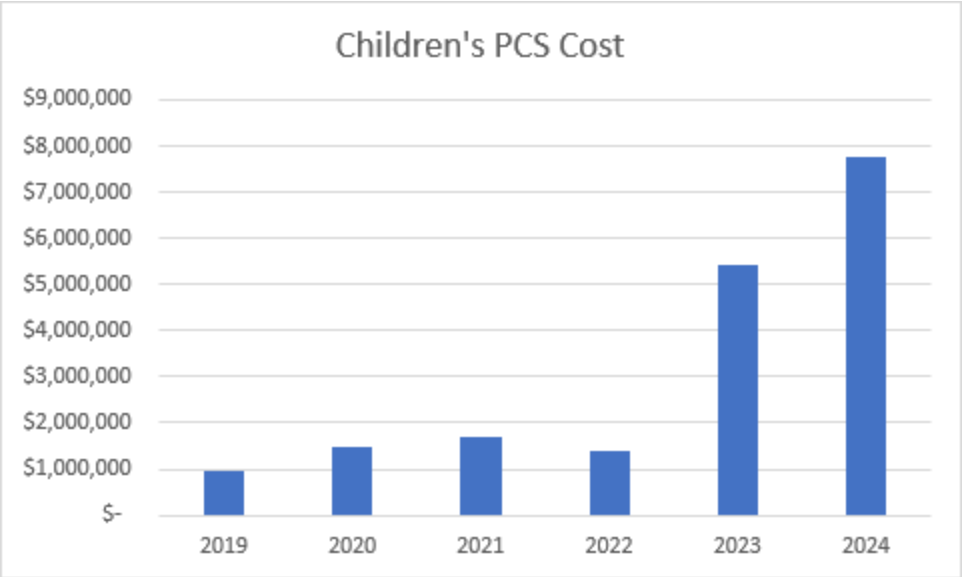
- Sharing information on how to manipulate and respond to the medical assessment in order to maximize authorized hours of service paid by Medicaid.
- Photocopying and sharing eligibility paperwork rather than obtaining independent confirmation from two direct care staffing agencies that they have insufficient staff to serve the child/spouse (as required by the program).
- Recruiting families outside Idaho to move to Idaho to be paid for these services.
- Advertising to employ parents to care for their child(ren) with special needs, saying there is, "No need to work away from home." This incentivizes parents who never previously had a need or interest in these services to apply.
- Communicating the starting pay rates for area provider agencies, resulting in participants switching agencies *not* due to a quality-of-care concern, but exclusively to maximize the household's income.

Other fraudulent and problematic activities include:

- Claiming to care for children but performing other activities at the same time (i.e., driving for Uber).
- Inappropriately double- and triple-billing by caring and billing for multiple children simultaneously (the program only allows a provider to care for one individual at a time). This also presents serious questions of quality and adequacy of care when the child has been identified to need a specific number of hours of care, but it is physically impossible for the parent to serve multiple children for those hours. This includes some parents logging more than 24 hours of care rendered in a day, as confirmed by electronic visit verification (EVV) data.
- Using Medicaid as supplemental household income by determining the needs of the child(ren) on the income received. To quote one mother, "I want PCS for four of my kids. When I find out what my income will be, I might get PCS for [the others]."
- Repeatedly calling department staff to inquire about the status of assessments and actively encouraging others to do the same, taking time away from employees actually completing those assessments and other work for the other Medicaid participants.
- Households that have had continuous Medicaid coverage in the past, but never requested or identified a need for a child (or children) in the household to receive PCS until this flexibility was implemented, with no discernible change in the child's condition that would warrant such a request.
- Instances in which one individual is clocking in and out of services for multiple participants in multiple households that appear to be efforts to avoid detection by quality assurance monitoring of EVV data. In the last calendar quarter, one individual clocked in and out with overlapping visit segments (which is prohibited) for 21 FPCS participants.
- Households selectively providing service hours to attempt to control income that would affect eligibility for other public benefits, which suggests that the child did not medically require the total number of hours authorized.

Not only has enrollment increased, costs have nearly quadrupled since 2022 and are not sustainable within the current appropriation if the program growth continues.[1] We are nearing $8,000,000 spent so far in 2024, with one full quarter remaining in the calendar year. By comparison, the FY 2025 budget authorized by the legislature included just $4,200,000 in anticipated expenditures for FPCS, a difference of 90%.

[1] Medicaid rates changed in summer 2024. The historical costs have been adjusted to account for the change in reimbursement rates.



While expenditures are based on authorized hours of services that are approved by clinical staff, we are aware of many inappropriate attempts to increase the number of authorized hours by families. Further, as described above, the department is aware of significant fraud, waste, and abuse and identified health and safety concerns for participants identified with this program since the benefit was made permanent in late 2023. As stewards of taxpayer dollars and in our role in overseeing this entitlement program serving vulnerable children and adults, we cannot continue to operate a program with such high rates of suspected and known fraud, waste, and abuse potential health and safety issues for participants.

Many of these cases have come to our attention through complaints or observed and experienced interactions with families, content posted on social media, referrals from other state agencies that serve the same population, and referrals by word of mouth from community partners and individual community members. While several of these examples and cases have been referred to the Medicaid Program Integrity Unit, we do not have the infrastructure to administratively identify all cases warranting additional inquiry and pursuit of recovery. Moreover, if fraud is being perpetrated by the household/family, any recovery of funds would be from the agency that the parent/spouse is technically employed by, therein weakening Idaho's already tenuous network of direct care agencies.

The Department recognizes that there are still many families who use this benefit and program appropriately, legitimately need support, and cannot find direct care workers to provide services to their children. The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the last two years and has observed an approximately 10% growth in the number of unduplicated direct care workers, not including parents and spouses, as identified in the state's Electronic Visit Verification data. The Department will share options through external communications to agencies and families during this transition. Department staff are always available to families and provider agencies to discuss options.

The Bureau of Long Term Care team responsible for administration and oversight of the FPCS program will be implementing additional safeguards and operational processes to provide as much oversight as we are able to during the remaining months of the FPCS flexibility. These activities will include:

- Quarterly supervisory oversight forms submitted by provider agencies will require a narrative to validate that each visit did, in fact, occur and is reflective of adequate clinical oversight.
- Functional assessments for whom the primary respondent is also the direct care worker (including parents and spouses) will be subject to post-processing internal review by the Medical Director to validate that PCS are medically necessary. Additional medical documentation to substantiate the participant's ongoing need for services may be requested.

Processing timeframes for new requests will be moved to 30 days. The team is unable to maintain the current 14-day timeline without detrimental impact to other programs and services administered by these staff. In addition, the Medicaid Program Integrity Unit is actively pursuing recoupments and assessing penalties as appropriate and will refer all credible allegations of fraud to the Medicaid Fraud and Control Unit in the Office of the Attorney General.

Next Steps

CMS has advised the Department that an amendment to the authority currently invoked for this flexibility is necessary to carry out early termination of the program. Early termination will allow the Department to pause enrolling new applicants, and therefore ensure the Legislature has maximum flexibility to determine the appropriate path forward.

The Department will post the draft amendment on Townhall Idaho and send a letter to Idaho Tribes as required. The Department will accept comments for thirty (30) calendar days and send the submission to CMS in early December with a requested effective date of January 31, 2025.

It is our hope that program advocates and participants can work with the Legislature to determine which safeguards are appropriate to resolve the troubling issues we are seeing on the ground, recognizing the need for additional staff capacity if labor-intensive safeguards are selected.

We look forward to working collaboratively with provider agencies, parents and spouses of participants needing personal care services, and other stakeholders to design and implement a sustainable program with integrity deserving of Idahoans' support.

JC

The content of this guidance document is not new law but is an interpretation of existing law prepared by the Idaho Department of Health and Welfare to supply clarity to the public about existing requirements under the law. This document does not bind the public, except as authorized by law or as incorporated into a contract. For additional information or to provide input on this document, contact the Division of Medicaid by emailing MCPT@dhw.idaho.gov or by calling 888-528-5861

Idaho Department of Health and Welfare

APPENDIX D

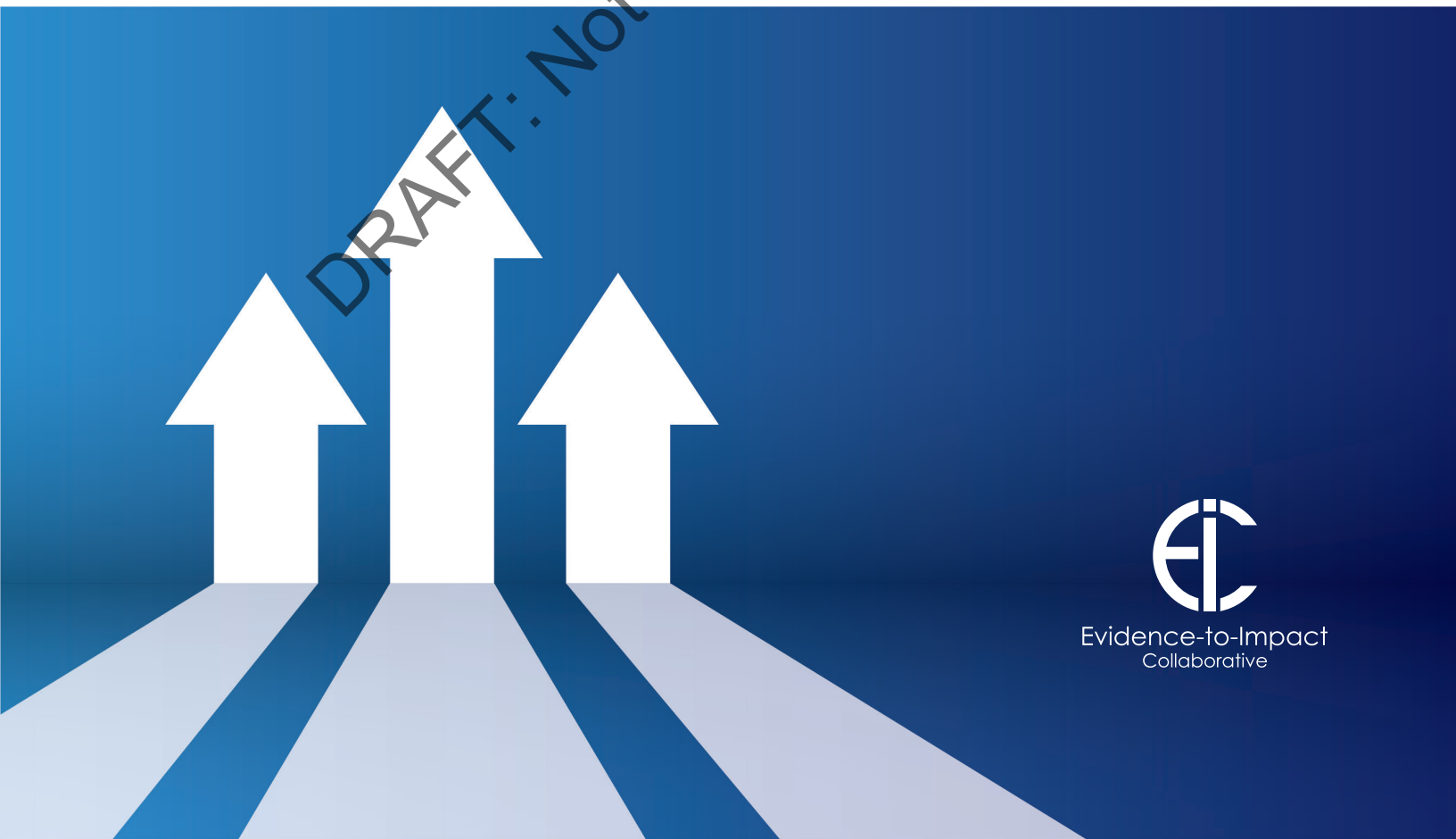
Idaho Interim Evaluation 2024

Interim Evaluation Report for Idaho's 1115 Behavioral Health Transformation Waiver

September 30, 2024

Evidence-to-Impact Collaborative

Prepared for: Idaho Department of Health and Welfare



Interim Evaluation Report for Idaho's 1115 Behavioral Health Transformation Waiver

September 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 (hereafter Idaho BHT Waiver) was approved by the Centers for Medicaid and Medicare Services (CMS). 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/or 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 (EIC) have compiled this report.

This Interim Evaluation Report (hereafter Interim Report) evaluates the changes in each SUD and SMI/SED outcome between the baseline (either 2018-quarter 1 of 2020 or just quarter 1 of 2020 depending on the outcome) and demonstration periods from April 17, 2020-March 31, 2023.

Summary of Findings

The evaluation conducted for the period of baseline and April 17, 2020 - March 31, 2023, suggests Idaho is making sufficient progress toward SUD and SMI/SED milestones. We are generally seeing increases in utilization. We also observe evidence of important increases in capacity including intensive outpatient services as well as residential mental health facilities and beds. Other key impacts include improved treatment coordination for OUD and decreases in risky opioid prescribing (albeit likely more due to changing national provider norms). Idaho also appears to continue to meet budget neutrality targets.

Going forward, below we note a few points of emphasis to monitor but do not have major concerns about meeting milestones. There are still some key data that need to be obtained such as mortality data.

The largest points of emphasis moving ahead are focusing on successfully implementing the new managed care contract to ensure patients receive care when and where they need it; continuing to manage coordinating data will be important in the face of the IHDE bankruptcy; and ensuring access in rural and frontier areas where care availability is likely to remain an ongoing issue. Finally, we also note the increase in the overdose death rate among beneficiaries with SUD and the suicide rate as an important area to continue to monitor.

Recommendations

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

- Ensure implementation of the new managed care contract meets patient needs and work with providers to ensure as seamless a transition as possible to the new contract.
- Continue to work to find ways to obtain and share key data across providers in the face of the IHDE bankruptcy.
- Continue to engage with providers to attract and maintain Medicaid enrollment to ensure capacity for both SUD and SMI/SED meets the needs of patients in Idaho.
- Continue to ensure that there are needed sites of care that provide MAT
- Continue to explore options to ensure access to behavioral health care for patients living in rural or frontier areas

Chapter 1: Introduction and Background

This introduction provides important context surrounding the implementation of the Idaho BHT Waiver.

Idaho's Health care System

Idaho's health care system has been historically fragmented and reliant upon partnerships among agencies, provider organizations, and the community. Health Professional Shortage Areas (HPSA) are designated in 98.7% of the state for primary care, 95.7% for dental health, and 100% for mental health[1]. As of 2022 Idaho had less than 100 total psychiatrists and less than 25 practicing child and adolescent psychiatry[2,3]. Idaho responded to access issues created by rural geography and HPSA designations with policy initiatives to improve the health of its citizens.

The first step in this journey was the citizen-initiated ballot measure, Idaho Proposition 2, a Medicaid expansion initiative, that was included on the 2018 general election ballot. This measure 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 138% of the federal poverty guidelines and not otherwise eligible for Medicaid coverage[4,5,6]. Proposition 2 was approved by voters on November 6, 2018. Subsequently, Senate Bill 1204 was signed into law April 9, 2019, outlining requirements for implementation of Medicaid expansion. For example, this law states "the director is hereby encouraged and empowered to obtain federal approval in order that Idaho design and implement changes to its Medicaid program that advance the quality of services to participants while allowing access to needed services and containing excess cost"[7,8]. The law necessitated the application for Section 1115 Waiver funding. Idaho expanded Medicaid and IDHW applied for the 1115 BHT waiver in January 2020[9,10,11]. The "Idaho 1115 Behavioral Health Transformation" (Project Number 11-w-00339/10) was approved by CMS April 17, 2020, with an end date of March 31, 2025[12].

Idaho's Health Data Exchange

The Idaho Health Data Exchange (IHDE) was created in 2008 to mitigate fragmentation by facilitating secure sharing of patient data between health care providers[13]. The IHDE was tapped to assist Idaho in meeting many of its BHT Waiver health information technology implementation criteria, but in August 2022, IHDE filed for Chapter 11 bankruptcy in response to lawsuits filed by multiple out-of-state contractors[14]. The upcoming IBHP contract will require behavioral health providers to utilize software to securely share patient electronic health records (EHR) for care coordination. The bankruptcy has raised questions about how the state will move forward with the IHDE to meet its Health IT plan for the duration of the BHT Waiver. The IHDE had been the subject of an October 2023 Office of Performance Evaluations inquiry report[15].

MAT Waiver

On December 29, 2022, the President signed into law the Consolidated Appropriations Act, 2023 effectively eliminating the "Drug Addiction Treatment Act (DATA)-Waiver Program" also known as the Medication-Assisted Treatment (MAT) Waiver or X-Waiver Program[16]. This act changed provider requirements, eliminated discipline restrictions and limits to prescription medications to treat opioid use disorder (OUD), and changed certification related to providing counseling. Now in conjunction with state law, all providers with a current Drug Enforcement Administration (DEA) license, including Schedule III authority, can prescribe buprenorphine for OUD in their practice[17].

Regarding provider training requirements and the end of the MAT waiver, according to Substance Abuse and Mental Health Services Administration (SAMHSA), "beginning June 27, 2023, (health care providers) who will be renewing or registering for a new Drug Enforcement Administration (DEA) license will need to complete at least one of the following, attest to a minimum of 8 hours of opioid or SUD training Board certification in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, American Board of Addiction Medicine, or the American Osteopathic Association; or Graduation within five years and status in good standing

from medical, advanced practice nursing, or physician assistant school in the United States that included successful completion of an opioid or other substance use disorder curriculum of at least eight hours." These changes have the potential to result in an increase in access to MAT treatment for OUD and will be monitored to see if this change can be observed[17].

Idaho's Behavioral Health Plan Managed Care Organization Contract

Within this report, we note the impact of delays in the Idaho Behavioral Health Plan Managed Care Organization (IBHP MCO) contract procurement. As of March 2023, IDHW is contracted with Optum, a subsidiary of United Behavioral Health, to cover only Idaho Medicaid outpatient behavioral health services[18]. 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 MCO contract. The IBHP MCO contract solicitation was released on December 30, 2021, in an invitation to negotiate (ITN) format[19,20]. This procurement, at an estimated value of $1.2 billion over 4 years, is the largest contract IDHW has awarded to date. The original expected contract award date was October 2022 however, Letters of Intent were not released until December 6, 2022[21]. These letters led to an appeals process among the bidders that lasted beyond the scope of this report. The upcoming IBHP MCO contract is anticipated to be awarded to Magellan in June 2023 with the conclusion of the contracting stage. The anticipated services start date is projected for July 1, 2024. Delays throughout the procurement process are resulting in delays in state actions to implement milestones. The current contract with Optum includes Medicaid outpatient behavioral health services only, whereas the contract procurement will also include inpatient behavioral health, emergency department, and SUD residential services[19].

Idaho's Behavioral Health Plan Governance Bureau

In January 2023, Penn State was notified that a new Idaho Behavioral Health Plan Governance Bureau was being formed to provide oversight of the Idaho Behavioral Health Plan. The bureau works collaboratively with two divisions within the Department of Health and Welfare, the Division of Medicaid and the Division of Behavioral Health. This bureau is housed in the Division of Medicaid and has three main functions including unified collaboration and IBHP governance with the MCO; oversight of quality, performance and innovation within IBHP; and oversight of MCO contract requirements[22].

COVID-19 Public Health Emergency and Medicaid Unenrollment

In response to the COVID-19 outbreak, on January 31, 2020, a public health emergency (PHE) under section 319 of the Public Health Service Act (42 U.S.C. 277d) was declared by the Secretary of Health and Human Services. This declaration enabled the Secretary to "temporarily waive or modify certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs and of the Health Insurance Portability and Accountability Act Privacy Rule throughout the duration of the public health emergency declared in response to the COVID-19 outbreak"[23].

The Consolidated Appropriations Act, 2023 was signed into law on December 29, 2022, unlinking the continuous coverage requirement from the PHE while creating a new requirement for states. This new requirement dictates that state must provide 12 months of continuous eligibility for enrollees under the age of 19 in both Medicaid and CHIP (Children's Health Insurance Plan) beginning January 2024 as well as makes permanent the state plan option to provide 12 months of postpartum coverage in Medicaid and CHIP. Continuous coverage meant that no state could remove anyone from Medicaid unless they were determined to have relocated out of state, requested to be removed, or passed away[24]. With the COVID-19 Public Health Emergency (PHE) set to expire May 11, 2023, Idaho began identifying those enrolled in Medicaid who were no longer eligible for Medicaid benefits and as of February 1, 2023, sent out re-evaluation notices. This process is scheduled to continue through August 2023 at the rate of 30,000 notices per month, with 153,193 individuals out of nearly 450,000 identified as not qualified or did not reply to the notice of redetermination[25]. The re-evaluation of these individuals was scheduled to be completed by September 2023. The two major aforementioned changes occurred outside the scope of this report. We have included these topics here as the process began during DY3 and provides important context for recommendations moving forward.

Chapter 2: Waiver Milestones and Evaluation Methodology

Idaho BHT Waiver Overview

The Idaho BHT Waiver focuses on Medicaid enrollees with SUD and/or SMI/SED. 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.

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 health care 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 health care when and where they need it.

To achieve this goal, IDHW is implementing three broad 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 goals and milestones as markers of success. For evaluation purposes, the Penn State team aligned the proposed CMS milestones with a broader set of goals for both SUD and SMI/SED. See the goals and milestones for SUD and SMI/SED listed below.

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 misuse 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 Interim Evaluation Report

CMS requires that an Interim Evaluation Report be conducted by an independent evaluator to assess progress toward meeting the milestones included in the approved Idaho BHT Waiver. IDHW contracted with 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 EIC have compiled this Interim Report that presents the EIC's findings.

For evaluation purposes, the Interim Report focuses on comparing changes in outcomes from the baseline period (either 2018-quarter 1 of 2020 or just quarter 1 of 2020 depending on the outcome) through the end of demonstration year 3 (DY3) (i.e. March 31, 2023), Subsequent reports will evaluate final outcomes through the end of the demonstration period in March 2025. The Interim is further divided into outcomes focused on SUD and SMI/SED.

The required elements of the Interim Report, per IDHW's Subsequent Terms and Conditions (STC), include:

- Executive Summary - A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation
- General Background Information about the Demonstration
- Evaluation Questions and Hypotheses
- Methodology
- Methodological Limitations
- Results
- Conclusions
- Interpretations, and Policy Implications and Interactions with Other State Initiatives
- Lessons Learned and Recommendations
- Attachment(s)

Throughout these sections we will discuss evaluation progress and present findings to date as per the approved evaluation design. Evaluation progress is determined and presented in the context of milestones as defined in the IDHW Implementation plan. These milestones are evaluated using monitoring metrics and feedback from key stakeholders and other relevant Idaho-specific data sources to determine Idaho's progress towards achieving each milestone. If it is determined there is risk of not achieving a milestone, recommendations for improvement are provided for Idaho's waiver implementation and a description of internal and external factors that impacted early implementation noting facilitators and barriers to progress. A status update on budget neutrality requirements and cost analysis based on budget neutrality documentation is provided as well.

Data sources included feedback from key stakeholders and input and information from IDHW staff including data, technical documentation, policy documents, and reporting documents such as quarterly and annual reports. The Penn State team met at least 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:

- Undertaking quantitative analyses to assess progress toward each milestone in the Implementation Plan utilizing data sources listed above
- Conducting interviews with key stakeholders
- Conducting cost analysis based on budget neutrality documentation
- Determining factors affecting performance and progress and assessing risk of milestones not being met through reviewing outside qualitative resources, conversations with IBHP Governance Bureau Team and IDHW groups as well as reviewing quarterly monitoring metric reports
- Providing IDHW drafts throughout report development and presenting findings to leadership

Methodology

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[26,27]. The quantitative approach aimed to assess changes in the performance metrics between the baseline and demonstration periods (DY1- DY3). 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 context of the Idaho BHT Waiver, accomplishments to date, fidelity to the proposed Implementation Plan, perceptions of barriers and facilitators to success, and important next steps.

Quantitative Methods Approach

Broadly, the quantitative approach entailed a pre-post design[28]. 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 calendar year (CY) 2020 (i.e., January – March)
- Demonstration Year 1 (DY1): April 2020 through March 2021
- Demonstration Year 2 (DY2): April 2021 through March 2022
- Demonstration Year 3 (DY3): April 2022 through March 2023

For each outcome we estimated three mean differences:

Change in Demonstration Year 1 (DY1) = $Y_{(DY1)} - Y_{(Baseline)}$ and;
Change in Demonstration Year 2 (DY2) = $Y_{(DY2)} - Y_{(Baseline)}$ and;
Change in Demonstration Year 3 (DY3) = $Y_{(DY3)} - Y_{(Baseline)}$

We report these as both absolute changes and percentage changes. The reason for including 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 after the beginning of the demonstration. Thus, there was little time between the Idaho BHT Waiver beginning without an impact of the pandemic. Following CMS guidance[28], we will attempt to account for this in all analyses. One way is to separately estimate changes in outcomes by demonstration and to focus much of our discussion on the difference between DY3 and baseline in order to best account for the most complete level of implementation as well as the major disruptions from the most acute period of the COVID-19 pandemic, between 2020 and 2022.

Quantitative Limitations

With individual-level data, we are able to incorporate more granular data that affords us the opportunity to use nuanced approaches to better isolate the impact of the Idaho BHT Waiver on each of the outcomes. The clearest way to isolate and evaluate the impact of the Idaho BHT Waiver using a pre-post design would be to follow a broadly consistent group from a baseline prior to the Waiver through the post-Waiver period. However, there are three main complications. The first is that Medicaid expansion beginning in January of 2020 means there is very little baseline period for the Medicaid expansion population. Further, the Medicaid expansion population is likely changing over the course of 2020 as newly eligible Medicaid beneficiaries determine their eligibility and enroll in Medicaid. Most concerning (which we show evidence for later) is that the earliest to enroll may be those most in need of Medicaid coverage because of greater health needs. This would mean that Medicaid expansion population enrolled in the baseline period (quarter 1 of CY 2020) may be higher acuity and utilize more care than those enrolled later on. The issue is that it may appear utilization is declining during the demonstration period when it is actually a selection problem driving the decline.

The second complication is the IDHW reporting metrics for SUD change starting in 2021 (as part of changes in SMI/SED technical reporting specifications). This makes it more difficult to compare those diagnosed with SUD or SMI/SED in the post-Waiver period to the baseline period. Since the change is to add diagnosis codes, our concern is that there are individuals added to the denominator in later periods that have less severe SUD or SMI/SED since the codes are largely meant to identify cases. As a result, utilization rates may be lower for this lower acuity group and may not be comparable to earlier periods. The final complication is the COVID-19 pandemic. The pandemic likely had the largest impact on care in the second half of 2020 through 2022. As we enter later demonstration years (e.g. DY3) that are less acutely impacted by care disruptions due to the COVID-19 pandemic, we are likely to see less disrupted care.

Ultimately, this means that we believe the cleanest comparison is to focus on the population eligible for Medicaid prior to expansion (non-expansion) and to use the "static" definition for SUD so that we are comparing a similar group of individuals both at baseline and in the Waiver period. This population also allows for a longer baseline period as we can observe this population prior to 2020 and so we can use an alternative 2018-quarter 1 of 2020 baseline period. For completeness, and to identify how these different complexities affect our estimates, we present a range of estimates – (a) populations that include everyone, just those eligible prior to expansion ("non-expansion") or those eligible only after expansion; (b) a "static" definition of SUD that does not change as well as the "rolling" definition that changes over time; and (c) 2018 to Q1 of 2020 as a baseline vs. just Q1 2020 as a baseline. We note the different baseline only practically applies to the "non-expansion" population as the "expansion" population is not observable prior to Q1 2020. Thus, the changes in the "overall" numbers across baseline definitions are only due to changes in the "expansion" population.

Finally, future analyses will 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

Eleven interviews were conducted via Zoom November 15, 2023 - December 8, 2023. Purposive sampling was used to recruit respondents, including state administrators from the IDHW; providers from IMD and other mental health provider organizations; and health policy and patient advocacy groups. Stakeholders who had direct knowledge of different aspects of the implementation of the Idaho BHT Waiver included both individuals who participated in round one and those who did not.

A comprehensive list of potential participants was compiled, and a recruitment email was sent to 28 stakeholders. Twelve of the potential participants contacted for this round of interviews were former participants of round one. Six of the potential participants were contacted in round one interviews, but either did not respond to round one emails or declined to participate. The remaining 10 potential participants were not contacted in round one. As many as four subsequent emails were sent over 6 weeks to those who did not respond to the initial email(s). All participants who agreed to be interviewed also gave verbal consent to be recorded.

A semi-structured interview protocol was developed to elicit the respondents' perspectives on the implementation of the waiver. The objectives were 1) to understand what was new or had changed with the implementation of the waiver since the round one interviews (e.g., describe key implementation steps including your role in the implementation process); 2) to learn what successes were noted (e.g., describe major milestones that were achieved, the process and keys players that facilitated this success, and your role in achieving these milestones), 3) to identify any barriers or challenges that occurred or persist with the implementation (e.g., describe any challenges in the implementation process that impeded progress or that you faced in your role in implementing the waiver), and 4) to determine what lessons had been learned (e.g., describe any lessons learned or share advice with others who are implementing a program like the waiver). The protocol was tailored to capture the nuanced perspectives of the different stakeholder groups. Interviews were with a single individual except for one, where two participants from the same organization requested to be interviewed

together. Interview length in minutes ranged from 25-102 minutes and all but two interviews lasted 45 minutes or longer. All interviews were audio-recorded and transcribed. Transcripts were verified and de-identified by one researcher.

The transcripts were uploaded to Dedoose, a qualitative data management system. A priori code book was established using the research questions noted above (e.g., key implementation steps, major milestones achieved, processes and key players that facilitated success, challenges that impeded progress, challenges faced by individual respondents, lessons learned). The transcripts were coded by two researchers independently using the established codes. One researcher reviewed the coded text and compared discrepancies between the two researchers. The two researchers met to discuss discrepancies until a consensus was reached. A larger team of four researchers reviewed the coded text and met to discuss potential themes. However, the approach described above did not seem to yield practical detail or context and therefore, the research team pivoted and conducted additional analysis. Next, each of the four researchers was assigned six transcripts to review. All transcripts were read independently, and each researcher identified potential codes. At least two researchers read each transcript for interrater reliability and each researcher developed a list of potential codes by participant. The codes were compiled, compared, and discussed until consensus was reached by all researchers. Finally, two researchers recoded the transcripts independently and themes emerged. An additional meeting was held to discuss the themes, reach consensus and identify exemplary quotes to support these themes.

Qualitative Limitations

Each person interviewed expressed thoughtful insights and concerns about the implementation of the Idaho BHT Waiver. This analysis, however, does not reflect the experiences and viewpoints of all those who have encountered the Idaho BHT Waiver. In particular, the insights of patients and other community stakeholders were not included during this phase. Also, the views of those who were not invited, nor those who declined to participate in these analyses are unknown.

Refer to the Evaluation plan in Appendix E for full description of the Evaluation questions and hypotheses for this waiver.

Chapter 3: Results

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.

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

Results

The results in Table E.1 demonstrate the complexity of the analyses. As mentioned in the methods section, the clearest way to isolate and evaluate the impact of the Idaho BHT Waiver using a pre-post design would be to follow a broadly consistent group from a baseline prior to the Waiver through the post-Waiver period. However, as we have noted there are three main complications—the short period between expansion and the start of the demonstration in which to obtain a baseline period for the Medicaid expansion population (along with issues that early Medicaid enrollees may require more care); the changing definition of the SUD and SMI/SED population, and the COVID-19 pandemic. To best address these issues, we believe the cleanest comparison is to focus on the population eligible for Medicaid prior to expansion (non-expansion) and to use the "static" definition for SUD so that we are comparing a similar group of individuals both at baseline and in the Waiver period. This population also allows for a longer baseline period as we can observe this population prior to 2020 and so can use an alternative 2018-quarter 1 of 2020 baseline period. For completeness and to identify how these different complexities affect our estimates, we present a range of estimates – (a) populations that include everyone, just those eligible prior to expansion ("non-expansion") or those eligible only after expansion; (b) a "static" definition of SUD that does not change as well as the "rolling" definition that changes over time; and (c) 2018 to Q1 of 2020 as a baseline vs. just Q1 2020 as a baseline. We note the different baseline only practically applies to the "non-expansion" population as the "expansion" population is not observable prior to Q1 2020. Thus, the changes in the "overall" numbers across baseline definitions are only due to changes in the "expansion" population. Finally, we primarily focus on the DY3 to baseline comparison because it best accounts for both the fullest implementation of the Waiver and the period least impacted by the COVID-19 pandemic.

Promisingly, when we focus on the "non-expansion" population using the "static" definition (our preferred subpopulation), Table E.1 indicates increasing rates of SUD care utilization for those with SUD. Specifically, for DY3, relative to a baseline of Q1 2020, we observe a 17.2% increase in outpatient utilization, a 80.7% increase in

intensive outpatient utilization, a 18.7% increase in inpatient utilization, and a 38.6% increase in MAT utilization. We generally see slightly higher estimates when using the broader baseline period. We attribute some of the lower numbers in DY1 and DY2 as a result of the COVID-19 pandemic.

We consistently observe that using the "rolling" definition, which allows for the denominator to change over time, leads to "lower" estimates of changes in utilization. This includes both smaller positive values and larger negative values. Again, we believe this results from the change in definition expanding the denominator of those categorized as having SUD to include a lower acuity group who may be less likely to utilize care. Because this occurs several times during the Waiver demonstration period, this reduces values in this period relative to the baseline period.

We also consistently observe large and negative values for the expansion population, which is in stark contrast to what we observe for the non-expansion population. Again, we believe this is because those who become eligible for Medicaid upon expansion in quarter 1 of 2020 and enroll may be those who have the highest acuity and are most likely to utilize care. For example, we know that hospitals and other providers in many expansion states have staff to help patients enroll in Medicaid. So many of the earliest enrollees may be those who are seeking and receiving care, particularly at hospitals; whereas later enrollees may be those who apply for coverage with less urgent care needs.

The one exception to the increases in utilization is continuity of pharmacotherapy (i.e. those with at least 180 days of continuous MAT). While decreases are implicitly smaller in the non-expansion population, they are still over 65% lower in DY3 compared to baseline. Some of this may be increasing the number of patients with MAT, some of whom may discontinue. But an important area to monitor is patients continued access to and adherence to MAT.

Table E.1a: Performance on SUD Milestone 1 Metrics by varying baseline and definition for Medicaid SUD population (denominator).

Metric		Period	Percent Change					
			Overall		Non-expansion		Expansion	
			Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Outpatient (Metric #8) [a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-21.1	-18.9	-9.3	-5.9	-36	-35.8
		DY2 (Apr. 2021-Mar. 2022)	-33.9	-24.3	-16.8	-3.3	-50.4	-44.9
		DY3 (Apr. 2022-Mar. 2023)	-35.3	-9.3	-19.3	17.2	-51.4	-34.6
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	4.3	14.4	-6	2.4	-36	-35.8
		DY2 (Apr. 2021-Mar. 2022)	-12.6	6.8	-13.8	5.3	-50.4	-44.9
		DY3 (Apr. 2022-Mar. 2023)	-14.5	28	-16.4	27.6	-51.4	-34.6
Intensive Outpatient (Metric #9) [b]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-12.8	-10.4	0.8	4.5	-34.4	-34.1
		DY2 (Apr. 2021-Mar. 2022)	-15.4	-3.5	8	25	-42.5	-36.4
		DY3 (Apr. 2022-Mar. 2023)	0.4	40.7	24.4	80.7	-32.5	-9.2
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	215.7	237.3	126.8	143.5	-34.4	-34.1
		DY2 (Apr. 2021-Mar. 2022)	206.5	263.4	142.9	191.3	-42.5	-36.4
		DY3 (Apr. 2022-Mar. 2023)	263.5	429.8	179.8	321.2	-32.5	-9.2
Inpatient (Metric #10) [c]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	2.4	5.2	38.4	43.3	-27	-26.7
		DY2 (Apr. 2021-Mar. 2022)	-48.4	-42.7	-22	-13.7	-66.6	-63.9
		DY3 (Apr. 2022-Mar. 2023)	-49.8	-29.6	-18.3	18.7	-68.8	-58
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	104.4	122.9	51.8	65.2	-27	-26.7
		DY2 (Apr. 2021-Mar. 2022)	3	21.3	-14.4	-0.5	-66.6	-63.9
		DY3 (Apr. 2022-Mar. 2023)	0.2	49.1	-10.3	36.8	-68.8	-58
MAT (Metric #12) [d]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	3.9	6.8	12	16.1	-6.5	-6.1
		DY2 (Apr. 2021-Mar. 2022)	7.2	20.8	18.4	35	-5.6	3.4
		DY3 (Apr. 2022-Mar. 2023)	-14.2	20.2	-4.5	38.6	-24.8	1.2
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	28.4	41	28.1	39.3	-6.5	-6.1
		DY2 (Apr. 2021-Mar. 2022)	32.6	59.5	35.5	62	-5.6	3.4
		DY3 (Apr. 2022-Mar. 2023)	6.1	58.7	9.2	66.3	-24.8	1.2

Note: SUD Milestone 1: Access to critical levels of care for OUD and other SUDs. Goal 1: Increased Rates of Identification, Initiation, and Engagement in Treatment for OUD and Other SUDs.

SUD: substance use disorder.
DY: Demonstration year.
Percent change= (rate of metric at demonstration period x - rate of metric at baseline)/rate of metric at baseline*100.
Rolling definition: The number of Medicaid SUD population (SUD metric #3) is extracted from the state data vendor's quarterly/annual reports, which adopt changing definitions of SUD population over time.
Static definition: The number of Medicaid SUD population is calculated by the PSU research team following the latest definition in Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 5.0).

a: Number of beneficiaries who used outpatient services for SUD during the measurement period.
b: Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD during the measurement period.
c: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.
d: Number of beneficiaries who receive MAT or SUD-related treatment services with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period.

Table E.1b: Performance on Milestone 1 Metrics (SUD #22) by expansion and non-expansion status

		Percent change %		
		Overall	Non-expansion	Expansion
Continuity of pharmacotherapy (Metric #22) [e]	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-6.7	6.7	-
	DY2 (Apr. 2021-Mar. 2022)	-54.1	-48.3	-
	DY3 (Apr. 2022-Mar. 2023)	-73.3	-68.6	-

Note: Annual data.
e. Percentage of adults 18 years of age and older with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment

Metrics are only reported at the calendar year (CY), so we note they do not perfectly align with the demonstration years which run from April through March.

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

Results

For nearly all definitions and approaches, we observe an increase in the number Medicaid beneficiaries treated in an IMD for SUD (Table E.2a). This is not surprising as a primary component of the Idaho BHT Waiver is to allow Medicaid to reimburse for IMD stays. Thus, it would be expected that this number would increase significantly. Again, we believe that the static definition for the non-expansion is the most reliable approach to estimation and the rolling definition for the expansion population is the least consistent. So, we believe the drop for DY2 in the rolling definition within the expansion population is likely due to the analytic issues raised above.

Table E2.b shows consistent results of declining average length of stay in an IMD for SUD patients. This is likely due to both an ongoing emphasis on ensuring patients are in the correct level of care as well as pressures from high demand for IMD care (which was noted in some of the key stakeholder interviews). The one exception to these results is the increase in length of stay for the expansion population. We believe this is further evidence of the concerns we have about initial Medicaid enrollees eligible through expansion being higher acuity patients with greater care needs.

Table E.2a: Performance on SUD Milestone 2 Metrics (SUD #5) by different definitions for Medicaid SUD population (denominator).

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Medicaid Beneficiaries Treated in an IMD for SUD[a] (SUD #5)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	636.3	666.2	541.5	570.5	212.8	208.7
		DY2 (Apr. 2021-Mar. 2022)	124.4	228.4	156.8	289.4	-17.3	12.6
		DY3 (Apr. 2022-Mar. 2023)	182.6	309.2	223.3	386.6	3.1	38.7

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.

Rolling definition: The number of Medicaid SUD population (SUD metric #4) is extracted from the state data vendor's quarterly/annual reports, which adopt changing definitions of SUD population over time.
Static definition: The number of Medicaid SUD population is calculated by the PSU research team following the latest definition in Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 5.0).

a: SUD Metric #5, Number of beneficiaries who were treated in an IMD for SUD during the measurement period.

Table E.2b: Performance on Milestone 2 Metrics (SUD #36) by expansion and non-expansion status

		Percent change %		
		Overall	Non-expansion	Expansion
Average Length of Stay for SUD in IMD[b] (SUD #36)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-3.3	-25.3	49.1
	DY2 (Apr. 2021-Mar. 2022)	-40.2	-34.1	-19.4
	DY3 (Apr. 2022-Mar. 2023)	-37.3	-23.9	-18.3

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

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

No metrics required by CMS.

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

Results (Table E.3)

First, we note that in this section we do not have "rolling" and "static" columns. This is because these values are not rates based on denominators of beneficiaries with SUD. Overall, we generally find positive results indicating increasing capacity for SUD care (Table E.3). Relative to a baseline of 2018-2019, we observe large increases in the number of providers enrolled in Medicaid qualified to treat SUD and even greater increases in those able to prescribe MAT. We observe increases in the number of sites that provide methadone in both DY1 and DY2 (although we do not have data for DY3 in order to provide a more recent update). Regardless of how the baseline was defined, we observed increases in the number of community mental health centers. Although numbers appear to have dropped from earlier peaks, they are still higher than baseline numbers.

Patient satisfaction values increased from a baseline of quarter 1 of 2020. But are largely level relative to a baseline of 2018-quarter 1 of 2020. We note that there are understandable drops in satisfaction during the COVID-19 pandemic. Given the higher satisfaction scores, we believe that maintaining rates is largely a positive since there is little room for an increase. Although providers should continue to make sure they are meeting patients' and their families' needs.

The one concerning area might be the drop in sites enrolled in Medicaid that provide MAT and the number of community mental health centers between DY2 and DY3. Ensuring access to sites is important to ensuring patients are able to obtain and continue with MAT.

Table E.3: 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)	2,978	1,358	83.8%
	DY2 (Apr. 2021-Mar. 2022)	2,836	1,216	75.1%
	DY3 (Apr. 2022-Mar. 2023)	3,122	1,502	92.7%
Number of providers enrolled in Medicaid and able to prescribe MAT [2b] (SUD #14)	Baseline (2018-2019)	204	-	-
	DY1 (Apr. 2020-Mar. 2021)	435	231	113.2%
	DY2 (Apr. 2021-Mar. 2022)	606	402	197.1%
	DY3 (Apr. 2022-Mar. 2023)	706	502	246.1%
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	-	-
	DY3 (Apr. 2022-Mar. 2023)	3	-	-

Number of sites that provide methadone[1d]		Baseline (Jan.-Mar. 2020)	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	ND	-	-
		DY2 (Apr. 2021-Mar. 2022)	3	-	-
		DY3 (Apr. 2022-Mar. 2023)	3	-	-
Number of community mental health centers[1e]	Baseline (Jan. 2020-Mar. 2020)	Baseline	207	-	-
		DY1 (Apr. 2020-Mar. 2021)	250	43	20.9
		DY2 (Apr. 2021-Mar. 2022)	243	36	17.2
		DY3 (Apr. 2022-Mar. 2023)	224	18	8.5
	Baseline (Apr. 2018-Mar. 2020)	Baseline	215	-	-
		DY1 (Apr. 2020-Mar. 2021)	250	35	16.4
		DY2 (Apr. 2021-Mar. 2022)	243	28	12.8
		DY3 (Apr. 2022-Mar. 2023)	224	10	4.4
Patient satisfaction[1f] (MCO survey)	Baseline (Jan. 2020-Mar. 2020)	Baseline	85.1	-	-
		DY1 (Apr. 2020-Mar. 2021)	90	4.9	5.8
		DY2 (Apr. 2021-Mar. 2022)	94.3	9.2	10.8
		DY3 (Apr. 2022-Mar. 2023)	94	8.9	10.5
	Baseline (Apr. 2018-Mar. 2020)	Baseline	94.8	-	-
		DY1 (Apr. 2020-Mar. 2021)	90	-4.7	-5
		DY2 (Apr. 2021-Mar. 2022)	94.3	-0.4	-0.5
		DY3 (Apr. 2022-Mar. 2023)	94	-0.8	-0.8

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

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

Results

Table E.4 show promising results that high-risk prescribing appears to be declining relative to 2018-2019. We observed decreases in high dosage opioid prescribing, adults with opioid prescriptions from multiple providers, and concurrent opioid and benzodiazepine prescriptions. However, this was likely due to both BHT Waiver efforts as well as broader national trends informing providers about the dangers of high-risk prescribing.

We found mixed results for the change in ED visits for SUD. For our preferred sample (non-expansion, static definition), we observed increases in ED visits for SUD. As the most acute phase of the COVID-19 pandemic passed, this may explain part of the increase in DY3. The drop in ED visits for SUD in the expansion population may be in part to the analytic issues noted above where earlier enrollees may be higher acuity so the later enrollees end up pulling these rates in the later DYs.

We found mixed results for overdose deaths. We observed an increase in overdose deaths per Medicaid beneficiaries with SUD within the non-expansion static definition. This is concerning and may reflect nationwide patterns of increased overdose deaths due to synthetic opioids such as fentanyl. The declines for other groups are more promising but also warrant attention due to the methodological issues mentioned previously – e.g. a larger increase in the number of Medicaid beneficiaries with SUD in subsequent years, especially if lower acuity, may lead to declines in overdose deaths. To be consistent with other metrics, we focus more on the concerning increase in overdose deaths among the non-expansion static definition sample.

Table E.4a: Performance on Milestone 5 Metrics by expansion and non-expansion status

		Percent change %		
		Overall	Non-expansion	Expansion
Percent of adults prescribed opioids at high dosage [1a,e] (SUD #18)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-30.3	-10.4	-
	DY2 (Apr. 2021-Mar. 2022)	-37.2	-11.6	-
	DY3 (Apr. 2022-Mar. 2023)	-40.8	-14.6	-
Percent of adults with opioid prescriptions from multiple providers [1b,e] (SUD #19)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-60.7	-57.9	-
	DY2 (Apr. 2021-Mar. 2022)	-57	-70.3	-
	DY3 (Apr. 2022-Mar. 2023)	-56.4	-62.6	-
Percent of adults with high dosage opioids prescriptions or from multiple providers [1c,e] (SUD #20)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-65.9	-44.4	-
	DY2 (Apr. 2021-Mar. 2022)	-100	-100	-
	DY3 (Apr. 2022-Mar. 2023)	-100	-100	-
Percent of adults with concurrent prescription of opioids and benzodiazepines [1d,e] (SUD #21)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-31.4	-20.3	-
	DY2 (Apr. 2021-Mar. 2022)	-25.3	-11.5	-
	DY3 (Apr. 2022-Mar. 2023)	-26.3	-12.9	-

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.Metrics are only reported at the calendar year (CY) so we note they do not perfectly align with the demonstration years which run from April through March.

Table E.4b: Performance on SUD Milestone 5 Metrics by different baselines and different definitions for Medicaid SUD population (denominator).

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
ED visits for SUD[2e] (Metric #23)	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-19.4	-17.1	-0.1	3.6	-38.3	-38
		DY2 (Apr. 2021-Mar. 2022)	-23.6	-11.7	9.7	28.2	-47.3	-40.7
		DY3 (Apr. 2022-Mar. 2023)	-17.7	15.4	17.3	70.4	-42.9	-23.1
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	3.4	13.5	-4.1	4.4	-38.3	-38
		DY2 (Apr. 2021-Mar. 2022)	-2	21	5.2	29.2	-47.3	-40.7
		DY3 (Apr. 2022-Mar. 2023)	5.6	58.1	12.5	71.7	-42.9	-23.1
Overdose death for SUD[2f] (SUD #27)	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-21.9	-19.8	24.7	29.3	-48.7	-48.5
		DY2 (Apr. 2021-Mar. 2022)	-28.3	-19.8	17.1	30.6	-54.6	-50.2
		DY3 (Apr. 2022-Mar. 2023)	-37.5	-12.4	9	58.4	-61.8	-48.7
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-11.3	-2.8	-1	7.8	-48.7	-48.5
		DY2 (Apr. 2021-Mar. 2022)	-18.6	-2.8	-7	8.9	-54.6	-50.2
		DY3 (Apr. 2022-Mar. 2023)	-29.1	6.2	-13.4	32.1	-61.8	-48.7

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.

e: Number of ED visits for SUD during the measurement period.
f: Rate of overdose deaths (number of deaths per 100,000 Medicaid beneficiaries with SUD) for SUD during the measurement period.

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

We observed somewhat mixed results for the Milestone 6 metrics. First, we note that these data are reported by Idaho at an aggregate level, so we are not able to disentangle expansion and non-expansion eligible populations. We observed improvements in treatment initiation in DY3 overall for those newly diagnosed with SUD, which was driven by increases in those newly diagnosed with either alcohol use disorder (AUD) or OUD which offset a decrease for other SUD diagnoses. However, total engagement (i.e. the percentage of patients with a newly diagnosed SUD who initiated treatment and were still engaged 34 days later) saw an overall nearly 5 percentage point drop in DY3 compared to baseline which was a nearly 20% decline. However, this overall decline masked an increase in OUD engagement; meaning the decline was due to the declines in AUD engagement and other SUD diagnosis engagement. So, an important area to watch in the next DY is AUD and other SUD treatment engagement to ensure patients continue to have access to treatment even beyond the initial 30-day period that is common to SUD treatment.

We also observed improvements in 7-day and 30-day follow-up rates following an SUD emergency department visit in DY3 (relative to baseline). This is important to ensure that patients receive well-coordinated care after an acute SUD event. Worryingly, we observed declines in 7-day and 30-day follow-up rates following a mental illness emergency department visit for patients with SUD. Since these patients have complex comorbidities (both SUD and mental illness) they are most in need of well-coordinated follow-up care. So, this too, is an area to continue to monitor into the next DY.

Finally, we observed mixed results for readmission rates. We observed a decline in readmissions for patients with SUD who were eligible prior to expansion. But we saw a noted increase in readmission for SUD patients eligible via expansion, which is something to continue to monitor.

Results

Table E.5a: 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	8.6	21.5
	DY2 (Apr. 2021-Mar. 2022)	43	3.1	7.8
	DY3 (Apr. 2022-Mar. 2023)	40.5	0.6	1.4
IET-AD Alcohol Engagement[b] (SUD #15)	Baseline (2018-2019)	18.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	25.5	6.8	36.2
	DY2 (Apr. 2021-Mar. 2022)	14	-4.7	-25.3
	DY3 (Apr. 2022-Mar. 2023)	14.4	-4.3	-22.9

IET-AD Opioid Initiation[c] (SUD #15)	Baseline (2018-2019)	46.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	57.2	10.5	22.6
	DY2 (Apr. 2021-Mar. 2022)	50	3.3	7.2
	DY3 (Apr. 2022-Mar. 2023)	59.3	12.6	27.1
IET-AD Opioid Engagement [d] (SUD #15)	Baseline (2018-2019)	23.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	32.6	8.8	37.1
	DY2 (Apr. 2021-Mar. 2022)	28	4.3	17.9
	DY3 (Apr. 2022-Mar. 2023)	35.2	11.5	48.3
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	-1.3	-2.8
	DY3 (Apr. 2022-Mar. 2023)	44.5	-1.7	-3.8
IET-AD Other Engagement[f] (SUD #15)	Baseline (2018-2019)	29	-	-
	DY1 (Apr. 2020-Mar. 2021)	34.2	5.2	17.9
	DY2 (Apr. 2021-Mar. 2022)	18	-11	-38
	DY3 (Apr. 2022-Mar. 2023)	19.3	-9.7	-33.6
IET-AD Total Initiation[g] (SUD #15)	Baseline (2018-2019)	44.3	-	-
	DY1 (Apr. 2020-Mar. 2021)	52.1	7.7	17.4
	DY2 (Apr. 2021-Mar. 2022)	44	-0.3	-0.7
	DY3 (Apr. 2022-Mar. 2023)	45.2	0.9	2
IET-AD Total Engagement[h] (SUD #15)	Baseline (2018-2019)	24.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	31	6.2	25.1
	DY2 (Apr. 2021-Mar. 2022)	19	-5.7	-23.2
	DY3 (Apr. 2022-Mar. 2023)	19.8	-4.9	-19.9
7-day follow-up after SUD emergency department visits[i] (SUD #17(1))	Baseline (2018-2019)	27.5	-	-
	DY1 (Apr. 2020-Mar. 2021)	32.5	5	18.3
	DY2 (Apr. 2021-Mar. 2022)	31.4	3.9	14.2
	DY3 (Apr. 2022-Mar. 2023)	29.1	1.6	6
30-day follow-up after SUD emergency department visits[j] (SUD #17(1))	Baseline (2018-2019)	33.9	-	-
	DY1 (Apr. 2020-Mar. 2021)	40.9	7.1	20.9
	DY2 (Apr. 2021-Mar. 2022	39.2	5.4	15.9
	DY3 (Apr. 2022-Mar. 2023)	43.6	9.7	28.7
7-day follow-up after mental illness emergency department visits[k] (SUD #17(2))	Baseline (2018-2019)	61.9	-	-
	DY1 (Apr. 2020-Mar. 2021)	59.4	-2.5	-4.1
	DY2 (Apr. 2021-Mar. 2022	62.6	0.7	1.1
	DY3 (Apr. 2022-Mar. 2023)	37.1	-24.8	-40

30-day follow-up after mental illness emergency department visits[l] (SUD #17(2))	Baseline (2018-2019)	77	-	-
	DY1 (Apr. 2020-Mar. 2021)	72.4	-4.6	-6
	DY2 (Apr. 2021-Mar. 2022)	74.6	-2.4	-3.1
	DY3 (Apr. 2022-Mar. 2023)	55.4	-21.6	-28

Table E.5b Performance on SUD Milestone 6 Metrics by expansion and non-expansion status

			Percent Change		
			Overall	Non-expansion	Expansion
Metric		Period			
Readmissions among beneficiaries with SUD[m *] (SUD #25) [a]	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	
		DY1 (Apr. 2020-Mar. 2021)	3.6	0.8	62.2
		DY2 (Apr. 2021-Mar. 2022)	-6.7	-6.4	42.9
		DY3 (Apr. 2022-Mar. 2023)	-15.1	-7.6	22.7

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

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.
Metrics are only reported at the calendar year (CY), so we note they do not perfectly align with the demonstration years which run from April through March

Key Takeaways

Our updated analytic approach highlights a couple of key takeaways. First, we are generally seeing improvements for the SUD population eligible according to pre-Medicaid expansion criteria (i.e. “non-expansion”). We also have evidence in support of our hypothesis that SUD patients eligible via Medicaid expansion in the baseline period (i.e. quarter 1 of 2020) appear to have greater health care needs. Thus, when estimating the impact of the Idaho BHT Waiver on this population we tend to see “worse” outcomes, especially regarding utilization.

However, we believe this is largely a selection effect where we compare high utilizers in the very short baseline period of quarter 1 2020 to a broader group in the later demonstration years. Ultimately, estimates of the effect of the Waiver on the expansion population are likely to be biased so we focus primarily on the "non-expansion" population. Further, the changing nature of the SUD definition may also lead to biased estimates – by expanding the definition of SUD in later years (i.e. during the demonstration period) where the added sample is likely to have lower needs and lower utilization, this will lead to biased estimates that appear "worse." So, again, we prefer the "static" definition for defining the SUD population.

Given these analytic caveats, we broadly see improvements in utilization among SUD Medicaid beneficiaries, shorter length of stay in IMDs, continuing drops in high-risk drug prescribing, and generally improved treatment coordination for OUD. We also tend to see increases in provider capacity.

The primary areas of possible concern that may warrant more attention moving forward are: (a) the drop in the number of sites enrolled in Medicaid that provide MAT between DY2 and DY3; (b) continue to ensure continuity of pharmacotherapy; (c) ensuring follow-up care for high risk SUD patients who have an ED visit with a mental illness primary diagnosis; (d) ensuring patients remain engaged in treatment for AUD and other non-opioid SUD diagnoses; and (e) the increase in overdose and the suicide mortality rates within the non-expansion sample.

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

Similar to results in the SUD section, our preferred analytic sample is the "non-expansion, static definition" sample. We see promising improvements in utilization of behavioral health services for this population in DY3 after slight declines during the COVID-period. Again, similar to the SUD section, we have concerns that the expansion population and the rolling definition lead to biased estimates that tend to look "worse" for the Waiver progress. As such, we see promising increases in utilization of behavioral health services in this population (i.e. non-expansion, static definition). We believe the larger declines in other columns reflect the analytic issues raised in earlier sections.

Results

Table E.6: Performance on Milestone 1 Metrics by different baselines and different definitions for Medicaid SMI/SED population (denominator)

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Utilization of behavioral health treatment services (SMI #18) [a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-13.7	-9.9	-9.3	-5.3	-24.8	-14.5
		DY2 (Apr. 2021-Mar. 2022)	-25.6	-9.9	-17.6	-2	-39.6	-16.6
		DY3 (Apr. 2022-Mar. 2023)	-31.7	-4.7	-21.9	4.1	-46.4	-10.3
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-15.8	-12.6	-11.2	-6.4	-24.8	-14.5
		DY2 (Apr. 2021-Mar. 2022)	-27.3	-12.7	-19.4	-3.1	-39.6	-16.6
		DY3 (Apr. 2022-Mar. 2023)	-33.4	-7.6	-23.6	2.8	-46.4	-10.3

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

Rolling definition: The number of Medicaid SMI/SED population (SMI/SED metric #4) is extracted from the state data vendor's quarterly/ annual reports, which adopt changing definitions of SMI/SED population over time.
Static definition: The number of Medicaid SMI/SED population is calculated by the PSU research team following the latest definition in Medicaid Section 1115 Serious Mental Illness and Serious Emotion Disturbance Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 4.0).
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.

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

Results for changes in 30-day unplanned readmission following a psychiatric admission are mixed. On the one hand, the overall decline appears to be positive. However, the increase in the non-expansion population is concerning and may warrant additional attention to ensure appropriate post-discharge care for this more complex patient population.

Results

Table E.7: Performance on Milestone 2 Metrics by expansion and non-expansion status

		Percent Change		
		Overall	Non-expansion	Expansion
Metric	Period			
30-day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) (SMI #4)	Baseline (Apr. 2018-Mar. 2020)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-6.5	1.8	-
	DY2 (Apr. 2021-Mar. 2022)	-7.6	6.8	-
	DY3 (Apr. 2022-Mar. 2023)	-3.3	5.8	-

Note: SMI/SED Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care.
Annual data.
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.
Metrics are only reported at the calendar year (CY), so we note they do not perfectly align with the demonstration years which run from April through March

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

Focusing primarily on the non-expansion, static definition SMI population we observed increases in inpatient utilization, intensive outpatient or partial hospitalization, and a large increase in telehealth utilization (regardless of choice of baseline period). Conversely, we observed decreases in outpatient rehabilitation and ED visits in the same population. The decline in ED visits may be a positive as it may mean patients are receiving more appropriate care outside of the ED – this may be particularly true as we observe an increase in inpatient utilization. Since most inpatient visits originate in the ED, this likely means there was a decline in ED visits not leading to an admission, which may be ones best suited to other settings of care. The large increase in telehealth is not surprising given the nationwide increase in this time period as well. Again, for other groups (i.e. expansion as well as rolling definitions for SMI/SED) we tended to see declines in utilization for many of the same analytic reasons mentioned previously[29].

Crisis service utilization increased relative to a baseline period of 2018-2019, although a high rate in the first quarter of 2020 suggests that some of this likely pre-dates the waiver. Average IMD length of stay remained relatively constant going from 9.5 to 9.4 days between DY2 and DY3 in the non-expansion population and 7.8

to 8.9 days in the expansion population. One thing that may be difficult to untangle is how much this is due to moving further out of the most acute COVID-19 period.

For suicide rates, we saw a worrying increase. This is particularly true for the non-expansion, static definition (or preferred group for all analyses). While the drop for the expansion population is a positive, we have methodological concerns that it may be driven, in part, by the changing expansion population. Namely, that lower acuity patients are added so the denominator expands driving the rate down (an issue discussed extensively above).

Finally, we see promising increases in the availability of community-based behavioral health services and a slight increase in the number of federally qualified health centers (FQHCs). We unfortunately lacked data on availability of virtual visits as well as co-located physical and behavioral health providers.

Results

Table E.8a: Performance on Milestone 3 Metrics by different baselines and different definitions for Medicaid SMI/SED population (denominator)

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Mental Health Services Utilization – Inpatient (SMI #13)[a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	4.8	9.5	5.9	10.5	-28.7	-19.2
		DY2 (Apr. 2021-Mar. 2022)	-11.5	7.1	-0.8	18	-55	-38
		DY3 (Apr. 2022-Mar. 2023)	-20.8	10.6	-6.7	24.4	-63.2	-38.3
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	28.3	33.2	12.1	18.2	-28.7	-19.2
		DY2 (Apr. 2021-Mar. 2022)	8.4	30.2	5.1	26.2	-55	-38
		DY3 (Apr. 2022-Mar. 2023)	-3	34.5	-1.2	33.1	-63.2	-38.3
Mental health Services Utilization – Intensive Outpatient and Partial Hospitalization (SMI #14) [b]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	3.5	8.4	6	10.9	-27.2	-17.1
		DY2 (Apr. 2021-Mar. 2022)	15	39.6	38.6	65.1	-45.7	-24.5
		DY3 (Apr. 2022-Mar. 2023)	20.6	68.3	46.4	94.9	-42.6	-3.9
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	40.5	46.2	30.1	37.5	-27.2	-17.1
		DY2 (Apr. 2021-Mar. 2022)	56.2	88.3	70.2	104.7	-45.7	-24.5
		DY3 (Apr. 2022-Mar. 2023)	63.8	127	79.7	141.7	-42.6	-3.9
		Baseline	-	-	-	-	-	-

Number of beneficiaries who used outpatient rehabilitation services related to SMI/SED (SMI #15) [c]	Baseline (Jan.-Mar. 2020)	DY1 (Apr. 2020-Mar. 2021)	-39	-36.3	-34.3	-31.5	-48.7	-41.8
		DY2 (Apr. 2021-Mar. 2022)	-40.8	-28.3	-32.7	-20	-52.5	-34.4
		DY3 (Apr. 2022-Mar. 2023)	-44.1	-21.9	-34.6	-12.8	-55.7	-25.8
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-42.1	-39.9	-36.9	-33.4	-48.7	-41.8
		DY2 (Apr. 2021-Mar. 2022)	-43.8	-32.4	-35.4	-22.3	-52.5	-34.4
		DY3 (Apr. 2022-Mar. 2023)	-46.9	-26.3	-37.1	-15.3	-55.7	-25.8
Mental Health Services Utilization – ED (SMI #16)[d]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-37.5	-34.6	-30.1	-26.8	-56.8	-51
		DY2 (Apr. 2021-Mar. 2022)	-42.9	-30.1	-29.8	-15.5	-67.7	-55.5
		DY3 (Apr. 2022-Mar. 2023)	-44.7	-22.7	-28.1	-4.2	-71.6	-52.5
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-49.7	-47.7	-44.3	-41.1	-56.8	-51
		DY2 (Apr. 2021-Mar. 2022)	-54	-44.1	-44	-31.9	-67.7	-55.5
		DY3 (Apr. 2022-Mar. 2023)	-55.4	-38.2	-42.7	-22.9	-71.6	-52.5
Telehealth (SMI #17) [e*]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	314.9	333.5	347.2	366.6	206.1	248.7
		DY2 (Apr. 2021-Mar. 2022)	160.8	215.3	188.7	243.3	94.9	168.3
		DY3 (Apr. 2022-Mar. 2023)	109.4	192.5	140.1	220.1	49.7	150.6
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	2613.9	2732.8	2816.8	2951.3	206.1	248.7
		DY2 (Apr. 2021-Mar. 2022)	1605.9	1960.6	1783.1	2145	94.9	168.3
		DY3 (Apr. 2022-Mar. 2023)	1269.9	1811.3	1466.3	1993.4	49.7	150.6

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
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.
Rolling definition: The number of Medicaid SMI/SED population (SMI/SED metric #4) is extracted from the state data vendor's quarterly/ annual reports, which adopt changing definitions of SMI/SED population over time.
Static definition: The number of Medicaid SMI/SED population is calculated by the PSU research team following the latest definition in Medicaid Section 1115 Serious Mental Illness and Serious Emotion Disturbance Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 4.0).
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 who used outpatient rehabilitation services related to SMI/SED.
d: Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.
e: Number of beneficiaries in the demonstration population who use telehealth services for mental health during the measurement period.
*Not used for answering research questions but present here as a critical metric listed by CMS to be included in the report.

Table E.8b: Performance on Milestone 3 Metrics

Metric		Period	Value	Absolute change	Percent change %
Crisis service utilization[a]	Baseline (Jan.-Mar. 2020)	Baseline	203	-	-
		DY1 (Apr. 2020-Mar. 2021)	166	-36	-18
		DY2 (Apr. 2021-Mar. 2022)	141	-62	-30.5
		DY3 (Apr. 2022-Mar. 2023)	169	-34	-16.7
	Baseline (Apr. 2018-Mar. 2020)	Baseline	114	-	-
		DY1 (Apr. 2020-Mar. 2021)	166	53	46.2
		DY2 (Apr. 2021-Mar. 2022)	141	27	23.8
		DY3 (Apr. 2022-Mar. 2023)	169	55	48.4

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
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.
a: Number of beneficiaries in the demonstration population who use inpatient services related to mental health.
b: 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.

Table E.8c: Performance on Milestone 3 Metrics by expansion and non-expansion status

			Overall	Non-expansion	Expansion
Metric		Period			
Average Length of Stay in IMDs [b] * (SMI #19a short stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	7.8	8.5	7.2
		DY2 (Apr. 2021-Mar. 2022)	8.5	9.5	7.8
		DY3 (Apr. 2022-Mar. 2023)	9.1	9.4	8.9
Average Length of Stay in IMDs [b] * (SMI #19a long stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	67	67	NA
		DY2 (Apr. 2021-Mar. 2022)	77.8	72	86.5
		DY3 (Apr. 2022-Mar. 2023)	84.3	79.8	88
Average Length of Stay in IMDs [b] * (SMI #19a total stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	7.8	8.6	7.2
		DY2 (Apr. 2021-Mar. 2022)	8.7	9.8	7.9
		DY3 (Apr. 2022-Mar. 2023)	9.5	9.9	9.3

Note: Average Length of Stay in IMDs is calculated based on individuals aged 21 to 65 years

Table E.9a: Performance on Milestone 3 Metrics

		Count	Absolute change	Percent change %
Availability of community-based 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%
	DY3 (Apr. 2022-Mar. 2023)	224	18	8.5%
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
	DY3 (Apr. 2022-Mar. 2023)	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
	DY3 (Apr. 2022-Mar. 2023)	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)	32	0	0
	DY3 (Apr. 2021-Mar. 2022)	32	0	0
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)	47	1	2.2%
	DY3 (Apr. 2022-Mar. 2023)	48	2	4.3%

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 health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.
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.

Table E.9b: Performance on Milestone 3 Metrics (suicide rates by Medicaid SMI population)

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Suicide rates	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	34.4	41	63	71.3	-37.5	-29
		DY2 (Apr. 2021-Mar. 2022)	-16.6	-1.8	29.8	50.4	-74.2	-65.5
		DY3 (Apr. 2022-Mar. 2023)	2.5	43.2	20	59.7	-65.8	-42.7
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	125.7	135.1	28.6	36.5	-37.5	-29
		DY2 (Apr. 2021-Mar. 2022)	40.1	63.7	2.5	19.9	-74.2	-65.5
		DY3 (Apr. 2022-Mar. 2023)	72.2	138.7	-5.2	27.3	-65.8	-42.7

Note: SMI Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.

Rate of suicidal deaths (number of deaths per 100,000 Medicaid beneficiaries with SMI) during the measurement period.

Table E.9c: Performance on Milestone 3 Metrics (suicide rates by Medicaid population)

			Percent Change		
			Overall	Non-expansion	Expansion
Metric		Period			
Suicide rates	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	37.3	57.1	24.3
		DY2 (Apr. 2021-Mar. 2022)	-12.3	27.6	-32.9
		DY3 (Apr. 2022-Mar. 2023)	13.1	25.3	0.2
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	44.6	28.3	24.3
		DY2 (Apr. 2021-Mar. 2022)	-7.6	4.2	-32.9
		DY3 (Apr. 2022-Mar. 2023)	19.1	2.3	0.2

Note: SMI Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.

Rate of suicidal deaths (number of deaths per 100,000 Medicaid beneficiaries) during the measurement period.

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

Results

We still do not have data on the number of enrollees receiving care from co-located physical and behavioral health facilities.

Table E.10: Performance on Milestone 4 Metrics

		Count	Absolute change	Percent change %
The number of enrollees receiving care from co-located physical and behavioral health facilities (FQHC colocation report)	Baseline (Jan.-Mar. 2020)	ND	ND	ND
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND
	DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND

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.

Key Takeaways

Similar to the SUD results, we see evidence of the key analytic issues we have noted previously – early Medicaid expansion enrollees appear to be higher acuity and with such a short baseline make evaluation of the Medicaid expansion population difficult, if not impossible, to do accurately. We see promising increases in utilization of behavioral health treatment, telehealth utilization, community-based behavioral health services, intensive outpatient and partial hospitalization utilization in our preferred analytic specifications. Declines in ED visits suggest patients may be getting care in more appropriate locations and increases in crisis services may be a combination of need as well as greater awareness of and availability of services. We see mixed results for readmissions and length of stay, but neither rises to the level of major concern.

We are also still missing data on a few key outcomes such as care from co-located physical and behavioral health providers, and availability of virtual visits.

Budget Neutrality Metrics

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

Expenditure		DY1	DY2	DY3	DY4	DY5
FFS-SMI/SED	Total	$21,097,040	$23,146,408	$23,931,828	$27,483,390	$31,561,616
	PMPM	$8,590.00	$8,968.00	$9,363.00	$9,775.00	$10,205.00
	Member-Months	2,456	2,581	2,556	2,812	3,093
FFS-SUD	Total	$4,718,965	$1,690,355	$2,748,294	$3,155,981	$3,624,366

	PMPM	$6,889.00	$7,193.00	$7,509.00	$7,839.00	$8,184.00
	Member Months	685	235	366	403	443

Source: Idaho Behavioral Health Transformation Year 3 Quarter 4 Budget Report.

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

Expenditure		DY1	DY2	DY3	DY4	DY5
FFS-SMI/SED	Total	$13,195,433	$14,980,110	$15,488,732	$27,483,390	$31,561,616
FFS-SUD	Total	$3,194,506	$556,420	$942,281	$3,155,981	$3,624,366

Source: Idaho Behavioral Health Transformation Year 3 Quarter 4 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)	$25,816,005	$50,652,768	$77,332,890	$107,972,261	$143,158,243
Allowed Cumulative Variance (= CTP X CBNL)	$516,320	$759,792	$773,329	$539,861	$-
Actual Cumulative Variance (Positive = Overspending)	$(9,426,066)	$(18,726,299)	$(28,975,409)	$(28,975,409)	$(28,975,409)

Source: Idaho Behavioral Health Transformation Year 3 Quarter 4 Budget Report.

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 3, Quarter 4).

Separately for SUD and SMI/SED spending, the Tables E.19a,b,c 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. The three sets of tables from the latest Budget Neutrality Report include: (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, DY2, and DY3 as well as then 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.

Provider Availability Assessment

Overall, we believe Idaho has made sufficient progress on provider availability, especially as states nationwide face behavioral health provider shortages. Maintaining availability for some types of care while increasing some is promising. Most promising are the large increases in residential mental health facilities (adding 8 in DY3 along with an additional 114 beds) and intensive outpatient services.

Notable instances of maintaining availability (i.e. neither large increases nor declines) include public or private hospitals, crisis stabilization services, and federally qualified health centers.

Finally, we note a few important declines. Drops in Medicaid enrolled psychiatrists and other practitioners (a drop of 160 despite an overall increase of nearly 500), suggest it may be important to continue to engage and enroll providers in Medicaid where possible. This is, of course, despite known difficulties and national patterns of declines in Medicaid enrollment among psychiatrists. We also observed declines in overall and Medicaid enrolled licensed psychiatric hospital bed (due in part to a loss of 2 of 9 psychiatric units in acute care hospitals between DY1 and DY2) and the loss of one IMD (in DY1). However, both of these did not see further drops in DY3.

There are also 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 the IBHP managed care contract. 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)

Table E.12: Availability of Practitioners

			Value	*Absolute change*	*Percent change*
Practitioners	*Psychiatrists*[a]	Baseline (2019)	115	-	-
		DY1	94	-21	-18.3%
		DY2	100	-15	-13.0%
		DY3	99	-16	-13.9%
	Medicaid enrolled psychiatrists[b]	Baseline (2019)	80	-	-
		DY1	84	4	5.0%
		DY2	73	-7	-8.8%
		DY3	73	-7	-8.8%
	Other practitioners for treating mental illness[c]	Baseline (2019)	6,601	-	-
		DY1	7,099	498	7.5%
		DY2	7033	432	6.5%
		DY3	7506	905	13.7%
	Medicaid enrolled other practitioners for treating mental illness[d]	Baseline (2019)	1,638	-	-
		DY1	1,927	289	17.6%
		DY2	1848	210	12.8%
		DY3	1688	50	3.1%

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.

Results of Performance on Availability of Intensive Outpatient, Residential, IMD, and Outpatient Treatment Metrics (Tables E.13, E.14, and E.15)

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%
		DY2	45	31	221.4%
		DY3	64	50	357.1%
	Medicaid-enrolled providers offering intensive outpatient services[b]	Baseline (2019)	14	-	-
		DY1	38	24	171.4%
		DY2	45	31	221.4%
		DY3	64	50	357.1%

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 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.

Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr.2021, DY3: Yr. 2022. Prvdr_intnsv_ot: Providers Offering Intensive Outpatient Services, Mdcd_prvdr_intnsv_ot: Medicaid-Enrolled Providers Offering Intensive Outpatient Services.

Table E.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
		DY2	4	0	0
		DY3	12	8	200%
	Medicaid-enrolled residential mental health treatment facilities (Adult)[b]	Baseline (2019)	4	-	-
		DY1	4	0	0
		DY2	4	0	0
		DY3	12	8	200%
	Residential mental health treatment facility beds (Adult)[c]	Baseline (2019)	56	-	-
		DY1	56	0	0
		DY2	56	0	0
		DY3	170	114	203.6%
	Medicaid-enrolled residential mental health treatment beds (Adult)[d]	Baseline (2019)	56	-	-
		DY1	56	0	0
		DY2	56	0	0
		DY3	170	114	203.6%
Psychiatric residential treatment facilities	*Psychiatric residential treatment facilities (PRTF)[e]*	Baseline (2019)	1	-	-
		DY1	1	0	0
		DY2	0	-1	-100%
		DY3	0	-1	-100%
	Medicaid-enrolled PRTFs[f]	Baseline (2019)	1	-	-
		DY1	1	0	0
		DY2	0	-1	-100%
		DY3	0	-1	-100%
	PRTF beds[g]	Baseline (2019)	12	-	-
		DY1	12	0	0
		DY2	0	-12	-100%
		DY3	0	-12	-100%
	Medicaid-enrolled PRTF beds[h]	Baseline (2019)	12	-	-
		DY1	12	0	0
		DY2	0	-12	-100%
		DY3	0	-12	-100%

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
		DY2	0	0	0
		DY3	0	0	0
	Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs[b]	Baseline (2019)	0	-	-
		DY1	0	0	0
		DY2	0	0	0
		DY3	0	0	0
	Psychiatric Hospitals that Qualify as IMDs[c]	Baseline (2019)	4	-	-
		DY1	3	-1	-25%
		DY2	3	-1	-25%
		DY3	3	-1	-25%

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.

Results of Performance on Availability of Inpatient Services Metrics (Table E.16)

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	6	1	20%
		DY2	5	0	0
		DY3	6	1	20%
	Medicaid-enrolled public and private hospitals[b]	Baseline (2019)	4	-	-
		DY1	4	0	0
		DY2	5	1	25%
		DY3	5	1	25%
Psychiatric units	*Psychiatric units in acute care hospitals*[c]	Baseline (2019)	9	-	-
		DY1	9	0	0
		DY2	8	-1	-11.1%
		DY3	7	-2	-22.2%
	Psychiatric units in critical access hospitals (CAHs)[d]	Baseline (2019)	1	-	-
		DY1	1	0	0
		DY2	1	0	0
		DY3	1	0	0
	Medicaid-enrolled psychiatric units in acute care hospitals[e]	Baseline (2019)	9	-	-
		DY1	9	0	0
		DY2	7	-2	-22.2%
		DY3	7	-2	-22.2%
	Medicaid-enrolled psychiatric units in CAHs[f]	Baseline (2019)	1	-	-
		DY1	1	0	0
		DY2	1	0	0
		DY3	1	0	0

Psychiatric beds	*Licensed psychiatric hospital beds*[g]	Baseline (2019)	823	-	-
		DY1	806	-17	-2.1%
		DY2	723	-100	-12.2%
		DY3	599	-224	-27.2%
	Medicaid-enrolled licensed psychiatric hospital beds[h]	Baseline (2019)	768	-	-
		DY1	730	-38	-4.9%
		DY2	647	-121	-15.8%
		DY3	544	-224	-29.2%

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.

Note: Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. 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

Results of Performance on Availability of Crisis Stabilization Services Metrics (Table E.17)

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
		DY2	16	0	0
		DY3	16	0	0
	Mobile Crisis Units[b]	Baseline (2019)	7	-	-
		DY1	7	0	0
		DY2	7	0	0
		DY3	7	0	0
	Crisis Observation/Assessment Centers[c]	Baseline (2019)	9	-	-
		DY1	9	0	0
		DY2	9	0	0
		DY3	9	0	0

Crisis Stabilization Units[d]	Baseline (2019)	0	-	-
	DY1	0	0	0
	DY2	0	0	0
	DY3	0	0	0
Coordinated Community Crisis Response Teams[e]	Baseline (2019)	0	-	-
	DY1	0	0	0
	DY2	0	0	0
	DY3	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.

Results of Performance on Availability of Federally Qualified Health Centers (FQHC) Metrics

(Table E.18)

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%
		DY2	47	1	2.2%
		DY3	48	2	4.35%

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.

Key Takeaways

We believe our updated analytic approach was critical to attempting to deal with a number of key analytic difficulties. Primarily, Medicaid expansion happened for only a quarter before the Waiver went into effect and we saw strong evidence that earlier enrollees via Medicaid expansion had greater health needs making it infeasible to provide accurate estimates of the effect of the Waiver on the population eligible for Medicaid via expansion.

However, in our preferred analytic specifications we found evidence that both SUD and SMI/SED utilization was increasing, as intended for the non-expansion population. We also saw evidence of important increases in capacity including intensive outpatient services as well as residential mental health facilities and beds. Other key improvements included improved treatment coordination for OUD, drops in risky opioid prescribing (albeit likely more due to national changing provider standards of practice); and for SMI/SED increases in intensive outpatient care, telehealth, and community-based services.

Idaho also appeared to be continuing to meet budget neutrality targets.

We do not have major concerns about meeting the goals of the BHT Waiver but do note a few items to continue to monitor. On the SUD side, these include drops in sites that can provider MAT, maintaining continuity of pharmacotherapy, ensuring follow-up care for high-risk SUD patients who have an ED visit for mental illness diagnosis, and ensuring patients remain engaged in treatment for AUD and other non-opioid SUD diagnoses. While we acknowledge important, national difficulties in availability of behavioral health providers (especially for patients with Medicaid coverage) a few key provider availability areas include drops in Medicaid enrolled psychiatrists and other practitioners and declines in overall and Medicaid enrolled licensed psychiatric hospital bed, and the loss of one IMD (in DY1). There are also still a few areas where data availability was an issue to completing estimates including mortality data, data on care from co-located physical and behavioral health providers, and availability of virtual visits.

Finally, concerns about rural and frontier care availability are likely to remain an ongoing issue.

Key Informant Interview Findings – Stakeholder Input

This section describes findings from the second round of key informant interviews focused on the implementation of the Idaho BHT Waiver. The interviews took place from November 2023 – December 2023. These findings build on lessons learned in our first round of interviews conducted with 12 key informants between December 2021 and March 2022.

This section includes:

1. A brief summary of the first round of key informant interviews
2. Updates on key contextual factors since the first round of key informant interviews, such as changes in IDHW leadership and behavioral health needs in Idaho
3. A summary of the impacts of the Idaho BHT Waiver thus far
4. A summary of challenges to implementing the Idaho BHT Waiver
5. A description of the upcoming Idaho Behavioral Health Plan Managed Care Organization (IBHP MCO) contract with Magellan
6. A summary of important considerations moving forward

Summary of First Round of Key Informant Interviews (December 2021 – March 2022)

The focus of the first round of interviews was largely the development and submission of the Idaho BHT Waiver and early experiences with implementation. We interviewed respondents who could speak to historical context as well as individuals who were involved in Medicaid expansion, treatment of mental and behavioral health, and various community advocates and other stakeholders.

During the initial rounds of interviews, respondents reported challenges with implementing the Idaho BHT Waiver, namely delays in SUD treatment facility certification and enrollment, and concerns about the overall level of resources to support the Idaho BHT Waiver. Respondents described the IDHW as almost solely focused on the procurement of the new IBHP MCO contract. Multiple respondents, especially providers, reported being unaware of the Idaho BHT Waiver and, if they were aware, were not familiar with the details. Those who were familiar described the successful application and early implementation as positive and were complimentary of the collaboration with IDHW.

Some believed that many Idahoans in need of SMI/SED/SUD treatment were continuing to access care through the criminal justice system (e.g., court appointed, funded by the criminal justice system), while others believed that Medicaid expansion and the Idaho BHT Waiver had a positive impact on reducing the burden of court systems (e.g., individual could self-refer, access care, and no longer needed treatment paid for by the court system). Respondents reported challenges with the IHDE, an important stakeholder in supporting the health IT goals of the Idaho BHT Waiver. Two final key points that were perceived as barriers included the need to amend the Idaho BHT Waiver to serve the under-18 population and the impact of the COVID-19 pandemic on the implementation progress and budget management.

Updates and New Insights about Contextual Factors (2023)
We have included additional information about IDHW, as well as changes or updates in other contextual factors such as Idaho's demography, health needs, Medicaid expansion, and the COVID-19 Public Health Emergency (PHE) as reported by respondent's during the second round of interviews.

Health and Human Services is housed under a single umbrella within a single administration, unlike in some states with several departments with separate administrations. As of 2023, the IDHW continues to be the largest state agency with four areas and 11 divisions with individual bureaus and programs providing services to the communities throughout the state that supplement services provided through Medicaid. The IDHW divisions include Behavioral Health, Community Partnerships, Early Learning and Development, Financial Services, Information and Technology Services, Licensing and Certification, Management Services, Medicaid, Public Health, Self-Reliance, and Youth Safety and Permanency. There is also an office of Legislative and Regulatory Affairs and the office of Communications within the IDHW organizational structure.

In 2023, Idaho ranked 38th smallest state in population, which is a change from our previous report, where it ranked 39th. The state has 44 counties, 35 of which are rural, and 16 are designated as remote, meaning those counties have fewer than six people per square mile. Approximately thirty percent (30%) of the state's population lives in rural areas[30].

Health care access is challenging since Idaho is a designated HPSA that ranks 50th for total physician supply per capita and was previously ranked 49th. In addition, Idaho ranks 49th in active primary physician supply per capita[31]. The state has seven public health districts/regions that work closely with IDHW with one main outpatient treatment center in each region.

Pertaining to behavioral health care 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 IDHW. It also maintains a statewide program to restore the competency of criminal justice patients.

Respondents reported concerns about rising overdoses and overdose deaths saying, "there's definitely a spike since the Waiver." Similarly, there is a concern about suicides in the youth population, particularly in Boise. One respondent reported that Idaho was "third in the country for suicide." Finally, there has been a longstanding

challenge with housing in Idaho. According to one respondent, “We've always, always struggled with housing. Housing's a horribly difficult thing, we're rural.”

Several participants noted that as Medicaid expansion rolled out, the state had underestimated the severity of the need for services and the number of self-referrals and as a result, the overall health care costs were much higher than anticipated.

PHE: As the Idaho BHT Waiver was launched in 2020, the COVID-19 pandemic began. The “silver lining” of the pandemic, and the associated PHE declaration, according to some respondents, is that telehealth services utilization increased. Governor Little signed an executive order in June 2020 making more than 150 emergency telehealth rules permanent. The state saw the positive impact of these services and extended broad access to telehealth post-PHE through House bill 162 introduced in February 2023 and signed by governor in March 2023. This amendment to the Idaho Telehealth Access Act aimed to enable out-of-state mental and behavioral health providers the opportunity to register and comply with the state regulations, permitting them to offer telehealth services to individuals in Idaho. This was a benefit, especially in rural and frontier areas, where non-emergency medical transportation was a barrier.

Initially, when the PHE ended (admittedly partially outside the scope of the timeframe for the interim report as this began in 2023 but extended past March of 2023), patients lost coverage, and providers were not prepared for the repercussions. Providers noted that patients would seek care believing they had coverage but realized they had been disenrolled. As providers were treating patients who were no longer covered, payments were delayed until the patient was reestablished, or in some cases, non-payment led to uncompensated charity care. Not all providers could absorb this, and it created a financial burden. In some cases, providers were not able to support patients and provide services. Not only did this hinder care, but also impacted the ability to place patients in care settings post-IMD discharge. This created higher readmission rates to the IMD. Providers exhausted human resources, and in some cases had a designated staff member to assist patients in re-establishing Medicaid coverage. Idaho Medicaid/Self Reliance was able to review, and the redetermination process was prompt. One respondent summarized this and stated,

> *“I believe Idaho, in following the guidance…and working with CMS, determined that there was a group of folks that CMS didn’t feel that we conducted that the way we should, so we’re going to go ahead and put them back on the rolls for now. I believe the state has done that in the last 60 days or so. I forget how many people exactly, but it’s not an insignificant number….”*

Overall, many believed that re-enrollment went well, but the SMI/SED/SUD population is a vulnerable population and timing for treatment is important.

Investments in Behavioral Health Care Outside of the Idaho BHT Waiver: Respondents also talked about Idaho’s investments in behavioral health care above and beyond the Idaho BHT Waiver, summarized by one respondent,

> *“We’ve had some pretty significant investments in our behavioral health continuum of care over the past year through legislative authority. The Governor’s Office put forward about $72 million for us to invest in our behavioral health continuum of care. There were some grants that were awarded in addition to that.”*

> *“We also put some grants out to help providers establish psychiatric residential treatment center in the state of Idaho. I believe $12 million already has been in the state.”*

Key Impacts of the Idaho BHT Waiver according to Key Stakeholder Interviews
The following section summarizes the key impacts of the Idaho BHT Waiver thus far, according to the 12 respondents interviewed.

Enhanced Access for Patients with SMI/SED/SUD

The Idaho BHT Waiver application and implementation plan happened quickly and had an impact on getting people with SMI/SED/SUD to the appropriate level of care (e.g., admitting people with SMI or SUD concerns to IMDs, not acute care hospitals; and continuing to provide access to lower acuity levels of care to prevent admissions). Concerning improvements with access to care, one respondent said,

> *"There are communities with no behavioral health services at all. They're now being provided largely through the FQHCs [Federally Qualified Health Centers]. I think that [the Idaho BHT waiver] has been helpful…Clearing folks out of hospital space to put them in an appropriate level of care and appropriate care setting has been helpful. We [the state] still struggle in Idaho with behavioral health and access to care, but things have improved."*

Summarized by another respondent,

> *"Because if we did not have this waiver, yes, we would have still had Medicaid expansion, had these members on Medicaid—these adult members, 21 to 64—but they would not be able to get that type of inpatient care that they might need. It wouldn't be in their benefits. I think just overall, that is one success that we have had."*

Another respondent added an increase in access to SUD treatment,

> *"I think a significant increase in access to substance use disorder broadly...but still a lot of work that needs to be done to improve access and reduce stigma and get the provider community broadly to take on MOUD."*

Prior to the Idaho BHT Waiver, there was no consistent funding source to support medications for Opioid Use Disorder (MOUD) in outpatient settings, which hindered patient progress and increased reoccurrence. For individuals without private insurance, there was no access to withdrawal management outside of acute care hospitals, which further burdened acute care hospitals. Idaho did not have the acute care bed capacity to serve people with SMI/SED/SUD, in addition to those seeking services for acute/chronic physical health problems. One respondent highlighted the limited capacity of acute care hospitals in Idaho and noted,

> *"Before the waiver, they had to be hospitalized at either the state hospital or there are only two state hospitals in Idaho. Both are pretty small facilities…less than 50 beds…, and then at one of our medical-surgical hospitals…I think a total of one med surg facility has 20 beds, and the other one has around 20 beds…"*

Patients seeking care for SMI/SED/SUD are better suited for IMDs. In addition, the waiver expanded outpatient services to include MOUD (e.g. pharmaceutical coverage/benefits) and eliminated authorization to prescribe buprenorphine. Before the expansion, MOUD treatments were a financial burden for patients.

Implementation of the American Society of Addiction Medicine Levels of Care

The development and implementation of ASAM 3.5 and 3.7 levels of care was a priority of the Idaho BHT Waiver. ASAM levels of care provided a framework for assessing and matching patients with appropriate levels of addiction treatment services[32]. The levels range from less intensive outpatient services to more intensive inpatient services, depending on the individual's needs. ASAM developed these levels to standardize and improve the quality of addiction treatment across the state.

- Level 3.5: Clinically managed residential services designed for people with serious psychological or social issues who need 24-hour oversight and are at risk of imminent harm.
- Level 3.7: Medically managed high-intensity inpatient treatment, a service for people who need intensive medical or psychological monitoring in a 24-hour setting but do not need daily physician interaction.

In Idaho, ASAM levels of care implementation was done in collaboration between state agencies, managed care organizations, providers, and other stakeholders. The IDHW played a key role in adopting and implementing the ASAM levels of care as the standard for addiction treatment in Idaho. This involved reviewing the ASAM criteria and determining how they align with existing regulations and treatment practices. Providers integrated the ASAM levels of care into their admission process, including intake procedures, treatment planning protocols, and documentation to align with the ASAM criteria and receive reimbursement.

The implementation of these levels of care expanded patient access and providers' ability to bill for these services. While this increased overall spending on behavioral health services for the state, the levels of care implementation shifted costs to create a more consistent spending pattern throughout the year. Nearly all key informants mentioned the success of the implementation of ASAM 3.5 and 3.7 levels of care. One respondent stated,

> *"One of the milestones is being able to stand up and reimburse for—…[the] American Society of Addiction Medicine, Levels of Care 3.5 and 3.7, which had been a goal of the demonstration. We [the state] had to work to get a provider base willing, ready, and able to deliver those services, and we [the state] started this year in delivering that, so it achieved that milestone…or much further along in achieving the milestone."*

There were a few provider concerns about the implementation of the ASAM levels of care. Providers reported barriers to timely reimbursement resulting from confusion around patient authorizations and subsequent billing challenges. Providers expressed the importance of increased transparency and communication so that providers can efficiently serve patients. Several respondents suggested that the IBHP MCO provide resources for provider groups to assist with a better understanding of these new standards and prevent the challenges faced with the initial implementation.

Another challenge that has yet to be addressed in the current contract is the high rates of co-morbidities, which complicates the treatment length of stay and subsequently adequate reimbursement to cover the cost of treatment. Many provider groups are requesting that this be reassessed with the new IBHP MCO so that lengths of stays are "right sized" and treatment coordination offers the greatest opportunity for positive patient outcomes.

Certified Community Behavioral Health Clinics

Through the Idaho BHT Waiver, Idaho is trying to build out the outpatient continuum of care, with a key mechanism being Certified Community Behavioral Health Clinics (CCBHCs). At the time of the interviews, there were 4 CCBHCs accredited or moving toward accreditation. These are FQHCs that include a behavioral health clinic, being reimbursed as a FQHC through Medicaid. CCHBC services were not paid for to date, but there were grant monies to offset the additional costs.

According to a respondent, these FQHCs *"are ready to transition to CCBHC model. However, we're trying to determine a public authority to put that benefit on there. We're looking at the demonstration or state plan and amendments."* Analyzing cost reports and working to establish rates because the facilities will take on more services as a non-traditional FQHC, and anticipated Medicaid reimbursement at a CCCHC rate sometime in 2025.

> *"When they're able to be credentialed and paid as a CCBHC by Medicaid, is we're looking at the additional services that are within the scope of responsibility of CCBHC and determining what the cost is to set a new PPS rate, which will most likely be higher. At that point, instead of billing the $300 mark, maybe it's 350, 375, 400, so there will be additional revenue received for those additional services they're providing."*

Challenges
This section summarizes key challenges with implementing the Idaho BHT Waiver according to the 12 respondents interviewed.

Provider Shortage
Idaho, like many other states, continues to have a provider shortage at all levels of behavioral health care. The provider shortage was a major barrier to the rollout of the Idaho BHT Waiver and the new IBHP MCO. One participant noted,

> *"Having the right staff is probably the biggest area of challenge of the providers themselves as well as a shared area of concern with the state. in that for the services, kind of a crux for services to be delivered safely and effectively, and right certification training levels there to deliver such services."*

Respondents described the bureaucracy around credentialing provider staff causing delays in standing-up operations. Navigating the complexity of credentialing and hiring staff created delays in inpatient services. There seemed to be a particular challenge related to hiring peer support staff and bachelor-prepared staff. Peer support staff must be credentialed through a specific program.

Many providers wanted to hire potential peer support employees but do not have the resources to employ them when they cannot treat and bill for services for 30 days. A respondent acknowledged that this was frustrating but understood that this seemed to be the standard for all health care plan reimbursements, not just the Idaho BHT Waiver.

Provider reimbursement under the Managed Care Contract (MCC) was another issue that created challenges to provider groups. Respondents reported that, under Optum as the MCO, Medicaid reimbursement is not adequate to support the case mix of mostly Medicaid recipients. Providers that had a healthy mix of private insurance, Medicare, and Medicaid can stay solvent because of the private contracts/insurance; however, in many cases, they were losing or breaking even on the Medicaid clients.

Providers who were not as fortunate and have largely Medicaid clients struggled to stay open, as reimbursement was sometimes less than the cost of care. Providers advocated for higher reimbursements to cover the cost of treatment and keep "doors" open, but some believed providers can provide care on current reimbursement rates. Many noted that if reimbursement rates were not increased with the new MCC, some providers may no longer be willing/able to take Medicare/Medicaid, further intensifying the provider shortage for those most in need.

While the waiver had freed up some of the acute beds, there remained a greater need than capacity to serve inpatient SMI/SED/SUD.

More than one participant was hopeful that Magellan (the new IBHP MCO contract holder) will be an asset to building a strong provider network to support SMI/SED/SUD health care needs across both inpatient and outpatient care.

Idaho Health Data Exchange
In 2006, the Idaho Legislature created the Health Quality Planning Commission (HQPC) "charged with promoting improved quality of care and health outcomes through investment in health information technology[13,33]." As a result of the Commission's work, the IHDE was launched in 2008 to implement a formalized data collection process so that patient data (e.g. comprehensive medical history to include medications, laboratory/testing results, treatments) could be securely shared between providers, the state, and CMS to make data-driven decisions. Initial funding for IHDE came via the Idaho Legislature, followed by funding appropriated by the Federal American Recovery and Reinvestment Act (ARRA) grant funds.

Initial support for the IHDE was split. Some stakeholders were in favor and financially supported the IHDE, while others thought the IHDE cost outweighed the value of the IHDE.

Initially, IHDE members held stakeholder meetings and focus groups to encourage buy-in and build out functionality that would entice IHDE engagement, yet many respondents reported that members believed the IHDE platform was not user-friendly. Early on, the IHDE faced technological challenges. Some stakeholders were not very supportive and thought the IHDE was overpriced and lacked value. This was emphasized by one respondent,

> *"The level of take-up by providers has rarely met their projected goals. Small hospitals thought it was too expensive. Small providers thought it was too expensive."*

Healthy Connections, Idaho Medicaid's primary care case management (PCCM) program, offered incentives to promote participation in the IHDE; yet these incentives had little impact on uptake. One participant noted, "Our members mostly have been supportive," but sometimes there are clinical and ideological concerns at the patient level and beyond. One example is providers' and patients' hesitancy to share behavioral health information with the state.

A lot of resources were used to create the IHDE and the financial decisions and viability of the IHDE were highly publicized.

> *"One is mostly from reading newspaper articles, generally aware that there are some financial problems… and some concerns about whether or not—not only financial viability but whether or not financial decisions were appropriately made..."*

Given all the resources dedicated to standing up the IHDE, the lack of enrollment was a concern and to salvage the IHDE,

> *"…they [IHDE work group] started to have mission creep and try to move into other areas because they weren't generating the revenue they needed on the data exchange site, so then they were looking at other things. "What can we do with the data? Could we be more of an all-claims database?" Just it's been frustrating…"*

In August 2022, the IHDE was not able to overcome the financial challenges and filed for Chapter 11 bankruptcy as a way to buffer themselves from financial and litigation challenges while attempting to continue service delivery. While IHDE exited bankruptcy in mid-2023, many respondents referred to uncertainty and skepticism about the future of the IHDE. Because the health IT plan had been relying on the IHDE to fulfill many of its criteria, now "having to think outside the box in others ways that we can demonstrate compliance with that [HIT] requirement or...[a] potential proposal to supplement that with something different."

Despite the challenges with the IHDE, one respondent believed, "that there's been increased exchange of information in other ways." One example of this is the use of a shared electronic medical record platform, Epic and one respondent noted,

> *"The Health Data Exchange maybe isn't as helpful as we had hoped, but...a lot of hospitals using the same medical record systems, I think we are seeing more collaboration and just better communication of those things coming up in a patient chart and their provider being pinged."*

Another example is the opioid workgroup and interagency collaboration including the PDMP, which is not owned by Idaho Medicaid, but controlled by a contract with Bamboo Health through the Board of Pharmacy, which can be another source of information sharing beyond the IHDE.

The Delays with the new IBHP MCC

Respondents cited challenges with the delays in awarding and implementing the new IBHP MCC with Magellan Healthcare Inc. Namely, Magellan filed suit against the state's original awardee, Beacon Health. The state ultimately rescinded the contract due to a conflict of interest.

Both Optum Health, the current managed care contract, and Beacon filed suits, which were dismissed in late 2023. Judges in both cases stated the court had no jurisdiction over state contracts, per Idaho state law. After litigation and delays cited in report sections above, Magellan was awarded the contract in June/July 2023. This was summarized by one respondent,

> *"We [the state] rescinded that letter of intent as a result of that determination of the recommendation and awarded it to the next highest bidder. That was Magellan. Beacon Health was the original potential award that was rescinded based on their work on the crisis continuum with us a couple of years ago. We've [the state] got specific prohibitions in our procurement act. We [the state] talked about if the contractor was—if someone was contracted with and paid for work and informed or contributed to a solicitation, they are prohibited from getting it. That's what happened. They unfortunately were disqualified from procurement. We [the state] awarded Magellan."*

Initially, the Magellan's contract was to begin March 1, 2024, but the go-live date has been delayed until July 1, 2024. During the interviews, one respondent reported this as late-breaking news,

> *"In the last 24 hours, the department has issued a press release saying that the go-live date for Magellan to administer the Idaho Behavioral Health Plan will now be July 1, 2024."*

All but one of our interviews took place before the state announced the delay of the go-live date. That respondent noted that the delayed start was announced less than 24 hours before the interview, which was a relief. Several interviewees were concerned that the provider contracts with Magellan would not be ready for a March start date.

Future Considerations

While we have identified key impacts and challenges from our second round of key informant interviews, it is important to emphasize that the implementation of the Idaho BHT Waiver is still in early stages and the implementation of the new IBHP MCO is forthcoming. As such, respondents discussed several important future considerations.

Upcoming IBHP MCC with Magellan

In general, respondents were optimistic about Magellan and believed that Magellan will be able to "deliver for Idaho." Respondents described Magellan as having a strong track record in other states and expertise in behavioral health managed care plan experience, a strong provider network, case management services, and clear understanding of criteria for billing. Magellan appeared to understand the importance of the right services/right places/right time to positively impact patient outcomes while balancing cost containment. Magellan could create more outpatient options for patients who did not have them historically, especially for those in rural and frontier areas. Magellan can harness their wide provider network, which several participants were hopeful could reduce provider shortage and further reduce the burden on in-patient admissions. One respondent summarized as follows,

> *"I think Magellan's going to make a difference in that area [provider and network adequacy]. I think Magellan has the right pathway in mind in terms of gathering that, I think they realize they're going to have to bring in some resources from outside the state. Yeah, I do think the new contract will make a difference in that area."*

Another respondent noted that given the lack of mental health and substance use specialists, Magellan will be looking to primary care providers to address some types of care (e.g., anxiety, depression) and mentioned that there have already been discussions about this. One participant stated,

> *"We're still going to have some primary care folks providing behavioral health services at a higher level than other states just because there's no one else to do it. Hopefully, with telemedicine and the other resources available, they're feeling more supported in that."*

However, given the national provider shortage, the state may need to consider its part in building a provider network.

Some respondents attributed their optimism to the fact that Magellan will be the first comprehensive IBHP MCO for the state, which many believed was necessary to support feasibility and improved transitions in care across the health care services. As a reminder, Optum's contract did not include inpatient care services. ASAM level of care certification will be folded into Magellan's contract. Others noted that their optimism was due to the ambitious goals Magellan has set beyond the IBHP MCC. However, the interviews ended before the final IBHP MCO was established with the state. One respondent discussed both the need to positively improve the fragmentation in the system and expansion of the IBHP MCO to non-Medicaid coverage, as well and stated,

> *"Well, I think the overall flow between Medicaid, non-Medicaid, and inpatient and outpatient care—the whole infrastructure—is going to be better because it's all in one place, there's one pathway. Idaho's system has historically been fairly fractured because we have so many different systems—…to being able to have the system contained in one management and oversight structure and one access pathway is going to make a huge difference."*

While many respondents were optimistic, at the time of the interviews, there was still uncertainty around the upcoming IBHP MCO.

> *"What I've learned from Magellan is they just started training this last week. We still don't have a provider handbook. We don't have a fee schedule. We've had three trainings that have said nothing…I sent in five questions right before this meeting, and I got one answered…It was, "It's coming."…I'm kind of worried that they don't know what they're doing."*

Both the state-level and provider respondents expressed some apprehension about the new IBHP MCO. There is some concern about 1) enrolling providers under new contracts in a seamless manner to maintain access for patients through the transition; 2) establishing a fair, balanced contract between providers/MCO; 3) ongoing litigation around MCOs; and 4) building a provider network to meet patient needs. Several respondents emphasized that the "new" IBHP MCO with Magellan must be done "right." Infrastructure and technology must be "stood up" before transition to ensure a seamless transition. Providers cannot afford to go without reimbursement for an extended period, which happened when Optum was first onboarded. In addition, at one of the training sessions with Magellan, providers expressed concerns over the administrative burden to providers to meet the IBHP MCO requirements. One respondent stated,

> *"…we have to report if kids are verbally abused on playgrounds…if they get injured, like if they sprain their ankle somewhere. We have to report that now in their little system. That's craziness…for a mental health provider to...are you serious? That's odd to me."*

Furthermore, building and growing outpatient services, including peer support services, under the new managed care contract and mobile crisis units seems to be an important priority after Magellan takes over on July 1, 2024. Peer support services will need to expand to meet the high need. Lastly, several respondents mentioned the need for housing stabilization for the clients using the waiver. A few participants suggested that the waiver should be expanded to support house insecurity.

"We're pulling together all the resources that somebody might need and being able to support them with housing, inpatient services, and residential treatment in the community. We leverage Medicaid dollars where we can but also leverage state general funds."

Under 21 population
Respondents expressed desire to see SMI/SED/SUD coverage for the under-21 population, particularly those aged 18-20. This population was not part of the Idaho BHT Waiver; however, it was made clear by several participants that there is a need for services for this population. According to one respondent,

"But 18 to 20, there was a gap there where those folks couldn't go to the community-based provider. They can be served in a hospital, but there's not a lot of hospital 3.5s, if any, actually that are available. It's a gap in care there, and we're...in the process of amending [the] waiver to include that population. We would bring down the age allowability for the community-based residential 3.5 and 3.7 to 18 years."

Provider Capacity and Workforce Shortages
Provider capacity and workforce shortage were thought to be one of the greatest concerns in executing the Idaho BHT Waiver. Some key informants expressed optimism that Magellan will be able to build provider/provider capacity; however, given the national provider shortage, others believe this will be an ongoing struggle.

Telehealth Can Support Infrastructure and Capacity Challenges
When the PHE was established, utilization of telehealth increased and providers were able to quickly build out capacity, which allowed for additional support and services for patients. The transition for billing and reimbursement was a seamless process and providers reported few barriers.

With the conclusion of the PHE, telehealth flexibilities remain, and authorization for telehealth will be fully reimbursed. The expansion of telehealth was part of the state's commitment during the implementation of the Idaho BHT Waiver to support rural/frontier areas.

Many stakeholders are supportive of extending the telehealth reimbursement to audio-only telehealth to increase reach and access. Transportation is a barrier as many services require long commutes and transportation to deliver in-person results, which was and, in some instances, continues to be a requirement. This is a burden to patients and decreases follow-up/coordinated care.

Coordination and Integration of Services
Respondents noted the importance of care coordination and that transitions in care must be seamless across the continuum, not only for Medicaid but for non-Medicaid as well. Integrating various services across different sectors, such as health care, social services, and criminal justice, requires effective coordination among multiple stakeholders. Another consideration was Medicaid's portability across state lines. Idaho provider organizations are burdened by non-Idahoan patients (e.g. eastern Oregon) using treatment resources without a payment mechanism. Creating a mechanism for cross-state portability could decrease the provider's financial burden.

Addressing Stigma and Other Barriers
Stigma surrounding mental health and substance use disorders are a barrier to seeking help and accessing services. Additionally, the rurality of the state presents challenges in effectively reaching and serving diverse populations within Idaho.

Data Needs
As previously mentioned, respondents discussed concerns and uncertainty around the IHDE and what this means for the future of behavioral health data collection and sharing. Given the public pushback to the IHDE, careful attention must be paid to finding a mechanism to collect and share accurate and timely data, ensure data privacy and security, and effectively use data to inform decision-making and measure outcomes. There are opportunities to build upon existing systems in Idaho, such as shared electronic health record platforms.

Sustainability
Ensuring the long-term sustainability of the Idaho BHT's Waiver initiatives beyond the initial funding period is crucial for achieving lasting improvements in behavioral health outcomes. Challenges may arise in securing continued funding, maintaining community support, and addressing evolving needs and priorities over time. There is public and stakeholder skepticism that the expected cost savings will materialize as a result of the waiver.

Summary
Despite challenges and barriers to the implementation of the Idaho BHT Waiver and the MCC, overall, many of the respondents were optimistic about the progress to date. Many key informants were encouraged and trying to spread their enthusiasm to all stakeholders across the state. This was expressed by one respondent,

> *"I think everybody's pretty excited about this. I think we've hyped it up pretty well. Hopefully, it meets folks' expectations.*

While all providers interviewed believed the Idaho BHT Waiver and the IBHP MCO were important and necessary to their patient population, they appeared to have the most concerns, as it impacts their day-to-day operations and patient care. However, there is hope that Magellan will understand adequate reimbursement and efficiency to minimize provider burdens. One respondent believes that the necessary adjustments can be made and noted,

> *"…[For] Providers...an MCO can be challenging. They're worried about their rates and administrative burden. Participants we know want more services—better access to services. We'll hopefully adjust that."*

Despite the continued barriers, it does appear that progress has been made and the Idaho BHT Waiver has already had an impact on patients. Specific successes include the implementation of the ASAM levels of care; right-sizing care; reducing burden to acute care hospitals; expansion of case management services; and more consistent, stable spending for the state. This was expressed by a respondent,

> *"Yeah. I still think we're having a huge impact by being able to treat participants in an IMD setting. It's the appropriate care. It's less costly to them than an acute care hospital. We're bringing up those additional services, everything that was established in post-authorization set in 3.5, and 3.7 in the community. We've been able to expand said services, case management services that it's really—I've seen the investment in the financial sense, that behavioral health continuing in Idaho…I think that it's had a large impact…"*

Looking into the future, there is a significant amount of potential for the Idaho BHT Waiver and excitement about the new IBHP MCO,

> *"…but I think that there's still a lot of opportunity or things needed to improve. We're pretty excited about this new contract. I think that having one entity really in charge of inpatient, outpatient, and other public funding is going to be a resource… where we could help folks access the care they need to get back on their feet when insurance is not helping. I'm very excited about getting that contract up, and hopefully, we don't hit any delays because it's already been a long procurement process, but we're at the tail end of it".*

Chapter 4: Conclusions, Interpretations, and Recommendations

Summary of Findings and Evaluation of State Capacity to Provide SUD and SMI/SED Services

SUD Utilization

We generally observed increases in SUD care utilization by DY3 for the Medicaid population eligible prior to expansion. This included outpatient care, intensive outpatient care, inpatient care, and MAT. Some declines in DY1 and DY2 we believe may be due to the COVID-19 pandemic. We also observed a decline in IMD length of stay. The area of concern was continuity of pharmacotherapy (i.e. at least 180 days of continuous OUD treatment) which declined dramatically. Our hope is that this partially represents an increase in the overall number of patients with OUD being reached and that this can convert to great continuity over time. Overall, we believe these are promising outcomes.

Our analytic approach also highlights important analytic limitations that are important to account for in future analyses as well. First, given the short time between Medicaid expansion and the start of the Waiver implementation (approximately one quarter of 2020) we do not believe it is possible to provide an accurate evaluation of the impact of the Waiver on the Medicaid expansion population. If the Medicaid expansion population enrolled in that time period were more representative of the overall Medicaid expansion population, this would not be as big of an issue. However, the early enrollees due to Medicaid expansion appear to have greater health needs. Additionally, the changing definition of SUD and SMI/SED over time must also be accounted for to get correct estimates.

SMI/SED Utilization

We also observed promising increases in any behavioral health care, largely due to increases in inpatient, intensive outpatient/partial hospitalization, and telehealth care. Notably, we also observed declines in outpatient rehabilitation services and ED services; and a slight uptick in IMD length of stay. Overall, we believe the increase in utilization is promising but overall, still warrants monitoring to ensure patients have access to necessary care. Similar to SUD care, we believe the same analytic issues mean we can only provide accurate estimates for the population eligible for care prior to Medicaid expansion.

Providers

We observed promising increases in SUD providers enrolled in Medicaid and qualified to treat SUD as well as those able to prescribe MAT. On the SMI/SED side, we observed promising increases in providers of intensive outpatient behavioral health services, residential mental health facilities and beds, non-psychiatrist providers (although there was a drop in those enrolled with Medicaid between DY1 to DY3).
The increase in community mental health centers since baseline is positive although worth monitoring the slight decline since DY1. Largely maintaining FQHCs offering behavioral health care and crisis service centers (including crisis call centers and mobile crisis units) is good but increases in demand highlight the importance of maintaining and possibly increasing the availability of these service sites.

Important areas to watch are the decline in sites that can provide MAT. We also observed drops in the number of psychiatrists both overall and those enrolled in Medicaid, psychiatric residential treatment facilities, the loss of one IMD, and a drop in Medicaid-enrolled licensed psychiatric hospital beds.

Care Coordination

Care coordination appears strong for OUD with increases in both treatment initiation and engagement. Above we noted some concerns about longer term continuation but overall, we see promising improvements in OUD treatment engagement relative to baseline.

Declines in alcohol and other SUD treatment engagement relative to baseline are worth examining, especially in the face of declines in some types of providers. Follow-up for SUD patients visiting the ED for a mental illness-related visit also declined and it is worth exploring how to improve this type of follow-up. This is especially important as this complex set of patients (co-occuring SUD and mental illness) are particularly high risk for adverse health outcomes.

Opioid prescribing
We observed large declines in high-risk opioid prescribing. While this is certainly promising, we believe it is likely a combination of Waiver efforts as well as broader national provider patterns to reduce risky opioid prescribing.

Budget
Idaho is still on track to achieve substantial per enrollee savings relative to a counterfactual of no Waiver according to the agreed upon methodology for estimating savings. We have little concern they will not achieve savings by the end of the Waiver demonstration. We do believe that some part of these savings is likely due to the approach basing per capita spending in the pre-expansion period where enrollees are likely higher cost.

Recommendations

Managed Care Contract
One of the primary Waiver implementation tasks to date has been the new managed care contract. While there have been a variety of delays, largely due to litigation hurdles, the MCC is now being implemented albeit outside the full scope of this report (i.e. implementation is beginning in July 2024 which is after the end of scope for this report which was March of 2023). This has been a significant undertaking and represents a potentially major shift in care coordination. Specifically, the new contract will include both outpatient and inpatient care within the contract with the goal of further incentivizing patients to receive care at the most appropriate level of care.

With such a major change in contracting, there are also a number of implementation hurdles in order to ensure providers remain Medicaid enrolled and taking patients, patients care is well coordinated, and monitoring to ensure that managed care is not leading to any access issues.

Overdose and suicide mortality
We observed concerning increases in overdose mortality rates for Medicaid beneficiaries with SUD (non-expansion and static definition sample). While this is similar to national increases in overdose mortality due to synthetic opioids such as fentanyl, we believe it is an important area to continue to monitor. In addition to treatment, harm reduction efforts (which were outside the scope of analysis plan so we do not have data available) may be important. Similarly, the increase in the suicide rate will be important to address.

Provider availability/ Rural and frontier care
Idaho has made promising progress in increasing or maintaining provider availability in the face of national trends of a behavioral health care workforce shortage. More recent drops in community mental health centers, psychiatrists (especially those enrolled in Medicaid), psychiatric residential treatment facilities, the loss of one IMD, and a drop in Medicaid-enrolled licensed psychiatric hospital beds are all important to watch.

Ensuring adequate providers who are enrolled in Medicaid is important, is especially in the face of a new MCC. As Medicaid reimbursement rates tend to be lower than many other payers' rates this will be an important area to continue to monitor as MCC rollout continues. Making sure managed care is operating in a way that does not harm access or availability of providers is critical.

Provider availability issues are also particularly acute in rural and frontier areas.

Care coordination
Care coordination remains an area of important attention, particularly for alcohol and other SUD treatment engagement as well as post-ED discharge mental illness visits for SUD patients. Further, continuing to monitor coordination for SMI/SED is important especially as we observed a slight increase in IMD LOS for SMI/SED, which on its own may be fine if patients are getting necessary care. But may also reflect a lack of care availability outside of IMD, something mentioned in key stakeholder interviews. We also lacked data on co-located behavioral and physical health care and mortality data.

Expansion to ages 18-21
In interviews, IDHW has mentioned the possibility of expanding the Waiver to adults ages 18-21 who are likely to also benefit from the Waiver activities, especially due to need and in terms of access to care. In addition, interviews noted ensuring access to and coordination of care for minors within the Medicaid program. While adolescents were outside the scope of the Waiver, we note that many will become adults with SUD and/or SMI/SED health needs within Medicaid. In addition, from an overall Medicaid perspective adolescents are a high need population often impacted by changes to the overall behavioral landscape that occurs due to the Waiver.

Data
The IHDE bankruptcy is an important issue related to ensuring sufficient data sharing capability to providers. Admittedly, IHDE faced a number of issues related to data sharing prior to bankruptcy. In the meantime, efforts to coordinate data are critical to ensuring patient care is well coordinated. While the MCC may provide some avenues to data sharing, figuring out a consistent, quality approach to provider data sharing (whether formal or informal) is an important area to address.

Additionally, we are still missing data on a few key outcomes such as care from co-located physical and behavioral health providers as well as availability of virtual visits. Some of this stems from issues that data needed for the evaluation may be quite different from data needed to operate the Waiver from the perspective of IDHW and Medicaid programs.

Housing/IMD care
One item brought up in multiple key stakeholder interviews was the issue of lack of housing intersecting with the complex needs of SUD and SMI/SED patients. Lack of housing can mean patients are not able to be released from IMD or inpatient care which further strains these providers as well as further limits access to care. Lack of housing not only harms patients and access to care but also has financial strains as patients remain in expensive, high acuity care.

Unwinding
The Medicaid unwinding process after the PHE is another area to monitor. While much of this occurred outside of the scope of this report (i.e. after March 2023), this is an area to monitor. Overall, we heard that re-enrollment went smoothly according to key stakeholder interviews. However, some noted issues with re-enrollment which may be particularly acute within the high risk/high need population with SUD and/or SMI/SED. Ensuring timely re-enrollment is an important area to monitor.

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Appendices Overview

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 2

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.

Potential Participants:

Module 1: Introduction

All: Before we get started, can you please confirm that your current position is [*position title*]?
ONLY IF NOT PREVIOUSLY INTERVIEWED Can you provide a high-level overview of your role?

Module 2: Background & History of Behavioral Health in Idaho

Only if not previously interviewed
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: Implementation of the Demonstration Waiver

All: We'd like to start out by talking about the implementation of the demonstration waiver between April 2022-March 2023.	
	ALL - [Note to interviewers: details of the implementation plan will be provided with background material.] 1. At a high level, please describe your role(s) in implementing the demonstration waiver. 2. Can you describe some of the key implementation steps in the April 2022-March 2023 period? 3. From your understanding and knowledge, how closely did the implementation of the demonstration waiver align with the implementation plan?
	ALL - [Note to interviewers: details on implementation milestones will be provided with background materials.] 4. To date, what are the major milestones achieved or what has been successful in the demonstration waiver? a. What did you identify as the short-term goals? 5. Can you share with us, how the waiver is meeting expectations? a. What successes did you have in achieving the short-term goal identified [Probes for key goals below]? [Note to interviewers: details of the identified gaps in policy and standards of care will be provided with background material]

	Prior to the implementation of demonstration waiver, gaps in policy or standard of care were identified. How, if at all, did the demonstration waiver address those gaps? 6. Can you describe how the waiver has fallen short of meeting expectations? What shortfalls that have been identified [Probes for key goals below]? 7. The execution of the waiver was delayed. How, if any, will this delay affect the expectations?
	Please describe the logistics of the implementation of the demonstration waiver thus far. 1. What has been challenging as the waiver was implemented? a. Probe: Are there unique characteristics about your facility or the community that you serve that created challenges? 2. Looking forward, what challenges, if any do you anticipate your facility with face as the waiver is implemented? 3. Looking back, 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 that could have eased the challenges? 4. Looking forward, what challenges, if any, do you anticipate the Idaho Department of Health and Welfare will have related to the demonstration waiver?
	If not previously mentioned by interviewee:
	Idaho Health Data Exchange
	1. First, can you talk a little about the Idaho Health Data Exchange and its anticipated role in the waiver demonstration? 2. Realizing a little outside the timeframe, can you talk some about IHDE bankruptcy? [probe] 3. How does that impact the waiver demonstration?

	Managed Care Contract
	1. Can you share your experience with the managed care contract? a. What has the experience been like with Optum? i. Initial contract implementation? ii. What are some successes of the MCC under Optum? iii. What are some barriers faced under Optum? b. It has been a while coming but can you talk about the plans for the new managed care contract? What were the goals of the new MCC (Magellan) compared to the original one (Optum)? i. Can you talk at all about delays/issues? ii. Where does it currently stand? c. As the MCC is transitioned from Optum to Magellan, what are essential steps to implementation? i. How can Magellan support the waiver better than Optum? What excites you about Magellan? What would be early signs of success? ii. What are some concerns you have or anticipate with Magellan? Are there other barriers/concerns?
	Medicaid Eligibility
	1. Can you discuss the impact that the expansion of Medicaid Eligibility had on Idaho? 2. After the COVID-19 emergency authorization ended there were issues about re-establishing Medicaid eligibility. a. Can you talk about that process? b. Were there complications/hurdles? 3. Has the process for determining Medicaid eligibility changed?

Module 4: Impact of the Demonstration Waiver

Note to interviewers: details on the goals of the demonstration waiver sent to interviewee.

We'd like to now talk with you about the impact of the demonstration waiver.	
ALL: As think about expanding access, increasing availability and coordinating care throughout the state but especially in rural and frontier areas, can you describe the impact of waiver implementation. These could be successes or challenges?	
	What, if any, impact has the demonstration waiver had on stakeholder groups (patients/community; providers) and Idaho Department of Health and Welfare?
	What is your degree of confidence that the demonstration waiver has made or will make a meaningful difference in Idaho? Why? [Probe: give a candid reflect about the intended timeline relative to the intended impact of the demonstration waiver.]
	Do you think there is sufficient stakeholder buy-in for the demonstration waiver to be successful? Why or why not? If not, whose buy-in is missing?
	Beyond of your role, what feedback, suggestions, or advice would you like to give to those working on the demonstration waiver?
	Thinking about a broader impact of the waiver. How, if at all, could the demonstration waiver benefit other states? If a counterpart in another state was looking to replicate the demonstration waiver, what, if any, feedback, suggestions, or advice would you like to give them?

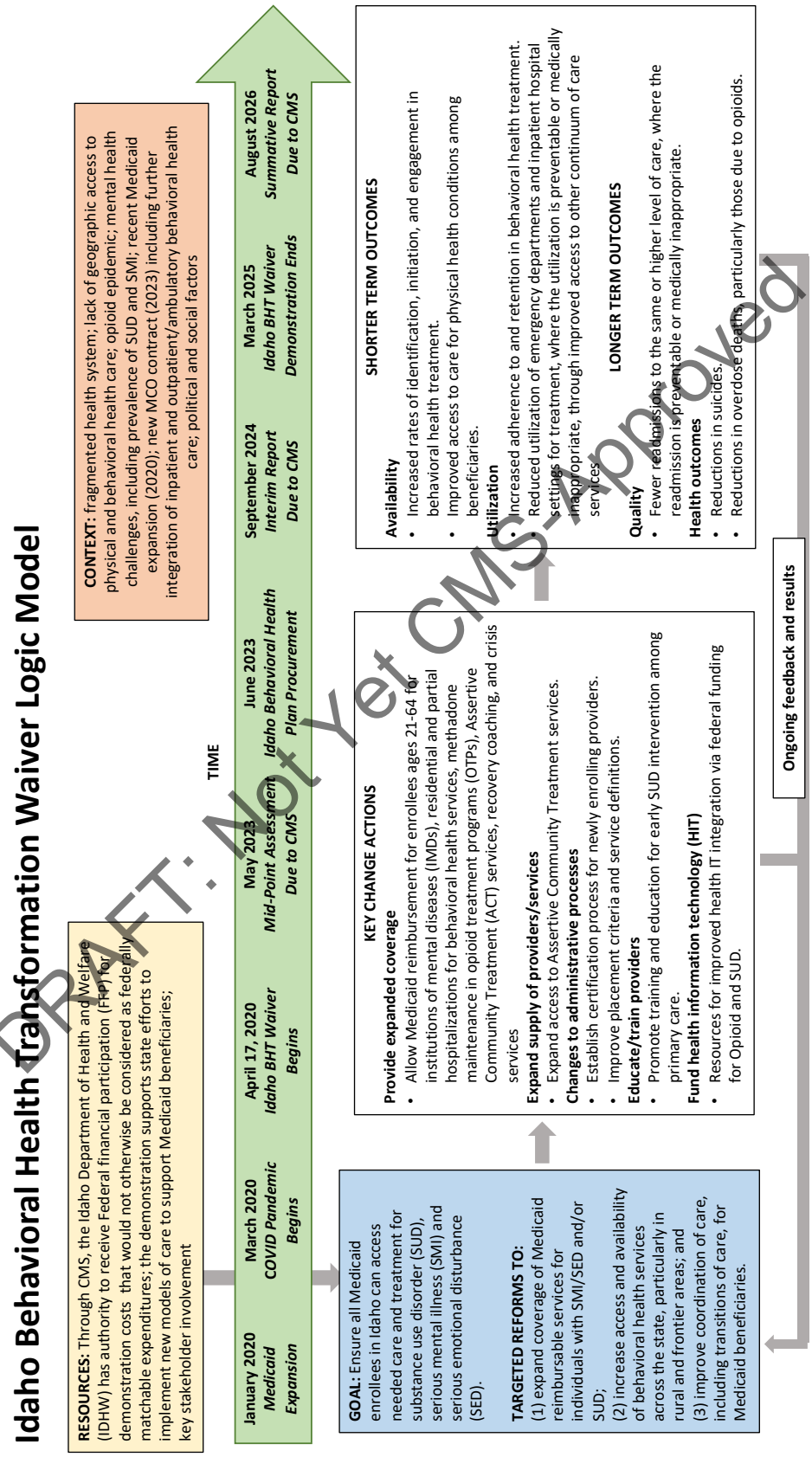
Module 5: Reflections/Wrap-Up Module

We have just a handful of questions left before we wrap-up.	
	Do you think there is anyone else that would be critical for us to interview to fully understand the development and implementation of the demonstration waiver thus far?
	Is there anything else that we did not discuss today that you feel is important for us to understand 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

Appendix C. Logic Model



Appendix D. Data Tables and Graphics

Table E.1a: Performance on SUD Milestone 1 Metrics by varying baseline and definition for Medicaid SUD population (denominator).

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Outpatient (Metric #8) [a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-21.1	-18.9	-9.3	-5.9	-36	-35.8
		DY2 (Apr. 2021-Mar. 2022)	-33.9	-24.3	-16.8	-3.3	-50.4	-44.9
		DY3 (Apr. 2022-Mar. 2023)	-35.3	-9.3	-19.3	17.2	-51.4	-34.6
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	4.3	14.4	-6	2.4	-36	-35.8
		DY2 (Apr. 2021-Mar. 2022)	-12.6	6.8	-13.8	5.3	-50.4	-44.9
		DY3 (Apr. 2022-Mar. 2023)	-14.5	28	-16.4	27.6	-51.4	-34.6
Intensive Outpatient (Metric #9) [b]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-12.8	-10.4	0.8	4.5	-34.4	-34.1
		DY2 (Apr. 2021-Mar. 2022)	-15.4	-3.5	8	25	-42.5	-36.4
		DY3 (Apr. 2022-Mar. 2023)	0.4	40.7	24.4	80.7	-32.5	-9.2
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	215.7	237.3	126.8	143.5	-34.4	-34.1
		DY2 (Apr. 2021-Mar. 2022)	206.5	263.4	142.9	191.3	-42.5	-36.4
		DY3 (Apr. 2022-Mar. 2023)	263.5	429.8	179.8	321.2	-32.5	-9.2
Inpatient (Metric #10) [c]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	2.4	5.2	38.4	43.3	-27	-26.7
		DY2 (Apr. 2021-Mar. 2022)	-48.4	-42.7	-22	-13.7	-66.6	-63.9
		DY3 (Apr. 2022-Mar. 2023)	-49.8	-29.6	-18.3	18.7	-68.8	-58
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	104.4	122.9	51.8	65.2	-27	-26.7
		DY2 (Apr. 2021-Mar. 2022)	3	21.3	-14.4	-0.5	-66.6	-63.9
		DY3 (Apr. 2022-Mar. 2023)	0.2	49.1	-10.3	36.8	-68.8	-58

MAT (Metric #12)[d]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	3.9	6.8	12	16.1	-6.5	-6.1
		DY2 (Apr. 2021-Mar. 2022)	7.2	20.8	18.4	35	-5.6	3.4
		DY3 (Apr. 2022-Mar. 2023)	-14.2	20.2	-4.5	38.6	-24.8	1.2
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	28.4	41	28.1	39.3	-6.5	-6.1
		DY2 (Apr. 2021-Mar. 2022)	32.6	59.5	35.5	62	-5.6	3.4
		DY3 (Apr. 2022-Mar. 2023)	6.1	58.7	9.2	66.3	-24.8	1.2

Note: SUD Milestone 1: Access to critical levels of care for OUD and other SUDs. Goal 1: Increased Rates of Identification, Initiation, and Engagement in Treatment for OUD and Other SUDs.
SUD: substance use disorder.
DY: Demonstration year.
Percent change= (rate of metric at demonstration period x - rate of metric at baseline)/rate of metric at baseline*100.
Rolling definition: The number of Medicaid SUD population (SUD metric #3) is extracted from the state data vendor's quarterly/annual reports, which adopt changing definitions of SUD population over time.
Static definition: The number of Medicaid SUD population is calculated by the PSU research team following the latest definition in Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 5.0).

a: Number of beneficiaries who used outpatient services for SUD during the measurement period.
b: Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD during the measurement period.
c: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.
d: Number of beneficiaries who receive MAT or SUD-related treatment services with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period.

Table E.1b: Performance on Milestone 1 Metrics (SUD #22) by expansion and non-expansion status

		Percent change %		
		Overall	Non-expansion	Expansion
Continuity of pharmacotherapy (Metric #22)[e]	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-6.7	6.7	-
	DY2 (Apr. 2021-Mar. 2022)	-54.1	-48.3	-
	DY3 (Apr. 2022-Mar. 2023)	-73.3	-68.6	-

Note: e. Percentage of adults 18 years of age and older with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment
Metrics are only reported at the calendar year (CY), so we note they do not perfectly align with the demonstration years which run from April through March.

Table E.2a: Performance on SUD Milestone 2 Metrics (SUD #5) by different definitions for Medicaid SUD population (denominator).

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Medicaid Beneficiaries Treated in an IMD for SUD[a] (SUD #5)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	636.3	666.2	541.5	570.5	212.8	208.7
		DY2 (Apr. 2021-Mar. 2022)	124.4	228.4	156.8	289.4	-17.3	12.6
		DY3 (Apr. 2022-Mar. 2023)	182.6	309.2	223.3	386.6	3.1	38.7

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.

Rolling definition: The number of Medicaid SUD population (SUD metric #4) is extracted from the state data vendor's quarterly/annual reports, which adopt changing definitions of SUD population over time.
Static definition: The number of Medicaid SUD population is calculated by the PSU research team following the latest definition in Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 5.0).

a: SUD Metric #5, Number of beneficiaries who were treated in an IMD for SUD during the measurement period.

Table E.2b: Performance on Milestone 2 Metrics (SUD #36) by expansion and non-expansion status

		Percent change %		
		Overall	Non-expansion	Expansion
Average Length of Stay for SUD in IMD[b] (SUD #36)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-3.3	-25.3	49.1
	DY2 (Apr. 2021-Mar. 2022)	-40.2	-34.1	-19.4
	DY3 (Apr. 2022-Mar. 2023)	-37.3	-23.9	-18.3

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

Table E.3: Performance on Milestone 4 Metrics

			Value	Absolute change	Percent change %
Number of providers enrolled in Medicaid qualified to treat SUD provider[2a] (SUD #13)		Baseline (2018-2019)	1,620	-	-
		DY1 (Apr. 2020-Mar. 2021)	2,978	1,358	83%
		DY2 (Apr. 2021-Mar. 2022)	2,836	1,216	75.1%
		DY3 (Apr. 2022-Mar. 2023)	3,122	1,502	92.7%
Number of providers enrolled in Medicaid and able to prescribe MAT [2b] (SUD #14)		Baseline (2018-2019)	204	-	-
		DY1 (Apr. 2020-Mar. 2021)	435	231	113.21%
		DY2 (Apr. 2021-Mar. 2022)	606	402	197.1%
		DY3 (Apr. 2022-Mar. 2023)	706	502	246.1%
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	-	-
		DY3 (Apr. 2022-Mar. 2023)	3	-	-
Number of sites that provide methadone[1d]		Baseline (Jan.-Mar. 2020)	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	ND	-	-
		DY2 (Apr. 2021-Mar. 2022)	3	-	-
		DY3 (Apr. 2022-Mar. 2023)	3	-	-
Number of community mental health centers[1e]	Baseline (Jan. 2020-Mar. 2020)	Baseline	207	-	-
		DY1 (Apr. 2020-Mar. 2021)	250	43	20.9
		DY2 (Apr. 2021-Mar. 2022)	243	36	17.2
		DY3 (Apr. 2022-Mar. 2023)	224	18	8.5
	Baseline (Apr. 2018-Mar. 2020)	Baseline	215	-	-
		DY1 (Apr. 2020-Mar. 2021)	250	35	16.4
		DY2 (Apr. 2021-Mar. 2022)	243	28	12.8
		DY3 (Apr. 2022-Mar. 2023)	224	10	4.4
Patient satisfaction[1f] (MCO survey)	Baseline (Jan. 2020-Mar. 2020)	Baseline	85.1	-	-
		DY1 (Apr. 2020-Mar. 2021)	90	4.9	5.8
		DY2 (Apr. 2021-Mar. 2022)	94.3	9.2	10.8
		DY3 (Apr. 2022-Mar. 2023)	94	8.9	10.5
	Baseline (Apr. 2018-Mar. 2020)	Baseline	94.8	-	-
		DY1 (Apr. 2020-Mar. 2021)	90	-4.7	-5
		DY2 (Apr. 2021-Mar. 2022)	94.3	-0.4	-0.5
		DY3 (Apr. 2022-Mar. 2023)	94	-0.8	-0.8

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

Table E.4a: Performance on Milestone 5 Metrics by expansion and non-expansion status

		Percent change %		
		Overall	Non-expansion	Expansion
Percent of adults prescribed opioids at high dosage[1a] (SUD #18)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-30.3	-10.4	-
	DY2 (Apr. 2021-Mar. 2022)	-37.2	-11.6	-
	DY3 (Apr. 2022-Mar. 2023)	-40.8	-14.6	-
Percent of adults with opioid prescriptions from multiple providers[1b] (SUD #19)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-60.7	-57.9	-
	DY2 (Apr. 2021-Mar. 2022)	-57	-70.3	-
	DY3 (Apr. 2022-Mar. 2023)	-56.4	-62.6	-
Percent of adults with high dosage opioids prescriptions or from multiple providers[1c] (SUD #20)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-65.9	-44.4	-
	DY2 (Apr. 2021-Mar. 2022)	-100	-100	-
	DY3 (Apr. 2022-Mar. 2023)	-100	-100	-
Percent of adults with concurrent prescription of opioids and benzodiazepines[1d,e] (SUD #21)	Baseline (2018-2019)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-31.4	-20.3	-
	DY2 (Apr. 2021-Mar. 2022)	-25.3	-11.5	-
	DY3 (Apr. 2022-Mar. 2023)	-26.3	-12.9	-

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: Metrics are only reported at the calendar year (CY), so we note they do not perfectly align with the demonstration years which run from April through March.

Table E.4b: Performance on SUD Milestone 5 Metrics by different baselines and different definitions for Medicaid SUD population (denominator).

Metric		Period	Percent Change					
			Overall		Non-expansion		Expansion	
			Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
D visits for SUD[2e] Metric #23)	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-19.4	-17.1	-0.1	3.6	-38.3	-38
		DY2 (Apr. 2021-Mar. 2022)	-23.6	-11.7	9.7	28.2	-47.3	-40.7
		DY3 (Apr. 2022-Mar. 2023)	-17.7	15.4	17.3	70.4	-42.9	-23.1
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	3.4	13.5	-4.1	4.4	-38.3	-38
		DY2 (Apr. 2021-Mar. 2022)	-2	21	5.2	29.2	-47.3	-40.7
		DY3 (Apr. 2022-Mar. 2023)	5.6	58.1	12.5	71.7	-42.9	-23.1
Overdose death for SUD[2f] (SUD #27)	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-21.9	-19.8	24.7	29.3	-48.7	-48.5
		DY2 (Apr. 2021-Mar. 2022)	-28.3	-19.8	17.1	30.6	-54.6	-50.2
		DY3 (Apr. 2022-Mar. 2023)	-37.5	-12.4	9	58.4	-61.8	-48.7
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-11.3	-2.8	-1	7.8	-48.7	-48.5
		DY2 (Apr. 2021-Mar. 2022)	-18.6	-2.8	-7	8.9	-54.6	-50.2
		DY3 (Apr. 2022-Mar. 2023)	-29.1	6.2	-13.4	32.1	-61.8	-48.7

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.

e: Number of ED visits for SUD during the measurement period.
f: Rate of overdose deaths (number of deaths per 100,000 Medicaid beneficiaries with SUD) for SUD during the measurement period.

Table E.5a: 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	8.6	21.5
	DY2 (Apr. 2021-Mar. 2022)	43	3.1	7.8
	DY3 (Apr. 2022-Mar. 2023)	40.5	0.6	1.4
IET-AD Alcohol Engagement[b] (SUD #15)	Baseline (2018-2019)	18.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	25.5	6.8	36.2
	DY2 (Apr. 2021-Mar. 2022)	14	-4.7	-25.3
	DY3 (Apr. 2022-Mar. 2023)	14.4	-4.3	-22.9
IET-AD Opioid Initiation[c] (SUD #15)	Baseline (2018-2019)	46.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	57.2	10.5	22.6
	DY2 (Apr. 2021-Mar. 2022)	50	3.3	7.2
	DY3 (Apr. 2022-Mar. 2023)	59.3	12.6	27.1
IET-AD Opioid Engagement [d] (SUD #15)	Baseline (2018-2019)	23.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	32.6	8.8	37.1
	DY2 (Apr. 2021-Mar. 2022)	28	4.3	17.9
	DY3 (Apr. 2022-Mar. 2023)	35.2	11.5	48.3
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	-1.3	-2.8
	DY3 (Apr. 2022-Mar. 2023)	44.5	-1.7	-3.8
IET-AD Other Engagement[f] (SUD #15)	Baseline (2018-2019)	29	-	-
	DY1 (Apr. 2020-Mar. 2021)	34.2	5.2	17.9
	DY2 (Apr. 2021-Mar. 2022)	18	-11	-38
	DY3 (Apr. 2022-Mar. 2023)	19.3	-9.7	-33.6
IET-AD Total Initiation[g] (SUD #15)	Baseline (2018-2019)	44.3	-	-
	DY1 (Apr. 2020-Mar. 2021)	52.1	7.7	17.4
	DY2 (Apr. 2021-Mar. 2022)	44	-0.3	-0.7
	DY3 (Apr. 2022-Mar. 2023)	45.2	0.9	2
IET-AD Total Engagement[h] (SUD #15)	Baseline (2018-2019)	24.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	31	6.2	25.1
	DY2 (Apr. 2021-Mar. 2022)	19	-5.7	-23.2
	DY3 (Apr. 2022-Mar. 2023)	19.8	-4.9	-19.9
	Baseline (2018-2019)	27.5	-	-

7-day follow-up after SUD emergency department visits[i] (SUD #17(1))	DY1 (Apr. 2020-Mar. 2021)	32.5	5	18.3
	DY2 (Apr. 2021-Mar. 2022)	31.4	3.9	14.2
	DY3 (Apr. 2022-Mar. 2023)	29.1	1.6	6
30-day follow-up after SUD emergency department visits[j] (SUD #17(1))	Baseline (2018-2019)	33.9	-	-
	DY1 (Apr. 2020-Mar. 2021)	40.9	7.1	20.9
	DY2 (Apr. 2021-Mar. 2022	39.2	5.4	15.9
	DY3 (Apr. 2022-Mar. 2023)	43.6	9.7	28.7
7-day follow-up after mental illness emergency department visits[k] (SUD #17(2))	Baseline (2018-2019)	61.9	-	-
	DY1 (Apr. 2020-Mar. 2021)	59.4	-2.5	-4.1
	DY2 (Apr. 2021-Mar. 2022	62.6	0.7	1.1
	DY3 (Apr. 2022-Mar. 2023)	37.1	-24.8	-40
30-day follow-up after mental illness emergency department visits[l] (SUD #17(2))	Baseline (2018-2019)	77	-	-
	DY1 (Apr. 2020-Mar. 2021)	72.4	-4.6	-6
	DY2 (Apr. 2021-Mar. 2022)	74.6	-2.4	-3.1
	DY3 (Apr. 2022-Mar. 2023)	55.4	-21.6	-28

Table E.5b Performance on SUD Milestone 6 Metrics by expansion and non-expansion status

			Percent Change		
			Overall	Non-expansion	Expansion
Metric		Period			
Readmissions among beneficiaries with SUD[m*] (SUD #25) [a]	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	3.6	0.8	62.2
		DY2 (Apr. 2021-Mar. 2022)	-6.7	-6.4	42.9
		DY3 (Apr. 2022-Mar. 2023)	-15.1	-7.6	22.7

Note: SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care.
Annual data
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.
Metrics are only reported at the calendar year (CY) so we note they do not perfectly align with the demonstration years which run from April through March

Table E.6: Performance on Milestone 1 Metrics by different baselines and different definitions for Medicaid SMI/SED population (denominator)

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Utilization of behavioral health treatment services (SMI #18) [a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-13.7	-9.9	-9.3	-5.3	-24.8	-14.5
		DY2 (Apr. 2021-Mar. 2022)	-25.6	-9.9	-17.6	-2	-39.6	-16.6
		DY3 (Apr. 2022-Mar. 2023)	-31.7	-4.7	-21.9	4.1	-46.4	-10.3
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-15.8	-12.6	-11.2	-6.4	-24.8	-14.5
		DY2 (Apr. 2021-Mar. 2022)	-27.3	-12.7	-19.4	-3.1	-39.6	-16.6
		DY3 (Apr. 2022-Mar. 2023)	-33.4	-7.6	-23.6	2.8	-46.4	-10.3

Note: SMI/SED Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.
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.
Rolling definition: The number of Medicaid SMI/SED population (SMI/SED metric #4) is extracted from the state data vendor's quarterly/ annual reports, which adopt changing definitions of SMI/SED population over time.
Static definition: The number of Medicaid SMI/SED population is calculated by the PSU research team following the latest definition in Medicaid Section 1115 Serious Mental Illness and Serious Emotion Disturbance Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 4.0).
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.

Table E.7: Performance on Milestone 2 Metrics by expansion and non-expansion status

		Percent Change		
		Overall	Non-expansion	Expansion
Metric	Period			
30-day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) (SMI #4)	Baseline (Apr. 2018-Mar. 2020)	-	-	-
	DY1 (Apr. 2020-Mar. 2021)	-6.5	1.8	-
	DY2 (Apr. 2021-Mar. 2022)	-7.6	6.8	-
	DY3 (Apr. 2022-Mar. 2023)	-3.3	5.8	-

Note: SMI/SED Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care.
Annual data.
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.
Metrics are only reported at the calendar year (CY) so we note they do not perfectly align with the demonstration years which run from April through March

Results (Table E.8)

Table E.8a: Performance on Milestone 3 Metrics by different baselines and different definitions for Medicaid SMI/SED population (denominator)

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Mental Health Services Utilization – Inpatient (SMI #13)[a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	4.8	9.5	5.9	10.5	-28.7	-19.2
		DY2 (Apr. 2021-Mar. 2022)	-11.5	7.1	-0.8	18	-55	-38
		DY3 (Apr. 2022-Mar. 2023)	-20.8	10.6	-6.7	24.4	-63.2	-38.3
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	28.3	33.2	12.1	18.2	-28.7	-19.2
		DY2 (Apr. 2021-Mar. 2022)	8.4	30.2	5.1	26.2	-55	-38
		DY3 (Apr. 2022-Mar. 2023)	-3	34.5	-1.2	33.1	-63.2	-38.3

Mental health Services Utilization – Intensive Outpatient and Partial Hospitalization (SMI #14) [b]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	3.5	8.4	6	10.9	-27.2	-17.1
		DY2 (Apr. 2021-Mar. 2022)	15	39.6	38.6	65.1	-45.7	-24.5
		DY3 (Apr. 2022-Mar. 2023)	20.6	68.3	46.4	94.9	-42.6	-3.9
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	40.5	46.2	30.1	37.5	-27.2	-17.1
		DY2 (Apr. 2021-Mar. 2022)	56.2	88.3	70.2	104.7	-45.7	-24.5
		DY3 (Apr. 2022-Mar. 2023)	63.8	127	79.7	141.7	-42.6	-3.9
Number of beneficiaries who used outpatient rehabilitation services related to SMI/SED (SMI #15) [c]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-39	-36.3	-34.3	-31.5	-48.7	-41.8
		DY2 (Apr. 2021-Mar. 2022)	-40.8	-28.3	-32.7	-20	-52.5	-34.4
		DY3 (Apr. 2022-Mar. 2023)	-44.1	-21.9	-34.6	-12.8	-55.7	-25.8
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-42.1	-39.9	-36.9	-33.4	-48.7	-41.8
		DY2 (Apr. 2021-Mar. 2022)	-43.8	-32.4	-35.4	-22.3	-52.5	-34.4
		DY3 (Apr. 2022-Mar. 2023)	-46.9	-26.3	-37.1	-15.3	-55.7	-25.8
Mental Health Services Utilization – ED (SMI #16)[d]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-37.5	-34.6	-30.1	-26.8	-56.8	-51
		DY2 (Apr. 2021-Mar. 2022)	-42.9	-30.1	-29.8	-15.5	-67.7	-55.5
		DY3 (Apr. 2022-Mar. 2023)	-44.7	-22.7	-28.1	-4.2	-71.6	-52.5

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
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.
Rolling definition: The number of Medicaid SMI/SED population (SMI/SED metric #4) is extracted from the state data vendor's quarterly/ annual reports, which adopt changing definitions of SMI/SED population over time.
Static definition: The number of Medicaid SMI/SED population is calculated by the PSU research team following the latest definition in Medicaid Section 1115 Serious Mental Illness and Serious Emotion Disturbance Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 4.0).
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 who used outpatient rehabilitation services related to SMI/SED.
d: Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.
e: Number of beneficiaries in the demonstration population who use telehealth services for mental health during the measurement period.
*Not used for answering research questions but present here as a critical metric listed by CMS to be included in the report.

Table E.8b: Performance on Milestone 3 Metrics

Metric		Period	Value	Absolute change	Percent change %
Crisis service utilization[a]	Baseline (Jan.-Mar. 2020)	Baseline	203	-	-
		DY1 (Apr. 2020-Mar. 2021)	166	-36	-18
		DY2 (Apr. 2021-Mar. 2022)	141	-62	-30.5
		DY3 (Apr. 2022-Mar. 2023)	169	-34	-16.7
	Baseline (Apr. 2018-Mar. 2020)	Baseline	114	-	-
		DY1 (Apr. 2020-Mar. 2021)	166	53	46.2
		DY2 (Apr. 2021-Mar. 2022)	141	27	23.8
		DY3 (Apr. 2022-Mar. 2023)	169	55	48.4

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
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.
a: Number of beneficiaries in the demonstration population who use inpatient services related to mental health.
b: 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.

Table E.8c: Performance on Milestone 3 Metrics by expansion and non-expansion status

Metric		Period	Overall	Non-expansion	Expansion
Average Length of Stay in IMDs [b] * (SMI #19a short stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	7.8	8.5	7.2
		DY2 (Apr. 2021-Mar. 2022)	8.5	9.5	7.8
		DY3 (Apr. 2022-Mar. 2023)	9.1	9.4	8.9
Average Length of Stay in IMDs [b] * (SMI #19a long stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	67	67	NA
		DY2 (Apr. 2021-Mar. 2022)	77.8	72	86.5
		DY3 (Apr. 2022-Mar. 2023)	84.3	79.8	88
Average Length of Stay in IMDs [b] * (SMI #19a total stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	7.8	8.6	7.2
		DY2 (Apr. 2021-Mar. 2022)	8.7	9.8	7.9
		DY3 (Apr. 2022-Mar. 2023)	9.5	9.9	9.3

Note: Average Length of Stay in IMDs is calculated based on individuals aged 21 to 65 years

Table E.9a: Performance on Milestone 4 Metrics

		Count	Absolute change	Percent change %
Availability of community-based 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%
	DY3 (Apr. 2022-Mar. 2023)	224	18	8.5%-
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
	DY3 (Apr. 2022-Mar. 2023)-	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
	DY3 (Apr. 2022-Mar. 2023)	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)	32	0	0
	DY3 (Apr. 2021-Mar. 2022)	32	0	0
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)	47	1	2.2%
	DY3 (Apr. 2022-Mar. 2023)	48	2	4.3%

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

Table E.9b: Performance on Milestone 3 Metrics (suicide rates by Medicaid SMI population)

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Suicide rates	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	34.4	41	63	71.3	-37.5	-29
		DY2 (Apr. 2021-Mar. 2022)	-16.6	-1.8	29.8	50.4	-74.2	-65.5
		DY3 (Apr. 2022-Mar. 2023)	2.5	43.2	20	59.7	-65.8	-42.7
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	125.7	135.1	28.6	36.5	-37.5	-29
		DY2 (Apr. 2021-Mar. 2022)	40.1	63.7	2.5	19.9	-74.2	-65.5
		DY3 (Apr. 2022-Mar. 2023)	72.2	138.7	-5.2	27.3	-65.8	-42.7

Note: SMI Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
Rate of suicidal deaths (number of deaths per 100,000 Medicaid beneficiaries with SMI) during the measurement period.

Table E.9c: Performance on Milestone 3 Metrics (suicide rates by Medicaid population)

			Percent Change		
			Overall	Non-expansion	Expansion
Metric		Period			
Suicide rates	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	37.3	57.1	24.3
		DY2 (Apr. 2021-Mar. 2022)	-12.3	27.6	-32.9
		DY3 (Apr. 2022-Mar. 2023)	13.1	25.3	0.2
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	44.6	28.3	24.3
		DY2 (Apr. 2021-Mar. 2022)	-7.6	4.2	-32.9
		DY3 (Apr. 2022-Mar. 2023)	19.1	2.3	0.2

Note: SMI Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
Rate of suicidal deaths (number of deaths per 100,000 Medicaid beneficiaries) during the measurement period.

Table E.10: Performance on Milestone 4 Metrics

		Count	Absolute change	Percent change %
The number of enrollees receiving care from co-located physical and behavioral health facilities (FQHC colocation report)	Baseline (Jan.-Mar. 2020)	ND	ND	ND
	DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND
	DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND
	DY3 (Apr. 2022-Mar. 2023)-	ND	ND	ND

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.

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

Expenditure		DY1	DY2	DY3	DY4	DY5
FFS-SMI/SED	Total	$21,097,040	$23,146,408	$23,931,828	$27,483,390	$31,561,616
	PMPM	$8,590.00	$8,968.00	$9,363.00	$9,775.00	$10,205.00
	Member-Months	2,456	2,581	2,556	2,812	3,093
FFS-SUD	Total	$4,718,965	$1,690,355	$2,748,294	$3,155,981	$3,624,366
	PMPM	$6,889.00	$7,193.00	$7,509.00	$7,839.00	$8,184.00
	Member Months	685	235	366	403	443

Source: Idaho Behavioral Health Transformation Year 3 Quarter 4 Budget Report.

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

Expenditure		DY1	DY2	DY3	DY4	DY5
FFS-SMI/SED	Total	$13,195,433	$14,980,110	$15,488,732	$27,483,390	$31,561,616
FFS-SUD	Total	$3,194,506	$556,420	$942,281	$3,155,981	$3,624,366

Source: Idaho Behavioral Health Transformation Year 3 Quarter 4 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)	$25,816,005	$50,652,768	$77,332,890	$107,972,261	$143,158,243
Allowed Cumulative Variance (= CTP X CBNL)	$516,320	$759,792	$773,329	$539,861	$-
Actual Cumulative Variance (Positive = Overspending)	$(9,426,066)	$(18,726,299)	$(28,975,409)	$(28,975,409)	$(28,975,409)

Source: Idaho Behavioral Health Transformation Year 3 Quarter 4 Budget Report.

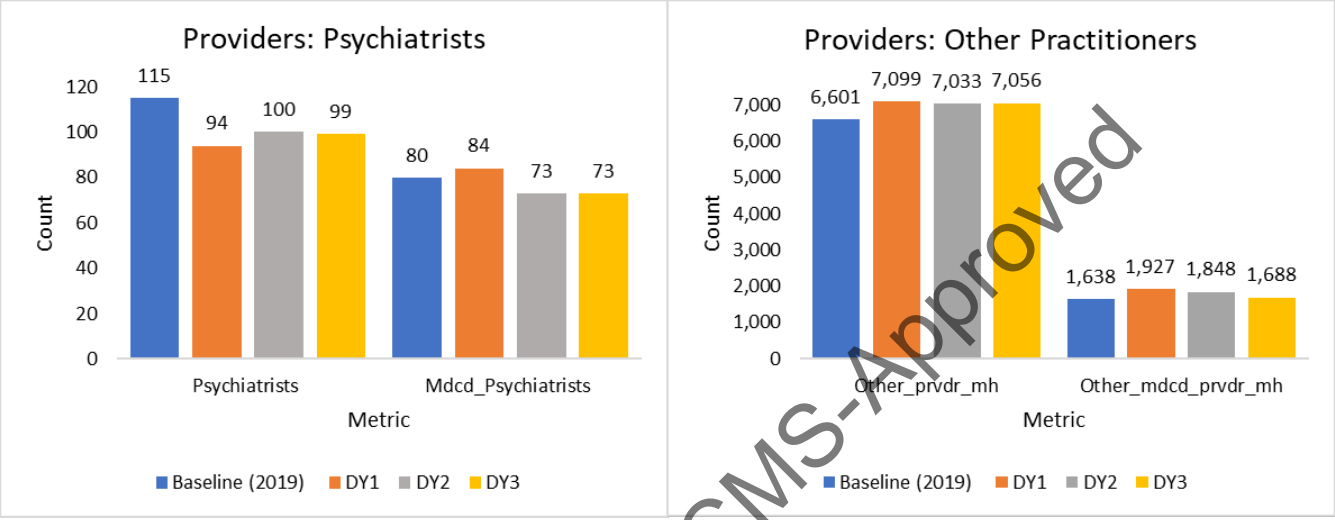
Table E.12: Availability of Practitioners

			Value	*Absolute change*	*Percent change*
Practitioners	*Psychiatrists*[a]	Baseline (2019)	115	-	-
		DY1	94	-21	-18.3%
		DY2	100	-15	-13.0%
		DY3	99	-16	-13.9%
	Medicaid enrolled psychiatrists[b]	Baseline (2019)	80	-	-
		DY1	84	4	5.0%
		DY2	73	-7	-8.8%
		DY3	73	-7	-8.8%
	Other practitioners for treating mental illness[c]	Baseline (2019)	6,601	-	-
		DY1	7,099	498	7.5%
		DY2	7033	432	6.5%
		DY3	7506	905	13.7%
	Medicaid enrolled other practitioners for treating mental illness[d]	Baseline (2019)	1,638	-	-
		DY1	1,927	289	17.6%
		DY2	1848	210	12.8%
		DY3	1688	50	3.1%

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.12a Availability of Practitioners



Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. Psychiatrists: Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications, Mdcd_psychiatrists: Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications, Other_prvdr_mh: Other Practitioners Certified or Licensed to Independently Treat Mental Illness, Other_mdcd_prvdr_mh: Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness.

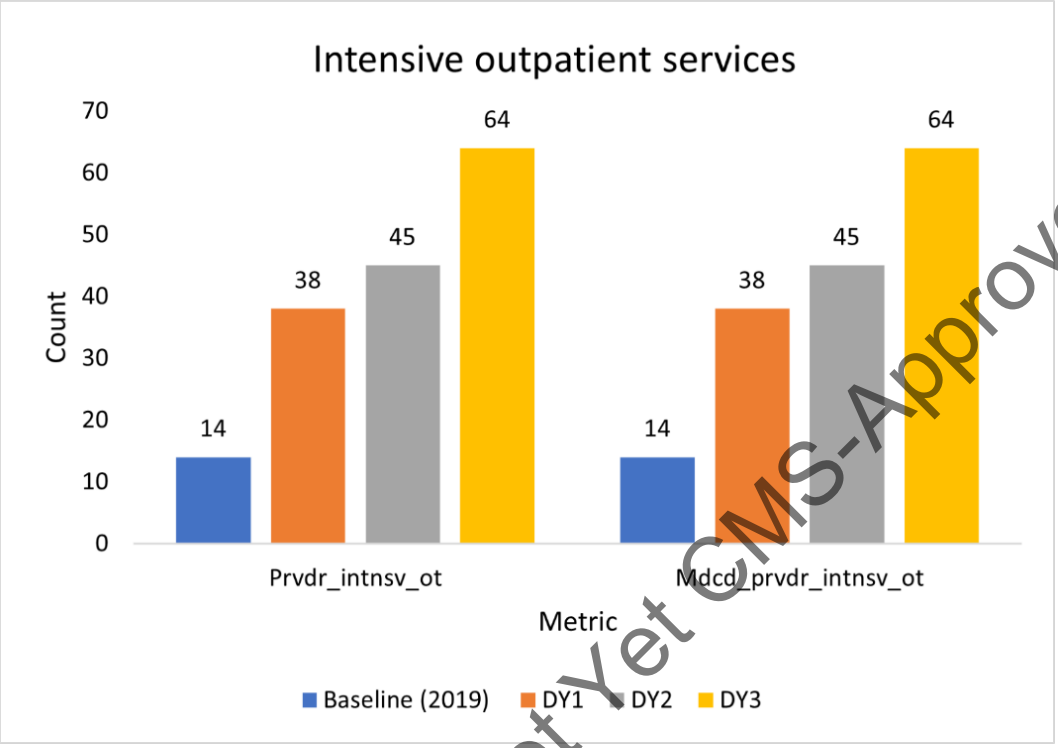
Table E.13: Availability of Intensive Outpatient Services

			Value	*Absolute change*	*Percent change*
Intensive outpatient services	*Providers offering intensive outpatient services*[a]	Baseline (2019)	14	-	-
		DY1	38	24	171.4%
		DY2	45	31	221.4%
		DY3	64	50	357.1%
	Medicaid-enrolled providers offering intensive outpatient services[b]	Baseline (2019)	14	-	-
		DY1	38	24	171.4%
		DY2	45	31	221.4%
		DY3	64	50	357.1%

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 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.13 Availability of Intensive Outpatient Services



Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr.2021, DY3: Yr. 2022. Prvdr_intnsv_ot: Providers Offering Intensive Outpatient Services, Mdcd_prvdr_intnsv_ot: Medicaid-Enrolled Providers Offering Intensive Outpatient Services.

Table E.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
		DY2	4	0	0
		DY3	12	8	200%
	Medicaid-enrolled residential mental health treatment facilities (Adult)[b]	Baseline (2019)	4	-	-
		DY1	4	0	0
		DY2	4	0	0
		DY3	12	8	200%
	Residential mental health treatment facility beds (Adult)[c]	Baseline (2019)	56	-	-
		DY1	56	0	0
		DY2	56	0	0
		DY3	170	114	203.6%
	Medicaid-enrolled residential mental health treatment beds (Adult)[d]	Baseline (2019)	56	-	-
		DY1	56	0	0
		DY2	56	0	0
		DY3	170	114	203.6%
Psychiatric residential treatment facilities	*Psychiatric residential treatment facilities (PRTF)*[e]	Baseline (2019)	1	-	-
		DY1	1	0	0
		DY2	0	-1	-100%
		DY3	0	-1	-100%
	Medicaid-enrolled PRTFs[f]	Baseline (2019)	1	-	-
		DY1	1	0	0
		DY2	0	-1	-100%
		DY3	0	-1	-100%
	PRTF beds[g]	Baseline (2019)	12	-	-
		DY1	12	0	0
		DY2	0	-12	-100%
		DY3	0	-12	-100%
	Medicaid-enrolled PRTF beds[h]	Baseline (2019)	12	-	-
		DY1	12	0	0
		DY2	0	-12	-100%
		DY3	0	-12	-100%

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
		DY2	0	0	0
		DY3	0	0	0
	Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs[b]	Baseline (2019)	0	-	-
		DY1	0	0	0
		DY2	0	0	0
		DY3	0	0	0
	Psychiatric Hospitals that Qualify as IMDs[c]	Baseline (2019)	4	-	-
		DY1	3	-1	-25%
		DY2	3	-1	-25%
		DY3	3	-1	-25%

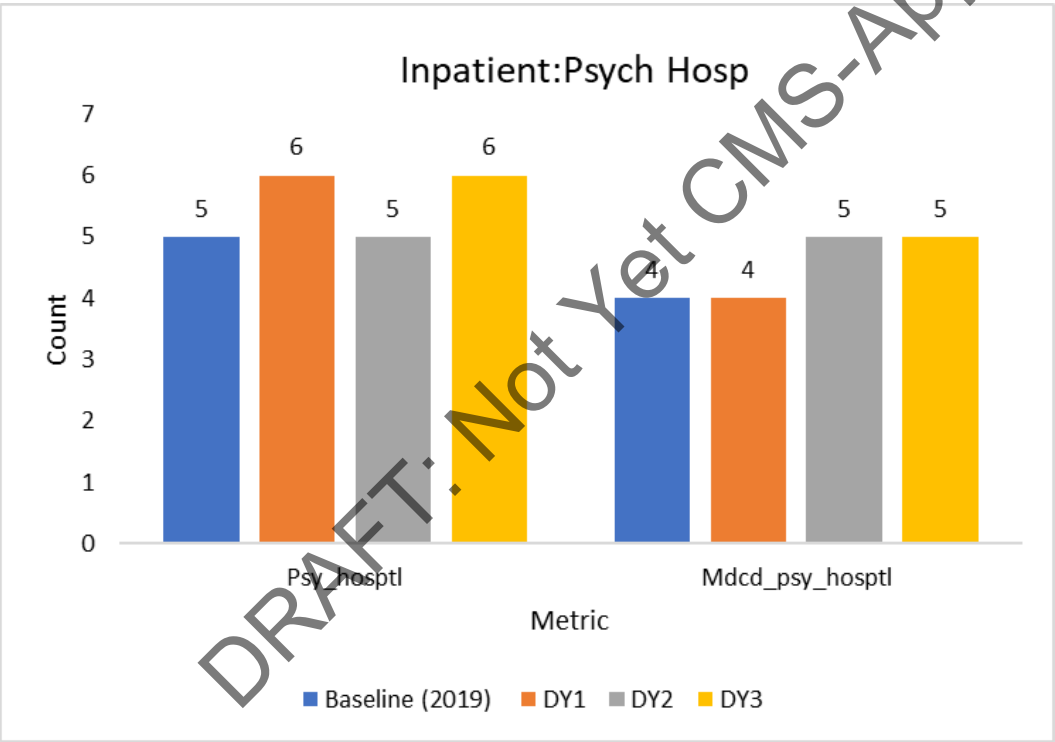
Note: Annual data. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.
IMD: Institution for mental diseases.
a: The number of residential mental health treatment 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	6	1	20%
		DY2	5	0	0
		DY3	6	1	20%
	Medicaid-enrolled public and private hospitals[b]	Baseline (2019)	4	-	-
		DY1	4	0	0
		DY2	5	1	25%
		DY3	5	1	25%
Psychiatric units	*Psychiatric units in acute care hospitals*[c]	Baseline (2019)	9	-	-
		DY1	9	0	0
		DY2	8	-1	-11.1%
		DY3	7	-2	-22.2%
	Psychiatric units in critical access hospitals (CAHs)[d]	Baseline (2019)	1	-	-
		DY1	1	0	0
		DY2	1	0	0
		DY3	1	0	0
	Medicaid-enrolled psychiatric units in acute care hospitals[e]	Baseline (2019)	9	-	-
		DY1	9	0	0
		DY2	7	-2	-22.2%
		DY3	7	-2	-22.2%
	Medicaid-enrolled psychiatric units in CAHs[f]	Baseline (2019)	1	-	-
		DY1	1	0	0
		DY2	1	0	0
		DY3	1	0	0
Psychiatric beds	*Licensed psychiatric hospital beds*[g]	Baseline (2019)	823	-	-
		DY1	806	-17	-2.1%
		DY2	723	-100	-12.2%
		DY3	599	-224	-27.2%
	Medicaid-enrolled licensed psychiatric hospital beds[h]	Baseline (2019)	768	-	-
		DY1	730	-38	-4.9%
		DY2	647	-121	-15.8%
		DY3	544	-224	-29.2%

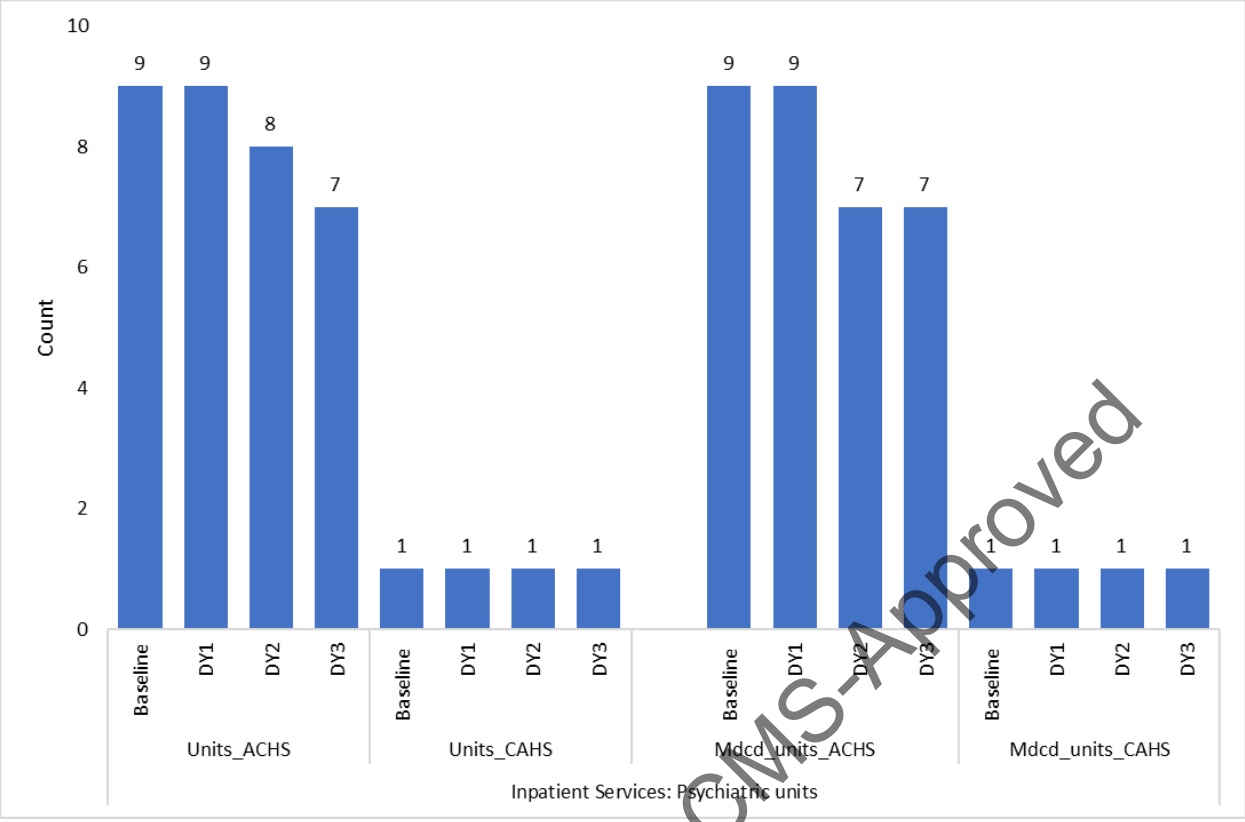
Note: Annual data. Absolute change= value of metric at mid-point - value of metric at baseline. Percent change= (value of metric at demonstration period x - Value of metric at baseline)/value of metric at baseline*100.
a: The number of public and private psychiatric hospitals during the measurement period. (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.16a Availability of Inpatient Services: Psychiatric Hospitals



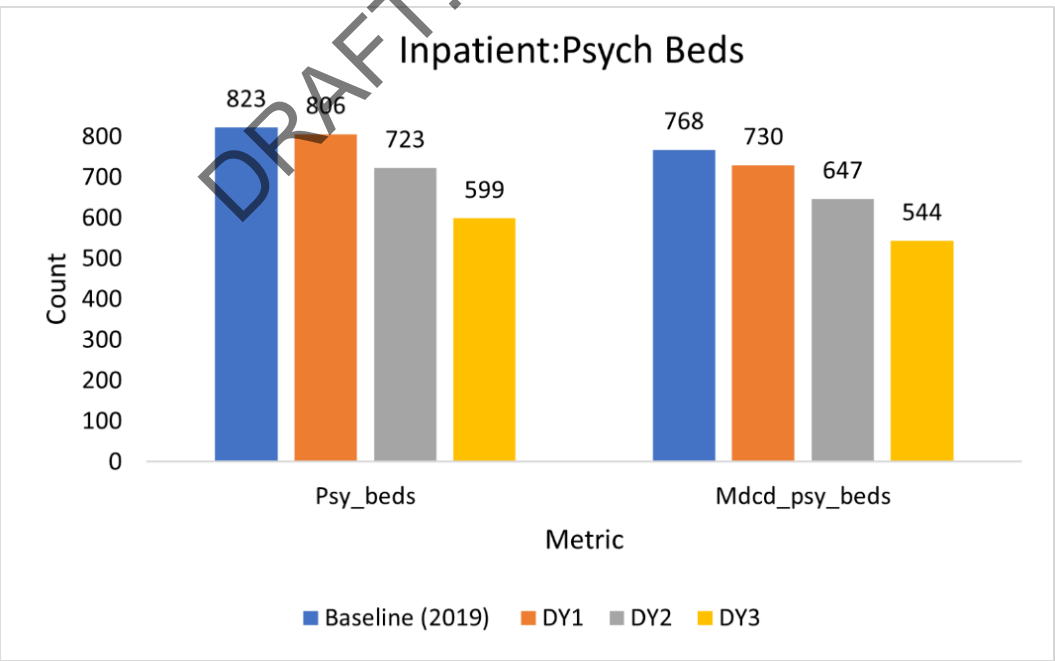
Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. Psy_hosptl: Public and Private Psychiatric Hospitals, Mdcd_psy_hosptl: Public and Private Psychiatric Hospitals Available to Medicaid Patients.

Figure E.16b Availability of Inpatient Services: Psychiatric Units



Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. Units_ACHS: Psychiatric Units in Acute Care Hospitals, Units_CAHS: Psychiatric Units in Critical Access Hospitals (CAHs), Mdcd_units_ACHS: Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals, Mdcd_units_CAHS: Medicaid-Enrolled Psychiatric Units in CAHs.

Figure E.16c Availability of Inpatient Services: Psychiatric Beds



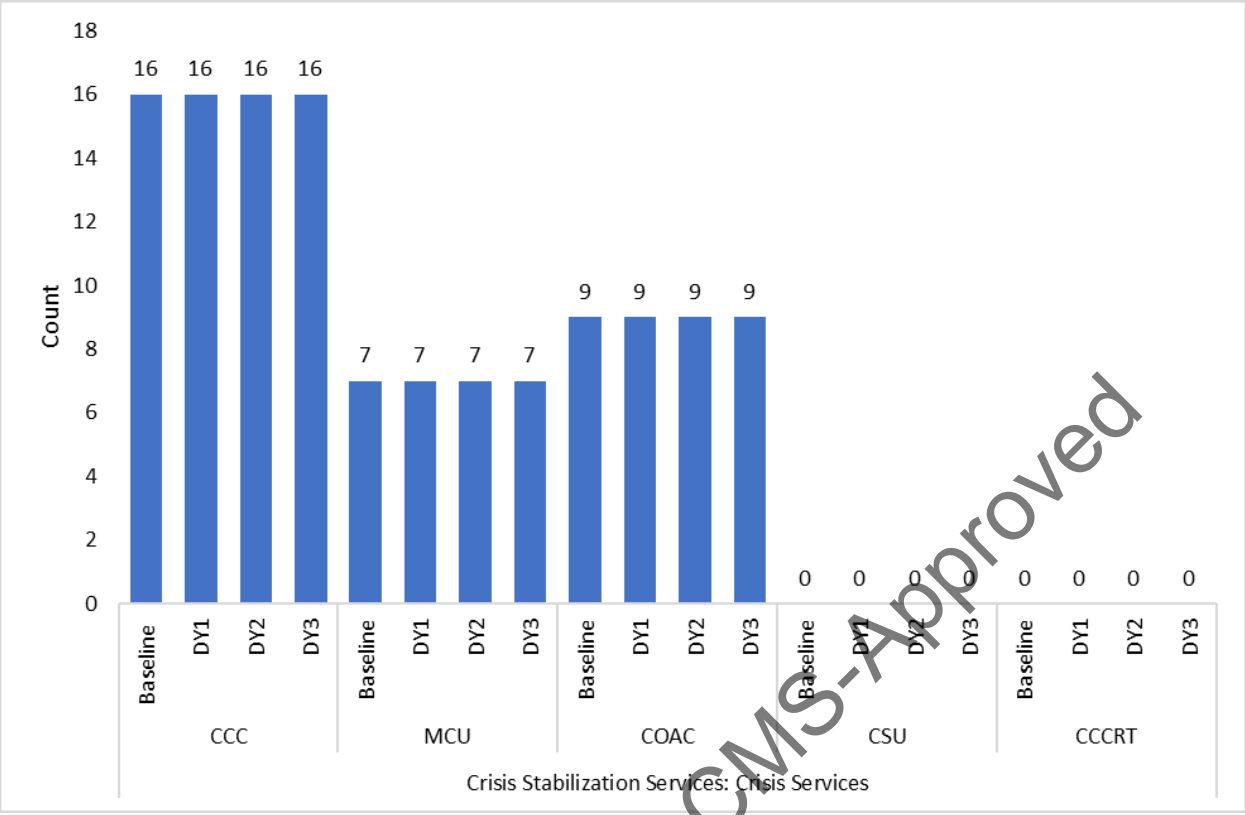
Note: Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. Psy_beds: number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units). Mdcd_psy_beds: number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) available to Medicaid patients

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
		DY2	16	0	0
		DY3	16	0	0
	Mobile Crisis Units[b]	Baseline (2019)	7	-	-
		DY1	7	0	0
		DY2	7	0	0
		DY3	7	0	0
	Crisis Observation/Assessment Centers[c]	Baseline (2019)	9	-	-
		DY1	9	0	0
		DY2	9	0	0
		DY3	9	0	0
	Crisis Stabilization Units[d]	Baseline (2019)	0	-	-
		DY1	0	0	0
		DY2	0	0	0
		DY3	0	0	0
	Coordinated Community Crisis Response Teams[e]	Baseline (2019)	0	-	-
		DY1	0	0	0
		DY2	0	0	0
		DY3	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.

Figure E.17 Availability of Crisis Stabilization Services



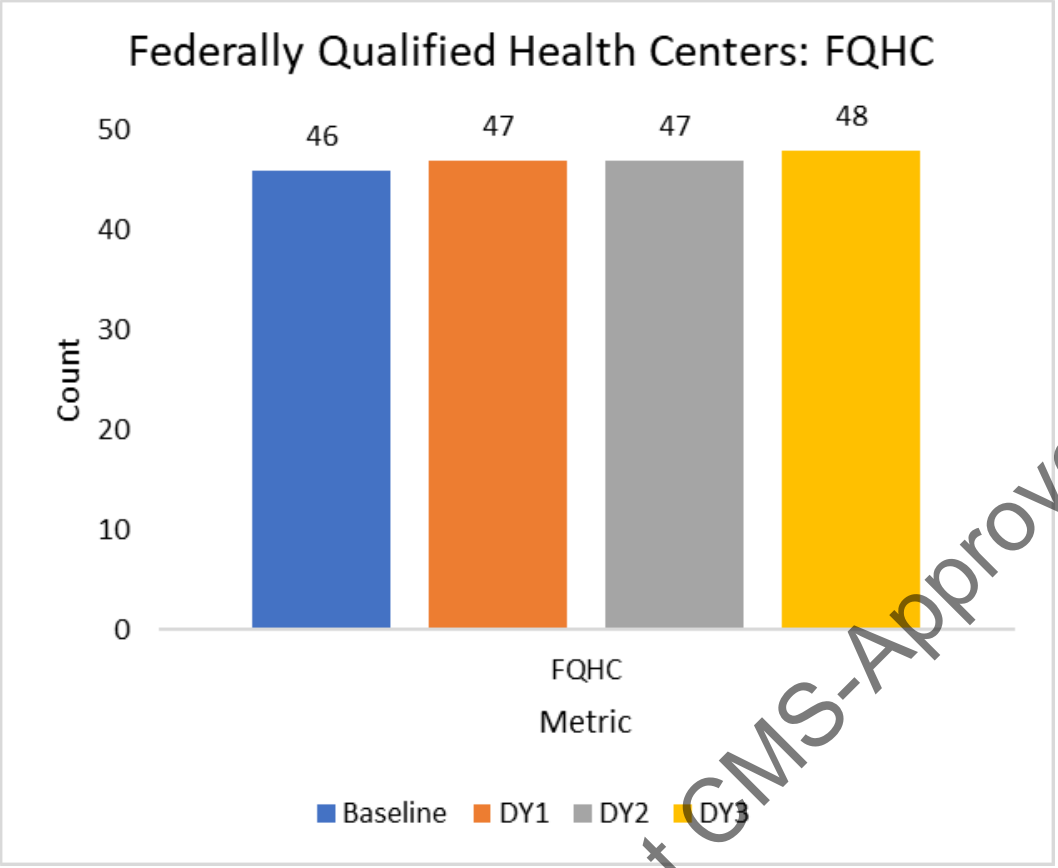
Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. CCC: Crisis Call Centers, MCU: Mobile Crisis Units, COAC: Crisis Observation/Assessment Centers, CSU: Crisis Stabilization Units, CCCRT: Coordinated Community Crisis Response Teams.

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%
		DY2	47	1	2.2%
		DY3	48	2	4.35%

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.

Figure E.18a Availability of Federally Qualified Health Centers (FQHC)



Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. FQHC: Federally qualified health center.

Appendix E. Evaluation Design

Evaluation Plan
for
Idaho Behavioral Health Transformation
Section 1115 Medicaid Waiver Demonstration Project

Prepared by Penn State University
February 25, 2021

SECTION A: General Background Information

General Background, Demonstration Name, approval date, and evaluation period

Similar to states across the country, Idaho has struggled in recent years with a rise in substance use disorders (SUD), in particular opioid use disorder (OUD), with 14.8 drug overdose deaths per 100,000 population in 2019. In addition, Idaho faces significant mental health challenges, including a high rate of suicide (23.8 suicide deaths per 100,000 population in 2018, 20.4 suicide deaths per 100,000 in 2019), which is the fourth leading cause of premature death for Idahoans under age 75. Although the population is relatively small at 1.8 million people, it is the 14th largest state in geographic area, highlighting issues with coordinating care across large, often rural, geographic areas. Furthermore, one third of the population lives in rural or frontier counties, and overall the population density is 19 people per square mile, much lower than the US average of 83 people per square mile.

Further complicating access to behavioral health care, Idaho's terrain is largely mountainous or desert, with limited infrastructure for transportation, business, health care, and digital services. This has resulted in a behavioral health care system that is fragmented and has significant problems related to access to behavioral health care services. Additionally, 100% of the state has the federal designation of Health Professional Shortage Area for mental health services, 97.7% for primary care, and 94% for dental health. To improve access for patients with serious mental illness (SMI) and serious emotional disturbance (SED), IDHW has made meaningful progress in improving access to crisis care for behavioral health. Yet significant gaps remain across the entire continuum of behavioral health care.

In January of 2020 Idaho expanded their Medicaid program, increasing access to mental health services for a total of 100,529 members by the start of 2021. At the time of approval for their 1115 SMI/SUD waiver demonstration they had already added 72,551 individuals. However, with limited behavioral health care capacity due to lack of mental health care providers, a remaining concern is ensuring that all Medicaid enrollees are able to access needed care for treatment of mental health and substance use concerns. The Centers for Medicare and Medicaid Services (CMS) approved Idaho's Section 1115 Medicaid demonstration to address these gaps for people with SMI, SED, and SUD. The demonstration period for the "Idaho Behavioral Health Transformation" continues through March 31, 2025.

One component of the 1115 waiver approval is an evaluation of the demonstration's impacts, whether the demonstration is being implemented as intended, if intended effects are occurring, and whether outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration. **The evaluation period considers the following three periods: i)** baseline period of January 2018 through March 2020; **ii)** early demonstration period of April 2020 through December 2022; and **iii)** late demonstration period of January 2023 through March 2025. An additional, important evaluation challenge of note is that the COVID-19 pandemic struck near the beginning of the demonstration period. The pandemic will likely have important impacts on both mental health (due to isolation, stress, anxiety, etc.) as well as access to care (both due to facility closures/reductions in care, as well as patients deciding to avoid places of care).

A.2: Demonstration Goals and Key Change Actions

The 1115 SUD/SMI waiver provides the state with the authority to provide high-quality, clinically appropriate treatment to Medicaid beneficiaries aged 21-64 with a diagnosis of SMI, SED, and/or SUD in an IMD setting. The subsequent demonstration supports efforts by the state 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 are able to access needed care and treatment when they need it. To this end, Idaho is implementing a multi-pronged strategy to address behavioral health care reform. This approach has three broad, overarching reform 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.

Within the framework of these three aims, Idaho and their evaluation team have aligned the 11 specific goals set by CMS. Goals are divided across both SUD and SMI/SED care:

SUD Specific Goals:

1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
2. Increased adherence to and retention in treatment for OUD and other SUDs.
3. Reductions in overdose deaths, particularly those due to opioids.
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.
5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate for OUD and other SUDs.
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

SMI/SED Specific Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
2. Reduced preventable readmissions to acute care hospitals and residential settings.
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.
4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Critical to achieving these specific goals, IDHW will undertake a series of actions over the course of the 1115 waiver demonstration period. These actions are captured within demonstration implementation milestones which are outlined in detail in the state's SUD and SMI/SED implementation plans. Below each action is categorized into five key domains of change, including:

Provide Expanded Medicaid Coverage

Idaho's 1115 waiver demonstration proposes providing expanded coverage to Medicaid enrollees. This includes the availability to use Medicaid funds for a wider range of services for those individuals aged 21-64. Expansion of coverage includes:

- Reimbursing institutions for mental diseases (IMDs)
- Reimbursing residential behavioral health services. Talks are ongoing about increasing reimbursement rates.

Expand supply of providers and services

- The 1115 waiver demonstration proposes expanding access to services for beneficiaries. Specific actions include:
  - Expand access and utilization of peer and family support services
  - Expand the number of MAT waivered providers

- Develop a comprehensive statewide crisis service plan to expand availability of crisis services
- Increase the integration of physical and behavioral health services
- Expand the provision of transportation benefits for behavioral health care

Transform Administrative Processes

- To accomplish proposed changes a number of administrative processes will be transformed. These include:
  - Establish a certification process for newly enrolled behavioral health providers to improve access to high-quality providers
  - Establish mandatory post-discharge requirements following inpatient, residential, and ED visits
  - Require all IMDs to provide at least two forms of Medication Assisted Treatment (MAT)
  - Implement an interoperability platform to improve coordination between first responders and behavioral health treatment providers
  - Simplify and standardize telehealth coverage rules
  - Adjust the details of the upcoming IBHP managed care contract to improve care coordination

Provide education and training

- To provide high-quality services the state proposes the following actions regarding education and training:
  - Develop a standardized approach for SUD identification
  - Promote training for early SUD identification
  - Educate providers on new reimbursement opportunities for SUD and SMI/SED care

Fund health information technology (HIT)

- Critical to coordination of care and care expansion the state proposes changes to HIT including:
  - Utilize federal opioid and SUD funding to improve IT for the purpose of improving SUD and SMI/SED care coordination
  - Utilize funding to improve providers integration with Prescription Drug Monitoring Program (PDMP) and Idaho Health Data Exchange (IHDE) platforms to further coordinate SUD and SMI/SED care

Finally, to meet the goals of the 1115 waiver demonstration, IDHW has agreed to implement recommended milestones outlined by CMS for SMI/ SUD demonstrations. These will inform the evaluation's assessment and research questions (Section B).

A.3: Description of the demonstration and implementation timing.

Over the past decade, Idaho has made significant improvements in access to care for those with SUD and/or SMI/SED. However as mentioned above, gaps continue to exist. Idaho's 1115 waiver demonstration focuses on three broad reforms resulting in five change categories that encompass the demonstration's implementation (Section A.2). Implementation Milestones are provided in full in the CMS Special Terms and Conditions for the Demonstration6, and are discussed further in the evaluation plan as they relate to research questions and hypotheses.

A.4: Other relevant contextual factors

There are several important contextual factors which the evaluation design will consider alongside the direct impact of the demonstration. For example, Idaho Medicaid expansion began January 2020. This has significantly increased the number of Medicaid enrollees, including the number of enrollees with SMI and/ or SUD who have coverage for behavioral health treatment. The Medicaid 1115 demonstration began shortly after Medicaid expansion. Given the proximity in timing, from an evaluation standpoint, it will be important to attempt to disentangle the effects of the changes to Idaho's Medicaid policy. To this end, the evaluator will make comparisons to changes in utilization for non-behavioral health treatment in order to tease out the relative impacts of Medicaid expansion (which affects both behavioral and physical health care) and the 1115 waiver (which focuses on behavioral health care). While there are likely to be spillover effects from one to the other, this approach will provide a first approximation to the relative impacts.

In addition, prior to Medicaid expansion in January 2020, many behavioral health services were covered through the Idaho Department of Health and Welfare's (IDHW) Division of Behavioral Health (DBH). Following the State's Medicaid expansion, these services will be reimbursed using Medicaid funds, with the aim of improving coordination of comprehensive services.

Other factors to consider include that beginning January 1, 2020, Idaho Behavioral Health Plan (IBHP) began reimbursing partial hospitalizations for behavioral health care. On January 1, 2021, IBHP began reimbursing methadone maintenance care in opioid treatment programs (OTPs)--relevant coverage to the waiver. Additionally, the State is in the process of finalizing a Request for Proposals (RFP) to solicit vendor submissions that will result in a new contract award to operate the IBHP, which currently provides outpatient behavioral health care through a Medicaid carveout. The contract will be awarded in late 2021 with behavioral health services available through the new contract beginning on July 1, 2022, This RFP proposes a new structure for the IBHP, in which the selected contractor will assume responsibility for all behavioral health services across the continuum of care—both inpatient and outpatient. Crisis centers may be covered as part of the IBHP MCO contract in 2022. Through contract monitoring, the selected contractor will be held accountable for achieving specified performance targets, including affirmative treatment outcomes for IBHP enrollees. In reviewing responses to this RFP and performance targets of the awardee, the state will give special emphasis to candidates' demonstrated propensities for mitigating the need for inpatient admissions and maximizing the effectiveness of community-based services offered as part of the continuum of care.

Further, pursuant to state legislation passed in 2015, naloxone, an important overdose reversal drug, was made available to anyone in Idaho without a prescription by simply asking a pharmacist. In 2019, the law was further expanded to permit other licensed health professionals to dispense naloxone, rather than just prescribers and pharmacists. With eased regulations and easier access to this lifesaving drug, the Idaho Office of Drug Policy is now focused on expanding naloxone distribution, particularly to first responders, through a temporary grant program. Specific to crisis services, in 2016, the State established a Suicide Prevention Program, which provides support for the Idaho Suicide Prevention Hotline and public awareness campaigns. Regarding improvement of care for SMI/SED, coverage of crisis stabilization services and partial hospitalizations began in January 2020 but is independent of the 1115 waiver itself. Finally, an important but unavoidable complication to the evaluation is the COVID-19 pandemic that began just around the beginning of the demonstration period. The evaluator will flexibly vary the time periods examined in sensitivity analyses (including dropping the 2020 time period and dividing the demonstration period into both an early and a late period).

SECTION B: Evaluation Research Questions and Hypotheses

This evaluation plan includes an overarching logic model (Appendix 3) depicting the demonstration's overall theory of change – the underlying assumptions about how the demonstration will lead to outcomes and in what time frame. Broadly, the IDHW is utilizing federal funding resources to implement the 1115 waiver demonstration with a goal of improving access, utilization, quality, and health outcomes related to both SUD and SMI/SED treatment. Appendices 2 and 3 describe the key demonstration actions that are occurring as part of the implementation plan, along with their anticipated outcomes. Given the complexity and multi- faceted nature of the demonstration, it is important to understand the timing and scope of how changes may ultimately be implemented.

As outlined in section A.2, the primary, initial set of demonstration activities include expansion to the types of care that can now be reimbursed using Medicaid funds for the eligible population of Medicaid enrollees ages 21-64. Second, ongoing work focuses on expanding funding as well as other strategies to increase the supply and breadth of behavioral services available in Idaho, particularly in rural areas. Third, an ongoing set of administrative process changes and initiatives further seek to improve the availability and quality of SUD and SMI/SED care. Fourth, IDHW has been working to provide education and training for providers regarding what services can be reimbursed using Medicaid funds as well as improving best practices for identifying SUD in the

primary care setting. Finally, IDHW is utilizing federal funding to improve the health IT infrastructure to better connect providers as well as improve ability to query the PDMP.

Each demonstration goal will be accomplished through achieving specific implementation milestones that have been established considering demonstration aims, goals and milestones NB: Milestone numbering aligns with the order outlined in the implementation plan). The evaluator will test the below hypotheses—that build on and refine the tentative hypothesis proposed in the original waiver application. Each hypothesis will in turn be tested by multiple research questions.

SUD Specific Goals:

Goal 1: Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs

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

- Hypothesis 1: The 1115 waiver demonstration will lead to improved access to critical levels of care for OUD and other SUDs.
  - Research Question 1.1: Did initiation of SUD treatment increase during the demonstration period?
  - Research Question 1.2: Did outpatient services increase during the demonstration period?
  - Research Question 1.3: Did intensive outpatient and partial hospitalization services increase during the demonstration period?
  - Research Question 1.4: Did residential and inpatient services increase during the demonstration period?

Goal 2: Increased adherence to and retention in treatment for OUD and other SUDs

Implementation Milestone 3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications

- Hypothesis 2: The 1115 waiver demonstration will lead to increased use of nationally recognized, evidence-based SUD program standards.
  - Research Question 2.1: Did screening increase during the demonstration period?
  - Research Question 2.2: Did initiation of alcohol use disorder and SUD treatment increase during the demonstration period?
  - Research Question 2.3: Did MAT utilization (sub-analysis specific to methadone) increase during the demonstration period?
  - Research Question 2.4: Did adherence to MAT for OUD users increase during the demonstration period?
  - Research Question 2.5: Did re-engagement of MAT for OUD patients increase during the demonstration period?

Goal 3: Reductions in overdose deaths, particularly those due to opioids

Implementation Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

- Hypothesis 3: The 1115 waiver demonstration will lead to increased use of evidence-based, SUD-specific patient placement criteria.
  - Research Question 3.1: Did opioid overdose death rate (overall, in-hospital, and out- of-hospital) increase during the demonstration period?
  - Research Question 3.2: Did ED visits for SUD increase during the demonstration period?
  - Research Question 3.3: Did repeat overdoses increase during the demonstration period?

Goal 4: Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services

Implementation Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

- Hypothesis 4: The 1115 waiver demonstration will lead to implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
    - Research Question 4.1: Did use of opioids at high dosage in persons without cancer (OHD-AD) decrease during the demonstration period?
    - Research Question 4.2: Did use of opioids from multiple providers in persons without cancer (OMP) decrease during the demonstration period?
    - Research Question 4.3: Did use of opioids at high dosage and from multiple providers in persons without cancer (OHDMP) decrease during the demonstration period?
    - Research Question 4.4: Did concurrent use of opioids and benzodiazepines (COB- AD) decrease during the demonstration period?
    - Research Question 4.5: Did emergency department utilization for SUD per 1,000 Medicaid beneficiaries decrease during the demonstration period?
    - Research Question 4.6: Did ED visits for OUD and SUD decrease during the demonstration period?

Goal 5: Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate for OUD and other SUDs

Implementation Milestone 6: Improved care coordination and transitions between levels of care

- Hypothesis 5: The 1115 waiver demonstration will lead to improved care coordination and transitions between levels of care.
    - Research Question 5.1: Did follow-up after emergency department visits for mental illness (FUM-AD) increase during the demonstration period?
    - Research Question 5.2: Did readmissions among beneficiaries with SUD decrease during the demonstration period?
    - Research Question 5.3: Did preventive care utilization (connecting OUD patients to broader care) increase during the demonstration period?
    - Research Question 5.4: Did follow-up with patients prescribed an anti-psychotic increase during the demonstration period?
    - Research Question 5.5: Did follow-up with patients post-ED discharge increase during the demonstration period?
    - Research Question 5.6: Did medication continuation post inpatient discharge for SUD increase during the demonstration period?

Goal 6: Improved access to care for physical health conditions among beneficiaries.

Implementation Milestone 4: Sufficient provider capacity at each level of care, including MAT

- Hypothesis 6: The 1115 waiver demonstration will lead to sufficient provider capacity at each level of care.
    - Research Question 6.1: Did SUD provider availability increase during the demonstration period?
    - Research Question 6.2: Did SUD provider availability for MAT increase during the demonstration period?
    - Research Question 6.3: Did provider availability for MAT increase during the demonstration period?
    - Research Question 6.4: Did provider availability for methadone increase during the demonstration period?
    - Research Question 6.5: Did availability of community-based SUD services increase during the demonstration period?
    - Research Question 6.6: Did patient satisfaction increase during the demonstration period?

SMI/SED Specific Goals:

Goal 1: Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings

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

- Hypothesis 7: The 1115 waiver demonstration will lead to improved quality of care in psychiatric hospitals and residential settings.
  - Research Question 7.1: Did utilization of behavioral health treatment services increase during the demonstration period?

Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings

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

- Hypothesis 8: The 1115 waiver demonstration will lead to earlier identification and engagement in treatment through increased integration.
  - R8.1 Did the number of enrollees receiving care from co-located physical and behavioral health facilities increase during the demonstration period?

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

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

- Hypothesis 9: The 1115 waiver demonstration will lead to increasing access to continuum of care, including crisis stabilization services.
  - Research Question 9.1: Did mental health services utilization increase in inpatient settings during the demonstration period?
  - Research Question 9.2: Did mental health services utilization increase in intensive outpatient and partial hospitalization settings during the demonstration period?
  - Research Question 9.3: Did mental health services utilization increase in ED settings during the demonstration period?
  - Research Question 9.4: Did crisis service utilization increase during the demonstration period?
  - Research Question 9.5: Did outpatient rehabilitation increase during the demonstration period?
  - Research Question 9.6: Did case management increase during the demonstration period?
  - Research Question 9.7: Did home and community services increase during the demonstration period?
  - Research Question 9.8: Did long-term services/supports increase during the demonstration period?
  - Research Question 9.9: Did ED visits for SMI/SED increase during the demonstration period?

Goal 4: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care

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

- Hypothesis 10: The 1115 waiver demonstration will lead to increasing access to continuum of care, including crisis stabilization services.
  - Research Question 10.1: Did availability of community-based behavioral health services (overall, outpatient, inpatient/residential, office-based) increase during the demonstration period?
  - Research Question 10.2: Did suicide rates decrease during the demonstration period?
  - Research Question 10.3: Did availability of virtual visits increase during the demonstration period?
  - Research Question 10.4: Did availability of clinics with co-located physical and behavioral health providers increase during the demonstration period?
  - Research Question 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?
    - Research Question 10.6: Did availability of behavioral health in FQHCs increase during the demonstration period?
    - Research Question 10.7: Did per capita availability of outpatient mental health professionals, by type (e.g., psychologists, social workers) increase during the demonstration period?

Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities

Implementation Milestone 2: Improving Care Coordination and Transitioning to Community- Based Care

- Hypothesis 11: The 1115 waiver demonstration will lead to improved care coordination and transition to community-based care?
    - Research Question 11.1: Did 30-day readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF) increase during the demonstration period?

Qualitative Research Questions

Additionally, the evaluator will conduct a qualitative analysis to contextualize and provide further insights into the implementation and consequent outcomes. These include the following research questions:

- Research Question 12.1: Is the demonstration being implemented as intended?
- Research Question 12.2: Is the demonstration having the intended effects on the target population?
- Research Question 12.3: What factors may have driven the observed results in terms of access to SUD and SMI/SED care?
- Research Question 12.4: What factors may have driven the observed results in terms of health care outcomes?
- Research Question 12.5: What are the valuable lessons learned and successes?

Cost Analysis Research Questions

The evaluator will also estimate impacts of the demonstration on costs both on SUD- and SMI/SED-specific treatment as well as on overall spending. This will include addressing the following research questions:

- Research Question 13.1: Has total spending for SUD-related care changed over the 1115 waiver demonstration period?
- Research Question 13.2: Has total spending for SMI/SED-related care changed over the 1115 waiver demonstration period?
- Research Question 13.3: Has total spending by site of care for SUD-related care changed over the 1115 waiver demonstration period?
- Research Question 13.4: Has total spending by site of care for SMI/SED-related care changed over the 1115 waiver demonstration period?
- Research Question 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)?

SECTION C: Methodology

C.1 Evaluation Methodology

The methodology will be similar for both the SUD and the SMI/SED portions of the evaluation. The methods outlined below will apply to both portions of the evaluation except where indicated. The evaluator will use an explanatory sequential mixed methods approach. Initially, the evaluator will utilize both quantitative and qualitative data collection. The quantitative approach will include aggregation of data from multiple sources (further detailed below) to assess changes in availability, utilization, quality of care, and health outcomes. Concurrently, the evaluator will collect qualitative data from key stakeholders in order to understand more

precisely what specific components of the demonstration plan have been implemented, the fidelity to the implementation plan, the timing of implementation, and an understanding of how widespread implementation may be (effectively the "dose" of the intervention). This will help to guide subsequent refinement of the quantitative approach. For example, if certain components of the waiver demonstration are delayed, that can then be appropriately accounted for in the quantitative analyses. Similarly, if certain components appear to be implemented more quickly than expected that can also be accounted for quantitatively. Results of the qualitative assessment can also be used to inform Idaho demonstration leaders of progress and if, or where changes might be needed. In later stages of the evaluation, key informant interviews will be used to identify demonstration programs and interventions that were most effective as well as understanding barriers and facilitators for success.

Quantitative analyses are outlined in more detail in section C.4. Broadly, the evaluator proposes an interrupted time series approach to assess changes in each of the outcomes across both SUD and SMI/SED treatment from before to after the 1115 waiver demonstration. For each set of research questions, the evaluator includes accompanying hypotheses.

Testing Hypotheses

For each research question and related hypothesis, the evaluator will test whether the demonstration has been successful in meeting that particular objective by testing for whether the evaluator can observe a significant change in a majority of the relevant, primary outcomes (see Appendix 4 for a list of outcomes. Where feasible, the evaluator will also attempt to incorporate a control group or benchmark data. For the access to care outcomes, the evaluator will attempt to use the Treatment Episode Data Set (TEDS) data to provide a control group in a difference-in- differences framework. Similarly, for the mortality-related health outcomes the evaluator will use the Center for Disease Control (CDC)Vital Statistics detailed mortality data as a control group. For utilization and quality outcomes, the evaluator will continue to explore benchmark data options for the accounting of secular changes occurring outside the 1115 waiver demonstration. Finally, to provide additional explanatory clarity to our quantitative results, the evaluator will supplement with qualitative data including the collection of barriers and facilitators of success, approaches that drove successes, and lessons learned.

C.2 Evaluation Period

The demonstration period began on April 17, 2020 and concludes on March 31, 2025. The final evaluation report is due 18 months later, on August 31, 2026. Data from January 2018 – March 2020 will be considered the baseline, or "pre-demonstration" data. The evaluator will divide the demonstration period into an "early" period (April 17, 2020 – December 2022) and a "late" period (January 2023 – March 2025). This is in part to account for the transition to a new behavioral health MCO contract which will begin services in 2022. This design will explicitly capture these potentially differential impacts on outcomes. In addition, given the complexity of the demonstration, the evaluation should explicitly account for both the phased roll-out of various components of the implementation as well as the anticipated time for changes to be realized in the form of impacts on the stated outcomes. The analytic plan will account for Idaho's multi-pronged approach to address health care reform in the state (Appendix 2). Finally, the evaluation will also include analyses that omit 2020 both to allow for time for the demonstration to be implemented and to account for disruptions from the COVID-19 pandemic. The summative evaluation report will include data from January 2018 through December 2025. Thus, the evaluation will include nine quarters of data for the baseline period prior to the start of the demonstration, and data for all but the final quarter of demonstration implementation. This will allow the evaluator to complete the analysis and report prior to the August 2026 deadline.

C.3 Data Sources and Preparation

The quantitative portion of the evaluation will include member-level data from Idaho Medicaid and Department of Behavioral Health (claims, enrollment, and pharmacy data; IMD utilization data), Optum Idaho (outpatient behavioral health claims), the new behavioral health vendor starting in 2022 (inpatient, residential, and

outpatient behavioral health claims), Vital Statistics (data on overdose and other causes of death). In addition, provider-level data about waivers for and use of medication-assisted treatment (MAT) as well as naloxone availability will be obtained from the Board of Pharmacy and the Prescription Data Monitoring Program (PDMP). Finally, the Mental Health Availability Assessment will require collecting data from insurance carriers, providers, licensing boards, and other associations to obtain information regarding staff counts and facility characteristics (number of beds, providers, etc.). Prior to the MCO change, the evaluator will utilize claims data, licensing board information, and other data sources to determine mental health availability as well as conduct quantitative analyses. After the MCO transition, the evaluator will continue to use these sources of data, but direct comparisons pre and post MCO transition will be undertaken to ascertain if the transition itself has influenced any of the outcomes data. The state will monitor and manage data quality throughout the process using tools within its IBM supported data system to identify and rectify missingness incorrect values or any other system errors potentially due to input and linking.

The qualitative portion of the evaluation will require secondary document analysis and key informant interviews. Methodology for the qualitative portion of the evaluation is described in section C.8.

The evaluator will obtain all data for quantitative analysis via secure file transfer protocol (SFTP) or other approved, secure transfer methods from IDHW. IDHW's data team will perform quality checking and assurance with their data warehouse vendor, IBM. Data from disparate sources will be linked using unique and persistent identifiers (Medicaid ID) and/or via probabilistic "fuzzy" and deterministic matching when needed. The evaluator will prepare the data received from IDHW to be loaded into an analytic database, a process called staging. They will then organize the staged data into a relational database structure that will enable them to track Medicaid members and their outcomes over time and across data sources.

Data from multiple sources are required for some analyses, and not all sources use the same unique member identifiers. Thus, a major component of the staging process will be linking members across data sources. This will require the evaluator to create its own unique member identifier and then use an algorithm to match members between datasets. The algorithm will use member information such as name, gender, date of birth, zip code, and other identifiers, and a process called "fuzzy matching." This process is needed because the identifiers listed above are not always entered accurately and consistently across data sources. For example, one data source may list a member as "Elizabeth Doe", while in other data sources she is listed as "Beth Doe," "Liz Doe," "Elizabeth A Doe," "Elizabeth Dole," or other variations. The fuzzy matching process gives different weights to different potential matches, based on the probability that the individuals are the same person in the different sources.

C.4 Quantitative Analysis Plan

Prior to beginning the processes described above of creating the analytic database, the evaluator will propose a detailed Quantitative Analysis plan, which will include specifics regarding:

- Measure specifications: Precise definitions for all measures to be used for the evaluation, as specified by the organization that defined the measure (e.g., Health care Effectiveness Data and Information Set (HEDIS) or National Committee for Quality Assurance (NCQA), Agency for Health care Research and Quality (AHRQ) Prevention Quality Indicators (PQI), Pharmacy Quality Alliance-PQA). The monitoring protocol metric specifications will be updated annually based on guidance from CMS.
- Medicaid population and subgroup definitions: Criteria that will be used to identify all populations and subgroups for whom measures will be reported (e.g., Medicaid eligibility codes, continuous enrollment criteria, and diagnosis or procedure codes that will be used to identify members with specific conditions).
- Subgroups: Subgroups of interest for each measure, and criteria that will be used to identify these groups outcomes of interest (e.g., geographic region, gender, age, eligibility category). Further, three subgroups of specific interest will be: i) children in foster care; ii) mothers with OUD and infants with neonatal abstinence syndrome; and iii) individuals prescribed multiple anti-psychotic medications.
- Statistical models: Statistical models that will be used to estimate change in outcomes associated with the demonstration, including functional form, control variables, and baseline periods. A general model is

discussed below, and detailed models will be included in the detailed analysis plan.

- Steps to address other methodological challenges: The evaluation design lists potential challenges with evaluating the waiver's effects, including Medicaid members who "churn" between Medicaid and other coverage (or no coverage), unequal penetration of waiver reforms in different geographic regions, and state or national policy changes occurring at the same time as the waiver. The analysis plan will describe how such challenges may affect results and any steps planned to address such challenges.

C.5 Calculate Measures

- The evaluator will calculate values for each proposed measure using data from the analytic database. Standard metrics from HEDIS or NCQA will be used whenever possible, and published definitions from the metric stewards will be used to create the metrics. Measures with binary outcomes—for example, whether or not the member received any services from an Institution for Mental Disease (IMD) —are calculated by determining who was eligible for the measure based on the published definition (the denominator) and then calculating whether eligible members met the criteria for the measure within a given timeframe (the numerator).
- Measures with non-binary outcomes—for example, number of visits of a specific type—are calculated by determining who was eligible for the measure (the denominator) and calculating a total for each eligible member (the numerator). A value is calculated for each individual for each calendar quarter, so that measures are available at the person/quarter level. Results are aggregated to calculate outcome measures for Medicaid members as a whole and for specific subgroups of Medicaid members. See Appendix 4 for a complete list of data elements.

C.6 Perform the Quantitative Analysis

- The evaluator will perform a series of analyses to address each of the hypotheses outlined in section B.2. The gold standard analytic approach is to find a comparison group that is similar to the intervention group (in this case, adult Idaho Medicaid recipients with SUD and/or SMI/SED). Because the intervention in Idaho is statewide, the evaluator cannot create a comparison group based on Idaho Medicaid members who do not receive the intervention. While some states may be able to take advantage of geographically staggered implementation, the unique geography of Idaho precludes this – nearly half of the population lives in the Boise metropolitan area. In looking at other states that could potentially serve as comparisons, the state should:
- Be similar to Idaho
- Not have CMS waivers related to SUD and/or SMI/SED
- Be willing to share de-identified Medicaid claims data with Idaho for this purpose across the entire demonstration period plus the baseline

Many western states have waivers related to SMI/SED or SUD, making it difficult to find a reasonable comparison state. Thus, the evaluator proposes an interrupted time series approach. In addition to the traditional approach defining a time variable as a running count of quarter since the beginning of the baseline period, the evaluator will also estimate an alternate model that drops the "early" implementation period prior to new MCO contract, which will likely lead to additional changes. Thus, would allow distinguishing between three time periods: baseline (January 2018 – March 2020), early post-implementation (April 2020 – December 2022), late post-implementation (January 2023 – March 2025). However, empirically, in both models, the evaluator treats April – December 2020 as a washout period. The unit of analysis will be the person-quarter (although unit of analysis may vary by outcome – see Appendix 4), and members will be included if they are enrolled for all 3 months of a quarter. Those enrolled for only part of the quarter will be excluded from the analysis for that particular quarter. The analytic model will be:

$$Y_{it} = \beta_0 + \beta_1 Time + \beta_2 Post + \beta_3 (Time * Post) + \theta X_{it} + e_{it}$$

Definitions within the model are as follows:

Time is a running count of quarters since the beginning of the baseline period (i.e., January 2018)*Post* is an indicator for the period after the implementation of the 1115 waiver (i.e., April 2020) X_{it} is a vector of demographic, geographic, and risk-adjustment covariates; and *eit* is a random error term associated with the unmeasured variation in the outcome of interest. Given the uncertainty surrounding the timing of the different components as well as the complexity surrounding the broader Medicaid expansion and the COVID-19 pandemic, the evaluator highlights a series of sensitivity analyses surrounding the definition of the "pre-" and "post-periods'. First, as mentioned above, the evaluation will consider three time periods: baseline (January 2018 – March 2020), early post-implementation (January 2021 – December 2022), late post-implementation (January 2023 – December 2025. In baseline analyses, the evaluator considers April 2020 through the end of the year a wash-out period. In sensitivity analyses, the evaluator will alternatively drop January – March 2020 from the baseline period and focus exclusively on that period. These analyses will account for the initial three-month period of Medicaid expansion prior to the 1115 waiver demonstration. The evaluator will also consider shortening the early post-implementation period depending on how the COVID-19 vaccination roll-out continues.

The model specification above is general and can be used for a variety of different outcome variables. The specific model used will vary based on the distribution of the outcome variable. For example, the evaluator will use logistic regression models for dichotomous outcomes, i.e., those coded as "Yes/No" or "Present/Absent." For continuous outcomes, the evaluator prefers linear models; with large N available, linear models are appropriate even when some of the usual assumptions are not met. Linear models have the additional advantage of having coefficients that are easily interpretable. The evaluator will also consider count models, two-part models or mixed effects models where appropriate. All statistical tests will be 2-sided with $p < 0.05$ considered statistically significant.

Model covariates: Models will be adjusted for demographic, geographic, and physical health factors including:

Demographic factors: Age, gender, Medicaid eligibility group, race/ethnicity. Note: based on the distribution of racial groups in Idaho, the evaluator may be able to focus on only a limited number of racial/ethnic categories, for example, non-Hispanic White, Hispanic, and Native American, with all other racial groups defined as "Other." This will be determined by the racial/ethnic distribution of the data; all racial groups with sufficient numbers will be included as separate race categories.

Geographic factors: urban/rural/frontier residence, Region (1 – 7), residence on Indian reservation.

Physical health: Chronic conditions will be identified based on either the Chronic Illness and Disability Payment System (CDPS), or the CMS Chronic Condition Warehouse. Both of these sources include ICD-10 definitions of common chronic conditions in a Medicaid population. To account for the presence of comorbid conditions, the evaluator will define the Elixhauser comorbidity index.

Outcome Metrics: Outcome metrics are listed in Appendix 4, based on CMS evaluation guidance. Additional metrics may be added if Idaho chooses to monitor additional metrics, and changes may be made based on future guidance from CMS as well as data availability. For example, should data availability preclude measurement of a specific outcome, it may be omitted from the analysis. The analytic and modeling approaches described above are appropriate for all outcomes that measure member-level outcomes (e.g., ED use, IMD use and length of stay).

In addition to these measures, the evaluator will include quarter of year fixed effects to account for seasonality.

Hypothesis Testing. This evaluation will employ a hypothesis testing approach that seeks to build convergent evidence from multiple research questions. In this context, hypotheses will be rejected or confirmed based on analyses of multiple research questions. If research questions indicate mixed evidence for a hypothesis in either direction, findings will be contextualized in terms of each proposed question.

C.6.1 Subgroups of Focus

It is important that the interventions do not perpetuate or exacerbate historical inequities in health care access or treatment among various subgroups of the population. In Idaho, these groups have included racial/ethnic minority groups, those living in frontier areas, and those with mental health and substance use disorders. The demonstration targets those with SMI/SED or SUD concerns, so all analyses that look for improvements in access or care outcomes will assess whether the demonstration has narrowed the gaps in care experienced by this group. For other historically marginalized or underrepresented groups, analyses will be designed to assess whether changes experienced by these groups were comparable to those experiences by their counterparts that do not face the same disparities. For example, did racial or ethnic minorities with SUD experience the same improvements in access to MAT as white members? Additional subgroups of interest that Idaho is monitoring include individuals with multiple anti-psychotic medications, pregnant women and SUD/OUD, children born with neonatal abstinence syndrome (NAS), families with experience in the foster care / child welfare system, individuals residing in rural and non-rural locations, and criminally and not criminally involved individuals. The evaluator will also consider inclusion of these additional sub-populations to examine differential outcomes in the four areas of outcomes. Analyses will also address whether gaps widened or narrowed during the demonstration period. For each of the subgroups identified in Section C.4, we will add an additional interaction term per subgroup to the equation above (i.e. interact the post variables by the subgroups one-by-one).

C.7 Cost Analysis

The evaluator will examine the impact of the 1115 waiver demonstration on spending with the goal of better quantifying the Medicaid program costs for SMI/SED and SUD and will conduct three levels of analyses following CMS guidance on conducting cost analyses.14

Level 1:
Total Costs of Demonstration: The total costs will be calculated as the sum of all benefit and administrative costs due to waiver. Specifically, to understand the overall impact on federal spending, the evaluator will estimate changes to SUD and SMI/SED spending multiplied by the FMAP and added to the total spending on additional federal administrative funding for the demonstration. Separate cost analysis will be conducted for SMI/SED and SUD beneficiaries.

Level 2:
Costs Related to Diagnosis and Treatment SMI/SED and SUD: The second level is the costs related to SMI/SED and SUD. Specifically, the evaluator will focus on spending specifically for SUD diagnosis and treatment and SMI/SED diagnosis and treatment among the target population. This analysis will include identification of cost drivers by identifying major costs associated with a SMI/SED diagnosis and/or service receipt as well as with SUD diagnosis and/or services. Separate cost analysis will be conducted for SMI/SED and SUD beneficiaries.

Level 3:
Source of Treatment Drivers: The third level will identify key treatment cost drivers for SMI/SED and SUD populations separately. Benefit costs will be split by outpatient, inpatient, RX drugs and long-term care costs. Additionally, ED costs will be separated from other forms of outpatient costs. In particular, the evaluator will seek to understand whether variation in changes in spending by specific categories of care (IMD/inpatient, ED, outpatient, prescription drug, crisis services, and telehealth) to understand potential drivers of changes in spending. Separate cost analysis will be conducted for SMI/SED and SUD beneficiaries.
Dataset construction for the cost analysis will also follow CMS guidance. In particular, the evaluator will construct separate beneficiary level datasets from both populations of beneficiary level claims. This will include identifying all beneficiaries with relevant diagnosis and/or service utilization during the demonstration evaluation time periods. Then the evaluator will create datasets that identify each month a beneficiary is enrolled and has relevant diagnoses and/or service utilization and the 11 months following the most recent relevant diagnosis and/or service use. For each month during the identification and follow-up period, the beneficiary's Medicaid costs for that month will be specified (total as well as breakdown across setting. Demographic variables will be included within the dataset. Using this dataset, the evaluator will calculate and report average and median costs--plotting mean and median trends visually.

In parallel to the quantitative analyses above, the evaluator will employ a similar time series modelling approach to understand costs and related predictors. The evaluator will adopt a similar strategy to previous work in this space to increase comparability where appropriate. Specifically, the evaluator will estimate linear effects in the pre-demonstration and post-demonstration periods including estimating marginal effects and standard errors in the evaluation reports. The evaluator will run separate ITS models for each cost outcome and each outcome of focus (SMI/SED or SUD).

C.8 Qualitative Analysis

The qualitative portion of the evaluation will be focused on two primary goals. First, the evaluation team will seek to fully describe all components of the demonstration, including each of the key change actions, the timing of the key change actions, the change strategy, owner(s) of the change process/action, and key contextual factors in order to understand both which changes have been implemented and when they occurred. Second, the evaluation team will seek to identify what aspects of the demonstration were most effective in driving any observed changes in outcomes, as well as identifying barriers and facilitators to implementation encountered along the way. These lessons learned will be valuable to Idaho as well as other states considering 1115 behavioral health waivers.

Systematic document collection and review:

The evaluation team will use two primary types of data to inform the qualitative component: 1) systematic collection of secondary documents and 2) semi-structured interviews with key informants.
Through ongoing and systematic document review of proposals, meeting minutes, progress reports, publicly available documents, websites, and media, the evaluation team will track the progress of the demonstration waiver, any pivots, and/or challenges in order to develop a full narrative and timeline of events, including key contextual factors. The evaluation team will collaborate with Idaho state Medicaid and Behavioral Health division staff to identify and access to relevant documents.

Key informant interviews:

The evaluation team will conduct three phases of key informant interviews.

The first phase of key informant interviews is planned for the last quarter of 2021. Evaluation team members will interview 8-12 individuals who were involved in the design of the demonstration or who are actively involved in implementing it, as well as leaders or staff involved in each key change categories shown in the logic model. The evaluation team will work with Idaho state Medicaid and Behavioral Health division staff to identify relevant individuals and will use snowball sampling.

In conjunction with the document review, the first phase of interviews will provide a thorough description of the waiver demonstration and how it is expected to be implemented including each key change category, challenges, and key informant perspectives on the feasibility of on-time implementation of each component of the demonstration.

The second phase of key informant interviews is planned for early 2023. Evaluation team members will interview the same individuals interviewed in phase 1. The purpose of this round of interviews is to understand more precisely what specific pieces of the demonstration plan have been implemented, the fidelity to the implementation plan, the timing of implementation, and an understanding of how widespread implementation may be. This will help to guide subsequent refinement of the quantitative approach. For example, if certain components of the waiver demonstration are delayed that can be appropriately accounted for in quantitative evaluations.

Results of the qualitative assessment can also be used to inform Idaho demonstration leaders of progress and if or where changes might be needed.

The third phase of key informant interviews is planned for early 2025. Evaluation team members will interview 25-30 individuals or until saturation is reached, including key individuals leading the implementation and a variety of SUD and SMI/SED providers (making sure to incorporate members that provide for key subgroups including patients in rural areas, providers treating neonatal abstinence syndrome, providers with patients receiving multiple anti-psychotic medications, and providers caring for families involved in the child welfare/ foster care systems). The evaluation team will work with Idaho state Medicaid and Behavioral Health division staff to identify relevant individuals and will use snowball sampling.

The third phase of interviews will be used to identify demonstration programs and interventions that were most effective as well as to understand barriers and facilitators for success. Interviews in all phases will be recorded and transcribed. Qualitative data will be stored in a qualitative analysis software program such as Dedoose, a software platform for team-based qualitative analysis. A team of analysts will draft a codebook to guide the systematic tagging of topics and concepts in each phase of interviews. After testing the codebook on numerous transcripts, the team will revise the codebook until the analysts reach consensus. Analysts will apply codes to each transcript and a second analyst will review the coding for quality and consistency.

Once all transcripts are coded in each phase, team members will analyze the coded passages, and write memos summarizing what was learned from each respondent related to the specific topics covered in the codebook. After aggregating what is learned on a specific topic across each type of interviewee, team members will draft a final memo for that topic, summarizing findings across all respondents. A second team member will review memos, and differences in interpretation and questions about clarity until all issues are resolved. Finally, the analytic memos will be synthesized by the lead analyst into the final evaluation report, which was then be reviewed by all evaluation team members and revised for clarity, where needed.

C.9 Interim and Summative Reports

The evaluator will deliver Mid-point, Interim and Summative Evaluation Reports that are meaningful and accessible to the primary audiences for the evaluation. Given the six-month time lag for maturation of claims/ encounter data and the time needed to analyze these data, the evaluator anticipates that the reports will cover results for the following time periods:

- The Midpoint Assessment due to CMS in March 2023 will include an overview of the state's methodology used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations.
- The Interim Report due to CMS in March 2024 will include results through June 2022.
- The Summative Report due to CMS in August 2026 will present results through December 2025, one quarter prior to the end of the demonstration period.

The evaluator anticipates that each of the above referenced reports will contain a large volume of quantitative results, including comparison of measures with benchmarks, changes associated with the waiver as identified by regression analysis, and results for populations of focus and other sub-populations. The reports will also include qualitative results such as whether the demonstration is being implemented as expected and whether the demonstration is having intended effects on the target population. The reports will use visual representations (e.g. charts) to convey information quickly and concisely to a general audience to facilitate general population interpretation of results. To provide context and help explain results, the reports will draw on information from Idaho's quarterly reports to CMS and other background documents as needed.

C.10 Support Tasks

The evaluator will carry out the following tasks to support the quantitative and qualitative evaluations and deliver Interim and Summative Evaluation Reports:

- Facilitate kickoff meeting and regular meetings with state staff: The evaluator will facilitate a kickoff meeting with Idaho's Medicaid Division to introduce the evaluation team and clarify scope as needed. In

addition, the evaluator will facilitate twice a month (every 2 weeks) check-ins with the division to provide progress updates and address any challenges with the evaluation. Ad-hoc meetings can occur as needed.

- Manage research compliance: The evaluator will obtain necessary permissions to collect and use data needed for the evaluation. This includes obtaining Institutional Review Board (IRB) approval for the evaluation protocol and executing any data use agreements needed to obtain and use the data.
- Provide project management: The evaluator will provide general project management to ensure deliverables are high-quality and delivered on time.

SECTION D: Methodological Limitations

This evaluation will have a number of limitations. The first known limitation is the on-going COVID-19 global pandemic and its impacts on health care and mental health service utilization and access. The evaluator expects to see increases in health care and behavioral health utilization as well as an increase in telehealth services. The evaluation team will develop a timeline of critical contextual factors/events to relate to demonstration major milestone timelines and implementation. This information will be used to inform our methodology to more precisely isolate effects from the demonstration.

Second, the absence of a direct comparison group limits the ability to absolutely determine whether the demonstration caused the observed changes in outcomes and to assess what the outcomes would have been in the absence of the demonstration. The evaluator will leverage existing data sources where possible (e.g., TEDS, CDC detailed mortality, national benchmarks) to act as comparisons and/or benchmarks. These are outlined in Appendix Table 4. In cases where we are unable to identify appropriate benchmarks, we will work with CMS to identify national Medicaid benchmarks. In addition, the evaluator will develop synthetic cohorts, providing the availability of data, to serve as comparison groups. Lastly, the evaluator will make comparisons to changes in utilization for non-behavioral health treatment in order to tease out the relative impacts of Medicaid expansion (which affects both behavioral and physical health care) and the 1115 waiver (which focuses on behavioral health care). While there are likely to be spillover effects from one to the other, this approach will provide a first approximation to the relative impacts.

A third known limitation is that Medicaid members often "churn" between Medicaid and other coverage (or no coverage), which can make it difficult to follow individuals over time and assess trends. The evaluation team will use identifiers above and beyond a unique Medicaid ID (e.g., name, address, DOB) to more precisely match data at the beneficiary level deterministically and probabilistically, including across data systems and over-time. Further, the state data team has been working with their data warehousing vendor, IBM to quality check unique identifiers to ensure correctness.

Fourth, there could be unequal penetration of waiver reforms across geographic regions, and this could lead to limitations. Much of Idaho's population is concentrated in a few urban areas, with the rest of the state characterized by low or very low population density. This makes implementing reforms in a uniform way across the state very difficult. The realities of population scatter may require modifications of planned reforms in some areas. The current intention of the demonstration is to have the new MCO drive workforce development within rural areas which may also address potential for unequal penetration rates.

Fifth, other state or national policy changes may occur at the same time as the waiver. This could limit the ability of the evaluator to determine whether observed changes were due to the 1115 demonstration or to other policy changes. As mentioned in the beginning of this section the evaluation team will develop a timeline of critical events and policy changes through document analysis and key informant interviews to account for changes within our quantitative analyses.

Specific state and/or national policy changes that the evaluator considers include the following:

1. Idaho has had an Idaho Response to Opioid Crisis (IROC) grant to pay for MAT services for the past 3 ½ years. This grant was slated to end in September 2020 although has received an initial extension due to the

pandemic. Outside of the grant, Idaho's Medicaid program has not paid for MAT services. Policies are being developed, with the plan that Medicaid will begin paying for MAT services through Optum in January 2021. The evaluation team will work with Idaho to understand the data available to assess MAT data availability during the IROC grant funding period and the subsequent transition to Optum January 2021. In addition, in the IBHP contractor change in 2022, the evaluator will continue to assess changes resultant from the transition and account for these changes in our quantitative and qualitative methods. At this time, it is not yet clear what data regarding MAT services have been collected by DBH during the IROC funding period program, so availability of baseline data for MAT may be limited or incomplete.

2. Idaho Medicaid currently has an MCO contract with a single vendor for all outpatient behavioral health care. Outpatient care is paid through this MCO contract, and inpatient care is paid through fee-for-service. Idaho is preparing a request for proposals to re-bid for this vendor in 2021, and all behavioral health care will transition to the MCO at that time. Services under the new vendor will start in 2022, and data submission is likely to differ between the old and new vendors. This could impact data quality, timeliness, and/or completeness.

SECTION E: Additional Information/Attachments

1.1 Independent Evaluator – No Attachment

The Center for Health Systems Effectiveness (CHSE) at Oregon Health & Science University was originally planning to perform the evaluation. However, due to COVID-19 related staffing changes and changes in workload, CHSE had to withdraw as the independent evaluator. CHSE developed the draft evaluation plan but was not involved beyond that point. Idaho Division of Medicaid staff contacted CMS for recommendations for potential experienced evaluators. From the list that CMS provided, Idaho Division of Medicaid contacted potential evaluators, sent them the draft evaluation plan, and invited them to submit proposals. Six potential evaluators submitted proposals, and The Pennsylvania State University (Penn State) was selected based on evaluation requirements as established by CMS and review evaluation budget.

IDHW and Penn State will execute a contract based on the evaluation design and CMS evaluation requirements. Penn State will conduct analysis of Idaho's Behavioral Health Transformation Demonstration and write the evaluation reports. Penn State and Idaho Medicaid utilized the draft evaluation plan design from OHSU and expanded on methodologies, data sources, design capabilities and effective timelines. Idaho will utilize contract monitoring practices to ensure Penn State will conduct a fair and impartial evaluation, as part of the state's contract and procurement laws. As part of the development of the contract with the evaluator, IDHW will create a risk assessment that includes mitigation strategies to address these potential situations.

Timeline

The following timeline presents anticipated start and end dates for tasks described in the work plan based on deadlines.

Evaluation Timeline

Task	Start	End	Status
Support Tasks	12/1/20	3/31/25	In Progress
Facilitate Kick off meetings	12/1/20	12/31/20	Complete
Prepare Quantitative Analysis Plan	12/1/20	3/15/21	In Progress
Obtain IRB approval (if needed)	12/1/20	3/15/21	In Progress

Execute data use agreements	12/15/20	4/30/21	In Progress
Facilitate bimonthly check-in	1/25/21	3/31/25	In Progress
Build database and process data	2/1/21	7/15/25	In Progress
Create database structures and schema	2/1/21	4/1/21	In Progress
Obtain baseline & Q1 data (Jan 2018 - Jun 2020), create database	3/4/21	5/21/21	
Calculate quality measures for quarterly report	5/1/21	8/13/21	
Calculate additional quality measures and add to staging process	8/15/21	11/15/21	
Obtain remaining 2020 data, process, & prep for analysis	11/1/21	12/15/21	
Obtain 2021 data, process, & prep for analysis	7/1/22	7/15/22	
Obtain/process Jan - Jun 2022 data for Interim Eval. Report	9/1/22	3/30/23	
Obtain 2022 data, process, & prep for analysis	7/3/23	7/18/23	
Obtain 2023 data, process, & prep for analysis	7/1/24	7/15/24	
Obtain 2024 data, process, & prep for analysis	7/1/25	7/15/25	
Mental Health Availability Assessment	2/1/20	3/31/25	In Progress
Demonstration Year 1	2/1/20	5/31/21	In Progress
Demonstration Year 2	11/2/21	3/31/22	
Demonstration Year 3	11/2/22	3/31/23	
Demonstration Year 4	11/2/23	3/29/24	
Demonstration Year 5	11/2/24	3/31/25	
Mid-Point Assessment Report	9/1/21	5/31/23	Not Started
Key informant interviews and analysis for Mid-Point Report	9/1/21	12/31/21	
Prepare Draft #1 for IDHW review	9/30/22	11/30/22	
IDHW reviews Draft #1 (assume 30 days)	11/30/22	12/30/22	
Prepare Draft #2 for CMS review (OFFICIAL DUE DATE)	1/2/23	5/31/23	
Interim Evaluation Report	1/2/23	3/29/24	Not Started
Key informant interviews and analysis for Interim Report	1/2/23	4/28/23	
Calculate measures for Interim Report	4/1/23	6/30/23	
Perform quantitative analysis including modeling	6/30/23	11/15/23	
Prepare Draft #1 for IDHW review	10/1/23	2/16/24	
IDHW reviews Draft #1 (assume 30 days)	2/16/24	3/15/24	
Prepare Draft #2 for CMS review (OFFICIAL DUE DATE)	3/16/24	3/29/24	

Summative Evaluation Report	1/6/25	8/31/26	Not Started
Key informant interviews and analysis for Summative Report	1/6/25	5/2/25	
Obtain & process complete 2024 data	7/1/25	8/29/25	
Calculate measures for Summative Report	9/1/25	10/31/25	
Carry out quantitative analysis for Summative Report	10/15/25	3/31/26	
Prepare Draft #1 for IDHW review	1/1/26	6/16/26	
IDHW reviews Draft #1 (assume 30 days)	6/16/26	7/16/26	
Prepare Draft #2 for CMS review (OFFICIAL DUE DATE)	7/16/26	8/31/26	

Appendix F. Acronyms

AOD- Alcohol or Other Drug

ASAM- American Society for Addiction Medicine

BHT Waiver- Behavioral Health Transformation Waiver

CCBCH- Certified Community Behavioral Health Clinic

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

DY3- Demonstration Year 3

ED- Emergency Department

EHR – Electronic Health Record

EIC- Evidence to Impact Collaborative

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

HPSA- Health Professional Shortage Area

HIT- Health Information Technology

IBHP- Idaho Behavioral Health Plan

IBHP MCO- Idaho Behavioral Health Plan Managed Care Organization

IBM- International Business Machines Corporation

IDHW- Idaho Department of Health and Welfare

IHDE- Idaho Health Data Exchange

IMD - Institution for Mental Diseases

IOP- Intensive Outpatient Programs

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

OHDMP – Opioids at High Dosage and From Multiple Providers

OHSU – Oregon Health and Science University

OTP- Opioid Treatment Programs

OUD- Opioid Use Disorder

PCCM- Primary Care Case Management

PDMP – Prescription Drug Monitoring Program

PSU- The Pennsylvania State University

SAMHSA- Substance Abuse and Mental Health Services Administration

STC- Special Terms and Conditions

SUD- Substance Use Disorder

SED- Serious Emotional Disturbance

SMI- Serious Mental Illness

Appendix G. 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 health care policies and interventions. This has included evaluations and studies of health care 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. 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 H. Conflict of Interest Statement

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,

[redacted]

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

Idaho Department of Health and Welfare

APPENDIX E

Supplemental Evaluation Information

APPENDIX E

Supplemental Evaluation Information

The State Medicaid Agency proposes to continue the initial research hypotheses, questions, and data sources from the original demonstration for the following SUD and SMI/SED components of the demonstration. Additional information regarding the interim findings can be found in the interim evaluation report. Additional information about the specific hypotheses, questions, and data sources can be found in the April 26, 2021, approved evaluation design available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/id-behavioral-health-transformation-appvd-eval-des-04262021.pdf A copy of the evaluation design is included for reference.

For the proposed 1915(i)-like population, the State Medicaid Agency expects to develop an evaluation design that would include quality and performance measures that are identified in the recently approved 1915(i) SPA via SPA ID-22-0009 1915(i) HCBS Serious Emotional Disturbance (SED) Renewal available at: https://www.medicaid.gov/sites/default/files/2023-01/ID-22-0009.pdf). A copy of the recently approved SPA is included for reference.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

April 26, 2021

Matt Wimmer
Administrator
Division of Medicaid
Idaho Department of Health and Welfare
PO Box 83720
Boise, Idaho 83720

Dear Mr. Wimmer:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the state's "Behavioral Health Transformation" Evaluation Design, which is required by the Special Terms and Conditions (STCs) for the Section 1115 Demonstration, Project Number (11-W-00339/10). CMS determined that the evaluation design meets the requirements set forth in the STCs and, therefore, hereby approves the state's evaluation design.

The evaluation design is approved for the demonstration period through March 31, 2025, and is incorporated into the attached demonstration STCs as Attachment F. Per 42 CFR 431.424(c), the approved "Behavioral Health Transformation" evaluation design may now be posted to your state's Medicaid website. CMS will also post the approved evaluation design as a standalone document, separated from the STCs, on Medicaid.gov.

Please note that an interim evaluation report, consistent with the approved evaluation design is due to CMS one year prior to the expiration of the demonstration or at the time of the extension application if the state chooses to extend the demonstration. Likewise, the state must submit to CMS a draft of the final evaluation report within 120 days after expiration of the demonstration, consistent with this approved design.

Your CMS project officer, Ms. Kelsey Smyth, is available to answer any questions concerning this approval or your section 1115 demonstration. Ms. Smyth may be reached by email at kelsey.smyth@cms.hhs.gov. We look forward to our continued partnership on the Idaho Behavioral Health Transformation section 1115 demonstration.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2021.04.26 11:28:19 -04'00'

Andrea J. Casart -S
Digitally signed by Andrea J. Casart -S
Date: 2021.04.26 11:37:42 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Andrea Casart
Director
Division of Eligibility and Coverage Demonstrations

cc: Laura D'Angelo, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Evaluation Plan
for
Idaho Behavioral Health Transformation
Section 1115 Medicaid Waiver Demonstration Project

Prepared by
Penn State University
February 25, 2021

Evaluation Plan for Idaho's Behavioral Health Transformation Waiver

February 25, 2021

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SECTION A: General Background Information

A.1 General Background, Demonstration Name, approval date, and evaluation period

Similar to states across the country, Idaho has struggled in recent years with a rise in substance use disorders (SUD), in particular opioid use disorder (OUD), with 14.8 drug overdose deaths per 100,000 population in 2019[1]. In addition, Idaho faces significant mental health challenges, including a high rate of suicide (23.8 suicide deaths per 100,000 population in 2018, 20.4 suicide deaths per 100,000 in 2019)[2], which is the fourth leading cause of premature death for Idahoans under age 75[3]. Although the population is relatively small at 1.8 million people, it is the 14th largest state in geographic area, highlighting issues with coordinating care across large, often rural, geographic areas. Furthermore, one third of the population lives in rural or frontier counties, and overall the population density is 19 people per square mile, much lower than the US average of 83 people per square mile.

Further complicating access to behavioral health care, Idaho's terrain is largely mountainous or desert, with limited infrastructure for transportation, business, health care, and digital services[3]. This has resulted in a behavioral health care system that is fragmented and has significant problems related to access to behavioral health care services[3]. Additionally, 100% of the state has the federal designation of Health Professional Shortage Area for mental health services, 97.7% for primary care, and 94% for dental health[4]. To improve access for patients with serious mental illness (SMI) and serious emotional disturbance (SED), IDHW has made meaningful progress in improving access to crisis care for behavioral health. Yet significant gaps remain across the entire continuum of behavioral health care.

In January of 2020 Idaho expanded their Medicaid program, increasing access to mental health services for a total of 100,529 members by the start of 2021. At the time of approval for their 1115 SMI/SUD waiver demonstration they had already added 72,551 individuals.[5] However, with limited behavioral health care capacity due to lack of mental health care providers, a remaining concern is ensuring that all Medicaid enrollees are able to access needed care for treatment of mental health and substance use concerns. The Centers for Medicare and Medicaid Services (CMS) approved Idaho's Section 1115 Medicaid demonstration to address these gaps for people with SMI, SED, and SUD. The demonstration period for the "Idaho Behavioral Health Transformation" continues through March 31, 2025.

One component of the 1115 waiver approval is an evaluation of the demonstration's impacts, whether the demonstration is being implemented as intended, if intended effects are occurring, and whether outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration. **The evaluation period considers the following three periods: i)** baseline period of January 2018 through March 2020; **ii)** early demonstration period of April 2020 through December 2022; and **iii)** late demonstration period of January 2023 through March 2025. An additional, important evaluation challenge of note is that the COVID-19 pandemic struck near the beginning of the demonstration period. The pandemic will likely have important impacts on both mental health (due to isolation, stress, anxiety, etc.) as well as access to care (both due to facility closures/reductions in care, as well as patients deciding to avoid places of care).

A.2: Demonstration Goals and Key Change Actions

The 1115 SUD/SMI waiver provides the state with the authority to provide high-quality, clinically appropriate treatment to Medicaid beneficiaries aged 21-64 with a diagnosis of SMI, SED, and/or SUD in an IMD setting. The subsequent demonstration supports efforts by the state 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 are able to access needed care and treatment when they need it. To this end, Idaho is implementing a multi-pronged strategy to address behavioral health care reform. This approach has three broad, overarching reform 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.

Within the framework of these three aims, Idaho and their evaluation team have aligned the 11 specific goals set by CMS. Goals are divided across both SUD and SMI/SED care:

SUD Specific Goals:

1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
2. Increased adherence to and retention in treatment for OUD and other SUDs.
3. Reductions in overdose deaths, particularly those due to opioids.
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.
5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate for OUD and other SUDs.
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

SMI/SED Specific Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
2. Reduced preventable readmissions to acute care hospitals and residential settings.
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.

4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care.
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Critical to achieving these specific goals, IDHW will undertake a series of actions over the course of the 1115 waiver demonstration period. These actions are captured within demonstration implementation milestones which are outlined in detail in the state's SUD and SMI/SED implementation plans[6]. Below each action is categorized into five key domains of change, including:

1. Provide Expanded Medicaid Coverage

Idaho's 1115 waiver demonstration proposes providing expanded coverage to Medicaid enrollees. This includes the availability to use Medicaid funds for a wider range of services for those individuals aged 21-64. Expansion of coverage includes:

- Reimbursing institutions for mental diseases (IMDs)
- Reimbursing residential behavioral health services. Talks are ongoing about increasing reimbursement rates.

2. Expand supply of providers and services

- The 1115 waiver demonstration proposes expanding access to services for beneficiaries. Specific actions include:
    - Expand access and utilization of peer and family support services
    - Expand the number of MAT waivered providers
    - Develop a comprehensive statewide crisis service plan to expand availability of crisis services
    - Increase the integration of physical and behavioral health services
    - Expand the provision of transportation benefits for behavioral health care

3. Transform Administrative Processes

- To accomplish proposed changes a number of administrative processes will be transformed. These include:
    - Establish a certification process for newly enrolled behavioral health providers to improve access to high-quality providers
    - Establish mandatory post-discharge requirements following inpatient, residential, and ED visits
    - Require all IMDs to provide at least two forms of Medication Assisted Treatment (MAT)
    - Implement an interoperability platform to improve coordination between first responders and behavioral health treatment providers
    - Simplify and standardize telehealth coverage rules

- Adjust the details of the upcoming IBHP managed care contract to improve care coordination

4. **Provide education and training**

- To provide high-quality services the state proposes the following actions regarding education and training:
    - Develop a standardized approach for SUD identification
    - Promote training for early SUD identification
    - Educate providers on new reimbursement opportunities for SUD and SMI/SED care

5. **Fund health information technology (HIT)**

- Critical to coordination of care and care expansion the state proposes changes to HIT including:
    - Utilize federal opioid and SUD funding to improve IT for the purpose of improving SUD and SMI/SED care coordination
    - Utilize funding to improve providers integration with Prescription Drug Monitoring Program (PDMP) and Idaho Health Data Exchange (IHDE) platforms to further coordinate SUD and SMI/SED care

Finally, to meet the goals of the 1115 waiver demonstration, IDHW has agreed to implement recommended milestones outlined by CMS for SMI/ SUD demonstrations. These will inform the evaluation's assessment and research questions (Section B).

A.3: Description of the demonstration and implementation timing.

Over the past decade, Idaho has made significant improvements in access to care for those with SUD and/or SMI/SED. However as mentioned above, gaps continue to exist. Idaho's 1115 waiver demonstration focuses on three broad reforms resulting in five change categories that encompass the demonstration's implementation (Section A.2). Implementation Milestones are provided in full in the CMS Special Terms and Conditions for the Demonstration[6], and are discussed further in the evaluation plan as they relate to research questions and hypotheses.

A.4: Other relevant contextual factors

There are several important contextual factors which the evaluation design will consider alongside the direct impact of the demonstration. For example, Idaho Medicaid expansion began January 2020. This has significantly increased the number of Medicaid enrollees, including the number of enrollees with SMI and/or SUD who have coverage for behavioral health treatment. The Medicaid 1115 demonstration began shortly after Medicaid expansion. Given the proximity in timing, from an evaluation standpoint, it will be important to attempt to disentangle the effects of the changes to Idaho's Medicaid policy. To this end, the evaluator will make comparisons to changes in utilization for non-behavioral health treatment in order to tease out the relative

impacts of Medicaid expansion (which affects both behavioral and physical health care) and the 1115 waiver (which focuses on behavioral health care). While there are likely to be spillover effects from one to the other, this approach will provide a first approximation to the relative impacts.

In addition, prior to Medicaid expansion in January 2020, many behavioral health services were covered through the Idaho Department of Health and Welfare's (IDHW) Division of Behavioral Health (DBH). Following the State's Medicaid expansion, these services will be reimbursed using Medicaid funds, with the aim of improving coordination of comprehensive services.

Other factors to consider include that beginning January 1, 2020, Idaho Behavioral Health Plan (IBHP) began reimbursing partial hospitalizations for behavioral health care. On January 1, 2021, IBHP began reimbursing methadone maintenance care in opioid treatment programs (OTPs)--relevant coverage to the waiver. Additionally, the State is in the process of finalizing a Request for Proposals (RFP) to solicit vendor submissions that will result in a new contract award to operate the IBHP, which currently provides outpatient behavioral health care through a Medicaid carveout. The contract will be awarded in late 2021 with behavioral health services available through the new contract beginning on July 1, 2022, This RFP proposes a new structure for the IBHP, in which the selected contractor will assume responsibility for all behavioral health services across the continuum of care—both inpatient and outpatient. Crisis centers may be covered as part of the IBHP MCO contract in 2022. Through contract monitoring, the selected contractor will be held accountable for achieving specified performance targets, including affirmative treatment outcomes for IBHP enrollees. In reviewing responses to this RFP and performance targets of the awardee, the state will give special emphasis to candidates' demonstrated propensities for mitigating the need for inpatient admissions and maximizing the effectiveness of community-based services offered as part of the continuum of care.

Further, pursuant to state legislation passed in 2015, naloxone, an important overdose reversal drug, was made available to anyone in Idaho without a prescription by simply asking a pharmacist. In 2019, the law was further expanded to permit other licensed health professionals to dispense naloxone, rather than just prescribers and pharmacists. With eased regulations and easier access to this lifesaving drug, the Idaho Office of Drug Policy is now focused on expanding naloxone distribution, particularly to first responders, through a temporary grant program. Specific to crisis services, in 2016, the State established a Suicide Prevention Program, which provides support for the Idaho Suicide Prevention Hotline and public awareness campaigns. Regarding improvement of care for SMI/SED, coverage of crisis stabilization services and partial hospitalizations began in January 2020 but is independent of the 1115 waiver itself. Finally, an important but unavoidable complication to the evaluation is the COVID-19 pandemic that began just around the beginning of the demonstration period. The evaluator will flexibly vary the time periods examined in sensitivity analyses (including dropping the 2020 time period and dividing the demonstration period into both an early and a late period).

SECTION B: Evaluation Research Questions and Hypotheses

This evaluation plan includes an overarching logic model (Appendix 3) depicting the demonstration's overall theory of change[7] – the underlying assumptions about how the demonstration will lead to outcomes and in what time frame. Broadly, the IDHW is utilizing

federal funding resources to implement the 1115 waiver demonstration with a goal of improving access, utilization, quality, and health outcomes related to both SUD and SMI/SED treatment. Appendices 2 and 3 describe the key demonstration actions that are occurring as part of the implementation plan, along with their anticipated outcomes. Given the complexity and multi-faceted nature of the demonstration, it is important to understand the timing and scope of how changes may ultimately be implemented.

As outlined in section A.2, the primary, initial set of demonstration activities include expansion to the types of care that can now be reimbursed using Medicaid funds for the eligible population of Medicaid enrollees ages 21-64. Second, ongoing work focuses on expanding funding as well as other strategies to increase the supply and breadth of behavioral services available in Idaho, particularly in rural areas. Third, an ongoing set of administrative process changes and initiatives further seek to improve the availability and quality of SUD and SMI/SED care. Fourth, IDHW has been working to provide education and training for providers regarding what services can be reimbursed using Medicaid funds as well as improving best practices for identifying SUD in the primary care setting. Finally, IDHW is utilizing federal funding to improve the health IT infrastructure to better connect providers as well as improve ability to query the PDMP.

Each demonstration goal will be accomplished through achieving specific implementation milestones that have been established considering demonstration aims, goals and milestones NB: Milestone numbering aligns with the order outlined in the implementation plan). The evaluator will test the below hypotheses—that build on and refine the tentative hypothesis proposed in the original waiver application. Each hypothesis will in turn be tested by multiple research questions.

SUD Specific Goals:

Goal 1: Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs

<u>Implementation Milestone 1: Access to critical levels of care for OUD and other SUDs</u>

- Hypothesis 1: The 1115 waiver demonstration will lead to improved access to critical levels of care for OUD and other SUDs.
    - Research Question 1.1: Did initiation of SUD treatment increase during the demonstration period?
    - Research Question 1.2: Did outpatient services increase during the demonstration period?
    - Research Question 1.3: Did intensive outpatient and partial hospitalization services increase during the demonstration period?
    - Research Question 1.4: Did residential and inpatient services increase during the demonstration period?

Goal 2: Increased adherence to and retention in treatment for OUD and other SUDs

<u>Implementation Milestone 3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications</u>

- Hypothesis 2: The 1115 waiver demonstration will lead to increased use of nationally recognized, evidence-based SUD program standards.
    - Research Question 2.1: Did screening increase during the demonstration period?

- Research Question 2.2: Did initiation of alcohol use disorder and SUD treatment increase during the demonstration period?
- Research Question 2.3: Did MAT utilization (sub-analysis specific to methadone) increase during the demonstration period?
- Research Question 2.4: Did adherence to MAT for OUD users increase during the demonstration period?
- Research Question 2.5: Did re-engagement of MAT for OUD patients increase during the demonstration period?

Goal 3: Reductions in overdose deaths, particularly those due to opioids

Implementation Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

- Hypothesis 3: The 1115 waiver demonstration will lead to increased use of evidence-based, SUD-specific patient placement criteria.
  - Research Question 3.1: Did opioid overdose death rate (overall, in-hospital, and out-of-hospital) increase during the demonstration period?
  - Research Question 3.2: Did ED visits for SUD increase during the demonstration period?
  - Research Question 3.3: Did repeat overdoses increase during the demonstration period?

Goal 4: Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services

Implementation Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

- Hypothesis 4: The 1115 waiver demonstration will lead to implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
  - Research Question 4.1: Did use of opioids at high dosage in persons without cancer (OHD-AD) decrease during the demonstration period?
  - Research Question 4.2: Did use of opioids from multiple providers in persons without cancer (OMP) decrease during the demonstration period?
  - Research Question 4.3: Did use of opioids at high dosage and from multiple providers in persons without cancer (OHDMP) decrease during the demonstration period?
  - Research Question 4.4: Did concurrent use of opioids and benzodiazepines (COB-AD) decrease during the demonstration period?
  - Research Question 4.5: Did emergency department utilization for SUD per 1,000 Medicaid beneficiaries decrease during the demonstration period?
  - Research Question 4.6: Did ED visits for OUD and SUD decrease during the demonstration period?

Goal 5: Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate for OUD and other SUDs

Implementation Milestone 6: Improved care coordination and transitions between levels of care

- Hypothesis 5: The 1115 waiver demonstration will lead to improved care coordination and transitions between levels of care.
    - Research Question 5.1: Did follow-up after emergency department visits for mental illness (FUM-AD) increase during the demonstration period?
    - Research Question 5.2: Did readmissions among beneficiaries with SUD decrease during the demonstration period?
    - Research Question 5.3: Did preventive care utilization (connecting OUD patients to broader care) increase during the demonstration period?
    - Research Question 5.4: Did follow-up with patients prescribed an anti-psychotic increase during the demonstration period?
    - Research Question 5.5: Did follow-up with patients post-ED discharge increase during the demonstration period?
    - Research Question 5.6: Did medication continuation post inpatient discharge for SUD increase during the demonstration period?

Goal 6: Improved access to care for physical health conditions among beneficiaries.

Implementation Milestone 4: Sufficient provider capacity at each level of care, including MAT

- Hypothesis 6: The 1115 waiver demonstration will lead to sufficient provider capacity at each level of care.
    - Research Question 6.1: Did SUD provider availability increase during the demonstration period?
    - Research Question 6.2: Did SUD provider availability for MAT increase during the demonstration period?
    - Research Question 6.3: Did provider availability for MAT increase during the demonstration period?
    - Research Question 6.4: Did provider availability for methadone increase during the demonstration period?
    - Research Question 6.5: Did availability of community-based SUD services increase during the demonstration period?
    - Research Question 6.6: Did patient satisfaction increase during the demonstration period?

SMI/SED Specific Goals:

Goal 1: Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings

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

- Hypothesis 7: The 1115 waiver demonstration will lead to improved quality of care in psychiatric hospitals and residential settings.
    - Research Question 7.1: Did utilization of behavioral health treatment services increase during the demonstration period?

Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings

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

- Hypothesis 8: The 1115 waiver demonstration will lead to earlier identification and engagement in treatment through increased integration.
    - R8.1 Did the number of enrollees receiving care from co-located physical and behavioral health facilities increase during the demonstration period?

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

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

- Hypothesis 9: The 1115 waiver demonstration will lead to increasing access to continuum of care, including crisis stabilization services.
    - Research Question 9.1: Did mental health services utilization increase in inpatient settings during the demonstration period?
    - Research Question 9.2: Did mental health services utilization increase in intensive outpatient and partial hospitalization settings during the demonstration period?
    - Research Question 9.3: Did mental health services utilization increase in ED settings during the demonstration period?
    - Research Question 9.4: Did crisis service utilization increase during the demonstration period?
    - Research Question 9.5: Did outpatient rehabilitation increase during the demonstration period?
    - Research Question 9.6: Did case management increase during the demonstration period?
    - Research Question 9.7: Did home and community services increase during the demonstration period?
    - Research Question 9.8: Did long-term services/supports increase during the demonstration period?
    - Research Question 9.9: Did ED visits for SMI/SED increase during the demonstration period?

Goal 4: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care

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

- Hypothesis 10: The 1115 waiver demonstration will lead to increasing access to continuum of care, including crisis stabilization services.

- Research Question 10.1: Did availability of community-based behavioral health services (overall, outpatient, inpatient/residential, office-based) increase during the demonstration period?
- Research Question 10.2: Did suicide rates decrease during the demonstration period?
- Research Question 10.3: Did availability of virtual visits increase during the demonstration period?
- Research Question 10.4: Did availability of clinics with co-located physical and behavioral health providers increase during the demonstration period?
- Research Question 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?
- Research Question 10.6: Did availability of behavioral health in FQHCs increase during the demonstration period?
- Research Question 10.7: Did per capita availability of outpatient mental health professionals, by type (e.g., psychologists, social workers) increase during the demonstration period?

Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities

Implementation Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

- Hypothesis 11: The 1115 waiver demonstration will lead to improved care coordination and transition to community-based care?
    - Research Question 11.1: Did 30-day readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF) increase during the demonstration period?

Qualitative Research Questions

Additionally, the evaluator will conduct a qualitative analysis to contextualize and provide further insights into the implementation and consequent outcomes. These include the following research questions:

- Research Question 12.1: Is the demonstration being implemented as intended?
- Research Question 12.2: Is the demonstration having the intended effects on the target population?
- Research Question 12.3: What factors may have driven the observed results in terms of access to SUD and SMI/SED care?
- Research Question 12.4: What factors may have driven the observed results in terms of health care outcomes?
- Research Question 12.5: What are the valuable lessons learned and successes?

Cost Analysis Research Questions

The evaluator will also estimate impacts of the demonstration on costs both on SUD- and SMI/SED-specific treatment as well as on overall spending. This will include addressing the following research questions:

- Research Question 13.1: Has total spending for SUD-related care changed over the 1115 waiver demonstration period?
- Research Question 13.2: Has total spending for SMI/SED-related care changed over the 1115 waiver demonstration period?
- Research Question 13.3: Has total spending by site of care for SUD-related care changed over the 1115 waiver demonstration period?
- Research Question 13.4: Has total spending by site of care for SMI/SED-related care changed over the 1115 waiver demonstration period?
- Research Question 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)?

SECTION C: Methodology

C.1 Evaluation Methodology

The methodology will be similar for both the SUD and the SMI/SED portions of the evaluation. The methods outlined below will apply to both portions of the evaluation except where indicated. The evaluator will use an explanatory sequential mixed methods approach. Initially, the evaluator will utilize both quantitative and qualitative data collection. The quantitative approach will include aggregation of data from multiple sources (further detailed below) to assess changes in availability, utilization, quality of care, and health outcomes. Concurrently, the evaluator will collect qualitative data from key stakeholders in order to understand more precisely what specific components of the demonstration plan have been implemented, the fidelity to the implementation plan, the timing of implementation, and an understanding of how widespread implementation may be (effectively the "dose" of the intervention). This will help to guide subsequent refinement of the quantitative approach. For example, if certain components of the waiver demonstration are delayed, that can then be appropriately accounted for in the quantitative analyses. Similarly, if certain components appear to be implemented more quickly than expected that can also be accounted for quantitatively. Results of the qualitative assessment can also be used to inform Idaho demonstration leaders of progress and if, or where changes might be needed. In later stages of the evaluation, key informant interviews will be used to identify demonstration programs and interventions that were most effective as well as understanding barriers and facilitators for success.

Quantitative analyses are outlined in more detail in section C.4. Broadly, the evaluator proposes an interrupted time series approach to assess changes in each of the outcomes across both SUD and SMI/SED treatment from before to after the 1115 waiver demonstration. For each set of research questions, the evaluator includes accompanying hypotheses.

Testing Hypotheses

For each research question and related hypothesis, the evaluator will test whether the demonstration has been successful in meeting that particular objective by testing for whether the evaluator can observe a significant change in a majority of the relevant, primary outcomes (see Appendix 4 for a list of outcomes. Where feasible, the evaluator will also attempt to incorporate a control group or benchmark data. For the access to care outcomes, the evaluator will attempt to use the Treatment Episode Data Set (TEDS) data to provide a control group in a difference-in-differences framework. Similarly, for the mortality-related health outcomes the evaluator will use the Center for Disease Control (CDC)Vital Statistics detailed mortality data as a control group. For utilization and quality outcomes, the evaluator will continue to explore benchmark data options for the accounting of secular changes occurring outside the 1115 waiver demonstration. Finally, to provide additional explanatory clarity to our quantitative results, the evaluator will supplement with qualitative data including the collection of barriers and facilitators of success, approaches that drove successes, and lessons learned.

C.2 Evaluation Period

The demonstration period began on April 17, 2020 and concludes on March 31, 2025. The final evaluation report is due 18 months later, on August 31, 2026. Data from January 2018 – March 2020 will be considered the baseline, or "pre-demonstration" data. The evaluator will divide the demonstration period into an "early" period (April 17, 2020 – December 2022) and a "late" period (January 2023 – March 2025). This is in part to account for the transition to a new behavioral health MCO contract which will begin services in 2022. This design will explicitly capture these potentially differential impacts on outcomes. In addition, given the complexity of the demonstration, the evaluation should explicitly account for both the phased roll-out of various components of the implementation as well as the anticipated time for changes to be realized in the form of impacts on the stated outcomes. The analytic plan will account for Idaho's multi-pronged approach to address health care reform in the state (Appendix 2). Finally, the evaluation will also include analyses that omit 2020 both to allow for time for the demonstration to be implemented and to account for disruptions from the COVID-19 pandemic. The summative evaluation report will include data from January 2018 through December 2025. Thus, the evaluation will include nine quarters of data for the baseline period prior to the start of the demonstration, and data for all but the final quarter of demonstration implementation. This will allow the evaluator to complete the analysis and report prior to the August 2026 deadline.

C.3 Data Sources and Preparation

The quantitative portion of the evaluation will include member-level data from Idaho Medicaid and Department of Behavioral Health (claims, enrollment, and pharmacy data; IMD utilization data), Optum Idaho (outpatient behavioral health claims), the new behavioral health vendor starting in 2022 (inpatient, residential, and outpatient behavioral health claims), Vital Statistics (data on overdose and other causes of death). In addition, provider-level data about waivers for and use of medication-assisted treatment (MAT) as well as naloxone availability will be obtained from the Board of Pharmacy and the Prescription Data Monitoring Program (PDMP). Finally, the Mental Health Availability Assessment will require collecting data from insurance carriers,

providers, licensing boards, and other associations to obtain information regarding staff counts and facility characteristics (number of beds, providers, etc.). Prior to the MCO change, the evaluator will utilize claims data, licensing board information, and other data sources to determine mental health availability as well as conduct quantitative analyses. After the MCO transition, the evaluator will continue to use these sources of data, but direct comparisons pre and post MCO transition will be undertaken to ascertain if the transition itself has influenced any of the outcomes data. The state will monitor and manage data quality throughout the process using tools within its IBM supported data system to identify and rectify missingness incorrect values or any other system errors potentially due to input and linking.

The qualitative portion of the evaluation will require secondary document analysis and key informant interviews. Methodology for the qualitative portion of the evaluation is described in section C.8.

The evaluator will obtain all data for quantitative analysis via secure file transfer protocol (SFTP) or other approved, secure transfer methods from IDHW. IDHW's data team will perform quality checking and assurance with their data warehouse vendor, IBM. Data from disparate sources will be linked using unique and persistent identifiers (Medicaid ID) and/or via probabilistic "fuzzy" and deterministic matching when needed. The evaluator will prepare the data received from IDHW to be loaded into an analytic database, a process called staging. They will then organize the staged data into a relational database structure that will enable them to track Medicaid members and their outcomes over time and across data sources.

Data from multiple sources are required for some analyses, and not all sources use the same unique member identifiers. Thus, a major component of the staging process will be linking members across data sources. This will require the evaluator to create its own unique member identifier and then use an algorithm to match members between datasets. The algorithm will use member information such as name, gender, date of birth, zip code, and other identifiers, and a process called "fuzzy matching." This process is needed because the identifiers listed above are not always entered accurately and consistently across data sources. For example, one data source may list a member as "Elizabeth Doe", while in other data sources she is listed as "Beth Doe," "Liz Doe," "Elizabeth A Doe," "Elizabeth Dole," or other variations. The fuzzy matching process gives different weights to different potential matches, based on the probability that the individuals are the same person in the different sources.

C.4 Quantitative Analysis Plan

Prior to beginning the processes described above of creating the analytic database, the evaluator will propose a detailed Quantitative Analysis plan, which will include specifics regarding:

- **Measure specifications:** Precise definitions for all measures to be used for the evaluation, as specified by the organization that defined the measure (e.g., Healthcare Effectiveness Data and Information Set (HEDIS) or National Committee for Quality Assurance (NCQA), Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI), Pharmacy Quality Alliance-PQA). The monitoring protocol metric specifications will be updated annually based on guidance from CMS.
- **Medicaid population and subgroup definitions:** Criteria that will be used to identify all populations and subgroups for whom measures will be reported (e.g., Medicaid eligibility

codes, continuous enrollment criteria, and diagnosis or procedure codes that will be used to identify members with specific conditions).

- **Subgroups:** Subgroups of interest for each measure, and criteria that will be used to identify these groups outcomes of interest (e.g., geographic region, gender, age, eligibility category). Further, three subgroups of specific interest will be: i) children in foster care; ii) mothers with OUD and infants with neonatal abstinence syndrome; and iii) individuals prescribed multiple anti-psychotic medications.
- **Statistical models:** Statistical models that will be used to estimate change in outcomes associated with the demonstration, including functional form, control variables, and baseline periods. A general model is discussed below, and detailed models will be included in the detailed analysis plan.
  Steps to address other methodological challenges: The evaluation design lists potential challenges with evaluating the waiver's effects, including Medicaid members who "churn" between Medicaid and other coverage (or no coverage), unequal penetration of waiver reforms in different geographic regions, and state or national policy changes occurring at the same time as the waiver. The analysis plan will describe how such challenges may affect results and any steps planned to address such challenges.

C.5 Calculate Measures

The evaluator will calculate values for each proposed measure using data from the analytic database. Standard metrics from HEDIS or NCQA will be used whenever possible, and published definitions from the metric stewards will be used to create the metrics. Measures with binary outcomes—for example, whether or not the member received any services from an Institution for Mental Disease (IMD) —are calculated by determining who was eligible for the measure based on the published definition (the denominator) and then calculating whether eligible members met the criteria for the measure within a given timeframe (the numerator). Measures with non-binary outcomes—for example, number of visits of a specific type—are calculated by determining who was eligible for the measure (the denominator) and calculating a total for each eligible member (the numerator). A value is calculated for each individual for each calendar quarter, so that measures are available at the person/quarter level. Results are aggregated to calculate outcome measures for Medicaid members as a whole and for specific subgroups of Medicaid members. See Appendix 4 for a complete list of data elements.

C.6 Perform the Quantitative Analysis

The evaluator will perform a series of analyses to address each of the hypotheses outlined in section B.2. The gold standard analytic approach is to find a comparison group that is similar to the intervention group (in this case, adult Idaho Medicaid recipients with SUD and/or SMI/SED). Because the intervention in Idaho is statewide, the evaluator cannot create a comparison group based on Idaho Medicaid members who do not receive the intervention. While some states may be able to take advantage of geographically staggered implementation, the unique geography of Idaho precludes this – nearly half of the population lives in the Boise metropolitan area. In looking at other states that could potentially serve as comparisons, the state should:

- Be similar to Idaho

- Not have CMS waivers related to SUD and/or SMI/SED
- Be willing to share de-identified Medicaid claims data with Idaho for this purpose across the entire demonstration period plus the baseline

Many western states have waivers related to SMI/SED or SUD, making it difficult to find a reasonable comparison state.[8] Thus, the evaluator proposes an interrupted time series approach. In addition to the traditional approach defining a time variable as a running count of quarter since the beginning of the baseline period, the evaluator will also estimate an alternate model that drops the "early" implementation period prior to new MCO contract, which will likely lead to additional changes. Thus, would allow distinguishing between three time periods: baseline (January 2018 – March 2020), early post-implementation (April 2020 – December 2022), late post-implementation (January 2023 – March 2025). However, empirically, in both models, the evaluator treats April – December 2020 as a washout period. The unit of analysis will be the person-quarter (although unit of analysis may vary by outcome – see Appendix 4), and members will be included if they are enrolled for all 3 months of a quarter. Those enrolled for only part of the quarter will be excluded from the analysis for that particular quarter. The analytic model will be:

$$Y_{it} = \beta_0 + \beta_1 Time + \beta_2 Post + \beta_3 (Time * Post) + \theta X_{it} + e_{it}$$

Definitions within the model are as follows:

Time is a running count of quarters since the beginning of the baseline period (i.e., January 2018)
Post is an indicator for the period after the implementation of the 1115 waiver (i.e., April 2020)
X_{it} is a vector of demographic, geographic, and risk-adjustment covariates; and
e_{it} is a random error term associated with the unmeasured variation in the outcome of interest.
Given the uncertainty surrounding the timing of the different components as well as the complexity surrounding the broader Medicaid expansion and the COVID-19 pandemic, the evaluator highlights a series of sensitivity analyses surrounding the definition of the "pre-" and "post-periods'. First, as mentioned above, the evaluation will consider three time periods: baseline (January 2018 – March 2020), early post-implementation (January 2021 – December 2022), late post-implementation (January 2023 – December 2025. In baseline analyses, the evaluator considers April 2020 through the end of the year a wash-out period. In sensitivity analyses, the evaluator will alternatively drop January – March 2020 from the baseline period and focus exclusively on that period. These analyses will account for the initial three-month period of Medicaid expansion prior to the 1115 waiver demonstration. The evaluator will also consider shortening the early post-implementation period depending on how the COVID-19 vaccination roll-out continues.

The model specification above is general and can be used for a variety of different outcome variables. The specific model used will vary based on the distribution of the outcome variable. For example, the evaluator will use logistic regression models for dichotomous outcomes, i.e., those coded as "Yes/No" or "Present/Absent." For continuous outcomes, the evaluator prefers linear models; with large N available, linear models are appropriate even when some of the usual assumptions are not met[9]. Linear models have the additional advantage of having coefficients that are easily interpretable. The evaluator will also consider count models, two-part models or mixed effects models where appropriate. All statistical tests will be 2-sided with $p < 0.05$ considered statistically significant.

Model covariates: Models will be adjusted for demographic, geographic, and physical health factors including:

Demographic factors: Age, gender, Medicaid eligibility group, race/ethnicity. Note: based on the distribution of racial groups in Idaho, the evaluator may be able to focus on only a limited number of racial/ethnic categories, for example, non-Hispanic White, Hispanic, and Native American, with all other racial groups defined as "Other." This will be determined by the racial/ethnic distribution of the data; all racial groups with sufficient numbers will be included as separate race categories.

Geographic factors: urban/rural/frontier residence, Region (1 – 7), residence on Indian reservation.

Physical health: Chronic conditions will be identified based on either the Chronic Illness and Disability Payment System (CDPS)[10], or the CMS Chronic Condition Warehouse[11]. Both of these sources include ICD-10 definitions of common chronic conditions in a Medicaid population. To account for the presence of comorbid conditions, the evaluator will define the Elixhauser comorbidity index[12,13].

Outcome Metrics: Outcome metrics are listed in Appendix 4, based on CMS evaluation guidance. Additional metrics may be added if Idaho chooses to monitor additional metrics, and changes may be made based on future guidance from CMS as well as data availability. For example, should data availability preclude measurement of a specific outcome, it may be omitted from the analysis. The analytic and modeling approaches described above are appropriate for all outcomes that measure member-level outcomes (e.g., ED use, IMD use and length of stay).

In addition to these measures, the evaluator will include quarter of year fixed effects to account for seasonality.

Hypothesis Testing. This evaluation will employ a hypothesis testing approach that seeks to build convergent evidence from multiple research questions. In this context, hypotheses will be rejected or confirmed based on analyses of multiple research questions. If research questions indicate mixed evidence for a hypothesis in either direction, findings will be contextualized in terms of each proposed question,

C.6.1 Subgroups of Focus

It is important that the interventions do not perpetuate or exacerbate historical inequities in health care access or treatment among various subgroups of the population. In Idaho, these groups have included racial/ethnic minority groups, those living in frontier areas, and those with mental health and substance use disorders. The demonstration targets those with SMI/SED or SUD concerns, so all analyses that look for improvements in access or care outcomes will assess whether the demonstration has narrowed the gaps in care experienced by this group. For other historically marginalized or underrepresented groups, analyses will be designed to assess whether changes experienced by these groups were comparable to those experiences by their counterparts that do not face the same disparities. For example, did racial or ethnic minorities with SUD experience the same improvements in access to MAT as white members? Additional subgroups of interest that Idaho is monitoring include individuals with multiple anti-psychotic medications, pregnant women and SUD/OUD, children born with neonatal abstinence syndrome (NAS), families with experience in the foster care / child welfare system, individuals residing in

rural and non-rural locations, and criminally and not criminally involved individuals. The evaluator will also consider inclusion of these additional sub-populations to examine differential outcomes in the four areas of outcomes. Analyses will also address whether gaps widened or narrowed during the demonstration period. For each of the subgroups identified in Section C.4, we will add an additional interaction term per subgroup to the equation above (i.e. interact the post variables by the subgroups one-by-one).

C.7 Cost Analysis

The evaluator will examine the impact of the 1115 waiver demonstration on spending with the goal of better quantifying the Medicaid program costs for SMI/SED and SUD and will conduct three levels of analyses following CMS guidance on conducting cost analyses.[14]

Level 1:

Total Costs of Demonstration: The total costs will be calculated as the sum of all benefit and administrative costs due to waiver. Specifically, to understand the overall impact on federal spending, the evaluator will estimate changes to SUD and SMI/SED spending multiplied by the FMAP and added to the total spending on additional federal administrative funding for the demonstration. Separate cost analysis will be conducted for SMI/SED and SUD beneficiaries.

Level 2:

Costs Related to Diagnosis and Treatment SMI/SED and SUD: The second level is the costs related to SMI/SED and SUD. Specifically, the evaluator will focus on spending specifically for SUD diagnosis and treatment and SMI/SED diagnosis and treatment among the target population. This analysis will include identification of cost drivers by identifying major costs associated with a SMI/SED diagnosis and/or service receipt as well as with SUD diagnosis and/or services. Separate cost analysis will be conducted for SMI/SED and SUD beneficiaries.

Level 3:

Source of Treatment Drivers: The third level will identify key treatment cost drivers for SMI/SED and SUD populations separately. Benefit costs will be split by outpatient, inpatient, RX drugs and long-term care costs. Additionally, ED costs will be separated from other forms of outpatient costs. In particular, the evaluator will seek to understand whether variation in changes in spending by specific categories of care (IMD/inpatient, ED, outpatient, prescription drug, crisis services, and telehealth) to understand potential drivers of changes in spending. Separate cost analysis will be conducted for SMI/SED and SUD beneficiaries.

Dataset construction for the cost analysis will also follow CMS guidance. In particular, the evaluator will construct separate beneficiary level datasets from both populations of beneficiary level claims. This will include identifying all beneficiaries with relevant diagnosis and/or service utilization during the demonstration evaluation time periods. Then the evaluator will create datasets that identify each month a beneficiary is enrolled and has relevant diagnoses and/or service utilization and the 11 months following the most recent relevant diagnosis and/or service use. For each month during the identification and follow-up period, the beneficiary's Medicaid costs for that month will be specified (total as well as breakdown across setting. Demographic variables will be included within the dataset. Using this dataset, the evaluator will calculate and report average and median costs--plotting mean and median trends visually.

In parallel to the quantitative analyses above, the evaluator will employ a similar time series modelling approach to understand costs and related predictors. The evaluator will adopt a similar strategy to previous work in this space to increase comparability where appropriate. Specifically, the evaluator will estimate linear effects in the pre-demonstration and post-demonstration periods including estimating marginal effects and standard errors in the evaluation reports. The evaluator will run separate ITS models for each cost outcome and each outcome of focus (SMI/SED or SUD).

C.8 Qualitative Analysis

The qualitative portion of the evaluation will be focused on two primary goals. First, the evaluation team will seek to fully describe all components of the demonstration, including each of the key change actions, the timing of the key change actions, the change strategy, owner(s) of the change process/action, and key contextual factors in order to understand both which changes have been implemented and when they occurred. Second, the evaluation team will seek to identify what aspects of the demonstration were most effective in driving any observed changes in outcomes, as well as identifying barriers and facilitators to implementation encountered along the way. These lessons learned will be valuable to Idaho as well as other states considering 1115 behavioral health waivers.

Systematic document collection and review:

The evaluation team will use two primary types of data to inform the qualitative component: 1) systematic collection of secondary documents and 2) semi-structured interviews with key informants.

Through ongoing and systematic document review of proposals, meeting minutes, progress reports, publicly available documents, websites, and media, the evaluation team will track the progress of the demonstration waiver, any pivots, and/or challenges in order to develop a full narrative and timeline of events, including key contextual factors. The evaluation team will collaborate with Idaho state Medicaid and Behavioral Health division staff to identify and access to relevant documents.

Key informant interviews:

The evaluation team will conduct three phases of key informant interviews.

The first phase of key informant interviews is planned for the last quarter of 2021. Evaluation team members will interview 8-12 individuals who were involved in the design of the demonstration or who are actively involved in implementing it, as well as leaders or staff involved in each key change categories shown in the logic model. The evaluation team will work with Idaho state Medicaid and Behavioral Health division staff to identify relevant individuals and will use snowball sampling.

In conjunction with the document review, the first phase of interviews will provide a thorough description of the waiver demonstration and how it is expected to be implemented including each key change category, challenges, and key informant perspectives on the feasibility of on-time implementation of each component of the demonstration.

The second phase of key informant interviews is planned for early 2023. Evaluation team members will interview the same individuals interviewed in phase 1. The purpose of this round of interviews is to understand more precisely what specific pieces of the demonstration plan have

been implemented, the fidelity to the implementation plan, the timing of implementation, and an understanding of how widespread implementation may be. This will help to guide subsequent refinement of the quantitative approach. For example, if certain components of the waiver demonstration are delayed that can be appropriately accounted for in quantitative evaluations. Results of the qualitative assessment can also be used to inform Idaho demonstration leaders of progress and if or where changes might be needed.

The third phase of key informant interviews is planned for early 2025. Evaluation team members will interview 25-30 individuals or until saturation is reached, including key individuals leading the implementation and a variety of SUD and SMI/SED providers (making sure to incorporate members that provide for key subgroups including patients in rural areas, providers treating neonatal abstinence syndrome, providers with patients receiving multiple anti-psychotic medications, and providers caring for families involved in the child welfare/foster care systems). The evaluation team will work with Idaho state Medicaid and Behavioral Health division staff to identify relevant individuals and will use snowball sampling.

The third phase of interviews will be used to identify demonstration programs and interventions that were most effective as well as to understand barriers and facilitators for success. Interviews in all phases will be recorded and transcribed. Qualitative data will be stored in a qualitative analysis software program such as Dedoose, a software platform for team-based qualitative analysis. A team of analysts will draft a codebook to guide the systematic tagging of topics and concepts in each phase of interviews. After testing the codebook on numerous transcripts, the team will revise the codebook until the analysts reach consensus. Analysts will apply codes to each transcript and a second analyst will review the coding for quality and consistency.

Once all transcripts are coded in each phase, team members will analyze the coded passages, and write memos summarizing what was learned from each respondent related to the specific topics covered in the codebook. After aggregating what is learned on a specific topic across each type of interviewee, team members will draft a final memo for that topic, summarizing findings across all respondents. A second team member will review memos, and differences in interpretation and questions about clarity until all issues are resolved. Finally, the analytic memos will be synthesized by the lead analyst into the final evaluation report, which was then be reviewed by all evaluation team members and revised for clarity, where needed.

C.9 Interim and Summative Reports

The evaluator will deliver Mid-point, Interim and Summative Evaluation Reports that are meaningful and accessible to the primary audiences for the evaluation. Given the six-month time lag for maturation of claims/encounter data and the time needed to analyze these data, the evaluator anticipates that the reports will cover results for the following time periods:

- The Midpoint Assessment due to CMS in March 2023 will include an overview of the state's methodology used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations.
- The Interim Report due to CMS in March 2024 will include results through June 2022.
- The Summative Report due to CMS in August 2026 will present results through December 2025, one quarter prior to the end of the demonstration period.

The evaluator anticipates that each of the above referenced reports will contain a large volume of quantitative results, including comparison of measures with benchmarks, changes associated with the waiver as identified by regression analysis, and results for populations of focus and other sub-populations. The reports will also include qualitative results such as whether the demonstration is being implemented as expected and whether the demonstration is having intended effects on the target population. The reports will use visual representations (e.g. charts) to convey information quickly and concisely to a general audience to facilitate general population interpretation of results. To provide context and help explain results, the reports will draw on information from Idaho's quarterly reports to CMS and other background documents as needed.

C.10 Support Tasks

The evaluator will carry out the following tasks to support the quantitative and qualitative evaluations and deliver Interim and Summative Evaluation Reports:

- Facilitate kickoff meeting and regular meetings with state staff: The evaluator will facilitate a kickoff meeting with Idaho's Medicaid Division to introduce the evaluation team and clarify scope as needed. In addition, the evaluator will facilitate twice a month (every 2 weeks) check-ins with the division to provide progress updates and address any challenges with the evaluation. Ad-hoc meetings can occur as needed.
- Manage research compliance**:** The evaluator will obtain necessary permissions to collect and use data needed for the evaluation. This includes obtaining Institutional Review Board (IRB) approval for the evaluation protocol and executing any data use agreements needed to obtain and use the data.
- Provide project management: The evaluator will provide general project management to ensure deliverables are high-quality and delivered on time.

SECTION D: Methodological Limitations

This evaluation will have a number of limitations. The first known limitation is the on-going COVID-19 global pandemic and its impacts on health care and mental health service utilization and access. The evaluator expects to see increases in health care and behavioral health utilization as well as an increase in telehealth services. The evaluation team will develop a timeline of critical contextual factors/events to relate to demonstration major milestone timelines and implementation. This information will be used to inform our methodology to more precisely isolate effects from the demonstration.

Second, the absence of a direct comparison group limits the ability to absolutely determine whether the demonstration caused the observed changes in outcomes and to assess what the outcomes would have been in the absence of the demonstration. The evaluator will leverage existing data sources where possible (e.g., TEDS, CDC detailed mortality, national benchmarks) to act as comparisons and/or benchmarks. These are outlined in Appendix Table 4. In cases where we are unable to identify appropriate benchmarks, we will work with CMS to identify national Medicaid benchmarks. In addition, the evaluator will develop synthetic cohorts, providing the availability of data, to serve as comparison groups. Lastly, the evaluator will make

comparisons to changes in utilization for non-behavioral health treatment in order to tease out the relative impacts of Medicaid expansion (which affects both behavioral and physical health care) and the 1115 waiver (which focuses on behavioral health care). While there are likely to be spillover effects from one to the other, this approach will provide a first approximation to the relative impacts.

A third known limitation is that Medicaid members often "churn" between Medicaid and other coverage (or no coverage), which can make it difficult to follow individuals over time and assess trends. The evaluation team will use identifiers above and beyond a unique Medicaid ID (e.g., name, address, DOB) to more precisely match data at the beneficiary level deterministically and probabilistically, including across data systems and over-time. Further, the state data team has been working with their data warehousing vendor, IBM to quality check unique identifiers to ensure correctness.

Fourth, there could be unequal penetration of waiver reforms across geographic regions, and this could lead to limitations. Much of Idaho's population is concentrated in a few urban areas, with the rest of the state characterized by low or very low population density. This makes implementing reforms in a uniform way across the state very difficult. The realities of population scatter may require modifications of planned reforms in some areas. The current intention of the demonstration is to have the new MCO drive workforce development within rural areas which may also address potential for unequal penetration rates.

Fifth, other state or national policy changes may occur at the same time as the waiver. This could limit the ability of the evaluator to determine whether observed changes were due to the 1115 demonstration or to other policy changes. As mentioned in the beginning of this section the evaluation team will develop a timeline of critical events and policy changes through document analysis and key informant interviews to account for changes within our quantitative analyses. Specific state and/or national policy changes that the evaluator considers include the following:

1. Idaho has had an Idaho Response to Opioid Crisis (IROC) grant to pay for MAT services for the past 3 ½ years. This grant was slated to end in September 2020 although has received an initial extension due to the pandemic. Outside of the grant, Idaho's Medicaid program has not paid for MAT services. Policies are being developed, with the plan that Medicaid will begin paying for MAT services through Optum in January 2021. The evaluation team will work with Idaho to understand the data available to assess MAT data availability during the IROC grant funding period and the subsequent transition to Optum January 2021. In addition, in the IBHP contractor change in 2022, the evaluator will continue to assess changes resultant from the transition and account for these changes in our quantitative and qualitative methods. At this time, it is not yet clear what data regarding MAT services have been collected by DBH during the IROC funding period program, so availability of baseline data for MAT may be limited or incomplete.

2. Idaho Medicaid currently has an MCO contract with a single vendor for all outpatient behavioral health care. Outpatient care is paid through this MCO contract, and inpatient care is paid through fee-for-service. Idaho is preparing a request for proposals to re-bid for this vendor in 2021, and all behavioral health care will transition to the MCO at that time. Services under the new vendor will start in 2022, and data submission is likely to differ between the old and new vendors. This could impact data quality, timeliness, and/or completeness.

SECTION E: Additional Information/Attachments

E.1 Independent Evaluator – No Attachment

The Center for Health Systems Effectiveness (CHSE) at Oregon Health & Science University was originally planning to perform the evaluation. However, due to COVID-related staffing changes and changes in workload, CHSE had to withdraw as the independent evaluator. CHSE developed the draft evaluation plan but was not involved beyond that point. Idaho Division of Medicaid staff contacted CMS for recommendations for potential experienced evaluators. From the list that CMS provided, Idaho Division of Medicaid contacted potential evaluators, sent them the draft evaluation plan, and invited them to submit proposals. Six potential evaluators submitted proposals, and The Pennsylvania State University (Penn State) was selected based on evaluation requirements as established by CMS and review evaluation budget.

IDHW and Penn State will execute a contract based on the evaluation design and CMS evaluation requirements. Penn State will conduct analysis of Idaho's Behavioral Health Transformation Demonstration and write the evaluation reports. Penn State and Idaho Medicaid utilized the draft evaluation plan design from OHSU and expanded on methodologies, data sources, design capabilities and effective timelines. Idaho will utilize contract monitoring practices to ensure Penn State will conduct a fair and impartial evaluation, as part of the state's contract and procurement laws. As part of the development of the contract with the evaluator, IDHW will create a risk assessment that includes mitigation strategies to address these potential situations.

E.2 Timeline

The following timeline presents anticipated start and end dates for tasks described in the work plan based on deadlines.

Evaluation Timeline

Task	Start	End	Status
Support Tasks	12/1/20	3/31/25	In Progress
Facilitate Kick off meetings	12/1/20	12/31/20	Complete
Prepare Quantitative Analysis Plan	12/1/20	3/15/21	In Progress
Obtain IRB approval (if needed)	12/1/20	3/15/21	In Progress
Execute data use agreements	12/15/20	4/30/21	In Progress
Facilitate bimonthly check-in	1/25/21	3/31/25	In Progress
Build database and process data	2/1/21	7/15/25	In Progress
Create database structures and schema	2/1/21	4/1/21	In Progress
Obtain baseline & Q1 data (Jan 2018 - Jun 2020), create database	3/4/21	5/21/21	
Calculate quality measures for quarterly report	5/1/21	8/13/21	
Calculate additional quality measures and add to staging process	8/15/21	11/15/21	

Obtain remaining 2020 data, process, & prep for analysis	11/1/21	12/15/21	
Obtain 2021 data, process, & prep for analysis	7/1/22	7/15/22	
Obtain/process Jan - Jun 2022 data for Interim Eval. Report	9/1/22	3/30/23	
Obtain 2022 data, process, & prep for analysis	7/3/23	7/18/23	
Obtain 2023 data, process, & prep for analysis	7/1/24	7/15/24	
Obtain 2024 data, process, & prep for analysis	7/1/25	7/15/25	
Mental Health Availability Assessment	2/1/20	3/31/25	In Progress
Demonstration Year 1	2/1/20	5/31/21	In Progress
Demonstration Year 2	11/2/21	3/31/22	
Demonstration Year 3	11/2/22	3/31/23	
Demonstration Year 4	11/2/23	3/29/24	
Demonstration Year 5	11/2/24	3/31/25	
Mid-Point Assessment Report	9/1/21	5/31/23	Not Started
Key informant interviews and analysis for Mid-Point Report	9/1/21	12/31/21	
Prepare Draft #1 for IDHW review	9/30/22	11/30/22	
IDHW reviews Draft #1 (assume 30 days)	11/30/22	12/30/22	
Prepare Draft #2 for CMS review (OFFICIAL DUE DATE)	1/2/23	5/31/23	
Interim Evaluation Report	1/2/23	3/29/24	Not Started
Key informant interviews and analysis for Interim Report	1/2/23	4/28/23	
Calculate measures for Interim Report	4/1/23	6/30/23	
Perform quantitative analysis including modeling	6/30/23	11/15/23	
Prepare Draft #1 for IDHW review	10/1/23	2/16/24	
IDHW reviews Draft #1 (assume 30 days)	2/16/24	3/15/24	
Prepare Draft #2 for CMS review (OFFICIAL DUE DATE)	3/16/24	3/29/24	
Summative Evaluation Report	1/6/25	8/31/26	Not Started
Key informant interviews and analysis for Summative Report	1/6/25	5/2/25	
Obtain & process complete 2024 data	7/1/25	8/29/25	
Calculate measures for Summative Report	9/1/25	10/31/25	
Carry out quantitative analysis for Summative Report	10/15/25	3/31/26	
Prepare Draft #1 for IDHW review	1/1/26	6/16/26	
IDHW reviews Draft #1 (assume 30 days)	6/16/26	7/16/26	
Prepare Draft #2 for CMS review (OFFICIAL DUE DATE)	7/16/26	8/31/26	

E.3 Evaluation Budget –

Table E.1 below presents the total demonstration budget for tasks in this work plan.

Demonstration Year 1	Estimated Budget*
Project Planning and Management	$105,963.00
Data Collection and Analysis	$97,372.00
CMS Deliverables	$21,193.00
Travel	$18,900.00
DY 1 TOTAL AMOUNT NOT TO EXCEED	**$243,428.00**

Demonstration Year 2	Estimated Budget*
Project Planning and Management	$119,942.00
Data Collection and Analysis	$102,254.00
CMS Deliverables	$23,988.00
Travel	$18,900.00
DY 2 TOTAL AMOUNT NOT TO EXCEED	**$265,084.00**

Demonstration Year 3	Estimated Budget*
Project Planning and Management	$122,941.00
Data Collection and Analysis	$104,653.00
CMS Deliverables	$24,588.00
Travel	$18,900.00
DY 3 TOTAL AMOUNT NOT TO EXCEED	**$271,082.00**

Demonstration Year 4	Estimated Budget*
Project Planning and Management	$106,848.00
Data Collection and Analysis	$113,115.00
CMS Deliverables	$106,816.00
Travel	$18,900.00
DY 4 TOTAL AMOUNT NOT TO EXCEED	**$345,679.00**

Demonstration Year 5 & Final Reports	Estimated Budget*
Project Planning and Management	$109,380.00
Data Collection and Analysis	$109,346.00

CMS Deliverables	$110,125.00
Travel	$18,900.00
DY 5 through end of contract term TOTAL AMOUNT NOT TO EXCEED	**$347,751.00**

MAXIMUM CONTRACT AMOUNT	**$1,473,024.00**

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14. SMI/SED and SUD Evaluation Design Guidance: Appendix C.

Appendix 1. Demonstration Goals and Milestones

SUD Goals:

1. Increased rates of identification, initiation, and engagement in for OUD and other SUDs.
2. Increased adherence to and retention in treatment for OUD and other SUDs.
3. Reductions in overdose deaths, particularly those due to opioids.
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.
5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate for OUD and SUD.
6. Improved access to care for physical health conditions among beneficiaries with OUD or SUDs.

SUD Milestones

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

SMI/SED Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
2. Reduced preventable readmissions to acute care hospitals and residential settings
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.
4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities

SMI/SED Milestones

1. Ensuring quality of care in psychiatric hospitals and residential settings
2. Improving care coordination and transitioning to community-based care
3. Increasing access to continuum of care, including crisis stabilization services
4. Earlier identification and engagement in treatment, including through increased integration

Appendix 2. Domains of Change Activities and Timelines

Provide Expanded Coverage			
Name of change	**Description**	**Start Date**	**Outcome categories likely impacted**
Reimburse IMDs with Medicaid funds	Medicaid enrollees ages 21-64 can now access IMD services covered by Medicaid funds.	April 2020	Utilization, Quality, Health Outcomes
Reimburse residential behavioral health services	Medicaid enrollees ages 21-64 can now access residential behavioral health services covered by Medicaid funds.	April 2021	Utilization, Quality, Health Outcomes
Cover crisis services	Medicaid enrollees ages 21-64 can access crisis services covered through the IBHP MCO contract.	January 2020	Utilization, Quality, Health Outcomes
Reimburse partial hospitalization services	Medicaid enrollees ages 21-64 can access partial hospitalization services covered by Medicaid funds. These services include support therapy, medication monitoring, and skills building from intensive ambulatory care programs offering less than 24-hour daily care.	January 2020	Utilization, Quality, Health Outcomes
Reimburse Assertive Community Treatment (ACT) services	Medicaid enrollees ages 21-64 can access ACT services (integrated delivery of community mental health services to those with SMI/SED) covered by Medicaid funds. Goal is to facilitate a smoother transition to services post inpatient discharge for SMI/SED patients.	July 2022	Utilization, Quality, Health Outcomes
Reimburse recovery coaching for SUD	Medicaid enrollees ages 21-64 can access recovery coaching covered by Medicaid	January 2020	Access, Utilization, Quality, Health Outcomes
Reimburse OTPs for methadone maintenance treatment	Medicaid enrollees ages 21-64 will access methadone maintenance treatment provided by OTPs reimbursed by Medicaid. Ongoing discussions about increasing reimbursement rates to further facilitate expansion.	January 2021	Utilization, Quality, Health Outcomes

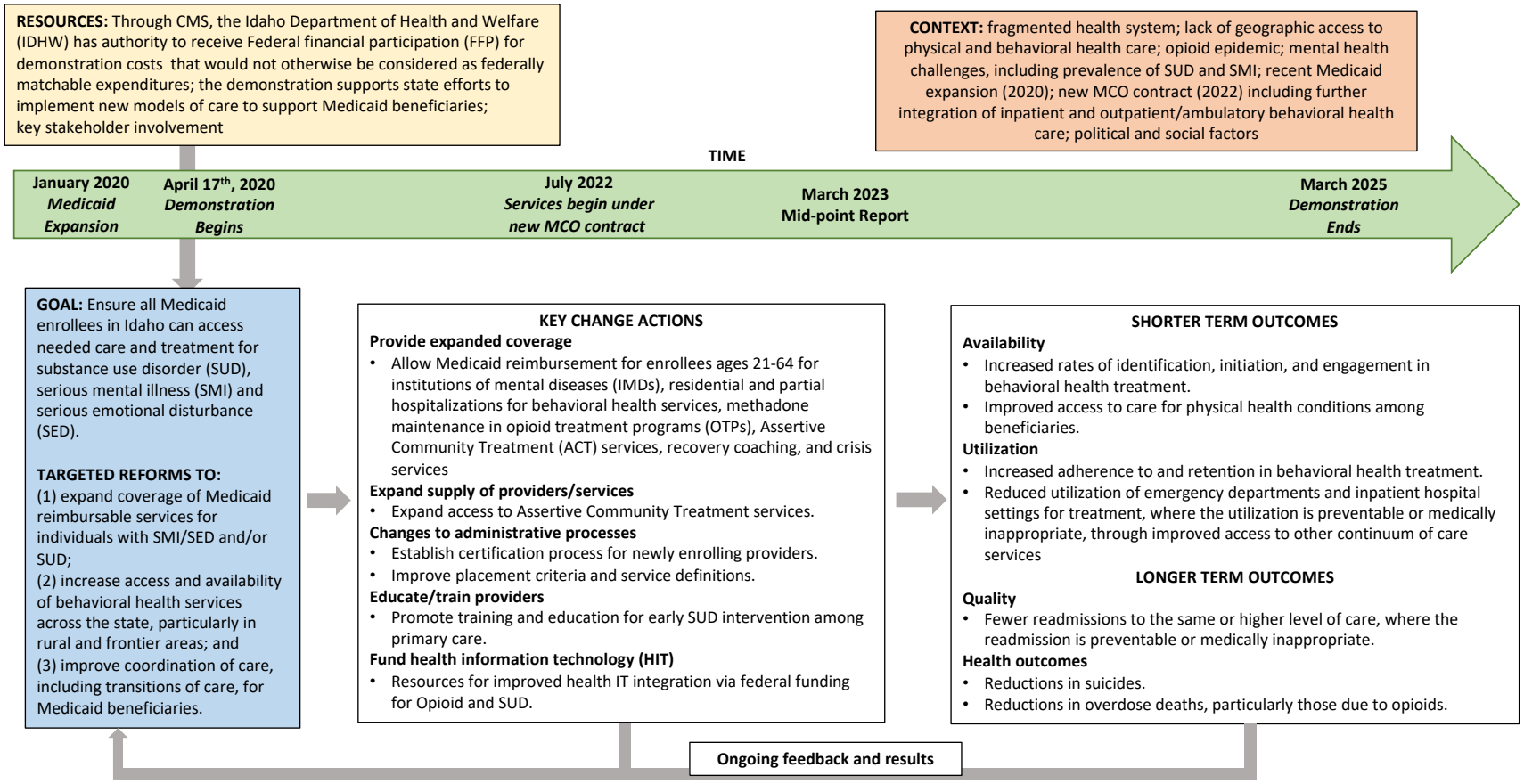
Expand Supply of Providers and Services			
Name of change	**Description**	**Start Date**	**Outcome categories likely impacted**
Expand number of MAT waivered providers	Idaho Medicaid collaborates with Idaho ECHO to encourage more providers across the state to become waivered to prescribe MAT.	2018	Access, Utilization, Health Outcomes
Develop a comprehensive statewide crisis response plan and system to expand crisis service availability	Implementing a plan that: • Develops a statewide inpatient and crisis bed registry • Improve access to same day crisis services (in person or telehealth) • Expand availability of mobile crisis units, particularly for rural areas • Implement single, statewide crisis line • Proactive and reactive crisis plans for all care transitions and discharges for those with SMI/SED	Bed Registry and same day crisis services April 2020 Mobile crisis and single statewide crisis line July 2022	Availability, Utilization, Quality, Health Outcomes
Increase integration of physical and behavioral health	• Pursuing physical-behavioral health integration by: • Adding behavioral health measures to quality evaluation • Enable billing simplifications so primary care can more easily provide behavioral health • Partner with Idaho ECHO to promote physical-behavioral health integration	August 2020 – October 2022 ECHO is ongoing PHI will occur with new MCO contract July 2022	Access, Utilization, Quality
Expand provision of transportation benefits	To increase access and utilization of behavioral health care in rural areas, the new NEMT contractor will improve uptake of the reimbursable travel fee.	2022	Access, Utilization

Changes to Administrative Processes			
Name of change	**Description**	**Start Date**	**Outcome categories likely impacted**
Provider certification process	Establish certification process for newly enrolled behavioral health providers together with re-certification process to ensure availability of high-quality providers.	April 2021	Availability, Quality
Improve discharge planning to community-based standards	Establish new mandatory post-discharge requirements (following inpatient, residential, and ED visits) including: • Must follow-up with patient within 7- and 30-days post-discharge • Case management for up to 30-days post-discharge • Minimum standards (TBD) for discharge planning • Plans to follow up with patients' MAT • Work with MCO to ensure robust discharge plans via telehealth for patients being discharge in rural areas	July 2022	Quality
Require all IMDs to provide at least 2 forms of MAT	Change IMD requirements that they must provide at least two forms of MAT in order to meet patient needs and increase utilization rates of MAT	July 2022	Utilization, Quality, Health Outcomes
Improve coordination between first responders and treatment providers	Implement an interoperability platform to better enable information sharing	TBD	Utilization, Quality, Health Outcomes
Simplify telehealth coverage rules	IBHP will work to simplify and standardize coverage of telehealth to facilitate behavioral health care delivered via telehealth, particularly for rural areas	2020	Access, Utilization, Quality, Health Outcomes
IBHP improvements to care coordination	The new IBHP managed care contract will aim to incorporate the following changes to the existing behavioral managed care contract: • Add inpatient and residential behavioral health services (in addition to current outpatient services) • New minimum standards for discharge planning that will be mandatory in all provide agreements on which MCO will be evaluated	July 2022	Access, Utilization, Quality

	• New requirement for case management for all hospitalized patients (both inpatient and ED visits) from early discharge through 30-day post-discharge on which MCO will be evaluated • Requirements to provide staff to work with enrollees through post-discharge transition and post-discharge care coordination		
Educate/Train Providers			
Name of change	**Description**	**Start Date**	**Outcome categories likely impacted**
Promote training for early SUD identification	Promote training for providers to identify SUD in primary care (e.g. using SBIRT). Promotion will be provided via the Health Connections primary care case management program.	July 2022	Utilization
Create standardized assessment process for SUD identification	Create a standardized approach that can be given to providers, particularly primary care providers, in order to improve early identification of SUD. Goal would be to create a standardized SBIRT tool/approach.	July 2022	Utilization
Educate providers on new reimbursement opportunities	Provide education to providers about the various behavioral health services that can now be reimbursed through Medicaid.	July 2022	Availability, Utilization
Fund Health Information Technology (HIT)			
Name of change	**Description**	**Start Date**	**Outcome categories likely impacted**
Improve health IT integration	Utilize federal opioid and SUD funding to improve health IT integration to better coordinate SUD and SMI/SED care	TBD	Access
Facilitate access to PDMP and Idaho Data Health Exchange	Provide funding to allow linking of these databases to an expanded set of providers in order to facilitate use of the PDMP and Idaho Data Health Exchange to further coordinate SUD care.	2020, integration with IHDE is ongoing	Access

Appendix 3. Logic Model

Idaho Behavioral Health Transformation Waiver Logic Model



Appendix 4. Demonstration Evaluation Outcome Definitions

	Availability				
Research Question(s)	**Outcome**	**Sample***	**Definition**	**Data source**	**Comparison Group**
6.1; 6.5	Availability of community-based SUD services	Providers	*Numerator*: # billing Medicaid for SUD *Denominator*: All providers	*Numerator*: Medicaid claims; IDHW data *Denominator*: Environmental scan	Possible matched control from TEDS data
6.2; 6.3	Provider availability for MAT	Providers	*Numerator*: # billing Medicaid for MAT *Denominator*: All providers	*Numerator*: Medicaid claims; IDHW data *Denominator*: Environmental scan	Possible matched control from TEDS data
6.4	Provider availability for methadone	Providers	*Numerator*5 # billing Medicaid for methadone *Denominator*: All providers	*Numerator*: Medicaid claims; IDHW data *Denominator*: Environmental scan	Possible matched control from TEDS data
10.1	Availability of community-based behavioral health services (overall, outpatient, inpatient/residential, office-based)	Providers	*Numerator*: # billing Medicaid for behavioral health *Denominator*: All providers	*Numerator*: Medicaid claims; IDHW data *Denominator*: Environmental scan	Possible matched control from TEDS data
10.3	Availability of virtual visits	Providers	*Numerator*: # billing Medicaid for SUD or SMI/SED telehealth visits *Denominator*: All providers	*Numerator*: Medicaid claims; IDHW data *Denominator*: Environmental scan	Possible matched control from TEDS data
10.4	Availability of clinics with co-located physical and behavioral health providers	Providers	*Numerator*: # of clinics with co-located physical/behavioral health	*Numerator*: Environmental scan	Possible matched control from TEDS data

			Denominator: All providers	*Denominator*: Environmental scan	
10.5	Availability of crisis care (separate by: overall; crisis call centers; mobile crisis units; crisis assessment centers; coordinated community response teams	Providers	*Numerator*: # of providers overall and by type *Denominator*: Population	Environmental scan	Possible matched control from TEDS data
10.6	Availability of behavioral health in FQHCs	Providers	*Numerator*: # FQHCs providing behavioral health *Denominator*: All FQHCs	*Numerator*: Medicaid claims; IDHW data *Denominator*: Environmental scan	Possible matched control from TEDS data
10.7	Per capita availability of outpatient mental health professionals, by type (e.g., psychologists, social workers)	Medicaid enrollees (ages 21-64); Providers	*Numerator*: # of providers *Denominator*: All Medicaid enrollees	*Numerator*: Medicaid claims; IDHW data *Denominator*: Environmental scan	Possible matched control from TEDS data
	<u>Utilization</u>				
Research Question(s)	**Outcome**	**Sample***	**Definition**	**Data source**	**Comparison Group**
1.1; 1.2; 1.3; 1.4	Utilization of SUD-related care by type: • outpatient • residential • inpatient • intensive outpatient and partial hospitalization	# Medicaid enrollees with SUD	*Numerator*: # using (and # of total uses) of each type of service *Denominator*: # Medicaid enrollees with SUD	Medicaid claims; IDHW data	Non-behavioral health utilization
2.1	Substance use screening	Medicaid enrollees	*Numerator*: # enrollees receiving screening *Denominator*: # Medicaid enrollees (ages 21-64)	Medicaid claims; IDHW data	Non-behavioral health utilization
2.2	Initiation of alcohol use disorder and SUD treatment	Medicaid enrollees with evidence of alcohol use	*Numerator*: # with claims for alcohol use disorder or SUD treatment (as defined by ICD-10 codes)	Medicaid claims; IDHW data	Non-behavioral health utilization

		disorder or SUD	*Denominator*: # Medicaid enrollees with evidence of alcohol use disorder or SUD		
2.3	MAT utilization (sub-analysis specific to methadone)	Medicaid enrollees with OUD	*Numerator*: # with claims for MAT *Denominator*: # Medicaid enrollees with OUD	Medicaid claims; IDHW data	Non-behavioral health utilization
5.3	Preventive care utilization (connecting OUD patients to broader care)	Medicaid enrollees with OUD	*Numerator*: # with claims for preventive care *Denominator*: # Medicaid enrollees with OUD	Medicaid claims; IDHW data	Non-behavioral health utilization
7.1	Utilization of behavioral health services	Medicaid enrollees with SMI/SED	*Numerator*: # enrollees with SMI/SED with claims for SMI/SED per month *Denominator*: # Medicaid enrollees with evidence of SMI/SED	Medicaid claims; IDHW data	Non-behavioral health utilization
8.1	Increased utilization of services from co-located physical and behavioral health facilities	Medicaid enrollees with SMI/SED or SUD	*Numerator: # with SUD/SMI/SED Diagnosis* *Denominator: All Medicaid enrollees*	Medicaid claims; IDHW data	Non-behavioral health utilization
9.1; 9.5; 9.6; 9.7; 9.8; 9.9	Utilization of behavioral health-related care by type: • outpatient rehabilitation • case management • home & community services • long-term services/supports • ED • inpatient	# Medicaid enrollees with SMI/SED	*Numerator*: # using (and # of total uses) of each type of service *Denominator*: # Medicaid enrollees with SMI/SED	Medicaid claims; IDHW data	Non-behavioral health utilization
9.2	Utilization of partial hospitalizations for SMI/SED	# Medicaid enrollees with SMI/SED	*Numerator*: # with a partial hospitalization *Denominator*: # Medicaid enrollees with SMI/SED	Medicaid claims; IDHW data	Non-behavioral health utilization
9.4	Crisis service utilization	Medicaid enrollees (or overall if unable to	*Numerator*: # of unique crisis service users (by type) *Denominator*: # of Medicaid enrollees (ages 21-64)	Medicaid claims; IDHW data; data from crisis centers	Non-behavioral health utilization

		identify Medicaid enrollment)			
	Quality				
Research Question(s)	**Outcome**	**Sample***	**Definition**	**Data source**	**Comparison Group**
2.4	Adherence to OUD for MAT users	Medicaid enrollees with OUD and at least one claim for MAT	*Numerator*: # with ≥180 days of continuous MAT without a gap of >7 days *Denominator*: Medicaid enrollees with OUD and at least one claim for MAT	Medicaid claims; IDHW data	TBD
2.5	Re-engagement of MAT for OUD patients	Medicaid enrollees with OUD with at least one gap of >30 days following initiation of MAT	*Numerator*: # who re-initiate MAT *Denominator*: Medicaid enrollees with OUD with at least one gap of >30 days following initiation of MAT	Medicaid claims; IDHW data	TBD
5.2; 11.1	Reduction of readmissions	Medicaid enrollees with an inpatient admission for SUD (separately SMI/SED)	*Numerator*: # readmitted within 30 days (60 days) with SUD (separately SMI/SED diagnosis) *Denominator*: # admitted with SUD (separately SMI/SED)	Medicaid claims; IDHW data	TBD
4.1	High dosage opioid prescribing	Medicaid enrollees with no cancer diagnosis	*Numerator:* # with high dosage opioid prescriptions *Denominator:* Medicaid enrollees (ages 21-64) with no cancer diagnosis	Medicaid claims; IDHW data	TBD
4.2	Opioid prescriptions from multiple providers	Medicaid enrollees with no cancer diagnosis	*Numerator:* # with opioid prescriptions from multiple providers in 60-day window	Medicaid claims; IDHW data	TBD

			Denominator: Medicaid enrollees (ages 21-64) with no cancer diagnosis		
4.3	High dosage opioid prescribing from multiple providers	Medicaid enrollees	*Numerator:* # with high dosage opioid prescriptions AND opioid prescriptions from multiple providers in 60-day window *Denominator:* Medicaid enrollees (ages 21-64) with no cancer	Medicaid claims; IDHW data	TBD
4.4	Concurrent use of opioids and benzodiazepines	Medicaid enrollees	*Numerator:* # of enrollees with concurrent prescriptions for an opioid and a benzodiazepine *Denominator:* Medicaid enrollees (ages 21-64)	Medicaid claims; IDHW data	TBD
4.5	ED utilization for SUD patients	Medicaid enrollees with SUD	*Numerator:* # with an ED visit *Denominator:* Medicaid enrollees with SUD	Medicaid claims; IDHW data	TBD
4.6	Mental health related ED utilization for OUD and SUD patients	Medicaid enrollees with OUD and SUD	*Numerator:* # with an ED visit *Denominator:* Medicaid enrollees with OUD and SUD	Medicaid claims; IDHW data	TBD
5.4	Follow-up with patients prescribed an anti-psychotic (to test for possible unintended spillovers will also test for ages 6-17)	Medicaid enrollees prescribed an anti-psychotic	*Numerator*: # of enrollees with a behavioral health provider within 28 days of prescription *Denominator*: Medicaid enrollees (ages 21-64) prescribed an anti-psychotic	Medicaid claims; IDHW data	TBD
5.1; 5.5	Follow-up with patients post-ED discharge (to test for possible unintended spillovers will also test for ages 6-17)	Medicaid enrollees with an ED visit for SMI/SED	*Numerator*: # with a behavioral health provider within 28 days of ED discharge *Denominator*: Medicaid enrollees (ages 21-64) with an ED visit for SMI/SED	Medicaid claims; IDHW data	TBD
5.6	Medication continuation post inpatient discharge for SUD (to test for possible unintended spillovers will also test for ages 6-17)	Medicaid enrollees with an inpatient	*Numerator*: # with evidence-based prescription within 2 days prior to discharge and within 30 days post-discharge	Medicaid claims; IDHW data	TBD

		admission for SUD	*Denominator*: Medicaid enrollees (ages 21-64) with an inpatient visit for SUD		
6.6	Patient satisfaction	Providers	*Numerator*: # with overall satisfaction rating of 9 or 10 *Denominator*: Behavioral health providers (by type)	Medicaid claims; IDHW data	TBD
	<u>Health Outcomes</u>				
Research Question(s)	**Outcome**	**Sample***	**Definition**	**Data source**	**Comparison Group**
3.1	Opioid overdose death rate (overall, in-hospital, out-of-hospital)	Medicaid enrollees (with inpatient admission for SUD; without admission for SUD)	*Numerator*: # death with OUD overdose/poisoning diagnoses *Denominator*: Medicaid enrollees (with/without an inpatient admission for SUD)	Medicaid claims; IDHW data; vital statistics	Synthetic control state using CDC mortality data
3.2	ED visits for SUD	Medicaid enrollees with SUD	*Numerator*: # with ED visit *Denominator*: Medicaid enrollees with SUD	Medicaid claims; IDHW data	TBD
3.3	Repeat overdoses	Medicaid enrollees with SUD	*Numerator*: # with multiple overdose admissions within 30 days (or 90 days) *Denominator*: Medicaid enrollees with SUD	Medicaid claims; IDHW data	TBD
9.9	Mental health-related ED visits for SMI/SED	Medicaid enrollees with SMI/SED	*Numerator*: # of mental health-related ED visits per 1000 member months among members with SMI/SED *Denominator*: Medicaid enrollees with SMI/SED	Medicaid claims; IDHW data	TBD
9.3	ED visits for SMI/SED	Medicaid enrollees with SMI/SED	*Numerator*: # of all-cause ED visits per 1000 member months among members with SMI/SED	Medicaid claims; IDHW data	TBD

			Denominator: Medicaid enrollees with SMI/SED		
10.2	Suicide rate	Medicaid enrollees	*Numerator*: # with suicide as cause of death *Denominator*: Medicaid enrollees	Vital statistics	Synthetic control state using CDC mortality data
	<u>Qualitative Interim and Summative Findings</u>				
Research Question(s)	**Outcome**	**Sample***	**Definition**	**Data source**	**Comparison Group**
12.1; 12.2; 12.3; 12.4; 12.5	Identification of demonstration activities or components that were most effective in facilitating or were barriers to: • Improving access to SUD/SMI/SED treatment • Increasing retention in SUD/SMI/SED treatment • Reducing inpatient readmissions • Improving patient satisfaction • Improving care coordination • Improving data sharing	Providers; Policymakers; TBD stakeholders	Key informant interviews will be conducted to gain an understanding of first-hand knowledge of the demonstration.	Qualitative primary data collection	N/A
	<u>Costs</u>				
Research Question(s)	**Outcome**	**Sample***	**Definition**	**Data source**	**Comparison Group**
13.1	Total SUD spending	Medicaid enrollees with SUD	Total expenditures for SUD care	Medicaid claims; IDHW data	Non-behavioral health spending
13.2	Total SMI/SED spending	Medicaid enrollees with SMI/SED	Total expenditures for SMI/SED care	Medicaid claims; IDHW data	Non-behavioral health spending
13.3	Total SUD spending by site of care	Medicaid enrollees with SUD	Total expenditures for SUD care by site of care	Medicaid claims; IDHW data	Non-behavioral health spending
13.4	Total SMI/SED spending by site of care	Medicaid enrollees with SMI/SED	Total expenditures for SMI/SED care by site of care	Medicaid claims; IDHW data	Non-behavioral health spending

13.5	Total federal spending	Medicaid enrollees with SUD or SMI/SED	Total federal spending (including both FMAP for SUD and SMI/SED care as well as additional administrative costs) Alternative analyses to split by SUD and SMI/SED as well as examine all spending	Medicaid claims; IDHW data	Non-behavioral health spending

Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 22-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

December 21, 2022

David Jeppesen, Director
Department of Health and Welfare
Towers Building – Tenth Floor
PO Box 83720
Boise, ID 83720-0036

RE: 1915(i) ID Benefit 22-0009 & 1915(b) Waiver ID-02.R02 Concurrent Renewal Approval

Dear Director Jeppesen:

The Centers for Medicare & Medicaid Services (CMS) is approving your request to renew Idaho's Home and Community Base Services (HCBS)1915(i), Yes Empowerment Services (YES)State Plan Benefit, targeting children with serious emotional disturbances (SED). This benefit will provide respite services for children and youth who have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified independent assessor clinician. CMS will engage the state in future discussions regarding the 1915(i) needs based criteria. This 1915(i) SPA is assigned control number ID-22-0009, which should be referenced in all future correspondence relating to this program. It is important to note that CMS' approval of this 1915(i) HCBS state plan benefit renewal solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

Concurrently, the CMS is approving Idaho's request to renew its 1915(b) Waiver, CMS control number ID-02.R02, titled Idaho Behavioral Health Plan. This waiver allows Idaho to continue to serve beneficiaries eligible for behavioral health services through managed care. This 1915(b) waiver is authorized under section(s): 1915(b)(1) and 1915(b)(4) of the Social Security Act (the Act) and provides a waiver of the following section of Title XIX:

- Section 1902(a)(23) Freedom of Choice
- Section 1902 (a)(4) and 1932(a)(3) Mandatory Enrollment into a Single PIHP or PAHP

Our decision is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all of the statutory and

regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to enrollees under this waiver.

The 1915(i) SPA will offer the following services: Respite Care.

The 1915(b) waiver and the 1915(i) SPA are effective for five years beginning January 1, 2023 through December 31, 2027 and operate concurrently. The state may request renewal of these authorities by providing evidence and documentation of satisfactory performance and oversight. Idaho's request that these authorities be renewed should be submitted to the CMS no later than September 30, 2027. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

The state will report all managed care waiver expenditures on the CMS 64-9 and 1915(b) waiver expenditures on the CMS64 Schedule D report. Respite services included under the 1915(i) authority are included in the capitation rate for the Contractor providing services under the 1915(b) authority. Idaho is also responsible for documenting cost- effectiveness, access and quality in subsequent renewal requests.

Idaho will be responsible for documenting the applicable cost-effectiveness and quality in subsequent renewal requests for this authority. On a quarterly basis, the state is required to submit to CMS the previous quarter's member months by approved MEG on the attached "1915(b) Worksheet for State Reporting of Member Months." The report is due 30 days after the end of each quarter and should be submitted to the DMCO Actions mailbox, MCOGDMCOActions@cms.hhs.gov.

The State should also conduct its own quarterly calculations using Tab D6 of the approved 1915(b) Waiver Cost Effectiveness Worksheets and request an amendment to the waiver should the State discover the waiver's actual costs are exceeding projections. Additionally, the State must submit a waiver amendment to reflect any major changes impacting the program, including changes in waivers/statutory authority needed, type/number of delivery systems, geographic areas, populations, services, quality/access, monitoring plan.

The state has identified its intent to use money realized from section 9817 of the American Rescue Plan (ARP). Approval of this action does not constitute approval of the state's spending

plan. The state must have an approved spending plan to use the money realized from section 9817 of the ARP.

We appreciate the cooperation and effort provided by you and your staff during the review of these waiver renewals. If you have any questions concerning this information, please contact Elizabeth Heintzman at (206) 615-2596 or via email at Elizabeth.Heintzman@cms.hhs.gov for the 1915(i) SPA or Aimée Campbell-OConnor at (207) 441-2788 or via email at Aimee.Campbell-OConnor1@cms.hhs.gov for the 1915(b) waiver.

Sincerely,

cc: Charles Beal, David Bell, David Welsh, Jenna Tetrault, State of Idaho
Lynn Delvecchio, DMCO Branch Chief
Erin Cassady, FMG CMS-64 Analyst
Wendy Hill Petras, CMS
Dominique Mathurin, CMS
Courtenay Savage, CMS
Kevin Patterson, CMS
James Moreth, CMS
Katherine Berland, CMS

Enclosure: 1915(b) Worksheet for State Reporting of Member Months
Special Terms and Conditions

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0009

2. STATE: ID

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01-01-2023

5. FEDERAL STATUTE/REGULATION CITATION
SSA 1902(a)(10)(A); SSA 1902(r)(2)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0 $6,107,258.
b. FFY 2024 $ 0 $6,346,432

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, pages 1-33
Attachment 4.19B

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, pages 1-36
Attachment 4.19B

9. SUBJECT OF AMENDMENT
Renewal for a period of five years of the state's 1915(i) State plan option to continue providing HCBS to the target population of children with serious emotional disturbance (SED).

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]

12. TYPED NAME
JULIET CHARRON

13. TITLE
Administrator

14. DATE SUBMITTED
07-12-2022

15. RETURN TO
JULIET CHARRON, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009

FOR CMS USE ONLY

16. DATE RECEIVED
7/12/2022

17. DATE APPROVED
12/20/2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
1/1/2023

19. SIGNATURE OF APPROVING OFFICIAL George P.

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations and Oversight

22. REMARKS
12/1/2022-State authorized CMS to make P&I changes to Blocks #6, #7, and #8

12/8/2022-State authorized MS to make P&I change to block #6

Instructions on Back

1915(i) State Plan Home and Community-Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Respite Care.

2. **Concurrent Operation with Other Programs.** *(Indicate whether this benefit will operate concurrently with another Medicaid authority):*

Select one:

○	**Not applicable**
◉	**Applicable**
Check the applicable authority or authorities:	
☑	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* ***Contractor for the Idaho Behavioral Health Plan (IBHP)*** *(b) the geographic areas served by these plans;* ***Statewide*** *(c) the specific 1915(i) State plan HCBS furnished by these plans;* ***Respite*** *(d) how payments are made to the health plans; and* ***PMPM capitated rate*** *(e) whether the 1915(a) contract has been submitted or previously approved.* ***Yes, the contract has previously been approved.***
☑	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:* ***Idaho Behavioral Health Waiver, ID.02.R01. This waiver application has been previously approved.***

Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
☑	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

☐	§1915(b)(2) (central broker)	☑	§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*		
☐	**A program authorized under §1115 of the Act.** *Specify the program:*		

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one):*

◉	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	◉	The Medical Assistance Unit *(name of unit)*:	Division of Medicaid
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☒ *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed *(check each that applies):*

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☑	☐
3 Review of participant service plans	☑	☐	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☐	☐	☑	☐
6 Qualified provider enrollment	☐	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☑	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☑	☐
10 Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

3, 4, 5:	IBHP (Idaho Behavioral Health Plan) Contractor
6:	Credentialed behavioral health agency verifies qualifications of respite providers, IBHP Contractor
7, 8:	IBHP Contractor

9: IBHP Contractor, appropriate IDHW program
10: IBHP Contractor

The State Medicaid Agency (SMA) is the final determination for approval of service plans.

The state will employee a variety of administrative tools in its oversight, including use of sampling.

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

N/A

6. ☒ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	January 1, 2023	December 31, 2023	1,454
Year 2			
Year 3			
Year 4			
Year 5			

2. ☒ **Annual Reporting.** (By checking this box the state agrees to): annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Level (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.) States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.

2. **Medically Needy.** *(Select one):*

☒ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy *(select one):*
☐ The state elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.
☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed *(select one):*

◉	Directly by the Medicaid agency
○	By Other *(specify State agency or entity under contract with the State Medicaid agency):*

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Independent Assessors are state-licensed, master's-level clinicians or higher. Independent Assessors receive specialized training in how to conduct the functional assessment, and hold certification in a Department-approved tool for assessing children who might require HCBS and might qualify to be participants in this program.

The regulations that specify the state's licensure criteria applicable to independent assessors appear in Idaho Code in the locations cited below:

- **Psychologists:** Title 54, Chapter 23 (Psychologists), with specific criteria listed in §54-2307, Qualifications for License.
- **Counselors and Therapists:** Title 54, Chapter 34 (Counselors and Therapists), with specific criteria listed in §§54-3405, 54-3405A, 54-3405B, and 54-3405C, Qualifications for Licensure.
- **Clinical Social Workers:** Title 54, Chapter 34 (Social Work Licensing Act), with specific criteria listed in §54-3206, Licensing – Qualifications.

Medicaid Agency staff do not have the same qualifications as Independent Assessors.
Medicaid Agency staff must pass a background check, and are trained:
(a) On Medicaid and YES program eligibility criteria.
(b) On working with Medicaid programs.
(c) To conduct and document sensitive fact-finding interviews.
(d) To deal with individuals who are in stressful situations from varying cultural/socioeconomic backgrounds.
(e) To de-escalate emotionally charged situations.
(f) To apply written policies and criteria and determining qualifications for services or benefits.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Potential program participants seeking 1915(i) state plan option services will be referred to the independent assessment provider (IAP), which along with the Medicaid Agency, will determine whether the child meets the diagnostic and functional impairment criteria required to access 1915(i) services through this program.

The independent assessment will include a comprehensive clinical diagnostic assessment, or review of a current CDA, to verify a diagnosis that is consistent with serious emotional disturbance (SED), and the administration of the CANS (Child-Adolescent Needs and Strengths) assessment tool, which will

identify the child's needs, strengths, and initial functional impairment score. (See assessment scoring criteria on the following page.) The initial assessment process also includes:
a. Evaluation of the child's current behavioral health, living situation, relationships, and family functioning;
b. Contacts, as necessary, with significant individuals such as family and teachers; and
c. A review of information regarding the child's clinical, educational, social, behavioral health, and juvenile/criminal justice history.

The independent assessment, however, is only one component of the eligibility process; the other component, Medicaid eligibility, is determined by the Self-Reliance (Welfare) Division of the Department. They will verify other eligibility criteria—state residency, age, household income, etc. Once the applicant is determined to be Medicaid-eligible, the plan facilitator will initiate the person-centered planning process.

The reevaluation includes a review of a current CDA (one that has been updated from the original CDA utilized at the initial evaluation), and conducting an updated CANS assessment. A review of additional materials could take place if necessary to inform any diagnostic changes.

4. ☒ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Participants eligible to receive services under this 1915(i) have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified independent assessor clinician.

Substantial Functional Impairment

The CANS assessment tool is used to measure substantial functional impairment, which is a condition of participation in the Medicaid SED program in support of the YES system of care. Using the CANS, the independent assessor assigns the child a rating from 0 to 3 (where 0 = no evidence of a need, 1 = monitoring for need, 2 = need requiring intervention, and 3 = need requiring immediate or intensive intervention) on each item. The following three domains are central to a determination of substantial functional impairment associated with a treatable mental health condition:

1) Behavioral and Emotional Needs (this subscale contains 12 items on which the child is rated);

2) Life Domain Functioning (8 items);

3) Risk Behaviors (14 items).

The child is considered to have substantial functional impairment when the following criteria are met:

1) Behavioral and emotional needs—at least one item is rated a "2" or higher (indicating the presence of a psychiatric syndrome requiring treatment); AND

2) Life domain functioning—at least one item is rated a "2" or higher, (indicating substantial functional impairment associated with the psychiatric syndrome); OR

3) Risk behaviors—at least one item rated at least a "2" (indicating danger to self or others associated with the psychiatric syndrome).

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
Participants eligible to receive services under this 1915(i) have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified independent assessor clinician. **Substantial Functional Impairment** The CANS assessment tool is used to measure substantial functional impairment, which is a condition of participation in this program. Using the CANS, the independent assessor assigns the child a rating from 0 to 3 (where 0 = no evidence of a need, 1 = monitoring for need, 2 = need requiring intervention, and 3 = need requiring immediate or intensive	**[Excerpted/adapted from IDAPA 16.03.10.223]** The participant requires nursing facility level of care when a child meets one (1) or more of the following criteria: **01. Supervision Required for Children.** Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. **02. Preventing Deterioration for Children.** Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration	**[Excerpted/adapted from IDAPA 16.03.10.584]** **01. Diagnosis.** Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and IDAPA Sections 500 through 506; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. **02. Must Require Certain Level of Care.** Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would	**[Excerpted/adapted from IDAPA 16.03.09.701]** Participants must have a DSM-5 diagnosis with substantial impairment in thought, mood, perception or behavior. **01. Medical Necessity Criteria.** Both severity of illness and intensity of services criteria must be met for admission to a psychiatric unit of a general hospital. **a. Severity of illness criteria.** The child must meet one (1) of the following criteria related to the severity of his psychiatric illness: i. Is currently dangerous to self, as defined in IDAPA 16.03.09.701.01.a; ii. Is actively violent or aggressive and exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others, as defined in IDAPA 16.03.09.701.01.a; or iii. Is gravely impaired, as defined in IDAPA 16.03.09.701.01.a., which

intervention) on each item. The following three domains are central to a determination of substantial functional impairment associated with a treatable mental health condition: 1) Behavioral and Emotional Needs (this subscale contains 12 items on which the child is rated); 2) Life Domain Functioning (8 items); 3) Risk Behaviors (14 items). The child is considered to have substantial functional impairment when the following criteria are met: 1) Behavioral and emotional needs—at least one item is rated a "2" or higher (indicating the presence of a psychiatric syndrome requiring treatment); AND 2) Life domain functioning—at least one item is rated a "2" or higher, (indicating substantial functional impairment associated with the psychiatric syndrome); OR 3) Risk behaviors—at least one item rated at least a "2" (indicating danger to self or others associated with the psychiatric syndrome).	potential of a child, even where full recovery or medical improvement is not possible. **03. Specific Needs for Children.** When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitate the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. **04. Nursing Facility Level of Care for Children.** Using the above criteria, plus consideration of the developmental milestones, based on the age of the child, the Department will determine nursing facility level of care.	require institutionalization, other than services in an institution for mental disease, in the near future. **03. Functional Limitations.** a. Persons Sixteen Years of Age or Older. Persons sixteen (16) years of age or older may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (SIB-R, or subsequent revisions) would qualify. b. Persons Under Sixteen Years of Age. Persons under sixteen (16) years of age qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age. **04. Combination Functional and Maladaptive Behaviors.** Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in IDAPA 16.03.10.584 at a level that is significant and it can be determined they are in need of the level of services provided in an ICF/ID, including active treatment services.	specifies that the individual meet at least (1) of the following criteria: (1) The child has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or (2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment (details of the child's behaviors must be documented); or (3) There is a need for treatment, evaluation or complex diagnostic testing where the child's level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication or behavior or both. **b. Intensity of service criteria.** The child must meet all of the criteria set forth in IDAPA 16.03.09.701.01.b.: i. It is documented that the child has been unresponsive to treatment at a less intensive level of care; ii. The services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that inpatient services will no longer be needed; and iii. Treatment of the child's psychiatric condition

		05. Medical Condition. Individuals may meet ICF/ID level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services.	requires services on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist.

* Long Term Care/Chronic Care Hospital
** LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). *(Specify target group):*

Children, under eighteen (18) years, who are determined to have serious emotional disturbance (SED) in accordance with Section 16-2403, Idaho Code, and have a Diagnostic and Statistical Manual of Mental Disorders (DSM, per the most current edition) mental health condition diagnosable by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan):*

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority.** As provided in 42 CFR §441.715(c), the State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly, or, if the need for services is less than monthly, the participant requires regular monthly

monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is:
	1
ii.	**Frequency of services.** The state requires (select one):
○	**The provision of 1915(i) services at least monthly**
◉	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: At least annual provision of 1915(i) services.

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Description of the settings where individuals will reside: Individuals may reside in the family home, a foster family home, or another private residence. Individuals may not reside in locations that are institutional in nature.

Description of the settings where individuals will receive HCBS Respite Care: Respite may be provided by a credentialed behavioral health agency in the participant's home, another private residence, the credentialed agency, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.

All settings mentioned above are presumed to meet HCBS compliance, since none have the qualities of an institutional setting as set forth in 42 CFR §441.530.

In contrast with both of the state's existing State Plan options for participants with developmental disabilities, this 1915(i) does not involve any of the following types of settings: Certified Family Homes; Residential Assisted Living Facilities; residential treatment facilities; DD agency facilities; or day health centers.

IDAPA 16.03.10.318 states that new HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. The Department is responsible for ongoing enforcement of quality assurance compliance. Regarding settings where services and supports are delivered under this program, IDAPA 16.03.10.318 also requires all current providers of HCBS to complete a Department-approved self assessment form related to the setting requirements and qualities described in 42 CFR 441, Subpart M.

The self-assessment form, which is included as an attachment with this submission, will identify the provider and agency, and require that the provider complete a table for every setting in which the provider delivers HCBS under this program. The provider is required to complete assurances of the following (by means of a checkbox) for each HCBS setting:

1. None of the following facility types describe this setting: nursing facility, institution for mental diseases, intermediate care facility for persons with intellectual disabilities (ICF/ID), or hospital.
2. This setting is not located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.

3. This setting is not located on the grounds of, or immediately adjacent to, a state or federally operated inpatient treatment facility.
4. The qualities of this setting do not have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

The IBHP contractor will ensure that every current provider of HCBS to program participants completes this form at least annually as part of the process of enrolling providers in its network for this program.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered planning process in accordance with 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the participant's circumstances or needs change significantly, and at the request of the participant.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The regulations that specify the state's licensure criteria applicable to independent assessors appear in Idaho Code in the locations cited below:

- **Psychologists:** Title 54, Chapter 23 (Psychologists), with specific criteria listed in §54-2307, Qualifications for License.
- **Counselors and Therapists:** Title 54, Chapter 34 (Counselors and Therapists), with specific criteria listed in §§54-3405, 54-3405A, 54-3405B, and 54-3405C, Qualifications for Licensure.
- **Clinical Social Workers:** Title 54, Chapter 34 (Social Work Licensing Act), with specific criteria listed in §54-3206, Licensing – Qualifications.

The Department assures that independent assessors will not be involved in providing 1915(i) services to participants. Training on assessment tools is provided to assessors.

5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The plan facilitator is primarily responsible for the development of the individualized, person-centered service plan, and the facilitator works closely with the person-centered planning team to accomplish this objective. The members of the person-centered planning team are selected by the participant and family, and will work together in accordance with a Child and Family Team (CFT) model.

Qualifications for the plan facilitator include a bachelor's degree in a human-services field, experience working with the SED population, and state-required training in person-centered plan development. The Department or its designee will employ plan facilitators, and the state assures that plan facilitators will not be involved in providing direct services to participants.

The goal is for the team to develop the person-centered plan and submit it to the contractor or the designee of the Department for approval within 90 days of eligibility verification; the contractor or designee of the Department will have five business days to review and approve or reject the plan. The review will ensure that all requirements established by Medicaid and CFR, as well as all services needed by the participant, are properly documented on the plan. If the plan does not meet all applicable CFR and Medicaid requirements, the contractor or designee of the Department will send the plan back to the plan facilitator for revision by the person-centered planning team.

Participants will be informed in writing of any denials, and that communication will also include instructions on how to appeal adverse decisions and the opportunities for the participant to request a fair hearing.

6. **Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The primary supports for the participant during plan development are the plan facilitator and the other members of the person-centered planning team, who are selected by the participant and family. The facilitator and team will support the participant in selecting among the many qualified providers available in the IBHP provider network.

Item #7 below describes information that the independent assessor provides to applicants; this information, which includes lists of community resources and qualified service providers, may be reviewed by the planning team and plan facilitator during development and included in the person-centered service plan.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

During the initial assessment process, the independent assessor links applicants with the resources needed to take full advantage of Medicaid services and this program, including lists of community resources and qualified service providers. If the applicant is deemed eligible by the SMA's Division of Self-Reliance, the SMA or its designee will reach out to begin the person-centered planning process. During the person-centered planning process, services and qualified providers will be identified and related documentation will be provided to participants.

On an ongoing basis, the plan facilitator and/or case manager will be able to provide the participant and the planning team with ready access to information concerning selection of qualified providers and available service providers.

process by which the person-centered service plan is made subject to the approval of the Medicaid

ultimate oversight for service plan approval through a retrospective review process. Furthermore, as the basis of one of the reporting requirements documented elsewhere in this application (see Service Plans, Sub-requirement (a) in the QIS section), the Department or its designee will

- Plans have been developed in accordance with the policies and procedures set forth in this 1915(i);
- Plans initially approved by the Department or its designee do in fact accurately reflect participant's needs, goals, and risk factors as identified in the assessment;
- Plans meet other required criteria set forth in applicable CFR; and
- Plans comply with all applicable Medicaid requirements.

The retrospective review process will entail pulling a statistically significant sample every quarter that is representative of the total population receiving services through the 1915(i) benefit for each month in that quarter, then completing the analysis and review activities quarterly. Consistent with the QIS activity documented under Service Plans, Sub-requirement (a), the SMA will compile the results of the retrospective plan review process annually.

9. **Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☑	Case manager
☑	Other (*specify):*	IBHP Contractor, or if applicable for the service being provided, Network Providers			

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Respite Care

Service Definition (Scope):

Respite care is short-term or temporary care for a child/youth with SED provided in the least restrictive environment that provides relief for the usual caretaker and is aimed at de-escalation of stressful situations.

Respite may be provided by a credentialed behavioral health agency in the participant's home, another private residence, the credentialed agency, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(choose each that applies):*

☑ Categorically needy *(specify limits):*

Limitations:

- Maximum of 72 hours of respite care consecutively when respite is not delivered in a community location; maximum of 10 hours consecutively when respite is delivered in a community location; and 300 hours total in a 12-month calendar period.
- Payments for respite services are not made for room and board.
- Respite services shall not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. In addition, as a result of care coordination efforts, a participant who may be receiving services under 1915(c) waiver programs will not receive duplicate services. As part of the reimbursement process, the IBHP contractor will verify that there are not multiple claims for providing respite care to the same participant on the same dates of service. This will preclude potential duplication of respite services.

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Respite Care Provider			To provide respite, providers must be affiliated with a Medicaid-enrolled, credentialed behavioral health agency and: 1) Be at least eighteen (18) years of age with a high school diploma or GED;

			2) Have at least six (6) months' full-time (1,040 hours) work or volunteer experience working with children experiencing SED and their families; 3) Have the knowledge and skills to provide the service and effectively address participants' needs; 4) Successfully complete the training for respite care developed by the IBHP contractor; 5) Have received classroom or on-the-job training on the following: a. Characteristics of an SED; b. Behavior management principles and strategies; c. How to de-escalate and prevent, as well as manage, a crisis; d. Confidentiality and mandated reporting requirements; e. Basic First Aid training.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Respite Care Provider	Credentialed behavioral health agency	• At initial provider agreement approval or renewal • At least every two years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

8. ☒ Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians: *(By checking this box the state assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the State ensures that the provision of services by such persons is in the best interest of the individual; (d) the State's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

A parent/legal guardian, relative, or legally responsible individual cannot furnish paid State plan HCBS.

Providers are not allowed to be in a position to both influence a participant and parent/legal guardian's decision-making and benefit financially from these decisions. Additionally, the participant's case manager and the Department are available to address any potential conflicts of interest that may arise.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

Election of Participant-Direction. *(Select one):*

◉	The State does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.
2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
3. Providers meet required qualifications.
4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
5. The SMA retains authority and responsibility for program operations and oversight.
6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	**Service Plans, Sub-requirement (a):** **Plans address assessed needs of 1915(i) participants**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of approved service plans that: • Have been developed in accordance with the policies and procedures specified in this 1915(i); • Accurately reflect the participant's needs, goals, and risk factors as identified in the assessment; • Meet other required criteria set forth in applicable CFR; and • Comply with all applicable Medicaid requirements. **a. Numerator:** Number of approved plans reviewed that meet the requirements specified in the bulleted list above. **b. Denominator:** Number of approved plans reviewed.

Discovery Activity *(Source of Data & sample size)*	Data Source: Analysis of individual service plans by IDHW staff or contractor to ensure the accuracy of plan approvals and determine whether the plan: (1) is accurately aligned with the needs, goals, and risk factors as identified in the independent assessment; (2) is in accordance with the policies and procedures specified in this 1915(i); (3) meets other required criteria set forth in applicable CFR; and (4) complies with all applicable Medicaid requirements. Sampling Approach: 100% review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Service Plans, Sub-requirement (b):** **Plans are updated annually**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed and approved by the Department or its designee prior to the expiration of the current plan of service. **a. Numerator:** Number of service plans that were reviewed and approved by the Department or its designee prior to the expiration of the current plan of service. **b. Denominator:** Number of service plans reviewed and authorized by the Department or its designee.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Service Plans, Sub-requirement (c):** **Plans document choice of services and providers**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of approved service plans that document, for every service whose need was indicated by the results of the independent assessment, either: • The participant's choice among the available providers qualified to deliver that service; or • In cases where a given service was called for by the results of the independent assessment but was declined, the participant's choice not to receive that service. **a. Numerator:** Number of approved plans reviewed whose content meets the criteria specified in the bulleted list above. **b. Denominator:** Number of approved service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of service plans developed for program participants receiving HCBS services. Confidence interval = 95% with -/+ 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities *(Who corrects,*	The State Medicaid Agency is responsible for data aggregation and analysis.

analyzes, and aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Eligibility Requirements: Sub-requirement (a):** **An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of applicants who are likely in need or qualify for 1915(i) services, scheduled for Independent Assessments with the state's contractor, for whom a completed assessment was obtained. **a. Numerator:** Number of Independent Assessments completed by the state contractor. **b. Denominator:** Number of scheduled Independent Assessments for program services.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency from the independent assessor on delegated administrative functions. Sampling Approach: 100% review of remediation issues.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Eligibility Requirements: Sub-requirement (b):** **The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately**
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of eligibility determinations for which criteria were evaluated appropriately and in accordance with policy. **a. Numerator:** Number of eligibility determinations that were completed based on the instruments and processes in the approved 1915(i) benefit. **b. Denominator:** Total number of eligibility determinations reviewed.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of eligibility determinations performed. Confidence interval = 95% with -/+ 5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**Eligibility Requirements: Sub-requirement (c):** **The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility within 364 days of their previous eligibility evaluation. **a. Numerator:** Number of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility within 364 days of their previous eligibility evaluation. **b. Denominator:** Number of enrolled participants who received an annual redetermination of 1915(i) Benefit eligibility.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review of annual redeterminations of eligibility.
Monitoring Responsibilities	The State Medicaid Agency is responsible for data collection/generation.

(Agency or entity that conducts discovery activities)	
Frequency	Annual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Providers meet required qualifications**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of enrolled program service providers who meet state and program requirements for certification and have successfully completed state-required training. **a. Numerator:** For a given 1915(i) service, the number of enrolled providers delivering that service who meet required licensure or certification standards and have completed state-required training, and are therefore qualified to be program service providers. **b. Denominator:** For a given 1915(i) service, the number of enrolled providers delivering that service to participants.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency	Annual

(of Analysis and Aggregation)	

Requirement	**Compliance with HCBS Settings Requirements**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of providers whose Department-required self-assessment forms confirm that the provider's settings meet HCBS settings requirements as stated in this SPA and applicable CFR. **a. Numerator:** Number of HCBS providers whose self-assessment forms were approved by the Department or its designee. **b. Denominator:** Number of HCBS providers who submitted self-assessment forms for review and approval.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports from contractor to the SMA, giving statistics regarding Department-approved self-assessment forms related to setting requirements and qualities, which all current providers of HCBS are required to complete as a condition of becoming a Medicaid provider, in accordance with IDAPA 16.03.10.318. Sampling Approach: 100% review of providers' self-assessment forms by the Department or its designee.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and ongoing.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Administrative Authority and Program Oversight**
Discovery	

Discovery Evidence *(Performance Measure)*	The number and percent of remediation issues that the state followed up on that were identified in the contract monitoring reports. **a. Numerator:** Number of remediation issues followed up on identified in the contract monitoring reports. **b. Denominator:** Number of remediation issues identified in the contract monitoring reports.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on all delegated administrative functions. Quality Management Improvement and Accountability Plan will monitor key quality performance management indicators from implementation through ongoing operation. Sampling Approach: 100% review of remediation issues
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency shares responsibility for data aggregation and analysis with the State Medicaid Authority and assigned contractors.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**Financial Accountability:** **Claims are paid for services that are authorized and are delivered by qualified providers**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims denied for 1915(i) services that were not authorized or were furnished by unqualified providers. **a. Numerator:** Number of claims denied because services were not authorized or were furnished by unqualified providers. **b. Denominator:** Total claims submitted for 1915(i) services.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: Representative sample of child participants receiving SED services. Confidence interval = 95% with -/+ 5% margin of error.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Identifying, addressing and preventing incidents of abuse, neglect, and exploitation: Sub-requirement (a)**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reported incidents of abuse, neglect or exploitation—to include reported incidents involving the use of restraints—for which follow-up was completed within policy timelines. **a. Numerator:** Number of reported incidents related to abuse, neglect or exploitation where action/resolution was completed within policy timelines. **b. Denominator:** Number of reported incidents related to abuse, neglect or exploitation.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review of critical reports.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.

Frequency *(of Analysis and Aggregation)*	Annual

Requirement	**Identifying, addressing and preventing incidents of abuse, neglect, and exploitation: Sub-requirement (b)**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of participants and/or family who received information/education about how to report abuse, neglect, exploitation, the use of restraints, and other critical incidents. **a. Numerator:** Number of participants or family who received information/education about how to report critical incidents. **b. Denominator:** Number of participants receiving services.
Discovery Activity *(Source of Data & sample size)*	Data Source: Reports to State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The State Medicaid Agency is responsible for data collection/generation.
Frequency	Annual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The State Medicaid Agency is responsible for data aggregation and analysis.
Frequency *(of Analysis and Aggregation)*	Annual

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. **Methods for Analyzing Data and Prioritizing Need for System Improvement**

a. Complaints and incident reports are investigated.

b. Services are delivered in accordance with care plans.

c. How are children and families showing improvement in functioning?

d. Annual QM Report.

e. Are children provided services in the least restrictive environment appropriate for their care?

2. **Roles and Responsibilities**

a. Quality Management, Improvement and Accountability (QMIA): This is a group of dedicated state agency employees who will look at complaints and issues across the continuum of care.

b. Department Analyst: This resource will examine quality management issues across the continuum of care.

c. QMIA: The QMIA team is responsible for steering the quality assessment and improvement process.

d. Medicaid's program manager: The program manager takes overall responsibility for leading team members, finalizing annual QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.

e. QMIA: The QMIA team is responsible for steering the quality assessment and improvement process.

3. **Frequency**

a. Ongoing.

b. Ongoing.

c. Annual

d. Annual Report.

e. Annual.

4. **Method for Evaluating Effectiveness of System Changes**

a. Annual QM report is submitted to administration.

b. Annual QM report is submitted to administration.

c. Annual QM report is submitted to administration.

d. Annual QM report is submitted to administration.

e. Annual report is submitted to administration.

Methods and Standards for Establishing Payment Rates

(a) Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☒	HCBS Respite Care
	The state's rates for respite reimbursement—$7.55 per unit of 15 minutes for individual respite, and $3.75 per unit of 15 minutes for group respite—were determined by a comparative analysis of other states' Medicare/Medicaid rates for code S5150, which was conducted by a national pricing consultant retained by the IBHP contractor. Specifically, the rates above were those found to be most closely aligned with the current Medicare/Medicaid rates of other states providing the same service.
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)

Idaho Department of Health and Welfare (DHW)
1115 IMD Waiver Renewal
Working DRAFT Estimated Enrollment and Expenditures for Completeness Review

Projected Enrollment Trend Rate: 5.0%

		April 1, 2023 to March 31, 2024	April 2, 2024 to March 31, 2025	April 1, 2025 to March 31, 2026	April 1, 2026 to March 31, 2027	April 1, 2027 to March 31, 2028	April 1, 2028 to March 31, 2029	April 1, 2029 to March 31, 2030
		DY 4	DY 5	DY 6	DY 7	DY 8	DY 9	DY 10
Proposed 1915i-like population	Expected Annual Enrollment	1,536	999	1049	1101	1156	1214	1275
	Expected Annual Expenditures	$15,014,400	$10,194,795	$11,240,297	$12,387,365	$13,656,479	$15,058,749	$16,606,178

Idaho Department of Health & Welfare (DHW)
1115 IMD Waiver Renewal
Working DRAFT Estimated Enrollment and Expenditures for Completeness Review

Projected PMPM Trend Rate:	5.0%
SMI/SED Projected Caseload Trend Rate:	8.0%
SUD Projected Caseload Trend Rate:	8.0%

		April 17, 2020 to March 31, 2021	April 1, 2021 to March 31, 2022	April 1, 2022 to March 31, 2023	April 1, 2023 to March 31, 2024	April 1, 2024 to March 31, 2025
		DY 1	DY 2	DY 3	DY 4	DY 5
FFS SMI/SED	*Expected Annual Enrollment*	2,456	2,556	2,728	3,092	3,339
Historical	*Expected Annual Expenditures*	$13,195,433	$14,896,265	$17,328,313	$21,498,287	$24,379,057

		April 1, 2025 to March 31, 2026	April 1, 2026 to March 31, 2027	April 1, 2027 to March 31, 2028	April 1, 2028 to March 31, 2029	April 1, 2029 to March 31, 2030
		DY 6	DY 7	DY 8	DY 9	DY 10
FFS SMI/SED	*Expected Annual Enrollment*	3,607	3,895	4,207	4,543	4,907
Projected	*Expected Annual Expenditures*	$29,845,609	$33,844,921	$38,380,140	$43,523,079	$49,355,171

		April 17, 2020 to March 31, 2021	April 1, 2021 to March 31, 2022	April 1, 2022 to March 31, 2023	April 1, 2023 to March 31, 2024	April 1, 2024 to March 31, 2025
		DY 1	DY 2	DY 3	DY 4	DY 5
FFS SUD	*Expected Annual Enrollment*	685	235	373	425	459
Historical	*Expected Annual Expenditures*	$3,194,506	$556,420	$961,655	$1,273,805	$1,444,495

		April 1, 2025 to March 31, 2026	April 1, 2026 to March 31, 2027	April 1, 2027 to March 31, 2028	April 1, 2028 to March 31, 2029	April 1, 2029 to March 31, 2030
		DY 6	DY 7	DY 8	DY 9	DY 10
FFS SUD	*Expected Annual Enrollment*	496	535	578	624	674
Projected	*Expected Annual Expenditures*	$2,162,410	$2,452,173	$2,780,764	$3,153,386	$3,575,940