SMI/SED Implementation Plan

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

State Point of Contact:

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

State	*Idaho*
Demonstration name	*Idaho Behavioral Health Transformation*
Approval date	*4/17/2020*
Approval period	*4/17/2020 through 3/31/2025*
Implementation date	*4/17/2020*

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td colspan="2">SMI/SED. Topic 1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings</td></tr>
<tr><td colspan="2">To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.

To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</td></tr>
<tr><td colspan="2">Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings</td></tr>
<tr><td rowspan="3">1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid</td><td>Current State: Milestone achieved.

The Department's Division of Licensing and Certification has established licensing and certification requirements for psychiatric hospitals. Participating psychiatric hospitals will be licensed and approved by Idaho's Division of Licensing and Certification. Through the state survey process psychiatric hospitals are required to meet 42 CFR part 482. The Division of Licensing and Certification uses the State Operations Manual survey guidelines for psychiatric hospitals. The enrollment process and requirements for psychiatric hospitals are posted on the Division's external website.</td></tr>
<tr><td>Future State:
Idaho will continue operation of current requirements</td></tr>
<tr><td>Summary of Actions Needed:
No actions needed</td></tr>
<tr><td rowspan="2">1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements</td><td>Current State: Milestone achieved.

The Department's Division of Licensing and Certification has established licensing and certification requirements for psychiatric hospitals. The Division of Licensing and Certification staff may conduct on-site surveys at any time (or at a minimum annually) to ensure compliance with standards.</td></tr>
<tr><td>Future State:
Idaho will continue operation of current requirements</td></tr>
</table>

Prompts	Summary
	Summary of Actions Needed: No actions needed
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	***Current State:*** *Milestone achieved.* Inpatient treatment is currently provided through Idaho Medicaid fee for service. These services are authorized by the state's Quality Improvement Organization (QIO). The QIO conducts utilization management reviews to ensure beneficiaries have access to the appropriate inpatient levels of care and lengths of stay. For inpatient psychiatric stays, the QIO conducts prospective prior authorization as well as reviews during the hospitalization for continued stays to provide oversight on length of stay. Since inpatient care is handled through fee for service, and outpatient treatment is delivered through the Idaho Behavioral Health Plan (IBHP) managed care carve-out, the state and QIO work closely with IBHP staff to monitor transitions and discharges among inpatient and outpatient levels of care. The IBHP contractor employs a statewide team of Field Care Coordinators (FCCs). These FCCs are licensed clinical professionals and assist with facilitating transitions across the continuum of care. As members transition from inpatient or residential to community-based care (or vice versa), FCCs assist to promote seamless transitions in care.
	Future State: In 2021, Idaho Medicaid will rebid the IBHP contract and make several changes to improve coordination, including transitioning to a prepaid inpatient health plan. By carving in inpatient services to the IBHP, one contractor will provide utilization management (UM) activities for all inpatient, residential and outpatient behavioral health services. The goal of the UM and review processes will be to ensure beneficiaries have access to appropriate levels and types of care, provide oversight on lengths of stay and provide seamless transitions between levels of care. The IBHP will utilize state approved, nationally informed best practices that define what high-quality care is and by whom and in what setting the care should be delivered. The IBHP staff will work closely with state oversight staff as well as UM counterparts and discharge planners in hospitals and residential programs. The IBHP will employ qualified UM staff and will have the support of physicians, clinical supervisors and administration through policy and procedures to carry out effective UM and review processes. The state will work closely with the IBHP to assure UM procedures align with state standards. These standards will be followed by the IBHP contractor and provider network. The IBHP contractor will be required to employ staff in each of the state's seven regions who will be responsible for care coordination. As Medicaid members transition from inpatient or residential to community-based care (or vice versa), IBHP staff ensure that enrollees are placed at the appropriate level of care and link Medicaid members with available providers, services and supports. These IBHP staff will be licensed clinical professionals.
	Summary of Actions Needed: • Idaho Medicaid will rebid the Idaho Behavioral Health Plan (IBHP) contract, which will consolidate utilization

Prompts	Summary
	management activities for all behavioral health services (inpatient and outpatient) effective July 1, 2022. o Prior to the release of the RFP, the Divisions of Medicaid and Behavioral Health will collaborate to define UM standards that will be utilized in the IBHP contract and provider agreements. o The Division of Behavioral Health will determine whether the developed standards will also need to be formalized and established in administrative rules and/or state statutes.
1.d Compliance with program integrity requirements and state compliance assurance process	***Current State:*** *Milestone achieved.* Department program integrity rules establish clear provider requirements, which assure program integrity and quality compliance, including fraud detection and investigation, the prevention of improper payments, and provider participation. During provider enrollment and re-enrollment, the Division of Medicaid verifies that providers meet federal program integrity requirements.
	Future State: Idaho will continue operation of current requirements and will continue to reinforce and re-educate providers about compliance with program integrity standards.
	Summary of Actions Needed: No action needed
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	***Current State:*** *Milestone achieved.* All Medicaid-enrolled psychiatric hospitals, including the participating IMD facilities, are required to comply with all applicable state and federal laws, such as all CMS Conditions of Participation (COP), including but not limited to 42 CFR 482.60-482.66 specific to psychiatric hospitals and units. The relevant COPs include the requirement that assessment data include information on the diagnosis of co-morbid conditions, as well as the requirement for psychiatric hospitals to make appropriate medical personnel available to provide necessary medical diagnostic and treatment services.
	Future State: The Divisions of Medicaid and Behavioral Health will collaborate to develop state standards to screen beneficiaries for co-morbid physical health conditions, SUDs and suicidal ideation. The Divisions of Medicaid and Behavioral Health will also collaborate to develop standards for linking beneficiaries to continued care for these conditions, as appropriate. Through provider network agreements, the IBHP will ensure network providers for all levels of care follow the screening standards set by the state.
	Summary of Actions Needed: The Divisions of Medicaid and Behavioral Health will develop and implement screening standards. These standards

Prompts	Summary
	will be incorporated into IDAPA rules that all Medicaid-enrolled psychiatric hospitals will be required to use during intake. These state standards will specifically outline screening for suicidal ideation and co-morbid physical health conditions by a licensed medical professional and utilization of ASAM Criteria for SUD screening. (Timeline 18-24 months) Additionally, the Divisions of Medicaid and Behavioral Health will develop and implement IDAPA rules and/or standards to ensure access to treatment for co-morbid physical health conditions, suicidal ideation and SUDs. (Timeline 18-24 months) These standards will need to be incorporated into the IBHP contract to ensure the provider network is utilizing the state standards. (Timeline 18-24 months) The IBHP contractor will establish provider network agreements that require these standards.
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current State:*
	Future State:
	Summary of Actions Needed:

Prompts	Summary
SMI/SED. Topic 2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.	***Current State:*** *Milestone achieved.* All Medicaid-enrolled psychiatric hospitals, including the participating IMD facilities, are required to comply with all applicable CMS Conditions of Participation (COP), including but not limited to 42 CFR 482.43, which establishes minimum discharge planning requirements aligned with this milestone. Additionally, since inpatient is currently handled as a fee for service benefit, and outpatient treatment is delivered through the IBHP managed care benefit, the state works closely with IBHP staff to monitor transitions and discharges among inpatient/residential and outpatient levels of care. The IBHP contractor employs a staff of Field Care Coordinators (FCCs) in each of the state's seven regions. These FCCs are licensed clinical professionals and are responsible for care coordination. As Medicaid members transition from residential to community-based care (or vice versa), FCCs work directly with community providers to assist with the transition.
	Future State: Effective July 1, 2022, the IBHP contract will include inpatient services allowing for improved oversight and management of care transitions. The IBHP contract will require intensive pre-discharge planning and inclusion of community-based providers in care transitions by assigning licensed clinical professionals (e.g., nurses, doctors, psychologists, social workers, or professional counselors) and/or certified peer support specialists or family support partners under appropriate supervisory protocols to conduct care coordination. These requirements will be based on transition standards developed by the state. At minimum, the IBHP contract will require the following: (i) tracking of hospital follow-up with members within 72 hours, 7 days and 30 days after discharge; (ii) case management for all patients hospitalized related to SMI/SED or SUD and continuing at least 30 days post-discharge; and (iii) minimum standards for discharge planning, including full access to robust discharge plans even in rural areas of the state. Additionally, this demonstration proposes to add to the Medicaid State Plan reimbursement for transition planning services provided by behavioral health providers (including community-based care managers) for individuals with SMI/SED (and/or SUD) being discharged into their care from an inpatient, residential or other institutional setting. This service will promote continuity of care and ensure appropriate services and supports are identified as early as possible and accessed appropriately after discharge. This service may be provided in person and/or remotely via telemedicine.

Prompts	Summary
	Summary of Actions Needed: The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards to ensure intensive pre-discharge planning is conducted, including collaboration with community-based providers during transitions. (Timeline 18-24 months) The Divisions of Medicaid and Behavioral Health will also collaborate to develop and implement criteria via IDAPA rules and/or standards for the new transition planning service. (Timeline 18-24 months) Add necessary State Plan language for transition planning services. (Timeline 18-24 months) Update 1915(b) managed care waiver to reflect transition planning services. (Timeline 18-24 months) Update IBHP contract language to include discharge and transition standards. (Timeline 18-24 months)
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	***Current State:*** There is currently no requirement in place to ensure that psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.
	Future State: By January 1, 2021, all psychiatric hospitals participating in the demonstration will be required to assess beneficiary housing situations and coordinate with housing services providers. This requirement will also be expanded via the IBHP contracts. Specifically, effective July 1, 2022, the IBHP contract will also include inpatient services allowing for improved oversight and management of beneficiaries' housing situations. The IBHP contract will require network providers to conduct housing assessments and coordinate with housing service providers, including the appropriate HUD Continuum of Care Coordinated Entry Program. The transition planning services described in 2.a will assist in ensuring beneficiaries' needs for non-clinical supports, including housing, are appropriately assessed and planned for prior to discharge.
	Summary of Actions Needed: The Division of Medicaid will update the Medicaid Provider Handbook with requirements for hospitals to assess beneficiaries' housing situations and coordinate services when discharging Medicaid members. (Timeline 6-12 months) The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards to ensure beneficiaries' housing situations are assessed and that housing services providers are included in discharge planning, when appropriate. (Timeline 18-24 months) The Divisions of Medicaid and Behavioral Health will also collaborate to develop and implement criteria via

Prompts	Summary
	IDAPA rules and/or standards for the new transition planning service. (Timeline 18-24 months) The Division of Medicaid will update IBHP contract language to ensure compliance by the contractor and provider network with the developed standards. (Timeline 18-24 months) Add language to IBHP provider network agreements covering this requirement. (Timeline 18-24 months)
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	***Current State:*** There is currently no requirement in place to ensure that psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge.
	Future State: The new IBHP contract will include inpatient services, allowing for improved quality assurance of follow up contacts with Medicaid members post discharge. Specifically, the new contract will require IBHP network providers to contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge. The transition planning services and state standards described in 2.a will assist in ensuring beneficiaries are appropriately transitioned to community providers. In addition, the new managed care contracts will include enhanced case management requirements for all hospitalizations related to SMI/SED, regardless of the duration or type of hospitalization (acute inpatient at psychiatric hospitals, residential treatment in an IMD, or an emergency department visit). IBHP contractor staff will be required to work directly with the member through at least 30 days post-discharge.
	Summary of Actions Needed: The Divisions of Medicaid and Behavioral Health will collaborate to develop contact requirements within 72 hours of discharge from a psychiatric hospital and/or residential treatment settings. (Timeline 12-18 months) The Divisions of Medicaid and Behavioral Health will collaborate to develop standards for the new transition planning service (Timeline 12-18 months) Formalize IDAPA rules and/or standards regarding contact requirements within 72 hours of discharge from a psychiatric hospital and/or residential treatment settings. (Timeline 18-24 months) Formalize IDAPA rules and/or standards regarding standards for the new transition planning service. (Timeline 18-24 months) The Division of Medicaid will update IBHP contract language to ensure compliance by the contractor and provider network with the developed standards. (Timeline 18-24 months)

Prompts	Summary
	Add language to IBHP provider network agreements covering this requirement. (Timeline 18-24 months)
2.d Strategies to prevent or decrease lengths of stay in EDs	***Current State:*** *Milestone achieved.* Idaho currently has a continuum of crisis services available. At the heart is a statewide investment in crisis intervention teams by law enforcement and the mental health system. Comprehensive crisis centers for adults, open 24 hours, have been established in each of the seven regions of the state to de-escalate acute mental health crises and deter unnecessary incarceration. In addition, Idaho has mobile crisis teams in each region of the state as well as 24-hour crisis centers for both mental health and SUD- related crises. Each region of the state has a state-operated mental health center that operates the mobile crisis teams. Idaho has a single statewide suicide prevention hotline that is connected to the national suicide hotline. The Medicaid State Plan already includes service definitions for Crisis Response and Crisis Intervention, which are delivered through the IBHP provider network.
	Future State: The Division of Behavioral Health (DBH) is working to expand the crisis system to follow national best-practice models and include additional elements consisting of expanded use of call center technology, mobile outreach via mobile crisis units, and crisis stabilization. While the state's current efforts related to mobile outreach and crisis intervention have been largely a DBH led initiative, in the future state, the Division of Medicaid intends to work with DBH to significantly expand the number of mobile crisis units in all regions, in part by adding Medicaid reimbursement and leveraging the IBHP contractor resources and network.
	Summary of Actions Needed: The Division of Medicaid will incorporate contract language within the new IBHP contract that outlines support and compliance with the Idaho crisis system to include substantial access to identified crisis services across all of Idaho. (Timeline 18-24 months)
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current State:*
	Future State:
	Summary of Actions Needed:

Prompts	Summary
SMI/SED. Topic 3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports. These reports should include which providers have waitlists and what are average wait times to get an appointment.	***Current State:*** *Milestone achieved.* The state has conducted the initial environmental scan for the Idaho Behavioral Health Transformation Waiver.
	Future State: The Division of Medicaid will work with Oregon Health Science University's Center for Healthcare Effectiveness Program to conduct and report the required environmental scan waiver activities over the course of the demonstration.
	Summary of Actions Needed: The Division of Medicaid will execute a contract with OHSU's Center for Healthcare Effectiveness outlining the demonstration environmental scan requirements. (Timeline 3-6 months) Submit a legislative budget request to fund this contract. (Timeline 3-6 months) OHSU will perform ongoing environmental scan activities. (Throughout the demonstration period)
3.b Financing plan – See additional guidance in Topic 5.	***Current State:*** See Topic 5 for additional information on the state's financing plan.

Prompts	Summary
	Future State: See Topic 5 for additional information on the state's financing plan.
	Summary of Actions Needed: See Topic 5 for additional information on the state's financing plan.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	***Current State:*** *Milestone achieved.* In July 2019, the Division of Behavioral Health launched the Idaho Psychiatric Bed and Seat Registry (IPBSR), an online platform specifically designed to track the number, availability, and associated demographics for psychiatric beds and crisis seats across Idaho. The IPBSR is intended primarily for use by mental health professionals, medical professionals, and first responders who need to identify available placements for psychiatric inpatient treatment or crisis stabilization. In early 2019, DBH was awarded a National Association of State Mental Health Program Directors' (NASMHPD) Transformation Transfer Initiative (TTI) Grant in the amount of $150,000. The TTI Grant is a federally funded grant that assists states in transforming their mental health system of care. TTI funds are to be used to identify, adopt, and strengthen transformation initiatives and activities that can be implemented in the state, either through a new initiative or expansion of one already underway. TTI grant funding allowed DBH to implement the Idaho Psychiatric Bed and Seat Registry (IPBSR) across Idaho. The IPBSR was launched in January 2020 as an online platform specifically designed to show end users the number, availability, and demographics of psychiatric beds and crisis seats across Idaho. The Division of Behavioral Health (DBH) and Division of Public Health (DPH) are working to modify a component of their hospital bed registry software called EMResource (Juvare). This system is currently used by DPH to monitor and coordinate hospital bed availability related to large scale health emergencies, such as a mass casualty event. DBH has created a specific view within EMResource that, when accessed, shows users the total number of psychiatric beds/seats, the demographics of those beds/seats, and the availability of those beds/seats for Idaho's psychiatric hospitals and regional behavioral health crisis centers.
	Future State: Already implemented. The Divisions of Behavioral Health and Medicaid will continue to add and train community stakeholders in the use of the IPBSR platform. As necessary, the IDHW will modify contract and regulatory requirements to require the use of the IPBSR.
	Summary of Actions Needed: No action needed

Prompts	Summary
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	***Current State:*** In the case of Medicaid enrollees, treatment needs are currently assessed by IBHP network providers primarily through a Comprehensive Diagnostic Assessment (CDA). Idaho Medicaid has previously implemented the use of a tool known as the CANS (Child and Adolescent Needs and Strengths) to work in tandem for determination of SED diagnoses for children.
	Future State: The divisions of Medicaid and Behavioral Health will develop patient clinical domain assessment requirements for comprehensive diagnostic assessments (CDA). These CDA requirements will be widely recognized, publicly available and help determine appropriate level of care and length of stay. The requirements selected will be used throughout the Idaho Behavioral Health system of care.
	Summary of Actions Needed: The Divisions of Medicaid and Behavioral Health will collaborate to identify clinical domain assessment requirements. (Timeline 6-12 months) The Division of Medicaid will update the Medicaid Provider Handbook to reflect these state-approved requirements. (Timeline 6-12 months) Develop and implement requirements in IDAPA rules and/or standards to ensure Comprehensive Diagnostic Assessments are conducted to determine appropriate levels of care and length of stay. (Timeline 18-24 months) The Division of Medicaid will add contract language to the IBHP contract regarding clinical domain assessment requirements. (Timeline 18-24 months)
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current State:*
	Future State:
	Summary of Actions Needed:

Prompts	Summary
SMI/SED. Topic 4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, including through supported employment and supported education programs	***Current State:*** *Milestone achieved.* The state employs a number of strategies to engage individuals in treatment as early as possible, including the following examples. • Vocational Rehabilitation. While Idaho Medicaid does not currently offer supported employment and supported education programs, the state recognizes the importance of employment and education to recovery. Vocational rehabilitation staff are integral members of Assertive Community Treatment (ACT) service teams. The close partnership between ACT and vocational rehabilitation supports individuals following inpatient discharge to receive additional support in the community. The co-located model ensures that individuals with SMI are supported as they prepare to reenter the workforce. • First Episode Psychosis Initiative (STAR Program). The Division of Behavioral Health is currently implementing an evidence-based model, Coordinated Specialty Care (CSC), to respond to early serious mental illness and first episode psychosis. The Idaho CSC program is called the STAR (Strength Through Active Recovery) program and is based on the On-Track New York coordinated specialty care model. CSC is a collaborative, recovery-oriented treatment program involving clients, treatment team members, and when appropriate, relatives, as active participants. CSC promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan that addresses the client's overall mental and physical health. The specialists offer psychotherapy, medication management geared to individuals with SMI, family education and support, case management, and employment or education support, depending on the individual's needs and preferences. CSC operates a low client-to-staff ratio, with accessibility to staff 24/7. Although the team approach lends itself to the client working with multiple staff members, the client will have one provider who acts as their principal care manager and coordinates internal and external resources necessary to meeting the goals of the client's treatment plan. The CSC treatment experience is time-limited to three years, after which most clients can move to a lower level of specialized care, and then eventually transition to regular mental health services. Idaho Star CSC serves clients between the ages of 15 and 30 years. Presently there are three regional STAR programs in Regions 3, 6, and 7, financed primarily through federal block grants and state general funds. • Crisis System. The DBH comprehensive crisis system has been a very successful and effective tool in

Prompts	Summary
	identifying and engaging beneficiaries with SMI or SED in treatment sooner. While the crisis system provides de-escalation and stabilization services, it also is a critical community resource, not only for individuals with SMI or SED, but also family members, law enforcement, or others who are seeking assistance and resources for an individual with SMI or SED. The most effective part of the crisis center system has been the strong referral model in which individuals are connected with available treatment options in the community. By offering strong early intervention and outreach, this model is able to engage individuals in effective treatment sooner to avoid future crises.

	Future State: Throughout the demonstration, IDHW will continue to enhance its strategies for early identification and engagement in treatment for individuals with SMI or SED, including the following actions: • STAR Program Expansion. Idaho will expand its successful STAR program. Currently, a fourth regional STAR CSC program is in the planning stage, with the intent that the contract will be completed, signed and implemented in 2020. The Region 4 contract serves as a pilot for future statewide expansion of the program and new STAR CSC contracts in other regions without STAR CSC programs. The long-term goal is to have STAR CSC programs contracted with community providers in each of the seven regions. The Divisions of Medicaid and Behavioral Health will collaborate to establish IBHP requirements to implement strategies for the early identification and engagement of beneficiaries with or at risk of SMI or SED. Through this strong partnership with DBH, Medicaid, and local hospital systems, the goal is that every provider will utilize the evidence-based model to respond to early serious mental illness and first episode psychosis for any Idahoan in need, regardless of payor. • Healthy Connections. In addition, Idaho will leverage the Medicaid primary care case management program, Healthy Connections, to promote training and education for early identification at the primary care level through the implementation of a standardized evidence-based assessment process. When behavioral health needs are identified, the primary care provider will be able to refer the individual to the appropriate services and engage the patient in treatment sooner.
	Summary of Actions Needed: The Division of Behavioral Health will continue with STAR expansion efforts as noted above. (Timeline Ongoing) The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards regarding early identification and engagement of beneficiaries with or at risk of SMI or SED. (Timeline 18-24 months)

	The Division of Medicaid will outline the requirement for the IBHP contractor to implement strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, including through supported employment and supported education programs, as well as coordination with the Healthy Connections primary care network. This requirement will be included in the IBHP contract language and the IBHP contractor will be required to have a policy that supports these efforts. (Timeline 18-24 months) Leverage the Medicaid primary care case management program, Healthy Connections, to promote training and education for early identification at the primary care level through the implementation of a standardized evidence-based assessment process. (Timeline 18-24 months)
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	***Current State:*** *Milestone achieved.* The IDHW employs a number of strategies to engage individuals in treatment as early as possible, including the following examples. • Patient Centered Medical Home Model. Idaho's State Innovation Models (SIM) grant and the resulting Statewide Healthcare Innovation Plan have made strides in improving integration of primary care and behavioral health services via the patient-centered medical home (PCMH) model. Grant funds have been used to provide training and support to primary care practices that were committed to transforming their practices to the PCMH model. Currently, there are 12 primary care practices/organizations statewide that have received the Health Resources and Services Administration (HRSA) FY2019 Integrated Behavioral Health Services (IBHS) Award. These clinics are mostly comprised of Federally Qualified Health Centers (FQHCs) and Indian Health Centers that have received funding from HRSA for behavioral health integration in the past and have participated in several statewide initiatives related to PCMH before this award. There are several Rural Health Centers (RHCs) that have also achieved behavioral health integration, which is advantageous considering the rural service area footprint of the FQHCs and RHCs. • Healthy Connections. In Idaho Medicaid's Healthy Connections Program providers must meet minimum requirements in order to achieve higher per member per month (PMPM) compensation and progress through the Healthy Connections tier structure. To advance to Tier 3, providers must be able to coordinate services to include behavioral health needs and also share information via the Idaho Health Data Exchange (IHDE). Further, through the Healthy Connections Program, IDHW has successfully increased the adoption of patient-centered medical homes, by promoting training and education for early intervention, as well as encouraging the co-location of behavioral health professionals in primary care clinics. • Integrated Fee Schedule. Within the IBHP, providers can bill for Health and Behavioral Assessment and Intervention (HBAI) codes. These codes allow for behavioral health interventions to be performed in non-specialty settings; in addition, qualified masters level clinicians now have the ability to enroll and bill for

	these services, whereas previously only physicians could provide these services. The new integrated fee schedule has helped to increase integration of physical health and behavioral health services to support improved early identification and referrals to treatment.
	Future State: Throughout the demonstration, IDHW will continue to enhance its strategies for increasing integration of behavioral health care in primary care settings. This is a critical strategy employed by the state to expand access to behavioral health services in the rural and frontier regions with specialty provider shortages. Future state strategies for improvement include the following actions: • The IBHP contractor will work directly with Idaho Medicaid's Healthy Connections providers to promote opportunities for advanced behavioral health integration in the primary care setting. Specifically, behavioral health measures will be explicitly added to the suite of quality measures in year two of the Healthy Connections Value Care initiative, and the payment tiers will be restructured to increase integration of behavioral health. • Idaho Medicaid will continue to support opportunities for behavioral health consultants to co-locate or integrate into the primary care setting. The IBHP will incentivize behavioral health providers who co-locate or integrate with primary care. This will be particularly important to increasing the success and coordination of the early identification efforts, as primary care providers will more effectively make real-time referrals to engage beneficiaries in treatment sooner. • Idaho Medicaid will explore opportunities that provide additional compensation for IBHP providers who meet certain requirements when working directly with primary care providers to support coordination of physical and behavioral health. Further, to incentivize integration of behavioral health services, Idaho Medicaid will seek to implement billing simplifications to encourage more primary care providers to provide mental health services in the primary care setting. • The IBHP contractor will offer trainings to primary care providers. These trainings will focus on ways to integrate behavioral health into the primary care setting and best practices on care coordination. • In addition, Idaho will leverage the Medicaid primary care case management program, Healthy Connections, to promote training and education for early identification at the primary care level through the implementation of a standardized evidence-based assessment process. When behavioral health needs are identified, the primary care provider will be able to refer the individual to the appropriate services and engage the patient in treatment sooner
	Summary of Actions Needed:

	Idaho Medicaid will update the IBHP contract language to cover the following: *1.* Requirements to push health information to IHDE *2.* Incentives for co-location or integration with primary care *3.* Trainings to primary care providers on integration of behavioral health and best practices on care coordination. *4.* Requirements for the IBHP provider network to work with Idaho Medicaid's Heathy Connections providers on ways to support behavioral health integration (Timeline 18-24 months) Idaho Medicaid will seek to implement billing simplifications to encourage more primary care providers to provide mental health services in the primary care setting. (Timeline 18-24 months)
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	***Current State:*** *Milestone achieved.* The state has made a number of recent improvements focused on improving access to evidence-based mental health treatment specific to children and adolescents. These improvements have focused on early identification, expanded eligibility for services, and a new coordinated system of care specifically designed for children with SED. • Youth Empowerment Services. Specifically, pursuant to a settlement agreement in a class-action lawsuit, the Department has established, under 1915(i) authority, specialized supports and services targeting children experiencing SED. This is known as the Youth Empowerment Services (YES) program. In addition to the new and enhanced behavioral health services outlined in in in Appendix C of the Jeff D. Settlement Agreement, the YES program provides one specialized support service, Respite Care, as a 1915(i) benefit. Through the 1915(i) Medicaid was able to expand Medicaid eligibility for children under 18 years of age to families whose adjusted gross income was within 300% of the Federal Poverty Level. Lastly, regarding crisis stabilization, YES enrollees receive the same two services as other IBHP enrollees—Crisis Response and Crisis Intervention. • Children's Mental Health. The seven regional DBH offices offer walk-in crisis services, in addition to YES wraparound. Additionally, CMH (Children's Mental Health) providers across the state have been trained and have access to the ICANS system to enter the Idaho Child Assessment of Needs and Strengths assessment. This functional assessment assists providers with identifying SED. Wraparound promotes collaboration between community-based providers and other supports identified by the family to better support children in their communities versus in residential or state hospital settings. Children and youth have access to 30-day aftercare following discharge from a State Hospital. DBH's CMH staff have worked to develop relationships with schools to become a consultation resources for children and youth who may be at risk. • STAR Program. The CSC STAR program (detailed in Section 4.a of this implementation plan) focuses on first episode psychosis, and is therefore a very specialized tool targeting adolescents and young adults

	between 15 and 30 years of age.
	Future State: The IBHP contractor will continue to expand access to specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI. In addition to YES program services, DBH Children's Mental Health Regional Chiefs are researching options for child/youth crisis stabilization centers and they are working to develop teams with expertise in CMH crisis. The regional offices are also working to develop/implement telehealth where possible. All regions are working to develop more formal collaborative community partnerships including CIT-C (Crisis Intervention Team Collaboratives).
	Summary of Actions Needed: The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards establishing specialized settings and services for young people experiencing SED/SMI, including crisis stabilization. (Timeline 18-24 months) The Division of Medicaid will incorporate IBHP contract language that outlines state requirements around services for young people experiencing SMI/SED. (Timeline 18-24 months) The Division of Medicaid will incorporate IBHP contract language that outlines state requirements for telephonic and face-to-face crisis stabilization services for young people experiencing SMI/SED. (Timeline 18-24 months)
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current State:*
	Future State:
	Summary of Actions Needed:

<table>
<tr><th>Prompts</th><th>Summary</th></tr>
<tr><td colspan="2">SMI/SED. Topic 5. Financing Plan</td></tr>
<tr><td colspan="2">State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.</td></tr>
<tr><td rowspan="2">5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.</td><td>Current State:
Idaho has several current initiatives going on regarding crisis services. Creating a sustainable crisis system is one of the primary goals of the new Idaho Behavioral Health Plan. The state intends to mitigate the need for the highest levels of care through a comprehensive crisis system that is grounded in the IBHP.
Currently Medicaid members can access the following services through the IBHP:
1. Crisis Response
2. Crisis Intervention
3. Member Crisis Line

The Division of Behavioral Health offers:
1. Mobile crisis in all regions of the state
2. STAR CSC program in regions 3, 6 and 7

Most recently the Division of Behavioral Health worked closely with Medicaid to cover services at the regional crisis units around the state.</td></tr>
<tr><td>Future State:
The Idaho Behavioral Health Plan is expected to include the following:
1. Enhanced 24-hour crisis line with the ability to triage and refer to community services
2. Crisis Response (Existing)
3. Crisis Intervention (Existing)
4. Mobile Crisis
5. Improved access to urgent behavioral health care services, including same-day crisis psychiatric services available in person or via telehealth
6. Proactive and reactive crisis plans to be included in transition and discharge planning between all levels of care
7. Community crisis trainings (providers, law enforcement, first responders)
8. Statewide access to the STAR CSC program, reimbursable by Medicaid

The Divisions of Behavioral Health and Medicaid will work directly with the IBHP contractor to promote improved connectivity between first responders and treatment providers. Ongoing training opportunities will be offered to community providers and first responders on crisis services throughout the state.</td></tr>
</table>

Prompts	Summary
	Summary of Actions Needed: Incorporate crisis service requirements and community training requirements into the IBHP contract. (Timeline 12-18 months) As part of the budget request for including inpatient behavioral health services into the IBHP, the Division of Medicaid will be able to support a comprehensive crisis system and additional community-based services to include the enhanced 24-hour crisis line. (Timeline 24-30 months) Update 1915(b) managed care waiver to include inpatient and residential services. (Timeline 18-24 months) The Division of Medicaid will add contract language to the upcoming IBHP request for proposal and new contract language requiring the IBHP contractor to support Idaho's crisis vision by offering the crisis service array listed above. (Timeline 18-24 months)
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	***Current State:*** Idaho currently offers a comprehensive continuum of community-based services. The state continuously monitors access to services and has recently worked to expand access to several evidence-based treatment options. For example, partial hospitalization services were added to the Medicaid State Plan in January of 2020. Partial hospitalization is a bundle of services that includes support therapy, medication monitoring, and skills building, in an intensive ambulatory treatment program offering less than 24-hour daily care. This service is now available for both children and adults. We are continuing to expand this network in the IBHP. Currently, there are 12 primary care practices/organizations statewide that have received the Health Resources and Services Administration (HRSA) FY2019 Integrated Behavioral Health Services (IBHS) Award. These clinics are mostly comprised of Federally Qualified Health Centers (FQHCs) and Indian Health Centers that have received funding from HRSA for behavioral health integration in the past and have participated in several statewide initiatives related to PCMH before this award. There are a few Rural Health Centers (RHCs) that are also advanced in behavioral health integration, which is advantageous considering the rural service area footprint of the FQHCs and RHCs.
	Future State: As referenced in 4.b, the Division of Medicaid continues to support behavioral health integration into primary care settings, as this strategy is essential to expanding access to behavioral health services in rural and frontier areas of the state. Expanding behavioral health integration into existing primary care settings will be a critical requirement for the

Prompts	Summary
	new IBHP contractor. The state also seeks to expand the number of behavioral health professionals who are co-located or integrated with primary care clinics. The eventual goal is to promote care coordination at the highest level to achieve better outcomes. Idaho Medicaid will expand access to Assertive Community Treatment (ACT) services to provide integrated delivery of community mental health services to individuals with SMI/SED. Idaho currently offers ACT through the DBH; however, these services will be added to the Medicaid fee schedule and the IBHP. This will allow the highest risk patients discharging from inpatient hospitalizations to receive additional support and crisis services in the community to help prevent readmissions The Division of Medicaid and the IBHP contractor continue to identify and enroll partial hospitalization providers in the IBHP network.
	Summary of Actions Needed: The Division of Medicaid will request funding to support a comprehensive crisis system. (Timeline 18-24 months) Expand access to Assertive Community Treatment (ACT) services. (Timeline 6-12 months) Draft IBHP request for proposal requirements that support the state's plans to increase availability of ongoing community-based services. (Timeline 18-24 months) Incorporate outpatient levels of care provider access requirements into the IBHP contract. (Timeline 18-24 months) Promote growth of the IBHP provider network to expand the number of providers who offer telehealth services. (Timeline 18-24 months) Implement IBHP contract language that supports the growth and sustainability of Certified Behavioral Health Clinic Models within the IBHP network. (Timeline 18-24 months)

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[4] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period.	Yes. Idaho has focused on achieving a high level of Electronic Health Record (EHR) adoption and Health Information Exchange (HIE) interoperability needed to achieve the goals of the demonstration. Multiple statewide initiatives over recent years have leveraged SIM, HITECH, and other funding opportunities to support HIE development and promote adoption of HIT. Despite significant progress, Idaho has identified additional opportunities to increase adoption of HIT technology among behavioral health providers and improvements to HIE capabilities to promote integrated care coordination. Idaho plans to include requirements for improving behavioral health provider use of HIT in the next iteration of the state's behavioral health managed care contract, which is anticipated to be implemented in 2022. In addition, multiple initiatives designed to drive HIE improvements using SUPPORT Act funding are described in this HIT plan. Idaho currently has a single Health Information Exchange (HIE). The Idaho Health Data Exchange (IHDE) is a non-profit 501(c)(3) company. IHDE was created in 2008 as a result of the efforts of Idaho's Health Quality Planning Commission. Commission members are appointed by the Governor and charged with promoting improved quality of care and health outcomes through investment in health information technology. House Bill 375 was passed during the 2016 Legislative session reauthorizing the Health Quality Planning Commission to provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care. IHDE participates in a nation-wide Patient Centered Data Home (PCDH) initiative to connect and exchange information across states and health systems to ensure the health and safety of patients throughout the US. IHDE is 1 of 72 HIE members of SHIEC – Strategic Health Information Exchange Collaboration. SHIEC shares health information nationwide.

Prompts	Summary
Statement 2: Please confirm that your state's SMI/SED Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Yes. Idaho's SMI/SED Health IT plan is aligned with the state's approved Medicaid HIT plan. Both plans are developed and managed by the Department of Health and Welfare's Division of Medicaid.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[6] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security,	Yes, the state intends to assess applicability of the Interoperability Standards Advisory and 45 CFR 170 Subpart B and incorporate the relevant standards where applicable, including in the next iterations of managed care contracts.

Prompts	Summary
data transport and encryption, notification, analytics and identity management.	
To assist states in their health IT efforts, CMS released SMDL #16-003 *which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact.* [7] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."* [8]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/ mental health provider	**Current State:** Idaho has made strategic program and reimbursement design decisions that promote care coordination, closed loop referrals and e-referrals and incentivize primary care providers for enhanced care coordination capabilities. Idaho's Primary Care Case Management (PCCM) program, Healthy Connections, operates as a managed fee-for-service model in which a network of primary care physicians and health care providers serve as the "medical home" for Medicaid patients. Under this arrangement, the Primary Care Provider (PCP) is responsible for monitoring and managing members' care, providing primary care services and making timely referrals to other providers to ensure medically necessary services are provided promptly without compromise to quality of care. There are currently 511 Healthy Connections service locations across the state, which are owned by 302 organizations and account for 90% of Medicaid primary care providers. Most Medicaid members are required to enroll in the program. Members are attributed to practices based on the member's selection, or if no provider is selected, based on past claims and proximity to provider locations and provider availability. Healthy Connections providers receive monthly care management payments for each attributed member in addition to traditional fee for service reimbursements for services provided. Care management payments are based on a 4-tier structure designed to incentivize patient centered medical home development and to support activities directed towards improved patient care and coordinated services. All Healthy Connections PCPs are required to meet coordinated care standards including monitoring and managing care, providing preventative routine and urgent care, coordinating care, providing referrals, medication management and 24/7 access to a medical professional for referral to services. Providers enrolled in Tier 3 of the program meet these coordinated care standards and are additionally required to:

Prompts	Summary
	- maintain a connection to Idaho's HIE, the Idaho Health Data Exchange (IHDE) - Provide at least one expanded patient access option, such as expanded access to primary care, patient web portal with 2-way communication capability (electronic messaging) or provision of telehealth Tier 3 providers also must meet at least one of the following requirements: - Have achieved PCMH national recognition or accreditation - Offer additional enhanced care management activities – Community Health Emergency Medical Services (CHEMS), Community Health Workers, promotora model, home visiting model or similar coordination model with proven results - Population Health Management capabilities – active registry reminder system or other proactive patient management approach - Behavioral Health Integration – co-located or highly integrated model of behavioral and physical health care delivery - Referral tracking and follow-up system Tier 4 providers must meet the same coordinated care and enhanced access to care standards as required for tier 3 and must have the following: - Dedicated care coordination staff/support - A bi-directional connection to the IHDE with demonstrated share relationship - National Committee Quality Assurance (NCQA) level 2 or 3 PCMH recognition or Utilization Review Accreditation Commission (URAC), Joint Commission Accreditation Association for Ambulatory Health Care (AAAHC) or other national recognition - Continuous quality improvement program - Since February 2016, 9 Healthy Connections service locations supported by 5 organizations qualified for Tier 3 by meeting the Behavioral Health Integration option. Since that time, 6 of the 9 service locations, owned by 4 Organizations, have advanced to Tier 4 by establishing a bi-directional connection with the IHDE and achieving PCM recognition. Currently 103 service locations owned by 48 organizations have achieved Tier 4 status. - Providers enrolled in the HIE can use Direct messaging for e-referrals with or without an EHR system. Direct is an effective, secure mechanism for use in the point-to-point exchange of sensitive, protected health information through a trusted network. Direct functions like regular email with additional security measures and ensures that messages are only accessible to the intended recipient.
	Future State: The state will a develop a baseline of current use of closed loop and e-referrals and identify options for tracking and increasing use.
	Summary of Actions Needed: - The state Medicaid HIT team will convene a stakeholder workgroup charged with identifying barriers and options for increasing use of closed loop and e-referrals (estimated completion: 10/2020) - The state Medicaid HIT team will conduct a survey to assess use of referral technology and related business practices used by providers (estimated completion: 12/2020)

Prompts	Summary
	- The state Medicaid HIT team will use survey data to develop a baseline of current activity and for tracking on-going of use of closed loop and e-referrals (estimated completion: 12/2020) - The state Medicaid team will include requirements to promote use of closed loop and e-referrals in the upcoming behavioral health managed care contract. (estimated completion: 01/2021)
1.2 Closed loop referrals and e-referrals from institution/ hospital/clinic to physician/ mental health provider	**Current State:** Currently outpatient behavioral health services for Medicaid members in Idaho are administered under a single managed care Prepaid Ambulatory Health Plan (PAHP). Inpatient behavioral health services are administered by the state. This model has created challenges for effective discharge planning. Although hospitals connected to the HIE can transmit secure messages and structured discharge information to the next level of care, behavioral health providers who do not operate within the hospital's internal HIT environment or not connected to the HIE cannot make use of this information. To address these challenges, the state's QIO contractor sends an inpatient report daily to the behavioral health contractor who directly accesses the QIO electronic system to retrieve patient information to support discharge planning and care coordination.
	Future State: -The state HIE (IHDE) will identify strategies for expanding behavioral health provider adoption of EHR and HIE (estimated completion: 12/2020) -The state HIE (IHDE) will implement IHDE enhancements to support behavioral health provider needs by expanding use of ADT, CCDA interface capabilities and Direct Messaging communications (estimated completion 01/2021). (Timeline: 18-24 months)
	Summary of Actions Needed: The state HIE (IHDE) will Contract with technology partners for establishing new interface connection builds (estimated completion: Nov 2021) (Timeline: 18-24 months)
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community-based supports	**Current State:** Use of e-referrals for community-based services and resources is limited. Idaho CareLine (2-1-1) is a statewide, no cost information and referral service that provides information and referral to community resources and services via a public facing web-based tool and call center.
	Future State: Assess feasibility of implementing a community resource platform for use by state and local agencies, including first responders, to enhance case management and crisis response by providing connections and referrals to community-based supports using a closed loop referral system with real time notification abilities.
	Summary of Actions Needed: - Contract with consultant (Julota) to assess government agencies for workflow gaps and service opportunities (estimated completion 07/20) - Contract with consultant (Julota) to conduct environmental scan for interested regions, communities, and resources-medical, community, etc. (estimated completion 07/20)
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	**Current State:** Idaho Medicaid's EHR Incentive Program, now called the Promoting Interoperability Program has been in effect since 2012. Through this initiative, 2,686 Eligible Professionals and 81 Hospitals have received incentive payments to adopt, implement and upgrade certified EHR systems and for successfully demonstrating meaningful use of these systems.

Prompts	Summary
	Approximately 80-85% of behavioral health providers use EHR in varying degrees. The state's HIE conducts outreach to engage additional participants from the health care community in use of HIT.
	Future State: Increase numbers and types of providers connected to HIE. The IHDE will conduct an outreach campaign to engage health care entities with no connection, outbound only, or portal-only access connection to upgrade to bi-directional connections. Engagement effort targets include 14 critical access hospitals, 11 hospitals, and 27 rural health clinics, 1 federally qualified health care center, 4 behavioral health hospitals, and 167 behavioral health treatment sites.
	Summary of Actions Needed: - The state HIE (IHDE) will identify and classify facilities by type, location, and contact information (estimated completion 05/2020) - The state HIE (IHDE) will engage for business needs, data needs (estimated completion: 10/2020)
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	**Current State:** Medicaid Primary Care and Behavioral Health providers have actively adopted use of certified EHRS. Levels of interoperability vary, ranging from ability to connect within internal organizations, broader connectivity to affiliated data hubs, and connections to Idaho's HIE. Currently, of Idaho's 511 Healthy Connections primary care service locations the following HIE connectivity is established: • Bi-directional Inbound/Outbound -157 Service Locations (primarily PCMH early adopters – with a focus on FQHC's & Pediatrics) • Inbound Only - 27 Service Locations • Outbound Only - 23 Service Locations • View Only - 42 Service Locations Other participants connected to the IHDE include 5 critical access hospitals 15 FQHCs, 12 home health agencies, 3 hospice centers, 12 hospitals, 1 long-term care facility, 5 rural health clinics, and 5 skilled nursing facilities, 3 military organizations, the Veterans Administration, 1 corrections institute, 1 imaging center, 3 labs, 1 outpatient/surgery/dialysis center, 3 payers, 1 pharmacy, 3 registries and 3 rehabilitation centers Despite this progress, providers face challenges with HIE licensing costs and high maintenance costs charged by EHR vendors. Some providers use an EHR that currently does not have the ability to provide inbound transactions to the HIE. Finally, because hospitals are not yet connected in the southern part of the state there is less primary care clinic connectivity there geographically, as well as less VIEW utilization.
	Future State: Increase numbers and types of providers connected to HIE. The IHDE will conduct an outreach campaign to engage medical community with no connection, outbound only, or portal-only access connection to upgrade to a bi-directional connection. - Engagement targets include 14 critical access hospitals, 11 hospitals, and 27 rural health clinics, 1 federally qualified health care center, 4 behavioral health hospitals, and 167 behavioral health treatment sites.

Prompts	Summary
	Summary of Actions Needed: - The state HIE (IHDE) will identify and classify facilities by type, location, and contact information (estimated completion: 05/2020) - The state HIE (IHDE) will engage for business needs, data needs (estimated completion 10/2020)
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** The state does not currently collect data regarding methods used for transitioning Medical records for youth-oriented systems.
	Future State: As adoption of EHR and HIE increase more providers will have ability to share records electronically. The state will work to increase the number of providers connected to HIE. The IHDE will conduct an outreach campaign to engage medical community with no connection, outbound only, or portal-only access connection to upgrade to a bi-directional connection. Engagement targets include 14 critical access hospitals, 11 hospitals, and 27 rural health clinics, 1 federally qualified health care center, 4 behavioral health hospitals, and 167 behavioral health treatment sites.
	Summary of Actions Needed: - The state HIE (IHDE) will identify and classify facilities by type, location, and contact information (estimated completion 05/2020) - The state HIE (IHDE) will engage for business needs, data needs (estimated completion 10/2020)
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Idaho's outpatient behavioral health managed care contractor provides Optum Supports and Services Manager (OSSM). This tool is an EHR platform set up specifically for Targeted Care Coordination. Targeted Care Coordinators use the tool to share and track information with the Child and Family Team and to submit person-centered service plans to the Managed care contractor for review. These care plans can be shared through electronic communications when youth transition to the adult behavioral health system.
	Future State: The State will include support for electronic care plans for children, youth and adults as an expectation for the next iteration of the behavioral health managed care contract.
	Summary of Actions Needed: The state Medicaid team will include requirements for supporting electronic care plans in the upcoming behavioral health managed care contract. (Estimated completion: 01/2021)
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	**Current State:** The state's HIE has successfully launched Direct Messaging and Supports ADT messages to communicate admission, discharge and transfer information. This functionality and the ability to share care summaries support enhanced care coordination for providers who use EHR and HIE technology.
	Future State: Assess feasibility of implementing a community resource platform for use by state and local agencies, including first responders, to enhance case management and crisis response by providing connections and referrals to community-based supports using a closed loop referral system with real time notification abilities.
	Summary of Actions Needed: - Contract with consultant (Julota) to assess government agencies for workflow gaps and service opportunities (estimated completion 07/20) - Contract with consultant (Julota) to conduct environmental scan for interested regions, communities, and resources-medical, community, etc. (estimated completion 07/20)

Prompts	Summary
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	**Current State:** Consent/privacy is managed largely at the provider level across the Medicaid system. Processes range from standardized electronic capture to manual, non-standardized and paper-based processes. The HIE provides individuals a method to "opt out" from having their health information made available to providers participating in the data exchange. Health care providers who participate in the HIE may only access data for purposes of treatment, payment, and healthcare operations which promote efficiency of communication in care, patient safety, and enhance patient health. These participants also must abide by the IHDE programs and policies which include privacy, security and HIPAA standards. Use of the IHDE system for any other reason is strictly prohibited. Additional development is needed to facilitate sharing and segregation of 42 CFR Part 2 sensitive information.
	Future State: The HIE will create a project to facilitate seamless sharing of sensitive information, segregation and protection of highly sensitive records. Project scope will include: -Defining 42 Part 2 data requirements -Engaging behavioral health, SUD, and community partners to define use cases for continuity of care and building more complete health records for authorized users -Use of recommendations from federal partners for de-identified patient data reporting -Adding a behavioral health access audit report function in Orion portal (access controls)
	Summary of Actions Needed: 1. The state HIE (IHDE) will revise the current master participant agreement and Qualified Service Organization Agreement (QSOA) to include prescription drug and 42 Part 2 data (Estimated timeline: 02/20-04/20) 2. The state HIE (IHDE) will enhance user roles and audit reporting functionality in portal with vendor, Orion Health (12/2019-06/2021) 3. The state HIE (IHDE) will enhance data warehouse capabilities to support 42 Part 2 data (04/2020-09/2020)
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	**Current State:** Idaho Medicaid's outpatient behavioral health managed care contractor requires clinicians to complete a standardized Comprehensive Diagnostic Assessment (CDA) to guide treatment for children and youth diagnosed with a Serious Emotional Disturbance (SED) and adults with Severe and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI). Providers are also required to use a standardized functional assessment tool to identify the member's strengths and needs. Providers use the CDA and functional assessment tools to guide individualized treatment planning and make recommendations for an array of services based on the severity and complexity of the member's symptoms and needs. The state has selected The Child and Adolescent Needs and Strengths (CANS) assessment as the functional assessment tool to be used for youth under the age of 18 receiving Medicaid benefits. There is no specific functional assessment tool which is mandated for adults, but one is required to be used. For substance use concerns, the provider may administer the GAIN or another specialized SUD assessment tool.

Prompts	Summary
	Use of these standardized assessment instruments paves the way for transitioning to structured data capture and increased operability. However, currently there is no requirement for structured data capture for adult assessments. The CANS functional assessment for children and youth does use a structured data capture process using the ICANS platform. Information from CANS results and updates guides person-centered plan development and follows the member throughout the system of care.
	Future State: The State will include requirements for progress towards transitioning standardized assessments into structured data capture processes as an expectation for the next iteration of the behavioral health managed care contract.
	Summary of Actions Needed: - The state Medicaid team will include requirements for transitioning standardized assessments into structured data capture processes to improve interoperability in the upcoming behavioral health managed care contract. (estimated completion 01/2021)
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	**Current State:** In July 2019, the Health Transformation Council of Idaho (HTCI) with endorsement by the Health Quality Planning Council, (HQPC) approved formation of a Telehealth Task Force. The task force is charged with identifying drivers, opportunities and strategies for telehealth services adoption and expansion in Idaho for providers, clinics, specialists, hospitals, and other health system partners. Telehealth has the potential to help overcome challenges of provider shortages and can help expand access to health care services. In Idaho, telehealth is governed by statute. During the 2020 legislative session, the Telehealth Access Act was amended to more specifically define allowable uses of telehealth. Idaho Medicaid reimburses providers for a broad range of telehealth services, including primary care and behavioral health.
	Future State: The state will use Support Act funds for a telehealth environmental scan of current use, barriers, and future state of telehealth and telehealth services
	Summary of Actions Needed: The environmental scan will be conducted by a vendor, Stonewall Analytics, anticipated completion is September 2020.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment	**Current State:** The state's current Medicaid managed care contractor for outpatient behavioral health services provides an electronic tool, Algorithms for Effective Reporting and Treatment (ALERT®). The ALERT® tool is an outcomes and outlier management system that uses member self-reports of symptom severity and impairment as measured by a wellness assessment in combination with claims to identify members who may be at-risk or who may be over or under-utilizing outpatient services. It provides decision support (utilization algorithms) for the authorization and/or clinical review of outpatient services. It also generates provider profiles that enable quality improvement and clinical staff to act when trends are identified.

Prompts	Summary
continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment)	**Future State:** Work with current managed care contractor to evaluate effectiveness of workflow related to Alert functionality
	Summary of Actions Needed: - The state Medicaid team and Optum Idaho (current managed care contractor) will conduct evaluation of current Alert workflow (estimated completion 09/20) - The state Medicaid team will Include requirements for HIT capabilities for identifying patients at risk for discontinuing treatment in the upcoming behavioral health managed care contract (estimated completion 01/2021)
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	**Current State:** The state's HIE has successfully launched Direct Messaging and Supports ADT messages to communicate admission, discharge and transfer information. This functionality and the ability to share care summaries support enhanced care coordination for individuals experiencing their first episode of psychosis.
	Future State: Conduct analysis to determine levels of adoption of EHR and HIE by IMDs
	Summary of Actions Needed: - The state HIE (IHDE) will define business needs, data needs, priorities, connection types (estimated completion: 05/2020) - The state HIE (IHDE) will conduct readiness assessment for bi-directional interfaces (estimated completion 10/2020)
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	**Current State:** Ability to link parent-child relations is a feature of some certified EHRs, however, this is not a current feature of Idaho's HIE or broadly available in the state's health system. Systems used within the state's Department of Health and Welfare to administer Medicaid, SNAP, Child Care Assistance, Cash Assistance, Foster Care, Child Welfare and other social services programs are integrated, use common identifiers and can link child and parent records.
	Future State: The state will perform a feasibility analysis to determine benefits, constraints, costs and relative priority of this functionality.
	Summary of Actions Needed: The Medicaid HIT team will Identify subject matter expertise needed to perform analysis, engage stakeholders, document results, present findings to state leadership. (Estimated completion: 12/2020)
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	**Current State:** The state's HIE recently performed a self-evaluation and tuning exercise on their current MPI and determined that a backlog of mismatched and/or duplicate patient records exist. The HIE is conducting a detailed analysis of the status of exceptions in the MPI and will execute a cleanup of existing anomalies while establishing a program for constant monitoring and remediation on a regular basis.
	Future State: Enhanced reliability and usability of data resulting from regular monitoring and remediation of MPI exceptions.
	Summary of Actions Needed:

Prompts	Summary
	- The state HIE (IHDE) will develop standard operating procedures for monitoring and remediating MPI exceptions (Estimated timeline: 07/20-03/21) - IHDE Staff training (Estimated timeline: 09/20-03/21) - IHDE Compliance audits (Anticipated audits: 06/20, 12/20, 06/21)