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

August 21, 2025

Juliet Charron
State Medicaid Director
State of Idaho, Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720

Dear Director Charron:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Interim Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #42 "Interim Evaluation Report" of Idaho's section 1115 demonstration, "Idaho Behavioral Health Transformation" (Project No: 11-W-00339/10), effective through September 30, 2025. This Interim Evaluation Report covers the period from January 2021 through March 2023. CMS determined that the Evaluation Report, submitted on September 26, 2024, and revised on May 12, 2025, is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore approves the state's Interim Evaluation Report.

The evaluation findings from the Interim Evaluation Report demonstrate some progress toward demonstration goals. For example, compared to the pre-demonstration period, findings suggest that the number of Medicaid-enrolled providers qualified to deliver substance use disorder services increased. The evaluation findings also suggest that the number of beneficiaries receiving substance use disorder related treatments as well as the number of beneficiaries utilizing behavioral health services increased compared to the pre-demonstration period. However, several evaluation measures trended opposite the desired direction, such as increased emergency department utilization for substance and opioid use disorders and decreased follow-up to beneficiaries with a principal diagnosis of mental illness after an emergency department visit. The COVID-19 public health emergency coincided with the evaluation period, and Medicaid expansion was implemented in the state three months prior to the start of the demonstration. Both developments potentially had an impact on evaluation findings, though the state attempted to account for these factors through their analytic methods. The state utilized a pre-post design method, along with descriptive statistics, for quantitative analyses as opposed to a CMS recommended quasi-experimental design method. The state noted they will utilize a quasi-experimental design method for quantitative analyses in their Summative Evaluation Report. Finally, the state brought on a managed care organization in 2024 to support their behavioral health delivery system and expect this systemic shift to support more desired outcomes and trends in future evaluation measures. We look forward to further evaluation of the demonstration.

In accordance with STC #46, the approved Interim Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Interim Evaluation Report on Medicaid.gov.

We look forward to our continued partnership on the Idaho Behavioral Health Transformation section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2025.08.21 07:07:57 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Courtaney Savage, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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

May 13, 2025

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 of SUD and SMI/SED services. 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.

Hypothesis Summary Table

Demonstration Goals	Hypothesis	Hypothesis Supported Yes or No
SUD Goal 1: Increased rates of identification, Initiation, and engagement in treatment for OUD and other SUDs	SUD Hypothesis 1: The 1115 Waiver demonstration will lead to improved access to critical levels of care for OUD and other SUDs.	Yes
SUD Goal 2: Increased adherence to and retention in treatment for OUD and other SUDs	SUD Hypothesis 2: The 1115 Waiver demonstration will lead to increased use of nationally recognized, evidence-based SUD program standards	Mixed (increases for OUD, declines for alcohol and SUD)

SUD Goal 3: Reductions in overdose deaths, particularly those due to opioids	SUD Hypothesis 3: The 1115 Waiver demonstration will lead to increased use of evidence-based, SUD-specific patient placement criteria.	Mixed Mixed (higher for non-expansion, lower for expansion)
SUD 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	SUD Hypothesis 4: The 1115 Waiver demonstration will lead to implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.	Mixed (ED visits and inpatient visits increased, but not clear whether inappropriate)
SUD 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	SUD Hypothesis 5: The 1115 Waiver demonstration will lead to improved care coordination and transitions between levels of care.	Yes
SUD Goal 6: Improved access to care for physical health conditions among beneficiaries	SUD Hypothesis 6: The 1115 Waiver demonstration will lead to sufficient provider capacity at each level of care.	Mixed (increased community-based care, no data for co-located behavioral and physical care availability)
SMI/SED		
SMI/SED 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	SMI/SED Hypothesis 7: The 1115 Waiver demonstration will lead to improved quality of care in psychiatric hospitals and residential settings.	Yes
SMI/SED Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings	SMI/SED Hypothesis 8: The 1115 Waiver demonstration will lead to earlier identification and engagement in treatment through increased integration.	Mixed (small increase but not clear preventable; small decline in rural areas)

SMI/SED 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	SMI/SED Hypothesis 9: The 1115 Waiver demonstration will lead to increasing access to continuum of care, including crisis stabilization services.	Yes
SMI/SED 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	SMI/SED Hypothesis 10: The 1115 Waiver demonstration will lead to increasing access to continuum of care, including crisis stabilization services.	Yes
SMI/SED Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential	SMI/SED Hypothesis 11: The 1115 Waiver demonstration will lead to improved care coordination and transition to community-based care.	Not sufficient data

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 health1. 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 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]. 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 evaluation progress and present findings to date as per the approved Idaho BHT Waiver evaluation Plan. 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)

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.

Where available we examined differences by subgroup, specifically rural vs. urban population. We were concerned about data limitations for other demographic groups, but can revisit for the summative report.

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 for the summative report will build on these analyses by implementing an interrupted time series approach to estimate the impact of the Waiver on the outcomes. However, due to data limitations we will still be limited to a single state's data so will not be able to compare outcomes to a control state.

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. In these summary tables listed below, we outline each milestone, corresponding research questions, metrics used to answer the research questions and the estimated direction of the targeted trend (i.e., hypothesized increase or decrease in demonstration period relative to baseline period).

- Table 3.1: Summary of SUD Research Question and metric findings
- Table 3.2: Summary of SMI/SED Research Questions and metrics findings
- Table 3.3: Cost Analysis metrics

Quantitative Results

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

Goal 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 Questions: 1.1, 1.2, 1.3, 1.4

Results

The results in Table E.1a 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—i) 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); ii) the changing definition of the SUD and SMI/ SED population, and iii) 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 "non-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.1a indicates increasing rates of SUD care utilization for those with SUD. Specifically, for DY3, relative to a baseline of Q1 2020, we observe a 13.8% increase in SUD Initiation, a 17.2% increase in outpatient utilization, a 80.7% increase in intensive outpatient utilization, and a 18.7% increase in inpatient 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.

In addition to the overall results in Table E.1a, we also estimate differences in outcomes for a specific subgroup (rural vs. urban residents) in Table E.1a.i. In discussions with IDHW, this was an important subgroup but we can expand to additional subgroups in the summative report. Interestingly, we observed greater increases for the rural population compared to the urban population (or smaller decreases) for each outcome and each DY with the exception of inpatient utilization. These results are a promising indication the Waiver is helping connect rural patients to SUD care.

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
SUD Initiated (Metric #2) [a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-57.8	-56.6	-21.4	-18.5	-73.5	-73.4
		DY2 (Apr. 2021-Mar. 2022)	-65.6	-60.2	-26.4	-13.1	-80.7	-78.4
		DY3 (Apr. 2022-Mar. 2023)	-63.4	-48.7	-21.6	13.8	-79.5	-72.4
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-9.2	-1.2	-12.9	-5.2	-	-
		DY2 (Apr. 2021-Mar. 2022)	-26.1	-9.4	-18.3	1.1	-	-
		DY3 (Apr. 2022-Mar. 2023)	-21.3	16.8	-13.1	32.4	-	-
Outpatient (Metric #8) [b]	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	-	-
		DY2 (Apr. 2021-Mar. 2022)	-12.6	6.8	-13.8	5.3	-	-
		DY3 (Apr. 2022-Mar. 2023)	-14.5	28	-16.4	27.6	-	-
Intensive Outpatient (Metric #9) [c]	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	-	-
		DY2 (Apr. 2021-Mar. 2022)	206.5	263.4	142.9	191.3	-	-
		DY3 (Apr. 2022-Mar. 2023)	263.5	429.8	179.8	321.2	-	-

Inpatient (Metric #10) [d]	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	-	-
		DY2 (Apr. 2021-Mar. 2022)	3	21.3	-14.4	-0.5	-	-
		DY3 (Apr. 2022-Mar. 2023)	0.2	49.1	-10.3	36.8	-	-

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.
Quarterly data.
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 Medicaid beneficiaries with newly initiated SUD treatment/diagnosis
b: 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.

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

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
SUD Initiated (Metric #2) [a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-56.6	-18.5	-73.4	-19.2	-18.4	-73.3	-73.5
		DY2 (Apr. 2021-Mar. 2022)	-60.2	-13.1	-78.4	-8.1	-15	-76.5	-78.9
		DY3 (Apr. 2022-Mar. 2023)	-48.7	13.8	-72.4	26	9.5	-70.5	-73
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-1.2	-5.2	112.7	-8.8	-4	-	-
		DY2 (Apr. 2021-Mar. 2022)	-9.4	1.1	73	3.7	0	-	-
		DY3 (Apr. 2022-Mar. 2023)	16.8	32.4	120.5	42.3	28.8	-	-

Outpatient (Metric #8) [b]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-18.9	-5.9	-35.8	-6.5	-5.9	-36.2	-35.8
		DY2 (Apr. 2021-Mar. 2022)	-24.3	-3.3	-44.9	-2.3	-4	-44.5	-45.2
		DY3 (Apr. 2022-Mar. 2023)	-9.3	17.2	-34.6	26.4	13.7	-31.1	-35.8
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	14.4	2.4	-	0.9	2.6	-	-
		DY2 (Apr. 2021-Mar. 2022)	6.8	5.3	-	5.4	4.7	-	-
		DY3 (Apr. 2022-Mar. 2023)	28	27.6	-	36.4	24	-	-
Intensive Outpatient (Metric #9) [c]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-10.4	4.5	-34.1	54.1	-2.1	-35.2	-34.5
		DY2 (Apr. 2021-Mar. 2022)	-3.5	25	-36.4	71.1	17.4	-37.8	-37.1
		DY3 (Apr. 2022-Mar. 2023)	40.7	80.7	-9.2	162.3	66.1	-3.2	-11.8
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	237.3	143.5	-	172.4	136.5	-	-
		DY2 (Apr. 2021-Mar. 2022)	263.4	191.3	-	202.6	183.6	-	-
		DY3 (Apr. 2022-Mar. 2023)	429.8	321.2	-	363.7	301.1	-	-
Inpatient (Metric #10) [d]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	5.2	43.3	-26.7	26.7	47.8	-34.4	-24.8
		DY2 (Apr. 2021-Mar. 2022)	-42.7	-13.7	-63.9	-22.8	-11.7	-68.8	-62.8
		DY3 (Apr. 2022-Mar. 2023)	-29.6	18.7	-58	24.4	15.7	-73.7	-54.4
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	122.9	65.2	-	29.5	77.2	-	-
		DY2 (Apr. 2021-Mar. 2022)	21.3	-0.5	-	-21	5.9	-	-
		DY3 (Apr. 2022-Mar. 2023)	49.1	36.8	-	27.2	38.7	-	-

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.

This table only includes the rates calculated by the denominator with the static definition
SUD: substance use disorder.
DY: Demonstration year. Quarterly data.
Percent change= (rate of metric at demonstration period x - rate of metric at baseline)/rate of metric at baseline*100.
Static definition: The number of Medicaid SUD population is calculated by the PSU research team following the latest definition in Medic- aid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Manual (Version 5.0).
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.
a: Number of Medicaid beneficiaries with newly initiated SUD treatment/diagnosis
b: 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.

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

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

Hypothesis 3: The 1115 Waiver demonstration will lead to increased use of evidence-based, SUD-specific patient placement criteria.

Research Questions: 3.1, 3.2. 3.3, State Metrics

Results

We found mixed results for the change in ED visits for SUD and OUD (Table E.2a). For our preferred sample (non-expansion, static definition), we observed increases in ED visits for SUD and OUD. 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, due 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. We did not have data available to estimate changes in repeat overdoses for SUD.

When examining differences between rural and urban beneficiaries, we saw larger increases in ED visits for SUD for the rural population than urban population (Tabel E.2ai). However, we found little difference in rates of OUD ED visits between urban and rural populations. We observed similar increases in overdose deaths for urban and rural populations when using the 2018-2020 baseline, which is preferable since a Q1 2020 is likely too short of a baseline period for an outcome like overdose deaths.

Finally, we observed declines in average IMD length of stay for SUD (Table E.2b). This is potentially promising as there was an emphasis on ensuring patients are in the correct level of care but also could be due to pressures from high demand for IMD care (which was noted in some of the key stakeholder interviews). We observed large declines in length of stay for rural patients compared to urban patients (Table E.2bi). While IMD length of stay was not in the evaluation plan, we included it based on discussions with IDHW that noted this was a critical metric for them.

Table E.2a: Performance on SUD Milestone 2 Metrics by different baselines and different definitions for Medicaid SUD population (denominator) (SUD Metrics 23, 27).

Metric		Period	Percent Change					
			Overall		Non-expansion		Expansion	
			Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
ED visits for SUD[2a] (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	-
		DY2 (Apr. 2021-Mar. 2022)	-2	21	5.2	29.2	-47.3	-
		DY3 (Apr. 2022-Mar. 2023)	5.6	58.1	12.5	71.7	-42.9	-
ED visits for OUD[2a] (Metric #23)	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-2.5	0.3	16.8	21.1	-20.8	-20.5
		DY2 (Apr. 2021-Mar. 2022)	-4.5	12.6	37.4	63.3	-31.3	-21.1
		DY3 (Apr. 2022-Mar. 2023)	24.8	74.9	70.8	148.1	-6.1	26.3
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-12.8	-3.8	-8.8	-0.5	533.5	-
		DY2 (Apr. 2021-Mar. 2022)	-14.5	8	7.3	34.2	450	-
		DY3 (Apr. 2022-Mar. 2023)	11.6	67.9	33.3	103.8	651	-
Overdose death for SUD[2b] (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	-
		DY2 (Apr. 2021-Mar. 2022)	-18.6	-2.8	-7	8.9	-54.6	-
		DY3 (Apr. 2022-Mar. 2023)	-29.1	6.2	-13.4	32.1	-61.8	-
Repeat overdoses for SUD[2c]	(Jan.-Mar. 2020) Baseline	Baseline	ND	ND	ND	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	ND	ND	ND
		DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	ND	ND	ND
		DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND	ND	ND	ND
	(Apr. 2018-Mar. 2020) Baseline	Baseline	ND	ND	ND	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	ND	ND	ND
		DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	ND	ND	ND
		DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND	ND	ND	ND

Note: SUD Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria.
1.Annual data. 2.Quarterly data. SUD: substance use disorder. OUD: Opioid use disorder. ND: No data.
DY: Demonstration year.

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).

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: Total number of ED visits for SUD/OUD per 1,000 beneficiaries in the measurement period.
b: Rate of overdose deaths (number of deaths per 100,000 Medicaid beneficiaries with SUD) for SUD during the measurement period.
c: Number of beneficiaries experiencing multiple overdoses during the measurement period.

Table E.2a.i: Subgroup Analysis for SUD Milestone 2 Metrics (SUD Metrics 23, 27).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
ED visits for SUD[2e] (Metric #23) [e]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-17.1	3.6	-38	4.2	3	-36.8	-38.5
		DY2 (Apr. 2021-Mar. 2022)	-11.7	28.2	-40.7	34.2	25.5	-37.7	-41.8
		DY3 (Apr. 2022-Mar. 2023)	15.4	70.4	-23.1	123	54.9	-10.4	-26.6
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	13.5	4.4	-	6.3	3.3	-	-
		DY2 (Apr. 2021-Mar. 2022)	21	29.2	-	36.9	25.9	-	-
		DY3 (Apr. 2022-Mar. 2023)	58.1	71.7	-	127.4	55.3	-	-
ED visits for OUD[2e] (Metric #23) [e]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	0.3	21.1	-20.5	16.9	22.3	-5.8	-23.5
		DY2 (Apr. 2021-Mar. 2022)	12.6	63.3	-21.1	48.1	67.6	-12.4	-23.5
		DY3 (Apr. 2022-Mar. 2023)	74.9	148.1	26.3	143.2	147.8	73	16.8
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-3.8	-0.5	-	3.3	-2.2	-	-
		DY2 (Apr. 2021-Mar. 2022)	8	34.2	-	30.8	34	-	-
		DY3 (Apr. 2022-Mar. 2023)	67.9	103.8	-	114.8	98.2	-	-
Overdose death for SUD2[f] (SUD #27)	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-19.8	29.3	-48.5	-17.4	48.5	7.4	-52.8
		DY2 (Apr. 2021-Mar. 2022)	-19.8	30.6	-50.2	29.5	31	45.2	-57.3
		DY3 (Apr. 2022-Mar. 2023)	-12.4	58.4	-48.7	38.9	65.6	96.1	-58.9
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-2.8	7.8	-	-18.1	15.8	-	-
		DY2 (Apr. 2021-Mar. 2022)	-2.8	8.9	-	28.4	2.2	-	-
		DY3 (Apr. 2022-Mar. 2023)	6.2	32.1	-	37.7	29.2	-	-
Repeat overdoses for SUD[2g]	Baseline (Jan.-Mar. 2020)	Baseline	ND	ND	ND	ND	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	ND	ND	ND	ND
		DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	ND	ND	ND	ND
		DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND	ND	ND	ND	ND
	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND	ND	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	ND	ND	ND	ND
		DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	ND	ND	ND	ND
		DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND	ND	ND	ND	ND

Note: SUD Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Addiction and OUD. 1.Annual data. 2.Quarterly data. SUD: substance use disorder. OUD: Opioid use disorder. DY: Demonstration year. ND: No 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: Total number of ED visits for SUD/OUD per 1,000 beneficiaries in the measurement period.
b: Rate of overdose deaths (number of deaths per 100,000 Medicaid beneficiaries with SUD) for SUD during the measurement period.
c: Number of beneficiaries experiencing multiple overdoses during the measurement period.
This table only includes the rates calculated by the denominator with the static definition.
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).
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

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

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

Note: SUD Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria.
a: SUD Metric #36, The average length of stay (days) for beneficiaries who were treated in an IMD for SUD during the measurement period.
SUD, substance use disorder. IMD, institution for mental diseases. DY: Demonstration year. 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.
DY: Demonstration year.

Table E.2b.i: Subgroup analysis for SUD Milestone 2 Metrics (SUD Metric 36).

			Percent Change %						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Average Length of Stay for SUD in IMD[a] (SUD #36)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-3.3	-25.3	-	-57.1	-5.9	-	-
		DY2 (Apr. 2021-Mar. 2022)	-40.2	-34.1	-	-53.3	-18.6	-	-
		DY3 (Apr. 2022-Mar. 2023)	-37.3	-23.9	-	-51.2	-6.4	-	-

Note: SUD Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria.
a: SUD Metric #36, The average length of stay (days) for beneficiaries who were treated in an IMD for SUD during the measurement period.
SUD, substance use disorder. IMD, institution for mental diseases. DY: Demonstration year. 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.
DY: Demonstration year.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

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

Goal 2: Increased adherence to and retention in treatment for OUD and other SUDs.

Hypothesis 2: The 1115 Waiver demonstration will lead to increased use of nationally recognized, evidence-based, SUD program standards.

Research Questions: 2.1, 2.2, 2.3, 2.4, 2.5

Results

Promisingly, when we focus on the "non-expansion" population using the "static" definition (our preferred subpopulation), Table E.3a indicates increasing rates of MAT utilization (a 38.6% increase from a baseline of Q1 2020 and 66.3% increase when using the broader baseline period). In contrast to the results for the non-expansion population, we observed declines in MAT utilization for the expansion population. Although we believe this is likely due to the analytic limitations outlined above. We did not have data available to assess early intervention or re-engagement of MAT. We observed similar increases in MAT for both urban and rural populations when using the broader baseline and a larger increase in MAT for rural populations when just using Q1 2020 as the baseline period (Table E.3ai).

Also in contrast to the increases in MAT, we observed a decline in continuity of pharmacotherapy (i.e. those with at least 180 days of continuous MAT) [Table E.3c]. 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 due to the increasing 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. While this metric was not in the original analysis plan we wanted to be sure to capture a measure of sustained use of MAT, given its importance to longer term OUD treatment success.

We observed somewhat mixed results for the substance-related initiation and engagement metrics (Table E.3b). 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.

Table E.3a: Performance on SUD Milestone 3 Metrics by varying baseline and definition for Medicaid SUD population (denominator) (SUD Metric 7, 12).

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
Early Intervention (Metric #7) [a]	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	ND	ND	ND
		DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	ND	ND	ND
		DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND	ND	ND	ND

Re-engagement to MAT[b]	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	ND	ND	ND
		DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	ND	ND	ND
		DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND	ND	ND	ND
MAT (Metric #12) [c]	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 3: 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
Quarterly Data.
SUD, substance use disorder. IMD, institution for mental diseases. DY: Demonstration year. 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.
DY: Demonstration year.
a: SUD Metric #7, Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.
b: Number of beneficiaries who have MAT (and OUD) and have a gap of at least 30 days between fills (i.e. have a 30 day period with no MAT), then identify % that re-engage.
c: SUD Metric #12, Number of beneficiaries who have a claim for MAT for SUD during the measurement period.
ND: No data.

Table E.3a.i: Subgroup analysis for SUD Milestone 3 Metrics (SUD Metric 7, 12).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Early Intervention (Metric #7) [a]	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND	ND	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	ND	ND	ND	ND
		DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	ND	ND	ND	ND
		DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND	ND	ND	ND	ND
Re-engagement to MAT[b]	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND	ND	ND	ND	ND	ND	ND
		DY1 (Apr. 2020-Mar. 2021)	ND	ND	ND	ND	ND	ND	ND
		DY2 (Apr. 2021-Mar. 2022)	ND	ND	ND	ND	ND	ND	ND
		DY3 (Apr. 2022-Mar. 2023)	ND	ND	ND	ND	ND	ND	ND

MAT (Metric #12) [c]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	6.8	16.1	-6.1	28.5	11.8	-9.8	-5.1
		DY2 (Apr. 2021-Mar. 2022)	20.8	35	3.4	38	33.5	-6.4	6.1
		DY3 (Apr. 2022-Mar. 2023)	20.2	38.6	1.2	63	30.6	3.2	0.6
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	41	39.3	-	35.4	40.8	-	-
		DY2 (Apr. 2021-Mar. 2022)	59.5	62	-	45.3	68.1	-	-
		DY3 (Apr. 2022-Mar. 2023)	58.7	66.3	-	71.7	64.4	-	-

Note: SUD Milestone 3: 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
Quarterly Data.
SUD, substance use disorder. IMD, institution for mental diseases. DY: Demonstration year. 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.
DY: Demonstration year.
a: SUD Metric #7, Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.
b: Number of beneficiaries who have MAT (and OUD) and have a gap of at least 30 days between fills (i.e. have a 30 day period with no MAT), then identify % that re-engage.
c: SUD Metric #12, Number of beneficiaries who have a claim for MAT for SUD during the measurement period.
ND: No data.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

Table E.3b: Performance on SUD Milestone 3 Metrics by varying baseline and definition for Medicaid SUD population (SUD Metric 15).

		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

Note: SUD Milestone 3: 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
Annual data.
SUD, substance use disorder. IMD, institution for mental diseases. DY: Demonstration year. 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.
DY: Demonstration year.
IET-AD (Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence 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.

Table E.3c: Performance on Milestone 3 Metrics by expansion and non-expansion status (SUD Metric 22).

		Percent change %		
		Overall	Non-expansion	Expansion
Continuity of pharmacotherapy (adherence to MAT, Metric #22) [a]	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: SUD Milestone 3: 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
Annual data.
SUD, substance use disorder. MAT, medication assisted treatment. DY: Demonstration year. 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.
DY: Demonstration year. 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.
a. Percentage of adults 18 years of age and older with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment

Table E.3c.i: Subgroup analysis for SUD Milestone 3 Metrics (SUD Metric 22).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Continuity of pharmacotherapy (Metric #22) [a]	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-6.7	6.7	-	12.3	4.4	-	-
		DY2 (Apr. 2021-Mar. 2022)	-54.1	-48.3	-	-39.6	-51.4	-	-
		DY3 (Apr. 2022-Mar. 2023)	-73.3	-68.6	-	-61.8	-71	-	-

Note: SUD Milestone 3: 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
Annual data.
SUD, substance use disorder. MAT, medication assisted treatment. DY: Demonstration year. 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.
DY: Demonstration year. 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.
a. Percentage of adults 18 years of age and older with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

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

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

Hypothesis 6: The 1115 Waiver demonstration will lead to sufficient provider capacity at each level of care.

Research Questions: 6.1, 6.2, 6.3, 6.4, 6.5, 6.6

Results

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.4: Performance on Milestone 4 Metrics (SUD Metrics 13, 14).

		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	83.8%
	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

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.

Hypothesis 4: The 1115 Waiver demonstration will lead to implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.

Research Questions: 4.1, 4.2, 4.3, 4.4, 4.5, 4.6

Results

Table E.5a shows 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 observed similar declines in both rural and urban populations (Table E.5a.i).

Similar to what was noted in Milestone 2, we found mixed results for the change in ED visits for SUD and OUD (Table E.5b). For our preferred sample (non-expansion, static definition), we observed increases in ED visits for SUD and OUD. Table E.5bi shows similar rates of change for OUD ED visits for rural and urban patients; but a greater increase in ED visits for SUD for rural patients in the non-expansion population.

Table E.5a: Performance on Milestone 5 Metrics by expansion and non-expansion status (SUD Metrics 18, 19, 20, 21).

		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.5a.i: Subgroup analysis for SUD Milestone 5 Metrics (SUD Metrics 18, 19, 20, 21).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Percent of adults prescribed opioids at high dosage [1a,e] (SUD #18)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-30.3	-10.4	-	-7.9	-11.4	-	-
		DY2 (Apr. 2021-Mar. 2022)	-37.2	-11.6	-	-0.2	-15.5	-	-
		DY3 (Apr. 2022-Mar. 2023)	-40.8	-14.6	-	-6.8	-18	-	-
Percent of adults with opioid prescriptions from multiple providers [1b,e] (SUD #19)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-60.7	-57.9	-	-63.2	-55.7	-	-
		DY2 (Apr. 2021-Mar. 2022)	-57	-70.3	-	-61.7	-73.8	-	-
					-			-	-
		DY3 (Apr. 2022-Mar. 2023)	-56.4	-62.6		-70.6	-59.8		
Percent of adults with high dosage opioids prescriptions or from multiple providers [1c,e] (SUD #20)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-65.9	-44.4	-	-15.9	-58.5	-	-
		DY2 (Apr. 2021-Mar. 2022)	-100	-100	-	-100	-100	-	-
					-			-	-
		DY3 (Apr. 2022-Mar. 2023)	-100	-100		-100	-100		
Percent of adults with concurrent prescription of opioids and benzodiazepines [1d,e] (SUD #21)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-31.4	-20.3	-	-21.3	-20	-	-
		DY2 (Apr. 2021-Mar. 2022)	-25.3	-11.5	-	-8.2	-13	-	-
					-			-	-
		DY3 (Apr. 2022-Mar. 2023)	-26.3	-12.9		-4.7	-16.2		

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.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

Table E.5b: Performance on Milestone 5 Metrics by expansion and non-expansion status (SUD Metric 23).

			Percent Change					
			Overall		Non-expansion		Expansion	
Metric		Period	Rolling definition	Static definition	Rolling definition	Static definition	Rolling definition	Static definition
ED visits for SUD[2a] (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	-
		DY2 (Apr. 2021-Mar. 2022)	-2	21	5.2	29.2	-47.3	-
		DY3 (Apr. 2022-Mar. 2023)	5.6	58.1	12.5	71.7	-42.9	-
ED visits for OUD[2a] (Metric #23)	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-2.5	0.3	16.8	21.1	-20.8	-20.5
		DY2 (Apr. 2021-Mar. 2022)	-4.5	12.6	37.4	63.3	-31.3	-21.1
		DY3 (Apr. 2022-Mar. 2023)	24.8	74.9	70.8	148.1	-6.1	26.3
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-12.8	-3.8	-8.8	-0.5	533.5	-
		DY2 (Apr. 2021-Mar. 2022)	-14.5	8	7.3	34.2	450	-
		DY3 (Apr. 2022-Mar. 2023)	11.6	67.9	33.3	103.8	651	-

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.
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. ED visits for SUD (Metric #23): Total number of ED visits for SUD/OUD per 1,000 beneficiaries in the measurement period.

Table E.5b.i: Subgroup Analysis for SUD Milestone 5 Metrics (SUD Metric 23).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
ED visits for SUD[2a] (Metric #23)	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-17.1	3.6	-38	4.2	3	-36.8	-38.5
		DY2 (Apr. 2021-Mar. 2022)	-11.7	28.2	-40.7	34.2	25.5	-37.7	-41.8
		DY3 (Apr. 2022-Mar. 2023)	15.4	70.4	-23.1	123	54.9	-10.4	-26.6
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	13.5	4.4	-	6.3	3.3	-	-
		DY2 (Apr. 2021-Mar. 2022)	21	29.2	-	36.9	25.9	-	-
		DY3 (Apr. 2022-Mar. 2023)	58.1	71.7	-	127.4	55.3	-	-
ED visits for OUD[2a] (Metric #23) [a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	0.3	21.1	-20.5	16.9	22.3	-5.8	-23.5
		DY2 (Apr. 2021-Mar. 2022)	12.6	63.3	-21.1	48.1	67.6	-12.4	-23.5
		DY3 (Apr. 2022-Mar. 2023)	74.9	148.1	26.3	143.2	147.8	73	16.8
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-3.8	-0.5	-	3.3	-2.2	-	-
		DY2 (Apr. 2021-Mar. 2022)	8	34.2	-	30.8	34	-	-
		DY3 (Apr. 2022-Mar. 2023)	67.9	103.8	-	114.8	98.2	-	-

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. DY: Demonstration year.

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. ED visits for SUD (Metric #23): Total number of ED visits for SUD/OUD per 1,000 beneficiaries in the measurement period.
This table only includes the rates calculated by the denominator with the static definition.
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).
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

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

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.

Hypothesis 5: The 1115 Waiver demonstration will lead to improved care coordination and transitions between levels of care.

Research Questions: 5.1, 5.2, 5.3, 5.4, 5.5, 5.6

Results

In table E.6a, we 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. We see increases in 7- and 30-day follow-up for SUD ED visits which we view positively. 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. We observed small declines in preventive care utilization, but rates remained over 98% so more an issue that rates started so high.

Next, we observed mixed results for readmission rates (Table E.6b). 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. Furthermore, the decline seems to be driven by the urban population, especially in DY3 (Table E.6b.i). Unfortunately, we did not have data available to assess medication continuation (Table E.6c).

Table E.6a: Performance on Milestone 6 Metrics (SUD Metrics 17(1), 17(2), 32).

		Value	Absolute change	Percent change %
7-day follow-up after SUD emergency department visits[a] (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[b] (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[c] (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[d] (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
Preventive care utilization[e] (SUD #32)	Baseline (2018-2019)	99.3	-	-
	DY1 (Apr. 2020-Mar. 2021)	99.4	0	0
	DY2 (Apr. 2021-Mar. 2022)	99	-0.3	-0.3
	DY3 (Apr. 2022-Mar. 2023)	98.3	-1	-1

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. DY: Demonstration year.
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: 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).
b: 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).
c: 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).
d: 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).
e: The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period. 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.6b Performance on SUD Milestone 6 Metrics by expansion and non-expansion status (SUD Metric 25).

			Percent Change		
			Overall	Non-expansion	Expansion
Metric		Period			
Readmissions among beneficiaries with SUD[a] (SUD #25)	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. DY: Demonstration year.
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: 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.

Table E.6b.i: Subgroup analysis for SUD Milestone 6 Metrics (SUD Metric 25).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Readmissions among beneficiaries with SUD[a] * (SUD #25)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	3.6	0.8	62.2	18.3	-4.5	583.9	169.8
		DY2 (Apr. 2021-Mar. 2022)	-6.7	-6.4	42.9	-6.7	-7.1	573.6	130.9
		DY3 (Apr. 2022-Mar. 2023)	-15.1	-7.6	22.7	7.2	-12	376.7	105.6

Note: SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care. Annual data.
SUD: substance use disorder. DY: Demonstration year.
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: 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.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

Table E.6c: Performance on SUD Milestone 6 Metrics.

		Value	Absolute change	Percent change %
Medication continuation post inpatient discharge for SUD[a]	Baseline (2018-2019)	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
Medication continuation post inpatient discharge for SUD (possible unintended spillovers will also test for ages 6–17)[b]	Baseline (2018-2019)	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: SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care.
Annual data.
SUD: substance use disorder. DY: Demonstration year. ND: No 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: Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for SUD and who had a follow-up visit with a mental health practitioner.
b: Percentage of discharges for children ages 6 to 17 who were hospitalized for SUD and who had a follow-up visit with a mental health practitioner.

Table 3.1: Summary of SUD research question and metric findings

Milestone	Research Question	Metric/Outcome	Estimated Trend	Observed Trend
Milestone 1: Access to critical levels of care for OUD and other SUDs	1.1 Did initiation of SUD treatment increase during the demonstration period?	SUD Metric 2: Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Increase	Increased
	1.2: Did outpatient services increase during the demonstration period?	SUD Metric 8: Number of beneficiaries who used outpatient services for SUD during the measurement period	Increase	Increased
	1.3: Did intensive outpatient and partial hospitalization services increase during the demonstration period?	SUD Metric 9: Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD during the measurement period	Increase	Increased
	1.4: Did residential and inpatient services increase during the demonstration period?	SUD Metric 10: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Increase	Increased
Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria	3.1: Did opioid overdose death rate (overall, in-hospital, and out-of-hospital) increase during the demonstration period?	SUD metric 27: Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration.	Decrease	Decreased overall. Increased for non-expansion population.
	3.2: Did emergency department visits for SUD increase during the demonstration period?	SUD metric 23: ED utilization for SUD per 1k beneficiaries	Decrease	Increased
	3.3: Did repeat overdoses increase during the demonstration period?	Rate of with multiple overdose admissions within 30 days (or 90 days) during the measurement period .	Decrease	ND
	No RQ: Did Medicaid beneficiaries treated in an IMD for SUD decrease during the demonstration period?	SUD Metric 5: Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period	Decrease	Increased
	No RQ: Did average length of stay (ALOS) in IMDs decrease during the demonstration period?	SUD Metric 36:The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD	Decrease	Decreased

Milestone 3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications	2.1: Did screening increase during the demonstration period?	Metric 7: Number of beneficiaries who used early intervention services for SUD during the measurement period.	Unable to calculate	Unable to calculate
	2.2: Did initiation of alcohol use disorder and SUD treatment increase during the demonstration period?	SUD Metric 15: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit	Increase	Increased for Alcohol Initiation Decreased for Alcohol Engagement Increased for Opioid Initiation Increased for Opioid Engagement Decreased for Other Drugs initiation Decreased for Other Drugs Engagement Increased for Total Initiation Decreased for Total Engagement
	2.3: Did MAT utilization (sub-analysis specific to methadone) increase during the demonstration period?	SUD Metric 12:Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Increase	Increased
	2.4: Did adherence to MAT for OUD users increase during the demonstration period?	SUD Metric 22:Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment.	Increase	Decreased
	2.5: Did re-engagement of MAT for OUD patients increase during the demonstration period?	No data available	Unable to calculate	Unable to calculate
Milestone 4: Sufficient provider capacity at each level of care, including MAT	6.1: Did SUD provider availability increase during the demonstration period?	SUD Metric 13:The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Increase	Increased
	6.2: Did SUD provider availability for MAT increase during the demonstration period?	SUD Metric 14: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Increase	Increased
	6.3: Did provider availability for MAT increase during the demonstration period?	No SUD Metric: Number of sites enrolled in Medicaid that are able to provide MAT.	Increase	ND

	6.4: Did provider availability for methadone increase during the demonstration period?	SUD Metric S4: Number of sites that provide Methadone.	Increase	ND
	6.5: Did availability of community-based SUD services increase during the demonstration period?	No SUD Metric: Number of Community Mental Health Centers	Increase	Increased
	6.6: Did patient satisfaction increase during the demonstration period?	No SUD Metric: Patient satisfaction	Increase	Increased relative to Q1 2020 as the baseline but slightly decreased relative to the period from April 2018 to March 2020 as the baseline.
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	4.1: Did use of opioids at high dosage in persons without cancer (OHD-AD) decrease during the demonstration period?	SUD Metric 18:The percentage of beneficiaries aged 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Decrease	Decreased
	4.2: Did use of opioids from multiple providers in persons without cancer (OMP) decrease during the demonstration period?	SUD Metric 19:The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Decrease	Decreased
	4.3: Did use of opioids at high dosage and from multiple providers in persons without cancer (OHDMP) decrease during the demonstration period?	SUD Metric 20:The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Decrease	Decreased
	4.4: Did concurrent use of opioids and benzodiazepines (COB-AD) decrease during the demonstration period?	SUD Metric 21: Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Decrease	Decreased
	4.5: Did emergency department utilization for SUD per 1,000 Medicaid beneficiaries decrease during the demonstration period?	SUD Metric 23: Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period.	Decrease	Increased
	4.6: Did emergency department visits for OUD and SUD decrease during the demonstration period?	SUD Metric 23: Total number of emergency department visits for OUD per 1,000 beneficiaries in the measurement period.	Decrease	Increased

Milestone 6: Improved care coordination and transitions between levels of care	5.1 Did follow-up after emergency department visits for mental illness (FUM-AD) increase during the demonstration period?	SUD Metric 17(2):Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) addiction or dependence who had a follow-up visit for AOD addiction or dependence. Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness.	Increase	Decreased
	5.2: Did readmissions among beneficiaries with SUD decrease during the demonstration period?	SUD Metric 25: The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.	Decrease	Decreased
	5.3: Did preventive care utilization (connecting OUD patients to broader care) increase during the demonstration period?	SUD Metric 32: Access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD)	Increase	Decreased
	5.4: Did follow-up with patients prescribed an anti-psychotic increase during the demonstration period?	SMI Metric 30: Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Moved to SMI Milestone 2	
	5.5: Did follow-up with patients post-emergency department discharge increase during the demonstration period?	SUD Metric 17(1): follow-up after emergency department visit for alcohol or other drug dependence	Increase	Increased
	5.6: Did medication continuation post inpatient discharge for SUD increase during the demonstration period?	Medication continuation post inpatient discharge for SUD	Increase	ND

Key SUD 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.

We generally found larger percentage increases for the rural subgroup. For increases in utilization this is promising.

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

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

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.

Hypothesis 7: The 1115 Waiver demonstration will lead to improved quality of care in psychiatric hospitals and residential settings.

Research Questions: 7.1

Results

Similar to results in the SUD section, our preferred analytic sample is the non-expansion sample defined using the static definition. 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. Finally, we note that the data do not allow us to break out behavioral health treatment into case management, home/community services, or long-term care services and support, which were mentioned in the analytic plan.

Table E.7: Performance on Milestone 1 Metrics by different baselines and different definitions for Medicaid SMI/SED population (denominator) (SMI/SED Metric 18).

Metric		Period	Percent Change					
			Overall		Non-expansion		Expansion	
			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: serious mental illness. SED: serious emotional 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 #21/ #22) 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

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

Hypothesis 11: The 1115 Waiver demonstration will lead to improved care coordination and transition to community-based care.

Research Questions: 11.1

Results

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 (Table E.8). 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. Furthermore, while we see a slight decline in 30-day all case unplanned readmissions for the rural population, we see a slight increase for the urban population. The differences are modest and likely combine differences in follow-up care as well as possibly more difficulty in finding hospitals in rural areas (so readmissions are lower because it is more difficult to be readmitted all else equal).

Table E.8a: Performance on Milestone 2 Metrics by expansion and non-expansion status (SMI/SED Metric 4).

		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

Table E.8a.i: Subgroup analysis for SMI/SED Milestone 2 Metrics (SMI/SED Metric 4).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
30-day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) (SMI #4)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-6.5	1.8	-	-22.3	10.2	-	-
		DY2 (Apr. 2021-Mar. 2022)	-7.6	6.8	-	-24.3	16.8	-	-
		DY3 (Apr. 2022-Mar. 2023)	-3.3	5.8	-	-0.9	9.5	-	-

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
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

Table E.8b: Performance on SMI/SED Milestone 2 Metrics by expansion and non-expansion status (SMI/SED Metric 30).

			Percent Change		
			Overall	Non-expansion	Expansion
Metric		Period			
Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication[a] (SMI/SED #30)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-5.5	-6.2	-
		DY2 (Apr. 2021-Mar. 2022)	-4.2	-2.9	-
		DY3 (Apr. 2022-Mar. 2023)	-6.3	-4	-

Note: SMI/SED Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care. Annual data.SMI/SED: Serious mental illness/Serious emotional disturbance. DY: Demonstration year.
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.
SMI/SED 30: Percentage of Medicaid beneficiaries age 18 years and older with new antipsychotic prescriptions who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.

Table E.8b.i: Subgroup analysis for SMI/SED Milestone 2 Metrics (SMI/SED Metric 30).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication[a] (SMI/SED #30)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-5.5	-6.2	-	-8.8	-5.4	-	-
		DY2 (Apr. 2021-Mar. 2022)	-4.2	-2.9	-	-5.1	-2.2	-	-
		DY3 (Apr. 2022-Mar. 2023)	-6.3	-4	-	-6.6	-3.3	-	-

Note: SMI/SED Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care. Annual data. SMI/SED: Serious mental illness/Serious emotional disturbance. DY: Demonstration year.
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.
SMI/SED 30: Percentage of Medicaid beneficiaries age 18 years and older with new antipsychotic prescriptions who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

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

Goal 3: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.

Hypothesis 9: The 1115 Waiver demonstration will lead to increasing access to continuum of care, including crisis stabilizations services.

Research Questions: 9.1, 9.2, 9.3, 9.4, 9.5, 9.6, 9.7, 9.8

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.

Hypothesis 10: The 1115 Waiver demonstration will lead to increasing access to continuum of care, including crisis stabilizations services.

Research Questions: 10.1, 10.2, 10.3, 10.4, 10.5, 10.6, 10.7

Results

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). [Table E.9a] 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 emergency department, 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].

We tended to see larger increases in inpatient services for urban residents relative to rural residents. Some of this may be due to hospitals being more likely to be located in urban areas. We see something similar for intensive outpatient and partial hospitalization. We observed similar rates of change for outpatient rehabilitation and ED visits for both urban and rural residents.

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.

Overall average IMD length of stay increased by 12% for the non-expansion population (Table E.9c). There was an initial decline (likely due to the COVID-19 pandemic) and then an increase in DY2 and DY3). The increase was larger in rural areas than urban areas (Table E.9c.i). We note that average length of stay was not a metric in the evaluation plan but was added based on discussions with IDHW about it being one of their critical metrics.

Next, we see promising increases in the availability of community-based behavioral health services (Table E.9d) and a slight increase in the number of federally qualified health centers (FQHCs). We observed no change in availability of clinics with crisis care availability. We unfortunately lacked data on availability of virtual visits as well as co-located physical and behavioral health providers.

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). While not a metric in the evaluation plan, this was a critical area of concern with IDHW and we agreed that it is a critical metric for SMI/SED care.

Table E.9a: Performance on Milestone 3 Metrics by different baselines and different definitions for Medicaid SMI/SED population (denominator) (SMI/SED Metrics 13, 14, 15, 16, 17)

			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

		Baseline	-	-	-	-	-	-
Mental Health Services Utilization – ED (SMI #16)[d]	Baseline (Jan.-Mar. 2020)	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
		Baseline	-	-	-	-	-	-
Telehealth (SMI #17) [e*]	Baseline (Jan.-Mar. 2020)	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: serious mental illness. SED: serious emotional 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 #21/#22) 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.9a.i: Subgroup analysis for Milestone 3 Metrics (SMI/SED Metrics 13, 14, 15, 16, 17)

			Percent Change %						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Mental Health Services Utilization – Inpatient (SMI #13)[a]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	9.5	10.5	-19.2	4.1	12.5	-38.4	-11.3
		DY2 (Apr. 2021-Mar. 2022)	7.1	18	-38	7.6	20.5	-53	-32.2
		DY3 (Apr. 2022-Mar. 2023)	10.6	24.4	-38.3	18	26.2	-51.1	-33.7
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	33.2	18.2	-	7.5	22.5	-	-
		DY2 (Apr. 2021-Mar. 2022)	30.2	26.2	-	11	31.2	-	-
		DY3 (Apr. 2022-Mar. 2023)	34.5	33.1	-	21.8	37.4	-	-

Mental health Services Utilization – Intensive Outpatient and Partial Hospitalization (SMI #14) [b]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	8.4	10.9	-17.1	-34	18.8	-31.6	-14.2
		DY2 (Apr. 2021-Mar. 2022)	39.6	65.1	-24.5	18.7	69.1	-50.4	-20.4
		DY3 (Apr. 2022-Mar. 2023)	68.3	94.9	-3.9	13.5	99.8	-22.2	-3.4
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	46.2	37.5	-	-14.8	47.2	-	-
		DY2 (Apr. 2021-Mar. 2022)	88.3	104.7	-	53.2	109.6	-	-
		DY3 (Apr. 2022-Mar. 2023)	127	141.7	-	46.5	147.5	-	-
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)	-36.3	-31.5	-41.8	-34.4	-31	-41.1	-42
		DY2 (Apr. 2021-Mar. 2022)	-28.3	-20	-34.4	-24.6	-18.9	-42.4	-31.9
		DY3 (Apr. 2022-Mar. 2023)	-21.9	-12.8	-25.8	-19	-11.2	-37.6	-22.7
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-39.9	-33.4	-	-37.1	-31.9	-	-
		DY2 (Apr. 2021-Mar. 2022)	-32.4	-22.3	-	-27.7	-19.9	-	-
		DY3 (Apr. 2022-Mar. 2023)	-26.3	-15.3	-	-22.4	-12.3	-	-
Mental Health Services Utilization – ED (SMI #16)[d]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-34.6	-26.8	-51	-71.2	-19.2	-54	-48.2
		DY2 (Apr. 2021-Mar. 2022)	-30.1	-15.5	-55.5	-28.8	-14.7	-70.3	-42.7
		DY3 (Apr. 2022-Mar. 2023)	-22.7	-4.2	-52.5	2.1	-11	-64.1	-41.6
	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-47.7	-41.1	-	-78.2	-28.3	-	-
		DY2 (Apr. 2021-Mar. 2022)	-44.1	-31.9	-	-46.1	-24.4	-	-
		DY3 (Apr. 2022-Mar. 2023)	-38.2	-22.9	-	-22.7	-21.1	-	-
Telehealth (SMI #17) [e*]	(Jan.-Mar. 2020) Baseline	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	333.5	366.6	248.7	361.4	376.9	172.7	280.7
		DY2 (Apr. 2021-Mar. 2022)	215.3	243.3	168.3	239.8	246.4	98.3	196
		DY3 (Apr. 2022-Mar. 2023)	192.5	220.1	150.6	199.3	222.3	86.9	174
	(Apr. 2018-Mar. 2020) Baseline	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	2732.8	2951.3	-	2506.9	3181.9	-	-
		DY2 (Apr. 2021-Mar. 2022)	1960.6	2145	-	1820.1	2283.9	-	-
		DY3 (Apr. 2022-Mar. 2023)	1811.3	1993.4	-	1591.2	2118.1	-	-

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
ED: emergence department. SMI: serious mental illness. SED: serious emotional 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.
This table only includes the rates calculated by the denominator with the static definition.
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.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.
*Not used for answering research questions but present here as a critical metric listed by CMS to be included in the report.

Table E.9b: Performance on Milestone 3 Metrics (No SMI/SED Metric)

Metric		Period	Value	Absolute change	Percent change %
Crisis service utilization[a]	Baseline (Apr. 2018-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: serious mental illness. SED: serious emotional 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.
*Not used for answering research questions but present here as a critical metric listed by CMS to be included in MPA.

Table E.9c: Performance on Milestone 3 Metrics by expansion and non-expansion status (SMI/SED Metric 19a)

			Overall	Non-expansion	Expansion
Metric		Period			
Average Length of Stay in IMDs[a] * (SMI #19a short stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-8.7	-0.4	-
		DY2 (Apr. 2021-Mar. 2022)	-0.6	11	-
		DY3 (Apr. 2022-Mar. 2023)	6.4	10	-
Average Length of Stay in IMDs[b] * (SMI #19a long stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND**	ND**	-
		DY1 (Apr. 2020-Mar. 2021)	-	-	-
		DY2 (Apr. 2021-Mar. 2022)	-	-	-
		DY3 (Apr. 2022-Mar. 2023)	-	-	-
Average Length of Stay in IMDs[c] * (SMI #19a total stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-11.3	-2.8	-
		DY2 (Apr. 2021-Mar. 2022)	-1.7	10.3	-
		DY3 (Apr. 2022-Mar. 2023)	8.1	12	-

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
Annual data. ND – no data available.
SMI: serious mental illness. SED: serious emotional disturbance. DY: Demonstration year.
a: The average length of short stays (ALOS, less than or equal to 60 days)) for beneficiaries in the demonstration discharged from an inpatient or residential stay in an IMD.
b: The average length of long stays (ALOS, greater than 60 days) for beneficiaries in the demonstration discharged from an inpatient or residential stay in an IMD.
c: The average length of total stays (ALOS) for beneficiaries in the demonstration discharged from an inpatient or residential stay in an IMD.
Average Length of Stay in IMDs is calculated based on individuals aged 21 to 65 years.
*Not used for answering research questions but present here as a critical metric listed by CMS to be included in the report.
**No data due to no valid long-stays reported during Apr. 2018-Mar. 2019.

Table E.9c.i: Subgroup analysis for Milestone 3 Metrics (SMI/SED Metric 19a)

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Average Length of Stay in IMDs [a] * (SMI #19a short stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-8.7	-0.4	-	-6.1	-0.8	-	-
		DY2 (Apr. 2021-Mar. 2022)	-0.6	11	-	21.9	6.3	-	-
		DY3 (Apr. 2022-Mar. 2023)	6.4	10	-	44.2	1.9	-	-
Average Length of Stay in IMDs [b] * (SMI #19a long stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	ND**	ND**	-	ND**	ND**	-	-
		DY1 (Apr. 2020-Mar. 2021)	-	-	-	-	-	-	-
		DY2 (Apr. 2021-Mar. 2022)	-	-	-	-		-	-
		DY3 (Apr. 2022-Mar. 2023)	-	-	-			-	-
Average Length of Stay in IMDs [c] * (SMI #19a total stays)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-11.3	-2.8	-	-0.9	-5	-	-
		DY2 (Apr. 2021-Mar. 2022)	-1.7	10.3	-	31.9	3.1	-	-
		DY3 (Apr. 2022-Mar. 2023)	8.1	12	-	44.2	4.2	-	-

Note: SMI/SED Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
a: The average length of short stays (ALOS, less than or equal to 60 days)) for beneficiaries in the demonstration discharged from an inpatient or residential stay in an IMD.
b: The average length of long stays (ALOS, greater than 60 days) for beneficiaries in the demonstration discharged from an inpatient or residential stay in an IMD.
c: The average length of total stays (ALOS) for beneficiaries in the demonstration discharged from an inpatient or residential stay in an IMD.
Average Length of Stay in IMDs is calculated based on individuals aged 21 to 65 years
SMI: serious mental illness. SED: serious emotional 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.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.
*Not used for answering research questions but present here as a critical metric listed by CMS to be included in the report.
**No value due to a zero denominator.

Table E.9d: Performance on Milestone 3 Metrics (No SMI/SED 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.9e: Performance on Milestone 3 Metrics (suicide rates by Medicaid SMI population)(No SMI/ SED Metrics)

Metric		Period	Percent Change					
			Overall		Non-expansion		Expansion	
			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, Quarterly data.
SMI: serious mental illness. SED: serious emotional 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.
Rate of suicidal deaths (number of deaths per 100,000 Medicaid beneficiaries with SMI) during the measurement period.

Table E.9f: Performance on Milestone 3 Metrics (suicide rates by Medicaid population) (No SMI/SED Metrics)

Metric		Period	Percent Change		
			Overall	Non-expansion	Expansion
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.
Quarterly data.
SMI: serious mental illness. SED: serious emotional 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.
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

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

Hypothesis 8: The 1115 Waiver demonstration will lead to earlier identification and engagement in treatment through increased integration.

Research Questions: 8.1

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.
ND: No data. FQHC: Federally Qualified Health Center.
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 3.2 Summary of SMI/SED research questions and metric findings

Milestone	Research Question	Metric/Outcome	Estimated Trend	Observed Trend
Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	7.1: Did utilization of behavioral health treatment services increase during the demonstration period?	SMI/SED Metric 18: Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.	Increase	Increased
Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	11.1: Did 30-day readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF) increase during the demonstration period?	SMI/SED Metric 4: The number of 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	Decrease	Increased
	SUD 5.4: Did follow-up with patients prescribed an anti-psychotic increase during the demonstration period?	SMI Metric 30: Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Increase	Decreased

Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	9.1: Did mental health services utilization increase in inpatient settings during the demonstration period?	SMI/SED Metric 13: Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.	Increase[1]	Increased
	9.2: Did mental health services utilization increase in intensive outpatient and partial hospitalization settings during the demonstration period?	SMI/SED Metric 14: Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.	Increase[2]	Increased
	9.3: Did mental health services utilization increase in emergency department settings during the demonstration period?	SMI/SED Metric 16: Number of beneficiaries in the demonstration population who utilized emergency department services for mental health during the measurement period.	Decrease	Decreased
	9.4: Did crisis service utilization increase during the demonstration period?	No SMI/SED Metric: Number of crisis calls related to SMI/SED services.	Decrease	Decreased if Q1 2020 as the baseline while increased relative to a baseline period of 2018-2019
	9.5: Did outpatient rehabilitation increase during the demonstration period?	SMI/SED Metric 15: Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period.	Increase	Decreased
	9.6: Did case management increase during the demonstration period?	No SMI/SED Metric: Cannot break down from any service.	Increase	N/A
	9.7: Did home and community services increase during the demonstration period?	No SMI/SED Metric: See 9.6	Increase	N/A
	9.8: Did long-term services/supports increase during the demonstration period?	No SMI/SED Metric: See 9.6	Increase	N/A
	10.1: Did availability of community-based behavioral health services (overall, outpatient, inpatient/residential, office-based) increase during the demonstration period?	No SMI/SED Metric: The number of community-based behavioral health services (overall, outpatient, inpatient/residential, office-based) per 1000 members	Increase	Increased
	10.2: Did suicide rates decrease during the demonstration 2022 period?	No SMI/SED Metric: Suicide or Overdose Death Within 7 and 30 Days of Discharge from an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries with SMI or SED (count/rate)	Decrease	Increased
	10.3: Did availability of virtual visits increase during the demonstration period?	No SMI/SED Metric: The number of providers delivering telehealth services per 1000 members	Increase	ND
	10.4: Did availability of clinics with co-located physical and behavioral health providers increase during the demonstration period?	No SMI/SED Metric: The number of clinics with co-located physical and behavioral health providers per 1000 members	Increase	ND

	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?	No SMI/SED Metric: The number of crisis care service facilities per 1000 members?	Increase	Did not change
	10.6: Did availability of behavioral health in FQHCs increase during the demonstration period?	No SMI/SED Metric: Number of FQHCs with behavioral health services available	Increase	Increased
	10.7: Did per capita availability of outpatient mental health professionals, by type (e.g., psychologists, social workers) increase during the demonstration period?	No SMI/SED Metric: The ratio of the number of outpatient mental health professionals and the number of members.	Increase	ND
	No RQ	SMI/SED Metric 19a: Average length of stay in Institution of Mental Diseases	ND	ND
Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	8.1 Did the number of enrollees receiving care from co-located physical and behavioral health facilities increase during the demonstration period?	No SMI/SED Metric: The number of enrollees receiving care from co-located physical and behavioral health facilities	Increase	ND

Key SMI/SED 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 an increase in inpatient utilization driven by patients in urban areas. 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.

Cost Analysis Metrics

Table E.11: Performance on SUD Milestone 6 Metrics by expansion and non-expansion status (SUD Metric 28).

			Percent Change		
			Overall	Non-expansion	Expansion
Metric		Period			
Total SUD spending[a] (SUD #28)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	504	137.5	949.1
		DY2 (Apr. 2021-Mar. 2022)	964.7	289.5	1808.3
		DY3 (Apr. 2022-Mar. 2023)	1167.1	331	2237.4

Note: SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care. Annual data.
SUD: substance use disorder. DY: Demonstration year. 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: Total Medicaid SUD spending during the measurement period.

Table E.11.i: Subgroup analysis for SUD Milestone 6 Metrics (SUD Metric 28).

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Total SUD spending[a] (SUD #28)	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	504	137.5	-	93.6	153.4	-	-
		DY2 (Apr. 2021-Mar. 2022)	964.7	289.5	-	225.6	312.7	-	-
		DY3 (Apr. 2022-Mar. 2023)	1167.1	331	-	278.7	349.9	-	-

Note: SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care.
Annual data.
SUD: substance use disorder. DY: Demonstration year. 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: Total Medicaid SUD spending during the measurement period.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

Table E.12: Performance on SUD Milestone 6 Metrics by expansion and non-expansion status (SUD Metric 29).

		Value ($)	Absolute change	Percent change %
Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period[a] (SUD #29).	Baseline (2018-2019)	884,084.7	-	-
	DY1 (Apr. 2020-Mar. 2021)	ND*	-	-
	DY2 (Apr. 2021-Mar. 2022)	ND	-	-
	DY3 (Apr. 2022-Mar. 2023)	ND	-	-

Note: SUD Milestone 6: Improved Care Coordination and Transitions between Levels of Care.
Annual data.
SUD: substance use disorder. DY: Demonstration year. 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: Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.
*: No data after Mar. 2019.

Table E.13: Performance on total spending by site of care for SMI/SED-related care (SMI/SED Metrics 32, 33, 34, 35)

			Percent Change						
			Overall	Non-expansion	Expansion	Non-expansion		Expansion	
Metric		Period				Rural	Urban	Rural	Urban
Total Costs SMI/SED - Not Inpatient or Residential[a]	Baseline (Apr. 2018-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	531.8	400	-	313	427.8	-	-
		DY2 (Apr. 2021-Mar. 2022)	646.2	454.4	-	327.2	494.9	-	-
		DY3 (Apr. 2022-Mar. 2023)	637.9	432.4	-	272.5	483.4	-	-
Total Costs SMI/SED - Inpatient or Residential[b]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	255.7	103.9	-	71	117.8	-	-
		DY2 (Apr. 2021-Mar. 2022)	263.3	93.9	-	83.5	98.3	-	-
		DY3 (Apr. 2022-Mar. 2023)	304.1	103.9	-	86.5	111.3	-	-

Per Capita Costs SMI/SED - Not Inpatient or Residential [c]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	-17.6	-8.4	-	-17.4	-6.3	-	-
		DY2 (Apr. 2021-Mar. 2022)	-22.1	-8.3	-	-17.9	-6.5	-	-
		DY3 (Apr. 2022-Mar. 2023)	-20.6	-5	-	-15.2	-3.7	-	-
Per Capita Costs SMI/SED - Inpatient or Residential [d]	Baseline (Jan.-Mar. 2020)	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	16	18.3	-	7.1	23	-	-
		DY2 (Apr. 2021-Mar. 2022)	6.7	5.4	-	7.7	4.9	-	-
		DY3 (Apr. 2022-Mar. 2023)	12.7	7.7	-	15	5.9	-	-
Total Costs SMI/SED[e]	(Apr. 2018-Mar. 2020) Baseline	Baseline	-	-	-	-	-	-	-
		DY1 (Apr. 2020-Mar. 2021)	342.6	201.9	-	140.6	225.6	-	-
		DY2 (Apr. 2021-Mar. 2022)	383.7	213.2	-	153.5	236.3	-	-
		DY3 (Apr. 2022-Mar. 2023)	409.1	212.7	-	140	240.7	-	-

Note: SMI/SED Milestone 4: Earlier Identification and Engagement in Treatment, Including through Increased Integration.
Annual data.
SMI: serious mental illness. SED: serious emotional 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.
a. Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential
b. Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential
c. Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential
d. Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential
e. Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED
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.
Urban: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) ≤ 3.
Rural: Beneficiary's residential county has a Rural-Urban Continuum Code (RUCC) > 3.

Results of Cost Analysis

Total SUD spending went up by a lot from baseline although less for the non-expansion population (331%) than the expansion population (2237%), due to analytic reasons noted earlier (Table E.11). SUD spending increases were slightly higher for the urban population compared to the rural population. We did not have data available to assess changes in spending for inpatient or residential SUD care other than at baseline (Table E.12).

For SMI/SED care, we observed similarly large increases in total costs with the larger increases for non-inpatient/non-residential care. Although inpatient and residential care also increased. Promisingly, per capita costs for non-inpatient/non-residential care actually decreased. This suggests the large increase is due to more patients rather than higher per patient costs. The pandemic likely increased behavioral health needs and an emphasis on diagnosis may have also contributed to more patients with SMI/SED care needs. Generally, we also observed larger increases in costs for patients in urban areas.

Budget Neutrality Metrics

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.

Results of Performance on Budget Neutrality

Table E.14 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.15 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.16 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

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 Met

Table E.17: 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	-	-5.0%
		DY1	84	4	
		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

Table E.18: Availability of Intensive Outpatient Services

			Value	*Absolute change*	*Percent change*
Intensive outpatient services	*Providers offering intensive outpatient services*[a]	Baseline (2019)	14	-24	-171.4%
		DY1	38		
		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.19: 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.20: 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.21 Availability of Inpatient Sevices

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%

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.22 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.23: 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.

Overall 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 capita31. 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 services32. 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

Conclusions and Interpretations of State Capacity to Provide SUD and SMI/SED Services

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-occurring 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.

Lessons Learned and 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?

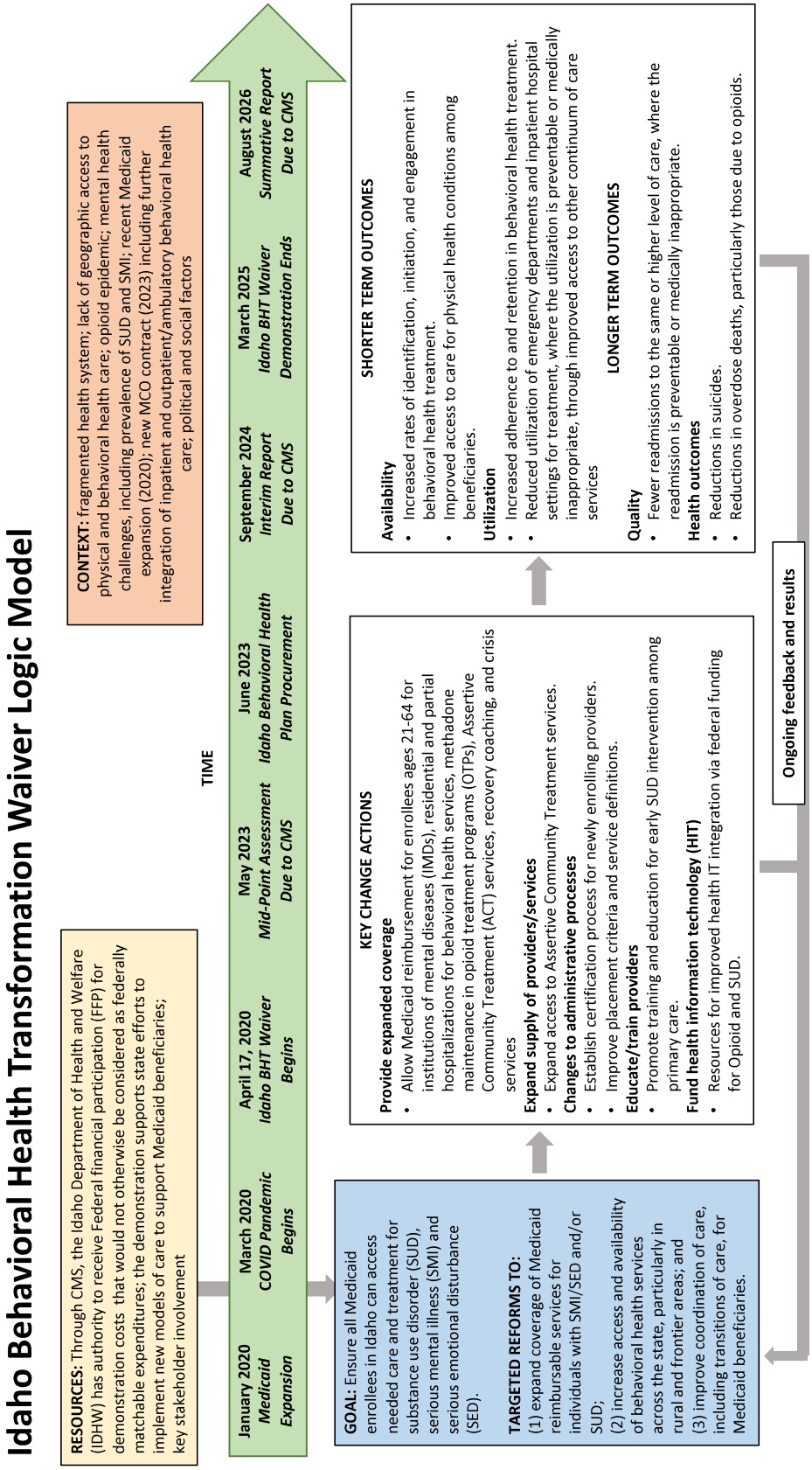
Module 5: Reflections/Wrap-Up Module

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?

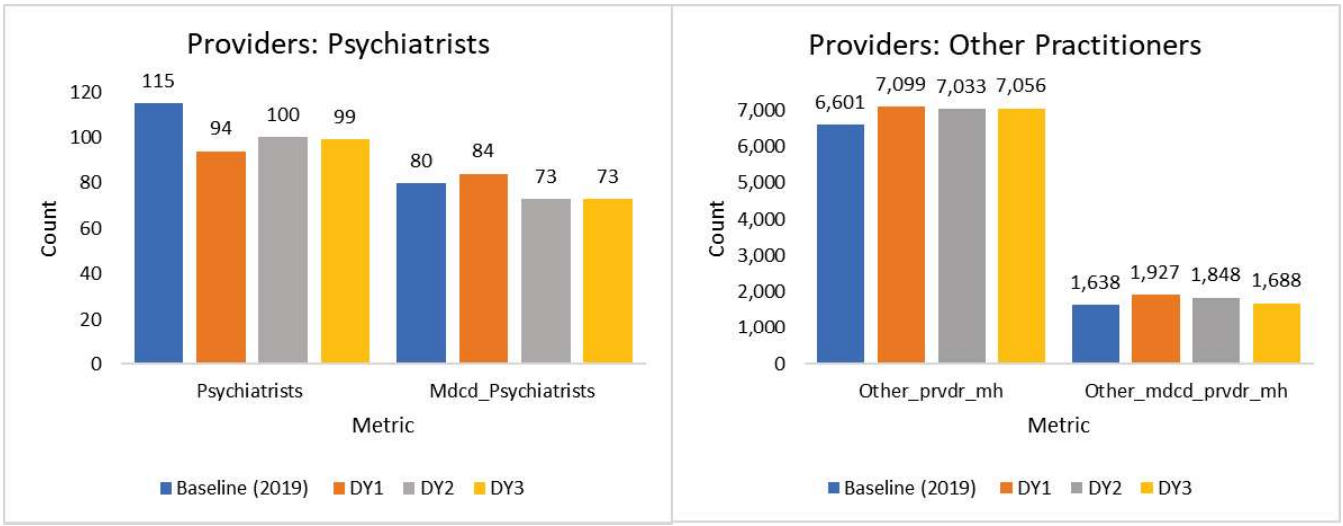
PROTOCOL END

Appendix C. Logic Model



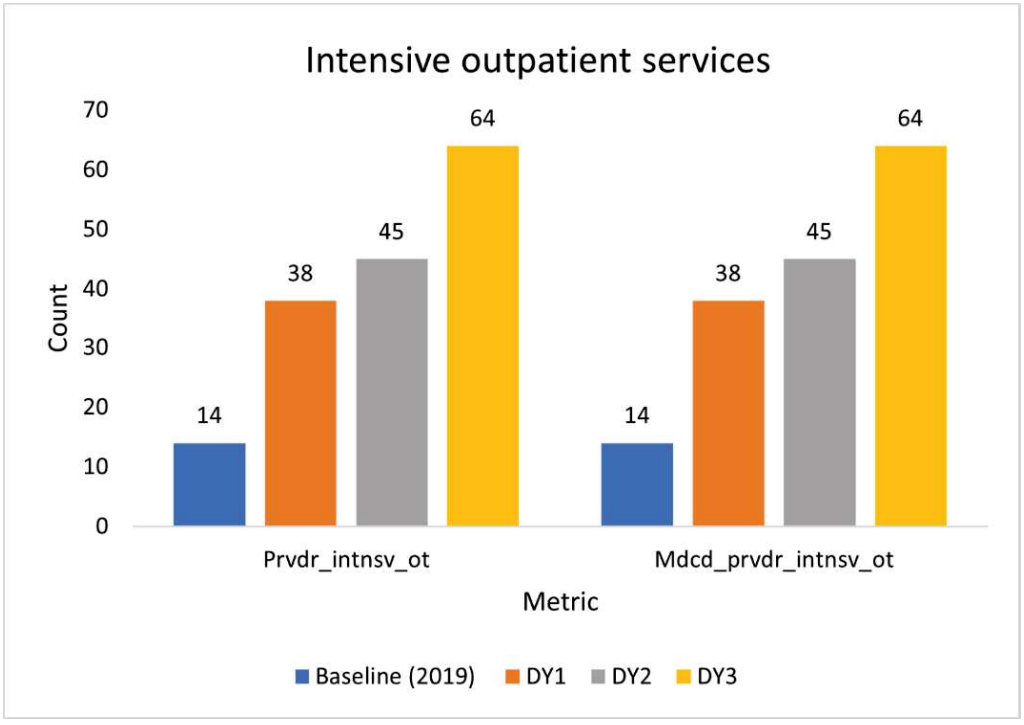
Appendix D. Data Graphics

Figure E.12a Availability of Practitioners



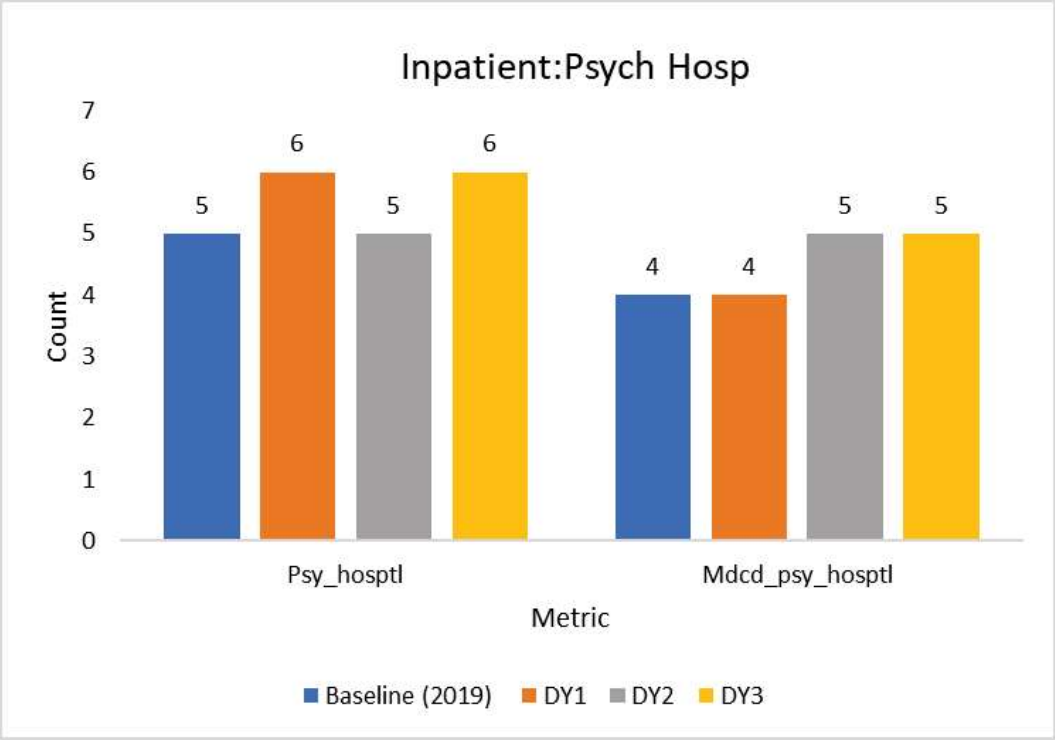
Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. Psychiatrists: Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications, Mdcd_psychiatrists: Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric 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.

Figure E.13: Availability of Intensive Outpatient Services



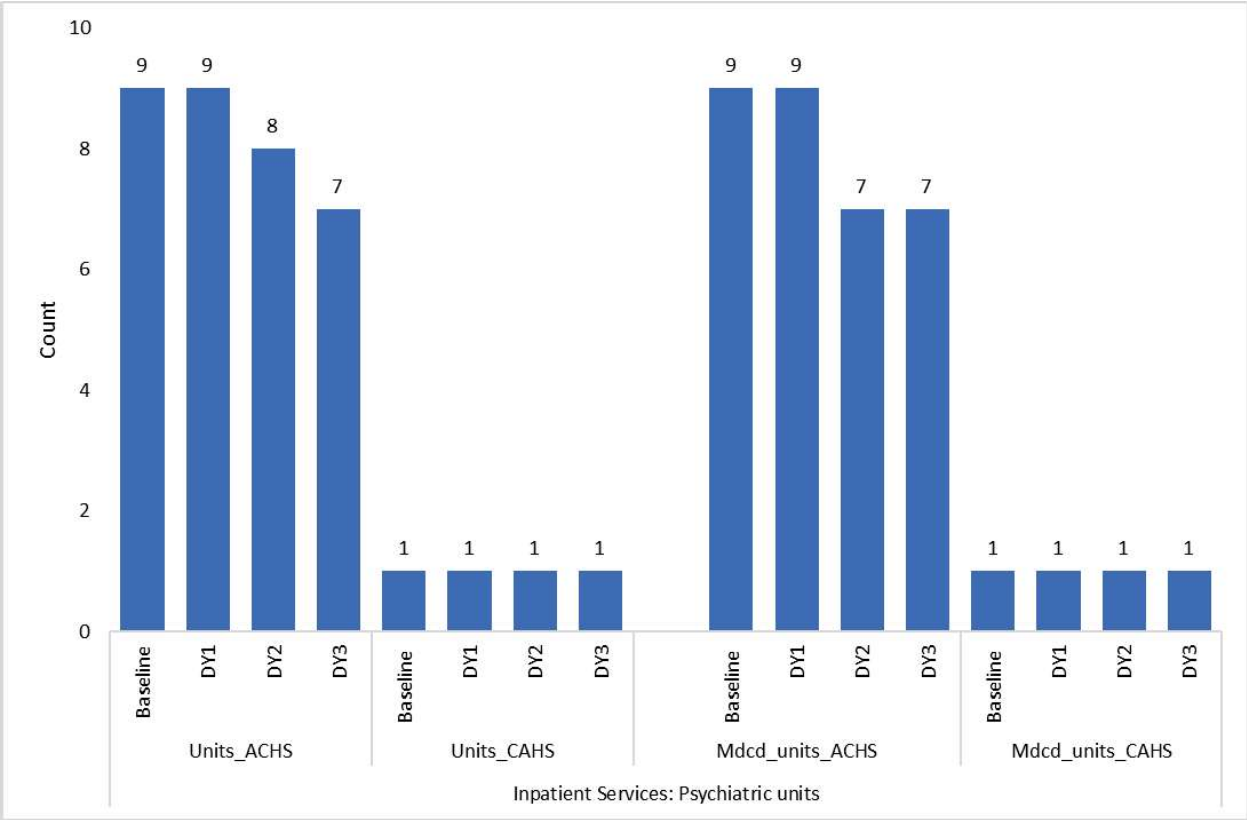
Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr.2021, DY3: Yr. 2022. Prvdr_intnsv_ot: Providers Offering Intensive Outpatient Services, Mdcd_prvdr_intnsv_ot: Medicaid-Enrolled Providers Offering Intensive Outpatient Services.

Figure E.16a Availability of Inpatient Services: Psychiatric Hospitals



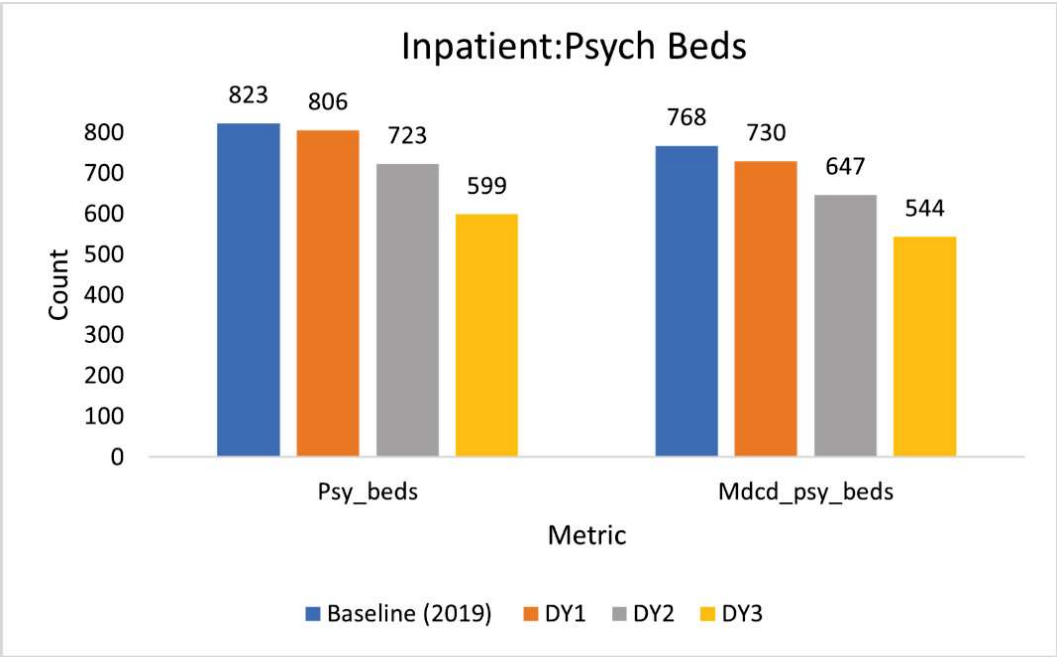
Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. Psy_hosptl: Public and Private Psychiatric Hospitals, Mdcd_psy_hosptl: Public and Private Psychiatric Hospitals Available to Medicaid Patients.

Figure E.16b Availability of Inpatient Services: Psychiatric Units



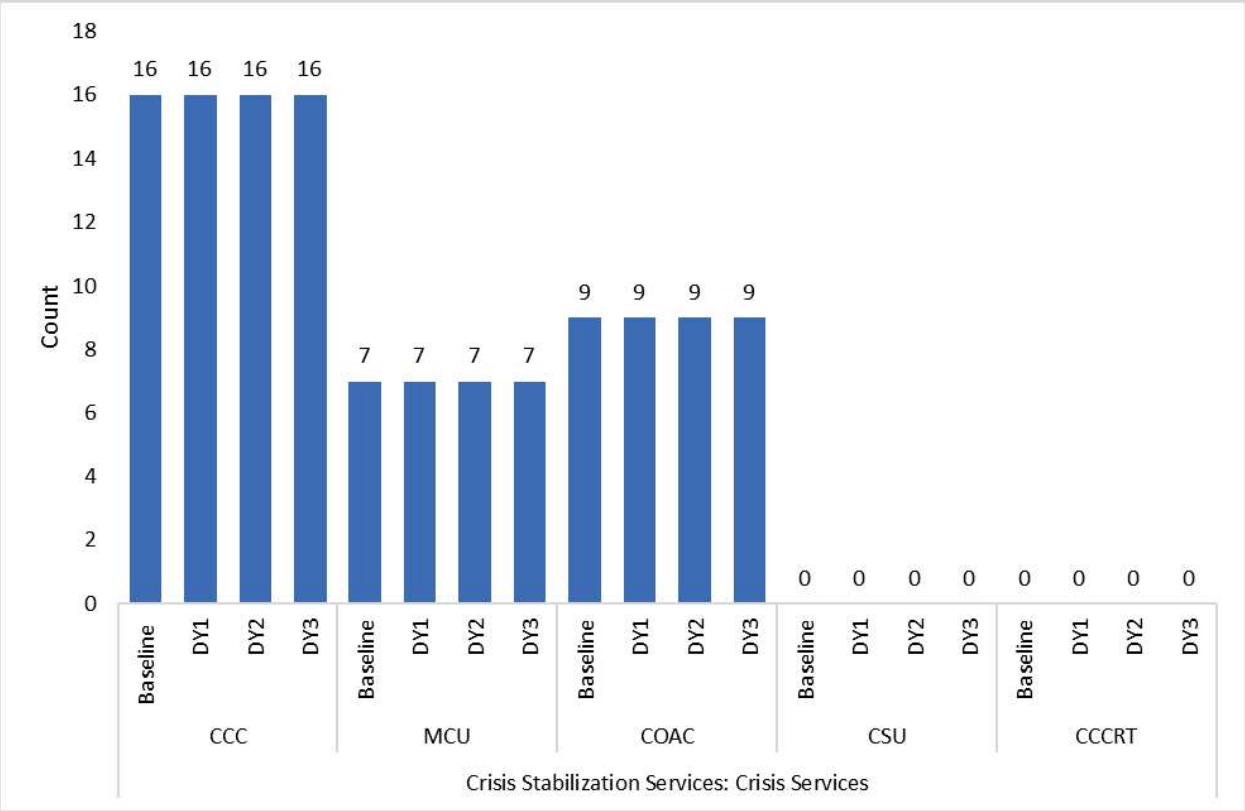
Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. Units_ACHS: Psychiatric Units in Acute Care Hospitals, Units_CAHS: Psychiatric Units in Critical Access Hospitals (CAHs), Mdcd_units_ACHS: Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals, Mdcd_units_CAHS: Medicaid-Enrolled Psychiatric Units in CAHs.

Figure E.16c Availability of Inpatient Services: Psychiatric Beds



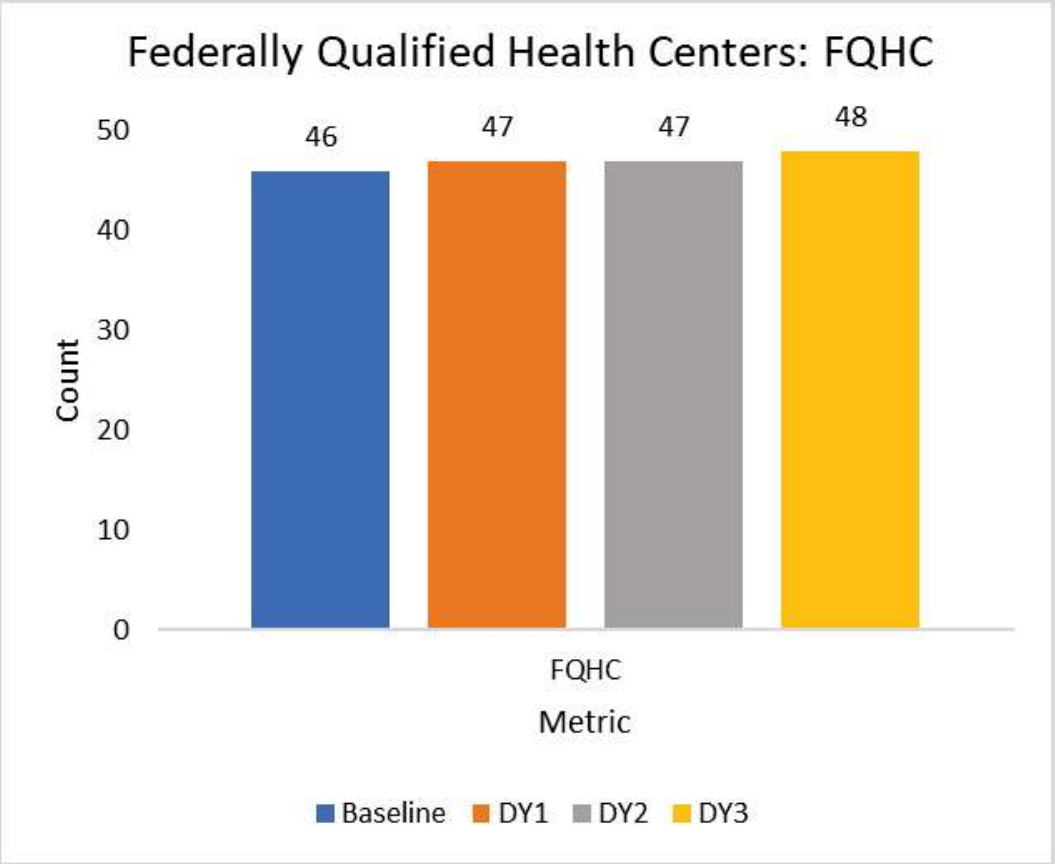
Note: Annual data. Baseline: Yr. 2019, DY1: Yr. 2020, DY2: Yr. 2021, DY3: Yr. 2022. Psy_beds: number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units). Mdcd_psy_beds: number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) available to Medicaid patients

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.

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,

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