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January 3, 2020

Judith Cash, Director
State Demonstrations Group
Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare and Medicaid Services (CMS)
7500 Security Blvd., Mail Stop S2-25-26
Baltimore, MD 21244

Dear Ms. Cash:

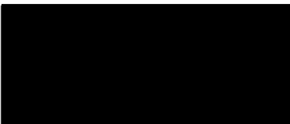
I am pleased to submit Idaho's application for an 1115 demonstration waiver relating to behavioral health transformation and reimbursement of mental health and substance use disorder services in Institutions for Mental Diseases (IMDs).

In conjunction with this waiver, the Idaho Department of Health and Welfare will propose changes to expand and improve the entire behavioral health continuum of care across the state. These improvements are described at a high level in the application and will be detailed in the comprehensive implementation plan to be developed for this waiver.

This application is submitted in accordance with legislation enacted by the 2019 Idaho Legislature. Included within this transmittal is the text of the proposed demonstration, a description of how Idaho meets the transparency requirements outlined in federal regulations and the budget neutrality calculations.

We appreciate your review of this application and we look forward to working with you towards its approval. Please direct any questions regarding the application to Matt Wimmer, Administrator for the Division of Medicaid, at (208) 364-1804 or matt.wimmer@dhw.idaho.gov.

Sincerely,



DAVE JEPPESEN
Director

Enc:

cc: David Meacham, Deputy Director, Centers for Medicare & Medicaid Services

Idaho Department of Health and Welfare

DRAFT

Idaho Behavioral Health Transformation
Section 1115 Medicaid Waiver Demonstration Project Application

January 3, 2020

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Section 1: Executive Summary

Like the rest of the nation, Idaho has been impacted by the scourge of the opioid epidemic and has been struggling to provide adequate addiction and mental health services to meet the increased demand of Idahoans in need of behavioral health services. The state, through various initiatives and partnerships, has undertaken significant efforts to address the crisis; however, despite best efforts to date, gaps in the health care system remain. With these factors as the backdrop, the state is now at a critical crossroads. With the upcoming expansion of Medicaid eligibility on January 1, 2020, the Idaho Department of Health and Welfare (IDHW) will become the primary payor source for thousands of newly eligible, low-income Idahoans – many of whom live with serious mental illness (SMI), serious emotional disturbance (SED), and/or substance use disorder (SUD), and who will look to Idaho Medicaid to help them access needed health care services. The IDHW is rising to this challenge by implementing a broad set of mental health and SUD strategies and hereby seeks approval from the Centers for Medicare and Medicaid Services (CMS) for this Section 1115 Behavioral Health Transformation demonstration waiver application (the Waiver or Section 1115 Waiver) to assist the state in addressing the ongoing challenges within Idaho's continuum of behavioral health care services.

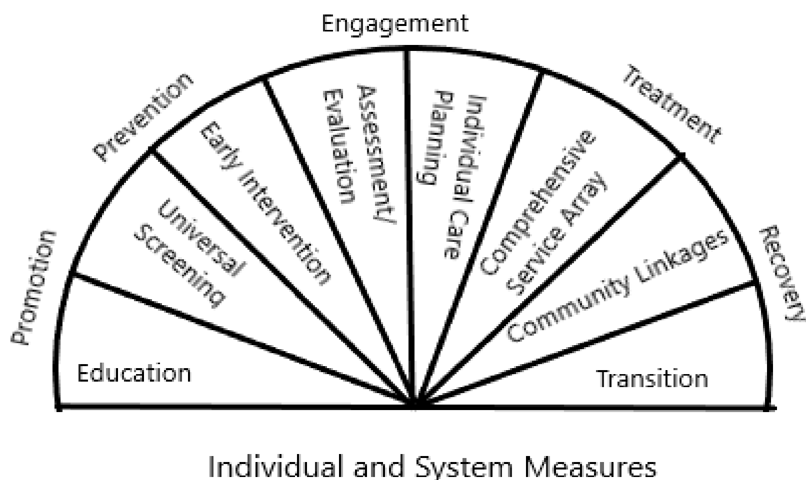
Currently, the state's behavioral health care system is fragmented and involves several partnerships between agencies, practitioners, and community-based organizations. While Idaho is investing ever-increasing resources to respond to individuals with SMI/SED and/or SUD, the many silos across the system and other barriers to access lead to missed opportunities for treatment and are exacerbated by a number of challenges, including a growing prison population and increased deaths from suicide and overdose. To create a better quality of life for Idahoans and to improve our communities, beginning in 2020, the state will embark on a long-term collaborative Behavioral Health Initiative, encompassing all three branches of Idaho government, local governments, education, and other community partners, working together to develop a single organized statewide behavioral health strategic plan for Idaho.

The state's overarching vision is that adults, children, youth, and their families who live with mental illness and addiction can access the behavioral health care services they need when they need them. Through the Behavioral Health Initiative, the state will launch a collaborative Behavioral Health Council to bring this vision to life and aim to design a cost effective, coordinated system that more efficiently maximizes resources to care for people with behavioral health conditions. Only through extensive collaboration will a more effective and efficient system of care be developed in Idaho.

In coordination with and in support of this larger ongoing statewide strategic reform initiative, and mindful of the pressing challenge to care for the newly eligible Medicaid expansion population, the IDHW intends to leverage national best practices to implement more immediate reforms to the Medicaid program through this Waiver. Specifically, the IDHW seeks authority from CMS to reimburse institutions for mental diseases (IMDs) for inpatient and residential services provided to Medicaid-enrolled patients with SMI/SED and/or SUD. In addition to adding more inpatient and residential options for Medicaid beneficiaries, the state will enhance and improve access to a broad array of critical community-based behavioral health care services

and support individuals as they move through the continuum of care toward recovery, as detailed in the behavioral health transformation conceptual system model in *Figure 1* below.

Figure 1: Behavioral Health Transformation Conceptual System Model



This "protractor" model places focus across the entire continuum of care, including promotion, prevention, early intervention, treatment, and recovery.[1] By intentionally considering where gaps in services, supports, and interventions may exist within each of these domains, this illustration will serve as a useful tool for Idaho's future service array planning and overall behavioral health strategy.

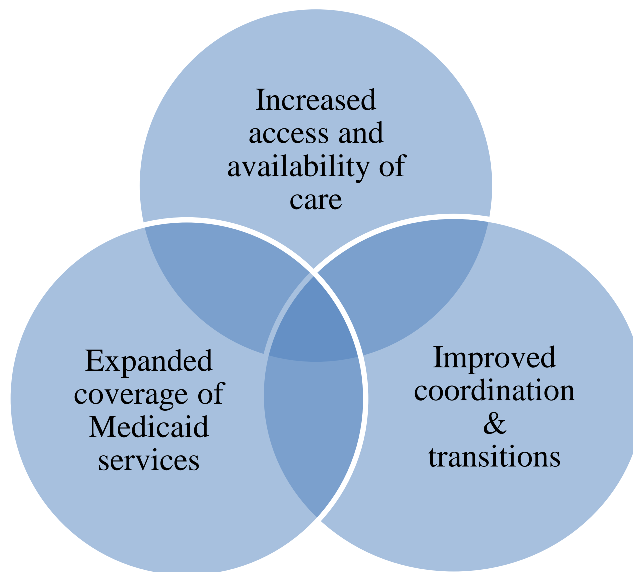
While the IDHW currently provides reimbursement for a broad set of behavioral health services through its State Plan, these services often remain hard to access for Medicaid-enrolled individuals living in rural and frontier counties in the state. In fact, most of the state is federally designated as a Health Professional Shortage Area (HPSA) for mental health services based on a number of factors, including provider to population ratios. These access issues are only expected to be exacerbated with the expansion of Medicaid to (and increased service needs of) an estimated additional 91,000 Idahoans in 2020. Therefore, in addition to expanding the scope of recovery-focused services eligible for Medicaid reimbursement, a key element to the success of this Waiver will be increasing access to those services through a comprehensive network of providers and service locations across the state.

The IDHW seeks to transform the overall behavioral health system to more effectively meet the needs of Medicaid-enrolled adults, children, and their families by identifying and engaging all participants who need treatment at the right time and at the right place, whenever possible, before their conditions are at risk of progressing and becoming more complex, more costly and more difficult to treat. This will require specific steps to assure enrollees are linked to services, such as improved coordination through early identification and appropriate mental health and SUD screening in primary care settings, as well as ensuring successful transition into community-based outpatient services following episodes of crisis.

[1] Adapted from the Institute of Medicine (IOM) continuum of care model, as first envisioned by the National Research Council and IOM.

Based on the unique challenges and needs in Idaho, the IDHW will specifically target the Waiver to achieving three primary objectives for behavioral health delivery system improvements: (1) expanding Medicaid reimbursable services to include the full continuum of care for individuals with SMI/SED and/or SUD; (2) increasing availability of and access to services across the state, particularly in rural and frontier areas; and (3) improving coordination of care with emphasis on transitions between levels of care. Critical to each of these themes will be ensuring quality services and improving data collection to measure success and identify opportunities for continued improvement.

Figure 2: Idaho Behavioral Health Transformation Waiver Strategic Priorities



The reform initiatives implemented through this Waiver, taken together with the broader collaborative work of the statewide strategic planning of Idaho's Behavioral Health Council, will ensure success in the development of a purposeful system of behavioral health care aimed at effectively improving early intervention, reducing behavioral health mortality rates, and ensuring long-term positive health outcomes for Idahoans experiencing SMI/SED and/or SUD.

In accordance with CMS guidance SMD #17-003 re: Strategies to Address the Opioid Epidemic (SUD Guidance) and SMD #18-011 re: Opportunities to Design Innovative Service Delivery System for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (SMI/SED Guidance), the State of Idaho, through the IDHW, respectfully submits this Section 1115 Waiver to CMS for review and approval as set forth herein.

Section 2: Program Overview

2.1 HISTORICAL NARRATIVE

In 2007, the Idaho legislature passed legislation to commission an in-depth review of Idaho's behavioral health delivery system and to develop an actionable list of recommendations to

improve the system.[2] The report was released in 2008, and the IDHW, through the Division of Behavioral Health (DBH), worked to implement many of the recommended reforms included in the report. In 2018, ten years after the original report was released, the IDHW contracted with the Western Interstate Commission for Higher Education's Mental Health Program (WICHE MHP) to analyze the status of the recommendations and to provide additional recommendations to improve the efficiency and efficacy of the behavioral health system in Idaho.[3] The 2018 report applauded the DBH for making significant strides in adopting the comprehensive list of recommendations, including, but not limited to, the creation of regional behavioral health boards, development of regional crisis centers, and implementation of a managed care delivery system for Medicaid-funded behavioral health treatment. At the same time, and despite these advances, the report concluded that the overall behavioral health system in Idaho remains largely fragmented. Ultimately, there are a number of specific challenges in Idaho that must be addressed in any behavioral health transformation initiative particularly related to system fragmentation and lack of geographic access at a time of surging mental health and SUD needs in the population.

A. Fragmented Health System

Idaho's behavioral health system of care is an evolving, complex, and often difficult-to-navigate mix of payers, payment mechanisms, administering agencies, and funding sources. Many federal, state, and local government agencies and private entities administer or provide funding for different aspects of behavioral health services for children and adults throughout Idaho. The IDHW, through the work of its many divisions, including the Division of Medicaid, the DBH, and the Division of Public Health, has responsibility to oversee behavioral health services in the state and works in conjunction with many other state and local entities, including, but not limited to, the judicial system, the Department of Correction, the Office of Drug Policy, and the Suicide Prevention Action Network. Despite the best efforts of these collective agencies to implement advancements throughout the state, the disjointed funding system and lack of administrative coordination have led to inefficiencies in the system to date. Gaps in coverage remain and opportunities must be addressed in the areas of early intervention, diagnosis, and treatment for Idahoans with SMI/SED and/or SUD.

Idaho's system of care for individuals with behavioral health needs has not evolved fully under the burden of this changing health care system. Restrictions within funding streams, regulatory changes, and the burden of the continued steady growth of Idaho's population (almost 1% per year since 2000) has increased the complexity for the IDHW in facilitating coverage for programs and has complicated the IDHW's mission to improve access to critical behavioral health services. Major gaps in the continuum of care exist, which add an additional barrier for providing services to individuals who would benefit most from care provided closer to home where their families and natural supports are. These gaps also prevent individuals from receiving the right care, at the right time, at the least restrictive level of care. Ultimately, these complexities drive the need for a systemic redesign that will allow for a more integrated system of care driven by early intervention for SMI/SED and SUD, increased access to evidence-based services, and a consistent and smooth transition between those levels of care.

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[2] Senate Concurrent Resolution Number 108 (2007).

[3] http://healthandwelfare.idaho.gov/Portals/0/Medical/Mental%20Health/WICHE_2018_ID_FINAL_REPORT_4.30.18.pdf

B. Lack of Geographic Access

While the current behavioral health delivery system provides a variety of health services to address SMI/SED and SUD for Medicaid beneficiaries, access and availability of these critical services remains one of the biggest challenges for the state. Lack of access to an ample supply of health care providers is not new to Idaho, as much of Idaho has long been a federally designated HPSA. Idaho's landmass of roughly 83,000 square miles includes many rural and frontier areas and is home to a population of approximately 1.7 million individuals, making it one of the least densely populated states in the nation.

This geographic reality complicates the effective delivery of face-to-face services. Further, the lack of access to adequate internet service is a challenge within many areas preventing effective utilization and delivery of telehealth services. The current Idaho behavioral health system of care creates bottlenecks and barriers to accessing specialized services, leading to increased lengths of stay in hospitals and emergency departments. Given the rural and frontier nature of the state, specialized providers are not easily accessible and health professional shortages may cause available appointment schedules to be months out. These barriers result in the unfortunate reality that crisis intervention for individuals with SMI/SED and/or SUD in areas of rural Idaho is too often a default assignment for local law enforcement, first responders or under-resourced critical access hospitals.

The State of Idaho has responded to these challenges by empowering local communities and organizing the funding and delivery of behavioral health care services around Regional Behavioral Health Centers (RBHCs) located in each of the seven geographical regions of the state. Each RBHC provides mental health services through a system of care that is both community-based and consumer-guided. However, continuing to increase access to community-based behavioral health services in each of the seven regions continues to be a challenge and a priority for the IDHW. The Idaho Behavioral Health Plan (IBHP) (Medicaid's behavioral health managed care plan for outpatient services) has targeted alleviation of the provider shortage areas in Idaho with some success, but the need to continue incentivizing specialists to come to Idaho and provide services in rural areas is an ongoing strain against Idahoans receiving the specialized care needed when they require it to avoid long stays in hospitals and emergency departments.

In order to establish a baseline for the availability of services in the Medicaid network (both for purposes of this Waiver and in advance of Medicaid expansion being implemented in 2020), the IDHW recently conducted an asssement of the availability of mental health and SUD services across the state. Overall, the assessment found each of the seven regions contains a crisis center as well as offers a variety of outpatient and intensive outpatient treatments for individuals with a SMI/SED and/ or SUD diagnosis, but many lack access to higher levels of care, particularly for children and adolescents. The full report of the Idaho Behavioral Health Services Availability Environmental Scan is available in *Appendix A*, attached hereto.

C. Opioid Epidemic in Idaho

The SUD epidemic, which has swept the country in recent years, has not bypassed Idaho. Although still lower than the national average, the drug-induced mortality rate in Idaho increased

significantly by 23% between 2011 and 2016.[4] Increases have been identified among Idahoans misusing prescription drugs, heroin, alcohol, crack/cocaine, and marijuana, among other substances.[5] The rise in substance use across the state also has significant economic impacts to state and local law enforcement, such as the greater need for resources to investigate suspected incidents of impaired driving, to process more arrests for criminal infractions, to procure equipment and training to perform such work, and numerous other resulting downstream impacts to the city, county, and state judicial and corrections systems. Individuals who become justice-involved due to "missed opportunities" for early intervention and appropriate access to treatment create ripple effects throughout every facet of society from broad economic impact down to the nuclear family.

D. Mental Health Challenges

The incidence of suicide and attempted suicide skyrocketed between 2013-2017 with 110 Idaho school children (ages 6-18 years old) tragically dying by suicide in that time period, and Idaho's overall rate continues to be above the national average. Idaho ranked fifth in the nation in 2017, and intentional self-harm (suicide) ranks as the fourth leading cause of premature death for Idahoans under the age of 75.[6] The IDHW believes implementing an integrated and redesigned system of care, with a clear emphasis on early intervention, can help change this trajectory of premature mortality and improve the lives of Idaho families for years to come.

The evidence is clear that there is a strong linkage between SMI and SUD. The 2018 National Survey on Drug Use and Health reported that nearly 50% of individuals using illicit drugs had a co-occurring SMI.[7] See *Table 2.1*, below, which depicts the distribution of behavioral health diagnoses among Idaho Medicaid beneficiaries. In state fiscal year 2018, approximately 20% of Medicaid beneficairies had a behavioral health diagnosis, while only 10% of those total behavioral health diagnoses include SMI, SED, and/or SUD. While Idaho Medicaid statistics are currently well below these national trends, the state anticipates that as the 2020 Medicaid expansion brings coverage for nearly 91,000 newly enrolled adults, we will likely see significant increases in Medicaid behavioral health prevalence rates over the coming years as these new individuals engage in the healthcare system.

As these new beneficiaries engage, it will be critically important to ensure the system has no wrong "front door" for these individuals to access the services they need to be healthy. IDHW will continue to work to improve access and encourage individuals to engage with the behavioral health system at places and times when crisis can be prevented. By concurrently implementing this Waiver and building access to the full continuum of behavioral health care, we will have the tools necessary to treat the whole person regardless of specific primary diagnosis, or which diagnosis is discovered first.

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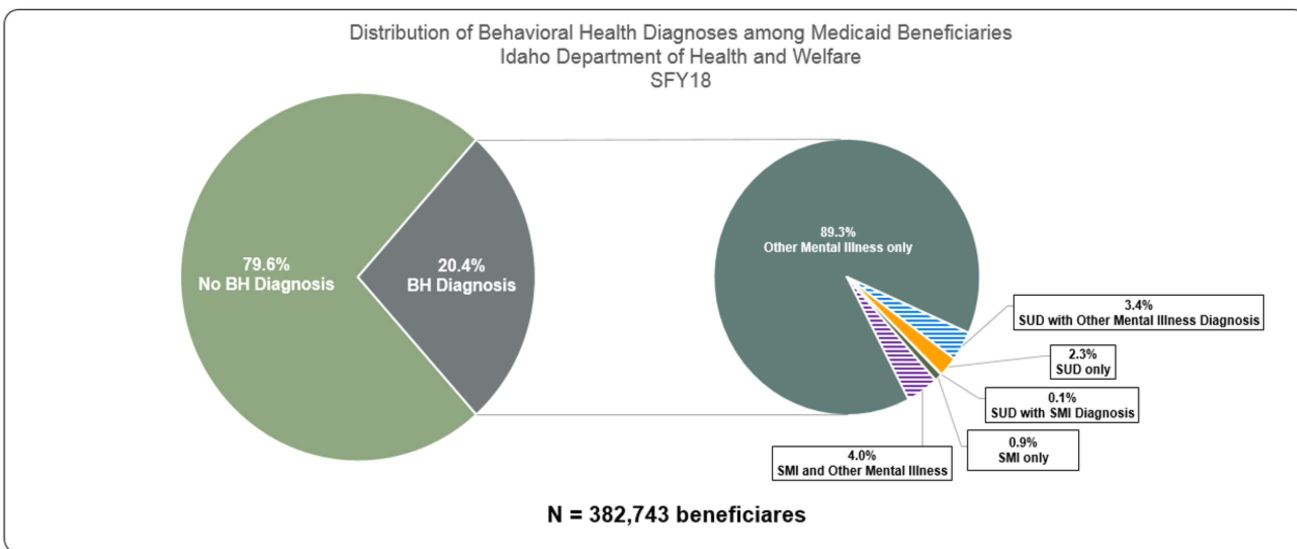
[4] Idaho Office of Drug Policy, 2017 Needs Assessment. Available at: https://prevention.odp.idaho.gov/wp-content/uploads/sites/33/2018/03/2017-Needs-Assessment_Final.pdf.

[5] *Id.*

[6] http://healthandwelfare.idaho.gov/Portals/0/Health/GetHealthyIdahoV2019.pdf

[7] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Assistant-Secretary-nsduh2018_presentation.pdf

TABLE 2.1: Distribution of Behavioral Health Among Medicaid Beneficiaries



**Number of beneficiaries represents total number of unique Medicaid enrolled lives in SFY 2018*

2.2 CURRENT INITIATIVES

In light of these challenges, Idaho has undertaken a number of initiatives to identify areas for targeted interventions to improve treatment rates and outcomes, while working to enhance the overall quality of life and well-being of Idahoans. Specifically, the IDHW, in collaboration with other agencies across the state, has implemented several strategies to address the opioid epidemic as well as to improve the behavioral health system of care for both adults and children.

A. Comprehensive Treatment & Prevention Strategies to Address SUD

Several of the state's recent initiatives have focused on addressing the opioid epidemic. In 2010, the Division of Medicaid Pharmacy Program began focusing on safe opioid prescribing, and this has become an emphasis of both the Pharmacy and Therapeutics Committee and the Drug Utilization Review Board. These Medicaid advisory committees regularly analyze drug utilization, especially as it pertains to controlled substances and medication assisted treatment for opioid use disorder (MAT). In addition, the state's Divisions of Behavioral Health and Public Health have received significant federal funding to combat the opioid epidemic, which has been focused on provider education, naloxone distribution, recovery supports, and MAT.[8] State agencies meet regularly to discuss progress and coordinate activities related to combating the opioid epidemic. As well, under the leadership of the Office of Drug Policy, state agencies and community stakeholders have formed an Opioid Overdose and Misuse Workgroup which has developed a five-year strategic plan (2017-2022) to help prioritize statewide efforts related to the epidemic.[9] In 2019, the Governor also issued an executive order creating the Opioid and

[8] Idaho's Response to the Opioid Crisis (IROC). http://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/IROC/tabid/1728/Default.aspx

[9] Opioid Overdose and Misuse Workgroup. https://odp.idaho.gov/opioid-use-and-overdose-workgroup/

Substance Use Advisory Group, which has brought together additional stakeholders.[10] These collective initiatives have led to numerous reforms in the state to implement best-practice prevention strategies and treatment options to address the opioid crisis.

Prescribing Practices and Policies.
Medicaid has implemented a series of prescribing practices and policies to address opioid-related activities. These practices and policies are both preventive in nature and also designed to meet the treatment challenges of patients with SUD. These efforts have included: (i) limiting long-acting opioid prescriptions to not more than one agent at a time, with strict requirements for use in non-cancer patients; (ii) prohibiting pharmacy providers from allowing a known Medicaid participant to pay cash for any controlled substance; (iii) excluding opioid-containing cough preparations from coverage; (iv) providing cooperative Medicaid pharmacist and provider case management for participants currently using methadone for pain management; and (v) providing various forms of educational outreach to opioid prescribers. In addition, Medicaid has implemented a phased-in implementation for all new opioid prescriptions to cumulative amounts of ninety (90) morphine milligram equivalents (MME) or less daily. The Division of Medicaid is working with providers to establish medically appropriate tapering plans and alternative treatment options for non-cancer high-utilizer patients.

To address the use of opioids for treating chronic pain, Idaho has explored non-medication and non-opioid medication alternatives for chronic pain management that are safe, effective, and not addictive in nature. In addition, the state has removed restrictions on non-opioid pain medications, including duloxetine, gabapentin, and topical lidocaine and diclofenac products.

In addition, the state has facilitated access to life-saving treatments for opioid use disorder, making buprenorphine-naloxone available without prior-authorization requirements, duration limits, or dosage limits, beyond FDA-approved maximum doses.

Prescription Drug Monitoring Programs and Provider Education.
The IDHW's Drug Utilization Review Board has conducted prescription drug utilization studies since 2017. Many of these studies have included sending letters directly to providers regarding patients who fall outside of established standards. Examples of utilization studies conducted by the Review Board include: (i) Top 150 Utilizers of Opioids based on dosage and duration; (ii) Methadone patterns of use; (iii) Tramadol Utilization; (iv) Codeine and Tramadol Use in Children; and (v) CMS Substance Use Disorder Measures. In addition, the various initiatives stemming from the work of the Statewide Opioid Misuse and Overdose Workgroup has increased accessibility to resources that will assist in reducing the incidences of opioid misuse by reducing access and preventing overdose deaths. Methods include: using prescriber report cards to create social norms of decreased opioid prescribing; reducing diversion of opioids by establishing drop-box programs in pharmacies statewide; and educating prescribers on use of the Prescription Drug Monitoring Program.

[10] Opioid and Substance Use Advisory Group. https://odp.idaho.gov/governors-opioid-and-substance-use-disorder-advisory-group/

Opioid Treatment Services and Supports.
The various DBH programs have provided opioid specific treatment and recovery support services to individuals with an Opioid Use Disorder (OUD). Treatment services through this program have included access to MAT, including methadone, buprenorphine/naloxone, and extended release naltrexone. In addition, the grant has expanded community-based services that connect individuals with an OUD to peer supports and sober living activities. Once the Medicaid expansion in Idaho takes effect, many of the grant dollars currently supporting basic treatment needs for adults will be redirected to evidence-based services and supports that cannot be covered by Medicaid but which complement the Medicaid service array to better promote improved treatment outcomes.

Overdose Reduction Strategies.
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.

B. Improved Care Coordination and Access to Mental Health Services.
The IDHW facilitates access to community-based mental health services through Regional Behavioral Health Centers (RBHCs), which are located in each of the seven geographical regions of the state. Not only do the RBHCs provide mental health services through a system of care that is both community-based and consumer-guided, but they also provide input to state policymakers on the various behavioral health needs and challenges of Idahoans across the state. Through this ongoing collaborative work, the state has improved access to mental health services in meaningful ways, including the following:

Suicide Prevention.
The Suicide Prevention Program was established in 2016 to implement specific strategies identified in the Idaho Suicide Prevention Plan. The program is housed within the Division of Public Health in the IDHW and focuses on supporting (i) youth education, (ii) the Idaho Suicide Prevention Hotline, and (iii) public awareness campaigns.

Crisis System.
The DBH is leading efforts within the state to develop a comprehensive crisis system to meet the needs of Idahoans. The State of Idaho currently has a continuum of crisis services available. At the heart is a statewide investment in crisis intervention teams by law enforcement and the mental health system. Comprehensive crisis centers for adults, open 24 hours, have been established in each of the seven regions of the state to de-escalate acute mental health crises and deter unnecessary incarceration. In addition, Idaho has mobile crisis teams in each region of the state as well as 24-hour crisis centers for both mental health and SUD- related crises. Each region of the state has a state-operated mental health center that operates the mobile crisis teams. Idaho has a single statewide suicide prevention hotline that is connected to the national suicide hotline. In addition, beginning in 2020, the IBHP will begin providing reimbursement across its network for crisis intervention and response services. The DBH is working to expand the crisis system to follow national best-practice models and include additional elements consisting of

expanded use of call center technology, mobile outreach with mobile crisis units, and crisis stabilization.

Primary Care and Behavioral Health Integration.
Idaho's State Innovation Models (SIM) grant and the resulting Statewide Healthcare Innovation Plan have made strides in improving integration of primary care and behavioral health services via the patient-centered medical home (PCMH) model. Grant funds have been used to provide training and support to primary care practices that were committed to transforming their practices to the PCMH model. Currently, there are 12 primary care practices/organizations statewide that have received the Health Resources and Services Administration (HRSA) FY2019 Integrated Behavioral Health Services (IBHS) Award. These clinics are mostly comprised of Federally Qualified Health Centers (FQHCs) and Indian Health Centers that have received funding from HRSA for behavioral health integration in the past and have participated in several statewide initiatives related to PCMH before this award. Most of the primary care practices that have made strides to integrate behavioral health have been FQHCs. There are a few Rural Health Centers (RHCs) that are also advanced in behavioral health integration, which is beneficial considering the rural service area footprint of the FQHCs and RHCs.

In addition, in an effort to encourage increased integration of physical health and behavioral health services, Medicaid introduced a new integrated fee schedule in 2018. The health and behavioral assessment and intervention (HBAI) service codes support a more integrated clinical approach for assessments and interventions. This change addressed a previous system restraint by allowing qualified masters level clinicians the ability to enroll and bill for these services when previously only physicians could provide these services.

C. Improvements to Children's Mental Healthcare Services.
The State of Idaho has made a number of recent improvements focused on improving access to evidence-based mental health treatment specific to children and adolescents. These improvements have focused on early identification, expanded eligibility for services, and a new coordinated systems of care specifically designed for children with SED.

To quickly identify youth with unmet mental health needs, the state recently launched the Mental Health Checklist for Youth, a new online tool which can be accessed by anyone in the public. The state also launched the Idaho Children's Mental Health (CMH) Screener to identify additional youth with unmet mental health needs. The CMH Screener is based on the Child and Adolescent Needs and Strengths (CANS) tool, can be accessed by individuals who are CANS certified and will help to better connect families to mental health treatment services in their communities. By making this tool available broadly to families as well as to practitioners in non-mental health settings, the goal is to facilitate earlier identification and linkage to services.

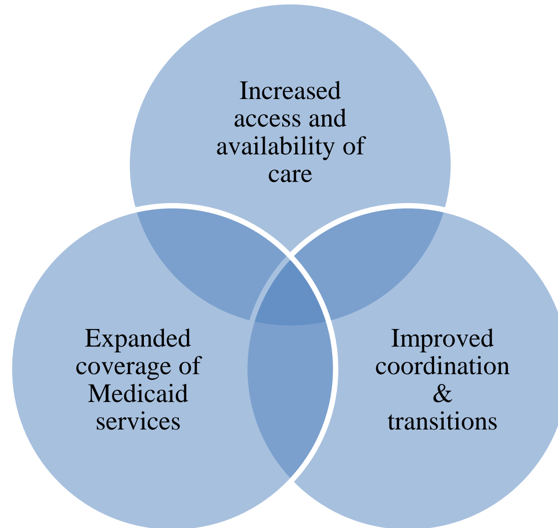
Once identified, children with SED in households earning up to 300% of the federal poverty level are eligible to access critical behavioral health services through the Youth Empowerment Services (YES) program. YES provides individualized care with a coordinated team-based approach across the IDHW, the State Department of Education, and Idaho Department of Juvenile Corrections to allow all agencies to communicate treatment goals and improve coordination of care to children and adolescents. The YES system of care includes best practices for community-based rehabilitation services, person-centered service planning, and medication

management. In addition, other Medicaid services are reimbursable through this model, including: (i) CANS assessment; (ii) care planning through the Child and Family Team (CFT); (iii) behavior modification and consultation; (iv) crisis intervention and response; (v) psychological and neuropsychological testing; (vi) targeted care coordination; (vii) psychotherapy; (viii) intensive outpatient program; (ix) family psycho-education; and (x) skills building.

2.3 IDAHO'S VISION FOR BEHAVIORAL HEALTH REFORM

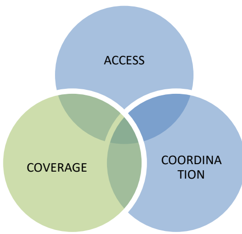
Although Idaho has made strides in improving the behavioral health system of care, given the upcoming expansion of Medicaid to an anticipated 91,000 additional adults, the state recognizes the critical importance of increased coordination of reforms currently occurring across our state government agencies so that limited resources can be focused to maximize access to behavioral health resources. As the statewide Behavioral Health Initiative begins to craft its strategic plans over the course of calendar year 2020, the IDHW will support these activities by using this Section 1115 Waiver to further build on our initial actions that have already taken place as well as build a foundation for future improvements.

As outlined earlier in this Waiver, Idaho will leverage this demonstration to implement targeted reforms to: (1) expand **coverage** of Medicaid reimbursable services for individuals with SMI/SED and/or SUD; (2) increase **access** and availability of behavioral health services across the state, particularly in rural and frontier areas; and (3) improve **coordination** of care, including transitions of care, for Medicaid beneficiaries.



The services, supports, programs, and initiatives proposed in this Waiver will be continuously reviewed and improved throughout the course of the five-year demonstration project, as well as enhanced to reflect Medicaid's coordination with the stakeholder involvement under Idaho's Behavioral Health Council and the resulting long-term behavioral health strategic planning process. With an intentional flexibility given these future planning efforts, the strategies outlined in this Waiver will begin with this three-fold approach.

A. Expanding Coverage of Medicaid Reimbursable Services for SMI/ SED and SUD.



Creating a complete continuum of care for behavioral health services will be imperative to ensuring Medicaid participants who experience a mental health or SUD diagnosis can be treated in the least restrictive and most effective level of care to avoid high-cost acute hospitalizations or residential placements. Implementing an evidence-based continuum of care throughout the state will require structural changes within the Medicaid provider network and individual facilities to build out any missing levels of care. In addition, existing services will be enhanced to align with national best-practice service definitions. Over the course of the demonstration period, the IDHW will work to **increase the Medicaid service array to include all levels of care** currently missing in the Idaho behavioral health care system, from early intervention to high intensity inpatient services.

Inpatient and Residential Services in an IMD

Although Medicaid currently reimburses for an inpatient level of care for adults with SMI and/or SUD, lacking the ability to reimburse in an IMD setting, these patients often must end up in emergency departments and acute care hospitals. Through this Waiver, Idaho will expand access to these critical services by reimbursing for **medically necessary acute short-term stays in an IMD** for Medicaid beneficiaries with SMI/SED and/or SUD. By making inpatient and high-intensity crisis residential and stabilization services available in an IMD setting, the IDHW seeks to **reduce over-reliance on general acute care settings** for these services. As part of these efforts to provide new reimbursement for inpatient and residential services in IMD settings, Idaho will establish a certification process for all newly enrolling providers as well as an ongoing process to periodically re-evaluate existing providers to ensure beneficiaries have access to high-quality care. Specifically, the state will ensure that all participating hospitals and residential settings are licensed and accredited by a nationally recognized accreditation entity, as well as ensure that participating facilities meet federal program integrity requirements to protect against potential fraud and abuse.

In addition, the IDHW will work to align service definitions and placement criteria with national evidence-based definitions, particularly for newly added inpatient and residential services in IMDs. For SUD treatment services, Idaho will **utilize the American Society of Addiction Medicine (ASAM) patient placement criteria**, the most widely accepted and comprehensive set of guidelines for patient placement across the full continuum of care.

Additional Support Services

Expanding the complementary support services for behavioral health will assist with participants’ compliance and retention in treatment. The development and expansion of support services is a critical component of building out the full continuum of behavioral health care. While Medicaid currently reimburses for a broad array of community-based mental health and SUD treatment services, as part of the overall strategy related to this Waiver, the IDHW seeks to expand and supplement these services in several key ways.

First, Idaho seeks to **expand access to and utilization of peer and family support services**, which are existing Medicaid covered benefits. In addition, recovery coaching will be added as a

newly Medicaid reimbursable service. These recovery support services provided in the community are cost-effective benefits for preventing relapse and supporting long-term recovery.

In addition, Idaho will **expand access to Assertive Community Treatment (ACT) services** to provide integrated delivery of community mental health services to individuals with SMI/SED. Idaho currently offers ACT through the DBH; however, these services will be added to the Medicaid fee schedule and the IBHP. This will allow the highest risk patients discharging from inpatient hospitalizations to receive additional support and crisis services in the community to help prevent readmissions.

Medication Assisted Treatment (MAT).

Medicaid does not currently cover medication assisted treatment (MAT) at opioid treatment programs (OTPs). The IDHW recognizes that methadone maintenance can be one of the most cost-effective MATs and can help to significantly reduce the risk of death from overdose, decrease hospitalizations and ER visits, increase retention in treatment, and reduce recidivism. Beginning in 2020, the IDHW will provide **methadone maintenance as a covered behavioral health service** to eligible participants, in accordance with admission requirements and federal opioid treatment standards outlined in 42 CFR 8.12.

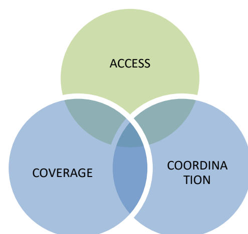
Although Idaho Medicaid has made headway in expanding access to MAT for OUD over the last few years (by, for example, eliminating prior authorization requirements for buprenorphine/naloxone), access to MAT remains low across the state. The addition of methadone maintenance coverage alone is unlikely to change this, as Idaho currently only has four OTPs (run by two companies), all located in the greater Boise area. In addition, collaborations between the IDHW and Project ECHO (Extension for Community Healthcare Outcomes) Idaho to train providers has significantly increased the number of waivered providers in the state with the ability to prescribe buprenorphine/naloxone; however, few providers are utilizing their waiver and access for patients remains low.

To increase access to and utilization of this benefit, Idaho will undertake a number of specific actions. First, Idaho Medicaid will **assess its reimbursement for MAT at OTPs** to ensure that it not only makes continuing to provide MAT to Medicaid members financially viable for the providers in our state but also makes it feasible for them to expand into other areas of our state, including Southeastern and Northern Idaho. Idaho Medicaid will also continue to assess buprenorphine/naloxone utilization in its drug utilization review activities and will **collaborate with Project ECHO Idaho to encourage more providers to become waivered** and to support waivered providers, as they provide treatment to members across the state.

Lastly, to supplement the expansion of acute inpatient and residential SUD treatment services, the IDHW will **require all IMDs receiving Medicaid payment to provide at least two forms of MAT**. Patients with OUD are at high risk of relapse (as well as increased risk of overdose and death) after detoxification or an inpatient hospital stay. Safe discharge planning following acute inpatient and residential stays will involve making sure that patients on MAT are able to follow-up with a provider offering this service on discharge. This may require the IBHP managed care organization (MCO) to incentivize psychiatric medication managers in its network to obtain their waiver to prescribe buprenorphine. It may also mean expanding access to SUD care through telehealth and collaborating closely with primary care providers who may already be offering

these services. MAT is a critical tool to assist individuals to be successful in their recovery. The IDHW seeks to ensure that not only is the full offering of effective MAT available for Medicaid reimbursement, but that all community partners and providers are incentivized to provide adequate access to Idahoans in need.

B. Expanding Availability and Access to Services Across the State, Particularly Rural & Frontier Areas



Idaho is a rural state, with approximately 30% of its population residing in frontier areas. As well, much of Idaho comprises HPSAs, with Idaho ranking 49th out of 50 states for number of physicians per capita. This translates into significant challenges for delivering healthcare, including behavioral health care. Access to specialty services, such as child psychiatry and neuropsychiatry, is extremely limited, even in the larger metropolitan areas in the state. Over the course of the Waiver demonstration period, the IDHW will work to expand geographic access and availability of evidence-based services within the continuum of care, with particular emphasis on ambulatory services in rural and frontier areas of the state. The strategy will involve expanded use of crisis stabilization services, increased behavioral health integration into primary care, and utilization of telehealth services. The IDHW will continually monitor and assess the availability of these services throughout the state and continuously work to increase the availability of services.

Crisis Stabilization Services.

The IDHW will continue its efforts to **expand crisis stabilization services** and develop a robust network to effectively engage participants who are experiencing behavioral health crises and quickly transition them into the Medicaid treatment network at the appropriate level of care. Currently, at least one 24-hour crisis center is located in each of the seven regions of the state. In addition, crisis response and intervention are two newly added services within the IBHP.

The IDHW is committed to building upon the effective crisis response system in place today, particularly in rural and frontier areas of the state, throughout the Waiver demonstration period. The vision for the comprehensive crisis system in Idaho is that it will be based on principles of recovery, trauma-informed care, use of peers, and strong commitments to the safety of both individuals in crisis and staff. At the same time, preventing crises is always preferable to managing a crisis, so Idaho will undertake efforts to align crisis services within the broader continuum of care.

Specifically, Idaho has recently contracted with a consultant to **develop a comprehensive statewide crisis response plan and system**. Many of the elements of that comprehensive plan are either under development or the state has committed to implementing, including the following:

- Development of a statewide inpatient and crisis bed registry;
- Medicaid reimbursement for a comprehensive crisis service array, including for services delivered at the 24-hour crisis centers;
- Expanded availability of mobile crisis units in all seven regions with the ability to respond to all rural areas within the region;

- Implementation of a single front door statewide crisis line, which will eventually evolve into a true "air traffic control" model;
- Improved access to urgent behavioral health care services, including same day crisis psychiatric services available in person or via telehealth; and
- Proactive and reactive crisis plans to be included in all transition and discharge planning between all levels of care.

In addition, recognizing that the ability to communicate in the moment with the crisis system and healthcare providers is imperative to positive outcomes, IDHW is committed to developing **improved connectivity between first responders and treatment providers**. Specifically, the IDHW will investigate implementation of an interoperability platform such as Julota (or a similar mobile health integration platform) to enable sharing of consent and information sharing between healthcare, law enforcement and community organizations. Such a system will strengthen the proactivity of response and prevention of behavioral health crises and perform a key role in the development of a statewide Idaho community response crisis system.

Primary Care Integration.

The IDHW recognizes that behavioral health integration into primary care will be another critical tool to expanding access to behavioral health services across the state, particularly in rural and frontier areas. Medicaid's Healthy Connections currently incentivizes behavioral health integration by including it in the Healthy Connections Care Management Program and Medical Home Program. Clinics must be committed to transitioning to the primary care medical home (PCMH) model of care, or have already become nationally accredited in PCMH, and can receive an increased payment if they provide proof to Medicaid they are meeting specific criteria – one of which is behavioral health integration. These are often referred to as payment tiers within the Healthy Connections program, with Care Management being Tier III, and Medical Home being Tier IV (the highest tier).

Idaho Medicaid is currently pursuing an accountable care organization model that will increase incentives for providers to address their patients' behavioral health needs. This model, known as Healthy Connections Value Care, will allow participating clinical integrated networks or primary care practices to share savings with the state for controlling the cost of care and improving quality for their patients. **Behavioral health measures will be added to the suite of quality measures** in year 2 of Healthy Connections Value Care to incentivize better care. As part of this initiative, Idaho Medicaid plans to work with providers to re-structure payment tiers to support future value-based payment progress. Support for behavioral health integration will be a critical factor for this restructuring. To further incentivize integration, Medicaid will **enable billing simplifications to encourage more primary care providers to provide mental health services**.

Supporting behavioral health integration is a key strategy in expanding access to the more rural areas of the state. However, this strategy will require increased provider capacity and education. The IDHW will leverage existing resources to **increase the capacity of primary care providers to manage complex patients with SMI/SED and SUD** by partnering with Project ECHO Idaho, which already supports community providers through biweekly case-based conferences and didactics on chronic pain, SUD, and SMI/SED. Medicaid will work with providers, the Division

of Public Health, the Division of Behavioral Health, and its managed care partners to explore means of supporting Project Echo using Medicaid funding streams.

While primary care providers are not traditional behavioral health providers, with sufficient education and support, primary care providers are critical to improving access to medication management for SMI/SED and SUD, especially in more rural areas of the state. Moreover, many of the medication managers across the state are psychiatric nurse practitioners or physician assistants. Through Project ECHO Idaho, these advanced practice clinicians will be able to receive the support necessary from psychiatrist and child psychiatrist consultants to provide quality care to Medicaid-enrolled patients. Increasing primary care expertise in behavioral health and supporting integration allow patients discharging from behavioral health hospitalizations to obtain psychiatric medication management or specialized counseling within their own community, promoting better health outcomes.

Telehealth.

Idaho Medicaid currently reimburses for telehealth, both through the IBHP and through fee-for-service (FFS) Medicaid, as a means to bring behavioral health services into remote areas of the state. However, the IBHP and FFS Medicaid's approaches to telehealth and reimbursement strategies currently differ, leading to confusion for providers. As a result, the utilization of telehealth services throughout the state has remained low. Over the course of the demonstration period, the IDHW will support strategies to increase the utilization of this service by working with the IBHP MCO to **simplify and standardize telehealth coverage rules** between the IBHP and FFS.

In order to further facilitate access to specialty behavioral health care via telehealth in rural communities, Idaho Medicaid will collaborate with the DBH to **create a hub for crisis-related telehealth** – that will help facilitate access to psychiatric medication management and counseling services in a timely fashion. In the most rural and frontier areas, it is unlikely that even the highest risk members discharging from hospitals will have access to psychiatric care in a timely fashion within their community. Telehealth to their primary care provider's office or even their own smartphone could serve as a bridge to in-person follow-up or be their primary mode of receiving behavioral health care.

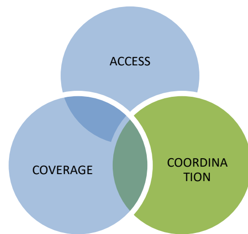
Ultimately, removing barriers and incentivizing widespread acceptance of telehealth is critical to ensuring access to specialized behavioral health services in Idaho's most rural communities. To better understand the barriers and opportunities for growth, the IDHW will work with the Health Transformation Council of Idaho to **conduct an environmental scan to fully understand current telehealth utilization and barriers**. In addition, the IDHW will also conduct statewide outreach to providers to educate them about the telehealth benefit and encourage them to take advantage of this technology.

Transportation

To encourage providers to deliver services in less populated areas, the IBHP reimburses providers a travel fee. However, it continues to be difficult to encourage providers to bring services to the more rural and frontier areas in our state. Idaho Medicaid will continue to work with the IBHP to **increase utilization of the transportation benefit to improve access** to specialty providers in rural areas.

In addition, Idaho Medicaid provides a non-emergency medical transportation benefit for members who need to travel to their appointments; however, time needed for travel over long distances continues to be an issue for both members and vendors. The transportation vendor's ability to keep up with demand, especially during peak hours, also remains a challenge. Idaho Medicaid is in the process of rebidding its non-emergent medical transportation contract and will make transportation to behavioral health services a priority for this contract to further improve access to these services throughout all areas of the state.

C. Improving Coordination of Care, including Transitions of Care



Recognizing that access to services alone can only accomplish so much, the IDHW will simultaneously focus on improving care coordination of behavioral health services. Coordination of care between levels and settings of care is a key component to ensuring improved health outcomes for individuals with SMI/SED and/or SUD. Improving care coordination, particularly transitions to community-based care following episodes of acute inpatient or residential treatment, will drastically improve the effectiveness of these services for individuals with SMI/SED and/or SUD. For this reason, implementation of the Waiver will require a deliberate and systematic approach for coordinating transitions not only between the IMDs and the IBHP, but across the entire delivery system as well. The IDHW seeks to improve care coordination through a number of strategies including: (1) improvements to the IBHP, such as additional accountability metrics for the MCO and providers; (2) increased early identification and referrals for individuals with SMI/SED and/or SUD; (3) improved discharge planning to community-based services; (4) improved health information technology connectivity for providers; and (5) increased provider education.

IBHP Improvements

The IBHP currently provides only ambulatory behavioral health services, which creates coordination challenges for members transitioning into and out of hospital or residential settings. For this reason, IDHW has worked with our current IBHP MCO to continuously refine care coordination and transition activities for Medicaid beneficiaries. For example, Discharge and Field Care Coordinators interact directly with high risk members and coordinate with inpatient and residential facilities to ensure outpatient behavioral health services are established prior to transitioning back into the community. In addition, Idaho's Quality Improvement Organization has provided the IBHP MCO access to its utilization management system to assist the coordinators with timely information on members presenting to emergency departments or admitted to inpatient treatment.

With the upcoming expansion of Medicaid and the subsequent expansion of services via this Waiver, care coordination, particularly transitions to community-based services following acute inpatient hospital stays, will become even more critical. To continue to improve care, as part of the upcoming 2021 rebid, the IDHW will make several changes to the IBHP to improve coordination and increase accountability measures for the MCO, hospitals, and community-based behavioral health providers.

First, the IBHP will be transitioned to a prepaid inpatient health plan, as **all behavioral health services will be carved into the IBHP managed care contract**, including inpatient and

residential services. This programmatic revision will better align incentives to decrease unnecessary inpatient admissions and reduce lengths of stay by efficiently transitioning individuals with SMI/SED and/or SUD to the most effective lower level of care. In addition, the Medicaid managed care plan(s) will be held accountable and incentivized for high performance on hospital readmissions related to SMI/SED or SUD. Specifically, the IBHP will require tracking of crucial HEDIS measures, including both hospital follow-up within seven days and thirty days after discharge, prioritizing and incentivizing the former. The IBHP MCO will also be required to manage and closely monitor key performance measures and require its network providers, including inpatient and outpatient providers, to follow specific discharge criteria. Under the new contracts, **new minimum standards for discharge planning** (to be determined by Idaho Medicaid and the DBH) will be mandatory in all provider agreements with hospitals and IMDs.

Finally, the new managed care contracts will include **enhanced requirements related to case management**. Specifically, the IBHP will require case management for all patients hospitalized related to SMI/SED or SUD, regardless of the duration or type of hospitalization (acute psychiatric inpatient hospitalization, residential treatment in an IMD, emergency department visit, etc.), starting within days of admission and continuing at least thirty days post-discharge. Moreover, the IBHP MCO will be required to have staff dedicated to work directly with members through their transitions and assist with care coordination activities. Idaho also plans to reimburse community-based care managers when they go into residential and inpatient settings pre-discharge to assist with care coordination and transitions.

Discharge Planning

One of Idaho's care coordination strategies will focus on improving the discharge process by engaging all stakeholders directly in the process. Specifically, the hospital, outpatient provider, and the IBHP managed care contractor will be held to increased requirements and accountability metrics to ensure patients are supported by appropriate and intensive pre-discharge planning and care coordination, as they move from the inpatient or residential setting to a community-based provider. Attention will be given to **developing and promoting evidence-based systematic protocols and communication procedures to support post-discharge follow-up visits** and other coordination activities to help prevent potentially avoidable hospital readmissions and symptom exacerbation. Discharge planning will be required between all levels of care and will include proactive and reactive crisis plans.

To improve discharge planning, Idaho Medicaid will require the following: (i) tracking of hospital follow-up with members within seven days and thirty days after discharge, with prioritizing the former; (ii) case management for all patients hospitalized related to SMI/SED or SUD and continuing at least thirty days post-discharge; and (iii) minimum standards for discharge planning. Also, Medicaid will work with the IBHP MCO to ensure robust discharge plans are available even in the most rural areas of the state by facilitating access to specialty behavioral health care via telehealth as well as facilitating increased capacity of primary care providers to manage complex SMI/SED and SUD.

The IDHW will also create plans to ensure that patients on MAT are able to follow up with providers, as necessary, to receive this service upon discharge. The aforementioned strategies are

just several ways that Medicaid plans to improve care coordination through the discharge process, support members through this stage of treatment, and circumvent readmissions.

Early Identification.
Recognizing the strong correlation between physical health and mental health, Idaho will continue to improve care coordination and integration of behavioral health and primary care, with particular emphasis on early identification. Such integration efforts will help ensure that individuals with SMI/SED and/or SUD are identified early and can be connected to appropriate treatment and supports as soon as possible. To this end, Idaho will leverage the Medicaid primary care case management program, Healthy Connections, which has successfully increased the adoption of patient-centered medical homes, by **promoting training and education for early intervention for SUD**, specifically promoting the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT). This will expand the skillset of Healthy Connections providers who can successfully screen the adolescent and adult populations to prevent missed opportunities. In addition, the state will work towards implementing a **standardized evidence-based assessment process**, such as SBIRT, with screening tools for SED/SMI to enable early identification at the primary care level or other potential entry points within the community. When behavioral health needs are identified, the focus will be to refer the member to the appropriate service and follow up to ensure care is established. To increase success and coordination of follow-up care, Idaho will continue to encourage the integration and co-location of behavioral health providers in primary care settings.

Leveraging Health Information Technology.
In addition to the care coordination strategies outlined above, Idaho will **devote resources to improve health IT integration across the state**. The IDHW is collaborating with the Governor's Opioid and Other Substance Use Disorders Advisory Group and community stakeholders to identify ways to improve health IT infrastructure throughout the state through federal grants. One of the most significant efforts to improve health IT infrastructure will be **facilitating access to the Idaho Health Data Exchange and the Prescription Drug Monitoring Program** to all medical and behavioral health providers across the state. This increased access to adequate documentation of hospitalizations and controlled substance prescriptions will help community providers to support their patients through the discharge process and also prevent readmissions.

Lastly, additional access to, and utilization of, the Idaho Health Data Exchange and Prescription Drug Monitoring Program will help to streamline care coordination among the state's community mental health and primary care providers. The Idaho Board of Pharmacy has made significant progress integrating the PDMP into provider electronic health records in recent years. Funding is available to support the integration of both the Idaho Health Data Exchange and the PDMP directly into a provider's electronic health record. This integration alleviates some of the administrative burden providers face, while simultaneously providing real-time history of a patient's prior and current controlled substance prescriptions. A more widespread adoption of this integration software directly supports care coordination among providers.

These and other health information technology efforts will be guided by input from the Governor's Opioid and Substance Use Disorders Advisory Group and will include other

approaches identified by that group with potential to improve behavioral health care coordination in Idaho.

Provider Education

As part of the overall Waiver efforts, Idaho will undertake **additional education and training to Medicaid providers** on new (and existing) State Plan reimbursement opportunities that encourage attention to transitions of care for individuals with SMI/SED and/or SUD, including a currently-underutilized limited benefit for transitions of care. Ultimately, Idaho's vision is that transitional service providers will be, wherever possible, co-located at the regional and community level to facilitate these critical transitions and be available to link the transitioning patients to a care coordinator at the IBHP, as well as available crisis intervention services and their primary care provider.

2.4 DEMONSTRATION GOALS AND OBJECTIVES

The combination of the above-listed enhancements to Idaho's behavioral health system, when strategically developed, effectively implemented, monitored for quality assurance and measured against national quality metrics, will provide the opportunity to implement effective systemic behavioral health reform for the State of Idaho. Collectively, these reforms will provide the necessary tools to allow individuals to be stabilized in the most effective setting and supported within their own communities. By expanding access to appropriate services and supports along the evidence-based continuum of care, Idaho seeks to support individuals affected by SMI/SED and/or SUD to live healthier lives and achieve more successful outcomes, regardless of the challenges they face.

This demonstration will allow the IDHW to address the ongoing behavioral health needs of Idahoans, promote resources to increase the availability of ancillary health services, improve treatment rates and outcomes, and improve the overall quality of life for Idaho residents. The aforementioned goals for this Section 1115 Waiver support the specific goals for the SUD and SMI/SED demonstrations outlined by CMS in its SUD Guidance (SMD #17-003) and SMI/SED Guidance (SMD #18-011), as described below:

SUD Goals:

1. Increased rates of identification, initiation, and engagement in behavioral health treatment;
2. Increased adherence to and retention in behavioral health treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care hospitals and residential settings;
3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Idaho will provide detailed information on its strategies and state actions for meeting the demonstration milestones (as identified in the guidance from CMS) in its Implementation Plan. Idaho will finalize and submit its Implementation Plan as soon as possible following submission of this application to CMS.

2.5 HYPOTHESIS & EVALUATION PLAN

In conducting the evaluation for this demonstration, the IDHW will contract with an independent external evaluator, the Oregon Health & Science University (OHSU) Center for Health Systems Effectiveness, to ensure a critical and thorough assessment of the program is conducted in a manner consistent with sound and accepted research practices. The OHSU will develop detailed evaluation approaches, data sources, collection frequency, proposed analyses, timelines for deliverables, and other specific components related to the evaluation of this demonstration consistent with CMS guidance and the requirements of the special terms and conditions for the Waiver. The Center for Health Systems Effectiveness has experience in evaluating 1115 Waivers for the states of Oregon and Washington, and they previously worked with Idaho in producing the evaluation of IBHP’s coverage of inpatient care in 2016.

The section below summarizes some tentative hypotheses and a high-level evaluation plan for this Waiver based on the combined SMI/SED and SUD specific goals of the demonstration as set forth in both the formal SMI/SED Guidance and the SUD Guidance.

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

- *Hypothesis*: Earlier identification and engagement in treatment will assist individuals with SUD and/or SMI/SED by avoiding the need for crisis intervention and increasing utilization of community-based supports.
- *Evaluation Plan*: The IDHW will monitor utilization trends and the first level of care utilized by individuals diagnosed with SUD and/or SMI/SED.
- *Potential Data Source*: Claims and assessment data.

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

- *Hypothesis*: Increased adherence to and retention in treatment for individuals with SUD and/or SMI/SED will reduce readmissions in emergency departments and inpatient settings.
- *Evaluation Plan*: The IDHW will monitor trends in duration of treatment at each level of care for individuals with SUD and/or SMI/SED, as well as monitor emergency department utilization and inpatient admissions and readmissions for this population.
- *Potential Data Source*: Claims data.

Goal 3: Reductions in deaths in Idaho related to overdose and suicide.

- *Hypothesis*: Through earlier identification and engagement in treatment, the IDHW can work towards an overall reduction in overdose deaths. In addition, through expanded crisis intervention services and engagement with treatment, the IDHW can reduce deaths by suicide.
- *Evaluation Plan*: The IDHW will monitor follow up and initiation of treatment for individuals following an emergency response to overdose reversal. The IDHW will monitor follow up and initiation of treatment for individuals following utilization of crisis intervention services. The IDHW will monitor trends in number of deaths by overdose and suicide.
- *Potential Data Source*: Claims data; Death records through Division of Public Health; Crisis service utilization data through DBH.

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

- *Hypothesis*: Reducing the utilization of emergency departments and inpatient hospital settings for behavioral health treatment will help individuals receive the appropriate duration and type of treatment needed.
- *Evaluation Plan*: The IDHW will monitor trends in emergency departments and inpatient hospital utilization relative to utilization trends for community-based services among individuals with SUD and/or SMI/SED.
- *Potential Data Source*: Claims data.

Goal 5: Improved access to care for physical health conditions among beneficiaries with SUD and/or SMI/SED.

- *Hypothesis*: Improved care coordination efforts will increase diagnosis and treatment of co-morbid physical health conditions among beneficiaries with SUD and/or SMI/SED, particularly for ambulatory care-sensitive conditions such as diabetes, hypertension, and asthma.

- *Evaluation Plan*: The IDHW will monitor quality metrics related to key physical health services among beneficiaries with SUD and/or SMI/SED. In addition, the IDHW will track mental health assessments in primary care settings, as well as physical health assessments in IMDs and other behavioral health settings.
- *Potential Data Source*: Claims data and applicable quality metrics; Assessment data.

Goal 6: Improve access to community-based services, including crisis stabilization services, to address the chronic mental health care needs of beneficiaries with SMI or SED.

- *Hypothesis*: Increasing access to community resources and supports will improve overall health outcomes and reduce readmissions and unnecessary stays in hospital or other inpatient settings.
- *Evaluation Plan*: The IDHW will utilize information on readmission rates to track the frequency of readmissions and which individuals are most susceptible to readmissions. In addition, the IDHW will monitor utilization of crisis stabilization services and whether there was a corresponding decrease in the number of individuals with SMI or SED presenting to hospital emergency departments in crisis.
- *Potential Data Source*: Claims data.

2.6 DEMONSTRATION AREA, IMPACT, & WAIVER TIMEFRAME

Idaho is requesting a five-year waiver approval for this demonstration, effective as soon as possible following Waiver approval. This Waiver will be implemented on a statewide basis. It will have no other impact to Medicaid and CHIP programs, other than the benefit enhancements for behavioral health services discussed in this application.

Section 3: Behavioral Health Transformation Waiver Eligibility

3.1 ELIGIBILITY

The Idaho Behavioral Health Transformation Waiver will include all mandatory and optional Idaho Medicaid eligibility groups approved for full benefits under the Medicaid or CHIP State Plans. In addition, the Waiver will only directly impact adult beneficiaries ages 21-64 years of age.

Only the eligibility groups listed below will be excluded from the enhanced behavioral health benefits available through this Waiver, due to their limited Medicaid eligibility status:

- Qualified Medicare Beneficiaries (QMB);
- Special Low-Income Medicare Beneficiaries (SLMB);
- Qualified Individual Special Low-Income Medicare Beneficiaries (QI/SLMB2);
- Qualified Disabled Working Individuals (QDWI);
- Individuals who reside in an inpatient hospital setting, except for discharge planning; and
- Non-citizens qualifying for emergency services only benefits.

Although eligible for the benefits available through this Waiver, all beneficiaries receiving services through this Waiver must meet medical necessity criteria. Utilization management procedures will ensure all eligible beneficiaries have access to the appropriate levels of care with appropriate lengths of stay in inpatient and residential settings based on defined clinical criteria for medical necessity.

3.2 ENROLLMENT

Currently, about 270,000 Idahoans are enrolled in the state's Medicaid program. Beginning in January 2020, approximately 91,000 newly eligible adults may also enroll in the program as part of Idaho's expansion of Medicaid. Since this Section 1115 Waiver imposes no waiver-specific eligibility criteria, the Waiver is not anticipated to result in any increase or decrease in total enrollments in Idaho's Medical Assistance Program over the course of the five-year demonstration. See *Appendix B* for more detailed information regarding Idaho Medicaid enrollment projections with and without the Waiver.

Section 4: Health Plan Coverage

4.1 DELIVERY SYSTEM

This Waiver does not propose any changes to the Medicaid delivery system, and as such the delivery system will continue to operate as a statewide FFS delivery system with a limited managed care system for outpatient mental health treatment only. Since 2013, Idaho has contracted with one MCO to manage the IBHP, which provides all outpatient behavioral health services for Medicaid-enrolled adults and children in Idaho. All outpatient services, including all SUD services specific to ASAM levels 1, 2.0, 2.1 and 2.5, will continue to be provided through the IBHP managed care contract, while the newly added inpatient and residential services (ASAM levels 3.5, 3.7 and 4.0) will be reimbursed through FFS. Notwithstanding the foregoing, as mentioned previously, IDHW intends to move all inpatient and residential behavioral health services into managed care as part of the upcoming IBHP reforms to be included in the new contract in 2021 to improve the coordination of care, particularly as patients transition from inpatient to outpatient settings. Idaho will pursue necessary State Plan and 1915(b) waiver amendments to support delivery system changes described in this application.

4.2 BENEFITS

Currently, Medicaid-enrolled individuals have access to a wide array of behavioral health services. Over the course of the demonstration period, Idaho will seek to enhance these benefits by improving quality, access, and utilization. A description of these Medicaid-covered behavioral health services and the anticipated enhancements to the same are summarized below.

- *Inpatient Services.*[11] Inpatient behavioral health services are currently a covered benefit for Medicaid-enrolled individuals. However, due to the federal IMD exclusion, these services are currently only furnished in general acute inpatient settings. Through this Waiver, inpatient services for both mental health and SUD diagnoses will be available in IMD settings as well (acute, short term stays only).

- *Residential Treatment Services*. Residential treatment services are currently not a Medicaid covered service. However, the DBH has a limited program that leverages block grants and other funding sources to provide these critical services to Idahoans in need. Over the course of the demonstration period, clinically managed high-intensity residential services will be added to the Medicaid service array. Residential services will be limited to ASAM levels 3.7 and 3.5 for SUD treatment.

- *Partial Hospitalization.*[12] Partial hospitalization services will be added to the Medicaid State Plan in 2020. Partial hospitalization is a bundle of services that include support therapy, medication monitoring, and skills building, which is organized in an intensive ambulatory treatment program offering less than 24-hour daily care.

- *Intensive Outpatient Program.*[13] Intensive outpatient program (IOP) treatment is a Medicaid benefit already available to individuals with mental health conditions, SUD, or co-occurring mental health and SUD. IOP is available as a step-down service for individuals needing less intensity than inpatient or residential treatment, but more intensity than routine outpatient services. IOP requires a minimum of three (3) days per week and at least nine (9) hours of treatment for adults and at least six (6) hours for adolescents.

- *Outpatient Behavioral Services.*[14] Outpatient behavioral health services, including individual, family, and/or group, are in-person, non-electronic services (except when telehealth is provided in accordance with board regulations), and are used to treat mental health conditions and SUD. These services are reimburseable through Medicaid in a home or community-based setting as well as traditional clinical settings.

- *Crisis Stabilization Services.*[15] Crisis services are currently being added to the Medicaid State Plan with an anticipated effective date of January 1, 2020. Currently, the DBH supports 24-hour crisis centers available in each of the state's seven regions that are available to SMI and SUD patients.

- *Peer Support Services.*[16] Medicaid currently reimburses for adult peer support and youth support services. Adult peer support services are available to adults with SMI or co-

[11] Idaho State Plan Amendment (SPA) TN18-0006, Idaho's Basic Alternative Benefit Plan (Basic ABP), P. 25, *available at:* https://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/BasicPlan.pdf.
[12] *Id.* at 26.
[13] *Id.* at 28-29.
[14] *Id.* at 27.
[15] *Id.* at 63.
[16] *Id.* at 60-61.

occuring mental health and SUD who are actively involved in their own recovery process. Youth support services are available for individuals aged 21 or younger with a diagnosed SED, although participants may also have a co-occuring SUD or developmental disability.

- *Medication-Assisted Treatment* (MAT).[17] Medicaid reimburses for MAT, including buprenorphine and naltrexone; however, as described above, the IDHW is committed to expanding the MAT benefit to also reimburse for methadone maintenance provided at opioid treatment programs.

- *Other*. The Idaho Medicaid State Plan also currently provides reimbursement for the following additional behavioral health services: (i) skills building for adults and children; (ii) targeted care coordination services through the Idaho Behavioral Health Plan; (iii) behavioral consultation and interventions in an educational setting; (iv) family psychoeducation; (v) family support services; and (vi) behavioral medication and consultation.

While Idaho Medicaid currently covers a broad array of services along the behavioral health continuum of care, with the expansion of Medicaid to the new adult group in 2020, the IDHW will focus on expanding access to these existing covered services throughout the state. The addition of IMDs to the Medicaid network will help ease some of the current access challenges. Ultimately, by expanding access to the full continuum of evidence-based care, including residential services, the IDHW will be able to more efficiently provide these critical behavioral health services and meet individuals where they are, allowing them to gradually step-down services and ensure long-term treatment success.

4.3 COST SHARING

The Waiver does not impose new cost-sharing requirements. Rather, those individuals determined eligible for Medicaid will be subject to the same nominal copayments and cost sharing as authorized under Idaho's Medicaid State Plan.

4.4 OTHER PROGRAM FEATURES

No other program features are proposed to be modified through this Waiver under Idaho's Medicaid program, beyond the waiver to allow reimbursement for covered services provided in an IMD. All other initiatives described in this Waiver application will be implemented through a State Plan Amendment or other existing authorities.

Section 5: Waiver Implementation & Timeline

Through this demonstration, the IDHW will address each of the goals and milestones outlined by CMS in the SUD Guidance (SMD #17-003) and SMI/SED Guidance (SMD #18-011), which are

[17] *Id.* at 27-28.

detailed below. Idaho's comprehensive strategy for meeting these demonstration milestones will be detailed in the state's Implementation Plan, which will be submitted to CMS following submission of this Waiver application.

<u>SUD Waiver Milestones</u>

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

<u>SMI/SED Waiver Milestones</u>

- Ensuring quality of care in psychiatric hospitals and residential settings;
- Improving care coordination and transition to community-based care;
- Increasing access to continuum of care, including crisis stabilization services; and
- Earlier identification and engagement in treatment through increased integration.

In addition to the Implementation Plan, Idaho will submit a Health IT Plan (HIT Plan) that will describe the state's ability to leverage health IT, advance health information exchange, and ensure health IT interoperatbility in support of the Waiver's goals. The IDHW will work closely with its Medicaid and behavioral health divisions, external stakeholders, and CMS in the development of the formal Implementation Plan and HIT Plan. Both documents will outline the specific timelines and state action items that will need to occur to meet each of the above-listed milestones.

Section 6: Demonstration Financing

6.1 BUDGET NEUTRALITY

The demonstration financing summary, including expected changes in Medicaid expenditures, and the detailed budget neutrality worksheets are available in *Appendix B*, attached hereto.

6.2 MAINTENANCE OF EFFORT

In accordance with the SMI/SED Guidance (SMD #18-011), the IDHW understands that this Waiver is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient and residential treatment does not reduce the availability of outpatient community-based behavioral health treatment options.

Table 6.2, below, details the outpatient community-based mental health expenditures for state fiscal year 2018 distributed by population and stratified into federal share, state share general funds, and state share regional level funding. The specific distinct populations included in the table are as follows:

- *Idaho Behavioral Health Plan (IBHP)*. The IBHP serves most non-dual and dual eligible enrollees through a managed care delivery system for all outpatient behavioral health services.
- *Medicare-Medicaid Coordination Program (MMCP)*. The MMCP serves dual eligible enrollees through the managed care contract, including all medically necessary outpatient community-based mental health services.
- *Fee-for-service (FFS)*. FFS provides all Medicaid covered services, including outpatient community-based treatment services, for all other Medicaid enrollees. In addition, FFS provides reimbursement for other certain services not otherwise covered under the IBHP managed care plan.

TABLE 6.2: Idaho SFY 2018 Expenditures on Community-Based Mental Health Services

Medicaid Population	Total Claim Dollars (Millions)	Federal	State - General Funds (Matchable)	State - County Funds (Local)
Managed Care+	$104.0	$74.0	$30.0	$0.0
MMCP Data	$2.9	$2.1	$0.8	$0.0
FFS Services	$181.4	$129.2	$52.2	$8.5
Total Community Based Mental Health Spend	**$296.9**	**$205.3**	**$83.0**	**$8.5**

+ Data reported by Optum, the current IBHP MCO.

While Idaho is committed to maintaining or improving access to community-based mental health services, the following are concerns with strictly using Medicaid claims and benefit data to measure MOE.

- Any potential future program changes, including expansion, may affect expenditures.
- County and local funding does not necessarily fall under the purview of the state.
- If the state transitions to more value-based reimbursement, may decline slightly without any loss of access or quality.

Section 7: List of Proposed Waivers

Idaho requests expenditure authority under this Section 1115 Waiver for otherwise covered services furnished to otherwise eligible individuals, ages 21 through 64, for short-term stays for acute care in a psychiatric hospital that qualifies as an IMD.

No additional waivers of Title XIX or Title XXI are requested through this demonstration application. All other initiatives and proposed program enhancements will be implemented through other authorities outside of this Section 1115 Waiver.

Section 8: Transparency

8.1 PUBLIC NOTICE

The IDHW is providing the public the opportunity to review and provide input on this Section 1115 Waiver in accordance with the requirements set forth at 42 CFR §431.408. On November 22, 2019, the draft Waiver was publicly posted on the IDHW website, which serves to formally open the public comment period. In addition, public notice was also published in newspapers in the state which serve cities with populations of at least 100,000, which includes the Idaho Statesman serving the cities of Boise (population 228,790) and Meridian (population 106,804).

Two public hearings will be held in two different locations: (1) December 2, 2019, in Boise, Idaho, which will have statewide teleconference capabilities; and (2) a public meeting at the Medical Care Advisory Committee (MCAC) on December 3, 2019. See *Appendix C* for a copy of the formal public notice document. Public comments will be received in person and in writing at the hearings, as well as in writing via mail and electronically via email through the comment period, which ends December 24, 2019.

8.2 TRIBAL NOTICE AND CONSULTATION

Separate notice to tribal representatives was provided on May 13, 2019. An update to that notice was also provided on November 22, 2019. See *Appendix D* for a copy of the tribal notices. A tribal meeting covering all of the concepts contained in Senate Bill 1204, the state legislation underlying this Waiver, was held on June 17, 2019. Further, following the posting of this Waiver, the IDHW has offered to provide an additional opportunity to meet with tribal representatives to cover any additional comments on the specific draft Section 1115 Waiver prior to submission to CMS, if requested.

8.3 PUBLIC COMMENT SUMMARY

The Idaho Department of Health and Welfare (IDHW) opened the formal public comment period on the draft of the waiver application on November 22, 2019 and closed December 24, 2019. Idaho used the following methods to provide notice to the public about the opportunity for public comment for this proposed waiver:

1. Web postings – Throughout the comment period, the IDHW's website at https://healthandwelfare.idaho.gov, featured a banner message specific to this waiver and the opportunity for public comment. The messaging provided comprehensive information and simple links to access the complete waiver application and all noticing. The comprehensive public notice and tribal update were also posted on this date on the Medicaid Expansion website located at https://medicaidexpansion.idaho.gov. An abbreviated version of the public notice was published in the *Idaho Statesman* on November 26, 2019.

2. E-mail – The IDHW established for this waiver a dedicated e-mail box, 1115.IMDBH@dhw.idaho.gov, which received a total of 366 e-mails by the December 24, 2019 deadline. In all, 312 (85%) of the emailed comments expressed support, and five (1%) opposed the waiver. The remaining comments were either indeterminate as to support/opposition or were directed toward one of the other waivers the state is pursuing.

3. Mailed – IDHW provided a U.S. Postal Service address: Comments were sent to the Division of Medicaid through traditional mail to P.O. Box 83720, Boise, Idaho 83720, as provided on the notices. A total of 3 comments were delivered via this method postmarked on or before the December 24, 2019 deadline.

4. Testimony at public hearings – The IDHW held two public hearings to receive the public's feedback on the Waiver. The first hearing was held on December 2, 2019 at the JR Williams Building, located at 700 W. State Street, Boise. The second was held on December 3, 2019 during a Medical Care Advisory Committee meeting at the Medicaid Central Office, 3232 Elder Street, Boise. Statewide access to both hearings was provided via teleconference lines and both were recorded for documentation. Individuals volunteered to provide oral testimony. In all, 11 individuals provided comments during the two public hearings.

Common themes expressed by commenters
The public comment period for this Section 1115 Waiver generated robust public input, with 380 comments total being submitted by various stakeholders during the comment period. Commenters included current Medicaid participants, participants' relatives, medical and behavioral health providers, advocacy organizations, and other interested parties. With the overwhelming share of responses conveying support (85%) and only a small minority expressing opposition (1%), a variety of common themes were raised, as discussed below.

General Opposition to the Waiver
Very few stakeholders opposed the waiver, but those who did tended to differ with the state on grounds of anti-government sentiment, opposition to Medicaid in general, and disagreement with tax dollars being spent helping addicts who, it was argued, developed their substance use disorders "by choice." Below are some typical expressions (adapted and paraphrased by the state) of general opposition to the waiver:

- Healthcare should be provided to the needy through religious charities, not through government.
- Drug abusers should pay for their own treatment and recovery.
- Substance abuse and addiction are choices that the addict has made, and taxpaying citizens should not be responsible for treatment.

The state received and took these comments under consideration, but since they were counter to direction to pursue the waiver under SB 1204, made no changes to the waiver application in response to the public comments received on this theme.

General Support for the Waiver
A vast majority of the respondents expressing support for the waiver participated in the public comment process through an automated email comment form set up through advocacy

organizations. Commenters—a significant number of whom were from out of state—had the option of sending the boilerplate talking points compiled for this advocacy campaign or customizing them per the commenter's own choices or experience with mental illness or substance abuse. The result was that most of the comments received by email reiterated many of the same talking points.

The talking points developed for the advocacy campaign were not fully accurate regarding the general purpose and impacts of the 1115 Demonstration. Specifically, the following three talking points contained errant information:

1. ***The IMD Waiver would allow for better reimbursement for mental health treatment in larger institutions.***
2. ***Rural Idahoans will be able to access treatment closer to their homes.***
3. ***Many Idahoans currently travel hundreds of miles to Boise*** to receive treatment, and this waiver will ameliorate this situation**.**

Addressing these in order:
Statement 1 focuses on reimbursement. While the 1115 waiver would allow Medicaid reimbursement of IMD services, there are no plans to increase reimbursement rates.

Statements 2 and 3 imply that Idaho has IMDs in rural areas, but that people with mental health diagnoses and substance use disorders have been unable to access these facilities. The further implication is that once the waiver is operational, these patients will be admitted to these local facilities and be treated closer to their homes, instead of being forced to seek treatment in Boise, which could involve a transport of 200 miles or more. In reality, all of the facilities that currently meet the definition of an IMD are located in non-rural areas. Over the short term, access to an IMD for Medicaid enrollees residing in Idaho's rural and frontier areas will continue to be a significant issue, which the state will seek to rectify over the term of the Demonstration. Notably, the state hopes that more treatment providers will participate in Idaho's healthcare system as a result of this waiver's implementation.

It is accurate to state that Idaho intends to improve access to inpatient care in the long term across all areas of the state. However, this issue runs counter to the overall purpose of the waiver. Fundamentally, Idaho seeks to achieve across-the-board reductions in the need for inpatient care through enhancement and expansion of the outpatient behavioral health continuum of care. The overall intent of the waiver is to reduce hospitalizations and Emergency Room visits by improving access to quality outpatient services.

Mental illness disproportionately affects those of lower socioeconomic status
Comments from a family medicine physician in Pocatello were typical of respondents who emphasized this theme. The physician mentioned his "struggle to access resources for these patients—people who cannot privately fund a substance abuse treatment facility, people who struggle to pay for the gas or bus fare to get to a treatment center, people who occupy a bed in our hospital for days beyond the necessity of their stay as we wait for a bed to open in a mental health facility."

The state acknowledges the respondent’s personal experience with barriers to health care access and appreciates the other commenters who weighed in on this common theme.

The state made no changes to the waiver application in response to the public comments received on this theme.

Everyone benefits when improvements to mental health treatment are implemented
Comments from a mental health professional with 30 years in the field were representative of the input received on this theme. She stated: “This is practical, not partisan... [G]iving poor people access to mental health services keeps them employable and productive members of society. Everyone benefits.”

The state commends the respondent’s long record of serving people who will be affected by this waiver and appreciates the others whose comments reflected this common theme.

The state made no changes to the waiver application in response to the public comments received on this theme.

Earlier intervention helps prevent the later need for criminal justice involvement
Comments from a former administrative official for one of Idaho's two public psychiatric hospitals pointed out that Idaho consistently ranks in the top 10 of all states for suicides, and additionally ranks at the bottom of all states for per capita public mental health funding.

Based on his personal experience working in the state public mental health system, the respondent made a strong case for expanding early intervention initiatives for mentally ill Idahoans:
“Access to the public psychiatric hospitals only occurs when a person has gone through the court system and found to be mentally ill and a danger to self or others or gravely disabled. That process in and of itself is very stressful to the person. Often a short stay in a local [hospital] can successfully address the immediate crisis without requiring a longer term, court ordered commitment.”

The state commends the respondent for his dedicated service to Idahoans diagnosed with mental health disorders. While early intervention was not among the common themes mentioned by numerous respondents, these comments provide valuable insights regarding criminal justice involvement as the state lays the groundwork for this waiver’s review/approval process and future implementation efforts.

The state made no changes to the waiver application in response to the public comments received on this theme. However, early intervention is a goal of the waiver, and efforts to address this critical need will be included in the state’s implementation plan for the waiver.

Recommendations to improve behavioral health service delivery
One respondent, a director for a community services organization, recommended changes to Idaho Medicaid’s current operational scheme for behavioral health. Outpatient services are

carved out and delivered through Optum Idaho, the contractor for the Idaho Behavioral Health Plan (IBHP).

The commenter stated that if the IBHP contractor were held responsible for hospital stays—i.e., made accountable for the entire behavioral health continuum of care—this would eliminate situations in which Optum is incentivized to save money by denying community-based services for high-need participants. In her estimation, the IBHP contractor should bear the financial burden of the consequences resulting from inadequate care.

State Response:
Although this suggestion does not directly call for changes to the waiver application content, the state wholeheartedly agrees with this recommendation. In fact, 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 in 2021 to operate the IBHP.

This RFP proposes a new structure for the IBHP, in which the selected contractor(s) will assume responsibility for all behavioral health services across the continuum of care—both inpatient and outpatient. Through contract monitoring, the selected contractor(s) 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 awardee(s), the state will give special emphasis to candidates'/awardees' 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.

8.4 DEMONSTRATION ADMINISTRATION CONTACT

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Appendix A: Idaho Behavioral Health Treatment Services Availability Environmental Scan

Combined Mental Health & Substance Use Disorder Services Availability Environmental Scan for Idaho

Prepared for

Idaho Department of Health and Welfare

Version: December 5, 2019

Mental Health Services

I. Summary of Available Services for Mental Health Treatment and Recovery in Idaho

With a population of approximately 1.7 million and an area of roughly 83,000 square miles, Idaho is the 7th least densely populated of the U.S. states. The state's capital and largest city is Boise located in Ada County in Region 4. The populations of Ada County and neighboring Canyon County comprise roughly 40% of Idaho's population and just 2% of its land mass. Much of the state of Idaho is very rural or frontier. Despite the rural nature of much of the state, Idaho offers access to outpatient and intensive outpatient mental health services in all of the 7 regions of the state. On the other hand, Idaho offers more limited access to intensive services, especially for adolescents and children.

Outpatient Service Choice Available Across Regions and Communities.

All seven regions offer outpatient service provider choice for mental health treatment services. Providers include facilities, integrated behavioral health clinics, individual practitioner offices, primary care clinics and telehealth. Idaho does not have any community mental health centers but does offer a strong network of 52 federally qualified health centers (FQHCs) delivering behavioral health services to residents in all seven regions.

Table 1A: Outpatient Mental Health Provider Availability by Region

Region	**Prescribers** Psychiatrists + Other Practitioners Authorized to Prescribe		**Non-Prescriber Providers** Psychologists, Counselors and Social Workers Independently Licensed		**Federally Qualified Health Centers with Behavioral Health Services**
	Licensed and Located in Idaho*	**Serving Medicaid, Accepting New Patients**	**Licensed and Located in Idaho**	**Serving Medicaid, Accepting New Patients**	
1	22	18	448	79	13
2	9	9	170	27	2
3	6	6	420	70	11
4	62	48	1632	196	9
5	6	2	290	27	4
6	6	2	304	21	10
7	12	6	455	37	3
Statewide	123	91	3719	457	52

**Licensed psychiatric nurse practitioner (NP) data is unavailable. Medicaid enrolled psychiatric NPs utilized for authorized provider count, which may underreport available prescribers.*

Idaho has long supported a telepsychiatry program, offering services in rural communities through telehealth to critical access hospitals and other rural sites across Idaho. 3 prescribers not located in

Idaho have served Medicaid patients in the past 12 months. Although not reflected in the data above, certain specialists based in one region will travel to deliver in person services in rural communities in other regions. For example, a child psychiatrist based in Boise in Region 4 travels to Regions 2 and 7 to deliver services to children and adolescents.

Other licensed professionals serve people with mental health disorders in Idaho, under the direction of the independently licensed professionals in Table 1. There are over 2300 licensed social workers who may serve people with mental health under appropriate supervision. Professionals offering peer support services and/or family support services are certified by a contractor for the Idaho Department of Health and Welfare. Idaho has 543 certified peer support partners and 88 family support partners statewide. Skills building / community-based rehabilitation services may be delivered by non-licensed individuals under the direction of independently licensed clinicians to build a person's competency and confidence while increasing functioning and decreasing mental health and/or behavioral symptoms.

Crisis Services: Each region has a behavioral health crisis center and access to one or more residential facility (Region 2 will open its first crisis center mid-2019.) The behavioral health crisis centers along with emergency rooms and 27 critical access hospitals throughout rural Idaho offer the first level of crisis support. Additionally, the state of Idaho delivers mobile crisis services. Only Boise in Region 4 and Spokane near Region 1 offer adolescent psychiatric crisis services. Adolescents in crisis are served through toll free crisis lines, hospital emergency rooms and a network of critical access hospitals in rural Idaho.

Idaho continues to develop comprehensive services for youth. For example, partial hospitalization for adolescents is newly offered in Region 4 and included in Table 2. Intensive outpatient and partial hospitalization services are available throughout Idaho although more rural areas have fewer service sites.

Table 2: Intensive Outpatient and Partial Hospitalization Services by Region

	Intensive Outpatient and Partial Hospitalization Services		
Region	**Provider Sites**	**Providers**	**Sites Accepting New Medicaid Patients**
1	11	2	11
2	1	1	1
3	1	1	1
4	7	6	7
5	3	3	3
6	1	1	1
7	6	3	6
Statewide	**30**	**15**	**30**

Idaho licensing and behavioral health authorities do not license, track or approve intensive outpatient or partial hospitalization providers as a distinct category. Number of providers based on credentialing for Idaho Medicaid via Optum Idaho and provider self-report. Fifteen (15) Idaho Behavioral Health Plan (Medicaid) credentialed providers by Tax Identification Number offer PHP or IOP services sometimes with multiple sites across regions.

Residential and Inpatient Services: While 413 adult psychiatric beds are available in all regions of the state, children and adolescents have much more limited service capabilities. Children and adolescents in Idaho must travel to Idaho Falls or Boise for the 63 inpatient adolescent beds, 12 PRTF beds and 6 inpatient child beds. In addition to the psychiatric beds in Table 4B, a Medicaid-enrolled acute care hospital in Region 7 will add additional 21 adult and 25 adolescent beds by 12/31/19.

Residential psychiatric care has not proliferated in Idaho. In addition to the 3 residential facilities in Table 3, 181 Residential Assisted Living Facilities in Idaho identify themselves as serving adults with mental health needs. However, only two in Region 4 as identified in Table 3 focus primarily on serving adult people with SMI. Idaho has only one licensed Psychiatric Residential Treatment Facility in Region 7 that serves adolescent females. Adolescents and children with SED residing in the state are also served in licensed certified family homes. These residential care facilities across the state provide a myriad of services not limited to mental health, including developmental disability services and rehabilitation.

Table 3: Residential Treatment Facilities

Region	**Residential Treatment - Adult**		**Psychiatric Residential Treatment - Adolescent**	
	Facilities - All	Beds - Accepting New Medicaid Patients	Facilities - All	Beds - Accepting New Medicaid Patients
1	--	--	--	--
2	--	--	--	--
3	--	--	--	--
4	2	24	--	--
5	--	--	--	--
6	--	--	--	--
7	--	--	1	12
Statewide	**2**	**24**	**1**	**12**

Table 4A: Psychiatric Hospital Services by Region

	Psychiatric Hospitals that Qualify as IMDs	Psychiatric Units in Hospitals*	
Region	Number of Psychiatric Hospitals that Qualify as IMDs	All	Accepting New Medicaid Patients
1	--	1	1
2	1	1	1
3	--	1	1
4	2	1	1
5	--	1	1
6	--	1	1
7	1	1	1
Statewide	**4**	**7**	**7**

*Data includes both acute care and critical access hospitals. One Idaho critical access hospital offers psychiatric services. It is located in Region 6 and serves the geriatric population.

Table 4B: Psychiatric Hospital Beds by Region and Age

	Psychiatric Inpatient Beds - Psychiatric Hospitals and Units in Acute Care Hospitals				
Region	**Adult**	**Adolescent**	**Child**	**Combined Total - All Ages**	**All Ages Accepting New Medicaid Patients**
1	16	--	--	16	16
2	75	--	--	75	20
3	19	--	--	19	19
4	142	47	6	195	45
5	28	--	--	28	28
6	19	--	--	19	19
7	114	16	--	130	24
Statewide	**413**	**63**	**6**	**486**	**171**

A public skilled nursing facility in Region 7 offers 29 beds serving adults with SMI.

II. Provider Maps

Region 1

Prescribing Practitioners	18
Non-Prescribing Practitioners	79
IOP and PHP Programs	11
Adult Residential Beds	--
Adolescent Residential Beds	--
Psychiatric Hospitals/IMDs	--
Hospitals with Psychiatric Units	1
Acute Care Beds (All Ages)	16
FQHC	13

Region 2

Prescribing Practitioners	9
Non-Prescribing Practitioners	27
IOP and PHP Programs	1
Adult Residential Beds	--
Adolescent Residential Beds	--
Psychiatric Hospitals/IMDs	1
Hospitals with Psychiatric Units	1
Acute Care Beds (All Ages)	20
FQHC	2

Region 3

Prescribing Practitioners	6
Non-Prescribing Practitioners	70
IOP and PHP Programs	1
Adult Residential Beds	--
Adolescent Residential Beds	--
Psychiatric Hospitals/IMDs	--
Hospitals with Psychiatric Units	1
Acute Care Beds (All Ages)	19
FQHC	11

Region 4

Prescribing Practitioners	48
on-Prescribing Practitioners	196
IOP and PHP Programs	7
Adult Residential Beds	24
Adolescent Residential Beds	--
Psychiatric Hospitals/IMDs	2
Hospitals with Psychiatric Units	1
Acute Care Beds (All Ages)	45
FQHC	9

Region 5

Prescribing Practitioners	2
Non-Prescribing Practitioners	27
IOP and PHP Programs	3
Adult Residential Beds	--
Adolescent Residential Beds	--
Psychiatric Hospitals/IMDs	--
Hospitals with Psychiatric Units	1
Acute Care Beds (All Ages)	28
FQHC	4

Region 6

Prescribing Practitioners	4
Non-Prescribing Practitioners	21
IOP and PHP Programs	1
Adult Residential Beds	--
Adolescent Residential Beds	--
Psychiatric Hospitals/IMDs	--
Hospitals with Psychiatric Units	1
Acute Care Beds (All Ages)	19
FQHC	10

Region 7

Prescribing Practitioners	6
Non-Prescribing Practitioners	37
IOP and PHP Programs	6
Adult Residential Beds	--
Adolescent Residential Beds	12
Psychiatric Hospitals/IMDs	1
Hospitals with Psychiatric Units	1
Acute Care Beds (All Ages)	24
FQHC	3

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III. Additional Tables

Please see "Idaho MH Environmental Analysis Data v20191203.xlsx" which was submitted with this document.

IV. Resources, Methodology and Limitations

The following resources were utilized for preparing this report:

- Optum Idaho, Blue Cross of Idaho and MMIS Provider Data for Medicaid providers
- BPA Health provider network data as of May 2019
- Optum Idaho Provider data September 2019
- Idaho hospital license data as of June 2019 and other facility licensure as of September 2019 through Idaho Department of Health and Welfare.
- Professional licensure and certification data as of June 2019 through Board of Medicine, IBOL and IBADCC
- Crisis center data available online as of June 2019
- Member counts reported by Idaho Department of Health and Welfare, Division of Medicaid, as of August 2019

Adolescent providers are designated as those who treat individuals under 18 in Idaho.

Idaho facility and hospital licensure does not track bed by bed type; therefore, bed detail was obtained through telephone inquiry June – September 2019.

Substance Use Disorder Services

V. Summary of Available Services for Substance Use Disorder Treatment and Recovery in Idaho

With a population of approximately 1.7 million and an area of roughly 83,000 square miles, Idaho is the 7th least densely populated of the U.S. states. The state's capital and largest city is Boise located in Ada County in Region 4. The populations of Ada County and neighboring Canyon County comprise roughly 40% of Idaho's population and just 2% of its land mass. Much of the state of Idaho is very rural or frontier. Despite the rural nature of much of the state, Idaho offers access to outpatient and intensive outpatient substance use disorder services in all of the 7 regions of the state. In addition to nearly 200 medication-assisted therapy prescribers, any licensed pharmacist and pharmacy technician can prescribe Naloxone in Idaho. On the other hand, Idaho offers more limited access to more intensive services, especially for adolescents.

Outpatient Service Choice Available Across Regions and Communities.

All seven regions offer outpatient service provider choice for substance use disorder (SUD) treatment services. Providers include SUD-focused facilities, integrated behavioral health clinics, individual practitioner offices, primary care clinics and telehealth.

Table 1A: Licensed Provider Availability by Region – ASAM Level 1.0

Region	**Prescribers** Psychiatrists + Other Practitioners Authorized to Prescribe		**Medication-Assisted Therapy (MAT) Prescribers** All specialties~	**Non-Prescriber Providers** Psychologists, Counselors and Social Workers Independently Licensed	
	Licensed and Located in Idaho*	**Serving Medicaid, Accepting New Patients**	**Licensed and Located in Idaho**	**Licensed and Located in Idaho**	**Serving Medicaid, Accepting New Patients**
1	22	18	36	448	79
2	9	9	16	170	27
3	6	6	25	420	70
4	62	48	69	1632	196
5	6	2	16	290	27
6	6	2	17	304	21
7	12	6	18	455	37
Statewide	123	91	197	3719	457

**Licensed psychiatric NP data is unavailable. Medicaid enrolled psychiatric NPs utilized for authorized provider count, which may underreport available prescribers.*

~MAT providers were not compared to enrolled providers since provision of MAT services is beyond behavioral health specialties.

Consistent with Idaho's MAT strategies statewide, the Medication Assisted Treatment Provider data for this report includes all prescribers as recorded in the SAMHSA Treatment locater. These data include specialties beyond behavioral health. In addition to the nearly two hundred MAT Prescribers with DATA 2000 waivers listed in Table 1A, legislation passed in 2015 made Naloxone available to anyone in Idaho by simply asking their pharmacist. In 2019, Idaho enhanced access by adding pharmacy technicians as legal prescribers of Naloxone.

Idaho has long supported a telepsychiatry program, offering services in rural communities through telehealth to critical access hospitals and other rural sites across Idaho. 3 prescribers not located in Idaho have served Medicaid patients in the past 12 months. Although not reflected in the data above, certain specialists based in one region will travel to deliver in person services in rural communities in other regions. For example, a child psychiatrist based in Boise in Region 4 travels to Regions 2 and 7 to deliver services to children and adolescents.

Table 1B: Intensive Outpatient Provider Site Counts by Region – ASAM Level 2.1

Region	Adult Intensive Outpatient		Adolescent Intensive Outpatient	
	Service Sites	Sites Accepting New Medicaid Patients	Service Sites	Accepting New Medicaid Patients
1	14	14	9	9
2	7	5	4	4
3	16	12	11	11
4	15	11	8	8
5	14	11	10	10
6	9	2	8	8
7	22	20	20	20
Statewide	97	75	70	70

Intensive Outpatient Services are available for all ages throughout Idaho although more rural areas have fewer service sites. Other certified and/or licensed professionals serve people with substance use disorder in Idaho, often as part of intensive outpatient services, under the direction of the independently licensed professionals in Table 1A. Their certifications are maintained by professional boards including the Idaho Bureau of Occupational Licenses and the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC) which oversees alcohol and drug counselors, prevention specialists and peer recovery coaches. There are 376 currently certified Alcohol/Drug Counselors, nearly fifty recovery coaches and over 2300 licensed social workers who may serve people with substance use disorder under the direction of clinicians in Table 1A.

While all regions offer ASAM 1.0 outpatient services including medication assisted treatment (MAT) services and ASAM 2.1 intensive outpatient services, availability of higher levels of care is not as

comprehensive in more rural areas. Idaho adults have access to residential or inpatient SUD services in 6 of 7 regions.

Idaho offers more limited access to residential and inpatient substance use disorder services, especially for adolescents. Each region has a behavioral health crisis center and access to one or more inpatient or residential facility serving adults with SUD including either social or medical detoxification. (Region 2 will open its first crisis center mid-2019.) The behavioral health crisis centers along with emergency rooms and 27 critical access hospitals throughout rural Idaho offer (not depicted in the table below) the first level of crisis support.

Table 2: Adult SUD Services ASAM 2.5-4.0

Region	Adult SUD Beds	ASAM 3.1 Adult Facilities	ASAM 3.5 Adult Facilities	ASAM 3.7 Adult Facilities	ASAM 4 Adult Facilities
1	62	1	1	2	--
2	--	--	--	--	--
3	26	2	1	--	--
4	54	--	--	1	1
5	74	1	--	--	1
6	14	1	1	--	--
7	34	2	2	--	--
Total	**264**	**7**	**5**	**3**	**2**

In addition, Regions 3, 4 and 5 have 86 adult psychiatric beds available for those who also have a co-occurring SUD diagnosis. State hospitals in Regions 2 and 7 also serve adults in psychiatric crisis.

Adolescents in Idaho have limited access higher levels of care within the state. Only Boise in Region 4 and Spokane near Region 1 offer adolescent psychiatric crisis services and the Boise facility is limited to those with a primary mental health diagnosis. Adolescents are served through hospital emergency rooms and a network of critical access hospitals in rural Idaho.

Adolescent boys must travel outside of the state for residential or inpatient SUD treatment. If their primary diagnosis is mental health, there is an inpatient facility in Boise with 17 male beds that can serve them. Idaho has two adolescent locations offering ASAM Level 3.1 or higher. Located in Region 6 in eastern Idaho, one facility provides 12 beds for adolescent girls and the other in Boise offers space for male and female adolescents. In North Idaho, neighboring city of Spokane offers additional residential

treatment for adolescents. Beyond these facilities, adolescents must travel to urban areas of Seattle, Portland and Salt Lake City.

Table 3: Adolescent SUD Services ASAM 2.5-4.0

Region	SUD Beds	Crisis Facilities	ASAM 2.5 Facilities	ASAM 3.1 Facilities	ASAM 3.3 Facilities	ASAM 3.5 Facilities	ASAM 3.7 Facilities	ASAM 4 Facilities
	Adolescent Only							
1	--	--	--	--	--	--	--	--
2	--	--	--	--	--	--	--	--
3	6	--	--	1	--	--	--	--
4	8	1	--	1	--	--	--	--
5	--	--	--	--	--	--	--	--
6	12	--	--	1	--	--	--	--
7	--	--	--	--	--	--	--	--
Total	**26**	**1**	--	**3**	**--**	**--**	--	**--**

VI. Provider Map

Region 1	
Prescribers	18
MAT Prescribers	36
Non-prescribers	79
Adult IOP Programs	14
Adolescent IOP Programs	9
Adult Residential Beds	62
Adolescent Residential Beds	--

Region 2	
Prescribers	9
MAT Prescribers	16
Non-prescribers	27
Adult IOP Programs	5
Adolescent IOP Programs	4
Adult Residential Beds	--
Adolescent Residential Beds	--

Region 3	
Prescribers	6
MAT Prescribers	25
Non-prescribers	70
Adult IOP Programs	12
Adolescent IOP Programs	11
Adult Residential Beds	26
Adolescent Residential Beds	6

Region 4	
Prescribers	48
MAT Prescribers	69
Non-prescribers	196
Adult IOP Programs	11
Adolescent IOP Programs	8
Adult Residential Beds	54
Adolescent Residential Beds	8

Region 5	
Prescribers	2
MAT Prescribers	16
Non-prescribers	21
Adult IOP Programs	11
Adolescent IOP Programs	10
Adult Residential Beds	74
Adolescent Residential Beds	--

Region 6	
Prescribers	2
MAT Prescribers	17
Non-prescribers	21
Adult IOP Programs	2
Adolescent IOP Programs	8
Adult Residential Beds	14
Adolescent Residential Beds	12

Region 7	
Prescribers	6
MAT Prescribers	18
Non-prescribers	37
Adult IOP Programs	20
Adolescent IOP Programs	20
Adult Residential Beds	34
Adolescent Residential Beds	--

VII. Additional Tables

We have adapted the "Draft Mental Health Services Availability Assessment Template 05022019.xlsm". We have updated the table to represent substance use disorders levels of service. Please see "Idaho SUD Environmental Analysis Data 20191203.xlsx" which was submitted with this document.

VIII. Resources, Methodology and Limitations

The following resources were utilized for preparing this report:

- Optum Idaho, Blue Cross of Idaho and MMIS Provider Data for Medicaid providers
- BPA Health provider network data as of May 2019
- Optum Idaho Provider Network pulled from optumidaho.com in June 2019 and current as of February 2019
- SAMHSA Provider Locator Data as of June 2019 for DATA 2000 waivered prescribers
- IDHW Approved Provider Lists by Region as of June 2019
- Idaho 211 Provider Lists as of June 2019
- Idaho hospital license data as of June 2019. Idaho facility and hospital licensure does not track bed by bed type; therefore, bed detail was obtained through telephone inquiry June – September 2019.
- Professional licensure and certification data as of June 2019 through Board of Medicine, IBOL and IBADCC
- Crisis center data available online as of June 2019
- Member counts and Members with SUD reported by Idaho Department of Health And Welfare, Division of Medicaid, as of August 2019

Idaho Department of Health and Welfare, Optum Idaho, Blue Cross of Idaho and SAMHSA data did not contain details on ASAM Level. ASAM Level 2.1 data may not be comprehensive and was obtained through internet research, telephone inquiry and BPA Health provider network data.

There are co-occurring inpatient beds where patients are required to have a primary mental health diagnosis. These beds are not counted in the overall SUD bed counts.

Adolescent providers are designated as those who treat individuals under 18 in Idaho.

Introduction to the Assessment of the Availability of Mental Health Services

This template has four tabs: 1) Instructions, 2) Definitions, 3) Narrative Description, and 4) Availability Assessment.

States are expected to complete the Narrative Description once, at the beginning of the demonstration, and the Availability Assessment annually following the instructions on the Instructions tab

Questions should be directed to your CMS Project Officer

Instructions for Completing the Narrative Description ("Narrative Description" tab)

The state will provide a brief narrative of baseline conditions in place at the beginning of the demonstration in the Narrative Description tab. The state should provide a brief response in the space below each question. The state should complete this at the beginning of the demonstration only.

Instructions for Completing the Assessment of the Availability of Mental Health Services ("Availability Assessment" tab)

Before you begin:	**The state will submit multiple availability assessments. The state will submit an initial assessment at the time of application and annual assessments thereafter.**
	The state should select a consistent month in each year to populate the information in the availability assessment (e.g. provide initial information based on counts covering August 2019, and update the information based on counts covering August 2020, August 2021, August 2022, and August 2023).
	Enter the state name, data entry date(s), and time period reflected in the availability assessment in cells C1-3.
	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
B	In column B, enter each geographic designation starting in cell B8. Add rows as needed to capture all geographic designations. Geographic designation means a state-defined geographic unit for reporting data, such as county, region, or catchment area. The state should consider how it divides its mental health system into smaller units or catchment areas to select geographic designations that will yield meaningful, actionable information.
C	In column C, starting in cell C8, please select whether geographic designation entered in the corresponding cell in column B could be considered urban or rural. If the geographic designation should be categorized as something other than urban or rural, select "Other-please explain" and record an explanation in the notes box in column D. Urban is defined as a Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget (42 CFR § 412.64(b)) Rural is defined as any area outside an urban area as defined in 42 CFR § 412.64(b).
D	In column D, beginning in cell D8, please use this space to explain the state's response if the state selects 'Other-please explain' in column C.
E	In column E, starting in cell E8, enter the total number of adult Medicaid beneficiaries **ages 18-20** in each geographic designation at the selected point in time. Medicaid beneficiary means a person who has been determined to be eligible to receive Medicaid services as defined at 42 CFR §400.200. Note: this age category is separate in order to avoid double counting beneficiaries in the residential treatment category and to facilitate the calculation of certain ratios in the assessment. See the note in the following cell for additional explanation

Instructions for Completing the Narrative Description ("Narrative Description" tab)

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	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
F	In column F, starting in cell F8, enter the number of adult Medicaid beneficiaries **ages 18-20 with SMI** in each geographic designation at the selected point in time. As defined on page 1 of the State Medicaid Directors Letter, serious mental illness means persons age 18 and over who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. Note: in the State Medicaid Directors letter (SMDL #18-011), SMI is defined to include individuals age 18 years and older, and SED includes children younger than 18. However, the residential treatment section of the availability assessment requests data on PRTFs, and the federal definition for PRTFs includes facilities that serve individuals under the age of 21. In order to avoid double counting beneficiaries in the residential treatment category, the assessment requests data on beneficiaries age 0-17, 18-20, and 21 and older separately.
G	In column G, starting in cell G8, enter the total number of adult Medicaid beneficiaries **age 21 and older** in each geographic designation at the selected point in time.
H	In column H, starting in cell H8, enter the number of adult Medicaid beneficiaries **age 21 and older with SMI** in each geographic designation at the selected point in time. Note: in the SMDL, SMI is defined to include individuals age 18 years and older, and SED includes children younger than 18. However, the residential treatment section of the availability assessment requests data on PRTFs, and the federal definition for PRTFs includes facilities that serve individuals under the age of 21. In order to avoid double counting beneficiaries in the residential treatment category, the assessment requests data on beneficiaries age 0-17, 18-20, and 21 and older separately.
I	In column I, starting in cell I8, the availability assessment will automatically calculate the percent of adult Medicaid beneficiaries who have SMI in each geographic designation. The state should not input any values into this column or modify the formulas in this column.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

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	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
J	In column J, starting in cell J8, enter the total number of Medicaid beneficiaries **under the age of 18** in each geographic designation at the selected point in time.
K	In column K, starting in cell K8, enter the number of beneficiaries **under the age of 18 with SED** in each geographic designation at the selected point in time. As defined on page 2 of the SMDL, individuals with SED are those from birth up to age 18 who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment" is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills.
L	In column L starting in cell L8, the availability assessment will automatically calculate the percent of beneficiaries **under the age of 18 who have SED** in each geographic designation. The state should not input any values into this column or modify the formulas in this column.
M	In column M, starting in cell M8, the availability assessment will automatically calculate the number of Medicaid beneficiaries (total) in each geographic designation.
N	In column N, starting in cell N8, the availability assessment will automatically calculate the percent with Medicaid beneficiaries with SMI or SED (total) in each geographic designation.
O	In column O, starting in cell O8, the availability assessment will automatically calculate the percent with SMI or SED (total) in each geographic designation.
P	In column P, beginning in cell P8, please use this space to provide notes about or qualifications to beneficiary data. For example, use this cell to explain data limitations or missing data.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

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	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
Q	In column Q, starting in cell Q8, enter the number of **psychiatrists or other practitioners who are authorized to prescribe** in each geographic designation. A psychiatrist is any psychiatrist licensed to practice in the state under state licensure laws. Other prescribers authorized to prescribe means the number of mental health practitioners other than psychiatrists who are authorized to prescribe as defined by state licensure laws.
R	In column R, starting in cell R8, enter the number of **Medicaid-enrolled psychiatrists or other practitioners who are authorized to prescribe** in each geographic designation. Medicaid-enrolled means any provider enrolled in Medicaid to obtain Medicaid billing privileges, as defined in 42 CFR §455.410.
S	In column S, starting in cell S8, enter the number of **Medicaid-enrolled psychiatrists or other practitioners who are authorized to prescribe and are accepting new Medicaid patients** in each geographic designation. Accepting new Medicaid patients means any provider enrolled in Medicaid to obtain Medicaid billing privileges who will treat new Medicaid-enrolled patients.
T-V	In columns T-V, starting in cell T8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
W	In column W, beginning in cell W8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
X	In column X, starting in cell X8, enter the number of **other practitioners certified or licensed to independently treat mental illness** in each geographic designation. Other types of practitioners certified or licensed to independently treat mental illness means non-psychiatrist mental health providers who are certified or licensed to independently treat mental illness as defined by state licensure laws. This may include, but is not limited to, licensed psychologists, clinical social workers, and professional counselors.
Y	In column Y, starting in cell Y8, enter the number of **Medicaid-enrolled other types of practitioners certified and licensed to independently treat mental illness** in each geographic designation.
Z	In column Z, starting in cell Z8, enter the number of **Medicaid-enrolled other types of practitioners certified and licensed to independently treat mental illness accepting new Medicaid patients** in each geographic designation.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

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	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
AA-AC	In columns AA-AC, starting in cell AA8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
AD	In column AD, beginning in cell AD8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
AE	In column AE, starting in cell AE8, enter the number of **community mental health centers (CMHCs)** in each geographic designation. A community mental health center is an entity that provides outpatient mental health services, 24 hour emergency care services, day treatment, screenings, and consultation and educational services, as defined at 42 CFR §410.2.
AF	In column AF, starting in cell AF8, enter the number of **Medicaid-enrolled CMHCs** in each geographic designation.
AG	In column AG, starting in cell AG8, enter the number of **Medicaid-enrolled CMHCs accepting new Medicaid patients** in each geographic designation.
AH-AJ	In columns AH-AJ, starting in cell AH8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
AK	In column AK, beginning in cell AK8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
AL	In column AL, starting in cell AL8, enter the number of **intensive outpatient/partial hospitalization providers** in each geographic designation. Partial hospitalization or intensive outpatient services means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting.
AM	In column AM, starting in cell AM8, enter the number of **Medicaid-enrolled intensive outpatient/partial hospitalization providers** in each geographic designation.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

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Instructions for Completing the Assessment of the Availability of Mental Health Services ("Availability Assessment" tab)

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Column	Instructions
AN	In column AN, starting in cell AN8, enter the number of **Medicaid-enrolled intensive outpatient/partial hospitalization providers accepting new Medicaid patients** in each geographic designation.
AO-AQ	In column AO-AQ, starting in cell AO8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
AR	In column AR, beginning in cell AR8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
AS	In column AS, starting in cell AS8, enter the number of **residential mental health treatment facilities (adult)** in each geographic designation. A residential mental health treatment facilities (adult) is a facility not licensed as a psychiatric hospital, whose primary purpose is to provide individually planned programs of mental health treatment services in a residential care setting for adults as defined for SAMHSA's N-MHSS. Please exclude residential SUD treatment facilities.
AT	In column AT, starting in cell AT8, enter the number of **Medicaid-enrolled residential mental health treatment facilities (adult)** in each geographic designation.
AU	In column AU, starting in cell AU8, enter the number of **Medicaid-enrolled residential mental health treatment facilities (adult) accepting new Medicaid patients** in each geographic designation.
AV-AX	In column AV-AX, starting in cell AV8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
AY	In column AY, starting in cell AY8, enter the total number of **residential mental health treatment facility beds (adult)** in each geographic designation.
AZ	In column AZ, starting in cell AZ8, enter the total number of **Medicaid-enrolled residential mental health treatment beds (adult)** in each geographic designation.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

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	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
BA	In column BA, starting in cell BA8, enter the total number of **Medicaid-enrolled residential mental health treatment beds available to adult Medicaid patients** in each geographic designation. Available to Medicaid adult Medicaid patients means any facility or bed available to serve Medicaid patients over the age of 18.
BB-BD	In column BB-BD, starting in cell BB8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
BE	In column BE, beginning in cell BE8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
BF	In column BF, starting in cell BF8, enter the number of **psychiatric residential treatment facilities (PRTF)** in each geographic designation. A PRTF is a non-hospital facility with a provider agreement with a state Medicaid agency to provide the inpatient psychiatric services to individuals under age 21 benefit (psych under 21 benefit). The facility must be accredited by the Joint Commission, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting organization with comparable standards recognized by the State. PRTFs must also meet the requirements at 42 CFR §441.151 - §441.182, and 42 CFR §483.350 – §483.376.
BG	In column BG, starting in cell BG8, enter the number of **Medicaid-enrolled PRTFs** in each geographic designation.
BH	In column BH, starting in cell BH8, enter the number of **Medicaid-enrolled PRTFs accepting new Medicaid patients** in each geographic designation.
BI-BK	In column BI-BK, starting in cell BI8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.

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Column	Instructions
BL	In column BL, starting in cell BL8, enter the total number of **PRTF beds** in each geographic designation.
BM	In column BM, starting in cell BM8, enter the number of **Medicaid-enrolled PRTF beds** in each geographic designation.
BN	In column BN, starting in cell BN8, enter the number of **Medicaid-enrolled PRTF beds available to Medicaid patients** in each geographic designation. Available to Medicaid patients means any facility or bed available to serve Medicaid patients.
BO-BQ	In column BO-BQ, starting in cell BO8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
BR	In column BR, beginning in cell BR8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
BS	In column BS, starting in cell BS8, enter the number of **psychiatric hospitals** in each geographic designation. A psychiatric hospital is an institution which provides diagnosis and treatment of mentally ill persons, as defined at 42 USC §1395x.
BT	In column BT, starting in cell BT8, enter the number of **psychiatric hospitals available to Medicaid patients** in each geographic designation.
BU-BV	In column BU-BV, starting in cell BU8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
BW	In column BW, beginning in cell BW8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

The state will provide a brief narrative of baseline conditions in place at the beginning of the demonstration in the Narrative Description tab. The state should provide a brief response in the space below each question. The state should complete this at the beginning of the demonstration only.

Instructions for Completing the Assessment of the Availability of Mental Health Services ("Availability Assessment" tab)

Before you begin:	**The state will submit multiple availability assessments. The state will submit an initial assessment at the time of application and annual assessments thereafter.**
	The state should select a consistent month in each year to populate the information in the availability assessment (e.g. provide initial information based on counts covering August 2019, and update the information based on counts covering August 2020, August 2021, August 2022, and August 2023).
	Enter the state name, data entry date(s), and time period reflected in the availability assessment in cells C1-3.
	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
BX	In column BX, starting in cell BX8, enter the number of **psychiatric units in acute care hospitals** in each geographic designation. A psychiatric unit is a separate inpatient psychiatric unit of a general hospital that provides inpatient mental health services and has specifically allocated staff and space (beds) for the treatment of persons with mental illness, as defined for SAMHSA's N-MHSS.
BY	In column BY, starting in cell BY8, enter the number of **psychiatric units in critical access hospitals (CAHs)** in each geographic designation. A critical access hospital is a small facility that provides 24-hour emergency care, outpatient services, as well as inpatient services to people in rural areas, as defined in 42 CFR §485.606.
BZ	In column BZ, starting in cell BZ8, enter the number of **Medicaid-enrolled psychiatric units in acute care hospitals** in each geographic designation.
CA	In column CA, starting in cell CA8, enter the number of **Medicaid-enrolled psychiatric units in CAHs** in each geographic designation.
CB	In column CB, starting in cell CB8, enter the number of **Medicaid-enrolled psychiatric units in acute care hospitals accepting new Medicaid patients** in each geographic designation.
CC	In column CC starting in cell CC8, enter the number of **Medicaid-enrolled psychiatric units in CAHs accepting new Medicaid patients** in each geographic designation.
CD-CI	In column CD-CI, starting in cell CD8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
CJ	In column CJ, beginning in cell CJ8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
CK	In column CK, starting in cell CK8, enter the number of **licensed psychiatric hospital beds (psychiatric hospital + psychiatric units)** in each geographic designation. Please enter the number of licensed psychiatric hospital beds as defined by state licensure requirements.
CL	In column CL, starting in cell CL8, enter the number of **licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) available to Medicaid patients** in each geographic designation.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

The state will provide a brief narrative of baseline conditions in place at the beginning of the demonstration in the Narrative Description tab. The state should provide a brief response in the space below each question. The state should complete this at the beginning of the demonstration only.

Instructions for Completing the Assessment of the Availability of Mental Health Services ("Availability Assessment" tab)

Before you begin:	**The state will submit multiple availability assessments. The state will submit an initial assessment at the time of application and annual assessments thereafter.**
	The state should select a consistent month in each year to populate the information in the availability assessment (e.g. provide initial information based on counts covering August 2019, and update the information based on counts covering August 2020, August 2021, August 2022, and August 2023).
	Enter the state name, data entry date(s), and time period reflected in the availability assessment in cells C1-3.
	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
CM-CN	In column CM-CN, starting in cell CM8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
CO	In column CO, beginning in cell CO8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
CP	In column CP, starting in cell CP8, enter the number of **residential mental health treatment facilities (adult) that qualify as an institution for mental diseases (IMDs)** in each geographic designation. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services per section 1905(i) of the Social Security Act. See also 42 CFR §435.1010 and section 4390 of the State Medicaid Manual.
CQ	In column CQ, starting in cell CQ8, enter the number of **Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs** in each geographic designation.
CR	In column CR, starting in cell CR8, enter the number of **Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs accepting Medicaid patients** in each geographic designation.
CS-CU	In column CS-CU, starting in cell CS8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
CV	In column CV, starting in cell CV8, enter the number of **psychiatric hospitals that qualify as IMDs** in each geographic designation.
CW	In column CW, starting in cell CW8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
CX	In column CX, beginning in cell CX8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

The state will provide a brief narrative of baseline conditions in place at the beginning of the demonstration in the Narrative Description tab. The state should provide a brief response in the space below each question. The state should complete this at the beginning of the demonstration only.

Instructions for Completing the Assessment of the Availability of Mental Health Services ("Availability Assessment" tab)

Before you begin:	**The state will submit multiple availability assessments. The state will submit an initial assessment at the time of application and annual assessments thereafter.**
	The state should select a consistent month in each year to populate the information in the availability assessment (e.g. provide initial information based on counts covering August 2019, and update the information based on counts covering August 2020, August 2021, August 2022, and August 2023).
	Enter the state name, data entry date(s), and time period reflected in the availability assessment in cells C1-3.
	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
CY	In column CY, starting in cell CY8, enter the number of **crisis call centers** in each geographic designation. Please enter the number of crisis call centers as defined by the state.
CZ	In column CZ, starting in cell CZ8, enter the number of **mobile crisis units** in each geographic designation. A mobile crisis unit is a team that intervenes during mental health crises, as defined by the state.
DA	In column DA, starting in cell DA8, enter the number of **crisis observation/ assessment centers** in each geographic designation. Please enter the number of observation or assessment centers as defined by the state.
DB	In column DB, starting in cell DB8, enter the number of **crisis stabilization units** in each geographic designation. Crisis stabilization units offer medically monitored short-term crisis stabilization services, as defined by the state.
DC	In column DC, starting in cell DC8, enter the number of **coordinated community crisis response teams** in each geographic designation. Coordinated community crisis response means a community-based program or entity that
DD-DH	In column DD-DH, starting in cell DD8, the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.
DI	In column DI, beginning in cell DI8, please use this space to provide notes about or qualifications to category data. For example, use this cell to explain data limitations or missing data.
DJ	In column DJ, starting in cell DJ8, enter the number **FQHCs that offer behavioral health services** in each geographic designation. Federally qualified health center (FQHC) means an entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR §405.2434 and 42 CFR §405.2401.
DK	In column DK, starting in cell DK8,the availability assessment will automatically calculate the ratios in each geographic designation. The state should not input any values into these columns or modify the formulas in these columns.

Instructions for Completing the Narrative Description ("Narrative Description" tab)

The state will provide a brief narrative of baseline conditions in place at the beginning of the demonstration in the Narrative Description tab. The state should provide a brief response in the space below each question. The state should complete this at the beginning of the demonstration only.

Instructions for Completing the Assessment of the Availability of Mental Health Services ("Availability Assessment" tab)

Before you begin:	**The state will submit multiple availability assessments. The state will submit an initial assessment at the time of application and annual assessments thereafter.**
	The state should select a consistent month in each year to populate the information in the availability assessment (e.g. provide initial information based on counts covering August 2019, and update the information based on counts covering August 2020, August 2021, August 2022, and August 2023).
	Enter the state name, data entry date(s), and time period reflected in the availability assessment in cells C1-3.
	To add rows for additional geographic designations, click the "Add row" button.

Column	Instructions
DL	In column DL, beginning in cell DL8, please use this space to provide notes about or qualifications to category data.
DM	Beginning in column DM, add additional counts and ratios for provider and setting types that the state considers important to its mental health system. The state should not modify any of the previous columns.

Definitions of terms used in the Availability Assessment	
Term	**Definition**
Accepting new Medicaid patients	***Accepting new Medicaid patients*** means any provider enrolled in Medicaid to obtain Medicaid billing privileges who will treat new Medicaid-enrolled patients.
Available to Medicaid patients	***Available to Medicaid patients*** means any facility or bed available to serve Medicaid patients.
Adult	An ***adult*** is a person age 18 and over [SMDL].
Community mental health center (CMHC)	A ***community mental health center (CMHC)*** is an entity that provides outpatient mental health services, 24 hour emergency care services, day treatment, screenings, and consultation and educational services, as defined at 42 CFR §410.2.
Coordinated community crisis response	***Coordinated community crisis response*** means a community-based program or entity that manages crisis response across various community entities or programs, as defined by the state.
Crisis call center	C***risis call centers*** are defined by the state.
Crisis stabilization unit	***Crisis stabilization units*** offer medically monitored short-term crisis stabilization services, as defined by the state.
Critical access hospital	A ***critical access hospital*** is a small facility that provides 24-hour emergency care, outpatient services, as well as inpatient services to people in rural areas, as defined in 42 CFR §485.606.
Federally qualified health center	***Federally qualified health center (FQHC)*** means an entity that has entered into an agreement with CMS to meet Medicare program requirements under 42 CFR §405.2434 and 42 CFR §405.2401
Geographic designation	***Geographic designation*** means a state-defined geographic unit for reporting data, such as county, region, or catchment area.
Institution for mental diseases (IMD)	An ***institution for mental diseases*** is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services per section 1905(i) of the Social Security Act. See also 42 CFR §435.1010 and section 4390 of the State Medicaid Manual.
Intensive outpatient services or partial hospitalization	***Intensive outpatient services or partial hospitalization*** means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting.
Licensed psychiatric hospital bed	***Licensed psychiatric hospital beds*** are defined by state licensure requirements.
Medicaid beneficiary	***Medicaid beneficiary*** means a person who has been determined to be eligible to receive Medicaid services as defined at 42 CFR §400.200.
Medicaid-enrolled	***Medicaid-enrolled*** means any provider enrolled in Medicaid to obtain Medicaid billing privileges, as defined in 42 CFR §455.410.

Definitions of terms used in the Availability Assessment	
Term	**Definition**
Mobile crisis unit	A ***mobile crisis unit*** is a team that intervenes during mental health crises, as defined by the state.
Mental health practitioners other than psychiatrists who are authorized to prescribe	***Mental health practitioners other than psychiatrists who are authorized to prescribe*** are defined by state licensure laws.
Mental health practitioners other than psychiatrists who are certified or licensed by the state to independently treat mental illness.	***Mental health practitioners other than psychiatrists who are certified or licensed to treat mental illness*** are non-psychiatrist mental health providers who are certified or licensed to independently treat mental illness as defined by state licensure laws. This may include, but is not limited to, licensed psychologists, clinical social workers, and professional counselors .
Observation or assessment centers	***Observation or assessment centers*** are defined by the state.
Psychiatric hospital	A ***psychiatric hospital*** is an institution which provides diagnosis and treatment of mentally ill person, as defined at 42 USC §1395x.
Psychiatric residential treatment facility (PRTF)	A ***psychiatric residential treatment facility*** is a non-hospital facility with a provider agreement with a state Medicaid agency to provide the inpatient psychiatric services to individuals under age 21 benefit (psych under 21 benefit). The facility must be accredited by the Joint Commission, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting organization with comparable standards recognized by the State. PRTFs must also meet the requirements at 42 CFR §441.151 - §441.182, and 42 CFR §483.350 – §483.376.
Psychiatric unit	A ***psychiatric unit*** is a separate inpatient psychiatric unit of a general hospital that provides inpatient mental health services and has specifically allocated staff and space (beds) for the treatment of persons with mental illness, as defined for SAMHSA's National Mental Health Services Survey (N-MHSS).
Psychiatrist	A ***psychiatrist*** is any psychiatrist licensed to practice in the state under state licensure laws
Residential mental health treatment facilities (adult)	A ***residential mental health treatment facilities (adult)*** is a facility not licensed as a psychiatric hospital, whose primary purpose is to provide individually planned programs of mental health treatment services in a residential care setting for adults as defined for SAMHSA's N-MHSS. Please exclude residential SUD treatment facilities.
Rural	***Rural*** means any area outside an urban area as defined in 42 CFR § 412.64(b)

Definitions of terms used in the Availability Assessment	
Term	**Definition**
Serious emotional disturbance	*Persons with* ***serious emotional disturbance*** means individuals from birth up to age 18 who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment" is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills [SMDL].
Serious mental illness	*Persons with* ***serious mental illness*** means individuals, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. [SMDL] Note: in the SMDL, SMI is defined to include individuals age 18 years and older, and SED includes children younger than 18. However, the residential treatment section of the availability assessment requests data on PRTFs, and the federal definition for PRTFs includes facilities that serve individuals under the age of 21. In order to avoid double counting beneficiaries in the residential treatment category, the assessment requests data on beneficiaries age 0-17, 18-20, and 21 and older separately.
Urban	***Urban*** means a Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget (42 CFR § 412.64(b)).

Narrative Description (to be completed at baseline)
1. In the space below, describe the mental health service needs (e.g. prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. [Limit responses to 500 words if possible]
The current Idaho behavioral health delivery system provides a variety of behavioral health services to address SMI and SED for Medicaid beneficiaries. Access and availability of these critical services remains one of the biggest challenges for the State, with much of Idaho being been a federally designated health professional shortage area (HPSA). The need for behavioral health care is high, with approximately 45% of adult Medicaid members experiencing SMI and 21% of children experiencing SED. Almost 50% of Idaho Medicaid members with SMI or SED reside in Regions 3 and 4, with the remaining 50% of these members residing in the remaining five largely rural and frontier Regions of Idaho.
2. In the space below, describe the organization of the state's Medicaid behavioral health service delivery system at the beginning of the demonstration. [Limit responses to 500 words if possible]
Idaho has operated the Idaho Behavioral Health Plan (IBHP) under 1915(b) authority since 2013. This state-wide pre-paid ambulatory health plan is administered by Optum Behavioral Health. The IBHP provides an array of evidenced based, medically necessary outpatient behavioral health services. Inpatient behavioral health services are managed by the State Medicaid Agency through fee-for-service. To better serve dual eligible members, Idaho operates two different managed care programs. The Medicare Medicaid Coordinated Plan integrates all Medicaid and Medicare Part A, B and D benefits into one plan. The Idaho Medicaid Plus program (IMPlus) coordinates Medicaid benefits for individuals eligible for both Medicaid and Medicare who choose to have their Medicare benefits administered through a different, separate plan.
3. In the space below, describe the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. At minimum, explain any variations across the state in the availability of the following: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. [Limit responses to 1000 words if possible]

Narrative Description (to be completed at baseline)
Providers: All seven Regions offer outpatient service provider choice for mental health treatment services. Providers include facilities, behavioral health clinics, individual practitioner offices, primary care clinics and telehealth. Idaho does not have any community mental health centers but does offer a strong network of 52 federally qualified health centers (FQHCs) delivering behavioral health services to residents in all seven regions. Idaho has long supported a telepsychiatry program, offering psychiatry through telehealth to critical access hospitals and other rural and frontier sites across Idaho. Three prescribers not located in Idaho have served Medicaid patients in the past 12 months. Certain specialists also travel from their home Region to provide services in more rural and frontier Regions. For example, a child psychiatrist based in Boise in Region 4 travels to Regions 2 and 7 to deliver services to children and adolescents. Idaho has over 2300 licensed social workers in the state who may serve people with mental health. Idaho has 543 certified peer support partners and 88 family support partners statewide. Skills building / community-based rehabilitation services may be delivered by non-licensed individuals under the direction of independently licensed clinicians to help improve patients' functional status while decreasing mental health and/or behavioral symptoms. Crisis Services: Each region has a behavioral health crisis center and access to one or more residential facilities. The behavioral health crisis centers along with emergency rooms and 27 critical access hospitals throughout rural Idaho offer the first level of crisis support. Additionally, the state of Idaho delivers mobile crisis services. Only Boise in Region 4 and Spokane, Washington, near Region 1 offer adolescent psychiatric crisis services. Adolescents in crisis are served through toll free crisis lines, hospital emergency rooms and a network of critical access hospitals in rural Idaho. Idaho continues to develop comprehensive services for youth. For example, partial hospitalization for adolescents is newly offered in Region 4. Intensive outpatient is available throughout Idaho although more rural areas have fewer service sites. Idaho licensing and behavioral health authorities do not license, track or approve intensive outpatient or partial hospitalization providers as a distinct category. The number of providers in this environmental scan is based on credentialing for Idaho Medicaid via the IBHP MCO Optum Idaho and provider self-report. Fifteen providers currently offer PHP or IOP services at one or more locations across the state. Residential and Inpatient Services: While a total of 413 adult psychiatric beds are available in the state, children and adolescents have much more limited access to inpatient care. Children and adolescents in Idaho must travel to Idaho Falls or Boise for the 67 inpatient adolescent beds, 6 inpatient child beds, and the 12 psychiatric residential treatment facility (PRTF) beds. In addition to the psychiatric beds in Table 4B, a Medicaid-enrolled acute care hospital in Region 7 will add an additional 21 adult and 25 adolescent beds by 12/31/19. Residential psychiatric care has not proliferated in Idaho. 181 Residential Assisted Living Facilities in Idaho identify themselves as serving adults with mental health needs. However, only two in Region 4 focus primarily on serving people with SMI. Idaho has only one licensed PRTF, located in Region 7 and only serves adolescent females. Adolescents and children with SED residing in the state are also served in licensed certified family homes. These residential care facilities provide multiple services, including mental health care, developmental disability services, and rehabilitation.

Narrative Description (to be completed at baseline)
4. In the space below, describe any gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment. [Limit responses to 500 words if possible]
Because of Idaho’s rural landscape, we expected to see significant gaps in service availability for all age groups. Our assumptions were confirmed when we performed the Mental Health Availability Assessment. Idaho experiences significant access opportunities across the entire behavioral health continuum of care.
5. In the space below, describe any gaps in the availability of mental health services or service capacity NOT reflected in the Availability Assessment. [Limit responses to 500 words if possible]
There are two gaps in service availability not reflected in the Mental Health Availability Assessment. The first gap is behavioral health integration. The focus on supporting integration and co-location of behavioral health professionals in primary care clinics can provide Medicaid members residing in rural and frontier communities easier access to immediate behavioral health supports. The second gap not identified in the Mental Health Availability assessment is access to care coordination services. In order to engage and assist members transitioning between levels of care, access to care coordinators and case managers needs to be a primary focus when enhancing the behavioral health continuum of care.

State Name	
Date of Assessment	
Time Period Reflected in Assessment	

	Geographic Designation			Benefici					
				Adult					
	Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of adult Medicaid beneficiaries (18 - 20)	Number of adult Medicaid beneficiaries with SMI (18 - 20)	Number of adult Medicaid beneficiaries (21+)	Number of adult Medicaid beneficiaries with SMI (21+)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (0 - 17)
1.	Region 1	Rural	20% counties part of MSA	3338	1099	14451	6481	43%	26165
2.	Region 2	Rural	16.7% counties part of MSA	1111	376	6286	3058	46%	8885
3.	Region 3	Rural	50% counties part of MSA, most landmass rural.	5763	1956	20710	9306	43%	48746
4.	Region 4	Rural	50% counties part of MSA, most landmass rural.	5909	2290	24071	12276	49%	46107
5.	Region 5	Rural	25% counties part of MSA	3566	1115	11461	5109	41%	30508
6.	Region 6	Rural	25% counties part of MSA	2880	977	11452	5739	47%	24301
7.	Region 7	Rural	28.6% counties part of MSA	3447	1306	13666	6134	43%	33613
8.								-	
9.								-	
10.								-	
11.								-	
	Total			**26014**	**9119**	**102097**	**48103**	**45%**	**218325**

aries												
Children		Total				Psychiatrists or Other Practitioners Who Are Authorized to Prescribe					
Number of Medicaid beneficiaries with SED (0 - 17)	Percent with SED (0-17)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)	Beneficiary Category Notes	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Total Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients
5429	21%	43954	13009	30%		22	18	18	722.7222222	1.222222222	1
1895	21%	16282	5329	33%		9	9	9	592.1111111	1	1
10344	21%	75219	21606	29%		6	6	6	3601	1	1
11452	25%	76087	26018	34%		62	48	48	542.0416667	1.291666667	1
5352	18%	45535	11576	25%		6	2	2	5788	3	1
5359	22%	38633	12075	31%		6	2	2	6037.5	3	1
6842	20%	50726	14282	28%		12	6	6	2380.333333	2	1
	-	0	0	-					-	-	-
	-	0	0	-					-	-	-
	-	0	0	-					-	-	-
	-	0	0	-					-	-	-
46673	**21%**	**346436**	**103895**	**30%**		**123**	**91**	**91**	**1141.703297**	**1.351648352**	**1**

Providers								Community Mental Health			
	Other Practitioners Certified and Licensed to Independently Treat Mental Illness										
Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Category Notes	Number of Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Other Practitioners Certified or Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness Accepting New Patients	Other Practitioner Category Notes	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs
	448	79	79	164.6708861	5.670886076	1	Psychologists,	0	0	0	-
	170	27	27	197.3703704	6.296296296	1	Counselors,	0	0	0	-
	420	70	70	308.6571429	6	1	Social Workers.	0	0	0	-
	1632	196	196	132.744898	8.326530612	1	See supplemental	0	0	0	-
	290	27	27	428.7407407	10.74074074	1	data. 46 providers	0	0	0	-
	304	21	21	575	14.47619048	1	outside Idaho are	0	0	0	-
	455	37	37	386	12.2972973	1	contracted to serve	0	0	0	-
				-	-	-	Idaho Medicaid.				-
				-	-	-					-
				-	-	-					-
r states are contra				-	-	-					-
	3719	**457**	**457**	**227.3413567**	**8.13785558**	**1**		**0**	**0**	**0**	**-**

Centers			Intensive Outpatient or Partial Hospitalization Providers									
Ratio of Total CMHCs to Medicaid-Enrolled CMHCs	Ratio of Medicaid-Enrolled CMHCs to Medicaid-Enrolled CMHCs Accepting New Patients	CMHC Category Notes	Number of Intensive Outpatient/ Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Ratio of Total Partial Hospitalization/ Day Treatment Providers to Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Ratio of Medicaid-Enrolled Partial Hospitalization/ Day Treatment Providers to Medicaid- Enrolled Intensive Outpatient/ Partial Hospitalization Providers Accepting New Medicaid Patients	Intensive Outpatient/ Partial Hospitalization Category Notes	Number of Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)
-	-	Idaho	11	11	11	1182.636364	1	1	Data are provider sites	0	0
-	-	does	1	1	1	5329	1	1	Idaho does not license,	0	0
-	-	not have	1	1	1	21606	1	1	track or approve IOP	0	0
-	-	CMHCs	7	7	7	3716.857143	1	1	or PHP as a category.	2	2
-	-		3	3	3	3858.666667	1	1	Data from credentialing via	0	0
-	-		1	1	1	12075	1	1	Optum Idaho and self-report.	0	0
-	-		6	6	6	2380.333333	1	1	15 providers by Tax ID	0	0
-	-					-	-	-	often with >1 site in >1 region		
-	-					-	-	-			
-	-					-	-	-			
-	-					-	-	-			
-	**-**		**30**	**30**	**30**	**3463.166667**	**1**	**1**		**2**	**2**

Residential Menta

Residential Mental Health Treatment Facilities (Adult)

Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities Accepting New Medicaid Patients (Adult)	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Total Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) Accepting New Patients	Total Number of Residential Mental Health Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Adult Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Total Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Medicaid Patients	Residential Mental Health Treatment Facility Category Notes (Adult)
0	-	-	-	0	0	0	-	-	-	Adult residential mental health treatment facilites are licensed as Residential Assisted Living Facilities in Idaho
0	-	-	-	0	0	0	-	-	-	
0	-	-	-	0	0	0	-	-	-	
2	7283	1	1	24	24	24	606.9166667	1	1	
0	-	-	-	0	0	0	-	-	-	
0	-	-	-	0	0	0	-	-	-	
0	-	-	-	0	0	0	-	-	-	
	-	-	-				-	-	-	
	-	-	-				-	-	-	
	-	-	-				-	-	-	
	-	-	-				-	-	-	
2	**28611**	**1**	**1**	**24**	**24**	**24**	**2384.25**	**1**	**1**	

l Health Treatment Facilities

Psychiatric Residential Treatment Facilities											
Number of Psychiatric Residential Treatment Facilities (PRTF)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PTRFs	Ratio of Total PTRFs to Medicaid-Enrolled PRTFs	Ratio of Medicaid-Enrolled PRTFs to Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds	Number of Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Total Number of PRTF Beds to Medicaid-Enrolled PRTF Beds	Ratio of Medicaid-Enrolled PRTF Beds to Medicaid-Enrolled PRTFs Available to Medicaid Patients
0	0	0	-	-	-	0	0	0	-	-	-
0	0	0	-	-	-	0	0	0	-	-	-
0	0	0	-	-	-	0	0	0	-	-	-
0	0	0	-	-	-	0	0	0	-	-	-
0	0	0	-	-	-	0	0	0	-	-	-
0	0	0	-	-	-	0	0	0	-	-	-
1	1	1	6842	1	1	12	12	12	570.1666667	1	1
			-	-	-				-	-	-
			-	-	-				-	-	-
			-	-	-				-	-	-
			-	-	-				-	-	-
1	**1**	**1**	**46673**	**1**	**1**	**12**	**12**	**12**	**3889.416667**	**1**	**1**

Psychiatric Residential Treatment Facility (Under 21) Category Notes	Psychiatric Hospitals								
	Number of Psychiatric Hospitals	Psychiatric Hospitals Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals Available to Medicaid Patients	Ratio of Psychiatric Hospitals to Psychiatric Hospitals Available to Medicaid Patients	Psychiatric Hospital Category Notes	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs
Site is female only. 27 other facilities licensed as Residential Care Facilities may serve under 21 with SED Licenure does not indicate specialization in mental health services	0	0	-	-		1	0	1	0
	1	0	-	-		1	0	1	0
	0	0	-	-		1	0	1	0
	3	2	13009	1.5		1	0	1	0
	0	0	-	-		1	0	1	0
	0	0	-	-		1	0	1	0
	1	1	14282	1		1	1	1	1
			-	-					
			-	-					
			-	-					
			-	-					
	5	**3**	**34631.66667**	**1.666666667**		**7**	**1**	**7**	**1**

Inpatient											
Psychiatric Units									Psychiatri		
Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Psychiatric Unit Category Notes	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units) Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients
1	0	13009	-	1	-	1	-	see supplemental data	16	16	813.0625
1	0	5329	-	1	-	1	-		75	20	266.45
1	0	21606	-	1	-	1	-		19	19	1137.157895
1	0	26018	-	1	-	1	-		195	45	578.1777778
1	0	11576	-	1	-	1	-		28	28	413.4285714
1	1	12075	-	1	-	1	0		29	19	635.5263158
1	0	14282	14282	1	1	1	-		124	24	595.0833333
		-	-	-	-	-	-				-
		-	-	-	-	-	-				-
		-	-	-	-	-	-				-
		-	-	-	-	-	-				-
7	**1**	**14842.14286**	**103895**	**1**	**1**	**1**	**1**		**486**	**171**	**607.5730994**

Ratio of Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	Psychiatric Beds Category Notes	Number of Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities that Qualify as IMDs	Ratio of Total Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting New Medicaid Patients	Number of Psychiatric Hospitals that Qualify as IMDs	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	Facilities That Qualify As IMDs Category Notes
...c Beds		Institutions for Mental Diseases: Residential Treatment Facilities That Qualify As IMDs						Psychiatric Hospitals That Qualify As IMDs		
1	Region 7 adding 21 adult and 25 adolescent beds by 12/31/19. 29 public SNF beds in Region 7 serving adults with SMI.	0	0	0	-	-	-	0	-	
3.75		0	0	0	-	-	-	1	5329	
1		0	0	0	-	-	-	0	-	
4.333333333		0	0	0	-	-	-	2	13009	
1		0	0	0	-	-	-	0	-	
1.526315789		0	0	0	-	-	-	0	-	
5.166666667		0	0	0	-	-	-	1	14282	
-					-	-	-		-	
-					-	-	-		-	
-					-	-	-		-	
-					-	-	-		-	
2.842105263		**0**	**0**	**0**	**-**	**-**	**-**	**4**	**25973.75**	

Crisis Stabilization Services											Federally
Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Crisis Stabilization Units	Number of Coordinated Community Crisis Response Teams	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	Ratio of Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response Teams	Crisis Stabilization Services Category Notes	Number FQHCs that Offer Behavioral Health Services
2		1			6504.5	-	13009	-	-	Region 2 Crisis Center planned to open late 2019.	13
2		0			2664.5	-	-	-	-		2
2		1			10803	-	21606	-	-		11
2		1			13009	-	26018	-	-		9
2		1			5788	-	11576	-	-		4
2		1			6037.5	-	12075	-	-		10
2		1			7141	-	14282	-	-		3
					-	-	-	-	-		
					-	-	-	-	-		
					-	-	-	-	-		
					-	-	-	-	-		
14	**0**	**6**	**0**	**0**	**7421.071429**	**-**	**17315.83333**	**-**	**-**		**52**

Qualified Health Centers

Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	FQHC Category Notes
1000.692308	
2664.5	
1964.181818	
2890.888889	
2894	
1207.5	
4760.666667	
-	
-	
-	
-	
1997.980769	

State Name	Idaho
Date of Assessment	10/8/2019
Time Period Reflected in Assessment	June 2019

	Psychiatric Hospital Beds by Age		
Geographic designation	Number of Licensed Psychiatric **Adult** Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Licensed Psychiatric **Adolescent** Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Licensed **Child** Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)
Region 1	16	0	0
Region 2	75	0	0
Region 3	19	0	0
Region 4	142	47	6
Region 5	28	0	0
Region 6	19	0	0
Region 7	114	16	0
Total	**413**	**67**	**6**

Non-licensed Providers					Population Data	
Medicaid Enrolled Provider **Agencies** offering Peer Support Services through certified Peer Support Specialist(s)	Medicaid Enrolled Provider Agency **Sites** offering Peer Support Services through certified Peer Support Specialist(s)	Medicaid Enrolled Provider **Agencies** offering Family Support & Training Services by certified Family Support Partner(s)	Medicaid Enrolled Provider Agency **Sites** offering Family Support & Training Services by certified Family Support Partner(s)		% Urban (Count Urban Counties / Total Counties)	% Urban (Urban County Sq Mi/Total Sq Mi)
10	13	9	14		20%	16%
5	6	8	10		17%	5%
11	18	9	18		50%	73%
19	25	20	34		50%	30%
9	16	8	12		25%	22%
16	22	9	15		25%	16%
22	29	22	27		29%	24%
92	**129**	**85**	**130**			

Prevalence: No SMI/SED or SUD			
0 - 17	18 - 20	21 and Up	Total
20,673	2,058	6,064	28,795
6,954	666	2,346	9,966
38,243	3,495	9,172	50,910
34,537	3,364	9,762	47,663
25,028	2,210	5,157	32,395
18,878	1,768	4,486	25,132
26,705	1,977	6,596	35,278
171,018	**15,538**	**43,583**	**230,139**

Prevalence: Both SMI/SED and SUD			
0 - 17	18 - 20	21 and Up	Total
271	294	3,333	3,898
81	90	1,623	1,794
453	502	4,658	5,613
434	580	5,596	6,610
282	314	2,452	3,048
190	253	2,942	3,385
262	353	2,657	3,272
1,973	**2,386**	**23,261**	**27,620**

Prevalence: Either SMI/SED or SUD			
0 - 17	18 - 20	21 and Up	Total
5,221	986	5,054	11,261
1,850	355	2,317	4,522
10,050	1,766	6,880	18,696
11,136	1,965	8,713	21,814
5,198	1,042	3,852	10,092
5,233	859	4,024	10,116
6,646	1,117	4,413	12,176
45,334	**8,090**	**35,253**	**88,677**

Appendix B: Budget Neutrality

Financing and Budget Neutrality Summary

IDHW engaged Milliman, Inc. (Milliman) to develop the response to the Budget Neutrality Form section for the Section 1115 Medicaid Demonstration Waiver Application (1115 Waiver) for Behavioral Health Transformation. Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. Per Capita Method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate Method: Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for the 1115 Waiver will be demonstrated through the use of the per capita method. The budget neutrality projections were developed using CMS budget neutrality requirements. The IMD budget neutrality worksheets prepared by Milliman are attached below as *Attachment I* to this *Appendix B, Financing and Budget Neutrality Summary*.

Milliman has relied upon certain data and information provided by IDHW and the Division of Behavioral Health (DBH) in the development of the estimates contained in the Budget Neutrality Worksheet. Milliman has relied upon the IDHW for the accuracy of the data and accepted them without audit. To the extent that the data provided are not accurate, the results of this analysis may need to be modified to reflect revised information.

Differences between Milliman's projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the Budget Neutrality Form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

Appendix I illustrates the 1115 Waiver Behavioral Health Transformation budget neutrality worksheets. The rest of this section documents the supporting data and methodology included in the worksheets using guidance provided by CMS in the Budget Neutrality Form.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Historical Actual Data

The IDHW actual historical data has been divided into two Medicaid eligibility groups (MEGs):

- **IMD MEG 1: FFS – SMI/SED** – Member months reflect adult eligible recipients who incurred an inpatient admission containing a Serious Mental Illness (SMI)/ Severe Emotional Disturbance (SED) primary diagnosis code in the eligibility month.
- **IMD MEG 2: FFS - SUD** – Member months reflect adult eligible recipients who incurred an inpatient admission containing a Substance Abuse Disorder (SUD) primary diagnosis code in the eligibility month.

For both MEGs, the services include all fee-for-service (FFS) program expenditures that will be covered under the waiver, as well as any other state plan services incurred in the same month as the inpatient admission.

As described throughout this waiver, IDHW seeks to address the challenges of the current fragmented behavioral health system. As noted previously Idaho will utilize the American Society of Addiction Medicine (ASAM) patient placement criteria, the most widely accepted and comprehensive

set of guidelines for patient placement across the full continuum of care. This new behavioral health benefit will included SMI, SED, and SUD treatment in an IMD under specific procedure codes. IDHW believes SFY 2018 reflects the projected per member per month (PMPM) cost currently covered through the inpatient setting and those services that will potentially shift to an IMD during the five-year demonstration.

B. Without-Waiver and With-Waiver Trend Rates, PMPM costs and Member Months

Based on CMS guidance regarding IMD 1115 Waivers, both the WoW and WW scenarios equal one another. The projected PMPM cost trend reflects the estimated President's budget trend (4.8% for FFS). The projections utilized the Expansion population cost trend of 4.8% because the populations receiving IMD services will be most similar to the Expansion adult population. Based on discussions with IDHW regarding ramp-up in IMD facility treatment under the behavioral health transformation and new facility providers potentially coming online to provide mental health and SUD treatment, Milliman has assumed a 10% annual caseload trend over the five-year demonstration.

II. Cost Projections for New Populations

Not applicable

III. Disproportionate Share Hospital Expenditure Offset

Not applicable

IV. Summary of Budget Neutrality

Appendix B illustrates the IMD 1115 Waiver budget neutrality spreadsheet, which includes the following applicable tabs:

i. IMD Historical
ii. IMD Without-Waiver
iii. IMD With Waiver
iv. IMD Summary (of Budget Neutrality)
v. IMD Caseloads

V. Additional Information to Demonstrate Budget Neutrality

Milliman does not believe there is any other information necessary for CMS to complete its analysis of the budget neutrality submission.

VI. Diagnosis Code Assumptions

Table 1 and 2 over the next two pages includes the diagnosis codes used to identify SMI/SED and SUD respectively.

ICD-10 Diagnosis Codes of Interest

SMI/SED

F3164	F315	F312	F22	F333	F323	F250	F251	F258
F259	F202	F201	F2089	F200	F205	F203	F209	

Table 2
ICD-10 Diagnosis Codes of Interest

SUD								
F1210	F1094	F11981	F13188	F14129	F1514	F1614	F17228	F1911
F12129	F10950	F11982	F1319	F1414	F15150	F16150	F17229	F19120
F1221	F10951	F11988	F1320	F14150	F15151	F16151	F17290	F19121
F1220	F10959	F1199	F1321	F14151	F15159	F16159	F17291	F19122
F1290	F1994	F1211	F13220	F14159	F15180	F16180	F17293	F19129
F1010	F19982	F12120	F13221	F14180	F15181	F16183	F17298	F1914
F1020	F1096	F12121	F13229	F14181	F15182	F16188	F17299	F19150
F1219	F1097	F12122	F13230	F14182	F15188	F1619	F1810	F19151
F1024	F10980	F12150	F13231	F14188	F1519	F1620	F1811	F19159
F1119	F10981	F12151	F13232	F1419	F1520	F1621	F18120	F1916
F1229	F10982	F19950	F13239	F1420	F1521	F16220	F18121	F1917
F1129	F10988	F19988	F1324	F1421	F15220	F16221	F18129	F19180
F1021	F1110	F12159	F13250	F14220	F15221	F16229	F1814	F19181
F1029	F1111	F12180	F13251	F14221	F15222	F1624	F18150	F19182
F1099	F11120	F12188	F13259	F14222	F15229	F16250	F18151	F19188
F1123	F11121	F12220	F1326	F14229	F1523	F16251	F18159	F1919
F1011	F11122	F12221	F19951	F1423	F1524	F16259	F1817	F1920
F10120	F11129	F12222	F1999	F1424	F15250	F16280	F18180	F1921
F10121	F1114	F12229	F1327	F14250	F15251	F16283	F18188	F19220
F10129	F11150	F1223	F13280	F14251	F15259	F16288	F1819	F19221
F1014	F11151	F12250	F13281	F14259	F15280	F1629	F1820	F19222
F10150	F11159	F12251	F13282	F14280	F15281	F1690	F1821	F19229
F10151	F11181	F12259	F13288	F19959	F15282	F16920	F18220	F19230
F10159	F11182	F12280	F1329	F14281	F15288	F16921	F18221	F19231
F10180	F11188	F12288	F1390	F14282	F1529	F16929	F18229	F19232
F10181	F1120	F12920	F13920	F14288	F1590	F1694	F1824	F19239
F10182	F1121	F12921	F13921	F1429	F15920	F16950	F18250	F1924
F10188	F11220	F12922	F13929	F1490	F15921	F16951	F18251	F19250
F1019	F11221	F12929	F13930	F14920	F1996	F16959	F18259	F19251
F10220	F11222	F1293	F13931	F14921	F15922	F16980	F1827	F19259
F10221	F11229	F12950	F13932	F14922	F15929	F16983	F18280	F1926
F10229	F1124	F12951	F13939	F14929	F1593	F16988	F18288	F1927
F10230	F11250	F12959	F1394	F1494	F1594	F1699	F1829	F19280
F10231	F11251	F12980	F13950	F14950	F15950	F17200	F1890	F19281
F10232	F11259	F12988	F13951	F14951	F15951	F1997	F18920	F19282
F10239	F11281	F1299	F13959	F14959	F15959	F17201	F18921	F19288
F10250	F11282	F1310	F1396	F14980	F15980	F17203	F18929	F1929
F10251	F11288	F1311	F1397	F14981	F15981	F17208	F1894	F1990
F10259	F1190	F13120	F13980	F14982	F15982	F17209	F18950	F19920
F1026	F11920	F13121	F13981	F14988	F15988	F17210	F18951	F19921
F1027	F11921	F13129	F13982	F1499	F1599	F17211	F19980	F19922
F10280	F11922	F1314	F13988	F1510	F1610	F17213	F18959	F19929
F10281	F11929	F13150	F1399	F1511	F1611	F17218	F1897	F19930
F10282	F1193	F13151	F1410	F15120	F16120	F17219	F18980	F19931
F10288	F1194	F13159	F1411	F15121	F16121	F17220	F18988	F19932
F10920	F11950	F13180	F14120	F15122	F16122	F17221	F1899	F19939
F10921	F11951	F13181	F14121	F15129	F16129	F17223	F1910	F19981
F10929	F11959	F13182	F14122					

IMD Overview

How To Use This Spreadsheet:

Consult the tables below for a overview of the "IMD Services Limit" and "Non-IMD Services CNOM Limit" in Scenarios 1 and 2. The tables provide basic concepts and frameworks for establishing the budget neutrality limits--and expenditure reporting requirements for monitoring. The notes below the table provide additional information related to allowable IMD medical assistance services, estimation of the various budget neutrality limits, trend rates, "in lieu of" services and other details of estimation and expenditure reporting. For states proposing to include IMD services as a component of their broader 1115 demonstrations, the limits established in this spreadsheet--once approved by CMS--will be included in the comprehensive budget neutrality spreadsheet, STCs and expenditure monitoring tool (see State Medicaid Director Letter #18-009). The limits established may be used as an upper limit for all medical assistance services provided in an IMD--or separately tabulated by, for example, diagnosis-type (see glossary below for definition of abbreviations).

Scenario 1

Situation: Demonstration CNOM is limited to expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD, SMI and/or SED who are residents in facilities that meet the definition of an IMD (i.e., IMD exclusion related MA).	IMD Services Limit	Non-IMD Services CNOM Limit
Without Waiver (i.e., budget neutrality limit)	PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in BN Expenditure Limit · PMPM cost × IMD MMs	
With Waiver	Expenditures Subject to Limit · All MA costs with dates of service Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs separate from other MA costs	

Scenario 2

Situation: Demonstration CNOM include both CNOM for IMD exclusion related MA to *and* CNOM for additional hypothetical services that can be provided outside the IMD.	IMD Services Limit	Non-IMD Services CNOM Limit
Without Waiver (i.e., budget neutrality limit)	PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in · *Can* exclude months with ≤ 15 IMD inpatient days under managed care BN Expenditure Limit · PMPM cost × IMD MMs	PMPM Cost · Estimate of average CNOM service cost during Non-IMD MMs · Est. total CNOM service cost ÷ est. Non-IMD · CNOM service cost can include capitated cost of IMD services Member Months · Non-IMD MM: Any month of Medicaid eligibility in which a person *could* receive a CNOM BN Expenditure Limit · PMPM cost × Non-IMD MMs
With Waiver	Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs	Expenditures Subject to Limit · All CNOM service costs with dates of service during Non-IMD MMs Reporting Requirements State must be able to identify and report: · Non-IMD MMs separate from IMD MMs · IMD CNOM costs separate from other MA costs

Glossary of Abbreviations

CNOM = expenditure authority (cost not otherwise matchable)
Hypo = hypothetical, i.e., optional services that could be included in the state plan but are instead being authorized in the 1115 using CNOM
IMD = institution for mental diseases
MA = medical assistance
MM = member month
SUD = substance abuse disorder
SMI = serious mental illness
SED = serious emotional disturbance

Notes

1. Date of service for capitation payments is the month of coverage for which the capitation is paid.
2. The IMD Services Limit and Non-IMD Services CNOM Limit are intended to be two distinct budget neutrality tests separately and independently enforced.
3. Services provided in an IMD "in lieu of" other allowable settings are excluded from this budget neutrality test (see below).
4. Some specific unallowable costs are detailed below (see STCs for additional exceptions and caveats).

Estimation for the IMD Services Limit

The IMD Services Limit represents the projected cost of medical assistance during months in which Medicaid eligible are patients at the IMD. These are the acceptable ways for the

- States should present their most recent represenative year of historical data on overall MA costs for individuals with a SUD, SMI and/or SED diagnosis (or proxy) who received inpatient treatment those diagnoses (or could have received inpatient treatment if such services were available), to determine projected MA cost per user of SUD, SMI and/or SED inpatient services for each historical year.
- The per user per month cost(s) are then projected forward using the President's Budget PMPM cost trend--and the projected per user per month costs will become the PMPMs for the IMD Services Limit.
- If the state has an existing comprehensive Medicaid demonstration with already calculated without waiver PMPMs, CMS will incorporate the PMPMs established in this workbook.
- States may also "top off" IMD Services Limit PMPMs with an additional estimated amount representing any additional CNOM services that affected individuals may also receive during IMD months.
- State may use Alternate PMPM Development in Historical tab for estimating expenditures (see 'Supplemental Methodology Document' requirement below).

Trends

PMPM trend rates will generally be the smoothed trend from the most recent President's Budget Medicaid trends and will be supplied to states by CMS.

- The President's Budget trends should be for the eligibility groups that are participating in the IMD demonstration; most often, these will be the Current Adults, New Adults, or a blend of Current and New Adults, to determine average MA cost per user of SUD, SMI and/or SED inpatient services for each historical year.
- The per user per month costs are then projected forward using the President's Budget PMPM cost trend.
- The projected per user per month costs will become the PMPMs for the IMD Services Limit.

Multiple MEGs

There should be one set of MEGs for the current Medicaid state plan IMD Services Limit(s) with associated PMPMs and member months, and one for the Non-IMD Services CNOM Limit and/or Non-Hypothetical CNOM Limit, as applicable.

- States may also develop single, or multiple, PMPMs for SUD, SMI and/or SED.

Member Month Non-Duplication

IMD Services Limit member month must be non-duplicative of Non-IMD Services CNOM Limit member months, and must also be non-duplicative of general comprehensive demonstration budget neutrality limit member months.

- This means that month of Medicaid eligibility for an individual cannot appear as both an IMD Services Limit member month and a Non-IMD Services CNOM Limit member month; it has to be one or the other, and likewise for IMD Services Limit member month and general comprehensive demonstration budget neutrality limit member months.
- IMD Services CNOM Limit member months can be duplicative of general comprehensive demonstration budget neutrality limit member months.

State Data Inputs

States must add their data to the yellow highlighted cells for CMS review and discussion - and choose the appropriate drop-downs corresponding to their data inputs.

- CMS will provide template instructions with this spreadsheet.

"In Lieu of" Services

States must not report expenditures for a capitation payment to a risk-based MCO or PIHP for an enrollee with a short-term stay in an IMD for inpatient psychiatric or substance use disorder services of no more than 15 days within the month for which the capitation payment is made is permissible under the regulation at §438.6(e) for MCOs and PIHPs to use the IMD as a medically appropriate and cost effective alternative setting to those covered under the State plan or ABP.

· This flexibility is referred to in the regulations as "in-lieu-of" services or settings and is effectuated through the contract between the state and the MCO or PIHP.

· For more information on "in leu of" servies, see "Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e)" (August 2017).

Unallowable Costs

In addition to other unallowable costs and caveats outlined in the STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following :

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

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

· Costs for services provided to inmates of a public institution, as defined in 42 CFR 435.1010 and clause A after section 1905(a)(29), except if the individual is admitted for at least a 24 hour stay in a medical institution (see SMI/SED SMDL, p. 13).

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

Supplemental Methodology Document

The 'Historical Spending Data' and/or 'Alternate PMPM Development' in the IMD Historical tab must be accompanied by a supplemental methodology and data sources document that fully describes, for each MEG, a complete break-out of all SUD, SMI and/or SED services--with descriptions of accompanying expenditures and caseloads.

· There should also be sections/headings in the methodology document which describe all other state data inputs (see 'State Data Inputs' above).

Representative Data Year:	2018
Type of State Years:	State Fiscal

IMD Services MEG 1: FFS - SMI/SED	2018
TOTAL EXPENDITURES	$8,430,832
ELIGIBLE MEMBER MONTHS	1,093
PMPM COST	$7,713.48

IMD Services MEG 2: FFS - SUD	
TOTAL EXPENDITURES	$2,029,117
ELIGIBLE MEMBER MONTHS	328
PMPM COST	$6,186.33

Continue MEGs from Above, As Needed

			Managed Care PMPM (Replicate Column, as Necessary)	
Alternate Development: IMD Services + Non-IMD & Non-Hypo CNOMs	Estimated Total Expenditures for Medical Assistance Provided in an IMD that are:		$0.00	
IMD Services	Currently State Plan FFS (e.g. Carved Out) or Not Currently State Plan but Otherwise Approvable (Including Pending SPAs)	Absent 1115 Authority, Not Otherwise Eligible for FFP Under Title XIX, or "Costs Not Otherwise Matchable" ("Non-IMD" or "Non-Hypo" CNOMs)	Capitated PMPM for Currently Approved, non-IMD, State Plan or Other Title XIX Services	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD
Service 1			$0	
Service 2			$0	
Service 3			$0	
Service 4			$0	
Service 5			$0	
Service 6			$0	
Service 7			$0	
Service 8			$0	
Service 9			$0	
Service 10			$0	
Service 11			$0	
Service 12			$0	
Add additional services, as necessary			$0	
Totals				

	2018					
	Choose "Included" from Drop-Down(s) to Link Services with MEG(s)					
	CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)		
Estimated PMPM Cost for All Services Provided in an IMD	IMD Services MEG 1: FFS - SMI/SED	IMD Services MEG 2: FFS - SUD	IMD Services MEG 3	Non-IMD Services CNOM Limit MEG	Non-Hypothetical Services CNOM MEG
#DIV/0!					
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	$0.00	$0.00	$0.00	$0.00	$0.00

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY)					TOTAL WOW
				Start DY 2020	2021	2022	2023	2024	

IMD Services MEG 1: FFS - SMI/SED

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	2020	2021	2022	2023	2024	TOTAL WOW
Eligible Member Months	n.a.	n.a.	1093	1,387	1,526	1,678	1,846	2,031	
PMPM Cost	4.8%	30	$ 7,713	$ 8,673	$ 9,089	$ 9,525	$ 9,982	$ 10,462	
Total Expenditure				$ 12,029,711	$ 13,867,853	$ 15,986,860	$ 18,429,649	$ 21,245,705	$ 81,559,778

IMD Services MEG 2: FFS - SUI

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	2020	2021	2022	2023	2024	TOTAL WOW
Eligible Member Months	n.a.	n.a.	328	416	458	504	554	609	
PMPM Cost	4.8%	30	$ 6,186	$ 6,956	$ 7,290	$ 7,639	$ 8,006	$ 8,390	
Total Expenditure				$ 2,895,290	$ 3,337,690	$ 3,847,691	$ 4,435,617	$ 5,113,378	$ 19,629,666

IMD Services MEG 3

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	2020	2021	2022	2023	2024	TOTAL WOW
Eligible Member Months	n.a.	n.a.	0	0	0	0	0	0	
PMPM Cost	0.0%	0							
Total Expenditure									

Continue MEGs from Above, As Needed

Non-IMD Services CNOM Limit MEG

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	2020	2021	2022	2023	2024	TOTAL WOW
Eligible Member Months	n.a.	n.a.	n.a.	0	0	0	0	0	
PMPM Cost	0.0%	30	$ -	$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

IMD With Waiver

ELIGIBILITY GROUP	LAST HISTORIC YEAR	PB TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			2020	2021	2022	2023	2024	

IMD Services MEG 1: FFS - SMI/SED

Eligible Member Months			1,387	1,526	1,678	1,846	2,031	
PMPM Cost	$ 7,713	4.8%	$ 8,673	$ 9,089	$ 9,525	$ 9,982	$ 10,462	
Total Expenditure			$ 12,029,711	$ 13,867,853	$ 15,986,860	$ 18,429,649	$ 21,245,705	$ 81,559,778

IMD Services MEG 2: FFS - SUD

Eligible Member Months			416	458	504	554	609	
PMPM Cost	$ 6,186	4.8%	$ 6,956	$ 7,290	$ 7,639	$ 8,006	$ 8,390	
Total Expenditure			$ 2,895,290	$ 3,337,690	$ 3,847,691	$ 4,435,617	$ 5,113,378	$ 19,629,666

IMD Services MEG 3

Eligible Member Months								
PMPM Cost								
Total Expenditure								

Continue MEGs from Above, As Needed

Non-IMD Services CNOM Limit MEG

Eligible Member Months	n.a.		0	0	0	0	0	
PMPM Cost	$ -	0.0%	$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -

Main Budget Neutrality Test (i.e. NOT Hypothetical)

Non-Hypothetical Services CNOM MEG

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY)					TOTAL WOW
				DY 01	DY 02	DY 03	DY 04	DY 05	
Eligible Member Months	n.a.	n.a.	n.a.	0	0	0	0	0	
PMPM Cost	0.0%	30	$ -	$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

IMD Summary

Supplemetal Test #1: IMD Services Cost Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
IMD Services MEG 1: FFS - SMI/SED	$12,029,711	$13,867,853	$15,986,860	$18,429,649	$21,245,705	$81,559,778
IMD Services MEG 2: FFS - SUD	$2,895,290	$3,337,690	$3,847,691	$4,435,617	$5,113,378	$19,629,666
IMD Services MEG 3	$0	$0	$0	$0	$0	$0
Continue MEGs from Above, As Needed						
TOTAL	$14,925,001	$17,205,543	$19,834,551	$22,865,267	$26,359,083	$101,189,445

With-Waiver Total Expenditures

	2020	2021	2022	2023	2024	TOTAL
IMD Services MEG 1: FFS - SMI/SED	$12,029,711	$13,867,853	$15,986,860	$18,429,649	$21,245,705	$81,559,778
IMD Services MEG 2: FFS - SUD	$2,895,290	$3,337,690	$3,847,691	$4,435,617	$5,113,378	$19,629,666
IMD Services MEG 3	$0	$0	$0	$0	$0	$0
Continue MEGs from Above, As Needed						
TOTAL	$14,925,001	$17,205,543	$19,834,551	$22,865,267	$26,359,083	$101,189,445
Net Overspend	$0	$0	$0	$0	$0	**$0**

Supplemental Test #2: Non-IMD Services CNOM Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
Non-IMD Services CNOM Limit MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0

With-Waiver Total Expenditures

	2020	2021	2022	2023	2024	TOTAL
Non-IMD Services CNOM Limit MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0
Net Overspend	$0	$0	$0	$0	$0	**$0**

Main Budget Neutrality Test (i.e. NOT Hypothetical)

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
Non-Hypothetical Services CNOM MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	**$0**

Add Trend Rates & PMPMs from Table Below to 'SUD IMD Supplemental Budget Neutrality Test(s)' STC

SUD MEG(s)	Trend Rate	2020	2021	2022	2023	2024
IMD Services MEG 1: FFS - SMI/SED	4.8%	$8,673	$9,089	$9,525	$9,982	$10,462
IMD Services MEG 2: FFS - SUD	4.8%	$6,956	$7,290	$7,639	$8,006	$8,390
IMD Services MEG 3	0.0%	$0	$0	$0	$0	$0
Continue MEGs from Above, As Needed						
Non-IMD Services CNOM Limit MEG	0.0%	$0	$0	$0	$0	$0

Main Test: With Waiver "Coster(s)" (Amendments Only)

Non-Hypothetical Services CNOM MEG	0.0%	$0	$0	$0	$0	$0

IMD Caseloads

Projected IMD Member Months/Caseloads		DEMONSTRATION YEARS (DY)				
	Trend Rate	2020	2021	2022	2023	2024
IMD Services MEG 1: FFS - SMI/SED	10.0%	1,387	1,526	1,678	1,846	2,031
IMD Services MEG 2: FFS - SUD	10.0%	416	458	504	554	609
IMD Services MEG 3			0	0	0	0
Non-IMD Services CNOM Limit MEG			0	0	0	0
Non-Hypothetical Services CNOM MEG			0	0	0	0

Appendix C: Public Notice Documentation

IDAHO DEPARTMENT OF HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

MATT WIMMER – Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
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Idaho Department of Health and Welfare Behavioral Health Transformation (IMD) Waiver Notice of Public Hearing and Public Comment Period

Program Description and Affected Beneficiaries

Pursuant to 42 CFR 431.408, the Idaho Department of Welfare (IDHW) gives notice of its intent to apply on or after **January 3, 2020**, to the Centers for Medicare and Medicaid Services (CMS) for approval of a Section 1115 demonstration waiver, known as the *Idaho Behavioral Health Transformation Waiver*. The purpose of this waiver is to seek federal approval to waive the regulatory exclusion of reimbursement of mental health and substance use disorder services delivered to Medicaid enrollees ages 21 through 64 in Institutions for Mental Diseases (IMDs). The waiver makes new coverage available for Idaho Medicaid beneficiaries diagnosed with serious mental illness (SMI), serious emotional disturbance (SED) and/or substance use disorder (SUD).

During the 2019 session, the Idaho state legislature passed Senate Bill 1204, which created a new subsection in state law—Section 56-263(8), Idaho Code—to require the Director of the Idaho Department of Health and Welfare to research options and apply for federal waivers to enable cost-efficient use of Medicaid funds to pay for substance use disorder and/or mental health services in IMDs.

In addition to enabling reimbursement of IMD services, the waiver application describes Idaho's high-level vision for enhancing the entire behavioral health continuum of care; by expanding the depth and breadth of the overall array of behavioral health services available through state/federal-funded programs, this waiver will help decrease reliance on the most intensive and most costly levels of care, such as crisis services, acute psychiatric hospitalizations, and residential treatment services.

Idaho's comprehensive strategy for enhancing the behavioral health continuum of care will be detailed in the forthcoming Implementation Plan, which is currently under development and will be submitted to CMS upon completion.

Goals

The demonstration waiver application sets forth goals for improving the Medicaid continuum of care for enrollees diagnosed with SMI, SED and/or SUD. These goals are listed below.

SUD Goals:

1. Increased rates of identification, initiation, and engagement in behavioral health treatment;
2. Increased adherence to and retention in behavioral health treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

SMI/SED Goals:

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care hospitals and residential settings;
3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the State;
4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Implementation Milestones

In the forthcoming Implementation Plan, currently under development, the IDHW will address each of the goals and milestones outlined by CMS in the SUD Guidance (SMD #17-003) and SMI/SED Guidance (SMD #18-011), which are detailed below.

SUD Waiver Milestones:

- Access to critical levels of care for Opioid Use Disorder (OUD) and other SUDs;
- Widespread use of evidence-based, SUD-specific patient placement criteria;
- Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;
- Sufficient provider capacity at each level of care;
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and

- Improved care coordination and transitions between levels of care.

SMI/SED Waiver Milestones:

- Ensuring quality of care in psychiatric hospitals and residential settings;
- Improving care coordination and transition to community-based care;
- Increasing access to continuum of care, including crisis stabilization services; and
- Earlier identification and engagement in treatment through increased integration.

Hypotheses and Evaluation

The IDHW proposes to test the following tentative hypotheses for this demonstration:

- Earlier identification and engagement in treatment will assist individuals with SUD and/or SMI/SED by avoiding the need for crisis intervention and increasing utilization of community-based supports.

  In evaluating this hypothesis, the IDHW will monitor utilization trends and the first level of care utilized by individuals diagnosed with SUD and/or SMI/SED.

- Increased adherence to and retention in treatment for individuals with SUD and/or SMI/SED will reduce readmissions in emergency departments and inpatient settings.

  In evaluating this hypothesis, the IDHW will monitor trends in duration of treatment at each level of care for individuals with SUD and/or SMI/SED, as well as monitor emergency department utilization and inpatient admissions and readmissions for this population.

- Through earlier identification and engagement in treatment, the IDHW can work towards an overall reduction in overdose deaths. In addition, through expanded crisis intervention services and engagement with treatment, the IDHW can reduce deaths by suicide.

  In evaluating this hypothesis, the IDHW will monitor follow up and initiation of treatment for individuals following an overdose reversal. The IDHW will monitor follow up and initiation of treatment for individuals following utilization of crisis intervention services. The IDHW will monitor trends in number of deaths by overdose and suicide.

- Reducing the utilization of emergency departments and inpatient hospital settings for behavioral health treatment will help individuals receive the appropriate duration and type of treatment needed.

  In evaluating this hypothesis, the IDHW will monitor trends in emergency departments and inpatient hospital utilization relative to utilization trends for community-based services among individuals with SUD and/or SMI/SED.

- Improved care coordination efforts will increase diagnosis and treatment of co-morbid physical health conditions among beneficiaries with SUD and/or SMI/SED, particularly for ambulatory care-sensitive conditions such as diabetes, hypertension, and asthma.

  In evaluating this hypothesis, the IDHW will monitor quality metrics related to key physical health services among beneficiaries with SUD and/or SMI/SED. In addition, the IDHW will track mental health assessments in primary care settings, as well as physical health assessments

in IMDs and other behavioral health settings.

- Increasing access to community resources and supports will improve overall health outcomes and reduce readmissions and unnecessary stays in hospital or other inpatient settings.

  In evaluating this hypothesis, the IDHW will utilize information on readmission rates to track the frequency of readmissions and which individuals are most susceptible to readmissions. In addition, the IDHW will monitor utilization of crisis stabilization services and whether there was a corresponding decrease in the number of individuals with SMI or SED presenting to hospital emergency departments in crisis.

The detailed evaluation plan will be developed after approval of the demonstration; however, the high-level evaluation parameters will include monitoring available quality data as well as utilization trends in Medicaid claims data to evaluate the various goals and hypotheses, such as utilization of the various service options, duration of treatment, setting of care, and readmission rates for individuals with SMI, SED and/or SUD covered by Idaho Medicaid.

Enrollment and Annual Expenditures

- **Impact on Annual Medicaid Expenditures.** Idaho Medicaid Expansion, which goes live on January 1, 2020, is expected to add up to 91,000 newly eligible Medicaid enrollees to the program. After adjustments to expenditure data to offset the effects of expansion, the Idaho Behavioral Health Transformation Waiver is expected to reduce annual Medicaid expenditures throughout the 2020–2024 demonstration period. Beyond reimbursement for covered services received in an IMD, no other program features or benefits are proposed to be formally modified through the waiver authority.

  Projections of total expenditures with and without the waiver for Demonstration Years 2020-2024 are shown in the table below.

Without-Waiver Total Expenditures	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
IMD Services MEG 1: FFS - SMI/SED	$8,928,080	$10,292,290	$11,864,950	$13,677,917	$15,767,906	$60,531,143
IMD Services MEG 2: FFS - SUD	$2,454,748	$2,829,834	$3,262,232	$3,760,701	$4,335,335	$16,642,851
IMD Services MEG 3	$0	$0	$0	$0	$0	$0
Continue MEGs from Above, As Needed						
TOTAL	$11,382,828	$13,122,124	$15,127,182	$17,438,617	$20,103,242	$77,173,993
With-Waiver Total Expenditures						
	2020	2021	2022	2023	2024	TOTAL
IMD Services MEG 1: FFS - SMI/SED	$8,928,080	$10,292,290	$11,864,950	$13,677,917	$15,767,906	$60,531,143
IMD Services MEG 2: FFS - SUD	$2,454,748	$2,829,834	$3,262,232	$3,760,701	$4,335,335	$16,642,851
IMD Services MEG 3	$0	$0	$0	$0	$0	$0
Continue MEGs from Above, As Needed						
TOTAL	$11,382,828	$13,122,124	$15,127,182	$17,438,617	$20,103,242	$77,173,993
Net Overspend	$0	$0	$0	$0	$0	$0

- **Impact on Medicaid Enrollment.** The demonstration is not anticipated to result in any increase or decrease in total enrollments in Idaho's Medical Assistance Program. As of July 2019, there are approximately 228,250 Idahoans enrolled in Medicaid. Beginning in January 2020, approximately 91,000 newly eligible individuals could enroll as part of Idaho's expansion of Medicaid to the Adult population group. Adult expansion coverage is slated to go live on

January 1, 2020. Accounting for average enrollment growth, in addition to the expansion of the Medicaid program to these new adults, IDHW anticipates covering roughly 321,471 lives in 2020. Such enrollment projections will not be impacted by the waiver.

This waiver does not change eligibility criteria, but merely adds the ability for IDHW to reimburse for medically necessary services provided in an inpatient or residential treatment setting qualifying as an IMD to Medicaid enrolled adults ages 21 through 64 diagnosed with SMI, SED and/or SUD. Medicaid enrolled adults who have one or both of these diagnoses, including new enrollees from the adult expansion population, are estimated to consist of 2,184 enrollees**.** However, the broader behavioral health reform initiatives described in the waiver will target all Medicaid enrollees with a behavioral health diagnosis, which is estimated to be nearly 65,600 enrollees in 2020.

Program Features

Aside from the waiver to allow reimbursement for covered services provided in an IMD for individuals with SMI, SED and/or SUD, no other program features of Idaho's Medicaid program are proposed to be formally modified through this waiver authority, including benefits, cost sharing, and delivery system. IDHW will implement all other initiatives described in the waiver application through a State Plan Amendment or other existing authorities.

Waiver Authorities

Idaho has requested expenditure authority under this Section 1115 waiver for otherwise covered services furnished to otherwise Medicaid eligible individuals, ages 21 through 64, for short-term stays for acute care in a psychiatric hospital that qualifies as an IMD.

No additional waivers of Title XIX or Title XXI were requested through this demonstration application. All other initiatives and proposed program enhancements will be implemented through other authorities outside of this Section 1115 waiver.

Public Hearings

The IDHW is seeking public comment through public hearings, via email or traditional mail as indicated below. Public hearings will be held on the following dates and locations:

Boise Public Hearing
December 2, 2019, 3:30–5:00 PM
Joe R. Williams (JRW) Building East
700 W. State St.
Boise, ID 83702
Or call in to 1-877-820-7831, 301388#

Public Meeting – Medical Care Advisory Committee
December 3, 2019, 3:30–5:00 PM
Medicaid Central Office
3232 Elder St., Conference Room D
Boise, ID 83705
Or call in to 1-877-820-7831, 301388#

Written Comments

IDHW will carefully review and consider all public comments received related to the proposed Section 1115 Behavioral Transformation demonstration waiver and all of the behavioral health

initiatives described therein, including the specific IMD waiver, prior to submitting the full application for review and approval.

Interested parties may request hard copies of the waiver packet or may view it online by visiting our website at https://medicaidexpansion.idaho.gov/. In addition to the full waiver application, the website also contains a copy of the IDHW's abbreviated notice, all tribal communications, and other information supporting the waiver. This website will be periodically updated throughout the comment and review process.

Interested parties may also submit written comments via email or traditional USPS mail to:

Attention: Clay Lord
Medicaid Program Policy Analyst
Division of Medicaid
P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: 1115.IMDBH@dhw.idaho.gov

Public comments will be accepted through end of day Tuesday, December 24, 2019.

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

Idaho Department of Health and Welfare Behavioral Health Transformation (IMD) Waiver Abbreviated Notice of Public Hearing and Public Comment Period

The Idaho Department of Welfare (IDHW) gives notice of its intent to apply to the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 demonstration waiver on or after **January 3, 2020.** The purpose of this waiver, the *Idaho Behavioral Health Transformation Waiver,* is to seek federal approval to waive the regulatory exclusion of reimbursement for mental health and substance use disorder services delivered to Medicaid enrollees ages 21-64 in Institutions for Mental Diseases (IMDs). Affected beneficiaries comprise eligible Idahoans diagnosed with serious mental illness (SMI)/serious emotional disturbance (SED) and/or substance use disorder (SUD).

During the 2019 session, the Idaho state legislature passed Senate Bill 1204, which created a new subsection in state law—Section 56-263(8), Idaho Code—requiring the Director of the Idaho Department of Health and Welfare to research options and apply for federal waivers which would enable cost-efficient use of Medicaid funds to pay for substance use disorder and/or mental health services in IMDs.

In addition to enabling reimbursement of IMD services, the waiver application describes Idaho's high-level vision for enhancing the entire behavioral health continuum of care. By expanding the depth and breadth of behavioral health services available through state/federal-partnerships, this waiver will help to decrease reliance on the most intensive and most costly levels of care (crisis services, acute psychiatric hospitalizations, and residential treatment services) and to usher in a new era of behavioral health treatment in Idaho.

The IDHW's comprehensive public notice, tribal notice and the waiver application are available on our website at https://medicaidexpansion.idaho.gov/. The IDHW is providing public hearings to receive comments from the public on the following dates at these locations and times:

Boise Public Hearing
December 2, 2019, 3:30–5:00 PM
Joe R. Williams (JRW) Building East
700 W. State St.
Boise, ID 83702
Or call in to 1-877-820-7831, 301388#

Public Meeting – Medical Care Advisory Committee
December 3, 2019, 3:30–5:00 PM
Medicaid Central Office
3232 Elder St., Conference Room D
Boise, ID 83705
Or call in to 1-877-820-7831, 301388#

Interested parties may request hard copies of the waiver packet or submit written comments via email or traditional USPS mail to:

Attention: Clay Lord
Medicaid Program Policy Analyst
Division of Medicaid
P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: 1115.IMDBH@dhw.idaho.gov

Public comments will be accepted through December 24, 2019.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

PURCHASE ORDER

Date: November 25, 2019

PO Number: 09142018

Account Number: 262720

Email To: jhildreth@idahostatesman.com
ATTN: Janice Hildreth
Legals Advertising Clerk
Idaho Statesman
1200 N. Curtis Rd.
Boise, ID 83706
Tel: 208-377-6306
Fax: 208-377-6309

Bill To: ATTN: Robin Butrick
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009
(208) 364-1863

Description: Legal Notice – 1115 Waiver Behavioral Health IMD

Idaho Statesman

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Order Confirmation

Customer	Payor Customer
ID DEPT OF H&W / MEDICAID	ID DEPT OF H&W / MEDICAID

Customer Account
262720

Payor Account
262720

Customer Address
3232 ELDER ST
BOISE ID 837054711 USA

Payor Address
3232 ELDER ST
BOISE ID 837054711 USA

Customer Phone
208-364-1804

Payor Phone
208-364-1804

Customer Fax
208-334-2465

Customer EMail
Teresa.Martin@dhw.idaho.gov

Sales Rep
bjantzen@mcclatchy.com

Order Taker
bjantzen@mcclatchy.com

PO Number	Payment Method	Blind Box	Tear Sheets	Proofs	Affidavits
11/25/2019	Invoice		1	0	1

Net Amount	Tax Amount	Total Amount	Payment Amount	Amount Due
$123.84	$0.00	$123.84	$0.00	$123.84

Ad Order Number
0004474168

Order Source

Ordered By
Robin Butrick

Special Pricing

Invoice Text
Legal Notice – 1115 Waiver Behavioral Health IMD

Promo Type

Package Buy

Materials

Ad Order Information

Ad Number	Ad Type	Production Method	Production Notes
0004474168-01	BOI-Legal Liner	AdBooker	

External Ad Number	Ad Attributes	Ad Released	Pick Up
		No	

Ad Size	Color
3 X 43 li	

Product	Placement	Times Run	Schedule Cost
BOI-Idaho Statesman	0300 - Legals Classified	1	$123.84

Run Schedule Invoice Text	Position
Idaho Department of Health and Welfare B	0301 - Legals & Public Notices

Run Dates
11/26/2019

Idaho Department of Health and Welfare Behavioral Health Transformation (IMD) Waiver Abbreviated Notice of Public Hearing and Public Comment Period

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700 W. State St.
Boise, ID 83702
Or call in to 1-877-820-7831, 301388#

Public Meeting – Medical Care Advisory Committee
December 3, 2019, 3:30–5:00 PM
Medicaid Central Office
3232 Elder St., Conference Room D
Boise, ID 83705
Or call in to 1-877-820-7831, 301388#

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Attention: Clay Lord
Medicaid Program Policy Analyst
Division of Medicaid
P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: 1115.IMDBH@dhw.idaho.gov

Public comments will be accepted through December 24, 2019.

0004474168-01

Idaho Statesman

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AFFIDAVIT OF PUBLICATION

Account #	Ad Number	Identification	PO	Amount	Cols	Depth
262720	0004474168	Idaho Department of Health and Welfare Behavio	11/25/2019	$123.84	3	4.22 In

Attention: Robin Butrick

ID DEPT OF H&W / MEDICAID
3232 ELDER ST
BOISE, ID 837054711

Idaho Department of Health and Welfare Behavioral Health Transformation (IMD) Waiver Abbreviated Notice of Public Hearing and Public Comment Period

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Attention: Clay Lord
Medicaid Program Policy Analyst
Division of Medicaid
P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: 1115.IMDBH@dhw.idaho.gov

Public comments will be accepted through December 24, 2019.

0004474168-01

VICTORIA RODELA, being duly sworn, deposes and says: That she is the Principal Clerk of The Idaho Statesman, a daily newspaper printed and published at Boise, Ada County, State of Idaho, and having a general circulation therein, and which said newspaper has been continuously and uninterruptedly published in said County during a period of twelve consecutive months prior to the first publication of the notice, a copy of which is attached hereto: that said notice was published in The Idaho Statesman, in conformity with Section 60-108, Idaho Code, as amended, for:

1 Insertions

Beginning issue of: 11/26/2019

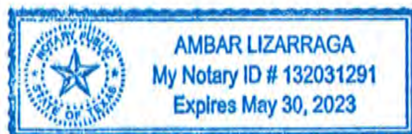
Ending issue of: 11/26/2019

V Rodela

(Legals Clerk)

On this 26th day of November in the year of 2019 before me, a Notary Public, personally appeared before me Victoria Rodela known or identified to me to be the person whose name subscribed to the within instrument, and being by first duly sworn, declared that the statements therein are true, and acknowledged to me that she executed the same.

Notary Public in and for the state of Texas, residing in Dallas County



Extra charge for lost or duplicate affidavits. Legal document please do not destroy!

From: Butrick, Robin - Medicaid
To: Idaho Statesman
Cc: Butrick, Robin - Medicaid
Subject: Legal Notice for Publication – 1115 IMDBH Waiver Application
Date: Friday, November 22, 2019 5:15:28 PM
Attachments: image001.jpg

Hello,

Here is a notice (in both PDF and Word) to be placed under the Legal Notices section of your paper to post in the next available publication for one (1) day only.

**I have attached the PO and request for a work order.

Please send invoice/billing to:

Robin Butrick
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009

Please provide me an email stating what day you will be publishing these notices and a copy of the confirmation/proof of publication with your invoice.

Please reach out if you have any questions or comments.

Sincerely,

Robin Webb Butrick

Robin Webb Butrick
Policy Analyst/Coordinator
IDHW Division of Medicaid, Policy
Robin.Butrick@dhw.idaho.gov
(208) 364-1836

HnW LogoSmall

We are Medicaid ! We pay for better health !

From:	Butrick, Robin - Medicaid
To:	Brasier, Jana K.; Davis, Rena - Reg2; Luna, Rita - Reg3; Pawson, Tami L. - Reg5; Rea, Gayle - Reg1; Wilson, Holly - Reg6; Johnsen, Debra - Reg4
Cc:	Butrick, Robin - Medicaid
Subject:	Legal Notice IDHW Offices – Product Subject
Date:	Friday, November 22, 2019 5:09:32 PM
Attachments:	image001.jpg

Hello Everyone,

I am contacting you to request your assistance in making Medicaid Public Notice information available in your local DHW offices on Monday

When the Division of Medicaid makes reimbursement changes to its Medicaid State Plan or waivers, we are responsible for ensuring that copies of the proposed reimbursement changes are available for public review in each county of the state. We are requesting your assistance because Medicaid does not have a presence in all DHW offices. We would like you distribute our public notice to the front desk staff in the following DHW offices, and ask staff to provide copies of the notice to stakeholders **who request a copy**:

- DHW Region 1, 207 Larkspur Street, Ponderay, ID 83852
- DHW Region 1, 35 Wildcat Way, Suite B, Kellogg, ID 83837
- DHW Region 2, Camas Resource Center, 216 South C Street, Grangeville, ID 83530
- DHW Region 2, 1350 Troy Highway, Moscow, ID 83843
- DHW Region 3, 515 N. 16th Street, Payette, ID 83661
- DHW Region 4, 2420 American Legion Blvd., Mountain Home, ID 83647
- DHW Region 5, 2241 Overland Avenue, Burley, ID 83318
- DHW Region 6, 701 East Alice, Blackfoot, ID 83221
- DHW Region 6, 223 North State, Preston, ID 83263
- DHW Region 7, 111 Lillian Street, Suite 104, Salmon, ID 83467
- DHW Region 7, 333 Walker Drive, Rexburg, ID 83440

We do not expect many stakeholders to request this information from your staff; however, we are happy to make arrangements to cover the cost of printing copies if needed.

Please find attached the following document(s) to be made available to stakeholders from

Monday, November 25th to Tuesday, December 24th :

- Legal Notice for Publication – Medicaid 1115 Waiver Behavioral Health Transformation (IMD) Public Notice

Please let me know if you have any questions or concerns.

Thank you for your partnership!

Sincerely,

Robin Webb Butrick

Robin Webb Butrick
Policy Analyst/Coordinator
IDHW Division of Medicaid, Policy
Robin.Butrick@dhw.idaho.gov
(208) 364-1836

From:	Butrick, Robin - Medicaid
To:	District Health 1 - Whelan, Lora; District Health 2 - Moehrle, Carol M.; District Health 5 - Bowyer, Melody; District Health 6 - Mann, Maggie; "PHD 3 - Southwest District Health- Director Nikole Zogg"; "PHD 4 - Central District Health Dept- Director Russ Duke"; "PHD 7 - Eastern Idaho Public Health- Director Geri Rackow"
Cc:	Butrick, Robin - Medicaid
Subject:	Medicaid 1115 IMD Waiver Documents for Distribution in Public Health District Local Offices
Date:	Friday, November 22, 2019 5:01:44 PM
Attachments:	image001.jpg

Hello All,

I hope all is well with you!

I am contacting you to request your assistance in making our Medicaid Product Subject Public Notice (attached) available in your office.

When the Division of Medicaid makes reimbursement changes to its Medicaid State Plan or waivers, we are responsible for ensuring that copies of the proposed changes are available for public review in each county of the state. We are requesting your assistance because Medicaid does not have offices in each Idaho county. As with similar previous requests, we would like you distribute our public notice and draft to the front desk staff in each public health office in your districts, and ask staff to provide a copy to stakeholders **who request a copy**. We do not expect many stakeholders to request this information from your staff; however, we are happy to make arrangements to cover the cost of printing copies if needed.

Please find attached the following document(s) to be made available to stakeholders from

Monday, November 25th to Tuesday, December 24th :

- Legal Notice for Publication – Medicaid 1115 Waiver Behavioral Health Transformation (IMD) Public Notice

Also, while Medicaid doesn't expect a high volume of these types of changes in the future, we will (from time to time) have some documents that will need to be made available in each Idaho county. I know you are very busy, so (if you are willing to continue helping us) please let me know if there is anything I can do to help streamline our requests and I will relay this information to my colleagues:

- Would a consistent subject line be helpful? e.g. "Medicaid Documents for Distribution in Public Health District Local Offices"
- Do you prefer an advance email letting you know that we will have documents for distribution in the future or would you just prefer one email with the documents attached 1-2 days before the comment period?
- Is there someone else in your district that you would prefer us to contact?

Thank you so much for your continued partnership!

Please reach out if you have any questions or comments.

Sincerely,

Robin Webb Butrick

Robin Webb Butrick
Policy Analyst/Coordinator
IDHW Division of Medicaid, Policy
Robin.Butrick@dhw.idaho.gov
(208) 364-1836

From:	Butrick, Robin - Medicaid
To:	Camas County Clerk"s Office - Korri Blodgett; Boise County Clerk Office- Mary T. Prisco; Adams County Clerk - Sherry Ward
Subject:	Medicaid 1115 IMD Waiver for Distribution in County Clerks Offices
Date:	Friday, November 22, 2019 4:53:00 PM
Attachments:	image001.jpg

Hello All,

I hope you are having a nice autumn!

I am contacting you to request your assistance in making our Medicaid (attached) available in your office.

When the Division of Medicaid makes reimbursement changes to its Medicaid State Plan or waivers, we are responsible for ensuring that copies of the proposed changes are available for public review in each county of the state. We are requesting your assistance because Medicaid does not have offices in each Idaho county. As with similar previous requests, we would like you distribute our public notice and draft to the front desk staff in each of your offices, and ask staff to provide a copy of the notice to stakeholders **who request a copy**. We do not expect many stakeholders to request this information from your staff; however, we are happy to make arrangements to cover the cost of printing copies if needed.

Please find attached the following document(s) to be made available to stakeholders from

Monday, November 25th to Tuesday, December 24th :

- Legal Notice for Publication – Medicaid 1115 Waiver Behavioral Health Transformation (IMD) Public Notice

Thank you so much for your continued partnership!

Please reach out if you have any questions or comments.

Sincerely,

Robin Webb Butrick

Robin Webb Butrick

Policy Analyst/Coordinator

IDHW Division of Medicaid, Policy

Robin.Butrick@dhw.idaho.gov

(208) 364-1836

We are Medicaid ! We pay for better health !

From:	Butrick, Robin - Medicaid
To:	"Angela Beauchaine, MD "; "April Dunham"; "barnold@sde.idaho.gov"; "Barton HIll, MD"; "bibiana.nertney@mycpid.com"; "Bill Benkula"; "Cathy McDougall"; "Ceci Thunes"; "Charles Davis"; "Corey Makizuru"; COREY SURBER; "Courtney Holthus"; "Daniel Meltzer"; "Davison, Eva"; "Deanne Schildan"; Denny, Wayne A.; "Dr. Kelly McGrath"; "Dr. Kelly McGrath "; "Elizabeth Caval-Williams"; "Eva Davison"; "Francois Cleveland"; "georganne.benjamin@optum.com"; Hahn, Christine; "idahoaap@gmail.com"; "idahopharmacists@gmail.com"; "idahorha@gmail.com"; "info@icdd.idaho.gov"; "info@idahopca.org"; "info@teamiha.org"; "info@theisda.org"; "iversons@slhs.org."; "James Torres MD"; "jann.stockwell@optum.com"; "jbrandt@sde.idaho.gov"; "John Rusche"; "kbrassfield@idcounties.org"; "kcundiff@idcounties.org"; "kellis@apublicpolicy.com"; "Ken Price"; "Kenneth Bramwell"; "Kevin Bittner"; Kris Ellis; "kstreagle@sde.idaho.gov"; "L Woodruff"; "Linda Rowe"; "Maija.Teppola@bcidaho.com"; "Margaret Henbest; Mel Leviton (SILC); "membership@idmed.org"; "Mitzi Lewis"; "Nalani Namauu"; "optum_idaho_mfa@optum.com"; "Pam"; "Pam Eaton"; "Patricia "Patt" Richesin"; "Paul Brannan (IHDE)"; Penny Beach MD; "rebecca@idmed.org"; "Rep. Fred Wood"; "Rhonda Robinson Beale"; "Richard Armstrong"; "Rob Anson"; "Robert Sundquist (Tim D Assist.)"; "robert@idhca.org"; "Sara Stover"; "Sen. Lee Heider"; "sgrigg@idcounties.org"; "shaunbills@soarwellness.com"; Shaw-Tulloch, Elke D.; Sheridan, Mary; Spencer, Dieuwke A.; "Stephanie Bender-Kitz"; "Susie Pouliot"; "Ted Epperly, MD"; Teresa Cerelli; "thibbard@idcounties.org"; "Tim Dunnagan (Chair) "; "Tina Bullock"; "Toni Lawson"; "Vaughn Holbrook"; "Yvonne Ketchum"; Andrew Baron; Besler, Shelby-Lyn - CO 4th; Charity Kennedy; Christina Thomas; COREY SURBER; Craig Belcher; David Pate, MD; Debra Lee; deenal; Denise Chuckovich; District Health 6 - Mann, Maggie; Dr. Sam Summers; Drew Hobby; Geri Rackow; Heintz, John; Hettinger, Lisa; Hilary Klarc; Janet Reis; Jason Haugen; Jayne Josephsen; Jeanene Smith; Jeff Crouch; Jenni Gudapati; Jensen, Burke - Medicaid; Jeppesen, Dave; Jim Borchers; Joshua Bishop; jwheeler; Karen Vauk; Karl Watts; Kathy Brashear; Keith Davis; Kevin Gray; Kevin Rich MD; Krista Stadler; Larry Tisdale; Leslie Mayer; Matt Bell; Melissa McVaugh; Michelle Anderson; Mike Hajjar; Neva Santos; Nikki Zogg; Norm Varin; Pam Catt-Oliason; Patt Richesin; Randall Hudspeth; Rhonda Robinson Beale; Richard Bell MD; Robbie Roberts; Russ Duke; Sayegh, Stephanie A.; Schreiber, Kymberlee; Scott Dunn; Shaw-Tulloch, Elke D.; Spencer, Dieuwke A.; Susie Pouliot; Ted Epperly, M.D.; Vasquez, Joey - Medicaid; Watkins, Ann; Westcott, Gina R.; Wimmer, Matt; Yvonne Ketchum-Ward
Cc:	Wimmer, Matt; Martin, Teresa M.; Butrick, Robin - Medicaid; Jensen, Burke - Medicaid; Schreiber, Kymberlee; Welsh, David; Libby, Catherine - Medicaid; Kriete, Elizabeth; Howard, Aaron - Medicaid; Loveless, Curtis B.; Edmunds, Ross D.; Hettinger, Lisa; Wolff, Lori A.; Kunz, Greg; Jackson, Robbie; Forbing-Orr, Niki; Petroff, Kelly - CO 10th; Lord, Clay; Bidwell, Jennifer - Medicaid; Hamso, Magni - Medicaid; Edmunds, Ross D.; Schreiber, Seth; Hammon, Julie; Beal, Charles - Medicaid; Bell, David - Medicaid; Case, Michael A. - Medicaid
Subject:	Medicaid 1115 Waiver Behavioral Health Transformation (IMD) Public Notice
Date:	Friday, November 22, 2019 5:07:40 PM
Attachments:	image001.jpg

Hello,

We are reaching out to you to let you know that we have posted a public notice and draft language for the 1115 Behavioral Health Transformation (IMD) Waiver (see attached). We are asking for your help in circulating this information to your colleagues and members of the organizations you represent for their feedback and comment.

You can find detailed information on this waiver application at https://medicaidexpansion.idaho.gov.

Public hearings will be held on the following dates and locations:

Boise Public Hearing
December 2, 2019, 3:30–5:00 PM
Joe R. Williams (JRW) Building East
700 W. State St.
Boise, ID 83702
Or call in to 1-877-820-7831, 301388#

Public Meeting –
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Medicaid Central Office
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Attention: Clay Lord
Medicaid Program Policy Analyst
Division of Medicaid
P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: 1115.IMDBH@dhw.idaho.gov

Public comments will be accepted through December 24, 2019.

We look forward to hearing from you!

Thanks,

Matt Wimmer
Administrator
Division of Medicaid

Idaho Department of Health and Welfare
(208) 364-1804
We pay for better health.
Please reach out if you have any questions or comments.
Sincerely,

Robin Webb Butrick

Robin Webb Butrick
Policy Analyst/Coordinator
IDHW Division of Medicaid, Policy
Robin.Butrick@dhw.idaho.gov
(208) 364-1836

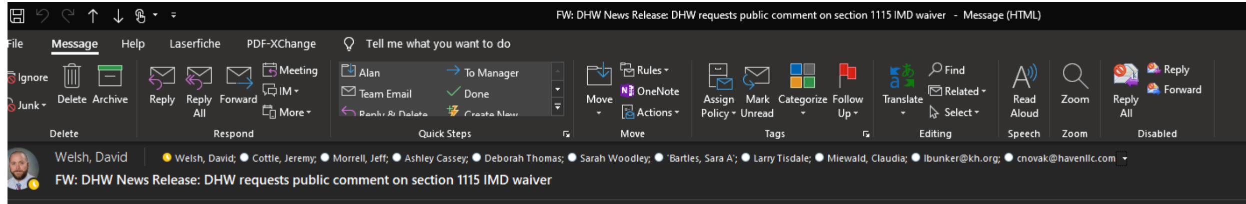
HnW LogoSmall

We are Medicaid ! We pay for better health !

From: Welsh, David
To: Schreiber, Kymberlee; Butrick, Robin - Medicaid; Lord, Clay
Subject: RE: other contact lists for IMD 1115 waiver
Date: Friday, December 13, 2019 12:58:34 PM
Attachments: image001.png

I BCC a bunch of folks from :

- IHA
- KBH
- Cottonwood Creek
- Intermountain
- BPA -BPA sent to their SUD Res providers
- Optum



Good Morning,
I wanted to make sure you received this public notice. Please forward to your team accordingly.

Best,

David Welsh
Program Manager
IDHW, Division of Medicaid
Medical Care Unit & Children's Medicaid
Office: 208.364.1813
Cell: 908.343.7214
david.welsh@dhw.idaho.gov

From: Forbing-Orr, Niki <Niki.Forbing-Orr@dhw.idaho.gov>
Sent: Friday, November 22, 2019 6:01 PM

-DW

From: Schreiber, Kymberlee <Kymberlee.Schreiber@dhw.idaho.gov>
Sent: Friday, December 13, 2019 12:31 PM
To: Butrick, Robin - Medicaid <Robin.Butrick@dhw.idaho.gov>; Lord, Clay <Clay.Lord@dhw.idaho.gov>
Cc: Welsh, David <David.Welsh@dhw.idaho.gov>
Subject: other contact lists for IMD 1115 waiver

Robin & Clay – attached is the email I forwarded for the notice, if you want to include these contacts with the CMS submission.

DW – I can't find the email you sent, could you share that with the group, please?

Kym

From:	Forbing-Orr, Niki
To:	Forbing-Orr, Niki
Subject:	DHW News Release: DHW requests public comment on section 1115 IMD waiver
Date:	Friday, November 22, 2019 6:01:39 PM
Attachments:	logo-color-horizontaRGB_LG.jpg image001.png image002.png image003.png

cid:566355120@11042011-32CB

www.healthandwelfare.idaho.gov

NEWS RELEASE--FOR IMMEDIATE RELEASE Date: Nov. 22, 2019

Contact: Niki Forbing-Orr
Public Information Manager
(208) 334-0668

DHW requests public comment on section 1115 IMD waiver

BOISE ID – In response to an increasing need for access to inpatient behavioral health care and changes in Idaho law during the 2019 legislative session, the Idaho Department of Health and Welfare (DHW) released a section 1115 IMD Waiver titled Behavioral Health Transformation Waiver on Friday for public comment. Public comments will be accepted through Dec. 24, 2019.

If approved by CMS, this waiver would allow Medicaid to cover inpatient psychiatric hospitalization at all facilities as part of the overall behavioral health system of care. Today, individuals who are admitted to a freestanding psychiatric hospital with more than 16 beds cannot have these services covered by Medicaid, even if they are Medicaid eligible. These services are only payable when rendered in a full-service hospital.

The waiver focuses more than just coverage for treatment in a psychiatric hospital and lays out the full continuum of care for individuals suffering from mental illness and substance use disorders. This waiver is also focused on the transformation of the behavioral health system in Idaho by expanding access to outpatient behavioral health services throughout the state, particularly in rural and frontier areas. Idahoans will be able to access a wider array of services and will benefit from improved coordination of care, particularly when transitioning between levels of care.

Confronting the opioid epidemic, a priority for both the Governor's Office and the Idaho Legislature, is a major component of this waiver. More, and more varied, resources will be made available under this waiver for assisting and treating those with substance and opioid use disorders, in particular by expanding the currently available levels of care.

"The department's vision is that Idahoans who live with mental illness and addiction can access the behavioral health care services they need when they need them," said DHW Director Dave Jeppesen. "If it's approved, this waiver will help make that vision a reality."

DHW's comprehensive public notice, tribal notice and the waiver application are available at https://medicaidexpansion.idaho.gov/. The department is

providing public hearings to receive comments on the following dates at these locations and times:

Boise Public Hearing

Monday, Dec. 2, 2019
3:30–5:00 PM
Joe R. Williams (JRW) Building East
700 W. State St., Boise
Or call in to 1-877-820-7831, 301388#

Public Meeting –
Medical Care Advisory Committee

Tuesday, Dec. 3, 2019
3:30–5:00 PM
Conference Room D in Medicaid Central Office, 3232 Elder St., Boise
Or call in to 1-877-820-7831, 301388#

Interested parties may request hard copies of the waiver packet or submit written comments via email or traditional USPS mail to:
Attention: Clay Lord
Medicaid Program Policy Analyst
Division of Medicaid
P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: 1115.IMDBH@dhw.idaho.gov

Public comments will be accepted through December 24, 2019.

Niki Forbing-Orr

Public Information Manager

Idaho Department of Health & Welfare

Media line: 208.334.0668

Desk: 208.334.0618

Cell: 208.514.5848

www.healthandwelfare.idaho.gov

Appendix D: Tribal Notice

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

November 22, 2019

Dear Tribal Representative:

We are writing to update you on our efforts to pursue Medicaid program waivers as described in the notice we sent to you on May 13, 2019 (attached). These waivers are being pursued to comply with new provisions in Idaho Code established during this year's legislative session. The Department intends to apply for a §1115 behavioral health transformation waiver to the Centers for Medicare and Medicaid Services (CMS) on or after January 3, 2020. We are posting formal public notice of this intent today (also attached). IDHW is requesting a five-year demonstration period and anticipates full implementation of the Idaho Medicaid Behavioral Health Transformation Waiver, also sometimes referred to as the IMD Waiver, within several months of federal approval.

In accordance with Senate Bill 1204, the purpose of this waiver is to expand the Idaho behavioral health continuum of care, not only enhancing the array of services but also increasing availability and access. In addition, this waiver will allow Medicaid reimbursement for psychiatric and substance use disorder services delivered in Institutions for Mental Diseases (IMDs).

Anticipated Impact on Indians/Tribal Health Programs/Urban Indian Organizations (ITU)
Impacts on Tribal members and organizations are not anticipated to be any different from other Medicaid enrollees. All participants will benefit from increased service offerings and access under this waiver, as well as the IMD services coverage, which will be available for the first time when the waiver is implemented.

Comments, Input, and Tribal Concerns
Idaho Medicaid would appreciate any input or concerns that Tribal representatives wish to share regarding this waiver. In order to allow for a timely submission to CMS, please submit any comments regarding the waiver **prior to December 24, 2019.** Idaho Medicaid's development of the proposed waiver will be reviewed as part of the Policy Update at the next quarterly Tribal Meeting.

Interested parties may also request hard copies of the waiver packet and submit comments via email or traditional USPS mail to:

Division of Medicaid
Attention: Clay Lord, Medicaid Program Policy Analyst
P.O. Box 83720, Boise, Idaho 83720-0009
E-mail to: 1115.IMDBH@dhw.idaho.gov

Lastly, if your tribe would like to set up a time for formal government-to-government consultation, please contact us as soon as possible so that we can work with you to arrange a meeting for this purpose.

Sincerely,

MATT WIMMER
Administrator

MW/cl

From:	Butrick, Robin - Medicaid
To:	Alvarez, Shirley D (IHS/POR; Axtel, Brenda; Bahe, Velma; Bergland, Paul; Broadsword, Joyce - Reg1; Bullock, Tina; Burke, Sharon; Crocker, Rebecca; DeGarmo, Taitum; Dixey, Wanda; Dombrowski, Debbie; Finkbonner, Joe; Griggs, Lisa; Hancock, Helo; Hansen, Karen; Helweg, Priya; Hendren, Karen; Hendrickx, Marquette; Honena, Donna; Hopkins, Jackienna; Jim, Ann; Joe Cladouhos; Jones, Johanna; Joyce, Elizabeth T. - SHN; Marimn Health Group; Marshall, Anthony; Martinez-McFarland, Rhonda (CMS/CMCHO; Marx, Kitty; Massey, Nicole; Mathieson, Nancy; Murray, Kathi; Neal, Walter; NPAIHB Mtg; Paul Brannan (IHDE); Penney, Loretta; Platero, Laura; Pokibro, Johnna M (IHS/POR; Randle, Sharon; Reisdorph, Pam; Rose, LaDawna; Sampson, Artrette; Smith, Emily; Smith, Gina; Smith, Leslie; Spencer, Dieuwke A.; Sullivan, Sarah; Teton, Randy"L; Tino Batt (Councilman); Tuell, Yvette; TwoBulls, Francine; Van Lente, Bill; Wahtomy, Nancy; Washakie, Morionna
Cc:	Bidwell, Jennifer - Medicaid; Butrick, Robin - Medicaid; Case, Michael A. - Medicaid; Choules, Susie - Reg3; Cook, Sheri E. - Medicaid; Eide, Tamara J.; Evans, Arthur - Medicaid; Fernandez, Alexandra; Finck, Michelle E.; Groesbeck, Joe - Medicaid; Hall, Meg L. - Reg1; Harris, Rick - Medicaid; Hoffman, Marlena - Reg4; Ivascu, Livia - Reg1; Killpack, Dustin - Reg5; Knigge, Kent L. - Reg2; Knigge, Sandra - Reg2; Kriete, Elizabeth; Lindsley, Lisa - Reg2; Loveless, Curtis B.; Lundholm, John - Reg1; Martin, Teresa M.; McArthur, Sandy C. - Reg6; Ray, Tammy; Stith, Sara; Toomey, Angela - Medicaid; Vasquez, Joey - Medicaid; Welsh, David; Wimmer, Matt; Jensen, Burke - Medicaid; Ayad, Katie - Medicaid; Brewington, Alan - Medicaid; Brock, Cindy S. - Medicaid; Childers-Scott, Alexandria - Medicaid; Connolly, Stacy - Medicaid; Davis, Katie - Medicaid; Deseron, William G.; Duncan, Gloria - Medicaid; Jensen, Burke - Medicaid; Leavitt, Kaylee; Lord, Clay; Pinkerton, Jennifer A. - Medicaid; Westbrook, Karen; Williams, Angie - Medicaid; Newell, Charina A.; Reynolds, Trish - Reg2; Schiller, Camille; Edmunds, Ross D.; Howard, Aaron - Medicaid; Libby, Catherine - Medicaid; Ayad, Katie - Medicaid; Kennedy-King, Jacquie; Hamso, Magni - Medicaid; Beal, Charles - Medicaid; David - Medicaid Bell (David.Bell@dhw.idaho.gov); Butrick, Robin - Medicaid
Subject:	ID Medicaid 1115 Waiver Behavioral Health Transformation (IMD) Tribal Notice
Date:	Friday, November 22, 2019 4:55:00 PM
Attachments:	image001.jpg

Hello,

The attached notice was posted to http://healthandwelfare.idaho.gov/meditribe on Tuesday, November 22, 2019.

The draft Medicaid 1115 Behavioral Health Transformation (IMD) Waiver application (with Public notices) is also attached for your review.

The notice will also be mailed to Tribal Headquarter Offices.

**It is no longer necessary to log in to view this page.

Please reach out if you have any questions or comments.

Sincerely,

Robin Webb Butrick

Robin Webb Butrick
Policy Analyst/Coordinator
IDHW Division of Medicaid, Policy
Robin.Butrick@dhw.idaho.gov
(208) 364-1836

HnW LogoSmall

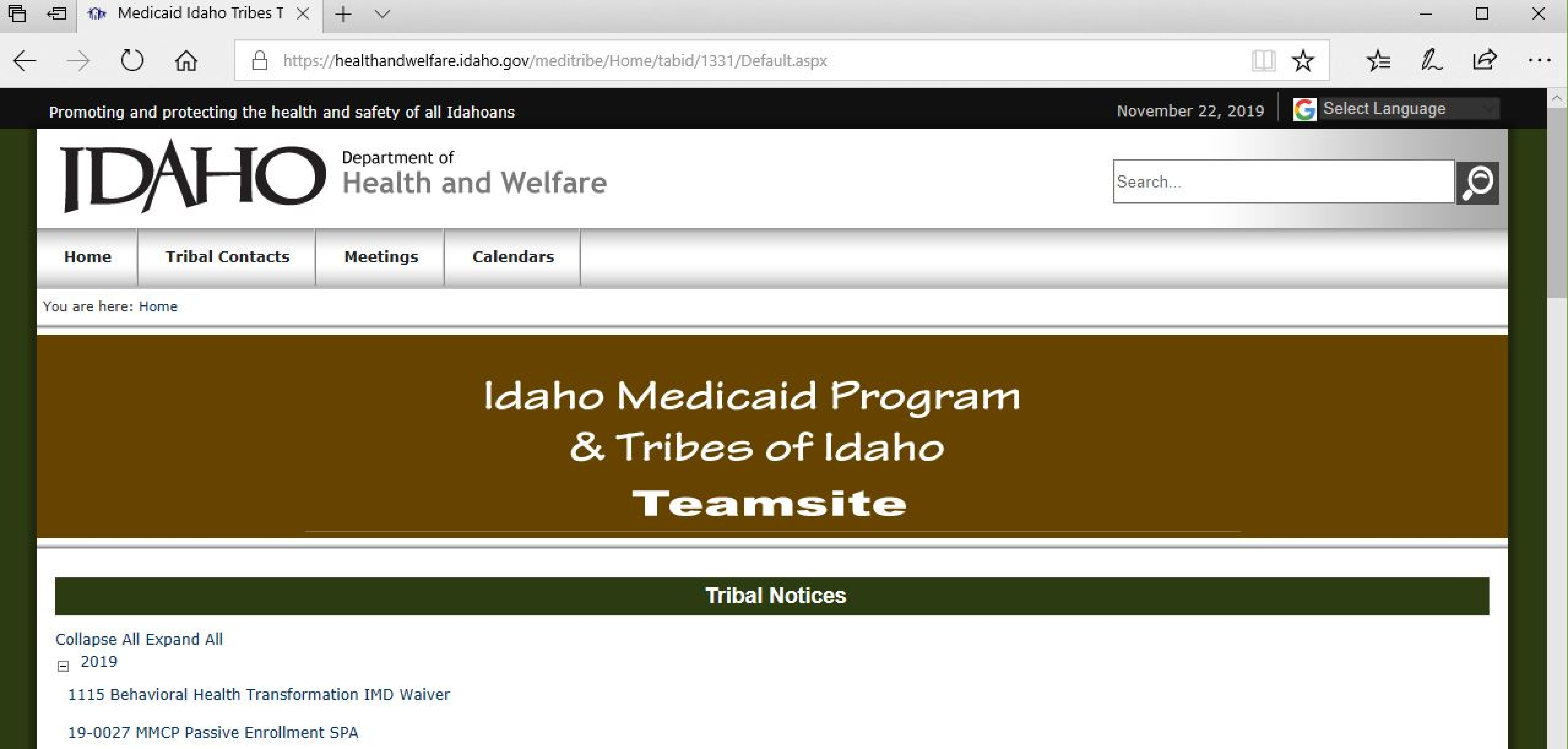
We are Medicaid ! We pay for better health !

Please reach out if you have any questions or comments.

Sincerely,

Robin Webb Butrick

Robin Webb Butrick
Policy Analyst/Coordinator
IDHW Division of Medicaid, Policy
Robin.Butrick@dhw.idaho.gov
(208) 364-1836


Medicaid Idaho Tribes T
https://healthandwelfare.idaho.gov/meditribe/Home/tabid/1331/Default.aspx
Promoting and protecting the health and safety of all Idahoans
November 22, 2019
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Health and Welfare
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Idaho Medicaid Program
& Tribes of Idaho
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Tribal Notices
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2019
1115 Behavioral Health Transformation IMD Waiver
19-0027 MMCP Passive Enrollment SPA

State of Idaho
DEPARTMENT OF INSURANCE

DEAN L. CAMERON
Director

BRAD LITTLE
Governor

DAVE JEPPESEN
Director

700 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0043
Phone 208-334-4250
Fax 208-334-4398
Website: https://doi.idaho.gov

450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5500
FAX 208-334-6558

May 13, 2019

Dear Tribal Leaders and Representatives,

We are writing to inform you that Idaho intends to submit three waiver requests to the federal government and to request your input and collaboration on our waiver applications. These requests to waive provisions of federal laws for Idaho's Medicaid and insurance exchange programs are expected to be submitted as soon as July 26th, 2019. We are requesting these waivers as required by changes to Idaho code in Senate Bill 1204* recently passed by the legislature and signed into Idaho law by Governor Little.

Many of the new provisions in Idaho code and the waivers we will be requesting revolve around Medicaid expansion coverage for adults established through ballot initiative last November. The initiative established coverage for Idahoans age 19 through 64 with incomes up to 138% of the federal poverty limit who do not otherwise qualify for Medicaid. Coverage for this adult expansion group will start on January 1, 2020.

The waivers we intend to request are described in the table below:

Waiver	*Purpose*	*Anticipated Impact to Tribal Members*
1. 1332 Waiver: Coverage Choice Waiver	To allow expansion group members with household incomes over 100% of the federal poverty limit to choose coverage supported by an Advanced Premium Tax Credit through Your Health Idaho instead of enrolling in Medicaid. Expansion group members may also decline their tax credit and choose to enroll in Medicaid coverage.	Tribal members may choose to keep their tax credit and cost share reductions to help pay for their Qualified Health Plan through Your Health Idaho rather than switching to Medicaid coverage. Those who choose exchange coverage will pay more for their insurance compared to Medicaid. Choice of coverage may have impacts on tribal healthcare systems and how they assist tribal members with their healthcare needs.

* https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2019/legislation/S1204E2.pdf

Waiver	*Purpose*	*Anticipated Impact to Tribal Members*
2. *1115 Waiver: Coverage Choice, Community Engagement, and Primary Care Family Planning*	a. To limit coverage for expansion group members with incomes over 100% of poverty to exchange coverage or Medicaid, but not both.	Tribal members in the adult Medicaid expansion group who qualify and select exchange coverage will not have access to Medicaid coverage in addition to exchange coverage. The impacts are described above.
	b. To require the adult Medicaid expansion coverage group to participate in work, volunteering, job training, or education as a condition of their eligibility.	Tribal members will be exempt from this requirement and there is no impact anticipated. Tribal health programs who serve non-tribal members may be impacted because some of the population they serve may be ineligible for Medicaid benefits because of these requirements.
	c. To require all Medicaid participants served through Medicaid's Healthy Connections primary care program to obtain a referral for family planning services or supplies before receiving them from a provider other than their chosen primary care provider*.	Tribal members will need to work with their primary care provider to obtain a referral rather than accessing services directly without a referral today. This may increase the work that needs to be done by tribal primary care providers serving tribal members or others eligible for Medicaid.
3. *1115 Waiver: Institution for Mental Diseases Waiver*	To allow Medicaid to pay for services provided to adults over age 20 and under age 65 in an institution for mental diseases	This will allow tribal members eligible for Medicaid with needs for these services an additional treatment option. Tribal health programs who help to pay for these services today may see reductions in their costs as coverage shifts to Medicaid.

The 1332 waiver is intended to be submitted through the Idaho Department of Insurance and the 1115 waivers are intended to be submitted through the Department of Health and Welfare. If you are interested in commenting on these waivers, learning more, or discussing them with state government representatives, we ask that you respond by June 13th, 2019. We will be working with the federal Centers for Medicare and Medicaid Services (CMS) on these requests and will keep tribes updated on the progression of waiver work and any changes to the approach presented here.

* Or an assigned primary care provider if they decline to choose one.

We will also be holding a meeting and conference call in Boise from 1:00 to 4:00 PM MDT on June 17th to discuss these waiver requests and their potential impact for tribes in Idaho:

East Conference Room
Joe R. Williams Building, 700 West State Street, Boise, ID 83702
Conference call: WEBEX 1-240-454-0879
Meeting Access Code: 806 527 494 Meeting Password: Qjze3dxJ (Dial: 75933395)
Meeting Link:
https://idhw.webex.com/idhw/j.php?MTID=m975f3d698bc1458e0db66aa820fcb160

We invite your participation and input at this meeting and will also meet with tribal representatives in person at other times upon your request.

To make commenting or asking questions about these requests simpler, we have designated a single point of contact for your responses. Please send your written comments via mail to:

Tribal Waiver Comments
P.O. Box 83720
Boise, ID 83720-0009

Please send email comments to *tribalwaivercomments@dhw.idaho.gov*. You may also fax written comments to (208) 364-1811. You may also call Cindy Brock with the Division of Medicaid at (208) 364-1983 with questions or verbal comments on these waivers.

We apologize for the limited time frame for the requested response. We wish we had more time to work with tribes in Idaho on these waivers but have a restricted amount of time to prepare and submit them in time for expansion coverage commencement on January 1st, 2020. We thank you for your comments and input in advance and appreciate the government to government relationship we share with your tribes.

Sincerely,

Dean Cameron
Director
Idaho Department of Insurance

Dave Jeppesen
Director
Idaho Department of Health and Welfare

Tribal Headquarters Distribution - Idaho
Shoshone - Bannock Tribes Attn: Nathan Small PO Box 306 Fort Hall, ID 83203-0306
Coeur D' Alene Tribe Attn: Ernie Stensgar, Chairman PO Box 408 Plummer, ID 83851-0408
Coeur D'Alene Tribe Attn: Marquette Hendricks Clinical Services Director PO Box 408 Plummer, ID 83851-0408
Kootenai Tribe of Idaho Attn: Gary Aitken, Jr, Chairman P.O. Box 1269 Bonners Ferry, ID 83805
Northwest Band of Shoshone Nation Attn: Darren Parry, Chairman 505 Pershing Ave Ste 200 Pocatello, ID 83201-5167
Shoshone - Paiute Tribes Attn: Mr. Theodore Howard, Chairman PO Box 219 Owyhee, NV 89832-0219
Nez Perce Tribe Attn: Mr. Shannon Wheeler, Chairman P.O. Box 305 Lapwai, ID 83540
Nez Perce Tribe Attn: Mary Jane Miles, Chairman P.O. Box 305 Lapwai, ID 83540
Northwest Portland Area Indian Health Board Attn: Lisa Griggs, Policy Analyst 2121 SW Broadway St., Ste 300 Portland, OR 97201
Portland Area Indian Health Service Attn: Nicole Dean, Program Assistant 1414 NW Northrup Street, Ste 800 Portland, OR 97209
Shoshone-Bannock Tribes Attn: Angela Mendez, Tribal Health Administrative PO Box 306 Fort Hall, ID 83203-0306

Tribal Notice Distribution - Idaho

Tribal Notice Distribution - Idaho
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