

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



March 29, 2024

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

Dear Director Charron:

The Centers for Medicare & Medicaid Services (CMS) is approving an amendment to Idaho's section 1115(a) demonstration entitled, "Idaho Behavioral Health Transformation" (Project Number 11-W00339/10) (the "demonstration"), in accordance with section 1115(a) of the Social Security Act (the Act). The approved requests under this amendment were submitted on November 7, 2023. On November 8, 2023, CMS approved a temporary extension of the state's existing COVID-19 expenditure authority in order to allow the state and CMS to continue negotiations over the state's demonstration amendment application. Approval of this amendment will enable Idaho to provide payment for legally responsible individuals (LRIs) providing 1905(a) personal care services (PCS). With this approval, the demonstration amendment will become effective March 29, 2024 through March 31, 2025, the current expiration date of the demonstration. The state may request to extend all authorities in the current demonstration, including the LRI PCS authority, when it submits its extension request

CMS's approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached expenditure authorities, special terms and conditions (STC), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures authorized under the demonstration.

Extent and Scope of Demonstration

During the COVID-19 public health emergency (PHE), the traditional provider workforce was diminished leading to inadequate capacity to provide medically necessary services such as supporting activities of daily living. To alleviate this provider workforce shortage, Idaho received approval on March 23, 2020, from CMS for section 1135 authority to provide payment to LRIs providing PCS. At the conclusion of the PHE on May 11, 2023, the section 1135 authority expired. On March 6, 2023, Idaho submitted a request to seek authority for these payments under COVID-19 PHE authority. CMS approved the state's request on May 16, 2023, which provided section 1115 authority through Idaho's Behavioral Health Transformation

demonstration retroactive to May 10, 2023, for payment for 1905(a) personal care services through six months following the end of the PHE. To ensure this authority would continue beyond six months post the PHE, the state was issued a temporary extension on November 8, 2023, to continue to provide payments under the COVID-19 PHE authority through March 29, 2024.

Under this demonstration amendment, Idaho will have the authority to provide payment to LRIs for providing PCS to beneficiaries currently accessing care through the 1905(a) PCS in the Idaho Medicaid state plan. This program aims to ensure the continuity of services for beneficiaries who were receiving PCS from LRIs during the PHE as well as increase access to PCS for individuals who are not able to identify a PCS agency provider, ultimately allowing the beneficiary the ability to stay in their home or community setting rather than receiving care in an institutional setting. The state will also implement additional requirements which were not required under COVID-19 PHE flexibilities. Beneficiaries will be required to make two attempts to obtain PCS from providers that are not LRIs. Additionally, LRIs will be required to abide by all oversight requirements from the hiring Personal Assistance Agencies (PAA) and the Idaho Department of Health and Welfare. Idaho will also require PAAs to conduct quarterly onsite supervisory visits of all beneficiaries accessing these services. These additional requirements will be phased in by the state and will be detailed in future monitoring reports.

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstrations are likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be “budget neutral,” meaning the federal costs of the state’s Medicaid program with the demonstration cannot exceed what the federal government’s Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the “without waiver” (WOW) costs).

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 State Medicaid Director Letter. CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for “mid-course” budget neutrality adjustments to situations that necessitate a corrective action plan, in which projected expenditure data indicated a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state’s baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the

state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a PHE; and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

The demonstration amendment is not expected to impact the overall number of people enrolled in the Medicaid program. The amendment does not change the eligible populations, rather it allows for a more long-term pathway for LRIs to continue delivering care to eligible beneficiaries receiving PCS as they have been doing during the PHE. The addition of this flexibility is projected to be budget neutral to the federal government. The state will be held to the budget neutrality monitoring and reporting requirements as per the STCs.

Monitoring and Evaluation

Consistent with CMS's requirements for monitoring and evaluation of section 1115 demonstrations, and as outlined in the STCs, the state is required to continue conducting systematic monitoring and robust evaluation of the demonstration, including the component included in this amendment. Throughout the life cycle of the demonstration approval period, monitoring will support tracking the state's progress towards its demonstration goals, and we expect that such monitoring will accommodate new policy areas such as the one approved with this amendment. Likewise, the state will accommodate this amendment in its evaluation deliverables, as applicable, for the remainder of this demonstration approval period. The state's monitoring and evaluation efforts must facilitate understanding the extent to which the amendment might support reducing existing disparities in access to and quality of care and health outcomes.

Consideration of Public Comments

CMS held a federal comment period from November 8, 2023, through December 8, 2023, for the demonstration amendment and received 169 comments.

Commentors shared strong support for continuing to provide payment for LRIs providing direct care after the end of the PHE. Commentors stressed the importance of the program in the face of worker shortages which made finding quality direct care services challenging or impossible. Multiple comments were received from direct care service providers confirming that position openings were difficult to fill.

More than 90 percent of commentors expressed concern about new requirements included in the state's submitted amendment which were not included during the COVID-19 PHE. Most commentors mentioned that the requirement to complete two attempts to obtain PCS or attendant care services from providers that are not LRIs in order to be reimbursed would be a barrier to family choice. To address these concerns, the state has agreed to modify their application to

phase in these new requirements, which are allowable under section 1115 demonstration authority and are intended to ensure continuity of care and assurance of adequate services. Although states are not required to, they have the flexibility to define limitations or specific circumstances under which LRIs and other family caregivers may be paid providers. The state's additional requirements do not conflict with any federal regulations or statutes; therefore, CMS does not have the authority to require the state to remove those provisions from its demonstration amendment.

After careful review of the public comments submitted during the federal public comment period and the information received from the state public comment period, CMS has concluded that the demonstration amendment is likely to advance the objectives of Medicaid.

Other Information

CMS's approval of this amendment is conditioned on compliance with the enclosed set of STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to your written acknowledgement of the award and acceptance of the STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Mr. Alex Desatoff. He is available to answer any questions concerning your section 1115 demonstration. Mr. Desatoff may be reached at Alex.Desatoff@cms.hhs.gov.

If you have any questions regarding this approval, please contact Ms. Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

A solid black rectangular box used to redact the signature of Daniel Tsai.

Daniel Tsai
Deputy Administrator and Director

Enclosure

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00339/10

TITLE: Idaho Behavioral Health Transformation

AWARDEE: Idaho Department of Health and Welfare

Under the authority of section 1115(a)(2) of the Social Security Act (“the Act”), expenditures made by Idaho for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from April 17, 2020 through March 31, 2025, unless otherwise specified, be regarded as expenditures under the state’s title XIX plan.

As discussed in the Centers for Medicare & Medicaid Services’ (CMS) approval letter, the Secretary of Health and Human Services has determined that the Idaho Behavioral Health Transformation demonstration, including the granting of the expenditure authority described below, is likely to assist in promoting the objectives of title XIX of the Act.

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

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

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00339/10

TITLE: Idaho Behavioral Health Transformation

AWARDEE: Idaho Department of Health and Welfare

I. PREFACE

The following are the Special Terms and Conditions (STC) for the “Idaho Behavioral Health Transformation” section 1115(a) Medicaid demonstration (hereinafter “demonstration”), to enable the Idaho Department of Health and Welfare (hereinafter “state”) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authority authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on the expenditure authority, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS related to the demonstration. The demonstration will be statewide and is approved for a five-year period, from April 17, 2020 through March 31, 2025.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Demonstration Programs and Benefits
- VI. Cost Sharing
- VII. Delivery System
- VIII. General Reporting Requirements
- IX. Monitoring
- X. Evaluation of the Demonstration
- XI. General Financial Requirements Under Title XIX
- XII. Monitoring Budget Neutrality for the Demonstration
- XIII. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: SMI/SED Implementation Plan and Financing Plan
- Attachment D: SUD Implementation Plan
- Attachment E: Reserved for SMI/SED/SUD Monitoring Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

This demonstration will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED) and/or substance use disorder (SUD) while they are short-term residents in residential and inpatient treatment settings that qualify as Institutions for Mental Diseases (IMDs). It will also support state efforts to implement models of care focused on increasing support for individuals in the community and home, outside of institutions, and improve access to a continuum of SMI/SED and/or SUD evidence-based services at varied levels of intensity. This continuum of care shall be based on the American Society of Addiction Medicine (ASAM) criteria and/or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

During the demonstration period, the state seeks to achieve the following goals:

SUD Demonstration Goals:

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

SMI/SED Demonstration Goals:

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

CMS approved an amendment to the demonstration on March 29, 2024, to allow the state to continue the temporary COVID-19 expenditure authority, which allows the state to reimburse legally responsible individuals (LRI) for providing 1905(a) personal care services (PCS) to beneficiaries otherwise eligible for PCS under the Idaho Medicaid state plan.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
2. **Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state thirty (30) business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7) as a result of the change in FFP.
 - b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

- 5. State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.
- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.
- 7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

 - a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
 - b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
 - c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - d. An up-to-date CHIP allotment worksheet, if necessary;
 - e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

- 8. Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 442 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.
- 9. Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the thirty (30) day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
 - b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
 - c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
 - d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination, as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance

affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

- e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. Adequacy of Infrastructure. The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

- 13. Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.
- 14. Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 15. Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. ELIGIBILITY AND ENROLLMENT

- 16. Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility. Standards and methodologies for eligibility remain set forth under the state plan. This demonstration will apply to otherwise-eligible Medicaid beneficiaries ages 21 through 64 while residing in institutions for mental diseases (IMD) for diagnoses of substance use disorder (SUD) and/or serious mental illness (SMI).

V. DEMONSTRATION PROGRAMS AND BENEFITS

- 17. SMI/SED and SUD Program Benefits.** Under this demonstration, Idaho Behavioral Health Transformation beneficiaries will have access to high quality, evidence-based SMI/SED and OUD/SUD treatment and withdrawal management services, ranging from medically supervised withdrawal management for SUDs and short-term acute care in inpatient and residential settings for SMI to ongoing chronic care for these conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. Idaho will be expected to achieve a statewide average length of stay of thirty (30) days in residential and inpatient treatment settings, to be monitored pursuant to the SMI/SED and SUD Implementation Plans as outlined in STC 18 and STC 19 below.

The coverage of SMI/SED and SUD treatment services during short term residential and inpatient stays in IMDs will expand Idaho's current SMI/SED and/or SUD benefit package

available to all Idaho Medicaid beneficiaries as outlined in Table 1 (see exceptions detailed in STC 48).

The state attests that the services indicated in Table 1 as being covered under the Medicaid state plan authority are currently covered in the Idaho Medicaid state plan.

Table 1: Idaho Behavioral Health Transformation SMI/SED and SUD Benefits Coverage with Expenditure Authority			
Benefit	Type	Medicaid Authority	Expenditure Authority
Crisis stabilization services	SMI/SED and/or SUD	State plan	N/A
Outpatient services	SMI/SED and/or SUD	State plan	N/A
Intensive outpatient services	SMI/SED and/or SUD	State plan	N/A
Peer Support Services	SMI/SED and/or SUD	State Plan	N/A
Partial Hospitalization	SMI/SED and/or SUD	State Plan	N/A
Inpatient services	SMI/SED and/or SUD	State plan (individual services covered)	Services provided to individuals residing in IMDs
Residential treatment services	SMI/SED and/or SUD	State plan (Individual services covered)	Services provided to individuals residing in IMDs
Medically Supervised Withdrawal Management	SUD	State plan	Services provided to individuals residing in IMDs
Medication-Assisted Treatment (MAT)	SUD	State plan (individual services covered)	Services provided to individuals residing in IMDs

18. SMI/SED Implementation Plan.

- a. The state must submit the SMI/SED Implementation Plan within ninety (90) calendar days after approval of the demonstration. The state must submit the revised SMI/SED Implementation Plan within sixty (60) days after receipt of CMS’s comments. The state may not claim FFP for services provided in IMDs to beneficiaries with a primary diagnosis of SMI/SED until CMS has approved the SMI/SED Implementation Plan and the SMI/SED Financing Plan described in STC 18(e). After approval of the applicable implementation plans required by these STCs, FFP will be available prospectively, not retrospectively.
- b. Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment C, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI/SED Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in

42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 26.

- c. At a minimum, the SMI/SED Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

- 1) Participating hospitals must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and be either: a) certified by the state agency as being in compliance with those conditions through a state agency survey, or b) deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
- 2) Participating residential treatment providers must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
- 3) Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
- 4) Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- 5) Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455

Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.407, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

- 6) Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

- 1) Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that community-based providers participate in transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);
- 2) Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who are homeless or who have unsuitable or unstable housing with community providers that coordinate housing services, where available;
- 3) Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider they were referred to;
- 4) Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
- 5) Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

- 1) Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;
 - 2) Commitment to implementation of the financing plan described in STC 18(e);
 - 3) Implementation of strategies to improve the state’s capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
 - 4) Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.
- iv. Earlier Identification and Engagement in Treatment Including Through Increased Integration.
- 1) Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;
 - 2) Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;
 - 3) Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.
- d. Health IT Plan. Implementation of the milestones and metrics as detailed in STC 19(d).
- e. SMI/SED Financing Plan. As part of the SMI/SED implementation plan required by STC 18(a), the state must submit, within ninety (90) calendar days after approval of the demonstration, a financing plan that will be approved by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment C and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:
- i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and
 - ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;

- iii. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

19. SUD Implementation Plan.

- a. The state must submit the SUD Implementation Plan within ninety (90) calendar days after approval of this demonstration. The state must submit the revised SUD Implementation Plan within sixty (60) days after receipt of CMS’s comments. The state may not claim FFP for services provided in IMDs to beneficiaries who are primarily receiving SUD treatment and withdrawal management services until CMS has approved the SUD Implementation Plan. Once approved, the SUD Implementation Plan will be incorporated into the STCs as Attachment D and, once incorporated, may be altered only with CMS approval. After approval of the applicable implementation plans required by these STCs, FFP will be available prospectively, not retrospectively.
- b. Failure to submit a SUD Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 26.
- c. At a minimum, the SUD Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:
 - i. Access to Critical Levels of Care for SUDs. Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of SUD demonstration approval;
 - ii. Use of Evidence-based SUD-specific Patient Placement Criteria. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;
 - iii. Patient Placement. Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;
 - iv. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in

particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

- v. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;
 - vi. Standards of Care. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;
 - vii. Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/ODU. An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;
 - viii. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/ODU. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;
 - ix. Improved Care Coordination and Transitions between levels of care. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.
 - x. SUD Health IT Plan. Implementation of the milestones and metrics as detailed in STC 19(d).
- d. SMI/SED and/or SUD Health Information Technology Plan (“Health IT Plan”). The SMI/SED, and/or SUD Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011 and #17-003, respectively, states must submit to CMS the applicable Health IT Plans, to be included as sections of the associated Implementation Plans (see STC 18(c) and 19(c)), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type (SMI/SED and/or SUD).

The Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED and/or SUD goals of the demonstration. The plans will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment C), and must be aligned with the state’s broader

State Medicaid Health IT Plan (SMHP) and, if applicable, the state’s Behavioral Health (BH) IT Health Plan.

- i. The state must include in its Monitoring Protocol (see STC 20) an approach to monitoring its SMI/SED and/or SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.
- ii. The state must monitor progress, each DY, on the implementation of its SMI/SED and/or SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Report (see STC 29).
- iii. As applicable, the state should advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SMI/SED and/or SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
- iv. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.
- v. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.
- vi. Components of the Health IT Plan include:
 - 1) The Health IT Plan must describe the state’s goals, each DY, to enhance the state’s prescription drug monitoring program (PDMP).¹
 - 2) The Health IT Plan must address how the state’s PDMP will enhance ease of use for prescribers and other state and federal stakeholders.² This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients’ history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
 - 3) The Health IT Plan will, as applicable, describe the state’s capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI/SED and/or SUD care delivery. Additionally, the Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The

¹ Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the “opioid” epidemic and facilitate a nimble and targeted response.

² *Ibid.*

state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

- 4) The Health IT Plan will describe how the activities described in (i), (ii) and (iii) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.³
- 5) The Health IT Plan will describe the state’s current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.
- 6) In developing the Health IT Plan, states should use the following resources:
 1. States may use federal resources available on Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to “Behavioral Health and Physical Health Integration” and “Section 34: Opioid Epidemic and Health IT” (<https://www.healthit.gov/playbook/health-information-exchange/>).
 2. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
 3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

20. SMI/SED and SUD Monitoring Protocol. The state must submit a Monitoring Protocol for the SMI/SED/SUD programs authorized by this demonstration within one hundred fifty (150) calendar days after approval of the demonstration. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS’ comments. Once approved, the SUD/SMI/SED Monitoring Protocol will be incorporated into the STCs, as Attachment E. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports. Components of the Monitoring Protocol include:

³ Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

- a. An assurance of the state’s commitment and ability to report information relevant to each of the program implementation areas listed in STC 18(c) and 19(c), reporting relevant information to the state’s financing plan described in STC 18(e), and reporting relevant information to the state’s Health IT plan described in STC 19(d);
- b. A description of the methods of data collection and timeframes for reporting on the state’s progress on required measures as part of the general reporting requirements described in Section VIII of the demonstration; and
- c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

21. Evaluation. The SMI/SED Evaluation and SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections VIII (General Reporting Requirements) and X (Evaluation of the Demonstration) of these STCs.

22. Availability of FFP under the SMI/SED demonstration. FFP is only available for services provided to beneficiaries during short term stays for acute care in IMDs. The state may claim FFP for stays up to sixty (60) days as long as it shows at its midpoint assessment that it is meeting the requirement of a thirty (30) day average length of stay (ALOS). If the state cannot show that it is meeting the thirty (30) day ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for stays up to forty-five (45) days until such time that the state can demonstrate that it is meeting the thirty (30) day ALOS requirement.

23. Use of Legally Responsible Individuals (LRI) to Render Personal Care Services (PCS).

The state will provide payment for PCS rendered by an LRI, which could be inclusive of legally responsible family caregivers, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements. The requested LRI must meet all qualifications to become a direct care worker to provide PCS as authorized in the Medicaid state plan, including abiding by all oversight requirements from the hiring agency and the Idaho Department of Health and Welfare. A beneficiary can receive PCS from a non-LRI beyond the hours provided by an LRI in accordance with a beneficiary’s assessed need and the plan of care. The state shall implement a phased-in approach, which will be detailed in the monitoring reports and must be submitted to CMS at least sixty (60) days in advance of implementation, for the following conditions that must be met for a beneficiary to receive PCS from an LRI:

- a. **Extraordinary Circumstance.** A beneficiary must demonstrate their care needs meet an extraordinary circumstance to allow for an LRI to provide PCS. An extraordinary circumstance is defined as no other caregiver being available to meet all of the beneficiary’s allocated hours.
- b. **Application Requirement.** The beneficiary must have attempted to arrange for a non-LRI direct care worker to provide needed PCS. The beneficiary must demonstrate a minimum of two unsuccessful attempts to obtain PCS from providers that are not an LRI.

VI. COST SHARING

24. Cost Sharing. Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

25. Delivery System. All demonstration beneficiaries will continue to receive services through the same delivery system arrangements as currently authorized in the state.

VIII. GENERAL REPORTING REQUIREMENTS

26. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement. The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state’s written extension request.
- c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits

the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

- e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

27. Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestones. Up to \$5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plans and the required performance measures in the Monitoring Plan agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to \$5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made. The state is expected to meet the milestones by the end of the first two years of the SMI demonstration.

28. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

29. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c. Submit deliverables to the appropriate system as directed by CMS.

IX. MONITORING

30. Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates. The operational updates will focus on progress toward meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the

- demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; updates on the state's financing plan and maintenance of effort described in STC 18(e); legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
 - c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements Section XI of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.
 - d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.
 - e. SMI/SED Health IT and/or SUD Health IT. The state will include a summary of progress made in regards to SMI/SED and/or SUD Health IT requirements outlined in STC 19(d).

31. SMI/SED and SUD Mid-Point Assessment. The state must conduct an independent mid-point assessment by April 1, 2023. In the design, planning and conduction of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, SMI/SED and/or SUD treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than sixty (60) days after April 1, 2023. This timeline will

allow for the assessment report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. The state must brief CMS on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SMI/SED Implementation Plan and/or the SUD Implementation Plan, the SMI Financing Plan, and the SMI/SED Monitoring Protocol and/or SUD Monitoring Plan for ameliorating these risks. Modifications to the applicable Implementation, Financing, and Monitoring Protocol are subject to CMS approval. Elements of the mid-point assessment include:

- a. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED and/or the SUD Implementation Plans, the SMI/SED Financing Plan, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol and/or SUD Monitoring Protocol;
- b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
- c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
- d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI/SED or SUD Implementation Plans or SMI/SED Financing Plan or to pertinent factors that the state can influence that will support improvement; and
- e. An assessment of whether the state is on track to meet the budget neutrality requirements.

32. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10.

33. Close-Out Report. Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

- a. The draft close-out report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the close-out report.
- c. The state must take into consideration CMS' comments for incorporation into the final close-out report.
- d. The final close-out report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 25.

34. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the

demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

- b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

35. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

X. EVALUATION OF THE DEMONSTRATION

36. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 25.

37. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

38. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

- a. All applicable Evaluation Design guidance, including guidance about SUD/SMI/SED. Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs).
- b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS' approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment components of the Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

39. Evaluation Budget. A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

40. Evaluation Design Approval and Updates. The state must submit the revised draft Evaluation Designs within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Designs, the documents will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the evaluation designs and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation designs, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

41. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and

hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

- 42. Interim Evaluation Report.** The state must submit an Interim Evaluation Report for each evaluation design, as applicable, and for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Reports should be posted to the state's website with the application for public comment.
- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
 - b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
 - c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting a renewal for the demonstration, the Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
 - d. The state must submit the final Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
 - e. The Interim Evaluation Report must comply with Attachment B of these STCs.

- 43. Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.
- a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
 - b. The final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

- 44. Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10
- 45. State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.
- 46. Public Access.** The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, the approved Evaluation Design, Interim Evaluation Reports, and Summative Evaluation Reports) on the state's website within thirty (30) calendar days of approval by CMS.
- 47. Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

- 48. Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.⁴
- 49. Unallowable Expenditures.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:
- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
 - b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
 - c. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

⁴ For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

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

50. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 (Quarterly Medicaid Expenditure Report), showing Medicaid expenditures made in the quarter that just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

51. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XI:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

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

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

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

53. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
- e. Under all circumstances, health care providers must retain one hundred (100) percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

54. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

55. Medicaid Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart					
MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
FFS-SMI/SED	Hypo 1	X		X	Medicaid beneficiaries diagnosed with a SMI/SED in fee-for-service
FFS- SUD	Hypo 2	X		X	Medicaid beneficiaries diagnosed with a SUD in fee-for-service

56. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00339/10). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

- c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
- d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
- e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in Section IX, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
FFS-SMI/SED	Medicaid beneficiaries diagnosed with an SMI/SED in fee-for-service	See STC 49	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	3/31/2020	2/28/2025
FFS-SUD	Medicaid beneficiaries diagnosed with a SUD in fee-for-service	See STC 49	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	3/31/2020	2/28/2025

57. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

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

58. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing demonstration’s actual expenditures to the budget neutrality expenditure limits described in Section XI. CMS will provide technical assistance, upon request.⁵

59. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar

⁵ 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

60. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

- a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
- c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

61. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 61(c). If

- approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state’s Medicaid expenditures that are unrelated to the demonstration and/or outside of the state’s control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
- i. Provider rate increases that are anticipated to further strengthen access to care;
 - ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
 - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
 - iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
 - v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
 - vi. High cost innovative medical treatments that states are required to cover; or,
 - vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
- i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
 - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state’s Medicaid expenditures that are unrelated to the demonstration and/or outside the state’s control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

62. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist

of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

- 63. Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 64. Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 65. Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.
- 66. Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population

or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to refund the FFP to CMS.

67. Hypothetical Budget Neutrality Test 1: SMI/SED and/or SUD Services (see Expenditure Authority #1). The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5: Hypothetical Budget Neutrality Test									
MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR [2018]	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
FFS- SMI/SED	PC	Both	\$7,713	4.4%	\$8,590	\$8,968	\$9,363	\$9,775	\$10,205
FFS- SUD	PC	Both	\$6,186	4.4%	\$6,889	\$7,193	\$7,509	\$7,839	\$8,184

68. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration’s approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

69. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from April 17, 2020 to March 31, 2025. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

70. Mid-Course Correction. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 6: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 7: Schedule of Deliverables for the Demonstration Period		
Date	Deliverable	STC
30 calendar days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after approval date	SMI/SED and SUD Implementation Plans (including Health IT Plans and Financing Plan)	STC 18(a) and STC 19(a)
60 calendar days after receipt of CMS comments	Revised SMI/SED and SUD Implementation Plans (including Health IT Plans and Financing Plan)	STC 18(a) and STC 19(a)
150 calendar days after Implementation Plan Completeness	Monitoring Protocol	STC 20
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	STC 20
180 calendar days after approval date	Draft Evaluation Design	STC 38
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STC 40
No later than 60 calendar days after April 1, 2023	SMI/SED and SUD Mid-Point Assessment	STC 31
March 31, 2024, or with renewal application	Draft Interim Evaluation Report	STC 42(c)
60 calendar days after receipt of CMS comments	Final Interim Evaluation Report	STC 42(d)
Within 18 months after March 31, 2025	Draft Summative Evaluation Report	STC 43
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 43(a)
Monthly Deliverables	Monitoring Calls	STC 34
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4 th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 29
	Quarterly Expenditure Reports	STC 30(c)
Annual Deliverables - Due 90 calendar days after end of each 4 th quarter	Annual Reports	STC 30

ATTACHMENT A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

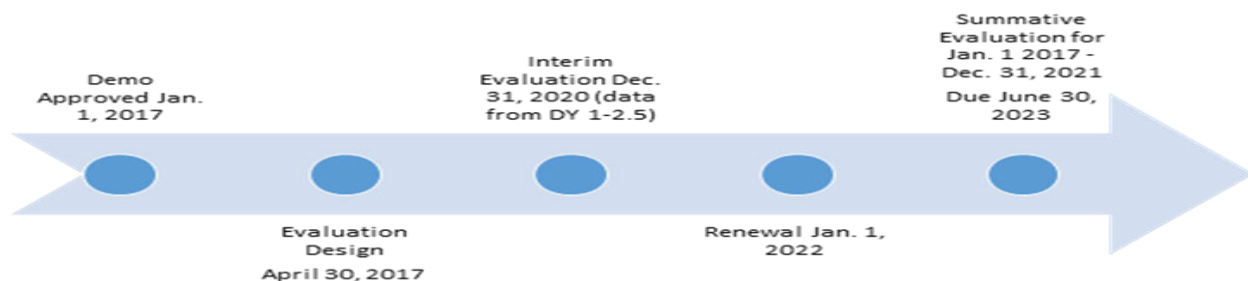
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state’s Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>
- 3) Identify the state’s hypotheses about the outcomes of the demonstration:
- 4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
- 5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.

- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
- a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

- b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
- 7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

- 1) When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
- 2) When the demonstration is also considered successful without issues or concerns that

would require more regular reporting, such as:

- a. Operating smoothly without administrative changes; and
- b. No or minimal appeals and grievances; and
- c. No state issues with CMS-64 reporting or budget neutrality; and
- d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

- 1) **Independent Evaluator.** This includes a discussion of the state’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include “No Conflict of Interest” signed by the independent evaluator.
- 2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- 3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

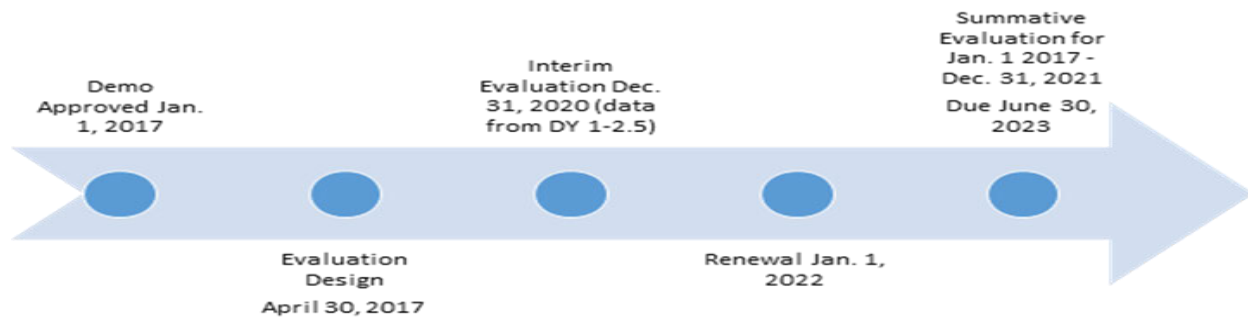
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state’s submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state’s website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
 - 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
 - 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
 - 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
 - 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
 - 5) Describe the population groups impacted by the demonstration.
- C. Evaluation Questions and Hypotheses** – In this section, the state should:
 - 1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

- 2) Identify the state’s hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected
4. *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

A. Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

B. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

C. Conclusions – In this section, the state will present the conclusions about the evaluation results.

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

F. Attachment - Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C

SMI/SED Implementation Plan and Financing Plan

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

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

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

State may submit additional supporting documents in Section 3.

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

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

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

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

State Point of Contact:

Idaho Behavioral Health Transformation
Approval Period: April 17, 2020 through March 31, 2025
Amendment Approved: March 29, 2024

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

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

Prompts	Summary
SMI/SED. Topic 1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
<p><i>To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</i></p> <p><i>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</i></p>	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
<p>1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid</p>	<p>Current State: <i>Milestone achieved.</i></p> <p>The Department’s Division of Licensing and Certification has established licensing and certification requirements for psychiatric hospitals. Participating psychiatric hospitals will be licensed and approved by Idaho’s Division of Licensing and Certification. Through the state survey process psychiatric hospitals are required to meet 42 CFR part 482. The Division of Licensing and Certification uses the State Operations Manual survey guidelines for psychiatric hospitals. The enrollment process and requirements for psychiatric hospitals are posted on the Division’s external website.</p> <p>Future State: Idaho will continue operation of current requirements</p> <p>Summary of Actions Needed: No actions needed</p>
<p>1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements</p>	<p>Current State: <i>Milestone achieved.</i></p> <p>The Department’s Division of Licensing and Certification has established licensing and certification requirements for psychiatric hospitals. The Division of Licensing and Certification staff may conduct on-site surveys at any time (or at a minimum annually) to ensure compliance with standards.</p> <p>Future State: Idaho will continue operation of current requirements</p>

Prompts	Summary
	<p data-bbox="550 261 909 293">Summary of Actions Needed:</p> <p data-bbox="550 297 772 329">No actions needed</p>
<p data-bbox="138 349 525 511">1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay</p>	<p data-bbox="550 349 968 381">Current State: <i>Milestone achieved.</i></p> <p data-bbox="550 414 1934 576">Inpatient treatment is currently provided through Idaho Medicaid fee for service. These services are authorized by the state’s Quality Improvement Organization (QIO). The QIO conducts utilization management reviews to ensure beneficiaries have access to the appropriate inpatient levels of care and lengths of stay. For inpatient psychiatric stays, the QIO conducts prospective prior authorization as well as reviews during the hospitalization for continued stays to provide oversight on length of stay.</p> <p data-bbox="550 617 1934 812">Since inpatient care is handled through fee for service, and outpatient treatment is delivered through the Idaho Behavioral Health Plan (IBHP) managed care carve-out, the state and QIO work closely with IBHP staff to monitor transitions and discharges among inpatient and outpatient levels of care. The IBHP contractor employs a statewide team of Field Care Coordinators (FCCs). These FCCs are licensed clinical professionals and assist with facilitating transitions across the continuum of care. As members transition from inpatient or residential to community-based care (or vice versa), FCCs assist to promote seamless transitions in care.</p> <p data-bbox="550 836 716 868">Future State:</p> <p data-bbox="550 872 1934 1034">In 2021, Idaho Medicaid will rebid the IBHP contract and make several changes to improve coordination, including transitioning to a prepaid inpatient health plan. By carving in inpatient services to the IBHP, one contractor will provide utilization management (UM) activities for all inpatient, residential and outpatient behavioral health services. The goal of the UM and review processes will be to ensure beneficiaries have access to appropriate levels and types of care, provide oversight on lengths of stay and provide seamless transitions between levels of care.</p> <p data-bbox="550 1071 1934 1266">The IBHP will utilize state approved, nationally informed best practices that define what high-quality care is and by whom and in what setting the care should be delivered. The IBHP staff will work closely with state oversight staff as well as UM counterparts and discharge planners in hospitals and residential programs. The IBHP will employ qualified UM staff and will have the support of physicians, clinical supervisors and administration through policy and procedures to carry out effective UM and review processes. The state will work closely with the IBHP to assure UM procedures align with state standards. These standards will be followed by the IBHP contractor and provider network.</p> <p data-bbox="550 1307 1934 1365">The IBHP contractor will be required to employ staff in each of the state’s seven regions who will be responsible for care coordination. As Medicaid members transition from inpatient or residential to community-based care (or vice</p>

Prompts	Summary
	<p>versa), IBHP staff ensure that enrollees are placed at the appropriate level of care and link Medicaid members with available providers, services and supports. These IBHP staff will be licensed clinical professionals.</p> <p>Summary of Actions Needed:</p> <ul style="list-style-type: none"> • Idaho Medicaid will rebid the Idaho Behavioral Health Plan (IBHP) contract, which will consolidate utilization management activities for all behavioral health services (inpatient and outpatient) effective July 1, 2022. <ul style="list-style-type: none"> ○ Prior to the release of the RFP, the Divisions of Medicaid and Behavioral Health will collaborate to define UM standards that will be utilized in the IBHP contract and provider agreements. ○ The Division of Behavioral Health will determine whether the developed standards will also need to be formalized and established in administrative rules and/or state statutes.
<p>1.d Compliance with program integrity requirements and state compliance assurance process</p>	<p>Current State: <i>Milestone achieved.</i></p> <p>Department program integrity rules establish clear provider requirements, which assure program integrity and quality compliance, including fraud detection and investigation, the prevention of improper payments, and provider participation. During provider enrollment and re-enrollment, the Division of Medicaid verifies that providers meet federal program integrity requirements.</p> <p>Future State: Idaho will continue operation of current requirements and will continue to reinforce and re-educate providers about compliance with program integrity standards.</p> <p>Summary of Actions Needed: No action needed</p>
<p>1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions</p>	<p>Current State: <i>Milestone achieved.</i></p> <p>All Medicaid-enrolled psychiatric hospitals, including the participating IMD facilities, are required to comply with all applicable state and federal laws, such as all CMS Conditions of Participation (COP), including but not limited to 42 CFR 482.60-482.66 specific to psychiatric hospitals and units. The relevant COPs include the requirement that assessment data include information on the diagnosis of co-morbid conditions, as well as the requirement for psychiatric hospitals to make appropriate medical personnel available to provide necessary medical diagnostic and treatment services.</p> <p>Future State: The Divisions of Medicaid and Behavioral Health will collaborate to develop state standards to screen beneficiaries for</p>

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

Prompts	Summary
SMI/SED. Topic 2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
<i>Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i>	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.	<p data-bbox="552 410 968 443"><i>Current State:</i> Milestone achieved.</p> <p data-bbox="552 475 1898 579">All Medicaid-enrolled psychiatric hospitals, including the participating IMD facilities, are required to comply with all applicable CMS Conditions of Participation (COP), including but not limited to 42 CFR 482.43, which establishes minimum discharge planning requirements aligned with this milestone.</p> <p data-bbox="552 612 1919 813">Additionally, since inpatient is currently handled as a fee for service benefit, and outpatient treatment is delivered through the IBHP managed care benefit, the state works closely with IBHP staff to monitor transitions and discharges among inpatient/residential and outpatient levels of care. The IBHP contractor employs a staff of Field Care Coordinators (FCCs) in each of the state’s seven regions. These FCCs are licensed clinical professionals and are responsible for care coordination. As Medicaid members transition from residential to community-based care (or vice versa), FCCs work directly with community providers to assist with the transition.</p> <p data-bbox="552 846 716 878"><i>Future State:</i></p> <p data-bbox="552 878 1929 1183">Effective July 1, 2022, the IBHP contract will include inpatient services allowing for improved oversight and management of care transitions. The IBHP contract will require intensive pre-discharge planning and inclusion of community-based providers in care transitions by assigning licensed clinical professionals (e.g., nurses, doctors, psychologists, social workers, or professional counselors) and/or certified peer support specialists or family support partners under appropriate supervisory protocols to conduct care coordination. These requirements will be based on transition standards developed by the state. At minimum, the IBHP contract will require the following: (i) tracking of hospital follow-up with members within 72 hours, 7 days and 30 days after discharge; (ii) case management for all patients hospitalized related to SMI/SED or SUD and continuing at least 30 days post-discharge; and (iii) minimum standards for discharge planning, including full access to robust discharge plans even in rural areas of the state.</p> <p data-bbox="552 1216 1898 1383">Additionally, this demonstration proposes to add to the Medicaid State Plan reimbursement for transition planning services provided by behavioral health providers (including community-based care managers) for individuals with SMI/SED (and/or SUD) being discharged into their care from an inpatient, residential or other institutional setting. This service will promote continuity of care and ensure appropriate services and supports are identified as early as possible and accessed appropriately after discharge. This service may be provided in person and/or remotely via</p>

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

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

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

Prompts	Summary
based care	<i>Summary of Actions Needed:</i>

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

Prompts	Summary
waitlists and what are average wait times to get an appointment.	
3.b Financing plan – See additional guidance in Topic 5.	Current State: See Topic 5 for additional information on the state’s financing plan.
	Future State: See Topic 5 for additional information on the state’s financing plan.
	Summary of Actions Needed: See Topic 5 for additional information on the state’s financing plan.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	<p>Current State: Milestone achieved.</p> <p>In July 2019, the Division of Behavioral Health launched the Idaho Psychiatric Bed and Seat Registry (IPBSR), an online platform specifically designed to track the number, availability, and associated demographics for psychiatric beds and crisis seats across Idaho. The IPBSR is intended primarily for use by mental health professionals, medical professionals, and first responders who need to identify available placements for psychiatric inpatient treatment or crisis stabilization.</p> <p>In early 2019, DBH was awarded a National Association of State Mental Health Program Directors’ (NASMHPD) Transformation Transfer Initiative (TTI) Grant in the amount of \$150,000. The TTI Grant is a federally funded grant that assists states in transforming their mental health system of care. TTI funds are to be used to identify, adopt, and strengthen transformation initiatives and activities that can be implemented in the state, either through a new initiative or expansion of one already underway. TTI grant funding allowed DBH to implement the Idaho Psychiatric Bed and Seat Registry (IPBSR) across Idaho.</p> <p>The IPBSR was launched in January 2020 as an online platform specifically designed to show end users the number, availability, and demographics of psychiatric beds and crisis seats across Idaho. The Division of Behavioral Health (DBH) and Division of Public Health (DPH) are working to modify a component of their hospital bed registry software called EMResource (Juvare). This system is currently used by DPH to monitor and coordinate hospital bed availability related to large scale health emergencies, such as a mass casualty event. DBH has created a specific view within EMResource that, when accessed, shows users the total number of psychiatric beds/seats, the demographics of those beds/seats, and the availability of those beds/seats for Idaho’s psychiatric hospitals and regional behavioral health crisis centers.</p>

Prompts	Summary
	<p>Future State: Already implemented. The Divisions of Behavioral Health and Medicaid will continue to add and train community stakeholders in the use of the IPBSR platform. As necessary, the IDHW will modify contract and regulatory requirements to require the use of the IPBSR.</p> <p>Summary of Actions Needed: No action needed</p>
<p>3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay</p>	<p>Current State: In the case of Medicaid enrollees, treatment needs are currently assessed by IBHP network providers primarily through a Comprehensive Diagnostic Assessment (CDA). Idaho Medicaid has previously implemented the use of a tool known as the CANS (Child and Adolescent Needs and Strengths) to work in tandem for determination of SED diagnoses for children.</p> <p>Future State: The divisions of Medicaid and Behavioral Health will develop patient clinical domain assessment requirements for comprehensive diagnostic assessments (CDA). These CDA requirements will be widely recognized, publicly available and help determine appropriate level of care and length of stay. The requirements selected will be used throughout the Idaho Behavioral Health system of care.</p> <p>Summary of Actions Needed: The Divisions of Medicaid and Behavioral Health will collaborate to identify clinical domain assessment requirements. (Timeline 6-12 months)</p> <p>The Division of Medicaid will update the Medicaid Provider Handbook to reflect these state-approved requirements. (Timeline 6-12 months)</p> <p>Develop and implement requirements in IDAPA rules and/or standards to ensure Comprehensive Diagnostic Assessments are conducted to determine appropriate levels of care and length of stay. (Timeline 18-24 months)</p> <p>The Division of Medicaid will add contract language to the IBHP contract regarding clinical domain assessment requirements. (Timeline 18-24 months)</p>
<p>3.e Other state</p>	<p>Current State:</p>

Prompts	Summary
requirements/policies to improve access to a full continuum of care including crisis stabilization	<i>Future State:</i>
	<i>Summary of Actions Needed:</i>

Prompts	Summary
SMI/SED. Topic 4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
<i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i>	
Earlier Identification and Engagement in Treatment	
<p>4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, including through supported employment and supported education programs</p>	<p>Current State: Milestone achieved.</p> <p>The state employs a number of strategies to engage individuals in treatment as early as possible, including the following examples.</p> <ul style="list-style-type: none"> • <u>Vocational Rehabilitation</u>. While Idaho Medicaid does not currently offer supported employment and supported education programs, the state recognizes the importance of employment and education to recovery. Vocational rehabilitation staff are integral members of Assertive Community Treatment (ACT) service teams. The close partnership between ACT and vocational rehabilitation supports individuals following inpatient discharge to receive additional support in the community. The co-located model ensures that individuals with SMI are supported as they prepare to reenter the workforce. • <u>First Episode Psychosis Initiative (STAR Program)</u>. The Division of Behavioral Health is currently implementing an evidence-based model, Coordinated Specialty Care (CSC), to respond to early serious mental illness and first episode psychosis. The Idaho CSC program is called the STAR (Strength Through Active Recovery) program and is based on the On-Track New York coordinated specialty care model. CSC is a collaborative, recovery-oriented treatment program involving clients, treatment team members, and when appropriate, relatives, as active participants. CSC promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan that addresses the client’s overall mental and physical health. The specialists offer psychotherapy, medication management geared to individuals with SMI, family education and support, case management, and employment or education support, depending on the individual’s needs and preferences. CSC operates a low client-to-staff ratio, with accessibility to staff 24/7. Although the team approach lends itself to the client working with multiple staff members, the client will have one provider who acts as their principal care manager and coordinates internal and external resources necessary to meeting the goals of the client’s treatment plan. The CSC treatment experience is time-limited to three years, after which most clients can move to a lower level of specialized care, and then eventually transition to regular mental health services. Idaho Star CSC serves clients between the ages of 15 and 30 years. Presently there are three regional STAR programs in Regions 3, 6, and 7, financed primarily through federal block grants and state general funds.

Prompts	Summary
	<ul style="list-style-type: none"> <p>Crisis System. The DBH comprehensive crisis system has been a very successful and effective tool in identifying and engaging beneficiaries with SMI or SED in treatment sooner. While the crisis system provides de-escalation and stabilization services, it also is a critical community resource, not only for individuals with SMI or SED, but also family members, law enforcement, or others who are seeking assistance and resources for an individual with SMI or SED. The most effective part of the crisis center system has been the strong referral model in which individuals are connected with available treatment options in the community. By offering strong early intervention and outreach, this model is able to engage individuals in effective treatment sooner to avoid future crises.</p>
	<p>Future State:</p> <p>Throughout the demonstration, IDHW will continue to enhance its strategies for early identification and engagement in treatment for individuals with SMI or SED, including the following actions:</p> <ul style="list-style-type: none"> <p>STAR Program Expansion. Idaho will expand its successful STAR program. Currently, a fourth regional STAR CSC program is in the planning stage, with the intent that the contract will be completed, signed and implemented in 2020. The Region 4 contract serves as a pilot for future statewide expansion of the program and new STAR CSC contracts in other regions without STAR CSC programs. The long-term goal is to have STAR CSC programs contracted with community providers in each of the seven regions. The Divisions of Medicaid and Behavioral Health will collaborate to establish IBHP requirements to implement strategies for the early identification and engagement of beneficiaries with or at risk of SMI or SED. Through this strong partnership with DBH, Medicaid, and local hospital systems, the goal is that every provider will utilize the evidence-based model to respond to early serious mental illness and first episode psychosis for any Idahoan in need, regardless of payor.</p> <p>Healthy Connections. In addition, Idaho will leverage the Medicaid primary care case management program, Healthy Connections, to promote training and education for early identification at the primary care level through the implementation of a standardized evidence-based assessment process. When behavioral health needs are identified, the primary care provider will be able to refer the individual to the appropriate services and engage the patient in treatment sooner.</p> <p>Summary of Actions Needed: The Division of Behavioral Health will continue with STAR expansion efforts as noted above. (Timeline Ongoing)</p>

	<p>The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards regarding early identification and engagement of beneficiaries with or at risk of SMI or SED. (Timeline 18-24 months)</p> <p>The Division of Medicaid will outline the requirement for the IBHP contractor to implement strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, including through supported employment and supported education programs, as well as coordination with the Healthy Connections primary care network. This requirement will be included in the IBHP contract language and the IBHP contractor will be required to have a policy that supports these efforts. (Timeline 18-24 months)</p> <p>Leverage the Medicaid primary care case management program, Healthy Connections, to promote training and education for early identification at the primary care level through the implementation of a standardized evidence-based assessment process. (Timeline 18-24 months)</p>
<p>4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</p>	<p><i>Current State: Milestone achieved.</i></p> <p>The IDHW employs a number of strategies to engage individuals in treatment as early as possible, including the following examples.</p> <ul style="list-style-type: none"> • <u>Patient Centered Medical Home Model</u>. Idaho’s State Innovation Models (SIM) grant and the resulting Statewide Healthcare Innovation Plan have made strides in improving integration of primary care and behavioral health services via the patient-centered medical home (PCMH) model. Grant funds have been used to provide training and support to primary care practices that were committed to transforming their practices to the PCMH model. Currently, there are 12 primary care practices/organizations statewide that have received the Health Resources and Services Administration (HRSA) FY2019 Integrated Behavioral Health Services (IBHS) Award. These clinics are mostly comprised of Federally Qualified Health Centers (FQHCs) and Indian Health Centers that have received funding from HRSA for behavioral health integration in the past and have participated in several statewide initiatives related to PCMH before this award. There are several Rural Health Centers (RHCs) that have also achieved behavioral health integration, which is advantageous considering the rural service area footprint of the FQHCs and RHCs. • <u>Healthy Connections</u>. In Idaho Medicaid’s Healthy Connections Program providers must meet minimum requirements in order to achieve higher per member per month (PMPM) compensation and progress through the Healthy Connections tier structure. To advance to Tier 3, providers must be able to coordinate services to include behavioral health needs and also share information via the Idaho Health Data Exchange (IHDE). Further, through the Healthy Connections Program, IDHW has successfully increased the adoption of patient-centered medical homes, by promoting training and education for early intervention, as well as

	<p>encouraging the co-location of behavioral health professionals in primary care clinics.</p> <ul style="list-style-type: none"> • <u>Integrated Fee Schedule</u>. Within the IBHP, providers can bill for Health and Behavioral Assessment and Intervention (HBAI) codes. These codes allow for behavioral health interventions to be performed in non-specialty settings; in addition, qualified masters level clinicians now have the ability to enroll and bill for these services, whereas previously only physicians could provide these services. The new integrated fee schedule has helped to increase integration of physical health and behavioral health services to support improved early identification and referrals to treatment.
	<p><i>Future State:</i> Throughout the demonstration, IDHW will continue to enhance its strategies for increasing integration of behavioral health care in primary care settings. This is a critical strategy employed by the state to expand access to behavioral health services in the rural and frontier regions with specialty provider shortages. Future state strategies for improvement include the following actions:</p> <ul style="list-style-type: none"> • The IBHP contractor will work directly with Idaho Medicaid’s Healthy Connections providers to promote opportunities for advanced behavioral health integration in the primary care setting. Specifically, behavioral health measures will be explicitly added to the suite of quality measures in year two of the Healthy Connections Value Care initiative, and the payment tiers will be restructured to increase integration of behavioral health. • Idaho Medicaid will continue to support opportunities for behavioral health consultants to co-locate or integrate into the primary care setting. The IBHP will incentivize behavioral health providers who co-locate or integrate with primary care. This will be particularly important to increasing the success and coordination of the early identification efforts, as primary care providers will more effectively make real-time referrals to engage beneficiaries in treatment sooner. • Idaho Medicaid will explore opportunities that provide additional compensation for IBHP providers who meet certain requirements when working directly with primary care providers to support coordination of physical and behavioral health. Further, to incentivize integration of behavioral health services, Idaho Medicaid will seek to implement billing simplifications to encourage more primary care providers to provide mental health services in the primary care setting. • The IBHP contractor will offer trainings to primary care providers. These trainings will focus on ways to integrate behavioral health into the primary care setting and best practices on care coordination.

	<ul style="list-style-type: none"> In addition, Idaho will leverage the Medicaid primary care case management program, Healthy Connections, to promote training and education for early identification at the primary care level through the implementation of a standardized evidence-based assessment process. When behavioral health needs are identified, the primary care provider will be able to refer the individual to the appropriate services and engage the patient in treatment sooner <p>Summary of Actions Needed: Idaho Medicaid will update the IBHP contract language to cover the following:</p> <ol style="list-style-type: none"> Requirements to push health information to IHDE Incentives for co-location or integration with primary care Trainings to primary care providers on integration of behavioral health and best practices on care coordination. Requirements for the IBHP provider network to work with Idaho Medicaid’s Healthy Connections providers on ways to support behavioral health integration (Timeline 18-24 months) <p>Idaho Medicaid will seek to implement billing simplifications to encourage more primary care providers to provide mental health services in the primary care setting. (Timeline 18-24 months)</p>
<p>4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI</p>	<p>Current State: Milestone achieved.</p> <p>The state has made a number of recent improvements focused on improving access to evidence-based mental health treatment specific to children and adolescents. These improvements have focused on early identification, expanded eligibility for services, and a new coordinated system of care specifically designed for children with SED.</p> <ul style="list-style-type: none"> <u>Youth Empowerment Services</u>. Specifically, pursuant to a settlement agreement in a class-action lawsuit, the Department has established, under 1915(i) authority, specialized supports and services targeting children experiencing SED. This is known as the Youth Empowerment Services (YES) program. In addition to the new and enhanced behavioral health services outlined in in Appendix C of the Jeff D. Settlement Agreement, the YES program provides one specialized support service, Respite Care, as a 1915(i) benefit. Through the 1915(i) Medicaid was able to expand Medicaid eligibility for children under 18 years of age to families whose adjusted gross income was within 300% of the Federal Poverty Level. Lastly, regarding crisis stabilization, YES enrollees receive the same two services as other IBHP enrollees—Crisis Response and Crisis Intervention. <u>Children’s Mental Health</u>. The seven regional DBH offices offer walk-in crisis services, in addition to YES wraparound. Additionally, CMH (Children’s Mental Health) providers across the state have been trained

	<p>and have access to the ICANS system to enter the Idaho Child Assessment of Needs and Strengths assessment. This functional assessment assists providers with identifying SED. Wraparound promotes collaboration between community-based providers and other supports identified by the family to better support children in their communities versus in residential or state hospital settings. Children and youth have access to 30-day aftercare following discharge from a State Hospital. DBH’s CMH staff have worked to develop relationships with schools to become a consultation resources for children and youth who may be at risk.</p> <ul style="list-style-type: none"> • <u>STAR Program</u>. The CSC STAR program (detailed in Section 4.a of this implementation plan) focuses on first episode psychosis, and is therefore a very specialized tool targeting adolescents and young adults between 15 and 30 years of age. <p><i>Future State:</i> The IBHP contractor will continue to expand access to specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI.</p> <p>In addition to YES program services, DBH Children’s Mental Health Regional Chiefs are researching options for child/youth crisis stabilization centers and they are working to develop teams with expertise in CMH crisis. The regional offices are also working to develop/implement telehealth where possible. All regions are working to develop more formal collaborative community partnerships including CIT-C (Crisis Intervention Team Collaboratives).</p> <p><i>Summary of Actions Needed:</i> The Divisions of Medicaid and Behavioral Health will collaborate to develop and implement criteria via IDAPA rules and/or standards establishing specialized settings and services for young people experiencing SED/SMI, including crisis stabilization. (Timeline 18-24 months)</p> <p>The Division of Medicaid will incorporate IBHP contract language that outlines state requirements around services for young people experiencing SMI/SED. (Timeline 18-24 months)</p> <p>The Division of Medicaid will incorporate IBHP contract language that outlines state requirements for telephonic and face-to-face crisis stabilization services for young people experiencing SMI/SED. (Timeline 18-24 months)</p>
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	<p><i>Current State:</i></p> <p><i>Future State:</i></p> <p><i>Summary of Actions Needed:</i></p>

Prompts	Summary
SMI/SED. Topic 5. Financing Plan	
<i>State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.</i>	
<p>5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.</p>	<p>Current State:</p> <p>Idaho has several current initiatives going on regarding crisis services. Creating a sustainable crisis system is one of the primary goals of the new Idaho Behavioral Health Plan. The state intends to mitigate the need for the highest levels of care through a comprehensive crisis system that is grounded in the IBHP. Currently Medicaid members can access the following services through the IBHP:</p> <ol style="list-style-type: none"> 1. Crisis Response 2. Crisis Intervention 3. Member Crisis Line <p>The Division of Behavioral Health offers:</p> <ol style="list-style-type: none"> 1. Mobile crisis in all regions of the state 2. STAR CSC program in regions 3, 6 and 7 <p>Most recently the Division of Behavioral Health worked closely with Medicaid to cover services at the regional crisis units around the state.</p> <p>Future State:</p> <p>The Idaho Behavioral Health Plan is expected to include the following:</p> <ol style="list-style-type: none"> 1. Enhanced 24-hour crisis line with the ability to triage and refer to community services 2. Crisis Response (Existing) 3. Crisis Intervention (Existing) 4. Mobile Crisis 5. Improved access to urgent behavioral health care services, including same-day crisis psychiatric services available in person or via telehealth 6. Proactive and reactive crisis plans to be included in transition and discharge planning between all levels of care 7. Community crisis trainings (providers, law enforcement, first responders) 8. Statewide access to the STAR CSC program, reimbursable by Medicaid <p>The Divisions of Behavioral Health and Medicaid will work directly with the IBHP contractor to promote improved connectivity between first responders and treatment providers. Ongoing training opportunities will be offered to</p>

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

Prompts	Summary
	<p>As referenced in 4.b, the Division of Medicaid continues to support behavioral health integration into primary care settings, as this strategy is essential to expanding access to behavioral health services in rural and frontier areas of the state. Expanding behavioral health integration into existing primary care settings will be a critical requirement for the new IBHP contractor. The state also seeks to expand the number of behavioral health professionals who are co-located or integrated with primary care clinics. The eventual goal is to promote care coordination at the highest level to achieve better outcomes.</p> <p>Idaho Medicaid will expand access to Assertive Community Treatment (ACT) services to provide integrated delivery of community mental health services to individuals with SMI/SED. Idaho currently offers ACT through the DBH; however, these services will be added to the Medicaid fee schedule and the IBHP. This will allow the highest risk patients discharging from inpatient hospitalizations to receive additional support and crisis services in the community to help prevent readmissions</p> <p>The Division of Medicaid and the IBHP contractor continue to identify and enroll partial hospitalization providers in the IBHP network.</p>
	<p><i>Summary of Actions Needed:</i></p> <p>The Division of Medicaid will request funding to support a comprehensive crisis system. (Timeline 18-24 months)</p> <p>Expand access to Assertive Community Treatment (ACT) services. (Timeline 6-12 months)</p> <p>Draft IBHP request for proposal requirements that support the state’s plans to increase availability of ongoing community-based services. (Timeline 18-24 months)</p> <p>Incorporate outpatient levels of care provider access requirements into the IBHP contract. (Timeline 18-24 months)</p> <p>Promote growth of the IBHP provider network to expand the number of providers who offer telehealth services. (Timeline 18-24 months)</p> <p>Implement IBHP contract language that supports the growth and sustainability of Certified Behavioral Health Clinic Models within the IBHP network. (Timeline 18-24 months)</p>

Prompts	Summary
SMI/SED. Topic 6. Health IT Plan	
<p><i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”⁴ The HIT Plan should also describe, among other items, the:</i></p> <ul style="list-style-type: none"> • <i>Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i> • <i>Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i> <p><i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i></p>	
Statements of Assurance	
<p>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period.</p>	<p>Yes. Idaho has focused on achieving a high level of Electronic Health Record (EHR) adoption and Health Information Exchange (HIE) interoperability needed to achieve the goals of the demonstration. Multiple statewide initiatives over recent years have leveraged SIM, HITECH, and other funding opportunities to support HIE development and promote adoption of HIT.</p> <p>Despite significant progress, Idaho has identified additional opportunities to increase adoption of HIT technology among behavioral health providers and improvements to HIE capabilities to promote integrated care coordination. Idaho plans to include requirements for improving behavioral health provider use of HIT in the next iteration of the state’s behavioral health managed care contract, which is anticipated to be implemented in 2022. In addition, multiple initiatives designed to drive HIE improvements using SUPPORT Act funding are described in this HIT plan.</p> <p>Idaho currently has a single Health Information Exchange (HIE). The Idaho Health Data Exchange (IHDE) is a non-profit 501(c)(3) company. IHDE was created in 2008 as a result of the efforts of Idaho’s Health Quality Planning Commission. Commission members are appointed by the Governor and charged with promoting improved quality of care and health outcomes through investment in health information technology.</p> <p>House Bill 375 was passed during the 2016 Legislative session reauthorizing the Health Quality Planning Commission to provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care.</p>

Prompts	Summary
	<p>IHDE participates in a nation-wide Patient Centered Data Home (PCDH) initiative to connect and exchange information across states and health systems to ensure the health and safety of patients throughout the US.</p> <p>IHDE is 1 of 72 HIE members of SHIEC – Strategic Health Information Exchange Collaboration. SHIEC shares health information nationwide.</p>
<p>Statement 2: Please confirm that your state’s SMI/SED Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.</p>	<p>Yes. Idaho’s SMI/SED Health IT plan is aligned with the state’s approved Medicaid HIT plan. Both plans are developed and managed by the Department of Health and Welfare’s Division of Medicaid.</p>
<p>Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the <u>Interoperability Standards Advisory (ISA)</u>⁶ and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following</p>	<p>Yes, the state intends to assess applicability of the Interoperability Standards Advisory and 45 CFR 170 Subpart B and incorporate the relevant standards where applicable, including in the next iterations of managed care contracts.</p>

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

Prompts	Summary
	<p>services. Providers enrolled in Tier 3 of the program meet these coordinated care standards and are additionally required to:</p> <ul style="list-style-type: none"> - maintain a connection to Idaho’s HIE, the Idaho Health Data Exchange (IHDE) - Provide at least one expanded patient access option, such as expanded access to primary care, patient web portal with 2-way communication capability (electronic messaging) or provision of telehealth <p>Tier 3 providers also must meet at least one of the following requirements:</p> <ul style="list-style-type: none"> - Have achieved PCMH national recognition or accreditation - Offer additional enhanced care management activities – Community Health Emergency Medical Services (CHEMS), Community Health Workers, promotora model, home visiting model or similar coordination model with proven results - Population Health Management capabilities – active registry reminder system or other proactive patient management approach - Behavioral Health Integration – co-located or highly integrated model of behavioral and physical health care delivery - Referral tracking and follow-up system <p>Tier 4 providers must meet the same coordinated care and enhanced access to care standards as required for tier 3 and must have the following:</p> <ul style="list-style-type: none"> - Dedicated care coordination staff/support - A bi-directional connection to the IHDE with demonstrated share relationship - National Committee Quality Assurance (NCQA) level 2 or 3 PCMH recognition or Utilization Review Accreditation Commission (URAC), Joint Commission Accreditation Association for Ambulatory Health Care (AAAHC) or other national recognition - Continuous quality improvement program <p>Since February 2016, 9 Healthy Connections service locations supported by 5 organizations qualified for Tier 3 by meeting the Behavioral Health Integration option. Since that time, 6 of the 9 service locations, owned by 4 Organizations, have advanced to Tier 4 by establishing a bi-directional connection with the IHDE and achieving PCMH recognition. Currently 103 service locations owned by 48 organizations have achieved Tier 4 status.</p> <p>Providers enrolled in the HIE can use Direct messaging for e-referrals with or without an EHR system. Direct is an effective, secure mechanism for use in the point-to-point exchange of sensitive, protected health information through a trusted network. Direct functions like regular email with additional security measures and ensures that messages are only accessible to the intended recipient.</p> <p>Future State: The state will a develop a baseline of current use of closed loop and e-referrals and identify options for tracking and increasing use.</p> <p>Summary of Actions Needed:</p>

Prompts	Summary
	<ul style="list-style-type: none"> - The state Medicaid HIT team will convene a stakeholder workgroup charged with identifying barriers and options for increasing use of closed loop and e-referrals (estimated completion: 10/2020) - The state Medicaid HIT team will conduct a survey to assess use of referral technology and related business practices used by providers (estimated completion: 12/2020) - The state Medicaid HIT team will use survey data to develop a baseline of current activity and for tracking on-going of use of closed loop and e-referrals (estimated completion: 12/2020) - The state Medicaid team will include requirements to promote use of closed loop and e-referrals in the upcoming behavioral health managed care contract. (estimated completion: 01/2021)
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	<p>Current State: Currently outpatient behavioral health services for Medicaid members in Idaho are administered under a single managed care Prepaid Ambulatory Health Plan (PAHP). Inpatient behavioral health services are administered by the state. This model has created challenges for effective discharge planning. Although hospitals connected to the HIE can transmit secure messages and structured discharge information to the next level of care, behavioral health providers who do not operate within the hospital's internal HIT environment or not connected to the HIE cannot make use of this information. To address these challenges, the state's QIO contractor sends an inpatient report daily to the behavioral health contractor who directly accesses the QIO electronic system to retrieve patient information to support discharge planning and care coordination.</p> <p>Future State:</p> <ul style="list-style-type: none"> -The state HIE (IHDE) will identify strategies for expanding behavioral health provider adoption of EHR and HIE (estimated completion: 12/2020) -The state HIE (IHDE) will implement IHDE enhancements to support behavioral health provider needs by expanding use of ADT, CCDA interface capabilities and Direct Messaging communications (estimated completion 01/2021). (Timeline: 18-24 months) <p>Summary of Actions Needed: The state HIE (IHDE) will Contract with technology partners for establishing new interface connection builds (estimated completion: Nov 2021) (Timeline: 18-24 months)</p>
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community-based supports	<p>Current State: Use of e-referrals for community-based services and resources is limited. Idaho CareLine (2-1-1) is a statewide, no cost information and referral service that provides information and referral to community resources and services via a public facing web-based tool and call center.</p> <p>Future State: Assess feasibility of implementing a community resource platform for use by state and local agencies, including first responders, to enhance case management and crisis response by providing connections and referrals to community-based supports using a closed loop referral system with real time notification abilities.</p> <p>Summary of Actions Needed:</p> <ul style="list-style-type: none"> - Contract with consultant (Julota) to assess government agencies for workflow gaps and service opportunities (estimated completion 07/20) - Contract with consultant (Julota) to conduct environmental scan for interested regions, communities, and resources-

Prompts	Summary
	medical, community, etc. (estimated completion 07/20)
Electronic Care Plans and Medical Records (Section 2)	
<p>2.1 The state and its providers can create and use an electronic care plan</p>	<p>Current State: Idaho Medicaid’s EHR Incentive Program, now called the Promoting Interoperability Program has been in effect since 2012. Through this initiative, 2,686 Eligible Professionals and 81 Hospitals have received incentive payments to adopt, implement and upgrade certified EHR systems and for successfully demonstrating meaningful use of these systems.</p> <p>Approximately 80-85% of behavioral health providers use EHR in varying degrees.</p> <p>The state’s HIE conducts outreach to engage additional participants from the health care community in use of HIT.</p> <p>Future State: Increase numbers and types of providers connected to HIE. The IHDE will conduct an outreach campaign to engage health care entities with no connection, outbound only, or portal-only access connection to upgrade to bi-directional connections.</p> <p>Engagement effort targets include 14 critical access hospitals, 11 hospitals, and 27 rural health clinics, 1 federally qualified health care center, 4 behavioral health hospitals, and 167 behavioral health treatment sites.</p> <p>Summary of Actions Needed:</p> <ul style="list-style-type: none"> - The state HIE (IHDE) will identify and classify facilities by type, location, and contact information (estimated completion 05/2020) - The state HIE (IHDE) will engage for business needs, data needs (estimated completion: 10/2020)
<p>2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers</p>	<p>Current State: Medicaid Primary Care and Behavioral Health providers have actively adopted use of certified EHRs. Levels of interoperability vary, ranging from ability to connect within internal organizations, broader connectivity to affiliated data hubs, and connections to Idaho’s HIE. Currently, of Idaho’s 511 Healthy Connections primary care service locations the following HIE connectivity is established:</p> <ul style="list-style-type: none"> • Bi-directional Inbound/Outbound -157 Service Locations (primarily PCMH early adopters – with a focus on FQHC’s & Pediatrics) • Inbound Only - 27 Service Locations • Outbound Only - 23 Service Locations • View Only - 42 Service Locations <p>Other participants connected to the IHDE include 5 critical access hospitals 15 FQHCs, 12 home health agencies, 3 hospice centers, 12 hospitals, 1 long-term care facility, 5 rural health clinics, and 5 skilled nursing facilities, 3 military organizations, the Veterans Administration, 1 corrections institute, 1 imaging center, 3 labs, 1 outpatient/surgery/dialysis center, 3 payers, 1 pharmacy, 3 registries and 3 rehabilitation centers</p> <p>Despite this progress, providers face challenges with HIE licensing costs and high maintenance costs charged by EHR vendors. Some providers use an EHR that currently does not have the ability to provide inbound transactions to the</p>

Prompts	Summary
	<p>HIE. Finally, because hospitals are not yet connected in the southern part of the state there is less primary care clinic connectivity there geographically, as well as less VIEW utilization.</p> <p>Future State: Increase numbers and types of providers connected to HIE. The IHDE will conduct an outreach campaign to engage medical community with no connection, outbound only, or portal-only access connection to upgrade to a bi-directional connection.</p> <ul style="list-style-type: none"> - Engagement targets include 14 critical access hospitals, 11 hospitals, and 27 rural health clinics, 1 federally qualified health care center, 4 behavioral health hospitals, and 167 behavioral health treatment sites. <p>Summary of Actions Needed:</p> <ul style="list-style-type: none"> - The state HIE (IHDE) will identify and classify facilities by type, location, and contact information (estimated completion: 05/2020) - The state HIE (IHDE) will engage for business needs, data needs (estimated completion 10/2020)
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	<p>Current State: The state does not currently collect data regarding methods used for transitioning Medical records for youth-oriented systems.</p> <p>Future State: As adoption of EHR and HIE increase more providers will have ability to share records electronically. The state will work to increase the number of providers connected to HIE. The IHDE will conduct an outreach campaign to engage medical community with no connection, outbound only, or portal-only access connection to upgrade to a bi-directional connection.</p> <p>Engagement targets include 14 critical access hospitals, 11 hospitals, and 27 rural health clinics, 1 federally qualified health care center, 4 behavioral health hospitals, and 167 behavioral health treatment sites.</p> <p>Summary of Actions Needed:</p> <ul style="list-style-type: none"> - The state HIE (IHDE) will identify and classify facilities by type, location, and contact information (estimated completion 05/2020) - The state HIE (IHDE) will engage for business needs, data needs (estimated completion 10/2020)
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	<p>Current State: Idaho’s outpatient behavioral health managed care contractor provides Optum Supports and Services Manager (OSSM). This tool is an EHR platform set up specifically for Targeted Care Coordination. Targeted Care Coordinators use the tool to share and track information with the Child and Family Team and to submit person-centered service plans to the Managed care contractor for review. These care plans can be shared through electronic communications when youth transition to the adult behavioral health system.</p> <p>Future State: The State will include support for electronic care plans for children, youth and adults as an expectation for the next iteration of the behavioral health managed care contract.</p> <p>Summary of Actions Needed: The state Medicaid team will include requirements for supporting electronic care plans in the upcoming behavioral health managed care contract. (Estimated completion: 01/2021)</p>
2.5 Transitions of care and other community supports are	<p>Current State: The state’s HIE has successfully launched Direct Messaging and Supports ADT messages to communicate admission, discharge and transfer information. This functionality and the ability to share care</p>

Prompts	Summary
accessed and supported through electronic communications	summaries support enhanced care coordination for providers who use EHR and HIE technology.
	Future State: Assess feasibility of implementing a community resource platform for use by state and local agencies, including first responders, to enhance case management and crisis response by providing connections and referrals to community-based supports using a closed loop referral system with real time notification abilities.
	Summary of Actions Needed: <ul style="list-style-type: none"> - Contract with consultant (Julota) to assess government agencies for workflow gaps and service opportunities (estimated completion 07/20) - Contract with consultant (Julota) to conduct environmental scan for interested regions, communities, and resources-medical, community, etc. (estimated completion 07/20)
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	Current State: Consent/privacy is managed largely at the provider level across the Medicaid system. Processes range from standardized electronic capture to manual, non-standardized and paper-based processes. The HIE provides individuals a method to “opt out” from having their health information made available to providers participating in the data exchange. Health care providers who participate in the HIE may only access data for purposes of treatment, payment, and healthcare operations which promote efficiency of communication in care, patient safety, and enhance patient health. These participants also must abide by the IHDE programs and policies which include privacy, security and HIPAA standards. Use of the IHDE system for any other reason is strictly prohibited. Additional development is needed to facilitate sharing and segregation of 42 CFR Part 2 sensitive information.
	Future State: The HIE will create a project to facilitate seamless sharing of sensitive information, segregation and protection of highly sensitive records. Project scope will include: <ul style="list-style-type: none"> -Defining 42 Part 2 data requirements -Engaging behavioral health, SUD, and community partners to define use cases for continuity of care and building more complete health records for authorized users -Use of recommendations from federal partners for de-identified patient data reporting -Adding a behavioral health access audit report function in Orion portal (access controls)
	Summary of Actions Needed: <ol style="list-style-type: none"> 1. The state HIE (IHDE) will revise the current master participant agreement and Qualified Service Organization Agreement (QSOA) to include prescription drug and 42 Part 2 data (Estimated timeline: 02/20-04/20) 2. The state HIE (IHDE) will enhance user roles and audit reporting functionality in portal with vendor, Orion Health (12/2019-06/2021) 3. The state HIE (IHDE) will enhance data warehouse capabilities to support 42 Part 2 data (04/2020-09/2020)
Interoperability in Assessment Data (Section 4)	

Prompts	Summary
<p>4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem</p>	<p>Current State: Idaho Medicaid’s outpatient behavioral health managed care contractor requires clinicians to complete a standardized Comprehensive Diagnostic Assessment (CDA) to guide treatment for children and youth diagnosed with a Serious Emotional Disturbance (SED) and adults with Severe and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI). Providers are also required to use a standardized functional assessment tool to identify the member’s strengths and needs. Providers use the CDA and functional assessment tools to guide individualized treatment planning and make recommendations for an array of services based on the severity and complexity of the member’s symptoms and needs.</p> <p>The state has selected The Child and Adolescent Needs and Strengths (CANS) assessment as the functional assessment tool to be used for youth under the age of 18 receiving Medicaid benefits.</p> <p>There is no specific functional assessment tool which is mandated for adults, but one is required to be used. For substance use concerns, the provider may administer the GAIN or another specialized SUD assessment tool.</p> <p>Use of these standardized assessment instruments paves the way for transitioning to structured data capture and increased operability. However, currently there is no requirement for structured data capture for adult assessments. The CANS functional assessment for children and youth does use a structured data capture process using the ICANS platform. Information from CANS results and updates guides person-centered plan development and follows the member throughout the system of care.</p> <p>Future State: The State will include requirements for progress towards transitioning standardized assessments into structured data capture processes as an expectation for the next iteration of the behavioral health managed care contract.</p> <p>Summary of Actions Needed:</p> <ul style="list-style-type: none"> - The state Medicaid team will include requirements for transitioning standardized assessments into structured data capture processes to improve interoperability in the upcoming behavioral health managed care contract. (estimated completion 01/2021)
Electronic Office Visits – Telehealth (Section 5)	
<p>5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care</p>	<p>Current State: In July 2019, the Health Transformation Council of Idaho (HTCI) with endorsement by the Health Quality Planning Council, (HQPC) approved formation of a Telehealth Task Force. The task force is charged with identifying drivers, opportunities and strategies for telehealth services adoption and expansion in Idaho for providers, clinics, specialists, hospitals, and other health system partners.</p> <p>Telehealth has the potential to help overcome challenges of provider shortages and can help expand access to health care services. In Idaho, telehealth is governed by statute. During the 2020 legislative session, the Telehealth Access Act was amended to more specifically define allowable uses of telehealth. Idaho Medicaid reimburses providers for a broad range of telehealth services, including primary care and behavioral health.</p> <p>Future State: The state will use Support Act funds for a telehealth environmental scan of current use, barriers, and</p>

Prompts	Summary
	future state of telehealth and telehealth services
	Summary of Actions Needed: The environmental scan will be conducted by a vendor, Stonewall Analytics, anticipated completion is September 2020.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment)	Current State: The state’s current Medicaid managed care contractor for outpatient behavioral health services provides an electronic tool, Algorithms for Effective Reporting and Treatment (ALERT®). The ALERT® tool is an outcomes and outlier management system that uses member self-reports of symptom severity and impairment as measured by a wellness assessment in combination with claims to identify members who may be at-risk or who may be over or under-utilizing outpatient services. It provides decision support (utilization algorithms) for the authorization and/or clinical review of outpatient services. It also generates provider profiles that enable quality improvement and clinical staff to act when trends are identified.
	Future State: Work with current managed care contractor to evaluate effectiveness of workflow related to Alert functionality
	Summary of Actions Needed: <ul style="list-style-type: none"> - The state Medicaid team and Optum Idaho (current managed care contractor) will conduct evaluation of current Alert workflow (estimated completion 09/20) - The state Medicaid team will Include requirements for HIT capabilities for identifying patients at risk for discontinuing treatment in the upcoming behavioral health managed care contract (estimated completion 01/2021)
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	Current State: The state’s HIE has successfully launched Direct Messaging and Supports ADT messages to communicate admission, discharge and transfer information. This functionality and the ability to share care summaries support enhanced care coordination for individuals experiencing their first episode of psychosis.
	Future State: Conduct analysis to determine levels of adoption of EHR and HIE by IMDs
	Summary of Actions Needed: <ul style="list-style-type: none"> - The state HIE (IHDE) will define business needs, data needs, priorities, connection types (estimated completion: 05/2020) - The state HIE (IHDE) will conduct readiness assessment for bi-directional interfaces (estimated completion 10/2020)
Identity Management (Section 7)	

Prompts	Summary
<p>7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records</p>	<p>Current State: Ability to link parent-child relations is a feature of some certified EHRs, however, this is not a current feature of Idaho's HIE or broadly available in the state's health system. Systems used within the state's Department of Health and Welfare to administer Medicaid, SNAP, Child Care Assistance, Cash Assistance, Foster Care, Child Welfare and other social services programs are integrated, use common identifiers and can link child and parent records.</p>
	<p>Future State: The state will perform a feasibility analysis to determine benefits, constraints, costs and relative priority of this functionality.</p>
	<p>Summary of Actions Needed: The Medicaid HIT team will Identify subject matter expertise needed to perform analysis, engage stakeholders, document results, present findings to state leadership. (Estimated completion: 12/2020)</p>
<p>7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient</p>	<p>Current State: The state's HIE recently performed a self-evaluation and tuning exercise on their current MPI and determined that a backlog of mismatched and/or duplicate patient records exist. The HIE is conducting a detailed analysis of the status of exceptions in the MPI and will execute a cleanup of existing anomalies while establishing a program for constant monitoring and remediation on a regular basis.</p>
	<p>Future State: Enhanced reliability and usability of data resulting from regular monitoring and remediation of MPI exceptions.</p>
	<p>Summary of Actions Needed:</p> <ul style="list-style-type: none"> - The state HIE (IHDE) will develop standard operating procedures for monitoring and remediating MPI exceptions (Estimated timeline: 07/20-03/21) - IHDE Staff training (Estimated timeline: 09/20-03/21) - IHDE Compliance audits (Anticipated audits: 06/20, 12/20, 06/21)

ATTACHMENT D
SMI/SED Implementation Plan

CMS' Opioid and Other SUDs 1115 Demonstration Initiative:

Goals and Milestones to be Addressed in State Implementation Plan Protocols

CMS is committed to working with states to provide a full continuum of care for people with opioid use disorder (OUD) and other SUDs and in supporting state-proposed solutions for expanding access and improving outcomes in the most cost-effective manner possible.

Goals:

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

Milestones:

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

Section I – Milestone Completion

Milestones

1. Access to Critical Levels of Care for OUD and Other SUDs

Specifications:

To improve access to OUD and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary. To meet this milestone, state Medicaid programs must provide coverage of the following services:

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

Current State:

The State of Idaho, through the Idaho Department of Health and Welfare (IDHW), has made significant advancements over the last decade to increase access to care for Idahoans challenged by substance use disorder (SUD). Through concerted efforts by state agencies, IDHW currently offers a range of services across the continuum of care for Medicaid beneficiaries with SUD. Such services include coverage of outpatient services, intensive outpatient services, medication-assisted treatment (MAT) and acute care in inpatient settings. The current Medicaid State Plan outlining all behavioral health services is available for review at:

<https://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/EnhancedPlan.pdf>.

These comprehensive treatment services are made available to adults, children and adolescents who suffer from SUD. Moreover, state agencies have worked collectively to address care coordination issues to ensure beneficiaries can access the appropriate level of care. However, despite the state's progress, Idaho has recognized gaps in the availability of behavioral health services, particularly access to intensive levels of care in residential and inpatient settings across the state. Currently, for adults ages 21-64, these services may only be reimbursed by Medicaid in hospital inpatient settings due to the federal IMD exclusion. An IMD is defined as an institution with more than 16 beds primarily engaged in the diagnosis, treatment, or care of individuals with mental diseases. Through the waiver, IDHW seeks authority from CMS to reimburse IMDs for inpatient and residential services provided to Medicaid-enrolled patients in order to expand access and add more inpatient and residential options for Medicaid beneficiaries.

However, as a preliminary note, in the fall of 2019, Idaho also submitted a 1915(l) state plan amendment to allow Medicaid reimbursement for inpatient treatment at IMDs for enrollees with SUD in order to provide potential gap coverage for these critical services prior to the approval of the more expansive Section 1115 waiver. Once this SUD Implementation Plan, in conjunction with the previously submitted Section 1115 Waiver, is approved by CMS, Idaho will utilize the

waiver authority to provide coverage for services provided in IMDs. As part of this implementation plan, the state will take all necessary actions to effectuate the formal transition of waiver authority for the IMD exclusion.

Future State:

Although Idaho currently offers a comprehensive continuum of care coverage for its Medicaid beneficiaries, the state has recognized several areas for improvement. In particular, with the expansion of Medicaid eligibility, the state will transition many of the services covered through the Department of Behavioral Health (DBH) to be directly covered through Medicaid. Idaho’s future state goal is to follow the “protractor” model of comprehensive individual and system measures to support a holistic behavioral health transformation system. Idaho Medicaid will provide a broad service array to support individuals through the entire behavioral health continuum of care, from promoting education to supporting universal screenings and early intervention to engagement and finally continued recovery.

Idaho plans to expand coverage of Medicaid reimbursable services to provide the full continuum of care for behavioral health services, including:

- i. Increasing and offering new reimbursement for inpatient and residential services provided in IMDs;
- ii. Expanding coverage of medication assisted treatment options; and
- iii. Offering additional community-based support services.

The table below further expands on Idaho’s future state plans to address gaps in coverage of behavioral health services.

Below is a table that describes: 1) current SUD treatment services covered by the State at each level of care; 2) plans to improve access to SUD treatment services for Medicaid beneficiaries; and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 1. Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Coverage of outpatient services</p>	<p>Outpatient SUD services are carved out of fee for service and provided by a single managed care entity (MCE) through a Section 1915(b) waiver.</p> <p>The Idaho Medicaid State Plan provides coverage for a wide array of outpatient services, including:</p> <ul style="list-style-type: none"> • Treatment Planning • Screening, Evaluation and Diagnostic Assessments • Psychotherapy • Drug Screening • Pharmacologic Management • Psychological and Neuro-psychological Testing • Community-based Rehabilitation Services • Case Management • Community Crisis Intervention 	<p>Idaho will continue to provide services in accordance with the current state plan, and offer a full array of evidence-based outpatient behavioral health services in accordance with ASAM, which will be available in home and community-based settings as well as traditional clinical settings as appropriate.</p> <p>In addition to the current state plan benefits, Idaho will also expand outpatient coverage through the addition of recovery coaching to the state plan.</p>	<ul style="list-style-type: none"> • Amend State Plan to include new recovery coaching services <u>(Timeline 6-12 Months)</u> • Add recovery coaching to 1915(b) <u>(Timeline 6-12 Months)</u> • Add recovery coaching to IBHP contract <u>(Timeline 6-12 Months)</u> • Review all outpatient service definitions and staff qualifications to ensure alignment with ASAM <u>(Timeline 18-24 Months)</u>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Coverage of intensive outpatient services</p>	<p>Intensive Outpatient Program services aligned with ASAM 2.1 service definitions are covered under the Medicaid state plan and provided through the IBHP.</p> <p>Partial Hospitalization is also covered under the Medicaid state plan. Partial hospitalization was added as a new IBHP service effective 1/1/2020.</p>	<p>Expand the partial hospitalization benefit across Idaho. Partial hospitalization is a bundle of services that includes support therapy, medication monitoring, and skills building, in an intensive ambulatory treatment program offering less than 24-hour daily care.</p>	<ul style="list-style-type: none"> Over the demonstration period, Idaho Medicaid and the IBHP contractor will continue to enroll new Partial Hospitalization providers.
<p>Coverage of medication assisted treatment (medications as well as counseling and other services)</p>	<p>Medication assisted treatment (MAT) for opioid use disorders (OUD) is available as a pharmacy benefit under the state plan, and reimbursed through the fee for service delivery system. Currently, only buprenorphine and extended release naltrexone are available.</p> <p>The state is currently participating in the CMS MAT Affinity Group TA Opportunity, which will last from February 2020 through August 2020.</p>	<p>OUD MAT coverage will be expanded to add methadone maintenance at opioid treatment programs (OTPs) for the treatment of SUD.</p> <p>In addition, the state will transition provision of MAT from FFS to managed care through the IBHP.</p> <p>Establish reimbursement methodology that appropriately incentivizes provision of MAT throughout the state, including rural and frontier areas.</p>	<ul style="list-style-type: none"> Align Idaho service definition with ASAM Criteria <u>(Timeline 6-12 Months)</u> Modify existing state plan language and 1915(b) authorities to ensure coverage of methadone maintenance. <u>(Timeline 6-12 Months)</u> Develop new policies and rules for provision of MAT at OTPs. <u>(Timeline 6-12 Months)</u> Restructure reimbursement following completion of CMS MAT Affinity TA

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			Group. <u>(Timeline 18-24 Months)</u>
<p>Coverage of intensive levels of care in residential and inpatient settings</p>	<p>The Medicaid State Plan provides coverage for inpatient treatment at ASAM levels 3.7 and 4.0. These services are reimbursed through the fee-for-service delivery system.</p> <p>Residential treatment services are not currently a covered Medicaid benefit. Instead, the Division of Behavioral Health (DBH) provides limited intensive residential care for Idahoans in need through grants and other state funds.</p>	<p>Medicaid will expand coverage to include residential treatment at ASAM level 3.5. These services will also be available in IMD settings previously excluded from participation in the Medicaid program.</p> <p>In addition, over the course of the waiver, inpatient and residential services will transition from fee-for-service to the IBHP program.</p>	<ul style="list-style-type: none"> • Align Idaho service definition with ASAM Criteria <u>(Timeline 6-12 Months)</u> • Provide avenue for residential providers to enroll as Idaho Medicaid providers <u>(Timeline 6-12 Months)</u> • Add coverage of residential services equivalent to ASAM 3.5 <u>(Timeline 6-12 Months)</u> • Define reimbursement methodology for residential services, and make necessary revisions to MMIS to reflect changes to provider enrollment and reimbursement for these services. <u>(Timeline 6-12 Months)</u> • Develop regulations, rules and/or standards to establish provider qualifications and service definitions for residential treatment providers that align with ASAM standards for

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			<p>types of services, hours of clinical care and credentials of staff. <u>(Timeline 18-24 Months)</u></p> <ul style="list-style-type: none"> • Add residential and inpatient services to the future IBHP contract rebid <u>(Timeline 24-30 Months)</u>
<p>Coverage of medically supervised withdrawal management</p>	<p>Medicaid covers withdrawal management for medically complex SUD patients in a hospital setting via the covered inpatient level of care benefit.</p> <p>DBH currently provides coverage for medically supervised withdrawal management (ASAM 3.7-WM) in IMD and non-IMD settings. This is not currently a Medicaid-funded service.</p>	<p>Medicaid will add medically supervised ASAM level 3.7 withdrawal management services to the Medicaid state plan, and make these services available in residential and inpatient settings.</p>	<ul style="list-style-type: none"> • Align Idaho service definition with ASAM Criteria <u>(Timeline 6-12 Months)</u> • Add withdrawal management to Medicaid State Plan. <u>(Timeline 12-18 Months)</u> • Develop regulations to establish provider qualifications and service definitions for residential treatment providers that align with ASAM standards for types of services, hours of clinical care and credentials of staff. <u>(Timeline 18-24 Months)</u>

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

Specifications:

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Current State:

The system for behavioral healthcare in Idaho includes multiple different payors and delivery systems. For Medicaid services, the Idaho Behavioral Health Plan (IBHP) utilizes a managed care model for all outpatient behavioral health services. The IBHP provider network utilizes patient placement guidelines aligned with ASAM for all covered SUD outpatient services, and formally assesses treatment needs through a comprehensive diagnostic assessment (CDA) tool. For SUD treatment services not covered by Medicaid and reimbursed through the Division of Behavioral Health, providers utilize the Global Assessment of Individual Needs (GAIN) assessment tool for patient treatment placement and planning. Further, all payors utilize various utilization management approaches to ensure appropriate levels of care are accessed for individual treatment needs.

Future State:

IDHW will align service definitions and placement criteria with national evidence-based definitions, particularly for newly added inpatient and residential services in IMDs. Specifically, for SUD treatment services, IDHW will utilize the ASAM patient placement criteria, the most widely accepted and comprehensive set of guidelines. The SUD service definitions, patient placement tools, and utilization management review criteria will align with ASAM throughout the entire Idaho behavioral health system of care, regardless of level of care needs or payor source.

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines</p>	<p>The IBHP provider network uses <i>The ASAM Criteria</i> to guide outpatient service delivery and level of care placement for SUD services. Further, IBHP network providers assess formal treatment needs through the use of a Comprehensive Diagnostic Assessment (CDA).</p> <p>Idaho Medicaid’s fee for service providers and Quality Improvement Organization (QIO) use <i>Milliman</i> and <i>ASAM Criteria</i> to guide service delivery and level of inpatient placement for SUD services.</p>	<p>The IBHP contract will encompass both inpatient and outpatient services and will require providers to apply <i>The ASAM Criteria</i> while conducting a CDA in order to guide service delivery and level of care placement.</p> <p>The Divisions of Medicaid and Behavioral Health will collaborate to select and implement SUD-specific, multi-dimensional assessment tools aligned with ASAM that will become the Department-approved assessment tools used universally throughout the Idaho behavioral health system of care.</p>	<ul style="list-style-type: none"> Amend IBHP contract to require inclusion of a full psychosocial assessment covering the six dimensions in accordance with <i>The ASAM Criteria</i>. <u>(Timeline 12-20 Months)</u> Develop and implement criteria via IDAPA rules and/or standards to ensure beneficiaries’ treatment needs are assessed based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines. <u>(Timeline 18-24 Months)</u>
<p>Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing</p>	<p>The IBHP provider network uses <i>The ASAM Criteria</i> to guide service delivery and level of care placement for outpatient SUD services. Further, the IBHP contractor maintains a utilization management (UM) program to ensure that enrollees have access to outpatient</p>	<p>Based on <i>The ASAM Criteria</i>, the IBHP contractor will be required to develop and use a UM program that aligns with state standards to ensure that beneficiaries have access to SUD services at the appropriate level of care.</p> <p>The IBHP contractor will be required to incorporate quality</p>	<ul style="list-style-type: none"> Establish necessary administrative rules, regulations or statutes, to ensure access to the appropriate levels of care and oversight on lengths of stay. <u>(Timeline 6-12 Months)</u> Establish an independent UM process used to ensure beneficiaries

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>placement in residential treatment settings.</p>	<p>SUD services at the appropriate level of care.</p> <p>The IBHP contract currently covers only outpatient BH services. Therefore, placements in inpatient SUD treatment settings are a Medical Care benefit, authorized by the state's QIO. The QIO is responsible for the UM reviews of all inpatient SUD services, including oversight of lengths of stay. Idaho's QIO utilizes ASAM and Milliman criteria when determining the appropriate level of care for Medicaid members.</p> <p>Further, the IBHP contractor employs a staff of Field Care Coordinators (FCCs) to ensure that enrollees are placed at the appropriate level of care upon discharge back to the community following an inpatient stay.</p>	<p>measures into the UM review processes. The effectiveness of treatment decision will be evaluated to determine if client care is enhancing the overall health of the population.</p> <p>As part of the 2021 rebid, the IBHP will transition to a prepaid inpatient health plan, as all behavioral health services will be carved into the IBHP managed care contract. As part of this transition, the IBHP contractor will be required to establish a detailed UM approach such that there is an independent process for reviewing placement in residential treatment settings. Specifically, all placements in inpatient and residential treatment settings will require prior authorization and independent review of provider placements and treatment decisions from IBHP contractor clinical staff trained in ASAM criteria.</p>	<p>have access to SUD services at the appropriate level of care with the appropriate interventions based on <i>The ASAM Criteria</i>. <u>(Timeline 6-12 Months)</u></p> <ul style="list-style-type: none"> • Incorporate requirements into IBHP rebid to include additional quality measures related to UM and outcomes, and to establish minimum processes for reviewing and approving placements in inpatient and residential treatment settings in accordance to <i>The ASAM Criteria</i>. This UM process will promote the appropriate placement in level of care and ensure interventions are appropriate for the presenting diagnosis and level of care. <u>(Timeline 24-30 Months)</u>

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

Specifications:

Through the new Section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases. To meet this milestone, states must ensure that the following criteria are met:

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

Current State:

Idaho's current residential facility licensing and certifications requirements through the Department's Division of Licensing and Certification are primarily designed for inpatient hospitals and Psychiatric Residential Treatment Facilities (PRTFs) treating patients with SMI/SED. The current licensing and certifications standards are not specific to SUD treatment programs.

Future State:

With the expansion of SUD services, particularly the addition of residential treatment facilities, Idaho will establish a provider qualification and 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. All Medicaid-enrolled residential treatment programs will be required to meet program standards described in the ASAM Criteria appropriate for the level of care, including, but not limited to the types of services, hours of clinical care, and credentials of staff for residential treatment settings.

Below is a table that describes: 1) current provider qualifications for residential treatment facilities; 2) plans to enhance provider qualifications for residential treatment; and 3) a summary of action items that need to be completed to meet the milestone requirements.

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings</p>	<p>Idaho Division of Medicaid does not currently reimburse for residential level of care for SUD treatment.</p> <p>Through State General Funds and SUD Block Grants, DBH has begun efforts to establish program standards for types of services, hours of clinical care, and credentials of staff for residential treatment settings at every ASAM level of care.</p>	<p>The state will ensure that all residential treatment providers are qualified to provide services in accordance with ASAM Criteria through the establishment of SUD residential treatment program requirements in IDAPA rules and/or standards. These requirements will incorporate ASAM Criteria and include types of services, hours of clinical care, and credentials of staff.</p> <p>All residential SUD treatment programs enrolled in Idaho Medicaid will be required to meet these requirements. Further, the IBHP contractor will be required to ensure compliance with the requirements throughout the IBHP network.</p>	<ul style="list-style-type: none"> Update Medicaid provider handbook with guidance regarding residential treatment provider qualifications, requirements regarding ASAM criteria and other program standards. <u>(Timeline 6-12 Months)</u> Establish statute, licensure IDAPA rules, and/or other standards for SUD residential treatment programs providing publicly funded services enrolled with Medicaid. <u>(Timeline 12-18 Months)</u> Incorporate residential services in IBHP contract rebid, including requirement that all providers enrolled in the IBHP network must adhere to these minimum provider qualification standards. <u>(Timeline 24-30 Months)</u>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards</p>	<p>Idaho does not currently have a process for reviewing residential treatment providers to ensure compliance with these standards.</p>	<p>The Divisions of Medicaid and Behavioral Health will collaborate to establish SUD residential treatment program requirements in IDAPA rules and/or standards. These standards will describe state requirements for certifying and reviewing residential treatment providers to ensure compliance.</p>	<p><u>Months)</u></p> <ul style="list-style-type: none"> Establish a state certification process for all SUD residential treatment programs enrolled with Medicaid. <u>(Timeline 18-24 Months)</u> Establish an ongoing process to periodically reevaluate existing publicly funded SUD residential treatment programs to ensure residential treatment providers adhere to state-developed standards. <u>(Timeline 18-24 Months)</u>
<p>Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off-site</p>	<p>Idaho Division of Medicaid does not currently reimburse for residential levels of care for SUD treatment.</p>	<p>The Division of Medicaid is expanding coverage of residential treatment and MAT. All newly enrolled residential treatment providers will be required to, at minimum, align services with ASAM best practices, including provision of MAT. IDHW will require all IMDs receiving Medicaid payments to provide at least two forms of</p>	<ul style="list-style-type: none"> Revise Medicaid enrollment policies, regulations and standards to require all Medicaid-enrolled SUD residential treatment providers to offer at least two forms of MAT. <u>(Timeline 6-12 Months)</u> In 2021 rebid, include a new requirement for the IBHP contractor to ensure all network

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		MAT for OUD, either on-site or through facilitated access off-site through strategic community partnerships.	inpatient and residential treatment providers comply with MAT policy requirements. <u>(Timeline 24-30 Months)</u>

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Specifications:

To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

Current State:

In late 2019, Idaho completed an assessment of the availability of providers across the state, including those enrolled in Medicaid and accepting new patients, at each of the critical levels of the SUD continuum of care. Idaho currently offers access to outpatient and intensive outpatient SUD services in each of the state's seven regions. Providers who offer these services include SUD-focused facilities, integrated behavioral health clinics, individual practitioner offices, primary care clinics, and facilities that offer telehealth services. In addition, Idaho has at least one 24-hour crisis stabilization center in each of the seven regions, available to assist individuals with SUD. Furthermore, Idaho offers 52 FQHCs that deliver behavioral health services throughout the seven regions. The state also has nearly 200 DATA-waivered providers who can prescribe buprenorphine. Moreover, any licensed pharmacist and pharmacy technician may dispense naloxone for reversal of opioid overdose, without a prescription. While services are available in each of the state's seven regions, the more rural and frontier areas face significant SUD provider shortages, with regard to inpatient and outpatient levels of care.

Future State:

Based on the information from the assessment, the state has identified several strategies to expand provider capacity across the state, with particular emphasis on addressing provider shortages in rural and frontier areas. Generally, Idaho's plan to address issues of provider capacity will focus on the utilization of existing state resources, and identification of which regions need resources and services currently unavailable. Such broad strategies include the following:

- (i) Crisis Stabilization Services. The state plans to expand such services, including ensuring availability of Medicaid reimbursement for services delivered at a 24-hour crisis center, enhance the statewide inpatient and crisis bed registry, expand mobile crisis units, and improve connectivity between first responders and treatment providers.
- (ii) Behavioral Health Integration. IDHW seeks to increase provider capacity by leveraging the state's strong primary care network to provide SUD early intervention, treatment, and care management. To encourage behavioral health

integration and support primary care providers, IDHW will simplify billing procedures and expand provider education through programs like Project ECHO.

- (iii) Telehealth Services. Increased access to telehealth services will include simplifying and standardizing telehealth coverage rules, creating a hub for crisis-related telehealth, and conducting an environmental scan related to current telehealth utilization and existing barriers.
- (iv) Improved Transportation. Transportation improvements for non-emergency transportation benefits.
- (v) Medication Assisted Treatment. IDHW seeks to educate providers about MAT and encourage more providers to become DATA-waivered to expand access to buprenorphine across the state. Further, through the expansion of MAT to include methadone maintenance at opioid treatment programs, IDHW seeks to establish a sustainable reimbursement methodology that will permit geographic expansion of MAT services into more rural areas.

Lastly, to build off of the work of the current environmental scan, the state will pursue stronger monitoring and data analytics around provider capacity to continue to monitor the availability of providers enrolled in Medicaid and accepting new patients at each level of care. Idaho will continue to expand coverage of residential treatment, partial hospitalization and recovery supports. As part of these efforts, Idaho seeks to develop a behavioral health provider directory that will allow providers to be sorted by specialty, available services, and ability to accept new Medicaid patients.

Table 4. Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT:</p> <ul style="list-style-type: none"> (i) Outpatient Services; (ii) Intensive Outpatient Services; (iii) Medication Assisted Treatment (medications as well as counseling and other services); (iv) Intensive Care in Residential and Inpatient Settings; (v) Medically Supervised Withdrawal Management. 	<p>Idaho has SUD providers in each of the seven regions of the state. Prior to submission of the Section 1115 Behavioral Health Transformation Waiver, Idaho completed an initial assessment of the available of providers enrolled in Medicaid and accepting new patients in each of the required categories. Please refer to “Attachment A: Combined Mental Health & Substance Use Disorder Services Availability Scan for Idaho.”</p>	<p>Over the course of the demonstration, Idaho will diligently work to ensure continuous improvement in the availability of Medicaid-enrolled providers providing SUD treatment in each of the critical levels of care.</p> <p>Based on the initial assessment, Idaho will focus on the following goals:</p> <ul style="list-style-type: none"> • Expand crisis stabilization services • Incorporate SUD treatment services into primary care settings • Improve accessibility to services through improvements in NEMT and expanded use of telehealth • Expand access to MAT for OUD, including efforts to increase number of DATA-waivered providers and OTPs • Create a behavioral health provider 	<ul style="list-style-type: none"> • Initial assessment is complete. The state will continue to assess provider capacity throughout demonstration period to monitor effect of new policies to expand capacity. <p>Medicaid will fund services in 24-hour crisis centers in each region of Idaho. <u>(Timeline 6-12 Months)</u></p> <p>DBH will expand inpatient and crisis bed registry as a first responder community resource <u>(Timeline over the course of the demonstration)</u></p> <ul style="list-style-type: none"> • Continue to strengthen the NEMT provider network in Idaho. The new NEMT contract will have specific requirements the contractor will have to meet regarding availability of NEMT services across Idaho. <u>(Timeline 12-18 Months)</u> • The IBHP rebid contract will outline specific incentives

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		directory	<p>for behavioral health professionals who operate within primary care settings. <u>(Timeline 24-30 Months)</u></p> <ul style="list-style-type: none"> • The new IBHP contract will outline specific access metrics that pertain to increased use of telehealth services in Idaho <u>(Timeline 24-30 Months)</u> • The new IBHP contract will outline specific real-time dashboard requirements regarding network specialties, levels of care, provider types and accepting new patients. <u>(Timeline 24-30 Months)</u> • The IBHP contract will require MAT for OUD to be available in all regions of Idaho. <u>(Timeline 24-30 Months)</u>

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

Specifications:

To meet this milestone, states must ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Current State:

Idaho has taken on a number of initiatives to implement comprehensive treatment and prevention strategies in response to the opioid epidemic. Through the collective efforts of various state agencies and community stakeholder partners and under the leadership of the Office of Drug Policy, the state has accomplished each of the key milestones related to opioid abuse and OUD treatment and prevention strategies.

- Implementation of Opioid Prescribing Guidelines. Medicaid has implemented a number of policies focused on safe prescribing practices to prevent opioid misuse and assist 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.
- Expanded Coverage and Access to Naloxone. Under current Idaho law, naloxone is available to anyone in Idaho without a prescription directly through a pharmacist, without first having to go to a traditional prescriber. This was further expanded to permit other licensed health professionals to dispense naloxone, rather than just prescribers and pharmacists. In addition, Good Samaritan Laws shield anyone who administers naloxone from liability.

With these eased regulations for expanded coverage and access, Idaho is focused on expanding distribution. Idaho's Response to the Opioid Crisis (IROC) is an initiative funded by a grant from SAMHSA, which has been used, in part, to expand access to naloxone, as well as to offer training for first responders and persons in the community who may come in contact with individuals suffering from OUD. This grant also funds distribution of naloxone kits to involved parties throughout the state.

In addition, expanded distribution also requires expanded training. Therefore, the state is

also focused on training and has supported the production of a series of online training videos for EMS and the general public on naloxone administration. Naloxone trainings are ongoing, including through the Public Health Districts, and have been presented in the community to a variety of audiences, including the general public, medical providers, and prevention professionals

- Increased Utilization/ Functionality of Prescription Drug Monitoring Programs. Another initiative undertaken by Idaho providers has centered on increased use of the state's Prescription Drug Monitoring Program (PDMP). Idaho has made great strides in use of the PDMP. Idaho providers have increased the number of PDMP searches tenfold, from 353,000 searches in SFY15 to 3.8 million in SFY18. In its 2019 session, the Idaho Legislature approved rule changes to prohibit Medicaid pharmacists from accepting cash/credit cards/checks as payment for controlled substances from persons known to be Medicaid participants.

Following intensive drug utilization studies, the state has taken a number of steps to increase provider education on prescribing standards, create prescriber report cards to establish social norms of decreased opioid prescribing, reduce diversion of opioids through use of drop-box programs, and educate prescribers on the benefits of using the PDMP. Further, the Department has received a CDC grant to improve the Idaho Health Data Exchange (IHDE), to make it more user-friendly and integrate the PDMP with the exchange to further increase the benefits and functionality of the PDMP.

Further details regarding Medicaid's current treatment and prevention measures are included in the table below.

Future State:

Although the state has made significant progress over the years to implement comprehensive treatment and prevention strategies to address OUD, the state's long-term overarching vision is aimed a continuous improvement to ensure that all adults, children, youth and their families who live with addiction and mental illness can access the behavioral health care services they need when they need them. With this in mind, the state is embarking on a collaborative initiative across all three branches of Idaho state government, local governments, education and other community partners to develop a single coordinated strategic plan to continually improve not only the state's response to the opioid epidemic, but also the entire statewide system of behavioral health care in Idaho.

This Section 1115 Behavioral Health Transformation Waiver seeks to supplement this larger ongoing strategic reform initiative by utilizing Medicaid to increase access to critical behavioral health care services. Specifically, over the course of this demonstration, Medicaid will support the state's larger goals by participating in number of initiatives, including, but not limited to, developing a robust statewide SUD continuum of care, including crisis response, as well as increasing health IT integration across the state.

Below is a table that describes: 1) current treatment and prevention strategies to reduce opioid abuse; 2) plans to implement additional prevention strategies and 3) a summary of action items that need to be completed to meet the milestone requirements.

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	<p>In 2019, Idaho Medicaid implemented MME limits (90 MME), including tapering strategies for current users of opioids whose dosages exceed these limits.</p> <p>All prescribers must check the PDMP before prescribing opioids and buprenorphine.</p> <p>In February 2020, CMS approved a SPA for changes to achieve compliance with SUPPORT Act pharmacy provisions. This SPA was just a formality, since the implementation of SUPPORT Act requirements had already taken place.</p>	Already implemented.	No action needed.
Expanded coverage of, and access to, naloxone for overdose reversal	Under current Idaho law, naloxone is available to anyone in Idaho by simply asking a pharmacist, without first having to go to a traditional prescriber. The state has also taken	Over the course of the demonstration, Idaho will continue to support the statewide distribution of naloxone, and provide consistent and integrated trainings conducted across stakeholder types.	<ul style="list-style-type: none"> • Develop and use an integrated acquisition and tracking platform for naloxone distribution. • Identify and partner with critical

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>a number of efforts to provide training not only to first responders and medical professionals, but also the community at large.</p>		<p>stakeholders to expand naloxone distribution.</p> <ul style="list-style-type: none"> Standardize training content across stakeholders and platforms. <u>(Timeline Demonstration Period)</u>
<p>Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs</p>	<p>Idaho has made great strides in use of the prescription drug monitoring program (PDMP). Idaho providers have increased the number of PDMP searches tenfold, from 353,000 searches in SFY15 to 3.8 million in SFY18. In its 2019 session, the Idaho Legislature approved rule changes to prohibit Medicaid pharmacists from accepting cash/credit cards/checks as payment for controlled substances from persons known to be Medicaid participants. The Legislature also passed the first state law in the nation to expand prescriptive authority for naloxone to pharmacy technicians, a move that is expected to significantly increase distribution of this</p>	<p>A pending IAPD HITECH application, when approved by CMS, will use associated funding to enhance PDMP functionality, interoperability, ease of use, and patient matching capabilities.</p> <p>PDMP enhancements are expected to include making interstate data-sharing hubs more interoperable with one another, bolster intrastate data-sharing within Idaho, improve the returned results from the sending state through better patient matching, and enhance integration of the interstate sharing platform within EHRs and the PDMP itself. Patient matching is a significant obstacle to complete and ensure accurate retrieval results, and this would be a focus between</p>	<ul style="list-style-type: none"> Access CMS HITECH funding <u>(Timeline 6-12 Months)</u> Enhancements from HITECH <u>(Timeline 12-24 Months)</u>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>critical opioid antagonist in the state’s rural/frontier counties.</p> <p>The Department has received grants from the CDC and CMS. The CMS grant funds two pharmacists, who will attack the issues around misuse of both opioids and benzodiazapines; the CDC grant aims to improve the Idaho Health Data Exchange (IHDE), to make it more user-friendly and integrate the PDMP with it.</p>	<p>states participating in this endeavor.</p>	
<p>Other</p>	<p>The Office of Drug Policy has undertaken efforts to promote and broaden drug disposal programs; evaluate and pursue further opioid education, prevention measures, and resiliency training; and encourage and partner with county and local law enforcement, paramedics, and correctional officials to supply naloxone and apply for grant funding for naloxone distribution.</p> <p>On June 13, 2019,</p>	<p>The Department will undertake new initiatives to combat the Opioid Crisis, in response to policy recommendations issued by the Opioid and Substance Use Disorder Advisory Group.</p>	<p><u><i>Timeline Over Course of Demonstration</i></u></p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>Governor Brad Little issued Executive Order 2019-09. This executive order established an Opioid and Substance Use Disorder Advisory Group to research and evaluate best practices in other states used to combat opioid abuse and substance use disorders, and make recommendations across a wide spectrum of policy areas, including treatment options, law enforcement and prosecutorial policies, education, and public awareness campaigns.</p>		

6. Improved Care Coordination and Transitions between Levels of Care

Specifications:

To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Current State:

The IBHP currently provides only ambulatory behavioral health services, which creates coordination challenges for members transitioning into and out of hospital or residential settings. Idaho has taken a number of steps to continuously improve care coordination for patients as they transition from fee-for-service inpatient SUD treatment back to the IBHP network and community-based settings. Currently, the IBHP utilizes Discharge and Field Care Coordinators to coordinate care for high-risk members to ensure outpatient behavioral health services are established prior to transitioning from inpatient settings back into the community. In addition, Idaho's fee-for-service Quality Improvement Organization has provided the IBHP contractor access to its utilization management system to assist the field coordinators with timely information on members presenting to emergency departments or admitted to inpatient treatment.

Future State:

IDHW recognizes that with the expansion of Medicaid to the new adult group coupled with the expansion of inpatient and residential treatment programs to IMDs, a more coordinated and streamlined approach to assist beneficiaries as they transition from residential and inpatient facilities to the community will be essential. Care coordination, particularly these critical transitions between levels of care, is a key component to ensuring the effectiveness of treatment and improved long-term health outcomes for individuals with SUD. As such, IDHW has considered several measures to improve care coordination efforts and transitions between levels of care. The primary approach will be to fully integrate the IBHP contract for all behavioral services in Idaho. In addition to the integration, additional accountability metrics will be included in the new IBHP contract aimed at improving care coordination and transitions between levels of care, including: (i) additional HEDIS measures related to follow up after inpatient or residential care; (ii) new contract standards and provider requirements related to discharge planning, and (iii) enhanced requirements for case management.

A more detailed overview of the state's current and future care coordination and transition efforts is provided below.

Table 6. Milestone #6: Improved Care Coordination and Transitions between Levels of Care

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities</p>	<p>Currently inpatient facilities work directly with community behavioral health providers and IBHP Field Care Coordinators to establish services post discharge.</p> <p>The IBHP contractor has access to Idaho’s Quality Improvement Organization’s utilization management portal. This access promotes real-time information regarding inpatient admission and emergency room visits.</p> <p>The current IBHP contract outlines performance incentives based on HEDIS FUH-30 Day.</p> <p>IBHP Field Care Coordinators contact members post discharge to promote adherence to scheduled follow-up appointments.</p>	<p>The new IBHP contract will be a fully integrated behavioral health contract. The new IBHP contractor will have specific transition standards outlined in their contract. These performance standards will be required within community provider and inpatient/residential provider contracts with the managed care organization.</p> <p>The new IBHP MCO will have a team of clinicians that perform direct interventions to high-risk Idaho Medicaid members. This IBHP team will directly interface with community providers and residential/inpatient discharge coordinators.</p>	<ul style="list-style-type: none"> • Develop transition of care standards. <u>(Timeline 12-20 Months)</u> • Notify residential treatment providers of requirements. <u>(Timeline 20-24 Months)</u> • Implement the new IBHP contract. <u>(Timeline 24-30 Months)</u> • Include Idaho transition of care standards in new IBHP contract. <u>(Timeline 24-30 Months)</u> • Include transition of care standards in IBHP provider agreements. <u>(Timeline 24-30 Months)</u> • Include additional HEDIS FUH measures tied to performance in IBHP contract. <u>(Timeline 24-30 Months)</u>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Idaho does not have a standard policy or guidance for coordination of care for co-occurring physical and mental health conditions	Develop state standard for coordination of care for co-occurring physical and mental health conditions	<ul style="list-style-type: none"> • Idaho’s Mental Health Authority develop standards for coordination of care for co-occurring physical and mental health conditions <u>(Timeline 18-20 Months)</u> • Notify providers of standards <u>(Timeline 20-24 Months)</u> • Execution of the new IBHP contract. <u>(Timeline 24-30 Months)</u> • New IBHP contract outlines Idaho standards <u>(Timeline 24-30 Months)</u> • IBHP provider agreements outline transitions of care standards <u>(Timeline 24-30 Months)</u>

Section II – Implementation Administration

The state’s point of contact for the Implementation plan is:

Name and Title: Matt Wimmer, Administrator, Division of Medicaid

Telephone Number: (208) 364-1804

Email Address: Matt.Wimmer@dhw.idaho.gov

Section III – Relevant Documents

Not Applicable.

Attachment A – SUD Health Information Technology (IT) Plan

Section I.

Specifications:

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state’s PDMP.

Current State:

The Idaho Board of Pharmacy maintains and administers the state of Idaho’s prescription drug monitoring program (PDMP). Since 2016, the Idaho Board of Pharmacy has contracted with Appriss Health, Inc. to manage the prescription drug monitoring program. Idaho’s PDMP contains controlled substances schedules II-V and other drugs of concern within Idaho. Access to and use of the PDMP is controlled in Idaho Statute and is limited to licensed prescribers, pharmacists, or their delegates for treatment purposes.

Verification and access to the PDMP happens in two stages: Board approval of application and Appriss user account with a login name and password. PDMP information and limited-use access to PDMP information can be requested by the following: individuals employed by boards, peace officers enforcing laws regulating controlled substances, authorized individuals at the Idaho Department of Health and Welfare, practitioner or delegates, pharmacists or delegates, individual or individual’s attorney, individual with lawful court order, limited attorneys, and medical examiner or coroner for cause of death determination. Limited-use is defined as view-only, de-identified or identified prescription information reports based on approved request.

The PDMP can be accessed online through a user account or built into the electronic health record workflow for clinicians and prescribers and pharmacy dispensing systems for pharmacists and dispensers. Methadone and narcotic treatment program clinics do not report to the PDMP due to 42 CFR Part 2 confidentiality.

Future State:

The Idaho Board of Pharmacy will continue to maintain and administer the state of Idaho’s prescription drug monitoring program (PDMP). The board and its vendor will continue to verify and authenticate access to the PDMP according to Idaho Statute and other Idaho Board of Pharmacy stipulations. A goal of the Idaho Board of Pharmacy is connecting all providers to the PDMP with a statewide Gateway license.

The state’s health information exchange, Idaho Health Data Exchange, is the sole health information exchange in Idaho and can bridge the gap for social determinates of health information, population health and morbidity data, and individual health data, including prescription information. The Idaho Health Data Exchange plans to connect to the PDMP through Appriss Health, Inc. to provide authorized individuals with prescription drug information within the data exchange and make it a part of a patient’s electronic health record.

To enhance interstate interoperability, Idaho Health Data Exchange plans to connect to Washington, Oregon, Nevada, and Utah’s health information exchange to provide better patient data for those travelling out of state for health care needs.

Summary of Actions Needed:

- Idaho Board of Pharmacy working with PDMP vendor, Appriss Health, to use a statewide Gateway connection for the state of Idaho by October 1, 2020. A blend of SUPPORT Act funds and Department of Justice - Bureau of Justice Administration funds will be used to support the statewide Gateway connection.
- Idaho Health Data Exchange contract with Appriss Health to get PDMP access through a SUPPORT Act funded project with the data exchange and Idaho Department of Health and Welfare (in process)
Idaho Health Data Exchange enhancing their master participation agreement for HIPAA and 42 CFR Part 2 data, data warehouse capabilities, security and compliance capabilities, APIs, bidirectional connections to data exchange with Medicaid providers and SUD treatment centers and providers, and master patient index.

Below is a table that describes: 1) current PDMP functionalities; 2) plans to enhance PDMP functionalities and interoperability; and 3) a summary of action items that need to be completed to meet the milestone requirements.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program (PDMP) Functionalities			
<p>Enhanced interstate data sharing in order to better track patient specific prescription data</p>	<p>Idaho Board of Pharmacy’s PDMP, managed by Appriss Health, shares controlled substances prescription data with 51 PDMPs through PMP InterConnect.</p> <p>Required data transmitters include in-state pharmacies, in-state mail order pharmacies, out-of-state mail order pharmacies, dispensing doctor, long-term care facility pharmacies, correctional facility pharmacies, Veterans Administration, and Indian Health Services.</p> <p>The Idaho Health Data Exchange is currently working on enhancing its data and technology infrastructure, master patient index, and revising participation agreements to house criminal justice information, substance use disorder information, and prescription drug information.</p>	<p>The Idaho PDMP will expand its data sharing by purchasing a statewide PMP Gateway license. As of December 2019, 39 states use PMP Gateway.</p> <p>Idaho Health Data Exchange, the health information exchange in Idaho, plans to connect to some of the contiguous states’ health information exchanges to better track patients who are transient with their medical care. (i.e. Northern Idaho utilizing Washington State resources, Southeastern Idaho utilizing state of Utah resources, etc.).</p>	<p>April 2020 – September 2020: Increase and enhance terminology services within the data exchange’s data warehouse. Increase and enhance the storage capacity of data exchange’s data warehouse.</p> <p>June 2020 – August 2020: Build a data lake within the data exchange supported by FHIR APIs. Refine data exchange’s data extraction engine solutions for PDMP data reporting enhancements.</p> <p>July 2020 – September 2020: Connect Utah and eastern Oregon’s health exchange networks to Idaho Health Data Exchange.</p> <p>September 2020: Roll out new interface connection onboarding specifications, documentation, and training to new participants.</p> <p>September 2020 – December 2021: Connect contiguous states’ health information exchanges to Idaho Health Data Exchange. May expand further than contiguous states depending on patient population information within health information exchange. (e.g. Arizona, New Mexico, Florida, etc.)</p>
<p>Enhanced “ease of</p>	<p>The PDMP</p>	<p>The PDMP</p>	<p>April 2020 – September</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
use” for prescribers and other state and federal stakeholders	<p>integrates into most electronic health records for clinician and prescriber use. The PDMP integrates into most pharmacy dispensing systems for pharmacist and dispenser use. Integration into systems eliminates the use of web-based sign on for “ease of use.”</p> <p>Idaho PDMP information is sent and updated within 24 hours or the next business day.</p> <p>As of 2018, there were 8,917 DEA registered prescribers and 332 DEA registered prescribers.</p>	<p>information is not stored and integrated into patient records. Idaho Health Data Exchange plans to integrate PDMP information into clinical records that are in the data warehouse of the data exchange.</p> <p>If Idaho Health Data Exchange connects to Appriss Health, the data exchange can enhance “ease of use” for data exchange participants by creating an additional tabbed link and view-only access to Appriss Health available in the data exchange portal.</p>	<p>2020: Idaho Board of Pharmacy to purchase statewide PMP Gateway license. PMP Gateway available in established EHR workflow. Prescriber and dispenser trainings are available during this period.</p> <p>April 2020 – August 2020: Idaho Health Data Exchange to build API connection to PDMP, build and test authentication process for PDMP access, conduct readiness assessment with at least one EHR vendor and clinician/organization, and go live with data exchange’s view-only access to PDMP.</p>
Enhanced connectivity between the state’s PDMP and any statewide, regional or local health information exchange	<p>Idaho Health Data Exchange and Idaho Board of Pharmacy’s PDMP are not connected. Idaho Health Data Exchange is the sole, statewide health information exchange.</p>	<p>Idaho Health Data Exchange will contract with Appriss Health, to integrate PDMP information into clinical records. Idaho Health Data Exchange will use an API to integrate into portal with view-only access to PDMP data for prescribers and delegates.</p>	<p>January 2020 – April 2020: Idaho Health Data Exchange and Idaho Board of Pharmacy convene meeting to establish infrastructure scope for connecting data exchange to PDMP.</p> <p>April 2020 – September 2020: Idaho Health Data Exchange to build API connection to PDMP and go live with view-only clinical portal access.</p>
Enhanced identification of long- term opioid use directly correlated to	<p>Idaho’s PDMP contains information on schedules II-V controlled</p>	<p>The Board of Pharmacy’s PMP Gateway license will be implemented into clinical workflows</p>	<p>July 2020: Board of Pharmacy to add appropriate DEA Schedule I controlled substances into the Idaho’s Uniform Controlled</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>clinician prescribing patterns</p>	<p>substances prescriptions. The PDMP has the authority to monitor other substances as required by the Idaho Board of Pharmacy.</p> <p>The PDMP allows reporting on queries to PDMP for controlled substances and other drugs of concern. Data dashboards and prescriber report cards are sent to prescribers monthly.</p> <p>The Board of Pharmacy has implemented NarxCare into the PDMP workflow. NarxCare reports include a patient's NarxScore, Predictive Risk Scores, Red Flags, Rx Graph, and access to resources.</p>	<p>for prescribers and dispensers (EHRs, EMRs, dispensing software) with NarxCare reports.</p> <p>With PDMP integration into Idaho Health Data Exchange records, reports and filtering for attributed patients may be reportable on-demand or as needed or required by organizations, medical board, or to comply with federal or state regulation.</p>	<p>Substance information</p> <p>July 2020 - August 2020: Terminology services/data quality program to identify all long-term opioids within the controlled substance information in the PDMP.</p> <p>August 2020: Identify the report parameters including the frequency of reports, data, and prescriber and dispenser information to write into new reporting structure.</p> <p>August 2020 – September 2020: Either (1) build a report through Appriss Health for identification of required report information; or (2) have IHDE build a report with the information above and in the SUPPORT Act applicable sections.</p> <p>October 2020 – onward: Idaho Medicaid to align covered providers daily limits with SUPPORT Act sections when required (e.g. daily MME for covered patients)</p> <p>October 2020 – June 2021: Develop, convene, and report on stakeholder meetings and focus groups with state agencies and prescribers to establish recommendation on measures to address prescribing pattern issues.</p>

Current and Future PDMP Query Capabilities

Milestone Criteria	Current State	Future State	Actions Needed
<p>Facilitate the state's ability to properly match patients receiving opioid prescriptions with</p>	<p>Idaho PDMP's criteria to query to PDMP has the following minimum data elements:</p>	<p>Idaho Health Data Exchange will continue work on the master patient index for patient records</p>	<p>May 2020 – July 2020: Idaho Health Data Exchange to use an outside vendor to assist in cleanup of master patient index.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)</p>	<p>patient's first name, last name, and date of birth. Additional query options are patient phone number, driver's license number, and city, state, and ZIP code.</p> <p>The Idaho Board of Pharmacy allows PDMP access to the Medicaid Medical Director and pharmacy team to attributed patients.</p> <p>In addition to a patient master index, the Idaho Board of Pharmacy is working with Appriss Health on provider, prescriber, dispenser, and prescription information matching (including DEA, NPI, and prescription information). Currently, error correction requirements are sent every 24 hours until correction is made.</p>	<p>exchanged through and housed in the data exchange.</p> <p>By connecting to the PDMP, the Idaho Health Data Exchange adds another criterion and source to increase match rates within its master patient index.</p> <p>For the prescription information matching, there is currently no time frame for pharmacies to correct when errors occur. Other states' time frames vary from 24 hours to 7 days. The Idaho Board of Pharmacy is responsible for determining time frame, education, and training.</p>	<p>July 2020 – September 2020: Enhance match rates of master patient index with an active/active exchange with two MPI vendors within the data exchange. One MPI will be embedded in technology stack, one MPI will be outside stack to enhance match rate.</p> <p>September 2020 – December 2020: Two MPIs will transition from active/active to master/slave to continue the matching capabilities to produce proper matching.</p> <p>2020-2021: Explore feasibility of HIE integration of Medicaid claims data and Medicare claims data – enhancing the information to match with patient records.</p> <p>Ongoing: The Idaho Board of Pharmacy may establish a time frame, education, and training around prescription information matching.</p>

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Milestone Criteria	Current State	Future State	Actions Needed
Develop enhanced provider workflow/ business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	As of August 2019, Idaho is one of five states plus DC and Puerto Rico, that does not mandate a query of the PDMP before prescribing an opioid or other controlled substance.	<p>The Idaho Board of Pharmacy will purchase a statewide PMP Gateway license. The PMP Gateway integrates into established clinical workflows for clinicians using an EMR/EHR.</p> <p>The Idaho Health Data Exchange will connect to Appriss to add a view-only connection to the PDMP for clinician use.</p> <p>The Idaho Board of Pharmacy recognizes the MISSION Act requirements for the Veteran Affairs Health Systems and has access to the VA prescription drug monitoring program.</p>	<p>November 2019 – September 2020: Engage prescribers and dispensers on current workflow, including access to PDMP prior to prescribing an opioid or other controlled substance.</p> <p>April 2020 – September 2020: Idaho Board of Pharmacy to purchase statewide PMP Gateway license. PMP Gateway available in established EHR workflow. Prescriber and dispenser trainings are available during this period.</p> <p>April 2020 – August 2020: Idaho Health Data Exchange to build API connection to PDMP, build and test authentication process for PDMP access, conduct readiness assessment with at least one EHR vendor and clinician/organization, and go live with data exchange’s view-only access to PDMP.</p>

<p>Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP-prior to the issuance of an opioid prescription</p>	<p>As of August 2019, Idaho is one of five states plus DC and Puerto Rico, that does not mandate a query of the PDMP before prescribing an opioid or other controlled substance.</p>	<p>Starting October 1, 2020, prior to issuing a patient a prescription for outpatient use of an opioid analgesic or benzodiazepine listed in schedule II, III, or IV, the prescriber or delegate must check the PDMP for the prior 12 months of prescription drug history.</p> <p>The Idaho Board of Pharmacy will purchase a statewide PMP Gateway license. The PMP Gateway integrates into established clinical workflows for clinicians using an EMR/EHR.</p> <p>The Idaho Health Data Exchange will connect to Appriss to add a view-only connection to the PDMP for clinician use.</p> <p>Project ECHO will partner with providers to train provider community on reducing opioid prescriptions and opioid alternative practices being used in Northern and Eastern Idaho hospitals (inpatient and outpatient use cases).</p>	<p>April 2020 – September 2020: Idaho Board of Pharmacy to purchase statewide PMP Gateway license. PMP Gateway available in established EHR workflow. Prescriber and dispenser trainings are available during this period.</p> <p>April 2020 – August 2020: Idaho Health Data Exchange to build API connection to PDMP, build and test authentication process for PDMP access, conduct readiness assessment with at least one EHR vendor and clinician/organization, and go live with data exchange's view-only access to PDMP.</p> <p>June 2020 – June 2021: Project ECHO work on provider trainings for opioid alternative practices.</p>
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Master Patient Index / Identity Management

Milestone Criteria	Current State	Future State	Actions Needed
<p>Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.</p>	<p>Currently, the Idaho PDMP’s criteria to query to PDMP has the following minimum data elements: patient’s first name, last name, and date of birth. Additional query options are patient phone number, driver’s license number, and city, state, and ZIP code.</p> <p>Data collection for the PDMP in Idaho is daily or the next business day. Data collection is managed by Apriss Health, not the state of Idaho or Idaho Board of Pharmacy.</p>	<p>Idaho Health Data Exchange is in discussion with substance use treatment centers and clinicians to gauge interest in connecting to data exchange. Anticipation is a bi-directional feed (sending data and receiving data). Also, in discussions with Department of Health and Welfare’s Division of Behavioral Health to gauge connection interest. Including data points will enhance match options for master patient index in data exchange.</p> <p>Idaho Health Data Exchange would like to integrate Medicare and Medicaid claims data as an additional data set.</p> <p>When connected to the PDMP, various PDMP data points can also be used to enhance the data exchange’s master patient index.</p>	<p>April 2020 – September 2020: Increase and enhance terminology services within the data exchange’s data warehouse. Increase and enhance the storage capacity of data exchange’s data warehouse. SUD data will be siloed, and user access authenticated.</p> <p>May 2020 – July 2020: Idaho Health Data Exchange to use an outside vendor to assist in cleanup of master patient index.</p> <p>July 2020 – September 2020: Enhance match rates of master patient index with an active/active exchange with two MPI vendors within the data exchange. One MPI will be embedded in technology stack, one MPI will be outside stack to enhance match rate.</p> <p>September 2020 – December 2020: Two MPIs will transition from active/active to master/slave to continue the matching capabilities to produce proper matching.</p> <p>2020-2021: Explore feasibility of HIE integration of Medicaid claims data and Medicare claims data – enhancing the information to match with patient records.</p>

Overall Objective for Enhancing PDMP Functionality & Interoperability			
Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.</p>	<p>As of August 2019, Idaho is one of five states plus DC and Puerto Rico, that does not mandate a query of the PDMP before prescribing an opioid or other controlled substance.</p> <p>Idaho Board of Pharmacy reports include Naloxone/Narcan dispensing, monthly pharmaceutical sales (dispense date, pharmacy, pharmacy DEA, prescriber, prescriber DEA, address, city, drug, drug strength, quantity, size and drug form), monitor prescription trends in specific areas/counties in the state of Idaho.</p>	<p>Starting October 1, 2020, prior to issuing a patient a prescription for outpatient use of an opioid analgesic or benzodiazepine listed in schedule II, III, or IV, the prescriber or delegate must check the PDMP for the prior 12 months of prescription drug history. The mandate applies to all prescribers and delegates required to register for the PDMP in Idaho Statute 37-2722.</p> <p>Idaho Health Data Exchange would like to integrate Medicare and Medicaid claims data as an additional data set for the data exchange.</p> <p>The state of Idaho may utilize more electronic prescription exchange rather than written prescriptions.</p>	<p>August 2020: Medicaid may access reports or request reports on Medicaid prescriber checks to the PDMP prior to issuing a schedule II, III, IV prescription as mandated by state law.</p> <p>October 2020 – onward: If a prescriber is unable to check PDMP, Medicaid shall request the documentation of good faith effort and why a check was unable to be performed.</p> <p>Medicaid prescribers who are unable to check the PDMP will submit a working plan to Medicaid detailing steps the prescriber or entity shall take to comply with the mandatory state law, including a timeframe for compliance with regular reports updating its progress on compliance.</p> <p>October 2020 – June 2021: Develop, convene, and report on stakeholder meetings and focus groups with state agencies and prescribers to establish recommendation on measures to address inability to check PDMP.</p> <p>2020 – 2021: Idaho Health Data Exchange to build PDMP infrastructure before integrating claims data.</p>

<p>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period.</p>	<p>Yes. Idaho has a sole source statewide health data exchange, a sole vendor for its prescription drug monitoring program (PDMP), and prescribers and dispensers within Idaho have a high adoption rate of electronic health records (EHR), electronic medical records (EMR), and prescription dispensing software systems.</p> <p>Idaho has made progress on achieving the goals of mandating a check of the PDMP prior to prescribing opioids and increasing the interoperability of the data exchange and the PDMP. To support the transition of limited checking of the PDMP to required checking, the Idaho Board of Pharmacy (oversight of PDMP) will purchase a statewide license of PMP Gateway. The PMP Gateway will be active prior to September 30, 2020. PMP Gateway integrates into prescriber and dispenser workflows without additional sign-on requirements. Additionally, the Idaho Health Data Exchange (IHDE) will integrate view-only access to the PDMP through its clinical portal. The clinical portal view-only access of PDMP information may assist prescribers who cannot adopt an EHR/EMR into their regular workflow. The IHDE-PDMP integration will be developed April 2020 – August 2020 and go live prior to September 30, 2020.</p> <p>IHDE and the Idaho PDMP participate in nationwide data sharing efforts. IHDE participates in the Strategic Health Information Exchange Collaboration (SHIEC) with 71 other health information exchanges. The PDMP shares data through PMP Interconnect with 51 states, county/territories, and federal agencies. Interstate sharing will continue as IHDE develops further data agreements with Idaho’s contiguous states and through the PDMP as more states, territories and federal agencies as more connect through PMP Interconnect and PMP Gateway.</p>
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<p>Statement 2: Please confirm that your state’s SMI/SED Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.</p>	<p>Yes. Idaho’s SUD Health IT plan is aligned with the state’s approved Medicaid HIT plan. The plan is developed and managed by the Department of Health and Welfare’s Division of Medicaid.</p>
<p>Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.</p>	<p>Yes, the state intends to assess applicability of the Interoperability Standards Advisory and 45 CFR 170 Subpart B and incorporate the relevant standards where applicable, including in the next iterations of managed care contracts.</p>

ATTACHMENT E
Reserved for SMI/SED/SUD Monitoring Protocol

ATTACHMENT F
Reserved for SMI/SED/SUD Evaluation Design