Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations Monitoring Report Template

1. Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration

State	Idaho
Demonstration name	Idaho Behavioral Health Transformation
Approval period for section 1115 demonstration	04/17/2020-03/31/2025
SMI/SED demonstration start date[a]	04/17/2020
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals 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.
SMI/SED demonstration year and quarter	DY2Q4
Reporting period	01/01/2022-03/31/2022

2. Executive summary

For Demonstration Year 2 Quarter 4 (DY2Q4), the Idaho legislature appropriated funds to support the state's behavioral health care system, following recommendations from the Idaho Behavioral Health Council (IHBC). The money will be used to expand the 988 National Suicide Prevention Lifeline in Idaho and develop crisis centers specifically for adolescents. Idaho will also use the funds to explore the Certified Community Behavioral Health Clinic (CCBHC) model to expand the state's capacity to address overdose crisis and establish innovative partnerships with law enforcement, schools and hospitals to improve care, reduce recidivism and prevent hospital readmissions.

Idaho achieved several successes in DY2 to complete the waiver's implementation. The state received final approval of its monitoring protocols on November 18, 2021 and submitted the first round of metrics on February 28, 2022. Throughout DY2Q4, the state's Medicaid team worked diligently to get a new SUD residential treatment provider type ready for enrollment in collaboration with the Medicaid Enterprise Team and contractors to allow qualified providers to provide American Society of Addiction Medicine (ASAM) 3.5 and 3.7 levels of care to Medicaid beneficiaries. The state also released a solicitation for a new Idaho Behavioral Health Plan contract on December 30, 2021. The contract resulting from this procurement will integrate inpatient, emergency department and residential services into the current outpatient behavioral health plan, in accordance with the Idaho Medicaid Behavioral Health Transformation Waiver.

The COVID-19 pandemic has continued to impact Idahoans' behavioral health and access to health care services. Idaho Medicaid and the Division of Public Health continue to remind Idahoans about the importance of choosing to get vaccinated, to wear masks in indoors with others, and to social distance when community spread is high.

CMS provided feedback to Idaho on October 31, 2022, on several metrics. The state reviewed data and re-calculated trends, per CMS's feedback, Idaho's response is in the following report.

3. Narrative information on implementation, by milestone and reporting topic

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.1. Metric trends			
1.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	X		
1.2. Implementation update			
1.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1a. The licensure or accreditation processes for participating hospitals and residential settings	X		
1.2.1b. The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	X		
1.2.1c. The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	X		
1.2.1d. The program integrity requirements and compliance assurance process	X		
1.2.1e. The 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	X		
1.2.1f. Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.2. The state expects to make other program changes that may affect metrics related to Milestone 1.			Idaho expanded access to inpatient mental health treatment for adolescents with the opening of State Hospital West on May 10, 2021. This 18,000 square-foot facility provides inpatient mental health treatment in a secure setting for up to 16 adolescents between 12 and 17 years old. Most adolescents needing these services come from the metropolitan areas surrounding Boise and Nampa. Previously, these state services for adolescents had only been available in Eastern Idaho, far away from family and community supports.
2. Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)			
2.1. Metric trends			
2.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.	X		
2.2. Implementation update			
2.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1a. Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	X		
2.2.1b. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers	X		
2.2.1c. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2.1d. Strategies to prevent or decrease the lengths of stay in EDs 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)	X		
2.2.1e. Other State requirements/policies to improve care coordination and connections to community-based care	X		
2.2.2. The state expects to make other program changes that may affect metrics related to Milestone 2.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3. Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.1. Metric trends			
3.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.		SMI #13: Mental Health Services Utilization-Inpatient SMI #14: Mental Health Services Utilization-Intensive Outpatient and Partial Hospitalization SMI #15: Mental Health Services Utilization – Outpatient SMI #16: Mental Health Services Utilization-ED SMI #17: Mental Health Services Utilization-Telehealth	The state calculated the following changes that were less or more than 2% between DY2Q2 (7/1/2021-9/30/2021) and DY2Q3 (10/1/2021-12/31/2021). The state can attribute some of these changes to the COVID-19 omicron surge that occurred during the winter months. • There was a 4.48% decrease in the number of beneficiaries receiving inpatient services. • There was a 22.82% increase in intensive outpatient and partial hospitalization in Medicaid beneficiaries. The state can attribute some of this to the small numbers in this measure. • There was a 2.52% decrease in the number of beneficiaries receiving outpatient services. • There was a 3.95% decrease in the number of beneficiaries received ED services. • There was a 3.69% increase in the number of beneficiaries receiving telehealth services.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.2. Implementation update			
3.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1a. State requirement that providers use an evidenced-based, publicly-available patient assessment tool to determine appropriate level of care and length of stay	X		
3.2.1b. Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	X		
3.2.2. The state expects to make other program changes that may affect metrics related to Milestone 3.			The SAMHSA Emergency COVID-19 Grant funding continues to support services for those suffering behavioral health emergencies during COVID-19. The grant is supporting three Emergency Department Psychiatric Triage Centers (ED-PTC) located in regions 5, 6 and 7, which completed 337 triages during DY2 for people in behavioral health crisis, helping to alleviate strain on hospital emergency departments. The state legislature allocated funds to stand up 988 to contract, and where available, mobile response teams throughout the state. The 988 System/Behavioral Healthcare crisis line went live on July 16, 2022.
4. Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.1. Metric trends			
4.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.2. Implementation update			
4.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 4.2.1a. Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)	X		
4.2.1b. Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	X		
4.2.1c. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED	X		
4.2.1d. Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	X		
4.2.2. The state expects to make other program changes that may affect metrics related to Milestone 4.	X		
5. SMI/SED health information technology (health IT)			
5.1. Metric trends			
5.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics.	X		
5.2. Implementation update			
5.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 5.2.1a. The three statements of assurance made in the state's health IT plan	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1b. Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community-based supports	X		
5.2.1c. Electronic care plans and medical records			As of the end of DY2, twenty-one hospitals in Idaho contracted directly with Collective Medical, a real-time collaboration platform that allows for a flow of patient information going to and from the hospitals. Although six of Idaho's hospitals are not on Collective Medical networks directly, the hospitals and Collective Medical have a shared association with CareQuality, which allows different medical networks to connect, allowing medical documents and information to be shared.
5.2.1d. Individual consent being electronically captured and made accessible to patients and all members of the care team	X		
5.2.1e. Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem	X		
5.2.1f. Telehealth technologies supporting collaborative care by facilitating broader availability of integrated mental health care and primary care	X		
5.2.1g. Alerting/analytics	X		
5.2.1h. Identity management	X		
5.2.2. The state expects to make other program changes that may affect metrics related to health IT.	X		
6. Other SMI/SED-related metrics			
6.1. Metric trends			
6.1.1. The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2. Implementation update			
6.2.1. The state expects to make the following program changes that may affect other SMI/SED-related metrics.	X		

4. Narrative information on other reporting topics

Prompt	State has no trends/update to report (place an X)	State response
7. Annual Assessment of the Availability of Mental Health Services (Annual Availability Assessment)		
7.1. Description of changes to baseline conditions and practices		
7.1.1. Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.		In 2020, the state's Mental Health Availability Assessment showed a 24% prevalence of SMI/SED in all Medicaid beneficiaries, while the 2021 assessment showed an absolute increase of 4% to 28% prevalence of SMI/SED, placing a significant strain on an already taxed rural and frontier healthcare professional shortage area. In May 2020, the total number of Medicaid beneficiaries 21 and over with an SMI diagnosis was 63,779 and increased to 71,149 in February 2022. The increase may be due in part to requirement that states suspend redeterminations of enrollees' eligibility as part of the COVID-19 Public Health Emergency (PHE) that paused Medicaid disenrollment for the duration of the Public Health Emergency (PHE). Idaho also saw its population increase from 1,847,772 to 1,900,923 in 2021.In fact, 38 of Idaho's 44 counties grew by at least 1% with the largest growth happening in Ada, Canyon and Kootenai, with these three counties accounting for just under 50% of the state's total growth in 2021.
7.1.2. Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	X	

Prompt	State has no trends/update to report (place an X)	State response
7.1.3. Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of the Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.		In 2021, Idaho saw a sharp increase in partial hospitalization programs (PHPs). This dramatic increase is due to Idaho Medicaid allowing additional treatment services within PHPs in 2021. The state also saw a 19% decrease in 2021 in the number of licensed psychiatrists or other practitioners that are authorized to prescribe psychiatric medications.
7.1.4. Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Annual Availability Assessment compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.		In DY2Q2, Idaho added 16 beds to its psychiatric bed count for adolescents when State Hospital West opened in May 2021. There was a discrepancy in in the overall bed count in DY1Q4 due to including “transition beds” in the overall bed count twice.
7.1.5. Describe and explain whether any changes in the availability of mental health services have impacted the state’s maintenance of effort (MOE) on funding outpatient community-based mental health services. Recommended word count is 500 words or less.	X	
7.2. Implementation update		
7.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes: 7.2.1a. The state’s strategy to conduct annual assessments of the availability of mental health services across the state and updates on steps taken to increase availability	X	

Prompt	State has no trends/update to report (place an X)	State response
7.2.1b. Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	X	
8. Maintenance of effort (MOE) on funding outpatient community-based mental health services		
8.1. MOE dollar amount		

8.1.1. Provide as a dollar amount the level of state appropriations and local funding for outpatient community-based mental health services for the most recently completed state fiscal year.

	SFY 2021 (in Millions)			
Source	Total Claim Dollars	Federal	State - General Funds	State - County Funds
Optum Encounter Data	$159.8	$129.1	$30.7	$0.0
MMCP and IMPlus Encounter Data	$18.5	$14.1	$4.4	$0.0
FFS Data	$296.7	$222.6	$67.6	$6.5
Total Community Based Mental Health Spend	$475.0	$365.8	$102.7	$6.5

There were several different sources of data for this table:

1. Optum Encounter Data
    a. Managed Care serves non-dual, expansion, and some dual enrollees through a managed care contract with Optum for behavioral health outpatient community-based services.
    b. This is total costs incurred as shown in the Optum encounter data and financial summaries. We included costs for all services provided by Optum.
    c. Costs are allocated between Federal and State – General Funds columns based on the applicable federal matching rate:
        i. 90% FMAP for the expansion population
        ii. 76.54% FMP for the non-expansion population in Federal FY20 and 76.61% FMAP for the non-expansion population in Federal FY21. This includes the enhanced COVID match.
    d. The data used is not adjusted for completion and includes runout through December 2021.
2. MMCP and IMPlus Encounter Data
    a. The Medicare-Medicaid Coordination program (MMCP) and Idaho Medicaid Plus program (IMPlus) serve dual eligible enrollees through managed care contracts with Blue Cross of Idaho (BCI) and Molina for all outpatient community services.
    b. This includes costs incurred from the MMCP and IMPlus programs for dual beneficiaries enrolled with either BCI or Molina
    c. Because services covered by the program include more than just behavioral health services, we include costs for all beneficiaries, but limit it to services that map to the Milliman reporting lines “P66” and “P67” in the Milliman Grouper Model. These lines are defined as follows:
        i. Outpatient Psychiatric (P66): This benefit provides for psychiatric treatment by a qualified professional performed on an outpatient basis, including both therapy visits and medication management visits.
        ii. Outpatient Alcohol & Drug Abuse (P67): This benefit provides for outpatient treatment of alcohol and/or drug abuse by a qualified professional.

		d. Costs are mapped to these reporting lines based primarily on HCPC code. e. Pharmacy costs are not included. f. Costs are allocated between Federal and State – General Funds columns based on the applicable federal matching rate: i. 90% FMAP for the expansion population ii. 76.54% FMP for the non-expansion population in Federal FY20 and 76.61% FMAP for the non-expansion population in Federal FY21. This includes the enhanced COVID match. g. The data used is not adjusted for completion and includes runout through June 2021 for Blue Cross of Idaho (BCI) data and runout through December 2021 for Molina data. 3. Fee-For-Service Data a. Fee-for-service (FFS) serves for all other populations for outpatient community-based treatment for these conditions, as well as certain services not covered under managed care. b. This includes costs incurred from two sources: i. Medicaid FFS data ii. Approximate spend from the Division of Behavioral Health (DBH) on Medicaid eligibles c. For the FFS data, again because services covered include more than just behavioral health services, we include costs for all beneficiaries, but limit it to services that map to the Milliman reporting lines "P66" and "P67" in the Milliman Grouper Model (as defined above). i. Pharmacy costs are not included. ii. Costs are allocated between Federal and State – General Funds columns based on the applicable federal matching rate: 1. 90% FMAP for the expansion population 2. 76.54% FMP for the non-expansion population in Federal FY20 and 76.61% FMAP for the non-expansion population in Federal FY21. This includes the enhanced COVID match. iii. The data used is not adjusted for completion and includes runout through December 2021. d. For the DBH data, we relied on information you provided to us from DBH on 7/8/2022 i. Costs are limited to the estimated amount spent on Medicaid eligibles ii. Costs are allocated 100% to State – County Funds

Prompt	State has no trends/update to report (place an X)	State response
8.2. Narrative information		
8.2.1. Describe and explain any reductions in the MOE dollar amount below the amount provided in the state's application materials. The state should confirm that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.		The state confirms that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.
9. SMI/SED financing plan		
9.1. Implementation update		
9.1.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 9.1.1a. Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders	X	
9.1.1b. 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		In DY2Q3, the Idaho legislature appropriated additional funding for the implementation of the 988 National Suicide Prevention Lifeline. The 988 Line is part of a larger crisis continuum of care to help connect individuals in crisis with the appropriate care and services they need alleviating the strain on our hospital emergency departments, our law enforcement agencies, and jails. In DY2Q3, with backing from the Idaho Behavioral Health Council, the Governor recommended and the Idaho Legislature approved funding for a Certified Community Behavioral Health Clinic (CCBCH) pilot to improve access and the quality of behavioral health services in Idaho. CCBHCs provide a comprehensive array of behavioral health services, including crisis stabilization services.

Prompt	State has no trends/update to report (place an X)	State response
10. Budget neutrality		
10.1. Current status and analysis		
10.1.1. Describe the current status of budget neutrality and an analysis of the budget neutrality to date. If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole.		Idaho submitted the DY2Q4 Budget Neutrality workbook and supporting documentation files in the PMDA portal on June 29, 2022. The data extract for DY2Q4 included claims incurred mid-April 2021 to April 2022, so the data was stacked with data from the prior quarter and included any new runout from April 2021. In the supporting documentation, the data extract from DY2Q3 was included. The following assumptions for projected SUD utilizers was used for the DY2Q4 BN workbook: o April-June 2022: 50% of normal monthly SUD utilizers in DY1 o July 2022 – March 2023: 100% of normal monthly SUD utilizers in DY1 o DY4 and DY5: 10% caseload trend of monthly utilizers from DY3
10.2. Implementation update		
10.2.1. The state expects to make the following program changes that may affect budget neutrality.	X	
11. SMI/SED-related demonstration operations and policy		
11.1. Considerations		
11.1.1. The state should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.	X	

Prompt	State has no trends/update to report (place an X)	State response
11.2. Implementation update		
11.2.1. The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.	X	
11.2.2. The state is working on other initiatives related to SMI/SED.	X	
11.2.3. The initiatives described above are related to the SMI/SED demonstration as described (The state should note similarities and differences from the SMI/SED demonstration).	X	
11.2.4. Compared to the demonstration design and operational details, the state expects to make the following changes to: 11.2.4a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)	X	
11.2.4b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)	X	
11.2.4c. Partners involved in service delivery	X	
11.2.4d. The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency	X	

Prompt	State has no trends/update to report (place an X)	State response
12. SMI/SED demonstration evaluation update		
12.1. Narrative information		
12.1.1. Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. There are specific requirements per the Code of Federal Regulations (CFR) for annual reports. See Monitoring Report Instructions for more details.	X	
12.1.2. Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.		The Pennsylvania State University (PSU) is analyzing data received through DY2Q4 and has conducted several key stakeholder interviews during DY2. PSU is on track to complete the midterm assessment per the goals and time frames agreed upon in the waiver's Special Terms and Conditions.
12.1.3. List anticipated evaluation-related deliverables related to this demonstration and their due dates.	X	
13. Other demonstration reporting		
13.1. General reporting requirements		
13.1.1. The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.	X	
13.1.2. The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.	X	
13.1.3. The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	X	

Prompt	State has no trends/update to report (place an X)	State response
13.1.4. Compared to the demonstration design and operational details, the state expects to make the following changes to: 13.1.4a. The schedule for completing and submitting monitoring reports	X	
13.1.4b. The content or completeness of submitted monitoring reports and/or future monitoring reports	X	
13.2. Post-award public forum		
13.2.1. If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual monitoring report.		On September 22, 2021, the public forum for the 1115 IMD Waiver was held in conjunction with the Idaho Medicaid Medical Care Advisory Committee (MCAC). The MCAC membership includes stakeholders such as providers, beneficiaries, hospital associations, and tribal representatives. The 1115 waiver team presented information and answered questions regarding the credentialing of providers, mandatory managed care, and the potential to open additional IMDs. The response during the forum was positive and supportive. The stakeholders also expressed interest in being updated on the results of the waiver's metrics once data is received as anticipated in DY2Q4. The questions and answers were posted publicly on the DHW website for the 1115 IMD waiver on October 21, 2021. We anticipate conducting 2022's public forum as part of the October MCAC meeting.

Prompt	State has no trends/update to report (place an X)	State response
14. Notable state achievements and/or innovations		
14.1. Narrative information		
14.1.1. Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SMI/SED (or if broader demonstration, then SMI/SED related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.		Idaho released the IBHP contract solicitation on December 30, 2021, requesting proposals in a competitive negotiation process structured similarly to a request for proposal (RFP) process. The bids are in an evaluation phrase and the state anticipates awarding a new contract in Fall 2022. In DY2Q3 and Q4 the Idaho legislature approved financial appropriations to DHW to support several behavioral health initiatives. Fifteen million dollars in state general funds were appropriated for standing up three psychiatric residential treatment facilities across Idaho. Currently most children and youth who need services are sent out of state. Having these services available in state will allow them to remain closer to their families and communities. An additional twelve million dollars will be used to explore piloting a CCBHC model in Idaho. CCBHCs provide a comprehensive array of behavioral health services, including crisis stabilization services. The goal of the CCBCH pilot will be to improve access and the quality of behavioral health services in Idaho. As part of the Idaho Behavioral Health Council (IBHC) 2021-2024 Strategic Action Plan, a Behavioral Health Workforce Plan has been published to address the shortage of behavioral health professionals statewide. The plan focuses on five areas: recruitment, education, credentialing, employment, and retention. The next step for the IBHC in this project is to develop more detailed implementation plans for each recommendation. These plans will include specific action steps and timelines for achievement, identification of roles and responsibilities for sponsors and stakeholders, and criteria for how the system improvements will be measured. A final implementation plan will be anticipated in July 2022.