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

The state should complete this title page at the beginning of a demonstration and submit as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	Idaho
Demonstration name	Idaho Behavioral Health Transformation
Approval period for section 1115 demonstration	04/17/2020
SMI/SED demonstration start date[a]	04/17/2020 – 03/31/2025
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	DY1Q4 report
Reporting period	1/1/2021- 3/31/2021

2. Executive summary

The executive summary should be reported in the fillable box below. It is intended for summary-level information only. The recommended word count is 500 or less.

With waiver approval April 17th, 2020, the state has experienced opportunities for growth in both SMI and SUD milestone initiatives throughout this first demonstration year. Partnerships and collaborations with teams from Project ECHO Idaho, Pennsylvania State University (PSU), Collective Medical and many others, have brought new opportunities for population health initiatives that will enhance activities outlined in the approved Implementation Plan.

Medicaid expansion (beginning January 2020) added approximately one-hundred thousand new adult enrollees. Idaho saw 64,124 individuals enrolled before the public health emergency was declared in mid-March 2020. The state is evaluating data related to Medicaid enrollment during the COVID-19 pandemic and should have further reporting available in the DY2Q1 updates. The pandemic brought a near immediate halt to in-person services and forced closures for some healthcare offices, which limited access and increased utilization of telehealth. Idaho's governor issued an executive order allowing easier access and payments to providers for telehealth. The state's behavioral health managed care organization (MCO), Optum, added 272 new providers for in-network outpatient care. Throughout all of this change, the Annual Provider Satisfaction Survey (performed by Optum) showed an increase in year-over-year provider-satisfaction for plan enrollees.

The state and stakeholders, including the Idaho Behavioral Health Council, are working to identify solutions to known gaps in the statewide behavioral health system of care, while also addressing the Idaho Behavioral Health Plan (IBHP) contract rebid. This work continued during the pandemic with virtual, instead of in-person, meetings. The post award public forum was held virtually on October 21, 2020, and questions posed to the state focused on transitions between levels of care and step-down services for members with SMI/SED diagnoses. A public rules hearing held on October 20, 2020, focused on a temporary rule that would remove all mention of the federal Institutions for Mental Diseases (IMD) exclusion that was brought to the Idaho legislature in January 2021. In October through December 2020, the state facilitated stakeholder meetings about the rebid of the IBHP that included providers and community members, and also discussed the waiver implementation plan. Presentations on waiver implementation were also held at the October and November 2020 Medical Care Advisory Committee (MCAC), Health Quality Planning Commission (HQPC) and Tribal meetings. In each meeting, members were given insight into the demonstration, as well as its impact on the rebid of the future IBHP.

Idaho Medicaid and PSU combined efforts in late 2020 for the state's demonstration evaluation and were able to execute a full contract in April 2021.CMS approved the state's evaluation design soon after on April 26, 2021.

3. The state responded to CMS feedback on the monitoring protocols and re-submitted the most recent version on April 30, 2021. Therefore, this monitoring report does not include Part A, Metrics Workbook, nor any corresponding metric trends analysis. Only the SMI workbook will be submitted with the completed Mental Health Availability Assessment. Idaho will provide retrospective metrics data according to the CMS timelines for previous quarters, upon monitoring protocol approval.

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*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.1f. Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	*X*		
1.2.2. The state expects to make other program changes that may affect metrics related to Milestone 1.	*X*		
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			The state has chosen to add a metric to the monitoring protocols which will help monitor the MCO beneficiaries' housing situations.
2.2.1c. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge			The state has chosen to add a metric to the monitoring protocols which will help monitor timeliness of post-discharge MCO beneficiary follow up.
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			The Idaho Council on Developmental Disabilities continues their work to integrate person-centered planning initiatives for adults with disabilities and families of children with disabilities that 1) allows them to have maximum flexibility and control over their services and supports, 2) recognizes the importance of natural supports, and 3) embeds person-centered planning in state regulations and policies. The model developed as part of the person-centered planning initiative will adhere to best practice guidelines and include input from individuals with developmental disabilities and their families. Goal 1: Adults with intellectual/developmental disabilities experience improved quality in Home and Community Based Services. Objective 1.2 • Work with the Idaho Department of Health and Welfare, service providers, individuals with disabilities and families to develop and implement a plan for organizational change and support staff development in person-centered practices by September 2021. Objective 1.3 • Work with individuals with disabilities, their families, and other partners on systems change and policy development so that people with intellectual/developmental disabilities have access to Medicaid person-centered planning services provided by trained, qualified person-centered planning specialists by July 2021.
2.2.2. The state expects to make other program changes that may affect metrics related to Milestone 2.			The state plans to make changes to the provider handbook in July 2022, to align with the new IBHP contract. Changes will include

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			coordination of services post discharge and assessing member housing needs within 72-hours of hospital discharge.
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.	*X*		
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.			Optum implemented Partial Hospitalization Program payment on January 1, 2020.
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*		
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*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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			The state continues to collaborate with Project ECHO Idaho and is currently working to identify funding to continue to support their work. Project ECHO Idaho engages providers in interactive, virtual, case-based learning and allows providers working in rural and frontier communities access to specialty consultation.
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			The Division of Behavioral Health (DBH) expanded their Supervised Treatment After Release (STAR) program in September of 2020. By contracting with Pathways of Idaho in Region 4 they have now succeeded in establishing four programs in four of the seven Idaho regions. STAR program facilities serve those diagnosed with Serious and Persistent Mental Illness (SPMI) and support with engagement in treatment for the first episode of a psychotic illness using an evidence-based program called Coordinated Specialty Care On Track New York Model as well as the Early Assessment and Support Alliance (EASA) Oregon Model.
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	*X*		
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			The Division of Public Health contracted with Stonewall Analytics to complete a "Telehealth Environmental Scan." Final reporting was presented on September 25, 2020. Recommendations were passed on to the state's Telehealth Task Force which researched and explored rates of adoption, various uses, innovations, and challenges associated with integrating telehealth services into patient care. In December 2020, a nationally recognized leader in comprehensive telehealth and remote patient monitoring solutions partnered with the IHDE. The integration between the platform and IHDE will help increase remote access to essential healthcare services while improving safety and health outcomes for patients statewide.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1g. Alerting/analytics			Starting in July 2020, comprehensive analytic services were expanded through a new IHDE partnership with KPI Ninja. Their platform, Ninja Universe, has earned NCQA's eCQM Certification as well as Measure Certification for HEDIS Health Plan 2020. This partnership will maximize the usability of Idaho's health IT infrastructure by turning data into information and insights that providers, payers, and other stakeholders can use to ensure that Idahoans receive the best health services possible.
5.2.1h. Identity management			In 2020, IHDE implemented semantic interoperability and cleaned up the backlog of mismatched enterprise master patient index (EMPI) records.
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*		
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.	.	The state currently divides its regions differently for Medicaid, DBH and Public Health District purposes. In an effort to align these for best reporting, the state has decided to use Medicaid regions for CMS reporting on this 1115 waiver's deliverables and will be double-checking all future reports for alignment. Although the state's 2019 assessment showed a 30% prevalence of SMI/SED in the population, the 2020 assessment showed only 24% prevalence. Although the prevalence has decreased, the total number of individuals 21 and over with a SMI diagnosis has jumped by over 15,000 individuals, placing significant strain on an already taxed rural and frontier healthcare professional shortage area. The 2019 assessment did not account for out-of-state individuals who also tax the system. In 2020, over 750 out-of-state individuals with SMI/SED utilized needed behavioral health services, of whom 575 were 21 years or older.
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.		The current availability assessment reflects the same organizational content as past reporting. The state still does not have any community mental health centers and will continue to report Homes with Adult Residential Treatment (HART) in the Residential Treatment Facility (RTF) category. HART homes are licensed as Residential and Assisted Living Facilities (RALF) in the state.

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.		The State has seen many changes in overall availability of mental health resources due to region redistribution within the waiver reporting (as mentioned in 7.1.1), the COVID-19 pandemic, and changes in health system ownership statewide. As anticipated, facilities have increased bed counts, expanded Medicaid participation, and opened new service locations, increasing availability of resources. The state overall has maintained the number of Federally Qualified Healthcare Centers (FQHCs) serving SMI individuals with opening of service locations in some regions but closure or realignment of resources in others. The total number of FQHC behavioral health service sites increased to sixty-nine in-state facilities and six out-of-state facilities serving Medicaid enrollees. The state utilized its Medicaid claims system to run active provider data for prescriber and provider status. All providers with claims submission 2019 through 2020 were counted. Going forward, the state will continue to utilize this process for determining "active" Medicaid prescribers for yearly availability assessments. The process of using claims driven analysis also allowed better insight and allocation for patient services. Providers were de-duplicated within region analysis; however, if a provider had claims allocated in more than one region they were counted in each region with a claim. More notable changes in facility distribution occurred in the counts for Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP). Facility counts utilized for this reflect Optum's contracted facilities, as with the previous report. However, in the state's initial assessment, SUD IOP services were miscounted. In Region 1, Heritage Family Support, which has 10 locations, is no longer contracted with Optum, and only provides IOP for SUD.
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.	*X*	

Prompt	State has no trends/update to report (place an X)	State response
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 to: 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*	
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 2020 (in Millions)			
Source	Total Claim Dollars	Federal	State - General Funds	State - County Funds
Optum Encounter Data	$111.9	$84.7	$27.2	$0.0
MMCP and IMPlus Encounter Data	$18.2	$13.3	$4.9	$0.0
FFS Data	$231.6	$165.5	$58.7	$7.4
Total Community Based Mental Health Spend	$361.7	$263.5	$90.8	$7.4

There were several different sources of data for this table:

1. Optum Encounter Data
    a. Managed Care serves most non-dual 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.
    c. We included costs for all services provided by Optum
    d. Costs are allocated between Federal and State – General Funds columns based on the applicable federal matching rate: 90% FMAP for the expansion population, 70.34% FMP for the non-expansion population in 2019,76.54% FMAP for the non-expansion population in 2020 to account for the enhanced COVID match
    e. The data used is not adjusted for completion and includes runout through February 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 members 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 members, 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.

Prompt	State has no trends/update to report (place an X)	State response
		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: 70.34% FMP in 2019, 76.54% FMAP in 2020 to account for the enhanced COVID match. This data does not include an expansion members. g. The data used is not adjusted for completion and includes runout through July 2020 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 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 members, 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: 90% FMAP for the expansion population, 70.34% FMP for the non-expansion population in 2019, 76.54% FMAP for the non-expansion population in 2020 to account for the enhanced COVID match iii. The data used is not adjusted for completion and includes runout through September 2020 d. For the DBH data, we relied on information you provided to us from DBH on 7/16 i. Costs are limited to the estimated amount spent on Medicaid eligibles ii. Costs are allocated 100% to State – County Funds
8.2. Narrative information		

Prompt	State has no trends/update to report (place an X)	State response
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.		Idaho can confirm that the state did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services. With more Idahoans eligible under Medicaid due to expansion, county spend decreased beginning January 2020. Optum Encounter data decreased in the last quarter of SFY2020, with the realization of the COVID-19 pandemic within the state. Access to some service availability in behavioral health offices stalled and the uptick of telehealth was not fully utilized until the beginning of SFY2021.
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	*X*	

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.		The State utilized claims data extracts along with additional claims runout and values from the Schedule C report to populate the [C Report] tab within the Quarter 4 Budget Neutrality Workbook. The [Total Adjustments] tab has been populated to balance the amounts in the claims extracts and the amounts reported on Schedule C of the CMS 64 reports. Amounts on the [WW Spending Actual] tab reflect the actual incurred dollars with additional runout. For the projection sections, the projected per member per month (PMPM) costs for DY2 – DY5 are still consistent with the initial March 2020 application. However, the actual number of utilizer member months is greater than DY1 projections from the initial application. Thus, in both reports' utilizer member month projections for all demonstration years have been updated. The DY1 projection is based on historical member months. The DY2 – DY5 projections assume a 10% caseload trend from DY1 consistent with the initial application from March 2020. As a result of updating the utilizer member month projections, the total expenditures on the [WW Spending Projected] tab increased as well (compared to the initial March 2020 application), using the higher utilizer member month projections and the PMPM cost projections from the initial application. The COVID-19 pandemic likely influenced Medicaid enrollment and had an effect on behavioral health issues, which would be reflected in the actual experience. Note that the state has not yet updated projected values explicitly for the COVID-19 pandemic.
10.2. Implementation update		
10.2.1. The state expects to make the following program changes that may affect budget neutrality.		Idaho began Medicaid expansion in January 2020, with sign-ups starting in November 2019. On January 1, 2020, the state reported more than 53,000 new enrollees. Enrollment in expansion exceeded projections, and the state enrolled 97,877 new participants during calendar year 2020. Focusing on the 1115 demonstration year, April 2020 through March 2021, 32,533 new members were added through expansion. These factors should be considered as contributing factors to any changes in overall cost of care and budget neutrality.

Prompt	State has no trends/update to report (place an X)	State response
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*	
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*	

Prompt	State has no trends/update to report (place an X)	State response
11.2.2. The state is working on other initiatives related to SMI/SED.		In conjunction with the Idaho Office of Emergency Management (IOEM), the Division of Behavioral Health (DBH) established a new COVID-19 crisis counseling hotline, COVID Help Now, in August 2020. COVID Help Now offers support for anyone facing challenges associated with the global pandemic. COVID Help Now responders provide emotional support and aid for immediate crisis needs by connecting callers with resources in their own communities, and are available via phone or text, and a website chat feature, 12 hours a day, seven days a week. During the months of January, February, and March 2021, responders on the COVID Help Now Line answered approximately 900 phone calls and responded to over 110 text messages and about 35 chat messages daily. A team of individuals around the state provided outreach to foodbanks, schools, and other community resources to promote the COVID Help Now Line, provide education on the impacts of COVID-19, and offer coping strategies, as well as emotional support. DBH's efforts continued through Q4 to fully implement Emergency Department Psychiatric Triage Centers (ED-PTC) via a Funding Opportunity Announcement (FOA). The initial round of applications was received through 9/25/2020. Two applicants were awarded subgrants as of 10/19/2020, including Badger, Inc., for Southeast Idaho Behavioral Crisis Center in Pocatello and the Behavioral Health Crisis Center of East Idaho in Idaho Falls. Both ED-PTCs began providing services in February 2021. A third ED-PTC subgrant was awarded to the Crisis Center of South-Central Idaho in Twin Falls which became operational in March 2021. The ED-PTC subgrants allowed the existing crisis centers to update facility space and acquire additional medical equipment, PPE, and staff needed to operate the program. DBH continues to work with community partners to expand ED-PTC services to other areas in Idaho that have been seriously impacted by COVID-19.
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*	

Prompt	State has no trends/update to report (place an X)	State response
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*	
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.		The state provided CMS with a letter of commitment from PSU on October 30, 2020, to be Idaho's independent evaluator. The contract between Idaho Medicaid and PSU went into effect on April 9, 2021. The evaluation design was approved by CMS on April 26, 2021.
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 state submitted monitoring protocols on April 30, 2021. CMS has since provided feedback, and the monitoring protocols are currently being updated for resubmission to CMS. CMS has approved an extension for Q3 & Q4 budget neutrality workbooks as well as the Q4/Annual reporting. The new timelines for submission on all reporting to PMDA will be July 31, 2021. The state is on track to submit all other deliverables according to the STCs provided by CMS.

Prompt	State has no trends/update to report (place an X)	State response
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*	
13.1.4. Compared to the demonstration design and operational details, the state expects to make the following changes: 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 October 20, 2020, the state held a public rules hearing prior to finalizing temporary rules effective January 1, 2020. The amendments remove all mentions of the federal IMD exclusion, since this exclusion no longer applies with approval of Idaho Medicaid's Section 1115 Behavioral Health Transformation waiver.

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.	*X*	