



Medicaid Section 1115 Substance Use Disorder and Serious Mental Illness Demonstrations: Findings from Monitoring Data Chartbook

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Executive Summary

Executive Summary

A. Background on Medicaid section 1115 SUD and SMI demonstrations

The Centers for Medicare & Medicaid Services (CMS) initially announced the Medicaid section 1115 substance use disorder (SUD) demonstration opportunity in a State Medicaid Director Letter (SMDL #15-003) in July 2015 to support states in improving the continuum of care for beneficiaries with an SUD diagnosis. In November 2017, CMS announced a streamlined approach to the SUD demonstrations to accelerate states' response to the national opioid crisis by supporting improvements to SUD treatment access and quality (SMDL #17-003).

In November 2018, CMS published SMDL #18-011 announcing the opportunity for Medicaid section 1115 serious mental illness (SMI) and serious emotional disturbance (SED) demonstrations (hereafter referred to as "SMI demonstrations") to improve the continuum of care for beneficiaries with SMI.¹

Under both demonstration authorities, states can receive federal financial participation (FFP) for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment facilities that qualify as institutions for mental diseases (IMDs). As described in both SMDLs, states work toward demonstration goals and milestones to improve access to, quality of, and coordination across the continuum of behavioral health care services. States submit monitoring data to track progress toward these goals and milestones.

As of January 1, 2026, 39 states have approved SUD and/or SMI demonstrations. Sixteen states have both SUD and SMI demonstrations, 22 have an SUD demonstration only, and one state has an SMI demonstration only. Section I includes a map with SUD and SMI demonstration status by state.

B. Analyses in this chartbook

This chartbook presents analyses of monitoring metrics and narrative data from 35 SUD and 11 SMI demonstration states as well as quantitative data from Initial and Annual Availability Assessments from the 11 SMI states. It shows the metrics data over time and contextualizes those trends using the narrative monitoring data as well as data from other sources (such as Medicaid Core Set benchmarks). The analyses of these data depict states' progress toward demonstration goals, which is summarized in the table on the next page.

The chartbook uses demonstration monitoring data submitted to CMS through December 1, 2025, which span measurement periods from 2017 to 2025, varying by analysis and state. Several factors are relevant to understanding trends during this time period, including the COVID-19 public health emergency (PHE) and

related eligibility policy changes, such as maintenance of eligibility requirements and their unwinding (see Glossary in Section IX). For most metrics, we present data at the state level; however, we caution readers against comparing across states without considering all the factors that contribute to variation across states.

The number of states included in each analysis varies, as not all states met the inclusion criteria for each analysis, and some data did not pass data quality checks. For annual metrics, we typically analyze changes from the beginning of the demonstrations (baseline) to the most recent reported year of data. We analyze monthly metrics using linear regressions or descriptive analysis. Section IX, "About This Chartbook" details the data and methods used. Appendix Tables provide information on data availability by state and metric.

C. Discussion and looking ahead

This chartbook highlights progress toward SUD and SMI demonstration goals in many states. For example, provider availability for both SUD and SMI increased in most states. Among analyzed SUD demonstrations, inappropriate opioid prescribing, ED utilization for SUD, and inpatient utilization for SUD decreased, and SUD demonstrations were associated with a statistically significant increase ($p < 0.05$) in the receipt of medication-assisted treatment (MAT). Among analyzed SMI demonstrations, blood glucose testing for children on antipsychotics significantly increased ($p < 0.05$) in about half of states, and SMI demonstrations were associated with a statistically significant increase ($p < 0.05$) in the receipt of outpatient treatment.

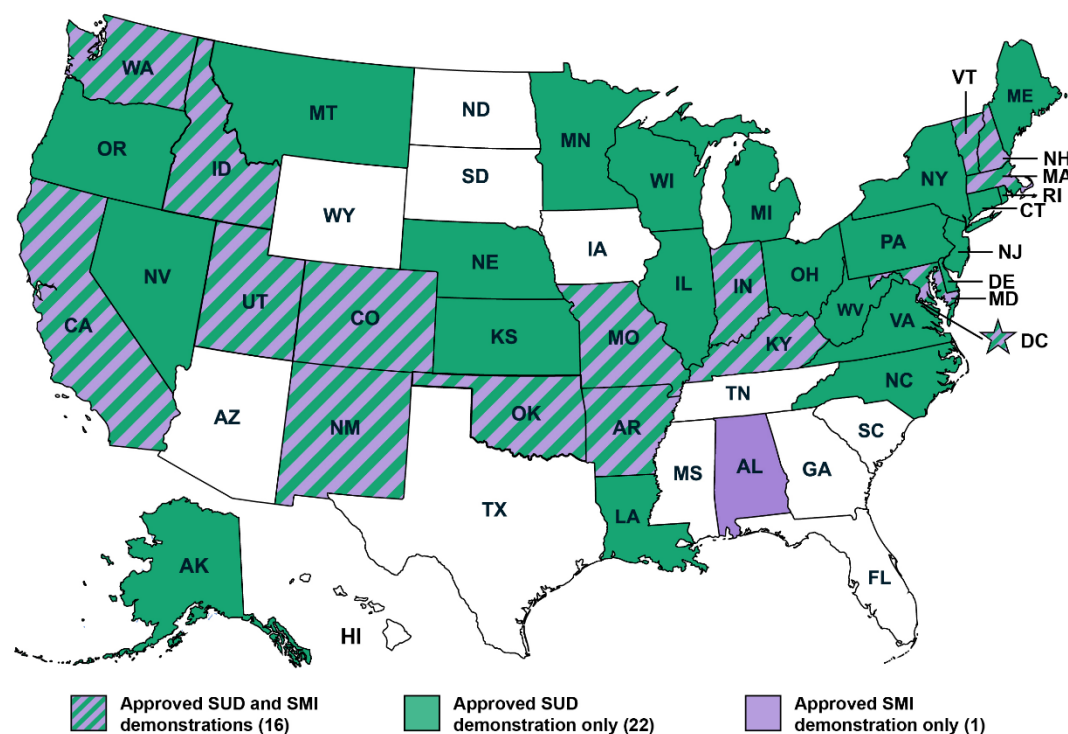
However, there is also room for improvement, especially in some measures of follow-up care. For example, readmissions for SUD and SMI significantly increased ($p < 0.05$) in about half of states.

States continue their commitment to SUD and SMI demonstration goals, as evidenced by their applications for new demonstrations and extensions of existing demonstrations. As states submit additional data that are incorporated into future analyses, findings across states for trends associated with the demonstrations may change.

 Demonstration goals	 Progress made to date	 Room for improvement
Increase access to and engagement in a continuum of SUD and SMI services SUD Goals 1 and 2, SMI Goals 3 and 4 Chartbook Section II	– The SUD demonstrations were associated with a statistically significant increase ($p < 0.05$) in receipt of MAT and the SMI demonstrations were associated with a statistically significant increase ($p < 0.05$) in outpatient treatment. – In more than half of analyzed states with SUD demonstrations, initiation or engagement in treatment for beneficiaries with opioid use disorder (OUD) significantly increased ($p < 0.05$). – SUD and SMI provider availability per 1,000 diagnosed beneficiaries increased in most states.	– Changes primarily involved the distribution of service types used by beneficiaries, rather than overall engagement rates. There was no statistically significant change in the percentage of Medicaid beneficiaries with SUD using any SUD services or the number of beneficiaries receiving any mental health treatment per 1,000 Medicaid beneficiaries, despite increases in those diagnosed with SUD or SMI. There continues to be opportunities to increase overall initiation of and engagement in services.
Improve coordination of care between settings for SUD and SMI services and for physical health conditions SUD Goal 6, SMI Goal 5 Chartbook Section III	– Rates of preventive or ambulatory health services among adults with SUD or SMI was consistently high. – Rates of follow-up after ED visits for SUD significantly increased ($p < 0.05$) in about half of states. – The average rate of follow-up after ED visits for SMI were higher than the Core Set national average. – Among the analyzed states with SMI demonstrations, follow-up after hospitalization for mental illness among adults significantly increased ($p < 0.05$) in half of states.	There are opportunities for improved follow-up care among adults with SUD or SMI: – Consistent with national trends, the average rate of follow-up after ED visits for SUD among SUD demonstration states was lower than the average rate of follow-up after ED visits for SMI reported among SMI demonstration states. – Among the analyzed states with SMI demonstrations, the percentage of adult beneficiaries with a new antipsychotic prescription who completed a follow-up visit significantly decreased ($p < 0.05$) in about half of states.
Reduce preventable or medically inappropriate ED or inpatient use SUD Goal 4, SMI Goal 1 Chartbook Section IV	– Average ED utilization and inpatient stays for SUD per 1,000 Medicaid beneficiaries decreased from 2019 to 2023 across most analyzed states with SUD demonstrations. – Average ED utilization for SMI remained steady across most analyzed states with SMI demonstrations from 2020 to 2023. Averaging across seven of nine states, 1 to 2% of beneficiaries receiving mental health treatment accessed care in an ED setting each year.	– Although average ED utilization decreased across SUD demonstrations and is low across most SMI demonstrations, states can further reduce preventable or medically inappropriate ED use by expanding access to primary or community-based care.
Reduce preventable readmissions SUD Goal 5, SMI Goal 2 Chartbook Section V	– Readmission rates significantly decreased ($p < 0.05$) in a few states with SUD or SMI demonstrations.	– Readmission rates in about half of the analyzed states with SUD or SMI demonstrations significantly increased ($p < 0.05$), potentially indicating room for improvement in care coordination and transitional care.
Reduce overdose deaths SUD Goal 3 Chartbook Section VI	– Among SUD demonstrations, inappropriate opioid prescribing decreased. Concurrent use of opioids and benzodiazepines significantly decreased ($p < 0.05$) in most states and use of opioids at high dosage significantly decreased ($p < 0.05$) in over half of states.	– Overdose death rates significantly increased ($p < 0.05$) in about half of states. Since the available data from SUD demonstration states are mostly from before 2024, we expect that future data will reflect the 2024 national decreases in overdose deaths.
Improve care for children and adolescents with serious emotional disturbance (SED) SMI Goals 4 and 5 Chartbook Section VII	– Among SMI demonstrations, blood glucose testing for children on antipsychotics significantly increased ($p < 0.05$) in about half of states.	– States have opportunities to improve care for children on antipsychotics, as rates of blood glucose testing were below the national average and the average rate of first-line psychosocial care slightly decreased from the baseline to most recent year.

SECTION I.
Overview of Medicaid Section 1115
SUD and SMI Demonstrations

Thirty-eight states have 1115 SUD demonstrations and 17 states have SMI demonstrations, as of January 1, 2026.



Start year	States with SUD demonstrations	States with SMI demonstrations
2015	CA	
2016	VA	
2017	MA, MD, NJ, UT	
2018	IL, IN, KY, LA, NH, PA, VT, WA, WI, WV	
2019	AK, DE, KS, MI, MN, NC, NE, NM, OH, RI	
2020	DC, ID, OK	DC, ID, IN, OK, UT, VT, WA
2021	CO, ME, OR	
2022	CT, MT	AL, MA, MD, NH
2023	MO, NV	MO, NM
2024	NY	
2025	AR	AR, CA, CO, KY

Note: The demonstration start year reflects the effective date at the time of CMS's initial approval of the SUD or SMI demonstration. In some cases, states did not begin reporting monitoring data in the year the demonstration started, so the baseline year of data may differ.

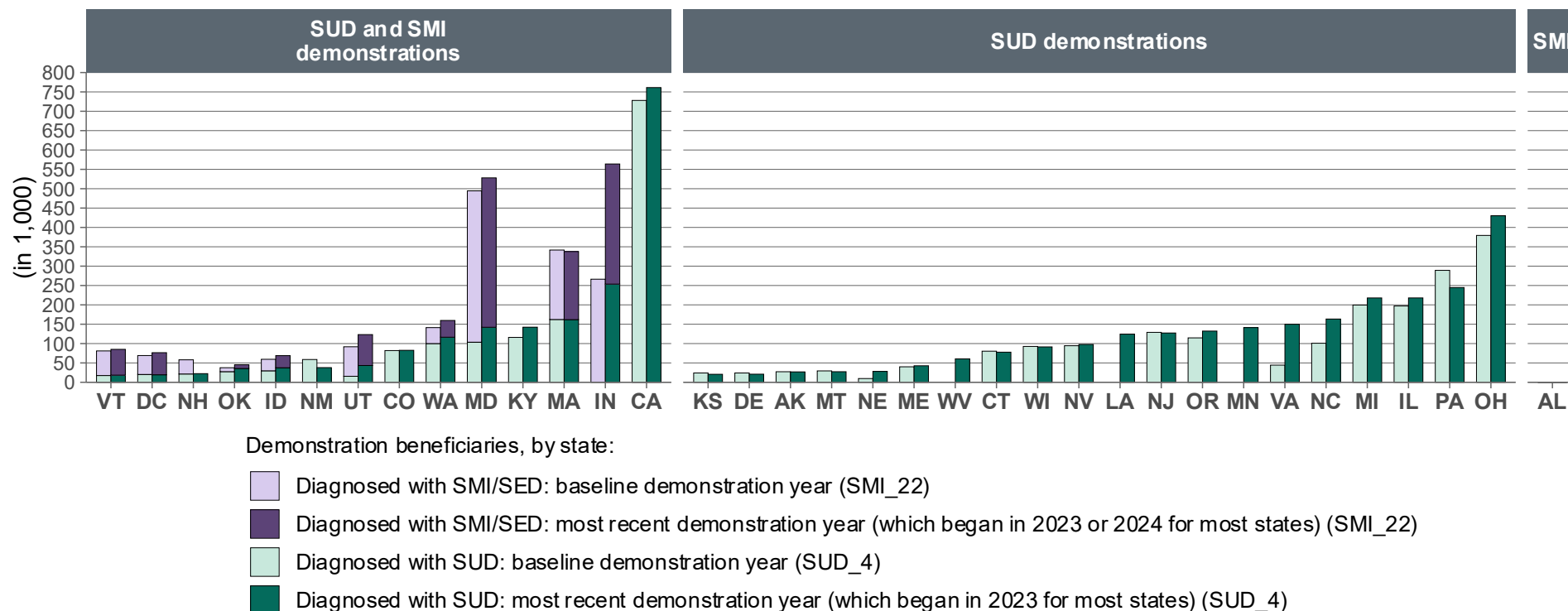
Source: Medicaid.gov State Waiver List information on demonstration approvals, as of January 1, 2026. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list>.

As of January 1, 2026, 39 states have approved SUD and/or SMI demonstrations. Sixteen states have both SUD and SMI demonstrations, 22 have an SUD demonstration only, and one state has an SMI demonstration only. States work toward demonstration goals and milestones to improve the behavioral health continuum of care (as outlined in the CMS SMDL #17-003 for SUD and SMDL #18-011 for SMI) and submit monitoring data to track progress.²

This chartbook analyzes monitoring data received by December 1, 2025, from 35 SUD demonstrations and 11 SMI demonstrations.

- As of December 1, 2025, three SUD demonstration states (AR, MO, and NY) and six SMI demonstration states (AR, CA, CO, KY, MO, and NM) did not submit enough data to be included in the remainder of this chartbook. For details on the data and methods used in this chartbook, see Section IX, "About This Chartbook." For more information on data availability, see Appendix Tables.
- Analyses generally focus on changes from the baseline measurement period to the most recent measurement period.
- The data span measurement periods from 2017 to 2025, varying by analysis and state, in part due to differences in demonstration start dates. See Appendix Tables for details on included data. Several factors are relevant to understanding trends during this time period, including the COVID-19 PHE and related eligibility policy changes, such as maintenance of eligibility requirements and their unwinding (see Glossary in Section IX), as well as decisions by some states to expand Medicaid eligibility during this period.

The demonstration populations increased in most states with SUD or SMI demonstrations.



Source: Medicaid Section 1115 SUD and SMI Monitoring Report Workbooks.

Note: Includes states with approved demonstrations and available baseline and/or most recent year data for SUD_4 and/or SMI_22. States missing baseline or most recent data either did not submit the metric or the metric did not pass data quality inclusion criteria. See Glossary in Section IX for the definition of demonstration population. States are sorted by SUD population size in the most recent demonstration year. AL's SMI population is too small to be visible. RI is excluded from the SUD analysis. See Appendix Table A.2 for more information.

SUD and SMI demonstration populations increased in most states compared to their baseline demonstration year (19 of 30 SUD demonstrations and seven of 10 SMI demonstrations). Notably, most SUD demonstrations have been in place longer, with most starting in 2019 or earlier, before the COVID-19 PHE's impact on Medicaid enrollment, while SMI demonstrations started later (2020 or after).

Across 30 states with SUD demonstrations with available baseline and most recent year data, the population with SUD:

- Increased from 3.36 million to 3.74 million (11%)
- More than doubled in three states (NE, UT, and VA) and increased by over 60% in one state (NC), coinciding with Medicaid eligibility expansion in those states
- Decreased by more than 5% in five states (DE, KS, MT, NM, and PA), potentially due to Medicaid eligibility unwinding, data reporting changes, or provider capacity constraints

Across 10 states with SMI demonstrations with available baseline and most recent year data, the population with SMI/SED:

- Increased from 1.11 million to 1.16 million (5%)
- Increased by more than 5% in three states (AL, DC, and IN)

This chartbook is organized by both SUD and SMI demonstration goals.

The table below outlines how the goals of SUD and SMI demonstrations align with each other and with the organization of this chartbook. Certain chartbook sections also reference demonstration milestones from the respective SMDLs.

Chartbook section	SUD goal(s) (based on SMDL #17-003)	SMI goal(s) (based on SMDL #18-011)
 Section II. Increase access to and engagement in a continuum of SUD and SMI services	– Goal 1: Increase rates of identification, initiation, and engagement in treatment – Goal 2: Increase adherence to and retention in treatment	– Goal 3: Improve availability of crisis stabilization services – Goal 4: Improve access to community-based services
 Section III. Improve coordination of care between settings for SUD and SMI services and for physical health conditions	– Goal 6: Improve access to care for physical health conditions	– Goal 5: Improve care coordination, especially following episodes of acute inpatient care
 Section IV. Reduce preventable or medically inappropriate ED or inpatient use	– Goal 4: Reduce preventable utilization of EDs and inpatient hospital settings for treatment	– Goal 1: Reduce utilization and length of stay in EDs
 Section V. Reduce preventable readmissions	– Goal 5: Reduce preventable readmissions	– Goal 2: Reduce preventable readmissions
 Section VI. Reduce overdose deaths (<i>SUD-only</i>)	– Goal 3: Reduce overdose deaths	n.a.
 Section VII. Improve care for children and adolescents with SED (<i>SMI-only</i>)	n.a.	– Goal 4: Improve access to community-based services – Goal 5: Improve care coordination, especially following episodes of acute inpatient care

n.a. = not applicable.

SECTION II.

**Increase Access to and Engagement in
a Continuum of SUD and SMI Services**

Introduction

Access to a full continuum of care for SUD and SMI enables beneficiaries to receive the appropriate care as their needs evolve. The SUD demonstrations require states to improve identification, initiation, engagement, adherence to, and retention in treatment (SUD Goals 1 and 2). Similarly, the SMI demonstrations require states to improve the availability of and access to community-based and crisis stabilization services (SMI Goals 3 and 4). This section includes data about the following topics and metrics:³

A. Service utilization, by type of service (SUD and SMI)

Early Intervention (SUD_7), Outpatient Services (SUD_8), Intensive Outpatient and Partial Hospitalization Services (IO/PH; SUD_9), Residential and Inpatient Services (SUD_10), Withdrawal Management (SUD_11), and Medication-Assisted Treatment (MAT; SUD_12) measure the number of Medicaid beneficiaries who received each type of SUD service. We divide each metric by **Any SUD Treatment (SUD_6)** to calculate the share of beneficiaries using any SUD service who received each type of service.

Mental Health Services Utilization - Inpatient (SMI_13), Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization (SMI_14), Mental Health Services Utilization - Outpatient (SMI_15), and Mental Health Services Utilization - Telehealth (SMI_17) measure the number of Medicaid beneficiaries who received each type of mental health service. We divide each metric by **Mental Health Services Utilization - Any Services (SMI_18)** to calculate the share of beneficiaries using any mental health treatment who received each type of service.

States implementing SUD and SMI demonstrations are expected to ensure that a full continuum of care is available. The directional goals for each service type vary based on state-specific policies and population needs. Generally, states with SUD demonstrations are expected to increase access to MAT and states with SMI demonstrations are expected to increase access to community-based services.

Medicaid Beneficiaries Treated in an IMD for SUD (SUD_5) and Beneficiaries With SMI/SED Treated in an IMD for Mental Health (SMI_20) measure the count of beneficiaries who received residential or inpatient treatment in an IMD for SUD or mental health, respectively. To calculate the percentage of demonstration beneficiaries with SUD or SMI/SED receiving these services, we divide SUD_5 by **Medicaid Beneficiaries with SUD Diagnosis (SUD_4)** and SMI_20 by **Count of Beneficiaries With SMI/SED (SMI_22)**. **Average Length of Stay (ALOS) in IMDs (SUD_36) and Average Length of Stay in IMDs (IMDs receiving FFP only; SMI_19b)** measure the ALOS for beneficiaries treated in an IMD. States should target an ALOS of less than 30 days.⁴

Initiation and Engagement of SUD Treatment (SUD_15) measures the percentage of beneficiaries aged 18 and older with a new SUD episode who initiated treatment within 14 days of diagnosis and engaged in ongoing treatment within 34 days of the initiation of treatment. We analyze data for the OUD cohort within this report, but states also report additional diagnosis-related cohorts. Higher rates are better.

Continuity of Pharmacotherapy for Opioid Use Disorder (SUD_22) measures the percentage of adults aged 18 and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment. Higher rates are better.

B. Provider availability (SUD and SMI)

SUD Provider Availability (SUD_13) and SUD Provider Availability - MAT (SUD_14) measure the number of providers enrolled in Medicaid and qualified to deliver any SUD services (SUD_13) or MAT (SUD_14). To calculate the number of SUD or MAT providers per 1,000 beneficiaries with an SUD diagnosis, we divide SUD_13 and SUD_14 by SUD_4. Higher rates are better.

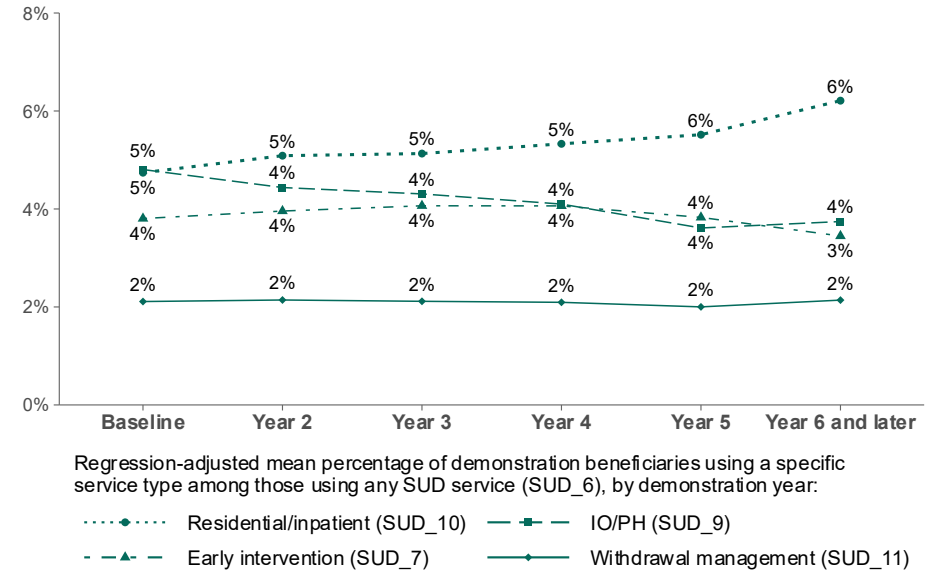
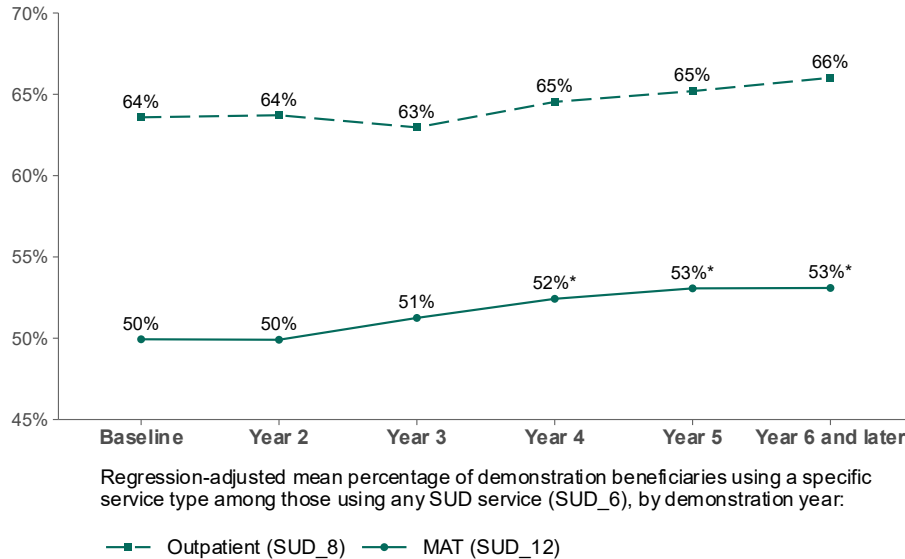
SMI demonstration states are required to submit Initial and Annual Availability Assessments, reporting counts of different types of mental health service providers, including **Medicaid-Enrolled Psychiatrists and Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications** and **Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness**. These assessments also include the number of beneficiaries with SMI or SED, which we use to calculate provider-to-beneficiary ratios per 1,000 beneficiaries with SMI or SED. Higher rates are better.



Key takeaways

- The SUD demonstrations were associated with a statistically significant increase ($p < 0.05$) in receipt of MAT, and the SMI demonstrations were associated with a statistically significant increase ($p < 0.05$) in outpatient treatment.
- In more than half of analyzed states with SUD demonstrations, initiation or engagement in treatment for beneficiaries with OUD significantly increased ($p < 0.05$).
- Trends in continuous pharmacotherapy for OUD varied, with states beginning demonstrations before the COVID-19 PHE showing greater success in sustaining or increasing rates.
- SUD and SMI provider availability per 1,000 diagnosed beneficiaries increased in most states.

SUD demonstrations were associated with an increase in the share of beneficiaries using any SUD service who used MAT.



Source: Medicaid Section 1115 SUD Monitoring Report Workbooks.

Note: All regression models control for state, demonstration year, seasonality (based on calendar month), periods of the COVID-19 PHE and subsequent Medicaid unwinding, and Medicaid eligibility expansion status. Standard errors are adjusted for clustering at the state level. See Section IX for more information on methods and Appendix Table A.2 for information on state inclusion.

* The difference between the baseline value and later demonstration years is statistically significant ($p < 0.05$) based on regression results.

After regression adjustment, the SUD demonstrations were associated with a statistically significant increase ($p < 0.05$) in the predicted share of beneficiaries using any SUD service who used MAT in Years 4, 5, and 6 and later compared to baseline.

- There were no significant changes associated with the SUD demonstrations for other types of services. On average, the regression model predicts 63 to 66% of beneficiaries receiving SUD treatment used outpatient services (including telehealth), 5 to 6% used residential/inpatient services, 4 to 5% used IO/PH services, 3 to 4% used early intervention services (driven by outlier rates in ME),⁵ and 2% used withdrawal management services over the years after the implementation of the SUD demonstrations.

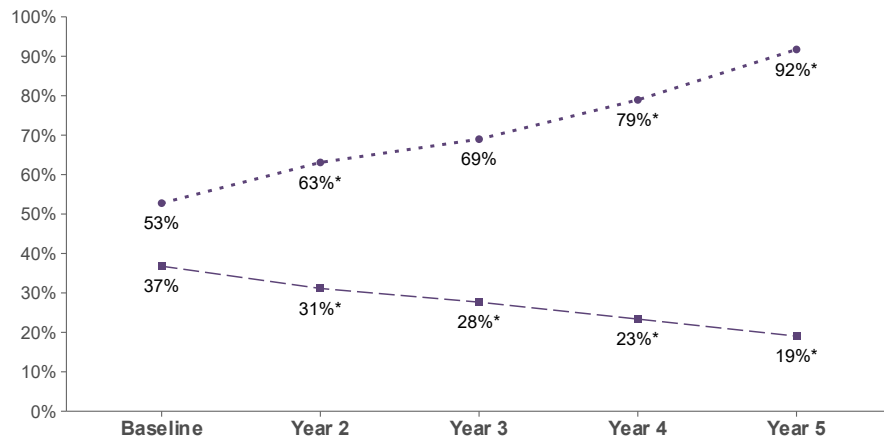
Based on a separate regression analysis (data not in figure), there was no significant change in the predicted percentage of Medicaid beneficiaries with SUD who used any SUD service across demonstration years (SUD_6/SUD_3).



Examples of state efforts to increase MAT access

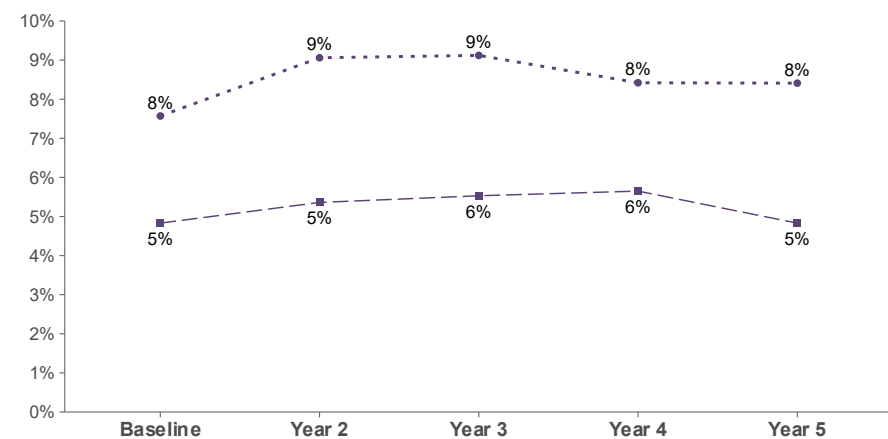
- CO attributed increases in MAT to residential SUD treatment facilities renewing or applying for licenses and 12 unique programs supporting MAT expansion to jail-based programs, primary care, and in-home induction.
- LA used COVID-related supplemental federal funding and its State Opioid Response grant to fund multiple projects across the state that increase access to MAT by expanding evidence-based prevention, treatment, and recovery for people with OUD.
- NM's Bridge Program helped to identify local outpatient programs capable of providing MAT, especially for patients in inpatient and ED settings. The state also streamlined the enrollment process for new MAT providers.

SMI demonstrations were associated with an increase in the share of beneficiaries using any mental health service who used outpatient services and a decrease in the share who used telehealth.



Regression-adjusted mean percentage of demonstration beneficiaries using a specific service type among those using any SMI/SED services (SMI_18), by demonstration year:

··◆·· Outpatient (SMI_15) —■— Telehealth (SMI_17)



Regression-adjusted mean percentage of demonstration beneficiaries using a specific service type among those using any SMI/SED service (SMI_18), by demonstration year:

··◆·· IO/PH (SMI_14) —■— Inpatient (SMI_13)

Source: Medicaid Section 1115 SMI Monitoring Report Workbooks.

Note: All regression models control for state, demonstration year, seasonality (based on calendar month), COVID-19 PHE onset and subsequent Medicaid unwinding, Medicaid eligibility expansion status, and implementation of 988. Standard errors are adjusted for clustering at the state level. See Section IX for more information on methods and Appendix Table A.2 for information on state inclusion.

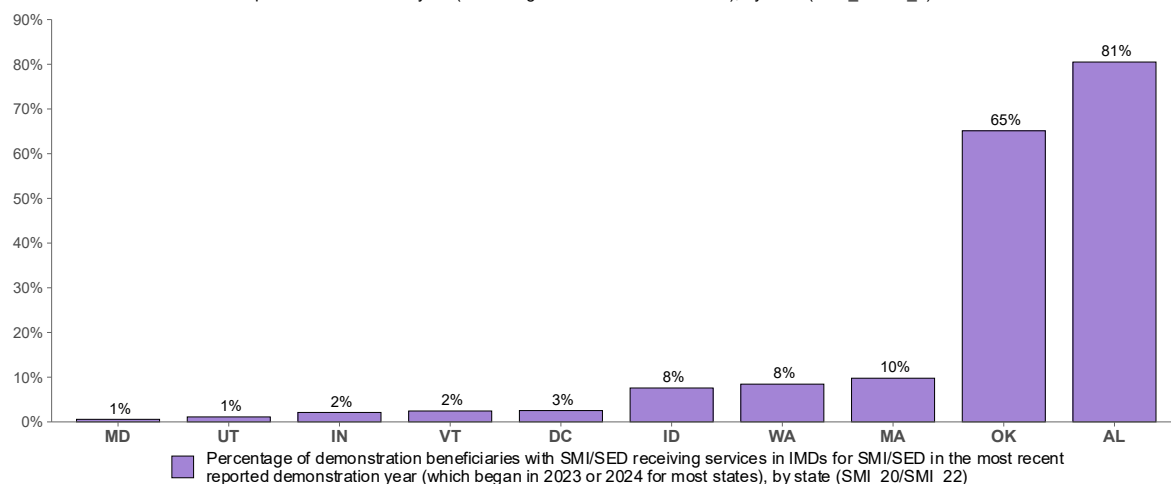
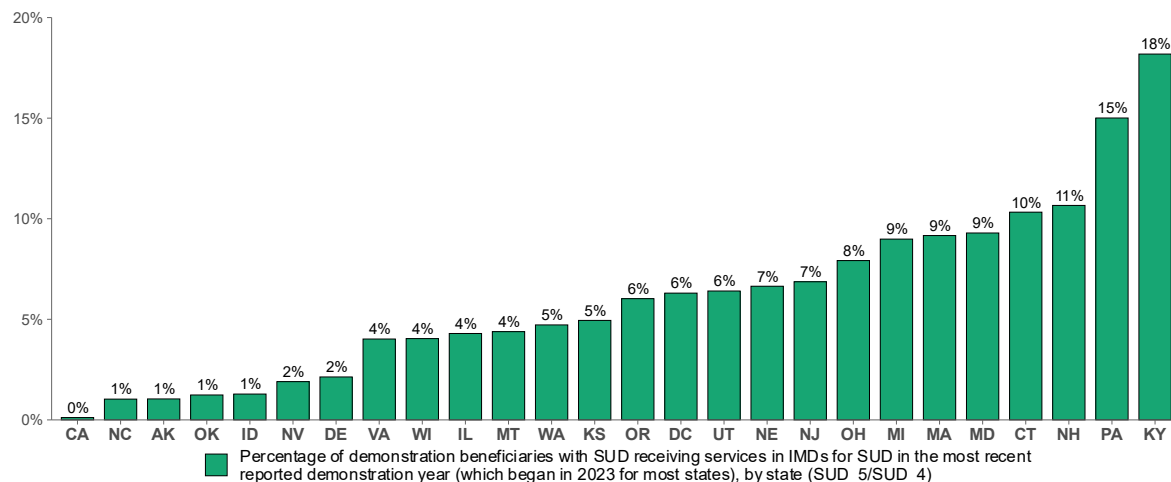
* The difference between the baseline value and later demonstration years is statistically significant ($p < 0.05$) based on regression results.

After regression adjustment, the SMI demonstrations were associated with a statistically significant increase ($p < 0.05$) in the predicted share of beneficiaries using any mental health service who used outpatient services in years 2, 4 and 5. They were also associated with a statistically significant decrease ($p < 0.05$) in the predicted share of beneficiaries using any mental health service who used telehealth services in all years following the baseline year.

- Although the SMI demonstrations were associated with increases in outpatient treatment, the SUD demonstrations were not. This might be because the SMI metrics separate outpatient and telehealth services (SMI_15 and 17), which had contrasting trends, while the SUD outpatient services metric (SUD_8) includes both outpatient and telehealth services.
- After regression adjustment, we found no significant changes associated with the SMI demonstrations in the share of beneficiaries accessing other types of services.
- The regression analysis examined trends since April 2020 (it excluded the first quarter of data from the three states that began SMI demonstrations in January 2020), and controlled for the onset of the PHE, the Medicaid unwinding period, and other factors (see Section IX). However, there may still be residual changes in the utilization metrics that were not explained with the model specification. For example, the baseline periods for most states coincided with providers reducing hours or switching to telehealth early in the PHE, and trends may partially reflect providers returning to more typical operation patterns in later demonstration years.

Based on a separate regression analysis (data not in figure), there was no statistically significant change in the predicted number of beneficiaries receiving any mental health treatment per 1,000 Medicaid beneficiaries across demonstration years (SMI_18 / Medicaid enrollment).⁶

Average IMD utilization was greater for SMI/SED than for SUD, driven by outlier rates in two states.



Source: Medicaid Section 1115 SUD and SMI Monitoring Report Workbooks.

Note: CO, IN, LA, ME, MN, NM, RI, VT, and WV are excluded from the SUD analysis and NH is excluded from the SMI analysis. See Appendix Table A.2 for more information.

The share of SUD and SMI demonstration beneficiaries receiving services in IMDs increased in many states, but there was little change in the average across states.

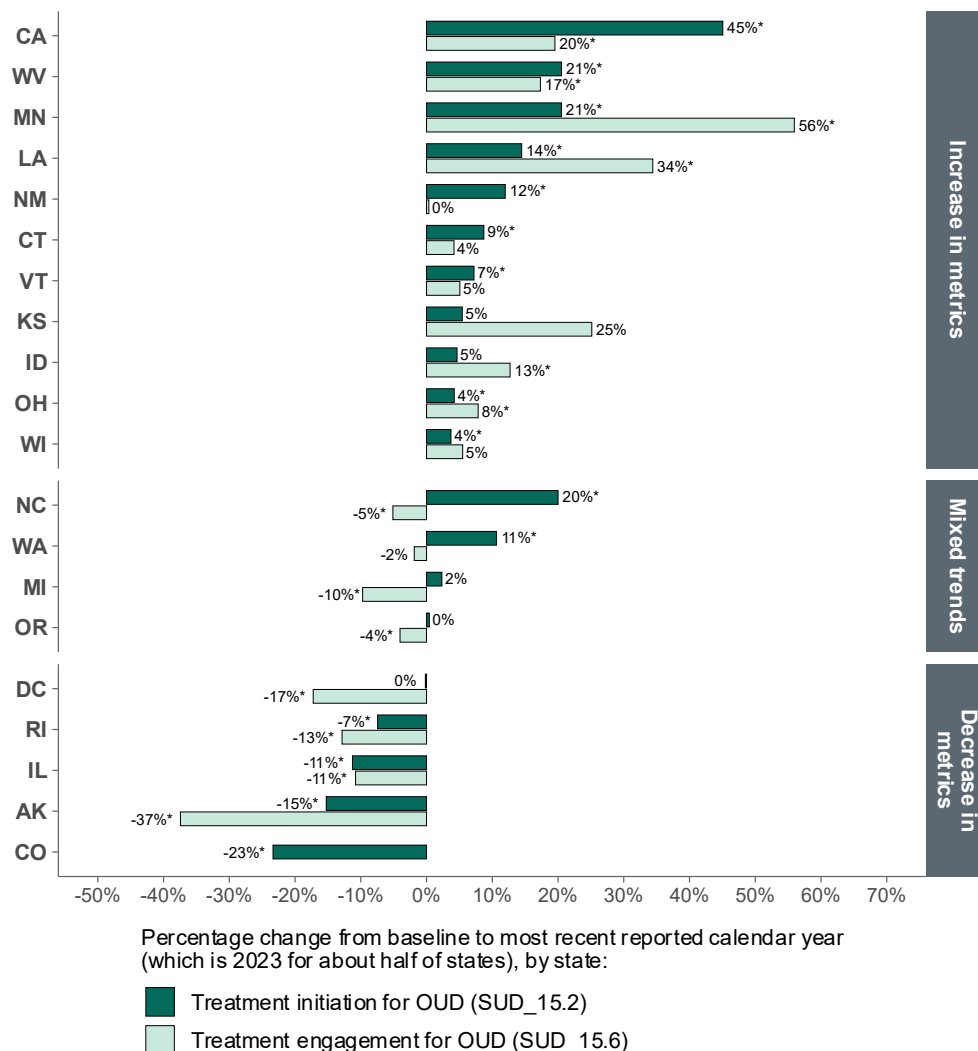
- In the 26 analyzed states with SUD demonstrations, an average of 6.0% of beneficiaries with an SUD received services in IMDs for SUD in the most recent year, compared to 5.5% in the baseline year.
- Relative to baseline, the share of beneficiaries with an SUD receiving SUD services in IMDs significantly increased ($p < 0.05$) in the most recent year in 17 states, significantly decreased ($p < 0.05$) in six states, and did not significantly change in three states.
- In the 10 analyzed states with SMI demonstrations, an average of 18% of beneficiaries with SMI/SED received services in IMDs for SMI/SED in the most recent year, compared to 17.6% in the baseline year.
- The SMI average was driven by outlier values in OK and AL. Demonstrations in these states focus more narrowly on individuals receiving services in IMDs.
- For SMI demonstrations, the share of beneficiaries with SMI/SED receiving services in IMDs for SMI/SED significantly increased ($p < 0.05$) in the most recent year in six states, significantly decreased ($p < 0.05$) in two states, and did not significantly change in two states.



ALOS in IMDs

- The ALOS in IMDs for SUD demonstration states (SUD_36) was below 30 days in the most recent year for 33 of 35 states; only ME (ALOS = 32.1 days) and UT (ALOS = 43.1 days) had a rate above 30 days. In four states (ME, MN, OK, and UT), the ALOS for SUD was above 30 days in a prior year.
- The ALOS in IMDs for SMI demonstration states (SMI_19b) was below 30 days in all demonstration years for all nine states with available data.

Initiation or engagement in treatment for beneficiaries with OUD significantly increased in over half of states.



Compared to the baseline, the percentage of adult beneficiaries with a new episode of OUD who initiated treatment within 14 days or engaged in treatment within 34 days significantly increased ($p < 0.05$) in 12 of 20 states. Three additional states had increases that were not statistically significant.

- Both percentages significantly increased ($p < 0.05$) in five states. Only the initiation percentage significantly increased ($p < 0.05$) in six states, and only the engagement percentage significantly increased ($p < 0.05$) in one state.

One or both rates significantly decreased ($p < 0.05$) in 8 of 20 states. One additional state had a decrease that was not statistically significant.

- Both percentages significantly decreased ($p < 0.05$) in three states. Only the initiation percentage significantly decreased ($p < 0.05$) in one state, and only the engagement percentage significantly decreased ($p < 0.05$) in four states.

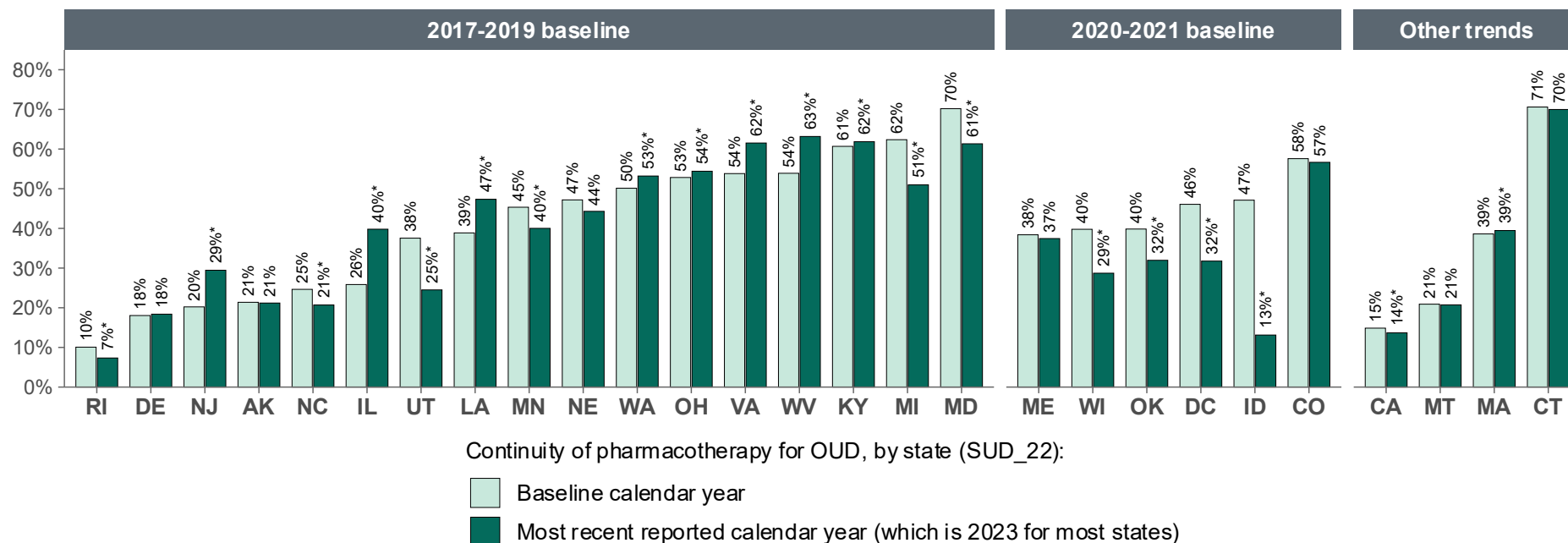
The average initiation and engagement percentages across all SUD demonstration states in the most recent year (55% and 29%) were similar to the 2022 Core Set (measurement year [MY] 2021) national averages (56% and 29%, respectively), the most recent year before HEDIS® specification changes led to a break in trend.⁷

Source: Medicaid Section 1115 SUD Monitoring Report Workbooks.

Note: Based on adjusted HEDIS® IET metric specifications. Analysis excludes CY 2017 data due to a break in trend associated with CY 2018 technical specifications updates. Due to a break in trend starting with MY 2022 HEDIS® specifications, the analysis only includes CY 2022 and later years of data from states that continued to use MY 2021 HEDIS® specifications in those years. DE, IN, KY, MA, MD, ME, MT, NE, NH, NJ, NV, OK, PA, UT, and VA are excluded from the analysis and CO is included only for SUD_15.2. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

Trends in continuous pharmacotherapy for OUD were mixed, although states beginning demonstrations before the COVID-19 PHE were more successful in sustaining or increasing rates.



Source: Medicaid Section 1115 SUD Monitoring Report Workbooks.

Note: This metric is CMIT #164 and is calculated over two calendar years. States listed under “Other trends” have only 2022 and 2023 data available; however, the SUD demonstration start dates in these states vary (2015 for CA, 2017 for MA, and 2022 for CT and MT). IN, KS, NH, NM, NV, OR, PA, and VT are excluded from the analysis. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

Among the 27 analyzed states, the percentage of beneficiaries receiving continuous pharmacotherapy for OUD significantly decreased ($p < 0.05$) in 11 states, significantly increased ($p < 0.05$) in nine states, and did not significantly change in seven states.

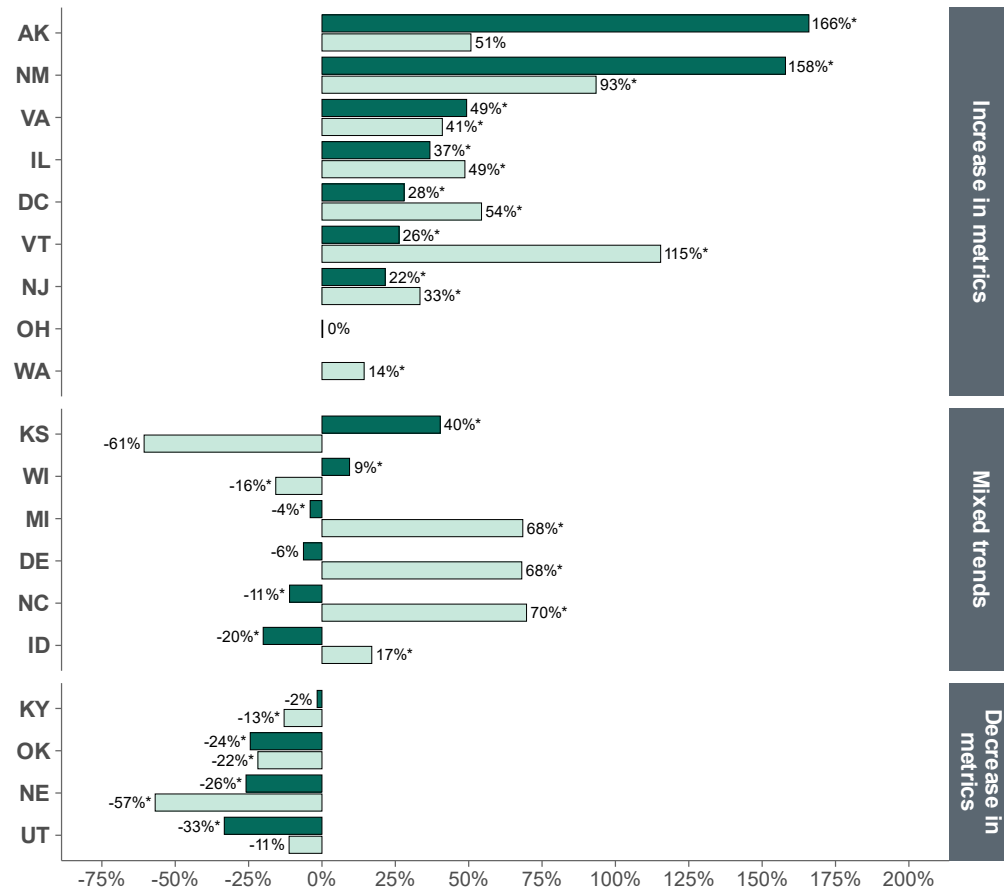
- Trends varied by states’ baseline start date. Among the 17 states with baseline years before the COVID-19 PHE (2017 to 2019), the percentage significantly increased ($p < 0.05$) in eight states and significantly decreased ($p < 0.05$) in six states. However, the percentage significantly decreased ($p < 0.05$) in four of six states with baselines beginning in 2020 or 2021. This suggests that states that started SUD demonstrations before the COVID-19 PHE were better able to sustain higher rates of continuous pharmacotherapy over the course of the demonstrations.
- Across the 27 states, the total number of beneficiaries receiving pharmacotherapy continuously for at least six months (SUD_22 numerator) increased by 36% (with the number increasing in 17 of 27 states). As states have engaged more individuals in MAT, the number of those receiving continuous pharmacotherapy increased (rate numerator). However, those increases have not kept pace with the larger increase in individuals receiving any pharmacotherapy (rate denominator). This points to an opportunity to better engage those who initiate pharmacotherapy.



Example of barriers to continuous pharmacotherapy

Louisiana reported barriers to continuous pharmacotherapy, including inconsistent medication adherence by enrollees and limited access at wholesale medication distributors and pharmacies. The state noted that managed care organizations (MCOs) and grant-funded projects are educating providers to address these issues.

The rate of SUD and/or MAT providers per 1,000 Medicaid beneficiaries with SUD significantly increased in most states.



Percentage change from baseline to the most recent reported demonstration year (which began in 2021 for most states), by state:

- Medicaid-enrolled providers qualified to deliver SUD services per 1,000 beneficiaries with SUD (SUD_13/SUD_4 * 1,000)
- Medicaid-enrolled providers qualified to deliver MAT services per 1,000 beneficiaries with SUD (SUD_14/SUD_4 * 1,000)

Source: Medicaid Section 1115 SUD Monitoring Report Workbooks.

Note: CA, CO, CT, IN, LA, MA, MD, ME, MN, MT, NH, NV, OR, PA, RI, and WV are excluded from the analysis, OH is included only for SUD_13 and WA only for SUD_14. Data from demonstration years including January 2023 and later are also excluded. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

The rate of SUD and/or MAT providers per 1,000 Medicaid beneficiaries with SUD significantly increased ($p < 0.05$) in 14 of 19 states; six of these states reported mixed trends.⁸ One additional state (OH) had an increase of 0.3% that was not statistically significant.

- Both rates significantly increased ($p < 0.05$) in six states. Only the SUD provider rate per 1,000 significantly increased ($p < 0.05$) in three states, and only the MAT provider rate per 1,000 significantly increased ($p < 0.05$) in five states.

One or both rates significantly decreased ($p < 0.05$) in eight of 19 states. Two additional states had decreases that were not statistically significant.

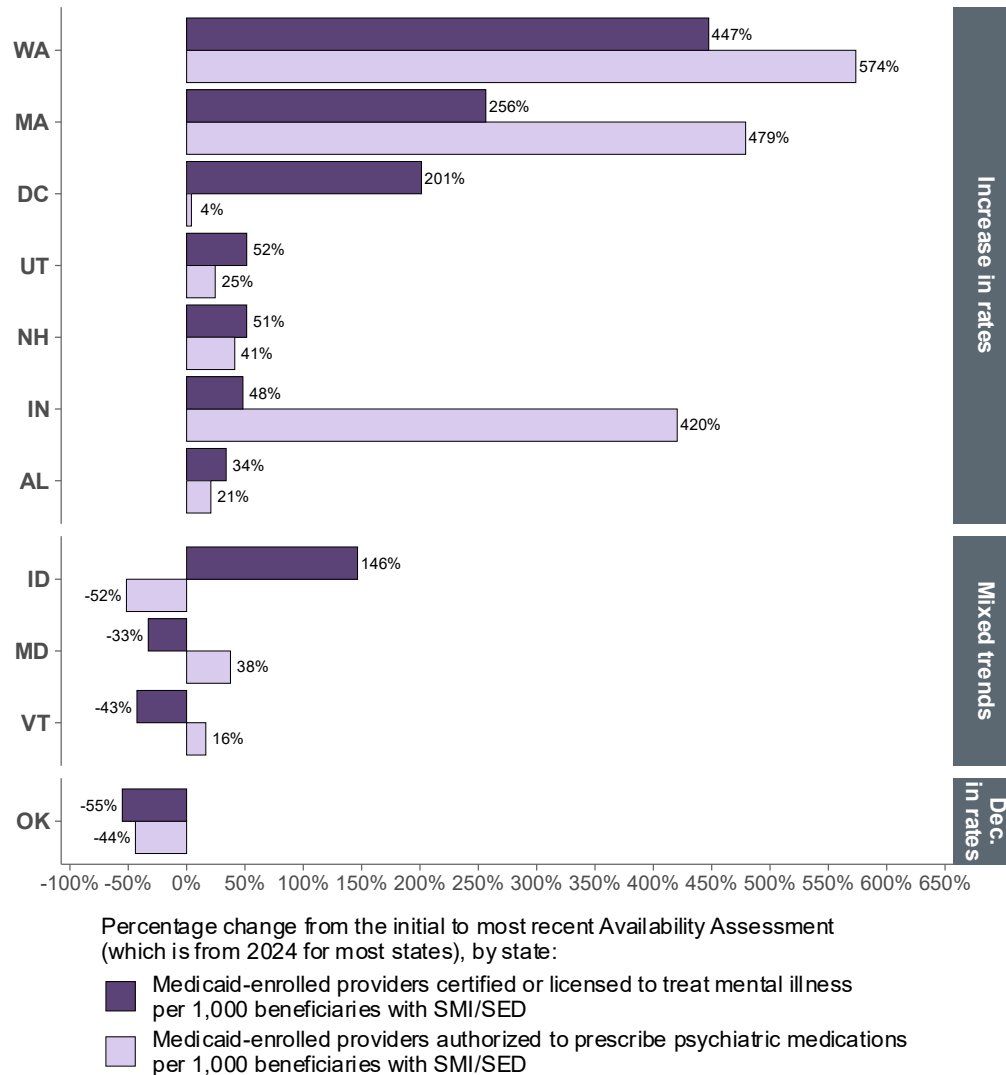
- Both rates significantly decreased ($p < 0.05$) in two states. Only the SUD provider rate per 1,000 significantly decreased ($p < 0.05$) in four states, and only the MAT provider rate per 1,000 significantly decreased ($p < 0.05$) in two states.
- Among the four states in which both the SUD and MAT provider rates decreased, the numerators (counts of providers) increased for most rates. However, the rate denominators (number of beneficiaries with SUD) also increased. Three of these states (OK, NE, and UT) expanded Medicaid eligibility between the baseline and most recent year.



MAT prescriber policy changes

At the end of 2022, federal law eliminated the DATA-waiver requirement for prescribing buprenorphine for OUD, greatly increasing the number of potential MAT prescribers. This policy change led numerous states with SUD demonstrations to update methodologies for reporting SUD and MAT providers. Because of these methodology changes, this analysis focuses on data through December 31, 2022.

The rate of mental health providers per 1,000 Medicaid beneficiaries with SMI/SED increased in most states.



Because states with SMI demonstrations do not report SMI provider metrics in their monitoring reports, we used data from states' Annual Availability Assessments to evaluate SMI provider availability. Although these assessments include data on various mental health services—such as inpatient and residential facilities, units, and beds, and community-based services (for example, Federally Qualified Health Centers, Community Mental Health Centers, and Mobile Crisis Teams)—we focus on the availability of Medicaid-enrolled mental health providers to align with the SUD metrics presented earlier.⁹

- The rate of Medicaid-enrolled certified or licensed mental health providers increased in eight of 11 states, and the rate of psychiatrists and other providers authorized to prescribe psychiatric medications increased in nine of 11 states.
- Across both mutually exclusive provider types, the average rate of providers increased between the Initial and most recent Annual Availability Assessments from 95 to 143 providers per 1,000 beneficiaries with SMI/SED. The combined rate increased in all states except for MD, OK, and VT.

As of December 2025, only 27% of the national population's needs for mental health professionals were met, according to external data on health professional shortage areas.¹⁰ All states with SMI demonstrations have room for improvement.

- In AL, ID, IN, NH, and UT, the share of the population who had their needs for mental health professionals met was higher than the national average.
- DC, MA, MD, OK, and WA had greater unmet needs for mental health professionals compared to the national average.

Source: SMI/SED Initial and Annual Availability Assessments.

Note: We did not perform z-tests on these rates. This is because the quality checks we perform on Availability Assessment data cannot determine whether the data are inaccurate and should be excluded from analyses. Additionally, some patterns in the assessment data suggest that states may change their reporting methods over time. See Appendix Table A.2 for information on included data.

SECTION III.

**Improve Coordination of Care
Between Settings for SUD and SMI
Services and for Physical Health
Conditions**

Introduction

Medicaid beneficiaries with SUD or SMI/SED require a range of physical, behavioral health, and supportive services. Without comprehensive, coordinated care, these beneficiaries often rely on costly inpatient and emergency care, which can lead to negative social and health outcomes such as homelessness and even premature mortality.¹¹

Both the SUD and SMI demonstrations require states to improve access to care for co-occurring physical health conditions among beneficiaries with an SUD or SMI diagnosis (SUD Goal 6, SMI Goal 4). States must also improve care coordination between levels of care (SUD Milestone 6) and following acute care (SMI Goal 5). This section presents data on the following topics and metrics, which focus on adults (aged 18 and older):

A. Access to preventive/ambulatory services (SUD and SMI)

Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries with SUD (SUD_32) or SMI (SMI_26) measures the percentage of adult Medicaid beneficiaries with SUD or SMI, respectively, who had an ambulatory or preventive care visit during the measurement period.¹² Higher rates are better.

B. Follow-up after ED visits (SUD and SMI)

Follow-Up After ED Visit for Substance Use: Age 18 and Older (SUD_17.1.1) measures the percentage of ED visits among adult beneficiaries with a principal diagnosis of SUD or any diagnosis of drug overdose for which there was follow-up treatment within 30 days. For SMI demonstrations, the equivalent metric (**Follow-up After ED Visit for Mental Illness: Age 18 and Older; SMI_10.1**) measures the rate of follow-up treatment within 30 days of an ED visit for a principal diagnosis of mental illness or intentional self-harm. States also report seven-day follow-up rates. Higher rates are better.

C. Continued care and follow-up (SMI)

1. **Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (SMI_8.1)** measures the percentage of discharges for adult beneficiaries who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days. States also report seven-day follow-up rates. Higher rates are better.
2. **Medication Continuation Following Inpatient Psychiatric Discharge (SMI_6)** measures whether adult psychiatric patients admitted to an inpatient psychiatric facility for major depressive disorder, schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within two days

before discharge and 30 days post-discharge. The performance period for the measure is two years. Higher rates are better.

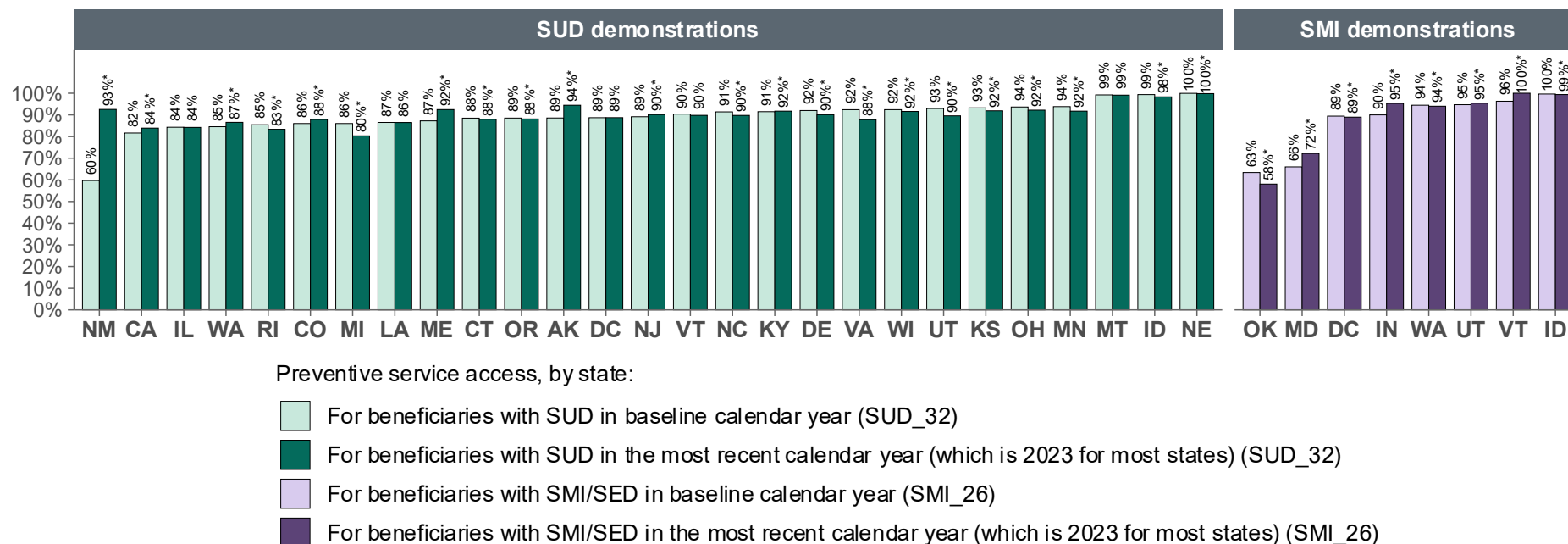
3. **Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (SMI_30)** measures the percentage of adult Medicaid beneficiaries with a new antipsychotic prescription who completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of the prescription. Higher rates are better.



Key takeaways

- Rates of preventive or ambulatory care for beneficiaries with SUD or SMI were consistently high.
- Follow-up rates after ED visits for SUD significantly increased ($p < 0.05$) in about half of SUD demonstration states. However, consistent with national trends, these rates were lower than rates of follow-up after ED visits for SMI in SMI demonstration states. The average rate of follow-up after ED visits for SMI was higher than the Core Set national average, whereas the average for SUD was similar to the national average.
- Among states with SMI demonstrations and available data:
 - Follow-up after hospitalization for mental illness among adults significantly increased ($p < 0.05$) in half of states.
 - Trends in medication continuation following inpatient psychiatric discharge among adults were mixed.
 - The percentage of adult beneficiaries with a new antipsychotic prescription who completed a follow-up visit significantly decreased ($p < 0.05$) in about half of states.

Access to preventive or ambulatory health services among adults with SUD or SMI was consistently high.



Source: Medicaid Section 1115 SUD and SMI Monitoring Report Workbooks.

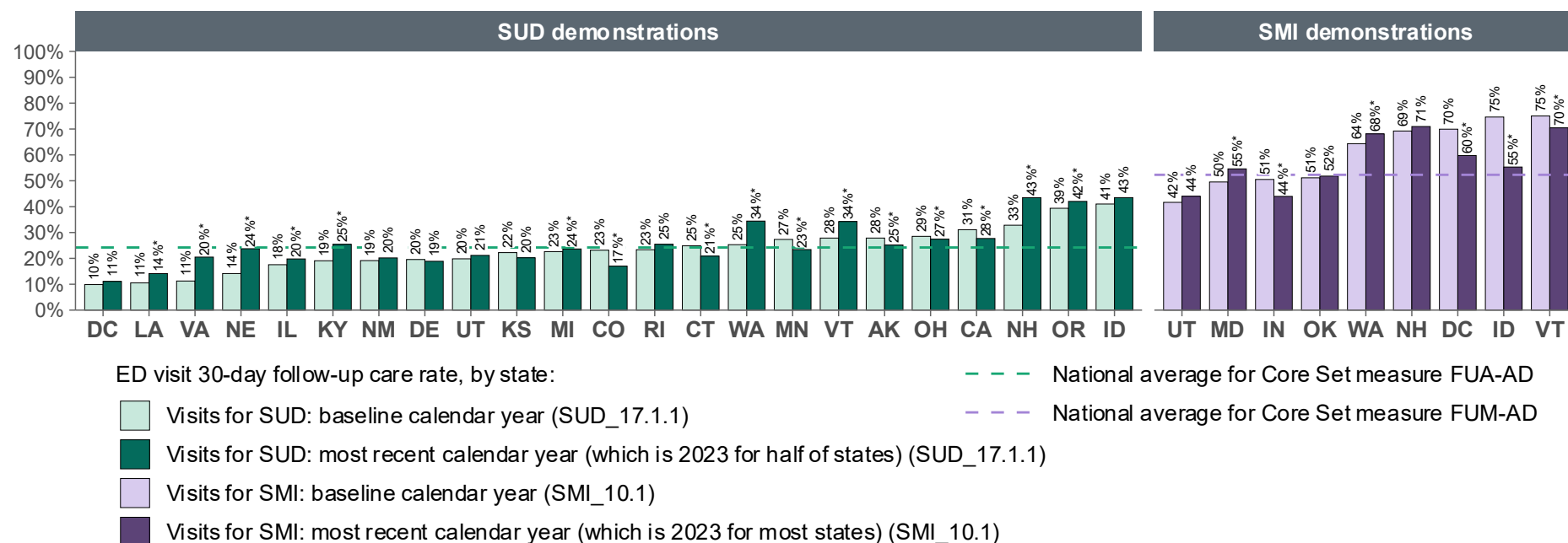
Note: Based on adjusted HEDIS® AAP metric specifications. IN, MA, MD, NH, NV, OK, PA and WV are excluded from the SUD analysis and AL, MA, and NH are excluded from the SMI analysis. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

Most states reported consistently high rates of preventive or ambulatory care for beneficiaries with SUD or SMI. Across all states, the average rate was 89% for SUD demonstrations and 87% for SMI demonstrations in the baseline year, with minimal change (<2%) between the baseline and most recent years.

- Among states reporting data, 12 of 27 states with SUD demonstrations and five of eight states with SMI demonstrations had rates at or above 90% during both baseline and the most recent year. For most states with SUD or SMI demonstrations, the rate was much higher than the national average among Medicaid beneficiaries of 74%, and more comparable to the national average among Medicare and commercial beneficiaries of 95%.¹³ Note that these national benchmarks are not limited to those with an SUD or SMI diagnosis.
- Though rates were consistently high, there was some state-level variation over time. Among the 18 analyzed states with SUD demonstrations with baselines beginning between 2017 to 2019, the rate of preventive or ambulatory care for beneficiaries with an SUD diagnosis declined after the onset of the COVID-19 PHE. Less than half of these 18 states have since returned to or improved relative to their pre-PHE levels for this metric; the rate significantly decreased ($p < 0.05$) in 10 states and significantly increased ($p < 0.05$) in five states. Among 9 states with baselines beginning in 2020 or later, the rate significantly decreased ($p < 0.05$) in four states and significantly increased ($p < 0.05$) in three states.
- Among eight analyzed states with SMI demonstrations, the rate of preventive or ambulatory care for beneficiaries with an SMI diagnosis significantly increased ($p < 0.05$) in four states and significantly decreased ($p < 0.05$) in four states. However, significant differences were greater than one percentage point in only four states (increases in IN, MD, and VT and a decrease in OK).

Rates of follow-up after ED visits for SUD among adults significantly increased in about half of states, but remained lower than the rates of follow-up after ED visits for SMI.



Source: Medicaid Section 1115 SUD and SMI Monitoring Report Workbooks. National average for FUM-AD based on 2024 Core Set (MY 2023) and FUA-AD based on 2022 Core Set (MY 2021) (due to the break in trend in CY 2022 for FUA-AD, as noted below).

Note: Based on adjusted HEDIS® FUA-AD and FUM-AD metric specifications. Due to a break in trend starting with MY 2022 HEDIS® specifications for the SUD metric, the SUD analysis only includes CY 2022 and later years of data from states that continued to use MY 2021 HEDIS® specifications in those years. IN, MA, MD, ME, MT, NC, NJ, NV, OK, PA, WI, and WV are excluded from the SUD analysis and AL and MA are excluded from the SMI analysis. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

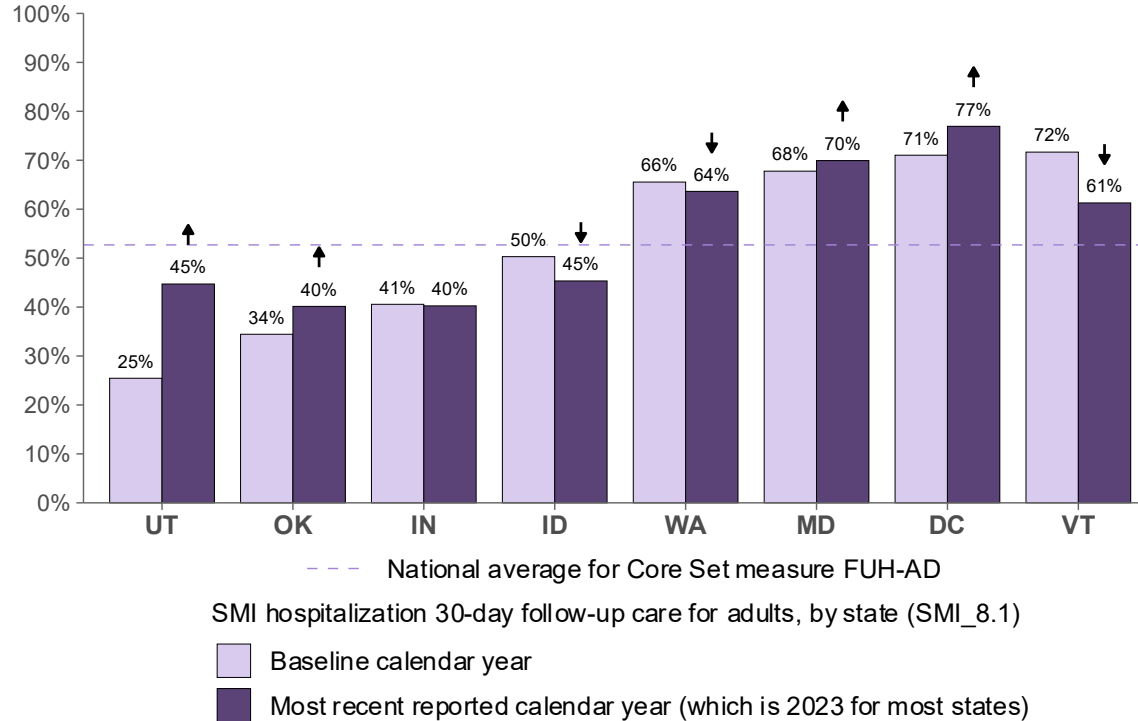
Consistent with national trends, rates of 30-day follow-up after ED visits were higher for SMI-related visits compared to SUD-related visits in both the baseline and most recent year.¹⁴

- The average SUD follow-up rate increased slightly from 23% to 25%, similar to the 2022 Core Set (MY 2021) national average rate of 24%, the most recent year before HEDIS® specification changes.¹⁵
- The average SMI follow-up rate decreased slightly from 61% in the baseline year to 58% in the most recent year, yet it remained higher than the 2024 Core Set (MY 2023) national average rate of 52%.
- Among 23 analyzed states with SUD demonstrations, the follow-up rate for SUD-related ED visits significantly increased ($p < 0.05$) in 10 states and significantly decreased ($p < 0.05$) in six states. Several states attributed decreases to Medicaid eligibility unwinding or provider shortages.
- Among nine analyzed states with SMI demonstrations, the follow-up rate for SMI-related ED visits significantly decreased ($p < 0.05$) in four states and significantly increased ($p < 0.05$) in two states.

Examples of statewide initiatives to improve post-ED care coordination and quality

Three states (NH, VT, and WA) reported high rates of SMI follow-up (>65%) and significant improvement in SUD follow-up ($p < 0.05$). These states are implementing initiatives that may contribute to improvements across the behavioral health system, such as updating discharge planning requirements, implementing community-based crisis care systems, and integrating electronic record and closed-loop referral systems between settings. See CMS's [Improving Behavioral Health Follow-up Care](#) for related resources.

Follow-up after hospitalization for mental illness among adults significantly increased in half of states.



Source: Medicaid Section 1115 SMI Monitoring Report Workbooks. National average based on 2024 Core Set (MY 2023).

Note: Based on adjusted HEDIS® FUH-AD metric specifications. MA, NH and AL are excluded from the analysis. See Appendix Table A.2 for more information.

↑ ↓ The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test. Arrows indicate the direction of the significant change.

Across the eight analyzed states with SMI demonstrations, rates of 30-day follow-up after hospitalization for mental illness among adults significantly increased ($p < 0.05$) in four states and significantly decreased ($p < 0.05$) in three states.

- The average rate in the most recent year among analyzed states with SMI demonstrations was 55%, slightly higher than the 2024 Core Set (MY 2023) national average of 53%.
- Half of states with SMI demonstrations reported rates higher than the 2024 Core Set (MY 2023) national average in the most recently reported calendar year. Other states have more room for improvement due to relatively lower baseline rates.



Examples of coordination and follow-up efforts

States with SMI demonstrations implemented various initiatives intended to increase follow-up after hospitalization and prevent future inpatient utilization by improving access to community-based care for beneficiaries with SMI.

Expanded access to community crisis care

- IN, OK, VT, and ID have introduced Medicaid-reimbursable Mobile Crisis Units.
- OK is expanding Urgent Recovery Clinics to provide crisis stabilization and follow-up care.
- Beginning in 2023, ID is adding youth crisis centers, as well as “privacy pods” at public libraries to use as spaces for private behavioral telehealth appointments in rural areas.

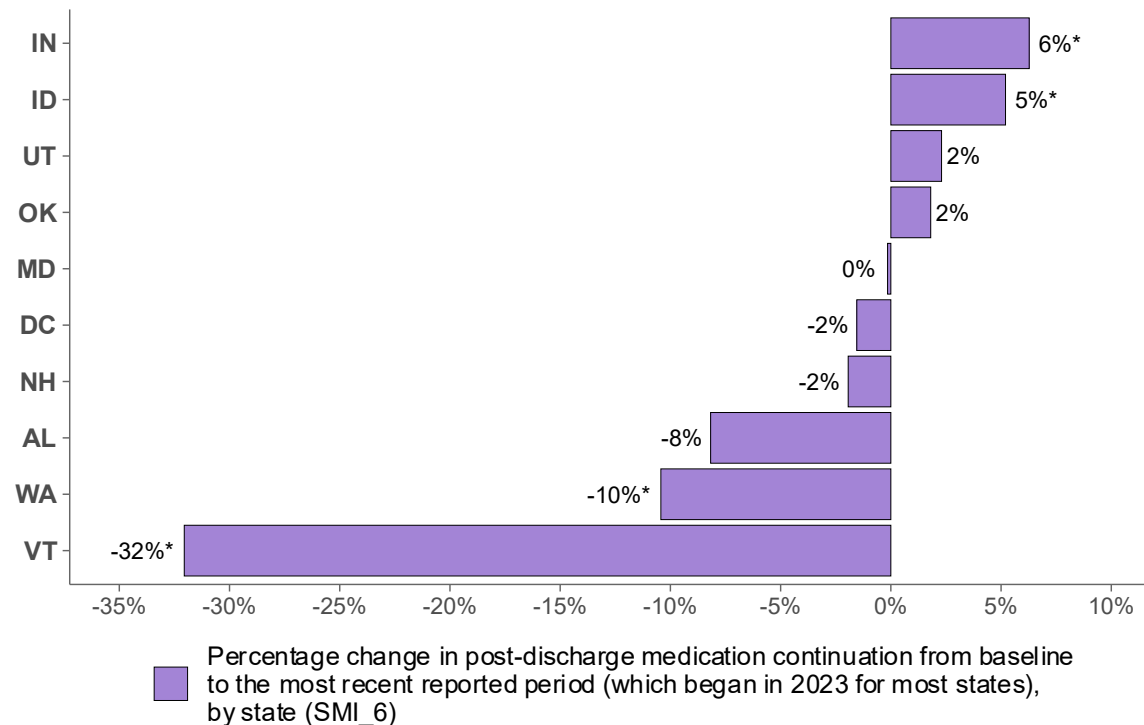
Systemwide integration and coordination

- In 2023, VT expanded its behavioral healthcare system by launching a statewide mobile crisis program and strengthening care transition protocols between inpatient settings and community providers.

Leveraging local and federal funds

- DC increased local funding for community mental health support services, including mental health rehabilitation services, by over 200% since fiscal year 2020.
- IN and VT are leveraging grants from the Substance Abuse and Mental Health Services Administration and 1115 demonstrations to expand Certified Community Behavioral Health Clinics (CCBHCs), which provide 24/7 crisis services.¹⁶

Trends in medication continuation following inpatient psychiatric discharge among adults were mixed.



Source: Medicaid Section 1115 SMI Monitoring Report Workbooks.

Note: This metric uses IPFQR MedCont measure specifications and is designed to be calculated over two calendar years. This figure includes two-year measurement periods from two states (ID and VT) and calendar year data from all other states. MA is excluded from the analysis. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

Among 10 analyzed states with SMI demonstrations, medication continuation following inpatient psychiatric discharge among adults significantly increased ($p < 0.05$) in two states and significantly decreased ($p < 0.05$) in two states.

- In IN, the rate increased from 55% to 58%. In VT, the rate decreased from 69% to 47%.
- Across all states, the average rate of medication continuation following inpatient psychiatric discharge was 68% in the baseline and 65% in the most recent year.

Among these states, the average rate of medication continuation in the most recent year was lower for Medicaid (65%) than for Medicare beneficiaries (77%).¹⁷

- The higher rates among Medicare beneficiaries compared to Medicaid beneficiaries may reflect additional barriers to care that Medicaid beneficiaries face, such as limited availability of appointments with providers and difficulties with transportation.¹⁸
- DC was the only state to report a higher rate for Medicaid beneficiaries compared to Medicare beneficiaries (72% versus 62%).
- VT reported the largest difference between rates; the Medicaid rate was 31 percentage points lower than the Medicare rate (47% versus 78%).

Examples of state efforts intended to improve post-discharge care coordination

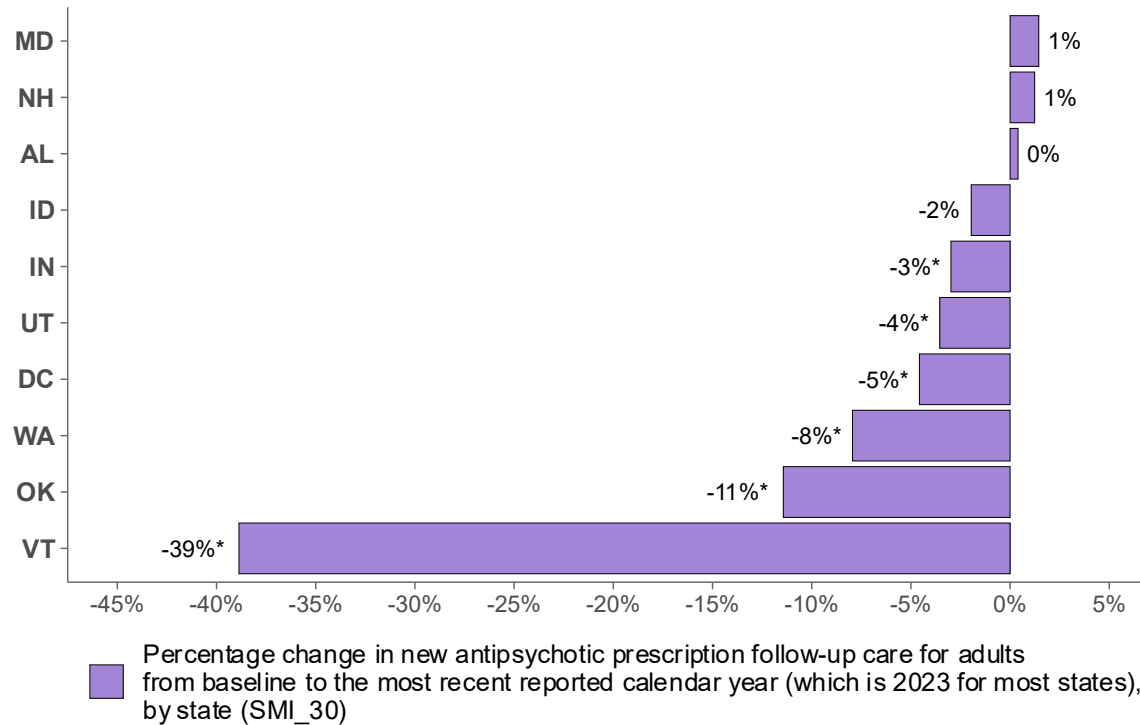
Discharge Planning. States with SMI demonstrations must implement discharge planning processes to meet SMI Milestone 2 requirements.

- In 2020, DC added new transition planning rules for providers that are designed to reduce readmissions and improve coordination after inpatient utilization for SMI and SUD.

Value-Based Care (VBC). CMS requires state Medicaid agencies contracting with MCOs to develop a quality strategy to evaluate and improve healthcare quality and outcomes. Many MCOs use VBC to link provider financial incentives to improved health outcome measures, encouraging better care coordination, including post-discharge planning.

- DC, IN, OK, and VT are using capitated and risk-adjusted managed care contracts and VBC models to incentivize flexible service delivery, stronger care coordination, reduced fragmentation, and improved managed care oversight and accountability.
- IN encourages MCOs to provide integrated physical and behavioral health services and emphasize collaboration across provider networks to ensure patients receive comprehensive and appropriate care.¹⁹

Follow-up care for adults who are newly prescribed an antipsychotic medication significantly decreased in about half of states.



Source: Medicaid Section 1115 SMI Monitoring Report Workbooks.

Note: This metric is CMIT #270. MA is excluded from the analysis. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

Among the 10 analyzed states with SMI demonstrations, the average rate of follow-up care for adults within 28 days of being prescribed a new antipsychotic medication significantly decreased ($p < 0.05$) in six states.

- The average rate across states declined slightly, from 72% at baseline to 67% in the most recent year. AL reported the highest rate (86%), and VT reported the lowest (45%).
- VT reported rates of 69% or higher for this metric in its first three demonstration years (2020–2022) and noted the drop in 2023 may have been related to medication delays stemming from decreased provider availability.
- Four states (DC, IN, UT, and AL) reported consistently high rates of follow-up, over 70%.

Washington's efforts to improve follow-up care for adults on antipsychotics

Coordinated Specialty Care (CSC) for early or first-episode psychosis is an evidence-based service that provides continuous team-based clinical support, including medication management, for two to three years.²⁰

- WA used Mental Health Block Grant funding to launch a CSC pilot in 2015 and expanded the program statewide in 2019.
- As of 2023, WA had 11 CSC teams running with six more in the start-up process.
- WA provided antipsychotic follow-up care to 70% of beneficiaries in 2020 and 64% in 2022.

CSC programs are typically supported by braiding federal, state, and local funds.

- In July 2022, WA added a team-based rate for Medicaid beneficiaries, which is estimated to cover 76% of all CSC program costs.
- Investments in psychosis treatment programs like CSC can generate cost savings by increasing treatment adherence and reducing ED and inpatient utilization.

SECTION IV.
**Reduce Preventable or Medically
Inappropriate ED or Inpatient Use**

Introduction

Both the SUD and SMI demonstrations share the goal of increasing access to care and reducing preventable or medically inappropriate ED utilization (SUD Goal 4, SMI Goal 1). The SUD demonstrations also aim to reduce preventable or medically inappropriate inpatient utilization (SUD Goal 4). Medicaid beneficiaries have higher rates of ED use compared to those with other types of insurance coverage.²¹ Beneficiaries with SUD or SMI may stay in the ED for hours or days if specialty care is unavailable (a practice known as psychiatric ED boarding).²²

In regions with limited access to acute inpatient treatment and intermediate care, beneficiaries with SUD or SMI needs often seek care in emergency settings when they could be better served in community-based settings.²³ As states improve availability and access to community-based and specialty SUD or SMI treatment, the share of SUD and SMI service utilization that occurs in ED or inpatient settings is expected to decrease.

In this section, we assessed trends for cohorts of states defined by their baseline year. This section includes data about the following topics and metrics:

A. Emergency department utilization (SUD and SMI)

ED utilization is measured differently for SUD and SMI demonstration metrics.

Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries (SUD_23) measures the total number of ED visits for SUD per 1,000 Medicaid beneficiaries. The measure includes ED visits with an SUD diagnosis in any position on the claim, which captures a range of ED visits that are related to SUD. Lower rates are better.

Mental Health Services Utilization - ED (SMI_16) measures the count of Medicaid beneficiaries who received services for mental health in the ED during the measurement period. SMI_16 counts visits with a principal mental health diagnosis to distinguish mental health-related ED visits from SUD-related visits among beneficiaries with co-occurring SUD and SMI. Consistent with our SMI/SED utilization analyses in Section II, we divide SMI_16 by Mental Health Services Utilization - Any Services (SMI_18) to show the share of all mental health service utilization that occurred in the ED. Lower rates are better.

B. Inpatient stays (SUD)

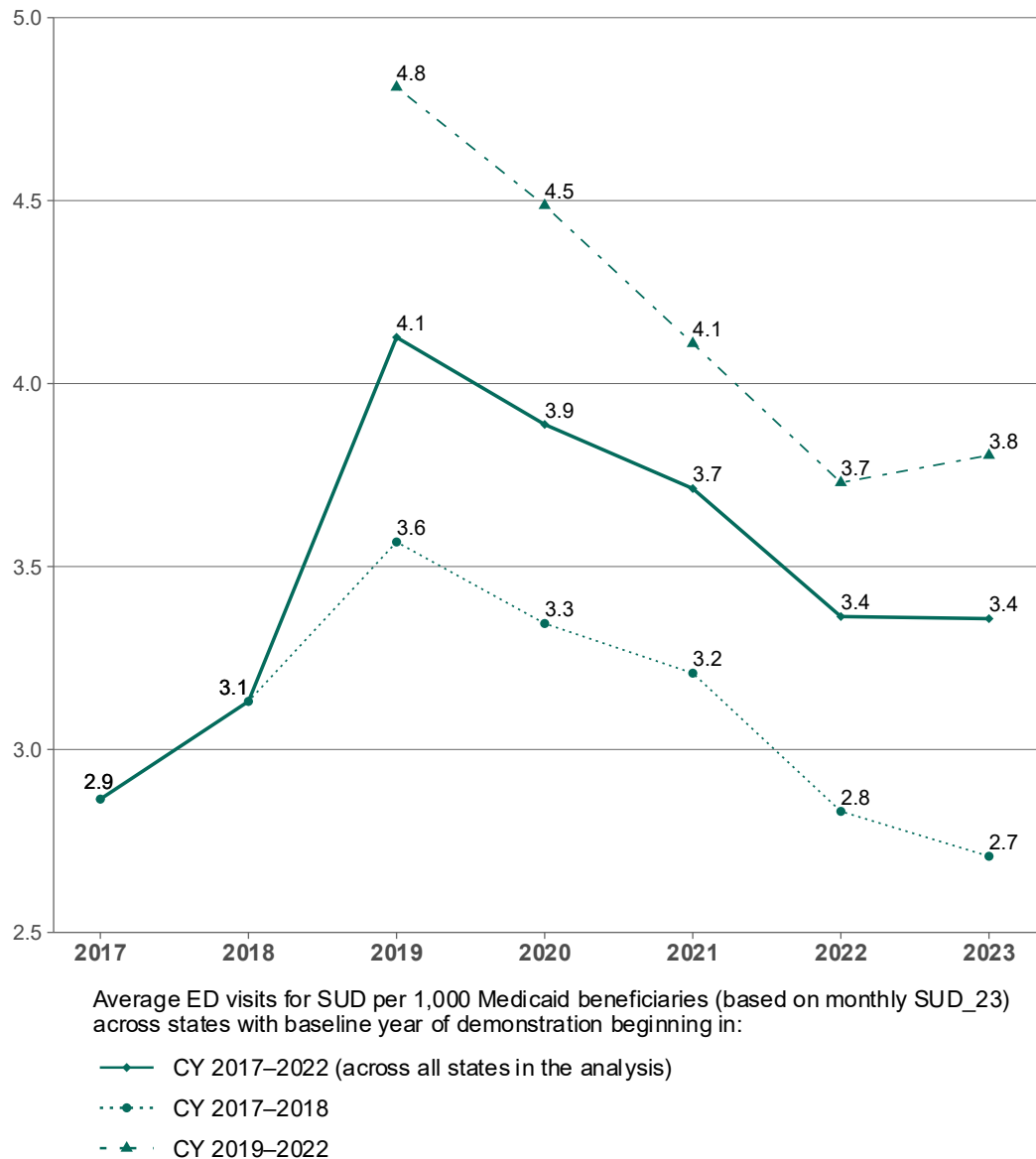
Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries (SUD_24) measures the total number of inpatient stays for SUD per 1,000 Medicaid beneficiaries. While SUD_10 (see Section II) includes only residential and inpatient stays with a principal diagnosis of SUD (aiming to capture utilization of SUD treatment), SUD_24 is a broader measure, including inpatient stays with an SUD diagnosis in any position on the claim.²⁴ Lower rates are better.



Key takeaways

- Average ED utilization and inpatient stays for SUD per 1,000 Medicaid beneficiaries both decreased from 2019 through 2023 across analyzed states with SUD demonstrations. This sustained decrease in ED visits for SUD contrasts with the national increase in all-payer SUD-related ED use during this period.
- Average ED utilization for SMI remained steady across most of the analyzed states with SMI demonstrations from 2020 to 2023. Averaging across seven of nine states, 1 to 2% of beneficiaries receiving mental health treatment accessed care in an ED setting each year.

Average ED utilization for SUD per 1,000 Medicaid beneficiaries decreased since 2019.



Source: Medicaid Section 1115 SUD Monitoring Report Workbooks.

Note: The CY 2017–2018 baseline group includes IL, LA, MD, NC, NH, NJ, UT, VA, VT, WA, and WV. The CY 2019–2022 baseline group includes AK, CO, CT, DC, DE, KS, KY, ME, MI, MN, MT, NE, NM, OH, OR, and WI. CA, ID, IN, MA, NV, OK, PA, and RI are excluded from the analysis. See Appendix Table A.2 for more information. Statistical significance of changes is not assessed.

In analyzed states with SUD demonstrations, average ED utilization for SUD per 1,000 Medicaid beneficiaries decreased from 2019 to 2023.

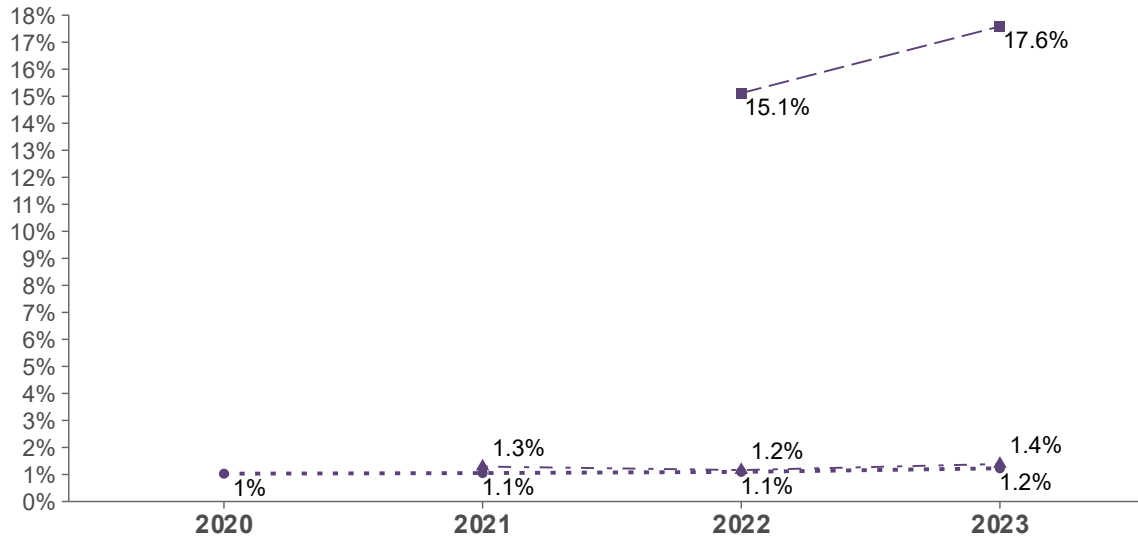
- Among the 11 states with a baseline year beginning in 2017 or 2018, average ED visits for SUD increased until 2019 and then decreased.
- In the 16 states with a baseline year beginning in 2019 and later, average ED visits for SUD also decreased from 2019 to 2023. These states had a higher average rate than states with earlier baseline years. The slight increase in the average from 2022 to 2023 is driven by a large increase in one state.
- This sustained decrease in ED utilization for SUD contrasts with national all-payer increases in SUD-related ED use (see box). The reason for these contrasting trends is unclear. Demonstration efforts to reduce ED use may have played a role. Another factor may be that the increase in Medicaid enrollment in 2020–2023 (resulting from maintenance of eligibility requirements during the COVID-19 PHE) increased the number of Medicaid beneficiaries, but these additional enrollees were less likely to use the ED for SUD, driving a decline in rates.



National data on ED visit trends

- External data show that from 2013–2018, ED visits for SUD increased, and became a larger share of total ED visits.²⁵
- National ED visit rates changed with the COVID-19 PHE. Between March and July 2019 and the same months in 2020, ED visits for SUD declined by about 17%.²⁶
- ED utilization for SUD rebounded to 2019 rates by the latter half of 2020, earlier than other ED visits.²⁷ From 2022–2023, national ED visits for SUD continued to increase, with the frequency of ED visits related to SUD increasing by about 6%.²⁸

ED utilization for mental health services has not changed significantly during SMI demonstrations and was low in most states.



Average percentage of demonstration beneficiaries using ED services among those using any SMI/SED service (SMI_16/SMI_18), across states with baseline year of demonstration beginning in:

- CY 2020 (ID, IN, VT, WA) - -▲- - CY 2021 (OK, UT)
- CY 2022 (AL, MD, NH)

Source: Medicaid Section 1115 SMI Monitoring Report Workbooks.

Note: DC and MA are excluded from the analysis. See Appendix Table A.2 for more information. Figure includes data that were included in the regression analysis (see Section IX for details). Therefore, data from before April 2020 and some outlier data were excluded.

The average across most analyzed states with SMI demonstrations remained steady from 2020 to 2023. Averaging across seven of nine states, 1 to 2% of beneficiaries receiving mental health treatment accessed care in an ED setting each year. A regression analysis (data not in figure) did not show any statistically significant change in ED utilization rate relative to the baseline.

- Average ED utilization rates across calendar years were lowest among states that began SMI demonstrations in 2020 and 2021. All states in these cohorts had average rates below 1.0% except for OK (2.5%) and WA (2.7%).
- States with baselines beginning in 2022 had a wider range of average rates across calendar years, likely reflecting underlying differences in statewide behavioral health systems of care—1.6% in NH, 10.9% in MD, and 37% in AL.
- Average ED utilization remained steady over time in all states but one. In AL, ED utilization increased from 33% in 2022 to 40% in 2023. The SMI demonstration population in AL (short-term residents in IMDs in two counties with large gaps in behavioral health service availability) may help explain AL's higher rates.
- Nationwide, the rate of mental health-related ED visits peaked during the COVID-19 PHE and has since decreased.²⁹



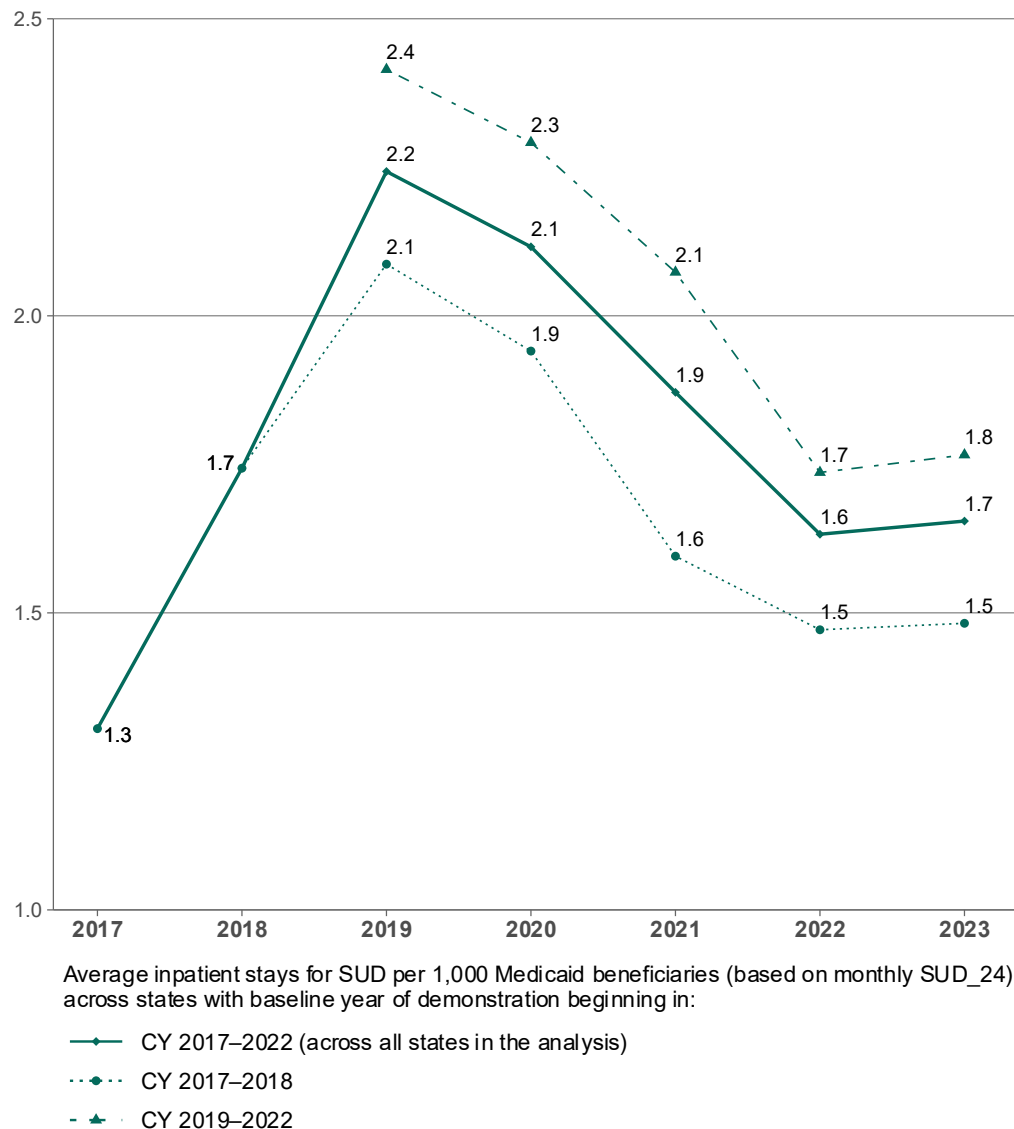
State efforts to reduce ED utilization for SMI

Most states are implementing demonstration activities related to expanding access to ED alternatives for SMI crisis treatment, such as mobile crisis teams, crisis stabilization centers, 988 call centers, and crisis coordination programs. Several states provide targeted outreach and care coordination to populations at high risk for ED utilization, including for beneficiaries:

- With co-occurring SUD and SMI (OK, VT)
- Re-entering from criminal justice settings (NH)

A major health system in AL provides psychiatric consultation to six hospital providers in ED settings to support care transitions. As of July 2024, the system has four sites certified as CCBHCs that coordinate with local hospitals and provide 24-hour crisis care to help prevent ED use.³⁰

Similar to ED utilization, the average rate of inpatient stays for SUD per 1,000 Medicaid beneficiaries has decreased since 2019.



Source: Medicaid Section 1115 SUD Monitoring Report Workbooks.

Note: The CY 2017–2018 baseline group includes IL, LA, MD, NC, NH, NJ, UT, VA, VT, WA, and WV. The CY 2019–2022 baseline group includes AK, CO, CT, DC, DE, KS, KY, ME, MI, MN, MT, NE, NM, OH, OR, RI, and WI. CA, ID, IN, MA, NV, OK, and PA are excluded from the analysis. See Appendix Table A.2 for more information. Statistical significance of changes is not assessed.

Like the trend for ED utilization for SUD, average inpatient utilization for SUD per 1,000 Medicaid beneficiaries decreased from 2019 to 2023.

- Among the 11 states with a baseline year beginning in 2017 or 2018, average inpatient stays for SUD increased until 2019 and then decreased.
- In the 17 states with a baseline year beginning in 2019 and later, average inpatient stays for SUD also decreased from 2019 to 2023. As with ED utilization for SUD, these states had a higher average rate than states with earlier baseline years.



State efforts to reduce ED utilization and inpatient stays for SUD

States reported numerous activities designed to reduce inpatient stays for SUD, often focused on ensuring that beneficiaries receive treatment in lower and more appropriate levels of care.

- In NM, MCOs have focused on case management for individuals with SUD. They leveraged data related to ED and inpatient admissions to ensure timely follow-up care through appropriate community providers. The state also funded the placement of certified peer support workers in hospitals to support people with SUD who visit the ED, and it launched new CCBHCs to reduce reliance on ED and inpatient settings.
- CO is working to create pathways to allow hospitals to initiate MAT within the ED and expanding provider capacity for services (such as withdrawal management and the American Society of Addiction Medicine 3.7 level of care) that it expects may help to reduce ED utilization.
- NJ suggested that the decrease in inpatient stays may be related to its Prevention is Key initiative, which focuses on harm reduction, recovery support, and prevention services.

SECTION V.
Reduce Preventable Readmissions

Introduction

SUD and SMI demonstrations both aim to reduce the rate of unplanned, preventable, acute inpatient readmissions for beneficiaries with SUD or SMI (SUD Goal 5, SMI Goal 2). Preventable readmissions are costly to healthcare systems, disruptive to patients, and increase the risk of complications.³¹ Patients with SUD are at higher risk of preventable readmissions.³² Higher rates of follow-up after inpatient psychiatric hospitalization are associated with lower rates of readmission.³³

The readmissions metrics for SUD and SMI focus on different populations, facilities, index diagnoses, and types of readmissions. The SUD metric focuses on all-cause readmissions among those with SUD discharged from a variety of acute inpatient settings. The SMI metric, by contrast, is based on the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization measure (IPFQR READM-30-IPF), which is tailored to the psychiatric patient population and to discharges from inpatient psychiatric facilities (IPFs). It supports monitoring the quality of care provided by IPFs.

For Medicaid beneficiaries with SUD, **Readmissions Among Beneficiaries with SUD (SUD_25)** measures the rate of unplanned, acute, 30-day readmission—for any reason and to any setting—following an acute inpatient discharge, among beneficiaries with a history of SUD diagnosis and any acute inpatient diagnosis at discharge. The measurement period is the demonstration year. Lower rates are better.

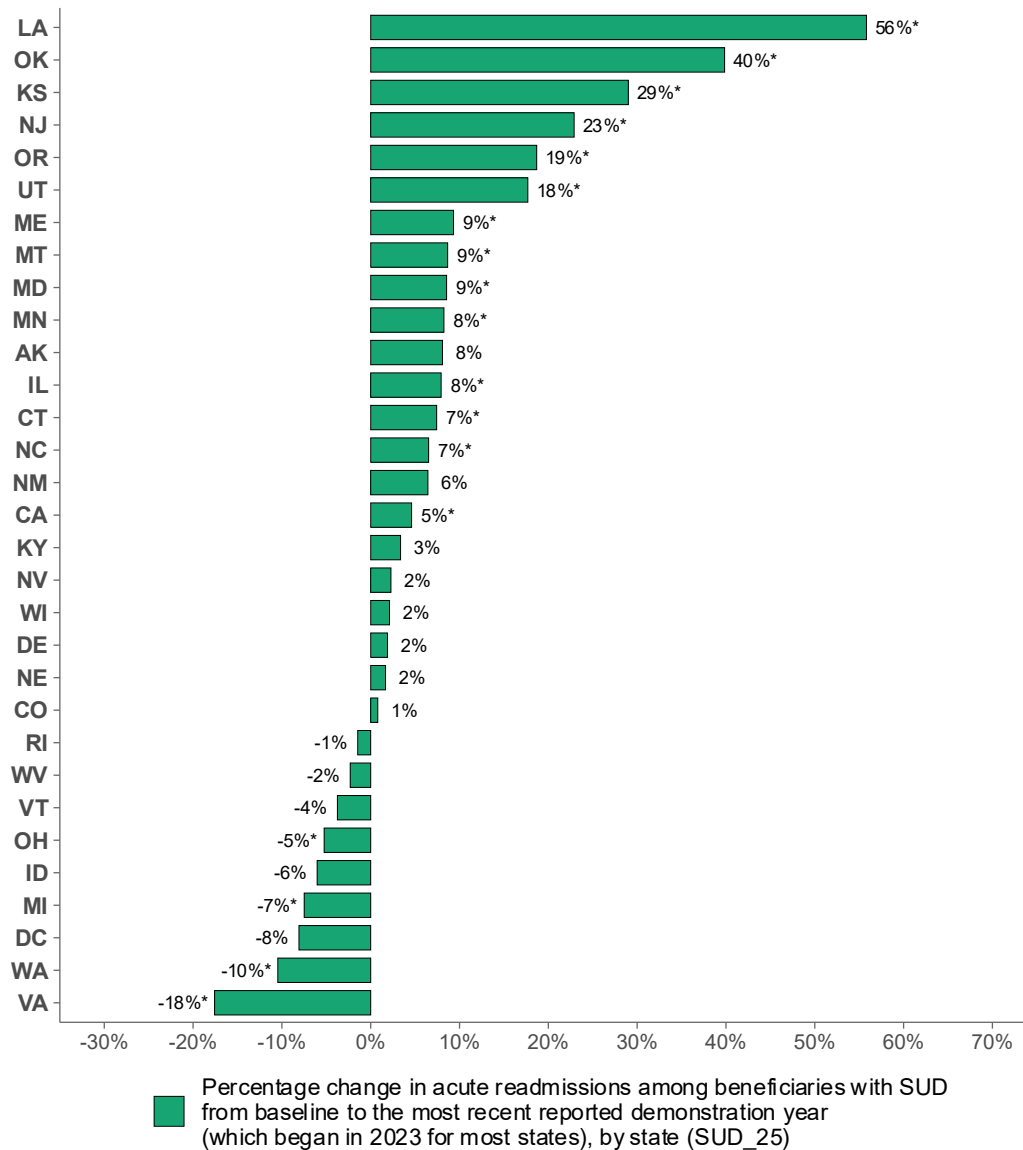
For Medicaid beneficiaries with SMI, **30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) (SMI_4)** measures the rate of unplanned, 30-day readmission—for any reason—to an IPF or short-stay acute care hospital, following discharge from an IPF, among beneficiaries with a principal discharge diagnosis of a psychiatric disorder. The measurement period is a calendar year. Lower rates are better.



Key takeaways

- Among states with SUD demonstrations, the readmission rate among beneficiaries with SUD significantly increased ($p < 0.05$) in about half of states.
- Among states with SMI demonstrations, the readmission rate following discharge from IPFs significantly increased ($p < 0.05$) in about half of states.
- The average readmission rate in the most recent year across states with SMI demonstrations was slightly lower than the national average rate among Medicare beneficiaries staying in IPFs.

Readmission rates among beneficiaries with SUD significantly increased in about half of states with SUD demonstrations.



In the 31 analyzed states with SUD demonstrations, the average acute readmission rate among beneficiaries with SUD significantly increased ($p < 0.05$) in 14 states, significantly decreased ($p < 0.05$) in four states, and did not significantly change in 13 states. The average rate was 19% in the baseline year and 20% in the most recent year.

- In the most recent year, the readmission rate ranged from 8% in MD to 33% in ME.
- The largest increases in the figure represent an increase in LA from 21% to 33% and OK from 12% to 16%.
- The largest decreases in the figure represent a decrease in VA from 25% to 20% and in WA from 16% to 15%.



Examples of state efforts to reduce readmissions among beneficiaries with SUD

States have worked to address SUD-related readmissions by improving post-acute care coordination and expanding access to lower levels of care.

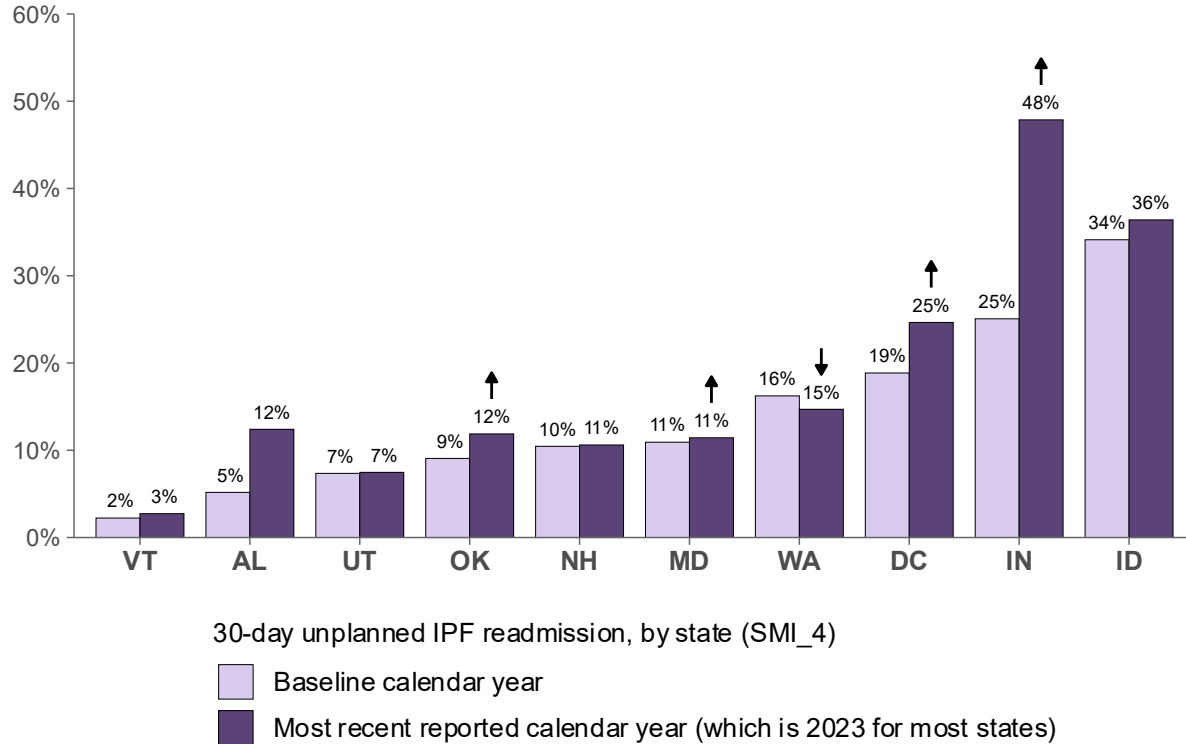
States with declining readmission rates attributed progress to factors such as better care level alignment and provider training (DC), expanded access to outpatient and community-based services (MI), and improved care coordination and integration of behavioral health and SUD services (VA).

Source: Medicaid Section 1115 SUD Monitoring Report Workbooks.

Note: IN, MA, NH, and PA are excluded from the analysis. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

Readmission rates following discharge from IPFs significantly increased in about half of states with SMI demonstrations.



Source: Medicaid Section 1115 SMI Monitoring Report Workbooks.

Note: This metric uses IPFQR READM-30-IPF measure specifications. MA is excluded from the analysis. See Appendix Table A.2 for more information.

↑ ↓ The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test. Arrows indicate the direction of the significant change.

Between the baseline and the most recent year, the average readmission rate following discharge from IPFs among 10 analyzed states with SMI demonstrations increased from 14% to 18%. The most recent year's average was slightly lower than the national average rate of 19% among Medicare fee-for-service beneficiaries staying in IPFs.³⁵

- The readmission rate significantly increased ($p < 0.05$) in four states and significantly decreased ($p < 0.05$) in one state. Like readmissions among beneficiaries with SUD, more states had increasing rates than decreasing.
- In the most recent year, unplanned IPF readmission rates among Medicaid beneficiaries with SMI ranged from 3% in VT to 48% in IN. In 2021–2023, the estimated readmission rate among Medicare fee-for-service beneficiaries staying in IPFs across all states nationally ranged from 11% to 27%.³⁶ Prior studies have also shown considerable variation in IPF readmissions across states, facility types, and characteristics of patient populations, including significant interactions with the percentage of discharges paid for by Medicaid.³⁷



Examples of state efforts to reduce readmissions among beneficiaries with SMI

Interventions such as improved discharge planning, provider coordination, and structured needs assessments can reduce the risk of psychiatric hospital readmission.³⁴

- To receive full capitated payments, MCOs in DC are required to reduce preventable hospital admissions and 30-day readmissions. MCOs are responsible for providing care coordination and transitional services between different care settings, including inpatient discharge planning, case management, and coordination with community providers. DC attributed reductions in psychiatric inpatient utilization to these improved care coordination efforts.
- In 2024, AL strengthened its efforts to ensure intensive pre-discharge planning in psychiatric hospitals and residential treatment settings. Specifically, the state added twice-weekly staff meetings involving Community Mental Health Center representatives, during which discharge goals are developed collaboratively with patients, guardians, and providers.

SECTION VI.
Reduce Overdose Deaths

Introduction

The SUD demonstrations aim to reduce overdose deaths, particularly those due to opioids (SUD Goal 3). States must also undertake prevention strategies, including implementing opioid prescribing guidelines to prevent opioid abuse (SUD Milestone 5).

This section includes data about the following topics and metrics:

A. SUD prevention strategies

States with SUD demonstrations report two metrics related to prevention strategies that address opioid prescribing:³⁸

Use of Opioids at High Dosage in Persons Without Cancer (SUD_18) measures the percentage of beneficiaries aged 18 and older who receive prescriptions for opioids with a daily dosage greater than 90 morphine milligram equivalents (MME) for 90 days.³⁹ This measure is important because clinical evidence indicates that higher opioid dosages are associated with increased risks for motor vehicle injury, OUD, and overdose, while the benefits of high-dose opioids for chronic pain have not been established in the clinical literature.⁴⁰ Lower rates are better.

Concurrent Use of Opioids and Benzodiazepines (SUD_21) measures the percentage of beneficiaries aged 18 and older who have at least two prescription claims for opioid medications with a cumulative supply of at least 15 days, and who concurrently use prescription opioids and benzodiazepines.⁴¹ This measure is important in overdose prevention because benzodiazepines contributed to nearly 14% of overdose deaths involving opioids in 2021.⁴² In 2022, the Centers for Disease Control and Prevention (CDC) released updated guidelines that continue to caution against prescribing benzodiazepines concurrently with opioids.⁴³ Lower rates are better.

B. Overdose death

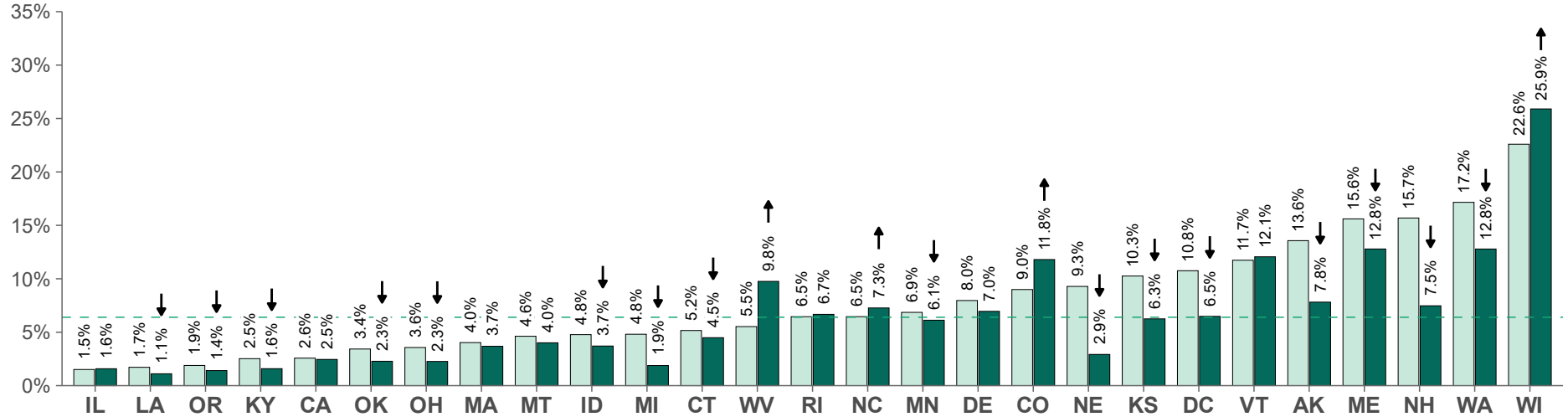
Overdose death rates (SUD_27) measures the rate of overdose deaths among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. Lower rates are better.



Key takeaways

- Measures of opioid prescribing suggest that many states with SUD demonstrations are making progress reducing inappropriate prescribing.
 - Use of opioids at high dosage in persons without cancer significantly decreased ($p < 0.05$) in over half of states.
 - Concurrent use of prescription opioids and benzodiazepines significantly decreased ($p < 0.05$) in most states.
- Overdose death rates significantly increased ($p < 0.05$) in about half of states, in line with national trends during the periods reflected in the data. We expect that future monitoring data will reflect the 2024 national decreases in overdose deaths.

Use of opioids at high dosage in persons without cancer significantly decreased in over half of states.



Use of opioids at high dosage in persons without cancer, by state (SUD_18):



Baseline calendar year

Most recent reported calendar year (which is 2023 for most states)

--- National average for Core Set measure OHD-AD

Source: Medicaid Section 1115 SUD Monitoring Report Workbooks. National average based on 2024 Core Set (MY 2023).

Note: Based on adjusted HEDIS® OHD-AD metric specifications. Analysis excludes 2017 data due to a break in trend associated with 2018 technical specifications updates. IN, MD, NJ, NM, NV, PA, UT, and VA are excluded from the analysis. See Appendix Table A.2 for more information.

↑ ↓ The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test. Arrows indicate the direction of the significant change.

Rates of opioid use at high dosage significantly decreased ($p < 0.05$) in 16 of 27 analyzed states. The rate significantly increased ($p < 0.05$) in four states and did not significantly change in seven states. The rates changed similarly across states regardless of SUD demonstration start date.

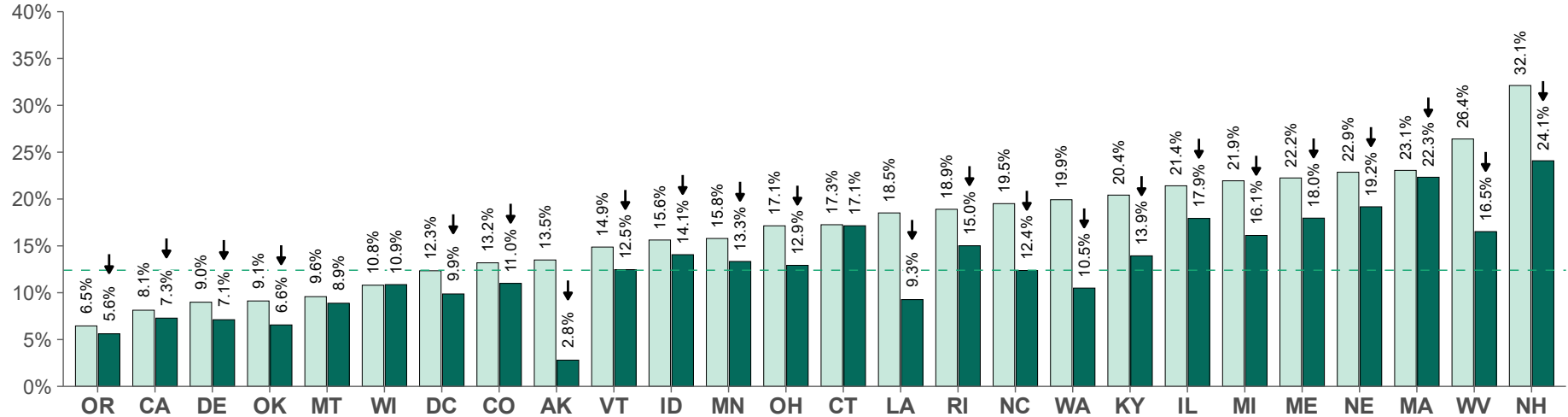
- The average rate across states also decreased from the baseline (7.8%) to most recent year (6.4%). The average rate in the most recent year was the same as the 2024 Core Set (MY 2023) national average rate.



Example of state efforts to address use of opioids at high dosages

Many states reported a range of programs and policies addressing use of opioids at high dosage, such as implementing effective and stricter prescribing guidelines and prior authorization requirements, enhancing the functionality and content of prescription drug monitoring programs to increase program use, and offering provider resources and education.

Concurrent use of prescription opioids and benzodiazepines significantly decreased in most states.



Concurrent use of prescription opioids and benzodiazepines, by state (SUD_21):

Baseline calendar year

Most recent reported calendar year (which is 2023 for most states)

--- National average for Core Set measure COB-AD

Source: Medicaid Section 1115 SUD Monitoring Report Workbooks. National average based on 2024 Core Set (MY 2023).

Note: Based on adjusted HEDIS® COB-AD metric specifications. 2017 is excluded from the analysis due to changes in metric specifications. IN, KS, MD, NJ, NM, NV, PA, UT, and VA are excluded from the analysis. See Appendix Table A.2 for more information.

↑ ↓ The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test. Arrows indicate the direction of the significant change.

Concurrent use of prescription opioids and benzodiazepines significantly decreased ($p < 0.05$) in 23 of 26 analyzed states. There was no significant change in three states.

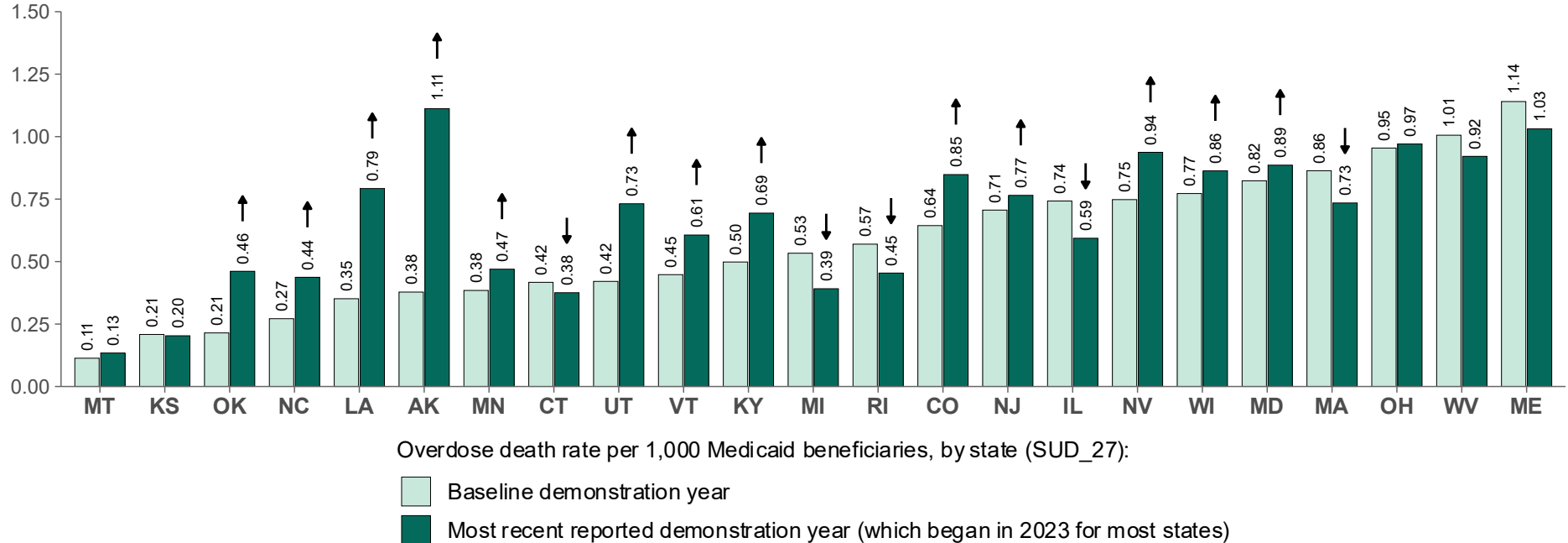
- Rates and trends varied by states' baseline start date. The rates significantly decreased ($p < 0.05$) in all 17 states with demonstration baseline years beginning in 2020 or earlier (declining from an average of 18.8% to 13.4%). These states started with higher baselines and have had more time to make progress in reducing the rate. All three states in which the rate did not significantly change had baseline start dates in 2021 or 2022. Across the nine states with baselines start dates in 2021 or 2022, the average baseline rate was 13.3% and the average most recent rate was 12.0%.
- The average rate for the most recent year was 12.9%, which is comparable to the 2024 Core Set (MY 2023) national average rate of 12.4%.



Impact of opioid prescribing guidelines

The 2016 Opioid Prescribing Guidelines by the CDC and rescheduling of hydrocodone may have influenced declines in concurrent use of opioids and benzodiazepines. In one study, concurrent use decreased from 19.3% to 9.8% from 2013 to 2019.⁴⁴ Additionally, the number of opioid prescriptions has been declining since 2012 and further decreased with the emergence of the 2016 Opioid Prescribing Guidelines.^{45,46} In 2022, the CDC released Clinical Practice Guidelines for Prescribing Opioids for Pain, which updated the 2016 Guidelines and newly included recommendations for managing acute, subacute, and chronic pain.⁴⁷

Overdose death rates significantly increased in about half of states.



Source: Medicaid Section 1115 SUD Monitoring Report Workbooks.

Note: CA, DC, DE, ID, IN, NE, NH, NM, OR, PA, VA, and WA are excluded from the analysis. See Appendix Table A.2 for more information.

↑ ↓ The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test. Arrows indicate the direction of the significant change.

Among 23 analyzed states with SUD demonstrations, overdose death rates per 1,000 Medicaid beneficiaries significantly increased ($p < 0.05$) in 13 states, significantly decreased ($p < 0.05$) in five states, and did not change significantly in five states. The average rate across states rose from 0.57 to 0.67 per 1,000 from the baseline to most recent years.

- The direction of changes was associated with baseline rates. Significant increases ($p < 0.05$) in overdose death rates were somewhat more common among states with below-average baselines (eight of 13 states) compared to states with above-average baselines (five of 10 states).
- The increases are in line with national trends in overdose death rates, which increased by about 50% from 2017 to 2022.⁵⁰ National rates then decreased by about 4% from 2022 to 2023⁵¹ and about 27% from 2023 to 2024.⁵² Notably, the most recent reported demonstration year ended before 2024 in 13 of 23 states. We expect that future monitoring data will reflect the 2024 national decreases in overdose deaths.
- To prevent overdose deaths, states are implementing a range of strategies such as increasing distribution of naloxone and fentanyl testing strips.

Impact of fentanyl on overdose deaths

Many states cited fentanyl as a factor in their high or rising overdose death rates. Fentanyl is a potent synthetic opioid that can be fatal at as low as 2 milligrams. Fentanyl is often mixed with other ingredients in illicit drugs and without testing it is impossible to determine its presence.⁴⁸

Overdose deaths due to fentanyl and fentanyl analogs rose sharply from 2013 to 2022 and then decreased by 2.2% from 2022 to 2023.⁴⁹

SECTION VII.
Improve Care for Children and
Adolescents with SED

Introduction

The SMI demonstrations aim to provide more comprehensive treatment to children and adolescents with SED by improving coordination between inpatient and outpatient mental health care providers and integration of behavioral and physical health systems (SMI Goals 4 and 5).

High-quality care for children and adolescents with psychotic symptoms should include documented use of psychosocial care prior to new antipsychotic prescriptions⁵³ and regular blood tests to identify weight and metabolic changes while children are on antipsychotics.⁵⁴ For children who require inpatient mental health treatment, follow-up care after hospitalization (such as a visit with an outpatient mental health provider) helps improve health outcomes in the days following discharge from inpatient mental health treatment.⁵⁵

A. High-quality and integrated care for children with SED taking antipsychotic medications

Antipsychotic medications can elevate a child's risk for developing serious metabolic health complications, including alterations in glucose metabolism, lipid abnormalities, and weight gain, which can lead to poor cardiometabolic outcomes in adulthood, such as type 2 diabetes.⁵⁶ Because of the risks associated with antipsychotics, psychosocial care is recommended as the first-line treatment for most psychiatric conditions in children and adolescents.

States with SMI demonstrations report two metrics that assess the quality of care provided to children ages 1 to 17 with SED who are prescribed antipsychotic medications. Both metrics are designed to help healthcare providers reduce or mitigate the risks associated with antipsychotic medication use among children. Higher rates are better.

- **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (SMI_2)** measures the percentage of children with SED who had documented psychosocial care as a first-line treatment (between 90 days prior to and 30 days after a new antipsychotic prescription).⁵⁷
- **Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing (SMI_29.1)** measures the percentage of children with SED who had two or more antipsychotic prescriptions and who received blood glucose testing. SMI_29 has two other rates, which measure the rate of cholesterol testing (SMI_29.2), and both glucose and cholesterol testing (SMI_29.3). These rates are described in the narrative text but not shown in the figure.

B. Care coordination for children with SED hospitalized for mental illness or intentional self-harm

30-Day Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (SMI_7.1)

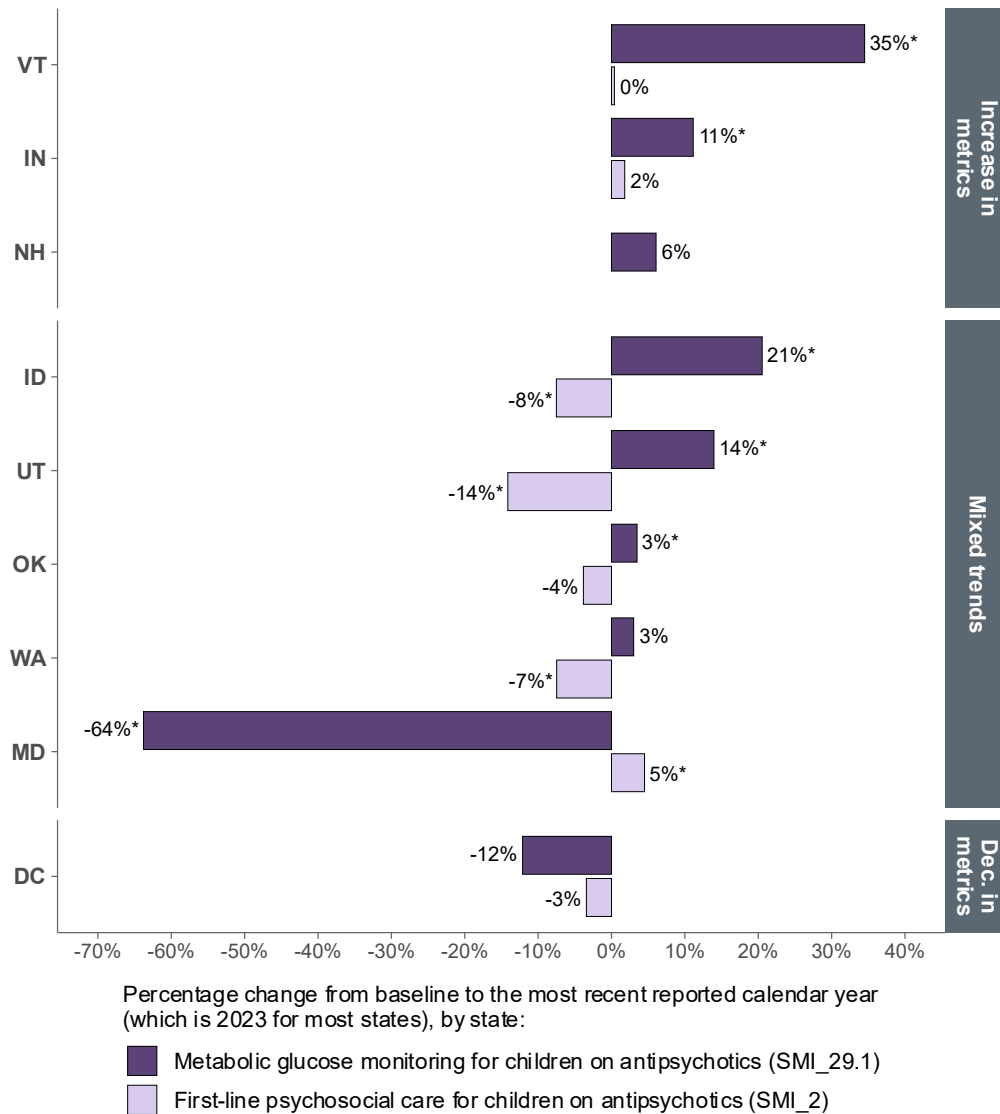
(SMI_7.1) measures the percentage of children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within 30 days after discharge. States also report seven-day follow-up rates. Higher rates are better.



Key takeaways

- Blood glucose testing for children on antipsychotics significantly increased ($p < 0.05$) in about half of the analyzed states with SMI demonstrations.
- States have opportunities to further improve care for children on antipsychotics:
 - The average rate of blood glucose testing was lower than the Core Set national average in the most recent year.
 - The rate of first-line psychosocial care significantly decreased ($p < 0.05$) in three states, contributing to a slightly lower average rate in the most recent year compared with the baseline.
- Most states' 30-day follow-up rate after hospitalization for mental illness among children remained steady from baseline to the most recent year. On average, the follow-up rate for children was higher than the follow-up rate for adults (see Section III).

While blood glucose testing for children on antipsychotics significantly increased in about half of states, states have opportunities to further improve care for children on antipsychotics.



Between the baseline and most recent year, the glucose testing rate among children ages 1–17 taking antipsychotics significantly increased ($p < 0.05$) in five of 9 states and significantly decreased ($p < 0.05$) in one state.

- The average glucose testing rate in the most recent year was 43%, lower than the 2024 Core Set (MY 2023) national average rate of 55%.
- The average rate of cholesterol testing (SMI_29.2) and cholesterol and glucose testing (SMI_29.3) significantly increased ($p < 0.05$) in four states (ID, IN, OK, and VT; data not in figure).
- SMI_29.2 significantly decreased ($p < 0.05$) in three states (DC, MD, and UT; data not in figure). DC attributed the decline to fewer well-child visits contributing to fewer lab tests.
- All three rates significantly decreased ($p < 0.05$) in MD (figure includes only SMI_29.1). The state attributed these declines to post-COVID changes in enrollment and utilization and to small denominators.

The average rate of psychosocial care decreased slightly, from 66% at baseline to 64% in the most recent year, but remained slightly higher than the 2024 Core Set (MY 2023) national average of 62%.

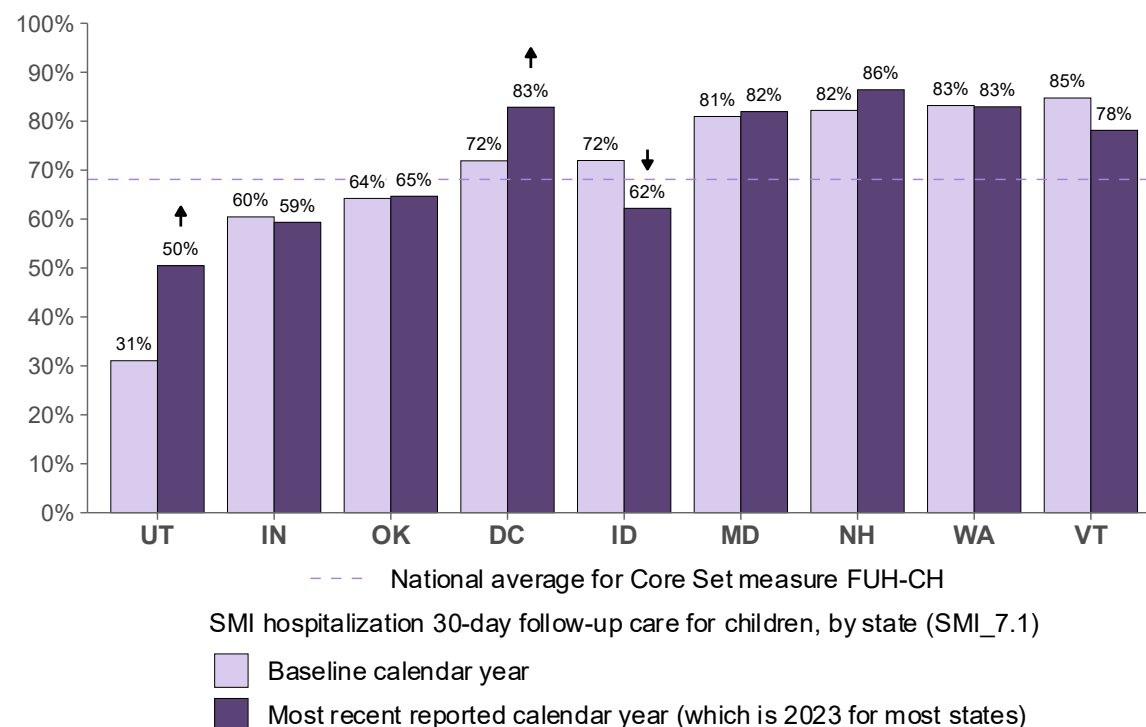
- Rates of children ages 1–17 receiving psychosocial care significantly decreased ($p < 0.05$) in three of eight states and significantly increased ($p < 0.05$) in one state.
- ID attributed the decline in psychosocial care to pandemic-related access barriers, and has since expanded access to care by adding a CCBHC. Other states did not provide details on policy changes that may have contributed to trends.

Source: Medicaid Section 1115 SMI Monitoring Report Workbooks.

Note: Based on adjusted HEDIS® APM-E and APP metric specifications. Three rates are reported for SMI_29: glucose (shown in figure), cholesterol, and glucose and cholesterol. AL and MA are excluded from the analysis, and NH is included only for SMI_29. See Appendix Table A.2 for more information.

* The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test.

Most states' 30-day follow-up rate after hospitalization for mental illness among children remained steady from baseline to the most recent year.



Source: Medicaid Section 1115 SMI Monitoring Report Workbooks. National average based on 2024 Core Set (MY 2023).

Note: Based on adjusted HEDIS® FUH-CH metric specifications. AL and MA are excluded from the analysis. See Appendix Table A.2 for more information.

↑ ↓ The difference between the baseline and most recent reported value is statistically significant ($p < 0.05$) based on z-test. Arrows indicate the direction of the significant change.

Among nine analyzed states with SMI demonstrations, the average rate of 30-day follow-up for children (ages 6–17) after hospitalization increased from 70% in the baseline year to 72% in the most recent year. The 2024 Core Set (MY 2023) national average rate of follow-up among children was 68%.

- The rate significantly increased ($p < 0.05$) in two states and significantly decreased ($p < 0.05$) in one state.
- On average, states reported higher rates of 30-day follow-up care for children relative to adults. The average 30-day follow-up rate among children was 72%, compared to 55% among adults in the most recent year (see Section III). Most states reported similar trends for follow-up among children and adults.
- For most states, the rate of 30-day follow-up care for the 2024 Core Set (MY 2023) and the most recent SMI demonstration year (MY 2022–2024) were similar.
- States with above-average rates for SMI demonstration reporting in the most recent year were in or near the top quartile nationally in Core Set reporting (DC, MD, NH, VT, and WA).

SECTION VIII.

Discussion and Looking Ahead

Discussion and Looking Ahead

Since CMS's initial announcement of the Medicaid 1115 SUD demonstrations in July 2015 and the SMI demonstrations in November 2018, 39 states have approved SUD and/or SMI demonstrations. Sixteen states have both SUD and SMI demonstrations, 22 have an SUD demonstration only, and one state has an SMI demonstration only. This chartbook presents, for the first time, analyses based on monitoring data submitted by states with either demonstration type through December 1, 2025.

This chartbook highlights progress toward SUD and SMI demonstration goals in many states, as described in the Executive Summary table on page v. For example, provider availability for both SUD and SMI increased in most states. Among analyzed SUD demonstrations, inappropriate opioid prescribing, ED utilization for SUD, and inpatient utilization for SUD decreased, and SUD demonstrations were associated with a statistically significant increase ($p < 0.05$) in the receipt of MAT. Among analyzed SMI demonstrations, blood glucose testing for children on antipsychotics significantly increased ($p < 0.05$) in about half of states and SMI demonstrations were associated with a statistically significant increase ($p < 0.05$) in the receipt of outpatient treatment.

However, there is also room for improvement, especially in some measures of follow-up care that trended contrary to demonstration goals. For example, readmissions for SUD and SMI significantly increased ($p < 0.05$) in about half of states, and the percentage of adult beneficiaries with a new antipsychotic prescription who completed a follow-up visit significantly decreased ($p < 0.05$) in about half of states with SMI demonstrations. While overdose death rates also significantly increased ($p < 0.05$) in about half of states with SUD demonstrations, the available data are mostly from before 2024. We therefore expect that future data will reflect 2024 national decreases in overdose deaths.

While SUD and SMI demonstrations all work towards common goals, variation across states is expected because states may have different target populations, service packages, timelines, and activities they undertake to achieve goals. These differences, together with factors such as variations in state Medicaid programs and population characteristics, all contribute to differences in metrics presented in this chartbook. We present most metrics as rates to account for the different sizes of demonstration populations. In addition, although we show metric data at the state level, we caution readers against comparing across states without considering all the factors that contribute to variation across states. Comparing the baseline to the most recent reported period within a state provides a better understanding of progress made by each state towards demonstration goals. As states submit additional data that are incorporated into future analyses, findings across states for trends associated with the demonstrations may change.

States continue their commitment to SUD and SMI demonstration goals, as evidenced by their applications for new demonstrations and extensions of existing demonstrations. Innovative strategies implemented by states that have made noticeable progress, such as those highlighted in this chartbook, may provide exemplars for states newly pursuing demonstrations and those seeking to accelerate progress in existing ones. CMS anticipates continuing to share emerging lessons from these efforts through targeted technical assistance opportunities.

SECTION IX.

About This Chartbook

About This Chartbook

A. Data sources

This chartbook presents analyses that are based on two types of monitoring data that states submitted as of December 1, 2025:

- Quantitative monitoring metric data from monitoring reports submitted by 35 SUD demonstration states and 11 SMI demonstration states
- Quantitative data from Initial and Annual Availability Assessments submitted by 11 SMI demonstration states.

States use CMS-provided technical specifications to report these metrics; some states report some metrics using approved deviations. We supplement these quantitative data with qualitative data from states' monitoring reports (focusing on data submitted from February 2, 2024 to December 1, 2025) and other sources for context. We conducted quality checks on the monitoring metric data and solicited feedback from states on a draft of the report. We excluded from our analyses data that states intend to resubmit or that failed any data quality checks, unless an explanation was provided by the state. Each analysis includes only states that have submitted data relevant to the analysis for a minimum period, as defined in the methods below. A state may be included in some analyses but excluded from others based on these decision rules. Information about data availability by state and by metric is in the Appendix Tables.

B. Methods

Reported findings focus on changes between the baseline and most recent years for each state. When findings from statistical analyses are reported, we identify those that meet or exceed a 95 percent confidence interval ($p < 0.05$) as statistically significant.

For **annual metrics**, we conducted descriptive analyses, including calculating percentage changes between values at the baseline versus most recent year. For annual metrics defined as proportions, we conducted statistical analyses using z-tests to determine whether the proportions for each state in the most recent year were significantly different from the baseline year. Unless otherwise noted, states were included in analyses if they had reported at least two years of data for a metric, including one year as the baseline year. The most recent years usually begin in 2023 or 2024. Average metric rates across demonstrations are unweighted and we did not test changes in averages for statistical significance.

For most **monthly metrics**, we conducted regression analysis to assess whether the regression-adjusted mean value for the baseline year was statistically different from that in later demonstration years. On top of the data quality checks previously mentioned, we applied additional inclusion/exclusion criteria to

ensure only states with sufficient data availability and reasonable data quality were represented in the regressions. First, we used a conservative Tukey outlier filter (allowing four times interquartile range) to remove extreme spikes or dips within a state without over-pruning valid data variation.⁵⁸ Second, we required a minimum number of months with non-missing data, taking into consideration the different number and duration of SUD and SMI demonstrations. For SUD, we included states only if they had data for at least 15 months or 75% of the expected reporting period (whichever is larger); for SMI, we included states if they had data for at least 12 months or 60% of the expected reporting period (whichever is larger). For both, we required a minimum of six months of non-missing data from the baseline year. After applying these criteria, we checked to ensure that (1) metric rates were not overly noisy due to unusually small underlying denominators and (2) the final regression model for each metric was estimated among enough states (minimum of half of reporting states) to represent the demonstrations; no further exclusions were needed based on these checks.

Both the SUD and SMI regressions control for state, seasonality via calendar month, and the implementation of Medicaid eligibility expansion during demonstrations (NC, NE, OK, UT, and VA for SUD; OK for SMI). Regressions for the SUD metrics include data from before the COVID-19 PHE and include controls for time since the onset of the pandemic to control for pandemic-related effects and the Medicaid eligibility changes during the Medicaid unwinding. The SMI regressions include only data from April 2020 and after and include controls for the onset of the COVID-19 PHE and unwinding periods. The SMI regressions also control for implementation of the 988 Suicide & Crisis Lifeline, which was launched in July 2022.

We estimated ordinary least squares models for the monthly utilization metrics at the state-month level, with state fixed effect and adjusted standard errors for the clustering of observations by state. Based on the regression results, we estimated the average predicted value for each outcome measure for each demonstration period (baseline, Year 2, Year 3, Year 4, Year 5, and [for SUD] Year 6 and later) and tested whether the difference between the predicted value for each demonstration year and the baseline year was statistically significant. We calculated average predicted values to represent the pre-expansion period for those states that expanded Medicaid eligibility during the demonstrations, and used the sample mean for all other regression variables.

C. Limitations

There are a number of limitations, including inconsistency in reporting across states and our inability to distinguish effects associated with the demonstrations from those associated with other simultaneously occurring shifts that may affect metrics, such as state activities to address the opioid epidemic and the COVID-19 PHE.

Glossary

A. Data-related concepts

Baseline or baseline period is the first measurement period for which a state reported monitoring metrics that aligned with the demonstration start or implementation date. Appendix Table A.1 provides details on baselines for each state.

Core Set refers to the Medicaid and Children's Health Insurance Program (CHIP) Core Sets of Health Care Quality measures, which are sets of standardized healthcare quality measures that CMS and states can use to measure quality of care delivered to Medicaid and CHIP beneficiaries.⁵⁹

Demonstration population is the subset of Medicaid beneficiaries targeted by the demonstrations—that is, Medicaid beneficiaries with SUD or SMI/SED for SUD and SMI demonstrations, respectively. For analyses in this chartbook, the demonstration populations are defined by annual metrics SUD_4 and SMI_22, which count those receiving SUD or SMI/SED services, respectively. States have discretion in identifying which services are included in metric SMI_22, while metric SUD_4 uses a standardized list of services.

Demonstration year is the 12 calendar months starting with the month a demonstration began.

Most recent year refers to the latest year of data that a state has reported to CMS as of December 1, 2025. For annual metrics analyses, we generally compare the baseline year to the most recent year. The most recent years usually begin in 2023 or 2024. See the Appendix Tables for information on dates of included data.

Measurement period is the time frame for which metric data are collected. This may be a month, demonstration year, or calendar year. Appendix Table A.2 includes the measurement period for each metric.

SMI demonstration metrics (referred to as SMI_X) are reported by states with SMI demonstrations based on the Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics Version 4.0 or earlier, as applicable.

SUD demonstration metrics (referred to as SUD_X) are reported by states with SUD demonstrations based on the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Version 5.0 or earlier, as applicable.

B. Policy-related concepts

988 is the national 988 Suicide & Crisis Lifeline launched in 2022, which provides 24/7 free and confidential emotional support to individuals in suicidal crisis or emotional distress across the United States.

COVID-19 PHE refers to the federal coronavirus disease 2019 public health emergency, which lasted from January 2020 through May 2023.

DATA-waiver is the waiver that was federally required for medical professionals to prescribe and dispense buprenorphine for OUD in office-based settings. The Drug Addiction Treatment Act of 2000 established this requirement and the Consolidated Appropriations Act of 2023 eliminated it.

Maintenance of eligibility requirements refers to the provision in the Families First Coronavirus Response Act which provided an increased federal match for certain Medicaid expenditures during the COVID-19 PHE to states that met certain maintenance of eligibility requirements, including ensuring continuous coverage for enrollees.

Medicaid eligibility unwinding refers to the process where states were required to complete Medicaid eligibility renewals for all enrolled beneficiaries following the expiration of the Families First Coronavirus Response Act's maintenance of eligibility requirements. Renewals began in April 2023, with timelines varying by state.

Medicaid eligibility expansion refers to state expansion of Medicaid eligibility to cover additional low-income adults (also known as expansion adults or Group VIII adults). Several states implemented Medicaid eligibility expansion during SUD or SMI demonstrations (NC, NE, OK, UT, and VA for SUD; OK for SMI).

Acronyms

ALOS	average length of stay	SMDL	State Medicaid Director Letter
CCBHC	Certified Community Behavioral Health Clinic	SMI	serious mental illness
CDC	Centers for Disease Control and Prevention	SUD	substance use disorder
CHIP	Children's Health Insurance Program	VBC	value-based care
CMIT	CMS Measures Inventory Tool		
CMS	Centers for Medicare & Medicaid Services		
COVID	coronavirus disease 2019 (SARS-CoV-2)		
CSC	Coordinated Specialty Care		
CY	calendar year		
DY	demonstration year		
ED	emergency department		
FFP	federal financial participation		
HEDIS®	Healthcare Effectiveness Data and Information Set		
IMD	institution for mental diseases		
IO/PH	intensive outpatient and partial hospitalization		
IPF	inpatient psychiatric facility		
IPFQR	Inpatient Psychiatric Facility Quality Reporting		
MAT	medication-assisted treatment		
MCO	managed care organization		
MY	measurement year		
NCQA	National Committee for Quality Assurance		
ODU	opioid use disorder		
PHE	public health emergency		
SED	serious emotional disturbance		

Appendix Tables

Table A.1. Summary of section 1115 SUD and SMI demonstrations and available monitoring data used in chartbook

This table includes information on the start and implementation dates for the 38 states with approved SUD demonstrations and 17 states with approved SMI demonstrations (as of January 1, 2026). Three states with SUD demonstrations (AR, MO, and NY) and six states with SMI demonstrations (AR, CA, CO, KY, MO, and NM) did not submit enough data (as of December 1, 2025) to be included in any analysis in this chartbook.

For the 35 states with SUD demonstrations and 11 states with SMI demonstrations with data in any analysis, this table indicates dates of the data included, by metric measurement period (exceptions are noted in Table A.2).

State	Demonstration type	Start date ^a (MM/DD/YYYY)	Implementation date, if different from start date ^b (MM/DD/YYYY)	Included in any analyses	Monthly metrics		Demonstration year metrics		Calendar year metrics	
					Baseline month ^c	Most recent month	Baseline year start ^c	Most recent year start	Baseline year ^c	Most recent year
Alabama	SMI	05/20/2022		Yes	May 2022	Dec. 2024	May 2022 ^d	Jul. 2023 ^d	2022	2023
Alaska	SUD	01/01/2019	07/01/2019	Yes	Jul. 2019	Dec. 2024	Jul. 2019	Jul. 2023	2019	2023
Arkansas	SUD	07/22/2025	NA	No						
Arkansas	SMI	07/22/2025	NA	No						
California	SUD	08/13/2015	NA ^e	Yes	n.a.	n.a.	Jan. 2022	Jan. 2023	2022	2023
California	SMI	01/01/2025	NA	No						
Colorado	SUD	01/01/2021		Yes	Jan. 2021	Sep. 2024	Jan. 2021	Jan. 2023	2021	2023
Colorado	SMI	07/01/2025	NA	No						
Connecticut	SUD	04/14/2022		Yes	Apr. 2022	Sep. 2024	Apr. 2022	Apr. 2023	2022	2023
Delaware	SUD	08/01/2019		Yes	Jan. 2019	Dec. 2024	Jan. 2019	Jan. 2024	2019	2023
District of Columbia	SUD	01/01/2020		Yes	Jan. 2020	Dec. 2024	Jan. 2020	Jan. 2024	2020	2023
District of Columbia	SMI	01/01/2020		Yes	Apr. 2020	Dec. 2024	Jan. 2020	Jan. 2024	2020	2023
Idaho	SUD	04/17/2020		Yes	Apr. 2020	Dec. 2023	Apr. 2020	Apr. 2022	2020	2022
Idaho	SMI	04/17/2020		Yes	Apr. 2020	Dec. 2023	Apr. 2020	Apr. 2022	2020	2022
Illinois	SUD	07/01/2018		Yes	Jul. 2018	Sep. 2024	Jul. 2018	Jul. 2023	2018	2023
Indiana	SUD	02/01/2018		Yes	n.a.	n.a.	n.a.	Jan. 2024	n.a.	n.a.
Indiana	SMI	01/01/2020		Yes	Apr. 2020	Dec. 2024	Jan. 2020	Jan. 2024	2020	2023
Kansas	SUD	01/01/2019	08/07/2019	Yes	Jan. 2019	Dec. 2024	Jan. 2019	Jan. 2024	2019	2023
Kentucky	SUD	01/12/2018	07/01/2019	Yes	Jul. 2019	Sep. 2024	Jul. 2019	Jul. 2023	2019	2023
Kentucky	SMI	01/01/2025	NA	No						
Louisiana	SUD	02/01/2018		Yes	Jan. 2018	Dec. 2024	Jan. 2018	Jan. 2024	2018	2023
Maine	SUD	01/01/2021		Yes	Jan. 2021	Dec. 2024	Jan. 2021	Jan. 2024	2021	2024
Maryland	SUD	01/01/2017	07/01/2017	Yes	Jan. 2017	Sep. 2024	Jan. 2017	Jan. 2023	2017	2022
Maryland	SMI	01/01/2022	07/20/2022	Yes	Jan. 2022	Dec. 2024	Jan. 2022	Jan. 2024	2022	2024

Table A.1 (continued)

State	Demonstration type	Start date ^a (MM/DD/YYYY)	Implementation date, if different from start date ^b (MM/DD/YYYY)	Included in any analyses	Monthly metrics		Demonstration year metrics		Calendar year metrics	
					Baseline month ^c	Most recent month	Baseline year start ^c	Most recent year start	Baseline year ^c	Most recent year
Massachusetts	SUD	07/01/2017	NA ^e	Yes	n.a.	n.a.	Jan. 2022	Jan. 2023	2022	2023
Massachusetts	SMI	10/01/2022		Yes	n.a.	n.a.	Jan. 2022	Jan. 2023	n.a.	n.a.
Michigan	SUD	04/05/2019	10/01/2019	Yes	Oct. 2019	Dec. 2024	Oct. 2019	Oct. 2023	2019	2023
Minnesota	SUD	07/01/2019	07/22/2020	Yes	Jul. 2019	Dec. 2024	Jul. 2019	Jul. 2023	2019	2023
Missouri	SUD	12/06/2023	NA	No						
Missouri	SMI	12/06/2023	NA	No						
Montana	SUD	07/01/2022		Yes	n.a.	n.a.	Jul. 2022	Jul. 2023	2022	2023
Nebraska	SUD	07/01/2019		Yes	Jul. 2019	Dec. 2024	Jul. 2019	Jul. 2023	2019	2023
Nevada	SUD	01/01/2023	08/01/2023	Yes	Jan. 2023	Dec. 2024	Jan. 2023	Jan. 2024	n.a.	n.a.
New Hampshire	SUD	07/10/2018		Yes	Jul. 2018	Sep. 2024	Jul. 2018	Jul. 2023	2018	2023
New Hampshire	SMI	06/02/2022	07/01/2022	Yes	Jul. 2022	Sep. 2024	Jul. 2022	Jul. 2023	2022	2023
New Jersey	SUD	10/31/2017	07/01/2018	Yes	Oct. 2017	Sep. 2024	Oct. 2017	Oct. 2023	2017	2023
New Mexico	SUD	01/01/2019		Yes	Jan. 2019	Dec. 2023	Jan. 2019	Jan. 2024	2019	2023
New Mexico	SMI	03/28/2023	NA	No						
New York	SUD	01/09/2024	NA	No						
North Carolina	SUD	01/01/2019		Yes	Nov. 2018	Oct. 2024	Nov. 2018	Nov. 2023	2018	2023
Ohio	SUD	10/01/2019		Yes	Oct. 2019	Dec. 2024	Oct. 2019	Oct. 2023	2019	2023
Oklahoma	SUD	12/22/2020	01/18/2021	Yes	n.a.	n.a.	Jan. 2021	Jan. 2024	2021	2024
Oklahoma	SMI	12/22/2020		Yes	Jan. 2021	Dec. 2024	Jan. 2021	Jan. 2024	2021	2024
Oregon	SUD	04/08/2021		Yes	Apr. 2021	Mar. 2025	Apr. 2021	Apr. 2024	2021	2024
Pennsylvania	SUD	07/01/2018		Yes	Jul. 2018	Sep. 2024	Jul. 2018	Jul. 2023	n.a.	n.a.
Rhode Island	SUD	01/01/2019	07/01/2019	Yes	Jan. 2019	Dec. 2024	Jan. 2019	Jan. 2024	2019	2024
Utah	SUD	11/01/2017	11/09/2017	Yes	Jul. 2017	Sep. 2024	Jul. 2017	Jul. 2023	2017	2023
Utah	SMI	12/16/2020	01/01/2021	Yes	Jan. 2021	Sep. 2024	Jul. 2020	Jul. 2023	2021	2023
Vermont	SUD	07/01/2018		Yes	Jan. 2018	Dec. 2024	Jan. 2018	Jan. 2024	2018	2023
Vermont	SMI	01/01/2020		Yes	Apr. 2020	Dec. 2024	Jan. 2020	Jan. 2024	2020	2023
Virginia	SUD	12/15/2016	04/01/2017	Yes	Apr. 2017	Dec. 2024	Apr. 2017	Apr. 2023	2017	2023
Washington ^f	SUD	07/17/2018	07/01/2018	Yes	Jul. 2018	Sep. 2024	Jul. 2018	Jul. 2023	2018	2023
Washington ^f	SMI	11/06/2020	12/23/2020	Yes	Dec. 2020	Sep. 2024	Jan. 2020	Jan. 2023	2020	2023
West Virginia	SUD	01/01/2018	01/14/2018	Yes	Jan. 2018	Dec. 2024	Jan. 2018	Jan. 2024	2018	2024
Wisconsin	SUD	10/31/2018	02/01/2021	Yes	Jan. 2021	Sep. 2024	Jan. 2021	Jan. 2023	2021	2023

Table A.1 (*continued*)

^a For monitoring purposes, the start date is the effective date listed in the state's special terms and conditions at the time of the SUD or SMI demonstration approval. In many cases, the effective date is distinct from the approval date of a demonstration (that is, in certain cases, CMS can approve a section 1115 demonstration with an effective date in the future).

^b Implementation date is the date the state began claiming FFP for treatment in IMDs, as provided in state-submitted monitoring deliverables. If blank, the implementation date is the same as the start date.

^c The baseline period is the first measurement period for which a state reported monitoring metrics that aligned with the demonstration start or implementation date. States and CMS mutually agree on baseline start dates. For most states, the beginning of the baseline DY aligns with the demonstration start date (which is also often the same as the implementation date). Exceptions include: (1) Two states for which SUD reporting requirements started in 2022, during the extension period for an SUD demonstration (CA and MA); (2) several states with baseline start dates that instead align with demonstration implementation dates (such as AK, KY, MI, VA, and WI); (3) several states with baseline start dates that align with dates of broader demonstrations or calendar years (such as DE, UT, and VT).

^d AL changed its demonstration years to align with CMS-64 reporting requirements. Because of this, its DY1 data include May 20, 2022 to May 19, 2023 and its DY2 data include July 1, 2023 to June 30, 2024.

^e The implementation dates for CA and MA are unavailable because these states' initial SUD demonstration periods did not include the current SUD reporting requirements. The implementation dates for the demonstration extensions are January 1, 2022 (CA) and October 1, 2022 (MA).

^f WA reported an additional year of data before the start of its SUD demonstration (July 2017 through June 2018) as the baseline. However, we used data that align with the state's SUD demonstration start date of July 1, 2018 for WA's SUD baseline year in analyses, for consistency with other states. WA also reported monthly data for its SMI demonstration beginning with January 2020. However, we used its monthly SMI data beginning with December 2020 to better align with its SMI demonstration start and implementation dates.

CMS = Centers for Medicare & Medicaid Services; CY = calendar year; DY = demonstration year; FFP = federal financial participation; IMD = institution for mental diseases; NA = not available; n.a. = not applicable; SMI = serious mental illness; SUD = substance use disorder.

Table A.2. Description of section 1115 SUD and SMI demonstration monitoring metrics included in chartbook

This table provides information on data exclusions, by metric, for the states with data included in any analysis in this chartbook (35 states with SUD demonstrations and 11 states with SMI demonstrations). As in Table A.1, some states with approved demonstrations do not have data included in any analysis (three SUD demonstration states [AR, MO, and NY] and six SMI demonstration states [AR, CA, CO, KY, MO, and NM]).

Metric or rate description	Page	Metric (measurement period)	Number of states included	Excluded states and reason for exclusion			States and start dates of most recent year of data, when date differs from Table A.1
				Data quality ^a	Insufficient data ^b	Other ^c	
Demonstration beneficiaries diagnosed with SUD	3	SUD_4 (DY)	34	RI			
Demonstration beneficiaries diagnosed with SMI/SED	3	SMI_22 (DY)	11				NH (baseline only)
Outpatient Services / Any SUD treatment	7	SUD_8 / SUD_6 (month)	27	KS, LA, MT, NM, OK	IN	CA, MA ^d	
Medication-Assisted treatment / Any SUD treatment	7	SUD_12 / SUD_6 (month)	28	LA, MT, NM, OK	IN	CA, MA ^d	
Early Intervention / Any SUD treatment	7	SUD_7 / SUD_6 (month)	23	LA, NM, MT, OK, PA	IN, NC, RI	DE, ID ^e CA, MA ^d	DC (Feb. 2024)
Intensive Outpatient and Partial Hospitalization Services / Any SUD treatment	7	SUD_9 / SUD_6 (month)	24	LA, MT, NM, OK, PA, WV	IN, MN, WA	CA, MA ^d	DC (Nov. 2023), MD (Jun. 2024)
Residential and Inpatient Services / Any SUD treatment	7	SUD_10 / SUD_6 (month)	24	CT, KS, LA, MD, MT, NM, OK, PA	IN	CA, MA ^d	
Withdrawal Management / Any SUD treatment	7	SUD_11 / SUD_6 (month)	27	CT, LA, MT, NM, OK	IN	CA, MA ^d	
Any SUD treatment / Demonstration beneficiaries diagnosed with SUD	7	SUD_6 / SUD_3 (month)	27	LA, MT, NM, OK, WV	IN	CA, MA ^d	
Mental Health Services Utilization - Outpatient / Mental Health Services Utilization - Any Services	8	SMI_15 / SMI_18 (month)	10	MA			AL (Sep. 2024)
Mental Health Services Utilization - Telehealth / Mental Health Services Utilization - Any Services	8	SMI_17 / SMI_18 (month)	10	MA			AL (Oct. 2024)
Mental Health Services Utilization - Inpatient / Mental Health Services Utilization - Any Services	8	SMI_13 / SMI_18 (month)	10	MA			AL (Oct. 2024)
Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization / Mental Health Services Utilization - Any Services	8	SMI_14 / SMI_18 (month)	9	MA	IN		AL (Oct. 2024)
Mental Health Services Utilization - Any Services / Medicaid enrollment	8	SMI_18 / Medicaid enrollment (month)	10	MA			MD (Nov. 2024)
Medicaid Beneficiaries Treated in an IMD for SUD / Medicaid Beneficiaries with SUD Diagnosis	9	SUD_5 / SUD_4 (DY)	26	CO, LA, ME, MN, RI, VT, WV	IN, NM		

Table A.2 (continued)

Metric or rate description	Page	Metric (measurement period)	Number of states included	Excluded states and reason for exclusion			States and start dates of most recent year of data, when date differs from Table A.1
				Data quality ^a	Insufficient data ^b	Other ^c	
Beneficiaries With SMI/SED Treated in an IMD for Mental Health / Count of Beneficiaries With SMI/SED	9	SMI_20 / SMI_22 (DY)	10	NH			
ALOS in IMDs for SUD ^f	9	SUD_36 (DY)	35				KS (Jan. 2019), MD (Jan. 2022), NM (Jan. 2020), WA (Jul. 2019), WV (Jan. 2023)
ALOS in IMDs for SMI ^f	9	SMI_19b (DY)	9	MA, AL			WA (Jan. 2022)
Initiation and Engagement in SUD Treatment, Initiation within 14 days, OUD cohort	10	SUD_15.2 (CY)	20	DE, KY, MA, MT, NE, NH, PA	IN, NV	ME, OK ^g MD, NJ, UT, VA ^h	DC (CY 2021), KS (CY 2021), LA (CY 2021), MI (CY 2021), NM (CY 2022), RI (CY 2021), VT (CY 2021)
Initiation and Engagement in SUD Treatment, Engagement in treatment within 34 days, OUD cohort	10	SUD_15.6 (CY)	19	CO, DE, KY, MA, MT, NE, NH, PA	IN, NV	ME, OK ^g MD, NJ, UT, VA ^h	DC (CY 2021), KS (CY 2021), LA (CY 2021), MI (CY 2021), NM (CY 2022), RI (CY 2021), VT (CY 2021)
Continuity of Pharmacotherapy for OUD	11	SUD_22 (CY)	27	KS, OR, VT	IN, NH, NM, NV, PA		LA (CY 2021), NJ (CY 2022), OK (CY 2023), WV (CY 2022)
SUD Provider Availability / Medicaid Beneficiaries with SUD Diagnosis	12	SUD_13 / SUD_4 (DY)	18	CO, LA, MN, PA, RI, WV	IN	CA, CT, MA, ME, MT, NV, OR ⁱ MD, NH ^j WA ^j	AK (Jul. 2021), DC (Jan. 2022), DE (Jan. 2022), ID (Apr. 2021), IL (Jul. 2021), KS (Jan. 2021), KY (Jul. 2021), MI (Oct. 2021), NC (Nov. 2021), NE (Jul. 2021), NJ (Oct. 2021), NM (Jan. 2021), OH (Oct. 2021), OK (Jan. 2022), UT (Jul. 2021), VA (Apr. 2021), VT (Jan. 2022), WI (Jan. 2022)
SUD Provider Availability - MAT / Medicaid Beneficiaries with SUD Diagnosis	12	SUD_14 / SUD_4 (DY)	18	CO, LA, MN, OH, PA, RI, WV	IN	CA, CT, MA, ME, MT, NV, OR ⁱ MD, NH ^j	AK (Jul. 2021), DC (Jan. 2022), DE (Jan. 2022), ID (Apr. 2021), IL (Jul. 2021), KS (Jan. 2021), KY (Jul. 2021), MI (Oct. 2021), NC (Nov. 2021), NE (Jul. 2021), NJ (Oct. 2021), NM (Jan. 2022), OK (Jan. 2022), UT (Jul. 2021), VA (Apr. 2021), VT (Jan. 2022), WA (Jul. 2021), WI (Jan. 2022)

Table A.2 (continued)

Metric or rate description	Page	Metric (measurement period)	Number of states included	Excluded states and reason for exclusion			States and start dates of most recent year of data, when date differs from Table A.1
				Data quality ^a	Insufficient data ^b	Other ^c	
Medicaid-Enrolled Psychiatrists and Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications and Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness, per 1,000 Beneficiaries with SMI/SED	13	No metric number Based on Availability Assessments	11				Based on Availability Assessment data as of the following dates (MM/DD/YYYY). AL: 05/01/2022 & 05/01/2023; DC: 12/31/2020 & 01/01/2024; ID: 04/01/2019 & 04/01/2023; IN: 01/01/2020 & 01/31/2025; MA: 12/31/2018 & 01/01/2024; MD: 01/01/2020 & 01/01/2024; NH: 5/31/2021 & 5/31/2024; OK: 02/01/2020 & 02/28/2024; UT: 01/01/2020 & 10/31/2023; VT: 01/01/2020 & 01/01/2024; WA: 06/01/2019 & 01/01/2023
Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries with SMI	16	SMI_26 (CY)	8	AL, MA, NH			OK (CY 2023)
Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries with SUD	16	SUD_32 (CY)	27	MA, NH, OK, WV	IN, NV, PA	MD ^k	DE (CY 2022), KS (CY 2021), KY (CY 2021)
Follow-Up After ED Visit for Substance Use: Age 18 and Older, 30-day rate	17	SUD_17.1.1 (CY)	23	MA, MT, NC, WI, WV	IN, NV, PA	ME, OK ^g MD, NJ ^k	DC (CY 2021), KS (CY 2021), LA (CY 2021), MI (CY 2021), NE (CY 2021), NH (CY 2021), NM (CY 2022), RI (CY 2021), VT (CY 2021)
Follow-up After ED Visit Mental Illness: Age 18 and Older, 30-day rate	17	SMI_10.1 (CY)	9	AL, MA			
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older, 30-day rate	18	SMI_8.1 (CY)	8	MA, NH		AL ^l	
Medication Continuation Following Inpatient Psychiatric Discharge	19	SMI_6 (CY)	10	MA			OK (CY 2021), WA (CY 2022)
Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	20	SMI_30 (CY)	10	MA			OK (CY 2023), WA (CY 2022)
ED Utilization for SUD per 1,000 Medicaid Beneficiaries	23	SUD_23 (month)	25	ID, OK, PA, RI	IN	CA, MA ^d NV ^m	
Mental Health Services Utilization - ED / Mental Health Services Utilization - Any Services	24	SMI_16 / SMI_18 (month)	9	DC, MA			VT (May 2024)
Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	25	SUD_24 (month)	26	ID, OK, PA	IN	CA, MA ^d NV ^m	
Readmissions Among Beneficiaries with SUD	28	SUD_25 (DY)	31	MA, NH	IN, PA		MD (Jan. 2022), NM (Jan. 2021), WA (Jul. 2021)

Table A.2 (continued)

Metric or rate description	Page	Metric (measurement period)	Number of states included	Excluded states and reason for exclusion			States and start dates of most recent year of data, when date differs from Table A.1
				Data quality ^a	Insufficient data ^b	Other ^c	
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	29	SMI_4 (CY)	10	MA			OK (CY 2023)
Use of Opioids at High Dosage in Persons Without Cancer	32	SUD_18 (CY)	27		IN, NM, NV, PA	MD, NJ, UT, VA ^h	WV (CY 2022)
Concurrent Use of Opioids and Benzodiazepines	33	SUD_21 (CY)	26	KS	IN, NM, NV, PA	MD, NJ, UT, VA ^h	WV (CY 2022)
Overdose death rate per 1,000 Medicaid beneficiaries	34	SUD_27 (DY)	23	DE, ID, NH, OR, PA	CA, DC, IN, NE, NM, VA, WA		IL (Jul. 2022), KS (Jan. 2021), LA (Jan. 2022), MD (Jan. 2022), ME (Jan. 2023), NC (Nov. 2022), NJ (Oct. 2021), OH (Oct. 2022), OK (Jan. 2023), WV (Jan. 2023)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	37	SMI_2 (CY)	8	AL, MA	NH		
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	37	SMI_29.1 (CY)	9	AL, MA			
30-Day Follow-up After Hospitalization for Mental Illness: Ages 6 to 17	38	SMI_7.1 (CY)	9	MA	AL		DC (CY 2022)

^a “Data quality” exclusions mean that a state did not meet the data quality inclusion criteria. Examples of quality checks to look for anomalous data include: comparing change over time within a metric, comparing numerators and denominators within rate metrics or across related metrics, comparing the sum of required subpopulation categories to the total population value, and comparing rate values across states to identify outliers. Data that failed any of these checks are excluded unless we identified an explanation from the state. Additionally, data were excluded at states’ request if their chartbook review raised validity concerns.

^b “Insufficient data” exclusions mean that a state does not have enough reported data to meet inclusion criteria for an analysis. This could be because the state has not submitted baseline data, has submitted only one year of annual data or has not submitted enough unsuppressed months to meet the inclusion criteria for monthly data, or does not submit the metric in its monitoring reports. For more information on the regression inclusion criteria, see Section IX, “About This Chartbook.”

^c “Other” exclusions are due to reasons that are not data quality or insufficient data. The specific reason is described in table notes.

^d CA and MA data are excluded from all monthly SUD analyses because their first reported year (2022) was many years after their SUD demonstration start dates (2015 for CA, 2017 for MA), which predated the standardized SUD demonstration monitoring framework. These states began reporting during the first demonstration extension period.

^e These states are excluded from an SUD regression because they reported values of zero for the metric for all months of submitted data that met regression inclusion criteria.

^f For ALOS analyses (in which we report on any year with an ALOS of greater than 30 days), we included all years of data that passed quality checks, regardless of whether the state had data for a baseline year.

^g Because of measure specification updates in 2022 that caused a break in trend, these states did not have a most recent year comparable to their 2021 baseline year.

^h Because of measure specification updates in 2018 that caused a break in trend, these states did not have a most recent year comparable to their 2017 baseline year.

ⁱ These states are excluded from the analysis of SUD or MAT providers because their baseline year included the period in which the DATA-waiver requirement was removed.

^j These states are excluded from the analysis of SUD or MAT providers because they changed the method for identifying providers after their baseline year.

^k MD is excluded from the analysis of SUD_32 and MD and NJ are excluded from the analysis of SUD_17.1.1 because the most recent year of data for these metrics for these states was 2020, during the onset of the COVID-19 PHE.

^l AL is excluded from the analysis of SMI_8.1 because the metric had a denominator value of less than 30.

^m NV is excluded from the SUD_23 and SUD_24 analyses because the state has a baseline year of 2023. The analyses of metrics SUD_23 and SUD_24 are limited to states with a baseline year beginning in 2022 or earlier in order to identify trends over at least two years.

ALOS = average length of stay; CY = calendar year; DATA-waiver = Drug Addiction Treatment Act waiver; DY = demonstration year; ED = emergency department; HEDIS® = Healthcare Effectiveness Data and Information Set; IMD = institution for mental diseases; MAT = medication assisted treatment; OUD = opioid use disorder; PHE = public health emergency; SED = serious emotional disturbance; SMI = serious mental illness; SUD = substance use disorder.

Endnotes

¹ SMDL #18-011 described the demonstration opportunity as related to adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). For brevity in this chartbook, we refer to the demonstrations as “SMI demonstrations” and refer to SMI and/or SED in the context of specific metrics and analyses, as relevant.

² See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf> for SUD and <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf> for SMI.

³ As noted in the Glossary in Section IX, SUD and SMI demonstration metrics are reported by states based on the relevant technical specifications and are referred to as SUD_X or SMI_X.

⁴ See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>.

⁵ The share of beneficiaries using early intervention services was driven higher by outlier early intervention use in ME, where average early intervention use was 70%, compared to an average of 1% across all other SUD demonstration states included in the regression over the reporting period.

⁶ Unlike in the regression analysis of the percentage of Medicaid beneficiaries with SUD who used any SUD service across demonstration years (SUD_6/SUD_3), we used overall Medicaid beneficiaries as the denominator for any utilization of mental health services (SMI_18/Medicaid enrollment) (see <https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data>). We did not use SMI_21 (monthly count of beneficiaries with SMI/SED) as the denominator because states have discretion in identifying which services are included in defining SMI_21, as opposed to a standardized list of services specified for SUD_3.

⁷ We use the 2022 Core Set (MY 2021) for comparison for this metric, as the National Committee for Quality Assurance (NCQA) noted a break in trend in CY 2022 compared with prior years due to changes in the measure specifications. (For more information, see <https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2022/06/HEDIS-MY2022-Measure-Trending-Determinations.pdf>.) Our analysis of this metric only includes CY 2022 and later years of data from states that continued to use MY 2021 HEDIS® specifications in those years. Additionally, our analysis excludes CY 2017 data due to a break in trend associated with CY 2018 technical specifications updates. (For more information, see https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2018/08/20180326_HEDIS_2018_Measure_Trending_Determinations.pdf.) NCQA also noted to allow trending with caution for CY 2020 compared with prior years. (For more information, see https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2021/02/20210226_HEDIS_MY_2020_Measure_Review_Memo.pdf.)

⁸ In providing feedback on an earlier draft of this chartbook, AK noted that its trend should be interpreted with caution, since the increase in its rate was due in part to new enrollment requirements implemented under the demonstration (which affected existing providers).

⁹ The Availability Assessment categories “providers certified or licensed to treat mental illness” and “psychiatrists and other providers authorized to prescribe psychiatric medications” are mutually exclusive. Licensed providers include non-psychiatrist mental health providers who are certified or licensed by the state to independently treat mental illness, such as psychologists or clinical social workers. Prescribing providers include psychiatrists and other prescribers authorized by the state to prescribe psychiatric medications.

¹⁰ Bureau of Health Workforce. “First Quarter of Fiscal Year 2026: Designated HPSA Quarterly Summary.” Health Resources and Services Administration, U.S. Department of Health and Human Services, 2026. <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>. Data are not available for VT.

¹¹ Kehn, M., R. Kleinman, A. Wishon Siegwarth, and J. Brown. “Improving the Coordination of Services for Adults with Mental Health and Substance Use Disorders: Profiles of Four State Medicaid Initiatives.” Office of the Assistant Secretary for Planning and Evaluation, February 26, 2015. <https://aspe.hhs.gov/reports/improving-coordination-services-adults-mental-health-substance-use-disorders-profiles-four-state-0>.

¹² NCQA noted to allow trending with caution for this metric for CY 2019 compared with prior years. (For more information, see <https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2019/03/HEDIS-2019-Measure-Trending-Determinations.pdf>.)

¹³ NCQA. “Adults’ Access to Preventative/Ambulatory Health Services (AAP).” n.d. <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adults-access-to-preventive-ambulatory-health-services-aap/>.

¹⁴ Lower 30-day follow-up rates after ED visits for SUD (relative to SMI) may reflect broader barriers to engagement in SUD treatment. For example, compared to people with SMI, people with SUD are much less likely to receive any treatment in the past year (19.3% for SUD and 70.8% for SMI) and report a lower perceived need for treatment. (For more information, see 2024 NSDUH: <https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf>.) Average follow-up rates for SUD increased after HEDIS® metric specification changes beginning in MY 2022 (changes included expanding the follow-up definition to include pharmacotherapy dispensing events). The gap between the Core Set national averages for SUD and SMI decreased from 28 percentage points in MY 2021 (24% for SUD vs. 52% for SMI) to 14 percentage points in MY 2023 (38% for SUD vs. 52% for SMI).

¹⁵ We use the 2022 Core Set (MY 2021) for comparison for this metric, as NCQA noted a break in trend in CY 2022 compared with prior years due to changes in the measure specifications. (For more information, see <https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2022/06/HEDIS-MY2022-Measure-Trending-Determinations.pdf>.) Our analysis of this metric only includes CY 2022 and later years of data from states that continued to use MY 2021 HEDIS® specifications in those years. NCQA also noted to allow trending with caution for CY 2018 and CY 2020 compared with prior years. (For more information, see https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2018/08/20180326_HEDIS_2018_Measure_Trending_Determinations.pdf and https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2021/02/20210226_HEDIS_MY_2020_Measure_Review_Memo.pdf.)

¹⁶ Substance Abuse and Mental Health Services Administration. “Certified Community Behavioral Health Clinics (CCBHCs).” April 24, 2023. <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics>.

¹⁷ This is based on Inpatient Psychiatric Facility Quality Measure Data covering July 2021 through June 2023. See <https://data.cms.gov/provider-data/dataset/dc76-gh7x#data-table>.

¹⁸ Allen, E.M., K.T. Call, T.J. Beebe, D.D. McAlpine, and P.J. Johnson. “Barriers to Care and Health Care Utilization Among the Publicly Insured.” *Medical Care*, vol. 55, no. 3, 2017, pp. 207–214. <https://doi.org/10.1097/MLR.0000000000000644>.

¹⁹ Indiana Office of Medicaid Policy and Planning. “2024 Annual EQR Technical Report.” Indiana Family and Social Services Administration, 2024. https://www.in.gov/fssa/ompp/files/2024_OMPP_Annual_Technical_Report.pdf.

²⁰ Center for Mental Health Services. “Coordinated Specialty Care for First Episode Psychosis: Costs and Financing Strategies.” HHS Publication No. PEP23-01-00-003. Substance Abuse and Mental Health Services Administration, 2023. <https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf>.

²¹ Cairns, C., J.J. Ashman, and K. Kang. “Emergency Department Visit Rates by Selected Characteristics: United States, 2022.” NCHS Data Brief no. 503. National Center for Health Statistics, August 2024. <https://www.cdc.gov/nchs/data/databriefs/db503.pdf>.

²² Institute for Health Policy and Leadership. “Rise in Emergency Department Visits due to Limited Access to Behavioral Health Services.” Loma Linda University Health, January 3, 2022. <https://ihpl.llu.edu/blog/rise-emergency-department-visits-due-limited-access-behavioral-health-services>.

²³ Burns, A., J.R. Vest, N. Menachemi, O. Mazurenko, P.I. Musey, M.P. Salyers, Jr., and V.A. Yeager. “Availability of Behavioral Health Crisis Care and Associated Changes in Emergency Department Utilization.” *Health Services Research*, vol. 60, no. 2, August 2024, e14368. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11911218/>.

²⁴ Note that early specifications for metric SUD_24 did not explicitly exclude residential stays. Starting in the version released in September 2021, states were instructed to exclude residential stays from SUD_24. The impact of this change has not been assessed. Whether residential stays were included in data reported before this exclusion depends on factors such as coding practices in a given state.

²⁵ Beckerleg, W., and J. Hudgins. “Substance Use-Related Emergency Department Visits and Resource Utilization.” *The Western Journal of Emergency Medicine*, vol. 23, no. 2, February 2022, pp. 166–173. <https://pubmed.ncbi.nlm.nih.gov/35302449/>.

²⁶ Pines, J.M., M.S. Zocchi, B.S. Black, J.N. Carlson, P. Celedon, A. Moghtaderi, and A. Venkat. “How Emergency Department Visits for Substance Use Disorders Have Evolved During the Early COVID-19 Pandemic.” *Journal of Substance Abuse Treatment*, vol. 129, April 2021, 108391. <https://pmc.ncbi.nlm.nih.gov/articles/PMC9581895/>.

²⁷ Venkatesh, A.K., A.T. Janke, J. Kinsman, C. Rothenberg, P. Goyal, C. Malicki, G. D’Onofrio, A. Taylor, and K. Hawk. “Emergency Department Utilization for Substance Use Disorders and Mental Health Conditions during COVID-19.” *PLOS One*, vol. 17, no. 1, 2022, e0262136. <https://doi.org/10.1371/journal.pone.0262136>.

²⁸ Substance Abuse and Mental Health Services Administration. “Drug Abuse Warning Network: National Estimates from Drug-Related Emergency Department Visits, 2023.” Center for Behavioral Health Statistics and Quality, 2024. <https://www.samhsa.gov/data/sites/default/files/reports/rpt53161/dawn-national-estimates-2023.pdf>.

²⁹ CDC. “Mental Health-Related Emergency Department Visits.” August 27, 2025. <https://www.cdc.gov/mental-health/about-data/emergency-department-visits.html>.

³⁰ AltaPointe Health Systems. “AltaPointe Health Systems, Inc. Strategic Plan 2024–2027.” n.d. <https://mh.alabama.gov/wp-content/uploads/2025/01/AltaPointe-Health-Systems-Inc.pdf>.

³¹ CMS. “Unplanned Hospital Visits.” n.d. <https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits>.

³² Rosen, A.D., S. Takada, C. Juillard, Y.L. Fernandez Montero, A.M. Richards, S. Ngeekeng, S.J. Shoptaw, and M.A. Bholat. “Unpacking the Link between Substance Use Disorders and 30-Day Unplanned Readmission.” *Addiction*, July 23, 2025. <https://pubmed.ncbi.nlm.nih.gov/40698401/>.

³³ Benjenk, I., M. Shields, and J. Chen. “Measures of Care Coordination at Inpatient Psychiatric Facilities and the Medicare 30-Day All-Cause Readmission Rate.” *Psychiatric Services*, vol. 71, no. 10, October 2020, pp. 1031–1038. <https://pubmed.ncbi.nlm.nih.gov/32838680/>.

³⁴ Vigod, S.N., P.A. Kurdyak, C-L. Dennis, T. Leszcz, V.H. Taylor, D.M. Blumberger, and D.P. Seitz. “Transitional Interventions to Reduce Early Psychiatric Readmissions in Adults: Systematic Review.” *British Journal of Psychiatry*, vol. 202, no. 3, 2013, pp. 187–194. <https://pubmed.ncbi.nlm.nih.gov/23457182/>.

³⁵ Based on Inpatient Psychiatric Facility Quality Measure Data. See <https://data.cms.gov/provider-data/dataset/s5xg-sys6>.

³⁶ CMS. “Inpatient Psychiatric Facility Quality Measure Data—by Facility.” Released November 26, 2025. <https://data.cms.gov/provider-data/dataset/q9vs-r7wp>.

³⁷ Benjenk, I., Shields, M., and Chen, J. “Exploring Publicly Reported Inpatient Psychiatric Facility Care Coordination Measures and 30-Day ‘All-Cause Unplanned Readmission After Psychiatric Hospitalization’ Rates.” *Psychiatric Services (Washington, DC)*, vol. 71, no. 10, 2020, pp. 1031–1038. <https://doi.org/10.1176/appi.ps.201900360>.

³⁸ Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or who are in hospice are excluded from the numerator and denominator of both metrics (SUD_18 and 21).

³⁹ For CY 2018, the threshold used to define high daily dosages in the specifications for this metric decreased from 120 MME to 90 MME. This analysis includes years after this change in threshold. For CY 2019, the metric specifications had minor changes (new exclusion criteria for those with sickle cell disease and the addition of a new opioid medication to qualified opioid medications), which might also affect trending.

⁴⁰ Dowell, D., T.M. Haegerich, and R. Chou. “CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016.” *Morbidity and Mortality Weekly Report, Recommendations and Reports*, vol. 65, no. 1, March 2016, pp. 1–49. <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

⁴¹ Concurrent use is identified using the dates of service and the number of days’ supply of an individual’s prescription claims. Days of concurrent use is the count of days with overlapping days’ supply for an opioid and a benzodiazepine. For CY 2018, the metric specifications changed to include additional medical and pharmacy claims. This analysis includes years after this change. For CY 2019, the metric specifications had minor changes (new exclusion criteria for those with sickle cell disease and the addition of a new opioid medication to qualified opioid medications), which might also affect trending.

⁴² National Institute on Drug Abuse. “Benzodiazepines and Opioids.” National Institutes of Health, November 7, 2022. <https://nida.nih.gov/research-topics/opioids/benzodiazepines-opioids>.

⁴³ Dowell, D., K.R. Ragan, C.M. Jones, G.T. Baldwin, and R. Chou. “CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022.” *Morbidity and Mortality Weekly Report, Recommendations and Reports*, vol. 71, no. 3, November 2022, pp. 1–95. <https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm>.

⁴⁴ Taha, S.A., J.R. Westra, D.H. Tacker, M.A. Raji, and Y.-F. Kuo. “Trends in Co-Prescribed Opioids and Benzodiazepines, Non-Prescribed Opioids and Benzodiazepines, and Schedule-I Drugs in the United States, 2013 to 2019.” *Preventive Medicine Reports*, vol. 38, February 2024, 102584. <https://www.sciencedirect.com/science/article/pii/S2211335523004758#ab010>.

⁴⁵ Dowell, D., K.R. Ragan, C.M. Jones, G.T. Baldwin, and R. Chou. “CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022.” *Morbidity and Mortality Weekly Report, Recommendations and Reports*, vol. 71, no. 3, November 2022, pp. 1–95. <https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm>.

⁴⁶ Bohnert, A.S.B., G.P. Guy, Jr., and J.L. Losby. “Opioid Prescribing in the United States Before and After the Centers for Disease Control and Prevention’s 2016 Opioid Guideline.” *Annals of Internal Medicine*, vol. 169, no. 6, September 2018, pp. 367–375. <https://pubmed.ncbi.nlm.nih.gov/30167651/>.

⁴⁷ Dowell, D., K.R. Ragan, C.M. Jones, G.T. Baldwin, and R. Chou. “CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022.” *Morbidity and Mortality Weekly Report, Recommendations and Reports*, vol. 71, no. 3, November 2022, pp. 1–95. <https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm>.

⁴⁸ National Institute on Drug Abuse. “Fentanyl.” National Institutes of Health. June 2025. <https://nida.nih.gov/research-topics/fentanyl#health-risks>.

⁴⁹ Garnett, M.F., and A.M. Miniño. “Drug Overdose Deaths in the United States, 2003–2023.” NCHS Data Brief No. 522. National Center for Health Statistics, December 2024. https://www.cdc.gov/nchs/products/databriefs/db522.htm#section_4.

⁵⁰ Garnett, M.F., and A.M. Miniño. “Drug Overdose Deaths in the United States, 2003–2023.” NCHS Data Brief No. 522. National Center for Health Statistics, December 2024. https://www.cdc.gov/nchs/products/databriefs/db522.htm#section_1.

⁵¹ Garnett, M.F., and A.M. Miniño. “Drug Overdose Deaths in the United States, 2003–2023.” NCHS Data Brief No. 522. National Center for Health Statistics, December 2024. https://www.cdc.gov/nchs/products/databriefs/db522.htm#section_1.

⁵² National Center for Health Statistics Pressroom. “U.S. Overdose Deaths Decrease Almost 27% in 2024.” CDC, May 14, 2025. <https://www.cdc.gov/nchs/pressroom/releases/20250514.html>.

⁵³ NCQA. “Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP).” n.d. <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-antipsychotics-app/>.

⁵⁴ NCQA. “Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM).” n.d. <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics-amp/>.

⁵⁵ Blackburn, J., P. Sharma, K. Corvey, M.A. Morrissey, N. Menachemi, B. Sen, C. Caldwell, and D. Becker. “Assessing the Quality Measure for Follow-Up Care After Children’s Psychiatric Hospitalizations.” *Hospital Pediatrics*, vol. 9, no. 11, November 2019, pp. 834–843. <https://doi.org/10.1542/hpeds.2019-0137>.

⁵⁶ Andrade, S.E., J.C. Lo, D. Roblin, H. Fouayzi, D.F. Connor, R.B. Penfold, M. Chandra, G. Reed, and J.H. Gurwitz. “Antipsychotic Medication Use Among Children and Risk of Diabetes Mellitus.” *Pediatrics*, vol. 128, no. 6, December 2011, pp. 1135–1141. <https://pubmed.ncbi.nlm.nih.gov/22106077/>.

⁵⁷ NCQA noted to allow trending with caution for this metric for CY 2024 compared with prior years. (For more information, see <https://wpcdn.ncqa.org/www-prod/HEDIS-MY2024-Trending-Memo.pdf>.)

⁵⁸ Tukey, J. *Exploratory Data Analysis*. Reading, MA: Addison-Wesley, 1977.

⁵⁹ See <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures> for more information. When relevant, we generally use the 2024 Core Set (MY 2023) data for comparison, which are the most recent data available as of February 2026. CY 2023 is also commonly the most recent reported year of monitoring data for relevant metrics.