Utah Medicaid Reform 1115 Demonstration: Serious Mental Illness and Substance Use Disorder Mid-Point Assessment

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EXECUTIVE SUMMARY

This Mid-Point Assessment (MPA) assesses the state of Utah's progress towards achieving the milestones associated with the SUD Demonstration Program and the SMI/SED Demonstration Program components of the state's Section 1115 Demonstration Waiver, "Medicaid Reform 1115 Demonstration." The MPA evaluates approximately the first two and half years of the respective demonstration periods.

SUD Demonstration Program Milestone Risk Assessment and Recommendations

The Independent Evaluator (IE) reviewed monitoring metrics, the Implementation Plan, stakeholder feedback and contextual information, and the MPA covering the previous SUD Demonstration Period to determine the state's risk of not achieving the following demonstration milestones:

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

The IE found Utah to be at low risk for not achieving SUD Milestones 1 and 3. Utah is moving in the expected direction on 85% of the critical metrics for Milestone 1. The IE does recommend, however, that the state examine an overall reduction in continuity of pharmacotherapy for OUD from the start of the demonstration in 2018 to the mid-point of the current demonstration period. There are no critical metrics associated with Milestone 3, and the IE has no recommendations for improvement.

The IE determined that Utah is at medium risk for not achieving Milestones 2, 4, 5, and 6. For Milestone 2, the state's Average Length of Stay in IMDs at the mid-point exceeds the 30-day target. Milestone 4 captures a decrease in SUD Provider Availability for MAT, which is explained by a shift in data reporting systems but also coincides with a potential provider shortage in the state. A critical metric associated with Milestone 5 demonstrates a significant increase in the prescribing of opioids at high dosages in persons without cancer. While 57% of the critical metrics associated with Milestone 6 progressed in the expected direction, the IE noted an increase in readmission rates among beneficiaries with SUD and decreases in follow-up after ED visits for SUD.

The IE recommends the state engage with stakeholders to better understand the drivers of length of stay in IMDs for SUD treatment, explore evidence-based strategies for reducing length of stay, examine the landscape of SUD provider capacity in the state, identify factors contributing to the increase of opioid prescribing for certain populations and employ evidence-based strategies to reduce unnecessary prescriptions, and finally to identify barriers to increasing initiation in treatment for beneficiaries with SUD.

SMI Demonstration Program Milestone Risk Assessment and Recommendations

The IE reviewed SMI monitoring metrics, the Implementation Plan action items, and stakeholder feedback and contextual information to determine the state's risk of not achieving the following demonstration milestones:

- **Milestone 1:** Ensuring quality of care in psychiatric hospitals and residential settings
- **Milestone 2:** Improving care coordination and transitions to community-based care
- **Milestone 3:** Increasing access to continuum of care including crisis stabilization services
- **Milestone 4:** Earlier identification and engagement in treatment including through increased integration

The IE found Utah to be at low risk for not achieving the Milestone 3. The IE determined that the critical metrics under Milestone 3 are moving in the expected direction. The IE has no recommendations for the state regarding increasing access to continuum of care including crisis stabilization services.

The IE determined that Utah is at medium risk for not achieving Milestones 2 and 4. For Milestone 2, while the state demonstrated significant improvement in follow-up metrics for 7- and 30-day hospitalizations for mental illness, the state had significant decreases in 7- and 30-day follow-up for emergency department visits for mental illness and for alcohol and other drug abuse or dependence. The IE recommends that the state review current standards that contribute to the success of 7- and 30-day follow-up for ED visits related to SUD and to review the strategies used to increase follow-up for mental illness for hospitalizations. For Milestone 4, the majority of critical metrics did move in the expected direction. However, two metrics did not show improvement: cholesterol testing in children or adolescents on antipsychotics and glucose and cholesterol testing in children or adolescents on antipsychotics. The IE recommends that the state continue their efforts to improve communication with the children and adolescents, or their guardians, to ensure they follow appropriate pre-medical visit protocol to allow for "fasting" lab collections.

The IE determined that Utah is at high risk for not achieving Milestone 1 as none of the critical metrics showed improvement. The IE recommends that the state review current quality standards, quality assurance requirements, and oversight processes for psychiatric hospitals and residential settings to identify areas that may need to be strengthened. The IE further recommends that the state engage with providers to identify systemic barriers to providing high quality care in these settings.

SUD and SMI/SED Provider Capacity and Recommendations

The SMI/SED provider availability assessment and the SUD provider capacity metrics do not provide a nuanced picture of Utah's provider capacity to meet the needs of Medicaid beneficiaries with behavioral health needs.

The SMI/SED provider availability assessment indicates a general decrease in provider capacity. There was a decrease in the majority of provider types with the exception of prescribing practitioners (e.g., Medicaid-enrolled psychiatrists or other practitioners who are authorized to prescribe and Medicaid-enrolled psychiatrist or practitioners who are authorized to prescribe or licensed to independently treat mental illness) and inpatient providers (e.g., psychiatric hospitals and psychiatric units in acute care hospitals) which showed an increase in provider capacity.

In contrast, there was an 18% increase in Medicaid-enrolled SUD providers (Milestone 4 of the SUD demonstration). Furthermore, state stakeholders have indicated qualitatively the likelihood of a provider shortage in the state. The IE cannot determine whether the number of SUD providers is adequate to meet the needs of Utah's beneficiaries without additional information.

The IE recommends that the state conduct a thorough behavioral health system capacity assessment. The state should consider creating and/or collecting additional behavioral health provider capacity metrics and engaging with providers and other stakeholders to better understand system capacity and accessibility. Such an assessment should include ratios of beneficiaries to providers, telehealth capacity, appointment wait times, and an assessment of distances between beneficiaries and providers.

A. General Background

A.1 Demonstration Name and Timing

On June 30, 2022, the Centers for Medicare & Medicaid Services (CMS) approved a five-year extension of Utah's section 1115 waiver, formerly known as the "Primary Care Network (PCN) Demonstration" (hereafter, "the Demonstration" or "the 1115 Demonstration"). The current extension is entitled "Medicaid Reform 1115 Demonstration" and is approved for the five-year period from July 1, 2022, through June 30, 2027. Through the Demonstration, CMS has granted the state expenditure authorities to expand service offerings for vulnerable populations, move some members into integrated managed care plans, and to provide coverage to populations not otherwise eligible for Medicaid. The Utah Department of Health and Human Services (DHHS) Division of Integrated Healthcare (DIH) administers the Utah Medicaid program and is responsible for the implementation of the Demonstration.

Utah first received approval of the SUD Demonstration Program on October 31, 2017, and CMS subsequently approved the SUD Demonstration Implementation Plan in November 2017. The Opioid Use Disorder (OUD) and SUD Program provides state plan behavioral health benefits to Demonstration participants. The state also received authority to provide residential and inpatient OUD/SUD treatment services to all Medicaid beneficiaries while they are short term residents in treatment settings that qualify as IMDs.

The SMI/SED Implementation Plan was approved in December 2020 and is similar in expenditure authority to the OUD/SUD program. The state is taking action to meet key milestones of the SMI/SED program including, ensuring quality of care in psychiatric hospitals and residential settings, improving care coordination and transitions to community-based care, increasing access to the continuum of care including crisis stabilization services, and earlier identification and engagement in treatment and increased integration.

Together, the SUD and SMI components expand access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services. The 1115 Demonstration supports state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SMI evidence-based services at varied levels of intensity, including crisis stabilization services.

SUD Demonstration Program Measurement Period

This mid-point assessment (MPA) includes approximately the first two years of the current SUD Demonstration Program. The data included in the MPA has a range of measurement periods; most of the state's monitoring metrics are collected on a calendar year cadence that does not align entirely with the demonstration year measurement periods. The MPA includes the following measurement periods:

Reporting Period	Dates
Baseline: SUD Demonstration Year 6 (SUD DY6)	7/1/2022 - 6/30/2023
Baseline: SUD Calendar Year 6 (SUD CY6)	1/01/2022 - 12/31/2022
Mid-Point: SUD Demonstration Year 7 (SUD DY7)	7/1/2023 - 6/30/2024
Mid-Point: SUD Calendar Year 7 (SUD CY7)	1/01/2023 - 12/31/2023

Table 1 SUD Demonstration Program Measurement Period

Additionally, since the SUD Demonstration Implementation Plan was first approved in November 2017, a previous MPA conducted by a different Independent Evaluator assessed the SUD Demonstration Program's progress from 11/1/2017—6/30/2020 (SUD DY1—DY3). The state's performance from 7/1/2020—6/30/2022 (SUD DY4—DY5) has

not been included in an MPA to date. This MPA acknowledges and takes into account the previous demonstration years when contextualizing the state's progress in this current demonstration period.

SMI/SED Demonstration Program Measurement Period

The SMI/SED MPA includes the first two and a half to three years of the demonstration. Metrics that are calculated based on demonstration years are reported through DY3 and metrics that are calculated based on calendar years are reported through 2023. Three provider availability assessments are included; the baseline assessment was completed in December 2020, the second one in March 2022, and the third in September 2023. The MPA includes the following measurement periods:

Reporting Period	Dates
Baseline: SMI Calendar Year 1 (SMI CY0)	1/1/2020 – 12/31/2020
Baseline: SMI Demonstration Year 1 (SMI DY1)	7/1/2020 – 6/30/2021
SMI Demonstration Year 2 (SMI DY2)	7/1/2021 – 6/30/2022
Baseline: SMI Calendar Year 2 (SMI CY1)	1/1/2021 – 12/31/2021
Mid-Point: SMI Demonstration Year 3 (SMI DY3)	7/1/2022 – 6/30/2023
Mid-Point: SMI Calendar Year 3 (SMI CY3)	1/1/2023 – 12/31/2023

TABLE 2 SMI/SED DEMONSTRATION PROGRAM MEASUREMENT PERIOD

A.2 POLICY GOALS

SUD Demonstration Program Policy Goals

The MPA assesses the state's progress in meeting the following milestones and associated milestone activities as articulated in the STCs:

Demonstration Milestone	Milestone Activities
Milestone 1: Access to critical levels of care for OUD and other SUDs	• Requirement for providers to assess treatment needs based on SUD-specific, multidimensional assessment tools that reflect evidence-based clinical treatment guidelines
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria	• Implementation of a utilization management approach to ensure beneficiaries have access to SUD services at the appropriate level of care and interventions are appropriate for diagnoses and level of care
Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities	• Implementation of residential treatment provider qualifications in licensure, policy, or provider manuals, managed care contracts or credentialing, or other requirements that meet program standards for nationally recognized, SUD-specific program standards

Milestone 4: Sufficient provider capacity at each level of care	• Assessment of provider availability in key levels of care throughout the state
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	• Implementation of opioid prescribing guidelines and other interventions to prevent prescription drug abuse and expand access to naloxone
Milestone 6: Improved care coordination and transitions between levels of care	• Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following facility stays

TABLE 3: SUD DEMONSTRATION POLICY GOALS

SMI/SED Demonstration Program Policy Goals

The MPA assesses the state's progress in meeting the following milestones and associated milestone activities as articulated in the STCs:

Demonstration Milestone	Milestone Activities
Milestone 1: Ensuring quality of care in psychiatric hospitals and residential settings	• Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services are residing must be licensed or meet the standards for licensing established by the state prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. • Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD. • Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements. • Use of a utilization review entity to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight. • Establishment of a process for ensuring participating psychiatric hospitals and residential

	settings meet applicable federal program integrity requirements. Establishment of a state process to conduct risk-based screening of all newly enrolling providers as well as revalidation of existing providers. ● Implementation of a state requirement that participating psychiatric hospitals and residential settings screen beneficiaries for comorbid physical health conditions and SUDs and demonstrate the capacity to address comorbid physical health conditions during short-term stays in residential or inpatient treatment settings.
Milestone 2: Improving care coordination and transitions to community-based care	● Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services ● Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available ● Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to ● Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers) ● Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED

Milestone 3: Increasing access to continuum of care including crisis stabilization services.	• Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability • Commitment to implementation of the SMI/SED Financing Plan described in STC 12.4 • Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need of that level of care as soon as possible • Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.
Milestone 4: Earlier identification and engagement in treatment and increased integration.	• Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs • Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers • Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

TABLE 4: SMI/SED DEMONSTRATION POLICY GOALS

A.3 IMPACT OF THE COVID-19 PUBLIC HEALTH EMERGENCY

The SUD and SMI/SED Demonstration time periods covered by the MPA overlap with the federal COVID-19 Public Health Emergency (hereafter, "the PHE"), declared on January 31, 2020, and lifted May 11, 2023. Nationally, the PHE led to declines in in-person health care visits; behavioral health visits dropped by up to 75% for those with commercial insurance. Telehealth access and utilization increased nationally, though adoption rates among Medicaid beneficiaries tended to be lower than rates among those with commercial insurance. [1] The PHE

[1] https://www.aha.org/system/files/media/file/2022/05/trendwatch-the-impacts-of-the-covid-19-pandemic-on-behavioral-health.pdf

exacerbated mental health issues including anxiety, depression, and substance use.[2] This combination of factors, barriers to accessing care and an increased need for services, likely impacted several SMI and SUD monitoring metrics. A comprehensive analysis of the state-specific impact of the PHE on behavioral health care needs and access is beyond the scope of this report. Findings should be cautiously interpreted given the overlap of the demonstration periods with the PHE.

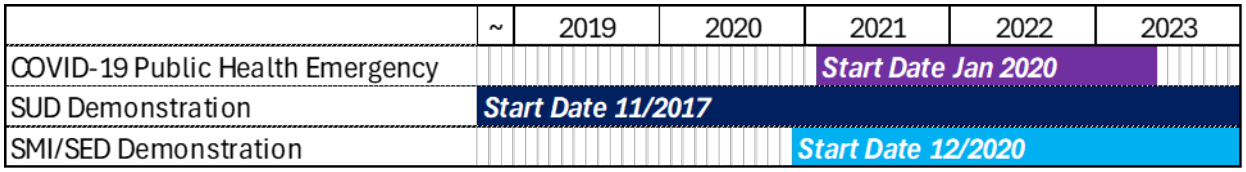

FIGURE 1 DEMONSTRATION TIMELINE AND THE COVID-19 PHE

[2] https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

B. METHODOLOGY

B.1 DATA SOURCES

The mid-point assessment utilized the following quantitative and qualitative data sources:

- Monitoring metrics
- Provider availability assessment (SMI/SED Demonstration Program only)
- Implementation plan action items
- Stakeholder feedback and contextual information
- Utah 1115 SUD Mid-Point Assessment Report (September 2022; SUD Demonstration Program only)

Monitoring Metrics

The Independent Evaluator (IE) utilized the monitoring reports prepared by the state for quarterly and annual CMS required reporting for the state's Section 1115 Demonstration. The IE extracted the relevant metrics (critical metrics, service utilization metrics, and any relevant monitoring metrics) from the CMS approved monitoring reports to conduct a comparison from baseline to mid-point. Additionally, the IE reviewed the monitoring report from the previous SUD Demonstration period for added context on the state's performance over time on the SUD Demonstration Program.

Provider Availability Assessment

States with 1115 SMI/SED demonstrations are required to complete an annual provider availability assessment (PAA), utilizing a data collection template developed by CMS. The PAA captures the ratio of Medicaid beneficiaries with SMI to the availability of different provider types or facilities that can serve them in the state. This MPA utilizes the PAAs conducted by Utah in December 2020, March 2022, and September 2023 and approved by CMS to assess changes in provider availability for SMI services. Provider availability for SUD services is captured in the monitoring metrics associated with the SUD Demonstration Program Milestone 1: Access to critical levels of care for OUD and other SUDs for the SUD Demonstration Program.

Implementation Plan Action Items

The Implementation Plans developed by the state and approved by CMS in June 2017 and December 2020 for the SUD Demonstration Program and the SMI/SED Demonstration Program, respectively, both remain in effect for the current 1115 Demonstration period from July 1, 2022, through June 30, 2027. The Implementation Plans document the state's approach to operationalizing the SUD and SMI/SED Demonstration Programs and include specific action items designated by the state to achieve progress on each demonstration milestone. The SUD Implementation Plan action items were completed during the previous demonstration period and were not re-evaluated for this MPA. The IE reviewed and extracted the state's SMI/SED Implementation Plan action items for the MPA.

Stakeholder Feedback and Contextual Information

The IE meets regularly with Utah state program administrators and managers to discuss the Independent Evaluation of the 1115 Demonstration, inclusive of the SUD Demonstration Program and the SMI/SED Demonstration Program. To conduct the MPA, the IE reviewed the relevant data sources and preliminary findings with state stakeholders, including Utah Department of Health and Human Services (DHHS) staff, SUD and SMI Demonstration Program staff, and members of the agency's data analytics team. Additionally, the IE conducted informal, semi-structured conversations with this same group of state stakeholders, and provided opportunities for the state to submit written feedback or broader contextual information. The IE did not independently convene or elicit feedback from a broader group of stakeholders.

Broader contextual information, including the perspectives of a wide range of stakeholders in Utah's behavioral health system, was gathered from a master plan issued by the Utah Behavioral Health **Coalition** (which no longer exists) and subsequently, reports issued by the Utah Behavioral Health **Commission** (hereafter, UBHC, or "the commission")[3].

The Utah Behavioral Health **Coalition** engaged stakeholders, including persons with lived experience, providers, state administrators, community-based organizations, educators, legislators, employers, payers, and justice system representatives in a collaborative process to develop the Utah Behavioral Health Master Plan (hereafter, "the plan"), which was issued in January 2024.[4] The plan incorporates the perspectives of over 300 individuals who engaged in interviews, focus groups, and other feedback mechanisms, from June 2022 to July 2023. The plan is a guide for private and public sectors, systems, and stakeholders striving to create more accessible and effective mental health and substance use disorder systems in Utah. The IE reviewed the coalition's outreach plan, needs assessment, and process for developing the plan, and concluded that it was comprehensive and aligned with best practices.[5]

Subsequently, the commission was established in 2024 pursuant to Utah Code §26B-5-703 to be a central authority for coordinating BH initiatives and to ensure that Utah's BH systems are effective and efficient. In addition to the plan, the UBHC issues annual reports.

The IE reviewed the plan and the UBHC's 2024 and 2025 annual reports and relied on this information to contextualize the MPA findings.

Utah 1115 SUD Mid-Point Assessment Report—Previous Demonstration Period

In September 2022 CMS approved the first mid-point assessment of Utah's 1115 SUD Demonstration. This MPA primarily examined data from 2018 (the first full year of the previous demonstration period). It was drafted and approved prior to the current CMS MPA guidance[6] and framework and is therefore structured differently than this MPA. The IE reviewed the previous MPA and utilized it as a reference point for previous trends and insights into the state's historical performance.

B.2 Analytic Methods

The IE assessed the state's overall demonstration progress and performance on monitoring metric targets using a range of analytic methods recommended in CMS's guidance on conducting the mid-point assessment. The application of these analytic methods supported the determination of the state's risk of not meeting demonstration goals and informed recommendations for the state.

The MPA assesses the state's progress in achieving the following demonstration milestones:

SUD Demonstration Program:

- **Milestone 1:** Access to critical levels of care for OUD and other SUDs

[3] Behavioral Health Commission | Substance Use and Mental Health. https://sumh.utah.gov/data-reports/behavior-health-commission/

[4] Utah Behavioral Health Assessment & Master Plan - Kem C. Gardner Policy Institute. https://gardner.utah.edu/public-policy/health-care-and-life-sciences/utah-behavioral-health-assessment-master-plan/

[5] The plan is informed by an assessment conducted by the Kem C. Gardner Policy Institute, in partnership with Leavitt Partners, a Health Management Associates company. The assessment identified needs, gaps, and challenges in Utah's behavioral health systems.

[6] 1115 SUD and SMI/SED Mid-Point Assessment Technical Assistance Version 1.0

- **Milestone 2**: Use of evidence-based, SUD-specific patient placement criteria
- **Milestone 3:** Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities
- **Milestone 4:** Sufficient provider capacity at each level of care
- **Milestone 5:** Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
- **Milestone 6:** Improved care coordination and transitions between levels of care

SMI/SED Demonstration Program:

- **Milestone 1:** Ensuring quality of care in psychiatric hospitals and residential settings
- **Milestone 2:** Improving care coordination and transitions to community-based care
- **Milestone 3:** Increasing access to continuum of care including crisis stabilization services
- **Milestone 4:** Earlier identification and engagement in treatment including through increased integration

Per CMS guidance, particular critical metrics are attributed to each milestone and analyzed to measure progress in achieving the milestone. The IE measured change from baseline to mid-point for monitoring by calculating the Absolute Change and Percent Change:

- *Absolute Change = value of metric at mid-point – value of metric at baseline*
- *Percent Change = (value of metric at mid-point – value of metric at baseline) / value of metric at baseline*

The IE used the same methodology to compare service utilization between baseline and mid-point, though it was not attributed to a particular milestone.

To measure the state's capacity for delivering SMI/SED services, the IE calculated changes (percent change and absolute change) from the baseline year PAA and the mid-point year PAA. The PAA collects information on a range of provider types including:

- General Providers (Psychiatrists and Other Practitioners Authorized to Prescribe, and Other Practitioners Certified or Licensed to Independently Treat Mental Illness)
- Community Mental Health Centers (CMHCs)
- Intensive Outpatient or Partial Hospitalization Providers
- Residential Mental Health Treatment Facilities
- Inpatient
- Institutions for Mental Diseases (IMDs)
- Crisis Stabilization Services
- Federally Qualified Health Centers (FQHCs)

For each provider type, the IE extracted the number of Medicaid-enrolled providers as well as the ratio of Medicaid-enrolled beneficiaries to the number of Medicaid-enrolled providers. The IE excluded any data for providers that are not Medicaid enrolled.

The IE assessed whether provider availability was changing in alignment with the state's Implementation Plan and demonstration goals. In general, an increase in the number of providers and a decrease in the ratio of beneficiaries to providers indicates improved provider capacity for mental health services in the state.

B.3 Milestone Risk Assessment

The IE provided a risk rating for each demonstration milestone, primarily determined by the state's performance on the critical metrics and further informed by progress on their Implementation Plan action items, sub-sections of the provider availability assessment, and stakeholder feedback.

Per CMS guidance, initial milestone risk ratings were calculated by measuring critical metric performance using the following framework:

- **Low risk**: For >75% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.
- **Medium risk**: For 25-75% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.
- **High risk**: For <25% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.

The state's progress on Implementation Plan action items were also considered in determining the risk of not meeting the milestones. The IE reported the percentage of action items that were completed by the mid-point for each milestone. While a contributing factor, the percentage of completed Implementation Plan action items did not change the IE's risk rating determination based on progress on the critical metrics.

Stakeholder feedback provided important context for understanding the state's performance on critical metrics and Implementation Plan action items and informed the IE's development of recommendations for improvements and next steps.

While not included in the risk rating determination, PAA data contributed to an overall understanding of the state's capacity to deliver SMI/SED services, as described in Section B.2., Analytic Methods. In particular, PAA data related to the availability of crisis stabilization services in the state is closely aligned with demonstration milestone three: increasing access to the continuum of care.

Data Source	Considerations
Critical metrics	For each metric associated with the milestone, is the state moving in the direction of the state's annual goal?
Implementation plan action items	Has the state completed each action item associated with the milestone as scheduled to date?
Stakeholder feedback	Did key stakeholders identify risks related to meeting the milestone?
Provider availability assessment data	Is the state moving in the expected direction as outlined in the demonstration goals and milestones and as described in the state's Implementation Plan for availability assessment data?

Table 5 MPA Data Sources and Considerations

B.4 Limitations

1. Methodology for assessing critical metric progression in the expected direction: The IE utilized the standard analytic approaches for conducting mid-point assessments to calculate change from baseline to mid-point and to determine risk ratings for demonstration milestones. While a helpful tool for broadly capturing the state's progress at the mid-point of their demonstration, interpreting any change from baseline to mid-point as potential progress or lack of progress, regardless of magnitude of change or the overall value of the metric, can mask nuances in critical metric findings and overall milestone performance.

2. Limited engagement with SUD and SMI/SED providers in Utah: The IE engaged extensively with the Utah DHHS stakeholders, including agency staff who oversee the implementation of the 1115 Demonstration waiver, staff whose focus is behavioral health Medicaid services, and a range of data analytics team members. The IE did not, however, engage directly with provider organizations or individual healthcare providers during MPA data collection and analysis. This stakeholder group may have been able to provide more detailed and nuanced information and responses to several of the IE's questions related to trends or changes in behavioral health service delivery and utilization in Utah, given their "on-the-ground" experience and first-hand knowledge.

C. Findings

C.1 Progress Towards SUD Demonstration Program Milestones

As outlined in Section A.1, Demonstration Name and Timing, this MPA assesses progress from the current demonstration period's baseline to the mid-point and takes into account findings from an MPA conducted during the previous demonstration period. Specifically, an MPA was conducted by a different Independent Evaluator to assess progress from 11/1/2017—6/30/2020 (SUD DY1—DY3)[7]. The program's performance from the remainder of the previous demonstration period, 7/1/2020—6/30/2022 (SUD DY4—DY5), has not been included in an MPA to date. Therefore, SUD DY4 and SUD CY4 results are provided in the tables in this section, providing additional context. The absolute change and percentage change columns in the tables represent change from the current demonstration period's baseline to mid-point. The narrative description of progress highlights previous demonstration year's performance when this information enhances overall understanding of progress over time.

SUD Demonstration Program Implementation Plan and Implementation Plan Action Items

The SUD Demonstration Program Implementation Plan was initially approved for the demonstration period covering November 1, 2017, through June 30, 2022. It remains in effect for the current demonstration period of July 1, 2022, through June 30, 2027. All Implementation Plan action items were completed during the previous demonstration period and were not re-evaluated for this MPA. Please see Attachment D.3 for Utah's SUD Implementation Plan for reference.

SUD Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs

Milestone 1 of the SUD Demonstration Program is primarily assessed by examining trends in SUD service utilization in relation to the size of the demonstration population (Medicaid beneficiaries with SUD diagnosis). Trends of one quality metric, Continuity of Pharmacotherapy for Opioid Use Disorder (Metric 22), also informs the assessment of this milestone.

[7] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-pcn-sud-midpoint-assmnt-09282022.pdf

The number of Medicaid beneficiaries diagnosed with SUD increased in Utah by 10.9% from baseline to mid-point. In line with this increase in beneficiaries who likely need SUD-related services, service counts increased across every measure except Measure 11: Withdrawal Management, which saw an 11.5% decrease from baseline to mid-point.

Although Continuity of Pharmacotherapy for Opioid Use Disorder (Metric 22) increased from this demonstration period's baseline to mid-point, it has decreased substantially since the first year of the demonstration. In 2018, Metric 22 was reported as 51.7% and 48.7% in 2019. In 2020, during the COVID-19 pandemic, Continuity of Pharmacotherapy for Opioid Use Disorder dropped substantially to 23.8% and has remained generally stable at that level since.

The previous MPA report found that the state rapidly expanded SUD services, which resulted in large increases in service counts. With the exception of Metric 11: Withdrawal Management and Metric 22: Continuation of Pharmacotherapy for Opioid Use Disorder, utilization of SUD services continues to increase in Utah.

Monitoring Metrics

Metric #	Metric Name	SUD CY6 (Baseline)	SUD CY7	SUD CY8 (Mid-point)	Absolute Change	Percent Change	Observed Direction at Mid-point	Progress (Y/N)
4[8]	*Medicaid beneficiaries with SUD diagnosis*	*39,063*	*43,828*	*43,341*	*4,258*	*10.9%*	*Increase*	*n/a*
7	Early Intervention	295	668	298	3	1.0%	Increase	Y
8	Outpatient Services	81,857	81,985	82,070	213	0.3%	Increase	Y
9	Intensive Outpatient and Partial Hospitalization Services	1,397	1,592	1,450	53	3.8%	Increase	Y
10	Residential and Inpatient Services	15,769	16,037	17,236	1,467	9.3%	Increase	Y
11	Withdrawal Management	393	449	348	-45	-11.5%	Decrease	N
12	Medication Assisted Treatment	5,528	6,368	5,737	209	3.8%	Increase	Y
22	Continuity of Pharmacotherapy for Opioid Use Disorder	**SUD CY4**	**SUD CY6 (Baseline)**	**SUD CY7 (Mid-Point)**[9]	**Absolute Change**	**Percent Change**	**Observed Direction at Mid-point**	**Progress (Y/N)**
		24.4%	21.8%	24.5%	2.7	12.3%	Increase	Y

TABLE 6 SUD MILESTONE 1 MONITORING METRICS

[8] Not a critical metric.
[9] 2024 SUD CY8 data is not available for Metric 22.

SUD Milestone 2: Use of Evidence-based, SUD-specific patient placement criteria

Milestone 2 is focused on the use of evidence-based SUD specific patient placement criteria and is assessed through two critical measures: Metric 5: Medicaid Beneficiaries Treated in an IMD for SUD and Measure 36: Average Length of Stay (ALOS) in IMDs. Metric 5 shows a 6.7% increase from baseline to mid-point, consistent with the state's goal of increasing Medicaid beneficiary utilization of IMDs for SUD treatment. Average Length of Stay in IMDs increased from 28.7 days at baseline to 43.1 days at mid-point. This increase exceeds the state's goal of maintaining an ALOS less than 30 days.

The previous MPA does not include ALOS data, but it does provide an independent review of budget neutrality. This review found that Utah did not meet budget neutrality requirements for DY1 or DY2 and cites length of stay for Medicaid beneficiaries in IMDs as the primary driver of cost.

Monitoring Metrics

Metric #	Metric Name	SUD DY4	SUD DY6 (Baseline)	SUD DY7 (Mid-Point)	Absolute Change	Percent Change	Observed Direction at Mid-Point	Progress (Y/N)
5	Medicaid Beneficiaries Treated in an IMD for SUD	2468	2603	2777	174	6.7%	Increase	Y
36	Average Length of Stay in IMDs (days)	39.6	28.7	43.1	14.4	50%	Increase	N

TABLE 7 SUD MILESTONE 2 MONITORING METRICS

SUD Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

There are no critical metrics associated with Milestone 3 for the SUD Demonstration Program. The IE reviewed the provider qualifications for residential treatment facilities in Utah made available by the Utah Office of Administrative Rules.[10] The IE obtained information from the state regarding the use of national recognized SUD-specific program standards to set provider qualifications for residential treatment facilities, and found that:

- Provider qualifications are set by the Utah Office of Licensing through state code and administrative rule. The Office of Licensing implements these provider qualifications.
- Utah Medicaid requires residential treatment facilities to follow the American Society of Addiction Medicine (ASAM) criteria guidelines, which are nationally recognized SUD-specific program standards.
- Utah Medicaid manuals are updated as needed to meet national standards.

[10] Health and Human Services, Human Services Program Licensing, Residential Treatment Programs Provider Qualifications. Utah Office of Administrative Rules. https://adminrules.utah.gov/public/rule/R501-19/Current%20Rules?searchText=501-19

SUD Milestone 4: Sufficient Provider Capacity at Each Level of Care

Milestone 4 measures provider capacity through Metric 13: SUD Provider Availability (Medicaid enrolled) and Metric 14: SUD Provider Availability—MAT (Medicaid enrolled). Unlike other metric tables in this report, the SUD DY4 year is not shown in the summary table. After the SUD DY4 year, the state transitioned from a legacy information system, the Utah Medicaid Management Information System (MMIS), to a new system called Provider Reimbursement Information System for Medicaid (PRISM). The state reports that the underlying provider table in the legacy system was outdated and thus the DY4 metrics are not comparable to years following the transition to PRISM (DY6 and DY7). Overall SUD Provider Availability increased by 18.1% from baseline to mid-point, consistent with the state's anticipated target. SUD Provider Availability specific to Medication Assisted Treatment (MAT) decreased significantly from 101 to 52 providers from baseline to mid-point. The state notes that the method for identifying MAT providers is based on MAT service utilization not provider enrollment under a specific provider type. Therefore, in DY6 there were 101 unique providers of MAT services based on claims submitted for MAT. In DY7, there were 52 unique providers of MAT services based on claims submitted for MAT.

The previous MPA found that there had been a rapid expansion of new SUD services to beneficiaries with significant needs, as well as extensive programming instituted to strengthen and build a strong foundation statewide for the SUD treatment agencies and individual providers. At the time, however, SUD providers still reported that the demand for treatment slots was high enough to create delays for those seeking treatment. The state confirms that this provider shortage still exists in the current demonstration period but does not know if it is specific to MAT providers.

Monitoring Metrics

Metric #	Metric Name	SUD DY6 (Baseline)	SUD DY7 (Mid-point)	Absolute Change	Percent Change	Observed Direction at Mid-point	Progress (Y/N)
13	SUD Provider Availability (Medicaid enrolled)	436	515	79	18.1%	Increase	Y
14	SUD Provider Availability – MAT (Medicaid enrolled)	101	52	-49	-48.5%	Decrease	N

TABLE 8 SUD MILESTONE 4 MONITORING METRICS

SUD Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone 5 assesses the implementation of treatment and prevention strategies known to impact opioid abuse and opioid use disorder, as well as measures that capture the impact of these strategies. Metric 18: Use of Opioids at High Dosage in Persons Without Cancer increased significantly by 170% from baseline to mid-point. The IE notes, however, that from SUD CY4 to SUD CY6, the metric improved dramatically. Metric 21: Concurrent Use of Opioids and Benzodiazepines decreased from baseline to mid-point, consistent with the state's anticipated directionality and goal.

Metric 23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries shows a similar trend to Measure 18, increasing from baseline to mid-point, but an overall decrease from SUD CY4. Metric 27: Overdose death rate remained stable at .07% from baseline to mid-point.

Monitoring Metrics

Metric #	Metric Name	SUD CY4	SUD CY6 (Baseline)	SUD CY7 (Mid-point)	Absolute Change	Percent Change	Observed Direction at Mid-point	Progress (Y/N)
18	Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)	11.1%	3.6%	9.7%	6.1	170%	Increase	N
21	Concurrent Use of Opioids and Benzodiazepines (NQF #3175)	21.8%	19.4%	19.1	-0.3	-1.4%	Decrease	Y
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries.[11]	4.2	3.1	3.5	0.5	15.1%	Increase	N
27	Overdose death rate.[12]	0.68%	0.07%	0.07%	0.0	0.0%	No change	Y

TABLE 9 SUD MILESTONE 5 MONITORING METRICS

SUD Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Milestone 6 measures improved care coordination and transitions between levels of care by examining beneficiaries' initiation and engagement in treatment for alcohol, opioid, and other drug dependencies, as well as rates of follow-up after SUD or mental health related emergency department visits.

Rates of Initiation in Alcohol and Other Drug Dependence Treatment (Metric 15) have been relatively stable since the demonstration began, with the 2023 rate (40.9%) only slightly higher than the 2019 rate (40.0%). The highest rates were in 2021 and 2022, at 42.3% and 42.5% respectively. Lack of progress on this measure may be due to a provider shortage issue.

Rates of Engagement in Alcohol and Other Drug Dependence Treatment (Metric 15) have increased substantially over time, from 2018 (9.71%) to 2023 (16.5%).

Follow-up after ED visits for SUD—7 day (Metric 17) are comparable in 2023 (12.2%) relative to the start of the demonstration (12.3% in 2018). Rates of 30-day follow-up have slightly increased from 2018 (19.2%) to 2023 (21.2%) with the highest rates observed in 2020 (28.4%) and 2022 (24.3%). In contrast, rates of Follow-

[11] Metric is reported monthly. Figures represent the average monthly utilization rate per 1,000 beneficiaries during the DY.
[12] Metric is reported based on DY

up after ED visits for MH increased from baseline to mid-point for both the 7-day (9.6%) and 30-day (6.6%) measure,

Readmission rates among beneficiaries with SUD were stable from 2020 (17.4%) to 2022 (17.5%) but then increased by 2023 (19.9%).

Lack of progress on Follow-up after ED visits for SUD and the increase in readmission rates among SUD beneficiaries may reflect breakdowns in communication/coordination between facilities and managed care plans, both of which are required to provide transitional care management. A lack of adequate outpatient SUD provider capacity to provide timely follow-up care may also be a factor.

Monitoring Metrics

Metric #	Metric Name[13]	SUD CY4	SUD CY6 (Baseline)	SUD CY7 (Mid-point)	Absolute Change	Percent Change	Observed Direction at Mid-point	Progress (Y/N)
15	IET: Initiation, alcohol	42.1%	40.3%	38.2%	-2.1	-5.2%	Decrease	N
15	IET: Engage, alcohol	11.6%	11.3%	10.3%	-1.0	-9.1%	Decrease	N
15	IET: Initiation, opioid	49.9%	54.2%	52.7%	-1.5	-2.7%	Decrease	N
15	IET, Engage, opioid	22.9%	25.7%	27.7%	2.0	7.9%	Increase	Y
15	IET: Initiation, other	38.4%	38.5%	36.9%	-1.6	-4.2%	Decrease	N
15	IET: Engage, other	11.3%	12.0%	11.1%	-0.9	7.3%	Decrease	N
15	IET: Initiation, total	41.4%	42.5%	40.9%	-1.5	-3.6%	Decrease	N
15	IET, Engage, total	15.0%	16.1%	16.5%	0.4	2.3%	Increase	Y
17 (1)	FU after ED visit, SUD, 7-day	15.8%	14.5%	12.2%	-2.3	-15.9%	Decrease	N
17 (1)	FU after ED visit, SUD, 30-day	28.1%	24.3%	21.2%	-.31	-12.8%	Decrease	N
17 (2)	FU after ED visit, MH, 7-day	24.9%	24.6%	27.0%	2.4	9.6%	Increase	Y
17 (2)	FU after ED visit, MH, 30-day	39.3%	41.3%	44.0%	2.7	6.6%	Increase	Y

[13] Full measure name for Metric 15 is: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004). It is reported separately for alcohol, opioid, other, and total. The milestone risk rating is based on the total initiation rate, and the total engagement rate.

25	Readmissions Among Beneficiaries with SUD.[14]	17.4%	17.5%	19.9%	2.4	13.7%	Increase	N

TABLE 10 SUD MILESTONE 6 MONITORING METRICS

C.2 PROGRESS TOWARDS SMI/SED DEMONSTRATION PROGRAM MILESTONES

SMI/SED Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

For Milestone 1 of the SMI/SED assessment, the state reported two critical metrics: Metric 2 - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) and Metric 23 - Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD).

From SMI CY1 to SMI CY3, metrics 2 and 23 did not meet the state's annual target for their respective categories. There was a 14% decrease in Metric 2, with an annual target to increase, and a 6.4% increase in Metric 23, which had an annual target to decrease. The decrease in the use of first-line psychosocial care for children and adolescents on antipsychotics may reflect a lack of adequate capacity of outpatient behavioral health providers serving children and adolescents. The increase in patients with SMI exhibiting poorly controlled diabetes may be driven by a decrease in engagement in primary care which in turn may be attributable in part to the COVID-19 public health emergency.

Monitoring Metrics

Metric #	Metric Name	SMI CY1 (Baseline)	SMI CY3 (Mid-point)	Absolute Change	Percent Change	State's Annual Target	Observed Direction at Mid-point	Progress (Y/N)
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	63.0%	54.1%	-8.9	-14.1%	Increase	Decrease	N
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	64.7%	68.9%	4.2	6.4%	Decrease	Increase	N

TABLE 11 SMI/SED MILESTONE 1 MONITORING METRICS

[14] Metric reported based on DY.

Implementation Plan Action Items

The state identified needed actions for one Implementation Plan action item, item 1.a, which focused on ensuring that participating hospitals and residential settings are licensed to provide mental health treatment and are nationally accredited. The state completed this action item.

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be completed	Current Status (completed, open, suspended)
1.a	Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	Update the Medicaid Provider Enrollment process to require submission of verification of accreditation; all necessary system program changes given the appropriate identifier	6-12 months	Completed
1.b	Oversight process (including unannounced visits) to ensure participating hospitals and residential settings meet state's licensing or certification and accreditation requirements	None	n/a	n/a
1.c	Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	None	n/a	n/a
1.d	Compliance with program integrity requirements and state compliance assurance process	No action needed at this time		
1.e	State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	None	n/a	N/a
1.f	Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	None	n/a	n/a

TABLE 12 SMI/SED MILESTONE 1 IMPLEMENTATION PLAN ACTION ITEMS

SMI/SED Milestone 2: Improving Care Coordination and Transitions to Community-Based Care

Milestone 2 is assessed using metrics that are impacted by the availability of care coordination, especially during transitions from acute to community-based care. The monitoring metrics include 30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (Metric 4) and follow-up rates after hospitalization for mental illness and after ED visits (Metrics 8, 9, and 10). Follow-up was measured after 7 days and after 30 days. The state also reported on a non-critical monitoring metric, medication continuation following inpatient psychiatric discharge (Metric 6).

Metrics 6, 7, and 8 all changed in the direction of the state's annual targets showing progress in these four areas from baseline to mid-point. However, metrics 4, and 9, changed contrary to the state's annual targets. Metric 4, 30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility, showed a slight increase of 1.6%. Metric 6, medication continuation following inpatient psychiatric discharge, showed a slight increase of 2.3%. Metric 7, or follow-up after hospitalization for mental illness: ages 6 to 17 (FUH-CH), showed an increase of 99.8% and 62.5% in 7- and 30-day, respectively. Metric 8, or follow-up after hospitalization for mental illness

Metric 9, follow-up after ED visit for alcohol and other drug abuse or dependence, showed the largest decrease for 7- and 30-day follow-up with a 33.4% decrease in 30-day follow-up and a 38% decrease in 7-day follow-up from baseline to mid-point. Metric 10, or follow-up after ED visit for mental illness, showed a increase of 2.3% for 7-day follow-up and a 5.4% increase for 30-day follow-up.

Overall, there was progress for 4 out of 6 critical metrics. The 7-day and 30-day metrics for Metrics 7, 8, 9, and 10 have been combined and Metric 3 data were unavailable. The majority of the progress occurred in follow-up after hospitalization and inpatient stays. Follow-up after ED visits demonstrated no progress.

Monitoring Metrics

Metric #	Metric Name	SMI CY1 (Baseline)	SMI CY3 (Mid-point)	Absolute Change	Percent Change	State's Annual Target	Observed Direction at Mid-point	Progress (Y/N)
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	7.4%	7.5%	0.1	1.6%	Decrease	Increase	N
6	Medication Continuation Following Inpatient Psychiatric Discharge	68.2%	69.8%	1.6	2.3%	Increase	Increase	Y
7	Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH) (7-Day)	16.0%	32.0%	16.0	99.8%	Increase	Increase	Y
7	Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH) (30-Day)	31.1%	50.0%	19.4	62.5%	Increase	Increase	Y
8	Follow-up After Hospitalization for Mental Illness (7-Day)	13.9%	26.0%	12.1	87.4%	Increase	Increase	Y
8	Follow-up After Hospitalization for Mental Illness (30-Day)	25.5%	44.7%	19.3	75.7%	Increase	Increase	Y
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse	19.8%	12.2%	-7.7	-38.7%	Increase	Decrease	N

	or Dependence (7-Day)							
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30-Day)	31.8%	21.2%	-10.6	-33.4%	Increase	Decrease	N
10	Follow-up After Emergency Department Visit for Mental Illness (7-Day)	26.3%	27%	0.6	2.3%	Increase	Increase	Y
10	Follow-up After Emergency Department Visit for Mental Illness (30-Day)	41.8%	44%	2.3	5.4%	Increase	Increase	Y

TABLE 13 SMI/SED MILESTONE 2 MONITORING METRICS

Implementation Plan Action Items:

The state identified two Implementation Plan action items, item 2.c and 2.d, which focus on ensuring that state psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours and the development of strategies to prevent or decrease length of stays in EDs among beneficiaries with SMI/SED. The state completed this action item.

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be completed	Current Status (completed, open, suspended)
2.a	Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.	None	n/a	n/a
2.b	Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	None	n/a	n/a
2.c	State requirement to ensure psychiatric hospitals and	Add requirement to	July 2021	Completed

	residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	the next amendment to applicable managed care contracts		
2.d	Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	UT implemented the Crisis Now model – no further action steps	n/a	n/a
2.e	Other State requirements/policies to improve care coordination and connections to community-based care	None	n/a	n/a

TABLE 14 SMI/SED MILESTONE 2 IMPLEMENTATION PLAN ACTION ITEMS

SMI Milestone 3: Increasing Access to Continuum of Care Including Crisis Stabilization Services

Milestone 3 focuses on increasing access to continuum of care including crisis stabilization services. Metric 19, average length of stay (ALOS) in IMDs, is the only critical metric for this milestone. Metric 19 has three data points: ALOS for all IMDs and populations, ALOS among short-term stays (less than or equal to 60 days), and ALOS among long-term stays (greater than 60 days).

From baseline to mid-point, the ALOS for all IMDs and populations and ALOS among short-term stays both aligned with the state's annual target of averaging under 30 days. The ALOS for all IMDs and populations showed a slight decrease of 3.64% and the ALOS among short-term stays showed a decrease of 1.8%. The ALOS among long-term stays showed a 24% decrease from baseline to mid-point. The state did not have a target for long-term stays.

The majority of Implementation Plan action items were completed with the exception of item 3.c which is ongoing.

Monitoring Metrics

Metric #	Metric Name	SMI DY1 (Baseline)	SMI DY2	SMI DY3 (Mid-point)	Absolute Change	Percent Change	State's Annual Target	Observed Direction at Mid-point	Progress (Y/N)
19a	ALOS for all IMDs and populations	11	10.5	10.6	-0.4	-3.64%	No more than 30 days	Stabilize	Y
19a	ALOS among short-term stays (less than or equal to 60 days)	10.6	10.3	10.4	-0.2	-1.8%	No more than 30 days	Stabilize	Y
19a	ALOS among long-term stays (greater than 60 days)	112.3	92.7	85.0	-27.3	-24%	--	Stabilize	Y

TABLE 15 SMI/SED MILESTONE 3 MONITORING METRICS

Implementation Plan Action Items:

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be completed	Current Status (completed, open, suspended)
3.a	The state's strategy to conduct annual assessment of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's	Utah will complete the next annual assessment of the availability of mental health providers	September 30 2021	Complete

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be completed	Current Status (completed, open, suspended)
	annual demonstration monitoring reports.			
3.b	Financing plan	*See 5.a/3.b*		
3.c	Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	Implementation of the platform – January 2021 Monitor with DSAMH the Utah Behavioral Health Availability Platform's progress.	Ongoing	Open - ongoing
3.d	State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	1. Modify managed contracts to include a requirement that they must use a "widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay". 2. Follow up with managed care plans to ensure they are requiring the utilization of a patient assessment tool (Timeline: 6-12 months)		Completed
3.e	Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	Follow through with needed action steps to ensure completion of the State Plan amendment process. (Timeline: 3-6 months)		Completed
5.a/3.b	Increase availability of nonhospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/ assessment centers, with a coordinated	1. On January 1, 2021, pending CMS approval, Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan.	Note: some action items are ongoing	Completed

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be completed	Current Status (completed, open, suspended)
	community crisis response that involves collaboration with trained law enforcement and other first responders.	2. By December 2020, Utah will finalize administrative rule governing Crisis Receiving Centers. 3. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021. 4. Expand MCOT statewide: Goal of statewide MCOT by July 1, 2022 pending sustainable funding plan approved and adopted. 5. Expand SMR statewide: Goal of SMR to be in four regions by Spring 2021 dependent on funding. 6. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22. 7. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans. Ongoing. 8. Engagement and partnership with police dispatch to divert non-public safety calls from		

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be completed	Current Status (completed, open, suspended)
		law enforcement into the crisis system. Ongoing. 9. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce. Ongoing.		
5.b	Increase availability of ongoing community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	[In] 2020 Utah will finalize the Utah administrative rule governing ACT Teams. The state will require an annual plan by each Local Mental Health Authority that outlines the local plan for service delivery to high acuity clients and will provide support to build out AOT and/or ACT services when clinical need arises.		Complete

TABLE 16 SMI/SED MILESTONE 3 IMPLEMENTATION PLAN ACTION ITEMS

SMI Milestone 4: Earlier Identification and Engagement in Treatment Including Through Increased Integration

Milestone 4 addresses earlier identification and engagement in treatment through increased integration. The critical metrics under this milestone include access to preventive/ambulatory health services for Medicaid beneficiaries with SMI (Metric 26), percentage of children and adolescents on antipsychotics who received blood cholesterol and/or glucose testing (Metric 29), and follow-up care for adult Medicaid beneficiaries who are newly prescribed an antipsychotic (Metric 30).

In alignment with state targets, Metrics 26 and 29 (specifically Metric 29 solely addressing glucose testing) showed an increase from baseline to mid-point (0.7% and 14%, respectively). Metric 30, follow up care for adults newly prescribed antipsychotic, also increased from baseline to mid-point (1.1%). Metric 29, monitoring both glucose and cholesterol testing decreased from baseline to mid-point (-2.5%).

The two implementation action plan items, 4.c and 4.d, were completed within the proposed timeframe of their Implementation Plan.

Monitoring Metrics

Metric #	Metric Name	SMI CY1 (Baseline)	SMI CY3 (Mid-point)	Absolute Change	Percent Change	State's Annual Target	Observed Direction at Mid-point	Progress (Y/N)
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	94.7%	95.4%	0.7	0.7%	Increase	Increase	Y
29	Percentage of children and adolescents on antipsychotics who received blood glucose testing	23.9%	27.3%	3.3	14.0%	Increase	Increase	Y
29	Percentage of children and adolescents on antipsychotics who received cholesterol testing	2.7%	1.4%	-1.3	-49.2%	Increase	Decrease	N
29	Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	28.0%	27.3%	-0.7	-2.5%	Increase	Decrease	N
30	Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	73.8%	74.6%	0.8	+1.1%	Increase	Increase	Y

TABLE 17 SMI/SED MILESTONE 4 MONITORING METRICS

Implementation Plan Action Items:

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be completed	Current Status (completed, open, suspended)
4.a	Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	None	n/a	n/a
4.b	Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	None	n/a	n/a
4.c	Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	SMR will expand to the Salt Lake region by January of 2021 and into the Eastern region by mid-year 2021	Mid-2021	Complete
4.d	Other state strategies to increase earlier identification/ engagement, integration, and specialized programs for young people	Within the next 12 months, the Department of Human Services will enter into a contract for an early childhood competencies and consultation program that will include training for Local Authorities and their community partners.	Within 12 months	Complete

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be completed	Current Status (completed, open, suspended)
		Within 18 months, DSAMH and the Local Authorities will continue to partner with the Utah State Board of Education and Local Education Agencies to increase the local involvement for services, including increasing access to telehealth services and in-person services that will be provided in local schools. A full school-based implementation manual will also be completed in that timeframe.		

TABLE 18 SMI/SED MILESTONE 4 IMPLEMENTATION PLAN ACTION ITEMS

Service Utilization Metrics

Service utilization metrics provide additional context to mental health services utilization trends from baseline year to the mid-point year. In Table 19 below the IE has included all available data on service utilization, spanning from 2021 to 2023. The majority (71%) of the service utilization metrics, mental health services utilization for intensive outpatient and partial hospitalization, ED, telehealth, and any services, did not meet the state's annual target. Inpatient and outpatient mental health services utilization did meet the state's annual target with a 21% decrease and 3.6% increase, respectively.

Metric #	Metric (Service)	2021	2022	2023	Absolute Change	Percent Change	State's Annual Target	Observed Direction at Mid-point
13	Mental Health Services Utilization - Inpatient	6,566	5,690	5,205	-1,361	-20.7%	Decrease	Decrease
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	8,359	9,485	10,301	+1,942	+23.2%	Stabilize	Increase
15	Mental Health Services Utilization - Outpatient	104,274	110,560	108,059	+3,785	+3.6%	Increase	Increase
16	Mental Health Services Utilization - ED	113	112	236	+123	+108.8%	Decrease	Increase
17	Mental Health Services Utilization - Telehealth	49,656	28,785	26,593	-23,063	-46.4%	Stabilize	Decrease
18	Mental Health Services Utilization - Any Services	142,063	141,581	134,751	-7,312	-5.8%	Increase	Decrease
21	*Count of beneficiaries with SMI/SED (monthly)*	169,917	163,871	154,995	-14,922	-8.8%	N/A	--

TABLE 19 SMI/SED SERVICE UTILIZATION METRICS

Provider Availability Assessment

The state completed an initial and annual provider availability assessment (PAA), utilizing CMS-developed PAA data reporting templates. An overall picture of provider availability in relation to the demonstration population (adult Medicaid beneficiaries with SMI) is helpful to understand overall capacity in the state to deliver SMI services to Medicaid beneficiaries.[15]

[15] The IE notes that count of providers reported in the Provider Availability Assessment report may not reflect true changes in provider capacity and are likely an artifact of challenges with data collection that should be interpreted with caution.

Beneficiaries

The number of adult Medicaid beneficiaries decreased by 16% between baseline and mid-point. The number of adult Medicaid beneficiaries with SMI (21+) increased by 32% in the same time period. Overall, the percentage of adult Medicaid beneficiaries with SMI (21+) decreased by 18.2%.

Measure Title	SMI CY0 (Baseline)	2021	2022	SMI CY3 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)
Number of Adult Medicaid Beneficiaries (21+)	295,733	390,884	215,528	249,574	-46,159	-15.6%
Number of Adult Medicaid Beneficiaries with SMI (21+)	33,752	40,363	31,705	44,711	10,959	32.5%
Percent of total Adult Medicaid Beneficiaries with SMI (21+)	11%	10%	15%	9%	-2	-18.2%

TABLE 20 PROVIDER AVAILABILITY ASSESSMENT: BENEFICIARIES

Providers

The number of Medicaid-enrolled psychiatrists or other practitioners who are authorized to prescribe increased by 22.1% from baseline to mid-point. Medicaid-enrolled practitioners certified or licensed to independently treat mental illness also increased but by 38.7%. As a result of an increasing number of Medicaid-enrolled psychiatrists or practitioners who are authorized to prescribe or licensed to independently treat mental illness, the ratio of Medicaid-beneficiaries to providers has decreased thus indicating an increase in provider capacity.

Measure Title	SMI CY0 (Baseline)	2021	2022	SMI CY3 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe.[16]	10,925	11,623	12,430	13,340	2,415	22.1%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	3.1	3.5	3.5	2.7	0	0%	Decreased
Number of Medicaid-Enrolled Other	3055	3438	3812	4236	1,181	38.7%	Increase

[16] This metric is inclusive of all providers in the state who are authorized to prescribe.

Measure Title	SMI CY0 (Baseline)	2021	2022	SMI CY3 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Practitioners Certified or Licensed to Independently Treat Mental Illness							
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	11	9	11	8	-3	-27.3%	Decrease

TABLE 21 PROVIDER AVAILABILITY ASSESSMENT: PROVIDERS

Community Mental Health Centers (CMHCs)

From baseline to mid-point the number of Medicaid-enrolled CMHCs remained the same as the number of Medicaid beneficiaries with SMI/SED increased. This increase in beneficiaries with the same number of Medicaid-enrolled CMHCs indicates an increase in the ratio of beneficiaries to CMHCs and therefore a decrease in provider capacity.

Measure Title	SMI CY0 (Baseline)	2022	SMI CY3 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Number of Medicaid-Enrolled CMHCs	12	12	12	0	0	Stabilized
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid- Enrolled CMHCs	2813	3618	2996	183	6.5%	Increase

TABLE 22 PROVIDER AVAILABILITY ASSESSMENT: CMHCS

Intensive Outpatient or Partial Hospitalization Providers

The number of Medicaid-enrolled intensive outpatient/partial hospitalization providers from baseline to midpoint cannot be reported as the available. The current data set cannot distinguish between levels of outpatient care, or which providers are available at each level of care. Therefore, the IE cannot report on the effect of outpatient/partial hospitalization providers on provider capacity.

Measure Title	SMI CY0 (Baseline)	2022	SMI CY3 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Number of Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	47	75	n/a	n/a	n/a	n/a
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid- Enrolled Intensive Outpatient/ Partial Hospitalization Providers	718	579	n/a	n/a	n/a	n/a

TABLE 23 PROVIDER AVAILABILITY ASSESSMENT: INTENSIVE OUTPATIENT OR PARTIAL HOSPITALIZATION PROVIDERS

Residential Mental Health Treatment Facilities

From baseline to mid-point, the number of Medicaid-enrolled residential mental health treatment facilities (adult) and Medicaid-enrolled residential mental health treatment beds (adult) decreased to zero treatment facilities for either measure. This in turn would lead to an increase in the ratio of beneficiaries with SMI (adult) to facilities and providers, thus decreasing provider capacity.

Measure Title	SMI CY0 (Baseline)	2022	SMI CY3 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	2	18	0	-2	+89%	Decrease

Measure Title	SMI CY0 (Baseline)	2022	SMI CY3 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	16,876	1761	--	n/a	-n/a	n/a
Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)	35	459	0	-35	n/a	Decrease
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	964	69	--	n/a	-n/a	n/a

TABLE 24 PROVIDER AVAILABILITY ASSESSMENT: RESIDENTIAL MENTAL HEALTH TREATMENT FACILITIES

Inpatient

From baseline to mid-point, there was an increase in the number of psychiatric hospitals available to Medicaid patients by 11.1%, and thus a decrease of 4.1% of beneficiaries to hospitals. The number of Medicaid-enrolled psychiatric units in acute care hospitals increased by 150%, decreasing the ratio of Medicaid beneficiaries to psychiatric units by 57.4%. Additionally, the number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric Units) available to Medicaid patients increased by 106.6% and had an accompanying decrease in the ratio of beneficiaries to beds. This change suggests an increase in provider capacity. Limited data were available for a comparison between baseline and mid-point for several other measures.

Measure Title[17]	SMI CY0 (Baseline)	2022	SMI CY3 (Mid-point)	Absolute Change	Percent Change	Observed Direction at Mid-point
Number of Public and Private Psychiatric Hospitals	--	8	--	n/a	n/a	n/a
Ratio of Medicaid Beneficiaries with SMI/SED to Public and Private Psychiatric Hospitals Available to Medicaid Patients	--	5426	--	n/a	n/a	n/a
Number of Psychiatric Hospitals Available to Medicaid Patients	9	--	10	1	11.1%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals Available to Medicaid Patients	3750	--	3595	-155	-4.1%	Decrease
Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	4	10	10	6	150.0%	Increase
Number of Medicaid-Enrolled Psychiatric Units in Critical Access Hospitals (CAHs)	0	0	0	0	--	--

[17] The 2020 naming of these measures appears to have changed between 2020 and 2022. The data names were aligned with CMS guidance for the 2022 measure names.

Measure Title[17]	SMI CY0 (Baseline)	2022	SMI CY3 (Mid-point)	Absolute Change	Percent Change	Observed Direction at Mid-point
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	8438	4341	3595	-4843	-57.4%	Decrease
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	n/a	n/a	n/a	--	--	--
Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units) Available to Medicaid Patients	679	675	1403	724	106.6%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	50	64	26	-24	-48.028%	Decrease

TABLE 25 PROVIDER AVAILABILITY ASSESSMENT: INPATIENT

Psychiatric Residential Treatment Facilities (PRTFs)

Utah does not report having any PRTFs (baseline through 2023).

Institutions for Mental Diseases (IMDs)

From baseline to mid-point, the number of Medicaid-enrolled residential mental health treatment facilities (adult) that qualify as IMDs decreased to 0 (-100%) and thus caused a sharp increase in the ratio of. beneficiaries to treatment facilities. The number of psychiatric hospitals that qualify as IMD remained the same and the ratio of Medicaid beneficiaries to qualifying psychiatric hospitals increased by 6.5%. These data

demonstrate that there is decreased provider capacity for beneficiaries that may require a Medicaid-enrolled residential mental health treatment facilities that qualify as IMDs, and decreased provider capacity for those that need a psychiatric hospital that qualifies as an IMD. Overall, provider capacity decreased for IMDs.

Measure Title	SMI CY0 (Baseline)	2022	SMI CY3 (Midpoint)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	1	8	0	-1	-100%	Decrease
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities that Qualify as IMDs	22796	3963	n/a	-18833	--%	Increase
Number of Psychiatric Hospitals that Qualify as IMDs	9	6	9	0	0%	Consistent
Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	3750	7235	3994	244	6.5%	Increase

TABLE 27 PROVIDER AVAILABILITY ASSESSMENT: IMDS

Crisis Stabilization Services

The number of crisis call centers, crisis observation/assessment centers, and crisis stabilization units remained consistent with an increase in the ratio of beneficiaries to call centers of 6.5% The number of mobile crisis units increased by 16.7% thus decreasing the ratio of beneficiaries to mobile crisis units. While provider capacity increased in some areas, overall provider capacity is still limited if not decreased overall.

Measure Title	SMI CY0 (Baseline)	2022	SMI CY3 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Number of Crisis Call Centers	1	1	1	0	0	Consistent
Number of Mobile Crisis Units	18	18	21	3	16.7%	Increase
Number of Crisis Observation/Assessment Centers	0	0	0	0	0	Consistent
Number of Crisis Stabilization Units	2	2	2	0	0	Consistent
Number of Coordinated Community Crisis Response Teams	0	0	0	0	0	Consistent
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	33,752	43,410	35,949	2197	6.5%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	1875	2412	1712	-163	-8.7%	Decrease
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	n/a	n/a	n/a	--	--	n/a
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	16,876	21,705	17,974	1098	6.5%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response Teams	n/a	n/a	n/a	--	--	n/a

TABLE 28 PROVIDER AVAILABILITY ASSESSMENT: CRISIS STABILIZATION SERVICES

Federally Qualified Health Centers (FQHCs)

The number of FQHCs increased from baseline to mid-point with an 8% decrease in the ratio of Medicaid beneficiaries with SMI/SED to FQHCs. These findings suggest that there is an increase in provider capacity regarding FQHCs.

Measure Title	SMI CY0 (Baseline)	2022	SMI CY2 (Mid-point)	Absolute Change (Baseline to Mid-point)	Percent Change (Baseline to Mid-point)	Observed Direction at Mid-point
Number of FQHCs that Offer Behavioral Health Services	19	19	22	-22	16%	Consistent
Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	1776	2285	1634	-142	-8%	Decrease

TABLE 29 PROVIDER AVAILABILITY ASSESSMENT: FQHCS

C.3 ASSESSMENT OF OVERALL RISK OF NOT MEETING MILESTONES

The milestone risk-rating methodology reflected in this section are based on CMS SMI/SUD MPA guidelines. The assessment risk criteria are as follows:

- **Low risk**: For >75% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.
- **Medium risk**: For 25-75% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.
- **High risk**: For <25% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.

SUD Demonstration Program

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

The IE determined that Utah is at low risk for not achieving demonstration milestone 1. The majority (6 out of 7, 85%) of critical metrics indicate progress. Although Metric 22: Continuity of Pharmacotherapy for Opioid Use Disorder, increased from baseline to mid-point in this current demonstration period, the state was performing significantly better on this measure at the start of the demonstration in 2018. The IE recommends the state explore the drivers of change in this metric and work towards a strategy to improve rates of continuation of pharmacotherapy for OUD that are closer to the state's pre-pandemic performance.

Milestone 2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria

The IE determined that Utah is at medium risk for not achieving demonstration milestone 2. Only one of the two metrics (50%) moved in the expected direction. The Average Length of Stay in IMDs at the mid-point exceeds the 30-day ALOS target. The state notes that service authorizations are based on medical necessity and consistently reassessed using the ASAM LOC criteria. Additionally, it is likely that increased access to community-based services, including crisis response, resulting in higher acuity cases being admitted to IMDs and requiring longer lengths of stay. The IE recommends the state continue to monitor ALOS, engage stakeholders in a process to understand the drivers of LOS in IMDs for SUD treatment and explore evidence-based strategies for reducing LOS consistent with treating patients in the most appropriate level of care.

Utah DHHS Response: Service authorizations are based on medical necessity reviews; therefore, some stays will exceed the 30-day LOS due to the beneficiaries' needs and ASAM level of care criteria.

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

The IE determines that Utah is at low risk of not achieving demonstration milestone 3. There are no critical metrics associated with milestone 3. All of the implementation action items associated with milestone 3 were completed in the previous demonstration period. The original Implementation Plan approved at the start of the first demonstration period is still in effect for the current demonstration period. The IE has no recommendations for the state.

Milestone 4: Sufficient Provider Capacity at Each Level of Care

The IE determined that Utah is at medium risk for not achieving demonstration milestone 4. Only one of the two critical metrics (50%) moved in the expected direction. Although the decrease in SUD Provider Availability for MAT from baseline to mid-point is considered to be explained by a shift in data systems from MMIS to PRISM, state stakeholders have noted potential provider shortages across Utah. The IE recommends the state examine the landscape of SUD provider capacity in Utah and engage with stakeholders to understand the most acute provider shortage needs and their impact on beneficiaries with SUD.

Utah DHHS Response: Utah's Office of the Legislative Auditor General recently completed an audit of behavioral health providers in Utah and Medicaid's Office of Managed Healthcare completes yearly surveys of provider network availability. In addition, the Utah Health Workforce Advisory Council conducted a behavioral health workforce assessment which will be published in the spring of 2026. The council also established a subcommittee charged with creating a behavioral health workforce strategic plan. Utah will work with these entities to understand the most acute provider shortage needs and their impact on beneficiaries with SUD.

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

The IE determined that Utah is at medium risk for not achieving demonstration milestone 5. Only two out of four critical metrics (50%) moved in the expected direction. To address the significant increase of prescribing opioids at high dosage in persons without cancer, the IE recommends the state engage with providers to identify factors contributing to the increase, identify strategies to reduce prescribing opioids at high dosage to this population, consider additional provider training, and provide real-time feedback on prescribing rates and patterns as feasible.

Utah DHHS Response: The UT Medicaid pharmacy team outreaches, incorporates, and engages with providers when reviewing high dose opioids prior authorization and for concurrent use of benzodiazepines/opioids prior authorization. The pharmacy point-of-sale system has a hard 90 Morphine Milligram Equivalents (MME) limit and quantity limit edits that prevent Medicaid recipients without cancer from acquiring high MME and high quantity opioids. In addition, UT Medicaid has open coverage for OUD treatments including long acting injectable Brixadi, Sublocade and Vivitrol along with oral options such as buprenorphine, buprenorphine/naloxone, and naltrexone for Medicaid recipients. Utah will continue to outreach and engage providers in reducing prescribing opioids at higher dosage.

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

The IE determined that Utah is at medium risk of not achieving demonstration milestone 6. Four out of seven critical metrics (57%) moved in the expected direction. The IE recommends the state engage with stakeholders to identify barriers to increasing initiation in treatment and understand drivers of readmissions for beneficiaries with SUD. Additionally, the state may consider investments to strengthen transitional care supports, such as inclusion of peers in transitional support services.

Utah DHHS Response: Utah will engage with stakeholders to identify barriers to increasing initiation in treatment and understand drivers of readmissions for beneficiaries with SUD.

SMI/SED Demonstration Program

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

The IE determined that Utah is at high risk of not achieving demonstration milestone 1. None of the two critical metrics (0%) moved in the expected direction. The IE recommends that the state review current quality standards, quality assurance requirements, and oversight processes for psychiatric hospitals and residential settings to identify areas that may need to be strengthened. The IE further recommends the state engage with providers to identify systemic barriers to providing high quality care in these settings.

Utah DHHS Response: Utah will review current quality standards, quality assurance requirements, and oversight processes for psychiatric hospitals and residential settings to identify areas that may need to be strengthened.

Milestone 2: Improving Care Coordination and Transitions to Community-Based Care:

The IE determined that Utah is at medium risk of not achieving demonstration milestone 2. Five out of the ten metrics (50%) moved in the expected direction. The state demonstrated significant improvement in follow-up metrics (7- and 30-day) for hospitalizations with nearly 100% percent change from baseline to mid-point for 7-day follow up and over 50% increase for 30-day follow-up. The IE recommends review of the strategies implemented for increasing follow-up for hospitalizations to improve 7- and 30-day follow-up for ED visits. Additionally, the IE recommends that the state review the current standards that contribute to the success of 7- and 30-day follow-up for ED visits related to SUD.

Utah DHHS Response: Utah recently added the HEDIS Adult Core Set metrics, which includes the discussed metrics, to their managed care plans contracts. Utah will continue to work with the managed care plans to improve these metrics.

Milestone 3: Increasing Access to Continuum of Care Including Crisis Stabilization Services

The IE determined that Utah is at low risk of not achieving demonstration milestone 3. Three out of the three critical metrics (100%) moved in the expected direction. The IE has no recommendations for the state.

Milestone 4: Earlier Identification and Engagement in Treatment Including Through Increased Integration

The IE determined that Utah is at medium risk of not achieving demonstration milestone 4. Three out of the five critical metrics (60%) moved in the expected direction. The two metrics that did not move in the expected direction were related to cholesterol testing in children or adolescents on antipsychotics. The IE recommends that the state continue their efforts to improve communications to the children and adolescents and their guardians to ensure they follow appropriate pre-medical visit protocol that would not interfere with the ability of the providers to perform cholesterol testing.

Utah DHHS Response: Utah will continue their efforts to increase follow-up care to Medicaid beneficiaries and to improve communications to the children and adolescents and their guardians to ensure they follow appropriate pre-medical visit protocol that would not interfere with the ability of the providers to perform cholesterol testing.

Milestone	Risk Rating	IE's recommendations (for medium or high-risk milestones)
SUD Milestone 1	Low	N/A
SUD Milestone 2	Medium	Engage stakeholders in a process to better understand the drivers of LOS in IMDs for SUD treatment and explore evidence-based strategies for reducing LOS.
SUD Milestone 3	Low	N/A
SUD Milestone 4	Medium	Examine the landscape of SUD provider capacity in Utah and engage with stakeholders to understand the most acute provider shortage needs and their impact on beneficiaries with SUD.
SUD Milestone 5	Medium	Engage with providers to identify factors contributing to the increase of prescribing opioids at high dosage in persons without

Milestone	Risk Rating	IE's recommendations (for medium or high-risk milestones)
		cancer, identify strategies to reduce prescribing opioids at high dosage to this population, consider additional provider training, and provide real-time feedback on prescribing rates and patterns as feasible.
SUD Milestone 6	Medium	Engage with stakeholders to identify barriers to increasing initiation in treatment and understand drivers of readmissions for beneficiaries with SUD. Strengthen transitional care supports, such as inclusion of peers in transitional support services.
SMI Milestone 1	High	Review current quality standards, quality assurance requirements, and oversight processes for psychiatric hospitals and residential settings to identify areas that may need to be strengthened Engage with providers and stakeholders to identify barriers for using first-line psychosocial care for children and adolescents on antipsychotics to develop a strategy to improve their use.
SMI Milestone 2	Medium	Engage with providers to identify barriers and means to increasing 7- and 30-day follow-up after an ED visit Review current protocol used to increase SUD-related ED visit 7- and 30-day follow-up
SMI Milestone 3	Low	N/A
SMI Milestone 4	Medium	Engage with providers to determine how to improve communication of visit preparedness to beneficiaries to allow for appropriate blood testing.

TABLE 30: IE RECOMMENDATIONS FOR MEDIUM OR HIGH-RISK SUD AND SMI/SED MILESTONES

C.4 ASSESSMENT OF STATE'S CAPACITY TO PROVIDE SUD AND SMI/SED SERVICES

Information in the SUD monitoring reports on the state's capacity to provide SUD services to Medicaid beneficiaries is somewhat limited. Milestone 4 of the SUD Demonstration measures provider capacity through counts of the number of Medicaid enrolled SUD providers generally, and Medicaid enrolled SUD providers,

specific to MAT. While the number of Medicaid enrolled SUD providers grew by 18% from baseline to mid-point, the IE cannot determine whether the number of providers meets the needs of Utah's beneficiaries without additional information. Additionally, state stakeholders have indicated qualitatively the likelihood of a provider shortage in the state. The IE recommends the state conduct a more thorough needs assessment of SUD provider capacity that includes ratios of beneficiaries to providers, measures of appointment wait-times, and an assessment of geographic distances between beneficiaries and providers.

The SMI/SED provider availability assessment from baseline to mid-point has demonstrated an overall decrease in provider capacity. More context is needed to better understand the cause of these observed changes. The IE recommends the creation or collection of additional metrics to speak to changes for certain provider types and where beneficiaries may be receiving alternative sources of care.

The SUD and SMI capacity issues noted above most likely are the result of workforce shortages, noted in the Utah Behavioral Health Coaition's master plan. Nearly all focus groups conducted by the coalition cited BH workforce shortages as a key challenge facing the state. The plan proposes several concrete steps to address these shortages, such as creating a Masters in Addiction Counseling degree, creating more training opportunities, expanding scope of practice for some professionals, increasing reimbursement, and developing a long-term strategic recruitment pipeline. Some of these recommendations resulted in legislative action, such as increasing rates for specific services.[18]

Provider Type	Capacity Directionality (Increase, Decrease, Stable or Unable to report)
Providers	Increase
Community Mental Health Centers (CMHCs)	Decrease
Intensive Outpatient or Partial Hospitalization Providers	Unable to report
Residential Mental Health Treatment Facilities	Decrease
Inpatient	Increase
Institutions for Mental Disease (IMDs)	Decrease
Crisis Stabilization Services	Decrease
Federally Qualified Health Centers (FQHCs)	Decrease

TABLE 31: SMI/SED PROVIDER AVAILABILITY ASSESSMENT: DIRECTIONALITY OF CAPACITY CHANGES BY PROVIDER TYPES

[18] Utah Behavioral Health Commission 2025 Legislative Report. Utah Behavioral Health Commission 2025 Legislative Report

C.5 Overarching Findings and Additional Context

The SUD and SMI milestone results were largely mixed, with no clearly identified drivers of success or poor performance, outside of workforce shortages. The demonstrations take place in the context of broader systems level challenges facing the state, which were identified and documented by the UBHC in the master plan updated in 2025.[19]. Systems level issues cited in the Utah Behavioral Health Coalition's master plan that are likely impacting the monitoring metrics are:

- Lack of system-level coordination and a unified approach to behavioral health
- Administrative burden on providers
- Siloed systems
- Workforce shortages
- Lack of sustainable funding

The UBHC outlines seven strategic priorities in the master plan:

1. Support continued use, implementation, creation, and innovation of evidence-based interventions.
2. Strengthen behavioral health prevention and early intervention.
3. Integrate physical and behavioral health.
4. Improve patient, family, and consumer navigation.
5. Continue to build out Utah's behavioral health crisis and stabilization systems.
6. Improve the availability of services and supports for individuals with SMI and complex behavioral health needs and their families.
7. Expand, support, and diversify Utah's behavioral health workforce.

The UBHC lacks authority to implement these strategies. The extent to which state level agencies have incorporated the UBHCs recommendations in their work is out of the scope of the IE to assess.

C.6 Next Steps

IE Recommendation	Utah DHHS's Proposed Next Steps and Planned Performance Improvement Activities
SUD Milestone 2: Engage stakeholders in a process to better understand the drivers of LOS in IMDs for SUD treatment and explore evidence-based strategies for reducing LOS.	Service authorizations are based on medical necessity reviews; therefore, some stays will exceed the 30-day LOS due to the beneficiaries' needs and ASAM level of care criteria.
SUD Milestone 4: Examine the landscape of SUD provider capacity in Utah and	Utah's Office of the Legislative Auditor General recently completed an audit of behavioral health providers in Utah and Medicaid's Office of Managed Healthcare completes yearly surveys of provider network availability. Utah will work with these entities to understand the most

[19] Utah Behavioral Health Assessment & Master Plan - Kem C. Gardner Policy Institute. https://gardner.utah.edu/public-policy/health-care-and-life-sciences/utah-behavioral-health-assessment-master-plan/

engage with stakeholders to understand the most acute provider shortage needs and their impact on beneficiaries with SUD.	acute provider shortage needs and their impact on beneficiaries with SUD.
SUD Milestone 5 Engage with providers to identify factors contributing to the increase of prescribing opioids at high dosage in persons without cancer, identify strategies to reduce prescribing opioids at high dosage to this population, consider additional provider training, and provide real-time feedback on prescribing rates and patterns as feasible.	The UT Medicaid pharmacy team outreaches, incorporates, and engages with providers when reviewing high dose opioids prior authorization and for concurrent use of benzodiazepines/opioids prior authorization. The pharmacy point-of-sale system has a hard 90 Morphine Milligram Equivalents (MME) limit and quantity limit edits that prevent Medicaid recipients without cancer from acquiring high MME and high quantity opioids. In addition, UT Medicaid has open coverage for OUD treatments including long acting injectable Brixadi, Sublocade and Vivitrol along with oral options such as buprenorphine, buprenorphine/naloxone, and naltrexone for Medicaid recipients. Utah will continue to outreach and engage providers in reducing prescribing opioids at higher dosage.
SUD Milestone 6 Engage with stakeholders to identify barriers to increasing initiation in treatment and understand drivers of readmissions for beneficiaries with SUD. Strengthen transitional care supports, such as inclusion of peers in transitional support services.	Utah will engage with stakeholders to identify barriers to increasing initiation in treatment and understand drivers of readmissions for beneficiaries with SUD.
SMI Milestone 1 Review current quality standards, quality assurance requirements, and oversight processes for psychiatric hospitals and residential settings to identify areas that may need to be strengthened Engage with providers and stakeholders to identify barriers for using first-line psychosocial care for children and adolescents on antipsychotics to develop a strategy to improve their use.	Utah will review current quality standards, quality assurance requirements, and oversight processes for psychiatric hospitals and residential settings to identify areas that may need to be strengthened.
SMI Milestone 2	Utah recently added the HEDIS Adult Core Set metrics, which includes the discussed metrics, to their managed care plans contracts. Utah

Engage with providers to identify barriers and means to increasing 7- and 30-day follow-up after an ED visit Review current protocol used to increase SUD-related ED visit 7- and 30-day follow-up	will continue to work with the managed care plans to improve these metrics.
SMI Milestone 3 N/a	
SMI Milestone 4 Engage with providers to determine how to improve communication of visit preparedness to beneficiaries to allow for appropriate blood testing.	Utah will continue their efforts to increase follow-up care to Medicaid beneficiaries and to improve communications to the children and adolescents and their guardians to ensure they follow appropriate pre-medical visit protocol that would not interfere with the ability of the providers to perform cholesterol testing.

TABLE 32: IE MPA FINDINGS RECOMMENDATIONS AND UT DHHS RESPONSE

D. ATTACHMENTS

D.1 INDEPENDENT ASSESSOR DESCRIPTION

Public Consulting Group (PCG) serves as the Independent Evaluator for Utah's Section 1115 Demonstration waiver; The Mid-Point Assessment deliverable is included in PCG's scope as IE. The PCG Evaluation Team worked with the Utah Department of Health and Human Services to develop and conduct the Mid-Point Assessment. The IE and state ensured that the MPA was fair, impartial, and accurate by taking the following steps:

- The IE reviewed the goals, process, CMS-guidance, and format of the MPA with the state in advance of initiating data collection and drafting
- The IE, state Medicaid agency program leadership and data analytics staff met to discuss any questions related to data quality or reporting inconsistencies related to the MPA data sources
- The IE analyzed data, drafted the report, made risk rating determinations, and developed recommendations independently of the state
- The IE provided the state with ample time to review and respond to the MPA draft, as outlined in the STCs. The IE appreciates the state's thoughtful review and feedback, but notes that it did not influence the independent determination of the milestone risk ratings.

As the Lead Evaluator of this Independent Evaluation, I attest that there are no conflicts of interest between the PCG Evaluation Team members who conducted the Mid-Point Assessment and the Utah DHHS.

(signature)

__ Colleen M. Florio, PhD, Senior Evaluation Manager (name, title)

_____ March 11, 2026 (date)

D.2 DATA COLLECTION TOOLS

There were no formal data collection tools developed or utilized for the MPA. Qualitative data was gathered informally. The stakeholder engagement process is described in Section B.1 Data Sources and is shown below.

The IE meets regularly with stakeholders from Utah to discuss the Independent Evaluation of the 1115 Demonstration, inclusive of the SUD Demonstration Program and the SMI/SED Demonstration Program. To conduct the MPA, the IE reviewed the relevant data sources and preliminary findings with state stakeholders, including Utah Department of Health and Human Services (DHHS) staff, including SUD and SMI Demonstration Program staff and members of the agency data analytics team. Additionally, the IE conducted informal, semi-structured conversations with stakeholders and provided opportunities for written feedback or broader contextual information with state stakeholders.

State of Utah SUD 1115 Waiver Implementation Plan

Division of Medicaid and Health Financing Utah Department of Health

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Overview

The Utah Department of Health (DOH) was created in 1981 to protect the public's health by preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; promoting healthy lifestyles; and monitoring health trends and events. The Utah Department of Health is the designated Medicaid single state agency pursuant to Title 26, Chapter 1 of the Utah Code Annotated. The Division of Medicaid and Health Financing (DMHF) is the agency authorized to administer Utah's Medicaid program.

The Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah Code Annotated (UCA) §62A-15-103 as the single state authority in Utah. It is charged with ensuring a comprehensive continuum of substance use and mental health disorder services are available throughout the state. In addition, DSAMH is tasked with ensuring that public funds are spent appropriately.

According to the annual report from the Division of Substance Abuse and Mental Health, Department of Human Services, State of Utah, 134,764 adults in the state were classified as needing treatment for alcohol and/or drug dependence or abuse in 2015. For youth in grades 6 through 12, 11,804 are in need of treatment for drug and/or alcohol dependence or abuse. Seventy four percent (74%) of all adults treated by the public system are Medicaid eligible. If amendment # 15 (Attachment 9) is approved by CMS the percentage of adults needing SUD services who are Medicaid eligible will increase. At the same time 46% of all youth receiving treatment in the public system are Medicaid eligible.

Utah, like other states, is trying to address a significant increase in opioid use. According to a report recently published by the Utah Department of Health, from 2012-2014 Utah ranked 4th in the U.S. for drug poisoning deaths. Every month, 49 Utahans die as a result of a drug overdose.

In 2014, 32.3% of Utah adults reported using at least one prescribed opioid pain medication during the preceding 12 months, an increase of 55.3% since 2008.

Furthermore, the prevalence of Utah adults who reported using prescription opioids that had not been prescribed to them increased 77.8% from 2008 (1.8%) to 2014 (3.2%). In 2012, Utah ranked 15th highest in the nation for high-dose opioid prescribing. A number of factors have contributed to the increase and widespread availability of prescription opioids. In the early 1990s, physicians were urged to be more attentive in identifying and aggressively treating pain. In addition, the pharmaceutical industry aggressively marketed the use of prescription opioids to providers. Consequently, opioid pain relievers, such as oxycodone and hydrocodone, gained widespread acceptance. Health care professionals prescribed opioid pain relievers more frequently as part of patient care. The increase in prescription pain medication prescribing resulted in these medicines being kept in home medicine cabinets, providing an increased opportunity for theft or misuse. Utah needs to use all available options in a continuum of care to treat this health care crisis in our state.

MILESTONE 1: Access to Critical Levels of Care for SUD Substance Use Disorder Delivery System

The Utah public mental health and substance abuse system provides an array of services that assure an effective continuum of care. Under the administrative direction of DSAMH, the counties and their local mental health authority (LMHA) are given the responsibility to provide mental health and substance use disorder services to its citizens. Counties set the priorities to meet local needs and submit an annual local area plan to DSAMH describing what services they will provide with State, Federal, and County money. State and Federal funds are allocated to a county or group of counties based on a formula established by DSAMH.

In Utah, a continuum of services has been designed to address the full spectrum of substance use problems. Treatment services are based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Comprehensive Benefit Design

Utah administers a comprehensive evidence–based MH/SUD benefit that offers a full continuum of care. Treatment services are based on the American Society of Addition Medicine (ASAM) Patient Placement Criteria. Effective July 1, 2017, Utah added coverage for SBIRT (Screening, Brief Intervention and Referral to Treatment) as a state plan covered service.

The following table provides an overview of each ASAM level of care with current Utah Medicaid coverage along with proposed changes:

ASAM Level of Care	Title	Description	Provider	Existing Medicaid Service Y/N	New Medicaid Service Y/N
0.5	Early Intervention	Screening, Brief Intervention and Referral for	Managed care or Fee for Services	Y as of	

		Treatment (SBIRT)	provider	July 1, 2017	
1	Outpatient Services	Less than 9 hours of services /week (adults); Less than 6 hours /week adolescents) for recovery or motivational enhancement therapies/strategies, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours /week (adolescents) to treat multi-dimensional instability, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
2.5	Day Treatment/ Psychosocial Rehabilitation Services	20 or more hours of service/week for multi-dimensional instability, not requiring 24 hour	DHS/OL Certified Outpatient Facilities	Y	

		care, MAT, TCM			
3.1	Clinically Managed Low-Intensity Residential Services	24 hour structure with trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.3	Clinically Managed Population Specific High Intensity Residential Services	24 hour structure with trained counselors to stabilize multi-dimensional imminent danger; Less intense milieu; and group treatment for those with cognitive or other impairments unable to use fill active milieu or therapeutic community and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	

3.5	Clinically Managed High Intensity Residential Services	24 hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.7	Medically Monitored Intensive Inpatient Services	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. 16 hour/day counselor availability, MAT, TCM	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	
4	Medically Managed Intensive Inpatient	24 hour nursing care and daily physician care for severe unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	

OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use. MAT includes methadone, Suboxone, Naltrexone	DHS/OL Licensed OTP Maintenance Providers, Licensed Prescribers	Y	

Table Two- ASAM Criteria for Withdrawal Services

Level of Withdrawal Management	**Level**	**Description**	**Provider**	**Existing Medicaid Service Y/N**	**New Medicaid Service Y/N**
Ambulatory Withdrawal Management Without Extended on-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision	DHS/OL Certified Outpatient Facility w/ Detox Certification; Physician, licensed prescriber; or	N	Y

			OTP for opioids		
Ambulatory Withdrawal Management with Extended On-site Monitoring	2-WM	Moderate withdrawal management and support and supervision; at night has supportive family or living situation	DHS/OL Certified Outpatient Facility w/ Detox Certification; Licensed Prescriber; or OTP for Opioids	Y	
Clinically Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal, but needs 24 hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery	DHS/OL Licensed Residential Facility w/ Detox Certification; Physician, Licensed Prescriber; Ability to Promptly Receive Step-downs	N	Y

Utah currently covers the discrete individual services if an individual is eligible for Medicaid and is in residential treatment for ASAM level 3.1, 3.3, 3.5 and 3.7 levels of

care. Utah's waiver allows Medicaid to cover services provided for ASAM level 3.1, 3.3,

and 3.7 on a per diem basis for all Medicaid eligible populations in facilities with 17 or more beds. Each of the ASAM levels of care will be addressed in more detail to describe current coverage, future coverage, and a timeline for implementation of any proposed changes. In addition, the Utah Medicaid Provider Manual, Rehabilitative Mental Health and Substance Abuse Disorder Services will be updated to reflect each ASAM level of care covered by Utah Medicaid. This update will be completed by July 1, 2018.

Residential treatment

Services for Adolescents and Youth with an SUD

Access to substance abuse treatment is especially important for the millions of children who live with at least one parent who is dependent on alcohol or an illicit drug. Utah provides coverage to all children under the age of 21 for screening, vision, dental, hearing, and other medically necessary health care services to treat, correct, or ameliorate illnesses and conditions discovered, regardless of whether the service is covered in the Utah Medicaid State Plan, as required by Early and Periodic screening, Diagnostic, and Treatment (EPSDT). This benefit extends to all substance abuse treatment identified through the ASAM continuum of care, including residential and inpatient treatment.

Level of Care: 0.5 (Early Intervention)

Current State:

Utah Medicaid provides coverage for several individual services around early intervention, including smoking cessation counseling and screening, brief intervention, and referral to treatment (SBIRT).

These services are available to all Utah Medicaid members without prior authorization.

Future State:

No changes are expected.

Summary of Actions Needed:

None

Level of Care: 1.0 (Outpatient Services)

Current State:

Utah Medicaid reimburses for outpatient treatment (OT) as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No changes are expected

Summary of Actions Needed:

None

Level of Care: 2.1 (Intensive Outpatient Services)

Current State:

Utah Medicaid reimburses for intensive outpatient treatment (IOT) as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans.

Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.
https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No changes are expected

Summary of Actions Needed:

None

Level of Care: 2.5 (Day Treatment/Psychosocial Rehabilitation Services/ Partial Hospitalization)

Current State:

Utah Medicaid covers Day Treatment/Psychosocial Rehabilitation Services for all members as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services. https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No immediate changes are expected.

Summary of Actions Needed:

None

Level of Care: 3.1 / 3.5 (Clinically Managed Low-Intensity Residential / Clinically Managed High-Intensity Residential)

Current State:

Residential treatment for substance abuse disorders can be provided within institutions for mental disease (IMDs). An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Federal law prohibits federal financial participation (FFP) from going to IMDs for individuals aged 21 through 64. One of the primary goals of the 1115 SUD waiver is to waive this restriction and allow IMDs to provide treatment to all Utah Medicaid members, including inpatient and residential treatment.

Utah Medicaid currently covers the discrete individual services provided to Medicaid members who are in a residential treatment facility at ASAM level 3.1 or 3.5 with no more than 16 beds. **Future State:**

Utah Medicaid determined a per diem rate to pay for residential treatment for substance use disorder. Therefore upon approval of Utah's amendment to its 1115 waiver and Utah's SUD Implementation Plan, Level 3.1 (clinically managed low-intensity residential) and Level 3.5 (clinically managed high- intensity residential) will be reimbursable in a facility with 17 or more beds (IMD) for all Utah Medicaid populations (fee-for-service and managed care).

The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for both Level 3.1 and 3.5 residential services will initially be based around a mix of current discrete services Medicaid eligible individuals receive while in a residential treatment setting. Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.1 or Level 3.5 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the Implementation Plan.

Summary of Action Items:

MMIS system modifications (including finalizing coding)

Update the Utah provider manual, "Rehabilitative Mental Health and Substance Abuse Disorder Services" to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7.

Provider notification and training

Action Implementation Timeline

Develop rate methodology for residential treatment- COMPLETE

MMIS system modifications (including finalizing coding)- November 1, 2017

Provider notification and training- Beginning November 2, 2017

Coverage and Reimbursement for ASAM levels of care 3.1/3.5 on a per diem basis in a facility with 17 or more beds (IMD) will be available immediately upon approval of Utah's SUD Implementation Plan.

Update the Utah provider manual, "Rehabilitative Mental Health and Substance Abuse Disorder Services" to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7 by March 31, 2018.

Level of Care: 3.7 (Medically Monitored Intensive Inpatient / Medically Managed Intensive Inpatient) Withdrawal Management Services (Inpatient Detoxification)

Current State

Utah Medicaid currently covers the discrete individual services provided to Medicaid members who are in a residential treatment facility at ASAM level 3.7 with no more than 16 beds.

Utah Medicaid has established a methodology to pay for residential treatment for substance use disorder. Therefore upon approval of Utah's amendment to its 1115 waiver Level 3.7 (Medically Monitored Intensive Inpatient) will be reimbursable for all populations (fee-for-service and managed care).

The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for Level 3.7 will initially be based around a mix of current discrete services Medicaid eligible individuals receive while in a residential treatment setting.

Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.7 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the Implementation Plan.

Summary of Action Items:

MMIS system modifications (including finalizing coding)

Update provider manuals

Provider notification and training

Action Implementation Timeline

Develop rate methodology for residential treatment- COMPLETE

MMIS system modifications (including finalizing coding)- November 1, 2017

Provider notification and training- Beginning November 2, 2017

Coverage and Reimbursement for ASAM levels of care 3.7 on a per diem basis will be available immediately upon approval of Utah's SUD Implementation Plan.

Update the Utah provider manual, "Rehabilitative Mental Health and Substance Abuse Disorder Services" to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7 by March 31, 2018.

Future State:

No changes are expected

Summary of Actions Needed:

None

Sub Support Service – Addiction Recovery Management Services Current State:

Utah currently covers addiction recovery management services. Please see the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No changes are expected

Summary of Actions Needed:

None

MILESTONE 2. Use of Evidence –based SUD Specific Patient Placement Criteria

Patient Assessments

The Utah State Division of Substance Abuse and Mental Health (DSAMH) requires that the Local Authority Substance Use and Mental Health Providers complete the following

(1) Biopsychosocial Assessment (2) ASAM Patient Placement Criteria and (3) Screening for substance use disorder, mental health and suicide risk. However, DSAMH does not require one specific multi-dimensional tool. The assessment should be ongoing, strength based, and comprehensive to identify individual strengths and needs. These requirements are found in the DSAMH Division

Directives: https://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison_Directives_FY_17_Final.pdf.

In addition, Utah Administrative Rule R523-4 requires: "Assessments shall identify the individual's level of motivation for treatment and implement strategies to increase engagement and need for clinically appropriate Mental Health Disorder services and/or Substance Use Disorder services in the following modified ASAM Patient Placement Criteria dimensions:

Risk of acute psychosis, intoxication/withdrawal;

Biomedical conditions or complications;

Emotional, behavioral, or cognitive conditions;

Readiness to change;

Relapse, continued use or continued problem potential; and

Recovery environment.

The assessment shall include relevant information on:

The individual's psychosocial function, substance use including tobacco/nicotine, mental and physical health, and other factors, such as educational experiences, trauma history, cultural issues, legal involvement, and family relationships that are relevant to the purpose of the assessment;

Strengths, resiliencies, natural supports, interests of the individual, and an evaluation of the individual's unique abilities;

Developmental and functional levels, social, emotional, communication abilities and strengths, and independent living skills;

Cognitive, social, and affective development; family, peer, and intimate relationships; trauma; current or past emotional, physical or sexual abuse; suicidality; and safety;

Collateral information from other sources that are relevant to the individual's situation and provides insight into the issues in Subsection R523-4-6(2)(a) through (2)(d).

The assessment shall include a diagnosis when clinically indicated.

Based on the screening and the assessment, the assessor shall make recommendations regarding the needed level of care and services to address the identified clinical needs.

The levels of care and array of services shall be based on the ASAM."

DSAMH conducts annual monitoring site visits to all county local authority treatment programs in which clinical records and client placement is reviewed. Our monitoring tools and reports are online at: https://dsamh.utah.gov/provider-information/contracts- monitoring/.

Retention in treatment is the factor most consistently associated with positive client outcomes. The appropriate length of a treatment varies based on the needs of the individual. However, the National Institute of Drug Addiction (NIDA) states: "Participation in residential or outpatient treatment for less than 90 days is of limited effectiveness and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered a minimum, and some individuals with opioid use disorders continue to benefit from methadone maintenance for many years." Just like treatment for any other chronic disease, addiction treatment must be of sufficient duration to succeed. Client progress over a short period of time should not be seen as a "cure." Likewise, relapse should not be a reason to discontinue care. Programs should employ multiple strategies to engage and retain clients. Successful programs offer continuing care, and use techniques that have been proven to enhance client motivation. It is also important to recognize that multiple episodes of treatment may be necessary.

Future State:

All providers will be trained on ASAM criteria

Summary of Actions Needed:

Ongoing provider training on ASAM criteria

Action Implementation Timeline

Provider education will continue to be provided on ASAM Criteria by the Division of Substance Abuse and Mental Health throughout 2017 and 2018

Independent Third Party

Once an eligible licensed professional completes a psychosocial assessment for individuals needing substance abuse treatment, those findings must be reviewed by an independent third party that has the necessary competencies to use the ASAM Patient Placement Criteria to assure the findings were correct.

The Division of Substance Abuse and Mental Health is responsible for monitoring and oversight of the public behavioral health system. DSAMH conducts annual, on-site monitoring of each Local Authority in the public behavioral health system. The monitoring visits are required by Utah Code and are intended to measure contract compliance, use of evidence-based practices, as well as ensure a cohesive, strategic direction for the state and to assure individuals are receiving services at the appropriate level of care.

In addition, if a Medicaid member is enrolled in a PMHP for their SUD services, the PMHP is responsible to assure the findings from a psychosocial assessment is correct for their enrollee. PMHPs may also implement utilization review in the form of prior authorization of services.

Future State:

Utah Medicaid does not currently require prior authorization for residential treatment based on ASAM Levels of Care for fee for service members. Utah Medicaid will need to establish a utilization review process based on ASAM criteria to assure that all residential placement for fee for service members are appropriate. In addition, Utah Medicaid needs to review PMHP contract language to assure this requirement is clear. Each entity will be allowed to utilize any evidence-based system for clinical guidelines that incorporates the medical criteria required for an individual to meet an ASAM level of care.

Summary of Actions Needed:

This requirement will be formalized in Medicaid policy and Managed Care contracts. Procedures need to be established and implemented for fee for service members.

Action Implementation Timeline:

Medicaid policy will be clarified by July, 1, 2018

PMHP contracts clarified no later than July 1, 2018.

Utah Medicaid will establish and implement procedures to review placements for appropriate ASAM level of care for fee for service members by July 1, 2018

Milestone 3: Use of Nationally Recognized SUD-specific Program Standard to Set Provider Qualifications for Residential Treatment Facilities

Certification of Residential Facilities

Utah through the Division of Substance Abuse and Mental Health established provider qualification requirements for residential treatment providers in their licensure standards, or other guidance that mirror the description of good quality residential treatment services in the ASAM Criteria or other nationally recognized SUD-specific program standards**,** **https://rules.utah.gov/publicat/code/r501/r501-19.htm.** In addition, counties that contract for residential services have detailed contracts with providers based on ASAM Criteria.

The Office of Licensing audits to these guidelines. DSAMH conducts annual monitoring site visits to Local Authorities reviewing Policy and Procedures, licensures, schedules, clinical documents. Copies of DSAMH monitoring tools and reports can be found

at: https://dsamh.utah.gov/provider-information/contracts-monitoring/.

Future State:

Utah Medicaid will have a process established to certify private residential treatment facilities based on ASAM criteria who may provide services to Medicaid fee for service members.

Summary of Actions Needed:

Utah Medicaid will need to establish and implement a process to certify private residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members. In addition, PMHP contracts language regarding this requirement should be reviewed to determine if changes to the contract to support this milestone are necessary.

Action Implementation Timeline

Utah Medicaid will establish and implement a process to certify private residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than July 1, 2018.

The Utah Division of Substance Abuse and Mental Health and the Office of Licensing will implement a process to certify public and private non-profit residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than December 31, 2018.

PMHP contracts language regarding this requirement will be reviewed and modified if appropriate by July 1, 2018.

Administrative rule making will be promulgated to support this milestone with an effective date of July 1, 2018.

An addendum to the Utah Medicaid Provider Agreement will be implemented to gather information on ASAM levels of care provided by private residential treatment providers by March 31, 2018.

MILESTONE 4- Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment

Network Development Plan

Overall Strategy- Addiction Treatment Services Providers

Network adequacy is a critical concern for the success of the 1115 SUD waiver. DSAMH certifies all mental health and addiction providers in Utah. In addition, SUD professionals are licensed by the Utah Division of Occupational and Professional Licensing. Finally residential treatment programs are licensed by the Division of Licensing, Utah Department of Human Services.

Local Substance Abuse authorities are responsible to provide SUD treatment to the residents of their county. Community mental health centers and their contracted providers are the core of public SUD services in Utah. The DSAMH monitors the Local authorities to assure appropriate access to care for county residents. In addition, the DMHF and DSMH are working with several private non-profit residential treatment providers to expand their capacity to provide treatment to Medicaid members in need of residential treatment. The state anticipates there will be at least 240 residential treatment beds available by July 1, 2018. DSAMH also prepared an inventory of additional residential treatment providers across the state who can provide treatment if the need arises.

The DSAMH works closely with the Local Mental Health and Substance Abuse Authorities to ensure there are a sufficient number of providers in the community to provide access to outpatient services. In addition, HSAG, Utah Medicaid contracted external quality review organization (EQRO) also conducts an assessment of the adequacy of provider networks for Medicaid contracted managed care entities. The Local MH/SA Authorities contract with Utah Medicaid as PIHPs or PAHPs pursuant to Utah's 1915(b) Prepaid Mental Health Waiver.

Future State:

The inventory of providers prepared by DSAMH does not identify providers by ASAM level of care nor identify if the provider is accepting new patients. The State may have a total of 240 residential treatment beds from private non-profit providers by July 1, 2018.

Summary of Actions Needed:

The DSAMH provider inventory needs to be updated to identify providers by ASAM level of care and whether or not providers are accepting new patients.

DMHF and DSAMH will continue to work together to assure Medicaid members in need of SUD treatment services have access to care.

Action Implementation Timeline:

DSAMH will update their provider inventory referred to above to include information on the providers at each ASAM level of care and whether or not the provider is accepting new patients by September 2018.

DMHF and DSAMH will meet on an annual basis to evaluate the adequacy of access to SUD providers for the entire continuum of care on an annual basis beginning May 2018.

Program Integrity Safeguards

Utah Medicaid complies with all required provider screening and enrollment requirements as outlined in *42 CFR 455, Subpart E*.

Risk-Based Screening

Each provider is subject to pre-enrollment screening. Providers are categorized by risk level - limited, moderate, or high - using the Centers for Medicare & Medicaid Services (CMS) guidelines for risk determination. The risk level assignment of an individual provider may be increased at any time as a result of a payment suspension, an overpayment, Office of Inspector General (OIG) exclusion within the past 10 years, or at the discretion of the State pursuant to Utah Administrative Code R. In these instances, the provider is notified by the State, and the new risk level will apply to processing enrollment-related transactions. Providers who are enrolling (including changes of ownership) or revalidating are screened according to their assigned risk levels. Providers assigned to the high-risk category are required to pass a national fingerprint-based criminal background check in order to enroll or remain enrolled with the Utah Medicaid. All individuals who have at least 5% ownership or controlling interest in the enrolling business entity are required to have criminal background checks. The requirement also applies to individual practitioners who have been assigned to the high-risk category.

The criminal background check requires affected individuals to submit to fingerprinting. When fingerprints are taken, a confirmation number is provided. Individuals being fingerprinted should be sure to record the confirmation number, as they will need this information when completing the IHCP provider enrollment application. Individuals who have had fingerprint-based federal criminal background checks for the IHCP within the last six months do not need to repeat the process for a new enrollment; the confirmation number of the prior fingerprinting is acceptable, as long as it was conducted within six months of submission. Individuals are responsible for the cost of the fingerprinting. It is important to follow instructions carefully, or it may be necessary to be fingerprinted.

Utah Medicaid may deny or terminate an individual's or entity's eligibility to participate as a Medicaid provider in the state of Utah if the agency finds that the provider or a person owning, directly or indirectly, at least 5% of the

enrolling/enrolled entity has been convicted of any offense (including guilty pleas and adjudicated pretrial diversions) that the agency determines is inconsistent with the best interest of Utah Medicaid members or the Medicaid program. The following list includes examples of offenses that may demonstrate that a provider is not eligible for participation. This list is not exhaustive. Felony crimes against persons, such as murder, rape, assault, and other similar violent crimes.

Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other crimes of criminal neglect, misconduct, or fraud

A criminal offense that may subject members to an undue risk of harm

Sexual misconduct that may subject members to an undue risk of harm

A crime involving a controlled substance

Abuse or neglect of a child or adult

A crime involving the use of a firearm or other deadly weapon

Crimes directly related to the provider's ability to provide services under the Medicaid Program

In addition, Utah Medicaid may implement administrative sanction against a provider who abuse or improperly apply the program pursuant to Utah Administrative Code R414- 22.

Provider Revalidation

The Centers for Medicare & Medicaid Services (CMS) requires state Medicaid programs to revalidate provider enrollments at intervals not to exceed every five years. The CMS revalidation requirement for durable medical equipment (DME) and home medical equipment (HME) providers, including pharmacy providers with DME or HME specialty enrollments, is more frequent, at intervals not to exceed every three years.

Utah Medicaid providers receive notification letters when it is time to recredential their enrollments. Notification with instructions for revalidating are sent 90 and 60 days in advance of the revalidation deadline. Notices are mailed to the Service Location address indicated on the provider's service location profile. Providers with multiple service locations must revalidate the enrollment of each service location. Providers that fail to submit revalidation paperwork in a timely manner will be disenrolled from participation in Utah Medicaid.

After disenrollment, the provider will need to submit a new Utah Medicaid Provider Enrollment Application and all Documents to reenroll with Utah Medicaid.

Disenrollment with subsequent re-enrollment may result in a gap in the provider's eligibility.

Provider Agreements

Before participating with Utah Medicaid, all substance abuse providers must have a signed Provider Agreement with Utah Medicaid pursuant to *42 CFR 431.107*. All providers on a PMHPs provider panel must also be enrolled directly with the Utah Medicaid program. In addition the provider is credentialed by the plan and enter into a contract with the PMHP.

Billing and Compliance Issues

As part of the Provider Agreement, providers agree to disclose information on ownership and control, information related to business transactions, information on changes in ownership, and information on persons convicted of crimes. In addition to DMHF, the Utah Office of Inspector General for Medicaid Services has responsibility for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of all Medicaid-eligible beneficiaries as well as referring cases of suspected fraud to the Utah Office of the Attorney General, Medicaid Fraud Control Unit. Additionally, each of Utah Medicaid MCEs are contractually obligated to have administrative procedures that detail the manner in which each will detect fraud and abuse, including the operation of special investigation units (SIUs).

The MCE SIUs meet regularly with the OIG and MFCU address program integrity issues. The MCEs are also contractually obligated to provide reports to Utah Medicaid on their activities.

Providers can find out how to enroll with Utah Medicaid at https://medicaid.utah.gov/become-medicaid-provider

Benefit Management

All Utah ACOs and PMHPs are required by contract to provide the same benefits as Utah's fee for service Medicaid program in accordance with Article 4 of the contract.

Future State:

No changes are expected.

Summary of Actions Needed:

None

MILESTONE 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders

Level of Care: OTS (Opioid Treatment Services)

Current State:

Utah Medicaid currently provides coverage for opioid treatment program (OTP) services, including the daily administration of methadone. Methadone programs are licensed by the Department of Human Services. Methadone is only administered by licensed clinics, which bill Utah Medicaid directly on a fee for service basis for any Medicaid member, even those enrolled in managed care. Methadone is a carved out service for managed care.

Methadone providers are enrolled as Utah Medicaid Providers or as an ordering, prescribing, or referring provider in accordance with Section 6401 of the Patient Protection and Affordable Care Act.

Utah Administrative Rule R523-4 requires that "All individuals with alcohol and/or opioid disorders shall be educated and screened for the potential use of medication-assisted treatment." In addition, the DSAMH Directives require that, "

Local Substance Abuse Authority treatment programs . . .

Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment (MAT) within the first 10 days of services and document the results of the assessment. Educate the client about MAT options; when clinically indicated and the client is amenable:

Include the use of MAT in the treatment plan, and

Either provide MAT as part of the treatment, or

Refer the individual for MAT.

Some Local Authority Residential Providers have a physician in their program that can provide MAT (Buprenorphine) to contracted residential treatment providers. In addition, they coordinate closely with the Utah State Opioid Treatment Providers who provide MAT to residential programs on or off site.

In Utah, the illegal use of prescription drugs has reached epidemic proportions.

An average of 21 Utahns die as a result of prescription opioids (pain killers) each month

Opioids contribute to approximately three out of four drug overdose deaths

The number of prescription opioid deaths decreased from 301 in 2014 to 278 in 2015

Over the last decade, prescription pain medications have been responsible for more drug deaths in Utah than all other drugs combined. However, coordinating with multiple partners and focusing prevention and intervention efforts has resulted in Utah seeing a decrease in opioid related deaths by % in one year https://www.health.utah.gov/vipp/pdf/RxDrugs/PrescribingPracticeInUtah.pdf. DSAMH collaborates with the Department of Health to increase access to naloxone, a drug that reverses opiate overdose, and to increase efforts to prevent abuse and misuse. Following the Strategic Prevention Framework, prevention efforts include coalition work, changing laws, and strategic use of evidence- based prevention programs. DSAMH has been actively involved in numerous state initiatives designed to reduce the impact of opioid abuse:

Use Only As Directed (UOAD) began in 2007 in collaboration with the Utah Department of Health, Department of Human Services, Law Enforcement, and private industry. This statewide campaign focuses on safe use, storage, and disposal of prescription medications. Since 2013, Intermountain Healthcare has been an active partner. In August 2016, Intermountain Healthcare and UOAD launched a new campaign at McKay Dee Hospital, showing that every day, 7,000 prescriptions are filled in Utah.

The Center for Disease Control released a revised set of Prescriber Guidelines in 2016. The guidelines outline appropriate prescribing protocols in an effort to decrease the over prescribing of opioids for non-cancer incidences.

Take Back Events—semi-annual event collecting thousands of pounds of unused and expired medications.

Successful treatment may include:

Detoxification (the process by which the body rids itself of a drug)

Behavioral counseling, medication (for opioid, tobacco, or alcohol addiction)

Evaluation and treatment for co-occurring mental health issues such as depression and anxiety with long-term follow-up to prevent relapse.

In 2016 Utah published a comprehensive report, “Opioid Prescribing Practices in Utah.” This report was a partner publication of the Utah Department of Health and

Utah Department of Commerce, Division of Occupational and Professional Licensing. The following Utah Department of Health programs contributed to this report: Center for Health Data and Informatics, Department of Technology Services, Executive Director’s Office, Health Informatics Program, Office of Health Care Statistics, and Violence and Injury Prevention Program. The report outlines Utah’s efforts to establish prescribing guidelines consistent with the CDC Guidelines. The report can be found at: https://www.health.utah.gov/vipp/pdf/RxDrugs/PrescribingPracticeInUtah.pdf

A range of care with a tailored treatment program and follow-up options can be crucial to success. Treatment should include both medical and mental health services as needed.

Follow-up care may include community- or family-based recovery support systems. Medication Assisted Treatment (MAT) is a safe and effective strategy for reducing opioid use and the risk of overdose.

Currently, there are three MAT medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine and naltrexone. These medications are used in combination with counseling and behavioral therapies, to provide a “whole-patient” approach. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stop a medication must always be discussed with a doctor. Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opioids. By law, methadone used to treat opiate-use disorder can only be dispensed through an Opioid Treatment Programs (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), regulated by the Drug Enforcement Agency (DEA), Licensed by Department of Human Services and accredited by one of the major healthcare accreditation entities.

There are 14 OTP providers in the State of Utah. Utah's OTP's provide safe and effective treatment that includes regular counseling sessions, drug testing, and medication assisted treatment and recovery support. In 2015, 3,495 individuals sought assistance at the OTP clinics in Utah.

Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Like methadone, buprenorphine suppresses and reduces cravings for the abused drug. Buprenorphine is prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs. SAMHSA has developed an online prescriber locator: samhsa.gov/medication- assistedtreatment/ physician-program- data/treatmentphysician-locator.

Strategies to Address Prescription Drug Abuse / Opioid Use Disorder

DSAMH assisted in passing Legislation related to Naloxone education and distribution. DSAMH also works closely with the Utah Department of Health (UDOH), Utah Naloxone and other stakeholders to increase access to Naloxone. DSAMH has provided funding to the Department of Public Safety, the Utah Department of Corrections and the Utah Department of Health for projects related to naloxone training, purchase and distribution.

DSAMH will also provide funding to the University of Utah's Utah Naloxone Project. Information about this project can be found at: http://www.utahnaloxone.org/. In addition, DSAMH will provide funds to support 13 local Naloxone training and distribution entities contracted with UDOH. In addition, the 2018 DSAMH Directives includes the following requirement: "Local Substance Abuse Authority treatment programs shall provide Naloxone education, training and assistance to individuals with opioid use disorders and when possible to their families, friends, and significant others." DSAMH will monitor to ensure this requirement is met during annual site visits.

Prior Authorization Criteria

Utah Medicaid's prior authorization criteria for pharmacy can be found on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/prior-authorization

Prescribing Guidelines

DSAMH participated with the UDOH and the Utah Medical Association (UMA) in the development of the Utah Clinical Guidelines on Prescribing Opioids published in 2008. DSAMH worked again with UDOH and the UMA to update these guidelines in 2016.

ADDITIONAL INFORMATION

Weber Human Services (WHS) and Davis

Behavioral Health received funding from Intermountain Healthcare to provide medication assisted treatment and counseling for individuals with opioid dependence from prescription drugs that may have also led to current heroin use. Since its beginning, 120 clients have been served in the Opioid Community Collaborative. Currently, in Salt Lake County, a pilot project was legislatively funded in FY15 offering clients coming out of jail or prison with the option of using Vivitrol in coordination with treatment. Salt Lake County Behavioral Health Services launched this project in September 2015 and has served 205 clients to date. The average length of stay in the program is 3-4 months.

Salt Lake County anticipates ongoing growth and increased participation and length of stay in the program. Syringe Exchange Programs (SEP) also known as syringe services programs (SSPs), needle exchange programs (NEPs), and needle-syringe programs (NSPs), are community-based programs that provide access to sterile needles and syringes free of charge. The programs also facilitate safe disposal of used needles and syringes. SEPs are an effective component of a comprehensive, integrated approach to HIV and hepatitis C prevention among people who inject drugs. Most SEPs offer other prevention materials and services, such as HIV/HCV education; overdose prevention, including Naloxone distribution; referral to substance abuse treatment programs; and counseling and testing for HIV and hepatitis C.

Syringe exchange programs became legal in Utah in 2016, the day Utah Governor Gary Herbert signed House Bill 308 into law. The bill went into effect May 2016, and states that agencies in Utah "may operate a syringe exchange program in the state to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs

and those individuals' contacts." HB 308 does not fund syringe exchange programs in Utah, it only provides guidelines and reporting requirements and follows the restrictions of federal funding.

Naloxone (Narcan®) is a life-saving prescription medication used as an antidote to opioid overdose. Naloxone has mainly been used in the past in the hospital or by emergency medical personnel. However, Naloxone kits are now available for patients to use for emergency treatment of overdoses at home. In 2016, the executive director of the Utah Department of Health signed a statewide standing order allowing to dispense Naloxone, without a prior prescription, to anyone at increased risk of experiencing or witnessing an overdose. Through this standing order, anyone can purchase Naloxone without a prescription. DSAMH has worked to provide Naloxone kits and training to first responders, as well as all Adult Probation & Parole agents, and individuals in the community.

Drug Courts

Individuals with a substance use disorder are disproportionately represented in our criminal justice system. Evidence indicates that approximately 80% of individuals in the criminal justice system meet the definition of substance use involvement and between one-half to two-thirds meet diagnostic criteria for substance abuse or dependence.

Drug courts are special court dockets designed to treat individuals with substance use disorders and provide them the tools they need to change their lives. The drug court judge serves as the leader of a multidisciplinary team of professionals, which commonly includes a program coordinator, prosecuting attorney, defense attorney, probation or community supervision officer, and treatment representatives. Drug Courts provide an alternative to incarceration. Eligible participants for these programs have a moderate-to-severe substance use disorder, are charged with non- violent, drug-related offenses, such as possession or sale of a controlled substance, or another offense caused or influenced by drug use, such as theft or forgery to support a drug addiction, and who are at substantial risk for reoffending, commonly referred to as high-risk and high-need offenders. To effectively work with this population, Drug Courts provide intensive supervision and treatment services in a community environment.

Successful completion of the program results in expunged charges, vacated or reduced sentences, or rescinded probation.

DSAMH funds 45 drug courts throughout the state of Utah; 25 adult felony drug courts, 15 family dependency drug courts, and 5 juvenile drug courts. In fiscal year 2016, Utah's drug court program served 2084 individuals, the majority of whom participated in the adult felony drug court program. DSAMH and partner agencies (the Administrative Office of the Courts and the Department of Corrections) work to improve quality assurance and monitoring processes of the program. In addition to conducting annual site visits and biennial certifications of the courts, DSAMH has partnered with the National Center of State Courts to conduct process and outcome evaluations at select Utah Drug Courts, once completed new performance measurements will be developed and implemented throughout the state to help insure best practice standards are followed.

Future State:

Utah Medicaid will implement a coverage policy to limit opioid prescriptions for dental procedures to 3 days without prior authorization

Summary of Actions Needed:

Draft policy and administrative rule Submit rule for public comment

Publish policy and notify providers and pharmacies

Action Implementation Timeline

Draft policy and rule by March 1, 2018

Notify providers and pharmacies in June and July 2018 Medicaid Information Bulletin

Implement coverage policy that limits opioid prescriptions for dental procedures to three (3) days by July 1, 2018.

Milestone 6 Improved Care Coordination and Transitions between Levels of Care Transitions of Care

Current State

Appropriate management of transition of care is critical to the success of the individual in overcoming their SUD. Several of Utah's residential treatment providers also provide a full continuum of outpatient SUD services.

Future State:

Utah will add an addendum to the Utah Provider agreement for enrolled residential treatment providers that outlines a specific requirement that the provider is responsible to assure appropriate transitions of care either by providing this service directly or coordinating the provision of this service with another provider.

Utah plans to amend the Utah Provider Manuals for, Targeted Case Management for Individuals with Serious Mental Illness, to include Substance Use Disorder. In addition, Utah will amend the Utah Provider Manual for Hospital services. Both manuals will clearly state the requirement for residential and inpatient treatment facilities to coordinate and facilitate transition of Medicaid member to community based services and supports following a stay at a facility.

In addition, Utah will modify the language in its Prepaid Mental Health Plan (PMHP) contracts in section 10.3 Coordination and Continuity of Care to specify the same requirements as stated in revised policy.

Summary of Actions Needed:

Utah will amend provider manuals and managed care contracts.

Providers and Managed Care Contractors will need to be notified and trained regarding the state's transitions of care requirement.

Action Implementation Timeline

Utah will amend provider manuals and the PMHP contracts by July 1, 2018

Providers will be notified of this change in the May, June and July 2018 Medicaid information Bulletin.

ADDITIONAL INFORMATION

Case Management

Case management is a central highlight of community mental health work, both in teams and individually working with people with mental illness and/or substance use disorders to help achieve their goals. Case Management is a mandated service in Utah, and the Local Mental Health and Substance Use Authorities are responsible to provide case management in their local areas. Case management provides four critical functions often referred to using the acronym CALM (Connecting, Advocating, Linking and Monitoring): connecting with the individual, advocating for the individual, linking and planning for services, and monitoring service provision.

Providers of case management services also provide skill development services, personal services, as well as psychosocial rehab groups. DSAMH has improved the quality of case managers through a certification process that has proven to be successful. DSAMH is also working with the local homeless service providers to develop a certification program with basic standards for all providers serving individuals that are homeless.

DSAMH developed preferred practices for case management, including a training manual, and an exam with standards to promote, train, and support the practice of case management and service coordination in behavioral healthcare. In SFY 2016, DSAMH has certified 184 case managers compared to 176 in SFY 15, for a total of 650 certified case managers.

Crisis Intervention Team (CIT)

The Crisis Intervention Team (CIT) Program is an innovative model of community policing that involves partnerships between law enforcement, the mental health system, and advocacy groups.

CIT provides law enforcement personnel with specialized crisis intervention training to assist a person experiencing a mental health or SUD crisis, which improves officer and consumer safety, and redirects individuals with mental illness from the judicial system to the health care system. This training includes a 40-hour course that is completed in a one-week session. DSAMH has partnered with CIT Utah Inc. and its board of directors to provide statewide law enforcement training and support. In this partnership, law enforcement personnel who take the 40 hour training and pass a state test will achieve the CIT certification. A total of 127 law enforcement agencies have sent representatives to the CIT Academies. For more information, visit the CIT website: CIT-Utah.com.

Certified Peer Support Specialists (CPSS)

Peer Support Specialists are adults in recovery from a substance use or mental health disorder that are fully integrated members of a treatment team. They provide highly individualized services in the community and promote client self-determination and decision-making.

CPSS also provide essential expertise and consultation to the entire treatment team to promote a culture in which each client's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self- help activities. Since the program's inception, 488 individuals have been certified by DSAMH as CPSS. DSAMH currently contracts with Utah State University, Optum Health and the Salt Lake City Veteran Affairs Medical Center to provide standardized training across the state. Utah State University has developed or is developing additional special population peer support training modules for Youth- In-Transition (age 16-25), Refugee, Native American and Hispanic populations. To date, 122 CPSS have received Youth-In-Transition Training.

Trauma-informed Approach

Most individuals with substance use disorders and mental illness are also dealing with trauma. Between 34% and 53% of people with a severe mental illness report childhood physical/sexual abuse. A Center for Substance Abuse Treatment publication states that as many as two-thirds of women and men in treatment for substance abuse report experiencing childhood abuse or neglect. Child abuse, sexual assault, military combat, domestic violence, and a host of other violent incidents help shape the response of the people we serve. Adverse childhood experiences are strongly related to development and prevalence of a wide range of health problems, including substance abuse and mental illness. Over time people exposed to trauma adopt unhealthy coping strategies that lead to substance use, disease, disability and social problems, and premature mortality.

Since 2012, DSAMH embarked on several statewide efforts to implement the Trauma- Informed Approach in public and private programs, by providing training; organizational evaluation and consultation; policy implementation and partnering with local and national organizations. Some of these initiatives and training events are listed below:

Ongoing Organizational Evaluation,

Consultation, Training and Technical Assistance on the Trauma-Informed Approach, provided by Gabriella Grant, M.A., Director for the California Center of Excellence for Trauma-Informed Care for CABHI Grantees, Volunteers of America, DSAMH and other groups.

Utah Trauma Academy: October 31, November 4, 2016 for 110 public and provide providers. The Utah Trauma Academy was developed and provided by Gabriella Grant and several local trauma experts. The Utah Trauma Academy was based on the Victim Academy developed by the Office of Victims of Crimes at the Department of Justice.

Implementation of the Trauma-Informed Approach: DHS, DSAMH and several public and private providers have started the process for implementing a Trauma-Informed Approach in their practices.

Future State:

No changes are expected.

Summary of Actions Needed:

None

Grievances and Appeals

Utah Medicaid members and providers receive notice of any adverse action pursuant to 42 CFR 341 Part E. In addition, all managed care entities contracted with the Utah Medicaid program must comply with the grievance and appeals provisions of 42 CFR 438 Part F. Finally all state Medicaid fair hearings are conducted in accordance with Title 63G Chapter 4 Utah Code Annotated, Utah Administrative Procedures Act and Utah Administrative Code R414-4, Administrative Hearing Procedure.

https://le.utah.gov/xcode/Title63G/Chapter4/63G-4.html?v=C63G- 4_1800010118000101.

https://rules.utah.gov/publicat/code/r410/r410-014.htm.

Future State:

Utah Administrative Code and internal procedures are consistent with recent changes to federal regulations.

Summary of Actions Needed:

Utah Medicaid will review 42 CFR 431 Part E and 42 CFR 438 Part F once again to assure Utah Code reflects the requirements of current federal regulation.

Action Implementation Timeline

Utah Medicaid will conduct a review of current administrative code and federal regulations to determine any needed updates by November 30, 2017.

Utah Medicaid will implement any necessary changes to administrative code and internal procedures by March 31, 2018

D.4 SMI Implementation Plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services 7500
Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 16, 2020

Nathan Checketts
Director
Utah Division of Medicaid and Health Financing
Department of Health
PO Box 143101
Salt Lake City, UT 84101 Dear

Mr. Checketts:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Serious Mental Illness (SMI) Implementation Plan for Utah's approved section 1115(a) demonstration, titled "Primary Care Network" (Project No. 11-W-00145/8 and 21-W-00054/8). We have determined that the implementation plan is consistent with the requirements outlined in the Primary Care Network Special Terms and Conditions (STCs). Therefore, CMS is approving the SMI Implementation Plan. With this approval, the state may begin receiving federal financial participation as of the effective date of December 16, 2020, for services provided to otherwise-eligible Medicaid beneficiaries while residing in institutions of mental disease (IMD) for primary diagnoses of SMI. A copy of the approved SMI Implementation Plan is enclosed and, hereby, incorporated into the STCs as Attachment N.

If you have any questions, please do not hesitate to contact your project officer, Ms. Dina Payne. Ms. Payne can be reached at (410) 786-3574 or Dina.Payne@cms.hhs.gov.

Sincerely,

12/16/2020

X Andrea J. Casart

Signed by: Andrea J. Casart -A

Andrea J. Casart Director
Division of Eligibility and Coverage Demonstrations

Enclosure

cc: Mandy Strom, State Monitoring Lead, Medicaid and CHIP Operations Group

Section 1115 SMI/SED Demonstration Implementation Plan July 23, 2019

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

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

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

State may submit additional supporting documents in Section 3.

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

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

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

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

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Jennifer Meyer-Smart
Telephone Number: 385-215-4725 Email
Address: jmeyersmart@utah.gov

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

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Utah*
Demonstration name	*Utah 1115 Primary Care Network Demonstration*
Approval date	*Enter approval date of the demonstration as listed in the demonstration approval letter.*
Approval period	*Enter the entire approval period for the demonstration, including a start date and an end date.*
Implementation date	*Enter implementation date(s) for the demonstration.*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	**Current State:** In accordance with Utah Administrative Code R432-101 Specialty Hospital, all psychiatric facilities must be licensed and certified through the Utah Bureau of Health Facility Licensing and Certification. Residential Treatment Programs are required to be licensed through the Utah Office of Licensing. **Hospitals**: Utah's Bureau of Health Facility Licensing and Certification has established licensing and certification requirements for psychiatric hospitals. Participating psychiatric hospitals will be licensed and approved by the Bureau of Health Facility Licensing and Certification. Through the state survey process psychiatric hospitals are required to meet 42 CFR part 482. The Division of Licensing and Certification uses the State Operations Manual survey guidelines for psychiatric hospitals. The enrollment process and requirements for psychiatric hospitals are posted on the Division's external website.

	Residential Treatment Programs: The Utah Department of Human Services, Office of Licensing licenses residential treatment programs. R501-19 details the requirements a program must meet to be licensed and includes regulations for specialized treatment services for substance abuse treatment, services for children and youth, and services for people with disabilities.
	Future Status: Utah will continue operation of current requirements for hospitals. The State will develop methodologies for enrollment of residential treatment programs that include verification of accreditation by a national accreditation association.
	Summary of Actions Needed: The Medicaid Provider Enrollment process will be updated to require submission of verification of accreditation by a national accreditation association. In addition, all necessary system program changes needed in order to enroll residential treatment programs with the appropriate identifier. (Timeline: 6-12 months)

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	**Current Status:** Currently the Utah Department of Health Facility Licensing, Certification, and Resident Assessment may conduct administrative inspections on a routine basis for any licensed facility. **Hospitals:** R432-3-4 requires: (1) The Department (Utah Department of Health Facility Licensing, Certification, and Resident Assessment) or its designee may, upon presentation of proper identification, inspect each licensed health care facility or agency as necessary to determine compliance with applicable laws, rules and federal regulations. (2) Each licensed health care facility or agency must: (a) allow authorized representatives of the Department immediate access to the facility or agency, including access to all staff and patients; and (b) make available and permit photocopying of facility records and documents by, or on behalf of, the Department as necessary to ascertain compliance with applicable laws, rules and federal regulations. Copies become the responsibility and property of the Department. In addition, current state law allows for on site, unannounced visits to ascertain compliance with licensure requirements **Residential Treatment Center:** Utah code states: 62A-2-118. Administrative inspections. (1) The office may, for the purpose of ascertaining compliance with this chapter, enter and inspect on a routine basis the facility of a licensee. (2) Before conducting an inspection under Subsection (1), the office shall, after identifying the person in charge: (a) give proper identification; (b) request to see the applicable license; (c) describe the nature and purpose of the inspection; and (d) if necessary, explain the authority of the office to conduct the inspection and the penalty for refusing to permit the inspection as provided in Section 62A-2-116. (3) In conducting an inspection under Subsection (1), the office may, after meeting the requirements of Subsection (2): (a) inspect the physical facilities; (b) inspect and copy records and documents;

	(c) interview officers, employees, clients, family members of clients, and others; and (d) observe the licensee in operation. (4) An inspection conducted under Subsection (1) shall be during regular business hours and may be announced or unannounced. (5) The licensee shall make copies of inspection reports available to the public upon request. (6) The provisions of this section apply to on-site inspections and do not restrict the office from contacting family members, neighbors, or other individuals, or from seeking information from other sources to determine compliance with this chapter.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	**Current Status:** Under Utah Administrative Code R432-101, Specialty Hospital-Psychiatric, psychiatric hospitals as well as residential treatment programs are to complete admission assessments to determine if the level of care provided is the least restrictive environment for the beneficiary. Discharge assessments are also to be performed in order to verify medical necessity and if the beneficiary no longer meets medical necessity criteria, discharge to a lower level of care should be completed. **Hospitals**: Prior to admission, Utah Medicaid's managed care plans require an assessment of the beneficiary in order to appropriately place the beneficiary. Beneficiaries may be referred to a different level of care based on the information gathered in the assessment. The managed care plans then monitor treatment of the beneficiary throughout the hospital stay to ensure that the facility is the least restrictive setting appropriate for their needs. Additionally, hospital must be in compliance with 42 CFR 482.30 which in part states, "The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs." Also, Utah Administrative Code R432-101-17 Admission and Discharge states:

	3(a) The facility shall assess and screen all potential patients prior to admission and admit a patient only if it determines that the facility is the least restrictive setting appropriate for their needs. The pre-screening process shall include an evaluation of the patient's past criminal and violent behavior. (4) The patient shall be discharged when the hospital is no longer able to meet the patient's identified needs, when care can be delivered in a less restrictive setting, or when the patient no longer needs care. **Residential Treatment Programs:** Prior to admission in a residential treatment facility, Utah Medicaid's managed care plans require an assessment of the beneficiary to ensure the beneficiary is appropriately placed. Beneficiaries may be referred to a different level of care based on the information gathered in the assessment. The managed care plans then monitor treatment of the beneficiary throughout the residential stay to ensure that the facility is the least restrictive setting appropriate for their needs. Additionally, Utah Administrative Code R532-4-6 Standards for Substance Use and Mental Health Disorder Screening and Assessment requires that an assessment be made "prior to admission to a clinical treatment level of care" and that the assessment uses a screening instrument that "has been evaluated and found reliable and valid by the scientific community". Additionally, the assessment shall "provide the basis for a treatment plan, and establish a baseline measure for use in evaluating a patient's response to treatment".
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
1.d Compliance with program integrity requirements and state compliance assurance process	**Current Status:** In order to receive reimbursement under Medicaid, participating psychiatric hospitals and residential treatment programs must be enrolled to participate in Utah Medicaid. Provider enrollment processes fully comply with 42 CFR Part 455 Subparts B&E. Utah's managed care plans have been reimbursing IMDs as an in lieu of service and are only permitted to contract with Utah Medicaid screened and enrolled providers, the State is currently screening and revalidating this provider type.

[Demonstration Approval]	**Future Status:** Continued operation of current requirements.

	Summary of Actions Needed: No action needed at this time.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	**Current Status:** In accordance with 42 CFR 482.61, Utah Administrative Code requires both hospitals and residential treatment programs to screen and assess all beneficiaries for co-morbid conditions, including mental health disorders, suicidal ideations, physical health conditions, and substance use disorder screening. **Hospitals:** Utah Administrative Code R432-101-20 Inpatient Services requires that upon admission: (a) A physician or qualified designee shall make an assessment of each patient's physical health and a preliminary psychiatric assessment within 24 hours of admission. The history and physical exam shall include appropriate laboratory work-up, a determination of the type and extent of special examinations, tests, or evaluations needed, and when indicated, a thorough neurological exam. (b) A psychiatrist or psychologist or qualified designee shall make an assessment of each patient's mental health within 24 hours of admission. A written emotional or behavioral assessment of each patient shall be entered in the patient's record. Additionally, hospitals must comply with 42 CFR 482.62(c). “Standard: Availability of medical personnel. Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.” **Residential Treatment Programs:** Utah Administrative Code R523-4-6 Standards for Substance Use and Mental Health Disorder Screening and Assessment, requires using screening instruments for mental health/substance use disorders. Additionally, the initial assessment is required to: (a) Determine the adult's eligibility for treatment, provide the basis for a treatment plan, and establish a baseline measure

	for use in evaluating a patient's response to treatment. (b) Identify comorbid medical and psychiatric conditions and diagnosis and to determine how, when and where they will be addressed; (c) Identify communicable diseases and address them as needed; (d) Evaluate the adult's level of physical, psychological and social functioning or impairment; (e) Assess the adult's access to social supports, family, friends, employment, housing, finances and legal problems; and (f) Determine the adult's readiness to participate in treatment.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	**Current Status:** According to Utah Administrative Code R432-101-11, both hospitals and residential treatment programs are required to "have a well-defined quality assurance plan designed to improve the delivery of patient care through evaluations of the quality of patient care services and resolution of identified problems". This rule further requires all providers maintain a "Plan for Patient Care Services", which is a "written plan that ensures the care, treatment, rehabilitation, and habitation services provided are appropriate to the needs of the patient population service and the severity of the disease, condition, impairment, or disability". The Plan for Patient Care services must be kept up to date and all corrective actions and meeting minutes must be presentable upon request by the State.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	**Current Status**: Both residential treatment centers and hospitals are required by Utah administrative code to have transfer and discharge policy in place in order for beneficiaries to be provided with the necessary aftercare and follow up services following discharge. **Hospital**: All Medicaid-enrolled psychiatric hospitals, including the participating IMD facilities, are required to comply with all applicable CMS Conditions of Participation (COP), including but not limited to 42 CFR 482.43, which establishes minimum discharge planning requirements aligned with this milestone. Additionally, Utah Administrative Code R432-101-17(4)(c) requires that, "Discharge planning shall be coordinated with the patient, family, and other parties or agencies (e.g. community-based providers) who are able to meet the

	patient's needs." **Residential Treatment Centers:** R501-2-6(7) Transfer and Discharge a. a discharge plan shall identify resources available to consumer. b. the plan shall be written so it can be understood by the consumer or legally responsible party. c. whenever possible the plan shall be developed with consumers participation, or legally responsible party if necessary. The plan shall include the following: 1) reason for discharge or transfer, 2) adequate discharge plan, including aftercare planning, 3) summary of services provided, 4) evaluation of achievement of treatment goals or objectives, 5) signature and title of staff preparing summary, and 6) date of discharge or transfer. d. The program shall have a written policy concerning unplanned discharge.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	**Current Status:** Utah's psychiatric hospitals and mental health residential centers provide care of the highest quality, which includes a comprehensive discharge plan. Utah's managed care plans work closely with psychiatric hospitals and mental health residential programs to ensure comprehensive discharge plans. The psychiatric hospitals and mental health residential programs, in coordination with Utah's managed care plans, assess beneficiaries' housing situations and coordinate with housing services providers when needed and available" as part of the best practices for care coordination. The requirement for case management and care coordination is mandated in the managed care contracts between Utah Medicaid and its contracted managed care plans.
	Future Status: Utah will continue operation of current requirements.

	Summary of Actions Needed: None

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	**Current Status:** Utah's managed care plans attempt to contact members as a follow up for all emergency departments and inpatient discharges within 72 hours. The care managers also reach out to members when they discharge from residential treatment programs to help the beneficiary arrange a follow up appointment. This effort is specifically done to improve the seven day follow up measure, but the care manager outreach will almost always happen within 72 hours
	Future Status: Utah will add specific requirements in our managed care contracts to reflect this requirement
	Summary of Actions Needed: Add this requirement to the next amendment to applicable managed care contracts Timeline: July 2021 contract amendment
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	**Current Status:** Utah is committed to preventing or decreasing ED and inpatient stays. By providing beneficiaries the proper services and interventions when needed, beneficiaries receive better care and more cost effective services. This minimizes the need for more costly services such as ED visits. Utah Medicaid recently implemented several strategies to prevent or reduce ED visits and inpatient admission in psychiatric hospitals or residential treatment programs. In the 2020 Utah General Session H.B. 32, Crisis Services Amendments was passed. H.B. 32 expanded the mobile crisis outreach team grant program, funded behavioral health receiving centers, and created the Behavioral Health Crisis Response Commission. Utah already has a statewide Crisis Line, Mobile Crisis Outreach Teams, and Assertive Community Treatment teams. These crisis services are designed to prevent ED and inpatient stays. Utah also has the Clinically Managed Residential Withdrawal Pilot. This pilot allows for beneficiaries to receive social detoxification services, also known as withdrawal management, as a covered service. Many beneficiaries that access social detoxification services are dually diagnosed with a substance use disorder and a mental health disorder. Social detoxification prevents ED and inpatient psych stays by allowing beneficiaries to have a level of care appropriate for their current needs instead of going to an ED or inpatient stay to withdraw. Additionally, beneficiaries will have case managers at the detox center to assess them and guide them into outpatient mental health services appropriate for their needs. Utah adopted the Crisis Now model for implementation and expansion of crisis services. In 2019, Utah established a statewide crisis line in which all crisis calls statewide are routed through one line. The Utah crisis

	line then serves to direct individuals into other appropriate care including warm hand offs for additional assessment to local behavioral health providers, to dispatch Mobile Crisis Outreach Teams based in communities throughout the state, or to higher levels of care when needed. As crisis stabilization services are built the crisis line will be able to provide direct referrals into those facilities as well.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
2.e Other State requirements/policies to improve care coordination and connections to community-based care	**Current Status:** Utah Medicaid services are operated predominantly through Managed Care Plans. On January 1, 2020, Utah Medicaid implemented four new Integrated Managed Care Plans. The Utah Medicaid Integrated Care (UMIC) plans manage both physical and behavioral health benefits for the Adult Expansion population. Prior to this time, Utah had separate physical health and behavioral health plans only. The UMIC plans are able to provide more holistic care to the beneficiaries. By using integrated care, the care managers in the UMIC plans can help beneficiaries get needed care more easily and efficiently. Non-integrated care plans are unable to see the whole person. Since these plans are new to Utah, outcome data is still being gathered. However, nationally integrated care has proven to be a benefit to the beneficiary, reduced ED stays, and inpatient stays.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of	**Current Status:** In partnership with local partners, Utah Medicaid completed the initial assessment on September 30th 2020. Some important results are the lack of IMD facilities available to beneficiaries, the need to increase crisis response in rural areas, and the need to increase crisis receiving centers throughout the state.
	Future Status: Utah Medicaid commits to conducting an availability assessment annually and will discuss any improvements that need to be made in ongoing assessments and reports.

the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	**Summary of Actions Needed:** Utah will complete the next annual assessment of the availability of mental health providers by September 30th, 2021.

Prompts	Summary
3.b Financing plan	**Current Status:** See Topic 5 for information on the State's financing plan.
	Future Status: See Topic 5 for information on the State's financing plan.
	Summary of Actions Needed: See Topic 5 for information on the State's financing plan.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	**Current Status:** Currently each organization, with inpatient and crisis stabilization beds, manages their own bed availability and capacity. Anyone seeking a bed has to inquire with each organization individually.
	Future Status: The Utah Behavioral Health Availability Platform is a search engine developed from the Juvare EMSResource© platform. Mental health inpatient bed availability will be the initial focus, followed by substance use disorder residential programs and social detoxification centers along the Wasatch front. Emergency room staff, participating inpatient units, call centers (including the University of Utah), and mobile crisis teams will be able to access the search engine, with bed availability updated twice per day. The kickoff for the platform is planned for January 2021.
	Summary of Actions Needed: Implementation of the platform – January 2021 Monitor with DSAMH the Utah Behavioral Health Availability Platform's progress. Timeline: Ongoing
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	**Current Status:** Utah Medicaid uses InterQual Criteria, an evidence-based clinical decision support tool, to determine appropriate level of care and length of stays. Utah Medicaid requires its managed care plans by contract to use evidence based practice guidelines consistent with current standards of care. They are required to ensure decisions on utilization management are based on the best practice guidelines. Although managed care plans are already using a tool as discussed above, the contracts currently do not have

	a specific requirement to use an assessment tool.
	Future Status: Add to contracts for managed care plans to use a "widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay".
	Summary of Actions Needed: 1. Modify managed contracts to include a requirement that they must use a "widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay". 2. Follow up with managed care plans to ensure they are requiring the utilization of a patient assessment tool (Timeline: 6-12 months)

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	**Current Status:** Utah Medicaid is currently working to implement a SAMHSA model of Crisis Receiving and Stabilization Services model called Utah Behavioral Health Receiving Centers. Utah Medicaid is working to add this service as part of the Medicaid State Plan.
	Future Status: Continue the State Plan amendment process. Pending CMS approval, the amendment will take affect 1/1/2021.
	Summary of Actions Needed: Follow through with needed action steps to ensure completion of the State Plan amendment process. (Timeline: 3-6 months)
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	**Current Status:** All of Utah's county behavioral health authorities are required to ask during intake if the individual is employed, unemployed, on disability etc. This includes use of the specific question - "Are you interested in looking for work/school". If the individual answers that they are interested, there is an automatic referral to the Individual Placement and Support (IPS) Supported Employment teams. Anyone can be referred whether they want full-time, part-time, volunteer, or education. Additionally, all county behavioral health authorities have a functional assessment tool, usually given by a case manager, and generally provided within the first few treatment sessions. The needs assessment scale, usually the Daily Living Activities Functional Assessment (DLA-20). This tool reviews how well someone is functioning across multiple domains from self-care, independent activities of daily living, health practices, etc. It identifies strengths and weaknesses, and becomes part of a treatment plan with referrals to case management, skills training, peer support, day programs, and engagement of community resources when needed. Utah's Division of Substance Abuse and Mental Health (DSAMH) requires that treatment plans are updated regularly, reviewing goals and determining if there are new or more emergent issues that should be the focus of treatment and

	care. DSAMH also has the ability to audit treatment plans to ensure quality of care. DSAMH also oversees First Episode Psychosis (FEP) programming targeting individuals ages 15-26 who are experiencing the first signs of psychosis. These programs are available in four areas throughout Utah, with additional training being offered across the State. FEP services focus on a Coordinated Specialty Care (CSC) model that allows for individuals who are seeking services to receive a range of necessary services including individual therapy, family therapy, medication management, case management, and peer support services. CSC services are also provided to individuals throughout their communities to ensure their services are more accessible. All of the county-based behavioral health authorities provide early intervention services for children and youth. These services included early childhood services, school based behavioral health, and family peer support services. Each of these services allow for earlier identification and access to care for children and their families.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None

[Demonstration Approval 4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	**Current Status:** On January 1, 2020 Utah Medicaid implemented integrated managed care plans. These plans, called Utah Medicaid Integrated Care (UMIC), combine physical and behavioral benefits under one payor. This allows for improved case management and care coordination. By having a more complete view of a member's needs the managed care plan's care coordinators can identify earlier SED/SMI concerns that may be arising for a member. After identifying a need for intervention, the care coordinators can help a member get the proper care for their unique needs. The Utah Division of Substance Abuse and Mental Health manages early intervention services for children and youth. These services are provided through the Local Authority Behavioral Health system and are focused on providing early access to care in non-traditional settings. These settings include partnerships with local education agencies and other health care providers. Through partnerships with schools, the local authority system is able to improve identification of SED and provides more access to services for children earlier in life. With support of a federal grant DSAMH is implementing the Utah- Promoting Integration of Primary

	and Behavioral Health Care (U-PIPBHC) Program. The U-PIPBHC program will provide mental and physical health services, substance abuse treatment and psychiatric consultation. In addition, DSAMH continues to work with the Association of Utah Community Health to integrate community health center services for physical health and local behavioral health centers services.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	**Current Status:** Utah Department of Human Services (DHS) oversees the Stabilization and Mobile Response (SMR) program. This program provides children, youth, and family's specific crisis intervention and stabilization strategies. These crisis intervention and stabilization strategies help teach skills to improve family functioning, create plans that prepare for and prevent future challenges, prevent the need for out-of-home services, and equip families with ongoing resources and support in home and community based settings. SMR currently operates in two DHS regions of the state and is currently planning to expand to two more regions with the goal of becoming statewide. DHS also operates Juvenile Receiving Centers (JCR) under the Division of Juvenile Justice in twelve communities across the state in order to prevent at-risk youth from entering the justice or child welfare systems. JRCs operate in conjunction with the Division of Juvenile Justice Services' (DJJS) Youth Services Model and allow for a safe environment for adolescents to be taken when they are not appropriate for other services. Here they are assessed and referred for other services throughout the community, including those services provided by community based mental health centers.
	Future Status: DHS will continue to work to implement SMR statewide. It is anticipated that SMR will expand to the Salt Lake region by January of 2021 and into the Eastern region by mid-year 2021. The expansion into the final parts of the state will occur when funding becomes available. DHS will continue to push integration and more robust behavioral health services into Juvenile Receiving Centers. DJJS recently partnered with a local county mental health provider to integrate services into a Juvenile Receiving Center and there are plans to expand this model into other counties across Utah to continue to provide more integrated behavioral health services to youth who are accessing services through these means.
	Summary of Actions Needed: SMR will expand to the Salt Lake region by January of 2021 and into the Eastern region by mid-year 2021
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	**Current Status:** The Utah Department of Human Services and Division of Substance Abuse and Mental Health oversees programming to increase early intervention strategies including preschool based programming for youth with co-occurring mental health and autism spectrum disorder needs. There are currently five programs operating throughout Utah. Each of these programs operates under different names. They provide services to youth ages 2-8 who are in need of co-occurring mental

	health and autism/developmental needs. Utah's Department of Human Services also uses the System of Care's High-Fidelity Wraparound (HFW) model, through this model and working with DSAMH, Utah is able to work with family advocacy and peer led organizations to provide high fidelity wraparound services and family and youth peer support services. These services are meant to provide early intervention for the youth and their families, and to help navigate the complex mental health system. Early childhood programs are also provided through Utah's Department of Child and Family Services with partnerships with local family support centers that provide mental health services and crisis nursery services. School based services are also provided in conjunction with county behavioral health authorities and schools to increase early engagement and access to services.
	Future Status: Early childhood training needs have been identified to help build out more robust mental health services and partnerships between agencies that serve children. These early childhood training needs include a consultation and competency model that will provide training to providers who serve younger children (0-5) throughout their communities. These trainings are meant for both clinical and non-clinical professionals and will increase the overall capacities throughout local communities. Ongoing efforts to increase partnerships and services with schools and Local Authorities. Currently there are partnerships with over 350 local schools throughout Utah. For the future, it is anticipated that these partnerships will continue to grow based on need in local areas with new schools being added yearly. Youth in Transition services and training opportunities are also being developed. DSAMH leads a State Youth In Transition team that meets monthly and are working on a health disparities project and creating a strategic plan.
	Summary of Actions Needed: Within the next 12 months, the Department of Human Services will enter into a contract for an early childhood competencies and consultation program that will include training for Local Authorities and their community partners. Within 18 months, DSAMH and the Local Authorities will continue to partner with the Utah State Board of Education and Local Education Agencies to increase the local involvement for services, including increasing access to telehealth services and in person services that will be provided in local schools. A full school based implementation manual will also be completed in that timeframe.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	**Current Status** Utah adopted the Crisis Now model for implementation and expansion of crisis services. In 2019, Utah established a statewide crisis line in which all crisis calls statewide are routed through one line. The Utah crisis line then serves to direct individuals into other appropriate care including warm hand offs for additional assessment to local behavioral health providers, to dispatch Mobile Crisis Outreach Teams based in communities throughout the state, or to higher levels of care when needed. As crisis stabilization services are built the crisis line will be able to provide direct referrals into those facilities as well. Utah Medicaid recently added Assertive Community Treatment and Mobile Crisis Outreach Teams to the State Plan. Utah Medicaid also submitted a SPA to receive approval for bundled daily rates for services provided at a Crisis Receiving Center or a mental health residential treatment program. Utah currently either operates or is in the process of implementing several crisis services related initiatives. 1. Crisis Line: Currently any individual in Utah can access crisis services via the Utah Crisis Line, which is funded by a mix of county and state funds. 2. Mobile Crisis Outreach Team (MCOT): The four urban counties/Local Authorities in Utah have been operating MCOT teams. Seven additional rural/frontier Local Authorities will begin operating MCOT services in FY21. These are funded via a mix of state general funds, local funds, and Medicaid reimbursement. 3. Stabilization and Mobile Response (SMR)- in three regions, currently in the works to expand to one additional region, 4. Crisis Receiving Centers: Four Local Authorities will be standing up crisis receiving centers between FY 21 and FY23. These will be funded by state general funds with a plan to add a bundled rate to the Utah State Plan. 5. Sub-Acute.

	Future Status Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan 1. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021. 2. Expand MCOT statewide: Goal of even additional rural/frontier local Authorities will begin operating MCOT services by January 1, 2021 pending sustainable funding plan approved and adopted. 3. Expand SMR statewide: Goal of SMR to be in four regions by Spring of 2021 dependent on funding. 4. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22. 5. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans. 6. Engagement and partnership with police dispatch to divert non-public safety calls from law enforcement into the crisis system 7. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce

[Demonstration Approval

Summary of Actions Needed

1. On January 1, 2021, pending CMS approval, Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan.

2. By December 2020, Utah will finalize administrative rule governing Crisis Receiving Centers.

3. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021.

4. Expand MCOT statewide: Goal of statewide MCOT by July 1, 2022 pending sustainable funding plan approved

	and adopted. 5. Expand SMR statewide: Goal of SMR to be in four regions by Spring 2021 dependent on funding. 6. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22. 7. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans. Ongoing. 8. Engagement and partnership with police dispatch to divert non-public safety calls from law enforcement into the crisis system. Ongoing. 9. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce. Ongoing.
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	**Current Status:** Utah currently offers a comprehensive continuum of community-based mental health services. Outpatient, partial hospitalization, and residential mental health treatment services have been part of the Utah State Plan since 1987. The state continuously monitors access to mental health services through its managed care plans, external quality reviews, and through the Utah Department of Substance Abuse and Mental Health (DSAMH). Managed care plans are required to follow 42 CFR 438.68 Network adequacy standards. In accordance with 42CFR 438.358, Utah Medicaid contracts with an external quality organization to validate the managed care plans for network adequacy for the preceding 12 months. Utah Code 62A-15-103 assigns responsibility to DSAMH to work with the county behavioral health authorities to conduct annual program audits and reviews to ensure adequate plans and community based services are available throughout Utah. DSAMH is required to review the Local Authority Area Plans annually and audit each county behavioral health authority to these plans.

	In 2019, Utah Medicaid began reimbursing for the Assertive Community Treatment (ACT) model of care. Utah currently has one ACT team at SAMHSA fidelity with plans to expand to more teams. On January 1 2020, Utah Medicaid implemented four new integrated managed care plans. These plans cover both physical health behavioral health services. Through these new integrated plans, beneficiaries are able to receive care management in a more complete manner.
	Future Status DSAMH will continue to monitor county behavioral health authorities to ensure provision of mandated services including issuing Division Directives and requiring annual Area Plans as well as annual audits. DSAMH will work with key stakeholders to identify gaps in services including workforce shortages and partner on strategies to build out increased access to a continuum of community based services. DSAMH will continue to expand access to ACT services and AOT services. An additional ACT team in SLCO will launch FY21 (current year) and an AOT team will launch in Weber county
	Summary of Actions Needed 2020 Utah will finalize the Utah administrative rule governing ACT Teams. The state will require an annual plan by each Local Mental Health Authority that outlines the local plan for service delivery to high acuity clients and will provide support to build out AOT and/or ACT services when clinical need arises.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: ● *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* ● *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	The State assures that it has a sufficient health IT infrastructure to achieve the goals of the demonstration. The State has an established health IT infrastructure that is based on the goal to improve interoperability across the continuum of care on behalf of all beneficiaries. The State's health IT infrastructure includes achieving goals that will improve health outcomes, facilitate access, simplify care, and reduce the overall costs of healthcare. In order to achieve these goals, the State utilizes the State Medicaid Health Information Technology Plan (SMHP), an incentive based program that encourages hospitals and providers to utilize Electronic Healthcare Technology in order to improve outcomes for beneficiaries. Currently the state utilizes the Clinical Health Information Exchange (cHIE), which has been accredited through the Electronic Healthcare Network Accreditation Commission. The cHIE is the state-designated Health Information Exchange platform that allows providers and MCOs to collect and connect patient data within one main system throughout the state of Utah. https://uhin.org/solutions/use-cases/clinical-use-cases/

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious

Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Utah confirms that the State's Behavioral Health IT Plan aligns with the State's Broader State Medicaid Health IT Plan and other State health IT plans. Utah's Prescription Drug Monitoring Program (PDMP) is called the Controlled Substance Database (CSD). Utah's CSD is part of the PMP Interconnect (PMPi), in conjunction with Appriss Health and the National Association of Board of Pharmacy that enables the secure sharing of PMP data across states and systems. InterConnect includes a 'smart hub' routing methodology and rules engine to enforce interstate sharing permissions. Utah also has a contract with Utah Health Information Network (UHIN) as part of the SUD Health IT Plan goals. Through UHIN, the cHIE is utilized by providers and managed care plans as stated above. The goal of the cHIE is to decrease over utilization of services, reduce hospital readmissions, provide quality reports, track and monitor transient patient populations, identify gaps in care, and gather data for HEDIS measures.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	Utah Medicaid will be in compliance with the standards set forth in 45 CFR 170 Subpart B. In addition, Utah Medicaid added this requirement as part of the July 1, 2020 amendments to the Managed Care Plan's contracts requiring the plans to implement the standards referenced in the Interoperability Standards Advisory (ISA)2 and 45 CFR 170 Subpart B by July 1, 2021.

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."* [4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	**Current State:** It is not a consistent practice to use the EHR to execute e-referrals and closed loop referrals between mental health providers.
	Future State: Describe the future state of the health IT functionalities outlined below: The future state will be determined following feedback from surveys by providers and managed care plans to determine a need for closed loop referrals. Based on the results of the survey, the State will develop a plan for closed loop referrals if determined necessary.
	Summary of Actions Needed: The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and managed care plans for completion. (Timeline: 18-24 months)

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no- wrong-door/index.html.

Prompts	Summary
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	**Current State:** As stated above, there is no current method or standard for closed loop referrals using the EHR to refer beneficiaries from an institution/hospital/clinic.
	Future State: The State will conduct a survey to determine the number of mental health providers who utilize closed loop referrals or e-referrals.
	Summary of Actions Needed: The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and managed care plans for completion. (Timeline: 18-24 months)
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	**Current State:** There is no current method or standard for closed loop referrals using the EHR to refer beneficiaries from physicians to community based providers.
	Future State: The State will conduct a survey to determine the number of mental health providers who utilize closed loop referrals or e-referrals.
	Summary of Actions Needed: The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and community based support programs for completion. (Timeline: 18-24 months)
Electronic Care Plans and Medical Records (Section 2)	

2.1 The state and its providers can create and use an electronic care plan	**Current State:** Electronic care plans are used as a means to create a plan of care for beneficiaries by providers. While it is common practice for providers to utilize an electronic care plan for treatment, there is no standardized programming or reporting established by the State. According to ONC Health IT statistics from 2017, 97% of Utah's acute care hospitals have adopted certified EHRs. In the physician community, 94% have adopted an EHR, with 85% using a certified EHR that meets the requirements for meaningful use. Almost 1200 unique providers participated in Utah's Promoting Interoperability incentive program attesting that they have adopted a certified EHR. This encompasses a wide range of providers in major health systems, mid-size clinics, FQHCs and smaller independent practices. Particularly within the major health organizations in Utah, accessing shared care plans between different health providers in the same system should be fairly simple.
	Future State: Although EHR adoption levels in Utah are quite high, the state scores much lower when it comes to sending, receiving, and integrating patient health information from outside sources in settings beyond the hospital setting. There is room for improvement in these areas and providers need to understand the benefit of sharing this information outside of the walls of their own organizations (when clinically necessary.)
	Summary of Actions Needed: Partner with UHIN to understand what options are available to the behavioral health community. Conduct outreach and education to encourage the sharing of care plans and the efficiencies that are gained when everyone is on the same page. (Timeline: 18-24 months)

Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	**Current State:** As mentioned previously, Utah has implemented Utah Medicaid Integrated Care (UMIC) to manage both physical and behavioral health for beneficiaries throughout the state. Under these managed care plans, the e-plans of care are available to all relevant providers, including behavioral health providers.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: No further action needed at this time.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Currently in the Local Authority Behavioral Health system, transitions of care for youth to adult records within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions from youth systems to adults systems outside of the agency are managed via secure email.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Currently in the Local Authority Behavioral Health system, electronic care plans for transitions of care for youth to adult records within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions from youth systems to adults systems outside of the agency are managed via secure email.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None.

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	**Current State:** Currently in the Local Authority Behavioral Health system transitions of care for community supports within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions of care outside of the agency are managed via secure email.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	**Current State:** Currently half of the local authority providers capture individual consent electronically in a way that is accessible to the care team in order to share protected health information.
	Future State: The state will continue to assess the need for change and update Health IT functionalities as needed.
	Summary of Actions Needed: The state will require an annual plan from each of the local authority providers that includes a plan for care coordination including communicating consent and will make changes as needed. DSAMH already implements the requirements for annual plans and UDOH will work with providers to ensure this is in place. (Timeline: 6-18 months)
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	**Current State:** Currently half of the Local Authority Behavioral Health providers utilize the cHIE and only one authority uses it to capture intake, assessment, and screening tools. However, all are able to capture within their organizations EHR.
	Future State: The state will continue to assess the need for change and update Health IT functionalities as needed.

	Summary of Actions Needed: The state will require an annual plan from each of the local authority providers that includes a plan for capturing intake, screening and assessment tools and will make changes as needed. DSAMH already implements the requirements for annual plans and UDOH will work with providers to ensure this is in place. (Timeline: 6-18 months)

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	**Current State:** Telehealth technologies are available in all of the Local Authority Behavioral Health systems. These systems allow for better access to care and communication between providers for more integrated approaches. Multiple authorities involved in integrated healthcare systems also utilize telehealth technologies to ensure broader integrated care access.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	**Current State:** It is not a common practice for the State to collect data and identify beneficiaries that are at risk for discontinuing engagement in treatment or have stopped engaging in treatment entirely. It is also not a practice of the State to notify care teams and managers of a beneficiary's disengagement in treatment.
	Future State: The future state will be developed based on feedback from surveying enrolled Utah care providers.
	Summary of Actions Needed: The State will work with DSAMH to develop a survey to identify a target population and assess the need for developing a standard process to identify patients who are at risk of disengagement from treatment and what roles the care teams may play in re-engaging the member in treatment. Once the survey has been developed, it will be distributed to the appropriate providers and community based support programs for completion. The State will then analyze the results and develop next steps based on the data. (Timeline: 18-24 months)

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Prompts	Summary
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	**Current State:** In the Local Authority Behavioral Health system, the entire care team providing services for an individual experiencing a first episode of psychosis utilizes the EHR in accessing records to coordinate care among the team.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	**Current State:** Currently no organizations in the Local Authority Behavioral Health system link children's records with parent caregiver records.
	Future State: No actions have been planned around this activity.
	Summary of Actions Needed: None
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	**Current State:** Currently all Local Authority Behavioral Health providers utilize an EHR that allows all services provided by employees of the agency which includes all types of providers, including prescriber, therapist and case management/Peer Support , etc...to capture all episodes of care of any given patient.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.