

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

Page 2 – Mr. Nathan Checketts

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.

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan

Utah 1115 Primary Care Network Demonstration

[Demonstration Approval Date]

Submitted on 12/4/2020

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

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	
<p><i>To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</i></p> <p><i>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</i></p>	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
<p>1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid</p>	<p>Current State: 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.</p> <p>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.</p> <p>Through the state survey process psychiatric hospitals are required to meet 42 CFR part 482. The Division of Licensing and Certification uses the State Operations Manual survey guidelines for psychiatric hospitals. The enrollment process and requirements for psychiatric hospitals are posted on the Division’s external website.</p>

	<p>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.</p> <p>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.</p> <p>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)</p>
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Prompts	Summary
<p>1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements</p>	<p>Current 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.</p> <p>Hospitals: R432-3-4 requires:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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. <p>In addition, current state law allows for on site, unannounced visits to ascertain compliance with licensure requirements</p> <p>Residential Treatment Center: Utah code states: 62A-2-118. Administrative inspections.</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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): <ul style="list-style-type: none"> (a) inspect the physical facilities; (b) inspect and copy records and documents;

	<p>(c) interview officers, employees, clients, family members of clients, and others; and (d) observe the licensee in operation.</p> <p>(4) An inspection conducted under Subsection (1) shall be during regular business hours and may be announced or unannounced.</p> <p>(5) The licensee shall make copies of inspection reports available to the public upon request.</p> <p>(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.</p> <p>Future Status: Utah will continue operation of current requirements.</p> <p>Summary of Actions Needed: None</p>
<p>1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay</p>	<p>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.</p> <p>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.</p> <p>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.”</p> <p>Also, Utah Administrative Code R432-101-17 Admission and Discharge states:</p>

	<p>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.</p> <p>(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.</p> <p>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.</p> <p>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”.</p> <p>Future Status: Utah will continue operation of current requirements.</p> <p>Summary of Actions Needed: None</p>
<p>1.d Compliance with program integrity requirements and state compliance assurance process</p>	<p>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.</p> <p>Future Status: Continued operation of current requirements.</p>

	<p>Summary of Actions Needed: No action needed at this time.</p>
<p>1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions</p>	<p>Current 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.</p> <p>Hospitals: Utah Administrative Code R432-101-20 Inpatient Services requires that upon admission:</p> <p>(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.</p> <p>(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.</p> <p>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.”</p> <p>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:</p> <p>(a) Determine the adult's eligibility for treatment, provide the basis for a treatment plan, and establish a baseline measure</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
 Utah 1115 Primary Care Network Demonstration
 [Demonstration Approval Date]
 Submitted on 12/4/2020

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

Prompts	Summary
<p>1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.</p>	<p>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.</p> <p>Future Status: Utah will continue operation of current requirements.</p> <p>Summary of Actions Needed: None</p>
<p>SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care</p>	
<p><i>Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i></p>	
<p>Improving Care Coordination and Transitions to Community-based Care</p>	
<p>2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.</p>	<p>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.</p> <p>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</p>

	<p>patient's needs.”</p> <p>Residential Treatment Centers: R501-2-6(7) Transfer and Discharge</p> <p>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:</p> <ol style="list-style-type: none"> 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. <p>d. The program shall have a written policy concerning unplanned discharge.</p> <p>Future Status: Utah will continue operation of current requirements.</p> <p>Summary of Actions Needed: None</p>
<p>2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries’ housing situations and coordinate with housing services providers when needed and available.</p>	<p>Current 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.</p> <p>Future Status: Utah will continue operation of current requirements.</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Utah 1115 Primary Care Network Demonstration
[Demonstration Approval Date]
Submitted on 12/4/2020

	Summary of Actions Needed: None
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Prompts	Summary
<p>2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge</p>	<p>Current 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</p> <p>Future Status: Utah will add specific requirements in our managed care contracts to reflect this requirement</p> <p>Summary of Actions Needed: Add this requirement to the next amendment to applicable managed care contracts Timeline: July 2021 contract amendment</p>
<p>2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
 Utah 1115 Primary Care Network Demonstration
 [Demonstration Approval Date]
 Submitted on 12/4/2020

	<p>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.</p>
	<p>Future Status: Utah will continue operation of current requirements.</p>
	<p>Summary of Actions Needed: None</p>
<p>2.e Other State requirements/policies to improve care coordination and connections to community-based care</p>	<p>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.</p>
	<p>Future Status: Utah will continue operation of current requirements.</p>
	<p>Summary of Actions Needed: None</p>

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
<p><i>Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.</i></p>	
Access to Continuum of Care Including Crisis Stabilization	
<p>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</p>	<p>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.</p> <p>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.</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Utah 1115 Primary Care Network Demonstration
[Demonstration Approval Date]
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<p>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.</p>	<p>Summary of Actions Needed: Utah will complete the next annual assessment of the availability of mental health providers by September 30th, 2021.</p>
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Prompts	Summary
3.b Financing plan	<p>Current Status: See Topic 5 for information on the State’s financing plan.</p>
	<p>Future Status: See Topic 5 for information on the State’s financing plan.</p>
	<p>Summary of Actions Needed: See Topic 5 for information on the State’s financing plan.</p>
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	<p>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.</p>
	<p>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.</p> <p>The kickoff for the platform is planned for January 2021.</p>
	<p>Summary of Actions Needed: Implementation of the platform – January 2021 Monitor with DSAMH the Utah Behavioral Health Availability Platform’s progress. Timeline: Ongoing</p>
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	<p>Current Status: Utah Medicaid uses InterQual Criteria, an evidence-based clinical decision support tool, to determine appropriate level of care and length of stays.</p> <p>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</p>

	<p>a specific requirement to use an assessment tool.</p>
	<p>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”.</p>
	<p>Summary of Actions Needed:</p> <ol style="list-style-type: none"> 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
<p>3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization</p>	<p>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.</p>
	<p>Future Status: Continue the State Plan amendment process. Pending CMS approval, the amendment will take affect 1/1/2021.</p>
	<p>Summary of Actions Needed: Follow through with needed action steps to ensure completion of the State Plan amendment process. (Timeline: 3-6 months)</p>
<p>SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration</p>	
<p><i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i></p>	
<p>Earlier Identification and Engagement in Treatment</p>	
<p>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</p>	<p>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.</p> <p>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.</p> <p>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</p>

	<p>care. DSAMH also has the ability to audit treatment plans to ensure quality of care.</p> <p>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.</p> <p>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.</p> <p>Future Status: Utah will continue operation of current requirements.</p> <p>Summary of Actions Needed: None</p>
<p>4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</p>	<p>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.</p> <p>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.</p> <p>With support of a federal grant DSAMH is implementing the Utah- Promoting Integration of Primary</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Utah 1115 Primary Care Network Demonstration
[Demonstration Approval Date]
Submitted on 12/4/2020

	<p>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.</p>
	<p>Future Status: Utah will continue operation of current requirements.</p>
	<p>Summary of Actions Needed: None</p>

Prompts	Summary
<p>4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>
<p>4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people</p>	<p>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</p>

	<p>health and autism/developmental needs.</p> <p>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.</p> <p>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.</p>
	<p>Future Status:</p> <p>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.</p> <p>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.</p> <p>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.</p>
	<p>Summary of Actions Needed:</p> <p>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.</p> <p>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.</p>

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
<i>State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state’s assessment of current availability of mental health services included in the state’s application.</i>	
<p>5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.</p>	<p>Current Status</p> <p>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.</p> <p>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.</p> <p>Utah currently either operates or is in the process of implementing several crisis services related initiatives.</p> <ol style="list-style-type: none"> 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.

	<p>Future Status Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan</p> <ol style="list-style-type: none"> 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 <p>Summary of Actions Needed</p> <ol style="list-style-type: none"> 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
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	<p>and adopted.</p> <ol style="list-style-type: none"> 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.
<p>5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.</p>	<p>Current 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).</p> <p>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.</p> <p>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.</p>

	<p>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.</p> <p>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.</p>
	<p>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.</p> <p>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</p>
	<p>Summary of Actions Needed 2020 Utah will finalize the Utah administrative rule governing ACT Teams.</p> <p>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.</p>

Prompts	Summary
SMI/SED. Topic 6. Health IT Plan	
<p><i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”¹ The HIT Plan should also describe, among other items, the:</i></p> <ul style="list-style-type: none"> ● <i>Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i> ● <i>Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i> <p><i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i></p>	
Statements of Assurance	
<p>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period</p>	<p>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.</p> <p>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/</p>

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

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Utah 1115 Primary Care Network Demonstration
[Demonstration Approval Date]
Submitted on 12/4/2020

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

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
 Utah 1115 Primary Care Network Demonstration
 [Demonstration Approval Date]
 Submitted on 12/4/2020

Prompts	Summary
<p>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.</p>	<p>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.</p> <p>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.</p> <p>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.</p>
<p>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.</p>	<p>Utah Medicaid will be in compliance with the standards set forth in 45 CFR 170 Subpart B.</p> <p>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.</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Utah 1115 Primary Care Network Demonstration
[Demonstration Approval Date]
Submitted on 12/4/2020

² Available at <https://www.healthit.gov/isa/>.

Prompts	Summary
	<p>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</p> <p>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</p>
<p>Closed Loop Referrals and e-Referrals (Section 1)</p>	
<p>1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider</p>	<p>Current State: It is not a consistent practice to use the EHR to execute e-referrals and closed loop referrals between mental health providers.</p> <p>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.</p> <p>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)</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Utah 1115 Primary Care Network Demonstration
[Demonstration Approval Date]
Submitted on 12/4/2020

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	<p>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.</p>
	<p>Future State: The State will conduct a survey to determine the number of mental health providers who utilize closed loop referrals or e-referrals.</p>
	<p>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)</p>
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	<p>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.</p>
	<p>Future State: The State will conduct a survey to determine the number of mental health providers who utilize closed loop referrals or e-referrals.</p>
	<p>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)</p>
<p>Electronic Care Plans and Medical Records (Section 2)</p>	

<p>2.1 The state and its providers can create and use an electronic care plan</p>	<p>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.</p> <p>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.</p>
	<p>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.)</p>
	<p>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)</p>

Prompts	Summary
<p>2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers</p>	<p>Current State: 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.</p> <p>Future State: The State will continue with the current state.</p> <p>Summary of Actions Needed: No further action needed at this time.</p>
<p>2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p>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.</p> <p>Future State: The State will continue with the current state.</p> <p>Summary of Actions Needed: None</p>
<p>2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p>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.</p> <p>Future State: The State will continue with the current state.</p> <p>Summary of Actions Needed: None.</p>

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.

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Utah 1115 Primary Care Network Demonstration
[Demonstration Approval Date]
Submitted on 12/4/2020

	<p>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)</p>
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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)

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Utah 1115 Primary Care Network Demonstration
[Demonstration Approval Date]
Submitted on 12/4/2020

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
<p>6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis</p>	<p>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.</p> <p>Future State: The State will continue with the current state.</p> <p>Summary of Actions Needed: None</p>
Identity Management (Section 7)	
<p>7.1 As appropriate and needed, the care team has the ability to tag or link a child’s electronic medical records with their respective parent/caretaker medical records</p>	<p>Current State: Currently no organizations in the Local Authority Behavioral Health system link children's records with parent caregiver records.</p> <p>Future State: No actions have been planned around this activity.</p> <p>Summary of Actions Needed: None</p>
<p>7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient</p>	<p>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.</p> <p>Future State: The State will continue with the current state.</p> <p>Summary of Actions Needed: None</p>

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.