Cross-State Analysis of Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstration Monitoring Data

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This report was prepared on behalf of the Centers for Medicare & Medicaid Services (CMS) as part of the Medicaid 1115 Demonstration Support Contract (contract number: HHSM-500-2014-00034I/75FCMC19F0008). Under the contract, Mathematica provides technical assistance focused on states' section 1115 demonstration monitoring and evaluation. This report presents analyses of data from states' section 1115 serious mental illness and serious emotional disturbance demonstration monitoring reports.

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Executive Summary

On November 13, 2018, the Centers for Medicare & Medicaid Services (CMS) published a State Medicaid Director Letter (SMDL #18-011) announcing opportunities for Medicaid section 1115 demonstrations to improve the quality of care for Medicaid beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED).[1] This demonstration opportunity allows states to develop service delivery systems that address specific concerns about the SMI/SED care continuum and to phase in a range of strategies to address those concerns. Under the SMI/SED demonstration authority, states can receive federal financial participation (FFP) for services provided to Medicaid beneficiaries during short-term stays for acute care services in psychiatric hospitals or residential mental health treatment facilities that qualify as institutions for mental diseases (IMDs). States' receipt of FFP for such services depends on the states taking actions to ensure that IMDs provide high-quality care and that beneficiaries have access to community-based services. States must demonstrate these actions by achieving four milestones described in the SMDL, which reflect the five goals of the demonstration (also stated in the letter).

The purpose of this cross-state analysis (CSA) is to support CMS in monitoring the progress of Medicaid section 1115 SMI/SED demonstrations. CSA reports present analyses of state-submitted monitoring data that describe the availability of mental health services at the beginning of the demonstrations and annually thereafter, implementation plans pertaining to demonstration milestones, and progress toward demonstration milestones. This report focuses on data from the 12 states that submitted implementation plans by February 1, 2024. Figure ES.1 shows the deliverables submitted by 13 states with approved demonstrations as of the report submission date, May 31, 2024.

[1] Centers for Medicare & Medicaid Services (CMS). "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Baltimore, MD: CMS, 2018. Available at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf.

Figure ES.1. Status of SMI/SED demonstration deliverables as of May 31, 2024

Note: Not all deliverables available on the date of this report's submission, May 31, 2024, are included in the report. Although states' special terms and conditions provide sequential due dates for these deliverables, some states do not complete these steps in the order listed above. States may also receive approval for their deliverables in a different order than that in which they are submitted. In this figure, monitoring reports for a state are designated as "approved" if CMS has confirmed receipt of the state's first quarterly report.

SED = serious emotional disturbance; SMI = serious mental illness.

[1] Alabama submitted its Initial Availability Assessment on August 31, 2023. The state will resubmit its initial assessment but the due date for this resubmission is unknown.

[2] Massachusetts's first Annual Availability Assessment was due on March 31, 2023, and its second Annual Availability Assessment was due on March 30, 2024.

[3] Vermont submitted a mid-point assessment for the original demonstration period one year after the start date of the demonstration. The demonstration has been extended and Vermont will be submitting the midpoint assessment for the extension period on August 29, 2025.

This report presents results from analyses of the following types of data submitted by states:

- Qualitative and quantitative data from Initial and Annual Availability Assessments (11 states).[2]
- Qualitative data from implementation plans (12 states) and monitoring reports (8 states).
- Standardized monitoring metric data from monitoring reports (6 states with monthly monitoring metrics, 6 states with annual monitoring metrics).

Each analysis in this report includes relevant data only from those states that submitted the data for a defined minimum amount of time (for example, at least nine months of data for monthly monitoring metrics). Thus, a state may be included in some analyses but excluded from others if it had not submitted data for the minimum amount of time.

For states that submitted Annual Availability Assessments, we identify changes in the availability of mental health services that occurred over the course of the demonstrations. Where possible, we used qualitative data from the Availability Assessments and monitoring reports to contextualize findings. To examine states' progress toward meeting demonstration milestones, we summarized information from states' implementation plans, monitoring protocols, and monitoring reports. Finally, we assess performance trends over time.

A. Overview of findings

1. Availability of mental health services

This CSA includes Availability Assessments for the 11 states that submitted data before the cutoff date for inclusion in the report (February 1, 2024). All 11 of these states completed the quantitative portion of their Initial Availability Assessments. The analysis includes information from multiple Availability Assessments for eight states.

Table ES.1 summarizes the changes in availability over the course of the demonstrations. It also indicates the alignment of these findings with the demonstration goals laid out in the SMDL #18-011.

[2] The District of Columbia and Vermont did not provide narrative descriptions in their Initial Availability Assessments, so only nine states are included in the qualitative data analysis. Eight states submitted an Annual Availability Assessment.

Table ES.1. Key findings about the availability of mental health services during the SMI/SED demonstrations

Topic	Key findings	Alignment with demonstration goals
Gaps in the availability of mental health services	• Before the demonstrations, states reported gaps in the availability of residential facilities (two states: ID, MD), inpatient services (seven states: AL, ID, OK, UT, WA, MD, MA), crisis services (three states: OK, MD, MA), mental health care providers (five states: ID, OK, IN, MD, MA), and coordinated or integrated care for Medicaid beneficiaries with SMI/SED (four states: ID, NH, MD, MA). Seven states (ID, IN, MD, MA, OK, UT, WA) specifically noted gaps in the availability of providers and facilities in rural areas.	• The gaps states described aligned with the gaps identified in the SMDL, and the purpose of the demonstration.
Changes over time in the availability of mental health services	• The numbers of certain inpatient services, outpatient and community-based services, and the workforce categories increased in most states, as follows: Medicaid-enrolled psychiatric hospitals (six states: ID, IN, OK, UT, VT, WA), beds in psychiatric hospitals and psychiatric units (six states: DC, ID, IN, OK, UT, NH), FQHCs (five states: DC, IN, UT, VT, WA), Medicaid-enrolled prescribers (five states: IN, UT, VT, NH, WA), and Medicaid-enrolled other independent mental health providers (six states: DC, ID, IN, UT, NH, WA). The numbers of services in the five categories associated with the residential mental health treatment and crisis services domains did not change for most states. • The increases in the ratio of Medicaid and CHIP beneficiaries per service in the psychiatric inpatient, residential, and community-based outpatient service domains suggest decreased availability. Among most categories of inpatient, residential, and crisis services, and some categories of community-based outpatient services and workforce providers, the number of services has grown or remained the same but has not kept pace with the number of beneficiaries. The Families First Coronavirus Response Act's continuous enrollment provision, as well as Medicaid expansion in several states, may have greatly influenced increases in the number of Medicaid and CHIP beneficiaries. In some instances, changes in the Availability Assessment tool and in states' reporting practices may explain differences in the number of services.	• Increases in the number of Medicaid-enrolled psychiatric hospitals are consistent with the third demonstration goal to improve the availability of services for crisis stabilization, including those in psychiatric hospitals. • Increases in the number of FQHCs are consistent with the fourth demonstration goal to increase access to community-based services. • The availability of crisis services generally did not keep pace with increased enrollment across states.

Note: The five demonstration goals are (1) reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while they await mental health treatment in specialized settings; (2) reduced preventable readmissions to acute care hospitals and residential settings; (3) improved availability of crisis stabilization services; (4) improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED; and (5) improved care coordination, especially continuity of care in the community after episodes of acute care in hospitals and residential mental health treatment facilities. The inpatient domain includes Medicaid-enrolled psychiatric hospitals, Medicaid-enrolled psychiatric units in acute care hospitals, and beds in psychiatric hospitals and psychiatric units. The residential treatment services domain includes Medicaid-enrolled residential mental health treatment facilities for adults and beds in Medicaid-enrolled residential mental health treatment

facilities for adults, Medicaid-enrolled psychiatric residential treatment facilities (PRTFs), and beds in Medicaid-enrolled PRTFs. The crisis services domain includes mobile crisis units, crisis call centers, crisis observation or assessment centers, crisis units, and coordinated community crisis response teams. The community-based outpatient services domain includes Medicaid-enrolled community mental health centers, Medicaid-enrolled community intensive outpatient or partial hospitalization facilities, and federally qualified health centers. The workforce domain includes Medicaid-enrolled prescribers and "Other" Medicaid-enrolled independent mental health providers.

CHIP = Children's Health Insurance Program; FQHC = federally qualified health center; SED = serious emotional disturbance; SMDL = State Medicaid Director Letter; SMI = serious mental illness.

2. Planned demonstration activities and milestone status

Each of the four milestones outlined in SMDL #18-011 describes the components that must be met to achieve the milestone. Most states met most of the components of Milestone 1 and some components of Milestones 2, 3, and 4 before demonstrations began. Table ES.2 identifies the components of each milestone met by each state at baseline and during the demonstrations. States are expected to describe efforts to meet previously unmet milestone components in Part B of their monitoring reports, and to complete milestones within the first two years of the demonstration. Of the states that have had demonstrations for at least two years, four states (the District of Columbia, Idaho, Vermont, Washington) have met some of the four milestones. One state (Utah) has not provided updates on milestone components in their monitoring reports, and we cannot assess the progress toward meeting previously unmet milestones. Appendix F provides more detail on individual state activities.

Table ES.2. Milestone components met at the start of and during the demonstrations

Mile-stone	Component description	States with demonstrations ≥ 2 years							States with demonstrations < 2 years				
		DC^	IN^	VT^	ID^	WA^	OK^	UT	AL^	NH^	MD	MA^	NM
1	State licensure	X	X	X	X	X	O	X	X	X	X	X	X
	National accreditation	X	X	X	X	X	—	—	X	—	X	X	—
	Oversight	X	X	X	X	X	—	X	X	X	X	X	—
	Utilization review	O	—	X	X	X	—	X	X	—	X	X	—
	Program integrity	X	X	X	X	X	O	X	X	—	X	X	—
	Screening and access to treatment	—	X	X	X	X	—	X	X	—	X	X	—
2	Discharge planning	O	X	X	X	O	—	X	X	O	—	—	—
	Housing assessment	—	—	—	—	X	X	X	O	—	X	X	—
	72-hour post-discharge follow-up	—	—	O	—	O	X	—	X	O	X	—	—
	Strategies to reduce ED LOS	X	—	—	X	X	X	X	—	—	—	—	—
3[a]	Bed tracking	—	—	X	X	—	—	—	X	X	—	—	—
	Patient assessment tool	—	X	O	—	O	X	—	—	X	—	X	X
4	Identification and engagement	O	X	X	X	X	X	X	—	X	—	—	—
	BH integration in non-specialty settings	O	—	X	X	—	X	X	—	X	—	—	—
	Specialized settings/crisis stabilization	O	—	X	X	X	—	—	X	--	—	—	—
	Milestones met	4	—	1,3,4	1,4	1, 2	—	—	1	3	1	1	--
	Milestones partially met	1,2	1,2,3,4	2	2,3	3,4	1,2,3,4	1,2,4	2,3,4	1,2,4	2	2,3	1,3
	Milestones not met	3	—	—	—	—	—	3	—	—	3,4	4	2,4

Source: Approved implementation plans, Medicaid Section 1115 SMI/SED Midpoint Assessments, and Medicaid Section 1115 SMI/SED Monitoring Reports, Part B submitted prior to February 1, 2024.

Note: X indicates component met at baseline; O indicates component met during demonstration; – indicates component is unmet; and ^ indicates the state has provided updates for activities during the demonstration. A milestone is considered "met" if the state has achieved all associated components, "partially met" if the state has achieved one or more component, and "not met" if the state has not achieved any of the associated components. At baseline, a state may have met some milestone components based on the policies and mental health infrastructure that existed in the state before the demonstration began.

[a] Milestone 3 component (a), which outlines the state's strategy for conducting Availability Assessments, is not included in this analysis. Milestone 3 component (b) discusses the state's financing plan, which is outside the scope of this analysis and is not included in this report.

BH = behavioral health; ED = emergency department; LOS = length of stay.

3. Performance on monitoring metrics among states reporting metrics data

Data from seven states (the District of Columbia, Idaho, Indiana, Oklahoma, Utah, Vermont, Washington) met criteria for inclusion in the analysis of one or more of the 13 annual metrics and 6 monthly metrics included in the CSA for this report. The number of states included in each metric data analysis varied, as not all states met the criteria for each analysis or their data did not pass data quality checks. Table ES.3 summarizes, by milestone, key findings for the SMI/SED monitoring metrics.

Table ES.3. Key findings on the SMI/SED monitoring metrics

Topic	Key findings	Alignment with demonstration milestones
Milestone 1. Ensuring quality of care in psychiatric hospitals and residential settings	Between the two most recently reported measurement years: • The percentage of children and adolescents newly started on antipsychotic medications without a clinical indication, who had documentation of psychosocial care as first-line treatment, significantly decreased ($p < 0.05$) in two states (Idaho, Washington), significantly increased ($p < 0.05$) in one state (Indiana) and did not change significantly in two states (the District of Columbia, Vermont).	Only one metric is used to assess the progress towards Milestone 1. This metric does not fully account for the milestone because the metric only pertains to children and adolescents and is not limited to assessing care in psychiatric hospitals or residential treatment facilities. Therefore, progress toward Milestone 1 must be interpreted with caution.
Milestone 2. Improving care coordination and transitions to community-based care	Between the two most recently reported measurement years: • The rate of all-cause, unplanned readmissions within 30 days of discharge from an inpatient psychiatric facility significantly increased ($p < 0.05$) in one state (Indiana) and did not change significantly in four states (the District of Columbia, Idaho, Vermont, Washington). • The rate of continuation of evidence-based medication following discharge from a psychiatric inpatient facility did not change significantly in any of the five states (the District of Columbia, Idaho, Oklahoma, Vermont, Washington). • The rate of follow-up after hospitalization for mental illness for children (within 7 and 30 days of discharge) significantly increased ($p < 0.05$) in one state (the District of Columbia), significantly decreased ($p < 0.05$) in two states (Indiana [within 7 days], Idaho [within 30 days], and did not change significantly in two states (Vermont, Washington). • The rate of follow-up after hospitalization for mental illness for adults (within 7 and 30 days of discharge) significantly increased ($p < 0.05$) in one state (the District of Columbia) and significantly decreased ($p < 0.05$) in four states (Idaho, Indiana, Vermont, Washington). • The rate of follow-up after an emergency department visit for alcohol or other drug abuse (within 7 and 30 days of discharge) significantly increased ($p < 0.05$) in one state (Washington) and did not change significantly in three states (the District of Columbia, Idaho, Vermont). • The rate of follow-up after an emergency department visit for mental illness (within 7 and 30 days of discharge) significantly decreased ($p < 0.05$) in two states (Indiana, Washington) and did not change significantly in the other three states (the District of Columbia, Idaho, Vermont).	Except for one metric, there were no improvements in metrics used to monitor Milestone 2 in most states with available data. Five states showed a significant decline or no significant change in the rate of follow-up after emergency department visits for mental illness (the District of Columbia, Idaho, Indiana, Vermont, Washington). One state showed improvement in the follow-up rate after hospitalization for mental illness for children and adults (the District of Columbia). Four states showed declines in the follow-up rate after hospitalization for mental illness for adults (Idaho, Indiana, Vermont, Washington).

Topic	Key findings	Alignment with demonstration milestones
Milestone 3. Increasing access to a continuum of care, including crisis stabilization services	• Among beneficiaries who used any mental health services, – In the two states in which the demonstrations started before the onset of the COVID-19 public health emergency (the District of Columbia, Vermont), use of telehealth services significantly increased ($p < 0.05$) while use of intensive outpatient/partial hospitalization, outpatient, and emergency department services significantly decreased ($p < 0.05$). Use of inpatient services also significantly decreased ($p < 0.05$) in one of these states (the District of Columbia) but did not change significantly in the other (Vermont). – In the four states in which the demonstrations started after the onset of the COVID-19 public health emergency (Idaho, Oklahoma, Utah, Vermont), use of telehealth services significantly decreased ($p < 0.05$) from the first month to the most recent month of the demonstrations. In three of these states, the use of most other services significantly increased ($p < 0.05$) (Idaho, Oklahoma, Washington), with use of outpatient services significantly decreasing ($p < 0.05$) in one of these states (Washington). Changes in use of services other than telehealth were mixed in the other state (Utah). • For the six states for which data were available, the average length of stay in any IMD, and in IMDs for which CMS provides FFP through the demonstrations, was less than 30 days for all years of the demonstrations (the District of Columbia, Idaho, Indiana, Oklahoma, Vermont, Washington). Between the two most recently reported measurement years, the number of beneficiaries treated in an IMD decreased in two states (Oklahoma, Vermont) and increased in four (the District of Columbia, Idaho, Indiana, Washington).	Changes in service use measures as indications of progress toward Milestone 3 should be interpreted with caution because they confound changes in access with changes in need. Monitoring data suggest that the onset of the COVID-19 public health emergency is associated with changes in some metrics used to assess progress toward this milestone. Findings suggest that all six states for which data are available are compliant with demonstration requirements regarding average length of stay in IMDs (the District of Columbia, Idaho, Indiana, Oklahoma, Vermont, Washington).
Milestone 4. Earlier identification and engagement in treatment, including through increased integration	Between the two most recently reported measurement years: • The percentage of Medicaid beneficiaries ages 18 years and older with SMI who had an ambulatory or preventive care visit significantly increased ($p < 0.05$) in one state (Washington) and significantly decreased ($p < 0.05$) in two states (the District of Columbia, Idaho). • The percentage of children and adolescents taking multiple antipsychotics receiving metabolic testing (glucose only, cholesterol only, and both glucose and cholesterol testing) did not change significantly in four states (the District of Columbia, Idaho, Vermont, Washington). • The percentage of adult beneficiaries with a new antipsychotic prescription who completed a follow-up visit with a prescribing provider significantly decreased ($p < 0.05$) in one state (Washington) and did not change significantly in four states (the District of Columbia, Idaho, Oklahoma, Vermont).	With the exception of one metric for one state (Washington, Metric #26), none of the metrics used to monitor Milestone 4 showed significant improvement in states with available data.

CMS = Centers for Medicare and Medicaid Services; FFP = federal financial participation; IMDs = institutions for mental diseases.

B. Conclusion

This analysis produced the following key findings:

- Increases in the number of Medicaid-enrolled psychiatric hospitals are consistent with the third demonstration goal to improve the availability of services for crisis stabilization. Increases in the number of federally qualified health centers are consistent with the fourth SMI/SED demonstration goal to increase access to community-based services.
- Among most categories of inpatient, residential, and crisis services, and some categories of community-based outpatient services and workforce providers, the number of services grew or remained the same but has not kept pace with the number of beneficiaries. Medicaid and CHIP beneficiary counts may continue to fluctuate as states are required to complete a Medicaid eligibility renewal for all enrolled beneficiaries to address the expiration of the Families First Coronavirus Response Act's maintenance of eligibility requirements. For example, it is possible that the expected decline in enrollment due to unwinding may appear as an increase in availability of services but is actually driven by the larger decreases in enrollment. If Medicaid and CHIP beneficiary counts stabilize in the future, ratios comparing Medicaid and CHIP beneficiaries per service may provide more reliable insight into how service availability is changing relative to need.
- Most states met many components of the demonstration milestones before the demonstrations began. Although states are undertaking a range of activities to implement SMI/SED demonstrations and achieve the demonstration milestones, so far only a few have reported completing one to two additional milestone components during the demonstrations.
- Of the seven states with a demonstration for at least two years, four have met some of the four milestones but the remaining three have not met any milestones.
- Few of the quantitative metrics CMS uses to monitor state progress toward the milestones have thus far shown improvements. Monitoring data suggest that the onset of the COVID-19 public health emergency may be associated with changes in some service utilization metrics used to assess progress toward Milestone 3. All six states for which data were available appear to be compliant with demonstration requirements regarding ALOS in IMDs. The number of beneficiaries treated in an IMD increased in four states and decreased in two states.

At this stage of the SMI/SED demonstrations, we have limited information for each of the demonstration states. In the future, analyses could incorporate additional states, data, and methods to assess progress toward demonstration milestones.

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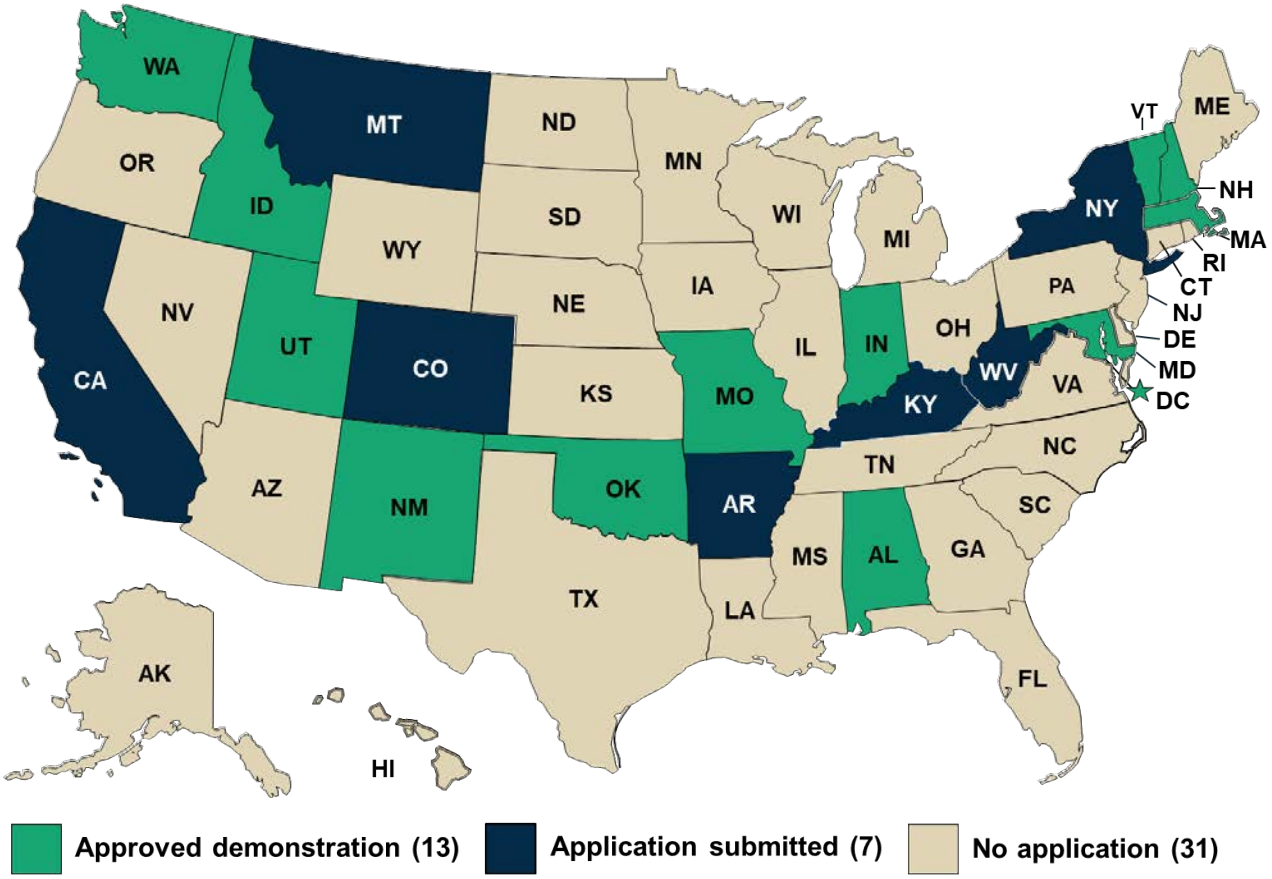
I. Introduction

On November 13, 2018, the Centers for Medicare & Medicaid Services (CMS) published a State Medicaid Director Letter (SMDL #18-011) announcing opportunities for Medicaid section 1115 demonstrations to improve the quality of care for Medicaid beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED).[3] This demonstration opportunity allows a state to develop service delivery systems and phase in a range of strategies that address its specific concerns about the SMI/SED care continuum. As of May 31, 2024, when this report was submitted, CMS had approved SMI/SED demonstrations for 13 states (Figure I.1).

Figure I.1. Status of section 1115 SMI/SED demonstration applications and approvals as of May 31, 2024



The purpose of this cross-state analysis (CSA) is to support CMS in monitoring the progress of Medicaid section 1115 SMI/SED demonstrations. This CSA uses available state-reported monitoring data to describe progress toward the SMI/SED demonstration goals and milestones described in the SMDL (Figure I.2).

[3] Centers for Medicare & Medicaid Services (CMS). "SMD #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Baltimore, MD: CMS, 2018. Available at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf.

Figure I.2. Goals and milestones required by the State Medicaid Director's Letter for the SMI/SED demonstrations

Demonstration goals

1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while they await mental health treatment in specialized settings
2. Reduced preventable readmissions to acute care hospitals and residential settings
3. Improved availability of crisis stabilization services
4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED
5. Improved care coordination, especially continuity of care in the community after episodes of acute care in hospitals and residential mental health treatment facilities

Demonstration milestones

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

Figure I.3 shows the status of demonstration deliverables as of May 31, 2024. For the analyses in this report, we focus on data from the 12 states that submitted implementation plans by the cutoff date for inclusion in the analysis of this report, February 1, 2024 (that is, Alabama, the District of Columbia,[4] Idaho, Indiana, Massachusetts, Maryland, New Hampshire, New Mexico, Oklahoma, Utah, Vermont, Washington). We included all data submitted prior to the cutoff date.

[4] For the purposes of this report, we refer to the District of Columbia as a state.

Figure I.3. Status of SMI/SED demonstration deliverables as of May 31, 2024

Note: Not all deliverables available on the date of this report's submission, May 31, 2024, are included in the report. Although states' special terms and conditions provide sequential due dates for these deliverables, some states do not complete these steps in the order listed above. States may also receive approval for their deliverables in a different order than that in which they are submitted. In this figure, monitoring reports for a state are designated as "approved" if CMS has confirmed receipt of the state's first quarterly report.

SED = serious emotional disturbance; SMI = serious mental illness.

[1] Alabama submitted its Initial Availability Assessment on August 31, 2023. The state will resubmit its initial assessment but the due date for is unknown.

[2] Massachusetts's first Annual Availability Assessment was due on March 31, 2023, and its second Annual Availability Assessment was due on March 30, 2024.

[3] Vermont submitted a mid-point assessment for the original demonstration period one year after the start date of the demonstration. The demonstration has been extended, and Vermont will be submitting the midpoint assessment for the extension period on August 29, 2025.

In the next chapter, we discuss the data and methods used in this CSA. Subsequent chapters present findings on the gaps in availability of mental health services before the start of demonstrations, changes in the availability of mental health services during the demonstrations, implementation of milestone components, and performance on monitoring metrics tied to demonstration milestones. Supplemental information is provided in the appendices.

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II. Data Sources and Methods

In this section, we present a brief overview of the data and methods we used for the CSA. We provide more detailed information about the data sources and methods in Appendix A.

A. Data

Table II.1 presents the analytic questions and the data sources used to address each question. This report presents results from analyses of the following types of monitoring data submitted by states:

- Qualitative and quantitative data from Initial and Annual Availability Assessments (11 states).[5]
- Qualitative data from implementation plans (12 states) and monitoring reports (8 states).
- Standardized monitoring metric data from monitoring reports (6 states with monthly monitoring metrics, 6 states with annual monitoring metrics).

Table II.1. Analytic questions and data sources

Analytic question	Data source
Availability of mental health services	
1. What gaps in mental health services did states identify before the demonstrations?	Qualitative data provided in the Initial Availability Assessment
2. What changes in mental health service availability have occurred over the course of the demonstrations?	Quantitative differences between Initial and most recent Annual Availability Assessments within states, supported by qualitative data from the Initial Availability Assessments and Part B monitoring reports
Implementation and milestones	
3. What changes to mental health service systems did states plan to make under the demonstrations?	Qualitative data from implementation plans, by milestone
4. What changes to mental health service systems have states implemented under the demonstrations?	Qualitative data from monitoring reports, by milestone
5. How do the changes to mental health service systems that states have implemented under the demonstrations align with initial state plans for the demonstrations?	Comparison of results for Research Question 3 and results for Research Question 4
6. How have the monitoring metrics assessing a state's progress toward demonstration goals and milestones changed over the course of the demonstration?	Quantitative data from monitoring reports

As required by CMS, states have continued to submit additional data since the cut-off date for this report, including updates to some data analyzed in this report. However, this report does not include data from new or resubmitted reports that were received past the cut-off date for this report.[6] In the narrative section of standardized monitoring reports, states are asked to describe and explain metric trends with

[5] The District of Columbia and Vermont did not provide narrative descriptions in their Initial Availability Assessments, so only nine states are included in the qualitative data analysis. Eight states submitted an Annual Availability Assessment.

[6] Eight states (Alabama, Idaho, Indiana, Massachusetts, New Hampshire, Oklahoma, Utah and Washington) resubmitted monitoring reports after cut-off date. Analyses presented in this report do not include these data.

changes of at least two percent and provide implementation updates.[7] For analyses related to implementation and milestones, each quantitative analysis in this report includes only states that have submitted relevant data for a minimum period. Thus, a state may be included in some analyses but excluded from others because it did not submit data for the required period for a specific metric relevant to the analysis. We included states in the analysis of monthly monitoring metrics if they reported data from the first month of the demonstration through the most recent reporting month and had at least nine months of data. We included states in the analysis of annual monitoring metrics if states had at least two years of annual data.

Monthly beneficiary enrollment numbers for Medicaid and for the Children's Health Insurance Program's (CHIP), pulled from the "Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data," were used to standardize some CMS-constructed metrics[8] and to calculate the ratios of Medicaid and CHIP beneficiaries per service. "Medicaid Section 1115 SMI/SED Demonstrations: Technical Specifications for Monitoring Metrics" includes the specifications for monitoring metrics that states are required to report for the demonstration.

B. Methods

For each chapter in this CSA, we include findings that may be the most valuable to CMS for program improvement. We report on findings from descriptive and statistical analyses. For findings from statistical analyses, we identify those that meet or exceed a 95 percent confidence threshold as "statistically significant." We conducted the following analyses:

Analyses pertaining to the availability of mental health providers and facilities. We defined five service domains to group categories of services in the Availability Assessment tool: inpatient services, residential services, crisis services, community-based outpatient services, and workforce. Definitions of these categories in the Availability Assessment tool, and a summary of changes in the tool by version, are provided in Appendix B. Data sources and definitions for each category and for each submission, by state, are provided in Appendix C.

To describe the gaps in the availability of mental health services before the demonstration, we thematically analyzed narrative descriptions from states' Initial Availability Assessments.

We constructed ratios to standardize our measures of availability of mental health services over time. Ratios compare the total number of Medicaid and CHIP beneficiaries in each state[9] to the count of services defined as providers, facilities, units, teams, or beds. Higher ratios of beneficiaries per service suggest lower availability of services. For example, if a geographic designation has 1,500 Medicaid beneficiaries and 2 crisis call centers, the ratio of Medicaid beneficiaries per crisis call center is 1,500/2 = 750, meaning there is 1 crisis call center for every 750 Medicaid beneficiaries. Whereas lower ratios of

[7] "Implementation updates" are defined as changes to demonstration design and operational details since submitting original implementation plans. However, many states also provide broader implementation updates, including updates about activities that are consistent with initial implementation plans.

[8] Available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.

[9] Data on total Medicaid and CHIP enrollees is from the CMS's "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data" (available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html). Enrollment numbers were extracted on the basis of the coverage dates of each Availability Assessment.

beneficiaries per service suggest greater availability of services. For example, if the geographic designation instead has 5 crisis call centers, the ratio would be 1,500/5 = 300, meaning there is 1 crisis call center for every 300 Medicaid beneficiaries.

For states with more than one Availability Assessment, we calculated changes in the availability of mental health services by comparing the number of Medicaid and CHIP beneficiaries and the number of services from the most recent Annual Availability Assessment to the numbers reported in the Initial Availability Assessment. When possible, we used qualitative information from Part B of states' monitoring reports to contextualize the changes in the availability of services.

Analysis pertaining to state progress toward meeting demonstration milestones. We extracted narrative information from 12 states' implementation plans and, where possible, monitoring reports to describe and categorize their activities to meet the demonstration milestones.[10]

We also analyzed data from monthly and annual metrics from state-submitted monitoring reports. Specifically, we examined trends over time for monthly metrics and reported common trends across states for the metrics we included in this report. To assess whether differences between years for annual metrics were likely to be attributable to normal variation, we conducted z-tests and indicated whether the differences were statistically significant ($p < 0.05$). For all four states with more than two years of metrics performance data, the baseline measurement year is 2020. To prevent comparing these states' most recent data against baseline data potentially impacted by the COVID-19 pandemic, we compared the most recent data against data from the prior measurement year (e.g., we compared data from year 3 to data from year 2 rather than comparing to year 1 [2020]). We used qualitative data from Part B of the monitoring reports to further contextualize progress on implementing milestone components and trends in monitoring metrics.

C. Limitations of the analyses

The statistical analyses we present in this report provide information on whether observed differences exceed those expected due to normal variation in the population. However, the analysis does not provide information about whether the differences are caused by the demonstration or other factors, such as the state activities to address the opioid epidemic or the COVID-19 pandemic. Furthermore, the level of detail states provided and the methods they use to collect data are inconsistent, which limits comparisons across states.

[10] Maryland, Massachusetts, and New Mexico submitted only an implementation plan, and did not submit any monitoring reports, before the cutoff date of February 1, 2024.

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III. Availability of Mental Health Services in SMI/SED Demonstration States

Key takeaways

- Before implementation of the demonstrations, states reported gaps in the availability of residential facilities (two states), inpatient services (seven states), crisis services (three states), mental health providers (five states), and coordinated or integrated care for Medicaid beneficiaries with SMI/SED (four states). Seven noted gaps in the availability of providers and facilities in rural areas specifically.
- The numbers of certain inpatient services, community-based outpatient services, and the workforce categories increased in most states, as follows: Medicaid-enrolled psychiatric hospitals (six states), beds in psychiatric hospitals and psychiatric units (six states), federally qualified health centers (FQHCs) (five states), Medicaid-enrolled prescribers (five states), and Medicaid-enrolled other independent mental health providers (six states). For most states, the number of all categories under the residential services and crisis services domains did not change.
- The ratios of Medicaid and CHIP beneficiaries per service suggested decreased availability for most service categories across the inpatient, residential, crisis, and community-based outpatient services domains. Among most categories of inpatient, residential, and crisis services, and some categories of community-based outpatient services and workforce providers, the number of services has grown or remained the same but has not kept pace with the number of beneficiaries. These findings may be explained by substantial increases in Medicaid and CHIP enrollment in every state, as well as by changes in the Availability Assessment tool and in states' reporting practices.
- Increases in the number of Medicaid-enrolled psychiatric hospitals are consistent with the third demonstration goal to improve the availability of services for crisis stabilization, including in psychiatric hospitals. Increases in the number of FQHCs are consistent with the fourth SMI/SED demonstration goal to increase access to community-based services. The availability of crisis services generally did not keep pace with increased enrollment across states.

A. Overview

This chapter describes the changes in the availability of mental health services within states that occurred over the course of the demonstrations. Appendices A, B, and C provide additional context important for the interpretation of findings, and Appendix D presents definitions of workforce provider categories.[11]

[11] Appendix A includes an overview of data sources, details on the methods used to analyze the data in this chapter, and a review of limitations. Appendix A also contains information on conceptual domains of mental health services—psychiatric inpatient services, residential mental health treatment services, crisis services, community-based outpatient services, and workforce availability— used to present findings throughout this chapter. Appendix B describes differences in definitions of services across versions of the Availability Assessment tool. Appendix C describes data sources and state definitions of each category for each submitted Availability Assessment, by state. Appendix D presents definitions of workforce provider categories.

This CSA includes assessments for 11 states that were submitted before the cutoff date for inclusion in the report (February 1, 2024). All 11 states completed the quantitative portion of their Initial Availability Assessments, and all states except the District of Columbia and Vermont completed the narrative description. Eight states had more than one Availability Assessment.

We constructed ratios to standardize our measures of the availability of mental health services over time. Ratios compare the total number of Medicaid and CHIP beneficiaries in each state at the time of the assessment to the count of each service.[12] Higher numbers of beneficiaries per service suggest lower availability; lower numbers of beneficiaries per service suggest greater availability. The ratios are based on total enrollment in Medicaid and CHIP and do not reflect the need for services by specific subpopulations. This is a limitation since some services may only be used by subpopulations of beneficiaries, such as Medicaid-enrolled psychiatric residential treatment facilities (PRTFs) (which only serve individuals under the age of 21), services available to individuals who have a defined level of need, and services available to all individuals including those not enrolled in Medicaid, such as crisis services. In addition, variations in the ratio of beneficiaries per service do not fully represent variations in state mental health service capacity, as the capacity of each service may also vary. For example, one state may have a few facilities that can serve many beneficiaries in need, while another may have smaller facilities that each serve fewer beneficiaries in need.

B. Gaps in the availability of mental health services before the demonstrations

In response to a prompt in the narrative assessment of the Availability Assessment tool, states reported gaps in the availability of mental health services before the demonstrations (Table III.1), identifying the following gaps in availability of mental health services:

- **Inpatient and residential services.**[13] Seven states described gaps in the availability of psychiatric inpatient facilities and beds (Alabama, Idaho, Oklahoma, Utah, Washington, Maryland, Massachusetts). Some states described gaps in patient services in certain regions (Alabama, Maryland, Oklahoma, Utah, and Washington. One state (Idaho noted gaps in inpatient treatment facilities for youth).

  Two states described gaps in residential facilities and beds (Idaho, Maryland). Idaho reported gaps in residential treatment facilities for both youth and adults, and Maryland highlighted gaps in the availability of Psychiatric Residential Treatment Facility (PRTF) beds.
- **Crisis services.**[14] Three states described gaps in crisis services broadly (Oklahoma, Maryland, Massachusetts), but did not describe gaps specific to categories of crisis services or how different categories of crisis services were related.

[12] Data on total Medicaid and CHIP enrollees is from the CMS's "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data" (available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html). Enrollment numbers were extracted based on each Availability Assessment's coverage dates.

[13] Includes Medicaid-enrolled psychiatric hospitals and beds, Medicaid-enrolled PRTFs, Medicaid-enrolled residential mental health facilities and beds.

[14] Includes mobile crisis units, crisis call centers, crisis observation or assessment centers, crisis units, and coordinated community crisis response teams.

- **Community-based outpatient services.**[15] No state specifically described gaps in community-based services. However, more broadly, several states described the need to improve available capabilities within outpatient settings, and across the mental health service system at large. For instance, states described lack of coordinated care (Idaho, New Hampshire, Maryland, Massachusetts) and lack of integrated services in outpatient settings (Idaho, Massachusetts).
- **Workforce availability.**[16] Five of the nine states described gaps in the availability of behavioral health providers (Idaho, Oklahoma, Indiana, Maryland, Massachusetts). Four of these states reported specific types of workforce shortages (such as dually licensed providers, midlevel providers, case management, and care coordination providers). Indiana and Maryland linked these shortages back to state laws and licensure issues.

Finally, seven states reported gaps in providers and facilities, broadly, for beneficiaries living in more rural areas of the state (Idaho, Indiana, Maryland, Massachusetts, Oklahoma, Utah, Washington).[17]

Table III.1. Gaps related to availability of mental health services reported by states

State	Gaps in the availability of mental health services before the demonstrations
AL	• Psychiatric inpatient services in the Mobile, Alabama, region
ID	• Inpatient psychiatric facilities for adults • Residential psychiatric facilities for adults • PRTFs • Co-located behavioral health services with primary care for rural areas • Workforce: Care coordination providers such as care coordinators and case managers to support integrated outpatient care
IN	• Mid-level behavioral health providers[12]; state law requires independent practitioners to review and approve mid-level treatment providers' behavioral health treatment plans • Psychiatrists in rural areas • Workforce: Psychiatrists and psychologists
MA	• Inpatient services and crisis care for more rural parts of the state • Integration within primary care practices, specifically integrated care for both mental health and substance use disorders • Specialized services for children and families, including evidence-based, trauma-specific practices and dyadic therapy in outpatient settings • Care coordination to support transitions between inpatient and community settings • Community-based crisis services and other forms of urgent care for behavioral health • Workforce: Providers who can offer case management services for high-need individuals

[15] Includes Medicaid-enrolled community mental health centers, Medicaid-enrolled community intensive outpatient or partial hospitalization facilities, and FQHCs.
[16] Includes Medicaid-enrolled prescribers and "Other" Medicaid-enrolled independent mental health providers.
[17] In analyses of quantitative data for the cross-state analyses, we do not analyze data disaggregated by rurality, so we cannot comment on how these patterns present in the quantitative assessment.

State	Gaps in the availability of mental health services before the demonstrations
MD	• Psychiatric inpatient facilities and psychiatric hospital beds • PRTF beds • FQHCs with behavioral health services • Crisis services, including mobile crisis units • Crisis services in rural areas • Workforce: Mental health providers licensed to treat co-occurring disorders given related billing barriers
NH	• Care coordination and care transitions that occur across several systems (for example, mental health and child welfare) or transitions between providers within the same system (for example, youth to adult services in mental health)
OK	• Limited inpatient care in rural areas • Statewide geographic coverage of mobile crisis services for adults • Workforce: Behavioral health providers • Providers clustered in metropolitan areas
UT	• Inpatient services in rural areas
WA	• Inpatient psychiatric facilities and beds in frontier (rural) parts of the state • Inpatient psychiatric hospital beds in some regions of the state in which residential treatment facilities provide evaluation and inpatient care

Source: Narrative assessments from Initial Availability Assessment.

CMHC = community mental health center; FQHC = federally qualified health center; PRTF = psychiatric residential treatment facility.

[a] Midlevel behavioral health providers include licensed clinical social workers, licensed mental health counselors, licensed clinical addiction counselors and licensed marriage and family therapists.

C. Changes in mental health service availability over the course of the demonstrations

For the eight states that submitted multiple Availability Assessments, we analyzed within-state changes in mental health services available to Medicaid and CHIP beneficiaries during the demonstrations. For each domain and its corresponding categories of providers and facilities, we summarized patterns in the changes between each state's Initial Availability Assessment and its most recent Annual Availability Assessment in the absolute number of services and ratios of Medicaid and CHIP beneficiaries per service; we report the direction of the change in the ratios of Medicaid and CHIP beneficiaries per service.[18] We advise caution when comparing ratios across states, due to differences in the number of years included in the analysis, as well as differences in state reporting practices and behavioral health delivery systems described in Appendix A. We provided context for instances where the magnitude of the changes appears implausible, when available from the states.

1. Overview of changes

Changes in the number of services. The numbers of certain inpatient services, outpatient and community-based services, and the workforce categories increased in most states, as follows: Medicaid-enrolled psychiatric hospitals (six states), beds in psychiatric hospitals and psychiatric units (six states), FQHCs (five states), Medicaid-enrolled prescribers (five states), and Medicaid-enrolled other independent

[18] Ratios were not calculated when states reported no providers or facilities. In instances where ratios could not be calculated because states reported no providers of or facilities, the direction of the arrow was based on the number changes in the service category and beneficiary count.

mental health providers (six states). Increases in the number of Medicaid-enrolled psychiatric hospitals (six states) and psychiatric hospital beds and psychiatric unit beds (six states) are consistent with the third goal to improve availability of crisis stabilization services.[19] Increases in the number of Medicaid-enrolled prescribers (five states), Medicaid-enrolled other mental health providers (six states), and FQHCs (five states) are consistent with the fourth goal[20] of the demonstration to increase access to community-based services. For some states, the change in the number of Medicaid-enrolled other independent mental health providers may reflect changes in the definitions between versions of the Availability Assessment tool and in states' reporting practices.

In most states, the numbers of certain community-based outpatient services, crisis services, and residential treatment services did not change. The number of Medicaid-enrolled community mental health centers (CMHCs) remained the same for a majority of states (six states), as was the case for the number of mobile crisis units (five states), crisis call centers (five states), coordinated community crisis response teams (six states), Medicaid-enrolled PRTFs (five states), Medicaid-enrolled adult residential mental health treatment facilities (five states), psychiatric hospitals that qualified as IMDs (five states), and Medicaid-enrolled adult residential mental health facilities that qualify as IMDs (six states).

Changes in the number of Medicaid and CHIP beneficiaries. The number of Medicaid and CHIP beneficiaries increased across all eight states (increases ranged from 5 percent to 60 percent between assessments). Five out of eight states had increases of greater than 15 percent in the number of beneficiaries between their Initial most recent Annual Availability Assessments. Three states (Idaho, Utah, Oklahoma) expanded Medicaid, and the number of Medicaid and CHIP beneficiaries grew with the expansion.[21] In addition, the Families First Coronavirus Response Act's maintenance of eligibility requirements affected all states, resulting in increased enrollment of Medicaid and CHIP beneficiaries.

Changes in the ratio of Medicaid and CHIP beneficiaries per service. The ratios of Medicaid and CHIP beneficiaries per service suggested decreased availability for most service categories across the inpatient, residential, crisis, and community-based outpatient services domains. Among most categories of inpatient, residential, and crisis services, and some categories of community-based outpatient services and workforce providers, the number of services grew or remained the same but has not kept pace with the number of beneficiaries.[22]

However, findings on changes in ratios should be interpreted with caution. It is unclear to what extent changes in ratios are likely to persist, or instead reflect increases in the number of Medicaid and CHIP beneficiaries due to policy changes, such as the continuous enrollment provision of the Families First Coronavirus Response Act and Medicaid expansion in three states (Idaho, Utah, Oklahoma) during the

[19] The third demonstration goal is to improve availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, and services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings.

[20] The fourth demonstration goal is to improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI/SED, including through increased integration of primary and behavioral health care.

[21] Idaho expanded Medicaid in 2020, as approved in a 2018 vote by voters, to include a broader range of low-income earners. Utah implemented Medicaid expansion in two phases, effective April 2019 (covered individuals up to the poverty level) and January 2020 (covered individuals up to 138 percent of the poverty level). Oklahoma's Medicaid expansion was effective on July 1, 2021.

[22] An increase in services and an increase in the number of beneficiaries could result in a lower the ratio of beneficiaries per service, which could indicate that the service availability is not keeping pace with population of need.

demonstration. In addition, the improvements in ratios of beneficiaries per workforce provider but not per facility might indicate that states are improving availability by adding providers to existing facilities rather than by adding facilities. Other factors (facility mergers, for example), which states may not address in their Availability Assessments, may also influence the availability of services.

Inpatient services.[23] The number of Medicaid-enrolled psychiatric hospitals, beds in psychiatric hospitals, and psychiatric hospital units increased in most states. However, the ratio of beneficiaries per facility or bed also increased, which could suggest that the increase in hospitals and beds did not keep pace with increases in beneficiaries (Table III.2). The number of psychiatric hospitals that qualify as an IMD increased in two states (Indiana, Idaho). The number of psychiatric hospitals and psychiatric unit beds increased in five states (the District of Columbia, Idaho, Indiana, Oklahoma, and Utah). Idaho reported adding 16 psychiatric beds for youth in May 2021.

The number of psychiatric hospitals and psychiatric unit beds decreased in only one state (Vermont), which the state reported may be due to lower utilization of psychiatric hospital services during the COVID-19 pandemic and shortages of staff with a psychiatric specialty.

[23] Domain includes Medicaid-enrolled psychiatric hospitals, Medicaid-enrolled psychiatric units in acute care hospitals, and beds in psychiatric hospitals and psychiatric units.

Table III.2. Change in inpatient service availability between the Initial and the most recent Annual Availability Assessment

State (most recent assessment)	Number of beneficiaries at Initial Availability Assessment	Number of beneficiaries at most recent Availability Assessment	Percent change in beneficiaries	Medicaid-enrolled psychiatric hospitals		Private and public psychiatric inpatient facilities that qualify as IMDs		Medicaid-enrolled Psychiatric hospital beds & psychiatric unit beds		Psychiatric units in acute care hospitals available to Medicaid beneficiaries	
				Change in number of hospitals	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of facilities	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of beds	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of hospitals	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)
DC (3)	254,316	285,803	12	no change	▼+	no change	▼+	57 △^	▼+	no change	▼+
ID† (2)	268,143	429,383	60	2 △^	△^	–1 ▼+	▼+	227 △^	▼+	no change	▼+
IN† (2)	1,521,703	1,947,609	28	5 △^	▼+	17 △^	△^	215 △^	▼+	–4 ▼+	▼+
NH (2)	225,020	242,682	8	no change	▼+	no change	▼+	1	▼+	–1 ▼+	▼+
OK† (2)	977,760	1,224,323	25	1 △^	▼+	1 △^	▼+	247 △^	▼+	–1 ▼+	▼+
UT† (1)	348,383	451,896	30	1 △^	▼+	no change	▼+	724 △^	△^	6 △^	△^
VT† (2)	179,545	189,060	5	1 △^	△^	no change	▼+	–36 ▼+	▼+	–6 ▼+	–▼+
WA (1)	1,726,976	1,988,361	15	1 △^	▼+	no change	▼+	no change	▼+	no change	▼+

Source: Mathematica analysis of Initial Availability Assessment quantitative data and Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data.

Note: For the Direction of Change column, we calculated the change in ratio values between assessments. Where we could not calculate the change in ratio value because a state reported zero services in either assessment (which led to divide by 0 issues), we approximated the direction of the ratio change by looking at the change in the number of Medicaid and CHIP beneficiaries and the change in the number of services between assessments. The most recent annual assessment is indicated in parentheses next to the state. If a state did not provide information on data sources for one or more Availability Assessments, we assumed it used the same data sources and definitions across assessments. Although some within-state changes are very large, we do not know if this reflects an actual change or a data quality issue.

△^ = Suggests increased availability based on an increase in the number of services or decrease in the ratio of Medicaid and CHIP beneficiaries per service; ▼+ = suggests decreased availability based on a decrease in the number of services or increase in the ratio of Medicaid and CHIP beneficiaries per service.

– = The change in the ratio could not be calculated when the state had no services for one of the Availability Assessments.

† Changes in state reporting practices: Five states (Idaho, Indiana, Utah, Oklahoma, Vermont) used Version 1.0 of the Availability Assessment tool for the Initial Availability Assessment, and either Version 2.0 or 3.0 for the most recent Availability Assessment. Versions 2.0 and 3.0 clarified the definition of Medicaid-enrolled psychiatric hospital that was used in Version 1.0, and states were instructed to report on both public and private psychiatric hospitals. It is unlikely that this change affected how states reported data. If a state did not provide information on data sources for one or more Availability Assessment, we assumed it used the same data sources and definitions across assessments.

Residential mental health treatment.[24] Among states with available data, the number of adult residential mental health treatment facilities did not change for three states, but the ratio of beneficiaries per facility or beds increased (New Hampshire, Vermont, Washington), suggesting a possible decrease in availability. In two states (Idaho, Indiana), the ratio of beneficiaries per adult residential mental health treatment facility and beds decreased, suggesting a possible increase in availability. One of the facilities that Indiana added also qualified as an IMD. However, Indiana did not provide any explanation for the large change in the number of Medicaid-enrolled adult residential mental health facilities and beds. Utah did not have any Medicaid-enrolled adult residential mental health facilities and beds as of its most recent assessment, a decrease from its Initial Availability Assessment.

Similarly, among the states with available data, the number of Medicaid-enrolled PRTFs and beds in Medicaid-enrolled PRTFs did not change in three states (Oklahoma, Vermont, Washington) and the ratio of beneficiaries per Medicaid-enrolled PRTFs and beds increased, suggesting a possible decrease in availability. Idaho did not have any PRTFs in its most recent assessment, a decrease from its Initial Availability Assessment. The number of PRTFs and beds in PRTFs both increased in one state (New Hampshire). Although the number of PRTFs substantially increased and the number of PRTF beds substantially decreased in Indiana, the state did not provide any explanation for these changes.

[24] Domain includes Medicaid-enrolled residential mental health treatment facilities for adults and beds, Medicaid-enrolled PRTFs, Medicaid-enrolled residential mental health facilities and beds.

Table III.3. Change in residential service availability between the Initial and the most recent Annual Availability Assessment

State (most recent assessment)	Number of beneficiaries at Initial Availability Assessment	Number of beneficiaries at most recent Availability Assessment	Percent change in beneficiaries	Medicaid-enrolled adult residential mental health facilities		Medicaid-enrolled adult residential mental health facilities: number of facilities that qualify as IMDs		Beds in Medicaid-enrolled adult residential mental health facilities		Medicaid-enrolled psychiatric residential treatment facilities (PRTFs)		Beds in Medicaid-enrolled PRTFs	
				Change in number of facilities	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of facilities	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of beds	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of facilities	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of beds	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)
DC (3)	254,316	285,803	12	no change	-- ▼**	no change	-- ▼**	no change	-- ▼**	no change	-- ▼**	no change	-- ▼**
ID (2)	268,143	429,383	60	2 △^	△^	no change	-- ▼+	32 △^	△^	–1 ▼+	-- ▼**	–12 ▼	-- ▼**
IN (2)	1,521,703	1,947,609	28	35 △^	△^	36 △^	-- △^	2,094 △^	△^	4 △^	△^	–131 ▼	▼+
NH (2)	225,020	242,682	8	no change	▼+	no change	-- ▼+	no change	▼+	1 △^	-- ▼+	12 △^	-- △^
OK (2)	977,760	1,224,323	25	no change	-- ▼**	no change	-- ▼**		-- ▼**	no change	▼+	12 △^	▼+
UT (1)	348,383	451,896	30	–2 ▼+	-- ▼**	–1 ▼	-- ▼+	–35 ▼+	-- ▼**	no change	-- ▼**	no change	-- ▼**
VT (2)	179,545	189,060	5	no change	▼+	no change	-- ▼+	no change	▼+	no change	-- ▼+	no change	-- ▼+
WA (1)	1,726,976	1,988,361	15	no change	▼+	no change	▼+	–80 ▼+	▼+	no change	▼+	no change	▼+

Source: Mathematica analysis of Initial Availability Assessment quantitative data and Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data.

Note: For the Direction of Change column, we calculated the change in ratio values between assessments. Where we could not calculate the change in ratio value because a state reported zero services in either assessment (which led to divide by 0 issues), we approximated the direction of the ratio change by looking at the change in the number of Medicaid and CHIP beneficiaries and the change in the number of services between assessments. The most recent annual assessment is indicated in parentheses next to the state. If a state did not provide information on data sources for one or more Availability Assessments, we assumed it used the same data sources and definitions across assessments. Although some within-state changes are very large, we do not know if this reflects an actual change or a data quality issue.

The District of Columbia reported that the state does not have any residential mental health treatment facilities or Medicaid-enrolled PRTFs, and that beneficiaries may access residential treatment facilities and PRTFs out of the state. Oklahoma reported that residential treatment facilities do not participate in Medicaid. Utah reported that PRTFs do not participate in Medicaid.

△^ = Suggests increased availability based on an increase in the number of services or decrease in the ratio of Medicaid and CHIP beneficiaries per service; ▼+ = suggests decreased availability based on a decrease in the number of services or increase in the ratio of Medicaid and CHIP beneficiaries per service.

* The state reported none of this particular service in one of its Availability Assessments

-- = The change in the ratio could not be calculated when the state had no services for one of the Availability Assessments.

Crisis services.[25] Across the categories in the crisis services domain, the number of crisis services did not change in most states, while the number of beneficiaries increased across all states, suggesting potential decreases in the availability of crisis services across categories (Table III.4). The number of mobile crisis units increased in three states (Indiana, New Hampshire, Utah), and the ratio of beneficiaries per mobile crisis unit decreased in two states (Indiana, New Hampshire). Similarly, the number of crisis stabilization units increased in three states (the District of Columbia, Oklahoma, Washington), and the ratio of beneficiaries per crisis stabilization units decreased in one (the District of Columbia). The decrease in the ratio of beneficiaries per mobile crisis unit or crisis stabilization unit in these states suggests a possible increase in the availability of these services. Oklahoma added six crisis observation or assessment centers and two crisis stabilization units and reported increasing availability of crisis stabilization facilities called Urgent Recovery Clinics, which provide crisis assessment, stabilization of acute symptoms, and care linkages. Three states (Idaho, Indiana, New Hampshire) reported a decrease in the number of crisis call centers. New Hampshire described that this reflected consolidation of crisis call center lines as part of the implementation of the National Suicide and Crisis Hotline (988 crisis hotline). Indiana reported 97 crisis call centers in its Initial Availability Assessment, which may reflect double counting if the call center served multiple geographic areas. Indiana did not provide additional information to explain the decline in the count of crisis call centers to zero in its most recent Annual Availability Assessment.

[25] Domain includes mobile crisis units, crisis call centers, crisis observation or assessment centers, crisis units, and coordinated community crisis response teams.

Table III.4. Change in crisis service availability between the Initial and the most recent Annual Availability Assessment

State (most recent assessment)	Number of beneficiaries at Initial Availability Assessment	Number of beneficiaries at most recent Availability Assessment	Percent change in beneficiaries	Mobile crisis units		Crisis call centers		Crisis observation or assessment centers		Crisis stabilization units		Coordinated community crisis response teams	
				Change in number of units	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of centers	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of centers	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of units	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of teams	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)
DC (3)	254,316	285,803	12	no change	▼+	no change	▼+	no change	▼+	2 △^	△^	no change	▼+
ID (2)	268,143	429,383	60	no change	▼+	–5 ▼+	▼+	2 △^	▼+	–8 ▼+	--▼+	–7	--▼+
IN† (2)	1,521,703	1,947,609	28	7 △^	△^	–97 ▼+	--▼+	–2 ▼+	--▼+	–2 ▼+	▼+	no change	--▼+
NH (2)	225,020	242,682	8	10 △^	△^	–52 ▼+	▼+	–1 ▼+	▼+	no change	--▼+	no change	▼+
OK (2)	977,760	1,224,323	25	no change	▼+	no change	▼+	6 △^	△^	2 △^	▼+	no change	▼+
UT (1)	348,383	451,896	30	3 △^	▼+	no change	▼+	no change	--▼+	no change	▼+	no change	--▼+
VT (2)	179,545	189,060	5	no change	▼+	no change	▼+	no change	▼+	no change	▼+	1 △^	△^
WA (1)	1,726,976	1,988,361	15	no change	▼+	no change	▼+	no change	▼+	3 △^	▼+	no change	▼+

Source: Mathematica analysis of Initial Availability Assessment quantitative data and Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data.

Note: For the Direction of Change column, we calculated the change in ratio values between assessments. Where we could not calculate the change in ratio value because a state reported zero services in either assessment (which led to divide by 0 issues), we approximated the direction of the ratio change by looking at the change in the number of Medicaid and CHIP beneficiaries and the change in the number of centers, teams, or units between assessments. The most recent annual assessment is indicated in parentheses next to the state. If a state did not provide information on data sources for one or more Availability Assessments, we assumed it used the same data sources and definitions across assessments. Although some within-state changes are very large, we do not know if this reflects an actual change or a data quality issue.

△^ = Suggests increased availability based on an increase in the number of services or decrease in the ratio of Medicaid and CHIP beneficiaries per service; ▼+ = suggests decreased availability based on a decrease in the number of services or increase in the ratio of Medicaid and CHIP beneficiaries per service.

-- = The change in the ratio could not be calculated when the state had no services for one of the Availability Assessments.

† Changes in state reporting practices: Indiana reported using a different data source between its Initial Availability Assessment and its subsequent Availability Assessments. In its Initial Availability Assessment, Indiana described that it will update the methods to collect data, but it did not provide additional updates in subsequent assessments. The changes in crisis services in Indiana may reflect these changes in the methodology.

Community-based outpatient services.[26] The number of CMHCs did not change in four states with available data (Oklahoma, New Hampshire, Utah, Vermont), while the ratio of beneficiaries per CMHC increased in these states, suggesting a potential decrease in the availability of CMHCs. The number of CMHCs increased and the ratio of beneficiaries per CMHC decreased in two states (Indiana, Washington), suggesting a potential increase in the availability of CMHCs. Washington reported a change in its data source for estimating the number of Medicaid-enrolled CMHCs between its initial and subsequent assessments, which may explain the increase in the number of CMHCs.

The ratio of beneficiaries per IOP/PH providers increased in six states (the District of Columbia, Idaho, Utah, New Hampshire, Vermont, Washington) and decreased in two (Indiana, Oklahoma), suggesting that most states had a possible decrease in availability. The number of IOP/PH providers increased in three states (Idaho, Indiana, Oklahoma). In two of these states (Indiana, Oklahoma), the ratio of beneficiaries per IOP/PH providers decreased, suggesting a possible increase in availability. In one of those states (Idaho), the ratio of beneficiaries per IOP/PH providers increased, suggesting a possible decrease in availability. Idaho changed its Medicaid policy in 2021 to allow additional treatment services within partial hospitalization programs. Idaho reported that this change in policy could explain the increase in outpatient partial hospitalization programs. The definition of IOP/PH services changed between Version 1.0 and Versions 2.0 and 3.0 of the Availability Assessment tools, and some states may have interpreted the new definition differently. This may explain the changes in the number of IOP/PH providers in five states (Idaho, Indiana, Oklahoma, Utah, and Vermont).[27]

In five states (the District of Columbia, Indiana, Utah, Vermont, Washington), the number of FQHCs increased. The ratio of beneficiaries per FQHC decreased in three of these states (the District of Columbia, Indiana, Vermont), suggesting an increase in the availability of FQHCs. The ratio of beneficiaries per FQHC increased in two states (Utah, Washington), suggesting a possible decrease in availability. The number of FQHCs decreased along with an increase in the ratio of beneficiaries per FQHC in three states (Idaho, New Hampshire, Oklahoma), suggesting a decrease in the availability of FQHCs.

[26] Domain includes Medicaid-enrolled community mental health centers, Medicaid-enrolled community intensive outpatient or partial hospitalization facilities, and FQHCs.

[27] Versions 2.0 and 3.0 of the Availability Assessment tool define intensive outpatient services as services designed to meet the needs of individuals who may be at risk for crisis or require a higher level of care, or who are in transition from a higher level of care. Intensive outpatient services may include partial hospitalization programs, day treatment services, intensive outpatient programs, the Assertive Community Treatment program, intensive case management, intensive peer supports, written standardized protocols for escalating outpatient services when an individual is experiencing a crisis or greater need, and other services and settings more intensive than regular outpatient and less intensive than inpatient or residential care. Version 1.0 of the tool defines intensive outpatient services as distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting.

Table III.5. Change in community-based outpatient service availability between the Initial and the most recent Annual Availability Assessment

State (most recent assessment)	Number of beneficiaries at Initial Availability Assessment	Number of beneficiaries at most recent Availability Assessment	Percent change in beneficiaries	Medicaid-enrolled community mental health centers		Medicaid-enrolled community intensive outpatient or partial hospitalization services		Federally qualified health centers	
				Change in number of centers	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of providers	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of centers	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)
DC (3)	254,316	285,803	12	no change	-- ▼+	no change	▼+	13 ▲^	▲^
ID (2)	268,143	429,383	60	no change	-- ▼+	15 ▲^	▼+	–5 ▼+	▼+
IN (2)	1,521,703	1,947,609	28	237 ▲^	▲^	954 ▲^	▲^	13 ▲^	▲^
NH (2)	225,020	242,682	8	no change	▼+	–1 ▼+	▼+	–3 ▼+	▼+
OK (2)	977,760	1,224,323	25	no change	▼+	12 ▲^	▲^	–5 ▼+	▼+
UT† (1)	348,383	451,896	30	no change	▼+	–47 ▼+	-- ▼+	3 ▲^	▼+
VT (2)	179,545	189,060	5	no change	▼+	–88 ▼+	▼+	3 ▲^	▲^
WA (1)	1,726,976	1,988,361	15	591 ▲^	▲^	–8 ▼+	▼+	28 ▲^	▼+

Source: Mathematica analysis of Initial Availability Assessment quantitative data and Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data.

Note: For the Direction of Change column, we calculated the change in ratio values between assessments. Where we could not calculate the change in ratio value because a state reported zero services in either assessment (which led to divide by 0 issues), we approximated the direction of the ratio change by looking at the change in the number of Medicaid and CHIP beneficiaries and the change in the number of services between assessments. The most recent annual assessment is indicated in parentheses next to the state. If a state did not provide information on data sources for one or more Availability Assessments, we assumed it used the same data sources and definitions across assessments. Although some within-state changes are very large, we do not know if this reflects an actual change or a data quality issue.

The definition of IOP/PH services changed between Version 1.0 and Versions 2.0 and 3.0 of the Availability Assessment tool, and some states may have interpreted the definition differently, which may explain the changes in the number of IOP/PH providers in five states (Idaho, Indiana, Oklahoma, Utah, Vermont). Versions 2.0 and 3.0 of the Availability Assessment tool define intensive outpatient services as services designed to meet the needs of individuals who may be at risk for crisis or require a higher level of care, or who are in transition from a higher level of care. Intensive outpatient services may include partial hospitalization programs, day treatment services, intensive outpatient programs, the Assertive Community Treatment program, intensive case management, intensive peer supports, written standardized protocols for escalating outpatient services when an individual is experiencing a crisis or greater need, and other services and settings more intensive than regular outpatient and less intensive than inpatient or residential care. Version 1.0 of the tool defines intensive outpatient services as distinct and organized intensive ambulatory treatment programs that offer less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting.

Two states (the District of Columbia, Idaho) reported no CMHCs because they did not have CMHCs that met the certification standards consistent with the federal definition of CMHCs used in the Availability Assessment tool.

▲^ = Suggests increased availability based on an increase in the number of services or decrease in the ratio of Medicaid and CHIP beneficiaries per service; ▼+ = suggests decreased availability based on a decrease in the number of services or increase in the ratio of Medicaid and CHIP beneficiaries per service.

* The state reported none of this particular service in one of its Availability Assessments.

-- = The change in the ratio could not be calculated when the state had no services for one of the Availability Assessments.

† Changes in state reporting practices: Utah changed the data sources used for Medicaid-enrolled community health centers between their assessments from provider enrollment to contract data, but there was no change in the number of CMHCs.

Workforce.[28] The ratio of beneficiaries per prescriber decreased and the number of prescribers increased in four states (Indiana, New Hampshire, Vermont, Washington), suggesting a possible increase in availability in these states (Figure III.5). However, in four states (the District of Columbia, Idaho, Oklahoma, Utah), the ratio of beneficiaries per provider increased, suggesting a possible decrease in availability. Idaho reported persistent challenges in the availability of providers in 2021, which aligns with decreases in the number of prescribers observed from its Initial to its most recent Annual Availability Assessment, which reflects data from April 2022.

The ratio of beneficiaries per Medicaid-enrolled other independent mental health provider decreased in five states (the District of Columbia, Idaho, Indiana, New Hampshire, Washington), suggesting a possible increase in availability. In one state (Utah), although the number of Medicaid-enrolled other independent mental health providers increased, so too did the ratio of beneficiaries per provider, indicating that the increase in providers did not keep pace with the increase in beneficiaries. Vermont reported its workforce was strained by domestic and childcare responsibilities and childcare stressors during the COVID-19 pandemic, which could explain the declines in its number of providers.

The changes in the number of other independent mental health providers may reflect changes in state reporting practices. Five states (Idaho, Indiana, Oklahoma, Utah, Vermont) used different versions of the Availability Assessment tool between the initial and most recent assessment, and the later version of the tool had a more inclusive definition for other independent mental health providers.[29] Additionally, Indiana reported that changes in the definitions, along with improvements in data collection, could explain increases in the number of prescribers and other independent mental health providers. Most states did not provide any additional context for changes in the number of providers. Idaho described persistent challenges in the availability of providers in 2021, which does not align with the increases observed in the number of other independent mental health providers from its Initial to its most recent Annual Availability Assessment.

[28] Domain includes Medicaid-enrolled prescribers and "Other" Medicaid-enrolled independent mental health providers.

[29] Due to changes in the Availability Assessment tool between Version 1.0 and subsequent versions, the definition of "Other" Medicaid-enrolled independent mental health providers was expanded to include providers who require the supervision of other providers who are certified or licensed by the state to independently treat mental illness. This change in definition may have affected how states reported this category if states used different versions of the Availability Assessment for their Initial and their most recent Availability Assessment.

Table III.6. Change in workforce availability between the Initial and the most recent Annual Availability Assessment

State (most recent assessment)	Number of beneficiaries at Initial Availability Assessment	Number of beneficiaries at most recent Availability Assessment	Percent change in beneficiaries	Medicaid-enrolled prescribers		Medicaid-enrolled other independent mental health providers	
				Change in number of prescribers	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)	Change in number of providers	Direction of change in ratios (Medicaid and CHIP beneficiaries per service)
DC (3)	254,316	285,803	12	–34 ▼+	▼+	73 △^	--△*
ID† (2)	268,143	429,383	60	–18 ▼+	▼+	1,391 △^	△^
IN† (2)	1,521,703	1,947,609	28	393 △^	△^	1,539 △^	△^
NH (2)	225,020	242,682	8	73 △^	△^	300 △^	△^
OK† (2)	977,760	1,224,323	25	–82 ▼+	▼+	–1,384 ▼+	▼+
UT† (1)	348,383	451,896	30	57 △^	▼+	223 △^	▼+
VT† (2)	17,9545	189,060	5	459 △^	△^	–2,675 ▼+	▼+
WA (1)	1,726,976	1,988,361	15	988 △^	△^	3,299 △^	△^

Source: Mathematica analysis of Initial Availability Assessment quantitative data and Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data.

Note: For the Direction of Change column, we calculated the change in ratio values between assessments. Where we could not calculate the change in ratio value because a state reported zero services in either assessment (which led to divide by 0 issues), we approximated the direction of the ratio change by looking at the change in the number of Medicaid and CHIP beneficiaries and the change in the number of services between assessments. The most recent annual assessment is indicated in parentheses next to the state. If a state did not provide information on data sources for one or more Availability Assessments, we assumed it used the same data sources and definitions across assessments. Although some within-state changes are very large, we do not know if this reflects an actual change or a data quality issue.

The District of Columbia reported no other independent mental health providers in its Initial Availability Assessment due to difficulties collecting licensure, specialty, or practice data. In its First Annual Availability Assessment, the District of Columbia reported 40 other independent mental health providers.

△^ = Suggests increased availability based on an increase in the number of services or decrease in the ratio of Medicaid and CHIP beneficiaries per service; ▼+ = suggests decreased availability based on a decrease in the number of services or increase in the ratio of Medicaid and CHIP beneficiaries per service.

* The state reported none of this particular service in one of its Availability Assessments.

-- = The change in the ratio could not be calculated when the state had no services for one of the Availability Assessments.

† Changes in state reporting practices: Five states (Idaho, Indiana, Oklahoma, Utah, Vermont) used two different versions of the Availability Assessment tool. Due to changes in the Availability Assessment tool between Version 1.0 and subsequent versions, the definition of "Other Medicaid-enrolled independent mental health providers" was expanded to include providers who require the supervision of other providers who are certified or licensed by the state to independently treat mental illness. This change in definition may have affected how states reported this category if states used different versions of the Availability Assessment for their Initial and most recent Availability Assessment. Table D.1 in Appendix D compares the definitions of workforce provider categories used by states.

IV. Progress Toward SMI/SED Demonstration Milestones

Key takeaways

Progress on activity-based milestone components

- Eight of 12 states reported meeting all components for at least one milestone. None of the seven states participating in the demonstration for two or more years have completed all activity-based milestones.
- Measuring progress toward meeting milestone components is limited in one of the states that did not provide narrative updates in its monitoring reports.

Performance on quantitative metrics associated with each milestone

- **Milestones 1, 2, and 4:** Most metrics from two states show progress toward Milestone 2, and most metrics from one state show progress toward Milestone 4. However, most metrics from most states show no progress toward Milestones 1, 2, or 4.
- **Milestone 3:** Between the first month of the demonstration and the most recent month of data, intensive outpatient and partial hospitalization utilization significantly increased ($p < 0.05$) in most states. Telehealth utilization significantly decreased ($p < 0.05$) in most states, but significantly increased ($p < 0.05$) in the two states with a demonstration start date prior to the onset of the COVID-19 pandemic. All states had an average length of stay of less than 30 days for all years and types of institutions for mental diseases.

The SMDL for the SMI/SED demonstration opportunity identifies four milestones on which states' performance is monitored (Figure IV.1). We assessed states' progress toward meeting these milestones in two ways:

1. Meeting specific **activity-based components** under each milestone, as documented in each state's approved implementation plan and narrative data in monitoring reports (Part B of the Medicaid Section 1115 SMI/SED Monitoring Reports) (Section A).
2. Performance on **quantitative metrics** associated with each milestone, as documented in each state's approved demonstration monitoring protocol and monitoring report workbooks (Section B).

Information used in this chapter from state implementation plans, monitoring protocols, and monitoring reports can be found in Appendices E, F, and G.

Figure IV.1. SMI/SED demonstration milestones

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

A. Status of milestone components at the start of and during the demonstrations

Key findings

- Eight of 12 states reported meeting all components for at least one milestone. Of the seven states participating in the demonstration for two or more years, none completed all four milestones. Most states met most of the components of Milestone 1 and some components of Milestones 2, 3, and 4 before demonstrations began.
- For one state, progress toward meeting the milestone components is unknown because they did not provide narrative updates in their monitoring reports.

Table IV.1 identifies the components of each milestone met by each state at baseline and during the demonstrations. Six states have met Milestone 1. Two states have met Milestone 3. Three states have met Milestone 4. No states have met Milestone 2. States have made some progress to achieve the milestones during the demonstrations:

- The District of Columbia met one additional component of Milestone 1 during the demonstration. Oklahoma did not meet any components of Milestone 1 at the start of the demonstration but met two components as of its most recent monitoring report.
- Four states (Alabama, District of Columbia, Washington, and Vermont) met one additional component of Milestone 2 during the demonstrations. New Hampshire, which had not met any components of Milestone 2 at the start of the demonstration, met two components during the demonstration.
- Two states (Washington and Vermont) met one component of Milestone 3, and Vermont completed the milestone during the demonstration.
- One state (the District of Columbia) met all three components of Milestone 4 during the demonstration.

The SMDL requires that states complete milestones within the first two years of the demonstration. Of the states that have had a demonstration for two or more years, four states (the District of Columbia, Idaho, Vermont, Washington) have met some of the four milestones and three states (Indiana, Oklahoma, Utah) have not met any milestones. Appendix F provides more detail on individual state activities.

Nine states (Alabama, the District of Columbia, Idaho, Indiana, Massachusetts, New Hampshire, Oklahoma, Vermont, and Washington) have provided updates for some activities during the

demonstrations (Table IV.1). One state (Utah) did have not provided updates on milestone components in their monitoring reports. Therefore, we cannot fully assess the progress of these states toward meeting previously unmet milestones. Two states (Maryland, New Mexico) did not have monitoring reports before the cutoff for this report (February 1, 2024).

Table IV.1. Milestone components met at the start of and during the demonstrations

Milestone	Component description	States with demonstrations ≥ 2 years							States with demonstrations < 2 years				
		DC^	IN^	VT^	ID^	WA^	OK^	UT	AL^	NH^	MD	MA^	NM
1	State licensure	X	X	X	X	X	O	X	X	X	X	X	X
	National accreditation	X	X	X	X	X	—	—	X	—	X	X	—
	Oversight	X	X	X	X	X	—	X	X	X	X	X	—
	Utilization review	O	—	X	X	X	—	X	X	—	X	X	—
	Program integrity	X	X	X	X	X	O	X	X	—	X	X	—
	Screening and access to treatment	—	X	X	X	X	—	X	X	—	X	X	—
2	Discharge planning	O	X	X	X	O	—	X	X	O	—	—	—
	Housing assessment	—	—	—	—	X	X	X	O	—	X	X	—
	72-hour post-discharge follow-up	—	—	O	—	O	X	—	X	O	X	—	—
	Strategies to reduce ED LOS	X	—	—	X	X	X	X	—	—	—	—	—
3[a]	Bed tracking	—	—	X	X	O	—	—	X	X	—	—	—
	Patient assessment tool	—	X	O	—	—	X	—	—	X	—	X	X
4	Identification and engagement	O	X	X	X	X	X	X	—	X	—	—	—
	BH integration in non-specialty settings	O	—	X	X	—	X	X	—	X	—	—	—
	Specialized settings/crisis stabilization	O	—	X	X	X	—	—	X	--	—	—	—
	Milestones met	4	—	1,3,4	1,4	1, 2	—	—	1	3	1	1	--
	Milestones partially met	1,2	1,2,3,4	2	2,3	3,4	1,2,3,4	1,2,4	2,3,4	1,2,4	2	2,3	1,3
	Milestones not met	3	—	—	—	—	—	3	—	—	3,4	4	2,4

Source: Approved implementation plans, Medicaid Section 1115 SMI/SED Midpoint Assessments and Medicaid Section 1115 SMI/SED Monitoring Reports, Part B submitted prior to February 1, 2024.

Note: X indicates component met at baseline; O indicates component met during demonstration; – indicates the component is unmet, and ^ indicates the state has provided updates for activities during the demonstration. A milestone is considered "met" if the state has achieved all associated components, "partially met" if the state has achieved one or more component and "not met" if the state has not achieved any of the associated components. At baseline, a state may have met some milestone components based on the policies and mental health infrastructure that existed in the state before the demonstration began.

[a] Milestone 3 component (a), which outlines the state's strategy for conducting Availability Assessments, is not included in this analysis. Milestone 3 component (b) discusses the state's financing plan, which is outside the scope of this analysis and is not included in this report.

BH = behavioral health; ED = emergency department; LOS = length of stay.

Figure IV.2 provides an overview of activities being planned by states to meet components of each milestone, as reported in the states' implementation plans. Appendix F provides the status of state activities for all milestones.

Figure IV.2. Commonly reported activities across states, based on implementation plans

1 **Milestone** Ensuring quality of care in psychiatric hospitals and residential settings	2 **Milestone** Improving care coordination and transitioning to community-based care	3 **Milestone:** Increasing access to continuum of care, including crisis stabilization services	4 **Milestone** Earlier identification and engagement in treatment, including through increased integration
Activity Four states planned to use Medicaid administrative rules to require screening for substance use disorders and other comorbid conditions upon admission. (Component 1[e]) **States:** *DC, NH, NM, OK*	**Activity** Seven states planned to add 72-hour post discharge follow-up requirements to MCO contracts and/or state Medicaid policy. (Component 2[c]) **States:** *DC, ID, IN, MA, NH, UT, WA*	**Activity** Eight states planned to develop or expand existing bed tracking systems. (Component 3[c]) **States:** *DC, IN, NM, MA, MD, OK, UT, WA*	**Activity** Eight states planned varied approaches to establish specialized settings and services for young adults with SMI, including expansion of mobile response units and reimbursement changes. (Component 4[c]) **States**: *DC, IN, NM, MA, MD, NH, OK, UT*

State spotlight: New Mexico

Innovations in care coordination to achieve Milestone 2

New Mexico plans to use certified peer support workers across multiple clinical settings to conduct housing assessments and post-discharge follow-calls. Peer support is an evidence-based model of care that is associated with improved patient outcomes, including a reduction in the need for inpatient and emergency services among individuals with behavioral health needs.

Source: States' approved implementation plans.

[a] See https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Workforce-Peer-Support-Workers and https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400266?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.

MCO = managed care organization; SMI = serious mental illness.

B. Performance on monitoring metrics tied to demonstration milestones

This section summarizes state performance on some quantitative metrics tied to demonstration milestones that states include in their monitoring reports. States used the most recent version of the SMI/SED technical specifications available to calculate quantitative metrics. We note when metric trends may be due to states using previous versions of the technical specifications or when there were significant revisions to the metric calculation. We advise caution in interpreting trends. Where possible, we contextualize metric findings with narrative data provided by states. However, the quantity of this narrative data is limited, and most states did not explain most metric trends.

Milestone 1. Ensuring quality of care in psychiatric hospital and residential settings

Key findings

- Between the two most recently reported measurement years, the percentage of children on antipsychotics with documentation of first-line psychosocial care showed significant improvement in only one of five states.

1. Introduction

Milestone 1 requires states to have or implement policies to ensure quality of care in psychiatric hospitals and residential settings through licensure and accreditation, oversight, utilization review, and screening of providers and enrollees. In this section, we analyze state-reported data for one annual established quality measure that CMS uses to assess progress toward this milestone:

- **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Metric #2)** measures the percentage of children and adolescents newly started on antipsychotic medications for conditions for which antipsychotic medications are not indicated who had documentation of psychosocial care as first-line treatment. A higher percentage indicates a higher quality of care.

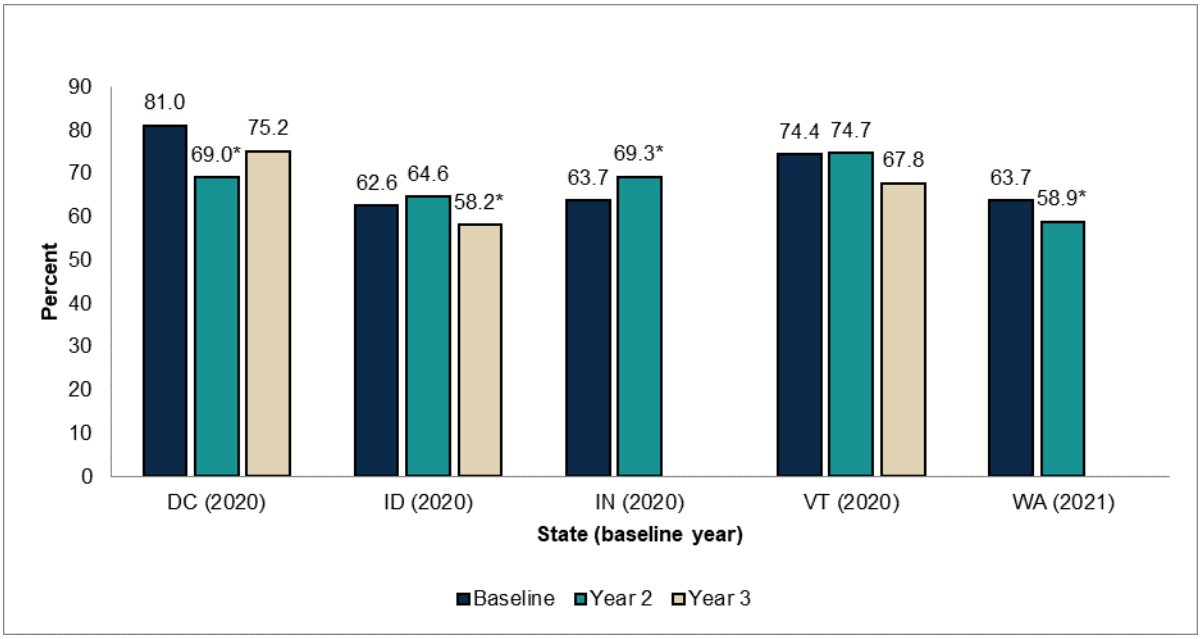
On its own, this metric is limited in its ability to measure progress toward this milestone since it does not include adults and is not limited to assessing care in psychiatric hospitals or residential treatment facilities.

2. Findings

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Metric #2)

- Between the two most recently reported measurement years, the percentage of children and adolescents that had a new prescription for antipsychotic medication and had documentation of psychosocial care as first-line treatment significantly decreased ($p < 0.05$) in two states (Idaho, Washington), significantly increased ($p < 0.05$) in one state (Indiana), and did not change significantly in two states (the District of Columbia, Vermont) (Figure IV.3).
- In Washington, the numerator (the number of children in this population with documentation of psychosocial care) is similar across years, while the denominator (total number of children receiving a new prescription for antipsychotic medication) increased, which may explain the statistically significant decrease in the rate. Washington did not provide an explanation for the increase.

Figure IV.3. Percentage of youth ages 1–17 who had a new prescription for antipsychotic medication and had documentation of psychosocial care as first-line treatment (Metric #2)



Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

Note: Indiana reported data for Year 3 of the demonstration. This analysis does not include this data because it did not pass the data quality checks. Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis.

* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

Milestone 2. Improving care coordination and transitioning to community-based care

Key findings

- The District of Columbia is making progress toward this milestone.
- Between the two most recent measurement years, the rate of all-cause unplanned psychiatric readmissions within 30 days of discharge from an inpatient psychiatric facility significantly increased ($p < 0.05$) in one state and did not significantly change in four states.
- Between the two most recent measurement years, only one state showed significant improvements in the rates of follow-up after hospitalizations for mental illness (child and adult).
- The rate of follow-up after an emergency department (ED) visit for alcohol or other drug abuse (within 7 and 30 days of discharge) significantly increased ($p < 0.05$) in one state and did not change significantly in three states.

1. Introduction

Milestone 2 focuses on improving care coordination and transitioning to community-based care through discharge planning and follow-up in psychiatric hospitals and residential treatment settings; strategies to prevent or decrease lengths of stay in EDs; and strategies to develop and enhance interoperability and data sharing among physical health, substance use disorder treatment, and mental health providers. Providing follow-up care after psychiatric hospitalization may improve outcomes, decrease the likelihood of rehospitalization, and lower the cost of outpatient care.[30] Providing follow-up care after ED visits is associated with fewer ED visits and hospital admissions.[31] In this section, we analyze state-reported data for six annual, established quality measures that CMS uses to assess progress on this milestone:

- **30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (Metric #4)** measures the rate of unplanned, 30-day, readmission for demonstration beneficiaries age 18 and older with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. A lower rate of unplanned readmissions indicates better performance.
- **Medication Continuation Following Inpatient Psychiatric Discharge (Metric #6)** measures whether psychiatric patients age 18 and older admitted to an inpatient psychiatric facility for major depressive disorder, schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. A higher rate indicates better performance.
- **Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (Metric #7)** measures the percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider (within 7 days and within 30 days). A higher rate indicates better performance.
- **Follow-Up After Hospitalization for Mental Illness: Age 18+ (Metric #8)** measures the percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider (within 7 days and within 30 days). A higher rate indicates better performance.
- **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse (Metric #9)** measures the percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence (within 7 and within 30 days). A higher rate indicates better performance.
- **Follow-Up After Emergency Department Visit for Mental Illness (Metric #10)** measures the percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness (within 7 and within 30 days). A higher rate indicates better performance.

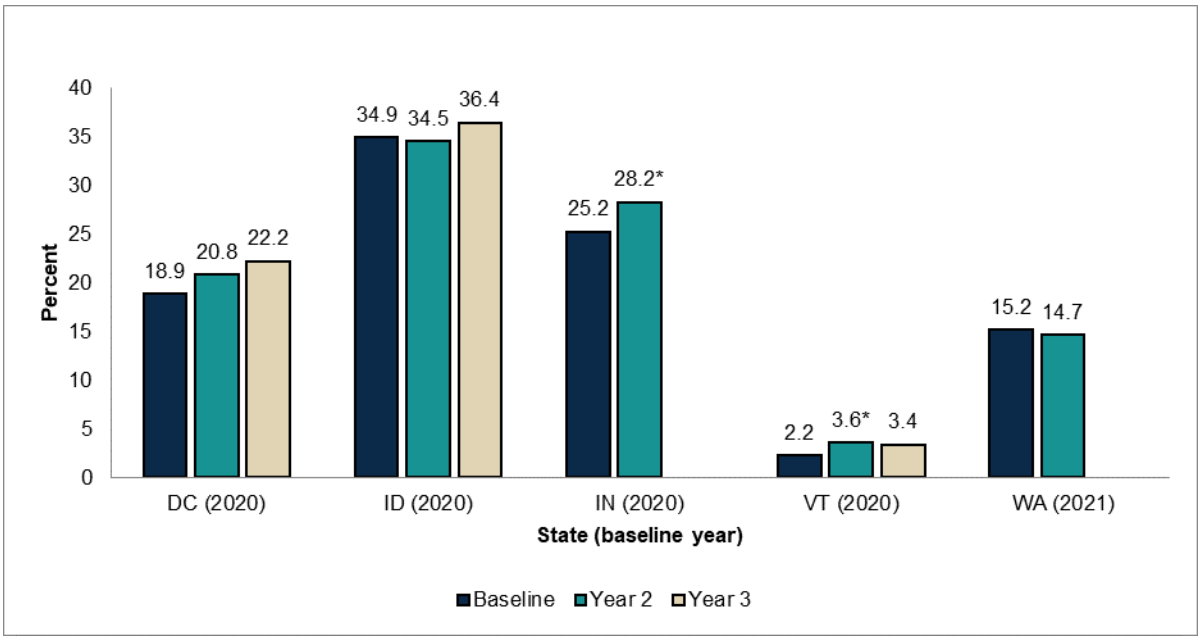
[30] See https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/.
[31] Available at https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/.

2. Findings

30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (Metric #4)

- Between the two most recently reported measurement years, the rate of all-cause unplanned readmission following psychiatric hospitalization in an inpatient facility significantly increased ($p < 0.05$) in one state (Indiana) and did not change significantly in four states for which data were available (Figure IV.4). In Indiana, the rate of readmission increased between the two most recently reported years, and the total count of individuals with qualifying diagnoses with hospitalizations in inpatient psychiatric facilities also increased. The state opened two inpatient psychiatric facilities during the demonstration, including one that qualifies as an IMD, so this increase could reflect a possible increase in availability of inpatient facilities. Indiana did not provide an explanation for the increase.
- Across the three years of available data, the rate of all-cause unplanned readmission consistently increased in one state (the District of Columbia), but these increases were not statistically significant.

Figure IV.4. Rate of 30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (Metric #4)



Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

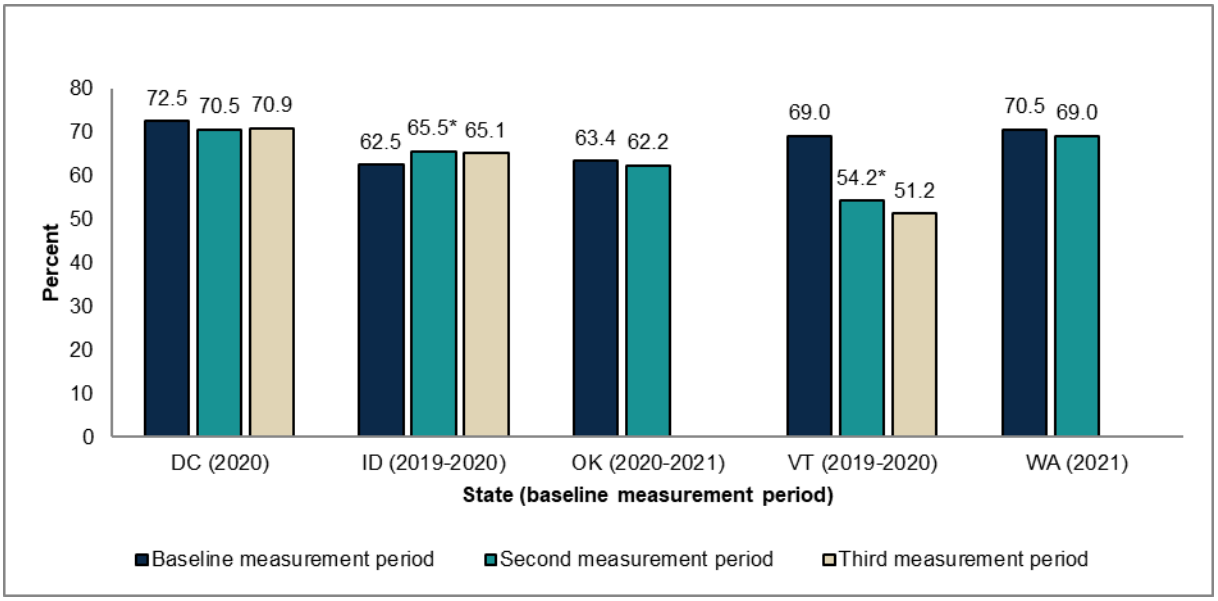
Note: The significant increase ($p < 0.05$) in the rates between the baseline year and Year 2 in Vermont should be interpreted with caution, as the total count of readmissions remained less than 100. Indiana reported data for Year 3 of the demonstration, but this analysis does not include these data because they did not pass data quality checks. Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis.

* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

Medication Continuation Following Inpatient Psychiatric Discharge (Metric #6)

- Between the two most recently reported measurement periods, the rate of continuation of evidence-based medications following discharge did not change significantly in any of the five states for which data were available (Figure IV.5).
- Across the measurement periods of available data, the rate of medication continuation following discharge consistently decreased across three years of available data in one state (Vermont), but the difference was statistically significant ($p < 0.05$) only between the first two years. In Vermont, the denominator (the total count of discharges of individuals with qualifying diagnoses with inpatient psychiatric hospitalizations) increased each year, while the numerator (the number of discharges of those individuals in this population with medication continuation) is similar across years. The statistically significant decrease ($p < 0.05$) in the rate may be driven by the increase in the number of discharges of those individuals in this population with medication continuation.

Figure IV.5. Rate of medication continuation following inpatient psychiatric discharge (Metric #6)



Source: Section 1115 SMI/SED Monitoring Report Workbooks.

Note: This metric has a baseline measurement period of two years, but the District of Columbia and Washington use a baseline measurement period of one year and the second and third measurement periods are two years. Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis.

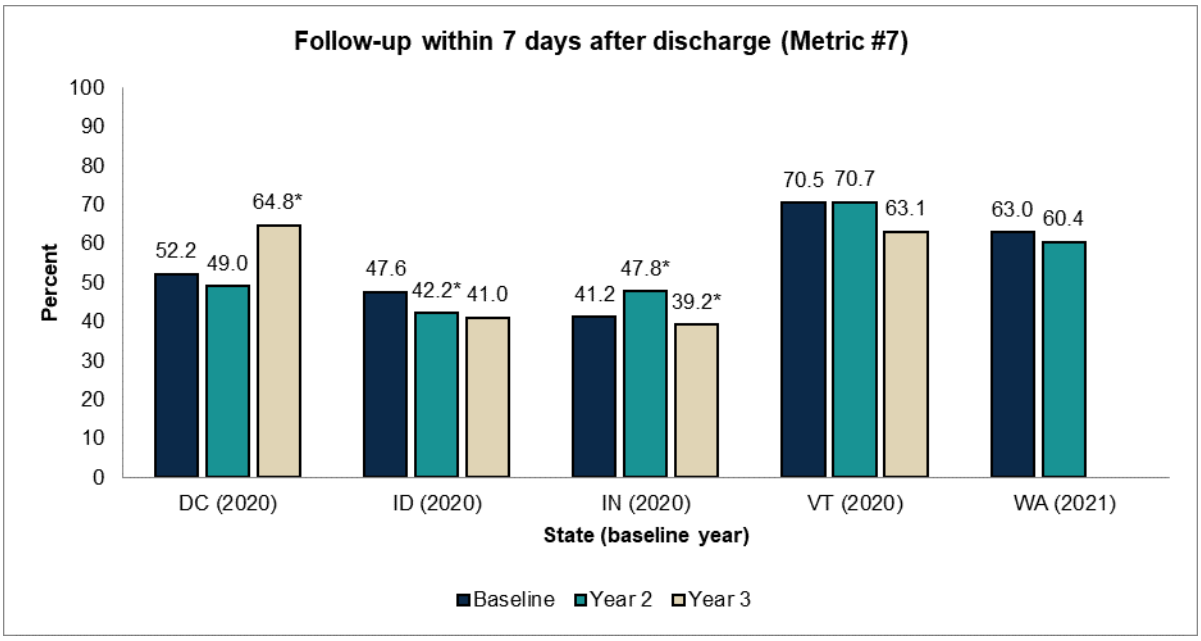
* The difference between value and prior measurement period value is statistically significant ($p < 0.05$) based on a z-test.

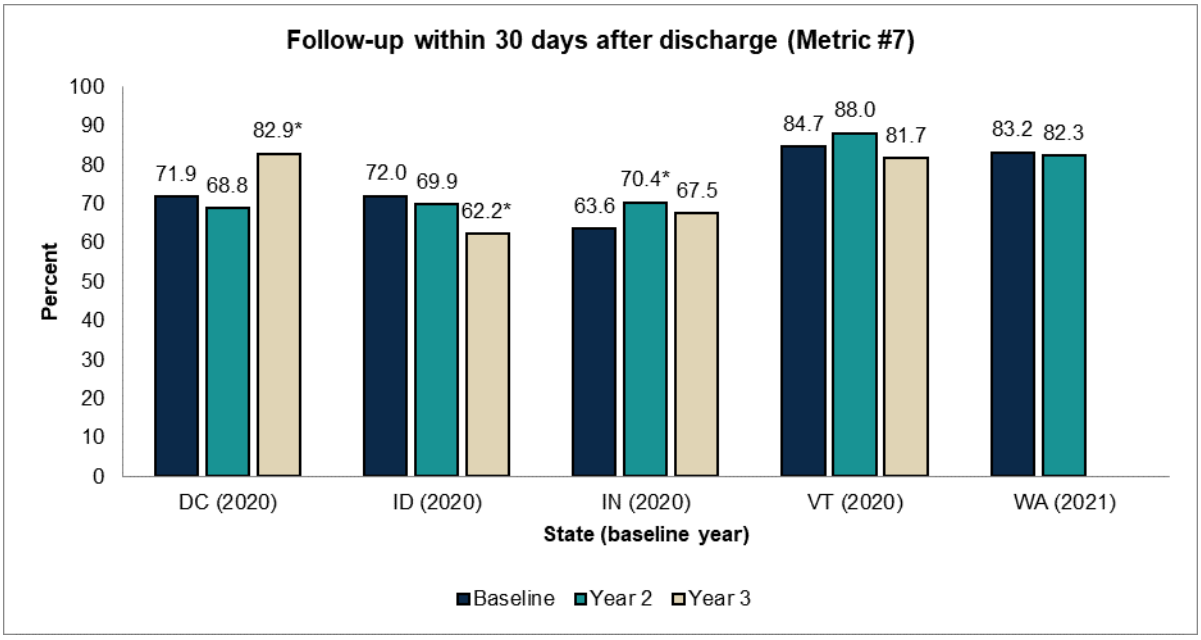
Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (Metric #7)

- Between the two most recently reported measurement years, the rate of follow-up after hospitalization for mental illness for children significantly increased ($p < 0.05$) in one state (the District of Columbia) (Figure IV.6) and significantly decreased ($p < 0.05$) in one state (Indiana) for follow-up within 7 days of discharge and significantly decreased ($p < 0.05$) in one state (Idaho) for follow-up within 30 days of discharge. The rate did not change significantly in three states for follow-up within 7 days of discharge (Idaho, Vermont, Washington) or 30 days of discharge (Indiana, Vermont, and Washington).
- The significant changes in the District of Columbia's rates should be interpreted with caution because the denominator (the count of children engaging in follow-up) has a low sample size and may be more sensitive to changes. However, the District of Columbia also implemented some behavioral health care coordination activities (as outlined in the implementation plan), which could contribute to the increased rate of follow-up.[32]
- The rate changes in Indiana appear to be driven by a change in denominator (count of Medicaid and CHIP beneficiaries ages 6–17 with a qualifying diagnosis discharged from an inpatient psychiatric facility). This count fluctuated across years, while the numerator (count of these beneficiaries who engaged in follow-up) remained similar across years, resulting in significant changes that do not reflect trends in the numerator.
- Across the three years of available data, the rate of follow-up after hospitalization for mental illness for children (within 7 days and 30 days of discharge) consistently decreased in one state (Idaho). Idaho attributes the decrease in the follow-up rates after hospitalization for mental illness to issues with accessibility of services during the COVID-19 pandemic. The state anticipates that the rates will stabilize in future reporting.

[32] See https://oca.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/DBH_FY22PAR.pdf.

Figure IV.6. Follow-up after hospitalization for mental illness (ages 6–17): Percentage of discharges for which the beneficiary received follow-up within 7 and 30 days after discharge (Metric #7)





Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

Note: Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis.

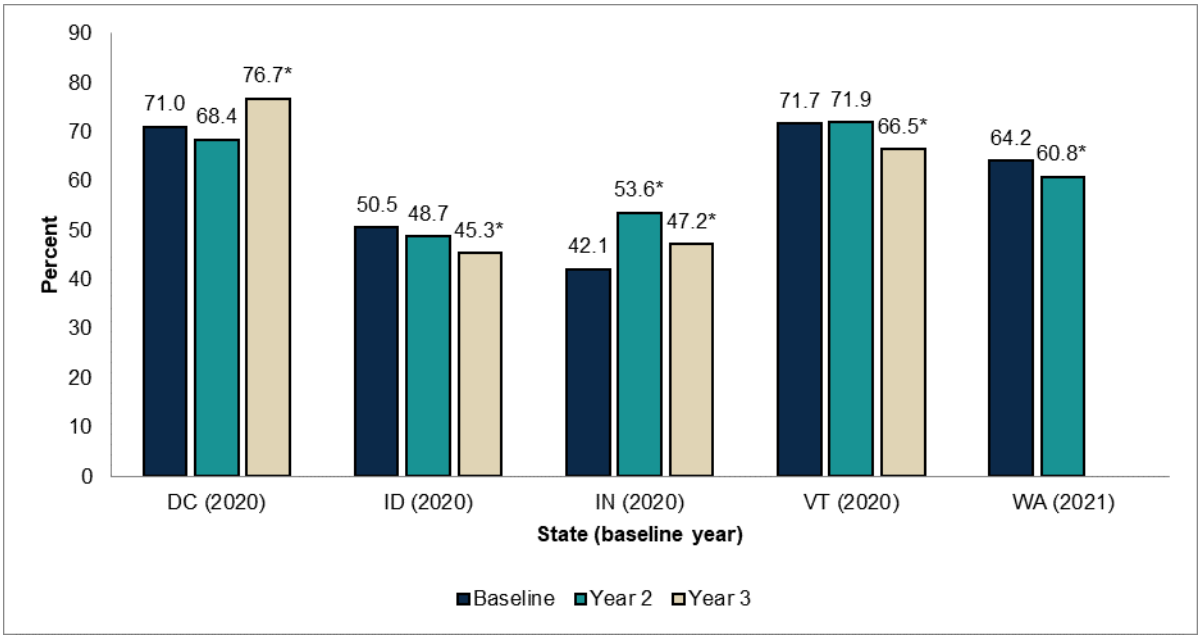
* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

Follow-Up After Hospitalization for Mental Illness: Age 18+ (Metric #8)

- Between the two most recently reported measurement years, the rate of follow-up after hospitalization for mental illness for adults (within 7 and 30 days of discharge) significantly increased ($p < 0.05$) in one state (the District of Columbia) and significantly decreased ($p < 0.05$) in four states (Idaho, Indiana, Vermont, Washington) (30 days- Figure IV.7). In Indiana, the rate of follow-up within 7 and 30 days of discharge significantly decreased ($p < 0.05$) between Year 2 and Year 3 but remained higher than the baseline rate. Across the three years with available data, the rate of follow-up after hospitalization for mental illness for adults (within 7 and 30 days of discharge) consistently decreased in one state (Idaho), but the difference was significant ($p < 0.05$) only between the two most recently reported measurement years.
- The rate changes in Indiana appear to be driven by a change in denominator (count of Medicaid and CHIP beneficiaries age 18 and over with a qualifying diagnosis discharged from an inpatient psychiatric facility). This count fluctuated across years, while the numerator (count of these beneficiaries who engaged in follow-up) remained similar across years, resulting in significant changes that do not reflect trends in the numerator. This is consistent with the findings for Indiana for Metric #7.
- The District of Columbia implemented some behavioral health care coordination activities (as outlined in the implementation plan), which could be contributing to the increased rate of follow-up.[33]
- Idaho reported that the decrease in the follow-up rates after hospitalization for mental illness could result from issues with accessibility of services during the COVID-19 public health emergency.

[33] See https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/FY22%20mid-year%20MHEASURES.pdf.

Figure IV.7. Follow-up after hospitalization for mental illness (age 18+): Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge (Metric #8)



Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

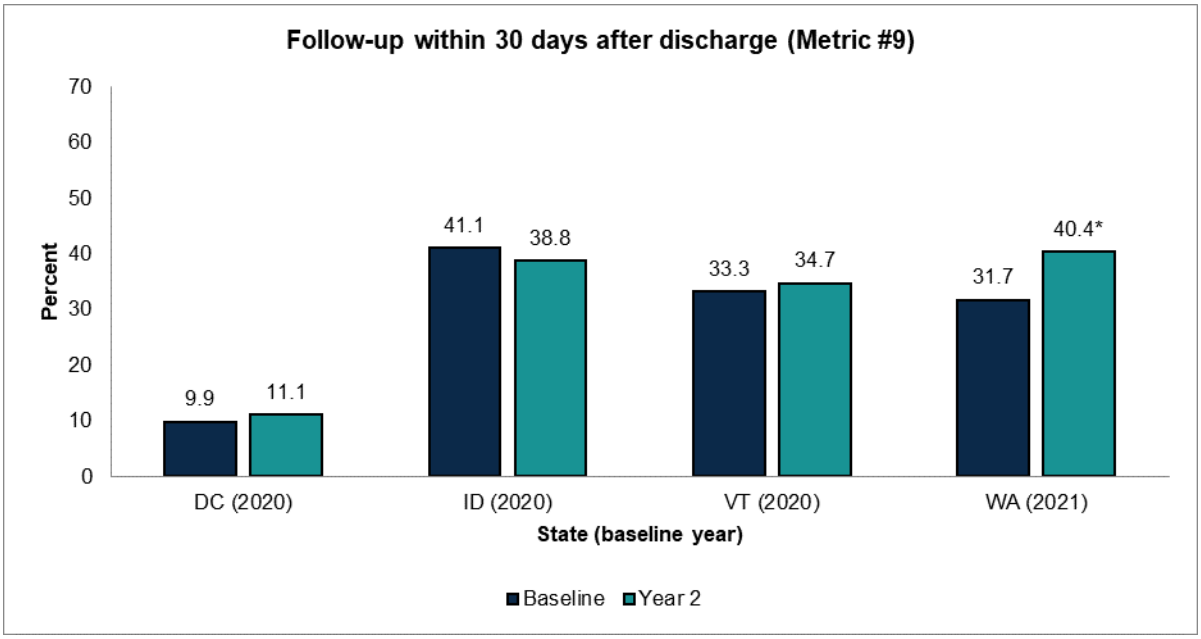
Note: Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis.

* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse (Metric #9)

- Between the two most recently reported measurement years, the rate of follow-up after an ED visit for alcohol or other drug abuse (within 7 and 30 days of discharge) significantly increased ($p < 0.05$) in one state (Washington) and did not change significantly in three (the District of Columbia, Idaho, Vermont) (Figure IV.8). Washington did not provide an explanation for the increase.

Figure IV.8. Follow-up after emergency department visit for alcohol or other drug abuse: Percentage of discharges for which the beneficiary received follow-up within 7 and 30 days after discharge (Metric #9)



Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

Note: Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis. All of Indiana's data and Year 3 of Idaho's data did not pass data quality checks and therefore are excluded from this analysis.

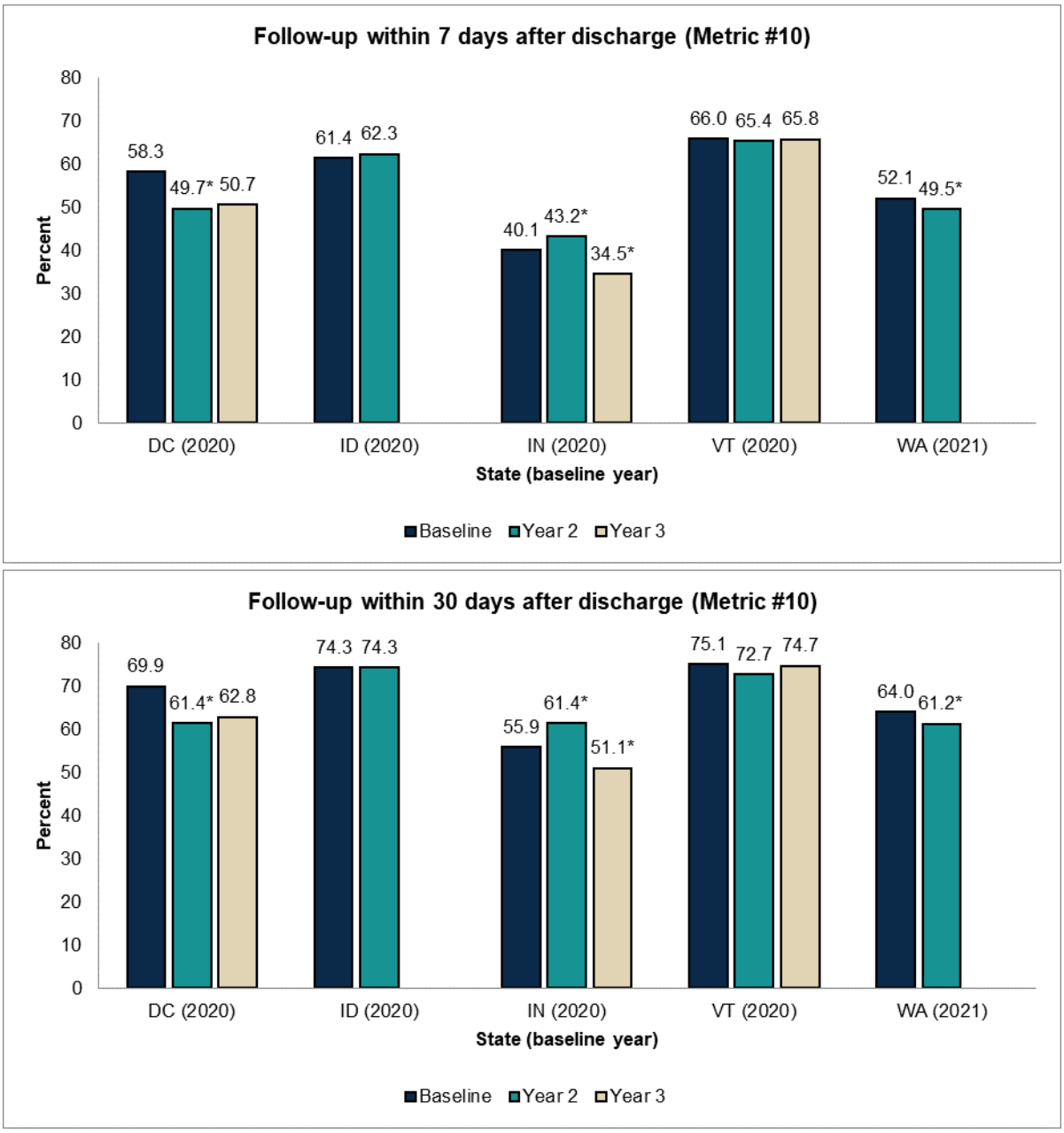
The District of Columbia used, and Vermont may have used, measurement year (MY) 2022 Healthcare Effectiveness Data and Information Set (HEDIS) specifications for Metric #9 for calendar year (CY) 2022 whereas other states used MY 2021 SMI/SED technical specifications for CY 2022. For MY 2022, the National Committee of Quality Assurance (NCQA) revised the measure names for Metrics #9 to Follow-Up After ED Visit for Substance Use. Additionally, the HEDIS specifications for Metric #9 underwent significant changes. Due to the significant changes to the measures, NCQA recommends breaking the link to the prior year's measure results. See https://www.ncqa.org/wp-content/uploads/2022/06/HEDIS-MY2022-Measure-Trending-Determinations.pdf. Therefore, Year 3 data from these two states were excluded from analysis.

* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

Follow-Up After Emergency Department Visit for Mental Illness (Metric #10)

- Between the two most recently reported years, the rate of follow-up after an ED visit for mental illness (within 7 and 30 days of discharge) significantly decreased ($p < 0.05$) in two states (Indiana, Washington) and did not change significantly in three states (the District of Columbia, Idaho, Vermont) (Figure IV.9).
- The rate changes in Indiana appear to be driven by a change in denominator (count of Medicaid and CHIP beneficiaries with a qualifying diagnosis with emergency room visits). This count fluctuated across years, while the numerator (count of these beneficiaries who engaged in follow-up) remained similar across years, resulting in significant changes that do not reflect trends in the numerator. This is consistent with the findings for Indiana for Metrics #7 and #8.

Figure IV.9. Follow-up after emergency department visit for mental illness: Percentage of discharges for which the beneficiary received follow-up within 7 and 30 days after discharge (Metric #10)



Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

Note: Idaho reported data for Year 3 of the demonstration. This analysis does not include this data because it did not pass data quality checks. Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis.

* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

Milestone 3. Increasing access to continuum of care, including crisis stabilization services

Key findings

- Outpatient service utilization as a share of any mental health service utilization changed significantly ($p < 0.05$) between the first month and the most recent month in all states for which data were available. Three states showed statistically significant increases ($p < 0.05$) and three states showed statistically significant decreases ($p < 0.05$).
- Inpatient and ED service utilization as a share of any mental health service utilization had statistically significant decreases ($p < 0.05$) in two states and statistically significant increases ($p < 0.05$) in two states between the first month and most recent month of data. Intensive outpatient and partial hospitalization service utilization as a share of any mental health service utilization had statistically significant increases ($p < 0.05$) in three states.
- Only the states with a demonstration start date prior to the onset of the COVID-19 pandemic (the District of Columbia, Vermont) showed significant increases ($p < 0.05$) in telehealth service utilization as a share of any mental health service utilization.
- All states have an ALOS of less than 30 days for all years and IMD types. The number of beneficiaries treated in an IMD decreased in two states (Oklahoma, Vermont) and increased in four (the District of Columbia, Idaho, Indiana, Washington).

1. Introduction

Milestone 3 focuses on improving access to the continuum of care in order to divert Medicaid and CHIP beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities. To standardize the findings, we calculated the percentage of beneficiaries receiving services in the specified setting (Metrics #13–17) as a share of beneficiaries receiving any mental health services (Metric #18). Comprehensive data for these metrics can be found in Appendix G. Service utilization metrics are relevant to Milestone 3 because they are proxies for access to care across the continuum, or they may reflect changes in need for services. For example, increases could reflect improvements in access (a positive development), increased need (a concern), or both. Likewise, decreases could reflect reduced access (a concern), reduced need (a positive development), or both. A lack of change in service utilization could reflect stability in the system or might arise from a balancing of changes in access and need (for example, need increases but access is reduced, or vice versa). As a result, findings regarding service utilization must be interpreted cautiously and in consideration of contextual factors affecting access and need.

In this section, we analyze state-reported data for six monthly and three annual CMS-constructed measures that are used to assess progress on this milestone:

- **Mental Health Services Utilization (Metrics #13–18)** measures the number of beneficiaries in the demonstration population who use a specified service for mental health during the measurement period.
  - **Inpatient (Metric #13)**
  - **Intensive Outpatient and Partial Hospitalization (Metric #14)**
  - **Outpatient (Metric #15)**
  - **ED (Metric #16)**
  - **Telehealth (Metric #17)**
  - **Any Services (Metric #18)**
- **ALOS in IMDs (Metric #19a)** and **ALOS in IMDs (IMDs receiving federal financial participation [FFP] only) (Metric #19b)** measure the ALOS for beneficiaries with SMI who are discharged from an inpatient or residential stay in an IMD.
- **Beneficiaries With SMI/SED Treated in an IMD for Mental Health (Metric #20)** measures the number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year. Expected trends for this metric are state determined to reflect each state's unique IMD utilization and access goals (Table IV.3).

2. Findings

Mental Health Services Utilization (Metrics #13–17 as share of Metric #18)

From the first month to the most recent month of data:

- The inpatient service utilization as a share of any mental health service utilization significantly increased ($p < 0.05$) in two states (Oklahoma, Washington), significantly decreased ($p < 0.05$) in two states (the District of Columbia, Utah), and did not significantly change in two states (Idaho, Vermont) (Table IV.2).
- The IOP/PH service utilization as a share of any mental health service utilization significantly increased ($p < 0.05$) in three states (Idaho, Oklahoma, Washington) and significantly decreased ($p < 0.05$) in two states (the District of Columbia, Vermont).
- The outpatient service utilization as a share of any mental health service utilization significantly increased ($p < 0.05$) in three states (Idaho, Oklahoma, Utah) and significantly decreased ($p < 0.05$) in three states (the District of Columbia, Vermont, Washington).
- The ED service utilization as a share of any mental health service utilization significantly increased ($p < 0.05$) in two states (Idaho, Washington) and significantly decreased ($p < 0.05$) in two states (the District of Columbia, Vermont).
- Telehealth service utilization as a share of any mental health service utilization significantly increased ($p < 0.05$) in two states (the District of Columbia, Vermont) and significantly decreased ($p < 0.05$) in four states (Idaho, Oklahoma, Utah, Washington). However, the states with significant increases were the only states with a demonstration start date prior to the onset of the COVID-19 pandemic.

Table IV.2. Statistically significant changes between first and most recent month in the proportion of mental health service users using each service type, by state (Metrics #13–17/Metric #18)

	First month	Most recent month	Inpatient	IOP/PHP	Outpatient	ED	Telehealth
DC*	Jan 2020	Jun 2023	⇩	⇩	⇩	⇩	⇧
ID	Apr 2020	Jun 2023	⇔	⇧	⇧	⇧	⇩
OK^	Jan 2021	Jun 2023	⇧	⇧	⇧	—	⇩
UT	Jan 2021	Mar 2023	⇩	—	⇧	—	⇩
VT*	Jan 2020	Mar 2023	⇔	⇩	⇩	⇩	⇧
WA	Jan 2021	Mar 2023	⇧	⇧	⇩	⇧	⇩

⇩ Indicates a statistically significant decrease. ⇧ Indicates a statistically significant increase. ⇔ Indicates no statistically significant change.

Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

Note: To calculate the percentage of beneficiaries receiving each type of MH service, we used Metrics #13–17 as the numerator and monthly Metric #18 as the denominator. New Hampshire did not meet the data availability requirements for Metrics #13–18 and it is not included in this analysis. Alabama and Indiana's data did not pass the change-over-time data quality check for Metrics #13–18 and are not included in this analysis. Oklahoma's data for Metric #16 is excluded from analysis due to consistently having a numerator of 1 to 11 beneficiaries. Utah reported data quality issues for Metrics #14 and #16 and thus these data are excluded from analysis.

— = not applicable; the state did not meet inclusion requirements.

* State's demonstration began prior to the start of the COVID-19 pandemic.

^ State implemented Medicaid expansion in July 2021, which may have increased rates of service utilization.

ED = emergency department; IOP/PHP = intensive outpatient/partial hospitalization program.

The significant rate changes in Washington appear to be driven by a change in denominator (Metric #18, count of Medicaid and CHIP beneficiaries with any mental health service utilization). This count decreased by around 30 percent between the first and most recent months of reported data. Metric #18 is a deduplicated sum of Metrics #13–17, and changes in Metrics #13–17 can impact the counts in Metric #18. The count for Metric #15 declined by 26 percent, and for Metric #17 by 63 percent, which may explain the 30 percent decline in Metric #18.

ALOS in IMDs (Metric #19a); ALOS in IMDs (IMDs receiving FFP only) (Metric #19b)

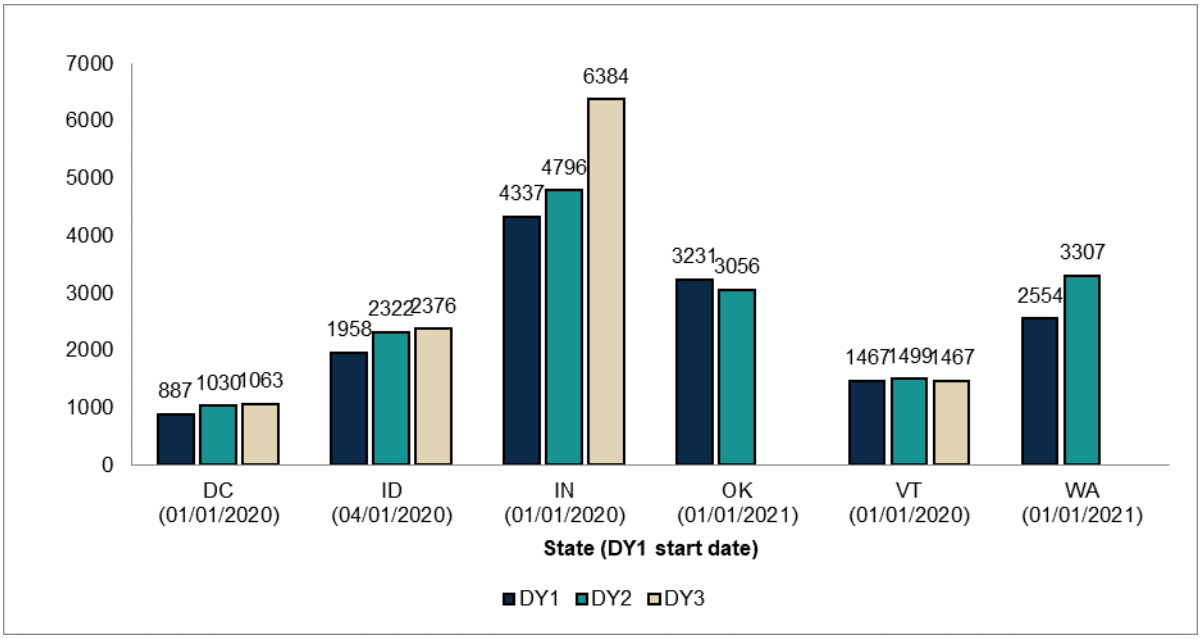
- For the six states for which data were available, the ALOS in any IMD and in IMDs for which CMS provides FFP through the demonstrations was substantially less than 30 days for all years of the demonstrations.

Beneficiaries With SMI/SED Treated in an IMD for Mental Health (Metric #20)

- Between the two most recently reported measurement years, the number of beneficiaries treated in an IMD decreased in two states (Oklahoma, Vermont) and increased in four states (the District of Columbia, Idaho, Indiana, Washington) (Figure IV.10).

- Washington explained the change by stating that the "increase from 2021 to 2022 is likely indicative of the [new] facilities being able to operate at full capacity".
- Of the six states with available data, two (Indiana and Vermont) have metric trends that align with the state's annual goal and demonstration target (Figure IV.10).

Figure IV.10. Annual count of unique beneficiaries treated in an IMD for mental health, by state (Metric #20)



Source: Section 1115 SMI/SED Monitoring Report Workbooks.

Note: Alabama and New Hampshire did not meet the data availability requirements for this metric and are not included in this analysis. Utah reported two years of data for Metric #20 using a measurement period that does not align with the technical specifications and is therefore excluded from analysis.

DY = demonstration year; IMD = institution for mental diseases.

Milestone 4. Earlier identification and engagement in treatment, including through increased integration

Key findings

- For the two most recently reported years, about 86 to 99 percent of adult beneficiaries with SMI had ambulatory or preventative care visits, but the percent significantly decreased ($p < 0.05$) in two states (the District of Columbia, Idaho) and significantly increased ($p < 0.05$) in one state (Washington).
- The rate of glucose-only testing for children and adolescents taking multiple antipsychotics is higher than other forms of metabolic testing.
- The percentage of adult beneficiaries with a new antipsychotic prescription who completed a follow-up visit with a prescribing provider did not significantly improve in any state for which data were available.

1. Introduction

Milestone 4 focuses on identifying and engaging individuals with serious mental health conditions—especially adolescents and young adults—in treatment sooner by increasing the integration of behavioral health services into non-specialty care settings, such as schools and primary care practices, and improving awareness and linkage to specialty treatment. The metrics related to Milestone 4 do not fully align with this focus. Instead, they focus on physical health care screening and monitoring rather than identification and engagement in mental health treatment. In this section, we analyze state-reported data for three annual, established quality measures that CMS is using to assess progress on this milestone:

- **Access to Preventive/Ambulatory Health Services for Medicaid and CHIP Beneficiaries With SMI (Metric #26)** measures the percentage of Medicaid and CHIP beneficiaries ages 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period. Individuals with SMI have higher rates of premature mortality than the general population, which can be associated with underuse of physical health services.[34] A higher rate indicates better performance.
- **Metabolic Monitoring for Children and Adolescents on Antipsychotics (Metric #29)** measures the percentage of children and adolescents ages 1 to 17 with two or more antipsychotic prescriptions who had metabolic testing. Three rates are reported—blood glucose–only testing, cholesterol-only testing, and both blood glucose and cholesterol testing. The use of antipsychotics in children and adolescents presents a risk of adverse metabolic effects, including alterations in glucose metabolism, lipid abnormalities, and weight gain.[35] A higher rate indicates better performance.
- **Follow-Up Care for Adult Medicaid and CHIP Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (Metric #30)** measures the percentage of Medicaid and CHIP beneficiaries who are age 18 years and older with a new antipsychotic prescription who completed a follow-up visit with a provider with prescribing authority within 4 weeks (28 days) of the prescription. A higher rate indicates better performance.

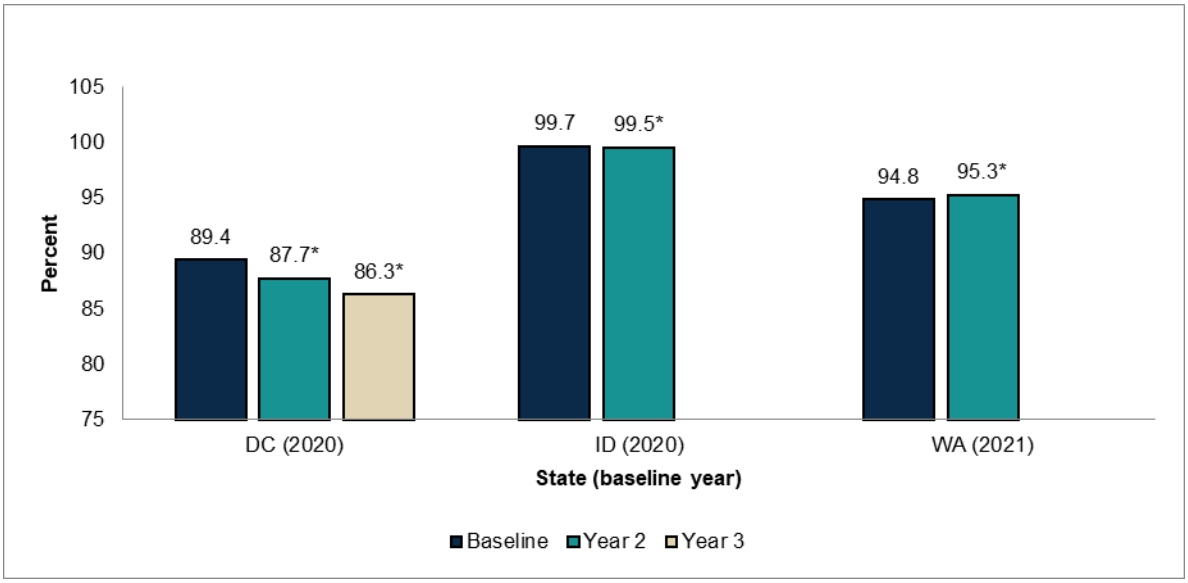
2. Findings

Access to Preventive/Ambulatory Health Services for Medicaid and CHIP Beneficiaries With SMI (Metric #26)

- Between the two most recently reported measurement years, the percentage of adult Medicaid and CHIP beneficiaries with SMI who had an ambulatory or preventive care visit significantly decreased ($p < 0.05$) in two states (the District of Columbia, Idaho) and significantly increased ($p < 0.05$) in one (Washington) (Figure IV.11). In Idaho, the percentage of adult Medicaid and CHIP beneficiaries with SMI who had a visit is greater than 99 percent despite the significant decrease.

[34] For more information, see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9819522/.
[35] For more information, see https://pubmed.ncbi.nlm.nih.gov/22106077/ and https://www.psychiatrictimes.com/view/metabolic-monitoring-antipsychotic-medications-what-psychiatrists-need-know.

Figure IV.11. Percentage of Medicaid and CHIP beneficiaries ages 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period (Metric #26)



Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

Note: Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis. This analysis excludes data that Idaho reported for Year 3 of the demonstration because the percent change in the denominator between Year 2 and Year 3 was 127%, and the change in the number of beneficiaries is 29,296. Vermont's data is excluded from this analysis because the percent change in the denominator between baseline and Year 2 in Vermont is 155%, and the change in the number of beneficiaries is 59,080. Therefore, Vermont and Idaho's data is excluded because the percentage change in the denominator is greater than 50 percent or the change in the denominator is greater than 50 beneficiaries. Indiana reported data quality issues for Metric #26 and these data are excluded from analysis.

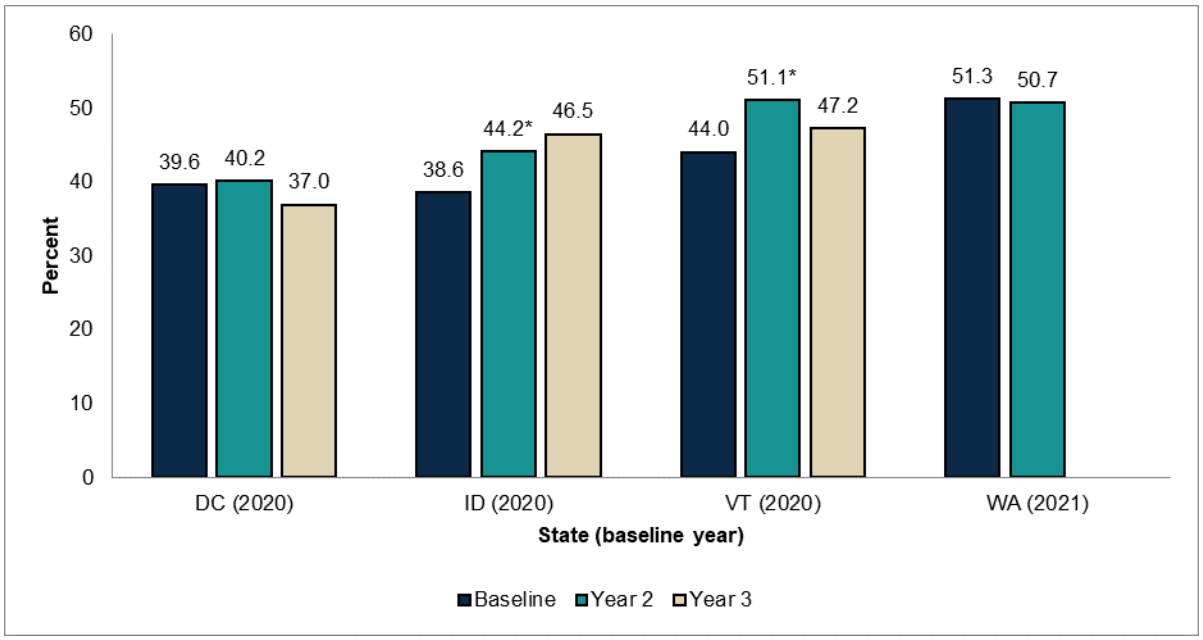
* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

SMI = serious mental illness.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (Metric #29)

- Between the two most recently reported measurement years, the percentage of children and adolescents taking multiple antipsychotics receiving metabolic testing (glucose only, cholesterol only, and both glucose and cholesterol testing) did not change significantly in any of the four states for which data are available (Glucose only - Figure IV.12).
- Across the three years of available data, the percentage of youth beneficiaries with a prescription for antipsychotic medications who received glucose-only testing consistently increased across three years of available data in one state (Idaho), with the increase being statistically significant ($p < 0.05$) between baseline and Year 2. The percentage of youth beneficiaries who received cholesterol-only testing consistently increased across three years in one state (Idaho) and consistently decreased across three years in two states (the District of Columbia, Vermont), however these changes were not statistically significant (Appendix G). The percentage of youth beneficiaries who received both glucose and cholesterol testing consistently increased across three years in one state (Idaho) and consistently decreased across three years in one (Vermont), however these changes were not statically significant (Appendix G).

Figure IV.12. Percentage of children and adolescent beneficiaries with a prescription for antipsychotic medications who received glucose testing (Metric #29)



Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

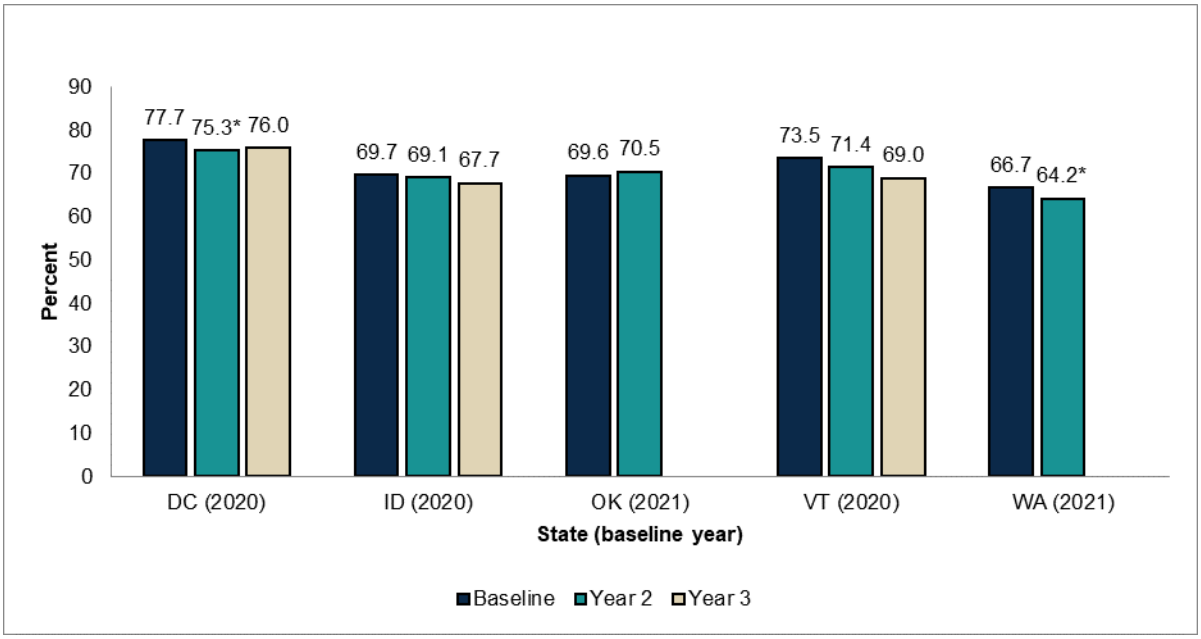
Note: Alabama, New Hampshire, Oklahoma, and Utah did not meet the data availability requirements for this metric and are not included in this analysis. Because Indiana reported data quality issues for Metric #29, these data are excluded from analysis.

* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

Follow-Up Care for Adult Medicaid and CHIP Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (Metric #30)

- Between the two most recently reported measurement years, the percentage of adult beneficiaries with a new antipsychotic prescription who completed a follow-up visit with a prescriber significantly decreased ($p < 0.05$) in one state (Washington) and did not change significantly in the other four states with available data (Figure IV.13).
- Washington noted, "The impact of COVID-19 on the receipt of these services is unknown."
- Across the three years of available data, the percentage of adult beneficiaries with a new antipsychotic prescription who completed a follow-up visit with a prescribing provider within 28 days of the initial prescription decreased in two states (Idaho and Vermont), but the decrease was not statistically significant.

Figure IV.13. Percentage of adult beneficiaries with a new antipsychotic prescription who completed a follow-up visit with a prescribing provider within 28 days of the initial prescription (Metric #30)



Source: Medicaid Section 1115 SMI/SED Monitoring Report Workbooks.

Note: Alabama and New Hampshire did not meet the data availability requirements for this metric and are not included in this analysis. Indiana's data did not pass the change over time inclusion requirement and is excluded from analysis.

* The difference between value and prior year value is statistically significant ($p < 0.05$) based on a z-test.

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V. Conclusions

This report provides information on states' SMI/SED demonstration activities, their availability of mental health services, and their progress toward meeting the demonstration milestones. The conclusions in this report are based on Availability Assessment data, monitoring metrics data, and narrative information submitted by states through February 1, 2024.

This analysis produced the following key findings:

- Increases in the number of Medicaid-enrolled psychiatric hospitals are consistent with the third demonstration goal to improve the availability of services for crisis stabilization, including in psychiatric hospitals. Increases in the number of FQHCs are consistent with the fourth SMI/SED demonstration goal to increase access to community-based services.
- Among most categories of inpatient, residential, and crisis services, and some categories of community-based outpatient services and workforce providers, the number of services grew or remained the same but has not kept pace with the number of beneficiaries. Medicaid and CHIP beneficiary counts may continue to fluctuate as states are required to complete a Medicaid eligibility renewal for all enrolled beneficiaries to address the expiration of the Families First Coronavirus Response Act's maintenance of eligibility requirements. For example, it is possible that the expected decline in enrollment due to unwinding may appear as an increase in availability of services but is driven by the larger decreases in enrollment. If Medicaid and CHIP beneficiary counts stabilize in the future, ratios comparing Medicaid and CHIP beneficiaries per service may provide more reliable insights into how service availability is changing relative to need.
- Most states met many components of the demonstration milestones before the demonstrations began. Although states are undertaking a range of activities to implement the SMI/SED demonstrations and achieve the demonstration milestones, so far only a few have reported completing one or two additional milestone components during the demonstrations.
- Most states met many components of the demonstration milestones before the demonstrations began. Of the seven states with a demonstration for at least two years, four states have met some of the four milestones, but the remaining three states have not met any milestones.
- Few of the quantitative metrics CMS uses to monitor state progress toward the milestones have thus far shown improvements. Monitoring data suggest that the onset of the COVID-19 public health emergency may be associated with changes in some service utilization metrics used to assess progress toward Milestone 3. All six states for which data were available appear to be compliant with demonstration requirements regarding ALOS in IMDs. The number of beneficiaries treated in an IMD increased in four states and decreased in two states.

At this stage of the SMI/SED demonstrations, we have limited information for each of the demonstration states. As data for more states and demonstration periods are submitted and incorporated into future analyses (including updates to some data analyzed in this report), the findings across states may change. In the future, analyses could incorporate additional states, data, and methods to assess progress toward demonstration milestones.

Future analyses could reflect the impact of numerous factors, such as:

1. **The 1115 SMI/SED demonstration monitoring reporting redesign.** CMS is simplifying reporting requirements for states and improving the actionability of monitoring data. CMS is implementing changes to monitoring report tools, which will, among other changes, revise the monitoring metrics and subpopulation stratifications states report and shift reporting frequency from quarterly to annual. Analytic methods and data analyses used in this CSA will need to be updated following these changes.
2. **The expiration of the Families First Coronavirus Response Act's maintenance-of-eligibility requirements.** Beginning on April 1, 2023, states had up to 12 months to complete a Medicaid eligibility renewal for all beneficiaries enrolled in Medicaid (a process known as unwinding) and return to normal eligibility and enrollment operations.[36] Changes in enrollment will likely impact data from the Availability Assessments and monitoring metrics, for example ratios of Medicaid and CHIP beneficiaries per service.

[36] See https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.

Appendix A.
Data Sources and Methods

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A. Data from state deliverables

This appendix provides details about the data and the methods used in this cross-state analysis (CSA). States submit demonstration applications and an Initial Availability Assessment as well as the following deliverables after approval of their application:

- **Implementation plan** specifying the approach and actions the state will take to implement demonstration requirements and meet the SMI/SED-specific milestones outlined in the State Medicaid Director Letter (SMDL).
- **Monitoring protocol** specifying the timeline, data collection methods, and content for state quarterly and annual monitoring reports.
- **Evaluation design,** which describes the timeline, scope, data sources, and methods for an independent evaluation of the SMI/SED demonstration.
- States with approved demonstrations must also submit **interim and final evaluation reports** presenting the results of their evaluations.
- **Monitoring reports** that include performance on monitoring metrics (reported in the Medicaid Section 1115 SMI/SED Monitoring Report Workbook [Part A]); the reports may include explanations for metric trends (reported in the Medicaid Section 1115 SMI/SED Monitoring Report Template [Part B]). Narrative information on the status of activities included in the state's approved implementation plan may also be reported in Part B. A state's monitoring reports must adhere to the state's monitoring protocol and the special terms and conditions of the demonstration approval.
- **Availability Assessments** describing the availability of various types of mental health services in accordance with the SMDL:
  - **Annual Availability Assessments** are intended to capture information about the availability of mental health services during each year of the demonstration.

CMS must have approved the state's Initial Availability Assessment and SMI/SED demonstration implementation plan for inclusion in the CSA. Using this information, we describe the availability of mental health services in the states before the demonstrations and the states' plans for the demonstration. In this report, we include analysis of data available through February 1, 2024, for the 12 states with approved SMI/SED demonstration implementation plans as of February 1, 2024. In Appendix E, we summarize the data available by state.

The CSA uses data from Availability Assessments, implementation plans, and monitoring reports. In the next two sections, we describe these data in detail and the analyses conducted for this report.

B. Data from Availability Assessments

Description of data. For the Initial Availability Assessment, states are asked to provide both quantitative data and a Narrative Description. Quantitative data include the number of services (providers, facilities, beds, units, teams) available in the state (Table A.1) with a focus on Medicaid-enrolled services (e.g., facilities, beds, providers), and ratios comparing Medicaid and CHIP beneficiaries per service. The most recent versions (2.0 and 3.0) of the Availability Assessment tool ask states to provide information for each category of services, clarify reporting instructions and definitions for selected service categories, and asks states to list data sources and note any data limitations. In Appendix B, we provide the definition of each category and how the definitions have changed across tool versions. In Appendix C, we provide

data sources and definitions for each category for each submission, by state. In the Narrative Description of the Initial Availability Assessment, states provide descriptions of the needs of the state's Medicaid beneficiaries with SMI/SED, the organization of the state's mental health system, the mental health services available to the state's Medicaid beneficiaries, and any gaps in mental health service availability. Subsequent Annual Availability Assessments capture only quantitative data. States submit additional narrative data in Part B of the monitoring reports and may provide context for changes in the availability of mental health services during the demonstration.

Domains of mental health services. In Table A.1, we identify the domains of mental health services based on the demonstration milestones and align selected categories from the Availability Assessment tool with each of the following domains: inpatient services, residential services, crisis services, community-based outpatient services, and workforce. In analyses, we use these domains of mental health services to summarize findings among the states on the status of the mental health service system before the demonstration and states' progress in achieving alignment with selected demonstration milestones (Table A.2).

Table A.1. Domains of mental health services aligned with demonstration goals and milestones

Domain(s)	Corresponding categories from Availability Assessment
Inpatient services Residential services	• Medicaid-enrolled psychiatric hospitals/beds, and facilities qualifying as IMDs • Facilities/beds in Medicaid-enrolled psychiatric residential treatment facilities • Facilities/beds in Medicaid-enrolled residential mental health facilities and facilities qualifying as IMDs • Medicaid-enrolled PRTFs • Beds in Medicaid-enrolled PRTFs
Crisis services	• Mobile crisis units • Crisis call centers • Crisis observation or assessment centers • Crisis stabilization units • Coordinated community crisis response teams
Community-based outpatient services	• Medicaid-enrolled community mental health centers • Medicaid-enrolled community intensive outpatient or partial hospitalization facilities • Federally qualified health centers
Workforce	• Medicaid-enrolled prescribers • Other Medicaid-enrolled independent mental health providers

Analyses. Below, we summarize the analyses for research questions addressed in Chapter III and the associated limitations.

1. **What gaps in mental health services did states identify before the demonstration?** We summarized the state's description of gaps in its mental health services before the demonstration by service domain based on the state's narrative data from its Initial Availability Assessment. The Narrative Description does not systematically ask about gaps by service domain.

2. **What changes in mental health service availability have occurred over the course of the demonstration?**
   - We described changes in the availability of mental health services available to Medicaid and CHIP beneficiaries during the demonstration for the eight states that submitted multiple Availability Assessments. Specifically, we examined changes in the absolute numbers and ratio of Medicaid and CHIP beneficiaries per service for each state's Initial Availability Assessment compared to its most recent assessment. We contextualized these changes by using narrative data from the Initial Availability Assessments and Part B of the monitoring reports. We also indicated when changes in the ratios may require more cautious interpretation, such as when the Availability Assessment tool's definition changed or when the state's methodology (definition or data source) changed.
   - For each domain and its corresponding categories of providers and facilities, we summarized patterns across states, focusing on the direction of change. For each mental health service category, we used arrows to indicate if the percentage change in ratio decreased (indicating a greater number of beneficiaries per service) versus increased (indicating a lower number of beneficiaries per service). When states reported zero services, we could not directly calculate ratios; in addition, the direction of change indicated by the arrows was based on both the number changes in the service category and the beneficiary count. If a state did not provide information on data sources for one or more Availability Assessments, we assumed that it used the same data sources and definitions for producing counts across submissions.

Limitations. In this section, we describe the limitations in comparing findings across states and across years. Limitations in the comparison of findings across states include the following:

- **Differences in state reporting practices.** States varied in the way they reported the time reflected in the assessment; for example, some states reported calendar years and others reported a specific time point**.** Several states reported that counts of certain services might be underreported or overreported because unique identifiers for the services were not available, and some states defined categories of services differently. For some categories, states reported gaps in their Narrative Description in ways that often did not align with the categories of services reported in the quantitative assessment; therefore, the narrative analyses on state-reported gaps were often not sufficiently specific to contextualize quantitative findings.
- **Differences in behavioral health service delivery systems.** States indicated that the data reported for certain providers or facilities might not fully reflect access to and availability of mental health services because of specific features of the state behavioral health system or Medicaid program. For example, states may have different licensing requirements for mental health providers.

In addition, several states reported no providers or facilities for some categories, but the zero counts could represent either lack of availability of these services or states' inability to report certain categories by using the CMS-provided definitions in the Availability Assessment tool.

Given variations in the versions of the Availability Assessment tool, states' data sources, and the service definitions used by states, differences over time must be interpreted cautiously. In addition, the requirement beginning in 2020 to maintain continuous Medicaid enrollment through the end of the coronavirus (COVID-19) public health emergency may have influenced the ratios that the states constructed with the use of Medicaid and CHIP beneficiary data. Limitations in the comparison of findings across years include the following:

- **Differences across versions of the assessment.** The Availability Assessment tool has undergone improvement from year to year, and eight of the 11 states that had multiple Availability Assessments used Version 1.0 or an unspecified version; in the latter case, definitions and data source fields differed. In Appendix B, we summarize the differences between versions of the assessment. In Version 2.0, the tool included an additional field for reporting on the data source used for each category. Not all states indicated a data source in the Initial Availability Assessment—likely because this section was not required[37]—so it was not possible to confirm that assessments relied on the same data source.
- **Differences over time in data sources used.** Direct comparisons of numbers and ratios from year to year are not advisable if a state changed data sources between assessments. Given that most states did not indicate data sources consistently across all assessments, it is not possible to identify all cases in which states changed their data sources. In Appendix C, we describe the data sources used in each Availability Assessment.
- **Differences over time in definitions and reference periods used.** Comparisons of assessments over time within a state are not advisable if a state changed how it applied or interpreted the definition of a service, or if the definition changed in the Availability Assessment tool (Appendices B and C). Most states either did not provide definitions or did not describe changes in their definitions. However, some states did indicate such changes, and their counts of providers or facilities changed between assessments.
- When states do not describe definitions for certain providers or facilities across assessments, it is not possible to know whether states used the same definitions and whether changes in data across assessments might reflect changes in definitions.

C. Implementation plans and monitoring report data

Description of data. In their implementation and/or monitoring reports, states provide narrative information on planned activities during the demonstration, updates to those activities, and explanations for trends observed in the metrics.

Of the 33 metrics with available data, we focused on 19 metrics that met the data availability and quality requirements for the report. A state's data had to meet the following criteria pertaining to data availability and quality requirements for a state's data to be included in the analysis of any of the 19 selected metrics (Table A.2):

[37] Recognizing variation in the version of the Availability Assessment used by states, we summarize in Appendix C the information, when available, about the data sources that states used in completing the Initial and Annual Availability Assessments.

Table A.2. Data availability and quality checks

Name	Metrics reviewed	Criteria for inclusion
Data availability (monthly)	Metrics #13–18	State must report data from the first month of the demonstration through the most recent reporting month and have at least nine months of data.
Data availability (annual)	Metrics #2, 4, 6, 7–9, 10, 19a/b, 20, 26, 29, 30	State must have reported at least two years of data, including the year before the demonstration (either DY1 or CY1, depending on the metric).
Report quality	All metrics	Data must meet basic quality checks, including the following: • Counts reported as integers • Only one data point allowed per metric per measurement period • Reported percentages less than or equal to 100 percent
State-indicated reporting concerns	All metrics	States may indicate metric-specific data reporting issues in their monitoring reports. Metrics will be included only if there are no state-identified reporting issues.
Sub rates	Metrics #7–10, 29	Include metrics for a state when the denominator is consistent for all sub rates, per technical specifications.
Change over time (rates)	Metrics #2, 4, 6–10, 19a/b, 26, 29, 30	If the percentage change in the denominator is greater than 50 percent ***and*** the change in the denominator is greater than 50 beneficiaries, exclude the state's data from the analysis because the data could reflect a data quality issue.
Change over time (counts)	Metrics #13–18, 20	If the percentage change in the count is greater than 50 percent ***and*** the change in the count is greater than 50 beneficiaries, exclude the state's data from the analysis because the data could reflect a data quality issue.
Utilization	Metrics #13–18	Include metrics for the state when the number of beneficiaries in the demonstration population who use a specified service for mental health in each month is greater than 11.

Analyses. Below, we summarize the analyses for the research questions addressed in Chapter IV and the associated limitations.

3. **What changes to mental health service systems did states plan to make under the demonstration?**
4. **What changes to mental health service systems have states implemented under the demonstration?**
5. **How do the changes to mental health service systems that states have implemented under the demonstration align with initial state plans for the demonstration?**
   - **Qualitative analysis.** We extracted narrative information from states' implementation plans and monitoring reports to describe which states met each milestone at the beginning of the demonstrations and report states' activities and progress toward meeting milestone requirements.
6. **How have the monitoring metrics assessing a state's progress toward demonstration goals and milestones changed over the course of the demonstration?**
   - **Quantitative analysis.** We analyzed metric data on states' SMI/SED demonstrations from their monitoring reports to describe progress toward meeting demonstration milestone requirements. We used the following approaches:

- **Descriptive analysis.** We examined trends for selected monthly metrics with at least nine months of data. We looked at service utilization metrics (Metrics #13–17) as a proportion of all beneficiaries receiving SMI/SED services (Metric #18) to understand the variation in service utilization over time and to normalize service use counts across states.
- **Statistical significance testing.** We conducted two-tailed z-tests to estimate the level of confidence that the difference between two means is not equal to zero for the first and most recent months of data for selected monthly and annual metrics with at least two years of data for a given state. We reported the *p*-values and indicated when they exceeded the 95 percent confidence level. These statistical analyses provide information on whether observed differences exceed expected differences because of normal variation in the population. The analyses are not designed to identify whether the demonstration or other factors are the cause of observed changes in metric values.

Appendix B.
Differences Across Versions of the Availability Assessment Tool

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Table B.1. Availability Assessment Tool terms and definitions and summary of changes across Versions 1.0, 2.0, and 3.0

Version 3.0 terms	Version 3.0 definitions	Notes on change in terms or definitions between versions
Accepting new Medicaid patients	*Accepting new Medicaid patients* means any provider enrolled in Medicaid to obtain Medicaid billing privileges who will treat new Medicaid-enrolled patients.	No changes.
Adult	An *adult* is a person age 18 and over (State Medicaid Director letter [SMDL]).	Compared with Versions 1.0 and 2.0, Version 3.0 clarifies the SMDL number (SMDL #18-011).
Available to Medicaid patients	*Available to Medicaid patients* means any facility or bed available to serve Medicaid patients.	No changes.
Community mental health center	A *community mental health center (CMHC)* is defined in §410.2 as "an entity that (1) provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and clients of its mental health service area who have been discharged from inpatient treatment at a mental health facility; (2) provides 24-hour-a-day emergency care services; (3) provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services; (4) provides screening for patients being considered for admission to state mental health facilities to determine the appropriateness of the admission; (5) meets applicable licensing or certification requirements for CMHCs in the state in which it is located; and (6) provides at least 40 percent of its services to individuals who are not eligible for benefits under title XVIII of the Social Security Act."	Compared with Version 1.0, Versions 2.0 and 3.0 directly quote 42 CFR instead of citing it. This change was likely inconsequential because Version 1.0 makes it clear that states should include CMHCs "as defined in §410.2" and includes a truncated version of the categories in the updated definition.
Coordinated community crisis response	*Coordinated community crisis response* means a community-based program or entity that manages crisis response across various community entities or programs, as defined by the state.	No changes.
Crisis call center	*Crisis call centers* are defined by the state.	No changes.
Crisis stabilization unit	*Crisis stabilization units* offer medically monitored short-term crisis stabilization services, as defined by the state.	No changes.
Critical access hospital	A *critical access hospital* is a small facility that provides 24-hour emergency care, outpatient services, and inpatient services to people in rural areas, as defined in 42 CFR §485.606.	No changes.

Version 3.0 terms	Version 3.0 definitions	Notes on change in terms or definitions between versions
Federally qualified health center	*Federally qualified health center (FQHC)* means an entity that meets all the requirements at section 1905(l)(2)(B) of the Social Security Act.	Compared with Version 1.0, Versions 2.0 and 3.0 change the requirement source from 42 CFR §405.2434 and 42 CFR §405.2401 to 1905(l)(2)(B) of the Social Security Act. This change was likely not consequential with respect to how states defined FQHCs; the CFR reference from Version 1.0 appeared specific to Medicare and was likely updated to provide a broader definition not dependent on Medicare.
Geographic designation	*Geographic designation* means a state-defined geographic unit for reporting data, such as county, region, or catchment area.	No changes.
Institutions for mental diseases	An *institution for mental diseases (IMD)* is a hospital, nursing facility, or other institution with 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, per section 1905(i) of the Social Security Act. See also 42 CFR §435.1010 and Section 4390 of the State Medicaid Manual.	No changes.
Intensive outpatient services	*Intensive outpatient services* are designed to meet the needs of individuals who may be at risk for crisis or require a higher level of care or who are in transition from a higher level of care. Intensive outpatient services may include partial hospitalization programs, day treatment services, intensive outpatient programs, the Assertive Community Treatment program, intensive case management, intensive peer supports, written standardized protocols for escalating outpatient services when an individual is experiencing a crisis or greater need, and other services and settings more intensive than regular outpatient and less intensive than inpatient or residential care.	The name of the category and the definition changed substantially from Version 1.0 definition: “Intensive outpatient services or partial hospitalization means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting.” In Versions 2.0 and 3.0, some states may have interpreted the definition as broader than in Version 1.0, which could lead to our seeing an artificial increase in the number reported.
Licensed psychiatric hospital bed	*Licensed psychiatric hospital beds* are defined by state licensure requirements.	No changes.

Version 3.0 terms	Version 3.0 definitions	Notes on change in terms or definitions between versions
Medicaid beneficiary	*Medicaid beneficiary* means a person who has been determined to be eligible to receive Medicaid services, as defined at 42 CFR §400.200.	No changes.
Medicaid enrolled	*Medicaid enrolled* means any provider enrolled in Medicaid to obtain Medicaid billing privileges, as defined at 42 CFR §455.410.	No changes.
Mental health practitioners other than psychiatrists who are certified or licensed by the state to independently treat mental illness	*Mental health practitioners other than psychiatrists who are certified or licensed by the state to independently treat mental illness* are non-psychiatrist mental health providers who are certified or licensed to independently treat mental illness, as defined by state licensure laws. This may include, but is not limited to, licensed psychologists, clinical social workers, and professional counselors. Practitioners who are required to work under the supervision of another practitioner or who are required to bill Medicaid under another practitioner should be excluded.	Compared with Version 1.0, Versions 2.0 and 3.0 expand the definition to include providers who require the supervision of other practitioners.
Mobile crisis unit	A *mobile crisis unit* is a team that intervenes during mental health crises, as defined by the state.	No changes.
Observation or assessment centers	O*bservation or assessment centers* are defined by the state.	No changes.
Other practitioners who are authorized to prescribe psychiatric medications	*Other practitioners who are authorized to prescribe psychiatric medications* are defined by state licensure laws.	Compared with Version 1.0, Versions 2.0 and 3.0 update the label from "mental health practitioners other than psychiatrists who are authorized to prescribe."
Psychiatric hospital	A *psychiatric hospital* is an institution that provides diagnosis and treatment of a mentally ill person, as defined at 42 USC §1395x. The state should report on both public and private psychiatric hospitals.	Compared with Version 1.0, Versions 2.0 and 3.0 clarify the definition of psychiatric hospital and instruct the state to report on both public and private psychiatric hospitals.
Psychiatric residential treatment facility	A *psychiatric residential treatment facility (PRTF)* is a non-hospital facility that has a provider agreement with a state Medicaid agency to provide inpatient psychiatric services to individuals under age 21. The facility must be accredited by the Joint Commission, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting organization with comparable standards recognized by the state. PRTFs must also meet the requirements at 42 CFR §441.151–§441.182 and 42 CFR §483.350–§483.376.	No changes.
Psychiatric unit	A *psychiatric unit* is a separate inpatient psychiatric unit of a general hospital that provides inpatient mental health services and specifically allocates staff and space (beds) for the treatment of persons with mental illness, as defined for the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Services Survey (N-MHSS).	No changes.

Version 3.0 terms	Version 3.0 definitions	Notes on change in terms or definitions between versions
Psychiatrist	A *psychiatrist* is any psychiatrist licensed to practice in the state under state licensure laws.	No changes.
Residential mental health treatment facilities (adult)	*Residential mental health treatment facilities (adult)* are facilities not licensed as psychiatric hospitals, whose primary purpose is to provide individually planned programs of mental health treatment services in a residential care setting for adults, as defined for SAMHSA's N-MHSS.[38] This excludes residential substance use disorder (SUD) treatment facilities.	No changes.
Rural	*Rural* means an area outside of an urban area, as defined in 42 CFR §412.64(b).	No changes.
Serious emotional disturbance	Persons with *serious emotional disturbance (SED)* means individuals from birth up to age 18 who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. "Functional impairment" is defined in the SMDL as difficulty that substantially interferes with or limits a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.	No changes.
Serious mental illness	Persons with *serious mental illness (SMI)* is defined in the SMDL as individuals age 18 and over who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Note: The residential treatment section of the Availability Assessment requests data on PRTFs, and the federal definition for PRTFs includes facilities that serve individuals under age 21. To avoid double counting beneficiaries in the residential treatment category, the assessment requests data separately on beneficiaries age 0–17, 18–20, and 21 and older.	No changes.
Urban	*Urban* means a Metropolitan Statistical Area or a Metropolitan Division (if a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget (42 CFR §412.64[b]).	No changes.

Note: In addition to changes noted in the table, columns and instructions were added for Versions 2.0 and 3.0 for the states to provide notes ("Brief description of the data source[s] used to populate this subsection"; see "Summary of Updates to Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstration Monitoring Tools, August 2020"). For Version 3.0, a new section was added for states to report the number of qualified residential treatment programs that qualify as IMDs (see "Summary of Updates to Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance [SMI/SED] Demonstration Monitoring Tools [Version 3.0]").

[38] These are facilities not licensed as psychiatric hospitals that primarily provide individually planned programs of mental health treatment in a residential care setting for adults. More information is available at https://www.datafiles.samhsa.gov/dataset/national-mental-health-services-survey-2020-n-mhss-2020-ds0001.

Appendix C.
Data Sources and Definitions Used in States' Availability Assessments

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Table C.1. Data sources used to complete Availability Assessments

Part 1. The District of Columbia, Idaho, Indiana

State and Availability Assessment	District of Columbia				Idaho[1]				Indiana		
	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment
Medicaid beneficiaries											
Number of adult Medicaid beneficiaries with SMI	Enrollment and claims data from DHCF MMIS	No change	No change	No change	Claims data	No change	No change	No change	Medicaid enrollment data	Unknown	Unknown
Number of Medicaid beneficiaries with SED	Enrollment and claims data from DHCF MMIS	No change	No change	No change	Claims data	No change	No change	No change	Unknown	Unknown	Unknown
Medicaid-enrolled providers											
Medicaid-enrolled psychiatrists or other non-psychiatrist mental health prescribers	Enrollment and claims data from DHCF MMIS	No change	No change	No change	Idaho Board of Medicine website and internal state claims	No change	No change	No change	Unknown	2019 Indiana Physician License and Supplemental Survey Data, 2019; Indiana RN License and Supplemental Survey Data, 2020; Psychologist License and Supplemental Survey Data, 2020; Medicaid Enrolled Provider Data, Family and Social Services Administration Office of Medicaid Policy and Planning	Unknown
Other Medicaid-enrolled independent mental health providers	Enrollment and claims data from DHCF MMIS	No change	No change	No change	Idaho Board of Medicine data and internal state claims data	No change	No change	No change	Unknown	Claims data based on provider type	No change
Community-based outpatient services											
Medicaid-enrolled community mental health centers	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Unknown	Unknown	Claims data based on provider type	No change

State and Availability Assessment	District of Columbia				Idaho[1]				Indiana		
	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment
Medicaid-enrolled intensive outpatient or partial hospitalization	DBH provider lists	No change	No change	No change	Data from managed care organizations	Unknown	Unknown	Unknown	Unknown	Claims data based on provider type and provider specialty	
Federally qualified health centers	Enrollment and claims data from DHCF MMIS	No change	No change	No change	Idaho Primary Care Association	No change	No change	No change	Unknown	Claims data based on provider type and provider specialty	No change
Medicaid-enrolled residential mental health treatment facilities (adult)											
Total number of facilities	Not applicable	Not applicable	Not applicable	Not applicable	DBH–contracted HART homes	No change	No change	No change	Unknown	Licensing data from Division of Mental Health and Addiction	No change
Number of facilities that qualify as IMDs	Not applicable	Not applicable	Not applicable	Not applicable	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Total number of beds	Not applicable	Not applicable	Not applicable	Not applicable	Facility websites and contacts with facilities	No change	No change	No change	Unknown	Unknown	Unknown
Medicaid-enrolled psychiatric residential treatment facilities (children/youth)											
Total number of facilities	Not applicable	Not applicable	Not applicable	Not applicable	Data from managed care organizations	No change	No change	No change	Unknown	Claims data	Claims data
Total number of beds	Not applicable	Not applicable	Not applicable	Not applicable	Facility websites and contacts with facilities	No change	No change	No change	Unknown	Unknown	Unknown
Inpatient Services											
Number of psychiatric hospitals available to Medicaid beneficiaries	DOH licensure data	No change	No change	No change	Licensed state psychiatric hospitals	No change	No change	No change	Unknown	Claims data	No change
Number of psychiatric units in acute care hospitals available to Medicaid beneficiaries	DOH licensure data	No change	No change	No change	DBH data	No change	No change	No change	Unknown	Claims data	No change

State and Availability Assessment	District of Columbia				Idaho[1]				Indiana		
	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment
Number of psychiatric hospital beds and psychiatric unit beds for Medicaid beneficiaries	DOH licensure data	DOH licensure data	DOH licensure data	DOH licensure data	DBH data	No change	No change	No change	Unknown	Unknown	Unknown
Number of private and public facilities that qualify as IMDs	DOH licensure data	Not Applicable	Not Applicable	Not Applicable	Idaho licensure data	No change	No change	No change	Unknown	Claims data	Unknown
Crisis Services											
Mobile crisis units	DBH provider lists; DHCF MMIS provider enrollment data	No change	No change	No change	DBH and managed care organization data	No change	No change	No change	Survey conducted by the state in 2014 and 2015	Survey of providers certified by Division of Mental Health and Addiction	No change
Crisis observation or assessment centers	DBH provider lists; DHCF MMIS provider enrollment data	No change	No change	No change	DBH and managed care organization data	No change	No change	No change	Unknown	Unknown	Unknown
Crisis stabilization units	DBH provider lists; DHCF MMIS provider enrollment data	No change	No change	No change	DBH and managed care organization data	No change	No change	No change	Unknown	Unknown	Unknown
Coordinated community crisis response teams	DBH provider lists; DHCF MMIS provider enrollment data	No change	No change	No change	DBH and managed care organization data	No change	No change	No change	Unknown	Unknown	Unknown

Note: Idaho provided the data sources used to populate the Initial and Annual Availability Assessments when Mathematica requested feedback from states on the May 2024 CSA in November 2024.

Part 2. Maryland, New Hampshire, Oklahoma

State and Availability Assessment	Maryland	New Hampshire		Oklahoma		
	Initial Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment
Medicaid beneficiaries						
Number of adult Medicaid beneficiaries with SMI	Paid claims data from BH-ASO	MMIS enrollment data	MMIS enrollment data and eligibility groupings based on rate cells	Unknown	Oklahoma MMIS	No change
Number of Medicaid beneficiaries with SED	Paid claims data from BH-ASO	MMIS enrollment data	MMIS enrollment data and eligibility groupings based on rate cells	Unknown	Oklahoma MMIS	No change
Medicaid-enrolled providers						
Medicaid-enrolled psychiatrists or other non-psychiatrist mental health prescribers	Maryland Medicaid's Electronic Provider Revalidation and Enrollment Portal	New Hampshire Office of Professional Licensure and Certificate databases	New Hampshire Medicaid MCO provider directories for Medicaid Enrolled (Column S) and Accepting New Patients (Column T)	Unknown	Licensure board data; Medicaid enrollment data	No change
Other Medicaid-enrolled independent mental health providers	Maryland Medicaid's Electronic Provider Revalidation and Enrollment Portal	New Hampshire Office of Professional Licensure and Certificate databases	New Hampshire Medicaid MCO provider directories for Medicaid Enrolled (Column AB) and Accepting New Patients (Column AC)	Unknown	Licensure board data; Medicaid enrollment data	No change
Community-based outpatient services						
Medicaid-enrolled community mental health centers	Not applicable	New Hampshire DHHS, Division of Behavioral Health	No change	Unknown	State certification data	No change
Medicaid-enrolled intensive outpatient or partial hospitalization	Maryland Medicaid's Electronic Provider Revalidation and Enrollment Portal	Data from a survey of CMHCs	Survey of individual CMHCs	Unknown	Medicaid provider enrollment data	No change
Federally qualified health centers	Maryland's BH-ASO's paid claims data	Bi-State Primary Care Association	Bi-State Primary Care Association Serving Vermont and New Hampshire	Unknown	Oklahoma Primary Care Association	No change

State and Availability Assessment	Maryland	New Hampshire		Oklahoma		
	Initial Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment
Medicaid-enrolled residential mental health treatment facilities (adult)						
Total number of facilities	Not applicable	New Hampshire DHHS, Division of Behavioral Health beds report	New Hampshire DHHS, Division of Behavioral Health beds report	Unknown	Oklahoma DOH licensing data	No change
Number of facilities that qualify as IMDs	Not applicable	New Hampshire DHHS, Division of Behavioral Health beds report	No change	Unknown	Unknown	Unknown
Total number of beds	Not applicable	New Hampshire DHHS, Division of Behavioral Health beds report	No change	Unknown	Oklahoma DOH licensing data	No change
Medicaid-enrolled psychiatric residential treatment facilities (children/youth)						
Total number of facilities	Maryland Medicaid's Electronic Provider Revalidation and Enrollment Portal	Not applicable	Unknown	Unknown	Medicaid provider enrollment and survey data	No change
Total number of beds	Maryland Medicaid's Electronic Provider Revalidation and Enrollment Portal	Not applicable	Unknown	Unknown	Medicaid provider enrollment and survey data	No change
Inpatient services						
Number of psychiatric hospitals available to Medicaid beneficiaries	Maryland Medicaid's Electronic Provider Revalidation and Enrollment Portal	New Hampshire DHHS, Division of Behavioral Health beds report	No change	Unknown	Oklahoma DOH licensing data; Medicaid provider enrollment data	No change
Number of psychiatric units in acute care hospitals available to Medicaid beneficiaries	Maryland Office of Health Care Quality	New Hampshire DHHS, Division of Behavioral Health beds report	No change	Unknown	Oklahoma DOH licensing data; Medicaid provider enrollment data	No change
Number of psychiatric hospital beds and psychiatric unit beds for Medicaid beneficiaries	Maryland Office of Health Care Quality	New Hampshire DHHS, Division of Behavioral Health beds report	No change	DOH licensing data	Oklahoma DOH licensing data	No change
Number of private and public facilities that qualify as IMDs	Maryland Office of Health Care Quality	New Hampshire DHHS, Division for Behavioral Health beds report	No change	Unknown	Oklahoma DOH licensing data	No change

State and Availability Assessment	Maryland	New Hampshire		Oklahoma		
	Initial Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment
Crisis Services						
Mobile crisis units	Maryland Behavioral Health Administration	New Hampshire DHHS, Division for Behavioral Health Policy Data	New Hampshire DHHS, Division for Behavioral Health Policy Team	Unknown	Oklahoma contract data	No change
Crisis observation or assessment centers	Maryland Behavioral Health Administration	New Hampshire DHHS, Division for Behavioral Health Policy Data	New Hampshire DHHS, Division for Behavioral Health Policy Team	Unknown	Oklahoma contract data	No change
Crisis stabilization units	Maryland Behavioral Health Administration	New Hampshire DHHS, Division for Behavioral Health Policy Data	New Hampshire DHHS, Division for Behavioral Health Policy Team	Unknown	Oklahoma contract data	No change
Coordinated community crisis response teams	Maryland Behavioral Health Administration	New Hampshire DHHS, Division for Behavioral Health Policy Data	New Hampshire DHHS, Division for Behavioral Health Policy Team	Unknown	Oklahoma contract data	No change

Part 3. Utah, Vermont, Washington, Alabama, Massachusetts

State and Availability Assessment	Alabama	Massachusetts	Utah				Vermont			Washington	
	Initial Availability Assessment	Initial Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Medicaid beneficiaries											
Number of adult Medicaid beneficiaries with SMI	Alabama Medicaid Agency; Alabama DMH	MassHealth claims data	Unknown	Medicaid data warehouse	Unknown	PRISM MMIS System	Unknown	Department of Vermont Health Access	No change	MMIS	No change
Number of Medicaid beneficiaries with SED	Alabama Medicaid Agency; Alabama DMH	MassHealth claims data	Unknown	Medicaid data warehouse	Unknown	PRISM MMIS System	Unknown	Department of Vermont Health Access	No change	MMIS	No change
Medicaid-enrolled providers											
Medicaid-enrolled psychiatrists or other non-psychiatrist mental health prescribers	Alabama Medicaid Agency; Alabama Medical Examiners Board; Alabama Board of Nursing	ACO and MCO data	Unknown	NPPES NPI Registry; Medicaid data warehouse	Unknown	NPI data matched with PRISM MMIS data	Unknown	Department of Vermont Health Access	No change	Washington Medical Commission Survey, 3rd quarter 2020; Managed Care Plan network adequacy individual providers list	No change
Other Medicaid-enrolled independent mental health providers	Alabama Medicaid Agency; Alabama Board of Examiners Psychologist; Alabama Board of Examiners of Counselors; Alabama Board of Examiners Marriage and Family Therapy; Alabama Board of Examiners Social Work	ACO and MCO data	Unknown	NPPES NPI Registry; Medicaid data warehouse	Unknown	NPI data matched with PRISM MMIS data	Unknown	Department of Vermont Health Access	No change	DOH licensing data system; MCO Managed Care Plan network adequacy provider list data, 3rd quarter 2020	No change

State and Availability Assessment	Alabama	Massachusetts	Utah				Vermont			Washington	
	Initial Availability Assessment	Initial Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Community-based outpatient services											
Medicaid-enrolled community mental health centers	Alabama Medicaid Agency; Alabama DMH	Massachusetts Behavioral Health Partnership	Unknown	Medicaid provider enrollment	Unknown	Unknown	Unknown	Vermont DMH	No change	Health Care Authority Operational Data Store	Health Care Authority Operational Data Store; DOH BHA licensure feed; Provider One
Medicaid-enrolled intensive outpatient or partial hospitalization	Alabama Medicaid Agency; Alabama DMH; Alabama Department of Youth Services; Alabama Department of Human Resources	Massachusetts Behavioral Health Partnership	Unknown	Utah Department of Human Services, Office of Licensing data; Utah Medicaid provider enrollment data	Unknown	Report from the Utah Office of Licensing–Human Services with the number of adult mental health day treatment providers	Unknown	Department of Vermont Health Access	No change	DOH BH licensure information; Health Care Authority Operational Data Store	No change
Federally qualified health centers	Alabama Medicaid Agency	MassHealth's Data Warehouse	Unknown	Association for Utah Community Health data	Unknown	Report from the Association of Utah Community Health (AUCH)	Unknown	Department of Vermont Health Access	No change	MMIS	No change
Medicaid-enrolled residential mental health treatment facilities (adult)											
Total number of facilities	Unknown	Massachusetts DMH	Unknown	Utah Department of Human Services, Office of Licensing; Utah Medicaid provider enrollment data	Unknown	Report from the Utah Office of Licensing–Human Services	Unknown	Vermont DMH	No change	DBHR lists of residential service providers	No change
Number of facilities that qualify as IMDs	Alabama Hospital Association	Massachusetts DMH	Unknown	Utah Department of Human Services, Office of Licensing	Unknown	Reports from the Utah Office of Licensing–Human Services	Not applicable	Not applicable	Not applicable	DBHR IMD list	No change
Total number of beds	Alabama Hospital Association	Massachusetts DMH	Unknown	Utah Department of Human Services, Office of Licensing; Utah Medicaid PRISM provider enrollment data	Unknown	Report from the Utah Office of Licensing–Health Facilities	Unknown	Vermont DMH	No change	Department of Health Integrated Licensing and Regulatory System information; DBHR lists of residential providers	No change

State and Availability Assessment	Alabama	Massachusetts	Utah				Vermont			Washington	
	Initial Availability Assessment	Initial Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Medicaid-enrolled psychiatric residential treatment facilities (children/youth)											
Total number of facilities	Alabama Medicaid Agency; Alabama DMH; Alabama Department of Public Health	Massachusetts DMH	Unknown	Utah DOH, Bureau of Health Facility Licensing	Unknown	Unknown	Not applicable	Not applicable	Not applicable	Children's Long-Term Inpatient Program webpage	No change
Total number of beds	Alabama Medicaid Agency; Alabama DMH; Alabama Department of Public Health	Massachusetts DMH	Unknown	Utah DOH, Bureau of Health Facility Licensing	Unknown	Unknown	Not applicable	Not applicable	Not applicable	Children's Long-Term Inpatient Program webpage	No change
Inpatient services											
Number of psychiatric hospitals available to Medicaid beneficiaries	Alabama Medicaid Agency; Alabama Hospital Association	Massachusetts DMH	Unknown	Utah DOH, Bureau of Health Facility Licensing	Unknown	Reports from the Utah Office of Licensing–Health Facilities	Unknown	Vermont DMH	No change	HCA Provider One Enrollment data	No change
Number of psychiatric units in acute care hospitals available to Medicaid beneficiaries	Alabama Medicaid Agency; Alabama Hospital Association	Massachusetts DMH	Unknown	Utah DOH, Bureau of Health Facility Licensing	Unknown	Report from the Utah Office of Licensing–Health Facilities	Unknown	Vermont DMH	No change	DOH Integrated Licensing and Regulatory System information; DBHR inpatient and diversion resource spreadsheet	No change
Number of psychiatric hospital beds and psychiatric unit beds for Medicaid beneficiaries	Alabama Health Planning and Development Agency	Massachusetts DMH	Unknown	Utah DOH, Bureau of Health Facility Licensing	Unknown	Report from the Utah Office of Licensing–Health Facilities	Unknown	Vermont DMH	No change	DOH data pull of licensed psychiatric beds in acute care hospitals and private psychiatric hospitals as well as DBHR's list of inpatient beds based on regularly staffed bed availability	No change
Number of private and public facilities that qualify as IMDs	Alabama Hospital Association	Massachusetts DMH	Unknown	Utah DOH, Bureau of Health Facility Licensing	Unknown	Reports from the Utah Office of Licensing–Human Services	Unknown	Vermont DMH	No change	Unknown	Department of Health licensure data and MMIS Provider Enrollment data

State and Availability Assessment	Alabama	Massachusetts	Utah				Vermont			Washington	
	Initial Availability Assessment	Initial Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Crisis services											
Mobile crisis units	Alabama DMH	Unknown	Unknown	Utah Division of Substance Abuse and Mental Health	Unknown	Report from the Utah Office of Substance Use and Mental Health	Unknown	Vermont DMH	No change	BH-ASO contractor information	No change
Crisis observation or assessment centers	Alabama DMH	Unknown	Unknown	Utah Division of Substance Abuse and Mental Health	Unknown	Report from the Utah Office of Substance Use and Mental Health	Unknown	Vermont DMH	No change	BH-ASO contractor information	No change
Crisis stabilization units	Alabama DMH	Unknown	Unknown	Utah Division of Substance Abuse and Mental Health	Unknown	Report from the Utah Office of Substance Use and Mental Health	Unknown	Vermont DMH	No change	BH-ASO contractor information	No change
Coordinated community crisis response teams	Alabama DMH	Unknown	Unknown	Utah Division of Substance Abuse and Mental Health	Unknown	Report from the Utah Office of Substance Use and Mental Health	Unknown	Vermont DMH	No change	BH-ASO contractor information	No change

Note: Unknown indicates a state did not report on the data source. Not applicable indicates a state did not have that category.

BH = behavioral health; BH-ASO = behavioral health–administrative services organization; BHA = behavioral health agency; CMHC = community mental health center; DBH = Department of Behavioral Health; DBHR = Division of Behavioral Health and Recovery; DHCF = Department of Health Care Finance; DHHS = Department of Health and Human Services; DMH = Department of Mental Health; DOH = Department of Health; HCA = Health Care Authority; IMD = institution for mental diseases; MMIS = Medicaid Management Information System; NPI = National Provider Identifier; NPPES = National Plan and Provider Enumeration System; PRISM = Provider Reimbursement Information System for Medicaid; SED = serious emotional disturbance; SMI = serious mental illness.

Table C.2. State definition changes in Availability Assessment providers and facilities

State and Availability Assessment	District of Columbia				Idaho				Indiana	
	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Medicaid beneficiaries										
Number of adult Medicaid beneficiaries with SMI	This reflects individuals enrolled as of December of the assessment year and any SMI/SED diagnosis in claims during each calendar year. The state used the SMI/SED definition included in its monitoring protocol to identify beneficiaries.	No changes	No changes	No changes	Count includes beneficiaries diagnosed with SMI or SED and those who are out of state. Data for SMI/SED are limited by claims collection. Because no diagnosis information is available to internal systems, internal MMIS data—including managed care organization and fee-for-service claims for SMI/SED services going back to 2017—were used to populate SMI/SED beneficiary information.	No change	No changes	No change	SMI and SED prevalence was determined by the number of Medicaid enrollees accessing a DMHA-certified provider. These data are used for block grant reporting for the Substance Abuse and Mental Health Services Administration.	SMI and SED prevalence was determined by the number of Medicaid enrollees with the state-identified definition of SMI with a behavioral health claim during the time period.
Number of Medicaid beneficiaries with SED	This assessment reflects individuals enrolled as of December of the assessment year and any SMI/SED diagnosis in claims during each calendar year. The state used the SMI/SED definition included in its monitoring protocol to identify beneficiaries.	No changes	No changes	No changes	Unknown	Unknown	Unknown	Unknown	SMI and SED prevalence was determined by the number of Medicaid enrollees accessing a DMHA-certified provider. These data are used for block grant reporting for the Substance Abuse and Mental Health Services Administration.	SMI and SED prevalence was determined by the number of Medicaid enrollees with the state-identified definition of SMI with a behavioral health claim during the time period.

State and Availability Assessment	District of Columbia				Idaho				Indiana	
	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Medicaid-enrolled providers										
Medicaid-enrolled psychiatrists or other non-psychiatrist mental health prescribers	Definition includes physicians (MD or DO), nurse practitioners, and physician assistants with a psychiatry specialty who had a primary service address in the District of Columbia or elsewhere (primarily Maryland or Virginia) and were enrolled in Medicaid as of December of the assessment year.	No changes	No changes	No changes	Unknown	Unknown	Unknown	Unknown	Includes only psychiatrists	Includes psychiatrists, psychologists, and advanced practice registered nurses.
Other Medicaid-enrolled independent mental health providers	Includes psychologists, independent social workers, marriage and family therapists, and professional counselor provider types who were individual and group providers with a primary service address in the District of Columbia or elsewhere—primarily Maryland and enrolled in Medicaid as of December of the assessment year.	No changes	No changes	No changes	Includes psychologists, counselors, and social workers	No changes	No changes	No changes	Includes psychologists	The definition for this category expanded to include licensed clinical social workers, licensed mental health counselors, licensed clinical addiction counselors, and behavioral health providers.
Community-based outpatient services										
Medicaid-enrolled community mental health centers	The District of Columbia's certification standards for CMHCs are not consistent with the federal CMHC definition; thus, the state did not report any CMHCs in any of its Availability Assessments.	No changes	No changes .	No changes	Idaho does not have CMHCs.	No change.	No change	No change	Unknown	Unknown

State and Availability Assessment	District of Columbia				Idaho				Indiana	
	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Medicaid-enrolled intensive outpatient or partial hospitalization	The count of Medicaid-enrolled intensive outpatient or partial hospitalization providers includes mental health providers certified by the District of Columbia's Department of Behavioral Health to provide intensive day and rehabilitation day treatment.	No changes	No changes	No changes	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Medicaid-enrolled residential mental health treatment facilities (adults)										
Total number of facilities	Although the District of Columbia reported no residential mental health treatment facilities, adult beneficiaries can access services in facilities in other states.	No changes	No changes	No changes	This number includes the residential assisted living facilities that provide serious and persistent mental illness services within the state, designated as homes with adult residential treatment.	No changes	No change	No change	These counts capture all facilities licensed under the Division of Mental Health and Addiction; information provided by the DMHA. The state currently is unable to identify residential facilities for adults only.	No change
Total number of beds	Although the District of Columbia reported no residential mental health treatment facilities, adult beneficiaries can access services in facilities in other states.	No changes	No changes	No changes	This number includes the residential assisted living facilities that provide serious and persistent mental illness services within the state, designated as homes with adult residential treatment.	No change.	No change.	No change	Unknown	Unknown
Medicaid-enrolled psychiatric residential treatment facilities (children/youth)										
Total number of facilities	Although the District of Columbia reported no PRTFs, beneficiaries younger than age 21 can access PRTFs in other states.	No changes	No changes	No changes	This number includes a site that is female only. The state noted there were other facilities that might serve the SED population	No change	No change	No change	Unknown	Unknown
Total number of beds	Although the District of Columbia reported no PRTFs, beneficiaries younger than age 21 can access PRTFs in other states.	No changes	No changes	No changes	This number includes a site that is female only. The state noted there were other facilities that might serve the SED population	No change	No change	No change	Unknown	Unknown

State and Availability Assessment	District of Columbia				Idaho				Indiana	
	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Inpatient services										
Number of psychiatric hospitals available to Medicaid beneficiaries	Unknown	Unknown	Unknown	Unknown	This state used Version 1.0 or an unspecified version for its Initial Availability Assessment but used Versions 2.0 or 3.0 in its most recent Availability Assessment. The definition of the psychiatric hospital was clarified, and the state was instructed to report on both public and private psychiatric hospitals.	No change	No change	No change	Unknown	Unknown
Number of psychiatric units in acute care hospitals available to Medicaid beneficiaries	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Number of psychiatric hospital beds and psychiatric unit beds available for Medicaid beneficiaries	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Number of private and public facilities that qualify as IMDs	Unknown	Unknown	Unknown	DC Department of Licensure data	The state reported the total number of psychiatric hospitals that qualify as IMDs in the state.	No changes	No changes	Unknown	Unknown	Unknown
Crisis services										
Mobile crisis units	Data as of December of the assessment year	No changes	No changes	No changes	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Crisis call centers	Data as of December of the assessment year	No changes	No changes	No changes	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Crisis observation or assessment centers	Data as of December of the assessment year	No changes	No changes	No changes	Behavioral health crisis centers, along with emergency rooms and 27 critical access hospitals throughout rural Idaho, offer the first level of crisis support.	No changes	No change	No change	Unknown	Unknown

State and Availability Assessment	District of Columbia				Idaho				Indiana	
	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment	Second annual Availability Assessment	Third annual Availability Assessment	Initial Availability Assessment	First annual Availability Assessment
Crisis stabilization units	Data as of December of the assessment year	No changes	No changes	No changes	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Coordinated community crisis response teams	Data as of December of the assessment year	No changes	No changes	No changes	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown

Note: Unknown indicates a state did not report notes on the definition.

CMHC = community mental health center; DMHA = Division of Mental Health and Addiction; DO = doctor of osteopathic medicine; IMD = institution for mental diseases; MD = doctor of medicine; MMIS = Medicaid Management Information System; PRTF = psychiatric residential treatment facility; SED = serious emotional disturbance; SMI = serious mental illness.

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Appendix D.
Findings Related to the Availability of Services

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A. State definitions of workforce categories

For the workforce domain, we described how states defined Medicaid-enrolled prescribers and other Medicaid-enrolled independent mental health providers in the notes sections of their Availability Assessments.

Table D.1. State definitions of workforce categories

State	Medicaid-enrolled prescribers	Other Medicaid-enrolled independent mental health providers
AL	Psychiatrists, physician assistants with psychiatry specialty, registered nurse practitioners with psychiatric mental health specialty	Clinical social workers, marriage and family therapists, master social workers, professional counselors, psychiatric and mental health nurse specialists, licensed bachelors-level social workers, associate licensed counselors
DC	Doctors of medicine (MD) or doctors of osteopathic medicine (DO), nurse practitioners, and physician assistants with psychiatry specialty	Psychologists, independent social workers, marriage and family therapists, and professional counselors (including individual and group practices)
ID[a]	Doctors of medicine (MD) or doctors of osteopathic medicine (DO), nurse practitioners, and physician assistants with psychiatry specialty	Clinical social workers, marriage and family therapists, master social workers, professional counselors, psychiatric and mental health nurse specialists, licensed bachelors-level social workers, associate licensed counselors
IN	Initial Availability Assessment: Psychiatrists Annual Availability Assessments: Psychiatrists, psychologists, and advanced practice registered nurses	Licensed clinical social workers, licensed mental health counselors, licensed clinical addiction counselors, and behavioral health providers
MA	Psychiatrists, advanced registered nurse practitioners with psychiatric specialty	Clinical social workers, marriage and family therapists, mental health counselors, psychologists, behavioral health analysts
MD	Psychiatrists, certified registered nurse practitioners with psychiatric mental health specialty, and advanced practice registered nurses with psychiatric mental health specialty	Licensed psychologists, licensed clinical social workers, licensed clinical professional counselors, licensed clinical alcohol and drug counselors, licensed clinical professional art therapists, licensed marriage and family therapists, outpatient mental health clinics licensed by Maryland's Behavioral Health Administration, and mental health group practices
NH	Physicians with psychiatric specialty as well as advanced nurse practitioners with a general psychiatric, family psychiatric, or adult psychiatric specialty	Professionals who independently treat mental illness, such as psychologists, pastoral psychologists, licensed mental health counselors, licensed independent clinical social workers, and marriage and family therapist
OK	Psychiatrists and advanced practice registered nurses with prescribing authority	Licensed psychologists, licensed clinical social workers, and licensed professional counselors
UT	Physicians, nurse practitioners, and physician assistants	Clinical social workers, mental health counselors, marriage and family therapists, and psychologists
VT	Not available	Not available
WA	Psychiatrists, child psychiatrists, and psychiatric advanced registered nurse practitioners	Certified case managers for behavioral health, clinical social workers, marriage and family therapists, master social workers, mental health counselors, professional counselors, psychoanalysts, psychiatric and mental health nurse specialists, psychologists, and child psychologists

Note: Idaho provided the definitions used to populate the Initial and Annual Availability Assessments when Mathematica requested feedback from states on the May 2024 CSA in November 2024.

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Appendix E.
Summary of Section 1115 SMI/SED Demonstrations and Available Monitoring Data Through February 1, 2024

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Table E.1. Summary of section 1115 SMI/SED demonstrations and available monitoring data used in analysis

State	Demonstration dates				Metric data reported by state			
	Approval date	Start date[a]	End date	Reporting status[b]	Monthly metrics	Annual CMS	Annual EQMs	Part B (narrative)
Alabama	5/20/2022	5/20/2022	5/19/2027	**Quarterly reports:** May 2022–August 2023 **Initial Availability Assessment** • Assessment submitted: March 2023	X			X
District of Columbia	12/12/2019	1/1/2020	12/31/2024	**Quarterly reports:** January 2020–November 2023 **Initial Availability Assessment** • Assessment submission date and period of assessment: Not reported **Annual Availability Assessment** • Assessment submitted: September 2021; March 2022; March 2023 • Period of assessment: Varies by category	X	X	X	X
Idaho	4/17/2020	4/17/2020	3/31/2025	**Quarterly reports:** Apr 2020–January 2024 **Initial Availability Assessment** • Assessment submitted: February 2020 • Period of assessment: not reported **Annual Availability Assessment** • Assessment submitted: July 2021; July 2022; September 2023[39] • Period of assessment: April 2020; April 2021; April 2022; April 2022	X	X	X	X
Indiana[c]	12/20/2019	1/1/2020	12/31/2025	**Quarterly reports:** January 2020–November 2023 **Initial Availability Assessment** • Assessment submitted: February 2020 • Period of assessment: January 2020 **Annual Availability Assessment** • Assessment submitted: March 2021; March 2022 • Period of assessment: February 2021; January 2022	X	X	X	X
Maryland	12/14/2021	1/1/2022	12/31/2026	**Initial Availability Assessment** • Assessment submitted: February 2022 • Period of assessment: Calendar year (CY) 2020				
Massachusetts	9/28/2022	10/1/2022	12/31/2027	**Initial Availability Assessment** • Assessment submitted: October 2020 • Period of assessment: CY 2018				
New Hampshire	6/2/2022	6/2/2022	6/30/2023	**Quarterly reports:** June 2022–November 2023 **Initial Availability Assessment** • Assessment submitted: July 2021; September 2023 • Period of assessment: May 2021; May 2022 **Annual Availability Assessment** • Assessment submitted: September 2023 • Period of assessment: not reported	X			X

[39] Idaho resubmitted their third Annual Availability Assessment in September 2023 (version used).

State	Demonstration dates				Metric data reported by state			
	Approval date	Start date[a]	End date	Reporting status[b]	Monthly metrics	Annual CMS	Annual EQMs	Part B (narrative)
New Mexico[d]	3/28/2023	3/28/2023	12/31/2024	**Initial Availability Assessment** • Assessment submitted: February 2024 • Period of assessment: August 2019				
Oklahoma	12/22/2020	12/22/2020	12/31/2025	**Quarterly reports:** January 2021–November 2023 **Initial Availability Assessment** • Assessment submitted: April 2020 • Period of assessment: February 2020 **Annual Availability Assessment** • Assessment submitted: February 2022; May 2023 • Period of assessment: February 2021; February 2022	X	X	X	X
Utah[e]	12/16/2020	12/16/2020	6/30/2027	**Quarterly reports:** January 2021–November 2023 **Initial Availability Assessment** • Assessment submitted: November 2020 • Period of assessment: January 2020 **Annual Availability Assessment** • Assessment submitted: February 2022; October 2023 • Period of assessment: February 2021; October 2023	X	X	X	X
Vermont[f]	12/5/2019	1/1/2020	12/31/2027	**Quarterly reports:** May 2022–November 2023 **Initial Availability Assessment** • Assessment submission date and period of assessment: Not reported **Annual Availability Assessment** • Assessment submitted: November 2022; March 2023 • Period of assessment: CY 2021; April 2022	X	X	X	X
Washington[g]	11/6/2020	11/6/2020	6/30/2023	**Quarterly reports:** January 2021–December 2023 **Initial Availability Assessment** • Assessment submitted: September 2020 • Period of assessment: Fiscal year 2019 **Annual Availability Assessment** • Assessment submitted: August 2022; March 2023 • Period of assessment: CY 2020; CY 2021	X	X	X	X

Note: This table summarizes findings from 11 states with approved section 1115 SMI/SED demonstrations that submitted monitoring reports to PMDA from December 1, 2020, to February 1, 2024.

[a] For monitoring purposes, the SMI/SED demonstration start date refers to the effective date listed in the state's STCs at time of section 1115 SMI/SED demonstration approval. In many cases, the effective date is distinct from the approval date of a demonstration (that is, in certain cases, CMS can approve a section 1115 demonstration with an effective date in the future). In many cases, the effective date also differs from the date a state begins implementing its demonstration. We are compiling information on implementation dates and might use those dates to inform future analysis.

[b] This table includes any section 1115 demonstration monitoring reports available in PMDA between December 1, 2020, and February 1, 2024.

[c] CMS approved Indiana's waiver extension, and the demonstration will have new effective dates of January 1, 2021, to December 31, 2025. CMS also approved the state's monitoring protocol on July 22, 2021. The dates included in this table reflect the original start date and the new effective end date.

[d] CMS approved New Mexico's waiver extension, and the demonstration will have new effective dates of March 28, 2023, to December 31, 2024. The dates included in this table reflect the original start date and the new effective end date. New Mexico submitted the Initial Availability Assessment after the report cutoff date; therefore, this assessment is not included in the analysis.

[e] CMS approved Utah's waiver extension, and the demonstration will have new effective dates of July 1, 2022, to June 30, 2027. The dates included in this table reflect the original start date and the new effective end date.

[f] CMS approved Vermont's waiver extension, and the demonstration will have new effective dates of July 1, 2022, to December 31, 2027. The dates included in this table reflect the original start date and the new effective end date.

[g] Washington was granted a temporary waiver extension in November 2022, extending the demonstration end date from December 31, 2022, to a temporary end date of June 30, 2023.

CMS = Centers for Medicare & Medicaid Services; EQM = established quality measure; PMDA = Performance Metrics Database and Analytics System; SED = serious emotional disturbance; SMI = serious mental illness; STCs = Special Terms and Conditions; SUD = substance use disorder.

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Appendix F.
Activities to Meet Milestones

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Table F.1. Status of planned activities for Milestone 1 components not met before the demonstration period, by state

Component description	State	Planned activities at baseline	Activity updates during demonstration (most recent quarterly report)[a]
State licensure (a)	NH	Plan to add accreditation requirement for IMDs.	No updates provided. (DY2Q1)
	OK*	Plan to add accreditation requirement for IMD crisis units.	Requirement added. Component met as of DY3Q3.
National accreditation (b)	NM	Plan to add accreditation requirements for RTFs to state administrative code.	Update schedule is pending Monitoring Protocol approval.
	OK*	Plan to create rules requiring accreditation of QRTPs and provide TA to providers.	The Specialized Placements and Partnerships unit is providing TA to QRTP providers. (DY3Q3)
	UT*	Plan to verify accreditation of RTFs.	No updates provided. (DY4Q1)
Oversight (c)	NM	Plan to develop oversight requirements for RTFs and update requirements for QRTPs, including unannounced visits.	Update schedule is pending Monitoring Protocol approval.
	OK*	Plan to develop procedures, rules, and contracts for oversight and ongoing monitoring of QRTPs, including unannounced visits.	The state is still working to develop a quality review tool for QRTP providers. (DY3Q3)
Utilization review (d)	DC*	Plan to establish new utilization review process of RTFs.	No updates provided. (DY4Q3)
	IN*	Plan to develop ALOS report and update provider manual with ALOS specifications.	No updates provided. (DY4Q3)
	NH	Plan to amend MCO contract requirements for MCOs to create admission and utilization review criteria for hospitals in the demonstration.	The state has a new care coordination program that uses event notification, closed-loop referrals, and multidisciplinary teams, including crisis services. (DY2Q1)
	NM	Plan to update prior authorization and stay requirements, including use of an assessment tool in the utilization review process.	Update schedule is pending Monitoring Protocol approval.
	OK*	Plan to require prior authorization for all residential stays newly authorized under the demonstration. Plan to update administrative code pertaining to utilization review to allow reimbursement for services in IMDs.	No updates provided. (DY3Q3)

Component description	State	Planned activities at baseline	Activity updates during demonstration (most recent quarterly report)[a]
Program integrity (e)	NH	Plan to increase provider monitoring during demonstration.	No updates provided. (DY2Q1)
	NM	Plan to update current program integrity requirements.	Update schedule is pending Monitoring Protocol approval.
	OK*	Plan to develop more robust program integrity requirements for QRTPs.	State has developed program integrity requirements for QRTPs. Associated contracts with QRTPs have been signed and implemented. Component now met.
Screening and access to treatment (f)	DC*	Plan to develop screening requirements for psychiatric hospitals.	No updates provided. (DY4Q3)
	NH	Plan to create new administrative rule requiring screening by hospitals in the demonstration.	No updates provided. (DY2Q1)
	NM	Plan to create administrative rule requiring providers to use Level of Care Utilization System, Children and Adolescent Level of Care Utilization System, and Child and Adolescent Needs and Strengths clinical assessment tools. Plan to require participating facilities to provide telemedicine for qualifying beneficiaries.	Update schedule is pending Monitoring Protocol approval.
	OK*	Plan to require QRTPs to assess a placed child within 30 days by using the Child and Adolescent Needs and Strengths clinical assessment tool. Provide TA to providers on new screening requirements.	State collected baseline data from Child and Adolescent Needs and Strengths assessment from QRTP population. The state is now using the data to update the algorithm for recommendations on level of care. (DY3Q1)

Source: Approved implementation plans and monitoring reports.

Note: * indicates the state has a demonstration that has been running for longer than two years.

[a] The date in parentheses indicates the most recent monitoring report Part B that we received from the state before February 1, 2024, the cutoff date for this report.

ALOS = average length of stay; DY = demonstration year; IMD = institution for mental disease; MCO = managed care organization; Q = quarter; QRTP = qualified residential treatment program; RTF = residential treatment facility; TA = technical assistance.

Table F.2. Status of planned activities for Milestone 2 components not met before the demonstration period, by state

Component description	State	Planned activities at baseline	Activity updates during demonstration (most recent quarterly report)[a]
Discharge planning (a)	DC*	Plan to develop policies for Medicaid reimbursement for tasks under discharge.	Component met as of DY1Q4.
	MA	Plan to communicate updated discharge planning expectations to hospitals and Community Behavioral Health Clinics.	State launched in January 2023 and continued strengthening connections between CBHCs and existing services. (DY2Q3)
	MD	Plan to develop approaches for discharge challenges and for providing resources for CMHCs.	Update schedule is pending Monitoring Protocol approval.
	NH	Plan to add discharge planning requirements to administrative rules.	Requirement added. Component met as of DY2Q1.
	NM	Plan to develop Certified Community Behavioral Health Clinics to support opportunities for FFS beneficiaries to receive care coordination for transitional services.	Update schedule is pending Monitoring Protocol approval.
	OK*	Plans to create procedures necessary to require QRTPs to provide discharge planning and coordinate with child welfare agency staff.	Specialized Placements and Partnerships programs team is developing a quality review tool that is completed with QRTP providers monthly. (DY3Q3)
	WA*	Plan to amend MCO contracts and state administrative code to require providers to conduct discharge planning and collaborate with community providers.	Component met as of DY2Q1.
Housing assessment (b)	AL	Plan to require use of psychiatric admission form that asks about housing needs.	Psychiatric admission form now required. Component met as of DY1Q4.
	DC*	Plan to develop policies to require psychiatric hospitals and RTFs to assess housing.	No updates provided. (DY4Q3)
	ID*	Plan to include housing assessment requirements in MCO contracts and provider network agreements.	State added a metric to its monitoring protocol that monitors MCO beneficiaries' housing. (DY4Q1)
	IN*	Plan to add housing assessment requirements to Medicaid provider manual.	No updates provided. (DY4Q3)
	NH	Plan to add housing assessment requirements to administrative rules. The state is awaiting outcome of 1915(i) supportive housing waiver request.	The state is forming a community of practice with multiple facilities and providers to support and advance shared learning and use of health IT. (DY2Q1)
	NM	Plan to leverage peer support workers to assess beneficiaries' housing situation and coordinate housing services.	Update schedule is pending Monitoring Protocol approval.
	VT*	Plan to change hospital licensing rule to allow the state to create a policy for housing assessment.	No updates provided. (DY4Q3)

Component description	State	Planned activities at baseline	Activity updates during demonstration (most recent quarterly report)[a]
72-hour post-discharge follow-up (c)	DC*	Plan to develop policies for 72-hour follow-up.	No updates provided. (DY4Q3)
	ID*	Plan to add 72-hour follow-up requirements to MCO contracts and provider network agreements.	State added a metric to its monitoring protocol that monitors timeliness of post-discharge MCO beneficiary follow-up. (DY4Q1)
	IN*	Plan to add 72-hour follow-up requirements to Medicaid provider manual.	No updates provided. (DY4Q3)
	MA	Plan to add 72-hour follow-up requirements to MCO and hospital contracts.	State launched Community Behavioral Health Clinics in January 2023 and continued strengthening connections between Community Behavioral Health Clinics and existing services. (DY2Q3)
	NH	Plan to add 72-hour follow-up to administrative rules.	Requirement added. Component met as of DY2Q1.
	NM	Plan to leverage peer support workers to assist with follow-up calls and develop a process to include family engagement in post-discharge services for children.	Update schedule is pending Monitoring Protocol approval.
	UT*	Plan to add 72-hour follow-up requirements to MCO contracts.	No updates provided. (DY4Q1)
	VT*	Plan to add a 72-hour follow-up policy for facilities and establish rules and a process to ensure adherence.	Policy implemented. Component now met as of DY4Q3.
	WA*	Plan to add 72-hour follow-up requirements to MCO contracts and administrative code for managed care and FFS beneficiaries.	Component met as of DY2Q3
Strategies to reduce ED LOS (d)	AL	Plan to expand intensive case management program to every county in the state.	No updates provided. (DY1Q4)
	IN*	Plan to pilot crisis stabilization units and monitor provider network capacity.	The state has started a Crisis Stabilization Services pilot program. (DY4Q3)
	MA	Plan to implement a network of Community Behavioral Health Clinics and a new statewide behavioral health admission platform, which will be implemented in two phases. The first phase will allow for more efficient clinical data exchange by connecting EDs to inpatient facilities using the new platform. The second phase will expand inpatient and outpatient service connections across the behavioral health continuum.	State completed Phase 1 and signed a contract with a vendor who will implement the statewide platform in July 2023. (DY2Q3)
	MD	Plan to add Assertive Community Treatment teams in two high-need areas.	Update schedule is pending Monitoring Protocol approval.

Component description	State	Planned activities at baseline	Activity updates during demonstration (most recent quarterly report)[a]
	NH	Plan to increase nonhospital psychiatric beds, implement Critical Time Intervention, expand first-episode psychosis programs, and amend contracts with CMHCs to create new supported housing beds.	The state will focus on all levels of care, utilization, and access to levels and how they impact SMI IMD use as well as ED use. The state aims to reduce ED stays. (DY2Q1)
	NM	Plan to add more peer support workers to emergency departments and implement mobile crisis teams and crisis triage centers to provide alternatives to the emergency department.	Update schedule is pending Monitoring Protocol approval.
Strategies to reduce ED LOS (d) *(cont'd.)*	VT*	Plans to enhance existing strategies and programs by drafting a report on residential capacity across the state, issue a request for proposals to expand peer supports, and create a 10-year plan for a holistic system of care.	Southwestern Vermont Medical Center is conducting a study to ensure that the inpatient psychiatric unit is stabilizing and improving availability of inpatient psychiatric services for children and youth with mental health needs. (DY4Q3)

Source: Approved implementation plans and monitoring reports.

Note: * indicates the state has a demonstration that has been running for longer than two years.

[a] The date in parentheses indicates the most recent monitoring report Part B that we received from the state before February 1, 2024, the cutoff date for this report.

CMHC = community mental health center; DY = demonstration year; ED = emergency department; FFP = federal financial participation; FFS = fee for service; LOS = length of stay; MCO = managed care organization; Q = quarter; RTF = residential treatment facility; SMI = serious mental illness.

Table F.3. Status of planned activities for Milestone 3 components not met before the demonstration period, by state

Component description	State	Planned activities at baseline	Activity updates during demonstration (most recent quarterly report)[a]
Bed tracking (a)	DC*	Plan to assess feasibility of modifying electronic health records to include bed tracking across the District.	No updates provided. (DY4Q3)
	IN*	Plan to expand SUD bed tracking system to include inpatient mental health and crisis stabilization beds.	No updates provided. (DY4Q3)
	MA	Plan to update existing behavioral health tracking system to include centralized real-time bed tracking, which will be implemented in two phases. The second phase will allow for automated updating of provider availability and incorporate the capacity to conduct centralized real-time bed-finding.	State completed Phase 1 and signed a contract with a vendor who will implement the statewide platform in July 2023. (DY2Q3)
	MD	Plan to implement a new bed tracking system.	Updates not yet expected.
	NM	Plan to procure a technology solution that will be implemented in two phases. The second phase will allow for real-time bed finding.	Updates not yet expected.
	OK*	Plan to expand current bed tracking system to include all Medicaid-contracted inpatient mental health facilities.	No updates provided. (DY3Q3)
	UT*	Plan to implement online bed tracker accessible by ED staff, inpatient units, call centers, and mobile crisis teams.	No updates provided. (DY4Q1)
	WA*	Plan to develop bed tracking system and modify MCO contracts and administrative rules to require use of system once implemented.	The state continues to work on the bed tracking system, and incorporates improvements in the crisis system infrastructure including implementation of the 988 emergency hotline (DY2Q3)
Patient assessment tool (b)	AL	Plan to review assessment tools for adults and implement a standardized tool.	No updates provided. (DY1Q4)
	DC*	Plan to develop and issue requirements for MCO providers to use standardized assessment tools (FFS providers have existing tools).	No updates provided. (DY4Q3)
	ID*	Plan to develop requirements for patient assessment through state behavioral health system.	No updates provided. (DY4Q1)
	MD	Plan to roll out components of comprehensive crisis stabilization model that will use the several population-specific patient assessment tools.	Updates not yet expected.
	UT*	Plan to modify managed care contracts to require the use of a patient assessment tool and verify MCO utilization of patient assessment tool.	No updates provided. (DY4Q1)
	VT*	Plan to require use of evidence-based patient assessment tool.	All IMDs now use assessment tool. Component met as of DY4Q3.

Source: Approved implementation plans and monitoring reports.

Note: * indicates the state has a demonstration that has been running for longer than two years.

[a] The date in parentheses indicates the most recent monitoring report Part B that we received from the state before February 1, 2024, the cutoff date for this report.

DY = demonstration year; ED = emergency department; FFS = fee for service; IMD = institution for mental diseases; MCO = managed care organization; Q = quarter; RTF = residential treatment facility; SUD = substance use disorder.

Table F.4. Status of planned activities for Milestone 4 components not met before the demonstration period, by state

Component description	State	Planned activities at baseline	Activity updates during demonstration (most recent quarterly report)[a]
Identification and engagement (a)	AL	Plan to assess the fidelity of existing supported employment services and assess expansion opportunities.	No updates provided.
	DC*	Plan to establish a new reimbursement methodology for emergency psychiatric services and community response teams, and issue rules and policies to establish vocational supported employment for adults with SMI.	Component met as of DY1Q2.
	MA	Plan to implement a tiered sub-capitation payment model to integrate behavioral health into primary care in spring 2023. This new system will offer referral and care coordination with appropriate services.	State launched new Community Behavioral Health Clinics in January 2023 and tiered sub-capitation payment model in April 2023. The state is continuing to implement system wide improvement to support the integration of behavioral health primary care services. (DY2Q3)
	MD	Plan to expand first-episode psychosis programs, behavioral health assisted living, crisis services, and behavioral health urgent care.	Updates not yet expected.
	NM	Plan to implement Phase 2 of primary care integration plan in spring 2023. The plan will operationalize a tiered sub-capitation payment model.	Updates not yet expected.
BH integration in non-specialty settings (b)	AL	Plan to require CMHCs to provide primary care screening and monitoring consistent with the Certified Community Behavioral Health Clinic model.	No updates provided.
	DC*	Plan to support pediatric primary care and behavioral health integration program and identify other opportunities for integration through a strategic planning process.	No updates provided. (DY4Q3)
	IN*	Plan to pursue grant funding to sustain and expand integrated care.	State has started the planning stages of implementing the designation process of certified community behavioral health centers (CCBHCs). The state plans to submit an 1115 waiver for the CCBHC project. (DY4Q3)
	MA	Plan to pursue grant funding to sustain and expand integrated care.	State provided about grant funding for integrated care. The state is continuing to implement system wide improvements to support the integration of behavioral health primary care services. (DY2Q3)
	MD	Plan to explore the collaborative care model.	Updates not yet expected.

Component description	State	Planned activities at baseline	Activity updates during demonstration (most recent quarterly report)[a]
	NM	Plan to implement primary care integration and increase referral and care coordination of SMI/SED individuals and ensure appropriate connection to services.	Updates not yet expected.
	WA*	Plan to collaborate with tribes to support identification of SMI/SED, expand service capacity, and increase integration.	No updates provided. (DY3Q1)
Specialized settings/crisis stabilization (c)	DC*	Plan to change reimbursement methodology to promote trauma-informed services, review findings in state's youth behavioral health reports, and seek grant funding to improve transitions and care integration for transition-age youth and young adults.	Component met as of DY1Q4.
	IN*	Plan to pilot new crisis stabilization units.	As of April 2023, state is in the process of developing a State Plan Amendment for crisis stabilization services, with the goal of creating a new provider enrollment specialty. (DY4Q3)
	MA	Plan to offer services for youth, including access to urgent care, crisis evaluation, intervention in Youth Community Crisis Stabilization services, and ongoing treatment services.	State launched Community Behavioral Health Clinics in January 2023 and plans to expand crisis stabilization services available through Community Behavioral Health Clinics. (DY2Q3)
	MD	Plan to conduct a survey to collect information about providers serving transition-age youth with psychosis and conduct an evaluation of current providers serving individuals with a first episode of psychosis.	Updates not yet expected.
	NH	Plan to expand behavioral health treatment options for youth and young adults and develop a comprehensive Medicaid benefit for at-risk infants and young children.	Updates not yet expected.
	NM	Plan to offer youth-specific evidence-based services in community behavioral health centers, including access to urgent care, crisis evaluation, intervention, and Youth Community Crisis Stabilization services. Plan to support behavioral health integration into pediatric primary care through increased screening capacity and coordination between community behavioral health centers and primary care providers.	Updates not yet expected.
	OK*	Plan to expand community-based assessments.	State has decided not to expand community-based assessments because it plans to implement managed care. (DY3Q3)
	UT*	Plan to expand Stabilization and Mobile Response across the state, increase integration with local providers, and increase behavioral health services at juvenile receiving centers.	No updates provided. (DY4Q1)

Source: Approved implementation plans and monitoring reports.

Note: * indicates the state has a demonstration that has been running for longer than two years.

[a] The date in parentheses indicates the most recent monitoring report Part B that we received from the state before February 1, 2024, the cutoff date for this report.

BH = behavioral health; CMHC = community mental health center; DY = demonstration year; Q = quarter; SED = serious emotional disturbance; SMI = serious mental illness.

Appendix G.
Monitoring Metric Performance

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For annual metrics, the baseline year is either the calendar year (CY) associated with the first demonstration year (DY) (for established quality measures [EQM]) or the first DY (for Centers for Medicare & Medicaid Services [CMS]-constructed metrics), depending on the metric.[40,41] The values in this appendix are reported exactly as provided by the state. The appendix includes all available data prior to the cut-off date, February 1, 2024, regardless of data quality. The most recent data submitted by states is available on Medicaid.gov. A blank cell indicates that the state has not reported data for that measurement period. The appendix does not include data from Alabama because of ongoing data resubmission requests from CMS to improve the state's data quality.

Table G.1. Metric #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	CY 2020	81%	69%	75%
Idaho	CY 2020	63%	65%	58%
Indiana	CY 2020	64%	69%	64%
Oklahoma	CY 2021	59%		
Vermont	CY 2020	74%	75%	68%
Washington	CY 2021	64%	59%	

Table G.2. Metric #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care (PMH-20)[a]

State	Baseline year	Performance year 1
District of Columbia	CY 2020	202.7
Indiana	CY 2020	283.9

[a] Metric #3 has been removed from Version 3.0 of the SMI/SED metrics technical specifications released in September 2021. We do not expect states to report this measure in the future. States were required to report the rate, and data for the numerator and denominator are not reported.

[40] Washington's demonstration began on January 1, 2021, but the state provided data for CY 2020 for all annual metrics. For consistency across states, we will report only data collected during the state's demonstration period and will not include in this appendix Washington's data from CY 2020. We consider the state's data from CY 2021 as its baseline data.

[41] Utah's demonstration began on January 1, 2021, but the state reported baseline data for annual Metrics #2, 4, 7–10, 19a, 19b, 20, 22, 23, 26, 29, 30, and 32–35 by using a measurement period of July 1, 2020, through June 30, 2021. For consistency across states, we will report only data collected during the state's demonstration period and will not include in this appendix Utah's baseline data from July 1, 2020, through June 30, 2021.

Table G.3. Metric #4: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	CY 2020	19%	21%	22%
Idaho	CY 2020	35%	34%	36%
Indiana	CY 2020	25%	28%	26%
Oklahoma	CY 2021	27%		
Vermont	CY 2020	2%	4%	3%
Washington	CY 2021	15%	15%	

Table G.4. Metric #6: Medication Continuation Following Inpatient Psychiatric Discharge

State	Baseline measurement period[a]	Baseline performance	Second measurement period	Second measurement period performance	Third measurement period	Third measurement period performance
District of Columbia	1/1/2020–12/31/2020	73%	1/1/2020–12/31/2021	71%	1/1/2022–12/31/2022	71%
Idaho	1/1/2019–12/30/2020	63%	1/1/2021–12/31/2021	66%	1/1/2022–12/31/2022	65%
Indiana	1/1/2021–12/31/2021	0.64%	1/1/2022–12/31/2022	0.29%		
Oklahoma[b]	1/1/2021–12/31/2021	62%	1/1/2021–12/31/2022	63%		
Utah[c]	1/1/2021–12/31/2021	68%				
Vermont	1/1/2019–12/30/2020	69%	1/1/2021–12/31/2021	54%	1/1/2022–12/31/2022	51%
Washington	1/1/2021–12/31/2021	71%	1/1/2022–12/31/2022	69%		

[a] The measurement period as defined by the technical specification is two calendar years. The values in this table directly reflect what the state reported, regardless of alignment to technical specifications.

[b] The state reported the initial rate for CY 2021, but it plans to report the rate for the complete two-year measurement period in future reports.

[c] Utah reported that its data for CY 2021 had coding errors and that it plans to resubmit data for this metric.

Table G.5. Metric #7: Follow-Up after Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
30-day follow-up				
District of Columbia	CY 2020	72%	69%	83%
Idaho	CY 2020	72%	70%	62%
Indiana	CY 2020	64%	70%	67%
Oklahoma	CY 2021	64%		
Vermont	CY 2020	85%	88%	82%
Washington	CY 2021	83%	82%	
7-day follow-up				
District of Columbia	CY 2020	52%	49%	65%
Idaho	CY 2020	48%	42%	41%
Indiana	CY 2020	41%	48%	39%
Oklahoma	CY 2021	40%		
Vermont	CY 2020	71%	71%	63%
Washington	CY 2021	63%	60%	

Table G.6. Metric #8: Follow-Up after Hospitalization for Mental Illness: Ages 18 and Older (FUH-AD)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
30-day follow-up				
District of Columbia	CY 2020	71%	68%	77%
Idaho	CY 2020	51%	49%	45%
Indiana	CY 2020	42%	54%	47%
Oklahoma	CY 2021	34%		
Vermont	CY 2020	72%	72%	66%
Washington	CY 2021	64%	61%	
7-day follow-up				
District of Columbia	CY 2020	56%	54%	62%
Idaho	CY 2020	32%	32%	29%
Indiana	CY 2020	26%	37%	31%
Oklahoma	CY 2021	19%		
Vermont	CY 2020	55%	56%	48%
Washington	CY 2021	45%	41%	

Table G.7. Metric #9: Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
30-day follow-up				
District of Columbia	CY 2020	10%	11%	54%
Idaho	CY 2020	41%	39%	29%
Indiana	CY 2020	30%	32%	54%
Oklahoma	CY 2021	11%		
Vermont	CY 2020	33%	35%	62%
Washington	CY 2021	32%	40%	
7-day follow-up				
District of Columbia	CY 2020	6%	6%	42%
Idaho	CY 2020	33%	31%	43%
Indiana	CY 2020	20%	21%	37%
Oklahoma	CY 2021	7%		
Vermont	CY 2020	22%	25%	44%
Washington	CY 2021	23%	29%	

Table G.8. Metric #10: Follow-Up after Emergency Department Visit for Mental Illness (FUM-AD)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
30-day follow-up				
District of Columbia	CY 2020	70%	61%	63%
Idaho	CY 2020	74%	74%	35%
Indiana	CY 2020	56%	61%	51%
Oklahoma	CY 2021	51%		
Vermont	CY 2020	75%	73%	75%
Washington	CY 2021	64%	61%	
7-day follow-up				
District of Columbia	CY 2020	58%	50%	51%
Idaho	CY 2020	61%	62%	37%
Indiana	CY 2020	40%	43%	35%
Oklahoma	CY 2021	39%		
Vermont	CY 2020	66%	65%	66%
Washington	CY 2021	52%	49%	

Table G.9. Metric #11: Suicide or Overdose Death within 7 and 30 Days of Discharge from an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries with SMI or SED (count)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
30-day follow-up [a]				
Idaho	CY 2020	0	0	2
7-day follow-up [a]				
Idaho	CY 2020	1	2	8

[a] The District of Columbia did not report expected data for this metric due to reporting issues.

Table G.10. Metric #12: Suicide or Overdose Death within 7 and 30 Days of Discharge from an Inpatient Facility or Residential Treatment for Mental Health among Beneficiaries with SMI or SED (rate)[a]

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
30-day follow-up				
Idaho	CY 2020	0.00%	0.00%	0.06%
7-day follow-up				
Idaho	CY 2020	0.03%	0.06%	0.23%

[a] The District of Columbia did not report expected data for this metric due to reporting issues.

Table G.11. Metric #13: Mental Health Services Utilization–Inpatient (count)

Month	DC	ID	IN	NH	OK	UT	VT	WA
Month 1	356	415	1,399		225	544	174	1,757
Month 2	318	541	1,491		225	539	164	1,715
Month 3	332	548	1,438		219	588	165	2,027
Month 4	307	546	1,068	120	548	562	114	1,806
Month 5	279	494	1,286	126	504	573	126	1,800
Month 6	321	550	1,329	119	418	566	113	1,910
Month 7	314	580	1,564	137	230	589	153	1,647
Month 8	307	541	1,593	112	229	546	137	1,526
Month 9	332	370	1,600	125	226	540	130	1,395
Month 10	274	505	1,638		628	536	148	1,595
Month 11	228	505	1,472		570	475	140	1,558
Month 12	245	619	1,437		477	508	147	1,534
Month 13	262	544	1,292		517	475	145	1,452
Month 14	240	585	1,495		507	476	141	1,528
Month 15	283	581	1,778		517	522	147	1,677
Month 16	271	551	11,690		699	487	156	1,650
Month 17	273	503	11,435		612	483	142	1,732
Month 18	274	532	11,328		478	420	147	1,678
Month 19	279	476	9,196		280	424	115	1,627
Month 20	275	542	9,026		297	544	124	1,816
Month 21	279	497	8,903		331	455	134	1,627
Month 22	279	523	9,662		724	480	118	1,752
Month 23	278	678	9,457		574	501	132	1,763
Month 24	282	524	9,040		349	423	137	1,631
Month 25	219	616	8,684		382	469	95	1,835
Month 26	266	656	8,453		409	403	105	1,825
Month 27	333	577	8,959		384	304	146	1,864
Month 28	318	548	8,855		391		136	
Month 29	318	562	9,042		373		134	
Month 30	304	556	9,078		341		175	
Month 31	261	578	9,196				155	
Month 32	316	566	9,026				150	
Month 33	280	549	8,903				122	
Month 34	285	563	13,514				135	
Month 35	292	530	13,344				143	
Month 36	266	618	13,119				135	
Month 37	288	599	17,920				145	
Month 38	276	663	17,741				140	
Month 39	287	546	18,024				182	
Month 40	327		17,462					
Month 41	342		17,751					
Month 42	330		17,073					

Table G.12. Metric #14: Mental Health Services Utilization–Intensive Outpatient and Partial Hospitalization (count)

Month	DC	ID	IN	NH	OK	UT[a]	VT	WA
Month 1	650	77	22,029		330	18	2,092	972
Month 2	663	87	21,473		314	34	1,988	961
Month 3	615	83	21,150		380	44	1,738	1,125
Month 4	180	112	15,480	79	385	53	304	1,088
Month 5	240	107	14,883	63	361	47	235	1,087
Month 6	294	114	15,866	75	111	48	266	1,195
Month 7	349	117	16,754	62	127	54	342	1,190
Month 8	381	99	17,159	68	134	55	406	1,146
Month 9	449	102	17,064	74	413	49	527	1,047
Month 10	519	133	19,618		354	60	609	1,037
Month 11	513	151	19,438		337	66	537	993
Month 12	512	152	19,560		351	55	503	980
Month 13	521	143	19,529		354	55	611	848
Month 14	534	131	19,750		390	25	556	824
Month 15	662	124	20,627		403	32	639	895
Month 16	658	140	29,037		393	51	634	1,024
Month 17	691	136	29,599		373	51	663	1,051
Month 18	751	136	29,271		116	70	819	980
Month 19	771	171	4,068		141	71	978	972
Month 20	741	185	4,813		137	75	1,111	1,039
Month 21	722	150	5,126		463	76	1,148	999
Month 22	772	149	4,465		445	847	1,259	1,153
Month 23	762	173	4,569		425	873	1,257	1,089
Month 24	733	195	4,067		174	782	1,145	1,038
Month 25	700	177	4,553		151	908	1,123	955
Month 26	750	179	4,482		167	850	1,072	994
Month 27	776	177	5,161		143	918	1,272	1,020
Month 28	759	145	5,108		153		1,297	
Month 29	776	167	5,119		140		1,317	
Month 30	790	152	3,598		380		1,256	
Month 31	786	193	4,068				1,230	
Month 32	754	202	4,813				1,329	
Month 33	749	192	5,126				1,284	
Month 34	785	198	10,165				1,410	
Month 35	834	219	10,634				1,409	
Month 36	828	203	9,779				1,336	
Month 37	859	207	11,244				1,598	
Month 38	821	205	11,666				1,639	
Month 39	751	163	11,560				1,714	
Month 40	756		449					
Month 41	789		496					
Month 42	718		462					

[a] Utah reported that its data for CY 2021 had coding errors and that it plans to resubmit data for this metric.

Table G.13. Metric #15: Mental Health Services Utilization–Outpatient (count)

Month	DC	ID	IN	NH	OK	UT	VT	WA
Month 1	22,329	3,568	9,156		3,805	6,523	17,562	17,129
Month 2	22,014	3,978	8,867		3,423	7,193	16,758	16,720
Month 3	20,434	4,510	8,296		4,108	8,548	16,123	18,546
Month 4	11,868	3,886	4,027	8,454	4,436	8,684	9,015	17,993
Month 5	11,175	3,849	4,372	8,546	4,398	8,597	8,775	17,312
Month 6	11,931	4,053	6,098	8,208	4,465	9,232	9,748	17,418
Month 7	12,742	4,222	6,841	7,472	3,164	9,137	9,760	17,120
Month 8	12,955	4,039	7,203	7,420	3,408	9,501	10,222	16,841
Month 9	13,625	3,945	7,420	7,904	3,414	9,331	11,202	16,333
Month 10	13,727	4,215	7,411		4,844	9,591	11,792	15,471
Month 11	12,916	4,252	6,649		4,797	9,185	11,329	14,789
Month 12	12,730	4,644	6,524		4,656	8,752	10,923	14,473
Month 13	12,357	4,727	5,844		4,401	9,590	11,428	11,853
Month 14	12,515	4,880	5,872		4,214	9,177	11,164	11,574
Month 15	14,119	5,073	6,790		4,695	9,968	12,490	12,635
Month 16	13,910	4,925	25,852		4,684	10,083	11,972	15,254
Month 17	13,870	4,931	26,376		4,499	10,073	12,292	15,247
Month 18	15,310	4,748	26,276		4,376	9,662	12,775	15,235
Month 19	15,126	4,767	23,193		2,958	9,217	12,046	13,281
Month 20	15,754	4,859	24,264		3,287	10,203	12,356	13,668
Month 21	16,792	4,610	24,471		3,161	9,131	13,068	13,169
Month 22	16,912	5,288	21,753		4,254	9,172	13,313	15,276
Month 23	16,957	5,443	21,851		4,224	8,389	13,144	14,859
Month 24	16,514	5,417	20,337		4,063	5,895	12,754	14,019
Month 25	15,802	5,821	21,871		3,222	7,869	12,568	12,074
Month 26	16,868	5,765	21,149		3,203	7,315	12,469	11,941
Month 27	18,045	5,727	24,371		3,398	6,227	13,864	12,604
Month 28	17,966	5,445	24,449		3,237		13,444	
Month 29	18,346	5,748	24,453		3,241		13,521	
Month 30	17,820	5,396	23,493		3,004		13,447	
Month 31	17,027	5,402	23,193				12,300	
Month 32	17,801	5,293	24,264				13,103	
Month 33	18,298	5,152	24,471				13,299	
Month 34	19,204	5,609	52,295				13,809	
Month 35	19,426	5,472	52,674				13,580	
Month 36	18,883	5,649	49,443				13,121	
Month 37	20,106	5,489	58,861				14,380	
Month 38	19,640	5,596	58,521				14,189	
Month 39	20,621	5,284	60,854				14,878	
Month 40	20,574		17,632					
Month 41	19,945		18,789					
Month 42	19,450		17,143					

Table G.14. Metric #16: Mental Health Services Utilization–ED (count)

Month	DC	ID	IN	NH	OK	UT	VT	WA
Month 1	365	14	7,784		13	6	94	501
Month 2	309	23	7,425		7	7	74	450
Month 3	319	18	3,211		5	11	72	584
Month 4	252	23	310	145	8	10	56	506
Month 5	307	22	351	147	8	11	63	530
Month 6	288	23	763	157	15	10	62	643
Month 7	300	30	1,571	167	87	13	74	652
Month 8	293	28	1,764	162	73	8	88	636
Month 9	268	21	2,109	162	82	7	69	580
Month 10	111	28	2,118		4	11	88	555
Month 11	109	33	1,250		10	13	59	467
Month 12	112	28	708		12	6	82	459
Month 13	139	31	1,067		6	7	93	371
Month 14	113	20	1,187		10	11	79	324
Month 15	133	23	1,946		13	11	98	408
Month 16	126	25	6		11	6	102	484
Month 17	129	22	5		10	13	103	489
Month 18	112	29	3		11	9	79	468
Month 19	116	28	3,572		79	8	97	442
Month 20	99	23	4,286		80	9	103	474
Month 21	94	22	4,604		77	10	87	447
Month 22	98	29	4,008		4	10	63	555
Month 23	96	47	4,064		4	9	52	533
Month 24	66	36	3,612		8	9	66	507
Month 25	74	30	4,118		89	26	67	492
Month 26	118	33	3,972		83	17	59	470
Month 27	103	29	4,576		93	15	67	521
Month 28	115	24	1,050		87		70	
Month 29	99	30	1,043		78		66	
Month 30	82	38	631		81		73	
Month 31	101	28	3,572				72	
Month 32	96	25	4,286				71	
Month 33	95	31	4,604				35	
Month 34	98	35	103				67	
Month 35	120	27	90				60	
Month 36	105	38	107				61	
Month 37	132	40	10,608				71	
Month 38	99	53	10,908				65	
Month 39	131	39	10,807				65	
Month 40	118		167					
Month 41	134		193					
Month 42	119		185					

Table G.15. Metric #17: Mental Health Services Utilization–Telehealth (count)

Month	DC	ID	IN	NH	OK	UT	VT	WA
Month 1	146	3,004	313		416	5,226	311	6,051
Month 2	133	2,686	388		463	5,661	348	6,056
Month 3	8,949	2,592	6,091		417	5,676	5,593	6,453
Month 4	17,252	2,926	13,987	4,862	269	5,013	8,419	5,930
Month 5	17,779	2,903	13,991	4,767	244	4,276	8,284	5,605
Month 6	17,951	2,883	13,350	4,768	246	4,038	8,121	5,435
Month 7	18,172	3,072	11,504	4,685	38	3,526	7,688	4,932
Month 8	18,427	3,166	11,446	4,566	49	3,507	7,458	4,781
Month 9	19,556	3,368	10,649	4,735	49	3,256	7,491	4,790
Month 10	19,453	3,118	6,804		240	3,238	7,759	4,413
Month 11	19,884	3,071	3,180		237	3,146	8,146	4,181
Month 12	20,759	2,833	3,281		212	3,093	8,925	4,239
Month 13	21,360	2,583	2,989		248	3,805	9,153	3,349
Month 14	21,794	2,338	2,906		235	3,168	9,264	3,336
Month 15	22,459	2,261	2,919		263	3,071	9,694	3,454
Month 16	22,041	2,093	5,249		236	2,967	9,097	3,809
Month 17	21,980	2,128	4,649		248	2,906	8,507	3,711
Month 18	21,293	2,229	4,316		190	2,694	8,047	3,590
Month 19	20,490	2,268	13,321		36	1,485	6,898	2,775
Month 20	20,385	2,236	13,389		67	1,608	6,734	2,850
Month 21	20,202	2,184	13,060		51	1,596	6,801	2,592
Month 22	20,166	2,756	12,188		170	1,947	6,742	3,118
Month 23	19,948	2,411	11,886		172	1,935	6,788	3,069
Month 24	19,768	2,142	11,539		167	1,603	6,856	2,861
Month 25	21,512	2,336	13,186		71	1,755	8,025	1,986
Month 26	20,651	2,279	13,171		56	1,751	7,746	1,975
Month 27	21,428	2,222	12,283		58	1,595	7,467	2,200
Month 28	21,150	2,157	11,802		52		7,077	
Month 29	21,196	2,162	11,644		58		6,945	
Month 30	21,325	2,009	11,044		37		6,743	
Month 31	21,847	2,012	13,321				6,206	
Month 32	22,553	2,076	13,389				6,353	
Month 33	22,556	2,120	13,060				6,229	
Month 34	23,206	2,253	18,464				6,356	
Month 35	23,524	2,153	18,667				6,388	
Month 36	23,179	2,189	18,503				6,245	
Month 37	23,368	2,095	22,130				6,938	
Month 38	22,477	1,998	20,933				6,670	
Month 39	21,946	1,827	22,149				6,778	
Month 40	21,574		20,631					
Month 41	21,673		20,709					
Month 42	21,468		19,602					

Table G.16. Metric #18: Mental Health Services Utilization–Any Services (count)

Month	DC	ID	IN	NH	OK	UT	VT	WA
Month 1	22,797	5,548	78,148		6,072	10,812	17,762	23,880
Month 2	22,477	5,819	74,457		5,864	11,729	16,973	23,661
Month 3	22,380	6,033	73,311		6,167	12,852	17,154	25,521
Month 4	22,614	5,924	67,976	11,738	5,373	12,583	14,924	24,660
Month 5	22,720	5,932	69,725	11,724	5,304	12,049	14,699	23,957
Month 6	23,024	6,132	75,067	11,506	5,309	12,322	15,187	23,998
Month 7	23,394	6,368	76,683	10,624	3,243	11,866	15,021	22,927
Month 8	23,689	6,271	78,960	10,524	3,474	12,179	15,339	22,302
Month 9	24,750	6,217	80,371	10,979	3,495	11,770	16,233	21,907
Month 10	24,627	6,411	81,069		5,829	12,100	17,022	20,631
Month 11	24,392	6,453	76,839		5,690	11,615	16,781	19,843
Month 12	24,669	6,631	77,735		5,494	11,186	17,044	19,465
Month 13	25,678	6,587	51,774		5,251	12,363	17,757	20,036
Month 14	26,080	6,589	51,214		5,057	11,634	17,621	19,278
Month 15	27,274	6,648	55,578		5,477	12,287	18,995	19,838
Month 16	27,365	6,426	51,797		5,610	14,614	18,242	17,493
Month 17	27,211	6,369	50,828		5,403	14,634	18,191	17,283
Month 18	26,540	6,298	49,541		5,137	13,977	18,174	17,106
Month 19	26,606	6,324	46,599		3,039	10,446	16,799	16,223
Month 20	26,955	6,492	47,974		3,384	11,524	16,942	16,671
Month 21	27,407	6,094	48,042		3,262	10,444	17,570	15,861
Month 22	27,757	7,088	45,008		5,108	11,239	17,873	16,273
Month 23	27,688	7,144	44,901		4,975	10,587	17,799	15,710
Month 24	27,221	7,030	42,417		4,670	7,832	17,436	15,023
Month 25	27,945	7,531	44,922		3,345	9,905	17,721	16,276
Month 26	28,311	7,449	44,016		3,319	9,261	17,627	15,858
Month 27	29,311	7,343	47,538		3,518	8,034	18,770	16,668
Month 28	29,094	7,006	44,402		3,353		18,188	
Month 29	29,201	7,272	44,410		3,357		18,167	
Month 30	28,731	6,899	42,243		3,120		17,925	
Month 31	28,652	6,911	46,599				16,613	
Month 32	29,380	6,792	47,974				17,430	
Month 33	29,833	6,706	48,042				17,574	
Month 34	30,605	7,205	86,785				18,138	
Month 35	31,027	7,051	87,500				17,922	
Month 36	30,217	7,227	83,296				17,372	
Month 37	31,099	7,007	100,404				18,985	
Month 38	30,330	7,085	100,525				18,720	
Month 39	30,051	6,613	103,635				19,324	
Month 40	30,271		52,306					
Month 41	29,907		53,629					
Month 42	29,402		50,568					

Table G.17. Metric #19a: Average Length of Stay (ALOS) in IMDs

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
ALOS for all IMDs and populations				
District of Columbia	1/1/2020–12/31/2020	13.3	12.7	12.6
Idaho	4/1/2020–3/31/2021	8.7	9.3	9.8
Indiana	1/1/2020–12/31/2020	14.7	15.5	8.9
Oklahoma	1/1/2021–12/31/2021	9.4	8.7	
Vermont	1/1/2020–12/31/2020	15.4	14.3	100.1
Washington	1/1/2021–12/31/2021	14.4	13.3	
ALOS among short-term stays				
District of Columbia	1/1/2020–12/31/2020	11.2	11.1	11.3
Idaho	4/1/2020–3/31/2021	8.5	9.0	9.2
Indiana	1/1/2020–12/31/2020	14.5	15.0	7.2
Oklahoma	1/1/2021–12/31/2021	9.3	8.6	
Vermont	1/1/2020–12/31/2020	14.1	12.8	12.2
Washington	1/1/2021–12/31/2021	11.6	10.7	
ALOS among long-term stays				
District of Columbia	1/1/2020–12/31/2020	222.8	324.0	326.7
Idaho	4/1/2020–3/31/2021	64.4	73.1	78.1
Indiana	1/1/2020–12/31/2020	79.3	15.1	168.2
Oklahoma	1/1/2021–12/31/2021	73.2	143.3	
Vermont	1/1/2020–12/31/2020	111.4	95.2	13.6
Washington	1/1/2021–12/31/2021	106.3	113.2	

Table G.18. Metric #19b: Average Length of Stay (ALOS) in IMDs Receiving FFP

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
ALOS for all IMDs and populations				
District of Columbia	1/1/2020–12/31/2020	13.3	12.7	12.6
Idaho	4/1/2020–3/31/2021	8.7	9.3	9.8
Indiana	1/1/2020–12/31/2020	27.0	15.5	7.3
Oklahoma	1/1/2021–12/31/2021	9.4	8.7	
Vermont	1/1/2020–12/31/2020	14.2	13.3	11.0
Washington	1/1/2021–12/31/2021	14.4	13.3	
ALOS among short-term stays				
District of Columbia	1/1/2020–12/31/2020	11.2	11.1	11.3
Idaho	4/1/2020–3/31/2021	8.5	9.0	9.2
Indiana	1/1/2020–12/31/2020	14.5	15.0	7.0
Oklahoma	1/1/2021–12/31/2021	9.3	8.6	
Vermont	1/1/2020–12/31/2020	14.1	12.8	11.0
Washington	1/1/2021–12/31/2021	11.6	10.7	
ALOS among long-term stays				
District of Columbia	1/1/2020–12/31/2020	222.8	324.0	326.7
Idaho	4/1/2020–3/31/2021	64.4	73.1	78.1
Indiana	1/1/2020–12/31/2020	1,214.1	15.1	105.3
Oklahoma	1/1/2021–12/31/2021	73.2	143.3	
Vermont	1/1/2020–12/31/2020	79.0	100.4	
Washington	1/1/2021–12/31/2021	106.3	113.2	

Table G.19. Metric #20: Beneficiaries with SMI/SED Treated in an IMD for Mental Health

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	1/1/2020–12/31/2020	887	1,030	1,063
Idaho	4/1/2020–3/31/2021	1,972	2,329	2,376
Indiana	1/1/2020–12/31/2020	4,337	4,796	6,384
Oklahoma	1/1/2021–12/31/2021	3,231	3,056	
Vermont	1/1/2020–12/31/2020	1,467	1,499	1,467
Washington	1/1/2021–12/31/2021	2,554	3,307	

Table G.20. Metric #21: Count of Beneficiaries with SMI/SED (monthly)

Month	DC	ID	IN	NH	OK	UT	VT	WA
Month 1	37,649	12,800	56,551		10,994	13,409	27,426	19,225
Month 2	37,192	13,120	56,991		10,696	13,928	28,405	18,921
Month 3	37,306	13,494	57,631		11,400	14,839	28,343	20,549
Month 4	37,182	13,843	56,841	15,526	11,821	14,676	25,354	19,688
Month 5	36,893	14,160	58,130	15,506	11,555	14,322	25,542	19,237
Month 6	37,059	14,564	59,741	15,152	11,718	14,522	24,628	19,318
Month 7	37,277	14,847	60,429	14,292	3,478	14,122	24,156	18,467
Month 8	37,406	15,167	60,529	14,073	3,723	14,290	24,403	17,956
Month 9	37,506	15,092	60,296	14,754	3,719	13,904	28,458	17,637
Month 10	36,251	15,350	59,156		12,246	14,264	29,566	1,837
Month 11	36,349	15,546	57,704		12,140	13,981	29,014	1,794
Month 12	36,497	15,963	57,081		11,846	13,660	27,027	1,776
Month 13	36,698	16,340	46,462		11,595	14,722	28,554	
Month 14	36,879	16,652	46,820		11,250	14,039	30,585	
Month 15	37,309	16,719	47,824		11,896	14,566	32,660	
Month 16	38,002	16,791			11,978	14,614	31,796	12,461
Month 17	38,432	16,884			11,818	14,634	31,616	12,330
Month 18	38,776	16,905			11,639	13,977	28,624	12,303
Month 19	39,450	16,877	147,075		3,375	13,108	26,608	11,548
Month 20	39,702	16,839	148,464		3,703	13,956	28,001	11,772
Month 21	39,937	16,802	146,978		3,614	13,083	29,647	11,484
Month 22	40,291	21,756	127,443		11,035	13,550	31,041	11,713
Month 23	40,307	21,535	127,285		10,875	12,997	30,923	11,117
Month 24	40,183	21,434	125,963		10,611	10,412	29,992	10,894
Month 25	40,404	21,113	85,819		3,724	12,201	28,473	11,804
Month 26	40,514	21,001	85,612		3,706	11,546	30,402	11,563
Month 27	40,384	20,875	87,420		3,865	9,929	32,042	12,190
Month 28	40,720	20,575	213,548		3,722		31,473	
Month 29	40,775	20,471	213,610		3,689		31,162	
Month 30	40,638	20,338	193,620		3,466		27,811	
Month 31	40,707	20,432	214,645				26,035	
Month 32	40,570	20,500	214,693				28,581	
Month 33	40,601	20,514	196,044				28,012	
Month 34	41,182	20,872	184,100				31,264	
Month 35	41,434	21,049	184,370				30,810	
Month 36	41,472	21,105	184,288				29,084	
Month 37	42,064	20,760	124,333					
Month 38	42,151	20,534	123,036					
Month 39	42,221	19,360	127,682					
Month 40	42,498		120,922				32,224	
Month 41	42,604		124,839				32,817	
Month 42	42,471		115,195				28,409	

Table G.21. Metric #22: Count of Beneficiaries with SMI/SED (annually)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	1/1/2020–12/31/2020	48,867	50,679	53,534
Idaho	4/1/2020–3/31/2021	29,271	32,283	31,330
Indiana	1/1/2020–12/31/2020	70,961	159,102	313,008
Oklahoma	1/1/2021–12/31/2021	19,085	23,565	
Vermont	1/1/2020–12/31/2020	63,543	70,285	70,900
Washington	1/1/2021–12/31/2021	39,428	42,611	

Table G.22. Metric #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (HPCMI-AD) [a]

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
Indiana	CY 2020		0.82%	0.75%
Oklahoma	CY 2021	72%		
Vermont	CY 2020	54%	47%	41%
Washington	CY 2021	96%		

[a] The District of Columbia. Idaho, Indiana, and Oklahoma did not report expected data for this metric due to reporting issues.

Table G.23. Metric #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries with SMI[a]

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	CY 2020	89%	88%	86%
Idaho	CY 2020	100%	100%	99%
Indiana	CY 2020		94%	94%
Oklahoma	CY 2021	53%		
Vermont	CY 2020	96%	81%	96%
Washington	CY 2021	95%	95%	

[a] One state (Indiana) did not report expected data for this metric due to reporting issues.

Table G.24. Metric #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
Percentage of children and adolescents on antipsychotics who received blood glucose testing				
District of Columbia	CY 2020	40%	40%	37%
Idaho	CY 2020	39%	44%	46%
Indiana	CY 2020	44%	54%	49%
Oklahoma	CY 2021	42%		
Vermont	CY 2020	44%	51%	47%
Washington	CY 2021	51%	51%	
Percentage of children and adolescents on antipsychotics who received cholesterol testing				
District of Columbia	CY 2020	27%	26%	25%
Idaho	CY 2020	16%	17%	18%
Indiana	CY 2020	29%	33%	30%
Oklahoma	CY 2021	20%		
Vermont	CY 2020	28%	27%	25%
Washington	CY 2021	29%	27%	
Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing				
District of Columbia	CY 2020	24%	24%	24%
Idaho	CY 2020	14%	16%	18%
Indiana	CY 2020	27%	32%	28%
Oklahoma	CY 2021	19%		
Vermont	CY 2020	28%	26%	24%
Washington	CY 2021	27%	26%	

Table G.25. Metric #30: Follow-Up Care for Adult Medicaid Beneficiaries Who Are Newly Prescribed an Antipsychotic Medication

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	CY 2020	78%	75%	76%
Idaho	CY 2020	70%	69%	68%
Indiana	CY 2020		138%	64%
Oklahoma	CY 2021	70%	70%	
Utah[a]	CY 2020	76%	74%	
Vermont	CY 2020	74%	71%	69%
Washington	CY 2021	67%	64%	

[a] Utah submitted EQM metric data with a measurement period of July 1, 2020, through June 30, 2021. Because this measurement period is not a calendar year, these data are not aligned with the SMI/SED technical specifications and are unusable for analyses.

Table G.26. Metric #32: Total Costs Associated with Mental Health Services among Beneficiaries with SMI/SED–Not Inpatient or Residential

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	1/1/2020–12/31/2020	$206,331,348	$243,753,431	$296,568,520
Idaho	4/1/2020–3/31/2021	$44,891,867	$48,528,958	$47,958,505
Indiana	1/1/2020–12/31/2020	$96,521,128	$265,820,951	$432,335,746
Oklahoma	1/1/2021–12/31/2021	$146,417,645	$137,291,238	
Utah[a]	1/1/2021–12/31/2021	-	$15,951,432	
Vermont	1/1/2020–12/31/2020	$261,354,862	$284,288,540	$306,336,665
Washington	1/1/2021–12/31/2021	$163,205,646	$160,523,446	

[a] Utah reported that its data for performance years 1 through 2 had coding errors and that it plans to resubmit data for this metric. We exclude data from performance year 1 from this table because the state-reported measurement period began before the demonstration start date.

Table G.27. Metric #33: Total Costs Associated with Mental Health Services among Beneficiaries with SMI/SED–Inpatient or Residential

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	1/1/2020–12/31/2020	$75,110,268	$75,959,613	$79,307,350
Idaho	4/1/2020–3/31/2021	$84,659,924	$84,045,110	$91,831,512
Indiana	1/1/2020–12/31/2020	$251,923,572	$234,208,437	$395,347,381
Oklahoma	1/1/2021–12/31/2021	$797,164	$3,538,115	
Utah[a]	1/1/2021–12/31/2021	-	$22,833,234	
Vermont	1/1/2020–12/31/2020	$65,862,806	$34,284,893	$57,332,984
Washington	1/1/2021–12/31/2021	$22,638,242	$20,646,619	

[a] Utah reported that its data for performance years 1 through 2 had coding errors and that it plans to resubmit data for this metric. We excluded data from performance year 1 from this table because the state-reported measurement period began before the demonstration start date.

Table G.28. Metric #34: Per Capita Costs Associated with Mental Health Services among Beneficiaries with SMI/SED–Not Inpatient or Residential

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	1/1/2020–12/31/2020	$4,222.30	$4,809.75	$5,539.82
Idaho	4/1/2020–3/31/2021	$1,510.54	$1,503.53	$1,530.75
Indiana	1/1/2020–12/31/2020	$1,360.20	$1,670.76	$1,381.23
Oklahoma	1/1/2021–12/31/2021	$1,931.74	$3,440.24	
Utah[a]	1/1/2021–12/31/2021	-	$1,012.47	
Vermont	1/1/2020–12/31/2020	$4,113.04	$189,652.13	$142.34
Washington	1/1/2021–12/31/2021	$4,139.33	$3,767.18	

[a] Utah reported that its data for performance years 1 through 2 had coding errors and that it plans to resubmit data for this metric. We excluded data from performance year 1 from this table because the state-reported measurement period began before the demonstration start date.

Table G.29. Metric #35: Per Capita Costs Associated with Mental Health Services among Beneficiaries with SMI/SED–Inpatient or Residential

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	1/1/2020–12/31/2020	$1,537.03	$1,498.84	$1,481.44
Idaho	4/1/2020–3/31/2021	$2,848.60	$2,603.15	$2,931.10
Indiana	1/1/2020–12/31/2020	$3,550.17	$1,472.06	$1,263.06
Oklahoma[a]	1/1/2021–12/31/2021	$112.64	$769.81	
Utah[a]	1/1/2021–12/31/2021	-	$1,449.27	
Vermont	1/1/2020–12/31/2020	$1,036.51	$22,871.84	$39,081.79
Washington	1/1/2021–12/31/2021	$574.17	$484.54	

[a] Utah reported that its data for performance years 1 through 2 had coding errors and that it plans to resubmit data for this metric. We excluded data from performance year 1 from this table because the state-reported measurement period began before the demonstration start date.

Table G.30. Metric #36: Grievances Related to Services for SMI/SED[a]

Quarter	DC	IN	NH	OK	UT[b]	WA
Quarter 1				0		5
Quarter 2				0		1
Quarter 3	1					2
Quarter 4	1	1		0	16	56
Quarter 5	14	4	0		51	92
Quarter 6	12	3			36	0
Quarter 7	2	1		0	45	0
Quarter 8	13	4		0	33	0
Quarter 9	3	0		0	59	0
Quarter 10	18	9		0		
Quarter 11	15	2		0		
Quarter 12	10	2				
Quarter 13	4	2				
Quarter 14	4	0				
Quarter 15	1	2				

[a] The District of Columbia, Idaho, Indiana, Oklahoma, and Vermont did not report expected data for this metric due to reporting issues.

[b] Utah reported that its data for quarters 1 through 9 had coding errors and that it plans to resubmit data for this metric.

Table G.31. Metric #37: Appeals Related to Services for SMI/SED [b]

Quarter	DC	IN	OK	UT[a]	WA
Quarter 1			0		26
Quarter 2			0		39
Quarter 3	0				32
Quarter 4	0	36	0	64	19
Quarter 5	3	35		39	30
Quarter 6	1	45		29	38
Quarter 7	0	35	0	33	46
Quarter 8	0	78	0	48	26
Quarter 9	0	81	0	28	25
Quarter 10	0	58	0		
Quarter 11	1	45	0		
Quarter 12	0	71			
Quarter 13	2	98			
Quarter 14	1	78			
Quarter 15	0	98			

[a] Utah reported that is data for quarters 1 through 9 had coding errors and that it plans to resubmit data for this metric.

[b] Five states (DC, ID, IN, OK, VT) did not report expected data for this metric due to reporting issues

Table G.32. Metric #38: Critical Incidents Related to Services for SMI/SED [b]

Quarter	DC	IN	OK	UT[a]	WA
Quarter 1		651	47		27
Quarter 2		806	16		29
Quarter 3		658			26
Quarter 4	171	1,136	6		20
Quarter 5	164	673		6	28
Quarter 6	137	458		6	51
Quarter 7	128	831	0	4	55
Quarter 8	169		8	5	41
Quarter 9	192		5	5	76
Quarter 10	99	784			
Quarter 11	127	957	4		
Quarter 12	151	662			
Quarter 13	127	915			
Quarter 14		742			
Quarter 15	169	781			

[a] Due to coding errors, Utah reported incorrect data for quarters 1 through 9 and plans to resubmit data for this metric.

[b] Five states (DC, ID, IN, OK, VT) did not report expected data for this metric due to reporting issues.

Table G.33. Metric #39: Total Costs Associated with Treatment for Mental Health in an IMD among Beneficiaries with SMI/SED

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	1/1/2020–12/31/2020	$12,455,993	$14,631,788	$17,404,203
Idaho	4/1/2020–3/31/2021	$0	$1,100	$0
Indiana[a]	1/1/2020–12/31/2020	NR	NR	NR
Oklahoma	1/1/2021–12/31/2021	$26,990,751	$12,807,516	
Vermont	1/1/2020–12/31/2020	$55,822,726	$29,245,597	$5,504,804
Washington	1/1/2021–12/31/2021	$17,282,707	$18,838,718	

[a] Indiana's data for years 1 – 3 are listed as "NR," as the state asked for data to be removed since certain residential facilities were incorrectly included in the metric totals.

Table G.34. Metric #40: Per Capita Costs Associated with Treatment for Mental Health in an IMD among Beneficiaries with SMI/SED

State	Baseline year	Performance year 1	Performance year 2	Performance year 3
District of Columbia	1/1/2020–12/31/2020	$14,042.83	$14,205.62	
Idaho	4/1/2020–3/31/2021	$0.00	$0.47	$0.00
Indiana[a]	1/1/2020–12/31/2020	NR	NR	NR
Oklahoma	1/1/2021–12/31/2021	$8,353.68	$3,611.82	
Vermont	1/1/2020–12/31/2020	$38,604.93	$19,840.98	$3,202.33
Washington	1/1/2021–12/31/2021	$6,766.92	$5,696.62	

[a] Indiana's data for years 1-3 are listed as "NR," as the state asked for data to be removed since certain residential facilities were incorrectly included in the metric totals.

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