SALT LAKE COUNTY

The Evolving Landscape of Behavioral Health Services in Salt Lake County

SALT LAKE COUNTY DIVISION OF BEHAVIORAL HEALTH SERVICES

February 2, 2021

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Executive Summary

Access to mental health and substance use disorder services are an integral part in addressing homelessness, suicide, and drug overdose fatalities in Utah, topics that are top-of-mind to many policy makers in Utah. Yet, the landscape of behavioral health services can be complicated and sometimes overwhelming to understand. This paper seeks to provide the reader a high-level digestible view of the significant gaps that have existed in services in the past, the reasons for these gaps, what was done to address the needs during this period and the seismic shifts that began occurring in 2017 that have resulted in an unprecedented expansion of services in Salt Lake County. This effort more than tripled the capacity of some services, and has led to "openings as needed", rather than long wait lists, in certain areas such as residential treatment in substance use disorder (SUD) settings.

Unprecedented expansions of Medicaid and services are accompanied by first of its kind challenges in accessing and reporting data. With no oversight or view into the data for the expansion populations, no longer can county data (reported to the state) solely be relied upon to give a full or accurate picture. Understandably, state auditors, analysts and legislators are finding themselves grappling with understanding the new streams of funding and searching for an accurate accounting of outcomes to inform policy.

Additionally, while analyzing data, it is important to consider outside influences such as the mass arrests that began in August 2017 as Operation Rio Grande rolled out, the Opioid Epidemic that swept our state and nation, the housing affordability crisis, a behavioral health workforce shortage, and now the impacts of COVID-19. This paper provides a high-level timeline and summary of these events.

Having a firm grasp on COVID-19 impacts to behavioral health settings will be imperative for policy makers moving forward. Changes in the criminal justice system led to reduced treatment referrals, policies to address quarantine and isolation protocols in congregate behavioral health settings resulted in decreased capacity, all as providers experienced unusual strains on the workforce. As examples, the capacity of the County's men's detox program dropped initially to 27% of normal and operates today at 73% capacity, while the largest provider of SUD residential services dropped initially to 50% and today remains at approximately 70% of pre-pandemic levels. The reverberations from COVID-19 responses will be felt for many years to come and should be expected to result in deviations in data for: numbers served, connections to employment, housing, and other significant variables. Last, while the 2020 state budget cuts (related to COVID-19) left harmless the funding to implement a new non-refusal receiving center in Salt Lake County, funding for 2020 House Bill 35 was cut, which resulted in a loss of 30 new Utah State Hospital beds. A loss sorely felt statewide by providers and residents.

In summary, incredible advancements have been made in recent years, and although 2020 presented unforeseen challenges, it also brought hope and opportunities through expanded Medicaid and services. As the workforce shortage eases, and if funding continues for services outside of Medicaid (such as housing, milieu, drug testing, etc.), and as vaccines become widely distributed, the future looks bright.

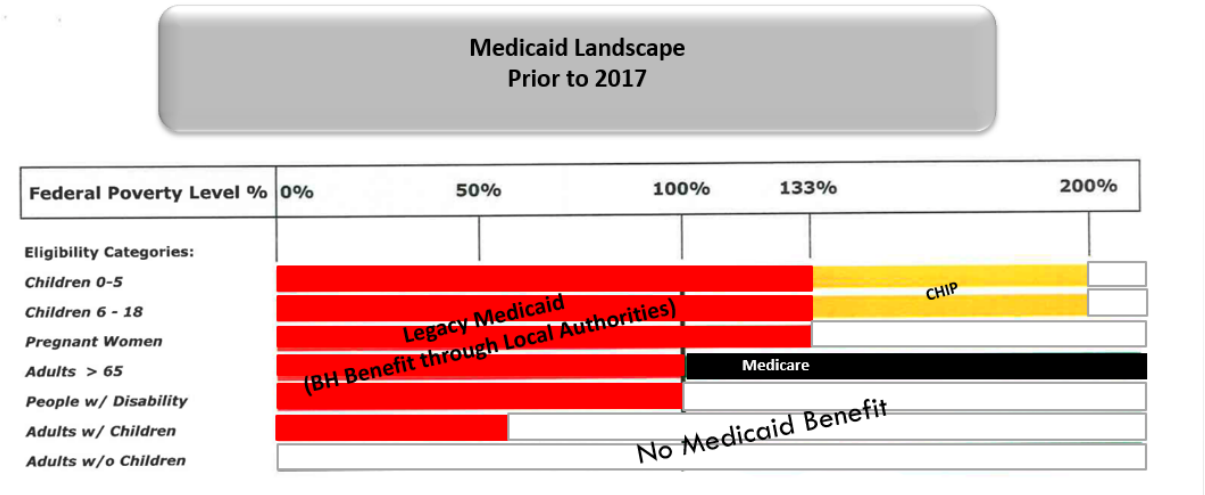
Background

Seismic shifts in funding and access to behavioral health services in Salt Lake County have occurred in recent years. Traditionally, especially prior to 2017, the largest source of funding available for these services focused on individuals with serious mental illness, through Medicaid. This occurred because an acute substance use disorder did not qualify an individual for disability Medicaid. For every Medicaid dollar spent, approximately 70% was federally funded, with the remaining 30% provided by a combination of state general fund and county general fund. This Medicaid plan is now referred to as "Legacy Medicaid". Counties manage the behavioral health (BH) benefit for this plan through a prepaid at-risk contract with the State Medicaid Office.

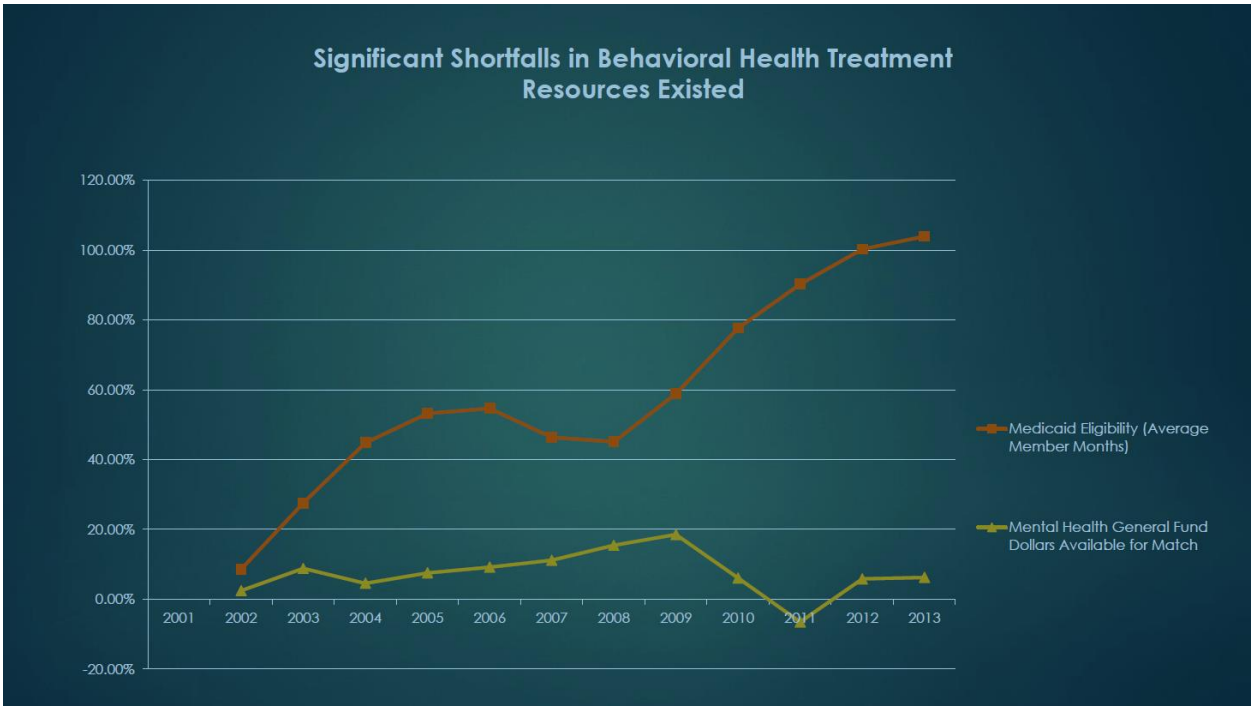
Even though Salt Lake County overmatched the state general fund dollars they received, the remaining funding for the uninsured or underinsured population (i.e., non-Medicaid) was a small fraction to meet the needs of this population, largely low-income individuals with substance use disorders.

Counties are required by statute to match the state general fund dollars they receive for behavioral health services (mental health and substance use disorder services), at a rate of 20%. Salt Lake County has consistently overmatched this requirement due to strong support from the county council and mayor who believe strongly in connecting residents to care, rather than the likely alternative of incarceration or hospitalization. Yet, individuals in need of residential substance use disorder (SUD) services found themselves waiting 6-9 months for an opening.

In the graph below, please reference the bottom line "Adults w/o Children" (without dependent children) as an example of the uninsured/underinsured population with a significant rate of BH conditions and criminal justice involvement. Low-income, non-parenting adults, often homeless and suffering with substance use disorders.



Budget cuts during the recession widened "the gap" just as the Opioid Crisis began to emerge in 2009, leading to a health and homeless crisis in following years. As the numbers of Medicaid eligibles increased, the funding did not. State general fund dollars increased in later years, but the gap remained large.



Understanding the gap in prior years and even more so after the recession, and wanting to serve as many individuals as possible, the Division of Behavioral Health Services (DBHS) worked to implement programs with an eye towards diversion from jails and hospitals, such as the University of Utah Crisis Line, Warm Line, Mobile Crisis Outreach Teams and Receiving Center, to connect individuals to care early, prevent loss of housing and employment, and avoid more costly levels of care to expand the reach of these dollars. Social detox programming offered individuals who had been picked up for public intoxication an alternative to jail and a safe environment focused on connection to treatment and recovery. A jail diversion outreach team was implemented, and a men's dual-diagnosis residential facility soon after, both connecting severely mentally ill individuals to treatment. The first Assertive Community Treatment (ACT) Team to SAMHSA fidelity was implemented, designed for severely mentally ill (SMI) individuals, commonly known as a hospital without walls, bringing a multidisciplinary team to where the client is. DBHS also funded housing projects to further support the success of these populations. Later studies would show significant reductions in jail recidivism for those housed within these programs.

During this period, even with this gap in funding, behavioral health programming presented through Salt Lake County's Sequential Intercept Model [1](SAMHSA's GAINS Center gold standard), was requested nationally and from the White House, and drew representatives from other states to tour local programs. These programs were designed to divert individuals with BH conditions from the criminal

[1] https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

justice system at numerous intercepts (i.e., emergency services, jail, courts, reentry and in the community). When visiting counties learned of Salt Lake County's overmatch, they were often left wondering how their counties could replicate this model. *Please reference the current Sequential Intercept Model in Attachment I, program descriptions are available upon request.*

It was a great model, but not to scale for the SUD population, something that Medicaid Expansion could remedy.

In 2014, as states were given the option to expand Medicaid, DBHS began in earnest to educate and advocate for a Utah model. Research showed that individuals in jails were expected to shift from ~90% uninsured to ~90% *insured*, should the state expand. Approximately 30% of the total expansion population was anticipated to have a behavioral health condition, equating to 18,000 individuals in Salt Lake County, essentially closing the gap. Estimates were made of behavioral health savings that could be enjoyed should the state expand and shared widely with policy makers.

Changing Policies and Funding (2015 – present)

2015

An all-hands-on-deck approach, with braided funding (federal, state and county), allowed several new initiatives to be launched.

- **The First Salt Lake County jail-based Medication-Assisted Treatment (MAT) program** – this program began in 2015, as an evidence-based treatment for individuals with Opioid Use Disorders (OUDs). Only one of the three FDA approved medications was offered, but it was innovative in its time, and a great start. State and County funding made this possible. This program showed a 71% reduction in jail recidivism when comparing one-year prior and one-year post.
- **The Justice Reinvestment Initiative** - the Justice Reinvestment Initiative passed, with a focus on connecting offenders to treatment, but the intended funding mechanism for treatment, Healthy Utah (the governor's Medicaid Expansion plan), did not pass the House. Counties instead received limited dollars, *meeting only a fraction of the need*. With these dollars used as seed dollars, a combination of state, federal and county funding supported two new highly successful programs called the Intensive Supervision Probation (ISP) Program, and CORE 2 a 16-bed women's residential program for severely mentally ill offenders (and other smaller initiatives), that yielded impressive reductions in recidivism (85.8% and 92.5% respectively). ISP later went on to win awards, including the National Association of Counties Achievement Award.

  These programs were highly successful and needed, but due to funding limitations, served only a small fraction of the criminal justice involved population.

2016

- **Legislative support for a Targeted Adult Medicaid Waiver** - although legislative support was not there for a full Medicaid Expansion, in the spring of 2016 a bill passed for a smaller Targeted

Adult Medicaid (TAM) expansion that focused on very low-income individuals with behavioral health conditions, earning less than $50/month. If approved by CMS (at the federal level), this waiver would also provide the opportunity to serve individuals with SUDs in programs with more than 16 beds through Medicaid funding. Although increasing the number of individuals eligible for Medicaid was important, allowing providers to implement programs in this fashion, with this type of economy of scale, would be the key to an impressive expansion of services. The TAM waiver was submitted, and the state began waiting for CMS approval. Approval and implementation would take more than a year, with implementation occurring in November 2017.

- **Health & Safety Crisis** - at the same time, a health and safety crisis brewed as the number of homeless individuals in Salt Lake City grew in tandem with an affordable housing crisis and the Opioid Epidemic as Utah ranked 7th in the nation for overdose deaths.
- **Operation Diversion** - Salt Lake County, in partnership with Salt Lake City, made an unprecedented attempt to address the problem, referred to as *Operation Diversion*. Utilizing one-time dollars, Salt Lake County DBHS funded approximately 60 additional SUD residential beds (including detoxification beds), MAT services, and additional outpatient services.

  Through this project a temporary pop-up receiving center was set up where a person was booked, received legal advice from a legal defender on what to expect, then after receiving a risk/need assessment, and an assessment for placement into behavioral health services, they ended by meeting with both the district attorney and legal defender's office, and entered into a voluntary diversion agreement. Under this agreement, no charges would be filed as long as the person was willing to enter into treatment that day. These individuals were then provided transportation directly to a treatment provider, most making a first stop at a MAT treatment facility to limit the impacts of withdrawal and enhance treatment engagement. This effort occurred three times in 2016.

  After the three operations ended, the Salt Lake City Police Department Social Work Program was given authority to make voluntary referrals from the Rio Grande area, which quickly consumed the remaining capacity. The project was scheduled to end on March 31st, 2017, but fortunately Salt Lake County, Salt Lake City, and CCJJ came forward with enough additional one-time funding to extend the program for an additional period. Though many benefited from this effort, and the one-time dollars were substantial (millions), the homeless crisis continued, barely addressing the need for services.
- **New Medication-Assisted Treatment Programs** - community MAT programing was expanded in Salt Lake City to support individuals with Opioid Use Disorders, and two new clinics opened in Murray and West Jordan through federal State Targeted Response dollars, to address hot spots for Opioid overdose deaths and emergency department encounters.
- **Justice Reinvestment Initiative** - additional JRI funding was allocated enabling the expansion of the ISP program, drug court treatment, and the hiring of a licensed mental health therapist housed within the UPD offices, co-responding with law enforcement to mental health crises within the community, and providing individualized follow-up. This program serves the cities of

Taylorsville, Kearns, Magna, Riverton, Holladay, Millcreek, Midvale, Canyons, Herriman, and White City. These dollars, while appreciated, continued to serve only a small fraction of the criminal justice population.

2017

- **Operation Rio Grande** - finally, in August of 2017, unable to curb the crisis in the Rio Grande area of Salt Lake City with one-time dollars, the state, in collaboration with the city and county, launched Operation Rio Grande (ORG). A portion of inmates in the Salt Lake County jail were moved to another jail to make space for the surge in arrests, initially with no funding for additional treatment. The Lt. Governor, Senate President, House Speaker, city and county mayors, SL Co District Attorney, SL Co Behavioral Health Director and others can be seen below, in one of many meetings that occurred over time.

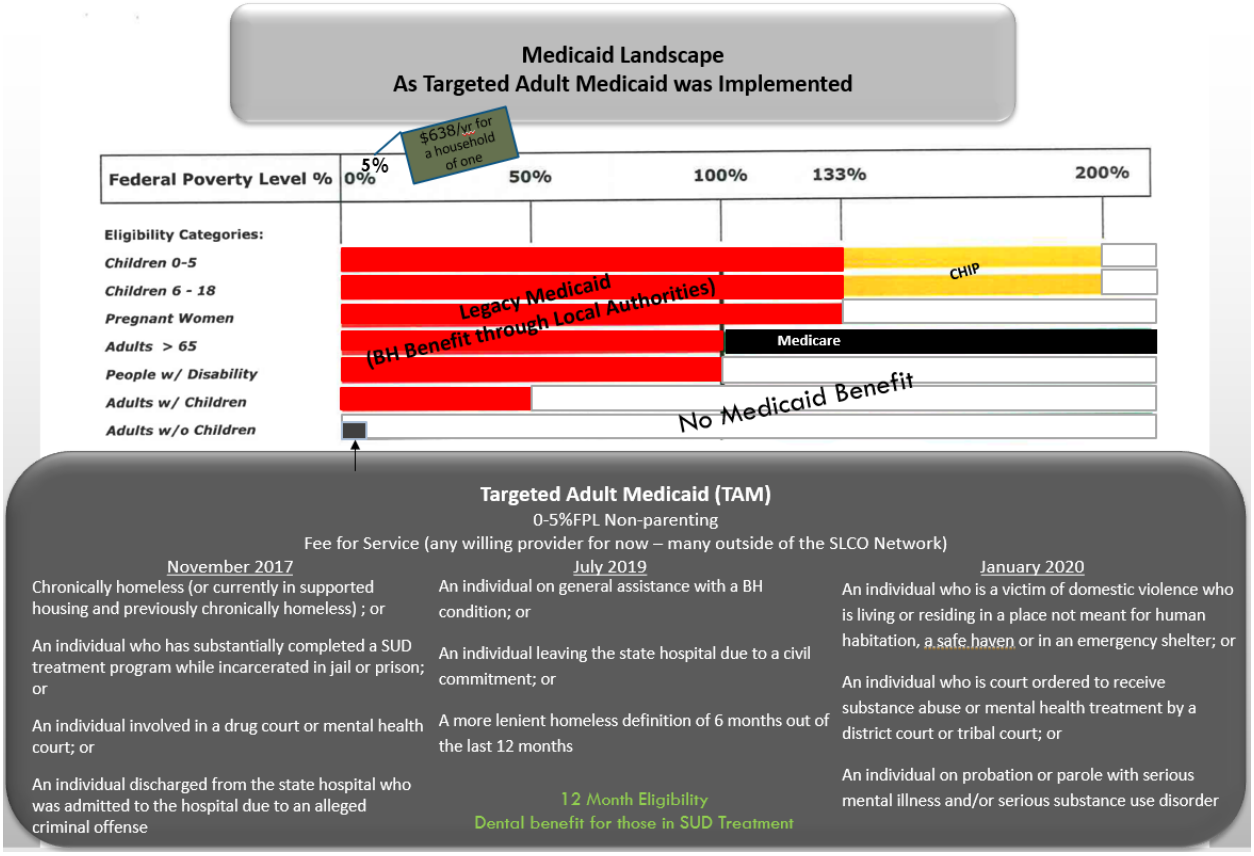
- **Targeted Adult Medicaid Waiver** - fortunately, in November of 2017, the TAM waiver was approved. This waiver dovetailed nicely with the low-income homeless population in the Rio Grande area, many suffering with mental health and substance use disorders. Prior to this waiver's implementation, DBHS' network of providers had ~170 SUD residential beds. **Today more than 550 exist**. As reliable ongoing funding became available, community treatment providers responded in a great way, **more than tripling residential capacity**, while also expanding other levels of care. Additional services were added outside of the Salt Lake County network of providers, exact numbers are unknown.

  This waiver had immense and long-reaching impacts on the behavioral health system, as it allowed an individual to remain eligible for a 1-year period and allowed for Medicaid reimbursement for SUD services provided in programs with more than 16 beds, the latter

supporting expansion in a very great way. The impact of this change, referred to as an IMD (Institution for Mental Diseases) waiver, was a revolutionary change in service delivery and/or reimbursement, allowing providers to quickly triple capacity, and still exists today as an integral piece of service delivery. Rep Dunnigan, the sponsor of this bill, would later receive an award for his outstanding efforts in the behavioral health field.

This Medicaid plan is NOT managed by counties. It is fee-for-service (any willing provider) and managed directly by the State Medicaid Office (lending DBHS no view into the data for this population). DBHS continues to fund this population for non-Medicaid reimbursable services such as milieu (room and board while in residential treatment), drug testing, sober living housing, bus passes, work clothes, etc., when receiving services through a county contracted provider.

Please reference the gray boxes in the graph below, for further information on the populations that qualify for TAM, and the ways in which the criteria expanded through the years.



- **Sober Living Program** - finally, in December 2017, with funding through the State Division of Substance Abuse and Mental Health (DSAMH) and the Department of Workforce Services (DWS), the County implemented a highly successful Sober Living Program. This program is

administered through DBHS, and to date has served more than 1,500 individuals. Individuals in this program demonstrate an 82.1% reduction in recidivism and an ~90% rate of negative drug tests.

This program supplemented an already active housing effort that houses hundreds of individuals annually with mental health or substance use disorders. These programs include permanent supportive housing units and are a combination of voucher-based or master leased units serving individuals with mental illness or substance use disorders. Some are specifically tailored to meet the needs of severely mentally ill individuals discharging from the state hospital. In-home BH case management is required by treatment providers for admittance into these programs. Funding for these programs runs in the millions.

2018

- **Expansion of BH Services** - providers in Salt Lake County began to respond to the expansion of TAM almost immediately, bringing the Speaker of the House, Rep Dunnigan, and Mayor McAdams to openings of new facilities expanding access to SUD residential facilities.

January 11, 2018 Ribbon Cutting Ceremony at a new Odyssey House SUD Residential Program (3944 S 400 E)

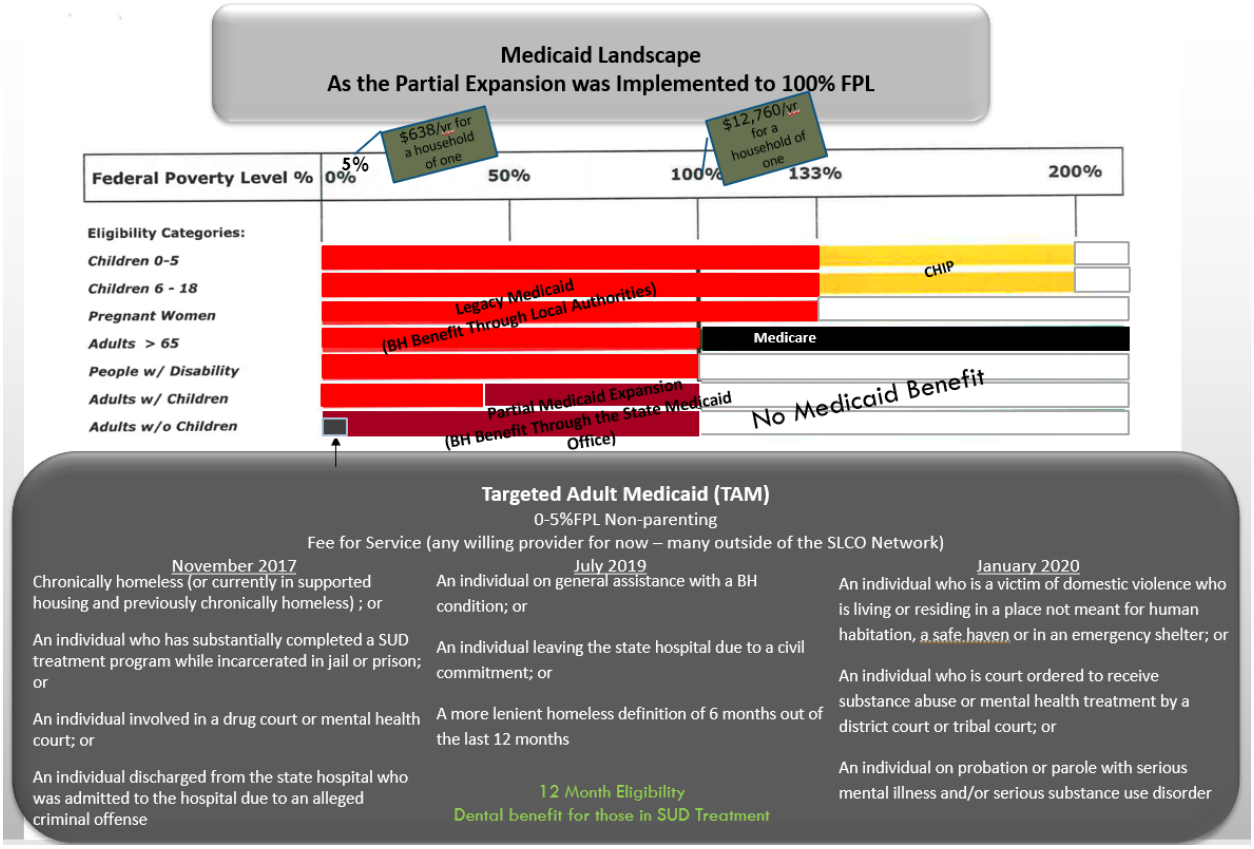
August 2018

- **Naloxone Overdose Reversal Kits** - integral in responding to the Opioid epidemic, is Naloxone, a medication that reverses the effects of an overdose from opioids such as heroin, fentanyl, and morphine. Thanks to a federal grant, DBHS distributed 1,400 overdose reversal kits in 2018 totaling more than $100,000, to local treatment programs, including the jail's MAT program. This number would more than double in 2019. *Please refer to attachment II for additional details on numbers and recipients.*
- **Proposition 3** - in November of 2018, Proposition 3 supporting the full expansion of Medicaid to 138% FPL passed (but would be replaced in the following general session, in the spring of 2019).

2019

- **Naloxone Overdose Reversal Kits** - demand for Naloxone overdose reversal kits increased as the Opioid Epidemic continued. DBHS dispersed twice as many as the previous year, 3,244 kits, totaling approximately $242,000, to treatment providers in Salt Lake County, including the jail's MAT program. *Please refer to attachment II for additional details on numbers and recipients.*

- **New Housing Projects** - DBHS and Optum worked with community partners on three new low-income tax credit housing projects, assisting with the application process, rental subsidies, supportive living funds through Medicaid, and by funding treatment for residents. The first project, the Denver Apartments for the SMI population, was a partnership between DBHS, Optum, Volunteers of America (VOA), Housing Connect, and Salt Lake City. VOA was awarded tax credits to fund housing for 22 VOA ACT Team participants. The project was also greatly supported by the Salt Lake County Council through a $400,000 capital investment through DBHS and opened in 2019.
- **Partial Medicaid Expansion** - another seismic shift occurred in February 2019, as the governor signed SB 96 into law, the replacement for Proposition 3. This allowed for a partial expansion of Medicaid on April 1st, referred to as the "Bridge Plan", up to 100% FPL, with many strings attached, such as a work requirement. Please refer to the maroon lines in the graph below. This expansion was anticipated to serve ~90,000 individuals across the state, and a large expansion of BH services followed again.



- **Budget Cuts** - due to anticipated savings through expansion, DBHS received state budgets cuts of $1M in SFY 2019, and $3.3 M in SFY 2020. Fortunately, with the additional Medicaid coverage these state cuts did not have a negative effect on treatment access.
- **Added Medicaid Benefit** - DBHS worked with the State Medicaid Office to pilot the first social detox benefit for Medicaid members, and designated VOA as the provider for these services. This provided for the first time the ability to draw down the Medicaid share from the federal

government for these services, with the county or state providing the required match depending on the Medicaid plan. Due to the partial expansion of Medicaid, this benefit covered a large number of clients.

- **Expansion of the Salt Lake County Jail MAT Program** - utilizing a federal grant as seed dollars, DBHS worked with the Salt Lake County jail, Project Reality, and DSAMH to expand the jail MAT program to all three FDA approved medications and to increase the number of individuals able to access these services. Now, through this effort, an individual on MAT in the community prior to being booked in jail, can continue his/her medication while incarcerated, receive behavioral therapies, coordinated referrals into the community upon release, and have the option of all three medications: Methadone, Buprenorphine or Naltrexone, as deemed clinically appropriate by the physician and in consultation with the patient. This expansion began in June of 2019 and served ~350 individuals in the first 12 months. This population also receives information and education regarding the use of Naloxone overdose reversal kits, and an actual kit while supplies last. Once supplies are depleted information will be provided on access within the community.
- **BH Workforce Shortage** - a new first was encountered in 2019, a shortage of BH workforce to accommodate the expansion of services. Some providers had the space and eligible Medicaid funding to pay for services, but not enough staff to provide the services. This workforce shortage continues to be a primary issue for providing care. It has replaced the lack of funding as the most significant barrier to treatment on demand. Efforts to address this workforce shortage would be addressed in the upcoming general session in 2020.

2020

- **Full Medicaid Expansion** - although 2020 brought with it some incredible challenges, it also arrived with more opportunities for expanding services.

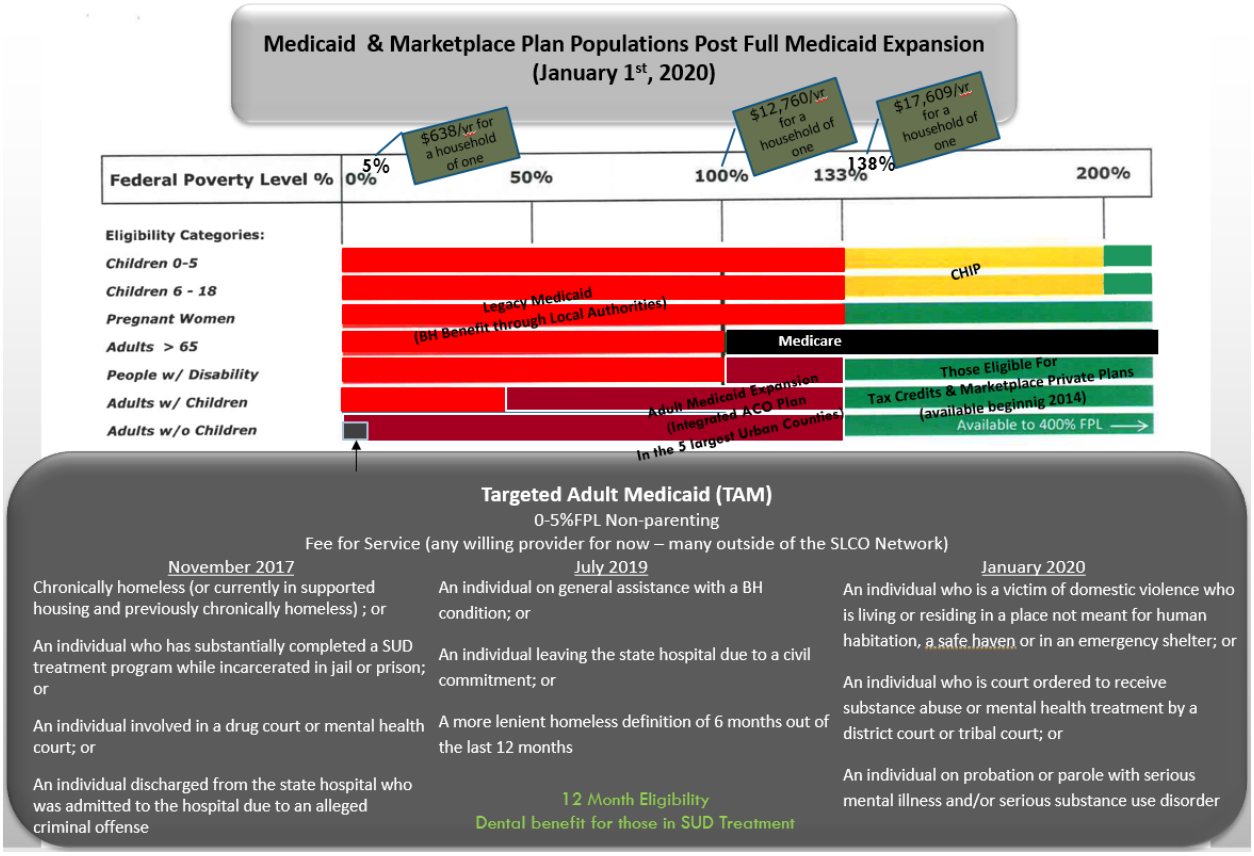
  January 1st began the implementation of Utah's "Fallback Plan", a full Medicaid Expansion, up to 133% FPL (138% when factoring in the 5% income disregard). As you will notice in the maroon bars of the graph below, this essentially filled "the gap", with the exception of undocumented individuals, the underinsured (individuals with skinny benefit plans or unable to afford their copays or deductibles), and those services not covered by Medicaid (such as milieu, drug testing, housing support, bus passes and other assistance for work clothes, etc.).

  Also depicted below, in the green bars, are individuals eligible for tax credits and subsidies to purchase private plans on the Marketplace. This coverage became available in Utahns in 2014 and is offered to individuals with incomes ranging from 133% FPL to 400% FPL.

  In the five largest counties, including Salt Lake County, the Adult Medicaid Expansion (AME) population became an integrated benefit (physical and behavioral health) managed by the four Accountable Care Organizations (ACOs). These are Select Health, Healthy U, Molina and Steward Health Choice.

  So, while the expansion itself, to total ~150,000 individuals from 0-138% FPL was a historical moment, it also offered the opportunity in some counties to provide BH services as an

integrated benefit. This effort is recognized as an evidence-based practice by improving the health of individuals and lowering costs, especially on the physical health side, as individuals are guided to address both. DBHS worked diligently to aid the four ACOs in contracting with DBHS's essential providers, educating on the recommended levels-of-care and duration of care for this population, and convening providers and ACOs to address initial barriers as they broke new ground. DBHS continues to work with the ACOs and provider network, and to fund this population for non-Medicaid reimbursable services such as milieu (room and board while in residential treatment), drug testing, sober living housing, bus passes, work clothes, etc., when receiving services through a county contracted provider.



Data

While the benefits of Utah's Medicaid expansions are many, it is imperative at this juncture to understand the implications of data sharing, and the newfound barriers in accessing program outcomes such as connections to treatment, changes in employment, changes in income, changes in housing, or time in treatment.

Bear in mind during treatment an individual may move within plans multiple times by losing/gaining a job, losing/gaining custody of a child, having a baby, changes in income, etc. When this occurs, the provider has the complicated task of switching payors (County for Legacy Medicaid, State Medicaid Office for TAM, and the four ACOs for AME), with each payor having no view into the data of others (due

to federal privacy law, including HIPAA and 42CFR Part 2). Additionally, data at the end of "a treatment episode" for one payor may not be the true "completion of treatment" for a client in flux between plans and yield faulty data.

No longer can data analysts rely solely upon County data submitted to DSAMH for reports or matching efforts regarding the provision of BH services.

The only entity with a view to all Medicaid data currently is the State Medicaid Office. Private health plans are the only entities with this data for Marketplace plans. A good example of this dynamic was recently shown in a legislative audit of the JRI initiative. The report referenced Legacy Medicaid data submitted through DSAMH, but did not include TAM or AME data, even though the TAM expansion is the largest payer now for the SUD criminal justice population.

Additionally, as the efficacy of BH treatment is examined, the analyst may no longer look solely to county programming, as large portions are now managed outside of counties. TAM through the State Medicaid Office, AME in the 5 largest counties by the ACOs. This is a huge shift in data gathering that state auditors, legislative analysts, etc., are only beginning to grapple with. *For additional information, please reference State Medicaid data in attachment III highlighting the numbers served and treatment dollars expended for the TAM and AME populations.*

Additional changes in 2020:

- **COVID-19** - The first challenges came with COVID-19 as DBHS worked to address their first priority, supporting their network of behavioral health providers during this unprecedented time, and by doing so, citizens in need of mental health and substance use disorder services. This included a quick transition to the ability to bill for telehealth services, keeping providers "whole" fiscally when unable to perform services in the same quantity and manner, assisting with access to Personal Protective Equipment (PPE)/Rapid Test kits, modifying utilization management and audit requirements to allow providers to focus on the tasks at hand, modifying drug testing requirements to keep everyone safe, and modifying sober living requirements for those experiencing barriers to employment and housing, allowing them to stay longer periods of time if needed.

  Providers have been impacted in a great way by the reduction in court operations, a primary referral source for treatment; a decline in jail SUD programming as the census decreased to accommodate quarantine and isolation protocols; and a diminished capacity in behavioral health congregate settings such as SUD residential programs and social detoxification programs as they struggled to address COVID infection safety protocols. Immense efforts were undertaken in congregate settings to separate residents, acquiring additional space when able, referring to the county's quarantine and isolation facility as needed, deploying rapid testing kits provided by the county, all as they faced the additional struggle of maintaining workforce as staff became ill, too high risk to remain in certain positions or redeployed to work on ordering and disseminating personal protective equipment and rapid test kits.

As an example, the VOA men's detox facility, normally with a capacity of 75, on occasions plummeted to 20 in the early stages of the pandemic. DBHS quickly worked with the state to utilize CARES Act funds to assist with retrofitting the detox facilities with physical barriers including visqueen and plexiglass for client and staff safety. Some prospective clients expressed fear in admitting into services due to fears of the Coronavirus, others left en masse when they learned that a client in the facility had tested positive. When clients tested positive at the residential detox facility, they were relocated outside of the facility and intakes were stopped until test results came back for other clients who may have been exposed by the positive individual. Once VOA received a CLIA waiver for the rapid COVID-19 tests, they were able to handle situations more rapidly and keep open for intakes on a regular basis, but their capacity today remains significantly impacted, at 55, rather than the 75 prior to the pandemic.

As another example, the impact on Odyssey House (OH) residential programming has been immense. Early in the pandemic, OH converted 3 of their smaller sites into new admission quarantine units. This required them to halt admissions for 6 weeks to allow for attrition to open the 80 beds they needed to accomplish this. This also required staffing these units 24/7 with entire treatment teams as these sites had only been used as sleeping quarters pre-pandemic. This was exceptionally expensive as you might imagine. Flow into treatment became more difficult as well for two reasons. First, when a positive patient admitted, they had to quarantine the entire unit. Testing times early on ranged from 36 hours to 7 days. So, assuming there were no additional positives they would have an admission unit locked down and unable to admit new people for 3 weeks or more. It has been tremendously hard for them to get back up to capacity when needing to lock down for extended periods of time. And second, the criminal justice system ground to a halt resulting in a significant decline in referrals. Previously court referrals comprised approximately 75-80% of the treatment beds available. Currently they equate to about 30%. In total, OH residential settings initially dipped to 50% of normal capacity, now they sit at approximately 70%. Prior to the pandemic, the program was full.

- **Receiving Center Funding** – DBHS applied for and was awarded the funds to implement a state-of-the-art non-refusal receiving center that will allow individuals in crisis to receive mental health and/or substance use disorder services and allow law enforcement and other emergency responders to bring individuals directly to these services, rather than jails or hospitals.

The expansions of Medicaid brought with them an incredibly fast and dramatic increase in services to the previously uninsured or underinsured SUD population, going from 6-9 month wait lists, to nearly treatment on demand. Lost over the years, however, were needed expansions in treatment for individuals with severe mental illness as this population increased. Mental Health Court stakeholders assisted in a new wave of program expansions in 2020 and planned for 2021, as they met with DBHS to educate on the demand and advocate for more programming. The reader will find many new programs coming online during this time as a full-out effort was and is underway to address the need. Examples include an additional ACT team, two new residential facilities, and housing programs listed below.

- **New Women's Mental Health Dual Diagnosis Residential Program** - The opening of a new women's Mental Health Residential Program through Odyssey House, for seriously mentally ill individuals, often homeless and cycling through the criminal justice system. This program opened in November 2020.
- **New Assertive Community Treatment Team** - The implementation of a second assertive community treatment (ACT) team to SAMHSA fidelity, this one to work specifically with the forensic population. An ACT Team is often referred to as a hospital without walls, a very high level of care to assist individuals with serious mental illness, meeting them "where they are at", often homeless, with the goal of enhancing their quality of life and reducing or eliminating their interaction with the criminal justice system. This program is now up and running through Recovery Innovations (RI) International.
- **New Permanent Supportive Housing Program** - The opening of a new permanent supportive housing tax credit project through First Step House (FSH), housing 75 individuals with serious mental illness. This program was a collaboration between FSH, DBHS, Optum, Housing Connect and the SLC Housing Authority. It opened late summer 2020 with assistance through DBHS for rental subsidies, a supportive living Medicaid benefit, and BH treatment to the residents residing there. This program is at full capacity today.
- **Additional housing** was made available to support the new women's residential program and ACT Team, with assistance through Housing Connect as managers of these funds.
- **Medicaid Enrollment** - DBHS assisted providers in navigating the new enrollment requirements as the state fully expanded Medicaid. Many trainings were held.
- **Data analysis -** efforts continued to support data driven decisions with alternatives to incarceration efforts, including monthly matching with jail data to inform on program efficacy as it relates to jail recidivism. This effort was made possible in years previous through a data sharing agreement between DBHS and the Salt Lake County Jail.
- **BH Workforce Capacity** - efforts were made to expand the BH workforce, the biggest barrier to date in access to services. Through the efforts of many, in the 2020 general session, millions of dollars were appropriated to schools to expand the output of behavioral health professionals, and in the form of education/tuition reimbursement to those in the behavioral health field in exchange for serving in a publicly funded program in the state of Utah.
- **Lost Funding for an Expansion of Utah State Hospital Beds** – due to the impacts of COVID-19, the state legislature cut funding to a great deal of appropriations in the 2020 budget. One of those cuts included a proposed expansion of 30 beds in the Utah State Hospital.

2021

- **New Women's Mental Health Dual Diagnosis Residential Program** - DBHS and Optum are working to implement a new MH residential program for men through RI, for the severely mentally ill population, with an anticipated opening in the spring of 2021. Expanding this type of programming became a high priority due to its success in the past and the demand from criminal justice stakeholders as waitlists grew to months.

- **Education on Data Analysis Barriers** - Efforts are ongoing to educate and advocate for the ability to report data across all Medicaid plans, to allow accurate reporting and data driven decisions.
- **Utah State Hospital Beds** - Additional efforts will be made in the 2021 general session to advocate for the funding to expand the number of beds in the Utah State Hospital (USH). A 30-bed expansion was funded in the 2020 general session, but subsequently cut during a special session due to the COVID-19 pandemic response. Over the years, due to a lawsuit to address long wait times for admittance to the USH from jails, the numbers of forensics patients have encroached on the number of beds available to civil patients in need of this level-of-care. There is a great need for this resource, especially as counties continue to fund some of these patients in other hospital settings as they await a bed in the USH (~$1,000/day).
- **New Receiving Center** - Last, but not least, significant efforts are underway to support the implementation of a new non-refusal Receiving Center in Salt Lake County.

Conclusion

In earlier years, many great programs were implemented, some receiving national attention and recognition. But due to the gap in funding for the uninsured population, long waitlists existed for certain services. Nothing interrupted this gap in behavioral health services as much as the various expansions of Medicaid beginning in November 2017. The Salt Lake County provider network expanded from ~170 SUD residential beds to more than ~550, more than tripling capacity (and this does not account for expansions in providers outside of this network). What were once 6-9 month waiting lists for this level of care, are now "openings as needed" in many programs. As the number of Medicaid eligibles grew, DBHS worked to add new Medicaid eligible services to enhance the effort further.

This blend of newfound funding, with a continued eye to services that support this population early on in a person's illness, such as Mobile Crisis Outreach Teams or a Receiving Center; and those diverting individuals with mental illness or substance use disorders from the criminal justice system such as ACT Teams, MAT programs, and housing, has enabled systems to make seismic shifts never seen before in Utah.

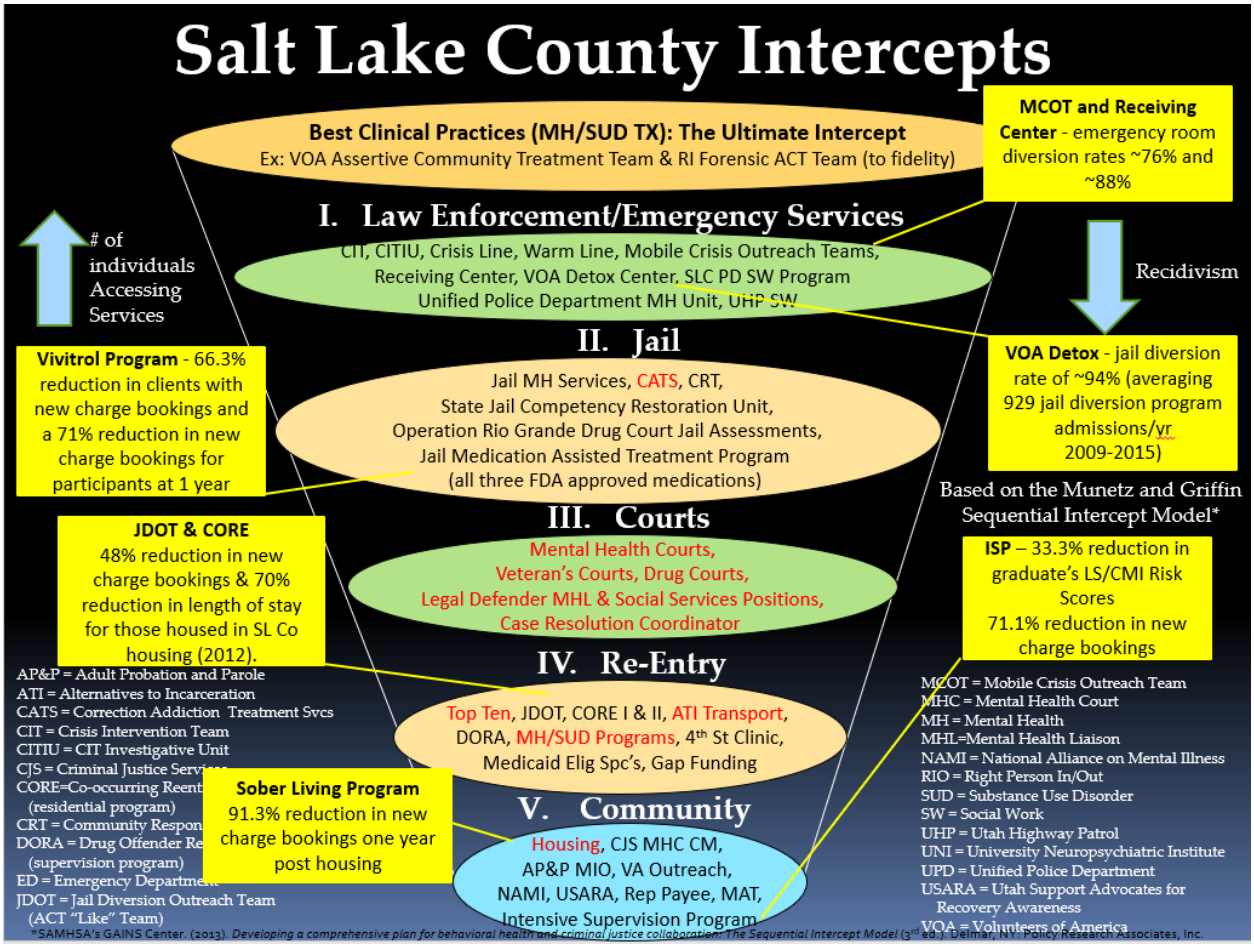
While these shifts occur, analysts need to incorporate data from *all three Medicaid systems*, Legacy Medicaid, Targeted Adult Medicaid (TAM), and Adult Medicaid Expansion (AME). Recent reporting on JRI treatment engagement did not include data from the largest SUD payors for the criminal justice population, TAM and AME (nor engagement for those in employer or private health plans). With no view into TAM or AME data, no longer can county data (reported to the state) solely be relied upon to give a full or accurate picture. Also integral in such reporting will be highlighting outside influencers in data such as the mass arrests that began in August 2017 as Operation Rio Grande rolled out, the Opioid Epidemic that swept our state and nation, the housing affordability crisis, a BH workforce shortage, and now the impacts of COVID-19.

COVID-19 has impacted services in a great way. Court calendars were dramatically altered resulting in decreases in court-ordered referrals. The jail decreased their census to allow for social distancing. BH providers saw an immediate drop in capacity in detox and residential settings as they incorporated

quarantine and isolation protocols, and quickly pivoted their outpatient services to telehealth. As examples, capacity of the County's men's detox program dropped initially to 27% of normal and operates today at 73% capacity, while the largest provider of SUD residential services dropped initially to 50% and today remains at approximately 70% of pre-pandemic levels. Many staff became ill or were too high-risk to work and others saw their duties transfer to COVID related efforts such as ordering and distributing PPE and Rapid Test Kits. Lastly, COVID-19 related state budget reductions cut funding for an expansion of 30 Utah State Hospital beds, a loss felt statewide to providers and residents.

In conclusion, the landscape of behavioral health services in Salt Lake County and Utah has changed in a dramatic way in recent years, bringing both unprecedented challenges and opportunities. As the workforce shortage eases, and if funding continues for services outside of Medicaid (such as housing, milieu, drug testing, etc.), and as vaccines become widely distributed, the future looks bright.

Attachment I



Attachment II

March 8, 2018
1,400 kits distributed
Spend: $105,000
Funding Source: State Targeted Response (STR) Grant

Agency	Kits	Date Received
Odyssey House	500	3/16/2018
Volunteers of America	50	3/16/2018
House of Hope	100	3/14/2018
Project Reality	100	3/15/2018
UofU Assessment and Referral Services	10	3/14/2018
Clinical Consultants	60	3/14/2018
First Step House	50	3/13/2018
Valley Behavioral Health	200	3/21/2018
Sheriff's Office (ISP Program)	30	3/14/2018
Behavioral Health Services	4	3/12/2018
Health Department	296	3/8/2018
Overall	1,400	3/8/2018

April 8, 2019
3,024 kits distributed
Spend: $226,800
Funding Source: State Opioid Response (SOR) Grant

Agency	Kits	Date Received
Odyssey House	1,000	4/15/2019
Volunteers of America	420	5/20/2019
House of Hope	300	4/12/2019
Project Reality	400	4/15/2019
UofU Assessment and Referral Services	20	5/8/2019
First Step House	200	4/15/2019
Valley Behavioral Health	600	4/18/2019
Sheriff's Office (ISP Program)	24	5/8/2019
Behavioral Health Services	10	5/29/2019
Salt Lake County Criminal Justice Services	50	5/8/2019
Overall	3,024	4/8/2019

July 18, 2019
204 kits distributed
Spend: $15,300
Funding Source: State Opioid Response (SOR) Grant

Agency	Kits	Date Received
Jail MAT Program	100	7/26/2019
Clinical Consultants	48	10/11/2019
Jail MAT Program	56	11/8/2019
Overall	204	7/18/2019

Attachment III

Medicaid Adult Expansion Report

December 11, 2020

Expansion Enrollment by Subgroup

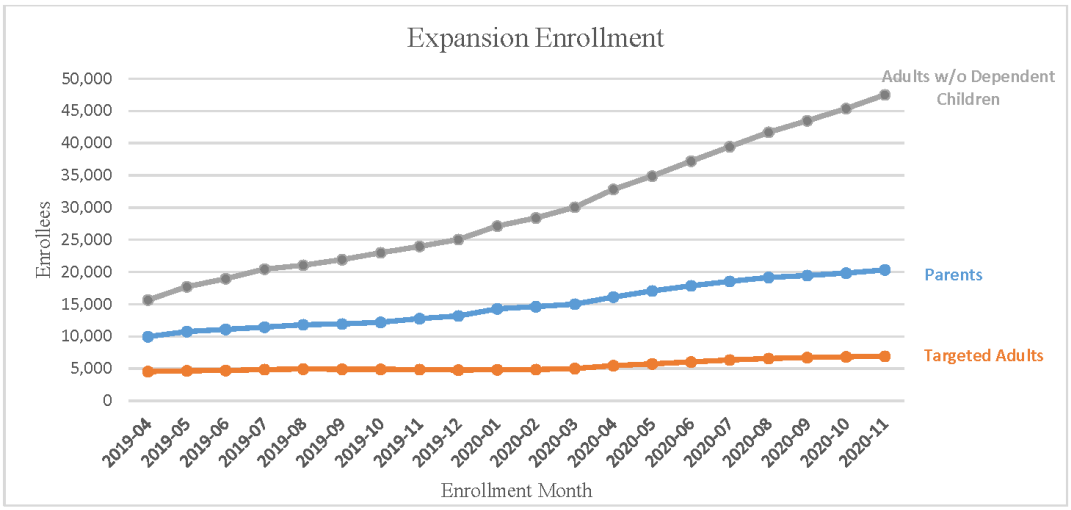


Figure 1

Expansion Enrollment

Bridge

Category	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
Adults w/o Dep. Children	15,674	17,721	18,977	20,451	21,066	21,910	22,995	23,999	25,031
Parents	9,975	10,766	11,092	11,453	11,812	11,941	12,198	12,773	13,178
Targeted Adults	4,553	4,682	4,703	4,871	4,931	4,901	4,901	4,878	4,795
Total	**30,202**	**33,169**	**34,772**	**36,775**	**37,809**	**38,752**	**40,094**	**41,650**	**43,004**

Table 1a

Fallback

Category	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11
Adults w/o Dep. Children	27,152	28,390	30,058	32,818	34,876	37,188	39,465	41,674	43,475	45,378	47,501
Parents	14,286	14,636	15,015	16,126	17,062	17,844	18,529	19,152	19,474	19,846	20,321
Targeted Adults	4,839	4,853	5,018	5,458	5,740	6,061	6,340	6,559	6,740	6,833	6,919
Total	**46,277**	**47,879**	**50,091**	**54,402**	**57,678**	**61,093**	**64,334**	**67,385**	**69,689**	**72,057**	**74,741**

Table 1b

Notes:
Enrollment as of December 11, 2020. Enrollment includes retroactive applications processed up to the run date.
Enrollment numbers reported here are subject to change with future applications that may include retroactive coverage.

Expansion Demographics

Last update: October 2020

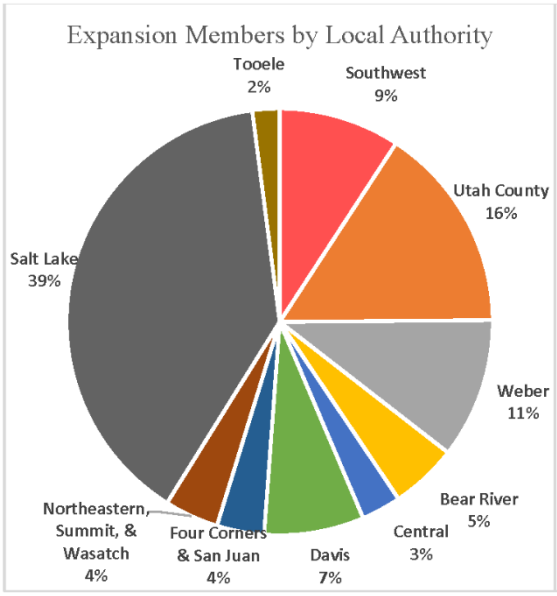


Figure 2

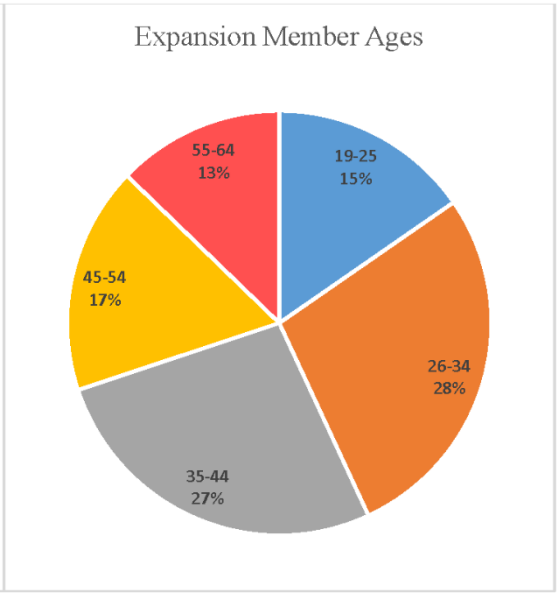


Figure 3

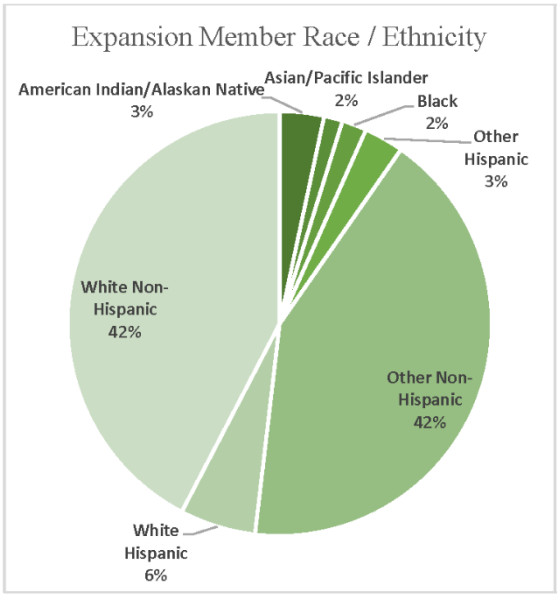


Figure 4

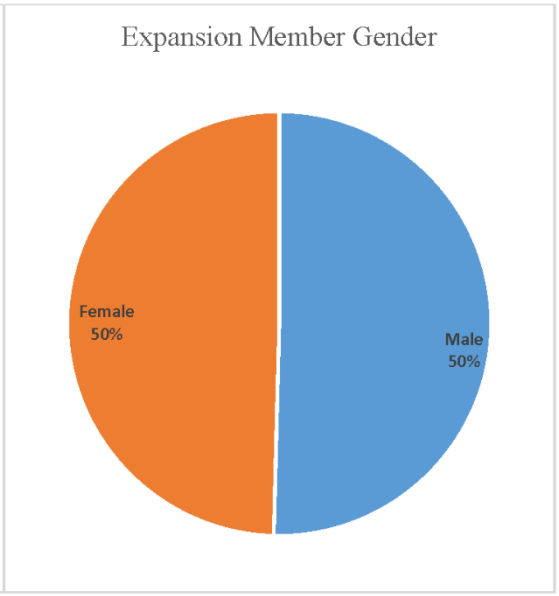


Figure 5

Targeted Adult Medicaid (TAM) Enrollment by Subgroup

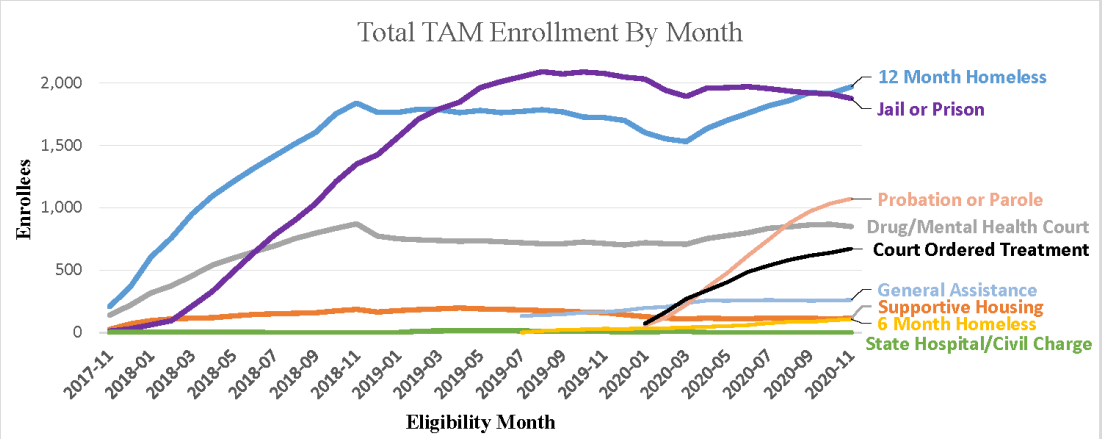


Figure 6

TAM Enrollment by Month

FY19 Totals	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06
Total	**3,042**	**3,321**	**3,591**	**3,975**	**4,243**	**4,126**	**4,256**	**4,438**	**4,517**	**4,553**	**4,682**	**4,703**

Table 2a

FY20 Category	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06
12 Month Homeless	1,771	1,786	1,768	1,727	1,723	1,698	1,600	1,552	1,530	1,633	1,701	1,758
6 Month Homeless	*	14	21	24	30	29	35	34	40	47	52	60
Supportive Housing	182	176	172	165	160	143	127	115	108	114	112	112
General Assistance	133	141	147	161	165	178	197	205	236	256	255	259
Court Ordered Treatmnt							72	164	270	337	403	487
Drug/Mental Health Crt	720	712	712	726	714	701	719	711	708	752	777	800
Jail or Prison	2,051	2,090	2,071	2,088	2,075	2,046	2,031	1,941	1,891	1,957	1,961	1,969
Probation or Parole							58	119	223	361	478	617
State Hospital/Civil Chrg	14	12	10	10	11	*	*	12	12	*	*	*
Total	**4,871**	**4,931**	**4,901**	**4,901**	**4,878**	**4,795**	**4,839**	**4,853**	**5,018**	**5,458**	**5,740**	**6,061**

Table 2b

FY21 Category	2020-07	2020-08	2020-09	2020-10	2020-11
12 Month Homeless	1,816	1,858	1,922	1,916	1,968
6 Month Homeless	76	85	85	97	107
Supportive Housing	115	115	114	112	113
General Assistance	260	259	254	257	261
Court Ordered Treatmnt	538	582	615	639	672
Drug/Mental Health Crt	835	848	862	867	849
Jail or Prison	1,954	1,935	1,918	1,911	1,876
Probation or Parole	746	877	970	1,034	1,072
Total	**6,340**	**6,559**	**6,740**	**6,833**	**6,919**

Table 2c

*Domestic Violence and selected months from State Hospital/Civil Charge are suppressed due to low enrollment

Notes: Enrollment as of December 11, 2020. Enrollment includes retroactive applications processed up to the run date. Enrollment numbers reported here are subject to change with future applications that may include retroactive coverage.

Targeted Adult Medicaid Reimbursements

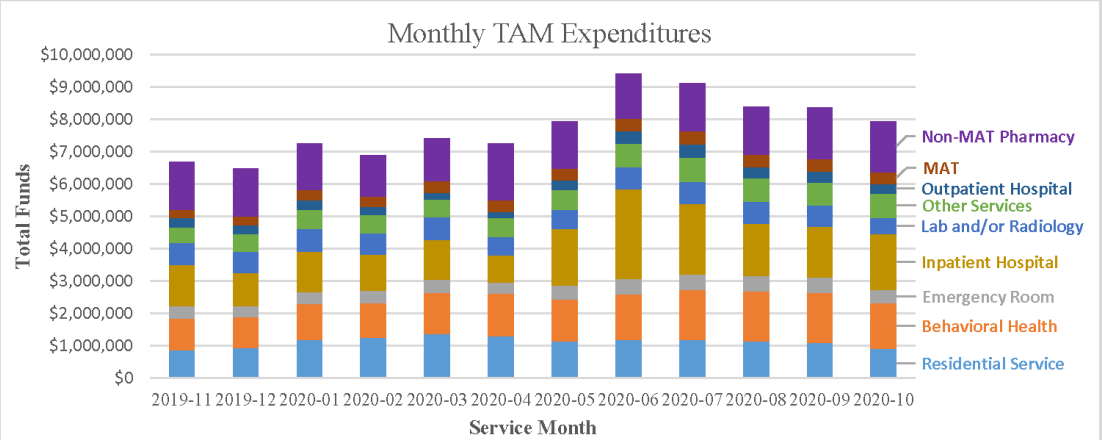


Figure 7

Monthly Expenditures (in 1,000's)						FY20				FY21			
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**	**Total**
Residential Serv.	$879	$932	$1,198	$1,259	$1,366	$1,298	$1,142	$1,185	$1,189	$1,144	$1,101	$917	**$13,611**
Behavioral Health	$982	$952	$1,096	$1,060	$1,282	$1,325	$1,290	$1,422	$1,540	$1,534	$1,537	$1,417	**$15,436**
Emergency Room	$369	$347	$375	$393	$411	$329	$443	$480	$486	$492	$473	$408	**$5,007**
Inpatient Hospital	$1,277	$1,025	$1,250	$1,104	$1,217	$844	$1,738	$2,763	$2,175	$1,614	$1,579	$1,725	**$18,311**
Lab & Radiology	$679	$668	$703	$664	$706	$577	$608	$691	$675	$667	$649	$507	**$7,794**
Other Services	$494	$544	$601	$569	$541	$580	$619	$714	$768	$735	$705	$752	**$7,622**
Outpatient Hosp.	$276	$263	$293	$254	$208	$201	$281	$384	$409	$341	$355	$292	**$3,556**
MAT	$266	$278	$305	$308	$366	$351	$365	$387	$411	$385	$379	$359	**$4,161**
Non-MAT Pharm.	$1,480	$1,486	$1,440	$1,276	$1,323	$1,747	$1,458	$1,401	$1,466	$1,478	$1,598	$1,578	**$17,731**
Grand Total	**$6,702**	**$6,495**	**$7,262**	**$6,890**	**$7,421**	**$7,254**	**$7,942**	**$9,426**	**$9,118**	**$8,390**	**$8,376**	**$7,954**	**$93,229**

Table 3

Distinct Members Served						FY20				FY21			
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**	
Residential Serv.	315	335	419	462	524	484	449	429	414	396	392	351	
Behavioral Health	1,364	1,275	1,423	1,442	1,579	1,608	1,678	1,710	1,645	1,667	1,539	1,442	
Emergency Room	498	509	504	502	556	438	544	577	608	625	619	632	
Inpatient Hospital	96	99	109	102	115	110	168	174	163	152	151	162	
Lab & Radiology	993	1,030	1,140	1,198	1,277	1,134	1,165	1,283	1,230	1,200	1,214	1,109	
Other Services	4,722	4,626	4,486	4,527	4,732	5,225	5,495	5,826	6,084	6,369	6,598	6,722	
Outpatient Hosp.	370	364	422	433	370	361	395	520	579	612	564	573	
MAT	480	506	546	550	605	655	686	735	749	751	771	696	
Non-MAT Pharm.	1,739	1,769	1,809	1,816	1,941	2,005	2,137	2,213	2,242	2,275	2,299	2,359	
Grand Total	**4,784**	**4,674**	**4,609**	**4,620**	**4,818**	**5,270**	**5,547**	**5,878**	**6,147**	**6,428**	**6,643**	**6,760**	

Table 4

- Monthly expenditures represent total fund payments to providers. Expenditures may not precisely sum up to total due to rounding.
- These total fund amounts consist of federal funds, state restricted funds, and hospital share.
- Pharmacy expenses shown here are subject to future reductions due to rebates.
- The months shown here represent the month of service, which is not necessarily the month of payment. They are subject to change with future billings and adjustments. Providers may bill up to one year after the date of service.

Expansion Parents Enrollment

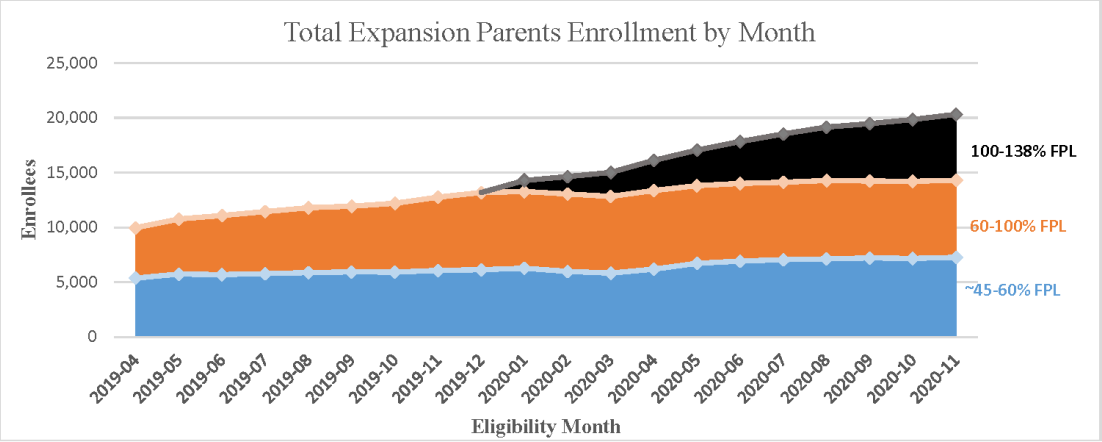


Figure 8

Expansion Parents Enrollment by Month

Bridge

Category	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
60-100% FPL	4,594	5,033	5,393	5,654	5,934	5,994	6,271	6,683	7,022
~45-60% FPL	5,381	5,733	5,699	5,799	5,878	5,947	5,927	6,090	6,156
Total	**9,975**	**10,766**	**11,092**	**11,453**	**11,812**	**11,941**	**12,198**	**12,773**	**13,178**

Table 5a

Fallback

Category	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11
100-138% FPL	1,000	1,592	2,192	2,766	3,258	3,840	4,402	4,875	5,226	5,630	6,022
60-100% FPL	7,014	7,061	6,994	7,161	7,083	7,079	7,073	7,158	7,037	7,040	7,026
~45-60% FPL	6,272	5,983	5,829	6,199	6,721	6,925	7,054	7,119	7,211	7,176	7,273
Total	**14,286**	**14,636**	**15,015**	**16,126**	**17,062**	**17,844**	**18,529**	**19,152**	**19,474**	**19,846**	**20,321**

Table 5b

Notes:
Enrollment as of December 11, 2020. Enrollment includes retroactive applications processed up to the run date.
Enrollment numbers reported here are subject to change with future applications that may include retroactive coverage

Expansion Parents Reimbursements

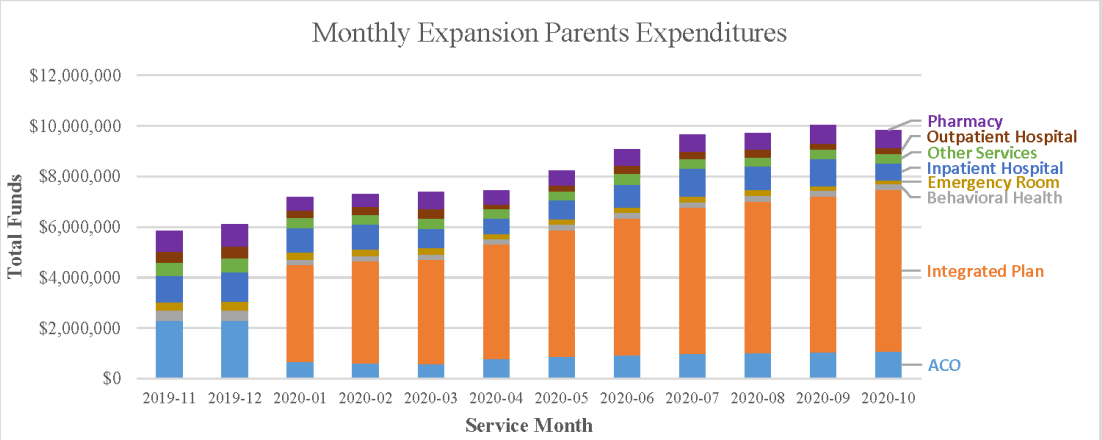


Figure 9

Monthly Expenditures (in 1,000's)						FY20			FY21				
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**	**Total**
ACO	$2,301	$2,297	$673	$620	$600	$788	$864	$935	$989	$1,015	$1,048	$1,087	**$13,217**
Integrated Plan	$0	$0	$3,835	$4,043	$4,104	$4,530	$5,006	$5,418	$5,782	$5,992	$6,163	$6,379	**$51,254**
Behavioral Health	$407	$427	$206	$201	$209	$217	$229	$229	$229	$245	$250	$242	**$3,090**
Emergency Room	$330	$325	$284	$269	$277	$183	$227	$190	$216	$223	$157	$149	**$2,831**
Inpatient Hospital	$1,026	$1,185	$965	$974	$762	$614	$731	$906	$1,105	$926	$1,071	$666	**$10,931**
Other Services	$551	$551	$417	$396	$404	$392	$351	$451	$390	$367	$398	$386	**$5,052**
Outpatient Hospital	$431	$445	$277	$317	$377	$165	$238	$312	$279	$316	$229	$237	**$3,622**
Pharmacy	$810	$895	$541	$479	$652	$568	$593	$637	$679	$634	$706	$693	**$7,889**
Grand Total	**$5,855**	**$6,124**	**$7,198**	**$7,300**	**$7,386**	**$7,458**	**$8,238**	**$9,078**	**$9,668**	**$9,720**	**$10,021**	**$9,840**	**$97,885**

Table 6

Distinct Members Served						FY20			FY21			
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**
ACO	4,537	4,539	1,553	1,438	1,417	1,861	2,043	2,202	2,325	2,381	2,436	2,532
Integrated Plan			7,844	8,283	8,401	9,299	10,263	11,085	11,822	12,257	12,596	13,006
Behavioral Health	6,314	6,401	3,717	3,858	3,939	4,160	4,369	4,517	4,677	4,847	4,924	5,001
Emergency Room	388	394	340	299	297	190	217	204	235	219	174	174
Inpatient Hospital	74	68	78	84	74	50	53	79	77	60	60	46
Other Services	1,949	1,935	1,331	1,349	1,404	1,199	1,187	1,355	1,259	1,252	1,311	1,278
Outpatient Hospital	659	638	409	399	367	240	311	398	391	340	341	335
Pharmacy	3,151	3,284	2,785	2,722	3,004	2,944	3,047	3,286	3,392	3,518	3,594	3,718
Grand Total	**8,783**	**8,899**	**12,374**	**12,870**	**13,095**	**14,163**	**15,252**	**16,275**	**17,183**	**17,674**	**17,991**	**18,489**

Table 7

- Monthly expenditures represent total fund payments to providers. Expenditures may not precisely sum up to total due to rounding.
- These total fund amounts consist of federal funds, state restricted funds, and hospital share.
- Pharmacy expenses shown here are subject to future reductions due to rebates.
- The months shown here represent the month of service, which is not necessarily the month of payment. They are subject to change with future billings and adjustments. Providers may bill up to one year after the date of service.

Expansion Adults without Dependent Children Enrollment

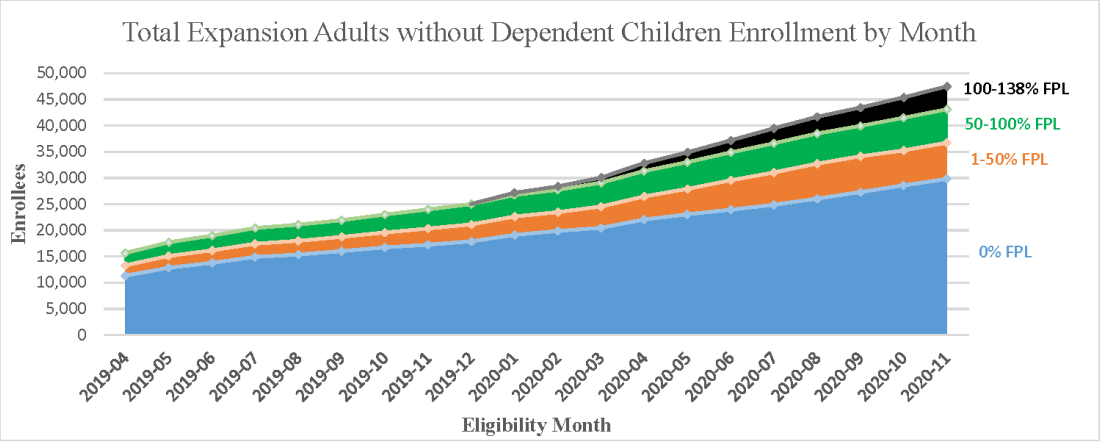


Figure 10

Expansion Adults without Dependent Children Enrollment by Month

Bridge

Category	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
50-100% FPL	2,343	2,615	2,824	3,007	3,080	3,164	3,389	3,666	3,889
1-50% FPL	1,996	2,258	2,388	2,547	2,609	2,715	2,870	3,068	3,224
0% FPL	11,335	12,848	13,765	14,897	15,377	16,031	16,736	17,265	17,918
Total	**15,674**	**17,721**	**18,977**	**20,451**	**21,066**	**21,910**	**22,995**	**23,999**	**25,031**

Table 8a

Fallback

Category	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11
100-138% FPL	390	642	960	1,482	1,849	2,308	2,826	3,163	3,503	3,897	4,383
50-100% FPL	4,142	4,262	4,542	4,843	5,095	5,323	5,574	5,786	5,802	6,211	6,380
1-50% FPL	3,494	3,621	4,058	4,431	4,886	5,625	6,187	6,692	6,863	6,684	6,917
0% FPL	19,126	19,865	20,498	22,062	23,046	23,932	24,878	26,033	27,307	28,586	29,821
Total	**27,152**	**28,390**	**30,058**	**32,818**	**34,876**	**37,188**	**39,465**	**41,674**	**43,475**	**45,378**	**47,501**

Table 8b

Notes:
Enrollment as of December 11, 2020. Enrollment includes retroactive applications processed up to the run date.
Enrollment numbers reported here are subject to change with future applications that may include retroactive coverage

Expansion Adults without Dependent Children Reimbursements

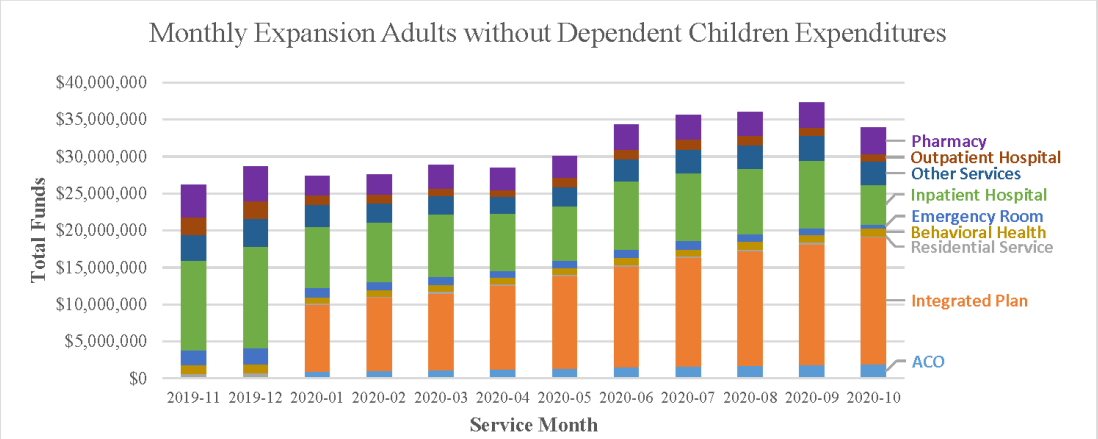


Figure 11

Monthly Expenditures (in 1,000's)						FY20			FY21				
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**	**Total**
ACO	$0	$0	$967	$1,050	$1,097	$1,234	$1,373	$1,514	$1,634	$1,751	$1,842	$1,972	**$14,432**
Integrated Plan	$0	$0	$9,056	$9,864	$10,406	$11,328	$12,508	$13,640	$14,667	$15,440	$16,315	$17,179	**$130,403**
Behavioral Health	$1,182	$1,241	$817	$832	$875	$862	$874	$933	$984	$1,050	$996	$1,020	**$11,665**
Emergency Room	$1,990	$2,130	$1,250	$1,153	$1,146	$885	$966	$1,115	$1,116	$1,060	$868	$572	**$14,251**
Inpatient Hospital	$12,136	$13,709	$8,299	$7,983	$8,393	$7,796	$7,378	$9,238	$9,157	$8,769	$9,206	$5,318	**$107,382**
Other Services	$3,506	$3,787	$2,919	$2,599	$2,558	$2,272	$2,595	$3,044	$3,155	$3,271	$3,377	$3,219	**$36,303**
Outpatient Hosp.	$2,390	$2,387	$1,320	$1,167	$995	$832	$1,290	$1,204	$1,426	$1,269	$1,045	$988	**$16,314**
Pharmacy	$4,347	$4,745	$2,611	$2,758	$3,181	$3,046	$2,831	$3,377	$3,308	$3,202	$3,364	$3,516	**$40,286**
Residential Serv.	$623	$704	$160	$191	$227	$209	$203	$195	$180	$233	$235	$111	**$3,271**
Grand Total	**$26,174**	**$28,704**	**$27,401**	**$27,597**	**$28,876**	**$28,463**	**$30,018**	**$34,260**	**$35,626**	**$36,044**	**$37,248**	**$33,895**	**$374,307**

Table 9

Distinct Members Served FY20									FY21			
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**
ACO			2,065	2,249	2,364	2,650	2,973	3,282	3,540	3,808	4,028	4,340
Integrated Plan			15,587	17,060	18,050	19,708	21,872	23,964	25,856	27,301	28,929	30,566
Behavioral Health	2,601	2,596	6,469	6,700	7,059	7,472	7,907	8,418	8,783	9,296	9,569	9,914
Emergency Room	2,392	2,535	1,364	1,328	1,328	1,014	1,056	1,137	1,181	1,096	1,011	829
Inpatient Hospital	800	830	575	531	528	453	476	545	533	536	494	413
Other Services	22,432	23,365	25,419	26,653	27,774	30,676	32,749	35,029	37,068	39,156	41,145	43,327
Outpatient Hosp.	2,753	2,899	1,187	1,084	942	755	900	1,115	1,038	1,026	1,028	942
Pharmacy	9,013	9,445	7,560	7,935	8,443	8,481	8,911	9,632	10,005	10,311	10,716	11,264
Residential Serv.	239	284	70	66	53	40	50	58	45	46	50	36
Grand Total	**23,027**	**24,012**	**26,530**	**27,750**	**28,970**	**31,769**	**33,811**	**36,142**	**38,236**	**40,296**	**42,201**	**44,233**

Table 10

- Monthly expenditures represent total fund payments to providers. Expenditures may not precisely sum up to total due to rounding.
- These total fund amounts consist of federal funds, state restricted funds, and hospital share.
- Pharmacy expenses shown here are subject to future reductions due to rebates.
- The months shown here represent the month of service, which is not necessarily the month of payment. They are subject to change with future billings and adjustments. Providers may bill up to one year after the date of service.