



BUDGET DEEP-DIVE INTO SUBSTANCE USE DISORDER TREATMENT

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: CLARE TOBIN LENCE

ISSUE BRIEF

SUMMARY

This brief describes the landscape of the public system for treatment of substance use disorder (SUD) in Utah. It focuses primarily on the system of 13 Local Substance Abuse Authorities (LSAAs), including drug courts and the Drug Offender Reform Act (DORA) program, with additional discussion of the relevant state-level agencies, namely the Department of Human Services - Division of Substance Abuse and Mental Health (DSAMH) and the Department of Health - Division of Medicaid and Health Financing (DMHF). Options for legislative action are provided in the next section, followed by the full discussion and analysis.

LEGISLATIVE ACTION

Based on the analysis provided in this brief, the Legislative Fiscal Analyst (LFA) recommends the Legislature consider the following three actions:

1. **Direct the Department of Human Services and Department of Health, with the Wasatch and Box Elder/Cache/Rich LSAs, to explore moving from fee-for-service to a capitated payment for SUD treatment provided through Medicaid, and to assess the potential associated costs or savings.**

The capitated system reduces the financial risk to the State and allows the State to better control increases in cost. It could also reduce the administrative workload for each state agency.

a. Department of Human Services Response:

“DSAMH will work with the Department of Health, Wasatch County and Box Elder/Cache/Rich Counties to explore the possibility of capitation beginning July 1, 2018. Currently Utah Code 17-43-201 and 17-43-301 allow the counties acting in the capacity of local mental health and substance abuse authorities to determine how best to meet the needs of their citizens locally. Although DSAMH/DHS will not save any administrative expenses, it will increase administrative efficiency having all the local authorities running under the same Medicaid payment model. DSAMH has various other funding line items that will need to continue to be used and monitored (block grants, drug courts, DORA, etc).”

b. Department of Health Response:

“The counties pay the State Match on SUD services. Because they bear the financial burden and have ultimate statutory responsibility for SUD services, participation in the capitated model is at the option of the county. If these counties were to switch to a capitated model, DOH would have to first have to amend the 1915(b) waiver and obtain Centers for Medicare and Medicaid (CMS) approval for this amendment. DOH would also need to ensure that the counties had the appropriate infrastructure in place to meet the extensive managed care regulations. Federal regulations require DOH to conduct a readiness review for all new managed care plans. In a

readiness review the counties would have to show, among other things, that these counties have sufficient provider network adequacy, had appropriate administrative and staffing resources, could conduct appeals, utilization reviews, and other program integrity functions, and could process claims and submit encounter data to the state.”

“There would be no reduction in workload for the Restriction team. The DOH Restriction Team conducts reviews based on a client’s enrollment in an Accountable Care Organization (ACO), not a Prepaid Mental Health Plan (PMHP). The ACOs conduct the restriction reviews for their enrollment. The DOH Restriction Team administers the Restriction Program for all clients who are not enrolled in an ACO. PMHPs do not conduct restriction reviews. DOH would see an increase in managed care administrative costs including: (1) increased actuarial costs as the counties would now require capitated rate development by the state’s actuaries; (2) increased external quality review costs; and (3) increased managed care program costs as the state would now have new PMHPs to conduct contractual compliance oversight.”

2. Require LSAAAs to provide greater expenditure detail in their financial reports to DSAMH, including whether personnel provide administrative or direct care functions. Additional detail will allow the division, the Legislature, and other stakeholders to better assess the efficiency of LSAA service provision.

a. Department of Human Services Response:

“Our current Substance Abuse (SA) Data system is based on an entire episode (extended period of time) data report, as required by our federal partners. Over the last year we have been evaluating our data structure and are in the process of changing our SA data spec to be based on event data (per treatment), which will include CPT codes. By doing this, DSAMH will be able to close the loop between data and financial information collected from the local authorities. Currently, in order to tie these areas together, DSAMH does an annual audit, using the local authorities’ electronic health record to establish the connection, but the changes in our data system will allow DSAMH to collect this data at a Division level throughout the year. Using the Medicaid Cost Report and the newly developed data submission, DSAMH will be able to determine administrative costs on a monthly basis and use the data submission as the basis for cost reimbursement billing from the local authority. The expected cost for this system change is estimated at \$250,000 and scheduled to be functioning for the 2019 fiscal year.”

b. Department of Health Response:

“The Department of Health does not have oversight of the LSAAAs. DOH receives a yearly audited financial report from the Prepaid Mental Health Plans (PMHPs). Additionally, the new managed care regulations require additional financial reporting from the PMHPs.”

3. Monitor key performance measures of legislative interest before providing new funding (see Appendix B for full scorecard). Legislative efforts often focus on getting individuals *into* treatment. The low rates of completion and other outcomes shown in DSAMH data, though due to some extent to the nature of SUDs, should be reviewed when the Legislature considers providing new funding for these programs. Key measures include:

- *Percent of Individuals Completing Treatment Episode Successfully* -- 44.7 percent in FY 2016, down 3.4 percent from the previous year. All but three LSAs scored below DSAMH's benchmark.
- *Percent of Individuals Completing Treatment Episode Successfully - Heroin & Other Opiates as Primary Drug* -- 36.1 percent in FY 2016, down 1.1 percent from the previous year. Outcome scores for this group also tend to be lower than other groups and some measures of success declined significantly from FY 2015 to FY 2016, including *Increased Drug Abstinence, Increased Employment, and Use of Social Recovery Support*.
- *Number of Justice-Involved Individuals Served* -- 10,411 individuals in FY 2016, down by 184 despite \$4.5 million in new funding from the Justice Reinvestment Initiative (JRI). DSAMH has previously attributed this to greater needs in the served population and to delays in certifying treatment providers, as required by the JRI legislation ([H.B. 348](#), 2015 General Session); some federal funding was also lost in FY 2016. Nonetheless, the impact of the new FY 2018 appropriation of \$6 million should be evaluated carefully before providing the remaining \$10 million in estimated unmet need related to JRI.

a. Department of Human Services Response:

"Substance Use Disorder is a chronic disease and individuals may require several episodes of formal treatment and may require ongoing treatment for optimal outcomes. Although clients may leave treatment prior to completion of all treatment objectives, many benefit from the treatment they receive with abstinence, harm reduction, decreased use or fewer problems associated with their substance use disorder. DSAMH continues to focus on this measure, and work with the local authorities to increase treatment retention, and take care to help individuals make transitions to different levels of treatment including appropriate aftercare (ongoing treatment and recovery support). In 2018, DSAMH is also putting a renewed emphasis on tracking recovery support services which provide non-clinical services that aid individuals in achieving and maintaining their recovery. Addiction as a chronic disease has a relapse rate comparative to diabetes, hypertension, and asthma (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment>)."

"Individuals with an opiate use disorder historically have had more obstacles to completing treatment. DSAMH is putting an increased focus on these individuals and encouraging local authorities to provide treatment that includes medication-assisted therapy (MAT), which has been shown to improve treatment outcomes. This improves treatment outcomes at higher cost per client as the majority of individuals receiving SUD treatment are not Medicaid eligible, the state typically has to cover the full cost of the medication. Methadone, the most cost-effective form of MAT currently, continues to face stigma that impedes expansion that would be necessary to combat the opiate epidemic we face as a state and a nation."

"DSAMH has been tracking and monitoring treatment admissions and services carefully. Treatment data in this first JRI report show a slight decrease in people served. Reasons for the decline are complex and vary from area to area. JRI clients served in Mental Health were not included in the overall count although \$1,192,400 in funding was allocated. In the second half of SFY 2016 when the "Justice Involved" data element was added, the public mental health system

served 447 individuals that were not included in this report. These numbers were not included because DSAMH could not provide baseline information for 2014 and 2015. Prior to the passage of JRI, the public mental health system collected a static referral source data element taken at the time of admission and changes were made to our data system after HB 348 passed so that this new data will continue to be provided. In some rural areas, workforce shortages prevented implementation of new JRI programming for a period of time. In other areas referrals from the criminal justice system declined over this time period due to new or expanded treatment options developed by Corrections. Furthermore, discretionary federal grant funding previously secured by DSAMH (Access to Recovery, ATR), which had been used to treat criminal justice populations, ended in FY 2016. In addition, Salt Lake County decreased substance use disorder funding to its provider network due to previous reductions in state and federal funds they had been filling with county funds that were no longer available. DSAMH recognizes that this trend should not continue due to Utah's Medicaid expansion waiver being resubmitted and additional treatment funding allocated by the legislature for JRI. DSAMH continues to work with county local authority programs to determine next steps to increase capacity and enhance the quality of services in FY 2018."

b. Department of Health Response:

"Generally, outcomes for clients needing SUD treatment are difficult to track or impact. Positive SUD treatment outcomes require an individual client to adhere to their treatment program. State agencies can impact whether a client enters treatment, however, whether the client completes the treatment program is ultimately the decision of the client and the state cannot force a client to successfully complete SUD treatment."

DISCUSSION AND ANALYSIS

This section addresses the following questions:

1. Who needs substance use disorder treatment and who is served by the public system?
2. Why is there a public treatment system and what is it intended to accomplish?
3. How is the public treatment system organized?
4. What are we buying with the public treatment system?
5. How do we pay for the public treatment system?
6. What budget changes are coming or may come in the future?

1. Who needs substance use disorder treatment and who is served by the public system?

Population Needs. The most recent National Survey on Drug Use and Health, conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), indicated that 134,172 adults in Utah needed treatment for alcohol and/or drug dependence or abuse in 2015. The Student Health and Risk Prevention (SHARP) Survey identified 12,080 youth as needing treatment in 2015. The Local Substance Abuse Authorities (LSAAs) in Utah are currently treating 14,729 individuals, or 9.9 percent.

Only Salt Lake County has a wait list for services, but DSAMH reports that needs exceed capacity throughout the State, especially for uninsured individuals. Individuals with private insurance coverage or the means to pay cash typically seek treatment from a private provider instead, although some LSAs are beginning to accept private insurance. A smaller number of individuals are served by state-organized programs. Further, many individuals who need treatment simply do not seek it.

Substance Use Disorder				
	Adults (18 years+)		Youth (Ages 12-17)	
	# Need Treatment	Capacity FY2016	# Need Treatment	Capacity FY2016
Bear River	6,977	887	713	88
Central	3,532	363	338	40
Davis County	13,163	1,003	1,479	69
Four Corners	1,924	512	142	40
Northeastern	2,286	427	250	31
Salt Lake County	56,112	6,575	4,077	636
San Juan County	694	63	73	15
Southwest	10,415	591	859	28
Summit County	1,696	237	158	25
Tooele County	2,404	346	302	30
Utah County	22,687	971	2,552	69
Wasatch County	1,139	131	130	19
Weber	11,152	1,460	1,001	243
State Totals*	134,172	13,400*	12,080	1,326*

* Because of rounding in the percentages, duplication of clients across Local Substance Abuse Authorities (LSAAs), LSA totals do not add up to the unduplicated total of clients served statewide.

¹ Adult-Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

Children/Youth-State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 5.

Figure 1. SUD Treatment Need and Capacity by LSAA.

(Source: DSAMH Annual Report 2016)

Clients Served. LSAs are overseen by the Division of Substance Abuse and Mental Health (DSAMH) and directed by statute, but they have latitude to determine types and aspects of programs and which populations they prioritize. Generally, individuals with the most acute needs are the first to receive services, as determined by screenings and/or assessments. LSAs detail their priorities in [Area Plans](#), which are submitted to DSAMH for approval annually.

Geographic Distribution. Salt Lake County accounts for more than 60 percent of LSA admissions and transfers, as shown in Figure 2. Other areas have much smaller client numbers.

Substance Use Disorder Treatment Admissions and Transfers in Utah Fiscal Year 2016

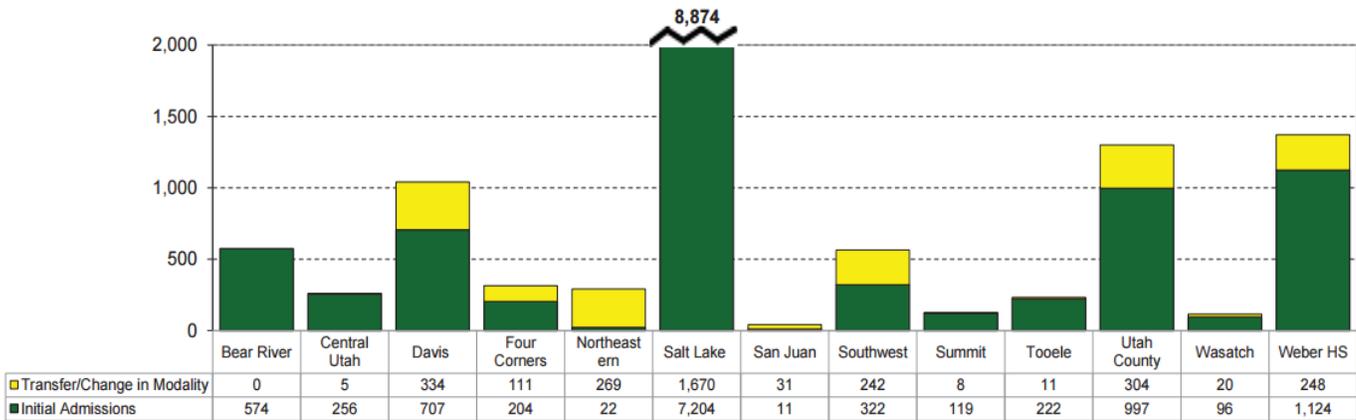


Figure 2. SUD Treatment Admissions and Transfers by LSA.

(Source: DSAMH Annual Report 2016)

Insurance Coverage. LSAs may accept clients with private insurance, or they may direct those individuals to private providers. Clients that are Medicaid-eligible allow the LSA to draw down additional federal funding to support treatment. However, of LSA clients, 84 percent have incomes below the federal poverty line and yet do not qualify for Medicaid. (Since welfare reforms in the 1990s, Medicaid coverage for SUD treatment has been more limited than for mental health treatment; see Figure 3 for a comparison of Medicaid versus non-Medicaid coverage for SUD as compared to mental health). Uninsured clients pay fees based on a sliding scale according to their income; the additional cost of their treatment is funded with county and state dollars.

Adult Substance Use and Mental Health Clients Medicaid and Non-Medicaid Fiscal Year 2012 - 2016

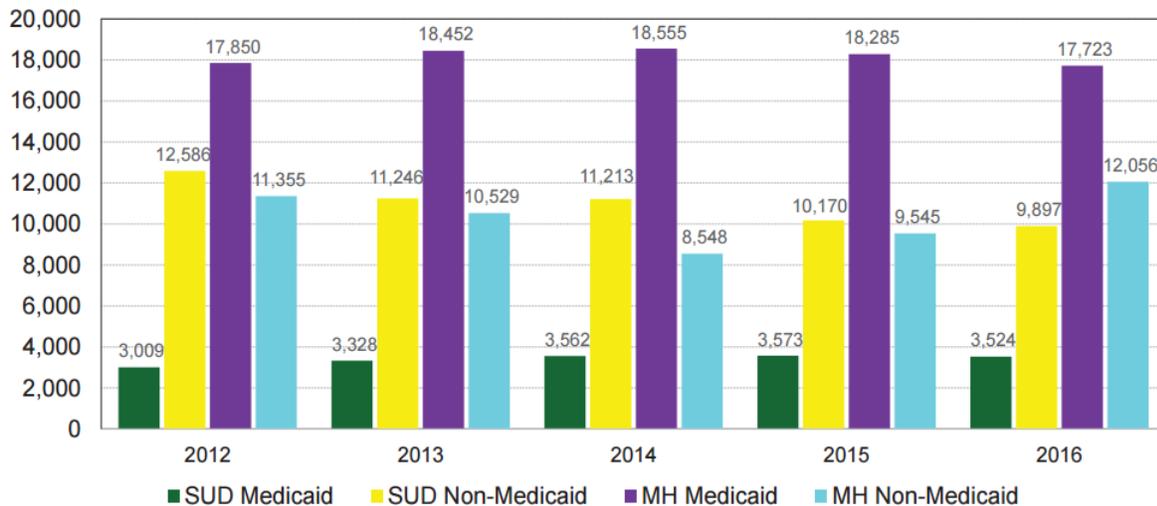


Figure 3. Medicaid and Non-Medicaid Coverage for Adults Receiving Treatment.

(Source: DSAMH Annual Report 2016)

Justice Involvement. Of LSAA clients, 60 percent are involved in the justice system. This figure includes participants in treatment related to drug courts and the Drug Offender Reform Act (DORA) program, which are operated by LSAs. Since the Justice Reinvestment Initiative (JRI) began in FY 2016, DSAMH and LSAs have been working to treat additional justice-involved individuals, as sentencing changes have moved many drug offenders from jail to community settings. Early estimates put the cost of treating this population at about \$20 million: the Legislature appropriated \$4.5 million beginning in FY 2016 and an additional \$6 million beginning in FY 2018. DSAMH is also involved in certifying treatment providers to work with the JRI population. The role of LSAs in treating justice-involved individuals and those who are actively incarcerated in jails varies by county, per the arrangement between the authorities and jails. (Specific information is available in the [Area Plans](#)). Offenders incarcerated in the state prisons are served by the Department of Corrections.

Type of Substance Use. Alcohol was historically the most common substance used by LSAA clients entering treatment, but its use has declined in recent years. DSAMH reports that the decline was due to coordinated alcohol-use prevention efforts with the Department of Health and the Department of Alcoholic Beverage Control, particularly targeted to children and youth. In FY 2016, opioids (which includes both prescription opioids and heroin) became the most common substance, with 29.1 percent of clients identifying them as their primary substance, followed by methamphetamines at 26.1 percent.

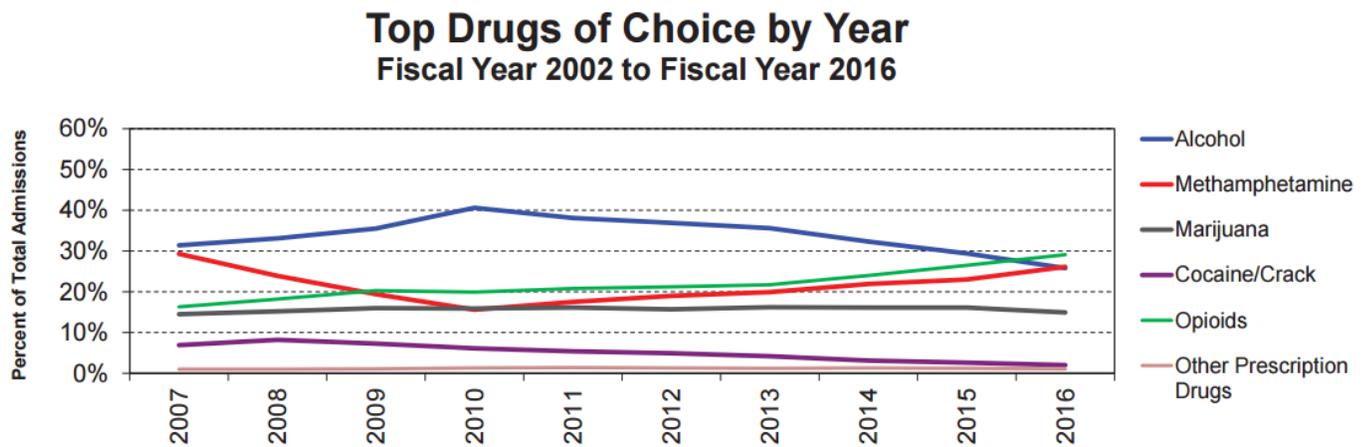


Figure 4. Primary Substance Used, Reported by Clients at Admission.

(Source: DSAMH Annual Report 2016)

2. Why is there a public treatment system and what is it intended to accomplish?

The current organizational structure of the public treatment system was created around 1984. The Legislature, executive branch, and counties agreed that individuals would be best served at the local level, which led to creation of the LSAA system. At that time, most services were paid for by federal block grants and Medicaid was a relatively small source of funding.

Authority for DSAMH is set in statute in UCA [62A-15-1](#). UCA [62A-15-103](#) creates the division and outlines its responsibilities, including education, development of administrative rules, program evaluation, contracts with local authorities, and review and approval of local plans for service delivery.

Authority for LSAAs is set in statute in UCA [17-43-2](#). Counties are designated by UCA [17-43-201](#) as the LSAA, with provisions for multi-county arrangements, and are directed to evaluate substance abuse prevention and treatment needs and services and to promote prevention programs, among other duties. The same section requires LSAAs to match 20 percent of state funds with county funds.

Administrative rules are outlined in Utah Administrative Code [Title R523](#).

Federal law provides the basis for public provision of rehabilitative SUD services, in Section [1905\(a\)\(13\)](#) of the Social Security Act and in [42 CFR 440.130](#), Diagnostic, Screening, Preventive, and Rehabilitative Services.

3. How is the public treatment system organized?

State and Local Authority. DSAMH is the State's public substance abuse authority and sets policy for programs funded with state and federal money. It establishes rules and minimum standards for service delivery at the local level, and develops formulas for distribution of public funds. State statute assigns local substance abuse authority to each county. Counties may create their own LSAA to carry out this responsibility or form an interlocal agreement between multiple counties. There are currently 13 LSAAs across Utah's 29 counties (see Appendix A for specific organization). The LSAAs are the primary organizational unit of the public treatment system in Utah and provide majority of public substance abuse services.

LSAAs also oversee the treatment aspects of drug courts and the DORA program.

- **Drug Courts.** Provide a judicial process that offers nonviolent drug abusing offenders intensive court-supervised drug treatment as an alternative to jail or prison.
- **DORA.** Designed to expand offender access to treatment, provide for more appropriate sentencing by judges, and provide increased community supervision. The program is available for probationers in eight county areas: Cache, Carbon, Weber, Davis, Salt Lake, Utah, Tooele, and Washington/Iron.

Non-LSAA Programs. Some SUD treatment services are operated at the state-level by DSAMH. (These programs are not included in the LSAA data presented in this brief).

- **State Office of Education.** Provides curriculum and training in drug abuse prevention for Utah schools.
- **University of Utah.** Provides counseling education, clinical services, evaluation, and data analysis and operates the Utah School of Alcoholism and Other Drug Dependencies.

- **Women's Residential Treatment.** Includes four residential facilities located in Salt Lake, Weber, Utah, and Washington counties which serve women and children from all areas of the State.
- **Other programs.** Funded largely by specific federal grants (see [COBI](#) for more information).

The Department of Corrections operates treatment programs for individuals incarcerated in the state prisons at Draper and Gunnison.

Service Provision. Most LSAAs, and particularly those in rural areas, use direct care staff to provide treatment services. Salt Lake County, on the other hand, contracts for all services with external treatment providers.

4. What are we buying with the public treatment system?

The public treatment system, through the LSAAs, provides SUD treatment to 14,729 individuals annually. DSAMH describes the benefit to the State as helping to “keep family intact, working, paying taxes and self-sufficient. [The system] also keeps people out of welfare, public housing, high cost Emergency Room use, criminal justice services, child welfare and juvenile justice systems.”

Treatment Services and Administrative Costs. The system is overseen by DSAMH. Fifty-eight percent of division funding is passed through to LSAAs or other entities and another 38 percent is used to operate the Utah State Hospital. The remaining funds, less than five percent of the total budget, are used for personnel and other administration. However, the division does not account for SUD treatment program administration costs separately from mental health administration, due in part to the structure of their Cost Allocation Plan with the federal government. LSAAs allocate administrative costs proportionately across all services, but do not report detailed expenditure categories to the division. They do provide more detailed Medicaid Cost Reports to the Department of Health.

Medicaid Administration. The Department of Health’s Division of Medicaid and Health Financing (DMHF), which operates the state Medicaid program, performs related administrative functions. Work specific to SUD treatment includes:

- **Bureau of Coverage and Reimbursement Policy.** The pharmacy team within the bureau, comprised of five FTEs and which receives input from two advisory committees, works to ensure appropriate utilization of SUD treatment drugs. One example is requiring prior authorization for these drugs. Annual personnel costs for the team are approximately \$479,800 in total funds.
- **Restriction Team.** If the team determines that a beneficiary has utilized services at a frequency or amount that is not medically necessary, the team may restrict the beneficiary to the use of only certain providers, which curbs over-utilization. Annual personnel costs for the team are approximately \$380,800 in total funds. The Restriction Team works specifically on fee-for-service clients and payments: only the Wasatch and Box Elder/Cache/Rich LSAAs operate on fee-for-service payments.

Expenditure Trends Across the Fiscal Year. State SUD treatment expenditures are weighted toward the end of the fiscal year, partly because LSAs are allocated funds on a reimbursement basis. DSAMH also reports that “it is fairly common in healthcare for the billing to lag as the payer of last resort is determined and eligibility solidified with insurance carriers. Since Medicaid eligibility is determined month to month it can be more pronounced, with clients moving on and off Medicaid frequently, causing billings to be delayed as coverage is worked out (Medicaid also has a three-month retroactive period that can occur any month).”

Service Setting. Most SUD treatment services, currently 68.9 percent of admissions, are provided on an outpatient basis. Medicaid does not cover room and board costs in residential settings for SUD treatment, which disincentivizes the development of residential services. The only inpatient service covered by Medicaid is medically necessary, inpatient detoxification. Medicaid only pays hospitals for this service and it is considered non-behavioral medical care: the annual cost is approximately \$1.3 million in total funds, which is not included in the expenditure charts below.

Service Types and Overall Trends. There are nine service categories provided by LSAs, each of which is listed in the next three figures. The Drug Testing and Screening & Assessment categories were recently added, whereas previously they were rolled into other categories; this change explains the apparent decline in expenditures from FY 2014 to FY 2016 in the Outpatient: Non-Methadone category. Funding for FY 2016 includes \$3.7 million in expenditures for JRI-related clients, the portion of a \$4.5 million appropriation that went to SUD and not mental health treatment. The designation of “clients” counts services provided, rather than unique individuals, and some individuals receive multiple services; hence the total client number for FY 2016 was 30,833, compared to the count of 14,729 unique individuals cited previously.

Total Clients Served by Service Type. Outpatient: Non-Methadone is the most common service provided to clients, and represents basic outpatient treatment. Drug Testing and Screening & Assessment services are provided to numerous clients as well. Detoxification Outpatient services have been provided to between one and five clients annually. The total number of clients has increased in recent years, but the number is skewed by the addition of the new Drug Testing and Screening & Assessment categories.

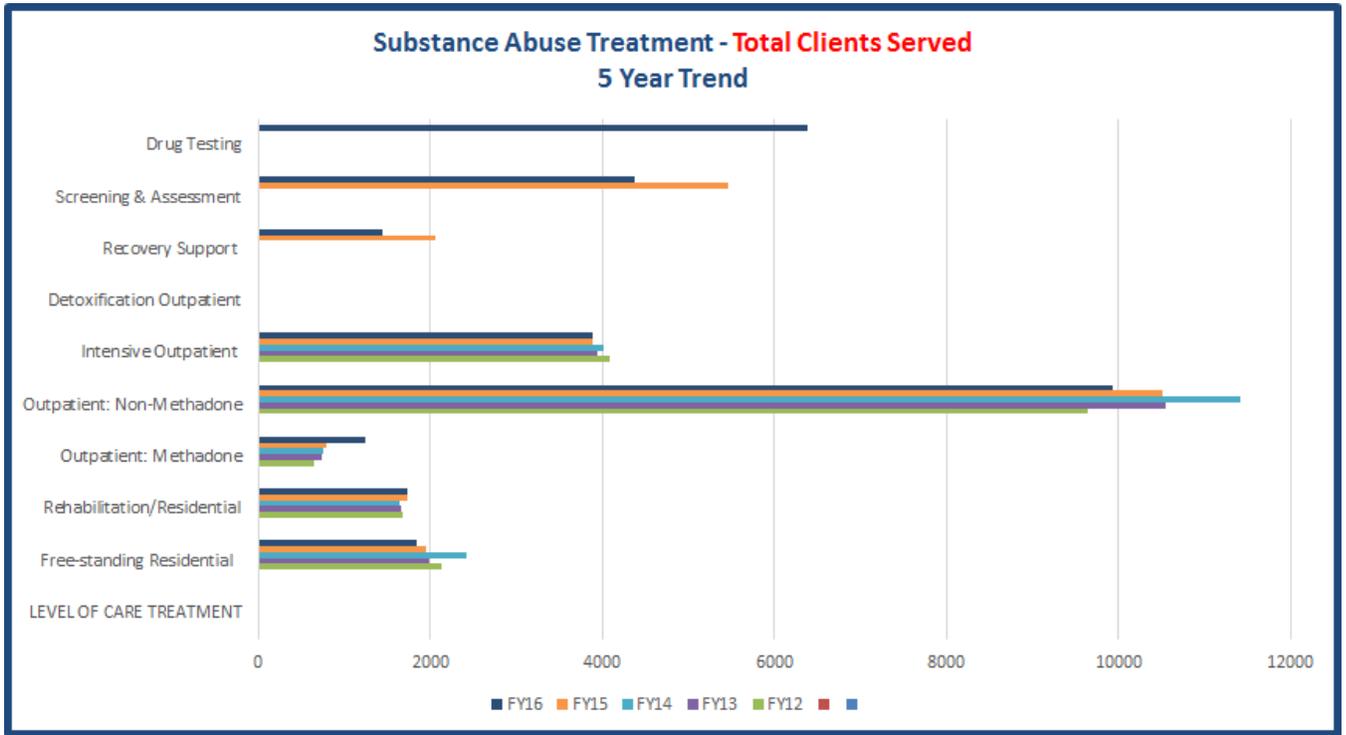


Figure 5. Total Clients Served.

(Source: DSAMH Deep-Dive Response)

Total Expenditures by Service Type. Outpatient: Non-Methadone represents the highest cost category in terms of total dollars spent, followed by Intensive Outpatient and Rehabilitation/Residential (also called social detoxification). Outpatient: Non-Methadone is also the most common service provided.

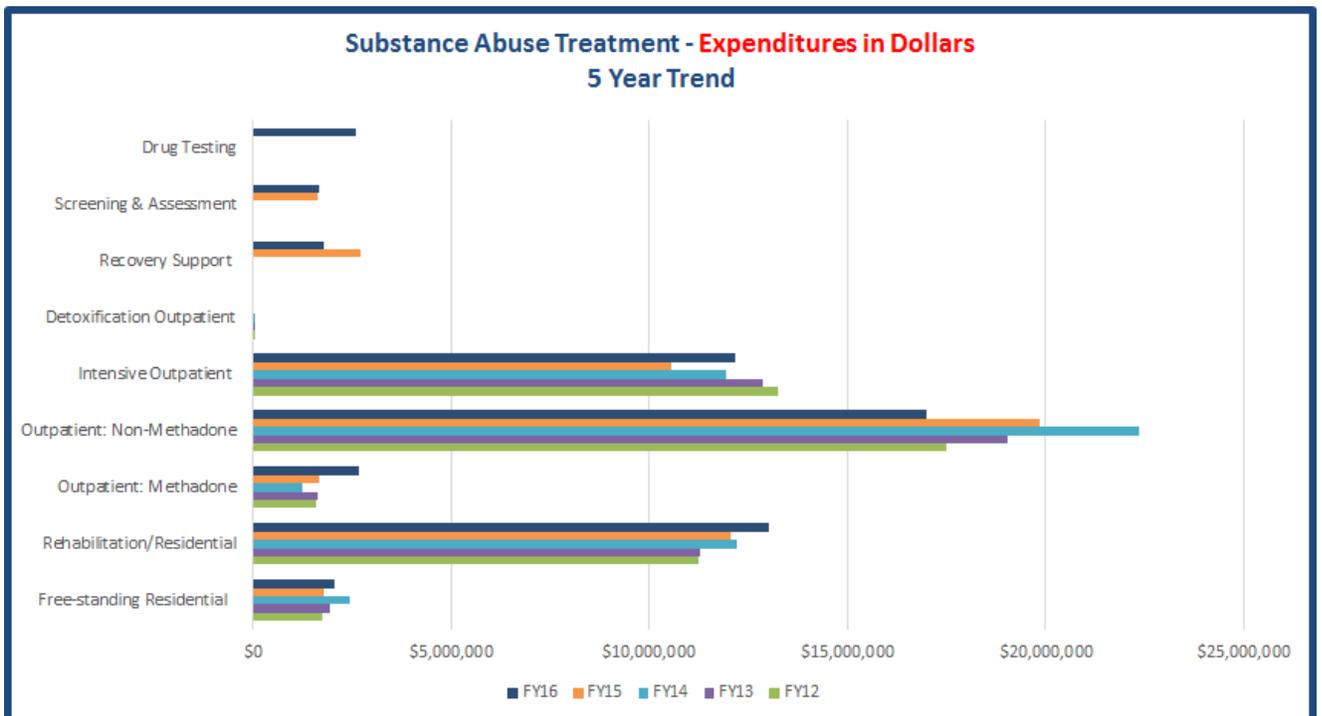


Figure 6. Expenditures in Dollars.

(Source: DSAMH Deep-Dive Response)

Cost-Per-Client Expenditures by Service Type. The high per-client cost for Rehabilitation/Residential is clearly demonstrated in this figure, compared to the relatively small costs of Drug Testing and Screening & Assessment. The highly variable cost of Detoxification Outpatient is due to the small number of clients receiving the service; sometimes these services are classified under Rehabilitation/Residential.

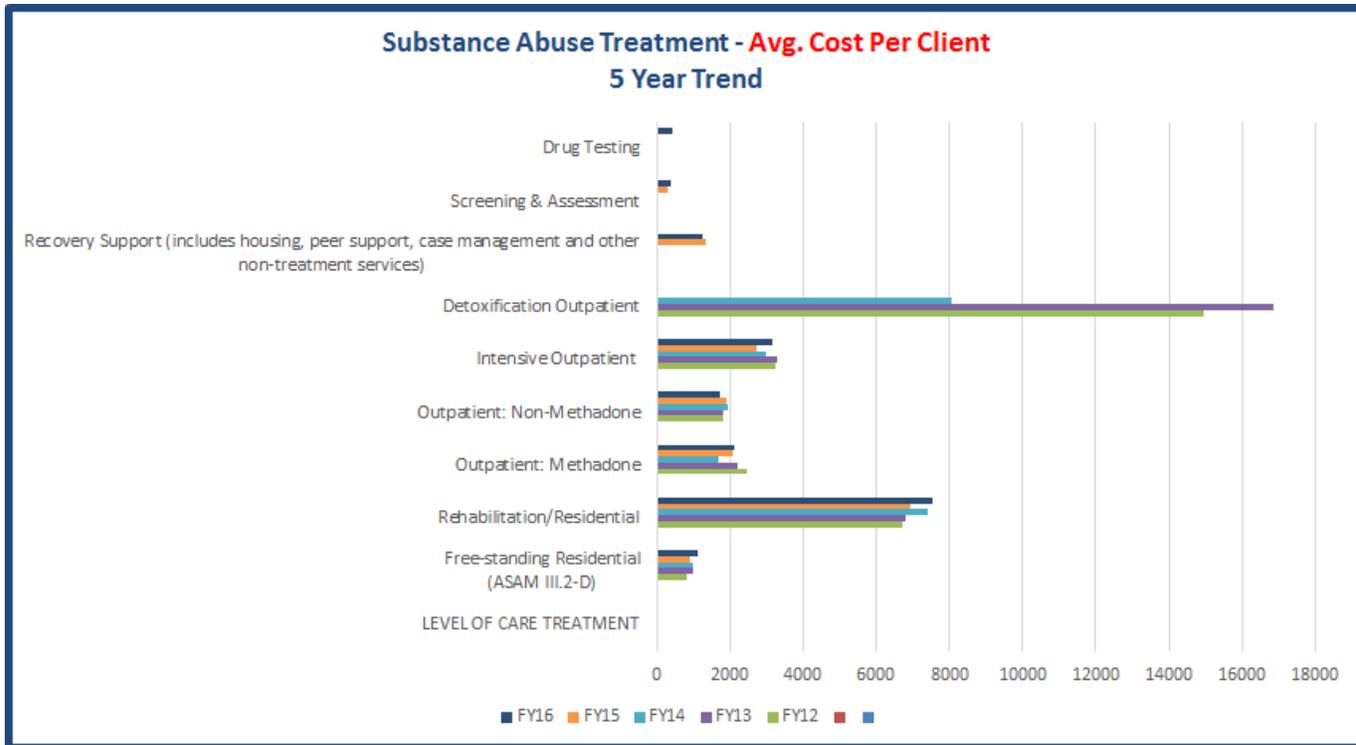


Figure 7. Average Cost Per Client.

(Source: DSAMH Deep-Dive Response)

Client Satisfaction. Client satisfaction scores are largely above benchmark for FY 2016 and have remained constant compared to the previous year.

Agency	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Bear River Health Dept.	*	*	*	*	*	*	*	*
Central Utah	*	*	*	*	*	*	*	*
Davis Behavioral	→ 89	→ 89	→ 95	→ 85	→ 87	→ 83	→ 88	→ 92
Four Corners	↓ 86	→ 95	→ 96	↑ 87	→ 88	→ 84	→ 90	→ 96
Northeastern	↑ 92	→ 86	→ 90	→ 76	→ 82	→ 89	→ 87	↑ 89
Salt Lake County	→ 81	→ 78	→ 83	→ 73	→ 80	→ 83	→ 82	→ 85
San Juan	→ 92	→ 100	→ 92	→ 67	→ 82	↓ 88	→ 92	↑ 91
Southwest	→ 93	↑ 83	→ 91	→ 73	→ 84	→ 85	→ 85	→ 93
Summit Co.	→ 69	↓ 61	→ 77	↑ 67	→ 66	→ 86	→ 67	↑ 77
Tooele Co.	*	*	*	*	*	*	*	*
Utah Co.	→ 86	↑ 83	↓ 87	↓ 81	→ 88	→ 90	→ 90	→ 91
Wasatch Co.	→ 100	→ 96	→ 96	↑ 91	→ 92	→ 96	→ 92	→ 96
Weber	→ 95	→ 96	→ 96	→ 87	→ 84	→ 85	→ 86	→ 96
State	84	78	86	76	81	84	84	88
National (2015)	88	83	88	82	72	71	72	

* Insufficient sample rate.

** Small numbers of surveys may make for unreliable comparisons year-to-year.

Green = Percentage meets or exceeds National Average for MHSIP (except Wellness) or Statewide Average for the YSS and YSS-F Surveys.

Yellow = Percentage between 75% of the National Average and the National Average for MHSIP (except Wellness) or 75% of the Statewide Average and the Statewide Average on YSS and YSS-F.

Red = Percentage below 75% of the National Average for the MHSIP (except Wellness) or of the Statewide Average for the YSS and YSS-F.

↑ ↓ Indicates change in color from prior year.

→ No change from prior year.

Figure 8. Client Satisfaction

(Source: DSAMH Consumer Satisfaction Scorecard 2016)

Treatment Outcomes. Treatment process and outcomes measures have more mixed results. A few areas of particular legislative interest show relatively low scores for FY 2016:

- *Percent of Individuals Completing Treatment Episode Successfully* -- 44.7 percent in FY 2016, down 3.4 percent from the previous year. All but three LSAs scored below DSAMH’s benchmark.
- *Percent of Individuals Completing Treatment Episode Successfully - Heroin & Other Opiates as Primary Drug* -- 36.1 percent in FY 2016, down 1.1 percent from the previous year. Outcome scores for this group also tend to be lower than other groups and some measures of success declined significantly from FY 2015 to FY 2016, including *Increased Drug Abstinence, Increased Employment, and Use of Social Recovery Support*.
- *Number of Justice-Involved Individuals Served* -- 10,411 individuals in FY 2016, down by 184 despite \$4.5 million in new funding from the Justice Reinvestment Initiative (JRI). DSAMH has previously attributed this to greater needs in the served population and to delays in certifying treatment providers, as required by the JRI legislation ([H.B. 348](#), 2015 General Session); some federal funding was also lost in FY 2016. For the full scorecard, see Appendix B or view the [reports](#) online.

FY2016 Utah Substance Abuse Treatment Outcomes Measures Scorecard for all clients

LSAA	Number of Clients Served		Percent Completing Treatment Episode Successfully	
	FY2015	FY2016	FY2015	FY2016
Bear River	948	975	51.5%	50.9%
Central Utah	434	403	69.5%	70.2%
Davis County	1,009	1,072	44.8%	51.1%
Four Corners	525	552	48.9%	44.0%
Northeastern	397	458	56.9%	41.3%
Salt Lake County	7,582	7,214	42.5%	40.0%
San Juan County	90	78	48.6%	36.4%
Southwest Center	639	619	45.5%	41.6%
Summit County	317	262	49.7%	40.5%
Tooele County	478	376	35.8%	21.1%
Utah County	946	1,040	67.1%	46.4%
Wasatch County	129	150	64.4%	60.7%
Weber Human Services	1,534	1,703	55.9%	49.9%
State Average/Total	15,049	14,729	48.1%	44.7%
State Urban Average/Total	10,922	10,938	47.2%	44.1%
State Rural Average/Total	3,919	3,862	50.2%	46.3%
National Average/Benchmark				
Men	9,217	9,025	52.7%	47.3%
Women	5,832	5,704	41.2%	40.7%
Adolescents	1,307	1,324	50.7%	52.1%
DORA	755	795	51.6%	50.9%
Drug Court	2,154	2,084	56.3%	54.0%
Justice Involved	10,595	10,411	53.4%	51.1%
Heroin & Other Opiates Primary	3,937	4,213	37.2%	36.1%
Non - White	4,278	4,333	46.2%	44.6%

Green = 90% or greater of the National Average or meets/exceeds division standards.
 Yellow = Greater than or equal to 75% to less than 90% of the National Average.
 Red = Less than 75% of the National Average or not meeting division standards.

Figure 9. Treatment Outcomes

(Source: DSAMH Outcomes Measures Scorecard 2016)

5. How do we pay for the public treatment system?

LSAAs operate primarily with state funds and federal funds passed through from DSAMH, county general funds, and federal Medicaid funds.

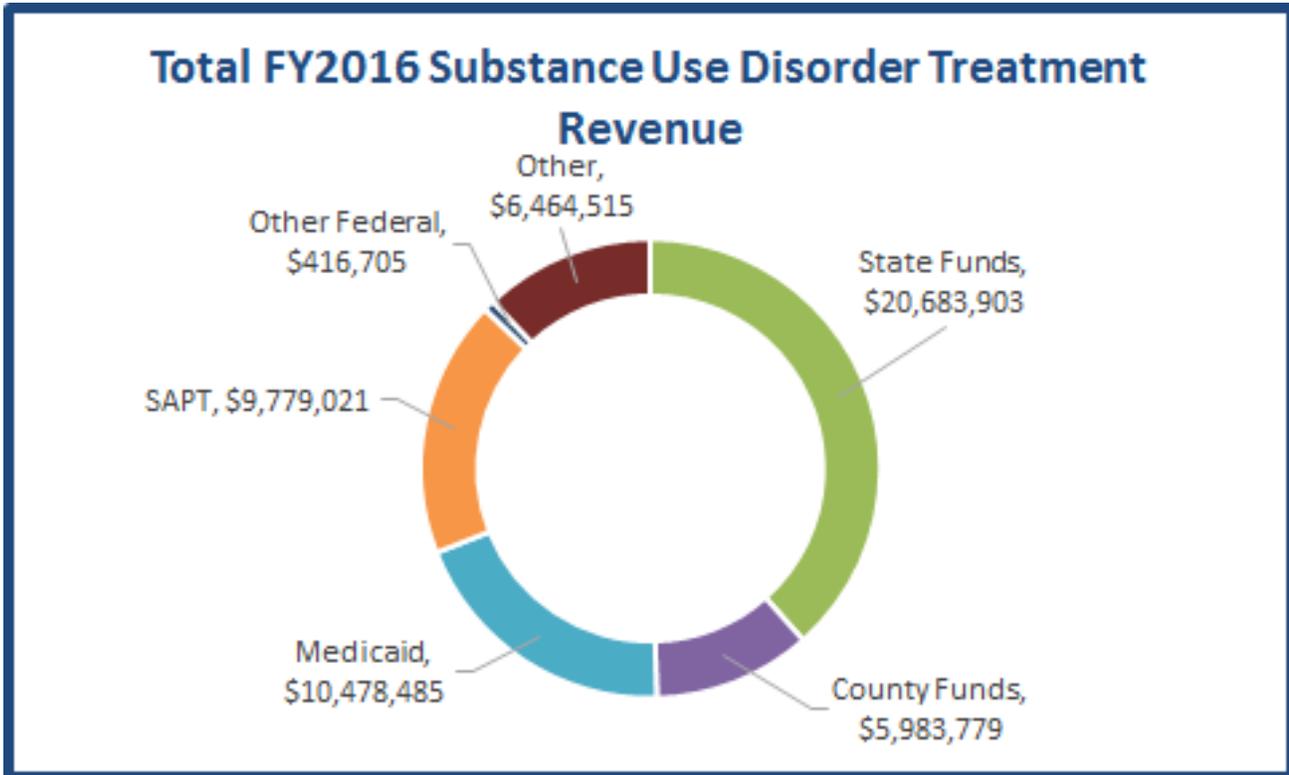


Figure 10. LSAA Revenue Sources

(Source: DSAMH Deep-Dive Response)

State Funds. The Legislature appropriates state General Fund to DSAMH to be passed through to the LSAAs. DSAMH develops formulas, based in statute (UCA [62A-15-1](#)) and administrative rule ([Title R523](#)), that determine the allocations. The formulas account for population and the incidence and prevalence of relevant conditions; there is a rural differential that provides additional funding to rural LSAAs. Formulas were not adjusted for a number of years, but have recently undergone a five-year gradual adjustment that places more weight on incidence and prevalence. The slow transition, which will be complete in FY 2019, allows LSAAs that are receiving less funding to adapt. DSAMH also awards some funding on an application basis, to “hotspot” particular needs. LSAAs are informed of their allocations, but are paid on a reimbursement basis once they have already provided services. State funds, along with county funds, may be used toward obtaining Medicaid matching funds, but actual use varies based on the eligibility of the population that presents at each LSAA during the year. In Figure 11, there is an apparent drop in state funding in FY 2015. This anomaly is actually due to a miscategorization, likely by one LSAA, that documented a portion of state General Fund in the Other category.

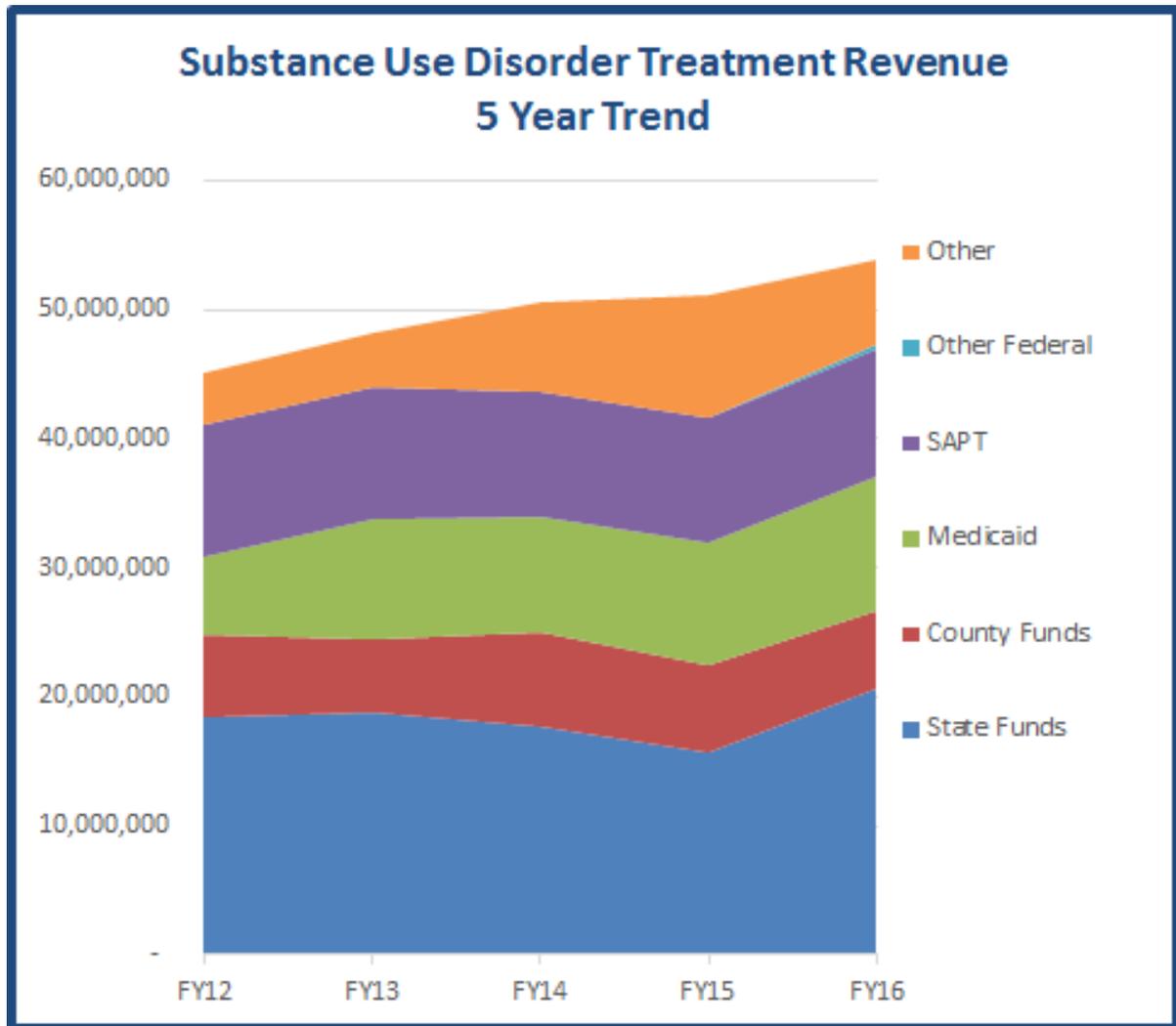


Figure 11. LSAA Revenue Trends - FY 2012-2016.

(Source: DSAMH Deep-Dive Response)

County Funds. Per UCA [17-43-201\(5\)\(k\)](#), counties must “provide funding equal to at least 20% of the state funds that it receives to fund services described in the plan.” However, LSAAAs are not limited to using their matching funds for any particular purpose. County funds may be used toward drawing down Medicaid funds or for individuals that have high needs but lack coverage. They are the most flexible funding source and are often used to balance programs.

Medicaid. Medicaid is a shared state-federal program, with the federal government matching about 70 percent of any state and/or county dollars put toward services for Medicaid-eligible individuals. The exact matching percentage changes slightly each year, based on federal calculations. LSAAAs use state (passed through from DSAMH) and county funds to draw down the match and provide services to Medicaid beneficiaries; they submit these funds directly to the Department of Health, which is the designated state agency for the Medicaid program. Eleven of the 13 LSAAAs have capitated Medicaid programs, in which LSAAAs are paid a flat per-member per-month rate for the care of a given individual. (These capitated programs, called Prepaid Mental Health Plans (PMHPs), are separate from the capitated programs for non-behavioral medical care, known as Accountable Care Organizations (ACOs); they operate similarly, but one

Medicaid-eligible individual could be in an ACO for medical care and fee-for-service for SUD treatment, or vice versa, depending on geographic area). When the State shifted from fee-for-service to capitated Medicaid payments for SUD about five years ago, it had the effect of shifting financial risk to the LSAs since they must manage all of an individual’s needs within the set payment. To incentivize the transition, the State increased the rate somewhat, which has led to a doubling of the proportion of LSA funding from Medicaid (see the green section in Figure 11). Two LSAs remain on the fee-for-service system, Wasatch and Box Elder/Cache/Rich, due to small Medicaid-eligible populations and in order to retain local control over contracting. Because LSAs have statutory responsibility for SUD services, they have the option to operate on a capitated or fee-for-service basis and these entities have not chosen to transition their delivery model.

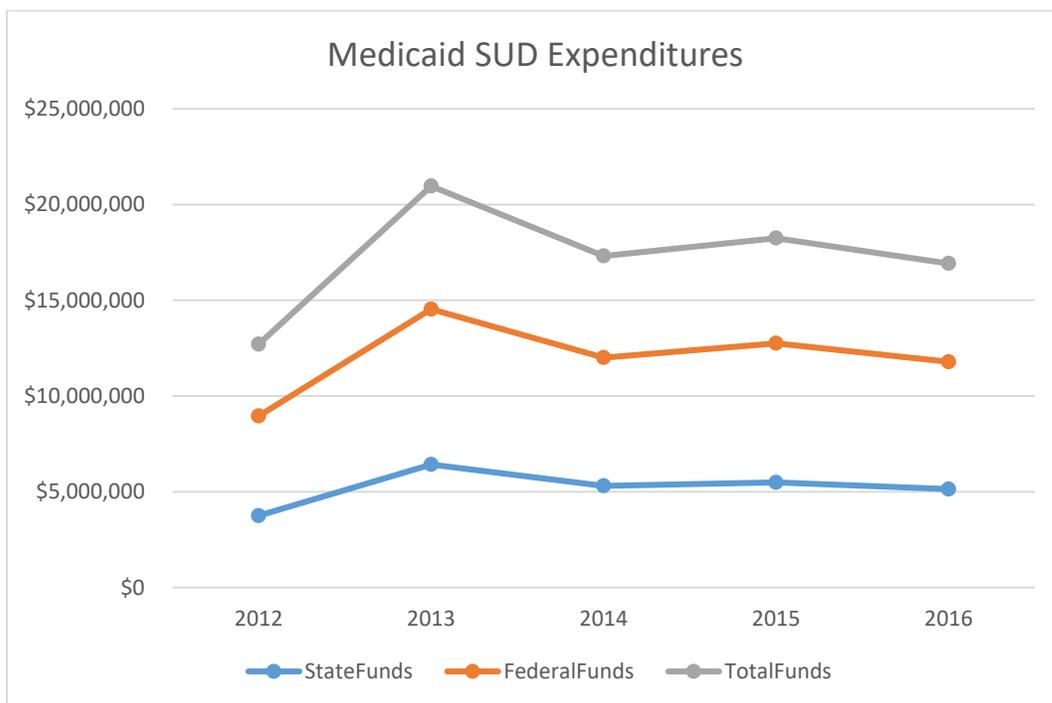


Figure 12. Medicaid SUD Expenditures by Date Served.

Note: “State Funds” includes a combination of state and county funds

(Source: DMHF Deep-Dive Response)

Substance Abuse Prevention and Treatment (SAPT) Block Grant. SAPT funds are dispersed by DSAMH to the LSAs. These federal funds have certain restrictions, but as a block grant, there is more flexibility than with some other grants. In addition to treatment, funds are used for prevention and early intervention, recovery support, and training; funding amounts for these other uses are not reflected here (more information is available in the [LFA Federal Funds Brief](#)). SAPT grants are phased across three years (see Figure 13), which can lead to variation in year-to-year spending and makes it difficult to assess the amount of unencumbered balances at a given time.

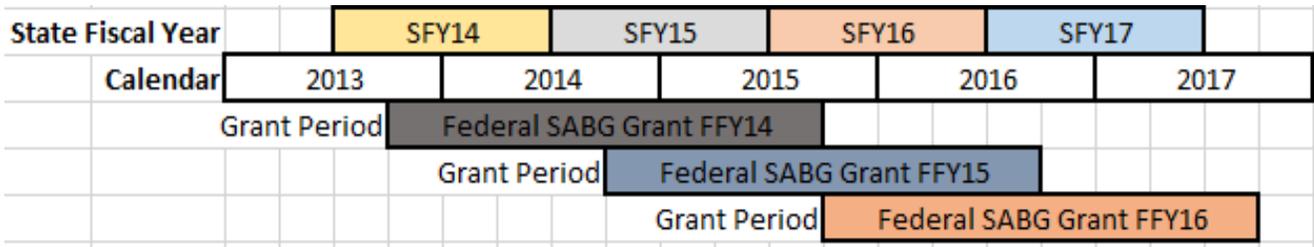


Figure 13. SAPT Grant Timing.

(Source: DSAMH Deep-Dive Response)

Other Federal Funds. LSAAs receive a small amount of funding from other federal grants that is passed through from DSAMH. These grants are usually for specific purposes. Examples include the Utah Opioid STR Grant and State Youth Treatment Grant.

Other Revenue Sources. The Other category of LSAA revenue consists of:

- Third party collections from private insurance companies
- Fees from clients, paid on a sliding scale based on their income
- Payments into an LSAA’s own risk management pool, which are no longer needed in the pool

6. What budget changes are coming or may come in the future?

Several recent or potential changes could impact the SUD treatment system budget.

Justice Reinvestment Initiative Funding. Beginning in FY 2018, the Legislature provided an additional \$6 million toward SUD and mental health services for the JRI population. [S.B. 261](#) (2017 General Session) created an application and review committee process for distribution of these funds. Early estimates suggested another \$10 million in unmet need may still remain.

H.B. 437 - Medicaid Extension. H.B. 437 from the 2016 General Session extended Medicaid benefits to certain new populations, pending waiver approval by the federal government. The ability to draw down the 70 percent federal match for additional individuals would increase the total funding and number of clients that could be served by LSAAs; it would also reduce the unmet funding needs associated with JRI.

Utah Opioid STR Grant Project. DSAMH recently received \$5.5 million in new federal funding to address the opioid epidemic. Of this amount, \$1.8 million will be distributed to LSAAs on formula for treatment and another \$1.8 million will be distributed on an application basis to “hotspot” areas with high opioid use and death rates.

Sixteen-Bed Rule Waiver. Medicaid rules prohibit reimbursement for treatment provides with more than 16 beds, to reduce the possibility that those with behavioral disorders will be warehoused. However, the rule limits providers from leveraging economies of scale and decreases the number of treatment slots available. DMHF is applying for a federal waiver from the requirement, which has been granted to other states.

Appendix A

Organization of Local Substance Abuse Authorities:

- Interlocal agreement between **Box Elder, Cache, and Rich counties** known as District 1 Substance Abuse Authority -- services provided through Bear River Health District
- Interlocal agreement between **Carbon, Emery, and Grand counties** -- services provided by Four Corners Community Mental Health Center, Inc., a private, not-for-profit entity
- Interlocal agreement between **Juab, Millard, Piute, Sevier, Wayne, and Sanpete counties** -- services provided by Central Utah Mental Health/Substance Abuse Center doing business as Central Utah Counseling Center, a governmental entity formed via the interlocal agreement
- **Davis County** -- services provided through a contract with Davis Behavioral Health Inc., a private, not-for-profit entity
- **Salt Lake County**, Division of Behavioral Health Services -- services provided by the county mainly through subcontracts with private substance abuse service providers
- **San Juan County** -- services provided through San Juan County Substance Abuse/Mental Health Special Service District operating as San Juan Counseling, a service district organized under the *Utah Special Services District Act*
- Interlocal agreement between **Beaver, Garfield, Iron, Kane, and Washington counties** -- services provided by Southwest Behavioral Health Center also known as Southwest Center, a governmental entity formed via the interlocal agreement
- **Summit County** -- services provided through a contract with Valley Behavioral Health, a private, not-for-profit entity
- **Tooele County** -- services provided through a contract with Valley Behavioral Health, a private, not-for-profit entity
- Interlocal agreement between **Daggett, Duchesne, and Uintah counties** -- services provided by Uintah Basin Tri-County Mental Health and Substance Abuse Local Authority doing business as Northeastern Counseling Center, a governmental entity
- **Wasatch County** -- services provided by Wasatch Mental Health Services Special Service District, organized under the Utah Special Services District Act and operates as Wasatch Mental Health
- **Utah County** -- services provided by Utah County Division of Substance Abuse through subcontracts with private substance abuse service providers
- Interlocal agreement between **Morgan and Weber counties** -- services provided by Weber Human Services, a governmental entity formed via the interlocal agreement

Appendix B

<https://dsamh.utah.gov/pdf/Outcomes/FY2016%20SUD%20Scorecard%20Final.pdf>

FY2016 Utah Substance Abuse Treatment Outcomes Measures Scorecard for all clients

10/31/2016

Process Measures														
LSAA	Admissions (Initial and Transfer)		Number of Clients Served		Percent of Admissions in Outpatient/IOP/ Residential/Detox		Number of Completed Treatment Episodes, excluding Detox		Median Days in Treatment		Percent of clients retained in treatment 60 or more days		Percent Completing Treatment Episode Successfully	
	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016
Bear River	527	574	948	975	85/15/0/0	89/11/0/0	520	586	149	113	73.1%	68.3%	51.5%	50.9%
Central Utah	231	261	434	403	96/3/1/0	99/1/0/0	167	248	195	135	87.4%	69.0%	69.5%	70.2%
Davis County	1,026	1,041	1,009	1,072	55/30/15/0	55/31/14/0	630	632	161	161	81.0%	78.0%	44.8%	51.1%
Four Corners	371	315	525	552	59/38/2/1	61/36/3/0	133	159	113	284	68.4%	82.4%	48.9%	44.0%
Northeastern	262	291	397	458	91/9/0/0	86/14/0/0	153	172	92	125	62.7%	68.0%	56.9%	41.3%
Salt Lake County	8,739	8,874	7,582	7,214	37/20/10/33	36/21/10/33	3,695	2,799	99	92	73.0%	65.4%	42.5%	40.0%
San Juan County	81	42	90	78	95/3/2/0	100/0/0/0	37	22	140	207	75.7%	72.7%	48.6%	36.4%
Southwest Center	613	564	639	619	49/31/20/0	44/35/21/0	356	433	237	234	80.6%	82.4%	45.5%	41.6%
Summit County	167	127	317	262	79/20/1/0	79/21/0/0	169	131	112	179	60.9%	69.5%	49.7%	40.5%
Tooele County	234	233	478	376	83/17/0/0	84/16/0/0	279	204	119	109	67.4%	64.2%	35.8%	21.1%
Utah County	1,277	1,301	946	1,040	29/30/22/19	29/29/27/15	569	603	99	54	67.0%	48.1%	67.1%	46.4%
Wasatch County	92	116	129	150	64/35/1/0	71/27/2/0	73	61	100	61	65.8%	52.5%	64.4%	60.7%
Weber Human Services	1,263	1,372	1,534	1,703	83/12/5/0	81/14/5/0	903	935	110	107	66.1%	68.7%	55.9%	49.9%
State Average/Total	14,923	15,111	15,049	14,729	48/21/10/21	47/22/10/21	7,716	6,985	114	102	72.2%	67.3%	48.1%	44.7%
State Urban Average/Total	12,305	12,588	10,922	10,938	43/21/11/25	42/22/11/25	5,797	4,969	106	93	72.2%	65.5%	47.2%	44.1%
State Rural Average/Total	2,578	2,523	3,919	3,862	73/21/6/0	74/21/5/0	1,887	2,016	148	147	72.4%	71.7%	50.2%	46.3%
National Average/Benchmark														
Men	9,386	9,463	9,217	9,025	46/19/9/26	45/20/9/26	4,640	4,270	105	98	72.0%	67.8%	52.7%	47.3%
Women	5,537	5,648	5,832	5,704	51/24/12/13	51/24/13/12	3,076	2,715	136	109	72.5%	66.4%	41.2%	40.7%
Adolescents	1,193	1,218	1,307	1,324	76/19/5/0	73/20/6/1	1,149	856	114	103	74.6%	71.1%	50.7%	52.1%
DORA	775	770	755	795	49/32/15/4	39/35/19/7	312	338	202	170	74.0%	72.2%	51.6%	50.9%
Drug Court	1,730	1,859	2,154	2,084	46/35/17/2	44/35/18/3	684	797	338	335	87.9%	84.8%	56.3%	54.0%
Justice Involved	9,584	9,516	10,595	10,411	53/26/10/11	51/27/11/11	5,518	5,018	115	113	74.8%	71.7%	53.4%	51.1%
Heroin & Other Opiates Primary	3,955	4,404	3,937	4,213	40/23/14/23	39/24/14/23	1,642	1,674	109	93	68.3%	62.7%	37.2%	36.1%
Non - White	4,269	4,222	4,278	4,333	51/22/6/21	51/21/7/21	2,219	2,006	103	96	72.2%	68.6%	46.2%	44.6%

Outcome Measures														
LSAA	Increased Alcohol Abstinence - Percent increase in those reporting alcohol abstinence from admission to discharge		Increased Drug Abstinence - Percent increase in those reporting other drug abstinence from admission to discharge		Increase in Stable Housing - Percent increase in non-homeless clients admission to discharge		Increased Employment - Percent increase in those employed full/part time or student from admit to discharge		Decreased Criminal Justice Involvement - Percent decrease in number of clients arrested prior to admission vs. prior to discharge		Social Support Recovery - Percent increase in those using social recovery support		Tobacco Use Percent decrease in number of clients reporting tobacco use from admission to discharge	
	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016	FY2015	FY2016
Bear River	158.8%	140.3%	316.7%	307.1%	-0.4%	-0.5%	15.3%	19.8%	57.1%	-271.4%	195.0%	54.2%	10.2%	5.5%
Central Utah	48.9%	44.6%	141.6%	166.9%	-1.2%	-0.4%	20.4%	32.2%	28.3%	72.3%	53.0%	49.2%	2.5%	-0.9%
Davis County	81.4%	78.0%	433.9%	445.9%	-1.6%	-0.3%	45.8%	54.7%	24.0%	58.3%	34.4%	45.5%	-1.2%	29.7%
Four Corners	12.4%	32.8%	76.8%	72.3%	0.7%	1.2%	35.3%	37.9%	18.2%	48.0%	107.6%	-1.0%	-9.2%	9.9%
Northeastern	59.8%	64.9%	103.6%	113.0%	0.0%	-2.3%	26.9%	13.6%	36.9%	50.3%	-25.0%	12.1%	9.9%	6.2%
Salt Lake County	20.6%	13.6%	89.0%	69.1%	2.2%	2.5%	21.2%	5.9%	66.2%	43.2%	88.2%	29.6%	17.7%	6.7%
San Juan County	93.6%	35.8%	54.9%	160.4%	*	*	36.3%	0.0%	-66.7%	0.0%	120.0%	0.0%	19.2%	31.2%
Southwest Center	26.4%	43.0%	260.7%	360.7%	-0.3%	2.8%	25.6%	19.6%	20.6%	0.0%	24.8%	23.2%	-1.3%	6.3%
Summit County	72.6%	60.5%	45.1%	23.8%	-1.2%	-0.8%	10.2%	-32.2%	74.2%	82.3%	48.8%	38.1%	3.9%	-1.6%
Tooele County	34.6%	21.4%	98.3%	28.4%	0.0%	0.5%	11.1%	-33.6%	74.8%	83.5%	36.4%	221.2%	-1.4%	6.2%
Utah County	60.9%	22.8%	668.8%	118.6%	0.5%	1.3%	26.8%	31.0%	48.0%	67.5%	32.6%	18.4%	-1.9%	3.7%
Wasatch County	87.1%	105.5%	166.3%	161.5%	-1.4%	1.6%	16.9%	7.9%	70.1%	47.3%	5.4%	7.0%	8.4%	0.0%
Weber Human Services	71.7%	64.8%	200.0%	268.6%	1.1%	0.7%	17.8%	11.8%	64.7%	72.5%	-9.0%	-9.4%	0.3%	0.2%
State Average/Total	39.3%	35.7%	131.1%	126.9%	1.0%	1.2%	22.4%	13.9%	53.7%	55.5%	55.1%	27.2%	9.3%	7.2%
State Urban Average/Total	33.8%	27.4%	127.7%	117.6%	1.4%	1.6%	23.8%	15.3%	55.2%	56.0%	59.6%	24.4%	11.0%	7.8%
State Rural Average/Total	60.7%	62.6%	146.7%	149.7%	-0.4%	0.3%	19.2%	11.6%	50.5%	53.4%	40.6%	34.7%	3.9%	5.2%
National Average/Benchmark	31.0%	21.3%	42.5%	36.7%	3.2%	3.0%	13.7%	13.7%	45.5%	29.9%	60.9%	54.0%		
Men	43.4%	40.3%	126.5%	123.6%	0.8%	1.1%	16.7%	9.8%	52.3%	55.6%	66.2%	28.1%	11.4%	8.2%
Women	33.6%	28.9%	139.1%	131.2%	1.2%	1.4%	35.3%	23.3%	56.2%	55.2%	40.2%	26.4%	6.0%	5.5%
Adolescents	29.3%	32.4%	153.4%	178.1%	-0.6%	-0.2%	-0.7%	-7.1%	52.2%	48.2%	31.7%	82.8%	-10.2%	9.2%
DORA	24.7%	29.9%	170.7%	204.2%	1.0%	0.8%	38.5%	26.5%	40.2%	57.1%	46.6%	38.1%	-2.4%	4.4%
Drug Court	36.2%	33.6%	304.8%	268.8%	2.7%	2.2%	52.3%	64.5%	62.9%	59.5%	36.8%	24.4%	12.2%	7.8%
Justice Involved	42.8%	41.1%	145.6%	150.9%	0.3%	0.8%	20.5%	15.3%	58.5%	58.2%	58.2%	30.0%	13.1%	8.4%
Heroin & Other Opiates Primary	11.5%	10.4%	340.9%	258.9%	1.6%	1.6%	52.0%	39.8%	46.4%	49.6%	45.1%	18.1%	11.7%	6.3%
Non - White	35.1%	32.2%	111.8%	102.5%	0.3%	1.4%	12.1%	4.8%	51.6%	51.3%	86.0%	27.6%	9.2%	8.7%

Note: Outcomes exclude detox discharges
Salt Lake, Davis, Weber (Mogan is included in Weber County), and Utah Counties are reported as Urban. All other counties are reported as rural.

Green = 90% or greater of the National Average or meets/exceeds division standards.
Yellow = Greater than reported by 25% to less than 90% of the National Average.
Red = Less than 75% of the National Average or not meeting division standards.

* No one homeless at admission so no opportunity for change.
** No one reported at discharge.
* Unknown count too high (above 50%)

Decreased Use and Completing Modality Successfully are not national measures and are not scored.
State Total for Clients Served is an unduplicated client count across all modalities and is not a sum of the clients served for the providers listed.
Final Discharges are reported by treatment episode.
Admissions are the number of duplicated admissions to a treatment modality that occurred within the fiscal year. Clients served are an unduplicated count of clients served during the fiscal year. Due to a change in reporting procedures, The numbers on this chart may not be the same as reported in previous years.
Justice Involved includes clients with DORA, Drug Court, Probation or Parole, arrests at admit, court compelled or referral from the criminal justice system.
Non - White includes Race other than "White" or Ethnicity of Hispanic decent.

Calculations for SA Outcomes:

All outcomes are percent increase or decrease. Specific percentages are calculated as follows using FY final discharges, excluding detox-only clients. Percents at admission and discharge are calculated by dividing the number of clients reporting the outcome divided by the total number of discharged clients with valid, non-missing, data for that measure.

Abstinence (Percent Increase):
(Percent abstinent at discharge minus percent abstinent at admission) divided by percent abstinent at admission

Stable Housing (Percent Increase):
(Percent not homeless at discharge minus percent not homeless at admission) divided by percent not homeless at admission.

Employment/School (Percent Increase):
(Percent employed/student at discharge minus percent employed/student at admission) divided by percent employed/student at admission.

Criminal Justice (Percent Decrease):
(Percent arrested at 30-days prior to admission minus percent arrested 30-days prior to discharge) divided by percent arrested 30-days prior to admission.

Length of Stay:
Median length of stay calculated from admission date to date of last contact for those discharged in the fiscal year