Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations Monitoring Report Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration

The state should complete this title page at the beginning of a demonstration and submit as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	Utah
Demonstration name	Utah's Medicaid Reform 1115 Demonstration
Approval period for section 1115 demonstration	07/01/2022 – 06/30/2027
SMI/SED demonstration start date[a]	12/16/2020
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	01/01/2021
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	The goal of this approval is for the state to maintain and enhance access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment to Medicaid beneficiaries with serious mental illness (SMI) and/or SUD. This demonstration will provide the state with authority to provide high quality, clinically appropriate treatment to beneficiaries with SMI while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. It will also support state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SMI evidence-based services at varied levels of intensity, including withdrawal management services.
SMI/SED demonstration year and quarter	SMI/SED DY3Q1
Reporting period	07/01/2022-09/30/2022

[a] **SMI/SED demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SMI/SED demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions of mental disease.

2. Executive summary

The executive summary should be reported in the fillable box below. It is intended for summary-level information only. The recommended word count is 500 or less.

During the last year, the State Medicaid system experience the impacts of the continued public health emergency declaration and the resulting maintenance of effort which led to continued increased growth in Medicaid enrollment and a subsequent increase in service delivery. The impact this had had on the State's SMI delivery system is demonstrated throughout the metrics. Due to the significant impact of COVID-19, the State will continue to monitor metrics in an effort to distinguish the effects of COVID-19 on the system versus the effects the waiver is having on the system.

Utah has had no providers enroll to provide services to beneficiaries with an SMI in a residential IMD setting. Feedback from stakeholders has been that the risk of exceeding 60-days of continuous treatment and then not being eligible for any FFP is too great. Also, stakeholders have expressed that they believe the high bar of accreditation is too costly and unnecessary since the state licenses and provides oversight to residential treatment programs to ensure the quality of services already.

3. Narrative information on implementation, by milestone and reporting topic

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.1. Metric trends			
1.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	X		
1.2. Implementation update			
1.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1a. The licensure or accreditation processes for participating hospitals and residential settings	X		
1.2.1b. The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	X		
1.2.1c. The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	X		
1.2.1d. The program integrity requirements and compliance assurance process	X		
1.2.1e. The state requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	X		
1.2.1f. Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	X		
1.2.2. The state expects to make other program changes that may affect metrics related to Milestone 1.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2. Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)			
2.1. Metric trends			

2.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.	X	#6d,e: Medication Continuation Following Inpatient Psychiatric Discharge #6d,e: Medication Continuation Following Inpatient Psychiatric Discharge #6d,e: Medication Continuation Following Inpatient Psychiatric Discharge #7-30: Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) #9-30: Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence.	#6d,e: The number of beneficiaries with a major depressive disorder (MDD), schizophrenia, or bipolar disorder who filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge increased for all three groups due to unknown reasons. The state will continue to monitor this metric. #7-30: The percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days increased by 2.2% due to unknown reasons. The state will continue to monitor this metric. #9-30: The percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence within 30 days increased by 3.7% due to unknown reasons. The state will continue to monitor this metric. #9-7: The percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence within 7 days increased by 4.0% due to unknown reasons. The state will continue to monitor this metric. #10-30: The percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness increased by 2.4% due to unknown reasons. The state will continue to monitor this metric.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
		#9-7: Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. #10-30: Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:	

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2. Implementation update			
2.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1a. Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	X		
2.2.1b. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers	X		
2.2.1c. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge	X		
2.2.1d. Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)	X		
2.2.1e. Other State requirements/policies to improve care coordination and connections to community-based care	X		
2.2.2. The state expects to make other program changes that may affect metrics related to Milestone 2.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3. Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.1. Metric trends			
3.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.		#13: Mental Health Services Utilization – Inpatient #14: Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization #15: Mental Health Services Utilization – Outpatient #16: Mental Health Services Utilization – ED #17: Mental Health Services Utilization – Telehealth #18: Mental Health Services Utilization – Any Services	#13: The number of beneficiaries in the demonstration population who use inpatient services related to mental health decreased by 3.0% probably due to the increase in IOP and PHP service utilization. #14: The number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health decreased by 38.1%. The large percentage change is due to the small number of beneficiaries in this metric. The total change was only 23 beneficiaries. #15: The number of beneficiaries in the demonstration population who used outpatient services related to mental health increased by 4.4% probably due to the continued increase in Medicaid enrollment due to the PHE. #16: The number of beneficiaries in the demonstration population who use emergency department services for mental health decreased by 3.3%. The percentage change is due to the small number of beneficiaries in this metric. The total change was only 1 beneficiary. #17: The number of beneficiaries in the demonstration population who used telehealth services related to mental health increased by 6.0%. This is an unexpected change that Utah will monitor with future reports. #18: The number of beneficiaries in the demonstration population who used any services related to mental health increased by 4.0% probably due to the increase in telehealth services.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.2. Implementation update			
3.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1a. State requirement that providers use an evidenced-based, publicXly-available patient assessment tool to determine appropriate level of care and length of stay	X		
3.2.1b. Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	X		
3.2.2. The state expects to make other program changes that may affect metrics related to Milestone 3.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4. Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.1. Metric trends			

4.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.		#22-Standard Definition SMI: Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period. #22-State Definition SMI: Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period. #29d-Had Both Tests: The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotics prescriptions and had metabolic testing. #29d-Missing Both: The percentage of children and adolescents ages 1	#22-Standard Definition SMI: The number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period increased by 2.2% due to continued increase in Medicaid enrollment due to the PHE. #22-State Definition SMI: The number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period increased by 17.8% due to continued increase in Medicaid enrollment due to the PHE. #29d-Had Both Tests: The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotics prescriptions and had metabolic testing increased by 4.7& due to Medicaid staff calling or sending letters to providers on this issue. #29d-Missing Both: The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotics prescriptions and were missing metabolic testing decreased due to Medicaid staff calling or sending letters to providers on this issue.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
		to 17 who had two or more antipsychotics prescriptions and had metabolic testing.	
4.2. Implementation update			
4.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 4.2.1a. Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)	X		
4.2.1b. Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	X		
4.2.1c. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED	X		
4.2.1d. Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	X		
4.2.2. The state expects to make other program changes that may affect metrics related to Milestone 4.	X		
5. SMI/SED health information technology (health IT)			
5.1. Metric trends			
5.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics.	X		This the first time the state is collecting these metrics so no trend is available.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2. Implementation update			
5.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 5.2.1a. The three statements of assurance made in the state's health IT plan	X		
5.2.1b. Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community-based supports	X		
5.2.1c. Electronic care plans and medical records	X		
5.2.1d. Individual consent being electronically captured and made accessible to patients and all members of the care team	X		
5.2.1e. Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem	X		
5.2.1f. Telehealth technologies supporting collaborative care by facilitating broader availability of integrated mental health care and primary care	X		
5.2.1g. Alerting/analytics	X		
5.2.1h. Identity management	X		
5.2.2. The state expects to make other program changes that may affect metrics related to health IT.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6. Other SMI/SED-related metrics			
6.1. Metric trends			

6.1.1. The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.	X	#32: The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period. #33: The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period. #34: Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period. #35: Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during	#32: The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period increased by 15.4% due to increased utilization of these services. #33: The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period decreased by 2.3% due to increased utilization of services outside of inpatient and residential settings. #34: Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period decreased by 2.3% due to increased utilization of IOP and PHP services. #35: Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period decreased by 7.9% due to increased utilization of services outside of inpatient and residential settings. #36: The number of grievances filed during the measurement period that are related to services for SMI/SED decreased by 29.5% due to unknown reasons. The state will continue to monitor this metric. #37: The number of appeals filed during the measurement period that are related to services for SMI/SED decreased by 26% due to unknown reasons. The state will continue to monitor this metric. #39: The total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year increased by 21.9% due to an increased population and increased utilization of services by the population. #40: The per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year decreased by 16.3% due to beneficiaries' utilization lower levels of care that are less costly than residential and inpatient settings.

		the measurement period. #36: Number of grievances filed during the measurement period that are related to services for SMI/SED. #37: Number of appeals filed during the measurement period that are related to services for SMI/SED. #39: Total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year. #40: Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2. Implementation update			
6.2.1. The state expects to make the following program changes that may affect other SMI/SED-related metrics.	X		

4. Narrative information on other reporting topics

Prompt	State has no trends/update to report (place an X)	State response
7. Annual Assessment of the Availability of Mental Health Services (Annual Availability Assessment)		
7.1. Description of changes to baseline conditions and practices		
7.1.1. Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	X	
7.1.2. Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	X	

Prompt	State has no trends/update to report (place an X)	State response
7.1.3. Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of the Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.	X	
7.1.4. Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Annual Availability Assessment compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	X	
7.1.5. Describe and explain whether any changes in the availability of mental health services have impacted the state's maintenance of effort (MOE) on funding outpatient community-based mental health services. Recommended word count is 500 words or less.	X	
7.2. Implementation update		
7.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 7.2.1a. The state's strategy to conduct annual assessments of the availability of mental health services across the state and updates on steps taken to increase availability	X	

Prompt	State has no trends/update to report (place an X)	State response
7.2.1b. Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	X	
8. Maintenance of effort (MOE) on funding outpatient community-based mental health services		
8.1. MOE dollar amount		
8.1.1. Provide as a dollar amount the level of state appropriations and local funding for outpatient community-based mental health services for the most recently completed state fiscal year.		*SFY22 Outpatient Community-Based Mental Health Services* *Sum of Federal Funds: $331,410,227.12* *Sum of State General Funds: $27,277,357.14* *Sum of State County Funds: $57,285,320.73* *Sum of Total Funds $415,972,905.00*
8.2. Narrative information		
8.2.1. Describe and explain any reductions in the MOE dollar amount below the amount provided in the state's application materials. The state should confirm that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.	*X*	*The state has not reduced the MOE dollar amount below what was provided in the state's application materials. The state has increased funding for community-based services.*
9. SMI/SED financing plan		
9.1. Implementation update		
9.1.1. Compared to the demonstration design and operational details, the state expects to make the following changes: 9.1.1a. Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders	X	

Prompt	State has no trends/update to report (place an X)	State response
9.1.1b. Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model	X	
10. Budget neutrality		
10.1. Current status and analysis		
10.1.1. Describe the current status of budget neutrality and an analysis of the budget neutrality to date. If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole.		*For the current 1115 Waiver, the state estimates the SMI eligibility group will be budget neutral. The waiver as a whole, is not projected to be budget neutral. The overall cause is due to two factors: 1) Adult Expansion population expenses have come in higher than projected, and 2) The current Adult Expansion PMPMs are ones the state submitted prior to submitting higher PMPMs for both the Integrated Care and Fallback Plans. The state is in discussions with CMS about budget neutrality.*
10.2. Implementation update		
10.2.1. The state expects to make the following program changes that may affect budget neutrality.	*X*	
11. SMI/SED-related demonstration operations and policy		
11.1. Considerations		
11.1.1. The state should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.	X	

Prompt	State has no trends/update to report (place an X)	State response
11.2. Implementation update		
11.2.1. The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.	X	
11.2.2. The state is working on other initiatives related to SMI/SED.	X	
11.2.3. The initiatives described above are related to the SMI/SED demonstration as described (The state should note similarities and differences from the SMI/SED demonstration).	X	
11.2.4. Compared to the demonstration design and operational details, the state expects to make the following changes to: 11.2.4a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)	X	
11.2.4b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)	X	
11.2.4c. Partners involved in service delivery	X	
11.2.4d. The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency	X	

Prompt	State has no trends/update to report (place an X)	State response
12. SMI/SED demonstration evaluation update		
12.1. Narrative information		
12.1.1. Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. There are specific requirements per the Code of Federal Regulations (CFR) for annual reports. See Monitoring Report Instructions for more details.	X	*The state's contracted evaluator, PCG, plans to make modifications to the evaluation design. The state is including a memo detailing the proposed modifications. The evaluation design will be submitted to CMS by March 15, 2023.*
12.1.2. Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.	X	
12.1.3. List anticipated evaluation-related deliverables related to this demonstration and their due dates.		*Submit the summative SMI evaluation to CMS by December 2023.*
13. Other demonstration reporting		
13.1. General reporting requirements		
13.1.1. The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.	X	
13.1.2. The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.	X	
13.1.3. The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	X	

Prompt	State has no trends/update to report (place an X)	State response
13.1.4. Compared to the demonstration design and operational details, the state expects to make the following changes to: 13.1.4a. The schedule for completing and submitting monitoring reports	X	
13.1.4b. The content or completeness of submitted monitoring reports and/or future monitoring reports	X	
13.2. Post-award public forum		
13.2.1. If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual monitoring report.		*The state held the required annual public forum for this DY during the January 2022 Medical Care Advisory Committee (MCAC) meeting. The State presented an overview of the waiver populations authorized under the 1115 demonstration waiver. No comments related to the 1115 SMI IMD waiver were provided. The next annual public forum will be held in January 2023.*
14. Notable state achievements and/or innovations		
14.1. Narrative information		
14.1.1. Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SMI/SED (or if broader demonstration, then SMI/SED related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.	*X*	

*The state should remove all example text from the table prior to submission.

Note: Licensee and state must prominently display the following notice on any display of Measure rates:

The MPT, FUH-CH, FUH-AD, FUA-AD, FUM-AD, AAP, and APM measures (#13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29) are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.

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