GOVERNANCE & OVERSIGHT NARRATIVE

Local Authority: Salt Lake County

Instructions:
In the cells below, please provide an answer/description for each question. **PLEASE CHANGE THE COLOR TO BLUE, OF SUBSTANTIVE NEW LANGUAGE INCLUDED IN YOUR PLAN THIS YEAR!**

1) Access & Eligibility for Mental Health and/or Substance Abuse Clients

<table>
<thead>
<tr>
<th>Who is eligible to receive mental health services within your catchment area? What services (are there different services available depending on funding)?</th>
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<tbody>
<tr>
<td>All residents of Salt Lake County are eligible for services regardless of their ability to pay. We do expect residents with insurance, adequate wages, or other forms of payment to pay for as much of their care as possible but payment is based on our Local Authority approved sliding fee schedules. The fee schedule aligns DBHS's fee policy with federal poverty guidelines related to the Affordable Care Act. Public funds, by contract language, and specifies that Salt Lake County is the payer of last resort. We consider insurance and other non-public funds to be third-party liability (TPL) payments and require Optum as well as other network providers to maximize TPL payments.</td>
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<td>All ASAM (American Society of Addiction Medicine) levels of care (LOC), from ASAM .5 to ASAM 3.5, and all mental health (MH) LOCs, from standard outpatient to acute hospitalization, are available to any qualifying Salt Lake County resident. To qualify for DBHS funded services, clients must meet a residency requirement and receive an ASAM or MH assessment to determine the appropriate level of care. For someone who is experiencing homelessness, and documentation can be provided to indicate the homeless status, residency requirements are waived.</td>
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<td>Within the Medicaid program, we maintain and adhere to Medicaid Access standards. For the Non-Medicaid population, we adhere to Federal priority guidelines.</td>
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<td>DBHS will submit their annual PMHP Financial Report (Medicaid Cost Report) to DSAMH annually within 15 days of finalizing the report with the Department of Health Division of Medicaid Financing.</td>
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<tr>
<th>Who is eligible to receive substance abuse services within your catchment area? What services (are there different services available depending on funding)? Identify how you manage wait lists. How do you ensure priority populations get served?</th>
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<tr>
<td>Same response as above for the first two questions. Regarding wait lists, there are no wait lists for Medicaid clientele due to the timely access standards required by Medicaid. However, this is only possible due to funding being available on-demand for Medicaid clientele. For those clients who are unfunded (i.e., Block Grant funding) each contracted provider must maintain their own wait list. The contracted providers have a person(s) designated for intakes. This individual maintains the waiting list. Most providers require clients to call in each day/week (program specific) to check-in, express their continued interest in SUD treatment, and will be told at that time if they can now be admitted or if their place on the waitlist has changed. Approximate dates are given for when the client may expect admission, but these can vary greatly due to the nature of those in SUD treatment and the course of treatment.</td>
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<tr>
<td>The Federal priority populations, along with the required timelines for accessing treatment, are in every provider’s contract. These priorities are reviewed during the annual monitoring visit. Additionally, when</td>
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a client contacts Assessment and Referral Services (ARS) for an assessment, the questions relating to the priority requirements are asked. Similarly, when a client contacts a provider directly for an assessment, the Federal priority questions are asked. Should anyone meet the Federal priorities, their admission and assessment are prioritized according to the required timelines.

What are the criteria used to determine who is eligible for a public subsidy?

As described above, we expect clients who either have the ability to pay or have adequate insurance to pay for as much of their treatment as possible. However, for the underinsured and uninsured client proof of income must be provided. When determining the appropriate fee for services, providers are encouraged to take into account other financial responsibilities the client has such as mortgage or rent, paying of fines, child support, etc., which demonstrate they are a contributing member of society and working toward recovery. For those who are indigent a history is obtained which shows the need for treatment and the lack of ability to pay for treatment. All providers are educated that the lack of ability to pay for treatment cannot be a barrier to treatment. The sliding fee scale applies to anyone who enters treatment under a public subsidy.

How is this amount of public subsidy determined?

In general, the amount of public subsidy is dependent on the appropriation amount by the legislature, the SLCo Council, and other grant/transfer funds available through DSAMH. Amounts are also dependent on the intent of the funding – for instance the prevention set-aside cannot be used for MH services, the early intervention funds cannot be used for SUD treatment, etc.

Treatment is not just one service but a comprehensive list of services and an entire treatment episode can range from several hundred dollars to several thousand, depending on the need and the length of stay in treatment. Instead of how much of a public subsidy a person will receive, it is based on how much a person can pay.

For the underinsured and uninsured client, proof of income must be provided. In addition to this, providers are encouraged to take into account other responsibilities the client has such as mortgage or rent, paying of fines, child support, and other things for which they are showing that they are a contributing member of society and working toward recovery. For those who are indigent, a history is obtained that shows the need for treatment and the lack of ability to pay for treatment. Based on this information all providers are required by contract to have a sliding fee agreement in every client’s file. All providers are educated that the lack of ability to pay for treatment cannot be a barrier to treatment.

How is information about eligibility and fees communicated to prospective clients?

All residents of Salt Lake County that need behavioral health services are eligible to receive them based on appropriations. All network providers are required via contract to apply the DBHS approved sliding fee schedule, or otherwise approved sliding fee schedule, and explain it adequately to all those Salt Lake County residents seeking care.

When a client first calls for an appointment, ideally the provider will inform the client of eligibility requirements, ask about Salt Lake County residency, and inform the client of required documents that he or she needs to bring to the intake. When a client first comes in for an intake, eligibility and fee criteria are communicated to the client in further detail. Providing the client has brought all the required documents, they can be immediately informed of eligibility and, if they qualify, what their financial responsibility is going to be.

Are you a National Health Service Corps (NHSC) provider? YES/NO
In areas designated as Health Professional Shortage Areas (HPSA) describe programmatic
implications, participation in National Health Services Corp (NHSC) and processes to maintain eligibility.

DBHS is not an NHSC provider. Additionally, DBHS is not advised when any particular area is designated as HPSA.

2) Subcontractor Monitoring

The DHS Contract with Mental Health/Substance Abuse Local Authority states: When the Local Authority subcontracts, the Local Authority shall at a minimum:

(1) Conduct at least one annual monitoring review of each subcontractor. The Local Authority shall specify in its Area Plan how it will monitor their subcontracts.

Describe how monitoring will be conducted, what items will be monitored and how required documentation will be kept up-to-date for active subcontractors.

All contracted network providers are monitored at least once per year. DBHS staff conduct regular on-site monitoring, electronic monitoring through our EHR, and spot check monitoring as needed for all vendors who are directly contracted with DBHS. This includes our SUD vendors and also our MH vendors who receive non-Medicaid monies. Optum monitors its network providers at least once during the contract cycle. High volume audits are completed on all large providers annually. DBHS monitors/audits Optum at least once per year, but more often if needed.

Additionally, the consistent, ongoing reviews and re-authorizations required by contract of any ASAM LOC higher than ASAM 1.0 and any MH contract where the client receives five or more hours a week of treatment immediately alerts us when any issues are identified.

A complete list of monitoring tools for SUD items and for MH services is available upon request. All documentation is contained in UWITS or Optum’s EHR, Netsmart, or other EHR approved by DBHS. All contracted network providers are required by contract to keep documentation up-to-date and accurate.

DBHS requires, through contract language with providers, that the treatment plan and ASAM assessment and mental health assessment be kept current. DBHS determines compliance with this during their annual monitoring visits.

For providers that directly contract with DBHS to provide non-Medicaid services, DBHS maintains current copies of insurance certificates, Division of Office of Licensing licenses, and conflict of interest forms in the contractor's file. Optum is responsible for maintaining this documentation for their contracted Medicaid providers. DBHS verifies this during their annual monitoring visit of Optum.

For DBHS’ audit of our contracted managed care organization (MCO), Optum, an audit is completed annually. There are two parts to the audit, clinical/administrative and financial.

For the clinical/administrative audit, that begins in the early spring and is concluded by June 30 of each year. The final report is issued by September 30 of each year. The reason for this timing is to give providers an opportunity to become familiar with any new requirements and implement them in a meaningful manner. Additionally Medicaid’s audit of our MCO for the previous calendar year is in July or August each year (varies year by year). There are some things which Medicaid measures which exceed the scope of our audit and we believe it crucial to add their findings into our audit report for a comprehensive review. We receive Optum’s response no later than October 31. Therefore, DSAMH can
expect to receive the clinical/administrative report no later than November 15 of each year.

For the financial audit, we consider that concluded once Medicaid has completed their financial audit. This is done in order to add validity to our audit and demonstrate that an agency independent of DBHS concurs with our findings. We receive the Medicaid audit report sometime in June and issue our final report by July 31 of each year. We receive Optum’s response no later than August 31. Therefore, DSAMH can expect to receive the financial audit report no later than September 15 of each year.