

## Issue Brief – Mental Health Services

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

NUMBERDHS-08-05

### MENTAL HEALTH SERVICES THROUGH LOCAL MENTAL HEALTH AUTHORITIES

The Division of Substance Abuse and Mental Health (DSAMH) is requesting ongoing General Funds of \$2,715,200 to provide services to approximately 2,900 indigent/uninsured mental health patients at the Mental Health Centers for FY 2008.

### OBJECTIVE

The local public mental health authorities provide mental health services to residents under the direction of the State Board and the Division of Substance Abuse and Mental Health.

### DISCUSSION AND ANALYSIS

Local Mental Health Authorities may choose to deliver services themselves or contract with a private provider. There are eleven mental health centers in the State. Seven of the local mental health centers are county (or multi-county) operated and four of the centers are private nonprofit corporations. The following table shows the mental health centers:

<b>Local Mental Health Centers</b>		
Center	Private / County	Counties Served
Bear River Mental Health	Private	Box Elder, Cache, Rich
Davis Behavioral Health	Private	Davis
Weber Human Services	County	Weber, Morgan
Valley Mental Health	Private	Salt Lake, Summit, Tooele
Northeast Counseling Ctr	County	Daggett, Duchesne, Uintah
Four Corners Mental Health	Private	Carbon, Emery, Grand
Wasatch Mental Health	County	Utah
Heber Valley Counseling	County	Wasatch
San Juan Mental Health	County	San Juan
Southwest Center	County	Beaver, Garfield, Iron, Kane, Washington
Central Utah Mental Health	County	Piute, Sevier, Juab, Wayne, Millard, Sanpete
<i>Private - Private Non-profit contract provider</i>		
<i>County - Services provided by one or more counties</i>		

The Division contracts with the local mental health authorities for state and federal funds based on local plans to provide mental health services. The plan must include services for adults, youth and children, including, but not limited to: inpatient, residential and outpatient care and services, 24-hour crisis care, psychotropic medication management, psychosocial rehabilitation, case management, community supports (such as in-home services, housing, family support and respite services), and consultation and education services.

### ***Statutory Requirements***

Statutorily, the local mental health providers or their private contractors are required to provide services to indigent mental health clients. [Section 17-43-306 \(1\)](#) and [Section 62A-15-713 \(7\)](#) However, there is a statute [Section 17-43-301 \(1\) \(b\)](#) which limits the mental health services provided by the counties within existing appropriations and county matching funds.

### ***Medicaid Policy***

All except two centers (Heber and San Juan) have chosen to use the “capitated” rate system in dealing with Medicaid clients. The “capitated” rate system is similar to the function of a Health Maintenance Organization (HMO) in the private insurance market. Medicaid pays the mental health center a set rate for each Medicaid eligible person in their area. These rates were originally based on costs experienced under the “fee for service”

system. They were then increased incrementally every year after that for inflation and usage. It is up to the center to deliver required services as efficiently and as effectively as possible. In the past, if a center could deliver the required services at a cost less than the rates collected from Medicaid, the center was able to use these “profits” for other purposes such as enhancing their delivery systems and serving non-Medicaid clients.

**Change in the Medicaid Policy**

Starting in FY 2005, the federal Center for Medicaid and Medicare Services (CMS) changed its rate setting policy. It switched from the incremental rate setting method to an actuarial system based on actual Medicaid client-related expenses. It also changed its policy on the use of the Medicaid “capitated” rate revenues, restricting its use to Medicaid clients only. As a result, each of the local mental health centers was unable to use Medicaid savings to cover uninsured patients. These policy changes resulted in a \$7.7 million loss in revenue. The Legislature appropriated one-time General Funds of \$2 million in FY 2006 and \$1 million in FY 2007 to offset the loss of federal funds.

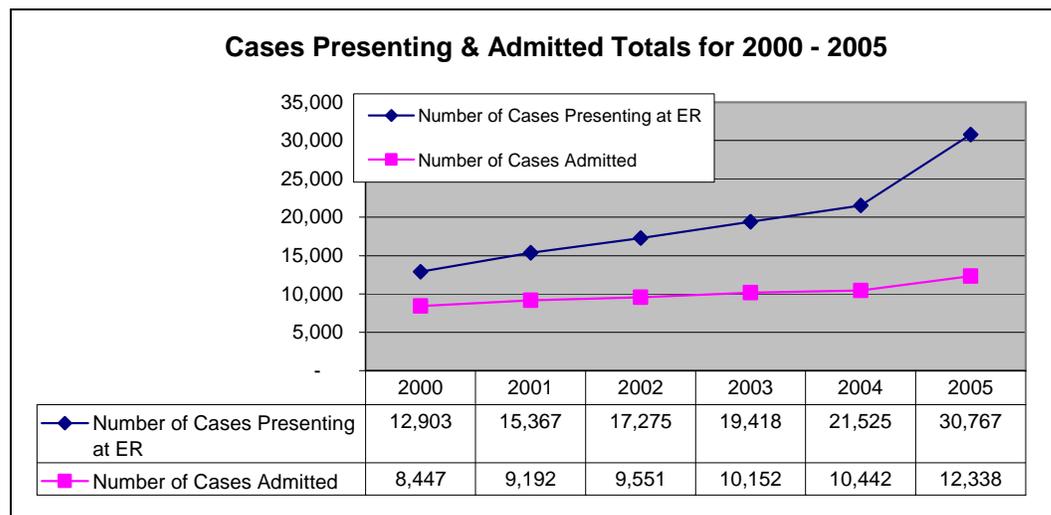
**Indigent/Uninsured Mental Health Clients Served**

The following chart shows the total number of mental health clients being served, the effect of the Medicaid policy change on non-insured/indigent clients and the General Fund Appropriations provided by the Legislature:

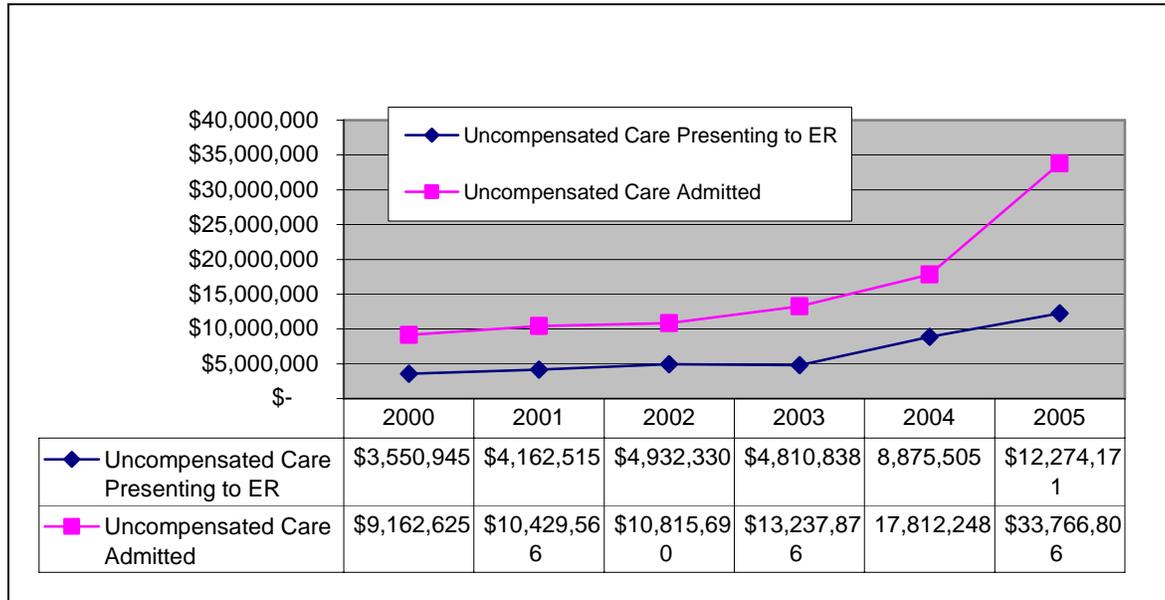
Mental Health Services for Indigent or Uninsured Clients						
A	B	C	D	E	F	G
Fiscal Year	Explanation	General Fund Appropriations Due to Policy Change	Clients Served with Existing Budget	Clients Served with General Fund Appropriations	Total Clients Served (D+E)	Estimate of Indigent/Uninsured Clients Denied Services Because of Policy Change (FY 2003 Column F before policy change less Column F of each fiscal year)
FY 2003	Mental Health Centers were able to use Medicaid savings for uninsured/indigent clients		20,380		20,380	
FY 2004	Mental Health Centers were able to use Medicaid savings for uninsured/indigent clients for 3/4 of the year		19,689		19,689	691
FY 2005	Change in Medicaid policy		15,862		15,862	4,518
FY 2006	Legislature provided one-time General Funds	\$2,000,000	15,862	1,373	17,235	3,145
FY 2007	Legislature provided one-time General Funds	\$1,000,000	15,862	686	16,548	3,832
FY 2008 Request	Agency is requesting ongoing General Funds	\$2,715,200	15,862	2,904	18,766	1,614

**Indirect Impact of Mental Health Clients not being Served**

According to the DSAMH and the Utah Hospital Association, the inability to serve indigent/uninsured clients has had an impact on the hospitals. In addition, many of the patients with mental illness also have a substance abuse problem which compounds the problem. The following graph shows the increase in patients presenting at the ER and admittances with primary or secondary alcohol/chemical dependency and/or psychoses diagnoses and/or acute self-harm risk (Note: this information was provided by the Utah Hospital Association):



The following graph shows the increase in the number of uncompensated cases presenting to the hospitals with primary or secondary alcohol/chemical dependency and/or psychoses diagnoses and/or acute self-harm risk (Note: this information was provided by the Utah Hospital Association):



**Serving the Non-Medicaid Mental Health Clients**

The DSAMH has a statutory obligation to serve the mentally ill population of the state. Two local mental health authorities, Wasatch and Southwest have developed innovative and cost effective treatment programs to meet the mental health needs of non-Medicaid eligible clients. In addition, two other entities, Intermountain Health Care (IHC) and the Veteran’s Administration (VA) have cost effective mental health programs. The DSAMH is proposing to use the funding request to develop programs throughout the state similar to the models already in existence to serve the indigent, under-insured and uninsured mental health population:

- The Wellness Clinic at Wasatch Mental Health
- The Assessment/Screening program at Southwest Behavioral Health
- The Family Advocate Program in several rural counties
- The Mental Health Integration in Primary Care associated with IHC
- Telemedicine utilized by the Veteran’s Administration and Southwest Behavioral Health

**RECOMMENDATION**

It is the recommendation of the Analyst that the Division of Substance Abuse and Mental Health be appropriated \$2,715,200 in General Funds for FY 2008 for uninsured and/or indigent mental health clients.