UTAH
ASSOCIATION OF
COUNTIES

The Unifying Voice for County Government

Local Authority Mental Health Medicaid Match
Health Reform Task Force Report
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COUNTY/STATE RESPONSIBILITY

The county and state relationship between the Counties and the State require joint responsibility for the public mental health system.

- Counties are responsible for the 20% match and local mental health authorities act as providers of services, and the State is responsible for the cost of mandated programs.

- The counties have chosen to use State dollars along with the required county 20% match to draw down Federal Medicaid dollars. By counties using these state and local dollars to draw down federal funds, they have been able to support the behavioral health system as a whole.

- **If funding is eliminated, the system is at jeopardy and quality of services would surely decrease**.

- Medicaid is a State responsibility and behavioral health providers contract to be the providers. Effective January 13, 2014, the Mental Health Parity and Addiction Equity Act moves mental health and substance use disorder services from the "Optional" category to those required for full health.

HISTORY OF COUNTY/STATE BEHAVIORIAL HEALTH PARTNERSHIP

In order to meet the increasing mental health need, the counties and state formed a partnership in 1986-1987. The relationship of this partnership can be described in the following lines of code:

- 17-43-301(1) states: “the county legislative body is the local mental health authority. Within legislative appropriations and county matching funds required by this section, under the direction of the division, each local mental health authority shall; provide mental health services to persons within the county;”

- Local authority requirements are found at 17-43-301(4) which includes submitting a plan to the Division each year for the delivery of 10 required services.

- 17-43-301(4)(a)(x) states that the local authority “provide funding equal to at least 20% of the state funds that it receives to fund services described in the plan;”

HISTORY OF COUNTY/STATE BEHAVIORIAL HEALTH PARTNERSHIP

- By 1996-1997, most county local authorities were operating in the capitated Medicaid system rather than the previous fee-for-service system, assuming risk of cost/need fluctuation for those within their scope of responsibility.

- This allowed for many of the centers to use services and programs to better manage those clients with high inpatient costs which required a high degree of care and by moving to a risk-based contract, centers did experience inpatient savings. These inpatient savings were intended to then help fund those clients that did not have funding, often those clients without children or families without insurance.

- In 2003, it was decided that retained savings were against Medicaid rules and rates were cut to correct any possible savings. **Since 1996, the number of residents eligible for Medicaid has increased dramatically and inflation has risen, with very little increase in State dollars**.

LEGISLATIVE NEED

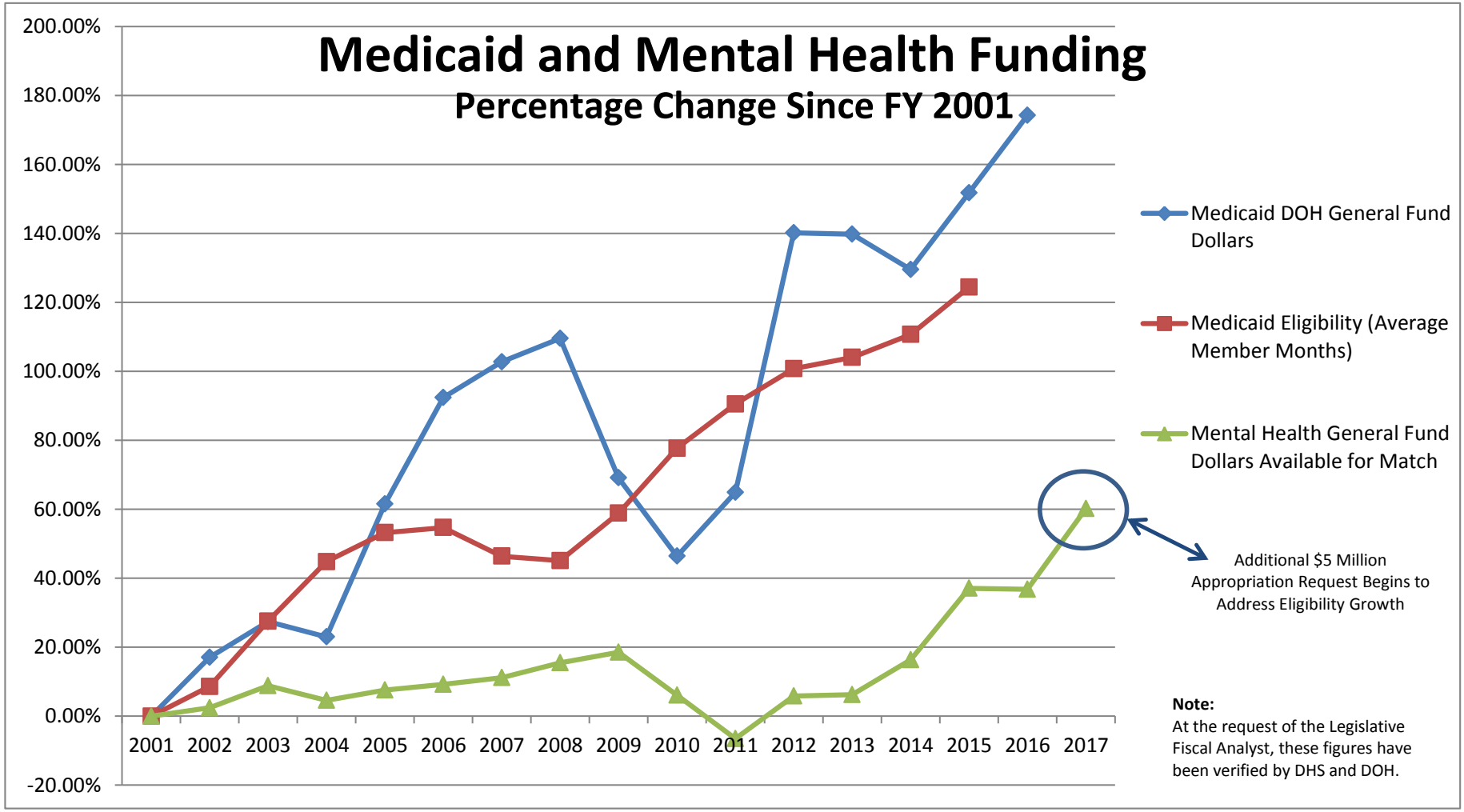
A Mechanism to Address Medicaid Match Year after Year.

- These funds are being used to draw down federal dollars to support the existing system.

- Current Medicaid Funding in the 2017 Legislative Session has allowed Counties to provide additional assistance to other statutorily defined and required populations outside of Medicaid.

- We have been able to address the current need in the Medicaid population as it is today but *medical costs continue to increase* as demonstrated in the previous slide. **We request that the Legislature address additional need by establishing a growth component for future need to keep the system whole.**

MEDICAID POPULATION AND FUNDING



SUMMARY AND QUESTIONS?