Utah's Mental Health System

A collaborative endeavor of the Kem C. Gardner Policy Institute and the Utah Hospital Association

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ANALYSIS IN BRIEF

Our country is in the midst of a mental health crisis. Increasing suicide rates, domestic violence, traumatic brain injuries, serious mental illness, and mass shootings are all signs of the need for accessible, affordable, and comprehensive mental health care services. Utah is not exempt from this crisis. Utah has a high rate of adults with mental illness, but a shortage of mental health providers.

This study assesses the current state of mental health services in Utah, highlighting gaps in services, barriers to providing and accessing care, and considerations for improving the system. It includes qualitative research from discussion groups and interviews held with key industry leaders from Utah's mental health system.

Key points include the following:

- **The demand for mental health care in Utah is increasing.** Close to one in five Utah adults experience poor mental health and demand for youth services is increasing. Almost 15 percent of males and 28.5 percent of females age 15-17 seriously considered attempting suicide in 2015-2017.
- **Utah's shortage of mental health providers could worsen over time.** Utah experiences mental health provider short–ages in all of its counties and has fewer mental health providers per 100,000 people than the national average. A newly expanded Medicaid program coupled with a rapidly growing state population will intensify the effects of existing shortages.
- **Funding for Utah's public mental health system is bifurcated across different systems, making it difficult to consistently deliver coordinated care.** A problem with the bifurcation between physical and mental health services is that a positive association exists between chronic disease and poor mental health.
- **Commercial health insurance coverage of mental health services is often limited, which can result in high out-of-pocket costs.** Even if commercial health insurance covers mental health services, there are still applicable copays and deductibles, which can prevent access to care.
- **Discussion group participants agreed that an ideal mental health system would:** (1) Provide integrated mental and physical health care services in a timely manner. (2) Consistently use mental health screenings to assess individuals and identify risk, allowing for early intervention. (3) Ensure people have the resources to access necessary mental health services as well as safe, acuity-appropriate places to seek treatment.

At-A-Glance

The Demand for Mental Health Care in Utah: Key Statistics

Close to one in five adults experience poor mental health.

Suicide

is the leading cause of death for Utahns ages 10 to 24.

66

Utahns sustain a Traumatic Brain Injury **every day**, which increases risk for mental health issues.

Veteran suicides

account for **13%** of all suicides in Utah.

Almost **40%** of Utah's depressed youth age 12–17 did not receive treatment for depression.

About **15%** of new mothers experience postpartum depression symptoms.

The percent increases to **21%** for low-income mothers.

Over half of Utah adults with mental illness did not receive mental health treatment or counseling.

Over **100,000** adults in Utah experience Serious Mental Illness (SMI).

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Introduction

Our country is in the midst of a mental health crisis. Increasing suicide rates, domestic violence, traumatic brain injuries, serious mental illness, and mass shootings are all signs of the need for accessible, affordable, and comprehensive mental health care services.

Utah is not exempt from this crisis. Utah has a high rate of adults with poor mental health, but a shortage of mental health providers. Utah also has one of the highest suicide rates in the country and the need for youth mental health services is increasing.

This study assesses the current state of mental health services in Utah, highlighting gaps in services, barriers to providing and accessing care, and considerations for improving the system. The Gardner Institute's goal is to prepare an independent and comprehensive review of Utah's mental health system to allow for informed discussions and decisions regarding potential solutions and reforms.

Figure 1 presents a snapshot of key statistics illustrating the demand for mental health care in Utah. More details on these and other statistics are provided in the "A Growing Demand for Mental Health Services" section and in Appendix III.

Figure 1: The Demand for Mental Health Care in Utah: Key Statistics

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Over half of Utah adults with mental illness did not receive mental health treatment or counseling.

Over **100,000** adults in Utah experience Serious Mental Illness (SMI).

Source: Data sources for key statistics provided throughout the report. Sixty-six people sustaining a traumatic brain injury every day is equal to about 24,000 people per year. There were 386 veteran suicides from 2012-2016. Postpartum data come from the Utah Department of Health.[2]

Methodology

This report combines quantitative and qualitative research methodologies. Quantitative data come from a number of sources and databases, including the Kem C. Gardner Policy Institute, the Utah Department of Health (UDOH), the Utah Division of Substance Abuse and Mental Health (DSAMH), the Utah Medical Education Council (UMEC), the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as other national research institutes and data sources.

Qualitative research findings are featured in **cream text boxes with red borders.** Qualitative findings come from eight discussion groups and seven in-depth interviews held with key industry leaders from Utah's mental health system (quotes and summarized statements from discussion group participants are italicized). The purpose of these discussion groups and interviews is to better understand the ideal mental health system and what gaps and barriers exist in the current system that prevent Utah from achieving the ideal. Key themes regarding these gaps and barriers are listed in the following text box and additional information on each theme is provided later in the report. Additional detail on the qualitative research methodology is included in Appendix I.

Some discussion group participants and interviewees suggested steps that can be taken to improve Utah's mental health system.[1] These steps, as well as recent policy or program changes that have led to system improvements, are highlighted in Appendix II.

Report Scope

While this report provides comprehensive information on Utah's public and private mental health systems, it is important to note that a complete review of all of the different subsystems is not included. For example, mental health services provided by county jails, Indian Health Services (IHS), and American Indian Tribes are not detailed in this report. Time and resources did not allow for a full review of these subsystems, but we recommend future reports include details on these important systems.

Although this report primarily focuses on mental health and not substance use disorders (SUD), some data and information on SUDs is included because the two are closely related. The term 'behavioral health' is used to describe both mental health conditions and SUDs, unless otherwise specified. When mental health conditions or SUDs are referred to separately, the term 'mental health' or 'SUD' is used.

The Ideal Mental Health System in Utah

Discussion group participants agreed that an ideal mental health system would:

- Provide integrated mental and physical health care services in a timely manner.
- Consistently use mental health screenings to assess individuals, identify risk, and allow for early interventions that prevent escalation.
- Ensure people in need of mental health care have the resources to access necessary services (including transportation and assistance with initial and ongoing paperwork requirements) as well as safe, acuity-appropriate places to reside or seek treatment while addressing mental health issues.

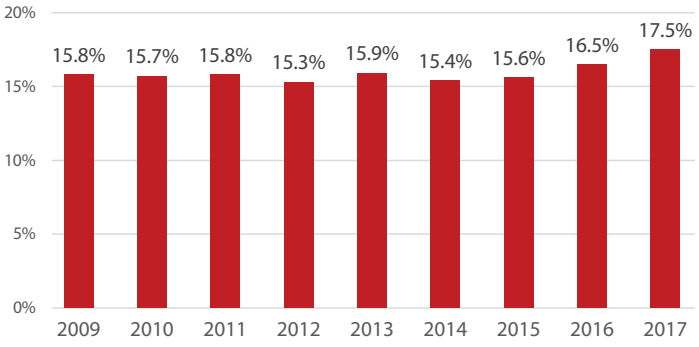
Gaps and Barriers to Achieving the Ideal System: Discussion Group Themes

- A lack of resources and flexibility in providing mental health care
- Stigma surrounding mental health
- Workforce shortages and limited access to services
- Restrictions on funding streams that prevent providers from providing appropriate, timely care
- Fee-for-service (FFS) reimbursement, which makes it difficult to provide preventive care and a full range of integrated physical and behavioral health services
- Forensic bed classifications overtaking available State Hospital beds
- Gaps in mental health services (see p. 13–14 for more detail)
- A lack of system collaboration
- Limited commercial coverage of mental health services

A Growing Demand for Mental Health Services

Close to one in five Utah adults experience poor mental health (Figure 2).[3] Mental health diagnoses range from mild to severe and include depression, schizophrenia, bipolar disorder, and anxiety disorders such as post-traumatic stress disorder, obsessive compulsive disorder, and specific phobias. They also include mental health issues caused by traumatic brain injury (TBI) and postpartum depression.

Figure 2: Percent of Utah's Adult Population with Poor Mental Health, 2009-2017



Note: Age-adjusted. Poor mental health is measured as seven or more days of not good mental health in the last 30 days.
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health.

Discussion Group Theme

A lack of resources and flexibility in providing mental health care

Discussion groups expressed frustration with increasingly insufficient resources to meet the growing demand for mental health care in Utah.

"The addition of just one to two more individuals who require more intensive services can stretch some health systems' resources, particularly if the person is uninsured."

Difficulties stem from:

- Increased demand for mental health care
- Increased severity of mental health care needs
- Insufficient funds to maintain existing levels of care
- Changing and restrictive program rules

While Medicaid expansion will address some of these issues, expansion alone will not address the many problems stemming from the growing need for mental health services in the state.

"We know our state is going to struggle with [getting the Medicaid expansion population] on board.… I'm less worried about patients' first appointment and more worried about the second appointment. Some mental health programs [were] developed from providers' reaction to current waitlists. They were like "whoa," it takes how long to see a psychiatrist, three months, five months?"

Utah Ranked Last on Adult Mental Health Measures in 2018

Mental Health America, a community-based nonprofit organization, compiles publicly available data across all 50 states and the District of Columbia to develop a composite mental health score and ranking for each state (Figure 3). In 2018, Utah ranked 37th on combined adult and youth measures. A low overall ranking indicates a higher prevalence of mental illness and lower rates of access to care. Utah ranked 24th on youth measures, but 51st on adult measures. Utah's high percentage of adults with any mental illness, adults with serious thoughts of suicide, and adults with any mental illness reporting unmet needs influences its low ranking on adult measures.

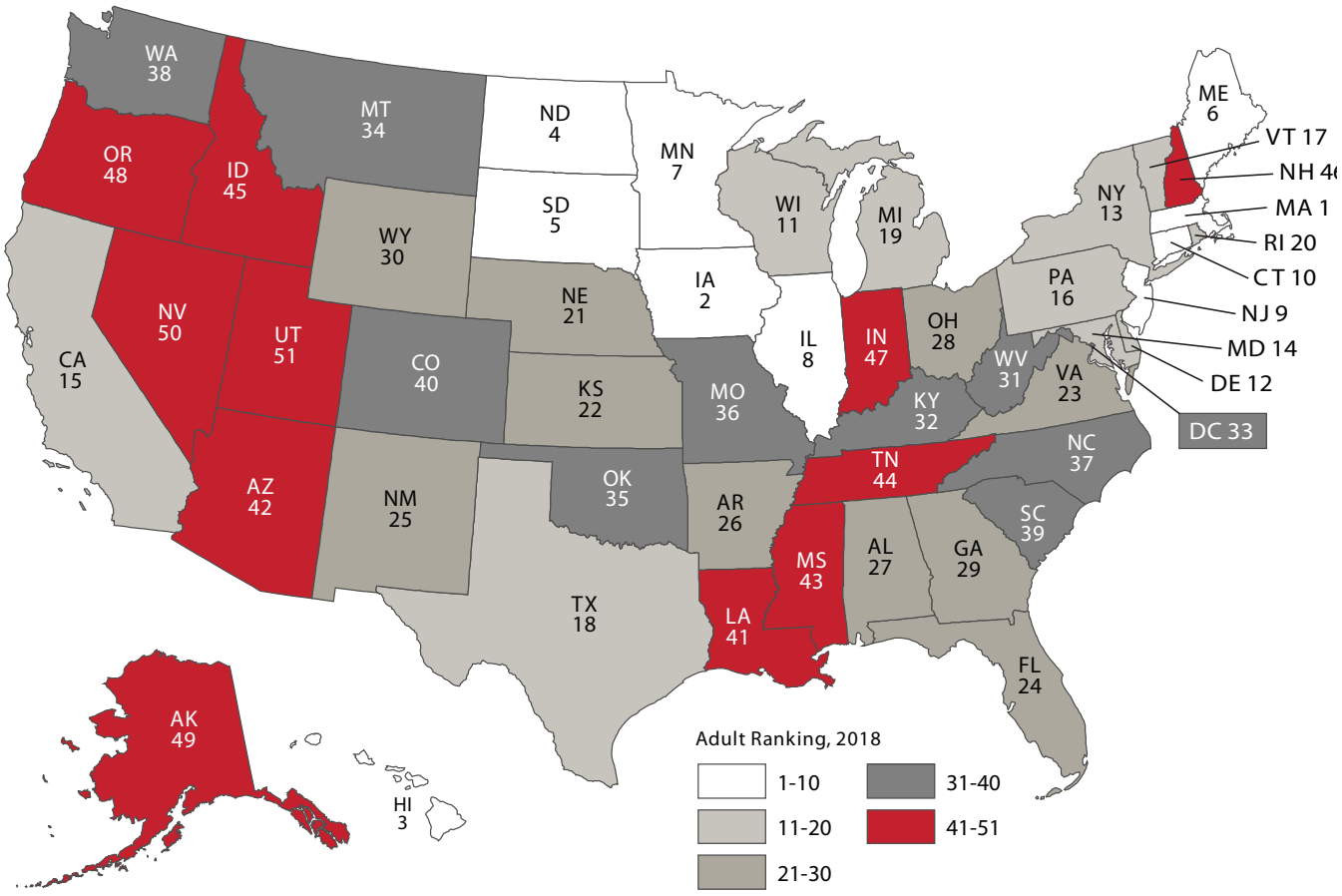
Each state's ranking is based on the combined scores from adult and youth measures of mental health prevalence and access to care.[4] It is important to note that there are limitations to the data used to develop each state's score and that the measures do not provide a complete picture of a state's mental health system.[5] However, it does provide a snapshot of how Utah ranks on certain public mental health measures compared to other states.

Demand for Youth Services is Increasing

Data from the Utah Bureau of Health Promotion show that 14.9 percent of males and 28.5 percent of females age 15–17 seriously considered attempting suicide in 2015–2017.[6] Almost 8 percent of males and 11.4 percent of females actually attempted suicide, while 3.1 percent of males and 4.8 percent of females reported making a suicide attempt that resulted in an injury that required medical attention.

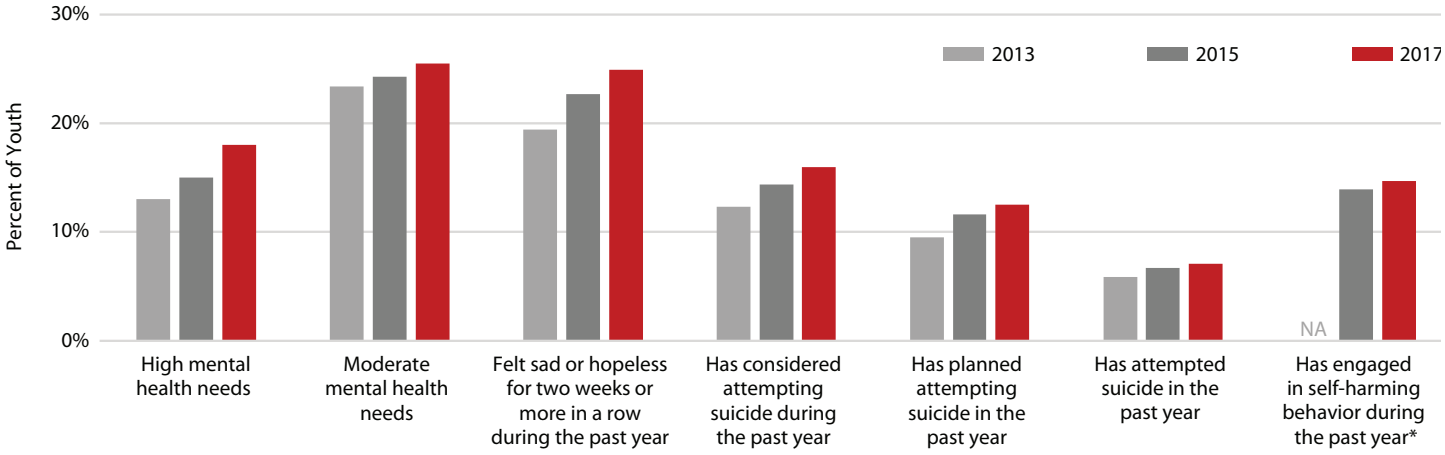
Figure 4 shows the percent of students, grades 6–12, who have reported mental health needs. While Utah is still below the national average on several mental health and risk indicators, there is a growing trend among students reporting risks for mental health issues.

Figure 3: State-by-State Mental Health Rankings for Adults, 2018



Note: Key measures used in this ranking include: "Adults with Any Mental Illness" (AMI); "Adults with Alcohol Dependence and Illicit Drugs Use" (e.g., marijuana, heroin, and cocaine); "Adults with Serious Thoughts of Suicide"; "Adults with AMI who Did Not Receive Treatment"; "Adults with AMI Reporting Unmet Need"; "Adults with AMI who are Uninsured"; and "Adults with Disability Who Could Not See a Doctor Due to Costs".
Source: Ranking the States. Mental Health America.

Figure 4: Utah Youth Mental Health and Suicide Indicators, 2013, 2015, and 2017



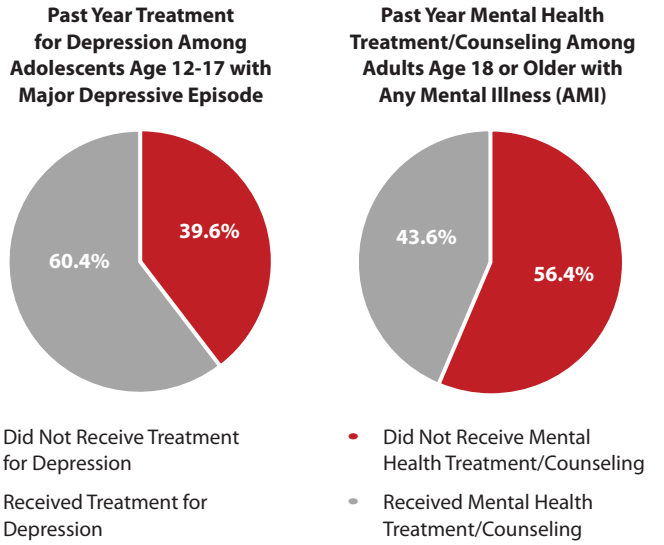
*Self-harm questions were introduced in the 2015 SHARP survey. Self-harming behavior is defined as self-destructive behavior other than suicide. "Students are considered to have engaged in self-harm if they responded they had done 'something to purposefully hurt yourself without wanting to die, such as cutting or burning yourself on purpose.'"
Note: Combined data for grades 6, 8, 10, and 12.
Source: 2017 Prevention Needs Assessment Survey. State of Utah Department of Human Services. Division of Substance Abuse and Mental Health.

Many Utahns Do Not Receive Mental Health Services

Figure 5 shows that almost 40 percent of Utah's youth age 12–17 with depression did not receive treatment. Over half of adults in Utah with a mental illness did not receive mental health treatment or counseling.[7] Untreated mental illness can seriously impact a person's health and wellbeing.[8]

A Utah study on barriers to mental health services for adolescents who died by suicide found that parents, siblings, friends, and other contacts reported stigma as the primary barrier to seeking mental health treatment.[9] In terms of secondary barriers, parents who sought mental health treatment for their child reported insufficient health insurance coverage or access to services as a main barrier. Parents who did not seek mental health treatment for their child reported not knowing where to go for help or problems with transportation.

Figure 5: Estimated Percent of Utah Youth with Depression and Adults with Any Mental Illness Not Receiving Mental Health Treatment, 2015



Source: Behavioral Health Barometer Utah, Volume 4. (2017). Substance Abuse and Mental Health Services Administration.

Discussion Group Theme

Stigma surrounding mental health

A lack of understanding of mental health issues continues to limit individuals, families, and others from seeking appropriate help. Discussion groups noted that stigma exists at the:

- Individual level
- Family/environmental level
- Provider level (which can prevent primary care and other providers from providing appropriate care)

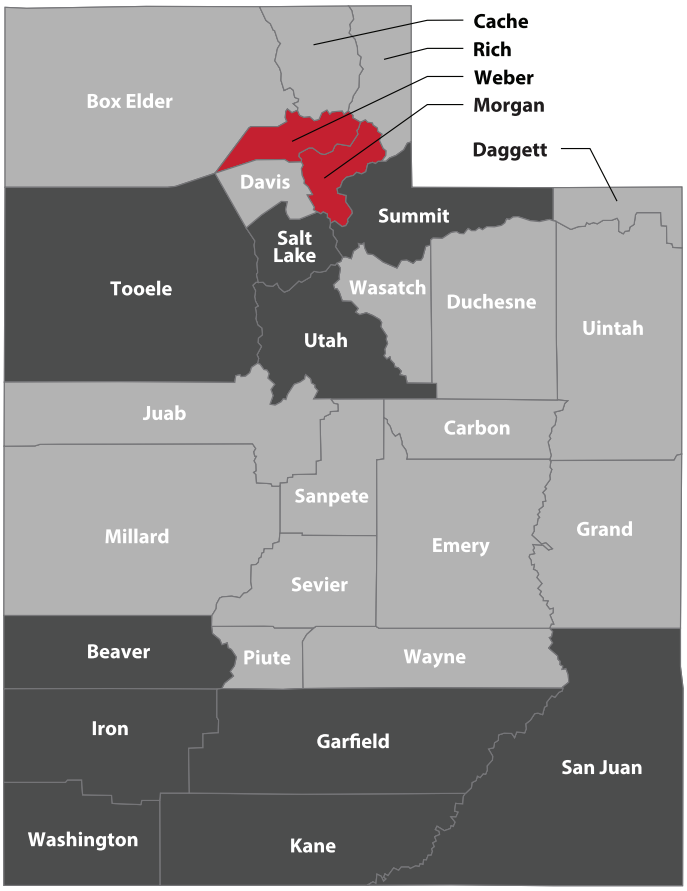
Expanding public education efforts is key to overcoming the stigma associated with seeking mental health care, even if it takes generations to eliminate.

"A big piece of [overcoming stigma] is education and awareness of services that exist and their effectiveness… I hear from people 'I always thought I had anxiety, I just didn't know it affected every single part of my life'—and this is 15 years after first identifying that they have anxiety."

Utah's Shortage of Mental Health Providers Could Worsen Over Time

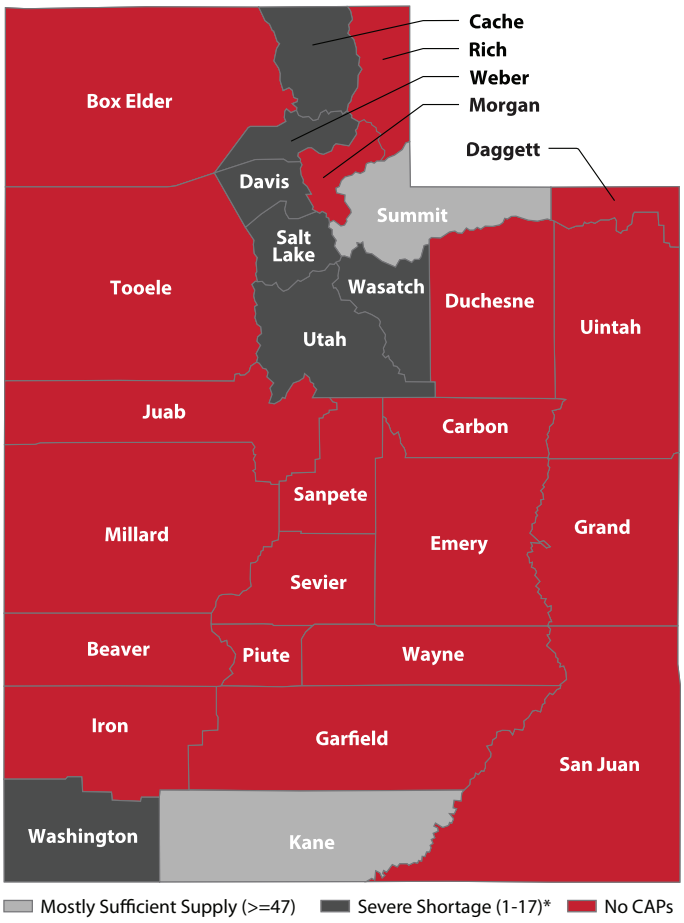
Utah experiences mental health provider shortages in all of its counties (Figure 6) and has fewer mental health providers per 100,000 people than the national average.[10] Provider shortages affect people's ability to access appropriate care and a newly expanded Medicaid program coupled with a rapidly growing state population will intensify the effects of existing shortages.

Figure 6: Mental Health Care Professional Shortage Areas (HPSAs) by County, 2017



Note: While mental health HPSA designations can include core mental health providers in addition to psychiatrists, most mental health HPSA designations are currently based on psychiatrists only. HPSA designations based on psychiatrists only do not take into account the availability of additional mental health providers in the area, such as clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. Data from 2017. HPSA Detail - Mental Health Care.
Source: First Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary. (2018, December). Health Resources and Services Administration (HRSA).

Figure 7: Utah Practicing Child and Adolescent Psychiatrist (CAP) Ratios by County, 2016



Note: Ratio is per 100,000 children (below age 18).
Source: Workforce Maps by State. American Academy of Child & Adolescent Psychiatry.

The ratio of child psychiatrists per 100,000 children in Utah is particularly low. Most counties have no access to a practicing child and adolescent psychiatrist unless they travel to a different county for services (Figure 7). The statewide ratio is six adolescent psychiatrists per 100,000 children.[11] Only Idaho and South Dakota have a lower ratio than Utah.

Connecting this low ratio with Utah's high prevalence of unmet mental health needs among children and increasing demand for youth services (Figure 4), reveals a need for more youth-based mental health services, particularly as Utah's population continues to grow.

Utah's rural areas particularly struggle with provider shortages. Data from UMEC show that Utah's urban areas had 171 mental health full-time equivalents (FTE) per 100,000 people in 2015.

Rural areas, however, only had 141 mental health professional FTEs per 100,000 people.

Discussion Group Theme

Workforce shortages and limited access to services

All of the discussion groups noted a lack of trained professionals available to provide mental health care in the state, some highlighting the specific need for more child psychiatrists (Figure 7).

"Waitlists to see a child psychiatrist are several weeks to months long throughout the state."

The shortage is particularly acute in rural areas where:

- It is difficult to attract people to live
- Positions can be dependent on intermittent grant funding
- Some positions require being on call for long periods of time

"Right now, we would hire three full-time therapists if we could find them."

Urban-based discussion group participants also expressed concern with long wait lists and limited access to care. Participants speculated that this was the result of inadequate salaries and decreased workforce supply.

"One of our challenges is that other organizations—school districts, court support services, and [other health care systems] are ramping up their mental health services, resulting in a tremendous shortage of mental health therapists in our area. We are desperate for therapists, we have more demand than we can meet."

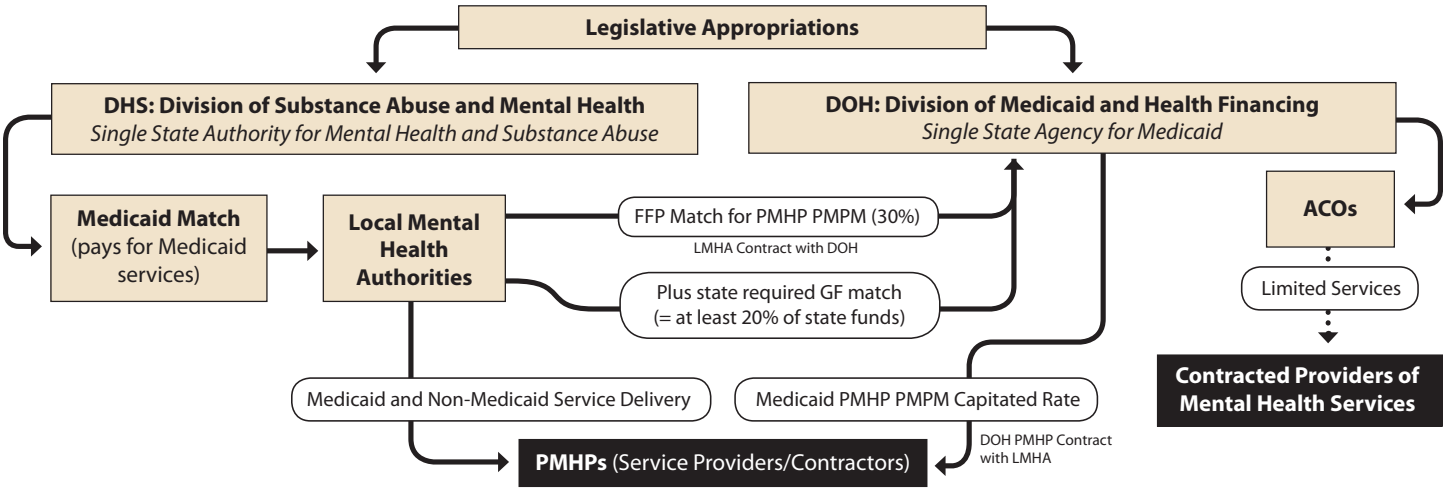
Utah must more than double its mental health workforce over the next 15 years

to keep up with population growth and move its mental health provider ratios closer to the national average.

Utah's Public Mental Health System

The state of Utah provides funding to support the provision of mental health services to Medicaid enrollees and the uninsured. These services are primarily provided through the Division of Substance Abuse and Mental Health (DSAMH) and the Division of Medicaid and Health Financing (DMHF). As illustrated in Figure 8, these divisions oversee a complex set of funding streams that support the delivery of publicly funded mental health services. Additional details on Utah's Medicaid and public mental health service delivery system is provided in Appendix IV.

Figure 8: Utah Medicaid and Public Mental Health Funding Flow



Note: This figure illustrates the flow of mental health funding. A more detailed funding flow is provided in Appendix IV. SUD funding has different statutory, administration, federal match, and service requirements that are not detailed in the above graphic.
Source: Gardner Institute analysis based on information from the Utah Division of Substance Abuse and Mental Health and Division of Medicaid and Health Financing.

Utah's Counties are the Main Provider of Public Mental Health Services

Utah's county authorities—or Local Mental Health Authorities (LMHAs)—oversee the provision of mental health and SUD services to all county residents, including Medicaid enrollees, uninsured individuals, and other underinsured populations. They also serve those with Medicare and private insurance (commercial or other third-party payers). There are currently 13 LMHAs in Utah serving all 29 counties (Figure 9). Most LMHAs contract with Prepaid Mental Health Plans (PMHPs) to administer and provide mental health services (Table 1).[12]

LMHAs primarily serve adults and children with serious and persistent mental illness (SPMI) and serious emotional disturbances (SED).[13] Since 2012, the number mental health clients seen by LMHAs increased more than 11,000 from 44,611 to 56,438 (Figure 10).[14] This represents a 27 percent increase in just six years.

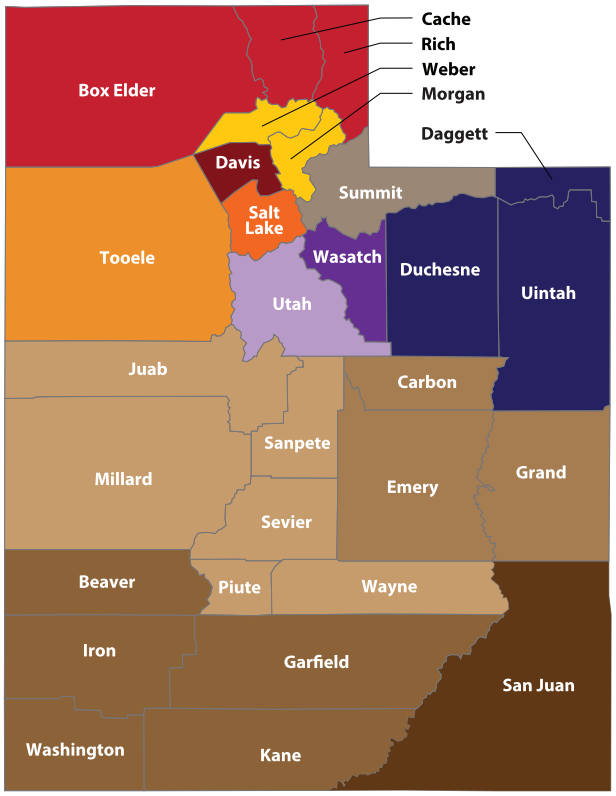
Mental health services are funded through a state General Fund appropriation to DSAMH, which oversees the Utah State Hospital and LMHAs. Additional financial support comes from federal block grants, county and local funds, time limited

Table 1: Utah's Prepaid Mental Health Plans

PMHP	Covered Counties
Bear River Mental Health	Box Elder, Cache, Rich
Southwest Behavioral Health	Beaver, Garfield, Kane, Iron, Washington
Four Corners Community Behavioral Health	Carbon, Emery, Grand
Northeastern Counseling Center	Daggett, Duchesne, Uintah, San Juan
Davis Behavioral Health	Davis
Central Utah Counseling Center	Piute, Juab, Wayne, Millard, Sanpete, Sevier
Salt Lake County Division of Behavioral Health Services: Optum Mental Health	Salt Lake
Valley Behavioral Health	Summit & Tooele
Wasatch Mental Health	Utah
Weber Mental Health	Weber, Morgan

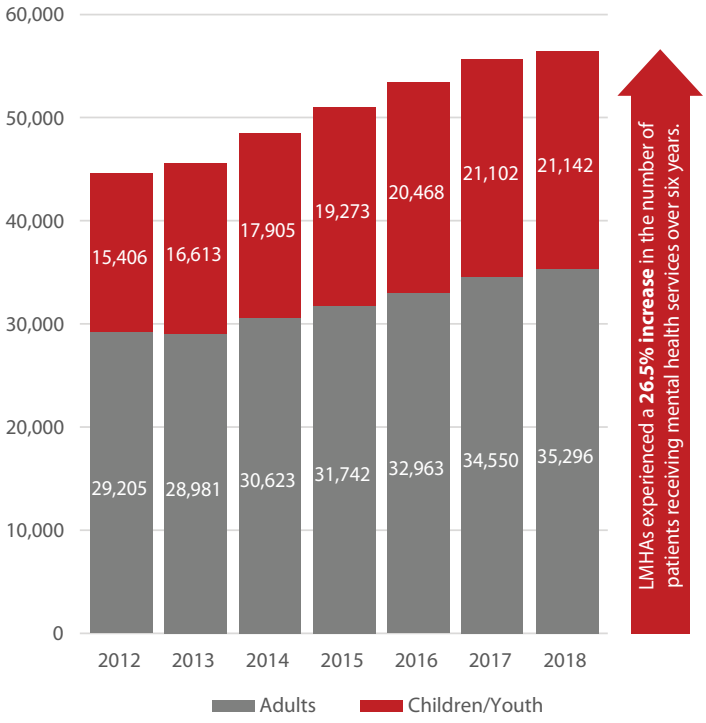
Note: Wasatch County is reimbursed on a FFS basis.
Source: Utah Medicaid Provider Manual - Rehabilitative Mental Health and Substance Use Disorder Services. (2018, October). Division of Medicaid and Health Financing.

Figure 9: Utah's Local Mental Health Authorities (LMHAs)



Source: Annual Report 2016. (2017, January). Division of Substance Abuse and Mental Health.

Figure 10: Total Number of Adults and Children/Youth Receiving Mental Health Services from Utah's LMHAs, FY2012–FY2018



Source: Utah Department of Human Services. Division of Substance Abuse and Mental Health.

Table 2: Utah LMHA Mental Health Client Demographics, FY2018

Funding Source	Percent
Medicaid	47%
Both Medicaid and Medicare	9%
Non-Medicaid	44%
Unfunded	16%
Mental Health Severity	
Serious and Persistent Mental Illness or Serious Emotional Disturbance	57.7%
Urban v. Rural	
Urban	69%
Rural	31%
Gender	
Male	48.3%
Female	51.7%

Source: Utah Department of Human Services. Division of Substance Abuse and Mental Health.

grants, special revenue funds, dedicated credits, agency transfers, payments from Medicaid, Medicare, private insurance (commercial or other third-party payers), and clients who self-pay. Medicaid pays PMHPs a capitated monthly fee for each Medicaid member enrolled in their plan. Additional detail on Utah's LMHAs and PMHPs is provided in Appendix IV.

Most Mental Health Services are "Carved Out" of Medicaid

DMHF calculates and pays the capitated rate PMHPs receive to cover the cost of services provided to Medicaid enrollees accessing services through LMHAs. DMHF also directly oversees the provision of select mental health services provided to some FFS Medicaid populations as well as beneficiaries enrolled in Medicaid Accountable Care Organizations (ACOs), the HOME Program,[15] and CHIP.[16]

As illustrated in Figure 8 (p. 8), Medicaid and other publicly funded mental health services in Utah are delivered through the following systems:

- Medicaid Fee-for-Service (FFS)
- Accountable Care Organizations (ACOs)
- Local Mental Health Authorities (LMHAs)
- Prepaid Mental Health Plans (PMHPs)
- Utah State Hospital
- The Healthy Outcomes, Medical Excellence (HOME) Program
- Children's Health Insurance Program (CHIP)

*Medical spending on individuals with a behavioral health diagnosis is **2-4 times** higher. One study found the addition of a mental illness to one or more chronic physical conditions can increase **Medicaid health care costs** by up to **75 percent**.*

Which system a person is assigned to depends on their age, income, other eligibility criteria, and severity of their mental health diagnosis. Some systems are overlapping, meaning a person may be assigned to two different systems to address differing health care needs. For example, a typical adult Medicaid enrollee is assigned to an ACO for their physical health care needs as well as a LMHA and PMHP for their mental health care needs.

Utah's Medicaid ACOs primarily provide physical health services to their Medicaid enrollees and only cover limited mental health screening, evaluation, and maintenance services. Consequently, patients in need of mental health care who seek treatment from their primary care provider are referred to PMHPs (operating under LMHAs).

Additional details on each of these systems, who they cover, and what services they provide is provided in Appendix IV.

Poor Physical and Mental Health are Closely Related

A problem with the bifurcation between physical and mental health services is that a positive association exists between chronic disease and poor mental health. One study found that the risk of having a stroke is 4.2 times higher in adults with symptoms of depression.[17] Similar studies found depression and anxiety increased the risk of coronary heart disease, atrial fibrillation (irregular and rapid heartbeats), and dementia.[18] [19] [20]

The costs of treating patients with co-occurring mental and physical health conditions is also higher. Research shows that spending on individuals with a behavioral health diagnosis is two to four times higher than for individuals without a behavioral health diagnosis.[21] One study found that the addition of a mental health disorder to one or more common chronic physical conditions can increase health care costs by up to 75 percent for the Medicaid population.[22] Improving integration between physical and mental health care can help reduce these costs.

Discussion Group Theme

Restrictions on funding streams that prevent providers from providing appropriate, timely care

Medicaid Carve Out – Discussion groups agreed that the bifurcation of physical and mental health services make it difficult to consistently deliver coordinated care to Medicaid enrollees.

> *"The inability to consistently deliver coordinated care to Medicaid recipients across multiple providers and practitioners is a limitation to the system. When patients are denied the right care, in the right place and at the right time, the result is often a less-than-desirable health outcome for the patient and greater costs to providers and ultimately to state taxpayers."* [23]

Many participants felt an integrated system would improve health outcomes and promote access to appropriate levels of care.

> *"In an integrated system, all of the economic incentives are in line. Those incentives help health care systems create and manage all levels of care so they can direct patients to where they need to be. If a health care system is not integrated, and different entities only own a piece of it, then those entities are only incentivized to fill appointments."*

Some participants cautioned that integration of physical and mental health care is more than just eliminating the Medicaid carve out. LMHAs have significant experience providing mental health services and simply changing the entity that administers those dollars will not guarantee a more integrated system.

> *"Integration requires breaking down provider networks and funding silos at the administrative and at the provider level to ensure providers can provide the best and most appropriate care to their patients."*

Reliance on Short-Term Grants – Many safety net providers rely on short-term grants (each with their own funding terms and restrictions) to supplement their mental health service offerings.

> *At times there is a need to "treat first and figure out funding later. That is pretty hard to do."*

Applying for these grants is time and resource intensive and the short-term nature of the grants limits the ability to provide consistent services or staffing over time. This problem is more acute in Utah's rural areas.

Funding for Dual Eligible – A portion of the population served by LMHAs are dual eligible, meaning they qualify for Medicaid and Medicare (Table 2). Dual eligible beneficiaries are more likely to experience high rates of chronic illness and 41 percent have at least one mental health care diagnosis.[24]

Providing care to this population can be challenging. Restrictions on reimbursement from certain payers can make it difficult to treat dual eligible beneficiaries.

> *"The state of Utah and many other payers separate people by Medicare and Medicaid—and your insurance determines who you can see. There are some providers that will provide Medicare services, and some will provide Medicaid services—and [the dual eligible population] struggle to stay on both programs because they don't get mail, they miss reviews, miss turning in paperwork, and go on and off the programs, meaning they don't have a consistent provider that is helping them and checking in on them … If they don't have a place that can help them with these hurdles, they just end up at the shelter, get evicted, or fall off of their insurance and can't get meds. They end up cycling through the most expensive services—police, fire, and the Utah State Hospital."*

It is important that dual eligible beneficiaries maintain eligibility for both programs so they can access appropriate care and so that providers can be reimbursed for the full range of care provided.

"Integration requires breaking down provider networks and funding silos at the administrative and at the provider level to ensure providers can provide the best and most appropriate care to their patients."

Fee-For-Service (FFS) Reimbursement Creates Additional Challenges

While ACOs and PMHPs are paid a capitated monthly fee for each Medicaid member enrolled in their plan, their contracted providers may operate under a FFS reimbursement arrangement.

Discussion Group Theme

FFS reimbursement makes it difficult to provide preventive care and a full range of integrated physical and behavioral health services

In a FFS payment model, providers are reimbursed for each service they provide, which can incentivize unnecessary services. In a capitated or global payment arrangement, providers are paid a set amount of funds to care for a specific population. This promotes flexibility, creativity, and encourages providers to focus on keeping patients healthy.

"What keeps us from getting better, from a payment standpoint, is that there's not a lot of incentive to improve outcomes for clients, and in some ways, there is a lot of disincentive to focus on those things that might produce better outcomes."

Discussion groups felt moving to capitated or global payments would allow providers to better meet the needs of their patients and encourage more preventive care to help mitigate the escalation of mental health issues.

It was also mentioned that FFS can magnify the bifurcation of mental and physical health services as well as the bifurcation of mental health and SUD treatment. Coupling this bifurcation with reimbursement rules, such as same-day billing, results in providers not being reimbursed for physical health and behavioral health services provided on the same day and can prevent the timely provision of mental health care.

Demand for Utah State Hospital Services is High

The Utah State Hospital is a 24-hour psychiatric facility that provides statewide inpatient mental health services to all age groups. The Utah State Hospital also provides forensic services to individuals found incompetent to stand trial or not guilty by reason of insanity, guilty of a crime and ordered to receive mental health treatment as part of their sentence, or who are in the custody of the Utah Department of Corrections.[25]

Each LMHA has a certain number of Utah State Hospital beds to serve its clients with inpatient mental health needs (all LMHAs provide acute short-term inpatient mental health services).[26] The allocation is derived from a formula based on the size of the county and the number of available beds.[27] The hospital does not maintain a waitlist and accepts clients on a first-come, first served basis. Additional detail on services provided by the Utah State Hospital is in Appendix IV.

Discussion Group Theme

Forensic bed classifications are overtaking available Utah State Hospital beds

States across the country are experiencing growth in 'forensic referrals,' which is creating waitlists for restoration programs and forensic hospital beds. In 2015, the Disability Law Center sued the state of Utah for not providing mentally ill inmates with timely access to the Utah State Hospital. The resulting settlement agreement included identifying assessment and treatment guidelines as well as reducing expected timeframes for accessing Utah State Hospital beds.

"The problem with the increased focus on forensic beds is that it reduces available civil beds, and in some cases, results in a complete lack of available beds for people with mental health issues who are not in the forensic system."

Although the Governor's Office of Management and Budget has worked with the Utah State Hospital to reduce the average length of stay by over 20 percent, the need for long-term acute care far exceeds the hospital's capacity.

"Adding a dozen beds to get the hospital to full capacity would still not address the state's need for long-term beds."

Utah Offers Robust Public Mental Health Services, but Gaps Exist

While the Medicaid program and the LMHAs cover a broad array of public mental health services (as detailed in Appendix IV), discussion groups outlined several gaps in available services that create barriers to people accessing necessary treatment.

Discussion Group Theme

Gaps in mental health services

Available Long-Term and Intermediate Beds – Discussion groups agreed that there are not enough long-term or intermediate beds in the state.

"Given the limited number of available beds at the Utah State Hospital, there are times when LMHAs are unable to provide inpatient services to their clients. This occurs when the LMHA has reached its allotted number of beds or the capacity is needed for forensic patients."

Similar concerns exist for hospitals that have to keep patients with severe mental health issues admitted in the hospital or ER if there is no alternative long-term or intermediate care facility available. This is known as "***ER boarding***." It is an expensive care option and the patient only receives limited mental health services available in the ER. A 2017 study revealed that Utah's current mental health system relies heavily on ERs and law enforcement to provide crisis services.[28]

"If someone walks into the ER and they want to kill themselves or kill others, or they are completely out of control, they get hospitalized and sometimes remain at the hospital for months (up to six months or a year). The hospital is trying to get them in to the State Hospital and the State Hospital can't take them. So the hospital just eats the cost."

Housing – While obtaining safe, affordable housing is key to managing mental health issues, people with mental health conditions face a number of obstacles to securing appropriate housing:

- Some have lost contact or severed family and community support
- Some are not candidates for nursing homes because of aggressive behavioral issues
- There is a lack of affordable housing in the state
- It is difficult to find staff for supportive living homes
- Good landlord laws make it unlikely that someone with a criminal history related to mental health can find a place to live

Residential Treatment Options – Federal rules do not allow Medicaid to reimburse mental health facilities with more than 16 beds, which limits the supply of available residential facilitates (participants noted these facilities financially break even at about 30 beds).

"There's no adult short-term residential housing in our whole county," which limits the ability of people to leave hospital beds and inpatient settings early and stabilize in the community.

Utah currently has a waiver to reimburse SUD residential treatment facilities larger than 16 beds.[29] Obtaining a similar waiver for mental health residential treatment facilities could improve the supply of mental health residential treatment options in the state.

Stepdown Care – Patients leaving the Utah State Hospital or other inpatient treatment facilities have few, if any places to go to receive "stepdown" support for their mental health care needs—needs that don't require inpatient treatment, but may require higher-acuity than what is available in the community. These middle-level patients tend to experience the biggest gaps in care.

"Discharging patients who have received intensive inpatient therapy back into a community where there are inadequate 'stepdown' facilities often creates recidivism and trauma for the patient and their family as well as wastes the precious resources spent healing that patient at the hospital."

Short-Term Crisis Services and Temporary Receiving Centers Discussion groups expressed a desire for more short-term crisis services and temporary receiving centers. This could include more:

- Medication detox programs
- Coordinated regional or statewide crisis call centers
- 24/7 mobile crisis teams
- Short-term crisis stabilization facilities
- Walk in clinics

"States with good systems have walk-in clinics. You may have to wait for an hour, but you can get medication if you need it or talk to somebody if you're starting to come apart. These clinics provide that availability and flexibility."

Care Options for the Homeless – It is difficult to provide comprehensive treatment to individuals who are homeless and this population can overwhelm existing safety net service providers.

"We had an individual that was released from the hospital in only a gown and was sent in a cab to our clinic. He had liver failure, no one would take him, and so they sent him to us instead of trying to figure out the system. We attempted to pink-sheet him, but because he wasn't aggressive, or a threat to himself or someone else (even though he was butt-naked except for a gown), we would've had to put him out on the street because no one was willing to take him. We jumped through a lot of hurdles [to provide him with care]."

Continued on next page

"Almost no one is doing case management anymore because you can't sustain that in a FFS model. And if you don't have a way to subsidize that service with other services, then it's not viable. But for the money you put in to it, it's probably the most valuable mental health service that can be provided. It's more important than any of the other disciplines in terms of managing treatment over a lifetime."

Discussion Group Theme *(Continued)*

Coordinated Care Transitions – Several discussion groups noted the difficulty patients experience when transitioning from youth to adult mental health services.

> *"Good transition should be a coordinated, purposeful, planned and patient-centered process that ensures continuity of care, optimizes health, minimizes adverse events, and ensures that the young person attains his/her maximum potential."*[30]

Better coordination is also needed when moving patients from crisis services into treatment. Necessary connections are not always made, which can prevent the patient from accessing appropriate care or prevent the provider from providing appropriate treatment.

> *"As crisis services are expanded, we need to ensure that appropriate transition supports are in place."*

Case Management – All of the discussion groups mentioned the need for more case management, care navigators, and/or peer supports. Participants noted that most systems don't have the appropriate financial incentives, reimbursement model, or sufficient resources to hire workers to help coordinate a patient's ongoing treatment (particularly as they move between health care systems) or help them fill out Medicaid and other insurance paperwork.

The lack of case management, care navigators, and/or peer supports can result in people getting lost between systems or different levels of care, and increases the probability of a persons' mental health condition escalating due to lack of appropriate follow-up care.

> *"Almost no one is doing case management anymore because you can't sustain that in a FFS model. And if you don't have a way to subsidize that service with other services, then it's not viable. But for the money you put in to it, it's probably the most valuable mental health service that can be provided. It's more important than any of the other disciplines in terms of managing treatment over a lifetime."*

Table 3: Range of School Mental Health Professional to Student Ratios in Utah, FY 2018

Profession	Low	High
Counselor	1:299	1:862
Psychologist	1:1,067	1:15,320
Social Worker	1:479	1:28,905
School Nurse	1:774	1:16,165

Note: Averages are for districts reporting at least one of a professional type. Several districts report zero FTEs for some professions.
Source: Mental Health in Schools: Survey of School Districts. (2019, February). Legislative Fiscal Analyst.

Information on Other Public Mental Health Services

Uninsured individuals receive services through LMHAs, federally qualified health centers (FQHCs), or though other community programs.

Federally Qualified Health Centers - FQHCs receive federal financial support from the HRSA to provide comprehensive, culturally competent, quality health care services to the uninsured, underinsured, Medicaid enrollees, and persons with other government or private insurance. They also address the needs of special populations such as the homeless or migrant workers.[31] Most FQHCs provide integrated physical and mental health care to their patients. The reimbursement FQHCs receive is dictated by the patients' insurance.

School-Based Mental Health Services - Some school-based mental health services are available for students in kindergarten through higher education. Funding for these programs comes from federal, state, and local governments,[32] grants, public education institutions, and Medicaid. LMHAs collaborate with the school districts in their areas to provide mental health services.[33] Table 3 shows the ratio of primary education school-based mental health professionals to students. The table includes the range of mental health professionals, highlighting how the supply of mental health professionals varies across the state. The state of Utah requires a student-to-counselor ratio of 1:350 or less.[34]

Discussion Group Theme

A lack of system collaboration

There is a need for broader system collaboration and coordination given the number of different entities providing mental health services across the state. This would help ensure that necessary services are provided at the right time, in the right place, as well as avoid duplication of services among different systems.

To achieve this broader level of collaboration, discussion group participants suggested the state develop a resource to help providers who don't have the funding or a physical place for a person to receive care.

One participant suggested empowering someone at the state level to allow for exceptions to established protocol in crisis situations and instances when a patient clearly needs, but is unable to obtain treatment.

"We had one difficult case a while back where we were calling the state every other week. It seems like state statutes sometimes prevent [the system from] being creative. It seems like you should, at a high enough level, be able to grant the authority to borrow from different pots of money to treat different things. It seems like if the state had a position high enough to cut through [all the red tape] ….that would be a relatively useful, but easy fix."

Broader system coordination could also help providers to better leverage community resources. Some providers are unaware of existing community mental health resources and therefore do not make the referrals or suggestions to their patients.

Utah's universities also struggle to meet recommended national standards for student-to-counselor ratios. A 2017 study found that only four of Utah's 10 public and private universities had student-to-counselor ratios less than the recommended 1:1,500.[35] Wait times can be two months or more.[36]

Utah Department of Corrections - A survey conducted by the U.S. Department of Justice found that over half of those incarcerated in state and local prisons had a mental health problem.[37] As such, the Utah Department of Corrections is the primary provider of mental health services for incarcerated offenders with mental health issues.

The department operates a stand-alone mental health unit, Olympus, where offenders with severe mental health issues are located. The women's correctional facility also has its own mental health unit. The Clinical Services Bureau assists with therapy and medication management. As noted above, for patients with more severe mental health needs, the Department of Corrections has access to a designated number of beds at the Utah State Hospital, which are located in a high-security setting.

In addition to these facilities, the Department of Corrections oversees an outpatient system for offenders on parole or moving to halfway houses. This system includes case managers who assist an offender with their transition to the community and helps to ensure they are receiving appropriate and necessary care.

Utah's Non-Public, or Private Mental Health System

While Medicaid and the public health system cover a significant amount of mental health services, most people in Utah have private health insurance coverage. The majority of Utahns receive health care coverage through their employers (61 percent) and Utah has the highest rate of employer-sponsored insurance (ESI) in the country.[38]

Mental Health Parity

Coverage of mental health services varies by commercial health insurance plan and product, making it difficult to assess its availability and coverage. That said, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prevents group health plans and health insurance issuers from imposing less favorable benefit limitations[39] on mental health or substance use disorder (MH/SUD) benefits than on medical/surgical benefits.[40] MHPAEA originally only applied to large group health plans and group health insurance coverage that chose to include mental health and SUD benefits in their plans. The Affordable Care Act (ACA), however, amended the MHPAEA by including mental health and SUD services as one of 10 essential health benefits ACA-compliant individual and small group plans are required to cover.[41] [42]

As noted in Table 4, several plans in Utah are exempt from MHPAEA requirements. This doesn't mean that these plans do not offer mental health and SUD benefits, but illustrate potential gaps in access to mental health care in Utah.

Table 4: Utah Private Health Insurance Plans Exempt from MHPAEA Requirements

Coverage Type	Percent of Utah Market	Coverage Details	Has to Comply with MHPAEA	Percent of coverage type
Employer Sponsored Self-Funded Plans				
Plans Administered by Commercial Insurers and other Self-Funded Plans	35.0%	Less than 50 employees	No	Unknown
		More than 50 employees, but does not cover MH/SUD	No	Unknown
		More than 50 employees and opts out of MHPAEA	No	Unknown
		More than 50 employees and covers MH/SUD	Yes	Unknown
Public Employee Health Program (PEHP)	4.4%		No*	100%
Federal Employee Health Benefit Plan (FEHBP)	3.4%		Yes	100%
Commercial Health Insurance Plans				
Individual Plans	7.8%	ACA compliant	Yes	90%
		Non-ACA compliant	No	10%
Small Group	5.8%	ACA	Yes	77%
		Non-ACA compliant	No	23%
Large Group	12.4%	Covers MH/SUD	Yes	Unknown
		Does not cover MH/SUD	No	Unknown

* Is not required to comply with MHPAEA requirements, but does provide mental health services.
Note: Government-sponsored plans make up the remaining 22.6 percent of Utah's market. 8.7 percent is uninsured.
Source: Gardner Institute analysis of MHAEA rule. Utah Insurance Department market estimates.

Coverage Restrictions

Utah's current benchmark plan is the PEHP Utah Basic Plus plan.[43] While individual products and policies in the ACA-compliant individual and small group market may be more robust than what is outlined in the benchmark, the plan provides a basis for the types of benefits provided and limits that exist in Utah's commercial insurance market.

Table 5 highlights the types of mental services that are excluded from coverage by Utah's Benchmark Plan. For example, residential treatment services are typically not covered by insurance and must be paid for out-of-pocket. The costs of these treatment centers can range from $10,000–$60,000 per month.[44]

Cost

Even if health insurance covers mental health services, there are still applicable copays, deductibles, and out-of-pocket costs. For example, the cost for private counseling or therapy can range from $50 to $240 for a one-hour session.[45] Commercial health insurance typically only covers 70 percent of the cost of these sessions if they are provided by a network provider and are for a diagnosed psychiatric disorder (e.g., marriage counseling is not covered).-

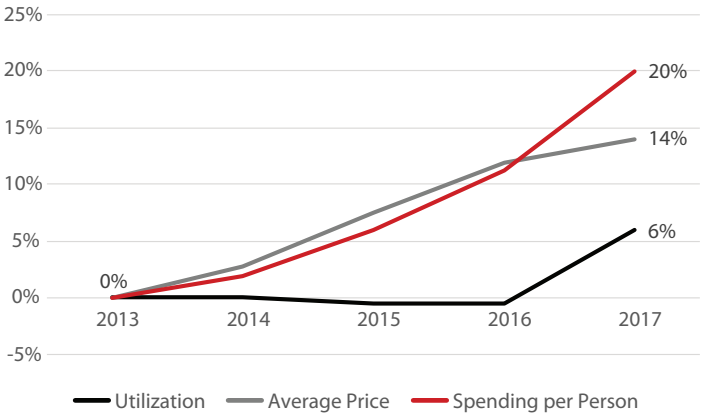
National data show the cost and utilization of mental health services is increasing. A study by the Health Care Cost Institute found that spending, use, and average prices of inpatient admissions for mental health increased steadily from 2013–2017 (Figure 11).[46] The population that suffers from mental health issues is also more vulnerable to unstable finances, which can limit their ability to access mental health care (Figure 12).

Table 5: Mental Health Coverage Restrictions in Utah's Benchmark Plan, Plan Years 2017+

Details
Services Not Covered
• Inpatient treatment without preauthorization (if required by the member's plan). • Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances. • Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions. • Wilderness programs. • Inpatient treatment for behavior modification, enuresis, or encopresis. • Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations. • Occupational or recreational therapy. • Hospital leave of absence charges. • Sodium amobarbital interviews. • Residential treatment programs. • Tobacco abuse. • Routine drug screening, except when ordered by a treating physician.

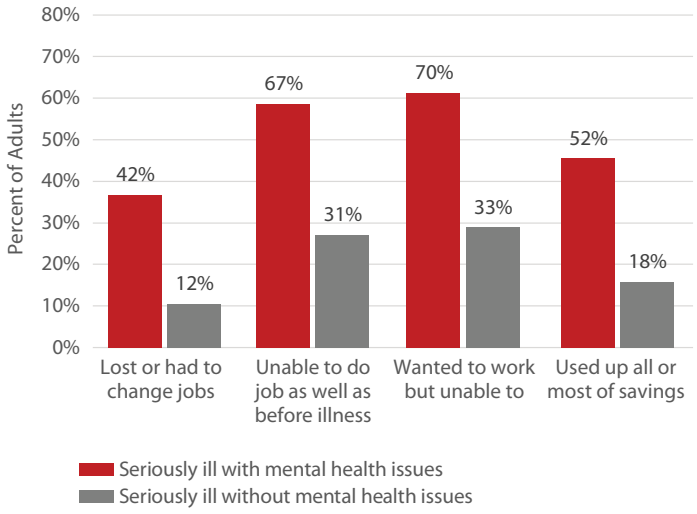
Source: Utah Basic Plus Benefits Summary. Utah Insurance Department.

Figure 11: Cumulative Change in National Mental Health Utilization, Average Price, and Spending per Person, 2013–2017



Source: 2017 Health Care Cost and Utilization Report. (2019, February). Health Care Cost Institute.

Figure 12: Financial Vulnerabilities of Seriously Ill Adults with Mental Health Issues, 2018



Source: Schneider, E., Lewis, C., & Tsega, M. (2019, January). Managing the Toll of Serious Illness on Mental Health. The Commonwealth Fund.

High-Deductible Health Plans (HDHPs)

HDHPs currently comprise about 30 percent of Utah's commercial health insurance market, compared to only 3 percent in 2007.[47] These plans have lower monthly premiums, but the higher deductibles require individuals and families to pay more in out-of-pocket costs before their insurance plan begins to cover expenses. Today, health savings account (HSA) qualified high-deductible family health plans have a minimum deductible of $2,700 with a maximum of $13,500 in out-of-pocket expenses.[48] This means that consumers enrolled in these plans are responsible for paying $2,700 of their covered health care expenses (or more if the deductible is higher) before the insurance company begins to pay a portion of the costs.

While HDHPs may save individuals and families money in the short run through lower monthly premiums, they can deter some individuals from seeking appropriate medical care because of the higher, upfront out-of-pocket costs.[49] Data from the National Health Interview Survey show that about one in 10 adults report delaying or going without medical care due to costs. This portion increases to one in four among uninsured adults.[50] Data also show that 4 out of 10 adults would either have to borrow money, sell personal items, or simply not be able to pay the cost if faced with a $400 unexpected expense.[51]

Medicaid as the De-facto Payer

Medicaid typically provides access to more mental health services than commercial health insurance. As such, some individuals who require costly intensive mental health services (e.g., residential treatment programs), and meet other Medicaid coverage requirements, may need to spend-down their assets in order to qualify for Medicaid.

Similar problems exist with Medicare coverage (see Appendix VI). Medicare does not pay for inpatient care past 190 days. It also does not pay for nursing homes or assisted living other than short-term medically necessary skilled care following an injury or illness.[52] This means any inpatient or residential costs associated with mental health needs must be paid for out-of-pocket or covered by Medicaid if the person is dual eligible.

Discussion Group Theme

Limited commercial coverage of mental health services

Commercial health insurance's limited coverage of mental health care is a major barrier to providing and accessing care.

"Benefit design in public and private insurance plays a big part in [shaping the current system]. Benefit design does not tend to recognize that substance use and mental health are chronic progressive relapsing diseases. [Making sure that appropriate mental health] treatment is available through commercial insurance and in the individual market is critical."

Not all employer-sponsored or commercial health plans are subject to the federal MHPAEA law and the law is not always enforced.

"[MHPAEA] is weakly enforced and a major issue. This isn't a disease that should be the burden of just taxpayers through public programs. Families should be able to access care through their commercial insurance."

High deductibles and copays can limit the ability of individuals to access mental health care even if they have insurance.

Appendix I: Qualitative Research Methodology

To better understand and catalogue gaps in mental health services, barriers to providing and accessing care, and considerations for improving the system, the Gardner Institute staff conducted eight discussion groups with key industry leaders from Utah's mental health system. The meetings were held in-person or via telephone.

The Gardner Institute also conducted seven in-depth interviews with key industry leaders between August 2018 and February 2019. Each interview lasted approximately 30–60 minutes. The purpose of these interviews was to obtain a deeper understanding of mental health care issues and concerns.

Discussion groups were conducted with:

- Intermountain Healthcare
- Local Mental Health Authorities – urban area representatives
- Local Mental Health Authorities – rural area representatives
- University Neuropsychiatric Institute/University of Utah Health
- Utah's Community Health Centers
- Utah Department of Health
- Utah Department of Human Services
- Utah NAMI members (speaker's bureau meeting)

Appendix II: Suggested Steps to System Improvement

Discussion group participants suggested first steps and future steps to improving Utah's mental health system. These steps are organized within the gaps and barriers that were identified by the discussion groups as preventing Utah from achieving the ideal mental health system.

First steps are defined as short-term or more immediate solutions achievable through policy changes or program implementation. Future steps require long-term planning or changes to current laws and regulations.

These steps reflect ideas brought up during the group discussions and interviews and are not meant to be a complete roadmap to achieving an ideal system. They are organized within the gap/barrier they most directly address; however, many of these steps could address multiple gaps and barriers in the system.

Where applicable, the table also highlights recent policy or program changes that have:

- Led to system improvements
- Address current gaps to achieving the ideal mental health system
- Align with suggested first or future steps

It is important to note that the list of policy or program changes highlighted in this report is not comprehensive or inclusive of all the invaluable work being done by systems and organizations across the state to improve Utah's mental health system.

Stigma surrounding mental health

FIRST STEPS

- Continue mental health public education efforts.

  H.B. 373: Student Support Amendments (2019 General Session) provides state funding to increase the number of mental health providers in local schools (Kindergarten through grade 12) as well as increase resources for the SafeUT Crisis Line (a mental health crisis and tip line) and youth suicide prevention programs.

- Continue to increase primary and specialty care provider training on identifying, understanding, and addressing mental health issues.

  The University of Utah Pediatric Psychiatry and Behavioral Health Faculty are developing a Child and Adolescent Mental Health certificate program for primary care physicians, nurse practitioners, and physician assistants. Providers will have access to empirically based best practice content related to assessment, diagnoses and treatment of psychiatric disorders in primary care settings. Content will be available in an on-line asynchronous format to facilitate accessibility. In addition to didactic content, participants will interact with psychiatric faculty in on-line, live, consultation groups for each diagnoses reviewed in the program. The University of Utah is planning to start with youth mental health issues and child and adolescent psychiatry, but hopes to expand the program.

- Enhance existing community coalitions.

Stigma surrounding mental health *(continued)*

FUTURE STEPS

- Promote the physical co-location of mental and physical health care services so that patients seeking mental health services can access care at the same practice or building.

  "Stigma is a major problem in frontier and rural communities. Having more mental health care in a primary care setting would help people avoid the stigma of having their car parked in front of the mental health facility."

Workforce shortages and limited access to services

FIRST STEPS

- Continue to increase the availability of emergency team/mobile crisis services.

  The state of Utah recently funded five additional Mobile Crisis Outreach Teams (MCOT) teams to launch in 2019. These team will be located in Salt Lake, Weber, Davis, and Utah counties as well as the Southwest LMHA region.

- Continue to leverage and promote knowledge of the Interstate Compact on Mental Health.

  The Interstate Compact on Mental Health allows Utah residents in need of mental health treatment to seek treatment in other state institutions or be transferred to an institution in another state if they could receive appropriate treatment there.[53]

- Continue to increase funding for school-based mental health providers.

  As noted above, H.B. 373: Student Support Amendments (2019 General Session) provides state funding to increase resources for the SafeUT Crisis Line and youth suicide prevention programs. Schools are incentivized to collaborate with local mental health authorities.

- Continue to expand the use of telehealth and tele-psych services.

  H.B. 393: Suicide Prevention Amendments (2019 General Session) provides grants to mental health facilities to implement programs to provide access to telehealth psychiatric consultation, including diagnostic clarification, when evaluating a patient for or providing a patient mental health treatment.

Workforce shortages and limited access to services *(continued)*

FIRST STEPS *(continued)*

- Continue to support universities in increasing program slots as well as providing incentives for students to stay in state.

  H.B. 174: Psychiatry Medical Residents Amendments (2019 General Session) funds four new psychiatry resident slots at the University of Utah each year for the next four years. Discussion group participants also noted the importance of providing incentives to keep these students working in state post-graduation and mentioned it may be helpful to examine equalizing resident placements across the state for broader coverage.

- Build on the success of "growing their own" by providing incentives to local workers to obtain mental health degrees.

- Provide resources or match funds to help health systems in underserved or rural areas better leverage existing federal workforce development grant and loan repayments programs such as those provided through the National Health Service Corps (NHSC).

FUTURE STEPS

- Change licensure requirements to increase reimbursable capabilities of APRMs, LCSWs, SSWs, CMHs, and LMFTs.
- Provide state-funded rural area workforce incentive grants and/or provide the state match for federal workforce incentive grants.
- Provide state-funded loan forgiveness/tuition reductions for rural areas.
- Increase/reinstate retirement benefits for public mental health providers.
- Provide statewide access to a psychiatrist hotline (expansion of H.B. 393).
- Encourage team-based or collaborative care models.

  Collaborative care models utilize a team-based approach that typically includes primary care providers, social workers, and psychiatrists. The primary care provider is responsible for patients' physical and mental health. They work with social workers to identify the patients' mental health or social care needs and then consult with a psychiatrist to determine the appropriate treatment plan.

Workforce shortages and limited access to services *(continued)*

FUTURE STEPS *(continued)*

This type of model allows one psychiatrist to oversee more patients by providing consultation to multiple primary care providers. It was noted by discussion group participants that collaborative care model codes are open and available in Utah's Medicaid program as well as used by other insurers.

Intermountain Healthcare's Mental Health Integration program and the Intensive Outpatient Clinic at University of Utah Health use utilize team-based approaches. An evaluation of Intermountain's Mental Health Integration program found that the model resulted in a lower rate of emergency room visits, a lower rate of hospital admissions, and cost savings.[54]

- Create a statewide system for mental health e-consultations.

  An e-consultations system would allow patients to receive electronic-based, skills-based therapy online while they wait for an in-person appointment. It can help reduce crisis symptoms, as well as use peer support to track patients' appointments and ensure they are receiving appropriate follow-up care.

Restrictions on funding streams prevent providers from providing appropriate, timely care

FIRST STEPS

- Medicaid expansion, which allows for mental health integration pilot projects, addresses the Medicaid carve-out by removing the funding stream restrictions for newly eligible Medicaid expansion enrollees.

  Pilot projects will commence in Weber, Davis, Salt Lake, and Utah counties. The pilots will also only integrate funding for newly eligible enrollees, not the traditional Medicaid population. While the pilot programs could expand to other counties over time, there will be bifurcated mental health system in the short-term with only a subset of the newly eligible population receiving integrated services.

- Medicaid expansion addresses lack of access to care by the uninsured by providing Medicaid to all adults up to 100 percent of the federal poverty level.
- Continue to increase Medicaid coverage of school-based services.

Restrictions on funding streams prevent providers from providing appropriate, timely care *(continued)*

FIRST STEPS *(continued)*

S.B. 106: Mental Health Services in Schools (2019 General Session) requires the Department of Health to develop a proposal to allow the state Medicaid program to reimburse a local education agency, local mental health authority, or private provider for covered mental health services provided at schools, school facilities, or by an employee or contractor of a local education agency.

- Increase the use of SBIRT codes by primary care physicians.

  "The codes are open and no one is using them. Are they not using codes because they do not have a referral in network? If we aligned incentives, would they do more?"

- Expand the use of more mental health Medicaid billing codes to primary care physicians or expand the use of some physical health billing codes to LMHAs.

FUTURE STEPS

- Based on the outcomes of the Medicaid expansion mental health integration pilot projects, consider developing an integration model for all Medicaid enrollees in all counties.

FFS reimbursement, which makes it difficult to provide preventive care and a full range of integrated physical and behavioral health services

FUTURE STEPS

- Incentivize or mandate that ACOs or PMHPs reimburse mental health providers through a capitated or global payment model.

Gaps in mental health services

FIRST STEPS

- Continue to increase the availability of crisis services.

  In 2017, the DSAMH worked with RI International to develop strategies and a capacity plan for optimizing the Utah mental health crisis system. The plan includes a number of details and recommendations, including creating four crisis receiving centers with 10 23-hour observation recliners that are each connected to a 16-bed sub-acute facility.[55] *As noted above, the state is also launching five additional MCOT teams in 2019.*

Gaps in mental health services *(continued)*

FIRST STEPS *(continued)*

- Continue to develop written guidelines or policies for those transitioning from child to adult mental health services.

  The University of Utah is currently developing guidance to help providers and health systems better assist patients with this transition.

- Continue to increase the availability of detox services.

  In February 2019, Utah submitted an 1115 waiver amendment to provide clinically managed residential withdrawal services to Medicaid eligible adults age 18 and older who reside in Salt Lake County. If approved, services will be provided by the Volunteers of America Adult Detoxification Center and Center for Women and Children (VOA).

- Continue to increase housing options and housing support services for individuals with mental health issues.

  As part of its Medicaid expansion 1115 waiver, Utah will request permission to use federal Medicaid funds for housing supports. The list of qualifying housing support is still being developed by the Utah Department of Health and the amount of available funding will be determined through the waiver process.

- Apply for an IMD waiver for mental health residential facilities.

  In late 2018, the federal government announced it was reversing the IMD exclusion on inpatient mental health treatment for Medicaid enrollees. States can apply for waivers from that restriction.

- Provide more Medicaid case managers to help patients with paperwork, including renewing Medicaid eligibility.

- Incentivize or mandate all systems/payers to reimburse case managers or community health workers charged with coordinating physical health and mental health services, paperwork, and support services (such as transportation, housing, and helping track and manage prescription medications). Alternatively, moving to a capitated or global payment model could help offset the cost of case managers or community health workers.

  "Very simple things like case management and transportation help people make their appointments and negotiate the systems. They're very inexpensive services in the big picture, but maybe some of the most powerful or most effective. Just helping people, advocating for them, getting them to their appointments. This used to be paid for and it's not now, so it doesn't happen."

Gaps in mental health services *(continued)*

FUTURE STEPS

- Increase the number of receiving centers designed specifically for youth.
- Continue to assess gaps in services as the above policies are implemented and evaluate whether additional policy or program changes are needed.
- Promote the use of health homes and centralized care.
- Establish or enable a community information exchange or digital platform that tracks patients through care transitions and different health and social service systems.

A lack of system collaboration

FUTURE STEPS

- Create a board to oversee coordination of mental health care services.
- Create a health care ombudsman as a resource for providers faced with difficult cases, particularly those that do not fit into usual funding categories.

Limited commercial coverage of mental health services

FUTURE STEPS

- Continue to improve enforcement of mental health parity among commercial health insurance plans.
- Encourage plans that are not subject to mental health parity laws to cover mental health services.

Appendix III: Additional Data on the Demand for and Supply of Mental Health Services in Utah

Traumatic Brain Injuries (TBI)

Data show that 66 Utahns sustain a TBI every day.[56] The majority of Utahns suffer TBIs from falls and motor vehicle crashes. TBIs are not considered a mental health disorder and public health funding for treating TBIs comes from the Utah Department of Health (UDOH). That said, TBIs increase the risk for developing or experiencing mental health issues.

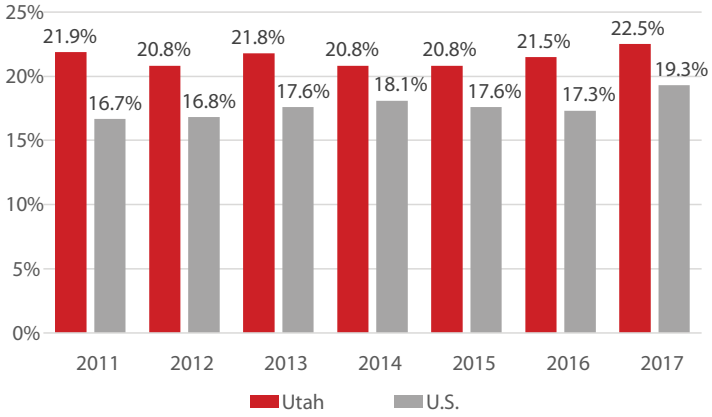
Several discussion groups mentioned the difficulty providing adequate mental health services to individuals who have a TBI. Some of these individuals develop aggressive behaviors, which can make treatment extremely challenging. It was noted that some treatment centers and nursing homes will not accept aggressive patients.

Depression

The rate of self-reported lifetime depression is higher in Utah compared to the U.S. (Figure 13).[57] The proportion of adults who reported being told they had a depressive disorder varies by income and location. Adults with lower income (below $25,000 per year) report higher rates of depression and poor mental health (Figure 14).

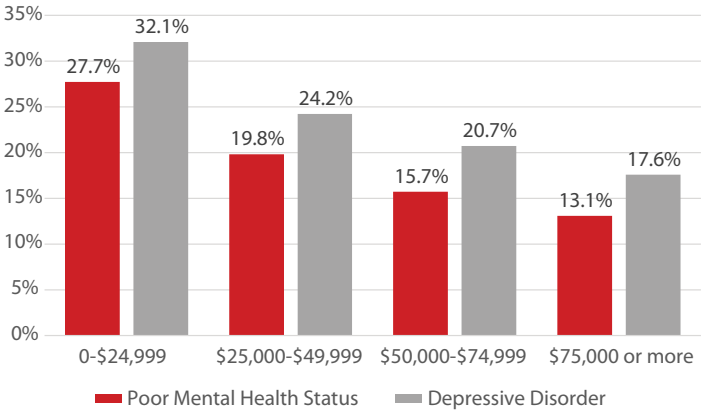
A considerable amount of research has focused on the relationship between income and mental health. One theory posits that poor mental health causes "downward drift," meaning that individuals' social and economic status declines as they experience declines in their mental health. However, other theories with stronger empirical support suggest that individuals in lower socioeconomic situations experience more psychological stress and have fewer supports, indicating poor mental health is more likely to be correlated with lower socioeconomic status.[58]

Figure 13: Depression Prevalence in Utah and the U.S., 2011–2017



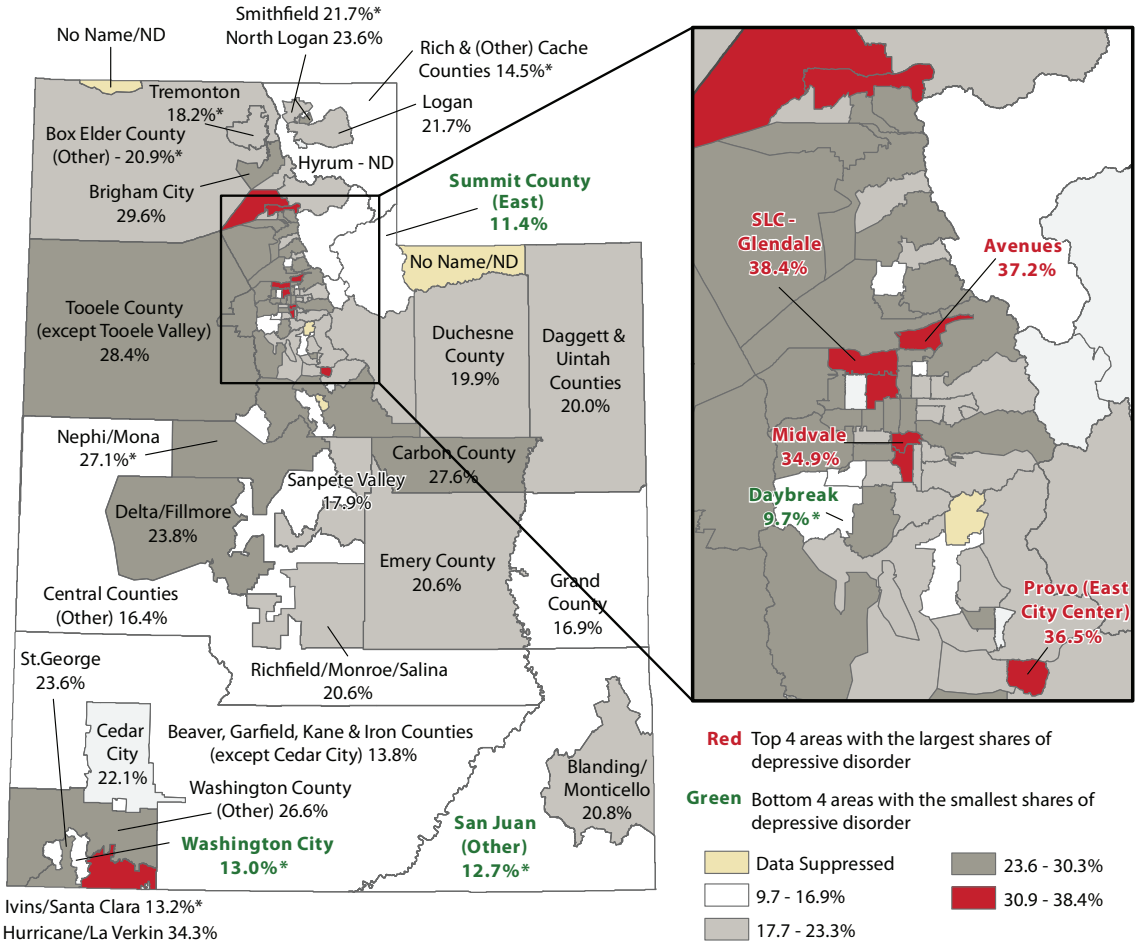
Note: Data is age-adjusted.
Source: Utah Behavioral Risk Factor Surveillance System.

Figure 14: Utah Mental Health Status by Income, 2017



Note: Data is age-adjusted. Depression is 2015-2017 (three-year average).
Source: Utah Behavioral Risk Factor Surveillance System.

Figure 15: Percent of Utah Adult Population with Diagnosed Depression by Small Area, 2017



Note: Data is age-adjusted. Along the Wasatch Front, the areas with the highest percent of reported depression include Glendale, the Avenues, Midvale, and Provo city center.
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health.

Serious Mental Illness

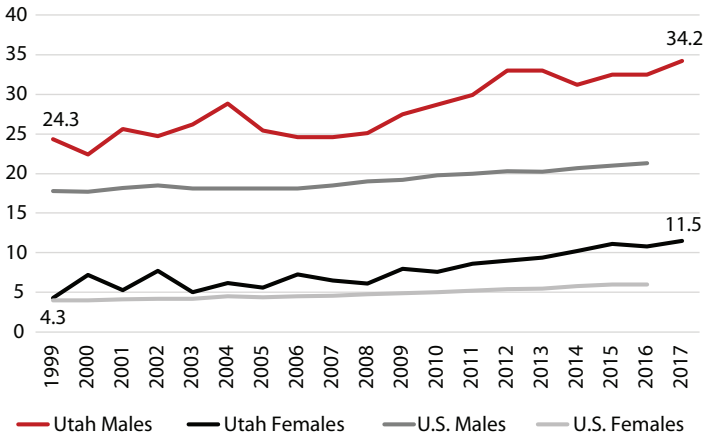
It is estimated that over 100,000 people in Utah have a Serious Mental Illness (SMI). Table 6 shows the estimated number of adults with SMI across Utah counties. Utah defines SMI or Serious and Persistent Mental Illness (SPMI) as having a diagnosed a mental health disorder and (1) being unable to independently perform activities of daily living, (2) having a condition that could deteriorate without continued behavioral health treatment, or (3) having social supports needs such as receiving public assistance, being socially isolated, or being marginally employed, among other criteria.[59]

Table 6: Estimated Utah Adults with Serious Mental Illness (SMI), 2018

	Local Mental Health Authority	Percent of Population with SMI	Number with SMI
Rural	Bear River (Box Elder, Cache, & Rich)	5.2%	6,278
	Central (Juab, Millard, Sanpete, Sevier, Piute, & Wayne)	5.0%	2,694
	Four Corners (Carbon, Emery, & Grand)	5.0%	1,467
	Northeastern (Duchesne, Daggett, & Uintah)	5.2%	2,058
	San Juan	5.0%	530
	Southwest (Beaver, Iron, Garfield, Washington, & Kane)	4.9%	7,832
	Summit	5.2%	1,526
	Tooele	5.2%	2,164
	Wasatch	5.2%	1,025
	Total	5.1%	25,574
Urban	Davis	4.6%	10,238
	Salt Lake	4.8%	38,364
	Utah	5.6%	21,221
	Weber (Weber & Morgan)	4.8%	8,698
	Total	5.0%	78,521

Source: FY 2018 Mental Health Scorecard for Audits. (2018, November). Department of Substance Abuse and Mental Health.

Figure 16: Utah's Suicide Rate per 100,000, 1999–2017



Note: Age-adjusted.
Source: Violence and Injury Prevention Program, Bureau of Health Promotion, Division of Disease Control and Prevention, Utah Department of Health.

Suicide

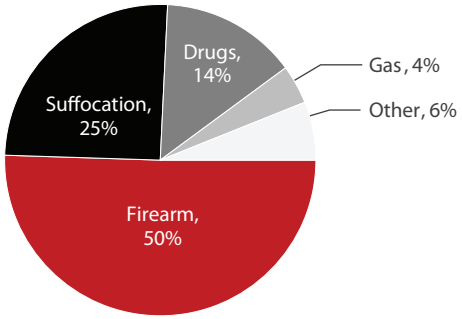
Utah's age-adjusted suicide rate in 2017 was 22 per 100,000 persons, with an average of 628 suicides per year. This was the fifth highest age-adjusted suicide rate in the U.S. (Figure 16).[60] In 2017, suicide was the leading cause of death for Utahns ages 10–24. It was the second leading cause of death for ages 25–44 and the fourth-leading cause of death for ages 45–64.[61]

More people in Utah are hospitalized or treated in an emergency room for suicide attempts than are fatally injured.[62] Recent research from the Harvard T.H. Chan School of Public Health found firearms account for half of all suicides in Utah (Figure 17) and that the higher suicide rate in Utah's rural counties is driven by a higher firearm suicide rate.[63]

Veteran Suicides – Veterans are particularly prone to poor mental health and have a high suicide rate. Veteran suicides accounted for 13.3 percent of all suicides in Utah from 2012–2016.[64] Of those who committed suicide, 44.3 percent had at least one diagnosed mental health problem at the time of their death. An additional 6 percent had a history of treatment, but their condition was going untreated at the time they died.[65] Documented behavioral health issues include post-traumatic stress disorder, alcohol problems, and other SUD problems.

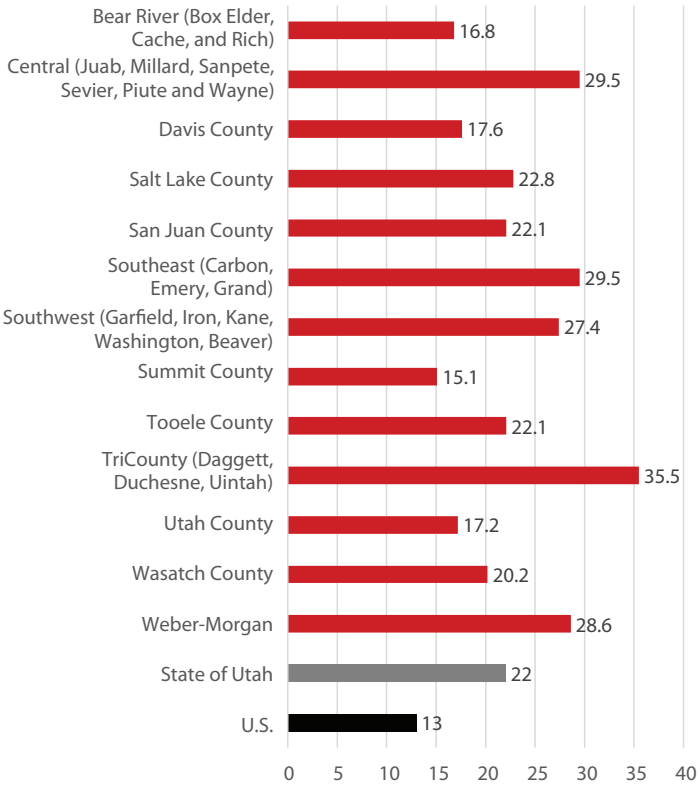
Urban vs. Rural Area Suicides – Rural areas in Utah experience higher rates of suicide compared to the state as a whole and the national average. For example, the TriCounty area (Daggett, Duchesne, and Uintah) had the highest suicide rate in the state, followed by Central Utah and Southeast Utah (Figure 18).

Figure 17: Methods of Suicide in Utah, 2016



Source: Suicide and Firearm Injury in Utah: Linking Data to Save Lives. (2018, October). Harvard T.H. Chan School of Public Health.

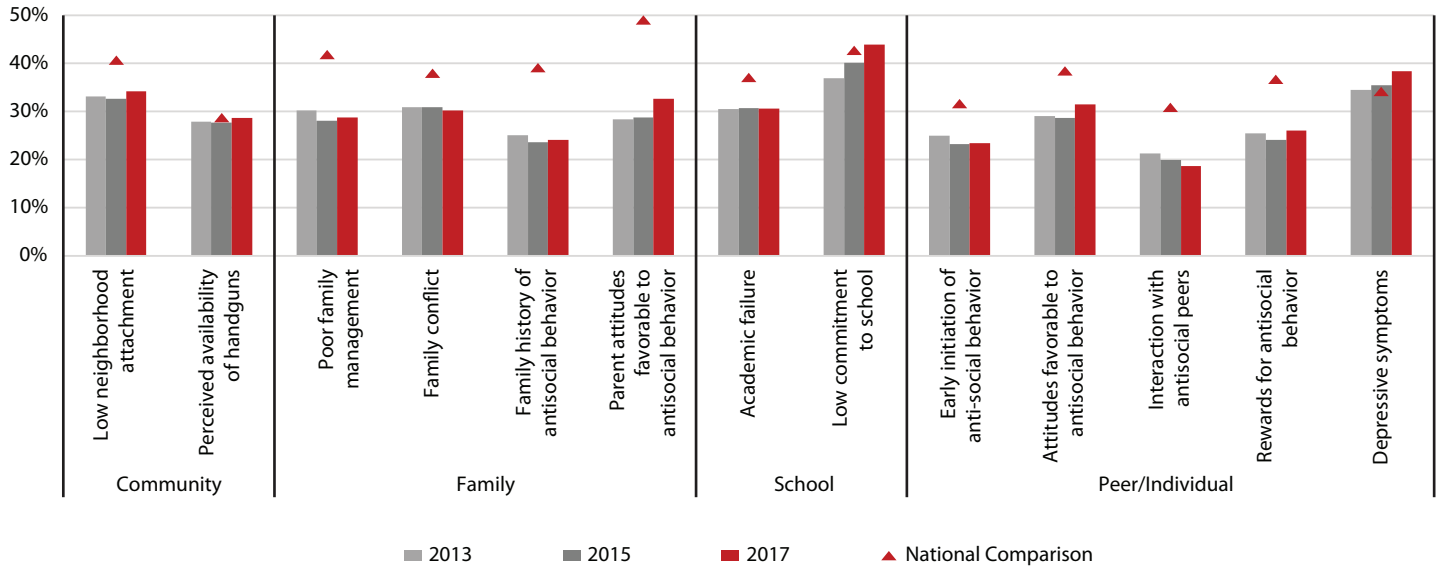
Figure 18: Utah Suicide Rates per 100,000 by Local Health District, 2017



Note: Age-adjusted. 2015-2017 (three-year average).
Source: Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health; Population Estimates: National Center for Health Statistics through a collaborative agreement with the U.S. Census Bureau, IBIS Version 2017; National Center for Injury Prevention and Control's Web-based Injury Statistics Query and Reporting System.

Suicide and Altitude – A recent study published in the Harvard Review of Psychiatry shows a positive relationship between high altitude and suicide or depression. The study found suicide rates were higher in states with higher altitudes and that the rate increased dramatically between 2,000 and 3,000 feet.[66] Adjusting for population density, the suicide rate at high altitude locations was 17.7 per 100,000 people, 11.9 at mid-altitude locations, and 4.8 at low altitude locations.[67]

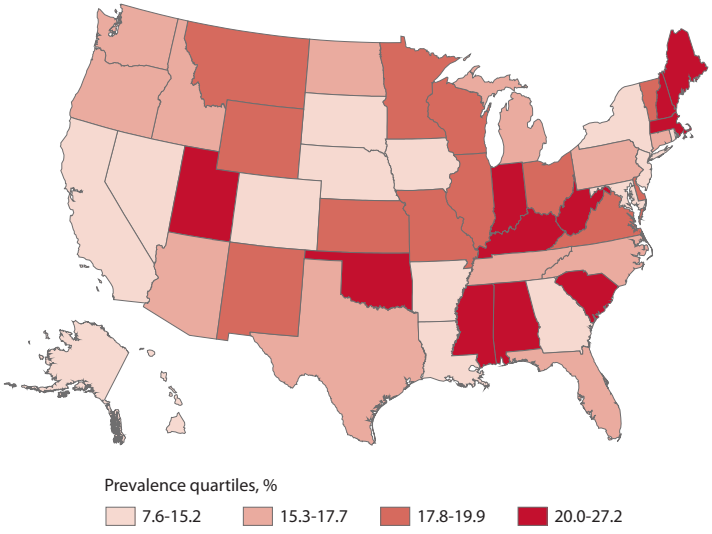
Figure 19: Percent of Utah Students Reporting Risk, 2013, 2015, and 2017



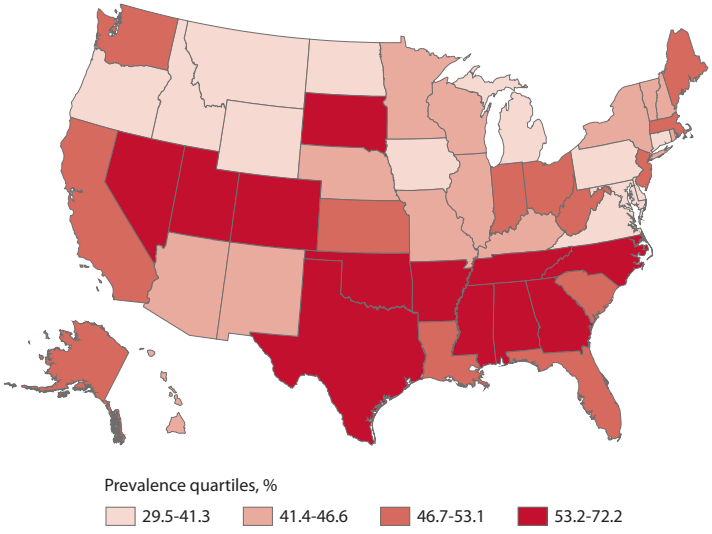
Note: Combined data for grades 6, 8, 10, and 12. The triangle represents national data from the Bach Harrison Norm. Bach Harrison Norm was developed by Bach Harrison LLC to provide states and communities with the ability to compare their results on risk, protection, and antisocial measures with more national measures. In order to keep the Bach Harrison Norm relevant, it is updated approximately every two years as new data become available. The last BH Norm update was completed in 2014.
Source: 2017 Prevention Needs Assessment Survey results. State of Utah Department of Human Services. Division of Substance Abuse and Mental Health.

Figure 20: State-by-State Prevalence of Child Mental Health Disorders and Mental Health Care Use, 2016

Prevalence of children with mental health disorders



Prevalence of children with mental health disorders not receiving care



Note: State-level prevalence presented as quartiles of at least one mental health disorder (i.e., depression, anxiety problems, and attention-deficit/hyperactivity disorder) in the total sample of children (weighted estimate, 46.6 million). State-level prevalence presented as quartiles of children with a mental health disorder not receiving needed treatment or counseling from a mental health professional (weighted estimate, 7.7 million).
Source: Whitney, D., & Peterson, M. (2019, February). US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatrics.

Increasing Demand for Youth Services

Data from the Utah Department of Human Services show an increasing need for mental health services among Utah's youth (Figure 4, p. 6). Figure 19 illustrates how these trends compare to national averages.

Untreated Mental Health Disorders

A recent study analyzing data from the 2016 National Survey of Children's Health shows Utah is among the group of states that have the highest prevalence of mental health disorders in children. Utah is also among the group of states that have the highest prevalence of children with untreated mental health disorders (Figure 20).

Adverse Childhood Experiences (ACEs) – The impacts of untreated mental health issues in children can be immediate and long-lasting. Research from UDOH shows that ACEs, which include physical, sexual, or verbal abuse as well as harmful exposure to mental illness, substance abuse, divorce, incarceration, or witnessing abuse, were statistically associated with developing obesity, fair or poor health, smoking, binge drinking, and depression as adults.[68] Adults with ACEs are almost three times as likely to be diagnosed with depression compared to those who did not experience childhood trauma and more than twice as likely to have poor mental health.[69]

Nationally, between 34–53 percent of people with a severe mental illness report childhood physical or sexual abuse,[70] and between 43–81 percent of people with severe mental illness have experienced lifetime exposure to mental illness.[71]

Mental Health Shortage Areas

To be considered a mental health shortage area, the population to psychiatrist ratio must be at least 30,000:1 (20,000:1 if the community is considered a "high need" area). If the shortage takes into account all mental health providers, the ratio of "core mental health providers" (psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists) must be 9,000:1.[72]

Mental health shortages are determined across three different domains. (1) Geographic, meaning there is a shortage of providers for the entire population within a defined geographic area. (2) Population groups, meaning there is a shortage of providers for a specific population groups within a defined geographic area (e.g., low income, migrant farm workers, etc.).[73] (3) Facility, meaning shortages are measured at the facility level, including at state mental hospitals, federally-qualified health centers (FQHCs), correctional facilities, etc. Areas qualify as "high need" geographic designation areas if at least 20 percent of the population has income below 100 percent of the federal poverty level, there is a high ratio of children or elderly in the population, there is a high prevalence of alcoholism, or there is a high degree of substance abuse.[74]

As of December 31, 2018, Utah had 41 designated mental health shortage areas.[75] Fourteen are geographical shortage areas, one is population-based (low-income in Weber and Morgan counties), and 26 are facility-based. Per HRSA's estimates, only 49.7 percent of Utah's mental health needs are being met.[76]

Impact of Policy Changes and Demographic Shifts on the Supply of Mental Health Providers

Impact from Medicaid Expansion – Utah's Medicaid program expanded eligibility to 100 percent of the federal poverty level on April 1, 2019 and will provide health care coverage to an estimated 70,000–90,000 uninsured adults. While expanding Medicaid will help alleviate some of the unmet mental health needs the state is currently experiencing, it will place more people into a system with an existing shortage of providers.

Table 7 shows the number of Medicaid enrollees to mental health providers who stated they accept Medicaid patients when surveyed by the Utah Medical Education Council (UMEC). UMEC found that only 35.7 percent of Utah's mental health workforce accepted Medicaid patients in 2015.[77] Given this low percentage, some of the increasing demand for mental health services from the Medicaid expansion population could be met by more of the existing mental health workforce accepting Medicaid patients.

Impact from Projected Population Growth – Over the next 50 years, Utah's population is projected to increase from approximately 3 million in 2015 to 5.8 million in 2065. Utah's growth rate will continue to exceed national rates, but is expected to decelerate over the next 50 years.[78] Utah County is projected to have the largest increase in its population over this period, adding over 1 million new residents by 2065. Four of every 10 new Utah residents will live in Utah County.[79] Other county estimates are provided in Table 8.

Required Provider Growth – Utah must more than double its current workforce over the next 15 years to keep up with population growth and move its mental health provider ratios closer to the national average.[80] Data from 2018 show there are about 220 mental health providers per 100,000 people in Utah (Table 9). Nationally, the ratio is more than 300.[81]

Table 7: Ratio of Utah Medicaid Mental Health Providers to Adult Medicaid Enrollees, 2015–2017

	Clinical Mental Health Counselors	Licensed Clinical Social Workers	Marriage and Family Therapists	Psychologists	All Categories
Ratio of Providers to Adult Medicaid Enrollees	1:48	1:13	1:168	1:97	1:9
Ratio with Medicaid Expansion	1:132	1:36	1:458	1:263	1:24

Source: Gardner Institute analysis of data from Christensen, J. (2016). Utah's Mental Health Workforce, 2016: A Study on the Supply and Distribution of Clinical Mental Health Counselors, Social Workers, Marriage and Family Therapists, and Psychologists in Utah. The Utah Medical Education Council.

Table 8: Utah Population Projections by County, 2015-2065

County	2015	2025	2035	2045	2055	2065	Absolute Change 2015-2065	Percent Change 2015-2065
Beaver	6,710	7,408	8,017	8,606	9,068	9,649	2,939	44%
Box Elder	52,971	60,984	67,664	74,440	80,334	86,218	33,247	63%
Cache	121,855	146,338	171,969	195,325	212,908	234,744	112,890	93%
Carbon	21,164	24,343	26,870	29,069	31,240	33,144	11,980	57%
Daggett	1,113	1,232	1,387	1,502	1,603	1,723	610	55%
Davis	336,091	385,800	428,627	474,028	510,712	544,958	208,867	62%
Duchesne	20,821	24,277	26,596	29,178	31,205	33,153	12,332	59%
Emery	10,659	11,550	12,507	13,345	14,226	15,364	4,706	44%
Garfield	5,164	5,845	6,405	6,697	7,083	7,509	2,345	45%
Grand	9,757	11,182	12,203	13,266	14,139	14,794	5,037	52%
Iron	49,406	59,900	67,803	74,812	81,589	89,599	40,193	81%
Juab	11,071	15,789	19,925	23,307	26,498	30,069	18,998	172%
Kane	7,271	8,684	9,611	10,179	10,736	11,446	4,175	57%
Millard	13,104	14,403	15,619	16,605	17,435	18,617	5,514	42%
Morgan	11,080	15,613	19,349	21,357	22,678	24,605	13,525	122%
Piute	1,631	1,699	1,872	1,938	1,995	2,149	518	32%
Rich	2,353	2,535	2,773	2,992	3,158	3,380	1,027	44%
Salt Lake	1,094,650	1,249,961	1,361,099	1,470,574	1,594,804	1,693,513	598,863	55%
San Juan	15,902	17,932	19,330	20,562	21,775	23,316	7,413	47%
Sanpete	29,088	33,696	38,580	41,682	44,609	49,590	20,502	70%
Sevier	21,238	24,494	26,896	28,879	30,774	32,802	11,563	54%
Summit	39,278	46,404	54,706	60,644	65,624	70,750	31,472	80%
Tooele	63,262	83,922	102,338	115,463	125,291	134,272	71,010	112%
Uintah	37,396	42,077	45,978	50,609	54,523	57,766	20,370	54%
Utah	585,694	768,346	968,498	1,192,304	1,396,997	1,620,246	1,034,552	177%
Wasatch	28,613	42,027	54,218	64,526	73,042	82,018	53,406	187%
Washington	154,602	219,019	286,768	355,549	429,295	508,952	354,350	229%
Wayne	2,725	2,985	3,363	3,593	3,792	4,130	1,405	52%
Weber	242,737	286,593	317,344	344,025	368,635	389,334	146,597	60%
State Total	2,997,404	3,615,036	4,178,317	4,745,057	5,285,767	5,827,810	2,830,406	94%

Source: Utah's Long-term Demographic and Economic Projections. (2017, July). Gardner Institute.

Table 9: Utah Mental Health Provider Ratios, 2018

Professions	Providers Per 100,000 People
Clinical Mental Health Counselors	48.8
Licensed Clinical Social Workers	102.1
Marriage and Family Therapists	23.1
Psychologists	37.6

Note: Table excludes ratio of psychiatrists.
Source: Utah Medical Education Council.

Appendix IV: Utah's Medicaid and Public Mental Health Service Delivery System

Division of Medicaid and Health Financing (DMHF)

Medicaid traditionally provides health care coverage to low-income children, pregnant women, parents with dependent children, seniors, and people with disabilities. It also helps low-income elderly adults pay for long-term medical care, such as nursing homes. S.B. 96: Medicaid Expansion Adjustments (2019 General Session) expanded Medicaid to cover all parents and adults without dependent children earning up to 100 percent of the federal poverty level.

The federal government matches state Medicaid spending according to a formula set by federal law. The federal match rate varies by state based on the state's per capita income—the lower a state's per capita income relative to the national average, the higher the state's federal match. The FY 2019 federal match rate for Utah is 69.71 percent, meaning the state is responsible for covering approximately 30 percent of Medicaid costs and the federal government covers the remaining 70 percent. Or, for every $1.00 the state spends on Medicaid, the federal government covers 70 cents.

As illustrated in the right side of Figure 21, DMHF directly oversees the provision of select mental health services provided to some FFS Medicaid populations as well as beneficiaries enrolled in Medicaid managed care plans (ACOs, the HOME Program, and CHIP). More information on these populations and services is provided in the following "Medicaid Delivery Systems and Covered Services" section.

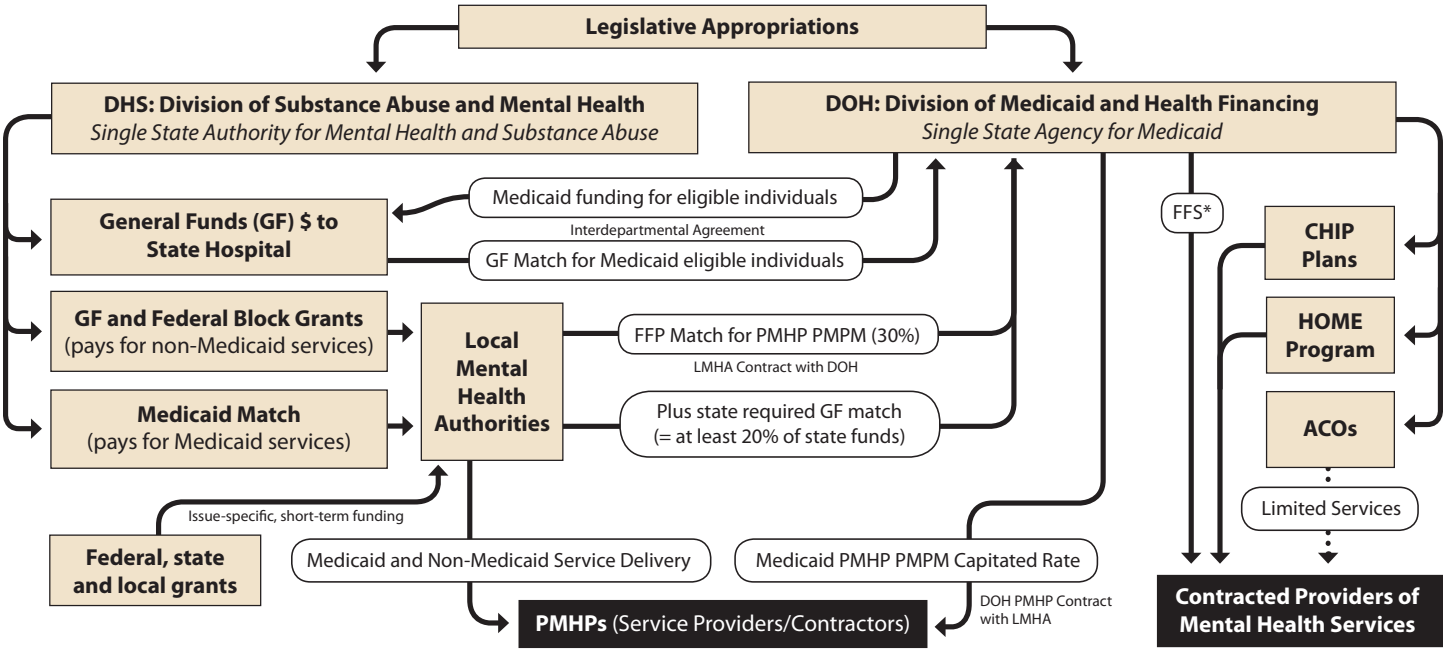
Division of Substance Abuse and Mental Health (DSAMH)

State funding is appropriated to Utah's counties to provide behavioral health services to Medicaid enrollees, uninsured individuals, and other underinsured populations. The Utah State Legislature appropriates state General Funds to DSAMH, which is the single state authority for mental health and substance abuse in Utah.

DSAMH uses these funds to support the provision of community-based mental health services through the Utah State Hospital and Local Mental Health Authorities (LMHAs). As illustrated in Figure 21:

1. General Fund dollars are used to support the Utah State Hospital. Medicaid pays for Medicaid-covered services provided primarily to children and seniors through the federal match rate. Medicare also provides reimbursement for some services.

Figure 21: Utah Medicaid and Public Mental Health Funding Flow



*Funds may be provided from other agencies to support the provision of services. E.g., school-based mental health services.
Note: This figure illustrates the flow of mental health funding. Substance use disorder funding has different statutory, administration, federal match, and service requirements that are not detailed in the above graphic.
Source: Gardner Institute analysis based on information from the Utah Division of Substance Abuse and Mental Health and Division of Medicaid and Health Financing.

2. A mix of General Fund and federal block grant dollars are paid to LMHAs to provide mental health services to the uninsured and underinsured as well as provide non-Medicaid covered support services to all populations.
3. Medicaid match dollars are paid to LMHAs to cover the payments made to Prepaid Mental Health Plans (PMHPs), which provide services to Medicaid enrollees.

Medicaid and Public Mental Health Funding

Medicaid Mental Health Match Dollars – DSAMH allocates the Medicaid match dollars to LMHAs using a needs-based funding formula (as specified by U.C.A. §62A-15-108). The formula takes into account: (1) Medicaid per member per month (PMPM) enrollment; and (2) PMHP Medicaid capitated rates from the most current 12-month data.[82]

Through actuarial analysis, the UDOH determines the capitated rates for different populations (over age 65, people with disabilities, children, etc.), accounting for the inpatient costs that are funded by dollars appropriated directly to Medicaid. UDOH then pays the calculated PMHPs' capitated rates for all the Medicaid beneficiaries in their areas.

Through a contract established with UDOH, each LMHA supplies UDOH with funding required to draw down the federal match for the capitated payments provided to the Medicaid covered population. This allocation includes a requirement that LMHAs provide at least 20 percent of the total state General Fund dollars they receive to provide mental health services in their area. Some counties provide more than the 20 percent minimum required by contract (i.e., "overmatch"). This funding is added to the state's regular Medicaid match for mental health services, which represents about 30 percent of total costs.

The share of the state match provided by the LMHAs is used to fund the outpatient portion of the capitated rates paid to the PMHPs. However, the PMHPs are also required to pay for inpatient mental health care. The state share for the cost of inpatient care is appropriated directly to UDOH. UDOH then utilizes the outpatient dollars provided by the LMHAs combined with the UDOH inpatient dollars to pay the full capitated rates to the PMHPs and draw down the 70 percent federal share of dollars used to provide mental health services to Medicaid enrollees in the state.

It's important to note that Proposition 3 (2018), amended by S.B. 96: Medicaid Expansion Adjustments (2019 General Session), directs all funding for the newly eligible Medicaid expansion population to UDOH.[83] As such, the funding and delivery system flows presented in this report are associated with the traditional Medicaid population, and may not reflect the system developed for the Medicaid expansion population. Funding for the LMHAs was also reduced due to the expected increase in federal Medicaid funds.

It is also important to note that UDOH and the Department of Human Services receive funding to provide public mental and behavioral health preventive services and education, such as suicide prevention data and information. These funds are generally not supported by Medicaid and are therefore not detailed in Figure 21.

Block Grants and Other Funds – DSAMH receives federal block grants that support the provision of mental health services, social services, and SUD prevention and treatment. Block grants are non-competitive payments awarded to all 50 states that submit an annual application demonstrating statutory and regulatory compliance. Awards amounts are formula-based and are used to:

- "Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services"[84]

A variety of other revenue streams are used to fund mental health services, including:

- County and local funds
- Payments from Medicare, private insurance (commercial or other third-party payers), and clients who self-pay
- Special revenue funds, dedicated credits, and agency transfers
- Time-limited federal and state grants for specific populations and services (typically used to fund pilot programs)

Medicaid Delivery Systems and Covered Services

Medicaid Fee-For-Service (FFS) – Medicaid's FFS network is used for certain populations and services that are excluded from, or "carved out" of managed care and other programs. These populations receive services from enrolled Medicaid providers who are reimbursed directly by the Medicaid agency under a FFS payment arrangement (i.e., reimbursed for each service they provide). Example populations include:[85]

- Targeted Adult Members[86]
- Children in foster care (out-patient behavioral health services only)

- Children with a state adoption subsidy (may be exempted from PMHP enrollment for outpatient behavioral health services)
- Medicaid members with presumptive eligibility (receiving temporary medical assistance while full Medicaid eligibility is being determined)

While mental health care services are largely delivered through contracted PMHPs, a few services are "carved out" of the PMHPs and delivered on a FFS basis. For example, some mental health evaluations and psychological testing for physical health purposes are provided on a FFS basis as well as some psychotherapeutic drugs.[87] [88]

Covered services and populations may change over time. Check data and information available from the state of Utah for complete and up-to-date information.

Medicaid Accountable Care Organizations (ACOs) – Utah Medicaid contracts with four health plans, or ACOs, to provide medical services to Medicaid enrollees living in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties. Enrollees living in other counties have the option to choose an ACO or the FFS Network. ACOs are paid a capitated monthly fee for each Medicaid member enrolled in their plan. ACOs may also provide services and benefits beyond those required by Medicaid. ACOs contract with a network of providers that are reimbursed for providing services.

ACOs are required to provide Medicaid members with all Medicaid-covered services, unless the service is carved out and provided under FFS or by the PMHPs. As a result, ACOs primarily provide physical health services[89] and only cover limited mental health screening, evaluation, and maintenance services as well as prescription medications for mental health diagnoses.[90] [91] [92]

Local Mental Health Authorities (LMHAs) – LMHAs are responsible for "providing mental health services to persons within the county; and cooperating with efforts of DSAMH to promote integrated programs that address an individual's substance abuse, mental health, and physical healthcare needs."[93] Some counties operate their own LMHA. Others coordinate efforts through a regional LMHA established via inter-local agreements, although each county retains its LMHA responsibility under these agreements.[94]

LMHAs not only provide mental health and SUD services to Medicaid enrollees, but to uninsured individuals, underinsured populations, and those with Medicare and private insurance (Table 10). A breakdown of mental health diagnoses for adults and children served by LMHAs is provided in Figure 22 and Figure 23. Many clients suffer from anxiety and depressive disorders, but LMHAs also serve a significant number of clients with more severe disorders. While most children receive mental health services directly from LMHAs, services provided in homes and at school have increased.[95]

Table 10: Utah's LMHA Medicaid and Non-Medicaid Client Counts, FY 2018

Local Mental Health Authority	Medicaid	Non-Medicaid	Dual-Eligible (Medicaid and Non-Medicaid)
Bear River	1,948	645	444
Central	1,082	307	74
Four Corners	773	828	97
Northeastern	117	1,892	502
San Juan County	2	639	64
Southwest	2,776	932	186
Summit County	82	701	82
Tooele County	374	1,377	376
Wasatch County	5	518	11
Davis County	2,777	2,846	515
Salt Lake County	8,459	5,205	1,308
Utah County	5,680	3,413	779
Weber	3,179	1,314	342

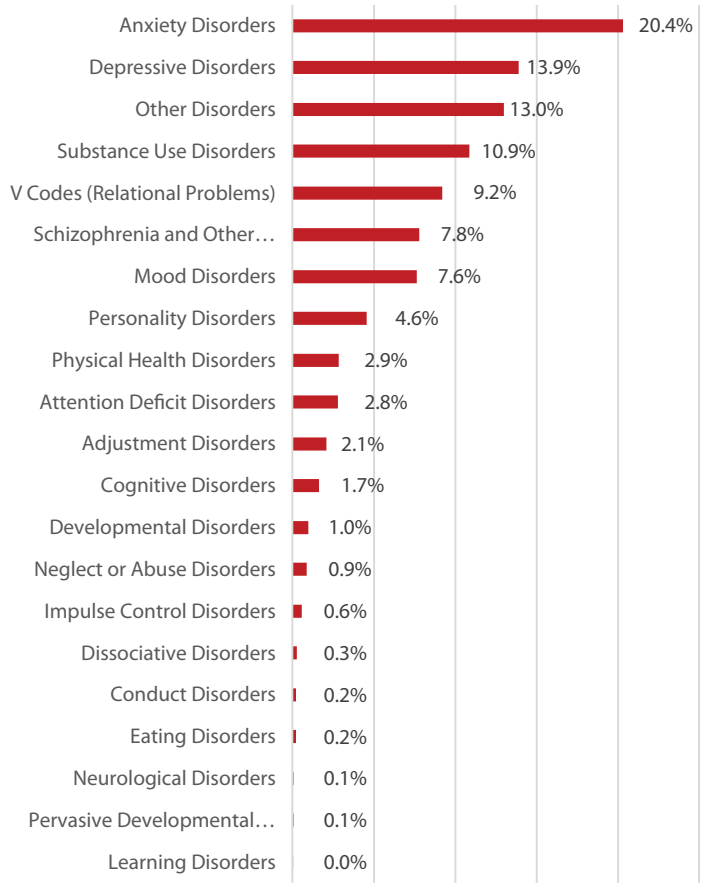
Source: Utah Department of Human Services. Division of Substance Abuse and Mental Health.

Utah state statute requires LMHAs to provide ten mandated mental health and SUD services to adult and children residents in their county:[96]

- Inpatient mental health services
- Outpatient mental health services
- Residential care
- 24-hour crisis care and services
- Psychotropic medication management
- Psychosocial rehabilitation, including vocational training and skills development
- Case management
- Community supports, including in-home services, housing, family support services, and respite services
- Consultation and education services, including case consultation, collaboration with other county service agencies, public education, and public information
- Services to persons incarcerated in a county jail or other county correctional facility

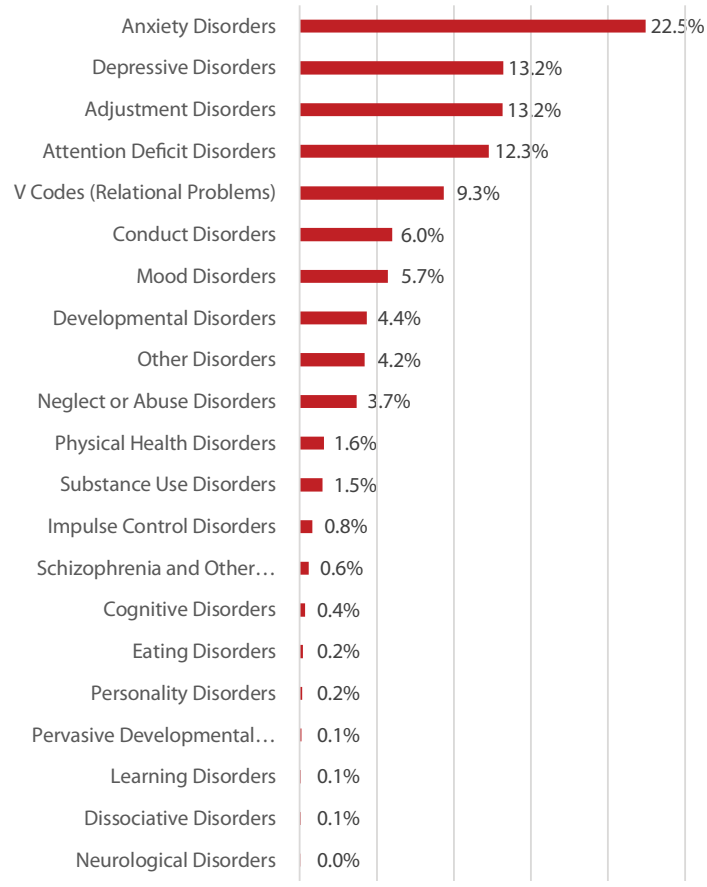
Additional services are available for some populations including housing, clubhouses, consumer drop-in centers, homeless services, forensic evaluations, nursing home and hospital alternatives, consumer education, and peer support centers.[97] [98]

Figure 22: Diagnoses of Utah's LMHA Mental Health Clients 18 Years and Older, FY 2018



Note: "Other Disorders" includes those not listed in the graph.
Source: Utah Department of Human Services. Division of Substance Abuse and Mental Health.

Figure 23: Diagnoses of Utah's LMHA Mental Health Clients Younger than Age 18, FY 2018



Note: "Other Disorders" includes those not listed in the graph.
Source: Utah Department of Human Services. Division of Substance Abuse and Mental Health.

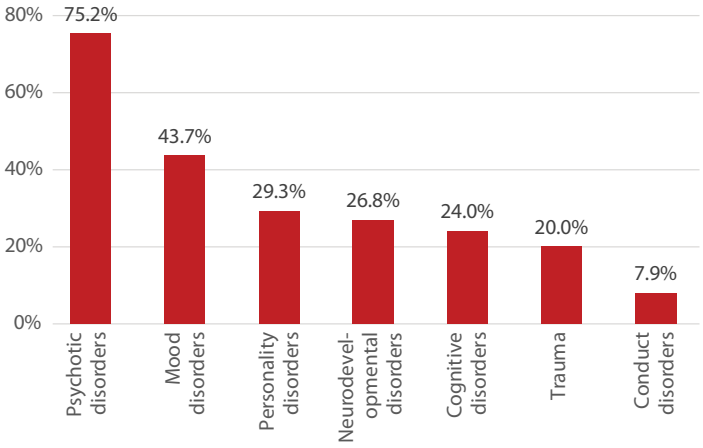
LMHAs also provide mental health education and awareness, promote prevention and early intervention, utilize evidence-based practices, and work with local schools to provide and support school-based mental health services, among other activities.[99] Some LMHAs are engaged in pilot programs with the state and/or other health care systems that allow for the provision of additional services or better integration of physical and mental health care.

Prepaid Mental Health Plans (PMHPs) – As noted above, Medicaid mental health services in Utah are carved out of the ACOs and provided by PMHPs operating under LMHAs.[100] LMHAs may also contract with PMHPs to provide non-Medicaid covered mental health services.

Medicaid covers inpatient, outpatient, and residential care services (limited to facilities with less than 16 beds). The scope of services includes:[101]

- Psychiatric diagnostic evaluations
- Mental health assessments
- Psychological testing
- Psychotherapy
- Psychotherapy for crisis
- Psychotherapy with evaluation and management services
- Pharmacological management
- Nurse medication management
- Therapeutic behavioral services
- Psychosocial rehabilitative services
- Peer support services
- Qualified targeted case management[102] (provided only to Medicaid recipients with SMI and individuals with SUD)

Figure 24: Percent of Utah State Hospital Patients with Major Psychiatric Diagnosis, 2018



Note: Patients can have more than one diagnosis.
Source: Annual Report 2016. (2017, January). Division of Substance Abuse and Mental Health.

Additional services are available for some populations including personal services,[103] respite care, psychoeducational services (educational, vocational, and job training services), and supportive living.

Utah State Hospital – As noted above, the Utah State Hospital is a 24-hour psychiatric facility located in Provo, Utah. It has a 152 bed capacity for adults and a 72 bed capacity for children.[104] For the forensic population, there are 124 inpatient beds as well as 22 jail-based competency restoration beds for Salt Lake County Metro Jail. Mental health services provided by the Utah State Hospital include:

- Psychiatric services
- Psychological services
- 24-hour nursing care
- Social work services
- Occupational therapy
- Vocational rehabilitation
- Physical therapy
- Recreation therapy
- Dietetic services
- Medical/ancillary services
- Adult and elementary education[105]
- Outreach Outpatient Restoration (qualifying individuals are pre-screened for short-term, 60-day treatment)

Healthy Outcomes, Medical Excellence (HOME) Program – The Neurobehavioral HOME Program at the University of Utah is an outpatient clinic that provides mental and physical health services to persons who are dually diagnosed with a developmental disability and a mental illness.[106] The program operates as a HMO[107] and receives capitated funding to provide physical and mental health services.[108] This promotes an integrated care model with co-located mental and physical health services, a shared electronic medical record, and care coordination.[109]

Enrollment in the HOME Program is currently capped due to clinician availability and space constraints. There is a 2-4 year waitlist for adults and a 4-6 month waitlist for youth up to age 18.[110]

Medicaid enrollees in the HOME Program have access all Medicaid services regardless of whether they are provided by the program. Services specifically provided by the HOME Program include:

- Annual physical exams and well-child checks
- Behavior management services
- Case management
- Crisis management
- Dietician/nutritional counseling
- Individual and group counseling
- In-house billing and insurance support
- Medication management
- Primary medical care
- Preventive care
- Psychiatric evaluations
- Psychology services (testing)
- Specialty care referral[111]

Children's Health Insurance Program (CHIP) – CHIP is a health plan for children with income up to 200 percent of the federal poverty level who do not have access to Medicaid or other insurance.

UDOH contracts with two health plans to provide physical and mental health services. Covered services vary by plan; however, the following services are listed as being covered in Utah:

- Inpatient and outpatient services provided at a mental health facility (covered after deductible is met; copays apply)
- Office visits (covered at no additional charge)
- Residential treatment (25 day limit; covered after deductible is met; copays apply)

Total out-of-pocket costs do not exceed more than 5 percent of a person's family income;[112] however, preauthorization and additional coverage limitations can apply.[113]

Appendix V: Utah's Non-Public, or Private Mental Health System

Utah's Benchmark Plan

ACA-compliant individual and small group health plans must provide mental health and SUD services as one of the 10 essential health benefits required by the ACA. Coverage must be "substantially equal" to the state's designated benchmark plan, both in the scope of benefits offered and any restrictions placed on those benefits such as visit limits.[114] The benchmark plan also highlights the type of coverage those purchasing insurance through HealthCare.gov receive, which under Utah's current Medicaid expansion scenario, includes those with income from 100–133 percent of the federal poverty level.

Changes in Federal Rules and Impacts on State Coverage Requirements

New federal rules provide greater access to short-term and other health plans exempt from ACA provisions. While these rules create more variety in the market, they could potentially leave persons with more limited access to mental health and SUD benefits.

CMS also recently changed Essential Health Benefits (EHB)-benchmark plan coverage requirements. Starting in plan year 2020, states will have more options for its EHB-benchmark plan. These include:

- Selecting the EHB-benchmark plan that another state used for the 2017 plan year.
- Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another state used for the 2017 plan year.
- Selecting a set of benefits that would become the state's EHB-benchmark plan.[115]

High-Deductible Health Plans (HDHPs)

HDHPs currently comprise about 30 percent of Utah's commercial health insurance market, compared to only 3 percent in 2007. They make up 36 percent of Utah's large group market (defined as employers with 51 or more employees), 31 percent of the state's small group market, and 21 percent of health plans purchased in the individual market.[116] Table 11 provides example HDHP costs for state employee coverage in Utah.

Table 11: Example HDHP/HSA Costs for Utah State Employee Coverage (Utah Basic Plus)

Plan Type		Single	Double	Family
Traditional Plan (non-HSA)	Deductible	$350	$700	$700
	Out-of-Pocket Maximum	$3,000	$6,000	$9,000
HSA-Qualified Plan	Deductible	$3,000	$6,000	$6,000
	Out-of-Pocket Maximum	$6,050	$12,100	$12,100

Note: Does not include premium payment.
Source: State of Utah Benefits Summary. (2018, July). Utah State Retirement Board.

Appendix VI: Other Government-Sponsored Coverage

Medicare Coverage

About 10–12 percent of Utah's population is covered by Medicare.[117] Some of these individuals have coverage because they are age 65 and older, while others qualify for coverage because of a disability.

Data from the UDOH show that more than one in six (18 percent) adults over age 65 have been diagnosed with a depressive disorder sometime in their lives. While Medicare does cover mental health services, like commercial insurance, there are limitations and associated copays. Table 12 provides details on what is covered by Medicare Part A, Part B, and Medicare Advantage Plans.

U.S. Department of Veterans Affairs (VA)

The VA provides a continuum of integrated outpatient, residential, and inpatient mental health services.[118] These services include, but are not limited to:

- Nonmedical Determinants of Health
- Immediate Crisis Response
- Mental Health Care Services
- Outpatient Mental Health Services
- Intensive Community Mental Health Recovery Services
- Psychosocial Rehabilitation and Recovery Centers
- Mental Health Residential Rehabilitation Treatment Programs
- Inpatient Mental Health Treatment Programs
- SUD Treatment
- PTSD Treatment
- Integrated Geriatric Mental Health Services
- Suicide Prevention
- Veterans Crisis Line
- Suicide Prevention Resources and Initiatives
- Treatment for the Effects of Military Sexual Trauma
- Women's Mental Health
- Tele-mental Health

These services are generally provided at VA facilities, unless alternative arrangements are made and coordinated by the VA.

Table 12: Medicare Coverage of Mental Health Services, 2019

Administered by Federal Government		Administered by Prescription Drug Plans	Administered by Health Plans
Medicare Part A	**Medicare Part B**	**Medicare Part D**	**Medicare Advantage**
Inpatient services	Outpatient medical services	Prescription Drugs	Inpatient and Outpatient
• Inpatient mental health services provided by hospitals or psychiatric hospitals. **Limits:** • Limited to 190 days in a lifetime. **Cost:** • $1,364 deductible. • Days 1–60: $0 copayment. • Days 61–90: $341 copayment. • After day 91: $682 copayment per each "lifetime reserve day" (up to 60 days in your lifetime). • After life time reserve days are used or a person reaches lifetime limits: all costs.	• One depression screening per year at no cost. • Individual and group psychotherapy with doctors or certain other licensed professionals allowed in Utah. • Family counseling. • Psychological test to determine the efficacy of treatment/services. • Psychiatric evaluation. • Medication management. • Non-self-administered psychiatric drugs (e.g. injectable drugs). • Diagnostic tests. • Partial hospitalizations. • One-time preventive visit to review your possible risk factors for depression. • A yearly "wellness" visit to talk to your doctor or other health care provider about changes in your mental health. **Limits:** • The screening must be done in a doctor's office or other primary care setting that can provide follow-up treatment and referrals. **Cost:** • $183 deductible. • Up to 20 percent of the Medicare-approved amounts for pre-authorized visits. • Associated copays for services received in a hospital outpatient clinic or department.	• Almost all drugs classified as antidepressants, anti-psychotics, and anti-convulsants.	• Covers all medically necessary Medicare Part A and B services. See Medicare Part A and Part B columns. • Certain plans may provide additional mental health services, but with additional limits and associated costs. • Note: May not cover prescription drugs unless it is a Medicare Advantage Prescription Drug Plan.

Source: 2018 Medicare Parts A & B Premiums and Deductibles. (2017, November). US Centers for Medicare & Medicaid Services. Mental Health Care (Outpatient). Centers for Medicare & Medicaid Services. Mental Health Care (Inpatient). Centers for Medicare & Medicaid Services.

Appendix VII: Acronyms

ACA	Affordable Care Act
ACE	Adverse childhood experience
ACO	Accountable Care Organization
AMI	Any mental illness
BMI	Body mass index
CAP	Child and adolescent psychiatrists
CHIP	Children's Health Insurance Program
DMHF	Division of Medicaid and Health Financing
DSAMH	Division of Substance Abuse and Mental Health
EHB	Essential Health Benefits
ESI	Employer-sponsored insurance
FEHBP	Federal Employee Health Benefit Plan
FFS	Fee-for-service
FQHC	Federally qualified health center
FTE	Full-time equivalent
HDHP	High-deductible health plan
HMO	Health maintenance organization
HOME	Healthy Outcomes, Medical Excellence Program
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HSA	Health savings account
IHS	Indian Health Services
LMHA	Local Mental Health Authority
MAF	Maximum allowable fee
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
PEHP	Public Employee Health Program
PMHP	Prepaid Mental Health Plan
PMPM	Per member per month
PTSD	Post-traumatic stress disorder
SBIRT	Screening, brief intervention, and referral to treatment
SED	Serious emotional disturbances
SPMI	Serious and persistent mental illness
SMI	Serious mental illness
SUD	Substance use disorder
TBI	Traumatic brain injury
UDOH	Utah Department of Health
UMEC	Utah Medical Education Council
VA	Veterans Affairs

Endnotes

1. The passage of Medicaid expansion during the 2019 General Session has resulted in a rapidly changing context for this research. As such, it's important to note that this report provides details on the current Medicaid mental health system and may not reflect the new system developed for the Medicaid expansion population. That said, many discussion group participants thought legislative approval of Medicaid expansion was likely and had already begun to think about ways to improve mental health care under a Medicaid expansion scenario. Their comments largely focused on barriers, challenges, and concerns that may not be addressed by expanding Medicaid. For example, poor Utahns not eligible for Medicaid and the middle class also have significant difficulties finding and affording mental health services.
2. Maternal and Infant Health Program, Division of Family Health and Preparedness, Utah Department of Health.
3. Poor mental health is measured as seven or more days of not good mental health in the last 30 days. Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health.
4. Ranking the States. (2018). Mental Health America.
5. For more information on Mental Health America's ranking guidelines see: http://www.mentalhealthamerica.net/issues/mental-health-america-ranking-guidelines.
6. Utah Department of Health Bureau of Health Promotion. (2018, November). Youth Risk Behavior Survey 2017 Results. Utah Department of Health.
7. Behavioral Health Barometer Utah, Volume 4. (2017). Substance Abuse and Mental Health Services Administration.
8. Cross, J. (2018, September). Does Medicare Cover Mental Health? eHealthInsurance Services, Inc.
9. Moskos, M., Olson, L., et. al. (2007). Utah Youth Suicide Study. Barriers to Mental Health Treatment for Adolescents. Suicide and Life-Threatening Behavior 37(2).
10. Christensen, J. (2016). Utah's Mental Health Workforce, 2016: A Study on the Supply and Distribution of Clinical Mental Health Counselors, Social Workers, Marriage and Family Therapists, and Psychologists in Utah. The Utah Medical Education Council.
11. Utah Child and Adolescent Psychiatrist (CAP) Workforce Distribution Map. (2018, March). American Academy of Child & Adolescent Psychiatry.
12. As illustrated in Table 1, some LMHAs serve the PMHP in some counties, using a traditional staffing model to provide services to their residents. In other counties, the LMHA contracts with a separate entity to serve as the PMHP. For example, Salt Lake County contracts with Optum Mental Health to serve as the administrator of Salt Lake County's Medicaid funds. In this role, Optum contracts with a network of mental health providers to provide services as well as reviews and pays claims for Medicaid reimbursement. Summit and Tooele counties contract with Valley Behavioral Health, which serves as the PHMP as well as is a provider of mental health services.
13. Frequently Asked Questions. (n.d.). Utah Behavioral Health Planning and Advisory Council.
14. Number of People Served in the Public Behavioral Health Systems. (2018). Utah Department of Human Services – Substance Abuse and Mental Health.
15. The Neurobehavioral HOME Program at the University of Utah is an outpatient clinic that provides both mental and physical health services to persons who are dually diagnosed with a developmental disability and a mental illness. The program operates as a health maintenance organization (HMO) and receives capitated funding to provide both physical and mental health services. This promotes an integrated care model with co-located mental and physical health services, a shared electronic medical record, and care coordination. Additional detail on this program is provided in Appendix IV.
16. CHIP is a health plan for children with income from roughly 138–200 percent of the federal poverty level who do not have access to Medicaid or other insurance. UDOH contracts with two health plans to provide both physical and mental health services. Additional detail on this program is provided in Appendix IV.
17. Salaycik, KJ., Kelly-Hayes, M., Beiser, A., Nguyen, AH., Brady, SM., Kase, CS., & Wolf, PA. (2007, January). Depressive symptoms and risk of stroke: the Framingham Study. National Institutes of Health.
18. Saczynski, JS., Beiser, A., Seshadri, S., Auerbach, S. Wolf, PA., & Au, R. (2010, July). Depressive symptoms and risk of dementia: the Framingham Heart Study. National Institutes of Health.

19. Jang, H. Y., Song, Y. K., Kim, J. H., Kim, M. G., Han, N., Lee, H. Y., Kim, I. W., et al. (2018, January). Impact of depression on change in coronary heart disease risk status: the Korean Genome and Epidemiology Study (KoGES). Therapeutics and clinical risk management.
20. Eaker, Ed., Sullivan, LM., Kelly-Hayes, M., D'Agostino, RB Sr., & Benjamin, EJ. (2005, Sep-Oct.). Tension and anxiety and the prediction of the 10-year incidence of coronary heart disease, atrial fibrillation, and total mortality: the Framingham Offspring Study. National Institutes of Health.
21. Melek, S., Norris, D., & Paulus, J. (2014, April). Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Milliman, Inc.
. Soper, M., (2016, April). Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators. Center for Health Care Strategies.
22. Boyd, C., Leff, B., Weiss, C., Wolff, J., Hamblin, A., and Martin, L. (2010, December). Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations. Center for Health Care Strategies, Inc..
23. Herbert, G. (2018). Budget Recommendations Fiscal Year 2020, Fiscal Year 2019 Supplements. The State of Utah.
24 People Dually Eligible for Medicare and Medicaid. (2019, March). Fact Sheet. Medicare-Medicaid Coordination Office. Centers for Medicare & Medicaid Services.
25. Annual Report 2016. (2017, January). Division of Substance Abuse and Mental Health.
26. State Hospital – Overview. (n.d.). Utah State Legislature.
27. Ibid.
28. Sellar, J. (2018, January 25). Crisis System Optimization. RI International Consulting.
29. Medicaid Institutions for Mental Diseases (IMD) exclusion under Section 1905(a)(29)(B) of the Social Security Act.
30. Singh S.P., Tuomainen H. (2015). Transition from child to adult mental health services: needs, barriers, experiences and new models of care. World Psychiatry. 14(3): 358–361.
31. What is a Community Health Center? (n.d.). Association for Utah Community Health.
32. Mental Health in Schools: Survey of School Districts. (2019, February). Legislative Fiscal Analyst.
33. Utah's School Behavioral Health Services Implementation Manual. (2010, August). Substance Abuse & Mental Health Services Administration.
34. Jacobsen, M. (2016, January). Report: Utah student-to-counselor ratio high but improving. Deseret News.
35. Stuckey, A. (2017, August). Struggling students forced to wait as Utah's public colleges don't have enough therapists. Salt Lake Tribune.
36. Tanner, C. (2018, December). 'No one can really get the help they need': BYU students are questioning wait times at their campus counseling center after a public suicide. Salt Lake Tribune.
37. Glaze, L. & Doris, J. (2006, December). Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics.
38. Gardner Institute analysis of Census Bureau's March Current Population Survey 2014-2017 data and 1-year American Community Survey 2016 data.
39. Includes annual or lifetime dollar limits, deductibles and copayments, and treatment limitations (e.g., number of visits or days of coverage, out-of-coverage network coverage). 2017 Health Insurance Market Report. (2018, January). Utah Insurance Commissioner.
40. The Mental Health Parity and Addiction Equity Act. (n.d.). Centers for Medicare and Medicaid Services.
41. Ibid.
42. Implementation of the Mental Health Parity and Addiction Equity Act. (2017, January). Substance Abuse and Mental Health Services Administration.
43. Health Reform: How It Affects You. (2018, October). Utah Insurance Department.
44. Tracy, N. (2016, March). Residential Mental Health Treatment Centers: Types and Costs. HealthyPlace. https://www.healthyplace.com/other-info/mental-illness-overview/residential-mental-health-treatment-centers-types-and-costs
45. How much does therapy or counseling cost? (n.d.). Informed Choices About Depression. https://depression.informedchoices.ca/types-of-treatment/counseling-or-therapy/how-much-does-therapy-or-counseling-cost/
46. 2017 Health Care Cost and Utilization Report. (2019, February). Health Care Cost Institute.
47. Hawley, J. (2018, January). 2017 Health Insurance Market Report, State of Utah Insurance Department.
48. 2019 limits set by the Internal Revenue Service (IRS).
49. Dixon, A., Greene, J., & Hibbard, J. (2008). Do consumer-directed health plans drive change in enrollees' health care behavior? Health Affairs, 27(4): 1120-31.
50. 2016 data. Kaiser Family Foundation analysis of National Health Interview Survey. Cox, C., Sawyer, B. (2018, January 17). How Does Cost Affect Access to Care? Preston-Kaiser Healthy System Tracker
51. The Federal Reserve System (2018, June 19). Report on the Economic WellBeing of U.S. Households in 2017 - May 2018. Washington D.C.
52. Health care & prescriptions in a nursing home. (n.d.) U.S. Centers for Medicare & Medicaid Services.
53. Interstate Compact on Mental Health. Utah Code Title 62A Chapter 15 Part 8. 62A-15-801.
54. Reiss-Brennan, B., Brunisholz, K., et. al. (2016). Association of Integrated Team-Based Care with Health Care Quality, Utilization, and Cost. JAMA *316*(8): 826-834.
55. Sellar, J. (2018, January 25). Crisis System Optimization. RI International Consulting.
56. Legislative Report FY 2018. (n.d.). Utah Department of Health - Utah Traumatic Brain Injury Fund.
57. Utah Health Improvement Plan 2018. (n.d.). Utah Department of Health – Office of Public Health Assessment.
58. Perry, M. (1996). The Relationship Between Social Class and Mental Disorder. The Journal of Primary Prevention *17*(1).
59. The Utah Scale on Serious Mental Illness (SMI) including Substance Use Disorders (SUD). (n.d.). The Utah Department of Human Services – Substance Abuse and Mental Health.
60. Health Indicator Report of Suicide. (2018, November). Utah Department of Health.
61. Ibid.
62. 2014 is the most recent year data is available. Ibid.
63. Barber, C. et. al. (2018, October). Suicide and Firearm Injury in Utah: Linking Data to Save Lives. Harvard T.H. Chan School of Public Health.
64. Brutsch, E. (n.d.). Utah Military Suicide Deaths, 2012-2016. Utah Department of Health.
65. Ibid.
66. Kious, B., Kondo, D., et al. (2018 March/April). Living High and Feeling Low: Altitude, Suicide, and Depression. Harvard Review of Psychiatry, *26*(2), 43–56.
67. Ibid.
68. Utah Health Status Update: Effects of Adverse Childhood Experiences. (2015, July). Utah Department of Health.
69. Age-adjusted. Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health.
70. Greenfield, S.F., Strakowski, S.M., Tohen, M., Batson, S.C., & Kolbrener, M.L. (1994). Childhood abuse in first episode psychosis. British J of Psychiatry, 164, 831-834. Jacobson, A. & Herald, C. (1990). The relevance of childhood sexual abuse to adult psychiatric inpatient care. Hospital and Community Psychiatry, 41, 154-158. Mueser, K.T., Goodman, L.B., Trumbetta, S.L., Rosenberg, S.D., Osher, F.C., Vidaver, R., Auciello, P. & Foy, D.W.(1998). Trauma and post-trauamatic stress disorder in severe mental illness. J of Consulting and Clinical Psychology, 66, 493-499. Rose, S. M., Peabody, C. G., & Stratigeas, B. (199 1). Undetected abuse among intensive case management clients. Hospital and Community Psychiatry, 42, 499-503.
71. Carmen, E. et. al. (1984). Victims of Violence and Psychiatric Illness. *American J of Psychiatry*, *141*, 378-382. Hutchings, P.S., & Dutton, M.A. (1993). Symptom severity and diagnoses related to sexual assault history. *Journal of Anxiety Disorders, 11*(6), 607-618. Jacobson, A. (1989). Physical and sexual assault histories among psychiatric outpatients. *Am J Psychi*, *146*(6), 755-758. Jacobson, A., & Richardson, B. (1987). Assault experiences of 100 psychiatric inpatients: evidence of the need for routine inquiry. *Am J Psychi, 144*(7), 908-913. Lipschitz, D.S., Kaplan, M.L., Sorkenn, J.B., Faedda, G.L., Chorney, P., & Asnis, G.M. (1996). Prevalence and characteristics of physical and sexual abuse among psychiatric outpatients. *Psychiatric Services, 47*(2), 189-191.
72. First Quarter of Fiscal Year 2019: Designated HPSA Quarterly Summary. (2018, December). U.S. Department of Health & Human Services – Health Resources and Services Administration, Bureau of Health Workforce.
73. Health Professional Shortage Areas (HPSAs). (2016, October). Health Resources & Services Administration.

74. Ryan, M. (2017, May). Key Principles of Shortage Designation. Centene Corporation.
75. First Quarter of Fiscal Year 2019: Designated HPSA Quarterly Summary. (2018, December). U.S. Department of Health & Human Services – Health Resources and Services Administration, Bureau of Health Workforce.
76. Ibid.
77. Christensen, J. (2016). Utah's Mental Health Workforce, 2016: A Study on the Supply and Distribution of Clinical Mental Health Counselors, Social Workers, Marriage and Family Therapists, and Psychologists in Utah. The Utah Medical Education Council.
78. Perlich, P., Hollingshaus, M., Harris R., Tennert, J., & Hogue, M. (2017, July). Utah's Long-Term Demographic and Economic Projections Summary. Gardner Institute.
79. Ibid.
80. Christensen, J. (2016). Utah's Mental Health Workforce, 2016: A Study on the Supply and Distribution of Clinical Mental Health Counselors, Social Workers, Marriage and Family Therapists, and Psychologists in Utah. The Utah Medical Education Council.
81. Ibid.
82. UAC R523-2. (n.d.). Utah Office of Administrative Rules.
83. S.B. 96 – Medicaid Expansion Adjustments. (2019). Utah State Legislature.
84. Substance Abuse and Mental Health Block Grants. (2019, January). Substance Abuse and Mental Health Services Administration.
85. Utah Medicaid Provider Manual - Rehabilitative Mental Health and Substance Use Disorder Services. (2018, October). Division of Medicaid and Health Financing.
86. The Targeted Adult Medicaid Program provides Medicaid services to a capped number of adults without dependent children who are: (1) chronically homeless; (2) involved in the justice system through probation, parole, or court ordered treatment needing substance abuse or mental health treatment; (3) needing substance abuse treatment or mental health treatment.
Targeted Adult Medicaid Program. (n.d.). Utah Department of Health.
87. Additional provider requirements apply when evaluations may be used to qualify an individual to receive Medicaid-covered autism spectrum disorder (ASD)-related services.
Utah Medicaid Provider Manual - Rehabilitative Mental Health and Substance Use Disorder Services. (2018, October). Division of Medicaid and Health Financing.
88. Accountable Care Organizations. (n.d.). Utah Department of Health.
89. Annual External Quality Review Report of Results. (2018, April). Division of Medicaid and Health Financing.
90. Medicaid Information Bulletin. (2017, July). Utah Department of Health.
91. Utah Medicaid Provider Manual - Rehabilitative Mental Health and Substance Use Disorder Services. (2018, October). Division of Medicaid and Health Financing.
92. Utah Medicaid Provider Manual – Physician Services Manual. (2018, July). Division of Medicaid and Health Financing.
93. U.C.A. §17-43-301 and U.C.A. § 62A-15-103. (n.d.). Utah State Legislature.
94. Each county also has a local substance abuse authority (LSAA) that is responsible for providing public substance use disorder (SUD) services. U.C.A. §17-43-201 and §17-43-301. (n.d.). Utah State Legislature.
95. Annual Report 2016. (2017, January). Division of Substance Abuse and Mental Health.
96. Utah Code 17-43-301. (n.d.). Utah State Legislature.
97. Frequently Asked Questions. (n.d.). Utah Behavioral Health Planning and Advisory Council.
98. Annual Report 2016. (2017, January). Division of Substance Abuse and Mental Health.
99. Ibid.
100. Outpatient mental health services in Wasatch County are reimbursed on a FFS basis. Medicaid PMHP enrollees may obtain behavioral health services from a FQHC (Medicaid directly reimburses the FQHC). American Indian and Alaska Native Medicaid PMHP enrollees may obtain behavioral health services directly IHS or by a program provided by an Indian Tribe, Tribal Organization, or an Urban Indian Organization. Medicaid directly reimburses providers. Utah Medicaid Provider Manual - Rehabilitative Mental Health and Substance Use Disorder Services. (2018, October). Division of Medicaid and Health Financing.
101. U.C.A. §17-43-301. (n.d.). Utah State Legislature.
102. Utah Medicaid Provider Manual – Targeted Case Management for Individuals with Serious Mental Illness. (2018, April). Division of Medicaid and Health Financing.
103. As an example, Volunteers of America operates the Assertive Community Treatment program, which is available to individuals who are 18 years or older and enrolled in Medicaid. The program uses a multidisciplinary team to provide integrated mental health services to clients in their homes, at work, and in other community settings.
104. Treatment Programs. (n.d.). Utah State Hospital.
105. Annual Report 2016. (2017, January). Division of Substance Abuse and Mental Health.
106. Managed Care Quality Strategy. (n.d.). Utah Department of Health.
107. About Neurobehavior. (n.d.). University of Utah Health.
108. Utah Medicaid Provider Manual - Rehabilitative Mental Health and Substance Use Disorder Services. (2018, October). Division of Medicaid and Health Financing.
109. Annual External Quality Review Report of Results. (2018, April). Division of Medicaid and Health Financing.
110. Robinson, J. (personal communication, January 9, 2019).
111. Neurobehavior Program. (n.d.). University of Utah Health. https://healthcare.utah.edu/uni/programs/home/
112. Frequently Asked Questions. (n.d.). Children's Health Insurance Program.
113. Member Guide. (2017, July). Children's Health Insurance Program.
114. Frequently Asked Questions on Essential Health Benefits Bulletin. (n.d.). Department of Health & Human Services – Centers for Medicare & Medicaid Services.
115. Information on Essential Health Benefits (EHB) Benchmark Plans. (n.d.). U.S. Centers for Medicare & Medicaid Services.
116. Hawley, J. (2018, January). 2017 Health Insurance Market Report, State of Utah Insurance Department.
117. 2017 Health Insurance Market Report. (2018, January). Utah Insurance Commissioner
118. VA Office of Mental Health and Suicide Prevention Guidebook. (2018, June). U.S. Department of Veterans Affairs.

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