# Utah Behavioral Health Committee

**Utah Legislative Interim Session**

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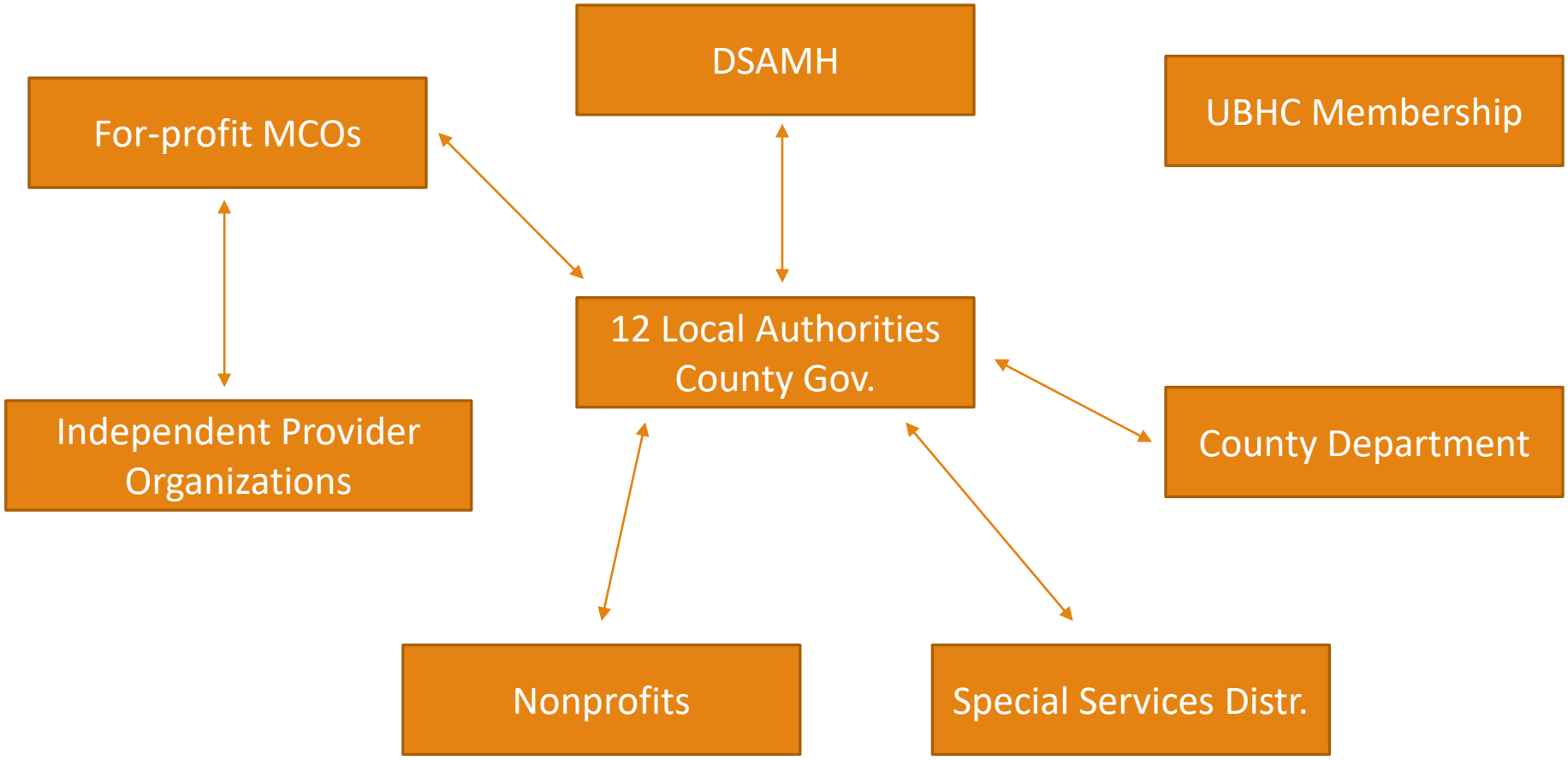
# Objectives

1. The value of Local and State partnership

2. Integrated Medicaid reimbursement

3. Workforce

# What Utah's Behavioral Health System Looks Like



# Restructure Necessitated by:

- State experienced large increase in Medicaid costs due to inpatient hospitalizations.
- Over 600 inpatient beds statewide!
- New laws passed clarifying counties' roles and responsibilities.
- Large number of county residents need treatment with limited funding and infrastructure.
- Utah State Department of Health Director and Local Authority Directors devised a plan to leverage limited state and county dollars to draw down additional Medicaid funds.

# Current LMHA and LSA
## *Implemented between 1992-1996*

**Three basic goals:**

- Save State Medicaid dollars by managing patients care in a less restrictive environment.
- Leverage limited state and county funds to expand community mental health system infrastructure and service capacity.
- Use the savings generated through managing patient care to serve unfunded state and county residents.

# Local Authority Responsibilities – Mental Health (MH)

- 17-43-301(2): "…[T]he county legislative body is the local mental health authority…Within legislative appropriations and county matching funds required by this section, under the direction of the [Division of Substance Abuse and Mental Health], each local mental health authority shall: provide mental health services to persons within the county…"
- Local authority requirements are found at 17-43-301(6) including submitting a plan to the Division each year for the delivery of ten required services.
- 17-43-301(6)(a)(x) states that the local authority shall "provide funding equal to at least 20% of the state funds that it receives to fund services described in the plan…"

# Local Authority Responsibilities – Substance Use Disorder (SUD)

- 17-43-201(1)(a)(i): “In each county operating under a county executive-council form of government under Section 17-52a-203, the county legislative body is the local substance abuse authority, provided however that any contract for plan services shall be administered by the county executive.”
- 17-43-201(i)(a)(iii): “In each county other than a county described [above], the county legislative body is the local substance abuse authority.”
- 17-43-201(1)(b): “Within legislative appropriations and county matching funds required by this section, and under the direction of the division, each local substance abuse authority shall:
  i. develop substance abuse prevention and treatment services plans;
  ii. provide substance abuse services to residents of the county; and
  iii. cooperate with efforts of the Division of Substance Abuse and Mental Health to promote integrated programs that address an individual's substance abuse, mental health, and physical healthcare needs, as described in Section 62A-15-103.

# This means:

1. The County is responsible to provide services; and

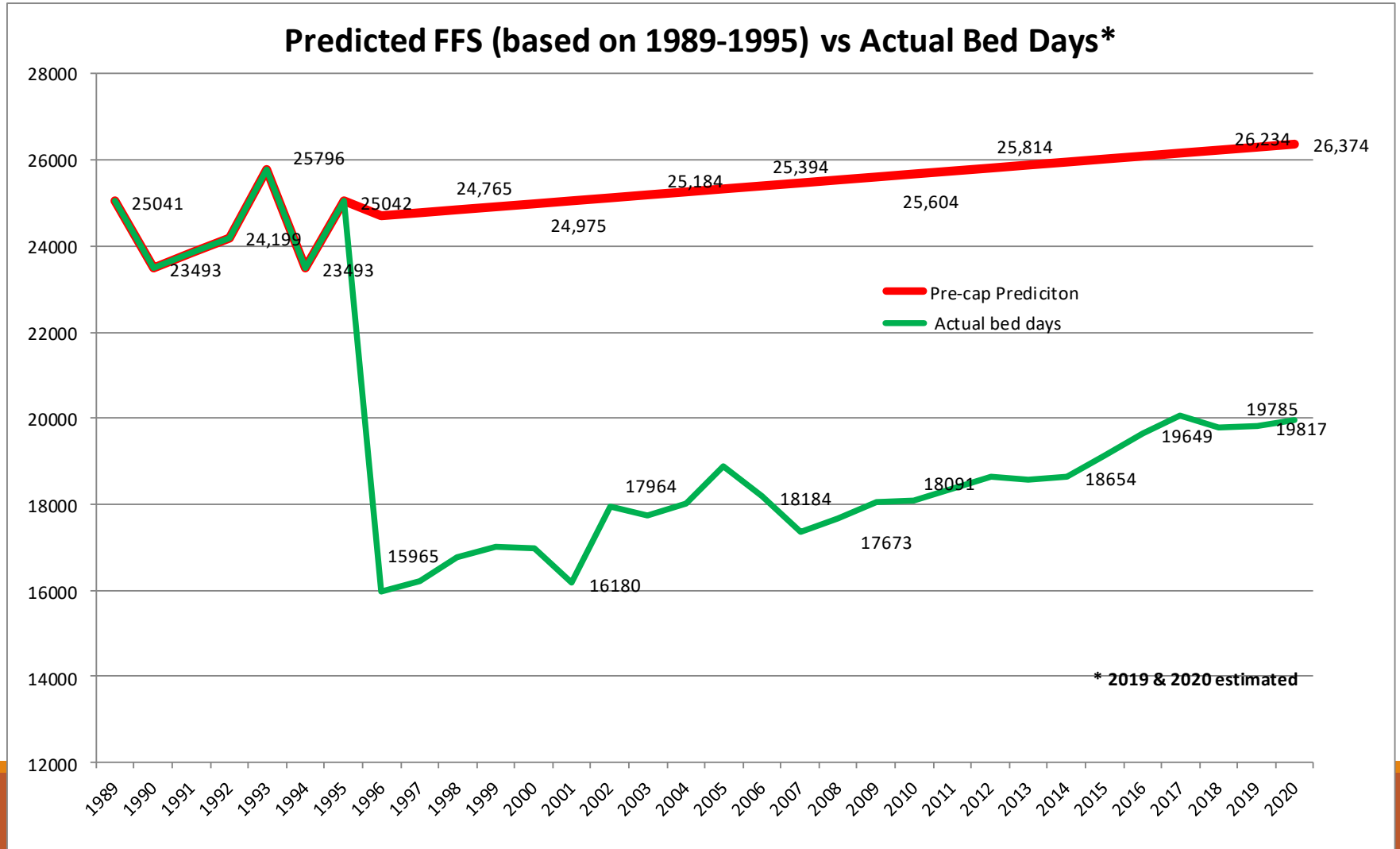
2. The DSAMH sets policies and gives direction.

# State/ Local Gov't partnership is successful!

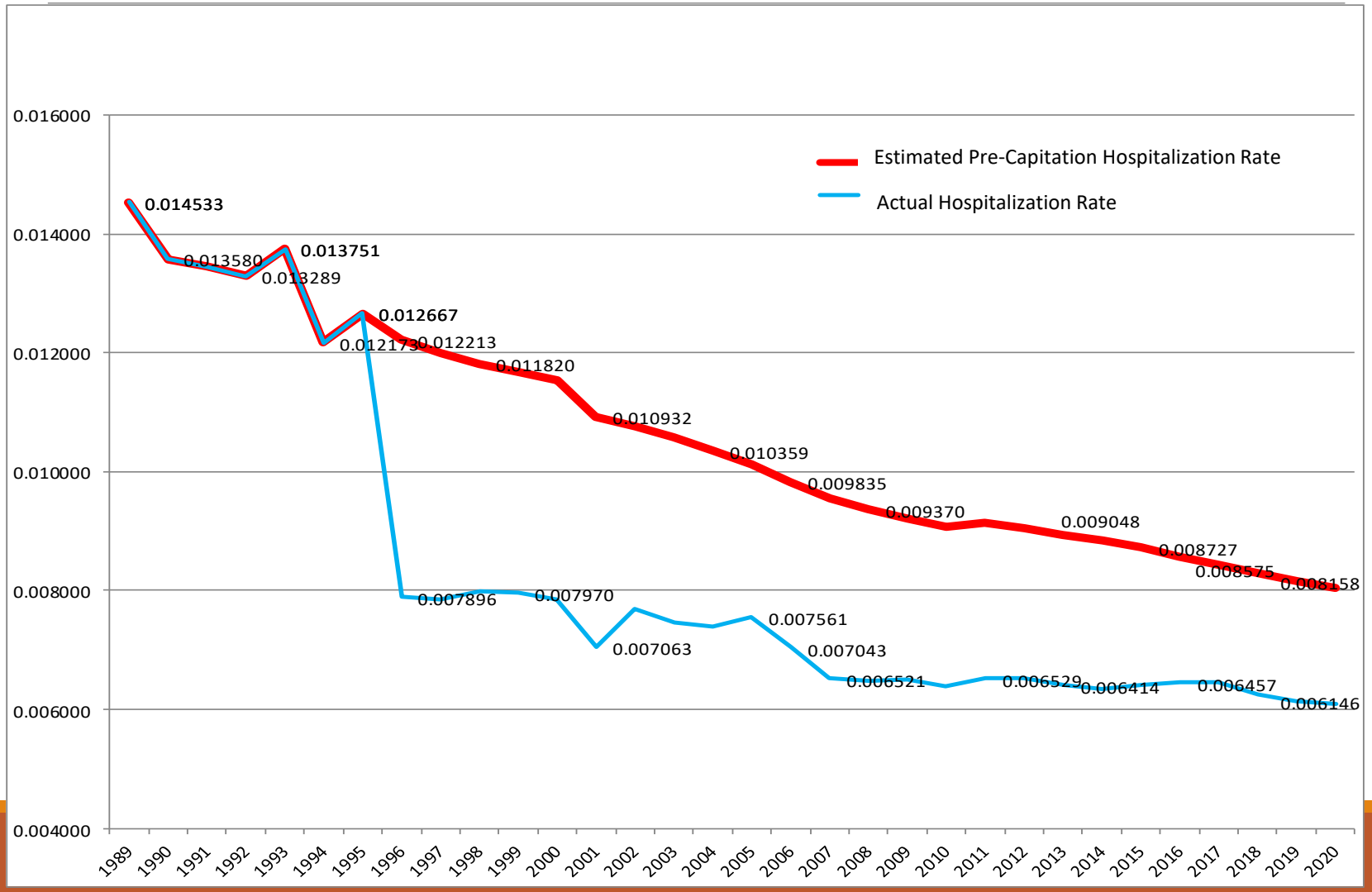
# Partnership resulted in

- Decreased inpatient beds statewide from 600 to less than 100 at one point! (Now about 350, including free-standing IMDs.)
- Hospitalization rates went down dramatically!
- Experienced substantial savings as evidenced by annual DOH FFS Equivalency Certification.
- Grew infrastructure and service capacity, especially in rural counties.
- Able to serve nearly all county residents seeking mental health treatment whether Medicaid funded or unfunded.

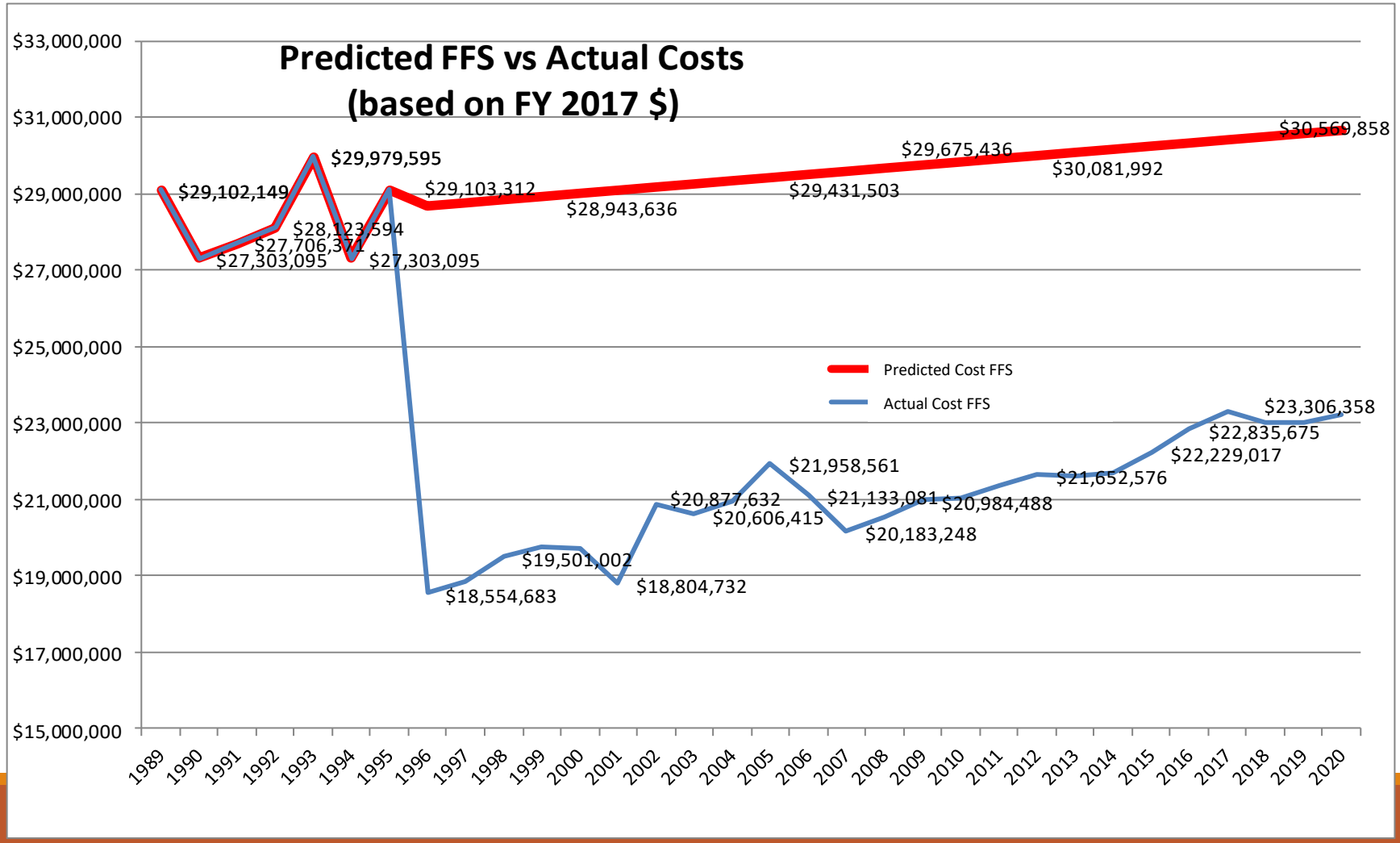
# Predicted vs. Actual Bed Days



# Predicted vs. Actual Hospitalization Rate



# Inpatient FFS Predicted Cost vs. Actual Cost



# Pre- & Post- Capitation Inpatient Rate

- Pre-Capitation (FY89-FY95):
  - 13 per 1000 Residents
- Post-Capitation (FY95-FY20):
  - 7 per 1000 Residents

# Savings of Capitation for UBHC

Materialized Inpatient Savings for UBHC

- FY95-FY20:
  $ 214,548,846
- Average Annual Savings:
  $ 8,581,954

# Contribution of Behavioral Health

- Two-thirds of clients seen in the LMHA system receive less than six services and stay in services for less than six months and do not re-enter services anywhere in the state for at least five years.
  - Utah Study of LA services

- "[Between 1970 and 2003]spending on health care grew twice as fast as spending on mental health care. Said another way, health care costs grew at two to three percentage points above GDP, whereas mental health costs grew only in proportion to GDP."
  - Trends In Mental Health Cost Growth: An Expanded Role For Management?
  - Richard G. Frank, Howard H. Goldman and Thomas G. McGuire

# Historical Perspective – Capitation

- 2003: CMS disallowed local authorities to use Medicaid funds for non-Medicaid clients.

➔This significantly reduced funds available for indigent/underfunded clients and created administrative burdens and challenges for LMHA/LSAs

  - (Two “buckets:” Medicaid and non-Medicaid)

- State General Funds were not keeping up with Medicaid growth.

# Historical Perspective – 2019

- Utah enacts Medicaid Expansion.
- Medicaid Expansion is FFS until December 31st, 2019.

  ➔Utah Medicaid favors an integrated payment model for Expansion population.

  ➔Starting January 2020, FFS Expansion funding moves to ACOs.

  ➔Expansion ACO funding pilots “integrated” proposal.

# Utah Medicaid Models

- Traditional Medicaid (PMHP)
- Expansion Medicaid (Integrated Medicaid)
- Two Levels of Integration
  - Administrative (payer)
  - Clinical (Based on service provision)

➔ Payer Integration  Service Integration

# ACO Reimbursement rates

- **New funding model results in FFS versus Capitated rates for LMHA/LSAs**

  ➔ Collection rates for ACOs: about 84%

  ➔ Collection rates for PMHP: about 95%+

➔ This 10% reimbursement rate difference is a NET loss to service capacity at the LMHA/LSA level (and is much more resource intensive to collect for LMHA/LSAs)

# Consolidation Considerations

- Cleary identify consumer and administrative goals for consolidation and decide on measurable outcome objectives
- Assure Safety Net Services for indigent/unfunded in terms of both access & funding.
- Keep local government involved: local solutions work!
- Decide on role of local government.
- True capitated/case rates for LA populations.
  - Service provision difficult with FFS model.
- Preserve/enhance public sector collaboration.
- Preserve/enhance criminal justice collaboration.
- Establish integration with ACOs and develop service delivery/funding models.
- Regional/statewide vs. county services for select services (e.g. crisis & MCOT).

# Workforce Shortage

Utah is experiencing a critical mental health workforce shortage

Higher competition for available workforce drive salaries up

Creative partnerships and incentives for educational system will take a couple years to take effect

LMHA/LSAs challenged to maintain service capacity