



State of Utah

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DEPARTMENT OF HUMAN SERVICES

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DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

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Chairman Hatch, Ranking Member Wyden and members of the Committee,

My name is Doug Thomas; I am the Director of the Division of Substance Abuse and Mental Health in the State of Utah and I am honored to be here with you today along with these distinguished guests.

Medicaid is the backbone of the public mental health system in Utah and throughout the United States. It provides the infrastructure and economy of scale necessary for States to standardize evidenced based practices to provide high quality care to individuals with serious mental health needs. The various Medicaid waivers and alternative benefit plans available to States allow them needed flexibility to customize plans to fit the unique challenges, needs and resources of each State. Case Management, Peer Support Services for individuals and families, Psychosocial Rehabilitation and Respite services are great examples of Medicaid reimbursable services that help people stay in their communities despite serious illness and allow people the opportunity to reintegrate in place of being alienated from their families and communities of origin.

In 2009 the Institute of Medicine (IOM) issued a lengthy publication about the prevention and early intervention of mental, emotional and behavioral (MEB) disorders. The report highlights that almost one in five young people have a MEB disorder at any given time and that “among adults in the United States, half of all of these disorders were first diagnosed by age 14 and three-fourths by age 24.” First symptoms usually precede a disorder by two to four years giving us a window of opportunity. Narrowing the gap between the onset of symptoms and evidenced based intervention is critical as the research is showing us that this early intervention preserves executive functioning and allows people, especially young people and people suffering from the first-episode of illness to recover more quickly with less life disruption. This allows them to accomplish and maintain important developmental tasks, such as “establishing healthy interpersonal relationships, succeeding in school, and making their way (into and succeeding) in the workforce.” For young people with Medicaid we are able to intervene early with positive outcomes showing that people can and do recover from mental illness. Treating a person’s mental illness improves physical health outcomes and reduces overall healthcare costs as well. There have been various Medicaid and other Health systems studies which show that collaborative physical and mental health care lowers costs and improves health outcomes. In Utah 3 years ago with a new State Legislative Appropriation and County matching funds we began to act on the IOM report with what we call Mental Health Early Intervention. This consists of 3 programs, School Based Behavioral Health, Mobile Crisis Outreach Teams for Youth in 4 of our 5 most populous Counties and Family Resource Facilitation with Wrap-Around to Fidelity. Over the last 3 years we have increased services to almost 5,000 more youth, the majority with Medicaid funding. Office Disciplinary Referrals are down, Literacy scores are up, symptoms of mental illness are being reduced often to the community norm, and families are receiving the supports they need to keep their children safely at home, in their own school and enhancing their family’s natural support system through Peer Support.

Utah recently passed a limited Medicaid expansion designed to target people with the lowest income in the greatest need, parents with dependent children already on Medicaid, people who are chronically homeless, people with mental illness and substance use disorders involved in the criminal justice system and people with mental illness and substance use disorders. We must have Medicaid work with us to find a way to approve a waiver allowing Utah to extend Medicaid coverage to these additional people in need.

People want to be served in the safest, least restrictive environment and providers want to provide these types of services. Sometimes children and adults need care beyond what can be provided appropriately in an outpatient or home like setting. Allowing Medicaid residential services the ability to bill and be paid for room and board would be a great step in the right direction. Room and board is covered during a more costly inpatient hospital stay, but not covered during a more economical residential stay. This disincentivizes local, lower cost, short term residential services in lieu of more costly inpatient hospital care.

With the Patient Protection and Affordable Care Act, The Mental Health Parity and Addiction Equity Act and more integrated care being provided there is a need to modernize the Medicaid Institutes for Mental Diseases (IMD) Exclusion. I applaud the efforts of the Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services and the Department of Health and Human Services to modernize rule, including the option of state waivers around the IMD exclusion. It must be done cautiously and systematically to ensure we are not reinstitutionalizing people, but that we are providing a short-term crisis intervention meant to help people stabilize and rejoin us in our communities where we all work and play and live.

Thank you for the opportunity to testify before you today. If there are any questions I would be happy to respond.

Best Regards,

Doug Thomas