

Northwest Arkansas Adult Acute Care Mental Health Plan

(For Benton, Carroll, Madison and Washington
Counties)

2010 Update



Created with funding support from the Care Foundation, Inc.,
a Fund of the Northwest Arkansas Community Foundation

September 2010

Northwest Arkansas Adult Acute Care Mental Health Plan: 2010 Update

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Executive Summary

This report was developed by 75 Northwest Arkansas key stakeholders and informants in acute mental health care services for adults. It is an update of the 2002 Plan produced by Washington County Judge Jerry Hunton's NWA Mental Health/HIV Crisis Stabilization Task Force.

This report contains the following:

- An affirmation of the need for cooperative work to complete a comprehensive and collaborative system of adult mental health acute care (see illustration on page 4).
- An update on system development accomplishments since 2002 plus an overview of current challenges and opportunities in service delivery along with funding, regulatory and structural considerations important to system of care development.
- The top three priority recommendations for system development in each of five major sectors of adult mental health acute care services for the next 2-4 years. The top priority for each sector was:

Sector 1: Hospitals (Inpatient Psychiatric Beds & Hospital Emergency Departments):

Develop 24/7 coordinated triage/treatment capacity with general and behavioral hospitals, jails and ambulatory health providers.

Sector 2: Partial Hospitalization/Intensive Outpatient Services: Expand Assertive Community Treatment (ACT) capacities and accessibility, including in Madison and Carroll counties.

Sector 3: Residential Crisis/Treatment Facilities and Mobile Options: Develop a complete follow-up, post-discharge program.

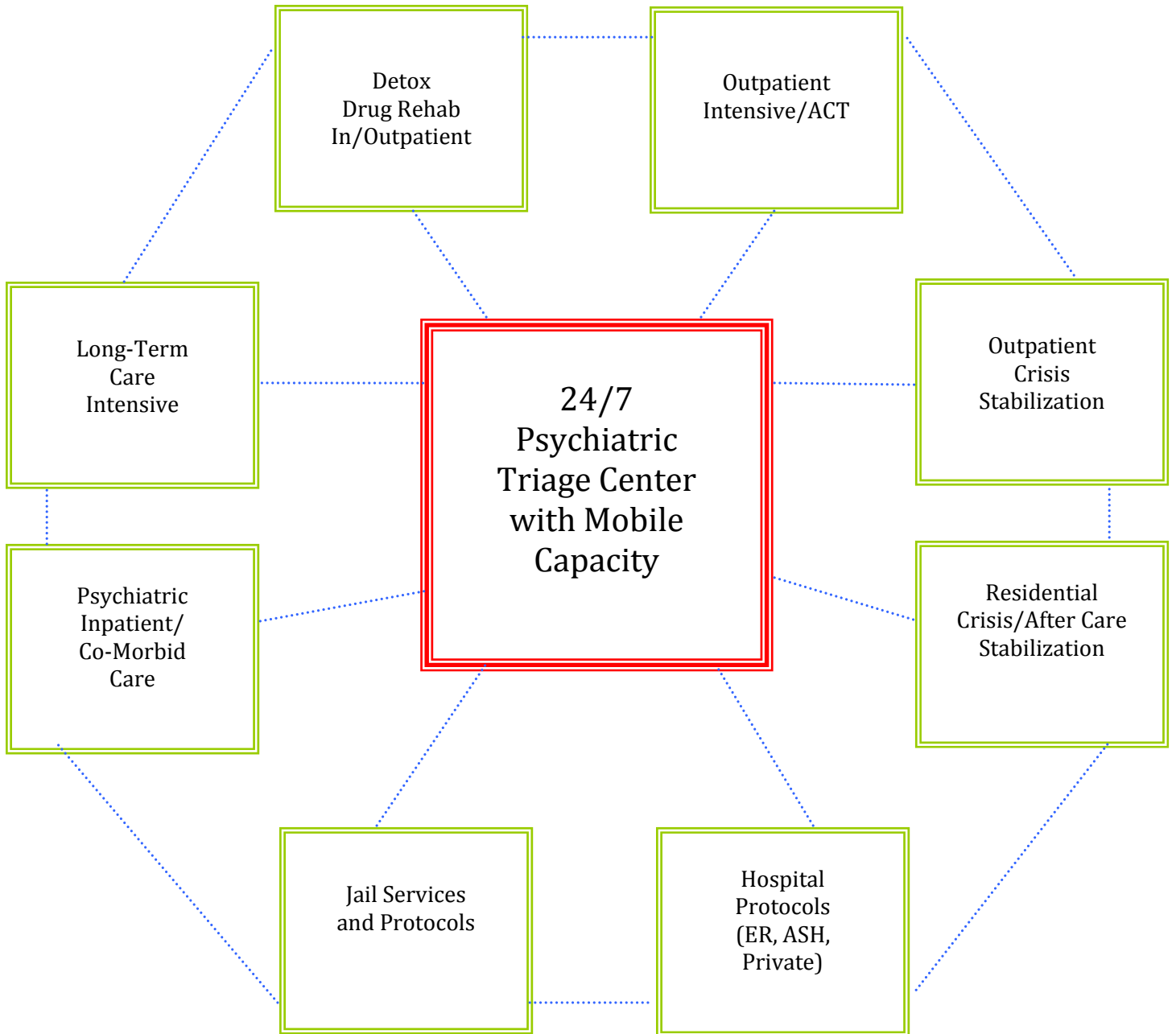
Sector 4: Law Enforcement/Jails/Courts Interface with Mental Health: Increase jail-based mental health services, medication and consultations.

Sector 5: Mental Health/Substance Abuse/Developmental Disabilities/Brain-Body Co-Morbidity: Support forming a task group that addresses all three co-morbidity acute care development needs to develop a comprehensive area approach over the next few years.

Three hopes permeate these findings and recommendations:

1. Mental health stakeholders in Northwest Arkansas will work together to complete a comprehensive system of adult acute mental health care that none of the organizations could do alone.
2. The collaborative system of behavioral health acute care will help contribute to a future when Northwest Arkansas has the healthiest population in mid-America at the lowest per capita cost.
3. One or more studies should be conducted to determine specific current data on unmet needs based on recognized best practices and national benchmarks.

LONG-TERM VISION FOR MENTAL HEALTH ACUTE CONTINUUM OF CARE



Updated from
Arkansas Public Health System
Services Analysis
March 2006

Introduction and Report Summary

This report is an update of the 2002 plan for Northwest Arkansas' adult acute mental health care system contained in Washington County Judge Jerry Hunton's "Report of the Northwest Arkansas Mental Health/HIV Crisis Stabilization Task Force." The 2010 Update was encouraged and supported by the Care Foundation with the intent to have an inclusive process involving a wide group of stakeholder organizations and individuals in the four-county area of Northwest Arkansas. Approximately 75 individuals were involved over the course of the process. Acknowledgements and a partial list of participants are shown in Appendix A.

The 2002 "Hunton" Report made recommendations for next steps in collaborative development of a comprehensive system of adult acute mental health care services to meet the needs of Northwest Arkansas adults, ages 22-64. The highest priority identified in that report was to develop a psychiatric inpatient unit in a general hospital which would be available and affordable regardless of any patient's ability to pay. The report recommended that the inpatient unit be established as the first step in building a comprehensive system which eventually would include a full range of outpatient, residential, mobile and institutional components of care.

In April 2009, seven years following the "Hunton" Report, the general hospital unit was established at Northwest Medical Center-Springdale. The unit is owned by Northwest Health System but was developed through the efforts of a coalition of six unrelated organizations. A few of the other components have been implemented or partially implemented as will be noted in the following sections of this report but the majority of the recommendations have not been implemented.

This 2010 Update contains:

- A review of the history of the major goals and accomplishments in the adult acute mental health care system development since 2002;
- Identification of current circumstances and challenges in the delivery and financing of adult acute mental health care;
- Identification of funding, regulatory and structural considerations important to system of care development and sustainability and;
- The results of a needs assessment process which identified the top three immediate, meaning 2-4 year, priorities for collaborative system development in each of five sectors.

The hope is that mental health stakeholders in Northwest Arkansas, individually and collectively, will build on the many resources already in existence in the region to complete a comprehensive system of adult acute mental health care – one that no organization could build alone. That system would be consumer sensitive and seamless by service recipients and their loved ones, would be outcome-driven by all stakeholders, and would be cost-effective. **The vision would be that a collaborative system of behavioral healthcare will help contribute to a future when Northwest Arkansas has the healthiest population in mid-America at the lowest per capita cost.**

Based on the findings of this report, one or more focused studies should be conducted to determine specific data on unmet needs related to a complete system of care. Specific data such as regional use rates as compared to national standards may be a key to securing adequate financial sources.

The report is a public document which has been distributed to participants and key stakeholders and is available on request from the Care Foundation, a Fund of the Northwest Arkansas Community Foundation. (To request, please call 479-361-4624.) The report is also available electronically by contacting the Care Foundation. It is distributed with the hope and trust that it will be a resource for collaborative strategic planning and initiatives that will promote efficient and effective development of a complete, comprehensive, accessible, affordable and cost-effective system of adult acute mental health care in Benton, Carroll, Madison and Washington Counties of Northwest Arkansas.

Description of Planning Process

The planning process for the 2010 Update involved several stages with the intention of having broad participation from professional as well as consumer stakeholders in the region. The stages of the process included:

- An initial meeting of several “alumni” from the 2002 task force. Nine alumni participated either by attending or providing input. With the perspective of the “before” and “after”, this group reviewed the 2002 report and developed an initial conversation piece which identified accomplishments and unfinished business based on that report’s recommendations. The group also observed current challenges and barriers and began to “dream” about future possibilities. The conversation piece addressed five sectors of the mental health system including:
 - Inpatient hospital beds and hospital emergency departments;
 - Partial hospitalization programs and intensive outpatient services;
 - Residential crisis/treatment facilities and mobile services;
 - Law enforcement, jail and courts interface with mental health;
 - Mental health/substance abuse/developmental disabilities/brain-body co-morbidity.
- A meeting of more than 40 stakeholders from approximately 130 who were invited to attend. At this meeting, small focus groups representing the five sectors built upon the work of the alumni group in developing both immediate and longer term recommendations to create a comprehensive system for behavioral health for the region. This group also added to the alumni group’s “dreams” for the future.
- Meetings held in Carroll and Madison Counties to explain the planning process and get input with emphasis on the unique challenges which exist in rural areas.
- Receipt of comments from individuals who wanted to participate but were unable to attend any of the meetings.
- A second meeting of the large stakeholder group at which the immediate priorities developed for each sector were evaluated and ranked by priority. Approximately 30 individuals participated in this meeting. Most of these attendees also participated in the first large group meeting while, for a few people, this was their first participation. In this exercise, the participants reviewed five priority choices in each sector that had “risen to the top” as frequent or strongly championed considerations. An electronic system was used for participants to vote on the sequence of priorities.
- The final report is the result of the process.

The next section of the report shows the findings that emerged as the immediate priority recommendations by sector, identified through the planning process. This included:

- Progress on 2002 goals;
- Current service issues, needs, concerns, possibilities and challenges;
- “Dreams” for the future;
- Identification of top 3 immediate priority recommendations (i.e. 2-4 year priorities) and other recommendations.

The next section is a summary of comments and observations related to funding, regulatory and structural considerations. These were developed based on overall findings since there is substantial overlap among the five sectors.

Finally, we felt it was important to recognize that national health reform, depending on its final details and timetable, is likely to have a dramatic impact on health insurance for mentally ill patients, especially those without insurance. For this reason a section is included on the highlights of the “Patient Protection and Affordability Act” as it pertains to behavioral health. Greater details are provided in Appendix B.

FINDINGS AND RECOMMENDATIONS OF THE SECTORS

SECTOR 1: Inpatient Hospital Psychiatric Beds and Hospital Emergency Departments

Progress on 2002 Goals:

Goal 1: Develop two 12 bed adult psychiatric units in general hospitals within 2-5 years to serve an estimated demand of year 2000 population

Current Status:

- Two small units were not cost-effective and no satisfactory location was developed.
- 28 general hospital adult psychiatric beds were developed at Northwest Medical Center-Springdale as the result of a coalition effort.
- 16 free-standing beds for adults remain at Vista Health System.
- 20 free-standing beds for adults were developed in 2009 at Springwoods Behavioral Health.
- Free-standing gero-psychiatric beds were developed in 2010 at Springwoods. Washington Regional Medical Center's gero-psychiatric program was transferred to Springwoods later in 2010. The unit has a total capacity of 20 beds.
- Ozarks Community Hospital in Gravette opened 10 gero-psychiatric beds.
- Youth Bridge expanded services to include residential care for young adults.
- Based on 2010 census estimate, the adult acute psychiatric beds available to the adult population, ages 22-64, are approximately 19 per hundred thousand population. That is close to the Arkansas statewide 2002 average and behind Little Rock's average of about 25/hundred thousand then.

Goal 2: Provide general funds via Division of Behavioral Healthcare appropriations to underwrite estimated \$1.25 million dollars annually of indigent care demand based on 2000 population utilization projections.

Current Status:

- General Improvement Funds (one time) funded start up and charitable care. Permanent funding will need to be appropriated and funded for sustainability with our population growth.
- Division of Behavioral Health Services (DBHS) has submitted a proposal for a \$2 million risk pool which would allow hospital compensation for Community Mental Health Center approved bed days after the Center has received year-to-date acute care allocations.

Goal 3: Expand adult Medicaid coverage eligibility to 100% of Federal Poverty Level (FPL).

Current Status:

- Federal health reform will extend Medicaid coverage to 133% of FPL for individuals under 65 years of age in 2014. That should reduce state charitable funding needs significantly, but projections are not currently available.

Goal 4: Establish a guarantee of 11% of Arkansas State Hospital (ASH) beds to be available on demand for NWA patients under commitment orders.

Current Status:

- No guaranteed access is available, access is slow and demand often exceeds timely availability.
- Given the Department of Justice lawsuit related to individuals with developmental disabilities and increased forensic demand, there will be increased demands for the limited resources available at Arkansas State Hospital (ASH).
- Several DBHS committees (Forensic and Adult Systems of Care) are looking at ways to increase the availability of community options so that those who are clinically ready for discharge can leave ASH and allow for more availability of new admissions.

Goal 5: Remove the Federal Institution for Mental Diseases (IMD) exclusion that prohibits Medicaid payments for acute psychiatric care for 22-64-year olds in freestanding hospitals (e.g., governmental, non-profit and for-profit hospitals)

Current Status:

- Federal legislation is proposed, but not passed to date. Also, health reform legislation allows the Department of Health and Human Services (DHHS) to do demonstration projects.

Goal 6: Develop and maintain capacity for appropriate treatment and triage for mentally ill patients presenting in each hospital emergency room or, when security for public or personal safety is a priority, in county or city jails.

Current Status:

- No single triage facility or coordinated triage protocols have been developed area-wide. This is an area where telemedicine could be used if there was an assessment hub (such as UAMS) and spokes to Emergency Departments, jails, etc. The cost of a psychiatrist available 24/7 could be spread across all hubs/spokes for efficiency.

Current Service Issues, Needs, Concerns, Possibilities and Challenges:

- See issues under outpatient and residential alternatives (page 13) and law enforcement/court/mental health interface (page 19).
- Is state indigent care funding adequate for demand and sustainable?
- Can multi-hospital emergency room protocols and access be standardized to any extent?

- Can behavioral hospital admission criteria be standardized to any extent? It is pretty standard because of payers—unfortunately more exclusive than inclusive.
- How can co-morbidity issues be addressed better: brain/body, substance addictions, and developmental disabilities? DBHS’ Adult Systems of Care plans to convene a group focused on these issues. NWA representatives are welcome.
- How can we deal with rising demand from areas outside NWA?
- Are free-standing and general hospital charges affordable and comparable?
- There is shortage of psychiatrists.
- Service gaps for those 18-21 years of age.
- Dismal reimbursement rates.
- Medicaid exclusion for free-standing units.
- There needs to be a system for treating indigent patients that is shared between all behavioral health units.
- Long time between discharge and follow up appointments. CMHC has a three month wait time to see a psychiatrist.
- Inappropriate use of hospitals’ emergency room resources. The need for people to receive crisis services and diagnosing in a community setting rather than emergency room where people do not have the expertise.
- Long response time when Single Point of Entry (SPOE) is needed.
- Transportation consistent with payment source, especially for rural patients.
- Education and public information about available services and legal options/rules.
- Volunteers to provide education about mental health needs and assist local citizens.

What is the adult mental health inpatient acute care future we wish to create together?

- A full range of adult mental health acute care services that are available on a timely basis with emphasis on care and payment mechanisms that address community retention among settings.
- Cost-effective behavioral health adult acute care that contributes to overall population health at lower per capita cost.
- A seamless system of acute care is experienced by patients, families and community users.
- Affordable acute care that is adequately supported financially.
- Best thing to happen would be a combination of comprehensive triage and intensive case management.
- 24/7 patient-centered behavioral healthcare medical records across providers.
- A regional crisis center/psychiatric emergency room. This would take the pressure off the emergency rooms and patients would be evaluated by mental health professionals who have the appropriate education for treatment and disposition, and would allow for “one stop” services for law enforcement.
- Train residents and physicians to recognize delirium in patients.
- Like the idea of “growing our own psychiatrists” with UAMS-PRI.
- Transportation, especially for acute patients from rural settings, needs improvement.
- Ability to have gero-psych units evaluate patients in nursing homes so that those patients don’t have to be evaluated in the emergency room.

- Have crisis staff at local mental health centers who can communicate directly with other resources, such as behavioral health units or emergency rooms.
- More options for day treatment, residential facilities, and other supportive services for homeless clients/patients.
- A system for communication between different facilities so that “treatment planning” becomes more holistic.

SECTOR 1: 2010 IMMEDIATE PRIORITY RECOMMENDATIONS:

Priority Recommendation # 1: Develop 24/7 coordinated triage/treatment capacity with general and behavioral hospitals, jails and key ambulatory health providers. This includes exploring ways to find most workable options ranging from telemedicine through shared, standardized protocols to a “one stop” regional psychiatric emergency facility plus mobile capacity when needed.

Priority Recommendation # 2: Develop more intensive case management to facilitate continuity of care. This includes facilitating Single Point of Entry (SPOE), hospitals/case manager liaison, post discharge follow up and continuity of care.

Priority Recommendation # 3: Develop a system for treating indigent patients that is shared by all behavioral health units. This includes developing shared clinical records, communication systems for comprehensive treatment plans, shared admission, levels of care and continuity of care protocols, funding access and designated liaison staff.

Other Priorities considered in this sector:

- Increase timely availability of access to Arkansas State Hospital (ASH) as back up for local overloads.
- Grow and support the workforce of Northwest Arkansas psychiatrists and mental health professionals connected with acute care. This includes recruitment, training, residencies, specialty development and quality of work life attention.

SECTOR 2: Partial Hospitalization Programs/Intensive Outpatient Services

Progress on 2002 Goals

Goal 1: Develop more intensive outpatient options as demand and funding allows.

Current Status:

- Assertive Community Treatment (ACT) capacity has expanded, but not enough to meet demand
- 20 intensive outpatient placements are available through Springwoods Behavioral Health
- Electroconvulsive Therapy (ECT) is available through Springwoods now
- Division of Behavioral Health Services (DBHS) proposals include funding for start up costs of ACT teams in 15 areas state-wide including Northwest Arkansas

Goal 2: Increase Federal block grant and community support funds for seriously mentally ill adults (and children). Note: This applies to all outpatient and mobile options.

Current Status:

- Federal and state funds for adult patients with serious and persistent mental illness have been minimally expanded during the period, but not adequate to demand. Recent state fund cuts have impacted capacities.
- DBHS and DMS (Division of Medical Services) are developing proposals to revise the funding model for behavioral health including the possibility of a state plan waiver to better serve some of the most seriously mentally ill individuals.
- Advocacy to maintain federal mental health and substance abuse block grant funding after initiation of health care reform could increase the state's ability to fund more innovative treatment models.
- Health reform legislation establishes a Community First Choice Option through which state Medicaid programs can offer community-based attendant services and supports to beneficiaries who otherwise would require the level of care offered in a hospital, nursing home, or intermediate care facility for the mentally retarded (expected implementation in Oct. 2011).

Current Service Issues, Needs, Concerns, Possibilities and Challenges:

- ACT and intensive outpatient services are underfunded for demand, so sometimes not available on a timely basis.
- ACT has been very effective at reducing hospitalization demand.
- Psychiatrist shortages negate timely availability.
- Currently, an ACT patient must be an Ozark Guidance client.
- Need for care coordination with ACT/intensive outpatient and inpatient services.
- Need for a liaison function with private psychiatrists and psychologists.
- What about funding host families for adults with mental illnesses who can't go home and don't want to live in group homes? This would be similar to adult therapeutic foster care home.
- Develop respite care options to provide a family with a "time out".

What is the adult mental health acute partial hospitalization/intensive outpatient future we wish to create together?

- ACT and intensive outpatient capacity available as needed
- Increased rural availability and financing with rates adjusted for higher rural costs
- Technology for daily ability to track status of and communicate with patients who have serious and persistent mental illnesses
- If Ozark Guidance case manager was immediately available on the unit, care continuity would be better
- Reimbursement for computer assisted therapy for addictions that has demonstrated effectiveness and is easily accessible, especially for rural settings

2010 IMMEDIATE PRIORITY RECOMMENDATIONS:

Priority Recommendation # 1: Expand Assertive Community Treatment (ACT) capacities and accessibility, including in Madison and Carroll counties. This includes exploring ways to share access for patients of providers other than Ozark Guidance and coverage of higher costs for rural ACT delivery.

Priority Recommendation # 2: Develop liaison/continuity-of-care functions between partial hospital, intensive outpatient and ACT units and private psychiatrists/psychologists/mental health professionals involved in adult acute mental health care episodes.

Priority Recommendation # 3: Develop more community-based attendant services, supports and respite care for patients and families. This includes developing host families for an adult therapeutic foster care-like system as well as specialized arrangements/options for co-morbidity (Mental Illness, Substance Abuse, Developmental Disabilities and Brain-Body co-morbidities).

Other priorities considered in this sector:

- Develop technology and protocols for daily ability to track and communicate with patients. Includes having mental health and functional status updates plus two-way instant communications with patients who have serious and persistent mental illnesses and/or are uniquely vulnerable during and after an acute episode of care. This includes computer-assisted therapies, crisis alert contact and other patient-friendly means to sustain gains and intervene quickly with set-backs.
- Watch utilization of new intensive outpatient programs (other than ACT) to assess need for expansion or multiple locations of these services in the four counties.

SECTOR 3: Residential Crisis/Treatment Facilities and Mobile Services Options

Progress on 2002 Goals

Goal 1: Develop residential crisis stabilization facilities as part of long term vision for adult acute continuum of care

Current Status:

- None have been developed but caution was suggested that crisis stabilization can be a “slippery slope.” Providers can easily be forced to admit patients who are too acute and medically involved. Safety can be compromised. Perhaps think of these as a step down unit after inpatient care.

Goal 2: Develop extended acute care residential facilities in NWA for patients under extended court commitments and/or needing extended supportive 24/7 residential care.

Current Status:

- None developed.

Goal 3: Sustain Ozark Guidance’s outpatient options for hospital diversion: emergency, crisis stabilization, single point of entry and Assertive Community Treatment (ACT) and expand as population demand and funding make necessary and possible.

Current Status:

- State funding cuts have hampered sustainability of crisis prevention and intervention options. There has been a shift of focus to general hospital emergency departments.

Goal 4: Develop area-wide 24/7 psychiatric triage center with mobile capacity.

Current Status:

- Not developed.

Current Service Issues, Needs, Concerns, Possibilities and Challenges:

- Lack of funding for residential crisis, extended acute care and committed patients’ housing alternatives.
- Consistent area-wide shared crisis protocols for emergency departments, behavioral health providers, and law enforcement interface.
- Safety protocols, consultations and escorts for mobile crisis teams.
- 24/7 patient-centered behavioral healthcare medical records access across providers.
- Issues with sharing clinical information. It is still difficult given federal and state confidentiality rules. One suggested solution is a “Total Care Consent” a person would sign with primary medical provider.

- Designating a care custodian. Most people have not designated a care custodian who can receive medical information and provide input into mental health care. One suggested solution is the promotion of Psychiatric Advance Directive and Powers of Attorney for Healthcare.
- The whole Single Point of Entry (SPOE) concept needs to be revisited as it may have outlived its usefulness from the perspective of the patient and families. A better option might be spend funds on tele-video assessments by psychiatrists.

What is the adult mental health acute residential crisis/mobile/ACT future we wish to create together?

- Coordinated law enforcement/mental health crisis teamwork area-wide, in all four counties.
- 24/7 triage and placement capacity that is time and hassle saving, including alternatives to hospitalization.
- Residential and intensive outpatient capacities with adequate resources for hospital alternatives when appropriate. See Jonesboro residential option as a model.
- Availability of outpatient services 7 days a week, 12 hours per day would be helpful to divert care and extend assessment/treatment options.
- Complete follow-up program post-discharge. Program would include attendant care covered by Medicaid, additional subsidy for medication expense and transportation expense to post-discharge appointment and availability of rapid post-discharge crisis appointments (note: Ozark Guidance added walk-in time at all adult services locations in July, 2009 to accommodate post-discharge appointments more quickly).
- Agreed upon discharge protocols—what cases go where, when and by what means?
- Shared services company for triage/mobile crisis. Create nonprofit shared services company that would have pooled resources of several non-profits, cities, counties, foundations and others to fund mobile crisis unit.
- Improve technology—implement applications for more rapid triage or assessment, e.g., video technology and Skype.
- Community training—comprehensive community training to reduce stigma and promote acceptance of seeking mental health assessment and treatment. An example is Mental Health First Aid (available through The National Council for Community Behavioral Healthcare at www.nccbhc.org).

2010 IMMEDIATE PRIORITY RECOMMENDATIONS:

Priority Recommendation # 1: Develop a complete follow-up, post hospital discharge program. This includes attendant care covered by Medicaid and other payers, additional subsidies for medication expenses and transportation expenses when needed plus availability of rapid post discharge appointments and continuity-of-care communications and liaison with private providers as well as public system providers.

Priority Recommendation # 2: Develop residential crisis and/or step-down facilities for stabilization and post-inpatient discharge care. This includes level of care criteria that clearly rules out inpatient necessity while ruling in 24 hour supervision and care need pre-and post-inpatient care.

Priority Recommendation # 3: Develop extended acute care residential facilities for patients under extended court commitments and/or needing appropriate 24/7 supervised longer term intensive residential care.

Other priorities considered in this sector:

- Develop ways and means to share timely patient clinical information 24/7 across multiple providers. This includes possibilities of shared electronic treatment plans/records, Total Care Consent, Advanced Directives, designated care custodians to assure timely coordinated care even when patient is not capable of informed consent at the moment.
- Revisit the Single Point of Entry Plan. Includes consideration that there are now electronic means to arrange tele-video assessments by psychiatrists that would provide more timely, patient and provider friendly assessments and treatments.

SECTOR 4: Law Enforcement, Jails and Courts interface with Mental Health

Progress on 2002 Goals

Goal 1: Establish capacity in Washington and/or Benton County jails (or other appropriate facilities) for up to 16 prisoners from the four county area to receive forensic evaluations and treatment in a timely manner consistent with Judge Reasoner's Federal Court order.

Current Status:

- Washington and Benton County Sheriffs cooperated in developing in-jail evaluation/treatment options with the Division of Behavioral Health Services and Ozark Guidance. It did not make the cut to be a priority for state funding.

Goal 2: Establish a law enforcement/mental health crisis intervention team to train and support 10% of all four counties' law enforcement personnel (city and county) in intervention and jail diversion options based on adaptations and improvements on the Memphis, Tennessee model.

Current Status:

- 100% of officers in Fayetteville, University of Arkansas and Washington County Law Enforcement Agencies (LEA) have been trained in a modified Memphis Crisis Intervention Training model. National Alliance for Mentally Ill, NWA Chapter (NAMI-NWA) and Fayetteville Police Department are developing a current training series for extending this to other law enforcement agencies in cities and counties intending to exceed the 10% area goal.

Goal 3: Create a fund in the Division of Behavioral Health Services to pay for a psychiatric forensic evaluation team to be based out of Ozark Guidance and provide timely evaluation, triage and treatment to prisoners in the four-county area, beginning in January, 2003.

Current Status:

- Did not receive priority for state funding.

Goal 4: Secure two-year grant funding for the training and development of coordinated law enforcement and mental health Crisis Intervention Teams (CIT).

Current Status:

- No grant funding.

Goal 5: Either change Arkansas' mental illness commitment laws or clarify options for outpatient commitments to help law enforcement, families and mental health providers have more options for intervening with treatment when patients are deteriorating but do not meet the criteria for commitment to an inpatient facility.

Current Status:

- It was clarified that outpatient commitments that allow minimum limits on patients' civil liberties to require treatment compliance are within the prerogative of judges under current Arkansas commitment laws. A few such commitments have been appropriate over the years.

Goal 6: Explore the feasibility of a mental health court to facilitate cost-effective civil and criminal court processes involving persons with mental illness

Current Status:

- There is not enough patient volume yet to justify a full-time mental health court.
- Video technology has advanced enough that it is feasible to explore inpatient hearings via telecommunications. Research indicates a need to have state legislation passed that would allow the video hearing without the need for the client to waive his/her right to confront witnesses face-to-face.
- Hearing options are a high priority from a patient respect stance.

Goal 7: Develop jail protocols and jail-based services consistent with a long-term vision for acute adult mental health continuum of care.

Current Status:

- Staffing shortages have prevented full access to in-jail services
- DBHS should add this to the System of Care (SOC) agenda

Current Service Issues, Needs, Concerns, Possibilities and Challenges:

- Judges need more less restrictive treatment alternatives to utilize in commitments and orders.
- Safe alternatives to use of chain cuffs/shackles in patient transport are needed.
- Need more mental health/psychiatric/practitioner consults to jail medical staffs. Related concerns include:
 - discontinuing Medicaid/Medicare coverage while incarcerated may hamper patients getting adequate medications,
 - how to monitor medication adequacy,
 - some use of generics may be less effective or have unwanted side effects,
 - reduced liability for jails with more appropriate treatment options,
 - need for mental illnesses to be treated just as other major illnesses that may occur when someone is in jail (examples: just as a person in jail having a baby or heart attack would be referred to appropriate medical facilities, so would a mentally ill person),
 - multiple funding sources needed for adequate mental health/jail/law enforcement interface.
- Need for multi-hospitals consistency in admission protocols and communication with LEA.
- 24/7 triage/disposition facility/protocols are needed.
- Increased involvement/cooperation of all jurisdictions in LEA/mental illness interface and solutions development.

What is the law enforcement/jails and court interface with adult acute mental health care future we wish to create together?

- 100% of area LEA officers trained in the modified Memphis CIT protocols.
- More training for judges for continuing education credits related to better options/outcomes in court-related dealings with mentally ill persons.
- Video commitment hearings in hospital psychiatric units.
- Increased commitment treatment options in less restrictive alternatives. More options should be available for judges to use in dealing with security and treatment needs for mentally ill persons.
- 24/7 triage/disposition capability.
- Electronic restraints instead of chain ones if patients need law enforcement agency transport.
- Increased jail-based mental health/illness communications, consultation, treatment and forensic evaluation capabilities in Northwest Arkansas.
- Clarify Medical Doctor and other mental health professional testimony options in NWA courts.
- Support law enforcement agencies which have or are pursuing accreditation via CALEA which has strong protocols and standards for addressing encounters with people who are mentally ill.
- Explore legislation/funding for treatment of indigent persons in jail and alternatives to Medicare/Medicaid coverage discontinuation when in jail.
- Adequate psychiatric, nurse practitioner and mental health professional/paraprofessional staff and funding available for jails and mentally ill persons in jail.
- Increased involvement/coordination from area city, county and state LEA jurisdictions in developing processes for better treatment and protocols for mentally ill people they encounter in public or in jails or courts.

Reference Notes:

- At www.nami.org there is an excellent article titled: "New Report Shows People Living with Severe Mental Illness more likely to be imprisoned than hospitalized."
- In 2008 the Washington County Sheriff's Department commissioned the University of Arkansas Department of Sociology and Criminal Justice to do a study of drug and mental health needs of inmates. When inmates were asked if they had ever experienced a mental illness in their lives, it was reported that 20% of all arrestees and 23% of all drug user arrestees had a diagnosed mental illness. 12% of all arrestees and 13% of all drug using arrestees reported having some form of mental health treatment. A copy of the report can be obtained by contacting Washington County Chief Deputy Sheriff Jay Cantrell, JCantrell@co.washington.ar.us.

2010 IMMEDIATE PRIORITY RECOMMENDATIONS

Priority Recommendation # 1: Increase jail-based mental health services, medication and consultations. This includes assumption that shared funding/staffing options would be developed by mental health and law enforcement agencies.

Priority Recommendation # 2: Expand the modified law enforcement/mental health Crisis Intervention Training and Protocols to be used by all Northwest Arkansas Law Enforcement jurisdictions. This includes increased opportunities for law enforcement agencies' involvement as public mental health system stakeholders and liability/risk reduction for patients, providers and LEAs.

Priority Recommendation # 3:

Note: There was a three-way tie for third priority in this sector between:

- Establish capacities in Washington and/or Benton counties jails for forensic evaluations and treatment. This includes joint mental health/law enforcement staffing and funding with ASH cooperation and back up.
- Develop telemedicine and other technology to make it possible for commitment hearings to be held on inpatient unit without patient transport to court. This includes pursuing legislation to allow the video hearing without the need for the patient to waive his/her right to confront witnesses face-to-face. Includes exploring use of electronic restraints as alternative to hand/leg cuffs if transport security is needed.
- Develop more "less restrictive treatment options" in Northwest Arkansas for judges to use as alternatives for lesser restrictions on liberties in situations where limited commitments would be appropriate personal and public protections.

SECTOR 5: Mental Health/Substance Abuse/Developmental Disabilities/Brain-body Co-Morbidity Continuum and Integration

Progress on 2002 Goals:

Goal 1: Develop Medicaid coverage for adults with substance abuse treatment needs.

Current Status:

- Federal health reform legislation will extend Medicaid coverage for adults to 133% of Federal Poverty Level in 2014 for persons under age 65. However, Arkansas Medicaid does not cover substance abuse treatment when substance abuse is the primary diagnosis except for teenagers and pregnant women. Legislation for this was passed but not funded.

Goal 2: Increase substance abuse and co-morbidity acute care options throughout continuum.

Current Status:

- Limited expansion of mental health/substance abuse training and service availability in a few providers in NWA.

Goal 3: Expand outpatient detoxification treatment options.

Current Status:

- No outpatient detoxification protocols/providers have been identified.
- Methadone maintenance is now available in the region.
- Availability of suboxone for substance abuse in the region has not been inventoried.

Current Service Issues, Needs, Concerns, Possibilities and Challenges:

- 80% of admissions to general hospital psychiatric units have substance abuse co-morbidity and there are many treatment issues that arise. (Note: The Agency for Healthcare Quality Research, 2006: 39.5 million hospitalizations; 1.4 million for a mental disorder; 7.1 million had a mental disorder in addition to the physical condition for which they were admitted.)
- **Nation-wide, one in five general hospital admissions for all illnesses have a mental health co-morbidity and very little integrated treatment is available. "Brain/body" co-morbidity is frequently under addressed.**
- Demand for Emergency Department and physician consultations from psychiatrists and other mental health professionals are very high and demand exceeds capacity to respond.
- Crisis situations involving co-morbidity of adults who have a combination of developmental disability and mental illness need more and better options in the region.
- Studies show increased sustained recovery with adequate treatment and support. Detoxification and rehabilitation need to be followed with ongoing treatment and support as with any other chronic disease.

What is the adult acute mental health/substance abuse/developmental disabilities co-morbidity continuum and integration future we wish to create together?

- Completion of an integrated, cooperative delivery system with full capacity to meet acute care needs for all co-morbid patients and to provide psychiatric and other mental health professional consultations and treatment teamwork as needed.
- A triage unit for assessment of patient needs with direction, coordination and continuity-of-care to appropriate levels of care and resources.
- Community supportive/instrumental services are needed in all three areas of co-morbidity.

Developmental Disabilities/Mental Health:

- Close state institutions for developmentally disabled and arrange adequate community care.
- Assure assessment of individuals on a case-by-case basis with an implementation of individualized treatment plan.
- Integrate developmentally disabled persons back into the community via group homes, job training and day programs.
- Use current funding for institutions to retrain employees so they can be incorporated into new supportive community programs in various staffing capacities.
- Use case managers for supportive services such as mentoring, assistance with job placement, medication compliance, and adult living skills.
- Use local professionals who know the community to scrutinize how Medicaid dollars are being used on a case-by-case basis.
- Isolate inpatient beds for these individuals, if needed, with one-on-one caregiver supervision (family member or trained sitter through hospital).

Brain-Body Co-Morbidity:

- Hospitals should have beds available for these complex patients with one-on-one sitter or family members available to assist and comfort patient since inpatient psych units are not equipped for the severe medical problems.
- Case management needs to be a part of discharge plan especially with regard to medication compliance and follow up with medical and mental health appointments.
- Increase case management services to address medical and mental health resources within the community.
- Must focus more on addressing the physical health treatment for individuals with serious, persistent mental illnesses.

Substance Abuse/Mental Health:

- Increase the levels of care to include partial hospital program with residential services, partial hospital services (4-5 days per week), intensive outpatient programs (3 days per week) and more individual and group counseling services.
- Case management services to follow client after discharge for aid with job placement, safe housing, medication compliance, possible continued drug testing.
- Medicaid funding for treatment of substance addition and abuse as primary disorder for adults.

- Funding to study other states and models that are working and development of similar programs.
- Include evidence-based computer assisted therapy for this population.

2010 IMMEDIATE PRIORITY RECOMMENDATIONS

Note: Contributors to this sector proposed several sweeping initiatives that constitute the development of an acute care co-morbidity “system within the system.” Their overall recommendation was for the development of system integrations for full capacities to meet acute care needs for all co-morbid patients and to provide psychiatric and other mental health professional consultations and treatment teamwork as needed. This would include triage capability for acute co-morbid patients assessment of needs and direction, coordination and continuity of care to appropriate levels of care and resources, connection with community supportive/instrumental services including primary health care as needed in all three areas of co-morbidity.

Here participants chose what they thought was the best way to approach meeting the mental health co-morbidity acute care needs in NWA over the next 2-4 years. Priorities were to:

Immediate Priority Recommendation # 1: Support forming a task group to address all three co-morbidity acute care system needs with the goal of developing a comprehensive area approach over the next few years.

Alternate Recommendation A: Support forming a task group to address co-morbidity acute care system development in NWA with Substance Abuse only.

Alternate Recommendation B: Support forming a task group to address co-morbidity acute care system development in NWA with Brain-Body co-morbidity only.

Other alternatives considered in this sector:

- Do not support the co-morbidity acute care system development recommendation at this time.
- Support forming a task group to address co-morbidity acute care system development in NWA with Developmental Disabilities only.

FUNDING, REGULATORY AND STRUCTURAL CONSIDERATIONS IN SUPPORT OF COMPLETING ALL COMPONENTS OF A NORTHWEST ARKANSAS ADULT MENTAL HEALTH ACUTE SYSTEM OF CARE

Several funding, regulatory and structural needs emerged as crucial to adult mental health acute care system development. They will need to be addressed in concert with program, protocol and service development initiatives. Chances for system completion and sustainability go up as these considerations facilitate system enhancements.

Funding:

- Assure adequate continuation of acute indigent care funds.
- Support 2010 census-based increase in per capita community mental health funds, plus inflation adjustment.
- Implement Medicaid coverage of adults at or below 133% of Federal Poverty Level ASAP.
- Develop Medicaid coverage of adults with substance abuse as a primary disorder.
- Support DBHS proposals for funding statewide ACT start ups and expansions, including NWA.
- Advocate for continuation of Federal block mental health and substance abuse block grants during Health Reform transitions.
- Support early implementation of Health Reform's Community First Choice Care program.
- Engage in DBHS' work to develop a better funding model for mental health services.
- Develop designated funding pools for regional forensic and jail-based mental health services.
- Include evidence-based computer-assisted therapies in funding formulas.

Regulatory:

- Remove federal rules prohibiting free-standing behavioral hospitals from receiving reimbursement for adult acute care.
- Update commitment laws to support telemedicine hearings honoring full patient rights including ability to confront petitioners.
- Redesign the Single Point of Entry System.

Structural:

- Develop system-wide integration of mental health/co-morbidities including substance abuse, developmental disabilities, brain-body co-morbidities and attention to total body health of patients.
- Explore creating a shared services cooperation for 24/7 triage services development.
- Expand Law Enforcement/County/Mental Health Interface arrangements, training and consultations.
- Enlarge the current stakeholders forum to include additional community stakeholder representation and engagement in system communication, development and accountability.
- Improve acute patient transportation, especially in rural settings.
- Expand technology triage/consultation/treatment options and secure protocols.

IMPLICATIONS OF NATIONAL HEALTH REPORT ON MENTAL HEALTH

National Health Reform:

The Patient Protection and Affordability Care Act provides the most sweeping changes in health care and health care insurance in many decades and a number of its provisions are designed to improve the overall mental health and substance abuse components of health care. By 2014 all U.S. citizens and legal residents will be required to have health coverage.

As written, the law is likely to have a dramatic impact on the public sector, including Medicaid, as well as the private insurance sector. Some of the major provisions include requiring parity coverage of mental health and substance abuse care, and the elimination of annual and lifetime limits of benefits. The law also addresses several mental health work force issues. The law also includes authorization for \$50 million in grants to create demonstration models for coordinated and integrated services.

The time tables related to the implementation of various provisions of the law differ and many details are yet to be finalized. Many details are not actually in the law itself, but will be in regulations which will follow.

The implications of health reform on the improvement of mental health services in Northwest Arkansas could be enormous and need to be studied in great depth. Appendix B contains an outline of the major provisions of the Patient Protection and Affordability Care Act with a focus on mental health services. A time table for implementation of the major provisions of the new law can be found at:

<http://www.thenationalcouncil.org/galleries/policy-file/HC%20Reform%20Law%20Timeline.pdf>

APPENDIX A

Special Acknowledgements and Partial List of Participants

2002 “Alumni” Group Participants:

Cris Arias	Northwest Medical Center-Springdale
Chuck Burklow	Vista Behavioral Health
Michael Hollomon, MD	UAMS-PRI - NMC Mental Health Unit Medical Director
Travis Jenkins, MD	Ozark Guidance
Mark Lindsay	Circuit Judge
Jerri Skaggs	NAMI Officer
John Skaggs	District Court Judge
David Williams	UAMS-PRI
David Williams IV	Fayetteville Police Department

Sector Group Leaders:

Cris Arias	Northwest Medical Center-Springdale
Lee Christenson	Northwest Medical Center-Springdale
Denise Garner	Advocate
Judi Middleton	Washington Regional Medical Center
Tom Petrizzo	Ozark Guidance
Jerri Skaggs	NAMI Officer
Judy Smith	UAMS-PRI
Abeer Washington, MD	UAMS Resident in Psychiatry
David Williams IV	Fayetteville Police Department

Project Facilitators:

Tom O’Neal
David Williams

Sponsoring Organizational Stakeholders:

Care Foundation

Mercy Health System of Northwest Arkansas

Northwest Health System

Ozark Guidance

University of Arkansas for Medical Sciences – Psychiatric Research Institute (UAMS - PRI)

Washington Regional Medical Center

Special Acknowledgements:

Nancy Baker, Ozark Guidance – assistance with editing and finalizing the report manuscript

Care Foundation Inc., a Fund of the Northwest Arkansas Community Foundation – funding support

National Council for Community Behavioral Healthcare – permission to re-print *Health Reform Summary*

Sue O’Neal – donation of catering services for events

Schmieding Center for Senior Health and Education – use of facilities and technology

Washington Regional Medical Center – use of meeting facilities

All of the 75-plus individuals who participated in the project by attending meetings or providing input

Appendix B

Summary of Major Provisions in the Patient Protection and Affordable Health Care Act

(see following pages 1-9)

Summary of the Major Provisions in the Patient Protection and Affordable Health Care Act

Updated 4/7/10

On March 23, 2010, President Barack Obama signed into law comprehensive health care reform legislation, the Patient Protection and Affordable Care Act. The legislation previously had received approval from the Senate on December 24, 2009, and from the House on March 21, 2010. The following chart provides a summary of the major health insurance market reform, mental health, and addiction provisions of the law. **Please note: Revisions made to the law under the Health Care and Education Reconciliation Act, which Obama signed into law on March 30, 2010, appear in red text.**

Patient Protection and Affordable Care Act (P.L. 111-148)	
HEALTH INSURANCE MARKET REFORMS	
High-Risk Health Insurance Pool Program	Sec. 1101: Establishes a temporary high-risk health insurance pool program for U.S. citizens and legal immigrants who have a pre-existing condition and have lacked coverage for at least six months. Appropriates \$5 billion to finance the program (begins 90 days after enactment and ends on January 1, 2014).
Pre-Existing Medical Conditions	Sec. 2704: Prohibits discrimination by group or individual health plans against individuals who have pre-existing medical conditions or have had illnesses in the past (begins on January 1, 2014).
Health Insurance for Young Adults	Sec. 2714: Requires group and individual health plans to provide dependent coverage for young adults until age 26 (begins six months after enactment). Sec. 2004: Allows all young adults who previously participated in foster care to qualify for Medicaid and all associated benefits, such as the Early Periodic Screening, Diagnosis, and Treatment Program, until age 25 (begins on Jan. 1, 2019)
Lifetime and Annual Limits on Benefits	Sec. 2711: Prohibits the establishment of lifetime limits on benefits by group and individual health plans (begins six months after enactment). Prohibits the establishment of annual limits on benefits by health plans

	(begins on January 1, 2014). Prior to 2014, allows health plans to impose annual limits on benefits as determined by the Department of Health and Human Services secretary.
Mental Health and Addiction Parity	Sec. 1311(j) and 1562(c)(4): Applies mental health and addiction parity to all health plans.
Public Health Insurance Options	<p>Sec. 1322: Establishes a Consumer Operated and Oriented Plan program to promote the creation of non-profit, member-administered co-operative health insurers to offer small group and individual health plans in all states.</p> <p>Sec. 1323: Establishes a community health insurance option that offers affordable, high-quality coverage in all states but allows states to pass a law to prohibit this option.</p> <p>Sec. 1324: Requires qualified health plans offered under the CO-OP program, coverage offered through a community health insurance option, and other qualified plans to adhere to all federal and state laws that apply to private insurers.</p>
Individual Responsibility	<p>Sec. 1501(5000A): Requires individuals to maintain minimum essential health insurance for themselves and applicable dependents in each month after 2013 or pay a penalty of \$95 or .5% of taxable income in 2014, \$350 or 1% of taxable income in 2015, \$750 or 2% of taxable income in 2016, and an indexed amount in subsequent years. For individuals younger than age 18, reduces penalties by half. Provides exemptions for individuals who cannot afford health insurance, those who have incomes less than the federal poverty level, members of Indian tribes, and those who lack coverage for less than three months in a year (begins on January 1, 2014).</p> <p><i>Reduces the flat penalty to \$325 in 2015 and \$695 in 2016, as well as increases the percentages for the penalty based on taxable income to 1% in 2014, 2% in 2015, and 2.5% in 2016. Changes the definition of the exemption for low-income individuals from those have incomes less than the federal poverty level to those who have incomes less than the tax filing threshold.</i></p>
Employer Responsibility	Sec. 1513: Requires employers that have more than 50 full-time employees, do not offer health insurance, and have at least one worker who receives premium assistance to make a payment of \$750 per full-time employee. For employers that have more than 50 full-time employees, offer health insurance, and have at least one worker who receives premium assistance, requires a payment of the lesser of \$3,000

	<p>per employee who receives premium assistance or \$750 per full-time worker. Exempts employers that have 50 or fewer full-time employees from the requirements (begins on January 1, 2014).</p> <p>Changes the amount of the payment for employers that have more than 50 full-time employees, do not offer health insurance, and have at least one worker who receives premium assistance to \$2,000 per full-time employee and excludes the first 30 workers from the calculation. For employers that have more than 50 full-time employees, offer health insurance, and have at least one worker who receives premium assistance, changes the amount of the payment to the lesser of \$3,000 per employee who receives premium assistance or \$2,000 per full-time worker.</p>
<p>Excise Tax on Health Insurers</p>	<p>Sec. 9001: Imposes an excise tax of 40% on health insurers and health plan administrators for any plan with a premium that exceeds \$8,500 for single coverage and \$23,000 for family coverage. Applies the tax to the amount of the premium in excess of the threshold (begins on January 1, 2013).</p> <p>Raises the thresholds for the imposition of the tax to any health plan with a premium that exceeds \$10,200 for individual coverage and \$27,500 for family coverage and allows an increase in the amounts of the thresholds in the event that health care costs increase more than expected prior to the implementation of the tax. Changes the implementation date for the tax to January 1, 2018.</p>
<p>Community Living Assistance Services and Supports Program</p>	<p>Sec. 8002: Establishes a voluntary, public long-term care insurance program for the purchase of community living assistance services and supports by individuals who have functional limitations. Provides cash benefits of at least an average of \$50 per day (begins on January 1, 2011).</p>
<p>HEALTH INSURANCE EXCHANGES</p>	
<p>Individual and Small Group Market for Health Plans (Exchanges)</p>	<p>Sec. 1311: Requires the HHS secretary to award grants to states to establish American Health Benefit Exchanges by Jan. 1, 2014, with no grants awarded after January 1, 2015.</p> <p>Sec. 1321: Requires the HHS secretary to establish standards for Exchanges, qualified health plans, reinsurance, and risk adjustment. In the event that the HHS secretary on or before January 1, 2013, determines a state will not have an operational Exchange by 2014, allows the secretary to operate an Exchange in that state.</p>

Eligibility for Participation in Exchanges	Sec. 1312: Allows U.S. citizens and legal immigrants who are not incarcerated to participate in Exchanges. In addition, permits small businesses to participate in Exchanges. After 2017, allows large employers to begin to participate in Exchanges.
Outreach and Enrollment Efforts	Sec. 2201: Allows individuals to apply for, and enroll in, Medicaid, CHIP, or Exchanges through Web site administered by states.
Essential Benefits Package (for Health Plans in Exchanges)	<p>Sec. 1302: Requires all health plans in Exchanges to offer essential benefits, which include rehabilitative and habilitative services; and mental health and addiction services, such as behavioral health treatments.</p> <p>Sec. 1311: Allows states to require health plans in Exchanges to offer benefits in addition to the essential benefits.</p>
Cost-Sharing in Exchanges	Sec. 1302: Mandates that annual cost-sharing for health plans in Exchanges cannot exceed \$5,000 for individuals and \$10,000 for families but does not apply the caps to the cost of premiums. For small group health plans in Exchanges, limits deductibles to no more than \$2,000 for individuals and \$4,000 for families.
Benefit Package Levels	Sec. 1302: Defines levels of benefits offered by health plans in Exchanges based on the amount of cost-sharing required: Bronze (plans must pay for 60% of costs), Silver (70%), Gold (80%), and Platinum (90%). Allows health plans in Exchanges that do not offer Bronze, Silver, Gold, or Platinum levels of coverage to offer catastrophic coverage to individuals younger than age 30 or individuals exempted from the mandate because of a hardship waiver. Requires catastrophic coverage to include the essential benefits and at least three primary care visits but allows this coverage to require more cost-sharing.
State Flexibility	<p>Sec. 1332: After December, 31, 2016, allows states to apply for a waiver for as many as five years of requirements related to Exchanges, qualified health plans, and cost-sharing. Requires states to prove that waivers would provide comprehensive and affordable health insurance to at least a comparable number of residents as Exchanges would provide and that waivers would not increase the federal budget deficit.</p> <p>Sec. 1333: By July 31, 2013, requires the HHS secretary to issue regulations for interstate Health Care Choice Compacts, which can begin operations after 2015. Allows the compacts to offer qualified health plans in all associated states but requires these plans to adhere to the consumer protection and other laws of each of the states.</p>
Premium	Sec. 1401(36B): Establishes premium assistance credits for individuals

<p>Assistance Credits, Caps on Out-of-Pocket Costs for Health Plans in Exchanges</p>	<p>and families that have incomes at or less than 400% of the federal poverty level and enroll in health plans in Exchanges. For individuals or families with incomes at or less than 133% of the poverty level, requires that the credits cover premium costs that exceed 2% of their income (begins on January 1, 2014).</p> <p>Sec. 1402: Caps standard out-of-pocket costs for health plans in Exchanges at \$5,950 for individuals and \$11,900 for families. For individuals and families that receive premium assistance credits, lowers the caps on out-of-pocket costs to one-third of the standard level for those with incomes between 100% and 200% of the federal poverty level, one-half of the standard level for those with incomes between 200% and 300% of the poverty level, and two-thirds of the standard level for those with incomes between 300% and 400% of the poverty level (begins on January 1, 2014).</p>
<p>MEDICAID AND CHIP</p>	
<p>Medicaid Expansion</p>	<p>Sec. 2001: Mandates that state Medicaid programs cover all individuals who are younger than age 65 and have incomes at or less than 133% of the federal poverty level. Provides limited Medicaid benefits packages to newly eligible individuals and requires states to design these packages based on rules for benchmark plans established in 2005. These benefit packages must include parity for mental and physical health services, but they are not required to offer the same level of coverage or range of services as traditional Medicaid (begins on January 1, 2014).</p> <p>From 2014 to 2016, requires the federal government to pay 100% of the cost of Medicaid coverage for newly eligible individuals, with the level of this contribution to decrease from 2017 to 2018. After 2018, provides states with an increase of 32.3 percentage points in their federal Medicaid assistance percentage for coverage of newly eligible individuals. Requires states to maintain current Medicaid income eligibility levels until January 1, 2014, but allows for possible exemptions for states with budget deficits. For children, requires states to maintain current Medicaid income eligibility levels through September 30, 2019.</p> <p>Changes the share of the cost of Medicaid coverage for newly eligible individuals covered by the federal government to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in subsequent years. Changes the date through which states must maintain current Medicaid income eligibility levels for children to December 31, 2015.</p>
<p>CHIP</p>	<p>Sec. 2101: Requires states to maintain current income eligibility levels</p>

	for CHIP through September 30, 2019. From 2015 to 2019, provides states with a 23 percentage point increase in their federal CHIP match rates, with a cap at 100%.
Medicaid Medical Home Pilot	Sec. 2703: Allows states to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness, into medical homes as part of pilot projects. Authorizes grants of as much as \$25 million to help states plan and implement these projects (begins on January 1, 2011).
Medicaid Accountable Care Organization Pilot Program	Sec. 2706: Establishes a demonstration project that will allow qualified pediatric providers to receive recognition and payments under Medicaid as accountable care organizations, as well as permit ACOs that meet quality of care standards and reduce costs to share in a portion of their savings to the program (begins on January 1, 2012).
Medicaid Emergency Psychiatric Demonstration Project	Sec. 2707: Requires HHS to establish a three-year Medicaid demonstration project to reimburse certain institutions for mental disease for services provided to beneficiaries who are between ages 21 and 65 and require medical assistance to stabilize an emergency psychiatric condition. Authorizes \$75 million for the project (begins on October 1, 2011).
Medicaid Community-Based Services	<p>Sec. 2401: Establishes a Community First Choice Option through which state Medicaid programs can offer community-based attendant services and supports to beneficiaries who otherwise would require the level of care offered in a hospital, nursing home, or intermediate care facility for the mentally retarded (begins on October 1, 2010).</p> <p>Changes the implementation date of the benefit to October 1, 2011.</p> <p>Sec. 2402: Allows states to provide more types of home- and community-based services to Medicaid beneficiaries with higher levels of need through a state plan amendment, rather than a waiver, and to extend full coverage to beneficiaries who receive HCBS under a state plan amendment.</p> <p>Sec. 10202: Establishes the State Balancing Incentive Payments Program to increase the proportion of Medicaid beneficiaries who receive long-term care outside of institutional settings. For states that qualify, provides FMAP increases for medical assistance expenditures for long-term care services and supports provided to Medicaid beneficiaries outside of institutional settings.</p>
MEDICARE	

<p>Medicare Part D</p>	<p>Sec. 3301: Requires pharmaceutical companies to provide a 50% discount to Medicare Part D beneficiaries for brand-name medications and biologics purchased in the “donut hole” coverage gap (begins on July 1, 2010).</p> <p>Changes the implementation date of the requirement to January 1, 2011.</p> <p>Sec. 3305: Requires HHS to transmit Medicare Part D formulary and coverage information to low-income subsidy beneficiaries who were automatically reassigned to new Part D plans.</p> <p>Sec. 3307: Codifies the current six classes of clinical concern.</p> <p>Sec. 3309: Eliminates cost-sharing for Medicare beneficiaries who receive care under an HCBS program and otherwise would require institutional care.</p>
<p>Specialized Medicare Advantage Plans for Special Needs Individuals</p>	<p>Sec. 3205: Extends the Special Needs Plan program through 2013 and requires SNPs to obtain approval from the National Committee for Quality Assurance. On January 1, 2001, allows HHS to apply a frailty payment adjustment to fully integrated, dual-eligible SNPs that enroll frail Medicare beneficiaries and requires an evaluation of Medicare Advantage risk adjustment for chronically ill beneficiaries. Requires SNPs to obtain approval from the National Committee for Quality Assurance after 2011. After 2012, mandates that dual-eligible SNPs contract with state Medicaid programs. Requires HHS to transition Medicare beneficiaries enrolled in SNPs that do not meet statutory target definitions by January 1, 2013.</p>
<p>Medicare Accountable Care Organizations</p>	<p>Sec. 3022: Allows ACOs that meet quality of care standards and reduce costs to share in a portion of their savings to Medicare (begins on January 1, 2012)</p>
<p>Medicare Medical Home Pilot Program</p>	<p>Sec. 3502: Establishes a program to create and fund the development of community health teams to support the creation of medical homes through increased access to comprehensive, community-based, and coordinated care (begins by January 1, 2012).</p>
<p>WORKFORCE AND OTHER PROVISIONS</p>	
<p>Co-Location of Primary and Specialty Care in Community-Based Behavioral Health</p>	<p>Sec. 5604: Authorizes \$50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.</p>

Settings	
National Health Service Corps	Sec. 5207: Authorizes specific funding amounts for the National Health Service Corps, with funding to increase from \$320,461,632 in 2010 to \$1,154,510,336 in 2016. After 2016, adjusts funding annually “by the product of (A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and (B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.”
Training for Behavioral Health Professionals	Sec. 5306: Allows the HHS secretary to award grants to schools for the development, expansion, or improvement of training programs in social work, graduate psychology programs, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. Authorizes funding for the grants from 2010 to 2013.
Loan Repayment for Pediatric Behavioral Health Specialists in Underserved Areas	Sec. 5203: Establishes and authorizes funds for a Pediatric Specialty Loan Repayment Program for individuals who are employed in health professional shortage or medically underserved areas for at least two years and provide pediatric medical subspecialty; pediatric surgical specialty; or child and adolescent mental and behavioral health services, which include substance abuse prevention and treatment services.
Educating Primary Care Providers About Behavioral Health	Sec. 5405: Establishes and authorizes funds for a Primary Care Extension Program to educate primary care providers about preventive medicine; chronic disease management; mental and behavioral health services, which include substance abuse prevention and treatment services; and evidence-based and evidence-informed therapies and techniques.
Community Transformation Grants	Sec. 4201: Authorizes competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Includes programs to prevent or reduce the incidence of mental illness.
Community Health Workforce Grants	Sec. 5313: Authorizes grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.
National Health Care Workforce Commission	Sec. 5101: Establishes a National Health Care Workforce Commission to evaluate education and training programs to determine whether they will meet the expected demand for health care workers in the future; identify barriers to improved coordination of these programs at the

	<p>federal, state, and local levels and recommend proposals to address these issues; and encourage innovations in these programs to address population needs, changes in technology, and other environmental factors (begins by September 30, 2010)</p>
<p>Federal Definition of Community Mental Health Centers</p>	<p>In Section 1861 of the Social Security Act, changes the definition of community mental health centers to include a requirement that these facilities provide at least 40% of their services to individuals who do not qualify for benefits under Medicare and excludes from the definition of partial hospitalization services provided by CMHCs or other entities any services provided in the homes of individuals or in inpatient or residential settings (begins on or after the first day of the first calendar quarter that begins at least 12 months after enactment).</p>