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## **Community-Based Adult Mental Health in Iowa**

Impact of the ACA and Health  
System Change on the Iowa  
Safety Net

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# Mental Health Care in Iowa

## Introduction

This is a report that inventories all the information we have collected on the administration, providers, funding, workforce, patients, current status, and the redesign of Iowa's mental health system. This information was collected as part of a study funded by The Commonwealth Fund to study the implications of the Affordable Care Act (ACA) on safety net health care providers. This report includes language from the ACA that relates to mental health.

## Iowa's Mental Health Care Administration

In Iowa, mental health care administration is determined by the services needed and the funding type. Based on these two circumstances, care is provided by a county or state non-profit organization. The Iowa Department of Human Services (DHS) administers Medicaid-funded mental health services through a contract with Magellan Behavioral Health Care at the state level. At the county level, a Central Point of Coordination (CPC) administers non-Medicaid funded services. The CPC coordinates and funds services according to its approved county management plan.<sup>1</sup>

DHS allocates funding based on a formula authorized by the legislature. Funds come from three appropriations (Property Tax Relief, MHDD Allowed Growth, and MHDD Community Services) and are placed into the county's MHDD Fund 10 along with funds from county property taxes. The county uses the MHDD Fund for institutional services, a portion of the non-Federal match for Medicaid funded services where that match is the responsibility of the county of legal settlement, and for services the county directly contracts with community providers.<sup>2</sup>

## The Status of Iowa's Mental Health Care System

According to *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness*, Iowa's mental health care system was given a grade of "D". This is an improvement from the state's grade of an "F" given by the same report in 2006. The average grade for the country in 2009 was also a "D".<sup>3</sup>

Many challenges to Iowa's mental health care system revolve around a unique decentralized structure in which services are primarily controlled by the individual counties. The current Mental Health and Disability Services (MHDS) system operates as if it were 99 separate systems with services based on each county's own resources and capabilities. Because of this, the system lacks a single point of authority or accountability.<sup>4</sup> Furthermore, there is little coordination between DHS and Magellan, which handle Medicaid-funded services, and the CPC, which oversees non-Medicaid funded services to the county. DHS has little authority over the counties, except in approving a county plan with the CPC.<sup>5</sup>

Iowa's decentralized mental health system also places a significant financial burden on individual counties. Counties use property tax revenue for mental health services, creating severe inequalities in services provided across the state. The availability and scope of services vary from too much to not enough resulting in over-served and under-served residents.<sup>6</sup>

With 90 counties designated as Federal Mental Health Professional Shortage Areas, another issue with Iowa's mental health care system is an insufficient workforce.<sup>7</sup> Further problems arise out of the state's legal settlement policy, which requires mental health consumers to provide proof of residence of at least one year in the county they are seeking services. An additional issue is that Iowa does not have a system set up to collect uniform data statewide, which makes it difficult for policy makers to analyze past and current trends.<sup>8</sup>

While there are numerous concerns with Iowa's mental health care system, efforts are being made to improve services. In 2007, the Iowa legislature enacted the Mental Health Systems Improvement (MHSI) Initiative, which provided recommendations on ways to reform the state's system. Recommendations included plans to address the mental health professional shortage and the establishment of core "safety net" services.<sup>9</sup> Additional efforts are currently underway with the Mental Health and Disability Services System Redesign which is projected to replace the current state mental health delivery system in 2013.<sup>10</sup>

### **Iowa Mental Health and Disability Services System Redesign**

Senate File 525 (SF 525) lays out a plan to redesign Iowa's mental health and disability service system. The plan calls for development of services that implement the principles of Olmstead in order to meet the goal of providing Iowans with disabilities with safe, healthy, productive, successful, determined lives in their homes and communities, regardless of where they reside. Key items in the legislation include the establishment of regional entities to replace the current county-level administration, expansion of state funding to cover the entire non-federal share of Medicaid funded services, the use of residency rather than legal settlement in order to determine payment responsibility for patients, and establishment of a core set of services to be available for any Iowans in need.<sup>11</sup>

Over 100 Iowans served on six redesign workgroups made up of consumers, family members, service providers, professionals, advocates, CPCs, and boards of supervisors. The workgroup members studied the current system, learned about best practices, and made recommendations for improvements of the system. Workgroup recommendations were grouped into three categories: Management/ Structure, Services, and Financing.<sup>12</sup>

This report incorporates the findings and recommendations of the Iowa Mental Health and Disabilities Services System Redesign Final Report dated December 9, 2011.

# Mental Health Provider Network

## State Mental Health Authority

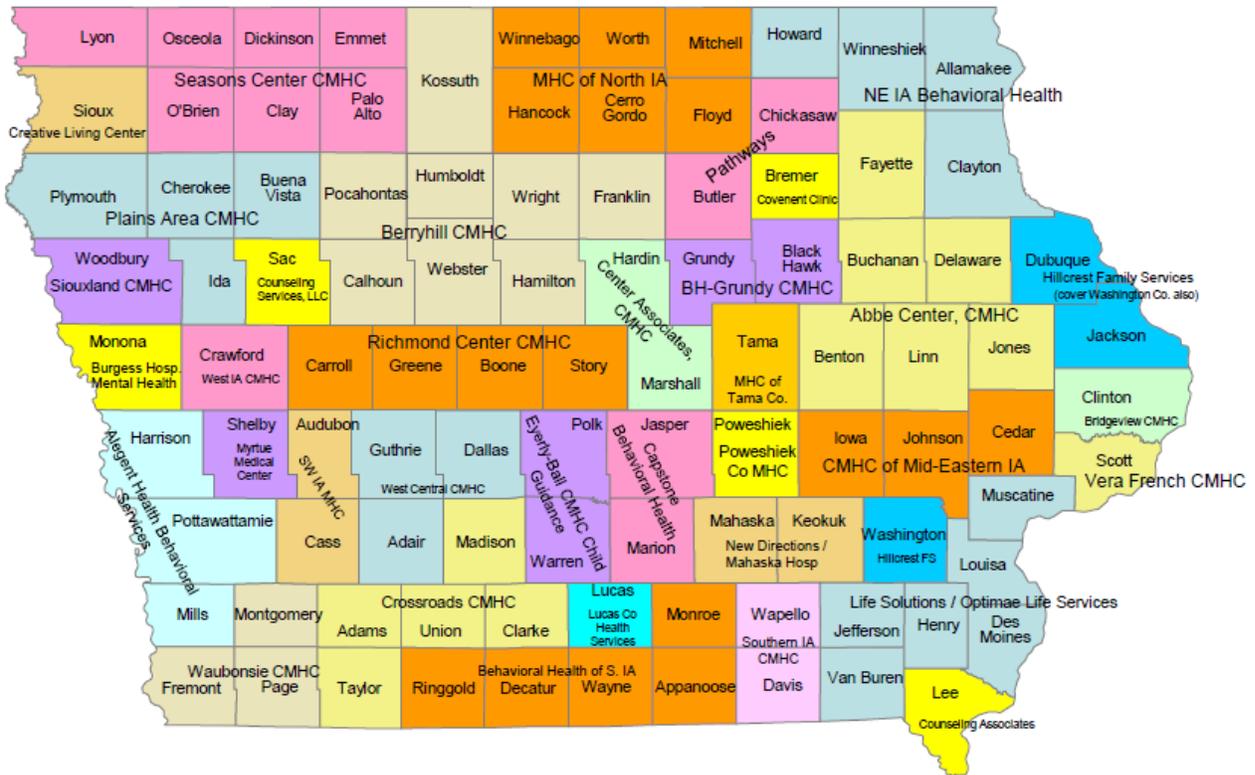
The State Mental Health Authority (SMHA) for Iowa is the Department of Human Services, Division of Mental Health and Disability Services (MHDS). The SMHA funds a total of four state psychiatric hospitals and 37 community mental health providers in Iowa.<sup>13</sup>

Community-based services for adults with mental illnesses in Iowa are primarily under the provision of each county government. Children and adolescent mental health services are provided by state agencies including the state mental health authority, state child welfare, Juvenile Justice, the Department of Education, the Department of Public Health, and county governments.<sup>14</sup>

## Community Mental Health Providers

Map 1 below illustrates Iowa's 37 Community Mental Health providers which deliver services to all 99 counties.

Map 1: Iowa Community Mental Health Centers and Mental Health Service Providers by County as of February 1, 2011



Source: [http://www.healthcare.uiowa.edu/icmh/iowa/documents/CMHC\\_MHSPiAcountymap2-2011.pdf](http://www.healthcare.uiowa.edu/icmh/iowa/documents/CMHC_MHSPiAcountymap2-2011.pdf)

## Redesign Plan – Structure

The MHDS System Redesign Report outlines recommendations for the establishment of five to fifteen regional MHDS administrative entities throughout Iowa before July 1, 2013. The ideal population size of the regions will fall between 200,000-700,000 people (where possible). Regions will be governed by a board of county supervisors or their designees. A minimum of three consumers or family members should also serve on each regional board.<sup>15</sup>

With the Redesign, regional entities will have performance-based contracts with the state. DHS will set standards and determine accountability. Non-Medicaid services will be handled at the regional level and entities will coordinate with DHS for Medicaid services. A key function of the regional entities will be to coordinate service access and delivery for all consumers. Other responsibilities of the region will include administrative duties such as staffing, service planning, budgeting for core services, working with local providers for non-Medicaid services, and selecting case management providers.<sup>16</sup>

The CPCs will not necessarily be eliminated as they may be needed as local points of access for consumers. Direct Services, points of service access, and case management will also be provided locally within the region and will not be affected by regional rather than county administration.<sup>17</sup>

An additional Redesign structure recommendation is a requirement for all regions to use the same uniform cost reporting and rate setting process. Performance data is to be submitted directly to DHS and will then be shared with regions, providers, Legislature and the public.<sup>18</sup>

## Mental Health Funding

Iowa's mental health system is funded through federal, state, and county dollars. Federal funds include Medicaid, Mental Health Block Grants, Social Service Block Grants, and Money Follows the Person Grants. State funds include the non-federal share for Medicaid, Mental Health Institute costs, property tax relief, growth, community service, replacement generation tax, State Payment Program, and risk pool. County dollars include county property taxes and miscellaneous public and private funds.<sup>19</sup>

### State Mental Health Authority Funding<sup>1</sup>

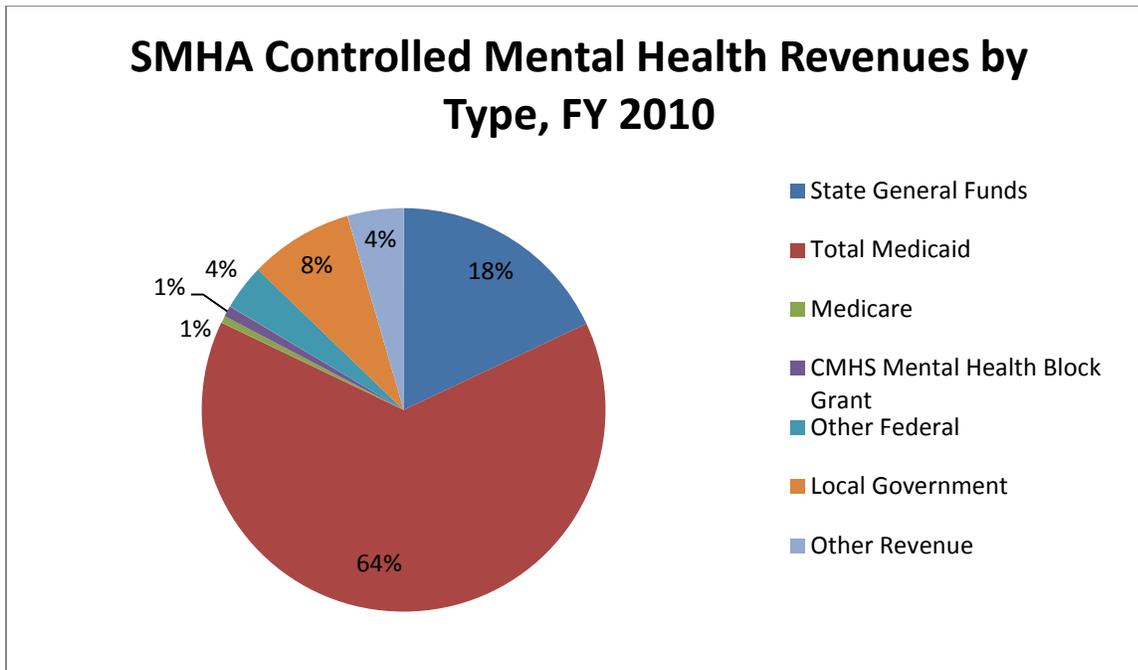
#### *Total State Mental Health Agency Revenue*

In FY 2009 State Mental Health Agency (SMHA) controlled mental health revenues equaled \$406.6 million, with over half of the total revenue coming from Medicaid (\$239.2 million or 59%). The total Medicaid amount consists of \$169.5 million federal Medicaid and \$69.7 million state Medicaid match. The second and third largest sources of revenue include state general funds (18%) and local governments (11%).<sup>20</sup>

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<sup>1</sup> State Mental Health Authority data includes community mental health centers and state mental health institutes.

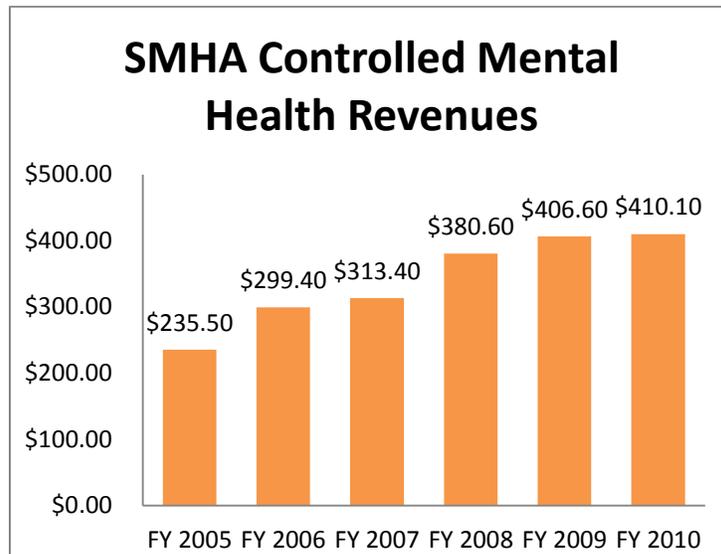
Figure 1: SMHA Controlled Mental Health Revenues by Type, FY 2010



Source: NRI Inc. State Mental Health Agency Profile Systems and Revenue Expenditure Study

From FY 2005 to FY 2010, total SMHA controlled mental health revenues increased by 174%. State general funds ranged from 15-26% of the total SMHA revenues while local governments were responsible for 8-18% of the total SMHA revenues from FY 2006 to FY 2010.<sup>21</sup>

Figure 2: SMHA Controlled Mental Health Revenues, FY 2005 – FY 2010

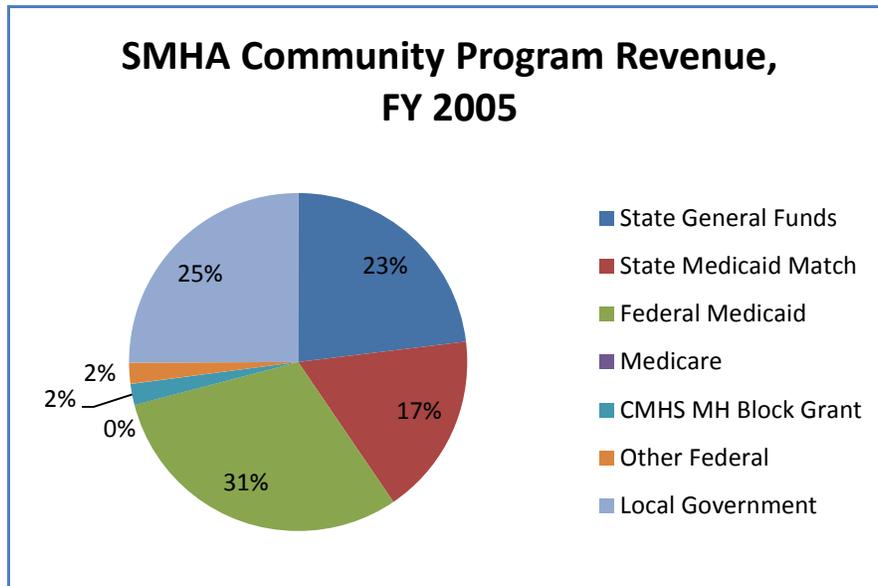


Source: NRI Inc. State Mental Health Agency Profile Systems and Revenue Expenditure Study

### Community Program Revenue

SMHA revenues to community programs totaled \$198.6 million in FY 2005. This amount includes \$94.8 million from Medicaid, \$49.7 million from local government, \$46.4 million from state general funds, \$4.2 million from other federal funds, and \$3.5 million from the Community Mental Health Services Block Grant.<sup>22</sup>

Figure 3: SMHA Community Program Revenue, FY 2005



Source: NRI Inc. State Mental Health Agency Profile Systems and Revenue Expenditure Study

### Community Program Expenditure

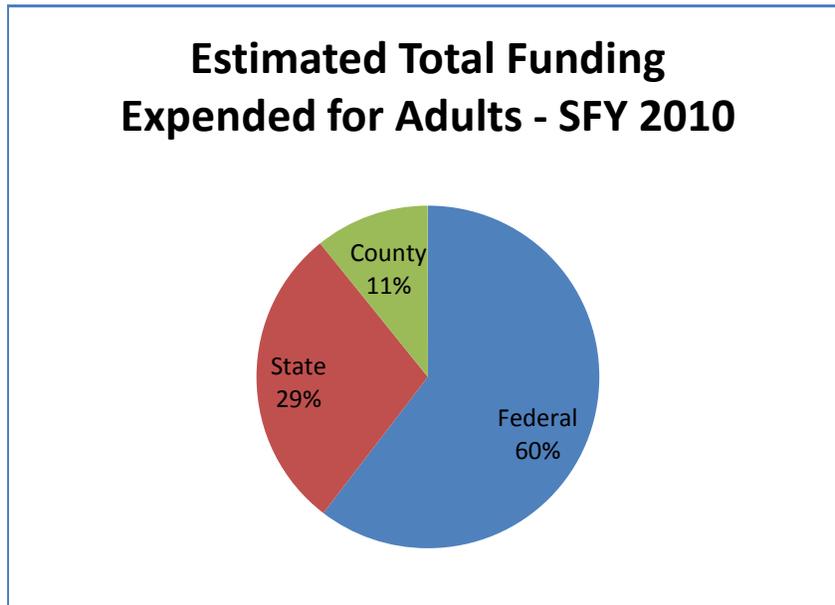
Total expenditure at community-based programs in FY 2009 was \$349.49 million, which is equivalent to \$116.26 per capita. Sixty-four percent of the total expenditure (\$223.80 million) served the population over 18 while 36% served children/adolescents (\$125.69 million). The per capita cost for adults was \$97.60 and the per capita cost for children/adolescents was \$176.24.<sup>23</sup>

The total expenditure for care at community-based programs can be broken down into three categories. Less than 24 hour care made up 70% of total expenditures or \$245.40 million, other 24 hour care made up 17% or \$57.50 million, and inpatient services made up 13% or \$46.6 million.<sup>24</sup>

*Funding for County Managed Services*

In SFY 2010 a total of \$999,349,924 was expended for county managed services. As Figure 4 below illustrates, approximately 60% of the total dollars spent were federal funds, 29% were state funds, and 11% were county funds.<sup>25</sup>

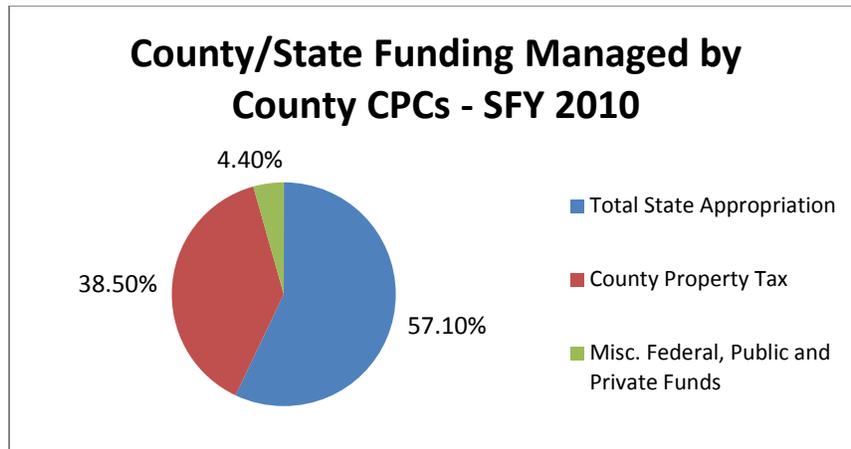
Figure 4: Estimated Total Funding Expended for County Managed Services for Adults, SFY 2010



Source: Iowa DHS 2013 Offer #041-HHS-013 Mental Health and Disability Services

The distribution of funding managed by county CPC's is shown in Figure 5 below for SFY 2010. Over half of funding managed by county CPC's is made up of state appropriations (\$164,403,369), 38.5% of funding is from county property taxes (\$110,690,026), and 4.4% is miscellaneous federal, public, and private funds (\$12,646,820). The total amount of funding managed by county CPC's is \$287,740,215. The graph does not incorporate Medicaid fee for service (Iowa Plan) and some other Medicaid funding for MHDS in Iowa. Eligibility for services is determined by counties so the availability of services covered by MHDD funds varies throughout the state. Data is compiled from SFY 2010 GAAP (Generally Accepted Accounting Principles) Financial Reports from county governments to the Department of Management.<sup>26</sup>

Figure 5: County/State Funding Managed by County CPCs, SFY 2010



Source: Iowa DHS 2013 Offer #041-HHS-013 Mental Health and Disability Services

Table 1 below shows services funded by county funds and the portion of expenditures for each category in SFY 2010.

Table 1: Services Funded by Counties and Expenditures, SFY 2012

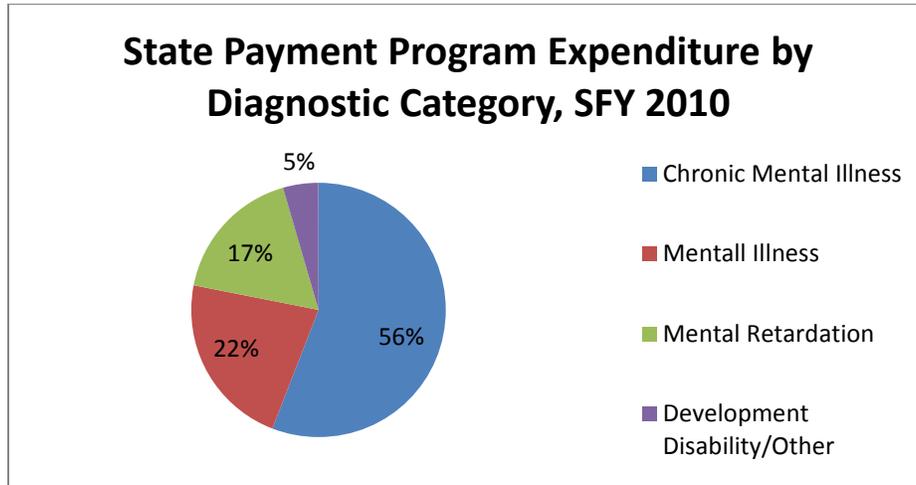
Services Funded by Counties	Dollars Spent	% of Dollars Spent
Coordination	\$15,962,342	6.62%
Personal and Environmental Support	\$27,817,697	11.53%
Treatment Services	\$26,418,697	10.95%
Vocational and Day Services	\$34,024,099	14.10%
Licensed Certified Living Arrangements	\$111,643,585	46.28%
Institutional/Hospital and Commitment Services	\$25,368,656	10.52%
<b>Total</b>	<b>\$241,235,076</b>	<b>100.00%</b>

Source: Iowa DHS 2013 Offer #041-HHS-013 Mental Health and Disability Services

*State Payment Program*

State Payment Program expenditures for SFY 2010 are shown by diagnostic category in Figure 6 and by services funded in Table 2 below.

Figure 6: State Payment Program Expenditure by Diagnostic Category, SFY 2010



Source: Iowa DHS 2013 Offer #041-HHS-013 Mental Health and Disability Services

Table 2: Services Funded by State Payment Program and Expenditures

Services Funded by State Payment Program	Dollars Spent	% of Dollars Spent
Administrative	\$0	0.00%
Coordination	\$157,588	1.33%
Personal & Environmental Support	\$1,116,787	9.46%
Treatment Services	\$2,297,916	19.47%
Vocational & Day Services	\$1,925,169	16.31%
Licensed Certified Living Arrangements	\$5,307,162	44.63%
Institutional/Hospital and Commitment Services	\$998,412	8.46%

Source: Iowa DHS 2013 Offer #041-HHS-013 Mental Health and Disability Services

## Redesign Plan - Funding

A five year financial roadmap has been designed to preserve current services as well as to support an expansion of new critical core services. The roadmap is specifically designed to provide a solution to potential reductions of non-Medicaid services and non-Medicaid consumers.<sup>27</sup>

As part of SF 525 and the new financial plan, the state will pay the entire non-federal share of Medicaid services which are currently paid by counties beginning July 1, 2013. DHS recommends for this to begin a year earlier on July 1, 2012 if funding is available. For this to occur, the legislature would need to redirect \$171 million in General Funds from the counties to the State Medicaid appropriation as well as add an additional \$47.4 million to the Medicaid appropriation. \$12.3 million in Social Services Block Grant (SSBG) would need to be moved to the State Payment Program. Counties would need to continue to levy local property taxes to fund non-Medicaid services and consumers. This assumes counties will use the state general fund to pay for the non-federal share of Medicaid services prior to using property tax revenue.<sup>28</sup>

With growth for both Medicaid and non-Medicaid services, the Redesign outlines two strategies that could offset new funding needed. First, participation in the Medicaid Balancing Incentive Program would increase Iowa's federal funding for certain Medicaid programs by 2%. Second, assuming the ACA is implemented, insurance coverage for the uninsured who would otherwise receive non-Medicaid funded services will provide savings and allow regions to redirect funds into expanded new core services.<sup>29</sup>

### *FY 2013- FY 2017 Estimated New Costs*

The overall impact to the State's General Fund is shown in Table 3 below. Assumptions include the savings identified above, estimates and assumptions for current services including annual growth, as well as the phasing in of new core services.<sup>30</sup>

**Table 3: FY 2013-FY 2017 Estimated Fund Increases**

	<b>Proposed State General Fund Increase (in Millions)</b>				
	<b>FY 2013</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016</b>	<b>FY 2017</b>
<b>Cumulative Increase</b>	\$42.3	\$68.8	\$10.5	\$121.2	\$133.0
<b>Year to Year Increase</b>	\$42.3	\$26.5	\$31.7	\$20.7	\$11.8

Source: Iowa Mental Health and Disability Services System Redesign Final Report

## Mental Health Workforce

### Psychiatrists

Iowa was ranked 47<sup>th</sup> out all states for the number of psychiatrists per 100,000 people in the year 2000. According to the Health Resources Service Administration (HRSA) Bureau of Health Professions State Health Workforce Profiles 2000, Iowa had a total of 164 psychiatrists creating a ratio of 5.7 per 100,000 people. The national ratio was 12.6 psychiatrists per 100,000 people.<sup>31</sup>

As of May 29, 2005, there were 231 total active psychiatrists working in Iowa. Of these, 199 were adult psychiatrists and 32 were child psychiatrists.<sup>32</sup> Table 4 below shows that the number of active psychiatrists in Iowa has not changed between 1995 and 2005 in recent years.

**Table 4: Total Number of Active Psychiatrists in Iowa on December 31<sup>st</sup>**

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
<b>Child</b>	34	37	38	37	36	35	32	30	31	32
<b>Adult</b>	190	178	183	190	190	197	205	202	206	199
<b>Total</b>	224	215	221	227	226	232	237	232	237	231

Source: [http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth\\_0306.pdf](http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth_0306.pdf)

In 2005, 35% of all psychiatrists in Iowa were 55 or older. Psychiatrists have the 5<sup>th</sup> highest percentage of workers 55 or older out of all licensed groups of health professionals in Iowa. This high number of psychiatrists nearing retirement is likely to result in a significant loss of personnel in upcoming years. Also in 2005, 177 or 77% of active psychiatrists were male.<sup>33</sup>

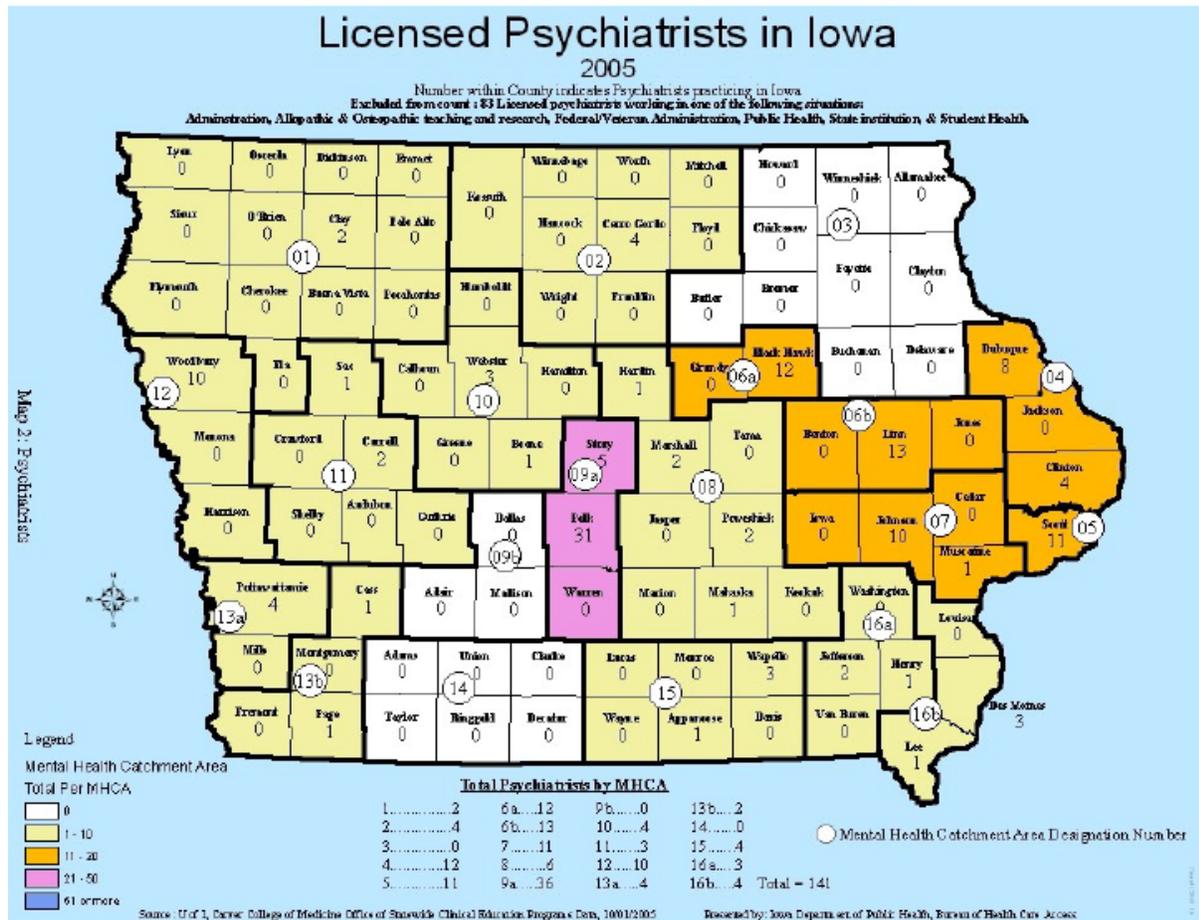
Table 5 shows the areas of practice for Iowa's psychiatrists and Map 2 depicts the number of psychiatrists in each of Iowa's counties. Psychiatrists work in 35 counties throughout the state, while 12 counties have more than five psychiatrists. Mental Health Catchment Area 14 has no psychiatrists employed within its six county service area. The ratio of psychiatrists per population is not necessarily proportional throughout the state. For example, in 2005 Johnson County with a population of approximately 126,000 had 56 psychiatrists. At the same time Polk County, which had a population of almost 416,000 had only 41 psychiatrists.<sup>34</sup>

**Table 5: Iowa Psychiatrists' Areas of Practice**

<b>Private Practice</b>	<b>Allopathic Teaching/ Research</b>	<b>State Institution/ Agency</b>	<b>Public/ Community Health</b>	<b>Federal/ Veterans Facility</b>	<b>Osteopath Teaching/ Research</b>	<b>Student Health</b>
<b>149</b>	42	14	12	10	1	1

Source: [http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth\\_0306.pdf](http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth_0306.pdf)

Map 2 – Licensed Psychiatrists in Iowa, 2005



Source: [http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth\\_0306.pdf](http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth_0306.pdf)

According to the Iowa Health Profession Tracking Center at the University of Iowa, the state had 16 psychiatrists enter the field as well as 16 psychiatrists exit in 2010, resulting in no net gain or loss. This number includes adult and child psychiatrists.<sup>35</sup>

### Psychologists

Iowa has 472 actively licensed psychologists, 304 of which are dually licensed as health service providers (64%). Forty-seven percent of licensed psychologists in Iowa are 55 or older. As a result the field has the highest percentage of older workers out of all of Iowa's licensed health care providers. Over half of Iowa's psychologists are male. This percentage of males in the profession is high compared to the national average provided by the Bureau of Labor Statistics where 66.7% of employed psychologists are female.<sup>36</sup>

### Advanced Registered Nurse Practitioners

Iowa has 1,219 Advanced Registered Nurse Practitioners (ARNP's) who are actively licensed and reside within the state. Twenty-four percent of Iowa's ARNP's are aged 55 or older, while only 3% are male.

Sixty-seven of Iowa's nurse practitioners specialize in psychiatric/mental health preparation. Of these 67 ARNP's, 23 are mental health nurse practitioners, seven are clinical nurse specialists in child/adolescent psychiatry, and 37 are clinical nurse specialists in adult psychiatry.<sup>37</sup>

Areas of practice for Iowa's ARNP's who specialize in psychiatric/mental health preparation include:

- Private psychiatrists/psychologists: 24
- Mental health clinics: 10
- Teaching/research: 8
- Hospitals: 6
- Federal/Veterans Facilities: 1
- No information available: 19<sup>38</sup>

#### *Social Workers*

There are 4,204 active social work licensees in Iowa. Twenty-eight percent of social workers are 55 or older, while 82% are female and 97% are white not of Hispanic origin. Seventy-four percent or 3,106 social workers are employed full-time in the social work field, while 582 are employed part-time in the field. Sixty-nine social workers are unemployed and seeking positions in the field of social work and 93 are unemployed but not seeking a position in social work. Two hundred and seventy-two licensed social workers work outside the field. Employment status of three social workers is unknown.<sup>39</sup>

#### *Mental Health Counselors*

Iowa has 535 mental health counselors with active licenses. Licensees reported addresses in 74 out of the 99 counties. Thirty-four percent of these mental health counselors are over the age of 55.<sup>40</sup>

#### *Redesign Plan – Workforce Development*

The Redesign identifies the need to address mental health workforce shortages as well as the need to improve workforce management practices. Recommendations include utilizing peer provided services more, expanding peer service training, and using the College of Direct Supports, online training for ID-DD and mental health Direct Support Professionals and supervisors.<sup>41</sup>

## Mental Health Patient Demographics

### State Mental Health Authority Demographics<sup>2</sup>

Data from the Iowa Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting Systems reports that the SMHA system served a total of 98,065 clients in 2011, slightly more than 2010 when it served 96,430 clients. This is a 9.4% increase from 2009, when the SMHA system served a total of 89,642 clients. The total number of clients served in a community setting is 44,364, while 1,040 clients were served in state hospitals. The utilization rate is 14.75 per 1,000 people for community settings and .35 per 1,000 for state hospitals. The utilization rate for total clients served by SMHA system is 32.61 per 1,000.<sup>42</sup>

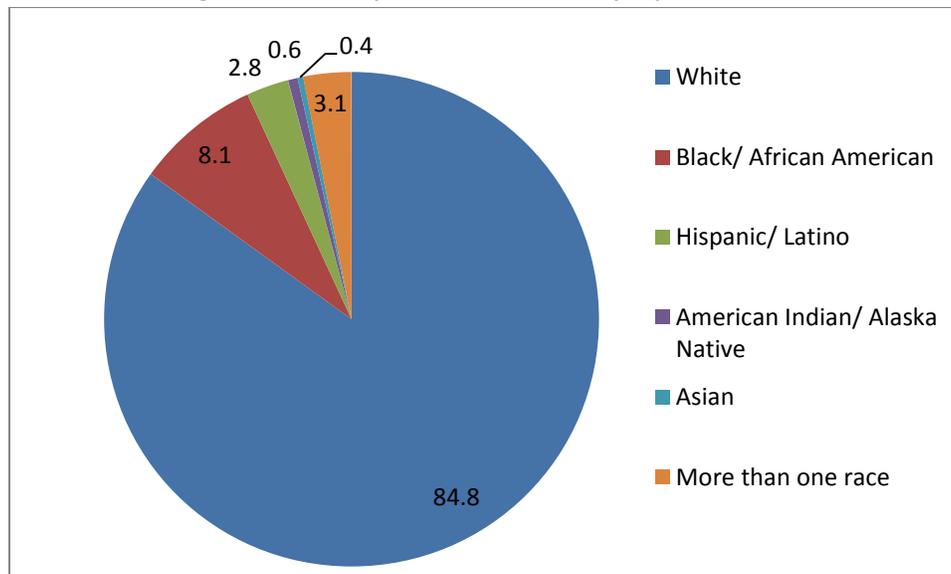
#### Gender

Of the total clients served by the SMHA system in 2011, 52.3% were female and 47.6% were male.<sup>43</sup>

#### Race/Ethnicity

In 2011, 79.9% of total client race/ethnicity was recorded. Of those, 84.8% were white, 8.1% were Black/African American, 2.8% were Hispanic/Latino, and 1.3% were more than one race. There was less than one percent of the recorded patient total of American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islander. A total of 17,364 clients (18%) did not record their race/ethnicity.<sup>44</sup>

Figure 7: SMHA Proportion of Race/Ethnicity of patients, 2011



Source: <http://www.samhsa.gov/dataoutcomes/urs/2011/iowa.pdf>

#### Employment

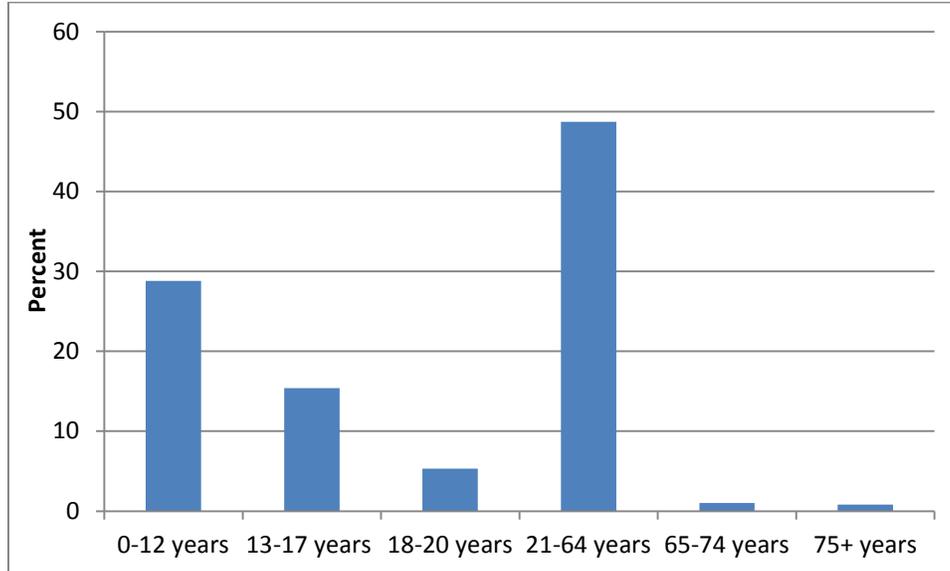
In 2011, 30.9% of clients were employed, 63.1% were unemployed, and 6.1% were not in the labor force.<sup>45</sup>

<sup>2</sup> State Mental Health Authority data includes community mental health centers and state mental health institutes.

### Age

Approximately half of clients (48.6%) fit within the 21-64 age range. The second largest clientele is the 0-12 age range with 28.8%, followed by the 13-17 age range with 15.37%.<sup>46</sup>

Figure 8: SMHA Age, 2011



Source: <http://www.samhsa.gov/dataoutcomes/urs/2011/lowa.pdf>

The age of those served in Community Mental Health Program is shown in Figure 9. Almost 70% of all patients utilizing services of Community Mental Health Programs are between the ages of 21-64 years old.<sup>47</sup>

### Admission Rates

Table 6 shows the admission rates for mental health providers in 2011. Community programs recorded 44,364 admissions, with 77% being adults and 23% being children.<sup>48</sup>

Table 6: Admission Rates for Mental Health Providers, 2011

	Total	Adults	Children
State Psychiatric Hospitals	1,040	766	274
Community Programs	44,364	34,212	10,152

Source: <http://www.samhsa.gov/dataoutcomes/urs/2011/lowa.pdf>

### Medicaid Funding Status

For the year 2011, almost two-thirds (64%) of patient services are paid for by Medicaid funding only. 27% are not covered by any Medicaid funds and 9% of services are covered by Medicaid along with other funds.<sup>49</sup>

*Patient Funding Source*

Table 7 shows the percent of clients served in SMHAs by funding type, based on gender and race/ethnicity for 2011.

**Table 7: Clients served SMHAs by Funding Type, 2011**

Gender	Percent Served		
	Medicaid	Non-Medicaid Only	Both Medicaid & Other
Female	68%	23%	9%
Male	67%	26%	8%
<b>Total</b>	67%	25%	8%
<b>Race/Ethnicity</b>			
American Indian/Alaska Native	67%	27%	6%
Asian	55%	33%	13%
Black/African American	74%	18%	8%
Native Hawaiian/Other Pacific Islander	97%	3%	0%
White	61%	29%	11%
Hispanic/Latino	76%	18%	6%
More Than One Race	99%	0%	1%
Race Not Available	82%	17%	1%
<b>Total</b>	67%	25%	8%

Source: <http://www.samhsa.gov/dataoutcomes/urs/2011/iowa.pdf>

Iowa Department of Human Services Patient Demographics

*Population Served*

According to the Iowa Council on Human Services Budget Submission for SFY 2013, the county mental health system served 50,321 unduplicated people with legal settlement in SFY 2010. This is a slight decrease from the 51,268 served in SFY 2009.<sup>50</sup> Table 8 shows the population served by type of disability in Iowa in SFY 2010.

**Table 8: Population Served by Disability Type, 2010**

Disability Population	Adults	Children	Total
Mental Illness	22,189	2,225	24,414
Chronic Mental Illness	11,969	128	12,097
Intellectual Disability	11,306	913	12,219
Developmental Disability	1,166	33	1,199
Other/Brain Injury	355	37	392
<b>Total</b>	<b>46,985</b>	<b>3,336</b>	<b>50,321</b>

Source: [http://www.dhs.iowa.gov/docs/13-401-HHS-013-MHDS\\_Narrative.pdf](http://www.dhs.iowa.gov/docs/13-401-HHS-013-MHDS_Narrative.pdf)

### Persons Served by County Funds

Table 9 shows county funded services and the number and percent of persons served by each category in SFY 2010.

**Table 9: Persons Served (Unduplicated by service) by Category of County Funded Services, SFY 2010**

Services Funded by Counties	Persons Served	% Persons Enrolled
Coordination	15,951	34.92
Personal and Environmental Support	16,736	36.64
Treatment Services	33,550	73.44
Vocational and Day Services	14,128	30.93
Licensed Certified Living Arrangements	9,405	20.59
Institutional/Hospital and Commitment Services	13,178	28.85

Source: [http://www.dhs.iowa.gov/docs/13-401-HHS-013-MHDS\\_Narrative.pdf](http://www.dhs.iowa.gov/docs/13-401-HHS-013-MHDS_Narrative.pdf)

### Persons Served by the State Payment Program

Iowa's State Payment Program provides services to adults who do not have a county of legal settlement. In the program, the county will purchase local services to maintain and improve self-sufficiency of adults with a mental illness, intellectual disability, and/or developmental disability. The State Payment Program reimburses the county for provision of these services.<sup>51</sup> Table 10 shows types of services funded by the State Payment Program and the number and percentage of people served by each type in SFY 2010.

**Table 10: Services Funded and Number Served (Unduplicated by Service) by State Payment Program, SFY 2010**

Services Funded by State Payment Program	Persons Served	% Persons Served
Administrative	0	0.00
Coordination	225	6.93
Personal & Environmental Support	799	24.61
Treatment Services	3,051	93.96
Vocational & Day Services	474	14.60
Licensed Certified Living Arrangements	542	16.69
Institutional/Hospital and Commitment Services	1,439	44.32

Source: [http://www.dhs.iowa.gov/docs/13-401-HHS-013-MHDS\\_Narrative.pdf](http://www.dhs.iowa.gov/docs/13-401-HHS-013-MHDS_Narrative.pdf)

**See Appendix A for the legal review of Affordable Care Act Provisions relating to Community-Based Adult Mental Health**

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## Appendix A

Section 2703 of the Affordable Care Act (“ACA”) allows states to cover, under Medicaid, eligible individuals with chronic conditions for health home services.<sup>52</sup> Eligible individuals include persons with, at least, one chronic condition and at-risk for a second chronic condition (a mental health condition qualifies as a chronic condition); or eligible individuals can have one serious and persistent mental health condition.<sup>53</sup>

According to the ACA, eligible individuals select a designated provider, team of health professionals, or health team for providing the eligible individual with health home services.<sup>54</sup> Health home services include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care;
- Patient and family support;
- referral to community and social support services; and
- Use of health information technology.<sup>55</sup>

In addition to physicians and community health centers, community mental health centers are explicitly listed as a designated provider in the ACA.<sup>56</sup> Further, behavioral health professionals are explicitly mentioned in the ACA as possible members of a team of health care professionals.<sup>57</sup> The payment for health home services established by the state must be tiered and prevent unnecessary utilization of services.<sup>58</sup> Further, states are required by the ACA to require procedures from Medicaid-participating hospitals for referring eligible individuals from the hospital’s emergency department to designated providers.<sup>59</sup>

The ACA establishes a grant for developing teaching health centers in order to prepare primary care residents for practice.<sup>60</sup> A community mental health center is explicitly defined by the ACA as a teaching health center.<sup>61</sup> Grants to teaching health centers for either developing or expanding primary care residency programs are limited to three years and a total award of \$500,000.<sup>62</sup> Funds from the grant can be used for:

- Establishing, or expanding, a primary care residency training program;
- Curriculum development;
- Recruitment, training, and retention of residents and faculty;
- Accreditation
- Faculty salaries; and
- Technical assistance.<sup>63</sup>

Further, a teaching health center listed as a sponsoring institution can be reimbursed for direct and indirect expenses for either the expansion or establishment of a medical resident training program.<sup>64</sup> Direct costs are calculated according to: payments per resident multiplied by the number of residents in the center’s residency program.<sup>65</sup> Additionally, indirect medical education expenses are also reimbursed

to a teaching health center.<sup>66</sup> Full-time equivalent resident funding for direct and indirect expenses is limited in order to ensure that program expenditures do not exceed program appropriations.<sup>67</sup>

Regarding depression disorders, the ACA provides grants for entities attempting to establish centers of excellence for depression.<sup>68</sup> The Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act (“ENHANCED Act”) provides for establishing up to 30 centers of excellence by 2016 and awarding grants for a maximum of five years in addition to one additional five year renewal.<sup>69</sup> Depressive disorders as defined by the ENHANCED Act include:

- Major depression;
- Bipolar disorder;
- Related mood disorders; or, in general,
- Any mental or brain disorder relating to depression.<sup>70</sup>

The ACA prioritizes awarding ENHANCED Act grants to eligible entities with the ability to establish agreements with community mental health centers.<sup>71</sup> The ENHANCED Act requires the centers of excellence to:

- Integrate interdisciplinary research and practice into evidence-based interventions;
- Develop a research agenda;
- Include stakeholders in evidence-based practices;
- Train and provide technical assistance to mental health professionals;
- Conduct translational research;
- Educated the public and policy-makers about depressive disorders;
- Develop standards and guidelines, and protocols emphasizing prevention, early intervention, and treatment;
- Communicate and collaborate with other centers and community-based providers;
- Leverage community resources; and
- Utilize electronic health records and tele-health technology.<sup>72</sup>

The ACA provides grants to qualified community mental health programs for co-locating primary and specialty care services in community-based mental and behavioral health settings.<sup>73</sup> The ACA targets the co-location grants to programs for adults with mental illnesses who have co-occurring primary care conditions and chronic conditions.<sup>74</sup> Grants may be used by qualified community mental health programs for:

- Providing on-site primary care services;
- Paying reasonable costs from referrals to qualified specialty care professionals, care coordinators, or specialty services provided on-site;
- Purchasing necessary information technology; or
- Necessary physical plant modifications.<sup>75</sup>

Finally, the Health Care and Education Reconciliation Act of 2010 (“HRA”) expands the statutory requirements for community mental health centers providing partial hospitalization services to include the provision of at least 40 percent of the center’s services to individuals not eligible for benefits under Medicare.<sup>76</sup> Further, any community mental health center providing partial hospitalization services must provide less than 24-hour care other than in an individual’s home, inpatient, or residential care setting.<sup>77</sup>

The ACA requires health insurers to provide coverage for specific health service categories including mental health and substance use disorder services.<sup>78</sup> The insurer is required by the ACA to provide a scope of benefits for each mandatory category equivalent to the scope of benefits provided under a typical employer plan.<sup>79</sup>

The ACA establishes health insurance exchanges.<sup>80</sup> As part of establishing the exchanges, the ACA specifically requires application of mental health parity rules to qualified health plans in the same manner and extent compared to health insurers and group health plans.<sup>81</sup> Further, the ACA mandates, for states establishing exchanges, procedures for conducting outreach to and enrolling individuals with mental health disorders.<sup>82</sup>

The ACA provides for the states to expand Medicaid coverage. Supporting the mandated coverage for specific health service categories, the ACA prescribes the minimum essential coverage for Medicaid benchmark benefits.<sup>83</sup> Mental health services are explicitly included as one component of the minimum essential coverage for either benchmark or benchmark-equivalent coverage.<sup>84</sup> The ACA does not define mental health services. Any non-Medicaid-managed-care company offering either benchmark or benchmark-equivalent benefits must offer mental health financial requirements and treatment limitations equivalent to medical and surgical benefits.<sup>85</sup>

The ACA establishes a Medicaid emergency psychiatric demonstration program involving institutions for mental diseases (facility containing 16, or more, beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases) in order for states to provide coverage for individuals:

- Between the ages of 21 and 65
- Are eligible for Medicaid; and
- Require medical assistance for stabilizing an emergency medical condition.<sup>86</sup>

The ACA defines an emergency medical condition as an individual expressing either suicidal or homicidal thoughts, or gestures, who is determined to represent a threat to either the individual or to others.<sup>87</sup> Further, the ACA defines stabilization as the time when the emergency medical condition no longer exists and the individual is not a threat to self or to others.<sup>88</sup> The demonstration program is limited to 3 consecutive years.<sup>89</sup>

A state participating in the emergency psychiatric demonstration project must develop a mechanism, activated after no later than three days into the inpatient stay, for ensuring that institutions for mental diseases determine patient stabilization.<sup>90</sup>

The ACA encourages the Secretary for Health and Human Services to conduct studies examining the causes of, and treatments for, postpartum depression.<sup>91</sup> The ACA also authorizes the Secretary of Health and Human Services to provide grants to eligible entities in order to establish, operate, and coordinate effective and cost-efficient service delivery to individuals with, and at risk for, postpartum depression.<sup>92</sup> Eligible entities are defined by the ACA to include: public or nonprofit hospital, community-based health center, migrant health center, public housing primary care center, or homeless health center.<sup>93</sup>

Further, the ACA provides that the postpartum-related grants can be integrated with other grant programs including grants for planning and developing health centers serving medically underserved populations.<sup>94</sup>

The ACA extends to 31 December 2010 the five percent payment increase for services that are either (1) insight oriented, behavior modifying, or supportive psychotherapy; or (2) interactive psychotherapy.<sup>95</sup> In order to support patient-centered medical homes, the ACA establishes grants for interdisciplinary health teams that include behavioral and mental health providers who support primary care providers. In order to receive a grant, a health team must agree to, among other things, collaborate with local primary care providers and existing community-based resources in addition to incorporating health care providers, patients, caregivers into the grant-supported program.<sup>96</sup>

In order to address the lack of a central, coordinating agency for chronic disease prevention and public health promotion, the ACA mandates that the National Prevention, Health Promotion and Public Health Council (established by the ACA) will submit an annual report to the President and Congress containing, inter alia, a list of national priorities addressing lifestyle behavior modification including mental and behavioral health.<sup>97</sup>

In addition to establishing a Council overseeing chronic disease prevention and public health promotion, the ACA directs the Secretary for Health and Human Services to conduct an outreach and education campaign.<sup>98</sup> As part of the outreach and education campaign, the Secretary will disseminate information regarding preventive care supported by the Substance Abuse and Mental Health Services Administration.<sup>99</sup>

School-based health centers were created attempting to connect health and education for school-aged children.<sup>100</sup> Supporting that effort, the ACA authorizes grants for operating the school-based health centers.<sup>101</sup> The ACA amends the Public Health Service Act (42 U.S.C. 289h et seq.) to include mental health and substance use disorder assessments, treatment, and referral to other services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.<sup>102</sup>

The HHS Secretary is authorized to prefer applicants for school-based health center grants who serve:

- Communities with barriers to primary health care, and mental health and substance use disorder prevention services for children and adolescents;
- Communities with high per capita numbers of uninsured and underinsured children and adolescents; and

- Children and adolescent populations with a history of difficult access to health and mental health prevention services.<sup>103</sup>

In the effort to reduce chronic disease rates, prevent development of secondary conditions, address health disparities, and develop an evidence base for prevention programming, the ACA authorizes grants to, among others, national networks of community-based organizations for implementing, evaluating, and—ultimately—disseminating evidence-based community preventive health activities for reducing health disparities.<sup>104</sup>

The eligible entities receiving community transformation grants must submit a community transformation plan, which can focus on emotional wellness in addition to many other health activities.<sup>105</sup> Additionally, the eligible entities receiving community transformation grants must measure changes in emotional well-being and overall mental health in order to track changes in the prevalence of chronic disease risk factors.<sup>106</sup>

The ACA authorizes the HHS Secretary to award grants to State and local health departments for implementing 5 year pilot programs for interventions, screenings, and clinical referrals to individuals between 55 and 64 years old.<sup>107</sup> The ACA allows grants to be used for public health interventions including activities for improving mental health.<sup>108</sup> Further, the ACA allows grants to be used for mental health, behavioral health, and substance use disorders screenings.<sup>109</sup>

In order to carry out the grant activities, the ACA mandates State and local health departments to contract with mental health and substance use disorder service providers (among other possible contracting providers) for assisting with at-risk patient referrals and treatment.<sup>110</sup> Finally, the ACA further mandates that the HHS Secretary review evidence, literature, best practices, and resources relevant to healthy lifestyle and risk reduction programs including mental health issues.<sup>111</sup>

The ACA amends the Public Health Service Act definitions for mental health service professional and paraprofessional child and adolescent mental health worker to include, respectively: individuals with either graduate or post-graduate degrees in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling; and individuals who are not service professionals but work at the first stage of contact with either children or families.<sup>112</sup>

One of the ACA's innovations is the establishment of a national health care workforce commission, which serves as a national resource, coordinates government efforts, evaluates activities for meeting the health care worker demand, identifies barriers to government coordination, and encourages innovation for addressing various factors affecting health care worker demand.<sup>113</sup> For purposes of the national health care workforce commission, the ACA defines the health care workforce and health professionals to include behavioral health professionals, mental health professionals, and substance abuse prevention and treatment providers.<sup>114</sup>

In addition to establishing a workforce commission, the ACA authorizes a workforce development grant program for enabling State partnerships that plan and implement workforce development strategies.<sup>115</sup> The ACA requires the State partnerships to: analyze labor market information; identify high-demand health care sectors; identify workforce-related private resources; describe academic and health care industry skill standards; describe workforce education and training policies and practices; and identify government policy-related workforce development strategies, barriers, and plans to resolve those barriers.<sup>116</sup>

Physicians specializing in pediatric practice areas are, increasingly, more difficult to find because of a shortage of pediatric practices.<sup>117</sup> In order to address the pediatric physician shortage, the ACA establishes a pediatric specialty loan repayment program.<sup>118</sup> According to the ACA, the physician must agree to provide mental and behavioral health care (among other health services) to children, adolescents, or both in an area experiencing a shortage of such care but with sufficient pediatric population.<sup>119</sup> The loans are provided for a maximum of 3 years and \$35,000 per year.<sup>120</sup>

Regarding mental and behavioral health care, the ACA defines a qualified health professional as an individual who: (1) received either specialized training or clinical experience relevant to child and adolescent mental health; (2) received a license (or State certification) for practicing allopathic or osteopathic medicine in addition to several other professions; or (3) a mental health professional completing either specialized training or clinical experience relevant to child and adolescent mental health.<sup>121</sup>

Similar to the situation with pediatric specialization, primary care physician shortages are projected to worsen and further negatively impact the population's health.<sup>122</sup> The ACA attempts to correct the primary care "imbalance" by enhancing and updating the HHS Secretary's authority for providing primary care training program contracts and grants.<sup>123</sup> The grants may be used for:

- providing need-based financial assistance (for example, either traineeships or fellowships to medical students, practicing physicians, or other medical personnel specializing in family medicine, internal medicine, or general pediatrics);
- similarly, financial assistance could be provided for programs training physicians who intend to either teach or research family medicine, internal medicine, or general pediatrics; or
- provide grants for "new competencies" demonstration training programs.<sup>124</sup>

When awarding grants, the ACA requires the HHS Secretary to prioritize applicants proposing inter-professional models of health care integrating physical and mental health provision in addition to applicants providing training for the care of individuals with mental health or substance-related disorders.<sup>125</sup>

The ACA also distributes funds for training the long-term care workforce in relation to caring for mentally retarded individuals, among others. Specifically, the ACA authorizes the HHS Secretary to award grants to institutions of higher education partnering with nursing homes, skilled nursing facilities, or other entities providing home and community-based care in order to offer tuition offsets to direct

care workers.<sup>126</sup> Included among the possible employing entities are intermediate care facilities for individuals with mental retardation.<sup>127</sup>

Similar to the funding for primary care training but focusing on oral health, the ACA establishes grants for institutions and individuals training for careers in general, pediatric, or public health dentistry.<sup>128</sup> Grant applicants conducting teaching programs targeting individuals with either mental health or substance-related disorders will be given priority when the HHS Secretary awards grants under this section in addition to applicants intending to establish dental training for dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, complex medical problems, significant physical limitations, vulnerable elderly, or cognitive impairment.<sup>129</sup>

The ACA attempts to support the philosophy behind the U.S. Supreme Court's Olmstead decision by funding State-initiated provision of medical assistance for home and community-based attendant services and supports for Medicaid-eligible individuals with incomes—subject to some exceptions—equal to, or less than, 150 percent of the FPL.<sup>130</sup> The home and community-based attendant services and supports comprise assistance for accomplishing activities of daily living, instrumental activities of daily living, and other health-related tasks in addition to the acquisition, maintenance, and enhancement of skills necessary for accomplishing activities of daily living, instrumental activities of daily living, and other health-related tasks.<sup>131</sup>

States are specifically excluded from providing home and community-based attendant services and supports to Medicaid-eligible Individuals located in institutions for mental disease and intermediate care facilities for the mentally retarded.<sup>132</sup> Further, room and board, medical supplies and equipment, and home modifications are explicitly excluded from possible home and community-based attendant services and supports.<sup>133</sup> Eligible individuals are select, manage, or dismiss services provided by the State model.<sup>134</sup>

States opting to provide home and community-based attendant services and supports are eligible for an additional 6 percent federal match rate for reimbursable program expenses.<sup>135</sup> However, in order to receive the federal support, the ACA mandates, among other things, that the State maintain, or exceed, State expenditures for medical assistance under sections 1905(a), 1915, and 1115.<sup>136</sup> The State shall utilize either an agency-provider model or other models identified by the ACA (for example, provision of vouchers, direct cash payments, or fiscal agents) for providing home and community-based attendant services and supports.<sup>137</sup>

The ACA establishes the Community Living Assistance Services and Supports (“CLASS”) program. However, the Department of Health and Human Services suspended the CLASS program in October 2011 and the U.S. House of Representatives passed a repeal of the CLASS Act in February 2012; the U.S. Senate has not passed a similar bill. The CLASS Act established a voluntary long-term care insurance program for eligible beneficiaries with functional limitations and who paid premiums into the insurance program.<sup>138</sup>

The ACA revises numerous factors for calculating the Medicaid market basket in order to improve Medicaid’s sustainability. Specifically, the ACA (amended by the HRA) adjusts the market basket for inpatient psychiatric facilities by adding a productivity factor.<sup>139</sup> The ACA (as amended by the HRA) reduces updates to the daily base rate for psychiatric hospitals by:

- 0.25 percentage points for 2010 and 2011 (rate years);
- 0.1 percentage points for 2012 and 2013 (rate years);
- 0.3 percentage points for 2014 (rate year);
- 0.2 percentage points for 2015 and 2016 (fiscal years); and
- 0.75 percentage points for 2017, 2018, and 2019 (fiscal years).<sup>140</sup>

The ACA ties quality reporting by inpatient psychiatric hospitals to Medicaid market basket adjustments.<sup>141</sup> Failing to report the required quality data to HHS will reduce the annual update to the market basket by two percentage points.<sup>142</sup> The ACA authorizes the HHS Secretary to develop and publish (by 1 October 2012) a list of quality measures psychiatric facilities will be required to report.<sup>143</sup> Finally, the required quality measures will be made publicly available after the psychiatric facilities have the opportunity to review the facility’s data.<sup>144</sup>

Finally, the ACA establishes a pilot test for a psychiatric hospitals and inpatient units pay-for-performance program.<sup>145</sup> In addition to psychiatric hospitals and inpatient units, the ACA establishes pilot programs for several other providers.<sup>146</sup> The ACA limits pay-for-performance program expenditures to not exceed the anticipated expenditures for each provider type if the pilot program had not been implemented.<sup>147</sup> The HHS Secretary is authorized by the ACA to expand the pilot program indefinitely if the expansion reduces spending without reducing quality, or reduces spending and improves quality.<sup>148</sup>

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<sup>52</sup> The Affordable Care Act (Pub. L. 111-148) Section 2703(a).

<sup>53</sup> ACA Section 2703(a).

<sup>54</sup> ACA Section 2703(a).

<sup>55</sup> ACA Section 2703(a).

<sup>56</sup> ACA Section 2703(a).

<sup>57</sup> ACA Section 2703(a).

<sup>58</sup> ACA Section 2703(a).

<sup>59</sup> ACA Section 2703(a).

<sup>60</sup> ACA Section 5508(a).

<sup>61</sup> ACA Section 5508(a).

<sup>62</sup> ACA Section 5508(a).

<sup>63</sup> ACA Section 5508(a).

<sup>64</sup> ACA Section 5508(c).

<sup>65</sup> ACA Section 5508(c).

<sup>66</sup> ACA Section 5508(c).

<sup>67</sup> ACA Section 5508(c).

<sup>68</sup> ACA Section 10410(b).

<sup>69</sup> ACA Section 10410(b).

<sup>70</sup> ACA Section 10410(b).

<sup>71</sup> ACA Section 10410(b).

<sup>72</sup> ACA Section 10410(b).

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- <sup>73</sup> ACA Section 5604.
- <sup>74</sup> ACA Section 5604.
- <sup>75</sup> ACA Section 5604.
- <sup>76</sup> The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) Section 1301(a).
- <sup>77</sup> HRA Section 1301(b).
- <sup>78</sup> ACA Section 1302(b)(1)(E).
- <sup>79</sup> ACA Section 1302(b)(2).
- <sup>80</sup> ACA Section 1311.
- <sup>81</sup> ACA Section 1311(j).
- <sup>82</sup> ACA Section 2201.
- <sup>83</sup> ACA Section 2001(c).
- <sup>84</sup> ACA Section 2001(c)(2).
- <sup>85</sup> ACA Section 2001(c)(3).
- <sup>86</sup> ACA Section 2707(a).
- <sup>87</sup> ACA Section 2707(h)(1).
- <sup>88</sup> ACA Section 2707(h)(5).
- <sup>89</sup> ACA Section 2707(d).
- <sup>90</sup> ACA Section 2707(b).
- <sup>91</sup> ACA Section 2952(a)(1).
- <sup>92</sup> ACA Section 2952(b).
- <sup>93</sup> ACA Section 2952(b).
- <sup>94</sup> ACA Section 2952(b).
- <sup>95</sup> ACA Section 3107.
- <sup>96</sup> ACA Sections 3502(a), (b), and (c).
- <sup>97</sup> ACA Section 4001(h)(3).
- <sup>98</sup> ACA Section 4004(a).
- <sup>99</sup> ACA Section 4004(a)(5).
- <sup>100</sup> CCH's Law, Explanation, and Analysis of the Patient Protection and Affordable Care Act, Volume 1, Paragraph 1413.
- <sup>101</sup> ACA Sections 4101(a), (b).
- <sup>102</sup> ACA Section 4101(b).
- <sup>103</sup> ACA Section 4101(b).
- <sup>104</sup> ACA Section 4201(a).
- <sup>105</sup> ACA Sections 4201(c)(2)(A),(B).
- <sup>106</sup> ACA Section 4201(c)(4).
- <sup>107</sup> ACA Section 4202(a)(1).
- <sup>108</sup> ACA Section 4202(a)(3)(B)(ii).
- <sup>109</sup> ACA Section 4202(a)(3)(C)(ii)(I).
- <sup>110</sup> ACA Section 4202(a)(3)(D)(iii).
- <sup>111</sup> ACA Section 4202(b)(2)(B)(i)(IV).
- <sup>112</sup> ACA Sections 5002(b)(2).
- <sup>113</sup> ACA Section 5101(a).
- <sup>114</sup> ACA Sections 5101(i)(1),(2).
- <sup>115</sup> ACA Section 5102(a).
- <sup>116</sup> ACA Section 5102(c)(5).
- <sup>117</sup> CCH's Law, Explanation, and Analysis of the Patient Protection and Affordable Care Act, Volume 1, Paragraph 1517.
- <sup>118</sup> ACA Section 5203 amending the Public Health Service Act (42 U.S.C. 294n et seq.).
- <sup>119</sup> ACA Section 5203 amending the Public Health Service Act (42 U.S.C. 294n et seq.).
- <sup>120</sup> ACA Section 5203 amending the Public Health Service Act (42 U.S.C. 294n et seq.).
- <sup>121</sup> ACA Section 5203 amending the Public Health Service Act (42 U.S.C. 294n et seq.).

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<sup>122</sup> CCH's Law, Explanation, and Analysis of the Patient Protection and Affordable Care Act, Volume 1, Paragraph 1533.

<sup>123</sup> CCH's Law, Explanation, and Analysis of the Patient Protection and Affordable Care Act, Volume 1, Paragraph 1533.

<sup>124</sup> ACA Section 5302 amending Section 747 of the Public Health Service Act (42 U.S.C. 293k et seq.).

<sup>125</sup> ACA Section 5302 amending Section 747 of the Public Health Service Act (42 U.S.C. 293k et seq.).

<sup>126</sup> ACA Section 5302 amending Section 747 of the Public Health Service Act (42 U.S.C. 293k et seq.).

<sup>127</sup> ACA Section 5302 amending Section 747 of the Public Health Service Act (42 U.S.C. 293k et seq.).

<sup>128</sup> ACA Section 5303(2) amending Section 748 of the Public Health Service Act (42 U.S.C. 293k et seq.).

<sup>129</sup> ACA Section 5303(2) amending Section 748 of the Public Health Service Act (42 U.S.C. 293k et seq.).

<sup>130</sup> ACA Section 2401 amending Section 1915 of the Social Security Act (42 U.S.C. Section 1396n).

<sup>131</sup> ACA Section 2401 amending Section 1915 of the Social Security Act (42 U.S.C. Section 1396n).

<sup>132</sup> ACA Section 2401 amending Section 1915 of the Social Security Act (42 U.S.C. Section 1396n).

<sup>133</sup> ACA Section 2401 amending Section 1915 of the Social Security Act (42 U.S.C. Section 1396n).

<sup>134</sup> ACA Section 2401 amending Section 1915 of the Social Security Act (42 U.S.C. Section 1396n).

<sup>135</sup> ACA Section 2401 amending Section 1915 of the Social Security Act (42 U.S.C. Section 1396n).

<sup>136</sup> ACA Section 2401 amending Section 1915 of the Social Security Act (42 U.S.C. Section 1396n).

<sup>137</sup> ACA Section 2401 amending Section 1915 of the Social Security Act (42 U.S.C. Section 1396n).

<sup>138</sup> ACA Section 8002 amending the Public Health Services Act (42 U.S.C. Section 201 et seq.).

<sup>139</sup> ACA Section 3401 (f) amending Section 1886 of the Social Security Act (42 U.S.C. Section ).

<sup>140</sup> ACA Section 3401(f) as amended by ACA Section 10319(e) and HRF Sections 1105(d)(1),(2).

<sup>141</sup> ACA Section 10322(a) amending Section 1886 of the Social Security Act.

<sup>142</sup> ACA Section 10322(a) amending Section 1886 of the Social Security Act.

<sup>143</sup> ACA Section 10322(a) amending Section 1886 of the Social Security Act.

<sup>144</sup> ACA Section 10322(a) amending Section 1886 of the Social Security Act.

<sup>145</sup> ACA Sections 10326(a),(b)(1).

<sup>146</sup> ACA Sections 10326(b)(2),(3),(4), and (5).

<sup>147</sup> ACA Section 10326(d).

<sup>148</sup> ACA Section 10326(e)(1).