ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Department of Human Services
Office of Substance Abuse and Mental Health

Arkansas Community Mental Health Center Study

April 26,2024

Table of Contents

1. Executive Summary

Summary of Engagement

Arkansas's Department of Human Services (DHS), Division of Aging, Adult, and Behavioral Health Services' (DAABHS), Office of Substance Abuse and Mental Health (OSAMH) engaged Guidehouse to assess the Community Mental Health Center (CMHC) provider network in Arkansas.

This report summarizes the findings of Guidehouse's analysis. Guidehouse took a systematic quantitative and qualitative approach, including interviews with the statewide CMHC network of providers to understand the unique characteristics of each public service area (PSA). Guidehouse sought to identify gaps, barriers, and strengths within the current infrastructure of the CMHC provider network.

Governor Sarah Huckabee Sanders and the Arkansas Department of Human Services announced February 13,2024 a plan to invest $10 million to improve mental health and substance use services across the state through a statewide coordinated crisis response system. The statewide crisis response system will have a 24-hour call center that will allow first responders to connect individuals in crisis with the help they need. It will also include a creation of mobile crisis teams, new training for EMT, police, and other first responders on telehealth and patient evaluation. DHS will release a request for proposals (rfp) in 2024 for the procurement of a contract to build the statewide crisis continuum.

Key Findings

Throughout this work, the shifting needs of people seeking behavioral health (BH) services and the needs of the CMHCs who serve them were made apparent. The underlying factors driving the need for change include the increased cost to do business and the limited state funding available to meet the needs of people who are uninsured or underinsured. It is noted since the expansion of Medicaid in Arkansas and the addition of the Provider-Led Arkansas Shared Savings Entity (PASSE) to support people who need BH services, an objective quantitative and qualitative analytical approach to review how OSAMH contracted services through the CMHC network was a necessary step in moving the BH network forward in the delivery of high-quality, community based BH services.

The CMHC contracts have not been updated to align with the policy and population changes for people with SMI and SED. The purpose of the work the state is doing is to address the need for change and identify any community-based needs that have not been identified at the state level. There are anticipate Medicaid policy changes that will potentially allow for payment of services in both Institutes of Mental Disease (IMDs) and carceral settings as well as crisis hub. As the state moves away from fee for service models for Medicaid beneficiaries with Serious Mental Illness (SMI) and the CMHCs test new models of service delivery and payment methodology from Substance Abuse and Mental Health Service Administration (SAMHSA) grants CMHC contracts

should also shift to address the subpopulations of focus but also use new service delivery and payment mechanisms to more create less administrative burden and move individuals in need as quickly as possible into Medicaid coverage with full continuum of services.

2. Introduction and Methodology

2.1 Introduction

The Arkansas Department of Human Services (DHS) contracted with Guidehouse to explore opportunities to increase efficiencies, reduce administrative burden, and address BH service needs in Arkansas. DHS DAABHS recognizes the importance of focusing on the evolving needs for BH services in the State. For this purpose, the Office of Substance Use and Mental Health (OSAMH) was formed July 1, 2023, and a director appointed. OSAMH is charged with overseeing the service delivery and network of BH providers including the Community Mental Health Centers (CMHCs).

This study was focused on the work of the CMHCs as they play a vital role in proving accessible and comprehensive BH services across their public service areas (PSAs). These centers are essential hubs, even considered community safety net providers, for a wide range of diagnostic, therapeutic, and supportive services. With a focus on prevention, treatment, and recovery, CMHCs aim to address the diverse needs of communities. As part of that work, they promote mental well-being, the reduction of BH stigma, and access to those who need it most.

2.2 Arkansas Behavioral Health System Evolution

Arkansas uses a combination of Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) and State General Revenue (SGR) to reimburse Community Mental Health Centers (CMHCs) for the provision of services to people who are uninsured or underinsured with the primary focus on those in need of BH crisis services and the population who have been clinically diagnosed with Seriously Mentally Ill (SMI) or Seriously Emotionally Disturbed (SED).

Arkansas's 75 counties catchment areas were not designed based on alignment with other Department of Human Services (DHS) divisions or other state agency public service areas (PSAs). In addition, some of the PSAs have shifted through the years based on provider changes. Catchment areas have not changed with Arkansas population shifts, community resources, or prevalence of high need populations.

In many states, the CMHCs are the only Medicaid behavioral health service providers and the states have been able to develop contracts in which the services for a region can be reimbursed for both Medicaid and non-Medicaid through a blended funding contract. Arkansas functioned much in this same way until a brief mental health managed care program resulted in recruiting and enrolling BH providers that were not certified by the state as CMHCs.

This BH provider network was further expanded with AR Code § 23-99-802 "any willing provider" law. "Any willing provider law" is a law that prohibits discrimination against a provider willing to meet the terms and conditions for participation established by a health insurer or that otherwise

precludes an insurer from prohibiting or limiting participation by a provider who is willing to accept a health insurer's terms and conditions for participation in the provision of services through a health benefit plan." Medicaid enrolled agency providers under the Rehabilitative Services for Persons with Mental Illness (RSPMI) program and provided outpatient counseling services as well as paraprofessional services to Medicaid beneficiaries clinically diagnosed as SMI or SED. Once the RSPMI provider type certification was developed, the certification of CMHCs was discontinued. The differentiation between a CMHC and a RSPMI agency was contained in the state CMHC contract. The CMHCs continued to serve people who are Medicaid eligible, and the population identified in the state fund contract as uninsured or underinsured and provide other services that were not reimbursed by Medicaid.

While the child/youth population had been largely a Medicaid population since the inception of ARKids A and B Children Health Insurance Program (CHIP) which expanded the Federal Poverty Level (FPL) to 138%[1], the adult population FPL remained at 17% and most adults served (particularly those with SMI) were eligible for AR Medicaid due to Social Security Disability (SSD). When a person was identified with SMI and in need of the full array of RSPMI services, they went through the arduous process of obtaining SSD in order to become eligible for Medicaid. In 2014 this changed when Arkansas became a Medicaid expansion state and began covering people with incomes up to 138% FPL. People could also be identified as "medically frail" allowing RSPMI providers to bill AR Medicaid for services.

AR Medicaid RSPMI providers grew at such a rate that a moratorium on new providers was instituted in 2008.[2] New BH providers enrolling with the state were primarily focused on RSPMI services for children and youth primarily in school settings.

In 2018 Arkansas moved from the RSPMI program to a 1915 (i) program. This change created the process of an independent assessment to be complete for Medicaid beneficiaries to determine SMI or SED. This also changed the agency provider type from RSPMI, to Outpatient Behavioral Health Agencies (OBHA). OBHA agencies could only be reimbursed for paraprofessionals services for Medicaid beneficiaries who had received the annual independent assessment and scored a Tier 2 or 3. This clearly defined the SMI and SED population. In conjunction with the RSPMI program, Arkansas also permitted terminally licensed clinicians to enroll in AR Medicaid to provide counseling services to those who did not need the full array of BH paraprofessional and professional services.

The last change in the BH system is the addition of the move of the SMI and SED populations into a managed care program. Instead of traditional Managed Care Organizations (MCOs), Arkansas has required organizations that are 51% owned by Arkansas providers called Provider-led AR Shared Savings Entity (PASSE) to manage the care for the AR Medicaid beneficiaries with SMI or SED. The Medicaid changes through the years have shifted the original population of people who are uninsured and underinsured traditionally served by CMHCs.

[1] https://www.arkleg.state.ar.us/Healthcare/Timeline/Detail?id=29
[2] https://www.sos.arkansas.gov/uploads/rulesRegs/Arkansas%20Register/2017/june2017/016.23.17-001E.pdf

The Arkansas State Hospital (ASH) is part of the BH system. Over the years, there has been a shift in population served by ASH and though this is not related to Medicaid policy, it does impact the BH system at large. The ASH had units that were designated to provide BH services for people who have been court ordered to receive restoration services after being clinically determined to be unable to be tried for a crime due to SMI. The other ASH units served as a psychiatric hospital and the CMHCs were Single Point of Entry (SPOE) evaluators for entry into ASH based on high acuity of BH needs. Due to the Institution of Mental Disease (IMD) exclusion, all adult beds at ASH are funded through state general revenue. ASH currently has a wait list for forensic patients who are awaiting admission in jails across Arkansas. Due to this need, ASH has been forced to accept forensic patients almost exclusively with an average length of stay of 14 months at a cost of $890 per day.

There is a large majority of people who are uninsured and diagnosed with SMI in jails or ASH. They are uninsured because Medicaid is required to be suspended for inmates of a public institution, or those who are in an IMD such as ASH. Other people with SMI may need assistance with enrolling in AR Medicaid or completing the annual re-enrollment requirement. People experiencing a BH crisis may for the first time be accessing the BH system. Stabilization of the crisis is the priority, with community BH providers being the service provider. As part of the BH crisis service spectrum, funding is available for people who are uninsured. Also, community BH providers need to continue to assist with care coordination with coverage of step-down crisis services and assistance with enrolling in AR Medicaid. With retroactive Medicaid coverage, services delivered can be paid by AR Medicaid after the service date. Currently hospitals struggle with providing the service with no guarantee of payment or a delay in receipt of payment.

2.3 OSAMH Charge

OSAMH is the oversight entity for Arkansas's BH network including the twelve CMHCs. With the unwinding of the public health emergency (PHE), the State has had to review their BH funding across payer sources to look for ways to create efficiencies to support community BH services. The growing demand for inpatient, crisis, and community BH services has created system strain that needs to be better understood to develop actionable implementation strategies for access to the highest quality of care in the least restrictive setting within the parameters of available funding.

2.4 OSAMH Vision Statement and Goals for CMHC Project

To ensure consistency of focus during the study, OSAMH developed a vision statement to provide a clear sense of direction and serve as the framework for the development of this study. The vision statement and goals were the foundation in the development of Guidehouse's research to work on behalf of OSAMH. The vision for this work is: **To establish CMHCs within the landscape of Arkansas' BH system to fill the current infrastructure gaps, including BH crisis and justice-involved service continuums, and operate in an efficient and fiscally responsible manner.**

The goal of this project was to develop a comprehensive understanding of the current state of work across each of the 12 CMHC PSAs with focus on populations served, funding mechanisms, and service offerings.

2.5 CMHC Project Methodology

Guidehouse used a systematic process for analyzing the current state of the CMHCs and identifying findings. Guidehouse's analysis focused specifically on the work of the CMHCs contracted and funded through state funds—specifically Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) and State General Revenue (SGR) funds. As CMHCs also work with a broader list of payer sources, including Medicaid and payments through the Provider-Led Arkansas Shared Savings Entity (PASSE), OSAMH's focus was on the specific work through these state funding sources only.

As OSAMH aims to enhance the behavioral health system, Guidehouse created specific categories of research into three focus areas—payer mechanism, populations to be served, and services to be provided. From those focus areas, Guidehouse deployed research methods to collect information for the development of findings. Guidehouse methodology included:

Step 1: Feedback from Stakeholders:

a. Strategic Planning Meeting: As part of the initial stage of the project, Guidehouse conducted an onsite strategic planning meeting on August 24, 2023, with all 12 CMHCs with over 50 attendees to gain insight and feedback on the current state of service delivery for Arkansans who are justice-involved, and the current state of mobile crisis services/programs offered by the CMHCs. See **Appendix F** for Justice-Involved and **Appendix G** Mobile Crisis Team Services Work Group Scorecards and **Appendix H** to review key themes from CMHC Strategic Planning Meeting.

b. CMHC Provider Interviews: Guidehouse conducted 12 individual, onsite interviews from October 20th – November 15th, 2023. Interviews were completed in person by Guidehouse staff. Guidehouse developed an interview guide and CMHC BH Service Matrix that were reviewed and approved by OSAMH leadership prior to use in onsite interviews with the CMHCs. Each site visit lasted three to four hours and included, at minimum, C-suite staff, including the Chief Executive Officer, Chief Financial Officer, Chief Operating Officers, and Clinical managers. See **Appendix C** to review the CMHC Interview Guide and **Appendix D** to review the CMHC BH Service Matrix.

    - Interviewees were informed at the start of each onsite meeting that any information provided by them to Guidehouse would be de-identified to maintain anonymity in an attempt for the interviewees to be candid in their responses.

Step 2: Documentation and Report Review: As part of environmental scan, Guidehouse completed an analysis of materials made available for quantitative and qualitative examination. The following key documents and reports to support its assessment were reviewed:

a. Arkansas DHS Performance Based Contracting

b. CMHC Scope of Work - State Fiscal Year (SFY) 2024: General Service Delivery

Requirements

c. Crisis Services Report (CSR) (SFY2022)
d. Community and Client Services (CCS) Report SFY2022 – Client Services for Uninsured and Underinsured (with no payer)
e. Resources Summary Reports - Financial (SFY2019-2023)
f. Data from Medicaid Management Information System on payer enrollment (SFY2022)
g. First Episode Psychosis (FEP) Client & Service Data Report (SFY2022)

Step 3: Findings: Using information gathered throughout the research and analysis process, Guidehouse identified key findings focused on strengthening the CMHC network service delivery model to meet OSAMH's vision and goals for BH service delivery system in the State.

Considerations

Guidehouse acknowledges this study had the following limits:

Stakeholder Engagement: The information collected from CMHC provider interviews was one of several sources of information used to inform key findings. Several factors should be considered when interpreting and generalizing the input gleaned from these interviews. While these interviews were an effective means of communication and dialogue with in-state providers and staff members, Guidehouse recognized that this process did not allow feedback from all relevant providers and stakeholders within Arkansas's BH network. Interviews did not include other BH providers as noted in Arkansas's Any Willing Provider Law.

Data Limitations: Based on a limited timeframe and accessibility challenges with obtaining validated claims data, analyses in this report were conducted using existing self-reported service and people data collected from CMHCs by OSAMH.

3. CMHC Current State

Community Mental Health Centers

CMHCs are designed to support people seeking BH services in their communities. There is federal legislation that laid the foundation for the development of CMHCs. The two most influential pieces of legislation are the **Community Mental Health Act of 1963**, which intended to provide community-based care/treatment as an alternative to high-cost and restrictive institutional care settings for people with serious mental illness (SMI); and the **State Mental Health Planning Act of 1986**, which granted reimbursement to entities such as the CMHCs through Medicaid and Medicare. See **Appendices A and B** for additional information on these pieces of legislation. It is notable that current PSAs of the CMHCs are not legislatively mandated and have been solely funded based on population density. Total funding across the 12 CMHCs through the state funds totals $28 million dollars. All 12 CMHCs currently have identical contracts and SOW for serving the 75 counties in the State and operate under Arkansas Code Ann. 19-11-267 for contract and performance-based standards.[3]

CMHCs operate under a multiple payer mix. Arkansas payer enrollment data demonstrates that in SFY2022, **33.9%** of Arkansas's population were **enrolled in Medicaid** and **8.2%** of the population was **uninsured**. **Figure 2** demonstrates the population make-up and payer source across each of the 12 CMHCs in SFY2022. Of note, in April of 2023, Arkansas DHS began its Medicaid unwinding period following the termination of special eligibility rules following the COVID-19 Public Health Emergency (PHE). During the six-month unwinding, more than 420,000 recipients in total were disenrolled from the Arkansas Medicaid program.[4] For CMHCs, the PHE unwinding has led to increased demand for providing services to uninsured individuals, especially with high-cost services such as inpatient acute care.

[3] Arkansas Code § 19-11-267 (2020) - Development and use of performance-based contracts — Findings :: 2020 Arkansas Code :: US Codes and Statutes :: US Law :: Justia

[4] https://www.kark.com/news/health-news/arkansas-completes-medicaid-unwinding-with-more-than-400000-disenrolled-in-last-six-months/#:~:text=Arkansas%20completes%20Medicaid%20unwinding%20with%20more%20than%20400%2C000%20disenrolled%20in%20last%20six%20months,-by%3A%20Alex%20Kienlen&text=LITTLE%20ROCK%2C%20Ark.,month%20unwinding%20of%20Medicaid%20subscribers.

Figure 2: Payer Source and Enrollment by CMHC Region (SFY2022)

Region	CMHC	Total Pop.	Medicaid % (No.)	Uninsured % (No.)
1	Ouachita Behavioral Health and Wellness	173,467	37.0% (64.2K)	7.7% (13.4K)
2	Counseling Associates, Inc.	326,802	34.0% (111.0K)	8.0% (26.2K)
3	Counseling Clinic, Inc.	125,233	20.3% (25.4K)	6.1% (7.7K)
4	Delta Counseling Associates	67,301	45.2% (30.4K)	8.0% (5.4K)
5	Western Arkansas Counseling & Guidance Center	256,341	38.1% (97.6K)	10.0% (25.6K)
6*	Centers for Youth and Families	198,911	32.0% (63.7K)	8.1% (16.2K)
7	Mid-South Health Systems	570,051	39.6% (225.7K)	7.5% (42.9K)
8	Ozark Guidance Center	693, 300	27.3% (188.0K)	9.4% (64.9K)
9*	Professional Counseling Associates	281,768	30.7% (86.5K)	7.6% (21.3K)
10	Newhaven Counseling & Health Services / South Arkansas Regional Health Center	102,554	39.4% (40.4K)	7.3% (7.5K)
11	Southeast Arkansas Behavioral Healthcare System, Inc.	121,224	38.0% (46.1K)	6.0% (7.2K)
12	Southwest Arkansas Counseling & Mental Health Center	108,931	42.5% (46.4K)	9.2% (10.0K)

*Note: Pulaski County is split between regions 6 and 9. For estimation purposes, the total population, Medicaid population, and uninsured population data for Pulaski County is split in half. Percentages may be off due to rounding.
Source: Medicaid Management Information System – Payer Enrollment (SFY2022)

Guidehouse conducted additional data analysis to develop a robust picture of the payer mix that funds BH services provided through the CMHCs. We reviewed and analyzed five (5) years' worth of CMHC financial reports (SFY2019-2023) provided by OSAMH. Consolidated, the data demonstrates an overall payer mix shift **away** from Medicaid and DAABHS state funded services towards Private Health Insurance and Other Grants (see **Figure 3**).

Figure 3: CMHC Payer Mix Analysis (SFY2019 –2023)

Revenue Stream	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Medicaid (ALL)	52%	47%	44%	42%	43%
Medicare	3%	2%	2%	2%	2%
Private	5%	7%	8%	9%	10%
Self-Pay	2%	2%	1%	1%	1%
DBHS Grants	23%	22%	20%	20%	20%
Other Grants*	8%	9%	12%	17%	17%
All Other Income	7%	10%	12%	9%	8%

Note: See Figure 16 in the report for a chart listing the different funding and grants procured and used by CMHCs.
Source: Resources Summary Reports - Financial (SFY2019-2023)

OSAMH's current CMHC contract and SOW includes an array of behavioral, social drivers of health (SDoH), and community support service requirements. This assessment primarily focused on the provision and funding of keystone services through state funds and included BH Crisis Services, Justice-Involved Services, and Expanded Services.

While CMHCs aim to serve their entire community and provide services to all people in their PSAs, OSAMH's objective through the contracted state funds is to provide essential BH services for people who are uninsured or underinsured. Based on CMHC CCS Report self-reported data, **Figure 4** shows the most utilized services for uninsured and underinsured individuals across the State. It may be worthy to note for the majority of the core services being accessed and funded through state funds is for people who are underinsured meaning their health insurance plan is a high deductible plan (HDP), or inadequately covers behavioral health services. This is causing the CMHCs to leverage state funds to cover service cost based on assessed clinical need. The exception is BH crisis intervention services were provided to people who were uninsured at 2.5 times the rate of the underinsured. Further analysis to accurately evaluate and describe these trends will require additional claims level data.

Figure 4: Service Utilization through CMHC State Contracts for SFY2022

Services Received	Uninsured (Service Encounters)	Underinsured (Service Encounters)	Total
Adult Life Skills Development	642	1,567	2,209
Adult Rehabilitative Day Service	879	6,344	7,223
Behavioral Assistance	258	644	902
Case Management	816	9,125	9,941
Crisis Intervention	2,354	936	3,290

Services Received	Uninsured (Service Encounters)	Underinsured (Service Encounters)	Total
Group Behavioral Health Counseling	709	4,702	5,411
Individual Behavioral Health Counseling	3,724	22,916	26,640
Mental Health Diagnosis	808	1,657	2,465
Mobile Crisis Intervention	85	145	230
Peer Support	107	1,149	1,256
Pharmacologic Management	1,370	8,966	10,336
Psychiatric Assessment	314	685	999
Treatment Plan	1,256	2,067	3,323

Source: CCS Report (SFY2022) – contains self-reported data from each CMHC on client services provided to uninsured and underinsured. Note: Data from one CMHC regarding services is not available.

Acute Care Funds

The contract states that CMHCs will administer acute care funds for people experiencing a BH crisis that require psychiatric hospitalization if they do not have a payer and are not currently enrolled in a PASSE. Additionally, the contract states on page 8 (number 4, section iv) that CMHCs will utilize the acute care funds to secure "*acute hospitalization with another provider if a bed is not available at ASH.*" During the interviews, Guidehouse found a common concern among CMHCs was the rate at which they were spending their acute care funds and how they would continue to provide services when funds were exhausted.

Based on the monthly CSR submitted to DHS, there were a total of 11,213 adult screenings for inpatient/crisis residential services, with 17.5% of those screenings resulting in admission to "contract local inpatient services". The accrued acute care funds for bed days for SFY2022 totaled $3.2 million dollars (see **Figure 5**).

The CSR report does not currently capture the total accrued acute care funds utilized for people that need acute hospitalization due to a lack of admission availability at Arkansas State Hospital (ASH).

Figure 5: Acute Care Funds Utilized for Contract Adult Inpatient Services

Total # of Adult Screenings (includes active and non-active peoples 18+)	Total # of Adult Screenings Resulting in Admission to Contract Local Inpatient Services	Total Accrued Acute Care Funds for Bed Days for Contract Inpatient Services
11,213	1,959	$3.2M

Note: Three CMHCs are missing data for one to three months.
Source: CSR (SFY2022)

3.1 CMHC Behavioral Health Service Matrix

Guidehouse developed a CMHC BH Service Matrix as part of the individual CMHC onsite interviews to help evaluate the current state of contracted services delivered through CMHCs in the State (see **Appendix E** for full aggregated data from the BH service matrix). During the CMHC provider interviews, Guidehouse collected information on the CMHC's self-reported capacity via the BH service matrix and used a scoring guide of full, partial, and none to aggregate the data collected from the CMHCs. This was an exercise aimed at providing a quantifiable picture of the scope of services required in the contract provided through each of the CMHCs. Guidehouse used this BH Service Matrix to inform the development of findings in Section 4 of this report. This CMHC BH Service Matrix includes services CMHCs are required to provide as stated in the current CMHC contract and SOW. The CMHC BH Service Matrix includes the following service categories:

- Crisis services
- Single Point of Entry (SPOE) for ASH
- Expanded services
- Forensic Evaluation services
- Non-Medicaid Serious Mental Illness services
- Services within the Social Services Block Grant (SSBG)
- Other services (e.g., substance use disorder treatment services)

Considerations:

- For CMHCs who did not fully complete or return the CMHC BH Service Matrix, missing fields were populated based on interview notes and findings.
- MidSouth Health Systems CMHC completed one BH Service Matrix and service matrix results were applied across all Arisa PSAs. It was also noted during the MidSouth Health Systems/Arisa onsite interview that they provide all services the same across all four PSAs.

As part of the interview process, Guidehouse reviewed the core service requirements of SSBG funding with each of the 12 CMHCs. For the majority of the CMHCs, the list was not something they had reviewed previously nor were aware these were service requirements for use of SSBG funds. **Figure 6** contains the list of SSBG service requirements referenced in the CMHC SOW.

Figure 6: List of SSBG Services through this funding source[5]

Mental Health Services	Mental Health Services, Additional Units
Diagnosis	Identification/Assessment/Reassessment and Care Plan
Treatment Program Plan	On-Site Intervention
Individual, Outpatient Treatment	Off-Site Intervention
Group, Outpatient Treatment	Crisis Stabilization Intervention
Group, Partial Day Treatment	Collateral Intervention

[5] Arkansas Department of Human Services – Social Services Block Grant Program Manual

Transportation	Rehabilitative Day Services
	Diagnosis and Evaluation (Medical)
Supportive Services for Children and Families	**Prevention/Intervention Services**
Intake/Assessment	Mentoring
Staffing/Case Plan	Tutoring
Casework	Respite
Legal Support Services	Activity Fees
Supportive Activities	Integrated Support Services
Counseling, Individual and Family	Supportive Childcare
Diagnosis and Evaluation	Recreation
Medical Support Services	Communication Equipment
	Devices/Aides/Appliances

Each of the CMHCs interviewed gave a different interpretation of the provision of services they provide through SSBG funds based on **Figure 6**. A notable gap area was under **Prevention/Intervention Services.** This service section includes services such as mentoring, tutoring, respite, activity fees, integrated support services, supportive childcare, recreation, communication equipment and devices/aids/appliance. One CMHC stated they previously provided services from the prevention/intervention list but stopped in the last five years, stating it was not presented as a priority from the State contract and SSBG funds were being depleted in other areas more quickly with the primary source being acute bed stays.

One of the more salient patterns Guidehouse recognized throughout the interviews was the attitude among the majority of CMHCs expressing they would continue to provide the services their clients need, regardless of availability of funds. While this approach to serve the full population is honorable, without some type of payment source, the risk for CMHCs to fall out of compliance with contract standards remains a risk. Since the state funds are not earmarked within the CMHC contract, and staff must be paid for the care they provide, if the CMHC is unable to secure outside funding, such as grants, these state funds have a considerable potential to be mismanaged.

Justice-Involved Services

The current CMHC contract requires CMHCs to deliver services to people with BH needs who are also involved with the justice system. This includes the provision of SPOE screening services for people referred to ASH, the provision of post-acute coordination of services for people discharged from ASH, and forensic evaluation services. As seen in **Figure 7**, eight out of 12 CMHCs self-reported they are providing the full capacity of SPOE screening services for ASH, and five of the 12 CMHCs are providing the full capacity of post-acute care coordination.

Figure 7: Aggregate BH Service Matrix Capacity – Self-reported current service capacity for SPOE Screenings and Post Acute Coordination for ASH Compliance.

8 of 12 Full Capacity **5 of 12 Full Capacity**

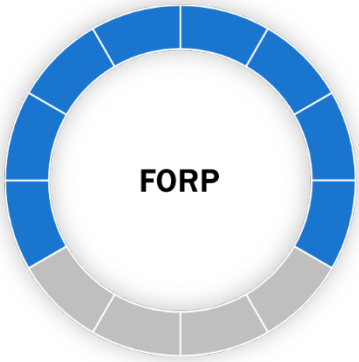
CMHC staff expressed substantial frustration with the number of referrals they receive from the judicial system to conduct SPOE screenings for ASH, as well as the significant amount of time needed to complete the assessments. While there is variation in the number of SPOE screenings conducted monthly across CMHCs, the data reflects SPOE screenings result in ASH admission less than 0.1% annually.[6] This is likely due to people with BH diagnoses not meeting the requirements for admission, long waitlists, and/or no capacity available at ASH. Additionally, people with forensic designation are typically a priority for admission. The CMHC contract requirement to deliver this service creates an unnecessary administrative and staffing bottleneck due to the lack of capacity at ASH.

Another contract requirement includes providing post-acute coordination for people discharged from ASH, and although five of the 12 CMHCs self-report they provide the full scope of these services in some respect, there are challenges associated with providing this coordination. CMHCs stated that individuals discharged from ASH may **not have housing** and because there is no funding for housing, **not all people discharged from ASH can be located and served**. Additionally, CMHCs are required to provide, at minimum, the "*pursuit of appropriate insurance coverage*" for people to be admitted to or discharged from ASH, and while CMHCs discussed multiple challenges with providing this service, including the administrative burden and large expenses associated with obtaining state-issued and approved IDs for people, most of the CMHCs continue to provide this service.

[6] CSR Report (SFY2022)

Figure 8: Aggregate BH Service Matrix Capacity – Self-reported current service capacity for Forensic Evaluation and Forensic Outpatient Restoration Program (FORP) Services compliance.

11 of 12 Full Capacity



8 of 12 Full Capacity

Although it was self-reported that most CMHCs provide the full scope of required forensic evaluation services (11 out of 12 CMHCs, shown in **Figure 8**), those CMHCs, in addition to the CMHC providing partial services, expressed challenges delivering these services**.** For example, on page 9 (section 5) of the contract, the current CMHC contract states that for forensic evaluation services, *"ensure a Qualified Psychiatrist or Qualified Psychologist is available to complete evaluations within required timeframes."* CMHCs noted that prosecutors' request, and judge's order a large volume of forensic evaluations and due to reported challenges with recruiting and retaining staff to perform forensic evaluations, some CMHCs have sub-contracted with forensic examiners to perform these services. The subcontractors can be an expensive addition due to the demand for their credentialing and services to meet this requirement.

Additionally, the contract/SOW requires that CMHCs administer FORP to people who have been deemed unfit to stand trial. While several CMHCs reported a strong FORP program (eight out of 12 CMHCs), other CMHCs noted challenges with keeping up with the increasingly high demand (i.e., more misdemeanor offenders being found unfit to stand trial) for FORP due to the large administrative burden, staffing shortages, and lack of available training for staff to administer FORP (see **Figure 8**). For any client the CMHC cannot serve in an outpatient setting, the "*CMHC must request ASH inpatient admission.*" As previously stated, there is minimal to no capacity for admittance to ASH, and as a result, CMHCs are required to provide additional services, including case management and medically necessary services to those clients awaiting admission to ASH using the contracted state funds at a significant rate and cost.

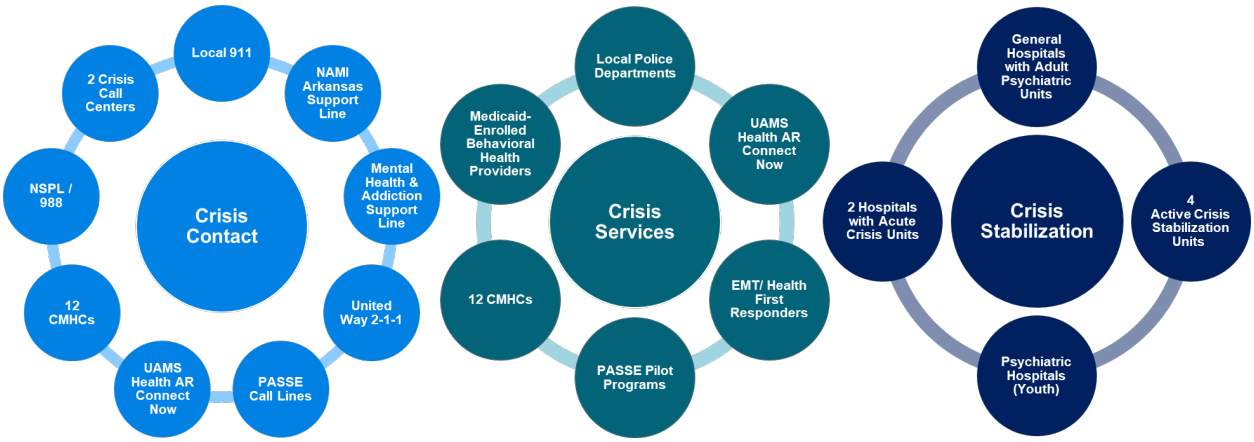
CMHCs demonstrated varying levels of success in partnering and collaborating with their associated justice systems. This includes engagement, communication, and training with law enforcement, judges, and prosecutors. One noted impact of this limited working relationship is the justice system misunderstanding of the role of CMHCs, as well as the availability of funding to provide the

necessary, contracted BH services. Some CMHCs stated that their associated judicial systems are under the assumption the CMHC has a 'petty cash' bucket of funding that is to be used at any time upon judicial request. There is a lack of consistent education and training between CMHCs, community organizations, and the judicial system around criminogenic thinking, specialty courts, and evidence-based practices such as FORP, Forensic Assertive Community Treatment, trauma-informed care, and substance use disorder (SUD) recovery-oriented care. CMHCs noted a need for reciprocal understanding with the justice system to ensure appropriate collaboration and delivery of justice-involved services. The relationships between the justice system and CMHCs impact the coordination of care, which impacts the treatment outcomes of people with BH diagnoses.

Behavioral Health Crisis Services

Arkansas's current BH crisis system infrastructure relies heavily on law enforcement and the use of local 911 emergency response centers for assistance. There are multiple organizations across the State through which a person can contact to receive crisis assistance, as seen in **Figure 9**. Most of these organizations operate independently of one another, creating a fragmented BH crisis network without shared data or the ability to track people through the care continuum.

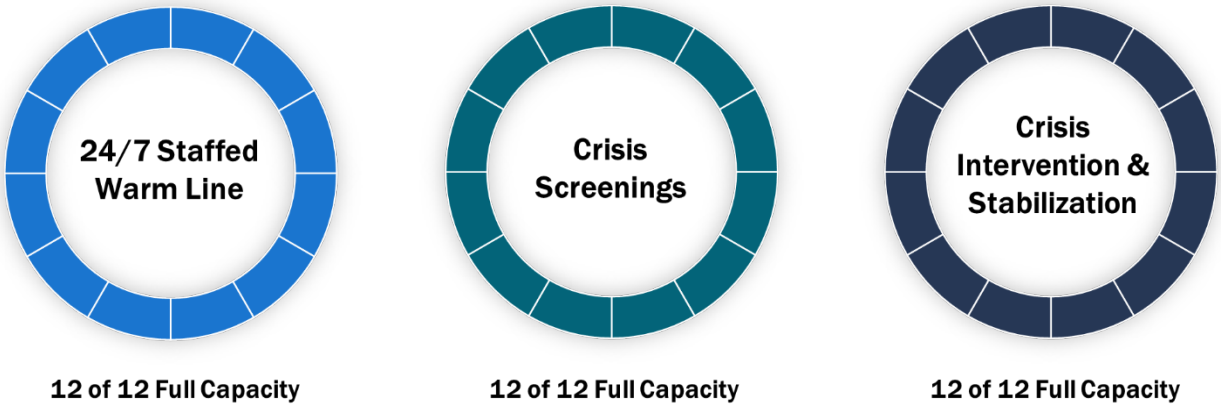
Figure 9: Current Behavioral Health Crisis System Infrastructure: Illustration of service availability with noted fractured interconnectivity across the BH service continuum.



CMHCs are part of the safety net of the crisis infrastructure within Arkansas, charged with providing essential services to people who are uninsured or underinsured. Within the State contract (pages 2-5), each CMHC is responsible for providing specific BH crisis services to people in the community, including "*Crisis Screenings*, *Crisis Intervention and Stabilization*, *Mobile Crisis Services*, *Mobile Crisis Assessment and Stabilization,"* and a "*24/7 Staffed Warm Line* ***or*** *Walk-In Clinic."* **Figure 10** shows a compiled view of the CMHC BH Service Matrix self-reported capabilities across CMHCs to meet

full requirements as defined within the contract and SOW for crisis services. The bulk of these crisis services are accessible in each service area and executed to contract standards.

Figure 10: Aggregate Service Matrix Capacity – Self-reported current service capacity for Crisis Services compliance



24/7 Staffed Warm Line

CMCH contract language for crisis services includes requirements to provide either a warm line *or* a walk-in clinic, with either service being required to be available evenings, weekends, and holidays. All 12 CMHCs have chosen to operate warm lines over walk-in clinics. Notably, the warm lines are implemented currently with varying degrees of contract compliance. Each CMHC operates an independent warm line, and few have integrated in any way with other community emergency services. Warm line coverage differences among CMHCs include variations in the following areas:

- Call center model with 24/7/365 access
- After-hours and weekend answering service
- On-call BH staff rotation
- Linked to 988 and calls routed to CMHC

While 12 of the 12 CMHCs report offering warm line services, Guidehouse was unable to acquire any data reporting to analyze related to call volume, demographics, referral sources, outcomes, etc. This lack of data availability into how the warm lines are being operated currently from a quantitative standpoint is a gap for the State to consider addressing in future state CMHC reporting.

Crisis Screening

CMHCs are to provide crisis screening services as the first step when a person presents with a BH crisis. From the BH screening, the CMHC can triage the situation and decide the appropriate level of response whether it be BH assessments, dispatch of mobile crisis teams (MCTs), engagement with law enforcement, etc. These services are meant to meet a person experiencing BH crisis urgent needs. While the contract details when and who these services must be provided to, it does not provide guidance on standardized tools beyond requiring it to be evidence-based. Consequently,

while all CMHCs report full capability to provide the services to their populations, the way this and the other crisis services based on screening findings differs vastly. For example, CMHCs completed over 18,000 BH crisis screenings in SFY2022 and **Figure 11** details the distribution of those screenings by population. There is a lack of data available to analyze the outcomes of the BH screenings currently. However, as of January 2024, many CMHCs have self-reported utilizing all or nearly all of their acute care funds for SFY2024.

Figure 11: Crisis Screenings (SFY2022) – Adult, Children, and Incarcerated Persons

Total # of Adult Screenings (18+)	Total # of Children Screenings (0-12)	Total # of Children Screenings (13-17)	Total # of Screenings for Incarcerated
11,213	1,447	2,156	3,642

Notes: Screenings of incarcerated persons includes screenings at ERs and other non-detention facilities; not all CMHCs reported crisis screening data for every month in SFY2022.
Source: CSR Report (SFY2022)

Crisis Intervention & Stabilization

CMHCs provide crisis intervention services via both telehealth and in-person across a variety of locations including schools, EDs, jails, and other community-based settings. The contract dictates many requirements in administering these services, such as, face-to-face assessments are to be completed within two hours. However, as there is no standard tool required within the contract and the CMHCs are currently utilizing different BH assessment tools. Several examples of these tools include the Patient Health Questionnaire-9, Columbia Suicide Severity Rating Scale, and Suicide Behaviors Questionnaire. Among the tools, there is a noted lack of suicide risk assessments being completed by all CMHCs. Following the assessment, the CMHC will develop an individual plan and, as necessary, include Suicide Assessment Five-Step Evaluation and Triage tools within said plan. There are many different BH services outlined within the SOW (pages 10-11, number 8) that meet people's BH needs which may include *Group BH Counseling*, *Individual BH Counseling*, *Mental Health Diagnosis*, *Peer Support*, *Pharmacologic Management*, *Psychiatric Assessment*, *Treatment Planning*, and *Acute Inpatient Admission*. It is noted that any emergency BH situations will override regularly scheduled appointments due to limited workforce to provide the array of services needed.

For some people experiencing a BH crisis, there is a service need that falls in between outpatient therapy and acute inpatient treatment. To account for this, Arkansas currently has four Crisis Stabilization Units (CSUs) that each serve multiple counties around the State. As of the writing of this report, one CSU in the Fayetteville area has announced plans to close. The CSUs were established as an alternative to partial inpatient psychiatric hospitalization, EDs, and jails for people experiencing a BH crisis. Approximately 50% of CMHCs self-reported having strong working relationships and communication with their local CSU, while other CMCHs, specifically in Southern Arkansas, are located two or more hours away from their closest CSU. The lengthy drive-time, in connection with pre-existing transportation issues and bed availability, have led the other half of CMHCs to struggle with utilizing their CSU as a resource. Out of the 12 CMHCs, only two identified having people experiencing a BH crisis admitted to a CSU during FY2022.[7] In addition to

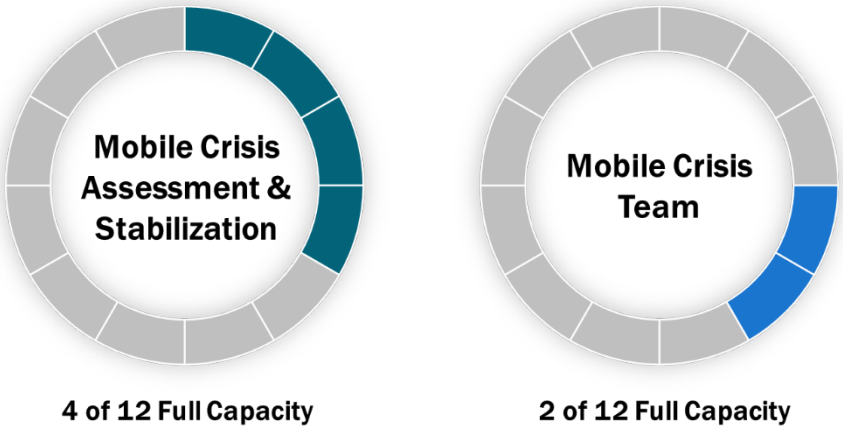
[7]Aggregated Crisis Services Reports (CSR) – State Fiscal Year (SFY) 2022

the CSUs, outlined in the contract, CMHCs must also provide supplemental crisis intervention and stabilization services in the form of Mobile Crisis Services and MCT.

Mobile Crisis Services

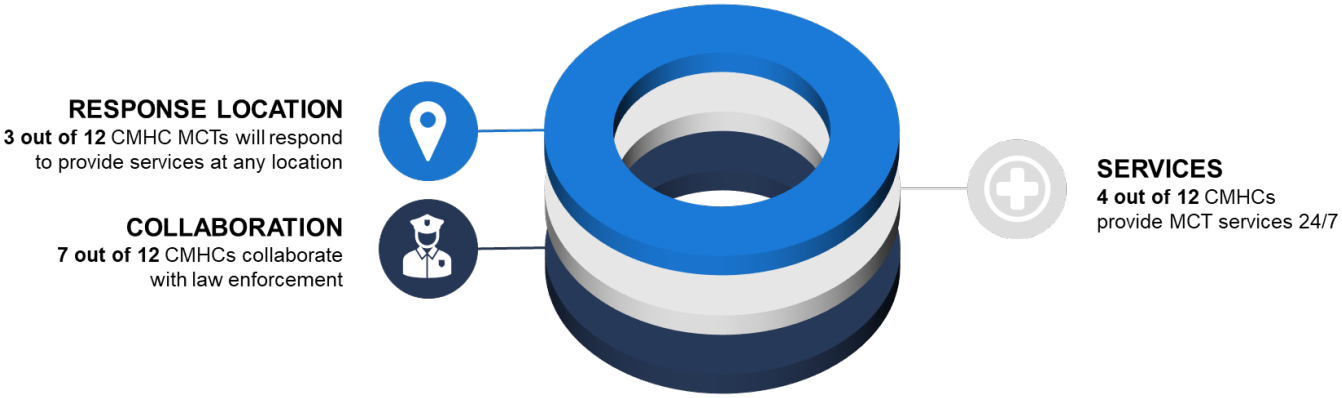
Mobile Crisis Services primarily consists of individualized triage, assessment, and stabilization activities, as outlined on page 2, number 2 of the SOW. It further defines MCTs as trained BH professionals who deliver the services and are available to respond to psychiatric or BH crises in the community 24/7. **Figure 12** demonstrates the self-reported capability of CMHCs to provide full Mobile Crisis Services.

Figure 12: Aggregate Service Matrix Capacity– Self-Reported current service capacity for Mobile Crisis compliance.



For most CMHCs, mobile crisis service delivery is limited to assessments of people experiencing a BH crisis who are either incarcerated, at their local ED, or (to a limited degree) in other public settings (e.g., parking lots). Several CMHCs noted their concern around safety issues associated with sending MCTs into the homes of people experiencing a BH crisis. Due to these safety concerns, lacking understanding of MCT services, funding, and other factors, eight out of 12 CMHCs are **not** currently providing full mobile crisis services and ten out of 12 are **not** providing MCTs to contract standards within their PSAs (see **Figure 12**). Those who do provide full MCTs utilize various staffing models: CMHC staff-only, co-responder models (CMHC staff plus law enforcement), or MCT embedded in law enforcement teams. **Figure 13** is a visual of the current MCT models deployed by CMHCs.

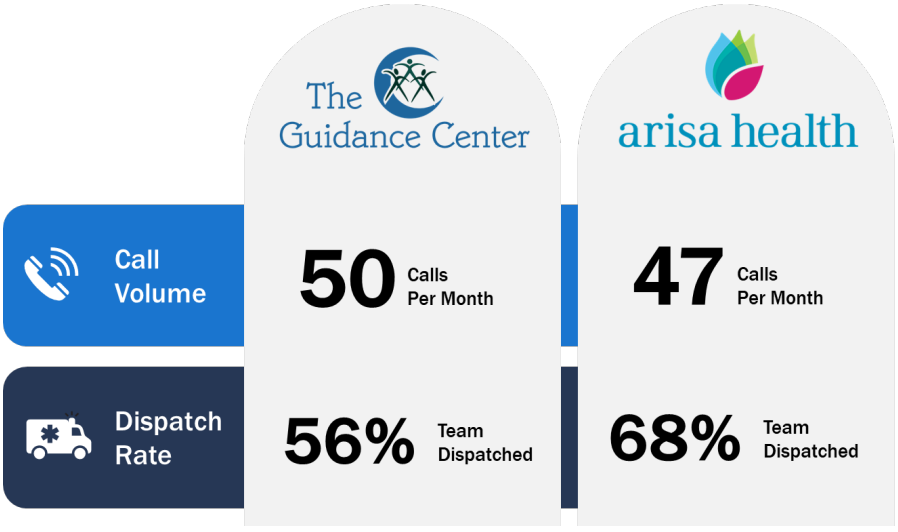
Figure 13: CMHC MCT Current State Models for BH Crisis Services



During CMHC interviews and subsequent analysis, Guidehouse found multiple associated factors that provide the basis for eight out 12 CMHCs being unable to provide full MCT services as defined within the contract. Services provided by MCTs are not yet billable through Arkansas Medicaid and while Arkansas DHS provides contract funding to provide these services, the funding is not sufficient to provide appropriate staff with proper training 24/7.

In April 2022, DHS launched two distinct MCT pilot projects, allocating funding through the MHBG and COVID Supplemental/CASH Act funds. Two CMHC providers, Western Arkansas Counseling and Guidance Center and Mid-South Health Systems (ARISA), were selected through a Request for Application and $1.5 million was divided between them to establish comprehensive MCTs. The pilot was originally meant to run from April 2022-March 2023, but a no-cost extension was approved to extend the pilot through March 14, 2024. These pilots are currently limited in providing response to people experiencing BH crisis in Sebastian, Crawford, and Craighead counties. Data on the outcome metrics on the performance of these pilot sites can be found in **Figure 14**.

Figure 14: Arkansas MCT Pilot Sites – Work Synopsis (Source: Arkansas DHS)



4. Findings

Guidehouse has synthesized all the information, both qualitative and quantitative, to develop study findings. Guidehouse then further categorized the findings into focus areas. See **Figure 15** for the finding categories used throughout section 4 of this report. It is important to note that Guidehouse received positive feedback from CMHCs regarding OSAMH's open, two-way communication, and it is suggested for this to continue.

Figure 15: Finding Categories

4.1 Service Delivery

The findings in this category are relevant to the delivery of behavioral health services through CMHCs in their assigned PSAs.

Finding #1: CMHC interviews demonstrated variation in how CMHCs interpret and implement the different service requirements within the CMHC contract. This open interpretation of the contract, along with the SOW language, has led to inconsistent service delivery that does not align with OSAMH's vision for services. For example:

- During interviews a common theme was the assertion that a 'requirement(s)' in the CMHC contract are old carry-over obligations and no longer services being delivered. This statement was also made by OSAMH staff.
- CMHCs report varied use of peer support models due to barriers in certification process of peers and having separate requirements for peers for mental health versus peers for substance use disorders. These is a lack of clarity of supervision of peers internally to each CMHC. There is a lack of consistent peer training for certification to be completed.
- CMHCs operate under a contract with a lump sum payment model. In the past the funding had specific line items with funding allowances attached for clarity in services to be provided. Due to this lump sum configuration, CMHCs have taken it upon themselves to internally obligate funds to services. Then, once a specific obligated budget is depleted, return to the State asking for additional funds to continue providing the service. CMHCs

also state they would have to start 'turning people away' due to the depletion of obligated funds.

Finding #2: There are contract requirements that represent a potential duplication of effort for services aimed at people who are justice-involved, as many jails are also contracting with medical providers to deliver medical and BH services to inmates. Relatedly, some contract requirements assume a level of engagement with jails that may not be present, putting them out of compliance. Approximately 50 percent of Arkansas's jails contract with a private health care company (i.e., Turnkey, Advanced Correction Healthcare, and Southern Health Partners) that currently provide both medical and some mental health services, while CMHCs continue to provide assessments and intervention services. There is potential duplication of service delivery by contracted private health providers in jails and service delivery through CMHCs.

The CMHCs relationship with law enforcement, including jails, determines their level of working collaboration. Some CMHCs provide a full array of BH services to incarcerated people, while others are only able to provide reduced services from behind glass. For example, the SFY24 CMHC SOW states:

- On page 5, number 7b- "*For difficult to place adults, or if there is delay in locating acute placement beyond twenty-four (24) hours, the CMHC shall work with the jail to ensure appropriate treatment, including medication management, is available.*"
- On page 9, number 3- *"If the CMHC has not previously been made aware of the need for mental health evaluation, the order for an ACT 327, 328 or ACT310 shall serve as a trigger event to alert CMHC to screen the individual for possible need for mental health services, including psychotropic medication for those not residing in jail. For people residing in jail, the CMHC shall work with the jail to ensure appropriate treatment, including medication management is available."*

Finding #3: While each CMHC operates their own 'warm line' for people experiencing a BH crisis, the warm line is not being utilized as a crisis line in all CMHC PSAs. The CMHC contract states on page 4 (section xi) that CMHCs are to offer a warm line that is "*available after business hours on weekdays and holidays, which will be highly accessible, well publicized, and capable of providing low-threshold mental health resource and access to a licensed mental health professional from which the public can seek support before they've reached a crisis point*". Operation of the warm line varies across the CMHCs, with each having their own local and toll-free number for people to call. This is a fragmented and confusing process for people experiencing BH crisis to navigate. For example:

- The CMHC contract language gives CMHCs the option to offer walk-in/drop-in clinic or a warm line as part of their contract deliverable, creating further variations in availability and access to BH crisis services.
- Some CMHCs have on-call staff 24/7/365, while others employ an answering service agency for after hours and weekend coverage. Staffing of the warm lines, including training or credentialing of staff answering the warm line also varied and appeared to be an internal CMHC decision.

Finding #4: CMHCs are currently using various screening tools, resulting in inconsistent data gathering. BH outcomes are not being identified statewide and tracked. There is a lack of defined use of suicide risk screening tool, staff models, and availability of training. On page 6 (number 2, section i), the contract includes the requirement to "*utilize the state-approved SPOE Screening form*" and an additional "*evidence-based crisis screening tool*" but does not specify standardized screening or assessment tool(s). For example:

- BH screening and assessment tools (e.g., Patient Health Questionnaire-9, Columbia Suicide Severity Rating Scale, Suicide Behaviors Questionnaire) when interacting with people seeking BH services, including for those experiencing BH crises. It was observed that CMHCs are varied in their deployment of suicide risk screenings when interacting with people seeking BH crisis service assistance.

Finding #5: Related to service delivery, CMHCs presented different approaches for providing their staff with training. Some reported they can provide training and certifications, while others struggle to find the resources to provide required training.

Finding #6: FEP services are included in CMHC contracts; however, it is not a highly utilized service. According to SFY2022 FEP reports, per month, only two CMHCs reported 26 or more FEP clients. Of the remaining, half reported between 10 and 25 FEP clients, and the other half* reported fewer than ten. Majority of the FEP clients each CMHC reported are the same FEP clients receiving services month to month. See **Figure 16**.

Figure 16: Number of FEP Clients Reported by CMHCs per Month (SFY2022)

# of FEP Clients	# of CMHCs
<10	5
10-25	4
>26	2

*Note: Not all CMHCs reported FEP data for every month in SFY2022. FEP data not available for one CMHC.
Source: FEP Reports (SFY2022)

Finding #7: During interviews with CMHCs, there was clear frustration with providing SPOE services. CMHCs articulated the staffing burden required to complete the SPOE screenings for ASH entry combined with the present, unresolved barrier to inpatient admissions—long waitlists and ASH beds being full of people with forensic designation.

- As seen in **Figure 17**, data from the SFY2022 CSR demonstrates that, of the 11,213 adult crisis screenings performed for both active and non-active peoples for inpatient / crisis residential services, only 15 (**0.1%**) people were admitted to ASH in that year.

Figure 17: Total Number of Adult Crisis Screenings & Number of Screenings Resulting Admission to ASH (SFY2022)

Total # of Adult Crisis Screenings	Total # of Screenings Resulting in Admission to ASH
11,213	15 (0.1%)

Note: CSR data does not include a separate count of the number of SPOE screenings or the number of incarcerated persons who were screened and admitted to ASH.
Source: CSR Report (SFY2022)

Finding #8: Although the CMHCs' contract outlines their role in transitioning individuals discharged to the community from ASH, there have been minimal positive outcomes of this service.

Finding #9: Many CMHCs are reporting a rise in the number of requests for psychiatric evaluations from judges and attorneys within the justice system without a matching rise in those who were deemed unfit to plead. This trend, which may be attributed to defense strategies, has led to additional staffing and financial challenges.

Finding #10: Despite Rehabilitative Day Service (RDS) being a Medicaid reimbursable service, CMHCs often use state funds to provide this service. As a Medicaid service, rural CMHCs' s RDS provides a broad array of SDoH support needs for people who are experiencing housing instability. Housing instability can cause people participating in RDS to lose Medicaid eligibility and when this happens, the CMHCs use state funds to cover the cost of RDS until Medicaid is restored. In many cases this means covering the continued basic necessities that would be covered through RDS such as meals, shelter during business hours, and transportation for this population.

- **State Example:** California's Medicaid transformation initiative called CalAIM launched in 2019 and one focus was on Day Rehabilitation programs for people experiencing homelessness that focus on building the skills necessary for community participation, maintaining interpersonal relationships, and daily living.[8]

Finding #11: CMHCs noted difficulty delivering services due to the variation in credentialing requirements for staff to deliver the service based on an individual's payer source (e.g., Medicaid, Medicare, private insurance). For example:

- The contract states on Page 2, number 1 (section iii) of the CMHC contract lists for mobile crisis services "*CMHC behavioral health professionals shall make phone contact with a requesting agency within fifteen (15) minutes of a request for a crisis assessment.*"
- The SOW states:
  - On page 3, number 2c- "*The CMHC's Mobile crisis team **shall** include a physician/APN and licensed behavioral health professional, available 24/7, and who have been trained in psychiatric and behavioral crises.*"
  - On page 3, number 2c (section ii)- "*The CMHC's Mobile Crisis team **shall** include a physician/APN, or at a minimum direct access to a physician, as needed.*"
  - On page 9, section C (number 5)- Forensic Evaluations - "*The CMHC shall provide a Qualified Psychiatrist or Qualified Psychologist to perform the initial ACT 327 or ACT 328*

[8] CalAIM Community Supports Early Adopters Webinar Series - Center for Health Care Strategies (chcs.org)

evaluation, or subsequent ACT 310 Evaluations, as defined in Arkansas Code Annotated (ACA) §§ 5-2-301 through 5-2-329"

- On page 10, number 8a (section i) FORP – "*Peoples being seen for FORP educational purposes involving restoration may be seen by either a Licensed Mental Health Professional and (or) a Qualified Behavioral Health Provider (QBHP); however, if psychotherapy is warranted for a People, this service must be provided by a Licensed Mental Health Professional.*"

Finding #12: CMHCs have stated they use state funds to cover Medicaid reimbursable services through PASSEs due to service denials. CMHCs are facing challenges with PASSE service denials due to variations across the four PASSE entities. This occurs when a person the CMHC provides BH services to switches PASSEs and then services (long rendered), are now denied inflicting stress and trauma upon the PASSE member. Oftentimes, the CMHCs choose to overcome this issue and attempt to continue to provide continuous services by using state funds while the person's care plan is reviewed. For example, CMHCs have had PASSEs stop payment on Therapeutic Community service stating, "*person does not meet medical necessity*." CMHCs then must rely on state funds to fill the payment gap as the CMHCs prioritize the needs of the person receiving services.

4.2 Funding

This category includes findings relevant to current state of CMHC contract work through the state fund contract.

Finding #13: CMHCs expressed that current funding does not meet service delivery costs. A review of contract budgets and findings from interviews with the CMHCs suggested current funding available to CMHCs through the state contract is not sufficient to cover contract requirements. The majority of the CMHCs are subsidizing the contract service delivery requirements with other funding sources, including grants. CMHC providers are notably out of compliance with their contracts and have had to take staff away from service delivery to attempt to secure additional funding to meet contract requirements (i.e., leveraging clinical staff to support grant writing). CMHCs seek additional grant money to subsidize programs and services. For example:

- CMHCs stated in interviews the physical location leased costs have increased with inflation, as have the cost of utilities, and insurance coverage of the physical locations.
- CMHCs have had to address workforce shortages to meet capacity requirements. Many BH professionals begin their career and build experience while working within a CMHC and then leave CMHC providers to go work private practice or for other BH providers who have a more limited-service delivery model including not being required to provide afterhours care and often list the local CMHC warm line number as an afterhours contact. For CMHCs to attempt to attract and retain high quality BH professionals, they have had to develop innovative investment efforts to include such things as: tuition assistance, enhanced benefits packages, bonus pay, paid time off cash out, telework agreements, and leadership academies.

Figure 18 is a self-reported list containing all additional funding sources captured during CMHC onsite interviews.

Figure 18: Additional Funding Sources

Additional Funding Sources		
United Way	Therapeutic Counseling Grant	Local community grants
SAMHSA CCBHC grants	Department of Children & Family Youth Services Contracts	Donations/fundraising
DHS Grant in Northeast	Department of Justice grants in NE and Central	Division of Youth Services programs
Blue and You Foundation	Giving Tree Foundation	Projects for Assistance in Transition from Homelessness
100 Families	Ark Crisis Hotline	Drug and Alcohol Safety Education Program
Fort Smith Boys and Girls	Fort Smith Police	Med Detox
MHTC Sebastian & Crawford	Safe Care	UAMS Medication assisted Treatment
Veterans Court	AR ORP Opioid Fund	Fort Smith Block Grant
US Probation	Harbor House	AR State Probation
Fundraising	CCBHC	SAMHSA grants

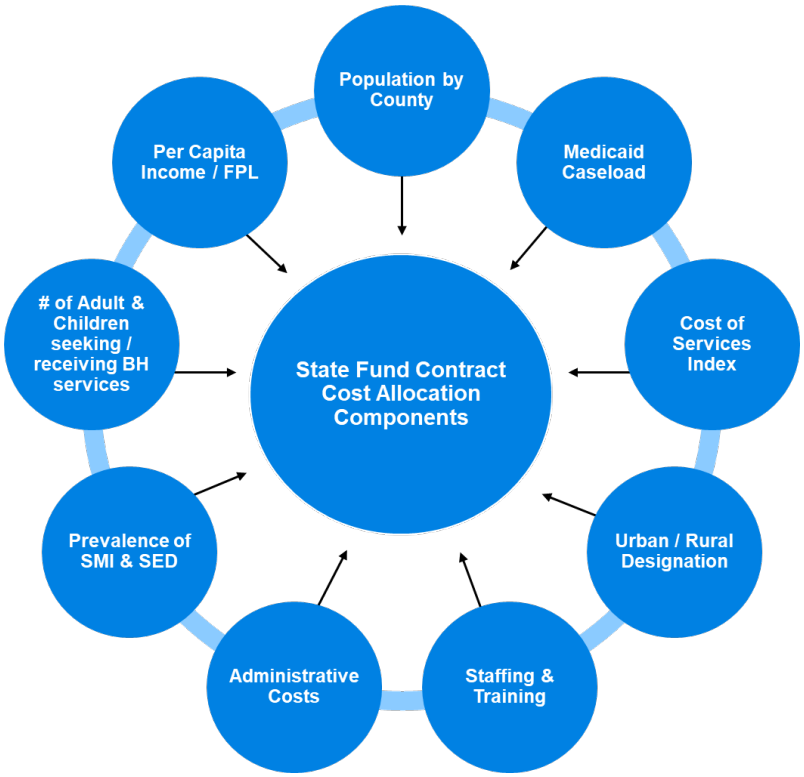
Finding #14: The CMHCs identified the need for more funding for care coordination (some CMHCs use CCBHC funding, but not sustainable), staff trainings (e.g., evidence-based treatment), administrative tasks (e.g., helping with obtaining Medicaid), transportation, staff recruitment/paying competitive wages, etc. CMHCs currently pursue other funding sources to supplement coverage of costs to do business and provide BH services in their communities.

Finding #15: Varying levels of financial stability amongst the CMHCs have led to disparate abilities to provide staff with evidence based BH training.

Finding #16: Current funding allocations do not include additional environmental and service capacity factors that impact utilization and need for state funded services as supported by the CMHCs.

Finding #17: Historically, in Arkansas, MHBG funds have been allocated to CMHC regions based on census data. Current funding allocations available through CMHC contracts to support people with BH needs who are under or uninsured have not kept pace with rising costs and do not factor in Arkansas's expansion of Medicaid services or demographics related to poverty shifts, causing strain on CMHC operations in their respective PSAs.

Figure 19: State Fund Contract Allocation Components – Best Practice Examples



- **State Example:** The Wisconsin's Division of Mental Health and Substance Abuse Services developed a "Community Aids Formula Allocation" for the allocation of MHBG funds.[9] The allocation is "based on each county's population, Medicaid caseload, and per capita income." In addition, Wisconsin requires reporting on the number of individuals served by the allocation, how much of the funding was spent, and how the funding was spent to inform future MHBG allocations.
- **State Example:** Alabama utilizes a hybrid resource-allocation model to ensure sustainable funding for the state's substance use prevention programs.[10] This hybrid model combines equity resource allocation and need of the population by county/catchment area to ensure there is additional funding available in areas based on the prevalence of substance use.

[9] Community Mental Health Services Block Grant – Community Aids Formula Allocation and Reporting Requirements (wisconsin.gov)
[10] Implementation (alabama.gov)

Finding #18: Through CMHC interviews, it was voiced that there is limited use of FEP services across the CMHC PSAs and the funding does not support extensive outreach and service coordination with the communities.

4.3 Reporting

This section of findings is focused on data and reporting observations in the current state of CMHC work.

Finding #19: The current contract includes broad language for *"general reporting"* and does not lay out the data collection requirements with a level of specificity that would provide clarity to providers and benefit OSAMH in tracking contract compliance and outcome driven measures. For example:

- The SOW states:
  - *On page 17, section 2b- "The CMHC shall document all services rendered via the Contract's funding sources."*
  - *On page 17, section 2d- "Reporting that is client specific and includes at a minimum, first name, last name, date of birth, social security number and service(s) rendered."*
- The contract states on page 20, section 11 (vii)- *"Report budget information, unduplicated Client identification, Maintenance of Effort (MOE), and quality improvement activities on an annual basis."*

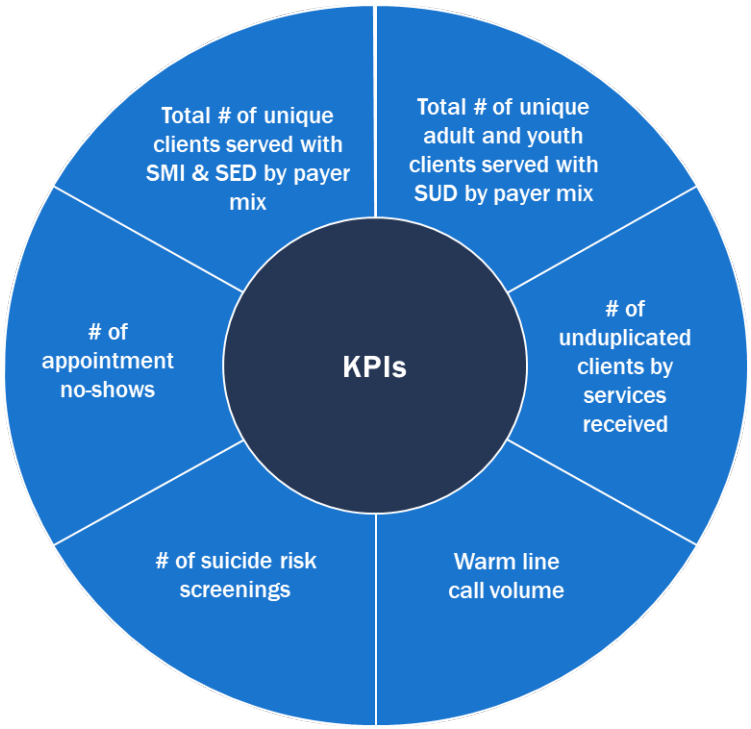
Finding #20: The current CMHC reporting requirements do not align with the focus of the CMHC scope of services and desired BH outcomes that OSAMH needs to track for quality assurance purposes and reporting to SAMHSA. CMHC report data metrics were last updated over 10 years ago per OSAMH staff interviews. OSAMH does not currently have the ability to review CMHC reports in a way that gives them the analysis they need to make management decisions, including contract revisions.

Finding #21: CMHCs stated the current monthly reports submitted to OSAMH take considerable staff time and capacity. Numerous reports must be run across systems at the CMHC level and tabulated to produce the data to populate the report for OSAMH. CMHCs stated they receive limited technical assistance for data reporting issues and errors.

Finding #22: Due to the misalignment of current reporting, monthly data reported to OSAMH is not used consistently to create, evaluate, or support quality improvement initiatives.

Finding #23: CMHCs reported varied awareness and utilization of the State Health Alliance for Records Exchange system (SHARE) electronic system. For CMHCs indicating they use the SHARE system, report and information pulling was inconsistent and cumbersome.

Figure 20: Key Performance Indicators (KPIs) across CMHCs: Examples of KPIs for OSAMH to consider for behavioral health system data tracking and reporting.



4.4 Community Partnerships

This section highlights finding relevant to the community-driven nature of the current state of CMHC work including interactions with other community providers, resources, and stakeholders.

Finding #24: The differences in services provided by rural versus urban CMHCs have corresponding effects on their roles in their respective communities. Most rural CMHCs have evolved to function more as holistic safety net providers within their communities due to the lack of other available providers, services, or resources.

Finding #25: Urban CMHCs demonstrate they have established connections with other community organizations to help meet the unique needs of people when services are outside of the CMHC contract scope, whereas rural CMHCs have adapted to providing more services themselves to address SDOH factors (e.g., socioeconomic status, housing and transportation options, smaller populations with higher rates of SMI, etc.). Examples of unique programs CMHCs developed in partnerships in the community:

- A gang violence coalition targeting prevention and offering grief counseling, engagement with local schools, in-house pharmacies, a food pantry, shuttle services, being a Representative Payee for people with BH diagnoses, paying bills on behalf of people living with SMI, etc.
- CMHC becoming a Representative Payee for people accessing services through their organization who are unhoused. This enables the people to receive their social security payments, pay their bills and have access to their money to purchase necessities.
- For people participating in RDS who are housing unstable and temporarily lose Medicaid coverage, CMHCs step in with other funds to cover access to the service to maintain consistency in the person's life and meet basic needs until Medicaid can be restored.

Finding #26: Several CMHCs stated they had minimal partnerships with law enforcement, the justice system, and providers specifically in the areas of comprehensive treatment and discharge planning and it varied greatly from PSA to PSA. The justice entities appear to work in silos due to a shortage of resources (e.g., funding and staff), despite all being vital partners in the continuum of care. Additionally, education and training for law enforcement and judicial system regarding the role CMHCs play within the BH system is fragmented. For example:

- The contract states:
  - On page 8, number 4 (section vi)- "*Coordinate discharge planning with the original referring CMHC*".
- The SOW states:
  - On page 3, number 2c- "*Coordinate with local law enforcement agencies, judges, jails, hospitals, and acute crisis units to develop procedures for treatment of crises in each of the facilities*".
  - On page 5, number 5- "*Coordinate with the community partners to ensure comprehensive aftercare planning for individuals with a psychiatric and behavioral crisis who are frequently jailed or are in frequent acute crises*".
  - On page 8, number 5e- "*Coordinate with the State to ensure"* people with Act 911 Status *"receive the needed treatment within the community".*

Finding #27: There is a misunderstanding in the communities they serve of the role of the CMHC. CMHCs express concern for their reputation because of these misunderstandings about roles and available funding. For example:

- CMHCs state having complaints filed against them by jails and prosecutors for not finding placement for inmates with BH needs.
- There are penalties for CMHCs in forensic services for missed deadlines of forensic reports, regardless of whether the delay is caused by the justice system itself.
  - CMHCs expressed they feel they have developed a reputation of "*not doing our jobs*" because of these misunderstanding of role and available funding.

Finding #28: Behavioral health stigma is an ever-present problem in communities, and it impacts people's ability to recognize and seek help when experiencing a BH crisis or even to seek out BH services to prevent the onset of a crisis. Pervasive stigmatizing attitudes and discriminatory practices

underlie many structural and nonstructural impediments and contribute to gaps in governance, financial and human resources, and legislation which limit the availability, accessibility, and affordability of mental health services.[11]

In conclusion, the information presented in this study is meant to serve as findings for consideration for the enhancement of the behavioral health system to meet the evolving behavioral health needs of the citizens of Arkansas. These findings are for informational purposes based on the qualitative and quantitative information provided to Guidehouse.

[11] https://www.emro.who.int/mnh/campaigns/anti-stigma-campaign.html

Appendices

Appendix A: Summary of BH Federal & State Laws & Regulations Impacting BH Agencies

As part of this work, Guidehouse researched federal and state laws and regulations that impact BH Agencies.

Federal Laws and Regulations

National Mental Health Act of 1946 (P.L. 79-487)[12]

- Established the National Institute of Mental Health (NIMH), an organization whose intent was to apply the public health approach to mental health. This act allowed the federal government to provide grants supporting state outpatient treatment and to create new centers.

The Community Mental Health Centers Act of 1963 (Title II OF P.L. 88-164)[12]

- Court rulings and laws emerged that made involuntary hospitalization more difficult and enforced higher-quality care in psychiatric hospitals. Thus, hospital administrators were encouraged to reduce their inpatient population, and the total number of people decreased eighty-two percent from 1955 to 1988.
- Provided federal funding for CMHCs and research facilities in the U.S.

Mental Health Systems Act of 1980 (Public Law 96-398)[12]

- Expanded the community mental health centers program and created a federal-state-local partnership to help the chronically ill, children, the elderly, minorities, women, the poor, and rural populations.

The State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660)[12]

- Amends title XIX (Block Grants) of the Public Health Service Act to authorize the Secretary of Health and Human Services to make grants to States for the development of State comprehensive mental health services plans.
    - Allowed CMHCs to receive reimbursement from Medicare and Medicaid.

Conditions of Participation (CoPs) for the Community Mental Health Centers (78 Fed. Reg. 64603)[13]

- The CMHC COPs are located at 42 CFR 485.904 through 42 CFR 485.918. The CMHC CoPS include:

[12] National Institute of Mental Health (NIMH) | National Institutes of Health (NIH)
[13] Community Mental Health Centers | CMS

- §485.914: Admission, initial evaluation, comprehensive assessment, and discharge or transfer of the people: The CMHC must ensure that all peoples admitted into its program are appropriate for the services the CMHC furnishes in its facility.
- §485.916: Treatment team, person-centered active treatment plan, and coordination of services: The CMHC must designate an interdisciplinary treatment team that is responsible, with the people, for directing, coordinating, and managing the care and services furnished for each people. The interdisciplinary treatment team is composed of people who work together to meet the physical, medical, psychosocial, emotional, and therapeutic needs of CMHC people.
- §485.917: Quality assessment and performance improvement: The CMHC must develop, implement, and maintain an effective, ongoing, CMHC-wide data-driven quality assessment and performance improvement program (QAPI). The CMHC's governing body must ensure that the program reflects the complexity of its organization and services, involves all CMHC services (including those services furnished under contract or arrangement), focuses on indicators related to improved BH or other healthcare outcomes, and takes actions to demonstrate improvement in CMHC performance. The CMHC must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.
- §485.918: Organization, governance, administration of services, and partial hospitalization services: The CMHC must organize, manage, and administer its resources to provide CMHC services, including specialized services for children, elderly people, people with serious mental illness, and peoples of its mental health service area who have been discharged from an inpatient mental health facility.

42 CFR Part 410 Subpart A -- § 410.2 – Definitions[14]:

- Community mental health center (CMHC) means an entity that —
  1. Provides outpatient services, including specialized outpatient services for children, the elderly, people who are chronically mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;
  2. Provides 24-hour-a-day emergency care services;
  3. Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services;
  4. Provides screening for people being considered for admission to State mental health facilities to determine the appropriateness of this admission;

[14] eCFR :: 42 CFR Part 410 – Supplementary Medical Insurance (SMI) Benefits

5. Meets applicable licensing or certification requirements for CMHCs in the State in which it is located; and
6. Provides at least 40 percent of its services to people who are not eligible for benefits under title XVIII of the Social Security Act.

42 CFR Subchapter G – Part 485 – Subpart J[15]:

- § 485.914 Condition of participation: Admission, initial evaluation, comprehensive assessment, and discharge or transfer of the people: Admission
    - Initial Eval
    - Comprehensive Assessment
    - Update on comprehensive assessment
        - Discharge or transfer of the people
- § 485.916 Condition of participation: Treatment team, person-centered active treatment plan, and coordination of services.
- § 485.917 Condition of participation: Quality assessment and performance improvement.
- § 485.918 Condition of participation: Organization, governance, administration of services, and partial hospitalization services.

State Laws and Regulations

AR Code § 20-47-202 (2020)[16]:

- "Community mental health center" means a program and its affiliates established and administered by the state, or a private, nonprofit corporation certified by the division for the purpose of providing mental health services to the residents of a defined geographic area and which minimally provides twenty-four-hour emergency, inpatient, outpatient, consultation, education, prevention, partial care, follow-up and aftercare, and initial screening and pre-care services. The division may contract with a community mental health center for the operation and administration of any services which are part of the state mental health system.

AR Act 243 (1987)[17]

- Revised laws relating to voluntary admissions and involuntary commitments of mentally ill persons and AR Act 944 (1989) made an appropriation for personnel services and operating expenses.
    - These acts led to an increase in responsibilities for the care and treatment of people with severe mental illness

[15] eCFR :: 42 CFR Part 485 Subpart J – Conditions of Participation: Community Mental Health Centers (CMHCs)
[16] Arkansas Code § 20-47-202 (2020) - Definitions:: 2020 Arkansas Code :: US Codes and Statutes :: US Law :: Justia
[17] Act 243 of the 1987 Regular Session (state.ar.us)

AR Act 423 (2017)[18]

- Mandates policies designed to make better use of State and local resources in three ways:
  1. Limits incarceration periods for people sanctioned for low-level violation of the terms of their supervision
  2. Requires training for law enforcement officers in how to respond to people who are experiencing a mental health crisis
  3. Creates local crisis stabilization units that enable law enforcement officers to divert people with mental illnesses who commit low-level offenses away from county jails to receive mental health treatment in the community

2020 Arkansas Code: Title 20 - Public Health and Welfare; Subtitle 3 - Mental Health; Chapter 46 - Mental Health Agencies and Facilities; Subchapter 3 - Community Mental Health Centers[19]

- § 20-46-301: Department of Human Services — Division of Aging, Adult, and Behavioral Health Services — Powers and duties
  - DHS has authority and power to create and maintain the Division of Aging, Adult, and BH Services and to provide services for CMHCs and centers
  - Engage in programs of mental health education in cooperation with the states governmental units and establish mental health education organizations
- § 20-46-302: Department of Human Services -- Power to regulate – Funding
  - ASH (through DHS) is authorized and empowered to assist CMHCs and clinics in providing funds for Medicaid required for treatment of mental illness for medically indigent people (not to exceed five cents per capita of the geographical area served by those CMHCs)
  - The restrictions of the Arkansas Procurement Law, § 19-11-201 et seq.; the General Accounting and Budgetary Procedures Law, § 19-4-101 et seq.; the Revenue Stabilization Law, § 19-5-101 et seq.; and other fiscal control laws of the state, where applicable, and rules promulgated by the Department of Finance and Administration, as authorized by law, shall be strictly complied with in disbursement of the funds
- § 20-46-303: Standards generally
  - Secretary of the DHS shall consider:
    - Adequacy of MH services including MH outpatient diagnostic and treatment services

[18] Bill Drafting Template (state.ar.us)
[19] Arkansas Code Title 20, Subtitle 3, Chapter 46, Subchapter 3 (2020) - Community Mental Health Centers:: 2020 Arkansas Code :: US Codes and Statutes :: US Law :: Justia

- Rehabilitative services
- Collaborative services with PH and other state, county, city and private groups for programs or prevention and treatment of Mental illness
- Consultative services to school courts, and to health and welfare agencies
- Informational and education services to public and to pay and professional group
- Study and training activities in the field of mental health

- § 20-46-305: Pledge to conform and filing of policies
  - As a condition of certification or recertification by the Department of Human Services, each community mental health center shall furnish to the department a resolution of its governing board expressing the board's pledge and intent to conform to the professional standards and accounting, statistical, and auditing standards prescribed by the board.
  - Each community mental health center shall file, as a condition of certification or recertification by the department, with the department a copy of the conflict-of-interest policies and purchasing policies of the board. The conflict-of-interest and purchasing policies shall conform to the minimum standards for the policies adopted by the department
- §20-46-306. Minimum standards -- Purchasing procedures
  - The minimum standards prescribed by the Division of Behavioral Health Services for purchases by community mental health centers, as far as practicable, shall be comparable to the limits set for small purchases pursuant to the purchasing procedures established by the State Procurement Director and shall require competitive bidding for purchases exceeding those limits.
  - The standards promulgated by the department shall also require the center to maintain adequate documentation concerning procedures used and the justification for the awarding of the professional contracts
- § 20-46-310. Duty to provide screenings and evaluation studies
  - Mental health centers shall provide screening and evaluation studies of such persons as shall be referred to the mental health center or clinic by the court
- § 20-46-312. Assistance, cooperation, and purchase of services by certain governmental units

- Any state board, state agency, county, municipality, court, school district, hospital district, or other political subdivision of the state is authorized to purchase mental health services from CMHCs or centers or to assist and cooperate with these clinics or centers by providing services, facilities, and professional assistance, wherever the assistance is reasonable and furthers the general welfare of the state, county, region, or community.

AR Code § 23-99-802[20]

- "Any willing provider law" is a law that prohibits discrimination against a provider willing to meet the terms and conditions for participation established by a health insurer or that otherwise precludes an insurer from prohibiting or limiting participation by a provider who is willing to accept a health insurer's terms and conditions for participation in the provision of services through a health benefit plan."
    - Arkansas law prohibits health care insurers from imposing any monetary advantage, penalty, or higher copayment under a health benefit plan that would affect a beneficiary's choice of health care providers.

[20] Arkansas Code § 23-99-802 (2020) - Definitions:: 2020 Arkansas Code :: US Codes and Statutes :: US Law :: Justia

Appendix B: SAMHSA CMHC Grant Program[21]

The CMHC grant program is authorized under Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act.

The purpose of the CMHC grant program is to enable CMHCs to support and restore the delivery of clinical services that were impacted by the COVID-19 pandemic and effectively address the needs of people with SED, SMI, and people with SMI or SED and substance use disorders, referred to as co-occurring disorder.

The following are the activities that every grant project must implement:

- Establish, strengthen, and/or sustain the infrastructure necessary to provide audio and audio-visual HIPAA compliant telehealth capabilities.
- Provide outpatient services for people with SED, SMI, and COD in your service area.
- Provide trauma informed screening, assessment, diagnosis, and patient-centered treatment planning and treatment delivery.
- Provide clinical and recovery support services (e.g., psychosocial rehabilitation, case management services, peer support).
- Develop and provide resources to address the mental health needs of CMHC staff.

Funding may also be used to support the following allowable activities for the population(s) of focus:

- Train BH professionals to work with schools to address behavioral health needs of school-age youth at risk for SED. This includes attention to services that address the needs of children, particularly regarding school reentry. Children and youth at risk for maltreatment or those who have been maltreated should also be considered.
- Provide staff specific training on behavioral health disparities including cultural and linguistic competence and strategies to engage and retain diverse people populations.
- Expand the capacity of CMHC staff to address crisis and emergency response.
- Expand support for increased capacity for and availability of crisis beds.
- Expand mobile crisis mental health services for the population(s) of focus.
- Coordinate with crisis centers/hotlines to ensure that strong referral pathways are established and/or restored.

[21] 42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart i: block grants for community mental health services (house.gov)

- Develop and implement outreach strategies and referral pathways for vulnerable populations, such as minority populations and people residing in economically disadvantaged communities.
- Train and support peer staff to serve as integral members of the team to address mental health needs which may have arisen because of the pandemic, including but not limited to trauma, grief, loneliness, and isolation.
- Provide diversion services to promote alternatives to hospitalization and incarceration, e.g., multiple intercept model.
- Provide support for prison/jail initiatives including reentry services, service provision while incarcerated, and partnerships.

Appendix C: CMHC Interview Guide

This is the interview document used across all 12 CMHC site visits as part of this project's work.

I. Introduction

Guidehouse to briefly review the overall objectives of the specific task with the interviewees.

a. Review the goals of our engagement and discuss the purpose of the interviews.
b. Confirm confidentiality and anonymity

Interviewees and Guidehouse briefly introduce themselves and share their primary role at respective organizations.

c. Please provide us with a summary of your role(s) within your organization.

II. Overview of Operations

a. What are your organization's strengths from an operational and service-offering perspective for serving people with behavioral health diagnoses?
b. Can you talk about staff training policies and procedures for services? Examples could include trauma informed care, person-centered care, recovery-oriented care, acceptance, and commitment therapy (ACT), crisis intervention team (CIT), crisis de-escalation, certified peer support, and mental health first aid?
c. Are there trainings you wish you could offer/implement but are restricted by funding?
d. How many staff positions are currently vacant and what are those positions?
e. Tell us about your organization's Processes, electronic data systems, and capacity to collect, report, and track encounter, outcome, and quality data? What types of data do you collect?
f. Tell us about your agency's quality improvement (QI) plan. What do you use to maintain an effective QI for clinical services and clinical management?

III. Discussion of OSAMH contracted scope of services provided – Current State

II.I Crisis Services

a. To what extent do you provide BH crisis services including screenings, intervention, and stabilization? What types of interventions? How are those services funded?
b. Are you able to offer those services to all age ranges? Are you able to support people living with substance use disorders (SUD)?

c. Do you have formal policies and procedures for BH crisis services? If yes, may we obtain a copy of these materials?
d. Do you provide a 24/7/365 staffed telephone “warm line”? Can you tell us about the demographics of who utilizes the warm line? What are your processes and procedures? Where do you send referrals? How is that funded?
e. What is the care coordination process between your CMHC and any of the crisis stabilization units (CSU)? How about care coordination with other Community Based Organizations (CBOs)? How is that funded?

III.II Assessments

a. Do you have a protocol for screening people who are seeking BH services? Do you have a suicide risk screening tool?
b. Do you utilize evidence based behavioral health assessment tool(s)? If yes, which tools do you utilize?

III.III Expanded Services

a. Tell us about the services you provide for people with diagnoses with no payer source including coordination with community partners, peer support, and therapeutic counseling? How are those services funded?
b. Do you also provide Medicaid enrollment assistance, medications, and care coordination to this population?
c. To what extent do you provide services to people with diagnoses related to Arkansas State Hospital (ASH)? Would you consider your CMHC to be a single point of entry (SPOE) for these people? How are those services funded?
d. To what extent do you provide care coordination for ASH peoples and people with no payer?
e. Do you offer a Walk-In or Club House model? What does the staffing model look like? What people do you serve, and how do you track outcomes? How is this funded?

III.IV Social Services Block Grant

a. Do you provide the full array of allowable services outlined in the applicable sections of the SSBG manual (29, 38, 43, 56) including; Mental Health Services, Prevention/Intervention Services, and Supportive Services for children and families?
b. Of the services offered through SSBH funding, what services are challenging for you to deliver and why? Are there services from this list that are under-utilized in your service area?
c. Do you utilize any additional funding sources for these services besides the SSBG? (e.g., other grand funding, donations, fundraisers, other contracts)

III.V Quality, Technology, and Reporting

a. What electronic data collection tools/systems do you currently utilize, including your electronic health record (EHR)? What funding do you utilize?
b. Do you participate in Arkansas's State Health Alliance for Records Exchange? (SHARE)

III.VI Community Based Services

a. Can you tell us about the collaborations and partnerships you have with community-based organizations (CBOs)? Is the relationship formal with regularly attended meetings?
b. Do you keep an updated and community resource directory or guide that people accessing assistance through your organization can access? How can they access (website, pdf, email, warm line)?
c. What community outreach and education programs do you provide or support? How is that funded?
d. Do you have a council? Tell us about who serves on it.

III.II Other

a. What unique programs do you offer and how do they serve your community? How are they funded?
b. How do you interact/share information/training with other CMHCs, other than monthly DSH meetings?
c. Do you think there are requirements in the current DHS/OSAMH contract that are difficult to fulfill?

IV. Review region and populations served by your CMHC

a. Is there a people population you feel you serve better than other Providers in your region? (Children, Families, Justice-Involved, etc.) Why that population?
b. Is there a population you struggle to provide comprehensive services for? Serious emotional disturbance (SED), serious mental illness (SMI), substance use disorder (SUD), intellectual and developmental disabilities (IDD).

V. Funding sources for the services you provide

a. Are there any additional funding sources you utilize that we have not yet covered today?
b. Are there any grants or other funds for which you are currently applying? What services would you utilize those funds for if awarded? E.g., SAMHSA Certified Community Behavioral Health Center (CCBHC) grant.

VI. Community Assessment – Gaps and barrier identification specific to your service area and the nuance of your region

a. What are some of your successes? Tell us more about any challenges/roadblocks/barriers to providing quality care that may have not come up during the strategic planning meeting on August 24th?

VII. Future State

a. What is your level of interest in working with adults who are justice-involved to meet their BH, and social determinants of health (SDOH) needs in the community?
b. What is your level of interest in providing BH crisis services, whether through 988, 911, or law enforcement for people experiencing BH crises? What about BH mobile crisis teams? What about crisis via telehealth with law enforcement?
c. Are there additional services you would like to be able to offer the people who live in your region?
d. Are there services you would like to discontinue? How are those currently funded?

VIII. Q & A

a. Do you have any materials/reports that you feel would be helpful for our analysis, or any other items or recommendations we should consider?
b. Do you have any other questions for our team at this time?

Appendix D: CMHC BH Service Matrix

CMHC BH service matrix used in conjunction with the CMHC site visits.

CMHC Service Matrix					
This exercise is for informational purposes ONLY and does NOT constitute a formal audit for regulatory compliance by Arkansas DHS. All information collected will be deidentified and aggregated before being shared with DHS.					
Contracted Services	**Capacity**	**Funding Source**	**Continuity of Services**	**Details on Continuity**	**Comments**
CRISIS SERVICES					
Crisis Screenings					
Crisis Intervention and Stabilization					
Mobile Crisis Team					
Mobile Crisis Assessment and Stabilization					
24/7 Staffed Warm Line or Walk-In Clinic					
SINGLE POINT OF ENTRY (SPOE) SERVICES					
SPOE Screening for ASH (AR State Hospital)					
Post Acute Coordination					
EXPANDED SERVICES					
Enrollment Assistance					
Medications and Injectables for Uninsured					
Peer Program / Support					
FORENSIC EVALUATION SERVICES					
Forensic Evaluations					
Forensic Outpatient Restoration Program (FORP)					
Protocols for First Episode of Psychosis (FEP) Treatment					
NON-MEDICAID SERIOUS MENTAL ILLNESS SERVICES					
Care Coordination					
Walk-In or Club House Model					
SOCIAL SERVICES BLOCK GRANT SERVICES					
Outlined Services Provided to Clients at or Below FPL (Please see SSBG Services tab for full listing)					
Mental Health Services					
Supportive Services For Children And Families					
Mental Health Services, Additional Units					
Prevention/Intervention Services					
OTHER					
Substance Use Disorder Treatment Services					
Additional Services Provided:					

Appendix E: Aggregated Responses for CMHC BH Service Matrix – Self-Reported

Please note that for CMHCs who did not fully complete or return the CMHC BH service matrix, missing fields were populated based on interview notes and findings.

Contracted Services	Full Capacity	Partial Capacity
Crisis Services		
• Crisis Services	12	0
• Crisis Intervention and Stabilization	12	0
• Mobile Crisis Team	3	9
• Mobile Crisis Assessment and Stabilization	2	10
• 24/7 Staffed Warm Line or Walk-in Clinic	12	0
Single Point of Entry (SPOE) Services		
• SPOE Screening for ASH	8	4
• Post Acute Coordination	5	7
Expanded Services		
• Enrollment Assistance	5	7
• Medications and Injectables for Uninsured	9	3
• Peer Program / Support	5	7
Forensic Evaluation Services		
• Forensic Evaluations	11	1
• Forensic Outpatient Restoration Program (FORP)	8	4
• Protocols for First Episode of Psychosis (FEP) Treatment	5	7
Non-Medicaid Serious Mental Illness Services		
• Care Coordination	5	7
• Walk-In or Club House Model	4	8
Social Services Block Grant		
• Mental Health Services	12	0
• Supportive Services for Children and Families	9	3
• Mental Health Services, Additional Units	9	3
• Prevention/Intervention Services*	1	4
Other		
• SUD Treatment Services	3	9

*Note: Seven CMHCs do not provide prevention/intervention services

Appendix F: Justice-Involved Work Group Scorecard

For the August 2023 CMHC strategic planning meeting, Guidehouse developed a justice-involved work group self-rating scorecard based on the eight principles provided by SAMHSA for CCBHCs that make up the foundation for high quality community BH treatment for people who are justice-involved. Each CMHC filled out the score cards and provided additional information (e.g., gaps and barriers) regarding their score that was taken into consideration during the development of recommendations for the future state.

1	2	3
Beginning state of, or Little to No Progress in the described principle	**Meets some of the components of the described principle**	**Meets majority, to all components of the principle**

No.	Principle CCBHC Criteria from SAHMSA	Components of Principle	Gaps/Barriers Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	What would you need to be able to self-score as a 3?	Describe reason for self-score
1	Community providers are knowledgeable about the criminal justice system	This includes the sequence of events, terminology, and processes of the criminal justice system, as well as the practices of criminal justice professionals.				
1a	Community providers are knowledgeable about the criminal justice system	Describe the training and resources you provide to staff about the justice system and your role within the communities you serve. Describe frequency of any trainings (*at hire, annual, ad hoc., etc.)* • Are there shared trainings between community provider organizations and criminal justice agencies?				

No.	Principle CCBHC Criteria from SAHMSA	Components of Principle	Gaps/Barriers Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	What would you need to be able to self-score as a 3?	Describe reason for self-score
		• Have local crisis providers actively participated in crisis intervention team (CIT) training or related mental health crisis management training sessions?				
2	Community providers collaborate with criminal justice professionals to improve BH, safety, and individual BH outcomes	Collaboration with the criminal justice system is essential for ensuring continuity of care and care coordination during transitions to and from incarceration and sustaining treatment and supports both in correctional settings and in the community. This includes sharing information, responsibility, and accountability.				
2a	Community providers collaborate with criminal justice professionals to improve BH, safety, and individual BH outcomes	List the criminal justice system partners you work with. Describe how you interact with them and the frequency (*e.g., XXX county sheriff's office calls X times per month for MCT assistance for a call they are responding to)*				

No.	Principle CCBHC Criteria from SAHMSA	Components of Principle	Gaps/Barriers Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	What would you need to be able to self-score as a 3?	Describe reason for self-score
		• Are there regular meetings scheduled between law enforcement and crisis providers, including EMS and dispatch, to continuously improve their practices? • How do you collaborate with specialized treatment courts (e.g., mental health and drug treatment courts)? • Is aggregate outcomes data such as numbers served, percentage stabilized and returned to the community, and connections to ongoing care shared across entities?				
3	Evidence-based practices for BH treatment services are provided to individuals who are justice-involved	Evidence-based practices for MH and SUD should be used and adapted to specific justice involvement, as necessary. Practices should address criminal thinking though cognitive-skills training focused on judgement and criminal behaviors.				

No.	**Principle** CCBHC Criteria from SAHMSA	Components of Principle	**Gaps/Barriers** Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	What would you need to be able to self-score as a 3?	Describe reason for self-score
3a	Evidence-based practices for BH treatment services are provided to individuals who are justice-involved	• What evidence-based practices do you currently use to treat the justice-involved? (e.g., assisted outpatient treatment, medication assisted treatment) • What trainings, or other resources, are utilized to support working with people who are justice-involved? (e.g., justice-involved peer support)				
3b	Evidence-based practices for BH treatment services are provided to individuals who are justice-involved	How does your organization work with the forensic population? • Do you offer Forensic Assertive Community Treatment and/or Forensic Intensive Case Management? • Do you utilize forensic peer specialists? • What other evidence-based practices are used with this population?				
4	Community providers understand and address criminogenic risk and need factors as part of treatment plans	Criminogenic means system, situation of place causing or likely to cause criminal behavior. (*e.g., the criminogenic nature of homelessness*)				

No.	**Principle** CCBHC Criteria from SAHMSA	Components of Principle	**Gaps/Barriers** Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	What would you need to be able to self-score as a 3?	Describe reason for self-score
4a	Community providers understand and address criminogenic risk and need factors as part of treatment plans	• What resources and partnerships do you have in the communities you serve to overcome justice-involved specific social determinants of health factors? • Describe gaps in services and access for this population.				
5	Integrated physical and BH care is part of treatment plans	Formerly incarcerated populations are at increased risk for serious and complex chronic health conditions and may require coordinated care with other health care professionals. Rates of infectious and noncommunicable chronic diseases are high *(e.g., over-dose is the #1 cause of death upon re-entry in the community).* Improved transition planning and care coordination reduces risk of recidivism which equates to less crime meaning increased public safety				

No.	Principle CCBHC Criteria from SAHMSA	Components of Principle	Gaps/Barriers Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	What would you need to be able to self-score as a 3?	Describe reason for self-score
5a	Integrated physical and BH care is part of treatment plans	• Does your organization offer integrated physical and BH care services? (e.g., health care providers on site, care coordination) • How do your treatment plans integrate physical and BH care to improve patient outcomes? • Do you offer integrated treatment for co-occurring mental health conditions and substance use disorders?				
6	Services are trauma-informed to support health and safety of staff and people who are justice-involved	People with behavioral health diagnoses (MH and SUD) who are justice-involved have high rates of exposure to traumatic events that have lasting adverse effects on functioning-mental, physical, social, emotional, or spiritual well-being				
6a	Services are trauma-informed to support health and safety of staff and people who are justice-involved	Has your organization integrated trauma-informed and recovery-oriented care into your work across services for people who are justice-involved? If yes, please describe how.				

No.	**Principle** CCBHC Criteria from SAHMSA	Components of Principle	**Gaps/Barriers** Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	What would you need to be able to self-score as a 3?	Describe reason for self-score
7	Case management incorporates treatment, social services and supports to reduce likelihood of recidivism	This would include the unique obstacles in finding housing, employment, and coordinating health and behavioral health care.				
7a	Case management incorporates treatment, social services and supports to reduce likelihood of recidivism	• How does your organization collaborate with PASSE care coordinators and is there a need for additional targeted case management for the population you serve? • Do case managers connect individuals with services related to supported housing and employment?				
8	Community providers recognize and address disparities in BH care and the criminal justice system	Community-based providers to understand these structural biases to prevent their further perpetuation and interference with positive treatment and justice outcomes based on race, ethnicity, gender, sexual orientation, and economic status.				

Appendix G: Mobile Crisis Team Services Work Group Scorecard

For the August 2023 CMHC strategic planning meeting, Guidehouse developed a mobile crisis team services work group self-rating scorecard based on the three core principles as provided by SAMHSA for CCBHCs that make up the foundation for high quality community behavioral health treatment for mobile crisis team services. Each CMHC filled out the score cards and provided additional information (e.g., gaps and barriers) regarding their score that was taken into consideration during the development of recommendations for the future state.

1	2	3
Beginning state of, or Little to No Progress in the described principle	**Meets some of the components of the described principle**	**Meets majority, to all components of the principle**

No.	**Principle** CCBHC Criteria from SAHMSA	**Components of Principle**	**Gaps/Barriers** Describe specific gaps in service or barriers preventing you from reaching a score of 3	**Score (1-3)**	**Score (1-3 What would you need to be able to self-score as a 3?** (Be as specific as possible	**Describe reason for self-score**
1	Mobile Crisis Teams (MCTs) are provided 24 / 7-365 to adults, children, youth, and families.	The MCT includes anywhere within the service area including at home, work, school, or anywhere else where the BH crisis is experienced.				
1a	Mobile Crisis Teams (MCTs) are provided 24 / 7-365 to adults, children, youth, and families.	• Can your MCTs provide all of the following essential services? ○ Triage/screening for BH crisis ○ Assessment of BH crisis level ○ De-escalation/resolution skills and tactics				

No.	Principle CCBHC Criteria from SAHMSA	Components of Principle	Gaps/Barriers Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	Score (1-3 What would you need to be able to self-score as a 3? (Be as specific as possible	Describe reason for self-score
		○ Peer Support Services for MH and SUD ○ Coordination with medical and behavioral health services ○ Crisis planning and follow-up care • Are there any restricted locations or services that currently cannot be served by your MCT? • Does your organization have partnerships or collaborate with local law enforcement, EMS, and dispatch? Schools? • Are outpatient follow-up appointments scheduled via warm handoff to support connections to ongoing care?				

No.	**Principle** CCBHC Criteria from SAHMSA	**Components of Principle**	**Gaps/Barriers** Describe specific gaps in service or barriers preventing you from reaching a score of 3	**Score (1-3)**	**Score (1-3 What would you need to be able to self-score as a 3?** (Be as specific as possible	**Describe reason for self-score**
2	MCTs are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours.	MCTs may be comprised of professionals and paraprofessionals (including trained peer support providers), who are trained in crisis intervention skills and in serving as the first responders.				
2a	MCTs are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours.	• What types of professionals most often make up a MCT for your CMHC? • Does your MCT partner with (e.g., ride-along, iPad remote access, telehealth with law enforcement, others) law enforcement? • Do you employ and utilize certified peer support specialists? (SUD specific, MH specific) • Does the MCT serve justice involved individuals? If so, how? • What key performance indicators (KPIs), or other metrics, are currently being collected and				

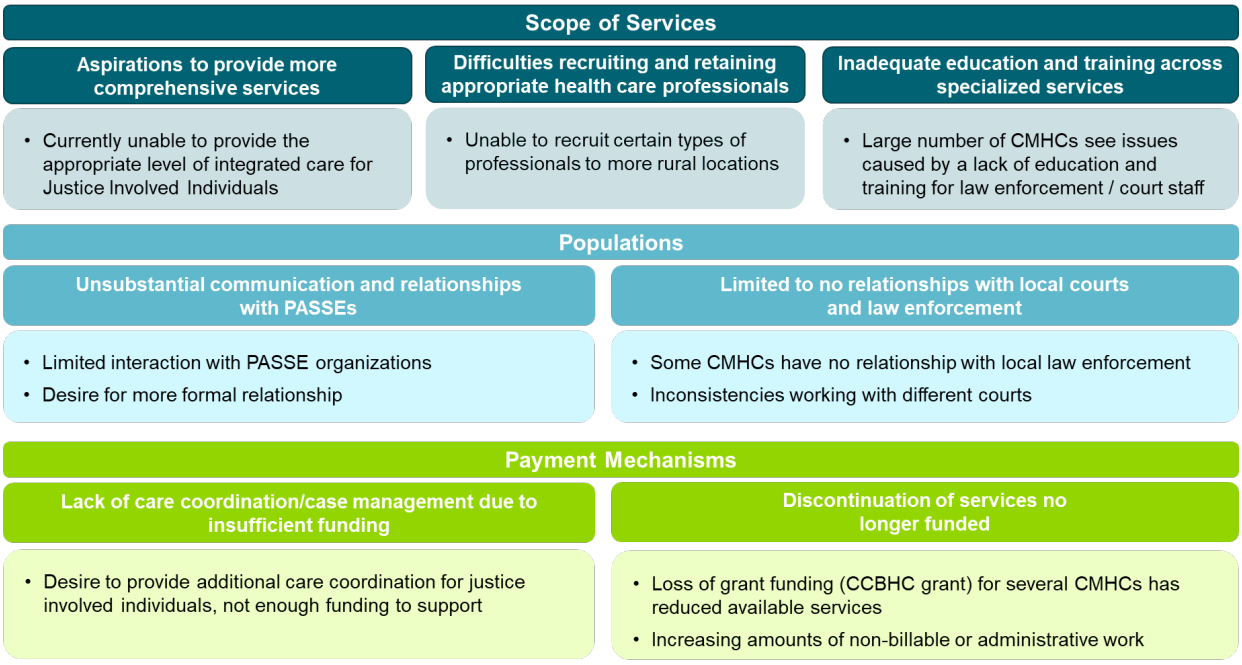
No.	Principle CCBHC Criteria from SAHMSA	Components of Principle	Gaps/Barriers Describe specific gaps in service or barriers preventing you from reaching a score of 3	Score (1-3)	Score (1-3 What would you need to be able to self-score as a 3? (Be as specific as possible	Describe reason for self-score
		measured to evaluate MCT response time, disposition status, and care coordination post initial response? • Does your MCT implement real-time GPS technology for tracking purposes?				
3	Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time.	Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety.				
3a	Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time.	• If Telemedicine is offered, what type of provider will the patient see? • How quickly are patients who meet the criteria identified and connected to a provider? • For patients that meet the criteria, how quickly can an in-person				

No.	**Principle** CCBHC Criteria from SAHMSA	**Components of Principle**	**Gaps/Barriers** Describe specific gaps in service or barriers preventing you from reaching a score of 3	**Score (1-3)**	**Score (1-3 What would you need to be able to self-score as a 3?** (Be as specific as possible	**Describe reason for self-score**
		encounter be scheduled following the emergency?				

Appendix H: CMHC Strategic Planning Meeting Key Themes

Guidehouse kicked off this project in partnership with OSAMH through an all-day in person strategic planning meeting with representation from all 12 CMHCs. During the session, focused workgroup discussion questions were used to guide discussion and gain feedback on how, in a future state, CMHCs would be able to focus their work through the CMHC contracted state funds on people with BH diagnoses who were involved with the justice system and people who are seeking assistance during BH crisis, specifically mobile crisis services. Guidehouse collected feedback and conducted analyses to devise key themes. See **Figure 1** for the key themes identified during the strategic planning meeting. These key themes, in addition to OSAMH outlined future state, were used in the development of the CMHC interview guide and BH service matrix for the individual CMHC interviews and the development of Guidehouse's findings.

Figure 1: Key Themes from CMHC Strategic Planning Meeting: Visual represents CHMC feedback summarized from the strategic planning meeting in August 2023.



Appendix I: Acronyms

Acronym	Definition
APN	Advanced Practice Nurse
ARPA	American Rescue Plan Act
ASH	Arkansas State Hospital
BH	Behavioral Health
CCBHC	Certified Community Behavioral Health Clinic
CMHC	Community Mental Health Center
CSR	Crisis Services Report
CSU	Crisis Stabilization Unit
DAABHS	Department of Aging, Adults and Behavioral Health Services
DBHS	Division of Behavioral Health Service
DHS	Department of Human Services
ED	Emergency Department
FEP	First Episode Psychosis
FORP	Forensic Outpatient Restoration Program
KPI	Key Performance Indicator
MCT	Mobile Crisis Team
MHBG	Mental Health Block Grant
MH	Mental Health
OSAMH	Office of Substance Abuse & Mental Health
PASSE	Provider-Led Arkansas Shared Savings Entity
PHE	Public Health Emergency
PSA	Public Service Area
RDS	Rehabilitative Day Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SDoH	Social Determinants of Health
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SHARE	State Health Alliance for Records Exchange system
SMI	Serious Mental Illness
SOW	Scope of Work
SPOE	Single Point of Entry
SSBG	Social Services Block Grant
SUD	Substance Use Disorder