NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
The voice of local authorities in the nation's capital

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NEWSLETTER

SEPTEMBER 23, 2013

PATRICIA RYAN: AN "ACCIDENTAL" LIFE IN BEHAVIORAL HEALTH
A NACBHDD STALWART TAKES HER LEAVE

[After a dozen years as Executive Director of the California Mental Health Directors Association, Patricia Ryan is moving on to other pursuits. During that time she has been a vital member of NACBHDD leadership and a voice for our field. Our conversation with her explores her unique path to the behavioral health field, her challenges and victories throughout her career of choice, and her hopes for the field's future directions.]

Q. What got you into the field? What kept you there?

My entry into the field of mental health was somewhat by accident, but it was consistent with my professional goals to promote social justice and contribute something meaningful to society. I grew up in a family in which social justice and public service were important. (My father was the late Congressman Leo J. Ryan, who was assassinated while attempting to help some of his constituents leave the Jonestown "cult" settlement in Jonestown, Guyana.) He was a huge influence in my life, and because of that I had always wanted a career in public policy/public service. After he died, I was able to get a job working for Congressman Tom Lantos (D-CA), who replaced my father a few years after his death. While in his district office, I directed constituent casework and became particularly interested in issues related to veterans – especially those who had developed severe emotional and substance use problems due to posttraumatic stress disorder (PTSD). In fact, I ended up volunteering at a local veterans' hospital that specialized in treatment of the disorder. When my mother unexpectedly died just 3 years after my father's death, I felt a need for change, and asked to be transferred to the Congressman's Washington, D.C., office. While there, I served as his legislative assistant on health, mental health, women's and veterans' issues. I obtained even more experience in these issues when I was hired by former Congressman Richard Ottinger (D-NY), a member of the Energy and Commerce Subcommittee on Health and the Environment. I also decided to seek a Master's degree, and was admitted to The George Washington University's graduate school for public administration, which I attended at night. When the Congressman retired about a year after I joined him, I decided to seek a government relations job with a health care association. I was hired by the American Psychiatric Association. Since then, every position I have held—both in Washington and here in California—has been in the mental/behavioral health field.

ALSO IN THIS ISSUE

With the historic startup of ACA enrollment on October 1, we focus much of the newsletter on topics related to ACA:

- Operation of the Marketplace
- Medicaid expansion
- Information to help consumers enroll.
- What we can do to help the people we serve get on board.

We'll return to our regular format next month.

COMING IN OCTOBER,
AN NARMH SPECIAL
Rural America, Veterans and Mental Health:
Taking Care and Services to Where the Veterans Are.
[Paul Force-Emery Mackie, PhD, LISW, and Mimi McFaul, PsyD]

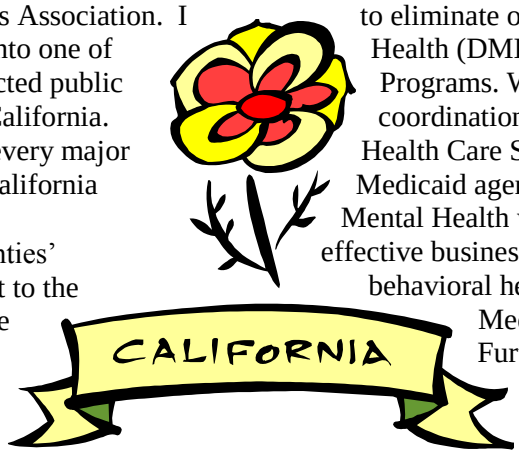
Teddi Fine, MA, Editor

Two primary things have kept me in the field: 1) I developed a good professional reputation in the mental health advocacy field, which led to being offered progressively higher positions in mental health-related associations; and 2) the complex, public policy issues related to behavioral health, including the rampant stigma and discriminatory treatment of those with behavioral health disorders, have made me feel that I wanted to and could make a positive public policy contribution in this area.

Q. *What do you see as your key achievements during your career in behavioral health? What milestones can you point to over the years?*

My proudest achievements in the field have really been over the past 12 years as Executive Director of the California Mental Health Directors Association. I believe I have built the organization into one of the most effective, credible and respected public policy and advocacy associations in California. We have been integrally involved in every major mental health public policy issue in California during that time, including:

- Advocating for and overseeing counties' implementation of services pursuant to the groundbreaking Proposition 63 – the Mental Health Services Act;
- Working with the State to create our Medi-Cal Specialty Mental Health Managed Care program under which counties, through a CMS "freedom of choice" waiver and using the Medicaid "Rehabilitation Option," act as the Medicaid "Mental Health Plans" for beneficiaries needing specialty care;
- Protecting and even increasing public mental health funding during times of severe budget deficits;
- Ensuring that changes to involuntary care statutes continue to promote appropriate community-based services in the least restrictive setting;
- Being instrumental in effecting needed, but controversial, changes to special education statutes regarding students with mental health needs; and
- Representing my members' (and their clients') needs and interests related to implementation of the Affordable Care Act (ACA).



Q. As a parallel, what were your greatest hurdles that needed to be overcome? What challenges remain?

The greatest hurdle has been battling ignorance and stigma related to behavioral health issues as a priority for public funding and policy. Because California has term limits, developing and maintaining a solid knowledge base among legislators and their staff has been difficult. With a relatively small staff of our own, it has been a constant challenge to educate those who need to and should know more about our public (and private) mental health/substance use systems in California. Also, the mental health advocacy community—at both the state and national levels—has a tendency to be splintered around issues related to involuntary care and "guild" issues. While understandable, the fragmentation makes it more difficult to advocate collaboratively and to be taken seriously on broader issues of importance (such as budget, parity, etc.).

Another significant challenge over the past few years has been insufficient leadership and knowledge at our State administration level. For many reasons, several years ago, our Association supported a decision to eliminate our state Departments of Mental Health (DMH) and Alcohol and Drug Programs. We felt that a dearth of coordination between the State Department of Health Care Services (our single State Medicaid agency) and the Department of Mental Health was a major barrier to creating an effective business relationship between county behavioral health directors and the State on Medicaid and other important issues. Further, with enactment of the ACA, the time seemed right to incorporate behavioral health into the broader health care framework. Frankly, the transition has been bumpy, but the State finally is making progress in rebuilding the necessary expertise to foster collaborative work to accomplish the goals of the ACA as they relate to behavioral health services.

Some of the remaining significant challenges include effecting needed reforms at the State and local levels related to the criminal justice population with behavioral health issues, ensuring that beneficiaries with serious mental and substance use issues are able to obtain the services they need and to which they are entitled under our newly reformed and expanded health care system, and addressing serious workforce shortages in the behavioral health field.

What role will be played by county behavioral health as the ACA moves forward? Where will the ACA be in 5 years when it comes to the needs of people with behavioral disorders?

In the short term in California, I believe county behavioral health will continue to play an integral role as specialty mental health/substance use systems. They are, after all, the only system that promotes and provides for comprehensive community-based acute and rehabilitative services and supports for individuals

with serious mental illness. From a practical standpoint, the State recently completed a "realignment" of all state responsibilities for public mental health and substance use services from the state to the counties, including Medi-Cal specialty mental health and drug Medi-Cal and other substance use services. Our funding structure in California is complex, and eliminating what people refer to as our behavioral health "carve-outs" would be very difficult to accomplish.

Recognizing the ACA's "triple aim"—to improve the health of the population, enhance the patient experience of care (including quality, access, and reliability), and reduce, or at least control, the per capita cost of total healthcare—counties are moving rapidly toward improved collaboration, coordination and communication with managed health plans and other parts of the health care system to ensure that individuals receive the services and supports they need when and where they need them.

Q. Where do you believe the future of county behavioral health is headed? Do you feel positive about the field's future?

I feel very optimistic about the future of both counties and behavioral health in general. The Affordable Care Act and its "essential health benefits" that specifically include mental health and substance use, in combination with the Mental Health Parity and Addiction Equity Act of 2009, have finally helped us to break the discriminatory barriers that have inhibited our ability to address the whole health needs of the individual, including behavioral health.

I believe for the foreseeable future -- at least in California -- there will continue to be a need for county behavioral health to be a part of the healthcare system, particularly with regard to providing rehabilitation, resiliency- and recovery-focused services as part of our overall health and supportive services safety net.

Q. What are your plans for the future?

My immediate plans are to simply take some time for myself – get more fit, do some traveling, spend more time with my family (including my grandson and his soon-to-come little brother), volunteer, and try to catch up on sleep! I will also likely stay involved with behavioral health policy on a much more limited basis for a while – as long as people value and see a need for my expertise as an occasional consultant. This has been an incredible professional journey, and I feel privileged to have had the opportunity to work with the committed people I have met along the way.

ACA Enrollment Launch Special

Just a few days remain until all 50 states and DC launch their Health Insurance Marketplaces and 26 states and DC launch their Medicaid Expansions for 2014. Thirty-nine million people who currently lack health insurance will be eligible to enroll on October 1. Almost 11 million of them are known to have behavioral health problems; countless others are at risk for them. All can benefit from the ACA in significant ways, whether through prevention and early intervention or through treatment and recovery support.

With just a few days to go before the first nationwide 6-month ACA enrollment period begins on October 1, it is critical that we debunk myths about the ACA, including the idea that it will be repealed, that it is an invasion of personal privacy, or that it will cost more than current health care coverage. And it is equally critical that we promote health insurance enrollment as broadly as possible.

It all begins with information: letting consumers know where they can get information about enrolling in the ACA; about the availability of Medicaid expansion in individual states and how to apply for it; and about the shape and structure of health insurance marketplaces in each state.

For Consumers

Information Sources

Consumers and family members can get information online, by phone through a toll-free call center, by mail, or in person. Accommodations will be available for persons with disabilities, such as telephone TTY and 508-compliant computer-based resources. Materials are adapted for non-English speakers in over 150 different languages; many Marketplace personnel, including navigators and other trained assisters, are multilingual (including ASL).

Consumers can:

- **Find out if they are eligible to buy health insurance through the Marketplace** at: https://www.healthcare.gov/am-i-eligible-for-coverage-in-the-marketplace/

- If they are eligible, they can learn more about **how a Marketplace works, key deadlines, and what they need to do** by going online to: https://www.healthcare.gov/using-the-marketplace/

The ACA portal is a particularly good resource for an overview of online information for consumers and families. Access it at: http://www.HealthCare.gov (English) or http://www.cuidadodesalud.gov (Spanish). Remember, most local libraries have computers available for library patrons, in case a computer isn't available at home for a consumer to use.

Alternatively, information is also available 24 hours a day, seven days a week by toll-free telephone at:

- 1-800-318-2596 ; or
- 1-855-889-4325 (TTY)

STEPS CONSUMERS SHOULD TAKE

Even before October 1, and certainly thereafter, consumers should be encouraged to—

- Sign up for e-mail or text messages about the Marketplace by going to the website https://www.healthcare.gov/subscribe/. They also can visit Facebook or Twitter, respectively, at http://facebook.com/healthcare.gov or follow on Twitter at @healthcare.gov.
- Learn about the different types of health insurance coverage by using the Marketplace. They can be better prepared to choose a plan if they understand the kinds of coverage from which they can choose.
- Make a list of questions about their coverage needs before it's time to choose a plan, including questions about how the coverage works regarding such topics as deductibles, out-of-pocket costs, co-payments, and coinsurance.
- Set a budget for health care insurance based on their needs and income. The Kaiser Family Foundation has created a health insurance cost and savings calculator to help consumers get a general idea of the potential cost of their health insurance under the ACA. Critically, this provides only a ballpark estimate. To directly access the cost estimator, they can go to: http://kff.org/interactive/subsidy-calculator/ or to: http://bit.ly/13YLrxq
- Know about other health care options, such as coverage through an employer, Medicaid, CHIP and Medicare.
- Find out which Marketplace is their marketplace. States that have chosen to run their own Marketplaces will have their own state websites. The federal government will manage the Marketplace for any state that has opted not to run its own. (Consumers can use the http://www.HealthCare.gov website as a first stop for information about their state Marketplace.)

MARKETPLACES AND MEDICAID EXPANSION

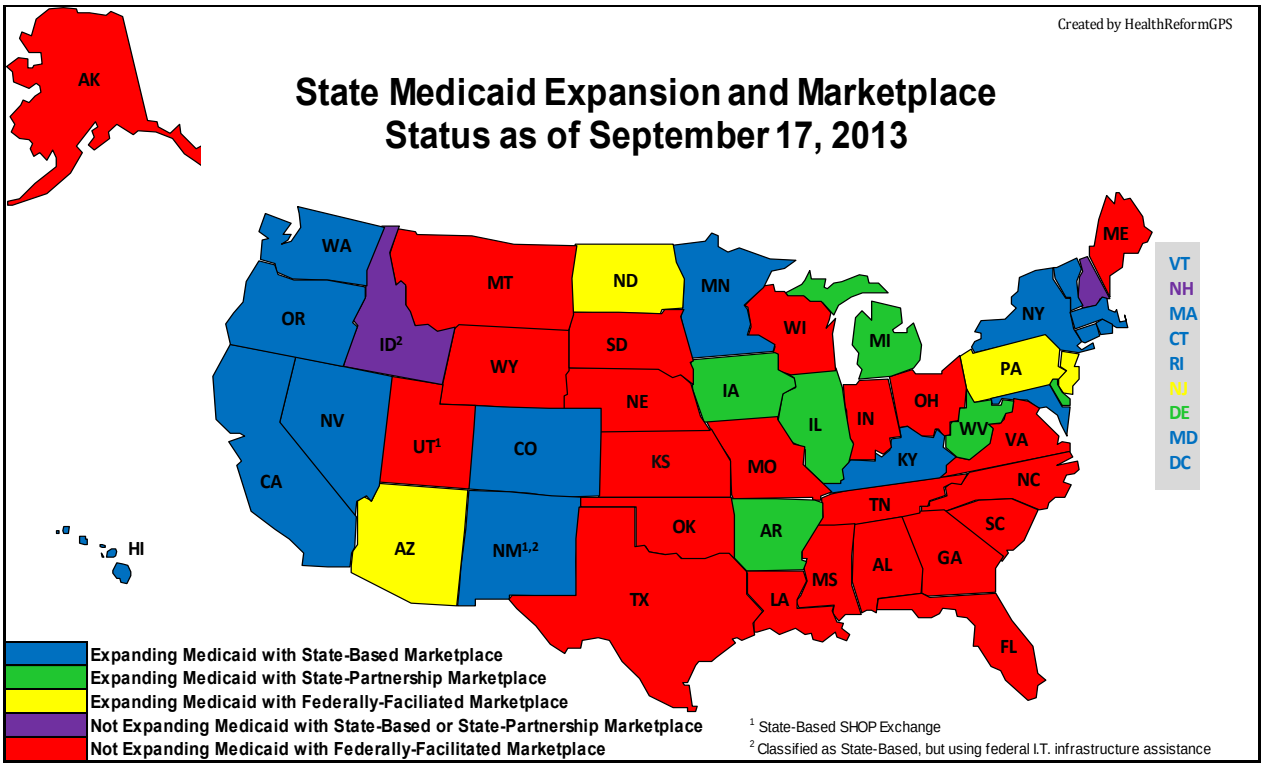
We need to educate ourselves, too. We should know what options are available to people with behavioral disorders and their families in our service areas. We should be familiar with ACA provisions applicable in our specific states. And we should have readily available copies of relevant web sites and phone numbers that the people we serve can use to get signed up for the ACA and to learn what coverage is best for them in our states.

We need to be up to speed on both Medicaid expansion and the health insurance marketplace:

- What is Medicaid expansion? What does it mean for the people we serve?
- Which states have adopted Medicaid expansion and which have not? What are the implications of each? Are there options for people who may not qualify for Medicaid expansion?
- Which states have chosen to establish their own health insurance marketplace? Which are partnering with the federal government to do so? Which have opted to let the federal government run a marketplace for the state?
- What about states that are seeking waivers to undertake their own programs of coverage?

This section of our special report provides an overview of Medicaid expansion and Health Insurance Marketplaces and where the two programs stand across the 50 states and the District of Columbia. It also suggests the role we have in helping the people we serve get enrolled, whether through Medicaid expansion, if qualified and if it is available, or through a subsidized plan available from the state Health Insurance Exchange.

STATE OF THE STATES
WHERE THEY STAND ON THE EVE OF ACA ENROLLMENT



www.healthreformgps.org

To date:

- 16 (blue) states have established their own Marketplaces and have expanded Medicaid.
- 6 (green) states have expanded Medicaid and are working in formal partnership with the Federally Facilitated Marketplace to implement ACA.
- 4 (yellow) states have expanded Medicaid and are relying on a federally facilitated marketplace.
- 2 (purple) states have chosen to operate their Marketplaces rather than use federal services, but will *not* participate in Medicaid expansion.
- 23 (red) states have opted for a federally facilitated marketplace, thereby enabling residents with incomes 100%-400% of the federal poverty level to secure coverage. However, they have chosen *not* to expand Medicaid, thereby foregoing health care coverage for the poorest residents of these states, a population of over 12 million potentially eligible individuals.

HHS reports that under the Health Insurance Marketplace launching on October 1st, nearly 6 in 10 uninsured Americans could get low-cost, high value health insurance for under $100 per person per month. Unfortunately, according to the Commonwealth Fund, 42% of those currently uninsured residing in states not expanding Medicaid will not have access to affordable health coverage. Since about half of the states are not expanding Medicaid, about 2 of every 5 uninsured individuals will not be able to capitalize upon the expanded coverage provisions of the ACA.

MEDICAID EXPANSION

Medicaid expansion is a "once in ever" opportunity to bring millions of uninsured people with behavioral disorders or ID/DDs under the health care coverage umbrella. While not all states have opted into Medicaid expansion, a growing number of previously wary states are moving into the expansion column. The graphic above provides a snapshot in time of the states participating in expansion.

It's a good deal for states, Fully 100% of the cost of the Medicaid expansion will be paid by the federal government for 2014, 2015, and 2016. Subsequently, this amount will decrease gradually to 90 % by 2020, where it will remain permanently. As such, Medicaid expansion is an extremely important tool for providing financial

resources to states to address the lack of health insurance among persons who are poor. It can lower federal, state and county costs associated with the use of emergency rooms as a primary source of care.

Key features:

- Medicaid expansion is designed to provide health insurance coverage to persons between 19 and 64 who are at or below 133 % of the federal poverty level, currently an income of about $15,200. Coverage will be at no cost to enrollees in states participating in Medicaid expansion.
- The benefit available through the Medicaid expansion, called the *Alternative Benefit*, varies from state to state, but must include the 10 categories of benefits available through Plans offered through state Health Insurance Marketplaces. (For a description of Marketplaces, see below.) Mental health and substance use service benefits must be included and offered at parity with the medical and surgical benefit. A pharmacy benefit is also required.
- In states undertaking Medicaid expansion in 2014, enrollment through the state Health Insurance Marketplaces begins October 1, 2013, with coverage effective January 1, 2014. *Medicaid expansion enrollment will be continuous from October 1 on.* The intent is to make it very easy to enroll from anywhere at anytime. Hence, one will be able to enroll online, over the phone, or in-person. Health insurance *Navigators* and *Enrollment Assisters* will be available through the Marketplaces to facilitate this process. They will also help consumers determine if they are eligible for Medicaid expansion or for subsidized insurance through the state Health Insurance Marketplace.

HEALTH INSURANCE MARKETPLACES

State Health Insurance Marketplaces (originally called Exchanges) are state-based competitive marketplaces where people and small businesses with fewer than 50 employees can shop for and purchase private health insurance. These are not private insurance companies or government-run health plans. *Rather, they are a state-specific resource consumers can use to find out if they qualify for private health insurance plans and other health insurance programs like Medicaid and the Children's Health Insurance Program (CHIP).* Marketplaces are designed to help consumers choose the best coverage for their individual needs and budgets. With one application, they can learn about all their options and enroll on the spot. And, based on their income, many consumers will be eligible for and receive tax credits, and cost-sharing reductions for insurance purchased through the Marketplace.

Key Features:

- States choose to have a State Operated Marketplace, a State Partnership Marketplace (operated jointly with the US Department of Health and Human Services (HHS)), or a federally Facilitated Marketplace operated entirely by HHS. If a state makes no determination, the default is to a Federally Facilitated Marketplace.
- The Marketplace operates a health insurance bazaar for prospective insurance enrollees. It organizes and monitors plans that are being offered; and engages in consumer outreach. The type of Marketplace chosen by a state will determine whether the state or HHS undertakes these specific functions.
- *Qualified Health Plans* (QHPs) offered through the Marketplace must include 10 essential health benefits, one of which is mental health and substance use care, which must be offered at parity with medical and surgical benefits. Four levels of health insurance (bronze, silver, gold and platinum) must be made available and equivalent, respectively, to 60, 70, 80, or 90% of the actuarial value of the essential health benefits. More about the essential health benefit in specific states is available at: http://kff.org/health-reform/state-indicator/ehb-benchmark-plans/
- Insurance will be available through the Marketplaces to persons at or above 133% of the FPL. Those with incomes from 133% to 400% of FPL are eligible for a federal tax subsidy on a decreasing sliding scale as well as reduced co-pays and deductibles. The tax subsidy will be paid directly to the plan in which a person is enrolled.
- E*nrollment* in QHPs through the Marketplaces, for insurance effective as early as January 1, 2014, will be open October 1, 2013 through March 31, 2014. Enrollment will then be closed until October 2014. HHS has undertaken an extensive enrollment campaign. The aim is to make it easy to enroll from anywhere at anytime, online, over the phone, or in-person, with insurance Navigators and Enrollment Assisters available to facilitate the process. Much more information on this process is available from www.enrollamerica.org.

OUR JOB: SHOWING THE WAY

We need to get involved. The people we serve need to be connected to the ACA's programs and services. After all, they are among those at greatest risk for reduced life expectancies and for a lack of health care coverage. Many are unaware of program opportunities; many may find navigation challenging, even with assistance. There is much

we can do, and much we must do, beginning now. Here are just a few examples of what we can do and why.

COVERAGE OPPORTUNITIES IN MEDICAID EXPANSION OPT-OUT STATES.

We need to get the word out about alternative means of health insurance coverage for people with behavioral health problems who are living in states that have opted out of Medicaid expansion in 2014. As many as 1 in 3 who would have been eligible for Medicaid expansion can be insured through the Marketplaces. And, of them, as many as 40% have a behavioral health problem. And, at the same time, we have an obligation to advocate for health insurance coverage for those people who will not be eligible for any ACA program, many of whom are people with behavioral health problems or ID/DD.

- In opt-out States, people with incomes as low as 100% FPL, not 133 % FPL, will be able to get insurance from qualified health plans available through state Health Insurance Marketplaces. *We need to make the people we serve aware of this opportunity.*
- Opt-out states' current Medicaid programs include provisions to cover medically frail individuals. Uninsured persons who are medically frail can be referred for Medicaid coverage in lieu of health insurance through the state Marketplace when they meet state criteria. *We need to understand and educate the people we serve about this feature of our own state's Medicaid program, including income limits.*
- Not everyone will qualify for coverage. *To keep anyone from falling through the cracks in opt-out states, all uninsured persons should be encouraged to seek enrollment.* That way, data counts can be developed on the numbers rejected for Medicaid coverage in opt-out states, and alternative means of coverage identified.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) ENROLLMENT SITES.

FQHCs have received more than $150 million in federal funds to help people enroll in health insurance. *Because many poor, uninsured persons with behavioral health problems or ID/DDs use FQHCs as sources of care, we need to help the FQHCs be very successful in reaching out and enrolling this population.*

COUNTY AND CITY ENROLLMENT SITES.

County and city governments operate many programs that will be very useful sites to engage and enroll uninsured persons. Many persons with behavioral health conditions will be seen in one or more of these sites, from hospital emergency departments to jails and from behavioral health and ID/DD programs to health, and public health departments. Homeless shelters and halfway houses, community centers and both religious and benevolent charitable programs are other locales where people we serve can be found. *Visit these places; work with them to help them help you get ready to enroll these uninsured persons as they are encountered in these sites after enrollment starts in October.*

HEALTH INSURANCE NAVIGATORS AND ENROLLMENT ASSISTERS.

Navigators will be available through state Health Insurance Marketplaces to help people enroll in health insurance, including the Medicaid Expansion. In addition, Enrollment Assisters will be available to perform a similar function in those states with state-operated Marketplaces. *It will be exceptionally important for us to work with the navigators and assisters so uninsured persons with behavioral health and ID/DD conditions are not overlooked in the outreach process.* To that end, peers have a large and important role to play in this process.

October 1 is just around the corner. While Washington may remain gridlocked, we certainly are not hampered by their inaction. We can and must move forward as voices for the people we serve, educators and collaborators, to assist in a once in a lifetime—perhaps once in forever—opportunity to make health coverage available, accessible and affordable for people in our communities living with or at risk for behavioral disorders and ID/DDs. We can do it by promoting their enrollment in the ACA. After all, it is the law of the land.

HILL HAPPENINGS: THE GOOD, THE BAD, AND THE UGLY

- **THEY'RE BAAAAK.** In a 230-189 vote on September 20, the House enacted a single bill to defund the Affordable Care Act and to adopt a continuing resolution to keep the government running through December 15, a short 10 days before Christmas. The House bill would fund the government at a rate of $986.3 billion, slightly below the post-sequester FY 2013 spending rate ($988 billion) and well below the FY 2013 pre-sequester rate. The bill was adopted in what was a virtual party-line vote. A

single Republican voted with 188 Democrats; two Democrats joined the majority votes. It now goes to the Senate where its chances of adoption are slim, at best. More likely, the Senate will restore ACA funding and send the measure back to the House as a straight continuing resolution. Will House Republicans blink? If no, these actions could result in a government shut-down. If yes, the right wing of the House may hold the debt limit ceiling extension hostage to repeal of the ACA. It's a dangerous game. Remember, unless Congress raises the $16.7 trillion debt limit, expected to be reached as early as mid-October, the Treasury would be unable to pay creditors. The nation's credit rating could decline and the U.S. ultimately would default. Stay tuned.

- **REPUBLICAN ACA REPUBLICAN ALTERNATIVE.** After promising their own bill for over 2 years, conservative members of the House Republic Conference's Republican Study Committee have unveiled their long-awaited alternative to the ACA. The measure would repeal the ACA, replacing it with expanded health savings accounts, medical liability reform and the elimination of restrictions on purchasing insurance across state lines. It remains unclear how the proposal would assure that insurers both expand coverage and make coverage available to people with preexisting conditions without resorting to a mandate for people to purchase coverage.
- **PRESS FOR MENTAL HEALTH LEGISLATION RENEWED**. In the wake of yet another senseless round of gun violence, Senators Begich (D-AK) and Ayotte (R-NH), sponsors of Senate mental health first aid legislation (S. 153) have urged that legislation designed to strengthen the mental health system nationwide be brought to the Senate floor for an immediate vote. One of these previously introduced measures, the Mental Health Awareness and Improvement Act (S. 689), was offered by Senators Harkin (D-IA) and Alexander (R-TN) and adopted by a vote of 95-2 in April as an amendment to the gun legislation then being considered on the Senate floor. It includes the Begich-Ayotte provisions and also calls for protocols to increase familiarity with mental health services available in local communities, and would provide grants for mental health awareness training programs for teachers, first responders, police officers, school and college administrators, veterans, nurses, among others. The future of these bills, nonetheless, remains unsettled.

HHS AND OTHER AGENCY NEWS AND NOTES

- **MOVEMENT ON ACA WAIVERS.** HHS has cleared the first ACA waivers. Under a one-year waiver from CMS, Indiana will be able to temporarily operate its own health insurance program. At the same time, Oklahoma has been granted its own one-year waiver to continue the current "Insure Oklahoma" low-income health program that serves nearly 30,000 individuals, while the state considers how to move forward under the ACA. The federal waiver comes with conditions, including that the State will be ineligible for the ACA's additional matching funds for low-income patients. To date, CMS has not made a determination on either the Arkansas or Iowa waiver requests. Stay tuned.
- **DRAFT BASIC HEALTH PROGRAM STANDARDS RULE RELEASED FOR COMMENT**. The CMS has released a proposed rule establishing the standards for the Basic Health Program that provides states the option to establish a health benefits coverage program for low-income individuals who otherwise would be eligible to purchase coverage through the Health Insurance Marketplace. This proposed rule sets out a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, state administration and federal oversight. The plan is primarily for those not eligible for Medicaid but who might not be able to afford health coverage for the new insurance exchanges. The plans must meet the level of basic coverage under the ACA, including preventive care and emergency services. Plans cannot discriminate based on age or health condition; their monthly premiums cannot exceed the amount an enrollee would pay for the second lowest cost silver plan on the new marketplaces. The proposed rule can be found online at: https://www.federalregister.gov/public-inspection More information on this rule can be found at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-09-20.html
- **HELPING PEOPLE WITHOUT BANK ACCOUNTS GET ACA COVERAGE.** At the urging of advocates, the Administration is moving ahead with a rule requiring health plans accommodate households that do not have traditional bank accounts. One in four of uninsured people eligible for federal insurance subsidies does not have a bank account, according to a report released earlier this year. Many of those people have behavioral health problems.
- **ACA MARKETPLACE TOOLKIT AVAILABLE**. SAMHSA has released its *Getting Ready for the Health Insurance Marketplace Toolkit.* This online resource includes three sections. The first describes the health care law, how it works, and why it is important for uninsured individuals with behavioral health conditions. The second explains

how the Health Insurance Marketplace works, how to apply for health coverage and where to get help. The third contains numerous communication ideas and materials from the Centers for Medicare and Medicaid Services (CMS) that you can use to create awareness and motivate uninsured individuals to enroll. Useful resources and materials can be downloaded directly from the toolkit. Access the toolkit at: http://tiny.cc/TreatmentProviders. When you open the link, complete the registration page to view the toolkit.

- **HEALTH INFORMATION TECHNOLOGY FORUM LAUNCHED**. SAMHSA has just launched a new forum on health information technology (HIT) designed to promote the exchange of ideas, suggestions, and personal experiences dealing with HIT for substance abuse treatment providers, mental health providers, software publishers, state agencies, consumers, families, and others involved in the field. Join in the exchange at: http://cmhbbs.samhsa.gov

UPCOMING ELECTIONS FOR 2014-15

Elections for the 2014-15 period will be held at the November 14-15, 2013, NACBHDD Fall Board Meeting. The following slate of candidates has been put forth:

- **President**: **Jeff Brown** – Executive Director, Oakland County Community Mental Health Authority, Michigan
- **Vice President**: **Cherryl Ramirez**, Executive Director, Association of Oregon Counties Community Mental Health Programs
- **Secretary**: **Kristen Rotz**, Executive Director, Pennsylvania Association of County Administrators of Mental Health and Developmental Services
- **Treasurer: Michael Deal**, Director, Southwest Behavioral Health, St. George, Utah

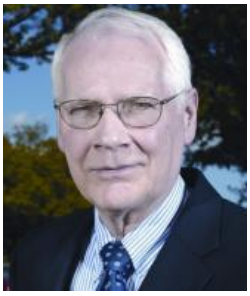
If you would like to self-nominate or nominate another NACBHDD member for one of the Board positions, please let Ron Manderscheid know no later than September 30.

REFLECTIONS ON TERRORISM FOR THE SEPTEMBER 11 ANNIVERSARY

IF WE ARE NOT TO REPEAT 9/11, WE MUST LEARN ALL THAT WE CAN FROM IT.

RON MANDERSCHEID, PHD

Reprinted from Behavioral Healthcare, Access at http://www.behavioral.net/blogs/ron-manderscheid/reflections-terrorism-september-11-anniversary



The passage of time has not really dulled our emotional reactions to the deadly terrorist attacks of September 11, 2001. We remember exactly where we were on that beautiful fall morning. We have vivid recollections of a plane flying into one of the Twin Towers of the World Trade Center in New York City. We still wonder how this could have happened. And we worry about the next attack—for ourselves; for our children, for our family and friends.

We must remember and honor all who lost their lives on that September morning. Without doubt, many of these people were true heroes. Each had a very valuable life, and none deserved to die when they did.

Again this year, the media have recounted the development of Al-Qaeda, the subsequent events leading up to the attacks on 9-11, and blow-by-blow accounts of the attacks themselves. This reporting is very factual and compelling. It provides viewers with an understanding of the social and cultural upheavals that led to Jihad, how the attacks were organized and executed by Al-Qaeda, etc. But, at another level, this reporting really is incomplete, and actually quite empty.

Next to nothing is said about the psychology and emotion associated with terrorism itself: What is terrorism? What is its purpose? How does it affect those who are targeted? How can we mitigate its effects? The current reporting fails to recognize that we must understand the psychology of terrorism very well if we actually are to respond effectively to it.

Terrorism is an extreme form of psychological warfare. By design, it is unpredictable, sudden, and devastating. It is an extreme effort to frighten and incapacitate people through identification with those who are maimed or killed in the attack. Because of our instant and ubiquitous communication media, the searing visual images of a terrorist attack can play a very large role in its psychological and emotional effects. Witness the video images of the Twin Towers or the Pentagon on 9-11.

The purpose of terrorism is not to kill all people in the target population, but rather to frighten them

extremely so that they become incapacitated. When this happens, those affected have a reduced capacity to fulfill their day-to-day roles: they function less effectively at work, reduce their participation in the community, and generally withdraw from their typical engagements. The clear presumption is that when people are frightened in an extreme way, then they will be afraid to act, and our society will suffer.

The fright engendered by terrorism has a range of psychological effects on those who are targeted. Some people become hypo-active; they freeze and are unable to act. Others become hyper-active; they are able to act with remarkable speed, but they make a greater number of errors in their actions. Yet other people continue with their routine activities. We just now are beginning to understand these different reactions. Clearly, these different responses are very important. For example, if a terrorist attack occurs, what type of person do we want in charge of a nuclear power plant?

As we develop more knowledge about how people respond to terrorist attacks, a key issue is how we can reduce the fright-flight response and the post-traumatic stress reactions that are very likely to accompany it. Work in this area is in its infancy and must be encouraged. Tragically, we are learning most about PTSD from our veterans returning from Iraq and Afghanistan.

We also must improve our capacity to predict likely terrorist attacks before they occur, and we must prepare people to respond in a more resilient way when they do occur. Better preparation and advance knowledge can help with the former; behavioral healthcare is likely to play a very prominent role in the latter.

If we are not to repeat 9-11, we must learn all that we can from it.

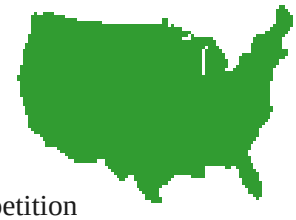
HOLD THE DATES

The NACBHDD Fall Board Meeting will convene on November 14-15, 2013, at the Renaissance Arts Hotel, New Orleans, LA. It immediately follows the NACBHDD-sponsored annual National Dialogues on Behavioral Health at the same site.

And pencil in March 3-5, 2014, for the NACBHDD annual Legislative and Policy Conference in Washington, DC. We'll convene over those 3 days at the Cosmos Club, with visits to Capitol Hill, too. The Spring Board Meeting will occur at the same venue on the afternoon of March 2.

AROUND THE STATES: AN UPDATE

- **MULTIPLE STATES**. Missouri and another 11 Republican-led states have enacted laws to thwart the ACA's navigator program from providing unbiased information that explains coverage to uninsured consumers. Some states have imposed licensing exams, required double and triple the training hours, or threatened severe fines for undertaking ACA-related navigator services. Some states have actually urged people to see private insurance agents or brokers. And Florida's Department of Health specifically has ordered county health units not to allow navigators onto their property to help uninsured people sign up for subsidized health coverage. These actions were taken in the wake of over 105 awards by HHS to organizations around the country to support navigators in their communities, and just weeks before enrollment begins.



- **ARIZONA:** Despite an effort to derail it, Medicaid Expansion has become law in Arizona. A petition drive to repeal expansion did not gain sufficient signature to put it on the ballot in November. Thus, thousands of low-income or unemployed Arizonans will now benefit from expanded Medicaid coverage under the ACA, with 100% of the costs covered by the federal government.
- **FLORIDA.** As noted above, the State Department of Health has precluded ACA navigators from undertaking outreach activities to help people understand and register for health coverage through the ACA's marketplaces. The argument against navigators seems to center on fears of confidentiality, something apparently not of concern with respect to either state databases or databases maintained in the private insurance market. HHS has expressed its displeasure in the development and that, ultimately, it expects navigators to be able to function in the State. Stay tuned.
- **LOUISIANA**. According to an audit conducted by the State's Legislative Auditor, Governor Jindal's privatization of mental health and addictive disorder treatment programs through a 2-year, $354 million contract to Magellan

Health Services, has created confusion and added costs for the local human services districts that provide the care. Reimbursement delays of weeks to months have led to serious cash flow problems for the human services districts, limiting the ability to provide services to people in need. Whether the problems will be rectified or the contract terminated remains unknown at this time.

- **MICHIGAN.** Republican Governor Rick Snyder has signed Medicaid expansion legislation into law. He had urged the legislature to enact a measure to expand Medicaid, leading to bipartisan support in both State House and Senate. His "morally and fiscally correct decision" was lauded, and legislative concurrence was urged in an OpEd in the *Oakland (MI) Press* penned by NACBHDD member Jeff Brown (Oakland County Community Mental Health Authority) and two colleagues from Macomb County and Detroit-Wayne County, respectively.

- **NEW MEXICO**. Medicaid reimbursements remain suspended for 14 behavioral health providers since the U.S. Court of Appeals for the 10th Circuit upheld a district court's decision not to order the New Mexico Human Services Department (NMHSD) to resume suspended Medicaid reimbursements. NMHSD subsequently denied 11 provider appeals, has resumed reimbursements to one provider, and is still reviewing appeals from three. To ensure continuity of services, NMHSD has reallocated $7.5 million from other programs to establish temporary contracts with five behavioral health providers from Arizona. It is unclear what will happen next.
- **PENNSYLVANIA**. After considerable initial balking, the State's Republican governor, Tom Corbett, has chosen to opt *into* the ACA's Medicaid Expansion program, thus broadening coverage to as many as 680,000 low-income uninsured individuals in the State. However, he wants to place cost-sharing and job-search requirements on new beneficiaries. Will it fly with the State legislature or DHHS? Stay tuned.
- **TENNESSEE.** The Department of Corrections and Department of Mental Health and Substance Abuse Services have launched what they believe is the first statewide recovery court in the Nation. The court, with 100 beds, will divert individuals with behavioral disorders from the criminal justice system into treatment programs at a daily cost of $35, compared with $65 for incarceration.
- **TEXAS.** There is good news and not so good news in the Lone Star State. The good news is that the East Texas Behavioral Healthcare Network (ETBHN), established by a confederation of organizations spanning 11 counties to help improve the quality of behavioral healthcare at reasonable costs, was recently awarded $1,337,000 to administer a Healthcare Navigation Grant for 75 counties in the state. In some not-so-wonderful news, the US Census Bureau has found that Texas leads the nation in the percentage of residents who lack health insurance, with more than 1 in 4 people younger than 65 without coverage of any kind. And, defying any logic, at the same time, the governor has asked the State to request a federal waiver to reform Medicaid as Texas sees fit - without expanding eligibility.

- **UTAH.** Beginning October 1, uninsured residents of Utah will be able to choose from among 99 health plans across 5 different plan levels being made available through the State's ACA health marketplace. According to news reports, the average premiums for the mid-range "silver" health care coverage are lower than expected: as little as $162 a month. Tax credits will be available to offset premium costs for low-income individuals.
- **WASHINGTON:** As the result of a class action suit first filed in 2009 that has been settled only in the past few weeks, the State of Washington has agreed to fundamentally change how it provides mental-health care to the most troubled children and youth who qualify for Medicaid. The settlement requires the State to make intensive in-home and community-based care regularly available for these youth, rather than continuing to rely on inpatient facilities as the standard source of care.

ON THE BOOKSHELF: RECENT PUBLICATIONS OF NOTE

- **GEORGE WASHINGTON UNIVERSITY/ROBERT WOOD JOHNSON FOUNDATION.** *Federal Policy Implementation under the ACA: Six Issues Whose Final Resolution Awaits* reviews ACA issues awaiting resolution, such as non-discrimination on the basis of race, national origin, gender, age, or disability in the provision of federally subsidized health insurance; non-discrimination by qualified health plans in the provision of essential health benefits; aligning the Medicaid and Exchange markets; among others. To read the brief, go to: http://www.healthreformgps.org/resources/federal-policy-implementation-under-the-affordable-care-act-six-issues-whose-final-resolution-awaits-as-implementation-moves-forward/

- **STATE HEALTH REFORM ASSISTANCE NETWORK/ROBERT WOOD JOHNSON FOUNDATION.** The ACA includes financial assistance programs to help low- to moderate-income people purchase

coverage through health insurance marketplaces. *Advance Premium Tax Credits and Cost-Sharing Reductions: A Primer for Assistors*, a visual presentation, explains the details of two of those programs: Advance Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR), describing how financial assistance works, including eligibility criteria and options for using APTCs and CSRs to purchase plans and reduce costs. The brief is geared toward marketplace staff, eligibility workers, navigators, certified application counselors and other assistors, and is a helpful tool for anyone seeking clear and in-depth information on APTCs and CSRs. To read the brief, go to: http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/08/advance-premium-tax-credits-and-cost-sharing-reductions.html?cid=xem_taxcredits9613A&cid=

- **INSTITUTE OF MEDICINE.** *Partnering with Patients to Drive Shared Decisions, Better Value, and Care Improvement* summarizes a workshop focused on empowering patients to become partners in, rather than customers of, health care, with discussion centered on the role of patient engagement in promoting better care, improved health, and lower health care costs. The workshop built on the ongoing work of the Roundtable on Value & Science-Driven Health Care to raise awareness and demand from patients and families for better care at lower costs and to create a health care system that learns and improves continuously. To read the proceedings, go to: http://iom.edu/Reports/2013/Partnering-with-Patients-to-Drive-Shared-Decisions-Better-Value-and-Care-Improvement.aspx
- **NETSMART.** *The Opportunity with Primary Care Integration* outlines the current state of primary and behavioral health care and the need for increased collaboration between the two areas to improve the likelihood of positive treatment outcomes and to reduce health care costs. Read the white paper, coauthored by the organization's chief medical and chief clinical offices, at: http://www.ntst.com/news/white_paper_form.asp

MARK YOUR CALENDAR

- **KENNEDY FORUM ON COMMUNITY MENTAL HEALTH.** An October 23-24 forum will be convened in Boston to celebrate 50 years of progress in meeting the mental health goals articulated by President Kennedy and to chart a future course for the field. Participate by organizing an event in YOUR community**.** To get materials for your use and to get more information, contact Bill Emmet at thekennedyforum@gmail.com or 508-549-5799.
- **NADD**. *30th Annual Conference & Exhibit*, October 23-25, 2013, Baltimore, Maryland. For information, go to: http://thenadd.org/30th/
- **OHIO NADD**. 11th Annual IDD/MI Conference, Mental Health Aspects: Treatment and Support, Columbus, OH, September 30-October 1, 2013. To register, go to: http://thenadd.org/ohio-highlights/
- **HOSPICE FOUNDATION OF AMERICA.** *Supporting Individuals with Intellectual and Developmental Disabilities through Serious Illness, Grief and Loss*. An Interactive Webcast, October 24, 2013, 2-4 pm ET. For more, go to: http://register.hospicefoundation.org/programs/supporting-individuals-with-intellectual-and-developmental-disabilities .
- **AMERICAN PUBLIC HEALTH ASSOCIATION.** *141 Annual Meeting*, November 2-6, Boston, MA. Go to: http://www.apha.org/meetings/AnnualMeeting .
- **AMERICAN ASSOCIATION FOR THE TREATMENT OF OPIOID DEPENDENCE.** *2013 National Conference*, November 9-13, Philadelphia, PA. Go to: http://www.aatod.org/national-conference/2013-aatod-conference-philadelphia/conference-at-a-glance/ .
- **NACBHDD/WICHE.** *The Evolving World of Behavioral Health on the Eve of ACA Implementation* (54th annual National Dialogues on Behavioral Health) November 10-13, 2013, Renaissance Arts Hotel, New Orleans, LA. For more, contact NACBHDD Office.
- **NACBHDD.** *Fall Board Meeting*, November 14-15, 2013, New Orleans, LA. Stay tuned.
- **NACBHDD.** *Spring Board Meeting*, March 2, 2014, Cosmos Club, Washington, DC; *Legislative/Policy Conference*, March 3-5, 2014, Cosmos Club Washington, DC. Stay tuned.

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