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

FEBRUARY 23, 2013

ISSUE BRIEF: HARNESSING COMMUNITY SUPPORT FOR HEALTH AND WELL-BEING

[Prepared for and Disseminated at ACMHA Policy Forum, December 2012]

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Health is a prerequisite and a goal of development and progress. As the pace of change in healthcare accelerates, leaders increasingly recognize the need to dramatically improve health outcomes for people at risk for, or living with, chronic illnesses in the United States. Current approaches will no longer be sufficient. Community support and development strategies are needed to foster prevention and health promotion.
Chronic conditions are the biggest drivers of health care and disability costs, and behavioral health conditions are increasingly recognized as major contributing factors to these costs. Managing and treating these conditions account for more than 75 percent of health care spending in the United States, while only 3 percent of health care spending goes to public health prevention programs.

Community health promotion fosters changes in our cities and towns that help promote and protect health. These changes can be accomplished through personal health improvement activities and through changes in the physical and social environments in which we live. Behavioral health conditions must be an explicit part of these prevention efforts. Trauma, mood disorders, substance use disorders, schizophrenia, bi-polar and other conditions have a huge impact on our nation's public health and affect more than 25% of our citizens at any one time. The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes that behavioral health is essential to health and has supported recent efforts to address behavioral health conditions in the United States. Some leading advocates have argued recently that behavioral disorders have had devastating effects on economic productivity, stability of our institutions, and global leadership and that we are suffering the consequences of preventable problems.

An array of socioeconomic factors makes up the "social determinants" of health and wellbeing, including behavioral health. These factors include housing, employment, poverty and equitable access to resources. These are issues that the health system cannot address alone. However, community health promotion efforts have to assess these social determinants and mobilize communities to address them incrementally and with the resources already at hand. Expanding health insurance coverage, improving the quality of care, and expanding community and behavioral health prevention can each save lives and reduce disability. But of these three, community health prevention is the only intervention that has saved lives and saved money in the long run – nearly $600 billion over 25 years. For decades, the federal government has recognized the importance of preventing substance use conditions in our communities through comprehensive community interventions. Similarly, we have proven public health initiatives in tobacco control, HIV/AIDS, obesity, and maternal health. While prevention was part of the vision of the landmark Community Mental Health Centers Act in 1963, more recently, the promotion of positive

ALSO IN THIS ISSUE

Teddi Fine, MA, Editor

mental health has not been an explicit part of federal health policy. Instead, we have focused only on treatment. Mental health and substance use providers need support to collaborate with other community health leaders to improve our capacity to promote health and wellness in communities where people live, learn, work, and play.

A growing body of evidence supports the effectiveness of community capacity building to improve health outcomes. Health promotion and prevention of adverse health conditions, including mental illness and substance use, must be part of broader community health goals. Building community capacity requires the adoption of an array of "community development tools" including but not limited to, health education, social marketing, community health needs assessments, participant-based research, community planning days, coalition building, and mobilizing self-help and peer services, including peer to peer and family centered services and supports. Community goals will vary depending on the priorities they establish and communities will differ in the levels of external support they will need. The specific goals will also change over time but they should all pursue a common goal of community health improvement – including both physical and behavioral health.

Trauma prevention, particularly in children, is an area that needs immediate attention in most of our communities. Trauma and adverse childhood experiences have an extraordinary impact on health status. For example, 70% of adults in the United States, approximately 220 million Americans, have experienced some kind of adverse or traumatic event at least once in their lives. With each additional adverse childhood experience, the risk increases for some of the most disabling and costly health problems. These include alcoholism, depression, chronic obstructive pulmonary disease (COPD), liver disease, smoking, adolescent pregnancy and risk for intimate partner violence. Reducing the prevalence of adverse childhood experiences and its associated chronic diseases must be a priority. In most communities, reducing trauma and adverse experiences will also require addressing unmet behavioral health conditions and the underlying social determinants of health.

Behavioral health is uniquely equipped to facilitate this important community-based work. We have demonstrated the ability to reduce illegal and prescription drug use, reduce the impact of depression, increase self-help and peer support for managing chronic conditions, and improve youth wellness and mental health literacy. We have a community workforce that is experienced in outreach, connected to healthcare and other community organizations, and skilled at engaging consumers in services. Yet, behavioral health prevention efforts have not been widely adopted in large-scale population health efforts.

Most of the focus on the role of social determinants in promoting good health status has occurred outside of the United States but U.S. policies are beginning to address these issues. There are multiple international initiatives to promote health and wellbeing through a "health in all policy" strategy, often focused on achieving health equity and social inclusion by addressing health status as a part of other economic development policies. A study in more than seventeen countries has shown efforts to reduce health risk factors had an empowering effect: communities and stakeholders were more willing and interested in participating in health promotion activities in a sustained manner; alliances and collaboration were strengthened; communication channels were opened; and municipalities were stimulated to review their planning and implementation processes in order to incorporate health promotion principles. The Robert Wood Johnson Foundation Commission to Build a Healthier America and the Centers for Disease Control (CDC) and Prevention Public Action Plan to integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention are examples of two U.S. policy efforts that have begun to adopt this approach - but more attention is needed for behavioral health conditions.

The social interventions needed to improve community health and reduce disability status are not billable interventions. They do not take place in an office or exam room. They require "community organizing" activities that are unique to each community and that build on and enhance each community's strengths, including businesses, schools, community health centers, and faith communities. As a place to begin, the CDC's CHANGE Action Guide is a proven community health planning tool, however it should be augmented to include behavioral health conditions.

To reap the benefits of better health and reduced healthcare costs, health promotion needs to be explicitly incorporated into all policies, including community development, education, law enforcement, as well as healthcare. Behavioral health needs to be an explicit part of each of these efforts. Thus, whenever spending or policies for treatment and support are considered, specific focus also should be given to improving health and reducing the incidence of

disease, including addictions, depression, anxiety and other behavioral health conditions. The nation's communities are ready and willing to participate. Law enforcement, clergy, educators, health professionals, and businessmen and women recognize that health and economic development are related. They need the right supports and incentives to spark and guide their actions. Reducing the incidence of trauma and adverse childhood experiences are important places to begin.

A Framework for Mental Health Programs and Funding
A California Model

The Honorable Darrell Steinberg
President Pro Tempore, State Senate of California

Darrell Steinberg, a leader of the California State Senate, is also a champion for mental health services, most notably in the form of Proposition 63, the Mental Health Services Act (MHSA), adopted by public referendum in 2004. Under that Act, California provides about $1 billion annually for essential mental health services, including prevention and early intervention services, suicide prevention, treatment services, primarily through the Full Service Partnerships, supportive housing, and workforce development. This investment is reducing the adverse impact of untreated mental illness and is supporting progress to serve children, transition-age youth, adults, older adults and families with mental health needs.

Following the Newtown tragedy, Senator Steinberg came to Washington to share a national mental health framework based on core elements of California's Proposition 63 in meetings at the White House and in hearings before the US Congress. This article summarizes key elements of this successful and cost-effective framework as he presented them for consideration, adaptation and adoption by leaders in Washington and in jurisdictions across the country.

Overview

Mental health services have been underfunded from the start due to stigma, discrimination and an historical lack of effective treatment models. Further, States have cut $4.35 billion in public mental health spending just between 2009 and 2012. While the Affordable Care Act, coupled with the Mental Health Parity and Addictions Equity Act, provide enormous potential and opportunity, we need to acknowledge that access to full mental health treatment and supports remains a substantial barrier.

My proposed $10 billion framework for investment in mental health services and supports is grounded in principles and approaches proven in effectiveness and have been implemented in California through its Mental Health Services Act (MHSA). It focuses on:

- Prevention and early intervention
- School-based health centers; and
- Mental health treatment services and supports to treat the whole person – "*whatever it takes.*"

The Act, a catalyst for transforming California's mental health system, has served as a key financing stream to attract other federal funds, private foundation support and local dollars. Critically, an average of 62% of the cost of providing a Proposition 63 funded Full Service Partnership is offset in savings in public money through reduced incarceration, reduced psychiatric hospitalization, reduced hospitalization for physical health, and reduced acute nursing needs. In two years, the public saved $85 million by investing in proper care. Proposition 63 services are reducing homelessness, acute psychiatric hospitalizations, arrests and incarcerations. In Los Angeles County, clients receiving Proposition 63 services have experienced 69% fewer days spent in homelessness; 21% fewer days of acute psychiatric hospitalization; 90% fewer days in other types of hospitals; and 46% fewer days incarcerated.

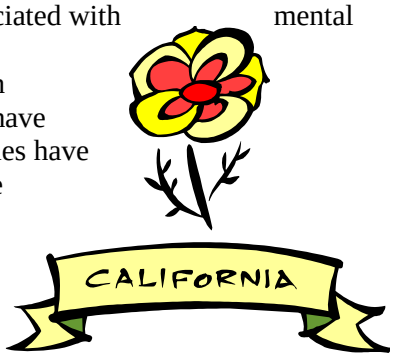
This $10 billion federal investment to states would have an immediate effect in local communities and would take a significant step in rebalancing the paradigm to one of providing assistance and fostering recovery and resilience.

Invest in Prevention and Early Intervention

California's MHSA requires that 20% of funds allocated to counties be spent on prevention and early intervention programs. The overall purpose is to prevent mental illnesses from becoming severe and disabling. It requires an approach to prevention and early intervention that is integrated, accessible, culturally competent, strength-based, effective, and that targets investments with the aim of avoiding costs (in both dollars and human suffering) for treatment services.

Both universal and selective approaches to prevention and early intervention efforts are used, including population-based approaches, and risk-based approaches. Over $1.3 billion in MHSA funds have been invested across the state since its inception. As a result, California currently has 421 prevention/early intervention programs in communities around the state. The programs have proven particularly crucial to meeting local needs in ethnically and culturally diverse communities in which increased stigma may be associated with mental disorders. This unprecedented investment is unmatched anywhere else in the Nation.

Today, every county in the State has at least one prevention and early intervention program for at-risk children, youth and young adults. Eighty-six percent of counties have programs to address both mental health and substance abuse. Over 3 of every 4 counties have programs to help reduce trauma; 76% have programs to reduce suicide; and 76% have programs to increase access to mental health services.



FUND SCHOOL-BASED HEALTH CENTERS FOR INCREASED MENTAL HEALTH SERVICES

Annually, an estimated 25% of children experience a mental disorder, including developmental disorders, anxiety, depression, trauma and eating disorders. Half of all lifetime case of mental and substance use disorders begin by age 14; 75% by age 24. Child and adolescent mental disorders can greatly affect functioning, not just at home, but also at school. That's why schools are a setting in which early mental health problems may first be identified. Schools provide an opportunity to identify youth at risk for mental problems and to link them to care and supports.

However, schools, from elementary to high school levels, often lack the resources to meet the needs of students requiring more intensive services. Partnerships and collaborations between schools and community programs can link students to services and supports. Today, over 1,900 School-Based Health Centers (SBHCs), spanning 44 states and the District of Columbia, provide primary medical care, mental health, substance abuse counseling, oral health, health promotion, nutrition management and case management services to children and youth. ACA grant funds are expanding these SBHCs to reach over 600,000 additional young patients; the Public Health Services Act funding also helps support these Center. However, in the main, 76% of SBHCs rely on state or local government funding for their operations; about half receive some support from private foundations.

In California, counties use MHSA funds to provide a variety of mental health-related services through school districts and selected SBHCs. Under the framework, federal funds would be invested to build capacity for a continuum of mental health services, such as early and periodic screening, behavioral intervention and supports, counseling, help with crisis management, and medication services. Federal funding could be conditioned on matching funds from the public or private sectors at the state or local levels, thereby leveraging resources and encouraging integrated care across behavioral health and physical health care. Such an approach would expand access to early screening, combat stigma, establish coordinated health care teams, establish a positive school learning environment for all students, and link readily to other prevention and early intervention programs.

MENTAL HEALTH TREATMENT SERVICES AND SUPPORTS: "WHATEVER IT TAKES"

The time is now for federal investment in mental and substance abuse treatment services and supports. Data consistently reinforce the cost-benefit of early treatment for mental illness and addiction, ranging from 1:2 to 1:10, or a return on each $1 spent of from $2 to $10 in the costs of health care, juvenile justice, education, and lost productivity. A client-focused service model can effectively deliver prevention, care and supportive services in a way that focuses on recovery, wellness, accountability and outcomes.

California created such a model under the MHSA—the Full Service Partnership program—since over 65% of the Act's ongoing funds are designated for community services and supports for persons with serious mental illnesses or serious emotional disturbances. Full service partnerships are designed to serve Californians across the life cycle, and to provide intensive "whatever it takes" services. The directive includes meeting both the service and quality-of-life needs of the patients and the social outcomes and service needs of the State. This can include housing, jobs, schooling, physical health care, clothing, food or treatment of serious or co-occurring disorders. The "whatever it takes" approach, provided by a team 24 hours a day, 7- days a week helps people on the path to recovery and wellness.

The Full Service Partnership Program is administered at the local level by county mental health departments in partnership with local service providers. A comprehensive "toolkit" for each segment articulates core principles, components and implementation strategies to facilitate a consistent approach throughout the State. MHSA funds are used to leverage local government funds, federal Medicaid dollars, private foundation monies, and other federal grants.

A recent comprehensive evaluation recognized the efficiency of the innovative service model for individuals getting services as well as the cost savings and cost avoidance realized because services have been provided, including reductions in psychiatric hospitalization emergency room visits, chronic homelessness, and incarcerations.

Federal funds can supplement treatment services and supports that are not supported through Medicaid or existing federal grants. California's Full Service Partnership can serve as a national model for integration of a continuum of health, mental health and substance use services, and funding streams. These funds could target specific outcome measures, certain underserved populations, and or specific access to service barriers. State contributions in the form of public or private funding could be required to encourage a strong partnership.

An immediate federal infusion of funds could help eliminate the severe underfunding of mental health and substance abuse treatment services and supports. The overall $10 billion investment would provide a firm foundation on which states and communities could revitalize a chronically undervalued sector of health care services. Such federal funds would acknowledge and make a commitment to the importance of comprehensive mental health and substance use services and supports as a key element of the Nation's overall health.

BITS FROM DC

Dear NACBHDD Colleagues:

Our upcoming DC Legislative and Policy Conference is just around the corner. Among the highlights:

- A presentation by Judge Robert T. Russell, the founder of the first Veterans Court in the United States.
- Meeting and legislative work on removing the Inmate Exception in Medicaid.
- Presentations on the Medicaid Expansion and the new Affordable Insurance Marketplaces.
- A Hill Reception on the Senate side, with several important awardees, including Director Kerlikowske of the White House Office of National Drug Control Policy.
- Our very first L & P Conference at the Cosmos Club, rather than at a hotel.
- Our first session at the NACo Spring Conference on the Medicaid Expansion.
- And much, much more.

I hope that you plan to come, and I hope that you also plan to bring an emerging leader from your own office. I look forward to seeing you on March 4!

Ron Manderscheid, PhD
Executive Director

THE IMPORTANCE OF PREVENTION

No ifs, ands or "butts" about it, more people with mental disorders than members of the general public place themselves at serious risk by smoking. According to the CDC and SAMHSA, adults with some form of mental illness have a smoking rate 70% higher than adults with no mental illness. According to a new *Vital Signs* report, 36% of adults with a mental illness are cigarette smokers, compared with only 21 percent of adults who do not have a mental illness. Among adults with mental illness, smoking prevalence is especially high among younger adults, American Indians and Alaska Natives, those living below the poverty line, and those with lower levels of education. Differences also exist across states, with prevalence ranging from 18.2 percent in Utah to 48.7 percent in West Virginia. For more, go to: http://www.cdc.gov/vitalsigns/SmokingAndMentalIllness/index.html

TRANSITIONS

- We can hope for this transition. It's been in the works for a while. President Obama has re-nominated **Marilyn Tavenner** to lead the Centers for Medicare and Medicaid Services (CMS). Tavenner herself isn't controversial —she worked with House Majority Leader Eric Cantor (R-Va.), when she led Virginia's Medicaid program. The job, however, is controversial, since it's the point position for ACA

implementation. Also at CMS, **Richard Foster**, a long-time employee and Medicare's chief actuary has retired from his post. His independent cost analyses of the Federal health care program for seniors and others will be missed.

- Finally, **Carolyn Clancy** is leaving her post as director of the Agency for Healthcare Research and Quality (AHRQ), where she had worked since 2003.

SEQUESTRATION: REDUCED ACCESS TO BEHAVIORAL HEALTH CARE

According to a White House fact sheet, detailing the effects of the impending March 1, 2013, sequestration, among numerous other consequences, cuts to the Mental Health Block Grant program would prevent over 373,000 individuals with SMI or SED from getting mental health services, while cuts to the Projects for Assistance in Transition from Homelessness (PATH) program would prevent nearly 9,000 individuals with SMI from getting outreach, treatment, housing or support services.

NATIONAL CALL TO ACTION ON GUN VIOLENCE AND BEHAVIORAL HEALTH CONCERNS

In a January 27, 2013, letter to the President and Vice President, NACBHDD and other behavioral health stakeholder organizations agreed that the Nation's response to Newtown not be limited solely to gun control, but also should focus on preventing mental illnesses and substance use in the young, identifying and intervening early when problems do occur, and ensuring easy access to care. The coalition also offered consensus language on gun purchaser background checks and reports of imminent violence by health professionals:

- **Screening for Sale or Transfer of Ownership for a Rifle, Shotgun, or a Pistol**. The mental health and substance abuse treatment and prevention community supports mandatory screening in advance of all gun sales and transfers. Previous use of a gun in the commission of an adjudicated crime by a prospective purchaser should be automatic grounds for denial of a sale or a transfer. Beyond this, screening must focus on expressed and intended violence toward others or toward oneself. Inappropriate use of substances, including alcohol and mental illness may be factors leading to expressed and intended violence, but they are not always present. Appropriate screening tools and standards must be developed. The mental health and substance abuse treatment and prevention community will assist in efforts to develop these tools and standards.
- **Duty to Protect from Expressed and Intended Violence**. The mental health and substance abuse treatment and prevention community recommends that "duty to protect" from expressed and intended violence mirror the successful, well-established surveillance and reporting mandates for child maltreatment, intimate partner violence, and elder abuse. State laws mandate that members of a broad net of designated professions (generally teachers and other school personnel, physicians and other health-care workers, mental health and substance use professionals, law enforcement officers, and often other professionals) report suspicion of child maltreatment, intimate partner violence, and abuse, neglect or exploitation of incapacitated or dependent adults. Typically, a report must be made when the reporter, in his or her official capacity, suspects or has reasons to believe that maltreatment has occurred or is at imminent risk of occurring. We recommend that similar processes be developed for reporting expressed and imminent violence and for separately assigning to entities other than reporting professionals the responsibility for conducting a subsequent screening for purchase or transfer of ownership of a weapon.

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

- **PROPOSING FEDERALLY QUALIFIED CMHCS**. Senator Debbie Stabenow (D-MI) has introduced the Excellence in Mental Health Act, which would establish standards to federally certify as many as 2,000 community mental health centers around the country, enabling the facilities to qualify as Medicaid service providers nationwide for the first time. Facilities would be required to provide such services as 24-hour crisis care and substance abuse treatment. Introduced in the wake of the Newtown tragedy, the measure has bipartisan co-sponsorship, including Roy Blunt (R-MO), Jack Reed (D-RI), Susan Collins (R-ME), Barbara Boxer (D-CA), Marco Rubio (R-FL), Patrick Leahy (D-VT), Lisa Murkowski (R-

AK), Mark Begich (D-AK), Jay Rockefeller (D-WV), Jon Tester (D-MT), and Chris Coons (D-DE). Stay tuned regarding potential fine-tuning to make it even more successful for everyone in the behavioral health and I/DD communities.

- **MENTAL HEALTH POST-NEWTOWN HEARING.** As part of the House Energy and Commerce Committee's ongoing review of mental health issues raised by the Newtown tragedy, the Oversight and Investigations Subcommittee has scheduled a March 5 forum with leading national experts to explore issues related to severe mental illness and violence, including problems related to access and stigma, how best to identify and treat people with serious mental disorders, prevention and early intervention, how treatment for people with serious mental illnesses has changed over time, and best practices in programs and treatments currently available. For further details on the forum, go to: http://energycommerce.house.gov/event/after-newtown-national-conversation-violence-and-severe-mental-illness
- **STILL ON THE EDGE.** Deadlines are upon the Hill: March 1 sequester deadline; March 27 continuing resolution expires; April 15 budget deadline; May 19 debt ceiling limit reached. Sequestration could spell hardship for behavioral health and I/DD program funding. Amid all the concern, the good news is that the debt ceiling measure signed by the present was supposed to extend the nation's borrowing authority to May 19, but it may actually go all the way to August.
- **COMPANION MENTAL HEALTH JUSTICE MEASURE IN HOUSE.** A House companion to Senator Franken's Justice and Mental Health Collaboration Act (a bill that improve access to mental health services for people in the criminal justice system) has been introduced by Rep. Rich Nugent (R-FL). In the meantime, Franken's bill has garnered 8 bipartisan Senate cosponsors.
- **ANTI-METH MEASURE.** The Methamphetamine Education, Treatment and Hope Act, first introduced in 2009 and passed by the House, has been reintroduced by a group of Representatives including Jerry McNerney (D-Calif.), Bobby Rush (D-Ill.), Charles Rangel (D-NY), G.K. Butterfield (D-N.C.), Alcee Hastings (D-Fla.), David Valadao (R-Calif.) and Ben Ray Luján (D-NM) The bill requires HHS to conduct screening and treatment of those addicted to methamphetamine and award grants to drug treatment centers in underserved or rural areas, with a particular emphasis on pregnant women and youth.
- **MORE HILL COMINGS AND GOINGS.** Among the latest to announce their retirement from the U.S. Senate when their terms end are long-term Senators Tom Harkin (D-IA) and Jay Rockefeller (D-WVA), both good friends in the health care field. Harkin's support for prevention will be particularly missed. In addition, a new Senator has been sworn in to replace Senator John Kerry (D-MA) who's off to the State Department. William "Mo" Cowan was appointed by Massachusetts Governor Patrick to hold the post until a June 25 special election.
- **MORE TIMELY MENTAL HEALTH CARE FOR VETERANS.** Following a hearing on the state of veteran's mental health care, House Veterans' Affairs Committee Chairman Jeff Miller (R-FL), posed a way to reduce long waits by veterans seeking behavioral health care: enabling veterans who have trouble getting timely mental health care from VA hospitals and clinics to tap into the Tricare program and be treated by physicians who provide care to active military and their families. The proposal would extend only to mental health care.

HHS AND OTHER AGENCY NEWS AND NOTES

Final ACA Essential Health Benefit Regs Issued. Just issued final HHS regulations clarify the benefits insurers are required to offer under the ACA. Ten broad categories of care are covered (e.g., behavioral *health care*, emergency services, preventive and early intervention care, inpatient and outpatient services and *prescription medications*). The regulations, which take effect in January 2014, allow four levels of coverage (with larger or smaller patient-borne copayments). Minimum benefits will vary from state to state, based on the state's approved benchmark plan. White House and HHS say the regulations close a major gap in coverage for people with mental disorders or drug problems. Prior to the rule, almost 20% of people purchasing insurance did not have access to mental health services, and nearly a third had no substance abuse disorder benefits. While insurers must set procedures in place that enable patients to get "clinical appropriate" medications that are not on the plan's list of covered drugs, the regulations also stipulate that insurers offer the greater of a single drug per category OR the same number as a state's benchmark plan (usually 2 per drug class). Given the nature of behavioral disorders and often highly individualized medication needs, this element may be of some concern to the behavioral health provider community. Stay tuned.

- **KEY GUIDANCE ON PARITY ACT AND ACA ISSUED.** HHS's Centers for Medicare & Medicaid Services (CMS) has provided guidance to state Medicaid directors and health officials on topics with significant implications for individuals with behavioral disorders. The guidance focuses on (1) Application of the Mental Health Parity and Addiction Equity Act (PL 100-343) to Medicaid MCOs, CHIP and Alternative Benefit (benchmark) plans; and (2) Recommended health home quality measures for states to use as they assess these service delivery models authorized by section 2703 of the Affordable Care Act. These quality measures will become the subject of future regulations as well. For more, go to: <http://ct.symplicity.com/t/eof/866e2c602d42d5e88817fc7c261704d1/3501518774/realurl=http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf> (Parity Act); and <http://ct.symplicity.com/t/eof/866e2c602d42d5e88817fc7c261704d1/3501518774/realurl=http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf> (Health Home Measures)
- **BUNDLED PAYMENT PROGRAM.** Over 500 organizations will participate in Medicare's Bundled Payment for Care Improvement initiative. Through this initiative, CMS will test how bundling payments for care episodes can better coordinate and lower costs of care. The program includes 4 models of bundling, based on the types of providers and services involved. The awards will be phased in over time. To see the list of awardees for Model 1 and participants for Phase 1 of Models 2, 3, and 4 and, please go to: http://innovation.cms.gov/initiatives/bundled-payments
- **DRAFT REGS OUT ON CAPPING PROFIT MARGINS.** CMS has issued proposed regulations to implement an 85% "medical loss ratio" requirement for Medicare's Part D (prescription medication) and Advantage programs. That means at least 85% of premiums must be spent on services that directly affect beneficiaries. Overhead and profits will be capped at 15%; providers would face penalties for non-compliance. For more, go to: https://www.federalregister.gov/articles/2013/02/22/2013-03921/medical-loss-ratio-requirements-for-medicare-advantage-and-medicare-prescription-drug-benefit?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov
- **NEW PARITY ISSUE BRIEF.** HHS's Office of the Assistant Secretary for Planning and Evaluation has released a new issue brief on implementation of the Parity Act within the context of the Affordable Care Act. It provides a historical look at the state of coverage for mental and substance abuse disorders before ACA implementation and the impact of various elements of the ACA on improved coverage of and access to behavioral healthcare. To read the full issue brief, go to the ASPE website at http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm.
- **MINIMUM ESSENTIAL BENEFIT REGS NEARLY THERE.** In the last step before final promulgation, the Office of Management and Budget (OMB) is reviewing final regulations on other aspects of the ACA's essential health benefits. The OMB notice refers to IRS-related provisions such as exemptions based on religious factors or on insufficient taxable income; and the process for determining household income and eligibility for tax subsidies. The regulations also will address the verification process to determine if individuals may buy employer-based healthcare and whether they are eligible for federal subsidies to help purchase private insurance. Stay tuned.
- **NEW JUSTICE-MENTAL HEALTH GRANT OPPORTUNITY.** The Justice Department's Bureau of Justice Assistance has announced the opportunity for FY 2013 grants under its Justice and Mental Health Collaboration Project. With nearly 1 in 5 individuals in jails or prisons experiencing a serious mental illness , this program aims is designed to improve the criminal justice system's response to individuals with mental disorders. *Applications are due March 25, 2013.* For more information, go to: https://www.bja.gov/ProgramDetails.aspx?Program_ID=66 Scroll to the bottom of the page to access the solicitation.

AROUND THE STATES: AN UPDATE

- **ARIZONA.** Governor Jan Brewer now supports Medicaid Expansion. She worried that if she didn't participate, her constituents' federal taxes would go into the national Medicaid pot and not help Arizonans.

CALIFORNIA. Governor Jerry Brown called a special session on healthcare to better help the State implement the provisions of the ACA, including Medicaid expansion, streamlined enrollment of new beneficiaries, and the creation of the State's Health Marketplace (formerly an 'exchange'). The Governor

wants the laws running in 90 days, rather than at the start of 2014. At the same time, the California Endowment will award at least $225 million to help communities and state programs implement the ACA in the State by funding outreach and enrollment assistance for Medicaid and the State's Health Insurance Marketplace, expand the State's primary care workforce, improve care management for chronic diseases, and explore ways to expand the ACA's coverage provisions to undocumented immigrants.

- **CONNECTICUT.** In the wake of Newtown, the State Office of Policy and Management authorized the Department of Mental Health and Addiction Services (CDMHAS) to stop $7.7 million in scheduled behavioral health provider cuts. CDMHAS officials will find offsetting cuts elsewhere in the department's budget. In addition, two bills were introduced in the legislature to mandate mental health screening for every child in school across the state. Other measures would mandate broader mental health coverage by insurers serving Connecticut residents.
- **ILLINOIS.** In a second phase of Medicaid care coordination, the Department of Healthcare and Family Services will provide long-term services and supports for seniors and individuals with disabilities through its Integrated Care Program that will move at least 50% of the Medicaid population into coordinated care by January 1, 2015.
- **MASSACHUSETTS.** Concern about overuse of antipsychotic medications and similar drugs in nursing homes, hospitals, and other health facilities has resulted in proposed legislation to require facilities in the State to inform patients, or their legal representatives, in writing of the medications' risks, benefits and alternatives.
- **MICHIGAN.** Republican governor Rick Snyder has decided to participate in the ACA's Medicaid Expansion program, giving Medicaid access to around 470,000 additional State residents.
- **MISSISSIPPI.** HHS Secretary Sebelius has rejected the State's proposed health insurance marketplace plan submitted in November by the State's insurance commissioner. Because Governor Phil Bryant (R) actually opposes the ACA, this rejection, resulting in federal management of a marketplace for the State, may have been a desirable outcome.
- **MISSOURI.** Governor Jay Nixon (D) has urged the legislature to approve adoption of the ACA's Medicaid expansion as "the smart thing to do." If adopted, as many as 300,000 would gain coverage. To sweeten the pot, he said he would support repeal if the federal funding share is altered.
- **NEW YORK.** In a 2013-2014 budget amendment, Governor Cuomo (D) proposes to cut $500 million from the Medicaid program to make up for the loss of federal funds resulting from earlier overpayments related to services for people I/DDs. Services for patients with I/DDs in State institutions would lose $120 million. Another $380 million would come from other health care programs for low-income people (e.g., delaying implementation of the health home program, imposing a 6% reduction to OPWDD Medicaid rates for non-profit providers, and a possible 2% across-the-board reduction in Medicaid reimbursements). The Governor also proposed creating a Mental Hygiene Stabilization Fund, supported by Department of Health Medicaid resources in annual amounts not to exceed $730 million in FY 2013-14, $445 million in 2014-15, and $267 million in both 2015-16 and 2016-17.
- **NEVADA.** A measure that advances "outpatient commitment" has been reintroduced in the State Assembly. The foremost aim is to stop the revolving door to jails, prisons and psychiatric hospitals for people with mental disorders. However, the measure can help lower costs, too. The bill's author cited data suggesting that outpatient commitment can lower hospitalizations, homelessness, arrests and incarcerations among participants by 74 percent to 88 percent.
- **OHIO.** Republican Governor John Kasich, a long-time critic of the ACA, has decided to participate in the law's Medicaid Expansion program, paid fully through federal funds for the first few years. The decision, coming just before the HHS deadline, means that as many as an additional 600,000 Ohioans, many with behavioral disorders or I/DDs, will be able to participate in the Medicaid program.
- **WISCONSIN**. Governor Scott Walker has rejected the ACA's Medicaid expansion. Instead, he has laid out his own plan to cover his state's low-income uninsured population. His proposal relies heavily on subsidized coverage through the ACA's healthcare marketplace, managed, in the case of Wisconsin, not by the state, but by the federal government.

SEEKING BETTER HEALTH THROUGH OUR COMMUNITIES AND OUR FAMILIES: THE INAUGURAL ACMHA DC POLICY FORUM

ARE WE PREPARED TO UNDERTAKE THE IMPENDING SHIFT FROM DISEASE CARE TO HEALTH PROMOTION?

Ron Manderscheid, PhD.

Reprinted from Behavioral Healthcare
Accessible at http://www.behavioral.net/blogs/ron-manderscheid/seeking-better-health-through-our-communities-and-our-families-inaugural-acmh

Our experiences of warmth, inclusion, and acceptance by our family and friends are particularly accentuated during the rapidly approaching Holiday Season. Why mention this here? Finally, we are beginning to appreciate that our family and our community support systems do play an essential role in promoting our good health and our sense of well-being.

As we implement the Affordable Care Act (ACA), we will devote much more attention to policies and interventions that promote positive health and well-being. This effort arises from the recognition that health and disease are two separate dimensions, and that effective health promotion can prevent, delay, and mitigate disease. Our work will include improving the positive social determinants of health—such as community and family self-actualization, which can enhance the nurturing environments and life chances needed to improve and maintain good health. In fact, by 2020, fully 30 percent of our health care dollars will be spent on promoting positive health, rather than on treating disease. Because continued good health can actually prevent or delay the onset of chronic diseases, many disease care dollars can be saved if we are successful in this work.

To underscore the viral implications of this dramatic change in our thinking about health and disease, **ACMHA: The College for Behavioral Health Leadership** conducted its inaugural **DC Policy Forum** this week on *Harnessing Community Support for Health and Well-being.* On December 4, at a gala reception and dinner event, more than 100 participants explored how community and family factors can improve or harm health. On December 5, Senator Sheldon Whitehouse (D-RI) hosted a Congressional Briefing for more than 150 participants to explore the role that communities and families ought to play as we seek to implement national policies that emphasize health promotion and disease prevention. (Also on December 5, Senator Whitehouse had an Op-Ed in *Politico* that addressed the subject of his comments: http://www.politico.com/story/2012/12/health-care-savings-without-medicare-cuts-84579.html).

Speakers included the noted physician, Dr. Vincent Felitti, former Medical Director of Kaiser Permanente and the principal author of the famed study of adverse childhood experiences, which demonstrated the potent effects of adverse events in harming subsequent health status. Dr. Felitti was joined by Dr. Carolyn Jenkins, a senior investigator at the Center of Excellence in the Elimination of Diabetes and Disparities, who has demonstrated how effective community and family self-actualization and support can reduce the adverse health consequences of diabetes in elderly minority populations.

Dr. Arthur Evans, Commissioner of the Philadelphia Department of Behavioral Health and Intellectual Disability Services, introduced a community mural preparation initiative in downtown Philadelphia to foster community self-actualization around health and well-being. Dr. Thom Bornemann, Director of the Carter Center Mental Health Program, observed that the time has come to recognize the potency of these social determinants of health in our public policies.

The message of the panel was highlighted by Tonier Cain, of the National Center for Trauma Informed Care, who shared her personal childhood and adult perspectives as a person in recovery, a trauma survivor and as a mother, and by Paolo Delvecchio, Director of the Center for Mental Health Services, also a consumer-advocate, who emphasized what we can learn from recovery communities and from trauma informed care as we undertake this work.

Some major points of consensus were reached by participants through these discussions: a need exists to educate national and state legislators and policymakers about the paradigm shift taking place in our approach to health; greater flexibility will be needed in program funding to accommodate a broader range of activities, including family and community initiatives; this flexibility will need to extend to breaking down traditional bureaucratic barriers among governmental agencies; new partners, especially public health and faith-based organizations, will need to be brought to the table. The timeline for undertaking this work is short, so that opportunities are not missed under the Affordable Care Act. Finally, we, ourselves, will not be able to effect this transformation unless we are able

to first transform our own thinking.

In preparation for the event, Forum planners also prepared an Issue Brief that underscores the importance of promoting good health to achieve economic and social progress. It summarizes the evidence that supports the key role that communities and social support actually play in this endeavor. The Issue Brief is available at http://www.acmha.org/content/current_events/DC_Policy_Forum_Issue_Brief.pdf.

ACMHA has initiated the DC Policy Forum to inform both the public policy and health advocacy communities about innovative approaches and practices that can reduce the burden and cost of disease, and promote better health. The College anticipates hosting similar events in the future.

ACMHA is recognized as the premier forum for the development of leaders and the exchange of innovations that impact the health and wellness of people with mental health and substance use conditions. Its membership consists of nationally recognized behavioral health leaders sponsoring programs to inform policy, increase awareness, and shape innovative solutions in the behavioral health field. For further information about ACMHA, please visit www.acmha.org. Our hats are off to Dick Dougherty, President of Dougherty Management Associates, who did a stellar job as chair of the DC Policy Forum Committee, and the other ACMHA members who provided expert advice on the Committee. These include Jennifer Andrashko, Bill Emmet, Sandy Forquer, Eric Goplerud, Eunice Hartman, Renata Henry, Steve Hornberger, Ryan Springer, and Ken Thompson. Two other ACMHA members, Katie Bess and Phyllis Vine, structured the social media for the event.

HOPKINS SUMMER OPPORTUNITY

Dr. Manderscheid again will be teaching the county leadership course at Johns Hopkins University this summer (June 17-18, 2013, 8:30 am -12:30 pm), The course reviews the key features of successful management of county and local authorities that oversee and conduct mental health, substance use, and developmental disability services. It also explores environmental factors that impact local operations, as well as facility with key tools to plan and implement services. Two principal environmental factors, i.e., National Health Reform and Medicaid, and two primary tools for management, i.e., strategic planning and needs assessment, are examined in depth. The course emphasizes practical knowledge so managers can apply the information immediately upon returning to their programs. As in the past, Dr. Manderscheid will be seeking federal funding but, at this time, has no assurance that such funding will be available. For more information, go to: **http://www.jhsph.edu/dept/mh/summer_institute/courses.html**

ON THE BOOKSHELF: RECENT PUBLICATIONS OF NOTE

- **CALIFORNIA HEALTHCARE FOUNDATION.** *Privacy Please: Health Consent Laws for Minors in the Information Age* explores the complexity of maintaining the privacy of mental health services among teens seeking such treatment The issue brief provides an overview of laws governing disclosure of minors' health information, spotlighting challenges the laws pose to comprehensive electronic health information exchange For more, go to: http://www.chcf.org/~/media/MEDIA LIBRARY Files/PDF/P/PDF PrivacyPleaseHealthConsentMinors.pdf
- **TRUST FOR AMERICA'S HEALTH.** *A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years*, provides high-impact recommendations to prioritize prevention and improve the health of Americans. For the report, go to: http://healthyamericans.org/report/104/
- **SAMHSA.** *Facilitating Cross-system Collaboration: A Primer on Child Welfare, Alcohol and Other Drug Services, and Courts*, reviews characteristics of child welfare, substance abuse services, and courts to support cross-system coordination within State, county, and tribal jurisdictions. It also considers the framework, population, legislation and funding sources, and services for each system. Go to: http://store.samhsa.gov/product/SMA13-4735
- **SAMHSA**. *Data-Based Planning for Effective Prevention: State Epidemiological Outcomes Workgroups* is a new publication presenting the key principles and core expectations of state and community decisions regarding prevention programs for substance abuse and mental health disorders. Go to:

http://store.samhsa.gov/shin/content/SMA12-4724/SMA12-4724.pdf

- **NEW ENGLAND JOURNAL OF MEDICINE.** *After Newtown — Public Opinion on Gun Policy and Mental Illness* reports new public opinion polls find that fear and stigma still surround mental illnesses. While Americans say they're concerned about discrimination people with mental illnesses face, not even 1/3 (29%) say they're willing to work closely with someone with a serious mental illness. Go to: http://www.nejm.org/doi/full/10.1056/NEJMp1300512
- **ROBERT WOOD JOHNSON FOUNDATION.** A policy brief explores requirements for establishing a *federally facilitated exchange (FFE)*, and suggests enormous challenges for the federal government in planning and implementing federally-operated exchanges. Go to: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404139
- **KAISER COMMISSION ON MEDICAID AND THE UNINSURED.** *Getting into Gear for 2014: Findings From a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013*, a comprehensive annual survey, found that nearly all states are advancing information technology and process improvements to develop faster, streamlined Medicaid enrollment systems as required under the ACA, whether or not the state elects to expand Medicaid coverage under the law. As of Jan. 1, 2013, 47 states had applied for or received increased federal funds to make major Medicaid enrollment system upgrades; 42 states had already begun system work. To read the report, go to: http://www.kff.org/medicaid/8401.cfm

MARK YOUR CALENDAR

- **26TH ANNUAL CHILDRENS MENTAL HEALTH RESEARCH AND POLICY CONFERENCE.** March 3-6, 2013, Tampa, Florida. The conference brings together over 500 stakeholders to share behavioral health inforamtion and policy direction in such areas as the impact of the ACA on behavioral care for children and youth, integrated care, community-based services, and early recognition and intervention, a particular concern following the events in Newtown, CT. For more, go to: http://cmhtampaconference.com/index.php
- **NJ ASSOCIATION OF MENTAL HEALTH AND ADDICTION AGENCIES.** *Riding the Coaster of Change: 2013 IT Project Conference*, March 5, 2013, Pines Manor, Edison, NJ. The conference focuses on the growing use of information technology in behavioral health care services and systems. For more, go to: www.njamhaa.org
- **Hold the Date! NACBHDD LEGISLATIVE AND POLICY CONFERENCE.** March 4-6, 2012, Cosmos Club, Washington DC.
- **ACMHA SUMMIT**. *Leadership for the Triple Aim: Better Care, Better Health, Lower Cost*, April 3-5, 2013, Marriott Waterside Hotel and Marina, Tampa, FL. More information, including registration materials, is available on the ACMHA website.
- **NATIONAL RX DRUG ABUSE SUMMIT**. April 2–4, 2013 | Omni Orlando Resort, Champions Gate, FL. Keynoters include CDC, DEA, FDA, ONDCP, NIDA and SAMHSA leaders. For more, go to: http://nationalrxdrugabusesummit.org
- **NATIONAL COUNCIL FOR BEHAVIORAL HEALTH.** 2013 Annual Conference, April 8-10, 2013, Las Vegas, NV. For more, go to: http://www.thenationalcouncil.org/cs/conference2013
- **WORLD PSYCHIATRIC ASSOCIATION REGIONAL CONGRESS, 2013.** *Facilitating Mental Health, Primary Care & Public Health Integration for Southeast Europe & Eurasia*, April 10-13, 2013, Bucharest, Romania. Go to: http://www.wpa2013bucharest.org.
- **ASSOCIATION OF COMMUNITY MENTAL HEALTH AUTHORITIES IN ILLINOIS.** *Spring Legislative Conference*, April 17-18, 2013, Crowne Plaza Hotel, Springfield, IL. For more information, go to: http://www.acmhai.org
- **GLOBAL ADDICTION. AMERICAN ASSOCIATION FOR THE TREATMENT OF OPIOID DEPENDENCE.** *Global Addiction and Europad Joint 2013 Conference*, May 7-10, 2013, Pisa Italy, provides an opportunity to gain knowledge from around the globe on opioid addiction treatments. For more, go to: http://www.globaladdiction.org.
- **NATIONAL RURAL INSTITUTE ON ALCOHOL AND DRUG ABUSE.** The 29th annual *National Rural Institute on Alcohol and Drug Abuse* is slated for June 9-13, 2013, in Menomonie, WI. For more information, go to: http://www.uwstout.edu/profed/nri/index.cfm
- **AMERICAN PUBLIC HEALTH ASSOCIATION.** 141st Annual Meeting, *Think Global, Act Local*, is scheduled for November 2-6, 2013, in Boston, MA. For more information about the meeting, go to: http://www.apha.org/meetings/AnnualMeeting
- **AMERICAN ASSOCIATION FOR THE TREATMENT OF OPIOID DEPENDENCE.** *2013 National Conference*, November 9-13, Philadelphia, PA. For more information, go to: http://www.aatod.org/national-conference/2013-aatod-conference-philadelphia/conference-at-a-glance/ ###