

National Association of County Behavioral Health and Developmental Disability Directors

The voice of local authorities in the Nation's capital

NEWSLETTER

August 2011

JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH (JHSPH) SUMMER INSTITUTE IN MENTAL HEALTH RESEARCH

Primary instructor/coordinator, Dr. Ron Manderscheid, Executive Director of NACBHDD.

Presenters included Dr. Philip Leaf and Dr. William W. Eaton of JHSPH

Kathryn Power, director of SAMHSA's Center for Mental Health Services provided logistical funds to make it possible for a core set of county behavioral health and developmental disabilities leaders to enroll in a June 20 - 21, 2011, course *Knowledge for Managing County and Local Mental Health, Substance Use and Developmental Disability Authorities*. We wish to express our sincere thanks to Director Power and CMHS for this support. The objectives for the training were to have leaders understand the impact of National Health Reform and Medicaid on their county and state, and to be able to utilize strategic planning and needs assessment tools to move their county agenda forward. Participants summarized the impact of their experiences at the training in the following ways:

- I want to extend my appreciation for the funding... which allowed me to attend the course. The information presented encouraged me to engage in conversation with staff and community partners around behavioral health care and integration. I very much look forward to continuing conversations with this cohort and seeing how this change in service delivery will impact both the local community and the nation.

-Amanda L. Bunger, MEd, Executive Director, Klamath County Mental Health, Klamath Falls, OR

- The course...[helped]me better formulate how to implement meaningful readiness for the ACA. At our agency, we had created a small study group to become informed and propose action steps related to readiness for direct and indirect changes that the ACA portends. While we have assiduously read and discussed, no actual action steps, other than the transition to an EHR, have been formulated. The focus of the training and the discussion with other county leaders helped me formulate several concrete actions...to implement in preparation.

-Mike O'Conner, LCSW, Executive Director, Henrico Area Mental Health and Developmental Services, Glen Allen, VA

- [Thanks to] SAMHSA and JHSPH for the opportunity to participate in the course. I received pertinent, timely information and resources related to national health reform and Medicaid that will be invaluable in helping me to plan and implement the necessary changes so Essex County will be in position to meet the needs of its residents during this period of system transformation. In addition to the expertise of the instructors and presenters, it was especially valuable to have the opportunity to learn and share strategies with my fellow county authorities from across the U.S.

-Stephen J. Valley, LCSW, Director, Essex County Community Services, Elizabethtown, NY

- As a new deputy director for mental health, alcohol and drug (AOD) programs, I found it valuable to meet face-to-face with both peers in

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Teddi Fine, MA, Editor

various states, as well as leaders in the field on a national level..., to learn from one another, gain insight into how each state is interpreting the ACA and gain knowledge from previous lessons learned to better impact our own behavioral health delivery systems. ...I found it beneficial to understand regional differences in...programs. ...to share strategies for systems change that have worked, as well as those that fell flat. I felt supported and energized, knowing that others are in the same boat; ...we are all just choosing different paths to get to the same destination – healthcare reform with behavioral health inclusion and parity. I would recommend this course and others like it to all behavioral health leadership in the nation!”

-Veronica Kelley, LCSW, Deputy Director Regional Operation, AOD Services/Cultural Competency Officer, San Bernardino County, CA

- The opportunity to...discuss national health reform and its potential impact on Medicaid was extremely beneficial. We are facing a new healthcare world and need to be ready for ACOs, CCO, PCHs, BHHs, FQBHCs and FQHCs, etc. These new concepts demand of us new processes and outcomes and yet it was very helpful to be reminded not to neglect the tried and true tools that are readily available. I especially welcomed the...needs assessment [discussion] and how to effectively employ prevalence and incidence methodologies. The ongoing learning group...[provides] a venue to share our combined wealth of information and tools...and a forum to brainstorm solutions and share successes.



-Mary Griffiths, LMSW, LPC, Director Planning and Community Development, Oakland County Community Mental Health Authority, Auburn Hills, MI.

- I appreciate...the professional development and learning experience offered in the classroom setting by JHSPH. I found the 3 sources of county data indicators especially helpful to research our local health status. I was able to immediately put these to use for the board training session on strategically positioning our agency to take a leadership role...[in] prevention and promotion. The distinction between prevalence and incidence data in research was informative and useful;... the in-depth presentations on national health reform and Medicaid, and the necessity for strategic planning around the local authority’s role in working with the insurance exchange and ACOs [was] very thought provoking. I will work to make sure we are linked with health homes and the primary care organizations...to reduce the mortality rates in our counties for people with mental illness and substance use disorders.”

-Larry Carroll, Executive Director, Permian Basin Community Centers for MHMR, Midland, TX

- This course provided insight into [how] national health reform and Medicaid...will impact Worcester County Health Department’s mental health, substance abuse and developmental disabilities programs. The innovative ideas, strategies and problem solving tools presented in this course, provided me with the ability to expand our current action plan and identify key partnerships which must be established and/or strengthened. The course allowed me...to approach the possibilities of preventative care with partners and staff. This information was shared in a clear, consolidated approach to assist our department with the next steps.

-Tracy Tilghman, LCPC, LCADC, Mental Health Director, Worcester County Health Department, Berlin, MD



- The course was a great experience interacting with leaders in behavioral health from across the country and learning from the most current thought leaders on the ACA and Medicaid reform. The paradigm shifts that need to occur in behavioral health mirror the future opportunities in our industry. The coursework and discussion challenged my current thinking and understanding... [of] our local system of care and the [future]partnerships I need to cultivate.

-Mark Carmona, Deputy CEO, Center for Health Care Services, San Antonio, TX

- Prior to attending the course, I worked with Stephen Orton, PhD, University of North Carolina, to develop a business plan to merge the Frederick County Health Department Mental Health Division and the Substance Abuse Division. Using knowledge gained during the course and...information provided by Dr. Manderscheid, I have written the feasibility plan...[including] a demonstration of market need/target, a comprehensive industry analysis identifying structures, trends, key success factors and barriers, partners/competitors, financial resources and timeline. The JHSPH course provided me with information regarding the impact of healthcare reform on national trends in behavioral health service models and financial resources. “

-Andrea Walker, MA, CPRP, Behavioral Health Services Director, Frederick County Health Department, Frederick, MD

- The course was a highly valuable overview of the changes driven by federal health reform and a strategic framework to address those issues. The course provided expert insight into the historical context of public system payment for health services and how those policies have evolved. The primary instructor, Dr. Ron Manderscheid is both very knowledgeable as well as a compelling speaker who can easily place seemingly different sets of issues into an effective framework. It is these frameworks which combine strategy and policy that has been the most useful in my leadership role in the public sector.

-George Braunstein, Executive Director, Fairfax Falls Church Community Service Board, Fairfax, VA

- Working for a nonprofit, I do not experience the same wide-angle view of the treatment delivery system [as do counties]. ... Hearing the different challenges that jurisdictions are facing ignited a fire that I hope will lead me to larger-scale management and implementation as health care reform is executed. I believe the training was informative, and, not able to use much of the material currently, I know it will help me in the future.

-Sadie Smith, Director, Baltimore Health Care Access, Baltimore, MD

- [E]xtend my sincere appreciation to NACBHDD, SAMHSA, and JHSPH for the collaborative opportunity to attend the training. Polk County Health Services' strategic plans have focused on creating an integrated/decategorized system for over 10 years, yet we live in a medical model funded world. I enjoyed discussions on the historical context of Medicaid, the Medicaid waivers, and the discussion about the length of time policy changes take to be implemented into daily services. Thanks for sharing the website information regarding [county level] disability prevalence...as well as Dr. Leaf's Positive Behavioral Support (PBS) information. Over the past 5 years, we have seen the benefits of implementing PBS philosophies and tools into our system's culture. Your challenge to utilize behavioral health strategies to influence public health is also helpful as we begin building our next strategic plan.

-Sara Lupkes, Quality Assurance Coordinator, Polk County Health Services, Des Moines, IA

BITS FROM DC



Dear Colleagues:

We have just obtained a copy of the guidance issued this week by the US Office of Management and Budget on FY2013 agency budget submissions. This which calls for agencies to cut their FY 2013 budget request by 10 percent below the enacted discretionary appropriation for 2011.

For SAMHSA, this will likely mean a cut of approximately \$350 million, unless we are able to turn this around. A cut of this magnitude would have major consequences for mental health and substance use care programs in the United States. Similar problems will occur for developmental disability programs through parallel cuts to ADD, RSA and NIDRR.

It is imperative that we advocate on this issue strongly, both now and when the actual FY 2013 budget is submitted and enacted. We will be identifying opportunities to do this.

In another important related development, the new Deficit Commission has been named and will begin work next week. (See related story.) At major risk in their deliberations will be funding for Medicaid, Medicare and Social Security. I will keep you informed as this process begins to play out. Undoubtedly, much advocacy will be needed here as well.

Despite these storm clouds on our horizon, I hope you and your family will have a very enjoyable end to summer and a great Labor Day holiday.

Ron Manderscheid
Executive Director

NACBHDD MEMBER NEWS

- Welcome to the NACBHDD Board, **Chad VonAhnen**, CDDO, Sedgwick County, KS. He will serve as the developmental disability representative and will be a great addition to the Board. Chad can be reached at cvonahne@sedgwick.gov. He will be a great board member!
- Congrats to **Leon Evans**, President and CEO of the Bexar County, TX, Mental Health Authority. He is a recipient of the 2011 *Behavioral Healthcare* Champion Award, honoring stand-out CEOs and executive directors of community mental health and addiction treatment provider organizations. He will receive his award in September at the National Conference on Addiction Disorders in San Diego, CA.



ENGAGING THE WHOLE PERSON

Sue Giordano, Vice President, Health Improvement
ValueOptions®

ValueOptions, a NACBHDD partner, is one of the nation's largest behavioral health care companies, providing a wide range of managed behavioral health services to more than 24 million people across the country.

In today's business climate, companies are constantly seeking ways to reduce health care spending, while keeping their employees productive, engaged and healthy. Integration of benefits, services and care, as well as a focus on environmental support, can help organizations achieve these goals.

Integrated support

ValueOptions®, a managed behavioral health and wellness company serving 24 million members, believes businesses can't afford to solely focus on employees' physical health by providing traditional medical health care benefits; attention must also be paid to behavioral health care, in order to optimize outcomes and cost savings. And, increasingly, employers agree.

In response to the market need for new and innovative solutions, ValueOptions brings its expertise in fostering behaviors of health, providing services tailored to suit the unique challenges and cultures of our clients. We employ a suite of products and services to engage the populations we serve, whether we are advising on environmental supports for an organization or engaging individuals in treatment.

Total population health

At ValueOptions, our mission is to help people live their lives to the fullest potential. Our person-centered strategy focuses on engagement and outreach along the continuum of care, for an entire population. We provide traditional managed care products, and integrated behavioral health care services, as well as employee assistance, wellness, prevention and work/life programs. Overall, our focus is to help people adopt healthy behaviors and proactively manage wellness and disease.

Working with organizational leaders to understand their unique cultures, we advise on how to create environments that value and support health (including help-seeking behaviors). A culture of health naturally drives greater program participation and more lasting behavioral change, thus magnifying the positive results of health programming efforts. It also reinforces the maintenance of healthy behaviors, thereby preventing the addition of health risks.

We also emphasize integration and connectivity among an organization's various benefit programs and

vendors so that we can bring all relevant tools together for a person. For example, this year we launched a telephonic and web-based program called Healthy Connections. This engagement center connects members to engagement specialists who assess their health needs and refer them to appropriate services (offered by their employer) to resolve their issue(s). A member might be referred to a counselor through the employee assistance program or to a life coach to help him or her achieve a personal goal, for example. Members can access the Healthy Connections website to learn about all of their medical and behavioral health benefits, which arms them with knowledge to appropriately utilize their health benefits.

Our suite of health and wellness services includes, but is not limited to, health and lifestyle coaching, biometric screenings and incentive programs. Each helps to build motivation to change unhealthy behaviors.

Overall, our products and services aim to promote good health for all.

Core expertise applied to challenge of comorbidity

While we have expanded our product offering and approach, our core expertise remains behavioral health. A key area of focus is tackling the challenges posed by comorbidity, which has the potential to significantly impact quality of life, outcomes and costs.

More than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder had a comorbid mental health condition, according to data from the 2003 National Comorbidity Survey Replication.

Looking at specific physical conditions, other data suggest that 36.4% of migraine sufferers also have a behavioral health condition, for example. Cancer patients often have a mental health disorder as well—including 42.4% of lung cancer patients. Similar findings hold true for other physical health diagnoses. This data derives from a co-morbidity study, which ValueOptions conducted in collaboration with Integrated Healthcare Information Services (IHCIS), using a national commercial claims database of 3.8 million members.

Despite the prevalence of comorbidity, most care-management programs continue to separate medical and



behavioral health care. As a result, many individuals with comorbid conditions are never diagnosed or treated for their mental health conditions. In turn, health care costs increase and health outcomes decrease for these individuals.

While it can be challenging to diagnose and treat individuals with comorbid conditions, studies suggest that medical and behavioral health care must be integrated in a qualitative and efficient manner for these individuals. Special expertise is also needed to inspire and support behavior change so that individuals adopt healthy habits (tobacco cessation, regular exercise, healthy diet) and adhere to their treatment plan.

ValueOptions supports the work of health care providers in this challenging work. With our substantial knowledge and understanding of comorbid conditions,

we have developed programs that provide solutions to address a member's health holistically. In the states where we have Medicaid contracts, we offer ongoing education and training to the network providers to ensure they have the most up-to-date information and expertise at hand.

As behavioral health experts, we continuously educate providers, individuals and employers about how behavioral health plays an integral role in health care. To fully meet the total health needs of populations, behavioral and medical health care must be aligned to effectively deliver the quality care individuals deserve. Working together, we can have the most impact on a member's health and achieves the best outcomes—a system everyone should agree on.

HILL HAPPENINGS

The House and Senate are in recess. The Senate will return for business on September 6; the House will do so on September 7.

- **Debt Ceiling Increase Spells Spending Cuts Now and Later:** Binding annual spending caps over the next 10 years in the 2011 budget control and debt ceiling increase law spell a reduction of almost \$1 trillion in spending cuts—with a down-payment of \$25 billion in FY 2012 alone. If the new “super committee” doesn't identify a further \$1.2-\$1.5 trillion in deficit reductions by November 23 (or such cuts aren't enacted by December 23), automatic across-the-board cuts will ensue. (Basic entitlements for the low-income and Social Security are exempted; Medicare is not, though cuts are limited to 2% and only on the provider side.)
- **Debit-Reduction Dozen Named;** House and Senate leaders announced the 6 Democrats and 6 Republicans for the super-committee to identify how to reduce the nation's debt: Democratic Senators Patty Murray (WA), Max Baucus (MT) and John Kerry (MA); Republican Senators Pat Toomey (PA), John Kyl (Az), Rob Portman (OH); House Democrats James Clyburn (SC), Chris Van Hollen (MD) and Xavier Becerra (CA) and House Republicans Dave Camp (MI), Jeb Hensarling (TX), and Fred Upton (MI).
- **URGENT: Take Action During Recess:** Contact your Federal representative to press for enactment of the *Combating Autism Reauthorization Act*—HR 2005. The Senate will vote shortly after recess ends, but House leadership, apparently, will not bring “disease or condition-specific” measures to a vote. The CAA has expanded NIH autism research and coordination, CDC awareness programs and, and interdisciplinary training of health professionals by HRSA to identify and support children with Autism Spectrum Disorder (ASD) and their families through the LEND programs. For more, go to the Association of University Centers on Disability (AUCD) Action Center website at: <http://www.aucd.org/template/capwiz.cfm>



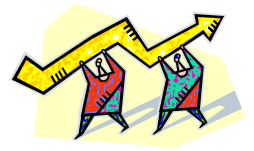
MARK YOUR CALENDARS: NACBHDD FALL BOARD MEETING

The NACBHDD Fall Board Meeting will be held in Albany, New York, on *Monday, October 24, and Tuesday, October 25*, at the *Desmond Hotel, 660 Albany Shaker Road, Albany, NY*, just a few minutes from the Albany airport. Shuttle service is available. Most likely, we will meet all day Monday and until lunchtime Tuesday.

A block of rooms have been reserved for the nights of October 23 and 24 (Sunday and Monday) at a single rate of \$135 + tax or a double rate of \$145 + tax for a queen, non-smoking room. For this rate, please register with the hotel (1-800-448-3500) by Saturday, October 1. Do identify yourself as a member of the “County Behavioral Health and Developmental Disability Directors” Group.

INSIGHT INTO HEALTH REFORM ESSENTIAL BENEFIT PACKAGE COST SHARING

An actuarial analysis by the **National Health Council** provides estimates of cost-sharing requirements under the ACA's essential benefits package. Under development by HHS, the essential benefits package will outline the basic coverage insurers must offer in the law's health exchanges. Using a model based on Blue Cross/Blue Shield's Federal Employee Health Benefit Standard Option plan, the analysis suggests that if they have a chronic condition, even beneficiaries qualifying for subsidized coverage may have difficulty affording it. The report encourages HHS to ensure the package offers a continuum of patient protections assuring access to affordable, quality health coverage. Go to: http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_ActuarialAnalysis.pdf



OMB 2013 BUDGET MEMO

As noted in Bits from DC this month, an August 17 Office of Management and Budget guidance to all federal agencies about their FY2013 budget submissions, now under development calls on agencies to cut, cut cut. It specifically directs:

“Unless your agency has been given explicit direction otherwise by OMB, your overall agency request for 2013 should be *at least 5 percent below your 2011 enacted discretionary appropriation*. As discussed at the recent Cabinet meetings, your 2013 budget submission should *also identify additional discretionary funding reductions that would bring your request to a level that is at least 10 percent below your 2011 enacted discretionary appropriation*. . . . These 5 and 10 percent reductions from the 2011 enacted level should not be achieved by proposing across-the-board reductions or reductions to mandatory spending in appropriations bills, reclassifications of existing discretionary spending to mandatory, or enactment of new user fees to offset existing spending.” [emphasis added]

This could mean a cut of approximately \$350 million at SAMHSA alone. Essentially obliterating the Agency's discretionary grant program altogether, a cut of this magnitude would have major adverse implications for mental health and substance use care programs nationwide. The proposed discretionary grant cut for FY 2013 would raise considerable problems for developmental disability programs resulting from similar cuts to ADD, RSA and NIDRR discretionary funding.

Stay tuned and get ready to get to work as NACBHDD and its colleague organizations work to determine the best course of action.

HHS NEWS AND NOTES

- **ACA Health Exchange Funds Awarded:** On August 12, the **U.S. Department of Health and Human Services** awarded 13 states \$185 million to support health exchange development, as required under the national health care reform law. Available to states that have taken preliminary action to set up exchanges, the grants will fund continued planning
- **Standardizing Descriptions of Health Plan Content:** The Departments of HHS, Labor and Treasury are about to issue proposed rules to require insurers to standardize health plan summaries to improve inter-plan comparability to promote simplified materials to facilitate plan choices by consumers. Beginning in 2012, insurers will be provided standard forms for summarizing plan benefits and coverage. Additionally, insurers will be required to provide consumers with a uniform glossary of terms used to describe health coverage and plan characteristics. Under the rules, insurers must provide the forms to individuals before they purchase coverage and any subsequent time they request them. These changes will help people with mental and substance use disorders select health coverage and reduce the complexity of the selection process. Federal officials will accept public comment on the draft rules for 60 days after they are published (which has not yet occurred)
- **ACA-related Draft Regulations Issued:** On August 17, HHS issued a pair of proposed ACA-related regulations that will provide the foundation for health care coverage to 32 million people in 2014, with a significant impact on people with mental health and substance use disorders. The first *extends and simplifies Medicaid eligibility*, by



replacing current provisions to make Medicaid available in 2014 to all individuals under age 65 with income at or below 133 percent of federal poverty level (provided the individual meets non-financial eligibility criteria, such as citizenship or satisfactory immigration status). Medicaid, CHIP and the Exchanges will use common income methodologies and will align the rules and methodologies used to evaluate eligibility for most individuals under all 3 programs. The result: real-time eligibility determinations and prompt enrollment of individuals in the “insurance affordability program” for which they qualify (including Medicaid, CHIP, advance payments of premium tax credits and cost-sharing reductions through the Exchange, and State-established Basic Health Program, if applicable). For more about the proposed regulation, go to: <http://www.healthcare.gov/news/factsheets/labels08172011a.html>. The second set of draft regulations, focused on *health exchange eligibility and exchange standards for employers*, proposes the specific standards for the Exchange eligibility process. To see the draft regulation, go to: http://www.ofr.gov/OFRUpload/OFRData/2011-20776_PI.pdf Comments on both sets of draft regulations are due by October 31.

- **Medicaid emergency psychiatric care demonstration:** A new 3-year, \$75 million CMS demonstration is designed to give states more flexibility and resources to care for Medicaid beneficiaries with mental illnesses. The Medicaid Emergency Psychiatric Care demonstration, authorized by the ACA, will demonstrate the benefits of caring for Medicaid patients with psychiatric emergencies, in private inpatient psychiatric facilities with 17 or more beds (institutions for mental diseases, IMDs). Currently, only care provided in non-IMD settings, like more expensive hospital emergency rooms, is reimbursed by Medicaid to States. The demonstration will allow federal reimbursement for psychiatric emergency treatment in IMD settings, providing Medicaid patients with improved access to psychiatric treatment and enabling states to ensure the provision of needed services at lower cost. CMS is accepting applications to participate in this demonstration from interested state Medicaid directors. <https://www.cms.gov/apps/media/press/release.asp?Counter=4054>
- **Reducing Substance Use in Indian Country:** A memorandum of agreement among the Departments of HHS, Interior and Justice has set a new federal framework in place to assist American Indian and Alaska Native communities in achieving their goals in the prevention, intervention, and treatment of alcohol and substance abuse. Called for in the Tribal Law and Order Act of 2010, the MOA describes how SAMHSA’s new Office of Indian Alcohol will coordinate tribal substance abuse programs across the federal government with a special emphasis on promoting programs geared toward reaching youth and offering alternatives to incarceration. To review the MOA, go to <http://www.gpo.gov/fdsys/pkg/FR-2011-08-05/pdf/2011-19816.pdf>
- **Learning Session Slated:** CMS is convening the second, Accountable Care Organization (ACO) Accelerated Development Learning Session (ADLS) is sc The ADLS is designed to help existing or emerging ACOs understand the steps they can take to improve care delivery and how to develop an action plan for moving toward providing better coordinated care. The content at each ADLS is repetitive and is not part of an ongoing series. Registration is free and open for teams of between two and four senior leaders from health care delivery organizations interested in forming an ACO or from an existing ACO. Additional information is available at <https://acoregister.rti.org/>.

NACBHDD SUMMER BOARD MEETING 2011 – NEXT STEPS

Katie Bess, MSW
NACBHDD Senior Policy Intern

The 2011 National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) Summer Board Meeting in Portland, Oregon, was a well-attended success! NACBHDD extends its appreciation to all who participated and provided information on their state’s status with regard to current developments and health reform scenarios. The Board will use this information as it moves forward to develop strategic initiatives.

County representatives were in attendance from California, Illinois, Iowa, Kansas, Michigan, Minnesota, Oregon, Ohio, Pennsylvania, Texas, Utah, Virginia, and Washington. A county representative from each state spoke

about issues currently being faced as well as the state’s readiness for health reform. Common themes that emerged will be incorporated into strategic initiatives. Five key common themes emerged:

- (1) Medicaid funding and enrollment changes;
- (2) Payment system model changes;
- (3) Delivery models that incorporate risk;
- (4) Service population growth and change; and
- (5) Influencing policy and the county role in policy development and change.

These key themes will help NACBHDD understand where it needs to focus its energies and activities over the next year. They also provide critical information on the

strengths and challenges counties are experiencing. With this information, NACBHDD can provide county-level technical assistance and can collaborate on state issues that may affect the direction counties will be able to take. Over the next few months, NACBHDD members should identify areas in which you are willing and able to help NACBHDD address over the next year.

The NACBHDD Board meeting was a great start in the brainstorming process. Special thanks to our presenters: Sharon Lewis (ADD), Barbara Edwards (CMS), Kana Enomoto (SAMHSA) and John Agosta (HRSI). We are also grateful to our corporate partners, Sue Bergeson, Ken Anderson, and Wayne Neff (OptumHealth); Sue Giordano (Value Options); and J.J. Farook and Vince Rogusky (InfoMC). The presentations provided participants with information about where the Nation stands in terms of health reform and about the resources that can help move the discussion forward. We look forward to our Fall Board meeting in Albany, New York. Don't forget to register today!

Topics for Strategic Planning/Initiatives

1. **Medicaid:** Funding and Future

- a. Waivers and State plan amendments
- b. 2014 expansion
- c. Current cutbacks/county realignment
- d. Proposed global budgets
2. **Payment Systems:** Changing models
 - a. Assuming risk
 - b. Case and capitation systems
3. **Delivery Models:** Incorporating risk
 - a. Carve out systems
 - b. Carve in systems
4. **Service Populations:** Growth and change
 - a. Current dynamics
 - b. Expansion under national health reform
 - c. Focus on dual eligibles
5. **Influencing Policy:** County role in policy development and change
 - a. IMD – Multiple county-level pilots (intrastate, where possible; interstate)
 - b. Inmate exception – Align nationally with NACo and locally with county officials
 - c. Basic benefits design – National/state levels

ACA-RELATED LEGAL HAPPENINGS

- **ACA Individual Mandate Lawsuits March Forward:** On July 26, the Thomas More Law Center formally petitioned the U.S. Supreme Court to hear its suit contesting the constitutionality of the national health care reform law: the first health reform lawsuit to reach the Supreme Court. Then on August 12 a 3-judge panel of the 11th U.S. Circuit Court of Appeals in Atlanta, Georgia, ruled in the multi-state lawsuit challenging the national health care reform law, that the law's individual insurance mandate is unconstitutional. However, the appellate judges disagreed about the lower court's holding regarding the mandate's centrality, ruling the law's other provisions should remain legally operative. Two other challenges (the 3rd and 6th U.S. Circuit Courts of Appeals) both upheld the law's legality. Courts in the District of Columbia and Virginia have yet to rule. The Supreme Court sits on the first Monday of October, 2011, making 2012 the earliest time that the court may hear the case, should it choose to do so. The timing of any decision by the Court will be closely watched by political pundits, politicians and the public alike.
- **California Medicaid Cut Challenge:** On October 3, the U.S. Supreme Court will hear oral arguments in a suit challenging California's 2008 Medicaid reimbursement cuts. In a set of cases consolidated under *Douglas v. Independent Living of Southern California*, private individuals and providers filed suit to challenge the 10 percent reduction, arguing that it negatively affects beneficiaries' access to care.



GET READY!

Mental Illness Awareness Week

October 2-8, 2011

REFRAMING THE DEFICIT-DEBIT DEBATE: ARE YOU READY?

[Reprinted from Behavioral Healthcare]

Ron Manderscheid, PhD



Tempers in Washington are hotter than the record-breaking midsummer weather outside. The President and Congressional leaders are engaged in an epic struggle between Democrat and Republican views about the desired future direction of American society. On one hand, Democrats seek to maintain Social Security, Medicare, and Medicaid, while increasing taxes on the wealthy. On the other, Republicans seek to cut these entitlement programs to reduce the tax burden on businesses and “free” the economy.

Let me be blunt: Neither “solution” will work. Why? Because neither does anything to address why we have such large deficits in the first place. Large, structural deficits are caused by the increasing inability of our national economic system to be innovative and competitive in the world. We attempt to compete with a poorly trained workforce using 19th century organizational processes.

Much of our workforce has skills that were required in the 1950s and 1960s, when production and service processes were done with virtually no automation. With the advent of computerized automation of these processes, many fewer of these workers are now required. Hence, we have a large, unemployed population that is unemployable in the absence of new skills training.

Similarly, our hierarchical, centralized, organizational structures were designed during the early period of industrialization. Today, they are costly and slow, and they do little to increase competitive ability. Those few organizations that have made the transition to a flat, virtual structure, with flexible matrix organization, principally in the social networking industry, are designed to compete much more effectively in today’s fast-paced environment.

Thus, rather than just being reactive and simply arguing that entitlement programs should not be cut, we from behavioral health must go forth with a much bolder agenda. We must seek today’s training with today’s training methods for our consumers and ourselves, and we must change our own antiquated organizational structures that are far too top-heavy and far too inefficient. Both of these steps will make us much more competitive, cost-efficient, and mission effective. Our greater productivity will not only contribute to the improvement of the U.S. economy, it will also make entitlement dollars go much, much farther.

Clearly, today’s training methods involve distance learning and virtual, simulated participation in related

processes, whether they be service delivery or production. They also emphasize the interpersonal skills necessary to work in small flexible groups that are matrix organized around task execution. Innovation and change are valued attributes communicated at each step of the training.

To envision what will be involved in this training, just think about tomorrow’s behavioral healthcare: Most care will be done at a distance by peers or providers, using modern social networking tools, or virtually using smart systems. These smart systems will employ avatars that are automated or person-directed. Obviously, we do need to provide appropriate training so that our peers, providers, and managers are capable of working in this new environment. These training concepts also extend to other sectors of the economy, such as education, services, and production of intellectual and material products.

Let me cite one specific example: As our elderly population doubles over the next two decades, it seems clear that we will need a dramatic expansion in our workforce trained in complex service roles who will have the capacity to work with our seniors. Clearly, peer and provider-led behavioral health services will be needed by this population.

We must also look inward and change our own organizational structures to make them much more adaptable and flexible in today’s environment. Areas that will require close examination include the size and nature of any leadership, management, or headquarters unit, the size and structure of mission-oriented units, the physical location of these units, and the role of information technology.

To envision what will be required here, imagine your future organization with no headquarters unit, small flexible mission-oriented workgroups of no more than seven to ten persons, no fixed physical location, and a modern IT system used to support the organization, coordinate care, and actually deliver care. Care will be both virtual and interpersonal, and will occur where the consumer is in the community, not in a traditional office.

Our organizations of tomorrow will hold their team and workgroup meetings virtually, and there will be no physical workspace to “manage”. Because the workgroups will be small, and semi-autonomous, like

franchises, multi-level management structures will not be appropriate.

These comments just barely scratch the surface of the topics that I have raised here. The approaches are intended to be provocative examples that will require further systematic analysis and demonstration. As we continue to engage in the deficit-debt debate, we need to contribute to the solution, not just remain part of the problem. As is almost always the case, simply arguing

in the negative that something should not be done or should not be changed will not produce a viable solution. Creating a new framework, based in social and technical innovation, will clearly be necessary. In fact, probably only by innovating in our training and our practice will we be able to move the issue forward in a productive way in the behavioral health field.

Are you ready to begin? I am

AROUND THE STATES: AN UPDATE

- **Multiple States Reject ACA funding:** Florida, Alaska, Oklahoma and Wisconsin are turning away ACA funds. In Florida, for example, the State refused fund to expand community health centers, move long-term care patients into community settings, enroll patients in Medicare, and educate teens about preventing pregnancy. It did, however, support community groups in the state applying for federal prevention and wellness funding.
- **Arizona:** Medical homes moved forward when an agreement was inked between Maricopa County's safety net health care system and Magellan Health Services to establish a patient-centered medical home program to coordinate care for Medicaid beneficiaries with serious mental illnesses. Authorized and funded under the ACA, the program's goal is to improve care quality while reducing costs.
- **Illinois:** Gov. Pat Quinn has signed new laws affecting treatment of behavioral health problems in Illinois. Quinn signed the legislation Thursday at Alexian Brothers Center for Mental Health in the Chicago suburb of Arlington Heights. One measure will require insurance companies to provide equal coverage for mental health and substance abuse disorders. Another creates a task force to develop a plan for state mental health and developmental disabilities services
- **Iowa:** A task force to address prescription drug abuse (including 32 physicians, pharmacists, substance abuse treatment providers, and law enforcement officials) will define the nature and scope of prescription drug abuse in Iowa and develop a strategy to address it, examining areas for action, such as education, secure drug disposal, and prescription drug monitoring and enforcement
- **New Jersey:** The state legislature has made the State's veterans mental health hotline a permanent program, rather than a temporary program funded on a year-to-year basis. Established by the New Jersey Department of Military and Veterans Affairs and the University of Medicine and Dentistry of New Jersey, the program serves as a mental health peer support network. All it needs is Governor Christie's signature, if it hasn't already occurred.
- **New York:** The New York State Office of Mental Health has begun a 3-year program to train 30,000 high school educators from public and private schools around the state in suicide prevention using an online training simulation. Schools should be in touch with the NYSOMH for more information.
- **North Carolina:** In a July 28 letter, the US Department of Justice told the state it must find community-based homes for thousands of people with mental illnesses now housed in adult care centers that segregate people from interaction in the community in violation of the Americans with Disabilities Act. At the same time, the current State budget includes nearly \$1 billion in state (and concomitantly federal) Medicaid cuts that could affect those in need of community-based health care. The State wants to hear from the public about which optional services to cut first.
- **Ohio ACA Ballot Initiative Certified:** The Ohio Secretary of State has certified sufficient, legal names appear on the petition submitted by 4 conservative groups that demands a proposed constitutional amendment be added to the November ballot to enable Ohioans to opt out of the ACA's health insurance mandate. If enacted, the amendment would add a section to the State constitution that says: "In Ohio, no law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in a health care system."
- **Pennsylvania:** The State has received \$1.4 million in SAMHSA youth suicide prevention funding to serve Allegheny, Berks, Bucks, Chester, Delaware, Montgomery, Philadelphia, and Westmoreland Counties. The grant will fund suicide prevention services for 14 to 24 year olds and promote early intervention



JOIN US: UPCOMING TA-LK WEBINAR, AUGUST 31

The next TA-lk webinar, *Using Healthy People 2020 to Advance Your County Agenda* (August 31, 3:30-4:30 p.m., EDT) will describe the Healthy People 2020 system and provide an online demonstration of the data benchmarking, evidence-based practice and social networking capabilities of the system. It's a must as you prepare to implement the ACA. Join us. Register at: <https://www1.gotomeeting.com/register/979620473>.

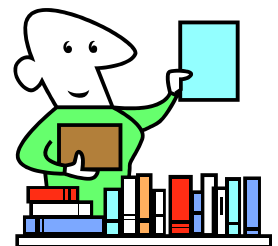
SAN BERNARDINO, CA: WORKING TO STRENGTHEN MH SYSTEM EFFICIENCY

The San Bernardino (CA) Department of Behavioral Health (DBH) offers a wide range of mental health, alcohol and substance abuse services for people of all ages. A key goal is to provide the most appropriate behavioral health services, in the least restrictive manner, at the earliest stage possible. After all, the right care is usually the most cost-effective care. Appropriate behavioral health services can help keep children in school and in their own homes; appropriate services can promote employment, enabling consumers to live independently as taxpaying members of the community.

To better coordinate care and dollars, and demonstrate effectiveness and efficiency, the DBH has partnered with a private organization, SAS, to create a data warehouse both to help ensure Medicaid and other program eligibility, and to demonstrate best practices and standards of care. Keith Harris, Ph.D., DBH Chief of Research and Evaluation, says the system should enable the DBH to use system indicators and performance outcome measures to identify what works in real time. The result, a data-driven, decision support system, will supplement and complement professional staff judgment. He notes, "With electronic health records and a data warehouse, the DBH eventually will end its reliance on paper-based charts. ... In the larger picture, providers can begin to see patterns on what treatments are helping consumers function most effectively that can help guide their clinical decisionmaking down the road."

ON THE BOOKSHELF: RECENT POLICY PUBLICATIONS OF NOTE

- **Commonwealth Fund:** *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers* Explains the legal framework governing collaborations between health centers and affiliates. Profiles partnerships developed within the framework to advance the centers' core missions by expanding patient services and access to medical information. Go to: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Jul/1525_Rosenbaum_ assessing_barriers_clinical_integration_CHCs.pdf
- **Henry J. Kaiser Family Foundation :** *Explaining Health Reform: Uses of Express Lane Strategies to Promote Participation in Coverage* explains how, under the ACA, states could share eligibility data with public assistance programs and federal agencies to expedite enrollment and retention in public coverage, a practice currently applicable only to children. Go to: <http://www.kff.org/healthreform/upload/8212.pdf>
- **Alliance for Health Reform:** Recognizing that 'all health care is local,' *Improving Health Care Quality through Community Collaboratives* reports on how community-based, local collaboratives are working to improve health care in ways reflecting specific community needs. Three types of initiative are explored: Aligning Forces for Quality (RWJ funded); Chartered Value Exchange (AHRQ supported) and Beacon Community Cooperative (funded by the HHS Office of National Coordinator for Health Information technologies. Go to: http://www.allhealth.org/publications/Quality_of_care/Improving_Health_Care_Quality_Through_Community_Collaboratives_107.pdf
- **Commonwealth Fund:** *Promising Payment Reform: Risk Sharing with Accountable Care Organizations* examines private sector ACO experiences with shared payer-provider risk payment models. Given the ACA's inclusion of such a model under the Medicare Shared Savings Plan, the report posits that insufficient infrastructure now exists to enable providers to assume and manage risk successfully, suggesting the need for improved data and analytic capacities. Go to: <http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Jul/Promising-Payment-Reform.aspx>



- **National Bureau of Economic Research:** *Gauging the Generosity of Employer-Sponsored Insurance: Differences Between Households With and Without a Chronic Condition* summarizes a study that found households with at least one family member with a chronic illness typically have less generous employer-sponsored health coverage than households without such individuals, when comparing out-of-pocket (OOP) expenses with total health care spending. However, the review posits the disparity is due to use patterns (e.g., individuals with chronic illnesses typically have higher expenditures in traditionally less generous coverage categories, including prescription drug coverage), not differences in benefit packages. The study also suggests health plan designs may exert a damaging economic impact on those with chronic illnesses, potentially adversely affecting their ability to adhere to treatment regimens *The paper is available online for purchase. Go to: <http://www.nber.org/papers/w17232.pdf> - 2011-07-21*
- **Mercer:** *State of California Financial Feasibility of a Basic Health Program* estimates the feasibility of creating a basic health program by assessing the number and demographics of enrollees in such a basic health program and the difference between premiums needed to fund such a program and available federal premium and cost-sharing subsidies. Go to: http://foundationcenter.org/gainknowledge/pubhub/pubhub_item.jhtml?id=fdc130400006
- **Henry J. Kaiser Family Foundation:** *Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs* analyzes how 3 Medicare supplemental insurance policy reform options that help cover cost-sharing requirements would affect Medicare sand beneficiary spending by income level, health status and inpatient hospital utilization.



ACMHA: The College of Behavioral Health Administration continues its webinar series featuring national topics and speakers in the public sector behavioral health care arena.

Measuring Peer Support Outcomes: What Have We Measured/What Have We Learned?,
Tom Lane, CPRS. national director, consumer and recovery services, Magellan Health Services.
August 25 2011, 2:00-3:30 p.m. EDT

To register, go to: <http://www.surveymonkey.com/s/PCLZ5KM>

For upcoming events or to review/download past webinar presentations and copies of slide shows, check the ACMHA website at: http://www.acmha.org/current_events_critical_issues.shtml

Register Today: APHA 139th Annual Meeting



For more: <http://www.apha.org/meetings/registration>.

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