OPIOID CRISIS UPDATE

Deaths involving opioids are rising, up nearly 28% from 2015 to 2016. Each day, 115 Americans die of an opioid overdose; that’s one person every 12.5 minutes. Since the passage of CARA as part of the 21st Century Cures Act, both the House and Senate have pushed dollars, mostly short-term dollars, at the crisis. We know that short-term dollars are insufficient to stem the problem. We also know that dollars aren’t as effective as they might be when they have many pass throughs before they finally flow to the community level, ground zero for the opioid crisis.

Thus, while grateful for the significant influx of funding, we remain hopeful that broader initiatives will be forthcoming from Congress and the Administration in the form of specific programs and activities that will address the issue on a longer-term, substantive basis.

ON THE HILL

Both the House and Senate are pressing forward to tackle the issue, we hope, in the way we suggested during our advocacy days in February. Following several rounds of hearings over the past months, the Senate’s HELP Committee has developed a bipartisan draft measure. The House (see below) is also hard at work.

The draft Senate bill, the Opioid Crisis Response Act of 2018, is focused on better enabling specific federal agencies and departments to address the crisis in a more comprehensive and integrated manner.

- The FDA is given clear authority to require opiate manufacturers to help curb overprescribing by packaging their medications in smaller 3-7 day supply packs and to have clear instructions on how consumers safely can dispose of leftover drugs. The measure also clarifies new and better pathways for FDA to assess new, non-addictive/non-opioid pain products.

- The state and tribal opiate-related grant programs, managed by SAMHSA, are tweaked to increase allocations to states hit hardest by the epidemic and to enable states to use the funds until they are gone, rather than turning back funds remaining after a 12-month grant period. Other SAMHSA-related provisions would expand the CARA program that provides first-responder training in the use of naloxone, and would create new grant programs to establish comprehensive opioid recovery centers.
to issue best practices for recovery housing facilities, and to issue grants for youth prevention and treatment of, and recovery from, substance use disorders.

- **CDC** would receive funding to establish evidence-based opiate abuse prevention programs, to provide public and provider education, to boost and speed controlled substance data collection capacity, and to gather data on both neonatal abstinence syndrome and infections associated with injection drug use.

- Other provisions would assess the economic and workforce impacts of the opioid crisis, improve the availability of treatment in rural and other underserved areas, and encourage states to share data on opioid prescribing and dispensing. DEA would be required to write regulations to permit prescription of controlled substances via telemedicine. The Justice Department would be required to draft a regulation specifying the circumstances under which telemedicine can be used for prescribing such drugs, including medications like buprenorphine. Further, mental health and addiction treatment centers could register with DEA to treat patients through the technology.

Concurrently, Rep. Elijah Cummings (D-MD) and Senator Elizabeth Warren (D-MA) have introduced a measure modeled after the 1990 Ryan White Act, to add $100 billion over 10 years to address opioid abuse. They posit that the opiate epidemic can be addressed in the same way as the Nation addressed the HIV/AIDS epidemic. Whether Congress has the appetite to appropriate more funds at this time is very much in question, given the state of the deficit resulting from the President’s tax cut.

However, Senate politics may well get in the way of some efforts in this election year. For example, an opioid-related measure by Senator Claire McCaskill (D-MO)—up for reelection this year—is being held up by Republicans, even though it would repeal a law that has been impeding the DEA’s ability to freeze suspicious opioid shipments. Also in limbo in both House and Senate are provisions to lift the law prohibiting behavioral health facilities with more than 16 beds to get Medicaid funding. The argument is that it would simply cost too much to do so, another election year fear.

As this newsletter goes to press, on the House side, 8 separate opioid-related measures are being considered by the House Energy and Commerce Committee.

- **Stop the Importation and Trafficking of Synthetic Analogues Act (HR 2851)** would help law enforcement get illicit synthetic drugs (e.g., fentanyl) off the streets and modernize scheduling guidelines.

- **Safe Disposal of Unused Medication Act (HR 5041)** would allow hospice workers to safely dispose of controlled substances in patients’ homes.

- **Ensuring Patient Access to Substance Use Disorder Treatments Act of 2018** would improve dispensing of implantable and injectable therapies developed to reduce abuse, misuse and diversion.

- **Special Registration for Telemedicine Clarification Act of 2018** would require implementation of statutory telemedicine waivers for health care providers to prescribe controlled substances via telemedicine.

- **Improving Access to Remote Behavioral Health Treatment Act of 2018** would enable community mental health and addiction treatment centers in underserved and rural communities to register with the DEA to engage in telemedicine.

- **Tableting and Encapsulating Machine Regulation Act of 2018** would allow DEA to regulate the use of tableting and encapsulating machines.

- **Opioid Preventing Abuse through Continuing Education Act of 2017 (HR 2063)** would require clinicians to have 12 hours of CME every 3 years on pain management and the opioid detection and treatment.

- **Empowering Pharmacists in the Fight Against Opioid Abuse Act (HR 4275)** would develop/disseminate materials to help pharmacists detect and decline to fill suspect prescriptions for controlled substances.

**IN THE ADMINISTRATION.**

- **Justice Department.** A new proposed regulation would cap pharmaceutical company annual opiate manufacturing. Agreements have been reached with 48 AGs to share information from a database that monitors the flow of painkillers from manufacturers.

- **SAMHSA.** The Agency has just released $485 million, the second year of funding, to 50 states, 4 territories, and the free associated states of Palau and Micronesia, to combat the opioid crisis by supporting evidence-based efforts at the state level to prevent misuse of opioids, expand access to effective treatment options, and support recovery.

- **FDA.** Commissioner Scott Gottlieb believes better use of electronic health records can help identify fraudulent prescriptions and document appropriate use for treating chronic pain patients. Concurrently, social media companies and internet service providers can crack down on illegal sales of opioids on their platforms. To address these issues, FDA will convene a summit with CEOs and other internet stakeholders, academics and
advocacy groups. He hopes those involved will commit to reducing the availability of opioids online and to meet again in a year to see how far along the effort has come. Stay tuned.

- **CMS.** A CARA-related final Medicare rule will allow Medicare Part D plan sponsors to implement drug management programs to limit at-risk beneficiaries' access to coverage for frequently abused drugs. Sponsors will be allowed to “lock-in” certain beneficiaries to a selected prescriber and/or pharmacy in order to limit their access to frequently abused drugs.

- **Surgeon General.** The Surgeon General has released a public health advisory urging more Americans, including family, friends, and those who are personally at risk for an opioid overdose, to carry and know how to use naloxone, a medication that can reverse the effects of an opioid overdose.

**BITS FROM DC**

Dear Colleagues:

This month we salute Frank Sullivan, our 2018 recipient of the prestigious Egnew Lifetime Achievement Award. Frank has had a very illustrious career in Anne Arundel County, MD, where he was a very early innovator on jail decarceration, as well as early integration of mental health and substance use care. More recently, he has become engaged in the development of training modules for evidence-based practices. Later this year, we will ask him to do a webinar on his new work. Congratulations Frank, our friend and colleague!

We also are tracking developments in the Congress on funding for opioid care. Clearly, our goal is to have more of these dollars actually reach the counties so that care can be provided. Such funds are badly needed to provide training in buprenorphine administration, medication assisted treatment, and Narcan distribution to police and EMS vehicles, as well as families and schools.

Please make sure that your calendar is marked for our Summer Board Meeting at the Nashville City Club on Monday and Tuesday, July 16 and 17, and our Summer I/DD Summit on Sunday, July 15.

Enjoy the beautiful spring weather!

Ron Manderscheid, PhD
Executive Director, NACBHDD and NARMH

**SPOTLIGHT: SULLIVAN RECEIVES NACBHDD’S EGNEW AWARD**

Each year, NACBHDD’s Robert C. Egnew Excellence in Advocacy and Innovation Award is given to a state/county/local authority, behavioral health or developmental disability director who has demonstrated exceptional advocacy and innovation at the state or federal level. Named in honor of the founder of NACBHDD, the award honors the lifetime achievement of an NACBHDD member who has made major contributions both nationally and locally.

The 2018 award was presented to Frank Sullivan, retired director of the Mental Health Agency of Anne Arundel County, MD, and NACBHDD Board of Directors emeritus member.

A licensed certified social worker, Frank has worked in public behavioral health for 48 years, serving the Anne Arundel County mental health community from 1994 to 2013, when he retired. Under Frank’s leadership, the county developed a host of innovative mental health services, among them a jail mental health service, case management, a housing development corporation for disabled adults, and a comprehensive crisis response system. Taken together, he created a structured care continuum that remains a model for its citizens and for communities nationwide.

His most significant achievements over his years of dedicated advocacy and services have included—though certainly were not limited to—guiding a multi-jurisdiction project to assure that both funding and community services were available following closure of a 200-bed state hospital in the county, creation of and funding for mental health services in the local detention center, bringing NetworkofCare.org to the State with the first network specifically for veterans, and introducing Assertive Community Treatment teams to the County’s behavioral healthcare programs. Frank’s advocacy has helped assure that mental health funds flow to community-based care,
that community-based mental and substance abuse services were integrated, and that the county develop and implement the State’s first comprehensive crisis response system.

His passion for quality mental health services is evident as he continues to advocate for ongoing comprehensive training for behavioral health workers, critical incident stress management training and consumer and family involvement in policy and program development and improvement. Frank’s commitment to the field is unsurpassed and, without question, he is most a deserving recipient of this prestigious award.

The award presentation took place at NACBHDD’S Legislative and Policy conference in Washington, DC, on March 3, 2018.

EPILEPSY AND BEHAVIORAL HEALTH: COMMONALITIES AND COMORBIDITIES

A recent CDC Morbidity and Mortality Weekly reported that active epilepsy affects some 3.4 million Americans. For 25-50%, it co-occurs with depression. Particularly when seizures are uncontrolled, epilepsy poses substantial burdens because of somatic, neurologic, and mental health comorbidity; cognitive and physical dysfunction; side effects of anti-seizure medications; higher injury and mortality rates; poorer quality of life; and increased financial cost. Treatments span medications, surgery, support and watchful vigilance to avoid triggers. Epilepsy sometimes can lead to early death.

That sounds a great deal like the issues confronting individuals with behavioral disorders. Like the mental health and substance use, those with epilepsy are often subjected to pervasive stigma, hampered by fear, constrained by lack of available information for consumers to choose needed treatments and often unconnected with mainstream health. Yet, at the same time, they are aided by family who desperately desire to help, supported by a national movement, aided by an emerging infrastructure, and buoyed by great passion and energy.

That is precisely why NACBHDD Director Ron Manderscheid participated in the annual Epilepsy Foundation Skill Building Institute in Columbus, OH, on March 19-20, 2018. The skills being honed at this national meeting resonate with the skills we are working to develop in the behavioral health field.

To improve treatment, promote recovery and begin the quest for prevention, the Epilepsy Foundation is undertaking several critical strategies, among them:

• **Building Partnerships:** Epilepsy touches education, health, behavioral health, social services and Medicaid. Ohio representatives from each of these fields discussed programs, strategies and possibilities. Most promising is that the Epilepsy Foundation is working to build these partnerships across these fields and to model them for all state affiliates.

• **Incorporating Social Determinants:** The Institute addressed the impact of social determinants on health status, and both access to and use of care access. Without doubt, efforts at prevention, treatment and recovery from epilepsy must be configured to take explicit account of critical differences across geography, gender, age and minority status.

• **Addressing Behavioral Health:** The co-occurrence of epilepsy and depression is well known and pervasive; thus, the Foundation places a high priority on behavioral health. Less well known, however, is the bidirectional relationship between depression and substance use, particularly prescription or illicit opioids. Opioid use doubles the probability that one will develop depression, and vice versa.

• **Using Information Technology:** The Foundation is making remarkable progress to develop apps and other electronic communication tools to promote better care adherence and disease self-management.

• **Moving Toward Self-Management:** A major theme of the Institute mirrored the broad-based collaboration between the Foundation and the CDC to develop online training modules that promote the capacity for epilepsy self-management. These include PACES in Epilepsy (Program of Active Consumer Engagement in Epilepsy Self-Management); HOBSCOTCH (Home-Based Self-Management Cognitive Training Changes Lives); TIME (Targeted Self-Management for Epilepsy and Mental Illness); SMART (Self-Management for People with Epilepsy and a History of Negative Health Events); MINDSET (Self-management epilepsy decision support for adult people with epilepsy and their providers); and UPLIFT (Using Practice and Learning to Increase Favorable Thoughts). We hope you will review these CDC modules, since self-management has become today’s watchword for epilepsy and behavioral health. To begin, find an article about HOBSCOTCH at: https://www.cdc.gov/prc/program-research/hobscotch.htm

During the Institute, Dr. Manderscheid had the honor of awarding our NACBHDD Award for exceptional national federal leadership to CDC’s Rosemarie Kobau, the Agency’s team lead for epilepsy. For more than a
decade, she has worked tirelessly to bring epilepsy out of the shadows. The growing success of the Epilepsy Foundation and this very Institute evidence that her efforts have borne very bountiful fruit.

Our hats also are off to the Epilepsy Foundations Senior Vice President, Steve Owens, and to the entire Foundation staff for an exceptional experience at this year’s Institute. They have achieved remarkable progress during the past year and, without doubt, will continue to do so.

**NEWS AND NOTES**

- **A LOSS.** We are sad to report that *Jim Meek*, a former member of the NARMH Board of Directors, passed away April 8, 2018. Jim was President of the AgriWellness Board of Directors, a collaborative of 7 north central Iowa farm assistance hotlines, from its inception in 2001 through 2004. He then served as training director from 2005 through 2013. Jim worked closely with several NARMH initiatives. Very involved with the PROSPER partnership programs, he also assisted with family mediation work. Through AgriWellness, Jim was vital to many state and federally (FEMA) funded crisis counseling programs in the wake of local disasters in the State. Cards and remembrances may be sent to: Pat Meek, 2915 Northridge Parkway, Ames, IA 50014

- **MOVING ON.** Behavioral Health Director of Orange County, CA, *Mary Hale*, has announced her plans to retire from that position. She was an exceptionally active member of the California Behavioral Health Directors Association (CBHDA) where she has served as an executive committee member since 2013, and as the longest serving CBHDA president (3/15 through 12/16). Her commitment, expertise and long-time contributions both to CBHDA and to Orange County will be missed.

- **HOUSE SPEAKER TO QUIT.** After 2 decades in the US House of Representatives, Speaker *Paul Ryan* (R-WI) will not seek another term of office. He has endorsed his colleague, House Leader *Kevin McCarthy* (R-CA) to succeed him. Stay tuned; anything can happen in this House of Representatives in this election year.

- **DEFICIT JUMPS HIGHER.** According to the Congressional Budget Office, the federal budget deficit will reach $804 billion this year (up $139 billion over the 2017 deficit). It is projected to rise to nearly $1 trillion in 2019. The hike is largely due to both the tax package and the $1.3 trillion continuing appropriation for FY 2018.


- **NEW SENIOR PERSONNEL NAMED AT HHS.** Secretary Alex Azar has made 3 high-level appointments. Assistant Secretary for Health *Brett Giroir, MD*, will also serve as the Secretary’s Senior Advisor for Mental Health and Opioid Policy. Giroir will be responsible for coordinating HHS’s efforts across the Administration to fight America’s opioid crisis. A 4-star admiral in the PHS Commissioned Corps, he has spent his career leading major projects for the U.S. Departments of Defense, HHS and VA. Former pharmaceutical industry executive, *Daniel M. Best*, who has worked for both CVS and for Pfizer Pharmaceuticals will serve as Senior Advisor for Drug Pricing Reform. In a letter to Secretary Azar, a number of House Democrats queried whether a former industry insider would be the best person to oversee HHS plans to lower drug prices. *James Parker*, long-time Anthem insurance executive, will serve as Senior Advisor for Health Reform and Director of the HHS Office of Health Reform where he will lead an initiative to address the cost and availability of health insurance.

- **SHULKIN OUT; PRESIDENT NOMINATES NEW VA SECRETARY.** With the ouster of Veterans Affairs Secretary David Shulkin, the President has nominated White House physician and Navy rear admiral, Ronny L. Jackson, to head the VA. Readers may recall that Jackson gained prominence during his effusive presidential health status update this past January. While well-schooled in medicine, he apparently has little management experience, particularly with an organization as large as the VA. Confirmation hearings are about to take place in the Senate. The most salient questions likely will focus on his views of privatizing the VA healthcare system. In the meantime, former Pentagon official, Robert Wilke, will continue to serve as interim VA Secretary.

- **PROTECTION AGAINST UNSCRUPULOUS REPRESENTATIVE PAYEES.** The *Strengthening Protections for Social Security Beneficiaries Act of 2018* imposes greater oversight on representative payees who manage Social Security and SSI benefits for those who can’t manage alone, as many as 8 million beneficiaries today. Critically, the new statute sets measures in place to ensure that representative payees are both qualified and trustworthy. It also gives beneficiaries
greater say in who handles money on their behalf. Federally mandated protection and advocacy groups will need to conduct more reviews of representative payee performance on behalf of the Social Security Administration.

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

- **SURPRISE! CONGRESS DID GOOD FOR VETS.** Tucked into the omnibus FY 2018 appropriations measure was a little-noticed provision that can open the door to behavioral health treatment for thousands of veterans. The bipartisan provision directs the VA to immediately begin to make screening and care available to former service members with “bad paper” discharges. An initial mental health assessment must be made available for these discharged veterans who deployed in a combat zone, including drone operators, or who took part in a contingency operation. Victims of sexual assault dismissed from the military also could get help. Based on those assessments, the VA would be required to treat the veterans’ conditions.

- **SCHOOL SAFETY POST-PARKLAND.** In a bipartisan 407-10 vote, the House of Representatives approved the STOP School Violence Act of 2018 (HR 4909), the first school safety-focused measure to pass in the House since the Parkland shooting. A comparable Senate bill awaits action. Developed in collaboration with Sandy Hook Promise, the measure reauthorizes and expands the Secure Our Schools law for 10 years to bring violence prevention programs to millions more students around the country. Its grant programs would train school-based threat assessment teams in evidence-based threat assessment and management; train school personnel, students and first responders to intervene to prevent suicide and violence against others; increase coordination between schools and first responders; and set in place anonymous reporting systems for school violence threats. It doesn’t train teachers in gun use, increase profiling, or pay for more law enforcement in schools. Whether the Senate takes the bill up remains an open question. Consider writing to your Senators about this important bill.

- **HHS URGED TO KILL DRAFT ACA-RELATED REGULATION.** The ranking Democrats of 5 House and Senate committees have written to the Secretaries of HHS, the Department of Labor and others to urge withdrawal of a proposed regulation that would allow people to buy short-term, so-called “junk” health insurance for up to 12 months, instead of the 3-month ACA limit. Such plans would allow people with pre-existing conditions to be charged more and could skip covering certain services, such as behavioral health care and medications. They charge that the rulemaking would “expand the availability of discriminatory, deceptive, and insufficient plans … that deceive consumers into thinking they are covered for major medical expenses.” The Administration hopes to have the regulation in place this summer, according to Labor Department Secretary Alex Acosta. At the same time, over 100 health care organizations have written to the Administration and to the Hill urging that the proposed regulation be withdrawn. At this time, it’s all up in the air.

- **GET TO WORK.** A provision in the 2018 Farm Bill would impose new work requirements for some of the Nation’s 42 million SNAP (food stamp) recipients. Under the proposal, most adults between 18 and 59 will be required to work part-time or enroll in 20 hours a week of workforce training to receive assistance. The measure sets aside $1 billion to fund training program expansion. Not surprisingly, the provision is opposed by House Democrats. According to the CBO, over 10 years, the provision could cut SNAP by as many as 1 million people.

- **BUILDING TOWARD ALL-PAYER HEALTHCARE.** With the ACA as prologue and the knowledge that healthcare is a key issue in the midterm elections and beyond, Democrats has unveiled a panoply new health reform proposals. Earlier newsletters have described Senator Sanders’s (VT) Medicare-for-all bill, as well as 2 Medicare buy-in proposals (one from Senators Tim Kaine (VA) and Mark Bennet (UT), and a second from Senator Brian Schatz (HI). Now, Senators Chris Murphy (CT) and Jeff Merkley (OR) have introduced their own Medicare buy-in proposal, the Choose Medicare Act. Their proposal would not only allow individuals to buy into Medicaid (as in the Kaine/Bennet measure), but also would enable companies to purchase Medicare for employees rather than buy coverage from the private health plan we currently use. This enables everyone to benefit from Medicare’s bargaining power. Individuals and companies would need to cover the costs for buying into Medicare, with the likelihood that premiums would be lower than those for private insurance. Those receiving ACA subsidies would be able to use the subsidies to buy into Medicare. Moreover, the proposal would expand subsidies to those earning less than 600% of the federal poverty level and give people sufficient funds to purchase a marketplace “gold” plan, rather than the less substantial “silver” plan now linked to subsidies. Movement isn’t likely now, but stay tuned. Much will depend on what happens in the midterm elections.
OVER THE FENCE: AFFORDABLE HOUSING

KEVIN MARTONE, LSW
EXECUTIVE DIRECTOR, TECHNICAL ASSISTANCE COLLABORATIVE, INC. AND NARMH BOARD MEMBER

By now, most in the mental health community know that the recent omnibus spending bill signed by the President provides new resources in support of programs for mental illness and substance use disorders for the current fiscal year that ends on September 30, 2018. Also important to know is that this federal budget directs significant resources toward affordable housing for people with disabilities, including mental illness and developmental disabilities. In a recent blog post, my colleagues Lisa Sloane and Gina Schaak highlighted FY 2018 funding increases that specifically address the needs of those with disabilities:

- $400 million (est.) will go to new Section 811 mainstream vouchers for non-elderly people with disabilities, providing nearly 50,000 new vouchers. HUD issued a grant opportunity on April 18, 2018, for the first $100 million of these funds.
- $82.6 million will go to new Section 811 Project Rental Assistance (PRA) capital advances and Project Rental Assistance, potentially providing an opportunity for states that have not yet received PRA funds to benefit from this program.

Other new affordable housing resources that may benefit people with mental illness, substance use disorders, and developmental disabilities include:

- A $130 million increase for Homeless Assistance grants. The National Alliance to End Homelessness estimates that this increase will be enough to move 20,000 to 25,000 more people from homelessness to permanent housing.
- $40 million for new supportive housing for homeless veterans with disabilities, through the HUD-Veterans Affairs Supportive Housing program.

- $20 million for new Family Unification Program vouchers that target two populations: families unifying with children who were placed or are at imminent risk of placement out of the home due to lack of adequate housing for family; and youth (18 to 24 years old) who are aging out of the foster care system.
- A 12.5% increase in the Low Income Housing Tax Credit allocation and a 30% increase in the HOME Investment Partnerships Program, both of which will help states and localities to increase affordable housing production.

Understandably, significant attention to homelessness has been focused on large urban areas like Los Angeles, Portland (OR), Seattle, and San Francisco. Homeless numbers are increasing in these areas as the rising costs of housing continue to outpace income. However, people with mental illness, substance use disorders, and other disabilities who live in rural areas also struggle with housing affordability. As we show in our most recent Priced Out report, there is not a single housing market in the country where a person with a disability on Supplemental Security Income (SSI) can afford even a modest rental unit.

In both urban and rural communities, this new infusion of support can help address the affordable housing needs of people with mental illnesses, substance use disorders, and other disabilities who are homeless or unnecessarily living in institutional settings due to lack of housing. Mental health, disability, and housing advocates should stay alert for further information on how these resources will be allocated, and engage with local public housing authorities, Continuums of Care, and state housing finance agencies to ensure that these resources benefit your communities.

AROUND THE DEPARTMENTS AND AGENCIES

- CONTINUING TO REGULATE AWAY THE ACA. A massive final regulation continues the Administration’s initiative to roll back the ACA, though CMS says the regulation—a final version of a proposal first proffered last fall-- is meant to give states more power to regulate their individual and small-group health insurance markets. Among the key changes in the 522-page regulation are some that can hurt the program and the millions it is designed to benefit, including—
  - New exemption from the ACA’s individual mandate (effective until the mandate expires in 2019) for people living in counties with one or no insurers and for people objecting to plans that cover abortion. Such individuals can claim an “exemption” from the requirement to purchase coverage.
• Allowing insurance companies to sell cheaper, short-term plans that are exempt from the basic coverage requirements under the ACA.
• Beginning in 2020, allowing states the option to (a) choose to adopt another state’s 2017 benchmark plan; (b) replace one or more benefit category with that from another state; or (c) create an entirely new essential benefit package that is consistent with a “typical employer plan.” The good news is that plans will still be required to offer the ACA’s 10 essential health benefits.
• Imposing new income checks to crack down on people the Administration says are wrongly qualifying for the law’s subsidies.
• Exempting student health insurance coverage from Federal rate review requirements, and raising the default threshold for review of what is defined as a reasonable insurance hike from 10% to 15%.

The CMS’s “Final Annual Issuer Letter” was also released, providing operational and technical guidance to issuers for plan years beginning in 2019, spelling out the so-called hardship exemption and other provisions contained in the new regulation. Read the Final Annual Issuer Letter at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Health Insurance Marketplaces

• GOING AFTER ENTITLEMENTS. A new White House executive order, the Reducing Poverty in America by Promoting Opportunity and Economic Mobility, requires Department Secretaries to review their welfare-related programs, from SNAP to public housing and welfare to Medicaid, as part of a government assistance plan overhaul. Within 90 days, agencies are required to report back to the White House on policies related to and new regulations on such topics as work requirements, exemptions and waivers. Already the Department of Agriculture wants to restore existing work requirements in states for which prior waivers had been approved due to high unemployment rates. Stay tuned to see what is happening in other agencies and Departments.

• COMMENTS SOLICITED. Working on behalf of CMS, Mathematica Policy Research seeks public comment on the measure specification and justification for a quality measure currently under development. The measures are called: “Improving or Maintaining Physical Health in Younger Dual Eligible Adults” and “Improving or Maintaining Mental Health in Younger Dual Eligible Adults.” A memo listing questions for public comment, as well as the measure information forms (MIF) and measure justification forms (MJF), are available in zip files on the webpage under “List of Currently Accepting Comments”. The public comment period for these measures is open until May 10, 2018. Please submit comments to MedicaidQualMeasures@mathematica-mpr.com

• RESCSSION AHEAD? As readers may know, the President has been rethinking the $1.3 trillion budget agreement he recently signed into law. He has directed OMB director Mick Mulvaney to develop a “rescission” proposal that would roll back certain aspects of funding that previously had been approved by Congress and the White House. Such a document—with potential cuts of as much as $60 billion—may be released in early May. Such a proposal requires concurrence by both House and Senate, something they likely are not anxious to undertake in this election year. Speaker Ryan’s decision to forego reelection doesn’t help the situation. Stay tuned.

• ACA 2018 ENROLLMENT POST-MORTEM. CMS’s final report on the 2018 ACA open season shows that approximately 11.8 million consumers either selected or were automatically re-enrolled in a marketplace plan nationwide, among them 8.7 million in the 39 states using Healthcare.gov and 3 million consumers in state-based marketplaces. The report shows that nearly ¾ of people who enrolled through marketplaces actively shopped for a policy versus letting their policy automatically renew. Among all consumers with a plan selection, 27% were new enrollees and 47% actively returned to select a plan. While CMS Administrator Verma reported “the individual market continues to see premiums rise and choices diminish,” after taking ACA subsidies into account, premiums actually dropped from an average of $106 per month last year to $89 this year. The vast majority of enrollees get a federal subsidy to help pay their premiums. Last year, the average value of that subsidy was $383; this year, it’s $550.

• OLDER ADULT MENTAL HEALTH AWARENESS DAY. SAMHSA, the Administration for Community Living and the National Coalition on Mental Health and Aging are convening a discussion to mark the first National Older Adult Mental Health Awareness Day, Friday, May 18, 2018, 10 am–12:30 pm, Eastern Time. Designed to raise public awareness about the mental health of older Americans and spur action to address the needs of this population, a panel of experts will discuss evidence-based approaches to mental health and substance use prevention, treatment, and recovery supports for older adults. The panel will also highlight the work of the Interdepartmental Serious Mental Illness Coordinating Committee and offer guidance for people who seek treatment and services. The event will be live webcast. Register for the event at: https://www.eiseverywhere.com/ehome/noamhad/home.

• ALCOHOL AND OPIOIDS RESOURCE. The CDC has a new quick guide, Alcohol Screening and Brief Intervention for People Who Consumer Alcohol and Use Opioids, to acquaint health care professionals with the value of ASBI and
to describe its utility in helping to avoid alcohol-related opioid overdoses – found to occur in as many as 22% of overdose deaths. Download at: https://www.cdc.gov/drugoverdose/pdf/prescribing/AlcoholToolFactSheet-508.pdf

**REDUCING SUDS.** CMS’s Medicaid Innovation Accelerator Program’s (IAP) Reducing Substance Use Disorder (SUD) program area is launching a new technical support opportunity for state Medicaid agencies. States are encouraged to attend an information session on Wednesday, May 2, 2018, 1:00-2:00 pm EDT to learn more. At the session states will learn about group and individualized technical support opportunities, including the Opioid Data Dashboards Flash Track, Rapid Response on Best Practices, Medication-Assisted Treatment Model/Payment Design and 1115 SUD Strategic Design Support. The Flash Track, which will run from June 2018-September 2018, can help states learn how to develop a data dashboard to display their SUD and/or opioids data and performance in Medicaid. To register for this webinar, go to: https://cc.readytalk.com/r/9eile2u0ezxi&em

**NEW EBP RESOURCE CENTER.** SAMHSA’s new Evidence-based Practices Resource Center will provide communities, clinicians, policymakers and others in the field with information and tools to incorporate evidence-based practices into their communities or clinical settings. The Resource Center contains a collection of science-based resources for a broad range of audiences, including Treatment Improvement Protocols, toolkits, resource guides and clinical practice guidelines. Critically, it includes an opioid-specific resources section. SAMHSA notes that the Resource Center is part of the Agency’s “new comprehensive approach to identifying and disseminating clinically sound and scientifically based policies, practices, and programs.” Check it out at: https://www.samhsa.gov/ebp-resource-center.

**ACT GRANT OPPORTUNITY.** SAMHSA will make up to 7 grants of $678,000 per year for up to 5 years to help reduce rates of hospitalization/death for people with serious mental illnesses (SMI) by utilizing the Assertive Community Treatment model which provides around-the-clock support in the form of teams available to respond to a home or other setting and avoid crises caused by symptoms of SMI. Eligibility is limited to states, political subdivisions of a state, American Indian and Alaska Native tribes or tribal organizations, mental health systems, health care facilities, and entities that serve individuals with serious mental illness who experience homelessness or are justice-involved. Applications are due May 29, 2018, 11:59 pm, EDT. Applications must be received by the due date to be considered for review.

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### AWARD NOMINATIONS SOLICITED

Each year, NARMH presents two awards for leadership in rural mental health. Both are presented at the award ceremony at the NARMH annual conference. It’s time to nominate this year’s potential winners.

**The Ann Schumacher Rural Clinical Practice Award** is presented to an experienced practitioner who has demonstrated excellence, innovation and professional development, and who has worked with domestic violence. **Award Criteria:** Rural practice; leads/participates in an innovative or cutting edge project; demonstrates knowledge of working in a challenging rural setting; attends workshops and/or works toward certification, licensure or an advanced degree; works with domestic violence issues; cross-generational and diverse ethnicity experience; faith as a critical part of life and practice without discriminating against other beliefs; and family and community involvement.

**The Peter G. Beeson Rural Arts Award** was established in 2007 to honor the lifelong contributions of Peter G. (Pete) Beeson to both rural mental health and the rural arts. A longtime member of NARMH who also served on its board of directors, Pete has been recognized for his masterful writing about rural life and for his beautiful photography, both of which have graced the pages of many NARMH publications. **Award Criteria:** Nominees will have been recognized for their contributions to the arts that highlight aspects of rural life as a central focus of their work. Nominations should explore the nominee’s preferred art form and how his or her work depicts rural life.

Please submit nominations [up to 200 words for the Schumacher Award and 500 words for the Beeson Award] to the Lu Ann Rice [luann@togevents.com]. **Nominations must be received by May 7, 2018.**
Evidence from the field suggests that a new, more complex health problem is emerging for persons who have serious mental illness (SMI). Today, a large and growing proportion of these individuals also use or are dependent upon opioids. Anecdotal reports from the field suggest that up to half of adults with SMI in our urban areas, particularly those with schizophrenia or bipolar disorder, have this comorbidity.

The devastating effects of opioids are well known. With today’s much stronger formulation of prescription opioids that include fentanyl or k-fentanyl (a particularly strong version of fentanyl produced in China), one can become addicted with the use of as few as three or four pills. Street opioids, such as heroin laced with impure k-fentanyl, can lead to death with a single use.

Overdose and death are very common; naloxone can save lives, but is not yet broadly available to persons with SMI, especially those who are homeless and live on the streets.

And other equally tragic effects can occur as well. Within as short as 30 days of starting to use opioids, the likelihood doubles that one also will develop depression. And the reverse also is true: a person with depression has twice the likelihood of using or becoming dependent upon opioids. Thus, this relationship is a downward-spiraling vicious cycle likely to lead directly to death from overdose or indirectly from suicide.

These linkages should not be surprising to anyone. Opioid use or other drug use is principally a “disease of despair.” The disease is an addiction. The despair is a psychological comorbidity reflected in the depression. Both must be addressed.

We have documented for more than three decades the relationship between SMI and long-term physical conditions, such as heart disease, diabetes, cancer, COPD, and arthritis, among others. Many of these conditions can and do lead to early death when not treated appropriately. Opioids frequently are prescribed to address pain associated with these conditions. Thus, it is easy to discern how an adult with SMI also could become addicted to opioids. It also is easy to understand how this addiction could morph from prescription opioids to street heroin, overdose, and death.

The action question is how we can respond to this growing epidemic in an effective way. Clearly, we must develop the capacity to offer integrated mental health and substance use care to this population. We also must make integrated primary care available at the same time and in the same encounters, with appropriate social supports linked to all of these services.

We have tools that can help us build the needed integrated delivery systems. Section 2703 of the Affordable Care Act (ACA) provides two years of funding to set up health homes, with accelerated federal Medicaid reimbursement for care during this period. Are you leveraging this provision?

Another part of the solution will involve more effective delivery of medication assisted treatment (MAT) to promote recovery from opioids. To do this will require a defined training plan so that providers are prepared to deliver MAT effectively, as well a plan for appropriate monitoring of the number of clients served, etc. What will be very new is adapting these treatments to persons who also have SMI. Have you been doing planning to accomplish this new design?

Similarly, from the mental health side, it will be important to adapt our care coordination practices to these new realities. We need to change care coordination so that the care coordinator monitors progress on recovery from addiction, in addition to progress in addressing mental illness, in addition to progress in treating long-term physical conditions, in addition to personal despair. How are you planning to make these adaptations?

Perhaps most important, we must call upon peers to help us develop and implement these key dimensions of care so that they will work well together. At the same time, we must incorporate peer support as a key ingredient in helping consumers successfully negotiate a more complex care system and regain personal self-worth and inclusion, both of which are bulwarks against despair.

The stakes are very high. We must be successful in this endeavor.
Mediticaid expansion has a new path to approval at the state level: the ballot initiative. In Utah, ACA advocates have gathered sufficient signatures to place a Medicaid expansion referendum on the November ballot. Similar efforts are underway in Nebraska and Idaho; one may be in the offing in Montana. Recall that Maine voters have already approved a similar referendum, though the Republican governor has held up implementation by demanding the legislature provide funding up front. Stay tuned for further developments.

Iowa. The State may have found a way around the ACA through a collaboration between the State’s largest insurer and the century old Iowa Farm Bureau. Under the measure, just signed into law by Governor Kim Reynolds (R), the partnership can sell “health benefit plans,” a term that falls outside the definition of “health insurance” under the ACA. In fact, the new law specifies that “a health benefit plan sponsored by a nonprofit agricultural organization domiciled in the state for its members shall not be deemed to be insurance and shall not be subject to the jurisdiction of the commissioner of insurance.” Thus, working through the Farm Bureau, the insurer could offer skimpier health coverage and doesn’t have to comply with ACA requirements such as covering pre-existing conditions and behavioral disorders. The Farm Bureau can set its own rules, it could hold down costs by covering only healthy individuals. Stay tuned; we see potential litigation in the future.

Maryland. Governor Larry Hogan (R) has signed two measures to help stabilize the State’s individual health insurance market. Under the first new law (HB 1795/SB1267), the Maryland Health Benefit Exchange would request a State Innovation Waiver from CMS to seek Federal pass-through funding and to establish a reinsurance program. This could take place very quickly following a public comment period. A second measure signed into law by Hogan, the Maryland Health Care Access Act of 2018 (SB 387) establishes the mechanisms to fund the reinsurance program. Because the provision is seen as a stopgap, the law also commissions studies to explore longer-term ways to assure that consumers can get affordable, high-quality care. And now, the Maryland Health Benefit Exchange (MHBE) Board of Trustees unanimously approved establishment of a State Reinsurance Program. It also authorized the submission of a State Innovation 1332 Waiver to the U.S. Secretary of the Department of Health and Human Services and U.S. Secretary of the Treasury.

New Jersey. The State legislature has adopted, and new Governor Phil Murphy (D) is about to sign into law, a provision that adopts the ACA’s individual mandate statewide, a mandate the US Congress voted to repeal nationwide, effective in 2019. Under the new New Jersey law, individuals would be required have health insurance or pay a fine of the greater of 2.5% of their household income, or $695 per adult and $347 per child, whichever is greater. If the Governor signs the provision into law, it will be the first to take this step to require healthy people to purchase coverage.

New York. A little-noted provision in the recently-adopted 2018-2019 budget makes New York the first state to directly and specifically require and fund mental health education for students from kindergarten through 12th grade. A million dollars will establish a technical assistance center which will use phone and web-based information and experts to help school districts develop individualized programs. Implementation will be left to each school district. The new law goes into effect on July 1, 2018.

Pennsylvania. In a 115-80 vote, the State House voted to impose a work/training requirement on “able-bodied” adults who are on Medicaid. Whether the Senate will concur in the measure is not entirely clear. What we do know, however, is that Governor Tom Wolf (D) has his veto stamp at the ready.

Utah. At the same time as Medicaid expansion will be placed on the November ballot (see related article), Governor Gary Herbert (R) has signed new legislation into law to partially expand Medicaid. Rather than cover people up to 138% of the federal poverty level, it would extend coverage for those up to 100% of the poverty level – somewhere between $20,000-25,000 for a family of four. Further, the plan would impose a work requirement on certain Medicaid beneficiaries. In all, the expansion would broaden coverage to an additional 70,000 in the State. However, the State will need to submit the partial expansion to CMS for approval, which isn’t necessarily a slam dunk. Remember, CMS declined to issue a decision about a partial expansion proposal submitted by Arkansas. Was it a rejection? We may learn more in the wake of the Utah expansion request.

Virginia. The State House of Delegates has approved a budget that funds Medicaid expansion. The provision imposes a work/training requirement on “able-bodied” Medicaid recipients and penalizes failure to do so with expulsion from the program. The budget proposal would also create high-risk insurance pools to help lower private
insurance costs. The measure has headed to the Senate where the likelihood of adoption is significantly greater than it was in the past. Stay tuned.

**ON THE BOOKSHELF: RECENT PUBLICATIONS OF NOTE**

- **BROOKINGS INSTITUTION.** A new analysis, *Do States Regret Expanding Medicaid?*, a product of the partnership between the Center for Health Policy at Brookings and the USC Schaeffer Center for Health Policy & Economics, is designed to help “inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations.” Read or download the analysis at: [https://www.brookings.edu/blog/use-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/](https://www.brookings.edu/blog/use-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/)

- **NATIONAL ACADEMIES OF SCIENCE, ENGINEERING AND MEDICINE.** *Health Care Utilization as a Proxy in Disability* analyzes health care utilization as it relates to both the severity of a disability’s impairment and the Social Security Administration’s stringent definition of disability. It identifies types of utilizations that might be good proxies for “listing-level” severity; that is, what represents an impairment or combination of impairments severe enough to prevent a person from doing gainful activity, without regard to age, education or work experience. Read or download the report at: [disability and health service utilization](https://www.brookings.edu/blog/usc-policy-expert/)

- **ROUTLEDGE PRESS.** The soon-to-be-released *Mental Health in America: A Field Guide, First Edition* by Ellen Greene Stewart, is a comprehensive overview of mental health in rural America. The aim is to promote urgently needed research and conversation about providing accessible, culturally competent mental health care to rural populations. The volume explains the history and structure of rural mental health care, the culture of rural living among diverse groups and the crucial "A's" and "S": accountability, accessibility, acceptability, affordability, and stigma. It examines poverty, disaster mental health, ethics in rural mental health, and school counseling. It ends with practical information and treatments for two of the most common problems, suicide and substance abuse, and a brief exploration of collaborative possibilities in rural mental health care. Check your local book purveyor or library on this one.

- **NATIONAL ACADEMIES OF SCIENCE, ENGINEERING AND MEDICINE.** *The Neurocognitive and Psychosocial Impacts of Violence and Trauma* summarizes the presentations and discussions from a 2-day workshop designed to better understand issues at the intersection of childhood experience, and both violence and trauma, through dialogue among trauma survivors researchers and practitioners. Read or download the summary at: [biologic and behavioral impact of violence and trauma](https://www.brookings.edu/blog/usc-policy-expert/)

- **MODERN HEALTHCARE.** *Where the ACA health insurance exchanges stand in 2018* details the status of the ACA’s healthcare marketplaces (exchanges) in the wake of efforts to dismantle the ACA itself. It clarifies that the situation may not be as dire as some suspect. Download or read the report at: [http://www.modernhealthcare.com/reports/180411where-aca-exchanges-stand/](http://www.modernhealthcare.com/reports/180411where-aca-exchanges-stand/)

**MARK YOUR CALENDAR**

- **CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH SOLUTIONS.** The 18th annual Behavioral Health Informatics Conference and Exposition, *Meeting the Information Management Needs of Mental Health and Substance Use*, will be held May 2-3, 2018, at the Sheraton Carlsbad, Carlsbad, CA. Dr. Manderscheid will be the keynote speaker. Get additional information or register at: [www.cibhs.org/events](http://www.cibhs.org/events).

- **THE MICHIGAN CENTER FOR RURAL HEALTH.** The 2018 Michigan Rural Health Conference will convene May 3-4 at the Soaring Eagle Resort and Casino, Mt. Pleasant, MI. Open to all rural stakeholders, the conference will feature topics including a federal update on rural health issues, MACRA, cyber security, and the opiate crisis, Register at: [http://events.r20.constantcontact.com/register/event?llr=9gwxyemab&oeidk=a07eevkb9kl85e9c29c](http://events.r20.constantcontact.com/register/event?llr=9gwxyemab&oeidk=a07eevkb9kl85e9c29c).


- **NATIONAL RURAL ALCOHOL & DRUG ABUSE NETWORK AND OTHERS.** *The 34th National Rural Institute on Alcohol and
Drug Abuse, a training conference, will be held June 10-14, 2018, on the campus of the University of Wisconsin-Stout, Menomonie, WI. For more information, log onto: Rural Institute on Alcohol-Drug Abuse.

- MENTAL HEALTH AMERICA. 2018 Annual Meeting, Is Mental Health Fit for the Future, June 14-16, 2018, at the Hyatt Regency Capitol Hill, Washington, DC. For more information, go to: MHA 2018

- NACBHDD. We will convene an I/DD Summit on July 15, 2018, in conjunction with the NACBHDD summer Board meeting. The all-day summit will be at the Hermitage Hotel, Nashville, TN. Stay tuned for more information.

- NACBHDD. Our 2018 summer Board meeting will convene July 16-17, 2018 at the Nashville City Club, Nashville, TN. Overnight accommodations will be at the city’s Hermitage Hotel. Mark your calendars now.

- NATIONAL COALITION FOR MENTAL HEALTH RECOVERY. The NCMHR is hosting its 34th annual Alternatives Conference July 29-August 3, 2018, at Catholic University, Washington, DC. This peer-organized conference provides an opportunity for exchange and connections for persons with lived experience (peers) across the U.S. This is the first year the conference will be sponsored without federal resources and support. To participate in or support the conference, log onto the NCMHR website: https://www.ncmhr.org/.

- NATIONAL ASSOCIATION OF RURAL MENTAL HEALTH. NARMH will hold its 44th annual conference, Rural Resilience, on August 23–26, 2018, at the Astor Crown Plaza, New Orleans, LA. The premier interdisciplinary rural behavioral health event, the conference provides a broad array of information and networking opportunities on rural practice, research and policy. For more information, go to: http://www.togpartners.com/narmh/2018/default.aspx


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