

National Association of State Mental Health Program Directors

Weekly Update

Health Care Cost Increases to Escalate

A report from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary published July 13 predicts national health care costs will average \$10,345 per enrollee this year, the first time they have exceeded \$10,000.

The CMS Actuary predicts annual cost increases in health care spending exceeding 5.7 percent from 2017 to 2019 and 6 percent annual growth from 2020 to 2025. The report, [published on-line in Health Affairs](#), says the projected growth, though more rapid than in recent years, is still slower than in the two decades prior to the Great Recession, largely due to increased patient cost-sharing in private insurance plans and value-based purchasing in Medicare.

The Actuary predicts Medicaid will spend about \$12,500 per beneficiary by 2025, up from \$8,191 in 2016. Medicare is projected to spend almost \$18,000 per beneficiary by 2025, when it will cover 20 percent of Americans. Medicare currently spends \$12,206 per beneficiary.

Greater economic growth, faster growth in medical prices, and population aging are expected to be the primary drivers of the increases. With the increases in health care coverage under the Affordable Care Act, the health share of the economy is expected to climb from 17.5 percent in 2014 to 20.1 percent in 2025.

Medicaid spending growth is expected to average 5.6 percent, as aging and beneficiaries with disabilities, who tend to require relatively more expensive care than those who are younger and not disabled, represent an increasing share of total beneficiaries.

Medicare spending is projected to accelerate (averaging 6.7 percent), because members of the baby-boom generation will continue to age into the program, and because existing beneficiaries are expected to use services more often than in the recent past.

The CMS Actuary's projected growth in per enrollee private health insurance spending to nearly \$8,600 in 2025 reflects a projected additional use of health care goods and services as consumer incomes grow, under an assumption that economic conditions will improve throughout most of the projection period.

CARA Passes Overwhelmingly, Awaits President Obama's Signature

The Senate on July 13 passed the Comprehensive Addiction and Recovery Act (CARA), [S. 524](#), by a vote of [92-2](#). The only nay votes were cast by Senators Mike Lee (R-UT) and Ben Sasse (R-NE).

The overwhelming vote to cut off debate, cast earlier in the day, was [90-2](#), with Senators Lee and Sasse casting the dissenting votes. The Senate needed 60 votes to proceed to a vote on the bill itself.

The bill now awaits signing by President Obama, who has indicated he will do so, despite the lack of additional significant funding within the bill. The Administration continues to seek a requested \$1.1 billion over two years for prescription opioid prevention and treatment.

A House Appropriations [Labor-HHS funding measure](#), which passed 29-19 on July 14 includes \$525 million in additional funding for FY 2017 for opioid and heroin programs. However, it is unlikely that bill will pass both houses before the end of the FY 2016 Federal fiscal year, given that it contains several "poison pills", including termination of the ACA navigator program and the agency charged with regulating Marketplace insurers, and a non-enforcement mandate for new Department of Labor overtime regulations. Congressional leaders foresee that an omnibus funding bill will need to be passed for FY 2017.

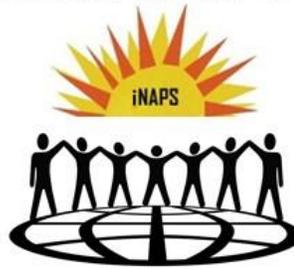
There has not been a stand-alone Labor-HHS funding measure enacted since 2007. Instead, those agencies have been funded through omnibus funding measures.

Work Days Left in the 114th Session of Congress (2015-2016)

- 17 – House Work Days before Election Day**
- 16 – House Work Days after Election Day**
- 23 – Senate Work Days before Election Day**
- 20 – Senate Work Days after Election Day**

InterNational Association of Peer Supporters

Cultivating a Culture of
Compassion



2016 Annual National Peer Supporter Conference

August 26 to 28, 2016

Sheraton Philadelphia Society Hill Inn

Theme: Collaborating for Unity



NIMH Conference on Mental Health Services Research: Harnessing Science to Strengthen the Public Health Impact

August 1 and August 2, 2016

Bethesda Marriott Hotel
5151 Pooks Hill Road
Bethesda, Maryland 20814
Phone (301) 897-9400

[REGISTER HERE](#)

The National Institute of Mental Health's 23rd [Conference on Mental Health Services Research \(MHSR\): Harnessing Science to Strengthen the Public Health Impact](#) will highlight scientific investigative efforts to improve population mental health through high-impact mental health services research. This meeting will bring together leading mental health services researchers, as well as clinicians, mental health advocates, and federal and nonfederal partners. MHSR 2016 will highlight opportunities for the next generation of high-impact research to drive mental health care improvement.

Conference Events

The conference events are scheduled August 1 and 2 at the Bethesda Marriott Hotel, and will feature keynote talks and an array of plenary panels, scientific paper sessions, posters, and technology demonstrations.

MHSR 2016 is free to attend, and selected sessions will be viewable via webcast. Seating is limited.

Questions regarding meeting logistics or registration should be directed by email to [Dytrea Langon](#) or by phone at 240-485-3288.

Questions about the conference program should be directed to [Ms. Janet Sorrells](#) by e-mail.



National Summit on Military and Veteran Peer Programs

Save the Date!

National Summit on Military and Veteran Peer Programs: Advancing Best Practices

November 2-3, 2016
University of Michigan - Ann Arbor

This two-day interdisciplinary forum will:

- Stimulate discussion and understanding of the latest research and best practices in peer programs
- Share tools for outreach and evaluation
- Feature innovative strategies for dissemination and sustainability
- Highlight the findings of a RAND Research Brief on peer programs

The National Summit will take place at the Michigan League on the University of Michigan campus in Ann Arbor. A complimentary cocktail reception will be held at the Jack Roth Stadium Club, a very special opportunity to see the famous U-M “Big House”.

Mark your calendars for this seminal event! Registration will be limited and will open in July 2016. Please email PeerSummit@umich.edu to be added to the priority listserv to receive event-related announcements. For additional information, please visit www.m-span.org.

This is an open event. Please share this information with others who may be interested in attending.

The National Summit is presented by M-SPAN (Military Support Programs and Network) at the University of Michigan Health System Department of Psychiatry and Depression Center. Funding for this event was provided by the Robert R. McCormick Foundation and the Bob Woodruff Foundation. Funding for the RAND research brief was provided by the Bristol-Myers Squibb Foundation.

Number of Practicing Psychiatrists Drops 10 Percent from 2003 to 2013

A study published in the July [Health Affairs](#) finds that the number of practicing psychiatrists declined from 37,968 to 37,889 from 2003 to 2013, which represented a 10.2 percent reduction in the median number of psychiatrists per 100,000 residents in hospital referral regions (HRRs).

The authors—Harold Alan Pincus, Joseph S. Ross, Tara F. Bishop, and Joanna K. Seirup—suggest the reduction may be one reason why only 40 percent of U.S. patients with mental illnesses are receiving treatment.

They note that there are 4,000 Health Professional Shortage Areas (HPSAs) designated by the Health Resources and Services Administration (HRSA) and that HRSA estimates that the current supply of psychiatrists meets needs in only half of them. They also suggest the workforce shortage likely impacts the effectiveness of the Mental Health Parity and Addiction Equity Act.

The authors of the study used data from the Area Health Resources Files, a county-level database maintained by HRSA, which contain data on health resources, including physician supply by specialty, and population census data. In determining the number of psychiatrists per 100,000 residents, the authors included all active non-federally employed psychiatrists.

From 2003 to 2013 there was a 0.2 percent decrease in the number of practicing psychiatrists in the United States. In contrast, there were increases in the numbers of neurologists (35.7 percent), adult primary care physicians (9.5 percent), and all practicing physicians (14.2 percent). The median number of psychiatrists per 100,000 residents in HRRs dropped by 10.2 percent, while neurologists increased 15.8 percent, and the other two groups of physicians remained fairly stable.

There was substantial variation across HRRs in the density of psychiatrists per 100,000 residents in 2013—a distribution that was similar to that in 2003. In 2013 there were large concentrations of psychiatrists in the New England region (24.47 per 100,000 residents), the mid-Atlantic region (19.91 per 100,000 residents), and the Pacific region (13.33 per 100,000 residents). Of the physician groups studied, psychiatrists were the most unequally distributed. Neurologists were a close second, while adult primary care physicians were found to be more evenly distributed.

Population density, percentage of high school graduates, and median household income were positively and significantly associated with the number of psychiatrists per 100,000 residents in 2013. The percentage of non-Hispanic whites and the percentage of people ages sixty-five and older were negatively and significantly associated with the number of psychiatrists. The percentage of people unemployed was not significantly associated with the number of psychiatrists.



MENTAL HEALTH DISPARITIES RESEARCH AT THE NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

Mental Health Disparities Research at NIMH: Cross-Cutting Aspects of the NIMH Strategic Plan in 2016

Wednesday, August 31, 2 p.m. to 3:00 p.m. ET

REGISTER [HERE](#)

Brian Ahmedani, M.D.

Director of Psychiatry Research, Behavioral Health Services
Research Scientist, Center for Health Policy & Health Services Research Henry Ford Health System

Olivia I. Okereke, M.S., M.D.

Associate Professor of Psychiatry, Harvard Medical School
Associate Professor of Epidemiology, Harvard T.H. Chan School of Public Health

ABOUT THE WEBINAR SERIES - The National Institute of Mental Health (NIMH) is proud to present two distinguished researchers who will explore some of the biologic and genetic underpinnings of reproductive hormone-related mood disorders.

WHO SHOULD ATTEND - This webinar is appropriate for NIMH-funded grantees, students, researchers, policy makers, clinicians and anyone interested in learning more about suicide prevention research at the NIMH and the NIH.

REGISTER NOW: Space is limited. Don't miss this valuable opportunity!

Center for Trauma-Informed Care

NASMHPD oversees the SAMHSA National Center for Trauma Informed Care (NCTIC). NCTIC offers consultation, technical assistance (TA), education, outreach, and resources to support a revolutionary shift to trauma-informed care across a broad range of publicly-funded service systems, including systems providing mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education.

July Trainings

Maryland

Bureau of Maternal and Child Health, Baltimore City Health Department—July 21

Pennsylvania

Carson Valley Children's Aid, Flourtown – July 26 and 27

Virginia

Rappahannock Area Community Services Board, Fredericksburg, July 18 and 19
Virginia Health Care Foundation, Richmond – July 20

For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.

NIH Funding Opportunity: Development of Technology to Support Zero Suicide

Title: [Products to Support Applied Research Towards Zero Suicide Healthcare Systems](#)

Open Date (Earliest Submission Date): August 5, 2016. **Due Date:** September 5 (Cycle I); January 5 (Cycle II); and April 5 (Cycle III).

Letter of Intent: Due 30 days prior to the application due date.

Funding: \$1,500,000 for FY 2017 to fund approximately 4 to 6 projects. Future funding amounts beyond FY 2017

will depend on annual Congressional appropriations.

Award Project Period: Phase I—up to 2 years; Phase II—up to 3 years

Applicants are encouraged to contact [Adam Haim](#) by email or at 301-435-3593 for further guidance.



CDC Finds Male Manual Laborers Have the Highest Suicide Rates among Occupations

A July [study](#) from the Centers for Disease Control and Prevention (CDC) of suicide rates in various occupational categories finds that the highest suicide rate is among males in manual labor (farming, fishing and forestry), at 85 suicides per 100,000 workers.



Carpenters, electricians, miners, and construction workers were second to top the list, followed by

mechanics and those who do installation, maintenance, and repair. Health care workers had an 80 percent lower suicide rate than manual laborers. Public service professionals (teachers, librarians, and educators) were found to have the lowest suicide rate across jobs (7.5 per 100,000). Females in the protective services occupation (police, correctional officers, and fire fighters) were found to have the highest suicide rate (14.1 per 100,000), followed by women in the legal field.

The CDC suggests that a high risk of suicide may be attributed to: work of an isolated nature, a stressful work environments, unsteady employment, and lack of access to behavioral health services. CDC looked at 12,300 out of more than 40,000 suicide deaths from 17 states, using 2012 data from the National Violent Death Reporting System (NVDRS). The report examined the frequency of suicides by occupational categories and calculated rates of suicide by gender and age groups for the occupational groups. Due to limited data, the researchers categorized occupations by categories and not by specific professions.

“Knowing suicide rates by occupation provides employers and other prevention professionals with an opportunity to focus on suicide prevention programs and messages,” commented Wendy McIntosh, one of the authors of the study and a

health scientist at the CDC’s Division of Violence Prevention.

The report illustrates the need for a comprehensive approach to suicide prevention in work settings. In a [statement](#) responding to the report, the National Action Alliance for Suicide Prevention released a list of resources, such as the National Suicide Prevention Lifeline (1-800-273-TALK), to integrate suicide prevention into work places to reduce suicide rates among high risk occupations.

SUICIDES PER 100,000 WORKERS			
Occupational Group	Overall	Male	Female
Farming, fishing & forestry	84.5	90.5	----
Construction and extraction	53.3	52.5	----
Installation, maintenance & repair	47.9	47.5	----
Production	34.5	39.5	10.8
Architecture & engineering	32.2	36.3	----
Protective service	30.5	34.1	14.1
Arts, design, entertainment, sports & media	24.3	32.9	12.4
Computer & mathematical	23.3	32.8	12.5
Transportation & material moving	22.3	30.2	4.8
Management	20.3	27.4	8.4
Legal	18.8	24.2	13.9
Healthcare practitioners and technical	17.4	31.6	13.3
Life, physical & social science	16.7	23.7	----
Business & financial operations	15.9	20.4	10.3
Health care support	14.6	32.9	11.8
Community & social service	13.6	18.6	8.9
Sales & related	13.4	21.0	5.3
Building & grounds cleaning & maintenance	13.3	16.5	4.5
Food preparation & serving related	12.8	19.3	7.7
Personal care and service	8.0	17.2	4.9
Office and administrative support	7.9	15.2	5.3
Education, training & library	7.5	15.1	4.7
Total	20.3	39.2	12.4

Technical Assistance on Preventing the Use of Restraints and Seclusion

For more than 10 years, NASMHPD has been contracted by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance and support to facilities committed to preventing the use of restraint and seclusion.

SAMHSA's National Center for Trauma Informed Care and Alternatives to Restraint and Seclusion offers on-site staff training and technical support to implement trauma-informed, strength-based approaches to prevent aversive interventions. Our in-house team and national consultants have many years of public hospital experience, both clinically and personally. This assistance is funded by SAMHSA and at no cost to your state.

To Apply for Technical Assistance, [Click Here](#):

We look forward to the opportunity to work together.

NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

In the spring of 2015, NASMHPD launched an Early Intervention in Psychosis (EIP) virtual resource center, which was made possible through the generous support of the Robert Wood Johnson Foundation (RWJF).

The intent of the EIP site is to provide reliable information for practitioners, policymakers, individuals, families, and communities in order to foster more widespread understanding, adoption and utilization of early intervention programming for persons at risk for (or experiencing a first episode of) psychosis. The site includes information from the national RWJF-funded demonstration to identify and prevent the onset of psychotic illness – the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) – as well as a variety of other early intervention initiatives.

EIP is designed to provide an array of information through a consolidated, user-friendly site; and it is updated on a periodic basis. To view the EIP virtual resource center, visit [NASMHPD's EIP website](#).

State Technical Assistance Available from the State Mental Health Technical Assistance Project (Coordinated by NASMHPD with SAMHSA Support)

NASMHPD coordinates a variety of SAMHSA-sponsored technical assistance and training activities under The State TA Project.

To Request On-site TA: States may submit requests for technical assistance to the on-line SAMHSA TA Tracker, a password-protected system. All of the Mental Health Directors/Commissioners are authorized to use this system, and Commissioners can give authorization to other SMHA staff as well. Once in this system, the user will be asked to identify the type of TA that is being sought, the audience, and the goals the state is seeking to address via the support.

On average, a given TA project includes as many as 10 days of consultant time (including prep and follow-up), along with coverage of consultant travel to your state.

The log-in for the Tracker is: <http://tatracker.treatment.org/login.aspx>. If a state has forgotten its password or has other questions about accessing the Tracker system, the Commissioner or authorized user can send an e-mail to: tatracker@treatment.org.

Note that technical assistance under this project cannot be specifically focused on institutional/hospital-based settings.

For answers to other questions, contact your CMHS State Project Officer for the Mental Health Block Grant, or Pat Shea at NASMHPD at 703-682-5191 or pat.shea@nasmhpd.org.

Only 7 of 23 ACA CO-OPs Remain, as Illinois' Land of Lincoln Health Plan Fails

The Illinois Department of Insurance moved on July 12 to shut down Land of Lincoln Health, a 3-year-old Affordable Care Act (ACA) CO-OP that lost \$90 million in 2015 and more than \$17 million through May 31 of this year.

Acting Insurance Director Anne Melissa Dowling announced her department was seeking a court order allowing the state to take over Land of Lincoln Health and prepare the company for liquidation.

The shutdown brings the number of nonprofit CO-OPs that have failed to 16, out of the 23 originally chartered.

Last month, Director Dowling tried to provide financial assistance for the company by blocking it from paying a \$31.8 million risk adjustment payment liability it owed the Federal government until it got the \$73 million risk adjustment payments it was owed by that same Federal government. The Centers for Medicare and Medicaid Services (CMS) would not suspend the company's risk adjustment program liability.

Rep. Jim Jordan (R-OH) predicted, at a [hearing](#) held July 13 by the House Oversight and Government Reform Subcommittee on Health Care Benefits and Administrative Rules, which, he chairs, that every co-op would eventually fail.

Rep. Scott DesJarlais (R-TN) noted at the hearing that about 870,000 people have been affected by the CO-OP failures.

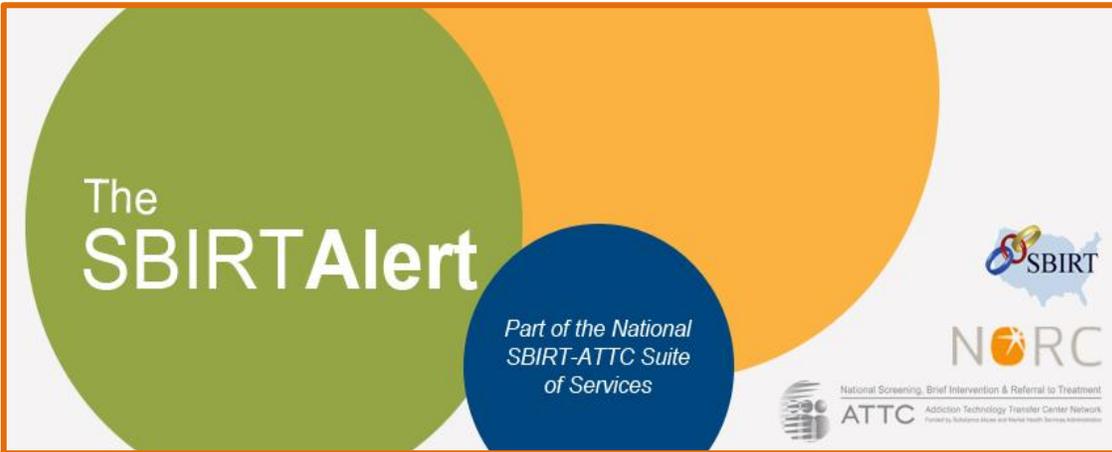
Kevin Counihan, chief executive officer of the Center for Consumer Information & Insurance Oversight (CCIIO), which governs plans in the ACA marketplace, said at the hearing that six of the seven remaining CO-OPs are on corrective

action plans, but that the CO-OPs have nevertheless offered consumers more choice and added competition in the ACA marketplace.

Mr. Counihan reminded the subcommittee that it is the states that certify the CO-OPs for meeting actuarial standards, capital standards, and solvency requirements. "If the state certifies [a] CO-OP, that feels to me that they should be on a level playing field with any other issuer," he said.

CMS awarded \$2.4 billion in Federal loans to help create the CO-OPs, but their ability to succeed was seriously undercut when Congress reduced the \$6 billion funding originally allocated for the program by two-thirds in the years after the ACA was enacted. It has also included language in the last few years' annual Health and Human Services funding prohibiting CMS from using funding to make risk adjustment payments owed to insurers with moneys not authorized for that use by Congress. As a result, the CO-OPs, like other insurers denied expected risk adjustment payments, have received far less income from the Federal government than they had budgeted. Even when paid, some CO-OPs have had to wait 21 months before receiving the promised payments.

Maryland's [Evergreen Health](#) is suing CCIIO over the risk adjustment payments it owes. It said in a lawsuit filed in June that it expects to owe between \$18 million and \$22 million this year, or about a quarter of its \$85 million premium revenue in 2015. The higher-than-expected fee could wipe out nearly half of its reserves, putting the CO-OP's solvency at risk and eliminating hopes of profitability.



The SBIRT Alert

Part of the National SBIRT-ATTC Suite of Services

SBIRT

NORC

ATTC

National Screening, Brief Intervention & Referral to Treatment

Addiction Technology Transfer Center Network

Parted by Substance Abuse and Mental Health Services Administration

SBIRT for Youth Learning Community

[REGISTER HERE](#)

July 26 at 1 p.m. ET

Featuring Karli Keator, MPH

Karli Keator is the Division Director, Juvenile Justice at Policy Research Associates. Since 2011, Ms. Keator has been the project director for a Substance Abuse and Mental Health Services Administration and MacArthur Foundation collaborative that aims to increase the number of youth with co-occurring mental and substance use disorders diverted out of the juvenile justice system to appropriate community-based behavioral health services at the earliest points of contact.

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NASMHPD Links of Interest

[MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BEHAVIORAL HEALTH ADMINISTRATION DATA SHORTS, JUNE 2016: IN-STATE OVERDOSE DEATHS OF MARYLAND RESIDENTS 2007-2014](#)

NIH COLLABORATIVE RESEARCH ON ADDICTION FOAs: (Areas supported by these FOAs include research to generate and conduct preliminary tests of targeted addiction treatment to address multiple substances, which may include alcohol, tobacco and other drug use.)

[\(1\) TARGET ASSESSMENT, ENGAGEMENT AND DATA REPLICABILITY TO IMPROVE SUBSTANCE USE DISORDERS TREATMENT OUTCOMES \(R33\) \(PAR-16-352\)](#)

[\(2\) TARGET ASSESSMENT, ENGAGEMENT AND DATA REPLICABILITY TO IMPROVE SUBSTANCE USE DISORDERS TREATMENT OUTCOMES \(R21/R33\) \(PAR-16-353\)](#)