



National Association of State Mental Health Program Directors Weekly Update

NASMHPD Urges MedPAC to Recommend Medicare Coverage and Payment for Peer Review

NASMHPD on October 6 urged the Medicare Payment Advisory Commission (MedPAC) to include Medicare Part B fee-for-service coverage for peer support services in its future recommendations to Congress on ways to improve access to behavioral health services under the Medicare program.

The NASMHPD public comment followed a 75-minute [presentation](#) by MedPAC staff to the Commission and a roundtable discussion by Commission members that included behavioral health conditions among Medicare enrollees, structural and cultural factors that have shaped current behavioral health treatment, and Medicare coverage provisions that govern diagnosis and treatment for behavioral health.

NASMHPD noted in its verbal comments, and in a comment letter filed with the Commission subsequently, that two-thirds of state Medicaid programs currently pay for peer support services, as does the Veterans Administration, Tricare, and Department of Defense Health Services. NASMHPD said that Medicaid coverage of peer support services had been facilitated—if not encouraged—since an [August 15, 2007 State Medicaid Director letter](#) and that coverage of peer support services for caregivers was noted in a [May 1, 2013 clarifying guidance](#).

NASMHPD noted in its verbal and written comments that a number of the issues raised by Commission members and staff throughout the October 6 presentation and discussion could be addressed through peer support services, including: patient isolation, difficulty in transitioning from

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

0 – House Work Days before Election Day
16 – House Work Days after Election Day

0 – Senate Work Days before Election Day
20 – Senate Work Days after Election Day

Both Chambers Return November 14

institutional to community-based settings, compliance with therapy and medication regimens, the barriers presented by stigma to obtaining necessary services, patient suicide risk, and workforce shortages.

The staff presentation and Commission discussion which preceded the NASMHPD comments did not touch on peer support, although it included a fairly comprehensive discussion of issues currently confronting the behavioral health provider and patient community, including the availability of inpatient services, co-occurring conditions and morbidity, the incidence of suicide, the shaping of service delivery by financing availability, workforce shortages, the lack of integration between behavioral health and medical/surgical services, the lack of progress in developing meaningful quality measures, and societal stigma driving patient unwillingness to seek care.

In its discussion of ways to better *(continued on page 2)*

Six TTI Grants of \$220,000 to be Awarded for FY 2017; Applications Due at End of October

NASMHPD has received the good news that SAMHSA’s Center for Mental Health Services will fund another year of the Transformation Transfer Initiative (TTI). Administered by NASMHPD, the TTI provides, on a competitive basis, flexible funding awards to states, D.C., and the U.S. territories to strengthen cutting-edge programs.

For FY 2017, CMHS will award TTI grants of \$220,000 to six (6) states or territories for projects related to developing, strengthening, or sustaining innovative projects or programs focusing on co-occurring intellectual/developmental disabilities (IDD) and mental health.

[Application proposals](#) must be submitted by October 31. If you have questions, please contact NASMHPD Project Director David Miller at david.miller@nasmhpd.org or 703-682-5194.

CMS Tentatively Approves Vermont Proposal for All-Payer Global Payment System

Vermont Governor Peter Shumlin (D) announced on September 28 that the Centers for Medicare and Medicaid Services (CMS) has tentatively approved his state's [proposal](#) to implement an all-payer global payment system that will cover services and align payments provided under private insurance with payments under Medicaid and Medicare Parts A (inpatient services) and B (outpatient services), all under an accountable care organization (ACO) structure.

Pharmaceuticals provided under Medicare Part D are not covered by the 44-page draft § 1115 waiver agreement.

The model, which will base payments to participating ACOs and their network providers on the quality of health outcomes rather than the volume of services they provide, must still be made available for public comment at the state and Federal levels before it can be finalized. The state's Green Mountain Care Board, which regulates the state's health care system, has already held three public hearings, with two additional hearings scheduled for October 11 and 13.

Vermont will be required to hold spending for services covered under the agreement at or below 3.5 percent. The state must also specifically bring the Medicare spending growth rate in Vermont to 0.1 percent or 0.2 percent below the national average. However, benefits currently provided under the Federal programs cannot be reduced nor existing providers eliminated.

The state must improve the quality of and access to primary care and reduce the prevalence and morbidity of chronic diseases. It must also reduce suicides through screening for clinical depression and follow-up after emergency room treatment. In addition, there are substance use treatment milestones that require the state to institute follow-up after emergency room discharge and require the administration of Medication Assisted Treatment to at least 150 of every 10,000 Vermont residents ages 18-64, or as needed to meet demand.

Providers who choose to participate will be able to receive a portion of their ACO's shared savings that rewards them for helping the ACO to limit growth in state spending.

Participating providers will also be permitted to set their own quality measures. Those who opt out will be paid on a fee-for-service basis, at least until Medicare alternative payment models under the Medicare Access and CHIP Reauthorization Act (MACRA) are implemented.

The agreement can be terminated, after 180 days' notice, by either the Federal or state government.

NASMHPD Urges MedPAC to Recommend Medicare Payment for Peer Support

(continued from page 1) integrate care, the Commission and staff reviewed the [Collaborative Care Model proposed by CMS](#) to be used in the CY2017 Medicare benefit year which will encourage the use of integrated care teams that include behavioral health care managers and psychiatric consultants, but staff raised concerns that the model could lead to multiple payments for the same patient, without the patient ever seeing a behavioral health provider or his or her own chosen behavioral health provider.

Staff also noted that primary care providers (PCPs) have begun delivering behavioral health care, but that studies suggest the PCPs need more support and training in behavioral health. Co-location was also discussed, but Commission members expressed some skepticism that the approach necessarily leads to real integration.

In its presentation of potential pathways for the Commission in recommending approaches to improving Medicare behavioral health services, staff policy analysts Dana Kelley, Kate Bioniarz, and Sydney McClendon suggested the Commission could either address payment for inpatient psychiatric facilities or improving access to ambulatory behavioral health services. The Commission members seemed to favor addressing ambulatory access.

However, a number of Commission members expressed disappointment that the staff presentation had not reviewed dementia and Alzheimer's treatment, and there appeared to be consensus that any Commission decision-making should include those conditions as well.

ASTHO Releases Digital Toolkit to Maximize Public Health Partnerships with Medicaid

The Association of State and Territorial Health Officials (ASTHO) has released a collection of digital tools to help public health agencies maximize partnerships with Medicaid agencies to improve population health. With support from the de Beaumont Foundation, ASTHO partnered with the National Association of Medicaid Directors (NAMD) to initiate new discussions and create resources to help bridge the gap between public health and Medicaid agencies to share promising practices and facilitate innovative policies. NASMHPD was also a participant in this initiative.

The newly developed resources include:

- [State Case Studies](#) – Detailed accounts of innovations undertaken in Colorado, Minnesota, New Hampshire, North Carolina, Texas, and Vermont.
- [A Medicaid-Public Health Learning Series](#) – Factsheets, an issue brief, fictional educational vignettes, webinars, and interviews, all designed to improve the basic understanding of Medicaid and public health and facilitate collaboration.
- [A Medicaid-Public Health Resource Library](#) – An online portal to discover best and promising practices in other states.

Presidential Proclamation: National Youth Justice Awareness Month 2016

The essential promise that we make to our young people -- that where they start must not determine how far they can go -- is part of what makes America exceptional. It is our shared responsibility to ensure all children are given a fair shot at life, including a quality education and equal opportunities to pursue their dreams. Too often in America, young people are not afforded a second chance after having made a mistake or poor decision -- the kind of chance some of their peers receive under more forgiving environments. Many of these young people lack institutional or family support and live in distressed communities. Others may have experienced trauma and violence or may struggle with disabilities, mental health issues, or substance use disorders. As a society, we must strive to reach these children earlier in life and modernize our juvenile and criminal justice systems to hold youth accountable for their actions without consigning them to a life on the margins. During National Youth Justice Awareness Month, we reaffirm our commitment to helping children of every background become successful and engaged citizens.

While the number of juvenile arrests have fallen sharply over the past decade, roughly 1 million juvenile arrests were made in 2014. An overwhelming majority of these arrests were for non-violent crimes, and nearly three-quarters of those arrested were male. Children of color, particularly black and Hispanic males and Native American youth, continue to be overrepresented across all levels of the juvenile justice system. Unfortunately, far too many youth become involved with the adult criminal justice system each year -- including in several States where 17-year-olds are prosecuted as adults regardless of their crime, and two where 16-year-olds are as well. Children in the adult system have less access to rehabilitative services and often face higher recidivism and suicide rates. Some States have recently raised the age so that 16- and 17-year-olds are not unnecessarily tried in adult courts, and many are reforming sentencing laws and expanding access to age-appropriate transition services upon reentry.

Even for those youth who were never convicted or otherwise found guilty, simply having had contact with our justice system can lead to lifelong barriers and an increased likelihood of ending up in a cycle of incarceration. To help break this cycle, my Administration increased funding for expunging juvenile records and took steps to ensure young people in juvenile and adult justice facilities can receive Pell Grants to pursue a quality education. The White House launched the Fair Chance Pledge to highlight employers and institutions of higher education that have committed to reducing barriers that justice-involved youth often face in accessing employment, training, and education. To build on these efforts, the Congress must reauthorize the Juvenile Justice and Delinquency Prevention Act (JJDP) to increase protections for youth and limit the number of minors held in adult jails and prisons. Reauthorizing the JJDP will promote evidence-based practices, quality education, and trauma-informed care for incarcerated youth, while reducing punishments for things such as breaking curfew and truancy.

We have also seen too many of our youth held in solitary confinement while incarcerated, which can lead to devastating, long-term psychological consequences. Earlier this year, my Administration took steps to implement reforms that include banning this harmful practice for juveniles under the custody of the Federal Bureau of Prisons. We must ensure that young people have quality legal representation throughout every stage of the legal process as well as age-appropriate and rehabilitative sentencing and placements. The financial costs of the juvenile court system can be debilitating and can unfairly penalize children from poor families -- by reducing the fees and fines imposed on youth, we can avoid pushing families into debt and decrease this disproportionate burden.

To meet these goals, we must engage young people before they find themselves locked into a path from which they cannot escape. The Departments of Justice and Education created the Supportive School Discipline Initiative to incentivize positive school climates and rethink discipline policies to foster safer and more supportive learning environments. They are also working to assist States, schools, and law enforcement partners in assessing the proper role of school resource officers and campus law enforcement professionals. The Departments of Justice and Health and Human Services released a joint policy statement against the use of suspension and expulsion in preschool settings -- which disproportionately affect children of color. As part of the Office of Juvenile Justice and Delinquency Prevention's Smart on Juvenile Justice initiative, we are providing services such as job training and substance use disorder treatment and counseling for youth in juvenile facilities, and we are expanding the use of effective community-based alternatives to youth detention. We are also screening youth for exposure to trauma that can put them at greater risk of entering the juvenile justice system. And through the My Brother's Keeper initiative, we are working to address persistent opportunity gaps and ensure all young people can reach their full potential -- including by helping them get a healthy start in life, enter school ready to learn, and successfully enter the workforce.

When we invest in our children and redirect young people who have made misguided decisions, we can reduce our over-reliance on the juvenile and criminal justice systems and build stronger pathways to opportunity. In addition, for every dollar we put into high-quality early childhood education, we save at least twice that down the road in reduced crime. That is why my Administration has sought to expand high-quality early education by increasing funding for programs like Head Start and investing in preschool, child care, and evidence-based home visiting. Investing in our communities and our kids makes sense, and if we recognize that every child deserves to remain connected to their families and communities, we can ensure youth who come in contact with the law can have a chance at a brighter future.

This month, we come together to ensure all young people are supported, nurtured, and provided an opportunity to succeed. We must make sure youth in every community and from every walk of life can be known for more than their worst mistakes. With enhanced possibilities, a sense of optimism, and an open mind, they can all thrive and live up to the full measure of their promise.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim October 2016 as National Youth Justice Awareness Month. I call upon all Americans to observe this month by taking action to support our youth and by participating in appropriate ceremonies, activities, and programs in their communities.

New SAMHSA Grant Opportunities

[Planning and Developing Infrastructure to Improve the Mental Health and Wellness of Children, Youth and Families in American Indian/Alaska Natives \(AI/AN\) Communities](#)

Application Due Date: Tuesday, December 20, 2016
Anticipated Award Amount: Up to \$418,000 per year

Length of Project: Up to 3 years
Number of Anticipated Awards: 11

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2017 Planning and Developing Infrastructure to Improve the Mental Health and Wellness of Children, Youth and Families in American Indian/Alaska Natives (AI/AN) Communities (Short Title: Circles of Care VII) grants. The purpose of this program is to provide tribal and urban Indian communities with tools and resources to plan and design a holistic, community-based, coordinated system of care approach to support mental health and wellness for children, youth, and families. These grants are intended to increase the capacity and effectiveness of mental health systems serving AI/AN communities. Circles of Care grantees will focus on the need to reduce the gap between the need for mental health services and the availability and coordination of mental health, substance use, and co-occurring disorders in AI/AN communities for children, youth, and young adults from birth through age 25 and their families.

Eligible Applicants: Federally recognized tribes and tribal organizations (as defined by USC 25, Chapter 14, Subchapter II, Section 450b), Tribal Colleges and Universities (as identified by the American Indian Education Consortium), and Urban Indian Organizations (as identified by the Office of Indian Health Service Urban Indian Health Programs through active Title V grants/contracts).

[Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances](#)

Application Due Date: Tuesday, January 3, 2017
Anticipated Award Amount: Up to \$3 million per year for state applicants; up to \$1 million for political subdivisions of states, territories, or Indian or tribal organizations.
Number of Anticipated Awards: 1 to 5

Length of Project: 4 years

CMHS is also accepting applications for fiscal year (FY) 2017 Cooperative Agreements for the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (Short title: System of Care (SOC) Expansion and Sustainability Cooperative Agreements). The purpose of this program is to improve behavioral health outcomes for children and youth (birth-21) with serious emotional disturbances (SED) and their families. This program will support the wide-scale operation, expansion, and integration of the SOC approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children's Mental Health Initiative or CMHI).

This cooperative agreement will support the provision of mental health and related recovery support services to children and youth with SED and those with early signs and symptoms of serious mental illness (SMI), including first episode psychosis (FEP), and their families.

The SOC Expansion and Sustainability Cooperative Agreements will build upon progress made in developing comprehensive SOC across the country by focusing on sustainable financing, cross-agency collaboration, the creation of policy and infrastructure, and the development and implementation of evidence-based and evidence-informed services and supports. Other activities supported will include the implementation of systemic changes, training, and workforce development.

Eligible Applicants: State and territorial governments, governmental units within political subdivisions of a state, such as a county, city or town; Federally recognized American Indian/Alaska Native (AI/AN) tribes, tribal organizations, Urban Indian Organizations, and consortia of tribes or tribal organizations; and Indian or tribal organizations (as defined in Section 4[b] and Section 4[c] of the Indian Self-Determination and Education Assistance Act).



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 University of Michigan “Big House.”

Mark your calendars for this seminal event! Registration will be limited. 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.**

Technical Assistance on Preventing the Use of Restraints and Seclusion

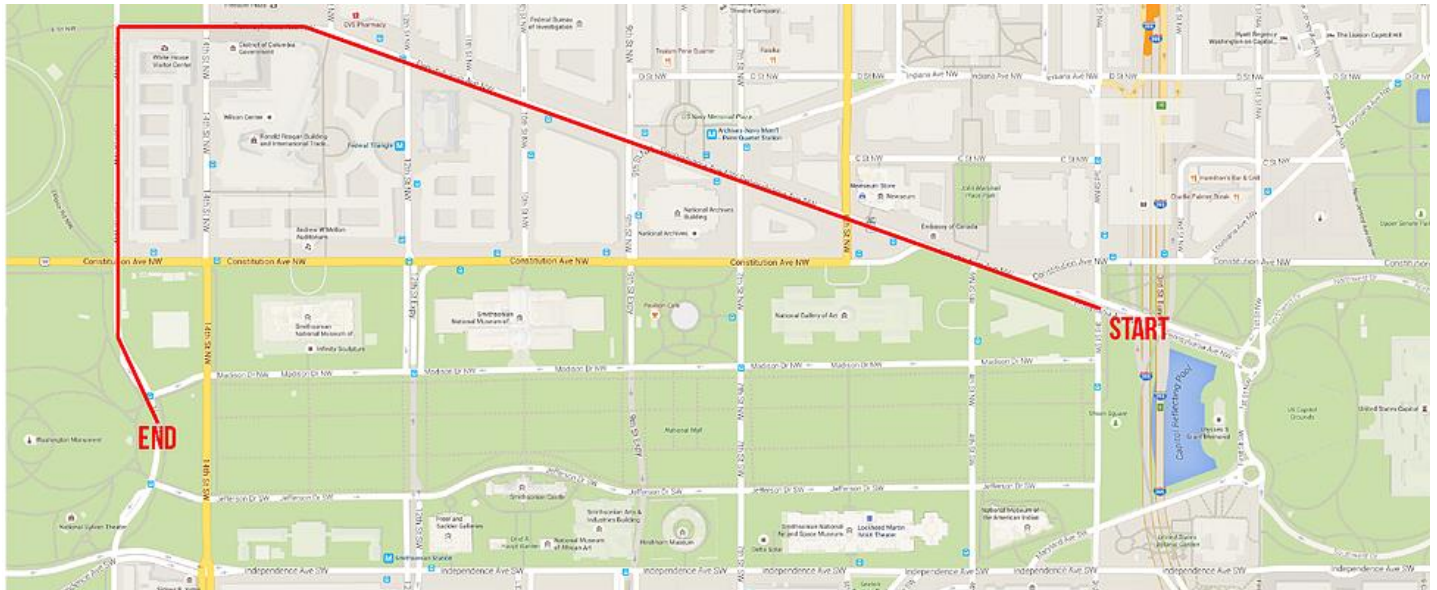
For more than 10 years, NASMHPD has been contracted by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance and support to facilities committed to preventing the use of restraint and seclusion.

The 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.

Destination Dignity Rally & March | October 10, 2016 | Washington, DC Join the March for Dignity and Change for Mental Health!



TIME OF MARCH: 11 A.M. to 3 P.M.

STARTING POINT: Capitol Reflecting Pool / END POINT: Washington Monument

The march will begin at the corner of 3rd St NW & Pennsylvania Ave NW. It will then head NW on Pennsylvania Ave for approx. 6 blocks (Pennsylvania Ave briefly merges w/ Constitution Ave NW, then resumes as Pennsylvania). At the end of the six blocks, it will head south on 15th St NW for approx. 2.5 blocks (until just past Madison Drive NW).

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 NASMHPD's [Pat Shea](#) by email or at 703-682-5191.

SPRC Releases Video on Treating Middle-Aged Men at Risk of Suicide

Men between the ages of 35 to 64 account for 40 percent of all suicides in the United States. They have the highest number of suicides than any other age group—their rate is double the national average.

To bring awareness of the suicide risk for this population, the Suicide Prevention Resource Center (SPRC) launched a SPARK Talks-short video, [Men in the Middle Years](#), featuring Seattle psychiatrist Dr. Jeff Sung, MD.

The aim of Dr. Sung's video is to help health professionals understand why it's important to address the suicide rates among men in the middle years and the challenges of reaching this demographic. Dr. Sung notes that "Men in the middle years historically have received less attention in the suicide prevention field, even though they account for a high number of suicide deaths." He says the cultural perception about men who are in their middle years is that they are independent, self-sufficient and can take care of themselves and their families.

Furthermore, the a literature review suggests that current suicide prevention approaches may not be suitable for this target group. Suicide prevention research tends to focus on youth and young adult females under age 30. Says Dr. Sung, "If we're going to reduce the overall number of suicide deaths in the United States, men in the middle years need our attention."

Dr. Sung recommends:

Reducing access to firearms. A contributing factor to having the highest suicide rate is that men have greater access to firearms when attempting suicide. Suicide attempts by firearms are the most lethal means and tend to be fatal. Suggestions to reduce access to firearms include building partnerships with gun shop owners and healthcare

professionals working with their clients to reduce access to firearms during times of high suicidal risk.

Investing in research on treatment to identify what works best for men. There is very little research being conducted on what suicide prevention treatments work best for men in the middle years. Dr. Sung says that mental health professionals should not assume that what works best for young women will work equally for older men. He suggests that researchers focus on older male study participants.

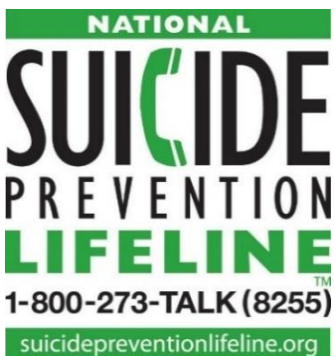
Exploring alternative treatment methods. Men are less likely to seek conventional mental health treatment. Clinicians should identify ways to engage men by going to where they are—work, family court, justice systems, jails, substance use agencies, and homeless shelters.—and develop messages that are tailored for men.

Developing an upstream suicide prevention approach. A focus on earlier identification—during depression, substance use, or following a violent episode—when intervention can change the trajectory for a man in his middle years so he doesn't become suicidal.

NIH Releases Recommendations on Advancing Youth Suicide Research

On October 4, NIH released the 29 [recommendations](#) of the Pathways to Prevention Workshop it convened last March to identify and advance research to prevent youth suicide.

The list includes improving surveillance by linking data sources to help identify people at risk for suicide, improving measurement across diverse populations and time, and training practitioners, schools, agencies, and families to recognize suicide risk and reduce stigma.



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.

October Trainings

Delaware

State of Delaware – October 28

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



American Association for the Treatment of Opioid Dependence, Inc.

Expanding Access to Quality Opioid Addiction Treatment Services Since 1984

2016 National Conference (October 29 to November 2)

2016 Awards Program

November 1, 2016

**Baltimore Marriott Waterfront
Baltimore, MD**

[REGISTER HERE](#)

The Friend of the Field Award: [Michael Botticelli, MEd](#), Director, White House Office of National Drug Control Policy (ONDCP)

This award was established by AATOD's Board of Directors and recognizes extraordinary contributions to the field of opioid use disorder treatment by an individual whose work, although not always directly related to treatment of opioid use disorders, has had a significant impact on our field.

Nyswander/Dole "Marie" Award

AATOD will be honoring 10 individuals who have been nominated and selected by their peers for extraordinary service in the opioid treatment community. These successful award recipients have devoted themselves to improving the lives of patients in our treatment system. Dr. Vincent Dole and Dr. Marie Nyswander were the first recipients of this award in 1983.

[Ray Caesar, LPC, Oklahoma](#)
[Spence Clark, MSW, North Carolina](#)
[Alice Gleghorn, PhD, California](#)
[Robert Kent Esq., New York](#)
[Robert Lambert, MA, Connecticut](#)

[Richard Moldenhauer, MS, Minnesota](#)
[Kenneth Stoller, MD, Maryland](#)
[Trusandra Taylor, MD, Pennsylvania](#)
[Hoang Van Ke, MD, Vietnam](#)
[Einat Peles, PhD, Israel](#)

The Richard Lane/Robert Holden Patient Advocacy Award: [Brenda Davis, MSW](#)

This award honors the work of Richard Lane and Robert Holden. Both are recovering heroin-addicted individuals who changed their lives and the lives of many by establishing and managing Opioid Treatment Programs. Their work and commitment has shown that medication-assisted treatment does work. This award was established in 1995 and recognizes extraordinary achievements in patient advocacy.

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](#).

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NASMHPD LINKS OF INTEREST

(Inclusion on this list should not be read to imply NASMHPD support for positions taken within the items linked.)

OCTOBER 5, 2016 REMARKS ON THE “[FUTURE OF HEALTH CARE IN AMERICA](#)” BY CMS ACTING ADMINISTRATOR ANDY SLAVITT AT THE, *MARKETPLACE YEAR 3: ISSUER INSIGHTS AND INNOVATIONS* FORUM WITH MARKETPLACE PLAN ISSUERS AT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

[PARENTAL PSYCHIATRIC DISEASE AND RISKS OF ATTEMPTED SUICIDE AND VIOLENT CRIMINAL OFFENDING IN OFFSPRING: A POPULATION-BASED COHORT STUDY](#), OCTOBER 2016 *JAMA PSYCHIATRY*

[IN MEDICAID EXPANSION STATES, UNINSURED ADULTS’ SHARE OF PHYSICIAN AND ED VISITS HAS DECLINED](#), STATISTICAL BRIEF BY AHRQ RESEARCHERS, *HEALTH AFFAIRS BLOG*, OCTOBER 5, 2016

[MANY ELIGIBLE FOR PREMIUM TAX CREDITS NOT RECEIVING THEM; A 2017 OPEN ENROLLMENT CALENDAR](#), TIMOTHY JOST, *HEALTH AFFAIRS BLOG*, OCTOBER 5, 2016

[ENHANCING ENROLLMENT OF INDIVIDUALS TRANSITIONING FROM MEDICAID OR CHIP TO MARKETPLACE COVERAGE](#), CENTER FOR MEDICAID AND CHIP SERVICES (CMCS) INFORMATIONAL BULLETIN, SEPTEMBER 29, 2016