Michigan Association of Community Mental Health Boards is now
Community Mental Health Association of Michigan.

February 9, 2018

FRIDAY FACTS

TO: CMH and PIHP Executive Directors
Chairpersons and Delegates
Provider Alliance Members
Executive Board Members

FROM: Robert Sheehan, Chief Executive Officer
Alan Bolter, Associate Director

RE:

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New e-mail addresses for Association staff: The Michigan Association of CMH Boards is now the COMMUNITY MENTAL HEALTH ASSOCIATION OF MICHIGAN.

Please update your email address for CMHAM staff:

Alan Bolter, Associate Director: abolter@cmham.org
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Robert Sheehan, CEO: rsheehan@cmham.org

Association soon to announce new membership opportunities: In response to requests for a broader range of membership options and a fuller list of benefits of each membership type, the CMH Association of Michigan will soon be announcing several new membership opportunities for organizations and individuals. Look for the revised Association membership brochure to be available in November.

Friday Facts to become a members-only electronic newsletter: Note that the receipt of this electronic newsletter will become a members-only benefit sometime in the next few months. While there will be another electronic newsletter for a wider range of non-members, it will not contain the depth or breadth of information contained in this newsletter. **So, if you find the information in this newsletter useful and are not an Association member, consider becoming a member when the new membership opportunities are announced**.

WORK AND ACCOMPLISHMENTS OF CMH ASSOCIATION MEMBER ORGANIZATIONS

SWMBH, CMHs in southwest Michigan and partners received federal grant

Below is an excerpt from a recent article in the WMU News highlighting the receipt of a federal grant to address the state's mental health workforce needs. As the article underscores, Southwest Michigan Behavioral Health (SWMBH) and the CMHs in the SWMBH region, all members of this association, are key partners in this effort.

> OT, social work faculty earn $1.8 million behavioral health grant: A four-year, $1.8 million grant for behavioral health workforce education and training will support a Western Michigan University project that aims to increase the number of thoroughly trained treatment providers who work with the region's underserved and vulnerable community members.
>
> Dr. Ann Chapleau, associate professor of occupational therapy, and Dr. Jennifer Harrison, assistant professor of social work, received the grant from the U.S. Health Resources and Services Administration. The funding will support WMU's Interprofessional Peer Education and Evidence for Recovery project, IPEER, a joint initiative of the Department of Occupational Therapy and School of Social Work.
>
> Chapleau and Harrison created IPEER to enhance interdisciplinary education for social workers, occupational therapists and peer specialists, and to expand the number of these professionals who are available to serve rural and medically underserved communities in southwest Michigan.

The IPEER project connects the educational training and direct service provided through WMU's College of Health and Human Services with numerous off-campus partner organizations where students complete their required fieldwork.
Organizations where that collective training takes place include the Kalamazoo Psychiatric Hospital**, Southwest Michigan Behavioral Health and the Recovery Institute of Southwest Michigan**, as well as community mental health programs and their providers **in Allegan, Barry, Berrien, Branch, Cass, Calhoun, Kalamazoo, Ottawa, St. Joseph and Van Buren counties.**

Harrison says the new grant funding will boost the ability of WMU and its partners to prepare students for interprofessional behavioral health practice as well as to provide innovative training that will strengthen the behavioral health workforce in southwest Michigan.

"The majority of the funding will be used to provide stipends to occupational therapy and social work master's students in their final-year field placements at our partner organizations," Harrison says. "Twenty-eight students will be eligible for $10,000 stipends each year. This will remove a significant financial burden from both the University and our students and allow the students to focus on their research and to make the most of their final-year clinical experiences."

The full article can be found at:
https://www.wmich.edu/news/2018/02/45083

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

Can new bipartisan group break through divisions and build reform consensus?

Below is an excerpt from a recent Modern Healthcare article on the formation of a non-profit group, headed up by former CMS Director, Andy Slavit,

American health policy is stuck in a deep political rut. Now a bipartisan group of prominent healthcare, political and not-for-profit leaders have come together to try to build a public consensus for how to reform the system.

The new not-for-profit group launched on Tuesday is called United States of Care (https://unitedstatesofcare.org/about-us/) and promises to move beyond partisan politics and find politically sustainable ideas to ensure that every American has a regular source of affordable care, no one faces financial devastation due to an illness or injury, and that any solutions are economically responsible and have broad political support.

You are forgiven for your initial skepticism. But what are the alternatives if not finding consensus and compromise?

"It's very hard to negotiate things that are acceptable to both sides of the political spectrum, particularly if you consider the left fringe of the Democratic Party and the right fringe of the Republican Party," said Dr. David Blumenthal, president of the Commonwealth Fund and a historian of health policy. "But American politics has gone through many changes over the centuries. It's not impossible to imagine another political or policy window opening."

Starting this month, United States of Care plans to hold public listening events in Minnesota, North Carolina and Utah bringing together residents, elected officials of both major parties, healthcare leaders, academic experts and patient advocates to discuss what they want to see from the healthcare system.

Andy Slavitt, founder and chairman of United States of Care and former acting CMS administrator during the Obama administration, said he and former GOP Sen. David Durenberger will lead the listening tour in their

> home state of Minnesota. Dr. Mark McClellan, a Republican who headed the CMS and the U.S. Food and Drug Administration, will lead the tour in North Carolina, while Mike Leavitt, Utah's former Republican governor and former HHS secretary, will head up the Utah sessions.

The full article can be found at:

http://www.modernhealthcare.com/article/20180206/BLOG/180209937

SAMHSA/HRSA CIHS issues healthcare integration sustainability guide

The federal SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) recently issued a guide book that addresses a question often asked by the members of this association who are engaged in healthcare integration efforts: Sustaining Integrated Behavioral Health and Primary Care: A Step-by-Step Guide. The details of the guide are described below:

> Clients, health care teams, and researchers agree that integrating care promotes a whole-person approach to health with immediate and lasting benefits. Whether just starting to integrate behavioral health services or working to enhance services already in place, the SAMHSA-HRSA Center for Integrated Health Solutions has created a step-by-step guide presenting four steps for safety net and other primary care providers to integrate behavioral health services and achieve sustainable integrated care models:
>
> - Step 1 – Operational and Administrative Readiness
> - Step 2 – Workforce Development
> - Step 3 – Clinical Practice Tools
> - Step 4 – Sustainability and Continuous Improvement

The Guide can be found at**:** https://integrationedge.readz.com/overview-and-step-1--operational-and-administrativ

Did you miss Part 1 of this email series, Sustaining Integrated Behavioral Health Services: Strategies and Tools for Workforce Development? Find it on the *Integration Edge***.** https://integrationedge.readz.com/home

Numerous Flaws Found in Flint Area Community Health and Environment Partnership Journal Articles

Below is a recent press release, issued by MDHHS, that outlines some of the flaws in the journal articles describing the Flint water crisis.

The Michigan Department of Health and Human Services (MDHHS) recently learned that Wayne State University, the University of Michigan and Colorado State University will publish two journal articles based on data from the Flint Area Community Health and Environment Partnership (FACHEP) project.

Previously, FACHEP provided MDHHS with a draft of these journal articles which claim to explore the statistical relationship between the change in water source and the incidence of Legionnaire's Disease in Flint and other Southeast Michigan counties and the prevalence of various strains of legionella found in the cities of Flint and Detroit. MDHHS reviewed the draft articles as did an external, independent third party, KWR Watercycle Research Institute (KWR). KWR was asked to review the FACHEP project on behalf of the Michigan Department of Management and Budget. Both MDHHS and KWR found numerous flaws in the articles which were brought to FACHEP's attention and appear to remain unaddressed. By publishing these inaccurate, incomplete studies at this point, FACHEP has done nothing to help the citizens of Flint and has only added to the public confusion on this issue.

The researchers not only failed to accurately describe conversations with MDHHS, but utilized variables in their dataset that inaccurately reflect the timing associated with cases of Legionnaires in Flint. Researchers also overestimate the risk to public health by focusing on a strain of the bacteria, serogroup 6, that is not typically associated with Legionnaires' disease. FACHEP acknowledges that 16/18 of the environmental isolates that it found were serotype 6. Not a single case of serogroup 6 Legionnaire's Disease was identified in Genesee county, despite widespread use of

legionella cultures. As even FACHEP recognizes, more research is needed to evaluate the risk of this strain. Publishing this report now, however, implies that a public health risk exists when there may not be one.

In addition KWR noted that the report focusing on the link between the switch in the Flint water and increase in Legionnaires' disease "…raises a number of serious critical questions with regard to the applied methodology, and gives little insight in the actual crude numbers in the various analyses." KWR added that "[t]he paper is difficult to follow in places and does not provide insight into the crude data with which the statistical analyses were performed. The authors claim that their analyses reveal causal relations, but failed to distinguish between the demonstration of a statistical association, and its interpretation as a causal relation."

Based upon concerns over FACHEP's methodology, the State of Michigan informed FACHEP that it was only willing to continue the partnership under the independent review and oversight of KWR. FACHEP rejected the State's offer to continue under these conditions.

Additional detail regarding the scientific concerns MDHHS has to these two journal articles can be found in "MDHHS Response to FACHEP Proceedings of the National Academy of Sciences Article" and "MDHHS Response to FACHEP American Society for Microbiology mBio Article" attachments.

Additional, related resources on this topic can be found at:

- MDHHS+Response+to+FACHEP+Proceedings+of+the+National+Academy+of+Sciences+Article+FINAL.pdf: (https://content.govdelivery.com/attachments/MIDHHS/2018/02/05/file_attachments/953946/MDHHS%2BResponse%2Bto%2BFACHEP%2BProceedings%2Bof%2Bthe%2BNational%2BAcademy%2Bof%2BSciences%2BArticle%2BFINAL.pdf)

- MDHHS+Response+to+FACHEP+American+Society+for+Microbiology+mBio+Article+FINAL.pdf (https://content.govdelivery.com/attachments/MIDHHS/2018/02/05/file_attachments/953945/MDHHS%2BResponse%2Bto%2BFACHEP%2BAmerican%2BSociety%2Bfor%2BMicrobiology%2BmBio%2BArticle%2BFINAL.pdf)

- 171108+KWR+2017.081+final+report+scoping+mission+DEF.PDF (https://content.govdelivery.com/attachments/MIDHHS/2018/02/05/file_attachments/953949/171108%2BKWR%2B2017.081%2Bfinal%2Breport%2Bscoping%2Bmission%2BDEF.PDF)

MI Bridges issues latest Community Partner Bulletin

Below is the announcement of the most recent issue of the MI Bridges Community Partner Bulletin. This association, a member of the MI Bridges Advisory Group, urges its members to become subscribers to this bulletin, a key tool in their work with persons in need of a range of health and human services and supports.

We are excited to share with you the January issue of the MI Bridges Community Partner Bulletin!

As part of MDHHS's Integrated Service Delivery effort, MI Bridges and the Assistance Application are undergoing transformative changes. These changes have been made in close collaboration with clients, community partners, and MDHHS caseworkers, who have provided input and feedback throughout the process. The new MI Bridges will enable residents to identify their needs and connect to community resources that meet those needs to improve stability over time. These resources include community programs and organizations through a partnership with Michigan 2-1-1.
We hope you find the bulletin useful as it contains information specifically designed for community partners, such as upcoming events, key MI Bridges updates, a timeline of key dates, and frequently asked questions.

Included in this issue:

- MI Bridges Soft Launch
- New Assistance Application

- MI Bridges Training for Community Partners
- MI Bridges Statewide Rollout Dates

The January Bulletin can be found at:
https://content.govdelivery.com/attachments/MIDHHS/2018/02/02/file_attachments/953121/Jan-MIBridgesBulletin-Community%2BPartner_Final.pdf

If you would like more information about the new MI Bridges, please visit our MI Bridges Partners website at www.michigan.gov/mibridgespartners.

If you have any questions or for more information, please contact us at MDHHScommunitypartners@michigan.gov.

Michigan Association for Suicide Prevention announces spring conference

Michigan Association for Suicide Prevention Conference
March 6 & 7, 2018
Comfort Suites; Mount Pleasant, Michigan

Educational topics include:

- Adult and youth mental health first aid training
- Crisis intervention
- Teams and trauma training
- Suicide prevention

:
$75 Registration Fee through February 16, 2018

To Register Visit: https://www.mymasp.org/

NASW-Michigan and MCCD offer at-risk youth workshop

Working with Transgender and Gender Nonconforming At-Risk Youth
A Training for Psychologists, Social Workers, Mental Health Providers and Juvenile Justice Professionals

Friday, April 6th, 2018 from 9:00am-4:00pm
Saturday, April 7th, 2018 from 9:00am-4:00pm

Held at the Michigan Council on Crime and Delinquency
1679 Broadway Street Ann Arbor, Michigan 48105

Hosted by the National Association of Social Workers (NASW) and the Michigan Council on Crime and Delinquency (MCCD)

A 2-day, in-depth training for practitioners who want to learn how to work more effectively with transgender/gender non-conforming at-risk youth. We will explore barriers and challenges, discuss successful strategies for engagement, hear directly from impacted people, and provide participants with an opportunity to learn from, and problem-solve with, local and statewide experts.

Registration:
Regular Price: $325
Student Price: $210
Discounted Price for NASW Members: $295
Discounted Price for NASW Student and Transitional Members: $150

Lunch will be provided and 12 CEs will be available for licensed social workers

.
Please register at **http://www.nasw-michigan.org/events**

HIPAA updates from Abilita and Enhanced Computing Solutions

Two corporate partners of this association, Abilita and Enhanced Computing Solutions periodically provide useful guidance, to the Association's members, on a range of healthcare information technology issues. Below is the most recent set of updates in this series:

- Misconception of HIPAA and the Opioid Crisis
  A common misconception of a HIPAA regulation is causing doctors to not notify families in the event of an overdose. HIPAA regulations tell us we cannot share patient health information without their consent. But what if the patient is unconscious and it is imperative to get information from the family?

- Sharing health information with family and close friends who are involved in the care of the patient if the provider determines that doing so is in the best interests of an incapacitated or unconscious patient is allowed. Also, informing persons in a position to prevent or lessen a serious and imminent threat to a patient's health or safety is allowed. It's important to note that whenever a state law conflicts with HIPAA, the more restrictive law is the winner. https://www.hhs.gov/about/news/2017/10/27/hhs-office-civil-rights-issues-guidance-how-hipaa-allows-info-sharing-address-opioid-crisis.html. We welcome you to join us at our CMHA pre-conference seminar to learn more.

- Why end user security awareness training is so important
  HIPAA training is required for compliance, but are you providing security awareness training? You may be asking; what does that have to do with HIPAA? A large percentage of patient data breaches are caused by phishing. The Office for Civil Rights has just released a newsletter regarding cyber extortion as well as a fact sheet and checklist. https://www.hhs.gov/sites/default/files/cybersecurity-newsletter-january-2018.pdf. Many of these attacks could have been prevented with continuous security awareness training.

- Whether its compromised email credentials, computer system credentials, or ransomware, it's critical for all end users with access to ePHI to know how to identify these emails to avoid becoming a victim. Compromised credentials to a system containing ePHI could mean a reportable breach for your organization. We welcome you to join us at our CMHA pre-conference seminar to learn more.

- What are the hot topics in HIPAA for 2018?
  In a study conducted by HIMSS Analytics, 78% of healthcare providers interviewed had experienced some form of cyber-attack with the past 12 months. According to a study by Bitglass, hacking and IT incidents pose the greatest risk to compliance. The volume of records that leak as a result of hacking is greater than all other breach events combined. As new technologies emerge, they also bring new challenges in protecting your network.

- The first breach settlements of 2018 are here and they're related to not having a proper risk analysis or risk management plan. https://www.hhs.gov/about/news/2018/02/01/five-breaches-add-millions-settlement-costs-entity-failed-heed-hipaa-s-risk-analysis-and-risk.html. Completing a risk analysis each year will help you stay on top of your constantly changing network environment and the security risks that come with it. No network is 100% secure, which is why having a risk management plan drafted each year can help continuously fill the gaps in security. We welcome you to join us at our CMHA pre-conference seminar to learn more.

- HIPAA Enforcement Rule
  Most of us have heard of the 1.5 million dollar maximum penalty for a HIPAA violation, but there is more to it. The 1.5 million dollar max per year is per identical provision. Meaning that the maximum per year can be

much more than you think. The highest HIPAA penalty to date was for $5.5 million and was related to one stolen laptop. https://www.storagecraft.com/blog/most-costly-hipaa-fines-in-history/. The reason the penalty was so high? They were found to not have a risk analysis or have implemented basic security principals.

- Penalties are broken down into a few categories. Did not know, reasonable cause, willful neglect – corrected, and willful neglect – not corrected. In short, if you have a breach but were completing your annual risk analysis, providing end user HIPAA training, and were updating your HIPAA policies and procedures but a human error or cyber incident occurs, then the fine would be much less than if you were not completing these tasks. We welcome you to join us at our CMHA pre-conference seminar to learn more.

LEGISLATIVE UPDATE

FY19 Executive Budget Proposal

Specific Mental Health/Substance Abuse Services Line items

	FY' 17 (final)	FY' 18 (final)	FY'19 (Exec Rec)
-CMH Non-Medicaid services	$120,050,400	$120,050,400	$120,050,400
-Medicaid Mental Health Services	$2,336,960,100	$2,315,608,800	$2,364,039,500
-Medicaid Substance Abuse services	$53,392,400	$52,408,500	$68,441,000
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$73,811,800	$77,380,000	$76,456,200
-Children's Waiver Home Care Program	$20,000,000	$20,241,100	$20,241,100
-Autism services	$61,168,400	$105,097,300	$199,841,400
-Healthy MI Plan (Behavioral health)	$247,822,900	$288,655,200	$292,962,900

Other Highlights of the FY19 Executive Budget:

Direct Care Staff Wages

The governor's FY19 budget continues the .50 cent wage increase to support direct care workers who provide critical hands-on supports and services (e.g., personal care services, mobility support) to residents served through Michigan's community mental health system. The funding is reflected in the budget within the Medicaid and HMP behavioral health line items to maintain the $0.50 wage increase for direct care workers. Boilerplate from FY18 requiring the $.50 increase is no longer in the budget because the increase is in place, however there is still a reporting requirement in section 1009 for PIHPs to report on wages paid to these workers.

Medicaid pharmaceutical savings

The governor's FY19 budget assumes $14 million Gross/$5 million GF savings in Medicaid pharmaceutical line item through implementing/refining a preferred drug list, enhanced rebates and other efficiencies. This reduction is not related to prior authorization and will not reduce overall services.

Boilerplate Sections

Section 298 – The FY19 executive budget continues the language from the final FY18 budget:

Sec. 298. (1) The department shall continue to pursue the implementation of the demonstration model as specified under subsection (2) of Section 298 of Article X of PA 107 of 2017. The department shall ensure that the demonstration model described in this subsection is implemented in a manner that ensures at least all of the following:

(a) That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot project described in this subsection must only be in effect for the duration of the pilot project described in this subsection.

(b) That the project is consistent with the stated core values as identified in the final report of the workgroup established in section 298 of article X of 2016 PA 268.

(c) That updates are provided to the medical care advisory council, behavioral health advisory council, and developmental disabilities council.

(2) The department shall continue to pursue the implementation of up to 3 pilot projects as specified under subsection (3) of Section 298 of Article X of PA 107 of 2017. The department shall ensure that the pilot projects described in this subsection are implemented in a manner that ensures at least all of the following:

(a) That allows the CMHSP in the geographic area of the pilot project to be a provider of behavioral health supports and services.

(b) That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot projects described in this subsection must only be in effect for the duration of the pilot projects described in this subsection.

(c) That the project is consistent with the stated core values as identified in the final report of the workgroup established in section 298 of article X of 2016 PA 268.

(d) That updates are provided to the medical care advisory council, behavioral health advisory council, and developmental disabilities council.

(3) For the duration of any pilot projects and demonstration models, the department shall require that contracts between CMHSPs and the Medicaid health plans within their pilot region mandate that any and all realized benefits and cost savings of integrating the physical health and behavioral health systems shall be reinvested in services and supports for individuals having or at risk of having a mental illness, an intellectual or developmental disability, or a substance use disorder. Any and all realized benefits and cost savings shall be specifically reinvested in the counties where the savings occurred in accordance with the Medicaid state plan and any applicable Medicaid waivers.

(4) The department shall continue to partner with 1 of the state's research universities to evaluate any pilot project(s) and demonstration model that are authorized under this section.

(a) The evaluation shall include information on the pilot project's or demonstration model's success in meeting the performance metrics developed in this subsection and information on whether the pilot project could be replicated into other geographic areas with similar performance metric outcomes.

(b) The evaluation shall include the performance metrics, at a minimum, from each of the following categories:

(i) Improvement of the coordination between behavioral health and physical health.

(ii) Improvement of services available to individuals with mental illness, intellectual or developmental disabilities, or substance use disorders.

(iii) Benefits associated with full access to community-based services and supports.

(iv) Customer health status.

(v) Customer satisfaction.

(vi) Provider network stability.

(vii) Treatment and service efficacies before and after the pilot projects and demonstration models.

(viii) Use of best practices.

(ix) Financial efficiencies.

(x) Any other relevant categories.

(c) The evaluation shall be completed within 6 months of the end of the pilot project or demonstration model and shall be provided to the department, the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office.

(5) Upon completion of any pilot projects or demonstration models advanced under this section, the managing entity of the pilot project or demonstration model shall submit a report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office within 30 days of completion of that pilot project or demonstration model detailing their experience, lessons learned, efficiencies and savings revealed, increases in investment on behavioral health services, and recommendations for extending pilot projects to full implementation or discontinuation.

<u>Section 909</u> –Language directing the use of revenue from the marihuana regulatory funds be used to improve physical health, expand access to substance use disorder prevention and treatment services; and strengthen existing prevention, treatment, and recovery systems. (Same as FY18)

<u>Section 920</u> –Requires that the Medicaid rate-setting process for PIHPs include any state minimum wage increases; also states legislative intent that any Medicaid rate increase due to minimum wage increase be also distributed to direct care employees. (Same as FY18)

<u>Section 928</u> – Local match draw down. Section 928 – Local match draw down , includes subsection (2) stating legislative intent that any lapse funds for Medicaid mental health services shall be redistributed to individual CMHSPs as a reimbursement of local funds. (Same as FY18)

<u>Section 940</u> – Transferring and Withdrawing CMHSP Allocations – Requires DHHS to review CMHSP expenditures to identify projected lapses and surpluses and to encourage the board of the CMHSP with a projected lapse to concur with the recommendation to reallocate the lapse to other CMHSPs and requires DHHS to withdraw funds from a CMHSP if those funds were not expended in a manner approved by DHHS, including for services and programs provided to individuals residing outside of the CMHSP's geographic region. (Same as FY18)

<u>Section 942</u> – A CMHSP shall provide at least 30 days' notice before reducing, terminating, or suspending services provided by a CMHSP to CMHSP clients, with the exception of services authorized by a physician that no longer meet established criteria for medical necessity. (Same as FY18)

<u>Section 1009</u> – Each PIHP shall report to the department by February 1 of the current fiscal year the range of wages paid to direct care workers, including information on the number of workers at each wage level.

(2) The department shall report the information required to be reported according to subsection (1) to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office by March 1 of the current fiscal year.

Section 1010 – From the funds appropriated in part 1 for behavioral health program administration, up to $2,000,000.00 shall be allocated to address the implementation of court-ordered assisted outpatient treatment as provided under chapter 4 of the mental health code, 1974 PA 258, MCL 330.1400 to 330.1491. (Same as FY18)

Section 1860 –Language requiring the Department to report by March 1 on the number of HMP participants who haven't paid their co-pays, the total amount of uncollected co-pays, and the steps taken by the Department and health plans to ensure greater collection of co-pays.

Section 1867 – The department shall continue a workgroup that includes psychiatrists, other relevant prescribers, and pharmacists to identify best practices and to develop a protocol for psychotropic medications. Any changes proposed by the workgroup shall protect a Medicaid beneficiary's current psychotropic pharmaceutical treatment regimen by not requiring a physician currently prescribing any treatment to alter or adjust that treatment.

(2) By March 1 of the current fiscal year, the department shall provide the workgroup's recommendations to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget office.

More Mental Health Task Force Bills Introduced

This week more CARES task force recommendations were released, including HBs 5450-5452, which allows those once convicted of some minor felonies and misdemeanors would be allowed to work in some mental health care jobs.

Additionally, first responders would be required to get opioid overdoes training according to HB 5460 and HB 5461 and a database of open psychiatric beds would be created under HB 5439.

Legislation to address the CARES task force report will be an immediate focus on the House Health Policy Committee. In total the report includes roughly 50 recommendations, our association submitted 13, many of them were included.

House Health Policy Chair Hank Vaupel (R-Fowlerville) said this is not going to be a short-term plan. "This is not going to be a one-year fix. This is going to take many years to come up with solutions. In fact, it is going to be ongoing forever. Things change and we have to change."

A link to the full report can be found below:

https://house.mi.gov/PDFs/HouseCARESTaskForceReport.pdf

NATIONAL UPDATE

Legislation of Potential Import to NACBHDD

Behavioral Health Services

- **Behavioral Health Coverage Transparency Act (S. 2647; HR 4276).** Introduced by Senator Elizabeth Warren (D-MA) and Rep. Joe Kennedy III (D-MA) and originally cosponsored by 12 Senators and 8 Representatives, all

Democrats. *Measure would hold insurers accountable for providing adequate mental health benefits (parity) and increase transparency for consumers seeking coverage for mental and substance use disorders.*

- **Medicare for All Act of 2017 (S. 1804).** Introduced by Senator Bernie Sanders (I-VT). *Measure would establish a universal Medicare program, including transitional Medicare buy-in option and transitional public option. Premium assistance/cost-sharing subsidies would be available. Establishes a Universal Medicare Trust Fund using funds from Medicare, Medicaid, FEHBP and TRICARE. Individuals must be covered without regard to pre-existing condition or nature of medical issue (e.g., parity for behavioral health) Coverage includes, among other provisions, preventive care and all necessary inpatient and outpatient care to prevent, diagnose, treat and maintain recovery from behavioral disorders.*
- **Mental Health and Substance Abuse Treatment Act of 2017 (HR 1253).** Introduced by Rep. Derek Kilmer (D-WA) *The measure would allow HHS to make loans/loan guarantees for construction or renovation of psychiatric or substance abuse treatment facilities, and to refinance such loans and loan guarantees. Revenues from the loans/loan guarantees in excess of program costs would be placed in a Mental Health and Substance Use Treatment Trust Fund and be made available for block grants for community mental health services*.
- **Trauma-informed Care for Children and Families Act of 2017 (S. 774).** Introduced by Senator Heidi Heitkamp (D-ND) *Measure promotes development, testing, dissemination, and application of best practices in trauma-informed identification, referral, care and support for trauma-exposed children and families through a task force, funding through the NCTSI, and specific responsibility for dissemination of identified best practices by a range of HHS agencies and offices.*
- **CHIP Mental Health Parity Act (S. 22543; HR 3192).** Introduced by Senator Debbie Stabenow (D-MI) and Rep. Joseph P. Kennedy III (D-MA). *Measure would ensure access to mental health services under the Child Health Insurance Program, including all services "necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders."*
- **ACE Kids Act of 2017 (S. 428, HR 3325)).** Introduced by Senator Chuck Grassley (R-IA) and Rep. Joe Barton (R-TX). *The measure amends Medicaid to enable, but not require, States to provide coordinated care to children with complex medical conditions through enhanced pediatric health homes using, as necessary, alternative payment mechanisms. Two MACPAC reports to Congress are to be developed—one (within 2 years) making recommendations on the program, the second (in 5 years) on the program's conduct, recommendations for the future, and potential expansion.*
- **CONNECT for Health Act of 2017 (S. 1016; HR 2556).** Introduced by Senator Brian Schatz (D-HI) and Rep. Diane Black (R-TN). *Measure would amend Medicare to allow ACOs, FQHCs, Native American health service facilities, and rural clinics to engage in and be reimbursed for telehealth services, including for stroke, patient monitoring, and expanded mental health care.*
- **Medicaid Bump Act of 2017 (HR 324).** Introduced by Rep. Joseph Kennedy III (D-MA) *Measure would provide a higher federal matching rate for increased expenditures under Medicaid for mental and behavioral health services, and require the Medicaid and Chip Payment and Access Commission to report to Congress annually on Medicaid mental and behavioral health services payment rates and service utilization*.
- **Road to Recovery Act (HR 2938).** Introduced by Rep. Brian Fitzpatrick (R-PA). *Measure would remove barriers to residential substance disorder treatment services provided in specialty substance use treatment facilities under Medicaid and CHIP for individuals under the age of 65.*
- **Family-based Care Services Act (S. 1357, HR 2290).** Introduced by Senator Tammy Baldwin (D-WI) and Rep. Rosa DeLauro (D-CT). *Measure would amend Medicaid to provide a standard definition of therapeutic family care services*, to wit: services for children under 21 who, due to mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, need the level of care provided in an institution (including a psychiatric residential treatment facility) or nursing facility, the cost of which could be reimbursed under the State plan but who can be cared for or maintained in a community placement, through a qualified therapeutic family care program.
- **National Suicide Hotline Improvement Act of 2017 (S. 1015, HR 2345).** Introduced by Senator Orrin Hatch (R-UT) and Rep. Chris Stewart (R-UT*). Measure would require the FCC to coordinate with SAMHSA and the VA to examine: (1) designating a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system; and (2) the effectiveness of the National Suicide Prevention Lifeline (1-800-273-TALK), including how well it addresses the needs of veterans.* [NOTE: Passed Senate, Nov. 7, 2017.]

OPIATE-SPECIFIC

- **Opioid Addiction Prevention Act of 2017 (S. 892; HR 4408).** Introduced by Senator Kirsten Gillibrand (D-NY) and Rep. John Katko (R-NY). *Measure would require clinicians to restrict initial prescribing of opiates for acute pain to 7 days as a condition of registration under the Controlled Substances Act.* [A similar bill, with a 10-day limit, HR 3964, was introduced by Rep. Phil Roe (R-TN)].
- **Youth Opioid Use Treatment Help Act of 2017 (YOUTH Act) (HR 3382).** Introduced by Rep. Katherine Clark (D-MA) *Measure would amend the PHS Act substance abuse program provisions to include **young adults** as well as children and adolescents, including access to prevention and treatment programs, including MAT.*
- **Safer Prescribing of Controlled Substances Act (S. 1554)**. Introduced by Senator Edward Markey (D-MA) *Measure would require health care professionals who want to receive or renew registration for prescribing opiates to complete training regarding best practices for pain management, including alternatives to prescribing controlled substances and other alternative therapies to decrease the use of opioids; responsible prescribing of pain medications; ways to diagnose, treat and manage a substance use disorder, including medications and evidence-based non-pharmacologic therapies; linking patients to evidence-based treatment for substance use disorders; and tools to manage adherence and diversion of controlled substances.*
- **Medicare Beneficiary Opioid Addiction Treatment Act (HR 4097).** Introduced by Rep. Richard Neal (D-MA). *Measure would make methadone available under Medicare Part B.*

JUSTICE-RELATED ISSUES

- **Law Enforcement Mental Health and Wellness Act of 2017 (S. 867, HR 2228).** Introduced by Senator Joe Donnelly (D-IN) and Rep. Susan Brooks (R-IN) **THIS HAS BEEN SIGNED INTO LAW (PL 115-113)**. *Under the new law, grants available under the Community Oriented Policing Services program can be used to establish peer mentoring mental health and wellness pilot programs at the state, local and tribal levels. The Department of Justice (DoJ) will (1) review existing crisis hotlines, recommending improvements; examine the behavioral health needs of federal officers; and assure privacy is maintained; (2) working with HHS, develop materials for mental health providers to educate about the culture of law enforcement and relevant therapies for common problems; and (3) report on DoD and VA mental health practices and services that could be adopted by law enforcement agencies, and on programs to address the mental health and wellbeing of law-enforcement officers.*
- **Veterans Treatment Court Improvement Act of 2017 (S. 946, HR 2147).** Introduced by Senator Jeff Flake (R-AZ) and Rep. Mike Coffman (R-CO). *Measure would require the VA to hire at least 50 Veterans Justice Outreach Specialists to serve at an eligible VA medical center to serve as part of a veterans treatment court justice team or other veteran-focused court. The individuals would work with veterans with active, ongoing, or recent contact with some component of a local criminal justice system.*
- **Keeping Communities Safe through Treatment Act of 2017 (HR 1763).** Introduced by Rep. Sean Maloney (D-NY). *Measure would require the Department of Justice to conduct a pilot program to provide grants to eligible entities to divert individuals with low-level drug offenses to pre-booking diversion programs*

SERVICE PROVIDERS

- **Mental Health Access Improvement Act of 2017 (HR 3032).** Introduced by Rep. John Katko (R-NY). *Measure would provide Medicare coverage for services of mental health counselors and marriage and family therapists within their scopes of practice.*
- **Medicare Mental Health Access Act (S. 448).** Introduced by Senator Sherrod Brown (D-OH). *Measure would expand Medicare's definition of 'physician' to include state-licensed, clinical psychologists for the purpose of providing services within a psychologist's scope of state licensure.*
- **Prescriber Support Act of 2017 (HR 1375).** Introduced by Rep. Katherine Clark (D-MA) *Measure would establish a grant program to states or groups of states through HHS to establish, expand or maintain a comprehensive regional, State, or municipal system to provide training, education, consultation, and other resources to prescribers relating to patient pain, substance misuse, and substance abuse disorders.*
- **Strengthening the Addiction Treatment Workforce Act (S. 1453).** Introduced by Sen. Joe Donnelly (D-IN). *The measure makes certain substance abuse treatment facilities, both inpatient and outpatient that meet specified criteria*

(e.g., use of MAT, counseling or other evidence-based services) eligible for National Health Service Corps (NHSC) service.

- **Addiction Treatment Access Improvement Act of 2017 (HR 3692).** Introduced by Rep. Paul Tonko (D-NY). *Measure would amend the Controlled Substances Act to provide greater flexibility in the use of MAT for opioid use disorders by eliminating any time limitations for nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, and physician assistants to become qualifying MAT practitioners*
- **Ensuring Children's Access to Specialty Care Act of 2017 (S. 989).** Introduced by Senator Roy Blunt [R-MO]. *Measure would add pediatric subspecialties (including child psychiatrists) to the roster of physicians eligible to participate in the NHSC, with relevant loan forgiveness.*

VETERANS' ISSUES

- **Mental Health Care Provider Retention Act of 2017** (**HR 1064).** Introduced by Rep. Beto O'Rourke (D-TX) *Measure would ensure that an individual transitioning from treatment through DoD to VA to continue receiving treatment from the DoD mental health care provider.*
- **Community Care Core Competency Act of 2017 (S. 1319).** Introduced by Senator Sherrod Brown (D-OH) *Measure directs the VA to establish a 5-year, no-cost online program of continuing medical education for non-VA medical professionals designed to (1) increase knowledge and recognition of medical conditions common to veterans, and (2) improve outreach to veterans and family members. CME topics include working with veterans and their family members; identifying and treating their common mental and physical conditions; and the VA health care system.*
- **Honor Our Commitment Act of 2017 (S. 699).** Introduced by Senator Christopher Murphy [D-CT]. *Measure would require the VA to provide behavioral health services to individuals discharged/released from active service under other than honorable conditions.*
- **Veteran Urgent Access to Mental Healthcare Act (HR 918).** Introduced by Rep. Mike Coffman (R-CO) *Measure would require the VA to give former members of the Armed Forces an initial mental health assessment and mental health services to treat a member's urgent mental health care needs, including risk of suicide or harming others. Such mental health services can be provided at a non-VA facility if VA care is clinically inadvisable or geographically untenable.* [NOTE: Passed House Nov 7, 2017.]

TENTH ANNUAL GAMBLING DISORDER SYMPOSIUM

MDHHS & CMHAM Present: Michigan's Tenth Annual Gambling Disorder Symposium, ""A Holistic Approach to Gambling Disorder Treatment…Mind, Body & Spirit." The Symposium will be held on Friday, March 2, 2018 at the Diamond Center at Suburban Collection Showplace in Novi, Michigan.

Registration Fee: $35 per person and includes all materials, continental breakfast, lunch and refreshments.
To Register Click Here!

Symposium Highlights:
- Assessment and Treatment of Gambling Disorder with an Emphasis on High Risk Populations
- Problem Gambling: A Growing Epidemic Among Youth & Using Adverse Childhood Experiences (ACE) in Treatment
- Neurobiology of Gambling and Other Addictions
- Prevention: An Open Panel Discussion
- Treating Gambling Disorder with Mindfulness and Spirituality
- The Problem Gambler and the Criminal Justice System
- Insider's View of Gamblers Anonymous: Open Meeting
- Gambling Behavior - it's Functional

CMH Association committee schedules, membership, minutes, and information go to our website at https://www.macmhb.org/committees

Have a Great Weekend!