June 15, 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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- Friday Facts to become a members-only electronic newsletter
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- Ethics Training for Social Work and Substance Abuse Professionals for 2018
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- CMHAM Association committee schedules, membership, minutes, and information

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
Chris Ward, Administrative Executive: cward@cmham.org
Dana Owens, Accounting Clerk: dowens@cmham.org
Michelle Dee, Accounting Assistant: acctassistant@cmham.org
Monique Francis, Executive Board/Committee Clerk: mfrancis@cmham.org
Annette Pepper, Training and Meeting Planner: apepper@cmham.org
Anne Wilson, Training and Meeting Planner: awilson@cmham.org
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Chris Lincoln, Training and Meeting Planner: clincoln@cmham.org
Nakia Payton, Receptionist: npayton@cmham.org
Robert Sheehan, CEO: rsheehan@cmham.org

Association 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 is developing 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, ACCOMPLISHMENTS, AND ANNOUNCEMENTS OF CMH ASSOCIATION AND ITS MEMBER ORGANIZATIONS

DWMHA receives 3-year national accreditation for quality management

Detroit Wayne Mental Health Authority (DWMHA) has met the qualifications required to be awarded Full Accreditation as a Managed Behavioral Healthcare Organization (MBHO) by the National Committee on Quality Assurance (NCQA). This accreditation is awarded for three years.

"This confirms what our board of directors, leadership and staff already know," said Willie Brooks, President and CEO of Detroit Wayne Mental Health Authority. "We are committed to quality care to our members throughout Wayne County."

NCQA administers the most comprehensive evaluation in the industry and is the only assessment that bases results of clinical performance and consumer experience. DWMHA participated in a rigorous review process, analyzing several years of documentation along with interviews of key personnel.

"DWMHA's MBHO Accreditation is proof that it's an organization which works hard to coordinate care, provide access and good customer support for members," said Margaret E. O'Kane, NCQA President, "It's a sign that DWMHA is focused on improving the behavioral health of its members."

NCQA MBHO Accreditation evaluates how well a behavioral health plan manages all parts of its delivery system -- physicians, hospitals, other providers and administrative services -- in order to continuously improve behavioral health care services throughout Wayne County.

"This accomplishment reflects the hard work of DWMHA staff who maintain the highest quality standards and practices," said Brooks. "We have a dedicated staff that is focused on effective and efficient planning and implementation for our network and the people we are committed to serving."

Detroit Wayne Mental Health Authority moves to bring services in-house

Below is an excerpt from a recent article in Crain's Detroit Business on an effort being undertaken by the Detroit-Wayne Mental Health Authority.

> The Detroit Wayne Mental Health Authority is moving to phase out or substantially downsize relationships with four managed care provider networks with which it contracts for behavioral health services and bring the majority of services in-house.
> In a resolution Wednesday, the DWMHA board unanimously approved a yearlong plan to assume direct responsibility for behavioral health services for its 80,000 clients. By Oct. 1, 2019, the authority also plans to contract with at least one Medicaid health plan on a pilot basis to integrate behavioral and physical health services at the provider level, said Willie Brooks, DWMHA's CEO.
>
> In the resolution, the board said it agrees with the authority's plan for system transformation, the elimination of the current MCPN structure and "DWMHA assuming full management of all services and supports thereby taking over the responsibility for delegated services and responsibilities."
>
> DWMHA contracts with MCPNs' Integrated Care Alliance Inc., Community Living Services Inc., CareLink Network and CommunityLink Network for behavioral health provider services, according to its website.
>
> "We are not renewing the contracts and are in negotiations now" with the MCPNs and will assume most of the administrative duties of the managed care provider networks, Brooks said.
>
> Over the next several weeks, Brooks said DWMHA expects to first absorb 20-25 employees from Integrated Care Alliance, the smallest MCPN. He said the authority also expects to soon reach agreement with Community Living to absorb some of its employees, but allow the organization to continue to manage some direct behavioral services.

The full article can be found at: http://www.crainsdetroit.com/article/20180614/news/663646/detroit-wayne-mental-health-authority-moves-to-bring-services-in-house

CMH Association named as recipient of RWJF funded grant to strengthen healthcare safety nets

Recently, the CMH Association of Michigan was named as one of ten participants in the State Learning and Action Collaborative initiative of the Delta Center for A Thriving Safety Net. This initiative, funded by the Robert Wood Johnson Foundation, involves primary care associations (PCAs) and behavioral health state associations (BHSAs), drawn from across the country, to expand and elevate their existing work around: healthcare transformation and integration, payment reform, and the development of sustainable learning communities. This initiative will provide technical assistance to the CMH Association and a team of trainers/coaches (to be identified) to provide, in concert with nationally renowned experts, training, coaching, shadowing, via both learning community and broad distribution approaches as well as working to change state policy, statute, and practices to support a range of healthcare transformation initiatives.

The goal is to enhance state associations' capacity to support the shift to value-based care and payment and to sustain this shift by cultivating the practices of learning organizations. The three major activities include:

- State Learning & Action Collaborative: The CMH Association will participate in a national learning and action collaborative focused on supporting state associations' understanding of and movement towards value- based payment and care. The collaborative will also seek to bolster partnerships between primary care and behavioral

health state associations, with the CMH Association inviting the Michigan Primary Care Association to join them in this effort.

- Engaging with Local Members: The CMH Association will use what the Association learns from our participation in the State Learning & Action Collaborative to support primary care and behavioral health providers across both urban and rural areas in Michigan as they transition to value-based care and payment.

- Advancing Policy: The CMH Association will engage with Association members and policy stakeholders in Michigan states to explore and advance payment transformation that can support and sustain care transformations aimed at improving health outcomes, care experiences and staff experiences, as well as reducing health disparities, and total costs of care.

CMH Association working with University of Wisconsin in seeking SAMHSA designation as technical assistance centers

Substance Abuse and Mental Health Services Administration (SAMHSA) Technology Transfer Center: The University of Wisconsin, which operates the Great Lakes Addiction Technology Transfer Center (funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is applying to build on this work by taking on the role of the regional Mental Health Technology Transfer Center (MHTTC), under the funding opportunity announcement (FOA) recently issued by SAMHSA.

As part of this application, the University of Wisconsin has approached the CMH Association of Michigan, inviting the Association to serve as the Technology Transfer Center for the state of Michigan.

The purpose of this program is to establish one MHTTC National Coordinating Center and ten (10) MHTTC Regional Centers (of which the University of Wisconsin would be one to develop and maintain a collaborative network to support resource development and dissemination, training and technical assistance, and workforce development to the field. It is expected that MHTTCs will work to ensure that high-quality, effective mental health disorder treatment and recovery support services, and evidence-based practices are available for all individuals with mental disorders including, in particular, those with serious mental illness.

The University of Wisconsin and the CMH Association of Michigan hope to hear about the outcome of this proposal later this summer.

RESOURCES FROM ASSOCIATION'S PREFERRED CORPORATE PARTNERS

Join us next Tuesday for a discussion of how a rich performance management analytics solution can bolster your existing clinical initiatives, targeting high-risk populations to deliver better care, all while keeping costs in check.

Designed for organizational and clinical leaders at behavioral health, managed care, and payer organizations, the webinar will provide an up-close look at how the Relias Analytics platform sorts through all your data and applies complex algorithms so that organizational leadership and clinicians can:

- Get a longitudinal view of individual members

- Identify high-risk probability and rising risk members
- Measure the impact of integrated care initiatives
- Identify opportunities for providers to standardize to evidence-based practice
- Focus on proactive, tiered interventions to deliver better, less costly outcomes

Details and registration at: http://go.reliaslearning.com/WBN2018-06-19IntegratedCareinaVBWorld_Registration.html?utm_source=partner_silver&utm_medium=email&utm_campaign=eb_2018-06-19_integrated-care-in-a-vb-world_integrated-care&mkt_tok=eyJpIjoiTkdNME5XTXlOR1ExTnpjeiIsInQiOiJWSVhzZWNHZzNnMUNUSzlnTFVpUEhxWkUxbTRVVWdlbytzblNETDFCNnMwaUFJMVRGZmFleWhKd0wwdEpXTm00WDdaS1pnXC9HZW80RVZ4Sk9yK0ljSFh3RzlpWEtwUUdrTnVMU1poY2RnbUN2c3lmTElUUDNuQUZMeWZXNXc5dGsifQ%3D%3D

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

Provision in Medicaid work bill could end Healthy Michigan program

Below is an excerpt from a recent article in the Detroit Free Press highlighting a provision in the recently passed Healthy Michigan bill.

> Tucked into the bill that requires able-bodied Medicaid recipients to work at least 80 hours a month is a provision that could kill the state's Healthy Michigan plan altogether.
>
> The poison pill would end the Medicaid expansion that was approved by the Legislature in 2013, which covers 680,000 Michiganders with health care, if the federal government fails to approve a waiver within 12 months.
>
> If the state's Medicaid expansion plan deviates from previous practices, it has to apply for a waiver from the federal government to implement those changes. In Michigan's case, it will have to apply for a waiver on a provision that would limit benefits for recipients to 48 months and if they exceed that time, they'll have to start paying 5 percent of their income into their health care and prove that they are practicing healthy behaviors, such as quitting smoking or losing weight.
>
> If the Trump administration, which has wanted to repeal Obamacare since taking office in 2017, wants to end the Medicaid expansion in Michigan, the 12-month trigger could give it the excuse to do that.
>
> It was that provision that had Democrats especially worried and opposed to the bill, which requires that an estimated 350,000 people who are receiving Medicaid benefits work or lose their coverage.
>
> "The goal is to kick people off health care. In the bill, it says if they don't get the waiver, Healthy Michigan ends," said Senate Minority Leader Jim Ananich, D-Flint. "That's 680,000 people losing health care. That's what it's about." Sen. Mike Shirkey, R-Clarklake, the sponsor of the bill, said he expects the waiver to be granted, but that recipients would have some time before the program ended if the federal government denies the waiver request.
>
> The state "would have to give notice to enrollees and the program stops in four months," he said.
>
> The movement toward requiring work for Medicaid coverage is growing across the nation with three states already requiring work for benefits and the administration of President Donald Trump reviewing requests from seven other states. The administration told Medicaid administrators earlier this year that it would support such requests and Trump signed an executive order last week asking for work requirements for recipients of federal benefits, such as food stamps and Medicaid.
>
> The bill, which received final passage Thursday in the Senate, is a compromise from what was initially proposed, which included a 29-hour workweek requirement and a controversial provision that would allow counties that had unemployment rates of 8.5% or more to be exempt from the work requirements. That would primarily benefit rural counties, but not urban cities such as Detroit, Flint and Saginaw that are in counties that have lower overall unemployment rates.

That provision was stripped out of the bill, in part, because it would cost the state Department of Health and Human Services too much to administer. But it also would have affected minority communities much harder than the rest of the population.

People who are exempt from the work requirements include pregnant women; people receiving disability benefits; full-time students; the medically frail; caretakers of a family member under age 6 or a dependent with a disability; a recipient who met a good cause temporary exemption; a recipient with a medical condition that resulted in a work limitation; a recipient who had been incarcerated within the last six months; a recipient of unemployment benefits, or a recipient under 21 who had previously been in foster care.

Shirkey estimated that about 350,000 of the 680,000 Healthy Michigan program recipients would be required to work under the bill.

Michigan has about 2.4 million people who get health care coverage through Medicaid. A majority are elderly, disabled or children, but in 2013, the Legislature passed the Healthy Michigan law to expand Medicaid to low-income Michiganders and 680,000 people signed up.

SAMHSA Announces Grant Opportunity for Medication-Assisted Treatment

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a funding opportunity for nonprofit organizations, including community mental health and addiction treatment providers, in certain states and tribal communities to improve access to medication-assisted treatment (MAT), a highly effective, evidence-based treatment for opioid use disorder (OUD). Eligible organizations wishing to compete for up to almost $525,000 per year must submit their applications by July 9th. Read more at:. https://www.samhsa.gov/grants/grant-announcements/ti-18-009

Taking on behavioral health workforce crisis

Below is an introduction and excerpt from recent edition of Behavioral Healthcare Executive, by Ron Manderscheid, PhD, Executive Director of NACBHDD and NARMH, on the behavioral healthcare workforce shortage.

> I am delighted to announce that the American Journal of Preventive Medicine has released a Special Supplement on workforce developments in behavioral healthcare. You can access this entire document gratis.
>
> Articles in this special issue cover a broad range of topics. Specifically, they address research on workforce planning, service delivery and practice, and workforce preparation. They also advocate for intelligent allocation of resources to ensure all clients have access to behavioral healthcare.
>
> No more important topic surrounds our field than the current and growing crisis in the availability of well-trained providers. Our baby boomers are retiring, and too few millennials are joining us. Thus, this Special Supplement could not come at a more opportune time. It focuses a spotlight on our human resource issues and provides an important glimpse into new developments that can allay this problem.
>
> On several prior occasions, I have argued that our human resource crisis is far, far too important to be ignored or left to chance. Here is one simple example of the growing magnitude of this crisis: By 2060, almost100 million Americans will be age 65 and older. Of this total, it is reasonable to estimate that about 20 million persons will require behavioral healthcare services. This latter group would represent an approximate doubling of the number who currently receive behavioral healthcare services today. Clearly, such growth simply will not be achievable unless we have a dramatic change in direction.
> What are some of our options?

Read more at: https://www.behavioral.net/blogs/ron-manderscheid/taking-our-workforce-crisis

Suicide rates rise sharply across the United States, new report shows

Below is an excerpt from a recent Washington Post article underscoring the findings of a recent CDC study on rising suicide rates.

> Suicide rates increased in 49 states between 1999 and 2016, according to a report released Thursday by the Centers for Disease Control and Prevention. The increases were seen across sex, age, race and ethnicity. In half of all states, the increase was 30 percent or more.
>
> In 2016, there were almost 45,000 suicides in the United States — more than twice the number of homicides. Suicide is now the 10th leading cause of death overall in America, and the second leading cause of death for people between the ages of 10 and 34.
>
> Anne Schuchat, the CDC's principal deputy director, called the data "disturbing" and said, "the widespread nature of the increase, in every state but one, really suggests that this is a national problem hitting most communities."

The full article can be found at:
https://www.washingtonpost.com/news/to-your-health/wp/2018/06/07/u-s-suicide-rates-rise-sharply-across-the-country-new-report-shows/?noredirect=on&utm_term=.2bc54ec86d93&wpisrc=al_news__alert-hse--alert-national&wpmk=1

NIH Unveils New Opioid Research Plans

The National Institutes of Health outlined its new HEAL initiative to combat opioid addiction and improve pain management in *JAMA* Tuesday.

In an editorial, NIH Director Francis Collins, MD, PhD -- along with Walter Koroshetz, MD, director of the National Institute of Neurological Disorders and Stroke, and Nora Volkow, MD, director of the National Institute on Drug Abuse -- discussed the role of the new NIH research program in the national opioid problem.

An in-depth discussion of this initiative can be found at: https://www.medpagetoday.com/primarycare/opioids/73439

SAMHSA-HRSA Center for Integrated Health Solutions offers medication adherence webinar

Webinar: Clinical Strategies to Promote Medication Adherence

June 19, 2018
2:00 - 3:30 PM ET

Presenter: Joe Parks, MD, Medical Director, National Council for Behavioral Health

Register for free here: https://goto.webcasts.com/starthere.jsp?ei=1194137&tp_key=10d9acb6df

The use of medications to treat mental illness and opioid and alcohol use disorders can produce life changing benefits. However, these medications also have significant side effects. Non-adherence to medications is generally more common among persons with mental disorders than individuals with physical health conditions and can negatively impact health outcomes and increase costs.

Interdisciplinary teams in integrated care settings have the opportunity to improve medication adherence among patients by incorporating shared decision making into the provider-patient relationship, using motivational interviewing to promote adherence, establishing pharmacies onsite to reduce barriers to accessing medications, and engaging family members in the treatment plan.

Join the SAMHSA-HRSA Center for Integrated Health Solutions for this webinar to review the importance of medication adherence and key recommendations for organizations to promote medication adherence.

After this webinar, participants will:

- Better understand the impact of medication non-adherence on the individual, family, and community
- Better understand consumers' perspectives and concerns related to medication
- Learn about several key recommendations to improve medication adherence
- Hear about how one integrated care setting is successful in promoting medication adherence
- Identify tools and resources to promote medication adherence

Please note the following:

Registration is free and closed captioning is available upon request.

The SAMHSA-HRSA Center for Integrated Health Solutions does not provide certificates of attendance or continuing education credits for webinar attendance.

Congress needs a broader approach to address opioid epidemic

Below is an excerpt from a recent editorial carried in the Hill, by Michael Botticelli and Richard Frank, on the need for a broader approach to the nation's opioid crisis.

> When it comes to addressing the opioid crisis, the United States is falling far short. Only 10 to 26 percent of those with an opioid use disorder are getting care. And among that group, only a bit more than a third are getting the most effective care, with one of the three FDA-approved medications — buprenorphine, methadone and naltrexone, known collectively as Medication Assisted Treatment, or MAT.
>
> But while policymakers are justifiably focused on the opioid crisis, a bill that the House will consider this week won't direct new federal resources where they're most effective. In fact, it might undermine efforts to improve the full continuum of care for people with substance use disorders (SUDs).
>
> That's because the bill would expand opioid disorder treatment in an unbalanced and potentially counter-productive way by simply letting Medicaid pay for that treatment in specialty residential and inpatient facilities. That is, it would scale back the prohibition — known as the Institutions of Mental Disease (IMD) exclusion — on using federal matching funds in Medicaid to pay for care in facilities with more than 16 beds that treat mental diseases.
>
> Opioid use disorder is a chronic recurring condition. However, effective treatment can involve a broad continuum of services that range from institutional care to pharmaco-therapies to psychosocial and rehabilitation services.
>
> That's why, under both Presidents Obama and Trump, the federal Centers for Medicare & Medicaid Services (CMS) has given states waivers from the IMD exclusion if they improved their community-based services. Eleven states already have waivers, while 12 others have proposals pending for them.
>
> CMS' guidance to the states in 2015, for instance, conditioned such waivers on states "developing comprehensive strategies to ensure a full continuum of services, focusing greater attention to integration efforts with primary care and mental health treatment, and working to deliver services that are considered promising practices or have fidelity to evidence-based models consistent with industry standards."
>
> The House bill, by contrast, doesn't tie federal funds for IMD care to improvements in community-based services. Thus, it would weaken states' incentives to pursue these needed improvements. And without incentives to improve access to treatment more broadly, narrowing the IMD exclusion through legislation may simply encourage greater use of expensive inpatient treatment, including for people for whom it may not be the best option.
>
> Access to treatment is particularly limited in rural areas, and waiving the IMD exclusion will do little to address that problem. Forty percent of rural counties lack a SUD treatment facility that provides outpatient care and accepts Medicaid. Rural counties are much likelier to lack access to outpatient SUD facilities that accept Medicaid, particularly in Southern and Midwestern states.

While some people certainly need inpatient or residential services, increasing bed capacity in in those facilities will sometimes mean expanding the wrong services. That's especially true because many of the facilities providing residential and inpatient care for opioid use disorders don't offer any form of medications for addiction treatment (MAT), the gold standard for treating opioid use disorder.

Most of these facilities provide detoxification services, but detoxification is only the first stage of addiction treatment, according to the National Institute of Drug Abuse's Principles of Effective Treatment. By itself does little to facilitate long-term recovery.

Indeed, it may increase the potential for overdose if patients do not remain in treatment since, with detoxification, their tolerance for opioids is significantly reduced. In fact, recent data suggest that inpatient detoxification is an important predictor of overdose, largely because many who receive inpatient care aren't then connected to community-based treatment programs or put on a medication, leaving them extremely vulnerable to relapse and overdose.

The House bill is troubling in other ways. While it focuses exclusively on opioid treatment, an estimated 64 percent of people seeking care for an SUD use multiple substances.

For those with an opioid use disorder, 41 percent had an alcohol use disorder and 43 percent had another drug use disorder. About 30 percent suffer from depression. Some 90 percent of people with these illnesses are treated in an outpatient setting.
All in all, the House bill could do more harm than good. Focusing the IMD policy narrowly on opioid use disorder fails to recognize the basic truth that most people with an SUD misuse multiple substances.

In fact, the House bill will likely result in an increase in the reported prevalence of opioid use disorder as a result of efforts to give people who don't fit the narrow policy access to needed care.

We strongly suggest that if Congress wants to change Medicaid IMD exclusion, it should do so in a way that promotes a greater state capacity to provide the full continuum of care, thus working in concert with CMS' guidance.

Michael Botticelli is director of the Grayken Center for Addiction Medicine at Boston Medical Center and was previously the Director of National Drug Control Policy. Richard G. Frank is the Margaret T. Morris Professor of Health Economics at Harvard University.

New Director of SAMHSA Center for Substance Abuse Treatment announced

I am very pleased to announce that CAPT Chideha Ohuoha, MD, MPH, will be joining SAMHSA as the new Director of the Center for Substance Abuse Treatment. Most recently, CAPT Ohuoha has been stationed at Fort Belvoir as an officer of the U.S. Public Health Service since 2008. He has served as the Director of Addiction Medicine there since 2015. Prior to assuming that position at Ft. Belvoir he was the Deputy Director of Addiction Medicine, Director Addiction Medicine Research, and the chief psychiatrist for the Wounded Warrior Transition Brigade. CAPT Ohuoha was responsible for implementing the Co-Occurring Partial Hospital program at Fort Belvoir. Dr. Ohuoha has many honors to his credit. Most recently he was awarded the Meritorius Service Medal (PHS) in 2016, Fort Belvoir Community Hospital ACE Awards, in 2014 and 2015, and in 2012 received the Army Commendation Medal as well as the Outstanding Service Medal (PHS).

CAPT Ohuoha completed his psychiatric residency at St Elizabeth's Hospital in Washington, DC and completed a three year addiction psychiatry fellowship at NIMH. He was awarded his MPH from Harvard University. CAPT Ohuoha's experience in addiction psychiatry will be a great asset to SAMHSA and CSAT. His official start date here at SAMHSA will be June 11.

In addition to welcoming CAPT Ohuoha, I would like to thank Acting Director Kathryn Power for stepping in to provide leadership and stability to CSAT during the past few months. I have been very gratified to have the opportunity to work with Ms. Power and to benefit from her extensive knowledge of federal government as well as her steady leadership of CSAT.

I hope you all will join me in welcoming CAPT Ohuoha to SAMHSA.

Thank you; Elinore F. McCance-Katz, MD, PhD
Assistant Secretary for Mental Health and Substance Use Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services

Encouraging Substance Use Disorder Treatment in Primary Care through Value-Based Payment Strategies

Across the US, it is nearly impossible to open a newspaper and not find an article about the opioid epidemic. Its impact is ubiquitous — families, communities, and states all feel its effect. Opioids, however, are not the only addictive substance impacting Americans. While the rate of overdose deaths related to opioid pain relievers and heroin increased by 200 percent from 2000-2014, excessive alcohol use continues to be a leading cause of preventable death. A clear gap in treatment remains for people with ***any*** substance use disorder (SUD) — drug or alcohol — with only one in 10 ever receiving specialty treatment.

To address this treatment gap, a comprehensive approach including primary care is needed. As the foundation of the health care system, primary care plays an important role in screening and treating SUDs. Furthermore, primary care is uniquely positioned to address comorbidities (e.g., lung disease, hepatitis C, and cardiovascular disease) that are common among people with SUDs. While SUD and physical health services have historically been siloed, recent efforts are creating opportunities to integrate care.

This CHCS blog post — drawing from a new brief*, Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care*, developed by CHCS and the Technical Assistance Collaborative and supported by the Melville Charitable Trust — explores how states and health plans can use value-based payment levers to encourage substance use disorder treatment in primary care.

https://www.chcs.org/encouraging-substance-use-disorder-treatment-in-primary-care-through-value-based-payment-strategies/

CMS issues, Improving the Balance: The Evolution of Long Term Services and Supports, FY 1981-2014

This historical expenditures report and corresponding state-by-state data tables document three decades Medicaid Long Term Services and Supports (LTSS) systems transformation from primarily institutional services to the present, where home and community-based services (HCBS) are a majority of LTSS spending. These reports include Medicaid expenditures for all LTSS, including institutional services and HCBS, by service category and state. The data comes primarily from the Centers for Medicare & Medicaid Services (CMS)-64 reports.

The report can be found at: https://www.medicaid.gov/medicaid/ltss/reports-and-evaluations/index.html

LEGISLATIVE UPDATE

FY19 & FY18 Supplemental Budgets Head to the Governor

On Tuesday the legislature passed SB 848, which is the FY19 omnibus budget for all non-educational departments and a FY18 supplemental budget. There were no changes from what I reported late last week related to the FY19 DHHS budget items.

Below is a link to the House Fiscal summary of the FY19 budgets and the FY18 supplemental (starts on page 107). Items of note included in FY18 supplemental:

http://www.house.mi.gov/hfa/PDF/Summaries/18s848h1cr1_General_Omnibus_Conference_Report_Summary.pdf

PIHP rate adjustment – provides $59.8 million gross ($17.1 million GF) to support a one-time rate adjustment paid to the PIHPs based on a review of previous fiscal year data indicating the rate trends assumed for the cost of behavioral health services were too low. (page 111)

Statewide PIHP Reimbursement Audit – Adds $1.5 million GF to perform a statewide reimbursement audit of the PIHPs to identify any reimbursement outliers. (page 111)

Lakeshore Regional Entity PIHP Risk Sharing – Provides $6.974 million GF to LRE for the state's share of the PIHP's FY17 liability. In total, the LRE FY17 liability totaled 10.25% (page 111)

Macomb County Community Mental Health – included in a long list of Michigan Enhancement Grants was $1 million GF for Macomb County Community Mental Health. (page 117)

Medicaid Work Requirements Head to the Governor

A compromised Medicaid work requirement bill passed the House last week and is headed to the Governor's desk for his signature. The Medicaid work requirement bill was changed in a House committee to impact only able-bodied Healthy Michigan recipients who are between 19 and 62 years of age. Below are the notable changes:

- The bill only applies to Healthy Michigan (not traditional Medicaid)
- Work requirement reduced to 20 hours per week (changed from 29)
- Work requirements only apply to individuals up to 62 years old (changed from 64)
- "Grace period" for non-working recipients is now a total of three months out of each year (as opposed to disqualification after one month)
- Failure to meet the work requirement only disqualifies an individual for one month and requires them to meet the requirement to be reinstated (as opposed to disqualification for an entire year--the penalty for intentional fraud in reporting is still a one-year disqualification)
- Removal of the county unemployment rate exemption, with the addition of allowing community service for three months out of a year
- Implementation date has been pushed back to 2020 (changed from 2019)

The Department of Health and Human Services would receive an extra $5 million under the bill for the additional personal auditors needed to track these recipients. Lastly, there has been a change to the bill that requires that after a recipient has received HMP coverage for 48 months, they must complete a health behavior assessment tailored towards stricter healthy behavior requirements. Additionally, these individuals would also have to pay a premium for HMP coverage equal to 5% of their income. This provision requires an additional waiver from CMS to implement and the bill will ultimately terminate HMP entirely if DHHS cannot obtain the waiver.

Once signed by the Governor the federal government must approve a waiver for the changes to go into effect.

NATIONAL UPDATE

House Passes First Wave of Opioid Bills

This week, the House of Representatives kicked off a two-week focus on legislation to address the nation's opioid crisis. The House passed dozens of measures this week and is slated to vote on more opioid legislation next week with the hopes of advancing a comprehensive package to the Senate. Bills that advanced this week included efforts to expand: telemedicine prescribing for medication-assisted treatment, student loan forgiveness for addiction treatment professionals, the use of electronic health records by behavioral health providers and recovery housing best practices.

All of the bills advanced with bipartisan support, and included many National Council priorities, such as:

- The Special Registration for Telemedicine Clarification Act (H.R. 5483): This bill would require the Drug Enforcement Agency (DEA) to establish a special registration process for certain providers that wish to prescribe controlled substances via telemedicine. This would remove barriers to accessing medication-assisted treatment for opioid use disorders in rural and frontier areas, and is a direct result of National Council advocacy efforts.

- The Substance Use Disorder Workforce Loan Repayment Act (H.R. 5102): This bill would create a program to help addiction treatment professionals repay student loans, adding incentives for students to pursue these professions and ultimately increasing timely access to treatment for individuals living with addiction. This legislation was introduced as a result of education and advocacy by the National Council and the Association for Behavioral Health in Massachusetts.

- Improving Access to Behavioral Health Information Technology Act (H.R. 3331): A longtime National Council priority, this bill would incentivize behavioral health providers to adopt electronic health records (EHRs). Behavioral health providers have adopted EHRs more slowly than physical health providers as they have traditionally not had the resources needed to implement the technology. A companion bill passed the Senate in May. Find our full analysis of this bill here [LINK NEEDED].

- Ensuring Access to Quality Sober Living Act (H.R.4684): The bill would require the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify and disseminate recovery housing best practices, such as the National Alliance for Recovery Residence's (NARR) quality standards, to the states and provide them with technical assistance to adopt the standards. The bill aligns closely with the recommendations of the National Council's State Policy Guide for Supporting Recovery Housing.

- The National Council applauds the continued advocacy of its members, many of whom played a key role in the introduction and advancement of these bills. For more detail on opioid bills that passed the House this week, see the following House Energy and Commerce Committee press release.

WHAT'S NEXT?

House leaders will hold votes on a second round of opioid legislation next week. More controversial measures are expected to be included in next week's roundup, including efforts to loosen the IMD rule for residential addiction treatment and 42 CFR Part 2, the federal regulation governing the privacy of addiction treatment records. A full list of bills to be considered next week will be posted here as they become available.

House Passes Behavioral Health Information Technology Bill

A bipartisan bill that would incentivize behavioral health providers to adopt electronic health records (EHRs) passed the House on Tuesday, following passage of a similar bill by the Senate last month. The Improving Access to Behavioral Health Information Technology Act (H.R. 3331), a long-standing National Council priority, would incentivize behavioral health providers to incorporate electronic health records (EHRs) into their practices. The House and Senate versions of the bill must now be reconciled before moving to the President's desk for his signature.

EHRs provide a digital record of a patient's chart, and can be more easily shared among all clinicians involved in that patient's care. Behavioral health providers have adopted EHRs more slowly than physical health providers as they have traditionally not had the resources needed to implement the technology. Since 2009, the National Council has fought for a solution to this problem by shepherding the introduction and advancement of legislation (including the Improving Access to Behavioral Health Information Technology Act) that would give mental health and addiction treatment providers the necessary resources to adopt EHRs. Further, the National Council led the formation of the Behavioral Health Information Technology (BH IT) Coalition, a group that has played a key role in raising the issue's profile on Capitol Hill. The House and

Senate's passage of behavioral health information technology legislation represents a huge victory for the National Council and its members.

On the House floor, Representative Lynn Jenkins (R-KS) explained why this measure has become increasingly important. "Our nation finds itself in a mental health and opioid crisis, and Congress must do all it can to ensure providers have the tools they need to effectively treat their patients," she said. "By utilizing electronic health records, they can better coordinate care, support delivery of treatment, and help to fully integrate recovery and prevention services for all Americans."

The Improving Access to Behavioral Health Information Technology Act would help to improve the coordination of care and behavioral health integration into physical health settings by tasking the Center for Medicare and Medicaid Innovation (CMMI) with creating a demonstration project to incentivize the use of EHR systems in mental health and addiction treatment settings. Providers and settings that would be included in these incentives are: clinical psychologists and clinical social workers at psychiatric hospitals, community mental health centers, residential or outpatient mental health treatment facilities and addiction treatment facilities. The major difference between two versions of the bill is that the House version was amended to add psychiatric nurse practitioners to the list of eligible providers that would qualify for the demonstration.

TRAININGS:

CO-OCCURRING COLLEGE: SELECTED WORKSHOPS FOR IMPLEMENTATION & SUSTAINABILITY

June 25-26, 2018
Kellogg Hotel and Conference Center
East Lansing, Michigan

WHO SHOULD ATTEND: Clinical directors, case workers, support coordinators, children's supervisors and other practitioners who must be able to address comorbid mental health and substance use disorders at all levels of practice (beginning, intermediate and/or advanced).

COST: $140 for two-day training, including breakfast, lunch and parking

CONTINUING EDUCATION: Approved for up to 11 CE hours for Social Work and 11 Specific MCBAP Education Contact Hours!

LOCATION: Kellogg Center Hotel: 219 S. Harrison Rd., E. Lansing, MI 48824; Phone: 517-432-4000

TO REGISTER FOR CO-OCCURING COLLEGE:
https://cmham.ungerboeck.com/prod/emc00/register.aspx?OrgCode=10&EvtID=5156&AppCode=REG&CC=118053182060&RegType=2005-42

MICHIGAN CLUBHOUSE CONFERENCE

"Opening New Doors" Conference will be held on July 15 – 18, 2018 at the Grand Traverse Resort in Traverse City.

CONFERENCE REGISTRATION: Conference Registration Fee: $75 per person
Fee includes opening reception, 3 breakfasts, 2 luncheons, 1 dinner and reception with entertainment.

HOTEL DETAILS & RESERVATIONS: Room Rates:
Hotel Room: $75 plus $16.95 resort fee and taxes
Tower Room: $209 plus $16.95 resort fee and taxes
Two Bedroom Condos: $279 plus $16.95 resort fee and taxes per room

Deadline for These Rates: Friday, June 15, 2018

Reservations: Call 800-968-7352 and use code: CLUBHOUSE CONF 2018

To Register for the Clubhouse Conference, Click Here:
https://cmham.ungerboeck.com/prod/emc00/register.aspx?OrgCode=10&EvtID=5160&AppCode=REG&CC=118060403651&RegType=MCCTC

ETHICS FOR SOCIAL WORK & SUBSTANCE USE DISORDER PROFESSIONALS TRAININGS FOR 2018

Community Mental Health Association of Michigan is pleased to offer 6 Ethics for Social Work & Substance Use Disorder Professionals Trainings presented by Tom Moore, LMSW, LLP, CCS, Owner and Principal, Two Moons, LLC.

This training fulfills the Michigan Social Work Licensing Board's requirement for licensure renewal for ethics.
This training fulfills the MCBAP approved treatment ethics code education – specific.

Trainings offered on the following dates.

- June 27 –Kalamazoo
- July 11 - Troy
- August 22 – Lansing

Training Fees: (fee includes training material, coffee, lunch and refreshments.
$115 CMHAM Members
$138 Non-Members

To register: https://cmham.ungerboeck.com/prod/emc00/PublicSignIn.aspx?&SessionID=fa7fe5ej2fe8fc5&Lang=*

REGISTER NOW! EMPLOYMENT FIRST CONFERENCE

Join us for the Employment First Conference! Hear from national subject matter experts who will help Michigan ensure that "everyone who wants a job, has a job!" Employment First is a state and national movement to help individuals with disabilities in Michigan realize their fullest employment potential through the achievement of individual, competitive integrated employment outcomes.

Employment First Conference: "When Everyone Who Wants A Job, Has A Job!"

July 11 & 12, 2018
Kellogg Hotel & Conference Center, East Lansing, Michigan

Registration Fee: $50

Who Should Attend: Staff who's involved in helping someone with an employment goal:

- Employment Practitioners
- Supports Coordinators/Case Managers
- CMHSP Leadership
- CRO Leadership

Workshop Tracks:

- Leadership
- Provider Transformation
- HCBS Implementation

Sponsored By: The Michigan Developmental Disabilities Council with support from Michigan's Employment First Partnership.

Additional conference details and registration, click here: CLICK HERE!

CMH ASSOCIATION COMMITTEE SCHEDULES, MEMBERSHIP, MINUTES, AND INFORMATION: go to our website at https://www.macmhb.org/committees