Michigan Association of
COMMUNITY MENTAL HEALTH Boards

June 23, 2017

FRIDAYFACTS

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

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

RE:

- Work and Accomplishments of MACMHB Member Organizations
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WORK AND ACCOMPLISHMENTS OF MACMHB MEMBER ORGANIZATIONS

Allegan County Community Mental Health receives a three year accreditation from CARF

Below is a recent announcement on the receipt of CARF accreditation by Allegan County Community Mental Health. Congratulations to Allegan CMH

> ACCMHS was accredited for multiple programs including: Assessment and Referral, Crisis Services, Assertive Community Treatment, Outpatient Treatment, Case Management/Services Coordination, Intensive Family-Based Services, Prevention, and Community Employment Services.
>
> Below are excerpts from the CARF accreditation report:

The leadership of ACCMHS is committed to the mission of the organization, and its members work together to achieve desired outcomes.

The persons served express gratitude for the compassionate and caring staff and value the services provided. The persons served stated the staff members are accessible and responsive to their concerns and needs.

Direct service personnel are creative and resourceful in finding ways to meet the needs of the persons served.

Employers spoke highly of the employment program staff and about the client and appreciate that personnel check in regularly with them and the employee.

The organization is the recipient of a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to provide a leading edge model of integrated healthcare for the persons served.

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

Media coverage of completion of MDHHS budget

As the state's budget moves towards the Governor's desk, for signing, the state's media have covered a number of segments of the MDHHS budget that are core to the operations of the state's public mental health system. Excerpts from the article, Budget deal advances plan to test Medicaid mental health integration, written by Jay Greene, in Crain's Business Detroit, appear below:

> A controversial plan to test out integrating the state's physical and mental health delivery system for Medicaid patients is set to go ahead under a 2018 budget deal worked out between the House, Senate and Gov. Rick Snyder.
> As many as four pilot studies in Michigan will be undertaken in the next three years to test whether a combined system can expand services and lower costs for thousands of patients under the deal.
>
> The budget deal allocates $2.8 million the first year to the fiscal 2017 budget to plan the pilots, and $3.1 million for fiscal 2018, which starts Oct. 1, to fund the pilots themselves. The $5.9 million funding includes $2 million in general state tax funds.
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> The implementation of the pilots will be overseen by the state Department of Health and Human Services, which must hire by Aug. 1 an experienced project facilitator. The manager must establish performance metrics and pilot plans.
> By Nov. 1, according to the proposed budget, MDHHS must create an implementation time frame for the pilot projects, identify barriers and present remedies and submit a report to the House and Senate HHS subcommittees. Planning for the pilots should begin this year and work toward implementation should begin by no later than March 1. Each pilot should last at least two years.
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> The Michigan Senate is expected to vote on the budget plan Thursday before going on summer recess. Snyder is expected to approve the $55 billion budget, a 2 percent increase from 2017.
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> Over the past 18 months, Michigan's 11 Medicaid health plans have lobbied legislators and the public to try a semi-privatized approach. They contend they can run an efficient $11.6 billion integrated delivery system, save the state several hundred million dollars of administrative money and plow back the savings into expanded services. There are an estimated 350,000 people in the state's Medicaid program with mental illness, developmental and intellectual disabilities, and substance abuse problems.

But mental health advocates, providers and families object to Medicaid HMOs taking over the system — even to test an integrated approach with which more than two dozen states are experimenting. They believe health plans have insufficient experience at overseeing complex populations and argue that private profit motivations of the health plans will trump public service.

Since January 2016, the mental health and Medicaid HMO associations have been at odds because Snyder's proposed 2017 state budget included a provision that could have allowed the state's managed care organizations to manage the $2.6 billion Medicaid behavioral health system. The Medicaid HMOs already manage a nearly $9 billion physical health system.

Currently, 10 prepaid inpatient health plans, which are operated by the public mental health system, manage the funding and contract with providers. There are three PIHPs in Wayne, Oakland and Macomb counties.

Sources told *Crain's* the only major change from previous boilerplate plans was that the Legislature agreed with the state MDHHS to keep the number of PIHPs at 10 regions instead of consolidating to four super-regions.

Sen. Mike Shirkey, R-ClarkLake, has been an outspoken advocate for Medicaid integration and pushed along the health plan pilots. He has said his only goal is to reduce administrative costs and wring out waste and duplication in order to spend more per person on physical and behavioral health services.

Shirkey, chair of the Senate health policy committee, has told *Crain's* the Medicaid HMOs will not be able to keep any savings. They must reinvest any savings into expanded services.

Bob Sheehan, CEO of the Michigan Association of Community Mental Health Boards, said he is concerned that the budget language allows Medicaid health plans to contract outside of the several dozen established community mental health agencies and provider networks.

"Making the local community mental health (agency) only one of many providers in the pilot communities will immediately drain dollars from the community's mental health safety net ... leaving it unable to fulfill its statutory safety net role," Sheehan said Tuesday night in an email to *Crain's.*

Medicaid funding makes up about 92 percent of the budget of a typical community mental health provider agency. "The loss of these Medicaid funds immediately destabilizes this safety net on which these communities and their residents have come to depend," he said.

Sheehan said it is inherently unfair to shortchange community mental health providers to test the impact of integrating physical and behavioral health services managed by Medicaid HMOs.

"Our association encourages MDHHS to ensure that the pilots include requirements that the Medicaid health plans in those pilot communities contract exclusively with the (mental health agencies) in those communities" and the provider networks for specialty services, Sheehan said.

Dominick Pallone, executive director of the Michigan Association of Health Plans, said Medicaid HMOs are happy with the budget deal and support testing integration.

"We believe that this methodical approach towards integrating behavioral health and physical health for Michigan's Medicaid enrollees is the best way in which health plans can demonstrate improvements in enrollee health outcomes, maximize efficiencies, and minimize unnecessary costs to taxpayers," Pallone said.

"Our members look forward to continuing to work with MDHHS and other stakeholders on developing and implementing these demonstration pilots," Pallone said in a statement to *Crain's*.

Jon Cotton, president of Detroit-based Meridian Health Plan of Michigan, said he understands the mental health provider community and families are fearful over the proposed changes. He said he has seen the dynamic unfold before.

"It happens every time a vulnerable population is rolled into managed care. Change can be a scary thing," he said. "We saw the exact same reactions when managed Medicaid was originally adopted in Michigan (in 1998)."

But Cotton said Michigan Medicaid health plans have some of the highest quality scores in the nation for adults and children.

"We saw it again when Michigan's Children's Special Healthcare Services was enrolled into managed care," Cotton said. "Now it is a huge success story. This time is no different and it is up to the health plans to quell those fears. The only way to do that is to prove it. It is 100 percent on us now."

Cotton said he believes Medicaid health plans will be able to prove that those people under integrated care will be healthier and the system will be more efficient.

The House-approved Section 298 language requires MDHHS to develop performance metrics to determine how well the Medicaid health plans are managing physical and mental health coordination. The areas include the following categories:

- Improvement of the coordination between behavioral health and physical health
- Improvement of services available to individuals with mental illness, intellectual or developmental disabilities, or substance use disorders
- Benefits associated with full access to community-based services and supports
- Customer health status
- Customer satisfaction
- Provider network stability
- Treatment and service efficacies before and after the pilot projects and demonstration models
- Use of best practices
- Financial efficiencies
- Any other relevant categories

MDHHS also is required to work with any willing community mental health service provider in Kent County and all willing Medicaid HMOs there to pilot a full physical and behavioral health integrated service demonstration model.
Implementation should include the following:

- That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot project must only be in effect for the duration of the pilot project.
- That the project is consistent with the stated core values as identified in the final report of the Section 298 workgroup in Public Act 268 of 2016.
- That updates are provided to the medical care advisory council, behavioral health advisory council and developmental disabilities council.

Moreover, MDHHS is required to implement up to three pilot projects to achieve a financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models.

These demonstration models shall use single contracts between the state and each licensed Medicaid health plan that is currently contracted to provide Medicaid services in the geographic area of the pilot project.

Iowa Medicaid privatization effort faces law suit

Below are excerpts from a recent story in the Des Moines Register on the filing of a law suit to protect the rights, health, and safety of persons with disabilities who were harmed by the privatization of Iowa's Medicaid system. This

story, and others like it across the country, echo the concerns that Michiganders have had regarding proposals to privatize the Medicaid behavioral health and intellectual/developmental disabilities system in Michigan.

> Iowa's roiling controversy over its for-profit Medicaid management spilled into federal court Tuesday when six Iowans with disabilities filed a lawsuit against Gov. Kim Reynolds.
>
> The lawsuit alleges that the state's chaotic shift to a privately run Medicaid program is depriving thousands of Iowans with disabilities the legal right to live safely outside of care facilities. The suit holds Reynolds and her human services director responsible for the private management companies' actions.
> "They are violating very basic human rights, but also very basic Medicaid law, rules and regulations. They're just totally disregarding them," said Roxanne Conlin, a Des Moines civil-rights lawyer who helped write the lawsuit. "It's kind of amazing to see how callous they are toward Iowa's most vulnerable people."
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> The prominent advocacy group Disability Rights Iowa organized the lawsuit against Reynolds and the director of the Department of Human Services. The group wants a federal judge to order the state to halt discriminatory cuts in services to 15,000 Iowans with serious disabilities.
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> One of the plaintiffs' first legal steps will be to request that the suit be declared a "class action" on behalf of all disabled Iowans suffering from such cuts.
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> The 2016 shift to private management of almost all of Iowa's $4 billion Medicaid program was spearheaded by Reynolds' predecessor, Gov. Terry Branstad.
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> The new lawsuit says Branstad and Human Services Director Charles Palmer promised that disabled Iowans' services would not change for at least two years.
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> That promise was broken within months, with numerous disabled people being told they would receive less help in their homes, the suit says.
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> Neal Siegel of West Des Moines is one of the lawsuit's six initial plaintiffs.
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> Siegel, 54, is a former financial consultant who suffered a devastating brain injury in a bicycle accident in 2013. He uses a wheelchair, can barely speak and needs help with eating, dressing and nearly every other basic life activity.
> The managed-care company overseeing his Medicaid benefits, AmeriHealth Caritas, abruptly decided in March to slash payments for his in-home care by more than half, from $7,201 to $3,013 per month.
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> Although state officials previously had allowed the higher rate, the private company contended the spending exceeded a limit set in state policy, said his longtime girlfriend, Beth Wargo.
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> Siegel needs the in-home care services to "feel like a human," Wargo said in a recent interview at their home. "He gets to get some of his dignity back."
>
> A lawyer from Disability Rights Iowa is helping the couple appeal the managed-care company's decision. Wargo said the couple also agreed to join the new federal lawsuit as plaintiffs to help other families push back against the managed-care companies' tactics.

The full article and a copy of the law suit filing can be found at: . http://www.desmoinesregister.com/story/news/investigations/2017/06/13/disabled-iowans-medicaid-privatization-lawsuit/370484001/

Editorial from MACMHB and Protect MI Care coalition underscores importance of Medicaid and ACA to opioid treatment

Below is a recent Detroit Free Press guest editorial, from the MACMHB CEO, developed as part of the Association's work with the Protect MI Care coalition – a broad-based coalition of leaders, within Michigan, concerned with the changes being proposed, at the federal level, in the nation's health care system. That editorial appears below:

> The opioid crisis is causing pain throughout Michigan. Our political leaders are rallying to address this epidemic. U.S. Department of Health and Human Services Secretary Tom Price recently visited the state to underscore this tragedy and the importance of swift and sustained action.
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> But the most important assistance of all is in danger of being taken away from Michigan families by Congress as it seeks to replace the Affordable Care Act with the American Health Care Act (AHCA) — and compromising access to health insurance coverage, including Medicaid and Medicaid expansion, known as the Healthy Michigan Plan here in our state.
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> Gutting the Affordable Care Act (ACA) — as the U.S. House has done, and there is little known about what the Senate will do — would have devastating consequences in every corner of our state, which is at a crucial point in combating opioid abuse.
>
> The abuse of prescription drugs and opioids is a problem that affects millions of people in our country. In 2015, 1,981 people died of drug overdoses in Michigan, according to the U.S. Centers for Disease Control and prevention.
>
> Prescription opioids were involved in nearly half of those deaths, and heroin was involved in an additional 20% of the overdoses. The best way to address this tragedy is with treatment that tackles immediate and long-term impacts, including steps to avoid addiction to heroin, which is often easier to obtain and cheaper.
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> In communities across the state, the members of the Michigan Association of Community Mental Health Boards have been able to expand care to those who need it, thanks to the ACA. There is no silver bullet to the opioid epidemic, but making treatment available and affordable is central to addressing this problem.
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> Replacing the ACA would have a sweeping impact. Very quickly, 650,000 Michigan residents who receive coverage through the Healthy Michigan Plan would find themselves without insurance. The bill that passed the U.S. House calls for other major cuts to Medicaid. It also raises serious concerns about whether those in the individual market who have a pre-existing condition related to addiction, including opioid addictions, will be able to purchase affordable insurance, leaving them without access to care.
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> The ACA went into effect in 2013 and played a crucial role in addressing this problem. The percentage of Michigan residents without health care fell from 11% to 6%, according to U.S. Census data from 2015. While the ACA may not be perfect, many people now have health care who previously had gone without.
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> The ACA, paired with the 2008 Mental Health Parity and Addition Equity Act, has made huge advances in treating people with substance use disorders:
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> - Increased access to insurance by expanding Medicaid eligibility, allowing young people to stay on their parents' plans to age 26, ensuring those Michiganders had access to the ACA's coverage for substance abuse
>
> - Closed gaps on insurance coverage by eliminating benefit limits on substance use disorder treatment and ending discrimination on pre-existing conditions.
> - Made treatment attainable and affordable by prohibiting high co-pays for substance use disorder treatment and other behavioral health services than for physical health services.

- Recognized that mental health and substance use disorder treatment is as important as physical health conditions by prohibiting insurance plans from imposing restrictive caps on number of treatments.

Insurance coverage is crucial to treat opioid addiction. We need Congress to work toward thoughtful solutions. The House-passed ACA replacement is poor legislation. It leaves Michiganders' futures hanging in the balance in a fight where Michigan can't afford to lose any ground.

It is important for the U.S. Senate to improve the ACA, not gut its important accomplishments in reducing the uninsured to record lows in our state. Failing to do so will only deepen our opioid epidemic.

The editorial can be found at:
http://www.freep.com/story/opinion/contributors/2017/06/16/guest-column-preserve-obamacares-addiction-care-services/400898001/

The Protect MI Care website is: https://protectmicare.com/

Opioid crisis is the subject of a recent Wayne State University forum

A recent Detroit News story described a recent community forum, at Wayne State University, on the state's opioid crisis. Excerpts from that article are provided below:

A man and woman found slumped in Ohio, just a few feet away from a 4-year-old, high on drugs. A mother sprawled on a store floor in Massachusetts, unable to respond to her daughter's cries. And in Detroit, two people filmed unconscious in a car — a syringe still hanging from someone's leg.

The video clips shown Wednesday during a town hall at Wayne State University powerfully illustrated the impact of a drug and opioid prescription epidemic that authorities in Michigan and across the country say are hiking the number of overdose deaths.

The fatalities in Metro Detroit in recent years also underscore the need for communities and law enforcement to address the problem, say experts and professionals in the field. Michigan ranked 10th nationwide in 2015 in overdose death rates

"This shows that things are changing and we have to respond," said Cynthia Arfken, a Wayne State University professor and epidemiologist.

The causes, effects and responses to the epidemic anchored the forum hosted by the Detroit Wayne Mental Health Authority. State, federal and local professionals explored its origins as well as offered the community tips on resources.

The event follows 52,404 overdose deaths across the United States in 2015, the latest data available from the federal Centers for Disease Control. Drug-related deaths climbed to nearly 2,000 in Michigan then, up about 500 two years earlier.

The state House on Tuesday approved a six-bill package meant to fight opioid and prescription drug addiction. The federal government in April also announced grants of nearly half a billion dollars for prevention and treatment programs to confront the opioid epidemic. Michigan is slated to receive nearly $16.4 million. And in May, Gov. Rick Snyder signed legislation into law that makes a narcotic overdose antidote available at pharmacies.

Panelists who spoke Wednesday night before a crowd of about 100 people linked the epidemic to several causes.

The full article can be found at:
http://www.detroitnews.com/story/news/local/detroit-city/2017/06/14/wsu-opioid-forum/102870652/

NACo outlines relationship between counties and Medicaid

Below is a recently issued report, from the National Association of Counties (NACo) on the longstanding relationship of the nation's counties to the Medicaid system. Excerpts of that report are provided below:

An overview of counties' role in healthcare and Medicaid

- Our counties invest over $80 billion annually in community health—which turns out to be about 1 of every 5 dollars of our county budgets. Our counties support almost 1000 hospitals (2/3 of which are in rural and small counties) and approximately 900 long-term care facilities (over half of which are in rural and small counties)
- These health systems are also major employers in our counties
- We provide behavioral health services through 750 behavioral health authorities and community providers. 75 percent of the U.S. population is served by county-based behavioral health systems.
- Approximately 2/3 of the nation's 2,800 local public health departments are county-based and an additional 8 percent serve multiple counties. Federal investments, mainly from the Centers for Disease Control and Prevention, are responsible for approximately ¼ of all local health department funding.
- Our counties have always served as a safety net for those who are unable to afford care. Many of our states require counties to provide some level of health care for low-income, uninsured or underinsured residents.
- For more than the last 50 years, the Medicaid program has been crucial in helping counties fulfill this obligation.
- Medicaid is the largest source of healthcare coverage in the U.S; it is also the largest single funder for mental health services and substance abuse treatment, funds ½ of all births in the U.S., and is the primary payer for long term services and supports. Proportionally, Medicaid covers more residents in our rural counties than our urban counties.
- While Medicaid is normally described as a federal-state program, most people do not realize counties play a key role in the Medicaid program.
- Counties in 26 states help fund the program and many of our counties help administer the program.
- Our county health systems also provide services to Medicaid beneficiaries.
- When people don't have Medicaid or another form of health insurance, counties are forced to provide uncompensated care—care that is often more expensive resulting from people getting care in emergency rooms, homeless shelters too often our county jails. This is not an efficient use of taxpayer dollars.

To better understand Medicaid and counties, click here for a detailed presentation.
http://www.naco.org/sites/default/files/documents/NACo-Medicaid-Presentation-updated%201.26.17.pdf

For a 1-pager, click here.
http://www.naco.org/resources/protect-federal-state-local-partnership-medicaid-1

Counties' role in health care extends beyond that of a health payer, provider and administrator; counties also provide health insurance to our workforce. We employ over 3.6 million people and invest approximately $25 billion annually to provide quality health benefits to our workforce.

2017 Healthy Aging Initiative Now Accepting Proposals

The Michigan Health Endowment Fund MHEF) recently announced its Healthy Aging RFP. Information on that RFP is provided below:

Health Fund is pleased to share our 2017 Healthy Aging Request for Proposals.

We're seeking innovative ideas to improve access and availability of integrated, comprehensive services for older adults that are delivered in a person-centered way. Our 2017 Healthy Aging Initiative will support strategies and service delivery models that integrate aging services into other health systems; develop innovative approaches through technology or nontraditional partnerships; increase access to preventative services; and achieve improved health outcomes.

We encourage applicants to submit concept papers by July 20 for early feedback!
Proposals are due Tuesday, August 8 at 5:00 p.m.

The full RFP can be found at:

https://gallery.mailchimp.com/dd4ad1765ed2571ad64adb17a/files/6fec8565-37a9-421f-aec3-14594a963c98/2017HealthyAging_RFP_20170619.pdf

CHCS issues report: Moving Toward Value-Based Payment for Medicaid Behavioral Health Services

The Center for Health Care Strategies (CHCS) recently released a report that outlines efforts, across the country, to move Medicaid to a value based payment system. This report is described below:

> States, health plans, and providers are beginning to develop value-based payment (VBP) arrangements to pay for Medicaid behavioral health care services. VBP approaches shift the focus from traditional fee-for-service systems that pay for volume of services to alternative payment models that reward high-quality, cost-effective care. Many state Medicaid programs have developed VBP approaches to improve quality and slow cost growth for physical health services, but these advances have been slower to emerge in Medicaid behavioral health programs.
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> This brief, produced with support from the California Health Care Foundation, describes how five innovative states and their contracted Medicaid managed care organizations are incorporating VBP arrangements into behavioral health programs. It explores key challenges in implementing VBP models in behavioral health settings related to quality measurement, provider capacity, oversight considerations, and privacy and data-sharing constraints. Lastly, it highlights considerations to help states advance these models

The report can be found at:
https://www.chcs.org/resource/moving-toward-value-based-payment-medicaid-behavioral-health-services/?utm_source=CHCS+Email+Updates&utm_campaign=8fe437da67-VBP+in+BH+-+061517&utm_medium=email&utm_term=0_bbced451bf-8fe437da67-152144421

Don't Forget About the 2017 PAC Campaign

Earlier this year we announced our 2017 CMH PAC campaign. We must increase our participation, last year we only had 15 boards participate in our PAC campaign. Please take some time over the next couple of board meetings to encourage your board and staff to participate in our 2017 PAC efforts. As you know, our CMH PAC is a key component to our overall advocacy efforts – the need to upgrade our PAC is greater today than ever before.

Boards should forward the results of their campaign and donations to the Board Association offices by May 5 (if available). The results of the campaign will be on-site at the Spring Conference in Dearborn. Final donations should be sent to MACMHB no later than June 30, 2017 in order to be in the drawing for the Detroit Tiger tickets if eligible. This year's Tiger game is Saturday, July 15 at 6:10pm vs. Toronto Blue Jays.

Make checks payable to: CMH PAC ~ 426. S. Walnut St. ~ Lansing, MI 48933 (no corporate checks, please)

Thank you. Please feel free to contact Bob or Alan with any questions.

LEGISLATIVE UPDATE

FY18 Budget on its Way to Governor for Approval

This week both the House and Senate passed HB 4323, which is the FY18 omnibus budget. The budget now goes the Governor for his approval. Below is a link to a summary document as well as a link to the complete bill.

Major changes include:

- Restores direct care wage back to executive budget recommendation – increase of .50 cents/hour beginning October 1.
- Restores state psychiatric hospital staffing back to executive budget recommendation – 72 new FTEs
- Restores Medicaid autism services back to executive recommendation - $105 million
- Adds $3.1 million to support implementation costs related to the pilot projects and demonstration models within boilerplate Sec. 298. Funding would support an independent project facilitator, evaluation costs, modifications to state contracts, and 3.0 FTEs.
- Section 298 changes – Revises section 2 Kent pilot language, removes number of PIHPs from language, adds language related to $3.1 million.

http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-4323-6EBFAFC9.pdf (DHHS budget begins on page 74)

http://legislature.mi.gov/documents/2017-2018/billconferencereport/House/pdf/2017-HB-4323-CR-1.pdf (DHHS budget begins on page 361)

Section 298 Language:

Sec. 298. (1) Before implementing the pilot projects and demonstration models described in subsections (2) and (3), the department shall enter into an agreement with an independent project facilitator with at least 5 years of project management experience to establish performance outcome metrics of the pilot projects and demonstration models, finalize each pilot project's or demonstration model's implementation milestones, determine and manage the critical path to the pilot project's or demonstration model's completion, provide independent guidance on resolving conflicts between parties, and perform other necessary oversight and implementation functions as determined by the department. These performance metrics shall evaluate how the pilot projects and demonstration models impact, at a minimum, each of the following categories:

(a) Improvement of the coordination between behavioral health and physical health.
(b) Improvement of services available to individuals with mental illness, intellectual or developmental disabilities, or substance use disorders.
(c) Benefits associated with full access to community-based services and supports.
(d) Customer health status.
(e) Customer satisfaction.
(f) Provider network stability.
(g) Treatment and service efficacies before and after the pilot projects and demonstration models.
(h) Use of best practices.
(i) Financial efficiencies.

(j) Any other relevant categories.

(2) The department shall work with a willing CMHSP in Kent County and all willing Medicaid health plans in the county to pilot a full physical and behavioral health integrated service demonstration model. The department shall ensure that the pilot project 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.

(3) In addition to the pilot project described in subsection (2), the department shall implement up to 3 pilot projects to achieve fully financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models. These demonstration models shall use single contracts between the state and each licensed Medicaid health plan that is currently contracted to provide Medicaid services in the geographic area of the pilot project. 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.

(d) That the project is consistent with the stated core values as identified in the final report of the workgroup described in subsection (2).

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

(4) The department shall begin to implement the pilot projects and demonstration models described in subsections (2) and (3) by no later than October 1, 2017 and shall work toward implementing the pilot projects and demonstration models described in subsections (2) and (3) by no later than March 1, 2018. Each pilot project shall be designed to last at least 2 years.

(5) For the duration of any pilot projects and demonstration models, 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.

(6) It is the intent of the legislature that the primary purpose of the pilot projects and demonstration models is to test how the state may better integrate behavioral and physical health delivery systems in order to improve behavioral and physical health outcomes, maximize efficiencies, minimize unnecessary costs, and achieve material increases in behavioral health services without increases in overall Medicaid spending.

(7) The department shall contract with 1 of the state's research universities at least 6 months before the completion of each pilot project or demonstration model to evaluate the pilot project or demonstration model. The evaluation shall include information on the pilot project's or demonstration model's success in meeting the performance metrics

developed in subsection (1) and information on whether the pilot project could be replicated into other geographic areas with similar performance metric outcomes. 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.

(8) From the funds appropriated in part 1, $3,088,200.00 shall support the implementation of the pilot projects and demonstration models described in this section, including funding for an independent project facilitator, evaluation of the pilot projects and demonstration models, modifications to state contracts, and the hiring of state staff to support the implementation of this section. By December 1 of the current fiscal year, the department shall provide a spending plan of these funds to 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.

(9) By November 1 of the current fiscal year, the department shall report to 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 on progress, a time frame for implementation, and any identified barriers to implementation and the remedies to address any identified barriers of the items described in subsections (2) and (3). The report shall also include information on policy changes and any other efforts made to improve the coordination of supports and services for individuals having or at risk of having a mental illness, an intellectual or developmental disability, a substance use disorder, or a physical health need.

(10) 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.

NATIONAL UPDATE

Register for Hill Day 2017

The time to protect our nation's most vulnerable populations is now, and we know that our voices are louder together.

Join us at Hill Day 2017, October 2-3, the nation's largest behavioral advocacy event, to stand up and be heard on mental health and addictions.

Register today.

Fired up and ready to go now? Start honing your advocacy skills by taking action today on our Unite4BH page.

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

Have a Great Weekend!