June 22, 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:

- **Contact information of the CMH Association's Officers:**
- **Work, Accomplishments, and Announcements of CMH Association and its Member Organizations**
  - **Network 180 leadership changes**
- **State and National Developments and Resources**
  - **SAMHSA publishes Spanish language version of "Finding Quality Treatment For Substance Use Disorders"**
  - **Michigan announces PCMH-like effort in areas outside of SIM regions**
  - **Two long-sought healthcare resolutions to be proposed at summer NACo conference**
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  - **SAMHSA announces CJ and SMI webinar**
  - **CHCS issues brief: Building Community-Based Behavioral Health and Long-Term Care Provider Readiness for Payment Reform**
- **Resources from association's preferred corporate partners (*A recent addition to the Friday Facts)***
  - **Relias webinar: Everything You Need to Know about CCBHCs**
  - **Relias provides HR tool kit – white papers and webinars**
  - **MyStrength explains digital dashboard**
- **Legislative Update**
  - **FY19 & FY18 Supplemental Budgets Head to the Governor**
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- **National Update**
  - **House Passes First Wave of Opioid Bills**
  - **House Passes Behavioral Health Information Technology Bill**
- **Michigan clubhouse conference**
- **Ethics Training for Social Work and Substance Abuse Professionals for 2018**
- **Employment First Conference**
- **CMHAM Association committee schedules, membership, minutes, and information**

Contact information of the CMH Association's Officers: The Officers of the CMH Association of Michigan recently proposed that their contact information be shared with the Association membership to foster dialogue. While this dialogue will not take the place of the regular dialogue and decision making that occurs during the meetings of the Association's Executive Board, Steering Committee, Provider Alliance, Association Committees, nor any of the great number of Association-

sponsored and supported dialogue venues, the Officers want to ensure that the members of the Association can reach them to discuss issues of interest to the Association's members. The contact information for the officers is provided below:

President: Joe Stone Stonejoe09@gmail.com; (989) 390-2284
First Vice President: Lois Shulman; Loisshulman@comcast.net; (248) 361-0219
Second Vice President: Carl Rice Jr; cricejr@outlook.com; (517) 745-2124
Secretary: Cathy Kellerman; balcat3@live.com; (231) 924-3972
Treasurer: Craig Reiter; gullivercraig@gmail.com; (906) 283-3451
Immediate Past President: Bill Davie; bill49866@gmail.com; (906) 226-4063

WORK, ACCOMPLISHMENTS, AND ANNOUNCEMENTS OF CMH ASSOCIATION AND ITS MEMBER ORGANIZATIONS

Network 180 leadership changes

Below are excerpts from a recent MLive article on changes in the leadership of Network 180.

> The head of Kent County's community mental health authority has resigned. It was announced this week Network 180 CEO Scott Gilman would not seek a contract renewal.
>
> Network 180's Chief Operating Officer Bill Riley was chosen as transition manager.
>
> Further cuts to staff and services, Riley said, don't appear to be on the horizon.
>
> "Our choice is to look forward at the opportunities that we're going to be working," he said. "We don't anticipate any major hiring or any additional losses at this point."
>
> Although Gilman couldn't be reached for comment, he did give a statement within a Network 180 press release on his departure.
>
> "My goal was to leave Network 180 in a stronger place," he said in the statement. "I take pride in my contributions of serving this community and an incredible team of employees and partners, while guiding us with grassroots advocacy and through one of the largest challenges in the organization's recent history."
>
> During his tenure, Gilman helped oversee the formation of Lakeshore Regional Entity in 2014, established an "innovative" Behavioral Health Home and started "the community process of addressing the need to develop a better community response to mental health crisis situations," Mast (Kent County commissioner and chairman of the Network 180 Board of Directors) said.
>
> Within the next month, Mast said the authority hopes to institute an interim CEO. Five to six months later, a permanent CEO is expected to be picked.
>
> "I think he decided to move on," said Harold Mast, "It was contract renewal time and he thought it was a good time."

The full article can be found at:
https://www.mlive.com/news/grand-rapids/index.ssf/2018/06/kent_county_mental_health_ceo.html

STATE AND NATIONAL DEVELOPMENTS AND RESOURCES

SAMHSA publishes Spanish language version of "Finding Quality Treatment For Substance Use Disorders"

SAMHSA's popular fact sheet, ***Finding Quality Treatment For Substance Use Disorders***, has been published in Spanish. It outlines the steps to using a treatment center, lists signs of a quality treatment center and more. Download the fact sheet here. https://store.samhsa.gov/product/PEP18-TREATMENT-LOCS

Michigan announces PCMH-like effort in areas outside of SIM regions

The Care Delivery component of the State Innovation Model (SIM) is designed to support the spread of Advanced Alternative Payment Methods (APM) across the state. The Michigan Department of Health and Human Services (MDHHS) continues to work with Medicaid Health Plans to support the expansion of current APMs and the development of new APMs. Through this work, the Department is supporting Medicaid Health Plans in pursuing a care delivery model, similar to the SIM Patient Centered Medical Home (PCMH) Initiative as a mechanism to continue the valued work of primary care transformation across Michigan.

This program will provide an opportunity for eligible practices and providers across the state (both those within and outside the SIM test regions) that are not currently participating in the SIM PCMH Initiative to engage in a similar care delivery model as that used in the SIM PCMH Initiative by working closely with the Medicaid Health Plans participating in this APM. While administered directly by each individual Medicaid Health Plan (not all Medicaid Health Plans will participate in calendar year 2019), participant eligibility for this program will mirror that of the MDHHS led SIM PCMH Initiative. Therefore, this program will require an application for all interested in participating. MDHHS will be facilitating an application process to support the participating Medicaid Health Plans as they execute this program.

The application is now open and submissions will be accepted through 11:59 PM EST on July 13, 2018. The application can be found at: https://umich.qualtrics.com/jfe/form/SV_eKF8K0s1gL6whOR

A live webinar on the application process will be held on June 26, 2018 1:00 PM - 2:00 PM EDT. To register for this informational session, register at:. https://register.gotowebinar.com/register/6176884092634235395

For more information, visit www.michigan.gov/SIM
Questions or comments may be sent to: MDHHS-SIM@michigan.gov

Two long sought healthcare resolutions to be proposed at summer NACo conference

Below are two resolutions, related to the work of the members and stakeholders of the CMH Association, that will be introduced in this summer's National Association of Counties (NACo) Board meetings, via the NACo Health Committee.

1. Integration of Mental Health and Addiction Care to Address the Opioid Crisis

Issue: Although opioid addiction very frequently follows the onset of depression, and opioid addiction frequently triggers depression within as few as 30 days, our patterns of care organization and funding do not make provision for a necessary linkage between mental health and substance use care.
Proposed Policy: NACo urges the federal government, specifically, SAMHSA, HRSA, CDC, and CMS, to modify grant, technical assistance, and service funding programs that support the development and operation of integrated care to include provision for the integration of mental health and addiction care, including care for depression and opioid addiction.
Background: County behavioral health programs currently are moving toward integration of mental health and primary care because many persons served in the public mental health system also suffer from chronic physical diseases, such as heart disease and diabetes. These efforts are supported by long-standing federal policy, grant, and service funding programs from SAMHSA, HRSA, CDC, and CMS. Within this environment, a subsequent step for counties is the integration of addiction care into this service framework. Because of the national opioid crisis, it is expected that new federal resources will become available for the improvement and implementation of this feature of addition care. Depression screening and treatment are key steps required to prevent opioid addition, as well as to treat it.

Fiscal/Urban/Rural Impact: This effort would provide new federal funds to counties and community-based organizations. It would not require new county resources, but rather require the linkage of current clinicians and clinical practice from the two fields.
Sponsor: Ron Manderscheid, Executive Director, National Association of County Behavioral Health and Developmental Disability Directors and National Association for Rural Mental Health.

2. Proposed Resolution to Prohibit Insurers from Denying Health Benefits to Preadjudicated Persons

Issue: Private insurance companies' "inmate exclusion" shifts health care costs from preadjudicated inmates to counties.

Proposed Policy: The National Association of Counties (NACo) urges the Department of Health and Human Services (HHS) to prohibit insurers from denying reimbursement under health benefit plans for covered services provided to preadjudicated persons in the custody of local supervisory authorities.

Background: Local governments are obligated to provide medical care to the people they incarcerate. Counties hire nurses, doctors, dentists, and mental health staff who have the same experience, credentials, and ability to improve care as in our county clinics or our hospitals.

As a result, counties throughout the United States are shouldering a tremendous cost for inmate health care. According to the Urban Institute, "Typically 9 to 30 percent of corrections costs go to inmate health care.

This amounts to hundreds of millions of dollars annually, and is an aspect of corrections of which the public and many decision makers are largely unaware. Inmate care costs are high in both prisons and jails."

According to the State of Oregon Legislative Counsel, "The Affordable Care Act requires all nonexempt individuals to have health insurance. Preadjudicated inmates are inmates who have not been convicted and who are being held pending disposition of charges. Such inmates are not excused from the requirement to have insurance until after they have been convicted and are incarcerated as a result of a conviction."

Legislative Counsel continues by explaining, "Insurance companies are required to provide health insurance to anyone who applies for insurance. An inmate may enroll in insurance that is offered in the private market outside of the exchange. Prior to conviction, an eligible inmate also may enroll in insurance through the health insurance exchange. Therefore, an insurance company must provide insurance to preadjudicated inmates and may not deny coverage for any service that is an essential health benefit."

Though some preadjudicated people who enter jails have private insurance, most insurers have an "inmate exclusion" and do not pay for health care services provided to their insured while they are in county jails. For those inmates pending disposition of charges, counties are paying their health costs despite the fact that their private insurer is collecting a premium. As a result, taxpayers bear the cost that otherwise would be paid by insurance companies.

An example of this issue is illustrated in Oregon. A recent survey of counties found an average of eight percent of inmates have private health insurance and 61 percent of inmates in jail are pre-adjudicated. Multnomah County, Oregon, estimates that they could save up to $1 million annually by billing private insurers for preadjudicated inmate health costs. Requiring counties to pay for health care for inmates who have private health care coverage is neither a good use of taxpayer dollars nor good public policy.

Fiscal/Urban/Rural Impact: If counties were able to bill private insurers for the health costs of their preadjudicated, insured clients, counties could shift the burden from taxpayers. Counties can use these funds for other critical services, including public safety.

Sponsor(s): Loretta Smith, Commissioner, Multnomah County, Ore.

Media story underscores rural mental health shortage

A recent Google News article, "Rural Areas Have The Highest Suicide Rates And Fewest Mental Health Workers" provides a clear picture of the mental health workforce shortage facing America's rural communities. Excerpts of that article are provided below.

> There isn't a single psychiatrist in 65 percent of nonmetropolitan counties, and there's no psychologist in almost half of them
> In the days and weeks following the suicides of celebrity chef Anthony Bourdain and handbag designer Kate Spade, a chorus of social media users urged people with depression to not be "afraid" to ask for help.
>
> But for most Americans, fear isn't the thing that stands in the way of therapy. It's having no one to turn to.
> This was the case for Sue, 57, who spent over 30 years trying to get effective treatment for bipolar disorder, depression, anxiety and a personality disorder.
>
> For years, whenever Sue felt a major anxiety attack coming on, she'd panic. She would grab her keys, bolt out the door and frantically search for help. In rural Nebraska, that often meant walking up to two miles to the nearest neighbor's house or emergency room, sometimes in the middle of the night.
>
> Sue estimates that she's been to the emergency room in crisis about 30 times. Staff members at the local hospitals she visited weren't usually equipped to treat her and would typically send her home in a matter of hours.
>
> Still, just having someone tell her she would be all right was enough of an incentive for Sue to return to the ER when her anxiety became too much to bear. "I ended up being released and going right back to the condition I was in," she said. "I would do it again about a month later."
>
> There is a severe shortage of mental health workers across the U.S., but the problem is most pronounced in rural areas.
>
> There isn't a single psychiatrist in 65 percent of nonmetropolitan counties, and almost half of those counties don't have a psychologist, according to a report from the American Journal of Preventive Medicine released this month. Patients like Sue, who are desperate for care, will often turn to overburdened emergency rooms, which often don't have the systems in place to help people with mental health issues.
>
> "People with mental illness will present in the ER because they don't know what else to do," said Stephanie Knight, a licensed independent mental health practitioner and the administrative director at Fillmore County Hospital in Geneva, Nebraska.
>
> But even when a rural area does have some mental health workers, they alone usually can't address the entire population's needs. Many residents are uninsured or underinsured, and can't afford regular treatment. Residents may have to travel dozens of miles to get to the nearest town where a therapist works, and may not have access to transportation. Some therapists have irregular office hours and may only visit town a few days a month. The inconsistency can be a deterrent to patients.
>
> Such was the case with Ann, 72, who lives in Crete, Nebraska. She has major depressive disorder and attempted suicide seven years ago. She enjoyed seeing a local therapist, but the therapist only came to her town once a month.
> "It was so infrequent," Ann said. "After a couple of weeks, I'd think: 'Why go back?' There was no momentum."
>
> Rural areas have the highest suicide rates, according to the Centers for Disease Control and Prevention, as well as a high concentration of veterans, who experience higher rates of suicide than nonveterans. Rates of drug overdoses in rural areas have surpassed those in metropolitan areas. There are also more elderly people, who are often socially isolated and at risk for depression, said Ron Manderscheid, executive director of the National Association for Rural Mental Health.

"If I went and looked at all those local communities, I will find a lot of socially isolated people. That is almost as deadly upon you as smoking," said Manderscheid. "When you put that all together, rural areas are a pretty risky place for being at risk for suicide."

Not enough people are going into the mental health field, and those in the field are aging, Manderscheid said. The average psychiatrist is in their mid-50s. Other specialists and primary care physicians are, on average, in their mid-40s. Those who do pursue careers in mental health typically find jobs in major cities.

"Historically, mental health has been an urban discipline," Manderscheid added. "If you're in New York, Chicago, San Francisco, Houston — any of our big areas — you will get the best mental health services we have to offer. If you're in some of these rural areas, you won't. It's just as simple as that."

While some government incentive programs help repay the student loans of therapists who work in underserved areas, many professionals don't stick around once they've paid off their debts, Knight said.
Manderscheid said improving telehealth programs, which allow patients to call or video chat with therapists in cities, is one potential solution. Encouraging young people from rural areas to go into the mental health field could also help.

"We need to start recruiting some of our providers from these rural areas, and work with people in high schools and colleges," he said. "They are most likely to go back. They have an appreciation for rurality and living in rural communities."

The Hill editorial: Medicaid exclusion remains a barrier to treatment

Below is a recent guest editorial rrom former Rep. Patrick Kennedy (D-R.I.), founder of The Kennedy Forum, former member of the President's Commission on Combatting Drug Addiction and the Opioid Crisis, co-founder of One Mind; and Mark Covall, president and CEO of the National Association for Behavioral Healthcare

We appreciate the experience that Michael Botticelli and Richard Frank call upon as they work to address our nation's deadly opioid crisis ("Congress needs a broader approach to address opioid epidemic," June 10). And we support their view that effective treatment for opioid use disorder "can involve a broad continuum of services that range from institutional care to pharmacotherapies to psychosocial and rehabilitation services." But we disagree with the authors about the effects of repealing Medicaid's Institutions for Mental Diseases (IMD) exclusion. Simply put, the IMD exclusion is a barrier to care. Since 1965, the IMD exclusion has prevented Medicaid beneficiaries between the ages of 21-64 from accessing behavioral health care in psychiatric hospitals and residential treatment facilities with more than 16 beds. The American Society of Addiction Medicine identifies adolescents, expectant mothers, people with unstable housing arrangements, or those with co-occurring substance use disorders as patients who typically require residential or hospital care. Many of these patients are also Medicaid beneficiaries, and the IMD exclusion prohibits them from accessing the care they need.

Proof that the IMD exclusion is not working: Our nation's prisons have become a de facto mental health and addiction treatment system. Tens of thousands of people with severe mental illness and substance use disorder are currently incarcerated because they could not secure a bed in a treatment facility. Providing appropriate services along the behavioral health care continuum will help to prevent this, thereby greatly reducing costs in the prison system.

Repealing the IMD exclusion and, consequently, opening access to inpatient treatment does not close access to outpatient treatment. At a time when the opioid crisis is still a public health emergency, we should all advocate that both inpatient and outpatient services be widely available so patients have access to the right care, in the right setting, at the right time.

Most important, we cannot have a comprehensive behavioral health care continuum without adequate access to one vital piece of that continuum: inpatient care. Dozens of opioid-related bills are currently circulating in both chambers of Congress, and most of those bills center on outpatient treatment. We applaud Rep. Mimi Walters (R-

Calif.) and Congress for recognizing the need for wider access to inpatient care. As Congress responds to America's opioid crisis, we urge it to remember that repealing the IMD exclusion is critical to developing our nation's behavioral healthcare system.

Lives depend on it.

SAMHSA announces CJ and SMI webinar

A SAMHSA (Substance Abuse and Mental Health Services Administration) sponsored webinar**,** "Criminal Justice and Serious Mental Illness: Moving to Patient Centered Care", developed under contract by the National Council for Behavioral Health, will take place Thursday, June 28 from 12:30-2:00 p.m. ET**.**

Please register here: https://nasmhpd.adobeconnect.com/patientcenteredcare_reg/event/event_info.html

Description: A 2010 report from the Treatment Advocacy Center found that jails and prisons have more than three times the individuals living with serious mental illness than hospitals. Labeled as the "new mental hospitals or asylums," at least 16 percent of inmates currently in jails and prisons have a serious mental illness compared to 6.4 percent in 1983. Unless gaps in care for these individuals are identified and effective patient-centered interventions are implemented, this problem will persist and potentially worsen.

Attendees of this webinar will learn about the factors contributing to the current situation, gaps in the systems, how to improve access to care in the community and the role of diversion programs such as Mental Health Courts and Drug Courts in decreasing criminalization of serious mental illness and substance use disorders.

Presenter: Angeline Stanislaus, MD, Chief Medical Director of Adult Services for the Missouri Department of Mental Health

CHCS issues brief: Building Community-Based Behavioral Health and Long-Term Care Provider Readiness for Payment Reform

Payment and delivery system reforms are critical to achieve the Triple Aim of improved health, improved patient experience and quality, and reduced cost. While involvement in payment reform grows, participation remains challenging for many community-based behavioral health and long-term services and supports (LTSS) providers.

This new CHCS brief examines the competencies necessary for community-based behavioral health and LTSS providers to successfully participate in alternative payment models, discusses the barriers they face, and explores how states, the federal government, and private organizations can increase community-based providers' readiness to participate in payment reform activities.

Two companion case studies highlight examples where public and private organizations successfully partnered to increase community-based behavioral health and LTSS provider readiness for payment reform.

A copy of this brief can be found at:
https://www.chcs.org/resource/building-community-based-behavioral-health-and-long-term-care-provider-readiness-for-payment-reform/

RESOURCES FROM ASSOCIATION'S PREFERRED CORPORATE PARTNERS

Relias webinar: Everything You Need to Know about CCBHCs

Are you applying for a CCBHC Expansion Grant? Don't miss our upcoming webinar for essential information and advice on preparation.

Webinar Details

Title: CCBHCs: What You Need to Know & How Relias Can Help

Date: Thursday, June 28

Time: 3:00 p.m. - 4:00 p.m. ET

The next wave of CCBHC opportunity is focused on readiness for delivering value-based care under a case rate model. This webinar will review the key principles behind the CCBHC model and discuss the grant requirements and objectives for participants. In addition, we'll discuss how Relias can help you prepare, implement and manage the CCBHC model of delivery.

Register at:
http://go.reliaslearning.com/WBN2018-06-28CCBHCExpansion_Registration.html?utm_source=marketo&utm_medium=email&utm_campaign=wbn_2018-06-28_ccbhc-expansion_population-health-management&mkt_tok=eyJpIjoiTlRNeE5EbGlOVEJsTjJFMSIsInQiOiJ2ODUzS3Q0eDNUQ0VjU0FFVmhBSTVUM3FESzVxNlwvSjNkTWc5S0FJaytlYnZiRE9NNlRFUE1DM09tc2pjUXEyWUlzV0xvbzNPekhySWpDRVpjOEo0Sjk4dFBTY05Yc0FPY0tPVGd4QkJ0bHhFSGluNCt5SVFlbWRMMktNbnN0XC8zln0%3D

Relias provides HR tool kit – white papers and webinars

White Papers:

Overcoming Hiring Conundrums: Hunting Unicorns or Chasing Cats (https://www.relias.com/resource/overcoming-hiring-conundrums?utm_source=partner_silver&utm_medium=referral)

- **Description:** This white paper explains the purpose, capability and function of assessments in making data-informed hiring decisions in healthcare.

Shining a Light on Employee Engagement (https://www.relias.com/resource/shining-light-on-employee-engagement?utm_source=partner_silver&utm_medium=referral)

- **Description:** This white paper discusses how to cultivate high levels of employee engagement as one key to combatting turnover and improving performance in healthcare.

Nurse Turnover: Do Generational Differences Impact Turnover? (https://www.relias.com/resource/generational-differences-impact-nurse-turnover?utm_source=partner_silver&utm_medium=referral)

- **Description:** This white paper explores the reasons why nurses decide to leave and whether generation plays a role in that decision.

Rewards and Recognition: A Key Player in Your Retention Strategy (https://www.relias.com/resource/reward-and-recognition-retention-strategy?utm_source=partner_silver&utm_medium=referral)

- **Description:** This white paper discusses the importance of a rewards and recognition program, especially in assisted living and senior care facilities, and how to implement a successful program.

Webinar Series:

Staff shortages, burnout and *challenging work environments contribute to the increasing turnover rates across the healthcare continuum. High turnover negatively impacts the quality of care and results in adverse clinical and financial outcomes.*

Join us for a 3-part webinar series to learn how to improve hiring and onboarding programs, evaluate and enhance competency, and develop the next generation of leaders— all to build and retain the best workforce.

1. Hiring in Healthcare – How to Find Your Unicorns (http://go.reliaslearning.com/WBN2018-06-28HireRetainLaunchPart1_Registration.html?utm_source=partner_silver&utm_medium=referral&utm_campaign=wbn_2018-06-28_hire-retain-launch-1_hiring-and-retaining)

- **Date:** June 28, 2018 at 2 p.m. ET
- **Presenters:** Leslie Jefferies, MSN, BSN, RN, Director of Clinical Solutions & Justin Hess, M.S., Product Manager, Assessments
- **Description:** This webinar will discuss two personnel challenges that all healthcare organizations face: staff shortages and high turnover. We will then explore using validated assessments as a pre-hire tool to help organizations choose and retain the best talent for their organization.

2. How to Go From Good to Great: Cultivate Your Leaders (http://go.reliaslearning.com/WBN2018-07-12HireRetainLaunchPart2_Registration.html?utm_source=partner_silver&utm_medium=referral&utm_campaign=wbn_2018-07-12_hire-retain-launch-2_hiring-and-retaining)

- **Date:** July 12, 2018 at 2 p.m. ET
- **Presenters:** John McGinn, Healthcare Industry Principal, Skillsoft®
- **Description:** This webinar will explore how leadership development is key to creating a culture of engaged employees. High-performing organizations are leading the industry through talent development, which positively impacts turnover and patient outcomes.

3. Retention Battle Cry: Onboarding & Development (http://go.reliaslearning.com/WBN2018-07-26HireRetainLaunchPart3_Registration.html?utm_source=partner_silver&utm_medium=referral&utm_campaign=wbn_2018-07-26_hire-retain-launch-3_hiring-and-retaining)

- **Date:** July 26, 2018 at 2 p.m. ET
- **Presenters:** Felicia Sadler, MJ, BSN, RN, CPHQ, Clinical Effectiveness Consultant & Justin Hess, M.S., Product Manager, Assessments
- **Description:** This webinar will focus how to address industry challenges such as outcomes, patient satisfaction, and turnover, through onboarding and staff development. We will discuss best practices for creating and maintaining effective onboarding programs, as well as how to engage and build future leaders by developing their skill sets.

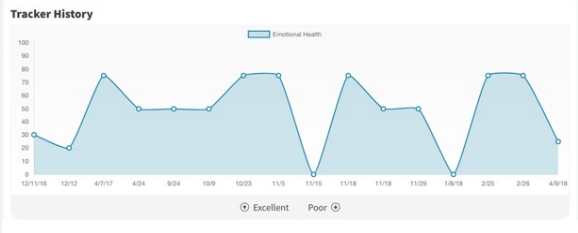
MyStrength explains digital dashboard

Mitigating Clinical and Financial Risk with Behavioral Health Transparency

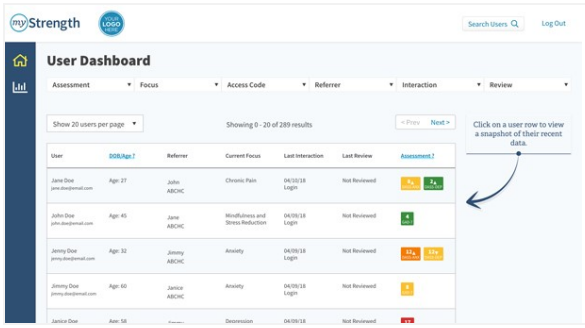
Between 1999 and 2016, suicide rates increased across 49 states, with most states experiencing an increase of more than 30%. With several prominent figures tragically ending their own lives recently, suicide is gaining attention as a national health issue.

myStrength's digital platform arose from a deep passion to help those challenged with behavioral health disorders, with the hope of preventing tragedies like suicide. In an effort to increase transparency into often "invisible" mental health challenges, myStrength is proud to announce the User Dashboard.

What is the myStrength User Dashboard?



Gain unparalleled transparency into consumer behavioral health and well-being data. myStrength can also facilitate this same visibility through direct integration with EHR systems.



Search and filter user data with the protection of enterprise-grade data security (including multi-factor authentication), access level customization, and workflow tracking of user record reviews.

Sample Use Cases:

- Identify high-risk users based on health assessment scores, then provide proactive interventions
- Review a user's record prior to/after an appointment
- Monitor adherence to assigned/recommended myStrength interventions
- Maximize utilization by incentivizing staff to refer consumers to myStrength

myStrength's digital behavioral health platform offers support that is affordable, accessible and free from stigma. myStrength includes self-care tools for depression, anxiety, stress, substance use, chronic pain, insomnia and more.

Learn more at: https://bh.mystrength.com/

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:

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