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National Association of State Mental Health Program Directors

Weekly Update

Robert Wood Johnson Study Finds at Least 4 Medicaid Expansion States Were Able to Shift Millions in State Behavioral Health Costs to Medicaid

A new Robert Wood Johnson report released this month, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, finds four Medicaid expansion states—Arkansas, Kentucky, Michigan, and Washington State—were able to achieve significant savings when individuals who previously relied on state-funded behavioral health programs and services were able to secure Medicaid coverage in the expansion's new adult coverage group. RWJF says 4 of the 11 states studied in the report funded behavioral health services with federal expansion dollars rather than state dollars without reducing services.

The report, authored by the State Health Reform Assistance Network managed by the Woodrow Wilson School of Public and International Affairs at Princeton University, found that the 4 states achieved the following savings by transitioning enrollees in state-funded behavioral health programs into the new adult Medicaid group:

- Michigan projected savings of $190 million in State Fiscal Year (SFY) 2015.
- Kentucky saved $9 million in SFY 2014 (six months of savings) and expected to save $21 million in SFY 2015 in state mental and behavioral health spending.
- Arkansas projected $7.1 million in savings in SFY 2015.
- Washington State saved $13.4 million in SFY 2014 and projected savings of $51.2 million in SFY 2015.

In addition, Arkansas was able to reduce state spending on community health centers and local health units by $6.4 million for SFY 2015 without reducing services, when those facilities received Medicaid payments for services provided to previously uninsured patients.

The report, an update of an April 2015 report, looks at Medicaid expansion and its impact on revenues and savings in Arkansas, California, Colorado, Kentucky, Michigan, New Mexico, Oregon, Maryland, Pennsylvania, Washington, West Virginia, and the District of Columbia. It finds that state Medicaid spending grew more slowly in states that expanded than in those that did not—by half as much as spending in non-expansion states between FY 2014 and FY 2015 (3.4% compared to 6.9%).

The report also finds that Medicaid expansion states saw average health sector job growth of 2.4 percent during 2014, while job growth in non-expansion states was only 1.8 percent in 2014.

Coverage expansions also contributed to a national reduction in hospital uncompensated care costs. Hospital uncompensated care costs were an estimated $7.4 billion (21 percent) less in 2014 than they would have been in the absence of coverage expansions. Expansion states saw a 26 percent reduction in uncompensated care, compared to a 16 percent drop in non-expansion states.

Health Insurance Group Launches 6-Month, 3-State Provider Directory Pilot

American's Health Insurance Plans (AHIP), the trade association representing many major managed care insurance plans, announced March 22 a new multi-plan pilot designed to keep health plan provider directories updated on a more timely and accurate basis.

Under the pilot, which begins in April and ends in September, AHIP will work with BetterDoctor and Availity, two health care information and technology firms with expertise in provider directory outreach and data updates, to launch its pilot in three states—California, Indiana, and Florida. The pilot will set one primary point of contact for providers to update or report changes to their practice information. BetterDoctor and Availity will share the reported data changes with the participating health plans to update the plans' online and hard-copy directories.

The plans participating operate in the commercial, Medicare, and Medicaid markets. They include Anthem of California and Indiana, Cigna and WellCare of Florida, HealthNet of California, Florida Blue, SCAN Health Plan of California, Molina of California, Blue Shield of California, AvMed of Florida, L.A. Care, Western Health Advantage of California, and Humana in all three states.

Study Finds Half of Emergency Room Patients with Suicidal Ideation Not Asked About Access to Deadly Firearms

A just-published study by researchers at the University of Colorado Anschutz Medical Campus finds that only about 50 percent of emergency department (ED) doctors ask patients who have attempted suicide or have suicidal ideation if they have access to firearms or other lethal implements.

The study, published online in the April issue of *Depression and Anxiety*, reports that when researchers asked 1,358 patients in eight emergency departments in seven states who had attempted suicide or were considering it whether they had access to firearms, and then reviewed their charts, there was no documentation in about 50 percent of cases that the patient had been asked about access to firearms. Patients seen only by an ED physician, without an evaluation by a mental health consultant, were less likely to have a documented lethal means assessment.

The researchers posit that the disparity in inquiries about lethal means may relate to differences in training or awareness about lethal means counseling among ED and mental health providers, but that it may also stem from overall perceived level of risk. While the researchers say ED providers are more likely to request a consultation with a mental health provider for patients with the highest perceived level of risk, they found—after comparing self-reported and medical record documentation about home firearms access—that the providers did not accurately suspect who did or did not have firearm access. Assessment appeared more common in those with a psychiatric chief complaint, who were not intoxicated, and were subsequently admitted to a psychiatric facility—suggesting admission is associated with overall assessment of risk severity—as compared to those who were discharged to their homes.

Documented interpersonal or domestic violence also appeared associated with a greater likelihood of assessment for lethal means for suicide, although a high proportion of charts were missing documentation about interpersonal violence and domestic violence.

The researchers suggest that ED physicians who do not ask about suicide often are reluctant to offend or alienate their patient by asking such a sensitive question.

About 25 percent of the patients interviewed who said they had at least one gun at home told the researchers they kept at least one of those guns loaded and unlocked. Although men and women were equally likely to report having at least one firearm at home, men were more likely to personally own the firearm.

National guidelines encourage ED physicians to ask about firearms and other items that could be lethal implements. A 2015 study published in Bio-Med Central/Public Health found that a patient's number of visits to the ED is an independent risk factor for suicide among patients not subsequently admitted for inpatient care. Individuals with suicidal ideation on average attend the ED twice as many times as patients who do not attempt or ideate suicide.

The authors of the study note that 60 percent of the patients in their study reported currently taking at least one medication for an emotional or psychological condition, raising the threat of medication overdose as another potential suicide method. But the authors note that approximately 90 percent of firearm suicide attempts are fatal, compared to as few as 2 percent of drug overdoses.

When asked what method of suicide they considered most often and what method they had used in their most serious past attempt (if applicable), approximately half of those both with and without firearms at home reported medication overdose. However, a larger percentage (22 percent) of those with a firearm at home than those without a firearm at home (6 percent) reported considering a firearm most often as a suicide method.

The median age of participants in the study was 36, and 56 percent were women. ED patients who had attempted suicide or had suicidal ideation and reported having at least one firearm at home were significantly more likely to be white, heterosexual, married, or co-habitating.

Final ACA Health Plan/Program Discrimination Rule at OMB for Review

The final rule on the Affordable Care Act's § 1557 nondiscrimination provisions were submitted by the Department of Health and Human Services (HHS) to the Office of Management and Budget for review on March 19. The nondiscrimination provisions have technically been in effect since the law was enacted, but the proposed rules were not published until last September.

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in Federal and Federally funded or subsidized health programs and activities, including state health programs, and would likely be interpreted to apply to state mental health programs.

In comments on the proposed rule, the 200-member "I Am Essential Coalition" urged HHS to better detail standards and parameters for benefit and plan design, and to expand the definition of those protected to include all beneficiaries with chronic conditions or serious illnesses.

State Technical Assistance Available from the State Mental Health Technical Assistance Project (Coordinated by NASMHPD with SAMHSA Support)

To Request On-site TA: States may submit requests for technical assistance to the on-line SAMHSA TA Tracker, a password-protected system. All of the Mental Health Directors/Commissioners are authorized to use this system, and Commissioners can give authorization to other SMHA staff, as well. Once in this system, the user will be asked to identify the type of TA that is being sought, the audience, and the goals that the state is seeking to address via the support.

Center for Trauma-Informed Care: Upcoming Sessions

NASMHPD oversees the SAMHSA National Center for Trauma Informed Care (NCTIC). NCTIC offers consultation, technical assistance (TA), education, and outreach, and resources to support a revolutionary shift to trauma-informed care across a broad range of publicly-funded service systems, including systems providing mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education.
Below is a listing of upcoming trainings.

District of Columbia
Washington – March 31 - DC CARE

Illinois
Chicago – March 31 & April 1- Trilogy Behavioral Healthcare

Maryland
Baltimore – March 29 & 30 -
Multi Agencies for Baltimore City

Senator Brown's S. 2438 Would Establish Medicaid Quality of Care Bonus Program

The *Medicaid and Chip Quality Improvement Act* introduced by Sen. Sherrod Brown (D-OH), S. 2438, would build on the existing Medicaid adult and child core quality measures to establish 10 annual Medicaid Quality Performance Bonus awards to states—five awarded to states for high quality attainment and five awarded for quality improvement.

As a condition of receiving a Medicaid quality performance bonus, a State would have to agree to devote at least 75 percent of the bonus received for the development and operation of quality-related initiatives that directly benefit providers or managed care entities, such as pay-for-performance programs, collaborations intended to improve quality performance, quality improvement initiatives aimed at improving care for special and hard-to-reach populations, and initiatives including managed care entities.

On average, a given TA project includes as many as 10 days of consultant time (including prep and follow-up), along with coverage of consultant travel to your state.

The log-in for the Tracker is: http://tatracker.treatment.org/login.aspx. If a state has forgotten its password or has other questions about accessing the Tracker system, the Commissioner or authorized user can send an e-mail to: tatracker@treatment.org.

For answers to other questions, contact your CMHS State Project Officer for the Mental Health Block Grant, or Pat Shea at NASMHPD at 703-682-5191 or pat.shea@nasmhpd.org.

Please note that technical assistance under this project cannot be specifically focused on institutional/hospital- based settings.

Answers to Frequently Asked Questions Available for Medicaid Provider Access Final Regulations

On March 16, the Center for Medicaid and CHIP Services released frequently asked questions (FAQs) on the *Methods for Assuring Access to Covered Medicaid Services* final rule, which requires states to follow a transparent, data-driven process for documenting access to care for services covered under the Medicaid state plan and fee-for-service, consistent with § 1902(a)(30)(A) of the Social Security Act.

The FAQs provide responses to questions CMS has received through ongoing technical assistance.

Behavioral health services are among those for which the FAQs say states must review access monitoring procedures every three years and when provider reimbursement is reduced or restructured. Additionally, if a state or CMS receives a significantly higher than usual volume of beneficiary, provider, or other stakeholder complaints regarding access to a particular type of provider for a geographic area, the state must add those services to its access monitoring review procedures. A state's access monitoring review plan must identify the data it will use that will give insight into:

- the extent to which beneficiary needs are fully met,
- the availability of care through enrolled providers, and
- changes in beneficiary service utilization.

The final rule made it clear that increasing provider reimbursement should not be the default approach to correcting limited access to services.

Additional questions beyond those answered in the FAQs may be sent to the Medicaid Access to Care mailbox.

Webinar & Resources Available on Promoting Community Inclusion by Behavioral Managed Care Companies

Monday, April 4, 2016 - 1 p.m. EDT

CLICK HERE TO REGISTER

Mental Health America (MHA) and The Temple University Collaborative on Community Inclusion (TUCollab) have published two new on-line resources designed to assist behavioral managed care companies and their county and state partners in mental health service delivery in promoting community inclusion policies, programs, and practices for individuals with mental health conditions. MHA and TUCollab have scheduled a Webinar for April 4 on Community Inclusion Policy Development designed to introduce participants to both resources and facilitate a national discussion on these topics. Registration is at the link above.

The publications, part of an ongoing series of monographs that spell out both the broad need for and specific opportunities associated with the growing community inclusion initiative, are:

Behavioral Health Managed Care Entities: Important Partnerships in Promoting Community Inclusion suggests a dozen practical strategies that behavioral managed care companies (BHMC's) can use to promote community participation and inclusion of service recipients in the life of their communities. This toolkit provides readings and key resources for the BHMC's to use—with topics that include revising mission statements, staff training options, program evaluation tools, and others key to facilitating the adoption of community inclusion initiatives.

Community Participation and Inclusion: Shifting Perspectives on Quality Measures contains TUCollab tips for encouraging the behavioral managed care industry, as well as federal, state, and local mental health administrators, to systematically assess the community participation needs of service recipients and the success of provider agencies in meeting those needs.

NASMHPD Link of Interest

STATE GUIDANCE FOR USE OF SAMHSA SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SABG) AND COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (MHBG) FUNDS TO ASSIST IN PAYING COST-SHARING FOR PRIVATE HEALTH INSURANCE

Upcoming Medicaid State-Only Technical Assistance Webinar

Overview of HITECH SMD Letter and Resources to Advance Health IT, HIE, and Interoperability through Medicaid Policy and Programs

March 31 – 1:30 to 2:30 p.m. EDT

Dial In: (877) 267-1577
Participant Code: 991 969 000

Link: **https://webinar.cms.hhs.gov/sota2016/.**

On February 29, CMS issued a State Medicaid Director letter updating prior guidance on when state costs related to promoting Health Information Exchanges (HIEs) can be matched at the 90 percent HITECH administrative rate to support the coordination of care and transitions of care requirements in Meaningful Use. CMS will walk through the letter and describe the new policy. In addition, there will be a live demonstration of the Health IT dashboard and HIT Policy Lever Compendium that focuses on Medicaid Levers to advance HIT, HIE, and Interoperability.

NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

In the spring of last year, NASMHPD launched an Early Intervention in Psychosis (EIP) virtual resource center, which was made possible through the generous support of the Robert Wood Johnson Foundation (RWJF).

The intent of the EIP site is to provide reliable information for practitioners, policymakers, individuals, families, and communities in order to foster more widespread understanding, adoption and utilization of early intervention programming for persons at risk for (or experiencing a first episode of) psychosis. The site includes information from the national RWJF-funded demonstration to identify and prevent the onset of psychotic illness – the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) – as well as a variety of other early intervention initiatives.

EIP is designed to provide an array of information through a consolidated, user-friendly site; and it is updated on a periodic basis. To view the EIP virtual resource center, visit NASMHPD's EIP website.

New Frontiers in Coordinating Housing and Medicaid Services for People with Behavioral Health Conditions

A Policy Forum and Live Webinar Sponsored by Mathematica's Center for Studying Disability Policy

Thursday, April 21, 12 p.m. to 1:30 p.m. EDT
at Mathematica's Washington, D.C. Office & by Webinar

Click to REGISTER

An abundance of evidence links housing to better health—and lower health care costs—for people with serious mental illness or other behavioral health conditions. But finding and maintaining housing can be a challenge for this population. Community-based services and supports, particularly those that provide coordination between housing and health services, are essential for helping people overcome this challenge. Yet these types of interventions—which require cross-system coordination—face major obstacles at the state level that include weak or non-existent partnerships between state Medicaid and housing agencies and the lack of a Medicaid-reimbursable mechanism for care coordination.

Join Mathematica's Center for Studying Disability Policy at its next policy forum to learn more about what state and federal partners are doing to coordinate and integrate health and housing services for people with behavioral health needs.

Speakers Jonathan Brown, Carol Irvin, and Matthew Kehn from Mathematica and **Jennifer Ho** from HUD will discuss:

- Why housing is an important part of efforts to treat high-need, high-cost Medicaid beneficiaries
- Challenges and lessons from the Money Follows the Person Demonstration's efforts to improve the availability of supportive housing for Medicaid beneficiaries moving out of institutions
- Innovative state efforts to better coordinate health and housing services for people with behavioral health conditions
- Efforts led by HUD to partner with other federal agencies, such as CMS and the Substance Abuse and Mental Health Services Administration, to coordinate health and housing services

Note: In-person check-in and lunch begin at 11:45 a.m.; the program begins at 12:00 p.m. All in-person guests must sign in and present a photo ID. For more information, email disabilityforums@mathematica-mpr.com.

National Quality Forum Seeks Measures Application Partnership Nominations

NATIONAL QUALITY FORUM

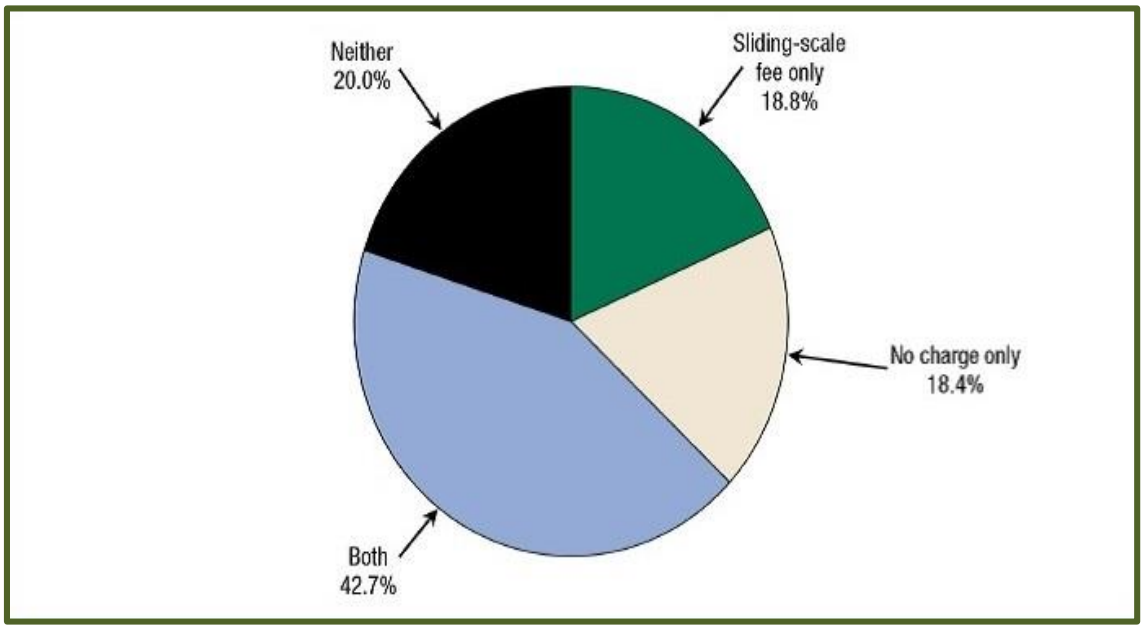
The National Quality Forum's (NQF's) Measures Application Partnership (MAP) has issued a call for nominations for the 2016-2017 pre-rulemaking cycle. The nomination period is open until April 15 at 6 p.m. EST for organizations and individual subject matter experts for four workgroups and the MAP Coordinating Committee, which sets strategy and provides direction to and ensures alignment among the various workgroups before finalizing input to HHS on the selection of performance measures for public reporting, and performance-based payment for public health programs. All nominations must be submitted via the nomination submission form.

The workgroups for which nominations are open are the:

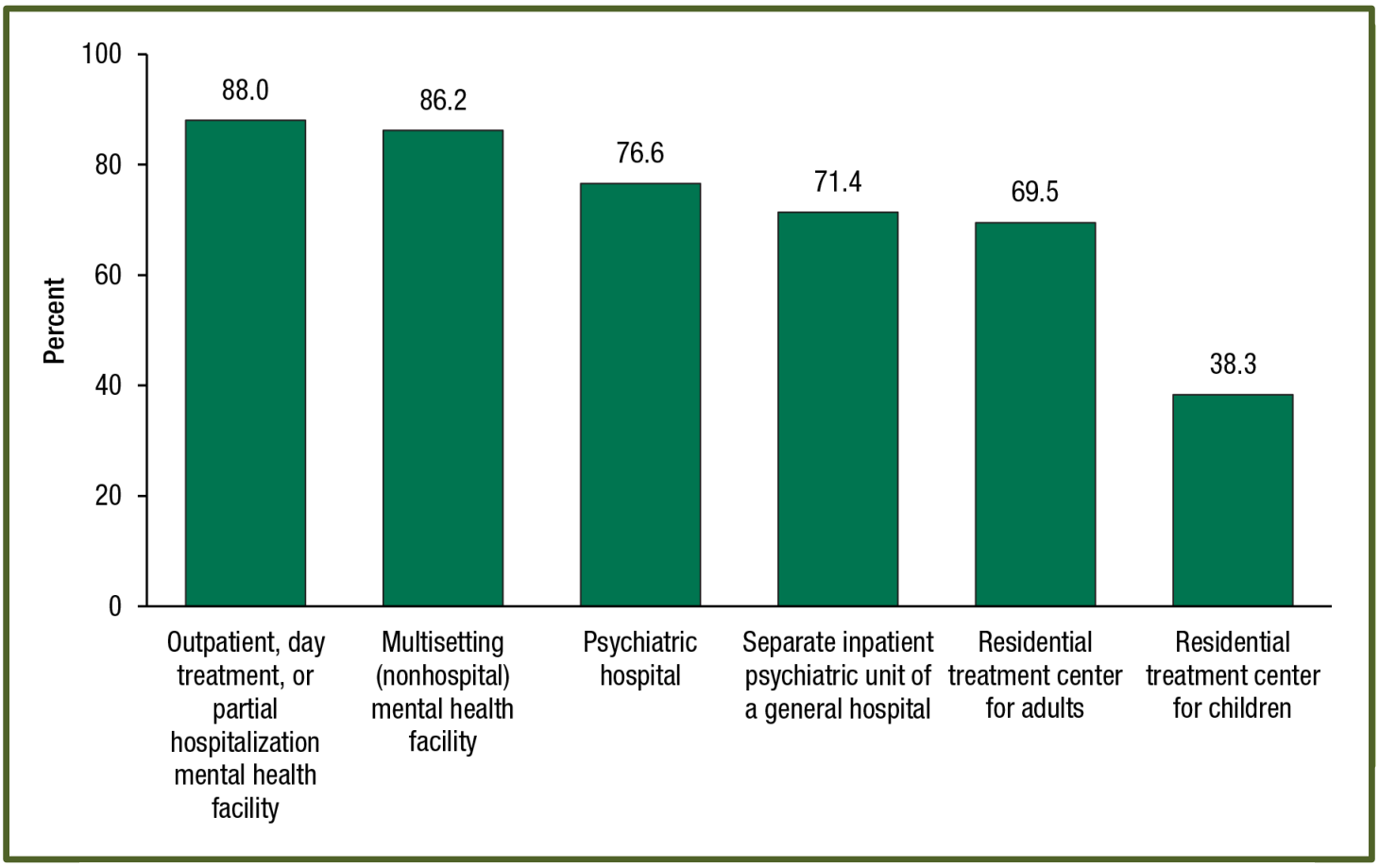
Hospital Workgroup – Provides input to the Coordinating Committee on matters related to the selection and coordination of measures for hospital performance measurement programs, including for inpatient acute, outpatient, cancer, and psychiatric hospitals.
Dual Eligible Beneficiaries Workgroup – Provides input to the Coordinating Committee on matters related to the quality of care for Medicare-Medicaid dual eligible beneficiaries across the care continuum.
Post-Acute Care/Long-Term Care Workgroup – Provides input to the Coordinating Committee on matters related to the selection and coordination of measures for post-acute care and long-term care performance measurement programs, including for hospices, inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities, and home health care.
Clinician Workgroup – Provides input to the Coordinating Committee on matters related to the selection and coordination of measures for clinician performance measurement programs.

For more information and requirements, view the Call for Nominations (PDF) available on the MAP webpage. Contact the project team at measureapplications@qualityforum.org with any questions.

From: *Availability of Payment Assistance for Mental Health Services in U.S. Mental Health Treatment Facilities*, Center for Behavioral Health Statistics and Quality (CBHSQ), Kelley Smith, Ph.D., M.S.W., Janet Kuramoto-Crawford, Ph.D., and Sean Lynch, Ph.D., L.C.S.W., March 23, 2016. Source of data: Source: SAMHSA, National Mental Health Services Survey (N-MHSS), 2010.



Mental Health Treatment Facility by Type of Payment Assistance Offered, as reported in 2010 N-MHSS



Mental Health Treatment Facilities Offering Payment Assistance by Facility Type, as reported in 2010 N-MHSS

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NASMHPD Staff

Brian M. Hepburn, M.D., Executive Director
Brian.hepburn@nasmhpd.org

Meighan Haupt, M.S., Chief of Staff
Meighan.haupt@nasmhpd.org

Shina Animasahun, Network Manager
Shina.animasahun@nasmhpd.org

Genna Bloomer, Communications and Program Specialist
Genna.bloomer@nasmhpd.org

Cheryl Gibson, Accounting Specialist
Cheryl.gibson@nasmhpd.org

Joan Gillece, Ph.D., Project Manager
Joan.gillece@nasmhpd.org

Leah Harris, Trauma Informed Peer Specialist/Coordinator of Consumer Affairs (PT)
Leah.harris@nasmhpd.org

Leah Holmes-Bonilla, M.A.
Senior Training and Technical Assistance Advisor
Leah.homes-bonilla@nasmhpd.org

Christy Malik, M.S.W., Senior Policy Associate
Christy.malik@nasmhpd.org

Kelle Masten, Program Associate
Kelle.masten@nasmhpd.org

Jeremy McShan, Technical Assistance and Data Management Specialist
Jeremy.mcshan@nasmhpd.org

Stuart Gordon, J.D., Director of Policy & News Letter Editor
Stuart.gordon@nasmhpd.org

Jay Meek, C.P.A., M.B.A., Chief Financial Officer
Jay.meek@nasmhpd.org

David Miller, MPAff, Project Director
David.miller@nasmhpd.org

Kathy Parker, M.A., Director of Human Resource & Administration (PT)
Kathy.parker@nasmhpd.org

Brian R. Sims, M.D., Senior Medical Director/Behavioral Health
Brian.sims@nasmhpd.org

Greg Schmidt, Contract Manager
Greg.schmidt@nasmhpd.org

Pat Shea, M.S.W., M.A., Deputy Director, Technical Assistance and Prevention
Pat.shea@nasmhpd.org

David Shern, Ph.D., Senior Public Health Advisor (PT)
David.shern@nasmhpd.org

Timothy Tunner, M.S.W., Ph.D., Technical Assistance Project Coordinator
Timothy.tunner@nasmhpd.org

Aaron J. Walker, M.P.A., Policy Analyst/Product Development
Aaron.walker@nasmhpd.org

NASMHPD Publications

The NASMHPD website contains a number of white papers, issue briefs, web-based tutorials, and technical assistance papers published over the last decade—including those associated with the SAMHSA-funded *Technical Assistance Coalition* and *Transformation Transfer Initiative* efforts. Some of the most recent include:

An Inventory & Environmental Scan of EBPs for Treating Persons in Early Stages of Serious Mental Disorders

Olmstead Risk Assessment and Planning Checklist Establishing Deaf-to-Deaf Peer Support Services and Training

NASMHPD State Housing Survey Pillars of Peer Support Behavioral Health and Criminal Justice Systems

Partnering with Tribal Governments to Meet the Mental Health Needs of American Indian/Alaska Native Consumers

From the Medical Directors Council: The Vital Role of State Psychiatric Hospitals

And from the State TAC Project: Web-Based Tutorial: Early Intervention in Psychosis: A Primer