Health Services SC Lt. Gov. Brian Calley
Medicaid SC 2-29-16

Lt. Gov. Brian Calley
Testimony before the joint meeting of
Appropriations Subcommittees on Medicaid and Health Services
Feb. 29, 2016

I am speaking today not only as the Lt. Governor but – perhaps more importantly – as the parent of a child with autism. Years ago, her diagnosis opened my eyes to the challenges parents and consumers face in navigating "systems" of care. I know from personal experience how difficult it can be.

I felt it necessary to use this experience to improve systems and outcomes for others facing similar challenges. It is for this reason I chaired the Mental Health and Wellness Commission, Opioid and Prescription Drug Abuse Task Force and Special Education Reform Task Force.

Additionally, I have led insurance reform efforts and am working toward transforming the state government into a model employer in hiring talented people with disabilities. Annually, I take the Polar Plunge to raise awareness of the value and potential of special children with additional needs.

I undertook each of these endeavors to enhance and improve how, as a state, we can and should enhance services and support for people with a mental illness, intellectual and developmental disabilities, and substance use disorders.

The suggested boilerplate language in the proposed 2017 budget does not adequately convey this goal. The language has some parents, consumers and advocates concerned. Upon hearing these concerns, I am convening advocates, consumers, parents, providers and many other stakeholders to engage in thoughtful discussions on how we can reimagine and reinvent the statewide behavioral health system in which we invest $2.4 billion dollars annually.

I am asking the state department and all stakeholders to come together to enhance, improve and better integrate our systems of care – with the needs of the consumer being the focal point.

I have challenged the group to develop a foundation of values, based on facts, as a framework for the roadmap showing where we need to go from here.

Among other things, one of the group's goals is to replace the original Section 298 budget language with a consensus proposal from this broad based stakeholder workgroup. We have held our first meeting and a subcommittee has been assembled to establish a set of facts from which the group can work.

I also have asked the Community Mental Health Association, health plans and other stakeholders to come to the table with a goal to reduce administrative costs so that we can maximumize public resources to consumers and produce the best outcomes for people in need of services. The pursuit of administrative savings should be for the sole purpose of investing more into services to consumers.

Together, I know we can and will find a sensible way forward with the needs and dreams of our consumers at the center of all we do. These are our neighbors, our friends, and our loved ones. They deserve the chance to reach their full potential. Working together, I know we can help these valuable citizens live self-determined and independent lives.

Thank you for your time today.

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Health Services SC
Medicaid SC

Robert Sheehan
2-29-16

(3)

Michigan Association of COMMUNITY MENTAL HEALTH Boards

Written comments for the House MDHHS Appropriations Subcommittee
February 29, 2016

Chairman VerHeulen and Members of the Committee:

My name is Robert Sheehan, Chief Executive Officer of the Michigan Association of Community Mental Health Boards. Our association represents the 46 community mental health boards, 10 Prepaid Inpatient Health Plans, and over 90 provider organizations that deliver mental health, substance use disorder, and developmental disabilities services in every community across thus state.

Boilerplate Section 298

As you may know, our Association is recommending that Section 298 be stricken from the DHHS budget bill. While the Governor's budget message calls for dialogue on the integration of physical and behavioral health care with the aim of improved care for patients, the language in that section of the bill precludes meaningful and deliberate discussion and planning for what would be dramatic and, in the eyes of many, damaging changes to the state's Medicaid system.

1

Our concerns revolve around the need for an inclusive planning process centered around the needs of the persons with behavioral health and developmental disability needs who are served by the healthcare system. I will not dwell further on our concerns related to Section 298, as I think you will hear those concerns voiced by others throughout today's hearing.

As my colleague, Rick Murdock indicated a few minutes ago, his organization and mine are jointly calling for the removal of this language and its replacement with language that describes a process that: involves a wide range of stakeholders in meaningful dialogue, is founded on a strong set of principles and goals; and is guided by facts. This recommendation is spelled out in a joint letter, from our two associations, to this committee, which accompanies this testimony.

This organization, its members, and our system's stakeholders are optimistic that the planning process that has been initiated by the Lieutenant Governor will be the kind of process that our two organizations are recommending – a dialogue-rich and deliberate process that will lead to the continued improvement in the design and operation of the state's Medicaid-funded healthcare system.

In a related effort, my organization has partnered with the Michigan Association of Health Plans to study, with the help of nationally known consultant group, the healthcare utilization patterns of Medicaid enrollees with both mental health and physical health needs. The findings of this study will be useful in fueling the redesign work of Lieutenant Governor Calley's workgroup.

In addition to the elimination of Section 298, our Association is recommending several other changes to the Governor's recommended DHHS budget; changes that will strengthen Michigan's nation-leading mental health system.

Local Match

Boilerplate Section 928 has been included in the budget for the past several years, which requires $25.2 million of CMH local county match funds to be used to draw down additional federal Medicaid resources, approximately $45 million. As you are well aware, CMHs across the state have seen a significant portion of their general fund resources reduced and local funds reduced or flattened, which in turn limits their flexibility at the local level to serve the needs of their communities. Currently, many counties struggle to meet the local match requirements for CMH services.

Last year, the House and Senate included boilerplate section 1010, which directed the department to return any lapse funding back to the community mental health agencies. This year we would request section 928 be amended to include subsection (2) which would direct the department to reimburse the local funds back to the CMHs if Medicaid funds are lapsed in FY17. Those local dollars are used to draw down Medicaid funds, if those Medicaid funds are not completely used those local funds should be returned to the CMHs, not the state. Below is the suggestion boilerplate language:

Sec. 928. Each PIHP shall provide, from internal resources, local funds to be used as part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

> *(2) It is the intent of the legislature that any funds that lapse from the funds appropriated Medicaid mental health services shall be redistributed to individual CMHSPs as a reimbursement of local funds that were used under this section. The funds shall be reimbursed on a proportion basis to those CMHSPs whose local funds were used as state Medicaid match.*

CMH Non-Medicaid Services (General Funds)

Our members certainly appreciate your attention to the general fund needs for CMH services during the FY16 and FY15 supplemental budget process. However, there are still several areas where needs are not being met and additional funding is needed.

Spend down

As you aware, statewide our members continue to struggle in providing services for persons who access Medicaid services through a spend down. These individuals do not qualify for Healthy Michigan because they also have Medicare insurance, but due to the implementation of Healthy Michigan and the shift away from CMH general fund dollars these individuals have fallen through the cracks. This population has historically relied on CMH general fund dollars to meet their spend down requirements (requiring these persons to spend from 60% to 70% of their total monthly income on health care in order to qualify for Medicaid). In FY13, our members spent over $30 million on the Medicaid spend down population. However, with the reduced general fund support

CMHs have not been able to provide the same level of support and in many cases have been forced to cut it out altogether.

This change was certainly an unintended consequence. While MDHHS has been looking into the issue, this issue remains unresolved. It is our understanding that simply changing the income disregard levels for this group would be too costly to the state, therefore we are suggesting additional general fund support so our members can provide the much needed care for this population.

CMH GF Redistribution

MDHHS is in the process of finalizing a new CMH non-Medicaid funding formula. While we certainly applaud the department's efforts and openness to work in conjunction with our membership on this important issue, we would request that additional general funds be added to the CMH non-Medicaid line in order to prevent the loss of GF resources for some of our members that will result from this GF reallocation. We strongly support the aim of this change, that of increasing funding for those lower funded CMHs, this long-awaited increase in GF funding should not be at the expense of persons served by CMHs who have higher funding levels. $25 million in GF revenues would be needed to prevent funding cuts to those CMHs slated to lose GF dollars with this reallocation.

Direct Care Worker Minimum Wage

In the spring of 2014, the Michigan Legislature passed a law to increase the standard minimum hourly wage, via annual increases, from $7.40 to $9.25 by January 1, 2018. The Legislature did not provide any additional funding for the wages of direct-support workers within the CMH system. These employees care for and support some of the most vulnerable people in our state.

An estimated 44,000 direct-support jobs are funded through Medicaid appropriations to support and serve people with intellectual and developmental disabilities, mental illnesses, and substance use disorders. Employers of these workers depend on Medicaid funding provided through the Michigan Department of Health and Human Services, and unlike other businesses, have little to no ability to increase revenues to meet increased staff costs.

The Partnership for Fair Caregiver Wages, which our association is a member, recommends $1 per hour wage pass through for three consecutive years – estimated cost about $99 million gross and $33 million in GF funds.

Healthy Michigan

The Governor's FY17 executive recommendation reduces behavioral health Healthy Michigan funding by nearly $130 million. We understand this change was made to better reflect the actual spending with these funds. With that said, we are concerned that too much is being taken out – $130 million is over a 30% reduction. Our main concern relates to the cause of the under spending in the area of substance use disorders (SUD) services. – the fact that the Medicaid rules and requirements that would guide the delivery of these services have not been finalized. There has been a great deal of uncertainty as to what can and cannot be covered related to SUD services. This lack of clarity has led to the lower than expected level of Healthy Michigan spending over the past two years. We recommend that the Behavioral Health Care funding through Healthy Michigan be reexamined with this cause of underspending in mind.

Respectfully submitted,

Robert Sheehan
Chief Executive Officer
Michigan Association of Community Mental Health Boards

To: Sen. Jim Marleau, Chair, Senate Subcommittee on Health and Human Services
Rep. Rob VerHeulen, Chair, House Subcommittee on Community Health

From: Robert Sheehan, Michigan Association of Community Mental Health Boards
Rick Murdock, Michigan Association of Health Plans

Date: February 18, 2016

Re: MDHHS Budget Boilerplate, Sec. 8-290 of Bill number regarding service integration

We are jointly writing this memo regarding the boilerplate language in the proposed Department of Health and Human Services budget addressing integration of mental health services with physical health treatments. As major stakeholders in this matter, we believe it is vital to get the process right before making any programmatic or resource changes. Therefore we want you to know that our two organizations along with other groups are already engaged with the Administration on this issue through a process convened by the Lieutenant Governor as envisioned by the proposed boilerplate.

We expect that one of the outcomes of this process will be recommendations that will help frame your final budget boilerplate recommendations that would result in replacing the section 8.298 with language that more closely reflect the wording in Gov. Rick Snyder's executive budget statement on integration. Gov. Snyder's executive budget statement reads:

> *The governor recommends that the state begin the process to better integrate mental and behavioral health services with a patient's physical health treatments. The governor expects to see improved coordination of care and a stronger focus on the needs of an individual patient by initiating a process by which all patient services are closely integrated. This budget recommendation asks the legislature and the health provider community to engage in an important conversation about integrating physical and behavioral health services into the larger consideration of patient need.*

This integration design effort must reflect:

- A robust and transparent stakeholder involvement (through a process that stakeholders help to design)
- The use of this stakeholder involvement in the development of a clear set of goals and principles for the effort (including the aim of integrating care at the consumer/patient/practice level and ensuring a person-centered approach to care)
- Only after these goals and principles are determined, the identification of best practices from across the state and nation to achieve those goals and principles, which are then built into a design that is guided by robust and transparent stakeholder involvement

Key to that process would be development of a clear set of principles, factual information and core design elements upon which efforts to integrate care would be based. These principles should include: person-centered planning, self-determination, and recovery orientation at the core of the effort; avoiding the return to a medical

and institutional model of supports and services for persons with behavioral health/developmental disability needs; easy access to services for persons with mental health needs; community-based supports and services including integrated employment and safe, affordable and accessible housing options; and compliance with all federal requirements aimed at consumer freedoms and community inclusion; and the integration effort focused on the point at which the patient/consumer receives care, supports, and services. The process should also develop appropriate goals and metrics aimed at, first and foremost, improving care for individuals who are in need of mental and behavioral health services.

The process needs to involve a robust and transparent stakeholder involvement(through a process that stakeholders help to design, including patients/consumers and the affected organizations to ascertain what they would see as a successful integration of mental and physical health services and to guide the design, planning, implementation, and monitoring of this effort. Only after principles, goals and metrics are properly determined can the state and the affected parties begin to consider what changes in policies, operations and contracts should be recommended, again with active and transparent stakeholder involvement.

A clear and early message from your offices of your receptivity to receive and willingness to adopt alternative budget boilerplate language as a result this process will be very appreciated.

Our two organizations are pleased to be part of this engagement process initiated by the Administration that will recommend alternate language (to Section 298), that will be consistent with the Governor's budget message. Since the intended process is to be guided by the MDHHS, and , that limited department staff resources are available we also recommend that the MDHHS utilize resources available from the State Innovation Model funding, the Michigan Health Endowment Fund or other similar innovation-promoting funding source, as this issue is consistent with the intended use of those funds. This would then enable outside firms to be used to facilitate research and discussions necessary to arrive at objective conclusions.

While we understand there is a "sense of urgency," we also cannot underscore too heavily that moving too quickly to affect change will likely fail to properly develop goals and metrics and place systems failing to align with the needs of patients.

In conclusion, we agree that a vigorous conversation needs to take place. We believe the needs of patients/consumers must be the primary concern. We think outside contractors are best suited to develop a research and conversation process that will drive stakeholders toward a set of desired outcomes. We know the SIM account has sufficient resources to provide outside facilitators and researchers to help drive an effective, collaborative process.

We are confident once those outcomes are clear, responsible parties can work together to evolve a set of processes with a high probability of achieving the desired result – as highlighted in the governor's statement: "*...improved coordination of care and a stronger focus on the needs of an individual patient...*"

To this end, we pledge our cooperation. Thank you for your consideration.

cc. Lt. Gov. Calley
Nick Lyon
Lynda Zeller
Christ Priest

Health Serv. SC
Medicaid SC

2-29-16
Rick Murdock

mahp
Michigan Association of Health Plans

February 29, 2016

Joint Committee Meeting—Subcommittee of Health and Human Services
Subcommittee on Medicaid & Subcommittee on Health Services

Testimony

Good morning. My name is Rick Murdock, and I am Executive Director of the Michigan Association of Health Plans. Our membership includes Medicaid Health Plans who contract with the state of Michigan to provide comprehensive health care services for over 1.6 million Michigan citizens in traditional Medicaid and expanded Healthy Michigan Program.

The Michigan Association of Health Plan's Board Vision for 2020 is to have improved coverage, access, value and choice for the State's population. These objectives align with those of the State to achieve greater access, value and have the impact of continuing to raise the "performance bar" for improved outcomes from Medicaid Health Plans.

Policy makers, administrators and the public rightfully expect (and we believe receive) value from the Michigan's Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management and single point of accountability. It is through this emphasis built into the state's Medicaid Contract that Michigan's Medicaid health plans continue to rank among the nation's best as determined by the National Committee on Quality Assurance, NCQA.

MAHP has recently completed its annual revision of its strategic objective for Medicaid and will be sharing that document and its information with members of these subcommittees and staff in the coming days and weeks as schedules permit. I appreciate the opportunity however to offer a few comments today regarding the Executive Budget for Fiscal Year 2017.

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1. **Medicaid Services**. Michigan has invested in developing and nurturing a strong Medicaid managed care program over the past 18 years, and most recently administering a re-procurement process that:
    a. Reduced the number of contracting health plans from 13 to 11
    b. Aligned the service area with the new "10 prosperity regions"
    c. Implements a common pharmacy formulary;
    d. Merges the MI CHILD contract and Healthy Michigan Program into a single contract;
    e. Continues inclusion of enrollment for CSHCS, Foster Care Children, Pregnant women; and
    f. Adds additional performance requirements in areas of population health, patient centered medical homes and health homes, information technology and integration.

Assuring the financial support for managed care is tied to actuarial soundness. Providing appropriate increases based on actuarial soundness criteria and assumptions are necessary to meet the contractual requirements. **The MAHP and members therefore appreciate and support the Executive Budget recommendations regarding actuarial soundness for both traditional Medicaid services and the Healthy Michigan Program.**

Funding Medicaid is always a challenge. Michigan has been creative over the years and has relied on a strong partnership with the provider and delivery systems to support the program with provider taxes, fees, and assessments. This will continue to be a challenge in coming years due to dynamics associated with the state's reliance of a use tax after December 31, 2016. **Making up a part of the loss of revenue was the caseload assumption for FY 17 and we are hopeful that these assumptions are on target and encourage a thorough review prior to completion of the budget and assume this will take place following the May's consensus revenue conference.**

2. **Behavioral Services.**

As we all know, the Executive Budget recommends a significant change regarding the delivery of behavioral services. While no change is recommended to take place during FY 17, the Executive Budget and its boilerplate language recommend an end point and process.

We believe it is vital to get the process right before making any programmatic or resource changes. Therefore we want you to know that MAHP has and will

be working with our colleagues in the Michigan Association of Community Mental Health Boards, MACMHB, to advocate strongly for a robust stakeholder process and as you know, our two organizations along with other groups are already engaged with the Administration on this issue through a process convened by the Lieutenant Governor similar to that as envisioned by the proposed boilerplate.

I was pleased to submit correspondence regarding this issue and to place in writing that we (MAHP and MACMHB) expect that one of the outcomes of this stakeholder process will be recommendations that will help frame your final budget boilerplate recommendations that would result in replacing the section 298 with language that more closely reflect the wording in Gov. Rick Snyder's executive budget statement on integration and I quote from the executive budget message:

The governor recommends that the state begin the process to better integrate mental and behavioral health services with a patient's physical health treatments. The governor expects to see improved coordination of care and a stronger focus on the needs of an individual patient by initiating a process by which all patient services are closely integrated. This budget recommendation asks the legislature and the health provider community to engage in an important conversation about integrating physical and behavioral health services into the larger consideration of patient need.

The MAHP and members are not only willing but anxious to participate in such a stakeholder process and look forward to working collaboratively with the administration and various groups. We have also begun a process of commissioning a study that will illustrate the utilization and cost of services provided by the Medicaid Health Plans and Prepaid Inpatient Health Plans, PIHPs to beneficiaries jointly served by these systems.

Summary

In summary, MAHP:

1. **Recommends support for the Executive Budget Recommendations regarding Actuarial Soundness for managed care.**
2. **Has concern regarding the underlying case load assumption and encourages a review prior to final budget.**
3. **Commits to participating in and supporting a stakeholder process, whose recommendations should be used to replace the current boilerplate language on integration.**

Health Services SC Bonnie Gonzalez 2-29-16
Medicaid Sc
(64)

Date: February 29, 2016

To: House Appropriations Committee

From: Bonnie Gonzalez
Recipient of Medicaid Specialty Mental Health Services and Supports
Board Member: HealthWest CMH
Board Member: Lakeshore Regional Entity; Chair Legislation and Advocacy Committee

Re: Governor Snider's FY17 DHHS Budget
Boiler plate Section 298 – Opposition as written

While I believe in Healthcare Integration has positive possibilities. While integrated healthcare provides for stability in lives of those with disabilities, it imposes so many different aspects of a person's life. Since HealthWest CMH began their integrated clinic I feel empowered by the team approach in which my doctors, therapists, and supports coordinator work together with me to maintain my health.

I do not think the Healthcare Plans are adequately equipped to meet the needs of individuals with developmental disabilities, mental illness, and substance use disorders in a way that's fiscally responsible and maintains a stable quality of life.
You see, for someone with healthcare needs such as ours medical necessity means something entirely different. To me, it means being functional and as independent as possible. This for me at times comes in the form of equipment. I think there needs to be a true understanding of how these things affect our lives.

A few years ago I was trying to get a power chair and I was denied a health plan. I appealed that decision many times in four years and still was denied. I was denied because the features of the chair weren't deemed medically necessary. It was fancy, but for me it wasn't a want it was a need. I live independently in my own home, not with family or roommates. I do this with assistance of 5 CLS workers. I am grateful to them, however if I had gotten that chair the amount of time and money spent on CLS, therapy, and other medical complications would have been reduced.

I don't believe a "carve in" will accomplish these goals in the timeframe specified in the Governor's budget by 2017. The changes need to be thought out and purposeful. This requires education, a willingness to think outside the box to find new ways to meet needs and provide services.

Individuals develop relationships with local CMHs and Providers who work diligently to improve the quality of life for the individuals they serve. They are already beginning to implement healthcare integration on a local level. They use innovative thinking and collaboration to effectively meet needs.

I worry that if Mental Health Service dollars are given to the Medicaid Health Plans, these options will no longer be able to be used by our people. It affects their stability of care and in turn quality of life. This would be fiscally devastating move as these types of changes could result in increased symptoms or need for more intensive services such as hospitalization or nursing home stays.

As a person with a disability I have had many experiences causing me concern should they carve in happen in such a rushed manner.

Give a solution ....purposeful...planned with the needs of people of first concern....not who controls the money. As a board member and advocate I feel a responsibility to others to ask you to reconsider the manner in which we pursue such a change.

Thank you for this opportunity to share my concerns.

Bonnie González

Health Services SC
Medicaid SC

Malkia Newman 2/29/16 (61)

Malkia Newman
433 Harvey Ave.
Pontiac, MI 48341
248-342-9921

Malkia M. Newman - My Statement to House Appropriations Committee
Public Comment February 29, 2016

"It's been a Long Time Coming but I Know, A Change Gon' Come! Oh yes it will!"

My name is Malkia Newman, I'm a resident of Pontiac, MI, born and raised. My entire life I have lived in this state and I've seen a lot of changes that have happened over the past 50 years.

I'm increasingly troubled by what I perceive is an all-out war on people with mental and physical challenges, substance use disorders, which many refer to as "the disabled", people of color, and people who live in the "lower-income" brackets.

It appears to be a steady erosion of the public safety net that was designed to support people who have limited options or opportunities. I shudder to think of what could happen to our most vulnerable citizens if the Boilerplate 298 language is not removed and is allowed to be a part the governor's proposed Health and Human Services FY' 17 budget.

I myself am a success story of the community mental health system. I came to Oakland Co. Community Mental Health Authority in crisis in 2004. I was successfully stabilized, given medication, support and a place to live.

Within one year I was working a part-time job in the system doing community education around mental health issues, most specifically stigma. Stigma was found to be one of the top reasons why people don't seek treatment as stated by US Surgeon General David Thatcher in his 1999 Report on Mental Health in America. I am happy to report that I have maintained 10 years of continuous employment at Community Network Services, Inc. a provider agency of mental health services to adults in Oakland Co.

In 2006 I married my husband, Dubrae Newman, June 5th we're celebrating our 10th year wedding anniversary.

My position at CNS was made full-time with benefits and as of August of 2015 I became team supervisor to the program I helped to create. We consumers of CNS' Anti-Stigma Program have spoken to audiences all over Michigan, all over our nation, as well as Nova Scotia, Canada.

In 2007 I was appointed to serve as a Consumer representative on the Oakland Co. Mental Health Authority Board. In 2013 I was elected Board Chair, where I served for 2 ½ years in that capacity. This is the 1st time in the 50 year history of OCCMHA that a person who have received services from Oakland CMH has chaired the board.

In 2012 my husband and I purchased our 1st home together, I'm a proud tax-payer and homeowner in the city.

In 2013 I spoke to more than 4,000 people at Caesar's Palace in Las Vegas at the National Council on Community Behavioral Health's annual conference sharing my recovery story as a tribute the 50th anniversary of the passage of Pres. Kennedy's Community Mental Health Act of 1963.

I have received honors and recognitions at local, state and national levels and my work has only just begun.

There was no way for anyone, including myself, to know those dark days in 2004, that this woman who was homeless, battling thoughts of suicide and long bouts of depression, would one day be able to stand before you full of life, full of hope, full of purpose, a confident example of what our community mental health system is able to achieve in a person's life.

I'm not naïve, I'm well aware that there's more that needs to be done to make our system more efficient but dismantling the community mental health system is not the right way to go about developing efficiencies.

Haven't we learned anything from the fiascos of privatization that took place within the state correctional system, the shameful mishandling of the Detroit Public Schools and the scandalous actions that resulted in poisoning a whole city?

We cannot afford to make any more decisions that could potentially have negative consequences or even dismantle a system that so many families depend on daily. Before you act, please put a face on this issue. Don't just crunch numbers without considering the negative consequences that these changes could bring.

I thank you all for your time and attention.

Medicaid SC HealthServ.SC Maxine Thome and Alan W. 2-29-16

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NASW MICHIGAN CHAPTER
National Association of Social Workers

59-60

FY17 Budget Testimony
February 29th, 2016

Medicaid Subcommittee of Health and Human Services subcommittee of the Standing Committee on Appropriations and the Health Services Subcommittee of Health and Human Services subcommittee of the Standing Committee on Appropriations

Thank you for the opportunity to provide testimony to the committee. My name is Maxine Thome. I am the Executive Director of the Michigan Chapter of the National Association of Social Workers (NASW-Michigan).

NASW-Michigan and our members oppose section 298, as written. However, we applaud Lt. Governor Calley's call for a workgroup to draft alternative language and make improvements to Michigan's mental health system. We also applaud the willingness of the Department of Health and Human Services, Michigan Association of Community Mental Health Boards, the Michigan Association of Health Plans, and legislators to join in dialogue.

It is important that all stakeholders have a voice in this transformational conversation. It is clear that many stakeholders are already present. It is our hope that throughout the process consumers, families, advocacy groups, service agencies, and front line workers will also have a voice at the table. This must also include social workers, as we provide the majority of behavioral health services, play a key role in physical health, and address the social determinants of health in both systems.

In coordination with stakeholders, a clear set of goals and principles must be outlined. Only then can best practices be identified and implemented. What is most critical is that stakeholders are guided by goals and principles that emphasize and embrace self-determination, person-centered planning, recovery orientation, and the social determinants of health. As social workers these values are at the core of our profession, guided by our Code of Ethics.

Consumers deserve to have services integrated. We want to see consistency in services across systems, regardless of zip code, that provide parity between mental health, physical health, and substance use disorders. It is important that this be done in a way that maximizes dollars to direct services without risking quality and maintains local oversight and consumer involvement. We don't want to see consumer services reduced, jobs of front line workers lost, or costs shifted from one system to another by conflicts over who should serve a consumer.

It is also critical that the Healthy Michigan Plan, General Funds, and traditional Medicaid are adequately funded to assure the health and well-being of the people of Michigan.

It is clear from the conversations thus far that these types of guiding goals and principles are all very important to other stakeholders as well. We look forward to engaging in the dialogue and supporting a system that provides a healthier Michigan for everyone.

Thank you for your time. I'm happy to answer any questions.

Health Services SC
Medicaid SC

(58) Jane Sherzer
2-29-16

House Appropriation Department of Health and Human Services Subcommittee
Testimony – Michigan Psychiatric Society
FY 2017 Budget
February 29, 2016

Thank you Chair and members of the committee, my name is Jane Sherzer and I represent the Michigan Psychiatric Society (MPS). MPS is the statewide organization representing psychiatry and psychiatrists in Michigan that includes over 750 number of MDs and psychiatry practitioners in across the state. On behalf of MPS, I would like to express our concern for Sec. 298 boilerplate language added to the DHHS budget that would re-design public mental health in Michigan and transfer service funds currently routed through the Prepaid Inpatient Health Plans (PIHPs), which oversee the Community Mental Health system, to Michigan's Medicaid Health Plans. As we understand this language, this provision would cede control and financing of all CMH programming to the Health Plans, effectively privatizing the non-profit mental health system in Michigan.

MPS has many concerns with this approach first of which is process. The success of such a large undertaking depends on the good will and coordinated effort of all key stakeholders. There are approximately 2 million combined Medicaid and Healthy Michigan Plan enrollees, of which 1.3 million are in managed care. The combined budget of the PIHPs and the Health Plans is over $10 billion.

We are disappointed that a major health policy shift such as this was not vetted through a collaboration of key stakeholders prior to introduction. As it is, it seems that the plan was developed without the involvement of the PIHPs, providers, and the advocates, all of whom will of necessity need to be positively engaged and involved for any plan like this to succeed. While the budget plan will force a lengthy and wide-ranging discussion amongst the involved stakeholders, it would seem to have gotten off to a rocky start with the piecemeal approach used to date.

Further, with the appearance of the plan in a budget document, we are discomforted by the implication that the primary driver for the change is financial. We certainly understand that there are obvious pressing financial needs in Michigan right now, but we firmly believe looking in the public mental health system is not the right place to save dollars right now. We have watched the public mental health system struggle for years with limited and shrinking funding. There already exists the considerable risk that significant mental illness can be underdiagnosed and undertreated, to no one's benefit. One can hardly peruse any media outlet these days without the need for improved mental health services being a topic. This is a problem inherent throughout the entire health treatment system in the United States, and Michigan certainly is not immune to the issue.

While the Governor's budget does not specify a dollar amount, the Health Plans have suggested that operational and administrative efficiencies could net some $200 million in savings. We

would like to see the detail of any such plan and have an opportunity to analyze it carefully. It is difficult for us to see, at least at the outset, how combining the administrative structures of 10 PIHPS and 11 Health Plans, all overseen by a contracted "administrative service organization" as specified by Section 298 will result in any savings. We are certainly in favor of any reasonably achievable savings. However, after witnessing the incredibly hard work on the part of the CMH system over the past 20 some years to cut costs and still present an effective detection and treatment effort, we are not convinced that savings of this magnitude are legitimately possible. The CMH system and the patients it serves have been subjected to numerous budget restrictions over the years, the most onerous being a $200 million cut, from FY 13 to 15, that accompanied the startup of the Healthy Michigan Plan. Instead, we are very concerned that taking money out of the mental health budget would of necessity come out of service delivery, a dangerous development, in our view. For example, after falling from 1990-2000, suicide rates (suicide remains the tenth most frequent cause of death in the United States) are on the rise again in our country. This surely is not a time to weaken our efforts to identify and treat mental illness.

And this discussion leads to another set of concerns and questions. The budget plan appears to rest on primarily financial and administrative drivers, and has not sufficiently involved the input of expert mental health providers from what we are able to determine to date. We would like to hear much more from expert clinical opinion readily available throughout the state about the best ways to look at any attempts to further integrate care. Michigan has many sources of clinical expertise in the mental health field and any recommended change would benefit from a collaboration of these resources.

Both the Health Plans and the PIHPs will benefit from the clinical synergies forged by improved integration, but this will surely require much thought and planning. While Section 298 does allow for the development of the plan over the next 18 months prior to full implementation, it appears that most of the effort over the next 6 months will be involved in sorting out administrative, financial, and political aspects of the plan. We would strongly caution that clinical imperatives not be overlooked, treated too lightly, or unduly delayed in this process.

Lt. Governor Calley has recently organized a workgroup consisting of the mental health community and the behavioral health community to begin the process of vetting the effects of Sec. 298. As discussed above, this will be an intense process that will require much consideration. MPS believes it is important to allow this workgroup process to fully form and provide recommendations. That being said, there are concerns that this process will not be able to be completed under the same time-line as the FY 2017 budget. <u>We respectfully request that this committee remove Sec. 298 from the proposed FY 2017 and reevaluate this proposal when once the workgroup has provided its recommendations.</u>

Thank you for your consideration. If you have further questions or would like additional information, please feel free to contact me at jsherzer@mpsonline.org

Health Services SC
Medicaid SC

Karen Bethley 2/29/16

51

Michigan Senior Volunteer Programs

HOUSE TESTIMONY

February 29, 2016

Good Morning Committee Members:

I am speaking on behalf of the Senior Volunteer Program of Michigan, which includes the Foster Grandparent Program (FGP), Retired & Senior Volunteer Program (RSVP) and the Senior Companion Program (SCP). Funded by the Michigan Department of Health and Human Services, Aging and Adult Services Agency, Michigan's Senior Volunteer programs provide meaningful opportunities for older adults, age 55 and better, to engage in service to their local communities. Michigan is home to 20 Retired & Senior Volunteer Programs, 19 Foster Grandparent Programs and 14 Senior Companion Programs. Together, we serve 73 of Michigan's 83 counties.

For more than 40 years, the Michigan Legislature has recognized the value and importance of one of our state's strongest resources, our senior volunteers. Through the funding allocated by the state each year, the Senior Volunteer Programs provide quality, life enhancing volunteer opportunities for older adults, while assisting nonprofit, health care, and government organizations in achieving their missions and expanding services.

Foster Grandparents are low-income older adults, who provide sustained one-to-one attention and assistance to vulnerable children, with the purpose of improving self-esteem and supporting the child's ability to learn, and succeed in school and life. Foster Grandparents commit an average of 20 hours per week to provide a stable, caring relationship for children who often come from chaotic and unpredictable environments. In exchange for their service, Foster Grandparent receive a small, non-taxable stipend of $2.65 per hour. Annually 1,057 Foster Grandparents provide service in 750 educational setting to support over 2,500 children who are academically delayed, lacking self-esteem or motivation, experiencing behavior or social problems and are at risk of dropping out of school, all of which can cause additional economic stress on our communities.

The Retired & Senior Volunteer Program (RSVP), one of the nation's largest volunteer efforts, invites older adults to utilize their skills, talents, and life experience to make a difference in their community, through direct service and collaboration with established non-profits, schools, government, and public organizations. RSVP Volunteers serve their communities by tutoring and mentoring children, providing companionship, support, and medical transportation for older adults, protecting the safety of their peers through partnerships with

law enforcement, and supporting the health of our state's lands and waters. Each year more than 8,100 RSVP Volunteers contribute in excess of 850,000 hours of service to nearly 1,500 organizations, projects and communities across Michigan.

Senior Companions are low-income older adults who play an important role in supporting frail seniors and adults with disabilities in their quest to live independently for as long as possible. Senior Companion volunteers add richness to the lives of their clients, while providing access to their community, including grocery shopping, transportation to medical appointments, and opportunities for socialization. Similar to Foster Grandparents, Senior Companions receive a small, non-taxable stipend for their service. Each year more than 500 Senior Companions support in-home and long-term care services for more than 3,300 Michigan citizens at risk of institutionalization. Senior Companions help seniors live independently in the communities where they choose to reside.

I'd like to highlight some of the ways that the senior volunteer programs are helping to make Michigan a safer, healthier, and happier place to live.

Education: An FGP or RSVP Volunteer in the classroom is more than helping hand. As eager to share their knowledge as the children are to learn, each year senior volunteers provide support to more than 1,000 educational settings and programs across Michigan. Engaged in tutoring and mentoring activities, literacy projects, and early childhood through adult education, more than 3,500 Foster Grandparent & RSVP volunteers contributed over 1 million hours of service in support of improved education for Michigan residents during 2015.

Health Care: Senior volunteers aid in a healthier Michigan by supporting prevention programs and services, providing respite for individuals and families with health concerns, navigate the complexities of Medicare and Medicaid and help enroll seniors for prescription coverage, and by providing access to care through medical transportation services. During 2015, 2,000 senior volunteers contributed in excess of 150,000 hours of service to 200 health-related organizations across the state.

Protecting the Vulnerable: RSVP & SCP Volunteers are significantly involved in programs that provide a safety net for Michigan residents. These volunteer deliver meals on wheels to homebound seniors, provide supportive services to help older adults remain as independent as possible, volunteer with food banks and provide free tax assistance to seniors. During 2015, 7,000 senior volunteers contributed more than 800,000 hours of service to protect Michigan's vulnerable populations.

For more than 40 years, FGP, RSVP, and SCP Volunteers have played a role in shaping successful communities across Michigan. We thank you for your support over the years and look forward to your continued support in the future.

Testimony Provided By:

Karen Betley
President, Michigan Association of Foster Grandparent/Senior Companion Programs (MAFG/SCP)
Director, Kalamazoo County FG/SCP
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Lindsey Brieschke

Michigan must address the Alzheimer's crisis.

Health Services SC/Medicaid SC

6 Alzheimer's is **the 6th leading cause of death** in the U.S.

"It's like having the volume turned slowly down on your favorite song; Alzheimer's takes them ever so gradually as their vitality, personality, and everything we know about them fades away."

– Cynthia, Ann Arbor

Michigan spends $1.2 billion caring for the more than **180,000 people** in our state living with Alzheimer's & dementia, a number that is expected to reach **more than 220,000 people** and **cost our state $1.7 billion** by 2025.

There are **more than 500,000 Michiganders serving as caregivers** for someone with Alzheimer's.

One in three seniors die with a diagnosis of Alzheimer's or another dementia.

Lindsey Brieschke 7/29/16 (Sob)

It is **the only cause of death among the top 10** that cannot be prevented, cured or even slowed.

Average per-person Medicaid **spending for seniors with Alzheimer's and other dementias is 19 times higher** than for all other seniors.

$$$$$
$$$$$
$$$$$
$$$$$

"I BELIEVE IN A WORLD WITHOUT ALZHEIMERS. I CLOSE MY EYES AND I CAN TELL YOU WHAT IT LOOKS LIKE AND THE EMOTIONS THAT I FEEL. WHEN I DON'T HAVE TO CLOSE MY EYES TO SEE IT, I CAN DIE HAPPY."

– TYLER, MARQUETTE

Alzheimer's is a triple threat with

Soaring prevalence

Lack of treatment

Enormous costs that no one can afford

The Michigan Care & Support Pilot Project

Michigan **must invest** in caring for people with Alzheimer's **in their own homes.**

three counties served

In 2014 Michigan implemented the Alzheimer's Care and Support Pilot project in Monroe, Macomb and St. Joseph Counties.

Now entering its third year, this project, through the Alzheimer's Association's Michigan Chapters, enables social workers to **provide care and support services for approximately 250 people living with Alzheimer's** disease and their caregivers. Services include:

- 24/7 Helpline
- care planning and ongoing consultation
- dementia education and community support groups

cost savings

Modeled after the North Dakota Care and Support Pilot, the Association is partnering with a third party researcher to collect and analyze program data related to **cost savings in Medicaid long term care, 911 calls, ambulance services, emergency room visits and hospitalizations.**

$150 thousand needed

The Alzheimer's Association Michigan Chapters **received $150,000 to support** years one and two of this pilot. An investment of $150,000 for year three will provide ongoing support & services to complete the project and **demonstrate savings by delaying and preventing Medicaid skilled nursing home care.**

savings of $40+ thousand per family each year

The average cost of a semi-private room in a nursing home in 2012 was $228 per day, or $83,230 per year. At the same time, the average cost for a paid non-medical home health aide was $168 a day, or $42,336 per year.*

**2014 Facts and Figures Report. Use and Costs of Health Care, Long-Term Care and Hospice. Pg50-51.*

By supporting families at home, **we can delay, and in some cases prevent** the need for skilled nursing care; thus **saving our state money.**

Programs & services for Michigan residents

The **Alzheimer's Association** provides care and support for Michigan residents living with or caring for someone with Alzheimer's disease and related dementias. Our mission is to eliminate Alzheimer's disease through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. Our vision is a world without Alzheimer's disease.®

24/7 Helpline - Serves 11,000 people annually. The 24/7 Helpline - 800.272.3900 - provides support, education and referral services to individuals seeking information about Alzheimer's disease and related dementias.

Care Consultations - Serves 3,500 families annually. Care Consultations help families understand Alzheimer's disease and develop an individualized care plan that maximizes symptom management and communication.

Education Programs - Annually reaches over 6,000 people through over 400 programs. Education programs inform professionals, families, and the community about Alzheimer's disease and research trends.

Safety Services - One in six seniors with Alzheimer's disease will wander. MedicAlert® + Alzheimer's Association Safe Return® and Comfort Zone® are devices and services that help protect and locate individuals with memory loss who wander or have a medical emergency.

Early-Stage Programs such as Social Clubs, Support Groups and Lectures - Reaches about 200 people every year. Participants in the early stages of memory loss meet to engage in activities that promote cognitive, physical and social stimulation. The Early-Stage Lecture Series is a six-week series that allows individuals in the early stages and their caregivers to learn about and discuss Alzheimer's disease.

Family Caregiver and Early-Stage Support Groups - Helps over 5,500 people annually. Support groups allow participants a safe and confidential place to share experiences, resources and support.

Creating Confident Caregivers/ Savvy Caregivers - In partnership with the Michigan Office of Services to the Aging and the Area Agencies on Aging, this program provides an in-depth education experience for family caregivers living with the person with dementia. This training program has been proven to reduce caregiver stress by empowering caregivers with useful tools and information.

A world without Alzheimer's must start in Michigan

2016 PRIORITIES:

Update and Implement Michigan's State Dementia Plan

An updated plan will prepare Michigan to address a range of issues including:

- Improving the quality of the health care system in serving people with Alzheimer's.
- Increasing awareness of Alzheimer's disease among the public; encouraging early detection.
- Better equipping health care professionals and others to deal with individuals with Alzheimer's.
- Meeting the needs of unpaid caregivers.

Continue the Michigan Dementia Care and Support Pilot Program

In 2014 Michigan implemented the Alzheimer's Care and Support Pilot project in Monroe, Macomb and St. Joseph Counties, enabling social workers to provide in-home care and support services for approximately 250 people living with Alzheimer's disease and their caregivers.

Increase State-Based Surveillance through the Behavioral Risk Factor Surveillance System (BRFSS)

Michigan aims to include questions related to cognitive impairment and caregiving in the state BRFSS to provide a better understanding of, and to identify opportunities for reducing the impact of Alzheimer's disease.

Improve Dementia Training

Michigan should implement policies that support dementia training for students, medical professionals, and first responders to prepare those that provide direct care to those facing Alzheimer's.

Raise Awareness

In 2014 and 2015, Governor Rick Snyder led the State of Michigan in "going purple" for the month of June, in order to help bring attention to Alzheimer's Disease.

Lessons Michigan can learn from other states

FLORIDA

Appropriated $3 million for research grants and $2.35 million for Alzheimer's respite care services to serve individuals on the waitlist statewide and Care and Support Services

MASSACHUSETTS

Appropriated $5.5 million to the advisory council on Alzheimer's disease and related disorders and $250,000 toward an initiative to address the needs of individuals with developmental disabilities who are aging, including individuals with Alzheimer's disease.

MISSOURI

Appropriated $100,000 for grants to non-profit organizations for services to individuals with Alzheimer's disease and their caregivers, and caregiver training programs including in-home training.

NEW YORK

Appropriated $50 million over two years for services related to expanding existing caregiver support services for persons with Alzheimer's and other dementias.

VIRGINIA

Appropriated $319,750 each year for Alzheimer's research; $456,209 each year for two years to continue a statewide Respite Care Initiative program; $70,000 each year for two years to provide dementia-specific training to long-term care workers in licensed nursing facilities, assisted living facilities and adult day care centers and local law enforcement.

Health Services SC Lindsay Brieschke
Medicaid SC 2-29-16
50a

Michigan House of Representatives
Appropriations Subcommittee on Community Health Committee Meeting
Monday, February 29, 2016
Text of Public Testimony Provided by Lindsay Brieschke, Alzheimer's Association – Michigan Chapters

Representative VerHeulen and members of the Committee,

My name is Lindsay Brieschke. I am the Director of Public Policy for the Alzheimer's Association – Michigan Chapters. Thank you for hearing my testimony today.

- Alzheimer's disease is the most expensive disease in America. More expensive than heart disease and cancer.
- Alzheimer's is not just memory loss. It's fatal. It has no cure, no treatment, and no way to slow its progression.
- 180,000 Michiganders are living with Alzheimer's or another dementia.
- More than a third of persons over age 85 will die of Alzheimer's or dementia.
- Lastly, Alzheimer's disease prevalence has increased by 68% since 2000 and it is expected to continue to skyrocket with the aging of the baby boomers. Michigan is anticipating nearly a 30% increase in Alzheimer's by the year 2025.

With this information as background, I'd like to urge the committee members to support the continuation of the Michigan Alzheimer's Care and Support Pilot for the third year. This pilot program aims to demonstrate that care consultation for caregivers and persons with Alzheimer's can delay or prevent long-term care placement and ultimately help to reduce Medicaid nursing home costs to the state of Michigan.

This pilot program currently provides care and support services in three Michigan Counties – Monroe, Macomb and St. Joseph. In these counties, master level social workers provide in-home care and support for people living with Alzheimer's and their caregivers. In addition, the Alzheimer's Association is partnering with the University of Michigan to study the program's return on investment to the State of Michigan and ability to improve caregiving outcomes. To date the program has shown increases in the caregivers' capacity to provide care and to keep their loved one at home.

In order to prepare for the aging of the baby boomers, we must invest in programs and services like these that help seniors to plan for the emotional and financial toll of this disease.

alzheimer's association

Investing in the continuation of this pilot program will support state agencies charged with caring for older adults and will help to prepare Michigan for the aging of the baby boomers. I kindly ask that you will consider our request to continue to fund the Michigan Alzheimer's Care and Support Pilot at $150,000 in fiscal year 2017.

Thank you again for hearing my testimony. I will he be happy to take any questions.

Sincerely,

Lindsay Brieschke
Director of Public Policy
Alzheimer's Association – Michigan Chapters
lbrieschke@alz.org
734-320-8898

Health Services SC
Medicaid SC

Bruce Timmons 2-24-16

(49)

February 29, 2016

Memorandum to: Members of the Medicaid Subcommittee and the Health Services Subcommittee of the Health and Human Services Subcommittee of the Michigan House Appropriations Committee

From: Bruce A. Timmons

Re: FY 2016-17 Proposed Budget for the Department of Health & Human Services – Funding for the Statewide Trauma System – CVRF

Three years ago I retired after 45 years as an employee of the Michigan Legislature, the last 30 years as a policy advisor for the House Republican Policy Office. I did not cover health or DHHS issues but I did cover judiciary and criminal justice issues for all 45 years, including working closely with Rep. William VanRegenmorter on the Crime Victim's Rights Act that now bears his name and on 1988 HJR P that is now Art I, Sec. 24. That is why I am concerned about what I believe is an inappropriate, if not illegal, use of the Crime Victim's Rights Fund (**CVRF**) for a statewide trauma system.

First, six years ago another House Committee heard testimony that Michigan was one of the few states without a statewide trauma system. I am not aware of anyone who is questioning the need or benefit of such a system. It would improve the medical response of anyone, whether resident or visitor, in immediate need of emergency time-dependent treatment. I support the effort to create the system.

Second, I would encourage the Committee to include in the FY 2016-17 Budget for DHHS **$3,500,000** from the general fund (**GF/GP**) for development of the statewide trauma system. This is a program that would benefit the entire state. The request represents – about 0.02% (0.00018) out of a budget of $19+ Billion. I am fully aware that Medicaid, federal funds, and restricted revenues may not be available, but the proposed sum would represent 0.1% (.001) of the proposed GF/GP. It is a matter of priorities.

Third, **Exec Rec represents misuse of the crime victim's rights fund (CVRF).** The authority for the CVRF is the Michigan Constitution, Article I, Section 24, that established 9 specific "rights" to which a crime victim is entitled. Art I, §24, allows for an "assessment against convicted defendants to pay for crime victims' rights". (Emphasis added.) Those rights are as follows:

The right to be treated with fairness and respect for their dignity and privacy throughout the criminal justice process.

The right to timely disposition of the case following arrest of the accused.

The right to be reasonably protected from the accused throughout the criminal justice process.

The right to notification of court proceedings.

The right to attend trial and all other court proceedings the accused has the right to attend.

The right to confer with the prosecution.

The right to make a statement to the court at sentencing.

The right to restitution.

The right to information about the conviction, sentence, imprisonment, and release of the accused.

(continued →)

The purpose of the assessment was to create a funding mechanism to reimburse counties for the expenses incurred in providing crime victim's rights under 1985 PA 87, the Crime Victim's Rights Act – to honor the portion of the **Headlee** Amendment against unfunded mandates on local government. 1985 PA 87 and HJR P (Art I, §24) were sponsored by the same legislator – William Van Regenmorter. The CVRF assessment enacted in 1989 applied only to felonies and to select misdemeanors where there was a potential for victimization, such as drunk driving.

The only expression of legislative direction to DHHS with regard to establishment of a statewide trauma system was in Section 1904 of the DCH Budget in 2014 PA 252 – for which 2015 PA 9 (SB 138) shifted the source of funding from GF/P to CVRF – stating how a $1.3 million 1-time appropriation for a statewide trauma system was to be used:

> **Sec. 1904**. From the funds appropriated in part 1 for the statewide trauma system, the department shall allocate funds to establish and operate statewide systems for **trauma, stroke, ST segment elevation myocardial infarction, perinatal, and other time-dependent systems of care**.

It is readily apparent that the purpose declared in Sec. 1904 has nothing to do with the rights specified in Art I, §24 – all of which are related to the criminal justice process. The purported benefit to crime victims is little more than a guise to access restricted revenue that was never intended for that purpose. The Legislature cannot amend the Constitution by statute. Use of CVRF assessment money for a statewide trauma system is contrary to what voters adopted in Art I, §24, in 1988.

Fourth, **in 2010** the crime victim rights assessment was extended to **all** misdemeanors (like trespass, minor damage to property {no injury to a person}, or minor in possession of alcohol) simply to raise enough money – not for crime victim rights services – but for the statewide trauma system. That is a misuse of the court system to raise revenue for purposes unrelated to the case – not as punishment for the crime, or to reimburse government for the cost of the criminal justice system, or for restitution to victims. That is a precedent we could do without.

Fifth, there is an utter lack of transparency in the budget about the statewide trauma system – both as to the amount appropriated for it and the source of funding. That program currently [2015 PA 84] and as proposed for FY 2016-17 is buried under a line-item for "Emergency medical services program" in the DHHS budget with no identification that the money for the trauma center system component is from the CVRF – obscured as to funding by the generic "other [unidentified] state restricted revenue". There is no reference whatever that the money to be used now is from the CVRF. In fact, even the appropriation for Crime Victim Services Commission does not identify the restricted revenue source and there is no reference to the CVRF among the state operating funds in PA 84, Art IX, Sec. 1201, even though the CVRF has more revenue and balance than many of those listed. That is basically continued under Exec Rec for FY 2016-17 (1 line of $15 million for service grants out of $78 million for the CVSC). Public has no way to track this funding in DHHS or how it is being spent – since 2010.

Therefore, I urge the Committee and Legislature to cease using the Crime Victim's Rights Fund as the source of funding for the statewide trauma system. Use GF/GP.

16-fy17-dhhs-022916-bt

Health Services SC
Medicaid Sc

MS, Feldman 2-24-16 (45)

MICHIGAN HEALTHCARE SERVICES

Who We Are

Maxim Healthcare Services, Inc. provides home healthcare, medical staffing, and wellness services to individuals with a variety of healthcare needs. Maxim has a unique expertise in providing services to specialized populations including many children who need assistive technology to sustain life. Many of Maxim's patients and clients qualify for medical assistance. Maxim employs more than 50,000 people across the country.

Our Homecare & Wellness Services

Maxim provides homecare services to a variety of different patient populations including many children, medically complex, permanently disabled and wheelchair-bound patients who require extended or continuous care with treatments such as ventilation, tracheotomy, G-tube feeding, specialty medication and oxygen administration. Maxim caregivers enable these patients to receive care in their homes in a way that is more comfortable and cost effective than treatment through a long-term hospitalization or skilled rehabilitation center.

These services also frequently allow parents to continue to work in their communities while caring for their children at home. The alternative treatment setting for many Maxim patients could be an institutional setting that may often be located far from the patient's home.

Our Staffing Services

Maxim Staffing Solutions offers a single point of contact for different healthcare facility needs. We are devoted to specific specialties, such as: Nurse Staffing, Allied Health, Administrative Staffing, Traveling Nurses & Allied Health, Supplemental Physician Staffing, Health Information Services, Government Services, Direct Hire and Executive Search for Healthcare Facilities, Physician Recruiting, and Interim and Professional Placement (Hospitals, Nursing Homes, Clinics, etc.).

Our Commitment to Compliance

Maxim has more than doubled the size of its Compliance Department, currently a Department of approximately 60 people, to enhance internal monitoring capabilities, introduce a new auditing program, and support a confidential disclosure hotline administered by an independent third party. All Maxim employees are required to complete annual compliance training that aligns with federal, state, and program requirements. The Company has also established a Clinical Education Department which has helped our employees complete more than 850,000 courses since August of 2010.

2015 Homecare Snapshot

Michigan Patients

- Total Patients: 385
  - Adult Patients: 224
  - Pediatric Patients: 161

Michigan Employees

- Caregivers: 542

Payor Mix

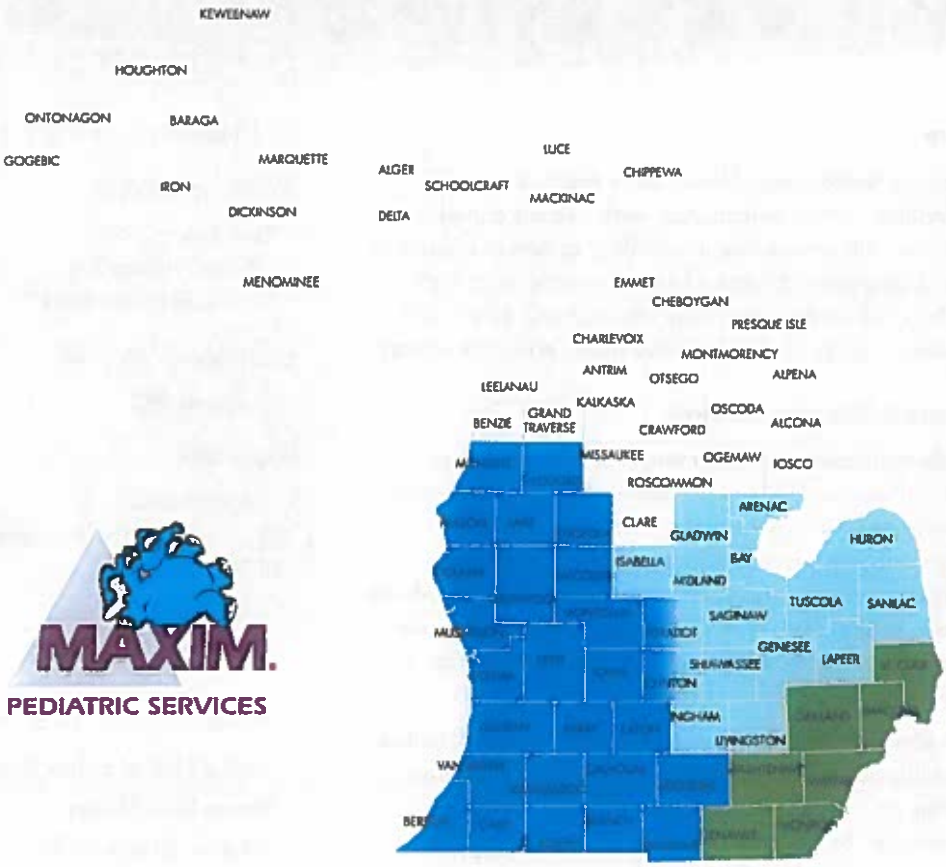
- 51.6% Medicaid
- 29.7% HMO/Workers Compensation
- 10.2% Government
- 8.4% Other

Some of our areas of expertise include*

- Skilled Medical and/or Non-medical Care
- Private Duty Nursing
- Infusion Therapy IV/IG
- Disease Management Teaching Visits
- Rx Injection Training
- Wound Management
- Visiting Nurse/RN Assessments
- Well Mom/Well Baby Visits
- 24-7 Companion Care
- Assistance with Activities of Daily Living
- Case Coordination Services
- Medication Management Visits

*Actual services provided vary by office, please contact your local office to determine the services provided.

Contact us Today and Experience the Maxim Difference in Michigan



MAXIM HEALTHCARE SERVICES

MAXIM PEDIATRIC SERVICES

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SURROUNDING COUNTIES
Please contact the closest Maxim office location for coverage information.

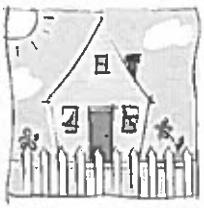
Health Services SC Jim Casha 2-29-16 (43)
Medicaid SC

National Organization on Fetal Alcohol Syndrome
Helping children & families by fighting the leading known cause of mental retardation & birth defects

FASD: What the Foster Care System Should Know

The majority of children with Fetal Alcohol Spectrum Disorders (FASD) are not raised by their birth parents.

- It is reported that up to 80% of children with FASD do not stay with their birth families due to the high needs of parents and children.
- Studies suggest that a rise in alcohol and drug use by women has resulted in 60% more children coming into state care since 1986.



The incidence rate of FASD is unusually high among the U.S. foster care population.

- It is estimated that almost 70% of the children in foster care are affected by prenatal alcohol exposure in varying degrees.
- Children from substance abusing households are more likely to spend longer periods of time in foster care than other children (median of 11 months versus 5 months for others in foster care).

Many children with FASD go unidentified or are misdiagnosed. Often, behavioral problems caused by brain damage due to prenatal alcohol exposure are mistakenly thought to be solely a result of difficulties in the child's previous home environment.

Secondary behavioral disorders associated with FASD can further complicate a child's transition into and out of foster care homes.

Children with FASD often have difficulty :

- translating body language and expressions;
- understanding boundaries;
- focusing their attention; and
- understanding cause and effect.

Children with FASD can be easily frustrated and require a stable, structured home and school environment. Adjusting to a new home, a new family, and a new school can be particularly difficult.

Children with FASD can benefit from:

- Consistent routines;
- Limited stimulation;
- Concrete language and examples;
- Multi-sensory learning (visual, auditory and tactile);
- Realistic expectations;
- Supportive environments; and
- Supervision.

The foster care system can help prepare for children with FASD by:

- Providing training to foster care/adoption personnel to help recognize the disorder's characteristics in order to seek diagnoses for suspected cases and ensure appropriate placements;
- Providing education to parents entering the foster care system, as well as for families who already have foster children, in order to help recognize the disorder's characteristics, seek a diagnosis, and appropriately respond to the unique needs of the child; and
- Developing and/or enforcing policies on obtaining and disclosing information on birth mothers' history of drinking during pregnancy.

900 17th Street • Suite 910 • Washington, DC 20006 • Phone: 202-785-4585 • 1-800-66-NOFAS • Fax: 202-466-6456 • E-mail: information@nofas.org

Health Services SC John Miles 2-24-16
Medicaid SC

39

My name is John Miles and I am a Parent Support Partner for Family Alliance for Change in Wayne County. I am one of 10 Parent Support Partners that partner with 12 Community Mental Health agencies throughout Wayne County and we service 150 to nearly 200 families weekly

There are approximately 300,000 Michigan residents who currently are being serviced by the public mental health system. I can honestly say, I don't know, of the 300,000 how many of those families are in Wayne County. I can honestly say I don't know how many families are not being counted because they have no idea of the services that are available to them

But this is what I do know. My families I service need to be the priority, not administrative pockets. My families are concerned about their services being protected and available not about who is making a profit. My families want to be "first" in consideration and first in conversation

Let the families have a voice at the table as changes are being proposed

And by the way my families are currently ~~saying no~~ opposed to Section 298

My Opposition to Section 298 of the FY 2017 MDHHS Budget Plan (38)

February 29, 2016

Section 298 seems to be the largest cuts to behavioral health services ever in Michigan. I don't believe integrated funding is parallel to integrated care. As a parent and a Parent Support Partner in Wayne County working with families and in the communities in which we serve, I've seen firsthand some of the more complex dynamics of mental health care needs. I've seen how it affects the community, schools, homes and even our children when services are eliminated. I understand the added stress to our public services when funding is cut; such as an increase in crime and arrests. I understand an increase in homelessness when jobs are loss and families are torn apart because of reduced treatment coupled with a lack of funding for medication. It requires a System of care with an array of non-traditional components such as housing, employment, education and transportation support to even begin to see an individual or a family address the trauma and regain stability. Healthcare plans are not held to the same standards. Mental health services require a collaboration of multiple entities working together to not only provide services but to also protect and provide a safety net. The proposed business model, for profit will heighten the risk for the populations we serve. Why must the most vulnerable and needy populations bear the burden of budget cuts? Isn't it the government's responsibility to care for and provide the best services possible for all citizens and their families? A lack of funding and services will ultimately force these citizens into a more costly in-patient or hospital setting. Services will decrease during this transition, putting the lives of us all in jeopardy and we often times see how that plays out tragically in the media. Not to mention what this will mean for Substance Use Disorder services. I do believe there needs to be more conversion surrounding these issues. These conversations should also include consumers, advocates and overall community voice. Finally, I believe the management should have public oversight.

Sheryl Calloway, Parent Support Partner
3627 W. Vernor Detroit, MI 48216
(313) 297-2975 (office)

Health/Services SC
Medicaid SC

Katie Cahill 4/7/16

(33)

Making Michigan a No Wait State
Testimony for the Silver Key Coalition
Health and Human Services Subcommittee
February 29, 2016

Silver Key Coalition
Working to Make Michigan a No Wait State for Senior In-Home Services
www.silverkeycoalition.com

My name is Katie Cahill and I am the Advocacy Specialist at the Area Agency on Aging 1-B. I would like to talk with you about the impact that increased funding for in-home services had on seniors throughout Michigan in FY 2015.

The Aging Network in Michigan over-delivered on their promise to serve the 4,500 older adults on wait lists at the beginning of FY 2015 with the $5 million allocated to support in-home services by actually serving 6,212 more seniors.

This 7.5% increase in funding enabled service providers to leverage additional resources and achieve an 8.9% increase in the number of people receiving in-home services, and a 20.6% increase in the number of hours of service provided to support seniors living in their communities. Home delivered meal providers achieved a 10.9% increase in people served, delivering 589,434 more meals to homebound seniors.

Despite the exceptional performance of the Aging Network in moving individuals off of the waiting list, wait-lists for in-home services continued to grow. During FY 2015 wait lists for in-home services increased from 4,336 older adults in the 1st Quarter to 7,043 at the end of the 4th Quarter. There are several factors that are contributing to his higher than anticipated level of demand for in-home services. Increased awareness of services due to outreach efforts related to the launch of Integrated Care, publicity generated by the Governor's commitment to making Michigan a no wait state and the Silver Key Coalition, and the growth of the older adult population have all contributed to this unprecedented demand for services.

The aging network in Michigan has demonstrated that they are able to provide these needed services efficiently, providing exceptional value to the state. I hope that you will continue to show your commitment to older adults by allocating $5 million to serve the 7,000 seniors requesting in-home services in Michigan.

Medicaid SC etal (32)

Silver Key Coalition

Working to Make Michigan a No Wait State for Senior In-Home Services

Silver Key Coalition Background:

The Silver Key Coalition (SKC) formed in 2013 with the goal of increasing access to key state in-home services funded through the Older Michiganians Act and the Michigan Aging and Adult Services Agency (AASA). Using a data driven approach, the coalition advocated for a funding increase of $10 million over 3 years to eliminate wait lists and fully meet the needs of older adults waiting for services such as home-delivered meals and personal care.

Governor Snyder and the Michigan Legislature made a strong commitment to Michigan's vulnerable older adults appropriating $5 million for FY 2015 to serve the 4,500 older adults on wait lists for services in 2014.

FY 2015 Return on Investment:

The Aging Network in Michigan over-performed and over-delivered on the promise to serve 4,500 older adults with the $5 million (7.5%) in increased funding. **In FY 2015, the aging network served 6,212 more seniors[1], a 10.5% increase.**

Impact of FY 2015 Budget Increase

	FY15 Funding Increase	Seniors Served	% Increase	In-Home Service Units	% Increase
In-home Care	$3.2 Million	1,778	8.9%	140,875 Hours	20.6%
Home Delivered Meals	$1.8 Million	5,207	10.9%	589,434 Meals	7.6%

Current Status:

Despite the higher than expected performance by Michigan's Aging Network to assist individuals seeking help to maintain their independence, waiting lists for in-home services continued to grow in FY 2015. In FY 2015, the number of older adults on wait lists for in-home services increased from 4,336 older adults in the 1st Quarter, to 7,043 at the end of 4th Quarter.

This increase in demand for in-home services could have been driven by an increased awareness of services due to increased outreach efforts related to the launch of Integrated Care and publicity generated by the coalition as well as population growth.

FY 2017 Budget Request:

The Coalition is advocating for an additional $5 million investment for FY 17 to expand services to reach the 7,043 vulnerable older adults who are currently waiting for in-home services in Michigan.

Contact or for more information: Website: www.silverkeycoalition.com Email: silverkeycoalition@gmail.com

[1] 773 individuals received both in-home services and home delivered meals.

Revised 2/23/2016

Silver Key Coalition Member Agencies

AAA of Western MI

AARP of Michigan

Advocates for Senior Issues

Alzheimer's Association

Area Agency on Aging 1-B

Area Agency on Aging Association of Michigan

Area Agency on Aging of Northwest Michigan

Community Home Supports

Community Living Services

Detroit Area Agency on Aging 1-A

Disability Network of Michigan

Leading Age

Macomb County Senior Citizen's Services Office

MCAAA

Michigan Adult Day Services Association

Michigan County Social Service Association

Michigan Directors of Services to the Aging

Michigan Association of Nutrition and Aging Service Providers (MANASP)

Michigan Association for Home Care

Michigan Association of Community Action Agencies

Michigan Senior Advocates Council

Montcalm County Commission on Aging

NASW-Michigan Chapter

National Multiple Sclerosis Society, MI Chapter

PHI – Midwest

Presbyterian Villages of Michigan

Region 2 Area Agency on Aging

Region 3-A Area Agency on Aging

Region 3-B Area Agency on Aging

Region 3-C Area Agency on Aging

Region IV Area Agency on Aging

Region VII Area Agency on Aging

Region 9 Area Agency on Aging

Senior Regional Collaborative

Senior Resources of West Michigan

Senior Services Midland County Council on Aging

The Senior Alliance

Tri-County Office on Aging

Upper Peninsula Commission for Area Progress (UPCAP)

Valley Area Agency on Aging

Contact or for more information: Website: www.silverkeycoalition.com Email: silverkeycoalition@gmail.com

COMMUNITY MENTAL HEALTH
CMH OAKLAND COUNTY
AUTHORITY

Health Services SC
Medicaid SC

Dr. Nicole Lawson
2-29-16
29

Concerns about Boilerplate 298 -- Creating a Carve-in System with Medicaid Health Plans

- **Accountability:** Medicaid Health Plans are not held to the same standards and accountability guidelines as the public mental health system. These guidelines protect service delivery for people.
- **Administration Costs:** The average administration costs for Michigan CMHSP's is 6%. Medicaid Health Plans administration costs range between 16-17%. This translates into an immediate 10% decrease of funds allocated toward services for people -- $200-$300 millions in reductions.
- **Assigned Responsibilities:** Plans have not been presented about who will assume the important responsibilities for Utilization Review, Utilization Management, Customer Services, Substance Use Disorders, and other delegated MDHHS requirements.
- **Budget Fluctuation:** The public mental health system reinvests reserves in the system for service delivery. Mental Health plans invest in profits. For example, Molina reported first quarter profits of $28 million.
- **Diminished Services:** Jail, emergency room, and hospital services will decrease with the transfer to Medicaid Health Plans, putting lives in jeopardy.
- **FY18 Budget Projection:** The public mental health system budget is at risk of being reduced by $200 million, with these funds transferred to Medicaid Health Plans.
- **Ignored Funding Request:** Regretfully, the additional $170 million General Fund request and the $99 million direct care wage increase were noticeably absent from the Governor's budget.
- **Local Dollars:** Local dollars received from Oakland County are at risk of being used for Medicaid Health Plan profits versus community benefit.
- **Mingling Funds:** Boilerplate 298 does not provide for protection from the co-mingling of CMHSP and Health Plan funds. Health Plans would have free access to public dollars to use at their discretion, including for their $200 million pharmacy deficit.
- **Multiple Contracts:** CMHSP's currently contract with one PIHP. The proposed plan could require CMHSP's to contract with the eight different Medicaid Health Plans.
- **System Devastation:** Specialty mental health services will no longer exist, leaving hundreds of thousands of people in limbo as the State works to implement this transition.
- **Transparency:** The Medicaid Health Plans are not required to hold open meetings or solicit input from people receiving services. "Not about me without me" will end.

Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

Protecting Michigan's Most Vulnerable Citizens

I <u>oppose</u> the drastic changes laid out in Section 298 of the Health & Human Services FY17 budget:

- ***Public management and oversight of Michigan's behavioral health system provides the BEST QUALITY OF CARE and ensures the MOST money is spent on consumers' needs.***

  - A publicly operated system reinvests resources back into services, not profits and have a long history of risk seeking – the aggressive seeking out and serving the needs of vulnerable community members with complex cross-system needs.

  - For-Profit entities by law are focused on maximizing its value to its shareholders and have a business model which avoids risk.

  - Minimizing administrative costs, ensuring that the greatest share of the healthcare dollar goes to serving consumers.

    - <u>Michigan's PIHP system has on average an overhead cost of 6%, giving them a medical loss ratio of 94%, which is significantly better than a for-profit entity.</u>

    - **<u>Section 298 would result in the LARGEST cut to behavioral health services ever in Michigan – $300 million (difference between PIHP overhead 6% vs. health plan overhead 15-17%)</u>**

  - The management or delivery of public behavioral health services by private companies simply to save money has not been effective.

    - Some states have even seen increased costs and inefficiencies through policies that seek to limit access to care – prior authorization and fail first practices on essential medications used in the treatment of serious mental illnesses have had devastating effects on individuals and families.

    - Providers have been forced to cut services or leave the system, weakening the local network.

    - States that have saved money through privatizing their behavioral health care have done so by moving from a fee-for-service model to a managed care model.
      - Michigan's public behavioral health care system transitioned to managed care almost 20 years ago, which would significantly reduce any promised savings.

Section 298 <u>WILL NOT</u> better integrate care:

- ***Integrated funding does NOT equal integrated care.***
  - Meaningful health care integration and coordination take place "on the ground" - at the point where the patient receives care.
  - Consumers served in Michigan's behavioral healthcare system have needs outside of traditional healthcare, which make it difficult for them to fit into a physical healthcare model – housing, transportation, employment.
    - Promoting a continued focus on the social determinants of health.
  - Most states that have moved their behavioral health services under physical health care managers only moved small sub populations whose needs were more mild/moderate because they are less expensive to serve and more closely fit the traditional health care model.
    - Michigan's current mild/moderate behavioral health carved-in benefit managed by the Medicaid health plans often under performs when compared to the publicly managed behavioral health services.
    - In many places, health plans have a long track record of failing to provide necessary access to services which exacerbates individuals' conditions forcing them into more costly settings for care.
    - Health plans do not have a history of serving people whose needs are outside the traditional medical realm – consumers, families, and advocates fear that care will be denied and reduced due to lack of understanding.

Section 298 puts my local public safety net at risk:

- ***Maintaining the public safety net is critical for Michigan's most vulnerable.***
  - Michigan's behavioral healthcare system is interwoven into the fabric of the communities, in which they work, maintaining a close working relationship with education, law enforcement, judiciary, housing and homeless services providers.
    - Local CMHs are public entities, either an official county agency or an authority, which is a public governmental entity separate from the county or counties that establish it. PIHP boards are made up of appointees from the CMHs within their respective regions.
  - Private entities do not have the same obligations to the community as the public behavioral health system.
    - There is no public oversight or accountability of the resources and no connection to the county safety net.

CRAIN'S DETROIT BUSINESS

Detroit and Southeast Michigan's premier business news and information website

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HMOs seek mental health bids

Health plans group lobbying to get state OK to pursue exclusive contracts

By Jay Greene

A move is underway in Michigan to further privatize the public nonprofit mental health system by turning over $2.4 billion in state funding to Medicaid HMOs, some of which are owned by for-profit insurers.

The Lansing-based **Michigan Association of Health Plans** has mounted a lobbying effort to gain state approval next year to bid for the potentially lucrative contracts that now are exclusively in the public health sector.

"Is it feasible for health plans to contract with networks as behavioral providers? It certainly makes sense," said Rick Murdock, MAHP's executive director. "Should the state of Michigan look at ways to continue to improve the effectiveness of the Medicaid program? Absolutely, we think they should."

Murdock said health plans are managing medical care, behavioral health, substance abuse and developmentally disabled in other states. They include Illinois, California, Florida, New Mexico, South Carolina, Washington, Wisconsin and Texas.

On the other side, officials for the **Michigan Association of Community Mental Health Boards** have warned state officials about the dangers that could face a vulnerable and needy population by allowing health plans to take over the state's mental health system.

"This budget is pretty attractive to the health plans," said Bob Sheehan, CEO of the mental health board association. "They see that market, and they believe they can do quite well" financially.

Sheehan said the health plans underestimate the difficulty in caring for a complex population and their plans' ability to earn high profit margins in behavioral health.

"This is not a traditional market most health plans are used to serving," Sheehan said. "(We) treat the more severe cases that involve the additional complexities of poverty, housing, employment, disease and environmental concerns."

Under the state's current mental health payment system, the **Department of Health and Human Services** makes monthly per-person Medicaid payments to "prepaid inpatient health plans," commonly called mental health authorities, in 10 regions that cover about 251,000 Michiganians. Wayne, Oakland and Macomb counties each make up one region with their mental health authorities.

The mental health authorities, in turn, contract with a variety of provider organizations and community mental health agencies to deliver services that include autism, developmental, substance abuse, behavioral health and serious mental disorders. The 46 community mental health agencies, which serve 83 counties, also receive general fund dollars for services not covered by Medicaid.

The opening foray by health plans, say some observers, began last year in Wayne County when for-profit **Molina Healthcare**, based in Long Beach, Calif., acquired a minority interest in **Integrated Care Alliance**, a developmental disability provider organization.

ICA has a contract with the **Detroit-Wayne Mental Health Authority**, one of the regional agencies that contract with HHS.

In September, Molina acquired 100 percent interest in ICA, a move that led Tom Watkins, CEO of DWMHA, to terminate ICA/Molina's contract for failure to notify the authority and other contract violations. The authority's board in mid-December suspended the termination until at least Jan. 31 to study the issue.

Molina said in a statement its acquisition of ICA is part of a broader strategy to integrate physical and behavioral health care for the people it serves in Michigan and at least seven other states.

Craig Bass, a Molina vice president, said the health plan is looking nationally to improve care coordination between physical and behavioral health. He said Molina in Michigan already treats many of the patients that ICA does, so the acquisition was a natural fit.

"We want to ensure our members get the best behavioral, medical and developmentally disabled care possible," Bass said. "Frequently that doesn't happen when you have two payers who are two different entities."

Of the people served by the mental health authorities in 2015, more than 70 percent are already enrolled in a Medicaid HMO, according to the Michigan HHS and the Ann Arbor-based **Center for Healthcare Transformation and Research**.

Taft Parsons, M.D., Molina's vice president of behavioral health, said managing diabetes and other chronic conditions in conjunction with mental health conditions results in better outcomes.

"We have multidisciplinary teams that work to improve (patients') illness burden by working with local social services (and community organizations) to deliver services the member needs," Parsons said.

Cost savings

If Gov. Rick Snyder and the state Legislature agree that Michigan should change its mental health contracting system, Bass said Molina would be better able to serve that population with the experience it is gaining through ICA and a dual eligible demonstration program in Michigan where it is coordinating physical and behavioral health care for Medicare and Medicaid patients.

Sources tell *Crain's* the health plans are suggesting to Snyder and state legislators that allowing them to manage medical and behavioral health in an integrated fashion could cut costs by $200 million from 2017 to 2019.

The cost savings then could help pay for state general fund transfers mandated by the $1.2 billion Michigan road bill, which Snyder recently approved and begins in 2017. Most of the road improvements will be paid by higher gas and license taxes, but $150 million must be shifted by 2018, rising to $600 million by 2020 and after.

Murdock acknowledged savings could accrue if the HMOs managed all care. But he said benefits to the state also could help to address the following over a three-year period: the pending shortfall of state revenue in fiscal year 2017 for the Medicaid program.

The shortfall, which could tally more than $1 billion, includes the potential loss of provider taxes that support the Medicaid program, rising specialty drugs costs and $150 million in 2017 in general funds to support Healthy Michigan, Murdock said.

"If we are truly interested in treating the whole person, we should move toward more of an integrated approach," Murdock said.

James Haveman, former community health director, said he supports the health plan's effort to coordinate both physical and behavioral health.

"I am in favor of anything that streamlines the current structure. We need to shrink the administrative costs," said Haveman, president of the **Haveman Group**, a consulting firm based in Grand Haven.

"The current structure ... has multiple levels of administration. I have come to the conclusion we need to lessen that so we can get out more services," he said.

Evolving care, financing

Over the past 50 years, Michigan's mental health delivery system has changed drastically. Starting in 1987, the state began closing 11 of 16 psychiatric hospitals and moved more into the outpatient arena.

In 1996, Michigan carved out behavioral health from physical health reimbursement under a federal waiver when the state began contracting with Medicaid HMOs.

"Now we are preaching integrated care. You can't preach that unless you carve back in those services," Haveman said. "I support the carve-in (to Medicaid HMOs). The community mental health board model has to change."

To reduce costs, Snyder in 2013 reorganized mental health delivery by funneling state dollars into geographic regions in no-bid contracts to 10 mental health authorities.

At the same time, Lt. Gov. Brian Calley headed the **Mental Health and Wellness Commission** to evaluate and recommend changes in the state's mental health system.

One still unmet recommendation is to "improve coordination of behavioral health and physical health."

This recommendation could mean more streamlining in the public mental health system to eliminate administrative duplication.

But mental health professionals told *Crain's* they fear Snyder could be persuaded to allow for-profit HMOs like Molina, **Aetna Inc.**, **Total Health Care** and **Meridian Health Plan** to take over the public system.

Officials for Snyder's office did not return several calls for comment.

Making a case

If Medicaid HMOs take over the system, said Willie Brooks, CEO of the **Oakland County Community Mental Health Authority**, the drive for profits by the health plans could take up to 10 percent of payments from an already underfunded mental health system.

Brooks explained that Medicaid HMOs' retain an average of about 15 percent of revenue as administrative overhead and profits. Nonprofit mental health agencies retain about 5 percent or less as overhead.

"Whenever you don't have to worry about shareholders' profit, the money goes back to the people," Brooks said. "HMOs' goal is to avoid risk, and they make more money by avoiding risk. Our goal is to approach risk and minimize the long-term affects by providing services."

Watkins, who is at the center of the for-profit versus public nonprofit mental health debate, said he is not opposed to further privatization of the mental health system.

"I am anti-profiteering," Watkins told *Crain's* in an email in a reference to the move by health plans to take over the public mental health system.

But Haveman said there is enough money in the system to allow for-profit HMOs to generate their return on investment and integrate care.

"Community health boards have sizable reserves," he said. "HMOs can contract with the people who know how to provide the services. (HHS) can write the regulations to ensure services are delivered to the people."

While opposing HMO takeover plans, Elmer Cerano, executive director of the federally funded consumer advocacy group **Michigan Protection & Advocacy Service**, agreed that the state mental health code would have to be modified to closely regulate for-profit HMOs.

"The concern we have is because there are high-cost users and there will be a temptation by for-profit companies to reduce services" to create adequate profit margins, Cerano said. "We are opposed to organizations taking profits out of the system because this removes needed resources."

Cerano said the 10 mental health authorities are capable of squeezing out more efficiency by reducing the number of community mental health agencies under contract.

"We don't need 46. They should be more aligned with the (mental health authorities) to reduce the administrative overstructure," said Cerano, noting that Detroit Wayne already has consolidated operations.

John Kinch, executive director of **Macomb County Community Mental Health**, said he also believes the public system can improve to reduce costs and deliver greater services to patients.

"We have come a long way (since the 1960s) to improve care for patients," he said. "It is silly to put that at risk."

Jay Greene: (313) 446-0325. Twitter: @jaybgreene

CRAIN'S DETROIT BUSINESS

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Letter: Consider impact of mental health service changes

Dohn Hoyle and Sherri Boyd of The Arc Michigan write, "Let's not forget the people at the center of this discussion. The people who receive important support will be negatively impacted by lobbying and contract changes."

Editor:

This letter is in response to the *Crain's* article "HMOs seek mental health bids" from the Jan. 18 edition.

Let's not forget the people at the center of this discussion. The people who receive important support will be negatively impacted by lobbying and contract changes.

Consideration of the reasons why we have a carve-out of long-term supports and services for people with developmental disabilities — and those with a mental illness — could be useful. It would certainly be more useful than the self-serving statements of those whose eyes grow large when looking at the potential increase in their bottom lines.

First, the support and assistance people with disabilities need and which are arranged, provided or administered by the public mental health system are not medical. They were not designed nor intended to be medical. They are personal care and assistance needed to accomplish daily goals of productivity, community inclusion and independence. While it is likely therapeutic, it is decidedly not medical, medical care, or health care.

Second, despite claiming success working with people with developmental disabilities in other states, the bulk of those efforts are in the area of acute health care. Nowhere have managed health care plans worked, for any period of time, with the long-term supports and services, for any substantial number of people with developmental disabilities. While some have done so with persons who have a mental illness, the results are, at best, mixed. People with a mental illness and their supporters are not in favor of such a move.

Third, nowhere else in the country do people with developmental disabilities have the opportunities they have in Michigan. Unlike the vast majority of states, we do not have a waiting list for services. In most states, thousands of people are on a waiting list and have been there for a decade or more. Michigan, in addition to being a leader in person-centered planning, has more people engaged in self-

determination and other innovative options, like independent support brokers, than any other state.

People with developmental disabilities, their families and advocates embraced and helped design managed long-term supports and services through the public mental health system. This has clearly stemmed the growth in the cost and been a boon to individuals and their families. Our 1915(b) waiver is also innovative in that it applies to people with a mental illness — as well as those with a developmental disability.

Understanding that nearly all the assistance provided through the public mental health system is funded through waivers is also ignored by those who want to expand their organizations. There also are many rules and requirements regarding home and community-based services established by the Centers for Medicare and Medicaid Services and other agencies.

The rules governing waivers, including person-centered planning, provide for an individualized planning and support plan that will be foreign to and beyond that capability of entities which manage acute health care.

The timing of the health plans' effort to "integrate" and expand their business is interesting. Michigan has just initiated four pilots on integrating health care for people eligible for both Medicare and Medicaid. These efforts utilize the carve-out for long-term supports and services for people with mental illness and developmental disabilities. Calling for integration, without allowing us to learn from the pilots, is silly at best.

Despite automatic enrollment (unless they take action to opt-out, people are automatically enrolled) and despite significant incentives to be and stay enrolled, people with a mental illness and especially those developmental disabilities are opting out. Could this demonstration of unwillingness of these populations to be enrolled with an ICO (Integrated Care Organization) be the reason the plans push for integration without seeing or hearing from the pilots?

Despite serious concerns about the discrepancies from one part of the state to another and others, our organization, on behalf of people with developmental disabilities and their families, continues to support the carve-out as clearly in their best interests. We also believe it remains clearly in the best interests of the State of Michigan.

Dohn Hoyle
Director of public policy
The Arc, Michigan

Sherri Boyd
Executive director
The Arc, Michigan

CMH OAKLAND COUNTY AUTHORITY

REMOVE BOILERPLATE 298 FROM MICHIGAN'S PROPOSED BUDGET

- Michigan residents deserve better than boilerplate 298. Governor Snyder should understand by now that it's not saving if people are losing.

- Section 298 would result in the largest cut to behavioral health services in Michigan's history - $300 million.

- This change would drastically impact more than 300,000 Michigan residents who receive valuable services through the public mental health system, as well as the family, friends, neighbors, and co-workers who are involved in their lives.

- "Boilerplate" language at the end of Governor Snyder's 408-page executive budget bill, Section 298, calls for carving in behavioral health benefits to the health plans by the end of fiscal year 2017, which ends Sept. 30, 2017.

    - Section 298 – Local match, Each PIHP shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

- Michigan's public mental health system is considered to be a carve-out service model. More specifically, it allows for the public mental health system to provide specialty mental health services not offered by tradition Medicaid Health plans.

- Examples of specialty services include assistance with housing, employment, transportation, community inclusion, and case management to name a few.

- What is the difference between publicly operated systems and for-profit entities?
    - A publicly operated system reinvests resources back into services, not profits and have a long history of risk seeking – the aggressive seeking out and serving the needs of vulnerable community members with complex cross-system needs.

    - For-Profit entities by law are focused on maximizing its value to its shareholders and have a business model which avoids risk.

    - Minimizing administrative costs, ensuring that the greatest share of the healthcare dollar goes to serving consumers.
        - Michigan's PIHP system has on average an overhead cost of 6%, giving them a medical loss ratio of 94%.
        - For-profit health plans have on an average an overhead cost of 15-17%.

- While some states have transferred one or two service populations to traditional plans, no state has transferred all three, which include intellectual/developmental disabilities, mental illness, and substance use disorders.

Carve-In/For-Profit Impact on Other States

North Carolina

- Few providers are willing to work for Medicaid reimbursement rates and deal with the red tape associated with the new system.
- Many programs failed because of low reimbursement rates, changing rules, and the expense of dealing with the bureaucracy.
- Hospitals are extremely overcrowded, people are not receiving necessary care, and patients are released without follow-up plans.

Illinois

- Two state operated in-patient, acute psychiatric facilities have closed, along with six public mental health clinics.
- The state has seen a 19% increase in emergency room visits among people experiencing psychiatric a crisis.

Wisconsin

- System forced to focus less on continued care and more on emergency psychiatric treatment - very large dependence on emergency care system.
- Doctors only have 24 hours to decide if the individual meets the legal requirement of dangerousness.
- Shortage of hospital beds available to mental health patients, along with a shortage in outpatient mental health care.

Arizona (Privatized care within the correctional facilities.)

- Eight suicides occurred in the first eight months.
- Health care spending in prisons dropped by nearly $30 million.
- Denials of care, lack of timely emergency treatment, failure to provide medication and medical devices, failure to provide care and protection from infectious diseases, denial of specialty care and referrals, and insufficient mental health treatment.

Visit the Michigan Association of Community Mental Health Boards for more information: www.macmhb.org or Oakland County Community Mental Health Authority at www.occmha.org

Key House MDHHS Committee Meeting Dates and Times:

- House Appropriations Subcommittee for the Department of Health and Human Services.
  Tuesday, February 23 at 10:30 a.m. – BHDDA presentation on the executive budget recommendations.

- The House public testimony for behavioral health services will be on Monday, February 29 at 9:00 a.m. – noon.

- House Appropriations Subcommittee for the Department of Health and Human Services.
  Tuesday, March 1 at 10:30 a.m. – Medicaid and Healthy Michigan presentation on the executive budget recommendations

Please note that all of the House hearings are located in the House Appropriations Room, 3rd Floor Capitol.

Key Senate MDHHS Committee Meeting Dates and Times:

- Senate Appropriations Subcommittee for the Department of Health and Human Services.
  Tuesday, March 1 at 2:30 p.m. – Medicaid and Healthy Michigan presentation on the executive budget recommendations AND public testimony.
  LOCATION: Senate Hearing Room, Ground Floor, Boji Tower, 124 W. Allegan St. Lansing, MI 48933

- Senate Appropriations Subcommittee for the Department of Health and Human Services.
  Tuesday, March 10 at 1:00pm – BHDDA presentation on the executive Budget recommendations AND public testimony.
  LOCATION: Senate Appropriations Room, 3rd Floor, Capitol Building.

House Appropriations Subcommittee on Health and Human Services, and Subcommittees

Meeting Schedule, February - March 2016

2/5/16 10:40am
("SC" is Subcommittee)

SCHEDULE IS SUBJECT TO CHANGE

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	**FEBRUARY** 8	9	10 (Joint Appropriations Mtg - Executive Recommendation Presented)	11	12	13
14	15 (Holiday)	16	17 (House Appropriations Committee - HFA presentation)	18 After Session - Health and Human Services SC - Overview of Exec Rec by DHHS, and Departmentwide unit topics	19	20
21	22	23 10:30 - 11:50 JOINT MTG - Medicaid SC & Health Serv SC - DHHS presents Exec Rec on Behavioral Health *Noon - 1pm - Human Services SC - DHHS presentation on Children's Services, Child Welfare, Juvenile Justice Programs, Kent County Pilot*	24	25 10:30 - Noon - Health Serv SC - DHHS presents Exec Rec on Public Health, and Crime Victims	26	27
28	29 9am - Noon JOINT MTG - Health Serv SC & Medicaid SC - Public Testimony on Behavioral Health, Medicaid, Healthy Michigan Plan	**MARCH** 1 10:30 - 11:50 JOINT MTG - Medicaid SC & Health Serv SC - DHHS presents Exec Rec on Traditional Medicaid, and Healthy Michigan Plan *Noon - 1pm - Human Services SC - DHHS presentation on Field Operations, Local Offices, Positions, Caseload*	2	3 10:30 - Noon - Health Serv SC - DHHS presents Exec Rec on Aging & Adult Serv Agency and Health Policy *After Session - Human Services SC - Public Testimony on all Human Services topics*	4	5
6	7 9am - Noon JOINT MTG - Health Serv SC & Medicaid SC - Public Testimony on Public Health, Health Policy, Aging & Adult Serv Agency, Crime Victims, or other topic	8 10:30 - 11:50 JOINT MTG - Medicaid SC & Health Serv SC - Agenda to be determined *Noon - 1pm - Human Services SC - DHHS presentation on MiBridges, Exec Rec, Public Testimony*	9	10 [10:30 - Noon - Health Serv SC - possible meeting]	11	12
13	14	15	16	17	18	19

Health and Human Services Subcommittee - Decision-Making and Report Bill week of March 21 or later, to be determined

Location for <u>all</u> Subcommittee meetings - Room 352 Capitol Building

Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

MEETING NOTICE

Telephone: (517) 373-2768
Fax: (517) 373-1986

DATE: February 16, 2016

TO: Members of the Senate Appropriations Subcommittee on Health and Human Services
Senator Jim Marleau, Chair
Senator Peter MacGregor
Senator John Proos
Senator Mike Shirkey
Senator Goeff Hansen
Senator Vincent Gregory
Senator Curtis Hertel Jr.

RE: SENATE HEALTH AND HUMAN SERVICES SUBCOMMITTEE MEETINGS

DATE: Tuesday, February 23, 2016
TIME: 2:30 p.m.
PLACE: Senate Hearing Room, Ground Floor, Boji Tower, 124 W. Allegan St., Lansing, MI 48933
AGENDA: 1. Children's Services Agency
2. Public Testimony

And any other business to come properly before the Subcommittee.

DATE: Tuesday, March 1, 2016
TIME: 2:30 p.m.
PLACE: Senate Hearing Room, Ground Floor, Boji Tower, 124 W. Allegan St., Lansing, MI 48933
AGENDA: 1. Medicaid
2. Public Testimony

And any other business to come properly before the Subcommittee.

DATE: Thursday, March 3, 2016
TIME: 1:00 p.m.
PLACE: Harry T. Gast Appropriations Room, 3rd Floor, Capitol Building,
100 S. Capitol Ave., Lansing, MI 48933
AGENDA: 1. Population Health
2. Aging and Adult Services
3. Health Policy
4. Public Testimony

And any other business to come properly before the Subcommittee.

DATE: Tuesday, March 8, 2016
TIME: 2:30 p.m.
PLACE: Senate Hearing Room, Ground Floor, Boji Tower, 124 W. Allegan St., Lansing, MI 48933
AGENDA: 1. Field Operations and Public Assistance
2. Public Testimony

And any other business to come properly before the Subcommittee.

Pursuant to the Americans With Disabilities Act, individuals with a disability should feel free to contact the Office of Secretary of the Senate by phone (517-373-2400) if requesting special services to participate in the meeting.
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DATE: Thursday, March 10, 2016
TIME: 1:00 p.m.
PLACE: Harry T. Gast Appropriations Room, 3rd Floor, Capitol Building,
100 S. Capitol Ave., Lansing, MI 48933
AGENDA: 1. Behavioral Health
2. Public Testimony

And any other business to come properly before the Subcommittee.

c: Senate Appropriations Committee Clerk
Julie Speckin, Office of the Secretary of the Senate
Laken Stoliker, Office of the Secretary of the Senate
Legislative Service Bureau Legal Division
Auditor General
Farnum Building Manager

Pursuant to the Americans With Disabilities Act, individuals with a disability should feel free to contact the Office of Secretary of the Senate by phone (517-373-2400) if requesting special services to participate in the meeting.
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Medicaid SC Health Services SC 2-29-16
Tina Reynolds
Paul Haan
Bree Anderson
24-26

Michigan Alliance for Lead Safe Homes

February 29, 2016

House Members
Medicaid and Health Services Subcommittee of the Health and Human Services subcommittee of the Standing Committee on Appropriations

On behalf of the Michigan Alliance for Lead Safe Homes (MIALSH) coalition we thank you for your time and attention. Our coalition has members throughout the state and includes health departments, lead-abatement contractors, small business owners, parents, homeowners, landlords, and other service providers. MIALSH works to end lead poisoning in the state and is before you today to thank you for your past funding support and seek an enhanced commitment for the FY 2016-17 budget cycle.

MIASLH is asking for $6.75 million in abatement funds to make homes lead safe. In 2014, 679 Michigan kids had blood lead levels of 10 micrograms per deciliter (ug/dL) or higher (5 ug/dL is the threshold for poisoning). At $10,000 per house for the lead work, that's a little more than $6.75 million and a very good target to hit with state funding support at this stage.

As you are all well aware, the call to end lead poisoning in Michigan is stronger than ever. Michigan ranks 5th in the nation for lead poisoned children and that is before the situation in Flint came to light. Studies link lead poisoning to I.Q. loss, poor test scores, violent crime, incarceration, and infant mortality. New research is looking at lead as a contributor to the development of Alzheimer's and Parkinson's diseases as victims' age. Adding to the crisis, scientists at the Centers for Disease Control have concluded that there is no safe level of lead in a child's blood.

There is currently $1.75 million in the state budget for lead abatement (to make homes lead safe). These are homes that poisoned at least one child and where the family needs help with the cost of repairs and lead removal. The Governor's budget recommendation for FY 2016-17 is continuation funding at the $1.75 million level for lead abatement. In light of the situation in Flint however, we anticipate many more families will get their homes and children tested for lead. With 70% of our state housing stock at risk of having lead paint, many more families will need help in making their homes lead safe. These increased dollars will help meet the need.

You have helped to help turn the tide in Michigan's battle against lead poisoning in the past, and we thank you. We are asking for a funding increase to $6.75 million to make more Michigan homes lead safe and help protect the next generation of our children. Thank you for your consideration and please do not hesitate to contact me with any questions you may have.

Sincerely,
Tina Reynolds

Tina Reynolds
Health Policy Director
Michigan Environmental Council

Safe Homes/Safe Kids

Michigan Alliance for Lead Safe Homes

Lead poisoning is still a problem in Michigan

Why? About 70% of the housing stock in Michigan was built before 1978, the year in which lead paint was banned. Because of these high numbers, in 2012, over 787 Michigan children under 6 years old were diagnosed with lead poisoning while another 5,706 children were found to have blood lead levels of 5 to 9 ug/dL. It is difficult to gauge the full extent of lead poisoning because only half of the kids who should be are tested each year. We expect the number of lead poisoned kids to be higher.

Conservative estimates show that childhood **lead poisoning costs Michigan at least $3.2 – $4.85 billion** for just the annual costs of lifetime earnings for children with lead poisoning. This estimate does not include the cost of medical treatment, special education, increased encounters with the juvenile system, or reduced high school completion. This loss of tax dollars hurts schools, roads, and other state priorities.

Thousands of children learn less due to lead poisoning

Complications from lead poisoning include behavioral problems such as aggressiveness, hyperactivity, and lethargy, all of which can result in learning struggles, organ damage, hearing deterioration, slowed growth, appetite and weight loss, digestive problems, headache, and fatigue. These complications are not reversible and hamper IQ and school performance and can lead to a higher rate of incarceration for lead-poisoned individuals.

Coalition forms to end lead poisoning in Michigan

To help unify and strengthen regional and statewide entities working to end lead poisoning, the Safe Homes/ Safe Kids: Michigan Alliance for Lead Safe Housing coalition formed in 2010. We are a group of concerned health, housing and environmental professionals, local business owners, community and child advocates, parents and others. We are committed to eliminating childhood lead poisoning in Michigan by identifying stable funding and policies to provide education, prevention, testing of children, and abatement of lead hazards.

To learn more about lead poisoning, please check out our coalition website, www.mileadsafehomes.org. You can also subscribe to our blog to stay up to date on coalition activities.

Michigan Alliance for Lead Safe Homes

602 W. Ionia Street
Lansing, MI 48933
517-487-9539

www.mileadsafehomes.org

printed on 100% post-consumer recycled paper

Michigan Alliance for Lead Safe Homes

Main Messages

- Lead poisoning is 100% preventable
- There is no safe level of lead in a child's blood
- Lead poisoning is irreversible
- We know how to end lead poisoning.
- Prevention of lead poisoning is achievable if we all work together and it is the only solution.

Michigan Alliance for Lead Safe Homes 2016 Action Items

- A strong commitment from the state to end lead poisoning
- Secure adequate resources for proactive education, surveillance, and blood lead testing for at risk kids.
- Support the families of Flint in securing all the resources needed now and in the future.
- Require a clean lead clearance for all residential properties before rent or sale.
- Increase state funds for making homes lead safe from $1.75 million (current year) to $6.75 million (based on: 679 kids with EBLL above 10 in 2014 at $10,000/house).
- Make lead poisoning prevention an essential local public health service so county health departments would have the mandate and resources to address this in every county in the state.
- Provide educational and nutritional interventions for kids impacted by lead across the state.

How Flint goes, so does Michigan

- Anticipate questions on Flint
- MIALSH is a statewide lead advocacy organization and we stand by Flint and all kids in Michigan.
- Lead in water is a major issue in Flint but for most of Michigan, lead paint in homes and soil is the source.
- No child should be lead poisoned ever by any source.
- Flint is a teachable moment and has galvanized the state's attention and commitment to end lead poisoning in Michigan.

- Solutions for Flint must look beyond quick fixes to structural, systemic solutions that work to protect and serve children statewide.
- Now is the time to finish the job.

Lead Highlights

General

- In 2014 at least 5,049 Michigan kids were lead poisoned.
- Michigan has the 5th highest rate of lead poisoned kids in the nation.
- Lead poisoning is an urban and rural problem with 70% of Michigan's housing stock built before 1978 when lead paint was banned.

IQ

- Even a low blood lead level of 5 ug/dL results in a 30% greater chances of kids failing 3rd grade reading and math tests.
- Lead exposure is responsible for a significant effect on the educational achievement gap.
- Estimates show a 4-7 point decrease in IQ for every 10 ug/dL increase in blood lead.

Physical Health

- Lead toxicity can affect every organ system
- Kids under age 6 are most impacted by lead because their brain is still developing and they absorb 50% of the lead they are exposed to.
- Lead exposure is linked to: hypertension, hearing loss, osteoporosis, anemia, tooth decay, Parkinson's, ADHD, kidney damage, reproductive issues and a host of other maladies.
- Pregnant women exposed to lead have increased spontaneous abortions, low birth weights babies, still births and babies suffering from lead poisoning from their first breath. Lead exposure also threatens the ability to safely breastfeed.

Crime

- A teen exposed to lead as a child is more likely to smoke, be truant, drop out of high school, commit criminal offenses and become pregnant as a teen.
- High lead levels are associated with aggression, hyperactive and bullying behavior in children.

Impacts to Workforce

- The largest cost to lead poisoning is the estimated $206 million each year in lost wages and productivity. Lead poisoning is a talent drain that hurts employers and economic activity in Michigan.

Elizabeth W. Bauer (6) 2-29-16
Health Services SC
Medicaid SC

Elizabeth W. Bauer, M.A.
725 W. Breckenridge Street
Ferndale, MI 48220-1251
248-677-4283
Ebauer7400@aol.com

Testimony Regarding 2016-2017 Executive Budget, Section 8-298
Before the
Michigan House of Representatives
Appropriations: Subcommittee on Medicaid Subcommittee of Health and Human Services, and
Appropriations: Subcommittee on Health Services Subcommittee of Health and Human Services
Room 352, House Appropriations, State Capitol Building, Lansing, MI

February 29, 2016

Chairman VerHeulen, Chairman Afendoulis, Members of the Subcommittees, thank you for this opportunity to share my views regarding the Governor's Executive Budget proposal "to transfer the service funds appropriated in part 1 currently provided to PIHPs through the Medicaid mental health services, Medicaid substance use disorder services, Healthy Michigan plan - behavioral health and Autism services lines to the Health plan services line by September 30, 2017." (Sec. 8 – 298 (1)).

I speak from the perspective of a person who has advocated the rights of individuals with intellectual/developmental disabilities, behavioral health and substance use disorders, and autism since 1958. For 58 years I have worked personally and professionally at state, national and international levels (see last page) to secure educational, pre-vocational, employment, housing, health care and other supports and services that enable individuals with these conditions to live dignified, productive, self-determined lives as fully included members of our communities. When I began my career as a Speech Pathologist most of these men, women and children were either living in institutions or hidden at home. There was no right to education and community –based supports and services were only a dream.

I was driven by one fundamental principle. **All people are valuable.** Each has unique contributions to make as an individual and to the various family units and communities of which he or she is a member. In 1967 my efforts got a turbo charge. Our third of four children, Virginia, was born with profound disabilities. She could not suck or swallow, did not move on her own, and did not respond to light or sound plus other life-threatening issues. At nine months of age an eminent neurologist said to us, "She is blind, deaf, and profoundly retarded. Put her away and forget her." Fortunately, my training permitted us to avoid that death sentence. I recruited and trained 40 volunteers who worked in shifts around the clock in our home for years. We kept Virginia moving. She was involved with her family and community. Today she is 47. Over the years slowly – developmentally – she increased her skills. She is not blind or deaf although she does not speak. She is a "force of nature" to use a phrase. She is valuable. And, she has influenced more lives than I ever will.

Like many here today, I came to speak to the provision in the Executive budget that would transfer the service funds from PIHPs to Medicaid health plans However, I did not come to advocate maintenance of the status quo nor did I come to support the Executive Budget proposal. Which, frankly, I oppose with every fiber of my being.

Rather, I came to suggest that by initiating this statewide discussion, the Governor and his Administration have opened an incredible opportunity to look at the system from top to bottom and design a new order that responds to the needs and desires of the men, women, and children who use supports and services including health care and more to live dignified lives as members of our community. I am pleased to learn that Lt. Governor Brian Calley will convene a workgroup to look at the issue. I hope the group will think "out of the box" and not just re-arrange the "boxes" we now have or, worse, add more.

Policy is best when it is informed by the people it affects. The litmus test question when a recipient of a service evaluates that service or support is, "Did you ask me?" We have a great opportunity to eliminate the redundant costly layers of bureaucracy and design anew. We must start with the individuals who use service and supports and design upward. I know in schools where the instruction is student–driven, students are purposefully engaged in learning. Teaching and learning become a productive partnership. Asking, not telling, makes all the difference. A system designed in response to people's expressed needs and desires, where the user's choice is central to the design; are effective, less costly, and result in better outcomes for the individuals served therein.

Personally, I want to see the people served in the driver's seat. What is it that will enhance the quality of their lives? How should supports and services be developed and organized to enable them to fulfill their personal needs, hopes, and dreams?

The principles of Self-Determination (Freedom, Authority, Support, and Responsibility) must guide the discussion. We cannot sacrifice the basic human right of persons with disabilities to direct their futures; have control over how they live their lives, where, and with whom; and have authority over the resources that support them. The elements of Person-centered plans, based upon the principles of Self-Determination, should dictate the system requirements. I am here to advocate for what ought to be. It may look different from anything we have now or is proposed by the Governor.

My mentor, Ron Lippitt, taught me early on that planned change is most effective when a system is in disarray from top to bottom. We have that condition now. There is a huge opportunity to organize and design a better way to support individuals with behavioral health conditions, substance use disorders, intellectual/developmental disabilities, and autism to direct their futures. Let's think about how we can put the people served front and center, listen to them, and advocate their expressed wishes. If we do this with fidelity, we can create a cost effective system of services and supports that makes a positive difference in the lives of people.

The Governor's Executive Budget proposes to reduce duplicative administrative functions, but I see nothing in the proposal to achieve that objective. If anything, the Executive proposal adds yet another layer of bureaucracy! Section 298-1(c) calls for "Contracting with an administrative service organization to provide oversight of the Medicaid health plans and the CMHSPs and ensure continuity of care for the served populations."

Duplication of effort, layers of bureaucracy that lie between the appropriation and the point of service have always been a sticking point for me. In 1980 I worked for a year as Director of Community Placement for Wayne County in the Metropolitan Regional Office of the Michigan Department of Mental Health. I saw first-hand that the Regional Offices were high cost, paper pushing organizations that impeded rather than improved progress. I could not in good conscience stay. The Department eliminated Regional Offices in the mid-1980s. Then, in the 1990s, Governor Engler created the PIHP system which was (to my mind) the Regional Office structure reincarnate. I served on the work group to vet the PIHPs (18 at the time) so had access to all the applications and supporting data. It was eye-popping.

In 2002 I developed a spreadsheet (supported by the PIHP application data) for incoming Governor Granholm that showed how the state could save hundreds of millions of dollars by contracting directly with the 94 core providers - essentially eliminating the PIHPs and CMHSPs. I proposed a small cadre of state employees who would perform contract management and compliance functions. This group would be less costly since civil service would control the salary and benefit structure. I proposed it again when I was a member of Governor Granholm's Mental Health Commission. The response was, "That is the elephant in the living room." Needless to say, "the elephant" did not emerge as a recommendation of the Commission which had a significant number of PIHP and CMHSP executives as members.

I still believe we have too many layers of bureaucracy. But I do not believe that the Governor's Executive Budget proposal addresses that issue. The arrangement offered in the Executive Budget proposal is not the answer. It defies reason to think that the array of services and supports that exist today can be maintained in such a system, let alone improved.

It also defies reason to think that we can continue to maintain so many layers of bureaucracy at such high cost when the basic human needs of so many individuals remain to be met. Just think, if we eliminated some of the layers of high cost bureaucracy, we might be able to compensate the people who actually provide the supports and services with a living wage. It is unconscionable that the direct care professionals who actually provide the hands-on supports and services too often make less than $10 an hour and work 12 hours shifts; while many in the layers above are making 6 figure salaries.

Can we set aside our thinking about how to preserve the structures that exist today and ask, what could we do differently? Better? Can we design to meet the unique needs of people who use behavioral health services, rather than fitting them in to existing programs? I am confident that a system designed in response to the needs and expressed desires of the intended beneficiaries will be effective in every measure: improved personal outcomes, full citizenship, and reduced costs.

Designing and implementing a better way forward would take effort. I believe it is effort worth exerting. We can advance the dignity, equality, independence, and expressed choices of individuals. Dare to be bold. Never fear change. Have courage and persevere.

Thank you.

Brief Listing of Professional Endeavors

1959 -1973 Speech Pathologist in rehabilitation and institutional settings. (NJ, NY, PA)
1973 - 1975 Obtained Master of Arts degree in Special Education, The Ohio State University
1975 –1978 Teacher Consultant, Special Education and Administrator, Adult Education for person with disabilities, dual appointment, Pontiac, MI
1978 - 1980 Director of Training, Michigan Department of Mental Health
1980 - 1981 Director, Community Placement, Wayne County, Department Mental Health, Metro Regional Office.
1981 – 2001 Incorporated Michigan Protection & Advocacy Service, Inc., Executive Director 1981- 2001
2002 – 2010 Elected Member, Michigan State Board of Education
2012 – present, Founder and Board President, W-A-Y Academy Detroit (Southwest and Brightmoor Campuses , grades 7 -12)
1994 - present, Consultant, Human Rights and Civil Society (many states of USA and 22 countries).

Family: Married George Bauer 1959; widowed 2012. Children: Anna 1963, Rob 1966, Virginia 1967, Edward 1969

MICHIGAN

PROTECTION & ADVOCACY SERVICE, INC.

"PROTECTING THE RIGHTS OF PERSONS WITH DISABILITIES"

Elmer L. Cerano, *Executive Director*

Testimony of Terri L. Land, Chairperson,
MPAS Public Policy Committee
Before the House Appropriations Subcommittee
on Health and Human Services
Regarding Mental Health Privatization Budget Language
February 29, 2016

Good morning! I am Terri Land, Chairperson of the Public Policy Committee of Michigan Protection and Advocacy Service. MPAS is a private, nonprofit, nonpartisan organization mandated to advocate for persons with disabilities in Michigan. MPAS provides short-term assistance and representation to over 7,000 people each year, including many people with intellectual or developmental disabilities and people with mental illness served by Michigan's public mental health system.

Budget language that moves funding for the public Community Mental Health services and a non-profit service delivery network to for-profit health plans, put Michigan's people with disabilities at a critical risk of losing quality community based supports and services.

The public community mental health system provides a broad

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MPAS website: www.mpas.org

set of long-term supports and services to persons with intellectual and developmental disabilities and people with serious mental illness. They include personal assistance, personal care, accommodation assistance, transitional supports, and crisis/emergency supports. They also include home- and community-based supports made available under Michigan's Medicaid waiver programs. All of these services are among those needed to accomplish daily goals of community inclusion and independence, productivity, and recovery - the tasks required to live a quality life. These goals are embedded in the foundations of the current Michigan Mental Health Code as well as Title II of the Americans with Disabilities Act, the federal Medicaid Home- and Community-Based Services rules, and Michigan's own recent Section 1115 Medicaid waiver application.

Providing community-based services and supports has therapeutic benefits, but these services and supports are not traditional medical services. As such, assessing, planning, implementing, and measuring outcomes from such services are not within the expertise of traditional health plans or most primary care providers. Traditional "medical treatment" is not all inclusive when it comes to providing the supports and services necessary to improve the quality of life for the diverse populations served by the public community mental health system.

We do not claim that the current system is perfect. The current division between services to address "mild or moderate psychiatric symptoms" and long-term services and supports can create fragmentation and risk avoidance between community mental health providers and health plans. There are significant geographic disparities in the availability of an appropriate range of supports and in the fidelity of implementation of person-centered planning among community mental health providers. State general fund reductions and adherence to an antiquated "spenddown" standard of Medicaid eligibility result in unnecessary and

harmful service denials leading to more expensive and less effective utilization of emergency and crisis interventions.

Shifting mental health resources from a public mental health system to for-profit health plans is not the correct answer to these problems. People with disabilities need a service and support system that:

- Avoids a return to a medical model of supports and services;
- Assures independence and integrity in person-centered planning;
- Maintains a broad range of community supports and services, including integrated employment and safe, affordable and accessible housing;
- Reinvests savings from improved health and well-being into additional supports for people with disabilities;
- Reduces duplicative layers of administration;
- Is transparent and accountable to the public and the people it serves; and,
- Is designed and evaluated through robust stakeholder participation.

Michigan leads the nation in honoring the principles of self-determination, meaningful choice, and community inclusion for people with intellectual or developmental disabilities and people with serious mental illness. We fully understand and support efforts to improve coordination between the physical and the behavioral health needs of the whole person. But, unless and until the Medicaid health plans can prove their understand and commitment to the guiding principles and values that anchor the current provision of long-term supports to people with disabilities, advocates cannot embrace a plan that eliminates the "carve-out" language in state law.

We strongly support the efforts of this Subcommittee and the Lieutenant Governor to bring together people with varying opinions in a time-limited process to develop language that integrates care, reduces unnecessary administrative

overhead, re-invests savings back into enhanced services, and clearly holds true to the values of person-centered community-based supports and services that are the hallmarks of a progressive and truly supportive mental health system.

Thank you for the opportunity to speak before you today. I am happy to answer any questions.

For more information, please contact Elmer L. Cerano, Executive Director, Michigan Protection & Advocacy Service, Inc., ecerano@mpas.org or (517) 487-1755 or Mark McWilliams, Director of Public Policy and Media Relations at mmcwill@mpas.org or 517-487-1755.

Mark Reinstein 2-29-16 (18)
Health Services SC
Medicaid SC

Testimony to House DHHS Medicaid and Health Services Appropriations Subcommittees
Mark Reinstein, Mental Health Association in Michigan; 2-29-16

Members of the Subcommittees –

I'm Mark Reinstein, representing the Mental Health Association in Michigan, the state's oldest advocacy organization for persons experiencing mental illness. Thank you for the opportunity to make comment today.

We oppose section 298 of the DHHS budget bill as presented by the Governor to the Legislature. The proposal is not well thought out or well developed, and the mental health community was not consulted on it. A conversation on integration of publicly funded health care services is important, and we're pleased that the Lt. Governor is organizing such a discussion and including our organization in it. But we don't know what, if anything, that will lead to, or when. The conversation can go on whether or not there is boilerplate, and the Governor's proposed section 298 should be stricken from the Legislature's budget bill.

My remaining testimony will be devoted to an issue that relates somewhat to these questions of who should be responsible for what in publicly funded health care, and how it is paid for. The specific issue is access to timely, effective medication services for vulnerable, high-risk populations. This has been a point of contention between the department and many elements of health advocacy communities for about 15 years.

In 2004, the Legislature enacted a law that Michigan Medicaid could not subject medications for the high-risk conditions of mental illness, epilepsy, HIV-AIDS, cancer, and organ replacement to bureaucratic prior authorization delays. These delays often last at least two months and require a consumer to fail on two other "preferred" medications before possibly getting the one that the doctor originally prescribed. And if the doctor originally prescribed a drug that has no generics, prior authorization results in therapeutic switching – i.e., the consumer doesn't necessarily receive a drug chemically equivalent to what the doctor prescribed.

Unfortunately, the 2004 law had a loophole – it didn't apply to the state's Medicaid HMOs. So DHHS had an immediate out available. It could have instantly turned management of drugs for the five vulnerable populations over to the HMOs. But it didn't, given the protective intent the Legislature had just expressed. And the department knew that in the late 1990s, giving the HMOs fiscal control over medications for mental health had proved disastrous to the point that in less than two years a totally new system of statewide reimbursement for mental health drugs was devised.

Subsequently, the department made several attempts at legislative repeal of the 2004 law. All of them failed. During those attempts, the department always said the law was costing $6 million GF for mental health. (No figures were ever given for the other drug categories involved.) Advocates asked for documentation, which was never provided. Advocates also noted that $6 million to the state budget is minuscule, and that several studies have found the cost-benefits of open access for mental health drugs to be far greater than $6 million annually.

During the post-2004 years, advocates also found the department unwilling to engage in meaningful negotiation about this issue. There was one very brief exception 5-6 years ago

when the state Medicaid director began serious conversations with us. After maybe three days, his superiors pulled the plug on those discussions.

That brought us to 2015 and the new, so-called "common formulary" for Medicaid HMOs. In two public meetings, the department made clear it had continued to that point in protecting access to mental health, epilepsy, and HIV-AIDS drugs. Less clear was to what degree drugs for cancer and organ replacement therapy were still being protected. The department went on to say that drugs still being protected as of 2015 would remain protected in calendar year-'16, but come January '17 those protections might end. If they do, we're signing a death sentence for some of the state's most vulnerable, high-risk consumers.

The health advocacy communities in Michigan don't believe such a monumental decision should simply be left to the whims of the bureaucrats in DHHS. Since the department won't commit to anything beyond December '16, we need the Legislature to once again step in. We are asking for budget boilerplate, which would take us through September '17, that the five original protected populations – mental health, epilepsy, HIV-AIDS, cancer, and organ replacement – shall be protected from prior authorization delays in all of Medicaid, regardless of who is responsible for the pharmacy management. This not only extends the protections eight months longer than the department might, but it buys time for all the discussions the state will have about integrated health care – and who is responsible for what, with how much money – to take place. Allowing the department to have unilateral authority over the fate of these medications (and the consumers who depend on them) before that dialogue is complete would be a huge mistake and would simply boost HMO profits on the backs of our constituents.

I've attached our specific boilerplate proposal and the very impressive list of 17 organizations endorsing it. Among those 17 are two cancer groups, the HIV/AIDS Alliance, the Michigan Council for Maternal & Child Health, three mental health professionals' societies, the Michigan Association of CMH Boards, and several adult and children's mental health and developmental disability groups.

I conclude by asking the question: Are all 17 of these organizations wrong, while DHHS alone is right? I don't think so. The 17 endorsers of the proposed boilerplate are in effect saying, "The water is brown here." Please don't leave the door open for DHHS to harm vulnerable citizens with high-risk chronic conditions come January.

Thank you for your thoughtful consideration.

Attachment

Draft Boilerplate (FY-17), Medicaid Drug Access for Vulnerable Populations

Sec. ___. (1) The department and its contractual agents may not subject Medicaid prescriptions to prior authorization procedures with respect to the following drugs:

(a) A prescription drug that is generally recognized in a standard medical reference or the American psychiatric association's diagnostic and statistical manual for the treatment of a psychiatric disorder.

(b) A prescription drug that is generally recognized in a standard medical reference for the treatment of cancer, HIV-AIDS, epilepsy or seizure disorder, or organ replacement therapy.

(2) "Prior authorization" means a process implemented by the department or its contractual agents that conditions, delays, or denies delivery of particular pharmacy services to Medicaid beneficiaries upon application of predetermined criteria by the department or its contractual agents to those pharmacy services. The process of prior authorization often requires that a prescriber do one or both of the following:

(a) Obtain pre-approval from the department or its contractual agents before prescribing a given drug.

(b) Verify to the department or its contractual agents that the use of a drug prescribed for an individual meets predetermined criteria from the department or its contractual agents for a prescription drug that is otherwise available under the Medicaid program in Michigan.

Endorsers

American Cancer Society Cancer Action Network
The Arc Michigan
Association for Children's Mental Health
Epilepsy Foundation of Michigan
HIV/AIDS Alliance of Michigan
Mental Health Association in Michigan
Michigan Association for Children with Emotional Disorders
Michigan Association of Community Mental Health Boards
Michigan Council for Maternal & Child Health
Michigan Disability Rights Coalition
Michigan Partners in Crisis (justice-&-mental-health coalition)
Michigan Protection & Advocacy Service
Michigan Psychiatric Society
Michigan Psychological Association
Michigan Society of Hematology and Oncology
National Alliance on Mental Illness - Michigan
National Association of Social Workers - Michigan

2-24-16

SEN. CASWELL
Health Services SC
Medicaid SC

TESTIMONY ON SECTION 298 OF DHHS BUDGET FOR 2016-2017

Much has been done to make the mental health system in Michigan more efficient and responsive to the consumer.

1. Reduction in the number of PIHPs
2. Consistent and clear guidelines to the CMHs for administrative cost reporting so that it is clear which CMHs can save money.
3. Consolidation of Mental Health and Substance Abuse.
4. Make the Detroit/Wayne CMH independent of the county government so that all money goes to services for the consumer.
5. A tracking program administered by the DCH to track primary care doctors who are prescribing psychotropic and psychotic meds to ensure that they are following best practices for the mental health disorder in question.

Our current system

1. For those consumers with mild and moderate mental health disorders the law requires that there be 20 visits available to them for psychiatric help from the Medicaid HMO if their condition is mild or moderate. If the disease progresses to a severe stage then these consumers become the responsibility of the CMH in that area. Thus, in my opinion, the current system encourages cost shifting from the HMO to the CMH. We pay very little to the HMOs for these psychiatric visits. It is hard to find doctors to take these patients just as it is on the physical side. If the consumer cannot get treatment then their disease worsens and they end up at the CMH for treatment and because of the advanced nature of the disease it is much more expensive to treat.
2. The CMHs are required to heavily involve consumers in the formulation of their programs thus making each CMH responsive to what that local community wants in their program. The HMOs do not have this requirement. Keeping this local touch is, I believe, very important for the success of a mental health program.

What a new program can look like

1. Move the 20 visits that the HMOs are responsible for to the CMHs. Then the system will have an encouragement to treat the consumer early and successfully so as to avoid higher costs later on. By having everything in the CMH they will be encouraged to achieve success earlier on.
2. By moving the 20 visits to the CMH there will be much less disruption to the system than if we were to move all of the high cost and high maintenance procedures to the HMOs. Consolidating the system makes sense but should be done in a way that disrupts the consumer the least, particularly those consumers who are most in need of care.
3. We could further reduce the number of PIHPs in the state. In 2011, when asked, I said we should have one for the entire state. I still believe this could work and would further reduce administrative costs without sacrificing the local touch that we have with our CMHs.
4. Through contract language with both the HMOs and the CMHs the DHHS could require software that would allow both to seamlessly converse with each other so that there is full awareness on both sides about the care being provided to a patient.
5. The consumers are not going away. If we fail to treat them successfully they will show up in other areas of the budget for which you are responsible.
6. For physical health there are known normal costs for various diseases. The Medicaid HMOs

are paid by the state partially on this basis. For mental health there are, I believe, no known normal costs for the various diseases. Thus, the Medicaid HMOs could find themselves being grossly underpaid for many patients who require ongoing help. They have not worked with such consumers. What has been talked about in the past is to set up a high risk pool paid for by the state for such patients. Is that being discussed now? CMHs are much more tuned in to current best practices and, I believe, can mitigate the costs of such patients. And, as I said above, the CMHs will have an incentive to successfully treat the mild and moderate patient so that they never progress to the severe stage.

I ask you to reform the proposed budget boilerplate so that there be discussions as to the best way to build a comprehensive system that is sensitive to the patient, the community, and the state budget. This is a complex problem. You have made great strides in reforming the system in the last five years. I simply and humbly ask you to use the greatest strength we have in Michigan for those with mental illness and that is our local CMH system

Ruth Sprague and Thomas Zmolek
Health Services SC 2-29-16 (15-16 B)
Medicaid SC

Employers Can't Attract Direct-Support Workers with Current Reimbursement Rates

Results of a Survey by the Partnership for Fair Caregiver Wages

In the spring of 2014, the Michigan Legislature passed a law to increase the standard minimum hourly wage, via annual increases, from $7.40 to $9.25 by January 1, 2018. The Legislature did not provide any additional funding for the wages of direct-support workers, the employees of state-funded programs that care for and support some of the most vulnerable people in our state.

An estimated 44,000 direct-support jobs are funded through Medicaid appropriations to support and serve people with intellectual and developmental disabilities, mental illnesses, and substance use disorders. Employers of these workers depend on Medicaid funding provided through the Michigan Department of Health and Human Services, and unlike other businesses, have little or no ability to increase revenues to meet increased staff costs.

An estimated 44,000 direct-support jobs are funded through Medicaid appropriations to support and serve people with intellectual and developmental disabilities, mental illnesses, and substance use disorders.

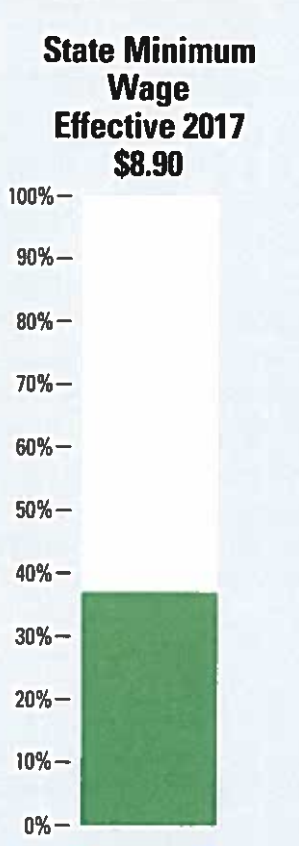
Even before the increases in the minimum wage, staffing shortages tied to low wage rates were creating soon-to-be-crisis-level consequences.

New survey paints a stark picture.

A recent survey (see page 4) sponsored by the Partnership for Fair Caregiver Wages highlights the challenge employers face in meeting the new minimum wage requirements.

The average starting wage for direct-support workers is $8.69 per hour, but 28 percent of state Medicaid-funded employers pay a starting wage of less than $8.50 per hour, the state minimum wage as of January 1, 2016. The majority pay an average starting wage of less than $8.90 per hour, the minimum wage scheduled to go into effect on January 1, 2017.

Only 37 percent of employers have a starting wage at $8.90 per hour or above



The Partnership for Fair Caregiver Wages is a coalition of state-wide organizations advocating for persons with disabilities, direct support staff, and employers as well as regional community mental health boards and individual employers. This coalition is seeking sufficient public dollars to raise the wages of direct support staff in Medicaid-funded programs supporting people with intellectual and developmental disabilities, mental illness, and substance use disorders. For more information, please contact Hollis Turnham at hturnham@PHInational.org or Robert Stein at rstein@miassistedliving.org

Uncompetitive wages result in high turnover and many unfilled jobs.

An ever-changing stream of staff due to high turnover and unfilled jobs destroys the continuity of supports and services and undermines the quality of support for people with disabilities.

In one week, surveyed employers reported over 2,600 vacant jobs meant to support and serve people with disabilities.

The average annual turnover rate was 37 percent, though a sizeable number of employers report much higher rates. Almost half of responding employers (48 percent) have a turnover rate higher than the average, ranging from 38 to 97 percent.

High Turnover

Among those surveyed, a 37 percent turnover rate = loss of 6,308 employees in a single year.

100% = 17,409

The labor market has changed.

With the recent change in the state minimum wage, these state-funded direct-support jobs are now "minimum wage jobs." This makes these challenging jobs even less attractive to workers who may find better wages in retail or food service.

The reality is that major retailers are raising their minimum wages to attract and retain employees. Michigan's direct-service providers are competing for labor with companies like Target, Walmart and Costco, all of whom have announced their intention to increase starting wages.

To ensure that their state-funded programs caring for vulnerable residents can compete for workers, other states are stepping up to increase wages. Maine, for example, increased reimbursement for home and community-based providers from $15 to $25 per hour, and required that 85 percent of the increase go to the home care aides who deliver services.[1] New York has created a wage floor of $10 per hour for its home care workers (the state minimum wage will be $9 per hour at the end of 2015),[2] and Oregon will pay state-funded personal care aides $14 per hour in 2016.[3]

Hourly Wages

Michigan Direct Support v. Major Retailers

Employers simply can't compete.

As this new survey shows, the vast majority of employers of direct-support staff cannot afford to raise starting wages to $8.90 per hour—or higher—to compete in the open job market with such behemoths as Walmart, Target, and others.

Just over one third of providers are considering discontinuing some services, identifying staffing shortages and insufficient reimbursement rates as the primary reason for doing so.

Potential workers are already choosing other employment where they can earn the same or a better wage with much less responsibility than that of a front-line caregiver. If publicly funded employers can't afford to pay more than the minimum wage, they will not be able to provide the caregiving services that Michigan residents need.

Direct-Support Workers Earning Poverty Wages

The average hourly wage for all direct-support workers is $9.52 per hour (including new and incumbent workers). With full-time hours, these workers earn just $19,801 annually, an amount just below the living wage earnings for a single person to live self-sufficiently ($20,761), and less than half that required to raise a child as a single parent ($44,322).[4] But notably, half the workforce works less than full-time, reducing their annual earnings.

Data shows that over half of Michigan's direct-care workers (including direct-support workers, home health aides, and nursing assistants) rely on public assistance, including food and nutritional assistance, Medicaid, and housing assistance to support their families.

Direct-support workers provide vital services to Michigan's families, but they don't earn enough to be self-sufficient themselves.

Solutions needed to stabilize support services.

State policies must change so that employers can recruit and keep skilled direct-support workers to support the independence of people with developmental disabilities, mental illness, and substance use disorders.

The Partnership is asking for a $1 per hour, per year wage increase for fiscal year 2017, 2018, and 2019 that will place starting and current wages at $10–$12 per hour.

By increasing the wage rate for direct-support workers, Michigan will demonstrate that caregiving is "not a minimum wage job" but is instead an important part of supporting and strengthening Michigan families and communities.

2,600 direct-support workers are needed *now*

Endnotes

1 Maine PCAs Will Receive Wage Increase (July 22, 2015). Found at: **http://phinational.org/blogs/maine-pcas-will-receive-wage-increase**

2 Home Care Worker Wage Parity Frequently Asked Questions (FAQs) (January 2014). Found at: **https://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-01-17_faq_information.pdf**

3 Oregon PCAs Could Earn $15/Hour by 2017 (September 3, 2015). Found at: **http://phinational.org/blogs/oregon-pcas-could-earn-15hour-2017**

4 **Dr. Amy K. Glasmeier** (2015). Living Wage Calculation for Michigan. **Massachusetts Institute of Technology**. Found at: **http://livingwage.mit.edu/states/26**.

About the Survey

The Partnership for Fair Caregiver Wages sponsored the survey of employers with the Michigan Assisted Living Association. The vast majority of the responding employers provide residential services (86 percent), community living supports (74 percent), and personal care (68 percent) to people with intellectual and developmental disabilities (96 percent) and mental illness (68 percent).

The response provides statewide representation of Medicaid-funded providers, with the majority of respondents working in Wayne, Oakland, and Macomb counties.

The 121 responding providers employ 17,409 direct-support workers, across the state. Half of direct-support workers work full-time.

For more information contact

Hollis Turnham at hturnham@PHInational.org
Robert Stein at rstein@miassistedliving.org

Thomas Zmolek
Health Services SC
Medicaid SC

2-29-16
15-16
A

moka We See the Individual in Everyone

Monday, February 29, 2016

Honorable Representatives,

Thank you for the opportunity to speak on the critical issue of the inadequate level of direct care wages in community based services for individuals with disabilities. My name is Tom Zmolek and I have the great privilege of serving as executive director for a nonprofit organization called MOKA, serving over 800 individuals with autism, developmental and other disabilities in a four county region of western Michigan.

I come here not only as a professional in the field, but also as a sibling. I grew up with a brother with autism who now lives in a specialized residential group home and so I can speak first hand to the importance and impact of locating and keeping competent and caring employees.

I'd like to read an excerpt from a story a parent of one of the individuals we support shared with us recently to illustrate this importance. This is a story about a young man who I'll call "Ben," because that's his name.

> "If you had asked me 15 years ago how I would feel about putting my son Ben in adult foster care, I would have said... positively... "No Way!" Ten years ago, when that decision became a necessity, I just cried. How would the staff know Ben's needs? His speech is almost non-existent, and his needs are so great. Most of his communication is accomplished through his form of signing and gestures to get his point across. Who could ever take care of him like we do?
>
> Today, I marvel at the freedom Ben enjoys and at the incredible supports that make his adult life full of accomplishments, relationships, and meaning. He has many choices. I've watched the staff's respect for Ben, as an adult, and have appreciated all the ways they make his life orderly and rewarding. Eric the home manager has hired incredibly loyal staff – persons of quality and longevity – that respect and come to love the individuals they serve. In addition, because of his increasingly dangerous behaviors, a home with employees who are specially trained and understand how properly support an individual with challenges like my son became the only option. I would hardly know behavioral homes exist if it weren't for Ben.
>
> I traveled around the country for seven years in my work, having many opportunities to meet with Moms of special needs individuals, in one-on-one settings. Michigan's service to developmentally delayed or physically challenged individuals outshines most of the states in many services.

715 Terrace Street, Suite 201, Muskegon, MI 49440 PH (231) 830-9376 (800) 644-2434 FX (231) 737-1464 www.moka.org

Because of Ben's diagnosis and needs, I've been privileged to meet the best of people – quiet, servant-hearted people with a passion, who make Ben's life great. Now, 10 years after placement, I have to say what a tremendous blessing Ben's home, has been to our family, and primarily to Ben. It was the right – the very best – move for Ben.

The point of this story is that the strong system of care that great leaders in Michigan's mental health system built and nurtured is at risk. Our organization alone has already closed two group homes and we are contemplating other closures. We haven't been able to accept to referrals for individuals who require additional staffing, and of course we cannot even consider responding to requests for proposals to open new homes. For all of these situations, it's due to the fact we are unable to recruit and retain competent and caring employees.

To be clear, this issue is not just about "keeping the doors open," although that is a major concern. We have studied the metrics and it takes approximately 100 applications to hire 10 competent employees. We conduct rigorous background checks where we screen all applicants, requiring among other things physical exams and screens for illegal drug use, check for adverse driving records and review for any past histories of abuse or neglect. Those who pass these many tests are then interviewed and scrutinized to find those applicants with the right attitude, desire to learn and competency to do this important work. After all that, they have to accept working at our starting rate of $8.81.

The job of a direct care professional is so much more than personal care taking—it involves the roles of mentor, instructor, empowerment coach as well as playing the role of extender staff for psychologists, nurses, occupational therapists and many other disciplines. The level of wages we are currently able to pay our front line employees is not commensurate with the skill level and deep insight this job requires.

John F. Kennedy Jr. said, ""Quality is defined at the point of interaction between the staff member and the individual with a disability." If you think about it, our entire mental health system of care is built upon these relationships and the ability our staff to competently support the individuals we are privileged to serve.

I urge you to defend the quality of services for our citizens with disabilities in Michigan by supporting the recommendations for wage increases put forth by the Partnership for Fair Caregiver Wages. Doing so will maintain Michigan's leadership by retaining the high quality employees individuals like Ben and my brother need to live as successful members of our communities.

Thank you for the opportunity to speak to you today on this critical issue.

Sincerely,

Thomas Zmolek
Executive Director

Health Services SC
Medicaid SC
Daniel Cherrin 2/29/16

WayneCountyCommunityMentalHealthCollaborative

Testimony Presented To
Joint House Appropriations Committee
Medicaid Subcommittee + Health Services Subcommittee
of Health and Human Services
Re. Behavioral Health Services

Daniel Cherrin, Facilitator
Monday February 29, 2016

Good morning, Mr. Chairmen and members of this joint committee. Thank you for the opportunity to testify today on the state of behavioral health services in the State of Michigan. I am Daniel Cherrin and I lead a collaboration of 19 community mental health organizations in Wayne County.

Together, these providers serve over 50 percent of the state's Medicaid population. Collectively this group represents over 72,000 consumers and employs over 12,000 people.

The care they provide runs the gamut -- Servicing adults with mental illness, children and adolescents with serious emotional disturbance, persons with developmental disorders, and persons with substance use disorders throughout Detroit and Southeast Michigan.

I hope all of you around the table chose public service and elected office to help people. In addition, we all like stability. Knowing that tomorrow we will have the chance to return to the same job we had today or knowing that your son, daughter, brother, sister, aunt or uncle living with a developmental disability are being taken care of with quality care.

Everyday, these providers are helping people live a quality life full of meaning and working hard to ensure some form of stability in their lives.

However, whenever a new budget is introduced, a new mental wellness commission is convened or funding for mental health is threatened in any way, that stability is at risk. Since the budget was first announced earlier this month, providers have been hearing from their consumers.

- Will I have to change my doctor?
- What clinic will I go to?
- Are their additional hoops we have to go through?

From an operations perspective, as providers, not knowing what the system will look like in 2017, prevents them from planning for the long term or recruiting a talented workforce.

I know there is a lot going on in this state. And as lawmakers, before you vote on a budget proposal, you need to evaluate what is already out there. If you pass this budget as written, what will happen to existing programs you recently approved, such as MI Health Link, that is piloting integrated health in four locations in Michigan (including Wayne County), or other programs that you have funded.

Under the current funding structure, these providers are able to not only provide a full range of behavioral health services, they are also able to provide extensive support and outreach for the basics that have to be in place for their clients to survive and thrive. This includes, providing access to safe housing, supported employment, coordination with primary care, on-site integrated care, and advocacy for financial entitlements, in addition to overall navigation through a very complex social system. The flexibility these providers have in providing an array of services is extremely important to their consumers.

The current system is neither perfect nor is it ideal, but for the consumers we serve and the families we support, it works. To make it work, these providers take the money you appropriate to the CMH and make that money grow through grants they secure from foundations such as Kellogg, Flinn, Kresge and others, in addition to private philanthropy.

To be blunt, the funding you appropriate is not adequate for these organizations to provide the quality of care you would expect or the quality the Governor and Lt. Governor are asking for in their current budget recommendation. But we make it work.

Likewise there is a lot of talk about integrated care. In fact, there is a lot of talk nationally about it. But here in Michigan we are already doing it. Take for example, a "School Based Mental Health Initiative," that was recently established in Wayne County, in which several mental health organizations are funded to provide "on school site" staffing support for the provision of Mental Health and Prevention services to children, youth and their families. A total of 77 schools will be served through this initiative. This is an example of integration and coordination of services with several Wayne County school districts, The Detroit Wayne Mental Health Authority, mental health providers and parents. I can offer other examples of integrated care, where mental health providers have formal relationships with physical care providers, such as FQHCs, to imbed full time behavioral health staff in clinics

The providers I work with have a lot to be proud. As I mentioned, they take the funding you appropriate and leverage additional federal and foundation funding. Take for example Southwest Counseling Solutions. They raised over $7 million in federal funding this year alone and have raised even more through their sister agency, Southwest Housing Solutions, to renovate over 25 abandoned apartment buildings in Detroit and created over 500 units of affordable housing, many of which are set aside for individuals / families with serious mental illness.

As providers and as elected leaders, we both need to put people first and focus on the communities we serve. Good government should be about creating better opportunities for people in our state and I strongly encourage each of you to seek out the providers in your district, visit them, talk with the consumers and their families, and get a strong sense of the vital role you play in the direct care of our consumers.

Thank you. I will be happy to answer any questions you have.

SNAPSHOT | WAYNE COUNTY COMMUNITY MENTAL HEALTH COLLABORATIVE

Our Purpose

Due to the evolving nature of community mental health, a number of well-established community-based organizations, providing quality programs to a community with very specific needs in Wayne County, formed a collaborative to collectively monitor activity, develop strategic relations and proactively work on ways to preserve the quality of care to the people that trust them in an efficient and caring way.

Our ***mission*** is to strengthen the position and profile of well-established and accredited community mental health providers in Wayne County through collaboration, information sharing and advocacy, to benefit and enhance the quality of care for the people we each serve.

Collaborative Members:

Adult Well-Being Service, Est.1953	Guidance Center, Est. 1958
Arab American Chaldean Council, Est. 1992	Neighborhood Services Organization, Est. 1959
The Children's Center, Est. 1929	New Center Community Services, Est. 1979
Community Care Services, Est. 1985	Northeast Guidance Center, Est. 1963
Black Family Development Est. 1978	Services To Enhance Potential, Est. 1972
Detroit Central City, Est. 1971	Starfish Family Services, Est. 1963
Development Centers, Inc., Est. 1983	Southwest Solutions, Est. 1970
Goodwill Industries of Greater Detroit, Est. 1921	The Guidance Center, Est. 1958
Hegira Programs, Inc., Est. 1971	Wayne Center, Est. 1973
Lincoln Behavioral Services, Est. 1978	

How we help our community.

Children + Adults + Seniors + Veterans + Homeless |Adult Mental Health | Developmental Disability Services | Children's Mental Health | Mental Health Access | Assessment | Treatment | Housing assistance| | Vocational assistance | Community Inpatient | Crisis Intervention | Case Management | Home-Based Services | Psychosocial Rehabilitation | Job Coaching | Work Training Placement | Peer Supports Services | Prevention | Head Start, Great Start, Early Head Start | Outpatient Treatment | Court Services | Adult Foster Care | Substance Abuse Services | Clubhouse | Literacy Programs | Workforce Development | Housing Services | Community Re-Entry | Skill-building, supports coordination, | Early Childhood | Children & Youth | Adult Services | DD | I/DD, SMI, SED, SUD when dual diagnosis, licensed for SUD Integrated Care | Jail Diversion | Police Training

For more information or to arrange site tours, contact:
Daniel Cherrin, 313.300.0932 dcherrin@northcoaststrategies.com

Health Serv SC
medicaid SC
Debra Johnson 2/24/16
(12)

St. Clair County Community Mental Health Authority

Promoting Discovery & Recovery Opportunities for Healthy Minds & Bodies

Debra B. Johnson
Executive Director

Malachy Browne, MD
Medical Director

Stephen Armstrong
Board Chairman

SECTION 298 TESTIMONY
Prepared for the House Appropriations Committee
Monday, February 29, 2016

- I am here today to testify on behalf of St. Clair County Community Mental Health Authority (SCCCMHA) to express our strong opposition to Section 298.

- I want to begin by thanking those legislators who have been open to the concerns I and many others have about Section 298. In particular, I would like to thank Lt. Governor Calley for convening a workgroup to seek consensus on how state-funded mental health care will be delivered. I want to thank him as well for his support in recommending the removal of Section 298 from the Fiscal Year 17 budget.

- I have heard it said that 298 does not privatize community mental health programs…which is simply a distinction without a difference, and stated in such a way as to seemingly minimize the danger and true intent of Section 298. While not calling for the privatization of community mental health organizations, Section 298 does require the management of mental health services be privatized. Thus, CMH, the community based provider network, and those who rely for services on these systems, for the first time in Michigan's history, will be answerable to for-profit, private corporations whose goals are to maximize profits, not maximize services.

- The current system represents the culmination of fifty years of hard work among individuals with mental illness, Intellectual/Developmental Disabilities, substance use disorders, their friends and family members, mental health professionals, and legislators from both sides of the aisle. While certainly not perfect, it is nonetheless the most progressive and comprehensive system in the country. In point of fact, the public behavioral health care system in Michigan is the example many other state's behavioral health care systems seek to emulate.

- The current system:

  - ✓ oversaw the de-institutionalization of individuals with mental illness and intellectual/developmental disabilities through the development of a community-based system of care

  - ✓ instituted a Person-Centered Planning process for creating support plans and services

  - ✓ is building a meaningful self-determination process

  - ✓ has successfully adapted to a managed care environment for the Medicaid program

  - ✓ has adopted numerous evidence base practices. For example, at SCCCMHA, we have instituted 26 different evidence based practices that have proved extremely effective in assisting those we serve in their recovery.

- However, because we agree that no system is perfect and there is always room for improvement, we welcome the honest and thorough review of Lt. Governor Calley's workgroup.

- Having said that, we strongly believe that simply discarding the current system in favor of an untested system, proposed by interested parties, based on questionable claims, would be devastating to the individuals we serve.

- We also strongly believe it represents bad faith on the part of the Snyder administration, in that the Department of Health and Human Services just completed a public review period for the 1115 Medicaid Wavier. Section IV., 5., (d) of that waiver reads:

  "In April 2014, Michigan required its 18 PIHPs to consolidate to 10 through an Application for Participation of Specialty Prepaid Inpatient Health Plans. As outlined…Michigan intends to continue the use of this managed care delivery system within this 1115 application, *but holds the ability to contract outside the PIHP and CMHSP system if the managed care entity and/or providers cannot meet the service delivery, quality, financial, and reporting requirements as determined by the state."*

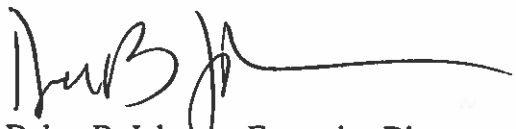
- But instead of the careful review process implied in the 1115 Waiver, the Governor's budget carte blanche ends the behavioral carve out, without an honest evaluation of the system, and system participants as promised in the waiver. I do not believe it is an exaggeration to say that slipping boilerplate language into the budget to end the behavioral carve out, without any input from stakeholders of the behavioral healthcare system, is an abuse of the legislative process.

- Again, I strongly urge you to oppose Section 298 of the Fiscal Year 17 budget. In my opinion, this represents the most serious challenge to behavioral health care services in the past fifty years, and virtually guarantees a diminished quality of life for the most vulnerable among us.

- I urge you to adopt Lt. Governor Calley's approach of a thoughtful, diligent examination based on facts of how state-funded mental health care is delivered, as opposed to a reckless effort to gut the current system in favor of special interests seeking nothing more than greater profits. Please be a champion for our fellow citizens with mental illness or Intellectual/Developmental Disabilities for whom passage of Section 298 would be catastrophic.

- I sincerely appreciate the opportunity to speak with you today. Please do not hesitate to contact me for additional information or discussion on this matter. Thank you.

Submitted by:



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(810) 985-8900

Health Services SC
Medicaid SC

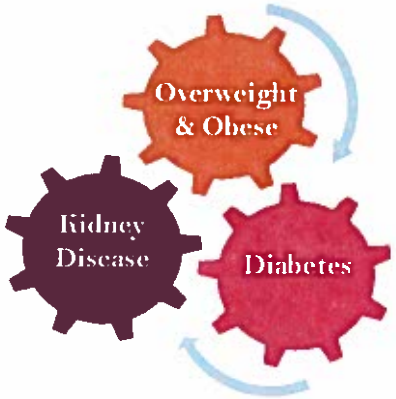
Charlene Cole/Sally Joy i

10-11

Diabetes and Kidney Programs
Supported by the Michigan Department of Health & Human Services

The Problem

Obesity → Causing Type 2 Diabetes → Causing kidney disease/failure



Prevention is possible in every part of this equation

Obesity:

- Michigan is the 5th most obese state in the nation.
- Over 66% of Michigan adults are overweight or obese.
- Obesity is directly correlated with type 2 diabetes.

Diabetes:

- Over 13% of Michigan adults have diabetes, but one third (1/3) don't know it.
- Over 29% of Michigan adults have pre-diabetes (blood sugar levels higher than normal). Most will develop type 2 diabetes without lifestyle changes.
- Diabetes is directly correlated with kidney disease and kidney failure.

Kidney Disease/Failure:

- Over 9% of Michigan adults have chronic kidney disease, but most don't know it.
- Diabetes is the leading cause of kidney failure.

The Solution

Reducing obesity, diabetes, and kidney disease can be achieved through:

- Diabetes Prevention Program – available in more than half of Michigan counties.
- Community programs that are evidence based and provide tools for self management
- Collaborative partnerships: MDHHS, schools, Head Starts, community-based organizations, non-profits, faith-based organizations, health plans, medical professionals, etc.
- Programs focused on minority populations at higher risk for diabetes, high blood pressure, and kidney disease
- Leveraging match funding
- Alignment with the Health and Wellness 4 x 4 plan

4 Key Health Behaviors	4 Key Health Measures
1. Maintain a healthy diet	1. Body Mass index (BMI)
2. Engage in regular exercise	2. Blood Pressure
3. Get an annual physical exam	3. Cholesterol Level
4. Avoid all tobacco use	4. Blood Sugar/Glucose Level

Please support prevention of obesity, diabetes, and kidney disease through by increasing funding to positively impact the health of children, families and communities.

Charlene Cole & Sally Joy, National Kidney Foundation of Michigan
ccole@nkfm.org or sjoy@nkfm.org; 734-222-9800

National Kidney Foundation™ of Michigan

Sally Joy
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Health Serv SC
Medicaid Sc
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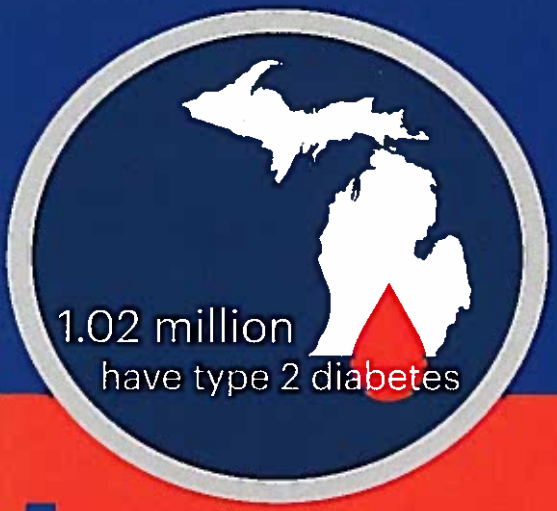
2015 -2016 Michigan
Guide for Policy Makers

National Kidney Foundation® of Michigan

The Challenge



Over 2 million **diabetes**
projected cases in 2030
at current pace

Take action, support solutions

Healthy Habits +

Disease Management =

Improved Quality of Life

National Kidney Foundation® of Michigan
1169 Oak Valley Dr
Ann Arbor, MI 48108
734-222-9800
www.nkfm.org

CHARITY NAVIGATOR ★★★★ Four Star Charity

Only 2% of charities receive 4 stars from Charity Navigator 8 years in a row.

National Kidney Foundation of Michigan

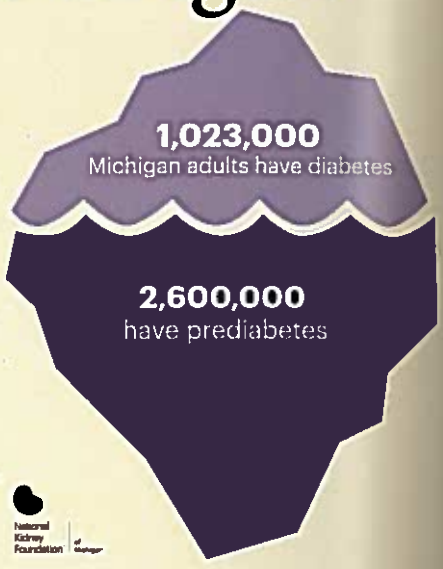
Preventing Diabetes Saves Money,

The Cost of Diabetes to Michigan

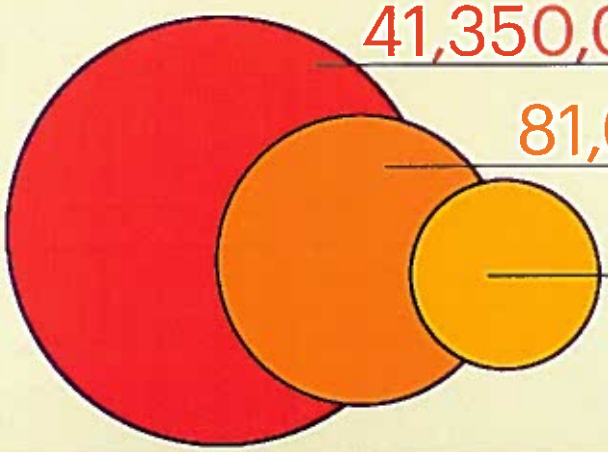
$7.2 billion Diagnosed type 2 diabetes

$1.1 billion Prediabetes

$1 billion Undiagnosed type 2 diabetes



The NKFM is leading the charge against diabetes and kidney disease



41,350,000 reached — Social Media

81,000 reached — Programs

18,000 reached — Public Events

The National Kidney Foundation of Michigan (NKFM) reaches thousands of children each year, and serves those most in need.

The NKFM touched the lives of more than 26,000 children last year.

Rego's Rainbow Adventure®

11,824 preschool families

NAP SACC

2,080 preschool families

Healthy Families Start with You

388 preschool families

PE-Nut

9,905 elementary and middle school families

Healthy Kids and Kidneys

1,611 kids ages 8-16

Kids Camp

917 kids ages 8-16 (over the last 29 years)

Kids in the NKFM's Early Childhood programs learn and adopt nutritional and physical activity behaviors that prevent chronic disease, promote their well-being and ultimately place them on a path to join a generation of healthy, prepared learners.

The NKFM provides Elementary and Middle School nutrition and physical activity educational programming through PE-Nut (Physical Activity and Nutrition Education Working Together) and Healthy Kids and Kidneys. These programs consist of dynamic, interactive, age-appropriate lessons designed to encourage a lifetime of healthy habits.

Kids Camp is a program that allows kidney patients between the ages of 8-16 the opportunity to engage in a camping experience with healthy peers. The goal is to let the kidney campers be a kid for a week, not just a patient, and not a victim of their disease. The interactions with volunteer staff and their peers provide life changing memories.

The NKFM's kids programs reach counties all over Michigan, including Allegan, Berrien, Cass, Hillsdale, Ionia, Jackson, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Macomb, Manistee, Mason ,Monroe, Muskegon, Newaygo, Oakland, Oceana, Osceola, Ottawa, Van Buren, Washtenaw, and Wayne.

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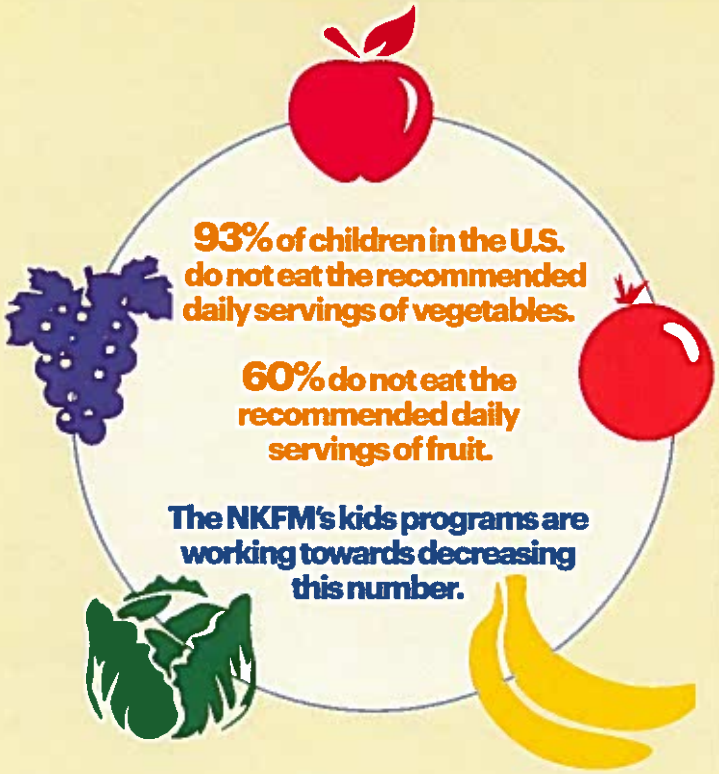
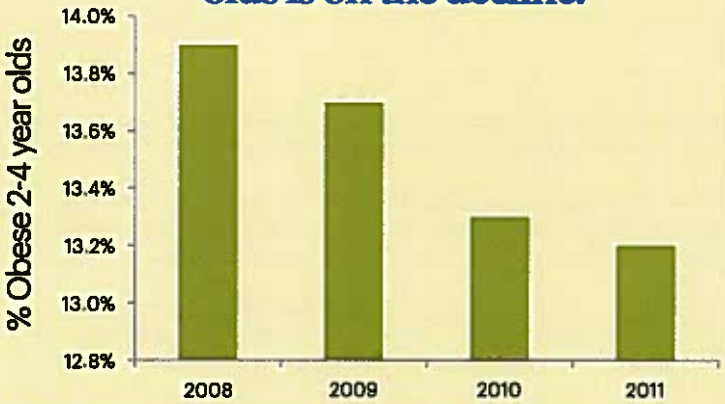
NKFM's Kids' Programs Make a Difference

Healthy Outcomes for Kids



Obesity in Michigan's 2-4 year olds is on the decline.



Sources: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6231a4.htm?s_cid=mm6231a4_w#tab2; http://www.cdc.gov/media/releases/2014/p0805-fruits-vegetables.html; http://www.cdc.gov/HealthyYouth/obesity/facts.htm

Promising Program Outcomes:

Regie's Rainbow Adventure®: 82% of parents say their child eats more fruits and 75% say their child eats more vegetables.

Nutrition and Physical Activity Self Assessment for Child Care: 63% of childcare centers increased how much fruit is offered and 80% of centers improved physical activity policies and practices.

Healthy Families Start with You: 71% of families eat healthier meals and 55% of families made at least one positive change.

Healthy Kids and Kidneys: 44% percent of classrooms reported an increase in fruit consumption and 52% of classrooms reported an increase in their vegetable consumption.

PE-Nut: 61% of kids now try new foods and 57% now ask someone at home to buy healthy foods.

The National Kidney Foundation of Michigan's kids programs can help children grow up to be healthy adults with lower risk of diabetes and kidney disease.

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& Kidney Disease
Saves Lives

"Diabetes is one of the most serious health challenges in America today.
My Choice...My Health: Diabetes Prevention Program is a powerful answer because it provides participants with the tools to take greater control over their health and work toward staying diabetes-free."
-James K. Haveman, former Director of Michigan Department of Community Health

RECOGNIZED BY THE CDC
TO PREVENT OR DELAY TYPE 2 DIABETES

My Choice...My Health: Diabetes Prevention Program at the NKFM served 734 adults with prediabetes:

110 Prevented 110 new cases of type 2 diabetes

11,189 Prevented 11,189 missed work days

80 Avoided the need for BP/Cholesterol pills in 80 people

5.8 Reduced participants' body weight by 5.8%

$256,729

$256,729 Net Savings in healthcare costs*

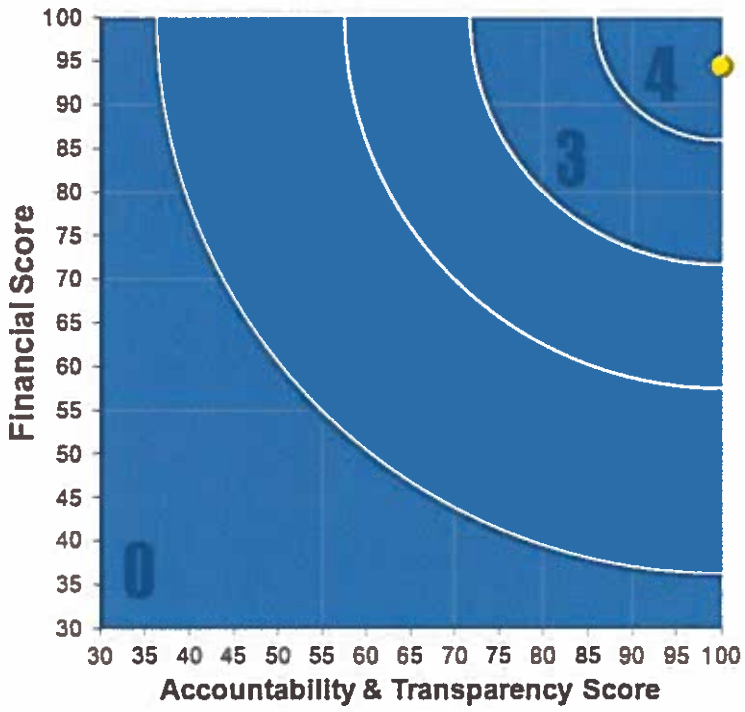
*American Medical Association: DPP cost savings calculator. All other references available upon request.

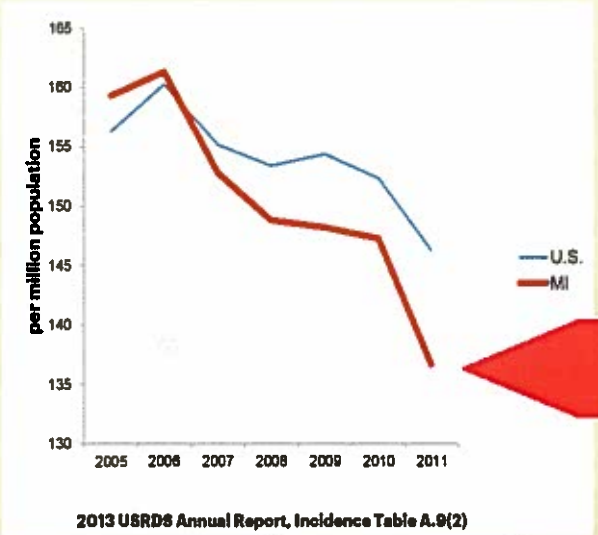
National Kidney Foundation of Michigan Rated One of America's Top Nonprofits

For the 8th consecutive year, the National Kidney Foundation of Michigan (NKFM) has been recognized for its sound fiscal management and performance by receiving the coveted 4-star rating from Charity Navigator.

- Charity Navigator is the leading charity evaluator in America and only gives the 4 out of 4-star ratings to 25% of the charities it evaluates.
- Only 2% of these charities have received the prestigious 4-star rating for eight consecutive years.
- At a 96.06 rating, the NKFM is in the upper 2% of all nonprofits in America.

This exceptional ranking demonstrates that the NKFM outperforms the majority of other nonprofit agencies in America in fiscal responsibility and performance.





2013 USRDS Annual Report, Incidence Table A.9(2)

The NKFM has been leading the charge to prevent kidney failure from diabetes in Michigan through our evidence-based programs.

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Sally Joy 2/29/16

Living With Diabetes

Living with type 1 diabetes isn't easy, but it's possible.
Here are some things I've learned over the last 50 years!

Diabetes is not always simple to manage.

Sometimes it feels like I'm living in an unfavorable environment.

Blood sugar ups and downs are always challenging.

Studying food values, measuring, calculating, blood sugar testing, taking my medications and physical activity <u>all</u> play and important part in managing my diabetes.

To guide me in my journey, I use my "diabetes lighthouse;"
a team including ***my doctor, nurse, dietitian <u>and ME.</u>***
Over the years, I've come to realize that
I am the most important member of the team!

Kirsten Elliot 2-29-16 (9)
Health Services SC
Medicaid SC

Testimony for Public Hearing
Health Services Subcommittee and Medicaid Subcommittee of the House
Appropriations Subcommittee on Health and Human Services February 29, 2016

Kirsten Elliott
47444 Greenview Rd.
Shelby Twp., MI 48317

FY 2016-17 Executive Budget Recommendation for Behavioral Health, Medicaid, Healthy Michigan Plan, Children's Special Health Care Services

Good morning House Sub-Committee Members. My name is Kirsten Elliott. I am speaking to you today as a parent of a son who receives mental health services from Oakland County Community Mental Health Authority. I am also employed by Community Housing Network, which provides housing related services for people in need, including people with disabilities and is partially funded my OCCMHA. But today I am speaking to you as a parent and concerned citizen.

My son Maxwell Elliott is 22 years old and was diagnosed with Quadriplegic Cerebral Palsy at the age of 9 months. He is dependent on mobility devices such as his power chair and daily living supports. These provide Max with the ability to live independently integrated in the community. Max is a bright young man who attends Oakland University and who I hope will be finally graduating in December with a Bachelor's degree in English. Max plans on pursuing a job in marketing and public relations and he currently lives on his own in Rochester Hills.

As a parent of a son who is dependent on mental health services to live a productive independent life, I have deep concerns about the proposed Section 298 boilerplate language in the fiscal 2017 budget. I understand that Lt. Gov. Brain Calley will now be leading a workgroup of stakeholders to develop a proposal with clear goals about how state-funded mental health care should be delivered, managed and paid for. Yet I am still concerned how the State is approaching the integration of behavioral health with the Medicaid HMOs. I don't oppose change but the way this has developed so far has not been transparent. Up until Lt. Gov. Calley stepped there has no discussion, no communication and no stakeholder involvement. There has been no one looking out for Max and his needs.

First, I certainly agree that integration needs to happen and that integration will provide an opportunity for improvement in terms of cost effectiveness, outcomes for consumers, like my son and efficiency of the current system. However, I am concerned that any realized cost savings of the public mental health funding will be redirected to the Medicaid HMOs to cover non mental health expenses to shore up shortages elsewhere.

Moreover, there is an underlying assumption there are savings to be had in the public mental health system, and I am sure there are some administrative efficiencies. Yes, we need to minimize administrative costs, ensuring that the greatest share of the

healthcare dollar goes to serving consumers. However the proposed plan does not make sense. Michigan's PIHP system has on average an overhead cost of 6%, giving them a medical loss ratio of 94%. For-profit health plans have on an average an overhead cost of 15-17%.

Even with the proposed projected minimal cost savings that will result by funneling the mental health funding to the Medicaid HMOs, the current public mental health system is already underfunded because there are not enough funds to pay direct care workers a living wage, let alone the new minimum wage which went into effect January 1, 2016. There were no funding increases to account for the new minimum wage and many consumers saw a cut in the number of service hours to make up for the increased wage.

This is one of the greatest threats to my son and others who depend on direct care staff. We simply cannot recruit and let alone keep good, dependable, and caring direct care staff because we cannot pay a competitive wage for doing the specialized work of taking care of our most vulnerable citizens. It is beyond difficult to find staff willing to do this hard work when the pay is minimum wage. Potential staff can make more money at working at McDonalds or Walmart.

So if savings are there, then they must be redirected only to recipients of the public mental health system. Any savings must only come from administrative efficiencies and not a reduction of services to consumers. The current boiler plate language does not provide for these protections.

Second, I have heard that this is not a call not call for privatization of the mental health system instead it is a plan is to merge administration of the state's 10 prepaid inpatient health plans, or PHIPs, into up to 13 Medicaid HMOs, which seven are nonprofit and six are for-profit. But all are private organizations, not public entities as are the mental health authorities (PIHPs). I worry about transparency and accountability with the private Medicaid HMOs.

All of which brings me to wonder, why the Medicaid HMOs are diligently lobbying to administer these dollars. At the end of the day, whether for-profit or non-profit, the HMOs are in business to make money. They are bottom-line driven, not mission driven like the public PIHPs. I do question why a business would want to take on something you can't make money at and will be more work. We have to ask, what is in it for the HMOs?

Finally, the current system has been considered a national model over the years and allows for specialty services not provided by traditional Medicaid health providers such as case management, employment, housing and transportation. The current behavioral health and developmental disabilities system is not perfect but it is not broken. Why place the gains we have made over the last several decades at risk for a proposal that is untried and has dubious savings and dubious outcomes.

We need to be very careful about making a sweeping change, such as has been proposed, when there may well be more strategic changes that would produce improved outcomes and savings without as much potential disruption. A few other states have tried similar changes to those proposed and have met with mixed results at best.

I know I choose to stay in Michigan because of the high quality of mental health services for my son Max. He has the opportunity to live a truly productive and independent self-directed life that would not be possible in most other states. This change would drastically impact more than 300,000 Michigan residents who receive valuable services through the public mental health system, as well as the family, friends, neighbors, and co-workers who are involved in their lives. I urge you to tread lightly and mindfully as you consider changes to the public mental health system, this is not just about saving money but about people's lives.

Thank you for your valuable time and consideration.

Sincerely,

Kirsten Elliott

Medicaid SC 2-29-16

Michigan
Dental Hygienists' Association

Testimony to the
House Appropriations Medicaid Subcommittee of Health and Human Services, and the Appropriations Health Services Subcommittee of Health and Human Services regarding Healthy Kids Dental Program Expansion
February 29, 2016

Mr. Chairman and Members of the Committee:

My name is Kathy Mielke and I am a Registered Dental Hygienist and Immediate Past-President of the Michigan Dental Hygienists' Association. I would like to thank you for the opportunity to testify today. MDHA represents and promotes registered dental hygienists in the state of Michigan through education, licensure, research, and best practice standards. We are here today to speak in support of Governor Snyder's proposed funding increase to the Healthy Kids Dental (HKD) Program.

When first implemented in 2000, the Healthy Kids Dental program set out to help children who otherwise would not have had access to dental care. The program provides X-rays, cleanings, fillings, root canals, tooth extractions, and dentures - all services many of us take for granted. The program was so successful that by 2004, the American Dental Association named the Michigan HKD program a "national model" for dental health.

By providing care and exposing children to good dental practices early on, we can cut down on the medical costs that will inevitably occur at a later date. In fact, polls from a 2013 survey conducted by the Marketing Resource Group have shown that the overwhelming majority of Michigan residents support expanding the services of HKD to the whole state.

As successful as HKD has been, there are children in Michigan who are still in need of dental care, which is why we are so excited about Governor Snyder's recommendation providing for a full expansion of HKD. This represents the final step in providing coverage everywhere in Michigan. The governor proposes a total of $25.6 million in additional funding which would impact over 125,000 additional children. We wholeheartedly support this recommendation. When addressing this proposed expansion for the upcoming fiscal year, there are a few key things we would like you to consider:

1. Tooth decay is the #1 chronic childhood disease and it is totally preventable.
2. 70% of all children will require some sort of dental work by the time they reach adolescence.
3. Research shows that regular dental visits can detect diseases such as diabetes, heart disease, and numerous other inflammatory disorders.
4. With passage of this proposal, coverage will be provided in every county in Michigan.

I would like to thank the committee for hearing us today, and urge you to carefully consider the points we have made and support additional funding for Healthy Kids Dental. We would now be happy to take any questions.

Health Services SC
Medicaid SC

Fred Cummins (5)
2-29-16

Testimony of Fred Cummins

President of the Alliance for the Mentally Ill of Oakland County

February 29, 2016

I am the father of a woman with serious and persistent mental illness who has been a recipient of public mental health services for the past 28 years. I am past president of NAMI Michigan and current president of the Alliance for the Mentally Ill of Oakland County.

I am very concerned that there is discussion of any form of privatization of the Michigan, public mental health system. We already have problems with privatization of direct care services that are not accountable for inadequate or incompetent services and hide behind closed board meetings and private records. Privatization of the management of mental health services will result in diversion of limited funds for profits and a loss of transparency and accountability that further conceals failures to meet the needs of our vulnerable and disabled citizens.

I consider a strategy of privatization to be an admission of a failure of leadership and loss of moral compass by the administration. Furthermore, this follows on an abandonment of concern for vulnerable citizens of this state by the legislature as well as the administration. There is a lesson to be learned in the poisoning of Flint citizens and the massive debt of the Detroit Public Schools. These are failures of state government as a result of an abrogation of responsibility to the people of this state. Regardless of the involvement of financial managers, these organizations are creations of the state, and the state us ultimately responsible for their mismanagement.

The public mental health system has many problems, none the least of which is a failure of state leadership reinforced by misguided Federal policies regarding the management of mental health services.

Over the past 25 years, there has been a policy of abdication of care for persons in need of mental health services. Hospitals were closed, moving responsibility for seriously ill and disabled people to local, community mental health organizations without the funding needed to provide proper services. The state department of mental health has been scaled down to be little more than a budgeting and accounting organization. General funds have been cut such that only the matching of Federal Medicaid funds keeps the community mental health network in business. Many persons in need of mental health services are denied services unless or until they are in crisis, creating risks to themselves, their families and others.

Managed care has allowed the state to set a budget with total disregard for the welfare of vulnerable citizens, and to devolve responsibility for inadequate funding to the local community mental health organizations, ultimately putting the burden on vulnerable persons and their families. The only benefit of managed care is that it ensures compliance with a fixed budget regardless of the need. Persons who receive services are served by a monopoly and have no recourse when the services are inadequate or inappropriate. It is the responsibility of state government to ensure that they receive appropriate services.

You, the legislature, are the governing body, effectively the board of directors, responsible for ensuring that the mental health system is doing the right thing and doing it well. You have failed. That responsibility will not go away with privatization—it will just get more difficult.

A reformation of the public mental health system is way overdue. The system is designed to fail. It is underfunded and without leadership. The system works against the best efforts of professionals and direct care personnel to do the right thing. Failures and denials of care continue to result in increased costs over time. The recent budget cuts have set the stage for relapses and more serious afflictions in the future. The system shifts costs of thousands of persons to the criminal justice system, in most cases where a criminal act was the result of a failure, abandonment, or denial of care by the mental health system.

Competent state leadership would take charge of the system, define uniform practices, consolidate administrative functions and provide incentives and oversight to encourage adequate and appropriate care along with prevention and prosecution of fraud and neglect. There is fraud and neglect today, but no prosecution. There would be outreach to persons in need and early intervention to address emerging symptoms. The jail and prison populations would decline along with homelessness and premature deaths of persons with mental illness.

I have provided a document I developed as chair of a work group of the Governor's commission on mental health. It describes incentives of the mental health system that discourage and sometimes prevent people from doing the right thing. Fix these, and the funding, and we will have a much better system.

The administration and the legislature must start to put people first. To quote Abraham Lincoln—a Republican, by the way—ours is a "…government of the people, by the people and for the people…." It is not about companies, budgets or doing what is good politics. It is about serving the interests of the people—all the people—doing the right thing and doing it well.

In the meantime, fix these problems:

- Remove the barriers to malpractice suits that hold professionals accountable.
- Remove the defense of governmental immunity of service providers funded by government funds.
- Make the Freedom of Information Act and the Open Meetings Act applicable to non-profits that receive the majority of their funds, directly or indirectly, from government sources.
- Eliminate the Medicaid purgatory where persons on disability income and Medicare are not eligible for Medicaid nor Healthy Michigan.

Thank You.

Fred Cummins

Recommendations to Improve Michigan's Mental Health System Incentives

Presented by Fred Cummins

Prepared by Work Group #3, Incentives Sub-Group of the
Michigan Mental Health and Wellness Commission, September 2013:

Fred Cummins (chair)	Alliance for the Mentally Ill of Oakland County
Fred Van Alstine, MD	Michigan Academy of Family Physicians
Gregory Dziadosz	Mental Health Association in Michigan
Patricia Jefferson	The Living Room Drop-In Center
Pam Lamb	Team Mental Health
Allen Kessler	Midwest Health Plan
Milan Gandhi	Med Share

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Recommendations to Improve Michigan's Mental Health System Incentives

Introduction

The Governor has chartered the Mental Health and Wellness Commission to provide guidance for the reinvention of the mental health system in Michigan. There are three primary drivers for reinvention:

- A very high number of persons with mental illness are in Michigan's jails and prisons as a result of symptoms that are not effectively managed with adverse consequences to both the person with the illness and others. While there is a need to improve the handling of persons engaged by the criminal justice system, it is essential that mental health services minimize the risk of dangerous or disruptive behavior and thus reduce the risk of encounters with criminal justice.
- There is widespread recognition that mental healthcare and physical healthcare should be integrated to achieve better outcomes and reduce costs. That does not mean that mental healthcare providers should become physical healthcare providers, but that mental healthcare should be one specialty in a spectrum of healthcare services where multiple specialties work together to meet the overall healthcare needs of each patient.
- Advances in technology are having and will continue to have major effects on the delivery, quality and efficiency of healthcare. Advances, including support for shared patient records, collaboration and coordination of care as well as telehealth, will fall short if implemented by ten, independent PIHPs.

In general, people involved in the mental health system, whether administrators, providers or clients, are doing the best they can under the circumstances. The inefficiencies and failures of the system are largely a product of people doing what they are told to do or are encouraged to do by the incentives they experience. Consequently, many of these needs for changes to incentives in this report were derived by examining the failures and weaknesses of the system and considering why people don't "do the right thing." Additional incentives are needed to overcome the payer and provider healthcare silos. This report does not consider the effects of the multi-tiered, contractual structure of the mental health system although that does affect incentives.

The problems and associated incentives highlight the need for substantial changes to the design and operation of the Michigan mental health system. These changes should fill the gaps, achieve needed integration and realize the benefits of advancing technology. The changes will be disruptive, particularly to the persons who deliver and manage mental health services.

The system is the way it is, in large measure, because of the incentives. Acceptance of these changes will be difficult given that most people are doing the best they can in the current system with its inappropriate incentives. For this reason, the system will not realize substantial improvement without changes to the incentives.

Consequently, focuses on changes needed to create an appropriate system of incentives. Incentives may take the form of policies, regulations, organization responsibilities and reimbursement, to support needed integration, close the gaps and promote quality care. Incentives may be in many forms including funding, policies, regulations, organizational responsibilities, reimbursement, performance measures, directives, contract terms and liabilities.

The following sections describe the needed changes and supporting incentives.

Leadership by the Department of Community Health

The current mental health system is the result of the evolution of relatively autonomous community mental health organizations. Needed improvements to the mental health system cannot be accomplished by 10 PIHPs acting independently. There must be state-level leadership with a unifying plan, transformation funding, and the development of appropriate incentives to harmonize the efforts of the PIHPs and those who work for them, directly or indirectly.

Consolidation of systems

The public mental health system is replete with duplicated business operations and incompatibilities that result in inefficiency, poor accountability, inconsistent levels of care, fragmented care and inadequate access to medical records.

- The Department of Community Health should have clear responsibility for the effective and efficient operation of the public mental health system through the elimination of duplicated and inconsistent efforts.
- Allocate funding to DCH to manage the development, deployment and maintenance of common information systems. Common systems will achieve economies of scale, improve compatibility of information, improve care equity across PIHPs, support best practices and enable state-wide agility in response to advances in information systems and medical technology.
- Require DCH to assess the impact of consolidation of accounting, purchasing and personnel services for PIHPs to improve economies of scale, ability to adapt and accountability.
- Provide funding and technical support for the sharing and exchange of healthcare records between PIHPs, providers and other healthcare organizations.
- Provide leadership and funding for information systems development forums for IT and clinical representatives of PIHPs and CMHs to develop consensus on project selection and system design.
- Provide a process by which advances in information technology proposed by PIHP/CMH personnel can be evaluated, funded and monitored.

Clinical leadership

- Perform clinical research and provide funding and collaborate with PIHPs in the development of (1) best practices, (2) personnel qualifications and training, (3) tools to support appropriate diagnosis, access to services and individual plans of service and (4) supporting information systems.
- Prescribe requirements for training case managers regarding local services and resources, and provide training materials for state-wide job responsibilities and practices.

- Require DCH to develop and continuously improve a level-of-care evaluation tool to be used, statewide, for assessment of individual level of care to be provided and as the basis for objective, community needs assessment. This must include assessment for early intervention.

Certifications and qualifications

The life of a person with disability may frequently be in the hands of an individual direct-care worker. There are persons in the role of direct-care worker who should not be in these jobs. Some may be terminated for misconduct only to find jobs with other providers. The persons in these jobs must understand what is expected of them and understand that if they are terminated for performance problems, they may lose their certification and be unable to get a similar job elsewhere.

- Establish certification requirements for direct care workers including peer support specialists. This may involve certification for specialized roles that require different skills and levels of responsibility.
- Track employment and performance problems of certified personnel.
- Establish a process by which certification may be terminated
- Certification training and evaluation must include aptitude and attitude for the job and ability to work with client families and close friends.
- Clarify qualifications and responsibilities of case managers for coordination, collaboration, quality of care and oversight of direct care services and for reporting on performance of care providers.
- Clarify responsibilities of direct care workers and their immediate managers for quality of care and reporting.

Improve PIHP performance criteria and evaluation mechanisms

Performance reporting provides an important incentive for effective performance of PIHPs and their contractual providers. DCH must improve performance reporting and take corrective action as appropriate. Measures should focus on prevention of defects with a zero-defect objective. DCH should perform periodic sampling to ensure the integrity of performance data. The following are examples of needed performance measures.

- Failures of collaboration and coordination of care
- Client status changes—incarceration, hospitalization, homeless, criminal justice contacts, deaths.
- Clients lacking support for participation in employment, education, psychosocial rehabilitation, and social activities as appropriate to their level of functioning.
- Unmet community needs based on the independent needs assessment
- Recipient rights complaints and observed violations.
- Delayed interventions
- Clients in poor quality housing situations
- Non-compliance of clients not petitioned for a Kevin's Law treatment order
- Deviations from treatment plans
- Premature hospital discharges as evidenced by recidivism or other disruptive behavior.

Formularies

Patients are subject to different formularies with different payers and in different settings: community, hospitals, jails, and prisons. This often causes medication choices and changes that are not in the best interest of the patient. Short-term savings from restrictive formularies have long-term costs including needs for more intensive services, poor outcomes and dangerous behavior.

- Periodically the legislature considers saving money by limiting access to generic medications without full consideration of the consequences. An independent study must be funded regarding the long-term effects of a restrictive formulary considering the trade-off between the cost of best medications and outcomes with alternative medications. Results of such a study should inspire more informed policy-making regarding medications.
- Formularies should be consistent regardless of treatment setting. For example, hospital reimbursement for medications must ensure hospital prescriptions are consistent with medications the patient receives or could receive in the community. Hospital formularies typically limit medications available for a bundled hospital rate. In the community, a patient may have access to formularies defined by any Medicare Part D insurer. Jails and prisons also have formularies that restrict inmates to less effective medications. A restrictive formulary in one setting must not discourage use of the most appropriate medications otherwise available to the patient.
- The effort for prior authorization interferes with the exercise of best medical judgment. Reimbursement should cover time spent by doctors obtaining prior authorizations.

Reduction of Dangerous Behavior and Criminalization

Persons who (1) are not diagnosed, (2) do not meet CMH access criteria, (3) deny their illness, or (4) are otherwise difficult to treat can be a risk to themselves or others. These persons tend to fall through the cracks, and a significant number of these become involved with the criminal justice system. Persons most at risk of criminalization are not, generally, those with the most disabling forms of mental illness. Criminalization increases and shifts costs from mental health to criminal justice.

Services for difficult to serve patients

- Fund an independent study of the long-term consequences of a failure to achieve early intervention. The study is expected to provide an incentive to fund and promote early intervention in order to improve outcomes and long term costs of care.
- Reimburse for early intervention efforts regardless of alternative funding sources and require private insurance payers to accept claims from PIHPs for services covered by the private insurance.
- Capitation of funding should apply only to the organization responsible for financial risk management (e.g., the PIHPs). Providers should be paid for the services they provide according to the treatment plan rather than being given a conflict of interest between cost-containment and appropriate care.

- Needs of chronically ill patients can be costly and diverse. Reimbursement of providers must reflect client difficulty to reduce the risk that difficult clients may not be adequately served.
- Treatment planning and review should determine the appropriate level, array and intensity of services provided. Fraud should be exposed by oversight, audits and billing analysis, not restrictive reimbursement rules.
- PIHPs must reimburse police agencies for the cost of interventions with PIHP clients. Police are often the first responders to a mental health crisis. This is intended to shift the cost burden to PIHPs as an incentive to avoid or minimize police involvement.
- On-call, intervention services and overtime for crisis resolution must be reimbursed to improve interventions.
- For more intensive supports, such as Assertive Community Treatment (ACT), working hours of members of the team should cover extended days (e.g., 8 am to 8 pm) and weekends, closer to what would be expected in a hospital setting. Reimbursement should reflect these extended hours.
- Length of hospitalization must be determined by patient stability not limitations of insurance coverage.
- Provider responses to clients in emergency rooms or police custody must be reimbursed.

Remove incentives for non-compliance

Persons with mental illness are reluctant to accept treatment. This is a result of stigma, side effects of medications, or anosognosia, the mental inability of a person to recognize their disability. Every effort should be made to avoid additional incentives for non-compliance.

- Co-pays may seem small but are not small to a person counting their pennies. They should be eliminated or there should be a simple mechanism for waiver.
- Spend down is a bureaucratic hassle that may save money because it creates a barrier to treatment for persons in need of treatment. Under spend-down, persons whose income might otherwise disqualify them for Medicaid, are required to re-qualify every month by reporting on their healthcare expenses. It is thus a disincentive for persons to accept treatment. Some states evaluate qualifications annually instead of monthly. Possibly require client to pay an appropriate fee for Medicaid coverage if income exceeds the current income limit.
- DNA testing is available to predict individual responses to certain psychiatric medications. This and other techniques should be utilized to avoid unnecessary adverse side effects that may cause patients to refuse any medication.

Amend Kevin's Law (court-ordered outpatient treatment)

A Kevin's Law, outpatient treatment order will frequently provide the needed incentive for a reluctant client to be compliant with the treatment plan. It is not used in most Michigan counties apparently due to court concerns about due process. Effective use of Kevin's Law can significantly reduce the cost of repeated hospitalizations, incarcerations and more intensive community care.

- Ensure that courts will apply Kevin's Law across the state. The legislature must address due-process issues to remove this disincentive of the courts.

- Allow continuation of an order when successful. Currently an order can only continue uninterrupted if the client has been non-compliant. An order should be continued if the client remains at risk of non-compliance in order to maintain the incentive for compliance.
- Provide independent review of the treatment plan to provide the incentive to develop a reasonable plan that is responsive to client concerns.
- Clarify PIHP responsibility to enforce the treatment plan so that the court order provides a meaningful client incentive.
- Define PIHP performance measures as an incentive for application of Kevin's Law.
- Define a penalty for an agency if the agency has not attempted to apply Kevin's Law for a non-compliant client and the client or others suffer adverse consequences.
- Reimbursement should cover preparation and court appearances for commitment hearings, criminal court hearings and Kevin's Law petitions.

Cost of Incarcerations

The recommendations, below, are intended to encourage PIHPs to find ways to keep persons with mental illness out of the criminal justice system. Currently, when a client is arrested (typically a difficult to serve client), the PIHP provider is no longer responsible for care. Thus criminalization relieves providers of difficult patients, and it increases and shifts costs from the PIHP to criminal justice. Inmates with mental illness represent a substantial portion of the jail and prison populations and thus a substantial cost.

- Transfer the portion of the Department of Corrections budget associated with each inmate with mental illness to the PIHP responsible for that inmate's area of residence, and provide for DOC to bill each PIHP for the cost of incarceration and treatment of all such inmates. This provides a financial incentive for PIHPs to provide needed services to mentally ill persons at risk of criminalization as well as those being released from jails and prison to reduce recidivism. A similar strategy was used to substantially down-size and close state hospitals. This action also improves Federal funding since these clients lose Federal benefits when incarcerated.
- When a person who may be a mental health client is detained, require criminal justice to notify the PIHP of the person's county of residence or the PIHP of the county where detained if residence is not clear. That PIHP is then responsible for the mental health care of the person whether incarcerated or released for community care.
- Require PIHPs to accept billing from jails for incarceration and treatment of inmates with mental illness who are residents of the PIHP catchment area. Billing should be based on county agreements to transfer to their PIHP the portion of the jail budget for incarceration and treatment of these individuals.
- The Department of Corrections and jails should have an incentive to participate to support this mechanism for cost recovery given the potential to reduce their inmate populations of inmates with mental illness who are difficult to manage.
- Establish a process for certification of new inmates who should be covered by PIHP funding

- Currently due to concerns about the mental health system, parole boards are incented to hold inmates with mental illness for their full term. A process is required for coordination of discharge and parole oversight of inmates with mental illness so they can qualify for parole. As a result they can be released earlier with the oversight of parole.
- Create a system for notification of the PIHP of a person's county of residence when the person is detained by criminal justice or admitted to an emergency room. Ensuring PIHP awareness creates the opportunity and a burden to intervene or at least ensure that the client has the benefit of the knowledge, if not the services, of his/her treatment team. Police and emergency rooms have the incentive to report encounters in order to reduce their involvement with persons in need of mental health treatment.

Integration of Care

A failure to integrate physical healthcare with mental healthcare results in poor quality care and increased costs. The life expectancy of persons with mental illness is 25 years shorter than the general population. In addition, poor integration of mental health services between hospital and community, public and private systems, mental health and criminal justice and different PIHPs results in gaps and conflicts in treatment.

Collaboration

- Reimbursement of professionals must include collaboration with families and other professionals for insight, consistency and continuity of care. Reimbursement removes the disincentive of using personal time and reinforces that collaboration is important.
- Reimbursement should cover coordination and support of clients for transitions between treatment settings and changes of personnel (doctors, case managers and direct care workers). This provides an incentive to coordinate in order to minimize discontinuity of care and the adverse impact of change on the client.
- Ensure that collaboration is supported by sharing of electronic health records and a shared and integrated, individual treatment plan.

Coordination with multiple payers and providers

The mental health system should recognize that it does not exist independent of all other sources of healthcare. An individual that is served by the mental health system is likely to receive some services from other providers covered by different payers. These must be coordinated.

- A patient must have a primary care provider and that provider must be reimbursed for treatment planning and coordination of care.
- Each shared treatment plan should be supported by tracking of service delivery to hold providers accountable for compliance with the treatment plan.
- Reimbursement must cover collaboration of participating providers.
- General health insurance does not cover all of the mental health services that are available in the public mental health system so patients must be allowed to obtain services from the public system that complement those available through their health insurance.
- Community mental health and FQHCs must be reimbursed by Medicaid HMO organizations for covered services. This conflicts with HMO cost saving incentives for

credentialed physicians. This conflict must be alleviated by alternative reimbursement mechanisms.

Objective Needs Assessment

Objective, independent needs assessment is required to establish the requirements for mental health system and PIHP funding requirements and performance expectations. Funding for the current system is driven by political interests, historical levels of service and anecdotal observations. Objective information will provide legislative and public incentives for more appropriate funding and policy decisions. The needs assessment should be the basis for determination of the appropriate level of funding and the performance objectives for each PIHP.

- Fund a contract for objective, initial and periodic, community needs assessment by an independent, epidemiological organization. The assessment should capture statistics on needs for mental health services in several dimensions: (1) persons in need of each level of care including early intervention and including current clients, (2) unmet level of care needs, (3) healthcare insurance of persons in need of services, (4) needed services that are not covered by insurance, (5) estimated costs of care to address needs for each level of care, (6) estimated costs that should be covered by private healthcare insurance
- The detail of the assessment must support analysis of the impact of budget limitations on the ability of each PIHP to meet the needs of persons in its catchment area. Thus the analysis should support determination of (1) the population that should receive adequate and appropriate levels of care given a specified PIHP budget based on priority for the most seriously ill persons, (2) the population that is potentially excluded from receiving services under the specified budget.
- DCH must report to the legislature the expected unmet needs per PIHP, associated with the current or any proposed mental health budget based on the objective needs assessment. Availability of objective assessment provides an incentive for improved PIHP performance, as well as more appropriate funding.
- The needs assessment must be based on the same evaluation tool as that used, state-wide, for level of care determination in order to support analysis of service gaps and costs.
- The analysis must determine the impact of mental health parity on the shifting of costs from the public mental health system to private insurance. The savings should provide added incentive for legislative adoption of mental health parity in addition to the potential to improve early intervention and long-term outcomes.

Separation of responsibility

The current system creates conflicts of interest that interfere with the effective delivery of quality services. These must be addressed by separation of responsibilities. These conflicts include

- An organization for the protection of recipient rights, and resolution of complaints, grievances and appeals should not be part of an organization that is a party to disputes they must resolve. Furthermore, in an integrated system of care, problem resolution may involve multiple provider or payer organizations.

- Case managers and doctors responsible for treatment planning and oversight, should not work for organizations responsible for the funding of services specified in the treatment plan.
- Organizations funded by capitation have a conflict between saving money and providing quality care. PIHPs must accept responsibility for risk management without passing risk on to providers (and thus to clients). This removes the provider conflict of interest that leads to inadequate services and undesirable, long-term, more expensive outcomes. PIHPs must develop incentives for efficiency and better, well-coordinated and necessary services based on reimbursement, oversight and transparency, not cost-cutting.
- Providers tasked with self-reporting of performance have a conflict of interest between accurate reporting and adverse evaluations.

Community inclusion

Community care is expected to enable persons with serious and persistent mental illness to become members of their community, but effective treatment and inclusion are not possible if the person does not have safe, affordable housing, transportation to community activities, and opportunities for recreation, education and employment appropriate to their level of functioning.

- Treatment planning must include reimbursed services to address the above needs.
- Manage access to safe, affordable housing including co-signing of leases. Clients typically do not have the income to qualify for rental without a co-signer.
- Include in treatment plans, appropriate client access to transportation as well as daily activity needs (e.g., employment, education, shopping, recreation and other social or religious activities).
- Evaluate and report performance regarding the actual living conditions of clients
- Evaluate and report performance regarding the actual access to transportation and access to employment, education, shopping, recreation and other social or religious activities appropriate to individual clients.

Accountability of Providers

Accountability is a fundamental source of incentives. Accountability of PIHPs and contract providers requires appropriate objectives, effective oversight, measurements of performance and appropriate corrective actions. In addition, organizations should be accountable to the public through public reporting and accessibility of business records.

Transparency

Not only are many on-profit service providers entrusted with people's lives, but they must be accountable to the public for their use of public funds and for fulfilling the public purpose for which they are tax exempt. These recommendations remove barriers to information about actions of service providers and provides transparency and accountability as incentives for responsible operation.

- Extend (restore) the Freedom of Information Act (FOIA) and the Open Meetings Act applicability to non-profits that receive 50% or more of their budget from public funds (including Medicaid and Medicare reimbursements). This transparency provides an

opportunity for public action and it provides an incentive for their boards of directors to take responsibility for agency performance problems.
- Measure PIHPs against community needs and performance of their providers.
- Evaluate providers based on outcomes, recipient and family satisfaction, rights protection, and consistent use of best practices and standards of care.
- Perform oversight independent of providers.
- Provide information on employee qualifications, service offerings and performance measurements for public access and to support client choice.
- Provide outcome statistics to the public regarding clients in different residential settings, clients with jobs, clients enrolled in education, clients in drop-in centers or club-houses, responses to clients in emergency rooms or arrested, clients incarcerated, deaths, etc.
- Track the association of adverse conditions and events to individual workers and their managers to assess needs for corrective action at all levels.

Services monitoring

Case managers, along with families and neighbors, are the eyes and ears of the system regarding the needs and the appropriateness of services being received by individual clients. Their involvement and knowledge should be a primary source of system oversight.

- Case manager reporting will provide incentives for quality care by providers and can provide recognition for the contributions of effective case managers.
- Review case management reports regarding coordination, collaboration, quality of care and oversight of direct care services.
- Provide for convenient reporting and follow-up of concerns of clients, families and others. The opportunity for clients, families and others to have a voice will provide an incentive for them to report problems (including identification of persons in need of early intervention) that require PIHP attention.

Corrective action

The public mental health system has evolved to multiple levels of delegation by contract whereby the contractor has lost operational control in order to avoid a co-employer relationship. The result is that contracted agencies cannot be directed to take prompt and effective action to resolve performance problems, particularly when they are related to poor management.

- Clarify mechanism by which PIHPs, providers and their individual employees can be held accountable without making the funding agency a co-employer. This should give the PIHP and DCH authority to fulfill their responsibility for proper operation of the mental health system. This removes the disincentive of DCH and PIHPs to resolve problems and provides added incentives for providers to optimize performance.
- Clarify mechanisms by which physical healthcare providers can be held accountable in an integrated system of care involving multiple provider and payer organizations.

Patient and Family Participation in Treatment Decisions

Patients and families should be encouraged to participate in treatment planning and decision-making. This requires collaboration and access to information. Families are often excluded

based on confidentiality as a barrier even though they may be a primary caregiver. Patients and guardians are often denied the opportunity to make informed decisions and consent to treatment.

- Clarify recipient right and provider liability (legal incentive) for failure to disclose treatment and personnel selection alternatives for informed choice and consent.
- Poor patients have a statutory right to access to their medical records at no charge except for records of mental health services. The Medical Records Act must be amended to remove the distinction for mental health records. In the long term, any client should have access at any time to his/her on-line health records at no charge. Provider cost will be negligible with electronic records. Clients, guardians and record-keepers must be informed of these rights.
- A client/patient must have access to all medical records that are used by a provider for diagnosis and treatment planning in order to verify accuracy and understand treatment recommendations. Currently providers will not provide access to records obtained from an independent provider. Legislative action is required to remove the barrier to disclosure of records received from other providers.
- Providers are required to retain medical records for seven years, after which they may be discarded. The law should be amended to require (a legal incentive) that the provider offer the records to patients or their representatives before they are discarded. In the future, these records may provide insights based on new research and may be important for understanding a family history and health conditions.
- Families who are directly involved as caregivers (e.g., the client lives in the family home) should be considered members of the treatment team for collaboration and access to information.
- Reimbursement must support the doctors' use of telecommunications facilities such as encrypted email, interactive messaging and video conferencing for immediate response to patient or family concerns, making unnecessary treatment delays, the scheduling of appointments and patient travel for face-to-face encounters.

Robert Stein (4)
2-29-16
Health Services SC
Medicaid Sc

MALA
Michigan Assisted Living Association
The Leader in Advocacy, Education, and Resources for Providers

February 29, 2016

The Honorable Rob VerHeulen, Chair
Health Services Subcommittee of the
House Appropriations Subcommittee on
Health and Human Services
Michigan House of Representatives
P.O. Box 30014
Lansing, MI 48909-7514

The Honorable Chris Afendoulis, Chair
Medicaid Subcommittee of the
House Appropriations Subcommittee on
Health and Human Services
Michigan House of Representatives
P.O. Box 30014
Lansing, MI 48909-7514

Re: 2016-17 Michigan Department of Health and Human Services Budget

Dear Representatives VerHeulen and Afendoulis:

Michigan Assisted Living Association (MALA) appreciates the opportunity to provide testimony regarding services funded through the Michigan Department of Health and Human Services (MDHHS) budget. Our organization's membership consists of 1,000 members providing supports and services to over 37,000 persons throughout the state. These persons include older adults and individuals with intellectual and developmental disabilities, mental illness, substance use disorders, traumatic brain injuries or physical disabilities.

Behavioral Health Services – Proposed Boilerplate Section 298

MALA opposes proposed boilerplate Section 298 which would transfer the Medicaid funding currently received by the Prepaid Inpatient Health Plans (PIHPs) to the Medicaid Health Plans by September 30, 2017. We are particularly concerned about the potentially adverse impact upon services and supports to persons with disabilities. The public mental health system has a long-standing commitment to provide a high quality of life to these individuals.

We are participating in the Lt. Governor's workgroup to develop an alternative to Section 298. It is essential for the various stakeholders to be involved in an in-depth analysis of the current mental health system. Major changes to the system without thorough planning create the risk of disrupting and potentially devastating the provision of specialty mental health services. Persons receiving services should be able to rely upon a continuity of services from the PIHPs and their Provider Networks throughout the state as system changes are considered.

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Workforce Challenges

MALA appreciates the decision by the Michigan Legislature to include boilerplate Section 1009 in the current MDHHS budget bill. Section 1009 established a workgroup within MDHHS to analyze the workforce challenges of recruitment and retention of staff providing Medicaid funded supports and services through the PIHPs. It is our understanding that the workgroup will be releasing its report soon.

The severe staff recruitment and retention challenges throughout the state threaten the stability of services for people with disabilities. More competitive wage levels for direct support staff are essential.

MALA is a convening member of the Partnership for Fair Caregiver Wages. We strongly support the Partnership's advocacy efforts for additional Medicaid funding to increase the wage levels of caregivers/direct support staff.

Medicaid Personal Care Supplement

MALA recommends a modest funding increase of $30.00 per month in the Medicaid Personal Care Supplement that is received by adult foster care (AFC) and home for the aged (HFA) providers. The executive budget recommendations do not include a funding increase in the Medicaid Personal Care Supplement. As indicated in the overview provided with this testimony, the Medicaid Personal Care Supplement has increased by only $29.54 per month since 2000 or a 16.9 percent total increase for the entire 16-year period.

Adequate Medicaid Personal Care Supplement funding is critical to the provision of personal care services to older adults and persons with disabilities. The personal care services include assistance with bathing, grooming, dressing, toileting, transferring, eating, medication, specialized skin care, and other services as needed. The AFC and HFA providers receiving the Medicaid Personal Care Supplement and behavioral health services providers funded through the PIHPs face similar workforce challenges.

Thank you again for the opportunity to testify. Please contact me if any additional information is needed regarding our organization's testimony.

Sincerely,

Robert L. Stein

ROBERT L. STEIN
General Counsel

cc: Health Services Subcommittee
Rep. Jon Bumstead, Majority Vice-Chair
Rep. John Bizon
Rep. Laura Cox
Rep. Harvey Santana, Minority Vice-Chair
Rep. Kristy Pagan

Medicaid Subcommittee
Rep. Rob VerHeulen, Majority Vice-Chair
Rep. Edward Canfield
Rep. Larry Inman
Rep. Pam Faris, Minority Vice-Chair
Rep. Harvey Santana

MICHIGAN ASSISTED LIVING ASSOCIATION

Overview of Medicaid Personal Care Supplement

1. Adult foster care (AFC) and home for the aged (HFA) licensees provide services to several thousand persons for whom licensees receive a Medicaid Personal Care Supplement of $203.92 per month. This payment level is clearly inadequate based upon the personal care needs of the adults choosing to obtain services in licensed AFC and HFA settings.

2. The Medicaid Personal Care Supplement level has increased minimally for the past 16 years as indicated below:
   - 10/01/2014 – increase to $203.92 per month
   - 10/01/2008 – increase to $192.38 per month
   - 10/01/2006 – increase to $184.38 per month
   - 10/01/2000 – increase to $174.38 per month

   Thus, the Personal Care Supplement payment has increased by only $29.54 per month since 2000 or a 16.9 percent total increase for the entire 16-year period.

3. The personal care services provided to AFC and HFA residents include assistance with the following:
   A. Bathing
   B. Grooming
   C. Dressing
   D. Toileting
   E. Transferring
   F. Eating
   G. Medication
   H. Specialized skin care
   I. Other personal care services as needed

4. A modest increase in the Medicaid Personal Care Supplement to $233.92 per month effective October 1, 2016 is essential to the health and well-being of AFC and HFA residents. This amount would result in an average of a 2.13 percent cost-of-living increase factor for each year since 2000.

For additional information on the Medicaid Personal Care Supplement, please contact Michigan Assisted Living Association.

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February 2016

Health Services SC Mary Ablan 2-29-16
Medicaid SC
(42)a

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TESTIMONY BEFORE THE HOUSE HEALTH SERVICES SUBCOMMITTEE
By Mary Ablan, MA, MSW, Executive Director
February 29, 2016

- Michigan's senior population is the fastest growing age group, with Baby Boomers now joining the ranks of older adults. Most older adults want to age in place, in their own homes, with the help of family and friends. But services from the government become necessary when adult children live in distant places, or are busy working and taking care of children, or loved ones with disabilities. Government services are also necessary when the burden is so great that family members can't assume it alone. This frequently happens when elders have dementia and require 24/7 care.

- The aging network, comprised of 16 Area Agencies on Aging (AAAs) with 1,000 employees, is Michigan's go-to solution for helping elders to live at home safely and with independence. The network is built on a well-vetted, quality-driven system of 1,100 service providers, who deliver over 40 different services. More than 100,000 seniors received in-home services, and almost 110,000 were served nutritious meals. Unfortunately, this impressive effort is not enough to meet the need.

- **Over 7,000 seniors are now on waiting lists for in-home services including meals-on-wheels, personal care, homemaker, transportation and care management. For this reason, the 40 organizations comprising the Silver Key Coalition are requesting a $5 million increase in the budget of the Aging & Adult Services Agency (AASA).**

- Michigan's aging network appreciates the past support of Legislators and Governor Rick Snyder for the Silver Key Coalition's goal of making Michigan a "No Wait State" for in-home services for seniors!

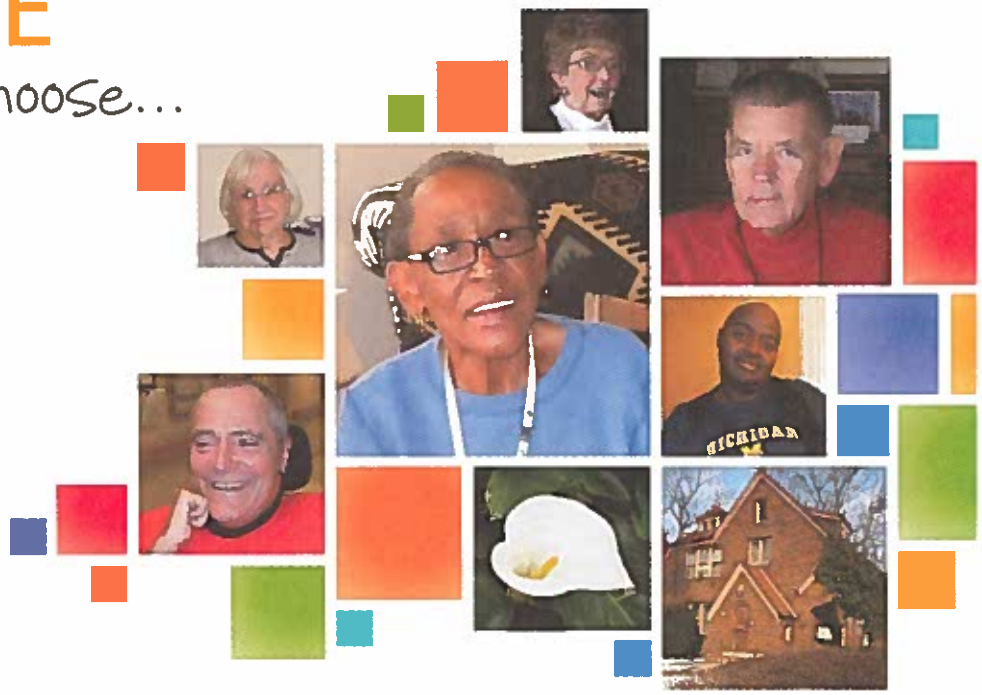
- The aging network supports Governor Snyder's FY 2017 budget recommendation to expand funding for the MI Choice Medicaid Waiver – a cost-effective alternative to placing adults in nursing homes to receive care. There are now 3,300 adults with disabilities on the waiting list for MI Choice. In 2014, the average MI Choice client cost Medicaid $75 a day, compared with $180 for the average nursing home resident.

- Michigan's nursing facility transition program is a stand out. Since 2005, MI Choice Waiver Agents including Area Agencies on Aging, along with Centers for Independent Living, have enabled over 12,000 nursing home residents on Medicaid to return to their homes or find new homes in their community. In the last five years, over 1,600 nursing home residents have been transitioned each year.

Mary Ablan 42 b

HOME

I can choose...



NURSING FACILITY TRANSITION STORIES

The people you will meet in this publication are diverse, living in small towns, large cities and on an island. They range in age from 55 to 92. Some have families active in their lives, others have friends, while others are on their own and are provided support from service agencies.

What do these people have in common? Each has spent time in a nursing home and then transitioned back to living in the communities they chose.

Don, Ricky, Mary, Catherine, Marilyn, and Jack understand the importance of community connections. Each has made a choice of where to live and a choice of who provides care in these settings. Don resides in a public housing apartment, Ricky lives in a rental home, Mary a home for the aged, and Marilyn and Jack live in the same home which they retired to. Care providers range from family members to agency employees and hired friends. All receive supports from caregivers through either the MI Choice Waiver program or the Adult Home Help Program. Some people are actively engaged in their community, while others are satisfied watching their community as they sit at a window or in a park. No one tells them when to get up, what they can or cannot do, or what is right or wrong for them.

These people have shared their stories as an inspiration to others living in a nursing home to imagine once again living in their own communities. They hope to provide assurance that support is available to create safe in-home environments for people who need long-term care.

HOME. *I can choose...*

Things were not going well for **Mary Casey...**

She was sick. She was becoming forgetful. She fell and found herself in a nursing home. She lost most of her belongings. She left to stay with a friend. She went to assisted living and then she returned to the nursing home. There she came to the attention of the county guardian who prevented her from moving out.

With the help of Disability Connections, the local Center of Independent Living, Mary went before a judge to remove the guardianship order.

"I'd like my own place," she told the judge.

"You are determined?" asked the judge.

"Yes."

"You are on your own," she responded.

MARY

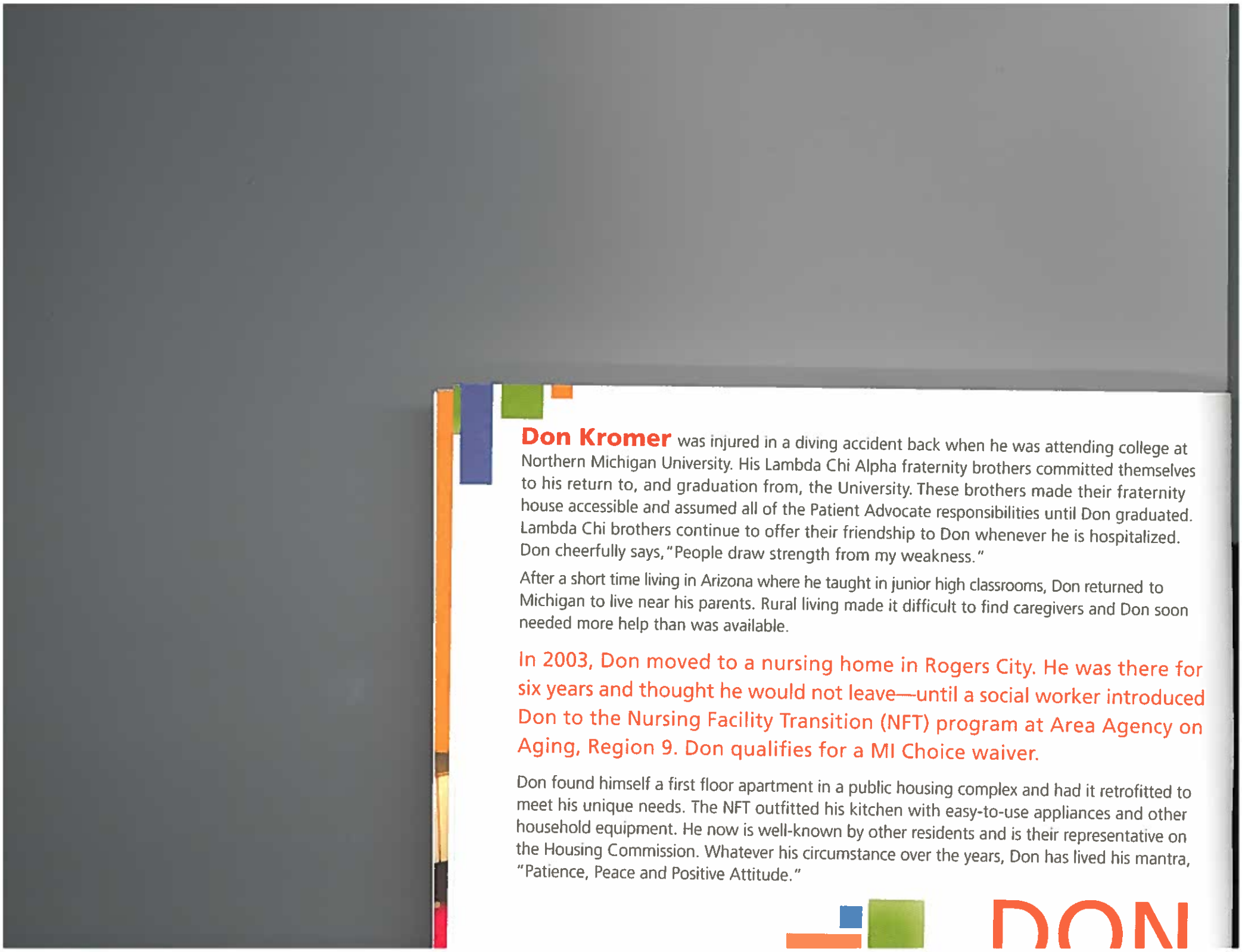
An apartment was found for Mary in a building of other seniors. The Nursing Facility Transition (NFT) program furnished it. It is in an area where, in the summer, there are many festivals to attend. Mary spends time sitting in front of her building with other residents and walking around downtown using her walker.

Two hours a day an agency, paid by the Adult Home Help program, sends a caregiver to fix Mary breakfast, help with cleaning, and help her with laundry. She receives Meals on Wheels. Once a week, a nurse puts Mary's medications into a device, bought by the NFT program, which prompts Mary when to take her medications. She wears a Personal Emergency Response System button in case she needs help. Everyday Mary chats on the phone with her friend, Josie. Her beloved nephew, Juan, calls often. Mary's extended family hosts her on Sundays and holiday celebrations.

A deeply religious woman, Mary is picked up each Sunday to attend the South Side Baptist Church worship service. There they call her Mother Casey.

"I love my place, it's mine. God brought me the people who can help me. I have a cheerful Spirit. God's been good to me. He's been blunt to me... It's a blessing—that's my testimony every Sunday..."

—Mary Casey, 73, Jackson

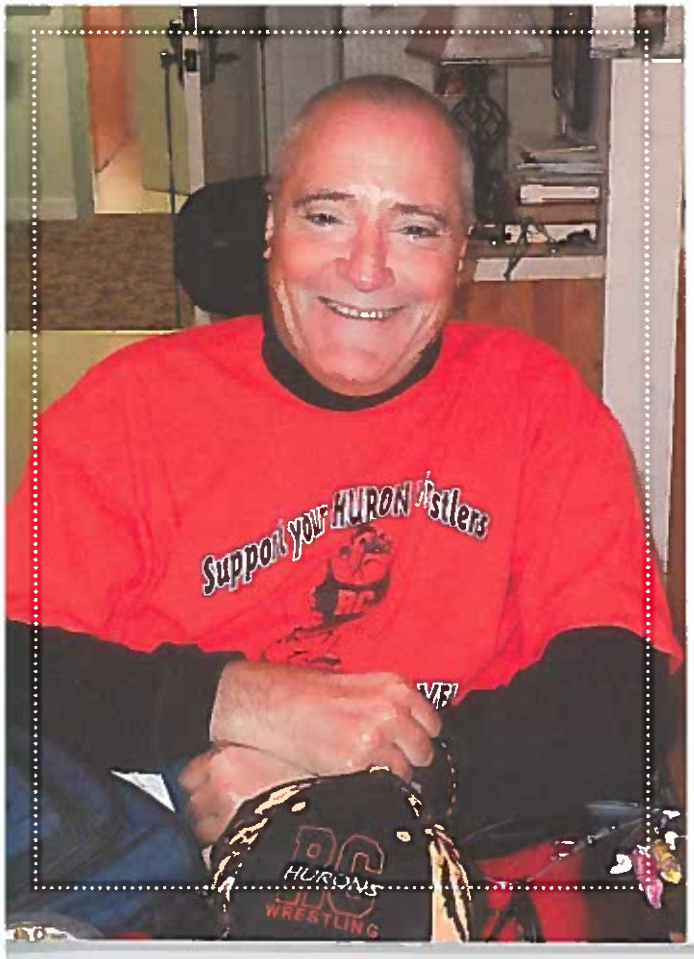


Don Kromer was injured in a diving accident back when he was attending college at Northern Michigan University. His Lambda Chi Alpha fraternity brothers committed themselves to his return to, and graduation from, the University. These brothers made their fraternity house accessible and assumed all of the Patient Advocate responsibilities until Don graduated. Lambda Chi brothers continue to offer their friendship to Don whenever he is hospitalized. Don cheerfully says, "People draw strength from my weakness."

After a short time living in Arizona where he taught in junior high classrooms, Don returned to Michigan to live near his parents. Rural living made it difficult to find caregivers and Don soon needed more help than was available.

In 2003, Don moved to a nursing home in Rogers City. He was there for six years and thought he would not leave—until a social worker introduced Don to the Nursing Facility Transition (NFT) program at Area Agency on Aging, Region 9. Don qualifies for a MI Choice waiver.

Don found himself a first floor apartment in a public housing complex and had it retrofitted to meet his unique needs. The NFT outfitted his kitchen with easy-to-use appliances and other household equipment. He now is well-known by other residents and is their representative on the Housing Commission. Whatever his circumstance over the years, Don has lived his mantra, "Patience, Peace and Positive Attitude."



Don Kromer now moves around his small community with ease. He serves on the school board, volunteers in the classroom and is an avid fan of the Rogers City sports teams. (Go Hurons!)

Living in his own apartment gives Don the peace and solitude that support his plan to write his memoirs. His book will demonstrate his belief that, "We all have choices."

"Life is like going down a river... you may not know what's around the bend, but you have the choice of making the best of it and meeting friends along the way, or being miserable and making all those around you miserable."

—Don Kromer, 55, Rogers City

Jack Masters and his wife Sue retired to Harsons Island in the mouth of the St. Clair River 20 years ago. They enjoy watching lake freighters pass in front of their home, which is only reachable by ferry. They know, and are known by, many of their neighbors in this community of 1500 permanent residents.

Jack experienced a series of strokes starting in 2011. Treated at Ford hospital, he moved to a nursing home rehabilitation program in Sterling Heights. Although it is more than an hour drive, for ten months Sue was with Jack every day, from morning until night.

"This was an excellent nursing home—good care, mature aides, excellent food—but I never believed he was there to stay," said Sue.

JACK & SUE

Macomb-Oakland Regional Center helped the Masters obtain a MI Choice Waiver that allowed Jack to come home to the island on June 28, 2012, just a day after their 59th wedding anniversary.

The local Council on Aging helped build them a ramp for their home. Through the MI Choice Self-Determination program, two women on the island took over Jack's care.

The women, who are neighbors and friends, create and manage their own schedule and provide back up for each other. They help Jack with his personal care, with some household chores and with ongoing physical therapy. Using his walker, Jack has regained enough strength to vacuum the house and also to walk the two blocks to the store where he can buy a lottery ticket.

To family members thinking about their loved one leaving the nursing home Sue would say, "The fear of care as your responsibility is daunting, but doable—and so rewarding."

When asked what advice he would give to people considering leaving a nursing home Jack said, "you will feel much better, make faster progress and accomplish more because you will be where you belong."

—Jack Masters, 84, Harsons Island

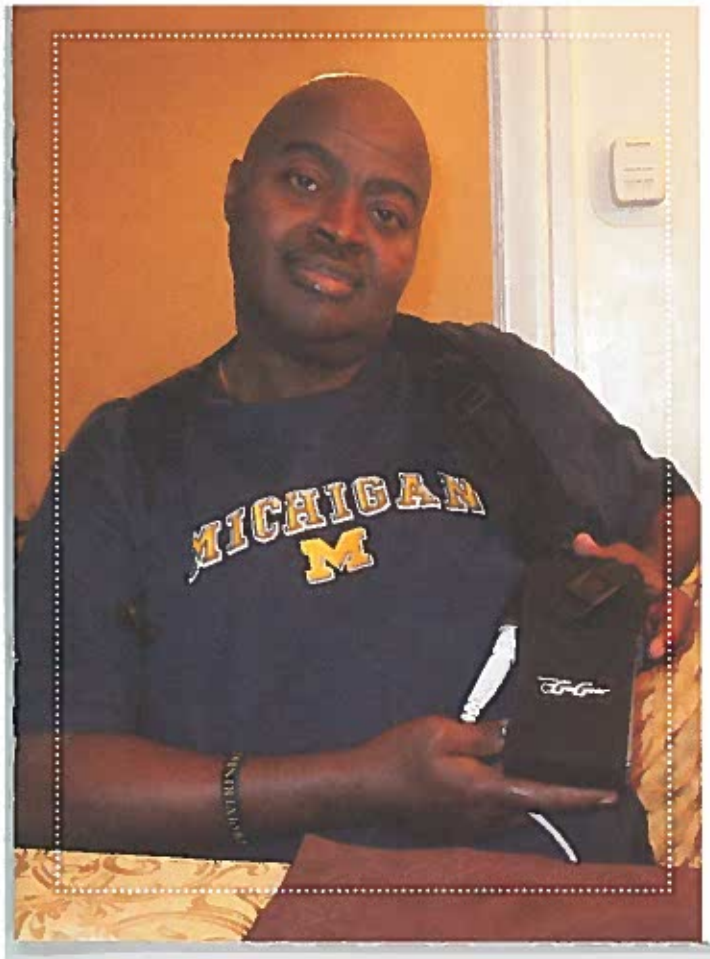
Ricky Hurst is one of one hundred twenty-two people in Michigan using a portable heart pump with a defibrillator.

When Ricky entered the hospital with gout he was expecting to be there a few days and home again. But the steroids he was given harmed his heart enough that he was moved from his local hospital to Ann Arbor and the University of Michigan Hospital. From there he was transferred to a nursing home in Ann Arbor – over an hour away from his family.

Using the Adult Home Help program, two local Centers for Independent Living worked with the Univeristy of Michigan Hospital to send Ricky home. Home Help pays personal assistants to provide support. On this particular program the personal assistants can be family members, in this case Ricky's son and daughter.

While Ricky is waiting for a heart transplant his care is complex. He is on kidney dialysis. University of Michigan Hospital staff can remotely monitor the machine through a wireless Internet connection. The attachment to his body demands a complex wound dressing and aides must be trained to change it. Ricky and his wife, Michele, chart his vital statistics and give them to a visiting nurse weekly.

RICKY



Since he has returned home to his family Ricky is off diabetes medications and has gained back most of the weight he lost while in the nursing home.

To assure that Ricky is well taken care of, Michele has taken a leave of absence from her job. Aside from sixteen hours monthly respite from a local Center for Independent Living program, she is home-caring for Ricky. Michele advises family members to, "Be ready both mentally and physically. The more complex the case, the more resources you must have in place, especially respite care. To be on top of everything is life changing."

"My faith in Jesus gets me through it day by day."

—Ricky Hurst, 51, Jackson

Catherine Tegue was happily married for 58 years and raised two sons. She worked outside the home her entire life and was active in her church. When her husband died, like many widows, she lived by herself with her family nearby.

One day her son found her at home unconscious. He took her to a hospital and from there she was sent to a nursing home.

In the nursing home she got along well. She enjoyed the people helping her and was pleased with the food—especially breakfast in bed! But after her recovery there was no medical reason for her to be there. She stayed because she often fell and she could not live alone.

Last year, with the help of the MI Choice Waiver program, Catherine moved to a licensed Home for the Aged (HFA). She has a room of her own decorated with her beloved calla lilies.

Catherine's meals are offered in a dining room. Using a walker she is free to move about as she likes. She participates in a variety of activities – bingo, ice cream parties with other residents, Wii-2 Bowling exercise and an occasional painting class. A doctor holds office hours in the building, and aides help her with her daily medication and do her laundry.

Tragically, her older son died in a motorcycle accident four years ago. "He died doing what he loved," Catherine said. Her younger son visits most Sunday afternoons and takes her out to dinner. She also stays in touch with her two grandchildren and eleven great grandchildren.

Catherine occasionally still attends services at Fuller Church of the Nazarene, but the service time conflicts with her mid-day meal. So often she attends church services in the building where she lives. Her pastor, his wife and other friends visit her at the HFA.

At ninety-two Catherine still thinks about her future. She says "I hope to keep staying strong, spend time with my family and continue to enjoy my life."

—Catherine Tegue, 92, Grand Rapids

CATHERINE

Marilyn Thompson was an attorney who had a career appointment as a clerk to a Federal Judge. After having a series of strokes, Marilyn spent three years living in five different nursing homes.

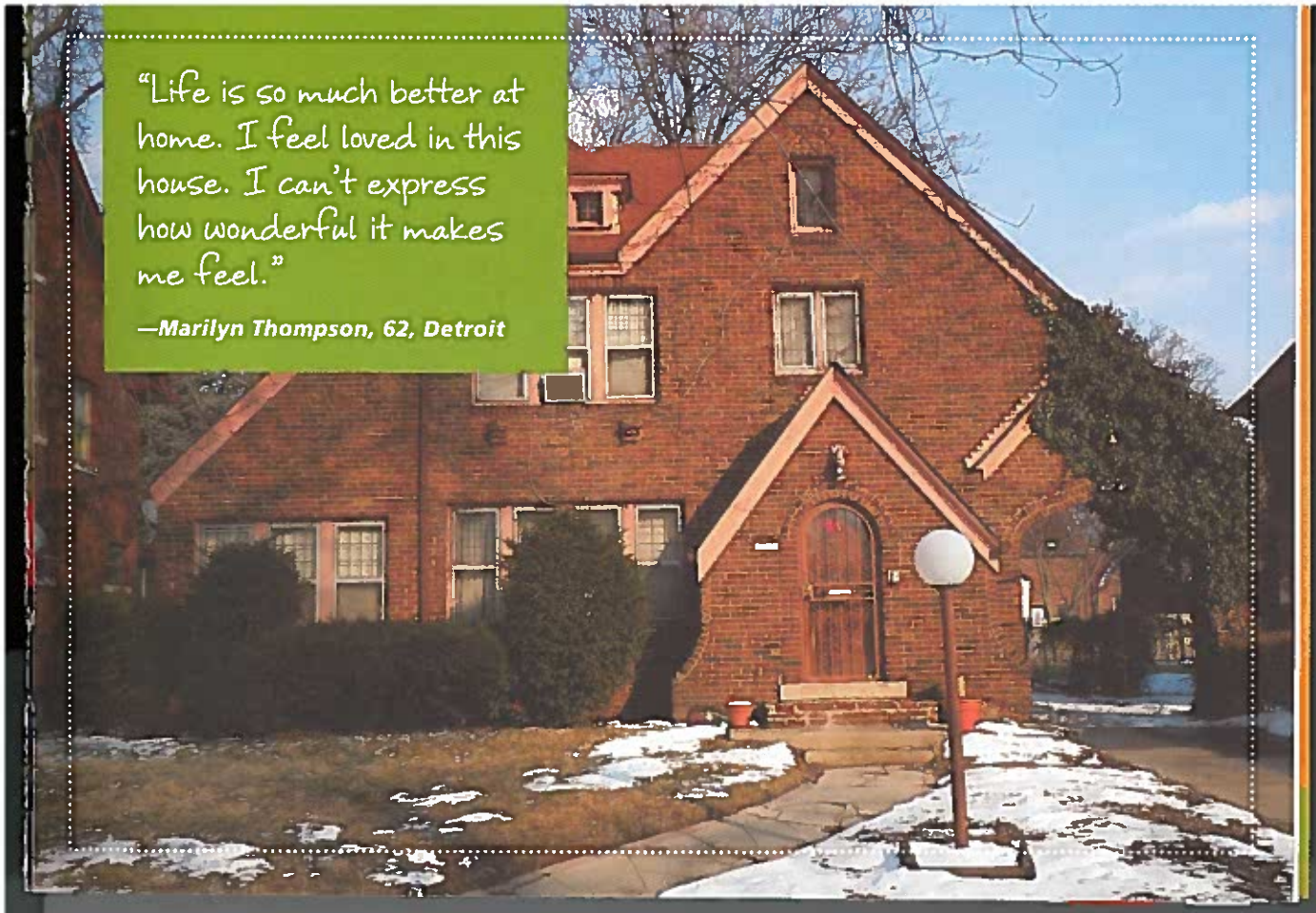
The nursing homes did not take good care of her. When she acquired pneumonia her daughter had to demand a transfer to the hospital. From a lawyer friend familiar with the Nursing Facility Transition program at the Detroit Area Agency for Aging, Marilyn learned she could get out of the nursing home. Staff resisted the plan; however, Marilyn knew she wanted more for her life.

Marilyn now spends her days in an adjustable bed in the living room of her gracious near-west Detroit home. She begins each day with her daughter's kiss followed by the words, "I love you mommy." She is editing her novel (a para-normal legal thriller) entitled, "Jury Selection" and readying it for publication.

Marilyn loves being at home. It is the home where she was raised. Her daughter lives with her and provides overnight care that is supplemented by 6 hours of daily care provided by MI Choice Waiver services. Her neighbor, who is ninety-six, also looks out for her and helps to welcome visitors who pop by.

Marilyn has lived her entire life in Detroit and feels things have turned out as intended. Her advice to people considering returning to their home is to try not to be afraid.

MARILYN



"Life is so much better at home. I feel loved in this house. I can't express how wonderful it makes me feel."

—Marilyn Thompson, 62, Detroit

MI Choice Waiver Service Areas

Contact the organizations listed in your region for more information.

1A DN/Wayne County – Detroit
313-923-1655

Detroit AAA
313-446-4444
(City of Detroit, Hamtramck, Harper Woods, Highland Park, all Grosse Pointes)

1B AAA Aging 1-B
800-852-7795

Ann Arbor CIL
734-971-0277

Blue Water CI
810-987-9337

DN/Oakland and Macomb
248-359-8960 *Oakland*
586-268-4160 *Macomb*

MORC Home Care, Inc.
866-593-7413

1C DN/Wayne County – Detroit
313-923-1655

The Information Center
734-282-7171
(Wayne County - Down River)

The Senior Alliance
734-722-2830
(Wayne County – Down River)

2 disAbility Connection
517-782-6054

Region 2 AAA
800-335-7881

3

DN/Southwest
269-345-1516

Region 3B AAA
269-441-0973 *(Calhoun County)*
800-626-6719 *(Outside Calhoun Co.)*

Senior Services
800-711-2113

4

DN/Southwest
269-345-1516

Region 3B AAA
269-441-0973 *(Calhoun County)*
800-626-6719 *(Outside Calhoun Co.)*

Region IV AAA
800-654-2810

5

Blue Water CIL
810-987-9337

Capitol Area CIL
517- 999-2760

Valley AAA
800-978-6275

The Disability Network
810-742-1800

6

Capitol Area CIL
517-999-2760

Tri-County Office on Aging
800-405-9141

7

A&D Home Health Care, Inc.
800-884-3335

Blue Water CIL
810-987-9337

DN/Mid-Michigan
800-782-4160

Region VII AAA
800-858-1637

8

AAA of Western Michigan
888-456-5664

Disability Advocates of Kent County
616-949-1100

Disability Connections
231-830-0088

DN/Lakeshore
616-396-5326

HHS, Health Options
800-447-3007

9

DN/Mid-Michigan
800-782-4160

DN/Northern Michigan
231-922-0903

NE Michigan Community Service Agency, Inc.
800-219-2273

10

AAA of NW Michigan
800-442-1713

DN/Northern Michigan
231-922-0903

Northern Health Care Mgt.
800-640-7478

11

SAIL
800-379-7245

UPCAP
2-1-1 *in the Upper Peninsula*
800-338-1119 *elsewhere*

14

Disability Connection
231-722-0088

HHS, Health Options
800-447-3007

DN/Lakeshore
616-396-5326

Senior Resources
800-442-0054

For more information statewide contact:

Michigan Long Term Care Ombudsman
866-485-9393

Medicaid SC Health Services SC Andrea Gold 2-29-16
(did not speak)

Andrea Zeme Gold
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I have a 25 year old daughter named Alyssa Michelle Gold. And, I'd like to tell you a little bit about her: Alyssa has a job; loves to go shopping and out to eat in restaurants with her friends and family. She also loves to go swimming, bowling, biking, and boating. Her favorite food in the world is chocolate cake with frosting. She possess a terrific sense of humor-scatological jokes included. And like many of our kids, she is opinionated, and doesn't like to clean up her room. Alyssa leads a 'normal' active life-like other peers of her age group.

Unfortunately, Alyssa is unable to come here today to tell you in person about her life because she can't. She relies upon me, her father, and beloved caregivers to assist her in ALL aspects of her life, 24 hours a day, 7 days a week, 12 months a year. Alyssa is representative of the vulnerable population this committee allocates the Medicaid funds to. She can't tell you how great her life is and how much she loves and relies upon her beloved caregivers, so I am tasked to do the job for her.

Alyssa leads a remarkable life despite being multi-disabled. She is blind, mentally impaired, suffers from psychomotor seizures and parasomnia. Additionally, she has Crohn's Disease and Natural Killer Cell Deficiency. Despite her disabilities, Alyssa lives a productive and fulfilling life with the aid of others. It's support, both physically and monetarily, that her father and I can't shoulder alone.

Previously I said that Alyssa has a job. Well, Alyssa's job entails delivering Friendship Bakery challahs (egg bread) and challah rolls with her trusted caregiver from JARC to customers. The bread and rolls are made by developmentally disabled young adults in a commercial kitchen sponsored by the Friendship Circle. Every Friday, Alyssa and her JARC caregiver deliver challahs to retail stores and to the staff at her school, Visions Unlimited. After school, she delivers more challah orders to her customers-with her caregiver. Alyssa could be in a bad mood, but once she realizes that it's time for her job, her attitude changes and her world becomes a better place, a world filled with purpose.

My husband and I are fearful, if Boilerplate Section 298 is adopted in the final budget for FY 17 that our daughter will lose the valuable services she currently receives. How does a for-profit corporation invest in my daughter, when their stakeholders are their shareholders, and not my daughter? There is no cure for my daughter. There isn't going to be any marked improvement in her conditions to warrant less services. In fact, over her lifetime she will probably require more services; more investment in

Alyssa will be needed, not less. How do for-profit corporations serve people like Alyssa, who have needs outside the traditional healthcare model, like housing, transportation, case management, employment, and respite? Meaningful healthcare integration and coordination does NOT mean the co-mingling all funds and services into one pool. How can a for-profit organization say that they can save $200 million in the behavioral health system when the system is already under-funded? How will a for-profit corporation handle the issues of paying living wages for Alyssa's caregivers?

I'd like to think that my husband and I will live forever, but that's not going to happen. I shudder to think what her life would be like without the assistance my husband and I, and of her trusted caregivers. What will happen to Alyssa? What will happen to all the other Alyssas throughout the State, who won't have access to the necessary services for survival because of privatization and lack of adequate funding? What will happen to all the Alyssas in the State who won't have access to the necessary services to lead a productive and fulfilling life?

Is the current behavioral health system perfect? No. Can it be improved? Absolutely! Achieving savings through privatization of the mental health care system is NOT the answer. I implore you to remove Boilerplate Section 298 from the State's budget for FY17. Privatization of the behavioral health system will ultimately translate to less and poorer quality services to the State's most vulnerable citizens; a population (for the most part) that can't advocate for itself. Please fund and allocate sufficient resources so that Alyssa and others like her are able to lead a productive, purposeful, fulfilling life.

Health Services SC
Medicaid SC

Nicole Urban
(did not speak)

2-29-16

Testimony, Michigan Association of Nutrition and Aging Service Providers (MANASP)
Health and Human Services Subcommittee
February 29, 2016

My name is Nicole Urban and I am a Program Manager with Macomb Community Action's Office of Senior Services, overseeing the home delivered and congregate meal programs. I am here today representing the Michigan Association of Nutrition and Aging Service Providers (MANASP), an organization comprised of service providers across the state of Michigan.

The Meals on Wheels Association of American (MOWAA) uses the slogan "more than a meal" when describing the Meals on Wheels Program, as the service we provide in the community is so much more than the nutritious meal we deliver to frail, homebound seniors.

- It's the welfare check each day; we notify emergency services or the participant's emergency contact if they indicate they are in distress or do not accept their meal delivery.
- It's a friendly smile with the meal delivery that helps to combat social isolation. This has been found to be as detrimental to an isolated older adult's health as smoking cigarettes. The delivery driver might be the only person they see that day.
- It's a connection to community resources that help provide the support needed to keep a senior living independently in their own home. This not only keeps seniors living where they want to be, but at a much lower cost than assisted living or a nursing home would be.

The value of the nutritious meal cannot be overlooked; as supported by the development of Defeat Malnutrition Today who identifies this as an older adult crisis. Many seniors admitted to the hospital are often found to be malnourished. This complicates their recovery while also increasing the cost and length of their stay.

In response to the annual satisfaction survey in May 2015, Macomb County Meals on Wheels participants, responded:

- 85% agreed: "Receiving Meals on Wheels has helped me to live independently in my home."
- 75% agreed: "Meals on Wheels are necessary for my continued health."

Respectfully submitted by:

Nicole Urban, MPH, Program Manager
Macomb Community Action, Office of Senior Services
Member, Michgian Assocation of Nutrition and Aging Service Providers
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(586) 469-5228

Medicaid SC
Health Services SC - Lisa Deddencooper 2-29-16
(did not speak) - Melissa Seifert

AARP Real Possibilities in
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facebook.com/aarp.michigan

February 29, 2016

The Honorable Robert VerHeulen, Chair, and Members of the House Appropriations
Health Services Subcommittee of Health & Human Services
The Honorable Chris Afendoulis, Chair, and Members of the House Appropriations
Medicaid Subcommittee of Health & Human Services
Room 352
State Capitol Building
Lansing, MI 48909

Re: **FY 2017 Department of Health and Human Services Budget**

Dear Chairman VerHeulen, Chairman Afendoulis and Subcommittee Members:

On behalf of AARP Michigan, we appreciate this opportunity to highlight the following items in the proposed FY 2017 Department of Health and Human Services budget. These items in particular impact Michigan's older adults and the extent to which they can continue to live safely and independently as they age:

- MI Choice Medicaid Waiver and PACE. AARP urges Michigan lawmakers to continue to increase access for older adults to home and community-based services through the MI Choice Medicaid Waiver program. Doing so is a win-win for our state. The overwhelming majority of Michigan residents – 81% – want to "age in place" in their own homes and communities. Moreover, helping seniors to live independently and better equipping the family caregivers who make it possible for them to stay at home can *save the state money*. On average, Medicaid dollars can support nearly three older adults or people with disabilities in home and community-based services for every one person in a nursing home. AARP also supports expansion of the Program for All-Inclusive Care for the Elderly (PACE), and the potential for better patient experiences and outcomes through MI Health Link where it is available.

- Non-Medicaid In-Home Senior Services. Together with Michigan's *Silver Key Coalition*, **AARP urges Michigan lawmakers to invest an additional $5 million in the FY 2017 budget for in-home senior services.** This investment would continue the progress begun two years ago to expand access and eliminate the waitlists for non-Medicaid supports such as Meals on Wheels and other in-home services provided through the Michigan Aging and Adult Services Agency and local Area Agencies on Aging. These services are extremely important to older adults and their families. Often, simply providing assistance with the "activities of daily living" – help with things like shopping, laundry, and cooking meals – can be the difference that allows someone to remain in their own home, rather than go to a nursing home. These services can also be the difference that allows an individual's family caregiver to remain in the workforce, avoiding lost productivity for

Michigan businesses. Unfortunately, the Executive Recommendation proposed flat funding for these services in FY 2017, as we also had in FY 2016.

- Respite Care. AARP urges Michigan lawmakers to **increase its investment and access to respite care services for family caregivers of older adults.** The vast majority (74%) of family caregivers have worked at some time during their caregiving experience, and more than half (58%) are employed in full or part time work. In fact, the "average" U.S. caregiver is a 49-year-old woman who works outside the home and spends nearly 20 hours per week providing unpaid care to her mother for about 5 years. Respite care such as adult day services or periodic visits in the home can help provide family caregivers a much needed break and a better opportunity to balance and maintain their work, caregiving and other responsibilities. Demographic changes and the prevalence of dementia in our aging population has increased the need for respite care services in our state, particularly for the family caregivers of loved ones with dementia. Nevertheless, the Executive Recommendation proposed flat funding for respite care services in FY 2017.

We certainly recognize that the state's budget dollars are limited. AARP members are careful stewards of their money, and they want the state to be a careful steward, as well. Helping seniors live independently and better equipping the family caregivers who make it possible for them to stay at home is not only what voters want – it also makes fiscal sense for the state.

We appreciate the opportunity to share AARP's priorities with the subcommittees, and thank you for your work on these important issues. If you have any questions or if there is further information we can provide, please feel free to contact Melissa Seifert at 517-267-8934 or mseifert@aarp.org.

Respectfully,

Lisa Dedden Cooper
Manager of Advocacy

Melissa Seifert
Associate State Director, Government Affairs

AARP is a nonprofit, nonpartisan 501(c)(4) social welfare organization that advocates on issues that matter the most to people age 50 and over, and their families. AARP has approximately 1.4 million members in Michigan. AARP does not endorse candidates for public office or make contributions to political campaigns or candidates.

Medicaidsc Health Services SC Stacie Burns (did not speak) 2-29-16

Protecting Michigan's Most Vulnerable Citizens

I <u>oppose</u> the drastic changes laid out in Section 298 of the Health & Human Services FY17 budget:

- ***Public management and oversight of Michigan's behavioral health system provides the BEST QUALITY OF CARE and ensures the MOST money is spent on consumers' needs.***
  - A publicly operated system reinvests resources back into services, not profits and have a long history of risk seeking – the aggressive seeking out and serving the needs of vulnerable community members with complex cross-system needs.
  - For-Profit entities by law are focused on maximizing its value to its shareholders and have a business model which avoids risk.
  - Minimizing administrative costs, ensuring that the greatest share of the healthcare dollar goes to serving consumers.
    - <u>Michigan's PIHP system has on average an overhead cost of 6%, giving them a medical loss ratio of 94%, which is significantly better than a for-profit entity.</u>
    - **<u>Section 298 would result in the LARGEST cut to behavioral health services ever in Michigan – $300 million (difference between PIHP overhead 6% vs. health plan overhead 15-17%)</u>**
  - The management or delivery of public behavioral health services by private companies simply to save money has not been effective.
    - Some states have even seen increased costs and inefficiencies through policies that seek to limit access to care – prior authorization and fail first practices on essential medications used in the treatment of serious mental illnesses have had devastating effects on individuals and families.
    - Providers have been forced to cut services or leave the system, weakening the local network.
    - States that have saved money through privatizing their behavioral health care have done so by moving from a fee-for-service model to a managed care model.
      - Michigan's public behavioral health care system transitioned to managed care almost 20 years ago, which would significantly reduce any promised savings.

Section 298 <u>WILL NOT</u> better integrate care:

- ***Integrated funding does NOT equal integrated care.***
  - Meaningful health care integration and coordination take place "on the ground" - at the point where the patient receives care.
  - Consumers served in Michigan's behavioral healthcare system have needs outside of traditional healthcare, which make it difficult for them to fit into a physical healthcare model – housing, transportation, employment.

- Promoting a continued focus on the social determinants of health.

- Most states that have moved their behavioral health services under physical health care managers only moved small sub populations whose needs were more mild/moderate because they are less expensive to serve and more closely fit the traditional health care model.

    - Michigan's current mild/moderate behavioral health carved-in benefit managed by the Medicaid health plans often under performs when compared to the publicly managed behavioral health services.

    - In many places, health plans have a long track record of failing to provide necessary access to services which exacerbates individuals' conditions forcing them into more costly settings for care.

    - Health plans do not have a history of serving people whose needs are outside the traditional medical realm – consumers, families, and advocates fear that care will be denied and reduced due to lack of understanding.

Section 298 puts my local public safety net at risk:

- ***Maintaining the public safety net is critical for Michigan's most vulnerable.***

    - Michigan's behavioral healthcare system is interwoven into the fabric of the communities, in which they work, maintaining a close working relationship with education, law enforcement, judiciary, housing and homeless services providers.

        - Local CMHs are public entities, either an official county agency or an authority, which is a public governmental entity separate from the county or counties that establish it. PIHP boards are made up of appointees from the CMHs within their respective regions.

    - Private entities do not have the same obligations to the community as the public behavioral health system.

        - There is no public oversight or accountability of the resources and no connection to the county safety net.
        - This will take us backwards in our progress
        - Another situation like the Flint water crisis about to happen if this is allowed

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Stacie Burns

Medicaid SC Health Services SC Deborah Garrett

PUBLIC COMMENT OFFERED 2/29/16 REGARDING SECTION 298

(did not speak) 2-29-16

Good morning Ladies and Gentlemen. My name is Deborah Garrett. I'm a person in long-term recovery and what that means to me is that I have not used alcohol or illicit drugs since November of 2000. I went into treatment as a result of my third DUI conviction. Fortunately, I had the good fortune of having a Judge who saw the wisdom of treatment over incarceration and was offered an opportunity that has since allowed me to become a voter, taxpayer, homeowner, Aunt, Daughter, College Graduate, and among many other things a fierce advocate. I am currently the Director of Recovery Communication for a Recovery Community Organization in Detroit. I am working under a SAMHSA grant to develop a statewide network of recovery community organizations. As such, I have traveled from Monroe to Sault Ste. Marie and can share with you that there is a deeply committed community of people with lived experience in recovery from substance use disorders that are working diligently to help deliver and advocate for access to quality services for others with the same chronic condition. Members of this community have a long history of having policy formed and decisions made "about us without us". I am here today asking for the thoughtful and genuine inclusion of the brilliant minds and compassionate personalities of the recovering community when creating policy regarding changes to the budget that affect the delivery of care for substance use disorders.

For the first time in recent history addiction issues are campaign issues. Michigan has been hard hit by the opiate epidemic and the increased demand due to Medicaid expansion. This is an issue that has touched every corner of every community in our state and it will not be resolved without the wisdom of lived experience. Michigan has a recovery community organization in every PIHP region of the state. These organizations can help provide valuable insight into what constitutes "quality care". They know the barriers that are currently being faced by those trying to access care. They can play a fundamental part in educating consumers how to navigate any changes to the current system. They are the experts in recovery support services, and in their communities. Please be inclusive of the members of this community as you consider what the changes to the language in section 298 might mean. We

stand ready to support other members of our community. We stand ready to support you as the burden of these decisions are made. All you need is to ask. We are used to sitting around tables talking. We're pretty good at it!

Presented by Deborah Garrett
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Roseville MI 48066
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dgarrett@recovery4detroit.com

Health Services SC
Medicaid SC

Robert White
(did not speak)

2-29-16

Narrative Submitted by Robert L. White On Behalf Of:

Fred White **Michael White**

My name is Robert White. My wife and I are parent advocates for our two adult sons, Fred and Michael, who are both on the autism spectrum and constituents living in the State of Michigan in Oakland County. We are also active catalysts in the parent/guardian advocacy group, Parent Alliance Of Metro Detroit. Please visit us on Facebook.

I am here today as others are to provide public comment specific to the boiler plate language that Governor Snyder has included in Section 298 of the Michigan Health and Human Services FY 2017 budget.
I am not here to advocate for or against maintaining the current PIHP system nor am I here to advocate for or against the changes proposed in Section 298 that would eliminate PIHPs, replacing the current PIHP structure with Managed Health Care Organizations. I am here to advocate for what I think is best for Fred and Michael and others like Fred and Michael whose voice we must represent.

I am advocating against combining physical and behavioral heath services under an integrated treatment philosophy managed by HMOs that is also recommended in Section 298.
Please consider several salient points that I feel support withdrawing all of Section 298 from Governor Snyder's recommendation as it would impact the 2017FY budget.

If one dare apply some Business 101 analysis as to why the current PIHP structure isn't working as effectively or efficiently as it could or must, should we really be surprised at our "current state", I don't think so:

1. There is little consistency in how each of the 10 PIHPs are organized and operate today and insufficient oversight by MDHHS or by local governments. Missing as well is an adequate, relevant and consistent set of quality or performance metrics and indicators to monitor or evaluate PIHP performance, other than by exception or when they fail. Due largely to lack of State or local government oversight and accountability, the 10 PIHPs operate today as independent franchises with only high level accountability and reporting back to MDHHS, largely on regulatory metrics required by either the Fed or the State that are in many cases non-value added when it comes to actually measuring the "quality of and improvement of the lives of the people served". So, thinking in terms of Business 101,"quality and improvement of the lives of the people served" is the outcome or the product that needs to be delivered. Like product specifications, the fundamentals that are required to ensure the "quality and improvement of the lives of people served" are not negotiable as these requirements are both a civil and constitutional right of the people served. If the metrics, assessment tools and quality systems are not in place today to allow MDHHS to actually measure the outcome or the "quality of the lives of people served"...then could this be one reason why the current PIHP system is under performing? Then, why would we believe that without relevant metrics,

assessment tools and quality systems in place that an outcome would have any different result under an HMO concept? Going back to Business 101, shouldn't we undertake an effort to apply basic FMEA or appropriate root cause methodology to provide for a thorough case study of the current PIHP system to better understand why PIHPs haven't delivered as expected before we are quick to move to a completely different CMH service delivery model that may represent even higher risks, costs and be plagued with the same outcome because the quality measures, tools, structure and oversight to ensure that any system considered is successful are not in place!

2. A second imperative that must be in place is a method of accurately measuring how much of every Medicaid or General Fund dollar actually gets to the person for which it is intended. Today, I don't believe we have the analytics that are capable of measuring this critical factor. Once more, without an accurate measurement process, how can we establish and accurate baseline today in order to measure improvement or decline in performance specific to this metric as the result of any change. The position I have read from those that support Section 298 is that a higher percentage of every Medicaid dollar will reach the "person" and not be lost to redundant administrative and layering cost as it is today. I have seen no data that provides the level of detail that measures, by PIHP or collectively, today's performance against this metric so how will we know that any radical change in the CMH service delivery model provides a better outcome.

3. A third imperative that must be in place is an accurate method of determining the true "cost to serve". Today this measurement tool is not in place where our assessment of cost to serve is based on level of Medicaid spend. MDHHS measures whether a PIHP has enough Medicaid and General fund dollars to meet their service requirements based on Medicaid overspend or lapse funds. MDHHS has addressed Medicaid overspend by the PIHPs, not by completing a detailed analysis that starts with the Personal Center Plan (PCP) and rolls up the cost for services based on "severity of needs" recognizing valid service cost differences from region to region. Instead, MDHHS has continued to apply a re-basing strategy across all of the PIHPs with the intended outcome of forcing the Medicaid spend down across all PIHPs to an average. The problem with this strategy is that it ignores or does not adequately consider the 'severity of needs factor" across the population served or the validity of service cost variance that legitimately exists from one region and PIHP to another. The result, Medicaid funding has been cut in some regions (Oakland County for example) to the extent that the entire Provider Network can no longer provide the essential services required by the PCPs, putting the quality of life and well being of the person served at risk. Once more, without an accurate measure of cost to serve in place then how can we effectively manage the outcome or ensure that a fair and accurate Medicaid funding process is in place? As well, in the absence of this data, PIHPs have no detailed data to make a case with MDHHS that they are under funded and MDHHS has no detailed data to make a case with CMS that Michigan is under

funded.

4. Last, I would like to provide comment regarding the proposal included in Section 298 that would integrate physical and behavioral health referenced as a carve-in as opposed to a carve-out of behavioral health under a waiver system as it is today. I have read reference to this proposal captured as "treating the entire person", "treating the whole person", "treating body and mind", "patient centered treatment" which does sound on the surface logical, good and right. However, when you research where the integration of physical and behavioral heath is operating successfully today under a managed health care or HMO model, the results are mixed and sparse. Many states are testing the water with an integrated physical and behavioral health care model..Tennessee, North Carolina, Illinois, Wisconsin, Arizona.. but to my knowledge no state has successfully integrated the service populations representing intellectual/developmentally disabled, mental illness and substance use disorders, which are populations that require the most specialized of service support needs. In fact, if you evaluate the status of the Michigan's dual-eligible demonstration pilot program (MI Health Link) with objectives similar to those stated in Section 298- "improve quality of care at reduced cost and eliminate duplication of services" you will find that results in Macomb and Wayne counties are falling short of expectations and a high percentage of recipients are opting out of the program. A report by RTI International concluded that care coordination is more costly and time consuming than the states anticipated. In addition, there are many problems with the Care Bridge database (Care Connect 360), an electronic database that is supposed to seamlessly transfer patient information among health plans, mental health organizations, physicians and under Section 298 would include the specialized Provider Network that now supports the behavioral health population. I have read comments from those closest to this program that they have had to develop "workarounds" to overcome shortcomings with Care Connect 360. Shouldn't we solve these existing infrastructure issues and investigate why qualified recipients are opting out of MI Health Link before we forge ahead with yet another integrated health care model that is even more complicated?

I know that Lt. Gov. Calley has organized a workgroup comprised of stakeholders who would be impacted by Section 298. It would be my suggestion that instead of focusing on what changes in Section 298 boiler plate language would be acceptable to all stakeholders that this workgroup spend their initial time and effort looking at the current PIHP CMH service delivery model to determine how or if the current system can be optimized.

Respectfully

Robert White

Health Services SC
medicaid sc
Dohn Hayle
Sherri Boyd
(did not speak)
2-29-16

The Arc.
Michigan

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Lansing, Michigan 48910
(517) 487-5426 or 1-800-292-7851
Fax: (517) 487-0303
Website: www.arcmi.org

Shari Fitzpatrick, President
Sherri Boyd, Executive Director/CEO

February 16, 2016

The Honorable Rick Snyder
Governor of Michigan
George W. Romney Building
P.O. Box 30013
Lansing, Michigan 48909

Delivered Electronically

Dear Governor Snyder,

The Arc Michigan, on behalf of our 30 chapters, our thousands of members and, especially, on behalf of this State's citizens with developmental disabilities and their families, is alarmed at the boilerplate (Section 298) in your proposed budget. We are very concerned with the jeopardy in which it would place one of this State's most vulnerable populations.

We were happy in the late 90s, to work with the then Department of Mental Health, to work for and adopt managed care for the long-term supports and services persons with developmental disabilities need. Those who worked on behalf of our citizens with a mental illness should also be credited for this achievement.

What we accomplished together had the desired results. We contained costs to only those necessary to maintain actuarial soundness. We saw the lives of persons with developmental disabilities and those with the most serious and persistent mental illness materially improved. Concomitant progress on person-centered planning allowed our State to establish and maintain national leadership in how these vulnerable populations are supported.

Our current system, under the Department of Health and Human Services, through the Public Mental Health System, has pioneered and fostered self-determination/self-direction and even support brokers, for independent supports coordination. Persons with developmental disabilities and mental illness are now part of a system which encourages and promotes innovation, all under managed care. Where there are "high utilizers" the 1115 waiver calls for addressing them. It could address the relatively small number of those individuals. They are mostly individual situations with individual solutions. We see no benefit from adding new bureaucracy.

Except for the brutal cuts to General Fund dollars and increasingly unfair wages paid to those most important to people with disabilities, those who directly support them, the

system has prospered. We have complaints about discrepancies and equity which can also be easily solved. However, we have a system of managed care: championed and adopted by those affected, accomplishing the control of costs and which can be answerable to both those served and their communities. Offering this up to Health Care HMOs makes no sense and puts those currently served at risk.

The reason long-term supports and services were carved-out was simple. They were and are not now, medical. They were, and are, the personal assistance and personal care needed to accomplish daily goals of community inclusion and independence, productivity and recovery. The tasks required to live a quality life. We believe it is therapeutic to work towards accomplishing these goals, they are, however, decidedly not medical. They were not designed nor intended to be medical. They continue to be outside the medical arena and outside the purview of acute, medical Managed Care entities.

Waiver services, and especially Michigan's 1915(b)(c) waiver combination, are especially outside the experience of the entities you propose have responsibility. The home and community-based services supported through these waivers are very different and have requirements very foreign to those who have "managed care" under the State Plan. Managed care for Specialty Long-Term Supports and Services utilizes Individual Plans of Support derived through a person-centered planning process beyond the experiences and capability of companies which manage acute health care. Current MI Health Link experience confirms this.

Despite claims and assurances of those representing the Health Care Plans, experiences in other states, with recent, very small minor exceptions, not involve persons with developmental services, except for State Plan, medical services. Waivers are specifically outside, as are most developmental disability populations, almost all efforts in other states. No other state has the combined 1915(b)(c) waiver, nor its innovation. And, no other state includes persons with a mental illness in this waiver. No experience, as grossly uneven and tenuous as these experiences have been, has dealt with what we have in Michigan. This includes no other state which has already established managed care for long-term supports and services. Nor does any other state's population have as much to lose. Their contention that "it's all health care" doesn't ring true upon a closer look.

This State's Constitution singles out two vulnerable populations as the State's responsibility. These are the populations you propose to offer up to the Health Care Plans who clearly drool as the prospect of adding 2.4 billion to their bottom line. With new, additional masters to be served by these private entities, and motives honestly at a variance with this State's obligation, it would be a mistake and put at risk vulnerable populations by turning this State's obligation over to unproven inexperienced entities.

The efforts of persons with developmental disabilities and those with a mental illness, their families and supporters sought, achieved and memorialized in statute the carve-out. They accomplished the same for the Integration Pilots, which became MI Health Link. Persons and their families experiences with HMOs, for their acute care, confirm their willingness to see their primary care physician for their health care needs, they do not want the same

entity or staff to be involved in their person-centered planning or their long-term supports and services.

Our organization, on behalf of persons with developmental disabilities and their families, continues to support the carve-out as clearly in their best interests. We also believe it remains clearly in the best interests of the State of Michigan.

Sincerely,

Sherri Boyd
Executive Director

Dohn Hoyle
Director of Public Policy

Health Services SC 2-29-16 Scott Schrum
Medicaid SC (Does not wish to speak)

February 29, 2016

The Honorable Rob VerHeulen, Chair
Health Services Subcommittee of the House Appropriations Subcommittee on Health and Human Services

and

The Honorable Chris Afendoulis, Chair
Medicaid Subcommittee of the House Appropriations Subcommittee on Health and Human Services

Dear Representatives VerHeulen and Afendoulis, and All Members of the Subcommittees:

First, thank you for your interest in Michigan's behavioral health system and everyone it supports. We all recognize the challenges that you as legislators face in creating and managing a budget with all of the needs being presented in the State. We appreciate your dedication to the citizens of Michigan.

I am representing Residential Opportunities, Inc., a provider of residential and support services in Kalamazoo County. We support over 500 people every month, including adults with intellectual and developmental disabilities and/or a mental illness as well as children with autism. We support people with some of the most challenging behavioral and serious physical disabilities living in our county. In order to accomplish these responsibilities we employ over 420 staff.

It is these direct care staff who bring me here today. Our staffing shortages clearly represent the crisis that has already arrived across the State of Michigan. Providers who utilize a direct care workforce are understaffed and those staff are overburdened. They are working too many hours to be effective and are therefore prone to error. And their supervisors are working direct care shifts right alongside of them. Therefore, the supervisors are not doing all of the staff training they would normally do, which increases risk. And they are not monitoring regulation compliance as they would normally do, which increases risk. Note that these are risks to people's lives and wellbeing.

ADDRESS 1100 South Rose Street • Kalamazoo, MI 49001 **PHONE** 269.343.3731 **FAX** 269.343.2940
www.residentialopportunities.org

In Kalamazoo County the unemployment rate is 3.2%. Throughout SW Michigan the County unemployment rates range from 3.1% to a HIGH of 5%. Economists have typically defined "full employment" as a 5% unemployment rate. We are basically operating in a workforce environment in which we have to employ the unemployable. All providers are now hiring people who we consider a high risk for success - and we still have significant staff shortages. This is the workforce the State of Michigan is requiring asking us to utilize to care for fragile people with multiple complications. At ROI we have over 40 FTEs of vacant positions. That equates to about 10% of our workforce. This is typical for providers throughout Michigan.

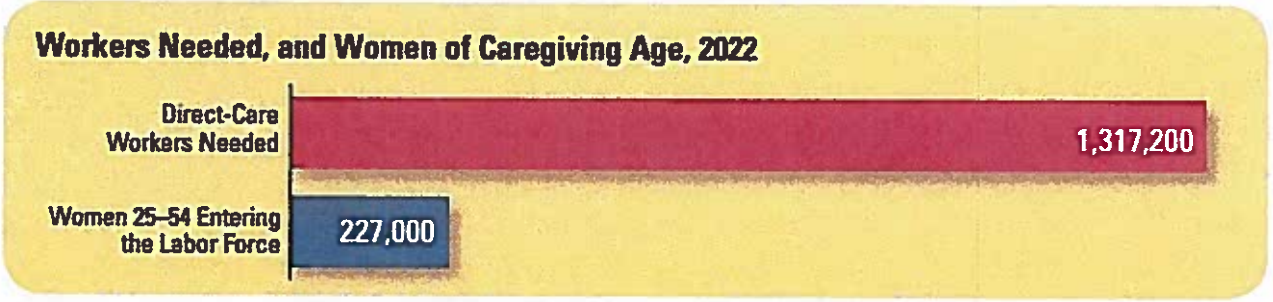
People with significant needs in the mental health system are now frequently underserved, getting delayed services or going unserved - all due to staff shortages around the entire State.

In the community mental health system, you can refer to the direct care workforce as the backbone, the foundation or the infrastructure. Without them, the system crumbles - and so do lives. I feel the crumbling has already begun. The State of Michigan should not delay in investing in this infrastructure. We have seen in Michigan and throughout the United States that delays in investing in the infrastructure end up costing more and damaging lives.

Without action, services will further deteriorate. According to a survey of direct care employers the average turnover in Michigan in 2014 ranged from 32% to 50%. According to the U.S. Department of Labor the demand for this workforce will drastically exceed the supply of potential employees. Our experience suggests that the demand already exceeds the available workforce.

Demand for Services Growing Faster than Labor Pool

Overall demand for direct-care workers is projected to increase by 37 percent over the next decade, adding 1.3 million new positions by 2022. At the same time, the number of women aged 25–54—the main labor pool from which direct-care workers are drawn—will grow by less than one percent. In sharp contrast, during the period 1992 to 2002, the number of women aged 25–54 increased at a double-digit rate—14 percent—providing a more sufficient labor pool.[6]



Recently, the magazine "MiBiz" reported, "Comerica Inc. projects continued strong job growth and lower unemployment through this year and next across Western Michigan. The Grand Rapids area alone added 20,000 jobs during 2015, driving the unemployment rate down to a 'very tight' 2.8 percent locally 'as job creation

outpaces labor force growth in the area,' according to a new economic briefing. The report covers a broad region that includes Grand Rapids, Kalamazoo, Battle Creek, Jackson and Lansing. Comerica projects the broader region's unemployment rate will decline from 4.1 percent for 2015 to 3.7 percent in 2016, and to 3.4 percent in 2017.

In Michigan direct care wages are worse than most states. In fact, Michigan ranks 32nd in compensation for direct care workers and most workers start at a wage below 133% of the federal poverty line. The most oft cited reason for leaving employment in this field is an inability to get by financially.

The Governor's budget proposal calls for a progress report by May 1st on implementation of a PIHP network analyzing recruitment and retention of the direct care workforce. Please study it carefully and take action. Additionally, the Michigan Association of Community Mental Health Boards has forwarded in its response to the Governor's budget proposal the recommendation of the Partnership for Fair Caregiver Wages. That calls for a $1.00 per hour raise for all direct care staff in the State for each of three consecutive years. I personally do not think a single increase of $1.00 per hour will have much of an impact but I do believe this three year plan would stabilize the workforce.

In his presentation of the proposed budget, Governor Snyder indicated the State needs to manage its budget responsibly by paying down debt, saving money for the future and making needed investments in critical areas.

Our direct care workforce can do none of these things. In fact, on a weekly basis they decide whether to pay their electric bill, buy clothing for their children or deal with personal medical issues. The direct care workforce represents a critical need in which the State of Michigan needs to invest. A life of poverty is no way to compensate people for working in Michigan's mental health field.

Sincerely,

Scott Schrum
Chief Executive Officer
Residential Opportunities, Inc.

MedicaidSC HealthServices SC Brian Boman 2/29/16
and Marianna Maver
(did not speak)

February 26, 2016

Dear Respected Legislators,

Thank you for taking the time to read my perspective. My name is Brian Boman and I am a contract employee of Allegan County Community Mental Health. I receive services there as well. I am living my life in recovery today and ACCMH as a non-profit plays a big role in that. I've been working there since last January in 2015. I have a Bachelor of Arts degree from Michigan State University. Before last January 2015 I hadn't had a Job since my days at Michigan State. I have a mental health condition and like any other medical condition including Parkinson's, Diabetes or Dementia it needs appropriate care. My needs are met by a non-profit system. It's a great system. I receive Psychiatric care, case management, job support and I am involved in therapy. I volunteer as a board member for a drop in center.

I feel that in therapy thru this setting I am learning things about myself that I have not been able to discuss and learn about before. I have had many therapists and all have had different clinical approaches. My therapy is ongoing as my problems are continuous. My therapist began working on my problem solving skills, which is an approach that goes along with dialectical behavioral therapy or DBT. DBT is met outside of therapy in a group setting.

There are so many good people there in the administration and in each of the departments. I have fun at work and look forward to being around the people there. I have relationships at ACCMH that have taken time to build.

ACCMH has been an important part of my health care because of the cost. Although I worked for a number of years before I became diagnosed ACCMH has been invaluable to me. I have Medicare part A and part B. I receive Medicaid as well. I did not have a job when I first started going to the agency in 2011. I did not have a way to pay for services beyond Medicare or Medicaid.

My job developer from ACCMH suggested I go to the drop in center in Holland for an interview to be a Peer Support Specialist. Peers help other peers solve their problems thru their own lived experiences. I kept going back to the drop- in even though I didn't land the job. I went to a meeting they would have on a weekly basis. A year later I volunteered for the Allegan Horizon Circle of Friends, which is a place like the Holland Drop In Center, It's a place where people with mental health issues can go and socialize, find others that have similar problems and get support from their peers. It was a non-profit organization that got me involved with this important social group.

Non-profits in Allegan county and Ottawa county made its drop in centers after others' like JIMHO in Lansing. The centers are all over Michigan and strengthen recovery. The supports that ACCMH has provided me through the ACT team and Career Concepts (case management and job development) and Psychiatric care may seem dispensable but they are not. They have been so important to my life...and to the lives of the people I have met.

My job coach at ACCMH is helping me with a Plan to Achieve Self Support. I am resubmitting a PASS in which I have a goal to become a Peer Support Specialist to obtain employment helping people

with disabilities solve their problems with my own lived experiences. I live in a rural area and the transportation system is different than the one in Lansing. There are fewer riders and rides are given more frequently to those closest to the city of Allegan versus Saugatuck a 40 min one way trip. The job of a Peer Support Specialist requires a car. I can include a co-signer for a loan or request accumulated set of monthly payments into the PASS for a lump sum payment to purchase a car. A vehicle would give me freedom again. It would renew my life. It would strengthen my recovery and so would the job as a peer. If the agency loses its funding I could lose that opportunity and then what?

The Talking Heads composed "We're On a Road to nowhere" and I ask what road are we on? Are we to return to nowhere? For some of us we won't have a place to return to. No more supports in the same place to our place of residence. No more people to help us find jobs in the community. We will have lost a great deal.

Brian Boman AA, BA

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Saugatuck MI 49453

616-990-1641

Medicaid SC Health Services SC 2-29-16
Karlene Ketola
(did not speak)

MICHIGAN
Oral Health Coalition

Testimony for House Appropriations Medicaid Subcommittee of Health and Human Services and Health Services Subcommittee of Health and Human Services
February 29, 2016

Representative Afendoulis and other distinguished committee members, thank you for the opportunity to provide testimony on the Fiscal Year 2017 Michigan Department of Health and Human Services budget. My name is Karlene Ketola, Executive Director of the Michigan Oral Health Coalition. The Michigan Oral Health Coalition serves as the collective voice of oral health— as our members include dental professionals as well as universities, community health centers, insurers, professional associations and local health departments who together work to improve the oral health of Michigan's nearly 10 million residents.

February 25th marked the nine-year anniversary of the tragic death of Deamonte Driver, the 12-year-old Maryland child who died from an abscessed tooth. Deamonte's story was a tragedy as his death was entirely preventable. What started out as a toothache turned into a severe brain infection that could have been prevented by an $80 tooth extraction. His death has also underscored the fact that there can be no health without oral health, and that dental decay is the most prevalent disease among children.

We are pleased that Governor Snyder has continued his support of dental programs for Michigan's low income adults and children in his Fiscal Year 2017 executive budget, especially his recommendation for the final expansion of the Healthy Kids Dental program. The Healthy Kids Dental program is a public-private partnership between the Department of Health and Human Services and Delta Dental of Michigan. The program, administered by Delta Dental, uses Delta's commercial network of dentists and pays higher rates than Medicaid. The Healthy Kids Dental program currently covers 810,000 Medicaid-enrolled children but leaves a large number of low-income adolescents with limited access to dental care in Kent, Oakland and Wayne counties—nearly 131,000 adolescents aged 13 to 20.

HEALTHY KIDS DENTAL IS AN INVESTMENT IN MICHIGAN'S CHILDREN

- Reports indicate that nearly 60 percent of U.S. adolescents have experienced tooth decay in their permanent teeth. And among adolescents, the prevalence of untreated tooth decay is highest for non-Hispanic black and Hispanic teenagers. [1]
- Children covered under the Healthy Kids Dental program more often seek dental care than those covered under fee-for-service Medicaid. [2]
- More dentists participate in Healthy Kids Dental than in Medicaid due to higher payment rates. [3]
- Children reporting recent toothaches are four times more likely to have a lower grade-point average than peers reporting no dental pain. [4]

As you deliberate the Fiscal Year 2017 Medicaid budget, we ask that you support the final expansion of the Healthy Kids Dental program in Kent, Oakland and Wayne counties to ensure ALL Michigan children receive the care they need for a healthy mouth, and a healthy body.

Respectfully Submitted,
Karlene Ketola, MHSA, CAE
Executive Director

Michigan Oral Health Coalition | 106 W. Allegan Street, Suite 510, Lansing, MI 48933
Tel 517.230.4381 | E-mail kketola@mohc.org | Web www.mohc.org

MICHIGAN
Oral Health Coalition

Testimony for House Appropriations Medicaid Subcommittee of Health and Human Services and Health Services Subcommittee of Health and Human Services
February 29, 2016

Sources:

1 Dental Caries and Sealant Prevalence in Children and Adolescents in the United States, 2011–2012, National Centers for Health Statistics, 2015

2, 3 Healthy Kids Dental Evaluation: Update of Trends through FY2013, Child Health Evaluation and Research Unit, University of Michigan, 2014

4 The Impact of Oral Health on the Academic Performance of Disadvantaged Children, Herman Ostrow School of Dentistry of University of Southern California, 2012

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Medicaid SC Health Services SC 2-29-1
Arlene Gorelick
(did not speak)

EPILEPSY FOUNDATION
Michigan

To: Senate Appropriations Subcommittee on Health and Human Services
House Subcommittee on Health and Human Services
House Medicaid Subcommittee of Health and Human Services

From: Arlene S Gorelick, MPH , Epilepsy Foundation of Michigan

Date: February 29. 2016

Subject: MDHHS Budget Boilerplate, Section 298

The Epilepsy Foundation of Michigan has serious concerns about Section 298 of the proposed state budget boilerplate, which would attempt to integrate behavioral and physical health care for people with disabilities and mental illness by transitioning state funding for the public mental health system to the Medicaid HMOs.

We have concerns with the current system because of the discrepancies from one part of the state to another and agree that the care for those served by the public mental health system would benefit by having care for their other health conditions addressed. However, we are not convinced that the moving a system which provides supports for people with developmental disabilities and mental illness would work best in a medical model. My understanding is that states that have moved behavioral health series under physical health care managers have done so with a smaller sub population who are not as severely affected. In fact, we are not aware that other states who have moved to using health care plans did not involve persons with developmental disabilities. No other state has the combined 1915 (b)(c) waiver service. A change of this magnitude and timeline is inviting problems.

Furthermore, we would be very concerned about the potential loss of self-determination and the person-centered plan. We are also concerned that this is appearing in the boiler plate without any input from those who use this service.

We would not support a move by the state to divest its responsibility by delegating its role in oversight to an administrative service organization. The state's constitution singles out two vulnerable populations as the State's responsibility. It would be a mistake to put those in these populations at risk by turning over the State's obligation to inexperienced entities.

While we are engaged with the Administration through a process convened by the Lieutenant Governor to look at the issue of integration, we urge the committee to reject the movement of the public mental health system to private insurance as specified in boiler plate.

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Medicaid SC Health Services SC 2-29-16
Dave Finkbeiner
(did not speak)

MHA Michigan Health & Hospital Association

Capitol Advocacy Center
110 W. Michigan Avenue, Suite 1200
Lansing, MI 48933
Phone (517) 703-8601
www.mha.org

To: House Appropriations Subcommittee on Health and Human Services

From: Dave Finkbeiner, Senior Vice President, Advocacy

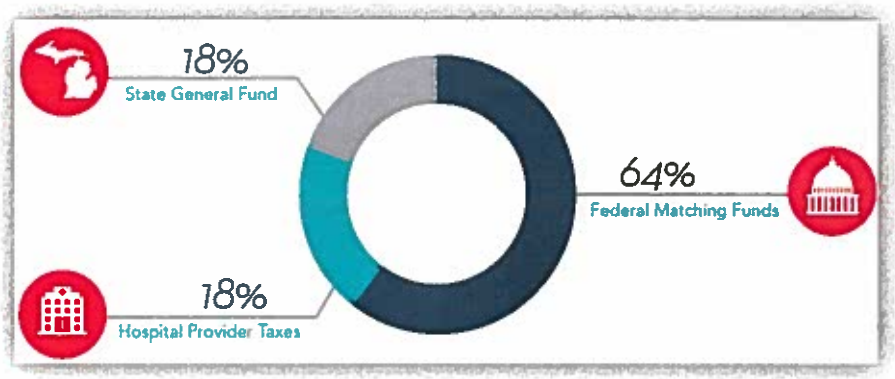
Date: February 29, 2016

Re: Fiscal Year 2017 Executive Budget Recommendation

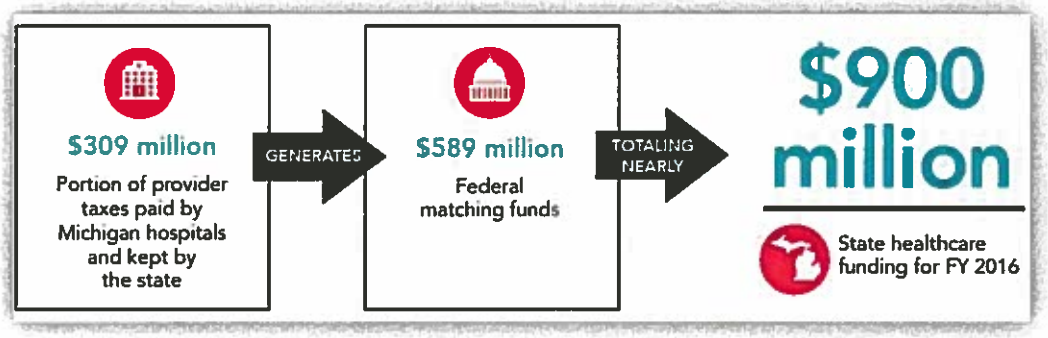
Thank you for the opportunity to submit comments on the fiscal year (FY) 2017 health and human services budget. The MHA asks the subcommittee to support Governor Snyder's executive budget recommendation for hospital Medicaid funding. The executive budget recommendation protects Medicaid payment rates, funds the Healthy Michigan Plan, funds important new pharmaceutical therapies, and preserves three important payment pools for graduate medical education, small and rural hospitals and the stabilization fund for small hospital labor and delivery services.

Funding for Michigan Hospital Medicaid Programs

The executive budget recommendation reflects Michigan's long-term funding strategy of using provider taxes to legally maximize federal dollars for healthcare. Michigan lacks sufficient general funds to pull down its full entitlement of federal funding for Medicaid. Instead of raising income or corporate taxes, Michigan hospitals are taxed to support both hospital Medicaid reimbursement and state health programs overall.



For FY 2016, Michigan hospitals paid $309 million of its quality assurance assessment (also known as the provider tax) directly to the state. Along with federal matching funds, this provides nearly $900 million to help fund Michigan's Medicaid program and other state healthcare needs. In FY 2017, Michigan hospitals propose to pay approximately $321 million for the same purpose. With the federal match, the hospital effort will provide over $920 million for Michigan healthcare.



Brian Peters
Chief Executive Officer

Funding Graduate Medical Education (GME)

The executive budget recommendation continues GME funding at the FY 2016 level. This investment helps grow the number of physicians practicing in Michigan, as nearly 50 percent of physician residents remain in state after completing their on the job training. GME also helps fund salaries and benefits for 7,200 doctors who care for patients in teaching hospitals every day.

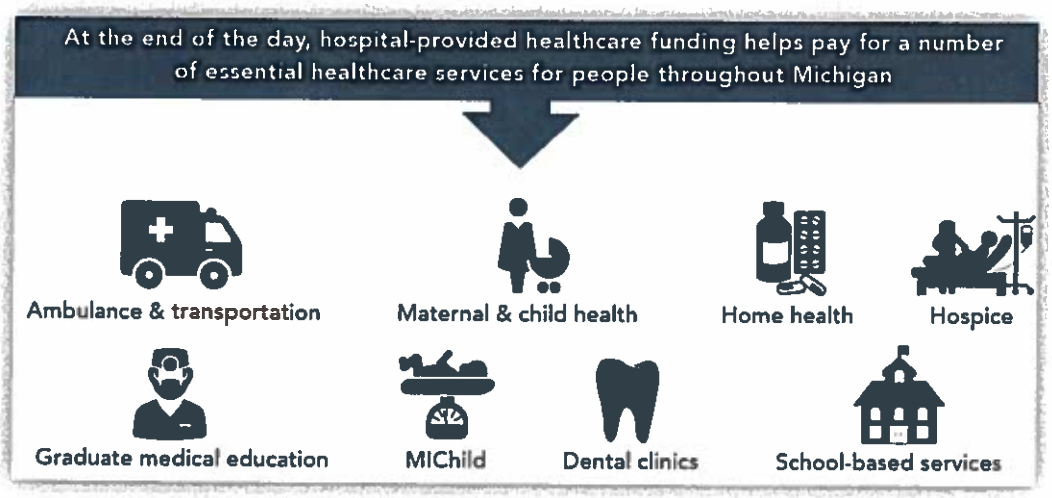
Funding for Small and Rural Hospitals

Two other significant funding pools are included in the FY 2017 executive budget recommendation: a $34 mil ($12 mil GF) small and rural hospital access pool and an $11.8 mil ($3.4 mil GF) obstetrics (OB) stabilization fund for small hospitals providing labor and delivery services.

Almost half of Michigan's hospitals are considered small and rural, and they serve an important role in bringing high-quality care and services to people throughout the state. Many rural hospitals are residents' only resource for physical therapy, dialysis, outpatient surgeries, community health services, emergency services, laboratory testing and imaging services. Since rural hospitals are often the sole site for patient care in the community, they are likely to offer services like hospice, home health, skilled nursing, adult day care and assisted living. Because of their size, high fixed costs due to low volumes, modest assets and financial reserves, small and rural hospitals disproportionately rely on government payments. The small and rural access pool helps more than 60 Michigan hospitals stay open and serve their communities.

Labor and Delivery Services

More than 16,000 babies were born in Michigan's small and rural hospitals during 2013 (the latest figures available). Expectant parents rely on their nearby community hospitals to safely deliver their children and meet their healthcare needs. These hospitals are often the primary resource for mothers who need extra assistance due to existing health behaviors or problems related to postpartum challenges. The OB stabilization fund protects this service line in hospitals throughout rural Michigan. Since this separate pool was created in FY 2014, no small or rural hospital has stopped labor and delivery services.



Health Services SC
(did not speak)

Feb 29 2016
Kayla Taylor ✓

Protecting Michigan's Most Vulnerable Citizens

We, members of Mitchell's Hope oppose the drastic changes laid out in Section 298 of the Health & Human Services FY17 budget, as written. However, we applaud Lt. Governor Calley's call for a workgroup to draft alternative language and make improvements to Michigan's mental health system. We also applaud the willingness of the Department of Health and Human Services, Michigan Association of Community Mental Health Boards, the Michigan Association of Health Plans, and legislators to join in dialogue.

It is important that all stakeholders have a voice in this transformational conversation. It is clear that many stakeholders are already present. It is our hope that throughout the process consumers, families, advocacy groups, service agencies, and front line workers will also have a voice at the table. This must also include social workers, as they provide the majority of behavioral health services, play a key role in physical health, and address the social determinants of health in both systems.

In coordination with stakeholders, a clear set of goals and principles must be outlined. Only then can best practices be identified and implemented. What is most critical is that stakeholders are guided by goals and principles that emphasize and embrace self-determination, person-centered planning, recovery orientation, and the social determinants of health. As social workers these values are at the core of our profession, guided by our Code of Ethics.

Consumers deserve to have services integrated. We want to see consistency in services across systems, regardless of zip code, that provide parity between mental health, physical health, and substance use disorders. It is important that this be done in a way that maximizes dollars to direct services without risking quality and maintains local oversight and consumer involvement. We don't want to see consumer services reduced, jobs of front line workers lost, or costs shifted from one system to another by conflicts over who should serve a consumer.

It is also critical that the Healthy Michigan Plan, General Funds, and traditional Medicaid are adequately funded to assure the health and well-being of the people of Michigan.

Sincerely, Kayla Taylor

Kayla Taylor

Mitchell's Hope Committee

Medicaid SC Health Services SC (did not speak) (7 min) 2/2 11:10
Steve Place

Protecting Michigan's Most Vulnerable Citizens

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It is important that all stakeholders have a voice in this transformational conversation. It is clear that many stakeholders are already present. It is our hope that throughout the process consumers, families, advocacy groups, service agencies, and front line workers will also have a voice at the table. This must also include social workers, as they provide the majority of behavioral health services, play a key role in physical health, and address the social determinants of health in both systems.

In coordination with stakeholders, a clear set of goals and principles must be outlined. Only then can best practices be identified and implemented. What is most critical is that stakeholders are guided by goals and principles that emphasize and embrace self-determination, person-centered planning, recovery orientation, and the social determinants of health. As social workers these values are at the core of our profession, guided by our Code of Ethics.

Consumers deserve to have services integrated. We want to see consistency in services across systems, regardless of zip code, that provide parity between mental health, physical health, and substance use disorders. It is important that this be done in a way that maximizes dollars to direct services without risking quality and maintains local oversight and consumer involvement. We don't want to see consumer services reduced, jobs of front line workers lost, or costs shifted from one system to another by conflicts over who should serve a consumer.

It is also critical that the Healthy Michigan Plan, General Funds, and traditional Medicaid are adequately funded to assure the health and well-being of the people of Michigan.

Sincerely, Steve Place

Steve Place

Mitchell's Hope Committee

Health Services SC
~~(did not speak)~~

Michelle Wagner
Feb 29, 16

Protecting Michigan's Most Vulnerable Citizens

We, members of Mitchell's Hope oppose the drastic changes laid out in Section 298 of the Health & Human Services FY17 budget, as written. However, we applaud Lt. Governor Calley's call for a workgroup to draft alternative language and make improvements to Michigan's mental health system. We also applaud the willingness of the Department of Health and Human Services, Michigan Association of Community Mental Health Boards, the Michigan Association of Health Plans, and legislators to join in dialogue.

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Sincerely,

Michelle L Wagner

Michelle L. Wagner
Mitchell's Hope Committee

Health Services
(did not speak)

Monica Place
Feb 29, 2016

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Sincerely, Monica Place

Monica Place

Mitchell's Hope Committee

Health Services SC
(did not speak)

Sharon Wagner
Feb 29, 2016

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Sincerely,

Sharon Wagner

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Mitchell's Hope Committee

MICHIGAN
DENTAL
ASSOCIATION
Michigan's Oral Health Authority Dedicated to the Public and the Profession

TESTIMONY FOR THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES - March 2016

My name is Dr. Larry DeGroat. I am President-elect of the Michigan Dental Association and I am a general dentist in Oakland County.

On behalf of the Michigan Dental Association I want to thank you for allowing me the opportunity to come before you today to testify on the Medicaid budget. The Michigan Dental Association represents more than 5,700 Michigan dentists, and we are very interested in the outcome of the state budget.

The Michigan Dental Association strongly supports the Governor's proposal to expand the Healthy Kids Dental program to all Medicaid eligible children in Michigan. Currently, children ages 13-21 in Kent, Oakland and Wayne are not in the Healthy Kids Dental program. The Governor's proposal would bring them in and, if approved by the Legislature, the goal of covering all Medicaid eligible children will have been reached.

Healthy Kids Dental is a very successful program and a national model for dental care for underprivileged children. The program is administered through Delta Dental of Michigan and the reimbursement rate is at Delta's PPO rate, which is higher than regular Medicaid, but still below the "usual and customary fee" charged by dental providers. This unique program has dramatically increased patient utilization and dentist participation as compared to traditional Medicaid fee for service. Currently, approximately 60% of the Healthy Kids Dental eligible children utilize the program. While there is definitely room for improvement, that utilization rate is much better than with traditional Medicaid. In addition, about 80% of the dentists in Michigan participate with the Healthy Kids Dental program, which greatly aids access to care.

Another important area of great need is adult dental Medicaid. This includes many special needs populations such as the mentally and physically impaired, and the elderly. The current fee-for-service program is ineffective because

reimbursement rates are too low. Michigan dentists who treat Medicaid-enrolled patients are reimbursed at about 20% of their usual and customary fee, compared to the national average of approximately 60 %, which is about the rate necessary for dentists to break even. This, coupled with the fact that it is sometimes difficult to get paid by Medicaid, causes the participation rate of dentists to be significantly lower than in the Healthy Kids program.

In spite of the lower rates, dentists do participate and the services they provide save the state money. In years when adult dental Medicaid was not funded in the state budget, hospitals reported a significant increase in the number of emergency room visits for dental problems. In 2008, the last time adult dental Medicaid was eliminated, visits increased about 15%. We all know that ER visits are far more costly than a trip to the dentist. Additionally, most ER doctors can only treat the symptoms, they cannot fix the problem. So, in many cases the person is prescribed addictive pain killers and returns to the ER again and again. We encourage you to consider these issues in your future discussions.

I would also like to highlight another program that is funded by the state and administered by the Michigan Dental Association. It is the Donated Dental Services Program. The money for this program pays for supplies, phones, computers and two full time employees who enlist dentists and labs to donate their services for the permanently disabled, chronically ill or elderly who do not have other means of obtaining care. These services include such extensive treatment as dentures, crowns, partials and oral surgery. These are people who are not covered by Medicaid or other programs. In 2015 alone, the donated dental services program arranged for $1,703,000 in donated services for 478 patients. Quite a return on a $150,000 investment by the state.

The Michigan Dental Association commends the Governor for his budget recommendations. The importance of oral health to our overall health is a key component in keeping the people of Michigan healthy. We hope you are able to support the Governor's proposal.

Susan Frey

From: Shannon Rozell <shannon.rozell@comcast.net>
Sent: Monday, February 29, 2016 9:52 AM
To: Kevin Koorstra; Susan Frey
Subject: OBJECTION TO SECTION 298 of the 2017 BUDGET, IT IS NO GOOD!!!!!!!!

OBJECTION TO SECTION 298 of the 2017 BUDGET, IT IS NO GOOD!!!!!!!!

Shannon Rozell, MPA
(810)399-9092