Michigan Association of Health Plans

Presentation of Michigan Association of Health Plans House Subcommittee on Department of Community Health Appropriations

March 5, 2012

My name is Rick Murdock and I am the Executive Director of the Michigan Association of Health Plans. Members of our association participate in the Medicaid Managed Care Program through a competitive bid process for the awarding of contracts. Medicaid Health Plans are currently responsible for the delivery of comprehensive health services for nearly 1.3 million Medicaid beneficiaries.

We want to thank you for your past support as the FY 12 budget was adopted last year and encourage your support for FY 13 Executive Budget for Medicaid Managed Care. The presentation last week by State Medicaid Director, Steve Fitton, illustrated many of the attributes that our industry brings as a partner for the Legislature and Administration in the provision of cost-effective delivery of services for Medicaid beneficiaries. The combined effort of our members is to continue to identify and focus on solutions that:

- Create administrative efficiencies through administrative consolidations and standardizations;
- Identify programs with evidenced based value and outcome and target existing resources to those programs; and
- Recommend elimination of redundancies.

MAHP believes the following principles can continue to be used to guide the changes necessary to transition Michigan's Medicaid program through the next year(s):

- Enroll current beneficiaries into managed care rather than reducing optional benefits;

- Focus on ways to integrate benefits and create savings rather than reducing provider reimbursement;
- Identify ways to streamline and consolidate state agency bureaucracy, eliminate regulatory redundancy, and focus on contract performance; and
- Promote those administrative rules and Medicaid policies that make fiscal sense to Michigan.

The Administration has emphasized that a "results" oriented budget will be in order—that is, programs must demonstrate a return of value in order to deserve continued support. We applaud this approach and our annual Medicaid White Paper includes the most current data demonstrating performance of our members in key areas, including prenatal care, diabetes, immunizations, blood lead screening and asthma. (Copies of the complete White Paper are available on the MAHP Website at: www.mahp.org) The accountability to produce a "results" oriented program requires the use of measurable objectives (contract performance standards) and audited data. Medicaid Health Plans are held accountable to the performance standards of the State Medicaid contract and continue to provide the highest level of service and noted by the annual rankings prepared by NCQA and reported in Consumer Reports where Michigan had 12 of the top 50 ranked Medicaid plans in the United States last year.

Over the last decade, we estimated that at least **$4.5 billion in total savings** has been realized due to Medicaid Managed Care or nearly **$400 million each year**. The savings (compared to fee-for-service) reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care in a partnership with the state in exchange for actuarially sound funding. The record over the past years is clear. It is far more efficient and cost-effective to use the managed care system than traditional fee for service. MAHP and members support the increased enrollment of Medicaid beneficiaries into managed care. In all instances of managed care enrollment the core principles provide for a "medical home", state accountability from a single organization, audited performance standards, and cost-savings to the State.

It is for this reason, and the demonstrated capacity of the Medicaid Health Plans to serve more beneficiaries, that we encourage the Administration and Legislature to support the full extension of the current contract with Medicaid Health Plans and not prematurely rebid.

RECOMMENDATIONS

1. **Actuarial Soundness**

Without an underpinning of actuarial soundness for the rates paid to Medicaid Health Plans, their financial viability becomes at risk along with the value provided to the state. MAHP recommends support of the Executive Budget recommendations for actuarial soundness. As decisions are made regarding the inclusion of coverage for autism, the increase of payments to primary care providers to Medicare levels and any other benefit or reimbursement change—it will be necessary to assure that such changes are included in the final actuarial construction of capitation payments for Medicaid health plans.

2. **Medicaid Enrollment in Managed Care**

- Dual-Eligible Population and begin working with overall long term care options
- MI CHILD Enrollment into Medicaid Managed Care
- Children's Special Health Care Services (mandatory enrollment)
- Complete and monitor the enrollment of Foster care Children
- Establish an enhanced beneficiary monitoring program to effectively control high utilization of services while maintaining access to needed care.

3. **Medicaid Eligibility (Accelerate enrollment into Managed Care)**

- Develop Eligibility Access Points:
  - Outstationed Workers in hospitals and similar settings
  - Application Assistance
  - Automation
- Consider Express Lane Eligibility (ELE) for children.
- Evaluate the feasibility of use of "pre-populated" redetermination forms and/or a simplified redetermination form for those subject to the "long form' and Pre-populated forms to simplified redetermination.

4. **Administrative Savings, Third Party Liability (TPL), Fraud/Abuse**

- Streamline unnecessary administrative costs by reducing or eliminating paper requirements in lieu of electronic documents and web-based information sites, requiring the use of deemed compliance by virtue of national accreditation such as NCQA or URAC, and

changing the perspective to a "regulation by exception"—that is focus on contractors who are not meeting standards established in the contract.

- Increase third party collections by health plans and fully complying with the federal requirements through provision of access to third party carrier information.

- Support efforts for improved fraud and abuse coordination and support the concept of enabling legislation to create the Medicaid Inspector General Office and focus collaboration efforts through Medicaid policy and new contract provisions regarding reducing "waste" in our health system that will benefit all payers, including Medicaid.

Summary

MAHP continues to appreciate the support of the House Subcommittee for the Medicaid program and services. Our core recommendations for your consideration that were identified above are included in our annual Medicaid White Paper—a copy of the Executive Summary is appended to this testimony.

Staff of the MAHP and members will continue to work with committee members on key budget detail issues and we will be happy to follow up on any of the issues raised today or other related issues on health care reform.

MICHIGAN ASSOCIATION OF HEALTH PLANS | 2012

Executive Summary

Performance, Value, Outcomes: Medicaid Managed Care

FY 2012-2013

The mission of the Michigan Association of Health Plans is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.

Medicaid White Paper: FY 13

Michigan Association of Health Plans • 327 Seymour, Lansing, MI 48933 • 517-371-3181
www.mahp.org

EXECUTIVE SUMMARY

MEDICAID RECOMMENDATIONS FOR FY 13 AND BEYOND

1. **Continue to assure actuarial sound rates** for all beneficiaries enrolled in Medicaid health plans.

2. **Assure the full six years of the Medicaid Health Plan Contract Term** (3 year contract with 3 one year extensions available) are completed. There is no need to establish a re-bid until the calendar year of 2015 with an effective date of 10/1/2015 (FY2016).

3. **Continue the process of moving more fee for service beneficiaries into managed care, including:**
    a. Persons with Dual-Eligibility (see MAHP White Paper on initiative for Integrated care).
    b. Children eligible for MI CHILD (enroll into Medicaid managed care and implement single contract).
    c. Persons eligible for Children's Special Health Care Services.

4. **Reform Medicaid eligibility**
    a. Implement the option to delink Medicaid application from other human services program applications.
    b. Start planning now for a faster, cheaper and more user-friendly system for determining Medicaid eligibility to go into effect in 2014.
    c. Establish an enhanced beneficiary monitoring program to effectively control high utilization of services while maintaining access to needed care.

5. **Streamline and Coordinate the Administration and Oversight of Medicaid Health Plans and related contracted entities.**
    a. Focus on coordination of an integrated benefit.
    b. Implement performance standards documented by audited data, and supported by actuarial sound rates.
    c. Focus on health outcomes using common metrics and objective and audited performance requirements.
    d. Streamline unnecessary administrative costs by reducing or eliminating paper requirements in lieu of electronic documents and web-based information sites, requiring the use of deemed compliance by virtue of national accreditation such as NCQA or URAC, and changing the perspective to a "regulation by exception"—that is focused on contractors who are not meeting standards established in the contract.

6. **Maximize all levels of non-state General Fund support (Federal, special use and local revenue) to** protect Michigan's Safety Net. This would continue efforts for:
    a. Medicaid Health Plan Special Access and Supplemental Programs to assure outreach and coverage for Medicaid beneficiaries

b. Options to additional federal support into Medicaid, including FQHC, grants and programs to bring wellness and prevention as a key component of Medicaid.
c. Increasing third party collections for Medicaid Managed Care Plans by providing access to other carrier data, including auto and BCBSM.
d. Improved fraud and abuse coordination through the Medicaid Inspector General Office.
e. Collaboration on efforts to reduce "waste" in our health system that will benefit all payers, including Medicaid.

7. Move the Medicaid Program and Medicaid eligibility responsibility into a separate program linked to Michigan's new Insurance Exchange

- **Recommendation Principles**

Without an underlying basis for reform in Medicaid—or other programs, the long-term sustainability will be weakened and opportunity for gaining public support will be missed. MAHP believes the following principles can be used to guide the changes necessary to transition Michigan's Medicaid program through the next year(s):

- Enroll current beneficiaries into managed care rather than reducing optional benefits;
- Focus on ways to integrate benefits rather than reducing provider reimbursement;
- Identify ways to streamline and consolidate state agency bureaucracy, eliminate regulatory redundancy, and focus on contract performance; and
- Promote those administrative rules and Medicaid policies that make fiscal sense to Michigan and not focus on revenue neutrality.

Savings Potential

Taking the above principles and assuming implementation can occur over the next 2 years, Michigan can begin to realize significant program savings while fostering a more accountable and cost-effective program. For instance:

- **Savings from movement of populations into managed care.** There is an underlying rule of thumb that at least 5 percent of medical care treatment costs can be saved by movement into managed care. The tools, techniques, programs, and results of using Medicaid managed care are listed later in the MAHP White Paper.

- **Savings from Administration Efficiency.** There is no question that Michigan's effort to serve the most vulnerable population has resulted in multiple initiatives and programs—all with administrative costs. By moving toward a comprehensive Medicaid benefit contract, Michigan can begin to reduce administrative cost and create a more seamless delivery of health care services.

- **Savings from State Administration.** Coupled with the development over the years of a number of initiatives to deliver various categorical or limited benefit programs, is the

state oversight responsibility and contract management or administration. Consolidation will likely minimize or eliminate the need to replace vacancies that took place in the last state early retirement program and will enable the MDCH to utilize existing staff in new and important key roles. These savings are cost avoidance as early retirement savings have already been realized. However, a new contract management program would also utilize electronic submission, the deeming of national accreditation and establishing a program of regulation and oversight by exception. This will result in savings to contractors that can be realized in the cost of contracts.

- **Savings from Enabling Contractors to access data and Third Party Liabilities for recoveries**. While Michigan has been very innovative in development of the managed care performance based contract, there has been notable exception in the designation by the State to the Contractors to access Third Party Liability (TPL) and recovery information. It is estimated that many Medicaid beneficiaries have other insurance coverage through a spouse or family member. In addition, services may be covered by financial recoveries made of estates or related to accidents and auto related injuries. The monthly capitation payment premium established under actuarial sound principles makes assumptions regarding the amounts that will be recovered and inserts that amount as a credit in the overall calculation. If Michigan enabled Medicaid contracting health plans to be considered a part of the Medicaid Program for purposes of recovery, then the amount of the credit can be increased and amount of the necessary capitation reduced over time.

- **Savings from development and implementation of policies addressing "waste" in our health system.** There has been extensive research and studies regarding waste in the U.S. Health System compared to other countries. Further, there is ample documentation of regional variations within each state and between states. By starting to apply best practices models to the underlying Medicaid reimbursement model, Michigan can create significant health care savings without compromising quality of care or access. These savings will be more difficult to generate as much of it is embedded in current practice management and protocols and in some instances supported by existing state policies. One simple measure that we know is the number of admissions to an inpatient stay that could otherwise be treated in the community with an effective coordination and reimbursement policy. Later in this paper we show an illustration that Medicaid hospital utilization is 62% higher than commercial utilization. If we could lower that difference by half, Medicaid and Medicaid health plans could save millions. The development of an appropriate observation stay policy in lieu of hospital admission is another cost saving effort. There are many more that will be identified over the coming months provided the legislature and administration create a receptive environment to not just receive but act on such recommendations.

The above are examples of some of the major savings that Michigan could begin to realize by fundamentally changing the nature of the Medicaid program to one of contract management of a performance based comprehensive Medicaid benefit contract rather than the ongoing bifurcation between that of fee for service and managed care. The focus could then be on

outcome, performance and customer service. This agenda is doable, but will require action to:

- Amend state Medicaid waivers,
- Develop new waiver/state plan amendments,
- Develop enabling state legislation in such areas as TPL, and various mental health, public health and insurance code, and
- Re-deploy state employees into a consolidated administrative structure to administer and conduct appropriate oversight of the new contract mechanism.

It is all too easy to say we cannot make the changes and list countless reasons for that answer. We believe the current environment must emphasize support for developing a plan for **how** such changes can be made.

As the first year of the Snyder administration drew to a close, it was evident a substantial part of the agenda was to re-invent government in order to be more efficient and fiscally prudent in all areas of state government. Sustaining support for Medicaid during the past year was not only a clear objective of the administration; it was embraced by the Legislature as sound policy. This has historical roots in the reputation that Michigan has for its forward thinking in Medicaid. Michigan's approach is not only far ahead of other states but is fully matured—a large part of this is due to the economic efficiency of its fully developed managed care program. We should all expect that the executive and legislative decisions that will be made will not be marginal--but will be far reaching and purposeful in order to achieve agreed upon objectives and sustain the Medicaid program within available resources.

From the perspective of MAHP, the undisputable key facts are:

- Nearly 3/4 **of the cost of Medicaid still resides with the remaining fee for service Medicaid population not enrolled in managed care**. MAHP believes that the state can achieve significant cost savings, extend the value, (already documented by managed care), through further expansion and/or the application of managed care principles with other Medicaid eligible population and/or programs.

- The usual "strategy" in Medicaid reductions is to reduce provider rates. However, reducing provider reimbursement (which is among the lowest in the United States) increases the **cost shifting** to commercial carriers—that issue combined with **uncompensated care** for the uninsured has already pushed additional commercial annual premium costs by over $1000 for families and nearly $400 for individuals and is growing.

- **The familiar admonition of "first, do no harm" would suggest that we take great care in making decisions in Medicaid as overall access for all citizens is at risk** if we fail to adequately support Medicaid. If a physician closes his or her office, they are no longer there for everyone and if a hospital closes a unit, service, or program, it is no longer available regardless of payer status.

We can all agree that it is far preferable to develop a Medicaid solution that will maintain eligibility and support essential networks of providers than to cut either eligibility or reimbursement or both. However, in this economic environment, can we achieve this objective within the available revenue? MAHP believes we can, if the decisions are to work from a managed care environment. If not, then the only other solutions is to reduce provider payments and eliminate optional benefits—solutions that have far reaching consequences to Michigan's overall health care.

Continue to focus on Value

Policy makers, administrators and the public expect (and 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. The most obvious strength is cost savings.

However, there are still too many large populations that remain served in costly and poorly managed settings and programs and should be brought into the folds of the existing managed care programs. While the challenge will be great, the potential results in improved health care status, more accountable care, and economic savings are too great to ignore. Michigan's Medicaid Managed Care Program has demonstrated that the effectiveness and efficiencies are in place to accomplish the expectations set forth by the Governor Snyder, namely wellness and prevention.

Based on prior economic studies the cost-effectiveness of Medicaid managed care continues to bring huge value to the state and federal government--minimally, over $5 **billion in total savings** has been realized due to Medicaid Managed Care between FY 00 and FY 12 or about **$400 million each year**. The savings (compared to fee-for-service) reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care in a partnership with the state in exchange for actuarially sound funding. This return on investment enabled both the State of Michigan and the federal government to redirect savings from Medicaid managed care to support programs in other high priority areas while preserving the Medicaid program.

MAHP appreciates and supports the policy determination that is based on facts, performance and demonstrated outcomes. These are the successful building blocks of Medicaid managed care and it is a reasonable expectation that future executive and legislative decisions will similarly be based in order to achieve desired outcomes and stretch available state resources. Moreover, it is time to move forward with the Governor's objective of having a patient centered model to achieve improvement in quality, promotion of wellness and realization of cost savings.

Current Opportunity

One of the greatest cost saving opportunities for Michigan is to better manage two unique Medicaid populations of vulnerable Michigan citizens. The first group includes a population, which is eligible for both Medicare and Medicaid, and is better known as the "persons with dual eligibility." These beneficiaries are generally the most chronically ill patients within both Medicare and Medicaid. They suffer from health problems such as diabetes, heart disease, Alzheimer's disease and often from some degree of cognitive impairment or disability because

of their illness. Persons with dual eligibility require an array of services from multiple healthcare providers. This often leads to treatment silos, where physicians are unaware of ongoing treatment for other conditions which can result in duplication of services and a lack of continuity in patient-centered care planning.

Although Medicare covers basic healthcare services, including physician and hospital care, Medicaid covers long-term care and services as well as Medicare premiums and cost sharing. Nationwide, persons with dual eligibility represent just 18% of the Medicaid population but account for 46% of Medicaid expenditures. The Medicaid and Medicare programs pay fee-for-service for all health procedures performed for participants in these Medicaid groups which add significant cost – over $7 billion annually. The second group is beneficiaries enrolled in the Children's Special Health Care Services program which will be discussed in detail below.

Examples from Past

In the past, responding to similar challenges and pressures, the Medicaid Administration mandated that all pregnant women and foster care children enroll into the existing managed care plans. This development has been effective and continues to assist with the savings Michigan realizes with the managed care programs. The partnership between the Medicaid Health Plans (contracted with the state) and the Medicaid Administration has been instrumental in the development of the operations to enroll these new populations and in the work to create an atmosphere that will "do not harm." Because these populations came with a unique set of health care issues, thoughtfulness and care was taken to make sure the transition into managed care was accomplished with the well- being of the beneficiary at the pinnacle of the decision making process. This process should serve as the model for bringing additional populations in managed care.

Persons with Dual Eligibility

MAHP expects that the enrollment of the persons with dual eligibility population into the managed care arena and the integration of all services should become a reality in 2013—following the development of a strategic plan, submission of a comprehensive waiver, negotiations with the federal government and completion of a request for proposal to select qualified managed care plans. Additional cost savings will be limited in the initial years but the potential overall savings as well as the overall provision of much needed services will be met. MAHP applauds the thorough stakeholder engagement process and believes the Medicaid health plans stand ready and able to assist in this transition and provide the necessary safety net for this vulnerable population. Working with other agencies responsible for the care of this population and developing an integrated model of care will be a major goal for the fiscal years 2013 and beyond. (MAHP has developed separate recommendations for this initiative and will have a separate "White Paper" for interested parties to review.)

Children with Special Health Care Needs

The next population that should be enrolled into managed care is the Children with Special Health Care Needs. This is a very unique population funded by the Title V program of the Federal Government as well as State General Fund dollars in addition to Medicaid. This group usually has very complicated and unique health care issues which requires a team of providers to care for the individual. Therefore, the case management and special guidance from the health

plan representatives will be a strong functional arm for this population. Assuring the families of these children that their needs will continue to be met and the sub-specialty providers will be available for the care of the children will be of utmost importance. Therefore, a group effort between the Health Plans, providers and the department will be needed to preserve these assurances.

MI CHILD

Another population to be considered is the MiChild Population. Michigan should combine the administration and contracting of this program and direct enrollment into the Medicaid Health Plans. This effort will eliminate the annual payments of at least $12 million paid by State Government associated with a costly and unique settlement agreement with BCBSM. Other positive features of this consolidation will be to improve and document performance consistent with the proven record of Michigan's Medicaid health Plans. Moreover, it will provide a continuity of care for children and adolescents and their families and capitalize on Medicaid outreach efforts to reach those children eligible but not yet enrolled in MiChild. The federal reauthorization of the Child Health Insurance Program permits increasing the eligibility level for MICHILD in Michigan. It is possible through implementation of the recommendations, including redirecting the Blue Cross cost settlement dollars to raise enough new revenue to provide the necessary state match for MI CHILD and increase eligibility to 300% of poverty. This is a key recommendation made by many advocates.

Further Opportunity for Efficiencies and Reduction of Waste

Without a doubt, waste in the Medicaid program must be addressed. There has been extensive research and studies regarding the waste in the U.S. Health System compared to other countries and there is ample documentation of regional variations within each state and between states. By starting to apply best practices and models and tying it to the underlying Medicaid reimbursement model, Michigan can create significant health care savings without compromising quality of care or access. Clearly, savings will be more difficult to generate as much of it is embedded in current practice management and protocols and in some instances supported by existing state policies. As an illustration, Medicaid hospital utilization is 62% higher than commercial utilization. If efforts can lower that difference by half, Medicaid and Medicaid health plans could save millions of dollars for taxpayers of this state.

The development of an appropriate observation stay policy in lieu of hospital admission is another cost saving effort. Additionally, avoiding hospital readmissions within 30 days of initial admission could prove to save health care dollars. .

Finally, MAHP and other organizations must continue to advocate for the immediate efforts to develop and implement the MI Health Marketplace (Michigan's Health Insurance Exchange). This effort will assist in the management and efficiency of administering the change in eligibility for Medicaid beneficiaries taking place in 2014.

Avoid Costly Rebid

The Department of Community Health has many initiatives commencing in the current year and to continue into FY 13 which include:

1. Development of the plan for the Integrated Care for the persons with dual eligibility Project to send to CMS along with Waivers prepared for CMS and an RFP prepared for the procurement process of this plan
2. Preparing for the advent of the Michigan Market Place (the Insurance Exchange) which will change the face of insurance procurement for the citizens of Michigan
3. Preparing for the potential of 500,000 more Medicaid beneficiaries
4. The development and deployment of a new version of diagnoses codes, namely the ICD-10, an enormous system change undertaking

All of these initiatives require a tremendous amount of staff resources and expertise of both the state of Michigan and its consultants and the current and interested health plans who would submit proposals for review. Therefore, the MAHP recommends that Michigan utilizes the full option of 3 one-year extensions and until the scheduled end date of September 30, 2015 for the current Medicaid health plans contract. As documented in this White Paper, the quality of the services provided by Medicaid health plans continues to be high as evident in the national rankings of the health plans. The *2010-2011 National Committee on Quality Assurance (NCQA) Health Insurance Plan Rankings* rated the MAHP member health plans among the highest rated in Medicaid plans, (10 MAHP member health plans were in the top 50 Medicaid plans in the nation). In addition, Medicaid health plans have and continue to document that they have adequate capacity to fulfill the needs of the current Medicaid population as well as the anticipated growth. Therefore, there is no need to re-bid this contract until the full contract period is completed—this decision by itself will save Michigan government millions in resources that can otherwise be used for priority purposes.

House Appropriations Subcommittee on

Community Health

March 5, 2012

Testimony on Fiscal Year 2012-13 and Fiscal Year 2013-14 Executive Budget Recommendation: Medicaid/Mi Choice Waiver

Christine Vanlandingham, Fund & Product Development Officer Region IV Area Agency on Aging

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Dignity, independence, choice... these are the words 69-year-old Barbara L. from Cassopolis uses to describe her life since she moved back to the community after a lengthy stay in a nursing home.

I'm Christine Vanlandingham with Region IV Area Agency on Aging [AAA] serving Berrien, Cass and Van Buren counties in southwest Michigan. It was through the AAA's Nursing Facility Transition work that Barbara was able to return to community living.

After suffering a massive stroke in 2009, Barbara was admitted to a nursing home in Three Rivers – thirty miles from her home. Isolated from her community of friends in Cassopolis, she was lonely, board and desperate to move back home. That was two and a half years ago. Today, Barbara lives in her own apartment, enjoys cooking her own meals with the assistance of an aide and is highly engaged in the life of the community thanks to the Nursing Facility Transition initiative – or NFTi.

Through NFTi, the AAA provided the home modifications, household supplies and transition services that allowed Barbara to move back to the community. 26 hours weekly of personal care and homemaking services combined with medication management and an emergency response button funded by the Mi Choice Waiver are the ongoing services that allow Barbara to continue living independently and participate in community life.

Since returning home, Barbara has added to the fabric of her community by organizing letter writing campaigns to troops serving overseas and visiting with people in her apartment complex who need a friendly ear.

Since the NFTi program began, Barbara and 192 other seniors and younger persons with disabilities in Berrien, Cass and Van Buren counties have been able to transition back to their homes and communities. Statewide in the last year alone, more than 1500 Medicaid nursing facility residents were able to transition home at a significant savings to the state.

The cost of home and community-based care is estimated to be one-quarter of the cost of institutional care. Investing in home and community-based care is far more cost effective, in economic and human terms, than paying for expensive Medicaid-funded nursing home care, or losing the economic and social contributions of older Michiganians like Barbara.

But Barbara is one of the lucky ones. There is a one-year waiting list for Mi Choice Waiver services in southwest Michigan – with 75 people currently waiting for services. Many more chose not to add their name to the list as their care needs are too pressing to wait that long.

In other regions, Waiver programs are effectively 'closed' due to extremely long wait lists. In these cases, the only avenue to receive Medicaid-funded home and community based services is to go to a nursing home – the most costly setting -- live there for six months and then transition back home.

According to the Kaiser Family Foundation State Health Facts, in FY 2009, Michigan spent almost two thirds of its long term care budget on nursing homes, a higher percentage than any other state.

With the senior population of Michigan projected to grow to 22% by the year 2020, it's critical that policy makers take the long view and reverse the state's structural reliance on the most costly setting to provide long term care services.

Expanding access to less costly and highly-effective home and community based services through the Mi Choice Waiver, Nursing Facility Transition initiative, and Programs of All Inclusive Care for the Elderly [PACE] will allow Michigan to lower the cost per person, serve a broader population and address the growing need.

The Governor's recently released budget recommendation includes increased funding critical to reducing the Mi Choice waiver wait list and expanding access to community based long term care services through PACE. On behalf of seniors and younger persons with disabilities in southwest Michigan and across the state who are waiting for home and community based services, I respectfully ask you to support those funding levels.

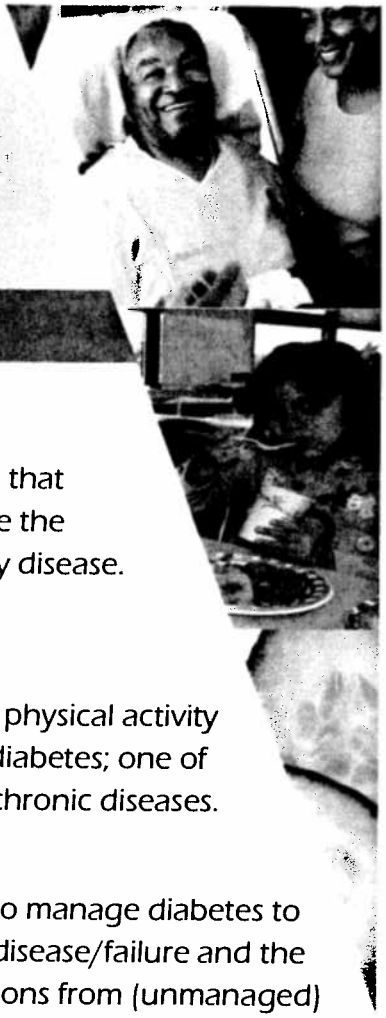
Thank you.

Christine Vanlandingham
Fund & Product Development Officer
Region IV Area Agency on Aging
2900 Lakeview Ave.
St. Joseph, MI 49085
269-983-0177

Diabetes & Kidney Disease Prevention

A Model Public-Private Partnership

2012 Guide for Michigan Health Policy Makers



Prevent OBESITY in order to **Prevent DIABETES** in order to **Prevent KIDNEY DISEASE**

Personal responsibility plus state programs that focus on lifestyle improvements can reduce the lifetime risk of obesity, diabetes, and kidney disease.

Reducing obesity and increasing physical activity can prevent the onset of type 2 diabetes; one of the most common, preventable chronic diseases.

We know how to manage diabetes to prevent kidney disease/failure and the other complications from (unmanaged) diabetes such as heart attack, stroke, blindness, and amputations. Diabetes is the leading cause of kidney failure.

And

Create A Healthier Michigan

The conditions in which we live, learn, work, and play – "the social determinants of health" — have an enormous impact on peoples lives. The Michigan Department of Community Health and the National Kidney Foundation of Michigan are working together to address the social determinants of health in communities and "move the needle" to improve lives for people living with, or at-risk-for, diabetes and kidney disease.

Preventing obesity and diabetes in addition to managing diabetes to prevent complications saves money for employers, health care, Medicare, and Medicaid.

Outcomes-Based Programs

Reducing Obesity & Increasing Physical Activity to Prevent Diabetes & High Blood Pressure

Regie's Rainbow Adventure™

Obesity prevention starts with Early Childhood Programs

Healthy Families Start with You, Regie's Rainbow Adventure, Pe-Nut

These programs focus on teaching pre-school age children about healthy lifestyles, including healthy eating habits and physical fitness.

- In 2011, over 12,000 kids learned about healthy living
- Over 75% of parents indicated that they and their children eat more fruits or vegetables, and over 70% were more physically active.

Obesity prevention continues from elementary through high school with education on healthy living & disease prevention

Kids and Kidneys (elementary school)
Students learn about good nutrition, exercise, and disease prevention.

Healthy Kids and Kidneys (6th grade)
In this intensive 8-week program, one thousand students at high-risk for diabetes, high blood pressure and kidney disease learned to improve their nutrition and exercise habits to stay healthy.

KICK (Kids Interested in the Care of Their Kidneys) (high school)
Students learn about diabetes, high blood pressure, disease prevention, and organ donation.

- In 2011, over 76,000 kids were educated statewide
- Served since 1997: Over1.3 million
- Students show a 15% increase in knowledge from pre to post testing

Focusing on Rural Areas:

Northern Michigan Diabetes Initiative (NMDI)
Based in Traverse City, NMDI is an 11-county collaborative of health and community organizations to prevent and manage diabetes. Since 2006 NMDI has achieved:

- 20% increase in patients with diabetes with an improved A1c
- 26% increase in A1c screenings to detect diabetes
- 16% increase in patient referrals to Diabetes Self-Management Education

Upper Peninsula Diabetes Outreach Network (UPDON)
Based in Marquette, UPDON is a 15-county organization that promotes partnerships to strengthen diabetes prevention and detection throughout the entire Upper Peninsula (UP). UPDON coordinates:

- Professional education and consumer resources
- Personal Action Towards Health (PATH) workshops
- Tribal, community and clinical partnerships

ınd Results

The Diabetes and Kidney line brings match dollars to Michigan

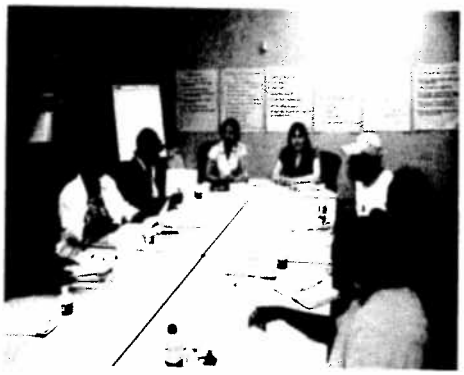
- And provides programs in under-served minority communities

Improving Diabetes & High Blood Pressure Control to Prevent Kidney Disease/Failure

Diabetes Self Management Education (DSME)

DSME is critical since diabetes patients are responsible for 99% of their care. Disease-management + DSME = a return on investment of $4:$1.

- In 2011, over 32,000 were educated statewide.
- National studies show that DSME provides:
  - Reduction in health care costs
  - Fewer emergency room visits
  - Fewer hospital admissions
  - More HbA1c testing
  - More kidney testing
  - More eye testing
  - More lipid testing



Personal Action Toward Health (PATH)

An evidence-based workshop where participants learn to take an active role in managing their chronic condition. Studies show: participants improve their self-efficacy, energy, symptom management and communication with health care providers. Better disease self-management results in fewer hospitalizations.

- Served statewide in 2011: 3,100
- Served since 2007: 9,500
- Estimated health care savings of $200/person over 2 years
- Estimated savings in 2011: Over $3 million

EnhanceFitness

A low-cost, evidence-based exercise program that helps adults become more active and empowered to sustain independent lives.

- In 2011: Nearly 2,000 participated in 52 sites in Michigan
- Results include weight loss, and in some cases, better blood sugar and blood pressure control
- Estimated health care savings of over $500 per person per year.
- Estimated Savings in 2011: Up to $1 million

Healthy Hair Starts with a Healthy Body™ and Dodge the Punch: Live Right™

African American beauty salon stylists and barbers are trained to provide health education in their communities.

- In 2011: over 2,000 clients were reached
- Served since 1999: 43,000 clients
- 71% of salon and barbershop clients made at least one healthy lifestyle change and improved medication adherence

WISEWOMAN

WISEWOMAN provides low-income women with diabetes screenings and information to improve their diet and physical activity levels.

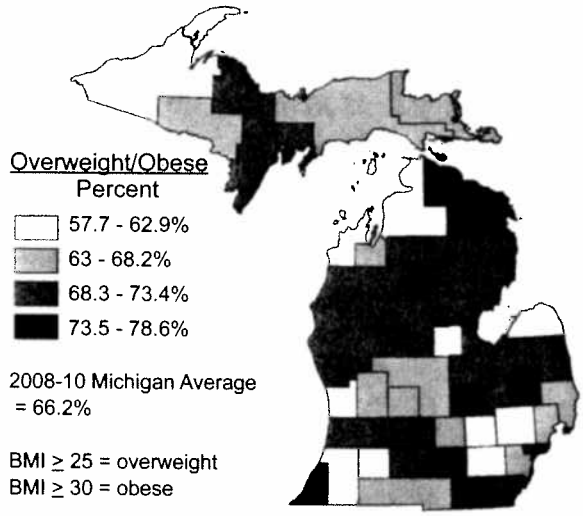
- 2008-2011: 9,200 served in 34 counties
- 303 women were diagnosed with diabetes

Obesity, Diabetes &Kidney Failure are <u>all related</u>.

Create
A Healthier Michigan

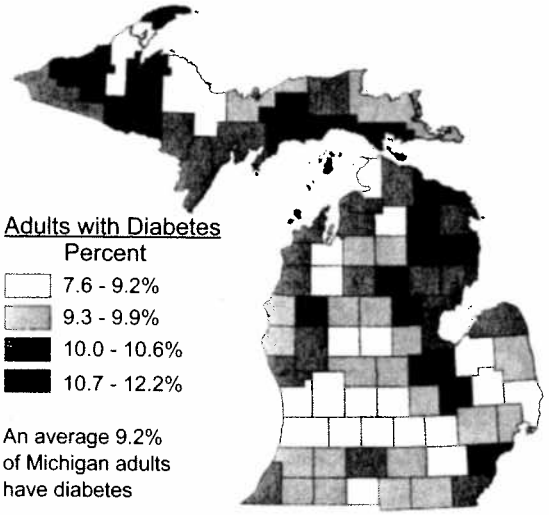
Obesity:

- Over 66% of Michigan adults are overweight or obese (having a Body Mass Index (BMI) over 25)
- Continues to increase among all ages
- Is expected to quadruple by 2018 (projected by CDC)
- Lowers quality of life
- **Can be prevented by adopting healthy lifestyle changes like eating healthy and increasing physical activity**



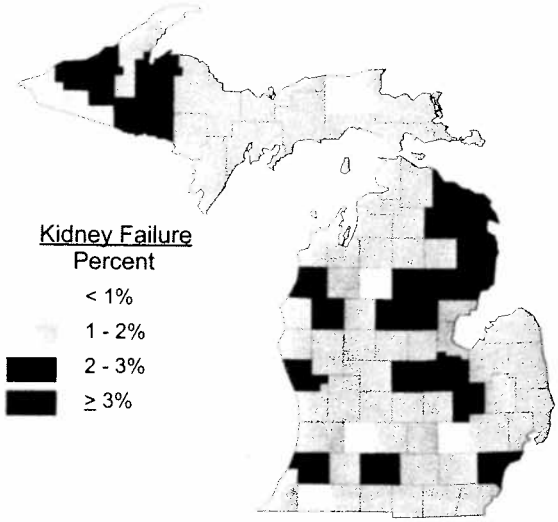
Diabetes:

- Is a serious health concern and economic issue
- Is often caused (type 2 diabetes) by obesity or being overweight
- **Can often be prevented (type 2 diabetes) by maintaining a healthy weight and engaging in physical activity**
- **Can be managed (type 1 and type 2) when diagnosed, to prevent kidney disease/failure and the other complications: heart attack, stroke, blindness, and amputations**



Kidney Failure:

- Is caused primarily by unmanaged diabetes and uncontrolled high blood pressure
- Disproportionately affects African Americans and other racial minorities
- Grew at an average rate of <u>9% per year</u> from 1987-1997 **but slowed** to an average of <u>3.7% per year</u> between 1999 and 2009
- **Can be prevented or delayed by preventing and managing diabetes and high blood pressure, the two leading causes of kidney failure**



Data and programs in this handout are provided/supported by the Michigan Department of Community Health (www.michigan.gov/diabetes) and the National Kidney Foundation of Michigan. (www.nkfm.org) *Cost savings are based on initial studies published in the AHRQ Publication, the Journal of Preventative Medicine, and www.DiabetesEducator.org. Using this data cost savings were estimated by the National Kidney Foundation of Michigan.

National Kidney Foundation of MICHIGAN www.nkfm.org 800.482.1455

CHARITY NAVIGATOR ★★★★ Four Star Charity — *Only 8% of charities receive 4 stars from Charity Navigator*

Diabetes Partners in Action Coalition
www.dpacmi.org
517-335-8378

Michigan House of Representatives Appropriations Subcommittee on Community Health
March 5, 2012

Diabetes and Kidney Programs Line

Michigan Department of Community Health

The Problem

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

Prevention is possible in every part of this equation

Diabetes:

- Type 2 diabetes is caused by lack of exercise and an abundance of unhealthy foods. (90% of diabetes is type 2 diabetes)
- Minority populations are at higher risk of developing type 2 diabetes.
- Over 13% of Michigan adults have diabetes, but one third (1/3) don't know it.
- Over 29% of Michigan adults are pre-diabetic (blood sugar levels higher than normal).
  - Most will develop Type 2 diabetes without lifestyle changes.

Kidney Disease/Failure:

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

The Solution

The Governor's Health and Wellness 4 x 4 Plan is aimed at improving the health of our state through 4 key health measures and 4 key health behaviors.

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 examination.	3. Cholesterol Level
4. Avoid all tobacco use.	4. Blood Sugar/Glucose Level

The programs supported by the Diabetes and Kidney Line are very closely aligned with this plan.

Diabetes and Kidney Programs Line provides:

- Solution driven, evidence-based programs with positive outcomes
  - Focused on reducing/preventing obesity, diabetes, and high blood pressure
- Match funding to Michigan
- Programs based in communities and health care systems
- Programs targeting minority populations at higher risk for diabetes, high blood pressure and chronic kidney disease.

Please support the state funding to the Diabetes and Kidney Programs line.

Sally Joy & Lindsay Bacon, National Kidney Foundation of Michigan

MHA
MICHIGAN HEALTH & HOSPITAL ASSOCIATION

SPECTRUM HEALTH

Kevin Splaine, President, Spectrum Health Medical Center, Grand Rapids
Testimony Before the House Appropriations Subcommittee for the
Michigan Department of Community Health
March 5, 2012

Good morning. I am Kevin Splaine, President, Spectrum Health Hospital Group. Spectrum Health is a not-for-profit health system based in Grand Rapids offering a full continuum of care through the Spectrum Health Hospital Group, which is comprised of nine hospitals throughout West Michigan, including Helen DeVos Children's Hospital, a world-class children's hospital that opened in January 2011. Our System also includes the Spectrum Health Medical Group and West Michigan Heart, a physician group totaling more than 1,500 providers; and our health plan, Priority Health, offering health insurance options to more than 625,000 members across the state through a broad portfolio of products for employer groups, individuals, and Medicaid and Medicare recipients. Spectrum Health System is West Michigan's largest employer with more than 19,000 employees. We provided $176.5 million in community benefit during our fiscal year 2011, by providing community outreach and health improvement programs through our Community Care Clinics, the Renucci Hospitality House, Research, and our Healthier Communities program. I am here today on behalf of the Michigan Health & Hospital Association, which represents all 137 of the community hospitals in the state. Thank you for the opportunity to testify today on Governor Rick Snyder's executive budget recommendation for funding the Michigan Medicaid program for FY 2013.

The mission of Michigan hospitals is to care for all who pass through our doors, regardless of their ability to pay. Despite the efforts of the Governor and the Legislature to avoid cuts to Medicaid, our ability to continue to provide care remains threatened. As you know, nearly one in five Michigan citizens rely on Medicaid to cover their health care needs, a program that pays providers less than 65 percent of the cost of delivering care (source: National Association of Children's Hospitals). Although children represent half of all Medicaid recipients, they only account for 21.1 percent of the costs. At Helen DeVos Children's Hospital, half of our patients are on Medicaid. This troubling trend in the growth of Medicaid eligibility is compounded by the fact that the number of Michigan citizens without health insurance of any kind increased to 1.35 million; taken together this means over three million people in Michigan are either enrolled in Medicaid or are uninsured, placing an unfair burden on health care providers to provide treatment with no or little payment for their services.

The hospital community is grateful that Governor Snyder recognized the need to avoid cuts to direct Medicaid provider payments. The executive recommendation includes a sizeable cut to graduate medical education (GME) through a further cut of $6 million in general fund dollars, which results in a $17 million cut to Michigan's teaching hospitals due to the loss of federal matching dollars. However, we are confident that on further reflection, the administration and Legislature will realize GME not only trains needed future physicians, but effectively supplies the people who provide direct patient care. The name "graduate medical education" may sound like a fund for paying tuition for medical school. In fact, these dollars support a teaching hospitals' ability to hire physician residents, who are licensed physicians who have

completed medical school, and pay for the teaching physicians who provide the actual oversight and training. Physician residents provide an immediate benefit to communities across the state by delivering health care in hospitals and clinics, homeless centers and laboratories and provide a large proportion of the care to Medicaid recipients. Upon completion of their residency, they are also statistically more likely to remain in Michigan, reducing our need to recruit physicians from other states to meet the future needs of Michigan residents. According to the Michigan State University College of Human Medicine, 60-70% of medical residents end up practicing in communities where they served their residency.

Between 2012 and 2013, the total cut to GME will be over $30 million which is a significant disinvestment in physician training and the provision of physician services. (Note: Spectrum Health's estimated annual loss is $1 million).

Given the current state budget surplus, we had hoped that the State would take a comprehensive look at Medicaid and its inadequate funding over the past decade and attempt to solve the underlying problems. The Medicaid reductions borne by providers - and the employer community that sustains our services - has contributed greatly to the disintegration of the health care safety net, reduced access to primary care services and has exacerbated challenges related to health care costs experienced by non-governmental payers. For the fourth year, Michigan hospitals will also need to carry the burden of providing the funds necessary (via the QAAP tax) to avoid an eight percent cut to provider rates that was first imposed in the state's fiscal year 2009. In addition, an investment of $10 million general fund dollars that was created last year for certain small and rural hospitals is left out of this year's executive recommendation. As the MHA testified last year, the fate of smaller, rural hospitals is in jeopardy from the underpayment for Medicaid services. Smaller hospitals have relatively higher fixed costs. If the Legislature values local hospitals within mid-sized and smaller communities, the impact of Medicaid funding needs to be acknowledged and the funding restored. The MHA encourages the state to move to cost-based reimbursement for outpatient services provided in hospitals with fewer than 50 beds.

Medicaid underfunding is most apparent in the area of labor and delivery services. Medicaid is the payer for more than half of the births in Michigan, yet pays less than the cost to staff and operate a labor and delivery service. Spectrum Health is recognized as having a low cost-structure. However, even with our low costs, for each Medicaid birth we receive an average of $5,312 for services that cost us on average $5,780 in overhead expenses. That's a loss of $467 for each Medicaid birth, providing no margin to reinvest in our services to care for these patients. Governor Snyder has set infant mortality as a benchmark on the state's new dashboard. We agree that everyone in health care must address this critical matter. To accomplish this goal, increased reimbursement for both physician and hospital services for prenatal care and labor and delivery must be a part of the solution.

The Snyder Administration has asked for innovation and demonstrable improvement as a condition of increasing funding. Michigan hospitals are doing that every day. The MHA is working with the Department of Community Health, the Medicaid HMOs and our physician partners to reorganize the funding proposals to allow for this investment. However, we are not

simply working to find more money. The MHA and its hospital members are committed to creating reforms within Medicaid to reduce the costs of the program.

Specifically at Spectrum Health, our Vision is to be the national leader for health by 2020. We have been recognized as one of the nation's top 100 integrated health systems, twelve times since 1997. The award recognizes health systems that have shown success in connecting technology to improved clinical outcomes. Furthermore, we believe there is a direct link between health care costs and the quality of care that is delivered. That is why we are committed to achieving the best outcomes. We accomplish this by focusing on patient safety, exceeding national patient safety goals and error prevention, increasing efficiencies, and using research and evidence-based practices to facilitate patient outcomes. Our advanced health care treatments are also delivered with the goal of creating an exceptional experience -- never forgetting whom we serve, our patients and their families.

Such efforts may not be scored as savings in the fiscal year 2013 budget, but they most certainly provide a value or return on investment with a financial benefit to patients, the business community, and indeed the State of Michigan as we improve health care for all patients, including the nearly two million people reliant on Medicaid for their health care coverage.

We applaud the Snyder Administration and Legislature for their work and recent success in improving the state's economic outlook. There certainly is a new sense of optimism in Michigan. But the last decade has taken its toll. Medicaid case loads have grown significantly across the state, and are expected to increase even further with the expansion of Medicaid as part of the federal health care reform law. It is in the state's best interest to protect access to affordable, high-quality health care as part of the overall economic recovery in Michigan. Like any other business, health care must have long term viability. To do otherwise, will either require services be eliminated or further shifting of the costs to the business community, which impedes our overall economic recovery. The first step to ensuring that Michigan hospitals will be a part of the Reinvention of Michigan is to prevent an increase in the "hidden-tax" on the business community, by keeping health care dollars in health care, and protecting the availability of services that we have in place.

On behalf of all of Michigan's hospitals, I ask you to support Governor Snyder's executive budget recommendation as a starting place. We look forward to working with the Legislature to include the restoration of the funds for (1) physician residencies through the GME program, (2) small, rural hospitals, and (3) to seek critical funding for prenatal and new baby care. I also ask that you join the MHA and its members in recognizing increased Medicaid caseload across the state and embracing, even rewarding new approaches to care delivery that demonstrate cost reductions and improved care for patients who are among the most vulnerable in our state.

MICHIGAN
Oral Health Coalition

Testimony for the House Appropriations Subcommittee on Community Health
March 5, 2012

Good morning, Chairman Lori and members of the committee. My name is Karlene Ketola, executive director of the Michigan Oral Health Coalition. I am here today representing the Michigan Oral Health Coalition's membership which includes families, 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. Thank you for the opportunity to comment on the FY 2013 Michigan Department of Community Health budget.

February 25, 2012 marked the five-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 recommended his support of the Healthy Kids Dental, Medicaid Adult Dental and Donated Dental Services programs. In his Michigan Health & Wellness Message, Governor Snyder shared how oral health complications exacerbate general health conditions and our members would agree. Periodontal disease is associated with diabetes, cardiovascular disease, coronary heart disease, respiratory disease, and adverse pregnancy outcomes. Poor oral health also results in school absences and inappropriate use of hospital emergency rooms. The 2011 Institute of Medicine Report, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations,* concluded that oral health care is an essential component of comprehensive

Michigan Oral Health Coalition | 7215 Westshire Drive Lansing, MI 48917
Tel 517.827.0466 | Fax 517.381.8008 | E-mail kketola@mohc.org | Web www.mohc.org

MICHIGAN
Oral Health Coalition

Testimony for the House Appropriations
Subcommittee on Community Health
March 5, 2012

health care. Such programs, Healthy Kids Dental and Donated Dental Services are not achievable without strong public-private partnerships.

In 2000, the Michigan Department of Community Health partnered with Delta Dental of Michigan to develop the Healthy Kids Dental program to improve dental care access. The program, which started in 10 counties as a pilot program, is now serving approximately 350,000 Medicaid-eligible children in 65 of 83 Michigan counties. Through your support in FY 2012, Mason, Muskegon, Newaygo and Oceana counties were the latest to implement the Healthy Kids Dental program.

As you deliberate the FY 2013 Community Health budget, we ask that you support Governor Snyder's recommendation to fund the phase-in expansion of Healthy Kids Dental to every county ensuring ALL Michigan children receive the care they need for a healthy mouth, and a healthy body.

The following counties are not current Healthy Kids Dental program counties specifically children in these counties do not have improved access to a dental provider. I have also attached the statewide Healthy Kids Dental map for your review.

Cass
Kent
Ottawa
Wayne
Ingham
Bay
Berrien
Calhoun
Grand Traverse
Jackson
Kalamazoo
Macomb
Mecosta
Montcalm
Oakland
Osceola
Washtenaw
Wexford

MICHIGAN
Oral Health Coalition

Testimony for the House Appropriations
Subcommittee on Community Health
March 5, 2012

Healthy Kids Dental:

An Investment in Michigan's Children

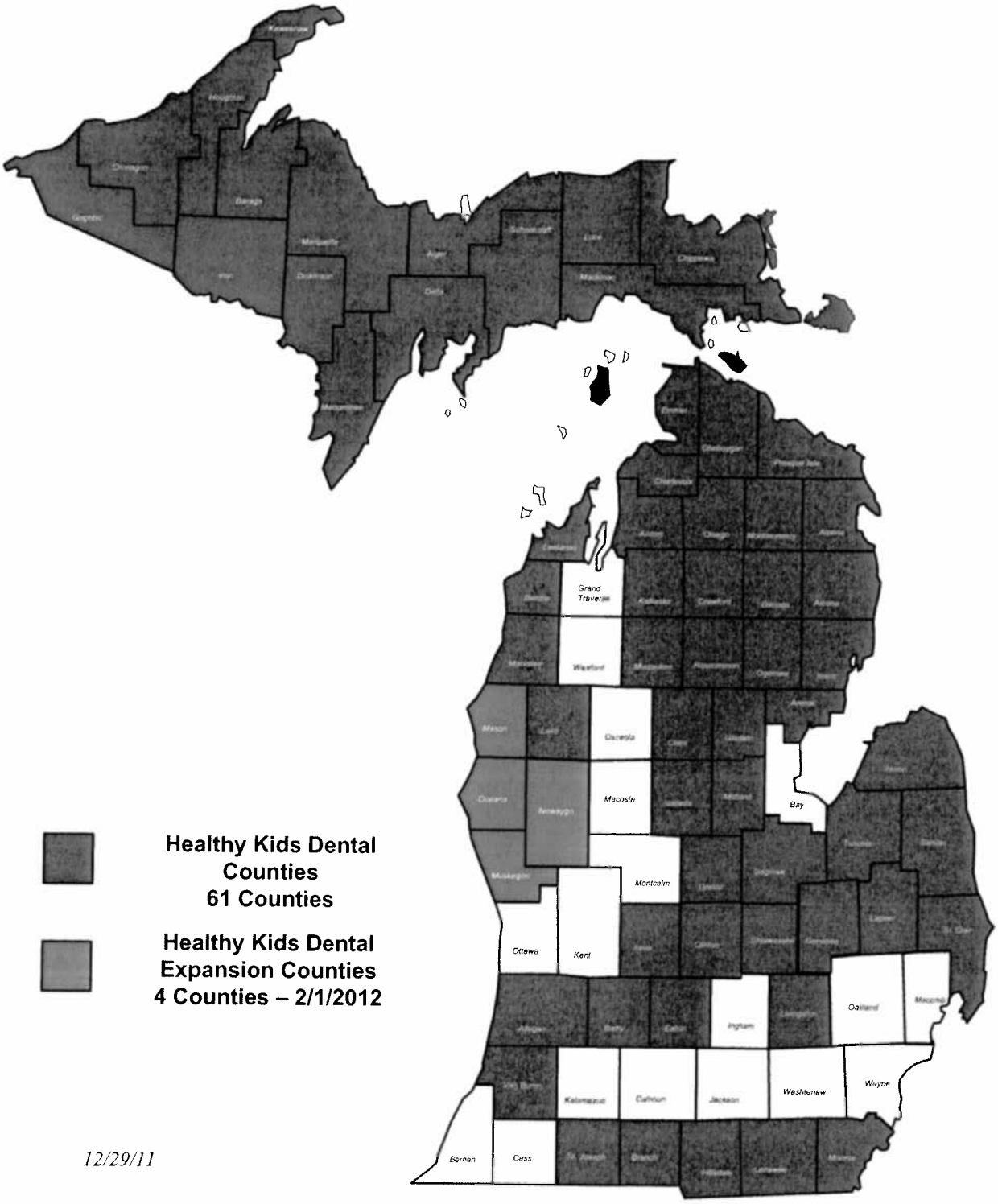
1. Nationwide, only 38 percent of such children received any dental care in 2007. Here in Michigan only 34% of Medicaid-enrolled children received care while 56% of Medicaid-enrolled children, living in a Healthy Kids Dental county, received care.
2. Compared to children enrolled in the state-administered Medicaid dental program, Healthy Kids Dental children were 60.6% more likely to receive preventive dental care by age 3 and 25% less likely to have used emergency dental care by age 3.

Mr. Chairman, on behalf of the Michigan Oral Health Coalition, we ask that Healthy Kids Dental's statewide expansion plan remain in the Community Health budget as proposed by Governor Snyder in FY 2013 through 2016. Thank you for your time and consideration.

Respectfully Submitted,

Karlene Ketola, MHSA, CAE
Executive Director
Michigan Oral Health Coalition
517.827.0466

Michigan Department of Community Health
Healthy Kids Dental



Healthy Kids Dental Counties
61 Counties

Healthy Kids Dental Expansion Counties
4 Counties – 2/1/2012

12/29/11

TESTIMONY
Dr. William Mayer
House Appropriations Subcommittee on Community Health
March 5, 2012

- Hello Representatives. Thank you for the opportunity to speak today. My name is Bill Mayer, Vice President for Community Health and Chief Medical Informatics Officer at Bronson Healthcare Group in Kalamazoo, MI. I am a licensed physician by the State of Michigan and Board Certified in Preventive Medicine and member of C-Change for more than 10 years. I am here representing the American Cancer Society, Great Lakes Division, as a member of the Board of Directors. I also serve on the Board of Directors for the American Cancer Society Cancer Action Network. I am here in support of increased funding for the Cancer Prevention and Control Program, specifically to discuss the benefit of the Michigan Cancer Consortium (MCC).

- MCC is a nationally-recognized, award-winning partnership of public, private, and voluntary organizations to reduce the impact of cancer in Michigan.

- MCC consists of 117 organizations whose members voluntarily work together to pool and conserve existing resources and also to leverage new resources for cancer prevention and control. Members include the American Cancer Society, Henry Ford Health System, Michigan State Medical Society, Pfizer, the Saginaw County Department of Public Health, and the University of Michigan Comprehensive Cancer Center, and William Beaumont Hospital, to name a few. The Consortium is staffed by the Michigan Department of Community Health Cancer Section.

- The burden of cancer to Michigan is important to your constituents and important to Michigan business
    - Over 57,000 new cancer cases are diagnosed in Michigan each year. For breast cancer alone, The American Cancer Society estimates Michigan has over 120,000 women living with this disease.
    - Cancer is the second leading cause of death in Michigan—resulting in approximately 20,000 deaths per year— Cass county has the 2nd highest cancer mortality rate in MI, St. Joseph County is #18. Chairman Lori, House District 59 has higher smoking rates and lower rates of cervical and colorectal cancer

screening than the state. However Branch/Hillsdale/St. Joseph have a higher mammogram and clinical breast exam use rate than the state.

- The ACS estimates that over 60% of cancer deaths are preventable—from cancers due to tobacco, poor nutrition, lack of physical activity, overweight, obesity and other lifestyle factors
- Cancer is a major contributor to an unhealthy, less productive workforce— Business leaders are beginning to recognize the importance of a healthy workforce to their competitiveness in the marketplace. A study published in the Journal of Occupational and Environmental Medicine found that every $1 in direct medical and pharmaceutical costs for employees is matched by $2.30 in health-related productivity costs.
- Cancer control can lower the cost of doing business in Michigan— According to an actuarial study published by Milliman, it would take an investment of only $2.95 per member per month for the typical employer to reach near full compliance among their employees to cover breast, colorectal and cervical cancer screening, and that this would yield savings of up to $3.75 per member per month.

- The key points are that prevention and early detection of cancer are highly cost-effective ways to save lives, and they produce an inherent economic benefit. In the current economic climate, cancer prevention and early detection programs are a vital component of controlling our state's rising health care costs and making our state a more attractive place to do business.

- This is why the MCC is so important. It helps save lives as well as Michigan taxpayer dollars.

- The MCC gathers clinical expertise from Michigan, other states and national partners to identify evidence-based strategies to lessen the burden on Michigan residents caused by cancer.

- The MCC has a wealth of resources on cancer and cancer control methods, including:
    - Cancer data by legislative districts
    - Cancer experts from around the state
    - Cost-benefit information
    - Special reports and position papers on new technology, and
    - Evidence-based and impact-oriented strategies developed by expert advisory committees.

- The MCC has produced major accomplishments for the State of Michigan. These include:
    - Initiatives to reduce tobacco use among youth in grades 9-12: MCC-sponsored collaboration at the state and local levels included reducing sales of cigarettes to minors, increasing smokefree regulations and ordinances in schools and childcare centers, limiting tobacco billboard advertising, and increasing tobacco excise taxes. Results: 58% reduction in youth tobacco use in ten years.
    - Promotion of colorectal cancer screening: Initiates include—
        - Creation of a new collaborative statewide Colorectal Cancer Awareness Network (CRAN) to promote colorectal cancer screening at the state and local levels.
        - Implementation of a colorectal cancer early detection pilot project.
        - Production and dissemination of Colorectal Cancer Early Detection Guidelines and professional education modules to Michigan health care providers.
        - Implementation of media campaigns and other public education efforts, including some special populations (i.e., African Americans, Asian Americans, and Arab Chaldeans).
        - Results: An increase in colorectal cancer screening among adults age 50+ from 30% to 50% in ten years.

- The MCC is recognized around the country for its leadership and excellence. In 2006, the MCC received the first-ever Comprehensive Cancer Control Implementation Award from the organization "C-Change".

- C-Change is the national coalition for cancer control chaired by President George H.W. Bush, with California Senator Dianne Feinstein serving as vice-chair. It is comprised of more than 100 leaders from the public, private and non-profit sectors from across the US, all concerned about winning the war on cancer. Leaders from across the nation agree that the MCC acts as a model for the rest of the country.

- By creating a framework that promotes the synergy of statewide resources across the public, private and voluntary sectors, the MCC provides a unique tool in the fight against cancer and higher healthcare costs for the residents and businesses of the state of Michigan.

- As part of its efforts to reducing the burden of cancer in Michigan, the MCC is committed to leveraging in-kind contributions from private and non-profit entities to supplement and enhance the support from the public sector.

- It is difficult to decipher whether or not we are making progress in increasing funding for cancer prevention with the new budget process of rolling several health and wellness initiatives together. I urge you to increase funding for the Cancer Prevention and Control Program to continue and enhance the exemplary work of the MCC.

- Thank you for your time.

AREA AGENCIES ON AGING ASSOCIATION OF MICHIGAN
6105 W. ST. JOSEPH, SUITE 204, LANSING, MICHIGAN 48917

PROTECT VULNERABLE ADULTS & FUNDING FOR THE MI CHOICE WAIVER

MI Choice is a special Medicaid program designed to give older adults and people with disabilities more choices in receiving long term supports. It provides services in a person's home similar to those provided in a nursing home. Even though it's a Medicaid program, funding is capped at $230 million and that limits the number of clients that can enroll. There are 8,000 people on MI Choice waiting lists.

Who is eligible for MI Choice?

- Low-income adults of all ages who have disabilities significant enough to qualify for nursing home care.
- People already living in nursing homes if they want to leave and are able to live safely at home.
- Income can be no greater than 300% of the SSI level ($2,094/month in 2012), and liquid assets can be no greater than $2,000 (spousal asset protections apply).

How does MI Choice operate?

- MI Choice is a public-private partnership in which the state uses 14 Area Agencies on Aging to administer the program along with seven other agencies.
- Waiver agents provide care management and contract with many local businesses and nonprofits to provide the services.

Is MI Choice cost-effective?

- MI Choice costs an average of $52/day compared with an average nursing home cost of $172/day (2010 figures).
- MI Choice and Home Help contributed to the first ever reductions in nursing home spending in Michigan in FY 2008 and 2009, despite the growth in the aging and disabled population, saving $30 million.
- MI Choice transitions people on Medicaid living in nursing homes back to the community for a direct and immediate savings to the Medicaid budget. Michigan is a leader in nursing home transitions, with over 1,600 transitions accomplished in 2011, more than the state-set benchmark.

What is the economic impact of MI Choice on local communities?

- According to a study done by Indiana University, a $10 million increase in MI Choice brings an additional $27 million in federal matching funds, creating 1,100 new jobs and returning $1.9 million in tax revenues to the state.

March, 2012

(517) 886-1029, fax (517) 886-1305, www.mi-seniors.net

AREA AGENCIES ON AGING ASSOCIATION OF MICHIGAN
6105 West St. Joseph, Suite 204, Lansing, Michigan 48917
Phone (517) 886-1029 www.mi-seniors.net Mary Ablan, Director

FACT SHEET ON MI CHOICE

MI Choice allows adults 18+ with serious disabilities to live at home and avoid or postpone nursing home placement.

What is MI Choice?
MI Choice is a statewide Medicaid program that enables older adults and younger adults with disabilities to function safely in their own homes with services, avoiding or postponing institutional placement. It works hand-in-hand with family caregivers, not to replace them, but to assist them so they can keep going.

Is it cost-effective to keep people at home?
Yes. MI Choice costs an average of $52/day compared with an average nursing home cost of $172/day. Despite the rapid growth in the aging and disabled populations, MI Choice and Home Help[1] have contributed to an unprecedented reduction in Medicaid nursing home spending in recent years.

However, Michigan has a ways to go in supporting home and community-based care. The state now spends 80% of its Medicaid long term care dollars on institutional care, and only 20% on home-based care, even though most people prefer services at home. In contrast, some states (Oregon, Washington, and others) spend more than half of their funding on home-based care, enabling them to serve more people while containing costs.[2] The federal government has made the 'rebalancing' of long term care spending one of its priorities. This is because of a 1999 U.S. Supreme Court decision in the case of Olmstead versus L.C., known as the "Olmstead decision." The Court ruled that unnecessary institutionalization is a type of discrimination prohibited by the Americans with Disabilities Act (ADA).

Which services are available?
Services can include personal care, homemaking, respite in the home, respite outside the home, respite in the home of another, adult day care, home-delivered meals, transportation, private duty nursing, personal emergency response systems, chore service, counseling, specialized medical equipment and supplies, caregiver training, nursing home transition services, community living supports and environmental accessibility adaptations. MI Choice uses an approach that is "person-centered," meaning clients are in control and make the decisions about their own care. MI Choice also gives clients the option of directing their own care and hiring their own helpers.

Who is eligible for MI Choice?
Low-income adults 18 and older who have disabilities significant enough to qualify for nursing home care can be eligible for MI Choice. Most MI Choice clients are on both Medicare and Medicaid – the so-called "dual eligibles" that suffer more chronic conditions and need more health care. Priority groups are young adults who age out of the Children's Special Health

[1]Home Help is another home and community-based program funded by Medicaid.

[2]Mary M. Ablan, "Has the Medicaid Waiver Reduced Nursing Home Utilization? Part I: The Michigan Experience, and Part II: The Experience in Other States," 2002.

Care Program, people already in nursing homes who want to go home, and people who need adult protective services. Income can be no greater than 300% of the SSI level ($2,094/month in 2012), and liquid assets can be no greater than $2,000. The income of a spouse is exempt and spousal asset protections apply.

How does the program work?
Care coordination is key. A registered nurse and a social worker visit the client in his/her home to determine what the client wants, and what family members and friends can do to help. The nurse or social worker provides a list of qualified agencies from which the client can choose, and contacts agencies if the client desires. After services are started, the nurse or social worker stays in touch with the client on a regular basis to make adjustments.

What is the role of Area Agencies on Aging (AAAs)?
AAAs employ the nurses and social workers that visit clients and coordinate care. AAAs are well suited to this task because they don't provide in-home services and have no financial self-interest in referring clients to particular services or service providers. AAAs are also responsible for implementing cost controls, data collection, and financial management. Fourteen AAAs administer MI Choice; six other agencies across the state also perform this role.[3]

How does MI Choice assist people in leaving nursing homes?
Professionals[4] identify residents who want to leave, then address the barriers that are preventing them from doing so. Some residents have lost their homes -- they are unable to pay mortgages or rent because most of their income goes to the nursing home. Professionals will find new homes along with furnishings, if needed. Some residents cannot live alone without help and have minimal assistance from others, so MI Choice services are essential; about 70% of the residents transitioned get services through MI Choice.

Michigan is a national leader in nursing home transitions. Almost 600 people were transitioned in 2008, 900 in 2009, and more than 1600 were transitioned in 2011.[5] Transitions play a key role in reducing Medicaid nursing home expenditures. In 2009, the Medicaid program saved $40 million because of the transition program.

Can home care save acute health care dollars too?
There is evidence that MI Choice and other home care programs contribute to a reduction in emergency room visits and hospitalizations. A 2008 study done by the U of M Institute of Gerontology analyzed the impact of MI Choice funding cuts on the clients served in Michigan. When funds were cut, home care services had to be scaled back for most clients. When services were reduced, there was a statistically significant increase in nursing home placements, emergency room use and hospitalizations.[6]

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[3]To see a list of all the waiver agents in the state and the areas they serve, search for "waiver agents" on the State of Michigan website at www.michigan.gov and click on the first link listed.

[4]Professionals are nurses, social workers, or others employed by Area Agencies on Aging, other Waiver Agents and Centers for Independent Living, also called Disability Networks.

[5]This is more than the state-set performance benchmark.

[6]Jennifer D. D'Souza, et. al, "Hard Times: The Effects of Financial Strain on Home Care Services Use and Participant Outcomes in Michigan," The Gerontologist, April 2009.

Another 2008 U of M study found that Wayne County residents on the MI Choice wait list used more acute health care services than did clients in the program.[7] Similarly, a 2006 national study showed that frail elders who live without help have higher rates of hospitalization while they are living with unmet needs but not after those needs are met with home and community-based services.[8]

How many people are helped by MI Choice?
In 2011, 11,000 adults in Michigan were able to remain in their own homes with assistance from MI Choice. The total budget for MI Choice was $206 million in FY 2011 - much less than the cost of serving these same individuals in nursing facilities. Recognizing its effectiveness, legislators increased the MI Choice budget to $230 million for FY 2012. The additional funds will be used to help more adults with disabilities leave nursing homes and return to the community at a much lower cost to the state.

Is there a waiting list for MI Choice?
Yes. MI Choice slots are limited, unlike the Medicaid nursing home benefit which is available to everyone eligible. About 8,000 individuals are waiting for MI Choice. In some areas, clients have to wait two years or more to get into the program. According to the Wayne County study cited earlier, clients on the waiting list are more likely to die the longer they wait, and very few are able to get services from another source.[9]

What is the economic impact of MI Choice for the state and local communities?
As a Medicaid program, MI Choice brings significant amounts of federal matching funds into Michigan. In FY 2012, the federal government will pay about 66% of MI Choice costs with the state paying 34%. The federal match rate is even higher (over 80%) for some of the individuals who are transitioned from nursing homes.

MI Choice also has a powerful positive impact on local economies in new jobs and the growth of small businesses. According to a study done by the Indiana University School of Public Health, a $10 million increase in MI Choice brings an additional $27 million in federal matching funds, creating 1,100 new jobs and returning $1.9 million in tax revenues to the state[10].

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[7]Marilyn Arndt, et. al, "Wayne County MI Choice Waiver Wait List Study: Final Report," University of Michigan Institute of Gerontology with DYNS Services and Center for Information Management, unpublished study, March 2008.

[8]Laura P. Sands, et. al, "Rates of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs," Journal of the American Geriatrics Society, February 2006.

[9] Marilyn Arndt, op. cit.

[10] Based on 2010 figures. Yong Li, "Economic Impact of the MI Choice Medicaid Waiver Program," Indiana University School of Public Health, unpublished study, July 2010.

Michigan Council for Maternal and Child Health

Executive Director
Amy Zaagman
azaagman@mcmch.org

Testimony for House DCH Appropriations Subcommittee hearing on 3/5/12

Dear Chairman Lori and members of the subcommittee:

Good morning, my name is Amy Zaagman and I am the executive director of the Michigan Council for Maternal and Child Health. On behalf of the Council's members collectively, we advocate for public policy that protects the health and well being of women, children and families in Michigan.

We are generally supportive of the Executive budget proposal for the Department of Community Health. We are particularly grateful for the attention to Medicaid rates for primary care and the expansion of Healthy Kids Dental. As the general fiscal health of our state improves however, it is time that we look to restore the state's commitment to public health.

Governor Snyder has given us two "dashboard measures" for Michigan's health status in infant mortality and obesity. The attention to these two indicators is to be applauded and we are grateful to have participated in both summits held last fall. The commitment to tackling both of these overwhelming public health issues in the Executive budget recommendation is, however, underwhelming at best.

In addition to the presentations and materials shared by Director Dazzo and her staff, the Health and Wellness Initiatives memo, an attachment to the Executive Budget, gives us more insight into the particular funding dedicated to each area. I have attached a copy for your convenience. The funding for Health and Wellness is comprised of both the Healthy Michigan Fund and other mostly "one-time" expenditures. The memo mentions the Healthy Michigan Fund dollars as "state restricted" which is an interesting choice of terminology given that the fund has been continually raided for Medicaid match over the past 10 years. I have included a history and timeline piece developed by several of our advocacy partners in the event you would like a reminder of the Healthy Michigan Fund history.

I would like to point out several particular items in the table of the Health and Wellness Initiatives memo. Under the obesity heading, "school health" is allocated $350,000. As with almost all of the current year "one-time" funding, this represents a cut from the FY 2011 amount now carried forward into FY 2013. This funding is used for the Michigan Model which provides education through information and resources to our students that enhance their healthy development and ability to make healthy choices. The program is on the national registry of evidence-based programs and practices. Published evaluation results demonstrated that students who received the MM had stronger social/emotional skills, enhanced self-management skills, less reported aggression within last 30 days, stronger drug refusal skills, less reported tobacco and alcohol use; later age of first alcohol and cigarette use and reduced intentions to use alcohol and smoke cigarettes. We have a program that helps with so many issues (including obesity) in the formative years, yet we are starving it.

221 N. Walnut Street · Lansing, MI 48933
phone 517.482.5807 · fax 517.372.5002 · http://www.mcmch.org

The Michigan Model is the basis of health education in a coordinated school health model. Comprehensive school health coordinators have pieced together funding from various sources for years to try and meets the needs of students. Federal funding such as that for Safe and Drug Free Schools has provided the backbone on which much of this education could occur while the state appropriations did not cover the cost but that funding has recently been cut.

Under the infant mortality header, you will see that pregnancy prevention is listed as a one-time expenditure of $900,000. As little as three years ago, and for many years prior to that, this line was well over $5 million. Last year during the budget discussions, I was asked, "How do you know that prevention works? Why is it a big deal for us to restore the cuts from FY '10 or FY '11 and before?" In the case of pregnancy prevention, it is a very big deal.

Using a very conservative methodology, we can show that the $4 million cut to pregnancy prevention in October of 2009 resulted in at least $16 million in Medicaid costs alone over the next year and a half through labor and delivery costs of unintended pregnancies. The data for last year is just about to be released and we will be updating this document, along with some more detailed information on the Medicaid costs of unintended births. The price of making services available pale in comparison to the costs of supporting families after birth and picking up the pieces as a society; numerous studies show that among women having unintended pregnancies, infant mortality rates are higher, dependence on welfare is greater and child abuse and neglect rates increase. We know that the children of unintended pregnancies have higher rates of encounters with the juvenile justice system, increased teenage smoking and promiscuity, and the costs of social programs to address these issues continue to increase.

Also under the pregnancy prevention header in the Health and Wellness memo, you will see that Smoking Prevention, a current year appropriation of $1.83 million is carried forward into FY 2013. MCMCH supports smoking cessation programs, but to say this money is being spent to address infant mortality is not genuine – unless of course, all of this funding is being spent on pregnant women and/or in homes where infants are present and may be in danger of sleep-related death.

The Council is very supportive of the agenda laid out by Director Dazzo and the administration to tackle infant mortality. We support restoring perinatal regionalization, promoting safe sleep practices, pursuing a hard stop on elective deliveries before 39 weeks gestation and supporting home visitation programs to name a few. We would simply say that we know what the problems are, but we need to be committed to the solutions – some of which need resources.

One last public health issue of great concern is that of lead poisoning prevention. Both state and federal funds have diminished as our problem has curbed only slightly in Michigan. We still have thousands of housing units in the state that are a huge danger to children and families. The costs of lead poisoning are immense with lower IQ's, increased aggression, health consequences and lower academic achievement. We have decreased out commitment at a time when the Centers for Disease Control (CDC) is poised to change the danger level and potentially rule that no level of lead is safe.

I started my comments by expressing our appreciation for the administration's proposal of increased Medicaid rates for primary care physicians. For the hard-working family practice, obstetricians/gynecologists and pediatricians across the state that bear the heavy Medicaid loads, this relief can not come soon enough. It is critical that the rates ensure that providers can afford to give patients access to care. We encourage you to keep the executive recommendation intact. One area that did not see a proposed increase in Medicaid is the Maternal Infant Health Program, the Medicaid-funded home visiting program. MIHP providers serve only Medicaid families – expectant mothers and infants – and

while many are embedded in larger programs like local public health departments and health systems, we should be reimbursing these programs a decent rate and we would ask you to consider that line under Medicaid.

We will join a chorus of voices speaking against the proposed cuts to Graduate Medical Education that have been proposed. I expect much attention will be paid to this issue, but you should know that we have a critical shortage of obstetricians in this state. GME provides the support for hospitals to be able to properly train our future obstetricians and also helps provide access in those facilities to many women in need of prenatal care.

The Council has joined other organizations to oppose the administration's continued push to assume savings from repealing statutory protections and putting certain classes of pharmaceuticals on the state's Preferred Drug List. Evident by your questions of Medicaid Director Steve Fitton last week, many of you have become very aware of these concerns and we thank you for asking good questions.

I have moved quickly through a list of concerns that touch maternal and child health. We will be following up with each of you but I thank you for your attention this morning.

Thank you,

Amy U. Zaagman

Amy U. Zaagman
Executive Director

DOES PREGNANCY PREVENTION FUNDING WORK?

In October 2009, $4 million was cut from the state pregnancy prevention line to fund services to low-income individuals in the state of Michigan.

Over the next year, clinics saw 9,454 fewer women, of these 1,101 were pregnant or seeking pregnancy, leaving 8,353 at risk for pregnancy.

Using a methodology that predicts "contraceptive failure", 1,418 of these women would become pregnant regardless.

Studies show that women who are denied services will turn to less reliable methods of birth control as their desire to avoid pregnancy does not go away. From PRAMS the unintended pregnancy rate among women having a live birth and who were using contraception is 54% (note: in PRAMS withdrawal is considered a contraceptive method).

Multiplying 54% by the number of women at risk for becoming pregnant, an estimated 4,511 more women had an unintended pregnancy. Subtracting the number that could be due to contraceptive failure (assuming they were using contraception) leaves 3,093 more women (estimated) who had an unintended pregnancy.

Some percentage of the 3,093 will have a miscarriage, the rate can be as high as 20%. Of 3,093 unintended pregnancies 2,475 would remain viable accounting for miscarriages.

Some of the women will choose abortion, the rate can be upwards of 40%. If you use this percentage, 990 of these pregnancies ended in abortion.

A very conservative estimate would be that the $4 million in services cut resulted in 1,485 unintended live births that would not have occurred otherwise. If all of those births were healthy, uncomplicated deliveries (which is not the case), the labor and delivery costs ($11,000 per birth) to Medicaid alone would be **$16,335,000.**

Sources: 2010 Family Planning Annual Report, MDCH
2009 Family Planning Annual Report, MDCH
2008 Pregnancy Risk Assessment Monitoring System (PRAMS), MCDH

221 N. Walnut Street - Lansing, MI 48933
phone: 517.882.5807 fax: 517.372.3002 http://www.mcmch.org

STATE BUDGET OFFICE
February 9, 2012

Health and Wellness Initiatives

Proposal:

The fiscal year 2013 Executive Recommendation includes $6 million general fund to expand the Department of Community Health's efforts in the area of health promotion, with a strong focus on the problems of obesity and infant mortality. In FY 2013, $5 million of this new funding is one-time; ongoing base funding is $1 million.

Background Information:

Governor Snyder's September 2011 Health and Wellness Message stressed the importance of building a healthier Michigan. Obesity is a significant contributor to diabetes, heart disease and other medical conditions. In Michigan, nearly $3 billion in annual medical costs are attributed to obesity.

The fiscal year 2013 proposal provides additional funding to support the Governor's objectives in the areas of obesity prevention and infant mortality. The Department currently has base funding of $5 million in state restricted Healthy Michigan Funds. These funds are used for a variety of public health initiatives, including smoking prevention, cardiovascular health and the Michigan Care Improvement Registry (MCIR).

The Michigan 4 x 4 Plan, with its focus on healthy behaviors and key health measures, will be used to engage local coalitions throughout the state. Communities, employers, providers, non-profit agencies and residents are developing innovative programs to promote health and wellness. These community-based collaborations will be the key to making Michigan a leader in the national wellness movement.

Although infant mortality rates have been decreasing nationwide, the rates in Michigan have increased over the last three years. The Department of Community Health will work with stakeholders to develop targeted community-based approaches that address the problem of infant mortality and teenage pregnancy.

The Department will also seek federal innovation grants and private foundation support to assist in these health and wellness activities.

A fiscal year 2013 spending plan is attached.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
FY 13 Health and Wellness Initiatives Spending Plan

Program Area:	FY 12 Current Law	FY 12 one time GF boilerplate Appropriation (not in Part 1)	EXECUTIVE BUDGET FY 13 base appropriation	EXECUTIVE BUDGET FY 13 on-going appropriation	EXECUTIVE BUDGET FY 13 one-time GF boilerplate appropriation (not in Part 1)	EXECUTIVE BUDGET FY 13 Health and Wellness Initiatives Total
Michigan Care Improvement Registry (MCIR)	$2,098,800		$2,098,800			**$2,098,800**
Cancer		$900,000			$900,000	**$900,000**
Obesity						**$4,120,000**
Cardiovascular Disease	$670,000		$670,000			$670,000
Diabetes		$600,000			$600,000	$600,000
School Health		$350,000			$350,000	$350,000
Health Disparities		$250,000			$250,000	$250,000
4 X 4 Wellness				$1,000,000	$1,250,000	$2,250,000
Infant Mortality						**$3,876,600**
Health Disparities	$250,000		$250,000			$250,000
Pregnancy Prevention		$900,000			$900,000	$900,000
Smoking Prevention	$1,830,000		$1,830,000			$1,830,000
Maternal and Infant Health				$146,600	$750,000	$896,600
Local Health Dept. Accreditation	$151,200		$151,200			**$151,200**
Totals	**$5,000,000**	$3,000,000	**$5,000,000**	**$1,146,600**	**$5,000,000**	**$11,146,600**
Healthy Michigan Fund	5,000,000	0	5,000,000	146,600	0	5,146,600
General Fund	0	3,000,000	0	1,000,000	5,000,000	6,000,000

What is the **Healthy Michigan Fund?**

What Difference Does It Make?

Medical care is NOT prevention

- Medical care focuses on treatment individuals who are already suffering from illness and chronic diseases, such as arthritis, heart disease, stroke, cancer, diabetes, and obesity. Chronic diseases develop over years and do not go away quickly. They can be prevented by healthy lifestyle behaviors.
    - Treatment relies on the science of medicine with services provided in the private sector.
    - It is very costly to treat illness and chronic disease.
- Prevention focuses on promoting lifelong health among individuals and populations. In prevents illness and chronic disease by improving nutrition and physical activity, and preventing tobacco use and other risk behaviors. It teaches individuals how to be personally responsible for their health and develops environments in which health is the easiest option to choose.
    - Prevention utilizes public health systems and epidemiology in the public sector.
    - It is inexpensive to prevent illness and chronic disease.

Michigan spends almost nothing on prevention

- Only 3.46% of Michigan Department of Community Health's General Fund is allocated to prevention (FY2009), including the following:
    - Medicaid and Children's Special Health Care Services receive $1,750,799,200 of General Fund (FY2009).
    - Public Health receives $60,536,000 of General Fund. $35 million of that goes to Local Health Departments (FY2009).

Prevention reduces escalating health care costs

- Prevention is critical to reducing treatment expenditures.
- An investment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent tobacco use could save Michigan more than $545 million in annual health care costs within five years. For every $1 invested in community-based prevention, the return amounts to $5.40. (Prevention for a Healthier America, 2008)
- Healthy Michigan Fund is a key strategy in preventing illness and chronic disease.

What is the **Healthy Michigan Fund?**

History of the Healthy Michigan Fund

1994: Tobacco tax increase is tie-barred to Proposal A

Michigan's constitution is revised, creating Article IX Section 36. It designates 6% of proceeds from the tax on tobacco products to be dedicated to improving the quality of health care of the residents of this state.

1995: Healthy Michigan Fund is created by Act 121 to use tobacco tax monies

- "The fund is in addition to, and is not intended as a replacement for, any other money appropriated to the department or other state agencies." (333.5953)
- "Money in the fund shall be used to improve the health of the citizens of this state... shall include, but not be limited to, chronic disease prevention, smoking cessation, anti-tobacco activities, maternal and child health initiatives, immunization activities, poison control, and local public health surveillance and evaluations." (333.5955)

1995-2001: Healthy Michigan Fund (~$41 million) is directed primarily to prevention programs

2002-2009: Fiscal crisis becomes obvious

- $16 million is annually diverted from Healthy Michigan Fund prevention programs to fund Medicaid.
- $25 million continues to focus on prevention programs annually.
- Each year, the legislature proposes cuts to the Healthy Michigan Fund to try to balance the state budget. Prevention advocates struggle to maintain vital programs.

2010-2011: Fiscal crisis deepens

- $23 million is diverted from Healthy Michigan Fund prevention programs to fund Medicaid.
- $10.9 million remains for prevention programs.
- Many prevention programs are lost or weakened.

2011-12: Fiscal crisis deepens further

- $25.9 million is diverted from Healthy Michigan Fund prevention programs to fund Medicaid.
- $8 million remains for prevention programs ($3 million for one year only).
- Prevention programming continues to be significantly lost or weakened.

Voices for Michigan's Children

To: Members of the House of Representatives, Community Health Appropriations Subcommittee
From: Jack Kresnak, President & CEO
Date: March 5, 2012
Re: Infant Mortality Funding

As you debate the fiscal year 2013 budget for the Department of Community Health, Michigan's Children urges you to take a close look at how the investments you make affect the Governor's priorities, as reflected in his dashboard indicators. Specifically, we hope that you will consider increased funding — beyond the Governor's recommendation — for targeted, community-based efforts to reduce the unacceptably high rate of infant deaths in Michigan, particularly for African American and Hispanic infants.

Michigan's infant mortality rate is approximately 8 deaths per 1,000 live births, a rate that ranks Michigan 39th in the nation. However, even more distressing are infant mortality rates by race and ethnicity – *Hispanic babies die at nearly twice the rate of White babies and African American babies die at three times the rate of White babies in their first year of life.* For African American babies, the infant mortality rate is the same as it was for White babies in 1974, indicating that the health and wellness of African American pregnant women and babies is nearly 40 years behind in progress.

While we are pleased that Governor Snyder's proposed fiscal year 2013 budget includes some increased investment for infant mortality prevention through his Health and Wellness Initiative, we believe that this funding will be insufficient to address the large racial and ethnic disparities in infant mortality that have driven Michigan's high infant mortality rate and placed the state at the bottom of the national rankings.

In the past, Michigan had dedicated funding through the Healthy Michigan Fund to reduce infant mortality in ten targeted communities with the highest African American infant mortality rates. This funding was eliminated in fiscal year 2010. Governor Snyder's recommendation to provide a small amount of funding through the new Health and Wellness Initiative is a step in the right direction, but will be insufficient to move the dial for the communities with the highest rates of infant mortality. To achieve the dashboard goals, Michigan needs to focus significant new resources on efforts to reduce disparities in targeted communities with the highest rates of infant mortality.

Attached is some background information for you as you consider the complex problem of infant mortality disparities. Michigan's Children would be happy to meet with you or provide additional information. We strongly believe that a healthy start is critical to the development of young children. With the next workforce set to be its most diverse yet, Michigan must be prepared to make investments needed in our children as the foundation of our future economy. Healthy kids equal a healthy Michigan.

Sincerely yours,

Jack Kresnak

Jack Kresnak,
President & CEO

A member of Voices for America's Children

428 W. Lenawee Street, Lansing, MI 48933-2240 p: 517.485.3500 *or* 1.800.330.8674 f: 517.485.3650 michiganschildren.org

Issues for Michigan's Children

An in-depth look at some of the public policy issues affecting children and youth in Michigan.

Voices for Michigan's Children

August 2011

Eliminating Disparities in Infant Mortality Critical to a Healthy Start

In his first State of the State address, Governor Rick Snyder outlined the "roadmap of initiatives" that will guide the Administration's work during 2011, and released 21 key measures, known as the Dashboard, by which Michigan will evaluate its success. The Dashboard identifies infant mortality as a key indicator for the state's health and well-being. According to the Dashboard, Michigan's infant mortality rate was nearly 8 deaths per 1000 live births in 2010, a rate that ranks Michigan at 37th in the nation. (National Kids Count data, utilizing 3-year averages, ranks Michigan at 40th on infant mortality).[i] Even more distressing is the infant mortality rate when compared by race – **Hispanic babies die at nearly twice the rate of White babies and Black babies die at three times the rate of White babies in their first year.**[ii] For Black babies, the infant mortality rate is the same as it was for White babies in 1974, indicating that the health and wellness of Black pregnant women and babies is nearly 40 years behind in progress.

Michigan Quick Facts

- Michigan is ranked 40th in the country on infant mortality with nearly 1,000 infants dying each year before their first birthdays.
- One in six Black babies are born too early compared to 1 in 10 babies overall.
- Prematurity/low birth weight is the leading cause of infant mortality.
- Black babies are 3 times more likely to die in the first year of life.
- Black and Hispanic babies are nearly two times more likely to be born following pregnancies with less than adequate prenatal care compared to White babies.

Luckily, we know how to reduce infant mortality. Michigan has a proven record of reducing infant mortality. In the past decade alone, Michigan's infant mortality rate has steadily declined from over 10 deaths per 1000 live births to under 8 deaths per 1000 live births. However, this reduction in the state's infant mortality rate is largely driven by the large drop in infant mortality for White babies. Key components to reducing infant mortality have focused not only on medical technology improvements but also on improving women's health before they become pregnant and increasing access to health care, particularly for women and families of color. Strategically targeting at-risk women of child-bearing age with key components of healthcare access – health insurance coverage and access to a source of consistent, comprehensive care (medical home) – can improve overall health while reducing infant mortality.

Why Equal Opportunity is Important

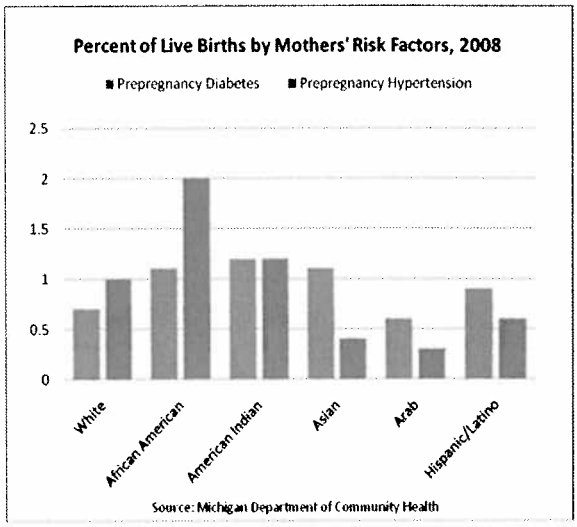
Increasing access to care reduces health care costs *and* infant mortality. Prematurity and low birth weight are the leading causes of infant mortality in Michigan, as well as the nation. As detailed below, access to health care including prenatal care are essential to reducing low birth weight and infant mortality while saving taxpayer dollars. Currently, low birth weight and preterm babies have a significant economic burden on the state's health care costs. The average cost per discharge for a premature or low birth weight infant in Michigan is $102,103, approximately 14 times higher than for a

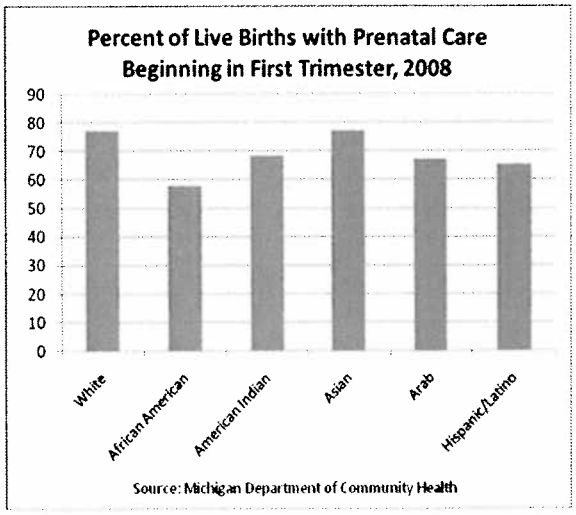
healthy infant.[iii] With 51 percent of Michigan births covered by Medicaid in 2010, reducing preterm/low birth weight babies – and ultimately infant mortality – will save thousands of dollars for Michigan taxpayers.

Embedded racial inequities create disparities in health. Systematic policies, practices and stereotypes work against racial/ethnic minorities, including women of child-bearing age. Studies to better understand the high infant mortality rate among Black infants have found that life experiences and covert racism increase preterm births. Covert racism has been linked to sustained, elevated cortisol levels – a stress hormone in the body. Increased cortisol levels, in turn, can impact an unborn baby, leading to prematurity and low birth weight.[iv] Furthermore, structural barriers such as access to quality education, quality employment and health insurance, fresh produce and safe spaces for exercise make it more difficult for women of color to maintain healthy lifestyles. To level the playing field, policymakers will need to better understand how current policies impact racial/ethnic disparities and how improved policy can reduce disparities in outcomes for mothers and babies.

Barriers to Equal Opportunity

Access to health care for young women. With 1 out of 6 Michigan women of childbearing age lacking health care coverage[v], efforts must be made to ensure that these women are healthy before they become pregnant. Statistics show that women of color are more likely to be uninsured, putting them at greater risk of health concerns even before getting pregnant. Specifically, statistics reveal that Black and American Indian women have higher rates of diabetes and hypertension before getting pregnant and are more likely to be overweight or obese at the start of their pregnancies.[vi] Clearly these health conditions put moms and their babies at greater risk for medical complications during pregnancy and after birth. Improving access to health care for women of childbearing age can help ensure that more women are healthy before getting pregnant, thus improving their chances of having healthy, full-term babies.





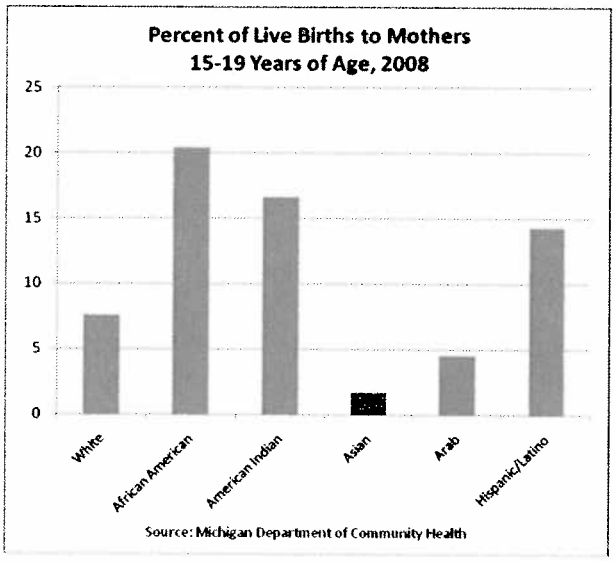
Access to care for pregnant women.
Prenatal care is the first health care intervention that new babies receive. Prenatal care can help pregnant women improve their health, thereby ensuring the best possible outcomes for their baby. Expectant women with prenatal care learn critical information, including the basics of what to expect while pregnant, healthy behaviors such as proper nutrition and physical activity, and basic skills for caring for an infant. Furthermore, prenatal services have proven to reduce preterm births and low birth weight babies while saving taxpayer dollars; every $1 invested in prenatal care saves $7 in neonatal care.[vii] Yet with all this knowledge, in 2008, Black

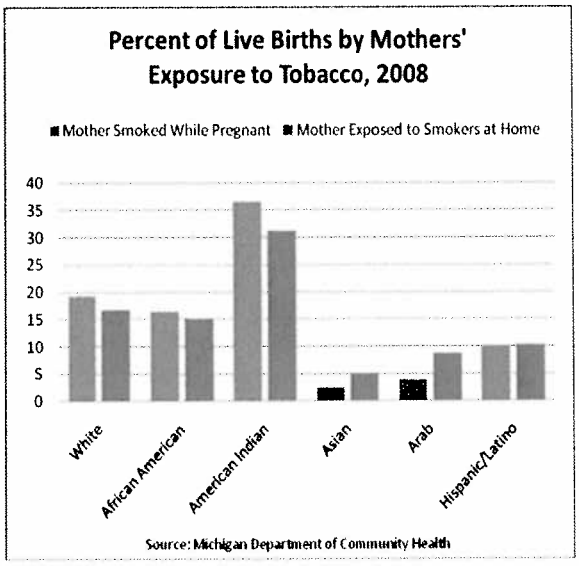
women were three times less likely than White women to receive any prenatal care during their pregnancy.[viii] Clearly increasing access to prenatal care for women of color is critical to reducing infant mortality.

Access to care for infants and new moms. Labor and delivery units at hospitals have been closing throughout the state due to the high costs of malpractice insurance as well as low Medicaid reimbursement rates, resulting in fewer obstetricians, gynecologists and pediatricians in these areas. Currently, Michigan has 17 contiguous counties in the Lower Peninsula lacking hospital labor and delivery units. Furthermore, doctors are leaving the area and facilities are no longer able to maintain an appropriate trauma system dedicated to infants born with health issues. Therefore, women and infants are traveling further to access basic and critical care, jeopardizing their health. Ensuring that women and infants have access to appropriate medical care can improve the outcomes of infants, particularly premature and very low birth weight infants.

For the most at-risk women, evidence-based home visiting programs provide services and support through a woman's pregnancy and into her infant's life. These programs – such as the Nurse-Family Partnership, Healthy Mothers Healthy Babies, and Medicaid's Maternal Infant Health Program – connect women to essential resources for pregnant women including medical care, transportation, nutritious food, and information to ensure a healthy pregnancy. These home visiting programs also provide counseling about risk factors such as smoking, drug use, lead exposure, and domestic violence and help women create a safe and healthy environment for a newborn baby. Evaluations of the Nurse-Family Partnership have found that it has resulted in improved prenatal health, fewer childhood injuries, fewer subsequent pregnancies, increased intervals between births, increased maternal employment, and improved school readiness – all of which result in fewer costs to taxpayers.[ix]

Births to teen moms. The statistics are clear. Young women of color, particularly Black, American Indian, and Hispanic women are 2-3 times more likely to be teen moms. One out of five Black babies is born to a teenage mother who is less likely to receive prenatal care than older moms.[x] Babies born to teenage mothers are more likely to be born too soon and too small, both of which are highly correlated to other serious health problems including infant mortality.[xi] Furthermore, nearly 85 percent of births to teen moms were unintended pregnancies; and of all unintended pregnancies, 69 percent were to Black moms compared to 48.5 percent to Hispanic moms and 37 percent to White moms.[xii] Women with unintended pregnancies are more likely to receive little or late prenatal care, which as noted, is associated with prematurity and low birth weight. To improve birth outcomes for young moms, it is imperative that teenage girls receive better information on reproductive health and resources to avoid unintended pregnancies.





Environmental factors impact infant mortality. Environmental factors impact low birth weight, preterm births, and infant mortality. Specifically, areas with higher rates of air pollution jeopardize the health of newborn babies and increase chances for respiratory-related infant mortality.[xiii] Historically, areas with higher environmental pollutants tend to be near low-income neighborhoods and communities of color, putting already disadvantaged mothers and infants further at risk.

At a more micro level, exposure to tobacco smoke also has health implications for infants. Mothers exposed to tobacco smoke were nearly twice as likely to have low birth weight babies compared to moms not exposed to tobacco smoke.[xiv]

The Consequences of Unequal Opportunity

Michigan will continue to struggle with health and well-being. With nearly 1,000 infants dying before their first birthdays, more efforts must be made to reduce infant mortality.[xv] It is crucial to better understand this disparity and to improve the health of pregnant women and young women of color. Unless strategic efforts are made in this area, Michigan will continue to rank poorly in this key Dashboard indicator.

Expensive health care costs. As noted above, low birth weight and preterm babies have a significant economic burden on the state's health care costs and are the leading cause of infant mortality in Michigan. Luckily, women who plan for their pregnancies; are healthy before becoming pregnant; and access appropriate care before, during and after their pregnancies are more likely to have healthy babies. Improving women's health through investments in preventive and prenatal care and reinvesting in perinatal regionalization can vastly reduce health care costs associated with infant mortality.

Strategies to Promote Equal Opportunity

Create incentives for providers to treat pregnant women and children covered by Medicaid by increasing Medicaid provider payments to Medicare levels and creating financial incentives for the full range of health services needed by low-income women and infants. In 2010, more than half (51%) of Michigan births were covered by Medicaid. Cuts in Medicaid provider payments have shut down labor and delivery units making it more difficult for pregnant women and infants to access basic preventative and critical health care.

Reinstate funding for crucial health prevention and promotion programs for women and infants to save millions of dollars in preventable health-related costs. Cuts over the last several years in local public health services, the Healthy Michigan Fund, and maternal and child health services have included reductions in proven programs such as family planning, pregnancy prevention, home visitation programs

for vulnerable pregnant women such as the Nurse Family Partnership, and smoking prevention programs.

Reinstate funding for programs that serve teenage girls and ensure that they receive the proper reproductive health education necessary to make smart decisions. Cuts over the last several years in local public health services have included reductions in proven programs such as pregnancy prevention and teen parent counseling. Furthermore, the movement for educational curricula to focus on standardized testing has pushed out many non-mandated classes such as health education. Yet, it is essential that teenagers learn about reproductive health and their sexual health options. And when teenage girls do become pregnant, they must have access to resources to help them through the challenging process.

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TESTIMONY
LYNN JONES
Breast and Cervical Cancer Control Program
House Appropriations Subcommittee on Community Health
March 5, 2012

Good afternoon. My name is Lynn Jones and I am the Coordinator of the Southwest Michigan Breast and Cervical Cancer Control Program. We are one of the larger programs in the state, serving over 1800 women annually in an eight (8)-county region.

I am here in support of increased funding for the Cancer Prevention and Control Program which provides funding for programs such as the Breast and Cervical Cancer Control Program (BCCCP).

The BCCCP provides free breast and cervical cancer screenings and diagnostic services to 26,000 low-income women in Michigan, annually. The American Cancer Society breast cancer screening guidelines recommend that women begin mammograms at age 40. The Cancer Program has made it possible for additional eligible women ages 40-49 to be screened. Because of the Cancer Program, approximately 9,000 women each year receive mammograms and necessary follow up care.

During the past fiscal year, in the eight (8) counties I serve, 32 women were diagnosed with breast cancer. Of those 32, 11 w*ere between the ages of 40 – 49.* Were it not for the Cancer Program, these 11 low-income, uninsured women would likely not have had access to a mammogram.

The BCCCP program has many success stories in my area and across the state. Farah is a 46-year-old uninsured, African American woman who found a lump on self-exam. Her older sister was diagnosed with breast cancer in her 40's, only a year or two earlier. Farah learned of the BCCCP from her doctor when she went in for an exam. The program paid for a clinical breast exam, mammogram and ultrasound that confirmed the presence of a suspicious mass. The BCCCP then helped pay for a surgeon consult and a

biopsy to diagnose an invasive ductal carcinoma. She was automatically enrolled in Medicaid and consequently is able to continue with her treatment today.

Sheela is a 45-year-old woman who had never been able to afford her first screening mammogram. She came in for a Free Mammogram offered by the Susan G. Komen Breast Cancer Foundation and was then enrolled in BCCCP to pay for follow-up radiology and surgeon consultation because her mammogram was abnormal. No cancer has been diagnosed and the doctors are currently watching her situation in case there is a change. Without the BCCCP follow-up services, Sheela would not be able to pay for her regular exams to ease her mind that no cancer has developed.

Breast and cervical cancers can be successfully treated if detected early. Mammography has proven to be the best available tool to detect breast cancer at an earlier, more treatable stage. As much as $20,000 is saved in initial treatment costs for each breast cancer case that is detected early.
In order to control health care costs, the state of Michigan must begin investing in prevention programs.

Since 1991, 3,525 low-income women enrolled in Michigan's Breast and Cervical Cancer Control Program, were diagnosed with breast cancer and received treatment. The early detection of breast & cervical cancer saves lives and reduces costs.

Unfortunately, at its current funding levels (level-funded since FY04/05), the Breast and Cervical Cancer Control Program only allows for 15% of the eligible population to be screened. Many Michigan women seeking screening may be left on waiting lists or do not receive services because our clinics do not have enough slots available, and very few slots for women age 40 to 49.

We have not actively recruited women for the BCCCP for the past few years because we cannot serve more women. Yet the need for the program is growing as women continue to lose their jobs and insurance benefits.

Prevention and screening programs are an important tool in saving lives and fighting the skyrocketing costs of healthcare in our state.

Without adequate funding, cancers are likely to be diagnosed at later stages, significantly increasing treatment costs and reversing the recent decline in death rates for breast and cervical cancer, as well as other cancers.

The Cancer Prevention and Control Program also leverages resources from the Federal Government and private partners. Federal grants for public health programs often require state matching funds. Without adequate funding of the Cancer Program, federal dollars will be lost.

Funding cancer prevention directly saves lives, promotes health, reduces the health care burden on state residents, and acts as a magnet for federal funds. We must continue to 'build the base' for these important prevention programs.

It is difficult to decipher whether or not we are making progress in increasing funding for cancer prevention with the new budget process of rolling several health and wellness initiatives together. Senators, I urge you to increase funding for the Cancer Prevention and Control Program so that we can increase the number of women screened.

Thank you for your interest and your time.