I am a mother as well as a guardian to my son that has developmental disabilities. My son is now 38 years old. Since the age of 18 we have used community mental health services for many issues arising with his disabilities. We are very thankful for the mental health workers that have assisted us thru some very challenging times.
My son has been very fortunate in some regards as he has progressed to the point that he is able to live independently WITH HELP FROM HOME AIDS.

He would not have the independence to live this life without help from home aids.

Home aids assist him with many of the activities we take for granted such as doing dishes, mopping the floor, laundry, socialization, shopping for food, meal prep, and on and on. Over the years and mostly the last 2 to 3 years there has been a decline in service within this system. The economy has made it too easy for workers to find better paying jobs. The home aids change frequently and sometimes the aids are people that are 'just there' and not competent to provide a decent level of service. Home aids are always in short supply and there have been times when there have not been any aids available. Guardians rely on home aides much like parents rely on teachers. We trust our schools to have qualified caring people in place to teach our children. I, as a guardian and a mother, rely on the home aids to do the same. Unfortunately this teaching and assistance will need to go on for the rest of my son's life.

Would you expect to get qualified staff for a wage that is so low they can not afford to support themselves? NO! The result is --one of the most needy areas of all people in our society-mental health - can not get qualified help.

PLEASE help our mentally disabled people get services they so desperately need -they can not live there lives to there full potential without your support.

Thank you

Diane Kowal
11728 Long Lake Dr
Sparta MI 49345
616-821-0957

to whom it may concern

im writing to say that i think that in home staff should have a significant increase in wages to help.

im concerned that if action is not taken staff shortage will be apparent and staff is need to help fill that shortage in

community living supports .

i have already felt shortage in the pass and this affects my daily life.

sincerely Andrew w

My name is Casey, and I live in Ann Arbor, Michigan.

I am 55 years old and suffer from Major Depression, Major Mood Disorder, and Post Traumatic Stress Disorder.

I am a survivor of Child Sexual Abuse that began at the age of 3 and went on well into my late teens.

I was physically, emotionally, and verbally abused as well.

In order to make me submit to oral and anal rape, I was tortured and beaten.

This occured every single day for many, many years.

My abuser was my step father, a man my mother cheated on my father with and later moved in with after my father's death.

I was 4 when my father died, but the man raping me had already been doing so since I was 3.

My mother claims to have had no idea.

The man was beating her, so I fail to see how she would think I was safe, but that was her claim.

She made choices borne of selfishness that put me in the hands of a brutal and viscous child molester who enjoyed the challenge of finding new horrific ways to make me submit to him.

His methods ranged from holding loaded guns to my head, beatings, being choked, tazed, near drowned, and numerous other unspeakable acts.

My mother thought only of herself and when he wanted to lock me out of the house from 6 am to 6 pm winter, spring, summer, or fall without food or shelter or water, when I was in my early teens, she did not try to stop him.

Her excuse was that he would be mad at her
if she refused.

He was not my only abuser however, for my mother got her licks in too.

She would beat my head against walls or slam it into the window of the car while driving, whenever she was upset, which was often.

If I was sick and couldn't stop coughing she would demand I stop and come over to punch me in the face to make me stop.

Her abuse was just as viscous as was her man's and

my life was utter hell.

To add to my woes I was tormented and
ostracized at school.

No one liked me or even wanted to be my friend. I was called names, threatened, and bullied.

I was abused at home

I was tormented at school.

I didn't understand why.

I felt I had been born bad and that I was no good.

These things were consistently said to me over and over, so it must be true I thought.

With that kind of history and mindset I made horrible choices in people to have relationships with as I grew older.

I did not then understand that we model what we see and experience from our parents.

I chose people who ended up abusing me also.

This went on all my life until well into my late 40's I turned a corner and found help.

That help, consisted of Mental Health Services.

I had studied psychology and behavioral sciences in college, and learned that when one suffers a traumatic event, it changes the brain chemistry and how one acts or reacts to situations and people.

I sought out a therapist that focused on survivors of Child Sexual Abuse and began to understand that what had been done to me, and all that I had endured was not my fault.

I learned that if you were abused as a child sexually, that abuse rips at the very core of who you are.

It derails you and alters how you feel about yourself, others, and the world around you.

It colors how you interact, think, feel and tears away at your self esteem because as a child we are dependent

on our parents or guardians to care for us, and when they are the one's hurting us it is very confusing and makes it difficult to cope.

A child cannot hope to make sense of what is happening or why. They know only that the parent is supposed to love them and if what they are doing to that child is hurting them, that child will only internalize it and will automatically think they, are bad and did something to deserve it.

The other confusing thing for a child to try to cope with, is that often the abuser will tell the child that it is a secret and they must never tell. The parent states they are only showing the child how to love, but it is a secret.

Now what child, can process that without being emotionally damaged?

You are hurting me, yet you love me.

Then there are abusers who do it for the joy of hurting you. They feel entitled and have no regard for the child or how that child feels.

To ensure their never caught the abuser threatens to kill the other parent, in an effort at making certain the child is so afraid they keep silent.

I had that, kind of abuser.

All of these things that I learned through seeing a counselor led me to delve deeper and seek relief from the horrible weight of a past I had not deserved and had been deeply damaged by.

I began to look for support groups in my area, and found skills training groups and processing groups that were available.

With One on One counseling sessions, talk therapy, and skills groups that teach how to manage triggering events, and how to manage my emotions; I have been able to begin the journey towards healing.

Without these vital services I would not be in a stable and loving relationship, or even alive.

My journey is not complete.

I have much work to do

But I know I will get there, because these services exist.

These services are as vital as the air we breathe.

They teach invaluable skills that help to rebuild broken and tormented souls that were ravaged throughout life through no fault of thier own.

People who have suffered abuse are vital and worthwhile people just as those who have not been abused are.

If these services were not available, I would have no hope. I would drown in the pain and remain broken.

Mental health services offer hope, healing, and rebirth.

We are all vital and worthy people who have much to offer to society, we do not deserve to have the services that are vital to our healing taken from us.

I spent the majority of my life abused and tortured in horrific ways, and finally I found help and hope to teach me that I do matter and this pain I have borne, does have an end point.

The existence of Mental Health Services tells me there is hope.

I never knew hope as a child.

I never dared to dream of anything remotely resembling a normal life.

Until I began working with the Mental Health team that I have now.

Please do not take this from me.

Doing so only sends the message that there is no hope.

I am living proof that hope does exist and I found it, through my team.

Levijoki, Stephanie 4/11/2019

Public Statement

There must be one thing that all of us have in common. All of us in this room and all of us in the Michigan House and Senate. It is probably this. We want to take care of our families, we want to give them all that they need and protect them from harm.

That's why I am here today. I want to speak on behalf of a person who cannot speak for herself. I am the legal guardian for a disabled young woman whom I regard as family. I want her to have all that she needs and protect her from harm. None of her family is involved in her life. Virginia has lived in a group home for most of her life and is dependent for all her daily needs on the conscientious, loving, service of care givers in a group home. It is difficult for parents to leave their adult children in a group home. It usually happens because of the heart-breaking reality that their needs and disability are complex and they can no longer be cared for at home. It is a traumatic though necessary decision to make on behalf of their loved ones. Those are the lucky ones. Some disabled adults and children are left in group homes and their parents or other family members forget them and leave them alone.

Sometimes when I visit Virginia and it's time to leave the group home where she lives, I keep looking back over my shoulder at the care givers in the home, hoping that they will show her the love and complex care that she needs. Often I find that Virginia does not want me to leave her. In the case of my loved one, she depends on these caregivers to feed her, bathe her, dress her, cut her hair and nails and change her depends every day. That is a lot to ask strangers to do. It is no consolation to me knowing that the people who are entrusted to Virginia's care are under-appreciated, not recognized as professionals, and worst of all, that their wages are so poor.

Many grateful parents and guardians would like to give caregivers monetary bonuses. But Medicaid regulations do not allow guardians to give bonuses to care givers.
We would like to show our appreciation for such acts as this. A house caregiver recognized one of their clients spiked a fever and rushed her to the hospital, then stayed with her throughout the afternoon and evening waiting for her patient to be seen at Emergency and then was admitted to the hospital. The caregiver waited until her patient and was settled in. Then and only then, did he leave the hospital at 1:00 AM.

The starting wage is $10.50 an hour for the men and women who take care of all Virginia's needs. That means their yearly salaries are somewhere hovering at the poverty level, especially if they have dependents they have to provide for. So, if they work a grueling 40 hour a week shift, they earn about $420. per month. They must also provide their own transportation which means car payments, insurance, and maintenance. Where Virginia and I live, in Washtenaw County, the cost of living is high. Many of the care givers cannot live in Washtenaw County because they can't afford it. So, they have to drive long distances outside of Ann Arbor, just to come to work. Here is another fact, if a person's income is hovering near the poverty level but not below the poverty level, it means that they do not qualify to receive public assistance.

Levijoki, Stephanie 4/11/2019

Caregivers in group homes need to have unselfish devotion and a definite skill set to be able to care for all or many of a person's bodily and medical needs 24/7. They also need to be screened properly, trained well and possess character traits that include compassion, patience and self-less persistence. Their salaries simply do not match their value and skills needed to do their work.

This is not a political issue, it is a humane issue. Is it fair or just to be blind to this situation and NOT act to increase, significantly increase, the wages of group home care workers throughout the state? This is not political, it is personal.

The people of Michigan recently voted in favor of a referendum to increase the state minimum wage to $15.00 an hour. Caregivers deserve a higher wage then this. But this referendum gives evidence that the people of Michigan agree that caregivers for the disabled should be paid wages that recognize their value and skills.

Here is another fact. Every person in this room may need the assistance of a caregiver one day. Most of us in this room think we
Are educated, self-sufficient, healthy. But what if you are in a car accident tomorrow and wake up in a hospital bed as a paraplegic or horribly damaged. Then you would be dependent on caregivers for years or even for the rest of your lives.

Then you will discover the courage and persistence and skills needed to live as a handicapped or disabled person. Then you will also hope that your caregivers are well-paid and compassionate. Then you would need for someone to advocate for you and with you. Then you would agree, this is not a political decision. It is personal.

A Vision for a **World-Class Public Mental Health System** in Michigan

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans [(PIHP) public health plans formed and governed by the CMH centers] and the private providers within the CMH and PIHP provider networks. Information on the CMH Association can be found at **www.cmham.org** or by calling **(517) 374-6848.**

Alan Bolter
Associate Director
abolter@cmham.org

Robert Sheehan
Chief Executive Officer
rsheehan@cmham.org

Executive Summary

Michigan's public mental health system is nationally recognized as one of the most comprehensive, innovative, person-centered and community-driven systems in the country. **For this system to continue to stay at the forefront of the mental health field and to serve Michiganders and the communities in which they live, concrete action – all within the reach of state policymakers – needs to be taken.** [1]

The Community Mental Health Association of Michigan has outlined these actions below and in greater detail in this document.

Overarching vision for a world-class public mental health system in Michigan

Michiganders deserve and expect a world class public mental health system building on the nationally-recognized system that Michigan has built over the past fifty years. Such a world class system is accessible, innovative, person-centered, and community-driven; fosters whole person and whole population health; addresses the social determinants of health; is a vital member of the community; and is fiscally and clinically strong.

Actions to fulfill the vision for a world-class public mental health system in Michigan

Core values of the system: **self-determination, person-centered planning, full community inclusion, recovery orientation and cultural competence.**

Governance: **Ensure the governance of managed care, provider and collaborative convener roles of the state's public mental health system remain local, public, and with the involvement of persons served by the system on those governing bodies.** The governance should be embedded and linked to the counties served by the system, including the fiscal control of the system via a direct contract with the State of Michigan.

Central role of public system: **Foster the safety net role of the public mental health system** to address the health of the community, and social determinants of health and advocacy for the vulnerable, and serve as a convener of community collaboratives.

[1] *In this document the term mental health system refers to the system that serves persons with mental illness, children with emotional disturbance, persons with intellectual/developmental disabilities and persons with substance use disorders.*

Financing: **Increase Medicaid and General Fund support** to ensure the ability to meet the needs of all Michiganders in the face of growing demand and expectations for access to mental health services. Allow for the use of smart risk management practices such as the development of sufficient risk reserves.

Full range of persons to be served: **Retain and expand service to include persons with mild/moderate mental health needs,** the full range of persons served by the system, meeting the needs and expectations of the community, and to include prevention and early intervention.

Primary and mental health care integration: **Promote clinical integration** (where the client/patient receives services and supports) by supporting the current and emerging models in local communities.

Evidence-based and promising practices: **Fund and support the use of evidence-based and promising mental health practices,** including access assurance methods, client/patient/clinician specific practices to organizational and community-wide practices.

Risk management: **Revise the structure of the financial-risk partnership** with the state of Michigan to allow for greater fiscal stability, innovative financing strategies and creative service-delivery models.

Workforce retention and recruitment: **Address the mental health workforce shortage** that exists for clinicians of all disciplines.

Administrative simplification: **Reduce administrative, regulatory, contractual and other requirements** by ensuring they tie to the core vision and values of the system and are uniform statewide and across payer types.

Health information technology, data analytics, outcome measurement: **Provide funding and support for the public mental health system** as it continues to build its health information technology and outcome measurement infrastructure.

Ensuring a financially sound

Public Mental Health System

for the future

PROBLEM

Trying to fix 2020 problems with 1990's solutions

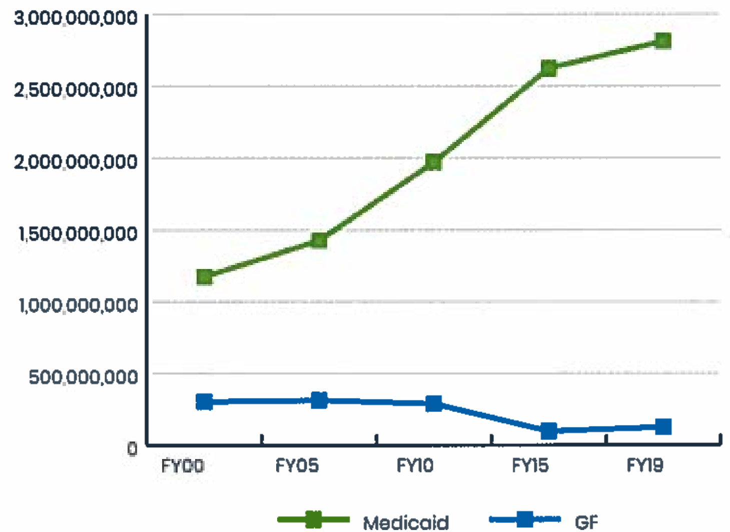
Michigan's PIHP system was developed in 1997 when the state moved the Medicaid behavioral health services into managed care. The financing and risk arrangements that were developed 20+ years ago are still in place today and dictate the financial makeup of the system.

A lot has changed since 1997. Behavioral health care has changed dramatically in the past 20 years.

What is outdated?

- No built in ability to save or put into reserves for future uses.
- Artificial risk limits cap PIHP reserves at 7.5%, far below industry standards and DO NOT include any ability to replenish reserves.
- Rates do not reflect changes in community demand nor expectations, demand and expectations that have grown dramatically over the last 20 years.
- Local match draw down requirements – state uses $25 million of local CMH funds to draw down Medicaid funds (established in the 1980's).

DRAMATIC CONVERSION FROM STATE SYSTEM (GENERAL FUNDS) TO MEDICAID-DOMINATED SYSTEM



What has changed?

1997 – FUNDING

Medicaid funding was **65%**

State general fund was **35%**

1997 – SERVICES

Adults with serious Mental Illness

People with Developmental / Intellectual Disabilities

Children with Serious Emotional Disturbances (examples: Obsessive-Compulsive Disorder (OCD) or Attention Deficit Hyperactivity Disorder (ADHD)

2019 – FUNDING

Medicaid funding is **95%**

State general fund is **5%**

2019 – SERVICES

Adults with serious Mental Illness (demand continues to grow)

People with Developmental / Intellectual Disabilities (demand continues to grow)

Children with Serious Emotional Disturbances (examples: Obsessive-Compulsive Disorder (OCD) or Attention Deficit Hyperactivity Disorder (ADHD) (demand continues to grow)

People with Substance Use Disorders opioid epidemic

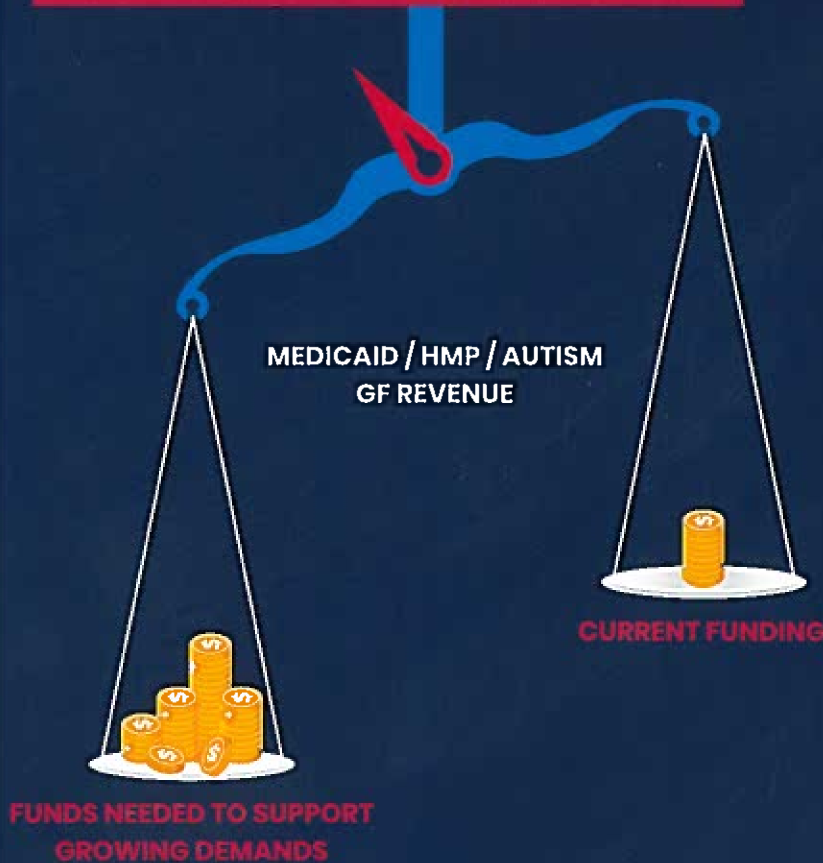
Healthy Michigan – Medicaid expansion

Medicaid Autism

CMHA
Community Mental Health Association of Michigan

PROBLEM

Demands for services are outpacing funding



ITEMS THAT CONTINUE TO ADD DEMAND

Demand for Services

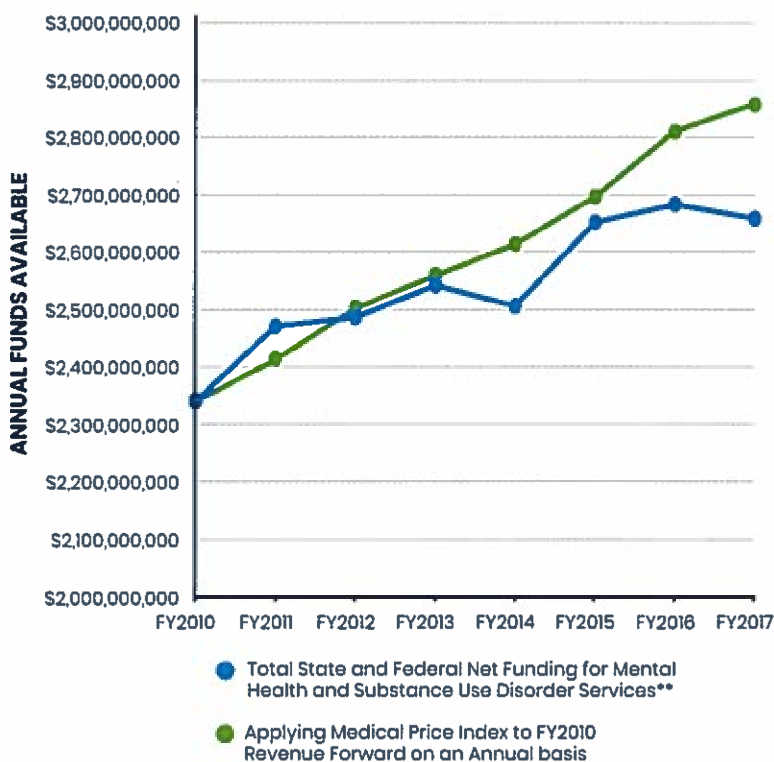
- Opioid Crisis
- Autism Services
- Increased staffing costs due to minimum wage increases
- Expanded Medicaid services
- Federal Rules changes for people living independently
- Jail Diversion Programs
- School safety
- Increased state reporting and assessment requirements
- Unfunded mandates, such as new statutory requirements

State Mandates

Employment Costs (direct care wages/psychiatrist costs)

Federal Rules for Living Arrangements

COMPARISON OF BEHAVIORAL HEALTH FUNDING TO MEDICAL PRICE INDEX FY2010 TO FY2017



ALL PEOPLE RECEIVING BEHAVORIAL HEALTH SERVICES

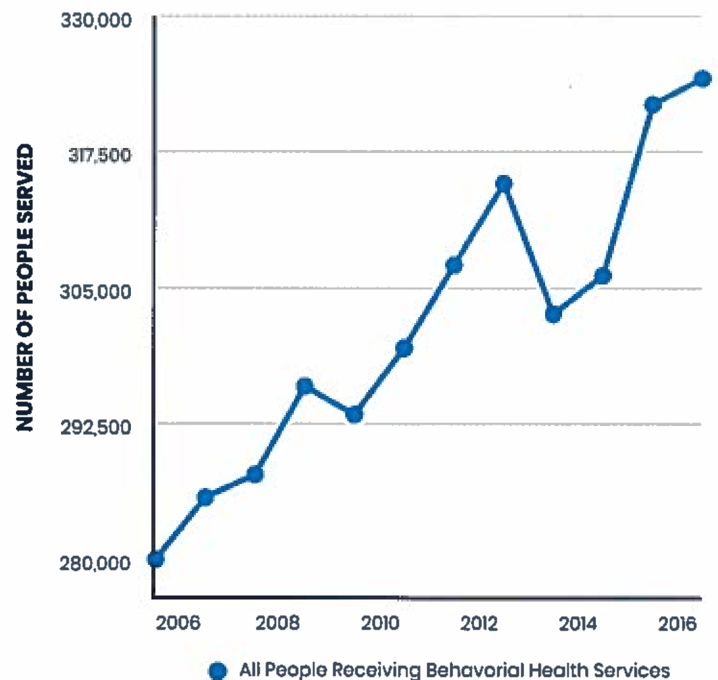
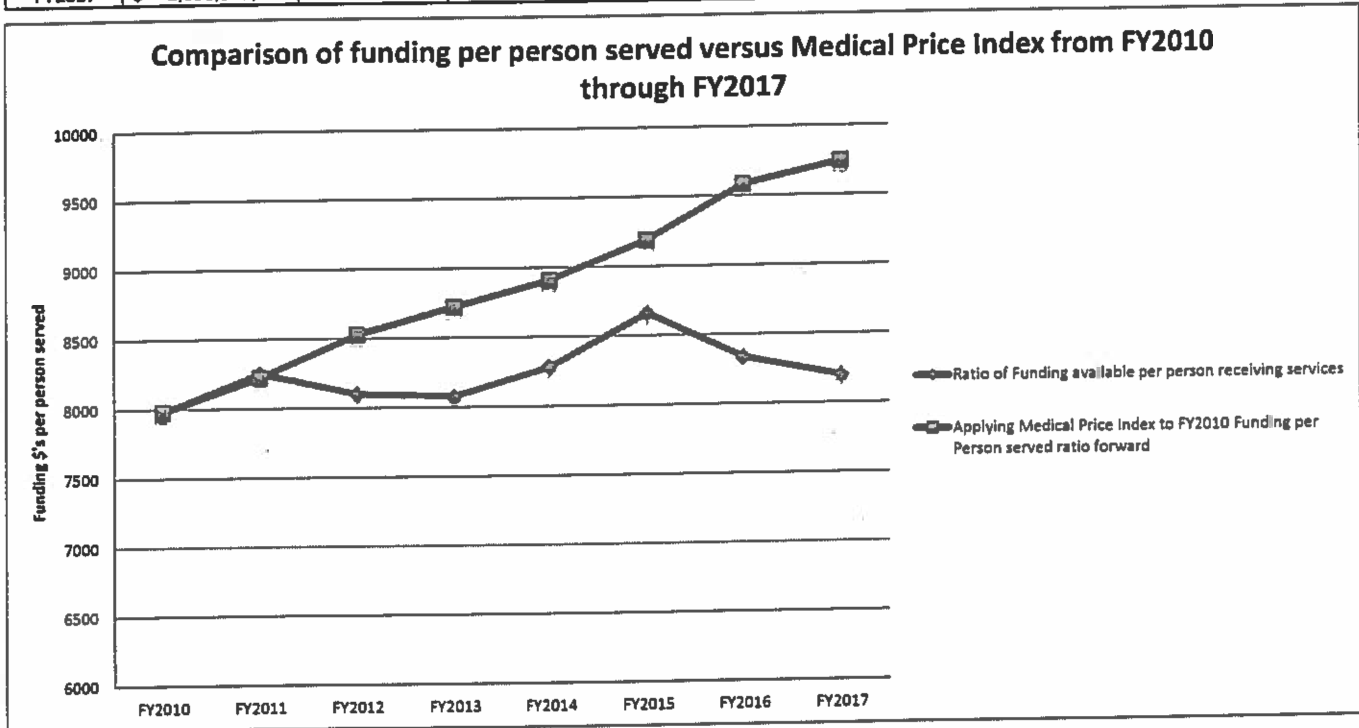


Table 6: Comparison of funding per perosn served versus Medicaid Price Index (FY 2010 -FY 2017)

Fiscal Year	Total State and Federal Net Funding for Mental Health and Substance Use Disorder Services**	All People Receiving Behavioral Health Services	Ratio of Funding available per person receiving services	Applying Medical Price Index to FY2010 Funding per Person served ratio forward	Annual Medical Price Index October through September
FY2010	$ 2,340,171,587	293,370	$ 7,977	$ 7,977	0.0333
FY2011	$ 2,471,106,249	299,486	$ 8,251	$ 8,224	0.0310
FY2012	$ 2,486,778,484	307,102	$ 8,098	$ 8,529	0.0371
FY2013	$ 2,541,846,836	314,620	$ 8,079	$ 8,723	0.0227
FY2014	$ 2,506,098,015	302,605	$ 8,282	$ 8,910	0.0214
FY2015	$ 2,651,908,808	306,136	$ 8,663	$ 9,191	0.0315
FY2016	$ 2,683,064,097	321,882	$ 8,336	$ 9,583	0.0427
FY2017	$ 2,658,515,702	324,273	$ 8,198	$ 9,745	0.0169



Data are from Financial Status Reports Provided by Michigan's Prepaid Inpatient Health Plans (PIHPs) - Excludes Taxes Paid, HRA Payments, Autism Services, State Inpatient, Local Funding and Grants for Mental Health Services & People Served in Section 904 & 908 reports with minor adjustments

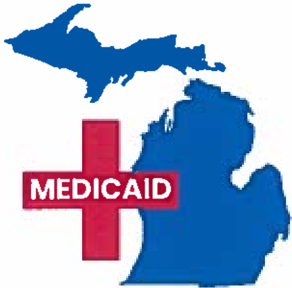
Ensuring a financially sound

Public Mental Health System

for the future

SOLUTIONS

Our public mental health system's funding solutions are 30 years out-of-date. Together, we need to address the ancient funding issues to accommodate new behavioral health care changes, services, and risks.



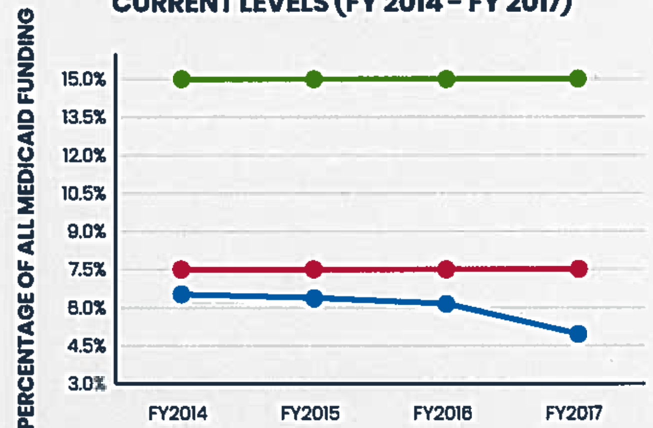
Set Medicaid rates to match demands & costs.

Reflect the actual and projected growth in demand for and the real costs of providing the services.

Make it so that Medicaid rates include contributions to risk reserves.

The contributions should be at a level sufficient for fiscal soundness of the public mental health system.

COMPARISON BETWEEN RECOMMENDED INTERNAL SERVICE FUND LEVELS, MINIMAL LEVELS, AND CURRENT LEVELS (FY 2014 – FY 2017)



- Recommended Rish Reserve = Two Years of Potential Losses @ 15%
- Minimal Risk Reserve for One Year of Potential Liability to Equal 7.5%
- Percentage of which Internal Service Funds are to All Medicaid Funding at Year End

Allow the public mental health system to hold sufficient risk reserves.

Increase the size of Prepaid Inpatient Health Plan (PIHP) risk reserves to a reasonable level and move to a shared CMH and PIHP savings model.

Remove the local match draw-down obligation, Section 928 in the appropriations boilerplate.

This language earmarks the $25.2 million local money given to CMH's by their counties to draw down additional Medicaid funds.

Restore General Fund dollars to the public mental health system.

CMH's need a full year of general fund allocation to be a minimum of $170 million.

/CMHAMich

CMHAM.org

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Michigan's Mental Health and Substance Use Disorders System

Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is a trade association, representing the 46 community mental health boards, 10 Prepaid Inpatient Health Plans, and over 90 provider organizations that deliver mental health, substance use disorder, and developmental disabilities services in every community across thus state. Last year over 350,000 persons received services from Michigan's community-based mental health and substance use disorder system. Those services assist individuals in achieving, maintaining and maximizing their potential and are provided in accordance with the principles of person centered planning.

Michigan Constitution

Community Mental Health Organizations are required to serve individuals with a severe mental illness or disability regardless of their ability to pay. An individual can not be denied a service that is medically necessary because of inability to pay or lack of insurance.

* **Article 8 – Section 8 of the Michigan Constitution reads: Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported.**

Community Mental Health Service Structure

- **Community Mental Health Services Programs (CMHSPs)** – The forty six (46) CMHSPs and the organizations with which they contract provide a comprehensive range of mental health services and supports to children, adolescents and adults with mental illnesses, developmental disabilities and substance use disorders in all 83 Michigan counties.
  - Providers, purchasers and managers of a comprehensive array of services and supports across a network of providers in fulfillment of statutory roles to serve the individuals, families and communities regardless of the ability to pay
  - Community conveners and collaborators – initiating and participating, often in key roles, collaborative efforts designed to address the needs of individuals and communities
  - Advocates for vulnerable populations and a whole-person, social determinant orientation
  - Sources of guidance and expertise, drawn upon by the public, to address a range of health and human services needs

- **Medicaid Prepaid Inpatient Health Plans (PIHPs)** – Ten (10) PIHPs manage the services and supports for persons enrolled in the Medicaid, MIChild, Healthy Michigan Plan, Autism services and substance use disorder programs.
  - Seven (7) of these regional entity PIHPs are made up of an affiliation of multiple CMHs (as few as 4 and as many as 12). These affiliations were created in order to realize administrative efficiencies in managing services and to provide a sufficiently large base of Medicaid enrollees to manage the risk-based, capitated funding system used to finance the system of care for Medicaid beneficiaries.
  - PIHPs contract with the CMHs and other providers within the region to deliver necessary services.

46 CMH Regions

Community Mental Health Services Programs

Single County CMHSPs

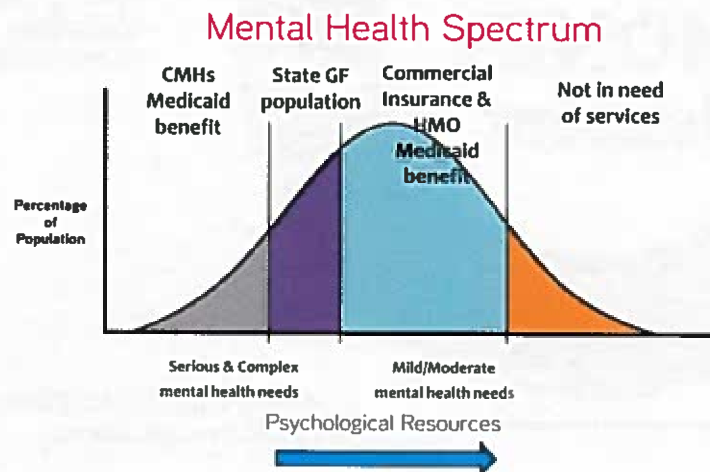
Copper Country
Gogebic
Pathways
Northpointe
Hiawatha
North Country
Northeast Michigan
Northern Lakes
Au Sable Valley
West Michigan
CMH for Central Michigan
Montcalm
Saginaw
Huron
Ionia
Allegan
Barry
Lifeways
Cass
Lenawee
Oakland
St. Clair

10 PIHP Regions

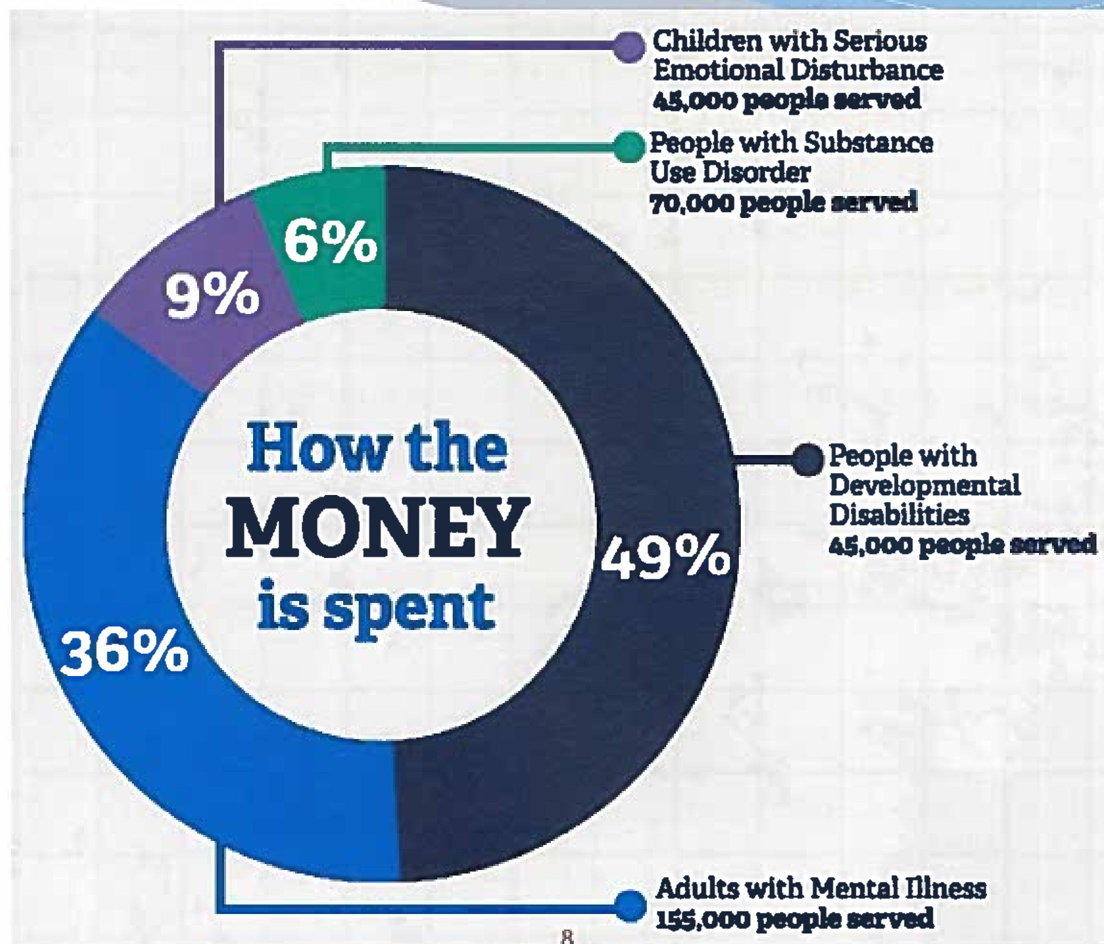
- *NorthCare Network*
- *Northern Michigan Regional Entity*
- *Lakeshore Regional Partners*
- *Southwest Michigan Behavioral Health*
- *Mid-State Health Network*
- *CMH Partnership of Southeast Michigan*
- *Detroit Wayne Mental Health Authority*
- *Oakland County CMH Authority*
- *Macomb County Mental Health Services*
- *Region 10*

Who We Serve

* Michigan's Public Mental Health System Serves 4 Main populations:
  * Children with Serious Emotional Disturbances (examples: Obsessive-Compulsive Disorder (**OCD**) or Attention Deficit Hyperactivity Disorder (ADHD)
  * People with Substance Use Disorders
  * People with Developmental/Intellectual Disabilities
  * Adults with Mental Illness.
* Michigan is the ***ONLY*** state that serves all 4 populations in a managed care setting.
  * Managed care was established in 1998 for behavioral health services.
*



How the Money Is Spent

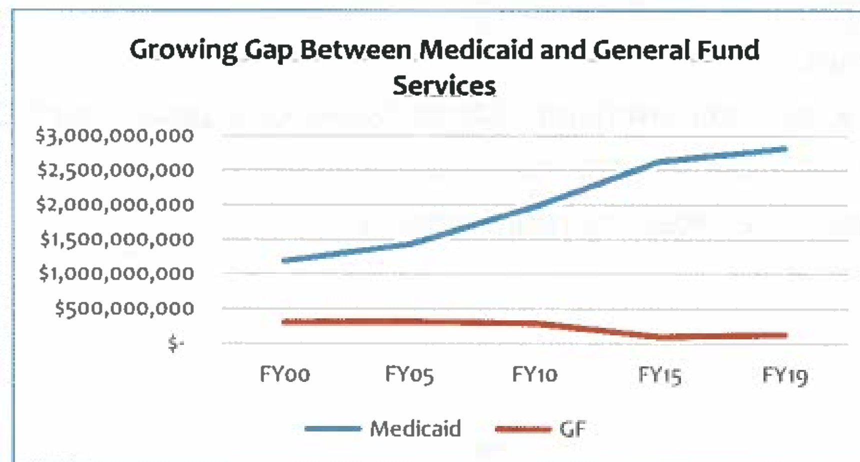


Challenges Facing Public Mental Health System

* Death by a thousand cuts – demand for services and increased responsibilities have outpaced funding for the system. **Current funding and risk methods must be updated.**

* PIHP & CMH financial and risk arrangements were developed back in the late 90's (1998 managed care started) - what has changed in the past 30 years?

  * **Funding changes since 1998:** Gap between Medicaid and general fund dollars continues to grow: FY00 (70/30 Medicaid vs GF) and FY19 (95/5 Medicaid vs GF).



Challenges Facing Public Mental Health System

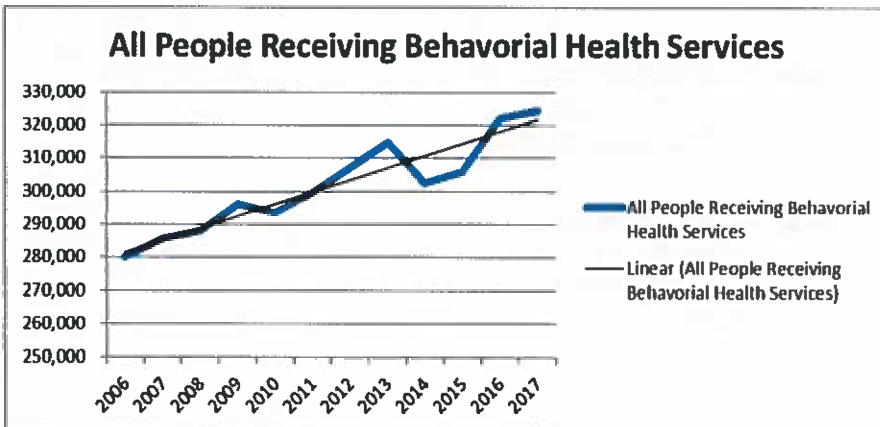
* **Services have changed since 1998:**
* Michigan's Behavioral Health system has changed dramatically since the late 90's, below is a list of items added to the PIHP/CMH responsibilities since 1998:
  * Substance Use Disorder services – Opioid Epidemic
  * Healthy Michigan – Medicaid expansion
  * Medicaid Autism
  * New federal Home and Community Based Waiver changes (more independent living)
  * Staffing costs – Minimum wage increases
  * Increased/duplicative reporting requirements
  * Unfunded mandates

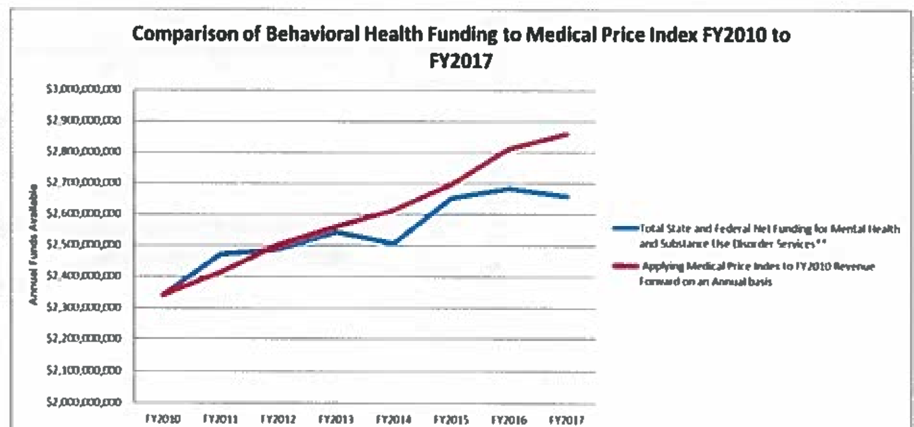
Recommended Ways to Update Financing

- 1. **Set Medicaid rates to match demand and costs:** Set the Medicaid rates to reflect the actual and projected growth in demand for and the real costs of providing the services associated with Michigan's Medicaid mental health benefit. **Current behavioral health funding not keeping pace with the cost of services.**

  - In FY17 state actuaries found a $133 million funding gap for PIHPs & CMHs (what was spent vs. what was received)

  - Roughly $16 million GF has been given to 2 PIHPs the last two year to help cover losses, if this money was added on the front end with improved Medicaid rates it would have been over $50 million.

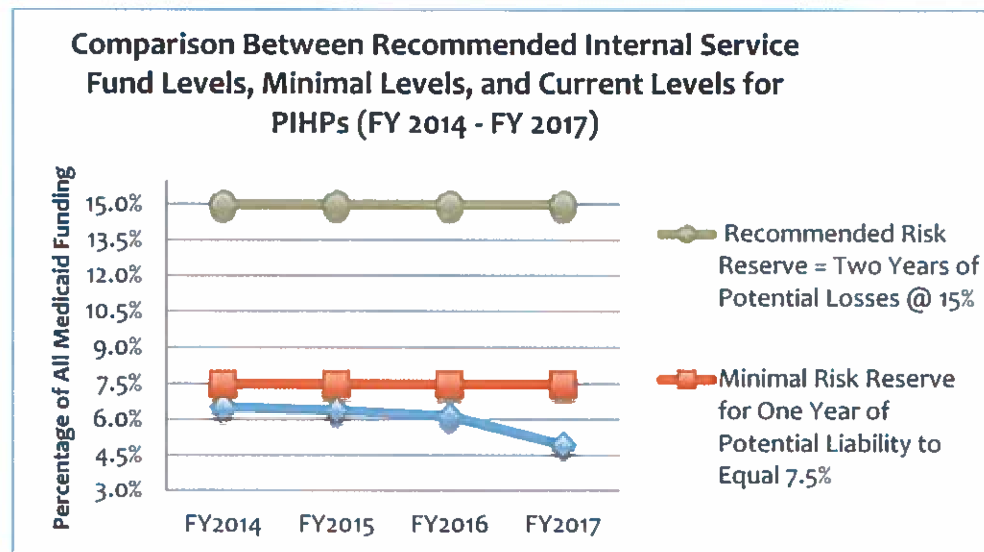




Recommended Ways to Update Financing

* **2. Medicaid rates to include contribution to risk reserve:** Include, in the Medicaid rates the federally required contribution to risk reserves at a level sufficient to allow for the fiscal soundness of the public mental health system.

* **3. Allow the public mental health system to hold sufficient risk reserves:** Allow the state's public Prepaid Inpatient Health Plans (PIHPs) to hold risk reserves of the size that would be held by any risk-bearing organization. Allow the CMHs to retain and reinvest any Medicaid savings that they generate through efficiencies and effective clinical practices.



Recommended Ways to Update Financing

- **4. Remove the Local Match drawdown obligation, section 928 in appropriations boilerplate:** This language earmarks $25.2 million of local money given to CMHs by their counties to draw down additional Medicaid funds. This language was added back in the 1990's when the state needed additional Medicaid revenue and before other financing mechanisms were in place.
  - CMH GF has dramatically decreased from $300 million+ back in the late 1990's to $125 million in the FY19 budget.
  - State has sufficient Medicaid revenue with new Medicaid financing mechanisms now in place – **HICA replacement tax generates over $60 more in Medicaid revenue.**
    - PIHPs pay into the new IPA Medicaid tax.

Integration – Section 298

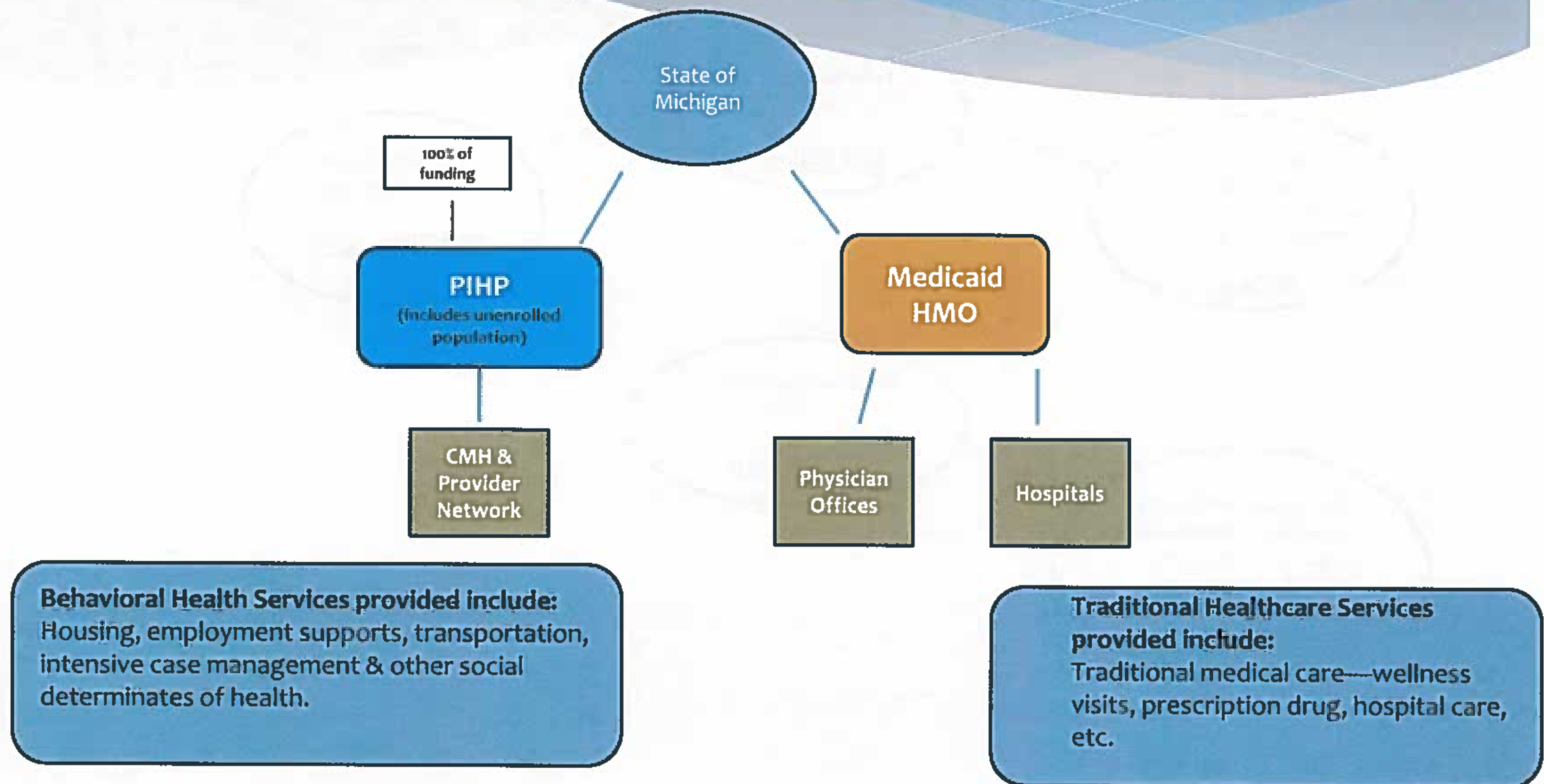
298 Intent

- In 2016 MDHHS officials described the original intent behind section 298 was way to **encourage more coordination of physical and mental health services**. The proposal is "not pulling money out of the mental health system," but is **"reinvesting more to direct services" for patients, "**

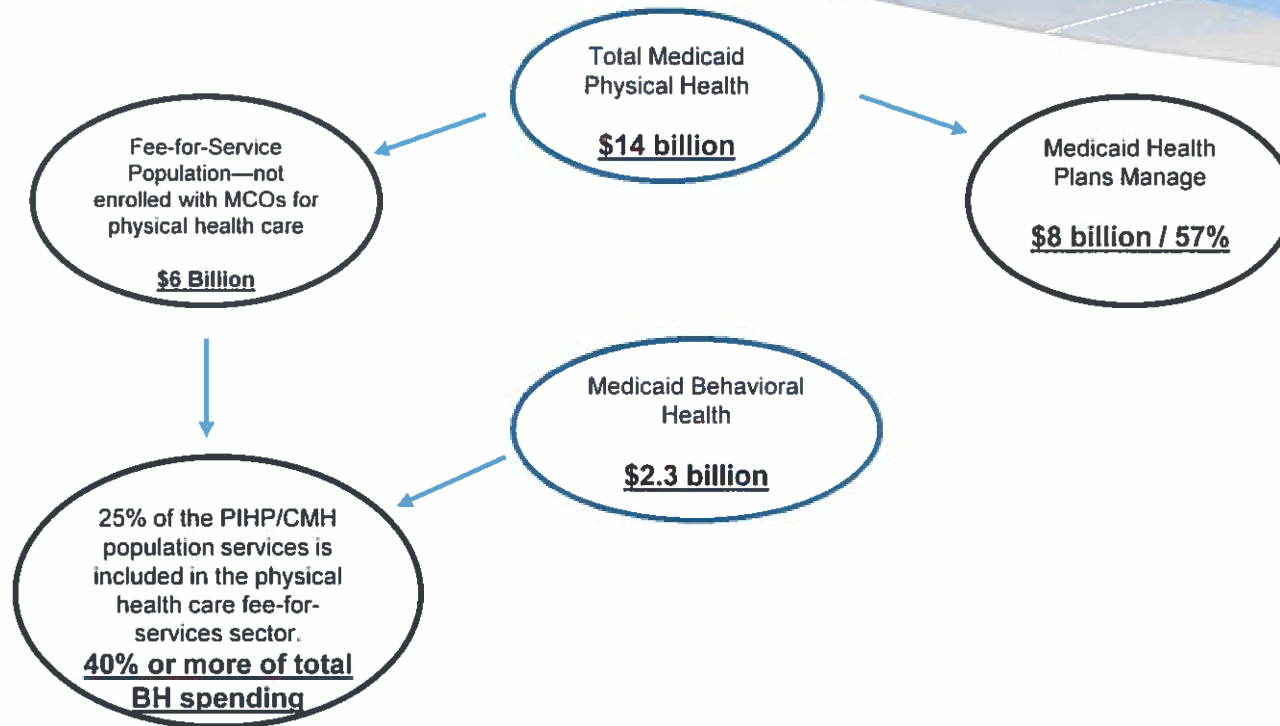
Current Integration Efforts in the CMH system

- Many CMHs work collaboratively with physical healthcare partners in order to better treat their clients. **In 2017 there were nearly 600 healthcare integration initiatives across Michigan in CMH system**, some of those efforts included:
  - Identifying patients without a primary care provider to regularly engage them in more preventative care and achieve better health outcomes
  - Screening patients to prevent untreated chronic diseases—a major factor in driving up costs of care for people with behavioral health issues or substance use disorders
  - Addressing the needs of high/super-utilizers through targeting, assertive outreach and case-management approaches, while working collaboratively with other support systems such as transportation, housing support, vocational services and advocacy
  - Co-locating services (either in primary care offices or primary care in behavioral health offices)

Current System

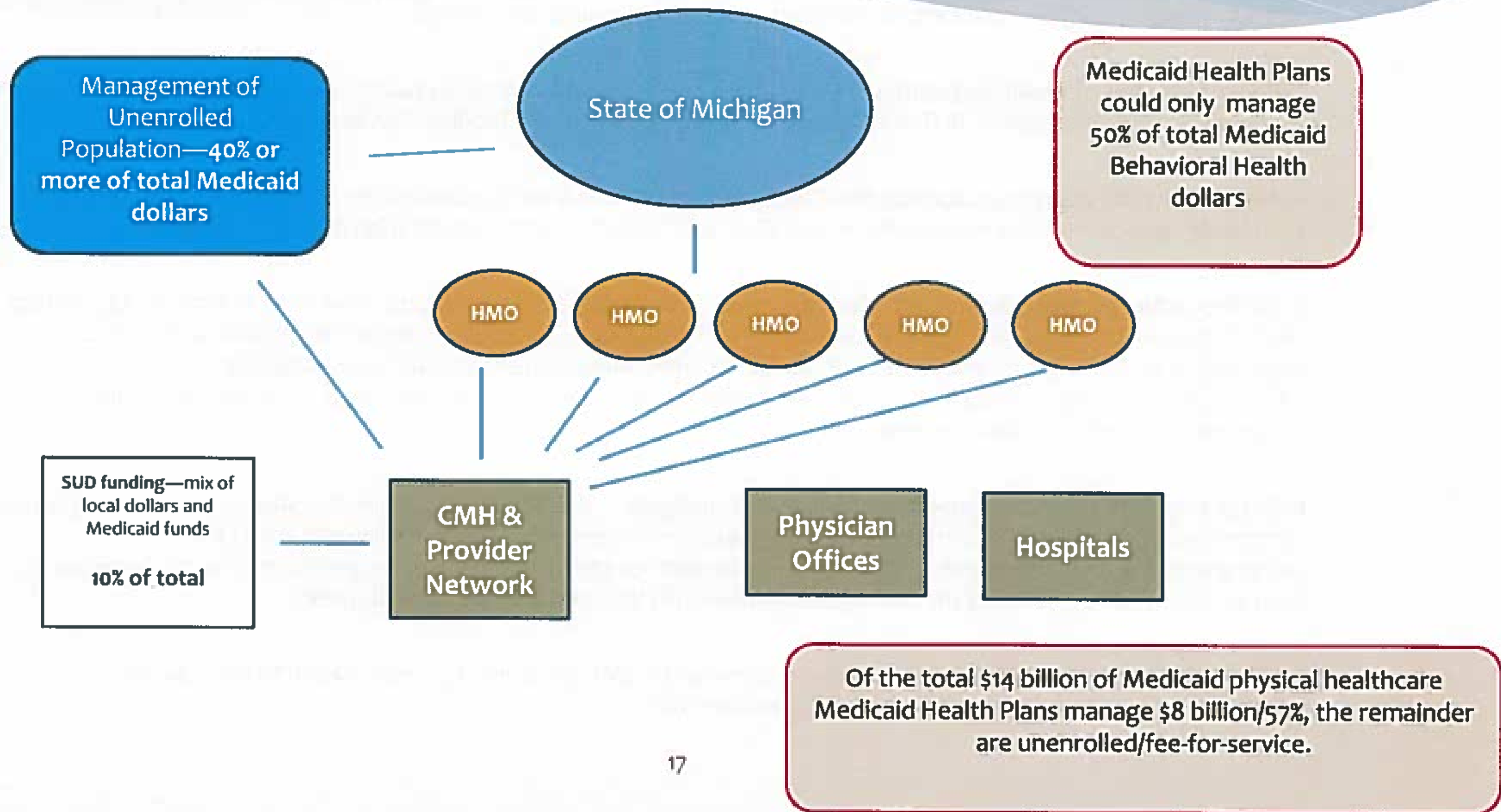


Medicaid Unenrolled / Fee-for-Service



Section 298 Pilot Sites

operational look for CMH pilots



Keys to Moving Forward

1. **Pilot remains a pilot** - Any determination regarding expansion of the pilot model to the larger system (statewide implementation) be determined only after clearly defined outcomes have been independently evaluated, appropriate changes implemented and tested as informed by the Pilot, and critical measures of success achieved.

* 2. **Extend pilot timeframe** – extend pilots to at least 3 years to both support a meaningful test of integration efforts and allow opportunity to realize improved healthcare outcomes and cost savings.

* 3. **Reduce number of Medicaid health plans in pilots** – in all three pilot areas 2-3 health plans represent over 80% of the covered lives in those regions, BUT in every pilot area there are 5-7 total Medicaid health plans.

* 4. **Medicaid health plans must standardize CMH interface** – There is no standardization across Medicaid health plans. Each health plan in the pilot region processes claims data, billing, IT, and authorization processes differently.

* 5. **Savings achieved through pilot and start up costs** – Savings achieved through the Pilot must not be used to recoup Pilot startup costs, nor to fund expansion of the Pilot. Savings must be used to support the provision of services, by the CMHSPs and their provider networks, in the pilot communities, to persons with mental health, intellectual/developmental disability, and/or substance use disorder needs. Start up costs for Medicaid health plans is considered research and development.

* 6. **Ensure stability of the behavioral health provider network** – The Pilot must require the MHPs in the Pilot region to contract exclusively with the CMHSPs in the pilot communities and through the CMHs with each CMH's comprehensive provider network. If either party – the CMH or MHP – wishes to add a provider to the provider panel, such additions can be made by the joint agreement of both the CMH and the relevant MHPs.

* 7. **Pilot CMHs manage unenrolled population** – allowing the CMH pilot sites to create a PIHP to manage the unenrolled population removes a potential duplicative layer.

Contact Information

Community Mental Health Association of Michigan

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Published March 27, 2019 by:

Local agencies stepping up recruitment to address paramedic shortage

GRAND BLANC TOWNSHIP, Mich. — They're the people you call when there's an emergency medical situation, but right now they have their own problem.

Fewer people are becoming licensed paramedics.

The Michigan Bureau of EMS, Trauma and Preparedness says the number of students graduating from paramedic training in the state has dropped from 1,200 per year to 250 in the past three years.

Now local EMS services like Swartz Ambulance are stepping up their recruitment efforts.

"It's just a strategy to try and figure out how to attract the people and to keep them for a period of time," says Alex Boros the education and performance manager at Swartz Ambulance.

It's something ambulance services across the country have been working to figure out.

"It's concerning because you know were constantly trying to attract people to keep out shifts filled and keep the trucks manned," says Boros.

Boros says with the competition high and the pay lower than ideal, they have to think outside the box.

"We try to attract them with sign on bonuses, we try to attract them with tuition bonuses for the classes they take to become an EMT or a paramedic," says Boros.

Paramedic programs can take anywhere from 18 months to two years to complete and typically cost somewhere between $3,500 to $5,000.

Boros says the biggest challenge is losing EMTs and paramedics around the 7 to 10 year mark to other medical careers.

"These jobs are kind of like stepping stones to other medical careers, nursing, physicians assistants and med schools," says Boros.

He says the job has the challenges like crazy hours and continuous training but every call is different and nothing beats that rewarding feeling.

"When somebody comes back to you later on after you treated them weeks or years or months down the road and they say thank you, that's pretty rewarding," says Boros.

Boros says another option they're considering is offering in house training.

That way once a student finishes their certification they can step right into the job.

Contact: Angela Madden at 517-281-4695 or angela@miambulance.org

House of Representative Hearing Testimony

April 11, 2019

Barbara Fowkes
320 W. Huron Street
Milford, MI 48381

Spectrum Community Services – Executive Director
28303 Joy Road, Westland Michigan 48185

House of Representative Subcommittee Members:

My name is Barbara Fowkes and I am the Executive Director for Spectrum Community Services, a non profit Human Service agency. I have come here for many years either providing written or oral testimony at these hearings.

Spectrum Community serves over 730 children and adults with intellectual and developmental disabilities including autism, and mentally ill adults. We provide a variety of services to these individuals to include: direct care in residential settings and personal homes, support coordination and enhanced health services. We provide these services throughout the state to include: Antrim County, Berrien County, Kent County, Manistee and Benzie County, Mason County, Missaukee County, Oakland County, Otsego County, Washtenaw, Wayne, and Wexford Counties. I am here today on behalf of the people I employ and the people I provide services.

I first want to thank you for your acknowledgement of the state's staffing crisis and the legislative pass through of the $.25 hourly pay increase for the people who work tirelessly to provide quality care to our vulnerable citizens. My staff is appreciative for this increase. Thank you!

We are now at a very critical time with the staffing crisis in our state. Not only do we not have enough people looking for jobs but we are not able to provide a competitive wage to even attract people to want to work in our industry. We beg every year for an increase in funding to address this short fall and continue to get no relief. I understand that the funding is not available in the current mental health budget. What are we going to do as a state to get the funding that is needed to attract people to want to work with our most vulnerable citizen of this state! We have to do something and it has to be now or you will continue to lose good providers and individuals who are currently providing this service because they are burning out from long shift or from not being able to hire people to fill open shifts. And needing to give up the services before something drastic happens and someone gets hurt.

Spectrum Community employs nearly 1,000 people. 60% of our employees work part time. We currently have and have had for over a year, 85 full time positions for direct care staff that we have had difficulty hiring people to fill. Still more than 50% of the people we employ have two or more jobs to assist them to pay their bills and not live in poverty. They need to work multiple jobs as the rate of pay for the direct support professional and managers is still not at a level that they can survive on one paycheck. It continues to be more and more difficult to recruit and hire for the direct care position. In many areas that we provide services, the fast food chains, super markets and chain stores are still paying more that we can pay our employees. The position of direct care professionals and managers are positions that require people to be dedicated and engaged with people who have special needs. It has not been easy to find people with these qualities who are willing to work in the human service field when they can find alternative employment for more money.

My staff is very hard working people and very dedicated to improving the lives of our most vulnerable citizens. However when they have to continue to work for multiple companies to make ends meet, they are not always at the top of their game. The continued need to pay people who serve our

disabled population needs to be recognized as a crisis in our field and addressed on a continual basis.

In all the counties Spectrum Community provides services in, the story is the same. We are not able to find anyone who is willing to work for the low wages we are able to pay with the current funding that we receive. There is a lot of responsibility that comes with providing day to day hands on services to the individuals we provide serves. The people who apply to work for us need to qualify with having the following: no criminal history, a valid driver's license with a good driving record, a negative drug screening, and a clearance on the DHHS child abuse registry. Another area of concern is transportation to get to the program site. Many staff does not have good reliable vehicles. Most can not afford car payments and rely on older vehicles. Most of the homes that our people live in are not on the bus line.

The Direct Support Staff have a lot of responsibilities. They are working with people who may have high medical needs or have high behavioral challenges. This can be very stressful for the employee. Intensive training is provided to all employees to meet the needs of the person served in all areas to assist the employee in providing the best service and to help them

feel comfortable to work alone. This training is initially and on going through out the year.

Often times stress for employees is the fear of not knowing if they will be able to go home at the end of their shift. This is an extreme reality with the staffing shortages. We provide 24/7 residential services in most of our sites so staffing is required around the clock. If staff calls in for the shift, then some one has to stay and work; either the home manager or the staff on shift.

I have been providing services to people with disabilities for more than 45 years. I have dedicated my life to help and advocate for our most vulnerable citizens. For the last 38 years I have worked for Spectrum Community and have worked in all levels of the agency. Finding people who want to work in the human service field is getting more and more difficult at the direct care level and management level. I am currently recruiting for a Director position and getting very few applicants. Our state continues to be at a critical point in providing good quality services because of the over worked employees and the inability to hire new employees to relieve our existing employees. Our current employees love working in this field wants to do a good job and they do enjoy working with our individuals but they are tired. We continue to need your help to fix this problem by increasing wages to a

competitive level by increasing the Medicaid rates, and to look at recognizing our direct care professionals by allowing for an associates degree or a state accreditation for the training and education they receive to provide the services they have been trained in to do so.

In closing, I would request that you consider another increase the direct care wage and or Medicaid rates so that we may be able to attract people who want to make this a long term career in the human service field and more quality people applying for a position. Having a pay scale $2.00 above minimum wage would have a great impact on our hiring of quality people. I know that my employees would be very grateful for any kind of a wage increase from you.

Thank you for allowing me to share with you my views. Please, continue your commitment to those with disabilities and we will honor that investment.

Thank you.

House Appropriations Subcommittee on Health and Human Services

April 11, 2019

Good Morning, I am Sara Lurie, CEO of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (or CEI) located here in Lansing. I would like to thank you for the opportunity to share information and ideas with you today as you prepare to make vitally important decisions that impact the care of some of our most vulnerable, yet resilient citizens. In 2018, CEI served nearly 13,000 individuals in our service area, nearly 1,000 over the previous year. We are seeing continued high demand and volume of individuals we have never seen before, entering services via our Crisis Services. We provide 24/7 Crisis Stabilization and comprehensive behavioral health specialty services for those with severe mental illness, serious emotional disturbance, intellectual or developmental disabilities, and/or Substance Use Disorders. I came to my job from an Educational Institution 3.5 years ago with no previous experience in the Community Mental Health Arena and quickly learned that uncertainty is the norm when it comes to stable funding as a public behavioral health provider, as well as, ongoing serious concerns about possible privatization of the system under section 298. Despite this, as public behavioral health providers we continue to seek improvement and innovation in our services, and to eagerly step up each day and deal with the threats, realities, and the rewards of doing the work that we do in our communities; inspired by those we serve, the progress that has been made and the work that must yet be done. I agree with many other CMH leaders here today in supporting the following recommendations for solving the systemic funding problems that exist that were outlined in Mr. ~~Alan Bolters~~ Bob Sheehan's remarks for your consideration, so that we can continue to put our focus on innovation in our service provision rather than survival.

First, Medicaid provides 85% of my organization's funding and 90% of the public system funding. To avoid destabilizing funding fluctuations, Medicaid rates need to be set to reflect the actual and projected growth in demand for and the real costs of providing the services associated with Michigan's Medicaid mental health benefit.

Second, the federally required state contribution to risk reserves has been non-existent to very minimal at best, and must be reviewed and set at a level sufficient to allow for the fiscal soundness of the public mental health system.

Third, allow the state's public Medicaid mental health/specialty health plans (the Prepaid Inpatient Health Plans; PIHPs) to hold risk reserves of the size that would be held by any risk-bearing organization and allow CMHs to retain and reinvest any Medicaid savings that we generate through efficiencies and effective clinical practices.

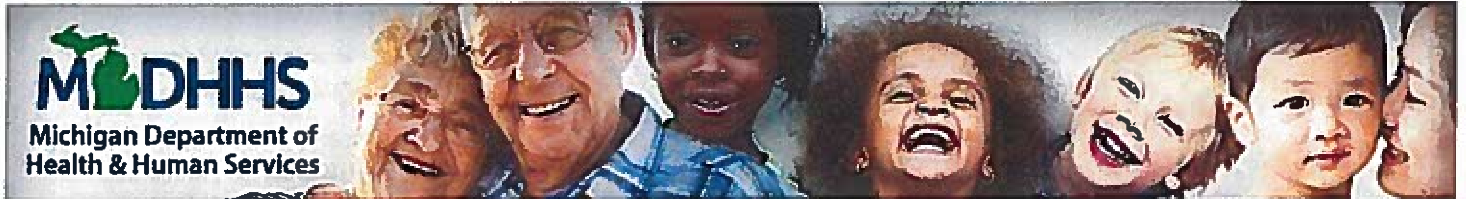
Fourth, free up local dollars to meet unmet non-Medicaid needs, by halting the drain of local dollars to fulfill state Medicaid obligations by eliminating the Local Match Draw Down requirement (section 928);

Lastly, just as I started my work here in 2015 the system was still reeling from 60% reduction to the state general fund dollars allocated to CMHs. This resulted in my organization and many others in depleting fund balances as we worked as quickly as possible to reduce and in some cases completely eliminate programs and services that were funded by general fund dollars in best effort to not seriously harm those impacted. Restoration of General Fund dollars to the public mental health system would ensure that persons, not covered by Medicaid, or on a large Medicaid spend down, have ongoing access to needed mental health services.

To close, across the State of Michigan there exists already in communities an incredible amount of healthcare integration partnership happening on the ground where it matters the most. These partnerships consist of public partnerships and public-private

partnerships. We are just one example, but I invite you while here in Lansing to come visit our facility and see the level of integration that is happening in our facility and locally. For example, we have a Federally Qualified Health Center in our building with our staff embedded in the clinic as well as our staff embedded in all of the FQHCs in Ingham County, we also have a pharmacy and lab on site. We have CMH staff in Sparrow Family Practices, and the McLaren-Great Lansing as team members in their Emergency Department. We are also a recent recipient of a federal SAMHSA Certified Community Behavioral Health Clinic expansion grant which will open additional care pathways and partnerships over the next two years.

I thank you for the opportunity to provide this information today. Please contact me at 517-346-8212 or luriesa@ceicmh.org if I can be of assistance.



MDHHS

Design firm approved to build new psychiatric hospital in Caro

FOR IMMEDIATE RELEASE: December 19, 2017

CONTACT: Angela Minicuci, 517-241-2112

LANSING, Mich. – A state Ad Board today has approved a contract with a Troy firm to design the new Caro Center that will be on the same site as the existing state-operated psychiatric hospital.

The contractor is Integrated Design Solutions, which will provide design, architectural and engineering services for the project.

"We are pleased to begin moving forward with the design of a new Caro Center that will better meet the needs of people who need mental health services," said Michigan Department of Health and Human Services Director Nick Lyon. "The State of Michigan made a commitment to the Caro community that the new psychiatric hospital would remain in the community, and we are keeping that promise."

Design of a more modern facility will allow the state to replace the aging hospital in Caro. The design phases kicks off in early 2018. State officials expect the new hospital to be completed in 2021.

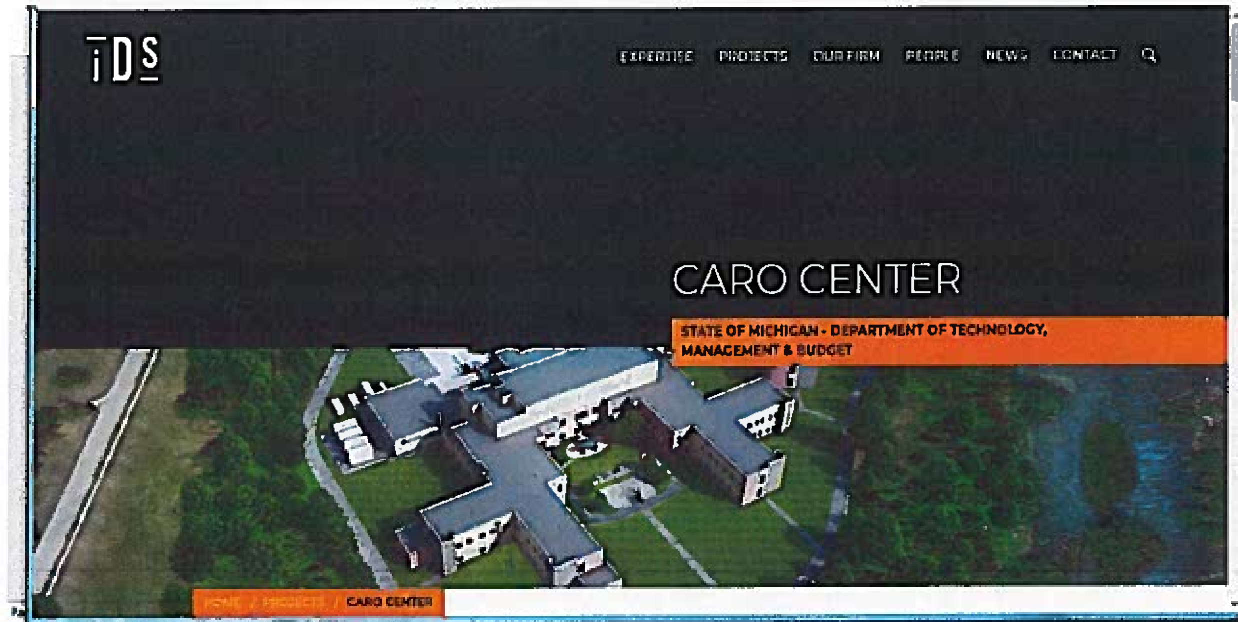
An evaluation committee with representatives from the Michigan Departments of Health and Human Services and Technology, Management and Budget, as well as the State Budget Office, recommended Integrated Design Solutions from 14 firms that submitted proposals. The committee determined that Integrated Design Solutions, a premier design consultant with expertise in psychiatric facility design, provides the best value to the state. The contract is for $5,483,490.

The Caro Center is a regional state hospital for adults with mental illness. The new facility is proposed to be built as a separate standalone complex on the existing Caro Center grounds. The vision and goals are for a new hospital to provide 200 beds – compared to the capacity of 150 beds in the current hospital – in an environment that is safe, efficient and flexible for patients and staff.

###

Images and Text from Integrated Design Solution (iDS) website (4/11/19)

https://ids-michigan.com/projects/caro-center/



Caro Center is currently a Regional State Hospital under the jurisdiction of the Department of Health and Human Services (DHHS) for adults with mental illness. The existing cottage style complex is located three miles from Caro, Michigan, in a rural setting of approximately 650 acres. Caro Center provides psychiatric services for up to 150 patients on a 24 hours/day and 365 days/year basis, for all of northern-lower Michigan and the Upper Peninsula. The vision and goal of the new hospital is to provide a single facility with capacity for 200 beds, supporting an efficient, comprehensive, safe and flexible environment for patients and staff, designed specifically to encourage and enhance rehabilitation of adults with mental illness.

Opened in 1914 to care for epileptic patients, the facilities at Caro Center are not designed to support rehabilitation of patients with mental illness. Nonetheless, the facility has housed psychiatric patients over the past four decades. The campus contributes to inefficiency of patient care and complicates security measures. Vehicles are required to transport patients from one building to another. Programmatic spaces are duplicated throughout the complex. The buildings are past their useful life and do not provide proper space or amenities for psychiatric rehabilitation in line with current regulations. DHHS acknowledges a wait list currently exists of patients to enter the Caro Center and forecasts an increase in demand over the next decade.

The new hospital will be a single, two-story facility with a partial basement and rooftop penthouse, totaling approximately 225,000 SF, housing 200 adult patient beds, clinical support/treatment areas, administration spaces, kitchen, loading dock, maintenance shops, pharmacy, environmental services, security and outdoor recreation spaces.

Site

Seven separate sites were considered on State of Michigan property at and surrounding the current Caro Center development. The sites were evaluated against a matrix of planning criteria that judged relative development opportunities, challenges, and costs. Those criteria consisted of the following:

- Need for existing building demolition
- Impact to existing Caro Center operations
- Proximity to existing utilities and infrastructure
- Vehicle accessibility
- Image / visibility / arrival experience
- Staff and patient environment
- Natural resource impact
- Potential for buffering to other sites

The evaluation of the sites resulted in selection of a site immediately adjacent to the Cass River, on a property southwest of the Chambers Road and Wells Road intersection. This approximately 34-acre site contains vacant residential structures formerly available to Caro Center staff. The site affords good access from both Chambers and Caro Roads via Graf Road and Wells Road, respectively. The property is surrounded by natural features and vegetation associated with the Cass River to the east. A wooded ravine and intermittent stream bed runs along the west and south sides of the site, providing natural buffering and nature views along the perimeter of the proposed development.

Intentionally modern in appearance, the facility will attempt to establish a new character for the Caro Center. Keeping in mind the existing aesthetic of the surrounding campus, the new facility will create a look that is distinctive from the existing buildings and context through the use of material, façade patterning, and building scale. The building will respond to the surround tree line and micro context in its use of glazing and controlled views.

Caro Center

Est. 1914

Rachel Richards

MEMORANDUM

TO: Members of the House Appropriations Subcommittee on Health and Human Services

FROM: Gilda Z. Jacobs, President and CEO

DATE: April 11, 2019

SUBJECT: 2020 DHHS Budget Recommendations

I am pleased to share the priorities of the Michigan League for Public Policy for the 2020 DHHS budget. Over the last year, the League listened to hundreds of Michiganders around the state and heard loud and clear that the state's economic recovery has not reached all of your constituents. In both urban and rural areas of the state, jobs with living wages and benefits are hard to find, child poverty rates are still high, and access to basic needs programs remains limited.

Fact sheets are attached with additional information related to the League's priorities, which are highlighted below.

- **Protect funding for healthcare services**. The League urges you to protect funding for Medicaid, the Healthy Michigan Plan, and the Children's Health Insurance program. The League has opposed work requirements for Healthy Michigan enrollees because the overwhelming evidence is that they do not work. Further, work requirement waivers in Arkansas and Kentucky were recently vacated by the courts, with the federal government's approval deemed arbitrary and capricious.
- **Increase funding for maternal and child health**. The League supports adequate funding for services for moms and babies, including home visiting, the creation of a centralized intake system for Michigan's home visiting program, and restored funding for state family planning and pregnancy prevention services.
- **Make Michigan's public assistance programs more responsive to need.** Since the beginning of Michigan's "welfare reform" efforts in 1993, the monthly payment for income assistance has been increased in a meaningful way only once, with monthly grants rising from $459 in 1993 to only $492 in 2018. More than three-quarters of the beneficiaries of Family Independence Program (FIP) benefits are children, with many under the age of five. With deeper poverty, pressures on the state's child welfare system have grown, as more parents lack the resources to provide for even the most basic needs of their children.

While not specifically within the purview of this Subcommittee, we also urge you to help families keep working, while putting money back into local communities, by modernizing the state's Earned Income Tax Credit (EITC) by expanding it to young childless workers, and incrementally increasing it to its former level of 20% of the federal credit. The EITC is only available to people who have earned income, and is used for such work supports as transportation and child care.

We hope the attached information is helpful as you deliberate a budget that touches thousands of Michigan residents with high needs. We look forward to working with you as the budget process proceeds.

1223 TURNER STREET • SUITE G1 • LANSING, MICHIGAN 48906
P: 517.487.5436 • F: 517.371.4546 • WWW.MLPP.ORG
A UNITED WAY AGENCY

2020 BUDGET PRIORITY: PROTECT STATE AND FEDERAL FUNDING FOR HEALTHCARE COVERAGE FOR ALL MICHIGANDERS

LEAGUE RECOMMENDATION:

- Protect state and federal funding for Medicaid, the Healthy Michigan Plan and the Children's Health Insurance Program.
- Invest in the services needed to comply with Healthy Michigan Plan work requirements should the waiver submitted to the federal government be approved.

BACKGROUND:

Continuation of the Medicaid program, the Healthy Michigan Plan and the Children's Health Insurance Program (CHIP or MIChild in Michigan) are critical to the League's goal of ensuring that all Michiganders are insured and have access to healthcare. Michigan was among the states that elected to expand Medicaid under the Affordable Care Act (ACA), and since 2014 over one million individuals have received health coverage and care through the Healthy Michigan Plan, with over 650,000 currently enrolled. The Michigan Legislature has appropriated sufficient state funding for the program through the end of the 2018-19 budget year. The Snyder administration recently submitted a waiver to the federal government to approve a plan that would impose work requirements and premiums on those enrolled in Healthy Michigan.

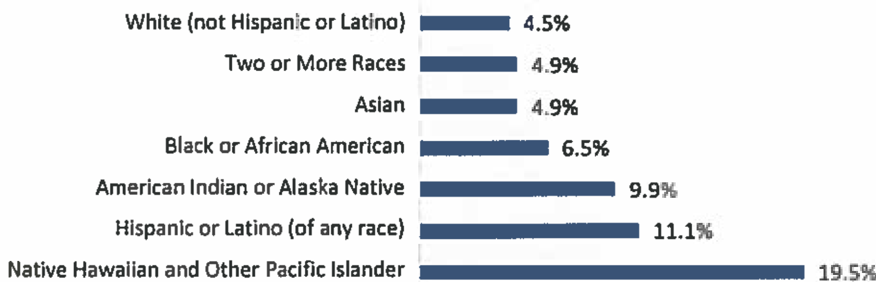
Sabotage attempts at the federal level still threaten healthcare coverage in Michigan. A new Democratic majority in the U.S. House of Representatives likely ends any serious attempts to repeal the Affordable Care Act, but the Trump administration's sabotage attempts to undermine the law are still of concern and threaten the progress Michigan has made in reducing the number of uninsured residents.

Michigan has a history of effectively covering children. Healthcare coverage for children has been a high priority and was increased by the passage of CHIP and the ACA at the federal level.

Despite the state's progress, people of color are more likely to be uninsured. Latinx Michiganders are uninsured at more than twice the rate of White residents, for example.

Data shows work requirements don't work. Michigan submitted a waiver to the federal government asking to have work requirements imposed on Healthy Michigan enrollees, despite overwhelming evidence that work requirements do nothing to improve an individual's health. The League opposes work requirements, but if the waiver is approved, resources will be needed for those required to comply.

LIKELIHOOD OF BEING UNINSURED IN MICHIGAN VARIES BY RACE AND ETHNICITY



Source: 2017 American Community Survey

Michigan League for Public Policy, 1223 Turner Street, Suite G1, Lansing, MI 48906-4369
Phone 517.487.5436 • Fax 517.371.4546 • www.mlpp.org • A United Way Agency

WHY DOES IT MATTER?

- **Michigan residents who are insured are much more likely to receive less expensive preventive and primary care.** Following Michigan's implementation of the Healthy Michigan Plan, over 80% of enrollees had a primary care visit and reduced their reliance on the emergency department as their primary source of care from 16% to just 1.7%
- **Access to health insurance has improved outcomes for children and adults.** While access to insurance is not the only influence on health outcomes, it does improve economic security for families, increase the likelihood of regular well-child and primary care visits, expand access to screenings for potentially expensive chronic illnesses like diabetes, and improve access to needed prescription drugs.
- **The Healthy Michigan Plan helped Michigan's economy grow.** The Healthy Michigan Plan resulted in 30,000 jobs annually, $2.3 billion in additional personal spending power, and $150 million in state tax revenue as a result of added economic activity. Uncompensated care by hospitals fell by nearly 50% across the state.
- **Access to transportation, affordable child care and job training are lacking.** Transportation, child care and training are lacking in our state, but they should not prevent someone from having health coverage. If the work requirement waiver is approved, Healthy Michigan enrollees would need to comply beginning Jan. 1, 2020. Funding must be devoted to address the barriers individuals may face trying to work.

2020 BUDGET PRIORITY: MAKE MICHIGAN'S PUBLIC ASSISTANCE PROGRAMS MORE RESPONSIVE TO NEED

LEAGUE RECOMMENDATION:

Improve access to public assistance for vulnerable families and individuals by eliminating the drug felony ban and updating the cash assistance payment standard.

BACKGROUND:

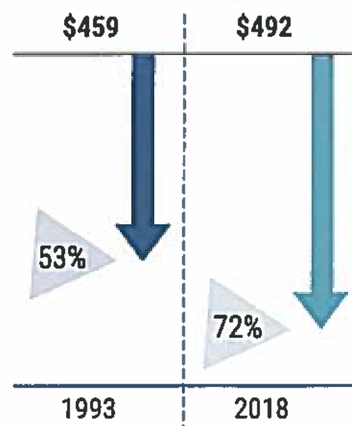
Food assistance through the Supplemental Nutrition Assistance Program (SNAP) and/or temporary cash assistance through the Family Independence Program (FIP) can help give Michigan residents the financial stability they need to get training and work supports, affordable housing and transportation. Through restrictive policies and spending, however, Michigan has created many barriers for families and individuals facing unemployment or with very low incomes. These include banning individuals with more than one drug felony conviction from receiving assistance and restricting cash assistance to very few households in poverty by not updating the payment standard since 2008.

> Between 1993 and 2018, the maximum cash assistance monthly grant fell 39% when adjusted for inflation.

The federal "welfare reform" legislation of 1996 bars states from allowing individuals with drug felonies to receive food or cash assistance, but states may request waivers from this prohibition. Michigan has a partial waiver in place that allows persons with only one drug felony since 1996 to receive assistance, while keeping those with more than one drug felony ineligible.

Since the beginning of Michigan's "welfare reform" in 1993, the FIP payment standard (which determines both the monthly benefit amount and the maximum household income allowed for eligibility) has been increased in a meaningful way only once, in 2006. This has resulted in both the income eligibility level and the benefit level eroding greatly with inflation and falling far below the federal poverty line. A family must have income not exceeding 47% of the poverty level (considered "deep poverty") to get cash assistance, and a three-person family with no other income will get a maximum of only $492 per month—72% below the poverty line and far too little to pay for rent, clothing and other household needs.

MICHIGAN'S FAMILY INDEPENDENCE PROGRAM MONTHLY GRANT



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WHY DOES IT MATTER?

- **Citizens returning from incarceration who are able to find employment and housing are more able to reintegrate into society and avoid recidivism than those who do not.** The ban on those with more than one drug felony prevents many returning citizens from receiving assistance as they get back on their feet, since many have more than one drug conviction. One study found that males with "drug trafficking" convictions who were subject to the ban were nine percentage points more likely to end up in prison than their counterparts who had access to SNAP benefits.
- **Children in families below the poverty level face increased risks to their well-being, including poor nutrition, frequent changes in residence, low academic performance, higher levels of stress and more exposure to environmental threats like lead.** Updating the FIP benefit and eligibility level helps to provide some economic stability to families and reduce such risks.

2020 BUDGET PRIORITY: SUPPORT THE HEALTH OF MOMS AND BABIES

LEAGUE RECOMMENDATION:

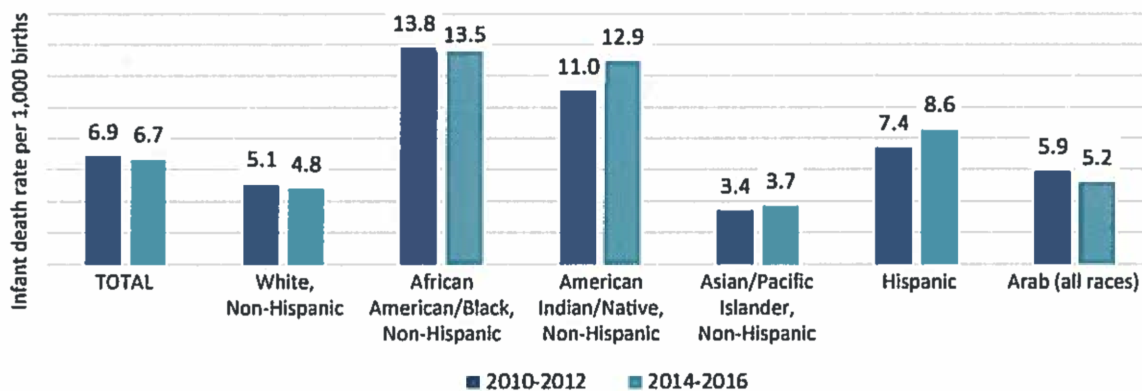
Support programs that help all moms and babies thrive, including expanded funding for home visiting, the creation of a centralized intake system for Michigan's home visiting programs, and restored funding for state family planning and pregnancy prevention services to previous levels.

BACKGROUND:

The health outcomes of mothers and children are good measures of a state's priorities. Home visiting and family planning programs work to improve the health and overall well-being of women and their children.

- **Michigan invests state, federal and private dollars to support evidence-based, voluntary home visiting services and served approximately 24,000 women and 23,000 children in the 2017 budget year; however, the need is much higher.** Of the total investment about 36% are state resources, 64% are federal and less than 1% are private.
- **There are currently seven home visiting models in Michigan, each of which focus on different challenges that families face.** Therefore, some models may be a better fit than others. A centralized intake system, similar to those in New Jersey and Ohio, would help match families with the program that best fits their needs, resulting in even more effectiveness.
- **Michigan has significantly reduced funding for pregnancy prevention even though an estimated 30% of births are unplanned.** Approximately $8.9 million dollars are dedicated to family planning and pregnancy prevention with the vast majority being federal funding—less than $300,000 is from the state's resources.

OVERALL IMPROVEMENTS IN INFANT DEATH RATES, BUT SIGNIFICANT DISPARITIES BY RACE AND ETHNICITY AND RISING RATES FOR SOME BABIES OF COLOR



Source: Michigan Department of Health and Human Services, Vital Statistics

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WHY DOES IT MATTER?

- **While there have been some areas of improvement, many women do not have access to necessary healthcare, like family planning and prenatal care, and Michigan experiences high rates of infant mortality and preterm and low-birthweight births.** Increasing access will improve the overall well-being of women and children, while saving the state money through reduced healthcare and other costs.
- **Home visiting programs work. Decades of evaluation and research show improved prenatal health and fewer babies with low birthweights.** Children participating in home visiting are more prepared for school and they experience improved social-emotional development, plus participating families have increased financial security.
- **Unplanned pregnancies can result in adverse health outcomes and higher costs for the state.** Babies that do not make it to their first birthdays are disproportionately born prematurely with low birthweight, born to mothers on Medicaid and the result of unintended pregnancy. Providing adequate access to family planning and pregnancy prevention services can improve the health and well-being of moms and babies.

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April 11, 2019

The Honorable Mary Whiteford, Chair, and
Members of the House Appropriations Health & Human Services Subcommittee

Re: **FY 2020 Department of Health and Human Services Budget**

Dear Chairwoman Whiteford and Subcommittee Members:

On behalf of AARP Michigan, we appreciate this opportunity to highlight the following items in the proposed FY 2020 Department of Health and Human Services budget. These items particularly impact the extent to which older adults in Michigan can live safely, independently, and in good health as they age.

Non-Medicaid In-Home Senior Services

As part of Michigan's Silver Key Coalition, AARP urges Michigan lawmakers to invest an additional $850,000 in state funding (GF/GP) for home-delivered meals and $5.15 million in state funding (GF/GP) for other in-home senior services in the FY 2020 Aging and Adult Services Agency (AASA) budget. This $6 million increase is needed to address the remaining waitlists for these services and to meet the increased need anticipated for FY 2020 due to growth in the senior population.

These services are extremely important to older adults and their families. Often, simply providing assistance with the "activities of daily living" – help with things like shopping, laundry, and meals – can be the difference that allows someone to remain in their own home, rather than go to a nursing home. These services can also be the difference that allows an individual's family caregiver to remain in the workforce, avoiding lost productivity for Michigan businesses and our economy.

MI Choice Medicaid Waiver, PACE and MI Health Link

AARP supports increased access for older adults to home and community-based services (HCBS) through the MI Choice Medicaid Waiver program. MI Choice provides HCBS for older adults who qualify for Medicaid and who, without those services, would need to move into a nursing home. Increasing access to MI Choice is a win-win for our state. AARP research shows that the overwhelming majority of Michigan residents prefer to "age in place" in their own homes and communities. In addition, rebalancing Michigan's long term care system – that is, allowing a greater share of the people needing services to remain in their homes – can also save taxpayer dollars.

In October 2018, AARP Michigan published *Disrupt Disparities: The Continuum of Care for Michiganders 50 and Older* in collaboration with Western Michigan University, Public Sector

Real Possibilities

Consultants and other partners. As that report set forth, if Michigan could delay entrance for 1% of the 38,801 Medicaid recipients currently in certified nursing care for one year and instead serve them through the MI Choice waiver program, the state could save $3.15 million in general fund Medicaid expenditures. This savings would allow the state to serve an additional 722 people through other home- and community-based services.

AARP also supports the continued expansion of integrated care options for consumers through the Program for All-Inclusive Care for the Elderly (PACE) and MI Health Link options, which are currently available for persons in only certain parts of the state.

Respite Care

AARP additionally urges Michigan lawmakers to increase access to respite care services for family caregivers, particularly those caring for a loved one with dementia. The majority of family caregivers are employed in full or part time work during their caregiving experience. Respite care, such as adult day services or periodic visits in the home, can help provide family caregivers a much needed break and a better opportunity to balance and maintain their work, caregiving and other responsibilities.

Dementia Issues

Finally, we want to share with you that AARP Michigan is currently working with the Alzheimer's Association Michigan Chapters, the Michigan Alzheimer's Disease Center and approximately 60 other organizational partners to make use of our combined knowledge, experience and resources to improve quality of life for people living with dementia and their families. In May we plan to publish our *2019-2022 Roadmap for Creating a Dementia Capable Michigan*, and we look forward to working with you to address the challenges and opportunities before us to make Michigan a dementia capable state.

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

Respectfully,

Lisa Dedden Cooper
Manager of Advocacy

Melissa Seifert
Associate State Director, Government Affairs

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

WRITTEN STATEMENT OF

AMANDA LICK

GOVERNMENT AFFAIRS MANAGER, GREAT LAKES REGION

NURSE-FAMILY PARTNERSHIP NATIONAL SERVICE OFFICE

April 11, 2019

Good afternoon! Thank you, committee members, for the opportunity to present to you today. My name is Amanda Lick, government affairs manager for Nurse-Family Partnership. Michigan is launching new efforts towards an integrated system which includes several home visiting models including Nurse-Family Partnership. I am here today to highlight the impact NFP sites have in Michigan.

A future where all children are healthy, families thrive, communities prosper, and the cycle of poverty is broken.

This is the vision statement of Nurse-Family Partnership.

Nurse-Family Partnership is a program of prenatal home visiting for low-income, first-time mothers and their families with the emphasis on the mother and baby. The nurses begin visiting their clients as early in pregnancy as possible through the child's second birthday (a total of 2.5

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years), helping the mother-to-be.... make informed choices for herself and her baby. Nurse-Family Partnership (NFP) has over 40 years of research with positive outcomes in pregnancy, child abuse and neglect prevention, school readiness, economic self-sufficiency and more.

NFP nurses work to impact the social determinants of health of mothers and babies in many ways through their trusted relationship as professionals and through the ongoing relationship developed between the nurse and mother. Nurses help mothers determine and set goals that often involve education, child welfare and development, employment, health & access, transportation, diet and housing. Nurses assess for health-related behaviors that compromise fetal development (smoking, alcohol, opioids, etc.) Additionally, nurses use their assessment and clinical expertise to identify health related issues and encourage women to seek office-based care before conditions become worse. By the time moms graduate from the NFP program they have the tools to set goals, take action and seek resources when needed, to continue on a path to a better future for themselves and their children.

Nurse-Family Partnership has three goals:

1. Improve pregnancy outcomes
2. Improve child health and development
3. Improve economic self-sufficiency of the family

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As an organization, we strive to enroll the highest-risk clients, defined by age, race, educational level, marital status and household income. In addition, high-risk clients of NFP may exhibit at least one of the following: serious mental health issues; substance use disorder; intimate partner violence; developmental or intellectual disability; pregnancy complications or chronic illness; under 19 years old and not in school; excessive economic hardship; homelessness or housing instability; and over 19 years old and less than 12th grade education.

Danielle, a Michigan mom living in Ingham county said it best, "After my son Mykah, nurse Kristin is the best thing that has ever happened to me. Mykah saved my life, and Kristin continues to make me better. She builds me up and she never makes me feel like I'm doing anything wrong. I'm so grateful for the support and wish every woman could feel as supported as I do."

In partnership with the Michigan Department Health and Human Services under the Michigan Home-visiting Initiative - Since 2000, approximately **5,700 Michigan families have been served** through the NFP model. **NFP partners in the following 10 counties (Berrien, Calhoun, Wayne with a focus on the City of Detroit, Genesee, Ingham, Kalamazoo, Kent Macomb, Oakland and Saginaw currently serving approximately 1,293 families today. In 2017, it is estimated 19,000 babies were born to first-time moms in Michigan. Our estimates indicate that NFP only serves about 7% of the total moms eligible for the program.**

In 2005, the RAND Corporation released a summary on the return on investment of early childhood investments. **It was noted in this study specific to NFP, that $5.70 ROI can be achieved when NFP serves high-risk**

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first-time moms. More recently, economist Ted Miller predicts that in Michigan, by a child's 18th birthday, state and federal cost savings due to NFP will average $25,861 per family served or 2.9 times the cost of the program.

How is this ROI achieved?

- A trusted relationship with a BSN nurse that works within their nursing practice to address and identify issues early with mothers and babies.
- A proven evidence-based model with 3 RCT's to test effectiveness
- Focus on early in pregnancy – the earlier the better and that is why NFP focuses on first-time moms before the 28th week in pregnancy.
- Consistent visits (visit schedule allows for 65 visits over 2.5 years)

With your support, NFP nurses in Michigan help the state face its most difficult challenges such as:

- **Breaking the Cycle of Poverty**
    - In Michigan the poverty rate is 15%, which is higher than the national average of 12.7%. Furthermore, 23% of children under the age of six live in poverty. By working to meet the needs of vulnerable mothers and their children together, NFP produces a number of outcomes that help families break the cycles of intergenerational poverty. **NFP outcome that shows effectiveness: 51% of mothers reported working when enrolled**

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in NFP. After 12 months of enrollment, 65% of mothers reported working.

- **Education - improving education begins in the First 1000 days after conception**
  - The model was designed to enroll moms early in pregnancy (by the 28th week) to impact the development pathways in the brain. In early childhood, research on the biology of stress shows how major adversity, such as extreme poverty, abuse, or neglect can weaken developing brain architecture and permanently set the body's stress response system on high alert. Protective factors, such as nurturing relationships help mitigate these risks. **This is where NFP comes in; Children enrolled in NFP 50% reduction in language delays and 67% reduction in behavioral and emotional problems at child age six.**
- **Substance Use**
  - **I would like to point out how NFP is committed to serving moms with substance use disorder.** Nationally, every 25 minutes a baby is born suffering from opioid withdraw. In Michigan rates of Neonatal abstinence syndrome are increasing. After a study showed that there had been a significant increase in the number of moms using opioids in

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pregnancy NFP decided that more had to be done. NFP developed a new education curriculum for nurses specifically focused on substance use in pregnancy and neonatal abstinence syndrome (NAS) that will be available in April 2019.

NFP is known for their evaluation and research. Here are a few of our most proud outcomes:

- 18% decrease in pre-term birth (pre term birth is a significant factor that predicts infant mortality)
- 82% increase in maternal employment
- 68% increase in father involvement
- 39% fewer injuries amongst children
- 48% reduction in child abuse and neglect
- 59% reduction in child arrests at age 15

Funding & Cost

As detailed in the 2017 Home Visiting Legislative Report, seven home visiting models received a combined amount of federal, state and private funds totaling approximately $41,201,803. **NFP implementing agencies receive about 13% of the total home visiting dollars invested in the state. Investing in NFP is creating a multigenerational change in families and communities across the state and will help transform the trajectory of the**

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most vulnerable families helping children and families thrive. Continued investment to serve more families through evidence-based home visiting with proven results will only strengthen the outcomes and create a future where families prosper.

Thank you for your time today and for the opportunity to share the story of Michigan's most tenacious mothers, babies and nurses.

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NASW. MICHIGAN CHAPTER
National Association of Social Workers

April 11, 2019

The Honorable Representative Mary Whiteford
Chairwoman, House Appropriations Subcommittee on Health and Human Services
House of Representatives
P.O. Box 30014
Lansing, MI 48909-7514

The National Association of Social Workers – Michigan Chapter (NASW) is a membership organization of professional social workers working in various critical health settings, including mental health and substance use disorder treatment. There are more than 24,000 licensed social workers in Michigan and various work within Community Mental Health Agencies and with individuals who rely on the public mental health system.

Social Workers have an ethical responsibility to assist those most vulnerable in society, in addition they have an ethical responsibility to ensure that individuals critical needs are met. Michigan's public mental health system is one of the most comprehensive and advanced in the country. However, several financing decisions by the State of Michigan, has resulted in the lack of financial stability for Michiganders who rely on the public system for their mental health needs whom social workers serve.

The causes of insufficient funding specifically include the following:

- Funding to the public system does not reflect actual and growing need: While the demand for wide range of mental health services, in communities across Michigan, has grown dramatically over the past several years, the funding for the public mental health system responsible for meeting those needs has not. Some of these needs include addressing the opioid crisis, preventing suicide and responding to mental health crises, serving children and adolescents with autism, preventing arrest and incarceration, preventing homelessness, keeping kids in school safe and successful, support persons with disabilities to live in the community.
- General Fund shortfall: While long insufficient to meet community need, the State General Fund support for the public mental health system and its ability to meet increasing community demand has fallen off dramatically. The $200 million cut to the GF revenues of the state's community mental health systems, where various social workers are employed and serve those in need, in 2014 and 2015 led to 10,000 fewer persons receiving services.

Concrete actions to address the systemic underfunding of Michigan's public mental health system include the following:

- Medicaid rates set to match demand and costs: Set the Medicaid rates to the state's public mental health system (the process that provides over 90% of the funding for this system) to reflect the actual and projected growth in demand for and the real costs of providing the services associated with Michigan's Medicaid mental health benefit.
- Restore General Fund dollars to the public mental health system: Restore the lion's share of the State General Fund dollars cut from the CMH budget to ensure that persons, not covered by Medicaid, have access to needed mental health services.

For these reasons, it is critical to address the systemic underfunding of Michigan's Public Mental Health System for the 300,000 Michiganders who rely on the system and the tens of thousands of Michiganders unable to access this system.

Therefore, I urge you to consider the recommendations provided. Please do not hesitate to contact me with any questions regarding this important matter.

Algeria Wilson
Director of Public Policy, NASW-Michigan