DCH SC 3/2/15
Stacey Domers

The Honorable Rob VerHeulen, Chair
House Appropriations Subcommittee on Community Health
Michigan House of Representatives
PO Box 30014
Lansing, MI 48909-7514

Dear Representative VerHeulen:
My name is Stacey Domers and I am the Administrator at Dunlop Court Group Home; I also run Adult Care Partners Networking & Advocacy Group. In preparation for today, I reached out to our group members and asked them to provide me with input so that I could report back a well rounded and accurate presentation of what homes are feeling and facing.

It is important for you to know that there are a couple of different ways that AFC homes receive revenue in a Licensed Setting for the State of Michigan. Most homes are either Private Pay and can request whatever they feel is an adequate Room & Board Fee to the level of care they are providing, or the homes primary source of Revenue is Medicaid dollars, which highly restricts allowed funding. I tell you this because the access to these Primary Funding Resources has a very real and direct impact on our ability to meet labor costs. For a 6 bed home with Medicaid funding, the Room and board amount we are allowed to receive is approximately $5,079/month. This amount is expected to cover everything: room and board, food, utilities, cares, medication passes, home maintenance (which is much higher than a "normal" home), and more. Staffing costs alone expense at $5,868/month. Obviously this is almost a $800 gap; If we consider all of this, and we look forward to the next minimum wage increase, January 1st, 2016, homes will pay out $6,120/mo for staffing; in 2017, homes will pay out $6,408/mo; and in 2018, homes will pay out $6,660/mo. Homes sustain this discrepancy by seeking out additional difficulty of care funding, which comes along with a substantial amount of increased cares, documentation and time. Units allocated to Recipients for these additional cares are reimbursed through an assigned daily rate per Recipient. A 6 bed facility can be known to expense $10,000 per month; right now, in order to simply meet costs, homes with expenses noted previously need to find a client that is reimbursed for care at a rate averaging $28/day, and this is no easy task. Right now my lowest paid resident has $17.20/day. As you can see, the gap between expectations for our homes to provide adequate and quality care and the amount we are allowed to receive by Medicaid, will continue to grow and place burden on homes, their staff, and ultimately the Recipients.

The inability for our homes to provide prospective employee's with a fair wage for the work that they do has a substantial impact on our ability to find quality staff. Unfortunately we are faced with the harsh truth that most of these candidates could easily walk into a Private Pay facility & get paid $10/hour, likely more. The current Medicaid Reimbursement makes it all but impossible to meet labor costs, without Homeowners putting in substantial amounts of overtime & likely

suffering from Caregiver burnout which further directly affects our business & Recipients quality of life.

There is a feeling of helplessness that resonates deeply in our industry. Providers are already feeling the impact of the new minimum wage and with the new CMS Final Rule in place, we are faced with the reality that TRULY providing each individual with Choice creates a substantially higher amount of work; I am facing this myself. Trying to coordinate 6 peoples lives when one person wants to go to the YMCA, 2 want to go to the Dollar Store, 2 want to go to Meijer; and you are required to be at a medical appointment with another; how do you coordinate this with limited staff hours and dollars? If some kind of increase in reimbursement is not granted, the numbers alone can prove that with Medicaid solely responsible for funding, there simply is not a way to sustain any type of quality home. CMS Rule aside, we need to remember that food costs are increasing as are most other expenses associated with maintaining a home & taking care of a large family with high needs & risk. When Minimum Wage is increased, the reality is, our homes will be forced to use money that was once taken to provide Community Outings and other important needs to provide quality care and settings, and turned over to the employee for pay, a much deserved increase of course. It is important to know that our homes, due to the individuals we serve, often times show to have a lot more wear and tear than traditional homes. It is of concern that not only will we need to make cuts to the previously noted topics, but the higher amount of Home Improvement costs that we face will be negatively impacted as well. With the CMS Final Rule expecting us to help these Recipients live and thrive in an environment that is as similar and independent as if they were not Recipients, how can the funding not be provided?

While funding and budget issues are hard on Homeowners from a business perspective, they are even harder on our Recipients. High turnover rates have a direct impact on the wellness of most Recipients in our care. My home has only recently stabilized its staff members, and the impact it had on our Recipients is absolutely substantial - more than I realized at first. Because I was only paying $8/hour (before the minimum wage increase), the staff that I had on hand were only there to make money, some left on their own accord, others I had to let go for various reasons. In a 2 month time frame, I lost 3 staff members, hired a new one, and lost her within a month; after this my residents were agitated, and sad. They would not tell us when they were not happy with staff because they feared their comments would play into losing another person with whom they had bonded with, whether they were doing well or not.

Ultimately, a $1/hour annual increase for our employees would allow staff to maintain a consistent position in a job that they love, and provide our Residents with the consistency that many need to thrive. It would further decrease Homeowner/Caregiver Burnout and allow for overall ease in providing services, and bring back to light the reason that so many of us came into the position we have - because after all of the exhaustion, we deeply deeply care about the individuals we serve.

On behalf of Adult Care Partners, I appreciate the opportunity to testify today.

Best Regards,

Stacey Domers
Adult Care Partners Networking Group
Dunlop Court Group Home
Email: sdomers@gmail.com
C: 616.292.2368

cc: Rep. John Bizon
Rep. Jon Bumstead
Rep. Chris Afendoulis
Rep. Edward Canfield
Rep. Laura Cox
Rep. Brandon Dillon
Rep. Harvey Santana
Rep. Kristy Pagan

Partnership for Fair Caregiver Wages

DCHSC 3-2-15
John Williams

March 2, 2015

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

Re: 2015-2016 Department of Community Health Budget

Dear Representative VerHeulen:

The Partnership for Fair Caregiver Wages is a coalition of employers, consumer advocacy organizations, regional community mental health boards, educational organizations, and worker or staff associations, which seeks sufficient public dollars to raise the wages of direct support staff in the Medicaid programs supporting people with intellectual and developmental disabilities, mental illness, and substance use disorders.

Staffing Crisis on the Horizon

An estimated 44,000 Michigan jobs are funded through Medicaid appropriations to support and serve people with disabilities. Staffing shortages tied to low wage rates have created soon-to-be-crisis-level consequences. Michigan direct support staff wages have been losing ground for many years, as the cost of living has increased; wages have remained virtually flat for the last decade or longer. The last time the state appropriated funds for a direct support staff wage increase was in 2008, and the effect on wages was an increase of $ .10 per hour. Ironically, taxpayers unknowingly subsidize these low wages by paying for food stamps and other public assistance programs that many of our direct support staff and their families rely on to survive. Exasperating the low wage issue are two important factors that did not exist until recently. First, last year the governor signed into law a mandated minimum wage increase. The Partnership supports the increase in minimum wage in principle. However, although employers are obligated to comply with the law, there was no additional funding passed through the Prepaid Inpatient Health Plan (PIHP) system that funds the Medicaid programs in the state. Second, as the economy picks up speed, the competition increases for workers. Just this past week, the nation's largest retailer, Walmart, found itself in the position of having to raise wages in an attempt to stem employee turnover. Unlike direct support staff employers, an extremely profitable corporation such as Walmart has the ability to raise prices or reduce profit margins to cover the cost of remaining competitive in the job market. Although entry level Walmart employees and direct support staff are largely drawn from the same labor pool, the playing field is becoming more distorted each day. Walmart has pledged to raise the starting wage to $10.00 per hour beginning in 2016.

Beginning in 2016, the State of Michigan's second mandated minimum wage increase will set the rate at $8.50 per hour. The Fair Caregiver Wage coalition believes that the vast majority of direct support staff employers will have difficulty even offering the new minimum of $8.50 per hour, let alone competing in the open job market with such behemoths as Walmart, Target, and others.

The Cost of Low Wages

Estimates of the average annual turnover for Michigan direct support staff employers range from 32 to 50% based upon previous surveys. These estimates were compiled prior to the mandated minimum wage increase or the recent upturn in the national and Michigan economy. High turnover does two things: it destroys continuity of services and supports; and it requires the mandated training of new direct support staff at a cost estimated to average $2,600 to $5,000 per new hire.

Heading off the Staffing Crisis

The Partnership requests additional Medicaid funding to the PIHPs for a directed provider rate increase of $1.00 per hour for each hour of community supports, and training, personal care services, and skill building in the Fiscal Year (FY) 15-16 Department of Community Health Budget. Providers would have to expend this funding exclusively on the cost attributable to direct support staff wages and benefits. This investment in Michigan workers will result in a more stable workforce which in turn will reinforce the notion that work is the path that leads to a more hopeful tomorrow and stronger communities across the State of Michigan.

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

Sincerely,

John R. Williams

John R. Williams
Executive Director
Progressive Lifestyles, Inc. and
Member of the Partnership
for Fair Caregiver Wages
(248) 336-9119
jwilliams@progressivelifetylesinc.org

Cc: Representative John Bizon
Representative Brandon Dillon
Representative Chris Afendoulis
Representative Jon Bumstead
Representative Edward Canfield
Representative Laura Cox
Representative Harvey Santana
Representative Kristy Pagan

DCHSC 3/2/15
Rosita & Hugh Trimble

Re: Defunding of Community Mental Health

Dear Representative or Senator,

We are the parents of Daniel Jonker, who is a multiply disabled person receiving services funded by Detroit Wayne County Community Mental Health Authority. He currently resides with us in Livonia, but we have built a home for him in Farmington Hills under a Supplemental Special Needs Trust. Due to Medicaid funding cuts to SE Michigan, the agencies involved are unable to provide staffing for him and roommates.

Here is a list of funding issues:

- MDCH attempts to "level" funding across the state by taking from SE MI and giving to outstate agencies. This is called 're-basing'. Unfortunately, it uses mostly assumptions about individual needs and cost of providing services.
- "Healthy Michigan" defunding of mental health under Medicaid was based on false assumptions. Existing recipients of Medicaid did not benefit from the program, but only new recipients are covered by Federal money, entirely.
- A more accurate survey of needs in Michigan is underway, called Supports Intensity Scale (SIS). This survey measures and evaluates the needs of disabled people. Any further re-basing should not be done until this data is available to MDCH.
- Wage markets and cost of services must be taken into account when re-basing. Competitive pay must be given to caregivers in order to assure quality care and to retain staff.

We thank you for your attention to this crucial matter.

Sincerely,

Rosita and Hugh Trimble

DCHSC
3-2-15
Robert & Sue White

My/Your-Our Responsibility to Adequately Fund Community Mental Health

My purpose of testifying and providing this narrative today is to emphasize that "Community Mental Health" has an "Identity". As parent advocates, that "Identity" includes our two sons, Fred White (44 years old) and Michael White (30 years old) who are both on the Autism Spectrum. Therefore, when we speak of, read about or refer to "Community Mental Health", please don't forget that CMH represents much more than a line item on a spreadsheet or a slice of a pie chart but instead is the "life line" and in many cases the only "life line" that developmentally disabled adults have to depend on for survival.

I am sure you are all familiar with the proverb: "It takes a village to raise a child" If you are a conservative then you will likely recall that phrase as the title of Hillary Clinton's 1996 book. If you are a liberal then you may be more comfortable with accepting the origin of the phrase being attributed to an old African proverb. In any case, my point here is that if "it takes a village to raise a child" then most certainly it takes a county, state and even a nation to raise a developmentally disabled child/adult.

Autism of course is not the only developmental disability but is one that I can speak to from experience. No matter what autism frequency statistics you accept as accurate..1 in 60, 1 in 68...the frequency is alarming. Autism does not discriminate between race, gender, social or economic status. The unfortunate result is that due to this frequency, today we are all likely to have a real life experience with autism through direct or indirect family members, a neighbor or a friend.

Adequate funding to support the needs of the developmentally disabled is critical at all age levels no matter if it is through our school system to age 26 or through Community Mental Health after age 26. Most certainly the after age 26 population of developmentally disabled adults and dependence on Community Mental Health is growing due largely to the Baby Boomer influence.

So if you had a role in developing and passing legislation like House Bill #4112 that includes budget cuts to Community Mental Health for the 2015 FY or have a role in developing the CMH budget for the 2016 FY, please realize the negative impact that direct cuts to CMH or cuts to CMH through the General Fund are having and will have on the developmentally disabled that have an "Identity" and who depend on you to be their advocate. Please support us in finding ways to increase funding for this critical cause.

Robert & Sue White
7355 Deerhill Drive
Clarkston, MI 48346

DCH SC
3-2-15
Barbara
Buczynski

1705 Welling Drive
Troy, MI 48085

248-225-6829

March 2, 2015

House Appropriations: Subcommittee on Community Health:

My daughter Stephanie is a 34 year old woman who is severely cognitively impaired and autistic with a seizure disorder. She lives in an outstanding SIP home with two of her best friends. The enclosed picture is Stephanie relaxing in her home. During the week, she attends New Gateways, a prevocational day program, where she is learning office skills which include hole punching, stapling and shredding. Because she is autistic, interacting with others who are like her is so important to improving her social skills. She is very happy with her life.

I am very concerned about her future because Oakland County Community Mental Health has received funding cuts and the 2015 budget is projected to be several million in the red. There are three reasons for this deficit. Money was rebased from Oakland County to other counties. There has been an increase in those who need services. Due to Healthy Michigan, there was a switch from the more flexible general fund dollars to the more restrictive Medicaid funding.

I fear that a decrease in funding will result in a decrease in staff. Because she is severely disabled, less staff would result in fewer hours of learning at New Gateways, and less community activities. Her quality of life would plummet. But most importantly it would result in a less safe environment. In her SIP home, only the afternoon shift is assigned two staff. They make dinner, do laundry, clean the house, transport the clients to activities, pack lunches, shower and spend quality time bonding with those in their care. My daughter needs total assistance in showering. If there was only one staff, it would be unsafe to leave the other two unattended.

Please fully fund Oakland County Community Mental Health so that Stephanie can lead a safe, productive, and full life and I can die in peace knowing that she will be in good care.

Sincerely,

Barbara Buczynski

Barbara.Buczynski@gmail.com

DCH SC
3-2-15
Allison Restauri

Michigan Dental Hygienists' Association

Testimony to the Department of Community Health House Appropriations Sub-Committee regarding Healthy Kids Dental program expansion
March 2, 2015

Mr. Chairman and Members of the Committee:

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

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

As successful as HKD has been, there are children in Michigan who are still in need of dental care. Many of these kids reside in counties excluded from the program. By providing and exposing kids to good dental practices early on, we can cut down on the medical costs that will inevitably occur at a later date. In fact, polls from a 2013 survey conducted by Marketing Resource Group have shown that the overwhelming majority of Michigan residents support expanding the services of HKD to the whole state.

The governor's proposed expansion of Healthy Kids Dental by investing $21.8 million ($7.5 million general fund) will cover children from 0-8 years old in Wayne, Oakland and Kent County. This will leave the remaining age groups in these three counties to be phased-in over the next several years. When addressing this proposed expansion for the upcoming fiscal year, there are a few key things we would like you to consider:

1. Tooth decay is the #1 chronic childhood disease and it is totally preventable.
2. 70% of all children will require some sort of dental work by the time they reach adolescence.
3. Research shows that regular dental checks can detect diseases such as diabetes, heart disease, and numerous other inflammatory disorders.
4. With passage of this proposal, 822,000 Medicaid-eligible children will now have coverage for the dental work that they need.

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

3-2-15
DCHSC
J. Williams
R. Rangi

COLUMN

Woman thinks caregivers deserve better pay

Jerry Wolffe
Voices of Disability

A single mother who works up to 50 hours a week as a caregiver at a Clarkston home for those with disabilities and another 20 for a Birmingham man is barely making it.

When Ajeenah Kalimah was asked when she sleeps and how can she work up to 70 hours a week, she said: "I am tired, but I can rest when I die."

Kalimah, 26, who has three sons ranging in age from 5 to 9, has worked at the Fawn Valley Independent Living home for a year, helping to care for three men with disabilities.

Executive Director John Williams of Progressive Lifestyles that operates the 24-hour, seven-day-a-week home where Kalimah is employed said workers are hired in at $8.15 an hour.

"Our average (pay) is $8.60," he said.

Kalimah said she earns $10.25 an hour.

"She has been with us for five years and is a former house manager," Williams said, explaining why her pay is higher.

"We put a great emphasis on relationships, this along with turnover (which ranges from 32 percent to 50 percent a year in the field), illness, absences and staff vacancies result in a high number for overtime expenses and is a constant worry," Williams said.

A review of research literature shows that a "long-term supports and services employer spends an average of $2,500 directly to recruit, screen, train and hire a new worker."

By comparison, caregivers at state-operated institutions such as the Hawthorne Center in Northville make at least $18 an hour and receive a full range of benefits.

It's not the fault of the operator of the Fawn Valley home that pay levels are what they are because there has been millions of dollars in recent budget cutbacks by the Department of Community Health for Oakland, Macomb and Wayne counties to fund homes that care for the mentally ill and those with disabilities. At the same time, the economic pressure on workers is worse because inflation has risen nearly 30 percent during the past decade and wages are flat.

PHOTO FROM AJEENAH KALIMAH'S FACEBOOK

Ajeenah Kalimah works to help care for three men with disabilities in Clarkston. She said making $10.25 an hour makes it difficult to afford the necessities for herself and her three children.

Kalimah pays $120 a month for medical coverage for herself with Progressive picking up the rest of the premium. She also receives paid vacation.

She said she pays $721 a month for a used car and insurance and just bought a home in Flint, which has been broken in to twice since it was purchased last February. She drops her sons off at her mother's home when she goes to work as well as her televisions, fearing for the boys' safety and more items being stolen from her home.

"I believe 100 percent that caregivers should be paid more than minimum wages, should receive health care for their family members and vacation and sick time."

—Ajeenah Kalimah, caregiver

Kalimah believes caregivers deserve around $15 an hour "because of the responsibility we have in our jobs and I don't want to live paycheck to paycheck. We try to follow every rule possible, including dietary needs, to make sure the people are safe and well cared for while we're working.

"I believe 100 percent that caregivers should be paid more than minimum wages, should receive health care for their family members and vacation and sick time," she said.

"I have worked with some who have cerebral palsy (and are non-verbal) and I can tell what they are trying to tell me through their eyes. ... Some of the caregivers I have worked with have a variety of skills that save lives which is much more than (the skills of) someone working in a factory."

"My job is mentally draining," she noted. "Whether I stay in this field depends upon the money situation."

Kalimah wants to earn a social work degree so she can improve her life.

"I'm smart. I was raised correctly. If you do well you will get rewarded," she said.

Her daily reward now is helping those most in need and hoping lawmakers will recognize more money is needed to pay those fairly who take care of the most vulnerable in society.

Jerry Wolffe is the writer-in-residence and advocate-at-large at the Macomb-Oakland Regional Center. He can be reached at 586-263-8950.

DCHSC 3-2-15
Josephine Feijoo
(Did not speak)

RESIDENTIAL ALTERNATIVES, INC.

P.O.BOX 709

HIGHLAND, MICH.

Dear Representative,

I am a service provider in the Northern Oakland County area. I operate 5 group home for the developmentally disabled and one Shared Lives program. I currently serve 27 individuals and have approximately 47 staff to accomplish the individual plans of each individual on-going.

The current fiscal year we are operating with a 6 % budget cut across the board due to funding issues in Oakland County which is threatening the services of the 7 individuals I serve along with all other consumers of services in Oakland County. There is a number of areas of concern: the increased costs over time which are 12%, the effort to reduce costs resulting in lowering per diem rates at approximately 10%, increased costs with the ACA including penalties and increases in the minimum wage which are not adjusted at any governmental level to address shrinking budgets.

Another area of concern is the statewide effort of the Department of Community Health to rebase all PIHP's that qualify. Oakland sustained a major loss of funding which impacts on the services of the developmentally disabled. They are under threat of another rebasing in the upcoming fiscal year which will be devastating to those we serve.

I would appreciate your support of funding that will support the kind of services that have brought people from all around the world to view our programs and services so that they could take this levwel of care and philosophy back to their countries.

Sincerely yours,

Josephine Feijoo,

Executive Director

DCH SC 3-2-15 Sean Bennett (Did not speak)

To Michigan House Appropriations Subcommittee on Community Health 3/2/2015 Hearing
Chair VerHeulen Clerk Sue Frey

STATEMENT ON MDCH BEHAVIORAL HEALTH SERVICES

MCL 330.1401,1718 LAWS AND PRACTICES PROMOTING FORCED/NON-CONSENSUAL PSYCHIATRIC TREATMENTS ARE UNCONSTITUTIONALLY MEDICALLY INAPPROPRIATE AND CONTRARY TO UNCORRUPTED EVIDENCE-BASED MEDICINE

One Constitutional requirement for non-consensual, assaultive psychiatric drug prescribing is that the drugs must be medically appropriate for that individual. Sell v U.S., 539 US 166, Riggens v Nevada, 504 US 127. The drugs must be medically beneficial. The drugs must not be counter-therapeutic. If the drugs are harmful rather than helpful then forced drugging may also constitute malpractice and fraud. Drugs which cause, instead of alleviating, illnesses, suffering and distress must not be forced on patients against informed consent. Michigan statutes, practices, and policies (MCL 330.1401) which force patients to suffer harmful or worthless psychiatric drugs, abuse medicine, abuse vulnerable persons and violate Constitutional, statutory and common law. Law-makers should be cognizant of the medical facts mandating reform of Michigan mental health laws.

Because 50%+ of the persons prescribed antipsychotic drugs will not be helped by the drugs, and psychiatrists do not have the ability to predict whether or not the drugs will be beneficial to any given individual, and generally only the patient can know and decide whether the drugs are helping or harming that person, policies which override the right of all persons to decline psychotropic medications are patently unconstitutional. If the drugs are just being used to disable a person from being dangerous without medical benefit then forced drugging must be limited to very short term 1-3 days. "The requirement that medical personnel determine that there is an imminent danger of harm cannot be overemphasized. The police power may not be asserted broadly to justify keeping patients on antipsychotic drugs to keep them docile and thereby avoid potential violence...Furthermore, the medication must be medically appropriate for the individual and it must be the least intrusive means" Steele v CMH Board, Ohio, 736 N.E.2d 10. Michigan's recipient rights statute on psychotropic drugging (330.1718) only prohibits non-consensual drugging the day before and the day of the court hearing. And even here the law is deficient on medical facts. Schultz, et al, Persistence of Haloperidol in Human Brain Tissue, American Journal of Psychiatry, June 1999.

The supposedly new and improved, and much more expensive, 2nd generation antipsychotic drugs have been found not beneficial for persons over 40 years old [not medically appropriate], regardless of drug or diagnosis. The drugs proved lacking in both safety and effectiveness. DJeste (past president American Psychiatric Association), et al., Journal of Clinical Psychiatry, Jan. 2013. The landmark NIMH funded CATIE 1 study concluded that the 2nd generation APDs drugs were no more safer and effective than the older APDs, and were intolerable or ineffective for the majority of those prescribed. JLieberman, et al., New England Journal of Medicine, Sept. 2005. Leucht, Arbter, et al, Journal of Molecular Psychiatry, 2009, Meta-analysis confirmed about 60% of patients did not gain any benefit from 2nd generation APDs.

But for many persons psychotropic drugs are far worse than just ineffective, APDs have proven extraordinarily harmful to both mental and physical health. The drugs have long been known to cause severe anxiety, distress, mental impairment, depression, exacerbate psychosis, and even damage the brain. Peter Breggin, Brain Disabling treatments in Psychiatry, 2008. Joanna Moncrieff, The Bitterest Pill: The Troubling Story of Antipsychotic Drugs, 2013. The drugs cause misery,distress, diminished functioning and quality of life for about 50%. VanPutten and Marder, Behavioral Toxicity of Antipsychotic Drugs, Journal of Clinical Psychiatry, Sept 1987. APDs can cause suicidal depression, Peter Lehmann, About The Intrinsic Suicidal Effects of Neuroleptics, International Journal of Psychotherapy,2012. APDs often worsen psychosis, Psychopharmacology, July 2013, Review of Cases Involving Psychotic Symptoms Worsened by Abilify, Rosebush, Neurology, March 1999, "The incidence and severity of dystonic reactions, akathisia, parkinsonism, and dyskinesia were comparable in the risperidone and haloperidol treated groups." Both 1st and 2nd generation APDs cause brain atrophy, Neuropsychopharmacology, March 2005. 44% of patients consuming APDs in study died within 10 years, Waddington, et al, British Journal of Psychiatry, 1998. Serious adverse health problems or death are much more frequent among older adults, 65+, when prescribed APDs, Rochon, et al, Archives Internal Medicine, 2008, Grace Jackson, Drug-Induced Dementia: A Perfect Crime, 2009.

Thank you. Sincerely,

Sean Bennett
1011 Crown St, Kal. Mich
49006, (734-239-3541)

DCH SC
3-2-15
(Did not testify)

Daniel and Linda CasaSanta

2761 South Lake Shore Drive, Harbor Springs, Michigan 49740

Phone: 231-526-2818

E-mail: ndwins1@yahoo.com

February 26, 2015

Representative Rob VerHeulen, Chairman
Via Email: robverheulen@house.mi.gov

Subject: Michigan Department of Community Health - Appropriations Subcommittee Meeting 3/2/15

Dear Representative VerHeulen:

It is my privilege to speak to you, and the Appropriations Subcommittee for Community Health.

My name is Dan CasaSanta. My wife and I are the parents of a 32 year old daughter who was born with mental disabilities. She is affectionately known as Maggie. Maggie attended Rochester Adams High School and received a certificate of completion in 2001.

Maggie now lives in a private home, with 3 other disabled, adult women in Rochester Hills. The home is owned by my wife and me. Services for the home are coordinated by MORC (Macomb Oakland Regional Center) and staffed by an Oakland County Service provider. Maggie also attends the Starting Points vocational program in Rochester Hills. Starting Points was established in 2006, by several mothers, including my wife.

The purpose for my testimony today is to let you know how important your legislative leadership is to our family. We have faith that government can work in developing budget strategies that ensure adequate Medicaid funding is available to Michigan's mental health system, and specifically, Oakland County. These strategies should include plans to:

1. Restore funding to the PIHPs that have received Medicaid budget reductions since 2010.
2. Reverse Oakland County General Fund reductions initiated on 4/1/14 in response to Medicaid Expansion.
3. A more equitable funding distribution method to reduce statewide funding variances without jeopardizing service delivery to our daughter, Maggie.

Representative VerHeulen…our daughter is blessed to be receiving positive and life enhancing experiences through the collaborative and dedicated work between the Oakland County Community Mental Health Authority (OCCMHA) and ourselves. My wife and I feel we are doing our part (private "group home" ownership and vocational program investment) to demonstrate the tremendous value the public mental health system offers the State of Michigan and the community of Oakland County. But, ***the burden is becoming overwhelming to us!***

In closing, my research has shown you have been known to cheer on the underdog. And now with your position, I am hopeful you will be able to persuade the legislature to support our view of the 3 points mentioned above. We will work tirelessly with you to accomplish these goals.

Margaret (Maggie) CasaSanta
32 Years Old
Rochester Hills, MI

Regards,
Dan & Linda CasaSanta

DCHSC
3-2-15
Rev. William Roberts

March 2, 2015

Honorable Representatives:

I am the Rev. William Roberts, a Priest at St. Anne's Episcopal Church in Walled Lake, and a retired elected official from Walled Lake having served 12 years as a Council Member and nearly 32 years as Mayor, and I've worked on 44 municipal budgets, but I am here today as the step-father of Scott Droste, age 47, who is challenged with autism and is a resident of a group home.

When I married Scott's mother 28 years ago, I was concerned that the facility where he was then a resident was not meeting his needs and when he would come for a weekend every other week it took time for him to orient himself. Some 27 years ago we were able to have Scott re-located with Residential Alternatives under jurisdiction of Macomb Oakland Regional Center and Scott has been blessed by the change.

Scott has been in his current home setting, with Residential Alternatives, since August 1998 in Waterford Township and the owner and the home manager are both professional and the staff are caring. He is content with his living situation, which is very important for the well-being of those with autism. The home manager takes Scott to vocational services where he works each weekday and to doctor's appointments. While Scott is healthy, and over the years his social behavior has improved, he is severely challenged regarding his conversation and decision making abilities and will need professional home assistance his entire life. Scott also needs help with crossing the street and personal care.

My wife Alicia is Scott's legal guardian and we are both pleased with the condition and operation of Scott's home. Also, and even more important, Scott is happy with his living situation and changes in his home environment would have a traumatic effect on him and any diminishment of services would have a negative impact on his mental and physical well-being.

These facilities, these homes, that are owned and operated by Residential Alternatives, and similar companies, are small businesses that greatly contribute to the communities they are in through the hiring of caring staff and providing for their clients.

DCHSC 3-2-15
Penny Canada

SUB-COMMITTEE ON APPROPRIATIONS FOR
THE MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

TESTIMONY -March 2, 2015

Hello, My name is Penny Canada and I am the mother of a 19 year old son with a developmental disability. I am also a staff advocate for The Arc of Oakland County, a non-profit agency that promotes full inclusion for people with Intellectual and Developmental Disabilities. My son Drew has developmental disabilities *and* big dreams and is pursuing them thanks to support from Oakland County Community Mental Health Authority, Department of Human Services and Michigan Rehabilitation Service. Drew is an engineering student at the University of Michigan in Ann Arbor, living independently in student housing and receiving 24 hour care. Drew's dream would not be possible without the tremendous help of the government. My husband and I would not be able to afford to fund Drew's staffing to allow for his independence. Your help is needed to remove people from waiting lists and the despair of not even having dreams. My fear is that Drew was raised during the heyday of Michigan's movement to advance the opportunities for people with disabilities. My fear is that the progress that has been made will be eroded.

I am hopeful that the programs, services and supports that have made Michigan a national leader in promoting individuals with disabilities to realize their potential will continue. Unfortunately, my hope is tempered by the reality that changes in funding have already meant losses for those served by Community Mental Health.

It's wrong when you are thankful that your son's disabilities are severe enough to push him near the top of the list for appropriate care. It's wrong that people with disabilities don't have the same access to opportunities because funding is parceled by geography not by need. It's wrong if people who are voting for constituents don't realize the impact they have on those who depend and need their government's help.

Appropriate funding allows people with disabilities to realize a life full of real opportunities, while creating jobs: If there were better programs, parents would have the option to work rather than being a lifetime caregiver for their child. Parents would be healthier without the wear and tear of a lifetime of caregiving. Individuals with disabilities who have an opportunity to develop their skills and abilities will also have an opportunity for a job to become a reality in their future. People that provide care and services will also have jobs. This is the ultimate Win-Win: More jobs and less dependence on social security programs.

I strongly urge your thoughtful consideration about the effects of the FY15 and the proposed FY16 budget reductions to the Oakland County Community Mental Health Authority (OCCMHA). Individuals with intellectual and developmental disabilities will lose services and be severely impacted if Michigan's Department of Community Health continues to reduce OCCMHA's overall budget relative to Medicaid as well as from the general fund (GF). The budgets for FY14 and FY15 were each reduced by $14 million; it is anticipated that the FY16 budget may realize an additional $8-10 million reduction.

Please increase funding to Community Mental Health for people with disabilities. Please help direct funds to where the greatest needs are. Rebasing and redirecting funds evenly to the PIHPS is not a proper solution. We need more real dollars to get to individuals with needs. Your vote for more funding can be the difference for people between living in the fringes of society and in the basements of homes, secluded from the community. You vote can mean participating in a rich life, gainfully employed thanks to programs like Project Reach and Oakland University's Incubator program employing individuals with Autism. It can mean a college experience and education. We as a state need to keep moving forward to help people with disabilities enjoy their civil rights. Michigan is a leader and needs to continue to lead this nation in how to support individuals with disabilities. People with disabilities have inherent difficulties due to their disabilities; it is wrong that a lack on government support would make their life even more difficult. Please visit www.realstoriesrealpeople.org to see the difference that funded versus unfunded supports and services make in the lives of people with disabilities.

It should be the best time to have a disability, given all of the federal and state initiatives to help people with disabilities to receive an education and employment; please don't let it be a hollow infrastructure more and more departments and organizations but no real programs and funding for the individuals these systems are meant to serve. As a parent and advocate, I urge you to use your power and influence, as my elected representative, to protect the most vulnerable citizens of our state and stop these proposed reductions. "...The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped. " ~ Last Speech of Hubert H. Humphrey"

Penny Canada (Canada.penny@gmail.com)

DCHSC
3-2-15
Kent Wood

NORTHERN MICHIGAN CHAMBER
ALLIANCE
ALPENA • BENZIE • CADILLAC • CHARLEVOIX • GAYLORD
PETOSKEY • TRAVERSE CITY • MARQUETTE COUNTY

February 27, 2015

The Honorable Representative Rob VerHeulen, Chair
Appropriations Subcommittee on Community Health
Michigan House of Representatives
124 North Capitol Avenue
Lansing, MI 48909

Dear Chairman VerHeulen;

We are writing regarding the FY2015-16 Department of Community Health Executive Budget Recommendation and its effect on access to rural healthcare in Michigan. Specifically we are concerned about the Governor's proposed elimination of the Small and Rural Access Pool and the Obstetrics (OB) Stabilization Fund, which if enacted would be devastating for business and economic development in rural Northern Michigan communities.

As you may know, combined the northern lower and upper peninsulas are an enormous geographic region that represent 36 counties north of Clare. Less than half of those counties have hospitals with OB service, and only 1 hospital in the entire northern Lower Peninsula contains a neo-natal clinic. For many who chose to call northern Michigan home, their small, local hospital is their only option for any number of critical health services including emergency services, physical therapy, dialysis, outpatient surgeries, and lab testing, just to name a few.

As a region in the state with tremendous growth potential, these are the services that could make or break the difference in our ability to attract and retain talented individuals and families. Eliminating these services or closing these hospitals would require individuals and families to travel many miles for care – in some cases across two or three counties.

Therefore, as an alliance of the eight largest Chambers of Commerce in northern Michigan, representing 12 communities and over 6,500 business and community members, we urge you to restore the $36 million in funding for the Small and Rural Hospital Pool, and $11.2 million in funding for the OB Stabilization Fund. These services are critical to the quality of life and economic development potential in northern Michigan.

Thank you for your consideration of this important request.

Sincerely,

Kent Wood
Director of Government Relations

DCHSC
3-2-15
Barbara Hoffman
(Did not speak)

The time for the state budget battles for fiscal year 2016 battles are drawing near and I want you to know what is important to me. My special-needs brother, John lives in an Angels' Place group home, and he and his housemates cannot afford the cuts that appear to be heading their way again this year. While John cannot vote, his family can and does vote. The Oakland County Community Mental Health Authority is facing an ever-increasing demand for services with decreasing dollars. Funding has been flat for this population for the past 12-14 years and although the proposed 5% cut last year was buoyed up with reserve dollars I understand those dollars are gone. Balanced budgets are important, but to do so at the expense of our most vulnerable citizens is inexcusable.

"...the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped." ~ Last Speech of Hubert H. Humphrey

John is 51 year old Downs' Syndrome man that lives and dies for the Red Wings and Tigers. When the doctors told my parents to put John in an institution 51 years ago and tell family and friends that my mother had miscarried they opted to ignore those experts. Can you imagine the expense to the state if he had lived in one of those draconian institutions for the past 51 years? Instead, we as a family fought for PA 94 142 and John was one of the youngest special needs children to attend school in Michigan almost 48 years ago. He "graduated" at age 26 and has attended JVS in Southfield for the past 25 years. Shortly before my mother died in 2006 we were fortunate enough to place John in one of the Angels' Place group homes. Today there are 300 individuals waiting for the privilege of living in an Angels' Place home.

My family instilled the need to advocate for John when we were all very young. Perhaps unfortunately for you and your counterparts in Lansing we have become passionate, even fierce, about our advocacy for him and others like him. We understand the challenges in caring for John and others like him and we understand the challenge that all group home providers face with the impending cuts under the new budget. If John cannot speak out for himself then it is my pleasure to do the talking for him. We cannot afford to lose another $21M this year. The dollars lost due to re-basing is forcing providers to do more with less when they were already looking at barren cupboards and facing staffing shortages due to poor wages. The thought that redistribution of dollars that will result in significant Medicaid funds not being used statewide and then reverting those funds back to the state's coffers for other projects and purposes is frustrating at best and inhumane at the very least. I just won't stand by and let that happen without a fight.

One of my mother's favorite sayings was "whatever you did for one of these least brothers of mine, you did for me.' Matthew 25:40. In her memory I ask that you reconsider the proposed budget cuts and help me honor the promise I made to her on her deathbed that John would always be cared for.

Please take the time to watch this video so that you can understand and appreciate those that you represent. https://www.youtube.com/watch?v=ANzvZ9OiTsw

Sincerely,

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ATTACHMENT B

Testimony of Elizabeth W. Bauer
before the
Senate Appropriations Sub-committee on Community Health
February 24, 2015

Mr. Chairman, Members of the Sub-committee,

Thank you for holding this hearing today and for welcoming the comments of individuals and organizations concerned with services to persons with behavioral health, intellectual and developmental disabilities, and substance use disorders. My name is Elizabeth Bauer. I am a resident of Ferndale and a long- time advocate[1] for individuals served by the Michigan Department of Community Health (MDCH) and its contract providers. I am also the parent of a 47 year old woman with profound developmental disability who receives services from MORC Inc. The charge you have been given to craft a budget for the Department and the public mental health system as a whole is huge and how you meet it impacts the lives of thousands of men women and children. Thank you for accepting this challenge.

This afternoon I will speak to five issues: They are:

1. Re-basing of funding to the PIHPs (Prepaid Inpatient Health Plans) and the resulting negative impact on recipients of services in the PIHP areas where funding was reduced

2. The importance of General Fund money to meet needs of those not eligible for Medicaid.

3. The importance of direct care personnel and current inadequacy of funding for their wages and benefits.

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[1]Current (among others):
Member, Board of Directors, MORC Inc.
Member, Board of Directors, The Futures Foundation
Member, Quality Care Task Force, Detroit Wayne Mental Health Authority
Member, Education, Outreach and Marketing Work Group MDCH Dual–Eligible Demonstration
Member, The Arc Oakland County
President, Board of Directors, W-A-Y Academy Detroit

Former (among others):
Elected Member Michigan State Board of Education 2003-2011
Executive Director, Michigan Protection and Advocacy Service, Inc. 1981-2001
Director of Community Placement, Metropolitan Regional Office, Dept. Mental Health 1980-81
Director of Training, Michigan Department Mental Health, 1978-1980

4. Structure of the current delivery system and suggestions for structural reforms to make better use of available resources and more effectively meet recipients' needs.

5. A suggestion for the future which could improve public education for children with disabilities particularly those with serious emotional impairments, and intellectual/developmental disabilities including Autism.

When thinking about public mental health and all publicly supported services to people, I keep in mind **the 5As of high quality services.** They are:
Available
Accessible,
Adequate
Acceptable
Affordable

Right now our system does not deserve a 5 A report card. We can do better.

1. Re-basing.

The transformation of the public mental health system from an institutional to community-based delivery model resulted in greater funding to those areas that created the most community-based services than to those areas of the state that did less. In fact, some of the counties, like Oakland, developed community living arrangements for many men and women whose county of origin was other than Oakland. Too often those counties did not reimburse Oakland for the cost of care of people for whom they were responsible and Oakland county providers bore the cost for many years thanks to adequate funding. In 2010 The Michigan Department of Community Health looked at the Medicaid rate structure and saw some counties were getting more funds than others and re-based the funding which effectively reduced rates in the counties like Oakland that had been getting a larger share.

At first the cuts were tolerated as there were an increased number of Medicaid-eligible recipients. However, as the economy improved and the number of Medicaid-eligible recipients declined, the impact of the reconfiguration was great. Now there were too few general fund dollars to support services to these folks and services were reduced. This consequence of the reduction in funding became apparent on the eve of FY 2014-15 and instantly and dramatically changed the situation for recipients of services in counties that lost funding through the re-basing effort.

The stress on the service delivery system at the point where it actually addresses the needs of the beneficiary cannot be exaggerated. Community Mental Health Authorities have tried to meet the challenge to keep their provider network "whole" (some doing a better job than others). The cuts to core providers were taken in part by those agencies and in part passed on to their residential, vocational, and health care service providers.

At the beneficiaries' level we see direct care staffing reduced. Direct care staff – who I posit are the most important people in this hierarchical structure - are working 10 and 12 hour shifts in jobs that are highly stressful under the best of conditions for pay that keeps them living in poverty!

You will receive lots of financial models from those administrative agencies on ways in which funding could be better allocated to meet needs. You will find a way to address the problems posed by the re-basing activity. When you make your decisions, please keep in mind the men, women, and children with intellectual/developmental disabilities, mental illness, and substance use disorders who need life-sustaining, developmental, and health care services and the people who directly provide those services every day and night for 365 days a year.

2. General Fund resources for the public mental health system

In recent years the system has relied almost solely on Medicaid funding. Healthy Michigan, while expanding eligibility for Medicaid services, still does not accommodate all in need. General Fund money in the system allows providers to meet unique needs of persons who are not eligible for Medicaid or Medicare and yet need services that can best be provided in the public mental health system. Yes, there is always the opportunity for providers to charge fees for services. Most will when the recipients are able to pay or have insurance that covers the service. But there are some services that are not covered by insurance (certain dental services for example) and there are families who live sufficiently above the poverty level that they are ineligible for Healthy Michigan and yet too stressed financially to pay for the counseling, Applied Behavior Analysis, dental services, or whatever is needed by the family member with intellectual/developmental disability, mental illness or substance use disorder. As a society, we are all better off when those among us are as healthy in mind and body as possible. General Fund money in the public mental health system allows for flexibility in service delivery. It does not need to be a lot, but it would be very helpful if it was sufficient to serve those most in need.

3. The importance of Direct Care Personnel and current inadequacy of funding for wages and benefits.

As mentioned earlier, the reduction in funding to the PIHPs has been passed on to the core providers in the PIHP network and passed on yet again to contracted providers of community living arrangements and pre-vocational and vocational programs. At each step some reductions have been absorbed and efficiencies made, but **by the time the few dollars left make their way to the provider who actually provides the hands-on service to the people with intellectual/ developmental disabilities, mental illness and substance use disorders, there is very little left.** The provider at this stage can only cut staff and hold wages in check.

The average wage for direct care personnel is about $8.50 per hour. Often they work without health care benefits and more often without any retirement plan. Turn-over is high as one can expect and yet the work they do requires a deep and meaningful relationship with the beneficiary to achieve the goals in the beneficiary's habilitation and rehabilitation plans. As the mother of Virginia who has profound intellectual disability, who does not speak, and relies of staff for most everything, I know immediately when there has been a change in staffing or routine. Virginia's affect will be different. Her behavior

regresses to an earlier stage of development. There were times during her school years when she regressed to infancy when teachers or therapists were changed. These days she lives in a fairly stable environment so we don't see dramatic regression, but we still see changes in affect when staff changes. In other settings where turnover is greater due to difficult working conditions, and low wages, recipients of services are negatively affected in many and diverse ways.

As a result of reductions in staffing, recipients have fewer opportunities for inclusion in community. One staff person cannot easily escort two or three people who use wheelchairs and who need an array of supports on a shopping trip. Nor can staff take one person out and leave two unattended at home. At this point in time, the reductions in funding have created a nearly impossible situation at the service delivery level. To see the heroic efforts of these men and women who actually provide the services for which you are appropriating funding is eye-opening, and genuinely disturbing. It is especially troubling because in the current public mental health "system" there are two, three, and even four layers of administrative organizations above the direct service provider. These administrative organizations have fairly well-paid staff with 40 hour work weeks, benefits, vacation pay, and retirement plans. We can do better.

4. Structure of the current delivery system and suggestions for structural reforms to make better use of available resources and more effectively meet recipients' needs.

I have alluded to the redundancy in the current services delivery system. It reminds me of the "old days" when the Department of Mental Health had Regional Offices that "passed paper" between the contacted service providers and the state. Ultimately someone recognized that the Regional Offices were staffed with high priced people (I was one) who merely reviewed papers that were reviewed yet again at the state level and they eliminated the Regional Offices. I may be too harsh, but working in the Metropolitan Regional Office as Director of Community Placement for Wayne County, I truly felt that passing the contracts for community services through me served only to delay their opening. So keenly did I feel that I was more a block than a help, I never let a contract sit on my desk overnight. If I had to stay until midnight, everything that came in that day was thoroughly processed and on its way to Lansing that night.

When Governor Engler moved to create the PIHP system I was one of the people he appointed to vet the applications for the PIHPs (there were 18 to start) and rather than replace the 57 county community mental health boards, they became yet another layer, embracing the CMHs within them. In some cases e.g. Oakland, Macomb, and Wayne Counties, the CMH became the PIHP. In creating the PIHP structure we added back another layer of bureaucracy. Further, these PIHPs and Boards that became authorities were in the private sector so there was no cap on salaries such as exists at the state level where Civil Service has a say in the rate of pay. Even then, wages at the direct care level were too low and it bothered me to see another layer with high priced administrators established. At the time I had the personnel information for all PIHPs. I calculated the costs and designed an alternative structure that could save money. I presented it to Governor Granholm's transition team and later her Mental Health Commission. It went nowhere. Although the Commission's facilitator from Public Sector Consultants did say "It was the elephant in the living room." So here is the elephant for your consideration. In 2002

there were 94 core providers in the state who would have contracts with the 18 PIHPs. For example, Oakland Community Mental Health Authority had 6 core provider agencies with which they would contract. I suggested that the Department create a 19 person contract monitoring and compliance unit at the state level (I realize no Governor wants to add state employees even when it is the most cost-effective action) to manage the 94 core provider contracts. I figured salaries high at $100,000 per monitor, plus the full state benefit package. Civil service would control the salaries so they would not rise at ridiculous rates. Appropriated funds would go directly from the state to the 94 core providers who would then disburse them through their contract agencies (residential, prevocational, vocational etc.). The PIHP level would be eliminated and, given the funding in the system at the time and including the 19-person unit in state government, the net savings would have been $100 Million!

I can't say what the savings would be today as I do not have the PIHP salaries and other information I had in 2002. However, knowing what some people are earning, I believe the savings would be substantial. There is precedence for eliminating a middle layer of contract management.

I believe that we could pay direct care staff better and provide them with benefits if savings due to restructuring – or even just a portion of those savings - were redirected to the actual service delivery level. The Oakland Press (February 22, 2015) ran an article on the pay given to care givers in the public mental health system. A direct care worker outlined her life, its stresses and more. She works 50 hours a week at a group home and 20 more hours a week for an individual receiving services in his own home. She has been employed for more than 5 years and her pay is now $10.25 per hour. Still she has three children and, as a family of four lives at the poverty level. She said, "Caregivers deserve around $15 per hour because of the responsibility we have in our jobs ....she believes they should earn more than minimum wages and should receive health care for their family members, and vacation and sick time." When I think of the layers and layers of people administering these programs that make substantially more and have all the benefits, I believe we can re-structure in a way that will make it possible for the people who do the most difficult work to live dignified lives above the poverty level.

5. A suggestion for the future which could improve public education for children with disabilities particularly those with serious emotional impairments, and intellectual/developmental disabilities including Autism.

The Potential for enhanced service delivery resulting from the combination of the Departments of Community Health (MDCH) and Human Services (DHS) is huge. As it is now, people have to go multiple places to get the various supports and services they need to live dignified, healthful lives. If the combination of the departments will result in the co-location of education, health and mental health and human services personnel, it will be a giant step forward. I realize your attention this year is on the budget for the Department of Community Health and, come fall, the Senate will organize to form an Appropriations Sub-committee to budget for the combined department (Health and Human Services). I would like you to begin to think holistically even now. This idea may be premature, but there is no time like the present to start to envision a new way to deliver public education, health, and human services.

The Governor has said he wants to **focus on people** and plan for their well-being instead of programs.

If we start with people at their earliest age, we also need to think about education. In a few states and even some places in Michigan, educational entities house public and private health, mental health, and human service personnel. **Pathways to Potential** placed social workers in schools. **Kent School Services Network** has located health and human services personnel –including clinics- in schools. This brings the supports and services closer to the people who use them. It facilitates parental participation in their children's education. It increases compliance with medication and other regimens. It moves the service delivery system toward a 5 A's Report Card.

When the mental health clinician is present in the school and available to work with the student who has emotional issues, teachers can focus on teaching and suspension and expulsion is deceased. This is the subject for discussion another day, but that day must come soon as we are losing too many youth. This is the year that educational policy is being rewritten at the Federal level. Policy-makers are looking for ways to re-engage and inspire youth and address their needs in more than just instructional ways. The Center at UCLA is leading the 2015 National Initiative for Transforming Student and Learning Supports. States already moving in this direction describe this as a paradigm shift from a two-to a three-component framework for school improvement policy. I posit it is also a paradigm shift for community health and human services. As Governor Snyder has said, we should focus on the people and not the programs. When we do this and we look first at a person and his or her array of needs, a more Accessible, Acceptable, Available, Adequate, and Affordable way to organize services becomes apparent.

For those of you who wish to get a head start on transforming our service delivery system to better meet the needs of people, I recommend the following free online book published by UCLA Center. *Transforming Student and Learning Supports: Developing a Unified, Comprehensive, and Equitable System* can be accessed at http://smhp.psych.ucla.edu/pdfdocs/book/book.pdf

The chapters provide protocol frameworks and many specifics for a systemic learning supports component to replace the existing marginalized and fragmented set of student and learning supports in districts and schools. The work also stresses that transformation can be done by redeploying existing resources and garnering economies of scale.) The initiative's URL is: http://smhp.psych.ucla.edu/newinitiative.html

Thank you for considering these ideas. The challenge before you is great. I am confident you will give every decision thoughtful consideration. I encourage you to think boldly, dare greatly. It is possible to create a 5 A's service delivery system with the financial resources at hand if we transform the way we organize and deploy our human resources. I will be pleased to discuss these ideas in greater depth at your convenience.

DCHSC
3-2-15
Robert and
Judy McReavy

MENTAL HEALTH SUCCESS STORY

THIS WAS A PORTABLE SUPPORTS PROGRAM THAT NEW PASSAGES STARTED AS A PILOT PROGRAM IN 2003 FOR MACOMB COUNTY COMMUNITY MENTAL HEALTH.

THIS PROGRAM BECAME A SUCCESS STORY BEYOND BELIEF. IT ALLOWED OUR SON TIME TO PROVE HE COULD LIVE INDEPENDENTLY.

THIS WAS A COST SAVINGS PROGRAM IF TIME OF TREATMENT EQUATES TO DOLLARS. INITIALLY THE TREATMENT WAS FRONT LOADED AND WORKERS WERE IN HIS APARTMENT APPROXIMATELY THREE (3) TIMES PER DAY TO MAKE SURE HE WAS TAKING HIS MEDICATIONS AND WAS STABLE. WHEN HE BECAME STABLE STAFF WAS IN HIS APARTMENT ON AN OCCASIONAL BASIS AS NEEDED.

TREATMENT:

PATIENCE KINDNESS UNDERSTANDING RESPECT

THIS PROGRAM ALLOWED HIM TO PROGRESS AT HIS OWN PACE

THIS WORKS LIKE A THIRD EYE LOOKING OVER HIM.

TREATMENT VARIES ACCORDING TO NEED

WE HAVE SEEN MEDICATION CHANGES WITHIN THE DAYLIGHT HOURS OF A DAY

WE HAVE A 24 HOUR EMERGENCY PHONE NUMBER.

WE HAVE GONE FROM COMPLETE CHAOS TO PEACE IN OUR FAMILY

WE HAVE NOT BEEN THROUGH THE REVOLVING DOOR IN THIRTEEN (13) YEARS WHICH PREVIOUSLY WAS THREE (3) TIMES A YEAR. EX: COURTS - POLICE - COMMITMENT ORDERS - COURT APPOINTED ATTORNEYS - TRANSPORTATION - HOSPITALIZATIONS - COMPLETE CHAOS.

THIS PROGRAM WAS TOURED BY THE DEPUTY DIRECTOR OF MENTAL HEALTH FOR THE STATE OF MICHIGAN AND WAS CONSIDERED FOR A STATE MANDATE

ROBERT B. MC REAVY AND JUDY K. MC REAVY

586 623 0648 586 713 5744

HOPE NETWORK - MENTAL HEALTH DISASTER

HOPE NETWORK DUMPED THIRTY (30) MENTAL HEALTH PATIENTS TO THE STREET FROM A PORTABLE SUPPORTS PROGRAM THEY PROVIDED FOR MACOMB COUNTY. DUE TO THE BUDGET CUTS FROM LANSING THEY REFUSED TO DO THE JOB. HOPE NETWORK CLOSED THE PROGRAM ON DECEMBER 13, 2014.

OUR SON WAS DENIED ACCESS TO A CASE MANAGER FROM NOVEMBER 15, 2013 TO FEBRUARY 15, 2014 - 3 MONTHS! IN FEBRUARY, 2014 THEY HIRED A TEMPORARY PART TIME CASE MANAGER TO HANDLE THIRTY (30) PATIENTS.

AS GUARDIANS WE WERE NOT NOTIFIED THAT A NEW DIRECTOR WAS HIRED IN AUGUST OF 2013. IN JANUARY OF 2014 WE WENT TO THE OFFICE TO SPEAK TO THE DIRECTOR BECAUSE NO ONE ANSWERED THE PHONE WHEN WE CALLED THE NUMBER WE WERE GIVEN. WE WERE INFORMED BY KAELENA HANSON THAT SHE HAD BEEN THE DIRECTOR SINCE AUGUST, 2013. SHE TOLD US THEY DID NOT HAVE ENOUGH STAFF TO TAKE CARE OF ALL THE PATIENTS AND OUR SON KIND OF GOT LEFT OUT.

IT WAS DETERMINED THAT HE WAS DECOMPED 75% BELOW HIS BASE LINE BY HIS PREVIOUS CASE MANAGER WHEN THE PATIENT ADVOCATE ASKED HER TO RE ASSESS OUR SON.

ON A SATURDAY IN OCTOBER, 2014 MEGHAN SLATER - HOPE NETWORK STAFF CALLED US AT 10:30 AT NIGHT TO TELL US THEY WERE GOING TO CALL THE POLICE AND HAVE THEM DO AN ANALYSIS BECAUSE HOPE NETWORK DID NOT HAVE STAFF AVAILABLE.

WE ASKED OUR OTHER SON TO PLEASE CHECK ON BOB. HE IMMEDIATELY WENT TO THE APARTMENT AND CALLED US TO TELL US THAT BOB WAS SITTING AT THE KITCHEN TABLE AND THEY WERE HAVING A CONVERSATION AND BOB WAS TALKING JUST FINE. WE ASKED MEGHAN SLATER TO PLEASE NOT CALL THE POLICE THAT BOB WAS ACTING JUST FINE, BUT SHE REFUSED. CALLING THE POLICE CAUSED ANOTHER MAJOR SET BACK.

HOPE NETWORK SPENT ONE (1) YEAR REFUSING TO DO THE JOB AND DENYING TREATMENT BECAUSE OF THE BUDGET CUTS IN LANSING.

IT TOOK HOPE NETWORK ONE (1) YEAR TO DESTROY A PERFECT PROGRAM.

UNDER A PREVIOUS OWNER - NEW PASSAGES - THIS PROGRAM WAS A SUCCESS BEYOND BELIEF. OUR SON HAD NOT BEEN THROUGH THE REVOLVING DOOR OF HOSPITALIZATION FOR TWELVE (12) YEARS.

HOPE NETWORK IS NOT FIT TO TREAT MENTAL HEALTH PATIENTS. THEY SHOULD BE RUN OUT OF THE STATE OF MICHIGAN.

ROBERT B. MCREAVY AND JUDY K. MCREAVY

586 623 0648 586 713 5744

NOTE: The housing subsidy of $350.00 was also eliminated on December 13, 2014

TALKING POINTS

FACTS THAT WE LIVE WITH AS FRIENDS AND FAMILIES OF THE MENTALLY ILL

1. WE ARE AFRAID TO DIE AND LEAVE OUR CHILD AT THE MERCY OF A FAILED MENTAL HEALTH SYSTEM.
2. IF YOU TAKE A PERSON WHO IS MENTALLY ILL TO A MENTAL HOSPITAL, YOU HAVE TO FIGHT WITH THE HOSPITAL TO GET TREATMENT.
3. PREMATURE RELEASE FROM A HOSPITAL WITHOUT STABLIZING THE PATIENT IS AN ONGOING PROBLEM.
4. FAMILY MEMBERS SHOULD NOT HAVE TO MICRO-MANAGE PROVIDERS OF MENTAL HEALTH CARE.
5. RECIPIENT RIGHTS CHARGES SHOULD GO TO A HIGHER AUTHORITY THAN THE DIRECTOR WHO IS IN CHARGE OF THE PROVIDERS CAUSING THE PROBLEM.
6. GENERIC MEDICATION FOR MENTALLY ILL PEOPLE SHOULD BE THE DECISION OF A DOCTOR NOT AN INSURANCE CLERK.

Detroit Free Press
OPINION
313-222-6583 letters@freepress.com

Editorial

State can't afford to keep best medicines from mentally ill

County jails and state prisons, tragically, have become Michigan's largest mental health care facilities, after two decades of policies that have dismantled the mental health care system.

Michigan closed psychiatric hospitals during the 1990s without putting additional resources into community-based mental health programs. And now, those programs face even deeper cuts.

Shortsighted legislation, now before the House, would further weaken and erode Michigan's anemic mental health care system by limiting access to medication for people with mental illness and epilepsy.

House Bills 4733 and 4757 would strip Medicaid patients with these conditions of drug access protections. They would, in effect, reverse laws enacted in 2004 to maintain access to single-source drugs — in other words, drugs with no current generic equivalents — by requiring prior authorization for certain drugs not on the state's preferred drug lists. Getting that would require patients to have a failure period with a generic drug, a dangerous practice for people with serious mental illness.

Drugs under patent don't have generic matches. Thus, patients without access to them would get generics for a different drug, not simply a cheaper version of the same drug.

It's already happening at the Michigan Department of Corrections. Earlier this year, it adopted a policy to dramatically decrease the use of brand-name psychotropic drugs like Seroquel. It requires prison mental health staff to use cheaper generic medications whenever possible, but Seroquel has no generic equivalent.

Prescription decisions are best left to physicians, not broad legislative mandates. Michigan will start saving millions of dollars next year after the patents on four major drugs expire and those markets open to generics.

The House bills aim to save about $6 million in brand-name drug costs, but those estimates don't include increased emergency room visits, prison, homelessness, acute care and other costs that such changes would incur, said Mark Reinstein, president of the Mental Health Association in Michigan. He cited a 2008 study in Ohio that estimated taxpayers would spend four times as much with a similar policy.

The bills would also deprive patients of new, breakthrough medications still under patent.

Gov. Rick Snyder said during the campaign that destroying Michigan's mental health care system was a mistake, something he hoped to correct if elected.

He can start by convincing backers of these shortsighted and fiscally imprudent bills that keeping the best medicines from mentally ill patients is a policy Michigan can't afford.

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ATTACHMENT A

Financial and Statistical

Analysis of Oakland CMH Services

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June 24, 2014

(Reviewed March 2, 2015)

Profile of Oakland CMH Individuals Served, Developmental Disability Support Measures

- **40%** (1,440) of our population require 24/7 paid supports (this includes AFC, FFC, and Private Residence)
- **28%** (1011) of our population does not communicate by using the English language – use of interpreters, assistive technology, foreign language, sign language, gestures, vocalizations, behaviors, or have no ability to communicate
- **30%** (1098) of our population has no ability or difficulty in the ability to make self understood
- **43%** (1546) of our population requires full assistance in all areas of community assistance such as leisure activities, money management, reading, writing, transportation, shopping, and socialization
- **17%** (616) of our population have the inability to swallow food without modification – liquid, puree, minced, thickened liquids, oral and parenteral (IV, G-tube, J-Tube).
- **84%** (3042) of our population need some level of assistance in taking medications.
- **52%** (1881) of our population requires full assistance in one or more area(s) of personal care
- **25%** (899) of our population has very little or no relationships with people defined as natural supports.

- **14%** (492) of our population need extensive or total support with mobility.
- **4%** (158) of our population are at risk with their unpaid caregiver support system

Issues that Threaten On-Going Care in 2014 Immediately and Beyond

Loss of State General Fund (GF)

In anticipation of the advent of Healthy Michigan last April, the state passed along a 60% reduction in GF dollars to OCCMHA. It was, and some suggest remains, the intent that Healthy Michigan will more than make up this shortfall. Because Healthy Michigan is limited to those who actually qualify for the program, the loss of GF will have a dramatically negative impact on our services. In particular, there are over 200 MORC individuals who rely on GF to fund respite services. Most of these are minors living with family. MORC identified only 12 of these who may qualify for Healthy Michigan. **The rest will simply lose their benefits under MORC.** This will not only present a hardship on families today, it will likely accelerate the demand for more

costly services such as residential placement and other supports once these young people qualify for Medicaid benefits.

Impact of Medicaid Rebasing

OCCMHA's impact from re-basing of Medicaid rates resulted in a $14 million reduction in its Medicaid funding effective 10/1/2013. Through the use of Medicaid savings and Medicaid ISF, OCCMHA covered all but $464,000.00 for the current fiscal year, which MORC has been required to contribute. Once their savings have been exhausted, OCCMHA expects to reduce MORC's budget much further.

At present the DD system accounts for nearly 60% of all Medicaid spending in Oakland County. In addition, OCCMHA advises that they have also been over spending in Medicaid for the past three years. The combination of Medicaid re-basing, elimination of over spending and elimination of Medicaid reserves is expected to result in a $20 million shortfall beginning 10/1/2014. Using the current calculation, this means that **MORC will be expected to absorb an $8.2 million reduction against our $135 million OCCMHA contract[1].**

While reductions in General Fund and Medicaid rebasing are bad enough, when combined with the following realties, the effect is greatly accentuated.

1. Lack of Cost of Living Adjustments
2. Lack of Acuity of Care adjustments
3. Lack of Adjustment for Private Duty Nursing demand.
4. Lack of adjustment for School Completers requiring vocational programs.
5. Lack of adjustments in pay for Caregivers

- **Lack of Cost of Living Adjustments**

Medicaid capitation rates were first deployed in fiscal year 1999 using FY98 fee-for-service data, rates and service array. The capitation rates were to have been adjusted each year to account for changes in population and cost of living. The last upward adjustment strictly for cost of living was in FY04. Nothing is factored into the rates to account for routine cost of living even as the overall Consumer Price Index reflects a 28.4% rise in the past ten years. As a result, our payment per case has remained relatively static for the past ten years.

The fact is that, while our community based program was at one time the object of envy across the country, our payment structure has left us stuck in neutral while expenses go speeding past. Every year the costs of providing services increase and our providers have to endure. They even consider themselves lucky if they're not cut from the previous year's budget. The truth, of course, is that a continuation budget is a reduced budget, as the cost of doing business becomes a force on its own.

[1] Eliassen, A., Summary of med and gf reductions.xls, Oakland County Community Mental Health Authority, June 18, 2014.

This truth was borne out by Kathy Haines of MDCH at the Improving Outcomes conference, where she noted that funding for the CMH system has increased by 13% since 2009, while demand for service has increased....13%. This lack of regular adjustment to rates is illustrated in recent studies that show, after years of national leadership, Michigan now ranks 31st in its community based support for persons with long term care needs[2].

- **Lack of Acuity of Care Adjustments**

The needs of the people receiving DD care is increasing in demand and complexity. 30% of people served by MORC are over age 50. We are now treating not just disabilities related to the cognitive and physical impact of developmental disability, but those related to aging, as well. With improvements in healthcare technology, and as the result of better care delivered in smaller, more intimate settings, people are living longer. The issue of Private Duty Nursing illustrated below is a case in point. Each of the Private Duty Nursing cases represents a child aging off the Children's Special Health Care Services (CSHCS) program. CSHCS is designed to serve those children with the most significant chronic illnesses and disabling conditions through age 21. The fact is that these children are outliving their benefit. **There is no provision in budgeting to account for acuity of need for our service population.**

We have also seen dramatic growth in our reliance upon care in unlicensed personal residences. In point of fact, fewer than 30% of people served by MORC in Oakland County reside in "traditional" licensed settings. This approach is consistent with newly published federal rules concerning allowable Medicaid expenditure under the waivers.[3] However, these services delivered in unlicensed versus licensed settings are **30.3% more costly**, on average.[4] **There is no provision in budgeting to account for increased use of unlicensed settings.**

- **Lack of Adjustment for Cost of Private Duty Nursing (PDN)**

Six PDN cases are moving from either State Plan coverage or Private Insurance Coverage to Hab Waiver Coverage under MORC this fiscal year. The Medicaid PDN rate is **$35/hr.** Anticipated daily cost is between **$420 and $560/day each** just for PDN supports. This does not include PDN Respite services which will need to be added, again, at $35/hr.

These six cases represent full year cost of **$1,124,200.00** for nursing services only. Each case will also require Supports Coordination and MORC Nursing authorization. Most will need PDN respite nursing and community living supports staffing. In addition to these six this year, we are aware of two individuals who will move to Hab Waiver PDN services in FY 2016

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[2] Reinhard, S. et al, Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Disabilities, and Family Caregivers, The Commonwealth Group, 2014.

[3] Department of Health and Human Services, Centers for Medicare and Medicaid, Fact Sheet: Summary of Key Provisions of the Home and Community Based Services (HCBS) Settings Final Rule (CMS 2249-F/2296-F), January 10, 2014.

[4] Teninty, L. and Howard, K., Historical Utilization Analysis: Services and Historical Utilization Analysis by Draft Level for Oakland County Community Mental Health Authority, Human Services Research Institute, May 12-13, 2014.

and one in the first quarter of FY 2017. **There is no mechanism to recognize these costs from state or county funders.**

- **Lack of Adjustment for Increase in School Completers Identified for Vocational Programs**

In Oakland County, we have **79** school completers identified with vocational services beginning in June 2014. Our average cost for vocational services (not including transportation) is **$15,034.05** per person. This will result in additional full year cost of **$1,187,690.00** to serve these individuals. **There is no budgetary adjustment anticipated for these individuals.**

- **Lack of Adjustment for Caregiver Wages and Provider Strain**

The last year the state supported a direct care wage increase was in FY08 and it was $0.10 per hour. The average hourly pay is $9.06 per hour for employees offering residential care[5].

. As a result of these poverty level wages, direct care staff turnover is higher than ever, often exceeding 50%. The cost for recruitment, hiring and training replacements taxes and already reed thin margin and is exceedingly disruptive to persons receiving services.

Providers are becoming increasingly disillusioned with the community living business as they deal more than ever with workmen's compensation claims, injuries, difficulty in paying for additional staff in emergencies and heavy handed scrutiny from Rights officers. The latter has led to two seasoned and exceptional group home providers relinquishing their homes this summer. **MORC rates and payments have no inflationary or cost of care accelerators and, as a result, these conditions are expected to continue or worsen.**

Something as simple, yet as important as the increased cost of gasoline is enough to rock the program. Ten years ago (when the cost of living was 28.4% less) the price per gallon of gasoline has risen from $1.50 to $3.71[6]. There has been no appreciable recognition of this increase other than to make it harder for caregivers to get to work, and reduce the number of times individuals can leave their homes.

The impact of these cuts ahead will be unhealthy, confining, and more than unpleasant for the people we serve. As providers reduce staff, the caregivers will be expected to do more, with little or no compensation. The home atmosphere will undoubtedly be strained. We can expect less individual attention and less focus on the details that make residences feel like homes.

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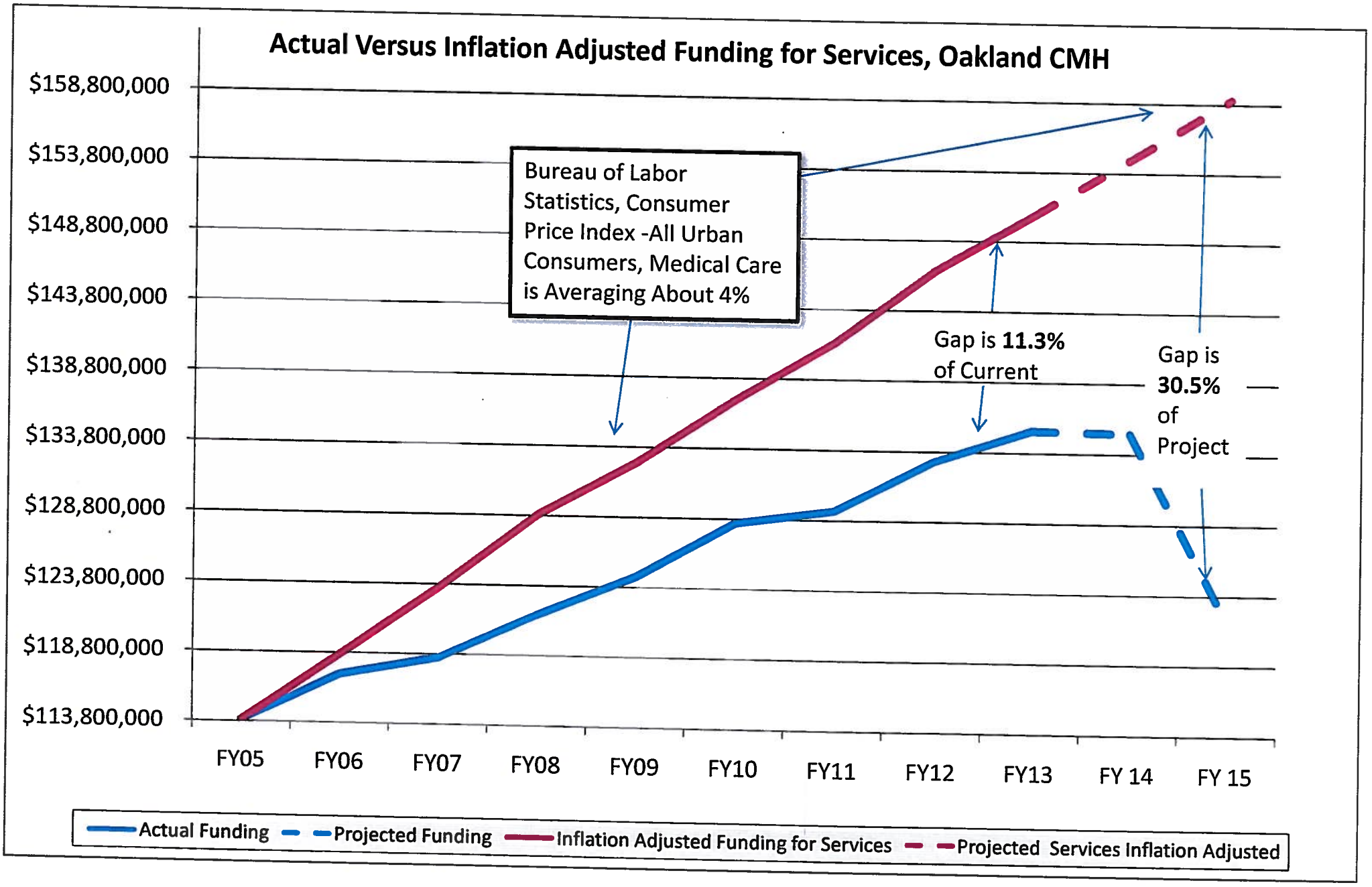
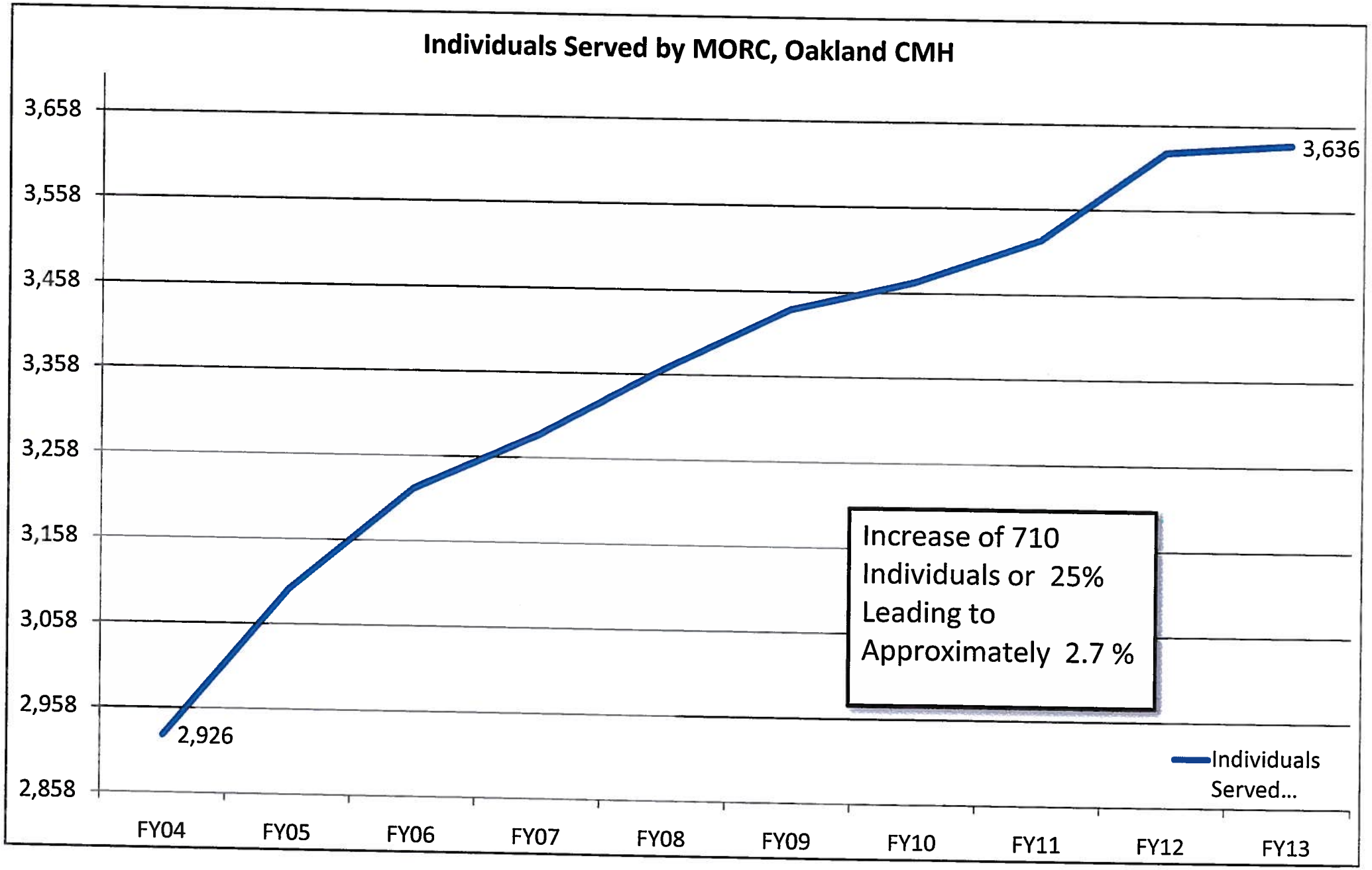
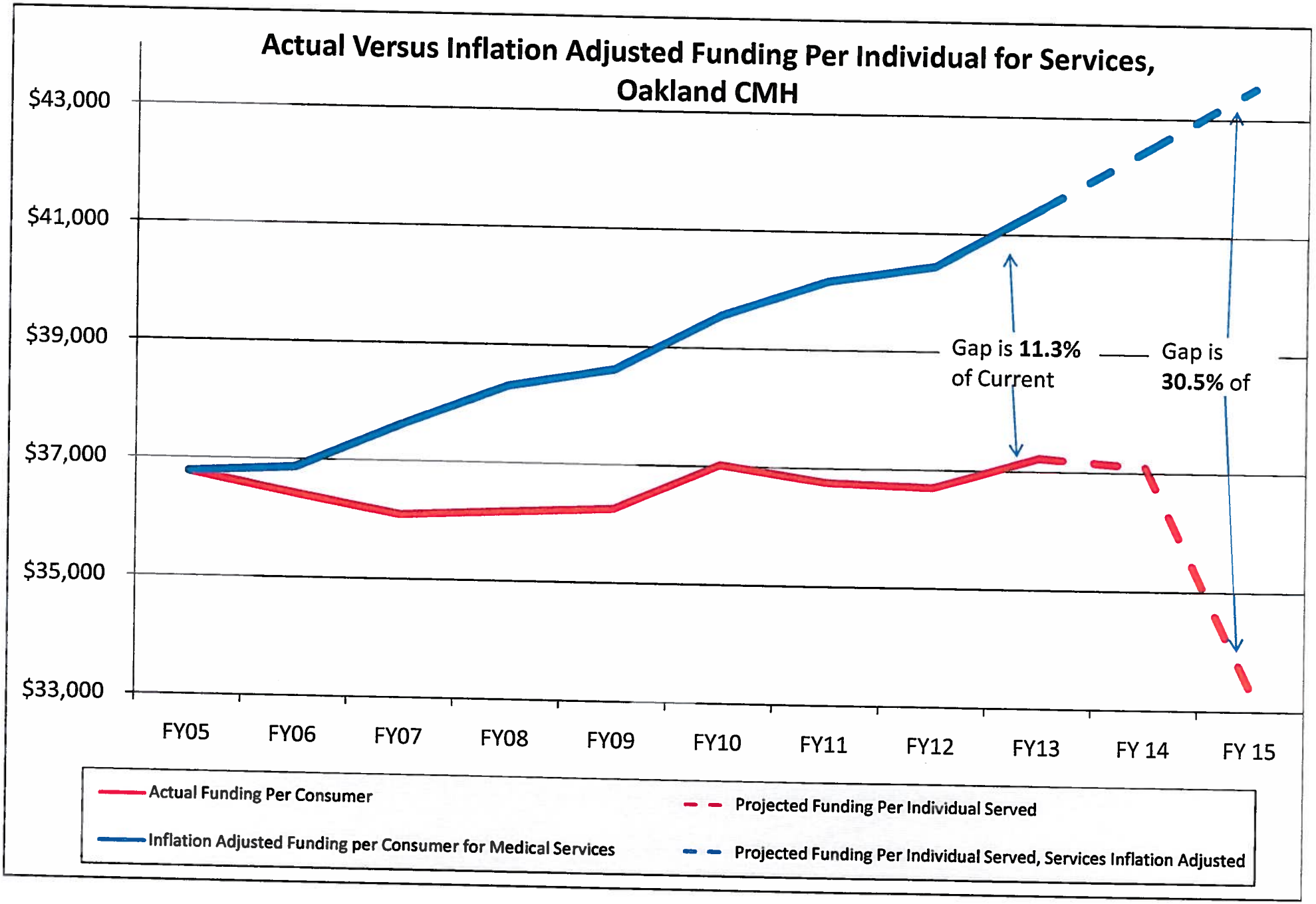
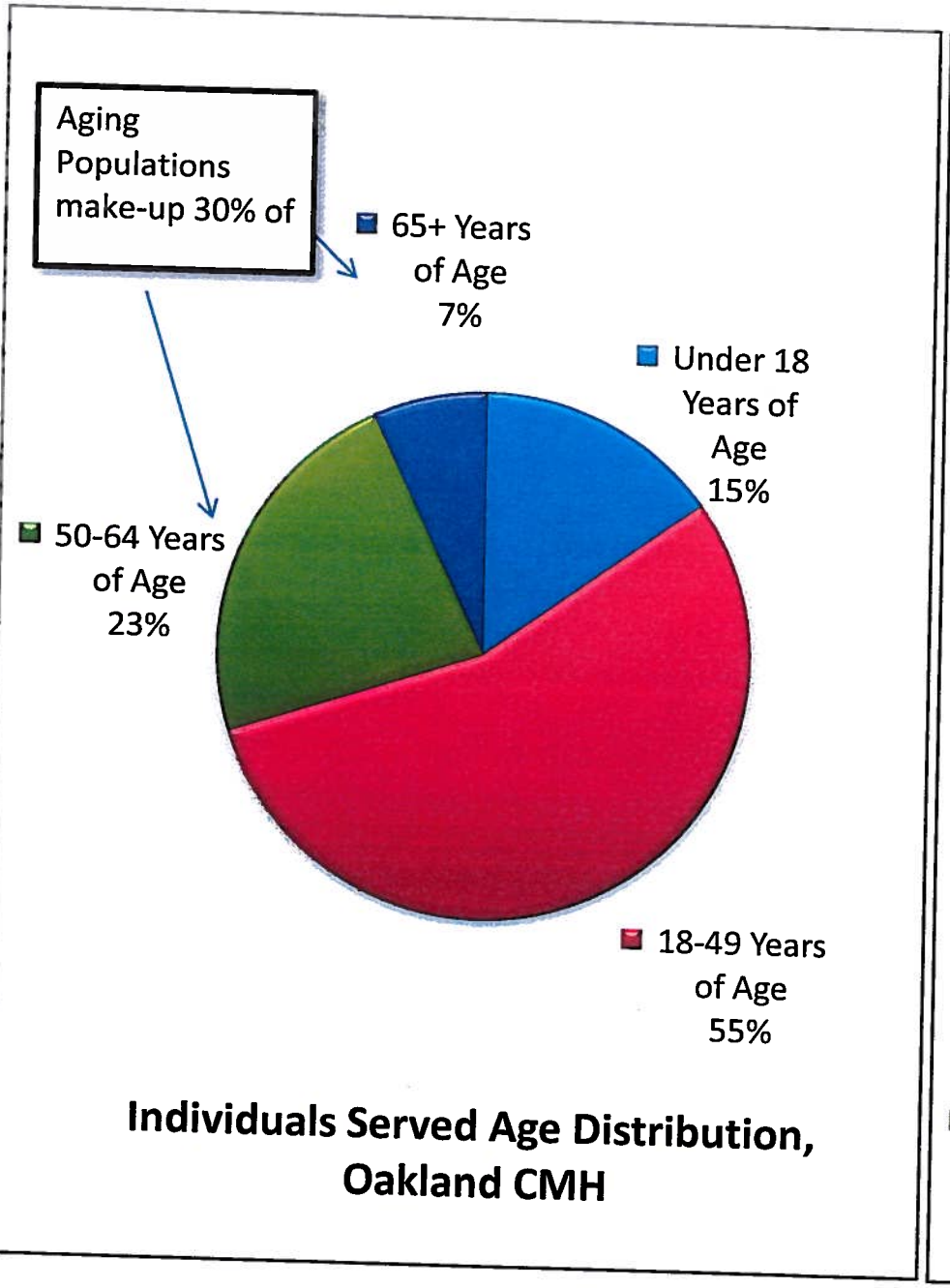
[5] Bridges, T. and Hollis, T. Findings from a Survey of Community Mental Health Provider Organizations: Understanding Michigan's Long Term Supports and Services Workforce, March 2013, Pg. 7.

[6] U. S. Energy Information Administration, Midwest Regular All Formulations Retail Gasoline Prices, January 2004 – June 2014.

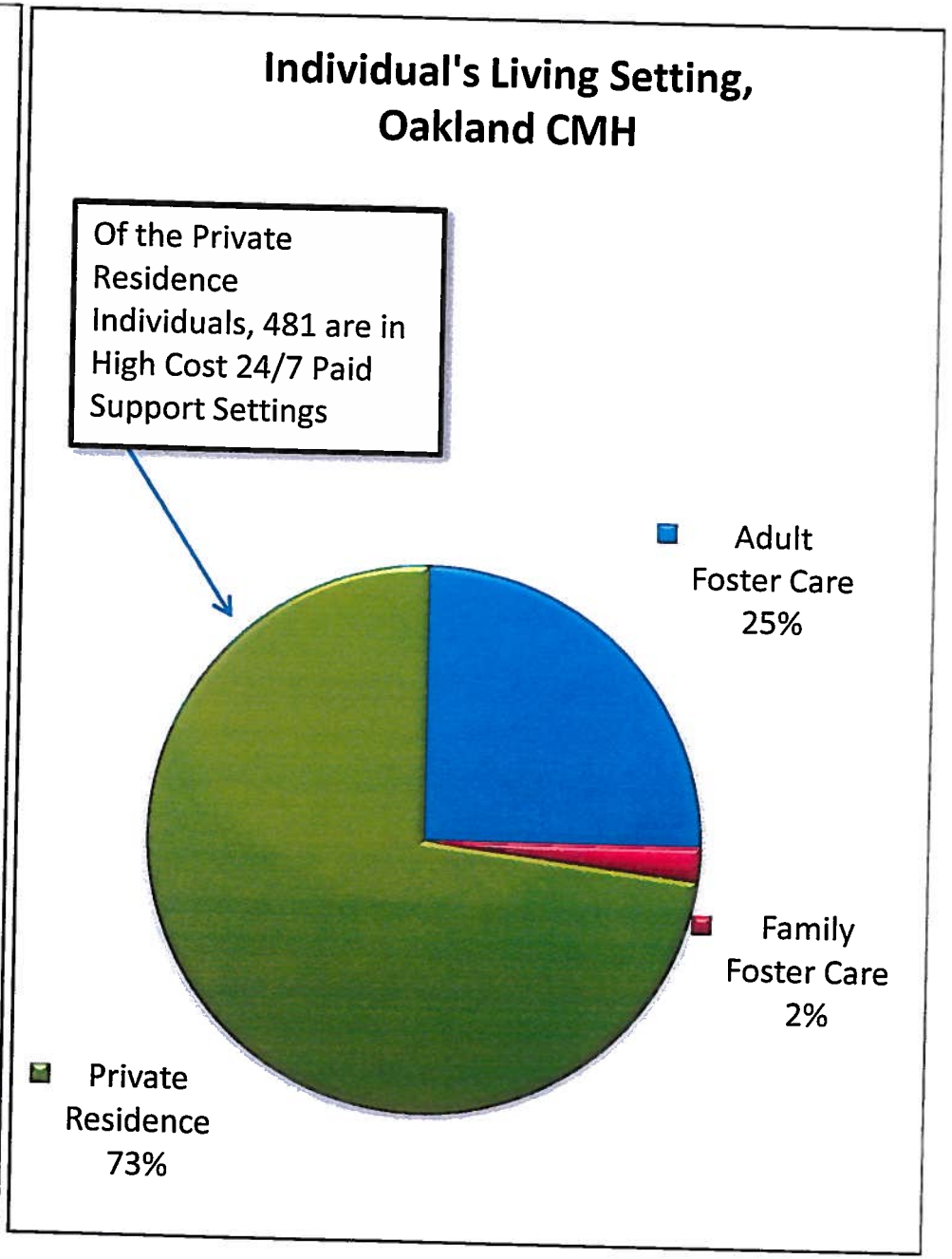

Actual Versus Inflation Adjusted Funding for Services, Oakland CMH
$158,800,000
$153,800,000
$148,800,000
$143,800,000
$138,800,000
$133,800,000
$128,800,000
$123,800,000
$118,800,000
$113,800,000
Bureau of Labor Statistics, Consumer Price Index -All Urban Consumers, Medical Care is Averaging About 4%
Gap is 11.3% of Current
Gap is 30.5% of Project
FY05
FY06
FY07
FY08
FY09
FY10
FY11
FY12
FY13
FY 14
FY 15
Actual Funding
Projected Funding
Inflation Adjusted Funding for Services
Projected Services Inflation Adjusted


Individuals Served by MORC, Oakland CMH
3,658
3,558
3,458
3,358
3,258
3,158
3,058
2,958
2,858
3,636
2,926
Increase of 710 Individuals or 25% Leading to Approximately 2.7 %
Individuals Served...
FY04
FY05
FY06
FY07
FY08
FY09
FY10
FY11
FY12
FY13


Actual Versus Inflation Adjusted Funding Per Individual for Services, Oakland CMH
$43,000
$41,000
$39,000
$37,000
$35,000
$33,000
FY05
FY06
FY07
FY08
FY09
FY10
FY11
FY12
FY13
FY 14
FY 15
Gap is 11.3% of Current
Gap is 30.5% of
Actual Funding Per Consumer
Inflation Adjusted Funding per Consumer for Medical Services
Projected Funding Per Individual Served
Projected Funding Per Individual Served, Services Inflation Adjusted



Individuals Served Age Distribution, Oakland CMH



MORC Professional Staff Assigned to Oakland CMH Individuals Served

Professional Staff Assigned			Difference	
	FY 01	FY 13	Number	%
Support Coordinators	70.3	63.4	-6.9	-10%
Registered Nurse	24.6	9.8	-14.8	-60%
Occupational Therapist	8.5	2.9	-5.6	-65%
Speech/Language Pathologist	6.5	0.7	-5.8	-89%
Psychologist	16.6	6.8	-9.8	-59%
Registered Dietitian	5.0	2.2	-2.8	-56%
Total	**131.5**	**85.8**	**-45.7**	**-35%**

NOTE- Total assumes 72% of clinical staff are assigned to OCCMHA consumers. Does NOT include staff assigned through CRS.

Clinical Services - 2002-2014

	2002 Services No Longer Provided in 2014	Current (2014) Services
Dietary	• Menu development services • Weight loss assistance • Food preparation assistance • Food service inspections • Wellness programs	• Providing evaluations only for those who have nutritional deficiencies resulting in mal-nourishment, individuals who each via a tube and severe diabetes and renal failure • Little coordination with families, physicians, staffing providers
Nursing	• Annual evaluations for all individuals • Nursing care plans for all individuals on psychotropic medications • Discharge planning for all individuals admitted to the hospital • Monthly home visits for all individuals with on-going services	• Only seeing individuals with unstable co-occurring physical conditions • At best, individuals are seen quarterly and only if unstable.
Psychology	• Active treatment plans for all individuals on psychotropic medication and those with restrictive programming • Monthly home visits (for monitoring and staff training) for all individuals with on-going services • Skill-building treatment plans	• Only seeing most severely co-occurring • More short-term intervention • Inadequate services due to increased drug and alcohol misuse; delinquency/justice issues • Over reliance on the use of psychotropic medication • Increased use of psychiatric hospitalizations • Increased use of calling 911 for "behavioral" issues
OT	• Therapy in the following areas: o Swallowing disorders o Range of motion o Sensory integration o Mobility training • Skill building treatment plans • Quarterly monitoring • On-going staff training	• DME (durable medical equipment) primarily – some sensory • Increased need for DME given aging of population • Spending more time dealing with insurance issues – increased documentation requirements; addressing denials and appeals;

		contacting multiple vendors • Insurance requirement of office activities precludes ability to observe in the natural environment and work with caregivers
Speech	• Communication training/therapy • Assistance with augmentative communication devices	• Focusing on swallowing disorders primarily • No therapy is provided
Recreation	• Evaluations • Direct therapy • "Recreation Quarterly" listing events in the community	• Total reliance on community opportunities • Minimal collaboration with community recreation organizations •
All disciplines	• Clinician attendance at all person centered planning meetings • The focus is on emergency/urgent needs only • Annual re-evaluations • Frequent home visits (weekly-quarterly) focusing upon caregiver support and training	• Little face to face collaboration with other disciplines and supports coordination • Providing service independent of other disciplines – Medicaid doesn't recognize overlapping services • Infrequent attendance at person centered planning meetings • Documentation for assessments is taking longer in order to meet insurance standards • Focus is on keeping people out of hospitals (physical and psychiatric) • Over-reliance on unskilled direct service workers to make medical judgments • Over-reliance on providers for on-going training of unskilled direct service workers • Infrequent clinical observation and oversight to observe and prevent caregivers errors • Increased burden on support coordinators • Insurance standards/requirements, need for authorizations has slowed service delivery

Individual Stories

Dan

Dan was overweight and participated in the Wellness classes offered by the dieticians. As a result of his participating, his health improved, he no longer took diabetic or hypertensive medication, his self-confidence improved, he socialized more and wanted to be a mentor to others in their weight loss journey. Due to workload, the dieticians are no longer able to offer the Wellness program and since then, Dan has gained most of the weight back, he is back on his medication, and has lost opportunities for greater self fulfillment.

Robert

The importance of dieticians is critical when individuals have feeding tubes because the general medical community is not knowledgeable about adequate nutrition. One of the most extreme examples of this is Robert who was discharged with 1 can of ensure per day which is 250 calories. He was 6 foot tall and 160 pounds. Luckily, 3 days later, the staff notified the dietician who was able to modify the diet so that he was no longer mal-nourished and dehydrated (which could've led to renal failure and death). At the time, the dietician was able to respond that day. With the current workload, it may have taken several days before the dietician could've addressed the situation.

Patty

Patty's current (2014) plan includes seeing the nurse every 3 months due to multiple health conditions related to her Down's Syndrome diagnosis – blood clots, pressure sores, hypertension, dementia, diabetes, seizures, obesity, MRSA and she is currently non-ambulatory. The nurse happened to be at the home visiting one of her housemates and noticed that her eye was full of blood. Patty was not due to have the nurse visit her for another 2 months. The staff reported that she had been seen by her primary care physician the month prior for her eye and was told that it was fine and related to her Coumadin. The nurse prompted the staff to take her immediately to the emergency room. She was admitted to the hospital's ICU with a brain bleed. If the nurse had not been visiting another individual, she would've most likely experienced a stroke. She is now back at her home and enjoying her life. Historically, nurses would be seeing individuals at a minimum of once per month and would be able to identify and prevent conditions before they became crisis situations.

Pauline

In 2013, Pauline was admitted to the hospital for a seizure and at discharge, her staff noticed that she was experiencing some respiratory issues. The nursing staff at the hospital administered a breathing treatment and sent her home (despite staff's expressed concerns). She died 1 ½ hours later at home. In the past, a nurse would've been at the discharge and would have been able to advocate for re-admission.

Steve

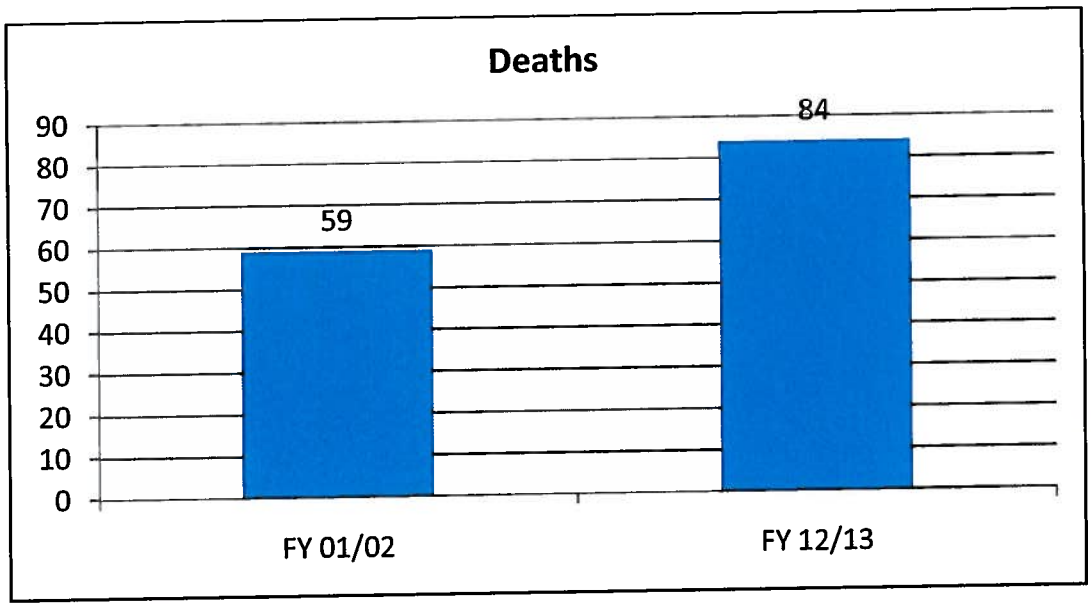
Steve used a power driven custom molded wheelchair for ambulation. The occupational therapist (OT) was seeing him and his staff at both home and his work setting frequently (4-6 week intervals) regarding positioning, range of motion, wheelchair maintenance, transferring techniques. As OT services were less available, he only saw the OT once per year at best, he missed much work due to the wheelchair or lift not working or health issues. Over time, he developed frequent pressure sores and his range of motion decreased (from lack of oversight and on-going training of caregivers) and his overall health deteriorated. Pressure ulcers, which are avoidable, oftentimes can lead to death. Steve has since passed.

James

James is an individual who has significant quadriplegia and utilizes a wheelchair for ambulation. It is highly likely that he does not have a cognitive impairment although he is non-vocal. In 2002, he was being seen regularly by the speech therapist because he was using an electronic device which he was able to operate with the little movement he had in his hand. The device required regular updating and maintenance that the speech therapist did. In addition, the staff needed training on how to support James in the use of the device. Since the speech department currently includes only 1 therapist, services for those with augmentative devices is non-existent and James has lost his voice.

Outcomes for Individuals

- Less coordination of services
- Delay in delivery of services (waiting for authorizations)
- Fewer direct service professionals (DSPs)
- Management/leadership of DSPs is spread too thin
- Increased reliance on emergency rooms and urgent care centers
- 42% increase in deaths



Future challenges

Aging population

Autism increase

Increasingly complex individuals – those involved with the justice system, substance misuse

No institutional settings for the most challenging to serve

Increased costs of choice and personal residences

Insurance covering less (i.e. DME)

Documentation requirements for insurances have increased

DCHSC
3-2-15

Gerald Provencal
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Clinton Township, MI 48038
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Testimony of Gerald Provencal
Executive Director, MORC
(Macomb-Oakland Regional Center)
before the
House Sub-committee on Appropriations on Community Health
Robert VerHeulen
Chairman
March 2, 2015

Mr. Chairman, Members of the Sub-committee,

Today we are both thankful for your attention to our concerns and appreciate that you have a difficult and complex task ahead of you. I along with my fellow colleagues and advocates, thank you for your time and sincere interest.

I have been thinking hard about the best way to convince you that the needs we are pressing you to regard as having a higher priority than pot holes, and other important matters, are indeed the most critical.

In the process I keep coming back to this: the best way of fully understanding the lives and the circumstances of people with developmental disabilities is to spend time with them in their homes, on work sites, with their families, their providers, and their precious caregivers. Look, see, feel, and listen to those who are closest to the action, ask them what matters most, least, and not at all.

The perspective that comes from such visits even if you've done this in the past, will be freshly revealing. It will help you determine the clearest assessment of our situation today. We would be privileged to set up tours to meet with those who could give the most unadulterated picture, we could attend, facilitate or be left behind. The important part is the picture told by those who know it best.

- I have supplied you with a document prepared by our Agency in June of 2014. It remains relevant today. The figures and conclusions are unequivocal. They show a program which serves over 3,700 individuals from Oakland County, all of whom have developmental disabilities. They all have had to contend in one way or another with the following:
    1. A steady decline in budget for services;
    2. A reduction in professional and direct care staff;
    3. An increase in numbers of consumers served;
    4. An increase in the complexity of need of those served;
    5. A rate of inflation rendering the U.S. Dollar 28.4 less in purchasing power than 12 years ago;
    6. An extraordinary increase in the cost of durable medical supplies;

7. An increase in the age, infirmity, and complications stemming from an ever-aging population among those we serve.

- We have a direct care workforce that is pathetically underpaid, at an average of $9.06 per hour, leading to unacceptable turnover, inconsistent treatment of consumers, and a workforce more than heavily relied upon and not prepared for the rigors of the future with its lack of promised income.

  These direct care staff, we must always remember:

  Nurture, counsel, comfort, teach, train, bath, feed, protect, mentor, guide, fight for, advocate for, those with the greatest needs. Yet, these staff are the first to be blamed, reprimanded, scapegoated, and fired.

  For all these reasons, it's clear that the pyramid of importance is upside down: those who matter most to the person with the disability, receive the least pay, recognition, and have the bleakest future.

- The scope of our services at MORC (The Macomb Oakland Regional Center) relies on approximately 10,000 caregivers, full and part time, for our 3,700 Oakland County citizens. When considering the great injustice of poverty wages paid to the caregivers, it must be noted and underlined in the boldest of ink that:

  Direct care staff who were State of Michigan (Department of Mental Health) employees working in institutions earned over $12.00 per hour, with a handsome health insurance and retirement package as well in ***1989***!

  Twenty Six years later, the average hourly wage hovers around $3.00 less.

  It is an inescapable truth that we have to reinvest in our caregivers by creating career ladders, fair wages, respectable images of their contributions and importance. Anything less not only devalues those doing this important work, it devalues those who rely on the rest of society to treat them properly.

- MORC (The Macomb Oakland Regional Center) was a State Department of Mental Health Agency from 1972 to 1996. Over that 24 year period, MORC did pioneering work in the field of developmental disabilities. The Agency was the catalyst in moving institutional residents from back wards to homes in the community at large. This was true in spite of widespread, volatile community resistance and litigation. MORC leadership was not only true in Michigan, but across the United States as well. Along with scores of local providers of residential and vocational nonprofits, MORC opened hundreds of homes and work opportunities throughout the metropolitan region. This all resulted in the closing of State institutions and opening worlds of opportunities not previously available to people with disabilities.

  Over the 24 years, MORC not only operated a program of national and international renown, but also distinguished itself by staying on budget, satisfying all audits, accreditation standards, and every type of monitoring review, by meeting or surpassing the highest standards for each.

- Things changed in 1996 when Oakland County Community Mental Health became "Full Management", then an "Authority".

MORC was converted from a State of Michigan Department of Mental Health Agency to a nonprofit entity which contracted with the new Oakland authority to provide services. This relationship continues to the present day, and there are difficulties with the relationship.

A large part of the difficulty in our view, is that OCCMHA has steadily over spent, under collected payments due from other counties, and over promised services without proper consideration of client eligibility and our "not to exceed" capacity. Together this has recently placed MORC in a vulnerable position ethically and legally. Further, we have been informed that certain delegated functions will be taken back by OCCMHA, and further budget cuts can be expected . . . however we "should keep an open mind". The delegated functions to be returned to CMH are absolutely crucial to our person centered plans, authorization, assurance of quality, and more. These functions have been at the heart of our Agency's relationship for the last 19 years, and are necessary to stay within our "not to exceed" contract as well.

- With regards to the broader view of the deliberation over a proper budget for the State to serve people with developmental disabilities, we feel that while more money is needed in the system – the way we spend it currently is in need of a change, a major change.

  First, let's be totally honest. "Cost efficiencies" within our nonprofit provider community have hit the wall. A review of the attachment *(A)* should be convincing of that.

  Secondly, "cost efficiencies" throughout my career, have typically meant cutting those individuals and organizations least able to protect themselves.

  Third, we should be careful about automatically assuming that costs in our system, overall, are too high. Rather than concluding extravagance in one County versus another, a deeper analysis, one better understood, accounting for more sensitive, even subtle provincial differences would be more likely accepted and lead to the results desired.

- The Governor has recently talked about "The River of Opportunities" in Michigan. He has mentioned the value of pilot projects to explore new ways of accomplishing old objectives, and encouraging thinking "outside the box". I think we are at a perfect juncture to explore new models of funding and management configurations in the area of developmental disabilities.

  One model was offered in the testimony of Elizabeth Bauer (see attachment *B*) that has excellent promise as it clearly moves decision making about services and financial accountability much closer to the consumer.

  A second model is a variation of the one MORC worked under for 24 years, where the core provider in the community is/was responsible to the Department of Developmental Disability Services.

  For each of these brief examples, budgets and management is relieved of one layer of administration. In this later "pilot", there is also the evidence of it having worked well

during the most demanding and challenging time in our history. Additionally, one doesn't have to imagine cost savings from these models or their variation, being used to close the gap in caregiver wages.

In each scenario, Community Mental Health Boards could be free to concentrate on services to people with mental illness, jail diversion, substance abuse, etc.

Thank you for taking the time to consider my experiences and points of view regarding individuals with developmental disabilities and Michigan's response to their needs.

VOLUNTEER DRIVER PROGRAM

freedomroad TRANSPORTATION

MOVING PEOPLE. REDUCING ISOLATION.

DCHSC
3-2-15
Liz Janovits

Good Morning –

My name is Liz Janovits and I am from Lake Orion, MI. Let me first discuss how rebasing the General Fund Dollars for Community Mental Health budgets affected people using mental health services. I can only speak for what happened in Oakland County last year. Some were graduated, that means they were told they would not have services available to them, services they have had for years, without much planning for the future in terms for therapy or prescriptions. This was done to get down to new budget levels that came from the state. Did the people involved feel like they were ready for this? Well, I was one of these people and I did not feel ready. I did finally find a physician to prescribe my medication. I still am not in therapy. I am doing okay, and holding up well, I have a strong support base. Thank God for them. My life is also filled with work and volunteerism, so I am

not sitting around with time to dwell about things. People normally complain that it has been a long time since they have seen me. I think this is a good thing?!?

I do mention that I am busy at work because even though I am a disabled individual, I have risen to Director of Operations and Board Member for a non-profit, 501c3 organization named Freedom Road Transportation Authority or FRTA for short. What FRTA does is provide mileage reimbursement for the underpriveleged, seniors, and disabled so they can get back into society and do the things most of us take for granted. FRTA helps folks get to work, school, go to doctors' appointments and other health care appointments, run personal errands, go grocery shopping, do regular shopping, go to religious activities, see family and friends, take care of court appointed appointments and everything else that makes up life. They must find their own

private driver or drivers (it cannot be a taxi) to be in the program. FRTA assists with mileage reimbursement to help pay those volunteer drivers up to a set amount every month. This way the ones in need (riders) are not forced to work with a pre-set schedule and they don't call in 72 hours in advance to get a ride. If their driver can take them with half hour notice, so be it, and if they want to go grocery shopping at 11:30 at night or religious service on Christmas Eve, it works out. You can't get that from bus service. FRTA currently has 120 riders in the program and 125 on the wait list. As soon as FRTA gets funding we will be able to bring those on the wait list into the program. Most have been waiting since last year. Some are needing help with dialysis or chemo therapy. Others with getting to work and/or school. Some are riding bikes or walking to their destinations even in winter, including those that are ill. Sure, some cities and towns have a van

or bus service. However, some van services close down when the schools close because of weather. People still need to get to dialysis, chemo and work. The buses that continue to run, not all will pick people up at the door. People must wait at the side of the road in the freezing cold for long periods of time to get to work or dialysis and then pay $2.00 one way. For dialysis that is 3 times a week, that is $12.00 a week. Depending on if it is a 4 week or 5 week month that comes to $48-60.00 a month. That is one week of groceries. Some are making a decision – do I eat or go to dialysis? Let alone stand in the freezing cold?

As you can tell, we at FRTA, have heard these situations more than once, and FRTA is trying to be a River of Opportunity as the Governor puts it. Because FRTA uses the community to help the folks in need stay connected and not adding a program, but focusing on the people who can help and the people who need the

help. FRTA also believes in using volunteers and contracting with the underprivileged, senior, and disabled base we serve. FRTA does need help with funding as do all small businesses/ nonprofits. FRTA needs help with the ever present time crunch. While we try for grants, FRTA is handed government grants that consist of 2 inches of paper that FRTA must read to find out if we qualify (since we don't own vehicles – we rarely qualify). Then submit the grant in 30 days. FRTA is still an operating business and usually has one or two people to commit to this project. It took me 52 hours to pull just the data needed for the 5310 SMART grant and 30 days total to submit the grant. Help us out, please. Thank you for your time and understanding.

DCH SC 3-2-15
Rosemary Rangi

March 2, 2015

The Honorable Rob VerHeulen, Chair
House Appropriations Subcommittee on Community Health
Michigan House of Representatives
P.O. Box 30014
Lansing, Michigan 48909-7514

Dear Representative VerHeulen,

I am the mother of a 35 year old son who resides in a non-licensed setting in Clarkston Michigan. He has lived here for the past ten years. He is severely developmentally disabled and autistic and requires round the clock monitoring as well as assistance with all his daily needs. His personal residence is leased by him and two other men. The rent and utilities are paid for with their combined monthly social security benefits.

Prior to his placement here, my son resided in a couple of other group homes. The oversight by management there was poor as were the services they provided. The staff was inadequately trained and my son's life, as evidenced in at least three documented instances, was placed at risk in these settings.

My son's current placement is good. He appears happy, safe and well-cared for. The staff turnover at his home has at times been an issue especially since my son functions at his best when things are kept to a routine. A change in personnel can really affect his daily behavior and need for sameness.

The direct services provider for my son does his best to try to allow for this. He is always receptive to my concerns that I voice as my son's guardian. His organization however, is greatly challenged because of the recent budget cuts that have now created a financial crisis for him as well as most providers.

The wage issue for direct care staff is a huge problem. Providers now have to compete with an increasing minimum wage. Direct care staff has not received an increase since 2008. We entrust these individuals with the care of our loved ones. They bathe, feed, toilet, and pass medications. For those who are medically challenged, this can include tube feedings, physical assistance & transportation. These are all vitally important job responsibilities. Why would anyone want to perform this type of work and be compensated so little?

We have started to see the effects of these budget cuts. Some providers are now refusing to accept new clients. Other providers are shutting their doors. The requirement of having to provide health care insurance to workers is another additional expense. Direct care staff is leaving to work somewhere that pays a decent wage. Many fast food chains pay more than what they are currently receiving and have little responsibility. Something needs to be done immediately to address this problem before people's lives are placed in real danger.

Respectfully,

Rosemary C. Rangi

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DCH SC 3-2-15
Tom Kendziorski

STATE OF MICHIGAN
HOUSE
SUB-COMMITTEE ON APPROPRIATIONS
FOR
THE MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

TESTIMONY
March 2, 2015

Good afternoon. My name is Tom Kendziorski.

I am employed as the Executive Director and staff attorney of The Arc of Oakland County, a non-profit charitable organization dedicated to providing advocacy on behalf of children and adults with an intellectual impairment and/or other developmental disabilities.

I am also the legal guardian and brother to two older gentlemen with a severe-profound intellectual impairment. Each lives in a small group home within Oakland County. Each is served through the Oakland County Community Health Authority (OCCMHA). Each is directly supported by the Macomb-Oakland Regional Center, Incorporated (MORC).

My testimony today is intended to ensure that appropriate, not merely "adequate," Medicaid funding is available to the entirety of Michigan's public community mental health system.

In Oakland County, we have recently experienced the following:

- Medicaid funding reductions of $14 million for FY14 and FY15 due to a state-wide re-basing of payment rates by the Michigan DCH;
- An $8 million General Fund (GF) decrease as a result of the unintended consequences of implementing Healthy Michigan; and,
- An ever-increasing service demand that totaled over $7 million last year.

The bottom line is that the OCCMHA is faced with a <u>$29 million budget deficit</u> during this current fiscal year. It does not look any better for the next one.

♦♦♦

A little history is in order. Beginning on October 1, 2013, the Michigan Department of Community Health (DCH) announced that it would "rebase" or "redistribute" its Medicaid dollars evenly across the ten Michigan "Prepaid In-patient Health Plans" (PIHPs). In our case the OCCMHA is its own PIHP. The result of this "rebasing" for Oakland County

meant that the budget for children and adults with developmental disabilities was cut by the above-mentioned $14 million in each of the fiscal years 2014 and 2015. After much discussion and intense advocacy, the OCCMHA covered the reduction for the entire fiscal year 2014 from its reserves. Not so for FY15, where reserves only covered about $10M of the $29M shortfall. OCCMHA Board has indicated that it will not provide additional reserves towards any future reductions.

Another hit to the OCCMHA budget is a significant reduction in the available GF dollars. These are funds to help people who do not qualify for Medicaid, but also cannot afford to pay for important mental health care services like medications, case management, respite care, and jail diversion, to name a few. This fiscal year, the state removed $20 million of GF dollars from OCCMHA's budget. This decision was made with the understanding that many people who had been receiving services through the GF would now be insured under the Medicaid expansion program known as "Healthy Michigan." OCCMHA originally had $30 million in GF, and then after the $20 million cut it only received about $12 million in return from "Healthy Michigan" payments, thus, leaving an $8 million dollar gap.

These budget shortfalls and cuts have resulted in the following:

- OCCMHA implemented a "Service Wait List;" essentially, no services without Medicaid eligibility;
- Elimination of all respite services last October for 179 minor children without Medicaid;
- Only state licensed camps will be allowed for respite because they can receive Medicaid dollars. Many families use certified, but unlicensed day camps for respite services to get a break from the rigors of caring for a child/adult with special needs;
- Wage reductions for workers in residential, vocational and in-home situations by at least 6%; some respite care providers experienced wage reductions as high as 20%;
- A long-time group home provider has decided to call it quits and cease providing residential services to its 5 group homes; 27 persons are affected; and,
- The significant reduction of GF dollars directly and negatively impacts a large group of adults with disabilities having a sizable "spend-down" or "deductible" that they must pay prior to Medicaid kicking in for them each month. GF dollars have historically been used to off-set this "spend-down" amount before Medicaid could be billed for a service. This covering of the "spend-down" amount is in jeopardy and could result in no mental health service whatsoever for some fairly difficult-to-care-for persons.

Oakland County offers innovative and quality services for persons with developmental disabilities that are evidenced-based and help people lead worthwhile lives.

Oakland County has developed nationally-recognized training programs for direct care workers that are shared with agencies throughout Michigan.

When the mental health institutions were closed, Oakland County took in people from around the state (whose own counties were not eager to welcome back) and created group homes for them.

A more equitable funding distribution model/method is necessary to reduce statewide funding variances without jeopardizing service delivery to vulnerable people. I have provided an attachment to this testimony offering a proposal for a more reasoned approach to any further re-basing.

♦♦♦

I am most grateful for my county's community mental health services and the wonderful people who work with my brother Bill and Ray every day. Both brothers spent many terrible years at a state institution. They have had a semblance of normalcy for a long time, but any additional cuts to services with developmental disabilities may threaten their support system with collapse. My brothers struggle every day to have a life that most of us take for granted.

I am also very mindful of the individual Direct Care Worker who is long overdue for a raise in wage. It is well-known that such personnel have had only $1.83 in pay raises since 2002, and none since 2008. The turnover rate is 50-60% or higher. These are the very people that we entrust with the responsibility of caring for our family members with special needs who receive services by way of the community mental health system. Any further cuts to direct care workers would be most troubling, whether it be in the form of wages, benefits, or training.

It is disconcerting to know that Bill's and Ray's care providers, who make less than $10 per hour and who have immense patience as well as ultimate responsibility for each of my brother's daily lives – had a **cut** in their pay last October. Sadly, many good workers have left this field, including my brother Bill's home manager and her assistant; each had been with his house for 25 years.

I convened an ad hoc group in Oakland County known as the "Committee for Essential Services." We have been meeting for a few months now and have developed a "common message" that includes the following points:

1. Promote collaboration between MDCH and the Pre-paid In-patient Health Plan's (PIHP) to develop budget strategies that ensure adequate Medicaid funding is available to Michigan's entire public mental health system. These strategies should include plans to restore funding to the five out of the 10 PIHP's that have continued to receive Medicaid budget reductions since 2010.

   Oakland County Community Mental Health Authority's (OCCMHA) Medicaid funding was reduced by $14 million for FY14, which continued into FY15.

Combined with an $8 million General Fund (GF) decrease in result to the impacts of Healthy Michigan, and a $7 million increase in service demand.

As a result of this, OCCMHA is faced with a $29 million budget deficit in FY15.

2. Revaluate and reverse GF reductions initiated on April 1, 2014 in response to Medicaid Expansion, also known as "Healthy Michigan." New GF funding guidelines must consider Federal service restrictions and lower service rates associated with Healthy Michigan.

3. Create awareness about the conflicting impact that re-basing has on the distribution of Medicaid funding; taking funds from one PIHP and giving it to another is not the solution. A more equitable funding distribution model/method is necessary to reduce statewide funding variances without jeopardizing service delivery to people.

4. Campaign for State and local public mental health infrastructures that complement one another. This can be accomplished by modeling PIHP's, like OCCMHA, that currently excel in service delivery to people.

5. Educate elected officials about the positive and life-enhancing outcomes that OCCMHA and its service provider agencies deliver to people through their ongoing commitment to improved efficiencies and future sustainability. This must also require a statewide commitment to reasonably compensate direct care staff workers to preserve the integrity and quality of the service delivery system.

6. Showcase the tremendous value that the public mental health system offers to communities throughout Michigan, not only to people receiving service, but to their family, friends, and neighbors as well.

7. Explain to financial actuaries the varying costs that are associated with service care based on the unique needs of individuals and the severity level of their disability.

As with any successful public policy, we must make certain that all of the logic, data analysis, assessments, and conclusions were designed and implemented in a manner that was fair, accurate and completed without bias. Good policy should also take into consideration geographical, population and historical differences.

- I respectfully request that the honorable DCH and DHS Director, Nick Lyon, immediately convene a state-wide select group of professionals and advocates to conduct a careful analysis of the practical effects of the implementation of the Michigan Department of Community Health's (DCH) current standardized Medicaid rate "re-basing" strategy.

My bias of course is toward the people I am privileged to serve and who count on us to deliver. A goal of The Arc of Oakland County's advocacy efforts is to always sustain and improve the community mental health delivery system, but, more importantly, continue to improve the lives of the people we serve.

The re-basing effort, while perhaps well-intentioned, has done harm to the very people we purport to serve and the community-based structure that we have fought so hard to build over the past three generations.

- I strongly urge your consideration about the effects of any proposed budget reductions that may be contained within the DCH FY16 budget. Individuals with intellectual and developmental disabilities will lose services and be severely impacted if Michigan's Department of Community Health continues to reduce my county's overall budget relative to Medicaid as well as from the general fund (GF).

We need to maintain these vital long-term mental health services in Oakland County.

The Arc of Oakland County will never accept merely "adequate" mental health care services. We will never reverse course from the hard-earned successes of the past!

Thank you very much.

The Arc
Oakland County

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A Proposal for Re-basing – A Reasoned Approach

Date: February 24, 2015

From: Thomas F. Kendziorski, Esq.
Executive Director
The Arc of Oakland County, Inc.
Troy, MI 48084
248-816-1900, ext. #226

Impact of the Current Re-basing Effort

The Medicaid rate structure for behavioral health and developmental disabilities services in Michigan relies heavily on "historical" factors. As a result, the rates favor those regions within the state that were instrumental in assisting with the closure of state-operated centers, particularly those serving people with intellectual and developmental disabilities (I/DD). In an effort to resolve the rate payment imbalance, and to simplify the system, the State of Michigan's Department of Community Health (MDCH) in 2010 embarked upon a process for "re-basing" the Medicaid rate structure, effectively reducing rates in those regions that historically benefited from higher rates and increasing rates in regions that have been historically low.

The impact of this endeavor was most pronounced on the eve of the 2014 fiscal year. Just days before the start of FY2014, the MDCH announced its re-basing strategy for the fiscal year. Up until FY2014, re-basing efforts were somewhat masked by increases in the overall Medicaid population, an artifact of the economic recession that plagued the state and the nation. However, as the economy improved in 2013, and as the Medicaid population started to decline, the reconfiguration of the Medicaid rates toward a statewide norm caused immediate and dramatic results.

The reality is that those communities that early on embraced community solutions for persons with I/DD created increasingly elaborate care models. These efforts include a fairly extensive array of options that afford individuals and families considerably more choices for support, and much more individually tailored service plans. These plans yield very positive outcomes. People are living longer and their lives are richer in experiences. This variety comes at a cost.

The 2014 re-basing instantly and dramatically changed the community landscape, particularly in Macomb and Oakland counties. The MDCH sponsored methodology of re-basing relied on a leveling theory of equalization and parity that reduced rates in those regions with historically high expenses, and increased rates in regions that are

historically low. An artifact of the FY2014 re-basing saw an overall reduction in PIHP rates in the aggregate. Unfortunately, the people most significantly impacted, such as individuals served, their families and their direct service staff, are those least capable of coping with the change.

An Alternative Approach

- Rather than redistributing resources among the existing Pre-Paid Inpatient Health Plans (PIHPs) based solely on state averages, it would seem that rates tied to "acuity of need" using standardized evaluations (LOCUS, CAFAS, SIS) would be a better approach. That way, regions within the state would be paid according to the needs of their specific population, and not solely on an average spread over the county Medicaid rolls.

- In the absence of this data, and using the state average model, it seems that using the money allocated for "actuarial soundness," typically 1.25% to 1.5% additional per year could be directed toward those communities that are below average, while allowing those communities that are above average to remain whole – just without an annual increase until parity is achieved.

- Communities that have not spent their Medicaid funds and have either used the excess to restore fund balances or who have lapsed funds would not receive an annual increase, thus allowing the most underfunded communities the opportunity to bring their rates in line with the average more quickly.

I believe that such an approach will both achieve the MDCH goal of a simplified and equitable rate structure while not improperly causing the dissolution of the varied and individualized services that many within our community have come to count upon.

DCH SC
3-2-15
Rick Murdock

mahp
Michigan Association of Health Plans

House Subcommittee on Community Health Appropriations

Public Hearing

March 2, 2015

Good Morning. My name is Rick Murdock, and I am Executive Director of the Michigan Association of Health Plans. MAHP member health plans have a long history of providing nationally ranked, comprehensive and cost-effective delivery of Medicaid services for Michigan's most vulnerable citizens. Members of MAHP are proud of this record over the past seventeen years and view that experience as a platform for future innovations and services.

While we have important and critical issues to raise in response to the Executive Budget recommendations which will be addressed later, I wanted to first spend a few moments on this 17 year history.

An Outline of Medicaid Managed Care History

Base (Pre 1997)

- Provider access
- Voluntary enrollment in areas of managed care and managed care "light"—physician sponsor program
- High utilization and no ultimate provider accountability
- Budget unpredictable

Launching Managed Care (1997-2000).

- Creation of MDCH
- Leadership: Gov, SBO, MDCH, DMB, Atty Gen
- Move toward contract management and privatization
- Total Integration as Strategy—Five Tracks to be developed
  - Enrollment services (mandatory enrollment, algorithms for auto-enrollment & statewide and inclusive of disabled population
- Competitive Bidding—use market forces not arbitrary decision to pick winners/losers—set thresholds (Price bid)

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- SE Michigan 1997
- Remainder of State 1998
- Budget Savings ($125 M GF taken in FY 98)
- Improved Access (40% more physician involvement)
- Rebid again in 2000

Fine Tuning (2001 – 2009)

- Actuarial Soundness (2002 federal rules—2004 effective date)
- License plans only
- Next RFP 2004 and 2009--State set rates for actuarial soundness
- Eliminated Duals (due to federal rules)
- Fully implemented electronic billing requirements
- Medicaid HMO QAAP Begins through state legislation 2002—convert to Use tax beginning in 2009 due to Federal DRA of 2006
- Psychotropic payments (60/40) and then carve out completely
- Adolescent Center Payments, HRA, GME, SNAF payments by health plans
    - Within terms of the contract, voluntary agreements, assurance of access and outreach
- New mandatory populations—pregnant women and Foster care children
- External study validates state savings (Sen. Stamas University of Maryland)

Preparing for the Future (2010 -)

- New populations (CSHCS), SNPs
- Systems challenges vis a vis CHAMPS, movement toward ICD 10, other HIPAA requirements for electronic billing
- MI CHILD as separate contract
- Repeal of Use Tax for HICA 2011, revised again 2014 with restoration of Use Tax
- Documentation that MHP Provider base can be platform for Healthy Michigan Plan
- Duals Innovation project planned and now launched
- LTC managed care required under HMP for 2016
- Patient centered medical homes (MiPCT), Meaningful use incentive payments
- Prosperity Regions (all or none)

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- New RFP to be released in May 2015 and new contracts effective January 1, 2016.

Summary:

Looking over this background, we firmly believe that the premise and objective for Medicaid Privatization has worked:

- Movement toward integration continues as the five tracks continue to come together; we now have Core/Comprehensive Medicaid, which now includes CSHCS. Long term care will be either part of Duals Initiative or LTC in 2016;
- The approach and partnership with the administration has historically been collaborative and interactive with our industry—find the solution that works—awareness of new initiatives in order to integrate systems and provider contracts requirements.
- Market forces continue to work—number of plans are reduced due to merger/acquisition (33 down to 13)—expect that to continue;
- Performance rankings continue 11 of top 50 nationally and 6 of top 30;
- Medicaid Plans continue to meet and exceed contract performance requirements and provide costs savings to state and federal taxpayers—over $6 billion since 2000—all while overall Medicaid health plan margins are now less than 1%.

Finally, Health Plans are at complete financial risk and not the state for the services offered under the contract. Removing this burden from the state has provided fiscal stability and predictability and eliminated additional costs.

Recommendations for FY 16

Our recommendations listed below are based on continuing the history, building on past performance, continuing a focus of raising the performance standards, becoming more transparent and focusing on outcomes. Our intent is to meet with all committee members and review our complete Medicaid Strategic Plan. Today, I want to focus on two specific recommendations:

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1. **Reverse Proposed Pharmacy Carve Out**

While we appreciate the overall recommendations within the FY 16 executive budget....we are concerned and troubled by the proposal to carve out pharmacy benefit and administered it at the state level. Without a pharmacy benefit and real time data that health plans can readily use, efforts on performance contracting cannot be met, projected savings (including those in Healthy Michigan Program) related to disease management /care coordination cannot be achieve, patient safety will be at risk and opportunities for fraud and abuse detection will be lost. Moreover, health plans have held the complete fiscal risk for managing this benefit—carving the benefit back to the state also returns financial risk of at least $450 million.

On behalf of MAHP member plans, MAHP have provided an alternative to the administration that we believe achieves the same budgetary savings and provides a consensus approach for operation of health plans formularies and creates greater opportunity to raise the performance on meaningful use, e-prescribing and other solutions and looks at other options for integrating further services. We are looking forward to meaningful discussion regarding our proposal and the find agreement that the pharmacy benefit should remain as part of the Medicaid Health Plan benefit package. Because of the pending RFP, these decisions need to be made in very near future.

2. **Support Actuarial Soundness Recommendation.**

MAHP has consistently advocated for actuarially sound rates for Medicaid Health Plans and support the Executive Budget proposed 2% increase for both regular Medicaid and Healthily Michigan Program.

Thank you for your consideration of our comments and we intend to work closely with you and your staff over the coming weeks and months as the budget discussion are finalized.

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DCH SC
3-2-15
Elizabeth Bauer

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Testimony of Elizabeth W. Bauer
before the
House of Representatives Appropriations Sub-committee on Community Health
March 2, 2015

Mr. Chairman, Members of the Sub-committee,

Thank you for holding this hearing today and for welcoming the comments of individuals and organizations concerned with services to persons with behavioral health, intellectual and developmental disabilities, and substance use disorders. My name is Elizabeth Bauer. I am a resident of Ferndale and a long- time advocate[1] for individuals served by the Michigan Department of Community Health (MDCH) and its contract providers. I am also the parent of a 47 year old woman with profound developmental disability who receives services from MORC Inc. The charge you have been given to craft a budget for the Department and the public mental health system as a whole is huge and how you meet it will impact the lives of thousands of men women and children. Thank you for accepting this challenge.

Today I will speak to five issues: They are:

1. Re-basing of funding to the PIHPs (Prepaid Inpatient Health Plans) and the resulting negative impact on recipients of services in the PIHP areas where funding was reduced

2. The importance of General Fund money to meet needs of those not eligible for Medicaid.

3. The importance of direct care personnel and current inadequacy of funding for their wages and benefits.

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[1]Current (among others):
Member, Board of Directors, MORC Inc.
Member, Board of Directors, The Futures Foundation
Member, Quality Care Task Force, Detroit Wayne Mental Health Authority
Member, Education, Outreach and Marketing Work Group MDCH Dual–Eligible Demonstration
Member, The Arc Oakland County
President, Board of Directors, W-A-Y Academy Detroit

Former (among others):
Elected Member Michigan State Board of Education 2003-2011
Executive Director, Michigan Protection and Advocacy Service, Inc. 1981-2001
Director of Community Placement, Metropolitan Regional Office, Dept. Mental Health 1980-81
Director of Training, Michigan Department Mental Health, 1978-1980

At the beneficiaries' level we see direct care staffing reduced. Direct care staff – who I posit are the most important people in this hierarchical structure - are working 10 and 12 hour shifts in jobs that are highly stressful under the best of conditions for pay that keeps them living in poverty!

You will receive lots of financial models from those administrative agencies on ways in which funding could be better allocated to meet needs. You will find a way to address the problems posed by the re-basing activity. When you make your decisions, please keep in mind the men, women, and children with intellectual/developmental disabilities, mental illness, and substance use disorders who need life-sustaining, developmental, and health care services and the people who directly provide those services every day and night for 365 days a year.

2. General Fund resources for the public mental health system

In recent years the system has relied almost solely on Medicaid funding. Healthy Michigan, while expanding eligibility for Medicaid services, still does not accommodate all in need. General Fund money in the system allows providers to meet unique needs of persons who are not eligible for Medicaid or Medicare and yet need services that can best be provided in the public mental health system. Yes, there is always the opportunity for providers to charge fees for services. Most will when the recipients are able to pay or have insurance that covers the service. But there are some services that are not covered by insurance (certain dental services for example) and there are families who live sufficiently above the poverty level that they are ineligible for Healthy Michigan and yet too stressed financially to pay for the counseling, Applied Behavior Analysis, dental services, or whatever is needed by the family member with intellectual/developmental disability, mental illness or substance use disorder. As a society, we are all better off when those among us are as healthy in mind and body as possible. General Fund money in the public mental health system allows for flexibility in service delivery. It does not need to be a lot, but it would be very helpful if it was sufficient to serve those most in need.

3. The importance of Direct Care Personnel and current inadequacy of funding for wages and benefits.

As mentioned earlier, the reduction in funding to the PIHPs has been passed on to the core providers in the PIHP network and passed on yet again to contracted providers of community living arrangements and pre-vocational and vocational programs. At each step some reductions have been absorbed and efficiencies made, but **by the time the few dollars left make their way to the provider who actually provides the hands-on service to the people with intellectual/ developmental disabilities, mental illness and substance use disorders, there is very little left.** The provider at this stage can only cut staff and hold wages in check.

The average wage for direct care personnel is about $8.50 per hour. Often they work without health care benefits and more often without any retirement plan. Turn-over is high as one can expect and yet the work they do requires a deep and meaningful relationship with the beneficiary to achieve the goals in the beneficiary's habilitation and rehabilitation plans. As the mother of Virginia who has profound intellectual disability, who does not speak, and relies of staff for most everything, I know immediately when there has been a change in staffing or routine. Virginia's affect will be different. Her behavior

there were 94 core providers in the state who would have contracts with the 18 PIHPs. For example, Oakland Community Mental Health Authority had 6 core provider agencies with which they would contract. I suggested that the Department create a 19 person contract monitoring and compliance unit at the state level (I realize no Governor wants to add state employees even when it is the most cost-effective action) to manage the 94 core provider contracts. I figured salaries high at $100,000 per monitor, plus the full state benefit package. Civil service would control the salaries so they would not rise at ridiculous rates. Appropriated funds would go directly from the state to the 94 core providers who would then disburse them through their contract agencies (residential, prevocational, vocational etc.). The PIHP level would be eliminated and, given the funding in the system at the time and including the 19-person unit in state government, the net savings would have been $100 Million!

I can't say what the savings would be today as I do not have the PIHP salaries and other information I had in 2002. However, knowing what some people are earning, I believe the savings would be substantial. There is precedence for eliminating a middle layer of contract management.

I believe that we could pay direct care staff better and provide them with benefits if savings due to restructuring – or even just a portion of those savings - were redirected to the actual service delivery level. The Oakland Press (February 22, 2015) ran an article on the pay given to care givers in the public mental health system. A direct care worker outlined her life, its stresses and more. She works 50 hours a week at a group home and 20 more hours a week for an individual receiving services in his own home. She has been employed for more than 5 years and her pay is now $10.25 per hour. Still she has three children and, as a family of four, lives at the poverty level. She said, "Caregivers deserve around $15 per hour because of the responsibility we have in our jobs ....she believes they should earn more than minimum wages and should receive health care for their family members, and vacation and sick time." When I think of the layers and layers of people administering these programs that make substantially more and have all the benefits, I believe we can re-structure in a way that will make it possible for the people who do the most difficult work to live dignified lives above the poverty level.

5. A suggestion for the future which could improve public education for children with disabilities particularly those with serious emotional impairments, and intellectual/developmental disabilities including Autism.

The Potential for enhanced service delivery resulting from the combination of the Departments of Community Health (MDCH) and Human Services (DHS) is huge. As it is now, people have to go multiple places to get the various supports and services they need to live dignified, healthful lives. If the combination of the departments will result in the co-location of education, health and mental health and human services personnel, it will be a giant step forward. I realize your attention this year is on the budget for the Department of Community Health and, come fall, the Legislature will organize to form Appropriations Sub-committees to budget for the combined department (Health and Human Services). I would like you to begin to think holistically even now. This idea may be premature, but there is no time like the present to start to envision a new way to deliver public education, health, and human services.

The Governor has said he wants to **focus on people** and plan for their well-being instead of programs.

DCH SC 3-2-15
Helen Warner-Bell

Hello, My name is Helen Warner-Bell and I am here on behalf of my son Wyeth Warner who cannot speak for himself. We live in West Bloomfield, Oakland County, Michigan.

Back in the year 2000, thanks to a HAB Medicaid Waiver, my severely disabled son, then aged 29, was granted a budget that allowed him to live alone with 24-hour staffing. Because of the $14 million rebasing of Medicaid funds, a carefully structured living arrangement that has worked well for him for over 15 years is threatened. When I say "worked well" I mean it has literally saved his life and mine -- and my husband's. This was not an unwarranted luxury.

MORC, the agency that coordinates my son's services, under the direction of OCCMHA, is now pushing us to accept a roommate for my son. This decision is purely a financial one caused by the rebasing of funds and if it stands, my son will suffer greatly.

My son has atypical Prader-Willi Syndrome, a rare genetic disorder that wreaks havoc on growth, metabolism, mental development, behavior, sleep patterns and general health. My son is atypical of the syndrome, because he is SEVERELY mentally impaired. He has no speech and needs significant assistance with all his daily activities, dressing, bathing, medication etc. (Most people with the syndrome are mildly to moderately cognitively impaired and need much less assistance.)

People with PWS have an obsessive drive to eat and that coupled with slow metabolism, small bone structure, and poor muscle mass and tone, leads to early death usually in late teens or early 20's from illnesses caused or exacerbated by obesity If diet is controlled and food is made inaccessible except at mealtimes, life expectancy is greatly increased. My son will eat anything within reach and that includes something that is on someone's else's plate or the ice cream cone a passerby may be enjoying. So "food situations" are avoided or if unavoidable, one-on-one monitoring is necessary.

Sadly, some people with PWS whose weights have been controlled, have died from internal ruptures after bingeing on food. Lifelong vigilance regarding diet is necessary. Prader-Willi Syndrome cannot be cured, it can only be managed.

Another characteristic of PWS is emotional volatility. My son will lose control in crowds or other noisy situations such as people shouting, arguing, or just talking in an animated way. He does not tolerate having to wait -- for example, until we "trained" his doctor, medical appts. could be a disaster. He does not tolerate someone insisting even gently, that he do something. Of course food can be a major cause of an upset. If food is visible and my son is not allowed to have it, he loses control.

When he loses control, he is not just "upset." He becomes physically abusive to himself and to anyone within reach. He will bite, grab, and pinch. A full-blown upset usually ends up with him biting his own arm, throwing himself on the floor, trying to bang his head, and ultimately biting his own shoe. It is a scary sight. Not only is it physically destructive to him -- or to anyone who has not learned to step back -- I shudder to think what other kind of damage he may be doing himself internally. So upsets are to be avoided at all costs.

My son functions best in a quiet controlled setting. He is calmed by routine and gets upset when routine is disturbed. He does not watch television or play video games. He likes one-on-one interactions with family and caregivers, but does not initiate socialization. His well-trained, long standing staff are his best friends. Because they are skilled and understanding of my son's needs they can take him out into the community, which he enjoys.

Until he was 26 my son who is now 44 attended a center school program for severely and profoundly disabled people. It was a segregated program, but my son was segregated even further in the "behavior" room.

Over the years he was kicked out of quite a few programs -- or as people like to say these programs or settings were found to be "inappropriate." Places where he had difficulties included camp for people with disabilities, programs for people with his syndrome, work programs for people with disabilities, a respite home, etc. For the most part these programs tried to serve my son, but without extensive knowledge of his syndrome, understanding of his unique needs, and the unavailability of one-on-one staff they were unable to do so.

As a mother it feels disloyal to publicly explain how difficult my son can be, but, like many parents of disabled children who are desperate for services, I have to do this. Instead of bragging about out children's accomplishments, we must describe over and over their weaknesses. We know this is necessary so you can understand and help us.

Back in 1999 and 2000, people at OCCMH recognized my son's needs and approved funding for him to have one-on-one 24-hour staff. My husband and I took our savings and bought a house near us. I monitor the house on a regular basis. Since my son cannot speak, I find face-to-face visits essential. I do the grocery shopping to ensure a good diet.

Because of his dependable, well-trained staff my son is thriving. He has maintained a good weight. When he was in his early 20's he was much heavier and was headed toward morbid obesity. We got him into the program for PWS at the rehab center at Children's Hospital in Pittsburgh where we had to vigorously advocate for him to remain the full time recommended. Like everywhere else, my son needed one-on-one supervision -- something the center was not expecting to provide.

His upsets which still occur are less frequent because his household atmosphere is calm and because the modifications made to his kitchen prevent him from "stealing" food. It is a delicate balance. The people at the agency that oversees his budget do not know him. His supports coordinator who visits monthly is getting to know him, but we his family and his longstanding staff know him well. We know that introducing a roommate would be disastrous for both my son and the roommate. In addition to the dietary regimen, anyone living with my son is subject to his irregular sleep patterns -- he is up and down during the night. It is very difficult for anyone to live full time under the restrictions dictated by his disabilities. I know because I did it for almost 30 years. His staff, in fact, do not live at his house, they rotate.

The agency that is pushing the roommate idea would not be doing so if Oakland County's funds had not been drastically cut. I am fighting for my son, and against the financial decisions which threaten his well-being.

Helen Warner-Bell

DCH SC
3-2-15

Andrea Zeme Gold
25700 Cody Lane
Novi, Michigan 48374
248-449-2711
andrea.gold77@gmail.com

I have a 24 year old daughter named Alyssa Michelle Gold. And, I'd like to tell you a little bit about her: Alyssa has a job; loves to go shopping and out to eat in restaurants with her friends and family. She also loves to go swimming, bowling, biking, and boating. Her favorite food in the world is chocolate cake with frosting. She possess a terrific sense of humor-scatological jokes included. And like many of our kids, she is opinionated, and doesn't like to clean up her room. Alyssa leads a 'normal' active life-like other peers of her age group.

However, there is nothing 'normal' about Alyssa's life. She leads a remarkable life despite being multi-disabled. She is blind, mentally impaired, suffers from psychomotor seizures and parasomnia. Additionally, she has Crohn's Disease and Natural Killer Cell Deficiency. Despite her disabilities, Alyssa lives a productive and fulfilling life with the assistance of her father and me, as well as, with the aide of her caregivers. Alyssa requires 100% support in ALL aspects of her life, 24 hours a day, 7 days a week, 12 months a year. It's support that her father and I can't shoulder alone.

Previously I said that Alyssa has a job. Well, Alyssa's job entails delivering Friendship Bakery challahs (egg bread) and challah rolls with her trusted caregiver from JARC to customers. The bread and rolls are made by developmentally disabled young adults in a commercial kitchen. Friendship Bakery operates under the auspices of Friendship Circle which serves over 3000 special needs families. And, 155 school districts from ALL parts of the State have partaken in LifeTown's life skills building programs.

Every Friday, Alyssa and her JARC caregiver deliver challahs to 2 grocery stores, an Italian bakery, and to staff and students at her school, Visions Unlimited. After school, she delivers more challah orders to her customers-with her caregiver. Alyssa could be in a bad mood, but once she realizes that it's time for her job, her attitude changes and her world becomes a better place, a world filled with purpose.

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

I implore you to reevaluate and reverse General Fund reductions initiated on April 1, 2014 in response to Healthy Michigan. Rebasing, Healthy Michigan, General Fund reductions and an increase in service needs created a $29 million deficit for Oakland County; the county where we live.

Alyssa was born in Boston. And when the opportunity arose 19 years ago, we **chose** to relocate to Michigan because of the tremendous services and opportunities available for her. Eight years ago, another opportunity arose to move out of state. And, my husband and I **chose** to stay in Michigan because of the outstanding services Alyssa received.

Please restore funding and allocate adequate resources for the valuable support services that Alyssa receives. Please restore funding and allocate adequate resources so that Alyssa and others like her are able to lead a productive, purposeful, fulfilling life.

jarc Enriching Lives. Erasing Barriers.

DCHSC
3-2-15
Rick Loewenstein

March 2, 2015

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

Re: 2015-2016 Department of Community Health Budget

Dear Representative VerHeulen:

My name is Rick Loewenstein and I am the CEO of JARC, a non-sectarian, nonprofit provider of residential and community services to adults and children with Developmental Disabilities. For over 45 years we have been steadfast in our mission to enrich the lives of people with disabilities through gentle and loving support, valued relationships, and engagement in the community, in accordance with Jewish values.

The following charts highlight the major challenges faced by JARC (and other direct service providers throughout the state), and the incredible strain on current (and historical) funding levels for Mental Health services. Simply stated, we are serving more people than ever before and their needs are increasing rapidly with age. At the same time, funding has not kept pace with demand and we are facing a crisis. I urge you and your colleagues to increase funding for mental health services in FY '16.

Thank you for the opportunity to speak on behalf of the hundreds of people we serve and their families, our 300 dedicated, caring staff, and of course, our grateful community.

Sincerely,

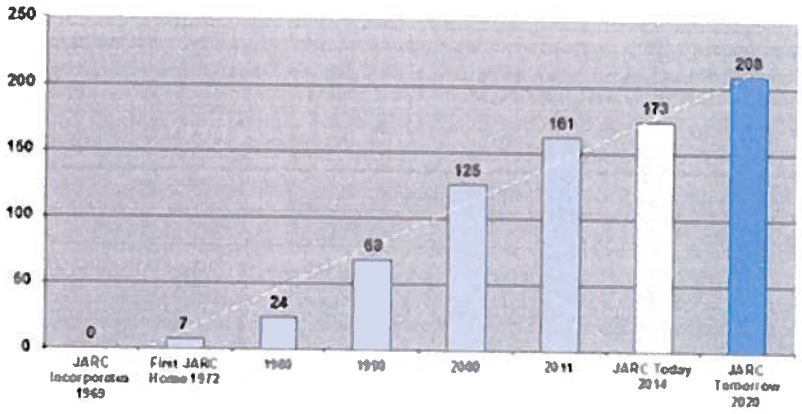
Richard A. Loewenstein
Chief Executive Officer

Cc: Representative John Bizon
Representative Brandon Dillon
Representative Chris Afendoulis
Representative Jon Bumstead
Representative Edward Canfield
Representative Laura Cox
Representative Harvey Santana
Representative Kristy Pagan

30301 Northwestern Hwy | Suite 100 | Farmington Hills, MI 48334 | 248.538.6611 v/tty | Fax 248.538.6615 | jarc@jarc.org | www.jarc.org

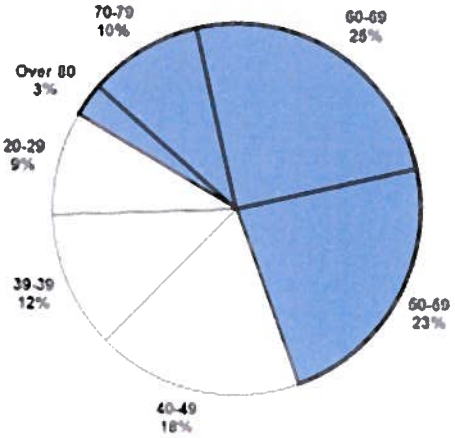
jarc Enriching Lives. Erasing Barriers.

JARC is serving more people than ever before.



Because of excellent care by JARC staff, people served are living longer.

Our Aging Population in Residential Settings
61% over age 50



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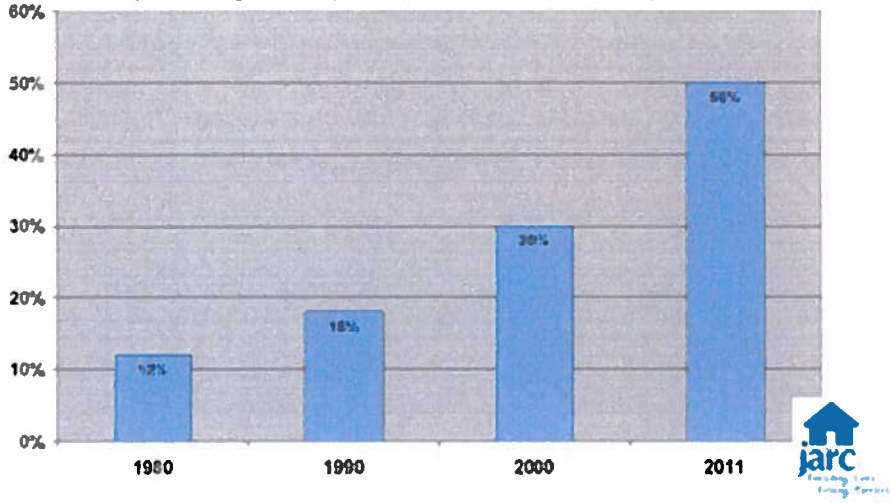
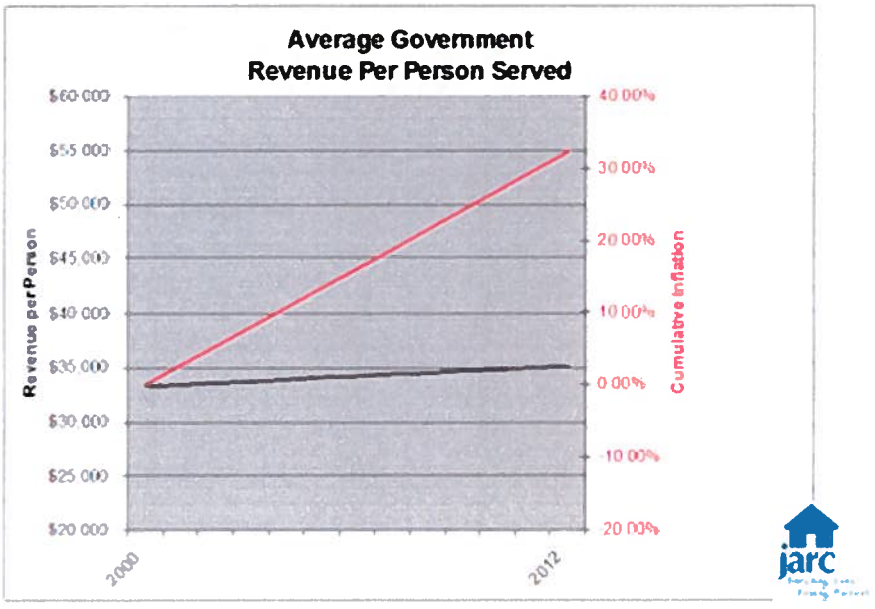
As people JARC serves live longer, their medical needs escalate.

INCREASED CARE NEEDS

Percent of people JARC serves who have, in addition to a developmental disability, another significant impairment such as cancer, dementia or psychosis.



Since 2000, government revenue per person has remained the same; inflation for the same period has increased by over 30%.



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DCHSC
3-2-15
Linda Brown

House Community Health Appropriations Subcommittee Meeting

March 2, 2015

Public Comment

Good Morning. My name is Linda Ronan Brown. My family resides in Clarkston, Oakland County, Michigan. Thank you for this opportunity to speak with you about the impact the cuts and re-basing of CMH funds and low minimum wages for direct care staff have had on my family and the people that work for our sons.

I am a lawyer, advocate, housing professional, non-profit employee and board member, and a former human resource professional. But the most important roles I fill are being mother to Ross, 26, and Bryan, 24, and wife to my husband, Craig Brown. Our sons are smart, funny, and loving. They also experience a long list of challenges between them – severe autism, non-verbal, seizures, bi-polar, sleep disorder, depression, anxiety disorder, Tourette's Syndrome, self injurious behavior, self restraint, aggression, hypothyroidism, incontinence, severe food allergies, reflux etc. – that result in an extremely high level of care and necessitated that I be a stay at home mom for 20 years.

Despite the challenges we have always believed Ross and Bryan deserve a quality life and while exhausting to maintain, it has been quality supports – including the Children's Waiver - that have made this possible. As our sons approached adulthood they were getting bigger and stronger – I could no longer safely or successfully intervene when they were afraid and hurting themselves, and I had developed health issues due to the stress and lack of sleep their care caused. I was getting older and more worn out, and my relationship with Bryan was deteriorating because I couldn't meet his and Ross' needs by myself for the many hours per day it was just the three of us.

Six and a half years ago, at their request, Ross and Bryan moved into their own home, that we own, with a roommate and full time care. This transition was not easy, but it has been a blessing and respite for our family and their roommate's family. We could supply the house, but without the necessary supports the house is meaningless. Ross and Bryan do well if they feel safe, accepted and loved. If they are afraid or feel unsafe they are likely to hurt themselves, damage property or hurt their staff (or parents).

vulnerable citizens, continuing the work of parents and schools in striving toward quality, purposeful lives for individuals with disabilities. Why do you value them so little? We love and value them for the care they give our children and will, hopefully, continue to give them once we are dead. If they cannot earn a living wage while giving so much of their time to work, they will leave this job and our sons will suffer the loss, again, of someone who makes their world work.

The institutions are closed – thank goodness. Now you are taking the supports needed to allow many people with disabilities to have a quality life. We parents can't live forever, so I would like to leave you with a question: what other option is left?

Please increase General Funding and Medicaid funding to the CMH's and appropriate funding to allow an increase in direct care staff wages.

Respectfully Submitted:

Linda Ronan Brown

Linda Ronan Brown
5716 Knob Hill Circle
Clarkston, MI 48348
(248) 620-0555

photo to Community Engagement Editor Monica Drake at monica.drake@oakpress.com to be featured in the Community section Thursday or Sunday.

COLUMN

Ajeenah works with our sons Linda Lou Brown

Woman thinks caregivers deserve better pa

Jerry Wolffe
Voices of Disability

A single mother who works up to 50 hours a week as a caregiver at a Clarkston home for those with disabilities and another 20 for a Birmingham man is barely making it.

When Ajeenah Kalimah was asked when she sleeps and how can she work up to 70 hours a week, she said: "I am tired, but I can rest when I die."

Kalimah, 26, who has three sons ranging in age from 5 to 9, has worked at the Fawn Valley Independent Living home for a year, helping to care for three men with disabilities.

Executive Director John Williams of Progressive Lifestyles that operates the 24-hour, seven-day-a-week home where Kalimah is employed said workers are hired in at $8.15 an hour.

"Our average (pay) is $8.60," he said.

Kalimah said she earns $10.25 an hour.

"She has been with us for five years and is a former house manager," Williams said, explaining why her pay is higher.

"We put a great emphasis on relationships, this along with turnover (which ranges from 32 percent to 50 percent a year in the field), illness, absences and staff vacancies result in a high number for overtime expenses and is a constant worry," Williams said.

A review of research literature shows that a "long-term supports and services employer spends an average of $2,500 directly to recruit, screen, train and hire a new worker."

By comparison, caregivers at state-operated institutions such as the Hawthorne Center in Northville make at least $18 an hour and receive a full range of benefits.

It's not the fault of the operator of the Fawn Valley home that pay levels are what they are because there has been millions of dollars in recent budget cutbacks by the Department of Community Health for Oakland, Macomb and Wayne counties to fund homes that care for the mentally ill and those with disabilities. At the same time, the economic pressure on workers is worse because inflation has risen nearly 30 percent during the past decade and wages are flat.

Kalimah pays $120 a month for medical coverage for herself with Progressive picking up the rest of the premium. She also receives paid vacation.

She said she pays $721 a month for a used car and insurance and just bought a home in Flint, which has been broken in to twice since it was purchased last February. She drops her sons off at her mother's home when she goes to work as well as her televisions, fearing for the boys' safety and more items being stolen from her home.

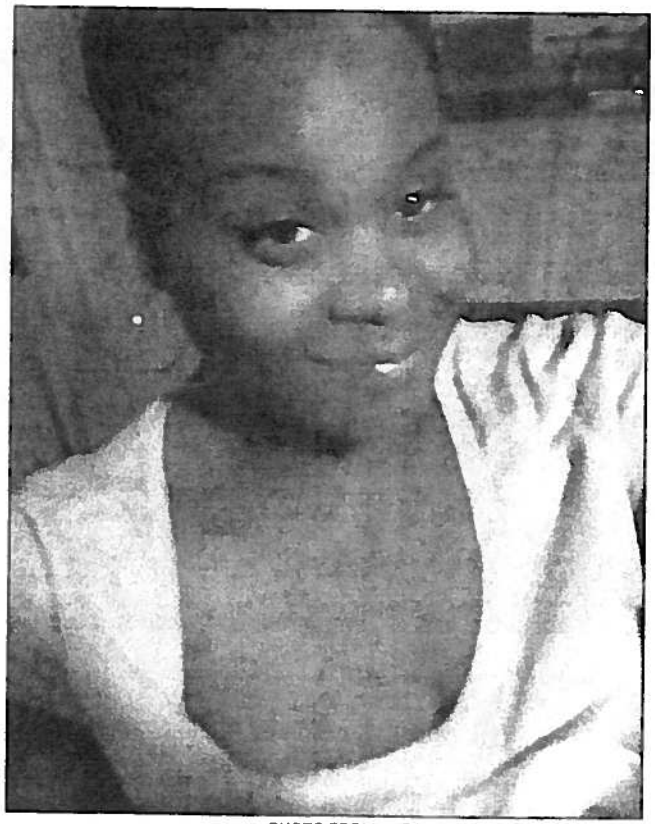

PHOTO FROM AJEENAH KALIMAH'S FACEBOOK

Ajeenah Kalimah works to help care for three men with disabilities in Clarkston. She said making $10.25 an hour makes it difficult to afford the necessities for herself and her three children.

"I believe 100 percent that caregivers should be paid more than minimum wages, should receive health care for their family members and vacation and sick time."

— Ajeenah Kalimah, caregiver

Kalimah believes caregivers deserve around $15 an hour "because of the responsibility we have in our jobs and I don't want to live paycheck to paycheck. We try to follow every rule possible, including dietary needs, to make sure the people are safe and well cared for while we're working.

"I believe 100 percent that caregivers should be paid more than minimum wages, should receive health care for their family members and vacation and sick time," she said.

"I have worked with some who have cerebral palsy (and are non-verbal) and I can tell what they are trying to tell me through their eyes. ... Some of the caregivers have worked with have variety of skills that sav lives which is much mo than (the skills of) som one working in a factor

"My job is mentally draining," she noted. "Whether I stay in this field depends upon the money situation."

Kalimah wants to ea a social work degree so she can improve her life

"I'm smart. I was rais correctly. If you do well you will get rewarded," she said.

Her daily reward nov is helping those most in need and hoping lawma ers will recognize more money is needed to pay those fairly who take ca of the most vulnerable i society.

Jerry Wolffe is the write in-residence and advocate-at-large at the Macomb-Oakland Regiona Center. He can be reache at 586-263-8950.

DCH SC 3-2-15
Barbara Fowkes

House of Representative Hearing Testimony

March 2, 2015

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. Spectrum Community serves nearly 700 children and adults with developmental disabilities including autism, and mentally ill adults in residential settings, support coordination and enhanced health services. We provide these services throughout the state to include: Berrien County, Ionia County, Kent County, Manistee and Benzie County, Oakland County, Otsego County, Washtenaw and Wayne Counties. I am here today on behalf of the people I employ and the people I serve.

Spectrum Community employs nearly 1,200 people. 60% of our employees work part time. More than 50% of the people we employ have one or two more jobs to assist them to pay their bills. My staff are very hard working people and very dedicated to improving the lives of our most vulnerable

citizens. However when they have to work for multiple companies to make ends meet, they are not always at the top of their game. The need to pay people who serve our disabled population needs to be recognized as a crisis in our field. 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. 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 DHS child abuse registry. Another area of concern is transportation to get to the program site. Many staff do not have good reliable vehicles.

I feel Spectrum Community distributes to our employees, as much as we are able to with the funding we receive for our salary line. The salary rate we receive varies from county CMH to county CMH. The salary rates we receive vary between $10.91 per hour to $15.00 per hour. 30% of this rate goes to paying taxes and benefits for our employees. Spectrum Community tries to maintain a low turn over rate by providing affordable health care, paid time off, and a matching contribution to a 403B Safe Harbor investment. Also out of this funding, Home Managers in the residential sites

are paid a minimum salary of $25,500 which is mandated by wage and hour for salaried personnel. This leaves my direct support staff at a starting wage between $8.15 per hour to $8.75 per hour. The $8.15 was raised from $7.60 due to the mandated and unfunded minimum wage increase. This wage puts them at the poverty level.

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. Often times stress for employees is just as much with their co workers and the fear of not knowing if they will be able to go home at the end of their shift. 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. Emergency relief staff is a luxury most providers don't have and can't keep due to the fact that people want set schedules to ensure an income.

I would request that you consider increasing the direct care wage 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. I know that my employees would be very grateful for any kind of a wage increase from you.

I have been providing services to people with disabilities for more than 40 years. I have dedicated my life to help and advocate for our most vulnerable citizens. For the last 33 years I have worked for Spectrum Community and have worked at all levels of the agency. What I am seeing currently in finding people to work is at its all time low. I currently have 60 full time positions around the state that I have not been able to find anyone to work. Overtime costs are at their highest level ever. Last year in every county I provide services with the exception of one, we ended the year at a loss, mostly due to the overtime expenses. Our state is 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 staff want to do a good job and do enjoy working with our individuals but they are tired. We need your help to fix this problem.

In closing, I am requesting of you to consider approving a pay increase for our employees who are working direct services in the homes including home managers to we are able to have better choices in hiring good quality people who want to work and who want to make a difference in people's lives.

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.

DCH SC 3-2-15
gabe Schneider

MUNSON HEALTHCARE

Testimony before the Michigan House Appropriations Subcommittee on Community Health

Monday, March 2, 2015

Gabe Schneider, Principal at Northern Strategies 360 provides the following testimony on behalf of a coalition of Northern Michigan hospitals including Munson Healthcare to the Michigan House Appropriations Subcommittee on Community Health

Mr. Chairman and members of the Committee;

Thank you for the opportunity to present testimony today on behalf of a coalition of rural Northern Michigan Hospitals who are deeply concerned about the proposed elimination of the Small and Rural Hospital Pool and OB Stabilization Fund in the Governor's Fiscal Year 16 Budget Recommendation.

The coalition, representing the interests of hospitals throughout Northern Michigan has joined with the Northern Michigan Chamber Alliance and the Michigan Hospital Association to ask that this critical funding for the over half million residents of Northern Michigan, be restored.

As you know, three years ago, the Michigan Legislature created the Small and Rural Access Pool to help maintain local access to critical hospital services such as primary care, emergency room and OB services, in smaller, more rural communities.

Last year, recognizing the importance of OB services, the Legislature dedicated a separate fund, the OB Stabilization Fund to support the continued availability of obstetric services in these same rural areas.

As a result, in FY15, the Michigan Legislature appropriated $36 million dollars for the Small and Rural Hospital Pool and $11.2 million dollars for the OB Stabilization Fund, funding that went directly to support continued access to these critical services throughout the state and specifically in Northern Michigan.

In a region of the state that spans over 11,000 square miles, access to care is essential to maintaining a strong quality of life, attracting and retaining talent and the continued economic growth of the region.

Unfortunately, with the elimination of these two funding pools, the threat of hospital closure or the loss of OB services is very real. Since 2010, the region has seen the closure of two hospital OB units, the closure of a neo-natal unit in Petoskey and the bankruptcy of a hospital in Cheboygan.

Despite the best efforts of the healthcare community to maintain these critical services, the reality is that combined, the Small and Rural Hospital Pool and the OB Stabilization fund equals many rural hospital's entire net income for the year.

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MUNSON HEALTHCARE

In addition, any increase in caseload that these hospitals might see due to the Healthy Michigan Plan are still offset by the loss to hospitals from traditional Medicaid payments, which pays only twenty cents on the dollar.

Therefore, the elimination of the $36 million dollar Small and Rural Hospital Pool and the $11.2 million dollar OB Stabilization Fund in the FY16 budget will put the lives of thousands at risk. With a break-even budget and no ability to reinvest in talent recruitment, retention or technology investments, rural community hospitals will close.

Not only will this impact Northern Michigan, but rural communities around the state. For example:

- Munson Healthcare, Northern Michigan- Combined impact of $9.85 million
- Spectrum Health, West Michigan- Combined impact of $4.67 million
- Oaklawn Hospital, Marshall/Albion- Combined impact of $2.146 million
- Charlevoix Area Hospital- Combined impact of $546,391
- Harbor Beach Community Hospital- Combined impact of $166, 117
- Kalkaska Memorial Health Center- Combined impact of $945,360

Therefore, for the health of our citizens, for the health of our communities and for the continued health of our economy, it is absolutely critical to restore funding in both the Rural Hospital Pool and OB Stabilization Fund.

Thank you again for your consideration of this request from the healthcare community of Northern Michigan, joining with the Northern Michigan Chamber Alliance and Michigan Hospital Association who are all imploring that this critical funding be restored so that the resident of rural Michigan will continue to have access to lifesaving medical care.

I would also like to submit a letter from the coalition to the Committee for the record as well as a full list of hospitals affected by these cuts.

Thank you for this opportunity to speak with you today.

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munsonhealthcare.org

MUNSON HEALTHCARE

March 2, 2015

Chairman Rob VerHeulen
Michigan House of Representatives
Appropriations Subcommittee on Community Health
124 North Capitol Avenue
Lansing, MI 48909

Dear Chairman VerHeulen;

As a coalition of rural Northern Michigan hospitals and joining with the Northern Michigan Chamber Alliance and Michigan Hospital Association, we are writing regarding the FY 2016 Department of Community Health Executive Budget Recommendation and its affect on access to rural healthcare in Michigan. Specifically we are concerned about the Governor's proposed elimination of the Small and Rural Access Pool and the Obstetrics (OB) Stabilization Fund, which if enacted would be devastating for rural Northern Michigan communities.

Three years ago, the Michigan Legislature created the Small and Rural Access Pool to help maintain local access to critical hospital services such as primary care, emergency room and OB services, in smaller, more rural communities. Last year, recognizing the importance of OB services, the Legislature dedicated a separate fund, the OB Stabilization Fund to support the continued availability of obstetric services in rural, underserved communities. As a result, in FY15, the Michigan legislature appropriated $36 million dollars for the Small and Rural Hospital Pool and $11.2 million dollars for the OB Stabilization Fund, funding that went directly to support continued access to these critical services throughout the state and specifically in Northern Michigan.

As a region, Northern Michigan spans over 11,000 square miles across 21 counties north of Clare. Yet, less than half of those counties have a hospital located within their borders, only 9 provide OB services and there is only 1 neo-natal center serving the entire region. As a result, for the over half million residents of Northern Michigan, each one of these hospitals is critical for maintaining strong quality of life, attracting and retaining talent and continued economic growth. Without the critical services that rural hospitals provide, not only would the residents of these communities suffer, but also the potential for regional prosperity would be greatly diminished.

The threat of closure or loss of OB services for many of these hospitals in Northern Michigan is very real. Since 2010, the region has seen the closure of two hospital OB units and the closure of a neo-natal unit in Petoskey, with many others on the brink. As a coalition, Northern Michigan hospitals have worked in a collaborative manor to reduce costs and maintain access to these services while relying on the Small and

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Rural Hospital Pool and OB Stabilization Fund to close the gap between operating in the red and in the black. To date, the coalition has maintained this most basic level of service, but the proposed elimination of these two funds puts those years of work and effort in jeopardy.

Therefore, as a coalition of Northern Michigan hospitals we urge you to restore this critical funding for the Small and Rural Hospital Pool ($36 million) and the OB Stabilization Fund ($11.2 million) as we find it unacceptable to put the lives of thousands at risk due to the loss of these funds. For many of these rural hospitals the combination of these two funding sources equals their entire net income for the year. With a break-even budget and no ability to reinvest in talent recruitment, retention or technology investments, rural community hospitals will close. Therefore for the heath of our citizens, for the health of our communities and for the continued health of our economy, it is absolutely critical to restore funding in both the Rural Hospital Pool and OB Stabilization Fund.

Thank you for your consideration of this request from the healthcare community of Northern Michigan, joining with the Northern Michigan Chamber Alliance and Michigan Hospital Association who all ask that you restore this critical funding and support access to lifesaving medical care for the residents of rural Northern Michigan.

Sincerely,

Edwin A. Ness, President & CEO
Munson Healthcare

Tonya Smith, President
Munson Healthcare Cadillac Hospital

James Barker, CEO
West Shore Medical Center

Kevin Rogols, CEO/Administrator
Kalkaska Memorial Health Center

Stephanie Riemer, President
Munson Healthcare Grayling Hospital

Tom Lemon, CEO
Otsego Memorial Hospital

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FY 2016 Executive Budget Proposal to Eliminate GME, Rural and OB Pools

Hospital Name	System	GME Payment Cut	Rural Payment Cut	OB Payment Cut	Total Cuts
Borgess Hospital	Ascension	($1,754,133)	$0	$0	($1,754,133)
Borgess Pipp Hospital	Ascension	$0	($287,010)	$0	($287,010)
Borgess-Lee Memorial Hospital	Ascension	$0	($1,384,763)	$0	($1,384,763)
Brighton Hospital	Ascension	$0	$0	$0	$0
Genesys Regional Medical Center	Ascension	($1,727,442)	$0	$0	($1,727,442)
Providence Hospital	Ascension	($1,809,385)	$0	$0	($1,809,385)
Saint Mary's Standish Community Hospital	Ascension	$0	($329,987)	$0	($329,987)
St. John Hospital and Medical Center	Ascension	($6,605,839)	$0	$0	($6,605,839)
St. John Macomb-Oakland Hospital-Macomb Center	Ascension	($2,006,924)	$0	$0	($2,006,924)
St. John River District Hospital	Ascension	($10,515)	($373,421)	($287,180)	($671,116)
St. Mary's of Michigan Medical Center	Ascension	($490,962)	$0	$0	($490,962)
Tawas St. Joseph Hospital	Ascension	$0	($446,722)	($303,780)	($750,502)
Aspirus Grand View Hospital	Aspirus	$0	($687,200)	($91,300)	($778,500)
Aspirus Keweenaw Hospital	Aspirus	$0	($490,496)	($78,850)	($569,346)
Aspirus Ontonagon Hospital	Aspirus	$0	($367,568)	$0	($367,568)
Beaumont Health System-Grosse Pointe	Beaumont	($189,204)	$0	$0	($189,204)
Beaumont Health System-Royal Oak	Beaumont	($3,476,053)	$0	$0	($3,476,053)
William Beaumont Hospital - Troy	Beaumont	($176,475)	$0	$0	($176,475)
Bronson Battle Creek Hospital	Bronson	$0	$0	$0	$0
Bronson Lake View Hospital	Bronson	$0	($977,722)	$0	($977,722)
Bronson Methodist Hospital	Bronson	($3,433,570)	$0	$0	($3,433,570)
Children's Hospital of Michigan	DMC	($21,014,360)	$0	$0	($21,014,360)
Detroit Receiving Hospital	DMC	($8,952,802)	$0	$0	($8,952,802)
Harper University Hospital	DMC	($10,977,741)	$0	$0	($10,977,741)
Huron Valley - Sinai Hospital	DMC	($244,674)	$0	$0	($244,674)
Rehabilitation Institute	DMC	($186,861)	$0	$0	($186,861)
Sinai-Grace Hospital	DMC	($6,393,188)	$0	$0	($6,393,188)
Henry Ford Hospital	Henry Ford	($16,280,220)	$0	$0	($16,280,220)
Henry Ford Macomb Hospital	Henry Ford	($1,152,328)	$0	$0	($1,152,328)
Henry Ford West Bloomfield Hospital	Henry Ford	($26,255)	$0	$0	($26,255)
Henry Ford Wyandotte Hospital	Henry Ford	($424,119)	$0	$0	($424,119)
Kingswood Psychiatric Hospital	Henry Ford	($151,009)	$0	$0	($151,009)
Lakeland Community Hospital - Watervliet	Lakeland	$0	($154,395)	$0	($154,395)
Lakeland Hospital - St. Joseph	Lakeland	($554,844)	$0	$0	($554,844)
Lakeland Specialty Hospital at Berrien Center	Lakeland	$0	($7,292)	$0	($7,292)
Bell Memorial Hospital	LifePoint	$0	($894,392)	($169,320)	($1,063,712)
Marquette General Hospital	LifePoint	($380,099)	($98,108)	($485,550)	($963,757)
Portage Health Hospital	LifePoint	$0	($269,969)	($161,020)	($430,989)
Barbara Ann Karmanos Cancer Hospital	McLaren	($1,741,192)	$0	$0	($1,741,192)
Bay Special Care Center	McLaren	$0	$0	$0	$0
McLaren - Central Michigan	McLaren	$0	$0	$0	$0
McLaren - Greater Lansing	McLaren	($1,223,984)	$0	$0	($1,223,984)
McLaren Bay Region	McLaren	($147,790)	$0	$0	($147,790)
McLaren Flint	McLaren	($1,371,376)	$0	$0	($1,371,376)
McLaren Lapeer Region	McLaren	$0	$0	$0	$0
McLaren Macomb	McLaren	($1,303,445)	$0	$0	($1,303,445)
McLaren Oakland	McLaren	($1,492,552)	$0	$0	($1,492,552)
McLaren Port Huron Hospital	McLaren	$0	$0	$0	$0
McLaren-Northern Michigan	McLaren	$0	($812,192)	($555,270)	($1,367,462)
Gratiot Medical Center	MidMichigan	$0	$0	$0	$0
Mid Michigan Medical Center - Gladwin	MidMichigan	$0	($357,454)	$0	($357,454)
MidMichigan Medical Center - Clare	MidMichigan	$0	($204,089)	$0	($204,089)
MidMichigan Medical Center - Midland	MidMichigan	($312,099)	($1,707,263)	($795,140)	($2,814,502)
Mercy Hospital - Cadillac	Munson	$0	($735,746)	($322,870)	($1,058,616)
Mercy Hospital - Grayling	Munson	$0	($418,320)	($343,620)	($761,940)
Munson Medical Center	Munson	($250,145)	($2,617,845)	($1,463,290)	($4,331,280)
Paul Oliver Memorial Hospital	Munson	$0	($260,014)	$0	($260,014)
Oakwood Annapolis Hospital	Oakwood	($540,992)	$0	$0	($540,992)
Oakwood Heritage Hospital	Oakwood	($303,718)	$0	$0	($303,718)
Oakwood Hospital and Medical Center	Oakwood	($2,503,289)	$0	$0	($2,503,289)
Oakwood Southshore Medical Center	Oakwood	($387,742)	$0	$0	($387,742)

FY 2016 Executive Budget Proposal to Eliminate GME, Rural and OB Pools

Hospital Name	System	GME Payment Cut	Rural Payment Cut	OB Payment Cut	Total Cuts
Emma L. Bixby Medical Center	Promedica	$0	$0	$0	$0
Herrick Memorial Hospital, Inc.	Promedica	$0	$0	$0	$0
Mercy Memorial Hospital	Promedica	$0	$0	$0	$0
Select Specialty Hospital - Ann Arbor	Select	$0	$0	$0	$0
Select Specialty Hospital - Battle Creek	Select	$0	$0	$0	$0
Select Specialty Hospital - Downriver	Select	$0	$0	$0	$0
Select Specialty Hospital - Flint	Select	$0	$0	$0	$0
Select Specialty Hospital - Grosse Pointe	Select	$0	$0	$0	$0
Select Specialty Hospital - Macomb County	Select	$0	$0	$0	$0
Select Specialty Hospital - Northwest Detroit	Select	$0	$0	$0	$0
Select Specialty Hospital - Pontiac	Select	$0	$0	$0	$0
Select Specialty Hospital - Saginaw	Select	$0	$0	$0	$0
Carson City Osteopathic Hospital	Sparrow	($5,670)	($476,600)	($348,600)	($830,870)
Clinton Memorial Hospital	Sparrow	$0	($447,419)	$0	($447,419)
Edward W. Sparrow Hospital	Sparrow	($3,748,504)	$0	$0	($3,748,504)
Ionia County Memorial Hospital	Sparrow	$0	($1,027,223)	$0	($1,027,223)
Sparrow Specialty Hospital	Sparrow	$0	$0	$0	$0
Memorial Medical Center of West Michigan	Spectrum	$0	($600,326)	($302,950)	($903,276)
Spectrum Health	Spectrum	($7,484,564)	$0	$0	($7,484,564)
Spectrum Health - Kent Community Campus	Spectrum	$0	$0	$0	$0
Spectrum Health - Reed City Campus	Spectrum	$0	($996,568)	$0	($996,568)
Spectrum Health Big Rapids	Spectrum	$0	($199,523)	($615,860)	($815,383)
Spectrum Health Gerber Memorial	Spectrum	$0	($464,653)	($489,700)	($954,353)
Spectrum Health United Memorial - Kelsey Campus	Spectrum	$0	($458,207)	$0	($458,207)
Spectrum Health United Memorial - United Campus	Spectrum	$0	($122,486)	($423,300)	($545,786)
Spectrum Health Zeeland Community Hospital	Spectrum	$0	$0	$0	$0
Chelsea Community Hospital	Trinity	$0	$0	$0	$0
Mercy Health Partners - Hackley Campus	Trinity	($228,142)	$0	$0	($228,142)
Mercy Health Partners - Lakeshore Campus	Trinity	$0	($443,763)	$0	($443,763)
Mercy Health Partners - Mercy Campus	Trinity	($218,594)	$0	$0	($218,594)
St. Joseph Mercy Hospital - Ann Arbor	Trinity	($976,978)	$0	$0	($976,978)
St. Joseph Mercy Livingston Hospital	Trinity	($238,701)	$0	$0	($238,701)
St. Joseph Mercy Oakland	Trinity	($1,090,550)	$0	$0	($1,090,550)
St. Joseph Mercy Port Huron	Trinity	$0	$0	$0	$0
St. Mary Mercy Hospital	Trinity	($483,265)	$0	$0	($483,265)
St. Mary's Health Care (Grand Rapids)	Trinity	($1,550,963)	$0	$0	($1,550,963)
Allegan General Hospital	Unaffiliated	$0	($1,022,434)	$0	($1,022,434)
Allegiance Health	Unaffiliated	$0	$0	$0	$0
Alpena Regional Medical Center	Unaffiliated	$0	($90,322)	($334,490)	($424,812)
Baraga County Memorial Hospital	Unaffiliated	$0	($699,482)	$0	($699,482)
BCA StoneCrest Center	Unaffiliated	$0	$0	$0	$0
Behavioral Center of MI (4040 AND 4042)	Unaffiliated	$0	$0	$0	$0
Botsford Hospital	Unaffiliated	($2,131,979)	$0	$0	($2,131,979)
CareLink of Jackson	Unaffiliated	$0	$0	$0	$0
Caro Community Hospital	Unaffiliated	$0	($389,858)	$0	($389,858)
Charlevoix Area Hospital	Unaffiliated	$0	($382,881)	($163,510)	($546,391)
Chippewa War Memorial Hospital	Unaffiliated	$0	($372,026)	($285,520)	($657,546)

FY 2016 Executive Budget Proposal to Eliminate GME, Rural and OB Pools

Hospital Name	System	GME Payment Cut	Rural Payment Cut	OB Payment Cut	Total Cuts
Community Health Center of Branch County	Unaffiliated	($94,056)	($510,812)	($273,070)	($877,938)
Covenant Medical Center, Inc.	Unaffiliated	($1,181,259)	$0	$0	($1,181,259)
Crittenton Hospital	Unaffiliated	($338,790)	$0	$0	($338,790)
Deckerville Community Hospital	Unaffiliated	$0	($292,576)	$0	($292,576)
Dickinson County Memorial Hospital	Unaffiliated	$0	($330,373)	($322,870)	($653,243)
Doctors' Hospital of Michigan	Unaffiliated	($272,670)	$0	$0	($272,670)
Eaton Rapids Medical Center	Unaffiliated	$0	($24,248)	$0	($24,248)
Forest Health Medical Center, Inc.	Unaffiliated	$0	$0	$0	$0
Forest View Psychiatric Hospital	Unaffiliated	$0	$0	$0	$0
Garden City Hospital	Unaffiliated	($978,526)	$0	$0	($978,526)
Great Lakes Specialty Hospital - Muskegon	Unaffiliated	$0	$0	$0	$0
Great Lakes Specialty Hospital-Oak	Unaffiliated	$0	$0	$0	$0
Harbor Beach Community Hospital	Unaffiliated	$0	($166,117)	$0	($166,117)
Harbor Oaks Hospital	Unaffiliated	$0	$0	$0	$0
Havenwyck Hospital	Unaffiliated	$0	$0	$0	$0
Hayes Green Beach Memorial Hospital	Unaffiliated	$0	($440,527)	$0	($440,527)
Healthsource Saginaw	Unaffiliated	$0	$0	$0	$0
Helen Newberry Joy Hospital	Unaffiliated	$0	($427,944)	$0	($427,944)
Hills & Dales General Hospital	Unaffiliated	$0	($485,282)	$0	($485,282)
Hillsdale Community Health Center	Unaffiliated	($21,133)	($88,246)	($357,730)	($467,109)
Holland Community Hospital	Unaffiliated	$0	$0	$0	$0
Hurley Medical Center	Unaffiliated	($5,049,389)	$0	$0	($5,049,389)
Huron Medical Center	Unaffiliated	$0	($685,179)	($340,300)	($1,025,479)
Kalkaska Memorial Health Center	Unaffiliated	$0	($945,360)	$0	($945,360)
Kindred Hospital Detroit	Unaffiliated	$0	$0	$0	$0
Mackinac Straits Hospital	Unaffiliated	$0	($588,277)	$0	($588,277)
Marlette Regional Hospital	Unaffiliated	$0	($302,840)	$0	($302,840)
Mary Free Bed Hospital & Rehabilitation Center	Unaffiliated	$0	$0	$0	$0
McKenzie Memorial Hospital	Unaffiliated	$0	($336,737)	$0	($336,737)
Memorial Healthcare	Unaffiliated	$0	$0	$0	$0
Metro Health Hospital	Unaffiliated	($1,142,903)	$0	$0	($1,142,903)
Munising Memorial Hospital	Unaffiliated	$0	($227,148)	$0	($227,148)
North Ottawa Community Hospital	Unaffiliated	$0	$0	$0	$0
Northstar Health Systems	Unaffiliated	$0	($537,922)	$0	($537,922)
Oakland Regional Hospital	Unaffiliated	$0	$0	$0	$0
Oaklawn Hospital	Unaffiliated	$0	($1,613,636)	($532,860)	($2,146,496)
Otsego County Memorial Hospital	Unaffiliated	$0	($564,150)	($247,340)	($811,490)
Pennock Hospital	Unaffiliated	$0	($460,521)	($273,900)	($734,421)
Pine Rest Christian Hospital	Unaffiliated	$0	$0	$0	$0
Scheurer Hospital	Unaffiliated	$0	($94,738)	$0	($94,738)
Schoolcraft Memorial Hospital	Unaffiliated	$0	($244,086)	$0	($244,086)
Sheridan Community Hospital	Unaffiliated	$0	($281,539)	$0	($281,539)
South Haven Community Hospital	Unaffiliated	$0	($82,598)	$0	($82,598)
Southeast Michigan Surgical Hospital	Unaffiliated	($21,640)	$0	$0	($21,640)
Southwest Regional Rehabilitation Hospital	Unaffiliated	$0	$0	$0	$0
St. Francis Hospital & Medical Group	Unaffiliated	$0	($1,472,053)	($199,200)	($1,671,253)
Straith Memorial Hospital	Unaffiliated	$0	$0	$0	$0
Sturgis Memorial Hospital	Unaffiliated	$0	($141,200)	($478,080)	($619,280)
Three Rivers Health	Unaffiliated	$0	($220,884)	($124,500)	($345,384)
University of Michigan Health System	Unaffiliated	($35,632,694)	$0	$0	($35,632,694)
Vibra of Southeastern Michigan	Unaffiliated	$0	$0	$0	$0
West Branch Regional Medical Center	Unaffiliated	$0	($133,244)	$0	($133,244)
West Shore Medical Center	Unaffiliated	$0	($1,049,024)	($124,500)	($1,173,524)
Total		($162,888,300)	($34,823,000)	($11,295,470)	($209,006,770)

FY 2016 Executive Budget Proposal to Eliminate GME, Rural and OB Pools

Hospital Name	System	GME Payment Cut	Rural Payment Cut	OB Payment Cut	Total Cuts
	Ascension	($14,405,200)	($2,821,903)	($590,960)	($17,818,063)
	Aspirus	$0	($1,545,264)	($170,150)	($1,715,414)
	Beaumont	($3,841,732)	$0	$0	($3,841,732)
	Bronson	($3,433,570)	($977,722)	$0	($4,411,292)
	DMC	($47,769,626)	$0	$0	($47,769,626)
	Henry Ford	($18,033,930)	$0	$0	($18,033,930)
	McLaren	($7,280,340)	($812,192)	($555,270)	($8,647,802)
	MidMichigan	($312,099)	($2,268,806)	($795,140)	($3,376,045)
	Lakeland	($554,844)	($161,687)	$0	($716,531)
	LifePoint	($380,099)	($1,262,469)	($815,890)	($2,458,458)
	Munson	($250,145)	($4,031,925)	($2,129,780)	($6,411,850)
	Oakwood	($3,735,741)	$0	$0	($3,735,741)
	Promedica	$0	$0	$0	$0
	Select	$0	$0	$0	$0
	Sparrow	($3,754,174)	($1,951,242)	($348,600)	($6,054,016)
	Spectrum	($7,484,564)	($2,841,763)	($1,831,810)	($12,158,137)
	Trinity	($4,787,194)	($443,763)	$0	($5,230,957)
	Unaffiliated	($46,865,040)	($15,704,264)	($4,057,870)	($66,627,174)
	Total	($162,888,300)	($34,823,000)	($11,295,470)	($209,006,770)
	# Hospitals	57	66	36	116

These amounts reflect FY 2015 payment amounts provided by the Medical Services Administration.

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Fred
Cummins

Incentives to Improve the Mental Health System

Testimony of by Fred A. Cummins

President, Alliance for the Mentally Ill of Oakland County

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Introduction

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

The problems and associated incentives highlight the need for substantial changes to the design and operation of the Michigan mental health system. These changes should fill the gaps, achieve needed integration and realize the benefits of advancing technology. The changes will be somewhat disruptive, particularly to the persons who deliver and manage mental health services, but they can be implemented incrementally, with positive effects on persons in need of services.

The system is the way it is, in large measure, because of the incentives. Acceptance of these changes will be difficult given that most people are doing the best they can in the current system with its inappropriate incentives. These incentives must drive cultural change.

The following sections describe the current problems and needed changes to incentives.

Leadership by the Department of Community Health

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

1. Consolidation of systems

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

- The Department of Community Health should have clear responsibility for the effective and efficient operation of the public mental health system through the elimination of duplicated and inconsistent efforts.
- Allocate funding to DCH to manage the development, deployment and maintenance of common information systems. Common systems will achieve economies of scale, improve compatibility of information, improve care equity across PIHPs, support best practices and enable state-wide agility in response to advances in information systems and medical technology.
- Require DCH to assess the impact of consolidation of accounting, purchasing and personnel services for PIHPs to improve economies of scale, ability to adapt and accountability.

- Provide funding and technical support for the sharing and exchange of healthcare records between PIHPs, providers and other healthcare organizations.
- Provide leadership and funding for information systems development forums for IT and clinical representatives of PIHPs and CMHs to develop consensus on project selection and system design.
- Provide a process by which advances in information technology proposed by PIHP/CMH personnel can be evaluated, funded and monitored.

2. Clinical leadership

- Perform clinical research and provide funding and collaborate with PIHPs in the development of (1) best practices, (2) personnel qualifications and training, (3) tools to support appropriate diagnosis, access to services and individual plans of service and (4) supporting information systems.
- Prescribe requirements for training case managers regarding local services and resources, and provide training materials for state-wide job responsibilities and practices.
- Require DCH to develop and continuously improve a level-of-care evaluation tool to be used, statewide, for assessment of individual level of care to be provided and as the basis for objective, community needs assessment. This must include assessment for early intervention.

3. Certifications and qualifications

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

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

4. Improve PIHP performance criteria and evaluation mechanisms

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

- Failures of collaboration and coordination of care
- Client status changes—incarceration, hospitalization, homeless, criminal justice contacts, deaths.
- Clients lacking support for participation in employment, education, psychosocial rehabilitation, and social activities as appropriate to their level of functioning.
- Unmet community needs based on the independent needs assessment
- Recipient rights complaints and observed violations.
- Delayed interventions
- Clients in poor quality housing situations

- Non-compliance of clients not petitioned for a Kevin's Law treatment order
- Deviations from treatment plans
- Premature hospital discharges as evidenced by recidivism or other disruptive behavior.

Formularies

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

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

Reduction of Dangerous Behavior and Criminalization

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

5. Services for difficult to serve patients

- Fund an independent study of the long-term consequences of a failure to achieve early intervention. The study is expected to provide an incentive to fund and promote early intervention in order to improve outcomes and long term costs of care.
- Reimburse for early intervention efforts regardless of alternative funding sources and require private insurance payers to accept claims from PIHPs for services covered by the private insurance.
- Capitation of funding should apply only to the organization responsible for financial risk management (e.g., the PIHPs). Providers should be paid for the services they provide according to the treatment plan rather than being given a conflict of interest between cost-containment and appropriate care.
- Needs of chronically ill patients can be costly and diverse. Reimbursement of providers must reflect client difficulty to reduce the risk that difficult clients may not be adequately served.
- Treatment planning and review should determine the appropriate level, array and intensity of services provided. Fraud should be exposed by oversight, audits and billing analysis, not restrictive reimbursement rules.

- PIHPs must reimburse police agencies for the cost of interventions with PIHP clients. Police are often the first responders to a mental health crisis. This is intended to shift the cost burden to PIHPs as an incentive to avoid or minimize police involvement.
- On-call, intervention services and overtime for crisis resolution must be reimbursed to improve interventions.
- For more intensive supports, such as Assertive Community Treatment (ACT), working hours of members of the team should cover extended days (e.g., 8 am to 8 pm) and weekends, closer to what would be expected in a hospital setting. Reimbursement should reflect these extended hours.
- Length of hospitalization must be determined by patient stability not limitations of insurance coverage.
- Provider responses to clients in emergency rooms or police custody must be reimbursed.

6. Remove incentives for non-compliance

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

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

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

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

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

8. Cost of Incarcerations

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

- Transfer the portion of the Department of Corrections budget associated with each inmate with mental illness to the PIHP responsible for that inmate's area of residence, and provide for DOC to bill each PIHP for the cost of incarceration and treatment of all such inmates. This provides a financial incentive for PIHPs to provide needed services to mentally ill persons at risk of criminalization as well as those being released from jails and prison to reduce recidivism. A similar strategy was used to substantially down-size and close state hospitals. This action also improves Federal funding since these clients lose Federal benefits when incarcerated.
- When a person who is or should be a mental health client is detained, require criminal justice to notify the PIHP of the person's county of residence or the PIHP of the county where detained if residence is not clear. That PIHP is then responsible for the mental health care of the person whether incarcerated or released for community care.
- Require PIHPs to accept billing from jails for incarceration and treatment of inmates with mental illness who are residents of the PIHP catchment area. Billing should be based on county agreements to transfer to their PIHP the portion of the jail budget for incarceration and treatment of these individuals.
- The Department of Corrections and jails should have an incentive to support this mechanism for cost recovery given the potential to reduce their inmate populations of inmates with mental illness who are difficult to manage.
- Establish a process for certification of new inmates who should be covered by PIHP funding
- Currently due to concerns about the mental health system, parole boards are incented to hold inmates with mental illness for their full term. A process is needed for coordination of inmate discharge with their PIHP and parole oversight of inmates with mental illness so they can qualify for parole. As a result they can be released earlier with the oversight of parole.
- Create a system for notification of the PIHP of a person's county of residence when the person is detained by criminal justice or admitted to an emergency room. Ensuring PIHP awareness creates the opportunity and a burden to intervene or at least ensure that the client has the benefit of the knowledge, if not the services, of his/her treatment team. Police and emergency rooms have the incentive to report encounters in order to reduce their involvement with persons in need of mental health treatment.

Integration of Care

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

9. Collaboration

- Reimbursement of professionals must include collaboration with families and other professionals for insight, consistency and continuity of care. Reimbursement removes the disincentive of using personal time and reinforces that collaboration is important.
- Reimbursement should cover coordination and support of clients for transitions between treatment settings and changes of personnel (doctors, case managers and direct care workers). This provides an

incentive to coordinate in order to minimize discontinuity of care and the adverse impact of change on the client.
- Ensure that collaboration is supported by sharing of electronic health records and a shared and integrated, individual treatment plan.

10. Coordination with multiple payers and providers

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

- A patient must have a primary care provider and that provider must be reimbursed for treatment planning and coordination of care.
- Each shared treatment plan should be supported by tracking of service delivery to hold providers accountable for compliance with the treatment plan.
- Reimbursement must cover collaboration of participating providers.
- General health insurance does not cover all of the mental health services that are available in the public mental health system so patients must be allowed to obtain services from the public system that complement those available through their health insurance.
- A case manager must be incented to help the recipient or his/her representative coordinate care without violating rights to privacy and choice.
- Community mental health and FQHCs must be reimbursed by Medicaid HMO organizations for covered services. This conflicts with HMO cost saving incentives for credentialed physicians. This conflict must be alleviated by alternative reimbursement mechanisms.

Objective Needs Assessment

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

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

- The analysis must determine the impact of mental health parity on the shifting of costs from the public mental health system to private insurance. The savings should provide added incentive for legislative adoption of mental health parity in addition to the potential to improve early intervention and long-term outcomes.

Separation of responsibility

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

- An organization for the protection of recipient rights, and resolution of complaints, grievances and appeals should not be part of an organization that is a party to disputes they must resolve. Furthermore, in an integrated system of care, problem resolution may involve multiple provider or payer organizations.
- Case managers and doctors responsible for treatment planning and oversight, should not work for organizations responsible for the funding of services specified in the treatment plan.
- Organizations funded by capitation have a conflict between saving money and providing quality care. PIHPs must accept responsibility for risk management without passing risk on to providers (and thus to clients). This removes the conflict of interest of a provider that leads to inadequate services and undesirable, long-term, more expensive outcomes. PIHPs must develop incentives for efficiency and better, well-coordinated and necessary services based on reimbursement, oversight and transparency, not cost-cutting.
- Providers tasked with self-reporting of performance have a conflict of interest between accurate reporting and adverse evaluations.

Community inclusion

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

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

Accountability of Providers

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

11. Transparency

Not only are many non-profit service providers entrusted with people's lives, but they must be accountable to the public for their use of public funds and for fulfilling the public purpose for which they are tax exempt.

These recommendations remove barriers to information about actions of service providers and provides transparency and accountability as incentives for responsible operation.

- Extend (restore) the Freedom of Information Act (FOIA) and the Open Meetings Act applicability to non-profits that receive 50% or more of their budget from public funds (including Medicaid and Medicare reimbursements). This transparency provides an opportunity for public action and it provides an incentive for their boards of directors to take responsibility for agency performance problems.
- Measure PIHPs against community needs and performance of their providers.
- Evaluate providers based on outcomes, recipient and family satisfaction, rights protection, and consistent use of best practices and standards of care.
- Perform oversight independent of providers.
- Provide information on employee qualifications, service offerings and performance measurements for public access and to support client choice.
- Provide outcome statistics to the public regarding clients in different residential settings, clients with jobs, clients enrolled in education, clients in drop-in centers or club-houses, responses to clients in emergency rooms or arrested, clients incarcerated, deaths, etc.
- Track the association of adverse conditions and events to individual workers and their managers to assess needs for corrective action at all levels.

12. Services monitoring

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

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

13. Corrective action

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

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

Patient and Family Participation in Treatment Decisions

Patients and families should be encouraged to participate in treatment planning and decision-making. This requires collaboration and access to information. Families are often excluded based on confidentiality as a barrier even though they may be a primary caregiver. Patients and guardians are often denied the opportunity to make informed decisions and consent to treatment.

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

Acknowledgements

This document is based on work of the Incentives Sub-Group of Work Group #3, of the Michigan Mental Health and Wellness Commission, September, 2013

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DCH SC 3-2-15
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MICHIGAN LEAGUE FOR PUBLIC POLICY

Testimony Presented to the House Appropriations Subcommittee for the Department of Community Health

Gilda Z. Jacobs, President and CEO

March 2, 2015

Good morning, Chairman Ver Huelin and members of the Subcommittee. I am Gilda Jacobs, President and CEO of the Michigan League for Public Policy. The League has been advocating for low-income families and children in Michigan for more than 100 years, and I am pleased today to have the opportunity to present our comments about the governor's proposed DCH budget for the upcoming fiscal year.

We are so pleased the Legislature approved the expansion of Medicaid eligibility with full federal funding and created the Healthy Michigan Plan. We support the governor's recommendation to continue federal funding for the program which provides comprehensive healthcare coverage to nearly 600,000 low-income residents. I congratulate you for this great success to date and encourage your continued support. Many of these individuals are working and either do not have employer coverage available to them, or it is unaffordable. This program is making a difference in people's lives with its focus on prevention and healthy lifestyle changes. The Healthy Michigan Plan is enabling individuals to take control of their health by focusing not only on prevention services but on also chronic disease management.

We support the recommended expansion of the Healthy Kids Dental program, although we are disappointed that, even with the recommended expansion, more than 170,000 kids in Wayne, Oakland and Kent counties will be left behind. We know that tooth decay remains the most prevalent chronic disease in children resulting in lost school days and learning, as well as the potential for long-term negative health consequences. Children cannot learn when they are in pain or not in school. Tooth decay is preventable. We look forward to the day when funding is available to cover all Medicaid-eligible children.

We are pleased that the governor is recommending state investments in Medicaid to continue half of the primary care rate increase implemented in FY2013. As you well know, primary care access is critical to attaining or maintaining good health.

We also support improvements to promote access to adult dental services in Medicaid. Access to dental services for adult Medicaid enrollees has been a long-standing problem that has resulted in escalated dental conditions and serious complications.

We support the governor's recommendation to add $20 million in state funds to cover behavioral health services for those not eligible for Medicaid or the Healthy Michigan Plan. This is a critical need many of you have heard about.

We support continued funding and efforts to eliminate the waiting list and serve more eligible individuals in the MIChoice waiver program. Study after study confirms that given a choice, those who are no longer able to care for themselves without assistance, prefer to receive assistance in their homes or communities rather than being forced into an institutional setting.

We support the governor's recommendation to continue implementation of the Mental Health and Wellness Commission recommendations. Removing service gaps, eliminating stigmas, and treating mental health conditions before they escalate or require Corrections' system interventions will be beneficial to all Michigan residents. In addition, coordination and integration of mental health and physical health services are critical to positive outcomes. People come as a package, not as individual parts.

In summary the League supports:

- Healthy Michigan Plan full funding in DCH and in the other departments where funding is recommended to ensure continuation of this highly successful program.
- Investments in children, including:
    - Healthy Kids Dental investments to expand coverage as recommended, and subsequently to all Medicaid-eligible children,
    - Investment of state funds to support families and promote the healthy development of infants and young children through home visiting programs,
    - Continued funding of the Infant Mortality Reduction Plan initiative – we are seeing significant declines in infant mortality, particularly in African-American babies.
- Investment of $20 million in state funds to close the gap in needed behavioral health funding for those not eligible for Medicaid or the Healthy Michigan Plan.
- Investment of state funds to continue a portion of the Medicaid primary care rate increase.
- Improvements to adult dental access for Medicaid enrollees.
- Continued implementation of the Mental Health and Wellness Commission recommendations to improvement mental health treatment and outcomes.
- Elimination of waiting lists for MIChoice services.

Thank you for the opportunity to testify before this committee. We look forward to working with you as the budget process progresses.

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DCH SC 3-2-15
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To: Representative Robert VerHeulen, Chairman
House Appropriations Subcommittee on Community Health
Members, House Appropriations Subcommittee on Community Health

From: Ginger Williams, MD, FACEP, FACHE
Oaklawn Hospital President and CEO|

Date: March 2, 2015

Re: Fiscal Year 2016 Community Health Budget – Small and Rural Hospital Access Pool and Obstetrical Stabilization Pool

Thank you for the opportunity to speak to you today on the critical issue of funding healthcare for the underinsured. Specifically I want to address the Small and Rural Hospital Medicaid pool and the OB Access pool.

Let me tell you a little about Oaklawn Hospital.

We are a 94-bed independent community hospital located about 40 miles south of here. We were recognized by Consumer Reports in their February edition this year as being the safest hospital *in the country*. In 2014 we were redesignated by the Magnet program (one of only a few hundred hospitals in the country to receive this prestigious quality designation). We are one of the very few US hospitals that is ISO 9001 certified.

Also during calendar year 2014 we made massive changes to our operations in order to try to survive under the constantly growing governmental mandates for reporting and infrastructure, and the constantly declining reimbursement from the government and private payors.

About 50 Oaklawn employees had their jobs eliminated last year; we reduced by about 70 full time equivalents.

And the Healthy Michigan Plan resulted in a $3 million **reduction** to our revenue (which I'll get to in a minute) from what is currently an operating margin of **only** 1% in the first place ... a margin that is not considered high enough for a business to be sustainable in the long run.

I tell you about some of our successes and our quality because I want you to understand that we are not simply whiners looking for a handout. We are very good at what we do. We, as Oaklawn and as community hospitals in general, are a critical access point for hundreds of thousands of Michigan's citizens. Community hospitals provide a structural cost advantage over larger hospitals by a significant percent.

We are a good bargain and often the largest employer in our community. We are a resource that you don't want to lose. And we are at increasing danger of being lost because of actions like the elimination of the Small and Rural Hospital funding pool and the OB Access pool.

There is also a misconception that Medicaid is a reasonably good payer and that the funding pools make us whole, or better. That is also incorrect.

Including the money we get from the Medicaid pools Medicaid reimburses us on average about 97% of what it actually costs to provide care. Without those pools we are reimbursed, on average, about 56% of the actual cost of providing care.

Funding this Medicaid payment hole from increasing the provider tax or the HICA tax is NOT the answer for at least 2 reasons.

First, a third of Michigan hospitals get back less than they pay in the provider tax already ... and most of us are struggling to get to a sustainable operating margin. Taking from one set of providers to give to another set of providers, rather than the State taking care of its most vulnerable citizens by supporting those who provide their care, is an abdication of responsibility.

Second, regarding the HICA tax, since the State has accepted responsibility for ensuring healthcare availability for its citizens the State should not foist the payment of that obligation on just a select group of individuals or businesses; this is a societal responsibility and should be funded accordingly. Also, the increase in the HICA tax is far from a given, and will likely face stiff opposition.

Let me touch for a minute on the misconception that the Healthy Michigan Plan has resulted in a windfall for hospitals.

Unfortunately, the Healthy Michigan Plan appears to have cost Oaklawn Hospital $3 million of lost bottom line revenue so far in our current fiscal year, which ends March 31.

I know that isn't what you've been told, but it IS what we have experienced. I'd like to explain why this is true for us and for a number of other hospitals.

We ended our last fiscal year with 3.4% self-pay patients and 13.4% Medicaid. We are currently running 1.8% self-pay (a decrease of 1.6% points) and 17.3% Medicaid (an increase of 3.9% points).

Less than half of our increase in Medicaid came from the self-pay group; **more than half came from those who used to have commercial insurance.**

Here's what that means to a hospital.

- Each percentage point moving from self-pay to Medicaid benefits us financially by about $300,000.
- Each percentage point moving from commercial insurance to Medicaid hurts us by about $1.1 million.

The loss from commercial insurance far exceeds the gain from improvement in bad debt. The more Medicaid patients we see, the faster we lose money. Healthy Michigan appears to have made that worse because we now have fewer commercially-insured patients to cross-subsidize the losses we sustain from Medicaid, ***so we need the Small and Rural Hospital pool and the OB Access pool now more than ever.***

I urge you to ***reject*** the misinformation that Healthy Michigan has been a windfall for hospitals. I urge you to ***reject*** a budget that eliminates the Small and Rural Hospital pool and the OB Access pool. I strongly urge you to ***reinstate*** these pools at, at least, the same amount of general fund dollars that were allocated to them before they were gutted mid-year this year by Executive Order.
Thank you for your time and consideration. Please don't hesitate to contact me if you have any questions.

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DCH SC 3-2-15
Alan Bolter

Michigan Association of COMMUNITY MENTAL HEALTH Boards

Written comments for the House DCH Appropriations Subcommittee
March 2, 2015

Chairman VerHeulen and Members of the Committee:

My name is Alan Bolter, associate director of the Michigan Association of Community Mental Health Boards, representing the 46 community mental health boards and 80+ provider organizations which deliver mental health, substance use disorder, and developmental disabilities services across the entire state.

On behalf of our members, we appreciate the Snyder administration's attention to mental health and substance use disorder services through the Mental Health and Wellness Commission, Diversion Council and various other health initiatives that include behavioral health services. Additional, we appreciate the work of Director Nick Lyon and his team as we worked through the Healthy Michigan transition issues regarding CMH funding.

Our members look forward to working with the Administration and Legislature on the FY16 budget initiatives. We are also requesting two key boilerplate provisions be amended which will provide for greater local innovation and reduce non-value added red tape.

CMH Non-Medicaid Services (General Funds)

We strongly encourage your support for the FY16 Executive Budget recommendation for CMH general fund services. MACMHB appreciates the leadership at MDCH and the State Budget Office for their continuous work on this very difficult situation. While the additional proposed general funds resources do not entirely close the hole left by Healthy Michigan, it certainly helps. Our members continue to meet and discuss with MDCH ways to reduce General Fund obligations on the CMH system so our members can continue to provide critical local safety net services to those in need.

Statewide our members continue to struggle providing services for two key groups who previously received general fund services – Medicaid spend down and Medicare only. These individuals do not qualify for Healthy Michigan because they have insurance. In FY13 our members spent over $30 million on the Medicaid spend down population and over $20 million on the Medicare only population. However, with the reduced general fund support CMHs have not been able to provide the same level of support.

We are hopeful with the creation of the new Department of Health and Human Services we will be able to better address the Medicaid spend down issues that have been historically split between DHS and DCH. This problem not only affects thousands of persons with serious mental illness or developmental disabilities, but also thousands of persons with physical disabilities and persons trapped in nursing home settings due to spend down considerations.

Support for Substance Use Disorder Services

We strongly encourage your support for the Executive Budget recommendation for substance use disorder initiatives. MACMHB appreciates Governor Snyder's and Lt. Governor Calley's leadership on these important issues. Michigan's support for substance use disorder services have been drastically cut over the years to one of the lowest levels in the country at a time when demand for services has steadily increased. General Fund support for substance use disorder services in 1995 was $35 million. In 2013, that funding is less than half – $16 million.

In addition to the initiatives outlined in the FY16 Executive Budget recommendation, we also recommend this committee seek additional substance use disorder funds. While Healthy Michigan has given access to health care to thousands of Michiganders there is still a need for a dedicated and reliable SUD funding. Medicaid has a limited substance use disorder benefit, with a limited array of treatment services.

A potential solution to produce additional funding for SUD services would be legislation introduced last session by Rep. Matt Lori. HB 4891 would have dedicated a portion of revenue from alcohol taxes and fees to substance use disorder services. Under a revised version of the bill 9.5% of net revenues from the Liquor Control Commission would go towards SUD services. With the state generating $363 million net income from alcohol in 2012, we think it both humane and just to dedicate a portion of that revenue to help those who contribute a disproportionate share of that income, but who have such serious problems with the product and will eventually seek help.

Support Sound Actuarial Rates

We strongly encourage you to support appropriate actuarial sound Medicaid and Healthy Michigan rates for our Prepaid Inpatient Health Plans (PIHPs) rather than rates based on enrollment estimates or other factors. To assure that access and quality services are available, full actuarial soundness must be implemented.

Local Match

Boilerplate Section 428 has been included in the budget for the past several years, which requires $25.2 million of CMH local county match funds to be used to draw down additional federal Medicaid resources, approximately $45 million. As you are well aware, CMHs across the state have seen a significant portion of their general fund resources reduced, which in turn limits their flexibility at the local level to serve the needs of their communities. Currently, many counties struggle to meet the local match requirements for CMH services.

We would request the current section 428 be replaced with language that returns the financing responsibility of the $25.2 million to the state and not our membership. This change would allow our members to invest those resources directly into their communities.

Deemed Status

While our membership strongly supports boilerplate section 494, which would adopt a "deemed status" model for reporting requirements, we are requesting the language be amended to require MDCH to grant this provision for our members. This change would significantly reduce thousands of hours our members spend on duplicative state departmental review requirements.

Deemed status for CMHSPs, PIHPs and provider organizations that have full accreditation by a national accrediting body would reduce their and the state's administrative costs, reduce these duplicative state reviews and move towards a less complicated system. Our neighboring states,

Illinois and Ohio both have adopted deemed status models, in fact the state of Illinois found about a 40% redundancy rate between the accrediting bodies' reviews and state reviews. It will enable us to redirect funding from these administrative costs to support more services in the community.

Respectfully submitted,

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COMMUNITY MENTAL HEALTH IN MICHIGAN:

Evidence and Innovation

JANUARY 201

Public Sectors Consultants Inc. (PSC) recently interviewed the directors and staff at 13 Community Mental Health (CMH) organizations to learn more about how they are helping improve the lives of Michigan residents with mental illness and developmental/intellectual disabilities. PSC also interviewed consumers, including those receiving services that foster recovery, independence and community inclusion. Its report highlights CMH activities across the state that best illustrate the innovative, cost-effective, evidence-based services and supports provided.

The report comes as Gov. Rick Snyder's administration begins developing a new people-based system that works smarter to deliver better, less fragmented services. The goal is to help struggling residents enter the mainstream and participate in Michigan's "river of opportunity."

Many elements of the governor's proposed people-based focus are already underway in Michigan's nationally recognized CMH system. As PSC concluded:

"Michigan's Community Mental Health system serves as a safety net and a champion for those with some of the most challenging mental and physical health conditions. Those who work in the system have a clear focus on identifying and delivering the services that will provide the greatest value for consumers and their families."

BEYOND THIS REPORT – What national leaders are saying:

"Michigan has one of the strongest, most fiscally responsible and innovative community behavioral health systems in the country. Michigan's CMH boards have pioneered advances in mental health, from emphasizing the use of evidence-based practices to covering one of the nation's broadest arrays of cost-effective behavioral health services through Medicaid waivers. Michigan stands as a model for the country."

– Linda Rosenberg, MSW, President & CEO, National Council for Behavioral Health

"With Healthy Michigan, thousands of previously uninsured people will have access to excellent, state-of-the-art care through Michigan's public mental health and substance use disorder system."

– Ron Manderscheid, Executive Director, National Association of County Behavioral Health and Developmental Disability Directors

WHAT PUBLIC SECTOR CONSULTANTS FOUND:

1 **As a result of the pioneering advances made by Michigan's CMH system over recent decades, changes now being promoted across the broader health care system are already in place in Michigan's CMH network. Michigan is ahead of the game in:**

- **putting people at the center of the services they receive,**
- **implementing innovative service delivery strategies,**
- **integrating and coordinating care, and**
- **controlling costs within a risk-based payment model.**

2 CMH staff are focused on doing what is needed to promote the recovery of individuals through the use of evidence-based, cost-effective practices. Meanwhile, they keep an eye on innovations that may provide even better solutions.

3 CMH leaders seeking to prevent the premature death of Michiganders with behavioral health issues have been at the forefront of Michigan's efforts to integrate mental and physical health care. Aware of the need to spend taxpayer resources efficiently and effectively, CMHs across the state are using innovative financial strategies to focus spending on people, not programs.

4 CMH has also leveraged financing and implemented new service delivery strategies. State General Fund dollars and local financing revenue are critical to these innovations because they don't have the same restrictions as Medicaid funding.

5 The unique position of local CMHs within the community is critical to meeting the needs of the people they serve. CMH's longtime partnerships with local stakeholders have been crucial to helping with employment, education, housing, community integration, health and wellness, and the development of mental health courts. As interviewees noted:

> ***"CMH is close to the heartbeat of the community. As a group, we have mastered other systems – how they are funded and how they work – so we can leverage community resources effectively. The CMH is at the intersection of cross-system integration. This leadership is what the public mental health system is about."***
> *– Sandra Lindsey, Saginaw County CMH*

> ***"Mental health (treatment) is only as effective as its community partners. ...we have to look at vocational, housing and basic needs, too. It requires relationships with the Michigan Department of Community Health, the Department of Human Services, the local health department, schools, employers and law enforcement, to name a few."***
> *– Greg Paffhouse, Northern Lakes CMH*

COMMUNITY MENTAL HEALTH IN MICHIGAN:

Evidence and Innovation

A policy brief highlighting the findings of a new report prepared by Public Sector Consultants Inc. The full report is available on the Michigan Association of Community Mental Health Boards website at **www.macmhb.org.**

JANUARY 2015

EXECUTIVE SUMMARY

INTRODUCTION

The health care system is increasingly moving toward patient-centered care, evidence-based treatment, integration of service delivery, and value-based payment models. Committed to innovation, the Michigan's community mental health (CMH) system has been leading the way in these areas as it delivers real value to people with mental illness and intellectual and developmental disabilities and their families.

Michigan's community mental health system leaders have long looked to evidence and innovation to meet the needs of the population they serve while working to control costs. As the heart of the state CMH system, local community mental health service programs (CMHSPs or CMHs) are responsible for identifying needs and serving and supporting people in their communities who are living with serious mental illness or an intellectual or developmental disability.

CMHs have sought out evidence-based strategies and pushed for new approaches that will enable them to better meet the needs of the population they serve. This report provides a strengths-based review of the community mental health system in Michigan, with a focus on its efforts to promote recovery, use evidence and innovation, integrate with physical health care, and control costs.

SYSTEM STRUCTURE

The Medical Services Administration (Medicaid in Michigan) contracts with ten prepaid inpatient health plans (PIHPs) to manage Medicaid-covered specialty mental health, developmental disability, and substance abuse services. Each of the state's 46 CMHs is affiliated with a PIHP and works to coordinate treatment and services in their respective areas, either by providing treatment directly or contracting with other mental health agencies and professionals for service.

Mental health funding comes primarily from two lines in the Michigan Department of Community Health appropriations budget: Medicaid mental health services and community mental health non-Medicaid (general fund/general purpose dollars).

Medicaid mental health funding is paid through capitation-based rates to PIHPs, which then contract with CMHs. CMHs use the funding they receive from the PIHPs along with general fund dollars and local county funding to provide services and supports in the community, as well as to purchase services from state or local community hospitals and community residential services.

A RECOVERY-BASED SYSTEM

While the health care system has been moving toward patient-centered care, especially with the increasing adoption of the patient-centered medical home model among primary care practices, the CMH system has been working since the mid-1990s to ensure that the people who are served guide the development of their own plans of service. A focus on recovery, along with a person-centered emphasis, provides a guidepost by which those who work in the CMH system make decisions and do their work, according to the CMH directors and staff who participated in the interviews. Examples of this were offered in descriptions of efforts to create a culture of recovery, the use of person-led processes and peer supports, community integration efforts, and the support of health and wellness among CMH consumers and staff.

EVIDENCE AND INNOVATION

Increasing calls for evidence-based treatment in medicine and evidence-based practices in public health, along with stronger promotion of health care innovation, are guiding the future of the health care system. With recovery as a guiding principle in the community mental health system, CMHs turn to evidence-based practices and innovative solutions to deliver services, make the most efficient use of resources, and provide the greatest value for consumers and their families.

A commitment to the use of evidence-based practices ensures that CMHs are delivering services that have a high probability of success. Mental health courts are showing up across the state as an evidence-based, innovative intervention to keep people with mental illness out of the criminal justice system. And multidisciplinary teams are being used by CMHs to better meet the variety of needs faced by their consumers.

HEALTH CARE INTEGRATION

Lawmakers and health insurers are promoting the integration of health care delivery across multiple service systems through patient-centered medical homes, accountable care organizations, and health homes for people covered by Medicaid. People with serious mental illness and intellectual and developmental disabilities often face unique challenges to accessing health care services, and providers in the CMH system have implemented unique solutions to address both the physical and mental health needs of the populations they serve.

These initiatives range from establishing protocols and pathways for communication between providers, assisting consumers with navigating the health care system, co-locating physical and behavioral health services, and establishing Medicaid health homes that focus on people with serious mental illness.

COST CONTROL AND FINANCING STRATEGIES

The health care system is moving away from fee-for-service payment methods toward payment models that promote value and the efficient use of resources. For a decade and a half, the community mental health system in Michigan has provided Medicaid-covered services for people with serious mental illness and intellectual and developmental disabilities within a capitation-based payment structure.

Interview participants described innovative strategies that they have implemented in payment, service delivery, and leveraging of funding to maximize the reach of the resources available. Many also described active utilization review and management strategies to limit the need for inpatient treatment.

METHODOLOGY

Public Sector Consultants Inc. conducted both primary and secondary research to prepare this report. PSC interviewed the directors and staff at 13 CMHs across the state to learn more about how the system is working in practice and what evidence these providers have of the success of the services they provide. PSC also conducted interviews with people who have received services from the CMHSPs to find out about their experience of care. In addition, PSC reviewed existing documentation on the public mental health system to provide an overview of the system and supplement information gathered during interviews with CMH directors and staff.

The same interview instrument was used across all interviews, and CMH directors and staff were asked to focus on one or two areas in which their CMH demonstrates particular strength. Thus, not all CMHs are represented in every section of the report. Attempts were made to ensure that relevant information shared in every interview is highlighted in the report, which also includes numerous vignettes that provide more detailed descriptions of innovative activities at each CMH. The report is not intended to act as a compendium of every activity happening at CMHs across the state, but to highlight those activities that best illustrate the strengths of the system.

CONCLUSION

- Michigan's Community Mental Health system serves as a safety net and a champion for those with some of the most challenging mental and physical health conditions. Those who work in the system have a clear focus on identifying and delivering the services that will provide the greatest value for consumers and their families.

- The advances in treatment and service delivery made within the community mental health system over the past few decades reflect many of the same changes that are currently being promoted within the broader health care system. The CMH system has often been out in front in efforts to:
    - put people at the center of the services they receive,
    - try innovative service delivery strategies,
    - integrate and coordinate care, and
    - control costs within a risk-based payment model.

- CMH staff are focused on doing what is needed to promote the recovery of individuals through the use of evidence-based, cost-effective practices. Meanwhile, they keep an eye on innovations that may provide even better solutions.

- CMH leaders seeking to prevent the premature death of Michiganders with behavioral health issues have been at the forefront of Michigan's efforts to integrate mental and physical health care. Aware of the need to spend taxpayer resources efficiently and effectively, CMHs across the state are using innovative financial strategies to focus spending on people, not programs.

- CMH has also leveraged financing and implemented new service delivery strategies. State General Fund dollars and local financing revenue are critical to these innovations because they don't have the same restrictions as Medicaid funding.

- The unique position of local CMHs within the community is critical to meeting the needs of the people they serve. CMH's longtime partnerships with local stakeholders have been crucial to helping with employment, education, housing, community integration, health and wellness, and the development of mental health courts.

INNOVATION IN ACTION

Clinton-Eaton-Ingham Community Mental Health Authority: Cost Control

The Clinton-Eaton-Ingham Community Mental Health Authority (CEI CMHA) has developed and implemented a clinical and fiscal management system that directs funds where and when they're most needed to most effectively serve consumers.

CEI CMHA worked closely with the CMHs in its region to carefully monitor and manage the region's Medicaid spending, using what CEO Robert Sheehan calls "leading edge financial management pillars": sub-capitated, shared-risk financing; accurate revenue and expenditure forecasting; active fiscal and risk management through regular reviews of region-wide revenues and expenditure trends; active management of the pooled revenue and risk reserve; and retaining a modest risk reserve made possible by these active fiscal management approaches. "This allowed us to keep a right-sized and modest risk reserve and send the largest amount of revenue possible to services," Sheehan said.

Sheehan said a key component of the active fiscal management approach was the submission of quarterly Medicaid financial status reports by all CMHs in the region. By reviewing and projecting revenues and spending on a quarterly basis, they were able to reallocate Medicaid revenues to different areas of the region as needed.

network180: Center for Integrative Medicine (Grand Rapids)

The Center for Integrative Medicine (CIM) is a partnership between network180 and Spectrum Health that identifies people who often turn to expensive hospital emergency rooms for treatment and instead provides them with more appropriate, cost-effective interventions. The approach is based on research by Dr. Corey Waller, network180's medical director for substance abuse and a former emergency department physician, who found that 950 people were responsible for more than 20,000 ER visits to two local hospitals in a single year, at a cost of $40-$50 million. CIM uses a biopsychosocial model of care that addresses biological, psychological, and social factors that contribute to a person's illness. A six-month pilot of the center with 30 patients demonstrated an 85 percent decrease in visits to emergency departments and a savings of about $1 million. The pilot led to the establishment of the CIM full time. The CIM is staffed by Dr. Waller, a physician assistant, and two network180 social workers. Patients undergo a brief screening, meet with a social worker for a more detailed assessment, and then have two to four sessions with interventions. If they need more services, staff work to authorize them for more care at network180. After about six months, patients are discharged to a primary care medical home.

Community Mental Health for Central Michigan: Evidence-based Practices

At Community Mental Health for Central Michigan, Linda Kaufmann says that evidence-based practices (EBPs) play a prominent role in the services they provide: "We have over 30 evidence-based practices at our CMH and have a unique way of implementing them and making them part of ongoing services. We've seen a lot of success." The CMH has developed a grid of all of the EBPs, including the criteria required for training and/or certification to provide the services, the target population for the service, frequency of fidelity monitoring required, and a lead subject matter expert, who is responsible for ensuring solid implementation. Kaufmann notes, "From my perspective, EBPs make mental health centers stand out. I can't tell you how often I've received calls from people with private insurance who want what we have to offer." Kaufmann considers her CMH to be an early adopter of evidence-based practices: "We were one of the first to use Parent Management Training-Oregon Model. And we're just getting started with Mom Power [a parenting and attachment skills group for mothers receiving Medicaid] with the University of Michigan; it is actually showing a difference in the frontal lobe of the brain after just ten weeks of therapy. It's very exciting."

Community Mental Health Services of Muskegon County: Multidisciplinary Teams

Community Mental Health Services of Muskegon County redesigned its service delivery approach to use multidisciplinary teams to improve services without increasing costs. The agency identified several very frequent users of CMH services that were not being well coordinated to maximize effectiveness. The CMH then developed a multidisciplinary team for each of the CMH's populations: an autism team, two high-intensive teams, and teams for adults with serious mental illness, children with serious emotional disabilities, adults with developmental disabilities, children with developmental disabilities, and those with co-occurring disorders. Each team is made up of different providers depending on the intended population, but each team has case managers, therapists, nurses, supports coordination, and peer supports. Embedding providers into the team improves coordination of services and ensures that services are working together to help reach the client's goals, even when the service provider is not employed by the CMH. Julia Rupp of CMH Services of Muskegon reports, "This model gives better team expertise, more cohesiveness, and the services are better. We are no longer 'throwing' services at people and seeing what works."

Northeast Michigan Community Mental Health Authority: Person-led Processes

Ed LaFramboise, executive director at Northeast Michigan CMH, describes the importance of person-centered planning and self-determination in supporting recovery. "Self-determination is something we use to engage people in living a life that they choose," says LaFramboise, "and it starts with the person-centered planning process, which is critical to identifying what people want, where they want to live, how they want to live, and how we might support them in achieving outcomes that are important to them."

LaFramboise emphasizes the level of control that consumers are given over their own lives through these processes, which differentiates the CMH system from the medical care system. "Person-centered planning has really changed our approach to allowing people to identify a lifestyle that is important to them and how we might assist them. Self-determination actually gives people control over dollars, in that they can purchase service from whomever they think is appropriate. We don't fit the traditional health care model."

Washtenaw Community Health Organization: Integrated Care

The Washtenaw Community Health Organization (WCHO) was created in 2000 to sponsor and develop integrated physical and mental health care. After struggling over the first decade with models that didn't work very well, in 2010 WCHO received a grant that provided funding to place physicians and nurse practitioners in the CMH setting. CEO Eric Kurtz describes this as "an ideal setup for the people who see CMH as their place for health and wellness, and who were not engaging with PCPs (primary care physicians) in the community." The grant has ended, but the WCHO continues to provide these services. "Even though we have limited general fund dollars and no dedicated funding stream, this is our mission, it is what our board expects us to do," Kurtz said. In addition to providing onsite integrated care, Washtenaw became a pilot health home site in July 2014. Individuals are identified by the state as meeting criteria, and then the CMH is paid a monthly fee per member for a set of administrative services including linking clients to services, registering clients, providing communication activities such as talking on the phone and physician consultation, and offering prevention activities. These efforts help people with different mental health issues meet their behavioral and physical health needs.

Detroit Wayne Mental Health Authority: Supported Education

Educational attainment, for many consumers, is part of their path to wellness and recovery, as well as better employment opportunities. Detroit Wayne Mental Health Authority (DWMHA) is helping consumers reach their educational goals through funding for a Supported Education Program (SEP), a six-month specialized course that focuses on preparing and supporting consumers to obtain college degrees. SEP provides an orientation to an academic lifestyle; it helps prepare students to manage mental health symptoms in an academic setting; it helps improve test-taking skills and reduces test anxiety; it helps students learn how to write academically appropriate essays and give oral presentations; it helps resolve defaulted student loans; it helps students obtain financial aid and scholarships; it develops a career plan and assistance registering for college classes; and it improves computer proficiency skills. DWMHA partners with Wayne State University and Wayne County Community College to provide this program. The program has served 372 consumers since it began in 2011. It has helped 150 consumers secure financial aid support, helped two-thirds of participants apply to a college, and over 30 consumers register for college classes.