Robert & Sue White- Parent Advocates For Fred and Michael White

7355 Deerhill Drive
Clarkston, Mi, 48346

Cell-248-789-2165

Michael White Fred White

Caregiver Staffing and Wage Crisis

The proposal and additional funding to increase Caregiver Wages by $.50 per hour in FY 18 is a start but.....if you read the detail of Section 1009 report, it is clear that if we are going to stop the mass exodus from this job market we must allocate funding to support $2.00 per hour above the minimum wage.

Lapse Funds

Add current (2) language back into Section 8-928

Stop Re-basing

Vote No on HB 4091

STATE OF MICHIGAN,

CERTIFICATE OF PROCLAMATION

ON BEHALF OF THE PEOPLE OF MICHIGAN

I, Rick Snyder, governor of Michigan, do hereby proclaim

September 13-19, 2015

DIRECT SUPPORT PROFESSIONALS RECOGNITION WEEK

WHEREAS, direct support professionals are the primary providers of publicly-funded long term support and services for millions of individuals with disabilities; and,

WHEREAS, direct support professionals must build close, trusted relationships with individuals and assist them with various needs on a daily basis; and,

WHEREAS, direct support professionals support individuals with disabilities in making choices that lead to meaningful and productive lives; and,

WHEREAS, direct support professionals provide essential support to keep individuals with disabilities connected to their families, friends and communities; and,

WHEREAS, the participation of direct support professionals in medical care planning is critical to the successful transition from medical events to post-acute care and long term supports and services; and,

WHEREAS, there is a critical and growing shortage of direct support professionals in communities throughout the United States; and,

WHEREAS, the role of direct support professionals is vital in enhancing the lives of individuals with disabilities of all ages;

NOW, THEREFORE, I, Rick Snyder, governor of Michigan, do hereby proclaim September 13 through September 19, 2015 as Direct Support Professionals Recognition Week in Michigan.

Rick Snyder
Governor

Executive Recommendation House & Human Services Budget FY18

Caregiver Wages

Sec. 8-1009. The department shall provide a progress report on implementation of recommendations from work with PIHP network providers to analyze the workforce challenges of recruitment and retention of staff who provide Medicaid-funded community living supports, personal care services, respite services, skill building services, and other similar supports and services by May 1 of the current fiscal year.

SB 133 Health & Human Services Budget FY 16

Caregiver Wages

Sec. 1009. (1) The department shall work with PIHP network providers to analyze the workforce challenges of recruitment and retention of staff who provide Medicaid-funded community living supports, personal care services, respite services, skill building services, and other similar supports and services. The department workgroup must consider ways to attract and retain staff to provide Medicaid-funded supports and services. (2) The department workgroup must include PIHP providers, CMHSPs, individuals with disabilities, and staff. (3) The department shall provide a status report on the workgroup's suggestions to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget director, making note in the report when the participants outlined in subsection (2) reached consensus on the workgroup's suggestions and when the participants outlined in subsection (2) had points of difference on the workgroup's suggestions.

SECTION 1009 REPORT

RECRUITMENT AND RETENTION CHALLENGES FOR THE WORKFORCE DELIVERING THE MOST FREQUENTLY USED SUPPORTS AND SERVICES

2016

I. Executive Summary

After months of discussion and review of available data, the Workgroup on the Direct Support Workforce (hereinafter called, "the Workgroup") mandated by the Michigan Legislature[1] has concluded that the critically important frontline workforce delivering face-to-face supports and services to the state's residents with intellectual and developmental disabilities, mental illness, or substance use disorders is not stable. Employers, including individuals using self-determination as well as organizational employers are not able to recruit or retain a qualified, competent workforce. In order to fulfill the service and support delivery requirements of both the state's Mental Health Code and the Medicaid program and ensure the ability to comply with the Centers for Medicare and Medicaid Services Home and Community Based Services rules, additional state investments and new state policies and practices are needed to secure the dignity, well- being, independence and community involvement of people living with disabilities.

Within its diverse membership, the Workgroup reviewed relevant information and data on workforce recruitment and retention. This information included the large numbers of job vacancies across the state, the high staff turnover rates, the current inability to provide supportive services due to staff shortages, the closure of supportive service organizations and programs because of staff shortages, and reports from beneficiaries on the pain of losing relationships and trust when direct support staff move to a higher paying job. Medicaid beneficiaries speak openly of a high "quality of life"—to pursue employment, education, and inclusion—that is not possible without a stable, competent direct support workforce.

The needed workforce is not small and the jobs require complex skills and knowledge. The direct support workforce currently provides the majority of Medicaid funded behavioral health services and these services comprise a growing proportion of the overall Medicaid funded behavioral health services.

The Workgroup concludes that immediate actions are needed to address the current and worsening staffing challenges and that other state policy changes are needed in the long-term. The Workgroup's unanimous recommendations are:

[1] P.A. 84 of 2015, Article X, Section 1009

Immediate Actions Needed to Improve Wages and Benefits

The Michigan Legislature and Governor need to make additional investments into all the named Medicaid covered supports and services to assure that:

- Direct support staff earn a starting wage of at least $2.00 per hour above the state's minimum wage. These investments and the starting wage rate should increase as the state's minimum wage increases and should include the mandatory employer costs (FICA, worker's compensation, etc.) associated with employment.

    1. Direct support staff earn paid leave time at the minimum rate of 1 hour for every 37 hours worked (i.e., 10 days a year for full-time employment).

- The Michigan Department of Health and Human Services (MDHHS) should use its contractual authority to set Medicaid payment and reimbursement rates that provide sufficient funding to provide and maintain a starting wage rate of at least $2.00 per hour above the state's minimum wage, associated employer costs, and paid time off to the direct support workforce.
- The Michigan Department of Health and Human Services and each Prepaid Inpatient Health Plan (PIHP) shall collect and publish data on the size, compensation, and stability (turnover rates and job vacancies) of the direct support staff providing the identified supports and services at least annually. The collected data shall be used to assess the impact of the funded wage increases on the wages paid, direct support staff turnover rates, job vacancies, service delivery, and the adequacy of the direct support workforce.

Long Range Solutions to Improve Workforce Stability

- Develop and fund a promotional campaign to build public awareness and appreciation of people with disabilities and those who chose a career to support them. The campaign should build off the system's mission of inclusion and stigma elimination. MDHHS, the PIHPs, employers, direct support staff, and people with disabilities should participate in the creation and execution of the campaign.
- Expand the existing MDHHS funded matching services registry for Home Help beneficiaries to include all Medicaid beneficiaries using the self-determination option to address the difficulties (conducting criminal background checks, advertising, recruiting, etc.) individuals using self-determination have in finding direct support staff.
- Change Michigan's current laws and policies on criminal background checks to include a "rehabilitation review" similar to those authorized in 17 other states in order to increase the potential pool of applicants for direct support careers. Implementing a review process of applicants for direct support careers. Implementing a review process would allow people with a disqualifying criminal conviction to demonstrate that they no longer represent a threat to people needing supports and services or to their property.
- Provide publicly financed tuition reimbursement or incentives to direct support workers who are actively studying to become psychologists, behavior specialists, nurses, therapists and other health care occupations that serve people with intellectual and developmental disabilities, mental illness, and substance use disorders in order to increase the number of people interested in doing direct support work. This effort will also improve the frontline skills and broaden the experiences of other health care occupations serving these populations.

- Legislatively require the creation of a workgroup to identify the wide ranging initial competences, skills, and aptitudes needed by the direct support staff and to provide recommendations for a training and credentialing program to assure a competent direct support workforce.

HB 5294 Health & Human Services Budget FY 17

Caregiver Wages

Sec. 920. (1) As part of the Medicaid rate-setting process for behavioral health services, the department shall work with PIHP network providers and actuaries to include any state and federal wage and compensation increases that directly impact staff who provide Medicaid-funded community living supports, personal care services, respite services, skill-building services, and other similar supports and services as part of the Medicaid rate.
(2) It is the intent of the legislature that any increased Medicaid rate related to state minimum wage increases shall also be distributed to direct care employees.

Sec. 1009. (1) The department shall work with PIHP network providers to analyze the workforce challenges of recruitment and retention of staff who provide Medicaid-funded community living supports, personal care services, respite services, skill building services, and other similar supports and services. The department workgroup must consider ways to attract and retain staff to provide Medicaid-funded supports and services.
(2) The department workgroup must include PIHP providers, CMHSPs, individuals with disabilities, and staff.
(3) By March 1 of the current fiscal year, the department shall provide a status report on the workgroup's suggestions to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget director, making note in the report when the participants outlined in subsection (2) reached consensus on the workgroup's suggestions and when the participants outlined in subsection (2) had points of difference on the workgroup's suggestions.

Executive Recommendation House & Human Services Budget FY18

Lapse Funds

Section 8-928 as included in the Executive Recommendation for the FY2018 proposed budget reads:

Sec. 8-928. Each PIHP shall provide, from internal resources, local funds to be used 17 as part of the state match required under the Medicaid program in order to increase 18 capitation rates for PIHPs. These funds shall not include either state funds received by a 19 CMHSP for services provided to non-Medicaid recipients or the state matching portion of the 20 Medicaid capitation payments made to a PIHP.

Need to add back in language below that is included in current budget boiler plate under Section 928

(2) It is the intent of the legislature that any funds that lapse from the funds appropriated in part 1 for Medicaid mental health services shall be redistributed to individual CMHSPs as a reimbursement of local funds on a proportional basis to those CMHSPs whose local funds were used as state Medicaid match. By April 1 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the lapse by PIHP from the previous fiscal year and the projected lapse by PIHP in the current fiscal year.

SB 133 Health & Human Services Budget FY 16

Lapse Funds

Sec. 1010. (1) If the federal government allows the redistribution of lapsed federal Medicaid match funds in the Medicaid mental health services line, the funds appropriated in part 1 for Medicaid mental health services funds, which have lapsed, shall be distributed to individual PIHPs based on the PIHP distribution formula in effect during the current fiscal year.

(2) It is the intent of the legislature that any funds that lapse from the funds appropriated in part 1 for Medicaid mental health services shall be redistributed to individual CMHSPs based on the community mental health non-Medicaid services distribution formula in effect during the current fiscal year. By April 1 of the current fiscal year, the department shall report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, and the state budget office on the lapse by PIHP from the previous fiscal year and the projected lapse by PIHP in the current fiscal year.

STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
GOVERNOR

BRIAN CALLEY
LT. GOVERNOR

June 17, 2015

Michigan Senate
State Capitol
Lansing MI 48909-7536

Ladies and Gentlemen:

Today I have signed Enrolled Senate Bill 133, which makes appropriations for various departments and agencies, the judicial branch and the legislative branch for the fiscal year ending September 30, 2016. The appropriations in Enrolled Senate Bill 133 total $38.6 billion and provide funding for critical services throughout the state.

I have, however, disapproved one item pursuant to Section 19 of Article V of the Michigan Constitution of 1963. The specific veto is detailed in the attached copy of the bill that has been filed with the Secretary of State.

I have disapproved the attempted re-appropriation of lapsed funds in section 1010(1) of Article X because the legislature has already appropriated, and I have approved, funding for the Prepaid Inpatient Health Plans as necessary to comply with federal regulations and state law.

I have considered the enforceability of boilerplate provisions as I provide direction to departments in implementing appropriations contained in Enrolled Senate Bill 133. Among the various provisions that are considered unenforceable, I note the following: section 453(2) (Article I); section 1069 (Article VIII); and section 382 (Article XVII).

Enrolled Senate Bill 133 also contains numerous boilerplate sections that include statements of legislative intent. We will take these legislative preferences into consideration as departments and agencies implement the appropriations. However, these legislative intent statements do not impose conditions on appropriations and are non-binding upon departments and agencies implementing the appropriations.

I commend the Legislature for completing its work on this omnibus appropriations bill. I look forward to reaching resolution on a road funding package with the same spirit of cooperation. A properly maintained transportation infrastructure is vital to Michigan's economy and to the safety of residents and visitors of this great state. I am hopeful that, in partnership with the Legislature, a permanent plan is set in motion to make this critical investment.

Respectfully,

Rick Snyder
Governor

Attachment
cc: Michigan House of Representatives
The Honorable Ruth Johnson, Secretary of State

HB 5294 Health & Human Services Budget FY 17

Lapse Funds

Sec. 928. (1) Each PIHP shall provide, from internal resources, local funds to be used as a part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.
(2) It is the intent of the legislature that any funds that lapse from the funds appropriated in part 1 for Medicaid mental health services shall be redistributed to individual CMHSPs as a reimbursement of local funds on a proportional basis to those CMHSPs whose local funds were used as state Medicaid match. By April 1 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the lapse by PIHP from the previous fiscal year and the projected lapse by PIHP in the current fiscal year.

VOTE NO On House Bill 4091

You may recall the re-basing of Medicaid dollars to PIHPs implemented by MDHHS starting 10/01/15 and ending 04/01/2017. Please find a copy of the Medicaid re-basing schedule and notice how re-basing has impacted Medicaid funding to each of the10 PIHPs.
My interpretation of HB 4091 is that this Bill will have a similar re-basing impact to the 10 PIHPs, only applied to General Fund dollars as opposed to Medicaid dollars.
In addition, approval of this Bill would also involve amending the Mental Health Code. Tinkering with the Mental Health Code could result in unintended consequences creating much more risk than value.

Medicaid Mental Health Risk Mitigation

State of Michigan, Department of Health and Human Services
SFY 2016 Medicaid Capitation Rate Development
Mental Health / Waiver (c) Risk Mitigation

PIHP	SFY 2015 Composite Paid Rates	100% Trended 0% Rebased 10/1/2015	67% Trended 33% Rebased 4/1/2016	33% Trended 67% Rebased 10/1/2016	0% Trended 100% Rebased 4/1/2017	
Northcare	$81.7	$83.1	$82.6	$82.1	$81.5	+ 1.6
Northern MI	138.8	141.3	142.0	142.7	143.4	+ 2.1
Lakeshore	222.6	226.4	227.6	228.8	230.0	+ 3.6
Southwest MI	204.4	208.2	204.0	199.8	195.6	- 12.6
Mid-State	388.5	395.7	403.3	410.9	418.6	+ 22.9
Southeast MI	130.7	132.9	132.2	131.4	130.7	- 2.2
Detroit Wayne	490.7	500.1	513.5	527.0	540.4	+ 40.3
Oakland	238.1	241.9	236.8	231.6	226.5	- 15.4
Macomb	171.3	174.2	165.2	156.1	147.1	- 27.1
Region 10	187.2	190.5	187.2	183.9	180.7	- 9.8
Total	**$2,254.0**	**$2,294.4**	**$2,294.4**	**$2,294.4**	**$2,294.4**	

Notes:

1. Trending reflects SFY 2015 Geographic Factors. Rebasing reflects the new methodology.
2. Values are shown in millions of dollars and are for illustrative purposes only.
3. **All scenarios reflect SFY 2016 (12 months) projected capitation payments and do not reflect potential trend increases beyond SFY 2016.**

HOUSE BILL No. 4091

January 26, 2017, Introduced by Rep. Miller and referred to the Committee on Appropriations.

A bill to amend 1974 PA 258, entitled

"Mental health code,"

by amending section 308 (MCL 330.1308), as amended by 1995 PA 290.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 308. (1) Except as otherwise provided in this chapter and subsections (2), ~~and~~ (3), **AND (6)**, and subject to the constraint of funds actually appropriated by the legislature for ~~such~~ **THIS** purpose, the state shall pay 90% of the annual net cost of a community mental health services program that is established and administered in accordance with chapter 2.

(2) Beginning in the fiscal year after a community mental health services program becomes a community mental health authority under section 205, if the department increases the amount of state funds provided to community mental health services programs for the

fiscal year, all of the following apply:

(a) The amount of local match required of a community mental health authority for that fiscal year shall not exceed the amount of funds provided by the community mental health services program as local match in the year in which the program became a community mental health authority.

(b) Subject to the constraint of funds actually appropriated by the county or county board of commissioners, the amount of county match required of a county or counties that have created a community mental health authority shall not exceed the amount of funds provided by the county or counties as county match in fiscal year 1994-1995 or the year the authority is created, whichever is greater.

(c) If the local match provided by the community mental health services program is less than the level of local match provided in the year in which the community mental health services program became a community mental health authority, subdivision (a) does not apply.

(d) The state is not obligated to provide additional state funds because of the limitation on local funding levels provided for in subdivisions (a) and (b).

(3) The state shall pay the family support subsidies established under section 156.

(4) If 2 or more existing community mental health services programs merge ~~pursuant~~ **ACCORDING** to section 219, the state shall pay 100% of administrative costs approved by the department for the newly created community mental health services program for 3 years

after the date of merger.

(5) If a county demonstrates an inability to meet its local match obligation due to financial hardship, the department may do either of the following:

(a) Accept a joint plan of correction from the county and its community mental health services program that ensures full payment over an extended period of time.

(b) Waive a portion of the county's obligation based on hardship criteria established by the department.

(6) THE STATE PAYMENT UNDER THIS SECTION SHALL BE CALCULATED AND MADE BASED ON RELEVANT FACTORS IN THE COUNTY, INCLUDING, BUT NOT LIMITED TO, DEMOGRAPHICS, UNEMPLOYMENT RATES, AND POVERTY LEVELS.

(7) THE DEPARTMENT SHALL WORK WITH ACTUARIES TO UPDATE FUNDING METHODOLOGY THAT IS BASED ON A COMMON STATEWIDE RATE WITH ADJUSTMENTS FOR MORBIDITY.

Enacting section 1. This amendatory act takes effect 90 days after the date it is enacted into law.

MALA
MICHIGAN ASSISTED LIVING ASSOCIATION

February 27, 2017

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

Re: 2017-18 Michigan Department of Health and Human Services Budget

Dear Representative Canfield:

Michigan Assisted Living Association (MALA) appreciates the opportunity to provide testimony regarding services funded through the Michigan Department of Health and Human Services (MDHHS) budget. Our organization's members provide a broad range of supports and services to over 38,000 persons throughout the state. The persons served include individuals with intellectual and developmental disabilities, mental illness, substance use disorders, traumatic brain injuries or physical disabilities and older adults.

Executive Budget Recommendation for Direct Care Wage Increase

MALA strongly supports the executive budget recommendation to provide $45 million gross ($14.2 million general fund) for a wage increase for direct care workers in Michigan's Pre-Paid Inpatient Health Plan (PIHP) system. MDHHS estimates that this funding would provide for a staff wage increase of $0.50 per hour.

This additional funding is urgently needed to respond to a staffing crisis that currently exists in the recruitment and retention of direct care workers providing Medicaid mental health services throughout the state. These services consist of community living supports, personal care, skill building, supported employment and other Medicaid mental health services.

Workforce Data and Challenges

The staffing crisis in the public mental health system is attributable in large part to the low wage levels for direct care workers. MALA conducted a survey of providers of mental health services in August 2016 on behalf of the Partnership for Fair Caregiver Wages. The survey findings include an average starting wage statewide for direct care workers of $9.30 per hour. This amount is substantially lower than the starting wage of at least $10.00 per hour for many large retailers and other employment sectors.

Direct support staff provide vital services to people with a wide range of disabilities including intellectual and developmental disabilities, mental illness and substance use disorders. The challenging work may include bathing, assistance with eating, administering medication, protection, daily companionship, supervision, and transportation to medical appointments and social events. Many staff must be trained to support persons who are medically frail or have behavioral needs or other special needs.

15441 Middlebelt Road • Livonia, MI 48154-3805
(Phone) 800.482.0118 • (Fax) 734.525.2453 • www.miassistedliving.org

The average turnover rate is 40% from the Partnership survey findings. Low staff wage levels and high turnover rates have an adverse impact upon the continuity of services and quality of life for individuals with disabilities funded through the public mental health system.

Urgent Need for Higher Staff Wage Levels

As indicated above, MALA is appreciative and supportive of the executive budget recommendation for a $0.50 per hour staff wage increase. Nevertheless, we urge that sufficient additional funding be provided in the 2017-18 MDHHS budget for a $1.00 per hour staff wage increase.

MALA appreciates the previous decision by the Michigan Legislature to include boilerplate Section 1009 in the 2015 – 2016 MDHHS budget bill which established a workgroup to analyze workforce challenges. The Section 1009 Report developed as a result of this boilerplate language included a recommendation for a starting wage of $2.00 per hour above the minimum wage.

The Interim Report of the 298 Facilitation Workgroup submitted to the Michigan Legislature last month also addresses the workforce challenges. In particular, Section 7 on workforce training, quality and retention indicates that all Affinity Group participants recommended raising the wages and benefits of direct care staff.

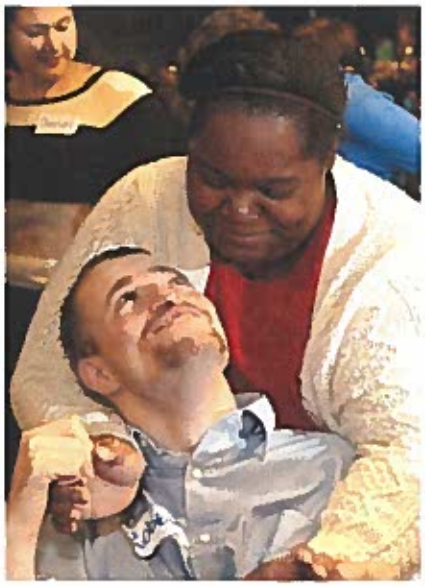
Thank you again for the opportunity to testify. Please contact me if any additional information is needed regarding our organization's testimony.

Sincerely,

Robert L. Stein

Robert L. Stein
General Counsel

cc: Representative Sue Allor
Representative John Bizon
Representative Larry Inman
Representative Kim LaSata
Representative Mary Whiteford
Representative Jeff Yaroch
Representative Pam Faris
Representative Robert Kosowksi
Representative Sylvia Santana
Representative Henry Yanez



February 27, 2017

Ms. Laura Cox, Appropriations Committee Chair

Dear Ms. Cox:

As you think about the upcoming budget, please take in to consideration the amazing work done by direct support professionals for people with disabilities. They provide life- saving services for the people in their care, including my son.

Robbie is 37 with very significant needs. He does not speak and cannot take care of himself in any way. He is dependent on them for his very life; making sure he is clean-he does not use the bathroom, ensuring that his teeth are brushed multiple times a day to prevent pneumonia, pureeing all of his food, safely transferring him in the shower, to his wheel chair and to the day program he attends, ensuring that he has ample time in the community and with his family, giving him his many medications at the specified times, ensuring proper posture when he is eating....and giving him love.

I think you have a sense of how important their work is. Not just for my son but for others requiring the same amount of care and even those who do not need quite so much physical care, but provide many of the above mentioned services.

It is so unfair that these workers' pay is so inadequate. Many of them have to have multiple jobs just to barely survive financially. Section 7 of the Interim report of the 298 Facilitation Workgroup specifically indicates that all Affinity Group participants recommended raising the wages and benefits of direct care staff. Extremely importantly, because of the present wage structure, the current average turnover rate is 40%.

As you can see from the description of my son's services in the second paragraph, what an adverse impact on him there is from the high level of staff turnover. Not only in terms of relationships with people, but even more importantly, his very safety and life is at stake.

I strongly recommend that additional Medicaid Funding of **$90** million be appropriated in the 2017-18 budget for the Michigan Department of health and Human Services. This funding would provide for a staff wage increase of $1 per hour to $10.30 as an average starting wage.

I make this request on behalf of my son and all others who are served by our wonderful direct care staff, my husband and family.

Please do not hesitate to call me with questions or to arrange a visit to our son's home.

Sincerely,

Carol Kaczander
14011 Nadine Street
Oak Park, MI 18237
248-229-6562

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

Testimony Regarding 2017-2018 Executive Budget
before the
Michigan House of Representatives
Health and Human Services Subcommittee of the Standing Committee on Appropriations
Room 352, House Appropriations, State Capitol Building, Lansing, MI

February 27, 2017

Chairman Canfield, Members of the Subcommittee, thank you for this opportunity to share my views regarding the FY 2017-18 Executive Budget Recommendation for Behavioral Health, Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Aging and Adult Services.

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

I have been driven by one fundamental principle. **All people are valuable**. Each has unique contributions to make as an individual and to the various family units and communities of which he or she is a member. In 1967 my efforts got a turbo charge. Our third of four children, Virginia, was born with profound disabilities. She could not suck or swallow, did not move on her own other than when having a seizure, did not respond to light or sound, plus other life-threatening issues. At nine months of age an eminent neurologist said to us, "She is blind, deaf, and profoundly retarded. Put her away and forget her." Fortunately, my training permitted us to avoid that death sentence. I recruited and trained 40 volunteers who worked in shifts around the clock in our home for years. We kept Virginia moving. She was involved with her family and community. This year she will celebrate her 50th birthday. Over the years slowly – developmentally – she increased her skills. She is not blind or deaf although she does not speak. She is a "force of nature" to use a phrase. She is valuable. And, she has influenced more lives than I ever will.

My personal and professional experiences give me opportunities to see human services from both top-down and ground-up perspectives. While we consider them in budgetary silos, there is at the recipient level one person, one family who needs supports and services from the various silos. Because we plan and budget in a non-integrated way, the services funded by the State are fragmented and the intended beneficiary must coordinate them where they live. This is difficult for the best-informed and financed citizen and almost impossible for those who are most vulnerable.

Today I came to suggest that we have an incredible opportunity to look at the system from top to bottom, silo to silo, and design a new order that responds to the needs and desires of the men, women, and children who use publicly funded supports and services including behavioral health and physical health care and more to live dignified lives as members of our community.

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

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

The principles of Self-Determination (Freedom, Authority, Support, and Responsibility) must guide the discussion. We cannot sacrifice the basic human right of persons with disabilities to direct their futures; have control over how they live their lives, where, and with whom; and have authority over the resources that support them. The elements of Person-Centered Plans, based upon the principles of Self-Determination, should dictate the system requirements. I am here to advocate for what ought to be.

Over the past year in response to legislation adopted in the previous session two important explorations have been undertaken. One is the **Section 298 Stakeholder initiative led by Lt. Gov. Brian Calley which responded to language in the FY 2017 approved budget.** Another is the **Workgroup on the Direct Support Workforce mandated by the Michigan Legislature in P A. 84 of 2015, Article X, Section 1009.** Since many of the members of this Subcommittee were not sitting when those initiatives were mandated and the reports developed, I ask that you read them in their entirety if you have not already done so. They provide the rationale for comments I make today.

Coordinated Program Planning and Budgeting across agencies of state government.

I note that each of you serves on other Sub-Committees of House Standing Committee on Appropriations: Corrections, Higher Education, School Aid and the Department of Education, Licensing and Regulatory Affairs & Insurance and Financial Services to name a few most critical to coordinated services and supports at the individual citizen level. The budgetary process at the state level is the place to begin to coordinate services.

Example: Currently there is talk of closing schools in which students are not performing well. Suggestions have been made that families could place their children in better performing schools as far as 50 miles away. This is preposterous. The most vulnerable people are being played like pawns on a chess board when what they need are wrap around supports and services as close to home as possible.

When students are not performing well, we need to ask why and consider what supports and services would help. Many students have been traumatized by events in their home and community, lack stable housing, lack nutritional food – or food of any kind, etc. Rather than destabilize them further, we could budget for appropriate instructional services to meet student needs, mental health and substance use services, nutrition services, housing supports and social services to name a few.

Pathways to Potential, which places social workers in schools is a good start, but more of that service is needed and it needs to be year-round. I visit schools during summer vacation when summer school is in session (usually serving the neediest youth) and staff tell me the Pathways person was a godsend during the school year, but they went back to their office during the summer. The need for their service, however, remained.

In some other states, schools in which students perform poorly get coordinated resources including social workers, paraprofessionals for the classrooms, public and private mental health workers in the building and psychiatrists on call. Family members are supported as well as the students. Often the courts are involved and court workers help assure student attendance. All of this is planned and budgeted at the state level and implemented at the local district level. Funding flows through the various budget streams, but in a coordinated way.

Another entity that needs coordinated mental health services is the Correctional System at all levels (Prisons, Jails, etc.). Many inmates have mental illnesses, substance use disorders, and intellectual/developmental disabilities. Absent appropriate services; recovery, developmental improvement, and health status are at risk. This costs the individual in terms of quality of life and society in term of lost productivity and added law enforcement and correctional service requirements. Providing the right care, at the right time is the most economical approach.

You can accomplish this coordinated program planning and budgeting given your various sub-committee memberships.

Streamlining the service delivery model for behavioral health and physical health care services

The Section 298 Stakeholder initiative engaged more than a thousand recipients and providers of behavioral health and health care services over a series of meetings. The Interim Report of the 298 Facilitation Workgroup contains 70 policy recommendations for inclusion in the final report. The attention currently is on funding models and pilots and benchmarks for implementation. Those will be included in the final report due to the legislature on March 15, 2017. In the meantime, I encourage you to look at the vision and values articulated in the Interim Report (January 13, 2017) and to keep them in mind as you consider funding models and benchmarks for implementation.

My mentor, Ron Lippitt, taught me early on that planned change is most effective when a system is in disarray from top to bottom. We have that condition now. There is a huge opportunity to organize and design a better way to support individuals with behavioral health conditions, substance use disorders, intellectual/developmental disabilities, autism, long term care services and support needs, and more. Let's think about how we can put the people we serve front and center, listen to them, and advocate

their expressed wishes. If we do this with fidelity, we can create a cost-effective system of services and supports that makes a positive difference in the lives of people.

The Section 298 Workgroup Report addresses the need to reduce administrative layers in the systems. Duplication of effort, layers of bureaucracy that lie between the appropriation and the point of service have always been a sticking point for me. In 1980 I worked for a year as Director of Community Placement for Wayne County in the Metropolitan Regional Office of the Michigan Department of Mental Health. I saw first-hand that the Regional Offices were high cost, paper pushing organizations that impeded rather than improved progress. I could not in good conscience stay. The Department eliminated Regional Offices in the mid-1980s. Then, in the 1990s, Governor Engler created the PIHP system which was (to my mind) the Regional Office structure reincarnate. I served on the work group to vet the PIHPs (18 at the time) so had access to all the applications and supporting data. It was eye-popping.

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

The models being vetted by the Section 298 Workgroup all maintain a publicly supported system. This is essential. Public systems are accountable to the citizens who fund them and governance is transparent. Private entities are accountable to their shareholders who expect profit. Transparency is in doubt.

While the current hierarchy is slimmer with only 10 PIHPs instead of 18, it defies reason to think that we can continue to maintain so many layers of bureaucracy at such high cost when the basic human needs of so many individuals remain to be met. Just think, if we eliminated some of the layers of high cost bureaucracy, we might be able to compensate the people who provide the supports and services with a living wage. It is unconscionable that the direct care professionals who provide the hands-on supports and services too often make less than $10 an hour and work 12 hours shifts; while many in the layers above are making 6 figure salaries.

Please pay close attention to the recommendations you will receive in the March 15, 2017 report and vet them with your constituents who use public mental health and health care services (Behavioral Health, Intellectual /Developmental Disabilities Services, Substance Use Disorders, Healthy Michigan, MI-Health Link, Home Help, etc.). If you ask them what they need and desire, you will make the best decisions.

Recruiting, Retaining, Compensating Direct Support Professionals and other Professionals

Action Alert: The public health and human services system needs workers at all levels. A significant shortage exists at the direct care, home help, staff level. The Section 1009 Report articulates the recruitment and retention challenges for the workforce delivering the most frequently used supports and services. This report of the legislatively commissioned workgroup calls for immediate action to improve wages and benefits. A start has been made in the Governor's current budget proposal, but it is inadequate to bring wages to a level that is humane, if not competitive.

The 1009 Report recommends:

- Direct support staff earn a starting wage of at least $2.00 per hour above the state's minimum wage. These investments and the starting wage rate should increase as the state's minimum wage increases and should include the mandatory employer costs (FICA, worker's compensation, etc.) associated with employment. Also, direct support staff should earn leave time at the minimum rate of 1 hour for every 37 hours worked. (10 days per year for full time employment).

- MDHHS should use its contractual authority to set Medicaid payment and reimbursement rates that provide sufficient funding to provide and maintain a starting wage rate of at least $2.00 per hour above the state's minimum wage, associated employer costs, and paid time off to the direct support workforce

- MDHHS and contracted agencies annually collect and report data on size, compensation, and stability (turnover rates and job vacancies) of the direct support staff providing the identified supports and services.

The Section 1009 Report provides statistical backup for all recommendations. It also addresses training and credentialing issues, recruiting strategies, and more. I witness the need for better support for direct support professionals first hand as I watch direct support staff working 12 hour shifts often back to back. Many hold a second job to make ends meet and most have families of their own to care for. We can do better for these men and women who provide essential, life sustaining, supports and services. I endorse the recommendations of the Section 1009 Report.

I also want to call attention to shortages at other levels of the services delivery system.

We need more professionals trained in Applied Behavior Analysis (ABA). How can we work with our institutions of higher education and other educational entities to increase the number of professionals in this area? Schools need more ABA professionals as do public behavioral health and health care services providers.

We have a **statewide shortage of psychiatrists - especially child psychiatrists**. Last Friday Representative Bizon asked about the number of psychiatrists participating in the Section 298 Stakeholder initiative. That was a time-consuming effort for participants and more time than a

professional in a shorthanded field may have been able to contribute. The Section 298 initiative did have input from psychiatrists and more would have been desired. The fact is there is a shortage of psychiatric services to the people who need them and we need more effective strategies to encourage men and women to enter this field. You may know it requires years of education beyond the medical degree to become qualified as a psychiatrist. That puts the field beyond the reach of many given current costs of higher education. Further, opportunities for necessary internships, residencies, and more have been reduced over the years.

We have a **shortage of dentists who will serve adults with Medicaid coverage**. This is especially acute for adults who require anesthesia to receive hygiene and restorative dental care services. What kinds of pre-service experiences can be built into their professional preparation to result in an increase of dental professionals available to vulnerable populations. What changes in reimbursement will make it possible for people with special needs to access dental care? Some changes in Medicaid reimbursement have expended services, but more needs to be done.

Here again is a situation in which those of you who serve also on the Subcommittee on Higher Education of the House of Representatives Standing Committee on Appropriations can make a difference.

In summary:

Approach the need for coordination from the perspective of the people who use the services. The child with severe emotional disturbance and his/her family may need an array of supports from a variety of providers, school, medical, psychological, dental, etc. If those services are planned and budgeted with that single child and family in mind, they will be coordinated from the start.

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

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

Thank you.

Brief Listing of Professional Endeavors

1959 -1973 Speech Pathologist in rehabilitation and institutional settings. (NJ, NY, PA)
1973 - 1975 Obtained Master of Arts degree in Special Education, The Ohio State University
1975 –1978 Teacher Consultant, Special Education and Administrator, Adult Education for persons with disabilities, dual appointment, Pontiac, MI
1978 - 1980 Director of Training, Michigan Department of Mental Health
1980 - 1981 Director, Community Placement, Wayne County, Department Mental Health, Metro Regional Office.
1981 – 2001 Incorporated Michigan Protection & Advocacy Service, Inc., Executive Director 1981- 2001
2002 – 2010 Elected Member, Michigan State Board of Education
2012 – 2016 Founder and Board President, W-A-Y Academy Detroit (Southwest and Brightmoor Campuses , grades 7 -12)
1994 - present, Consultant, Human Rights and Civil Society (many states of USA and 22 countries).

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

Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

Written comments for the House MDHHS Appropriations Subcommittee
February 27, 2017

Chairman Canfield and Members of the Committee:

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

Direct Care Worker Wage Increase

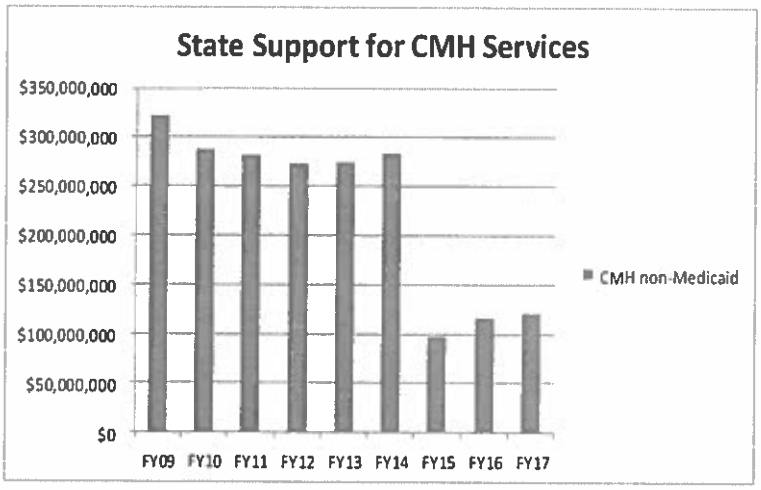
On behalf of our members, we appreciate the Snyder administration's attention to the much needed direct care worker hourly wage increase. As pointed out in the Section 1009 Report of 2016, the direct support staff workforce is unstable and employers are unable to recruit and retain qualified workers.

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

While we certainly support the $45 million gross increase for these workers, it would only result in a .50 cent/per hour wage increase, the 1009 Report recommended a $2 dollar above minimum wage increase for these workers.

On behalf of our membership and the Partnership for Fair Caregiver Wages, we ask that you support the Governor's request and add to it for FY18.

CMH Non-Medicaid Services (General Funds)



In 2014, CMH general fund was reduced by $200 million (60% reduction), which served as the state savings for the Medicaid expansion implementation. As a result, 10,000 Michigan residents (who do not qualify for Medicaid or HMP) lost their mental health coverage.

Our members certainly appreciate the Legislature's attention to the general fund needs for CMH services during the past two fiscal years, however, **there is only $120 million available for Michigan residents without Medicaid coverage** and includes services such as: inpatient psychiatric care, crisis intervention services, psychiatric care and medications, Medicaid spend down, psychotherapy, residential care, jail based services, and homebased care.

Spend down

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

This change was certainly an unintended consequence. While MDHHS has been looking into the issue, this issue remains unresolved. It is our understanding that simply changing the income disregard levels for this group would be too costly to the state, therefore we are suggesting additional general fund support so our members can provide the much needed care for this population. The FY17 budget did add $3 million in general fund support for this population, unfortunately that did not completely close the gap.

CMH GF Redistribution

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

Section 994 Administrative Burdens (Deemed Status)

Our membership strongly supports boilerplate section 994, which would adopt a "deemed status" model for reporting requirements, however, we are requesting the language be amended to require MDCH to grant this provision for our members. Michigan's CMH/PIHP system has administrative requirements that do not exist on physical health care for Medicaid services. 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.

Boilerplate Section 298

Our Association supports the 298 language included in the FY18 Executive Budget recommendation and fully supports the continuation of an advocate lead 298 workgroup process as well as the Interim Policy recommendations. The 298 policy recommendations must be the basis for any structural changes to Michigan's CMH/PIHP system.

In order to improve services for those individuals served we believe any change to Michigan's CMH/PIHP system should include the following principles:

- the need to retain the public management of the state's behavioral health and intellectual/developmental disability (BHIDD) services and supports system
- the centrality of person-centered planning, community-based care, and inclusion
- the fostering of healthcare integration at the point of service, where the consumer receives his or her services and supports
- the continued use of a whole person orientation and both traditional and non-traditional methods that addresses the full range of the social determinants of health, including housing, employment, education, income, and needs met by social/human services as well as by BHIDD and physical healthcare resources
- the control of administrative costs
- greater uniformity in access to and the quality of care across the state
- greater uniformity in contracting, reporting, and compliance requirements across the state

Local Match

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

Last year, the House and Senate included subsection (2) which would direct the department to reimburse the local funds back to the CMHs if Medicaid funds are lapsed in FY17. Those local dollars are used to draw down Medicaid funds, if those Medicaid funds are not completely used those local funds should be returned to the CMHs, not the state. We are requesting enforcement of section 928 boilerplate language that was included in the FY17 budget and further request that the language be added to the FY18 budget.

Healthy Michigan

Our membership appreciates Governor Snyder's continued commitment and advocacy for the Healthy Michigan Plan, which provides much needed healthcare for over 600,000 Michigan residents. We strongly encourage the continuation of the Healthy Michigan program. As previously

stated, the state of Michigan assumed $200 million in GF budget savings through the CMH non-Medicaid line item, replacing those GF dollars with Medicaid expansion dollars. if Healthy Michigan is repealed there would be a significant hole in CMH services due to the loss of both state general fund dollars and federal funds.

Respectfully submitted,

Alan Bolter
Associate Director
Michigan Association of Community Mental Health Boards

BAY ARENAC

BEHAVIORAL HEALTH

February 24, 2017

Representative Edward Canfield, Chairperson
House Appropriations Sub-Committee
Health and Human Services
PO Box 30014
Lansing, MI 48909

Dear Chairperson Canfield:

The purpose of this correspondence is to offer testimony regarding the Fiscal Year 2018 Executive Budget Recommendation for Health and Human Services. Bay Arenac Behavioral Health (BABH) is a multi-county community mental health services program serving Bay and Arenac Counties. In particular, BABH strongly supports the 2018 Executive Budget Recommendation in the following areas:

1) Preservation of the Healthy Michigan Medicaid Expansion
2) Direct Care Worker wage increase for persons providing critical supports and services to people served by the public mental health system
3) Improvement of care in the State Psychiatric Hospital system, including construction of a new facility to replace Caro Center
4) Expansion of the Medicaid Non-emergency Transportation Benefit to additional counties
5) Expansion of the Pathways to Potential Program to reduce school absenteeism

These proposals from the Governor will help protect the health and safety of many vulnerable Michigan citizens and we encourage the Legislature to support their inclusion in the final Appropriation Act.

If you have questions regarding this information, please contact me at 989-895 2348. Thank you.

Sincerely,

Christopher Pinter
Chief Executive Officer

Testimony on Medicaid

Hello, my name is Renee Uitto. I couldn't be here today, but I wanted to email my thoughts on Medicaid. I get Medicaid dollars to allow me to stay in my home and have staff come in every morning and help me with various tasks that I cannot do. These tasks include prepare meals, housework, showering, grocery shopping, housework, and other things. If Medicaid dollars are no longer available, I might be forced to live in an institution. Our society will be going backwards. People with disabilities deserve to live in the community just like everyone else. Please make sure the funding is there for Medicaid dollars. Thank you.

From: "Nelson Grit@gmail.com" <gritnb@gmail.com>
Date: February 20, 2017 at 9:17:34 PM EST
To: Scott Gilman <Scott.Gilman@network180.org>
Subject: Please submit to the House DHHS Budget Committee

It is time to submit some of my beliefs and concerns regarding the financial support the State of Michigan needs to provide its citizens, especially those who are served by the Mental Health System.

I have worked for the Department of Social Services (more recently DHS) for 14 years, and another 10 years for Community Mental Health. and more recently am serving on the boards of Community Mental Health and one of the PIHPs, the Lakeshore Regional Entity.. In all these roles I served people dependent on the state for their general welfare.

There is much discussion lately advocating changing the way we serve persons with disabilities. It is crucial that **funding levels** continue at least at the rate they currently are at. It would be disastrous if we lowered the income tax; the effect on those we serve would be devastating.

The current **carve out** for services for those with life-long disabilities needs to remain at least at the current level, and should remain the domain of the CMH system. Yes, there is a need for more coordination with the physical health providers, and that can continue and should be encouraged without merging the funding for the two entities.

General Funds have already been cut. There is a serious need for additional general fund dollars to provide flexibility to serve the population we are charged to serve.

Obamacare has been controversial, but it has been essential to provide health care, including mental health and substance use treatment, to a huge section of our population. If **Healthy Michigan** is to be changed, please assure that there is a better replacement before it is repealed.

The 298 workgroup has worked diligently to come up with recommendations. Please pay attention to those recommendations, as they represent people served and their advocates. It is especially important to approve the recommendation found in #1.

It was a good idea to raise the **minimum wage**, but the state may not have recognized at the time that there are some 40,000 + employees who serve vulnerable populations who depend on taxpayer dollars as a passthrough from the state for them to obtain the increased wages. Currently people can earn more at McDonalds and have jobs with less stress. Please pass a wage increase for those serving vulnerable populations, including those employed in nursing homes and foster care.

Where there are **mandates** from the state or federal government which adversely impact the services provided through the mental health system, please either fund those mandates or abolish the burdensome mandates.

Thank you.

Nelson Grit

FY 2017-18

mahp

Michigan Association
of Health Plans

MAHP: Who We Are

- The Michigan Association of Health Plans is a nonprofit corporation established to promote the interests of member health plans.
- MAHP's mission is "to provide leadership for the promotion and advocacy of high quality, accessible health care for the citizens of Michigan."
- Represents 13 health plans covering all of Michigan and more than 45 related business and affiliated organizations. Our member health plans employ about 8,000 persons throughout the state.
- Member health plans provide coverage for more than 3 million Michigan citizens – nearly one in every three Michiganders.
- Member health plans collect and use health care data, support the use of "evidence based medicine", and facilitate disease management and care coordination in order to provide cost-effective care.

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Michigan Association of Health Plans

Our members

Aetna Better Health of Michigan [1,2,3]

Fidelis SecureCare [3]

Harbor Health Plan [2]

Health Alliance Plan [1,2,3]

Molina Healthcare of Michigan [1,2,3]

Physicians Health Plan [1]

Total Health Care Plan [1,2,3]

McLaren Health Plan [1,2,3]

Meridian Health Plan [1,2,3]

Paramount Care of Michigan [1]

Priority Health [1,2,3]

Upper Peninsula Health Plan [2,3]

United Healthcare Community Plan [1,2,3]

Key: 1 = Commercial Health Plan **2 = Medicaid Health Plan** **3 = Medicare Advantage or Medicare Special Needs Plan**

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MAHP VISION

- ***By 2020, Michigan will provide health insurance coverage and options to more than 99% of the State's population.***

- ***By fostering competition, by 2020 Michigan will become one of the top 25 competitive states for health insurance. Today, we are third least competitive.***

- ***Michigan's Health Plans will work with partners in government, the provider community, community organizations, and business to improve the health status of Michigan residents.***

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Michigan Association of Health Plans

Managed Care

- **Medicaid services are managed and costs are predictable—savings** over $400 million/year (compared to FFS)—Nearly $5 billion in savings to Taxpayers since 2000.

- **Managed care provides greater access to care**
  - Primary care providers open to Medicaid
  - No wait list for Medically necessary and clinically appropriate services

- **Smart Incentives built into Medicaid Contracts with private health plans**
  - Provides the structure that generates state savings
  - Return on Investment (improved health status, access and costs savings)

- **Medicaid services under managed care are accountable**
  - Audited data related to clinical quality of care measures (HEDIS)
  - Use of external measures to determine customer satisfaction (CAHPS)
  - Contract performance standards (Status improvement, access measures, etc.)
  - Reporting requirements as licensed HMOs and Contracted Medicaid Plans

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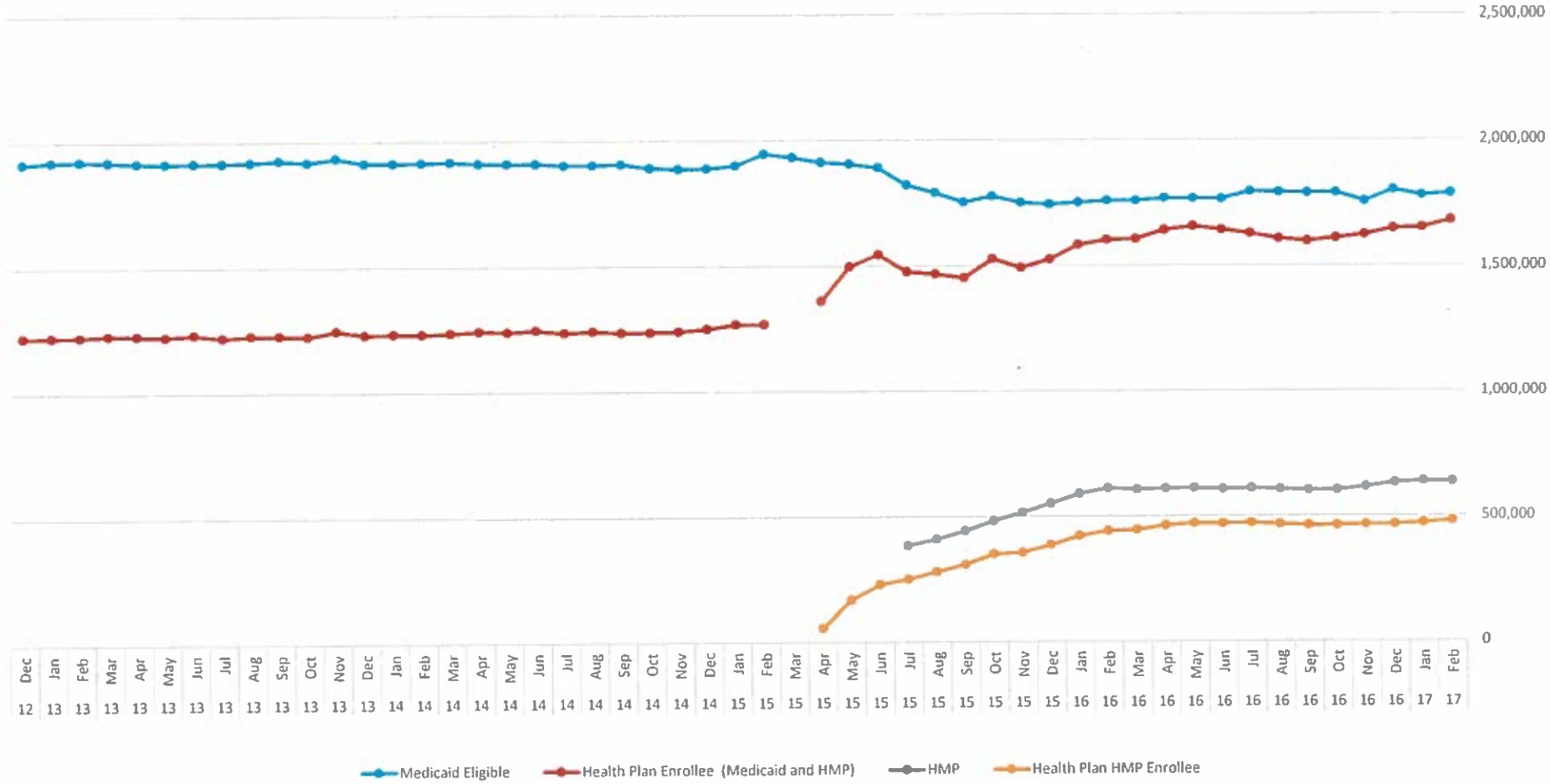
Medicaid Since 2012



FY 17 Monthly Average		Rate Development	Difference	Composite PMPM	Shortfall to Budget
Medicaid Health Plan	1,745,271				
HMP Health Plan	509,833	490,001	19,832	$455.61	$9,035,749
Medicaid minus HMP	1,235,438	1,138,965	96,473	$310.76	$29,980,012

Note: the composite PMPM for Medicaid Health Plan does not account for CSHCS

MI Health Link Cost Summary FY 16

Rate Cell	Estimated Monthly Enrollment	Actual Monthly Enrollment	PMPM	Monthly Total	Estimated Yearly Total	Actual Yearly Total (using PMPM estimate)	FY 16 Enacted Budget	FY 17 Enacted Budget	FY 18 Proposed
Nursing Facility-Sub tier A									
Over 65	1,646		$6,006.08	$9,886,007.68					
Under 65	218		$5,207.17	$1,135,163.06					
Nursing Facility-Sub tier B									
Over 65	196		$9,158.64	$1,795,093.44					
Under 65	13		$9,254.62	$120,310.06					
Nursing Facility-LOC Waiver									
Over 65	78		$2,229.41	$173,893.98					
Under 65	57		$2,771.22	$157,959.54					
Community Residents									
Over 65	12,696		$141.93	$1,801,943.28					
Under 65	18,557		$121.08	$2,246,881.56		Based on Composite PMPM of $517.54			
TOTAL	33,461	35,095		$17,317,252.60	$207,807,031	$217,956,796	$454,700,000	$230,633,300	$187,469,700

FY 17 monthly enrollment:	36,804
FY 17 annual cost estimate:	$228,571,748

Medicaid FFS RX Expenditures		
Fiscal Year	**Actual Expenditures**	**Change year to year**
2013	$248.4 million	
2014	$263.7 million	5.8%
2015	$268.0 million	1.6%
2016	$319.4 million	16.0%
2017	$537.5 million (allocated)*	40.0%

Prescription Drug Trends for Michigan Medicaid Managed Care Organizations			
Eligibility Category	**FY14 / FY13**	**FY15 / FY14**	**Average FY15/FY13**
TANF	16.4%	8.1%	12.3%
ABD	32.9%	5.5%	19.2%
CSHCS	31.5%	14.9%	23.2%

MEDICAID DRUG SPENDING DASHBOARD 2015

S - Drug selected due to high total program spending.
F - Drug selected due to high annual spending per prescription fill.
U - Drug selected due to large increase in average cost per unit (weighted).

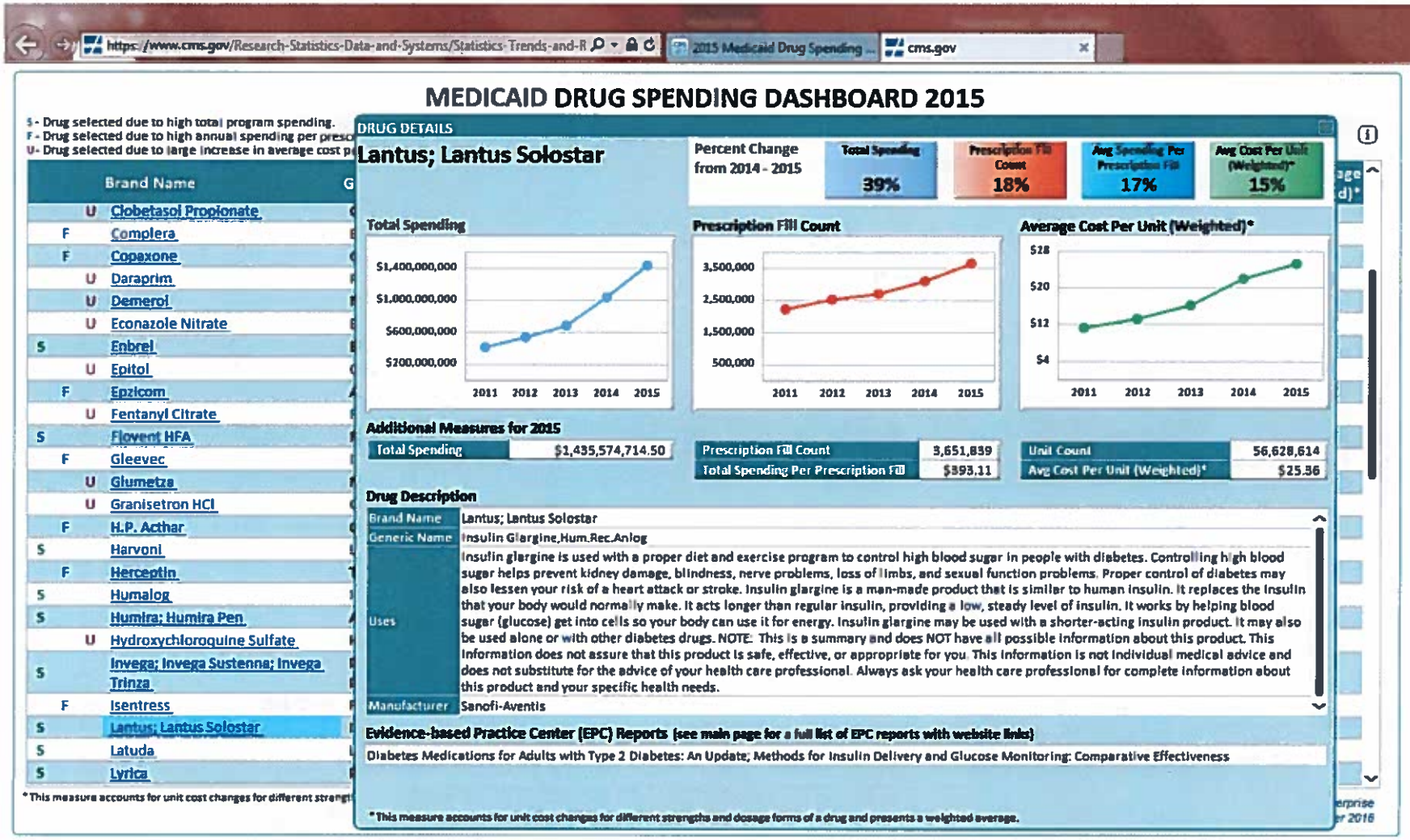
MEDICATIONS LIST | INFORMATION

		Brand Name	Generic Name	Total Spending	Prescription Fill Count	Total Spending Per Prescription Fill	Unit Count	Annual Change in Average Cost Per Unit (Weighted)*
S		Abilify	Aripiprazole	$2,029,596,059	2,074,321	$978	65,711,387	15%
S		Adderall XR	Dextroamphetamine/Amphetamine	$449,064,902	1,805,993	$249	61,283,669	1%
S		Advair Diskus	Fluticasone/Salmeterol	$580,892,328	1,758,551	$330	107,436,646	8%
	F	Advate	Antihemoph.FVIII,Full Length	$353,645,102	16,979	$20,828	300,873,016	1%
	U	Anucort-HC	Hydrocortisone Acetate	$5,024,488	18,364	$274	434,496	189%
S		Aripiprazole	Aripiprazole	$605,129,203	947,738	$638	28,720,496	0%
	U	Ativan	Lorazepam	$5,263,613	7,168	$734	141,807	1264%
S		Atripla	Efavirenz/Emtricitab/Tenofovir	$603,023,281	265,692	$2,270	8,096,820	9%
	F	Avastin	Bevacizumab	$187,568,406	144,610	$1,297	1,329,969	-5%
	U	Carbamazepine	Carbamazepine	$37,741,065	585,130	$65	86,163,517	141%
	U	Clindamycin Phos-Benzoyl Perox	Clindamycin Phos/Benzoyl Perox	$6,564,980	10,413	$630	460,002	181%
	U	Clobetasol Propionate	Clobetasol Propionate	$143,846,674	741,509	$194	45,393,879	159%
	F	Complera	Emtricitab/Rilpivirine/Tenofov	$313,442,459	138,938	$2,256	4,210,501	7%
	F	Copaxone	Glatiramer Acetate	$279,012,518	51,497	$5,418	1,127,085	14%
	U	Daraprim	Pyrimethamine	$15,704,936	2,585	$6,075	118,175	874%
	U	Demerol	Meperidine HCl/PF	$4,900,983	48,806	$100	136,314	210%
	U	Econazole Nitrate	Econazole Nitrate	$46,206,960	218,702	$211	12,779,028	254%
S		Enbrel	Etanercept	$437,474,118	136,508	$3,205	574,449	19%
	U	Epitol	Carbamazepine	$2,706,075	58,483	$46	5,529,061	460%
	F	Epzicom	Abacavir Sulfate/Lamivudine	$141,386,148	117,317	$1,205	3,493,055	8%
	U	Fentanyl Citrate	Fentanyl Citrate/PF	$55,317,741	474,760	$117	2,898,294	160%
S		Flovent HFA	Fluticasone Propionate	$441,361,058	2,264,825	$195	26,376,028	7%
	F	Gleevec	Imatinib Mesylate	$190,583,268	20,001	$9,529	820,837	23%
	U	Glumetza	Metformin HCl	$16,130,816	7,873	$2,049	433,709	296%
	U	Granisetron HCl	Granisetron HCl	$7,787,084	43,149	$180	170,769	312%
	F	H.P. Acthar	Corticotropin	$144,565,871	3,278	$44,102	21,943	5%

* This measure accounts for unit cost changes for different strengths and dosage forms of a drug and presents a weighted average of these percent changes.

CMS

Produced by the CMS/Office of Enterprise Data & Analytics (OEDA), October 2016


https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-R
2015 Medicaid Drug Spending ...
cms.gov
MEDICAID DRUG SPENDING DASHBOARD 2015
$ - Drug selected due to high total program spending.
F - Drug selected due to high annual spending per presc
U - Drug selected due to large increase in average cost p
Brand Name
U Clobetasol Propionate
F Complera
F Copaxone
U Daraprim
U Demerol
U Econazole Nitrate
S Enbrel
U Epitol
F Epzicom
U Fentanyl Citrate
S Flovent HFA
F Gleevec
U Glumetza
U Granisetron HCl
F H.P. Acthar
S Harvoni
F Herceptin
S Humalog
S Humira; Humira Pen
U Hydroxychloroquine Sulfate
S Invega; Invega Sustenna; Invega Trinza
F Isentress
S Lantus; Lantus Solostar
S Latuda
S Lyrica
* This measure accounts for unit cost changes for different strengt
DRUG DETAILS
Lantus; Lantus Solostar
Percent Change from 2014 - 2015
Total Spending 39%
Prescription Fill Count 18%
Avg Spending Per Prescription Fill 17%
Avg Cost Per Unit (Weighted)* 15%
Total Spending
$1,400,000,000
$1,000,000,000
$600,000,000
$200,000,000
2011 2012 2013 2014 2015
Prescription Fill Count
3,500,000
2,500,000
1,500,000
500,000
2011 2012 2013 2014 2015
Average Cost Per Unit (Weighted)*
$28
$20
$12
$4
2011 2012 2013 2014 2015
Additional Measures for 2015
Total Spending $1,435,574,714.50
Prescription Fill Count 3,651,839
Total Spending Per Prescription Fill $393.11
Unit Count 56,628,614
Avg Cost Per Unit (Weighted)* $25.36
Drug Description
Brand Name Lantus; Lantus Solostar
Generic Name Insulin Glargine,Hum.Rec.Anlog
Uses Insulin glargine is used with a proper diet and exercise program to control high blood sugar in people with diabetes. Controlling high blood sugar helps prevent kidney damage, blindness, nerve problems, loss of limbs, and sexual function problems. Proper control of diabetes may also lessen your risk of a heart attack or stroke. Insulin glargine is a man-made product that is similar to human insulin. It replaces the insulin that your body would normally make. It acts longer than regular insulin, providing a low, steady level of insulin. It works by helping blood sugar (glucose) get into cells so your body can use it for energy. Insulin glargine may be used with a shorter-acting insulin product. It may also be used alone or with other diabetes drugs. NOTE: This is a summary and does NOT have all possible information about this product. This information does not assure that this product is safe, effective, or appropriate for you. This information is not individual medical advice and does not substitute for the advice of your health care professional. Always ask your health care professional for complete information about this product and your specific health needs.
Manufacturer Sanofi-Aventis
Evidence-based Practice Center (EPC) Reports (see main page for a full list of EPC reports with website links)
Diabetes Medications for Adults with Type 2 Diabetes: An Update; Methods for Insulin Delivery and Glucose Monitoring: Comparative Effectiveness
* This measure accounts for unit cost changes for different strengths and dosage forms of a drug and presents a weighted average.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-R | 2015 Medicaid Drug Spending ... | cms.gov

MEDICAID DRUG SPENDING DASHBOARD 2015

S - Drug selected due to high total program spending.
F - Drug selected due to high annual spending per presc
U- Drug selected due to large increase in average cost p

		Brand Name
	U	Fentanyl Citrate
S		Flovent HFA
	F	Gleevec
	U	Glumetza
	U	Granisetron HCl
	F	H.P. Acthar
S		Harvoni
	F	Herceptin
S		Humalog
S		Humira; Humira Pen
	U	Hydroxychloroquine Sulfate
S		Invega; Invega Sustenna; Invega Trinza
	F	Isentress
S		Lantus; Lantus Solostar
S		Latuda
S		Lyrica
	U	Mestinon
S		Methylphenidate ER
	U	Morphine Sulfate
	U	Naproxen Sodium
	F	Neulasta
	F	Norditropin Flexpro
	F	Novoseven RT
	U	Phenergan
	F	Prezista

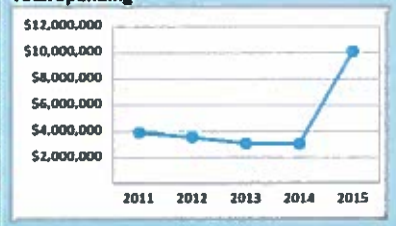
* This measure accounts for unit cost changes for different strengt

DRUG DETAILS

Naproxen Sodium

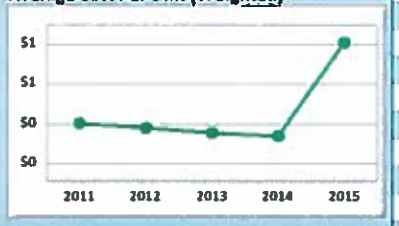
Percent Change from 2014 - 2015	Total Spending	Prescription Fill Count	Avg Spending Per Prescription Fill	Avg Cost Per Unit (Weighted)*
	226%	8%	201%	194%

Total Spending



Prescription Fill Count

Average Cost Per Unit (Weighted)*



Additional Measures for 2015

Total Spending	$10,126,814.68	Prescription Fill Count	370,485	Unit Count	14,991,095
		Total Spending Per Prescription Fill	$27.33	Avg Cost Per Unit (Weighted)*	$0.71

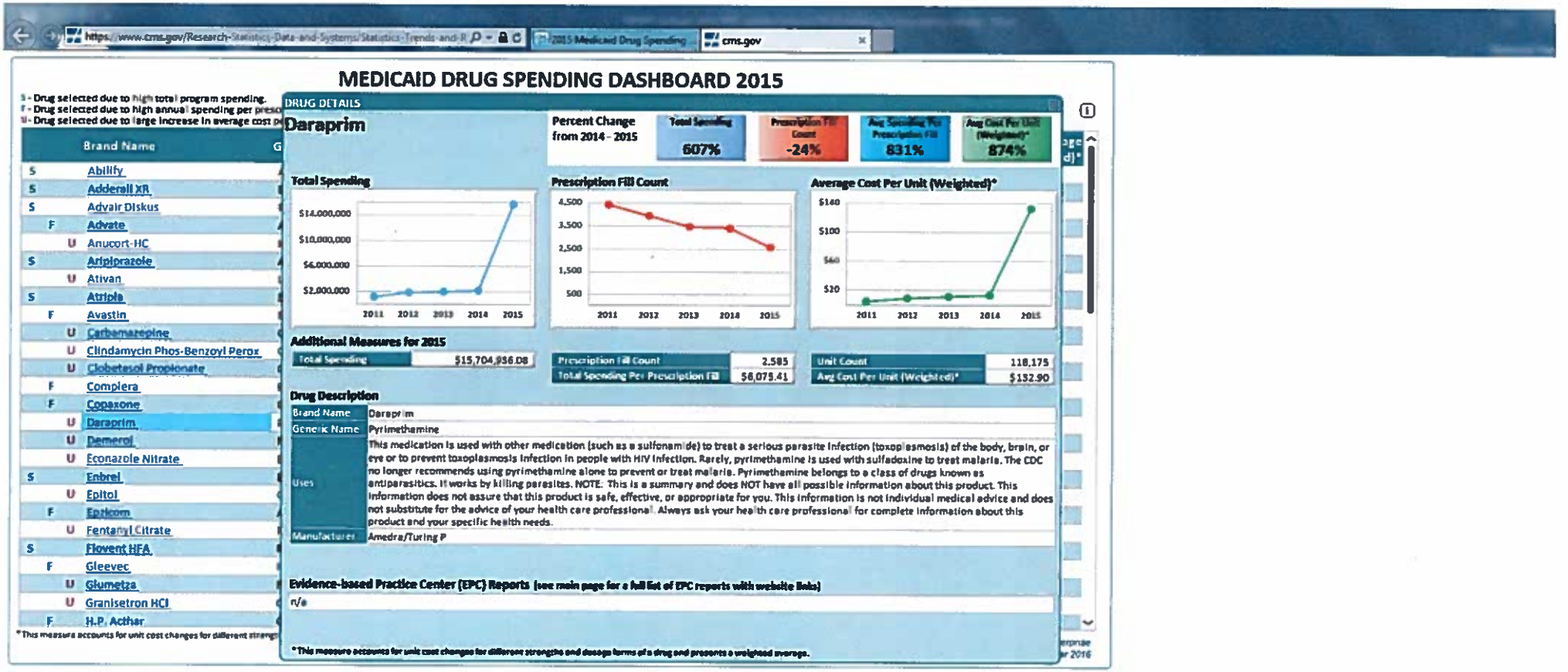
Drug Description

Brand Name	Naproxen Sodium
Generic Name	Naproxen Sodium
Uses	Naproxen is used to relieve pain from various conditions such as headaches, muscle aches, tendonitis, dental pain, and menstrual cramps. It also reduces pain, swelling, and joint stiffness caused by arthritis, bursitis, and gout attacks. This medication is known as a nonsteroidal anti-inflammatory drug (NSAID). It works by blocking your body's production of certain natural substances that cause inflammation. If you are treating a chronic condition such as arthritis, ask your doctor about non-drug treatments and/or using other medications to treat your pain. See also Warning section. NOTE: This is a summary and does NOT have all possible information about this product. This information does not assure that this product is safe, effective, or appropriate for you. This information is not individual medical advice and does not substitute for the advice of your health care professional. Always ask your health care professional for complete information about this product and your specific health needs.
Manufacturer	Multiple Manufacturers

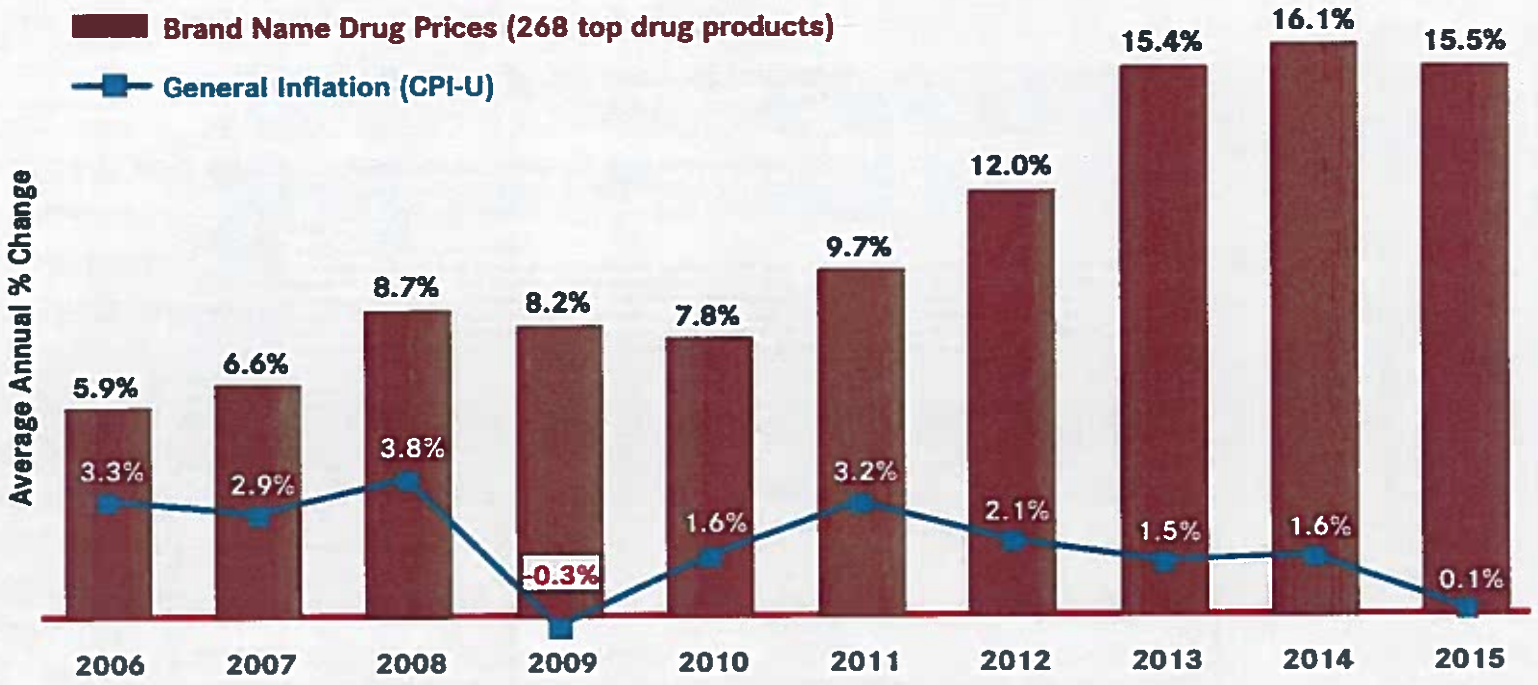
Evidence-based Practice Center (EPC) Reports (see main page for a full list of EPC reports with website links)

Management of Gout; Noninvasive Treatments for Low Back Pain

* This measure accounts for unit cost changes for different strengths and dosage forms of a drug and presents a weighted average.


MEDICAID DRUG SPENDING DASHBOARD 2015
S - Drug selected due to high total program spending.
F - Drug selected due to high annual spending per prescription
U - Drug selected due to large increase in average cost per unit
Brand Name
S Abilify
S Adderall XR
S Advair Diskus
F Advate
U Anucort-HC
S Aripiprazole
U Ativan
S Atripla
F Avastin
U Carbamazepine
U Clindamycin Phos-Benzoyl Perox
U Clobetasol Propionate
F Complera
F Copaxone
U Daraprim
U Demerol
U Econazole Nitrate
S Enbrel
U Epitol
F Epivir
U Fentanyl Citrate
S Flovent HFA
F Gleevec
U Glumetza
U Granisetron HCl
F H.P. Acthar
*This measure accounts for unit cost changes for different strengths
DRUG DETAILS
Daraprim
Percent Change from 2014 - 2015
Total Spending 607%
Prescription Fill Count -24%
Avg Spending Per Prescription Fill 831%
Avg Cost Per Unit (Weighted)* 874%
Total Spending
$14,000,000
$10,000,000
$6,000,000
$2,000,000
2011 2012 2013 2014 2015
Prescription Fill Count
4,500
3,500
2,500
1,500
500
2011 2012 2013 2014 2015
Average Cost Per Unit (Weighted)*
$140
$100
$60
$20
2011 2012 2013 2014 2015
Additional Measures for 2015
Total Spending $15,704,936.08
Prescription Fill Count 2,585
Total Spending Per Prescription Fill $6,075.41
Unit Count 118,175
Avg Cost Per Unit (Weighted)* $132.90
Drug Description
Brand Name Daraprim
Generic Name Pyrimethamine
Uses This medication is used with other medication (such as a sulfonamide) to treat a serious parasite infection (toxoplasmosis) of the body, brain, or eye or to prevent toxoplasmosis infection in people with HIV infection. Rarely, pyrimethamine is used with sulfadoxine to treat malaria. The CDC no longer recommends using pyrimethamine alone to prevent or treat malaria. Pyrimethamine belongs to a class of drugs known as antiparasitics. It works by killing parasites. NOTE: This is a summary and does NOT have all possible information about this product. This information does not assure that this product is safe, effective, or appropriate for you. This information is not individual medical advice and does not substitute for the advice of your health care professional. Always ask your health care professional for complete information about this product and your specific health needs.
Manufacturer Amedra/Turing P
Evidence-based Practice Center (EPC) Reports (see main page for a full list of EPC reports with website links)
n/a
*This measure accounts for unit cost changes for different strengths and dosage forms of a drug and presents a weighted average.

AVERAGE ANNUAL BRAND NAME DRUG PRICES CONTINUE TO GROW SUBSTANTIALLY FASTER THAN GENERAL INFLATION IN 2015



Note: Calculations of the average annual brand name drug price change include the 268 drug products most widely used by older Americans (see Appendix A).

Prepared by the AARP Public Policy Institute and the PRIME Institute, University of Minnesota, based on data from Truven Health MarketScan® Research Databases and MediSpan Price Rx Pro®.

Integration

Managed Care is the predominant financing model for state Medicaid programs, with nearly 40 states contracting with Managed Care Organizations (MCOs) to provide all or some physical health benefits for beneficiaries.

States are seeking better ways to coordinate physical and behavioral health services with the goal of improving outcomes and reducing unnecessary utilization.

As of January, 2016, 16 states provide or are planning to offer behavioral health services through an integrated managed care benefit – the very path originally proposed in the FY 17 Executive Budget Recommendation.

In response to feedback to the FY 17 Executive Budget, Lt. Governor Calley and DHHS convened an Ad Hoc group resulting in the "Calley Report". At that time the Legislature did not endorse the report and instead selected to amend FY 17 boilerplate designed to inform and guide the legislature on a future path towards integration with the formation of a 298 Facilitation Workgroup.

The Interim 298 Facilitation Workgroup report clearly illustrates that the status quo is unacceptable.

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Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 **Minimal Collaboration**	**LEVEL 2** **Basic Collaboration at a Distance**	**LEVEL 3** **Basic Collaboration Onsite**	**LEVEL 4** **Close Collaboration Onsite with Some System Integration**	**LEVEL 5** **Close Collaboration Approaching an Integrated Practice**	**LEVEL 6** **Full Collaboration in a Transformed/ Merged Integrated Practice**
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	**LEVEL 2 Basic Collaboration at a Distance**	**LEVEL 3 Basic Collaboration Onsite**	**LEVEL 4 Close Collaboration Onsite with Some System Integration**	**LEVEL 5 Close Collaboration Approaching an Integrated Practice**	**LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice**
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

Integration

Suggested Path Forward:

- The FY 18 budget should included boilerplate language which will require the Department to advance pilot and demonstration models that truly integrate (systems and services) the Medicaid behavioral and physical health benefit with a goal of achieving total benefit and financial integration by September 30, 2020.

- The State should only contract with licensed risk bearing entities, that meet all of the solvency and regulatory requirements provided in the state Insurance Code, and promulgated by DIFS.

- Contracts with the State should ensure continuity of care during any transition.

- Competition and consumer choice of contracted risk-bearing entity should remain key components in order to achieve the best outcomes through system coordination.

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Budget Concerns

- **Actuarial Soundness:** The 1% increase noted in the Governor's proposed budget is not based on any trend information and will need to be revised to account for updated caseload estimates. MAHP suggests that the Legislature cautiously revise this assumption to align with current caseload estimates and at least current trend estimates.

- **Restoration of FY 17 cuts**: Despite receiving a 2% increase by the Legislature in FY 17, Health Plan rates were cut by Department for FY 17, in part due to legislatively required arbitrary cuts to HMOs (lab fees and ED utilization reductions).

- **ICO Line Item:** As previously noted the FY 18 Exec Rec appears to be based on current caseload and current (FY 16) rate cells.

- **ACA Health Insurance Fee:** MAHP suggests unrolling this line item, similar to previous years so as to better track expected expense.

mahp
Michigan Association of Health Plans

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mahp
Michigan Association of Health Plans

Michigan House of Representatives
Appropriations Subcommittee on Health and Human Services Committee Meeting
Monday, February 27, 2017
Text of Public Testimony Provided by Lindsay Brieschke, Alzheimer's Association – Michigan Chapters

Representative Canfield and members of the Committee,

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

- Alzheimer's disease is the sixth leading cause of death in the United States.Alzheimer's disease is the only cause of death among the top 10 in America that cannot be prevented, cured or even slowed.
- 180,000 Michiganders are living with Alzheimer's today.
- The rate of diagnosis for Alzheimer's disease is increasing exponentially; it is estimated that within a decade, more than 220,000 Michigan residents will be living with Alzheimer's disease.
- Alzheimer's is the most expensive disease in the county. Nationwide, there is a projected 350% increase in Medicare and Medicaid spending on Alzheimer's by mid-century.

For the past three years, the Alzheimer's Association has contracted with the State of Michigan to implement a $150,000 pilot program called the Michigan Dementia Care and Support Program. This program, which is currently in Macomb, Monroe, and St. Joseph counties, aims to demonstrate that care consultation for caregivers and people living with Alzheimer's can delay or prevent long-term care placement and ultimately help to reduce Medicaid nursing home costs to the state of Michigan. The pilot is currently in it's third and final year.

Data from year two results of the pilot demonstrate success with reduced rates of long-term care placement in over 9% of clients in the program. This reduction in placement is equal to over half a million dollars in savings to the state of Michigan in 2016 alone.

At this time, with a demonstrated rate of success and a more than 250% return on investment to the State of Michigan, we respectfully ask the members of the Appropriations Committee to fully fund the Michigan Dementia Care and Support Program at $2 million. This statewide funding would allow over 1,000 families a year to receive services such as care planning, behavior management, grief and loss counseling, and connecting to already

available community services. Ultimately these key services would aid in helping to provide the best possible care to Michiganders with dementia and Alzheimer's until there is a treatment or cure that can change the course of this disease.

Investing in care and support for families facing dementia and Alzheimer's is critical. Michigan must make smart choices now to prepare our state for the aging of the baby boomers and the huge projected increase in Alzheimer's prevalence in the coming years. As part of Michigan's comeback, I sincerely hope that we can be ranked among the top in supporting families facing Alzheimer's.

Thank you again for hearing my testimony and for your thoughtful consideration of how we can best support Michigan residents facing Alzheimer's and dementia. I will he be happy to take questions.

Sincerely,

Lindsay Brieschke
Director of Public Policy
Alzheimer's Association – Michigan Chapters
lbrieschke@alz.org
734.320.8898

2017 POLICY PRIORITIES

CONTINUE MICHIGAN DEMENTIA CARE AND SUPPORT PROGRAM

The Alzheimer's Association aims to continue and expand the Michigan Dementia Care and Support program to better serve all Michiganders facing Alzheimer's and other dementias. By supporting families at home, we can delay, and in some cases prevent the need for skilled nursing care, thus saving our state money.

UPDATE AND IMPLEMENT THE MICHIGAN DEMENTIA STATE PLAN

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

- Improving the quality of the health care system in serving people with Alzheimer's
- Increasing awareness of Alzheimer's disease among the public; encouraging early detection
- Better equipping health care professionals and others to care for individuals with Alzheimer's
- Meeting the needs of more than 500,000 unpaid caregivers in Michigan

INCREASE STATE-BASED SURVEILLANCE THROUGH THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

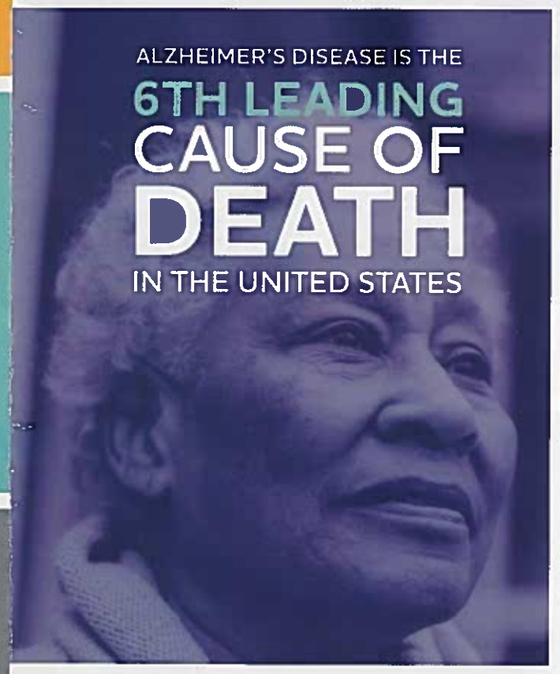
Michigan aims to include questions related to cognitive impairment and caregiving in the state BRFSS to provide a better understanding of and to identify opportunities for reducing the impact of Alzheimer's disease.

RAISE AWARENESS

Since 2014, Governor Rick Snyder led the State of Michigan in "going purple" during June, in order to help bring attention to Alzheimer's disease. We look forward to "going purple" in 2017 with your support.

PLEASE TAKE ACTION TODAY TO SUPPORT CAREGIVERS AND HELP END ALZHEIMER'S!

MICHIGAN MUST ADDRESS THE ALZHEIMER'S CRISIS.



ALZHEIMER'S DISEASE IS THE
6TH LEADING CAUSE OF DEATH
IN THE UNITED STATES

1 IN 3 SENIORS
DIES WITH ALZHEIMER'S
OR ANOTHER DEMENTIA

MORE THAN 180,000
MICHIGANDERS ARE LIVING WITH ALZHEIMER'S

IN 2015, MORE THAN HALF A MILLION CAREGIVERS PROVIDED AN ESTIMATED **5.8 MILLION HOURS OF UNPAID CARE**

IN 2015, ALZHEIMER'S AND OTHER DEMENTIAS COST MICHIGAN
$1.2 BILLION

BY 2025, IT WILL COST MICHIGAN
$1.7 BILLION

EVERY 66 SECONDS
SOMEONE IN THE UNITED STATES DEVELOPS THE DISEASE

IT KILLS MORE THAN **BREAST AND PROSTATE CANCER COMBINED**

ALZHEIMER'S ASSOCIATION
Michigan Chapters
800.272.3900 | alz.org

alzheimer's association®
THE BRAINS BEHIND SAVING YOURS.℠

THE MICHIGAN DEMENTIA CARE & SUPPORT PROGRAM

WHAT IT IS

The Michigan Dementia Care & Support Program (MDCSP) provides social work expertise, in-home care counseling, person-centered planning, and supplies and resources to families affected by dementia. The program is currently available to families in Macomb, Monroe, and St. Joseph Counties in the FY 2017 budget. We hope to expand this service to all counties in FY 2018.

RETURN ON INVESTMENT

- The project evaluation states the MDCSP reduced long-term care placement by 9.3% and resulted in a 10% reduction in emergency room visits among participants.
- The MDCSP saved the State and Michigan taxpayers $533,048 in 2016.

$533 THOUSAND SAVED IN 2016 ALONE

WHAT'S NEXT

- A $2 million expansion will support over 1,000 families throughout the State each year.
- If 9.3% of the MDCSP participants are not placed in long term care, the State will save $6,100,484.

$2 MILLION NEEDED

PLEASE SUPPORT A $2 MILLION INVESTMENT

IN THE MDCSP IN THE FY 2018 BUDGET TO ACCOMPLISH THE FOLLOWING:

- Provide for 35 Care Counselors to be deployed across the State
- Provide for two Outreach Coordinators to quickly grow awareness and referrals to the program
- Help provide a toll-free 24/7 Helpline

PROGRAMS & SERVICES FOR MICHIGAN RESIDENTS

THE ALZHEIMER'S ASSOCIATION PROVIDES care and support for Michigan residents living with or caring for someone with Alzheimer's disease and other dementias. Our mission is to eliminate Alzheimer's disease through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. Our vision is a world without Alzheimer's disease. Our programs and services include:

- **24/7 Helpline**
- **Care consultations**
- **Education programs for caregivers, persons with the disease, and professionals**
- **Safety services for those who wander**
- **Early-Stage dementia programs**
- **Support groups**
- **Region-specific programs, such as respite care, arts and cultural programming, and workforce development.**

OUR STORY...

My wife Dawn didn't become forgetful, she didn't become combative, she just stopped being who she was. Our family of three boys, ages 2, 5, and 9 at the time, and I saw subtle changes in 2007 when Dawn was 34. Something was different - she was no longer trying to figure things out, she became withdrawn. She was not the same mother that would plan the family calendar out for the month, including 4-course dinners each week. In 2012, she was in two car accidents, and she could not explain the second one at all. After the accident and a myriad of medical tests and doctor's visits, we were told that Dawn was probably suffering from some early form of dementia.

In December of 2015, I reached out to the Alzheimer's Association. In my first meeting with the Care Counselor I set a goal to keep Dawn at home with us. The Care Counselor helped us to create a plan which included, first, arranging for hospice care. At the end of the meeting, a sense of relief came over me that gave me hope. It helped us realize there were options, we were not alone, and people wanted to help. After our planning meeting, we met monthly. These meetings were quite honestly lifesaving. We learned to think beyond the feelings and situations we were facing moment to moment. We learned lifelong lessons and developed resources to help us past what we were dealing with in the present.

Dawn passed away in August of 2016 at the age of 43 - a short eight months after we first met with the Alzheimer's Association.

I am constantly reminded of how impactful the Alzheimer's Association's approach and help was to our family. We are able to carry on, albeit sad because of our loss, but with a positive approach that we have the tools to continue forward. **This program needs to be available to anyone that needs it - looking back now as I have a moment to reflect, it is hard to imagine how we were able to handle each day. The turning point was reaching out to the Alzheimer's Association.** This disease will impact almost everyone at some point - be it a close relative or friend. This program is vital, it gives families hope and tools as we wait for a cure. We cannot sit back and wish that Alzheimer's doesn't happen - we need to prepare and do more to be ready for when it does happen to families.

– Don Kowalski, Macomb County

Michigan Senior Volunteer Programs

HOUSE OF REPRESENATIVES TESTIMONY

February 27, 2017

Representative Canfield, distinguished members of the subcommittee, thank you for the opportunity to speak here today.

Grandma Bonnie is a new volunteer Grandma to the Foster Grandparent Program and just couldn't wait to share with NEMCSA FGP staff that the teacher of Mio's Head Start asked her to increase her volunteer hours from 15 to 24 stating "the Foster Grandparent Program has changed my life and I wish I joined up 10 years ago". At almost 70 years old, Grandma says "she feels like 30" since she began interacting with the children a few months ago. This has been confirmed by her physician who encourages her to keep doing what she's doing as a Foster Granny "because you're looking younger every time I see you". And who doesn't want to look younger!

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

Foster Grandparents are low-income older adults, who provide sustained one-to-one attention and assistance to vulnerable children, with the purpose of improving self-esteem and supporting the child's ability to learn, and succeed in school and life. Foster Grandparents commit an average of 20 hours per week to provide a stable, caring relationship for children who often come from chaotic and unpredictable environments. In exchange for their service, Foster Grandparent receive a small, non-taxable stipend of $2.65 per hour. In 2016, 1,108 Foster Grandparents provide service in 1,476 educational setting to support over 5,557 children who are academically delayed, lacking self-esteem or motivation, experiencing behavior or social problems and are at risk of dropping out of school, all of which can cause additional economic stress on our communities.

Senior Companions are low-income older adults who play an important role in supporting frail seniors and adults with disabilities in their quest to live independently for as long as possible. Senior Companion volunteers add richness to the lives of their clients, while providing access to their community, including grocery shopping, transportation to medical appointments, and opportunities for socialization. Similar to Foster Grandparents, Senior Companions receive a small, non-taxable stipend for their service. Each year nearly 500 Senior Companions support in-home and long-term

care services for more than 2,000 Michigan citizens at risk of institutionalization. Senior Companions help seniors live independently in the communities where they choose to reside.

The Retired & Senior Volunteer Program (RSVP), one of the nation's largest volunteer efforts, invites older adults to utilize their skills, talents, and life experience to make a difference in their community, through direct service and collaboration with established non-profits, schools, government, and public organizations. RSVP Volunteers serve their communities by tutoring and mentoring children, providing companionship, support, and medical transportation for older adults, protecting the safety of their peers through partnerships with law enforcement, and supporting the health of our state's lands and waters. Each year more than 7,000 RSVP Volunteers contribute in excess of 600,000 hours of service to nearly 1,254 organizations, projects and communities across Michigan. RSVP volunteers do not receive a stipend for their service.

For more than 40 years, the Michigan Legislature has recognized the value and importance of one of our state's strongest resources, our senior volunteers. An increase of $1,000,000 for expansion of the three Senior Volunteer Programs would provide for approximately 161,744 additional volunteer hours and increase the program's capacity to better serve the growing population of older adults. Approximately 66,000 of those hours would come from FGP, 47,000 from RSVP and 48,000 from SCP. This would provide an estimated value to Michigan communities of nearly 3.8 million dollars*, almost 4 times the cost of the proposals.

In closing, thank you for your support over the years and look forward to your continued support in the future.

***Based on the independent sector estimated rate for 2015.**

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February 27, 2017

The Honorable Edward Canfield, Chair, and
Members of the House Appropriations Health & Human Services Subcommittee
Room 352, House Appropriations, State Capitol Building

Re: **FY 2018 Department of Health and Human Services Budget**

Dear Chairman Canfield and Subcommittee Members:

On behalf of AARP Michigan, we appreciate this opportunity to highlight the following items in the proposed FY 2018 Department of Health and Human Services budget. These items particularly impact the extent to which Michigan's older adults can continue to live safely, independently, and in good health as they age:

Non-Medicaid In-Home Senior Services

As part of Michigan's *Silver Key Coalition*, AARP supports the Governor's recommendation to invest an additional $1.5 million for Home Delivered Meals in the Nutrition line item of the Aging and Adult Services Agency (AASA) budget, and an additional $2.1 million for other In-Home Services in the Community Services Line Item of the AASA budget. This $3.6 million in funding is needed to reduce the current waiting lists for in-home senior services administered by AASA and delivered through local Area Agencies on Aging across the state.

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

MI Choice Medicaid Waiver

AARP also urges Michigan lawmakers to continue to increase access for older adults to home and community-based services through the MI Choice Medicaid Waiver program.

MI Choice provides home and community-based services (HCBS) for older adults who qualify for Medicaid and who, without those services, would need to move into a nursing home. Increasing access to MI Choice is a win-win for our state. AARP research shows that the overwhelming majority of Michigan residents prefer to "age in place" in their own homes and communities. In addition, continuing to rebalance Michigan's long term care system – that is, continuing to allow a greater share of the people needing services to remain in their homes – can also save taxpayer dollars. Medicaid dollars can support nearly three older adults or people with disabilities in home and community-based services for every one person in a nursing home.

Healthy Michigan

AARP supports the Governor's recommendation to continue the Healthy Michigan Plan, which is particularly important to Michigan residents who are over age 50 but still under 65, so not yet eligible for Medicare.

The Governor recommends total funding for the Healthy Michigan Plan at $4.1 billion, which includes a 6% state general fund match of $200.4 million. As the executive budget recommendation reflects, that general fund cost will be more than offset in the FY 2018 budget by the state savings resulting from those federal dollars now being available to pay for corrections health care and other health care services for which state general fund dollars would otherwise pay. But when it comes to older adults in particular, there also are long-term savings – or costs – at stake to the health care system.

In our current economy, older workers increasingly find themselves in lower-paying service sector jobs without employer-provided insurance. Older adults are particularly vulnerable to deterioration in function and health status if they don't have health coverage, and that in turn increases their need for more costly health care and long term care in the future. The availability of health coverage for low-income workers ages 50-64 through the Healthy Michigan Plan helps them maintain better health now, and allows our health care system to avoid additional higher costs down the road.

Increased Staffing for Adult Protective Services

AARP supports the Governor's recommendation to invest an additional $11.3 million to improve staffing for adult protective services, adult community placement services, and independent living services. Current staffing levels have fallen short to meet the need for these services which help elderly persons and people with disabilities to live safely and independently, and which help protect vulnerable adults from abuse and exploitation.

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

Respectfully,

Lisa Dedden Cooper
Manager of Advocacy

Melissa Seifert
Associate State Director, Government Affairs

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

FEBRUARY 2017

Insight on the Issues

Stretching the Medicaid Dollar: Home and Community-Based Services Are a Cost-Effective Approach to Providing Long-Term Services and Supports

Jean Accius and Brendan Flinn
AARP Public Policy Institute

INTRODUCTION

Approximately 17.4 million children and adults with disabilities and older adults rely on Medicaid for health care and assistance with long-term services and supports (LTSS). Of these 17.4 million Medicaid enrollees,[1] approximately 5 million receive LTSS through Medicaid.[2]

LTSS include assistance with daily tasks such as eating, bathing, dressing, transportation, and managing medications and finances. LTSS can be delivered in institutional settings (such as nursing facilities) or through home and community-based services (HCBS). However, an overwhelming majority of people would prefer to live in their homes and communities for as long as possible.[3] Related to those preferences, they want to maintain their independence and have control over their own decisions.

The Medicaid program is the largest payer for LTSS, covering 51 percent of national LTSS expenses in 2013.[4] Over the past 30 years, Medicaid LTSS dollars have increasingly gone toward HCBS, allowing more people to stay in their homes and integrated within their communities. However, the pace has not been fast enough, particularly in light of the increase in the aging population. Importantly, HCBS are not only the preference of most people, they are cost-effective. HCBS are typically less expensive than nursing facility care, so increasing investments in and access to HCBS could allow the Medicaid program to serve more people without increasing costs.

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Despite these realities, however, certain federal Medicaid rules make nursing facilities more easily accessible than HCBS. For older people and adults with physical disabilities, nursing facility care still accounts for 59 percent of Medicaid LTSS spending.[5]

WHAT ARE HCBS?

Many people with physical, cognitive, or mental impairments need assistance with activities of daily living (ADLs) such as bathing, dressing, and toileting, or instrumental activities of daily living (IADLs) such as shopping, managing money, and preparing meals. The term HCBS refers to assistance with ADLs and IADLs, which generally helps older adults and people with disabilities maintain employment or remain in their homes and communities. HCBS also promote community integration through transportation and employment supports.

People of all ages with disabilities who use these services live in a variety of settings: their own homes or apartments; nursing facilities; assisted living facilities and other supportive housing settings; and integrated settings, such as those that provide both health care and supportive services. HCBS can come in many forms, and the services an individual uses are specific to functional needs.

MEDICAID HCBS SPENDING

Medicaid spent $152 billion on LTSS in fiscal year (FY) 2014;[6] a majority of the expenditures, in fact, have gone toward HCBS.[7] These figures, however, mask substantial spending variations, both by state and by demographic group. In short, older adults and people with physical disabilities are still disproportionately served in nursing facility settings. In FY2014, the majority of Medicaid LTSS funds for older adults and people with physical disabilities went to nursing facilities, with just 41 percent of the LTSS funds going toward HCBS[8] (see table 1).

MANAGED LTSS AND MEDICAID HCBS

Another trend of note is that states are increasingly turning toward managed care models to offer LTSS, including HCBS. Currently, 24 states have at least one managed LTSS (MLTSS) plan,[9] and MLTSS spending accounted for $22.5 billion in FY2014, a 55 percent increase from the $14.5 billion in MLTSS expenditures in FY2013.[10,11]

A 2017 report of select MLTSS plans found that states adopted a variety of policies to promote HCBS and reduce costs by delaying or preventing nursing facility placements. Some states, for example, adopted rate-setting methodologies that blend HCBS and nursing facility costs to encourage plans to use HCBS when possible. Some states provided other incentives to their MLTSS plans (such as bonus payments) to increase HCBS use and transition people from nursing facilities to their homes and communities.[12]

Some MLTSS states extended HCBS eligibility to people who have lower care needs but are "at risk" for a nursing facility placement. By offering HCBS to this population, these states and MLTSS plans found that they could save money by delaying and potentially preventing more expensive nursing facility care.[13]

IMPACT OF MEDICAID'S INSTITUTIONAL BIAS ON HCBS

Because Medicaid is a federal–state partnership administered at the state level, where people live affects their ability to access publicly funded HCBS to meet their LTSS needs.

Under current rules, states must offer Medicaid enrollees a certain package of services. These

TABLE 1
HCBS and LTSS Expenditures, FY2014

	HCBS Expenditures	All LTSS Expenditures (HCBS and non-HCBS)	% of LTSS as HCBS
Older adults and people with physical disabilities	$37.9 billion	$93.1 billion	40.7%
All LTSS recipients	$80.6 billion	$151.8 billion	53.1%

mandatory benefits include hospital, physician, and nursing facility services.[14] States also have the discretion to offer additional services, or optional benefits, to their enrollees. HCBS is an optional benefit in the Medicaid program, and states have substantial flexibility to design their own HCBS offerings and set eligibility criteria at their discretion.[15] This split in optional and mandatory benefits for Medicaid LTSS creates a structural bias toward nursing facility care and can limit one's ability to receive services in the setting of one's choice.

Every state has mechanisms through which they can offer HCBS, mainly through a variety of waiver and state plan options. Many of these programs limit enrollment to a certain number of "slots," which results in waiting lists for most HCBS programs. In 2015, more than 640,000 people were on an HCBS waiver waiting list.[16] In comparison, there are no waiting lists for Medicaid-funded nursing facility care, which as a mandatory Medicaid benefit is an entitlement for people who meet their state's eligibility criteria. This creates a bias toward placement in institutions.

This institutional bias is a costly component of Medicaid LTSS. Medicaid pays nearly three times as much for each person served in institutional settings as it does for each person served in the community. This is true across populations, including older people and adults with physical disabilities as well as people with intellectual disabilities.[17]

ADDITIONAL HCBS SPENDING

Programs under the Older Americans Act (OAA) provide home-delivered meals, in-home assistance (such as chore or homemaker), and adult day services for people ages 60 and older. OAA programs target people with the "greatest social or economic need." OAA was reauthorized in 2016, and for FY2016, Congress appropriated $1.2 billion for OAA meals and supportive services, such as family caregiver supports. OAA funds can serve as a safety net for older adults who are not yet eligible for Medicaid LTSS but still need some basic services (such as home-delivered meals). Studies have shown that increasing investment in OAA programs can realize savings for the Medicaid program.[18]

FOCUSING ON THE RETURN ON INVESTMENT: INVESTING IN HCBS IS COST-EFFECTIVE

There is significant evidence that investing in HCBS is cost-effective and can slow the rate of Medicaid spending growth.

- On average, Medicaid dollars can support nearly three older people and adults with disabilities with HCBS for every person in a nursing facility. In 2011, Medicaid spending for HCBS for older adults and adults with physical disabilities receiving services averaged $10,418 per person, compared with $29,855 for each person receiving services in a nursing facility.[19] See table 2 for state-level, per-user average costs for Medicaid HCBS and nursing facility care.
- A meta-analysis of 38 studies including state-specific public studies, evaluations, and fiscal analyses that examined the cost-effectiveness of HCBS programs consistently found that states that expanded HCBS experience a slower rate of Medicaid spending growth.[20] In Ohio, for example, the older adult population grew by 15 percent between 1997 and 2009. The state, however, actually spent approximately $100 million less on Medicaid LTSS for this population because it increased HCBS enrollment and reduced nursing facility placement.[21]
- Statistical modeling found that increasing the portion of Medicaid LTSS dollars toward HCBS by 2 percentage points annually can reduce overall Medicaid LTSS spending by 15 percent over 10 years. Spending cuts to HCBS would actually increase overall Medicaid LTSS spending because individuals would now receive these services in institutional settings.[22]
- The Money Follows the Person Rebalancing Demonstration Program encouraged states to transition Medicaid beneficiaries living in institutional settings back to their homes and communities. Independent evaluations of the program suggest that the cost of serving people who transition decreases once they are in their homes and communities. Among older adults in particular, there is an estimated cost decrease of 16 percent, which is an annual savings of $11,912 per person.[23]

- States that offer MLTSS spend less per beneficiary receiving HCBS than they do for those living in institutions. MLTSS plans in these states typically offer comprehensive health care and LTSS services to their beneficiaries. For all populations, the monthly cost per HCBS beneficiary was $1,949, and the cost for institutional care was $5,745. Among older adults only, the monthly per beneficiary costs were $1,153 and $3,381 for HCBS and nursing facilities in 2015, respectively.[24]
- Tennessee delivers all LTSS for older adults and people with physical disabilities through MLTSS. The state incentivized its managed care organizations to offer HCBS through incentives and benchmarks, and from 2010 to 2013, the portion of these populations receiving HCBS increased from 17 percent to 40 percent.[25]

In short, redirecting more resources to provide Medicaid HCBS instead of nursing facility services is cost-effective compared with nursing facilities. In addition, HCBS are more responsive to the preferences of older adults and people with disabilities to remain in their homes and communities, and have the potential to improve the quality of life of people receiving these critical services.

TABLE 2
Expenditures for Medicaid HCBS and Nursing Facility Care per Person in 2011, by State

Location	HCBS			Nursing Facilities
	Home Health	Personal Care	Aged/Disabled 1915(c) Waivers	
United States	$7,323	$10,954	$12,945	$29,855
Alabama	$4,362	N/A	$11,079	$31,612
Alaska	$1,242	$24,359	$25,020	$96,445
Arizona	$21,561	N/A	N/A	$25,214
Arkansas	$2,610	$5,397	$10,792	$19,606
California	$4,946	$9,527	$10,942	$33,335
Colorado	$13,393	N/A	$9,653	$33,384
Connecticut	$8,334	N/A	$12,221	$34,132
Delaware	$4,483	$0	$11,509	$48,751
District of Columbia	$4,413	$3,287	$25,456	$71,838
Florida	$16,514	$21,904	$9,327	$32,983
Georgia	$623	N/A	$10,563	$29,378
Hawaii	$2,010	N/A	N/A	N/A
Idaho	$2,394	$7,396	$11,394	$20,904
Illinois	$3,867	N/A	$10,478	$21,173
Indiana	$14,055	N/A	$11,984	$28,351
Iowa	$9,148	N/A	$6,472	$29,390
Kansas	$2,579	$16,193	$15,347	$24,017
Kentucky	$2,436	N/A	$7,348	$21,811
Louisiana	$4,048	$10,258	$19,531	$28,999
Maine	$432	$10,243	$17,713	$26,861

Location	HCBS			Nursing Facilities
	Home Health	Personal Care	Aged/Disabled 1915(c) Waivers	
Maryland	$721	$5,744	$22,052	$44,268
Massachusetts	$7,182	$20,226	$7,808	$36,111
Michigan	$823	$4,208	$12,265	$35,099
Minnesota	$10,076	$18,631	$17,382	$30,170
Mississippi	$855	N/A	$8,599	$32,662
Missouri	$1,047	$7,192	$6,311	$24,779
Montana	$1,211	$13,032	$15,420	$34,312
Nebraska	$4,458	$5,505	$11,735	$28,614
Nevada	$41,053	$13,039	$4,160	$38,283
New Hampshire	$1,361	$28,969	$13,353	$29,286
New Jersey	$3,298	$12,266	$15,160	$34,133
New Mexico	$1,022	$16,927	$10,101	N/A
New York	$17,514	$30,197	$2,018	$31,106
North Carolina	$3,548	$6,456	$17,715	$29,339
North Dakota	$8,922	$16,630	$10,688	$37,624
Ohio	$6,404	N/A	$13,940	$29,133
Oklahoma	$2,682	$3,201	$8,803	$25,991
Oregon	$160	$1,199	$11,194	$31,596
Pennsylvania	$8,577	N/A	$19,928	$30,517
Rhode Island	$1,741	$0	N/A	$48,337
South Carolina	$4,455	N/A	$10,461	$30,257
South Dakota	$2,814	$1,538	$9,213	$25,757
Tennessee	$17,463	N/A	N/A	N/A
Texas	$2,886	$7,945	$16,807	$20,605
Utah	$6,179	$3,304	$15,666	$31,627
Vermont	$1,999	$8,864	N/A	$28,102
Virginia	$1,663	N/A	$18,701	$31,186
Washington	$1,272	$13,319	$13,816	$22,393
West Virginia	$1,684	$6,422	$15,884	$44,136
Wisconsin	$3,213	$10,580	$23,090	$25,881
Wyoming	$4,102	N/A	$7,962	$31,002

Source: Ng et al., "Medicaid Home and Community Based Services Programs: 2011 Data Update" (HCBS) and 2013 Medicare and Medicaid Statistical Supplement (Nursing Homes).

Notes: For HCBS, Home Health and Personal Care reflect all populations; Aged/Disabled 1915(c) Waivers reflect older adults 65+ and people with physical disabilities.

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House Appropriations Subcommittee on

Health and Human Services

Feb 27, 2017

Making Michigan a No Wait State
Testimony for the Silver Key Coalition
Christine Vanlandingham, Fund & Product Development Officer Region IV Area Agency on Aging

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Aging and Adult Services Administration (AASA) Budget Testimony:

Aging and Adult Services Administration (AASA) services provide Michigan with a strong return on investment allowing older adults to live in their own home and communities and prevent or delay accessing Medicaid-funded long-term care.

I am Christine Vanlandingham, Fund and Product Development Officer at Region IV Area Agency on Aging serving Berrien, Cass and Van Buren counties. My Silver Key Coalition colleagues have aptly illustrated the need for additional resources to meet the needs of Michigan's older citizens and make Michigan a No-Wait State for Aging Services. I'd like to illustrate the return on that investment.

AASA in-home services are provided efficiently:
In FY 2015 the Aging Network received a $5 million increase in funding for in-home services. This 7.5% increase in funding led to a 10.5% increase in seniors served. The $5 million FY 2015 increase was intended to serve 4,500 of the individuals who were on wait lists during FY 2014. With these funds the Aging Network increased FY 2015 serving levels by 6,985 individuals; serving *55% more individuals than expected.*

AASA services help fill gaps families cannot manage:
Studies suggest that 80% of all care received by disabled older adults is provided by unpaid family and informal caregivers. However, many caregivers are not physically able or have other responsibilities that prevent them from being able to provide all the assistance needed.

The clear majority of AASA service recipients have lower incomes and cannot afford to privately pay for needed care. AASA services provide a very limited amount of assistance that helps prevent the caregiver burnout that often leads to nursing home placement.

No one knows that better than Terry Rose* of Watervliet in Southwest Michigan.

Terry, a 62-year-old former post office worker, has multiple sclerosis and needs nursing home level of care. Terry's daughter provides care for Terry in the evening and on weekends, but

needs to work during the day. Terry's sister helps with shopping and transportation to the doctor and other appointments but is not able to provide the hands-on assistance Terry needs.

AASA funded services fill the gap for Terry and her family. Ten hours of personal care a week provide Terry with the support she needs to continue to live in her own home. An aid comes each weekday morning to help Terry get up, dressed, be sure she has something to eat and is set for the day. This combined with the supports provided by her family is enough allow Terry to continue living independently.

Terry's income is just slightly above the MI Choice Waiver allowable limits. Without AASA funded services, Terry says she would have no other option than to move to a nursing home and utilize Medicaid through a spend-down.

The cost of Terry's AASA care plan is $29 a day as compared to $175/day for Medicaid funded nursing home care. Recognizing the value of the care she receives and the positive impact on her life, Terry contributes $240 month toward the cost of her care. This reduces the state's cost for Terry's care to just $7,705 per year.

Like Terry, 79% of seniors receiving AASA funded-services in Region IV contribute toward the cost of their care – increasing the aging network's capacity to serve other seniors.

AASA services are cost effective:
In addition to providing seniors like Terry with on-going services through AASA to help them remain at home, the aging network extends the reach of AASA services and reduces the wait list by providing seniors with Care Management services. Seniors receive an in-home consultation to assess needs and are connected to existing community resources to meet those needs. 51% of AASA clients served in Region IV in 2016 were able to be connected to other community resources to meet their needs without tapping into AASA-funded ongoing services.

In conclusion, **AASA services are efficient, effective and fill critical gaps for Michigan's older adults and their caregivers.** I respectfully ask that you support the Governor's recommendation of $3.6M additional investment in Aging and Adult Services Agency to continue progress in making Michigan a No-Wait State for Senior Services.

Thank you.

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

*Client story shared with permission.

My name is Kelly Arndt, I am the director of the East Lansing Prime Time Senior Center, today I am speaking as the President of the Michigan Association of Senior Centers.

Senior Centers – we all have a concept of what that is . . . a gathering place for our aging population, a place for wellness, services which allow our residents to age in place . . . AND the single most point of entry for services, information, and engagement for local retirees.

Relative to other supportive-service resources, senior centers are the single largest in terms of people served, over ten million nationwide, yet senior centers are at the bottom of the list – seventh, in terms of funding according to the National Council on Aging.

There are approximately 300 senior centers across the great state of Michigan – and up until 2005, the state included between 1.0 to 2.5 million dollars toward funding local senior centers thru **"senior center staffing funds"**. When the state was hit hard several years ago, this funding was eliminated. The impact of losing this support was felt throughout smaller communities with a one-person staff person running the center. We rely on seniors as an integral part of our communities and they rely on their local community senior center.

Eliminating funding to local senior centers is not a wise strategy as Michigan ranks among the top 13 states in the nation regarding residents over the age of 65.

The directors of the Michigan Association of Senior Centers realize the economy is recovering and we are now respectively requesting our legislators reinstate these funds in the amount of 2. million dollars. Senior Centers are located within the communities where seniors live and thus have direct access to services, social engagement, recreation, life-long-learning opportunities, vocational training, and opportunities to give back to their communities through volunteer programs facilitated at your local senior center. All of these dimensions are required for healthy aging, and that's what we want to keep our retirees healthy and active.

Attached is a list of senior center directors across Michigan, and Members of the Michigan Association of Senior Centers – I know all of your communities are represented here. Please call the directors in your area – we all have our stories and we'd love to share what makes us a good investment.

Name	Address	City	ST	Zip	E-mail Address	Phone No	Contact Name
AAA1-B	29100 Northwestern-Ste 400	Southfield	MI	48034	tabbatemarzolf@aaa1b.com	248-357-2255	Tina Abbate Marzolf
AAA-Region 9	2375 Gordon Rd	Alpena	MI	49707	sauerl@nemcsa.org	989-356-3474	Laurie Sauer
AgeWell Services of West MI	560 Seminole Rd	Muskegon	MI	49444	sharon@agewellservices.org	231-733-8630	Sharon TerHaar
Alpena Area Senior Center	501 River St	Alpena	MI	49707	smoe@alpenaseniorcenter.com	989-356-3585	Sarah Moe
Auburn Hills Senior Center	1827 N Squirrel	Auburn Hills	MI	####	kadcock@auburnhuills.org	248-370-9353	Karen Adcock
Barry COA	320 W Woodlawn Ave	Hastings	MI	49058	tpennington@barrycounty.org	269-948-4856	Tammy Pennington
Bedford Senior Center	1653 Samaria	Temperance	MI	48182	dianne.carroll@mybedford.us	734-856-3330	Dianne Carroll
Benzie COA	10542 Main St	Honor	MI	49640	bouramrad@benziecoa.org	231-525-0601	Douglas Durand
Big Rapids city of	226 N Michigan Ave	Big Rapids	MI	49307	hbowman@cityof br.org	231-592-4038	Heather Bowman
Bloomfield Twp Senior Center	4315 Andover Rd	Bloomfield Tw	MI	48302	ctvaroha@bloomfieldtwp.org	248-723-3500	Christine Tvaroha
Buchanan Area Senior Center	810 Rynearson St	Buchanan	MI	49107	bascdir@comcast.net	269-695-7119	Monroe Lemay
Cadillac Senior Center	601 Chestnut St	Cadillac	MI	49601	cadillacseniorcenter@hotmail	231-779-9420	Diane Patterson
Caledonia Resource Center	9749 Duncan Lake Ave	Caledonia	MI	49316	stehawers@calschools.org	616-891-8117	Sherry Stehawer
Canton Leisure Services	46000 Summit Parkway	Canton	MI	48188	stephanie.diago@canton-mi.org	734-394-5481	Susan Doughty
Carman Ainsowrth Senior Ctr	2071 S Graham Rd	Flint	MI	48532	cascflintwp@yahoo.com	810-732-6290	Pam Luna
Cass County COA	PO Box 5	Cassopolis	MI	49047	bobc@casscoa.org	269-445-8110	Bob Cochrane
Charlevoix County COA	218 W Garfield	Charlevoix	MI	49720	gillespies@charlevoixcounty.org	231-237-0103	shirley Gillespie
Cheboygon COA	1531 Sand Rd	Cheboygan	MI	49721	gtinker@3coa.com	231-427-7234	Gail Tinker
Chelsea Senior Center	512 Washington St	Chelsea	MI	48118	tpifer@chelseaseniors.org	734-475-9242	Trinh Pifer
Chesterfield Senior Center	47275 Sugarbush Rd	Chesterfield	MI	48047	crose@chesterfiledtwp.org	586-949-0400	Carol Rose
Civic Park Senior Center	15218 Farmington Rd	Livonia	MI	48154	kpeters@ci.livonia.mi.us	734-466-2556	Karl Peters
Clinton Twp Senior Center	40730 Romeo Plank Rd	Clinton Twp	MI	48038	mmakowski@clintontownship-MI.	586-723-8131	Matthew Makowski
Clio Area Senior Center	2136 W Vienna Rd	Clio	MI	48420	clioseniorcenter@gmail.com	810-687-7260	Theresa Burton
Crawford COA	200 W Michigan Ave	Grayling	MI	49738	director@crawfordcor.org	989-348-7123	Alice Snyder
Davison/Richfield Senior Center	10135 Lapeer Rd	Davison	MI	48423	kathy@davison-sc.org	810-658-1566	Kathy Davis
Dearborn Heights Senior Center	1801 N Beech Daly	Dearborn Heig	MI	48127	kconstan@ci.dearborn-heights.mi.	313-791-3600	Kim Constan
Dearborn Senior Services	15801 Michigan Ave	Dearborn Heig	MI	48126	tgraves@ci.dearborn.mi.us	313-943-2412	Teresa Graves
Dublin Comm Senior Ctr	685 Union Lake Rd	White Lake	MI	48386	kgordinear@whitelaketwp.com	248-698-2394	Kathy Gordinear
East Lansing Prime Time Sr Prgm	819 Abbot Rd	East Lansing	MI	48823	karndt@ci.east-lansing.mi.us	517-337-1173	Kelly Arndt
Eastside Senior Center	3065 N Genesee Rd	Flint	MI	48506	debra452@gmail.com	810-250-5000	Debra Gilbert
Eaton Area Senior Center	804 S Cochran Ave	Charlotte	MI	48813	eaton.area.senior.center@gmail.c	517-541-2934	Cindy Miller
Ecumenical Senior Center	702 N Burdick St	Kalamazoo	MI	49007	director@ecumenicalsc.com	269-381-9750	Denise Washington
Edna Burton Senior Center	PO Box 929 345 Ball St	Octonville	MI	48462	abeach@brandontownship.us	248-627-6447	Anette Beach
Farmington Hills Senior C	28600 W Eleven Mile Rd	Farmington Hills	MI	48336	mkoet@fhgov.com	248-473-1821	Marsha Koet
Flushing Area Senior Center	106 Elm ST	Flushing	MI	48433	cendirector@flushingseniorcenter	810-659-4735	Gary Dearing
Forks Senior Center	101 N Albion	Albion	MI	49224	executivedirector@forksseniorcen	517-629-3842	Thomas Hunsdorfer
Four Pointes Center	1051 S Beacon Blvd	Grand Haven	MI	49417	fourpointes@fourpointes.org	616-842-9210	Briget Hassig
frenchtown Senior Center	2786 Vivian Rd	Monroe	MI	48162	bmazor@frenchtownsenior.com	734-243-6210	Barbara Mazor
Friendship Centers of Emmet County	1322 Anderson Rd	Petoskey	MI	49770	sue@emmetcoa.org	231-347-3211	Susan Engel
Friendship Center of Harbor Springs	305 E Main Street	Harbor Springs	MI	49740	jsutkay@hotmail.com	231-526-0601	Jennifer Sutkay
Georgetown Seniors	7096 8th Ave	Jenison	MI	49428	haverdinkp@gmail.com	616-457-1170	Pam Haverdink
Gladwin COA	215 S Antler St	Gladwin	MI	48624	lauren@gladwinchc.net	989-426-5721	Lauren Essenmacher
Grand Traverse County Senior Ctr	801 E Front St	Traverse City	MI	49686	lwells@grandtraverse.org	231-922-4688	Lori Wells
Gratiot Community Senior Center	1329 Michigan Ave PO Box20	St. Louis	MI	48880	no email	989-681-4341	Jamie Bolsby
Great Niles Senior Center	1109 Bell Rd	Niles	MI	49120	nilesseniorcenter@sbcglobal.net	269-683-9380	Kathryn Ender

Hamburg Senior Center	PO Box 157 10407 Merrill	Hamburg	MI	48139	choskins@hamburg.mi.us	810-222-1140	Christine Hoskins
Hannan House	4750 Woodward	Detroit	MI	48201	pbaldwin@hannan.org	313-833-1300	Pat Baldwin
Hartland Senior Center	9525 Highland Rd	Howell	MI	48843	kimladd@hartlandschools.us	810-626-2135	Kim Ladd
Heart of Senior Citizen Serv Kraphol	5473 Bicentenial Dr	Mt. Morris	MI	48458	karen.reid@heartscs.org	810-785-2270	Karen Reid
Highland Activity Center	209 N John St	Highland	MI	48357	hbey.haac@comcast.net	248-887-1707	Heidi Bey
Hillsdale County of Senior Services	320 W Bacon St	Hillsdale	MI	49242	tvear@hillsdaleseniors.org	517-437-2422	Teresa Vear
Independence Twp Senior Center	6483 Waldon Center Dr	Clarkston	MI	48347	kadcock@auburnhuills.org	248-625-8231	Karen Adcock
Isabella COA	2200 S Lincoln Rd	Mt Pleasant	MI	48858	marcyhosking@isbellacounty.org	989-772-0748	Marcy Hosking
Kalkaska County COA	PO Box 28	Kalkaska	MI	49646	gavrowell@kalkaskacoa.com	231-258-5030	Julie Rzepecki
Leelanau County Senior Services	8527 E Gvrmnt Center Dr S-1(	Suttons Bay	MI	49682	amissias@co.leelanau.mi.us	231-256-8121	April Missias
Lenawee COA (affilate)	1040 S Winter St Ste 3003	Adrian	MI	49221	crebottaro@lenaweeseniors.org	517-264-5280	Cari Rebottaro
Loose Senior Ctr	707 N Bridge St	Linden	MI	48451	carl@loosecenter.org	810-735-9406	Carl Gabrielson
Ludington Area Senior Center	308 S Rowe St	Ludington	MI	49431	vcollins@ci.ludington.mi.us	231-845-6841	Vickie Collins
Manistee COA	457 River St	Manistee	MI	49660	showardmanistee@hotmail.com	231-723-6477	Sarah Howard
Manistee County COA	457 River St	Manistee	MI	49660	s.howardmanistee@hotmail.com	231-72-6477	Sarah Howard
Mecosta County COA	12954 80th Ave	Stanwood	MI	49346	beth.whyte@mccoasc-org	231-972-2884	Cynthia Mallory
Meridian Senior Center	4000 Okemos Rd	Okemos	MI	48864	cherie.wisdom@okemosK12.net	517-706-5045	Cherie Wisdom
Milford Senior Center	1050 Atlantic	Milford	MI	48381	scactivities@milfordtownship.com	248-685-9008	Debbie Shew
Missaukee County COA	PO Box 217	Lake City	MI	49651	coadirector@missaukee.org	231-839-7839	Pam Blevins
Monroe Center for Aging	15275 South Dixie Hwy	Monroe	MI	48161	sandie@monroectr.org	734-241-0404	Sandie Pierce
Montcalm County COA	613 N State St PO Box212	Stanton	MI	4888	limplom@co.montcalm.mi.us	989-831-7476	Lauri Czarnecki
Negaunee Senior Center	410 Jackson St	Negaunee	MI	49866	seniorcenter@cityofnegaunee.con	906-475-6266	Kristy Bassko-Malmsten
Newaygo County COA	93 S Gibbs, PO Box 885	White cloud	MI	49349	josephf@co.newaygo.mi.us	231-689-2100	Joseph Fox
Next-Your Place to stay Active & Connected	2121 Midvale St	Birmingham	MI	48009	cbraun@birmingham.K12.mi.us	248-203-5270	Christine Braun
North Berrien Senior Center	PO Box 730 6648 Ryno Rd	Coloma	MI	49038	nbsc2@i2k.com	269-468-3366	Debbie Ziemke
Northview Senior Center	4365 Hunsberger NE	Grand Rapids	MI	49525	cfriedt@nvps.net	616-365-6150	Christine Friedt
Novi Senior Center	45175 Ten Mile	Novi	MI	5E+05	kkapchonick@cityofnovi.org	248-347-0415	Karen Kapchonick
Oceana County Council on Aging	621 E Main St	Hart	MI	49437	premer@oceanacoa.com	231-873-4461	Kathleen Premer
Ogenaw COA	1528 S M-33	West Branch	MI	48661	director@ogemawcoa.org	989-345-3010	Carol Gillman
Older Persons Commission	650 Letica Dr	Rochester	MI	48307	renee_cortright@opcseniorcenter.	248-608-0255	Renee Cortright
Osceola COA	432 W 7th St	Evart	MI	49631	sschryer@osceolacoa.org	231-734-6002	Scott Schryer
Otsego COA	120 Grandview Blvd	Gaylord	MI	49735	dona@occoaoiline.org	989-732-1122	Dona Wishart
Pittsfield Twp Senior Ctr	701 W Ellsworth Rd	Ann Arbor	MI	48108	presleyc@pittsfield-mi.gov	734-822-2117	Christy Mattson
Portage Senior Center	320 Library Lane	Portage	MI	49002	phillipk@portagemi.gov	269-329-4553	Kimberly Phillips
Putnam Township Senior Center	350 Mower St	Pinckney	MI	48169	seniordirector@putnamtwp.us	734-878-1810	Beverly Smith
River ValleySenior Center	PO Box 275	Harbert	MI	49115	rusc@comcast.net	269-469-4556	Tim Hawkins
Romeo/Washington Senior Center	361 Morton St	Romeo	MI	48065	hoppb@rwbpr.org	586-752-6543	Becky Hopp
Royal Oak Senior Center	350 Marais	Royal Oak	MI	48073	paigeg@romi.gov	248-246-3900	Paige Gemborski
Saline Area Senior Ctr	7190 N Maple	Saline	MI	48176	cheminr@salineschools.org	734-429-9274	Rina Chemin
Senior Neighbors, Inc	678 Front Ave NW Ste 205	Grand Rapids	MI	49504	toosterbaan@seniorneighbors.org	616-233-0279	Tom Oosterbaan
Senior Svc of Van Buren Cnty	1635 76th St	South Haven	MI	49090	jcarver@ss-vbc.org	269-637-3607	Jennifer Carver
September Days Senior Center	46425 Tyler Rd	Belleville	MI	48111	ljordan@vanburen.mi.org	734-699-8918	Lynette Jordan
Services for Older Citizens	158 Ridge Rd	Grosse Pte Fa	MI	48236	ddietoresocservices.org	313-882-7600	David Dietes
Shelby Twp Senior Center	51670 Van Dyke Ave	Shelby Twp	MI	48316	seniors@shelbytwp.org	586-739-7540	Amy Drake
Shiawassee COA	300 N Washington St	Owosso	MI	48867	cmayhew@shiawasseecoa.org	989-723-8875	Rebecca House
St Clair COA	600 Grand River	Port Huron	MI	48060	scrawford@thecouncilonaging.org	810-987-8811	Scott Crawford

St Patrick Senior Center	58 Parsons St	Detroit	MI	48201	src.betts@stpatsrctr.org	313-833-7080	Satrice Coleman-Betts
St. Joseph County COA	103 S Douglas	Three Rivers	MI	49091	molivares@sjccoa.com	269-429-7768	Lynn Coursey
St. Joseph-Lincoln Senior Ctr	3271 Lincoln Ave	St Joseph	MI	49085	directorsllsc@comcast.net	269-429-7768	Shirley Reichert
Swartz Creek Senior Center	8095 Civic Dr	Swartz Creek	MI	48473	msoper@myscasc.org	810-635-4122	Melinda Soper
The Commons of Evergreen	480 State St	Holland	MI	49423	millarda@evergreencommons.org	616-396-7100	Amy Millard
Wawatam Area Senior Center	PO Box 615	Mackinaw City	MI	49701	dianefry@sbcglobal.net	231-436-5323	Diane Fry
West Bloomfield Twp Senior Center	4315 Andover Rd	Bloomfield Hill:	MI	48302	ctvaroha@bloomfieldtwp.org	248-723-3500	Cathy Tvaroha
Westland Friendship Center	1119 N Newburgh Rd	Westland	MI	48185	bmarcum@cityofwestland.com	734-467-3259	Barbara Marcum
Wixom Senior Center	49045 Pontiac Trail	Wixom	MI	48393	kmartin@wixomgov.org	248-624-0870	Kathy Martin
Wyoming Senior Center	2380 DeHoop Ave Sw	Wyoming	MI	49509	mywsc@wyomingmi.gov	616-530-3190	Molly Remenap

Michigan Alliance
for
Lead Safe Homes

February 27, 2017

Members
House Health and Human Services - Appropriations Subcommittee

On behalf of the Safe Homes/Safe Kids: Michigan Alliance for Lead Safe Homes (MIALSH) coalition we thank you for your time and attention. Our coalition has members throughout the state and includes health departments, lead-abatement contractors, small business owners, parents, homeowners, landlords, and other service providers. MIALSH works to end lead poisoning in the state and is before you today to thank you for your past funding support and in support The Governor's FY 2017-18 Budget recommendation for lead poisoning prevention and support services.

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

MIALSH supports Governor Snyder's FY 2017-18 budget recommendation to:

- Maintain general funding (GF) for lead abatement at $1.75 million. These monies have been used to leverage federal funds, sustain the department between federal grant lapses and provide assistance to lead impacted families when no other monies exist to help.
- Include $2 million in one-time monies to support implementation of the Governor's Lead Poisoning Elimination Board's recommendations issued in November of 2016. There are over 100 recommendations to get to work on and these dollars will help kick start implementation.
- Continue funding support for public health surveillance, nurse case management and outreach to both prevent lead poisoning and to help impacted families thrive.
- Provide State match to leverage federal Medicaid dollars coming to Michigan in a first in the nation program, to provide on the ground support to families.

Thank you for your consideration and please do not hesitate to contact me with any questions you may have.

Sincerely,

Tina Reynolds
Health Policy Director
Michigan Environmental Council

602 W. Ionia Street, Lansing, MI 48933 | 517-487-9539 | www.mileadsafehomes.org

Michigan Alliance for Lead safe Homes (MIALSH)
2017 Policy Priorities

Lead Testing

- **Universal lead testing** for all Michigan kids at ages 1 & 2.

Landlord/Sales

- Switch the **burden of proof** to the landlord to demonstrate his unit has been made lead safe after the unit poisoned a child.
- Require a one time **lead inspection** risk assessment (LIRA) of an owner occupied or rental property before the transfer or leasing of a pre-1978 home.
- Stop **retaliatory evictions** by putting a freeze on the eviction process when lead hazards have been found on the property or a child has been identified lead poisoned in the unit.
- **Bring Renovate, Repair and Paint (RRP) authorization to Michigan** from the federal government so Michigan can ensure properties are maintained and repaired in a lead safe way proactively protecting residents.
- Require local units of government to **verify a RRP certification** before they issue a permit on a job subject to the RRP requirements.

Communication and Education

- Make **proactive** lead poisoning prevention the clear and guiding state policy.
- Ensure that pre-school, childcare providers and state licensing staff, receive **proper training** to evaluate lead inspection reports and understand state requirements to protect our youngest residents under their care.

Sustainability

- Explore the feasibility of making lead poisoning a "**local public health service**" so there would be fairness and consistency in lead response statewide.
- Continue to advocate for state general fund **(GF) dollars** for the lead program to ensure state priorities and federal match requirements can be met.
- Establish a permanent **Lead Commission** in statute, to coordinate all efforts to eliminate lead poisoning in the state.
- Engage in policy discussion on these issues (above) and others, as they relate to ending lead poisoning in Michigan.

Safe Homes/Safe Kids

Michigan Alliance for Lead Safe Homes

Lead poisoning is still a problem in Michigan

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

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

Thousands of children learn less due to lead poisoning

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

Coalition forms to end lead poisoning in Michigan

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

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

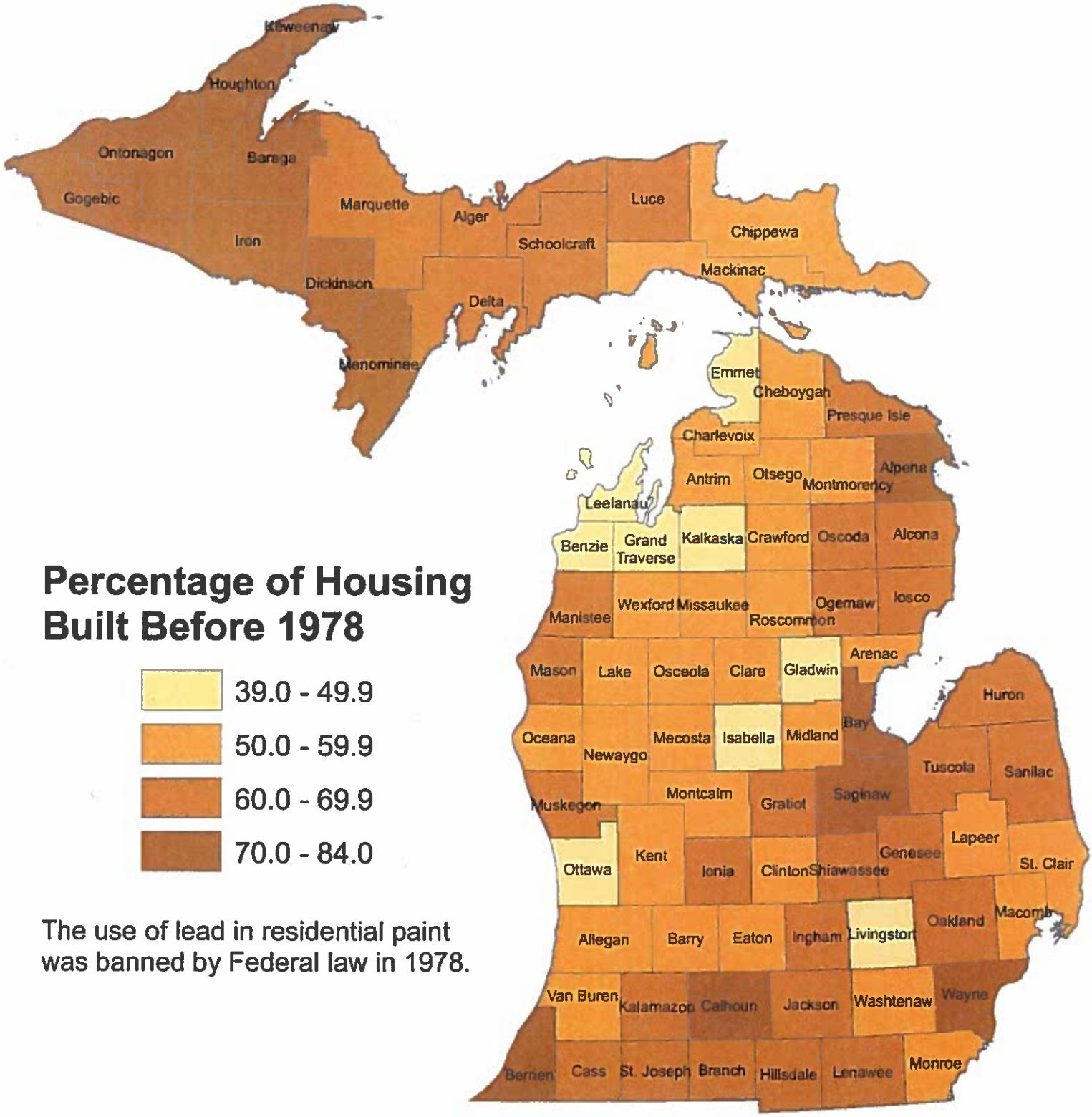
Michigan Alliance for Lead Safe Homes

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

www.mileadsafehomes.org

printed on 100% post-consumer recycled paper

Percentage of Housing Built Before 1978



Percentage of Housing Built Before 1978

- 39.0 - 49.9
- 50.0 - 59.9
- 60.0 - 69.9
- 70.0 - 84.0

The use of lead in residential paint was banned by Federal law in 1978.

Source: US Census Bureau, Census 2010

March 1, 2013

Childhood Lead Exposure

Amid growing evidence that even low levels of lead exposure can cause long-term damage to children's development, the American Academy of Pediatrics urges stronger federal action to eliminate exposure.

None

Level of lead exposure considered safe for children

$50 billion

Annual cost of childhood lead exposure in the United States

$17 to $221

Money saved for every $1 invested to reduce lead hazards in U.S. housing

Common sources of lead in the home:

- Dust
- Soil
- Water in lead pipes
- Toys
- Nutritional supplements
- Dishware
- Fishing sinkers
- Bullets
- Residue from parent occupations
- Paint/hobby materials

535,000

Estimated number of U.S. preschool children with blood lead levels high enough to call for medical management (more than 5 ug/dl)

37 million

Estimated number of housing units in United States that contain lead-based paint

U.S. housing built from 1940-1959: **39 percent**

U.S. housing built from 1960-1977: **11 percent**

U.S. housing built from 1978-1998: **3 percent**

23 million

Estimated total loss of IQ points among U.S. children today from lead toxicity

1 in 5

Attention Deficit Hyperactivity Disorder cases attributed to lead exposure

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

House Testimony
Monday, February 27, 2017

Representative Canfield and subcommittee members: I am Linda Smith-Wheelock, Chief Operating Officer, with the National Kidney Foundation of Michigan (NKFM).

We're here to update you on diabetes and kidney disease in Michigan.

- 10 % of adults in Michigan have diabetes AND 35% have prediabetes that will result in a diagnosis of type 2 diabetes – **unless steps are taken.**
- Obesity, diabetes and hypertension continue to be the leading causes of kidney failure.
- Diabetes and kidney disease cost Michigan $9.6 Billion annually in Michigan.

The good news is that we have programs that:

- Address childhood obesity by teaching children to make healthy lifestyle changes.
- Teach adults to prevent type 2 diabetes
- Teach people *with diabetes* to better manage their health avoiding the complications of blindness, amputation, heart attack, stroke, kidney disease and failure.
- Provide adults with proven physical activity programs that increase balance, strength and reduce depression.

Thank you for your support that has allowed us to improve health in MI. I will highlight a few of our programs referenced in the attached handout.

- Good News: Kidney failure incidence, due to diabetes, is declining at a higher rate in Michigan. This is occurring due to the investment that the Michigan Legislature has made to diabetes and kidney disease within the Health and Wellness Line for Diabetes and Kidney Disease.
- For children:
    - We provide a number of early childhood programs– the childhood obesity rate has trended from 13.9% (in 2008) to 13.4% (in 2014) – this has been credited by MDHHS to the NAPSACC (Nutrition and Physical Activity Self-Assessment for Child Care) program... the NKFM provides this program with state funding but has also received additional funding from other sources as part of our private public partnership.
    - We also provide Regie's Rainbow Adventure, that educates kids 3-5 years old about eating fruits and vegetables, serving 180 preschools. This program has received many accolades and is one of the tools day care centers can use to improve their star rating within Michigan's Quality Rating and Improvement System.
- For adults:
    - We have many evidence-based programs but we would like to highlight the Diabetes Prevention Program (data provided in the handout). The DPP is a lifestyle change program recognized by the CDC to prevent or delay type 2 diabetes. Over 1,400 people in MI have taken this NKFM program with an average of 6.1% weight loss. Over 11,000 pounds were lost and 188 people prevented diabetes by taking this class. The NKFM was the first in MI to be certified by the CDC Recognition Program and has served 46% of the people who have taken the program in the state of Michigan. Cost savings are $2,650,000 annually. This will increase as service expands.
- Another note of interest: NKFM is in the top 1% of all charities per Charity Navigator. In January 2017, the NKFM was in the top 5 of organizations in the country in the area of Diseases, Disorders and Disciplines. The legislature has made an excellent investment.

We support the governor's budget that provides stable funding for our diabetes and kidney disease programs. We are funded from the Health and Wellness line. Please also consider increased funding. Questions? Contact: lsmith-wheelock@nkfm.org.

Chronic Kidney Disease

Chronic kidney disease (CKD) is a condition in which your kidneys are ***damaged and cannot filter blood*** as well as healthy kidneys. Because of this, wastes from the blood remain in the body and may cause other health problems.

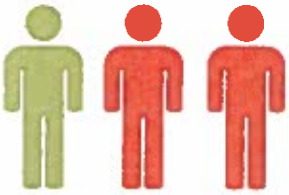
Facts

>900,000

More than 900,000 Michigan adults
have chronic kidney disease, and most don't know it.

Diabetes and high blood pressure cause more than
70% of all kidney failure cases in Michigan.

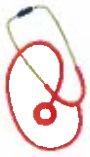
Over 70% of kidney failure cases caused by *diabetes and/or high blood pressure* could have been prevented or delayed.



1 in 3 American adults is at high risk for developing kidney disease. The risk increases to *1 in 2 over the course of a lifetime.*

People with an increased risk for chronic kidney disease include:

Individuals with diabetes



Individuals with high blood pressure

African Americans *Hispanics*
American Indians Asians
Pacific Islanders **Arab Americans**

Older individuals

Individuals with a family history of kidney failure

ABOUT YOUR KIDNEY FUNCTION

*By using a simple blood test, your doctor can determine your **glomerular filtration rate (GFR)**. Your GFR tells your doctor about your level of kidney function.*

Early detection and treatment can *slow or prevent* the progression of kidney disease.

By making healthy lifestyle choices and taking prescribed medicine, you can slow the progression of CKD.

Once your kidneys fail, you either have to have regular ***dialysis***, in which a machine filters your blood like healthy kidneys would, or have a ***kidney transplant***.

There are more than ***2,800 people waiting*** for a lifesaving kidney transplant in Michigan.

Every day 12 people die waiting for a kidney.

Sources: National Kidney Foundation of Michigan, Centers for Disease Control and Prevention's 2014 National Chronic Kidney Disease Fact Sheet, Gift of Life Michigan.

National Kidney Foundation® of Michigan
www.nkfm.org

PREDIABETES

Prediabetes is a condition where people have higher than normal blood glucose levels, but not yet high enough to be diagnosed with diabetes. People with prediabetes are at high risk for developing type 2 diabetes.

1 in 3
people have prediabetes,
and most don't know it

Could it be YOU?

Risk Factors

You could be at risk for developing type 2 diabetes if you...

- are overweight/obese
- are over the age of 45
- aren't regularly physically active
- have a family history of type 2 diabetes
- have African American, Hispanic/Latino, American Indian, Pacific Islander, or another racial/ethnic minority background
- were diagnosed with gestational diabetes during pregnancy

> 2.6 million

Over 2.6 million adults in Michigan have prediabetes, and most don't know it

Your doctor can test your blood to find out if your blood glucose levels are higher than normal

Type 2 Diabetes Prevention is Possible

Adapt a healthy, balanced diet

Lose 5-7% of your body weight

Be physically active for 150 minutes per week

DIABETES PREVENTION PROGRAM

Adults across Michigan have made the necessary lifestyle changes to prevent type 2 diabetes by joining our Diabetes Prevention Program.

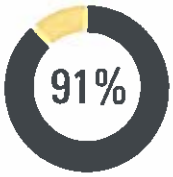
>1,250
participants since 2012

>11,000
participant pounds lost

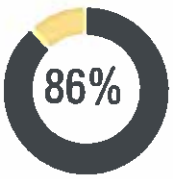
6.1%
average participant weight loss

183
average minutes of physical activity per week

After completing the first 16 weeks of the program, actively engaged participants said they were confident to make lifestyle changes to meet their weight goals.



91% of participants are confident in their ability to eat healthier



86% of participants are confident in their ability to be active 150 minutes per week

Diabetes Prevention Center
A DIVISION OF THE NATIONAL KIDNEY FOUNDATION OF MICHIGAN

Learn more at www.nkfm.org/dpp

Sources: National Kidney Foundation of Michigan, Centers for Disease Control and Prevention
Updated: January 2017

ENHANCE FITNESS®

Do you want to become fit and have fun at the same time? Start with Enhance Fitness, the exercise class with **you** in mind!

25+ classes

offered across Michigan through the National Kidney Foundation of Michigan

What is Enhance Fitness?

Enhance Fitness is an evidence-based, **physical activity** program that has been tested and studied to show its effectiveness for older adults to improve functional fitness and **well-being.**

The U.S. Department of Health and Human Services recommends **2.5 hours** of moderate-intensity exercise **weekly** for adults.

Regular exercise has been found to **decrease the risk** of developing chronic diseases, such as **type 2 diabetes, high blood pressure, and heart disease.**

Over **7,000 people** have participated in NKFM Enhance Fitness classes between **2008 and 2016.**

Seniors can **improve their health** and maintain their independence.

Of participants:

64% have maintained or improved in measures of upper body strength and endurance

72% have maintained or improved in measures of lower body strength and endurance

94% report a positive change in physical ability after participating in EF classes,

with **38%** of that group reporting "great improvement"

65% have maintained or improved in measures of balance

Participant Testimonials

"When you get older, you need someone to help motivate you. Having people there to coach us and assist us to get started made it fun and easy to exercise."
- Dorothy, Ecorse Senior Center Participant

"I am thankful for the trainer of the class and the NKFM's Enhance Fitness for helping me stay mobile." - Mollie, Turner Senior Resource Center Participant, who recently turned 100 years old!

What you can expect

Enhance Fitness classes are held 2-3 times a week.

They are taught by certified fitness instructors who are trained in the Enhance Fitness procedures and exercise program.

Participants are a diverse group of women and men, usually between 50-95 years old. Anyone is welcome!

Classes range from 10-60+ people in a class.

Classes focus on balance, strength, endurance, and flexibility exercises and are adjustable to all levels of fitness.

* EF is partially funded through the generosity of the following funders: Area Agency on Aging 1-B, The Senior Alliance, Region 7 Area Agency on Aging, Health Alliance Plan, & Michigan Department of Health and Human Services.

National Kidney Foundation® of Michigan

nkfm.org/enhance-fitness

Sources: The National Kidney Foundation of Michigan, Project Enhance, & Sound Generations. Updated: January 2017

NATIONAL KIDNEY FOUNDATION OF MICHIGAN 2015 EVALUATION FINDINGS

REGIE'S RAINBOW ADVENTURE®

93% of children in the U.S. **DO NOT** eat the recommended daily serving of vegetables.

48% of Detroit children are overweight or obese.

60% of children in the U.S **DO NOT** eat the recommended daily serving of fruit.

NKFM IS WORKING TO DECREASE THE NUMBER OF KIDS WHO DON'T MEET BASIC NUTRITION OR HEALTH GUIDELINES

2,181 children from **27** head start centers participate in a seven-week nutrition and physical activity education program.

Each session includes reading a book and trying a new fruit or vegetable.

HIGH ENGAGEMENT IN THE CLASSROOM

A teacher talked about a student who would draw Regie with Spiderman every day. When asked why he drew Regie with Spiderman, the student said,

"Because Regie is going to make sure Spiderman eats right because Spiderman needs his energy to fight the bad guys!"

"When broccoli is served at lunch, the children say, 'Broccoli, like Regie's Rainbow! I love broccoli!' They are much better about eating many vegetables now."
- Preschool Teacher

PROFESSIONAL DEVELOPMENT FOR TEACHERS

(RRA) staff provided materials and trained **131** teachers who implemented the program in their classrooms during the 2014-2015 school year.

WHAT ARE THE OUTCOMES FOR CHILDREN AFTER COMPLETING RRA?

82% of parents reported an **increase** in their children's fruit consumption.

Parents reported a **significant increase** in the number of hours their children were physically active.

Parents reported a **significant decrease** in children's TV time and time playing video games.

75% of parents reported an **increase** in their children's veggie consumption.

National Kidney Foundation® of Michigan

BIB TO BACKPACK

LIVE UNITED United Way

National Kidney Foundation of Michigan's Evidence Based Programs

National Diabetes Prevention Program (NDPP)	Personal Action Toward Health (PATH) and Diabetes PATH (for individuals with diabetes)
The NDPP, is a proven lifestyle change program for people with prediabetes and others at high risk, including those with obesity. Trained lifestyle coaches lead year-long groups to encourage proven lifestyle changes – losing 5-7% of weight and increasing physical activity to 150 minutes per week. Participants will reduce their risk for type 2 diabetes by 58%. For individuals aged 60 or older the risk reduction is 71%. **Treating 4,000 high risk adults:** • Prevents 600 cases of type 2 diabetes.[1] • Prevents 6,480 missed work days.[2] • Avoids the need for medication for high blood pressure and high cholesterol in 440 people.[3] • **Avoids $3,656,000 in health care costs.** [4] • Adds the equivalent of 20 years of health for every 100 served.[5] • Saves $2,650 per person (CMS,2016)	The PATH program is the Stanford Chronic Disease Self Management Program which has undergone rigorous evaluation. Results of a randomized study involving more than 1,000 people with chronic disease demonstrated that participants "who took the program, compared to those who did not, had significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatients visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:4." (http://patienteducation.stanford.edu/programs/cdsmp.html) Using 2007 MI hospitalization cost[6] and 2010 health care dollars for emergency room visits[7], **cost savings per participant[8] are between $2,010 and 2,141 per person over a 2-year period** after subtracting for the cost to run the program[9].

Enhance Fitness
Enhance Fitness implemented in vulnerable communities provides a safe, low cost, and effective exercise program 3x a week. • 14% improvement in physical functional performance on the CS-PFP10 (The Continuous Scale Physical Functional Performance) ; • 26% improvement in balance and coordination; • 18% improvement in endurance; • 33% improvement in general health on the SF-36 (Short Form, Health Survey); • 40% improvement in mental health (reduction in symptoms of depression); and • 89% improvement in social functioning Using physical inactivity calculator[10] and supplying county level data[11] [12], estimated cost savings for Michigan residents who go from being inactive to physically active was $755 per person.

[1] DPP Research Group. N Engl J Med. 2002 Feb 7 346 (6): 393-403

[2] DPP Research Group. Diabetes Care. 2003 Sep; 26 (9): 2693-4

[3] Ratner, et al. 2005 Diabetes Care 28 (), pp. 888-894

[4] Ackermann, et al.2008 Am J Prev Med 35 (4), pp.357-363

[5] Herman, et al. 2005 Ann Intern Med 142 (5), pp. 323-32

[6] Corteville, Lori. Data Analyst at Michigan Department of Community Health. Personal Communication. Mean hospital cost per day of hospitalization of chronic disease based on 2007 Michigan Inpatient Database.

[7] 2010 American College of Emergency Physicians. http://www.acep.org/practres.aspx?id=45887. Final Rules for 2010 Medicare Physician Fee Schedule.

[8] April 2002 AHRQ Publication No. 02-0018. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/elderdis.htm. Preventing Disability in the Elderly with Chronic Disease

[9] CDSMP (PATH, Diabetes-PATH and TCDSS) cost between $70 and $200/person to administer.

[10] Quantifying the cost of physical inactivity calculator. East Carolina University. https://www.ecu.edu/picostcalc.

[11] http://www.census.gov/acs/www. American Community Survey 2008 for Wayne County.

[12] Fussman, Chris. Michigan Behavioral Risk Factor Surveillance System Coordinator/Epidemiologist. Personal Communication. Percent of People Physically Inactive in Wayne County based on BRFSS 2009 Estimated data.

American Diabetes Association.

American Diabetes Association
2451 Crystal Drive, Suite 900
Arlington, VA 22202
1-800-DIABETES (800-342-2383)

National Diabetes Prevention Program Named the First Preventive Health Initiative Eligible for Medicare Coverage via CMMI Expansion

Alexandria, Virginia
March 23, 2016

Contact

Michelle Kirkwood
mkirkwood@diabetes.org
703-299-2053

The American Diabetes Association Applauds Historic Announcement

In a landmark advancement for preventive health care and the 86 million Americans currently most at risk of developing type 2 diabetes, Health and Human Services Secretary Sylvia Mathews Burwell today announced (http://www.hhs.gov/about/news/2016/03/23/independent-experts-confirm-diabetes-prevention-model-supported-affordable-care-act-saves-money.html) the National Diabetes Prevention Program (National DPP) will be eligible for Medicare coverage. This is the first time since the passage of the Affordable Care Act six years ago that a preventive health program has become eligible for expanded coverage under Medicare. The American Diabetes Association applauds today's announcement, which noted that new regulations to expand coverage of the National DPP for Medicare beneficiaries will be rolled out later this year by the Centers for Medicare and Medicaid Services (CMS)

The American Diabetes Association has long supported the National DPP, a network of community-based, lifestyle intervention programs administered by hospitals, health care centers and community organizations that meet Centers for Disease Control and Prevention (CDC) standards. Sec. Burwell revealed data produced by a 2012 Health Care Innovation Award (HCIA) grant, from the Center for Medicare and Medicaid Innovation (CMMI) to the YMCA, confirming the significant health care savings of the National DPP. During the 15-month period of the program, Medicare saved $2,650 for each person enrolled.

"The Association has spent the last eight years diligently advocating for Medicare coverage of the National DPP, and today's announcement is a powerful endorsement of the value of preventive health care for people who are at risk of developing type 2 diabetes," said Kevin L. Hagan, chief executive officer for the American Diabetes Association. "The evidence shared today confirms the National DPP delivers cost savings to individuals who are at risk for developing diabetes and to our health care economy. Most importantly, the National DPP showed improved health outcomes for participating individuals, demonstrating that interventions like the National DPP can help prevent many of our country's seniors from developing type 2 diabetes and its horrible complications, which can include blindness, amputation, heart disease, stroke and kidney failure."

The CDC (http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf) estimates that, if current trends continue, one in three American adults could develop diabetes by 2050. More than 29 million adults and children in the U.S. have diabetes, representing 9.3 percent of the population. Every day, more than 3,700 people are diagnosed with diabetes in the U.S., the equivalent of about one new diagnosis of diabetes every 23 seconds. In addition, 86 million Americans have prediabetes, a condition that can lead to type 2 diabetes. 11 percent of people with prediabetes will develop type 2 diabetes within five years of a prediabetes diagnosis unless they participate in intensive, early intervention such as the National DPP.

The potential for Medicare coverage expansion announced today by Sec. Burwell achieves the goals of the Medicare Diabetes Prevention Act of 2015 (S. 1131/H.R. 2102), introduced by Senators Al Franken (D-MN), Susan

Collins (R-ME), and Charles Grassley (R-IA) in the Senate, and Representatives Susan Davis (D-CA) and Peter King (R-NY) in the House of Representatives.

"Thank you, Sec. Burwell, for your leadership today, and thank you Sens. Franken, Collins and Grassley, and Reps. Davis and King, our long-time champions for diabetes prevention and care," continued Hagan. "Making the National DPP accessible to Medicare beneficiaries is an important step in our shared national imperative to end the diabetes epidemic."

The HCIA grant of $12 million over three years from CMMI covered the costs for qualified Medicare participants (adults age 65 or older, screened for and diagnosed with prediabetes) to complete this lifestyle intervention at one of the YMCA's 17 participating community centers. The CMMI grant to the YMCA was the first ever investment by CMS to test the success of a community-based diabetes prevention program.

"Approximately one in two seniors has prediabetes, and early intervention is critical to preventing or delaying the onset of type 2 diabetes. Medicare coverage of the National DPP, including the YMCA's program, will provide critical access to an intervention that can reduce the risk for our nation's seniors," said Robert E. Ratner, MD, chief scientific and medical officer for the American Diabetes Association. Ratner served as the lead investigator at MedStar Health Research Institute, one of the participating centers for the Diabetes Prevention Program Research Group's historic clinical trial, which led to the creation of the National DPP.

In 2002, the Diabetes Prevention Program Research Group's randomized clinical trial, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin (http://www.nejm.org/doi/pdf/10.1056/NEJMoa012512)," also known as the Diabetes Prevention Program (DPP), demonstrated that intensive lifestyle intervention was effective and successfully reduced risk for developing diabetes by 58 percent for the entire study population; and for those over the age of 60, risk for diabetes was reduced by 71 percent.

These powerful findings were later translated to a community classroom setting, where lifestyle interventions were replicated at a lower cost. This led to the creation of the National DPP, which is overseen by the CDC. The National DPP consists of an intensive, 12-month, evidence-based intervention program that includes 16 weekly core sessions followed by monthly maintenance sessions. Delivered in a classroom setting by trained coaches, the National DPP provides a supportive, small group environment to promote healthier eating habits and increase physical activity, with goals of reducing body weight by 5 to 7 percent and increasing physical activity to 150 minutes per week. In 2010, the National DPP was authorized by Congress as part of the Affordable Care Act to build an infrastructure of programs across the country. The cost to participate in the National DPP is not currently covered by Medicare. Today's announcement creates the pathway for Medicare to cover National DPP certified programs, thereby opening access to millions of Americans at risk for type 2 diabetes.

Health care costs for people with diabetes are 2.3 times higher than for individuals who do not have diabetes. In 2012, the cost of diagnosed and undiagnosed diabetes and prediabetes escalated to $322 billion, a 48 percent increase in just five years. This equates to one in every 10 health care dollars being spent treating diabetes and its complications, and one in five health care dollars being spent to care for people with diabetes. For Medicare beneficiaries, the numbers are greater, with one in every three Medicare dollars spent on care for people with diabetes.

For more information about diabetes and information about prevention programs, visit diabetes.org (http://www.diabetes.org/).

About the American Diabetes Association

More than 29 million Americans have diabetes, and every 23 seconds another person is diagnosed with diabetes. The American Diabetes Association (Association) is the global authority on diabetes and since 1940 has been committed to its mission to prevent and cure diabetes and to improve the lives of all people affected by diabetes. To tackle this global public health crisis, the Association drives discovery in research to treat, manage and prevent all types of diabetes, as well as to search for cures; raises voice to the urgency of the diabetes epidemic; and

Legislative Testimony 2017, Elder Law of Michigan, Inc.

Good afternoon. My name is Keith Morris and I am the President of Elder Law of Michigan, Inc. We are a statewide nonprofit that provides assistance to seniors through its various programs, like the Legal Hotline for Michigan Seniors, the Mid-America Pension Rights Project, and the MiCAFE program. MiCAFE stands for Michigan's Coordinated Access to Food for the Elderly. I would like to take just a few minutes to update you on the work of the MiCAFE program and the MiCAFE Network, composed of 120+ partners across Michigan, which the MiCAFE program oversees.

I'd like to start with a quick story about one of our MiCAFE clients, Mary from Jackson. She lived in a subsidized senior apartment complex and had very limited access to transportation. She struggled monthly to find enough money for food. She was also unable to apply for any food assistance because she could not get to the Department of Human Services Office and wasn't able to use a computer to fill out the application herself.

Mary attended a MiCAFE Network presentation at her apartment complex and immediately scheduled a phone appointment. Our staff helped Mary complete her application, gather her documentation, and submit the application. This was done by phone and with a follow up visit to her apartment by one of our staff.

Mary began receiving her benefits shortly after that. She shared that the fact that MiCAFE was willing to come to her apartment was instrumental in her getting the food assistance that she needed.

With the new food benefit, Mary can buy more nutritious fruits and vegetables and eats a balanced, healthy diet – something she wasn't able to do before getting this benefit. Mary said, when we last talked with her, that she was "grateful beyond words" for the help that MiCAFE gave her.

This story is pretty typical of the clients that MiCAFE helps each year. In fiscal year 2016, we educated over 20,000 likely-eligible seniors about the Supplemental Nutrition Assistance Program (SNAP). We screened over 5,000 of these seniors for the SNAP benefit and other benefits. Of those, we assisted over 1,100 seniors apply for this federal benefit, with 3 out of 4 being found eligible and receiving an average benefit of $91/month. That may seem like a small amount of money to many of us, but for many of our clients, it is a huge increase in their monthly available income and gives them the ability to buy the food needed to eat a healthier diet.

Mary's story exemplifies why Elder Law of Michigan, Michigan's Department of Health and Human Services, and over 120 local senior-friendly community locations have sustained a partnership for the past sixteen years to educate seniors about this federal benefit, to help each senior individually complete the application, and then to provide ongoing support with any issues that they may have.

Only one in three eligible seniors in the United States participates in the SNAP program. In Michigan, 60% of those eligible seniors are not participating. The reasons that prevent them from applying and using the benefit range from lack of knowledge, lack of transportation, stigma, etc. MiCAFE was conceived to try and address these barriers and to bring the service to the senior. This program started in Genesee County, and it has since expanded to partners located in 34 counties throughout the state. It is our hope to continue expanding to cover the entire state in the near future.

The concept is basically this: by reaching out to educate seniors that may have misconceptions about the SNAP benefit, then allowing them to go to a community center near where they live to apply, and also providing them with one-on-one help to fill out the application, the senior would be able to overcome several obstacles that may have kept them from applying.

The partners that formed the MiCAFE Network worked together to first identify people that were likely to be eligible for the benefit and then designed and tested outreach materials and messages to get the attention of these seniors and explain the program to them. These senior-specific messages are designed to explain the benefit to them in a way to dispel misconceptions.

Another obstacle that keeps seniors from applying is the embarrassment of having to ask for help. Many of these seniors always paid cash for everything and always paid their debts. The thought of asking for a handout was not something they would entertain. Oh, and not to mention the thought of their neighbor seeing them at the welfare office.

We probably all know someone like that. Someone that would never ask for help if they were sick or even as they got older, wanted to try and take care of everything themselves. So, if you think about it, these stigmas and misconceptions are real reasons that would keep a senior from taking the step to apply.

Additional obstacles included the inability to physically travel to the office and the inability to complete the application on their own due to limited literacy, cognitive impairments or other disabilities, or simply just not being able to understand it.

The MiCAFE Network set up a model that addresses each of these obstacles. By training and supporting community partners and application assistants that help seniors at these locations, MiCAFE has been able to provide a senior friendly, easy-to-get-to location that someone would not be embarrassed to be seen at. Additionally, having someone work with them one-on-one to explain the benefit, to walk through the questions, and then to help gather the paperwork over came other obstacles.

MiCAFE is successful because of the partnerships with the Department of Health and Human Services, who has worked with us to test several ways to increase access to the benefit for seniors, and its Aging and Adult Services Agency, formerly the Office of Services to the Aging, which provided the original web system that we used to do an electronic application. Together, we are able to provide education and access to the benefits through a senior-friendly community location, individualized application assistance, and supporting all this through technology.

I'd like to tell you a quick story about Patty, one of our clients. She is 71, divorced, and living alone. Her only income is a very modest social security check of about $1100 a month. While she didn't consider herself to be poor, she realized that she had to watch every penny and struggled each month to pay all of the bills.

MiCAFE reached out to Patty through a letter campaign in partnership with her local DHHS office. She called our toll-free number and was excited to learn that she might be eligible for this help. With the help of a nearby senior center, Patty applied for SNAP and she received nearly $200 a month in benefits. MiCAFE also helped her understand how to use her new card. A year later, MiCAFE also helped her go through the recertification

process so that she could keep her benefit.

Patty IS our typical client: a woman in her seventies, living alone due to the death of a spouse or a divorce. She takes medications, when she can afford them, for four or five chronic illnesses. She is under nourished and at risk of continuing nutritional deficiency. She pays nearly 80% of her gross income (often nothing more than survivor's Social Security) for housing and medical care. As a result, our typical client receives $91 a month to buy food.

From a purely economic standpoint, MiCAFE is good for Michigan's economy. In October 2016, there were over 6,000 seniors in Michigan who are receiving benefits because they were assisted by MiCAFE over the past few years. The average benefit for these cases is $91 a month. That equates to nearly $550,000 in federal SNAP benefits being brought into the state each month. Over a twelve-month period, these cases will generate nearly $7 Million in benefits for Michigan's poor seniors.

We ask that you fund this program at the amount in the Governor's recommended budget.

Thank you again for the opportunity to address the committee today, and on behalf of the Michigan seniors that we have already helped and those that we will be helping in the coming year, thank you for your support of the MiCAFE program.

Any questions?

Did you know that nearly 160,000 Michigan seniors face hunger everyday?

Thousands of these seniors have to choose between food, medicine, and utilities on a daily basis. MiCAFE, a program of Elder Law of Michigan, Inc., and the MiCAFE Network, a network of 125 community organizations across Michigan, work to connect eligible seniors with food assistance benefits. These benefits are vital to the health of these seniors, empowering them to purchase healthy foods that they otherwise could not afford.

Since 2001, the MiCAFE Network has helped seniors access over 22 million meals they could not otherwise afford to purchase.

In fiscal year 2016, the MiCAFE Network:

- Educated over 20,000 likely-eligible Michigan seniors on benefits programs and how to apply;
- Screened nearly 5,000 Michigan seniors for benefits eligibility;
- Supported over 3,000 Michigan seniors in SNAP benefit recertification;
- Assisted over 1,100 seniors from 40 Michigan counties apply for SNAP benefits; and,
- Helped 831 Michigan seniors receive an average SNAP benefit of $91 per month to purchase food they otherwise could not afford.

Due to the efforts of the MiCAFE Network, thousands of seniors have beat hunger.

MiCAFE network

www.micafenetwork.org | 877.664.2233

Elder Law of Michigan, Inc. (ELM), is a nonprofit organization whose mission is to advocate for, educate, and assist our target populations. While our services address the needs of many different people, we continue to target our services to older adults and persons with disabilities. For 25 years, we have provided no-cost counseling on legal, pension, housing, nutrition, and benefits access. MiCAFE, a program of ELM., helps individuals apply for benefits that meet their basic needs including food, utilities, housing, medical assistance, and prescriptions. For more information about ELM, contact us at 866.400.9164 or visit us at www.elderlawofmi.org.

Participate in the MiCAFE Network in your own way!

M MiCAFE Network Partners are found all across Michigan in various shapes and sizes, so it is important that each Partner supports the Network in a way that works for their organization. To facilitate this, there are varying levels of participation your organization can have as part of the MiCAFE Network, all of which are very important to getting benefits to seniors in your community who are in need.

I If your organization has a dedicated staff person who can focus on seniors a few hours a week or if your organization can just help spread the word about benefits access, you can be an integral part of the MiCAFE Network. Every effort helps as the MiCAFE Network aims to provide food assistance and other benefits to the nearly 160,000 Michigan seniors who face hunger every day.

C

Completing Partner

- Complete benefit applications with seniors (with possible reimbursements available to your organization for application completion);
- Reach out to potentially eligible seniors through co-branded mailings; and,
- Also serve as an Assisting, Finding and Referring, and Educating Partner.

A

Assisting Partner

- Assist seniors with signing and submitting benefits applications electronically;
- Receive continuing education credits for participation in training events; and,
- Also serve as a Finding and Referring and Educating Partner.

F

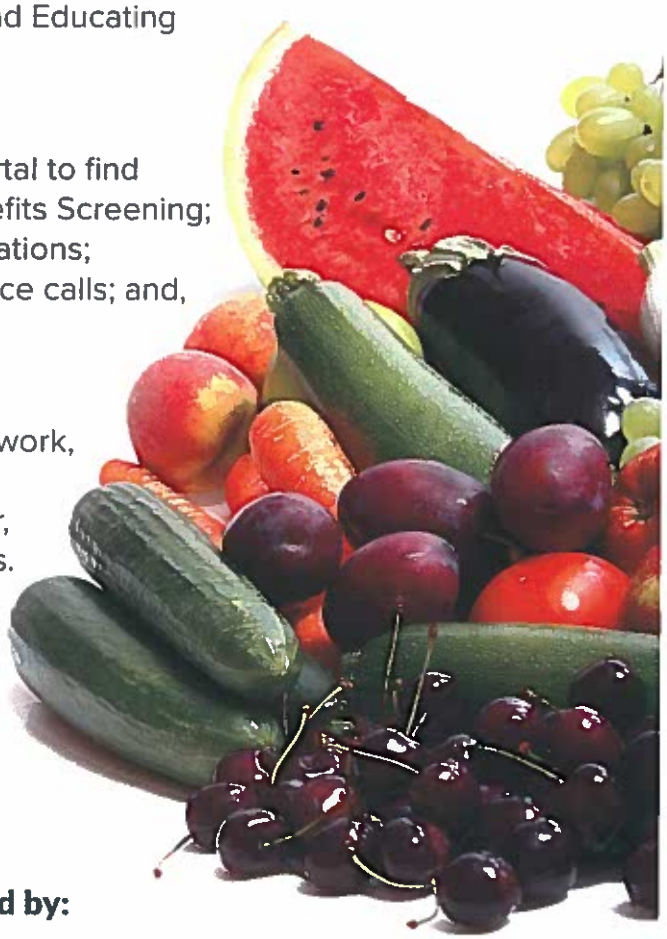
Finding and Referring Partner

- Use the MiCAFE Network's Mi-SOAP Portal to find potential eligibility through the Key Benefits Screening;
- Refer seniors to complete benefit applications;
- Participate in monthly Network conference calls; and,
- Also serve as an Educating Partner.

E

Educating Partner

- Display materials about the MiCAFE Network, SNAP, and benefit programs;
- Host community outreach events; and/or,
- Speak to seniors about benefit programs.



MiCAFE network

www.micafenetwork.org | 877.664.2233

Generously supported by:

MDHHS

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Community Foundation FOR SOUTHEAST MICHIGAN

Southeast Michigan Senior Regional Collaborative

AFSN
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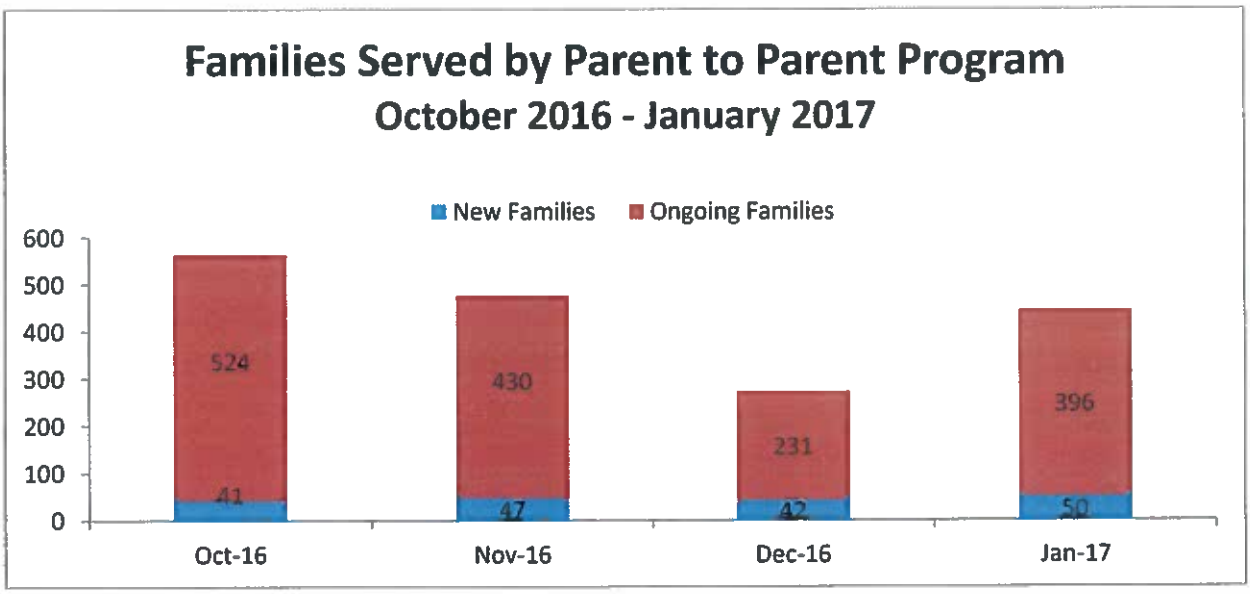
Statewide Parent to Parent Program Report

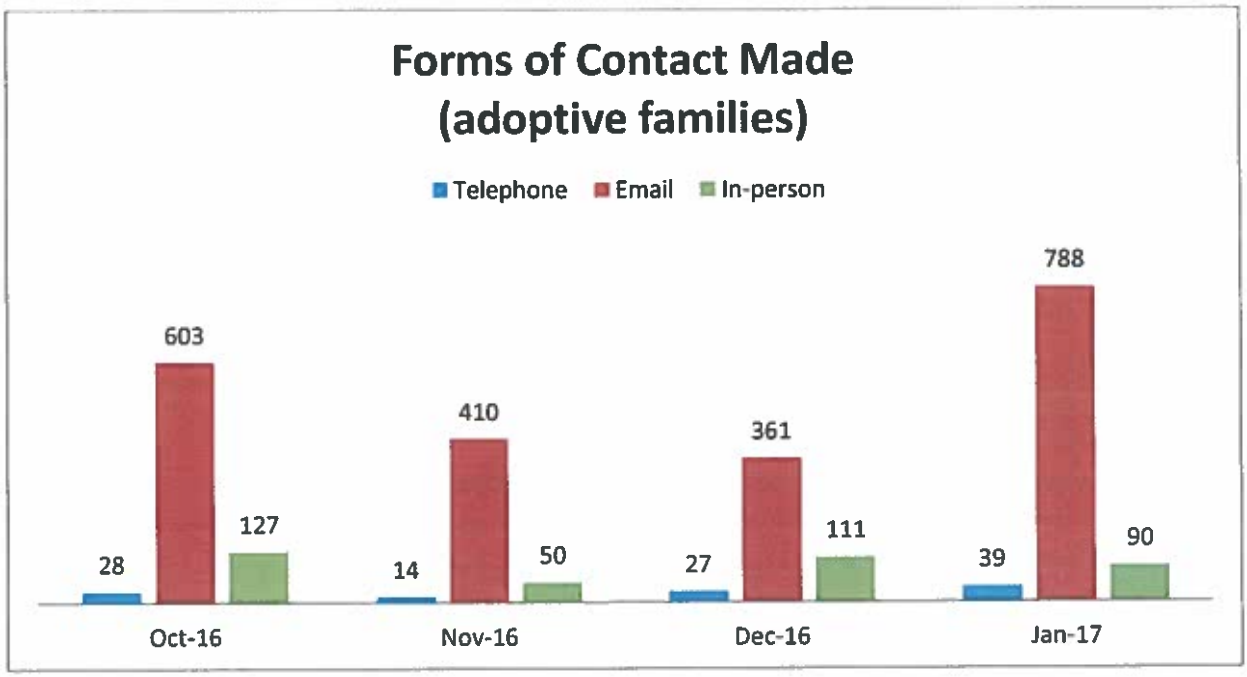
HB 5274

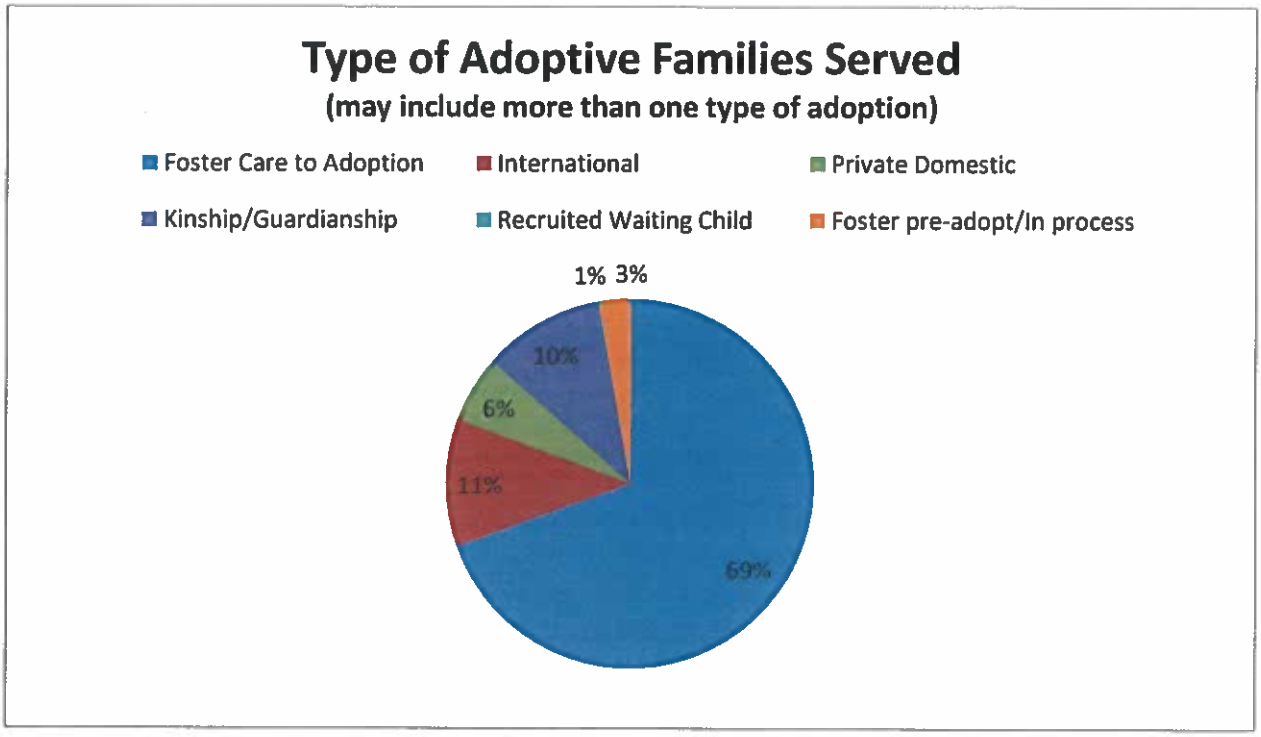
October 1, 2016 – January 31, 2017

Executive Summary:

- In the first four months of the contract cycle, AFSN's Statewide Parent to Parent Program has served 838 unduplicated adoptive families in the state of Michigan.
- 2616 total contacts were made with adoptive families in the first four months, averaging 1 hour total contact per family.
- 70 % of the families seeking services from AFSN are families who have adopted at least one child from the child welfare system, the remaining 30% families have adopted internationally, privately, and through kinship adoptions outside of the child welfare system are also seeking crucial support services. These families are often isolated and lack access to needed services and support groups due to program eligibility requirements, while AFSN assists ALL adoptive families.
- The three most common reasons given by families for connecting with AFSN's Parent to Parent Program are; interest in support groups/connection to other adoptive families, attendance at parent and family networking events, and families seeking resources to assist them with their child's challenging behaviors (including referrals for adoption competent therapists, school advocacy and respite).
- Despite AFSN's reduction from ten to five Adoptive Parent Consultants for FY 2016-2017, Adoptive Parent Consultants (staff and volunteer) are facilitating 26 different in-person monthly adoptive parent support groups serving families in 14 different counties.
- 26 adoptive parent leaders completed an 18 hour leadership certification program between May and July 2016. As a result of that training, AFSN was able to expand services throughout the state despite a 30% budget reduction for the current fiscal year.
- In the first quarter, 98% of families surveyed had all of their adopted children under the age of eighteen remaining in the home after receiving services from AFSN.
- 99% of first quarter survey respondents were "satisfied" or "very satisfied" with the support they received from AFSN's Parent to Parent Program.
- 99% of first quarter survey respondents "agreed" or "strongly agreed" with the statement; "I feel more able to access needed support and resources for my family since connecting with AFSN.


Families Served by Parent to Parent Program
October 2016 - January 2017
New Families
Ongoing Families
600
500
400
300
200
100
0
524
41
430
47
231
42
396
50
Oct-16
Nov-16
Dec-16
Jan-17


Forms of Contact Made
(adoptive families)
Telephone
Email
In-person
28
603
127
14
410
50
27
361
111
39
788
90
Oct-16
Nov-16
Dec-16
Jan-17



Program Outreach and Events:
During this reporting period, Parent to Parent Program staff have attended and/or made presentations about AFSN's services to **23** different community groups, agencies and schools in **18** counties.

Additionally, Parent to Parent Program Staff have organized and hosted **13** family fun/networking events and attended **12** community events with participants from **25** different counties. These events provide opportunities for families in surrounding areas to connect to one another.

Finally, Parent to Parent Staff facilitated **26** in-person support groups and educational forums serving families from **14** counties.

Website Usage:

www.afsn.org had 5,911 visits from 2224 users from October 2016 through January 2017, 64% of which were new to the site. 23% of the website traffic came through referrals from other websites, including state and national adoption support agencies, Michigan's Post Adoption Resource Centers and family resource guides, MARE and MSU School of Social Work. Website traffic came from 38 countries, 41 states and 209 cities in Michigan, showing the wide reach of AFSN's networks and demand for post adoption information.

Social Media Presence:

AFSN has a strong facebook presence, with 2,571 "likes" for the agency. AFSN's facebook pages feature trainings, events, program announcements and educational resources, as well as encouragement and mutual support of adoptive families. "Friends" of the AFSN facebook pages come from over 150 cities in Michigan.

AFSN operates and moderates 13 closed/secret online support communities for adoptive families with 2,040 total support group members. These groups include online support for Parent to Parent Statewide Adoptive Families 1635, Cedar Springs Parents 31, Parent to Parent Leaders 79, Adoptive Intentional Parent Book Club 135, Transracial Adoptive Families 564, LGBTQ adoptive families 41, Adoptive families who completed the Advanced Parenting for Challenging Children educational series 92, Singles in Support 77, Raising Healthy Families 54, Adoptive Dads 93, Special Needs Adoptive Families 47 and Mid-East Michigan AFSN Families 46

AFSN also has staff serving as contributors/administrators to other groups not initially started by AFSN. Those groups include; West Michigan Families Who Adopt- 374, Michigan Area Adoption Support Group- 504, Michigan Foster Care/Adoption- 2,637 Southeast Michigan Foster, Adoptive and Kinship Social Group 106.

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D.A. BLODGETT - ST. JOHN'S
HOMES AND HOPE FOR CHILDREN SINCE 1887

February 27, 2017

Human Services subcommittee of the Standing Committee on Appropriations, Rep. Edward Canfield, Chair

Testimony for Continuation of Parent Lead Support

The Adoptive Family Support Network has worked tirelessly to ensure a well-planned expansion of our statewide Parent to Parent Program model to now be nearly entirely run by volunteer adoptive parent leaders. We could not have done this without the continued legislation provided through both the Michigan House and Senate. Our efforts ensure there will be as much time as possible to provide direct support to adoptive families and provide technical assistance to parent leaders throughout Michigan. **To date, we have supported a total of 1,661 families from 70 of 83 counties in Michigan.** Yet our work has just begun.

Allow me to speak to the need for continuation of funding for this crucial program for next fiscal year. Establishing trusting relationships in communities takes time. Families often feel isolated and alone in their struggles, leading them to wait to reach out until they are in crisis. Ever-changing agency staff, contracts, eligibility requirements, and community resources exacerbate this problem. What is unique, cost effective and enduring about the Parent to Parent model is that we are focused on training parents to advocate, lead and support parents in their own communities with skills that cannot be taken away when the funding ends. The passion that these leaders have to support families throughout the adoption process and long after the agencies have closed their cases, cannot be replaced even by the best social work. Other adoptive parents can give hope and courage to adoptive parents who face the very real challenges that come with parenting children who have experienced trauma and loss in profound ways.

Parents tell us: *You could have said see ya next month. But you didn't, and through that my hope was renewed. We were at our wits end, but after meeting with you I got connected to support groups. We are not alone and knowing other parents get this crazy journey we are in, that brings a comfort and strength that is hard to describe. I appreciate all that AFSN provides through the many resources and services available. But you, our fearless leader, are one of a kind.*

Indeed, **42%** of families who contact the Parent to Parent Program are seeking to join support groups and connect directly with other adoptive parents in their area. Adoptive Parent

Consultants throughout the state are reaching out to existing groups to provide support, training and technical assistance to these leaders to strengthen their efforts, while developing new leaders and groups where there is a gap. To date, AFSN is currently facilitating 21 groups across Michigan.

But, we need more time to continue to empower, educate and train strong volunteer community leaders in ALL areas of our state so that the we have an organized and trained "army" of dedicated adoptive parents equipped with the tools to lead and mentor other parents for the long haul, decreasing the need for costly agency and system intervention. We know we are moving families from crisis to stability every day. We also know it takes the technical assistance and ongoing leadership of AFSN to keep a volunteer's passion fueled and their skills up to date. We are now focusing our work on create trainings our volunteer leaders can train themselves. We create events with locations across the state from SE Michigan to the Upper Peninsula, and all volunteer run. AFSN continues to maintain a Warmline 24/7 to support families anytime they need. We do not want to see this support for ALL Michigan adoptive families end.

I would like to end with an example of what AFSN is doing every day. This is a recent post from an adoptive parent in AFSN's Adoptive Parent, Intentional Parent online book club currently being offered to more than 100 adoptive families. The discussions are led by the parents themselves and also includes no cost webinars with the author.

I get NOTHING for letting you know about it (AFSN), except for maybe helping a family, like Carrie Burrows, helped our family by connected us to resources. Our family was over! Our marriage was on the edge of failing. One of our adoptions was on the brink of being a failed adoption. We had lost most of our friends. We were going INSANE! No doctors, psychiatrists, counselors, teachers, specialists, helped us. Seven YEARS we tried everything. Seven YEARS!!!!! No one had given us ONE SINGLE TOOL to help us. We now have TOOLS! The next morning, when the kids got up, we used those TOOLS!!! Our lives were changed overnight! Happy to say, we are still married, our adopted daughter is still our daughter!!! Is our life PERFECT? OH, HECK NO! Do we now know how to help our daughter and family? YOU BETCHA!!

I would like to close by saying thank you on behalf of the more than 1,600 Michigan foster, adoptive and kinship families we work with every day. Together we are bringing hope and stability to families.

Brooke Van Prooyen, Program Manager

Adoptive Family Support Network

Parenting with Confidence

Introducing the Parent to Parent Program from Adoptive Family Support Network

AFSN
AdoptiveFamilySupportNetwork
A service of D.A. Blodgett - St. John's

What is the Adoptive Parent to Parent Program?

This program provides a listening ear, knowledgeable guidance and community connections to any member of an adoptive family. Our services are offered at no charge, through consultants located throughout the state. We are here to serve any adoptive family member who has adopted in Michigan.

What Do We Offer?

The Parent to Parent Program encourages and supports adoptive families whenever, however and wherever they need it. We do this in three ways:

- Matching your family to one of our trained adoptive parent consultants whose adoption experience and background most closely fits your situation.
- Providing personal contact and support in whatever way and for however long you need it (phone, email, in person, etc.).
- Connecting your family to other adoptive families so that you can all support each other as you grow together.

When Should You Call?

Call us any time you have a question about adoption, such as:

- Identity. How do I answer my child's questions about his/her identity?
- Behavior. My child is exhibiting some difficult behaviors (mood swings, temper, disobedience, etc.). What can I do?
- Resources. What kinds of medical, emotional and financial support are available to us as an adoptive family?
- Advocacy. How do I obtain the help my child needs in school?
- Referrals. Can you help me find a physician, therapist, or other specialist with experience in adoption issues?
- Peer support. Can I connect with another adoptive family? Is there someone else out there like us?
- Grief and loss. I have heard that there are certain ages when children more commonly have questions about their adoption. How do I respond?

Free Support Available 24/7: 855-MICH-P2P

Email: Parent2Parent@afsn.org

MDHHS
Michigan Department of Health & Human Services

This program is funded by the Michigan Department of Health & Human Services.

House of Representative Hearing Testimony

February 27, 2017

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 over 700 children and adults with intellectual and 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: Antrim County, Berrien County, Ionia County, Kent County, Manistee and Benzie County, Mason County, Missaukee County, Oakland County, Otsego County, Washtenaw, Wayne, and Wexford Counties. I am here today on behalf of the people I employ and the people I serve.

Spectrum Community employs nearly 1,100 people. 60% of our employees work part time. We currently have 125 full time positions for direct care staff that we have had difficulty hiring people to fill. More than 50% of the people we employ have one or two more jobs to assist them to pay their

bills. They feel they need to work multiple jobs as the rate of pay for this position is not adequate and is within the poverty level. Over the last few years it has become more and more difficult to recruit and hire for the direct care position. This is a position that requires people to be dedicated and engaged with people who have special needs. It has not been easy to find people with these qualities who are willing to work for the current pay.

My staff is 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 DHHS child abuse registry. Another area of concern is transportation to get to the program site. Many staff does not have good

reliable vehicles. Most can not afford car payments and rely on older vehicles.

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.

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 35 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. 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 wants to do a good job and they do enjoy working with our individuals but they are tired. We need your help to fix this problem.

In closing, I would request that you consider approving the Governor's recommendation to increase the direct care wage by 50 cents and increase this by another $1.50 so that we may be able to attract people who want to make this a long term career in the human service field and more quality people applying for a position. Having a pay scale $2.00 above minimum wage would have a great impact on our hiring of quality people. I know that my employees would be very grateful for any kind of a wage increase from you.

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

MICHIGAN
Oral Health Coalition

Testimony for House Appropriations Subcommittee on Health and Human Services
February 27, 2017

Chairman Canfield and other distinguished committee members, thank you for the opportunity to provide testimony on the Fiscal Year 2018 Michigan Department of Health and Human Services budget. My name is Karlene Ketola, Executive Director of the Michigan Oral Health Coalition. The Michigan Oral Health Coalition serves as the collective voice of oral health— as our members include dental professionals as well as universities, community health centers, insurers, professional associations and local health departments who together work to improve the oral health of Michigan's nearly 10 million residents.

We applaud the Legislature for its support of Healthy Kids Dental—making it a statewide program in Fiscal Year 2017. The program has improved access to dental care for Michigan's one million Medicaid-enrolled children.

Medicaid is also the primary insurer of dental care for almost 700,000 low-income adults, who are pregnant, disabled, homebound or institutionalized. The current Medicaid fee-for-service Adult Dental program has struggled to attract enough dentists to serve such a large population. Due to the low number of participating dentists, adult Medicaid beneficiaries have great difficulty in accessing dental care. Many simply go without or end up visiting a hospital emergency department. Most emergency departments are not equipped to handle dental treatment, so Medicaid beneficiaries often just receive pain relief medication and an antibiotic. Unfortunately, this does not treat the underlying dental disease, so patients experience only temporary relief. In the end, the poor access to care simply results in return trips to the emergency department, unnecessary suffering and health care dollars unwisely spent.

As you develop your Fiscal Year 2018 budget proposal, we request that you provide funding to reform the Medicaid Adult Dental program. We believe an investment in Michigan's Medicaid Adult Dental program will eliminate unnecessary suffering, improve the likelihood that Michigan's vulnerable adults can find employment and generally improve their oral and overall health.

Respectfully Submitted,
Karlene Ketola, MHSA, CAE
Executive Director

Enclosure

Michigan Oral Health Coalition | 106 W. Allegan Street, Suite 310, Lansing, MI 48933
Tel 517.230.4381 | E-mail kketola@mohc.org | Web www.mohc.org

MICHIGAN
Oral Health Coalition

MEDICAID ADULT DENTAL REFORM

Fiscal Year 2017-18 Policy Statement

CALL TO ACTION

Bringing Michigan's Medicaid adult dental coverage in line with the state's Healthy Kids Dental and Healthy Michigan Plan will greatly expand access to critical oral health care for Michigan's low-income residents.

Today in Michigan, dentists who treat children receive higher payment rates than those who treat adults. Similarly, Michigan's adult dental payment rates are far lower than other states.

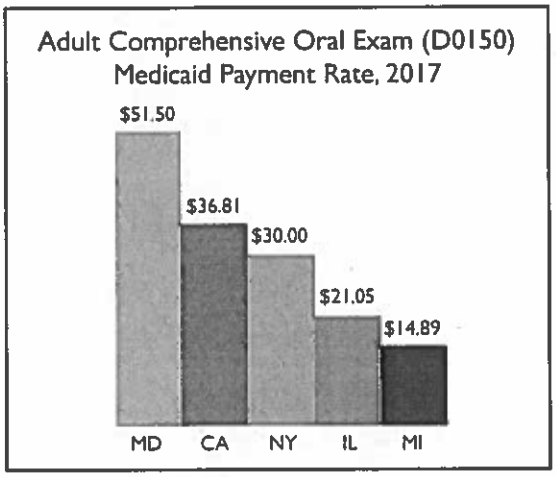
Michigan should bring those payments in line, and simplify the administration of the Medicaid Adult Dental Program, making it easier for providers to contract with Medicaid.

BACKGROUND

Access to dental care is **limited or nonexistent for nearly one million Michigan residents**, creating serious oral health care issues that can lead to tooth loss, pain and potential life-long ramifications.

Poor oral health elevates risks for chronic conditions such as diabetes and heart disease, and leads to lost workdays and reduced employability.[1] It can also lead to the preventable use of costly acute care. A recent study **identified $2.7 billion in dental-related hospital emergency department visits** in the U.S. over a three-year period. **30 percent** of these visits were by Medicaid-enrolled adults, and over **40 percent** were by individuals who were uninsured.[2]

- Low-income adults, who are disabled, homebound, or institutionalized, suffer a disproportionate share of dental disease.[3, 4]
- More than one-third of all Michigan seniors have lost six or more natural teeth due to tooth decay or gum disease. Low-income seniors are more than three times as likely to have lost six or more teeth due to tooth decay and/or gum disease.
- Poor oral health in pregnant women is linked to a high risk of pre-term birth and low-birth-weight babies.[5]



CHALLENGES TO ORAL HEALTH CARE ACCESS AND UTILIZATION FOR LOW-INCOME ADULTS IN MICHIGAN

Barriers to Care: While comprehensive dental coverage is provided for children enrolled in Medicaid, Medicaid-eligible adults in Michigan only have access to limited preventative and restorative services and **care is difficult to access because of low payment rates for providers, and bureaucratic hurdles.**

Provider Availability: Medicaid enrollees often have difficulty finding dental providers. Only 20 percent of dentists nationwide accept Medicaid, due to burdensome administrative requirements, lengthy payment wait times, low payment rates, and more.

Sources:

1 http://www.nashp.org/sites/default/files/Adult%20Dental%20Monitor.pdf

2 https://www.ncbi.nlm.nih.gov/pubmed/24686965

3 https://kaiserfamilyfoundation.files.wordpress.com/2013/03/7798-02.pdf

4 https://www.hrsa.gov/publichealth/clinical/oralhealth/improvingaccess.pdf

5 http://www.midentalaccess.org/research

STATE OF MICHIGAN
DEPARTMENT OF EDUCATION
LANSING

RICK SNYDER
GOVERNOR

BRIAN J. WHISTON
STATE SUPERINTENDENT

2015-2016 Annual Legislative Report

Public Act 84 of 2015

Sec. 1007. (1) From the increased funds appropriated in part 1 for child development and care - external support, the department shall create progress reports that shall include, but are not limited to, the following:

(a) Both the on-site and off-site activities that are intended to improve child care provider quality and the number of times those activities are performed by the licensing consultants.

(b) How many on-site visits a single licensing consultant has made since the start of the 2015-2016 fiscal year.

(c) The types of on-site visits and the number of visits for each type that a single consultant has made since the start of fiscal year 2015-2016.

(d) The number of providers that have improved their quality rating since the start of fiscal year 2015-2016 compared to the same time period in fiscal year 2014-2015.

(e) The types of activities that are intended to improve licensing consultant performance and child care provider quality and the number of times those activities are performed by the managers and administrators.

(2) The progress reports shall be sent to the state budget director, the house and senate subcommittees that oversee the department of education, and the house and senate fiscal agencies by April 1, 2016 and September 30, 2016.

Executive Order

Executive Order No. 2015 – 4 transferred the Office of Child and Adult Licensing (OCAL) from the former Michigan Department of Human Services (DHS) to the Michigan Department of Licensing and Regulatory Affairs (LARA). LARA effectively took over day-to-day operations of OCAL in the 3rd quarter of 2015. For purposes of this report, the "department" means the Department of Licensing and Regulatory Affairs.

608 WEST ALLEGAN STREET • P.O. BOX 30008 • LANSING, MICHIGAN 48909
www.michigan.gov/mde • 517-373-3324

Appropriated Funds

The Michigan Department of Education – Office of Great Start (MDE-OGS) entered into an agreement with the Michigan Department of Licensing and Regulatory Affairs (LARA) to implement the hiring of the additional child care licensing staff to ensure health and safety of children, as well as to reduce to the ratio of child care licensing staff; providing mutually agreed-upon support functions to the Child Development and Care (CDC) Program, and maintaining clear communications between both agencies in the interest of the citizens of this State in need of early childhood development and child care programs. The agreement is for a maximum appropriation of $16,340,200.00 and is intended to support the ongoing work of child care licensing as well as increase licensing consultants to reduce current caseloads.

In an effort to reduce caseloads and ensure the increased ability to do health and safety monitoring and support providers as they increase quality, LARA has begun to hire additional staff. At the beginning of the fiscal year there were 67 child care licensing consultants and six area managers across the state. Through Phase I hiring will increase front line staff to 88 child care licensing consultants and eight area managers to bring staffing to 96 and reducing caseloads to an average of 111 from approximately 150.

Due to the decline in licensed and registered programs and additional federal requirements that are still being assessed, LARA will continue to analyze the ratios and work with MDE to determine the actual needs to complete the legislative intent.

Reporting Requirements

Please note: this report reflects the activity of current child care licensing consultants as LARA is in the process of hiring and training the additional child care licensing staff.

(a) Both the on-site and off-site activities that are intended to improve child care provider quality and the number of times those activities are performed by the licensing consultants.

Overview: There are a variety of activities Child Care Licensing Consultants perform that are intended to improve child care provider quality as it relates to child care rules and regulations. These include activities such as, providing in-service trainings to licensees/registrants and trainings at conferences; providing child care center orientation; and participating on committees established to improve child care quality.

These types of activities were performed 160 times from October 1, 2016 through February 29, 2016. In addition, Child Care Licensing Consultants provide technical assistance and consultation to registrants/licensees on how to apply and comply with the licensing rules on a daily basis. This is the first

time that some of these activities have been tracked/counted. The chart below provides the breakdown.

Activities to Improve Quality as it Relates to Child Care Licensing Rules and Regulations that were Performed by Licensing Consultants October 1, 2015 through February 29, 2016	
Child Care Licensing Consultant Activities	**Number of Times Performed**
In-Service Trainings for Licensees/Registrants	20
Child Care Center Orientations Provided	16
Trainings Provided at Conferences	7
Committees Established to Improve Quality	43
Trainings Attended	79
Technical Assistance and Consultation Provided to Registrants/Licensees	Unlimited
Total	**165**

(b) How many on-site visits a single licensing consultant has made since the start of the 2015-2016 fiscal year.

Overview: Child Care Licensing Consultants must have a Master's degree in Child Development, Elementary Education, Early Childhood Education, Social Work, or Guidance and Counseling. Child Care Licensing Consultants conduct on-site inspections of child care facilities to assess compliance with the Child Care Organizations Act (1973 PA 116) and the applicable child care licensing rules. They incorporate the findings of these inspections into a licensing report and set time limits for the registrant/license to come into compliance. In addition, Child Care Licensing Consultants provide technical assistance and consultation to registrants/licensees on how to apply and comply with the licensing rules.

On-Site Inspections Per Child Care Licensing Consultant October 1, 2015 through February 29, 2016			
Consultant	**Total Number of Inspections**	**Consultant**	**Total Number of Inspections**
1	65	35	68
2	63	36	60
3	40	37	34
4	24	38	48
5	43	39	43
6	41	40	22
7	58	41	44
8	39	42	27
9	62	43	41
10	51	44	31
11	62	45	60
12	47	46	51
13	52	47	29
14	42	48	44
15	48	49	39
16	50	50	37
17	61	51	43
18	66	52	48
19	51	53	32
20	67	54	42
21	50	55	13
22	60	56	61
23	60	57	45
24	75	58	73
25	44	59	41
26	53	60	59
27	38	61	38
28	43	62	42
29	47	63	49
30	59	64	55
31	51	65	35
32	40	66	50
33	48	67	55
34	22		
Total	1722	Total	1459

(c) The types of on-site visits and the number of visits for each type that a single consultant has made since the start of fiscal year 2015-2016.

Overview: Child Care Licensing Consultants conduct a variety of different types of on-site inspections:

- **Renewal Inspection**: Conducted prior to renewing a child care facility's registration/license.
- **Follow-Up Inspection**: Conducted when a child care facility is put on increased monitoring due to serious or multiple violations or to ensure compliance with a corrective action plan.
- **Interim Inspection**: Conducted from 30 days before to 2 months after the midpoint of the license.
- **Modification Inspection**: Conducted when the registrant/licensee requests a change to the terms of the registration/license, such as increasing the capacity, changing the age range of children served, etc.
- **Original Inspection**: Conducted prior to issuance of the original license.
- **90-Day Inspection**: Conducted within 90 days of the issuance of the original registration for family home providers.
- **Special Investigation**: Conducted to investigate complaint allegations.

On-Site Inspections By Type Per Child Care Licensing Consultant October 1, 2015 through February 29, 2016

Consultant	Renewal	Follow-Up	Interim	Modification	Original	90-Day	Special Investigation
1	30	2	11	2	2	2	13
2	35	5	0	5	0	0	13
3	25	0	5	0	2	2	6
4	17	1	0	1	2	2	1
5	25	1	4	2	3	3	6
6	19	1	2	9	0	0	6
7	32	6	5	0	3	3	9
8	17	3	3	2	1	1	10
9	28	4	9	0	0	0	19
10	20	1	12	2	5	5	11
11	25	2	16	1	5	5	8
12	14	3	12	2	1	1	10
13	17	4	16	3	2	2	7
14	14	2	0	1	4	4	16
15	24	0	12	2	4	4	3
16	28	2	6	0	2	2	8
17	37	4	12	2	0	0	4
18	23	0	14	0	2	2	23
19	22	1	13	0	5	5	8
20	29	5	17	1	2	2	9
21	27	0	7	1	2	2	9
22	25	0	24	1	0	0	4
23	25	4	13	9	2	2	6
24	31	2	11	6	3	3	15

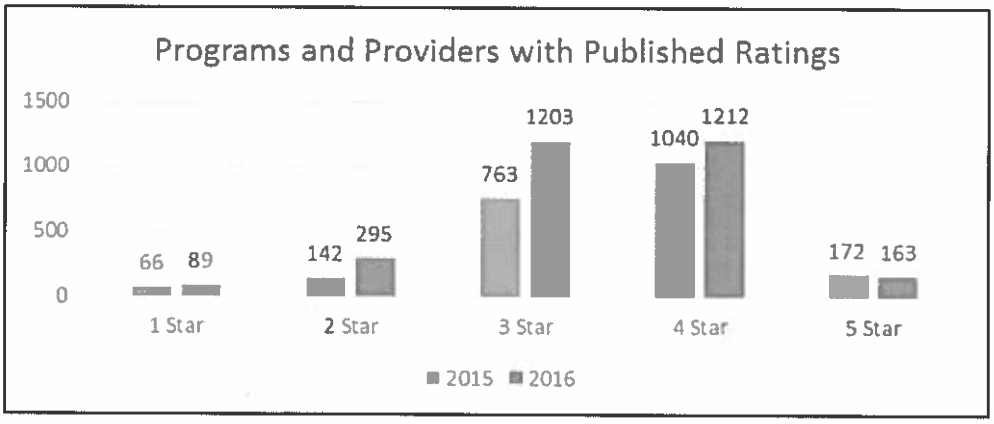
On-Site Inspections By Type Per Child Care Licensing Consultant October 1, 2015 through February 29, 2016							
Consultant	**Renewal**	**Follow -Up**	**Interim**	**Modification**	**Original**	**90-Day**	**Special Investigation**
25	21	0	8	0	5	5	8
26	31	1	2	10	5	5	3
27	20	0	8	2	0	0	8
28	22	1	11	0	4	4	5
29	18	2	0	4	5	5	12
30	30	2	10	2	1	1	14
31	23	0	10	2	2	2	12
32	27	1	3	2	1	1	4
33	28	2	8	1	4	4	4
34	12	3	1	1	0	0	5
35	29	4	24	4	0	0	4
36	25	2	3	5	3	3	21
37	11	4	0	3	1	1	15
38	26	6	4	0	4	4	5
39	21	0	7	1	4	4	8
40	11	1	6	0	0	0	2
41	28	1	6	2	1	1	5
42	13	1	0	0	1	1	11
43	11	0	5	4	3	3	17
44	20	1	0	0	2	2	6
45	31	0	17	2	0	0	9
46	21	2	2	8	2	2	16
47	9	4	6	1	1	1	7
48	22	5	9	0	4	4	0
49	21	1	0	0	0	0	12
50	16	1	0	0	13	13	6
51	25	2	7	3	0	0	4
52	18	3	6	5	3	3	9
53	18	2	4	1	0	0	4
54	27	1	2	3	2	2	4
55	5	0	3	0	2	2	1
56	25	1	12	2	3	3	14
57	8	5	0	0	1	1	25
58	40	2	16	2	4	4	8
59	20	0	2	0	7	7	8
60	24	9	4	5	7	7	8
61	23	0	0	0	7	7	8
62	21	1	5	2	1	1	6
63	24	3	7	5	1	1	7
64	33	4	0	2	2	2	9

On-Site Inspections By Type Per Child Care Licensing Consultant October 1, 2015 through February 29, 2016							
Consultant	**Renewal**	**Follow -Up**	**Interim**	**Modification**	**Original**	**90-Day**	**Special Investigation**
65	20	0	8	0	2	2	3
66	16	4	13	0	1	1	12
67	28	4	12	1	2	2	9
Totals	1511	139	475	137	163	163	582

(d) The number of providers that have improved their quality rating since the start of fiscal year 2015-2016 compared to the same time period in fiscal year 2014-2015.

Total Programs and Providers with Published Ratings by Star Rating

The chart below compares the total number of programs and providers with published ratings in March of 2015 to March of 2016. In March of 2015, a total of 2,183 of 9,390 eligible programs and providers had a published rating of 1, 2, 3, 4, or 5 Stars. In March of 2016, a total of 2,962, out of 9,137 eligible programs and providers had a published rating of 1, 2, 3, 4, or 5 Stars. It is important to note that Great Start to Quality data currently available through the STARS platform is point in time. At this time data is not available to show program level growth over time. Enhanced reporting capabilities are in development and will be available by the end of FY16.



Data Source: Great Start to Quality STARS Platform, Program Profile, SAS Rating and Overview Report (March 2015 and March 2016)

(e) The types of activities that are intended to improve licensing consultant performance and child care provider quality and the number of times those activities are performed by the managers and administrators.

Overview: There are a variety of activities area managers and administrators perform that are intended to improve child care provider quality, such as providing in-service trainings to licensees/registrants and trainings at conferences; participating on committees established to improve child care quality; holding staff meetings, and conducting on-site inspections with licensing consultants. These types of activities were performed 345 times October 1, 2015 through February 29, 2016. The chart below provides the breakdown.

Activities to Improve Quality Performed by Area Managers and Administrators October 1, 2015 through February 29, 2016	
Area Manager and Administrator Activities	**Number of Times Performed**
In-Service Trainings Provided for Licensees/Registrants	7
Provided Trainings Provided at Conferences	1
Committees Established to Improve Quality	15
Trainings Attended	11
One-on-One Staff Meetings Held	262
Group Staff Meetings Held	20
On-Site Inspections Conducted with Licensing Consultants	21
Training Sessions Provided for New Licensing Consultants	8
Total	**345**

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF EDUCATION
LANSING

BRIAN J. WHISTON
STATE SUPERINTENDENT

MEMORANDUM

DATE: April 1, 2016

TO: State Budget Director, Members of the Michigan House and Senate Education Subcommittees, and the House and Senate Fiscal Agencies

FROM: Kyle Guerrant, Deputy Superintendent (K.G) 4-1-16
Administration and School Support Services

SUBJECT: 2015-2016 Nonpublic Mandate Report

Pursuant to P.A. 84 of 2015, which included appropriations for the Department of Education including section 236, the Michigan Department of Education (MDE) prepared this report to meet the requirements of the section.

For additional questions, please contact the following MDE staff by email:

Caroline Liethen
Legislative Analyst
Michigan Department of Education
liethenc@michigan.gov

To contact by telephone, please call the MDE Legislative Affairs unit at (517) 241-4395.

Attachment

NONPUBLIC MANDATE REPORT

TO THE STATE BUDGET DIRECTOR, THE HOUSE AND SENATE APPROPRIATIONS SUBCOMMITTEES RESPONSIBLE FOR THE DEPARTMENT OF EDUCATION, AND THE SENATE AND HOUSE FISCAL AGENCIES

House Bill 4097 of 2015

Summary of Legislation

Sec. 236 of (House Bill 4097 of 2015) from the funds appropriated in part 1, the department shall compile a report that identifies the mandates required of nonpublic schools. In compiling the report, the department may consult with relevant statewide education associations in Michigan. The report compiled by the department shall indicate the type of mandate, including, but not limited to, student health, student or building safety, accountability, and educational requirements, and shall indicate whether a school has to report on the specified mandates. The report required under this section shall be completed by April 1, 2016, and transmitted to the state budget director, the house and senate appropriations subcommittees responsible for the department of education, and the senate and house fiscal agencies not later than April 15, 2016.

Summary of Data Collection of Nonpublic School Mandates

The list of Michigan Compiled Laws (MCL) and Michigan Administrative Regulations (R) that impose mandates on nonpublic schools is the product of a thorough search conducted by the Library of Michigan through Lexis. The Library of Michigan reference staff researched hundreds of pages of results one page at a time, screening the most recent edition of the Michigan Association of Nonpublic Schools (MANS) Manual, as well as the list compiled by the Michigan Catholic Conference and the School Legal Obligation Compliance Checklist. The research did not include federal law, nor did it include Pre-K or post-secondary provisions unless they also applied to K-12.

The list is comprehensive, but it is not exhaustive. As evidenced by examples, such as requirements regarding underground storage tanks and blood borne pathogen training, not all of these mandates are relevant based on the nonpublic school setting. They apply only because a school, as an institution, has to comply with laws regarding employment practices, environmental regulation, building codes, etc., just as any other institution or place of business would.

Summary of Nonpublic School Mandate Report

The laws found to be pertinent are presented in the table below. The report includes the MCL citation, a brief description of the law, the category assigned to the law, and a deliverable column. A deliverable represents if the mandate requires a report(s), the submission of a form(s), or other types of documents to be produced.

The categories used are listed and defined below:

- **Accountability:** pertaining to student, school, or other records
- **Building Safety:** pertaining to building and structural requirements
- **Educational Requirements:** pertaining to curriculum, teacher certification, instruction hours, etc.
- **School Operations:** pertaining to concerns such as fair labor practices, taxation, environmental regulations
- **Student Health:** pertaining to the physiological or mental health of students
- **Student/Staff Safety:** pertaining to the providing a safe environment for students and staff

NONPUBLIC MANDATES [1]

MCL/ RULE	DESCRIPTION	CATEGORY	DELIVERABLE
28.721	Sex Offenders Registration Act	Student/Staff Safety	no
29.5p	Hazardous Chemicals—Employee Right to Know	School Operations - Student/Staff Safety	no
29.19	Fire/Tornado Drills/Lockdown/Shelter in Place	Student/Staff Safety	yes
37.274	Internet Privacy Protection Act	School Operations	no
205.184	Auction events Tax Credit	School Operations	no
207.1035	Exclusion-Motor Fuel Tax	School Operations	no
257.710e	Child Vehicle Restraints	Student/Staff Safety	no
257.715a	State Police inspection 12+ passenger motor vehicles	Student/Staff Safety	no
257.801	$10.00 Motor Vehicle Tax on nonpublic school vehicles used for transportation of pupils	School Operations	no
257.1807—257.1873	(Pupil Transportation Act)-School bus owned/operated by nonpublic school must meet or exceed federal and state motor vehicle safety standards	Student/Staff Safety	no
289.1101-289.8111	Food Law	School Operations - Student/Staff Safety	no
324.8316	Notice of pesticide application at school or day care center	Student/Staff Safety	no
324.21102	Underground storage tank registration	School Operations - Building Safety	no
333.9105	Health examinations/services provided on equal basis	Student Health	no
333.9155	Concussion education	Student Health	no
333.9208	Immunizations	Student Health	no
333.17609	Licensure of school speech pathologist	Student Health	no
380.1135	Student records	Accountability	yes
380.1137a	Release of student information to parent subject to PPO	Accountability	no
380.1151	English as basic language of instruction	Educational Requirements	no
380.1166	Constitution and governments mandatory courses	Educational Requirements	no
380.1177—380.1177a	Immunization statements and vision screening	Student Health	yes
380.1179	Possession/use of inhalers and epinephrine auto-injectors	Student Health	no
380.1230—380.1230h	Required criminal background check by State Police/FBI; unprofessional employment history check; registered educational personnel	Student/Staff Safety	yes
380.1274b	Products containing mercury; prohibit in schools	Student/Staff Safety	no
380.1233	Teaching or counseling as noncertificated teacher ; special permits	Educational Requirements	no
380.1296	Scope of auxiliary services	Educational Requirements	no
380.1305	Bomb threat; search by untrained employee	Student/Staff Safety	no
380.1312	Corporal punishment	Student/Staff Safety	no

(1) Compiled October 2014 by Library of Michigan Reference Staff

NONPUBLIC MANDATES [1]

MCL / RULE	DESCRIPTION	CATEGORY	DELIVERABLE
380.1473	Manner of providing college-level courses	Educational Requirements	no
380.1531—380.1538	Teacher certification and administrator certificates	Educational Requirements	yes
380.1539b	Notification of conviction of listed offense	Student/Staff Safety	yes
380.1561	Compulsory school attendance	Educational Requirements	no
380.1578	Attendance records	Accountability	yes
388.514	Postsecondary Enrollment options	Educational Requirements	yes
388.519—388.520	Postsecondary Enrollment Act information and counseling	Educational Requirements	no
388.551—388.557	Private, Denominational & Parochial Schools Act	School Operations	no
388.851—388.855b	Construction of school buildings	Building Safety	no
388.863	Compliance with federal asbestos building regulation	Building Safety	no
388.1904	Career and technical preparation program; enrollment; records	Educational Requirements	yes
388.1909—388.1910	Career and Technical preparation information and counseling	Educational Requirements	no
408.411—408.424	Workforce Opportunity Wage Act (minimum wage)	School Operations	no
408.681—408.687	Playground Equipment Safety Act	Student/Staff Safety	no
409.104—409.106	Youth Employment Standards Act; work permits in student files	School Operations	no
423.501—423.512	Bullard-Plawecki Employee Right to Know Act (employee files)	School Operations	no
445.81	Social Security number privacy	School Operations	no
600.2165	Nondisclosure of student records by school personnel	Accountability	no
722.112	Child care organizations	School Operations	yes
722.115c	Child care organization criminal history and criminal background checks	Student/Staff Safety	yes
722.621—722.638	Child Protection Law	Student/Staff Safety	yes
R 205.74	Collection of retail sales taxes	School Operations	no
R 257.955	Annual school bus inspections	Student/Staff Safety	no
R 285.637	Pesticide use	Student/Staff Safety	no
R 289.570.1—289.570.6	Food establishment manager certification	School Operations	no
R325.70001—325.70018	Bloodborne Pathogens	Student/Staff Safety	yes
R340.281	Transportation of nonpublic school children	School Operations	yes
R340.293	Notification to district of auxiliary services needed	Educational Requirements	no
R340.484	Boarding school requirements	School Operations - includes aspects of all categories	no
R390.1146	Mentor teachers for noncertificated instructors	Educational Requirements	no
R390.1147	Certification of school counselors	Educational Requirements	no

(1) Compiled October 2014 by Library of Michigan Reference Staff

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF EDUCATION
LANSING

MICHAEL P. FLANAGAN
STATE SUPERINTENDENT

October 27, 2014

MEMORANDUM

TO: Members of the Michigan House and Senate Appropriations Subcommittees on Education, House Fiscal Agency and Senate Fiscal Agency

FROM: Susan Broman, Deputy Superintendent
Office of Great Start

SUBJECT: Annual Education Report (P.A. 252 of 2014)

Pursuant to P.A. 252 of 2014, which included appropriations for the Department of Education including section 1001, the Michigan Department of Education (MDE) prepared this report to meet the requirements of the section.

For additional questions, please contact the following MDE staff by email:

Benjamin J. Williams
Legislative Liaison
Michigan Department of Education
Williamsb7@michigan.gov

To contact by telephone, please call the MDE Public and Governmental Affairs Office at (517) 241-4395.

608 WEST ALLEGAN STREET • P.O. BOX 30008 • LANSING, MICHIGAN 48909
www.michigan.gov/mde • (517) 373-3324

P.A. 252 of 2014, which included appropriations for the Department of Education includes section 1001, which requires the following: By November 1, 2014, the department shall submit a report to the house and senate appropriations subcommittees on the department of education budget and the house and senate fiscal agencies on the number of eligible child care providers by type receiving payment for child care services from the department on October 1, 2014.

Boilerplate Section 1001

Number of eligible child care providers by type receiving payment for child care services from the department on October 1, 2014.

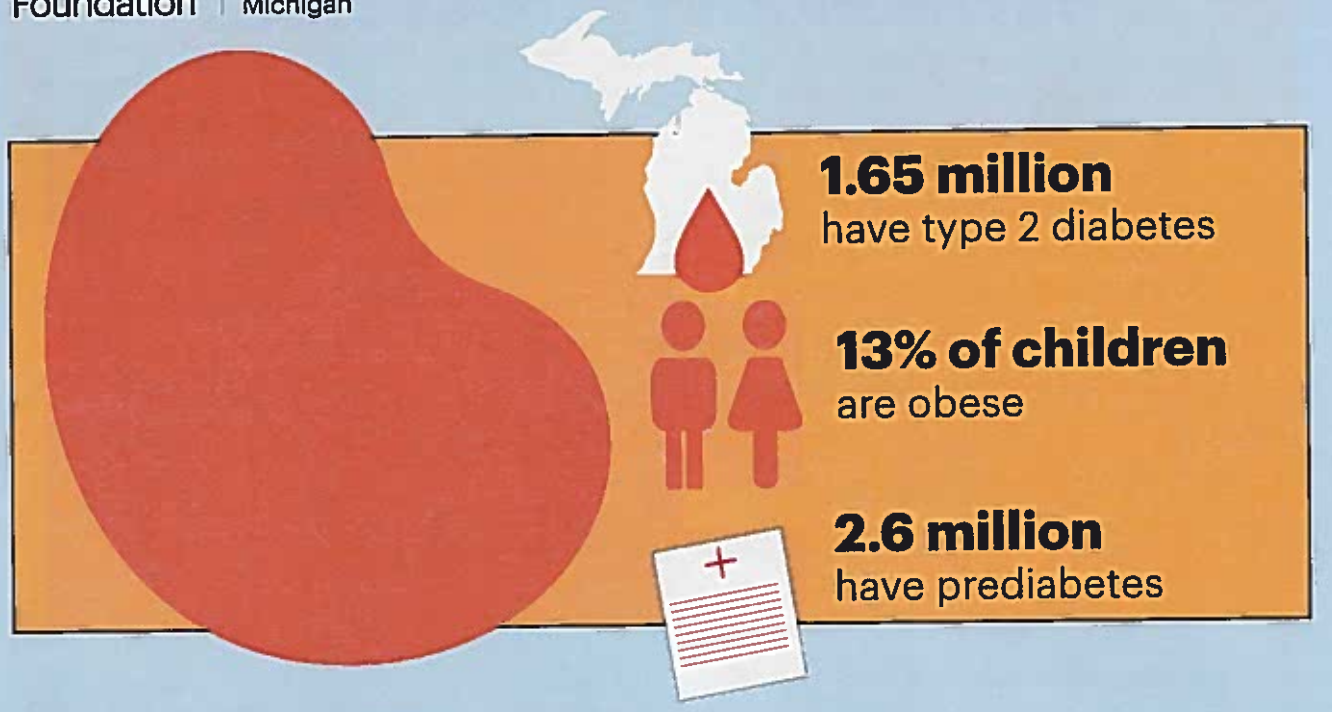
CDC Providers Receiving Payment
First Major Payroll Run in FY 2015
(Oct 2, 2014)

Provider Type	Distinct Providers
Child Care Center	1,008
Group Child Care Home	767
Family Child Care Home	810
Unlicensed Child Care Provider	0*
Center Located On Federal Land	5
TOTAL	**2,590**

**Payments for care provided by Unlicensed Child Care Providers are made the parent of the children in care (CDC client). 3,078 parents received a CDC payment to reimburse their approved, unlicensed child care provider on October 2, 2014.*

National Kidney Foundation® of Michigan

2016 -2017 Michigan Guide for Policy Makers and Stakeholders



1.65 million
have type 2 diabetes

13% of children
are obese

2.6 million
have prediabetes

Over 2 million

projected cases of **diabetes** in 2030 at current pace

Take action, support solutions:

National Kidney Foundation® of Michigan

www.nkfm.org
800-482-1455

CHARITY NAVIGATOR ★★★★ Four Star Charity

Only 1% of charities receive 4 stars from Charity Navigator 9 years in a row.

Preventing Diabetes and Kidney Disease Saves Money, Saves Lives

RECOGNIZED BY THE CDC
TO PREVENT OR DELAY TYPE 2 DIABETES

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

The Cost of Diabetes to Michigan

$7.2 billion
Diagnosed type 2 diabetes

$1.1 billion
Prediabetes

$1 billion
Undiagnosed type 2 diabetes

National Kidney Foundation of Michigan

www.nkfm.org
800-482-1455

CHARITY NAVIGATOR ★★★★ Four Star Charity

Only 1% of charities receive 4 stars from Charity Navigator 9 years in a row.

The NKFM is leading the charge against diabetes and kidney disease

The Diabetes Prevention Program at the NKFM serves 1000 adults with prediabetes each year:

188 » Prevented 188 #NewCases of type 2 diabetes

11,000 » Participant #PoundsLost

80 » 80 fewer patients using #BPLowering medication

40 » 40 fewer patients using #LipidLowering medication

6.1 » Reduced participants' #BodyWeight by 6.1%

$2,650,000 »

$2,650,000 Net Savings in healthcare costs*

* Outcome data based upon 1258 NKFM DPP participants. Cost data is over 15 months. Centers for Medicare and Medicaid Services (CMS) All other references available upon request.

NKFM reached last year:

{programs}		{public events}		{public education}
80,000	»	18,000	»	25,000,000

National Kidney Foundation® of Michigan

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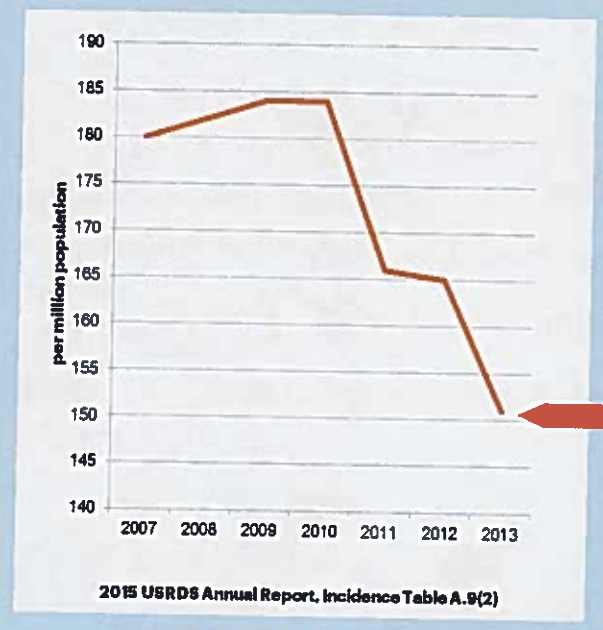
800-482-1455

CHARITY NAVIGATOR ★★★★ Four Star Charity

Only 1% of charities receive 4 stars from Charity Navigator 9 years in a row.

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



2015 USRDS Annual Report, Incidence Table A.9(2)

Diabetes Prevention Program
- Serving 1,000 annually
- Saving $2,650,000

Personal Action Toward Health (PATH) Program and Diabetes PATH
- 823 served in FY 2016
- Saving $1.7 - $1.89 Million

EnhanceFitness
- 2,586 served in FY 2016
- Saving $1.4 - $1.9 Million

4,667 people served annually in Michigan
$6,442,900 cost savings in Michigan

Incidence of end stage kidney disease in Michigan is on the decline. From 2010 to 2013 alone, this decline has resulted in a healthcare cost savings of **$2,568,000**.

For the 9th consecutive year, the National Kidney Foundation of Michigan (NKFM) has been recognized for its sound fiscal management and performance by receiving the coveted 4-star rating from Charity Navigator.

- Charity Navigator is the leading charity evaluator in America and only gives the 4 out of 4-star ratings to 25% of the charities it evaluates.
- Only 1% of these charities have received the prestigious 4-star rating for nine consecutive years.
- At a 98.5 rating, the NKFM is in the upper 1% of all nonprofits in America.

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

National Kidney Foundation of Michigan

www.nkfm.org
800-482-1455

CHARITY NAVIGATOR Four Star Charity

Only 1% of charities receive 4 stars from Charity Navigator 9 years in a row.

State programs to prevent and manage diabetes and kidney disease serve almost 80,000 Michiganders annually.

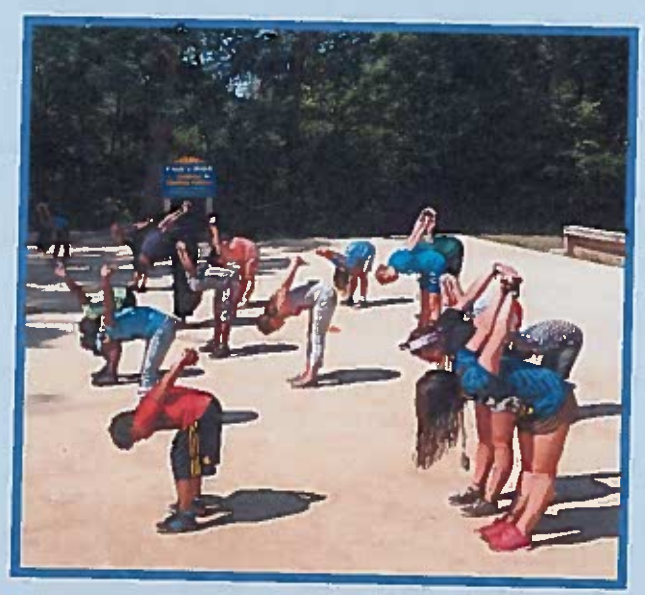
NKFM Kids Programs

Children learn how to eat healthy and adopt positive physical activity habits.

Regie's Rainbow Adventure® teaches preschool-aged children healthy living through a storybook hero named Regie.

Healthy Families Start with You educates parents and kids in preschool programs how to make healthy lifestyle changes.

PE-Nut (Physical Education and Nutrition) motivates youth and parents to be physically active and eat healthier by presenting simple, consistent nutrition and physical activity messages to elementary age youth.



Kids Camp is designed to provide an opportunity for kidney patients between the ages of 8 and 16 to experience a week away at camp with their healthy peers. Medication compliance, diet and a positive attitude all result from this experience.

Nutrition And Physical activity Self-Assessment for Child Care (NAP SACC) is an intervention for early childhood educational settings that is aimed at improving nutrition and physical activity environments, policies and practices through self-assessment and targeted technical assistance.

National Kidney Foundation® of Michigan

www.nkfm.org
800-482-1455

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State programs to prevent and manage diabetes and kidney disease serve almost 80,000 Michiganders annually.

NKFM Adult Programs

Empowering people with kidney disease through programs and services.

Peer Mentors can help empower kidney patients to move forward with their lives after being diagnosed with kidney disease.

The Luann Scheppelmann-Eib Emergency Fund provides a one-time help of up to $100 for the urgent needs of people with kidney disease.

CKD Intern Program provides part-time employment (2-8 hours a week) with an NKFM office for people living with chronic kidney disease.

Kidney PATH provides an accountable and supportive environment to learn new techniques to manage a variety of problems associated with kidney disease.

Worksite Wellness Initiatives create a healthy environment at work, encouraging employees to make healthy habits at work and at home.

Community Coalitions are formed with NKFM support by representatives from key community stakeholders to improve the community's health and well-being.

Managing chronic conditions saves money and improves quality of life.

Personal Action Toward Health (PATH) helps adults to navigate the health care system and manage chronic conditions. Specific programs include:

- **Cancer Thriving and Surviving (CTS)**
- **Building Better Caregivers**
- **Chronic Pain PATH**
- **Diabetes PATH**

Enhance Fitness is a physical activity class for those with chronic conditions.

Healthy Hair Starts with a Healthy Body* and **Dodge the Punch: Live Right*** provide health information to African American adults through their salon stylist or barber.

Diabetes Self Management Education (DSME) teaches people with diabetes the skills to manage their condition and prevent complications.

Diabetes Prevention Program is a year long lifestyle change program that brings the proven success of the diabetes prevention clinical trial to people in communities around the country.

Health Matters is a collaboration between academia and community-based organizations that aims to improve health of people with developmental disabilities.

Walk with Ease provides information on physical activity and is proven to reduce the pain of arthritis and improve overall health.

A Matter of Balance is an evidence-based program designed to reduce the fear of falling and increase activity levels of older adults who have concerns about falls.

National Kidney Foundation® of Michigan

www.nkfm.org
800-482-1455

Silver Key Coalition

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

House Appropriations Subcommittee on Health and Services

February 27, 2017
Testimony for the Silver Key Coalition

My name is Katie Cahill and I am the Advocacy Specialist at the Area Agency on Aging 1-B serving Livingston, Macomb, Monroe, Oakland, St. Clair and Washtenaw counties. I am speaking to you today with my Coalition colleagues from across the state as the Advocacy Committee Chair of the Silver Key Coalition, which was founded to advocate for state support for non-Medicaid senior in-home services provided through the Aging and Adult Services Agency (AASA).

The Silver Key Coalition is made up of more than 45 service agencies that deliver key in-home services such as meals on wheels, personal care, housekeeping, chore, and caregiver respite that help physically frail older adults remain living independently in their homes for as long as possible.

The Coalition was pleased to hear the Governor state his support for making Michigan a no-wait state in his State of the State address. We support the Governor's proposed funding increase of $3.6 million, which includes a $1.5 million increase for home delivered meals and $2.1 million for other in-home services. This increase, in addition to the $2.5 million appropriated in FY 2017 will enable the aging network to serve the 6,800 older adults that were waiting for in-home services at the end of FY 2016.

AASA in-home services offer a great value to seniors and taxpayers. Seniors who have limitations in their ability to perform necessary activities of daily living and cannot afford to pay for needed services at private market rates often end up costing more in health and public services when their health declines. A recent study in southeast Michigan found that those who languished on wait lists and never got help were five times more likely to enter a nursing home than their counterparts who went on a wait list but did receive services. They also had a much higher mortality rate and they extracted a significant burden on their family caregivers.

While this funding increase would enable the aging network to serve the older adults currently waiting for services, it is important to note that the aging network will face a number of challenges in coming years and further investment will be needed to support continuing growth in demand for in-home services due to population growth, and to address the shortage of direct care workers, who are essential to maintaining service quality.