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Testimony --- Emergency Shelter Program Requesting $4 per diem increase

I am here to speak on behalf of ESP funded shelter providers. The examples I will give, while from the shelter I work at, are to demonstrate that shelters provide a lot more than a "hot and a cot" also known as a meal and a bed. My name is Elizabeth Kelly and I am the Executive Director of HOPE. We operate two shelters in Pontiac in Oakland County but do not restrict shelter access to any particular city or county....anyone experiencing homelessness is welcome. HOPE Adult Shelter is the only low barrier emergency shelter in Oakland County. We serve both men and women and the facility has 62 beds. Our second shelter, HOPE Recuperative Care Center, is the first "medical respite" type of shelter in Michigan. This facility serves 15 medically complex homeless individuals who are "discharged to home" from an inpatient hospital setting but have no home to go to. HOPE Recuperative is a respectful place for them to begin the healing process.

I want to begin by stating how much we truly appreciate your support of the $4 per diem increase that we are now receiving through our Emergency Shelter Program grant. This was the first increase in this grant in more than a decade, and this welcome raise in our per diem has been critical to helping a small agency like HOPE better make ends meet.

I'd like to share with you what this increase of $4 a night per guest means to a small agency like HOPE. When an individual comes to one of HOPE's shelters, they receive shelter, meals, case management and overnight shelter in a bed with linens, three meals, case management, nursing care, and onsite services and coordination with mental health providers, housing providers and primary care. In other words, we are not just a place to flop for the night. We are a place where safe shelter becomes the vehicle for resolving the individual's homelessness once and for all. We operate these two shelters 24/7/365 days a year with 29 staff serving approximately 650 unique individuals annually on an annual budget of $750,000.

HOPE's staff are college educated and are social workers, nurses, and other human service professionals. Preserving the individual's dignity through trauma informed care while we are working with them is our overriding priority.

Your support of the $4 increase has allowed us to finally provide this hard-working college educated staff, some with advanced degrees, with a modest raise. Most have been making $12 per hour since they came to HOPE. They understand the economic challenges experienced by HOPE's guests because they, too, struggle financially.

The population we serve includes individuals who are chronically homeless, those with serious and persistent mental illness, some struggling with substance abuse, military veterans with PTSD including those from the Viet Nam War, those fleeing domestic violence, some experiencing sudden economic hardship through job loss and/or medical catastrophe and as well as those who are just simply poor and undereducated with few job prospects.

We understand the poverty that HOPE's guests experience as we stretch a dollar to the max to ensure we meet our mission to shelter and resolve the homelessness of those who cross our threshold . HOPE is involved in advocacy that will help an individual more expediently resolve homelessness. We provide pest control, clothing, shoes/boots, hygiene items, adult diapers, socks, underwear. Our water bills alone run more than $1000 a month for showers and laundry for this large number of guests that we house. Because we operate 24/7/365 we provide round the clock supervision and guidance. We help guests with everything from literacy training to finding an apartment. We stretch our meager staffing with social work interns and community volunteers. On dangerously cold weather emergency days, often I must abandon my executive director duties to provide additional staffing to those following our recommendations to shelter in place. We are that pressed to fund appropriate staffing. Yet another small increase in the per diem can yield greater results that put Michigan on the path of resolving homelessness.

We are hoping you will consider another $4 increase to our per diem in the budget you are now considering. This will translate into an increase of just under $100,000 to HOPE's budget. Yet the impact of that modest increase to what we

and other shelters can do to expeditiously resolve the homelessness of those we serve will be a bargain for Michigan's taxpayers. With an additional increase in the per diem of $4, HOPE can add a second case manager which will allow shelter guests to have more intensive navigation and case management which should result in quicker resolution of their homelessness.

This requested increase in the per diem will allow us to create critically needed post housing supports such as healthy leisure groups to help individuals through the transition from homelessness to housed. Often folks are inexperienced tenants, or don't know how to establish healthy friendships. Defaulting to old ways often results in a repeat of homelessness, which is more expensive to Medicaid and the healthcare system, more expensive to the mental health system with failed housing increasing the individual's cost to "the system" including increased risk of incarceration and hospitalization.

Lastly, this requested increase in the per diem is an investment that will allow HOPE to add a staff to all shifts at HOPE's shelters. This doesn't sound like a lot, but this results in better management of guest needs which should translate into more served with shortened length of stay....which puts us more solidly on the path of resolving homelessness in Michigan, and restoring the value of each of these individuals as productive citizens of our state.

On behalf of all those experiencing homelessness in Michigan and the agencies who serve them, I thank you for considering our request to increase the Emergency Shelter Program grant funding by an additional $4 in the next budget. I thank you for the raise that you provided us this year which helps us tremendously with staff retention of experienced staff.

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MHA Michigan Health & Hospital Association | Leading Healthcare

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

From: Terry Lerash, president and CEO, Scheurer Hospital, Pigeon, Michigan

Date: March 1, 2018

Re: FY 2019 Health and Human Services budget

Scheurer Hospital is located at the tip of the Thumb in Huron County. We are designated as a critical access hospital, with 25 inpatient beds, a full-time emergency department and robust outpatient services. Scheurer Hospital employs 485 employees including 15 physicians, operates four primary care clinics and four pharmacies. We also operate a set of elder care services, including independent living, assisted living, and long term care facilities with 98 seniors in residence.

For several years, the Michigan Legislature has funded a special pool of money for small and rural hospitals, including the more recent addition of a second pool for small and rural hospitals that are still doing labor and delivery services. Together these special funding sources have made a dramatic difference in the sustainability of small and rural hospitals in Michigan.

Unfortunately, due to the requirements of the federal Medicaid Managed Care rule and the adjustment that was necessary to some hospital payments, these traditional pool payments cannot continue as they have in the past and must be redesigned. The changes needed are detailed and nuanced, but in short, to continue these payments to Michigan's small and rural hospitals, including those payments for labor and delivery services, the state is limited to using general funds. On behalf of Michigan's small and rural hospital community, I am requesting an additional $3 million in state funding for fiscal years (FYs) 2018 and 2019 to help offset the adjustment to the pool payments due to the federal rule change.

In FY 2018, roughly $14 million in general fund was left unmatched. After working with the State Budget Office, another $7 million of general fund was added for FY 2018. The Governor's executive budget recommendation extends all of this into FY 2019. When combined with the growth in provider tax payments, the additional funding will come close to maintaining FY 2017 payment levels for Michigan's small and rural hospitals, funding that is critical to the health of Michigan communities and ensures patients have access to care when and where they need it.

As a beneficiary of the small and rural pool, we are able to bring programs to our schools to create a new generation of healthy kids. One example is our 5-2-1-0 program, which we have implemented in three school systems to encourage our youth to pursue healthier lifestyles. We teach them the benefits of consuming five fruits and vegetables every day, no more than two hours of electronic exposure per day, a minimum of one hour of physical activity per day, and zero consumption of sugar-based drinks. We are committed to not only serving our constituents when they are sick or injured, but getting them to a more active and healthier state. Maintaining a steady source of funding allows us to continue these unreimbursed programs into the future.

Caring for our community also means caring for our region. At Scheurer, we do not deliver babies. We depend on the hospital in Bad Axe. If Huron Medical Center were to drop labor and delivery services, that's a crisis for our community. That hospital's obstetrics program serves the entire Thumb. We can send young women more than an hour away to do their delivery, but we shouldn't be forced to do that. And without a place to do labor and delivery, it is hard to keep obstetricians and gynecologists. More distance to those specialists endangers access to prenatal care, even while we urge our pregnant moms to do everything they can to keep all prenatal visits.

We are fully aware of the challenges facing Michigan with regard to limited state resources, the need for road funding, the desperate problem we have with opioid addiction, the challenge of water contamination, and Michigan's effort to stay economically competitive by growing and keeping our talented young people and workforce. However, without the sustainable funding that the small/rural pool brings to places like Scheurer Hospital, we can't do the kind of work that improves the health of our community and ensures access to care, which is the fundamental reason our healthcare costs will eventually decline. Please do what you can to complete our funding for fiscal years 2018 and 2019 by incorporating the last $3 million into our line item for each year.

If you have any additional questions about this request, please contact Chris Mitchell at the MHA at cmitchell@mha.org or (517) 703-8622.

Testimony to House DHHS Appropriations Subcommittee, March 1, 2018
Mark Reinstein, Mental Health Association in Michigan

Representative Canfield and Members of the Subcommittee –

I'm Mark Reinstein, representing the Mental Health Association in Michigan, the state's oldest advocacy organization for persons experiencing mental illness. I also speak today on behalf of several other prominent organizations that are listed at the end of my testimony. Thank you for the opportunity to make comment.

We are concerned about the potential problem of lost Medicaid revenue for the Community Mental Health system due to beneficiaries not being categorized as Disabled, Aged, or Blind. The department, the PIHPs, and the CMHSPs don't appear to be in full agreement about what is taking place. It is critical that you carefully review the situation and determine if it needs remedial attention. On top of the recent CMH non-Medicaid funding cuts, it would be dangerous if Medicaid revenue were now being lost and threatening services.

My remaining testimony will be devoted to the vital issue of access to medications within Medicaid, more specifically: Access to timely, effective medication services for vulnerable, high-risk populations. This has been a point of varying attention in Michigan for the past 16 years. My two "asks" today, after providing some historical background, are retention of budget section 1875 and modification of section 1867.

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

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

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

During the post-2004 years, advocates also found the department unwilling to engage in meaningful negotiation about this issue. There was one very brief exception 7-8 years ago

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

That brought us to 2015 and the new, so-called "common formulary" for Medicaid HMOs. Since it began, the department has continued to protect by policy access to mental health, epilepsy, and HIV-AIDS drugs, but management of drugs for cancer had been primarily transferred to the HMOs at some point post-2004.

Advocates next asked the Legislature for budget boilerplate protection in all of Medicaid for FY-17. The Legislature responded by giving that protection to mental health, epilepsy, and organ replacement therapy. The Legislature continued that protection for FY-18 in budget section 1875. Now, we respectfully ask for continuation of the boilerplate for FY-19. We do this because the department is interested in amending the 2004 statute in a way it projects could save some money, and we are interested in amending the law so that mental health, epilepsy, HIV-AIDS and organ replacement therapy are protected in statute across all of Medicaid, something that was endorsed by the department's Section 298 Workgroup, which included three department deputy directors. Senator O'Brien has introduced a bill (SB 823) that would fulfill what the advocacy community seeks. With these statutory possibilities in the mix, and with the psychotropic drug work group called for in section 1867 not yet started, we think the current boilerplate protections need to remain for at least another year.

And with further regard to section 1867, this exists for FY-18 and would continue next year under the Governor's proposed budget. The language calls for a workgroup of psychiatrists, other mental health prescribers, and pharmacists to develop a psychotropic drug "protocol" (undefined). I've been involved with efforts like that before, such as a multi-year project funded by the Flinn Foundation, and if anyone thinks this will result in a narrow, highly specific, one-size-fits-all formulary, I think they're going to be disappointed.

The language also implies there will be changes to the way things are done now and that those changes will be implemented – assumptions we shouldn't make – and it doesn't call for any consumers, family members, or advocates to be on the workgroup (a major omission, as these are the parties directly affected by decisions made in Lansing). Attached to my testimony is a suggested revision of sec. 1867 for FY-19.

In closing, I've been asked why Medicaid beneficiaries should get drug access protections that are often unavailable to the privately insured. The advocacy community would welcome doing for private insurance what has been done in Medicaid the past 14 years. We would gladly work with you on that. Additionally, with Medicaid enrollees, we're dealing with a population where the level of mental illness dwarfs what it is for the rest of the population. It's an opportunity to connect with a large mental illness sub-population, one in which we know who they are and where they are. According to the Kaiser Family Foundation, 35% of Medicaid adults have chronic mental illness, compared to 5% or less of the adult American population. Looking at this from another angle, Kaiser says Medicaid enrollees account for 21% of all national adult mental illness, 26% of adult serious mental illness, and 17% of adult substance use disorder. It would be negligent of us not to intervene with such a high-mental illness sub-group. In fact, it can be argued that many Medicaid beneficiaries wouldn't be in the program if not for debilitating mental illnesses.

Thank you for your thoughtful consideration of our views.

Budget Section 1867, Recommended Revisions for FY-19

(1) The department shall continue a workgroup that includes psychiatrists, other relevant prescribers, ~~and~~ pharmacists, **and mental health service consumers and their family members and advocates,** to identify best practices ~~and to develop a protocol for~~ **in the prescribing, efficacy, safety, and care continuity, including successful regimen maintenance, of** psychotropic medications. ~~Any changes proposed by the workgroup shall protect a Medicaid beneficiary's current psychotropic pharmaceutical treatment regimen by not requiring a physician currently prescribing any treatment to alter or adjust that treatment.~~

(2) By March 1 of the current fiscal year, the department shall provide the workgroup's recommendations to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget office.

(3) The department shall not institute changes attributed to the report to Medicaid psychotropic policy without the approval of the full legislature.

Organizations Endorsing This Testimony

The Arc Michigan
Association for Children's Mental Health
Community Mental Health Association of Michigan
Epilepsy Foundation of Michigan
Mental Health Association in Michigan
Michigan Disability Rights Coalition
Michigan Partners in Crisis
Michigan Protection & Advocacy Service
Michigan Psychiatric Society
National Alliance on Mental Illness – Michigan
National Association of Social Workers – Michigan
State of Michigan Behavioral Health Advisory Council

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Ronald Kimball, President Sherri Boyd, Executive Director, CEO

2/28/18

Re: Comments on Governor Snyder's proposed budget from The Arc Michigan

The Arc Michigan, our 29 local chapters and thousands of members have the following comments expressing our disappointment at the lack of responsiveness in the Governor's Budget to these items:

- The ongoing crisis in enlisting and maintaining a competent work force to support very vulnerable persons served through the public Mental Health system. We are dismayed that there is no coordination to follow-up on the minimal $0.50 increase provided in the current year. Turnover rates of 40-50% and an inability to compete with fast food and big box store employers are creating a terrible shortage of those who are the most important to persons with disabilities, direct care workers. Please address this current crisis.

- Some of our most vulnerable citizens with developmental disabilities or mental illness are practically abandoned, as a result of the shortage of General Funds allocated to the CMHSPs. For persons who would be Medicaid eligible for part of the month (spend-down), those who receive Social Security benefits prior to becoming eligible for SSI, or those who have difficulty qualifying for Medicaid prior an emergency, there are precious few resources to assist. The Constitutional and Mental Health net populations are in severe and current jeopardy. Please restore sufficient General Fund dollars to address this issue.

- While also somewhat complex, the reduction in funding for CMHSPs which continues to increase as a result of changed characteristics of eligibility for Medicaid. Those, whose eligibility had been under the Disabled, Aged, and Blind (DAB) category but, for some reason, need to be re-enrolled in Medicaid and are being enrolled under Healthy Michigan. The state contribution to the Mental Health system then drops by about $200 for the same individual. It should be noted, that for those non-mental health staff that have responsibility to enroll individuals, it is easier and more efficient to enroll them under Healthy Michigan than the DAB program. Over time this has resulted in reductions to the CMHSP system of many millions of dollars and is only growing. Please help solve this reduction in funding for critical supports.