DCH SC 3-4-13 1-2
Tina Reynolds

March 4, 2013

House Members
Department of Community Health
Appropriation Subcommittee

On behalf of the Safe Homes/Safe Kids: Michigan Alliance for Lead Safe Housing (MIALSH) coalition we thank you for your time and attention. Our coalition has members throughout the state and includes health departments, lead contractors, small business owners, homeowners, parents of lead poisoned kids, landlords, and other service providers. Our coalition works to end lead poisoning in the state and is before you today to restore funding so we can make homes lead safe for families with a lead poisoned child.

MIALSH appreciates your past support . In FY2013, a $2 million line item for lead abatement was added and approved by wide margins in the House and Senate. Unfortunately, these dollars were vetoed by Governor Snyder over concerns with the revenue stream identified.

Building on this momentum, our coalition is before you once again in the FY 2014 budget cycle. The funding for lead poisoning prevention has eroded further this past year. The bulk of lead funding comes from federal Housing and Urban Development (HUD) and Centers for Disease Control (CDC). These federal fund sources have been cut drastically forcing most local health departments to cede lead program work to the state.

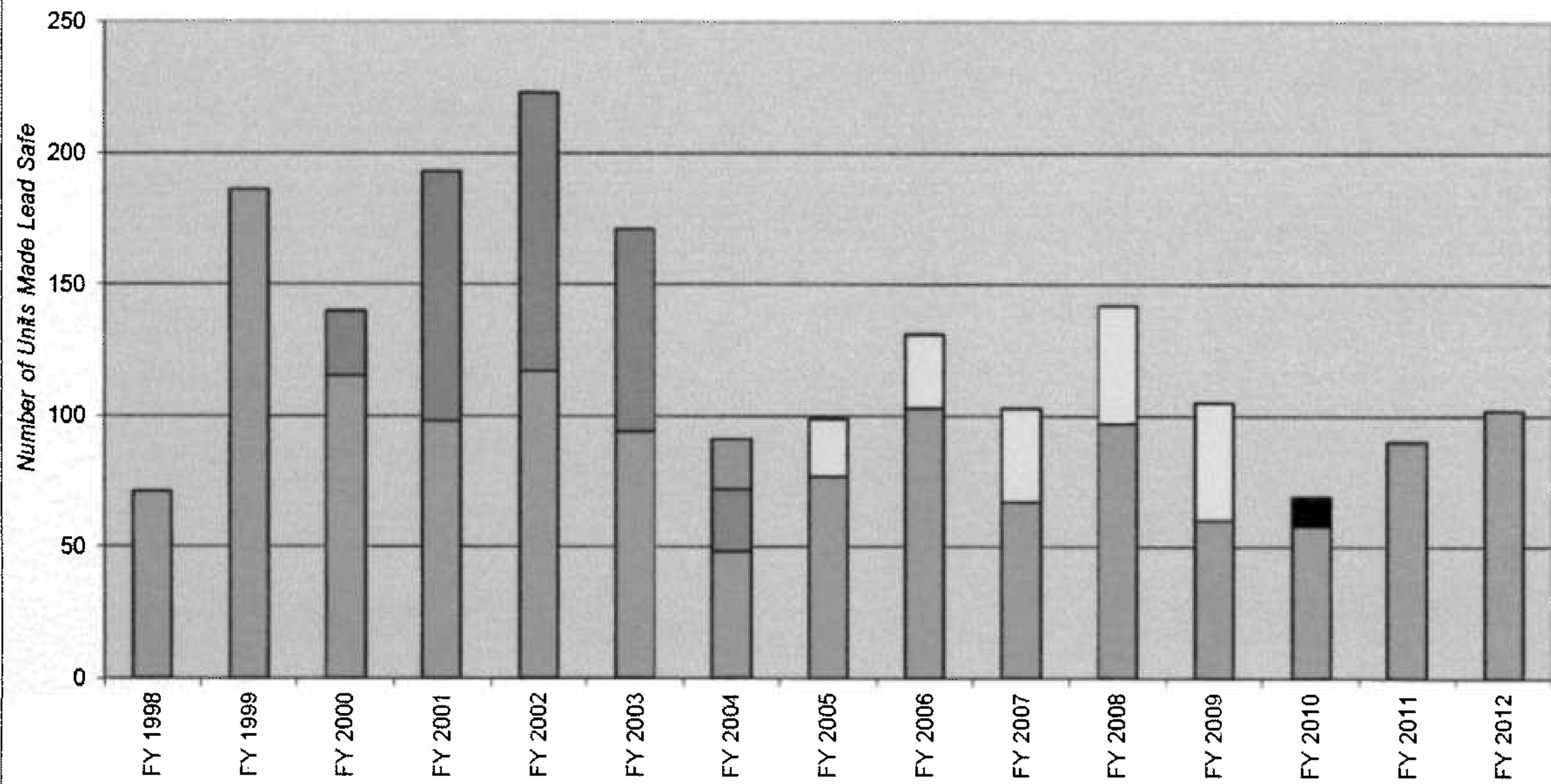
You can help turn this tide. $2 million additional state dollars will help make homes lead safe for poisoned children and eliminate the current wait list of families. We are asking for your support again this budget cycle. We understand dollars are tight but MIALSH strongly believes and studies prove, that preventing lead poisoning will increase school performance, decrease aggressive behaviors that lead to incarceration, increase earning potential, and decrease medical expenses. These are dollars well spent putting contractors to work in your districts and helping keep families safe. The attached graphs show the declining fund history and units made lead safe by past lead abatement dollars.

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

Michigan Department of Community Health, Healthy Homes Section, Lead Safe Home Program Units Made Lead Safe

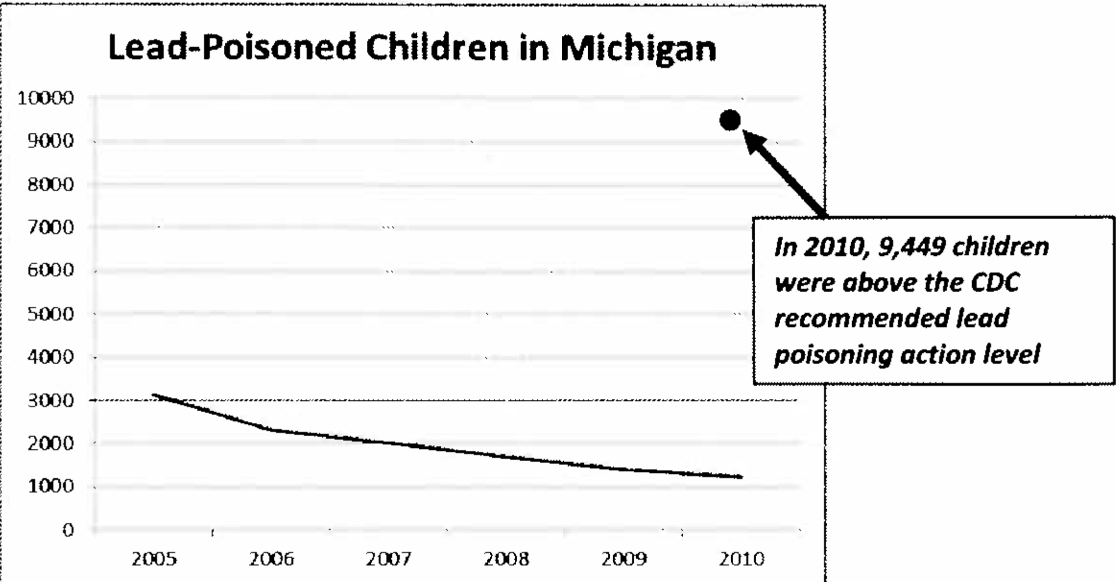


Fiscal Year (Oct 1 to Sep 30)

1916 Units Made Lead Safe to Date (rev. 1/2013)

Childhood Lead Poisoning in Michigan: A Snapshot

***THE GOOD NEWS*: The number of lead-poisoned children in Michigan is going down ...**



Source: Michigan Department of Community Health, Childhood Lead Poisoning Prevention Program

Studies link Childhood Lead Poisoning to...

- Lowered IQs
- Lowered academic achievement
- Increased attention deficit-hyperactivity disorder (ADHD) and autism
- Increased violent behavior in young adults
- Other cardiovascular, immunological, endocrine, and behavioral defects

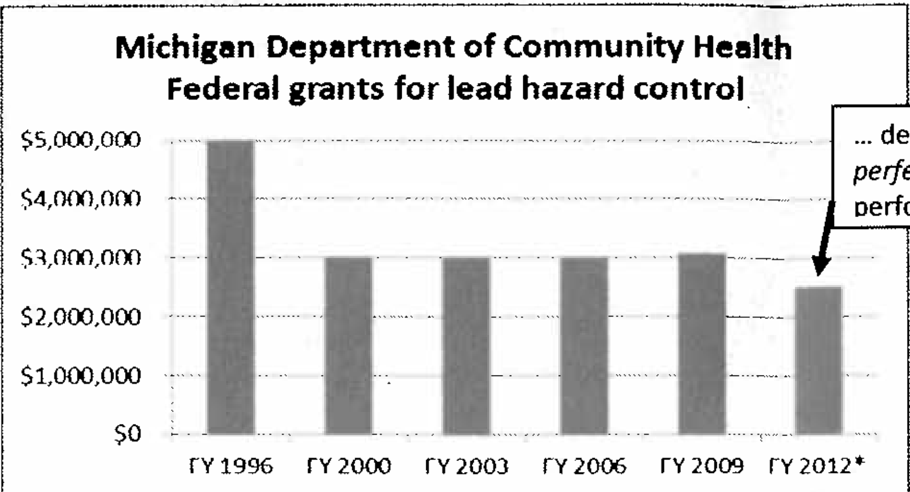
... Collectively it costs Michigan <u>$4.85 billion per year</u>.

Source: Michigan Network for Children's Environmental Health, "The Price of Pollution", June 2010.

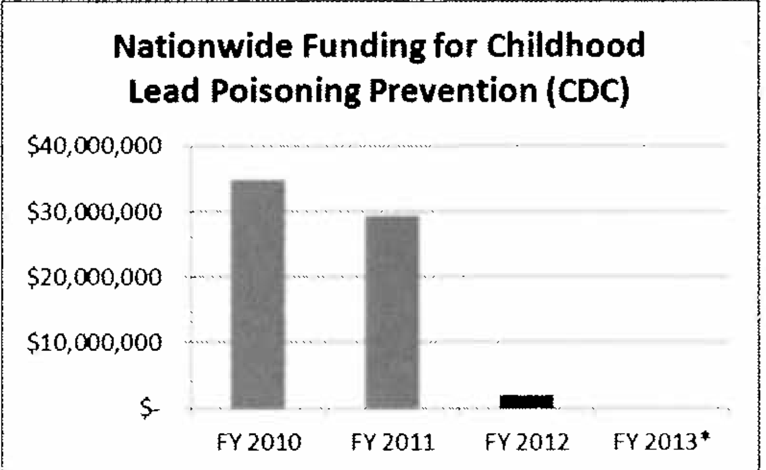
What we need:

- **Sustainable Funding** to identify and remove lead hazards in paint, dust, soil ***before*** children are poisoned
- **Blood Lead Screening** to identify young children already lead-poisoned
- **Partnerships** to promote and provide for lead-safe housing for young children and pregnant women

***THE BAD NEWS:* Funding for lead poisoning prevention continues to fall...**



Grant awards to the Michigan Department of Community Health for lead hazard control from the U.S. Department of Housing and Urban Development (HUD) . *FY 2012 amount pending acceptance of grant application.



Federal funding for the Centers for Disease Control and Prevention Childhood Lead Poisoning Prevention Program/Healthy Homes and Lead Poisoning Prevention Program. FY 2013 reflects current budget proposal.

Michigan Alliance for Lead Safe Housing

www.mileadsafehomes.org

The Source for Seniors

1279 CEDAR NE
GRAND RAPIDS, MI
49503-1378
Ph: 616.456.5664 Fx: 616.456.5692
1.888.456.5664
www.aaawm.org

TESTIMONY OF SUZANNE FILBY-CLARK, CARE MANAGEMENT SERVICES DIRECTOR FY 2014 MI CHOICE MEDICAID WAIVER BUDGET

MI Choice is a special Medicaid program that provides services in a person's home similar to those provided in a nursing home. Even though it's a Medicaid program, funding is capped at $282 million and that limits the number of clients that can enroll. There are 5,200 people on MI Choice waiting lists across the state. In the nine counties covered by AAAWM there are currently 168 people waiting, often for several months for MI Choice services. In FY 2012 54 individuals were placed in a nursing facility while waiting for MI Choice. 40 people died.

MI Choice Client Olive aged 62 worked at a variety of department stores and was at Marshall Fields for eighteen years before health complications forced to retire.
Blood clots and circulation problems in Olive's legs make walking difficult. A fight with shingles resulted in nerve damage and numbness in much of her left side. She now uses a walker or wheelchair to get around as too much activity causes hip pain.
Her care is mainly provided by her husband Dell, aged 71. He is a Navy veteran who has suffered three heart attacks and is currently in remission from bladder cancer.
Olive, an Allegan County resident, has been a Medicaid Waiver client since February 2009 and receives in-home services to help her remain independent. She has assistance for six hours per week to provide housekeeping, meal preparation, and laundry services, in addition to Care Management services. Other care needs are provided by her husband.
Her bathroom was remodeled to incorporate an accessible walk-in shower so she can shower without help again. "I've always been independent; it's been hard not to be able to do a lot for myself."
Without services through the Medicaid Waiver, Area Agency on Aging of Western Michigan and partner agencies, Olive says, "We would not be able to do it. We would have to move to a nursing home. This way we can stay home. **We would like to stay here as long as we can- this is our home, it is our home sweet home."**

Olive is just one example of the people that are waiting for services through MI Choice. For people like Olive and her husband Dell We support the Governor's budget request for $18 million additional dollars in FY 2014 to serve people on the waiting list and move more people out of nursing homes.

Who is eligible for MI Choice?

- Low-income adults of all ages who have disabilities significant enough to qualify for nursing home care.
- People already living in nursing homes if they want to leave and are able to live safely at home.

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

- Income can be no greater than 300% of the SSI level ($2,130/month in 2013), and liquid assets can be no greater than $2,000.

How does MI Choice operate?

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

Is MI Choice cost-effective?

- MI Choice costs an average of $52/day compared with an average nursing home cost of $172/day (2010 figures).
- MI Choice also transitions people on Medicaid living in nursing homes back to the community for a direct and immediate savings to the Medicaid budget. Michigan is a leader in nursing home transitions, with over 1,200 transitions accomplished in 2012. During the fiscal year 2012 179 individuals were transitioned from nursing homes to a community based setting with MI Choice services in our region alone. 62 individuals have transitioned since October first.

Nursing Facility Transition Client: Grace aged 85 was diagnosed with dementia in 2005 and was placed in Lakeview Nursing Home in July of 2008. Grace grew up attending Bristol Baptist Church; she played piano and was a Sunday school teacher. She is also the mother of 4 children and her main goal in life and joy was to raise her family. At the age of 32 she began work in a small factory near Jackson MI where she met her second husband, Ted. Married in 1971 they are going on 42 years together. When they lost their jobs the couple moved to Luther in Lake County.

Graces husband Ted also aged 85 was born and raised in Detroit and was a professional sign painter and artist. When Grace was placed in the nursing home Ted made the 20 mile drive from their home to the nursing home every day. For one year and 3 months he stayed with his wife 10 to 10 and a half hours a day seven days a week. He would arrive at about 9:00 am every morning and leave at about 8:00 pm. As Ted states "We've always been very close, so if shes gonna be there by golly I'm gonna be there with her". But he wanted her home with him. Grace was referred to the NFT program. The Nursing home agreed she would do better at home, but they needed to know she could be taken care of and Ted said "definitely, I can do it...I can do it." "She is now happy to be at home and closer to me, she knows people". Ted provides his wife's personal care and receives some supportive services through MI Choice including Respite care and Care Management services. There are so many things he is thankful for and having his wife with him in their home is top of the list. He also says "when I brought her home I am actually saving Medicaid a lot of money". "It is so much cheaper at home, there is no comparison".

The couple's son Carl adds "your agency has been a huge help. You guys provide a valuable service to people like my father and mother." "Tell the legislators that you guys really need your funds because it's important what you do for people."

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

- In addition to the difference in cost for Institutional care verses Home and community based care, according to a study done by Indiana University, a $10 million increase in MI Choice brings an additional $27 million in federal matching funds, creating 1,100 new jobs and returning $1.9 million in tax revenues to the state. MI Choice contracts with home health agencies among others to provide the direct hands on services adding jobs to support the need for workers in home health care.

Office of Services to the Aging (OSA) services. The Area Agency on Aging of Western Michigan also advocates for restoration of 8 million dollars in funding for services for older adults administered by OSA. This represents a restoration of funding cut from the OSA budget in fiscal years 2009 through 2011. OSA funded services are vital in helping older adults who do not qualify for MI Choice remain as independent as possible in the community and avoid unnecessary institutional placement.

BOTTOM LINE: PLEASE SUPPORT THE GOVERNOR'S REQUEST FOR AN $18 MILLION INCREASE IN THE MI CHOICE MEDICAID WAIVER (LINE ITEM CALLED "MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER")and RESTORE OSA FUNDING.

March 4, 2013

(616) 456-5664, fax (616) 456-5692, www.aaawm.org

MALA Michigan Assisted Living Association
The Leader in Advocacy, Education, and Resources for Providers

DCH SC 3-4-13 Robert Stein

March 4, 2013

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

Re: 2013-14 Department of Community Health Budget

Dear Representative Lori:

Michigan Assisted Living Association (MALA) appreciates the opportunity to provide testimony regarding services funded through the Department of Community Health (DCH) budget. Our organization's membership consists of 1,000 members providing supports and services to over 36,000 persons throughout the state. These persons include individuals with intellectual and developmental disabilities, mental illness, substance use disorders, traumatic brain injuries or physical disabilities and older adults.

Community Mental Health Funding

MALA urges this Subcommittee to support the executive recommendation regarding Medicaid funding for mental health services. It is our understanding that the executive recommendation is for a 1.25% funding increase to the Medicaid Specialty Prepaid Inpatient Health Plans (PIHPs). This increase is for the purpose of maintaining actuarially sound rates. The funding increase is also essential to preserving the health, safety and quality of life for tens of thousands of vulnerable Michigan citizens.

PIHP Consolidation

MALA supports the Department's new PIHP structure which will reduce the number of PIHPs from 18 to 10. This PIHP consolidation should result in more uniformity and consistency in the standards applied to the provider networks contracting with the PIHPs and the Community Mental Health Services Programs (CMHSPs). More generally, the PIHP consolidation is consistent with creating a more efficient public mental health system.

Medicaid Expansion

MALA supports the executive recommendation to expand Medicaid to cover individuals up to 133% of the federal poverty level. We recognize that there are several perspectives on the Medicaid expansion issue. However, from our organization's perspective, Medicaid expansion is important because it would provide health insurance coverage to an estimated 322,000 uninsured Michigan citizens in the first year. Medicaid expansion would also increase access to essential behavioral health services for persons who are not currently Medicaid eligible.

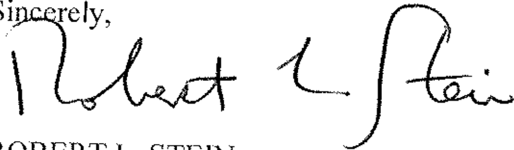
15441 Middlebelt Road • Livonia, MI 48154
(Phone) 800.482.0118 • (Fax) 734.525.2453 • www.miassistedliving.org

Medicaid Personal Care Supplement

MALA recommends a modest funding increase of $15.00 per month in the Medicaid personal care supplement that is received by adult foster care (AFC) and home for the aged (HFA) providers. The executive recommendations do not include a funding increase in the Medicaid personal care supplement. The current Medicaid personal care supplement funding level is $192.38 per month. This funding level has increased by only $18.00 per month since January 2001 or an average of less than 1% per year. The Medicaid personal care supplement funding is critical to the provision of services to persons with disabilities for whom AFC and HFA providers receive no mental health funding.

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
General Counsel

cc: Representative Rob VerHeulen
Representative Paul Muxlow
Representative Peter MacGregor
Representative Rashida Tlaib
Representative Brandon Dillon

Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

DCH SC 3-4-13
Alan Bolter

Written comments for the House DCH Appropriations Subcommittee
March 4, 2013

Chairman Lori and Members of the Committee:

My name is Alan Bolter, Associate Director of the Michigan Association of Community Mental Health Boards, representing the 46 community mental health boards and 75 provider organizations which deliver mental health, substance use disorder, and developmental disabilities services across the entire state.

On behalf of our members, I want to thank Governor Snyder for an increase in mental health awareness efforts and increased support for prevention and early intervention efforts. MACMHB supports the Governor's FY14 budget recommendations for behavioral health care, which includes additional funding for jail diversion programs, home based care for adolescents with complex behavioral needs, mental health first aid and Medicaid health homes.

Since the Newtown, Connecticut tragedy, mental health services have taken a much-needed front seat in policy and budget discussions at both the state and federal levels. In our estimation the best way to provide increased support for mental health services, remove barriers to accessing quality mental health services, and provide more uniform mental health services statewide is to expand Medicaid. Medicaid expansion will provide better access to behavioral care, save the state money and create good paying jobs.

Improve Access to Care

Cuts to general fund support for mental health and substance use disorder services over the past decade have resulted in a lack of access, reduction of services, and creation of waiting lists for persons without Medicaid. As a result, persons with emerging mental health and substance use disorders are not seen for care , and instead end up in emergency room and hospital settings, law enforcement and criminal justice proceedings, and in some cases, homeless on the street. Settings where they do not belong, and settings which are not equipped to provide the types of mental health and substance use disorder care they need.

If you want many of these individuals out of these settings and instead in community based mental health and substance use disorder services with providers trained to address their problems more effectively and more efficiently, expand Medicaid.

Saves State Resources

As in the case of physical illnesses, prevention and early intervention treatment for behavioral health disorders is the most cost effective care. Recovery from mental health and substance use disorders is possible when there are adequate resources to support such recovery. Medicaid expansion will provide such resources for 450,000 Michigan citizens. Research indicates that 20%, or 90,000 of those individuals, will experience a mental health or substance use disorder at some time during their adult life.

It costs 20 times more to treat an emergent/urgent behavioral health care case than a less severe, more preventative case. The state government is obligated under the Mental Health code to provide emergency mental health services. The average cost to provide emergency mental health services to an adult in 2009 was $13,037 compared to $626 spent on adults with moderate early intervention conditions (2010 Anderson Economic Group Study). Additionally, it is estimated that better access to mental health services would provide an annual savings of between $5-8 million due to fewer numbers of persons with mental illness in jail or prison (2010 Anderson Economic Group Study).

The State of Michigan will also save a significant amount of general fund resources because a large portion of the individuals who receive CMH non-Medicaid services would qualify for Medicaid expansion. However, it is important to point out that in order to achieve the proposed savings from Medicaid expansion on the behavioral healthcare side ($153 million for FY14), the expansion benefit must be the same as the current Medicaid behavioral healthcare benefit.

Create Health Care Jobs in Michigan

Under expansion, Michigan's economy will receive about $30 billion in new federal funds between 2014 and 2023. These funds will help to support and create thousands of health care jobs for Michigan workers and college and university students.

Health Homes

MACMHB also strongly endorses the Governor's recommendation of health home demonstrations for Medicaid recipients with chronic mental health conditions. Mental health disorders can reduce life expectancy by 25 or more years, primarily from treatable physical problems like obesity, smoking, heart disease and high blood pressure. By promoting disease management, patient education, electronic record-keeping and more personalized care, health homes are intended to improve the lives of people with chronic diseases and help healthy patients prevent illnesses. Overall spending is supposed to shrink because a sharper focus on individual patients leads to fewer emergency room visits, hospital readmissions, redundant and expensive tests, and major procedures such as amputations for diabetics.

Many people are skeptical about Medicaid expansion, calling it a massive government overreach. The fact of the matter is this program will provide much needed health insurance to a large number of working adults. Over the past decade employer based health insurance coverage in Michigan has fallen by 17%, new jobs being created typically do not provide access to affordable health insurance coverage. If we are serious about continuing Michigan's economic turnaround we need a healthy workforce. Governor John Kasich (R – Ohio), had a great quote when asked about his support of Medicaid expansion, "If Ohio doesn't extend Medicaid, federal tax dollars will be used to expand health coverage in other states and give businesses elsewhere a competitive advantage by creating a healthier workforce."

Expand Medicaid. It will save lives and it will save money. Again, thank you for your time and consideration of our remarks.

Respectfully submitted,

DCH SC 3-4-13

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Website www.midental.org

**Testimony to the
House of Representatives
Appropriations Subcommittee
On Community Health**

**Provided by
Kimberly Singh
Director of Community and Governmental Affairs
Michigan Community Dental Clinics Inc.**
March 4, 2013

Chairman Lori, Members of the Subcommittee, Citizens and Colleagues,

Thank you for the opportunity to provide testimony this afternoon. My name is Kimberly Singh; I am currently the Director of Community and Governmental Affairs for Michigan Community Dental Clinics, Inc. (MCDC) a private not-for-profit 501c3 dental services corporation established in 2006. Our mission is to create and expand access to dental care for Medicaid recipients and low income, uninsured persons throughout the State of Michigan. MCDC utilizes a *Social Entrepreneur Model* – implementing business concepts focused on innovation and sustainability - with a social mission and desire to do good.

MCDC operates 21 soon to be 22 public dental clinics on behalf of local health departments – from Marquette, Manistee, Hillsdale to Detroit. In calendar year 2012, a total of 72,000 Medicaid and low income patients were served, with over 194,000 office visits. Eighty-five percent (85%) of the persons served are on Medicaid, and fifteen percent (15%) were low income adults below 200% of the FPL.

Statewide staff consists of 268 dedicated professionals. (56 Dentists, 35 Hygienists, 142 Dental Assistants and Front Desk, 35 Central and Regional Administration). Our model focuses on efficiencies through the use of technology – all patient records are electronic, including digital x-rays. Economies of scale are achieved with centralized information technology, billing and patient registration. We strive for our services to be ever improving with a focus on continuous quality improvement.

Public dental clinics operated on behalf of local health departments, such as those operated by MCDC, are eligible to receive an enhanced Federal Medicaid rate, which allows for higher reimbursement than traditional state Medicaid, enabling the clinics to break even.

The MCDC model is sustainable and addresses a significant dental care need for a population who otherwise has very limited or non-existent access to dental care.

- Tooth decay is the single most common chronic disease of childhood.
- If parents do not have access to dental care, children are less likely to access care or to be non-compliant with measures that prevent disease.
- In 2009-10 there were 1000 preventable dental related hospital admissions that cost the State of Michigan over 9 million dollars.

I am here today to request the State's assistance to further enhance the economic and health well-being of low-income (Medicaid adults) and uninsured residents. There continues to be a critical need to expand access to Medicaid dental services throughout the state.

Several counties and local health departments have expressed interest in partnering with MCDC to establish additional dental clinics – some of the interested counties include – Midland, Washtenaw, Bay, Allegan, Ottawa, Kent, Ionia and Clare. Your assistance is needed to remove financial barriers and enhance the opportunities for expansion.

Our specific budget request is as follows:

- **Support the Governor's budget recommendation, and expand Medicaid eligibility to 133% of FPL. Just as important – keep the existing Medicaid benefit package that includes an adult dental benefit. For now, the expansion is 100% paid for by Federal government, is the right thing to do, and administratively cost effective.**

- **Enhanced Federal funding for Medicaid dental services provided by Local Health Departments relies on a county Intergovernmental Transfer process. Many counties cannot participate for lack of funds available for this process. We are requesting the state contribute 50% of the IGT amount - with counties contributing the remaining 50%, which would require $2.5Million per year in State appropriated funds, and result in $5Million in Federal dollars flowing to Michigan to provide dental services to folks on Medicaid.**

- **The dental clinics that MCDC operate are owned by the Counties, which require financial assistance to develop a clinic. On behalf of Local Public Health Departments, we request assistance from the State on a 50/50 basis, which would be a one-time investment of $500K per new clinic. Each clinic costs approximately $1 million, which would reduce the cost to the county to $500K. We anticipate the need to open 4 clinics per year over the next three years. A State investment of $2 million per year over three years = 12 new clinics – which will serve at least an additional 72,000 residents statewide.**

Benefits of this important investment –

- Critically needed dental services are expanded. Sustainable, ongoing community assets are established.

- Reduced costs for dental related emergency department visits and lower cost of medical care for diabetes, heart disease and stroke.
- Creates jobs and improves the employability of Medicaid enrollees and the uninsured.
- Results in a systematic approach to access to dental care that represents a true public-private partnership that does not grow local government.

Thank you, for the opportunity to present this needed dental access expansion plan to you in this forum; and for your leadership and the great work you do on behalf of the citizens of Michigan.

Healthy Kids Dental

In May 2000, Delta Dental expanded its commitment to Michigan communities by teaming up with the Michigan Department of Community Health to help improve the dental health of those in greatest need. With support from the Michigan Dental Association, the public-private partnership developed the Healthy Kids Dental (HKD) program to improve access to dental care for underserved children.

The program, which is available to Medicaid-eligible children in 75 Michigan counties, has over 442,000 enrollees. Nearly 80% of dentists who treat children in those counties participate in HKD. The program has been extremely successful in improving access to dental services for children, but unfortunately due to very low traditional Medicaid rates, there are virtually no private dentist accepting adult Medicaid patients.

Federally Qualified Health Centers (FQHC)/ Community Health Centers (CHC)

Michigan currently has 34 Health Centers, 30 are FQHC's, 2 are FQHC look-alikes and 2 both. Fundamental principles on which Health Centers were established 45 years ago setting them apart from other providers of health care:

- Located in or serve medically underserved area or populations
- Governed by a community board composed of 51 percent or more of Health Center patients who represent the population served
- Provide comprehensive primary health care services as well as support services (e.g. education, translation, transportation) that promote access to health. Emphasis on primary care, but may also provide dental, mental health and substance abuse services
- Services available to all with fees adjusted based on ability to pay

FQHC's are an important health care safety net for low income and uninsured residents serving approximately 600,000 patients statewide in 2011. Quite often the FQHC expertise focuses on the medical care and in most instances dental services are not delivered effectively or efficiently.

Michigan Community Dental Clinics (MCDC)

Michigan Community Dental Clinics (MCDC) is a not-for-profit 501c3 that operates 22 public dental clinics on behalf of local health departments throughout the state. MCDC is unique in that it utilizes a *Social Entrepreneur* model working in the non-profit sector applying business concepts focused on innovation and sustainably that distinguishes them from other old style non-profits. The MCDC mission is to expand access to quality dental care for low income (Medicaid) and uninsured residents. The organization focuses on efficiencies and economies of scale:

- Electronic patient records including digital x-ray
- Billing, information technology and patient registry is centralized
- Emphasis on Continuous Quality Improvement modeled after Mayo Clinic's – Patients First approach

This results in a network that resembles private practice – providing timely services to a greater number of people in need.

The Healthy Kids Dental program, FQHC and MCDC models are complimentary in nature and all are working to address access to dental care for vulnerable populations, although there continues to be significant unmet needs throughout the state.

MCDC Dental Healthcare Network

- Existing Dental Clinics
- Existing Hospital Dentistry Sites
- Potential Future Dental Clinics

Keweenaw, Houghton, Ontonagon, Gogebic, Baraga, Iron, Marquette, Dickinson, Menominee, Alger, Delta, Schoolcraft, Luce, Chippewa, Mackinac

Marquette

Cheboygan, Harbor Springs, Gaylord, East Jordan, Mancelona, Alpena, Traverse City, Cadillac, Manistee, West Branch, Hart, Big Rapids, Mt. Pleasant, Sidney, St. Johns, Charlotte, Port Huron, Detroit, Three Rivers, Hillsdale, Monroe

Emmet, Cheboygan, Presque Isle, Charlevoix, Antrim, Otsego, Montm., Alpena, Leelan., Grand Traverse, Kalkas., Crawford, Oscoda, Alcona, Benzie, Manistee, Wexford, Missau, Roscom., Ogemaw, Iosco, Arenac, Mason, Lake, Osceola, Clare, Gladwin, Huron, Oceana, Newaygo, Mecosta, Isabella, Midland, Bay, Tuscola, Sanilac, Muskegon, Montcalm, Gratiot, Saginaw, Genesee, Lapeer, St. Clair, Ottawa, Kent, Ionia, Clinton, Shiawas., Macomb, Allegan, Barry, Eaton, Ingham, Livings., Oakland, Van Buren, Kalamazoo, Calhoun, Jackson, Washtenaw, Wayne, Berrien, Cass, St. Joseph, Branch, Hillsdale, Lenawee, Monroe

Administrative Office
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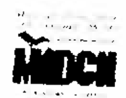


Characteristics of Dental-related Hospital Admissions in Michigan, 2009-2010

Adrienne V. Nickles[1], MPH, Mathew J. Reeves[2], PhD , Sarah Lyon-Callo[1], MA, MS, Christine Farrell[3], RDH, MPA

[1] Michigan Department of Community Health, Chronic Disease Epidemiology Section, [2] Michigan State University, College of Human Medicine, Department of Epidemiology, [3] Michigan Department of Community Health, Child Adolescent & Family Health Section

BACKGROUND

- Untreated dental disease can significantly impact systemic health and may result in costly hospitalizations.
- Preventable dental conditions impose a costly and unnecessary strain on national and state budgets.
- The burden of dental-related hospital admissions in Michigan has not been reported previously.

OBJECTIVES

- Describe the prevalence and characteristics of non-traumatic dental-related hospitalizations and resulting charges in Michigan from 2009-2010
- Compare characteristics of preventable versus unpreventable dental admissions

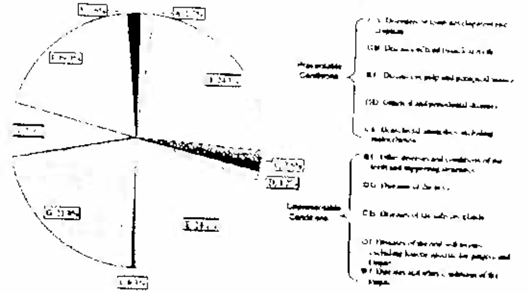
METHODS

- Hospital discharge data from the Michigan Inpatient Database were assessed to determine the prevalence, characteristics, and charges resulting from preventable non-traumatic dental-related hospitalizations in Michigan over a 2 year period.
- Primary diagnosis ICD-9-CM codes (520.0-529.9) were used to identify dental hospitalizations and were stratified into preventable (521.0-523.9, 525.0-525.9, 528.0-528.9) and unpreventable admissions.
- Multivariable logistic regression was used to determine independent factors associated with preventable versus unpreventable dental admissions.

RESULTS

- On average, there were 1978 non-traumatic dental-related hospitalizations annually during the two year period accounting for 0.15% of all hospital admissions in Michigan.
- Half (56.4%) of hospitalizations occurred to people under 45 years old, 53.3% to women, and 73.8% to white people.
- Forty-five percent of hospitalizations were charged to government insurance while 8.8% were expected to pay out-of-pocket.
- Half (49.9%) of all annual dental admissions were preventable. (Figure 1)
- Diseases of the hard tissues of teeth (48.7%) was the most frequent preventable hospitalization ICD-9 category followed by dentofacial anomalies, including malocclusion (40.3%).
- Annual charges for dental-related hospitalizations were over $25 million with over $9 million in preventable hospitalizations.

Figure 1. Distribution of Primary Diagnosis ICD-9 Codes Among All Dental-Related Hospitalizations, 2009-2010



RESULTS

Table 1. Characteristics of Dental Admissions by Preventable vs. Unpreventable Conditions

		Preventable %	Preventable N	Unpreventable %	Unpreventable N	χ2, p-value
Age Group	0-17	48.9%	363	51.1%	379	43.0, < 0.0001
	18-44	50.9%	764	49.1%	736	
	45-64	54.9%	542	45.1%	446	
	65-84	46.3%	261	53.7%	303	
	≥85	29.3%	51	70.7%	123	
Sex	Male	57.0%	1053	43.0%	795	88.8, < 0.0001
	Female	41.7%	821	58.3%	1100	
Race	White	49.7%	1325	54.3%	1573	63.2, <0.0001
	Black	62.7%	578	37.3%	345	
	Other	58.1%	61	41.9%	44	
Insurance Type	Private Insurance	58.1%	1026	41.9%	740	339.0, <0.0001
	Government	35.3%	631	64.7%	1156	
	Self-pay	80.5%	277	19.5%	67	
Admitted From	Referral*	35.4%	727	64.6%	1327	342.3, <0.0001
	Transfer**	48.5%	32	51.5%	34	
	Emergency Room	66.6%	1024	33.4%	514	
Type of Admission	Emergency	62.2%	1336	34.8%	716	441.8, <0.0001
	Urgent	62.7%	462	37.3%	275	
	Elective	13.3%	148	86.7%	974	

* Includes physician, clinic/outpatient, and HMO referral
** Transfer from hospital, skilled nursing facility, another health care facility

- Hospitalizations to patients who were younger, male, and non-white were more often for preventable compared to unpreventable dental conditions. (Table 1)
- Hospitalizations to patients with private or self-pay insurance types were admitted to the hospital with a preventable dental hospitalization more often.
- A higher percentage of hospitalizations admitted from the emergency room were due to a preventable dental condition.
- Admissions of an emergency or urgent type had a preventable dental-related hospitalization more often than those with an elective admission.

Table 2. Preventable vs. Unpreventable Dental Hospital Admissions, Crude and Adjusted Odds, Michigan, 2009-2010

		Crude OR	Crude 95% CI	Adjusted OR	Adjusted 95% CI
Age Group	0-17	Ref	—	—	—
	18-44	1.08	(0.91, 1.29)	0.71	(0.56, 0.91)
	45-64	1.27	(1.05, 1.54)	0.71	(0.56, 0.92)
	65-84	0.90	(0.72, 1.12)	0.32	(0.24, 0.43)
	≥85	0.43	(0.30, 0.62)	0.13	(0.08, 0.20)
Sex	Male	Ref	—	—	—
	Female	0.58	(0.52, 0.66)	0.64	(0.55, 0.75)
Race	White	Ref	—	—	—
	Black	1.59	(1.71, 2.32)	1.12	(0.82, 1.36)
	Other	1.65	(1.11, 2.46)	1.35	(0.83, 2.22)
Insurance Type	Government	Ref	—	—	—
	Private	0.39	(0.34, 0.45)	0.53	(0.43, 0.64)
	Self-pay	2.98	(2.28, 3.98)	1.67	(1.20, 2.34)
Admitted From	Referral	Ref	—	—	—
	Transfer	1.72	(1.05, 2.81)	1.28	(0.72, 2.21)
	Emergency Room	3.38	(3.16, 4.08)	1.15	(0.85, 1.40)
Type of Admission	Emergency	Ref	—	—	—
	Urgent	0.9	(0.75, 1.07)	1.01	(0.81, 1.25)
	Elective	0.08	(0.07, 0.10)	0.09	(0.07, 0.12)

- Age Group, Gender, Race, Insurance Type, Place Admitted From, and Type of Admission were included in a multivariable logistic regression model. (Table 2)
- Crude odds ratios reflect the results shown in Table 1.
- Adjusted odds ratios provide the following results:
  - *Hospitalizations in every age category were significantly less likely for a preventable dental condition compared to hospitalizations in people younger than 18 years.*
  - *Women were significantly less likely to be admitted for a preventable dental condition than men.*
  - *Hospitalizations charged to private insurance were less likely to be admitted for a preventable condition, while those expected to pay out-of-pocket were significantly more likely to be preventable.*
  - *Elective admissions were significantly less likely to be of a preventable nature compared emergency admissions.*

CONCLUSIONS

- There were approximately 1000 annual preventable dental-related hospitalizations in Michigan from 2009-2010 .
- Over $9 million in charges due to preventable dental admissions could be avoided by regular dental care and treatment.
- Efforts should focus on increased access to preventive dental care for groups with greater odds of preventable denta admissions such as expanding the Michigan School-Based Sealant Program to more schools with a high proportion of children at greater odds, increasing Medicaid reimbursement rates for dental services, and expanding the capacity of the healthcare workforce to provide dental services.
- Future studies should focus on regional differences in the burden of preventable dental admissions in Michigan

MCDC
One Water Street
Suite 200
Boyne City, MI 49712

DCH SC 3-4-13
Kim Singh
#3 of 3

Dental Care for the Underserved
Medicaid
and
the Low Income Uninsured

A "Social Entrepreneur" Model
of
Public Health Dentistry

2011 Annual Report

A Message from Our CEO

Michigan Community Dental Clinics, Inc. (MCDC) is a not-for-profit 501(c)3 dental services corporation, established in 2006 to allow the successful Dental Clinics North (DCN) model for delivery of Public Health Dental Services to expand to other areas of Michigan.

The MCDC practice model utilizes an electronic patient record, digital radiography, state of the art dental equipment, and compensation methods that encourage productivity, efficiency, and control costs. The result is Public Health dental clinics that optimally deliver care, with the outcome of more individuals provided needed services in a timely fashion. In addition, the dental program "breaks-even" so that it is sustainable for the long term. By using an efficient "Social Entrepreneur" dental practice model, MCDC is able to attract and retain exceptional dental practitioners who now have a viable alternative to owning their own private practice; we now have sixty-two full and part-time dentists providing care in our clinics, which is fourteen more than a year ago.

The populations served by MCDC clinics are adults and children on Medicaid (85% of those served) as well as low income, uninsured individuals, whose income is below 200% of the Federal Poverty Level. The non-Medicaid population receives care at a reduced fee schedule. When available, surplus funds over costs allow for the establishment of a Dental Access Fund to supplement the cost of care on a sliding percentage, based upon an individual's income. In 2011, MCDC clinics served over 68,000 individuals with nearly 178,000 visits.

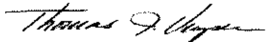
In 2011, MCDC opened clinics in Hillsdale, Detroit, and St. Johns, which brought the total number of clinics under MCDC direction to twenty-one. 2012 promises to be equally exciting - with a new clinic in Monroe, the remodel of clinics in Mancelona and Cheboygan, and a new twelve chair clinic in Traverse City that will replace an antiquated facility. MCDC currently partners with the University of Michigan to provide clinical dental education opportunities in four of our clinics, and will be providing that opportunity for as many as four students per day in Traverse City. Students from the University of Detroit School of Dentistry will be providing care in our Detroit clinic.

The MCDC Dental Internship was established in 2011 to provide a structured transition from dental school to public health dentistry, with rotations to work with MCDC dentists who are experts in various areas of dentistry. This unique program will be expanded in 2012. Dr. Nicole Beadle, a U of M 2011 graduate and our "pilot program" intern, will be joining MCDC as a full-time dentist in our Alpena clinic in July, 2012.

As you can imagine, this level of clinic expansion continually taxes our administrative team, necessitating significant growth to our administrative infrastructure statewide. Many areas of the state lack the financial resources to launch a dental clinic venture. For that reason, we continually search for sources of foundation support for the start-up costs associated with a new clinic, and to support the cost of care for those not covered by Medicaid, who are without dental insurance and require help to afford dental care.

We know that MCDC is filling a unique niche in Michigan's oral healthcare delivery system, and we are encouraged by the support from the Michigan Department of Community Health and the local public health community. Our MCDC Staff, totaling 255 at year's end (an increase of nearly 50 in 2011), will continue to work toward eliminating the gap that exists in accessing oral healthcare. We look forward to your continued input and support.

Sincerely,



Thomas J. Veryser, D.D.S., M.H.S.A.
Chief Executive Officer

Our Board of Directors

Patrick Shannon, J.D., M.P.H., Ed.D., Board Chairman
Director of Charter Schools, Bay Mills CC, Brimley

Wilhelm Piskorowski, D.D.S., Board Vice Chair
Director, Community & Outreach Programs, University of Michigan School of Dentistry, Ann Arbor

Kevin Cawley, M.H.S.A., Board Treasurer
C.E.O., Sheridan Community Hospital, Sheridan

Lonnie Stevens, M.A., Board Secretary
Executive Director, United Way of St. Clair County, Port Huron

Mert Aksu, D.D.S., J.D., M.H.S.A.
Dean, University of Detroit Mercy School of Dentistry, Detroit

Mary Kushion, M.S.A.
Director/Health Officer, Central MI District Health Dept., Mt. Pleasant

Howard Newkirk
Retired I.T. Executive from Compuware Corporation, resides in Boyne City

Daniel Sarya, D.D.S., M.P.H.
Orthodontist, Traverse City

Linda VanGills, M.A.
Health Officer, District Health Department #10, Hart

Thomas J. Veryser, D.D.S., M.H.S.A.
Chief Executive Officer, Michigan Community Dental Clinics, Boyne City

Gregory P. Heintschel, D.D.S., M.B.A.
Chief Dental Officer, Michigan Community Dental Clinics, Boyne City

Why We Exist

MISSION Our mission is to create and expand access to ever improving quality dental care for Medicaid recipients and low income, uninsured persons. This care is rendered through an entrepreneurial public health model, which incorporates health education to modify behavior, and is delivered in a fashion that upholds mutual respect and improves our patients' quality of life.

ACTION We assist in the development of dental clinics for Local Public Health Departments—to increase access to oral healthcare for those on Medicaid and the Low-income Uninsured.

We provide the Staff and Management Services that allow the clinics to maximize efficiency and productivity, thereby leveraging limited resources for the greater good.

VISION Our vision is a healthy Michigan population, who assume responsibility for their own wellness, with our staff's guidance and proper intervention.

Expansion of our clinic system to allow establishment of "dental homes" for persons unable to obtain care in traditional private sector settings.

Academic Partners
University of Detroit Mercy School of Dentistry
University of Michigan School of Dentistry
Baker College
Ferris State University
Montcalm Area Career Center
Northwestern Michigan College
Wayne State University College of Nursing
Wayne State University School of Medicine

Health Department Partners
Barry-Eaton District Health Department
Benzie-Leelanau District Health Department
Branch-Hillsdale-St. Joseph Community Health Agency
Central Michigan District Health Department
Detroit Department of Health & Wellness Promotion
District Health Department #2
District Health Department #4
District Health Department #10
Grand Traverse County Health Department
Health Department of NW Michigan
Marquette County Health Department
Mid-Michigan District Health Department
St. Clair County Health Department

Community Partners
East Jordan Family Health Center
Holy Cross Children's Services
Upper Great Lakes Family Health Center
Three Rivers Community Health Group
Traverse Health Clinic
United Way of St. Clair County

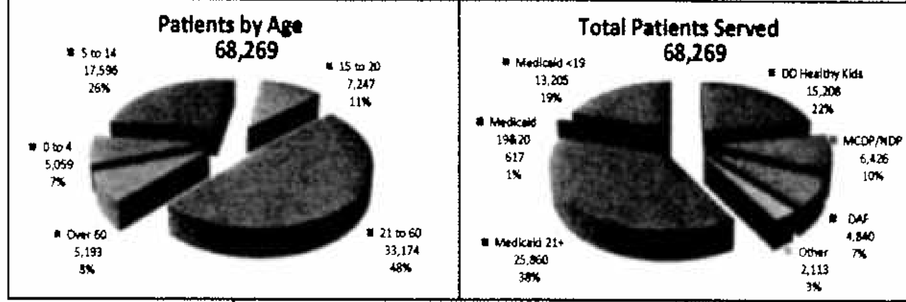
Hospital Partners
Bell Memorial Hospital
Charlevoix Community Hospital
Hackley Hospital
Marquette General Hospital
Munson Medical Center
Otsego Memorial Hospital
West Shore Community Hospital

Corporate Partners
Patterson Dental
3M
A-dec
ADOBE Systems, Inc.
Davis Dental Laboratory
Dental Art Laboratory
Dentsply
Hu-Friedy
Integrated Systems Consultants
SK Laboratory
LaDouce Dental Laboratory
Michigan Dental Association
MICROSOFT Corporation
Midmark
Procter & Gamble
SciCan

Foundation Partners
Broomfield Trust Fund
The Gerber Foundation
Father Fred Foundation
W.K. Kellogg Foundation

Those We Served in 2011

Practice Statistics
All Clinics
Calendar Year 2011



DD Healthy Kids - Delta Dental Healthy Kids MEDICAID Program
MCDP - Michigan Community Dental Plan
NDP - Northern Dental Plan
DAF - Dental Assistance Fund

Growing in Michigan

Providing Access to Oral Healthcare

Partnering with Local Health Departments

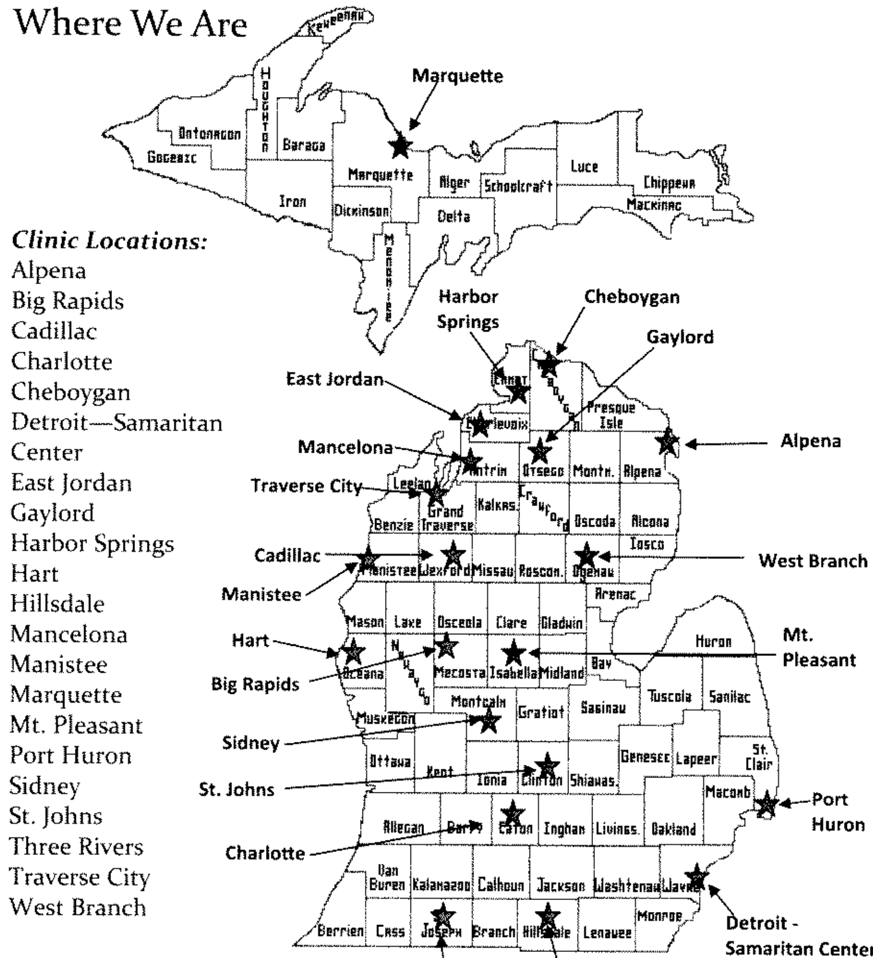
2011 Highlights

- Increased number of Total Patients Served to 68,269 from 53,621 in 2010. Increased Patients Served in our Hospital Program to 599 from 462 in 2010.
- Opened three new dental clinics, bringing the total to 21:
  - Hillsdale in March
  - Detroit (Samaritan Center) in August
  - St. Johns in September
- Increased our total MCDC Staff to 255 from 207 to include:
  - 62 Dentists
  - 29 Dental Hygienists
  - 139 Dental Assistants (clinical assistants and clinical front desk)
  - 25 Central Administration
- Achieved a 95% plus (satisfied & very satisfied) Patient Satisfaction Survey outcome from over 1200 patients randomly surveyed.
- Created and implemented standardized methods of clinical operations to affect increased efficiency and improved quality outcomes.
- Created and implemented a unique measurement tool to evaluate the clinical outcomes of dentists and hygienists.
- Expanded the Contact Center to facilitate patient access to our dental clinic system and hospital program.
- Updated our digital imaging capability, resulting in improved accuracy and efficiency, which allows more patients to be served.
- Expanded the MCDC Board of Directors to nine voting members.
- MCDC was accepted for membership in:
  - The Michigan Health & Hospital Association (MHA)
  - The Michigan Primary Care Association (MPCA)
  - The Institute for Healthcare Improvement (IHI)
- MCDC's CEO, Dr. Tom Veryser, was appointed by Governor Snyder to represent the Office of the Governor on the Board of the Michigan Center for Rural Health.

Where We Are

Clinic Locations:

Alpena
Big Rapids
Cadillac
Charlotte
Cheboygan
Detroit—Samaritan Center
East Jordan
Gaylord
Harbor Springs
Hart
Hillsdale
Mancelona
Manistee
Marquette
Mt. Pleasant
Port Huron
Sidney
St. Johns
Three Rivers
Traverse City
West Branch



MCDC Administrative Office

One Water Street, Suite 200
Boyne City, Michigan 49712
Phone: 231-547-7638
Website: www.midental.org

DCH SC 3-4-13
Carrie Collins
+ 2 item

Alzheimer's Association
Carrie Collins – State Director of Public Policy, Michigan Chapters
ccollins@alz.org

Thank you so much for allowing me to testify in front of your committee today.

The Alzheimer's Association Michigan Chapters work each and every day to provide programs and services to 273,804 Michiganders living with a diagnosed case of dementia and their caregivers. In my five years with the Alzheimer's Association I have come to learn that there are two types of families. Those that have been touched by Alzheimer's and those that will be. One thing I have consistently been proud of is the services that the Alzheimer's Association offers free of charge to your constituents. Caregivers, those living with a diagnosis and those concerned about the disease can get information, training, referrals and support. Since 80% of those living with a dementia diagnosis are at home with an unpaid family or friend serving as a caregiver, our services are often a lifeline of education and support.

Until 2009, the State of Michigan recognized the Alzheimer's Association as a partner in diverting those with the disease from costly and expensive long term care. We received $435,000 in the state budget through the Healthy Michigan Fund to offer our toll-free hotline and many other support services to those in Michigan. When you calculate the cost of long-term care and the fact that we touch thousands of clients around the state, it quickly paid for itself and then some. When that money was cut we had to cut back on our services. In good faith we have struggled to maintain as many of those services as we can through donor support the last 4 years, but we are reaching a critical point.

It is a fact that our services save the state money by
1. delaying long-term care placement
2. decreasing caregiver burnout
3. decreasing usage of 911 and emergency room services
4. decreasing the length of hospital stays .

Currently Michigan is not investing any money in the programs and services that could save the state money. Across the nation it appears that no one state at this time serves as a model state for the availability of dementia service and cost-prevention programs, a handful of states have funded specific programs and with a great return on investment. In North Dakota, the Dementia Care Services Program (DCSP) was created by the Dementia Care Services Bill (ND House Bill 1043) in 2009. It provides care consultations to caregivers; these consultations consist of assessing

needs, identifying issues and concerns and resources, developing care plans and referrals, and providing education and follow-up. These services were provided by phone, email, or in person through individual and family meetings. The target population for this program included North Dakota residents with a diagnosis and/or symptoms of dementia, and their caregivers. Two of the goals of the program and the funding of dementia services were Long-Term Care Cost Avoidance and Hospital and Emergency Services (inpatient hospital stays, emergency room visits, 911 calls, and ambulance) Cost Reductions. The Alzheimer's Association was selected to provide the services funded by House Bill 1043.

When the Centers for Rural Health looked at the impact of services in North Dakota provided by the Alzheimer's Association over a thirty month period (from January 2010-June 2012), the results indicated a clear and significant savings to the state, as well as increased mental well-being for caregivers.

Would like the subcommittee to consider pilots in several counties to see if MI's savings would be similar. We believe that expanding caregiver services is better for families, better for people diagnosed with Alzheimer's, and better for the state of Michigan.

DCH SC 3/4/13 Carrie Collins
#2 of 3

State of Michigan Dementia Care Services

Proposed Pilot Program

Alzheimer's disease is a serious problem. How we address it as a state will determine whether Michigan can continue to attract and retain people in key age demographics, such as retirees. In Michigan, 273,804 people are living with a diagnosed case of dementia. Alzheimer's disease, the most common form of dementia, accounts for 195,814 cases of dementia. Due to the large and growing number of individuals suffering from dementia, Michigan is consistently among the top ten states for the number of unpaid, volunteer dementia caregiver hours given by family and friends. In 2011, there were 504,550 unpaid caregivers. These caregivers allow 80% of people with dementia to be cared for at home, and this saves the state millions of dollars - $6.9 billion dollars a year, to be exact. For every Medicaid eligible person that goes into a nursing home the state spends approximately $35,000 per person, per year. Programs and services that the Alzheimer's Association offers work in tandem to delay or completely prevent nursing home placement saving the state money.

However, the State of Michigan currently invests no monies in assisting unpaid family and friend caregivers so that they can have access to services and learn care techniques and coping mechanisms. These educational interventions delivered in person, on the web and through a hotline at a variety of levels of depth, have been statistically shown to increase not only the amount of time someone with dementia can remain in the home, but the patient caregiver satisfaction in the experience. The data proves that these services save money by decreasing the number of 911 calls, decreasing emergency room visits and hospital stays.

The Alzheimer's Association Michigan Chapters have the ultimate goal of seeing dementia care services for those living outside of care facilities fully funded. We would like to propose a year-long multi county pilot program in counties with varying levels of prevalence of the disease/population. This will give us a chance to demonstrate our services in both a rural and urban county setting. We are asking for $100,000 to service three counties for one year to show that in Michigan investment in services and programs for those with dementia saves money. Three possible counties are listed below. However, the Alzheimer's Association offers services in all 83 of Michigan's counties.

Suggested Counties & Prevalence of the Disease

Macomb, 18,024 diagnosed

Monroe, 2,826 diagnosed

St. Joseph, 1, 282 diagnosed

DCH SC 3/4/13 Carrie Collins #3 of 3

North Dakota Study Finds Significant Cost Savings When Dementia Programs Are Funded

Problem Statement

Alzheimer's disease, the most common type of dementia, is a progressive, degenerative, neurological disorder with no known cure and high social and economic costs. Health and long-term care (LTC) costs for persons with Alzheimer's disease or other dementias are massive and continue to grow at an alarming rate. In 2012, the total U.S. amount spent on health care, LTC, and hospice for persons with Alzheimer's disease or other dementias was approximately $200 billion, which is projected to increase to $1.1 trillion in 2050 (Alzheimer's Association, 2012) as the numbers of those with the disease is expected to quadruple. In response to these projections, many states are starting to take measures toward reducing dementia related health and LTC costs. One method is to increase efforts to provide support to dementia caregivers in hopes of increasing their efficacy, easing the burden of dementia care, and thus reducing health and LTC costs. The state of Michigan has a dementia plan, but investment by the state in services for those living with the disease and their caregivers remains at an all-time low, while the prevalence of the disease grows. The projected rise in Alzheimer's as the population ages is troubling because without any interventions in place by the state to serve those impacted, it will continue to be a long and costly disease.

Dementia Caregiving and Patient Needs

In Michigan, caregiving for persons with dementia (PWDs) is typically provided by a spouse or other family member, an unpaid caregiver, 80 percent of the time (Alzheimer's Association 2012 Facts and Figures). While this recognizes a significant cost savings to the state, caregiving can be very difficult, costly to the individual, and time-intensive (Shriver, 2010; Alzheimer's Association, 2012), and is associated with poorer emotional, mental, and physical health among caregivers (Rose-Rego et al., 1998; Dunkin & Anderson-Hanley, 1998). Other factors that exacerbate the dementia caregiver crisis in the U.S. include the discontinuous and fragmented nature of health care services, shorter hospital stays for patients, and discharged patients having increasingly complex health needs (Levine et al., 2010). Caregiving in rural areas is even more difficult due to social isolation, poorer access to health and social services, and increased travel times to and from services (Butler et al., 2005).

Receiving education about dementia is another important goal for caregivers. Understanding the disease, its stages, and its effects on people can help to relieve stress and gain empowerment for the caregiver and PWD (Devor & Renvall, 2008). In short, caregivers are an invaluable link in our system of modern healthcare, but due to several factors without resources they are likely to predecease the person they are caring for, experience burnout and turn their PWD to the long-term care system or become higher users of the services of emergency rooms and first responders as a treatment option for the person that they are caring for.

History of Michigan Funding

For years the state of Michigan dispersed monies through the Healthy Michigan Fund to the Alzheimer's Association Michigan Chapters for preventative health activities, specifically the funding of a toll-free hotline that was answered 24/7/365 by a trained professional. While reduced every year due to state budgetary issues, the funds were $485,000 in 2009, the last year that the funds were distributed. Having services, such as a hotline, is of particular importance to those who are dementia caregivers because behaviors can change drastically from day to day. Satisfaction surveys conducted by the Alzheimer's Association indicated that dementia caregivers utilizing the services kept their PWD at home and out of long-term care at least 6 months longer when they had access to caregiver resources through the Association. In the 2007-2008 fiscal year, the Michigan Chapters provided over 8,000 individuals services and consultations on the 24/7 Alzheimer's Telephone Helpline. The Alzheimer's Association in turn had to eliminate and reduce some of the programs at a time when the demand for dementia services is increasing.

Summary of Center for Rural Health Assessment of North Dakota Dementia Care Services Program

While it appears that no one state at this time serves as a model state for the availability of dementia service and cost-prevention programs, a handful of states have funded specific programs and with a great return on investment. In North Dakota, the Dementia Care Services Program (DCSP) was created by the Dementia Care Services Bill (ND House Bill 1043) in 2009. The DCSP's aim is to inform persons with dementia (PWDs; approximately 8,000 in North Dakota residing outside of LTC facilities) and their caregivers about dementia care issues which, in turn, may lead to increased family support, decreased depression, delays in nursing home placement, and reductions in acute health service use. The DCSP provides care consultations to caregivers; these consultations consist of assessing needs, identifying issues and concerns and resources, developing care plans and referrals, and providing education and follow-up. These services were provided by phone, email, or in person through individual and family meetings. The target population for this program included North Dakota residents with a diagnosis and/or symptoms of dementia, and their caregivers. Two of the goals of the program and the funding of dementia services were Long-Term Care Cost Avoidance and Hospital and Emergency Services (inpatient hospital stays, emergency room visits, 911 calls, and ambulance) Cost Reductions. The Alzheimer's Association was selected to provide the services funded by House Bill 1043.

When the Centers for Rural Health looked at the impact of services in North Dakota provided by the Alzheimer's Association over a thirty month period(from January 2010-June 2012), the results indicated a clear and significant savings to the state, as well as increased mental well-being for caregivers. Program participation has continued to coincide with substantial estimated health care (i.e., E911, ambulance, emergency room, hospital) cost savings (current total for all PWDs=$393,249) for PWDs over the 30-month period. Total cost savings estimates by health service type were $349,179 for hospital, $26,578 for ER, $14,703 for ambulance, and $2,789 for E911. Estimated LTC

cost savings totaled $31,314,390 over the 30-month program period. Follow-up survey results indicated a moderately high level of overall satisfaction with DCSP services, and several respondent caregivers have provided comments that positively reflected on DCSP staff and services for increasing their feelings of support and empowerment, and bolstering their knowledge and understanding of dementia or Alzheimer's disease.

The services that were provided by the Alzheimer's Association in this study are all able to be provided by the Michigan Chapters of the Alzheimer's Association to Michigan residents. The Chapters have been good stewards of state funds in the past and have the networks in place to provide these services and LTC savings to the state of Michigan if properly funded by the state.

DCH SC 3-4-13
Brett Williams

I would like to thank Chair Person Lori and the distinguished members of this committee to allow me to testify before you today. I would like to begin this testimony by describing the expansion of Medicaid in Michigan as Dollars and Sense. Dollars as to the positive impact on Michigan's economy and sense as it just makes sense to being able to save the state of Michigan an estimated 1.083 billion dollars within the first decade, and in the same time, improve the health of Michigan's citizenship.

Under the proposed program, 100% of the cost of bringing Medicaid eligibility to 138% of the Federal Poverty Level (FPL) will be funded by federal funds until 2017, and only then, will they be gradually reduced to 90% over the next four years. This gives Michigan the opportunity to save approximately $200 million annually over the first three years. These savings are made possible without establishing a long term obligation and positions Michigan to withdraw from the program at any time.

Another positive aspect of the proposed expansion is that it will inject billions of dollars into the Michigan economy and will help create critical jobs in healthcare-related fields as well as other related industries. To expand on the positive impact of Medicaid expansion in the field of healthcare, it paves the way to ensuring hospitals in rural and underserved areas of Michigan will remain open and able provide exceptional healthcare to their patients. In conjunction to supporting local hospitals, it will help lower the overall cost of privately insured individuals by reducing the "hidden tax" incorporated into premiums to cover those who are unable to gain coverage privately, but still access and utilize the healthcare system within this state.

The impact on business is significant as well. Any business owner will agree that a sick workforce is a non productive workforce. Medicaid expansion based on one's wage will help cover a portion of the workforce where health insurance is unavailable. Many studies have proven that workers who have access to healthcare miss far fewer days and are more productive overall. In recent testimony, MDCH discussed a study in Oregon where it examined the impact of expanding Medicaid to a currently un-enrolled portion of the population. They referenced how there was a substantial drop in depression, an increase of monitoring cholesterol, less days missed at work and the list goes on. What was not mentioned was the fact that this was an expansive research project that followed 10,000 people and their outcomes. Many single adults without children who are entering the workforce are doing so at an entry level position; many of them part time. This would allow them to gain coverage as they become productive contributors to the Michigan economy. Remaining focused on the benefits to business, many larger businesses that employ entry level work forces ***will not*** be subject to federal tax assessments. Those who are at 137% of the FPL and below are not counted towards the full time equivalent (FTE) count as required under the healthcare reform act; providing the employer the ability to maintain a full time work force.

An additional benefit to this program would be the ability to offer caregivers of persons with disabilities the ability to receive access to healthcare. Many of these care givers are family members who dedicate themselves to care for loved ones, and while doing so, are unable to seek full time employment due to the needs of the family. This need also extends to veterans and their families. Many veterans and their families will qualify for coverage due to limited

income. Even though there are programs available such as the V.A. and Tri-Care, many veterans do not qualify or are not able to fully participate within these programs. Currently, there are only five V.A. medical centers in the state; Ann Arbor, Battle Creek, Detroit, Iron Mountain and Saginaw. According to the Department of Veteran Affairs state summary from November 2010, there are 723,368 veterans in Michigan. Many veterans live as far as 2 hours away for one of the five VA medical centers in this state. By expanding Medicaid in Michigan, it would provide a level of coverage for our veterans that would complement their VA coverage and allow them local access close to their home. Medicaid expansion will close those gaps for those brave men and women who served this country.

Thank you once again for allowing me to testify and I will be willing to answer your questions.

DCH SC 3-4-13
Mark
Reinstein

Testimony of the Mental Health Association in Michigan
House Appropriations Subcommittee on Community Health
March 4, 2013

Representative Lori and Members of the Subcommittee,

I'm Mark Reinstein, President & CEO of the Mental Health Association in Michigan, the state's oldest advocacy organization for persons experiencing mental illness. We are affiliated with Mental Health America and partly funded by local United Ways. I appreciate the opportunity to comment on the FY-14 Department of Community Health (DCH) budget.

We support the Governor's recommendation to expand Medicaid under the federal Affordable Care Act (ACA). This will provide critical assistance to many low-income individuals in need, at no state cost initially. Governor Snyder has wisely recommended that half the savings accruing to the state be put in a special fund to support Medicaid obligations down the road. There is no guarantee about what contingencies may or may not arrive in several years, but the Governor's plan would not leave us without some resources for them. And please keep in mind that under the ACA, persons at less than 100% of federal poverty level cannot enter the new health insurance exchanges, meaning many poor state residents (over 250,000) would remain without health coverage if there is no Medicaid expansion or alternative new step. We also note that *Families USA* is out with a new study showing several important benefits to Michigan's economy from Medicaid expansion. A key bottom line here is, the tax dollars Michigan sends to Washington should be supporting new Medicaid initiatives for citizens in our state, not residents of other states that accept expansion if we do not.

We also support the Governor's recommendations for youth mental health initiatives, justice-and-mental health activities, behavioral health homes, and assistance to veterans. We are concerned, however, about what might be left for Community Mental Health (CMH) non-Medicaid appropriations. The administration has projected that, given an expansion of Medicaid, this line can go from roughly $274 million in FY-13 to about $80 million come FY-15. That is a tremendous drop, and we respectfully ask you to subject the administration's assumptions and calculations to close inspection. Should Michigan expand Medicaid, we don't yet know what the expansion service package will be. Additionally, for everyone going into health insurance exchanges, the products there will not offer all the specialty services and supports that one can get through the publicly funded mental health sector.

Finally, with respect to budget boilerplate, we respectfully ask that the following FY-13 sections not recommended by the Governor be continued:

~Sec. 404, on CMH service reporting.
~Sec. 411, requiring CMH involvement in jail diversion programming.

~Sec. 474, requiring provision of guardianship information to mental health service recipients and their families.
~Sec. 492, permitting CMH programs to spend GF money on jail mental health service.
~Sec. 605, requiring certain steps to be taken if the administration proposes closing a state-operated psychiatric hospital.
~Sec. 1677, establishing the mental health and other services available to enrollees in the MIChild program.

Thank you for your thoughtful consideration of our views.

DCH SC 3-4-13

House Committee Testimony

March 4, 2013

Introduction: Kathleen Kovach, Deputy Directory, OCCMHA

OCCMHA Service System: OCCMHA serves nearly 22,000 people each year who qualify for public mental health services – people with developmental disabilities, mental illness, and substance use disorders.

- They are both children and adults, and cut across the entire lifespan, from infants and toddlers to older citizens.
- They live with family members, in their own homes, adult foster care homes, and specialized, licensed homes.

Support for Medicaid Expansion: OCCMHA supports the expansion of Medicaid to lower-income citizens of Michigan.

- We anticipate that approximately 30,000 people in Oakland County would qualify for services under the Medicaid expansion.
- The access to needed resources would support people who currently 'fall through the cracks.'
- Many people without health insurance end up in emergency rooms, hospitals, homeless shelters, or criminal justice settings.
  - This is more costly and less effective in addressing their needs.

Benefits of Medicaid Expansion: Increased access, financial savings, and healthier communities.

- Early Intervention alleviates crisis situations and emotional turmoil for individuals and families.
- Financial costs over time are reduced for individuals, businesses, and communities.
- Communities are strengthened by the improved health of all of its residents.

DCH SC 3-4-13

Testimony re Medicaid Expansion

I am your mother, your sister, your cousin, your neighbor. My name is Sherry Gerbi and I am a person with a mental illness. I was diagnosed in my early 30s and at that time had private insurance through my job. Four years ago, I found myself in dire straits. I lost my job and with that my health insurance. I had no money so was not taking my medications. I became profoundly depressed and very suicidal. I thought I had nothing to offer the world and therefore, had to leave it. That's when Oakland County Community Mental Health stepped in. They hospitalized me, got me back on my meds and began providing the supports and services I needed. They also helped me apply for disability and Medicaid. Over time, I began to recover and learned that I still had a lot to offer others. I became a member of Dreams Unlimited Clubhouse and was instrumental in setting up an education program helping people get their GED, helping to improve their reading and computer skills and to even become a citizen of the United States. I began to be involved in CMH committee work, to present at different conferences and to hone my skills as an advocate.

There are 2 points I want to make today. I have a good friend who is more like a sister. She has multiple sclerosis, problems with a kidney and has had 2 mini strokes; she is quite compromised with her physical health. She has not been able to get disability or Medicaid and doesn't have a primary doctor. Over the last several years, she has visited the emergency room a number of times and been admitted twice. Many of her physical issues could be addressed in a less costly manner if she had a primary care doctor. Instead, she has to wait until it becomes acute and then visit the emergency room. Medicaid expansion could help resolve this issue so that we use our resources in a more effective manner.

The second issue is about the Medicaid spend down. I have a pension and I work part-time as a sub-contractor at Oakland County CMH. This means I have a monthly spend down that's over $1500. The spend down does not take into account that I had to file bankruptcy in order to save my home and my bankruptcy/mortgage payment is about $1500. That leaves $800 to pay for food, utilities, car insurance, car repairs – I have a '97 Mercury Tracer that I'm driving on a wing and a prayer, - gas for the car, and those house emergencies that keep coming up (e.g., a sump pump that failed causing my basement to flood, a washer that won't spin out the water, a dryer that won't dry and a roof that is leaking). If I wasn't working, I could make my spend down. I'm kind of in a catch-22. I've been having a lot of health issues lately. In the last 2 months I have had an endoscopy, a colonoscopy, an abdominal ultrasound, a CT with contrast, an MRI, a bone scan and yesterday an ERCP. Fortunately, I have Medicare which is paying for the bulk of these procedures. If I could meet my spend down, Medicaid would pay for the rest. As it is, I still do not have a diagnosis, I don't know how much I will owe as co-pays, and I don't know if I will require further treatment. I also have teeth that are

breaking and crumbling in my mouth and as you know, dental is not covered by Medicare. As you can imagine, all of this produces a fair amount of anxiety. In order to maintain my mental health recovery, it is imperative that I manage my stress level. I've learned that working part-time helps me to stay in recovery but this creates a financial dilemma for me: By working, my spend down increases and this means that essentially Medicaid is of no help to me. I've heard other members at my Clubhouse say they would like to work but can't afford to as they are afraid they would lose their benefits or at the very least have an increased spend down. Even though it costs me financially to work, I have decided to continue to do so as there are intangibles I receive from working that I can't put a price tag on. I love the work I do, I love the people I work with and I'm totally committed to our CMH's mission of inspiring hope, empowering people and strengthening communities. Medicaid expansion would help keep a safety net under those of us who are struggling to live hand to mouth, the most vulnerable Michiganders of which I am one of. Thank you for your time and attention.

DCH SC 3-4-13
Mark Roman

Reasons for Medicaid Expansion

My name is Mark Roman and I have been diagnosed with bipolar disorder since I was 30 in 1990. I lost my job in 1990 due to back problems and my bipolar illness. I had insurance from my work for 2 years but when the insurance went out, I had to apply for Medicaid benefits.

Because I was able to get Medicaid, I was able to get my needed medicines and go to my doctor appointments. Because of this, I have come along ways in my recovery as a peer support specialist and am able to give others, like me, hope that recovery is possible.

I am grateful that we have had programs like this set up as it has improved my quality of life. Now I am able to work again, have relationships with others and do what other people do in society.

Like I said, I am a Certified Peer Support Specialist and work at our local Inter-Connections drop in center. There I have the opportunity to work with others like myself. There I see many people of the younger populations that have mental illness, that have no insurance I get to hear some of their stories how it impacts their life negatively. They are not able to get some of their needs met and thus have a lesser quality of life.

I believe that having the Medicaid Expansion would benefits these young people that deal with mental illness improving there overall physical and mental health and giving them more of a quality of life by integrating them into society and the helping them to get and keep employment.

I have a next door neighbor who could not afford her meds and doctor appointments because she wasn't able to get Medicaid at the time. If Medicaid expansion was in place she wouldn't need to miss her needed medicine for her Lupus and Bipolar illness.

I see a lot of people slipping through the cracks and not getting their medical needs met affecting their health and quality of life.

I think if the state would work with the medical expansion it would be a win, win for everyone.

I hope you will consider this needed proposal.

Sincerely,

Mark Roman,
Adrian Michigan
Lenawee County

DCH SC 3-4-13
Joseph Roman

Support of Medicaid Expansion

My name is Joseph Roman. I am a single, male living in Lenawee County. I have had difficulty finding work for the past few years until I was hired as a peer support specialist part time at the Inter-Connections Drop In Center in Adrian. Several months ago, I was hired as a Recovery Coach through McCullough Vargas Substance Abuse programs. Now I have two part time jobs working about 20 hours a week.

I have been on Medicaid in the past but have not qualified for the past two years. I have had problems with GERD for some time but cannot afford to see a doctor or afford the medication I need for it.

I am 51 years old. I should be getting routine medical check-ups but don't because I can't afford to pay the doctor's fees, or the testing costs. Its very hard to find a doctor who will see you once you tell their office staff that you don't have insurance. They are afraid they are not going to get paid. I probably can't pay them since I'm on such a low income.

I have an anxiety disorder and major depression. Because of all the cuts in the General Fund, I can't get services. I don't get any type of treatment for my anxiety or depression because I can't afford it. I don't feel like I can go see a doctor no matter what because I can't pay, even if it's for an antibiotic for the flu or some other illness.

If the expansion was available I'm pretty sure I would qualify since I only work about 20 hours a week and I am below the poverty level. I would be able to have regular preventative treatment like regular check ups, blood work and xray testing done. My anxiety would be less because I wouldn't have to worry so much about getting sick or injured and how I would pay for it if I did. I would be able to pay more of my bills like my car repairs, car insurance and other bills that you have to pay for to get me to work. My depression would be better too because I would be able to get medications to make it better. I think overall, my life would be better and then maybe I would feel better and could get a full time job. At least I hope so.

I see many others that are like me, just surviving. Wondering what they are going to do if something bad happens to them. Please vote for the Medicaid Expansion, it will help everyone in the long run.

Sincerely

Joseph Roman
Adrian, MI
Lenawee County

DCHSC 3-4-13
Jennifer Durell

The Medicaid Expansion Program is a very important aspect to the Affordable Care Act. I am just one example of why that is....

During my pregnancy, I dealt with a variety of physical and behavioral health issues that put both my unborn daughter and me at risk. Luckily I was eligible for a Medicaid program available to low-income pregnant women. It was because of that Medicaid coverage that I was able to continue the treatments that kept both of us stable until she was born.

Unfortunately, I am losing medical coverage because it has been almost three months since my daughter was born. With Medicaid expansion, I would still be eligible for insurance through Medicaid, even though I am working. Expansion would enable me to continue to receive services through our CMH without having to worry that funding for treatment won't be available. It would also allow my husband and me to access preventative care without having to choose between health care and providing the best life for our family that we can. I would be able to manage my sciatica and pregnancy-induced blood pressure problems; I can't guarantee that without Medicaid expansion.

There are thousands of families like mine in Michigan. We work hard and are involved in our communities. None of us wants to end up in a financial crisis because we got sick and had no health insurance. Even more important, none of us wants a family member to end up hospitalized or worse because we couldn't afford mental health treatment.

I work as director of a drop-in center serving mental health consumers in my area. I enjoy giving back to my community by helping others who are in recovery. Every day I see people benefit from the services they receive through Medicaid. Every day I benefit from the lessons I learn from those we serve. And every day I realize that my anxiety could get out of hand, making it difficult for me to work and take care of my family. Having Medicaid would help prevent that from happening, not only to my but to others in a similar situation.

Before you vote against Medicaid expansion, please take a moment to think about this: what if your family couldn't get insurance because they made too much money to qualify but couldn't afford the high premiums often charged by private insurance companies?

Jennifer Durell
Adrian, MI
Lenawee County

David Benjamin RN, MSN
Program Director
A&D Waiver Division
(989) 249-0929

DCH SC 3-4-13

Home and Community Based Services Waiver Program

My name is David Benjamin and I am the Program Director for A&D Home Health Care, Inc. which serves as a Waiver Agent in the Region 7 Service Area of the State of Michigan. As a Waiver Agent, A&D provides services to a population of "Nursing Home Eligible" Elderly and Disabled program participants who **choose** to reside in the community with needed supports.

The MI Choice Waiver Program provides a cost savings to the State of Michigan; this program helps people avoid Nursing Home Placement. The MI Choice Program also helps current Nursing Facility Residents move back into to the community through the "Nursing Facility Transition Initiative." During the current fiscal year the MI Choice Program will save the taxpayers of Michigan $110.00 per day for each successful nursing facility transition that is performed. Based on the current level of Statewide Nursing Facility Transition Activity: **When 1500 people move back into the community the State of Michigan can expect a savings in excess of $45 million dollars to the Long Term Care Line of the Budget.**

Our work is not yet done. There are more people who we want to help. We implore the legislature to continue to support the efforts of Waiver Agents and the Centers for Independent Living with the implementation of the Nursing Facility Transition Initiative. We would ask that the budget for the MI Choice Waiver Program be increased to support the ability of **2000** people to move back into the community in the coming fiscal year through the efforts of the Nursing Facility Transition Program.

In closing I would like to thank you for the support that the Governor and the Legislature has provided in the past to the Waiver Agents and Centers for Independent Living Agencies which work collaboratively to continue to offer people a **choice** in where they will live. We strive to allow people in need the opportunity to live as independently as possible in the community. I would urge the Legislature to continue to support the MI Choice Program and to expand the opportunity for greater Cost Savings to the State of Michigan Taxpayers in the coming fiscal year.

Thank you for allowing me to testify today.........

DCH SC 3-4-13
Jim McGuire

Area Agency on Aging 1-B Testimony before the House Appropriations

Department of Community Health Subcommittee

March 4, 2013

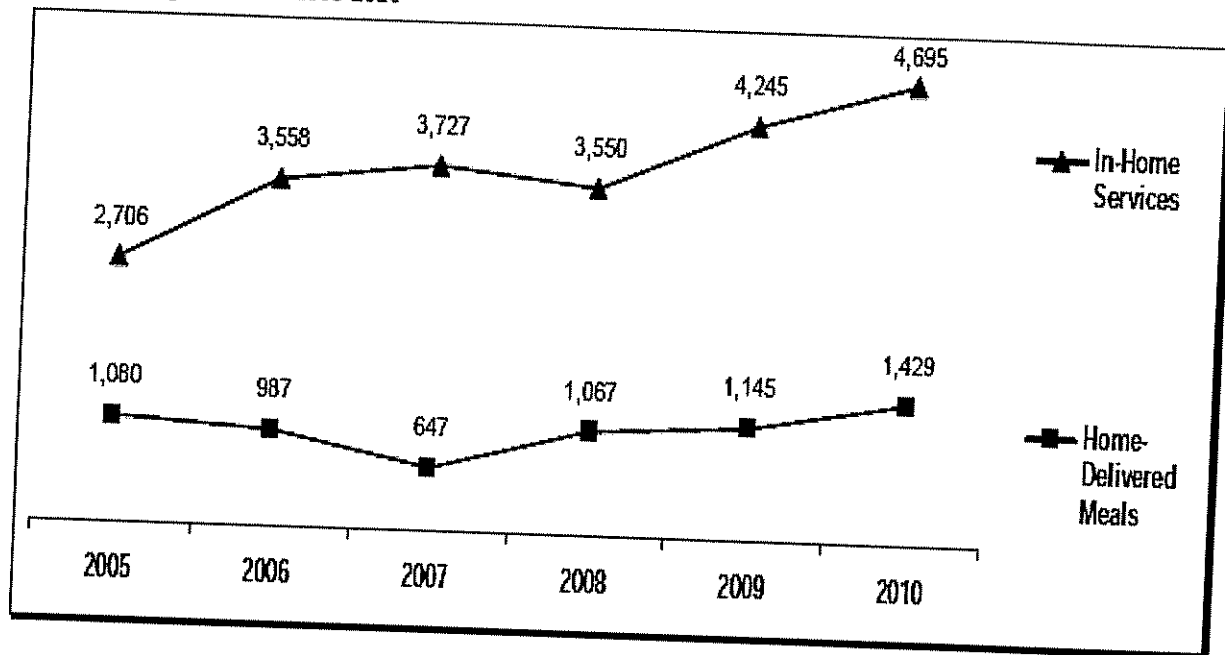
My name is Jim McGuire, and I am the Director of Research, Policy Development, and Advocacy for the Area Agency on Aging 1-B, which serves the counties of Livingston, Macomb, Monroe, Oakland, St. Clair and Washtenaw. I appreciate this opportunity to address state general revenues support for services to Older Michiganians through the Michigan Office of Services to the Aging (OSA).

First I want to thank the Legislature for eliminating Michigan's chronic structural budget deficits, which imposed a 29% reduction in state support for OSA from 2008 - 2011. Your efforts allowed our first increase in many years of $1.1 million for the current year. We are grateful for these resources, and I wanted to let you know what the return on your investment in services is producing for older adults and family caregivers in Region 1-B. The attachment to my testimony shows:

- 35 individuals at risk of going to a nursing home, many who are already on in-home service wait lists, are receiving assistance to remain living independently and avoiding nursing home admission.
- 150 individuals with a disability will receive options counseling and linked with resources through our Aging and Disability Resource Collaborative (ADRC), with many being served through our Centers for Independent Living/Disability Networks. This fulfills one of the Governor's Dashboard measures.
- We will launch our No Excuse for Elder Abuse campaign to promote the protections provided by the package of elder abuse bills passed in 2012, including implementation of the Mozelle bill's Silver Alert program.

The main purpose of me coming here today is to help you understand why advocates are so concerned about the harm caused by growing in-home service wait lists for services like home delivered meals, personal care, homemaking and caregiver respite. These services are needed by many Michigan seniors with limitations in their ability to perform activities of daily living such as bathing, dressing, housekeeping and meal preparation. The table below based on data from OSA shows that wait lists have been growing steadily in recent years.

Fig. 72 Waiting List Totals 2005-2010



Advocates are requesting an increase in OSA funding for in-home services to assist individuals on wait lists because **in-home service wait lists are a danger to both frail seniors and taxpayers, whose dollars support the Medicaid budget.** Please listen to the following reasons why:

OSA in-home services such as personal care, homemaking, caregiver respite, home delivered meals and care management are targeted to low-income seniors at risk of nursing home admission, and have proven successful in preventing or delaying more costly use of Medicaid long term care services.

These same in-home services have proven effective in reducing nursing home admissions in the MI Choice program, where total nursing home spending actually decreased in 2008 and 2009, and has grown slower than other health care costs since then.

An AAA 1-B study of what happens when older adults and adults with a disability go on wait lists and do not receive any help found:

- They are more than five times more likely to end up in a nursing home within two years than individuals who receive services (3.6% vs. 22%).
- The mortality rate for those not receiving services was much higher - 477 per 1,000 died, while only 352 per thousand who received help had died.
- Among working caregivers whose loved one did not receive services, three out of four reported that caregiving interfered with their work; only one in four who received services reported that caregiving interfered with their ability to work.

- The study found that two years after going on the AAA 1-B wait list, 76% of those who received some help were still in their own home, but only 56% of those who received no help were still at home.

AAA 1-B uses OSA funds to support our Community Living Program that gives individuals on wait list at least some help, and many times a little help is enough. The AAA 1-B PERS (Personal Emergency Response System) study found that just by offering wait list individuals PERS for a year, it was enough to relieve caregiver burden, and prompted one in four individuals to remove themselves from the wait list. After a year of publicly supported service, 60% agreed to pay the full cost of the service on an ongoing basis.

An earlier study in collaboration with the Health Alliance Plan on the impact of AAA 1-B care management found:

- AAA 1-B care management and limited in-home services were successful in achieving a 46% reduction in emergency room visits and a 34% decrease in hospital admissions for their high risk Medicare Advantage Plan population.

- 90% of participants increased confidence in their ability to manage their illness. This patient self activation is the key factor that is allowing our Care Transitions program to reduce hospital readmissions.

The AAA 1-B's OSA funded Community Living Program currently has around 1,200 participants. This Medicaid Diversion program assists individuals with limitations in their ability to perform basic activities of daily living with researching community resources, strategizing on using their own personal financial resources in a more efficient way, and providing minimal in home services for those individuals who need assistance to stay in their own home. The program uses state funds for in-home services and strategies that are helping individuals, many of whom are on wait lists, to prevent or delay depending on Medicaid long term care. Some of the strategies include:

- Using discount coupons to pay privately for needed in-home care.

- Accepting introductory service offers that provide free services for a limited time before the recipient pays privately with their own funds.

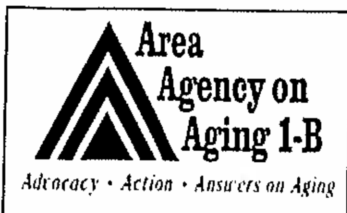
- Supporting family caregivers' efforts to avoid placing their loved one in a nursing home by offering limited respite and in-home services to those on the MI Choice Wait List.

- Providing 24/7 on call access to help for those receiving personal care and home-making. A survey we conducted in 2011 found that the 24/7 on call help available with these in-home services, saves an estimated $1.6 million to the state annually by home care providers responding to after hours emergency calls that often prevent a trip to the emergency room and subsequent hospitalization.

The AAA 1-B asks that priority and funding be given to further develop this Medicaid Diversion strategy that can prevent or delay many low and middle income individuals from depending on more costly Medicaid long term care. As you have heard, these OSA services are preventive in nature, and are allowing us to bend the cost curve of expensive health and long term care entitlement programs, and still provide Michigan families with a level of support that meets their needs.

Submitted by:
Jim McGuire, Director of Research, Policy Development and Advocacy
Area Agency on Aging 1-B
29100 Northwestern Highway, Suite 400
Southfield, Michigan 48034
(248) 262-9216

In FY 2013 the Legislature Invested $1.1 Million more in Senior Programs through the Office of Services to the Aging and Area Agencies on Aging



What did this $257,319 Investment Buy for Region 1-B Seniors?

Community Living Program's Medicaid Diversion

Why is CLP a Great Investment?

The majority of CLP services are personal care and homemaking. A soon to be released AAA 1-B study found that the 24/7 on call help available with these services saves an estimated $1.6 million annually by home care provider response to after hours emergency calls.

The default option for addressing health and social problems can no longer be to depend on the most expensive solutions. The Area Agency on Aging 1-B (AAA 1-B) is playing a leadership role with the Michigan Office of Services to the Aging in supporting structural change through an emphasis on self sufficiency strategies and redirecting individuals toward programs and behaviors that reduce dependence on the most expensive health and social service options, especially Medicaid .

The AAA 1-B Community Living Program (CLP) uses state funds for in-home services and strategies that are helping 35 more individuals, many on in-home wait lists, to prevent or delay depending on Medicaid long term care by:

- Using discount coupons to pay privately for needed in-home care
- Accepting introductory service offers that provide free services for a limited time before the recipient pays privately
- Supporting family caregivers' efforts to avoid placing their lived one in a nursing home by offering limited respite and in-home services to those on the MI Choice wait list.
- Providing 24/7 on call access to help for those receiving personal care and homemaking.

NO EXCUSE FOR Elder Abuse

Funding will support our legal service providers' elder abuse prevention public information campaign to promote the new protections passed by the Legislature in 2012, including implementation of a Silver Alert program, modeled after Amber Alert, which will help families find lost elders who are in danger.

Supporting Governor Snyder's ADRC Dashboard

The AAA 1-B allocated $124,319 to expand the ability of 16 Aging and Disability Resource Collaborative member organizations to perform long term care Options Counseling and link consumers with community resources that support their continued independence. A special emphasis on adults with disabilities included contracting with mental health providers and Centers for Independent Living. 150 vulnerable older adults and adults with a disability will potentially avoid or delay Medicaid dependence.

The AAA 1-B serves Livingston, Macomb, Monroe, Oakland, St. Clair, and Washtenaw counties

DCH SC 3-4-13

House of Representative Hearing Testimony

March 4, 2013

Barbara Fowkes
320 W. Huron Street
Milford, MI 48381
Spectrum Community Services – Executive Director
28303 Joy Road, Westland Michigan 48185

Subcommittee Members:

Rep. Matt Lori, Chair (R – Constantine)
Rep. Rob VerHeulen, Vice-Chair (R – Walker)
Rep. Paul Muxlow (R – Brown City)
Rep. Peter MacGregor (R – Rockford)
Rep. Rashida Tlaib, Minority Vice-Chair (D – Detroit)
Rep. Brandon Dillon (D – Grand Rapids)

My name is Barbara Fowkes and I am the Executive Director for Spectrum Community Services, a non profit Human Service agency. Spectrum Community serves nearly 650 children and adults with developmental disabilities including autism, and mentally ill adults in residential settings, support coordination and we provide enhanced health services. I am here today on behalf of my employees and the people I serve.

Spectrum Community employs nearly 1000 people. 60% of our employees are part time staff. With the expansion of Medicaid, these employees will be eligible for services along with many of my full time staff as they fall at the

poverty level stated in the Affordable Care Act. This is due to the funding that is received from the Community Mental Health agencies Spectrum contracts with. I feel Spectrum Community distributes to our employees, as much as we are able to, the funding we receive for our salary line. The salary rate we receive varies from county CMH to county CMH. The salary rates we receive vary between $10.80per hour to $15.00 per hour. 30% of this rate goes to paying taxes and benefits for our employees. Also out of this funding, Home Managers in the residential sites are paid a minimum salary of $25,500 which is mandated by wage and hour for a salaried personnel. This leaves my direct support staff at a starting wage between $7.50 per hour to $8.50 per hour. This wage puts them at the poverty level and eligible for Medicaid services.

Additionally at this wage, we have difficulty hiring people to work with individuals with a disability. Many people who apply to work for us do not qualify because they have: a criminal history, no valid drivers license, a positive drug screening, on the DHS child abuse registry, or they have no transportation to get to the program site.

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 which creates health issues for them. Many of Direct Support Staff are tobacco users. This goes with stressful jobs. Often times stress for employees is just as much with their co workers and the fear of not knowing if they will be able to go home at the end of their shift. We provide 24/7 residential services in most of our sites so staffing is required around the clock. If staff calls in for the shift, then some one has to stay and work; either the home manager or the staff on shift. Emergency relief staff is a luxury most providers don't have and can't keep due to the fact that people want set schedules to ensure an income.

I would request that you consider increasing the direct care wage so that we may be able to attract people who want to make this a long term career in the human service field and more quality people applying for a position. I know that my employees would be very grateful for any kind of a wage increase from you.

I am also requesting your support to the Medicaid expansion. This would serve both people with disabilities and many of our direct care staff. With the cost of insurance today, most of our staff can only afford insurance on themselves and not

their families. With the expansion, they would be able to get their children insured, get medial care timely and reduce shift call offs due to sick children. This would also help with our employees who work on a part time basis.

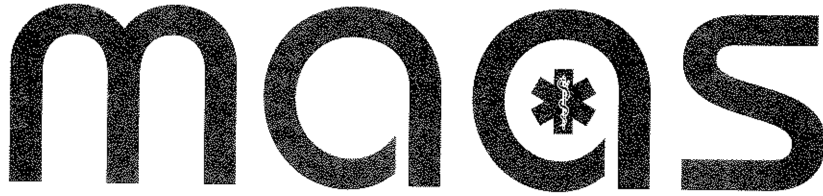
Even though our agency provides health insurance to our full time employees, our insurance does not adequately cover mental health services. There is a cap on the amount of visits and/or funding available to a person. I have seen staff struggling with a family member who has a mental health issue and not be able to get adequate services they desperately need. You see many of our employees who work for us have a family member with a developmental disability or a mental health issue. They are with us because know and want to help others.

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. I have seen many people who have fallen through the cracks of the system. They are making just enough money not to qualify for Medicaid services but can't afford to purchase insurance coverage and/or the insurance coverage does not cover mental health services adequately. It gets very frustrating to see this over and over knowing that intervention would help them greatly and not be able to do anything but listen and direct them to resources that I am aware of.

In closing, I am requesting of you to consider approving the Governor's desire for Medicaid expansion and a direct care wage increase by way of a funding pass through as you had done a few years ago.

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.

DCHSC 3-4-2013
Ron Slagell



Representing Pre-Hospital Care Providers

Medicaid Reimbursement for Ambulance Services

Presentation to the House Appropriations Committee
March 4, 2013

Medicaid reimbursement levels for Ambulance Service base rates have not been increased in more than a decade
- In fact **they have been reduced** and are about **12% lower now than they were in 2001**

Medicare pays significantly more for Ambulance Services than Medicaid
- Medicaid's payment for a Level 1 Advanced Life Support Emergency Transport was about **60% of the Medicare rate in 2004**
- In 2013, the rate is only **49% of the Medicare rate**

Blue Cross Blue Shield of Michigan's Ambulance rate has always been significantly higher than Medicaid
- In 2004, **BCBSM paid twice as much as Medicaid** for a Level 1 Advanced Support Emergency Transport
- BCBSM's rate is now **more than two and a half times higher** than Medicaid

The **cost of fuel** has a significant impact on the cost of Ambulance transports
- In 2004, the average price for a gallon of gas was **$1.80**
- In 2013 the price is now almost **$4.00**

The cost of an Ambulance transport varies across the state – rural transports are more expensive than urban transports
- **Average emergency transport costs in Michigan exceed Medicare reimbursement rates**

Ambulance services **must respond when called and provide their full services, regardless of ability to pay.** Ambulance services cannot select their patient mix based on payers as other health care providers can.

Other providers have a QAAP to help keep Medicaid reimbursement rates at a higher level. While we are supportive of a QAAP for ambulance services and are working to get one implemented, we do not currently have that benefit to increase Medicaid rates.

MAAS represents all of the various types of ambulance services in the state: public sector services operated by local government; private sector operations (both non-profit and for-profit); hospital operated systems; and volunteer groups providing service to small, rural communities.

(continued on reverse side)

Michigan Association of Ambulance Services
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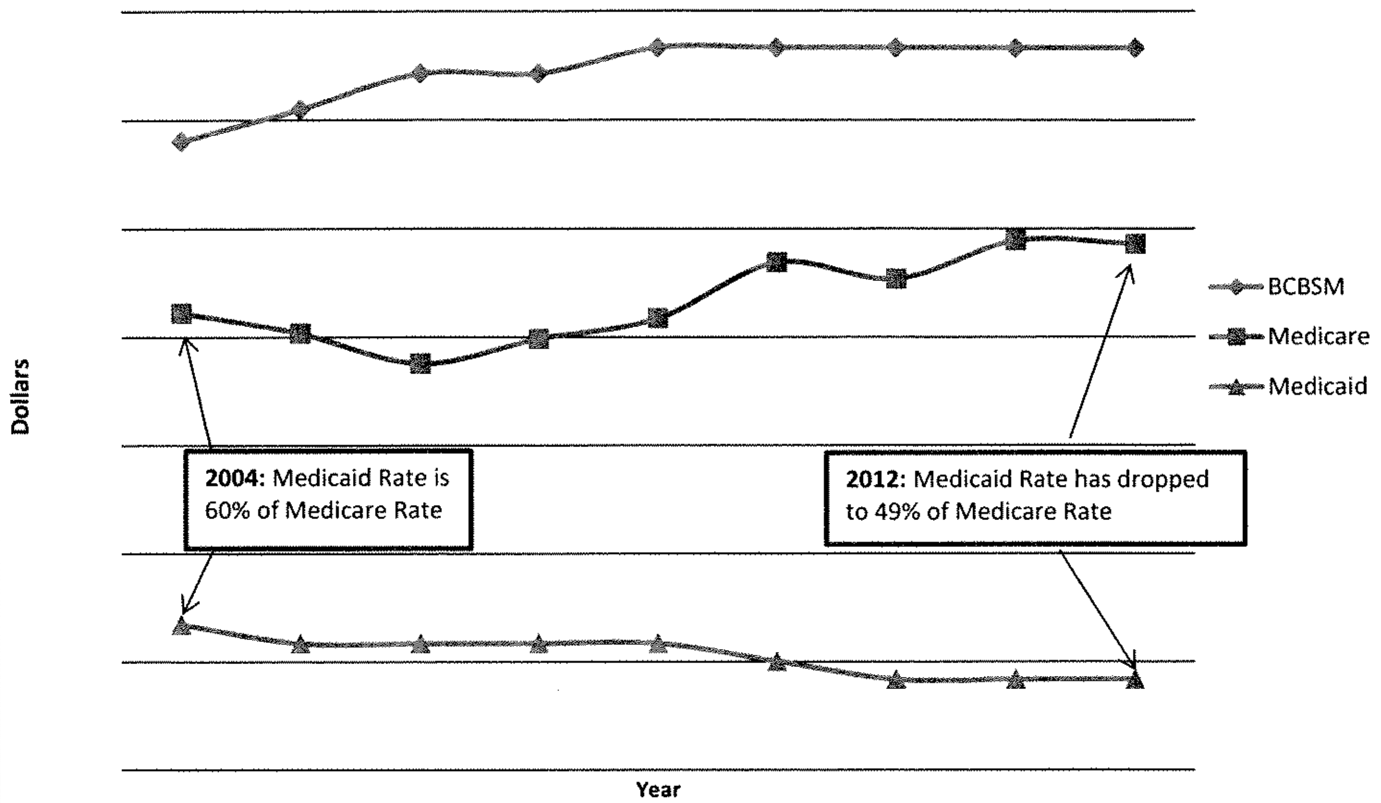


ABOUT AMBULANCE SERVICE IN MICHIGAN

Michigan ambulance service operators are critical components of every community's health care system, providing both emergency care, as well as the non-emergency medical transfers of patients between hospitals, medical facilities or residences. Ambulance services are provided through one or more of the following groups: public sector services operated by local government; private sector operations (both non-profit and for-profit); hospital operated systems and traditional volunteer groups providing service to small, rural communities.

Each year, Michigan ambulance service providers respond to approximately 400,000 emergency 9-1-1 calls. The ambulance industry is unique among most health care providers in that they are mandated by state law to respond to all emergency 9-1-1 calls and provide their full range of medical services without inquiring about the patient's ability to pay.

The prompt and skilled EMS service provided in those first moments of emergency care can make the difference between a patient's full-recovery or an extensive and costly patient rehabilitation. More importantly skilled and prompt emergency service also can make the difference between life and death of the patient.

DCH SC 3-4-2013
Alan Brown

House Appropriations Subcommittee on Community Health

Office of Services to the Aging Budget

3/4/13

Good afternoon. I am Alan Brown, Executive Director of the Midland County Council on Aging. I am here also representing the membership of the Michigan Directors of Services to the Aging Association, providers of local services to Michigan's older adults in most of our counties. Thank you for the opportunity to present our concerns over the absence of increases in the OSA budget, particularly for the Nutrition and Community Services line items.

Between 2009 and 2011, programs funded by OSA were cut by 28%. Since 2012, that level of funding from 2011 has been carried forward in the 2012 and 2013 budgets, and now is recommended to continue at those decreased and inadequate levels for another two budget years, through 2015. In the meantime, there has been and will continue to be significant growth in our senior population, with those over 80 the fastest growing of any group.

The recommended budget increases funding for nursing homes by 3.5% in 2014, with another bump again in 2015; Medicaid waiver by 6% in 2014, and the PACE program by over 40%. Medicaid Waiver and PACE are solid programs, but truly only serve a fraction of the need of the more frail elderly.

Community based and nutrition programs are every bit as critical to the health and well being of isolated and health impaired seniors, providing personal care, housekeeping and other home based support to keep seniors healthy and living in the community. Home Delivered Meals often provide the critical sustenance for home bound seniors to maintain strength and functions. Other community based services allow seniors to manage chronic health conditions, provide for case management and care coordination, all allowing seniors to avoid or delay costlier levels of care.

Higher costs over the last five years, the increasing population, especially in the over 80 demographic, the provision of critical prevention and health and independence maintenance programs all argue for providing increases in the OSA budget line items for Community Services and Nutrition. Logic dictates that these are the services that minimize the need for the costlier nursing home, Waiver, and PACE programs. If we neglect these services, we will never see true progress. A 5% increase in these line items for each of the two years would only be about a $5 Million total increase. This compares to the $15 Million proposed for PACE and $17 Million for waiver.

Thank you for your time and attention.

DCH SC 3-4-13
Mark Witte

MICHIGAN ASSOCIATION OF SUBSTANCE ABUSE COORDINATING AGENCIES

Testimony Presented to the House Appropriations Subcommittee for Community Health

Mr. Chairman and Members of the Subcommittee:

My name is Mark Witte. I am the Planning Director in the Substance Use Disorders Division of Network 180 in Grand Rapids, which is the Substance Abuse Coordinating Agency for Kent County. I am representing the Michigan Association of Substance Abuse Coordinating Agencies, known commonly as MASACA. The members of MASACA are the directors of the 16 Coordinating Agencies which are responsible by statute for planning, funding and oversight of substance use disorder treatment and prevention services in all 83 Michigan counties.

My purpose today is to convince you that an effective, reasonably funded substance use disorder treatment and prevention service, readily accessible across the state, is one of the most valuable assets this administration and this legislature have to achieve your ambitious goals.

The House Republican Plan for 2013-14 calls for much improved placement services for Michigan's 13,000 children in foster care. But of the children removed from abusive and neglectful homes, the vast majority come from homes with serious alcohol and drug problems. Without effective intervention, it is likely that the same experience will be repeated in those homes in the future. And even the kids who are successfully placed will often require substance use and mental health services, as your Plan acknowledges, because their life experience puts them at high risk of repeating the same thing in their lives.

The administration and the legislature also are considering a major expansion of the Medicaid program in accord with the Affordable Care Act. That consideration includes serious concern about managing the cost of the program as it grows. Since at least 30% of all hospital emergency visits involve alcohol or drugs – some studies put the percentage much higher, an effective intervention with substance use disorder services, not just handing someone a referral slip, is an essential element to control costs.

In addition, the legislature and the Governor have voiced a priority on finding proven strategies to divert more people from the high cost criminal justice system into cost effective community services. But we know, for example, that at least two-thirds of persons managed by the Dept. of Corrections have a history of alcohol or drug problems. And every sheriff and police chief in Michigan can tell about jails crowded with people whose primary problem underlying their criminal activity is alcohol or drug misuse. One excellent diversion program, the drug and sobriety courts, has proven its effectiveness in reducing drunk driving offenses, especially deaths, and are thereby one of the most cost effective diversion strategies found to date. But a key to the courts success is the availability of strong local treatment programs which partner with the courts. To think that any diversion initiative can be successful without readily available treatment and prevention services is at best naïve.

Let me add a comment about cost efficiency. It might be enlightening to consider the Dept. of Corrections' substance use disorder services program. That program duplicates the administrative structure already in place throughout the state in the local Coordinating Agencies. For the most part, they use the same local providers, the same clinical services and similar performance standards. The Coordinating Agencies could readily assume responsibility for oversight of those Corrections services and ensure that providers, with whom the Coordinating Agencies likely already have contracts, continue to meet the specific performance requirements demanded by the Dept. of Corrections. Eliminating this duplicate administration is a clear opportunity for cost savings with no diminishment of service.

All this data and examples demonstrate how often alcohol and drug disorders lay underneath and are contributing to so many of the problems that this legislature wants to address. A reasonably funded, effectively performing substance use disorder service all across the state can be one of Michigan's best resources to help achieve your lofty ambitions.

There is one problem. This service certainly has not been reasonably funded. Due to various budget cuts over the years, the annual General Fund support for treatment and prevention services has been cut from $35 million in 1995 to the current $15 million, a nearly 60% reduction. Waiting lists and reduced, less than optimal services have too often been the results in too many parts of the state. With a desire to create a reasonable, predictable and dedicated funding stream for substance use disorder services in Michigan, our organization is working with several different key stakeholders in the area of both the liquor industry and the substance abuse treatment industry to find mutually-agreeable solutions to replace the current inadequate and unpredictable General Fund dollars with an annual share of the state's net income, after all expenses, from alcohol tax and fees revenues. We all agree that, since the state benefits so substantially from the sale of alcoholic beverages, it is not only humane but just that a reasonable portion of that income be directed to services for those people who contribute a disproportionate share of that income because they consume a disproportionate share of the product and have such serious problems with the product. We look forward to working with members of this committee as this initiative gains detail and support.

MASACA can currently, and can still under the new structure for the merger of the remaining substance abuse coordinating agencies into the PIHP structure, be a partner to the legislature as the 2013-14 action plan comes to fruition with regard to reducing corrections spending and increasing access to mental health services.

Thank you for your attention. I will gladly answer any questions you may have.

DCH SC 3-4-2015
Kara Hamilton-McGraw

fact sheet

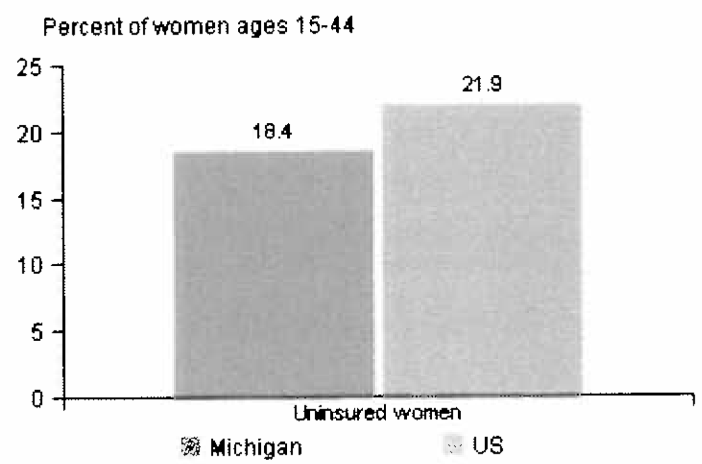
Medicaid Expansion

The March of Dimes supports expanding Michigan's Medicaid program to cover individuals newly eligible under the Affordable Care Act, particularly women of childbearing age.

Studies have shown conclusively that lack of access to health coverage causes women to delay or forego needed health treatment, including both preventive and sick care. For women of childbearing age, this means that critical opportunities to improve their health before pregnancy are missed. If women can obtain regular health care services to help them quit smoking, achieve a healthy weight, and maintain normal blood pressure and blood sugar levels, they are much more likely to have a healthy pregnancy and baby. The Medicaid expansion provides states with the opportunity to extend health coverage to women before and between pregnancies, improving health for both them and their infants.

In addition, extending health coverage to parents improves access to care and a greater use of appropriate care for children. Children with health insurance whose parents are insured are less likely to have unmet health care needs compared to insured children with uninsured parents.

Uninsured women: Michigan and US, 2009-2011 Average



Key Points

In our state, many women of childbearing age have no access to health coverage before they become pregnant.

- During the years 2009-2011, an average of 18.4% of women of childbearing age were uninsured in Michigan.
- About 159,000 uninsured women of childbearing age in our state would be eligible if Medicaid were expanded up to 133% of the federal poverty level.
- In our state, working parents of dependent children are eligible for Medicaid coverage up to 64% of the federal poverty level, while jobless parents of dependent children are eligible up to 37% of the federal poverty level.
- Women of childbearing age could benefit from preventive care such as tobacco cessation, nutrition counseling, and blood pressure monitoring to improve their health and help ensure a healthy pregnancy.

Contact Information:
Kara Hamilton-McGraw at (248) 359-1577
or khamiltonmcgraw@marchofdimes.com

The March of Dimes is a national voluntary health agency whose volunteers and staff work to improve the health of infants and children by preventing birth defects, premature birth and infant mortality. Founded in 1938, the March of Dimes funds programs of research, community services, education and advocacy. For the latest resources and information, visit **marchofdimes.com** or **nacersano.org**.

DCH SC 3-4-13
Jessica Yorko

Ingham County
Health Department

Renée Branch Canady, Ph.D., MPA, Health Officer

February 21, 2013

Dear House Appropriations Committee,

Since the mid-1990's the Ingham County Health Department (ICHD) has partnered with the Michigan Department of Community Health (MDCH) to remove lead hazards from the homes of more than 400 low-income residents in Ingham County.

ICHD mails applications for this program to county residents whose children have blood lead levels over 10 micrograms of lead per deciliter of blood (mg/DL). We consider anything over 10 mg/DL an "elevated blood lead level" and indicative of lead poisoning. Until 2006, the majority of lead abatement services in Ingham County were performed through this partnership, in the homes of children with elevated blood lead levels.

In 2006, Michigan Department of Community Health implemented three significant changes to the program in Ingham County:

1. The maximum amount available per home through this program for Ingham County residents was lowered from $20,000 per home to $8,000 per home
2. The program stopped providing resources for lodging for the family for the four-day duration of the actual abatement work on their home. (MDCH does not allow residents to be in their home while abatement work is being performed.)
3. MDCH began charging a $150 fee to apply for the program

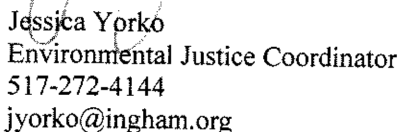
Between 2009 and 2011, we knew of 114 lead-poisoned children in Ingham County. Of these, five applied directly to ICHD for the MDCH/ICHD lead abatement program. Of these five applicants, two were denied by MDCH and one dropped out of the program. Of the 114 lead-poisoned children in Ingham County in 2009-2011, two received lead abatement services for their home. One of the denied applicants had a child with a blood lead level over 10 mg/DL in 2009. In 2010 they were denied the program's services because their income was slightly above the eligible limit. They have not been able to afford the repairs needed to make their home lead safe. Last year, their child's blood lead level test came in over 25 mg/DL, and we know that the impacts of lead poisoning on this child will likely be life-long. Before the changes to the program in 2006, the majority of those served by the program were lead-poisoned children, and the people most affected by lead poisoning got relief through the program.

Between 2009 and 2011, a total of 161 Ingham County residents applied directly to MDCH for lead abatement services. Sixty-nine applications were denied. Twenty-six applications were approved but dropped out of the program. Sixty-six projects were completed. None of these 66 completed lead abatement projects in Ingham were in the homes of lead-poisoned children.

Ingham County Health Department urges you to restore funding for Michigan's Lead Safe Home program. We specifically urge you to restore the amount per home to $20,000, provide relocation resources, and eliminate the application fee.

Please also keep in mind that private companies benefit from this program. Lead abatements are not performed by public agencies in Michigan. They are performed by private sector contractors. Changes to the program at the state-level has limited the revenue of these companies and their employees, because far less lead abatement work gets done in Michigan than it did before, these companies have been hurt by the changes made in Lansing. Sometimes what is good for peoples' health is good for business too, and this is definitely one of those cases. Let's keep making Michigan a business-friendly state.

Sincerely,



Jessica Yorko
Environmental Justice Coordinator
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DCHSC 3-4-13

Wisser, Debbie< wisserd@occmha.org>

Talking Points from Anita Warner-Medicaid Expansion

1 message

Anita Warner< anitabwarner@gmail.com> Thu, Feb 28, 2013 at 2:04 PM
To: wisserd@occmha.org
Cc: Anita Warner <anitabwarner@gmail.com>

Talking Points for Medicaid Expansion –
Comment from Anita Warner, Oak Park
My daughter was taken off of Medicaid when she turned 21 years old at the end of 2012. When she was cancelled from healthcare she had no other health insurance. At the time my daughter was receiving medical attention for a hip fracture. She had to discontinue her follow-up appointment with her specialist due to lack of health insurance. We can't afford the cost of a specialist to see her.

She applied for Oakland Primary Health Plan which will not be effective until 3/2013. However, this health coverage only covers basic medical. She has to go through the process of seeing a primary care physician as a new patient when an appointment opens up. In the meantime, she is not receiving follow-up treatment for her fractured hip until this happens. This has caused us distress and concern.
I have Adult Benefit Waiver (ABW) health coverage which does not adequately cover my mental health issues. I've had to use emergency room services on a number of occasions which is not a covered benefit under ABW. Neither are ambulance services which I've had to use on a couple of occasions. Both services I've had to use as a result of my mental illness. These are bills I have outstanding that are affecting my credit rating as well.
I live below poverty level, and extra expenses such as medical expenses create a hardship for my household (my daughter and me). We would benefit greatly from a Medicaid expansion.