AREA AGENCIES ON AGING ASSOCIATION OF MICHIGAN
6105 West St. Joseph, Suite 204, Lansing, Michigan 48917
Phone (517) 886-1029 www.mi-seniors.net Mary Ablan, Director

FACT SHEET ON OSA SERVICES

OSA services help frail older Michiganians who don't qualify for Medicaid but can't afford to purchase services privately, with the goal of helping them live safely in their own homes longer, and delaying or eliminating future use of Medicaid.

What are OSA services?

"OSA services" refers to the services funded by the Office of Services to the Aging (OSA), the federally-designated state agency charged with serving older Michiganians 60+. OSA services are available statewide and include a wide variety of in-home and community-based services designed to keep seniors living safely in their own homes, out of nursing homes, and off the Medicaid program. Most OSA services are "Medicaid prevention" services and are targeted to those in greatest economic and social need. Examples include meals-on-wheels, information and assistance, care management, personal care, homemaker, transportation, home repair, legal assistance, adult day care, etc. Over 40 services are now provided with new services created every year as needs dictate.[1] OSA services are funded with federal funds, state general funds, merit award funds, Blue Cross escheats funds, client contributions and a wide variety of local funding sources. The aging network also utilizes thousands of volunteers to keep costs down. State funding is required as match to bring federal funds into Michigan from the Older Americans Act.

Are OSA services cost-effective?

Yes. It costs, on average, $1,000 a year to keep seniors at home with meals-on-wheels and in-home services. Compare this to the $63,000 average daily cost of a nursing home. These savings quickly add up. In 2010, if OSA's 2,830 highest risk clients had been forced into nursing homes for one year, Medicaid expenditures would have increased by $191 million. In contrast, the cost of OSA services for this same group was $2.4 million.[2]

OSA services are cost-effective because they help to support and relieve the family members who provide most elderly care at no taxpayer expense. In fact, caregivers provide 80% of the care received by older adults, at an estimated annual value of $13 billion in Michigan.[3] It has become more difficult for modern families to maintain these caregiving responsibilities, because of the growth in the number of elderly and longer lifespans. Also making it harder - smaller families, the dispersion of younger relatives, and an increase in the number of working women. OSA services play a crucial role in supporting unpaid caregivers and helping them to keep going.

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[1] Every service is not available in every area because of limited funding. More information is available at www.michigan.gov/miseniors.

[2] Office of Services to the Aging, 2010 NAPIS data. Nursing home data for FY 2010 from the Department of Community Health.

[3] National Center on Caregiving, "State of the States in Family Caregiver Support," retrieved from www.caregiver.org on December 13, 2010.

How do OSA services compare with the MI Choice Medicaid Waiver?
Both programs provide home-based care, but they have different purposes. OSA services divert clients from Medicaid-funded long term care. In contrast, MI Choice services divert Medicaid clients from more costly institutions. While the services are similar, there are some differences: 1) OSA funds a wider variety of services and has more flexibility in creating and adding new services; 2) OSA state-federal match is dictated by the Older Americans Act while MI Choice match is dictated by Medicaid law; and 3) OSA services are targeted to those in greatest need, but are not bound by the strict financial and level-of-care tests required for Medicaid programs like MI Choice.

Aren't all low-income frail seniors served by the MI Choice Medicaid Waiver?
No. Some low-income seniors don't qualify for MI Choice because their income or assets are a few dollars over the Medicaid limits. Others are disqualified because their need for care is not judged severe enough. Still others meet the financial and level-of-care rules, but are put on a waiting list because there are not enough slots.

How do OSA services work?
Most OSA services are administered by 16 regional Area Agencies on Aging (AAAs) that partner with 1200 businesses and nonprofits that provide the services. AAAs directly provide Information & Assistance and Care Management, services that help older adults and families navigate the complex system of programs and housing options, make informed choices, and use their limited financial resources wisely. AAAs use a competitive bidding process for some services, for example, senior meals. For other services, like homemaker and personal care, clients select from a pool of qualified providers, and can change providers if they choose. AAAs use competition to incentivize quality and cost-effectiveness. This competitive structure has spurred the development of many new small businesses in communities with the greatest needs. Those receiving OSA services are encouraged to contribute through donations or a sliding scale; the funds are used to expand services.

How much funding is allocated for OSA services?
In FY 2011, $60 million in federal funds and $30 million in state funds are budgeted. Federal funds were cut in 2011. State funds have been cut by $10 million since 2009. Waiting lists for OSA services have grown during this period, from 4,619 in September of 2008, to almost 7,000 in September of 2011.[4]

Is there harm in having people wait for services?
Research shows that frail elders in the community with unmet needs are more likely to experience crises, such as falls, burns, dehydration, medication problems, etc. leading to emergency room visits, hospitalizations and nursing home stays. For example, a 2006 Purdue University study showed that frail older people with unmet needs have higher rates of hospital admissions while they have unmet needs but not after their needs are met.[5] Many studies indicate that poor nutrition in the elderly is associated with weight loss and health problems.

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[4] Information obtained from the Office of Services to the Aging.

[5] Laura P. Sands, et. al., "Rates of Acute Care Admissions for Frail Older People Living with Met Versus Unmet Activity of Daily Living Needs," Journal of the American Geriatrics Society, February 2006.

AREA AGENCIES ON AGING ASSOCIATION OF MICHIGAN
6105 W. ST. JOSEPH, SUITE 204, LANSING, MICHIGAN 48917

TESTIMONY ON THE BUDGET OF THE OFFICE OF SERVICES TO THE AGING BY MARY ABLAN

- There is no question that Medicaid is the biggest part of the Community Health budget, but today I want to focus my testimony on aging programs that are right now preventing seniors from going on Medicaid and costing the state more.

- First of all, we applaud Governor Snyder's support for senior independence and dignity in his fiscal year 2013 budget recommendations for the Office of Services to the Aging (OSA). We support the Governor's recommendation for $1.1 million in additional funding, to be used for Aging and Disability Resource Centers, dementia programs and elder abuse prevention.

- OSA services are helping very vulnerable older Michiganians, those who live alone, those with lower incomes, those with multiple health conditions, and those in danger of going on Medicaid.

- OSA services also help family caregivers who provide most elderly care at no cost to the state. It is estimated that caregivers provide 80% of the care, at an estimated annual value of $13 billion in Michigan. But when their burden is great and lasts year after year, caregivers can burn out and get sick themselves. OSA services prevent caregivers from burning out and seniors going on Medicaid as a result.

- Research shows that frail elders with unmet needs are more likely to experience crises like falls and dehydration, resulting in hospital and nursing home stays. Some simple, low-cost services like meals, a weekly bath, and a lifeline call button can prevent the need for high cost medical and hospital services.

- Please consider restoring some of the $10 million cut from meals-on-wheels, home care and volunteer programs between 2009 and 2011. Meals-on-wheels have been cut by $3.3 million, other home-based and community services by $4 million and volunteer programs by over $2 million. These services are preventing seniors from going on Medicaid and costing the state more.

- OSA services are cost-effective. The average annual cost of OSA services is about $1000 per client. In contrast, a nursing home costs an average of $63,000.

- OSA services allow seniors to contribute to the cost of their services.

BOTTOM LINE: Please include the Governor's recommended funding increases and restore some of the cuts in meals, community services and volunteer programs.

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

Ingham County
Health Department

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

March 12, 2012

The Honorable John Moolenaar
Chairman, Senate Appropriations Subcommittee on Community Health
State Capitol/ P.O. Box 30036
Lansing, MI 48909-7536

Dear Representative Moolenaar,

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.

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.

Sincerely,

Jessica Yorko
Environmental Justice Coordinator
517-272-4144
jyorko@ingham.org

MICHIGAN TRAUMA SYSTEM

WORKING TOWARD A COORDINATED RESPONSE FOR THE INJURED

In 2006, almost 3,500 Michigan Residents died from accidental injuries.

A patient receiving proper medical care in the first hour following an accident triples their chance of survival.

Michigan ranks 9th in the nation in injury death rates.

Trauma is the leading cause of death for people ages 1-44 in the U.S.

There are more years of "lost life" due to trauma than heart disease and cancer combined.

A state wide trauma system could save lives, reduce disability and reduce health care costs.

The total cost for trauma in the US is approaching $260 billion each year, combined with changes in health care financing, any system unable to decrease costs is certain to fail.

An inclusive trauma system with an emphasis on optimal resource utilization and prevention offers the

OVERVIEW

When someone experiences an emergency that requires fire or police response, they expect to receive it. And when a life-threatening accident or injury occurs, we know that we can call an ambulance or rush to an emergency department and receive immediate and expert medical care. The major difference is that our trauma system, unlike the police and fire departments, is not a government funded service and there is no guaranteed protection for it. It is a volunteer-based system funded by private and government sponsored payment mechanisms that don't come close to reimbursing hospitals or physicians for the extraordinary care they are required to provide all citizens.

Michigan must acquire a source of funding to develop the infrastructure needed to provide a coordinated response to the injured patient. This will provide the best and most timely match of a facility's resources with the continuum of care needed to provide the best possible outcome for the patient.

CURRENT SITUATION

Research on injuries at the national and state level demonstrate that a trauma system is likely to greatly reduce the number of deaths as well as the seriousness of long-term disability from trauma injuries and would ultimately result in a cost savings to society.

An analysis of the medical costs of injury in Michigan for 1997-1998 by the Michigan Department of Community Health revealed that the overall annual medical cost due to injury was almost $3.6 billion. When work loss and quality of life costs were considered, the overall cost of injuries was a $54.9 billion problem.

With the passing of the Administrative Rules in October 2007, the infrastructure is ready to be put in place. Funding is now the top priority!

THE BOTTOM LINE:

Michigan does NOT currently have an organized statewide trauma system. Without funding, the implementation of the infrastructure for an inclusive trauma system is in jeopardy.

MICHIGAN TRAUMA SYSTEM

WORKING TOWARD A COORDINATED RESPONSE FOR THE INJURED

WHAT IS A TRAUMA SYSTEM ?

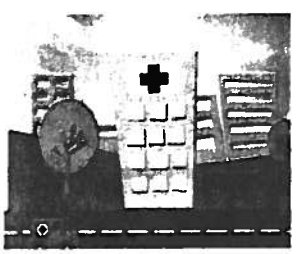
A trauma system reaches beyond the boundaries of hospital emergency departments and physicians. Although the trauma center is a key component of acute care for the severely injured, a trauma system encompasses all phases of care, from pre-hospital care through acute care and rehabilitation. The term "inclusive trauma system" is used for this all-encompassing approach. An Inclusive system guarantees that all injured patients will receive optimal care, given available resources, even if they do not require the resources of a specialized trauma center. An Inclusive system includes:

- Emergency Medical Services (EMS)
- Emergency Departments
- Trauma Teams
- Organ Procurement
- Rehabilitation Services
- Injury Prevention and Education
- Research

Michigan is one of four states that do not have an organized, statewide trauma system for the care of trauma patients. Currently, Michigan has a total of 22 American College of Surgeons (ACS) verified Level I, II and III trauma centers. Of the 22 trauma centers, 19 are located in the mid to southern portion of the state.

Currently, Michigan trauma centers exist due to the substantial, voluntary efforts of the individual hospitals. These hospitals are fully responsible and at financial risk for the operation and maintenance of the trauma centers.

This is a public safety issue. Residents deserve the assurance that they will get, the right amount of care in the right amount of time and a well-planned trauma system can do that.



MILESTONES

October 2007

Administrative rules became effective for implementation of a statewide trauma system. However, these rules are contingent on funding!

GOAL

Secure annual funding to support the statewide trauma system

FUNDING

Current funding

There is currently no specific funding allocated to support the development and maintenance of a statewide trauma system.

Future funding

We must look for funding sources to access at least 3 million dollars to support the infra-structure of a statewide trauma system which will include:

- Leadership
- System Development/Management
- Definitive Hospital Care
- Data Collection and Trauma System Evaluation
- Public Information, Education and Prevention

Future funding will help to ensure that the approach taken to care for trauma victims from the scene through rehabilitation is consistent, expedient, and focused on optimal patient care across the state. The framework and guidelines to allow the development of a statewide trauma system have been established through the administrative rules. The funding must now be allocated and secured for development and maintenance.

Funding source possibilities for Michigan may best be sought through a fee increase to the Crime Victims Services Fund, the State General Fund and/or Vehicle Registration Fees.

Other states have funded their trauma systems with property tax, license tax, motor vehicle fees, state ballot initiatives, vehicle insurance fees, and high risk behavior taxes (DUI).

TRAUMA TALKING POINTS

- Trauma is the leading cause of death for people ages 1-44 and the fourth leading cause of death overall.
- Trauma refers to people who have sustained severe injuries, requiring rapid evaluation and transport to specific hospitals with trauma care capabilities, staffed and equipped to provide the comprehensive care needed. All hospital emergency departments are **NOT** trauma centers.
- A statewide trauma system could save lives, reduce disability and reduce health care costs.
- Michigan is one of three states **WITHOUT** a statewide functioning trauma system.
- A patient receiving proper medical care in the **first hour** following an accident triples their chance of survival.
- *There is a **25% decrease in mortality** if severely injured are treated at Level 1 Trauma Centers compared with care at non-trauma centers.
- *Injured patients identified as needing inter-facility transfer have a **28% increase in mortality**.
- The connection between an EMS/Trauma System and crime victim's compensation, is that many injuries/fatalities that occur involve alcohol/drugs, assaults, and excessive speed. These are all occurrences in which a crime has been committed by an individual and who has caused harm to either themselves or others.
- An average of 112 people died each day in MVA in 2007-one every 13 minutes.
- A fatal injury occurs every six minutes. A disabling injury occurs every two seconds.
- Because trauma is a disease of the young, it takes a higher toll on society than heart disease, cancer, and stroke combined.

Item 1 of 1

1. Prehosp Emerg Care. 2011 Oct 18. [Epub ahead of print]

Large Cost Savings Realized From The 2006 Field Triage Guideline: Reduction in Overtriage in U.S. Trauma Centers.

Faul M, Wald MM, Sullivent EE, Sasser SM, Kapil V, Lerner EB, Hunt RC.

Source

From the National Center for Injury Prevention and Control, Division of Injury Response (MF, MMW, EES, RCH), and the National Center for Environmental Health (VK), Centers for Disease Control and Prevention, Atlanta, Georgia; the Department of Emergency Medicine, Emory University (SMS), Atlanta, Georgia; and the Department of Emergency Medicine, Medical College of Wisconsin (EBL), Milwaukee, Wisconsin.

Abstract

Abstract Background. Ambulance transport of injured patients to the most appropriate medical care facility is an important decision. Trauma centers are designed and staffed to treat severely injured patients and are increasingly burdened by cases involving less-serious injury. Yet, a cost evaluation of the Field Triage national guideline has never been performed. Objectives. To examine the potential cost savings associated with overtriage for the 1999 and 2006 versions of the Field Triage Guideline. Methods. Data from the National Hospital Ambulatory Medical Care Survey and the National Trauma Databank (NTDB) produced estimates of injury-related ambulatory transports and exposure to the Field Triage guideline. Case costs were approximated using a cost distribution curve of all cases found in the NTDB. A two-way sensitivity analysis was also used to determine the impact of data uncertainty on medical costs and the reduction in trauma center visits (12%) after implementation of the 2006 Field Triage guideline compared with the 1999 Field Triage guideline. Results. At a 40% overtriage rate, the average case cost was $16,434. The cost average of 44.2% reduction in case costs if patients were treated in a non-trauma center compared with a trauma center was found in the literature. Implementation of the 2006 Field Triage guideline produced a $7,264 cost savings per case, or an estimated annual national savings of $568,000,000. Conclusion. Application of the 2006 Field Triage guideline helps emergency medical services personnel manage overtriage in trauma centers, which could result in a significant national cost savings.

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Organizations that support the funding of a trauma system in Michigan

American Heart Association
American Cancer Society
Disability Network/Michigan
March of Dimes- Michigan Chapter
Michigan Sheriff's Association
Michigan College of Emergency Physicians
Michigan Crime Victim Services Commission
Michigan Association of Chiefs of Police
Michigan Health and Hospital Association
Michigan Home Health Association
Michigan Fraternal Order of Police
Michigan State Police
Michigan Domestic Violence Prevention and Treatment Board
Michigan State University/Kalamazoo Center for Medical Studies
Michigan Coalition Against Domestic & Sexual Violence
Michigan College of Emergency Physicians
The Accident Fund of Michigan
Michigan Chapter of the International Association of Forensic Nurses
Office of Highway Safety Planning
Emergency Medical Services Coordination Committee
Michigan Trauma Coalition
Blue Cross/Blue Shield of Michigan
5th District Medical Response Coalition
Prosecuting Attorneys Association of Michigan
State Trauma Advisory Subcommittee
Office of Public Health Preparedness

EPILEPSY FOUNDATION®
MICHIGAN
Not another moment lost to seizures™

Testimony, House Appropriations Subcommittee on Department of Community Health
March 12, 2012
Public Comment on Mental Health Budget

Representative Lori and members of the Subcommittee,

My name is Arlene Gorelick, and I am the President of the Epilepsy Foundation of Michigan. The Foundation has a number of concerns about the proposed budget, but today we would like to express our concern on the reductions proposed for Community Mental Health. The Foundation is generally supportive of the budget proposals made by Governor Snyder for Fiscal Year 2013, but we do want to express our concern, again, for one proposal contained in the Governor's recommendations.

We are concerned about the proposal put forth by the Department of Community Health to create savings in the Medicaid fee for service program by adding behavioral health medications and anti-convulsants, to the Preferred Drug List. Currently, behavioral drugs, anti-convulsants, and several other categories of drugs are exempt from the preauthorization process by statue.

Changing the practice that protects the health of people taking behavioral drugs, drugs for epilepsy, and certain other drugs from the prior authorization process would require a change in statue passed in 2004. This was passed into law by the legislature because it was recognized that the treatment for epilepsy and these other conditions was complicated, and that the people affected by these conditions would be adversely effected by having to wait for preauthorization of the medication they require. The Epilepsy Foundation of Michigan fought hard with our advocacy partners to have the drugs exempt.

A new comprehensive review by pharmacists and doctors at the University of Connecticut and Hartford Hospital found that efficacy, tolerability, and safety of brand-name and generic antiepileptic medications are virtually the same. However, switching from one version of the drug to another, including from generic to generic, may cause patients to have more hospitalizations and longer hospital stays. The study results were first reported in a Comparative Effectiveness Review issued by the Agency for Healthcare Research and Quality (AHRQ) in December 2011

The cost savings projected are questionable. Clinical data and cost continue to support the policy decision made in 2004.

With a potential increased demand in non-Medicaid mental heath cases, this is not the time to cut the general fund dollars to these programs.

Thank you for allowing me to air this concern today.

Founded in 1948, the Epilepsy Foundation of Michigan is the state's only nonprofit organization focusing solely on epilepsy. Our mission is to "ensure that people with seizures are able to participate in all life experiences; and will prevent, control and cure epilepsy through services, education, advocacy, and research".

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Tina Reynolds

Michigan Alliance
for
Lead Safe Housing

March 12, 2012

Chair Lori and esteemed colleagues on the Department of Community Health Subcommittee,

We are the Safe Homes/Safe Kids: Michigan Alliance for Lead Safe Housing, and we support increased general fund support for lead poisoning prevention initiatives in the Fiscal Year 2013 budget. Despite the fact that lead poisoning is totally preventable, Michigan ranks 5th worst in the nation based on our high number of lead poisoned kids. At a cost to the state economy of $3.2 - 4.85 billion a year in lost earnings alone, we need to end lead poisoning once and for all.

Our funding request comes at a critical time. No general fund dollars currently support the abatement of homes where lead poisoned kids reside. Federal monies which sustain this state program continue to be cut and future funding support is in question. This lack of resources means Michigan has over 600 families on statewide wait lists seeking help to make their homes lead safe. Additional federal cuts have also reduced the state's ability to identify lead poisoned kids and get them treatment. This dire situation has now reached a crisis level and it puts families in harm's way.

The state can help restore some of this funding and meet the critical need. We support efforts to increase the general fund support for lead poisoning prevention in the fiscal year 2013 budget. On behalf of all our coalition members and lead affected families statewide, we appreciate your consideration.

Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

House Appropriations Subcommittee on Community Health
Hearing – FY13 Proposed Executive Budget
March 12, 2012

Michael Vizena, Executive Director
Michigan Association of Community Mental Health Boards

Chairperson Lori and Members of the Subcommittee:

The Michigan Association of CMH Boards (MACMHB) provides legislative and public policy advocacy on behalf of its membership, which consists of 46 CMH boards and 70 provider agencies from throughout the state. On their behalf, I would like to offer the following testimony related to the proposed Executive Budget regarding services for persons with psychiatric disorders, substance use disorders, and persons with intellectual and developmental disabilities.

There are many elements of the administration's proposal that we support. For the first time in half a decade, there are no proposed reductions to general fund support of these services. At a time when Michigan leads the nation in the number of citizens losing private health insurance, and it remains 1 of only 7 states that does not require these private insurers to provide parity access to mental health treatment services, general funds represent the principle public resource to provide low income persons without Medicaid eligibility access to treatment services.

We also support the administration's Michigan 4X4 Plan, as persons with psychiatric and substance use disorders die 25 years sooner from health conditions such as diabetes and cardio vascular disease than those without these psychiatric and substance use disorders. Many of our members have begun evidence-based wellness initiatives to address these illnesses, and they look forward to working as active members of local, coordinated partnerships.

We stand ready to work and support the state's pursuit of Medicaid expansion and health homes for persons with multiple chronic health conditions. These are available options under healthcare reform that will increase access to healthcare for hundreds of thousands of people in Michigan, and which will improve health outcomes and bend the rising cost curve for some of our most vulnerable citizens.

Finally, and most importantly, the proposed budget continues this state's commitment to supporting Medicaid services funding, which provides the healthcare safety net and supports that enable persons with disabilities to live self-directed lives in their communities.

There are two areas where we believe the administration's plans and efforts are misdirected:

First, while we applaud the Governor's and Lieutenant Governor's passion and commitment to providing services to children with autism through Medicaid and MiChild programs, we do not believe it is good public policy to offer private insurance companies state general fund incentives to cover a single neurological brain disorder and no others.

Second, for the past twelve months, the administration has presented unnecessarily complicated depictions of our state's current contracting system for behavioral health and developmental disabilities services. It has suggested that administrative costs will be reduced and functions streamlined by the consolidation and reduction of contracting entities throughout the state. Even more alarming, it is unclear whether the current depictions suggest such consolidation and reduction might include efforts to privatize the system. This is not good public policy for two reasons, particularly as we work to improve integrated care.

First, all healthcare is local. Improving care, particularly for persons with high health care needs and costs, requires improving local healthcare provider partnerships. Good partnerships are based on good relationships, and you do not build good partnerships with physical healthcare providers in Midland, or Hillsdale, or Evart, or Southfield through negotiations with mental health managers half way across the state, or even half way across the country.

Second, administrative costs are not driven by the number of entities you have; they are driven by the administrative requirements that these entities must carry out. The best way to reduce administrative costs is to reduce administrative requirements that are redundant, do not provide fundamental protections for persons served, or do not improve outcomes for those persons. MACMHB strongly suggests strengthening two boilerplate sections that were included in the FY12 budget, which we feel would lead to a simpler more efficient system of care.

1) Section 494 called on MDCH to start exploring "deemed status" by forming a workgroup. This workgroup started meeting last week. While we think this is a good start, we would encourage this committee to strengthen the current language by pushing MDCH to adopt a "deemed status" model that would allow the use of full accreditation by a national accrediting body in lieu of many of the current state departmental review requirements. Deemed status for CMHSPs, PIHPs and provider organizations with such accreditation will reduce their and the state's administrative costs, eliminate duplicative state functions and move towards a less complicated system. Our neighboring states, Illinois and Ohio both have adopted deemed status models, in fact the state of Illinois found about a 40% redundancy rate between the accrediting bodies' reviews and state reviews.
2) Section 490 called on MDCH to form a work group to look at simplifying and standardizing contractual requirements. An initial round of meetings was conducted last fiscal year, and the Department has reconvened the group to continue discussions. We feel the meeting process is a good start, but it is time to adopt this administration's relentless positive action mode and implement workgroup recommendations.

Thank you for the opportunity to provide testimony, and we look forward to continuing to work closely with the Administration and members of the Legislature on the development of the budget.

Testimony of Mark Reinstein, Mental Health Assn. in Mich.
House Appropriations Subcommittee on Community Health, March 2012

Thank you, Representative Lori and Members of the Subcommittee.

I'm Mark Reinstein, President & CEO of the Mental Health Association in Michigan, now in its 75th year as the oldest state advocacy organization for persons experiencing mental illness. We are affiliated with Mental Health America (Alexandria, VA) and partly funded by local United Ways.

Thank you for the opportunity to testify.

I will address two issues today: 1) the executive branch proposal to revise state statute and subject Medicaid mental health medications to bureaucratic prior authorization procedures; and 2) the relative lack of boilerplate in the Governor's budget proposal.

Medication Access

The federal government has documented that 87% of adults experiencing major psychological distress from mental illness are prescribed medications. In fact, 35% receive only medications as their treatment. This is an area tremendously dependent on medication therapy. More than any factor, medication advances enabled society to dramatically reduce psychiatric hospital beds and treat people with mental illness in the community.

This is also an area with great individual variability in how people react to medications. What works for Person A with schizophrenia may not work for Person B with the same condition. The area is further one where some consumers struggle maintaining medication compliance.

Numerous studies have found that mental health drug access restrictions interfere with consumer compliance, increase the likelihood of treatment drop-outs and cost more in the long run than any short-term "savings" achieved. To provide just one of several examples, a recent study in Ohio by the firm of Driscoll and Fleeter found that $6 million dollars in annual state "savings" would be offset by more than $23 million in annual public costs due to negative consequences.

Persons with serious mental illness who are untreated or inadequately treated are at risk of grave potential consequences like job loss, homelessness, justice system incarceration and early death – those with serious mental illness experience 25 years of lost life compared to the rest of the population. Treatment deficiencies also yield more hospitalizations, emergency room trips and visits to general medical practitioners.

With the above in mind, the Legislature unanimously included mental health drugs in a 2004 law protecting vulnerable populations against bureaucratic prior authorization procedures in Medicaid. The law (PA 248 of 2004) only applies to single-source brand products (i.e., there's no generic equivalent). In other words, if a doctor wants to prescribe a brand for which a specific generic exists, Medicaid does not have to pay for the brand instead of the generic. No one is opposed to generic substitution.

The law only protects brand products for which no generic yet exists. Without that protection, we are moving from generic substitution to the very dangerous realm of therapeutic substitution; i.e., where administrators say, "Just take a drug that is similar even though it's not chemically the same." The practical effect in 2012 is that the law is primarily protecting a small number of modern antipsychotics that don't yet have generics but will over the next several years. The modern ("atypical") antipsychotics are to schizophrenia what the statin medications were to high cholesterol.

In 2009 (for FY-10), Governor Granholm proposed $6 million General Fund "savings" from a repeal of the mental health protections in PA 248 of '04. Governor Snyder repeated that proposal in 2011 (for FY-12). On both occasions, the mental health community rose up against the proposals, and we were grateful that the Legislature did not attempt to repeal the law. Legislators have recognized that if someone with serious mental illness has to fail twice on "preferred" products before a "non-preferred" one can be accessed, that person's mind could be lost to us forever – or the individual could be dead. If you think that's overly dramatic, please see the material I've attached from Washington State, describing how that state gave a generic drug "preferred" status because it was cheap, and now the state is putting out fatality warnings left and right about that drug. Contrary to our administration's claims, there is nothing "scientific" about linking "preferred" and "non-preferred" status to supplemental rebates from drug companies.

The Department of Community Health and Governor Snyder have now resurrected the proposal for FY-13, claiming over $18 million in gross "savings" would result. Two-thirds of those "savings" would simply be turning down federal matching funds. So what we're really talking about is the $6 million GF figure, which is exactly the same in the FY-13 proposal as it was for FY-12. And given the number of mental health drugs that are now losing patent exclusivity, it's mathematically impossible for the figure to be the same for FY-13 as it would have been for FY-12. This is just another sign that the $6 million GF "savings" figure the Department has been using for years has no basis in reality. The Department never makes public its calculations, claiming the information is "proprietary."

Our state does a poor job in most respects regarding mental health, and now the Senate is poised to improve private insurance coverage for autism while leaving mental illness behind to be discriminated against. The protection for mental health medication access is one positive step we do have through PA 248, and it is well worth retaining. We respectfully ask that you remove the Governor's suggested mental health pharmacy "savings" from the FY-13 DCH budget. Help us nip this in the bud for FY-13 so that you, the executive branch and the mental health advocacy community don't have to spend all year dealing with it.

Budget Boilerplate

The Governor has proposed only a small amount of boilerplate for the FY-13 DCH budget. For our testimony today, we list six FY-12 provisions with direct relationship to mental health that would be very important to repeat:

~Section 404, requiring an annual report to the Legislature on public mental health system service data and client demographics.

~Section 411, requiring CMH involvement in jail diversion programming.

~Section 458(a), requiring an annual report to the Legislature on progress implementing recommendations of the Governor's 2004 Mental Health Commission.

~Section 474, requiring provision of guardianship information to mental health service recipients and their families.

~Section 492, permitting CMH programs to spend General Fund money on mental health jail services.

~Section 1620(2), establishing the maximum drug co-pays the Department can ask of Medicaid enrollees.

We also respectfully request that two boilerplate provisions from FY-11, which did not make their way into the FY-12 budget, be reinstituted. These would be:

~Section 1604, establishing that the pre-existing Medicaid eligibility of an incarcerated individual is temporarily suspended, not permanently terminated (thus enabling community services to start quicker upon release from incarceration).

~Section 1677, establishing the mental health and other services available to enrollees in the MIChild program. (The Governor wants it stated that autism treatment is a covered MIChild service. That is commendable, but then why aren't we stating what else is covered?)

Thank you for your kind consideration of our views.

Attachment

The Seattle Times
Winner of Eight Pulitzer Prizes

Local News

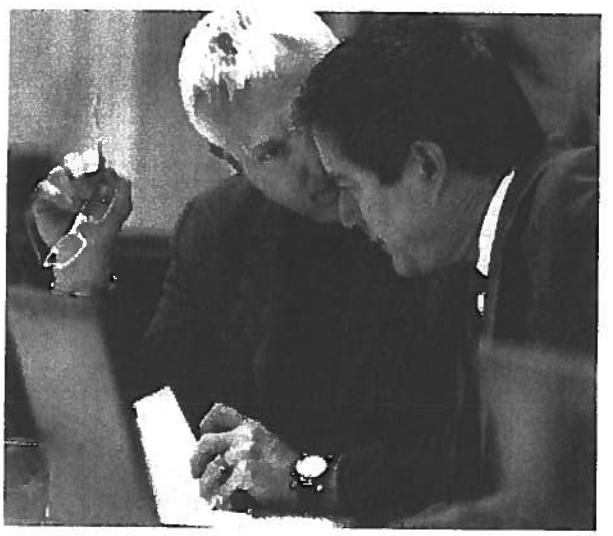
Originally published December 21, 2011 at 8:45 PM | Page modified December 30, 2011 at 2:00 PM

State plans emergency warning on risks of methadone

Washington state will issue a public health advisory that singles out the unique risks of methadone, a commonly prescribed pain medicine that's linked to the most accidental overdose deaths.

By Michael J. Berens and Ken Armstrong

Seattle Times staff reporters



Alarmed by evidence that hundreds of patients die each year from accidental overdoses of prescription pain drugs, the state of Washington will issue a public-health advisory that singles out the unique risks of methadone, a narcotic medication linked to the most fatalities.

The emergency measure, adopted Wednesday by unanimous vote of a committee of state-appointed medical experts, follows a Seattle Times investigation, "Methadone and the Politics of Pain," which detailed Washington's troubled history with methadone, a potent

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To save money, the state steers Medicaid patients, workers' compensation recipients and state employees toward methadone, a long-acting painkiller that costs less than a dollar a dose. Since 2003, at least 2,173 people in Washington have died from unintended overdoses linked to the drug, The Times found.

The poor have paid the highest price. Medicaid recipients represent about 8 percent of the adult population and 48 percent of methadone deaths.

Beginning early next week, state Medicaid officials will fax a health advisory to more than 1,000 pharmacists and drugstores about methadone, as well as oxycodone, fentanyl and morphine. That move will be followed by a written advisory from the state Department of Health to about 17,000 licensed health-care professionals.

The health advisory marks the first public acknowledgment by a powerful state committee that methadone can be more unpredictable than other pain drugs, or opioids. State officials had previously resisted attempts to single out methadone for special treatment, insisting the drug was as safe and effective as any other narcotic pain drug.

The Pharmacy and Therapeutics Committee — or P&T committee, for short — evaluates drugs for safety and effectiveness, a key step in the state's creation of a preferred drug list. On Wednesday, the committee gathered for what in years past had been a routine review and approval of methadone and morphine, the two long-acting pain drugs on the state's preferred registry.

But after a representative from the Health Care Authority — a state agency that oversees Medicaid and medical benefits for state employees — recounted Washington's "severe problem" with painkiller overdoses, the panel postponed any decision on methadone's status as a preferred drug and decided to authorize the advisory.

Duane Thurman, a program director for the Health Care Authority, told the committee that state senators were "extremely concerned" about methadone-related deaths as reported by The Times. He encouraged the committee to approve the health advisory and said, "I think it's important to do something immediately."

Dr. Barak Gaster, chairman of the committee, said during the meeting: "I think there is some sense that there are features that are unique to the way methadone needs to be prescribed and for it to be done safely."

Compared with other painkillers, methadone has a long half-life. OxyContin dissipates from the body within hours while methadone can linger for days, pooling to a toxic reservoir that depresses the respiratory system.

"Is methadone different? Yes," Dr. Jeff Thompson, chief medical officer of the state's Medicaid program, told a Times reporter during a break in the daylong session.

Last week, the state Senate Health & Long-Term Care Committee held a work group to get an update on Washington's new pain-management law. But much of the discussion focused on methadone, with lawmakers pressing for answers about the narcotic's pharmacological makeup and risks.

Committee Chairwoman Karen Keiser, D-Kent, became frustrated with Dr. Gary Franklin, medical director for the Department of Labor & Industries, which handles workers' compensation.

Keiser asked Franklin — a principal defender of the state's decision to designate methadone as a preferred drug — if the painkiller is more difficult to manage than other long-acting narcotics. When Franklin responded by discussing the toll of long-acting opioids in general, Keiser said: "Dr. Franklin, answer the question about methadone."

She later told him: "That's something I'd like to get a straight answer on. And I'm not getting a straight answer."

Franklin told lawmakers that methadone is not at the heart of the state's struggle with painkiller overdoses. "It's dose, not a specific opioid," he said.

"Almost no one dies from a single opioid. When you look at death certificates, and I've reviewed many of these at L&I, you never see just methadone or just OxyContin or just fentanyl listed," he told the committee.

"Coroners, in fact, will not ever say on a death certificate that this death is from methadone. It is always a combination of multiple opioids plus other drugs."

But a Seattle Times analysis of death certificates turned up 443 cases since 2003 in which methadone was the only drug listed when someone fatally overdosed. And this was using a conservative sift, excluding cases where the deceased had so much as a history of alcoholism.

Sen. Cheryl Pflug, R-Maple Valley, told Franklin that she was troubled even by those cases in which methadone had combined with other drugs to cause a fatal overdose.

"I don't really care that the coroner isn't willing to say this was caused by methadone," she said. "If the person has a toxic level, and they were taking methadone and other drugs known to have a synergistic, respiratory depressive effect, and they quit breathing, it doesn't take a rocket scientist to know we might have a problem."

She urged the state to create a list of factors that would caution against prescribing methadone in particular instances — for example, if a patient is taking another drug that doesn't mix well with the painkiller. "We should say, 'you can use it if,' rather than, 'you must use it unless,' " Pflug said.

A spokeswoman for the department of Labor & Industries said Wednesday that Franklin would not be available for an interview with The Times.

At the committee meeting, Sen. Mike Carrell, R-Lakewood, said two graphics distributed to the lawmakers — one showing methadone with the longest half-life, the other linking it to the most deaths — raised the question: "How could we end up pushing methadone?"

"Maybe we need some horse sense here rather than expertise on how well some of these things work," Carrell said.

Afterward, several committee members told The Times the Legislature will push to get more information about methadone and its risks.

"Across the political spectrum, I think everybody on that committee was concerned," Carrell said.

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

March 12, 2012

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

***Re:* 2012-13 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 1,200 members providing supports and services to over 35,000 persons throughout the state. These persons include individuals with intellectual and developmental disabilities, mental illness, traumatic brain injuries or physical disabilities and older adults.

Preserving Community Mental Health (CMH) Funding

We urge this Subcommittee to support the executive recommendation for a modest increase in Medicaid funding for mental health services. It is our understanding that the executive recommendation is for a 1.25% increase to the prepaid inpatient health plans (PIHPs) in order to maintain actuarially sound rates. This modest funding increase is essential to preserving the health, safety and welfare of tens of thousands of vulnerable Michigan citizens.

Creating Efficiencies in the CMH System

MALA appreciates this Subcommittee's efforts to maximize the uniformity and consistency in the standards applied to the provider networks contracting with the 18 PIHPs and 46 Community Mental Health Services Programs (CMHSPs). MALA is an active member of the DCH workgroup on this issue which was established pursuant to Section 490 of the DCH budget bill. This workgroup has recently reconvened to continue its efforts on this important initiative.

Reducing the Wait List for the MI Choice Waiver Program

We also urge this Subcommittee to support the executive recommendation for additional Medicaid funding to reduce the wait list for the MI Choice Waiver Program. We supported the state's decision in 2008 to expand DCH's MI Choice Waiver Program to licensed settings consisting of adult foster care homes and homes for the aged. This public policy change has expanded the array of options for older adults and people with disabilities who need long-term care services.

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Responding to Workforce Challenges

Providers of mental health and long-term care services face daunting workforce challenges over the next several years. Recruitment and retention of direct support staff remain an overwhelming concern for providers. Sufficient funding to maintain competitive wage levels is critical to satisfactory staff recruitment and retention.

Thank you again for the opportunity to testify. Please contact our organization if any additional information is needed.

Sincerely,

Robert L. Stein

ROBERT L. STEIN
General Counsel

cc: Representative Peter MacGregor, Majority Vice-Chair
Representative David Agema
Representative Robert Genetski II
Representative Rashida Tlaib, Minority Vice-Chair
Representative Joan Bauer