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

March 3, 2014

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

Re: 2014-15 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 older adults and individuals with intellectual and developmental disabilities, mental illness, substance use disorders, traumatic brain injuries or physical disabilities.

Strengthening Mental Health Services

MALA supports the executive budget recommendations for strengthening mental health services. We specifically support the funding to begin implementation of the recommendations from the Mental Health and Wellness Commission Report.

Enhancing Senior Services

MALA also supports the executive budget recommendations for enhancing senior services. In particular, we urge the Subcommittee's support for elimination of the MI Choice waiting list. The MI Choice program provides vital services to persons in their own homes or community based settings who are nursing home eligible. The community based settings include licensed adult foster care homes and licensed homes for the aged.

Medicaid Personal Care Supplement

MALA recommends a modest funding increase of $35.00 per month in the Medicaid Personal Care Supplement that is received by the adult foster care and home for the aged providers. The executive budget recommendations do not include a funding increase in the Medicaid Personal Care Supplement.

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As indicated in the overview provided with this testimony, the Medicaid Personal Care Supplement has not increased since October 1, 2008. In addition, the Medicaid Personal Care Supplement has increased by only $18.00 per month since 2000 or 10.3 percent total for the entire 14-year period. This supplement is critical to the provision of personal care services to older adults and persons with disabilities.

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

Sincerely,

Robert L. Stein

ROBERT L. STEIN
General Counsel

cc: Rep. Robert VerHeulen, Majority Vice-Chair
Rep. Paul Muxlow
Rep. Peter MacGregor
Rep. Jim Stamas
Rep. Mike Shirkey
Rep. Rashida Tlaib, Minority Vice-Chair
Rep. Brandon Dillon
Rep. John Olumba

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Overview of Medicaid Personal Care Supplement

1. Adult foster care (AFC) and home for the aged (HFA) licensees provide services to several thousand persons for whom licensees receive a Medicaid Personal Care Supplement of $192.38 per month. This payment level is clearly inadequate based upon the personal care needs of the adults choosing to obtain services in licensed AFC and HFA settings.

2. The Medicaid Personal Care Supplement level has increased minimally for the past 14 years as indicated below:
   - 10/01/2008 – increase to $192.38 per month
   - 10/01/2006 – increase to $184.38 per month
   - 10/01/2000 – increase to $174.38 per month

   Thus, the Personal Care Supplement payment has increased by only $18.00 per month since 2000 or 10.3 percent total for the entire 14-year period.

3. The personal care services provided to AFC and HFA residents include assistance with the following:
   A. Bathing
   B. Grooming
   C. Dressing
   D. Toileting
   E. Transferring
   F. Eating
   G. Medication
   H. Specialized skin care
   I. Other personal care services as needed

4. A modest increase in the Medicaid Personal Care Supplement to $227.38 per month effective October 1, 2014 is essential to the health and well-being of AFC and HFA residents. This amount would apply slightly less than a 3 percent cost-of-living increase factor for each year since 2008.

For additional information on the Medicaid Personal Care Supplement, please contact Michigan Assisted Living Association.

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February 2014

Michigan Association of Health Plans

House Subcommittee on Department of Community Health Appropriations

March 3, 2014

My name is Rick Murdock and I am the Executive Director of the Michigan Association of Health Plans. Members of our association participate in the Medicaid Managed Care Program through a competitive bid process for the awarding of contracts. Medicaid Health Plans are currently responsible for the delivery of comprehensive health services for nearly 1.3 million Medicaid beneficiaries.

Our membership wishes to thank you for your past support for the Medicaid managed care program. The presentation by the Department of Community Health last week illustrated many of the attributes that our industry provides in the cost-effective delivery of services for Medicaid beneficiaries—my only reaction would be, I know we can do better.

My testimony today is guided by the positions established by my Board of Directors. I have attached to this testimony our complete set of Recommendations and Executive Summary that is part of our annual Medicaid Strategic Paper. But for today I want to focus my few minutes of testimony on the key challenges before us:

1. Sustaining Expectations for Performance by Medicaid Health Plans
2. Flexibility Within Medicaid
3. Healthy Michigan Act Implementation
4. Core Support for Current Medicaid & Healthy Michigan Act **(Actuarial Soundness)**

Performance.

Policy makers, administrators and the public expect (and receive) value from the Michigan's Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management. The most obvious strength is cost savings.

There continues to be an estimated savings of $400 million each year due to the Medicaid Managed Care program compared to fee for service. This savings has now yielded nearly **$5 billion in total savings to state taxpayers** between FY 00 and FY 13. The savings reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care in a partnership with the state **in exchange for actuarially sound funding**.

This return on investment enables both the State of Michigan and the federal government to redirect savings from Medicaid managed care to support programs in other high priority areas while preserving access to quality health care services for the vulnerable populations served by Medicaid program and avoid reductions in provider reimbursement.

The continued national high performance ranking of Michigan's Medicaid Health Plans is a testament of the dedicated efforts of each of the health care partners in this arrangement; state administrators who set the standards, providers who deliver the care as part of the provider networks, and contracting health plans who put it all together. In the past year and once again, the **Michigan Medicaid Health Plans are cited as among the best in the nation** by Consumer Report/NCQA America's Best Health Plans. Their 2013 ranking cited Michigan Health Plans for excellence in all three categories: commercial, Medicare, and Medicaid. Specifically, Michigan Medicaid Health Plans are among eight in top 30, nine in top 50 and ten in top 60. These numbers clearly demonstrate the quality care provided to our Medicaid population.

Medicaid Flexibility

Our Association is likely among the first to encourage the Medicaid Program to adopt various programs and interventions that we believe will improve overall health care and improve efficiency. We do so, because history has shown us how flexible Medicaid can be—and Michigan's Medicaid program has quietly been one of the more efficient and flexible programs across the country. What is often widely praised as innovations in other state Medicaid programs is often a regular and long standing feature in Michigan. This is coupled by the considerable

partnerships that many of the provider groups have nurtured with Medicaid –often translated into various provider taxes and assessments and differing mechanism to substitute for general funds. It is this partnership route that the history of Michigan Medicaid has followed and has produced the results captured in one of the outstanding graphics produced by MDCH in their presentation. This is the graphic that indicates Medicaid program growth taking place over the past decade while state general fund support has remained flat or even declined.

As Trade Associations, we may have our differences in approach, but we are often united in these partnership efforts with the Department, and if past history is any measure, I expect this will continue into the future. I know it is a role our association intends to continue. But we need to realize that this flexibility comes with a price—the fees related to the ACA Premium tax are based on total reported income—which includes the various transfer payments built into the Medicaid Health Plan line item. These supplemental payments, in turn provide for additional revenue to the State to offset general fund costs and provide a means to help various providers obtain additional revenue to sustain their participation in Medicaid.

Healthy Michigan Act.

The process and steps for implementing the Healthy Michigan Act are proceeding. The submission and federal approval of the waiver, conference on diversion from Emergency Department use, report on incentives have all taken place in accordance with requirements of PA 107. The remaining issues are operational and financial. Operational issues include contract and protocols for the many new administrative functions while assuring that legislative intent is met and health plan flexibility is sustained and providing sound actuarial rates.

All observers understand that this is an unprecedented project for reform with many moving parts that is receiving national attention. MAHP and members were pleased to be strong supporters of the reform legislation, knowing that the ultimate accountability would reside in the contract between the State and contracting health plans. We also know that a main driver for legislative passage of the Healthy Michigan Act was to take advantage of a long and successful record of value and cost effective care delivered by Medicaid Health Plans.

Full transparency will now be required to document change, costs, and improvements in health status and a provision of fair and accurate rates. The ultimate success of the Healthy Michigan Act will be dependent of these changes to occur and savings to be realized.

Actarial Soundness: Why Recommendation related to actuarial soundness requirements are so important.

To assure the entire managed care program is financially viable and strong full actuarial soundness must be implemented. A key indicator of "actuarial soundness" is the industry average margin for Medicaid Health Plans. A strong and viable system would yield margins minimally between 2 percent and 3 percent each year. However the past three years have resulted in the following average Medicaid Health Plan margins as reported in year-end filings with the Department of Financial and Insurance Services, DIFS:

Calendar Year	Average Margin
▪ 2010	2.01 %
▪ 2011	1.59 %
▪ 2012	1.20 %

The filings by the Medicaid Health Plans for calendar year 2013 will be available in the near future, however we are anticipating that the overall Medicaid Health Plan average margin will continue to drop and may be less than 1 percent. While it is critical anytime to assure actuarial soundness, given the trend in overall margins and the pending launch of the new initiative for Healthy Michigan Act, the legislature's obligation to fund and the department's obligation to administer this program in an actuarial sound manner is now of paramount importance.

Medicaid is a large program because of the number of Michigan citizens served with a very comprehensive health care program. Between the regular Medicaid Program and the Healthy Michigan program, total health plan spending is expected to be nearly $7 billion dollars in FY 15. The small percentage increases necessary to fund actuarial soundness now become magnified due to size related to the underlying base—e.g., each percentage increase now represent about $70 million gross funding.

Summary

Continued success of Medicaid and projected success for the Healthy Michigan Act cannot occur without sound financial support at this critical juncture. **To adequately fund actuarial soundness for regular Medicaid and the Healthy Michigan Act combined, (including coverage for the state and federal taxes and fees) will minimally require at least an additional two percent or $130 million in total dollars over the amount recommended in the FY 15 Executive Budget for these two line items.** At the current federal match rate, this would

require an additional $25-$30 million in General Fund support—the remainder from federal match. To be clear, this recommendation will not increase the margins, as one percent increase does not translate to one percent margin—but the recommendations is intended to keep the overall margins from falling even lower.

In subsequent meetings with you and your staff, we will review these recommendations in more detail. Thank you for this opportunity to comment on the significant challenges facing Medicaid and Healthy Michigan Act.

Attachment:

Executive Summary: MAHP Strategic Medicaid Paper for FY 15

Performance, Value, Outcomes: Medicaid Managed Care

FY 2014-2015

The mission of the Michigan Association of Health Plans is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.

Executive Summary

Medicaid Strategic Paper: FY 15

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RECOMMENDATIONS FOR FY 15 AND BEYOND

1. The Department of Community Health should administer and the Legislature should **appropriate adequate funding to assure actuarially sound rates** in support of all aspects of Medicaid Managed Care, (CSHCS, Duals (including the model for Integration), Regular Medicaid, and Healthy Michigan Program). All Medicaid Policy bulletins issued by the Department after federal approval of actuarial soundness should include economic analysis to demonstrate that the approved rates are not compromised by proposed changes in Medicaid Policy. Consistent with federal and state requirements for actuarial soundness, costs related to the health insurance premium tax imposed by the Affordable Care Act, and health insurance claims assessment must be considered as part of actuarial soundness and certification of the health plan rates.

2. Implementation of the Healthy Michigan Act should be **consistent with the legislative intent and principles of managed care** that focus on innovations and flexibility.

3. The State of Michigan should consider implementing an **Integrated Long Term Care Initiative** in regions outside of the demonstration initiative for integrated care for Dual Eligibles.

4. The State of Michigan should **continue to improve and reform Medicaid eligibility** by:
   a. Operationally, creating a default eligibility and enrollment for newborns to be assigned to the same Medicaid health plan as the mother at the time of birth (consistent with the terms of the Medicaid contract).
   b. Considering the option to delink Medicaid application from other human services program applications in order to accelerate eligibility and enrollment.
   c. Considering the feasibility of expanding the new eligibility and enrollment process for Healthy Michigan Act to the base Medicaid program.
   d. To help reduce future enrollment and eligibility "churning", Michigan should consider the economic feasibility of Michigan implementing either a bridge plan or basic health plan in conjunction with the Insurance Exchange.

5. The State of Michigan should continue its efforts in **streamlining and coordinating the administration and oversight** of Medicaid Health Plans and related contracted entities. This may include such options as:
   a. Merging the state administered contracts for MI CHILD and Medicaid Health Plans at the next earliest opportunity;
   b. Reduce or eliminate paper requirements in lieu of electronic documents and web-based information sites and begin using "deemed compliance" by virtue of national accreditation such as NCQA or URAC;
   c. Consolidating the Program administration and Coordination of the Integrated Services Plan for Dual Eligibles, MI CHILD, Healthy Michigan Act and regular Medicaid Managed Care Program under a single administrative program.
   d. Changing the regulatory perspective to a "regulation by exception"—that is a focus on those who are performing below standards established in the contract.

6. The State of Michigan should continue efforts to **maximize all levels of non-GF Revenue** (federal, special use, local revenue, and cost avoidance) to protect Michigan's Safety Net. This focus would continue and expand efforts for:
    a. Medicaid Health Plan Special Access and Supplemental Programs to assure outreach and coverage for Medicaid beneficiaries;
    b. Securing additional federal support into Medicaid, including FQHC, grants and programs to bring wellness and prevention as a key component of Medicaid;
    c. Increasing third party collections for Medicaid Managed Care Plans by providing access to other carrier data, including auto and Blue Cross/Blue Shield of Michigan and designating Medicaid Health Plans as "agents of department" for purposes of this function.
    d. Improving fraud and abuse coordination through the Medicaid Inspector General Office and working with a variety of organizations regarding the development of more community based care to reduce current high cost utilization of care.
    e. Developing an effective Observation Stay reimbursement policy and incentives for alternatives for Emergency Department use.
    f. Continue and expand efforts to support medical homes and other forms of diversion from emergency department inappropriate use.

7. The Department should **enhance and improve the Encounter Data Quality Initiative** to assure the following expectations are met:
    a. Encounter data will be successfully used in health plan rate development.
    b. DRG rebasing, special financing initiatives and studies on quality development using encounter data as a main component for such studies; and
    c. The use of encounter data for special analysis and cost studies.

8. The State of Michigan should **begin to take all necessary preliminary steps to assure a fair, transparent and deliberative rebid of the Medicaid Managed Care Program for contracts effective October 1, 2015** that recognizes the value contributed by current contractors. Such steps should include the following:
    a. Production of a formal "solicitation document" (RFP, RFA, RFI) to be distributed no later than December 2014 to qualified bidders that are licensed as health plans in Michigan.
    b. Targeted new contract beginning October 1, 2015.
    c. Consideration of changing the length of the initial contract and extensions to a four year contract and three one-year extensions.
    d. Announcement of the bid regions that will be used for the Solicitation as soon as possible as well as capacity measures that will be used in each region to facilitate meaningful health plan/provider contract negotiations.
    e. A "Decision Process" that will continue to emphasize the value of choice for beneficiaries and competition.
    f. A final Contract between the State and health plans that will merge the separate contracts for MI CHILD, Healthy Michigan and Regular Medicaid into a single contracting document. Further, the solicitation process should facilitate recommendations regarding integration of physical and mental health services.

EXECUTIVE SUMMARY DISCUSSION

Policy makers, administrators and the public expect (and receive) value from the Michigan's Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management. The most obvious strength is cost savings.

The MAHP Board Adopted Vision for 2020 is to have improved coverage, access, value and choice for the State's population improved competition within the industry, and demonstrated continuous quality improvement in key health status areas for Michigan residents. To implement this vision and promote the growth and sustainability of our managed care system, critical objectives are necessary at the beginning and through the program's duration. The recommendations included in this document are intended to help reach this vision for Michigan

Value in Managed Care

There continues to be an estimated savings of $400 million each year due to the Medicaid Managed Care program compared to fee for service. This savings has now yielded nearly $5 **billion in total savings to state taxpayers** between FY 00 and FY 13. The savings reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care in a partnership with the state **in exchange for actuarially sound funding**.

This return on investment enables both the State of Michigan and the federal government to redirect savings from Medicaid managed care to support programs in other high priority areas while preserving access to quality health care services for the vulnerable populations served by Medicaid program.

Of even more value is the **high quality that is the hallmark of managed care**. The continued national high performance ranking of Michigan's Medicaid Health Plans is a testament of the dedicated efforts of each of the health care partners in this arrangement; state administrators who set the standards, providers who deliver the care as part of the provider networks, and contracting health plans who put it all together.

Once again, the **Michigan Medicaid Health Plans are cited as among the best in the nation** by Consumer Report/NCQA America's Best Health Plans. Their 2013 ranking cited Michigan Health Plans for excellence in all three categories: commercial, Medicare, and Medicaid. Specifically, Michigan Medicaid Health Plans are among eight in top 30, nine in top 50 and ten in top 60. These numbers clearly demonstrate the quality care provided to our Medicaid population.

What's next?

There is still much more work to be done. Following the leadership of MDCH and in partnership with MDCH, the Medicaid health plans have been very active in working through operational details and enrolling special populations into managed care to improve access, coordinate care and provide more cost effective and accountable care for Michigan's most vulnerable citizens. These special efforts already underway include the following, (most notably the Initiative for

Dual Eligibles and implementing the Healthy Michigan Act which will be further described below):

- Completing the transition of enrollment of Children's Special Health Care Services, CSHCS. This began October 1, 2012 and continued well into 2013. While there were bumps along the way, the transition was quite unremarkable due to the tremendous amount of work by the health plans in partnership with MDCH.

- Continued to work with MDCH to implement a reimbursement increase for primary care providers—to a level consistent with Medicare. This program was retroactive to January of 2013.

- Continued to work with MDCH to begin the process for an enhanced beneficiary monitoring program to effectively control beneficiaries with high utilization of services while maintaining access to needed care. This program will be fully operational in the summer of 2014.

- Implementation of Integrated Care for the Dual Eligibles. This project is very complicated, taking an enormous amount of finesse and guidance from both MDCH and the federal government. We look forward to implementation during the summer of 2014. And now of course,

- Implementation of the Healthy Michigan Act---enacting all of the provisions of Public Act 107. This is an enormously complicated implementation because of the many reforms from the base Medicaid Program and the administrative requirements necessary to meet legislative intent.

Reform Eligibility

The sooner an eligible person becomes enrolled into a Medicaid Health Plan, the more effective and timely care can be provided and coordinated. A good example of where improvements can take place is with newborns. Now that the Medicaid Program has moved the Children's Special Health Care Services, CSHCS, enrollment into managed care, it is critical that newborns be identified and enrolled into the same health plan as the mother in the birth month. While this provision is included in the Contract with Medicaid Plans, operationally it is always delayed for months and then creates retroactive enrollment during a critical period of time for coordinating care.

As we look to the new eligibility system that will be established for the expanded population under ACA—up to 133 percent of poverty (note—operationally it will be 138 percent) reform of the existing system should take place. Performance standards of care imposed on Medicaid Health Plans under the state's contract are more achievable with timely enrollment.

Other efforts should assure that the eligibility re-determination process becomes more transparent in order for Medicaid Health Plans to identify and assist beneficiaries. This effort

will result in more continuity of care and improved date and accountability as HEDIS measures are based on "continuous enrollment" files.

Streamline and Coordinate Administration and Oversight

The Department should be commended for continuing to meet with Medicaid health plans on a regular basis to jointly discuss how the program can be improved. In addition to those conversations, the following areas should receive more attention over the next year:

- Merging contracts for MICHILD with Medicaid. This will eliminate some administrative costs, focus more on performance and accountability using the audited data requirements that exist for Medicaid, and would eliminate a current cost-settlement program with BCBSM that costs between $12 and $15 million each year.

- Reduce paper requirements in lieu of access of electronic documents and web-based information sites.

- Continue the identification of areas that can be considered "deemed compliant" as a result of national accreditation and change the focus of contract oversight to raising the performance of those contractors that are under the state average.

- Coordinate efforts for identifying and managing beneficiaries who have high utilization of care, particularly in emergency departments and in pharmacy.
- High level interactions with health plan operational staff and Department staff and consultants responsible for assuring encounter data validity and utility.

Finally, as most of Medicaid beneficiaries are or will be enrolled in managed care, it is time for the development of Medicaid policy to be developed through the lens of managed care and not based on fee for service. Under the Medicaid Contract, once a policy is adopted, Medicaid Health Plans must comply. Often, this requires modifications of systems, adjustments of internal protocols and policies—all of which add administrative costs. Further, these policies are often developed after the annual rates for Medicaid Plans are approved by the CMS—therefore; costs must be absorbed within the existing rates—although these costs were never part of the rate development assumptions.

Maximize non-GF Revenue

The success of Michigan Medicaid has been largely related to the ability to identify and implement programs that establish non-general fund support. As a result, the overall state general fund support for Medicaid has stayed largely static over the past years—while overall enrollment has increased significantly. It is vitally important that this effort continues and be enhanced where possible. Medicaid Health Plans have been highly supported in several direct ways:

- Medicaid health plans continue to pay taxes to support Medicaid—first through a HMO Quality Assurance Assessment Program, QAAP; then through payments to

the state's use tax; and now as part of the Health Insurance Claims Assessment Act and the Affordable Care Act premium tax.

- Medicaid health plans provide transfer payments for Michigan's hospitals to account for uncompensated care and graduate medical education programs; to Specialty Programs to assure assess to care; to adolescent centers and programs to provide the core funding for teen health centers and health education curriculum.

- Medicaid health plans are expected to increase the identification and collection of third party insurance in order to reduce Medicaid exposure.

Additionally, the areas of fraud and abuse are areas that Medicaid Health Plans work closely with the Michigan Attorney General's office and the Medicaid Inspector General—and expect to do so even more in the future years. Cost avoidance through this coordinated effort is one of the expected outcomes.

The area of waste is one area that is of concern to all payers. Health care reform cannot truly take place unless the cost of health care is reduced. This will affect Medicare, Commercial and Medicaid services together and solutions should be seen not just as a Medicaid issue but much broader. We know that at many as 20 percent of admissions are for treatment and care that could be provided in a community outpatient setting—IF—such settings and programs were available. Efforts toward more medical homes and early treatment and interventions—prevention—will also have the benefit of reducing costs. Finally, all citizens, including those on Medicaid need to have incentives to take personal responsibility for managing their own health care. The implementation of Michigan's health and wellness plan—also known as the 4 X 4 Plan is a good start in this effort and the underlying premise of the Healthy Michigan Act has embodied this concept.

Conducting a successful Rebid

MAHP has recommended that Michigan utilize the full option of three one-year extensions until the scheduled current contract end date of September 30, 2015. This position was taken due to the recognition that the Department of Community Health had many initiatives underway or planned over the past several years that included:

1. Development of the plan for the Integrated Care for the persons with dual eligibility Project –now a regional demonstration which will require extensive negotiation with CMS along with necessary Waivers and/or state plan amendments.
2. The Michigan Market Place (the Insurance Exchange) that will change the face of insurance selection for the citizens of Michigan and is now implemented through a partnership model with the federal government. Medicaid needs to be part of the systems development in order to coordinate the enrollment of expanded Medicaid eligibility.
3. Medicaid reform will require a number of administrative activities, from the systems coordination (mentioned above) to operational development and specifications, enrollment packages, and contract revisions with Medicaid Health Plans.

4. Under development is the new version of diagnoses codes, namely the ICD-10, an enormous system change undertaking in health care and costing already millions of dollars in system changes.

All of these initiatives require a tremendous amount of staff resources and expertise of both the state of Michigan and its consultants and the current and interested health plans who would submit proposals for review. However, as all contract extensions are now exhausted, it is time for the State to conduct the preliminary planning, make critical operational decisions, and begin preparation for a successful rebid of the Medicaid program. MAHP and members will advocate that there is much to preserve from the current program in order to sustain the achievement of high national ranking, substantial cost savings, and full accountability. Our recommendations regarding the initial steps are intended to reflect these values.

Duals Initiative

Through the leadership of MDCH, health plans chosen to be the responsible carrier to implement this initiative (known also as Integrated Care Organizations, ICOs) have worked closely to activate the Integrated Care for the Duals Project. This process has taken longer than expected due to the unique nature of the Michigan Proposal--and the presence of both a strong physical health and behavioral health system that is not in place in other states. The challenge of integrating services and maintaining the underlying infrastructure has created unique issues in Michigan.

Therefore, the MOU (Memorandum of Understanding) process between MDCH and the federal government, which will be guidance tool for the project, has been very difficult to bring to fruition. While MDCH has worked diligently on the MOU process, they have moved forward by facilitating a successful Request for Proposal process and have awarded potential contracts to the successful bidders (ICOs). Once the MOU is finalized, the readiness reviews for the ICOs will begin and the final rates and contract awards should be made public. We are encouraged that MDCH is continuing to hold implementation meetings with key stakeholders. Because this project will be functioning in only four regions of Michigan, there is still opportunity for developing an integrative approach for long term care in the rest of the state—an option that MAHP and other organizations would support and which is incorporated in the Healthy Michigan Act.

Healthy Michigan Plan (Medicaid Reform)

The Michigan Legislature enacted and Governor Snyder signed Public Act 107 into law September of 2013. Since then there has been a tremendous amount of activity led by MDCH with Medicaid health plans as they will be the delivery system for this program that will serve up to 450,000 newly eligible Medicaid beneficiaries once fully implemented. The submission and approval of the federal waiver for this program and the plan for incentives (providers, consumers and health plans) have been completed. MDCH and Medicaid health plans have held frequent meetings and conference calls to identify and operationalize necessary tasks for a smooth implementation. Documenting the many new administrative functions, assuring that legislative intent is met and providing sound actuarial rates are the final steps for initial implementation.

Because of the complexity of the law, there are many unchartered waters to maneuver and decisions to be made over the next several years. All observers understand that this is an unprecedented project with many moving parts. MAHP and members were strong supporters of the reform legislation, knowing that the ultimate accountability would reside in the contract between the State and contracting health plans. A main driver for legislative passage of the Healthy Michigan Act was to take advantage of a long and successful record of value and cost effective care (documented in this paper). Full transparency will now be required to document change, costs, and improvements in health status. The ultimate success of the Healthy Michigan Act will be dependent of these changes to occur and savings to be realized.

Summary

The key points that MAHP will emphasize in various advocacy messages are the following:

- **Enrollment of Population Groups into Managed Care Saves Dollars and Improves Care**. In addition to the cost savings that the management of this population will realize, the actual care and treatment in a managed environment lends to better and more efficient health care as documented by external auditors and performance contract requirements by the State of Michigan.

- **Enrollment of Population Groups into Managed Care creates Administrative Efficiencies.** With the multiple initiatives and programs occurring in the Medicaid program, movement toward a single benefit contract covering all of the programs creates administrative cost savings. We believe further state oversight responsibility and contract management could be consolidated for more efficient administration of programs. Coupled with electronic capabilities and other streamlined tools for contract management, a realization of savings to the contractors and thus a savings in the cost of the contracts would be accomplished.

- **Enrollment of Population Groups into Managed Care will reduce Fraud and Abuse expenses and highlight savings potential that will reduce "Waste".** There are various "best practice" models for state governments to address the ever present fraud and abuse from the Medicaid beneficiary as well as some Medicaid providers. Michigan Medicaid Managed Care applies these best practices creating significant health savings without compromising the quality of care or access to care. In addition, studies have indicated that there are areas of potential savings if the waste in our health systems could be addressed. For example, Medicaid hospital utilization is significantly higher than the commercial utilization. By reducing that difference we could save millions of dollars. Examples of initiatives to address this hospital utilization are programs to tackle of the problem of readmissions to the hospital within 30 days of discharge and the development of a workable observation room policy.

By virtue of the state's contract, each Medicaid health plan has "purchased" all of the risk from the State of Michigan to provide all services and meet the technical and quality requirements of the contract. While most observers are familiar with the medical benefits included in the

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Contract with Medicaid health plans, many have not linked the essential fact that the costs and expenditure savings to the State **are the product of "administrative costs."**

It other words, **the state's return on investment** — the improved health status and access to care as documented in the MAHP Medicaid Strategic Paper and the hundreds of millions of dollars in savings compared to Medicaid fee-for-service — would not be possible without the investment in the Medicaid managed care infrastructure supported by administrative costs. It is critical that this benchmark remain viable in its partnership with the State of Michigan and that viability is measured through actuarial soundness of rates paid to Medicaid Health Plans.

Why Recommendation related to actuarial soundness requirements are so important. To assure the entire managed care program is financially viable and strong full actuarial soundness must be implemented. A key indicator of "actuarial soundness" is the industry average margin for Medicaid Health Plans. A strong and viable system would yield margins minimally between 2 percent and 3 percent each year. However the past three years have resulted in the following average Medicaid Health Plan margins as reported in year-end filings with the Department of Financial and Insurance Services, DIFS:

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While the filings for calendar year 2013 will be available in the near future, it is anticipated that the margins will continue to drop and may be less than 1 percent. While it is critical anytime to assure actuarial soundness, given the trend in overall margins and the pending launch of the new initiative for Healthy Michigan Act, the legislature's obligation to fund and the department's obligation to administer this program in an actuarial sound manner is now of paramount importance.

Medicaid is a large program because of the volume of Michigan citizens served with a very comprehensive health care program. Between the regular Medicaid Program and the Healthy Michigan program, total health plan spending is expected to be nearly $7 billion dollars for health plan services in FY 15. The small percentage increases necessary to fund actuarial soundness now become magnified due to size related to the underlying base—e.g., each percentage increase now represent about $70 million gross funding. **To fully fund actuarial soundness for regular Medicaid and the Healthy Michigan Act combined, (including coverage for the state and federal taxes and fees) will minimally require an additional two percent or $130 million in total dollars over the amount recommended in the FY 15 Executive Budget for these two line items**. At the current federal match rate, this would require an additional $25-$30 million in General Fund support—the remainder from federal match.


MedEncentive
Rewarding better health

The Program

A completely different approach to achieving the Three-part Aim (better health care, better health, lower costs)

What it is...
How and why it works...

MedEncentive

What is MedEncentive?

MedEncentive offers a web-based healthcare cost containment system that incorporates the company's patented "**trilateral health accountability model™**."

THAM™ works by aligning the interests of the healthcare consumer, provider and insurer, and by incorporating evidence-based medicine and information therapy (Ix) to promote health literacy.

The MedEncentive system has been tested for nearly a decade in multiple real-world trials.

The results of these trials have been examined by independent academic researchers and industry experts who have confirmed that the MedEncentive system lowers healthcare costs by simultaneously improving health and healthcare, thus accomplishing the famed "Three-part Aim."

MedEncentive

The Key to Health Care Cost Containment

No health care cost containment solution can be sustained without balancing the interests of the essential stakeholders; like a three-legged stool

Consumers/ Patients

Physicians

Employers/Insurers
(plan sponsor/risk-bearing entity)

Alignment-of-interests to create a win-win-win proposition

MedEncentive

The employer and insurer sponsored patient accountability movement

Consumers/ Patients

Patient Accountability
- Wellness and prevention
- High-deductible consumer-driven health care
- Disease/care management

No Physician Accountability

Employers/Insurers
(plan sponsor/risk-bearing entity)

Requires large financial incentives, which impedes ROI

MedEncentive

The government and insurer sponsored provider accountability movement

No Patient Accountability

Physicians

Provider Accountability
- Capitated HMO
- P4P
- Accountable Care Org.
- Episodic care payments
- Medical home

Employers/Insurers

(plan sponsor/risk-bearing entity)

Limited to no proof that this approach produces an ROI

MedEncentive

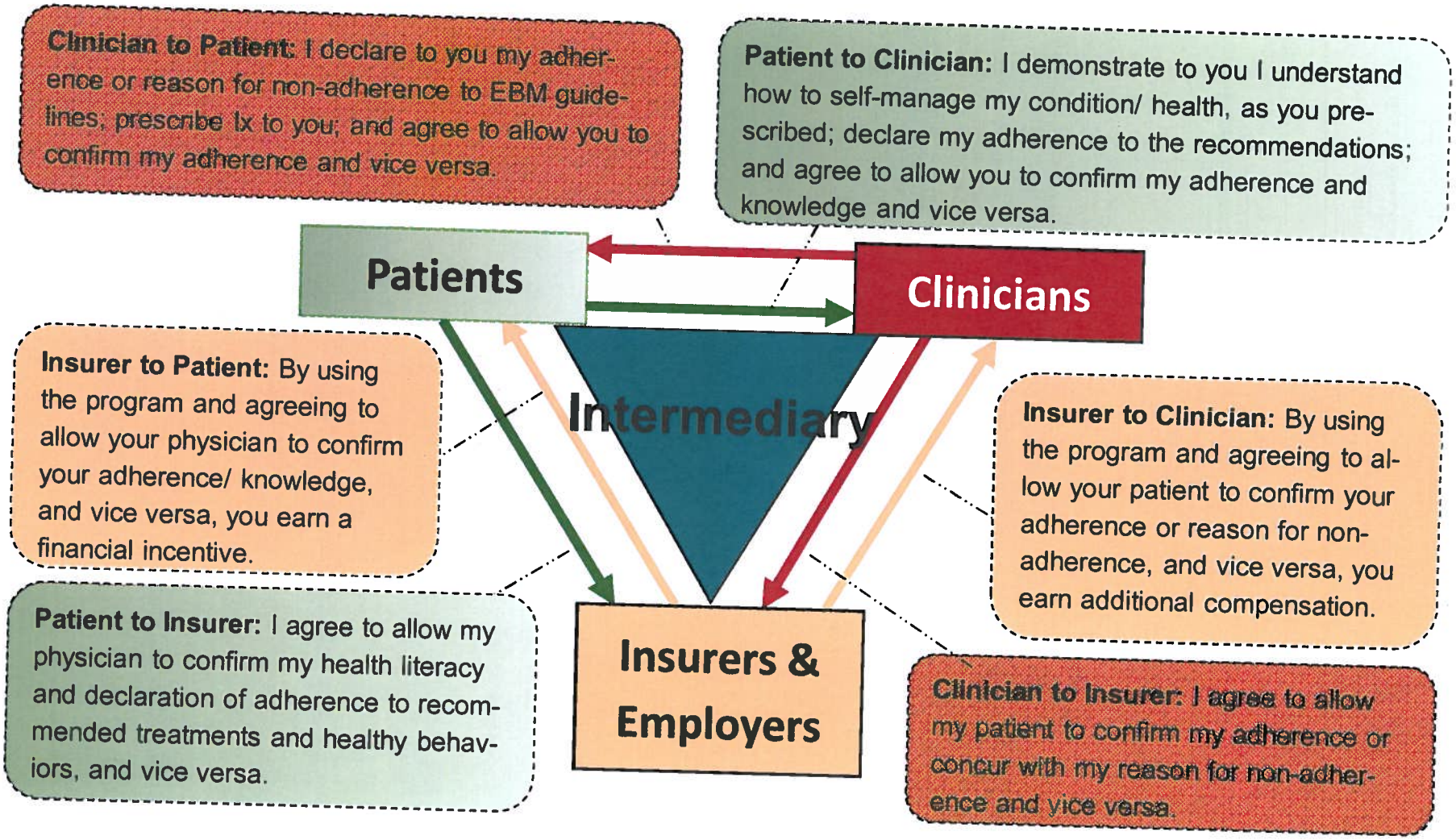
The MedEncentive THAM® approach is fundamentally different

"Triangulation" to achieve the "Three-part Aim"

This model has proven time and again to produce large ROI

MedEncentive

The Trilateral Health Accountability Model™



MedEncentive

Motivators

Understanding how motivators function is essential in developing solutions that improve human behavior.

- **Financial incentives** are like a sugar - very powerful, but they don't last very long
- **Interpersonal relationships** (what others think about us) are powerful and long lasting motivators
- **Knowledge** is a powerful and long lasting motivator

Combining these three motivators in a systematic manner is the key to improving human behaviors and controlling cost

MedEncentive

How does MedEncentive work?

MedEncentive is a patented, web-based incentive system that uses **"precision-guided financial rewards"** to:

- Tap into the doctor-patient relationship to achieve **"mutual accountability"**
- Advance patient health literacy by means of **"information therapy"**

MedEncentive

Overwhelming evidence indicates that the motivators present in the doctor-patient relationship influence behaviors...

CFAH CENTER FOR ADVANCING HEALTH
Evidence. Engagement. Equity.

Doctor-Patient Relationship Influences Patient Engagement

Release Date: November 29, 2011 | By Valerie DeBenedette, Contributing Writer
Research Source: Center for Advancing Health

Researchers asked 8,140 people in the U.S. with chronic illnesses about their experiences with their physicians, as well as about their socioeconomic status, overall health and how they make use of health services.

Patients who perceived their physicians were involved in their care were more likely to monitor their blood pressure, exercise five days a week and adhere to medication regimens, among other healthy behaviors. This explains the reason why "mutual accountability" is an important part of MedEncentive.

MedEncentive

Overwhelming evidence indicates that the motivators present in the doctor-patient relationship influence behaviors...

CFAH CENTER FOR ADVANCING HEALTH
Evidence. Engagement. Equity.

Doctor-Patient Relationship Influences Patient Engagement

Release Date: November 29, 2011 | By Valerie DeBenedette, Contributing Writer

Behavioral science refers to this phenomenon as the...

Authority-Adherence (Obedience) Response

...which is also analogous to the Hawthorne Effect

Patients who perceived their physicians were involved in their

This helps explain why the MedEncentive Program's "mutual accountability" feature is so important.

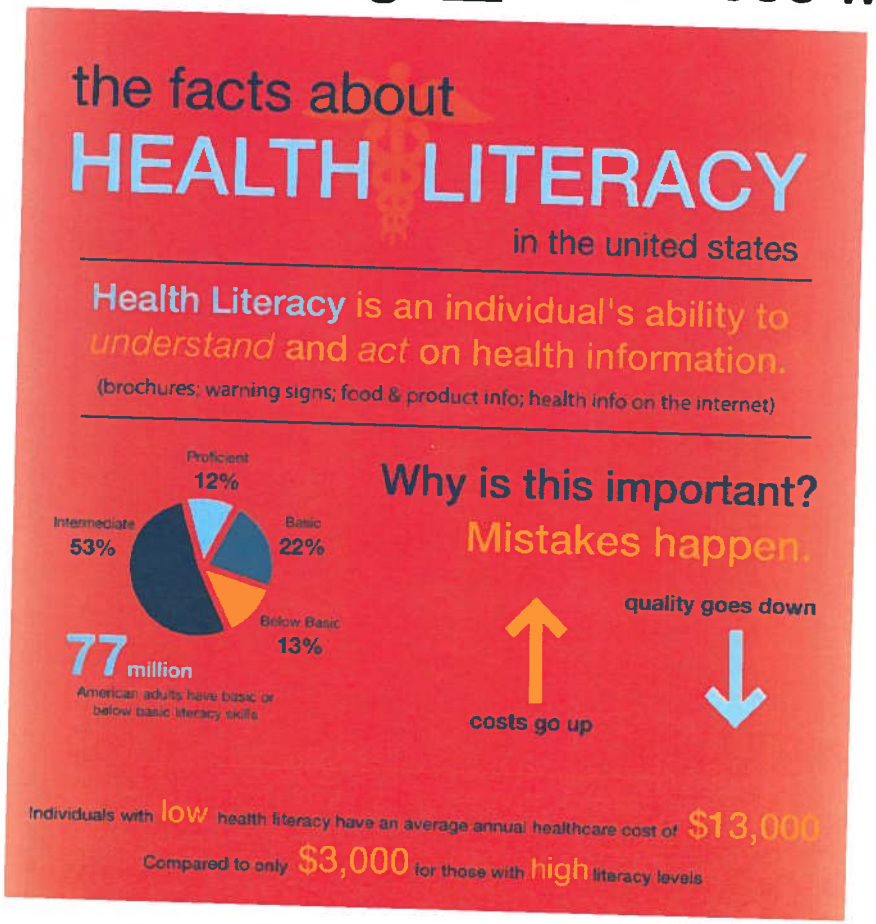
other healthy behaviors.

MedEncentive

Overwhelming evidence establishes the importance of health literacy on clinical and economic outcomes

Individuals with low health literacy have annual healthcare cost that is more than **4 times higher** than those with high health literacy...

This explains why "information therapy" is so important with MedEncentve.



*http://nnim.gov

MedEncentive

Overwhelming evidence establishes the importance of health literacy on clinical and economic outcomes

Individuals with low health literacy have annual healthcare cost that is more than **4 times higher** than those with high health literacy...

When people know the "how" and "why," they are more empowered and motivated to comply with recommended treatments and adopt healthy behaviors. Behavioral science calls this the:

Knowledge-Adherence Response

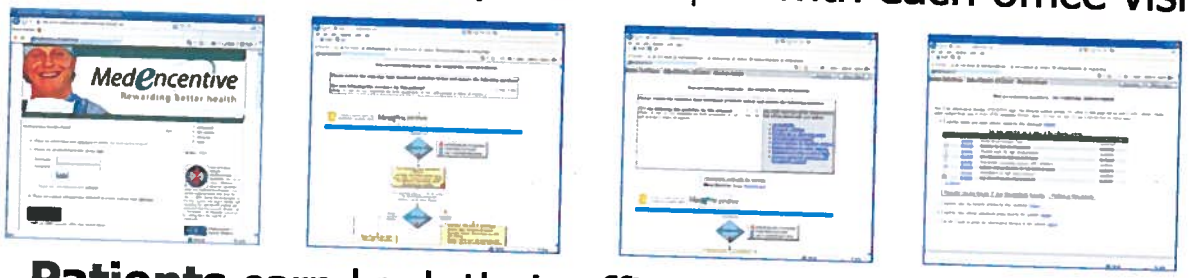
This helps explain why the MedEncentive Program's "information therapy" feature is so important.

*http://nnlm.gov

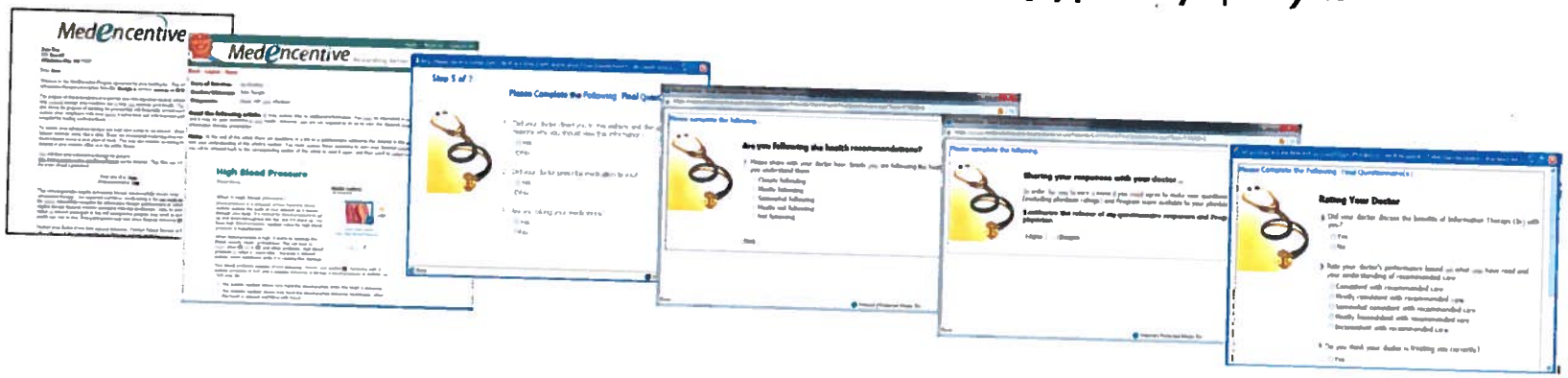
MedEncentive

The Information Therapy (Ix) Program Basics

- **Plan sponsor** underwrites Program, arranges to have eligibility and claims transmitted to MedEncentive, and pockets the savings
- Doctors and patients can earn financial rewards immediately by voluntarily accessing MedEncentive's website in conjunction with each office visit
- **Physicians** are compensated $15 with each office visit for...



- **Patients** earn back their office visit co-payment (typically $15)...

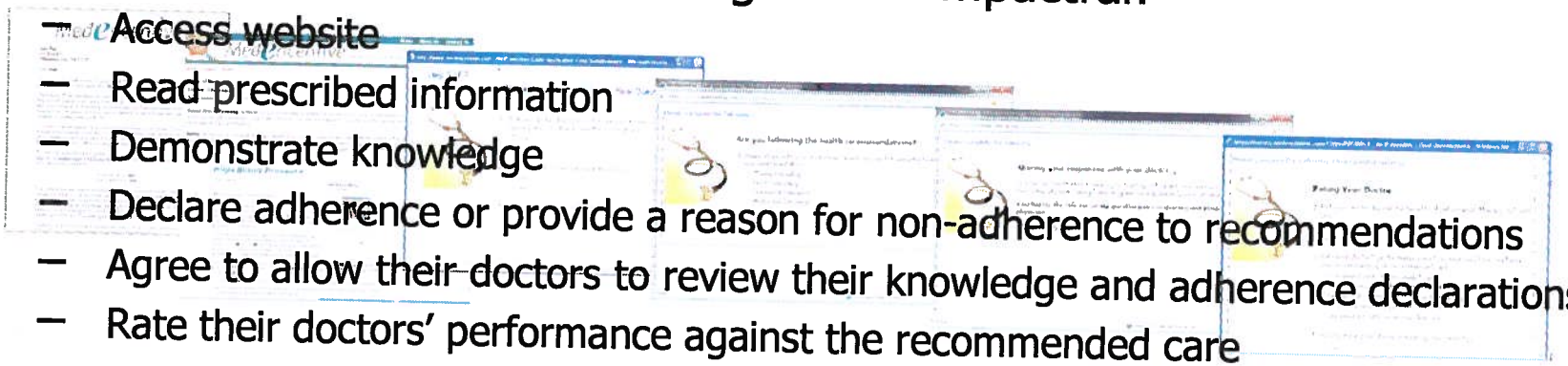


MedEncentive

The Information Therapy (Rx) Program Basics

- **Physicians'** experience is fast, easy, well compensated, and impactful:
  - Logon to website
  - Enter patient name and diagnosis
  - Declare adherence or provide a reason for non-adherence to a evidence-based treatment guideline
  - Agree to allow their patients to compare their adherence declaration against actual care
  - Prescribe information therapy to their patients as "homework"

- **Patients'** experience is meaningful and impactful:
  - Access website
  - Read prescribed information
  - Demonstrate knowledge
  - Declare adherence or provide a reason for non-adherence to recommendations
  - Agree to allow their doctors to review their knowledge and adherence declarations
  - Rate their doctors' performance against the recommended care



MedEncentive

Measuring How Well the Program Works

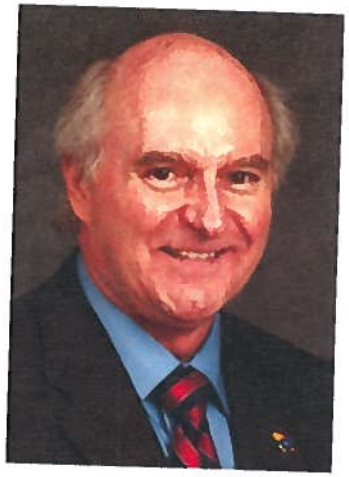
Trial results and independent analyses

MedEncentive

KU SCHOOL OF MEDICINE WICHITA
The University of Kansas

MedEncentive: An Independent Evaluation of a Cost Containment/Information Therapy Tool

MedEncentive's Estimated Impacts on Employer's Costs of Insurance and Individual Healthcare Costs: a Preliminary Case Study



- Douglas D Bradham, Dr.P.H., Kansas Health Foundation Distinguished Professor of Public Health – Health Economist
- Nikki Keene, MA, MPH, PhD Candidate – Behavioral Psychologist
- Traci Hart, PhD , Research Assistant Professor – Human Factors Psychologist
- Phillip Twumasi-Ankrah, PhD, Assistant Professor - Biostatistician
- Amy Chesser, PhD, Research Assistant Professor – Healthcare Communications

KU SCHOOL OF MEDICINE WICHITA
The University of Kansas

Department of Preventive Medicine and Public Health
University of Kansas, School of Medicine – Wichita

THE FORUM 10
Oct.13-15,2010 Washington,DC

The Oklahoma Trial

Over a four year period after implementation, the City of Duncan employee health plan realized a savings of between $3.1 and $17.7 for each $1 invested in the MedEncentive Program.

(Validated non-catastrophic and total claims expenditure against average trend over 4 years)

KU SCHOOL OF MEDICINE WICHITA
The University of Kansas

The Kansas Trial

In the 2½ years after the Wichita Clinic implemented the MedEncentive Program:

- Office visits increased 13%
- Medication adherence reported at 94%
- **Hospitalizations decreased 55%**

Refer to University of Kansas School of Medicine research abstract and poster (following slide)

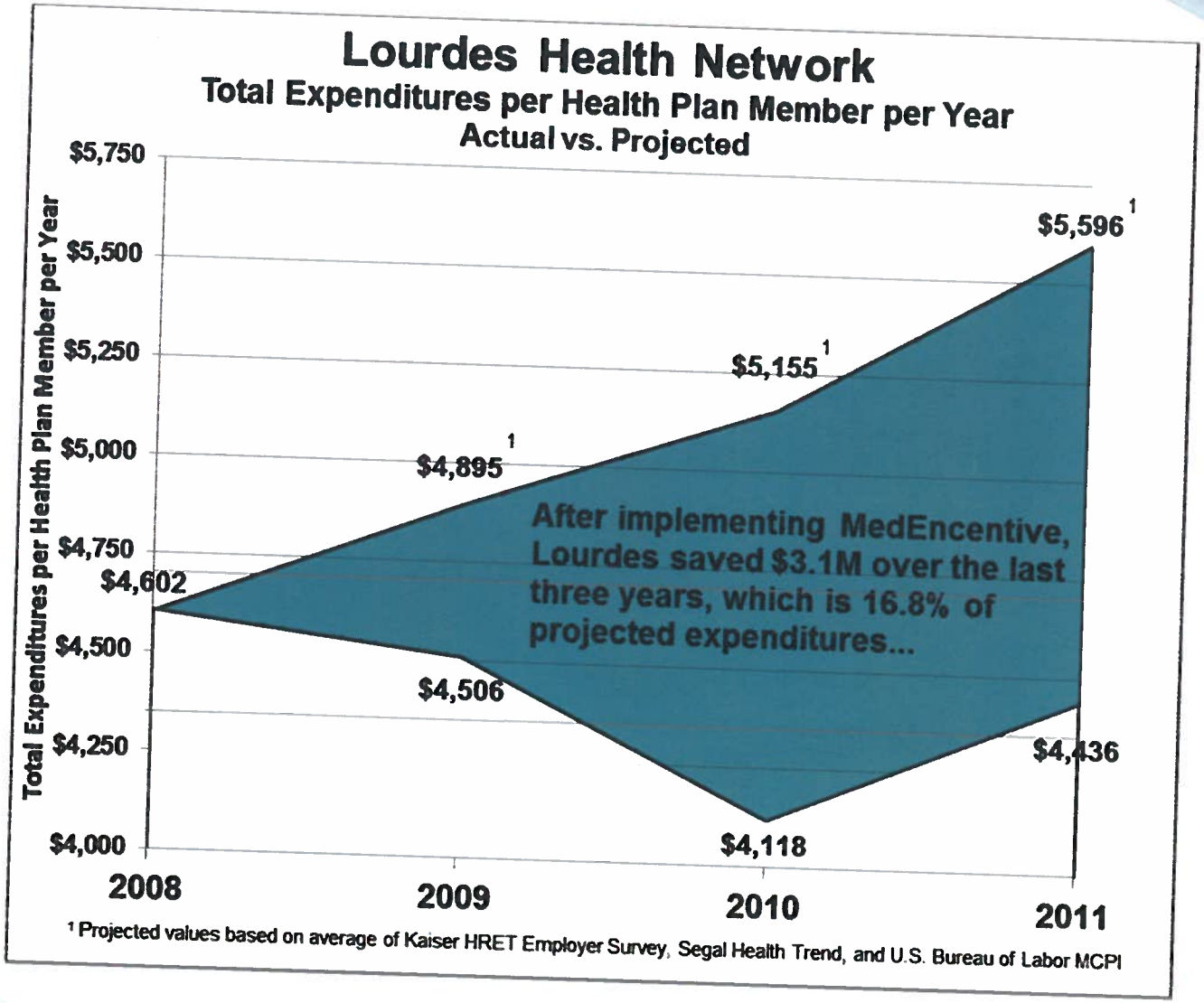
KU SCHOOL OF MEDICINE WICHITA
The University of Kansas

The Washington Trial

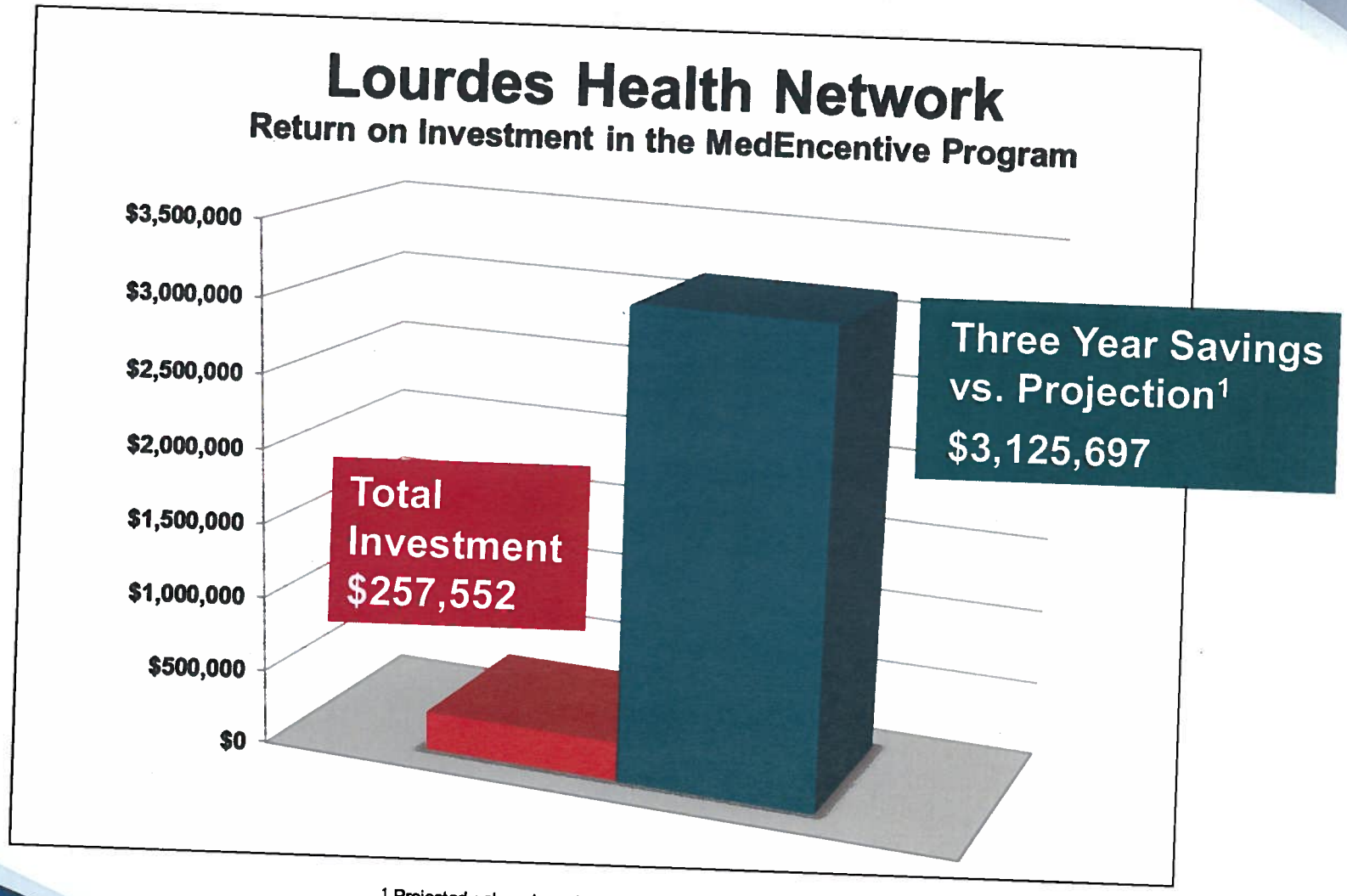
The Loomis Company Analysis of MedEncentive at Lourdes Health Network

- Located in Pasco, Washington
- Founded in 1916
- Faith-based hospital system
- 1,100 health plan members
- Unionized workforce
- Escalating healthcare costs prior to adopting the MedEncentive Program in 2008
- An Ascension Health facility

Over $3M savings in last three years



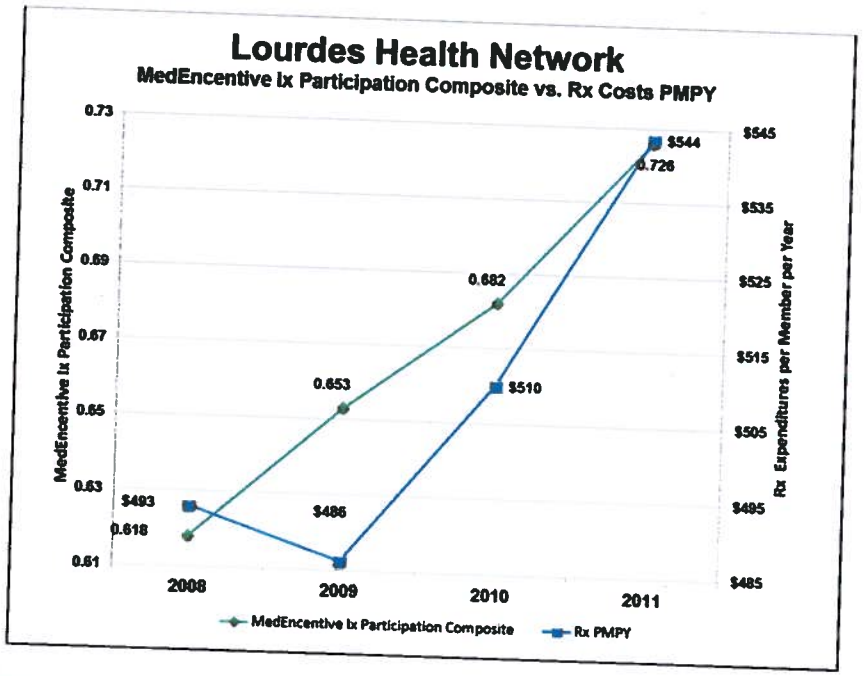
Three year savings vs. MedEncentive program investment = 12:1 ROI

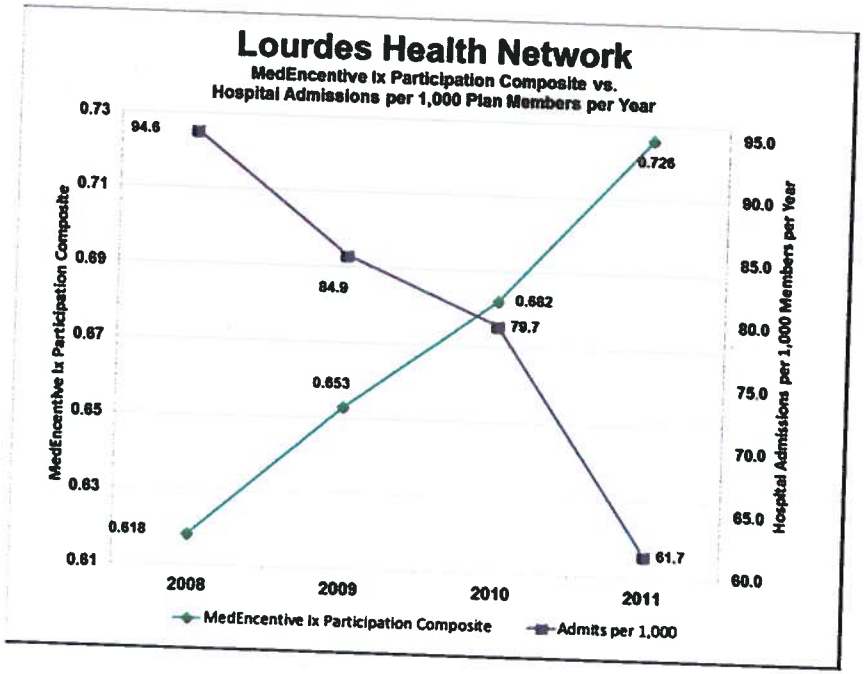


[1] Projected values based on average of Kaiser HRET Employer Survey, Segal Health Trend, and U.S. Bureau of Labor MCPI

Causality Question: How can the ROI be attributed to MedEncentive?

Answer: As participation in MedEncentive went up, health literacy and medication adherence increased, while hospitalizations declined, which produced the savings…





Independent validation to date...

Two separate independent evaluators plus three separate top ten stop-loss carriers examined three separate trials in three different states and found the same result...

MedEncentive works...

MedEncentive

To learn more about the Program, supplementary presentations and demonstrations are available...

MedEncentive

Q&A

MedEncentive

FIGHT CRIME: Invest in Kids Michigan

Hundreds of Police Chiefs, Sheriffs, Prosecutors, other Law Enforcement Leaders, and Violence Survivors Preventing Crime and Violence

Testimony for the House Appropriations Subcommittee on DCH Budget
Presented by
Gene Wriggelsworth, Sheriff, Ingham County
March 3, 2014

Mr. Chairman, members of the committee, thank you for the opportunity to testify today. My name is Gene and I'm the Sheriff of Ingham County. I'm pleased to be a member of FIGHT CRIME: INVEST IN KIDS *Michigan,* which is part of a national anti-crime organization of police chiefs, sheriffs, prosecutors, other law enforcement leaders and violence survivors with more than 500 in Michigan and 5,000-plus nationwide. Our members know that there are no better weapons in our arsenal to fight crime than the proven programs that help kids get on track and stay on track early on.

As law enforcement leaders, we see home visiting / parent-education as one of the most effective tools to fighting crime. We appreciate the Legislature's past commitment for these programs and now we ask you to support the Governor's proposal in the Department of Community Health Budget to maintain funding for the Maternal Infant Health Program, and the Nurse-Family Partnership, and to add $2.5 million for home visiting and parent-education programs in Michigan's Upper Peninsula and northern Lower Peninsula. We are also asking the leaders of the Appropriations Subcommittee on the K-12 Budget to restore $2.5 million for home visiting / parent-education in that budget.

Some may consider this funding proposal for home visiting / parent-education as new money, but we realize that these funds would partially restore funding that was available a dozen years ago for home visiting programs across 63 counties in Michigan. Those counties did a marvelous job of combining program funds from local, state, federal, and philanthropic funding streams to provide local services to at-risk families. The aim was to increase family functioning through parent education and community referrals to help decrease child abuse and neglect. Please note that at one time, the zero to 3 secondary prevention fund had close to $8 million that supported similar programs across 63 counties in Michigan.

It is important to note that, today, Michigan requires its state-funded home visitation, parent-education programs to be evidence-based or promising, which requires evaluation to show the outcomes and fidelity to high-quality model programs being funded. (See PA 291 of 2012)

In Michigan, taxpayers spend more than $2 billion a year on corrections. By contrast, Michigan spends just a fraction of that on early care and education for young children. Yet, the high-quality, voluntary home visiting / parent-education programs are proven to get families on track so that parents and kids never enter the justice system. The cost to taxpayers and society are a wise investment.

We appreciate your kind attention and consideration.

Boji Tower - Suite 1220 • 124 W. Allegan Street • Lansing, MI 48933 • Phone (517) 371-3565 • Fax (517) 371-3567 • www.fightcrime.org/mi

Breaking the Cycle of Child Abuse and Reducing Crime in Michigan

EXECUTIVE SUMMARY

Breaking the Cycle of Child Abuse and Reducing Crime in Michigan: Coaching Parents Through Intensive Home Visiting

The more than 400 police chiefs, sheriffs, district attorneys, leaders of police officer organizations and violence survivors who are members of *Fight Crime: Invest in Kids Michigan* have taken a hard-nosed look at what works—and what does not work—to cut crime and violence. Investing more in effective home visiting programs will save millions of dollars, protect children from abuse and neglect, and greatly reduce the number of children who grow up to become violent criminals.

The Annual Toll: 29,638 Abused and Neglected Children
The Future Toll: 1,185 Additional Violent Criminals

In Michigan, 29,638 children were officially confirmed as victims of abuse or neglect in 2007 – more than the seating capacity at the Palace at Auburn Hills where the Detroit Pistons play. The true number is likely far higher. In 2005, a child death review team found that 57 Michigan children were killed by abuse or neglect that year.

While most victimized children who survive never become violent criminals, being abused or neglected sharply increases the risk that children will grow up to be arrested for a violent crime. It also increases the chance that they will pass on this cycle of violence to their own children. The best available research indicates that, of the 29,638 children who had confirmed incidents of abuse or neglect in one year, 1,185 will become violent criminals as adults who otherwise would have avoided such crimes if not for the abuse and neglect they endured. Year after year in Michigan, abuse and neglect creates more violent criminals.

Most Abuse and Neglect in High-Risk Families Can Be Prevented

Home visiting is provided by trained professionals on a voluntary basis to interested at-risk young mothers starting as early as before they give birth and continuing until their first child is age two or beyond. It significantly reduces abuse and neglect. For instance, the Nurse-Family Partnership program (NFP) showed it can prevent nearly half of all cases of abuse or neglect of at-risk children. And, by the time the children in NFP had reached age 15, they had 59 percent fewer arrests than the kids left out. In Michigan, there are five programs serving more than 500 families.

One of the primary home-visiting programs funded by Michigan's Zero to Three Secondary Prevention Initiative Grants is Healthy Families. A randomized controlled trial was done of the Healthy Families home visiting program in New York (HFNY) which found that mothers in the program reported engaging in one quarter as many acts of serious physical abuse as the mothers not receiving services.

The Michigan Children's Trust Fund reports that, while "92 percent of families served per quarter [by home-visiting programs] have three or more risk factors for child abuse and/or neglect," even among such at-risk families, there was no record of Child Protective Services involvement for 99 percent of the children in the program while they were being served.

The Michigan Department of Community Health (MDCH) currently funds five NFP programs in Berrien County, Kent County, Oakland County, Kalamazoo County, and the city of Detroit through Wayne County. Together, they serve over 500 vulnerable families. Michigan's state-funded Zero to Three collaborative grants provide primarily home visiting services through 35 grants reaching 47 counties, and, in 2008, they were serving nearly 3,000 families each quarter.

Saving Lives, Preventing Crime, and Saving Money

Preventing child abuse and neglect also saves money. Researchers who studied the costs of abuse and neglect for the U.S. Justice Department estimated the total costs from abuse and neglect are over $2 billion each year in Michigan. A 2008 study by Steve Aos of the Washington State Institute for Public Policy also found strong results: $18,000 in net savings per family served by NFP because of reductions in crime and other problems in the families served, and three dollars saved for every dollar invested.

Law Enforcement Leaders are United

Law enforcement leaders and violence survivors are united in calling for greater investments in effective home visiting *not less.* The evidence is clear. Home visiting services can prevent as much as half of abuse and neglect in high-risk families, saving the people of Michigan more than two billion dollars a year while reducing crime. Even in these very tough times, this is a program that deserves to be expanded, not cut.

WH

MPTA MICHIGAN PUBLIC TRANSIT ASSOCIATION

Testimony before House Appropriations Committee

Subcommittee on Community Health

Monday, March 3, 2014

Presented by: Clark Harder

Executive Director

Michigan Public Transit Association

Thank you Mr. Chairman and members. I appreciate the time to address your committee this morning and promise not to overstay my welcome.

You may be wondering why a public transportation association representative wishes to address a committee discussion on health issues. Certainly I am not from an association you ordinarily hear from on this topic.

In public transportation we have been observing for several years the growing issue of transportation to Non Emergency Medical appointments. We are aware that this has become a large cost under the Medicaid program and that it is only going to expand further with Medicaid Expansion after April 1st since transportation to Non Emergency Medical appointments is guaranteed under the Affordable HealthCare Act and this will drive up need. But not only have we been observing, we believe we can be of assistance to the state in meeting this demand and do it cost-effectively. As a federally, state and locally-funded entity, we in public transportation believe that we have a responsibility to step up and do more to help.

2875 Northwind Drive • Suite 120 • East Lansing, MI 48823
517.324.0858 • FAX: 517.324.7034
www.mptaonline.org

As you may realize, state funding for public transportation exists in every one of our 83 counties in Michigan(Exhibit A attached). In the vast majority, this is through established public transit agencies which also receive federal and significant local tax support. In counties without an organized public transit agency, there are "Specialized Services" that receive state support to provide transportation service where there are critical needs. The state also uses state funding to support some private transportation options where no other means exist for people without private vehicles to move about the state. At the Michigan Public Transit Association, we work with all of these entities. We coordinate transportation for persons who have no other options as well as for those who choose public transportation as a preferred choice over using their own vehicles. Therefore, we offer a unique ability to move great numbers of people at reduced cost throughout the state.

The long-standing policy of the state has been to allow local county level decision-making on how best to move clients. We believe that a better model would be for statewide coordination with a clear emphasis on using public transportation and reliable private Michigan transportation businesses whenever possible. This would maximize the investment of public tax dollars the state already makes in these agencies, while reducing oversight costs since the infrastructure to schedule and deliver rides already exists in local public transit agencies.

We have explored this approach already with officials in the Snyder Administration and they are intrigued by the idea. We have also discussed it with representatives from the medical field, the Managed Care community, and with several private business partners that we know to be providing a quality, reliable service equal to the strict performance standards that the federal government sets out for public transportation agencies to follow and all agree that this concept makes sense.

As we have studied this issue we have also learned that, while there are many excellent private transportation companies based in Michigan, there are unfortunately a number of under-funded, poorly equipped, and poorly-trained contractors who are not performing up to expectations. Public transportation agencies are held to high standards and we would require similar standards for private contractors.

I'd like to share one additional observation that was recently brought to our attention. A member of our state's Congressional delegation told us of visiting a medical provider's facility and seeing an individual brought in by ambulance on a stretcher who, upon being wheeled into the facility, immediately stood up and walked into the examination room for his appointment. Upon asking about this, the Congressman was told that the person, even though ambulatory, has to be brought in by ambulance due to program restrictions that mandate that payment can only occur if the person requires emergency transportation.

The Congressman was told it is a common practice and widespread. Pure and simple, we all know this is wrong. It is deceptive and it results in an exorbitant cost to taxpayers. It also unnecessarily ties up emergency equipment and staff that may be unavailable in time of an actual emergency. The person was ambulatory and can easily be served, at a fraction of the cost, by public transportation.

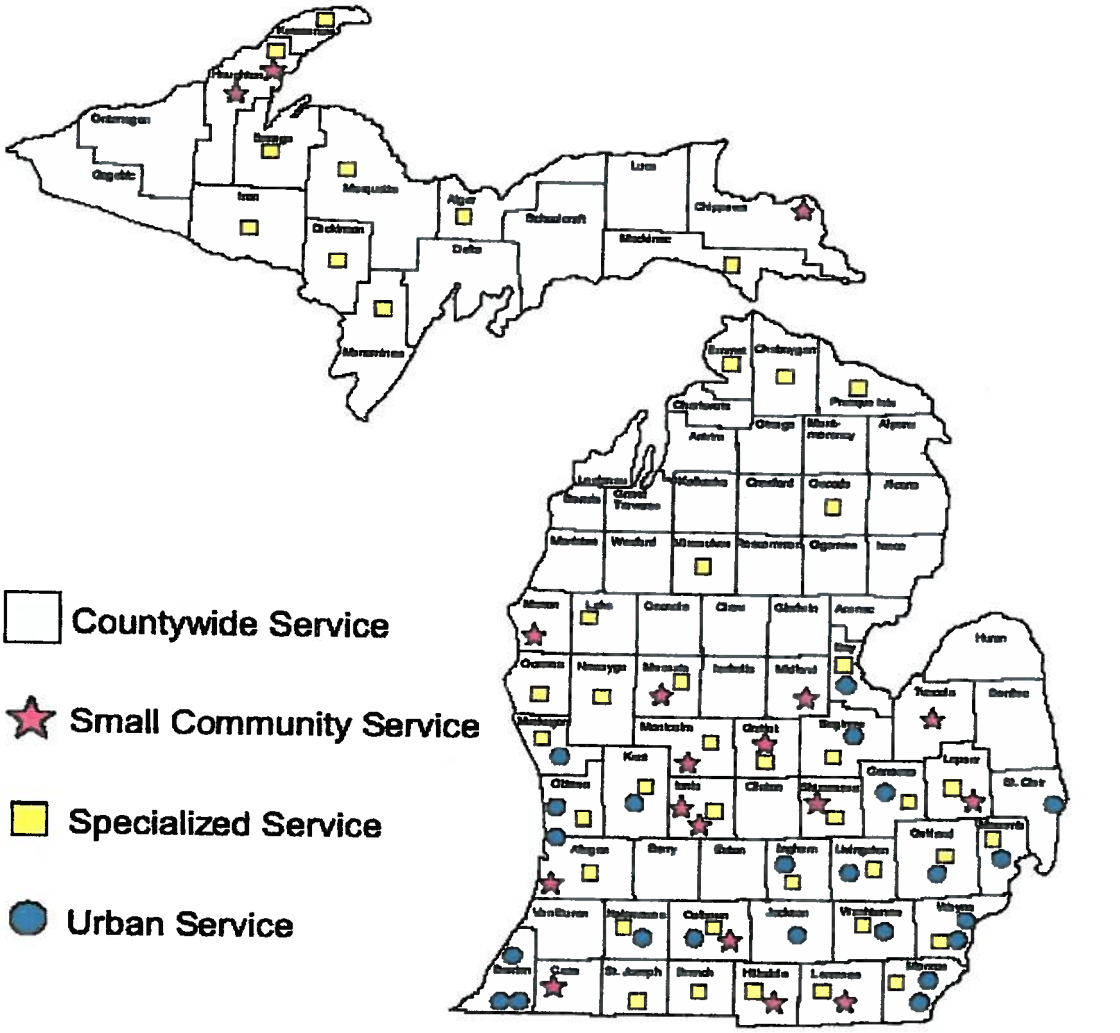
According to data from the Department of Community Health, in Fiscal Year 2012 Non Emergency Medical Transportation for the State's Fee For Service Medicaid population cost the State $13 million statewide, not including the counties of Wayne, Oakland and Macomb. This is a significant cost.

We, in public transportation, are ready and willing to help deliver a higher quality of transportation care, at a lower cost, while maximizing the state's investment in both transportation and medical care. We stand ready to assist.

Thank you very much for your consideration and I'd be happy to address any questions.

Exhibit A:

Michigan
Local Public Transit



Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

Written comments for the House DCH Appropriations Subcommittee
March 3, 2014

Chairman Lori and Members of the Committee:

My name is Michael Vizena, director of the Michigan Association of Community Mental Health Boards, representing the 46 community mental health boards and 77 provider organizations which deliver mental health, substance use disorder, and developmental disabilities services across the entire state.

On behalf of our members, we appreciate Governor Snyder's increased attention to mental health and substance use disorder services through the Mental Health and Wellness Commission report and the proposed funding of specific program initiatives to targeted and new priority populations. Our members look forward to working with the Administration and Legislature on these new initiatives. We also support two key boilerplate provisions which will provide for current funding to be redirected to finance local services.

Local Match

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

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

Deemed Status

We support the Governor's recommendation to include boilerplate section 494, which would adopt a "deemed status" model that will recognize full accreditation by a national accrediting body in lieu of many of the current duplicative state departmental review requirements. Deemed status for CMHSPs, PIHPs and provider organizations with such accreditation will reduce their and the state's administrative costs, reduce these duplicative state reviews and move towards a less complicated system. Our neighboring states, Illinois and Ohio both have adopted deemed status models, in fact the state of Illinois found about a 40% redundancy rate between the accrediting bodies' reviews and state reviews. It will enable us to redirect funding from these administrative costs to support more services in the community.

Healthy Michigan

Unfortunately, while we should be focusing our attention on these new recommendations and

WLC

these opportunities to redirect current funding to support more services, we have significant problems with Healthy Michigan that must be addressed. The administration's proposed financing of the implementation of Healthy Michigan in FY14 and FY15 will create serious harm to current recipients of care and further limit access to critical services.

The first area of concern relates to the proposed FY15 Medicaid financing to the PIHPs, which includes financing for the additional 400,000 Healthy Michigan beneficiaries. Based on our initial analysis, there are no additional funds to provide additional services to Healthy Michigan enrollees not currently served by the system. In fact, it appears that there will be less total funding to support these individuals. We also continue to question the Budget Office's projected savings of CMH general funds in a number of areas. As with many others in the healthcare community, our association and its members have been a strong advocate and supporter for Healthy Michigan. That support continues. That support is based on the improved access to physical and behavioral healthcare services for hard working, low income adults that your passage of Healthy Michigan intended. Unfortunately, the administration's proposed FY15 budget provides inadequate Medicaid financing to provide such behavioral health access for the new Healthy Michigan beneficiaries.

Our second problem with Healthy Michigan is not a concern. It is a crisis. The proposed FY14 supplemental budget requests removes 70% of the CMHs' General Funds effective April 1st, the first day of Healthy Michigan. It provides no provisions for startup implementation of Healthy Michigan implementation. The Healthy Michigan Plan required months of deliberation through the Legislature and with the federal government to be approved. As a result, the implementation work has been delayed. While the administration is working very hard, much remains to be done. The application process and forms are still being designed; it is not likely to be available until sometime in March at the earliest. The public information campaign to create awareness and assist persons in enrolling has not yet begun. Clearly, it will take months to ramp up the enrollment for the 400,000 who will be eligible.

If State General Fund dollars are removed from the public mental health system before persons are enrolled and the replacement financing of the Healthy Michigan Plan is in place, the community service providers will not have resources to serve those currently being served. Needless disruptions of necessary services will only increase costs to our state and to the vulnerable individuals our members are serving. CMHs are obligated by their contract with the state to provide written notice of termination of services. Thousands of persons currently in service are being notified in writing this month that their services are being terminated effective March 30th. If we remove state General Fund dollars before federal funds are in place, serious and potentially deadly consequences are likely to occur.

On behalf of the estimated 50,000 persons currently served with general fund resources, we request you take immediate action to avert this impeding crisis. Thank you for the opportunity to provide testimony.

Respectfully submitted,

Michael V. Vugina

hcam
PROMOTING EXCELLENCE IN SENIOR CARE

7413 Westshire Drive
Lansing, Michigan 48917

Phone: (517) 627-1561
Fax: (517) 627-3016
Web: www.hcam.org

Testimony on the FY2015 Department of Community Health Budget

House Appropriation Subcommittee on Community Health
Representative Matthew Lori, Chairperson --- March 3, 2014

Thank you Representative Lori and members of the subcommittee for the opportunity to speak with you today regarding the FY2015 Department of Community Health budget recommendation. My name is David LaLumia, and I am President/CEO of the Health Care Association of Michigan. HCAM represents proprietary, not for profit, county medical care and hospital-based nursing and rehabilitation facilities. We also represent assisted living programs through our affiliate, the Michigan Center for Assisted Living. There are 427 nursing facilities in Michigan employing 50,000 dedicated workers and caring for nearly 40,000 Michiganders each day.

Nursing facilities play a unique and integral role in our healthcare system. They are the most widely used post-acute setting for Medicare beneficiaries. They also serve a more medically complex and functionally limited long-term care population. This population has exhibited increasing severity of need over time. Medicaid is the primary payer for care provided in nursing facilities. On average, 66 percent of persons cared for in nursing facilities are Medicaid beneficiaries. The DCH/Medicaid budget is critical to improving quality of care and outcomes for the residents and patients we serve. This is yet another important reason to protect the Medicaid budget by filling the HICA tax shortfall in FY2014, FY2015 and beyond and to continue to resist Medicaid provider rate cuts which are not good for beneficiaries, providers or the state as a whole.

We support the Governor's recommendation to make Michigan a "no wait state" for in home meal services. HCAM has been a strong and outspoken advocate for increased funding to eliminate waiting lists for the waiver program. As such, we support the Governor's recommendation to add funding for home and community-based care to the FY2015 budget. We believe it is essential to have a full continuum of services and supports for Michigan seniors. We ask for your support to grow the LTC infrastructure our state will need in the years ahead.

Managed long-term care has arrived. We support the goals of the Michigan integrated care plan for beneficiaries who are dually eligible. We are actively working with the department, health plans who have been selected to be integrated care organizations and other stakeholders to make this transition as seamless as possible for beneficiaries. Some say that the goal should be to get people out of nursing facilities. This assumes that many individuals in a nursing facility can or should be cared for in other settings. It is clear to us that managed long-term care will not be just one thing. It's not just nursing facility care. It's not just home and community-based care.

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It's a continuum of services and supports. The goal should be to make sure that individuals are served in the most appropriate setting which will best address their individual clinical and support needs and reflect their personal choices.

The dual eligible demonstration pilots have provided new perspectives on services and expenditures for this population. States having dual eligible demonstrations now look at all health care expenditures for this population, not just Medicaid costs which affect the state's bottom line. While we know exactly what it costs to care for someone in a nursing facility, estimates of the total cost of community-based care have historically been incomplete. Looking at Medicare claims data, we now see costs for hospital admissions, ER visits, physician services and for other primary health services provided to this population. Last summer, CMS released results of a study looking at cost of caring for dual eligibles. The study compared the cost of care in nursing facilities vs. community-based settings in seven states. The study finds little difference between the average costs of receiving long-term care in the community versus the cost of nursing home care. The study urges policymakers to delve deeper into the issue as they attempt to reduce costs for dually eligible beneficiaries. Our interest is in comprehensive and integrated patient care and in being prepared for managed care. We are also interested in a fair and balanced comparison of health care costs and benefits across service settings. The CMS study provides important new insights and I would be happy to provide the subcommittee with a copy of the CMS findings.

We are optimistic about the essential role of skilled nursing in long-term care. While occupancy rates and Medicaid days of care delivered are declining, overall utilization of nursing facilities is up. Post-acute care financed by Medicare is growing. Acuity of patients served is up and length of stay is down. Quality indicators for Michigan nursing facilities are up and the average number of deficiencies cited during standard surveys is down.

Long term care in Michigan will continue to reinvent itself as we prepare for the ultimate challenge -- the aging of the baby boomers -- the largest generation in American history. 10,000 Baby Boomers turn 65 each day and this will continue for almost two decades. This reality challenges us to reinvent long-term care. We look forward to working with this subcommittee, the department and with other stakeholders as we prepare for the tremendous spike in demand for all types of long-term care supports and services. Nursing and rehabilitation communities are a common thread and presence in every county and community in our state and the need for twenty-four hour, quality, skilled nursing care will remain an essential element in the care continuum. HCAM is proud to represent these dedicated providers. Thank you again for this opportunity to testify today and for your interest in Medicaid, Medicare and long term care programs.

Respectfully submitted,

David A. LaLumia, MSW
President/CEO

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Michigan Health &
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To: Representative Matt Lori, Chairman,
House Appropriations Subcommittee on Community Health
Members, House Appropriations Subcommittee on Community Health

From: David Finkbeiner, Senior Vice President

Date: March 3, 2014

Re: Fiscal Year 2015 Community Health Budget

The Michigan Health and Hospital Association (MHA) appreciates the opportunity to offer our comments and recommendations on the fiscal year (FY) 2015 community health budget.

Last year the MHA worked in favor of the Healthy Michigan Plan coverage expansion, as our board of trustees made coverage expansion its highest priority. We appreciate the difficulty of achieving this and also recognize that some lawmakers could not support this effort. Despite the contention over expansion, we appreciate the House's action to allow the Healthy Michigan Plan to go forward.

MHA Budget Recommendations

On behalf of its members, the MHA requests the following changes to the Governor's executive budget recommendation, which removed significant funding from our health care system.

Specifically, the MHA requests funding for ***Graduate Medical Education*** (GME) at the FY 2014 level of $162.3 million. The executive budget reduced GME funding by $4.3 million which would save the state only $1 million in general fund expenditures, while adversely affecting our physician training programs. Graduate medical education funding allows Michigan to be a leader in post-graduate physician education. Every year Michigan fills nearly all of its residency slots, even with the increase in our medical school graduates. More than 6000 physicians practice in Michigan while doing their on-the-job training. Michigan is in the top 10 states for number of teaching hospitals and ranks 6th in the number of medical residents and fellows on duty.

While some physicians relocate after residency or return to their own home state, 45% stay in Michigan after completing their residency training. In addition, the residency slots are refilled every year with new doctors, assuring a continuous supply of physicians, most of whom provide high-intensity care or practice in underserved areas.

The MHA also requests restoration of the ***small and rural hospital access pool.*** This funding, approximately $36 million in FY 14, is not included in the executive recommendation. Smaller and rural hospitals provide vital access to services throughout the state. Fixed costs and shortfalls in reimbursement from numerous sources create economic hardship for small and rural hospitals, which are especially sensitive to changes in state funding, as access to capital and other financial resources are severely limited. For an investment of just over $12 million in general fund, more than 60 Michigan hospitals are assisted through the small and rural hospital access pool. Nearly half of Michigan hospitals benefit in a significant way, for less than $40 million in state and federal funding.

Members of the MHA Small and Rural Hospital Council believe the Small and Rural Hospital Access Pool has made a significant difference in protecting access to care throughout the state. However, it has not had the necessary impact on protecting our ability to keep ***labor and delivery services*** in rural and less densely populated areas of the state. This map (figure 1) shows the number of counties in Michigan without a hospital that offers labor and delivery services. Northern Lower Michigan and the Upper Peninsula already have long travel times to labor and delivery-equipped hospital facilities. The shortfall in Medicaid reimbursement for births creates more stress for hospitals that still offer these services, threatening their overall financial viability. Medicaid-reimbursed births now make up more than 50% of all births in Michigan and the numbers are much higher in rural areas of the state. Hospitals with a mission to serve new mothers and babies must still fulfill their fiduciary responsibility to their operations and the community. Losses in the range of $500,000 to $1 million on births threaten the availability of all services, as hospitals are forced to choose between subsidizing birthing services and keeping the entire facility operating.

Figure 1
Counties without labor and delivery services.
Source: MHA, 2014

Healthy Michigan Plan

The MHA is working in full coordination with the Snyder Administration and the Department of Community Health on the effort to enroll more than 300,000 people in the Healthy Michigan Plan this year. The MHA membership believes that coverage expansion will help achieve better health outcomes for people who are currently underserved and will support overall health status improvement for our state over the long run, while reducing uncompensated care for health care providers. Our current rates of chronic illness, infant mortality and lost work productivity due to

poor health are not sustainable and our state cannot regain full economic recovery as long as the overall health of our residents declines.

Coverage expansion alone is not sufficient to address the problems listed above. The Healthy Michigan Plan is one part of a comprehensive effort to change the trajectory of Michigan's health status and to assist the healthcare provider community as overall reimbursement for patient care declines. The MHA membership continues to work to improve quality and safety, which improves patient outcomes and saves money. In one year (2011-2012) Michigan hospitals saved $116 million using voluntary efforts to reduce patient readmissions, avoid infections and implement best practices in care in a number of practice areas. Improving care, improving coverage and reducing unnecessary care are all necessary to address the problems of chronic illness and inadequate reimbursement.

The MHA has been disappointed to hear commentary that the Healthy Michigan Plan is somehow a "windfall" in reimbursement for hospitals. It is true that we have the opportunity to receive reimbursement for patient care that is currently unreimbursed. It is not true that the rates for those new patients, or for existing patients, will increase, as Medicaid rates are almost always below the cost of providing care. A shortfall remains even when a patient is part of the coverage expansion and payment is made for needed medical services.

Since 1996, Michigan has used a system of private managed care organizations and companies to provide coverage for Medicaid enrollees. The same is true for the Healthy Michigan Plan. The appropriation for FY 14 related to expansion will almost entirely be paid as premiums to Michigan health plans. Funds related to expansion will only be paid to providers as patients seek care. The emphasis will be on getting patients to seek care in appropriate settings. If patients present themselves for care at hospitals, or require hospital-based care, those services will be reimbursed at Medicaid rates. Again, this represents payment for services rendered not higher payment rates for those services. No new lump sum payments for hospital services will be made out of the available federal funding.

Last year after the Healthy Michigan Plan passed, the Detroit Free Press asked hospitals how the new coverage would affect their levels of uncompensated care. Below are the estimates from four large health delivery systems in Michigan:

What hospitals will save

The Medicaid expansion will allow Michigan hospitals to get paid more often for serving low-income patients. Major Michigan hospitals and estimated annual savings:

- **Henry Ford Health System** reported **$230 million in uncompensated care for 2012 and estimates it could save about $30 million.**
- **St. John Providence Health System** reported **$264 million in uncompensated care in its last fiscal year and estimates it could save about $30 million.**
- **Spectrum Health Systems**, based in Grand Rapids, reported **$112 million in uncompensated care in its last fiscal year and estimates it could save about $12 million.**
- **CHE Trinity Health**, based in Livonia, said uncompensated care at its Michigan hospitals totaled **$302 million in its last fiscal year. The system estimates it could save about $25 million in Michigan.**

Source: DFP, 9/2/2013

Graduate Medical Education and Small and Rural Hospital Funding

Restoring the GME funding and the Small and Rural Hospital Access Pool in FY 15 is necessary to continue the level of care we are able to deliver in Michigan. While inpatient services are becoming less prevalent in many facilities, hospitals remain the backbone of our health care system. Many rural hospitals are the only resource for physical therapy, dialysis, outpatient surgeries, community health services, emergency services, laboratory testing and imaging services. Protecting and assuring the existence of small and rural hospitals in Michigan is a critical part of the health care system. New technologies are allowing more home care with monitoring from remote locations, such as rural hospitals. Connecting rural residents with chronic conditions to their local caregivers will assist patients who need regular treatment and monitoring without requiring long-distance travel to large medical facilities. Evidence shows much better compliance with routine screening and monitoring when care is local and familiar to the patient.

Protecting Obstetric, Labor and Delivery Services

The MHA is working with the Northern Michigan OB collaborative to identify the needs of pregnant women and newborns and finding ways to use the existing resources to serve those needs. This group is working together across 21 counties with physicians, county representatives, Department of Community Health representatives, expert assistance from Michigan State University, the Maternal and Child Health Association leadership and a number of individuals to ensure that pregnant women stay or become healthy and deliver healthy babies.

While this group and others around the state are finding considerable opportunity for improvement on a variety of services areas, these efforts will be relatively ineffective if the limited labor and delivery services shrink further because of inadequate reimbursement to the hospital facility. The MHA asks the House subcommittee to consider new financial resources specific to preserving the existing labor and delivery services for the next 3-5 years.

Summary

Michigan hospitals appreciate the efforts our legislature makes to assure the continued access to appropriate and timely health care services throughout the state. There is a common perception that state funding for Medicaid and other health care services has increased dramatically in the past several years. In fact, when the state's Medicaid matching rate increased during the 2008 recession, Michigan saved $1 billion in general fund expenditures in a single year. At the same time, provider rates were cut 8 percent and have never been restored.

The state general fund share of Medicaid support is holding steady, as it has for several years. In 2014 the general fund investment in Medicaid is lower than the investment in 2008. Provider

taxes, federal match and rate reductions were used instead of general funds to adjust for the huge growth in caseload between 2002 and 2012. There is great competition for the state's limited resources, but the MHA firmly believes that our healthcare investment is at a critical point. Michigan healthcare providers continue to put patient care first, despite ongoing funding challenges. However, without necessary resources, hospitals will not be able to continue to remain a stable element of the healthcare delivery system.

As you consider our state budget, please consider the healthcare needs of Michigan's residents. Every year hospitals:

- care for 4.8 million people in emergency departments,
- admit 1 million people for an inpatient stay,
- help deliver 106,000 babies, and
- treat 32 million patients in the outpatient setting.

We welcome the opportunity to work together to improve our system of care while we serve the people of Michigan.

MHA | 2014 FACT SHEET

MICHIGAN HOSPITALS:

PREPARED TO CARE

The Michigan Health & Hospital Association (MHA) represents nearly 170 hospitals, health systems and other healthcare providers that are committed to protecting and improving healthcare access and quality while promoting initiatives that ensure the health and well-being of Michigan residents.

Every year in Michigan hospitals, lives are touched.

Fiscal Year 2012

- **4.8 million** people treated in emergency departments
- **32 million** outpatient visits
- **1 million** patients admitted
- **106,000** babies delivered

Michigan hospitals serve their communities

24 hours a day / **7** days a week / **365** days a year

Healthcare is Michigan's leading source of private sector jobs.

570,000 direct healthcare jobs = **$34 billion a year** wages, salaries and benefits

225,000 hospital jobs

Michigan hospitals are focused on ensuring

high-quality, affordable patient care.

MHA Keystone Center

Leading the nation in patient safety and quality initiatives

The MHA Keystone Center works with hospitals, clinicians and insurers to identify best practices that reduce infections and medical errors while improving the care patients receive. These efforts have saved thousands of lives over the last decade and recently more than $116 million in one year alone.

Publicly posted pricing and quality data

Educating and empowering consumers to make more informed healthcare decisions

www.mhakeystonecenter.org

The MHA supports a strong Certificate of Need program to protect healthcare access for all Michigan residents.

Michigan hospitals use their resources wisely

Lower costs in Michigan hospitals have translated into annual savings to employers of at least $500 million.

Michigan hospitals are highly efficient, resulting in costs 6.5% below the national average.

Despite these efficiencies, the average operating margin in Michigan hospitals was just 3.4% in 2012, compared to the national average of 6.5%.

MHA | 2014 FACT SHEET

Michigan hospitals provided nearly $2.8 billion

in community benefits to support special activities to help meet the health and well-being of people throughout the state.

$141 million

Health screenings, free clinics, immunizations, free or discounted prescriptions

Fiscal Year 2012

1.2 million Michiganians without health insurance

1.9 million Michigan Medicaid enrollees

1.7 million Michiganians receiving Medicare

Nearly $1 billion

Uncompensated care

Financial assistance at cost (charity care)
$394 million

Bad debt at cost
$578 million

Michigan hospitals are dedicated to providing exceptional patient care to anyone who walks through their doors, regardless of their ability to pay, but the cost of uncompensated patient care is staggering. In FY 2012, hospitals operated on a -1.3% patient margin, which means hospitals lose money caring for patients.

$645 million

Professional education, clinical research, active community involvement

Medicaid and Medicare collectively provide healthcare coverage for 3.6 million families, senior citizens and disabled residents throughout the state. It is critical that these programs receive adequate resources so healthcare providers can meet the needs of the patients they serve.

How does the Healthy Michigan Plan work?

Legislature appropriates federal funding

which funds Healthy Michigan Plan...

which provides a health plan for new enrollees...

which pays for services if doctor delivers care...

or services if hospital delivers care

The Healthy Michigan Plan is a new healthcare program through the Michigan Department of Community Health. If the Healthy Michigan Plan is adequately funded in the 2015 budget, it eventually will extend coverage to more than 450,000 uninsured, working adults. While it will help reduce uncompensated patient care costs facing hospitals, it will not eliminate the problem.

Michigan hospitals are preparing a new generation of healthcare providers.

NATIONWIDE LEADER MICHIGAN HOSPITALS

Michigan is a nationwide leader in preparing future physicians.

Graduate medical education (GME) programs at teaching hospitals throughout the state:

- Provide hospital patients with access to physician care
- Attract federal and private research funding
- Help maintain a steady supply of physicians who live and work permanently in Michigan

Number of teaching hospitals — **6th in the Nation***

Student enrollment in public medical schools — **3rd in the Nation***

GME program residents and fellows on duty — **6th in the Nation***

*Source: 2013 Medicaid Graduate Medical Education Payments: A 50-State Study and 2013 State Physician Workforce Data Book, Association of American Medical Colleges

MHA Michigan Health & Hospital Association
www.mha.org

For more information or to request additional copies of this infographic, call (517) 703-8601.

Testimony to the Michigan House DCH Subcommittee of the Appropriations Committee
March 3, 2014

Good afternoon Chairman Lori and members of the subcommittee,

My name is John MacLeod and I am the chief executive officer at Mercy Hospital Cadillac. Thank you for the opportunity to speak with you today about obstetrical access in northern lower Michigan and the effects of low Medicaid reimbursement on women's ability to seek appropriate, timely care in our region.

Residents in the northern 21 counties of our lower peninsula are blessed to live in a beautiful region that attracts many small business and tourism activities to our state. At the same time, our residents live in an area that faces tremendous challenges when it comes to assuring timely access for obstetrical care. In our region of greater than 11,000 square miles, there exist many great services for the women of childbearing age – but at great distances in many cases. Oftentimes, women must travel as far as an hour or more to a delivery hospital to have their baby. Prenatal care requires less travel in most normal circumstances, but may result in travel times of two to three hours for those with high risk pregnancies. Whether or not the pregnant mother is high risk, difficulty with transportation is a problem.

In addition to the health risks this creates, the economic health of these counties is placed in jeopardy as businesses are leary to grow, or establish themselves, in a community that lacks access to strong maternal, prenatal and infant care for families.

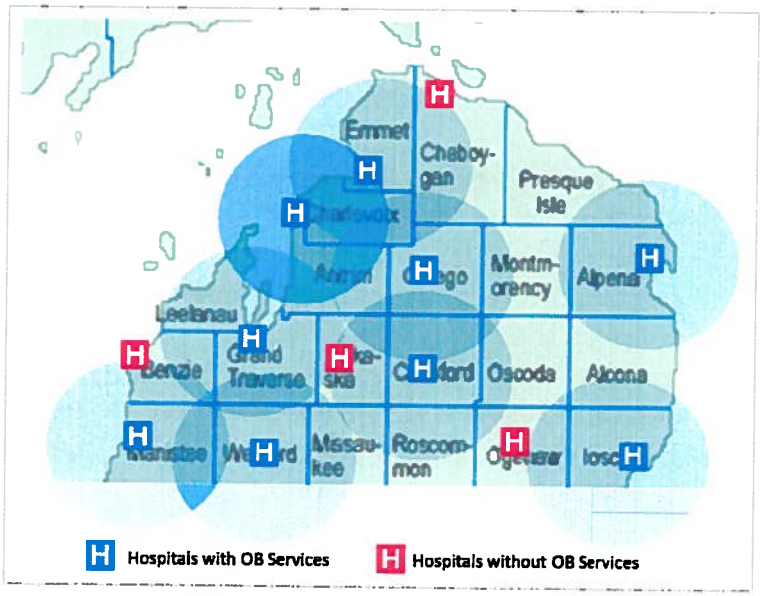

Figure 1: Travel Distances to OB Services
(Blue circles represent 30 minutes to an OB hospital.)

Medicaid is an important payer in the north as it is in the rest of the state. In fact, more than half the births across Michigan are covered by Medicaid. Many of the individuals covered by Medicaid are working yet do not have employer-sponsored insurance. This is expected to increase with Medicaid expansion, and while Healthy Michigan will eventually result in improved health, this will take time.

We are proud of the efforts of a northern Michigan Coalition for Perinatal Care that has developed in the past four years. Hospitals in northern lower Michigan, local health departments (LHD's), the Michigan Department of Community Health Perinatal Section,

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March of Dimes, Michigan Council on Maternal Child Health, Michigan Primary Care Association, Michigan Association of Health Plans, and Michigan Health & Hospital Association are working together **to assure a sustainable, integrated and coordinated network of perinatal care across the 21 counties.**

Despite this ongoing effort, the reality is that of the 13 hospitals in the region, four of them do not deliver babies; two of these have closed in the past four years. While as a hospital administrator I can understand the reasoning for these closures, the result is that the closures only exacerbate the problem for those of us still providing obstetrics care.

We have a foundation of extremely committed and competent providers who are limited in their capabilities to address these problems because obstetric reimbursement is well below cost. At Mercy Hospital Cadillac, Medicaid paid $683,000 less than the cost of care last year for OB services alone. These losses are not sustainable for hospitals of our size.

The economic impact expands well beyond our hospitals. When an OB unit closes, all women - not just those on Medicaid – lose access to care. The result is that young families relocate or refuse to move to into these communities. This paralyzes existing businesses and stymies new growth. Some businesses have even suggested it has an impact on tourism. This is why our chambers of commerce are also bringing this concern to your attention.

I implore you to address this crisis in the budget before you. Additional reimbursement for rural hospitals providing OB services in these 21 northern counties is critical – and we need more than a one-year patch. I need to know, for the good of our patients, that the state is committed to meeting the needs of pregnant women in northern Michigan. In addition, continued funding of the small and rural pool is critical.

Without action, more hospitals will be forced to close their obstetric programs, women in these 21 northern counties will have to travel even further for prenatal care and delivery, and most regrettably, more babies will die before their first year of birth. This can, and should, be avoided.

Thank you.

Key Facts

- 21 contiguous rural counties, land mass 11,000 square miles, approximately 5,000 births per year
- 15 counties with perinatal services; nine counties with OB delivery hospitals; one NICU and a number of maternal fetal medicine clinics
- Infant mortality higher than state in all but two counties
- Many women must travel out of home county for physician services; specialty services limited to a few locations

Good Morning Ladies and Gentlemen,

My name is Elizabeth Janovits. I am a contract employee for Freedom Road Transportation in Oakland County, a Board Member for Training and Treatment Innovations a public mental health service provider besides I receive mental health services from Training and Treatment Innovations in Oxford, MI. I would like to talk to you today about the deep cuts in the General Fund Dollars and why I believe it will hurt Michigan in the coming years.

Most people in Michigan have a vehicle to drive for errands, appointments, work, school, shopping, religious activities, seeing family and friends. There is a portion of our population that for one reason or another, be it being elderly or disabled are not allowed to drive. There are no transportation systems for these folks in this state, that goes beyond a city or two (like North Oakland Transportation Authority – NOTA, Older Persons Commission – OPC, Freedom Road Transportation – FRT.) NOTA and OPC charge their riders a small fee per ride to take them where they want to go and you have to make an appointment 72 hours in advance of going. If anything arises after that 72 hour window, they must find a ride or walk. FRT is different in that they use friends, family, and neighbors for drivers so if an emergency comes up (hopefully) they are covered and FRT provides the mileage money, within limits, to pay their drivers every month. All 3 systems, up to now, were relying on General Fund moneys to help pay expenses and defray costs to riders. Because of the proposed deep cuts in the General Fund, two of the transportation systems are starting to cut services to people without transportation. These are the citizens who are already on fixed incomes and many are already isolating from society. The proposed cuts are making it harder to get to doctor appointments, work, and other errands of everyday life.

How do I know about this? I am a person with a disability who does not drive and must rely on NOTA and friends to get around for my transportation. I am seen crossing busy M-24 (Lapeer Road) in Lake Orion during Spring, Summer, and Fall so that I can get my errands done.

If we lose these systems, people who are drivers and dispatchers will lose their jobs, meaning lost income coming into the community to buy goods and services, and lost taxes for the state. Also the riders will not have rides to work and other errands which will create lost income for goods and services and lost taxes for the state.

What we are asking for is a way for the riders to have transportation in these changing times. Right now, it is very much in jeopardy and we don't want too many riders crossing busy streets like I do. Please restore the General Fund until we can work out a transportation system for everyone.

If you have any questions please contact me: janovitselizabeth@yahoo.com or (248)881-4594. Thank you for this opportunity to testify.

Sincerely,

Elizabeth A. Janovits

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TESTIMONY FOR MICHIGAN HOUSE OF REPRESENTATIVES ON FY 2014-15 MICHIGAN DEPARTMENT OF COMMUNITY HEALTH APPROPRIATIONS FOR BEHAVIORAL HEALTH AND MEDICAL SERVICES

March 3, 2014

Submitted by Karen Schrock, President & CEO, Adult Well-Being Services

Adult Well-Being Services is celebrating its 61st year of providing comprehensive mental health, substance abuse, preventive health and care transitions services to adults. We recently began serving children with autism. We reach more than 18,000 people annually in 21 Michigan counties. As a nonprofit organization, we are faced with daily challenges of helping persons with co-occurring mental health and substance abuse disorders, and other health issues with shrinking resources. The personal challenges for the people we serve, however, are much greater.

Currently, persons with mental illness who do not qualify for Medicaid are only eligible to receive crisis-type services and four hours of case management each year. The General Fund budget does not currently cover critical services such as evidence-based Assertive Community Treatment which has been proven to divert people with serious mental illness from jails and emergency rooms. The General Fund budget also does not provide skill-building or intensive case management to link and coordinate services needed to stabilize them. The new Affordable Care Act health insurances will not fill the service gaps for people with mental illness who do not qualify for Medicaid.

An often invisible population is older adults with mental illness and/or substance abuse problems. The U.S. Surgeon General reports that nearly 20% of the population 55 and older experience specific mental disorders that are not part of "normal" aging. Older adults' ability to face their unique conditions, function well and maintain their well-being depends upon the availability and accessibility of appropriate services and support. The good news is that we know they *can* recover from mental illness and substance abuse to live independently and age successfully.

With the proposed cuts in General Fund for behavioral health services, these problems will only be exacerbated. It is important to remember that consumers do not disappear when funding is cut. Withdrawing essential mental health support for some of the most vulnerable people will result in tragic and costly outcomes including homelessness, incarceration and inappropriate use of emergency rooms. As the Governor's Mental Health and Wellness Commission reported, more resources are needed for jail diversion such as mental health programs and to address gaps in mental health service delivery. We agree. Adult Well-Being Services, along with many other human services organizations, has been successful in delivering innovative, evidence-based programs to provide critically needed services at less cost to the health care system.

We urge you to preserve General Fund dollars for critical mental health and substance abuse safety net programs. Thank you.

Maternal & Child

Written comments for House DCH Appropriations Subcommittee hearing on 3/3/14

Amy Zaagman
azaagman@mcmch.org

Dear Chairman Lori and members of the subcommittee:

Good morning, my name is Amy Zaagman and I am the executive director of the Michigan Council for Maternal and Child Health. The Council's membership includes large hospital systems, statewide organizations and local entities with a mission to advocate for policies that support the health of women and children. MCMCH strives to show how proven prevention strategies, when properly resourced and implemented, can result in better outcomes for families and for state government.

We believe the majority of the MDCH budget proposal shows the state's commitment to healthy moms, babies and kids. We support the Governor's call for expansion of Healthy Kids Dental and for funding to implement the recommendations of the Mental Health Commission. In the interest of time, I will not comment on all of the issues we track, such as funding for lead poisoning prevention and abatement or Children's Special Health Care Services, as many are not slated for major changes but are, of course, vital programs.

We continue to be buoyed by the attention to infant mortality and to strategies that can help ensure healthy pregnancies, good birth outcomes and thriving infants. The Governor calls for, and we strongly support, an additional $2.5 million in next year's budget to support home visiting family support and coaching programs. In the last few years the state has secured a good share of federal dollars for these programs, allowing expanded availability in our 10 highest-risk communities. The additional state dollars proposed would similarly invest in northern lower Michigan and the U.P. where, as you have heard today, there are unique challenges to ensuring good outcomes.

At the other end of the childhood spectrum, the Governor has called for a $2 million pilot program to expand the reach of several school-based health centers. This would allow them to establish satellite locations within a school district with the specific intent of providing much needed mental health and nursing services. This is a great opportunity. We believe there is a common misperception that our schools today are staffed with mental health professionals and nurses to meet the needs of students when, in fact, we have some of the lowest ratios in the nation—for school nurses we rank dead last among the states.

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MCMCH strongly believes in proven prevention strategies for maternal and child health. Over the past decade, the state's commitment to public health prevention strategies has waned significantly. This year, there is a flat budget proposed for the combination of lines that make up the Health and Wellness Initiatives—several of which are of great concern to us: pregnancy prevention, the Michigan Care Improvement Registry and the Michigan Model for Health.

No details have been forthcoming about any proposed modifications to the lines within this area. As we all know, the focus has been put on metrics and outcomes and we agree - we have and will continue to press for a set of common rigorous standards to be applied to this funding. Evidence-based programs with demonstrated positive outcomes and return on investment for taxpayers as well as statewide reach versus local projects are just some of the criteria we believe should be applied if this funding continues to be constrained.

We look forward to working with committee members on the array of budget items that directly impact the health and development of moms, babies, children and adolescents in Michigan.

Sincerely,

Amy U. Zaagman

Amy U. Zaagman
Executive Director

Testimony of David Gruber, Dispute Resolution Education Resources, Inc.
House Appropriations Subcommittee on Community Health, March 3, 2014

Thank you Representative Lori and Members of the Subcommittee.

I am David Gruber, executive director of Dispute Resolution Education Resources, Inc., (DRER), a Lansing nonprofit organization. DRER supports the Michigan Mental Health and Wellness Commission's recent recommendation that the mediation process be required as the "first step for complaints or concerns relating to publicly funded behavioral healthcare."

Mediation is a means of addressing the needs of all parties to a dispute through informal negotiation with a neutral third party aiding communication between them. According to research, mediation supports the goals of self-determination and recovery among mental health consumers. Many, though not necessarily all types of complaints in the mental health system are amenable to mediation. These may involve living or work arrangements, financial matters or the suitability of services. Where mutual agreement cannot be reached on such issues, other processes remains available.

Success rates for mediation generally are quite high. Michigan's Community Dispute Resolution Program, which was created by the Legislature in 1988, posted an agreement rate of nearly 70% across a wide range of cases from 2004 to 2012. The Michigan Special Education Mediation Program, which DRER administers for the Department of Education, posted an agreement rate averaging nearly 80% over the same period. Mediation is not designed or expected to resolve all issues. But it has demonstrated, year in and year out it, that it resolves most of them.

One key to this success is proper training for mediators. Michigan's mediators receive basic training certified by the State Court Administrative Office. Many go on to acquire training in specialized subjects such as guardianship, special education and domestic relations. Since the 1990s, materials for training mediators in mental health have become available, including some developed by DRER, that address mental health law and concepts, the Michigan mental health system, and common issues in dispute.

Mediation's use in many arenas has been found to save time and cost. Agreements often are reached in one session. A session often lasts a few hours or less, even in complex cases. New cases can be opened and closed within days or weeks, while hearings and investigations may take months, and litigation years.

Numerous studies have confirmed that mediation can be less expensive than other forms of dispute resolution. A 2001 study by the Oregon Department of Justice, for example, found that mediation was the least expensive of the seven methods examined. In 2010, North Carolina reported saving $25 million by using mediation in Medicaid termination appeals.

Public Sector Consultants (PSC) in Lansing recently completed a study for DRER on mediation in Michigan state government agencies. It found that dispute resolution costs varied among agencies and could not be compared. Instead, it diagrammed the formal dispute resolution processes of three agencies step by step, with each step representing a unit of cost. The study showed that mediation used early and successfully would avoid the later steps in each process, including the associated costs.

Under Michigan's mental health code, mediation is available only after an investigation. (MCL Sec. 330.1788.) According the PSC study, mediation ideally would be used "prior to an agency investigation." Amending the mental health code's current mediation provision would be one way of accommodating the Commission's recommendation to use mediation as a first step in dispute resolution. It should be noted that when truly used as a first step – even before a complaint is filed – mediation can avoid a formal process entirely.

DRER believes the mental health community would be well served by using the Community Dispute Resolution Program as a mediation provider. The CDRP is a proven low-cost service as the Legislature intended. It has an established, independent, statewide network; trained and experienced mediators that help resolve both simple and complex cases; and a wealth of experience in resolving disputes locally.

Should budgetary action be taken now or in the future to implement the Commission's mediation recommendation, DRER would be happy to help develop a program that meets the Commission's and the Legislature's goals.

Thank you.

PSC

PUBLIC SECTOR CONSULTANTS

Putting thought into action

November 2012

Funding for this report was generously provided by the JAMS Foundation, the Michigan State Bar Foundation, and the Dispute Resolution Education Resources Inc.

Mediation and Other Alternative Dispute Resolution Techniques in Michigan State Agencies

BACKGROUND

Over the past 25–30 years, alternative dispute resolution (ADR) at the community, administrative, and court levels has become increasingly popular with both consumers and practitioners. Originally conceived as a way to reduce burdensome caseloads and backlogs within the court system, the process has evolved far beyond the traditional mediation and arbitration that has historically defined it. ADR now includes a variety of techniques and facilitated outcomes such as collaborative decision making, partnering, aligning, and restorative practice—in other words, ADR can now be broadly defined as any process used to bring people together to solve problems.

Dispute Resolution Education Resources Inc. (DRER), a non-profit organization in Lansing, approached Public Sector Consultants to begin a series of discussions about how the State of Michigan approaches problem solving. Experience with the Community Dispute Resolution Program (CDRP) funded through the State Court Administrative Office, as well as programs in the Department of Education and Agriculture, prompted DRER to ask the question, "Just how widely is mediation used in state agencies?" Specifically, DRER wanted to know:

- **How prevalent is the use of mediation in state agencies?**
- **How does the use of mediation differ from the formal hearings process?**
- **Is there a cost-benefit to mediation over formalized hearings?**
- **What are the best practices in other states/areas of business for implementing mediation on a broader scale?**

These questions are particularly timely because of the emphasis the Snyder administration places on "reinventing" government and improving outcomes—particularly those that streamline the state's regulatory compliance process.

METHODOLOGY

Literature Review

We began our research by conducting a literature review of nationwide research on mediation practices in government at both the state and federal levels. We reviewed several states that had piloted or implemented mediation practices in their administrative case management systems by reading materials such as brochures, program summaries, and project evaluations. We also

looked at several federal reports that documented mediation examples in practice in the U.S. Departments of Justice and Defense.

Interviews

After completing our literature review, we embarked on stakeholder interviews with the DRER board and several "key informants" in Michigan state government. Our goal was to gain a sense of how dispute resolution is practiced in state agencies, ascertain to what extent mediation is being used, and understand what opportunities or barriers have presented themselves to administrators and mediators when incorporating dispute resolution processes into the complaint process.

Inside state agencies, our interviews ranged from conversations with department directors or bureau and section heads to discussions with policy analysts, program officers, case specialists, and database administrators. We also spoke to several individuals outside of state government who work with dispute resolution within a program of a state agency or as a private contractor/grantee to a state agency. These included conversations with several consultants, CDRP staff, private mediators, and the DRER board.

Modeling and Cost Benefit Analysis

Having uncovered several examples of how mediation works in state government, we began to document how cases flow from the point of intake at an agency to their final adjudication. For this process, we selected the Michigan Department of Education's Special Education State Complaint Process, the Michigan Department of Licensing and Regulatory Affairs, Bureau of Commercial Services Complaint Process, and the Michigan Department of Human Services Eligibility Determination Complaints Process. These agencies and their processes were selected based on the following factors:

- There is a well-documented complaint process within the agency
- The agency had existing data to support case resolution/adjudication
- The agency used a form of dispute resolution prior to advancing cases to an administrative hearing
- The agency could explain the differentiating factors between cases that closed during the case resolution process and those that resulted in a hearing

Once the agencies were identified, we conducted several interviews with key agency personnel on the dispute resolution process. In the course of these discussions, our goal was to determine:

- Whether the use of mediation (in particular third-party mediation) resulted in a cost savings to the agency
- Where mediation appeared to be most successful
- How the lessons from existing agencies could be replicated in areas that might not currently use a dispute resolution technique

OUR RESEARCH

Literature Review

With budgets tight, adverse awards costly, and the potential for proximate, peripheral, and long-term costs of disputes to be high, many states have adopted a culture of collaboration and institutionalized ADR methods within their governmental structure. Our literature review examined a number of state programs to look at both structural implementation and cost savings.

EXHIBIT 1. State Mediation Literature Review

State	Study	Year	Description	Conclusion
Cost Savings Studies				
National Overview	Alternative Dispute Resolution Compendium: Demonstrating Cost Effective and Efficient Resolution of Conflicts	2011	The study reviews various ADR methods in the resolution of public sector disputes.	The study concludes that dispute resolution processes such as mediation, facilitation, and consensus building bring people together to resolve conflicts and reduce costs when used in lieu of litigation. Highlights include: • $18 million in costs savings for the U.S. Department of Justice in litigation/discovery expenses • $20,000 per case savings on Equal Opportunity Cases filed with the Department of Defense • $56.7 million in liability savings over a four-year period in the Department of Defense
Arizona	*Partnering Programs Save ADOT Millions*, PCI Newsletter	2002	The Policy Consensus Initiative (PCI) looked at the implementation of partnering—or collaborative teamwork measures—between the Arizona Department of Transportation and the state's 750 construction contractors.	The report cites tangible cost savings amounting to $35 million over the course of ten years and 1,100 projects, significantly reduced construction time (projects finishing 8–10 percent ahead of schedule), and a reduction in the number of cases that head to trial.
Florida	State Agency Administrative Dispute Resolution Pilot Project Report, Florida Conflict Resolution Consortium	2000	The project's premise was to "demonstrate through pilot case examples and through training how mediation and facilitation may be integrated into the management and budgeting of administrative litigation."	The study cites more than $3 million in potential savings realized through the successful mediation of 31 of 36 administrative disputes selected from five state agencies and one environmental control district during 1998–99. Savings over anticipated litigation costs reported by participants ranged from $2,250 to $700,000.
Massachusetts	Report on the Use of Alternative Dispute Resolution (ADR) in Massachusetts' Executive Branch Agencies: Data & Analysis of the FY02 ADR Reports & Plans	2002	The report represents the state's first attempt to collect data about the use of ADR across Massachusetts state government.	According to the report, 57 percent of agencies that filed ADR Reports & Plans as required by executive order reported that ADR saved money over litigation or hearings. Eighty-one percent reported savings in staff time.

State	Study	Year	Description	Conclusion
North Carolina	Report to the North Carolina General Assembly by the Office of Administrative Hearings and Department of Health and Human Services	2010	Statutory changes to North Carolina's Medicaid recipient laws in 2009 helped to streamline the due process and hearings reinstatement process in the state's Department of Health and Human Services In implementing the legislative changes, NC made significant investments in document management systems and training to encourage alternative dispute resolution. This presentation to the state assembly looks at outcomes in the first 18 months of the new system.	The North Carolina Department of Health and Human Services reports $25 million in savings in the first 18 months of implementation.
Oregon	Oregon Department of Justice Review of pilot Collaborative Dispute Resolution (CDR) process in resolving civil cases involving the State of Oregon	2001	This study reviews the 1997 implementation of Oregon's Collaborative Dispute Resolution program, which was enacted to encourage mediation and other alternative dispute resolution methods in the disposition of civil cases involving the state of Oregon.	The study concludes that in the 500 civil cases reviewed, mediation was the least expensive of the seven dispute resolution options examined.
Texas	Study of Issues and Costs to Districts Related to Special Education Complaints	2000	A large number of special education complaints in Texas focus on parental disagreements with student placement. This study looked at alternatives to case-by-case litigation.	The study concluded that resolution at the district level is almost always more cost effective than proceeding to hearing
Efficiency Studies				
National Overview	Governing Tools for the 21st Century, a Report on How State Leaders Are Using Collaborative Problem Solving and Dispute Resolution by the Policy Consensus Initiative	2002	This Policy Consensus Initiative brochure outlines the various ways in which alternative dispute resolution has been implemented in government processes.	The group concludes that collaborative dispute resolution (or alternatives to court litigation) is not meant to replace traditional governmental processes, but to supplement existing practices in order to improve efficiency, save money, and promote shared outcomes.
Michigan	The Effectiveness of Case Evaluation and Mediation in Michigan Courts	2011	This study evaluates the comparative effectiveness of non-domestic civil case resolution in Michigan's circuit courts.	Evidence suggests that mediation is generally more effective and preferred over case evaluation and that Michigan courts should be encouraged to make mediation more available, while still allowing for both forms of ADR.
Oregon	Oregon Department of Justice Review of State Agency Dispute Resolution Programs and Collaborative Problem Solving Activities	2009	This study describes the depth and breadth of alternative dispute resolution and collaborative policy making in Oregon state government.	Although not evaluative in nature, this study is a comprehensive look at the manner in which Oregon has adopted alternative dispute resolution and collaborative decision making in state government agencies and public policy making since 2000. The state is a leader in implementing collaborative decision-making in policy development and rulemaking and uses dispute resolution techniques widely in its administrative agencies.

Attributing cost savings solely to mediation is tricky. There are a number of factors that may influence what an agency reports as cost savings, including business processes that change in order to accommodate mediation, technology improvement to streamline mediation and more accurately capture case data, etc. Overall, these studies show promising trends in terms of behavioral change and long-term savings both in real dollars and non-economic social impacts.

Interviews

PSC has conducted a number of key informant interviews with state agency personnel and others familiar with the use of mediation in state agencies. It is important to keep in mind that our interviews were subjective in nature and not scientific. Although we used a script to guide the discussions, the object of this activity was to develop case-study data about departmental attitudes and individual thoughts and perceptions about dispute resolution.

State Agency Interviews

All of the state agency personnel interviewed were able to point to some type of ADR method that is used in their agency—although they were not always able to define it as or equate it with mediation. The most common forms of alternative dispute resolution discussed were:

- *Pre-hearings or compliance conferences*—a technique in which the agency encourages an administrative conference between the complainant and the agency prior to a formal hearing to determine whether an agreement can be reached. In some agencies, this is a requirement prior to a hearing—in others, the request for a pre-hearing or compliance conference is handled on a more informal basis.
- *Mediation*—the use of a third party to resolve conflict between two individuals. Our interviewees appeared to understand the use of this term in a very broad sense—equating it with all the terms associated with "alternative dispute resolution" as well as defining it in the more traditional sense.

To a lesser extent agency personnel also cited the following practices as techniques used to resolve conflict:

- *Collaborative decision making*—a method in which a third-party facilitator is used to craft a solution between opposing parties prior to implementing a new rule or regulation. This is most commonly referred to as "stakeholder input" or an "advisory group," generally chaired by a department employee responsible for the project.
- *Restorative practice*—a set of problem-solving techniques used to engage individuals in finding alternative responses to wrongdoing. This was the least common form of ADR discussed, but it does appear to be gaining some traction—particularly in education. Practitioners often described it as "restorative justice" (a type of restorative practice)—whose protocol relies on a set of prescribed questions to facilitate conversations between disputing parties. In our research, the practice was most frequently used with adolescents involved in fights or other school disturbances.

Overall, it appears that state agencies are open to considering alternative dispute resolution processes. However, what that process is, and how and when it should be implemented in an agency's practice, is not well understood. In general, agency personnel tended to equate mediation with a legal proceeding—not an administrative practice. Because of this, the specifics of how and when mediation should factor into the administrative complaint process (for example, prior to an investigation versus after an investigation but prior to an administrative hearing) was unclear to our interviewees.

There was also a lack of clarity among interviewees about third-party dispute resolution services through centers such as the Community Dispute Resolution Programs (CDRPs) and third-party, private mediators. During conversations about the use of or potential use of third-party resources, a few themes emerged:

- Uncertainty as to what types of cases are best suited for mediation, and uncertainty about how to determine which types of cases are best suited for mediation
- Confusion about whether mediation would replace existing compliance conference/case settlement practices
- A strong sense that agency-level subject matter expertise is required to help resolve disputes
- Concern about contracting out disputes involving licensing (which represents someone's livelihood), entitlements, or public safety/public trust to a third party, non-governmental entity
- Concern that mediation might be used to delay an administrative hearing rather than expedite complaint resolution
- Concern about the quality/qualifications of third-party mediators

The Office of Regulatory Reform and Michigan Administrative Hearings offered us a bit of history about the institutionalized use of mediation in the administrative hearings process. Under the administration of Gov. John Engler the (then) State Office of Administrative Hearings and Rules opened an Office of Mediation. The first cases were consumer complaints from the Bureau of Commercial Services. In 2003, the practice expanded to the Wage and Hour Division to increase the mediators' caseloads and reduce hearings in Wage and Hour. In 2007, the office was closed according to the department because it "never paid for itself." This is likely because in the majority of the cases a settlement could not be achieved and they were ultimately referred back to administrative hearings.

Interviews with Consultants and Other Third Parties

In addition to speaking with state agency personnel, we captured some good information from individuals working with state agencies on dispute resolution techniques, as well as attorneys who have mediated disputes involving a state agency.

In the course of these conversations it became clear that there are several efforts within state government to involve the use of third-party facilitators/moderators (a form of mediation commonly referred to as collaborative decision making, but not always thought of as mediation) in collaborative discussions involving agencies and stakeholders. One consultant pointed to work she had done with the Michigan Department of Transportation in helping to bring to consensus a group of property owners and the department on the routing of a new road. Similarly, another consultant pointed to work that was done involving a panel of federal regulators, state officials, and a business entity involved in a permitting dispute. By and large, agencies seem to understand and value having a "disinterested" third party help direct conversation, engage participants, and keep large group discussions on topic.

Also of interest to us was the use of third-party, private mediators whose services were rendered to resolve an issue between a state agency and an individual that was not subject to an administrative review. Through these interviews we tried to ascertain when a manager might be authorized to use an outside mediator and when those cases head directly for litigation. Examples of these case types might be contract disputes (which often contain a contractual clause requiring mediation) or tort cases in which the state attempts to settle prior to a lawsuit filing. Because we could find no central data repository for "cases referred to outside mediators," it is impossible to know how many cases fall into this category, or to generalize as to how or when outside mediators are selected.

Discussions with the DRER Board

Discussions with DRER board members helped us to understand some outside perceptions about the use of mediation in state agencies. We used information from these conversations as "leads" in our discussions with agency personnel to test the factual basis for the perceptions and try to determine why they existed. In speaking with board members several themes emerged:

- State agencies do not use, or rarely use, mediation
- State agencies will not use mediation unless it is mandated to do so
- State agencies have case-load backlogs that could be eliminated through mediation
- Privatizing dispute resolution will likely save money, although money is not really the issue with mediation—long-term behavioral change and the impact on social costs is a bigger driver
- Constituents deserve the opportunity to make their case to an objective third party
- State government does not want its problems known by a third-party entity

In general, the interviews with board members echoed the confusion of state agency personnel on how and when mediation is employed by state agencies—and what effectively constitutes ADR. Many of these presumptions are factually difficult to prove or disprove. Based on our case study data, therefore, it seems that in the absence of a uniform, statewide policy that prescribes the disposition of complaints, the prevalence and specific use of mediation techniques depend very much on the agency.

Modeling and Cost Benefit Analysis

In response to the question, "Does mediation save money over administrative hearings in Michigan state agencies?" we have concluded, again, that it depends on different factors. While we feel certain that the social costs of effective dispute resolution are substantial, they are intangible and therefore impossible to document within the scope of this

project. As far as the administrative process and the opportunity to avoid those monetary costs, mediation does provide some opportunity for cost avoidance. However, it depends on when it is inserted into the complaint resolution workflow.

This conclusion is based on an analysis of three state agency processes—one that actively uses mediation, another that used mediation in the past, and a third that uses an administrative compliance conference for case settlement prior to a formal hearing.

Michigan Department of Education, Office of Special Education (Adjudication of Due Process Complaints)

WHY WE LOOKED AT OSE
Existing Mediation Project with DRER, Due Process Complaints

CASE TYPES
Simple disputes involving two parties, one that is regulated by state

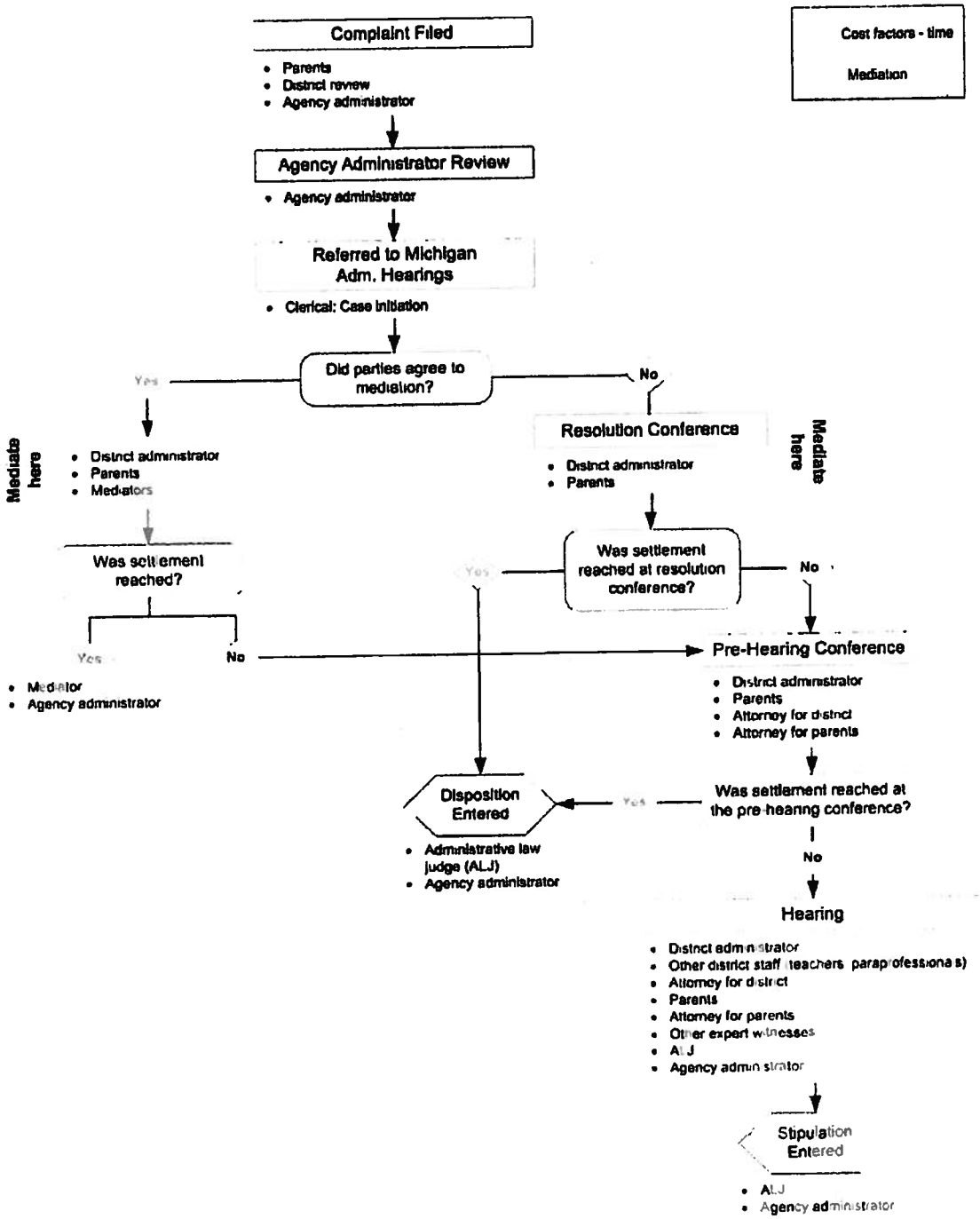
CASE VOLUME
Low

The Michigan Department of Education, Office of Special Education (OSE) currently uses mediation for complaints involving school districts and the execution of due process for children with disabilities. Offering the use of mediation is required for all due process complaints under the federal Individuals with Disabilities Education Act.

In researching whether or not mediation saves money over the administrative hearings process, our hope was to place a dollar value on an "average" due process complaint that was mediated versus a complaint that was resolved at the administrative hearings level. However, in discussions with agency staff it quickly became apparent that there is no "average" complaint, and that the number of allegations filed with each complaint makes a comparative analysis of complexity very difficult. We ran into time-keeping factors as well, which made it impossible to average the handling of a complaint at the state or local levels. In other words, the amount of time from filing to disposition of a case differs remarkably depending on such variables as case type, number of allegations, and type of staff assigned to handle complaints at the local level.

Instead of using numbers, we looked to the process involved in case disposition and the cost factors at each step of the process. When the process is mapped out on paper, the cost savings became very evident (see Exhibit 2).

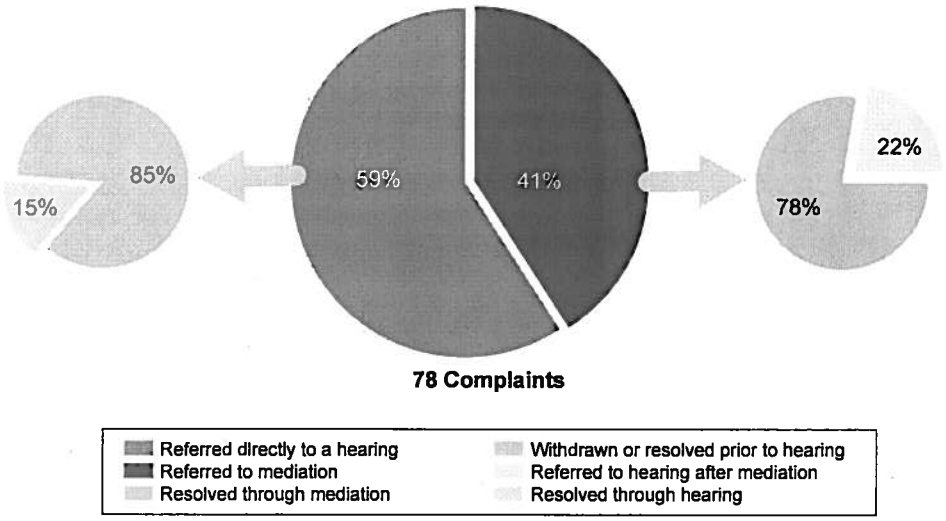
EXHIBIT 2. Michigan Department of Education, Office of Special Education
Due Process Complaint: *Mediation vs. Administrative Hearings*



SOURCE: Michigan Department of Education, Office of Special Education, "MDE OSE Complaints Database 20**."

Each step in the process shown in Exhibit 2 represents an administrative cost to the state agency as well as the parties involved in the dispute. Because mediation occurs prior to a hearing (in this case the hearing is the fact-finding or investigation stage of the complaint resolution process), anything that can be done to resolve the issue before the hearing is held ultimately saves money. The corollary to this, however, is that if mediation is unsuccessful, it adds costs to the process. Exhibit 3 shows the case resolution data for the Office of Special Education.

EXHIBIT 3. Case Resolution Data for Michigan Department of Education, Office of Special Education



SOURCE: Michigan Department of Education, Office of Special Education (MDE OSE) Complaints Database, 2011.

The theory that mediation is most successful in reducing costs if it is offered early in the process is supported by the model in use by the Michigan Department of Civil Rights (MDCR). MDCR is the initial point of contact for citizens who wish to file a discrimination complaint. Upon filing of a complaint, parties are given the option to try third-party mediation prior to formal fact-finding. This lessens the investigatory burden of the department, reducing costs and streamlining the case closure process.

Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Commercial Services (BCS)

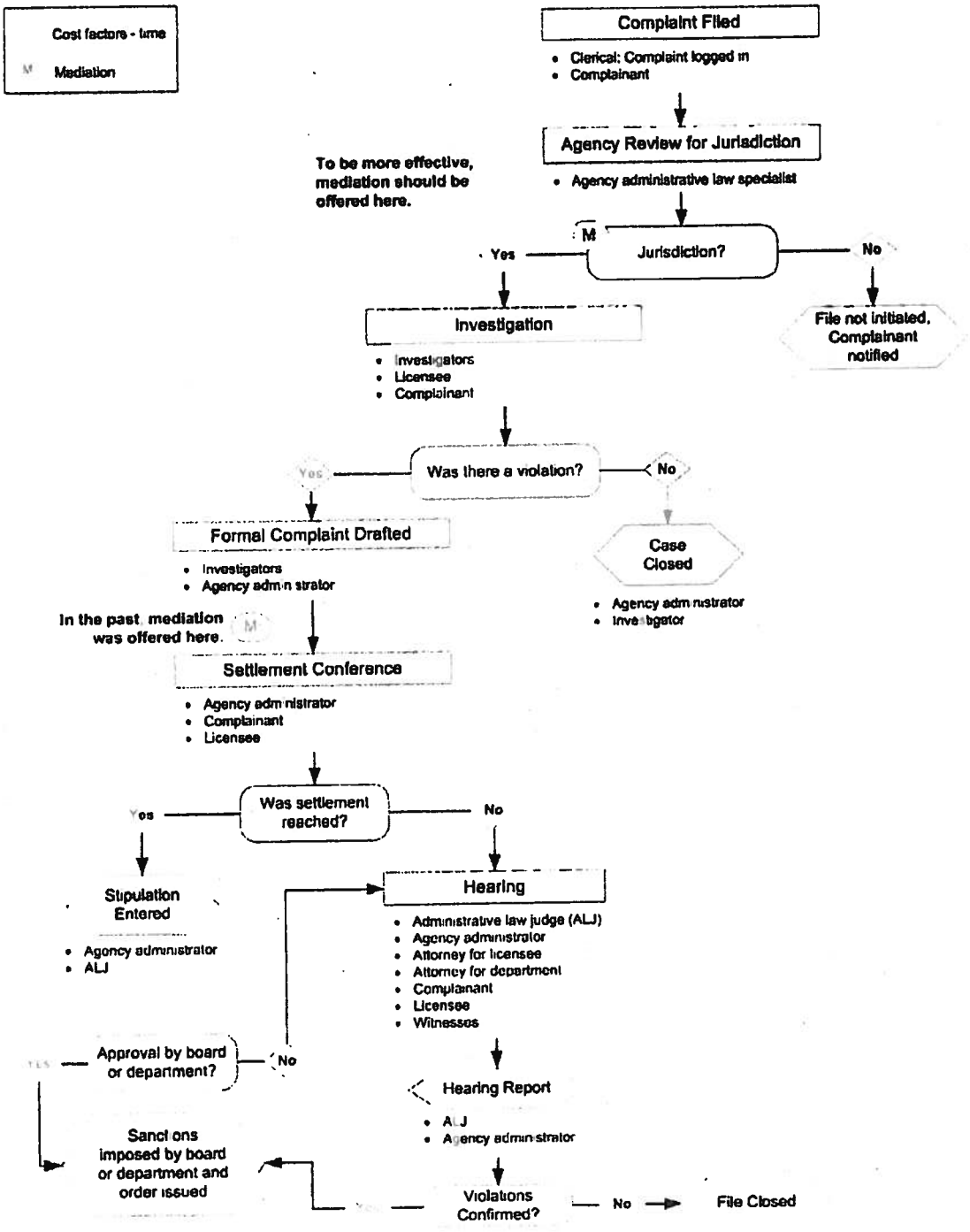
The experience of the BCS appears to substantiate an important finding from our analysis of the process in OSE. The BCS used mediation in the consumer complaint resolution process during the early 2000s, but found it difficult to reduce the number of cases heading to administrative hearing. This is likely because mediation occurred after the complaint investigation was complete. With the agency's recommendation already on the table there was no incentive for the parties to quickly resolve the complaint. This resulted in mediation being used as a strategy to delay an adverse outcome. And, because the majority of these cases were referred on to an administrative hearing, mediation ultimately cost the agency money. Had mediation occurred earlier in the process, this might not have been the case. We documented existing practices to see if this might be the case. Exhibit 4 shows the process currently used by BCS to resolve complaints, and indicates where mediation might have proven to be more useful.

WHY WE LOOKED AT BCS
Had mediation project in place, now discontinued

CASE TYPES
Complex disputes involving two parties, one that is regulated by the state

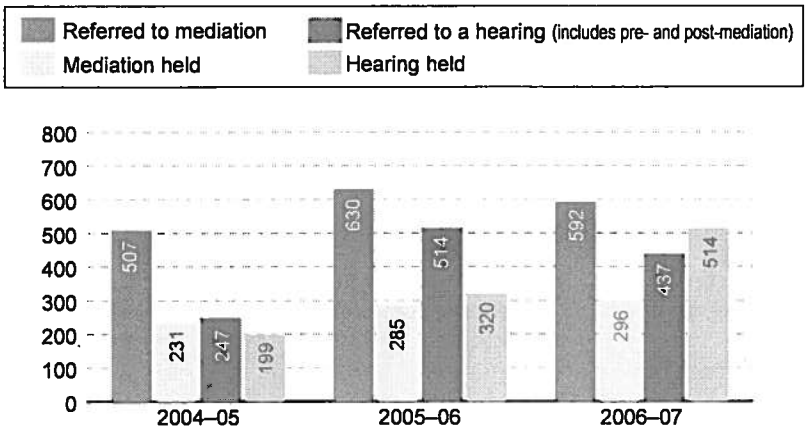
CASE VOLUME
Medium

EXHIBIT 4. Michigan Department of Licensing and Regulatory Affairs, Bureau of Commercial Services, Current Licensing Complaint Process



SOURCE: Michigan Department of Licensing and Regulatory Affairs, Bureau of Commercial Services Complaints Database, 2012.

EXHIBIT 5. Michigan Department of Licensing and Regulatory Affairs, Bureau of Commercial Services Caseload Data 2004–2006



SOURCE: Michigan Department of Licensing and Regulatory Affairs, Bureau of Commercial Services Complaints Database, 2012.

Exhibit 5 shows the caseload data for the BCS during the time that mediation was offered in the agency. As years went on the number of cases resolved through mediation declined and the number of hearings increased.

Michigan Department of Human Services (DHS), Public Assistance Eligibility Determinations

WHY WE LOOKED AT DHS
Perceived process failures in disputed eligibility cases

CASE TYPES
Disputes involving two parties, one of which is the state and the other a potential beneficiary

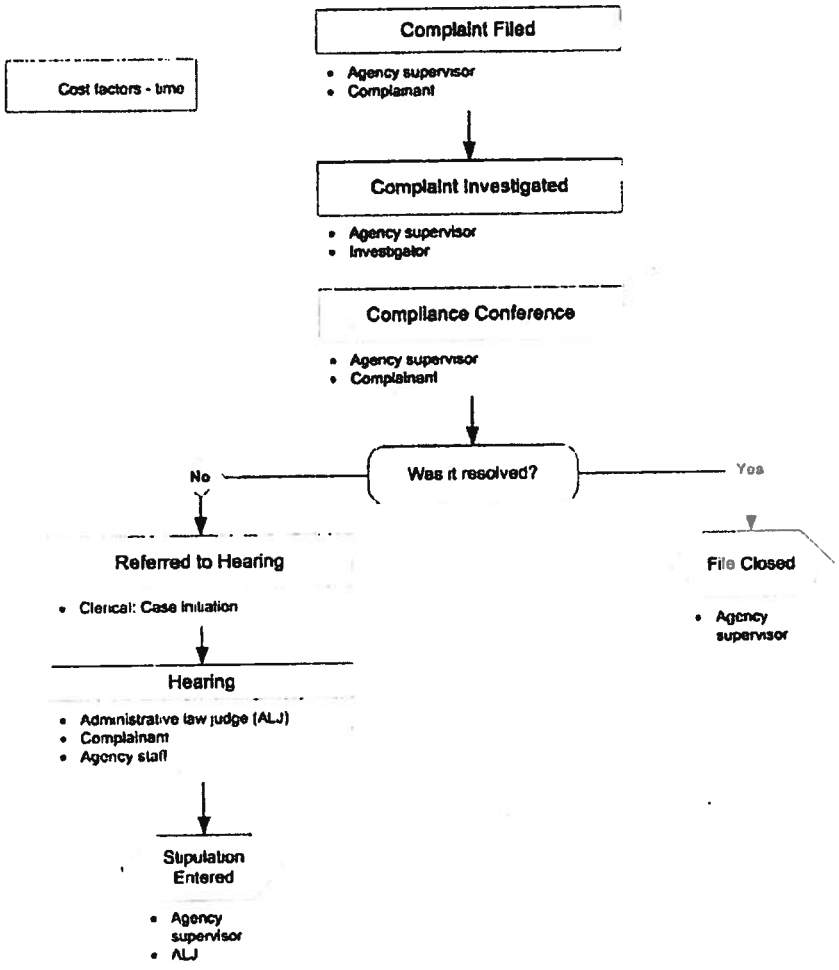
CASE VOLUME
High

Many of the individuals we interviewed considered DHS to be a good candidate for mediation. The belief that it would be beneficial for DHS to look for ways to reduce the number of administrative hearings was a common theme among most of the parties we interviewed.

The eligibility determinations process in the Department of Human Services represents a different case type than those we studied in the BCS and OSE. In DHS, the state is party to the dispute and is also responsible for "mediating" a complaint prior to an administrative hearing. In this case, "mediation" is referred to as a compliance conference by the state.

Another factor that makes the DHS complaint process different from the other agencies studied is that the eligibility determination—or basis of the dispute—is a calculation that, according to DHS, is prescribed and fairly straightforward and therefore not open to much interpretation. If a recipient contests the eligibility award, it is the policy of DHS that the supervisor in charge of the authorization is responsible for defending the calculation, hence the compliance conference. If, after the recipient has been given the opportunity to present additional information or learn more about the calculation, the amount still remains in dispute, then the supervisor refers the case to the administrative hearings process. During the administrative hearing, the hearing officer can only confirm (or refute) that the agency considered the appropriate information when calculating the benefit. There is no opportunity for changing the benefit amount at this time, and should the hearing officer determine a benefit was not correctly calculated, the case returns to the office for reconsideration.

EXHIBIT 6. Michigan Department of Human Services Eligibility Determinations Process



SOURCE. Michigan Department of Human Services, Eligibility Hearings Database, 2012.

DHS provided basic data regarding the number of hearings and pre-hearing resolutions.

As shown in Exhibit 7, the compliance conference, or mediation, is an important step in the hearings process, and significantly reduces the number of cases heading to administrative hearings.

EXHIBIT 7. 2011 Department of Human Services, Eligibility Hearings Data

Complaints—Public Assistance Eligibility	2011
Total Cases	60,015
Resolved prior to hearing (compliance conference)	9,275
Withdrawn or dismissed prior to hearing	37,329
Hearings held	13,411

SOURCE: Michigan Department of Human Services, Eligibility Hearings Database 2012.

CONCLUSION

Does mediation save money in state agencies? Yes, sometimes. Although there are many similarities in how state agencies are run, they are governed by myriad federal, state, and administrative laws and rules that make a blanket, "one-size fits all" solution impossible.

- ***Some agencies use mediation (or other dispute resolution techniques) to resolve problems—and others do not.*** There is a general lack of consistency regarding which agencies use mediation, how they use it, and when they choose to use it. In addition, some appear to be more comfortable than others in outsourcing complaint resolution to third parties. In order to expand the use of mediation in state agencies, mediation needs an advocate. The ideal advocate for changing executive agency processes is the governor, with support from his cabinet. The attorney general is another good voice for championing dispute resolution techniques. Either one or both need to be "out in front," or at a minimum, solidly behind any effort to universally change how state agencies handle complaint resolution.
- ***Mediation is most effective when it is used early and offered often.*** In general, mediation appears most likely to save money when the following conditions are met:
  - Mediation is offered early in the complaint process. Ideally, mediation should be offered, and take place, immediately following the filing of complaint, and prior to an agency investigation.
  - If parties do not elect to go to mediation, or a statute or rule prevents mediation until after a formal investigation, mediation can still be beneficial in resolving complaints/allegations prior to an administrative hearing. Anything that can be done to improve the likelihood of settlement prior to a hearing is beneficial to the parties and has the potential to save the state money. DRER should work with state agencies to develop best practices to help administrators determine when a case is likely to be settled through mediation, and to help agencies develop policies to ensure that mediation does not become a tool to delay the administrative hearings process.
- ***The state could benefit by gathering better metrics on the complaint resolution process.*** Quantifying a dollar value of cost savings is difficult, if not impossible, given the available data. Different agencies gather different information, use different case management systems, and quantify resolution and outcomes differently. If proving cost savings is important (rather than simply improving the relationships between government and its constituents), the complaint resolution process will need to be organized more systematically throughout state government. This could be accomplished in the following ways:
  - A statewide dashboard metric that tracks case disposition starting with complaint filing, including mediation (when offered) or internal settlement conferences, voluntary withdrawals, and hearings. Understanding why cases are not settled or withdrawn is also important in improving the resolution process. Presently, it is impossible to match or group case data based on "why" they were withdrawn or were dismissed without a manual review of cases.
  - A recommendation in the State-of-the-State and budget message that state agencies review their complaint resolution process and incorporate some form of mediation. Departments should be encouraged to resolve complaints as early in the process as possible because expedited complaint resolution benefits both agencies and consumers. Each agency should be encouraged to review statute, rules, and internal workflow to determine whether mediation (either internal or third party) can be used to streamline the complaint process and resolve issues expeditiously.
- ***There is a lack of understanding about when and where dispute resolution is most effective in the complaint process and more information about how to effectively use mediation is hard to find.***
  - Agencies need guidance as to where mediation or dispute resolution belongs in the complaint process. There is a paucity of access to and guidance on best practices. A workflow guide should be developed to help state agencies implement dispute resolution processes with fidelity—and to help managers understand what conditions are most

suitable for internal resolution or third-party resolution. Additionally, there should be a common referral point for access to third-party mediators, and mechanisms should be put in place to evaluate the effectiveness/satisfaction with using these services.

- ❖ It is common practice to include mediation in the drafting of any new or updated statute, yet clearly this is not enough to encourage the use of mediation. Statutes and rules should be crafted to provide agencies with more guidance as to how and when mediation should be used.

Mediation and ADR as Dispute Resolution Options in Health Care

Mediation and Behavioral Health

Mediation:

- Focuses on beneficiary's needs
- Empowers beneficiaries to express needs, goals
- Enables beneficiaries , providers to develop mutually agreeable solutions
- Provides beneficiaries with models and skills for collaborative resolution

Comments from research:

"Conflict management and ADR techniques are a natural fit in the mental health field for several reasons. First, the conflict management model in general, and the techniques of nondirective and transformative mediation in particular, are clearly consistent with the principles of recovery. Introducing this model in mental health settings reaffirms a commitment to recovery and empowerment."

- Managing Conflict Cooperatively: Making a Commitment to Nonviolence and Recovery in Mental Health, 2002

Despite the conventional wisdom which suggests that mentally disabled individuals cannot participate meaningfully in mediation to resolve mental health treatment disputes with community providers, initial research has proven that mediation is an effective and therapeutic alternative to the current rights-based and best-interest approaches.

- Resolving voluntary mental health treatment disputes in the community setting: benefits of and barriers to effective mediation, Ohio State Journal on Dispute Resolution, 1999

Medicare and Medicaid Applications

Medicare

CMS: Mediation used by QIOs to resolve beneficiary quality of care complaints

- Mediation contributes to a 93% satisfaction rate among complainants using the Medicare Beneficiary Compliant Review process

– Dept. of Health and Human Services Report to Congress, 2006

CMS: Provider Reimbursement Review Board, Medicare Part A: Mediation used to resolve payment disputes involving fiscal intermediaries, address multiple appeals involving same organization, assist in managing appeals caseload.

- Of 400 cases mediated, most resolved , less than 10 referred to hearing
- User response "overwhelmingly favorable" citing faster appeals, cost savings, relationship building, caseload control

- Symposium: "Medispute: Resolving Health Care Conflicts": Mediation and Medicare Part A Provider Appeals: A Useful Alternative, K. Scully-Hayes, 5 J. Health Care L. & Policy 356, 2002

Medicaid

North Carolina: Mediation used to resolve reduction of service disputes

- 2008-2010: 83% of cases resolved, 17% referred to hearing, $25 million saved
- 2010-2011: 99.4% of cases resolved, .06% referred to hearing

- Report to the General Assembly of North Carolina: Medicaid Recipient Appeal Process, Office of Administrative Hearings, DHHS, 2010

- Legislative Report on Appeals Process for Medicaid Applicants and Recipients, DHHS, 2011

Potential uses of mediation, ADR

Behavioral health care, managed behavioral health care:

- Treatment planning, medication use, quality of care
- Issues relating to standards of care, distribution of resources
- Disputes related to living and work arrangements
- Disputes between enrollee, provider over access to care
- Disputes between provider, payer over service reimbursement

- Managing Conflict Cooperatively: Making a Commitment to Nonviolence and Recovery in Mental Health Treatment Settings, A. Blanch, L. Prescott, National Assn. of State Mental Health Program Directors, 2002

- Mediation: An Alternative for Dispute Resolution in Managed Behavioral Healthcare, 1997

Private managed care:

- Patient safety
- Medical necessity, length of stay, appropriateness of place or provider
- Coordination of treatment across disciplines
- Reduction or termination of services

- Final Report, Commission on Health Care Dispute Resolution, AAA, ABA, AMA, 1998

Considerations

"Missing (from traditional approaches to dispute resolution in managed care) is the notion that conflicts are on a continuum and that early intervention into misunderstandings and disagreements may defuse full-blown disputes. ... The claims adjudication or member services model, standard in most managed care organizations, is simply inadequate to a collaborative and patient-centered system."

- Nancy Neveloff Dubler, Mediation and Managed Care, JAGS, 46:359-364,March 1998

"By using a superorndinate (interest-based) approach, we save approximately $52,000 per case in defense costs. This figure is typical of the experiences of other health care organizations applying a collaborative, interest-based system to claims management."

- Superordinate Claims Management: Resolution Focus from Day One, 2005

"Medicare should refocus financing in ways designed to sustain a collaborative doctor-patient relationship. ... Such a reorientation would shift the direction of Medicare from provider-oriented to beneficiary-centered. The mechanism for affecting this change would be mediation aimed at developing a collaborative medical treatment plan."

- Negotiating with an 800-lb. Gorilla: ADR and Medicare, P.E. Bernard, 60 Wash. & Lee L. Rev. 1417, 2003

W 13

DISPUTE RESOLUTION EDUCATION RESOURCES, INC.

About the Organization

Dispute Resolution Education Resources, Inc. (DRER) is a Lansing-based non-profit organization that promotes the use of collaboration in planning, decision making, and conflict resolution. Established in 2001, DRER provides training in collaborative communication, consensus building and conflict management to help organizations and individuals reach their goals. It provides alternative dispute resolution services through expertise available across Michigan.

DRER manages the statewide Michigan Special Education Mediation Program for the Michigan Department of Education (http://msemp.cenmi.org). The program provides mediation and meeting facilitation services to help parents and educators plan educational programming for students with disabilities. DRER also manages the Michigan Agricultural Mediation Program for the U.S. Department of Agriculture (www.agmediation.org). This program helps farmers and USDA agencies resolve loan, credit and regulatory compliance issues.

DRER training workshops provide skills in collaborative planning, communication, mediation, negotiation, meeting facilitation and conflict resolution. The workshops are designed to help agencies, organizations and individuals plan and solve problems together in the interest of creating and sustaining productive relationships and positive outcomes.

In addition, DRER conducts presentations about the uses of and differences between collaborative and traditional dispute resolution processes. It collects research in the field and in 2012 commissioned a study from Public Sector Consultants, Inc., on the use of mediation in Michigan state agencies. DRER also drafts articles about collaborative methods for organizations and the public.

Michigan Mediates! is an information campaign coordinated by DRER and the State Bar of Michigan Alternative Dispute Resolution Section. The campaign is designed to inform the public of mediation's benefits and availability through traditional and social media, and through community presentations. The campaign's website is located at www.michiganmediates.net.

DRER's website is located at www.mediationmichigan.org.

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Sherry Gerbi
90 Amherst Rd, Pleasant Ridge 48069
sherry.gerbi@yahoo.com
248.709.6734

Last year I testified before this committee, the Senate's Appropriations sub-committee as well as before the Commission on Mental Health & Wellness. At that time I was urging support for Medicaid Expansion so I thank you for passing Healthy Michigan.

My name is Sherry Gerbi and I live in Oakland County. I am a sister, a mother, and a grandmother. I love books, movies, horses and my computer. I'm an optimist, an advocate and I'm a person with a mental illness. Last year I expressed my gratitude for our mental healthcare system as it had saved my life. I told you I was receiving SS Disability, that I have a pension and that I work part-time as a sub-contractor for Oakland County CMH. I spoke of having Medicare and Medicaid but Medicaid with a high Spend Down. In fact it was costing me to work because it would drive up my Spend Down. My Spend Down was over $1500 and I realized that it was actually 70% of my income. I ask if you could pay 70% of your income in order to have healthcare. You might be able to do it for a month, maybe even 2 or 3 months but you certainly couldn't do it month after month after month.

My situation has changed somewhat. I turned 66 this year and my disability converted to retirement. Because I couldn't make my Spend Down I lost my Medicaid. I have a number of health issues and last year I had an endoscopy, a colonoscopy, an abdominal ultrasound, a CT with contrast, an MRI, an ERCP and two bone scans. Even with my Medicare I owe thousands of dollars. I have teeth that are breaking and as you know Medicare does not pay for dental. I need new glasses and people are beginning to complain when I can't hear them. I continue to receive mental health services that are currently paid through the General Fund.

I have many friends that are struggling with their high Medicaid Spend Downs. They need their medications in order to maintain their recovery. They are able to make their Spend Down by attending a Clubhouse which is a psycho-social program for those with a severe and persistent mental illness. I also could make my Spend Down by attending Clubhouse every day, all day, but that would mean I would have to give up my job, my volunteer work and my advocacy efforts. Essentially my work and my advocacy cost me money, a lot of money, but I'm unwilling to give up the intangibles I receive through my work as those intangibles make my life worth living. I know a number of people who have made a different decision; they would like to work but fear losing their Medicaid. I know people who have delayed their healthcare until the end of the month after their Spend Down is met. I know someone whose cold developed into pneumonia while

waiting to meet his Spend Down. I know people who have had their bridge card cut because they didn't make their Spend Down that month. It boggles my mind that food is related to the Medicaid deductible.

Currently, there is a lot of confusion and fear about how Healthy Michigan is going to work. No one has definitive answers and no one knows what are going to be the unintended consequences of a Healthy Michigan. We had hoped that Spend Down would be eliminated or at least lowered but no one seems to be able to give us an answer. I've tried to paint a picture for you of the human costs of high Spend Downs but I also want to call to your attention the administrative costs incurred by Spend Down. Case managers and DHS workers use a lot of time and resources on Spend Down paperwork. Oakland County pays for 3 MARA workers and their support staff to process Spend Downs. They are given **14 days** before it has to be entered in the computer and I know of folks that have been refused treatment because it wasn't showing in the system. I also know of times when a case manager will meet with a client twice a month or extend their visit in order to help meet a Spend Down. Sometimes people will request meeting with their psychiatrist twice a month for the same reason. I have no problem with being accountable for a co-pay for my medical and mental health treatment as long as it is a reasonable amount but this Spend Down issue is just crazy and fraught with unreasonable assumptions and misinformation. Please look at this issue and bring us some relief. Remember us vulnerable Michiganders of which I am one. I thank you for your time and attention.

MICHIGAN LEAGUE FOR PUBLIC POLICY

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

Gilda Z. Jacobs, President and CEO

March 3, 2014

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

We are so pleased the Legislature approved the expansion of Medicaid eligibility with full federal funding and created the Healthy Michigan Plan. We support the governor's recommendation to provide full-year funding for the program which will provide comprehensive healthcare coverage to more than 400,000 currently uninsured residents. Most of these individuals are working and either do not have employer coverage available to them, or it is unaffordable.

There are significant state savings included in the Executive Budget, more than $250 million, for full implementation of the Healthy Michigan Plan as individuals transition from state-funded programs in the mental health and corrections systems to the federally funded Healthy Michigan Plan. This is a win-win situation – a win for the state budget and a win for those who gain coverage.

We support the recommended expansion of the Healthy Kids Dental program, although we are disappointed that, even with the recommended expansion, more than 400,000 kids in Wayne, Oakland and Kent counties will be left behind – nearly 40% of the eligible children. We know that tooth decay remains the most prevalent chronic disease in children resulting in lost school days and learning, as well as the potential for long-term negative health consequences. Children cannot learn when they are in pain or not in school. But tooth decay is preventable.

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

We are pleased that the governor is recommending a state investment in Medicaid to continue half of the primary care rate increase implemented in FY13. As you well know, primary care access is critical to attaining or maintaining good health.

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

We support the recommended investments to expand home visiting programs to support families and promote the healthy development of infants and children and improve early childhood outcomes.

In summary the League supports:

- Healthy Michigan Plan funding in DCH and in the other departments where funding is recommended to ensure a successful implementation.
- Healthy Kids Dental investments to expand coverage as recommended, but also funding for all eligible kids to be covered.
    - **An additional investment of $22 million in state funds, bringing in an additional $44 million in federal funds, to cover the remaining 402,000 Medicaid-eligible children currently left behind.**
- Elimination of the MIChoice waiting list with funding to provide services to eligible indivlduals.
- Investment of state funds to continue part of the Medicaid primary care rate increase.
- Investment of state funds to begin implementation of the Mental Health and Wellness Commission recommendations to improve mental health treatment and outcomes.
- Investment of state funds to support families and promote the healthy development of infants and young children through home visiting programs.

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

Testimony for the House Appropriations Subcommittee on Community Health March 3, 2014

Good morning, Chairman Lori and members of the House Appropriations Subcommittee on Community Health. Thank you for the opportunity to provide testimony on the FY 2015 Department of Community Health budget. The Michigan Oral Health Coalition serves as the collective voice of oral health— as our members include families, dental professionals as well as universities, community health centers, insurers, professional associations and local health departments who together work to improve the oral health of Michigan's nearly 10 million residents.

February 25th marked the seven-year anniversary of the tragic death of Deamonte Driver, the 12-year-old Maryland child who died from an abscessed tooth. Deamonte's story was a tragedy as his death was entirely preventable. What started out as a toothache turned into a severe brain infection that could have been prevented by an $80 tooth extraction. His death has also underscored the fact that there can be no health without oral health, and that dental decay is the most prevalent disease among children.

We are pleased that Governor Snyder has continued his support of the Healthy Michigan Plan, Healthy Kids Dental, Medicaid Adult Dental and Donated Dental Services programs. In his 2011 Michigan Health & Wellness Message, Governor Snyder shared how oral health complications exacerbate general health conditions and our members would agree.

In 2000, the Michigan Department of Community Health contracted with Delta Dental to develop the Healthy Kids Dental program to improve dental care access. The program, which started in 22 counties as a pilot program is now serving approximately 500,000 Medicaid-eligible children in 78 of 83 Michigan counties. Through your support in FY 2014, Ottawa, Ingham and Washtenaw counties were the latest to implement the Healthy Kids Dental program.

Coalition member Bill Ridella is the Director and Health Officer of the Macomb County Health Department. What does the expansion of the Healthy Kids Dental program mean to his community? In Macomb County, nearly 75,000 children and youth are enrolled in Medicaid; therefore, implementing the Healthy Kids Dental program will improve oral health access and dental provider participation.

The facts are that dental disease is the most common unmet health treatment in children, the most common chronic illness for children, and yet dental disease is preventable. According to the Centers for Disease Control and Prevention (CDC), more than 25% of children have tooth decay in baby teeth before entering kindergarten.

Michigan Oral Health Coalition | 7215 Westshire Drive Lansing, MI 48917
Tel 517.827.0466 | Fax 517.381.8008 | E-mail kketola@mohc.org | Web www.mohc.org

MICHIGAN
Oral Health Coalition

Testimony for the House Appropriations Subcommittee on Community Health March 3, 2014

By age 19, almost 70% of youth have experienced tooth decay in their permanent teeth. Untreated tooth decay can lead to pain, weight loss, missed school days, poor appearance, decreased self-esteem, poor learning and even death. Furthermore, childhood tooth decay disproportionately affects low-income families and racial or ethnic minorities. The rate of untreated tooth decay in children from families with incomes below the poverty level is double that of non-poor children.

Therefore, access to preventive dental services through programs like Healthy Kids Dental is an effective way to improve children's oral health. In Macomb County, there are over 550 dental providers, however less than 25% of our dental practices accept Medicaid; similar to what is seen throughout the country. Many Medicaid children who are eligible for dental services in Macomb County are not receiving dental sealants and other preventive services because of access as well as a need for better oral health education and action from parents. With the availability of Healthy Kids Dental in Macomb County we expect an increase in the number of dentists serving Medicaid children and improved children's oral health in our county.

Continued Healthy Kid Dental expansion to Kalamazoo, Kent, Macomb, Oakland and Wayne counties will yield an increase in utilization of dental services and a decrease in pain and suffering for these children. Oral health diseases are preventable and through a combination of policy, community, professional and individual measures we can improve the health of Michigan's children.

As you deliberate the FY 2015 Community Health budget, we ask that you to support Governor Snyder's recommendation to fund the continued phase-in expansion of Healthy Kids Dental to every county ensuring ALL Michigan children receive the care they need for a healthy mouth, and a healthy body.

Respectfully Submitted,

William Ridella, MBA, MPH
Director/Health Officer
Macomb County Health Department
586.469.5510

Karlene Ketola, MHSA, CAE
Executive Director
Michigan Oral Health Coalition
517.827.0466

MDHA
Michigan Dental Hygienists' Association

adha American Dental Hygienists' Association
Michigan

Date: March 3, 2014

To: House Appropriations Sub-Committee on the Department of Community Health

From: Cheryl Bentley, President; Michigan Dental Hygienists' Association

RE: Healthy Kids Dental Funding

The Michigan Dental Hygienists' Association represents Registered Dental Hygienists throughout Michigan. We've been advancing and protecting the profession of dental hygiene for over 80 years.

To improve the public's total health, we work to:

- Ensure access to quality oral health care
- Increase awareness of the cost-effective benefits of prevention
- Promote the highest standards of dental hygiene education, licensure, practice and research
- Represent and promote the interests of dental hygienists

Prevention is the key to good oral health as well as good general health. Registered Dental Hygienists are the prevention specialists for oral health. We educate patients on the importance of effective daily oral health care and how that impacts their general health and we provide preventive oral health care services.

Since few dentists treat Medicaid patients on a regular basis, many children have difficulty accessing dental care. Expansion of Healthy Kids Dental will help alleviate that problem.

MDHA supports Governor Rick Snyder's recommendation to increase funding for the Healthy Kids Dental program in the FY 2015 budget. Expanding this important program to Kalamazoo and Macomb counties will add over 100,000 kids for a total of 611,000 enrolled in 80 counties.

Please support funding for Healthy Kids Dental as the budget moves forward in the process.

If you have any questions, please do not hesitate to contact me at chooey46@yahoo.com

TRAVERSE
CITY AREA CHAMBER OF COMMERCE

March 3, 2014

Dear Representative Lori:

On behalf of the Traverse City Area Chamber of Commerce and the Northern Michigan Chamber Alliance this Statement of Support for Rural OB Services Support is submitted for your consideration.

Fundamental to retaining families to work in the rural communities across northern Michigan is access to physician, hospital and support services associated with OB and pediatric care. Unfortunately, for a variety of reasons these basic health care services are unavailable in many of our communities and there is a strong likelihood of further loss of these services without change and support:

- 12 counties across northern Michigan have no OB hospital delivery services which means a mother and family must drive across multiple counties to deliver their newborn child.
- There is only 1 hospital with a NICU to service all high-risk deliveries and infants.
- Infant mortality is higher than the State average in all but 2 counties
- Rapidly increasing difficulty in recruiting primary care and OB physicians essential for access to maternity and pediatric care for women and children.

These challenges contribute to the difficulty in retaining and attracting young families to our rural communities necessary to sustain and grow the businesses and services in our communites. Without support the health status/infant mortality and morbidity in rural northern Michigan will further deteriorate which is a significant barrier to economic sustainability and growth in our communities.

Sincerely,

Doug Luciani
President & CEO

202 E. Grandview Parkway • Traverse City, MI 49684 • Phone: 231-947-5075 • Fax: 231-946-2565
www.tcchamber.org • E-mail: info@tcchamber.org

To whom it may concern

My name is Guy Bartlett and I receive disability from a mental illness.

I appreciate what I get and am glad I was able to pay in to the system for ten years.

The one concern I have is the Medicaid spend down. I feel it can be a hardship

If you cannot meet the spend down for some reason and that it should be eliminated for lower

income clients. Thank you for hearing my request.

Public Testimony submitted by Pam Casper
House Appropriations Community Health Subcommittee
March 3, 2014

Re: Department of Community Health - Behavioral Health Budget

Dear House Representative Lori and Members of this Subcommittee,

My name is Pam Casper. I receive mental health services through Oakland County Community Mental Health Authority. Thank you for this opportunity to testify about Michigan's Budget for Community Mental Health.

I'm very concerned that many individuals with serious mental illness (SMI) are at risk for losing access to medically necessary and clinically appropriate specialty mental health services that they receive through Community Mental Health (CMH). People at risk include individuals who have Medicaid with a Spend Down (which is a monthly deductible) and Medicare. Individuals who have Medicare aren't eligible for the "Healthy Michigan Plan" (Michigan's version of the Medicaid Expansion). Medicare has a limited mental health benefit and it doesn't cover specialty mental health services that are most needed for individuals with serious mental illness.

For example, case management is covered by Medicaid but not by Medicare. Case mangers assist individuals with serious mental illness to obtain access to needed services and supports such as mental health and physical health care, financial assistance, housing, employment, etc. Unfortunately, some individuals with SMI whose income is below 133% of the Federal Poverty Level (FPL) are at risk for losing access to the case management and other specialty mental health services that they need.

Currently, General Fund (GF) dollars allocated to CMH are used for people not covered by Medicaid. They are also used for people who have Medicaid with a Spend Down (a monthly deductible). GF dollars are used during the time between the first of the month and the time the "deductible" is met.

The Medicaid expansion will enable more people to have Medicaid and provide additional Medicaid revenue for Community Mental Health services. This is good. However, the proposed reductions for the CMH General Fund budget are too severe.

I respectfully request that you reconsider the proposed General Fund budget amount for Community Mental Health services. It's important to keep in mind that some individuals with serious mental illness aren't eligible for Medicaid because their Social Security Disability Insurance benefit amount is over 100% of the FPL. It's not ethical to exclude some individuals whose income is less than 133% of the FPL from the Community Mental Health safety net.

Thank you for the opportunity to provide input about the Community Mental Health budget. Please don't let an unintended consequence of the Medicaid expansion to remove the safety net for mental health services.

If you have any questions, you may contact me at pam.casper27@gmail.com or by phone at (248) 374-0646.

Sincerely,
Pam Casper

2/20/14

Dear Lansing,

I am a grandmother who spends most of my time and days at Dreams Unlimited Clubhouse to reach my spend down. This spend down has affected my life so much I cannot get anything else done. I suffer from mental illness and it is adding more stress on my life.

As you already know, during the month of January 2014, the weather was treacherous. Due to issues dealing with the snow (at my apartment complex and my personal vehicle), I was not able to meet my spend down that month. Therefore, I was not able to see my doctor at our scheduled appointment and I needed a green sheet from case manager to get my prescription medication.

Please take what I have to say into consideration as I know my fellow friends are struggling just as much as I am, if not even more.

Peggy Quinn

2/21/2014

Dear Lansing,

My name is Pepa Hamilton. I suffer from mental illness and as a result, I am consumer of Easter Seals Michigan as well as a member of Dreams Unlimited Clubhouse. I am writing to you because of my concerns for spend-down.

Spend down has been negatively affecting my life because there were two months this year where I have not been able to meet it. There are several reasons why, including: I got sick and my doctor told me I couldn't be around other people and the harsh weather. Due to the frigid weather, I couldn't drive my vehicle, and even if I could, Easter Seals and Dreams Unlimited Clubhouse were closed. I had to miss appointments with my case manager and doctors.

The devastating part about this is that for both months, I only missed my spend down by a few units. By not meeting my spend down, I was not able to receive my medications and I couldn't buy food because my bridge card didn't load. As a mental health consumer, I was not in a good state of mind because I was so stressed out. I think anyone would be stressed out if they were in my situation, regardless whether they had a mental illness or not.

Another concern of mine is why is my spend down so high? You make it nearly impossible for me to meet. Every month I am stressed out because it doesn't seem like there are enough days. My spend down is so high that I am worried if I will be able to meet it or not in February, where there are only 28 days.

Spend down doesn't seem to be working for me and many others, especially for people who are interested in working. I have had a desire to work for a few years now, and unfortunately, I cannot. I can't afford to miss days meeting my spend down. Additionally, if I were to find work, my spend down would be even higher than it is now. How outrageous! Work should never be such a barrier for anyone.

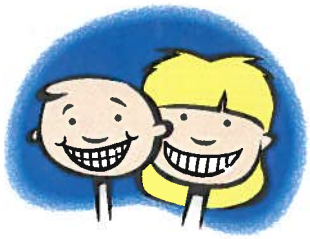
Please take what I have to say into consideration. I truly feel like I am being victimized from something I cannot control.

Pepa Hamilton 248-812-7107

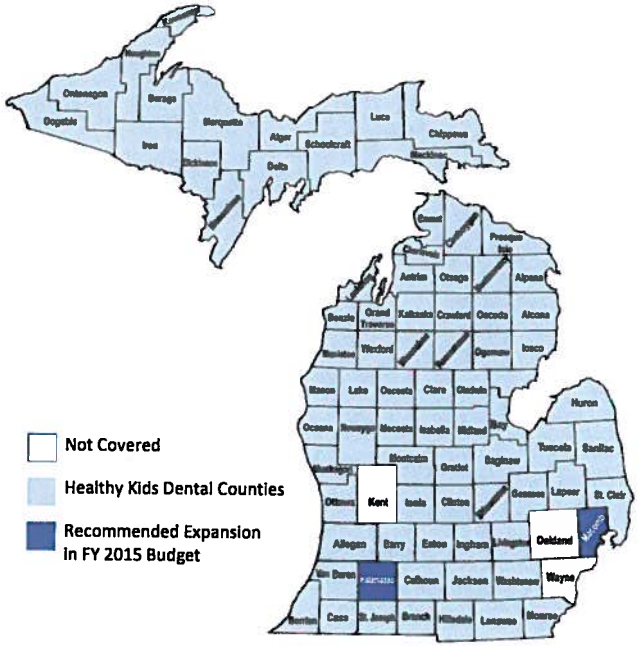
mlpp
MICHIGAN LEAGUE FOR PUBLIC POLICY

February 2014

Jan Hudson, Senior Policy Analyst



Healthy Kids Dental Program



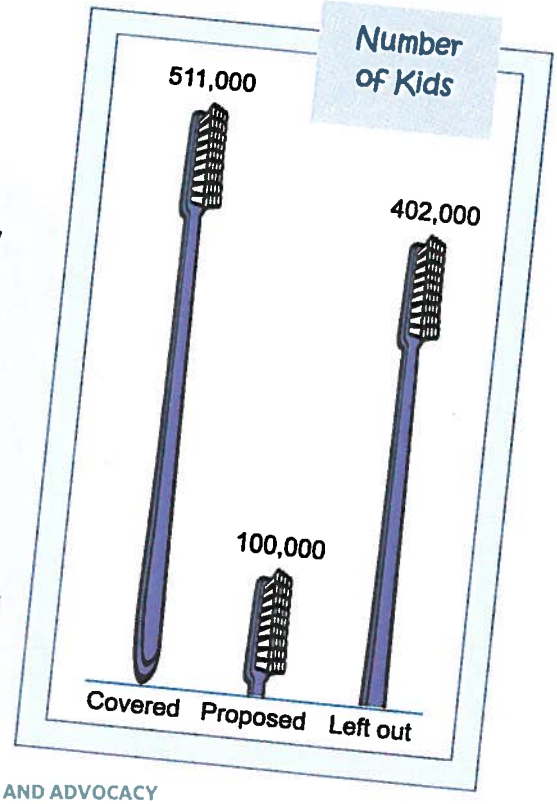
The Healthy Kids Dental program is a public-private partnership between the Department of Community Health and Delta Dental of Michigan. The program is available to Medicaid-eligible children under age 21 in all but five counties. The program, administered by Delta Dental, uses Delta's commercial network of dentists and pays higher rates than Medicaid.

Ingham, Ottawa and Washtenaw counties were the most recent additions.

The governor's budget for FY2015 recommends $5.4 million ($15.7 million with federal funding) to extend coverage to Kalamazoo and Macomb counties, adding another 100,000 children to the program for a total of about 611,000. That leaves a large population of low-income kids behind in Kent, Oakland and Wayne – more than 400,000 kids.

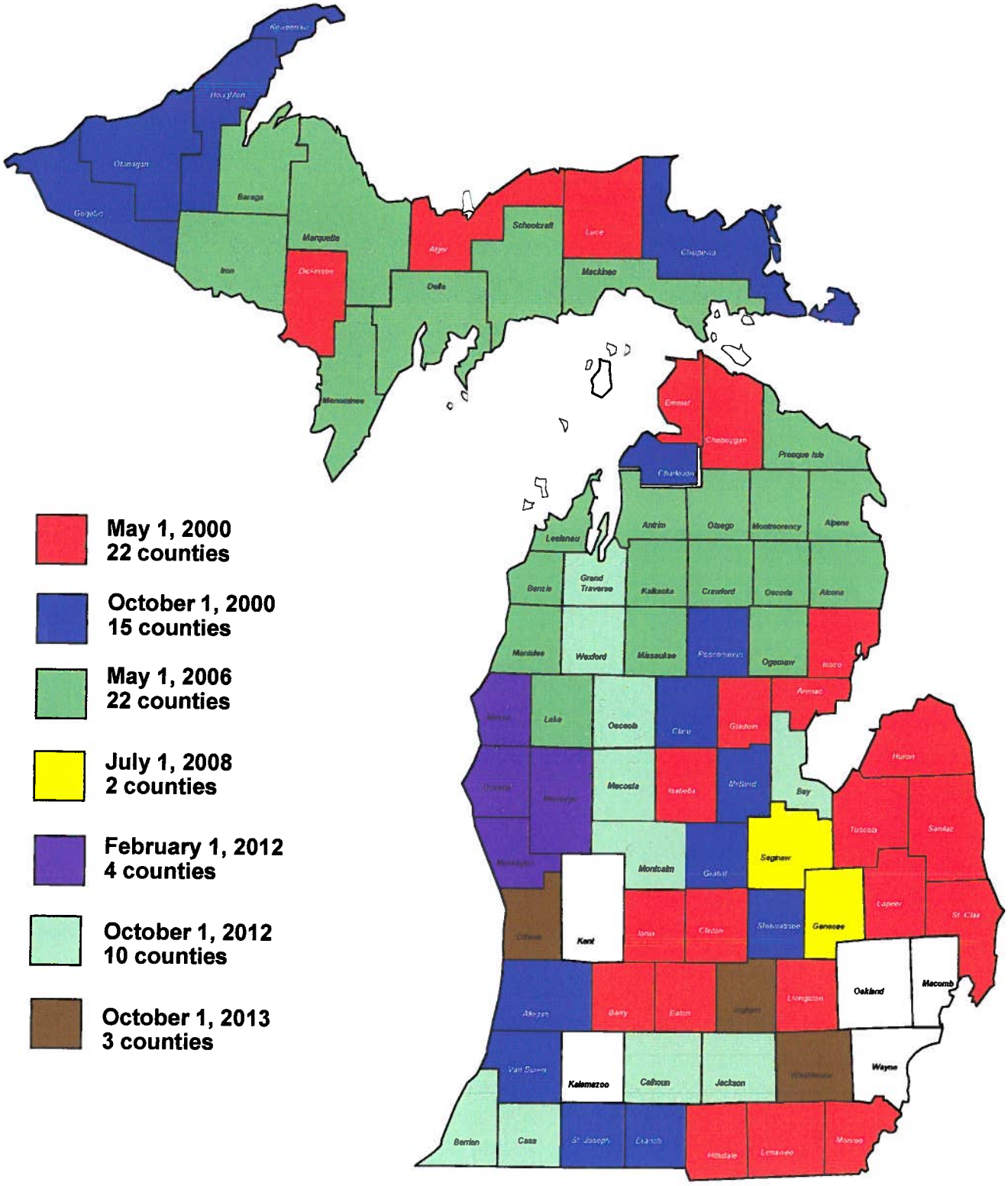
This program is critical to all of Michigan's Medicaid-eligible children.

- **Tooth decay is the no. 1 chronic disease in children.** Tooth decay is preventable with access to good dental care.
- **Children can't learn and progress in school** if they have a toothache.
- **Higher provider participation** than in Medicaid due to higher payment rates and simplified administration.
- **Healthy Kids Dental is a great state investment.** For every dollar the state contributes, the federal government provides $2.
- **A modest investment of $22.5 million in state funds** would cover the remaining Medicaid-eligible children and bring nearly $44 million in federal funds into the state and the economy.



Healthy Kids Dental Program Expansion

May 1, 2000 - current



Source: Michigan Department of Community Health, 2014