MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

Behavioral Health and Developmental Disabilities Administration

Fiscal Year 2019

Presentation to the Appropriations Subcommittee on Health & Human Services

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Presentation Agenda

- ***HIGHLIGHTED SERVICE STATISTICS***
- ***OVERVIEW: PROGRAMS AND PERSONS SERVED***
  - Community Based Services
  - State Psychiatric Hospitals and Inpatient Units
- ***FY 2018 STRATEGIC INITIATIVES UPDATES***
- ***FY 2019 EXECUTIVE BUDGET RECOMMENDATIONS***

Service Statistics

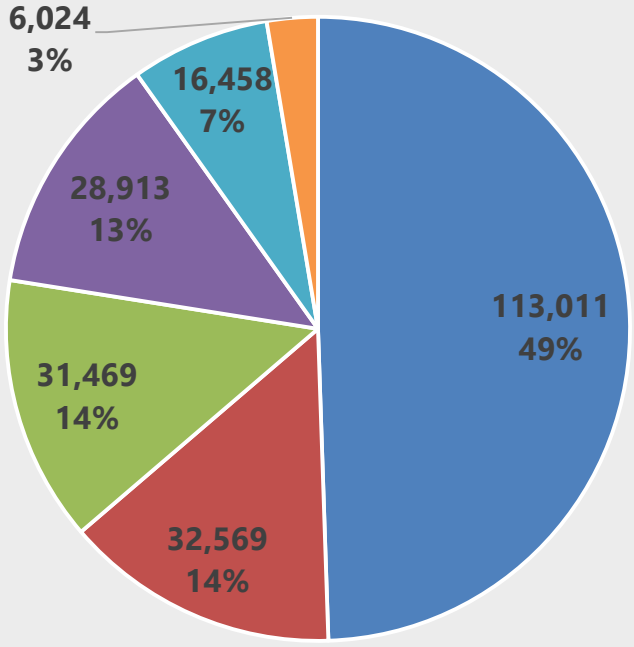
- 46 Community Mental Health Services Programs
- 10 Prepaid Inpatient Health Plans
  - 228,444 people served by Community Mental Health Services Programs and Prepaid Inpatient Health Plans in 2016
- 5 state-operated hospitals and centers
- 772 State Hospital census in house (January 24, 2018)
- 2,159 licensed psychiatric adult beds in the community; 260 for licensed child/adolescent psychiatric beds in the community
- 2,865 complaints received by MDHHS Office of Recipient Rights from state hospitals in FY17; 446 complaints were investigated and 1,197 interventions were completed
- 5,197 youth diagnosed with Autism and eligible for Applied Behavioral Analysis Service
- 41.0 percent increase in Certified Behavioral Analyst workforce (Autism) from FY16 to FY17
- 99.0 percent of discharges from a psychiatric inpatient unit are seen for Community Mental Health Services Program follow-up care within seven days
- 99.4 percent of mental health consumers received the initial face-to-face assessment with a professional within 14 days of request
- 31,469 total children with Serious Emotional Disturbance (SED) were served by the CMHSPs/PIHPs in FY16 according to the 904 report
- In 2017, 24 of 47 Psychosocial Rehabilitation Clubhouses are internationally accredited compared to 9 in 2015.
- Diversion Pilots showed that post incarceration, care continued at a rate 19 times greater for CMHSP clients versus non-CMHSP clients.
- 3,293 individuals entering the behavioral health system identified as Veterans in FY17; 85% were male, 15% female; 52% identified primarily mental health and 48% identified primarily SUD on admission.
- A reported 71,027 persons received substance use disorder treatment and recovery services in FY17
- 39.4 percent of persons admitted to substance use disorder treatment in FY17 also had a mental health issue
- In 2003, combined heroin and opioid admissions were less than one-sixth (17%) of all treatment admissions; in 2017, combined heroin and opioid admissions reached over two-fifths (45%) of all treatment admissions
- 20,471 persons received medication-assisted treatment during FY17, up from 5,875 during FY06
- $8.7 million received from successful federal grant applications for substance use disorder prevention and recovery
- 1,200 women reported being pregnant at admission to substance use disorder treatment in FY17
- Michigan's reported drug-abstinence rate at treatment discharge exceeded the national average rate by over 3% in FY17
- The reported percentage of persons employed increased 3.2% during the course of substance use disorder treatment in FY17
- The reported percentage of persons homeless decreased 11.8% during the course of substance use disorder treatment in FY17
- More than 200,000 persons attended substance abuse prevention programs in FY17

OVERVIEW: PROGRAMS & PERSONS SERVED

- ***Community Based Services***
  - Community Mental Health (CMH) Statistics
  - Substance Use Disorder Data and Statistics
- ***Inpatient Services***
  - State Psychiatric Inpatient
  - Local Psychiatric Inpatient

*Individuals Served by Michigan's Community Mental Health System**

228,444 Total Served in MI's CMHSPs

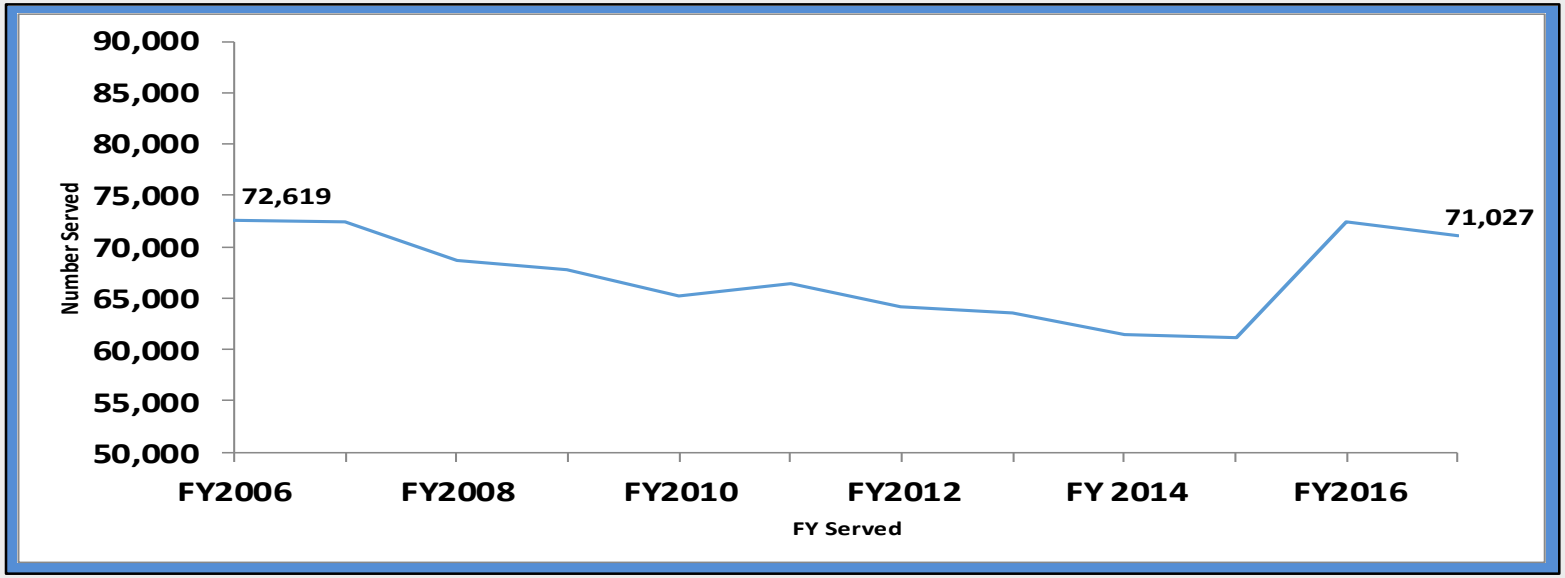


MI=Mentally Ill
I/DD=Intellectually/Developmentally Disabled

*Source: MDHHS (2017). FY16 Section 904 Boilerplate Report

*Individuals Served in Substance Use Disorder Treatment, Prevention, & Recovery Systems (FY 2006-FY 2017)**

Treatment



Prevention

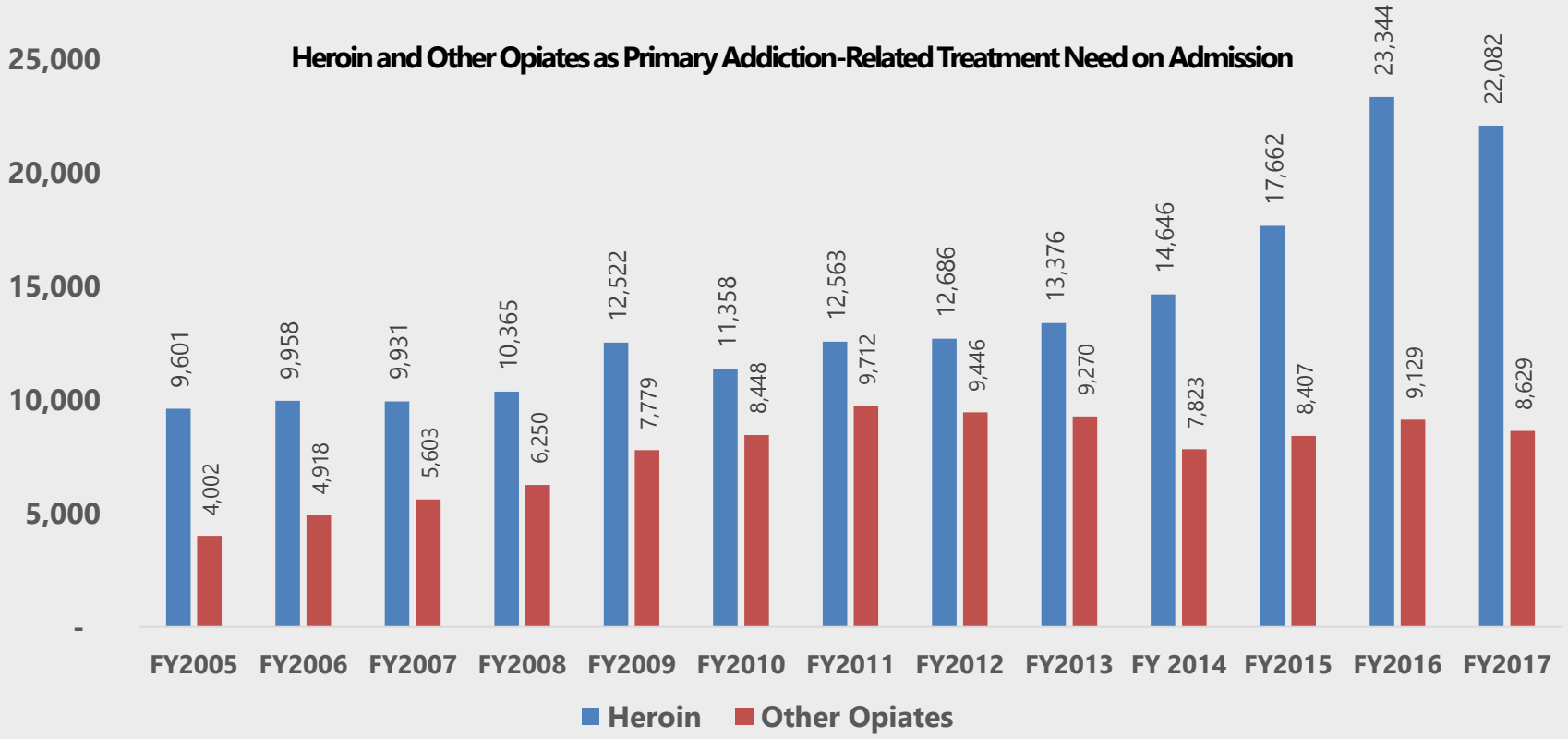
203,600 persons attended substance abuse prevention programs in FY17

Recovery

8,174 persons received recovery support services in FY17

*Source: MDHHS (2017). FY17 Behavioral Health Treatment Episode Dataset

Trends: Substance Use Disorder Treatment, Prevention, & Recovery Systems – Opioid Treatment Admissions



Source: MDHHS (2017). FY05 to FY17 Treatment Episode Dataset.

BHDDA Revenue Breakdown (FY18)

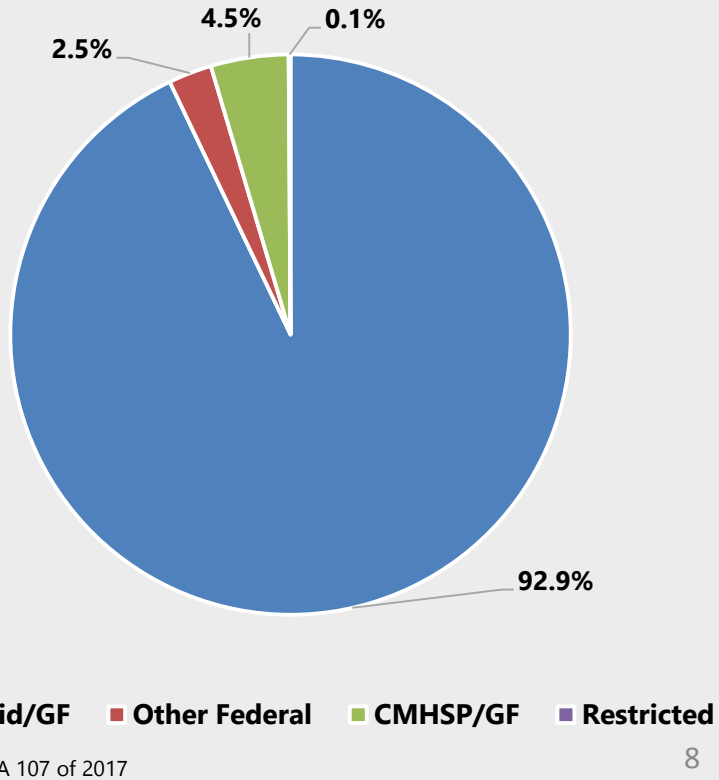
Community Based Services

Distribution by Source

- **Medicaid:**
  - Money flows from MDHHS to PIHPs for all Medicaid-covered lives (8.3% receive CMHSP services vs. 9.4% last year)
  - Rates must adhere to federal rules
  - Rate-setting process factors include:
    - Programmatic and Demographic Data
    - Historical Trends
    - Non-benefit costs (e.g., administration, coordination)
    - Adjustments (e.g., program changes, health status)
    - Medical Loss Ratio
    - Risk Adjustment (e.g., prospective or retrospective)
  - Individualized unit cost specific to CMHSP based on historical factors (unlike MHPs that utilize a statewide unit cost as a basis)

- **Non-Medicaid:**
  - Federal Grants: federal methodology based on need
  - GF Mental Health: based on past utilization only
  - GF SUD: based on need

Total Funding: $3.02 Billion*,**



***Source**: PA 107 of 2017
****Note**: 93% of funding is slated for mental health services; 7% is for SUD services

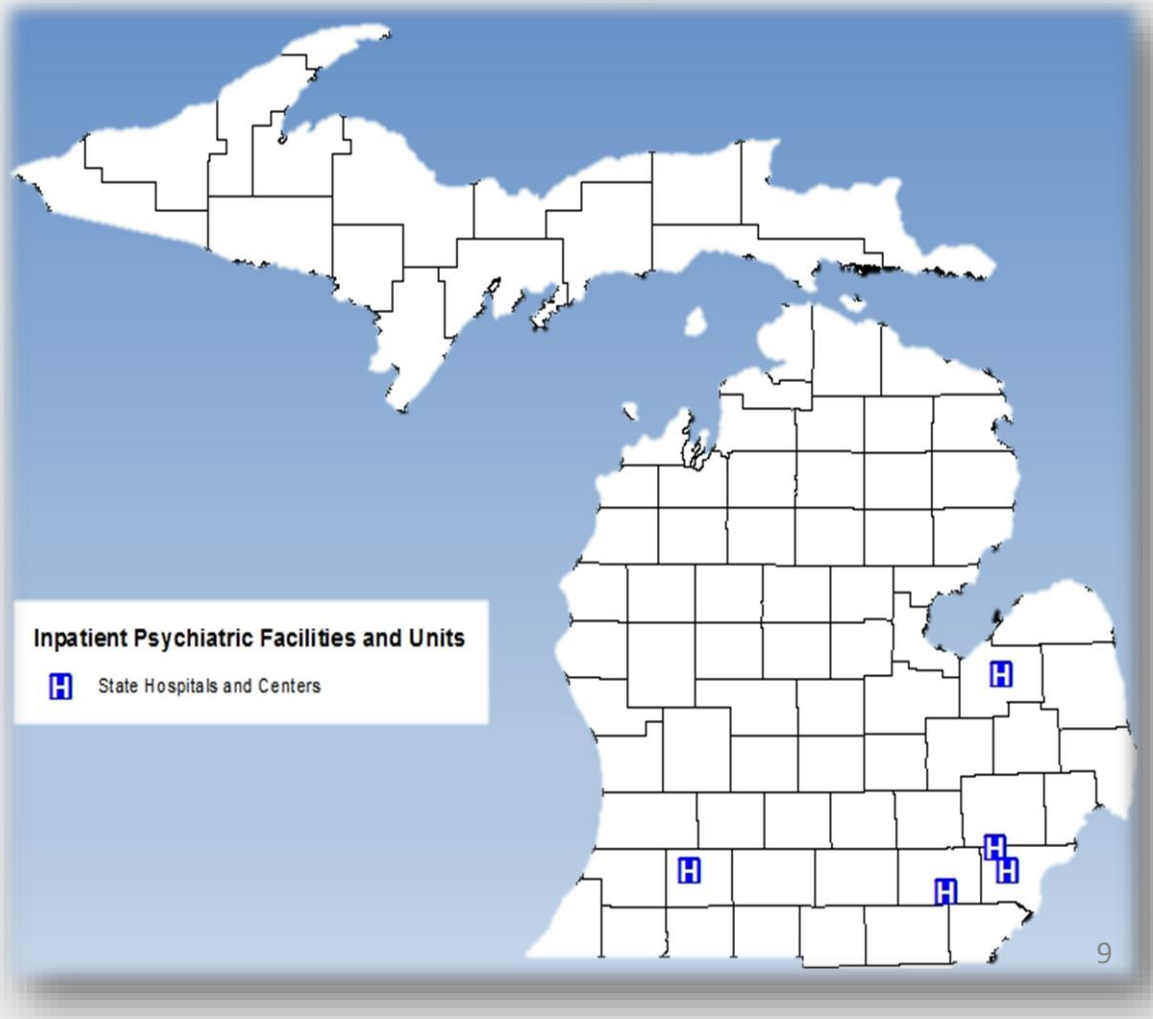
State Hospitals and Centers—Inpatient Census

Adult Hospitals (Patients):
- Caro (148)
- Reuther (167)
- Kalamazoo (141)

Forensic (Patients):
- Center for Forensic Psychiatry (262)

Children (Patients):
- Hawthorn (54)

In-house census as of January 24, 2018: 772 Patients



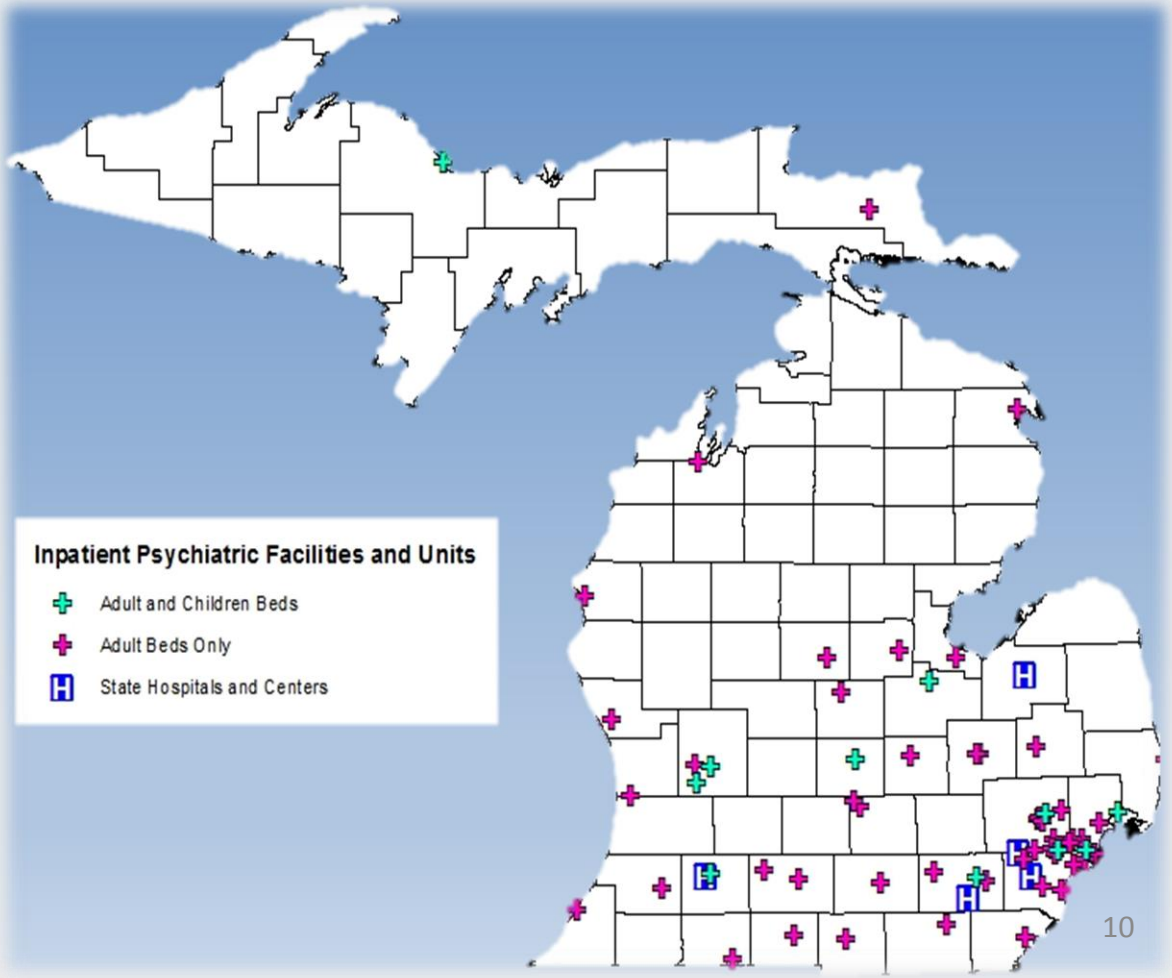
Total Inpatient Psychiatric Capacity

Local Inpatient Licensed Beds (private):

- Adult: 2197 beds; 59 facilities
- Child/Adolescent: 276 beds; 11 facilities

State Hospital Beds (public):

- Adult: 720 beds
- Child/Adolescent: 70 beds



FY 2018 STRATEGIC INITIATIVES UPDATES

- Fighting the Opioid Crisis
- Increasing Access to Inpatient Psychiatric Care
- Promoting Mental Health Diversion
- Enhancing Mental Health to Children and Families
- Integrating Behavioral and Physical Health
- Other Significant Projects

OPIOID ADDICTION IS A GROWING PROBLEM.

MDHHS
Michigan Department of Health & Human Services

In Michigan alone, an average of five people die from opioid overdose every day.
Help us change the numbers and stop this deadly epidemic.

All Drug Deaths

Total number of overdose deaths in Michigan involving any drug.

2011	2015
1,359	1,981

All Opioid Deaths

Number of deaths that involved at least one type of opioid (including prescription drugs, heroin, fentanyl or any other opioid), or one or more opioids combined with other drugs.*

2011	2015
622	1,275

Opioid Prescriptions

Total number of opioid prescriptions written by any licensed prescriber in Michigan.**

2011	2016
10,441,714	11,028,495

NAS Cases

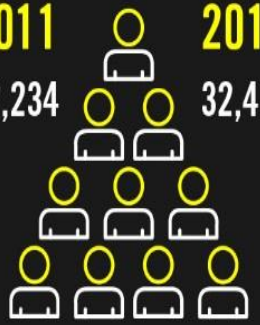
Neonatal abstinence syndrome (NAS) is a group of conditions associated with drug withdrawal in newborns after being exposed in utero.

2011	2016
630	927**

People in SUD Treatment for Opioids or Heroin

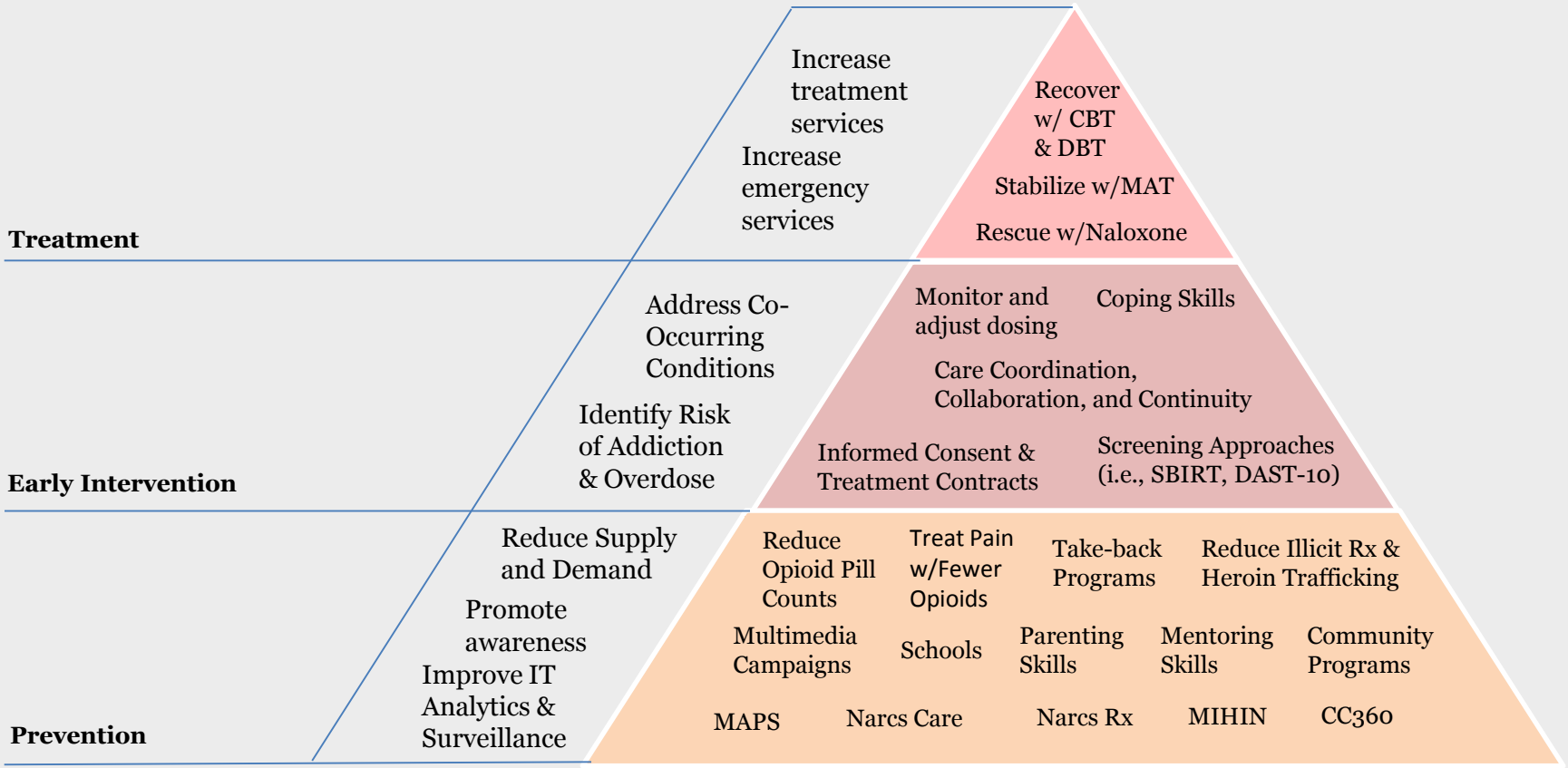
Total number of people receiving publicly funded drug treatment services in Michigan.

2011	2016
22,234	32,473



*2015 data. **Preliminary data for 2016. Numbers are not finalized and may change.

MDHHS Public Health Approach to Fighting the Opioid Crisis



Fighting the Opioid Crisis

- MDHHS is engaged in several initiatives to help mitigate the opioid crisis, inclusive of expanding/utilizing Medicaid services, implementing SAMHSA grants (i.e., block grant and the State Targeted Response grant), and executing recommendations from the Governor's Task Force.

- **SAMHSA State Targeted Response Grant ($16.3 Million),** focused on**:**
  - Prevention
  - Treatment
  - Recovery

- **SAMHSA block grant,** is aimed at affecting the following:
  - Prescription Drug and Opioid Overdose Prevention
  - Opioid Overdose Recovery
  - Innovative Strategies for Enhancing Treatment Services to Pregnant Women
  - Drug Court Peer Recovery Support

- Michigan is implementing several projects to mitigate issues with **Neonatal Abstinence Syndrome**

Fighting the Opioid Crisis (continued)

- **Recovery Coach Curriculum and Certification**
  - Policy effective on January 1, 2018
  - Formalizes standards for training, certification and practices for Peer Recovery Coaches as established by MDHHS

- **Opioid Health Home Pilot**
  - State Plan Amendment to bolster access to Medication Assisted Treatment for persons with Opioid Use Disorder
    - Crosses the "physical and behavioral health systems" by utilizing FQHCs and specialty BH providers
    - Utilize a hub and spoke model with Opioid Treatment Programs and Office Based Opioid Treatment providers
    - Comprehensive care management and coordination, including the sharing of data amongst participating providers
    - Robust provider staffing standards to ensure all facets of care are attended to

- **Working with LARA to Update the SUD Administrative Rules**
  - Initial discussion with LARA and the PIHPs on January 25, 2018

Inpatient Psychiatric Capacity Issues

- **Reduction in Inpatient Psychiatric Beds**
  - Community hospitals in 1993 vs. 2017:
    - **1993**: 3,041 adult beds, 729 child/adolescent beds; **2017**: 2,197 adult beds, 276 child/adolescent beds
    - **Reduction of 28% and 62% for adult and child beds, respectively (34% reduction overall)**
  - State Hospitals in 1991 vs. 2017:
    - **1991**: 29 hospitals serving 3,054 residents; **2017**: 5 hospitals serving 772 residents
    - **Reduction of 74% of residents served**

- **State Hospital Waitlist**
  - Averages **180** individuals at any given time

- **Forensic Capacity**
  - Competency to Stand Trial Evaluations
    - **49 percent** increase in court-ordered competency evaluations since 2010
    - No commensurate increase in staff/forensic examiners
  - Restoration Treatment
    - **113** IST-adjudicated criminal defendants awaiting inpatient admission for restoration treatment
    - Average wait time for admission is **93-100 days** depending on the hospital

Inpatient Psychiatric Capacity Issues (continued)

- **State Hospital Overtime**
  - June-August, 2017: number of state hospital workers with greater than 24+ hours of overtime grew from **410 to 727**

- **Inpatient Admission Denials Project**
  - Analyzing inpatient psychiatric denial data from July to December, 2017
  - All 46 CMHSPs and 10 PIHPs have been contacted
  - 26 CMHSPs have provided complete data
  - The pilot project from PIHP Region 2 showed the following (March 2016 to July 2017):
    - **31,107 denials among 1,676 patients** (average of 19 denials per patient)
    - Most common reason for denial was **"At Capacity" (81% of denial reasons)**
    - Other reasons for denial included "No callback/No response" and "Patient Does Not Fit Milieu"

State Hospital Resource Investments—Workforce

- **Expanding the Workforce**
  - Hiring 72 additional staff members at the State Psychiatric Hospitals
- **Section 1060 of PA 107 of 2017**
  - MDHHS, Legislature, and Key Stakeholders working to devise solutions to increase the workforce at State Psychiatric Hospitals and Centers
  - Researching Civil Service Rule Changes to potentially address compensation and overtime issues
- **State Loan Repayment Program (SLRP)**
  - Pediatric inpatient psychiatrists prioritized in 2018
  - MDHHS waived certain SLRP requirements to promote psychiatric provider participation
- **Telemedicine**
  - Formalized the use of telemedicine practice within community based Assertive Community Treatment to ensure psychiatric services are available

State Hospital Resource Investments—Facilities

- **Caro Center Replacement**
  - Construct a new 200-bed replacement facility for the Caro Center (50 bed net increase)
  - ***Integrated Design Solutions*** was chosen for the design and construction of a new Caro Center replacement facility
  - Design Development intended to be completed in December, 2018
  - Project completion estimated for 2021

Michigan Inpatient Psychiatric Access Discussion (MIPAD)

- **Priorities of the Short-Term Recommendations:**
  - Encouraging the Development of Specialty Units for Children
  - Addressing EMTALA Concerns in Emergency Departments
  - Standardizing Clinical Processes for Accessing Inpatient Psychiatric Services
  - Implementing Changes to Financing and Reimbursement for Inpatient Psychiatric Services
  - Developing a Psychiatric Bed Registry in Michigan

Inpatient Alternatives for Children

- **Children's Transition Support Team:**
  - Currently 32 children/youth are served representing 18 counties
  - Of the 16 youth discharged 100% remain in the community
  - No youth are in juvenile detention
  - As of January 12, 2018, a total of 81 children/youth have received CTST services
  - **Psychiatric hospital re-admission days reduced <u>60-85%</u>**

- **Hawthorn Center Transition Program:**
  - Served 52 youth with serious emotional disturbances in the past year
  - All youth have transitioned back into the community
  - **There have been no re-hospitalizations**
  - Patient and family surveys all very positive

Governor's Mental Health Diversion Council

Mental Health Diversion Council Report

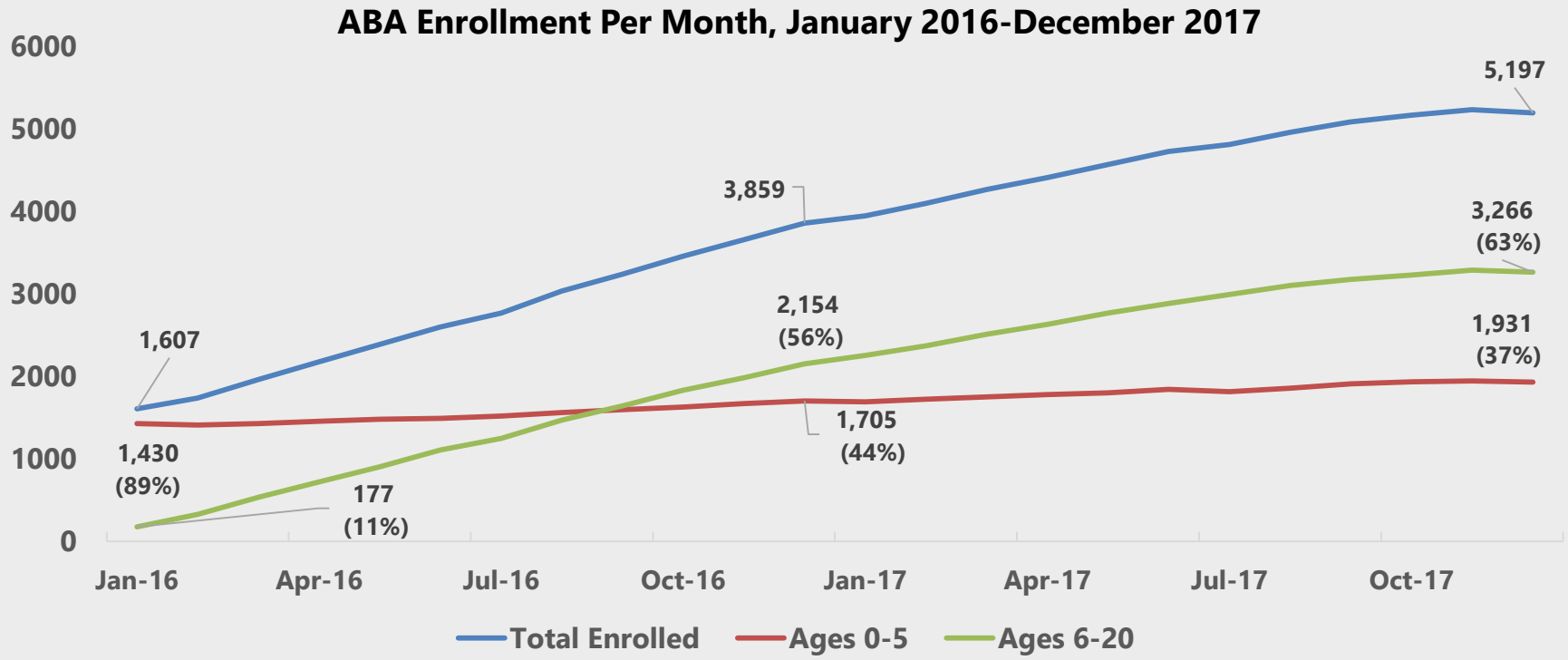
- Released on January 22, 2018:
  https://content.govdelivery.com/attachments/MIGOV/2018/01/22/file_attachments/946505/Diversion.Council.Progress.Report.pdf

- Highlights key findings and initiatives over the past 18 months, including:
  - Mental Health and Criminal Justice Strategic Planning Summit (page 14)
  - **Outcome Report on the pilots affiliated with the Mental Health Diversion Council with stats (page 7)***
  - Effective enactment of the revised Kevin's Law February 14, 2017 (page 16)
  - Michigan Juvenile Justice Assessment System (MJJAS) as the standard assessment tool being used across the state (page 9)
  - Juvenile Urgent Response Team pilots in Houghton and Muskegon (page 9)
  - Expanded law enforcement training endorsed by the Diversion Council [Managing Mental Health Crisis 2 day trainings] (page 13)
  - Crisis Intervention Team Trainings key stats from the pilots (page 7)
  - **Juvenile Justice Report on defining recidivism (page 9)**
  - Expanding initiatives from across the pilot sites (page 11)
  - MSU citing community relationships being key to pilots success (page 16)

*Diversion Pilots showed that post incarceration, **care continued at a rate *19 times* greater for CMHSP clients versus non-CMHSP clients**

Autism Services

Autism Applied Behavior Analysis (ABA) – Medicaid



- **2017 Experienced 34% Increase of Beneficiaries with Medical Necessity for ABA Services**

Autism Services: FY 2018 Initiatives

Autism Applied Behavior Analysis Workforce Capacity

- **Additional Need for Certified Behavior Analysts**
  - Medicaid has 68% (3,534) of youth eligible to receive ABA waiting for appropriate services
  - 39% (2,027) youth are receiving less ABA services than approved
  - 29% (1,507) youth are waiting to start ABA services

- **Certified Behavior Analysts:**
  - 685 in Michigan
  - 41% increase from 2016 (485)
  - Michigan is listed 10th in United States with ABA Providers

- **University Autism Contract Accomplishments**
  - Increase in number of University Autism Training Programs

Home Based and Wraparound Services

- **Home-Based Services Programs**
  - 10,240 children received home-based services*, and;
  - 31,469 children with SED were served*
  - 75 enrolled CMHSP programs

- **Wraparound Services**
  - 2,062 children with SED received wraparound services*
  - Significant clinical improvement in functioning before and after service (FY17):
    - **60 percent** improvement for children aged 0-6
    - **72 percent** improvement for children aged 7-19

*Source: MDHHS (2017). FY16 Section 904 Boilerplate Report

Integrating Behavioral and Physical Health

- **MDHHS has a myriad of behavioral health integration projects, including:**
  - MI Care Team – serving over 3,000 Medicaid beneficiaries in Michigan's FQHCs, specifically aimed at those with depression and/or anxiety in addition to a physical chronic condition
  - Opioid Health Home – pilot to serve individuals with Opioid Use Disorder in Michigan's PIHP Region 2 (described in earlier slide)
  - SIM PCMH and CHIR programs – integrating service delivery and enhancing care coordination between physical and behavioral health providers
  - Utilizing SAMHSA Block Grant funds to support integration activities within and outside of the PIHP structure
  - Partnering with the University of Michigan to continue the Collaborative Care Model focused on direct behavioral health integration
  - Developing a more robust set of contractual joint-metrics for the PIHPs and MHPs, some of which will be utilized for performance bonuses or withholds
  - Section 298 of PA 107 of 2017 – development of financially integrated pilots to provide primary and behavioral health care services through the MHPs

Other Significant FY 2018 Projects

- **Managed Care Rule Implementation**
  - BHDDA and MSA staff are working together to implement all elements of the CMS Managed Care Rule
- **Parity**
  - MDHHS planning to ensure compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA)
- **Home and Community Based Services (HCBS) Rule**
  - BHDDA in conjunction with the PIHPs have implemented a transition plan for providers of Home and Community Based Services to meet the requirements of the new federal rule
- **Electronic Visit Verification (EVV) Requirements of the 21st Century Cures Act**
  - Required compliance for Medicaid waiver programs containing personal care services by January 1, 2019
- **Veteran and Military Members Strategic Plan**
  - Embedding Regional Veteran Navigators in all 10 PIHP Regions
- **Mental Health & Wellness Commission**
  - Michigan Child Collaborative Care (MC3)
  - Special Olympics United Champion Schools (formerly Project UNIFY)
  - Project SEARCH

Governor Snyder's FY19 Recommendation

MDHHS 2019 Highlights

State Hospitals and Centers

- $1.4 M to provide an increase in base salaries for state psychiatrists

5-Year History of Major Line Item Appropriations: State Hospitals

(in millions)

Appropriation	FY 2015 Expenditures	FY 2016 Expenditures	FY 2017 Expenditures	FY 2018 Enacted	FY 2019 Executive Recommendation
Center For Forensic Psychiatry	$72.7	$71.5	$81.7	$82.8	$94.7
Walter P. Reuther Psychiatric Hospital	$49.1	$50.2	$56.9	$59.6	$57.7
Hawthorn Center	$23.4	$24.0	$29.1	$31.8	$32.2
Caro Regional Mental Health Center	$48.0	$47.3	$57.3	$59.2	$53.5
Kalamazoo Psychiatric Hospital	$59.3	$59.4	$65.7	$68.1	$69.5

5-Year History of Major Line Item Appropriations: Medicaid funded Services
(in millions)

Appropriation	FY 2015 Expenditures	FY 2016 Expenditures	FY 2017 Expenditures	FY 2018 Enacted	FY 2019 Executive Recommendation
Medicaid Mental Health Services	$2,311.3	$2,388.9	$2,337.0	$2,315.6	$2,364.0
Medicaid Substance Use Disorder Services	$47.3	$53.2	$53.4	$52.4	$68.4
Healthy Michigan Plan – Behavioral Health	$292.9	$222.6	$247.8	$288.7	$293.0
Autism Services	$40.1	$70.0	$61.2	$105.1	$199.8
Community Mental Health Non-Medicaid	$117.0	$117.0	$119.9	$120.1	$120.1

House HHS Subcommittee Alan Bolter 2-21-2018

Community Mental Health Association of Michigan

Written comments for the House MDHHS Appropriations Subcommittee
February 21, 2018

Chairman Canfield and Members of the Committee:

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

Medicaid Enrollment Trends – Shift of DAB Population

Since FY16 our members have seen a significant shift in Medicaid enrollment involving individuals identified as Disabled, Aged, and Blind (DAB) moving to Healthy Michigan Plan (HMP) & Temporary Assistance for Needy Families (TANF) programs. Our members conducted a study that showed nearly 42,000 individuals in FY16 & FY17 categorized as a DAB and are now categorized as HMP or TANF, which has resulted in nearly $100 million in lost revenue to our PIHP system.

The **base rate amount for a DAB enrollee payment is $266.90**, which includes state plan (**$135.84**) & 1915 (b)(3) (**$131.06**) (x age & gender x geographic region). The **base rate for a Healthy Michigan enrollee is $29, while each TANF enrollees is $15.28.**

It is clear between FY16 – FY17 there has been a significant **shift in enrollment of eligible DAB individuals to HMP, which has resulted in a net loss of revenue of $97,597,336.** At the same time, **between FY16 and FY17 Medicaid enrollment increased by 87,103, during that time the DAB population decreased.** Using the numbers it appears new people coming into Medicaid are being disproportionately moved into TANF or sent to HMP.

The shift of 41,775 individuals from DAB (a Medicaid program) to HMP or TANF is allowable under federal rules HOWEVER, that **assumption was not factored into the state's Healthy Michigan financial models or calculations** BECAUSE it was the **legislative and state's intent that only those adults who did not qualify for Medicare or other Medicaid programs would be covered under the Healthy Michigan Plan.** Individuals moving from HMP & TANF to DAB status is assumed in current Medicaid rates because that follows the typical enrollment patterns are individuals begin the disability determination process, however, a very small portion of enrollees shift from DAB to HMP or TANF.

According to the State of Michigan website under the Healthy Michigan Plan Program Information and History section it outlines who was intended to be eligible for HMP:

The Healthy Michigan Plan provides health care coverage for individuals who:

- Are age 19-64 years
- Have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology
- Do not qualify for or are not enrolled in Medicare

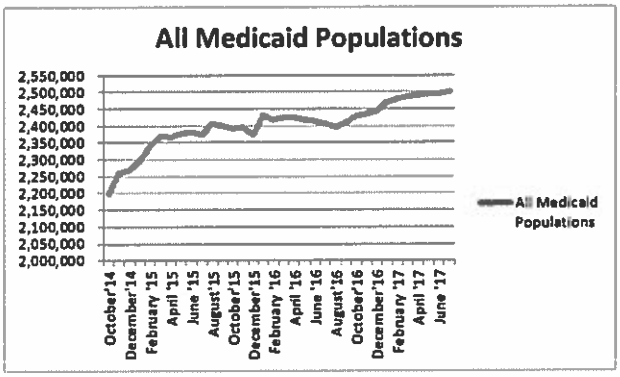
- **Do not qualify for or are not enrolled in other Medicaid programs**
- Are not pregnant at the time of application
- Are residents of the State of Michigan

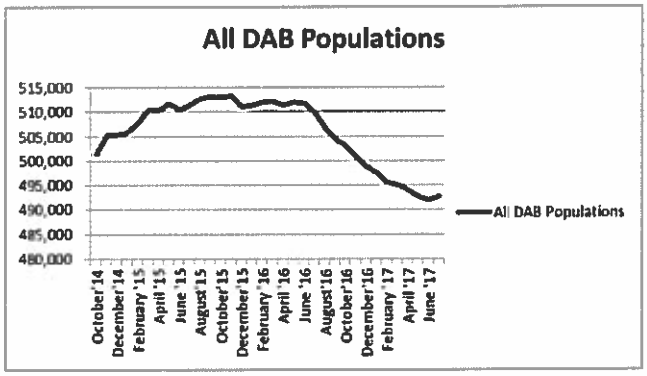
CMHAM strongly disagrees with the assertion that the gap in funding created by this migration/shift should be covered with PIHP's ISF. **Our members should not have to use their ISFs to cover such a substantial and unpredicted change.** This circumstance was **not assumed by the state nor the actuaries when they set the Medicaid behavioral health rates and is outside the normal ISF usage/function.**

- We recommend **a FY18 Legislative Transfer to close the FY16, FY17, & FY18 gaps**, we believe this can be achieved with Medicaid dollars in a **similar fashion to the Medicaid Health Plan transfer in December of 2017.**

- We recommend **the FY19 rate to more accurately reflect the change in Medicaid eligibility groups**.

- We will be recommending the Legislature include in the **FY19 budget, boilerplate that instructs MDHHS** to include, **in the FY 19 Medicaid rates paid to PIHPs, revenue to support reasonable contributions, by the PIHPs, to their ISFs, as is done with any at-risk health plan**.





Direct Care Worker Wage Increase

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

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

While we certainly support a .50 cent/per hour wage increase for these workers in the current fiscal year & proposed FY19 budget, however **the anticipated appropriations for the .50 cent increase does not cover the total cost incurred by employers.**

Besides hourly wage increase of 50¢, an employer must cover related Social Security and Medicare taxes (FICA), Workers Compensation insurance costs, Unemployment insurance costs, and overtime costs for

hours worked over 40 each week at a higher rate. Other benefits and costs are generally not wage related. In addition there are administrative costs in revising contracts and managing and assuring the cost increase goes to DCW employees. In terms of wage related cost items, the largest variability is related to workers compensation experience and the number of over forty a week hours an employer has to pay in order to meet staffing needs. Below is a chart with a rough estimate of per hour pay increase of 50¢ will result in a 66¢ per hour cost:

TABLE 3 - WAGE RELATED COST ITEMS	**PER HOUR COST**
Wage increase cost per hour	50.0¢
FICA Cost per Hour	3.8¢
Workers Comp (code 8835 using a rate of $8.18 per $100)**	4.1¢
Unemployment Insurance @ 2.7% of first $9,000 in annual earnings for each employee	1.4¢
Additional Overtime cost for 25% of Hours Worked	6.7¢
Total Estimated Hourly Cost of DCW increase	**66.0¢**
** Workers Compensation insurers use a "Modification factor" that adjusts this rate based on employer experience with some being lower and others being higher.	

The FY18 $45 million gross appropriation was not sufficient to cover the .50 cent/per hour wage increase for all identified workers and the total cost to implement the total wage increase, the revised estimate is $63.9 million, however, it is uncertain if that figure covers the employers share of the .50 cent / per hour increase. We appreciate MDHHS' clarification regarding the employer's share of FICA costs, however, **this policy still requires CMHs and providers to cover over .12 cents/per hour to implement the .50 cent wage increase, which equates to roughly a $12 million overall cost.** Below is the excerpt from a 12/14/17 MDHHS memo on Direct Care Wage Increase that outlines this policy:

> ***Employer's Share of FICA Costs***
>
> *The Appropriations Act language allows the funds to be used to cover FICA related expenses. The methodology used to allocate the direct care hourly wage increase to Prepaid Inpatient Health Plans did not directly include an identified component to cover the employer's share of FICA costs. However, the increase in the capitation payment rate attributed to implementing the direct care hourly wage increase was included in the base amount of funding for which the Prepaid Inpatient Health Plans receive on which administration costs are calculated and added to the capitation payment rate. This means that additional funds are available in the payment rate to cover the employer's share of FICA costs.*
>
> *Any additional employer costs associated with a direct care hourly wage rate increase, i.e., workers compensation, unemployment insurance, or other benefits calculated in whole or in part on the hourly wage rate paid, would be the employer's responsibility. It is MDHHS' belief that an such costs would be likely offset by reductions in staff turnover costs achieved by increasing direct care hourly wages.*

We recommend funding that covers the full cost of implementing the .50 cent direct care wage increase.

Integration – Boilerplate Section 298

While our association has expressed concerns throughout the 298 process **our members do NOT oppose healthcare integration**. Last year our we released a study that showed that **more than 570 healthcare integration efforts, led by Michigan's publicly sponsored Behavioral Healthcare and Intellectual/Developmental Disability service system (BHIDD)**, are yielding real-world benefits for patients and the state of Michigan by making overall care more cost-effective and seamless.

The report also showed that:

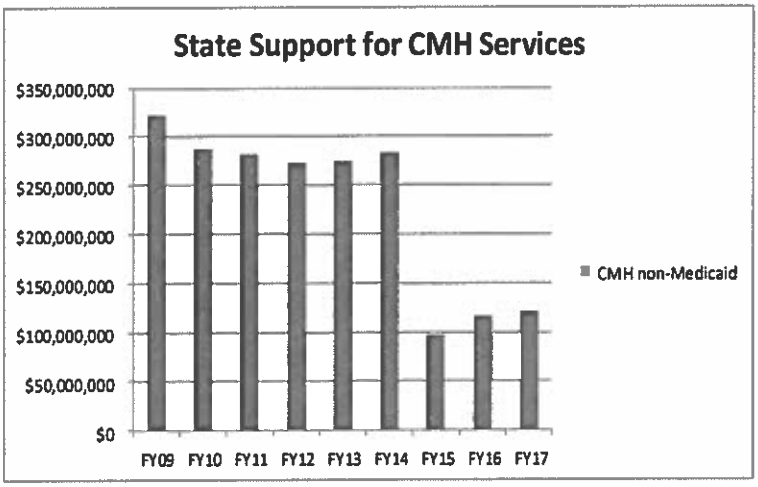
- There are now 50 initiatives with integrated electronic health records, increasing efficiency across all settings and services, creating a more person-centered care model
- There are now 42 co-location efforts occurring across the state, including either placing BHIDD clinicians in primary care clinics or placing primary care providers in BHIDD sites
- There are now 74 projects that have partnerships between BHIDD providers, payers, primary care practices, hospitals and physical health plans, in order to relieve the high number of Medicaid claim service users and overall effectively utilize healthcare resources.

Our membership believes that integration takes place at the patient level on the ground, with CMHs working hand-in-hand with FQ HCs and physician offices. We continue to **support an advocate lead 298 workgroup process** as well as the 298 policy recommendations as the basis for any structural changes.

We support improvements to the CMH system, any pilots or system changes should include the following principles:

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

CMH Non-Medicaid Services (General Funds)



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

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

Section 994 Administrative Burdens (Deemed Status)

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

Deemed status for CMHSPs, PIHPs and provider organizations that have full accreditation by a national accrediting body would reduce their and the state's administrative costs, reduce these duplicative state reviews and move towards a less complicated system. Our neighboring states, Illinois and Ohio both have adopted deemed status models, in fact the state of Illinois found about a 40% redundancy rate between the accrediting bodies' reviews and state reviews. It will enable us to redirect funding from these administrative costs to support more services in the community.

Local Match

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

Last year, the House and Senate included subsection (2) which would direct the department to reimburse the local funds back to the CMHs if Medicaid funds are lapsed in FY18. Those local dollars are used to draw down Medicaid funds, if those Medicaid funds are not completely used those local funds should be returned to the CMHs, not the state. **We are requesting enforcement of section 928 boilerplate language that was included in the FY18 budget as well as a report from the department on the status of this section and further request that the language be added to the FY19 budget.**

Respectfully submitted,

Alan Bolter
Associate Director
Michigan Association of Community Mental Health Boards

House HHS Subc. Robert Stein 2-21-2018

MALA
MICHIGAN ASSISTED LIVING ASSOCIATION

February 21, 2018

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

Re: 2018-19 Michigan Department of Health and Human Services Budget

Dear Representative Canfield:

Michigan Assisted Living Association (MALA) appreciates the opportunity to provide testimony regarding services funded through the Michigan Department of Health and Human Services (MDHHS) budget. Our organization's members provide a broad range of supports and services to over 40,000 persons throughout the state. The persons served include individuals with intellectual and developmental disabilities, mental illness, substance use disorders, traumatic brain injuries or physical disabilities and older adults.

Continuation of the Direct Care Worker Wage Increase

MALA is most appreciative of the support from the Snyder Administration and the Michigan Legislature for the $0.50 per hour direct care worker wage increase which became effective October 1, 2017. We urge that this wage increase continue to be funded in the 2018-19 MDHHS budget. The current staffing crisis results in severe challenges in the recruitment and retention of direct support staff to provide Medicaid mental health services throughout the state. The services consist of community living supports, personal care, skill building, supported employment and other Medicaid mental health services.

It is important to note that there have been challenges with the implementation of the $0.50 per hour wage increase as outlined below.

- In many instances throughout the state, there have been significant delays in the distribution of the funding for the wage increase to the Providers of mental health services.

- According to MDHHS guidance provided to the PIHPs, the funding distributed to them is intended to cover the cost of the $0.50 per hour wage increase and the employer's share of FICA. Depending upon whether a particular service is funded on a per diem or a unit rate such as hourly, the funding may not cover the full cost of the wage increase. Providers also have substantial additional employer costs related to the wage increase other than FICA including unemployment insurance, worker's compensation insurance and overtime.

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MALA recommends that sufficient funding be appropriated for the full cost of implementing the $0.50 per hour wage increase including the employer costs referenced above. It is not clear that the revised estimate of $63.9 million for this wage increase is sufficient.

Workforce Data and Challenges

The staffing crisis in the provision of mental health services is based in large part upon the low wage levels for direct support staff. The most recent Michigan-based data from August 2016 included a statewide survey finding for direct support staff of on average $9.30 per hour for the starting wage and $10.18 per hour for the overall wage. The survey findings also included an average turnover rate of 40%. We are hopeful that the $0.50 per hour wage increase will have at least some impact upon the staffing crisis. Nevertheless, it is obviously difficult for Providers of mental health services to compete with large retailers and other employment sectors.

National Perspective on the Workforce Issues

The direct support staffing crisis persists throughout the country as indicated in the Report to the President 2017: America's Direct Support Workforce Crisis from the President's Committee for People with Intellectual Disabilities. Attached to this testimony is the Executive Summary of the Report to the President 2017 which outlines the current staffing crisis and includes several recommendations.

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

Robert L. Stein
General Counsel

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

EXECUTIVE SUMMARY

People with an intellectual disability (ID) rely on Direct Support Professionals (DSPs) for daily support that enables them to live in U.S. communities. Their families rely on the DSP workforce to provide reliable quality support so they can work and have respite from the day-to-day stressors of caregiving. Challenges in finding, keeping and training this workforce persist and have reached crisis levels in the long-term services and supports (LTSS) industry.

The direct support workforce is one of the highest in demand in the U.S. The expansion needed in this workforce is unlikely to take place without significant changes in how direct support professionals are recruited, trained and supported. The pipeline for people entering the Direct Support Profession is not keeping pace with the number of DSPs needed by Americans with ID and their families. Low wages, scant benefits, limited training and lack of career advancement opportunities have led over the past 30 years to the following nationwide results:

- average DSP wages of $10.72 per hour
- average DSP wages below the federal poverty level for a family of four
- half of DSPs relying on government-funded and means-tested benefits
- most DSPs working two or three jobs
- average annual DSP turnover rates of 45 percent (range 18–76 percent)
- average vacancy rates of more than 9 percent

This currently untenable crisis stems from the following factors:

- high staff turnover;
- growing demand for services due to the growth and aging of the U.S. population in general;
- increased survival rates for people with ID;
- demographic shifts resulting in fewer people moving into the DSP workforce;
- persistently non-competitive aspects of direct support employment, including low wages, poor access to health insurance, and lack of paid time off (PTO) and other benefits;
- high stress and demands of direct support employment, including round-the-clock, seven-days-a-week work;
- insufficient training and preparation for DSP roles; and
- lack of professional recognition and status for skilled DSPs.

Not only does the DSP crisis impact individuals and families, but it is also extremely costly to the human services system and the overall U.S. economy.

These realities put people with ID who need assistance at great risk of harm, contribute to unreasonably long waiting lists for services and are leading many people to reconsider more expensive institutional models of segregated care outside their home. The direct support workforce and the service system that supports it are in a crisis that will result in catastrophic outcomes for people with ID and their families unless significant and immediate responses are implemented.

Solutions to the direct support workforce crisis are critical to ensuring that people with ID can live, work and contribute to their communities. Such solutions are also important because of their significant economic implications. Simply put, responding to the direct support workforce crisis makes economic sense.

Over the past two decades, small-scale efforts have been made to find solutions, with small investments provided by federal, state and local governments. Most of these efforts have been grant-funded demonstration projects that don't prove fully sustainable after the grant funding ends. Practices that would address the workforce crisis include:

- improving professional identity and recognition;
- teaching business and organization leaders skills to improve their ability to recruit, select and retain direct service employees;
- using self-directed services that permit individuals and families to recruit, select and retain their own DSPs;
- using worker cooperative and independent provider models;

- using competency-based training models that lead to credentialing or certification of staff and yield wage increases; and
- using technology-enhanced supports.

Finding solutions to this crisis requires bold leadership and commitment from the Administration and its many federal agencies with important roles to play in keeping promises made to persons with ID. It will also require bipartisan action on the part of Congress. The direct support workforce is where the rubber hits the road in the LTSS industry, and there is no issue more pressing in regard to sustainability of service provision for people with ID than responding to the serious crisis it now faces.

RECOMMENDATIONS

This direct support workforce crisis has been coming for decades. Policy makers and their allies have been slow to make finding and implementing solutions a priority. It will take courageous leadership within the Administration and Congress to fund and ensure implementation of targeted solutions to address this crisis. Without bold and swift action, the LTSS system is threatened for all people with ID who rely on it to meet their most basic needs. The President's Committee for People with Intellectual Disabilities encourages the Administration to consider the following Recommendations as possible contributions to resolving the direct support workforce crisis. We urge that the actions and programs presented here be developed and implemented, and that their outcomes be evaluated.

1. The U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services should ensure through review of Home and Community-Based Services Waivers or regulation that states include sufficient Direct Support Professional wages and compensation packages in their rate-setting methodologies for long-term services and supports to people with intellectual and developmental disabilities.

2. The U.S. Department of Health and Human Services, Administration for Community Living should provide technical assistance and financial or programmatic incentives to states to promote the use of technology solutions in long-term services and supports, such as remote monitoring, sensors, robotics, and smart homes, to create efficiencies, reduce costs and support community living for people with intellectual disabilities.

3. The U.S. Department of Health and Human Services, Administration for Community Living should provide funding to states through grants and contracts to develop, implement and evaluate comprehensive programs designed to provide training and technical assistance to employers that focus on improving business acumen to reduce Direct Support Professional vacancy rates, improve retention and promote efficient, high-quality long-term services and supports for people with intellectual and developmental disabilities.

4. The U.S. Departments of Education, Health and Human Services, and Labor should create grant programs and financial incentives for states to expand the pool of Direct Support Professionals through recognition programs, grassroots campaigns and training efforts designed to expand awareness about the profession and encourage greater participation by people with disabilities, men, retirees, and young adults across diverse racial, ethnic and cultural groups.

5. The U.S. Department of Health and Human Services should work with states to expand utilization of self-direction in long-term services and supports so that family, friends and neighbors can be hired as Direct Support Professionals.

6. The U.S. Department of Labor through the Bureau of Labor Statistics should investigate ways to recognize "Direct Support Professional" as a distinct occupation title and provide routine labor statistical reporting on this occupation.

7. The U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) should ensure through regulation and review of Home and Community-Based Services Waivers that states identify provider qualifications that recognize Direct Support Professionals as skilled practitioners who are community navigators, facilitating greater community and economic involvement for people with intellectual and developmental disabilities. Additionally, CMS and states should

ensure that compensation rates are aligned with appropriate status, value, respect, a living wage and benefits.

8. The U.S. Department of Health and Human Services, Administration for Community Living and Centers for Medicare & Medicaid Services should develop federal standards and work with the Department of Labor to implement specialized credentials and professional development opportunities for Direct Support Professionals, ensuring: (a) that people with intellectual disabilities are trainers and mentors, (b) that programs are focused on competencies specifically identified for DSPs, (c) that completion of training to meet standards is voluntary and occurs post-hire, and (d) that the credentials result in increased wages and access to benefits for DSPs.

9. The U.S. Department of Labor should engage the broader American workforce system to find solutions to this crisis by using community colleges and American job centers to develop and invest in career training and credentialing for Direct Support Professionals.

10. The U.S. Department of Health and Human Services and the U.S. Department of Labor should engage the business community and provide grants and other incentives to states to develop online matching registry services and other creative options to match people with intellectual disabilities and their families who need help finding available DSPs.

House HHS Subcommittee
2-21-2018

House of Representative Hearing Testimony

February 21, 2018

Barbara Fowkes
320 W. Huron Street
Milford, MI 48381

Spectrum Community Services – Executive Director
28303 Joy Road, Westland Michigan 48185

House of Representative Subcommittee Members:

My name is Barbara Fowkes and I am the Executive Director for Spectrum Community Services, a non profit Human Service agency. Spectrum Community serves over 700 children and adults with intellectual and developmental disabilities including autism, and mentally ill adults. We provide these individuals in a variety of services to include: direct care in residential settings and personal homes, support coordination and enhanced health services. We provide these services throughout the state to include: Antrim County, Berrien County, Kent County, Manistee and Benzie County, Mason County, Missaukee County, Oakland County, Otsego County, Washtenaw, Wayne, and Wexford Counties. I am here today on behalf of the people I employ and the people I serve.

I first want to thank you for your acknowledgement of the state's staffing crisis and the legislative pass through $.50 hourly pay increase for the people

knowing if they will be able to go home at the end of their shift. We provide 24/7 residential services in most of our sites so staffing is required around the clock. If staff calls in for the shift, then some one has to stay and work; either the home manager or the staff on shift.

I have been providing services to people with disabilities for more than 45 years. I have dedicated my life to help and advocate for our most vulnerable citizens. For the last 37 years I have worked for Spectrum Community and have worked at all levels of the agency. Finding people who want to work in the human service field is getting more and more difficult at the direct care level and management level. Our state continues to be at a critical point in providing good quality services because of the over worked employees and the inability to hire new employees to relieve our existing employees. Our staff wants to do a good job and they do enjoy working with our individuals but they are tired. We continue to need your help to fix this problem by increasing wages, address the DAB and Healthy Michigan Medicaid funding issue and look at recognize direct care workers by allowing for an associates degree or a state accreditation for the training and education they receive to provide the services they have been trained in to do so.

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

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

House HHS Subcommittee Sean Bennett
2-21-2018

TO MICHIGAN HOUSE HEALTH AND HUMAN SERVICES APPROPRIATIONS SUBCOMMITTEE MEETING
2-21-18 PUBLIC TESTIMONY ON BEHAVIORAL HEALTH

MCL 330.1401d should be repealed and MCL 330.1718 revised to ensure the right of informed consent for psychiatric drug prescribing (especially regarding "Antipsychotic drugs"-APDs). This is necessary to correct unconstitutional policies and practices, to protect the health and safety of recipients, and to reduce wasteful spending on fraudulent and harmful drugs.

Uncorrupted evidence-based medicine establishes that non-consensual psychiatric drug prescribing is not only medically and constitutionally inappropriate, it is medically and constitutionally abominable. Psychiatry's leading drugs have actually caused an increase in suicides and violence, a worsening of mental illnesses, a worsening of quality of life, psychological distress, impairment, and disability, and increase in patient deaths, and numerous serious physical harms. The MH Code should be reformed to recognize that persons who object to psychotropic drugs (especially APDs) don't prove that they lack understanding, they prove medical fraud. Uncorrupted medical science shows that the only persons incompetent regarding APDs is the Doctors who prescribe them.

These drugs are a substandard product whose benefits and harms are misrepresented by doctors and corporations. The legislature ought to be studying how fraud, false claims, bribery, kickbacks, conspiracy, racketeering, obstruction of justice and other laws can be brought against psychiatrists, psychiatric drug companies and other doctors who prescribe these drugs, instead of encouraging them to assault the minds and bodies of our most vulnerable citizens. Michigan is the only state to have a false claims act overridden by a drug company immunity statute. A recent study co-authored by a past president of the American Psychiatric Association, Dr Jeste, stated that because of risk of harms and lack of benefits APDs should not be prescribed to person over 40 years old. The legislature's mental health reform should strive to enhance quality not coercion.

The biggest health care fraud cases in US history have involved psychiatric drugs (Risperdal, Zyprexa, Seroquel) or drugs used on psychiatric patients (Depakote, Neurontin). These cases, prosecuted by the US govt., have shown doctors' prescribing judgment is all too corruptible. Psychiatric drug prescribing is dominated by thinly disguised bribes, kickbacks and misinformation from the drug industry. Editors of the most prestigious medical journals are horrified at the extent of drug company fraud and corruption that controls psychiatric drug prescribing. Many books have been written explaining drug company corruption by past employees, and many employees have filed False Claims Act cases revealing the extent to which the industry puts profits above patients health. Psychiatrists are already biased to prescribe drugs because they are out of business if they don't. The subjective and inexact nature of psychiatric science partly explains why drug companies spend more money to get them to prescribe than any other specialty. The former CEO and medical director of the American Psychiatric Association, Dr Scully, says that the amount of money being paid by big Pharma to psychiatrists to prescribe "boggles the mind".

The right to informed consent should be protected not just because of deficiencies, biases or corruption in psychiatric judgment. Informed consent is based on the values, experiences, preferences, feelings, goals, opinions, beliefs, knowledge, philosophy and religion of the individual. It cannot be replaced by a doctor without an invalidation of personhood.

Thank you,

Sean Bennett
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