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To: Senate Sub-Committee on Appropriations for MDHHS,
Senator Whiteford, Chairperson

From: Dohn Hoyle, Public Policy Director, The Arc Michigan

Date: 11/6/2019

Re: Testimony on Public Mental Health System

Thank you Chairperson Whiteford and member's of the Sub Committee

My name is Dohn Hoyle. I have the privilege of serving as the Director for Public Policy for The Arc Michigan. I offer this testimony on behalf of our 30 local Chapters across Michigan, our thousands of members and Michigan's citizens with developmental disabilities, their families and friends.

In my nearly 5 full decades of working for this organization at the local and then at the State level I watched and actively pushed for Michigan to move from its nearly total reliance on State Institution and deplorable conditions to support persons with developmental disabilities to get lives in their communities. It is a testimony to you, your predecessors and all others who helped Michigan to a preeminent position nationally.

As an aside, In my career I have been fortunate to have consulted and worked with many nonprofits, advocacy organizations provider and governmental entities. I have worked in almost every state, including Arizona. I don't know anyone who would hold Arizona out as a place where persons with developmental disabilities get the type or quality of service they should aspire to.

Our testimony:

- Unless we make a <u>significant</u> investment in the direct care workforce, it won't matter how you arrange the deck chairs, this ship will go down. It is imperative we address the current inability to attract and maintain staff so critical to those the system serves.
- Our agency worked with our states legislative and executive branches to establish managed care for Medicaid, specialty supports and services through mental health in the late 90's. Among the reasons we did so was the slow the rate of growth of Medicaid expenditures for same. What we're experiencing more recently is both an erosion in funding for non-Medicaid General Funds and a gradual starving of the Medicaid funding for the system. We have not kept up with real inflation or increased needs. These clear shortages must have a response.
- Integration, It's crucial that certain things be understood in any discussion of this subject.
  <u>First,</u> the supports and services people with developmental disabilities and mental illness need and receive from the mental health system, each and every day, are not medical. They range from the supports some people need to prevent them from running into traffic to those some need to transfer from their wheelchair to bed or anywhere else. They can include tasks as disparate as attending to personal hygiene or job coaching. With the exception of the psychiatric benefit, these supports don't fit the Medical Model or have any relationship to medical services. Health Plans have no special knowledge and

little if any experience which would be useful. The real experts are in the current public mental health system.

Second, not considering the "unenrolled population" when considering integration would be extremely limiting, further bifurcate the current system and lead to more administration. The current conservative estimate is that some 25% of the these currently served by the system and 40% of the Medicaid spent in the system could not be integrated in the fashion we've been asked to consider. In other words, one quarter of those served by the system, including many of those most expensive, won't/can't be placed in Health Plans by virtue of being eligible for Medicare.

When Michigan received dispensation to automatically enroll some of those people in the Dual Eligible Pilots, for testing purposes they were then forced to affirmatively opt out. Which they did in droves. Evidently, they did not want the Health Plans to manage their health care.

It strikes me there are a couple of lessons learned here. At least one of them should be: Two new systems, using different rules and with different players and two administrations, is not a logical answer.

Third, we currently have a "system" in place which secures the goals of "integration" and addresses what are currently called social determinants. Persons with developmental disabilities, currently served by the systems, 97-99% have a primary care physician (medical home), receive annual check-ups and far better preventative care than the general population. Their hospitalization rate is less than half that of the general population, according to Medicare.

In addition, people with developmental disabilities have someone whose responsibilities include those other aspects of their lives which impact their health and well-being. Supports, Coordinators, Case Manager for persons with developmental disabilities, have a job description which includes coordinating supports for the whole person not just those supports paid for by mental health.

While caseload size and the cyclical nature of some persons disability are some of the difficulty in generalizing, there is a model we can point to for examination. We commend it to you (We find it superior to asking Health Plans to address either the non-medical support people need or the Social Determinants.)

- We are asking for change. We are experiencing a real disparity in what's available from one place in Michigan to another. The availability of and quality of what is provided under the guide of Person-Centered Planning is incomprehensible, unexplainable and unacceptable. While we have models which we can proud of in some places, in others it's as though it hasn't been in statute since 1996 and isn't a Medicaid requirement. We are calling upon you to help us insist that the law, the rules and the contracts with PIHPs, CMHSPs be

enforced. Please also join us in insisting that Self-Determination is available no matter where you live in Michigan. We can't permit some CMHs to say "we don't do that here". That there is no consequence for either of these disparities, it can't continue. We need change. Either make the PIHPs responsible and remove CMHs from governance or reduce their role and number. We join the questioning of the need for 46 CMH entities.

We appreciate this opportunity and ask further future involvement.