

Testimony of Mark Reinstein, Mental Health Assn. in Mich.
Senate Judiciary Committee - September 9, 2014

Senator Jones and Members of the Committee,

I'm Mark Reinstein, President & CEO of the Mental Health Association in Michigan, the state's oldest advocacy organization for persons experiencing mental illness. We're affiliated with Mental Health America and partly funded by United Ways.

I thank Senator Caswell for introducing SB 1011, and I appreciate the opportunity to give input about the bill today.

Mental illness in settings of incarceration is a huge problem. When Wayne State University studied three Michigan jails in the late '90s, the prevalence of severe mental illness was 34%. When U-M examined state prisons about five years ago, more than 20% of inmates had symptoms of severe mental disability. And DHS reports high levels of mental illness at the three state-operated juvenile justice facilities, with a U-M study presently underway to get prevalence levels for private facilities contracted by DHS.

State officials and law enforcement have been clear that many inmates with mental illness are or could be made eligible for Medicaid. But one of the confounding factors with correctional response to mental illness is that federal Medicaid rules prohibit reimbursement of on-site health care services to inmates. Historically, this was a disincentive for worrying about or keeping up with Medicaid status of prisoners with mental illness.

But over the past decade or so, everyone has realized this inattention was a mistake. If a prisoner has to go off-site for a psychiatric hospitalization and the facility involved is part of Medicaid, we're needlessly spending Michigan taxpayer dollars when we aren't in position to access Medicaid. More significantly, if we're not up-to-date on Medicaid status, someone released from custody could have to go through an extended period of eligibility determination. While that is happening, the released individual's community services have to be fully paid by state and local government, if those entities can even afford to do that on their own. And make no mistake, persons with mental illness who are released from custody will need community services in order to have a chance of making it. In the critical area of medications alone, most inmates with mental illness will leave incarceration on medications that control or reduce their symptoms. If those medications stop in the community because state and local government can't bear the full cost of them, we are looking at a complete return of symptoms, a deterioration of health, and the return of risky behaviors likely to lead to new trouble with the law and re-incarceration. That is a human and societal toll we can and should do something about.

For several years now, the federal government has recommended that states suspend, but do not terminate, the existing Medicaid eligibility status of incoming inmates. And the professional literature is filled with the need to assess Medicaid eligibility of inmates who didn't enter already enrolled, and to make sure that annual redeterminations of inmates with eligibility are conducted.

If we were able to do these things, we would improve health outcomes for persons who have been incarcerated; we'd lessen their potential to be long-term cost drains for society in multiple ways; and the federal government would be paying the vast majority of their mental health treatment costs via Medicaid.

While the Departments of Community Health, Corrections and Human Services have all been sympathetic to this situation – and have stepped up their efforts regarding inmates and Medicaid – Michigan still lacks overarching and ongoing high-level state policy on Medicaid suspension rather than termination for inmates with mental illness. This is not dealt with in the state's Medicaid Plan, nor is it addressed in the state's Medicaid Provider Manual. We have had positive budget boilerplate on this for the last 5-6 years, but boilerplate is only good for a year at a time, and what we've had has primarily focused on state prisons, leaving out jails and juvenile detention.

SB 1011 would give us permanent, clear state policy establishing that:

- 1) The Medicaid status of an inmate with mental illness who entered incarceration with Medicaid coverage, or was found subsequently eligible for it while incarcerated, shall be suspended but not terminated.
- 2) An inmate with mental illness who possesses Medicaid eligibility and enrollment shall have his or her status periodically reassessed as required by federal law so that Medicaid eligibility isn't lost for want of such redetermination.
- 3) The suspension of a mental illness inmate's Medicaid coverage shall be immediately lifted upon his or her release or upon going off-site while incarcerated for a needed health care service.

SB 1011 is a common-sense, win-win approach for everyone that facilitates quicker access to care for vulnerable individuals at a reduced cost to Michigan taxpayers. It would also assure that if any future administration wanted to undo the bill's particulars, the Legislature would have a say in the matter. Further, the bill is highly consistent with the latest plans of the Governor's Diversion Council. In material released last month, the Council has the following as an objective under the heading of maximizing benefit eligibility for the incarcerated: "Eliminate Medicaid termination while incarcerated in Jail or prison." As an outcome or "deliverable" for this, the Council wrote, "Draft statute or other proposed solutions (e.g., Medicaid State Plan or Provider Manual Amendment)." SB 1011 covers two of these three options by establishing in statute that the State Medicaid Plan shall be amended.

This would render unnecessary the third (and probably least desirable) option mentioned by Council – i.e., amending the Medicaid Provider Manual.

We respectfully urge that the Committee report SB 1011 to the full Senate. Thank you for your thoughtful consideration of our views.