

# **MICHIGAN DEPARTMENT OF COMMUNITY HEALTH KEY ISSUES UPDATE**

Michigan Association of  
Community Mental Health Boards  
Conference  
February 23, 2010

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## **FY11 Executive Budget Recommendations**

- ◆ PIHP-FY11
  - Actuarial rate adjustment of 3% (matches health plans)
  - Medicaid enrollment increases-FY10 about 5.3%; FY11 about 2.9%
  - Freeze on C waiver enrollments-\$8.6 Million; about 300 waiver slots
  - HRA-Community Inpatient – increased by about \$15 Million (net of use tax)

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## FY11 Executive Budget Recommendations

- ◆ CMH Non-Medicaid
  - \$3.8 Million Administrative Reduction: 9% based on estimated non-Medicaid administration of \$42 Million
  - Application method for reduction undetermined; DCh will establish a work group of CMHSP representatives
- ◆ Other GF
  - Multicultural Services reduction of 20% (\$1.4 M)
  - \$3.8 Million reduction in Substance Abuse
    - ◆ Including elimination of the remaining State Disability Assistance Program funds
  - DCH administrative reductions, in addition to early retirement savings of approx. \$100,000

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## Considerations

- ◆ Continue to look to shared functions and consolidations as a means to achieving savings
- ◆ Support opportunities in PIHP affiliation arrangements
- ◆ Reductions in administrative burden and requirements is intended recognizing these may require DCH action
  - A work group to explore methods of reducing administrative demands will be established in April

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## State Employee Early Retirement

- ◆ Statewide, 7,900 are currently eligible and about 85%-- are expected to retire
  - Those eligible are the most experienced and comprise much of the management structure
- ◆ Current proposal would allow one replacement for each two retirees
  - except 1:1 replacement for “direct care” in state operated hospitals and centers
- ◆ Of the hospital/center workforce, 18% are eligible to retire; including all the hospital/center directors
- ◆ At Reuther, the percent eligible is almost 30% and Hawthorn about 25%
- ◆ In central DCH operations, more than half of the management team is eligible

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## OTHER ADMINISTRATION ISSUES

- ◆ 1915(b) waiver renewal discussions continue with CMS
- ◆ Children’s Waiver renewal work is commencing
  - CMS is requiring a reduced federal match for administrative costs not part of direct service delivery
- ◆ Habilitation/Supports Waiver renewal process is under way
  - Principles and practices of consumer self-direction will be incorporated with this renewal
  - These will more fully coincide with our Self-Determination Policy & Practice Guideline
- ◆ Adult Benefits Waiver renewal implementation

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## ADULT BENEFITS WAIVER

- ◆ Medicaid 1115 waiver was approved effective 1/1/2010;
- ◆ Remains full risk arrangement
- ◆ Inclusion of inpatient benefit requires use of the PIHP structure
- ◆ Intend to manage through one structure vs CMHSP/CA given BBA and PIHP requirements
- ◆ "General" work group planned to begin meeting week of February 22; service benefit work group shortly as well

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## ABW...Implications

- ◆ BBA requirements apply; use tax applies
- ◆ Requires actuarially certified rates...considering regional factors to bring rates closer to expenditure history....may affect those CMHSPs routinely under-spending ABW revenue
- ◆ State may impose amount, scope and duration limits
- ◆ ABW enrollment frozen for FY10; FY11 exec budget supports approximately 50,900 average
- ◆ Many implementation issues remain to be resolved; but, MI must submit contract, rate and benefit information by late March...

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## CHILDRENS SERVICES

- ◆ Collaboration with DHS Child Welfare Services
  - DHS is driven by the Children's Rights Lawsuit consent agreement
  - SED Waiver
    - ◆ Initially in five pilot Counties: Saginaw, Ingham, Oakland, Macomb, & Kalamazoo beginning in September
    - ◆ Expansion counties: Wayne, Genesee & Kent
    - ◆ Supports CW wards in out-of-home placements, to be supported in a home setting (natural or foster care) using wrap-around services
    - ◆ Child must be deemed to otherwise, in need of inpatient psychiatric hospital care
  - Examining the feasibility of utilizing ~ \$4.0 M in DHS funds to expand wrap-around services outside of the SED waiver to support additional children, not at the threshold of needing hospital care, to move to a home setting
    - ◆ Lots of complications but the partners commitment to pursue this is strong
  - Discussions continue on modifying the DHC local services contracting process to support expanded contracting with CMHSPs for local DHS-funded counseling services

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## SYSTEMS OF CARE DEVELOPMENT

Systems of Care must embrace family-driven and youth-guided services. This means:

- ◆ Providers take initiative to change policies and practices, moving to family-driven and youth guided approaches to service planning and delivery
- ◆ Providers and administrators embrace the value of shared decision-making and responsibility for outcomes with families and youth
- ◆ Transparency means parents, caregivers and youth are provided accurate, understandable and complete information necessary to set goals and make informed service delivery choices
- ◆ Parent support partners and youth peers work as support aides, advocates and service system navigators with involved families and youth

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## **FAMILY-DRIVEN AND YOUTH- GUIDED**

- ◆ Next week, we will issue a draft policy for 30-day review & comment detailing the expectations for achieving a family-driven and youth-guided orientation and operations in emerging systems of care
- ◆ Our System of Care demonstration sites: Kalamazoo, Ingham, Wayne (Southwest Solutions) and Network 180 (Kent) incorporate these practice principles into their evolving interagency efforts
- ◆ With the involvement of families and youth, including those who serve as parent support partners and youth peers, our focus on strength-based planning will improve, and the level of hope and the expectation of success will better permeate the work done to assist families and children who come to the mental health system for assistance

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## **RECOVERY TRANSFORMATION**

- ◆ Substance Abuse: Recovery-oriented System Of Care development
  - Steering committee
  - Major transformation with federal support
- ◆ Recovery Council
  - Recently completed a visioning and strategic planning process
  - Council aims to become more independent from DCH; more self-sustaining
  - Council will take the lead in developing a policy on recovery which will improve recovery guidance and will set benchmarks for recovery transformation
- ◆ We are watching for the conclusion of the REE scans
  - They provide feedback to all on the transformation process
- ◆ Recovery continues to be central to system transformation and redesign

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## EMPLOYMENT

- ◆ Employment is an essential element to enhance quality of life; moreover, it is the best route to greater independence
- ◆ Our data shows that we have been “flat”, or have even lost ground when it comes to consumer employment
  - Not due to the economy; this was occurring beforehand
- ◆ Our goal: ***Each individual will be supported to pursue his or her own unique path to work and a career. All individuals will be afforded an opportunity to pursue competitive work***
- ◆ Our expectation: ***Each time a Person Centered Plan (PCP) is developed or reviewed, a person’s options for work must be discussed and included in the PCP***

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## EMPLOYMENT

- ◆ Initiatives underway
  - ***New Agreement between DCH, MRS, and MCB to improve collaboration leading to more consumer employment***
  - ***New 2-Year CMS grant – Michigan Comprehensive Employment Services Grant (formerly MIG) to create Leadership Council and Strategic Plan to increase employment for persons with disabilities***
  - ***Working with the State Employment Leadership Network to learn what has worked in other states that may assist us in Michigan***
  - ***Regular meetings/work with key CMHSPs (Recharging Consumer Employment) and Supported Employment Evidence Based Practice Group***
  - ***Follow up with PIHPs/CMHSPs in response to ARR submission regarding consumer employment***

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## FORMER MT. PLEASANT RESIDENTS

- ◆ As of September 10, 2008, 110 of the 120 ICF/MR eligible MPC residents had transitioned to community living
- ◆ Overall, the individuals who transitioned continue to experience successful community living and an improved quality of life
- ◆ Ten individuals were moved to Caro Center, and two individuals who had been former MPC residents were admitted to Caro
  - Transition plans to support successful community living exist for all
  - These are not the 'most difficult' of the former MPC residents; only the ones who were not transitioned by their local CMHSP as of yet
  - A meeting is scheduled for March 3 with the remaining CMHSPs with individuals in Caro
  - PIHP lead CMHSPs are being asked to participate, since these are MA eligibles
- ◆ A few who transitioned required short-term hospitalization or support from the Michigan Center for Positive Living Supports, but most have been short-term

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## CENTER FOR POSITIVE LIVING SUPPORTS

- ◆ All but one CMHSP have a signed agreement with the MCPLS
- ◆ Center staff have conducted numerous training sessions, with providers and CMHSP staff
- ◆ The Center has provided consultation on a dozen individuals, including
  - On-site consultations
  - Mobile crisis team in seven situations
  - Crisis assessment unit has been utilized once, and will be utilized a second time starting this week
  - Feedback from CMHSPs and providers using the crisis support services have provided very positive feedback
- ◆ The Center will be involved in supporting four or five of the remaining residents during their transitions
- ◆ As the Center completes work on former PC residents, there should be an expanded capacity to assist with other crisis support needs in community settings

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## ENHANCING COMMUNITY CAPACITY

- ◆ Code requires that we prioritize services to those with the most severe impairments and those in urgent and emergent situations
  - Culture of Gentleness is the defining approach
  - Community integration and the opportunity to live in the world continue to define the desired outcomes
  - Our emphasis must be on those most vulnerable
- ◆ We cannot succumb to the apparent efficiency of re-institutionalizing individuals with developmental disabilities
  - Over 1700 individuals (7%) reside in specialized residential care settings of 7 or more beds, and many of these reside in settings of 12 or more
  - If we are not attentive, we will find ourselves the subject of lawsuits, because we have failed to assure the right of individuals with disabilities who require government support to live in the world, not apart from it
- ◆ Grouping individuals with developmental disabilities in segregated, large settings is not a Best Practice
- ◆ We need to address our practices and improve
  - It cannot be ignored because of capital investments
  - It cannot be ignored because of labor issues
  - It cannot be ignored because we do not know how to improve our practices
  - It cannot be ignored because we have inherent attitudes toward individuals with DD, that they are “second-class” citizens; that they are not worth the extra investment

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## IMPROVING SUPPORTS FOR VULNERABLE INDIVIDUALS WITH DD

- ◆ Improve the Person-centered Planning Process
- ◆ Improve the culture of the support environment
- ◆ Improve the ability of PIHPs, CMHSPs and providers to develop residential alternatives that support the right to live in the world
- ◆ Assure that a PIHP or regional Safety Net, and a state level Safety Net are available
- ◆ Increase the frequency and improve the focus of monitoring of vulnerable individuals at all levels (MDCH/PIHP/CMHSP)
- ◆ Improve the immediate reporting, and coordination of information about crises
- ◆ Improve the reporting of the outcomes about the individuals served

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