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Financial and Statistical

Analysis of Oakland CMH Services

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NOTE- This information was first developed in June 2014 and has been distributed to officials with the State of Michigan and included OCCMHA Director Willie Brooks, Jr.. It has been updated with current data.

Attached is a summary of several key issues which are part of what has been an increasingly serious problem for our agency in the supporting of people with intellectual/developmental disabilities through the Oakland County Community Mental Health Authority (OCCMHA). MORC has contracted with OCCMHA since 1996. As you know, we provide direct supports coordination, clinical and other essential services to consumers. We contract for residential, vocational, respite, community living supports and transportation through a network of dedicated providers. We have responsibility to monitor, oversee, audit, and assure required services to 3,636 citizens of Oakland County.

What has prompted this letter is that there has been a growing and great strain on our budget for the last 12 years. To put it simply: our budget has been declining in purchasing power while costs for everything under the sun have gone up and up since 2002. The fact is, the increases in costs and lack of corresponding budget adjustments has had a steady, and, weakening effect on the community living program, for our consumers.

While reductions in General Fund and Medicaid rebasing are bad enough, when combined with the following realties, the effect is greatly accentuated.

1. Lack of Cost of Living Adjustments
2. Lack of Acuity of Care adjustments
3. Lack of Adjustment for Private Duty Nursing demand.
4. Lack of adjustment for School Completers requiring vocational programs.
5. Lack of adjustments in pay for Caregivers

We recognize that the answer cannot just be a request for more money. We, rather, believe that the current system can be modified to take better advantage of our already effective and efficient delivery model. We believe that this analysis demands a different response, one that will prove more cost effective for the state and will provide a higher level of accountability to people served by the public system. We look forward to discussing some of our thoughts in future meetings.

Sincerely,

Gerald Provencal

Profile of Oakland CMH Individuals Served, Developmental Disability Support Measures

- **40%** (1,440) of our population require 24/7 paid supports (this includes AFC, FFC, and Private Residence)
- **28%** (1011) of our population does not communicate by using the English language – use of interpreters, assistive technology, foreign language, sign language, gestures, vocalizations, behaviors, or have no ability to communicate
- **30%** (1098) of our population has no ability or difficulty in the ability to make self understood
- **43%** (1546) of our population requires full assistance in all areas of community assistance such as leisure activities, money management, reading, writing, transportation, shopping, and socialization
- **39%** (1418) of our population has a psychiatric disorder (excluding autism) in addition to an identified intellectual/developmental disability.
- **17%** (616) of our population have the inability to swallow food without modification – liquid, puree, minced, thickened liquids, oral and parenteral (IV, G-tube, J-Tube).
- **84%** (3042) of our population need some level of assistance in taking medications.
- **52%** (1881) of our population requires full assistance in one or more area(s) of personal care


Using different colored highlighters, Rachel came up with her own system for sorting fabrics at the family's business.

- **25%** (899) of our population has very little or no relationships with people defined as natural supports.
- **14%** (492) of our population need extensive or total support with mobility.
- **4%** (158) of our population are at risk with their unpaid caregiver support system

Issues that Threaten On-Going Care in 2015 Immediately and Beyond

Loss of State General Fund (GF)

In anticipation of the advent of Healthy Michigan last April, the state passed along a 60% reduction in GF dollars to OCCMHA. It was, and some suggest remains, the intent that Healthy Michigan will more than make up this shortfall. Because Healthy Michigan is limited to those who actually qualify for the program, the loss of GF will have a dramatically negative impact on our services. In particular, there are over 200 MORC individuals who relied on GF to fund

respite services. Most of these are minors living with family. MORC identified only 12 of these who may qualify for Healthy Michigan. T**he rest have lost their benefits under MORC**. This not only presents a hardship on families today, it is likely to accelerate the demand for more costly services such as residential placement and other supports once these young people qualify for Medicaid benefits.

Impact of Medicaid Rebasing

OCCMHA's impact from re-basing of Medicaid rates resulted in a $14 million reduction in its Medicaid funding effective 10/1/2013. In FY2014, through the use of Medicaid savings and Medicaid ISF, OCCMHA's reserves were used but MORC's budget was still reduced $464,000.00. However, on October 1, 2014, MORC's budget was further reduced by $7.5 million[1] when those reserve funds were withdrawn.

At present the DD system accounts for nearly 60% of all Medicaid spending in Oakland County. In addition, OCCMHA advises that they have also been over spending in Medicaid for the past three years. The combination of Medicaid re-basing, elimination of over spending, loss of General Funds and elimination of Medicaid reserves has reportedly resulted in a $28 million shortfall beginning 10/1/2014. We are now advised that OCCMHA has determined they will be overspent again in FY2015[2].They expect to cover this shortfall by further using their reserves just until the end of the fiscal year. Using the current calculation, this means that MORC can anticipate another $5.0 million budget reduction on October 1, 2015. **In total we may be required to absorb a $13.0 million reduction against the $137 million OCCMHA contract we signed in 2013.**

- **Lack of Cost of Living Adjustments**

  Medicaid capitation rates were first deployed in fiscal year 1999 using FY98 fee-for-service data, rates and service array. The capitation rates were to have been adjusted each year to account for changes in population and cost of living. The last upward adjustment strictly for cost of living was in FY04. Nothing is factored into the rates to account for routine cost of living even as the overall Consumer Price Index reflects a 28.4% rise in the past ten years. As a result, our payment per case has remained relatively static for the past ten years.

  The fact is that, while our community based program was at one time the object of envy across the country, our payment structure has left us stuck in neutral while expenses go speeding past. Every year the costs of providing services increase and our providers have to endure. They even consider themselves lucky if they're not cut from the previous year's budget. The truth, of course, is that a continuation budget is a reduced budget, as the cost of doing business becomes a force on its own.

[1] Eliassen, A., Summary of med and gf reductions.xls, Oakland County Community Mental Health Authority, June 18, 2014.

[2] Brooks, W., FY2016 Budget Planning, OCCMHA e-mail correspondence dated February 17, 2015.

This truth was borne out by Kathy Haines of MDCH at the Improving Outcomes conference in June 2014, where she noted that funding for the CMH system has increased by 13% since 2009, while demand for service has increased….13%. This lack of regular adjustment to rates is illustrated in recent studies that show, after years of national leadership, Michigan now ranks 31st in its community based support for persons with long term care needs[3].

- **Lack of Acuity of Care Adjustments**

The needs of the people receiving DD care is increasing in demand and complexity. 30% of people served by MORC are over age 50. We are now treating not just disabilities related to the cognitive and physical impact of developmental disability, but those related to aging, as well. With improvements in healthcare technology, and as the result of better care delivered in smaller, more intimate settings, people are living longer. The issue of Private Duty Nursing illustrated below is a case in point. Each of the Private Duty Nursing cases represents a child aging off the Children's Special Health Care Services (CSHCS) program. CSHCS is designed to serve those children with the most significant chronic illnesses and disabling conditions through age 21. The fact is that these children are outliving their benefit. **There is no provision in budgeting to account for acuity of need for our service population**.

We have also seen dramatic growth in our reliance upon care in unlicensed personal residences. In point of fact, fewer than 30% of people served by MORC in Oakland County reside in "traditional" licensed settings. This approach is consistent with newly published federal rules concerning allowable Medicaid expenditure under the waivers.[4] However, these services delivered in unlicensed versus licensed settings are **30.3% more costly**, on average.[5] **There is no provision in budgeting to account for increased use of unlicensed settings.**

- **Lack of Adjustment for Cost of Private Duty Nursing (PDN)**

In the last year, six PDN cases have moved from either State Plan coverage or Private Insurance Coverage to Hab Waiver Coverage under MORC. The Medicaid PDN rate is **$35/hr**. Anticipated daily cost is between **$420 and $560/day each** just for PDN supports. This does not include PDN Respite services which will need to be added, again, at $35/hr.

These six cases represent full year cost of **$1,124,200.00** for nursing services only. Each case also requires Supports Coordination and MORC Nursing authorization. Most will need PDN respite nursing and community living supports staffing. In addition to these six this year, we are aware of two individuals who will move to Hab Waiver PDN services in FY 2016 and one

[3] Reinhard, S. et al, Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Disabilities, and Family Caregivers, The Commonwealth Group, 2014.
[4] Department of Health and Human Services, Centers for Medicare and Medicaid, Fact Sheet: Summary of Key Provisions of the Home and Community Based Services (HCBS) Settings Final Rule (CMS 2249-F/2296-F), January 10, 2014.
[5] Teninty, L. and Howard, K., Historical Utilization Analysis: Services and Historical Utilization Analysis by Draft Level for Oakland County Community Mental Health Authority, Human Services Research Institute, May 12-13, 2014.

in the first quarter of FY 2017. **There is no mechanism to recognize these costs from state or county funders.**

- **Lack of Adjustment for Increase in School Completers Identified for Vocational Programs**

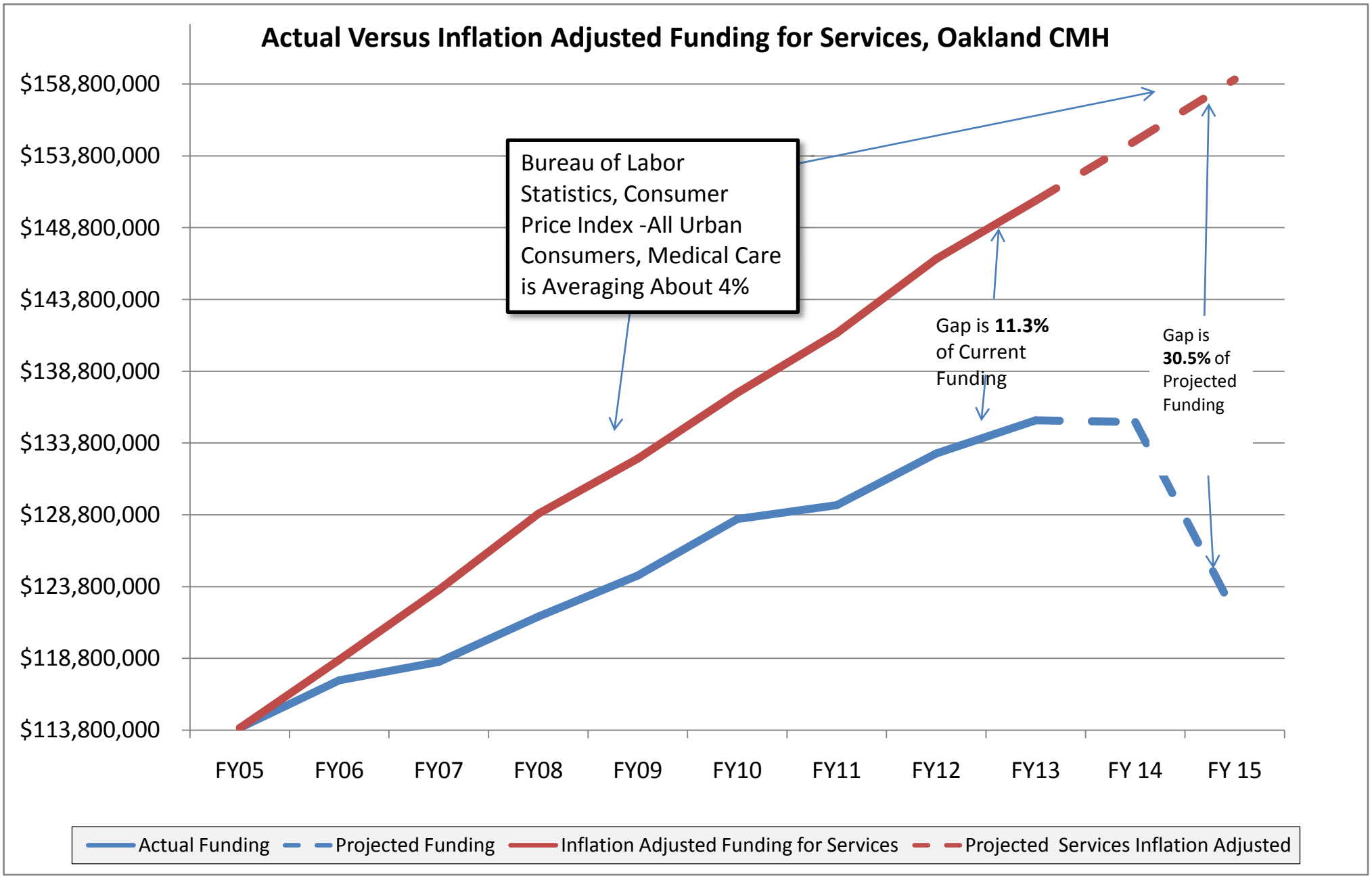
In Oakland County, we served **79** school completers identified with vocational services needs in June 2014. We anticipate another **95** school completers in June 2015 and **115** school completers in June 2016. Our average cost for vocational services (not including transportation) is **$15,034.05** per person. This will result in additional full year cost of **$1,187,690.00** to serve these individuals from FY2014; **$1,428,237.00** from FY2015; and **$1,728,915.00** from FY2016. **There is no budgetary adjustment anticipated for these individuals.**

- **Lack of Adjustment for Caregiver Wages and Provider Strain**

The last year the state supported a direct care wage increase was in FY08 and it was $0.10 per hour. The average hourly pay is $9.06 per hour for employees offering residential care[6]. As a result of these poverty level wages, direct care staff turnover is higher than ever, often exceeding 50%. The cost for recruitment, hiring and training replacements taxes and already reed thin margin and is exceedingly disruptive to persons receiving services.

Providers are becoming increasingly disillusioned with the community living business as they deal more than ever with workmen's compensation claims, injuries, difficulty in paying for additional staff in emergencies and heavy handed scrutiny from Rights officers. The latter has led to two seasoned and exceptional group home providers relinquishing their homes in the past six months. **MORC rates and payments have no inflationary or cost of care accelerators and, as a result, these conditions are expected to continue or worsen.** The impact of these cuts ahead will be unhealthy, confining, and more than unpleasant for the people we serve. As providers reduce staff, the caregivers will be expected to do more, with little or no compensation. The home atmosphere will undoubtedly be strained. We can expect less individual attention and less focus on the details that make residences feel like homes.

[6] Bridges, T. and Hollis, T. Findings from a Survey of Community Mental Health Provider Organizations: Understanding Michigan's Long Term Supports and Services Workforce, March 2013, Pg. 7.



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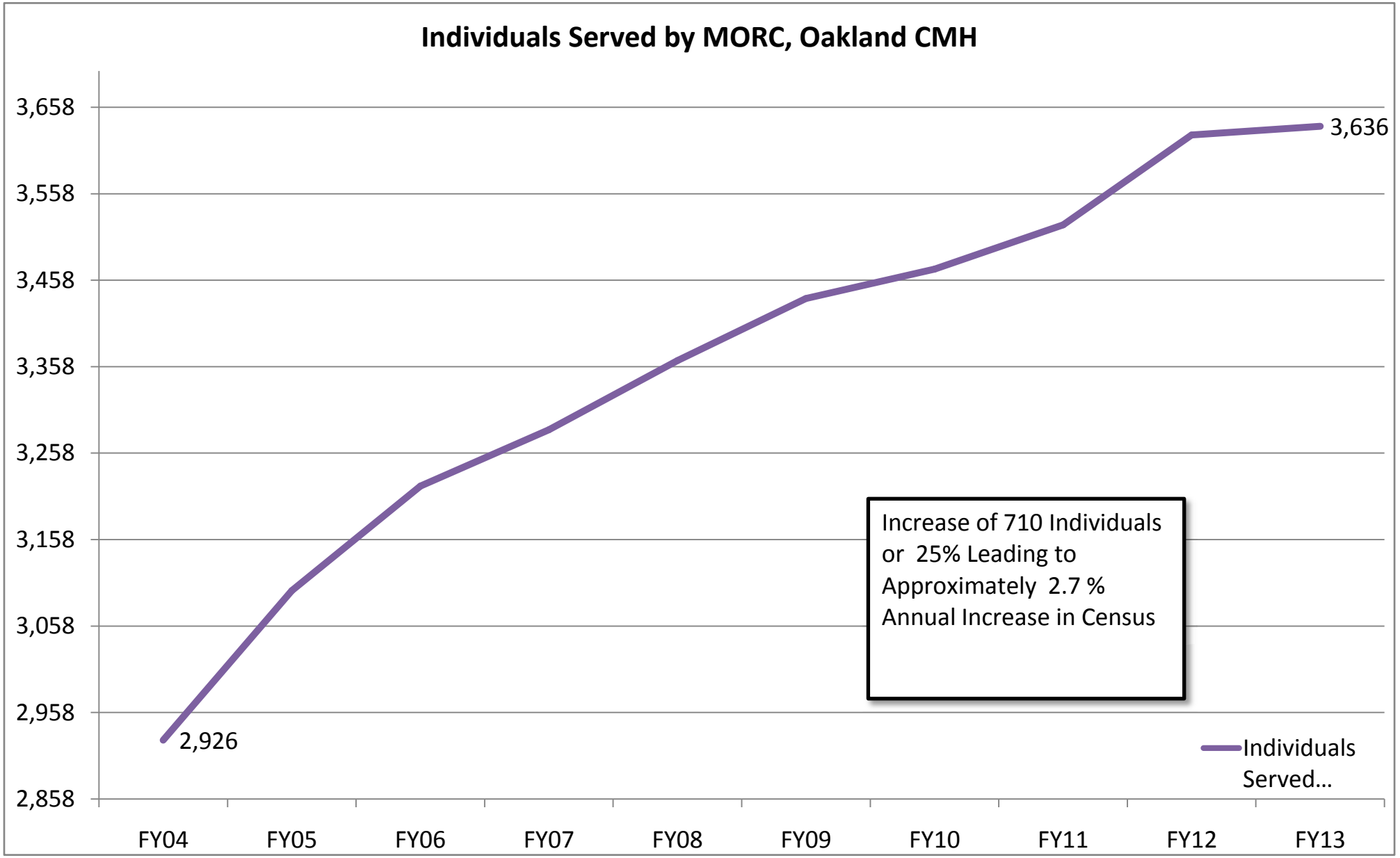
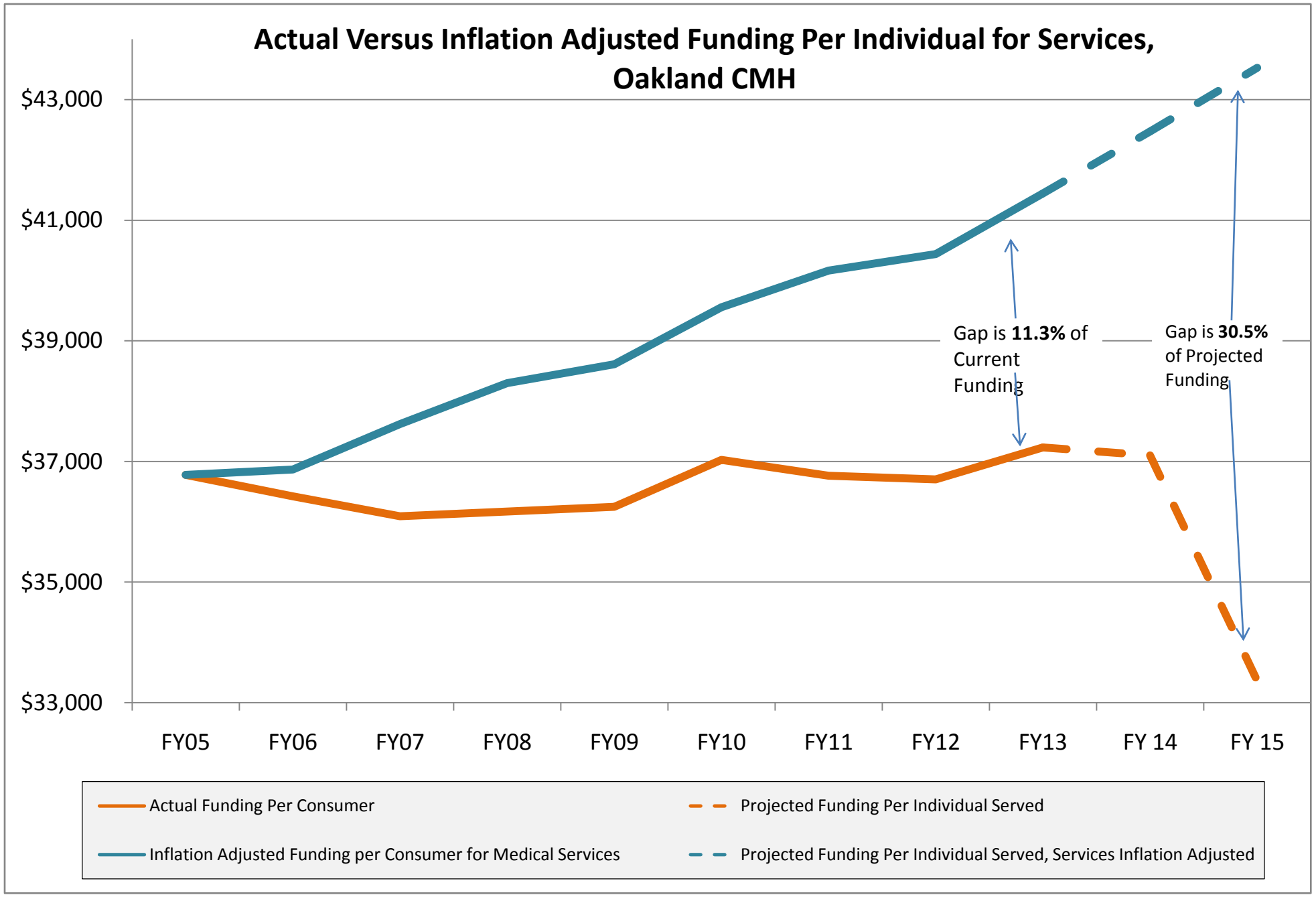
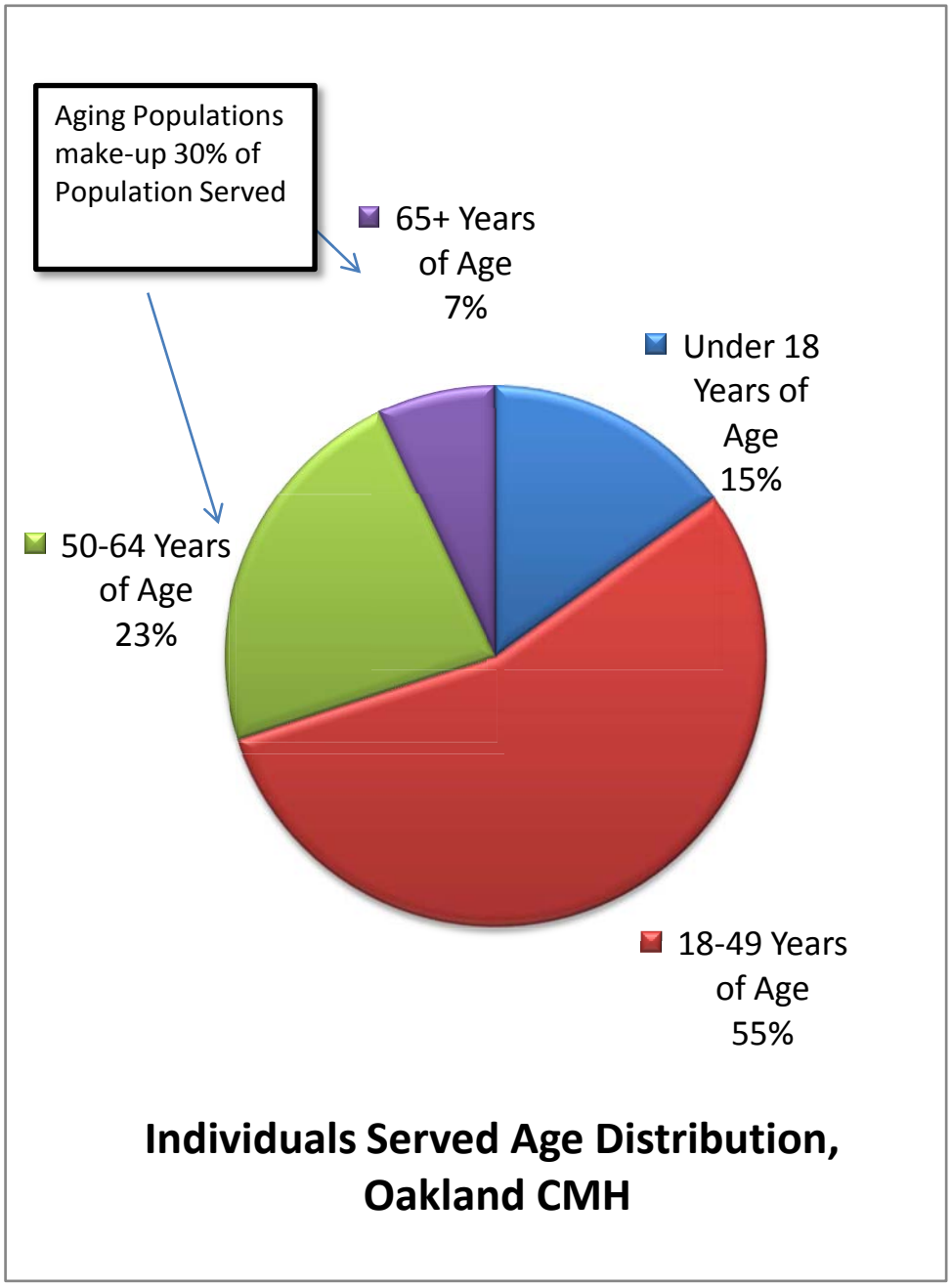
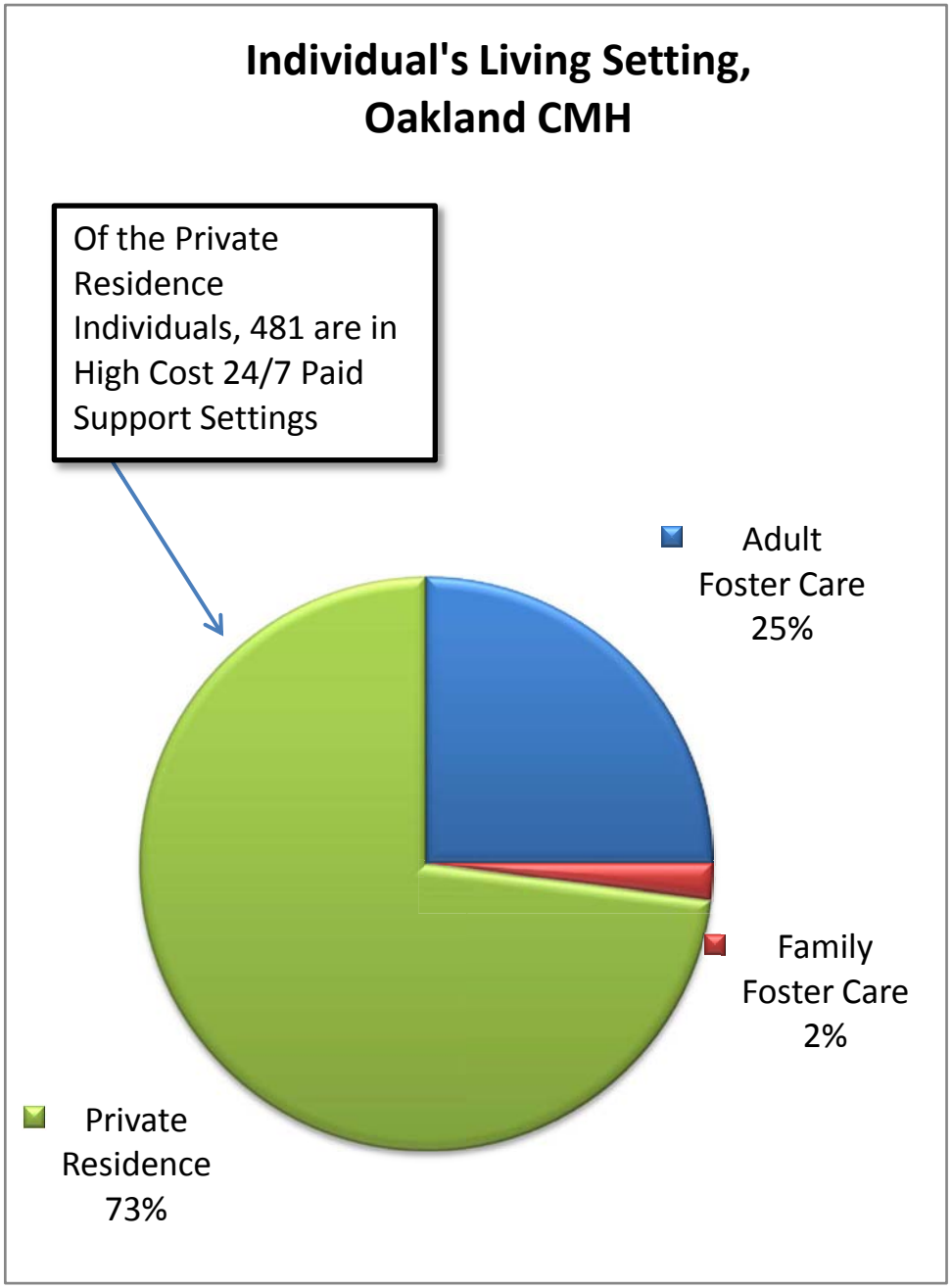

Individuals Served by MORC, Oakland CMH
3,658
3,558
3,458
3,358
3,258
3,158
3,058
2,958
2,858
3,636
2,926
Increase of 710 Individuals or 25% Leading to Approximately 2.7 % Annual Increase in Census
Individuals Served…
FY04
FY05
FY06
FY07
FY08
FY09
FY10
FY11
FY12
FY13


Actual Versus Inflation Adjusted Funding Per Individual for Services, Oakland CMH
$43,000
$41,000
$39,000
$37,000
$35,000
$33,000
FY05
FY06
FY07
FY08
FY09
FY10
FY11
FY12
FY13
FY 14
FY 15
Gap is 11.3% of Current Funding
Gap is 30.5% of Projected Funding
Actual Funding Per Consumer
Projected Funding Per Individual Served
Inflation Adjusted Funding per Consumer for Medical Services
Projected Funding Per Individual Served, Services Inflation Adjusted


Aging Populations make-up 30% of Population Served
65+ Years of Age 7%
Under 18 Years of Age 15%
50-64 Years of Age 23%
18-49 Years of Age 55%
Individuals Served Age Distribution, Oakland CMH


Individual's Living Setting, Oakland CMH
Of the Private Residence Individuals, 481 are in High Cost 24/7 Paid Support Settings
Adult Foster Care 25%
Family Foster Care 2%
Private Residence 73%

MORC Professional Staff Assigned to Oakland CMH Individuals Served

Professional Staff Assigned			Difference	
	FY 01	FY 13	Number	%
Support Coordinators	70.3	63.4	-6.9	-10%
Registered Nurse	24.6	9.8	-14.8	-60%
Occupational Therapist	8.5	2.9	-5.6	-65%
Speech/Language Pathologist	6.5	0.7	-5.8	-89%
Psychologist	16.6	6.8	-9.8	-59%
Registered Dietitian	5.0	2.2	-2.8	-56%
Total	**131.5**	**85.8**	**-45.7**	**-35%**

NOTE- Total assumes 72% of clinical staff are assigned to OCCMHA consumers. Does NOT include staff assigned through CRS.

Clinical Services - 2002-2014

	2002 Services No Longer Provided in 2014	Current (2014) Services
Dietary	• Menu development services • Weight loss assistance • Food preparation assistance • Food service inspections • Wellness programs	• Providing evaluations only for those who have nutritional deficiencies resulting in mal-nourishment, individuals who each via a tube and severe diabetes and renal failure • Little coordination with families, physicians, staffing providers
Nursing	• Annual evaluations for all individuals • Nursing care plans for all individuals on psychotropic medications • Discharge planning for all individuals admitted to the hospital • Monthly home visits for all individuals with on-going services	• Only seeing individuals with unstable co-occurring physical conditions • At best, individuals are seen quarterly and only if unstable.
Psychology	• Active treatment plans for all individuals on psychotropic medication and those with restrictive programming • Monthly home visits (for monitoring and staff training) for all individuals with on-going services • Skill-building treatment plans	• Only seeing most severely co-occurring • More short-term intervention • Inadequate services due to increased drug and alcohol misuse; delinquency/justice issues • Over reliance on the use of psychotropic medication • Increased use of psychiatric hospitalizations • Increased use of calling 911 for "behavioral" issues

OT	• Therapy in the following areas:
	  ○ Swallowing disorders
	  ○ Range of motion
	  ○ Sensory integration
	  ○ Mobility training
	• Skill building treatment plans
	• Quarterly monitoring
	• On-going staff training
		• DME (durable medical equipment) primarily – some sensory
		• Increased need for DME given aging of population
		• Spending more time dealing with insurance issues – increased documentation requirements; addressing denials and appeals;

		contacting multiple vendors • Insurance requirement of office activities precludes ability to observe in the natural environment and work with caregivers
Speech	• Communication training/therapy • Assistance with augmentative communication devices	• Focusing on swallowing disorders primarily • No therapy is provided
Recreation	• Evaluations • Direct therapy • "Recreation Quarterly" listing events in the community	• Total reliance on community opportunities • Minimal collaboration with community recreation organizations •
All disciplines	• Clinician attendance at all person centered planning meetings • The focus is on emergency/urgent needs only • Annual re-evaluations • Frequent home visits (weekly-quarterly) focusing upon caregiver support and training	• Little face to face collaboration with other disciplines and supports coordination • Providing service independent of other disciplines – Medicaid doesn't recognize overlapping services • Infrequent attendance at person centered planning meetings • Documentation for assessments is taking longer in order to meet insurance standards • Focus is on keeping people out of hospitals (physical and psychiatric) • Over-reliance on unskilled direct service workers to make medical judgments • Over-reliance on providers for on-going training of unskilled direct service workers • Infrequent clinical observation and oversight to observe and prevent caregivers errors • Increased burden on support coordinators • Insurance standards/requirements, need for authorizations has slowed service delivery

Individual Stories

Dan

Dan was overweight and participated in the Wellness classes offered by the dieticians. As a result of his participating, his health improved, he no longer took diabetic or hypertensive medication, his self-confidence improved, he socialized more and wanted to be a mentor to others in their weight loss journey. Due to workload, the dieticians are no longer able to offer the Wellness program and since then, Dan has gained most of the weight back, he is back on his medication, and has lost opportunities for greater self fulfillment.

Robert

The importance of dieticians is critical when individuals have feeding tubes because the general medical community is not knowledgeable about adequate nutrition. One of the most extreme examples of this is Robert who was discharged with 1 can of ensure per day which is 250 calories. He was 6 foot tall and 160 pounds. Luckily, 3 days later, the staff notified the dietician who was able to modify the diet so that he was no longer mal-nourished and dehydrated (which could've led to renal failure and death). At the time, the dietician was able to respond that day. With the current workload, it may have taken several days before the dietician could've addressed the situation.

Patty

Patty's current (2014) plan includes seeing the nurse every 3 months due to multiple health conditions related to her Down's Syndrome diagnosis – blood clots, pressure sores, hypertension, dementia, diabetes, seizures, obesity, MRSA and she is currently non-ambulatory. The nurse happened to be at the home visiting one of her housemates and noticed that her eye was full of blood. Patty was not due to have the nurse visit her for another 2 months. The staff reported that she had been seen by her primary care physician the month prior for her eye and was told that it was fine and related to her Coumadin. The nurse prompted the staff to take her immediately to the emergency room. She was admitted to the hospital's ICU with a brain bleed. If the nurse had not been visiting another individual, she would've most likely experienced a stroke. She is now back at her home and enjoying her life. Historically, nurses would be seeing individuals at a minimum of once per month and would be able to identify and prevent conditions before they became crisis situations.

Pauline

In 2013, Pauline was admitted to the hospital for a seizure and at discharge, her staff noticed that she was experiencing some respiratory issues. The nursing staff at the hospital administered a breathing treatment and sent her home (despite staff's expressed concerns). She died 1 ½ hours later at home. In the past, a nurse would've been at the discharge and would have been able to advocate for re-admission.

Steve

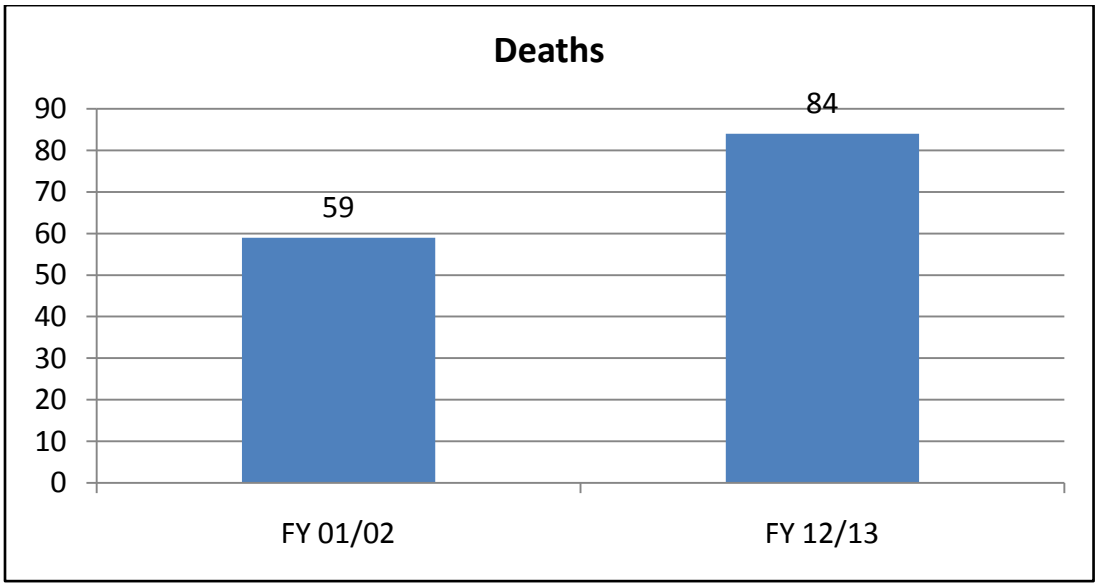
Steve used a power driven custom molded wheelchair for ambulation. The occupational therapist (OT) was seeing him and his staff at both home and his work setting frequently (4-6 week intervals) regarding positioning, range of motion, wheelchair maintenance, transferring techniques. As OT services were less available, he only saw the OT once per year at best, he missed much work due to the wheelchair or lift not working or health issues. Over time, he developed frequent pressure sores and his range of motion decreased (from lack of oversight and on-going training of caregivers) and his overall health deteriorated. Pressure ulcers, which are avoidable, oftentimes can lead to death. Steve has since passed.

James

James is an individual who has significant quadriplegia and utilizes a wheelchair for ambulation. It is highly likely that he does not have a cognitive impairment although he is non-vocal. In 2002, he was being seen regularly by the speech therapist because he was using an electronic device which he was able to operate with the little movement he had in his hand. The device required regular updating and maintenance that the speech therapist did. In addition, the staff needed training on how to support James in the use of the device. Since the speech department currently includes only 1 therapist, services for those with augmentative devices is non-existent and James has lost his voice.

Outcomes for Individuals

- Less coordination of services
- Delay in delivery of services (waiting for authorizations)
- Fewer direct service professionals (DSPs)
- Management/leadership of DSPs is spread too thin
- Increased reliance on emergency rooms and urgent care centers
- 42% increase in deaths



Future challenges

Aging population

Autism increase

Increasingly complex individuals – those involved with the justice system, substance misuse

No institutional settings for the most challenging to serve

Increased costs of choice and personal residences

Insurance covering less (i.e. DME)

Documentation requirements for insurances have increased