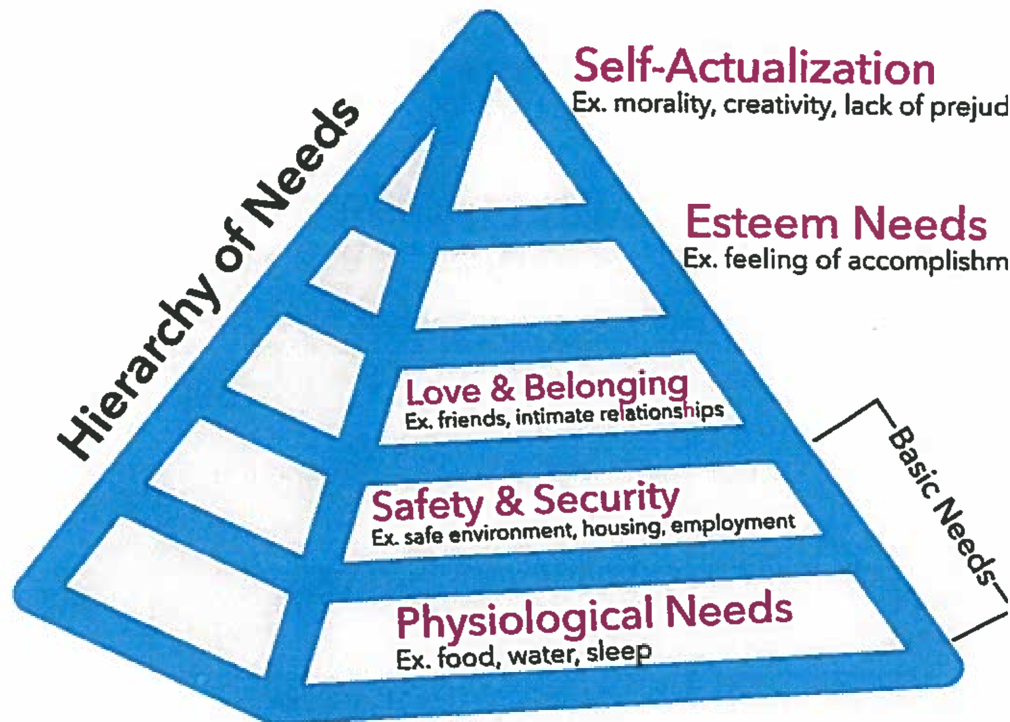
Reference Source: Michigan Constitution of 1963

Section 51 of Article VIII of the Michigan Constitution of 1963 states, "services for the care, treatment and rehabilitation of those who are seriously mentally disabled shall always be fostered and supported, the department shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state"

Behavioral health provider organizations have long understood that biopsychosocial factors have a significant impact on behavioral health. In 1943, the humanist psychologist Abraham Maslow introduced the concept of a hierarchy of needs.[1] In general, Maslow believed that in order for individuals to reach their full potential, their more basic needs must be met. Many of these needs are primarily physiological such as food, water, and sleep. Basic needs extend to safety and the need to belong. Safety needs include a safe environment, housing, and employment.[2] Today these factors are referred to as social determinants of health (SDoH). The World Health Organization defines SDoH as "the conditions in which people are born, grow, live, work, and age".[3] There is a growing recognition of the impact that a lack of social determinants, such as safe affordable housing, transportation, and access to nutritional foods, has on health outcomes and health care spending. Social determinants also impact how and if individuals access health care and the quality of health care services that they receive.[4]



Despite Maslow's recognition of social determinants on human growth, it is only more recently that the U.S. health system, both payers and providers, has become focused on social factors outside of direct health care services. In fact, it is estimated that medical care accounts for only 10% - 20% of the modifiable contributors to healthy outcomes.[4]

MICHIGAN'S DIRECT CARE WORKER CRISIS REQUIRES ACTION!

IMMEDIATE STEPS NEEDED:

- **An increase in Medicaid funding to provide for attractive wages for Direct Care Workers. Higher wages will increase the economic activity of the workers and the return on investment will be evident. Overtime expenses for providers will be reduced, thus cutting monetary waste in the system. An increase of $.50 per hour would require an estimated $65 million in gross Medicaid funding, which would be substantially offset by the ROI. Shockingly, half of current direct care workers themselves qualify for public assistance due to their low pay and lack of benefits. (1)**

- **Adoption of the other recommendations made in the 2016 Section 1099 legislative report, which will bolster Direct Care Worker recruitment and retention and improve the safety and quality of life of individuals with disabilities.**

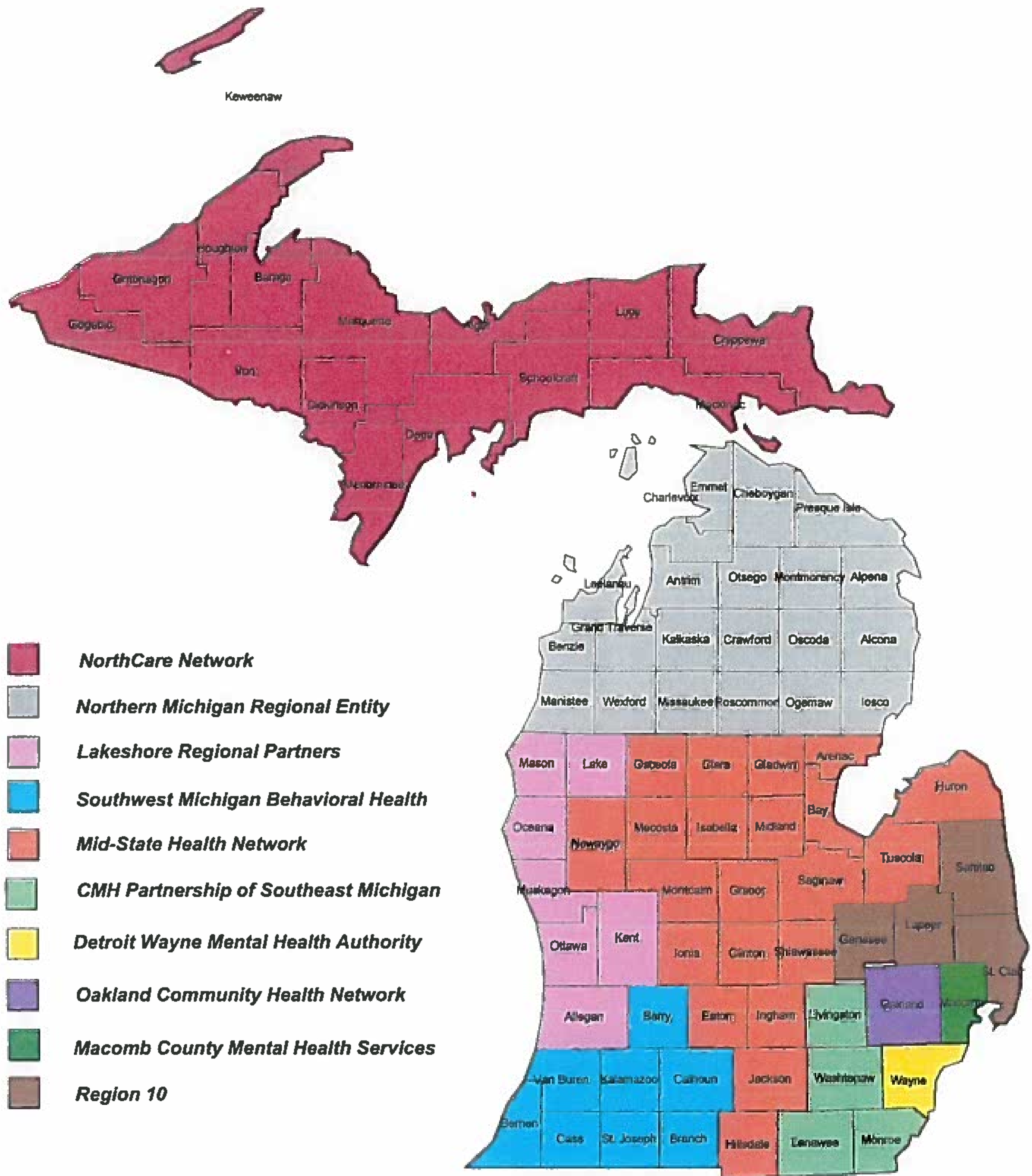
More than 300,000 Michigan constituents who have a mental illness and/or developmental disability rely on up to 50,000 direct care workers to provide crucial supports and services that enable them to access their communities, work and live full lives.

OTHER STATES HAVE ALREADY PASSED LEGISLATION TO RAISE WAGES, INCREASE ECONOMIC GROWTH AND ATTRACT AND RETAIN WORKERS. MICHIGAN LAGS BEHIND!

Source:PCPID Report to the President 2017: America's Direct Support Workforce Crisis

Issued: October 2019

Michigan PIHP Map



Updated 05/07/2019

HISTORICAL PERSPECTIVE

Community Mental Health Services in Oakland County 1999-2015

Thomas F. Kendziorski, Esq.

The Arc of Oakland County, Inc.

Executive Director

July 13, 2015

Community Mental Health Act

- On **October 31, 1963**, Congress passed, and President John F. Kennedy signed into law, the **Community Mental Health (CMH) Centers Act.** This legislation recognized society's growing awareness that people with mental illness are constitutionally entitled to receive voluntary treatment in the least restrictive environment

- In February, 1963, the Michigan Senate and House of Representatives had introduced identical bills that were later signed into law by then Governor George W. Romney as **Act 54 of the Public Acts of 1963**. This legislation was Michigan's own CMH Center Act and gave counties the option to create a CMH program if they so desired.

Michigan Mental Health Code of 1974

- The localized community care approach to services in Michigan was codified in 1974, with the passage of the **Michigan Mental Health Code, Public Act 258 of 1974**.
- A major revision of the mental health code was accomplished by **Public Act 290 of 1995**, which further decentralized responsibility for the system to county-based CMH Service Providers (CMHSP), which were then allowed to convert to **authority** status and encouraged to consolidate. The Code now defined CMHSP responsibilities to serve persons prioritized by the severity of their mental illness, emotional disturbance or developmental disability.
- Michigan began to rely increasingly on **Medicaid** funds to deliver services and at the end of the 90's, entered into a **capitated funding** arrangement with the federal Medicaid administration, via a waiver agreement. CMHs then took on new **managed care** responsibilities.

Pre- "Full Management" and "Authority" Status

- Prior to the mid-1990's, the Michigan Department of Mental Health **(DMH)** directly operated most of the DD services in Oakland County via its Regional Center located in Clinton Township.
- The Oakland Community Mental Health **(CMH)** agency was at that time a small office operating a day program for persons with developmental disabilities (DD).

Changes during the 1990's

- The Macomb-Oakland Regional Center **(MORC)** transitioned from a state agency to a non-profit organization in 1996; serving persons with developmental disabilities.
- The Clinton Valley Center **(CVC)** was closed in 1997 and demolished in 2000; serving adults with mental illness. The Fairlawn Center **(FC)** for children had closed in late 1996; demolished in 2011.

- On 1/1/99, the Oakland County Community Mental Health agency became an Authority **(OCCMHA)**.
- Independent of the County of Oakland.
- 90% state funding (Medicaid and General Funds) and 10% county.
- The County Commission appoints the OCCMHA Board members.

Pre-Paid In-Patient Health Plan (PIHP)

- There are **46** Community Mental Health Service Providers (CMHSPs) in Michigan.
- In 2002, Michigan had 18 PIHP regions, and in 2012 that number was consolidated to **10**.
- **Oakland County is PIHP region 8; a stand-alone CMHA and PIHP**. Wayne (region 7) and Macomb (region 9) are also stand-alone CMH/PIHP's.

County/Local Match Funding: Michigan Mental Health Code

R330.1316 – Expenditure of county's tax funds: Sec. 316. The expenditure of a county's tax funds *to pay for services provided by the state or to pay the county's cost* of supporting a community mental health services program may be made from the county's general tax fund or from the proceeds of a special tax established for such purpose." (underlined section by author)

R330.1308 – Financial Liability of state – Sec. 308 …(b) Subject to constraint of funds … the amount of county match … [for] a community mental health authority *shall not exceed* the amount of funds provided by the county or counties as county match *in fiscal year 1994-1995* or the year the authority is created, whichever is greater.

Final Points to Ponder

- OCCMHA taking back control from Core Providers:
  - Utilization Management
  - Quality Assurance
  - Intake/Access
- DHHS projected to increase Medicaid funding to OCCMHA during FY16 by 1.5% (about $4.5M); maintain General Funds rate at $12M
- Annual Oakland County match funds at $9.6M (level frozen in 1999)
- OCCMHA FY16 deficit projected to be $5M+
- OCCMHA does not intend to use additional reserves, which are pegged at around $23M at the end of FY15
- Lahser Respite Home anticipated closure: 10/1/15, unless current charitable fundraising drive is successful ($73K of $120K) by 8/31/15
- Individual PCP/IPOS services reductions occurring