



*Partnerships for increased access to
health care in our community*

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Washtenaw County Board of Commissioners

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Health Care Services and Specialty Supports for the County's Most Vulnerable

- Physical Health Care Services through WHP
- Publicly-Funded Mental Health, Substance Abuse, Developmental Disability and Coordinated Care Services Administered through WCHO



Health Care: Who are the Uninsured?

- 45.7 million Americans (U.S. Census Bureau, annual census survey, 2007)
- Basic facts on the Uninsured: (Kaiser Commission on Medicaid and the Uninsured)
 - Most of the 45 million uninsured are in working families, and do not have access to employer-sponsored insurance
 - More than 8 in 10 are in low-income families
 - Most low and moderate income uninsured adults are not eligible for Medicaid
 - The uninsured suffer from negative health consequences due to their lack of access to necessary medical care
 - Medical bills are a burden for the uninsured and frequently leave them in debt

Michigan: Who Are the Uninsured?

- In Michigan, 12.4% of the non-elderly population was uninsured in 2006-07 (Kaiser Commission on Medicaid and the Uninsured)
- Of the uninsured population in Michigan, 5.9% of kids are uninsured; 15.2% of non-elderly adults are uninsured; 66% are low-income (below 200% FPL)

Washtenaw County's Uninsured

- 15.2% or 36,764 non-elderly adults uninsured in 2006 (estimates based on Kaiser Family Foundation data)
- 24,264 non-elderly adults income eligible for WHP in 2006
- WHP estimates that over 35,000 County residents are WHP-eligible in 2009.

Washtenaw County's Medicaid Population

- Like the rest of the state, Medicaid enrollment in Washtenaw County has been steadily rising
- However, Medicaid does not cover all low-income individuals; you must fall into one of Medicaid's eligibility *categories*, along with meeting income, resources and legal status criteria.

WHP Program History

- Jindo lawsuit
- RCHP – Indigent Hospitalization (1989)
- Washtenaw County Health Care (1998)
- Washtenaw Health Plan (2001)

The primary purpose of the Washtenaw Health Plan is to increase access to quality health care in our community.



WHP Structure

- WHP is a non-profit organization, based on a community collaboration of Washtenaw County, SJMHS, UMHS and the support of non-profit clinics and many private physicians.
- WHP governance:
 - 7 members representing partner organizations.
- WHP operations:
 - 7 staff
 - contracts with hospital systems
 - management services contracts

WHP Plan A & Plan B Services

- Primary Care
- Specialty Care services determined to be “medically necessary”
- Lab
- Radiology
- Hospitalization
- Prescription drugs
- Emergency Ambulance (Plan A only)
- Mental Health (collaboration with WCHO & CSTS)
- Case management & care navigation services

Washtenaw County Funding for Indigent Care

- Disproportionate Share Hospital Funds (DSH)
 - County general fund appropriation is the non-federal share of special Medicaid DSH funds managed by the State
 - The County share is \$3M in 2008-09. Every local dollar brings more than \$1.51 in federal funds to Washtenaw County hospitals
 - St. Joseph Mercy Hospital receives DSH funds from the State and maintains an Indigent Care Agreements with WHP

WHP Revenues

- St. Joseph Mercy Health System contracts with WHP to provide indigent care services
- WHP budget includes:
 - Comprehensive health coverage (WHP Plan B) for eligible County residents (\$7.2 M in 2008-09)
 - State funding for management of ABW program for very low income community residents (WHP Plan A; \$1.4 M in 2008-09)
 - Contracts with CSTS, Public Health, HVA to provide indigent health care services (\$2.7M in 2008-09)
 - Grants to non-profit safety net clinics/providers (\$400K in 2008-09)

Other Major Contributors

- SJMHS and UMHS each provide more than 10 million dollars annually in support of health care access for WHP members.
- Private physicians and non-profit safety net providers subsidize care.

WHP Goals Beyond Access to Quality Health Care

- Shift pattern from urgent to preventive care, emergency room to primary care.
- Enhance primary care capacity to serve as an advanced medical home

Critical Health Plan Principles

- Support delivery of high quality, integrated care
- Maximize equity between the two health systems.
- Spread volume among physicians so no one physician or practice bears an excessive burden.

Washtenaw County Prescription Plan (WCPP)

- Enrollment
 - 3,060 county residents enrolled
 - 370 prescriptions filled on average monthly
 - Refer/assist eligible residents with patient assistance program applications (Needymeds.com)
 - Assist with enrollment into Ypsilanti Chamber of Commerce discount card program
- Savings
 - 15% – 18% discount off brand name drugs
 - 50% discount off generic drugs
 - YTD savings = \$41,824.55 (Jan – June 2009)

Before the Health Plan

'My life was chaos'

'I would wait till something was severe enough that I had no choice.'

'Basically I neglected myself because I couldn't see another way.'

'I had to choose whether to go to the doctor or keep my rent going.'

Thank You

'The people involved are phenomenal. I cannot say enough about the doctors, nurses and the WHP staff. They got me what I needed.'

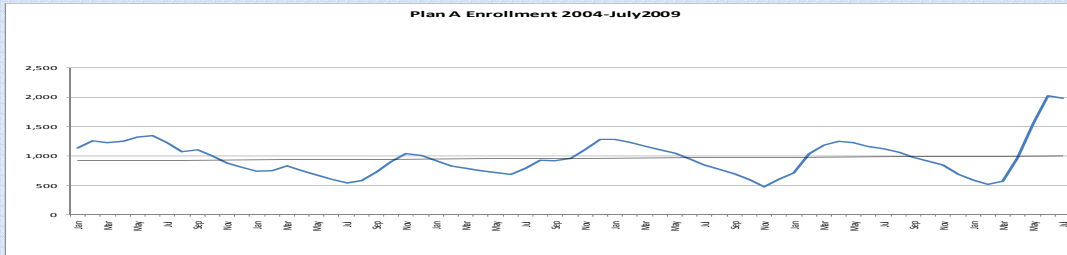


Current Reality and Challenges

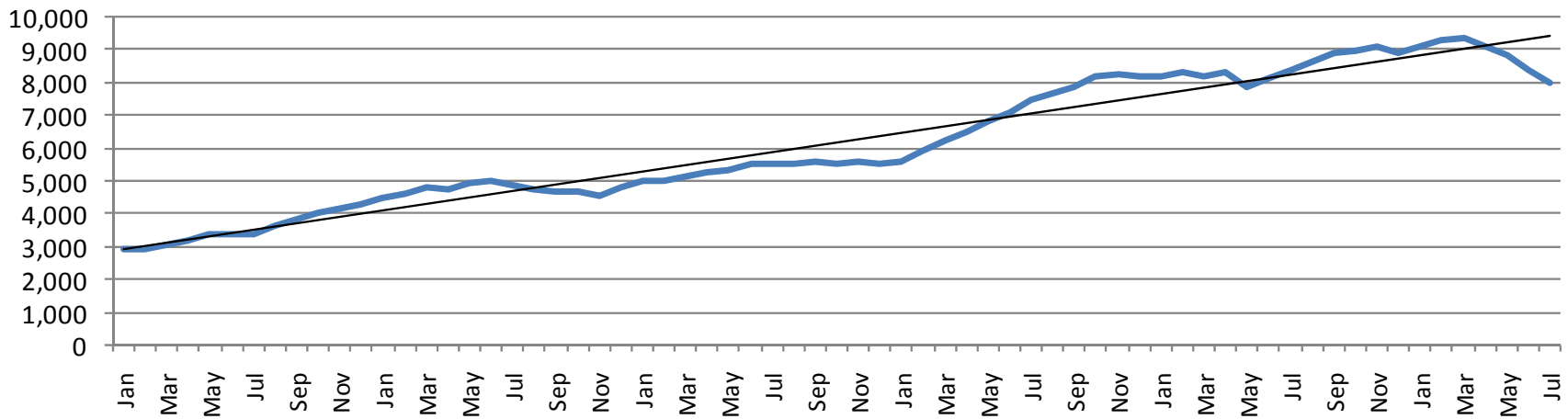


Current Reality

- Increasing demand, decreasing resources



Plan B Enrollment 2004-July 2009



Current Reality

- Modest, lagging help expected from Stimulus Bill
- Ability to compensate physicians and hospitals decreasing
- Critical need for broader community engagement at a very challenging time

WHP Board Actions

- Enrollment freeze
- Personnel cuts
- Benefits changes – e.g. limiting formulary (\$4 drugs)
- Modifying provider reimbursement rates
- Exploring additional administrative efficiencies

WCHO: Mental Health System Background

- Provisions regarding public responsibility for care/services to persons with a developmental disability or serious mental illness have been included in successive State Constitutions of 1850, 1909 and 1963. Article VIII, Section 8 of the 1963 Michigan Constitution explicitly states:

Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported.
- State Hospitals/Centers were historically the primary means to meet these obligations, but counties had some fiscal liability
 - Under PA 151 of 1923, if a “mentally diseased person” was admitted to a state hospital or center, the “county of which such person is resident shall be liable to the state for the care and maintenance of such patient for one year.”

Seeds of Change

- In the 1960s, the century-long practice of institutionalizing persons with a mental illness or developmental disability was challenged and a new approach emerged.
- It was recognized that the needs of the vast majority of persons with mental illness - and virtually all persons with developmental disabilities - could be addressed through programs located in communities where these individuals and their families resided.
- Michigan changed its Mental Health statute in 1974 (PA 258), and codified the rights of persons with mental illness or developmental disabilities to be treated in the “least restrictive setting.”

Changing Obligations & Opportunities

- The 1974 Mental Health Code changed county financial obligations, repealing PA 151 of 1923, and setting county financial liability at 10% of the net cost of any service that is provided by the state (department) “...directly or by contract, to a resident of that county.”
- The new Mental Health Code also included an opportunity for greater county involvement in management/delivery of care:
 - “... it shall be the objective of the department to shift from the state to a county the primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of the county.”
(Section 116e)

Community Mental Health

- Over time - responding new care philosophies, statutory policy preferences and strong state financial incentives – all counties eventually elected to establish (either as a single or as a multi-county venture) a community mental health services program (CMHSP), and to accept the transfer of responsibility for mental health and developmental disability services from the state.
- Washtenaw County was a leader in this transformation.
- As pointed out in the November 2002 paper (*Understanding the Mandated Service Argument*, by Gary Taylor), this transfer of functions from the state to CMHSPs is not a function mandated by law, but rather a function “...mandated by agreement” – counties derive benefit from the arrangement.

Forms of Community Mental Health

- Prior to the Code amendments of 1996, nearly all CMHSPs were agencies or departments of county-government.
- The 1996 amendments permitted other forms and legal arrangements for a CMHSP, including the option for the CMHSP to be constituted as an *Authority*, a separate governmental entity.
- In 2000, the Mental Health Code was further amended to allow Washtenaw County and the University of Michigan to form a community mental health *organization*, a third form of community mental health services program that is (like an authority) a public governmental entity separate from the county and the university.

Washtenaw Community Health Organization

- Established Under the Urban Cooperation Act
 - Separate Public Governmental Entity
 - 12 Member Board: 6 Appointed by County Commission and 6 Appointed by Regents of the University
- Rationale, Vision, Purpose
 - Manage Publicly-Funded Mental Health, Developmental Disabilities, and Substance Abuse Services
 - Pursue Public-Public Partnership - Connecting Mental Health System with an Academic Medical Center – to Improve Care and Consumer Outcomes.
 - Explore a Range of Approaches/Options to Integrate Care

WCHO: Complex Organization

- Has Many Designations
 - Community Mental Health Services Program (Washtenaw)
 - Substance Abuse Coordinating Agency (Washtenaw/Livingston)
 - Medicaid Specialty Prepaid Inpatient Health Plan
 - Washtenaw, Livingston, Lenawee, Monroe
- Manages Multiple Service/Funding Arrangements
 - All Targeted to Either Persons with Serious Mental Illness, Serious Emotional Disturbance, Developmental Disabilities, and/or Substance Use Disorders
 - Under Different Legal Auspices & Authority, Varying Eligibility Criteria and Distinctive Service/Benefit Obligations, in Different Areas
 - Major Funding Sources
 - State GF; Medicaid; County Local Match, ABW, MiChild, Grants
- WCHO and CSTS
- Relationship Between WCHO, CSTS, WHP

WCHO: Initial Integration Steps

- Laying the Foundation for Closer Physical/Mental Health Integration
- “Integrator” Platform
 - Collaboration, Planning and Sharing Key Staff
 - Personal Health Reviews
 - Mapping/Deploying Pathways, Protocols, Processes, and Teams to Address Physical/Behavioral Health Needs
 - Care Management and Clinical Integration Components
 - Electronic Health Record/Information Exchange
- Physical Health/Mental Health Funding Streams/Resources
 - Legally, Categorically Distinct
 - “Braided” Together to Underwrite Coordination

WCHO: Integration Approaches

- Tracking Health Status & Addressing Needs
 - Monitoring Health Status,
 - Promoting Wellness, Addressing Risk Factors
 - Care Coordination; Linking with Primary Health Home
- Moving Mental Health into Primary Care
 - High Volume Clinics and Other Practice Sites
- Medicaid Disease Management Pilot
 - Population, Disease States, Condition Clusters
 - Disease Management Interventions
- Moving Primary Care into Behavioral Health
 - On Site Primary Care Services
 - Behavioral Health Site as a Health Care Home

WCHO: Current Situation

- Rising Demand
- Cuts in State General Fund Allocations for Mental Health and Substance Abuse
- Budgetary Complexity, Uncertainty