

CENTERPOINT HUMAN SERVICES

Implementation Plan for SFY 10 Final Continuation Allocation

September 24, 2009

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (Division) recognizes the severity of reductions in funding enacted by the General Assembly for SFY2009-2011. As discussed previously with Area Directors, the Division requests that each Local Management Entity submit its Plan for implementation of the reductions by October 5, 2009.

CenterPoint's Implementation Plan consists of a Planning Process spanning January, 2009 through September 23, 2009. Information responsive to the Division's specific questions is provided below with references to supporting documentation.

Acknowledgements of Compliance with Division Instructions

- No LME reductions have been imposed on non-crisis state-funded Cross Area Service Program (CASP) funding.
- No reductions have been imposed on crisis funds including Mobile Crisis, Walk-In Clinic and DD START team funding.
- Reductions address state dollars only, with consideration given to the availability of federal service funds.

Fund Balance Utilization

The Division recommends that CenterPoint utilize \$350,000 from Fund Balance to defray the impact of the reductions. The Board of Directors approved the utilization of this amount on September 24, 2009, as shown by Attachment A.

The Planning Process

The Planning Process began in January, 2009, in anticipation of probable reductions in SFY 2010. A Request for Application tightened requirements for achievement of outcomes if awarded state or county funds and required psychiatric oversight of services as shown in Attachment B. Services were monitored and redesigned as demand grew allowing same day walk-in service for consumers with mental health and/or substance abuse issues. Priorities of services in each disability area were defined as stated in Attachment C. The diversion and step-down option of Partial Hospital was established with two providers. Contracts were re-negotiated with providers to maintain a focus on the recovery philosophy while reducing costs. Peer Support Specialists billing under CenterPoint's Alternative Service Definition were included in contracts with selected providers. Increased attention was placed on the development of community natural supports. A grant was secured from CCNC for further support of local integration efforts through the hiring of a care coordinator to work with Medicaid High Risk/High Cost individuals on medical and behavioral health services. Throughout the Planning Process discussions included CFAC, DD Advisory, consumers, family, Peer Support Specialists, Provider Council, safety net provider, hospitals and in-patient provider, elected officials, schools, law enforcement, DSS, DJJDP, CCNC, and community groups such as Forsyth Futures, MHA, NAMI, and Rockingham Stakeholders Group. The details of various meetings and consumer/family involvement are detailed on Attachment D.

Following receipt of the SFY 10 Final Continuation Allocation, two additional meetings were held with the community. The first on September 18, 2009 included invited representatives from various consumer and family groups and others who might offer additional input on further actions to be implemented. As of the time of the meeting the news regarding funding of the Hospital Diversion Pilot had not been received. The invitation and attendance list along with the written Overview provided is attached as Attachment E. On Tuesday, September 22, 2009, an additional meeting was held with various community and media representatives. The invitation and attendance list along with the written Updated Overview provided is attached as Attachment F. A previously scheduled Provider Forum on September 22, 2009, provided an opportunity to discuss the Allocation in depth with a packed auditorium of more than 160 individuals representing providers, many of whom are family members.

Single Stream Funding Reduction & Distribution

Reductions in funding were captured prior to notice of the Allocation Reduction through:

- Analysis and adjustment of allocations for SFY 2010 provider contracts;
- Elimination of state-fund supplementation for CAP MR/DD Waiver consumers (Davie, Forsyth and Stokes Counties) except for five individuals meeting criteria based on medical necessity;
- Revised admission criteria and length of stay limits for state-funded Day Treatment through child-specific contracts;
- Revision of the Benefit Design;
- Reduction of guaranteed in-patient beds from ten to eight;
- Elimination of use of state funds to supplement for Medicaid or insurance funding except where emergent care is needed and no inpatient benefit exists or where exception criteria is met; and
- Restructure of post-discharge services.

Hospital Diversion Pilot Funding

CenterPoint made difficult financial decisions not knowing whether the Hospital Diversion Pilot funding of \$1,500,000 would be paid. Effective and critical services under the Pilot were maintained but redesigned in the planning for SFY 2010. On September 17, 2009, CenterPoint received notice that this funding is allocated and applied that amount to narrow the reduction required.

Remaining Gap in Funding

The State Single Stream Funding Allocation Analysis, Attachment G, shows a remaining gap in funding of **\$475,396**. The gap includes a 3% reserve for future reductions supported by the Provider Council, CenterPoint management and it’s Board. This gap will be closed through the following actions:

- Recoup voluntary contract reductions by providers due to changes in services;
- Reconcile allocations in Rockingham County provider contracts based on claims submitted;
- Analyze state-funded supplementation of Rockingham County CAP MR/DD Waiver services based on medical necessity;
- Authorize residential services, verifying appropriate level of service is billed; and
- Terminate consumer-specific contracts where no longer required.

Distribution of Reductions

The funding reduction deals with Single Stream Funding and all funds are non-UCR.

The allocation of state funds subject to reduction across disability groups is:

Mental Health	36%
Developmental Disabilities	31%
Substance Abuse	15%
Crisis Services	18%

The disability allocations mirror the allocation percentages in last fiscal year.

Revision of Benefit Design

Revisions to the Benefit Design were approved by the Board on September 24, 2009. The changes are indicated on Attachment H in red. Revisions are based on funding reductions, mandated Legislative changes to services, and FY 2010 1st Qtr utilization tracking.



IPRS BENEFIT DESIGN

September 24, 2009

Dr. Nena Lekwauwa, Director Clinical Services

Medical Director

Why Benefit Design?

- To authorize care under clinical guidelines within limited available funding.

Serving the Most with Less

- **Mission**

As a public entity, CenterPoint serves as many in need as possible even though quantity of service may be inadequate at times.

- **The Benefit Design**

To manage IPRS (state) funds, the Benefit Design defines services to be authorized based on projections of service need adjusted to match funding availability.

Benefit Design

- Establishes a basic “package” of services to be authorized.
- Clinical decisions guide type and amount of services designated for each age, disability and consumer population group.

Input into Benefit Design

- Clinical input
 - Medical Director guides decisions about type and quantity of services available to each population.
 - Medical Director oversees response to requests for more/different services outside the benefit “package”.
- Stakeholder input
 - Internal Utilization Management Committee proposes benefit design.
 - External Utilization Committee provides feedback to finalize the benefit design.

IPRS Basic Benefit

An Example of the Benefit Design

- Initial assessment – was 1.5 hours (now 1 hour)
- Mobile Crisis Team - 8 hours
- Up to 4 Hours of Community Support Services weekly: (No new authorizations; service is being eliminated).
 - Consumers needing Medicaid application
 - Children at risk for out of home placement
 - Discharged consumers with limited support

Components of the Benefit Design

Child Mental Health Services

- Community Support – Being eliminated
- Assessments – Reduced from 6 units to 4 units
- Day Treatment—Only authorized with approval from the Medical Director and CEO
- Inpatient same; outpatient benefit increased to address discontinuation of other services
- Respite— Decreased hours authorized
- Intensive In Home – 10 to 8 hours/month for 4 months
- Multi-Systemic Therapy
- Psychiatric Residential Treatment Facility

Child Substance Abuse Services

- Community Support Services - **Being eliminated**
- Outpatient Services – Psychiatric and medication checks; individual, group and family therapy – **Adjusted (some increased; others decreased)**
- Intensive In Home Service – **Contacts decreased from average of 10 to average of 8 per month for 4 months**

Adult Mental Health Services

- Community Support Services – **Being eliminated**
- Community Support Team – **8 to 4 hours per week**
- Psychiatric Evaluation; Medication Evaluation – **12 to 8 visits per year**
- Individual and Group Therapy – **Increased due to expected increased demand due to service decreases or eliminations**
- Psychosocial Rehabilitation – **25 to 20 hours per week**
- Facility Based Crisis
- Inpatient Care
- Assertive Community Treatment Team (ACTT)
- Partial Hospitalization—added to FMC and Old Vineyard

Adult Substance Services

Women & Special Populations

- Community Support Services – **Being eliminated**
- Psychiatric Services; Medication Check
- Group, Family, Individual Therapy
- Medication Injection Services
- Nursing Services
- Ambulatory Detox
- Methadone – **No change; service dictated by federal guidelines**

Adult Substance Abuse

- Comprehensive Outpatient Treatment;
Intensive Outpatient Treatment
- Residential SA Treatment — New provider with lower rate allows longer stays (Residential Treatment Services of Alamance)
- Facility Based Crisis — No IPRS subsidy

Developmental Disability

Child & Adult

Services available under current system :

- Targeted Case Management
- Adult Developmental Vocational Program
- Respite – **Benefit reduced from quarterly to annual benefit several months ago**
- CAP MR/DD (Community Alternative Program) – **No subsidy unless exception criteria set by the state is met**
- Psychiatric Services

Developmental Disability (continued)

Child & Adult

- **Developmental Therapy (limited to small group of consumers receiving CBS prior to March 2006; no additional consumers may receive)**
- **Personal Care (blended with DT when possible to maximize service at reasonable cost)**
- **Supervised Living—Now subject to authorization**

IPRS BENEFIT DESIGN

- In addition to the above changes to the benefit package, IPRS funds can only be used to fund services for consumers with other insurance when certain exception criteria are met.

IPRS BENEFIT DESIGN

Summary

- To authorize care under clinical guidelines within limited available funding.
- To manage IPRS (State) funds, the Benefit Design defines services to be authorized based on projections of service need adjusted to match funding availability.
- Initial Assessment decreased to 1 hour.
- Elimination of Community Support Services. CenterPoint is working with safety net provider to transition the case management component of this service in order to better serve our consumers.
- Day Treatment available only with approval of Medical Director and CEO
- Respite Care decreased.
- Outpatient Services adjusted (some areas increased, others decreased).
- CAP MR/DD (Community Alternative Program) - No IPRS subsidy unless exception criteria is met.
- IPRS funds can only be used to fund services for consumers with other insurance when certain exception criteria are met.