

## Issues in the Creation of a Unified Budget Approach

### *Budget Structure*

Caseload forecasting (good processes that provide accurate data) and therefore funds would be allocated accordingly. There would be regular variance meetings and someone (EMMA) would be responsible for re-allocating funds according to current usage so that funds would be constantly channeled where they are presently doing the most good. In other words, the closest we can come to real-time allocation of dollars.

All LTC funds (state plan or “card” services would not be included) are contained in three line-items overseen by the LTC division of the state Medicaid agency

- One line item is for the “base” rates
- One line item is for incentive mechanisms to increase the base rate for such things as quality, transitioning individuals to a community, or person centered care; these are administration discretionary funds with possible earmarks
- One line item for “state only” programs to reduce barriers and fill gaps (e.g. housing); these are administration discretionary funds with possible earmarks

The General Assembly is responsible for establishing base bundled rates (prices). G.A. also establishes total dollars in the two other line-items.

- The bundle prices are based upon average costs adjusted by acuity and geographic measures, perhaps similar to Medicare, and are “base” rates
- The administration can adjust rates based upon incentives using the discretionary funds, so long as the rates do not go below the “base” rate
- Consumers are allowed to select any service and providers are reimbursed the price plus any incentive for the appropriate bundle, thus directing how funding is allocated among the different providers and settings.

A committee of at least four legislators and one LSC staffer, administrators of appropriate agencies (MH, AGE, OBM, JFS/EMMA), a non-government statistical consultant in forecasting methods, and a non-government research methods consultant will be responsible for determining caseloads for the bundles for budgeting purposes and analyzing impacts of current policy

- The committee would meet at least twice a year and allow for stakeholder input at the meetings
- The committee would be responsible for tracking caseloads, expenditures, and researching policy impacts (e.g. Are the incentives providing the expected outcomes?) and reporting results on a regular interval
- The committee would make policy recommendations to the GA and the LTC division of the state Medicaid agency

Prior action in June 08: create LTC Committee (permanent- could be part of the newly created Medicaid Oversight group) to

- 1) estimate annual client count for programs in Phase 1,

- 2) meet monthly during FY 10 and 11 to confirm or adjust estimates based on actual counts,
- 3) mandate transfers from specific line items to provide adequate funding for actual clients counts, within the total appropriation for LTC. \*

The committee should also meet in FY 09 to make transfers as needed.

Members: Deputy OBM Director (or Director), Aging and JFS Directors, Governor's Human Services staff. OBM chairs.

Retain existing lines for Phase 1 programs but with 525 broken out into at least two categories: one for NFs (excluding ICFMRs) and one for all other. (might be nice to break 525 into actual categories as LSC does in the budget Red Book) i.e. Hospitals, Physician Services, Prescription, Medicare Buy-In, Waivers, All other Care, Disability Assistance plus one for ICFMRs as well, of course, as NFs)

\*CAUTIONARY NOTE: may need funding advance/increase to ensure adequacy of case management system to cover NFs, hospitals, etc. Also technical infrastructure may need some funding.

#### ***Data/IT considerations***

Data must drive the issue. Understanding "per patient" or "per facility" costs will no doubt help to identify needed dollars available.

If MITS is the solution, then we must ensure that it is designed and configured to pull information relevant to our ultimate mission. The amount of needed planning and discussion around data and reporting could not be over-stated.

Whatever system is developed today needs to be driven by an "enterprise" approach to data collection, management, and reporting, thus enabling it to meet the needs of tomorrow. That is to say, all data regardless of entity source needs to be structured and collected in a compatible format so that it can be "sliced and diced" for different constituencies. Picking up on the Subcommittee's discussion, data could then be reported by: Legislative budget line item; service provider type (hospital, physician, home care agency, etc.); specific provider (Dr. A. Smith, Nationwide Children's Hospital); patient (Mary Smith, baby Jones); county (Franklin, Delaware); by department (Medicaid FFS, Aging, Mental Health); by time (month, year); type of service (Emergency Room visit, Inpatient Admission); diagnosis (CHF, URI), member demographics; populations ( all those with diabetes) etc.

Getting all the agencies involved to submit compatible data. (ODJFS probably does it better than any agency with the required "encounter" data that they require of the health plans and which Milliman uses for the development of premium rates. They enforce compliance with serious financial fines on the health plans if data is not submitted timely and accurately.)

Developing a system for reporting. This is more easily accomplished by allowing each agency/department to have access to the data through some kind of report writer that protects the integrity of the data while allowing each stakeholder (within parameters such as HIPAA) to mine the data.

### *Policy Issues*

Budget neutrality. I am concerned that people do not understand that the ULTCB must be budget neutral in this biennium. How do we cap spending, particularly if nursing homes backfill beds as people are transitioned back into the community?

Keeping the care and well-being of the consumers as the highest priority as we try to accomplish this without additional dollars.

Change from funding programs to funding services.

Different program and eligibility requirements - The state is currently operating several waiver programs and supplementing those with some state-funds-only programs, and the eligibility criteria vary across these programs. While we change our thinking from programs to services, it will be important to keep in mind the criteria for receiving Medicaid funding so that we can stretch the state dollars as far as possible. Again, the program aspect should be transparent to the consumer who is only concerned about receiving the needed services.

By combining too much we risk losing the specialization that allows us to serve certain consumer groups more affectively and cost-efficiently.

When PASSPORT first started there were only so many slots available, some sites enrolled at high speed to get more than their share of the pot. Could this happen with funds in flexible buckets and not in individual programs – and similarly - could a high cost need with a large waiting list, eat up all the funds so that fewer consumers would actually be served than today's method?

There should probably be a short-term solution on the way to the ultimate goal of money following the person. The above points (i.e., data collection) will help us to ensure that the needed financial resources can be moved from program to program in the short-term. Identifiable short-term goals would be beneficial. Eventually, with more analysis of available data, we can budget more specifically.

Identify and pursue additional dollars available for federal match.

As the budget construct continues, it is important to keep in mind the concept of equal, as opposed to equitable, access to the funding. The workgroup can not base its design and implementation recommendations on how the “pie” was previously “cut” but needs to understand that all entities should be able to access “savings” based upon consistent need and consumer focus principles rather than historical funding patterns.

Investments in lower cost preventative types of care should be incorporated into the planning/budget construction. Providing comprehensive healthcare and preventative services as early as possible usually results in cost savings over a person's lifetime, not immediate, but consistent long-term savings in cost growth.

Services. How to determine which services should be covered by the ULTCB and how to coordinate those services across systems.

### ***Interagency Coordination***

Turf issues – ODA, ODJFS, ODMRDD, and ODMH offer many of the same services through a variety of programs. It seems a unified budget would be most efficient if it concentrated on services and eliminated the barriers associated with various programs. It will require a lot of discussion to determine each department's role in the process and coordinate those functions.

Cross training and coordination – Change would be difficult if only the state agencies were involved, but the kind of changes we're considering will also affect county boards of MRDD, county departments of JFS, local ADMH boards, AAAs, and possibly others. Whoever determines eligibility will have to understand the full array of services available and the eligibility criteria for each. The case managers will also have to understand what services individual clients are eligible to receive and how to facilitate the clients receiving them.

### ***Other implementation issues***

CMS approval. Based on discussions so far, it seems that the ULTCB workgroup and Administration subcommittee envision a system that is far more flexible than we have today. This will likely require CMS approval and time needs to be built in for that process.

Care must be taken so that if state funding is transferred from one line to another, the budget structure does not cause Ohio to lose federal funding because we no longer comply with federal "maintenance of effort" requirements.