

**System Finance Principles & Process Team**

<b>PROJECT MISSION: (this may later be revised by the team)</b>	
Establish a process for working with constituents to develop a sustainable financing model for the behavioral health system based upon an agreed upon set of principles which support a consumer-centric system.	
<b>GUIDANCE TEAM (TEAM SPONSOR):(the individual(s) who own the existing process and have the authority to approve changes)</b>	
MOU Steering Committee	
<b>BACKGROUND: (strategic importance, what has been happening, importance to the customer)</b>	
The existing models for financing the behavioral health system do not necessarily reflect a focus on consumer needs and choices nor do they reflect current system structure (community rather than institutionally based).	
<b>BOUNDARIES: (limits on scope of process change allowable as defined by the team sponsor – authority to pilot improvements/or just recommend, legal restrictions, budget, etc.)</b>	
This team is limited in scope to making specific recommendations to the MOU Steering Committee. If requested this team will assist in implementation of the recommendations.	
<b>WHAT THE TEAM HAS THE AUTHORITY TO DO:</b>	
Develop principles and recommendations for updating the system financing models which take into consideration consumer access, choice and need.	
<b>ESTIMATED DATE FOR COMPLETION:</b>	<b>MEETING FREQUENCY &amp; DURATION:</b>
July, 2008	To be determined by team.
<b>MEMBERS: ODMH, ODADAS, OACBHA, Ohio Council (Pat Bridgman, Hugh Wirtz), OACCA, FSCO (Peg Burns), NAMI, Ohio Citizen Advocates (Dona Conley), OAMH, Ohio Federation of Families for Children’s Mental Health, Prevention Council of Central Ohio (Traci Mason), ADAPAO (Jim Ryan), County Commissioners.</b>	
<b>Members as Needed:</b>	
<b>GUIDANCE TEAM LIAISON:</b>	
<b>FACILITATOR:</b>	
<b>TEAM LEADER:</b>	
<b>TIMEKEEPER:</b> Rotating	
<b>SCRIBE:</b> Rotating	

## **System Principle Meeting Participant Groupings**

### **Group 1**

Debbie Nixon-Hughes  
Cheri Walter  
Tony Pollard  
Jim Mauro  
Mark Miller/Peg Burns  
Hugh Wirtz  
David Dhume  
Laura Moskow Sigel  
Cassandra Rufat  
Traci Mason  
Doug Day  
Terre Garner

### **Group 2**

Bill Harper  
Joan Englund  
Mike Jenks  
Pat Baumgarner  
Betsy Johnson  
Pat Bridgeman  
David Pepper  
Paddy Kutz  
Veronica Groff  
Peter Schoepflin  
David Royer  
Tony Williams

### **Group 3**

Rick Tully  
Linda Pickenpaugh  
Wendy Williams  
Gloria Walker  
Bill Bierie  
Beth Tsvetkoff  
Lisa Oswald  
Janet Galligan  
Bennett Cooper  
Sharon Tention  
Donna Conley  
Tracee Black

## Project Method

- Establish Principles
- Determine Variables
- Recommend Principles & Variables to the Directors.
  - The Principles inform and guide decision making related to the distribution formula.
  - The Variables are used in the formulas to operationalize the principles and can be adjusted or weighted to reflect the current needs of those we serve.

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## Project Method

- What is a Principle?
  - A basic generalization that is accepted as true and can be used as a basis for reasoning or conduct.
  - Implies something established as a standard or test, for measuring, regulating or guiding conduct or practice.
  - A general and fundamental truth that may be used in deciding conduct or choice.

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## Project Method

- What is a Variable?
  - A way of quantifying, measuring and/or attaching a value to a principle.
  - A proxy for a principle that can be used in an actual distribution formula.

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## Project Method

- Example of a Principle in the Initial Distribution Formula
  - Provide services in the least restrictive setting.
- Examples of Variables in the Initial Distribution Formula
  - Historical hospital use
  - SMD count
  - Unmet need factor

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## Project Method

- Example of Adjusting Variables to Reflect Changing Needs In the Initial Distribution Formula
  - Shifting the weighting of the factors over a 6-year implementation period
    - Historical hospital use – 90% to 0%
    - SMD count – 5% to 50%
    - Unmet Need Factor – 5% to 50%

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**System Finance Principles & Process Team  
Summary of Principles, Variables and Related Areas of Work**

**Principle 1: Uniform access to a core set of services and supports appropriate to the need of the consumer.**

Uniform Access: All Ohioans a theme across all 3 groups.

Variables: Per Capita  
Poverty Indicators  
Prevalence  
Capacity to raise local funds  
Population Density  
Distance from services  
Medicaid – i.e. entitlement – match sources/responsibilities  
Non-Medicaid  
Workforce

Core Services and Supports: Crisis intervention and stabilization a theme.  
Need to define a core set of services.  
XIX services available to all (eligible and non-eligible)

Variables: Core services once defined.  
For whom?  
In what amount?

**Principle 2: Scarce resources are prioritized to those most in need.**

Need to define SMD, SED and/or SPMI.  
Consideration of AoD levels of care and priority populations.

Variables: SMD, SED and/or SPMI count/Prevalence  
Population leaving prisons or other institutions  
Variables related to determining medically underserved status/health professional shortage areas  
Medicaid/Medicare Consumers  
Psychiatric Reduction – guaranteed loss

Need to determine impact of and how to handle from a financing perspective those consumers who have needs across multiple systems. This is also connected to assuring that pooled funding occurs to maximize dollars for direct services in Principle #3.

**Principle 3: Maximize dollars to direct services.**

Need to define administrative costs consistently at all levels.

Variables: Administrative cost  
% of funds to direct services  
Reduce administrative burden  
Funding inefficient  
Reduce administrative rules and guidelines  
Maximize dollars to direct services

**Principle 4: Funding supports economically viable provider system.**

Need to discuss how this translates directly to system financing. Many issues identified are being addressed through other mechanisms such as MOU, TSIG, or reimbursement methodology changes. All the principles discussed connect back to a viable provider system.

- Key Performance Indicators
- Liquidity Ratios
- Net Assets
- Credit Lines
- Revenues
- Reserve Levels
- Diversification
- Staffing levels
- Any willing provider? - balance
- Cost of XIX – only vs. XIX & ADAMH board contract
- Measurement of fee increases as relates to cost of living
- Level playing field – fair and uniform procurement system
- MR/DD system model?

**Principle 5: Funding supports outcomes that are consumer-driven, effective, high quality, least restrictive, and most appropriate.**

Incentivize consumer choice, quality, and culturally competent services through an incentive pool or separate subsidy that is not distributed via a formula.

Incentivize multi-board and multi-agency consortiums that achieve efficiency.

Administration as variable

Administrative Ratio

System efficiency/reduce duplication

Outcomes

Consumer choice

Need to define outcomes for all principles first

Retention is the key to AoD/MH treatment

Length of treatment  
Concern about funding outcomes and tendency to serve less-ill individuals  
Services to non-English speaking consumers  
Economies of scale to meet needs of racial and ethnic minorities  
Teleconferencing could help to share psychiatrists and other staff  
Measuring cultural competency  
Costs per level of improvement  
Consumer and family satisfaction

**Principle 6: Funding supports culturally competent services.**

Variables: Race and/or ethnicity counts that demonstrate disparity  
% of population other than Caucasian  
Complexity of racial composition  
Work free competency  
Crisis care/hospital usage

Formula Funding Workgroup Meeting  
Flip Chart Notes  
August 26, 2008

Group #1

Principle #1: Agree with amendment

1. Medicaid – i.e. entitlement – match sources/responsibilities  
Non-Medicaid – variable
2. Per capita – O.K. as variables but carries “low” weighting
3. Local funds as variable a concern – disincentive (?)
4. Population density – now applied (?)

Principle #2: Medicaid/Medicare Consumers

Medicare

\*Psychiatric Reduction – “guaranteed loss”

Principle #6: Ethnicity/Culturally

- See our group list

Principle #1:

What are the core services?

Need? Tx, Prevention, (?)

Adult/Kids?

Crisis Services:

1. To identified patient
2. To “anonymous”/not identified

Principle #2: Criminal Justice Referrals?

AoD – Female Gender-specific

Prevention

IVDU's

CJ – i.e. Drug Courts/D.I.P.'s

Principle #3: Administrative costs defined:

UCR definition – provider

Boards - ? – Culture of quality

State - ?

% of funds to direct services

- A “cap”/what’s reasonable
- Start with measuring at all levels (state, provider, board)
- System measure (?) – all together
- AoD prevention?

Principle #5: Administration as variable (?)  
Administrative Ratio  
System efficiency/reduce duplication (?)  
Outcomes – how?

Principle #4:  
KPI's  
Liquidity Ratios  
Net Assets  
Credit Lines  
Revenues  
Reserve Levels  
Diversification  
ETC.

Principle #6:  
Do 1, 2 & 3 “right” to support/address 4, 5 & 6  
Racial/ethnic disparities  
Outcomes – disparities are?  
- Service Utilization  
- DYS  
- School/DYS out (?)  
Work free competency  
Crisis Care/Hospital usage

### Group #2

Principle #1: Uniform Access

Variables:

Capacity to raise local funds:

- Property valuation factor
- AoD v. MH
- Concerns about disincentive for passing levies
- Avoid \$1:\$1 local/state

Core Services:

- Crisis intervention/available (hotline, face-to-face)
- XIX services available to all (XIX eligible and non-XIX eligible (include inpatient beds/population) includes detox and partial hospital

Other services to be considered:

- Vocational/employment?
- Housing?
- Outreach?
- Prevention?

- Wrap-around/service coordination?
- Transportation?
- Information & referral/
- Education and awareness?
- Training?
- Capacity building?

AoD/MH system responsibility?

\* Core package changes with definition of group serving

Workforce – add to principle #1

- Availability of key staff to provide core services
- Increasing demand
- Lack of AoD treatment profs.
- Staff turnover
- Professional staff/1,000 pop available to serve public/private N.P. system

Per Capita:

- Account for needs?
- Does account for shift in population which influences demand for services.

Prevalence:

Use of epidemiological research

- Holzer/Epidemiological catchment area
- Consequences for current provider systems

Understand difference between incidence and prevalence

- of what?
- SED? SMD?
- Substance use disorders?
- Any mental disorders?

- Concern about adverse impact of shifting to a prevalence basis (takes legislature “off the hook”)
- Hold harmless and phase-in to prevalence methodology
- Major disruption is a great concern (and will be for legislators)

SMD/SED/SPMI/Chemical Dependency, other AoD

- 508 count unreliable
- lack of consistency with current method of identifying
- ODADAS list of priorities
- Pregnant women/CSB referrals
- Level of care/needs for mental health system

Tie level of need to clusters?

- Can relate to core set of services (menu)
- Flexibility to select from a menu of services
- Valid, consistent, reliable and not gamed
- Pooled funding is “tricky” – care taken not to mess it up

Principle #3:

- Reduce administrative burden to reduce administrative costs
- Funding extremely inefficient (e.g. paper reporting)
- Reduce administrative rules and guidelines... (ODMH/ODADAS) target by date

Administrative Cost:

- Defined consistently
- Count all levels of the system
- Take into consideration differing demands (e.g. multi-county FCF's)
- Regional initiatives

Principle #4:

- Staffing levels
- KPI's (fiscal)
- Any willing provider? – balance
- Cost of XIX-only vs. XIX & ADAMH board contract (higher) (not accountable at same level)
- Measurement of fee increases as relates to cost-of-living (compensation for line staff)
- Level playing field - \* fair and uniform procurement system
- MR/DD system model?

Principles #5 & 6:

- Consumer choice – menu of services based on severity of illness/disorder
- Need to define outcomes for all principles first (hard to measure)
- Retention is the key to AoD treatment (& MH as well)
- Length of treatment (significance esp. in AoD)
- Concern about funding outcomes and tendency to serve less-ill individuals
- Services to non-English speaking consumers
- Economies of scale to meet needs of racial and ethnic minorities
- Teleconferencing could help to share psychiatrists, other staff (funding for technology)
- Measuring cultural competency
  - Behavioral health module (use data currently available)
  - Expand culture beyond race & ethnicity to include age, Appalachian, Amish, poverty, sexual orientation, military part.

### Group #3

Principles #1 and #2: Uniform (as a process for determining access) access to a core set of services & supports appropriate to the need of the consumer

Parking lot – age – uniform as process methodology to determine access to services

Variables:

- Per Capita: a significant factor but has less weighting – modified by variables like SMD, SED, SPMI
- Poverty Indicators: local vs. state poverty levels; income-based vs. under – or uninsured; sliding fee scale – determined and applied uniformly, or on board-by-board basis?

#### PI definitely a variable

Income

Free/reduced lunch

Governor's poverty determinants

Uniform Fee Schedule - ? Conflict b/w local and state dollars – disparity/variances across state. Would like to see uniform process in distribution of state administered dollars.

- Prevalence (hold)
- Capacity to raise local funds:
  - No disincentives to raising local funds; i.e., don't take state \$ away because of local levy
  - Degree of disability
  - Transportation availability
- Population Density:
  - Consider population density relative to distance from services
- Distance from services:
  - CMHC
  - State hospitals
  - Youth inpatient & residential services
  - AoD IP/Residential
  - Should there be a rural factor?
- Workforce Training & Capacity:
  - What is needed capacity to assure access?
  - Public health service corps – utilize to help down healthcare professional shortage
  - Medically underserved health professional shortage areas (HPSA)  
We recommend use of HPSA factors in funding formula

- Investigate FQHC criteria (eligibility)
  - Adult SMD/SPMI
    - Ohio's definition – very broad and inclusive
    - NAMI & SAMHSA have narrower definition/criteria for SMD/SPMI – considers level of functioning (functional impairment), but maintains case of re-entry to services/system
    - Medicaid – as a prioritizing factor
    - Includes AoD & dually dx'd (co-occurring); AoD/SPMI, AoD/MR
    - SED (youth) population (very broad definition) – includes most youth in system; emphasis on youth 0 – 5 years old (prevention and intervention)
    - Need service package to address SED population
    - Criminal justice – NGRI/Forensic population/re-entry services for AoD/DYS/MH – release rates for this population
  - Pooled funding to help with admission/intake services – entry point to system and needs to be truly integrated health system
  - Adult AoD – Priority Population
    - Dependence vs. abuse for prioritizing
    - Childless, Indigent adult with AoD, (no children) and not Medicaid eligible – poverty variable = HUGE
    - Criminal justice population
  - Youth AoD
    - Access sporadic and very limited
  - Child Welfare Population (484 \$ for AoD Youth)/Foster Care Population
    - What is prevalence of youth with AoD/MH in child welfare and foster care systems?
- Comments: Need to look at pooled funds/resources across all Human Services

**Principle #3: Maximize \$ to Direct Services**

Definition and criteria for administrative costs:

- Breakout purely administrative, support and direct services
- One consideration: if using fee schedule, market forces will determine # of providers (only for Medicaid)

Comments: unfunded administrative mandates (i.e., EBPs, outcomes)

**Principle #4: Funding supports economically viable provider system:**

- Look at Blue & Co. finance reports (days cash on hand, profit/loss, etc.)

**Principle #5: Funding supports outcomes that are consumer & family driven, effective, high quality, least restrictive and most appropriate**

- Costs per level of improvement (work towards this)
- Consumer and family satisfaction

**Principle #6: Funding supports culturally competent services**

- Cultural competence does not equal race
- Need definition for cultural competence (MACC)
- Needs to include different experiences of diverse groups using services  
i.e., need funding to address special populations in state hospitals  
(pregnant, single mothers, addicted to methadone)
- Do outcomes approximate different cultural groups?
- Values of every individual in the system need to be recognized,  
respected and integrated into their treatment.
- Engagement and retention needs to be measured and addressed
- Consumer and family satisfaction surveys