



MODERNIZE MEDICAID

Reset Medicaid payment rules to reward value instead of volume

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Share services across jurisdictions to improve operational efficiencies and related outcomes.

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Office of Health Transformation **Modernize Medicaid Eligibility**

Governor Kasich's Budget:

- *Requires premium payments for adults over 100 percent of poverty.*
- *Speeds up the transition off of Medicaid.*
- *Standardizes Medicaid coverage for adults above 138 percent of poverty.*
- *Saves \$100 million (\$47 million state share) over two years.*

Background:

Medicaid is funded jointly by the federal and state governments. The federal government sets some basic requirements concerning eligibility levels that must be covered in every state. While Ohio has some control over the income limit for each eligibility category, federal law requires Medicaid coverage to be provided to individuals who meet specific categorical requirements. Categorical and eligibility requirements are specified in a particular state's Medicaid state plan. Altering eligibility levels requires approval of a state plan amendment by the Center for Medicare and Medicaid Services (CMS). Ohio's current state plan covers the following groups:

- ***Modified Adjusted Gross Income (MAGI) coverage.*** Some individuals are eligible for Medicaid based on their household income, including:
 - *Children under age 19 below 206 percent of the federal poverty level (FPL);*
 - *Young adults aging out of foster care (no income limit);*
 - *Pregnant women below 200 percent FPL; and*
 - *Adults age 19 to 64 years, not covered by Medicare, below 138 percent FPL (133 percent plus a five percent income disregard).*
- ***Aged, Blind, and Disabled (ABD) coverage.*** Medicaid benefits are afforded to Ohioans who are age 65 or older, or who are living with blindness or a disability, using income calculations based on Social Security Income methodologies. Individuals are eligible for ABD coverage below 64 percent of poverty but can "spend down" from a higher income level on health care costs and, if they hit the 64 percent level, become eligible.
- ***Other categories of eligibility.*** In some cases, Ohioans at higher income levels who would not qualify for Medicaid based on MAGI or ABD criteria instead qualify because of other special circumstances. These groups include persons with long-term care needs (up to 225 percent FPL) and enrollees who came into the program through presumptive eligibility, or the Breast and Cervical Cancer Program (BCCP). There are also several "limited coverage" programs that are time-limited or offer limited services, including

Refugee Medical Assistance, Alien Emergency Medical Assistance, Family Planning Services, and the Medicare Premium Assistance Program.

In 2014, Ohio Medicaid provided health care coverage for 2.8 million low-income Ohioans, including 1.2 million children, 430,000 seniors and people with disabilities, and 1.1 million other adults. About half of the Medicaid eligible adults work (42 percent have earned income) and, for those without earned income, about half (46 percent) have a behavioral health diagnosis or using behavioral health services.

Executive Budget Proposal and Impact:

The Executive Budget makes eligibility changes that acknowledge the availability of subsidized coverage on the federal marketplace exchange and promote personal responsibility. In total, these changes save \$100 million (\$47 million state share) over two years.

- **Assess premiums for adults above 100 percent of poverty.** Ohio Medicaid currently requires cost sharing in the form of co-pays for everyone except children, pregnant women, and persons who are aged, blind or disabled (ABD). There are no premiums in the current Medicaid program. The Executive Budget requires childless, non-pregnant adults who have income between 100-138 percent MAGI to pay a monthly premium to the Medicaid program. Under Section 1115 of the Social Security Act, CMS may grant Ohio the authority to charge premiums for this population. After three consecutive months of premium payment delinquency, an individual may experience a disruption in coverage. Monthly premium amounts will be calculated using a similar methodology as used in the federal marketplace exchange and capped to not exceed two percent of household income. The average monthly premium charge is expected to be approximately \$20. This provision will take effect January 1, 2016 and save \$1.6 million in 2016 and \$3.2 million in 2017 (state share).
- **Eliminate Medicaid coverage for non-aged or disabled adults above 138 percent of poverty.** Because subsidized health insurance is now available on the federal marketplace exchange, the Executive Budget will eliminate Medicaid coverage above 138 percent MAGI for pregnant women, BCCP, and the Family Planning Group. Currently, individuals in these groups are eligible for Medicaid up to 200 percent of poverty, but those levels were set when the federal exchange did not exist and the only alternative to Medicaid was to be uninsured. Ohioans enrolled through the pregnant women and BCCP eligibility groups at the time of the change will be allowed to continue to receive services through Medicaid until their eligibility expires under current rules. Individuals with eligibility in the Family Planning Group with income below 138 percent MAGI can obtain full Medicaid coverage instead of the limited benefit, and those above 138 percent MAGI can obtain subsidized coverage through the federal marketplace. This provision saves \$15.3 million (\$7.4 million state share) in 2016 and \$31.4 million (\$15.4 million state share) in 2017. This provision does not apply to persons at higher incomes

who qualify for Medicaid through Medicaid Buy-In for Workers with Disabilities (MBIWD) or because they need long-term care services; these groups require services available through Medicaid but not necessarily covered by plans on the exchange.

- **Speed up the transition off Medicaid.** Currently in Ohio, when a parent or caretaker relative’s earned income increases above the eligibility threshold for the group (206 percent of poverty for children and 90 percent of poverty for parents and caretakers), a 12-month Transitional Medical Assistance (TMA) span is approved without requiring individuals to complete quarterly reporting of their income. The Executive Budget will return this eligibility policy to the pre-recession policy which will provide six months of continued Medicaid eligibility in addition to quarterly reporting. As long as the person’s income remains below 185 percent of poverty and he or she reports quarterly, six additional months of eligibility will be granted. This provision saves \$4.1 million (\$1.5 million state share) in 2016 and \$39.9 million (\$15.0 million state share) in 2017.
- **Raise the income level at which individuals with disabilities qualify for Medicaid and eliminate spend down.** The Executive Budget requires Ohio Medicaid and Opportunities for Ohioans with Disabilities (OOD) to replace Ohio’s two duplicative disability determination systems with one system that will determine eligibility for both Medicaid and Supplemental Security Income (see *Simplify Eligibility Determination*). Under the new system, the income standard for Medicaid will be raised from 64 percent FPL to 75 percent FPL to match eligibility for Supplemental Security Income, and the asset test will be raised from \$1,500 to \$2,000. As a result, an estimated 7,110 additional Ohioans will qualify for Medicaid at a cost of \$51.4 million (\$19.3 million state share) in 2016 and \$65.0 million (\$24.4 million state share) in 2017. At the same time, spend down will be eliminated, which will result in approximately 4,500 Ohioans no longer qualifying for Medicaid because their income is too high, resulting in savings of \$47.1 million (\$17.7 million state share) in 2016 and \$59.6 million (\$22.4 million state share) in 2017. The reduced cost of administering one system instead of two will generate additional savings of \$6.0 million (\$3.0 million state share) and \$7.4 million (\$3.7 million state share) in 2017. The net impact of these changes costs \$1.7 million (\$1.4 million state share) in 2016 and \$2.0 million (\$1.7 million state share) in 2017.
- **Why the Budget otherwise remains silent on Medicaid coverage levels.** Current Medicaid eligibility levels were approved on October 10, 2013 and went into effect on January 1, 2014. The Kasich Administration supports the current levels, so the budget bill is silent on this issue. The authority to set and keep Medicaid eligibility at current levels results from a combination of the following federal and state laws:
 - Federal law requires state Medicaid programs to cover a specified set of *mandatory* eligibility groups and permits them to cover *optional* groups.¹

- Ohio law requires Medicaid to cover “all mandatory eligibility groups” and permits the program to cover “any of the optional eligibility groups” unless otherwise prohibited by state law (Ohio Revised Code section 5163.03 enacted June 2013).²
- The most direct method to set Medicaid eligibility levels is via a State Plan Amendment (SPA). Ohio law permits the Medicaid director to seek a SPA without additional legislation (Ohio Revised Code section 5162.07 enacted June 2013)
- On September 26, 2013, the Ohio Medicaid director submitted a SPA to seek federal approval to extend coverage to Ohioans with income below 138 percent of poverty. (Ohio law does not prohibit covering this group.)
- On October 10, 2013, the Centers for Medicare and Medicaid Services (CMS) approved Ohio’s SPA request and made federal funds available to extend Medicaid coverage in Ohio beginning January 1, 2014.³

The existing state plan authority does not expire. Therefore, unless the Medicaid director submits another SPA to change Ohio’s policy, the current Medicaid eligibility levels – including the expansion group – remain in effect.

¹ The Affordable Care Act (ACA) amended Section 1902 of the Social Security Act to require each state to provide Medicaid coverage for poor adults under 138 percent of poverty even if they do not have either a disability or children at home. Section 1903 of the Social Security Act provides that a state can lose federal financial assistance if the state plan, or the state’s administration of the state plan, fails to comply with Section 1902. Specifically, division (a)(10)(A)(i)(VIII) of Section 1902 requires that, as a condition of receiving federal Medicaid dollars, a state’s Medicaid state plan “must ... provide [for] making medical assistance available ... to all individuals ... beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under [Medicare Part A], or enrolled for benefits under [Medicare Part B], and are not described in a previous subclause of this clause, and whose income ... does not exceed 133 percent of the poverty line [with a 5-percent disregard that increases the limit to 138 percent of the poverty line] ... applicable to a family of the size involved,” The United States Supreme Court upheld the ACA requirement on states to extend Medicaid coverage but restricted the federal government’s enforcement authority for that provision, making it expressly mandatory but effectively optional for states to comply.

² R.C. 5163.03: “(A) Subject to section 5163.05 of the Revised Code [which allows eligibility requirements for aged, blind, and disabled individuals to be more restrictive than the eligibility requirements for the supplemental security income program], the Medicaid program shall cover all mandatory eligibility groups. (B) The Medicaid program shall cover all of the optional eligibility groups that state statutes require the Medicaid program to cover. (C) The Medicaid program may cover any of the optional eligibility groups [that] state statutes expressly permit the Medicaid program to cover the optional eligibility group [or] state statutes do not address whether the Medicaid program may cover the optional eligibility group. (D) The Medicaid program shall not cover any eligibility group that state statutes prohibit the Medicaid program from covering.”

³ Ohio Medicaid routinely seeks and the federal government approves State Plan Amendments that set specific eligibility and benefit requirements for Ohio’s program. Since January 2011, Ohio Medicaid submitted 117 SPAs and CMS approved 80, disapproved one (now pending appeal), and 36 are pending consideration (January 2015).

Office of Health Transformation **Modernize Medicaid Benefits**

Governor Kasich's Budget:

- *Moves behavioral health services into managed care.*
- *Creates a special benefit program for adults with severe mental illness.*
- *Expands the Medicaid in Schools Program.*
- *Invests \$193 million (\$55 million state share) over two years.*

Background:

Ohio Medicaid makes health care coverage available to more than 2.9 million residents through five private managed care plan provider networks and its own network of 83,000+ providers in the fee-for-service program. Benefit thresholds for Medicaid vary from state to state. However, each state's Medicaid program must provide, at minimum, services within the following categories: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and behavioral health services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventative care and wellness services, and pediatric services. Ohio Medicaid's fee-for-service program goes beyond the essential health benefit (EHB) to include additional coverage such as, dental and vision services and physical therapy. Medicaid managed care plans are required to cover all services included in Medicaid fee-for-service. The plans also have the ability to cover additional services not included through traditional Medicaid.

Executive Budget Proposal and Impact:

The Executive Budget invests in three important benefit expansions that protect vulnerable populations and improve care in ways that will save taxpayer dollars over the long term. It moves behavioral health services in managed care, creates a new behavioral health waiver program, and expands the Medicaid in Schools Program (MSP). These provisions cost \$193 million (\$55 million state share) over two years.

- ***Improve care coordination and outcomes through managed behavioral healthcare.*** In order to improve care coordination and behavioral health and overall health outcomes for people with mental health and addiction service needs, Ohio Medicaid and the Ohio Department of Mental Health and Addiction Services (MHAS) will restructure all Medicaid-reimbursed behavioral health services under some form of managed care. Providers include community behavioral health organizations, inpatient hospitals, clinics, and specialty practitioners. Ohio Medicaid and MHAS will coordinate the effort to organize services under managed care with other reforms to modernize the

behavioral health benefit and identify high risk/high severity populations (see *Rebuild Community Behavioral Health System Capacity*). Ohio Medicaid and MHAS have not made any final decisions on the specific requirements for care coordination and the types of managed care entity or entities that will be contracted with for this purpose. Ohio Medicaid and MHAS will develop structured processes for stakeholder input to occur during March 2015, and will make final decisions shortly after that time. This provision costs \$68.9 million (\$25.9 million state share) in 2017.

- **Create a special benefit program for adults with severe mental illness.** As a result of the new single disability determination process proposed in the Executive Budget (see *Simplify Eligibility Determination*), the majority of people whose income will be above the Medicaid need standard adopted under the new system are adults with severe and persistent mental illness (SPMI). These Ohioans will have access to basic health care services through Medicare or private insurance. However, neither Medicare nor private insurance pay for a range of service coordination and community support activities currently covered in the Medicaid program. In order to ensure continued access to these services, Ohio Medicaid will seek a state plan amendment under section 1915(i) of the Social Security Act to provide for eligibility for adults with SPMI with income up to 225 percent of poverty (300 percent of the Federal Benefit Rate) who are not eligible under another Medicaid category and who meet diagnostic and needs assessment criteria established by the state and validated by a third party entity. Ohio will also identify home and community based services needed by this population to be covered as services under the 1915(i) authority. MHAS will contract with a vendor pursuant to requirements established by Ohio Medicaid to validate the diagnostic and needs assessments conducted by qualified behavioral health providers. These assessments will be used to authorize eligibility and services under 1915(i). The 1915(i) services will be developed in conjunction with a broader benefit redesign (described in *Rebuild Community Behavioral Health Capacity*). MHAS staff will conduct outreach efforts with behavioral health providers and consumer and family organizations to ensure support for people who need to enroll in the 1915(i) program. This provision costs \$34.4 million (\$12.9 million state share) in 2016 and \$43.5 million (\$16.4 million state share) in 2017.
- **Expand the Medicaid in Schools Program.** Ohio Medicaid reimburses schools through the Medicaid in Schools Program for services provided to children with an Individualized Education Plan (IEP), including but not limited to behavioral health, nursing, occupational therapy, targeted case management and specialized transportation. The school is responsible for providing these services, but can draw federal funds through the MSP program to reimburse 64 percent of the cost. Currently, there are 580 school systems enrolled in the MSP program serving 61,000 Medicaid-eligible students with an IEP. Ohio Medicaid recently made several important improvements in the MSP program, developing guidance on a number of topics including nursing in school versus use of state plan private duty nursing, using tele-health codes for speech-language pathology, updating claiming codes, billing for assessments and evaluations, and initiating discussions with schools and other stakeholders to improve program integrity. Although

Medicaid cannot cover all services that may be included in an IEP, the Executive Budget expands MSP program coverage to include intensive behavioral services provided by a Certified Ohio Behavioral Analyst (COBA), services provided by an aide under the direction of a registered nurse or COBA, and specialized transportation from a child's home to school. This provision will allow schools to claim federal funds totaling \$22.2 million in 2016 and \$24.3 million in 2017 for services that the school districts otherwise would have been required to provide with their own funds. There will be no impact on the state general revenue fund because the school districts provide the local match, through expenditures tied to eligible IEP services, to draw federal Medicaid funds.

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Office of Health Transformation **Reform Health Plan Payments**

Governor Kasich's Budget:

- *Shifts more populations from fee-for-service into managed care.*
- *Moves behavioral health services into managed care.*
- *Launches a significant new infant mortality initiative.*
- *Saves \$343 million (\$130 million state share) over two years.*

Background:

Most Medicaid beneficiaries – 79 percent in June 2014¹ – now receive Medicaid health care benefits through one of five private managed care plans. Ohio Medicaid paid those plans \$8.0 billion in 2014 to provide access and coordinate care to a comprehensive set of medically necessary services. Ohio Medicaid pays the health plans monthly, per person, using capitation rates. Health plan capitation rates are set annually using a combination of actual cost data and medical cost inflation data to establish reasonable costs for services and administration.

First Four Years:

Ohio Medicaid completely overhauled its managed care program during the first four years of the Kasich Administration. The Administration launched a series of reforms designed to improve care coordination for beneficiaries while reducing costs for taxpayers. As a result, Ohio now is viewed as a national leader in public-private partnerships to improve overall health system performance. Among the changes, Ohio Medicaid:

- ***Consolidated health plan regions and populations to be more efficient.*** In July 2013, Ohio Medicaid reduced the number of service regions from eight to three and combined coverage for families and children and aged, blind, and disabled populations. This new design increased individual choice and competition by offering five health plan choices statewide, compared to two or three per region previously.
- ***Linked health plan payments to performance.*** Ohio Medicaid implemented new health plan contract language, based on model language developed by the private-sector Catalyst for Payment Reform, to move Ohio's Medicaid health plans from paying for volume to paying for value. To accomplish this, health plans are required to develop incentives for providers tied to improving quality and health outcomes. Additionally, the

¹ Out of 2.561 million Ohioans receiving full Medicaid benefits in June 2014, 2.024 million were enrolled in a private sector managed care plan.

new contracts increased expectations around nationally recognized performance standards that health plans now must meet to receive financial incentive payments.

- **Improved care coordination for children with disabilities.** Approximately 40,500 Ohio children previously served through the traditional Medicaid fee-for-service system were transitioned to private health insurance plans as part of Ohio Medicaid's new managed care program. Many of these children have long-term, complex conditions, but received little assistance in accessing services or coordinating care. Today, these children have access to all medically necessary services, but also benefit from the availability of a 24/7 nurse advice line, support from member services, and access to care management.
- **Integrated care delivery for Medicare-Medicaid enrollees.** Ohio was the third state to earn federal approval for its plan to coordinate care for individuals receiving both Medicare and Medicaid benefits. *MyCare Ohio* is a three-year demonstration program launched in May 2014. As of January 1, 2015, approximately 100,000 individuals in 29 counties are being served through the demonstration and nearly \$1.2 billion in claims have been paid to *MyCare Ohio* providers.
- **Increased administrative efficiencies to hold down health plan rates.** Governor Kasich's Jobs Budget 2.0 (enacted in 2013) included multiple provisions to further improve managed care program efficiency and save taxpayer dollars. Primarily, reductions were made to the administrative and prescription drug components of the negotiated managed care rates. These changes resulted in savings of \$646 million over two years.

Executive Budget Proposal and Impact:

The Medicaid managed care program, after significant recent change, is stable and performs well. The Executive Budget proposes to move additional populations from fee-for-service into managed care, and use one-time unearned Medicaid health plan quality incentive funds to offset one-time conversion costs. The net impact of these changes is savings of \$73 million (\$27 million state share) in 2016 and \$270 million (\$103 million state share) in 2017. The Budget:

- **Gives individuals with developmental disabilities an option to enroll in managed care.** Approximately 40,000 Ohioans with developmental disabilities who reside in an institution or receive home and community based services are excluded from the benefits of better care coordination through managed care. Beginning January 1, 2017, these individuals will have the option (no requirement) to enroll in a health plan, which in some cases may improve their access to primary care physicians, specialists, and dental services. This provision costs \$3.6 million (\$1.3 million state share) in 2017.
- **Enrolls adopted and foster children in managed care.** Children in Ohio's child welfare system are enrolled in Medicaid's fee-for-service program and excluded from the benefits of better care coordination through Medicaid managed care. Beginning January

1, 2017, the Executive Budget proposes to shift 28,000 children in this situation from fee-for-service to managed care. These children have unique needs and their transition into managed care will be monitored to ensure consistent coverage, better care coordination, and improved access to services. This provision costs \$32.2 million (\$12.1 million state share) in 2017.

- ***Gives individuals access to better care coordination on day one.*** Currently, it takes an average of 45 days for an individual who qualifies for Medicaid to be enrolled into one of five managed care plans. The Executive Budget changes that process so an individual could enroll in a Medicaid managed care plan of their choosing upon enrollment. Immediate enrollment allows for faster access to care management and better access to services. This provision costs \$38.2 million (\$13.0 million state share) in 2017.
- ***Engages leaders in high-risk neighborhoods to connect women to health care.*** The Executive Budget requires Ohio Medicaid to direct its managed care plans to use community health workers who live in the most high-risk neighborhoods to assist with the outreach and identification of women, especially pregnant women, to make sure they are connected to ideal health care and other community supports. Rather than reach into a community and risk misunderstanding the issues that confront the women who live there, this proposal requires the plans to identify individuals from within the community who understand the issues and can remove barriers for the women living there. The community health worker will be expected to address more than just health care, and also connect women to community services outside the health plan that support healthy living and work. The health plans will be required to coordinate with local health districts in high-risk neighborhoods and, together, develop a communications plan to ensure all health care and community supports are aligned toward decreasing infant mortality and improving the health of families. This provision costs \$13.4 million (\$5.0 million state share) per year in 2016 and 2017.
- ***Sets managed care rates at the lower boundary.*** Ohio Medicaid is provided a range of actuarially sound rates from which to set managed care capitation rates. Beginning January 1, 2016, Ohio Medicaid will set rates at the lower boundary. This change will reinforce efficient operations from the Medicaid managed care plans and streamline internal processes at the state level. This provision will save \$35.8 million (\$13.4 million state share) in 2016 and \$115.5 million (\$43.4 million state share) in 2017.
- ***Uses one-time unearned managed care quality incentive funds.*** The Executive Budget proposes to offset the one-time cost associated with shifting current fee-for-services populations into managed care by using the unearned balance in the Medicaid managed care incentive fund. Beginning July 1, 2016, Ohio Medicaid will use the unclaimed balance to offset state general revenue fund expenditures. This provision saves \$51.4 million (\$19.3 million state share) in 2016 and \$236.9 million (\$89.1 million state share) in 2017.

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Office of Health Transformation **Reform Physician Payments**

Governor Kasich's Budget:

- *Increases physician rates \$156 million over two years.*
- *Increases dental provider rates \$5 million over two years.*
- *Converts hospital teaching subsidies into physician rate increases.*

Background:

Ohio trains more physicians than it retains. The state's six public medical schools¹ enroll over 3,700 medical students, which ranks Ohio 5th among states in terms of the number of public medical school enrollees per capita. However, only 44 percent of physicians who graduate from public medical school in Ohio stay in Ohio. As a result, Ohio ranks 16th in terms of active physicians per capita and 24th in terms of active primary care physicians per capita.² According to federal Health Professional Shortage Area designations, more than 1.1 million Ohioans reside in an area that is underserved for primary care, 1.4 million reside in an area that is underserved for dental care, and 2.7 million reside in an area that is underserved for mental health care. The individuals who live in these underserved areas are disproportionately from minority and low-income populations within rural and urban areas throughout the state.

Executive Budget Proposal and Impact:

The Executive Budget increases Medicaid primary care rates \$156 million over two years and offsets the cost of the increase from other savings (see Table 1). The Executive Budget:

- ***Increases Medicaid primary care rates.*** Ohio Medicaid currently pays physicians approximately 59 percent of the Medicare physician fee schedule. Aside from the recently discontinued federal Primary Care Rate Increase (PCRI), providers of physician services have not received a payment increase since the year 2000. Beginning January 1, 2016, Ohio Medicaid will provide an enhanced payment amount to eligible Medicaid providers that bill for office or outpatient services codes, and preventive services codes. Unlike the temporary PCRI, this initiative is not limited to particular primary care specialties, nor is it limited to primary care physicians or physicians alone. Many practitioners bill the office visit codes, including nearly all physicians, advanced practice nurses, physician assistants and a variety of clinic types. The enhanced payment

¹ The Ohio State University, the University of Cincinnati, Wright State University, The University of Toledo, Northeast Ohio Medical University, and Ohio University.

² Association of American Medical Colleges, [2011 State Physician Workforce Data Book](#) (2011) page 24: students enrolled in public medical or osteopathic schools for the 2010-2011 academic year.

provision will apply to services provided through both the fee-for-service and managed care delivery systems. Although not restricted by place of service delivery, facility/non-facility pricing rules will still apply, but at a somewhat higher payment level. The enhanced payment amount costs \$42.1 million (\$15.8 million state share) in 2016 and \$109.2 million (\$41.1 state share) in 2017, all of which is offset by savings.

Table 1. Proposed Medicaid Physician Rate Increases and Offsetting Savings.

All funds in millions	SFY 2016 proposed	SFY 2017 proposed
Rate Increases		
- Increase primary care and pediatric physician rates	\$ 42	\$ 109
- Increase dental rates	\$ 2	\$ 3
Subtotal	\$ 44	\$ 112
Savings		
- Apply Medicaid maximum methodology to physician claims	\$ (43)	\$ (86)
- Direct graduate medical education (GME) hospital reduction	\$ -	\$ (25)
- Reduce Holzer payments to 100% Medicaid	\$ (1)	\$ (1)
Subtotal	\$ (44)	\$ (112)

- Increases Medicaid dental provider rates.** Medicaid rates for dental providers have not increased since January 2000. The current average maximum dental fee in Ohio Medicaid is approximately 36 percent of the average charge of the 2011 American Dental Association survey of fees. The Executive Budget will increase dental provider rates one percent. This change costs \$1.5 million (\$562,000 state share) in 2016 and \$3.0 million (\$1.1 million state share) in 2017, all of which is offset by savings.
- Applies Medicaid maximum payment to Medicare crossover claims.** For individuals enrolled in Medicare and Medicaid, states have the option to pay the patient’s Medicare cost sharing amount (typically 20 percent) or reimburse up to the Medicaid maximum amount. Ohio has elected to only reimburse up to the Medicaid maximum for all services except physician services. Currently physicians are paid the full Medicare cost sharing, which can result in a provider being paid more than the Medicaid maximum amount. The Executive Budget requires Ohio Medicaid to reimburse only up to the Medicaid maximum for all Part B categories of service, including physician services. This provision will save \$43.1 million (\$16.2 million state share) in 2016 and \$86.2 million (\$32.4 million state share) in 2017, all of which is applied to primary care rate increases.
- Converts subsidies for medical education into a primary care rate increase.** Ohio Medicaid spends approximately \$100 million annually to subsidize physician training through direct graduate medical education (GME) payments to teaching hospitals. Teaching hospitals tend to offer residency programs that focus on specialized medicine,

rather than primary care, which is the state's priority to support. The Governor's Office of Health Transformation convened a series of meetings to explore revising the GME formula to better support primary care and, during those meetings, the point was made that a more direct strategy for attracting future doctors into primary care is to increase primary care rates. In response, and because the current GME formula subsidizes specialty training as well as primary care training, the Executive Budget transfers \$25 million in Medicaid GME to support a primary care rate increase in 2017.

- **Eliminates enhanced payment to Holzer Clinic.** Ohio Administrative Code was amended in 1992 to provide enhanced payment to the Holzer Clinic for medical staff to provide services typically administered through an outpatient hospital. The Holzer network recently underwent a merger that created the Holzer Health System which provides both inpatient and outpatient hospital services. As a result, there is no longer a basis to continue paying the Holzer Clinic at 140 percent of the standard Medicaid fee schedule. The Executive Budget proposes to eliminate the enhanced payment rate and revert payment to the standard Medicaid physician fee schedule. This provision saves \$1.5 million (\$560,000 state share) over two years, all of which is applied to the proposed primary care rate increases.
- **Recoups certain physician payments.** Hospital claims are currently subject to retrospective review for medical necessity. Under the policy, hospitals can be issued a technical denial and their payment may be taken back by Ohio Medicaid. The Executive Budget extends this recoupment policy to any physician claim associated with a technical denial received by a hospital. This provision saves \$76,000 over two years.
- **Supports payment innovation.** More than 40 percent of a primary care physician's day is spent in essential but non-reimbursed tasks such as care coordination³ and 27 percent of their revenue is spent on administrative activities such as insurance company and government compliance and regulations.⁴ New payment methodologies need to be developed to reward prevention, coordination of care, and management of chronic diseases. In January 2013, Governor Kasich convened an Advisory Group on Health Care Payment Innovation to align public and private health care purchasing power to reward the value of services, not the volume. The Advisory Group is exploring innovative payment models, including paying for better coordinated care and improved outcomes through patient-centered medical homes. After an initial net investment of \$1 million (\$345,000 state share) in 2016, this initiative is expected to save \$5 million (\$1.9 million state share) in 2017.

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³ New England Journal of Medicine, [What's Keeping Us So Busy in Primary Care?](#) (April 2010).

⁴ Health Affairs, [Peering Into the Black Box: Billing and Insurance Activities in a Medical Group](#) (January 2013).

Office of Health Transformation **Reform Hospital Payments**

Governor Kasich's Budget:

- *Reduces payments for preventable hospital readmissions.*
- *Converts medical education subsidies into a primary care rate increase.*
- *Increases the hospital franchise fee from 2.75 percent to 3.0 percent.*
- *Saves \$233 million (\$336 million state share) over two years.*

Background:

When Governor Kasich took office, Ohio was using prospective payment methods developed in the late 1980s to pay for inpatient and outpatient hospital services provided to Medicaid consumers. Prospective payment methods are designed to contain costs, permit providers to operate in a less regulated environment, and allow sharing of savings for those providers who identify ways to provide quality services more efficiently and economically. However, these types of payments are volume-based and do not have the ability to reward providers for improved outcomes. For these reasons, the Kasich Administration made it a priority to revise both outpatient and inpatient hospital reimbursement methodologies as a component of Medicaid modernization and movement toward improved outcomes.

First Four Years:

Governor Kasich's first budget (enacted in 2011) directed Ohio Medicaid to update its hospital diagnosis-related group (DRG) reimbursement system. At the time, Ohio was using DRG version 15, even though Medicare was on version 30, and more modern versions can assign up to two and a half times as many DRGs as Ohio's system, which allows for more accurate and efficient reimbursement. The updated DRG system was implemented in July 2013 with a three-year stop-loss transition policy to ensure no individual hospital is reduced more than three, five and eight percent in each subsequent year under the new system.

Governor Kasich's Jobs Budget 2.0 (enacted in 2013) reauthorized temporary assessment programs and supplemental payment programs that would otherwise have expired, reduced the rate taxpayers pay for hospital capital projects, made several significant changes in hospital payment policy, and proposed expanding Medicaid to adults with income below 138 percent of the federal poverty level, many of whom might otherwise be a source of uncompensated care for hospitals. Extending Medicaid coverage, which took effect in January 2014, resulted in Ohio's hospitals receiving a 27 percent increase in Medicaid payments in 2015 (Table 1).

Executive Budget Proposal and Impact:

The Executive Budget reduces Medicaid hospital spending \$97 million in 2016 and \$229 million in 2017 (Table 1). However, because additional Ohioans are now covered by Medicaid instead of entering the hospital uninsured, total Medicaid spending on hospital services increases 2.0 percent in 2015 and 4.3 percent in 2017.

- **Reform payment methodology for detail-coded drugs.** Most Medicaid outpatient services are reimbursed using Ohio’s prospective payment system, but in some cases hospitals are reimbursed 60 percent of their hospital-specific costs for administering drugs in an outpatient setting or when a hospital chooses to independently bill for an expensive drug. The Executive Budget will require Medicaid to pay for these drugs based on the Medicaid physician fee schedule instead of hospital costs. This change will result in greater payment consistency across provider types for essentially the same product. Any pharmaceutical(s) not currently on the Medicaid physician fee schedule will continue to be reimbursed at 60 percent of cost. This provision will save \$66.5 million (\$25 million state share) over the biennium.
- **Consolidate outpatient charges occurring within 72 hours of an inpatient stay.** Hospitals are currently permitted to submit outpatient claims for charges related to an outpatient visit the day before or after an inpatient stay to the same facility. The Executive Budget requires hospitals to include any outpatient charges that occur 72 hours before or after an inpatient stay to be included on the inpatient claim. This change will result in a more detailed claim of all the services provided related to the treatment, and not just the visit or stay. It will also make paying for episodes of care, through programs like the State Innovation Model (SIM), more efficient with all services included on one claim. This provision will save \$16.7 million (\$6.3 million state share) over the biennium.
- **Eliminate the five-percent rate add-on for outpatient services.** The Executive Budget will allow the temporary five percent rate increase for outpatient hospital services that was authorized in the last budget expire for all but children’s hospitals in December 2015. During the debate on Medicaid expansion, Ohio Medicaid argued that because hospitals benefit from converting previously uncompensated costs into Medicaid payments, the five percent increase was unnecessary. Now with Medicaid expansion in place, the Administration again recommends allowing the temporary rate increase to expire. This provision saves \$157 million (\$59 million state share) over the biennium.
- **Reduce potentially preventable hospital readmissions.** Across Ohio, the statewide average for inpatient hospital potentially preventable readmission (PPR) is 9.2 percent. While Ohio Medicaid currently targets claims related to readmissions at the same hospital within 30 days, the state’s utilization review process and policies do not focus on readmissions that occur *among* hospitals. The Executive Budget will require the

implementation of PPR software that analyzes clinically-related readmissions across hospital providers. By incorporating this critical tool, the statewide average PPR rate is expected to decrease by 1 percent annually and save \$42.4 million (\$15.9 million state share) over the biennium. The State will also implement a one-percent penalty on hospitals whose PPR rate exceeds an acceptable benchmark, saving an additional \$3.2 million (\$1.2 million state share) over the biennium.

- **Converts subsidies for medical education into a primary care rate increase.** Ohio Medicaid spends approximately \$100 million annually to subsidize physician training through direct graduate medical education (GME) payments to teaching hospitals. The current formula has not been updated since 1982 and currently results in different hospitals being paid from \$4,000 to \$64,000 to train a medical resident. The variation is an unintended consequence of the outdated formula. The Executive Budget requires Ohio Medicaid to update the GME formula in a way that is budget neutral, and also diverts a portion of Medicaid GME to offset the cost of a primary care physician rate increase (described under *Reform Physician Payments*). This provision will save \$25 million (\$9.4 million state share) in hospital GME payments in 2017 and apply the full amount to increase primary care physician rates \$25 million in 2017.
- **Implement correct coding standards to hospital claims processing.** The National Correct Coding Initiative (NCCI) was introduced to promote national correct coding methodologies that reduce instances of improper coding which may potentially result in inappropriate payments of Medicaid claims. Ohio Medicaid has aligned necessary edits within the Medicaid Information Technology System (MITS) to properly process outpatient Medicaid claims in accordance with federal regulations. The department will activate the NCCI edits in MITS not later than January 1, 2016. This will save approximately \$15 million (\$5.6 million state share) over the biennium.
- **Streamline administration of the hospital franchise fee program and increase the rate.** The assessment rate for Ohio's Hospital Franchise Fee Program must be established for each program year by amending the Ohio Administrative Code. This causes delays in Ohio Medicaid's ability to assess and collect fees in a timely manner and forces hospitals to make substantial payments to the state in a very short period of time. The Executive Budget streamlines this process by establishing a fixed assessment rate of 3.0 percent to be adopted in the Ohio Administrative Code (slightly above the current 2.7 percent fee). Ohio Medicaid will also work with the hospital industry to create a collection schedule that takes into account the cash flow needs of hospitals. This provision will save \$568.9 million (\$213.7 million state share) over two years, a portion of which (\$92.8 million in federal-only funds) will flow back to hospitals through the upper payment limit program.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017
All funds in millions	actual	estimated	proposed	proposed
Hospital Baseline (FFS + MCO)	\$ 4,302	\$ 5,434	\$ 5,722	\$ 6,105
- Total Hospital Franchise Fee ¹	\$ 514	\$ 554	\$ 661	\$ 695
Hospital Baseline (FFS + MCO) minus Franchise Fee	\$ 3,788	\$ 4,880	\$ 5,061	\$ 5,410
Supplemental Payments Supported by the Franchise Fee	\$ -	\$ -		
- Upper Payment Limit Program ²	\$ 492	\$ 582	\$ 612	\$ 644
- Managed Care Incentive	\$ 162	\$ 162	\$ 162	\$ 162
Subtotal	\$ 654	\$ 744	\$ 774	\$ 806
Baseline Plus Supplemental Payments	\$ 4,442	\$ 5,624	\$ 5,835	\$ 6,216
Hospital Payment Reforms (All Funds)				
- Reform payment method for detail-coded drugs			\$ 22	\$ 44
- Consolidate outpatient charges			\$ 6	\$ 11
- Eliminate the five percent rate add-on for outpatient services			\$ 50	\$ 107
- Reduce potentially preventable hospital readmissions			\$ 14	\$ 32
- Implement correct coding standards			\$ 5	\$ 10
- Convert medical education subsidies into a primary care rate increase ³			\$ -	\$ 25
Subtotal			\$ 97	\$ 229
Ohio Medicaid Hospital Spending	\$ 4,442	\$ 5,624	\$ 5,738	\$ 5,987
<i>Percent Change</i>		26.6%	2.0%	4.3%
1. Includes the Executive Budget proposal to increase the fee from 2.75 to 3 percent (\$107 million in 2016, \$142 in 2017).				
2. Includes funds that result from increasing the franchise fee (\$30 million in 2016, \$62 million in 2017).				
3. A portion of this amount will flow back to hospital based physicians via a rate increase.				

Updated February 2, 2015

Office of Health Transformation **Reform Nursing Facility Payments**

Governor Kasich's Budget:

- *Increases nursing facility reimbursement \$61 million over two years.*
- *Links 100 percent of the increase to quality performance.*
- *Removes the nursing facility reimbursement formula from statute.*

Background:

The Kasich Administration continues its efforts to improve the quality of care provided to individuals residing in nursing facilities. Ohio Medicaid supports approximately 50,000 Ohio residents live and receive care in nursing facilities at a cost of \$2.4 billion annually. The Administration's goal is to achieve better health, better care and reduced costs by creating incentives to continuously improve service features and characteristics to meet or exceed customer needs and expectations for quality.

First Four Years:

Beginning in 2011, Ohio Medicaid initiated reforms to rein in costs associated with nursing facility care and improve overall quality. The following reforms created a new approach to caring for some of Ohio's most vulnerable residents:

- ***Converted Medicaid Nursing Facility Reimbursement to a Price Based System.*** Governor Kasich's first budget (enacted in 2011) completed the transition from a cost-based Medicaid payment system for nursing facilities to a price-based system, a change that was initiated by the legislature in 2005 to reward efficiency. The final budget reduced nursing facility rates by 5.8 percent on average in 2012 and saved Ohio taxpayers \$360 million over two years.
- ***Linked Nursing Facility Reimbursement to Quality Outcomes.*** Governor Kasich's first budget strengthened the link between Medicaid payments for care services and quality by increasing Medicaid quality incentive payments for nursing facilities from 1.7 percent of the average Medicaid nursing facility rate in 2011 to 9.7 percent in 2013. A Nursing Facility Quality Measurement Subcommittee was created and achieved consensus recommendations on 20 specific accountability measures, which were enacted by the General Assembly in December 2011.
- ***Integrated Care Delivery through MyCare Ohio.*** In conjunction with the three year demonstration program to better coordinate care for individuals served by both

Medicare and Medicaid, nursing facilities and other health care providers are contracting with health plans to provide long-term services and supports to participating individuals. Prior to the May 1, 2014 launch, dual-eligible individuals had no choice but to receive their Medicaid benefit through the traditional fee-for-service program.

- **Connected veterans residing in nursing facilities to federal benefits.** The Kasich Administration initiated a pilot project to ensure that Ohio veterans living in nursing facilities were provided access to a broader set of benefits and services through the Veterans Administration (VA). Staff from the Ohio Departments of Medicaid, Aging, and Veterans Services made personal contact with veterans identified as eligible for benefits in a VA long-term care facilities. Work is underway to expand the project statewide.

Executive Budget Proposal and Impact:

After several years of flat funding, the Executive Budget proposes to increase nursing facility spending \$60.7 million (\$22.8 million state share) over two years. The net increase is achieved through a combination of reforms that:

- **Rebase Nursing Facility Rates With a Grouper Update.** Current nursing facility rates are based on costs from calendar year 2003. The Executive Budget proposes to update rates beginning in state fiscal year 2017 using calendar year 2013 costs as a basis. The update is required by current law and will result in rates more reflective of current health care costs and service delivery in Ohio's nursing facilities. Rebasing also creates the opportunity to update the resource utilization group (RUGs) methodology used to measure resident acuity in the state's nursing facilities. Ohio uses nationally recognized acuity measurement software that employs clinical data collected by the Centers for Medicare and Medicaid Services (CMS). In 2010, CMS updated the data collection tool and offered states the option of using an updated grouper. At the time, Ohio continued using the older grouper (RUGS III) because it aligned with the years-old rate components in effect, but now will update to RUGS IV to coincide with the calculation of new rate components during the rebasing process. The net impact of the effort to rebase nursing facility rates and implement a new grouper will increase nursing facility spending \$84.1 million (\$31.7 million state share) in 2017, all of which will be applied to a new quality improvement program, described below.
- **Pay for Quality.** The Executive Budget builds on the work of the previous four years and further strengthens the relationship between payment and quality. It requires that all of the spending increase related to rebasing (\$87 million in 2017) be used to support a new quality framework. Under this framework, the current quality component is eliminated and that funding is incorporated into the direct care component of the rate. The payment for quality will be replaced with a "Quality Reserve" that nursing facilities can earn back through objective measures of quality care. The current list of 20 measures is replaced by five measures directly related to outcomes and Medicaid spending. Facilities

will have to meet benchmarks for all five measures to receive the full quality payment. The five measures include two staffing measures and three clinical measures. The staffing measures include minimum staffing levels for nursing and STNA and consistent assignment. The Administration is proposing staffing levels recommended by the Consumer Voice, a national advocacy group representing nursing facility residents and their families. Consistent assignment of nurse aides is widely recognized as a key component of quality care for nursing facility residents and is a goal recognized and measured by the Advancing Excellence in America's Nursing Homes campaign. Two of the clinical measures rely on quality measures established by CMS and are calculated using information from the Minimum Data Set (MDS). Those measures include the rate of pressure ulcers across the facility census (both long-stay and short-stay measures), and the rate of atypical antipsychotic use for both long-stay and short-stay residents. The third clinical measure is the rate of avoidable inpatient admissions from nursing facilities and is the initial step in measuring potentially preventable events in Ohio's nursing facilities. The cost of this provision is already counted in the rebasing provision described earlier.

- **Reduce Reimbursement for Low Acuity Individuals.** Governor Kasich's first budget implemented a reduced rate for low-acuity individuals. The Executive Budget takes the next step in aligning payments across delivery systems based on the care needs of the beneficiary. The daily rate paid for the lowest acuity individuals in Ohio's nursing facilities will be reduced from \$130 per resident day to \$91.70 per resident day, more in line with what it would cost to serve these individuals in a community setting. This provision will save \$23.5 million (\$8.8 state share) in 2017.
- **Remove the Nursing Facility Rate Formula From Statute.** Nursing facilities are the only Medicaid provider group whose reimbursement is guaranteed in the Ohio Revised Code. The Executive Budget puts nursing facilities on the same footing as other provider groups by rescinding statutes which set forth payment methodology.
- **Make Administrative Changes to the Franchise Permit Fee Program.** The Executive budget makes two changes to the administrative operation of the Nursing Facility Franchise Fee Program. The first change gives Ohio Medicaid the authority to utilize electronic alternatives to traditional mail when issuing franchise fee assessments. This creates opportunities to reduce administrative costs related to the franchise fee, improve department efficiency and streamline communications with nursing facility providers. The second change closes a technical loophole in the franchise fee tax base to clarify that only beds that are permanently surrendered are exempt from the fee.

Updated February 2, 2015

Office of Health Transformation **Reform Home Care Payments**

Governor Kasich's Budget:

- *Ensures that care in the home is done safely and honestly.*
- *Implements electronic verification for home visits.*
- *Transitions to a home health care agency only model.*
- *Saves \$19 million (\$6 million state share) over two years.*

Background:

Ohio currently operates eight home and community based services (HCBS) waiver programs that rely on direct care workers to provide home health care services. Together, these HCBS waivers provide more than 70,000 Ohioans with home and community-based services annually. In addition, another 32,000 seniors and individuals with disabilities gain access to HCBS services, including home health care, through the *MyCare Ohio* demonstration project. *MyCare Ohio* is available in 29 Ohio counties and serves individuals age 18 or older who are enrolled in both Medicare and Medicaid, and require a nursing facility level of care.

Home health care services are critically important for a person to stay at home or other community setting, and avoid going into a nursing facility or other institution. However, home health care also presents some of the greatest challenges in Medicaid related to fraud and abuse, particularly among independent providers who are not subject to the oversight of a home health care agency. From 2010-2014, the Medicaid Fraud Control Unit of the Ohio Attorney General's Office (MFCU) received 1,473 referrals for home health-related Medicaid fraud. Of those, 634 (~43 percent) were tied to independent providers. During the same period, MFCU indicted 535 home health providers. Of those 535 fraud indictments, 335 (~63 percent) were for independent providers. From 2010-2014, 479 home health providers were criminally convicted, and independent providers accounted for 306 (~64 percent) of those convictions. During federal fiscal year 2014 (the most recent statistical data available), *home health convictions accounted for 87 percent of all MFCU convictions.*

Executive Budget and Impact:

Over the past four years, the Kasich Administration has vigorously pursued – and achieved – balance in long-term care spending while transforming the lives of thousands of Ohioans (see *Rebalance Long Term Services and Supports*). Just a decade earlier, many of these individuals would have had no choice but to receive care in institutional settings. This increased focus on better choices has resulted in an increased demand for home and community based services, and for home health care workers to provide care in those settings. In order for the

Administration to continue its work in this respect, concerted efforts must be made to ensure the safety and comfort for those individuals who wish to receive care inside the home. The Executive Budget advances this objective through new initiatives that target provider competency and assure honesty in provider billing and services rendered. The Budget:

- **Implements an Electronic Visit Verification (EVV) system for home health.** To combat potentially fraudulent home health providers, the Executive Budget requires Ohio Medicaid to implement an EVV system to validate service delivery to eligible individuals by authorized service providers. Similar systems are currently being implemented in states across the country. An EVV system may rely on various technology solutions, including telephony, GPS tracking, and biometrics to authenticate the presence of service providers. Additionally, these systems enable the individual receiving the services to verify that they are receiving care at the precise time of service delivery. An EVV system will significantly reduce the risk of improper claims being paid by Ohio Medicaid, as well as reduce certain administrative burdens associated with identifying fraud, waste, and abuse. Ohio Medicaid will implement EVV system by July 1, 2016. The introduction of this new technology is projected to cost \$13.8 million (\$6.9 million state share) in 2017 but that same year save \$23.3 million (\$8.7 million state share), for a net savings for the state of \$9.5 million (\$1.9 million state share) over two years.
- **Redesigns the home health/private duty nursing benefit.** Many individuals rely on the short-term services of home health providers and private duty nurses. However, not all of these individuals receive services through a managed care plan or an HCBS waiver. Therefore, such services must be redesigned to be a short-term acute care benefit. Meanwhile, individuals requiring long-term nursing and aide services will be directed to waiver or managed care resources in order to meet their health care needs. This reform will save the state \$9.6 million all funds (\$3.6 million state share) in 2017.
- **Expand existing delegated nursing authority.** Developmental disability personnel currently have the authority to administer prescribed medications, perform specified health-related activities, and perform tube feedings when the personnel are not otherwise authorized by state law to engage in those activities. The Executive Budget extends similar authority to unlicensed assistive personnel who provide services through HCBS waivers administered by Ohio Medicaid and the Department Aging. These agencies will work with DODD to develop a certification program to train unlicensed assistive personnel to perform a number of specific health care tasks. As part of the program, the agencies must maintain a registry of all unlicensed assistive personnel and registered nurses who have received the training and been certified.
- **Transition to a home health care agency model.** In order to improve programmatic oversight, decrease fraud and abuse, and improve health outcomes for individuals, a majority of states – and the federal Medicare program – only do business through Medicaid with home health care agencies, not independent providers. The Executive Budget requires Ohio Medicaid to eliminate the “independent service provider” option

as a strategy to improve the administrative oversight of the program, decrease programmatic fraud and abuse, and improve health outcomes for individuals. Ohio Medicaid will not take any new independent service providers after July 1, 2016 and by July 1, 2019 only accept claims submitted through home health agencies. This change will impact over 13,000 service contractors within seven HCBS waivers. These providers will be able to continue providing Medicaid-funded HCBS waiver services should they seek employment through an approved home health agency, or if they provide services to an individual who is using a self-directed option where the recipient is the employer of record. Ohio Medicaid and the related agencies will work with stakeholders to make the transition to the agency only model as smooth as possible for Ohio's direct care workforce.

Updated February 2, 2015

Office of Health Transformation **Fight Medicaid Fraud and Abuse**

Governor Kasich's Budget:

- *Invests in new, stronger measures to fight Medicaid fraud and abuse.*

Background:

Ohio Medicaid remains committed to combating Medicaid provider fraud, waste, and abuse that diverts money from needy children, the elderly, and people with disabilities. The majority of providers and their billings are honest and accurate. However, one dishonest provider can take thousands of dollars over time by billing for services not rendered or medically necessary, or through organized crime take hundreds of thousands of dollars illegally.

The size and scope of Ohio's Medicaid program requires strong financial stewardship. Ohio Medicaid employs auditors, analysts, and fraud examiners, as well as private-sector experts and other professionals to identify, recover, and prevent overpayments. In partnership with Ohio Medicaid, the Ohio Attorney General has become a national leader in convicting and indicting Medicaid fraud, waste, and abuse.

In addition to prosecuting fraud cases and chasing down overpayments, Medicaid program integrity is about promoting a policy environment in which expectations and incentives are aligned to promote efficiency and quality, and prevent misuse of services. It also includes effective program management and ongoing monitoring. These efforts create a culture that drives better health outcomes and common-sense ways to eliminate fraud, waste, and abuse.

First Four Years:

Governor Kasich's first budget (enacted in 2011) created Ohio Medicaid, which previously was organized as a division within the Ohio Department of Job and Family Services, as a stand-alone agency with full accountability to administer Ohio's Medicaid program. The new department is responsible for deterring and detecting fraud, waste, and abuse. Over the past four years, Ohio Medicaid launched several new initiatives to actively fight fraud, waste, and abuse:

- ***Established a new Bureau of Program Integrity.*** In 2014, Ohio Medicaid created a new Bureau of Program Integrity to coordinate program integrity activities with the state's five Medicaid managed care plans.
- ***Provided leadership as a member of Ohio's Program Integrity Group.*** The Program Integrity Group (PIG) relies on information sharing and constant innovation to combat deceptive and improper billing practices. In conjunction with the Office of the Ohio

Attorney General's Medicaid Fraud Control Unit, the Auditor of State, and federal contractors, the PIG has earned national recognition for its success in catching instances of fraud, waste and abuse. In 2013, the AG's Medicaid Fraud Control Unit ranked first nationally for fraud indictments or charges and fraud criminal convictions.

- **Reined in hospital utilization.** Ohio Medicaid contracted with Permedion to perform pre- and post-payment reviews of hospital services and to provide technical advice regarding utilization management policies.
- **Involved providers in third-party recoveries.** Ohio Medicaid is the payer of last resort and contracts with a vendor to recover Medicaid payments when the beneficiary has other insurance coverage that should cover all or part of the medical expenses. In some cases, the other insurance pays better than Medicaid, so the provider has an incentive to seek payment from the other insurance, not Medicaid. Ohio Medicaid now works with these providers to identify Medicaid overpayments and, rather than Medicaid billing the third party, providers recover claims directly from the third party.
- **Streamlined nursing facility claims review.** The FY14/15 Executive budget aligned the Medicaid claims review process for nursing facilities to match other provider types, streamlining the process and allowing nursing homes to resolve payment more quickly.
- **Required enrollment of ordering, referring and prescribing (ORP) providers.** Formal enrollment of ORP providers allows Medicaid to track occurrences of fraud down to the originating prescription or order of service.
- **Required providers to be revalidated every five years.** Providers must be re-screened by Ohio Medicaid at least every five years to ensure that they are eligible to serve individuals covered by Medicaid. The five-year revalidation is a federal requirement and assists in identifying and eliminating fraudulent providers.
- **Implemented provider site visits.** Ohio Medicaid contracted with Public Consulting Group (PCG) to conduct on-site surveys of provider types that have been identified as being at heightened risk for Medicaid fraud.

Executive Budget Proposal and Impact:

The Executive Budget includes several new Medicaid program integrity initiatives that, after an initial investment, are expected to generate significant savings over time. Ohio Medicaid will:

- **Use advanced analytics to mine existing data for indications of fraud.** Ohio Medicaid has access to terabytes of data that should be leveraged to further program integrity efforts. The department will initiate the procurement of a robust, state-of-the-art advanced data analytics system for pre-payment and post-payment review. Such a

system can prove vital in detecting billing patterns tied to potential fraud, waste, or abuse. The new system will require an initial investment of \$14 million (\$3.5 million state share) in 2016, but that will be offset by \$5 million in savings, and by the second year the program will pay for itself through additional savings.

The following initiatives also contribute to program integrity and together are estimated to save Ohio taxpayers \$90 million over the next two years. These savings are counted in other sections related to hospital, physician, and nursing facility payment reforms.

- **Procure a new Recovery Audit Contractor to ensure accuracy in payment.** Ohio Medicaid will competitively contract with one or more Recovery Audit Contractors (RACs) to identify payment inaccuracies and recoup overpayments. RACs are reimbursed on a contingency fee basis, incenting them to root out fraud, waste, and abuse. The RAC will be required to employ trained medical professionals, including a full time medical director, and work with Ohio Medicaid to develop and implement an education and outreach program around audit policies and procedures. The RAC also will be required to conduct customer service activities to alleviate unnecessary provider burden, but the focus will be to refer suspected cases of fraud, waste, or abuse to Ohio Medicaid.
- **Reduce potentially preventable hospital readmissions.** Across Ohio, the statewide average for inpatient hospital potentially preventable readmission (PPR) is 9.2 percent. While Ohio Medicaid currently targets claims related to readmissions at the same hospital within 30 days, the state's utilization review process and policies do not focus on readmissions that occur *among* hospitals. The Executive Budget will require the implementation of PPR software that analyzes clinically-related readmissions across hospital providers. By incorporating this critical tool, the statewide average PPR rate is expected to decrease by 1 percent annually and save \$42.4 million (\$15.9 million state share) over two years. The State will also implement a one-percent penalty on hospitals whose PPR rate exceeds an acceptable benchmark, saving an additional \$3.2 million (\$1.2 million state share) over two years.
- **Implement correct coding standards to hospital claims processing.** The National Correct Coding Initiative (NCCI) was introduced to promote national correct coding methodologies that reduce instances of improper coding which may potentially result in inappropriate payments of Medicaid claims. Ohio Medicaid has aligned necessary edits within the Medicaid Information Technology System (MITS) to properly process outpatient Medicaid claims in accordance with federal regulations. The department will activate the NCCI edits in MITS not later than January 1, 2016. This will save approximately \$15 million (\$5.6 million state share) over two years.
- **Recoups certain physician payments.** Hospital claims are currently subject to retrospective review for medical necessity. Under the policy, hospitals can be issued a technical denial and their payment may be taken back by Ohio Medicaid. The Executive

Budget extends this recoupment policy to any physician claim associated with a technical denial received by a hospital. This provision saves \$76,000 over two years.

- ***Reduces reimbursement for low acuity residents of nursing facilities.*** Governor Kasich's first budget implemented a reduced rate for low-acuity individuals. The Executive Budget takes the next step in aligning payments across delivery systems based on the care needs of the beneficiary. The daily rate paid for the lowest acuity individuals in Ohio's nursing facilities will be reduced from \$130 per resident day to \$91.70 per resident day, more in line with what it would cost to serve these individuals in a community setting. This provision will save \$23.5 million (\$8.8 state share) in 2017.
- ***Implements an Electronic Visit Verification (EVV) system for home health.*** To combat potentially fraudulent home health providers, the Executive Budget requires Ohio Medicaid to implement an EVV system to validate service delivery to eligible individuals by authorized service providers. Similar systems are currently being implemented in states across the country. An EVV system may rely on various technology solutions, including telephony, GPS tracking, and biometrics to authenticate the presence of service providers. Additionally, these systems enable the individual receiving the services to verify that they are receiving care at the precise time of service delivery. An EVV system will significantly reduce the risk of improper claims being paid by Ohio Medicaid, as well as reduce certain administrative burdens associated with identifying fraud, waste, and abuse. Ohio Medicaid will implement EVV system by July 1, 2016. This provision will save \$9.5 million (\$1.9 million state share) over two years.
- ***Transition to a home health care agency model.*** In order to improve programmatic oversight, decrease fraud and abuse, and improve health outcomes for individuals, a majority of states – and the federal Medicare program – only do business through Medicaid with home health care agencies, not independent providers. The Executive Budget requires Ohio Medicaid to eliminate the “independent service provider” option as a strategy to improve the administrative oversight of the program, decrease programmatic fraud and abuse, and improve health outcomes for individuals. Ohio Medicaid will not take any new independent service providers after July 1, 2016 and by July 1, 2019 only accept claims submitted through home health agencies. Ohio Medicaid and the related agencies will work with stakeholders to make the transition to the agency only model as smooth as possible for Ohio's direct care workforce.

Updated February 2, 2014

Office of Health Transformation **Overall Medicaid Budget Impact**

Governor Kasich's Budget:

- *Holds per member per month cost growth to below 3 percent.*
- *Invests in behavioral health, developmental disabilities, and primary care.*
- *Achieves savings from providers who benefit most from enrollment gains.*
- *Holds total program spending growth below state revenue growth.*
- *Saves \$107 million (\$319 million state share) over two years.*

Background:

Medicaid is funded and administered jointly by the state and federal governments. Under broad federal guidelines, states establish their own standards for Medicaid eligibility, benefits, and provider payment rates, although states must meet certain minimum standards. Ohio's current program covers children below 200 percent of poverty, adults below 138 percent of poverty and, in some limited cases, adults at higher incomes (the Executive Budget proposes to limit coverage for all adults to 138 percent of poverty and below). In 2014, Ohio Medicaid spent \$20.9 billion (\$5.3 billion GRF state share) to cover 2.8 million low-income Ohioans, including 1.2 million children, 430,000 seniors and people with disabilities, and 1.1 million other adults.

First Four Years:

In January 2011, Governor John Kasich created the Office of Health Transformation to control Medicaid spending and improve health outcomes. The new Office organized existing staff in the state's Medicaid-related agencies – aging, developmental disabilities, health, job and family services, mental health, and addiction services – to design and implement an aggressive package of Medicaid reforms. By most accounts, Ohio now leads the nation in the scope and impact of its reforms, and in the state's ability to control Medicaid spending.

Governor Kasich's first Medicaid budget (enacted in 2011) proposed spending \$500 million less than the trend on Medicaid in 2012 and \$942 million less in 2013. At the same time, the budget introduced new tools to improve care coordination, integrate behavioral and physical health care, rebalance long-term care spending, and modernize reimbursement to reward value instead of volume. Ohio Medicaid used these tools to drive program improvements and deliver *additional* savings, actually spending \$1.9 billion less than budgeted and saving Ohio taxpayers close to \$3.0 billion over two years compared to the trend (Figure 1).

Governor Kasich's Jobs Budget 2.0 (enacted in 2013) added to the momentum of the first two years of reform with new initiatives to fight fraud and abuse, improve care coordination in the

most at-risk populations, consolidate mental health and addiction services, make Medicaid more accountable as a stand-alone department, and extend coverage to more low income Ohioans. The Medicaid expansion went into effect in January 2014, resulting in a one-time upward shift in all-funds spending. Actual spending was significantly lower than budgeted in 2014 and on track to come in \$2.5 billion below budget over the biennium (2014-2015).

The state share of Medicaid spending has been impacted less than all funds because the Medicaid expansion is 100-percent federally funded for the first three years (the state share will be 5 percent beginning in the last six months of fiscal year 2017 and growing to a maximum of 10 percent beginning in calendar year 2020 and beyond). The state share of GRF Medicaid spending has come in under budget every year under the Kasich Administration and, after backfilling one time gaps left by the previous Administration in 2012, the rate of Medicaid growth has been steady and sustainable at 3.7 percent in 2013, 4.6 percent in 2014, and 6.8 percent in 2015 (Figure 2). The slight increase in 2015 is related to caseload growth and MyCare Ohio Medicare-Medicaid Enrollee Project implementation.

Executive Budget Proposal and Impact:

Medicaid Baseline. The total Medicaid “baseline” – what the Medicaid program would cost in the upcoming biennium assuming current eligibility, benefit, and payment policies remain unchanged – is projected to grow 10.3 percent to \$27.3 billion in 2016 and 3.5 percent to \$28.3 billion in 2017 (Table 1). The Medicaid expansion, which is included in the baseline, is 100-percent federally funded through December 31, 2016, and then requires a 5-percent state match totaling \$126 million in the last six months of the biennium (January 1 to June 30, 2017).

Executive Budget Reforms. The Executive Budget invests in critical priorities – most significantly to rebuild behavioral health system capacity and developmental disabilities services – and seeks cost savings from providers that benefit the most from projected enrollment growth, including health plans and hospitals. The net impact of these reforms is state general revenue fund savings of \$127 million in 2016 and \$193 million in 2017 compared to the baseline (Table 2).

Executive Budget Appropriations. After adjusting baseline projections for savings and cost avoidance, the Executive Budget increases overall Medicaid spending 10.2 percent to \$27.3 billion in 2016 and 3.2 percent to \$28.2 billion in 2017 (Figure 1 and Table 1). The state share-only GRF appropriations reflect projected growth of 4.4 percent to \$6.0 billion in 2016 and 6.1 percent to \$6.3 billion in 2017 (Figure 2 and Table 2). This level of Medicaid program growth is in line with state revenue growth, which means the Medicaid program is sustainable and not crowding out other state spending priorities.

Per Member Program Spending. In addition to total spending, the Joint Committee on Medicaid Oversight (JMOC) is required to develop a projected medical inflation rate for the Medicaid program based on the per member per month (PMPM) cost of continuing current Medicaid policy. JMOC then sets a goal for the Medicaid director to limit program growth to the lower of the JMOC rate or the three-year average Consumer Price Index (CPI) for medical

services. Based on these parameters, [JMOC recommends](#) limiting growth in PMPM costs to 2.9 percent in 2016 (the JMOC upper bound) and 3.3 percent in 2017 (medical CPI), or 3.1 percent on average over the biennium. The Executive Budget meets this test by holding growth in PMPM costs to 1.38 percent in 2016 and 4.5 percent in 2017, or 2.94 percent on average over the biennium. Much of the increase in 2017 is related to increases in spending on services for people with developmental disabilities. If Medicaid spending through the Ohio Department of Developmental Disabilities is excluded, then the remaining Medicaid growth in PMPM costs is 0.75 percent in 2016 and 4.05 percent in 2017, or 2.4 percent on average over the biennium (Table 3).

Table 3. Projected Rates of Ohio Medicaid Growth Per Member Per Month					
State Fiscal Year	JMOC Upper Bound	Medical CPI	JMOC Target	Ohio Medicaid with Policy Changes	
				(All Agencies)	(Excluding DODD)
2016	2.90%	3.30%	2.90%	1.38%	0.75%
2017	4.50%	3.30%	3.30%	4.50%	4.05%
Average	3.70%	3.30%	3.10%	2.94%	2.40%

Source: Optumas and Ohio Medicaid (January 2015).

Figure 1.

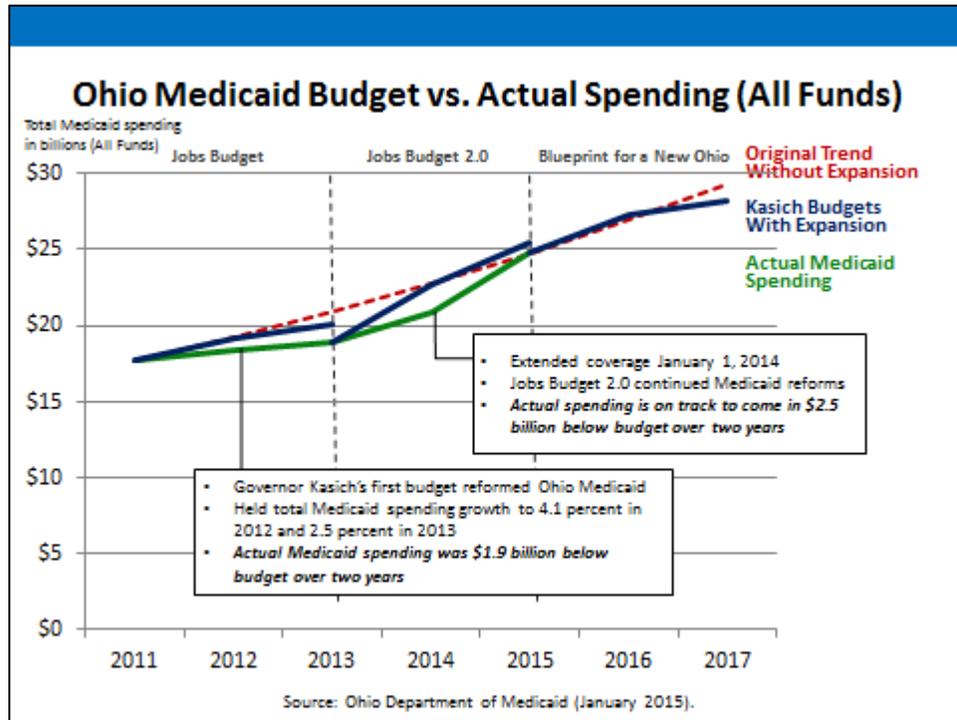


Figure 2.

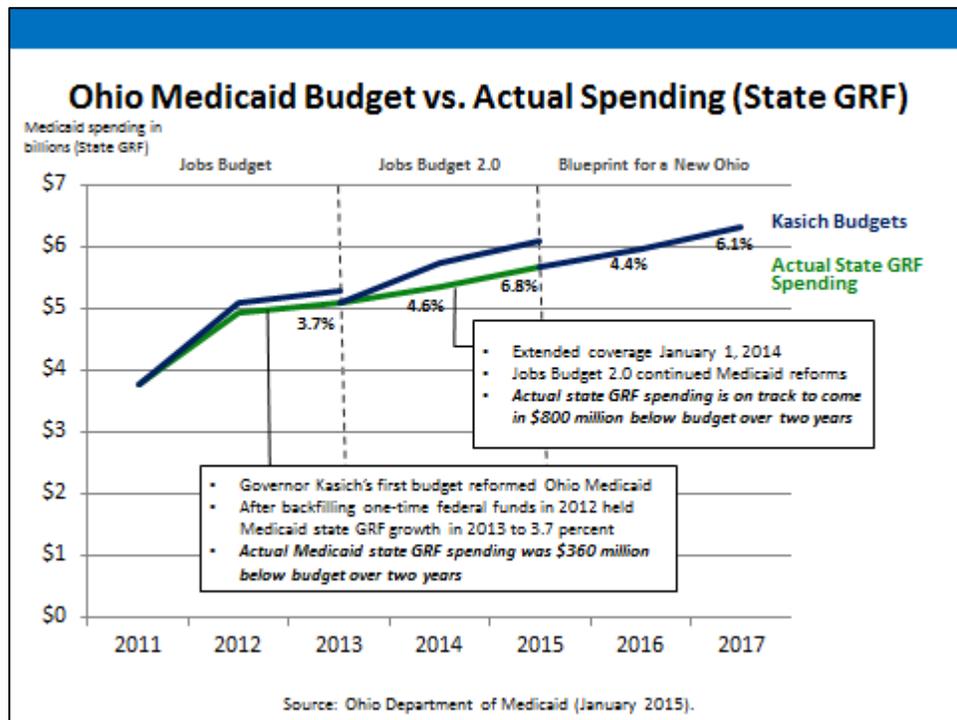


Table 1. Ohio Medicaid Spending (All Funds in millions)

All Funds	SFY 2012	SFY 2013	%	SFY 2014	%	SFY 2015	%	SFY 2016	%	SFY 2017	%	SFY 2016/17
Baseline Total	\$ 18,401	\$ 18,857	2.5%	\$ 20,859	10.6%	\$ 24,764	18.7%	\$ 27,309	10.3%	\$ 28,252	3.5%	\$ 55,561
Executive Budget Reforms												
Eligibility Reforms								\$ (23)		\$ (77)		\$ (99)
Benefit Reforms								\$ 57		\$ 137		\$ 193
Reform Health Plan Payments								\$ (73)		\$ (270)		\$ (343)
Reform Physician Payments								\$ -		\$ 25		\$ 25
Reform Hospital Payments								\$ (66)		\$ (167)		\$ (233)
Reform Nursing Facility Payments								\$ -		\$ 61		\$ 61
Reform Home Care Payments								\$ -		\$ (19)		\$ (19)
Enhance Community Developmental Disabilities Services								\$ 80		\$ 219		\$ 299
Program Integrity								\$ 9		\$ -		\$ 9
Subtotal								\$ (16)		\$ (91)		\$ (107)
Subtotal with Budget Reforms	\$ 18,401	\$ 18,857	2.5%	\$ 20,859	10.6%	\$ 24,764	18.7%	\$ 27,293	10.2%	\$ 28,161	3.2%	\$ 55,454
Include: Transfers	\$ 1,358	\$ 1,206		\$ 1,085		\$ 1,895		\$ 91		\$ 91		\$ 183
Executive Budget	\$ 19,759	\$ 20,063	1.5%	\$ 21,944	9.4%	\$ 26,660	21.5%	\$ 27,384	2.7%	\$ 28,253	3.2%	\$ 55,637
<i>Ohio Department of Medicaid</i>								\$ (96)		\$ (310)		\$ (406)
<i>Ohio Department of Developmental Disabilities</i>								\$ 80		\$ 219		\$ 299

Includes all state Medicaid expenditures regardless of agency. Excludes non appropriated local funding. SFY2012-2014 are actuals, SFY 2015 is an estimate. Totals may not add due to rounding.

Table 2. Ohio Medicaid Spending (State Share of General Revenue Funds in millions)

GRF State Share	SFY 2012	SFY 2013	%	SFY 2014	%	SFY 2015	%	SFY 2016	%	SFY 2017	%	SFY 2016/17
Baseline Total	\$ 4,935.3	\$ 5,115.8	3.7%	\$ 5,349.1	4.6%	\$ 5,715	6.8%	\$ 6,095	6.7%	\$ 6,527	7.1%	\$ 12,621
Executive Budget Reforms												
Eligibility Changes								\$ (12)		\$ (35)		\$ (47)
Benefit Changes								12.9		42.3		\$ 55
Health plan changes								\$ (27)		\$ (103)		\$ (130)
Physician changes								\$ -		\$ 9		\$ 9
Hospital changes								\$ (132)		\$ (204)		\$ (336)
Nursing Facility changes								\$ -		\$ 23		\$ 23
Home care changes								\$ -		\$ (6)		\$ (6)
Developmental Disabilities System Redesign								\$ 30		\$ 82		\$ 112
Fight fraud and Abuse								\$ 2		\$ (1)		\$ 0
Subtotal								\$ (127)		\$ (193)		\$ (319)
Executive Budget	\$ 4,935.3	\$ 5,116	3.7%	\$ 5,349	4.6%	\$ 5,715	6.8%	\$ 5,968	4.4%	\$ 6,334	6.1%	\$ 12,302
<i>Ohio Department of Medicaid</i>								\$ (157)		\$ (275)		\$ (431)
<i>Ohio Department of Developmental Disabilities</i>								\$ 30		\$ 82		\$ 112

Includes all state Medicaid expenditures regardless of agency. Excludes non appropriated local funding. SFY2012-2014 are actuals, SFY 2015 is an estimate. Totals may not add due to rounding.

Office of Health Transformation Prioritize Home and Community Based Services

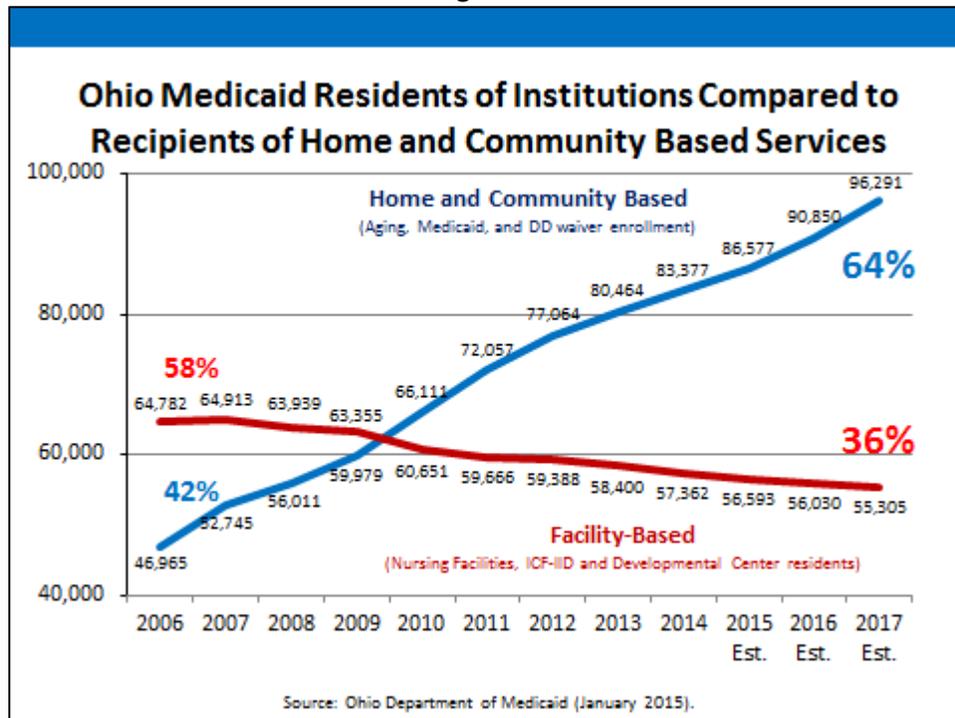
Governor Kasich's Budget:

- *Provides more home and community based alternatives to institutions.*
- *Enhances community developmental disabilities services.*
- *Rebuilds community behavioral health system capacity.*
- *Enables more Ohioans to live with dignity in the settings they prefer.*

First Four Years:

When Governor Kasich took office, Ohio was spending more of its Medicaid budget on high-cost nursing homes and other institutions than all but five states, and Ohio taxpayers were spending 47 percent more for Medicaid long term care than taxpayers in other states. Since then, the Governor's Office of Health Transformation has been working to rebalance Medicaid spending toward less expensive home and community based services (HCBS). Appendix A lists Ohio's current HCBS programs and enrollment, as well as eligibility requirements, services provided, and the agency that administers the program. The ultimate goal of these programs is for seniors and people with disabilities to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home.

Figure 1.



Governor Kasich's first two budgets increased spending on Medicaid home and community based services for seniors and people with disabilities. As a result, Ohio Medicaid now spends more on home and community based services than institutions, and the number of Ohioans served in the community has grown 20 percent over the past four years (Figure 1).

Ohio has received national attention for its significant investments in home and community based alternatives to institutions. For example, in September 2013, Ohio was recognized as a national leader in transitioning individuals into home and community based care settings. The federal Money Follows the Person (MFP) demonstration program reported that Ohio's HOME Choice program ranks first among states in transitioning individuals with mental illness from long term care facilities into alternative settings, and second overall in the number of residents moved from institutions into home and community based settings.

Executive Budget Proposal and Impact:

The Executive Budget further increases Ohio's investment in HCBS alternatives to institutions, and launches new reforms that enable seniors and people with disabilities can live with dignity at home or other community setting. These reforms:

- ***Implement standardized assessments and "no wrong door" entry into long term care.*** In June 2013, Ohio was awarded \$169 million in additional federal Medicaid matching funds as a result of the state's commitment to direct at least half of all Medicaid long-term care funding to home and community based services by September 30, 2015 (on September 10, 2014, Ohio Medicaid [announced](#) it surpassed the 50-percent spending target one full year ahead of the federal deadline). In addition, Ohio is required to provide "no wrong door" access to the system, a standard assessment for determining a person's level of need, and conflict-free case management. These reforms are on track for implementation in FY 2016. A new Now Wrong Door/Single Entry Point system will include a designated set of agencies that will perform screening and support navigator functions, a 1-800 number, and an information and referral website. Also, the same person-centered screening tool will be used across all state agencies by everyone seeking long term services and supports, along with a new comprehensive assessment tool for nursing facility level of care programs. These screening and assessment activities will take place in Ohio's newly developed assessment and case management system that Links Ohioans to Independence, Services and Supports (LOTISS). This system will interface with Ohio's new Ohio Benefits eligibility system and provide a seamless experience for individuals seeking Medicaid-funded long term services and supports.
- ***Develop a statewide HCBS transition plan to comply with new federal regulations.*** In January 2014, the Centers for Medicare and Medicaid Services (CMS) released new requirements for HCBS waivers administered by states. According to the new federal requirements, all HCBS settings must be integrated in and support full access to the

greater community; be selected by the individual from among setting options; ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint; optimize autonomy and independence in making life choices; and facilitate choice regarding services and who provides them. The new federal regulation also requires all states to submit a transition plan for their HCBS programs. To accomplish this, the Office of Health Transformation and Ohio Departments of Aging, Developmental Disabilities, and Medicaid posted a [draft transition plan](#) and are seeking input on the plan through public meetings that include waiver participants and caregivers, providers, and advocacy groups and provider organizations. These agencies also are conducting surveys to determine the extent to which Ohio's existing HCBS waivers meet the setting requirements in the new federal regulations. Ohio's transition plan must be drafted and submitted to CMS by March 17, 2015. CMS will decide whether it will accept the plan as submitted or request changes. Ohio is required to be fully compliant with the federal regulations by March 17, 2019.

- **Enhance community developmental disabilities services.** The Executive Budget creates more choices for Ohioans with developmental disabilities to live and work in the community. It increases access to HCBS waivers and downsizes institutions to reflect the increased demand for community services, and supports community employment for anyone who wants to work. These initiatives represent one of the most significant new investments in the state's entire budget, totaling \$316 million over two years (see *Enhance Community Developmental Disabilities Services*).
- **Rebuild community behavioral health system capacity.** The Executive Budget continues the state's commitment to rebuild community behavioral health system capacity. It adds services to the Medicaid behavioral health services benefit package, improves care coordination through managed care, and strengthens housing and other community supports for people most in need (see *Rebuild Community Behavioral Health System Capacity*).
- **Increase access to affordable housing.** The Executive Budget sustains recent increases in state funding to support affordable housing, enables more Ohioans to avoid entering an institution unnecessarily, establishes an Ohio Housing Trust Fund reserve, and aligns federal, state and local housing resources for the most at-risk populations (see *Increase Access to Housing*).

Updated February 2, 2015

Appendix A. Ohio Medicaid Home and Community Based Services (HCBS) Waiver Programs

Waiver	MyCare Ohio	Ohio Home Care	Transitions II	PASSPORT	Assisted Living	Transitions DD	Individual Options	Level One	S.E.L.F.
Enrollment (10/14)	24,105	5,705	1,374	18,069	2,598	2,903	17,803	13,765	332
Average Cost	Within managed care	\$23,360	\$24,106	\$10,936	\$12,564	\$23,944	\$58,181	\$11,124	
Eligibility	Eligible for Medicare Parts A,B,&D, and full benefits under Medicaid; age 18+; Reside in a demonstration county; must be enrolled in the MyCare demonstration; Intermediate or Skilled LOC; Require NF or hospital in the absence of MyCare waiver; require at least one waiver service monthly; not reside in NF or CF-IID.	Specific Financial Criteria, Nursing Facility Level of Care, Age 59 or younger	Specific Financial Criteria, Nursing Facility Level of Care, the individual must be age 60 or older and must transfer in from the Ohio Home Care Waiver.	Specific Financial Criteria, Nursing Facility Level of Care, Ages 60 +	Specific Financial Criteria, Nursing Facility Level of Care, age 21 or older	Specific Financial Criteria, ICF/IID Level of Care, All Ages; Available only to individuals enrolled on the Ohio Home Care Waiver whose intermediate or skilled level of care is reevaluated to be an ICF/IID level of care.	Specific Financial Criteria; ICF/IID Level of Care; All Ages	Specific Financial Criteria; ICF/IID Level of Care; All Ages	Specific Financial Criteria, ICF/IID Level of Care, All Ages; reserve capacity of 100 SELF waiver allocations for children w/ intensive behavioral needs is state funded.
Services	<ul style="list-style-type: none"> • Adult day health • Alternative meals • Assisted living service • Choices home care attendant • Chore • Emergency response • Enhanced community living • Home care attendant • Home delivered meals • Home medical equipment and supplemental adaptive and assistive devices • Home modification, maintenance and repair • Homemaker • Independent living assistance • Nutritional consultation • Out-of-home respite • Personal care aide • Pest control • Social work counseling • Waiver nursing • Waiver transportation 	<ul style="list-style-type: none"> • Adult day health • Emergency response • Home care attendant • Home delivered meals • Home modification • Out-of-home respite • Personal care aide • Supplemental adaptive and assistive devices • Supplemental transportation • Waiver nursing 	<ul style="list-style-type: none"> • Adult day health • Emergency response • Home care attendant • Home delivered meals • Home modification • Out-of-home respite • Personal care aide • Supplemental adaptive and assistive devices • Supplemental transportation • Waiver nursing 	<ul style="list-style-type: none"> • Adult day health • Alternative meal service • Choices home care attendant • Chores • Community transition • Enhanced community living • Environmental accessibility adaptation • Home care attendant • Home delivered meals • Homemaker/personal care • Independent living assistance • Non-medical transportation • Nutritional consultation • Out-of-home respite • Personal emergency response systems • Pest control • Social work and counseling • Specialized medical equipment and supplies • Transportation • Waiver nursing 	<ul style="list-style-type: none"> • Assisted living services • Community transition (for nursing home residents only) 	<ul style="list-style-type: none"> • Adult day health • Emergency response services • Home modification • Home-delivered meals • Out-of-home respite • Personal care aide • Supplemental adaptive and assistive devices • Supplemental transportation • Waiver nursing 	<ul style="list-style-type: none"> • Adaptive and assistive equipment • Adult day support • Adult family living • Adult foster care • Community respite • Environmental accessibility adaptations • Homemaker/personal care • Home-delivered meals • Interpreter • Non-medical transportation • Nutrition • Remote monitoring equipment • Residential respite • Social work • Supported employment (community and enclave) • Transportation • Vocational habilitation 	<ul style="list-style-type: none"> • Environmental accessibility adaptations • Habilitation (adult day support and vocational) • Homemaker/personal care • Non-medical transportation • Personal emergency response system (PERS) • Respite (institutional and informal) • Specialized medical equipment and supplies • Supported employment (adaptive equipment, community and enclave) • Transportation 	<ul style="list-style-type: none"> • Clinical/therapeutic intervention • Community inclusion • Functional behavioral assessment • Habilitation (adult day support and vocational) • Integrated employment • Non-medical transportation and services • Participant/family stability assistance • Remote monitoring and equipment • Respite (residential and community) • Support brokerage • Supported employment (enclave)
Administration	The Ohio Department of Medicaid (ODM) Administers this waiver. ODM contracts with MyCare Managed Care Plans	ODM contracts with a Case Management Agencies to provide administrative case management services.	ODM contracts with a Case Management Agency to provide administrative case management services.	ODM partners with the Ohio Department of Aging to administer the day to day operations. Passport Administrative Agencies (PAA) act as regional administrators and provide case management services.	ODM partners with the Ohio Department of Aging to administer the day to day operations. Passport Administrative Agencies (PAA) act as regional administrators and provide case management services.	ODM partners with the Ohio Department of Developmental Disabilities (DODD) to administer the day to day operations. Local County boards of DD provide case management services.	ODM partners with the Ohio Department of Developmental Disabilities (DODD) to administer the day to day operations.	ODM partners with the Ohio Department of Developmental Disabilities (DODD) to administer the day to day operations. Local County boards of DD provide case management services.	ODM partners with the Ohio Department of Developmental Disabilities (DODD) to administer the day to day operations.

Office of Health Transformation
Enhance Community Developmental Disabilities Services

Governor Kasich's Budget:

- *Provides more choices for Ohioans with developmental disabilities.*
- *Invests \$316 million over two years in DD system redesign.*
- *Downsizes institutions to reflect increased demand for community services.*
- *Supports community employment for anyone who wants to work.*

Background:

Ohio has a strong tradition of providing services for individuals with developmental disabilities. This tradition led parents, advocates and local communities during the 1950s, 60s and 70s to develop segregated schools in their communities when there were no other education options, sheltered workshops when there were no other employment options, and large institutions when there were no other residential service options. In an effort to keep individual services and supports connected to local communities, County Boards of Developmental Disabilities – consisting mostly of family members – were established to administer and later fund local programs. Today, Ohio's County Boards play a much more significant role in funding the system than their counterparts in other states, and account for approximately 70 percent of all local DD funding nationally. As a result, the challenges and opportunities of system change in Ohio are unique and will require an Ohio solution.

After investing early in what came to be viewed as “institutional” services, Ohio took historic steps in 2001 to increase access to less restrictive Home and Community-Based Services (HCBS). This change was controversial – individuals, advocates, County Boards, and private providers all expressed concern that too much change too fast could put individuals at risk. But they also saw that system redesign would enable thousands more Ohioans to leave or avoid institutions and instead live and work in the community. Redesigned local levy dollars leveraged for use as Medicaid match enabled an incredible growth in home and community-based services with little additional state funding. All of this was accomplished via a ten-year stakeholder plan that put the state on a steady course toward system transformation. As a result, today 29,000 more Ohioans with developmental disabilities live and work in the community with the support of waiver services.

First Four Years:

Governor Kasich's first Jobs Budget (enacted in 2011) continued the system transformation that began in 2001, and gave the Ohio Department of Developmental Disabilities (DODD) more authority to design and control programs that allow people with disabilities to move seamlessly

from one setting to another. It moved two programs from Medicaid to DODD: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs) and the Transitions DD (TDD) Waiver. It authorized DODD to implement additional services under the Individual Options (IO) Waiver program and create a new participant-directed Self-Empowered Life Funding (SELF) Waiver program. The budget also continued the process of downsizing state-operated institutions, and transitioning more individuals from ICFs into other community settings.

Governor Kasich's Jobs Budget 2.0 (enacted in 2013) focused on further downsizing ICFs by providing a financial incentive for private ICF providers to convert institutional beds into HCBS waiver services, and increased rates for providers serving former residents of institutions. The Governor's second budget also increased access to autism services, authorized several programs to eliminate barriers to employment, and created a presumption that all individuals with developmental disabilities are capable of community employment.

As a result of these reforms, Ohio is providing more choices for individuals with developmental disabilities who want to live at home or in other community settings. The number of Ohioans with access to home and community based services is increasing (from 5,661 in 2001 to 35,107 in 2015) and the number residing in state-operated institutions is decreasing (from 1,992 in 2001 to less than 870 by June 2015). This represents great progress, but challenges remain. For example, Ohio continues to have significantly more people living in large private institutions than other states, including residents who are waiting for home and community-based services. In addition, recent changes in federal HCBS guidelines may disqualify some of the settings that Ohio relies on today (e.g., sheltered workshops) from future federal funding.¹

Continued pressure to downsize or eliminate institutional settings, particularly from Disability Rights Ohio and the U.S. Department of Justice, has reawakened many of the same fears that threatened to undermine reform in 2001. In response to that and other challenges facing the system, in 2013 DODD convened a Strategic Planning Leadership Group comprised of individuals, families, providers, County Boards and state officials to identify benchmarks for system change. The Group clearly understands that changing too quickly could jeopardize health and safety, as well as not respect individual and family choices; and changing too slowly could withhold opportunities for full community participation and not respect individuals waiting for that opportunity. The Group's benchmarks² take these views into account, and sequence major policy changes and costs over a ten-year timeframe.

Executive Budget Proposal and Impact:

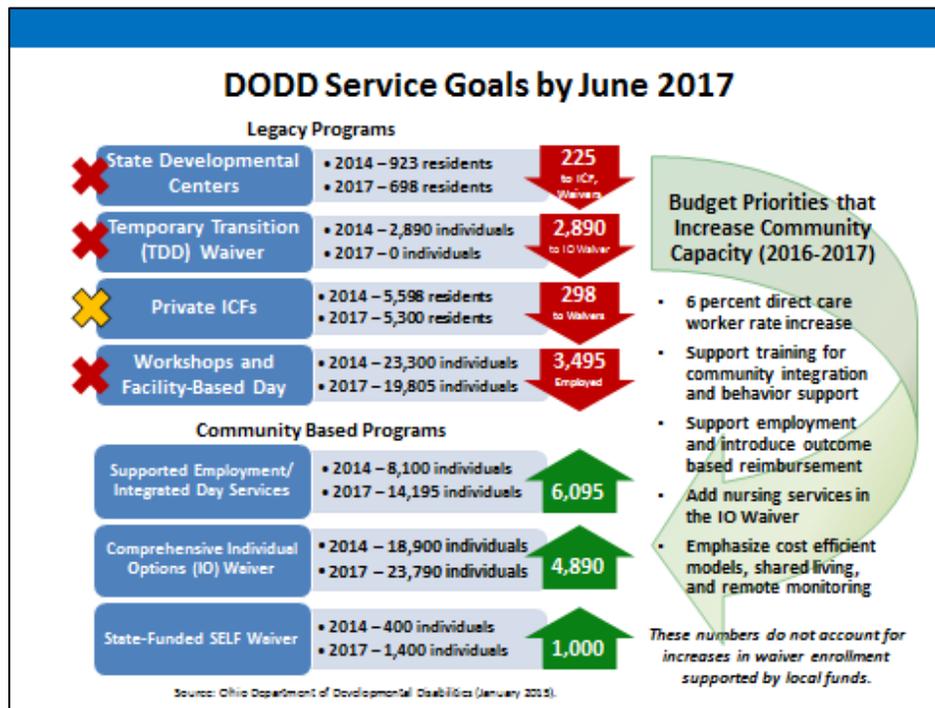
The Executive Budget invests \$316 million (\$120 million state share) over the next two years to increase opportunities for people with disabilities to live and work in the community. The goal is to try to honor the choices of individuals and help those who wish to move into the community to do so, and allow those who wish to remain in their current setting to do so. The

¹ Ohio's [draft plan](#) to comply with new federal HCBS requirements (December 15, 2014).

² Strategic Planning Leadership Group's [recommendations](#) (December 2014).

scale of change proposed, which is based on the benchmarks established by the Strategic Planning Leadership Group, is transformational not incremental. For example, over the next two years enrollment in state Developmental Centers, private ICFs, and temporary transitions waivers (Transitions DD Waiver) is estimated to decrease by 3,413 individuals as waiver enrollment grows to serve an additional 5,890 individuals in community settings (Figure 1). The number of individuals served in workshops and facility-based day settings is estimated to decrease 3,495 as participation in supported employment and integrated day services increases by 6,095 individuals. These numbers do not account for increases in waiver enrollment supported by local funds.

Figure 1.



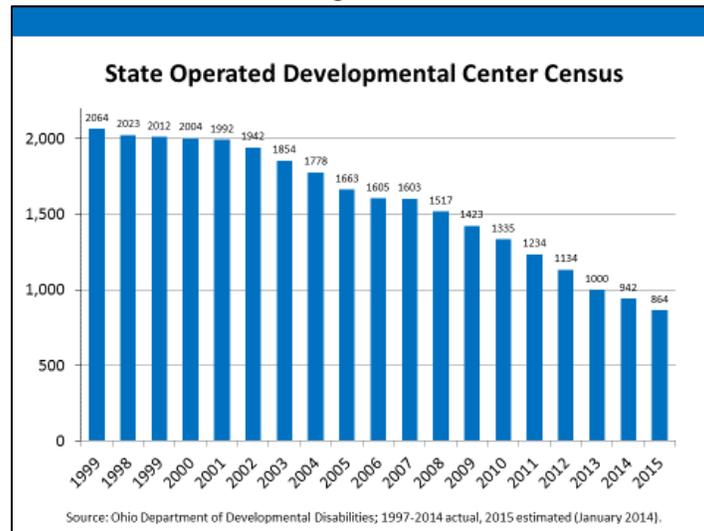
The financial resources necessary to achieve these gains represent the most significant health and human services investment in the Executive Budget. It continues the trend to downsize state-operated Developmental Centers and large private ICFs, convert ICF-funded beds into HCBS waivers, and expand community employment opportunities. Overall, these initiatives increase total DODD system spending \$88 million in 2016 and \$229 million in 2017. The state share increases \$34 million in 2016 and \$86 million in 2017. These amounts, as well as the cost of each of the reforms described below, are summarized at the end of this paper (Tables 1 and 2). As each initiative is implemented, funding may fluctuate based on the options individuals actually select.

STATE INSTITUTIONS

By June 2015, the census at state operated Developmental Centers (DCs) will be approximately 864 individuals, 30 percent less than four years ago (Figure 2). DODD has developed a

comprehensive discharge planning process and face-to-face follow up for any person who is discharged from a DC to make sure they are doing well in the community. Additionally, DODD has used technology, including tele-medicine, to support individuals and families, thereby limiting the need for the more extensive services provided by the DCs. DODD will continue to reduce the census at the DCs by approximately 90 individuals each year, with funding for these individuals redirected to the HCBS waiver program or small ICFs.

Figure 2.



The challenge now is the inefficiency of operating the same ten centers with significantly fewer residents in each. The average cost per bed has climbed from \$161,838 in 2010 to \$201,254 in 2014. This situation is no longer sustainable, and puts all of the centers at risk. The Strategic Planning Leadership Group recommended closing all ten DCs in the next ten years. The Kasich Administration has not adopted that position, but the number of DCs needs to be evaluated, and decisions made in the near future.

PRIVATE INTERMEDIATE CARE FACILITIES

Governor Kasich’s Jobs Budget 2.0 (enacted in 2013) transferred the operation of the ICF program from Medicaid to DODD. After the transfer, DODD began a process to encourage both the conversion of ICF homes to waiver homes, and the downsizing of large ICFs (9 or more beds). DODD secured a commitment from providers to downsize or convert 1,200 beds over five years. The Executive Budget focuses additional reforms on large ICFs, both reducing the number of people who live in them and offering community-based alternatives:

- **Provide incentives to downsize private ICFs.** The Executive Budget authorizes DODD to pay a flat rate for those residents residing in an ICF with less profound disabilities than other residents. The savings from this provision, along with additional dollars, will be used to support individuals with significant needs, provide for a modest rate increase, and cover transition costs when a large ICF downsizes. The total cost of these incentives

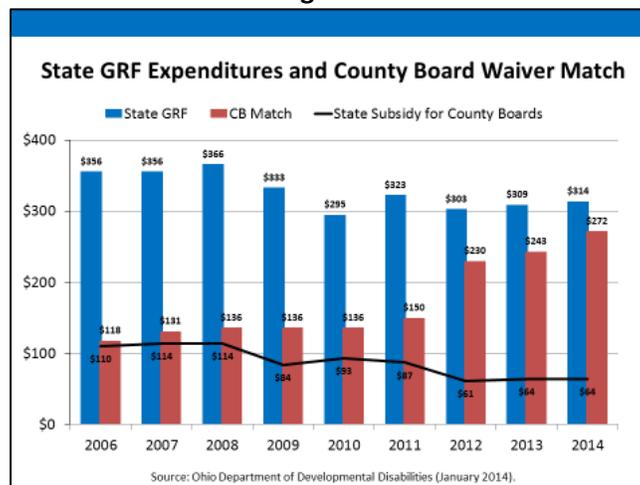
is \$7.2 million (\$2.7 million state share) in 2016 and \$17.2 million (\$6.5 million state share) in 2017.

- **Assist with conversion from ICF to waiver through rental assistance and purchase of ICF beds.** The Executive Budget, for the first time, gives DODD the authority to offer rental assistance for individuals leaving ICFs, and buy back ICF beds, strengthening community living. This provision costs \$2.1 million (\$1 million state share) in 2016 and \$4.1 million (\$1 million state share) in 2017.
- **Limit access to large ICFs (exceeding 8 residents).** The Executive Budget closes the front door on large ICFs in January of 2016 while at the same time expanding opportunities for individuals to live in the community. For the first time, the Executive Budget will specifically allocate waivers to divert ICF admissions, and allocate waivers for individuals who want to leave an ICF (described below under HCBS waivers).
- **Provide system transformation supports.** The Executive Budget incents person-centered planning, integrated day services, and integrated employment. This provision costs \$3.3 million state share per year in 2016 and 2017.
- **Provide objective options counseling.** DODD will contract with an independent third party to explain the option of a waiver to guardians and individuals in ICFs. This provision costs \$0.2 million state share per year in 2016 and 2017.

HOME AND COMMUNITY-BASED SERVICES WAIVERS

Thanks mainly to the availability of local tax levy dollars, Ohio has been able to continue to add individuals to DODD waiver programs even through the recession (Figure 3). As a result, over the past four years, Ohio has added approximately 2,000 individuals per year to DODD waiver programs. However, the capacity of the local system to add waivers is not infinite.

Figure 3.



Despite significant gains, there are more than 22,000 Ohioans with immediate needs on waiting lists, 8,000 of whom live with an aging caregiver, and 1,000 of whom will lose the support of their primary caregiver in the next year. In addition, new federal guidelines increasingly emphasize the importance of community integration and employment, and seek to separate the role of person-centered plan development from service provision (most County Boards do both). With the new federal guidelines in mind but, more importantly, in response to the urgent need to reduce waiting lists for home and community based services, the Executive Budget:

- **Increases rates for providers serving the most complex individuals.** The Executive Budget continues the Kasich Administration's policy objective favoring community-based services as an alternative to institutionally based care. Established in House Bill 482 (MBR), the budget extends a \$2.08 per hour rate increase for HCBS waiver providers if the individuals they are serving were residents of a public hospital, Developmental Center, or converted ICF immediately prior to enrollment in the waiver. An additional behavior support rate modification of \$2.52 per hour provides funding for the implementation of behavior support plans by staff who have the level of training necessary to implement the plans and who are working under the direction of licensed or certified personnel or other professionals who have specialized training or experience with implementing behavior support plans. A nursing service will be added to the IO Waiver to provide direct services from a licensed nurse to individuals with complex medical needs who require skilled care. This service will be offered in conjunction with the array of health-related supports currently available through the waiver by appropriately-trained, unlicensed personnel. This provision costs \$10.5 million (\$4.0 million state share) in 2016 and \$37.0 million (\$14 million state share) in 2017.
- **Increases Homemaker Personal Care (HPC) waiver provider rates 6 percent.** This rate increase will provide a more stable, consistent workforce by reducing the turn-over rate of direct care staff. This provision costs \$28.0 million (\$10.5 million state share) in 2016 and \$56.0 million (\$21.1 million state share) in 2017.
- **Provides additional state funding for IO and SELF waivers to bring down waiting lists.** This funding will enable individuals across the state currently on the waiting list for home and community-based services to access services. This provision costs \$6.3 million (\$2.3 state share) in 2016 and \$35.9 million (\$13.5 state share) in 2017.
- **Converts Transitions Developmental Disability (TDD) waivers to permanent IO waivers.** All individuals currently enrolled in the TDD Waiver will have the opportunity to enroll in the IO Waiver through which they may receive services that promote and enhance community integration. This provision costs \$14.5 million (\$5.4 state share) in 2016 and \$29.6 million (\$11.1 state share) in 2017.
- **Provides additional state funding for IO waivers to avoid ICF admissions, and to give individuals in ICFs a choice to leave.** The Executive Budget, for the first time,

specifically will allocate waivers to divert ICF admissions, providing more individuals with the opportunity to live in the community. It also allocates waivers for individuals who want to leave an ICF. This provision costs \$13.2 million (\$5.0 state share) in 2016 and \$42.0 million (\$15.8 state share) in 2017.

- **Submits a plan to reduce conflict of interest in the waiver program.** A plan to address conflict of interest in the waiver program has been submitted to CMS. There are no cost implications this biennium.
- **Develops a daily rate to reduce administrative complexity.** Using a cost projection tool to establish a consistent daily rate for services provided to an individual will reduce the need for frequent adjustments to payment authorizations and for frequent claims adjustments by providers. There are no cost implications this biennium.

EMPLOYMENT SERVICES

Ohio currently ranks 6th in the nation for enrollment in day services and 8th in the nation for integrated employment services, per capita. In March 2012, Governor Kasich signed an Executive Order establishing the Employment First initiative to provide individuals with developmental disabilities the skills and support they need to obtain meaningful work. Since then, DODD: created a partnership with Opportunities for Ohioans with Disabilities to fund 25 vocational rehabilitation counselors dedicated solely to serving individuals with developmental disabilities, giving priority to those served in segregated settings; developed online benefits and work incentives calculators for job seekers and their families; offered free web-based and in-person competency-based supported employment training for providers; implemented dual certification for vocational rehabilitation and developmental disability providers to ensure continuity in service delivery; engaged system transformation experts to consult with facility-based agencies to transition from segregated to integrated services; and contracted with national experts to develop a new waiver reimbursement system that provides financial incentives for incent integrated employment and integrated day services. As the next steps to build on these efforts, and based on benchmarks established by the Strategic Planning Leadership Group, the Executive Budget will:

- **Replace workshops and facility-based day services with new service models that promote community employment and integrated day services.** DODD will provide leadership to establish a new array of community employment and integrated day services, and establish a prolonged timeframe to transition individuals from sheltered workshops and facility-based day settings to community employment and integrated day settings. This provision costs \$3.0 million state share per year in 2016 and 2017.

Updated February 2, 2015

Table 1. Ohio Department of Developmental Disabilities Medicaid Spending (All Funds in millions)

All Funds	2012	SFY 2012	SFY 2013	SFY 2014	%	SFY 2015	%	SFY 2016	%	SFY 2017	%	SFY 2016/17
Baseline Total		\$ 1,482	\$ 2,151	\$ 2,301	7.0%	\$ 2,402	4.4%	\$ 2,531	5.4%	\$ 2,658	5.0%	\$ 5,189
Executive Budget Reforms: Medicaid												
Increase HPC waiver provider rates 6 percent								\$ 28.0		\$ 56.0		\$ 84.0
Increase rate for provider serving most complex individuals								\$ 10.5		\$ 36.8		\$ 47.3
Add IO and SELF waivers to bring down waiting lists								\$ 6.3		\$ 35.9		\$ 42.2
Convert transitions waivers to IO waivers								\$ 14.5		\$ 29.6		\$ 44.1
Add IO waivers to avoid ICF admissions and give people choice to leave								\$ 13.2		\$ 42.0		\$ 55.2
Incentives to downsize private intermediate care facilities (ICFs)								\$ 7.2		\$ 17.2		\$ 24.4
Subtotal								\$ 80.0		\$ 218.6		\$ 297.2
Executive Budget Reforms: Non-Medicaid												
Replace workshops and facility based day services with new service models								\$ 3.0		\$ 3.0		\$ 6.0
ICF bed buy-back and rental assistance								\$ 2.1		\$ 4.1		\$ 6.2
Provide options counseling								\$ 0.2		\$ 0.2		\$ 0.4
System transformations								\$ 3.3		\$ 3.3		\$ 6.6
Subtotal								\$ 8.5		\$ 10.5		\$ 19.2
Executive Budget		\$ 1,482	\$ 2,151	\$ 2,301	7.0%	\$ 2,402	4.4%	\$ 2,619	9.0%	\$ 2,884	10.1%	\$ 5,503
Note: SFY 2012-2014 are actual and SFY 2015 is an estimate Totals may not add due to rounding.												

Table 2. Ohio Department of Developmental Disabilities Medicaid Spending (State Share of General Revenue Funds in millions)

All Funds	SFY 2012	SFY 2013	SFY 2014	%	SFY 2015	%	SFY 2016	%	SFY 2017	%	SFY 2016/17
Baseline Total	\$ 222	\$ 434	\$ 436	0.3%	\$ 445	2.2%	\$ 456	2.4%	\$ 461	1.2%	\$ 917
Executive Budget Reforms: Medicaid											
Increase HPC waiver provider rates 6 percent							\$ 10.5		\$ 21.1		\$ 31.6
Increase rate for provider serving most complex individuals							\$ 4.0		\$ 14.0		\$ 18.0
Add IO and SELF waivers to bring down waiting lists							\$ 2.3		\$ 13.5		\$ 15.8
Convert transitions waivers to IO waivers							\$ 5.4		\$ 11.1		\$ 16.5
Add IO waivers to avoid ICF admissions and give people choice to leave							\$ 5.0		\$ 15.8		\$ 20.8
Incentives to downsize private intermediate care facilities (ICFs)							\$ 2.7		\$ 6.5		\$ 9.2
Subtotal							\$ 30.0		\$ 82.0		\$ 112.0
Executive Budget Reforms: Non-Medicaid											
Replace workshops and facility based day services with new service models							\$ 3.0		\$ 3.0		\$ 6.0
ICF bed buy-back and rental assistance							\$ 1.0		\$ 1.0		\$ 2.0
Subtotal							\$ 4.0		\$ 4.0		\$ 8.0
Executive Budget	\$ 222	\$ 434	\$ 436	0.3%	\$ 445	2.2%	\$ 490	10.0%	\$ 547	11.7%	\$ 1,037

Note: SFY 2012-2014 are actual and SFY 2015 is an estimate Totals may not add due to rounding.

Office of Health Transformation

Rebuild Community Behavioral Health System Capacity

Governor Kasich's Budget:

- *Improves care coordination through managed behavioral health care.*
- *Adds services to the Medicaid behavioral health services benefit package.*
- *Strengthens housing and other community supports for people most in need.*

Background:

When Governor Kasich took office, Ohio's publicly funded system of mental health and addiction services was in turmoil. Over the previous four years, state funding for mental health was reduced nearly 20 percent (\$112.4 million). Even before these cuts, the resources for people with severe mental illness transferred from state hospitals to communities in the 1990s had eroded over time. Limited state and local funding for mental health and addiction services became primarily used for Medicaid matching purposes. Significant cuts in state support for mental health and addiction services paired with increased demand for local match for Medicaid services in a period of economic recession significantly limited access to individuals in need of treatment, particularly for those most in need: adults with severe and persistent mental illness, seriously emotionally disturbed children and youth and persons with substance use disorders. The state cuts, combined with Medicaid match dislocation, forced a reduction in non-Medicaid supports, including housing and employment supports. The system was in crisis.

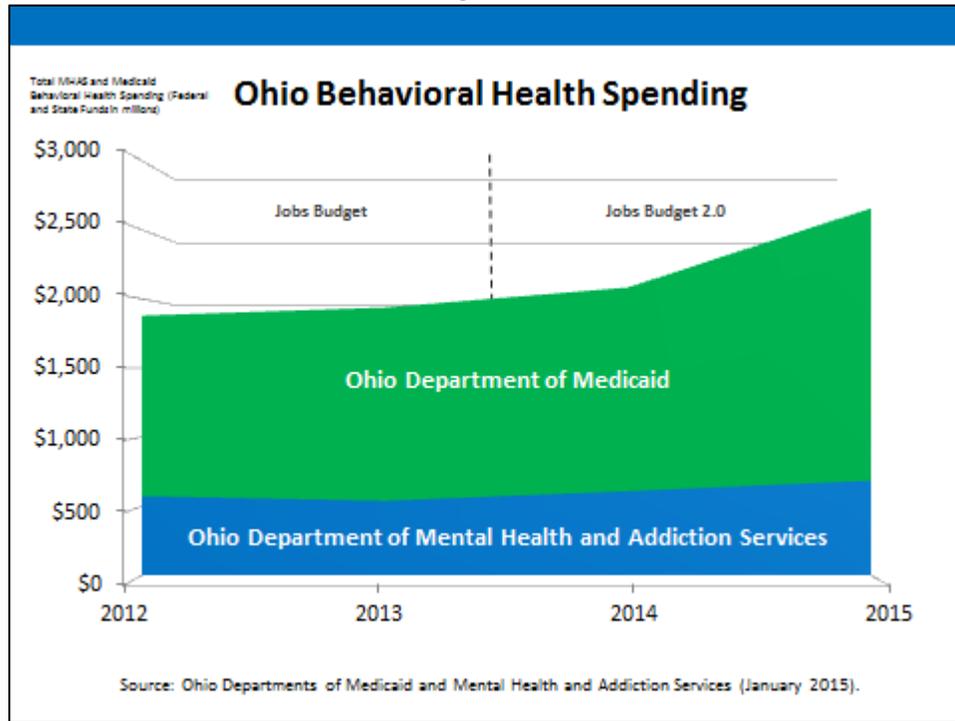
First Four Years:

Governor Kasich's first budget (enacted in 2011) increased state funding for mental health and addiction services, reversing the previous downward trend. It also freed local mental health and addiction treatment systems from Medicaid match responsibilities, initiated changes to increase access to medication assisted treatment for opiate addicted Ohioans, created Medicaid health home pilots for people with severe and persistent mental illness, and provided targeted investments to restore community behavioral health capacity. The Governor's Jobs Budget 2.0 (enacted in 2013) continued these reforms, providing one-time funds to address community priorities, launching a project to help nursing home residents with mental illness who wanted to move back into the community, and funding more safe and affordable housing.

The biggest step forward, however, occurred in October 2013 when the Ohio General Assembly's Controlling Board approved funding to extend Medicaid coverage to more low-income Ohioans who previously had no source of coverage and, if they had behavioral health needs, likely were relying on county-funded services. The combination of elevating match responsibility for clinical services to the state and then extending those services to more people

represented a paradigm shift for Ohio’s behavioral health system. The influx of resources into the system (Figure 1) represents a once-in-a-generation opportunity to facilitate Medicaid and non-Medicaid services working together to meet the needs of adults with severe mental illness, severely emotionally disturbed children and youth, and people with substance use disorders.

Figure 1.



Executive Budget Proposal and Impact:

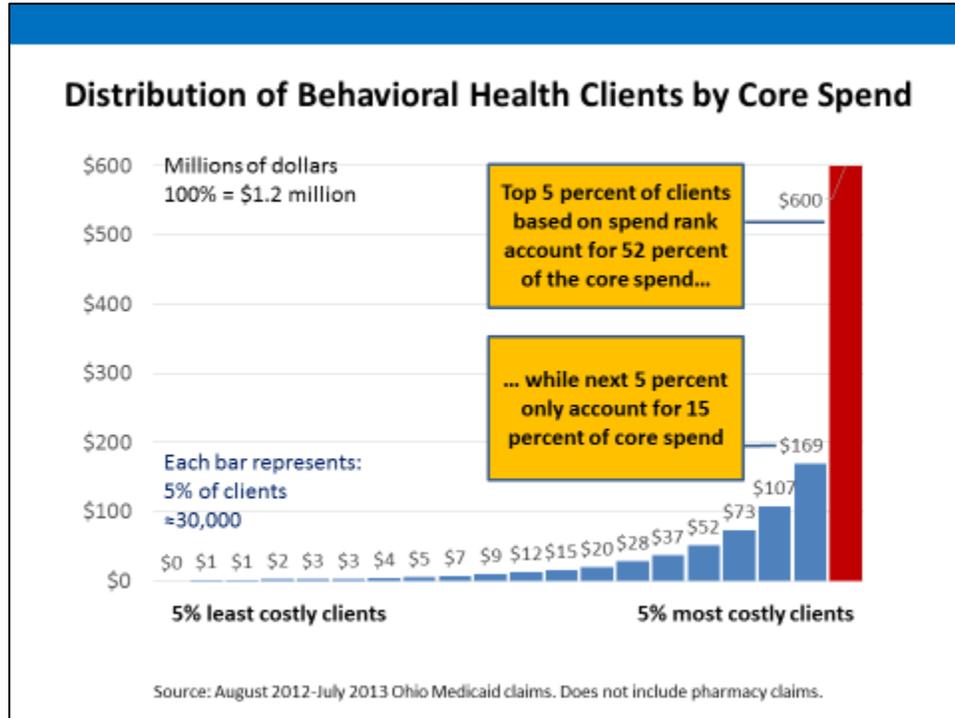
The Executive Budget continues the effort to rebuild community behavioral health system capacity. It modernizes the Medicaid behavioral health benefit and establishes a clear path to achieve better coordination and integration of physical health and behavioral health care services. It also invests in prevention services and non-Medicaid supports that help a person sustain their recovery, such as housing, employment and peer services, and creates an opportunity to partner with local systems on these unmet needs. Most importantly, it sets priorities for both programs in combination, and focuses resources where the need is greatest.

Modernize the Medicaid Behavioral Health Benefit

The Medicaid behavioral health population in Ohio represents 27 percent of Medicaid members but accounts for almost half (47 percent) of Medicaid spend. The most expensive five percent account for over half of behavioral health expenditures (Figure 2). Only 50 percent of the behavioral health population on Medicaid is seen through the Mental Health and Addiction Services (MHAS) system. People with serious and persistent mental illness who are not in the

behavioral health system often receive care in nursing homes, prisons and psychiatric inpatient hospitals. By making some key program reforms to the Medicaid program, and focusing where the need is greatest, Ohio can better serve individuals with high-end mental health and addiction needs while also bending the cost curve in the long run for these same individuals.

Figure 2.



The Executive Budget makes a significant investment through Medicaid to provide a more comprehensive behavioral health service package and improve care coordination. It invests an additional \$34.4 million (\$12.9 million state share) in 2016 and \$112.4 million (\$42.3 million state share) over the next two years:

- Redefines Medicaid Behavioral Health Services and Establish Additional Services.** Beginning in FY 2016, current behavioral health services will be redefined to update coding and definitions to align with national standards and support integration, including the identification and discrete pricing of specific service activities. An urgent need exists to redefine and code mental health Pharmacological Management and alcohol and other drug Medical/Somatic so community mental health and addiction providers can better integrate with the rest of the health care world. Ohio Medicaid and MHAS will redefine codes to align with national standards effective July 1, 2015. The remaining behavioral health services will be redefined beginning in January 2016 when new services are introduced. The overall redesign will be budget neutral and focused on aligning services according to a person’s acuity level and need. The specific components of community psychiatric supportive treatment, case management, and health home

services will be disaggregated, defined and priced accordingly in order to give providers greater flexibility to meet a person's clinical need. Lower acuity service coordination and support services will be defined for people with less intensive service needs. New services will be developed for people with high intensity service need, including Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), high-fidelity wraparound, peer services, supportive employment, and Substance Use Disorder (SUD) residential services. Some of these services for adults with severe and persistent mental illness will be covered under a 1915i Medicaid waiver, described below.

- ***Creates a special benefit program for adults with severe mental illness.*** As a result of the new single disability determination process proposed in the Executive Budget (see *Simplify Eligibility Determination*), the majority of people whose income will be above the Medicaid need standard adopted under the new system are adults with severe and persistent mental illness (SPMI). These Ohioans will have access to basic health care services through Medicare or private insurance. However, neither Medicare nor private insurance pay for a range of service coordination and community support activities currently covered in the Medicaid program. In order to ensure continued access to these services, Ohio Medicaid will seek a state plan amendment under section 1915(i) of the Social Security Act to provide for eligibility for adults with SPMI with income up to 225 percent of poverty (300 percent of the Federal Benefit Rate) who are not eligible under another Medicaid category and who meet diagnostic and needs assessment criteria established by the state. Ohio will also identify home and community based services needed by this population to be covered as services under the 1915(i) authority. MHAS will contract with a vendor pursuant to requirements established by Ohio Medicaid to validate the diagnostic and needs assessments conducted by qualified behavioral health providers. These assessments will be used to authorize eligibility and services under 1915(i). This provision costs \$34.4 million (\$12.9 million state share) in 2016 and \$43.5 million (\$16.4 million state share) in 2017.
- ***Implements a Standardized Assessment Tool to Prioritize Need.*** Access to high-severity services such as ACT, IHBT, high-fidelity wraparound and SUD residential, peer services, and supported employment will be assured through implementation of standardized assessment tools. These tools will be integrated in qualified provider organizations and performed in conjunction with the clinical assessment performed by qualified staff within the provider organizations. The standardized assessment will be independently validated by MHAS or an MHAS vendor authorized by Ohio Medicaid. The independent validation will be required for service authorization. The tools will include an assessment of housing needs and employment related supports not covered by Medicaid.
- ***Facilitates access to non-Medicaid housing supports for people most in need.*** People with severe mental illness and substance use disorders frequently experience longer than necessary stays in institutional settings such as hospitals and nursing facilities because of a lack of supportive housing options. An array of housing options is needed

for this population, including permanent supportive housing, rental assistance for independent living, licensed group homes, transitional housing, crisis housing, and recovery housing. The housing needs of people with severe mental illness and addiction disorders identified through the assessment tools described above will assist MHAS and county boards to plan and allocate available resources to meet these needs.

- ***Improves Care Coordination and Outcomes through Managed Behavioral Healthcare.*** In order to improve care coordination and behavioral health and overall health outcomes for people with mental health and addiction service needs, Ohio Medicaid and MHAS will restructure all Medicaid-reimbursed behavioral health services under some form of managed care. Providers in the new network will include community behavioral health organizations, inpatient hospitals, clinics, and specialty practitioners. Ohio Medicaid and MHAS will use one year of fee-for-service experience for the services redefined above and the data from identifying the high risk/high severity population in the planning and rate setting for organizing these services under managed care. Ohio Medicaid and MHAS have not made any final decisions on the specific requirements for care coordination and the types of managed care entity or entities that will be contracted with for this purpose, but will develop structured processes for stakeholder input to occur during March 2015 and make final decisions soon after. This provision costs \$68.9 million (\$25.9 million state share) in 2017.

Strengthen MHAS Community Supports

Preserves Hospital Capacity to Ensure High Quality Care for Individuals in Crisis. MHAS operates six psychiatric hospitals with a total of 1,181 beds. From 2011 through 2014, total admissions to state psychiatric hospitals increased 35 percent and the overall census increased 6 percent. During this same period, operating costs increased in areas including patient medications, employee insurance, information technology and food service. In response, MHAS took steps to reduce spending in other areas, including rebidding laboratory services and medication suppliers at lower costs, and working with a utility management firm to reduce utility costs at all hospitals. At the same time MHAS was working to reduce costs, the hospitals were losing revenue from other sources. Tighter billing requirements from CMS and its Medicare billing intermediary reduced the hospitals' revenue by \$5 million per year. As MHAS worked to identify and implement corrective action plans to respond to the intermediary's expectations, it was necessary to exhaust hospital cash reserves in order to maintain current operations. To address these circumstances, the Executive Budget provides \$10 million in additional state general revenue funds per year in 2016 and 2017 (federal funding is not available for state psychiatric hospitals).

- ***Supports Community Strategies to Impact Hospital and Jail Capacity.*** The criminal justice system is overwhelmed working with individuals who have committed offenses as a result of their mental illness or addiction. The connection between incarceration and treatment is not always as strong as it needs to be. There is a need in several areas

of the state to improve the connections between local jails, state hospitals and treatment providers in order to reduce transfers, improve safety and judicial oversight, and address strained capacity in both jails and state hospitals. The Executive Budget provides funding for MHAS and the state psychiatric hospitals in conjunction with local partners to make targeted investments in these programs.

- ***Supports Prevention and Crisis Intervention.*** Over the past year, MHAS and other stakeholders established a network throughout the state to share evidence-based practices that encourage the use of trauma-informed care. This approach is critical to helping people heal, and has been shown to reduce the need for seclusion and restraint. The Executive Budget provides funding for MHAS to continue its cross-agency efforts in this area. In addition, the Executive Budget provides funding for suicide prevention, and targets efforts using evidence based practices to focus on individuals who are leaving state psychiatric hospitals, as well as to build capacity within local coalitions and strengthen Ohio's efforts to prevent avoidable tragedies.
- ***Supports Strong Families and Safe Communities.*** In the last budget, a total of \$5 million was provided for a partnership between DODD and MHAS (called Strong Families, Safe Communities) to work with families in crisis with youth who are at risk to be a danger to themselves and others due to unmanaged symptoms related to their mental illness or developmental disability. This investment funded community projects across the state that focused on coordination and crisis intervention through collaboration. The Executive Budget provides \$3.0 million per year to sustain the partnership into 2017. The Executive Budget includes an investment to build infrastructure and support for prevention programming in a few critical hot spot areas is needed to promote resiliency and help youth to choose a path that does not include substance abuse. A key target population is children with incarcerated parents.
- ***Reduces Administrative Costs and Puts Savings into Services.*** The Executive Budget continues the commitment made with the original consolidation of the former Ohio Department of Mental Health and the former Ohio Department of Alcohol and Drug Addiction Services to streamline government and reduce administrative expenses. The Executive Budget includes a \$1 million reduction in MHAS central office expenditures with a goal of redirecting that appropriation to add value in the community. This reduction is in addition to the continuation of the \$1.5 million annual reduction taken in the 2014-2015 budget.

Updated February 2, 2015

Office of Health Transformation **Increase Access to Housing**

Governor Kasich's Budget:

- *Sustains recent increases in state funding to support affordable housing.*
- *Prioritizes federal, state and local housing resources for at-risk populations.*
- *Enables more Ohioans to avoid entering an institution unnecessarily.*
- *Establishes an Ohio Housing Trust Fund reserve.*

Background:

For people with severe and persistent mental illness or substance use disorders, individuals with developmental disabilities, and older adults with cognitive and physical health limitations, access to stable, affordable housing is often the key factor in being able to live in the community and avoiding long term institutional care. It is about more than having a roof overhead – an array of housing supports is required. Across this spectrum, some people may require group settings with higher levels of on-site supervision and support, others with moderate needs may be able to live in an apartment but with support available on premises, and many need only rental assistance and the availability of community based services.

Significant investments have already been made for housing for special populations, but significant gaps remain. Opportunities exist within state administered housing programs to better target resources to people with disabilities, and Medicaid expansion provides opportunities to free up resources within the behavioral health system to better assure housing needs are met. Aligning resources in this manner will help close housing support gaps for people who are homeless or at risk of homelessness, and avoid unnecessary and expensive placements into nursing homes and other long-term care facilities, hospitals and prisons.

First Four Years:

Over the past four years, much has been done to expand access to safe and affordable housing. Nearly all of the initiatives described below required significant partnership among the Ohio Housing Finance Agency, Development Services Agency, the Interagency Collaborative on Housing and Homelessness, the Ohio Department of Mental Health and Addiction Services (MHAS), and other Office of Health Transformation cabinet agencies.

- ***Exceeded HOME Choice goals.*** In 2008, Ohio Medicaid established a program to Help Ohioans Move, Expanding Choice (HOME Choice) with a goal to transition 2,000 residents of institutions into home and community-based settings. As of 2014, more than 5,000 people have achieved greater independence through HOME Choice, and

Ohio's program currently ranks first nationally in transitioning individuals with mental illness into community based settings and second in overall in transitions completed.

- ***Assisted individuals with mental illness who want to leave institutions.*** MHAS created the [Recovery Requires a Community](#) program to provide state resources that will enable people diagnosed with serious mental illness who are in an institutional setting and wish to live in the community to do so. Recovery Requires a Community is not a permanent housing subsidy but, in combination with HOME Choice, can act as a transitional bridge until other options are available. It can be used for housing assistance, debt elimination, supplemental independent living assistance and other services a person needs to remain in a community setting. The program is meant to “fill the gap” when no other resources can meet the need of the individual. Since it was created in July 2013, 214 Ohioans have returned to the community with support from Recovery Requires a Community.
- ***Provided additional rent subsidies to keep Ohioans out of institutions.*** MHAS administers the [Residential State Supplement](#) (RSS) subsidy program to help prevent premature or unnecessary institutionalization by supplementing a person's income, paying monthly allowable fees (or “rent”) for accommodations, supervision, and personal care services at eligible community residences (Adult Care Facilities, Adult Foster Homes, Residential Care Facilities and Assisted Living). Approximately 89 percent of RSS recipients have a mental health diagnosis, and 19 percent are over age 60. Governor Kasich's 2015 mid-budget review allocated an additional \$7.5 million to expand and improve the RSS program. In addition, MHAS provided RSS [Quality Payment Program](#) payments directly to operators of facilities that house RSS residents to improve the quality of care in the facility and promote community integration.
- ***Linked residents of adult care facilities to mental health and addiction services.*** MHAS created an [Incentive Program](#) that provides a cash supplement to licensed Adult Care Facility/Adult Foster Home operators that facilitate linkage of the homes' residents with local mental health or substance use disorder providers as needed. In 2014, there were 315 homes that provided housing for 5,880 clients who benefit from this initiative.
- ***Assisted adult care facilities make critical repairs.*** Funding from the [Ohio Housing Trust Fund](#) was used to assist eligible, licensed Adult Care Facilities with structural and life safety repairs. In 2012, the Ohio Housing Finance Agency and Ohio Housing Trust Fund managed by Development Services Agency provided \$1 million to assist 114 facilities make structural and life safety repairs to improve the quality of the living environment. The [Ohio Housing Finance Agency](#) allocated an additional \$300,000 in 2013 that provided funding to 36 more facilities to complete structural and life safety repairs.
- ***Added recovery housing beds.*** In 2015, MHAS provided \$10 million in funding to strengthen and expand housing options for Ohioans in recovery from addiction. The funding, comprised of \$5 million in operating funds set aside in the 2015 mid-budget review and \$5 million appropriated in the 2015-2016 Capital Budget, is helping to

increase Ohio's [Recovery Housing](#) capacity by nearly 660 beds and provide technical assistance for Ohio's emerging [recovery housing network](#).

- ***Provided supportive housing for prisoners reentering the community.*** The Ohio Department of Rehabilitation and Corrections expanded funding for the Returning Home Ohio program. This program provides stable supportive housing in selected counties for individuals reentering the community from prison who have a serious mental illness and are homeless or at risk of homelessness. A study of the program by The Urban Institute found a significant increase in the participation in and use of behavioral health services, while also finding a decrease in rates of recidivism.
- ***Piloted housing subsidies for individuals involved in mental health courts.*** As part of the Attorney General's Task Force on Criminal Justice and Mental Illness, \$215,250 was awarded to expand the Home for Good program. In partnership with the Ohio Housing Finance Agency, the award created a pilot to offer rent subsidy to individuals involved in mental health courts in Hamilton County. In addition, Ohio Medicaid awarded \$415,000 for Hamilton and Cuyahoga counties to pilot using HOME Choice for eligible individuals with criminal backgrounds that make it difficult to use other housing subsidies.

Executive Budget Proposal and Impact:

The Executive Budget continues the Kasich Administration's commitment to increase access to affordable housing as a strategy to avoid unnecessary institutional placements, and to support Ohioans who take personal responsibility to restore their lives, contribute to a community, and move out of poverty. Over the next two years, the Governor's Offices of Health Transformation and Human Services Innovation will align federal, state and local resources to support housing and employment efforts for priority populations, including those with behavioral health disorders, involved with criminal justice system, at risk of entering an institution, and transition age youth. Working together, the state agencies and community partners will:

- ***Sustain funding for Residential State Supplement enrollment.*** MHAS will continue its efforts to improve the RSS program, consistent with recommendation made by a [legislative review panel](#). Specifically, MHAS will work to improve the quality of RSS housing, streamline program management, and reduce disparities in the level and quality of services provided to RSS residents. The Executive Budget provides \$15.0 million in both 2016 and 2017 to sustain the RSS program at current levels.
- ***Expand recovery housing capacity.*** The Executive Budget provides \$2.5 million in both 2016 and 2017 to increase the state's recovery housing capacity. The investment builds on progress made in 2015 by providing start-up funds for capital operating costs as additional recovery residences are established throughout Ohio.

- **Increase job opportunities and supports for youth at risk of homelessness.** The federal Workforce Innovation and Opportunity Act (WIOA) provides funding to help job seekers access employment and support services to succeed in the labor market. A portion of WIOA funds (15 percent) are set aside in the Governor’s Discretionary Fund to carry statewide employment and training activities for youth, adults, and dislocated workers. A critical focus for these funds in Ohio will be to support at-risk youth ages 16-24 as they transition to adulthood and employment. A portion of WIOA discretionary funds will be used to support these youth in permanent supportive housing as they gain employment. In addition, the Ohio Departments of Job and Family Services and Mental Health and Addiction Services will partner to improve training for home/housing providers and youth services providers about the special needs and risks of transitional age youth.
- **Pilot a subsidy for housing providers that support low-income persons with disabilities.** Ohio Medicaid will use \$1 million annually from existing federal Money Follows the Person funds to increase the supply of housing for persons with disabilities living below 18 percent of the area’s gross median income. Ohio Medicaid will partner with the Ohio Housing Finance Agency to provide five years’ worth of Project Based Rental Assistance to developers who increase the supply of Americans with Disabilities Act (ADA) accessible units in affordable housing developments from 10 percent (the current requirement to receive Low Income Housing Tax Credits) to 25 percent of total units. The purpose of the subsidy is to fill the gap between a 50-percent Low Income Housing Tax Credit unit rent and 30 percent of the tenant’s gross income. During the five year pilot, Ohio Medicaid will work with the Office of Health Transformation to seek additional funding for this type of rental subsidy through other state agencies.
- **Establish an Ohio Housing Trust Fund reserve.** The Ohio Housing Trust Fund (OHTF) was established in 1991 to serve housing needs for Ohio’s military veterans, senior citizens, people who are homeless, people with disabilities, and working families. Since 2003, the Ohio Housing Trust Fund has been supported by a fee tied to documents recorded at the county level up to a maximum annual appropriation of \$50 million. The Executive Budget amends the OHTF statute to create a \$15 million reserve fund for the trust fund with fees received above the \$50 million cap. Once the \$15 million reserve amount is reached, any additional revenues would revert to the GRF. The reserve will be used to fill the gap in years when revenues fall below \$50 million.
- **Provide outreach and supportive services to chronically homeless individuals.** MHAS was awarded a \$3.6 million through a federal Cooperative Agreement to Benefit Homeless Individuals (CABHI) in 2014 to provide programming and services for individuals who are chronically homeless. MHAS will leverage these funds to support existing Projects for Assistance in Transition from Homelessness (PATH) in Hamilton, Cuyahoga, Franklin, Montgomery and Summit counties. The goal is to reach 820 participants in these programs over the next three years.

- ***Provide supportive housing for individuals with disabilities.*** Early in 2015, the federal government will announce funding awards to states for Supportive Housing for Persons with Disabilities (HUD Section 811 grants). If Ohio is awarded funds, OHFA and Ohio Medicaid will coordinate with other state agencies and local partners to develop and subsidize rental housing with the availability of supportive services for low-income adults with disabilities.
- ***Designate Development Services to Administer National Housing Trust Fund Program.*** The National Housing Trust Fund (NHTF) provides revenue to build, preserve, and rehabilitate housing for people with the lowest incomes. Ohio is expected to receive up to \$25 million from this source in 2015. Governor Kasich will designate the Development Services Agency to administer the NHTF program in Ohio, and the Ohio Housing Finance Agency will participate as a sub-grantee to allocate the program dollars.
- ***Expand Medicaid benefits that support beneficiaries remaining in stable housing.*** Ohio Medicaid will seek a state plan amendment under section 1915i of the Social Security Act to provide a special waiver program for adults with SPMI with income up to 225 percent of poverty (300 percent of the Federal Benefit Rate) who are not eligible under another Medicaid category and who meet diagnostic and needs assessment criteria established by the state. The purpose of the waiver is to protect these individuals from changes in disability determination (see Simplify Eligibility Determination) that otherwise might cause them to lose benefits. The creation of the waiver creates an opportunity to identify home and community based services needed by this population, including certain housing supports under the 1915i authority.

Updated February 2, 2015

Office of Health Transformation **Improve Population Health Planning**

Governor Kasich's Budget:

- *Aligns population health planning to improve health outcomes.*
- *Connects hospital community benefit to population health priorities.*
- *Strengthens infectious disease planning and preparedness.*
- *Focuses resources to reduce infant mortality and tobacco use.*

Background:

There are 123 county and city health departments in Ohio operating at various levels of capacity. These local health districts (LHD) range from employing 2 to 275 full-time workers, from serving 6,441 to 854,975 residents, and from expending \$8 to \$232 in public health funding per resident. For 50 years, experts have been recommending better ways to organize public health. A 1960 report recommended a minimum size for LHDs, and used as examples 100,000 residents for city health departments and 50,000 residents for all other health districts.¹ A 1993 report recommended that LHD jurisdictions be required to have the critical mass necessary to provide core public health functions and that, in most cases, county boundaries would provide the critical mass necessary.² And a 2012 Institute of Medicine report recommended providing a “minimum package of public health services” in every community, and greater collaboration between public health and its clinical care counterparts to improve the outcomes of clinical care and the field’s contributions to population health.³

First Four Years:

In 2011, the Association of Ohio Health Commissioners (AOHC) established a *Public Health Futures* project to explore new ways to structure and fund local public health. The project guided AOHC members through a critical look at the current status of local public health and a careful examination of cross-jurisdictional shared services and consolidation as potential strategies for improving efficiency and quality. Members defined the core public health services that each LHD should provide, and foundational capabilities that can be internal or accessed through cross-jurisdictional sharing. The project culminated in recommendations that linked future decisions about services, jurisdictional structure, and financing to each LHDs capacity to provide core public health services.⁴ The report concluded that most LHDs may benefit from cross-jurisdictional sharing, but LHDs serving populations of 100,000 residents or less would particularly benefit from pursuing cross-jurisdictional sharing or consolidation.

¹ Ohio Legislative Service Commission, [Organization and Financing of General Health Districts](#) (1960)

² Ohio Public Health Services Study Committee, [Healthy People, Healthy Communities](#) (1993)

³ IOM, [For the Public's Health: Investing in a Healthier Future](#) (2012)

⁴ AOHC, [Public Health Futures Final Report and Recommendations](#) (June 2012)

In response to *Public Health Futures*, Governor Kasich's Jobs Budget 2.0 (enacted in 2013) included several new initiatives designed to give public health more tools to collaborate and integrate programs. It standardized the collection and reporting of public health quality indicators from LHDs, required accreditation of all LHD's by 2020, created incentives to share services among LHDs, and required continuing education for LHD board members.

Executive Budget Proposal and Impact:

The Executive Budget expands on earlier steps to improve collaboration among LHDs and creates a new opportunity through better regional planning to address Ohio's infant mortality rate, ongoing tobacco use, and chronic disease burden. The thoughtful coordination of hospital community benefit resources, for example, presents an opportunity to positively impact the health of all Ohioans. The Executive Budget proposes the following:

- ***Facilitate local health district accreditation through regional assessment and planning.*** The Executive Budget requires ODH to convene a *Population Health Planning and Hospital Community Benefit Advisory Workgroup* to recommend strategies for conducting regional community health needs assessments (CHA) and developing regional community health improvement plans (CHIP). The goal is to support LHD accreditation and align with the State Health Assessment (SHA), State Health Improvement Plan (SHIP), and State Innovation Model (SIM) population health plan. Regional CHAs and CHIPs create an opportunity to set clear population health priorities, align resources to improve outcomes, and share services to achieve better results with existing resources.
- ***Align hospital community benefit to improve population health outcomes.*** Historically, "community benefit" has been the Internal Revenue Service's (IRS) legal standard that nonprofit hospitals must satisfy in order to qualify for federal tax exemptions. In 2010, the federal government clarified community benefit requirements by establishing new standards for community health needs assessments and implementation strategies. In 2013, 171 Ohio hospitals registered as nonprofit⁵ based on claiming \$3.12 billion in total community benefit statewide, including Medicaid losses, charity care, and special projects.⁶ While a number of states have enacted laws setting forth additional expectations of nonprofit hospitals, including specific community benefit requirements, there are no requirements in Ohio law for nonprofit hospitals to provide a specified level of community benefit, report community benefit, conduct community health needs assessments, or develop community benefit plans or implementation strategies. The Executive Budget establishes a *Population Health Planning and Hospital Community Benefit Advisory Workgroup* to recommend what specific demonstration of community benefit should be required for a nonprofit hospital to retain tax exempt status.

⁵ Ohio Department of Health, [Hospital Registration Data](#) (2013)

⁶ Ohio Hospital Association, [Community Benefit Report](#) (2013)

Specifically, the Workgroup will recommend the extent to which community benefit should be used to address prioritized population health outcomes in direct alignment with the regional CHIP. The Workgroup also will consider the potential benefit of establishing regional community health and wellness trusts to receive and distribute hospital community benefit funds, tobacco settlement funds, or other grant funds in alignment with the regional CHIP.

- **Coordinate infectious disease regional planning and preparedness.** In 2014, Ohioans were confronted with contaminated drinking water in northwest Ohio, mumps and measles record outbreaks, and the Ebola exposures that affected 19 local health districts and multiple hospital systems in northeast Ohio. A recent article in the Centers for Disease Control and Prevention’s Morbidity and Mortality Weekly Report highlighted several best practices in Ohio’s Ebola response but reiterated the need for specific planning and collaboration among public health, hospitals and first responders.⁷ The Executive Budget provides \$2.75 million each year in 2016 and 2017 that can be used during an infectious disease outbreak or other emergency. In addition, a portion of this funding will assist LHDs and hospitals to jointly plan to ensure Ohioans are protected.
- **Monitor reductions in clinical services as a result of coverage expansions** ODH contracted with Mathematica to evaluate the impact of extending Medicaid coverage and the creation of Marketplace Exchanges on services provided by the department. In a December 2014 report, Mathematica concluded that population that have benefited from several ODH programs will gain insurance or Medicaid that will cover many of the services the ODH programs have provided with state and federal funds. Because ODH is the payer of last resort, Mathematica estimates that moving Ohioans to coverage will reduce the need for ODH spending in the Children with Medical Handicaps Program (\$6.8 million less required), Ryan White HIV/AIDS Part B Program (\$6.8 to \$8.6 million less required), Breast and Cervical Cancer Project (\$823,000 less required), and other Bureau of Child and Family Health Services programs (\$609,400 less required). Also, because immunizations are now an essential health benefit that insurance is required to cover, Mathematica estimated reduced spending by the ODH Immunization Program (\$8.8 million less required). Although ODH will prioritize getting these Ohioans connected to a regular source of insurance coverage, the Executive Budget does not reduce funding for these programs in order to ensure that no Ohioans go without needed services during this transition period. For the next two years ODH will monitor actual utilization levels and, if increased access to insurance results in less demand for these programs, adjust future funding levels accordingly. This approach has no impact on the budget because it flat-funds the programs described above with one exception, immunizations as described below.
- **Require local health districts to bill for immunizations.** ODH currently encourages local health districts (LHDs) to bill Medicaid or private insurance for eligible services to reduce

⁷ CDC MMWR, [Response to Importation of a Case of Ebola Virus Disease, Ohio](#) (November 2014)

their need for general revenue funds. In addition, AOHC has been working with LHDs to ensure they have the capability to bill for services, specifically immunizations. The Executive Budget requires ODH to notify LHDs that the state will no longer provide GRF-funded vaccines beginning on January 1, 2016. ODH will provide funding for vaccines for the first half of FY 2016 (June 1–December 31, 2015) so LHDs can build up their inventory upon which to conduct this billing. This provision reduces immunization program spending \$2.8 million in 2016 and holds funding flat in 2017.

- ***Leverage better public health planning to address specific health challenges.*** In addition to the activities described above, the Executive Budget also includes several major initiatives to improve specific health outcomes. It focuses on reducing infant mortality by providing enhanced maternal services through Medicaid health plans for every woman in neighborhoods most at risk for poor infant health outcomes, and requires Medicaid health plans to engage leaders from within high-risk neighborhoods to connect women to health care and other services (see *Reduce Infant Mortality*). It also commits Tobacco Master Settlement Agreement funds to launch a significant new campaign to reduce tobacco use (see *Reduce Tobacco Use*). These initiatives are complex and require collaboration across multiple entities and levels of government. Better public health planning, as proposed in the budget, will assist to leverage these activities to their fullest potential.

Updated February 2, 2015

Office of Health Transformation **Reduce Infant Mortality**

Governor Kasich's Budget:

- *Provides enhanced maternal services through Medicaid health plans for every woman in neighborhoods most at risk for poor infant health outcomes.*
- *Requires Medicaid health plans to engage leaders from within high-risk neighborhoods to connect women to health care and other services.*
- *Launches new initiatives to prevent maternal smoking.*

Background:

Infant deaths – when a baby who is born alive dies within the first year of life – account for 63 percent of all childhood deaths in Ohio. The three leading causes of infant death are preterm births (47 percent), birth defects (14 percent), and sleep-related deaths (15 percent). Some risk factors, such as smoking, increase the risk of all three leading causes of infant death. There are many non-medical factors that correlate to poor infant health outcomes, including race, poverty, poor nutrition, and education.

Ohio's high infant mortality rate is among the worst in the nation. In 2011, Ohio's infant mortality rate was 7.88 (infant deaths per 1,000 live births) compared to the national rate of 6.07. Infant mortality impacts Ohio families differently, greatly influenced by race and location. In 2011, the black infant mortality rate was 15.45, more than twice the white rate of 6.39. Black babies are more likely to die within the first year of life even when social and economic factors are considered. Metropolitan and Appalachian counties also have higher rates of infant mortality compared to the state as a whole.

First Four Years:

In March 2011, Governor Kasich made reducing low birth weight babies a priority in his State of the State address. The Governor's Office of Health Transformation, working with Ohio Departments of Medicaid, Health, Mental Health and Addiction Services, and other human services agencies initiated an unprecedented package of reforms to improve overall health system performance for pregnant women and infants (*see more detail on each initiative [here](#)*). Although it is too early to see results in infant mortality outcomes, the scope and focus of these efforts is expected to significantly improve birth outcomes over time:

Improve Overall Health System Performance

- Extended Medicaid coverage to previously uninsured parents.
- Simplified the Medicaid eligibility and enrollment process for pregnant women.

- Supported the development of regional systems of perinatal care.
- Provided enhanced maternal care management for high risk pregnancies.
- Used vital statistics data linked to Medicaid claims to identify high-risk women.
- Required better discharge planning for babies in neonatal intensive care units.
- Financially rewarded health plans that improve infant health outcomes.
- Expanded access to Medicaid family planning benefits.

Focus Resources Where the Need is Greatest

- Supported community-specific efforts to reduce infant mortality.
- Increased local capacity to conduct fetal infant mortality reviews.
- Created “pregnancy pathways” connecting women to health care and other services.
- Provided more comprehensive care for opiate-challenged mothers.
- Standardized treatment options for Neonatal Abstinence Syndrome.

Prevent Premature Birth

- Facilitated Progesterone therapies for mothers at risk for preterm birth.
- Reduced scheduled deliveries prior to 39 weeks without medical necessity.
- Improved antenatal corticosteroid use to promote lung development in newborns.
- Increased the use of human milk to reduce infections in premature infants.
- Encouraged breast feeding, which is highly correlated to preventing infant death.
- Provided pregnant mothers access to tobacco cessation programs.

Prevent Birth Defects

- Trained nurses to encourage women to take folic acid supplements.
- Required newborn screening for Critical Congenital Heart Disease.
- Required newborn screening for Severe Combined Immunodeficiency.
- Piloted an obesity control program in the highest-risk counties.

Prevent Sleep-Related Deaths

- Launched a “safe sleep” campaign.
- Implemented a Sudden Unexpected Infant Death training protocol.

Executive Budget Proposal and Impact:

On December 4, 2014, Governor Kasich previewed elements of his Executive Budget with a group of 1,700 local leaders attending the 2014 Ohio Infant Mortality Summit sponsored by the Ohio Department of Health, in conjunction with the Ohio Collaborative to Prevent Infant Mortality. At the event, the Governor said the current infant mortality rate is “clearly unacceptable” and announced that the Ohio Departments of Medicaid and Health would work together to surge resources into the neighborhoods with the highest incidence of preterm birth and low-birth weight babies. Specifically, the Executive Budget will:

Focus Resources Where the Need is Greatest

- **Support enhanced care management for every woman in high-risk neighborhoods.** Ohio Medicaid managed care plans will be required to provide enhanced care management services for both pregnant and non-pregnant women in the most high-risk neighborhoods as a strategy to improve health status and future birth outcomes. The Ohio Department of Health is using vital statistics data to pinpoint specific “hot spot” neighborhoods that have the poorest birth outcomes in the state as measured by preterm birth and low-birth weight babies. Using this data, Ohio Medicaid will be directing its health plans to automatically connect pregnant women and infants in these neighborhoods to enhanced care management services. In addition, women in these neighborhoods who are not pregnant now have access to additional care management services to improve their overall health and ultimately impact the health of future babies. The cost of this initiative is included in the rate currently paid to health plans and has no impact on the budget.
- **Engage leaders in high-risk neighborhoods to connect women to health care.** In addition to automatically requiring enhanced care management for all women of child-bearing age in high-risk neighborhoods, Ohio Medicaid will also direct its managed care plans to use community health workers who live in the most high-risk neighborhoods to assist with the outreach and identification of women, especially pregnant women, to make sure they are connected to ideal health care and other community supports. Rather than reach into a community and risk misunderstanding the issues that confront the women who live there, this proposal requires the plans to identify individuals from within the community who understand the issues and can remove barriers for the women living there. The community health worker will be expected to address more than just health care, and also connect women to community services outside the health plan that support healthy living and work. The health plans will be required to coordinate with local health districts in high-risk neighborhoods and, together, develop a communications plan to ensure all health care and community supports are aligned toward decreasing infant mortality and improving the health of families. This provision costs \$13.4 million (\$5.0 million state share) per year in 2016 and 2017.
- **Focus evidence-based strategies to reduce maternal smoking.** Smoking during pregnancy accounts for 20 to 30 percent of low-birth weight babies, up to 14 percent of preterm deliveries, and about 10 percent of all infant deaths.¹ The Executive Budget proposes a number of initiatives to reduce tobacco use, including a significant increase in the tobacco tax (see *Reduce Tobacco Use*). In addition, ODH and Ohio Medicaid will use Tobacco Master Settlement Agreement funds to develop two standardized tobacco cessation toolkits, one to *initiate* tobacco cessation (2-3 months duration) and one to *maintain* tobacco cessation (up to 12 months). The toolkits will be used by Medicaid health plans, health care providers, and local health districts to provide individualized

¹ HHS, Women and Smoking: A Report of the Surgeon General (2001).

assessments and match individuals to the most effective services available for them. This effort will focus first on neighborhoods identified by ODH as most at risk for poor birth outcomes, and provide an opportunity for multiple community partners to target tobacco cessation messages, health-related activities, and grassroots engagement in ways that account for regional and cultural differences. Over five years, \$13.7 million in Tobacco Master Settlement Agreement funds will support this initiative.

- **Expand access to peer support programs for expecting mothers.** “Centering Pregnancy” is an evidence-based health care delivery model that integrates maternal health care assessment, education, and support. The Ohio Department of Health together with the Ohio Association of Community Health Centers will establish and evaluate the Centering Pregnancy model of care in two urban and two rural settings. The four projects will be located in communities that are at high risk for poor infant health outcomes. Governor Kasich committed \$900,000 over three years from Ohio’s Health Innovation Fund for this project, so there is no impact on the Executive Budget.

Strengthen Ongoing Initiatives

- **Eliminate payments for medically unnecessary scheduled deliveries.** In 2007, ODH and Ohio Medicaid created the Ohio Perinatal Quality Collaborative (OPQC). This group is committed to reducing preterm births and improving outcomes of preterm newborns through evidence-based practices and data-driven strategies. From 2008-2010, OPQC worked with 20 Ohio maternity hospitals to prevent unnecessary scheduled early deliveries between 36 and 39 weeks and, based on the success of that early work, expanded to all maternity hospitals. These efforts coincided with a substantial decrease in early scheduled deliveries, moving 31,600 births from 36-38 weeks to 39 weeks or more between 2008 and 2013. Based on recent Ohio experience and data, this decrease in near term births likely prevented as many as 950 Neonatal Intensive Care Unit (NICU) admissions, with an estimated cost savings of \$19 million. Now Ohio Medicaid will revise its rules to only pay providers if the gestational age of the fetus is at least 39 weeks or maternal and/or fetal conditions indicate medical necessity.
- **Improve the administration of Progesterone for at-risk mothers.** Providing Progesterone to women at risk is an effective way to prevent preterm birth. Progesterone treatment (called 17P) has the potential to reduce the incidence of preterm birth by as much as 30 percent, and specifically to reduce the number of infants born before 32 weeks when rates of infant mortality are highest. Ohio Medicaid estimates that currently less than 20 percent of high-risk women enrolled in Medicaid that are eligible for 17P are receiving it. Ohio Medicaid initiated a Progesterone Quality Improvement project to increase the number of eligible high-risk pregnant women receiving 17P. As one of two states receiving federal permission for Ohio Medicaid to restructure quality improvement and data processes, it allows for a continuous accounting of health plan performance using data from birth certificates identifying birth outcomes and providing this information back to health plans in real time. This

data transparency is in alignment with OPQC and health system processes, and holds promise for accelerating improved preterm birth rates that can be measured at a population level.

- **Strengthen regional systems of perinatal care.** Perinatal regionalization is a system of designating and planning for at-risk mothers and infants to be matched to facilities that can manage their complex care. ODH will work to update rules regarding Maternity Units and Homes to align with the professional standards in the most recent edition of the Guidelines for Perinatal Care, and convene a Maternity and Newborn Advisory Council to engage stakeholders to provide recommendations on rules that reinforce effective regional systems of perinatal care.
- **Partner with hospitals to educate parents about safe sleep for their infant.** The Ohio Hospital Association and ODH have been working together to educate Ohioans about infant safe sleep, and recently launched the Safe Sleep is Good4Baby statewide initiative to draw attention to the importance of safe sleep in the hospital and at home. This initiative focuses on modeling safe sleep practices in the hospital, educating parents and families, and advocating and educating community members. As a result, new moms and dads now receive a safe sleep kit prior to leaving the hospital, including education materials to protect their newborn and a book called *Sleep Baby Safe and Snug*.
- **Invest in research to reduce infant mortality.** To better understand the factors contributing to Ohio's unacceptable infant mortality rate, the Executive Budget provides \$1 million per year in 2016 and 2017 from the Third Frontier Fund to the Board of Regents to advance collaborative research at institutions of higher education.
- **Conduct state infant and child fatality reviews.** Every county maintains a local board to review all infant and child deaths in each of Ohio's 88 counties. These local boards annually submit a report to ODH, including data about each death. The Executive Budget allows ODH to convene a state-level review board composed of experts to examine this data and, if necessary, review particularly difficult or complex cases. This review will assist in not only increasing knowledge about these deaths, but help support the development of future recommendations to decrease infant mortality.
- **Increase the state's capability to analyze and respond to infant mortality data.** ODH holds a tremendous amount of vital statistics data within its data warehouse that can be used to drive Ohio's infant mortality reduction initiatives. As the State continues to increase investments and focus on these initiatives, there is a need for increased analytical capacity and evaluation of both state and local efforts. ODH will work with state and local partners to develop information sharing capabilities and evaluation of existing interventions. The goal is to expand state capability to measure progress in reducing infant mortality, and ensure that decisions are data-driven and investments are outcome based. This provision costs \$1 million per year in 2016 and 2017.

Office of Health Transformation **Reduce Tobacco Use**

Governor Kasich's Budget:

- *Increases the cigarette tax to deter smoking.*
- *Commits 100 percent of Tobacco Settlement Funds to reducing tobacco use.*
- *Prohibits anyone from using tobacco products at K-12 schools or activities.*
- *Launches new initiatives to prevent maternal smoking.*

Background:

Ohio's adult smoking rate was 23.4 percent in 2013 – more than 1.6 million Ohioans smoke every day – significantly higher than the U.S. rate of 18.1 percent and nearly double the Healthy People 2020 target of 12.0 percent.¹ Ohio ranks 8th in the nation in the percent of adults who smoke. In addition, 15.1 percent of high school students and 3.7 percent of middle school students were current smokers in 2013.²

Ohio's very high rate of smoking correlates to a very high incidence of infant mortality. Smoking during pregnancy accounts for 20-30 percent of low-birth weight babies, up to 14 percent of preterm deliveries, and about 10 percent of all infant deaths.³ Tobacco use also directly impacts the chronic disease burden in Ohio. Smoking causes cancer, heart disease, stroke, lung diseases (including emphysema, bronchitis, and chronic airway obstruction), and diabetes – all of which can be prevented by not smoking and otherwise choosing healthy behaviors. Health care expenses directly caused by smoking in Ohio are estimated to cost \$5.64 billion annually, including approximately \$1.7 billion in Medicaid costs. In addition, smoking-related productivity losses are estimated to cost Ohio businesses about \$5.88 billion per year.⁴

The health burdens and financial costs of smoking impact some populations more than others. Smoking is more prevalent among poor adults, Appalachian adults, and African American adults. Nearly two in five Ohio residents in poverty smoke. Smokers living below the poverty line are not only more likely to start smoking, but also less likely to quit than higher-income smokers.⁵ Although African American Ohioans have a smoking rate that is similar to whites (about one in four), the burden of smoking-related illnesses and deaths due to heart disease, stroke, and lung cancer are disproportionately higher in this population.

¹ U.S. Behavioral Risk Factor Surveillance System as reported at statehealthfacts.org (January 2014).

² Ohio Youth Tobacco Survey (2012)

³ HHS [Women and Smoking: A Report of the Surgeon General 2001](#)

⁴ Tobacco Free Kids, [The Toll of Tobacco in Ohio](#) (2014).

⁵ CDC Behavior Risk Factor Surveillance System (2013).

First Four Years:

Prior to 2008, tobacco settlement funds were available through the Ohio Tobacco Foundation to support tobacco cessation efforts. However, those funds were exhausted and the Tobacco Foundation ceased operations in 2008. Governor Kasich's first budget (enacted in 2011) provided funding for the Ohio Department of Health (ODH) to enforce Ohio's Smoke Free Workplace law, and ODH coordinated additional tobacco cessation efforts using federal grants from the Centers for Disease Control and Prevention (CDC). Governor Kasich's Jobs Budget 2.0 (enacted in 2013) more than doubled funding for enforcement and other cessation activities, in addition to the continuation of CDC funding for cessation efforts and quit line services.

In 2014, Ohio received another \$38.6 million in tobacco settlement funds. Governor Kasich committed the entire amount to tobacco cessation efforts, and convened a Tobacco Cessation Workgroup comprised of state agency leaders to set priorities for settlement funding and make recommendations for the Executive Budget. Based on the Workgroup recommendations, the Executive Budget:

Executive Budget Proposal and Impact:

- ***Increases the tobacco tax to deter tobacco use.*** Increasing the price of tobacco is the single most recommended and proven strategy for decreasing smoking prevalence and preventing youth from starting to smoke. The Executive Budget proposes to increase the cigarette tax rate by \$1.00 per pack to \$2.25 per pack, impose a cigarette floor stock tax of \$1.00 per pack, eliminate cigarette discounts, increase the other tobacco product (OTP) tax rate from 17 percent to 60 percent (to equalize OTP and e-cigarette tax rates), eliminate the 2.5 percent discount for early payment of the OTP tax, and tax e-cigarettes at a rate equivalent to OTP. These provisions are expected to generate \$527.9 million in state general revenue funds in 2016 and \$453.5 million in 2017.
- ***Bans cigarettes and tobacco in K-12 settings.*** Most K-12 settings are already tobacco free, but some are not, and the policy is not always applied uniformly to everyone at the school. The Executive Budget requires boards of education to ban smoking and tobacco use or possession by students, and ban use by staff or visitors anywhere on school grounds or at school activities.
- ***Requires colleges and universities to adopt tobacco use policies.*** The Executive Budget requires ODH and the Ohio Board of Regents to develop a model policy for tobacco use on campuses and, within one year, requires state institutions of higher education to adopt tobacco-free policies that are not less stringent than the model policy.
- ***Strengthens and enforces Ohio's Smoke Free Workplace Law.*** The Executive Budget requires proprietors to permit entry for the department of health or its local designees to investigate violations of the law, authorizes fines for reporting violations, and

provides \$1.4 million annually to enforce Ohio's Smoke Free Workplace Law. In addition, ODH will increase coordination of enforcement activities with the Attorney General's Office and the Ohio Department of Mental Health and Addiction Services (MHAS), which conducts compliance checks to ensure merchants are not selling tobacco to youth.

- ***Allows for revocation of a food license.*** The Executive Budget makes compliance with Ohio's Smoke Free Workplace law a condition of licensure for food service operators, and gives local health districts the authority to revoke food service licenses for repeat violators of the Smoke Free law. The majority of repeat violators of the Smoke Free law are establishments that that hold food service licenses.

Tobacco Settlement Funds:

- ***Enforces the Tobacco Master Settlement Agreement.*** A portion of the settlement funds will enable the Ohio Attorney General (AG) to continue enforcement of the Tobacco Master Settlement Agreement between the state and participating tobacco manufacturers. Over five years, approximately \$8 million in settlement funds will support this initiative.
- ***Focuses evidence-based strategies to reduce maternal smoking.*** ODH will partner with Ohio Medicaid and other stakeholders to develop two standardized tobacco cessation toolkits, one to *initiate* tobacco cessation (2-3 months duration) and one to *maintain* tobacco cessation (up to 12 months). The toolkits will be used by Medicaid health plans, health care providers, and local health districts to provide individualized assessments and match individuals to the most effective services available for them. This effort will focus first on neighborhoods identified by ODH as most at risk for poor birth outcomes, and provide an opportunity for multiple community partners to target tobacco cessation messages, health-related activities, and grassroots engagement in ways that account for regional and cultural differences. Over five years, \$13.7 million in settlement funds will support this initiative.
- ***Supports community projects to adopt tobacco free environments.*** ODH will partner with the Ohio Department of Education and MHAS to support community projects to adopt tobacco-free schools, campuses, outdoor spaces and smoke-free multi-unit public housing. These projects will focus first on settings in Ohio with the highest prevalence of smoking, evaluate interventions, and then replicate proven best practices in other areas of Ohio. Over five years, \$2.1 million in settlement funds will support this initiative.
- ***Supports demonstration projects for local organizations to address tobacco disparities.*** ODH will partner with the Ohio Commission on Minority Health and MHAS to fund demonstration projects for local organizations to address tobacco use in minority, low-income, and mental health populations. Over five years, \$2.1 million in settlement funds will support this initiative.

- ***Educates merchants who sell tobacco products.*** MHAS, which conducts compliance checks to ensure that merchants are not selling tobacco to youth, will update and distribute “Ohio Tobacco Laws” signs that merchants are required to display, along with warning signs at the point of sale to inform pregnant women about the risk of tobacco use. In addition to the signs, MHAS will develop additional educational materials, including an online module, to educate merchants on Ohio’s youth tobacco and smoke free laws. A “toolkit” of these materials will be included in liquor permit applications sent by the Ohio Department of Commerce, incorporated into the Alcohol Server Knowledge program administered by the Ohio Department of Public Safety, and distributed through the Ohio Petroleum Retailers Association of Convenience Stores to their members. Over five years, \$400,000 in settlement funds will support this initiative.
- ***Trains communities in merchant compliance and incentive programs.*** MHAS will partner with ODH, ODPS, the AG and Ohio Commission on Minority Health to provide incentives for communities and local organizations to conduct separate tobacco inspections, particularly in communities and populations disproportionately impacted by tobacco use. This program will be a collaboration for training and will use existing enforcement designees or contractors of ODH to conduct tobacco inspections. ODPS and ODH will provide training and the AG’s office will provide information to national retail chains participating in voluntary compliance agreements. Over five years, \$2.4 million in settlement funds will support this initiative.
- ***Modernizes the Smoke Free Workplace Law complaint database and tracking system.*** ODH administers a database system that tracks all smoking complaints statewide along with all due process steps, which are extensive. Required updates will fix storage issues and integrate the system with a new Environmental Health Data Integration System. \$500,000 in settlement funds will be used to update the database in 2016.

Updated February 4, 2015

Office of Human Services Innovation
Move Ohioans Up and Out of Poverty

Governor Kasich's Budget:

- *Provides an individualized approach to case management.*
- *Removes barriers to employment, like affordable child care.*
- *Simplifies and automates enrollment.*
- *Creates new opportunities for county shared services.*

Background:

Many Ohioans remain trapped in poverty despite numerous federal, state and local programs intended to assist low-income families, and the human services programs designed to help the poor often are fragmented and uncoordinated. In addition, many human services programs provide a benefit without connecting individuals to work opportunities or encouraging self-sufficiency. As a result, many low-income families have a long-term reliance on benefits.

The Office of Human Services Innovation (OHSI) was established in August 2014 by Governor Kasich to transform programs designed to lift Ohioans out of poverty. OHSI's charge is to work with state and local agencies and stakeholders to pursue a better-coordinated, person-centered human service system across the [existing array of services](#) the state administers to assist Ohioans get a job, succeed at work and prevent or move out of poverty.

The foundation OHSI's work has been laid by the Governor's Offices of Health and Workforce Transformation. These offices provide clear evidence that better-coordinated, person-centric programs can begin to lift up Ohioans in need, provide taxpayers with better value, and chart a course toward a better workforce for Ohio employers. OHSI will apply the same transformative and innovative approach to Ohio's array of human services programs in order to help extend the benefits of the state's continued economic recovery to more Ohioans.

The Executive Budget Proposal and Impact:

The Executive Budget seeks to fulfill the original promise of welfare reform, which John Kasich voted for as a Congressman. That reform was the right idea, but it was implemented on top of an existing system that was not challenged to change. Now, as Governor, and in this budget, the challenge will be to change, to create an individualized approach to case management, remove barriers to employment, and simplify and automate enrollment.

An individualized approach to case management

A job is the most critical, long-term element to stabilizing families and moving them up and out of poverty. However, many families have multiple needs across multiple systems, ranging from housing to behavioral health to education. To ensure that families find long-term success in becoming self-sufficient, a more holistic approach is needed to address the many factors that contribute to a family's economic instability.

In addition, Ohio's teens and young adults, ages 16-24, face higher rates of unemployment than any other age group and many teens struggle to complete high school. Many of these youth also encounter additional barriers to reaching their full potential including homelessness, substance abuse, teen pregnancy and mental health issues. Addressing these issues and barriers early on in a coordinated way, could break the cycle of poverty for more Ohioans.

- **Combine TANF and WIOA.** Create a comprehensive case management and employment program to serve low-income individuals. The program will integrate Temporary Assistance for Needy Families (TANF) and Workforce Innovation and Opportunity Act of 2014 (WIOA) monies to be funded with \$310 million from existing TANF and WIOA dollars over the biennium. County commissioners will be asked to appoint a lead agency to oversee program coordination and serve as fiscal agent between county jobs and family services offices and local workforce boards to ensure the most effective utilization of combined public resources.
- **Create a comprehensive case management and employment system.** Individuals participating in the program shall receive a comprehensive assessment of employment and training needs as developed by the Department in consultation with the Office of Workforce Transformation. Completion of the comprehensive assessment of employment and training needs will direct which of the following services the individual will receive: individualized employment plan, provision of services and benefits in support of the employment plan, support for educational attainment of a high school diploma or equivalence if needed, job placement, job retention support, and review and closure of individualized employment plan.
- **Strengthen work supports for TANF/WIOA-eligible teens and young adults.** Because teens and young adults have the highest rate of unemployment, and earlier barrier removal can prevent a life-time of poverty, a cornerstone of the strategy to strengthen services and work supports will begin first Ohioans ages 16-24. Through this budget, the TANF Summer Youth and WIOA Youth programs will be integrated into a comprehensive case management and employment program, effective Dec. 15, 2015. What is learned with this age group will inform how comprehensive case management is rolled out to all age groups on cash assistance and/or who have a work requirement to receive benefits, effective July 1, 2016.

Remove barriers to employment

The lack of access to affordable and quality child care remains one of the key barriers to work. The loss of subsidized child care once a family reaches an income above 200 percent the federal poverty level (FPL), approximately \$3,298 a month for a family of three, represents one the biggest benefit cliffs for the working poor and often is a deterrent for individuals to take better paying jobs. Many working families also are in need of short-term assistance in the areas of housing and transportation, two additional significant barriers to work.

- **Expand access to child care statewide.** In order to reduce the benefit cliff for working families, the Office of Human Services Innovation recommends raising the income limit for initial child care eligibility from the current 125 percent FPL to 130 percent FPL, aligning child care eligibility with food assistance, and allowing families to keep child care assistance from the current cap of 200 percent FPL until their income reaches 300 percent FPL or approximately \$4,948 a month for a family of three. The estimated cost is \$14 million over the biennium. In addition, the Ohio Department of Job and Family Services will waive child care copays for families with income at or below the 100 percent FPL.
- **Provide better work supports.** There are inconsistencies across the state in how individuals are supported with short-term barrier removal for employment and self-sufficiency. This budget recommends that the Ohio Department of Job and Family Services establish guidelines for the use of Prevention, Retention and Contingency (PRC) dollars, funded through TANF, for supported services, including but not limited to emergency transportation and housing, to better support a new comprehensive case management and employment program.

Simplify eligibility determination

Public assistance programs currently have separate eligibility processes and systems, making it difficult to holistically manage an individual's case across various support programs. By standardizing and automating eligibility for public assistance programs, Ohio can better serve needy Ohioans as well as create better value and accountability for taxpayers. Improved uniformity of services in conjunction with better sharing of client information will provide the backbone for a system that will focus more on individuals and less on general processing.

Shared data is an inherent part of the *Ohio Benefits* system. Seamlessly combining eligibility data across Medicaid, SNAP, TANF, WIC, and child care will give Ohio a unique ability to understand the benefits and resources families utilize and need on their path to self-sufficiency. The *Ohio Benefits* team also is integrating other data such as Medicaid claims and early childhood data. This combined data will allow state policy makers to make data driven decisions and objectively measure the effectiveness of those policies.

- **Transition additional income-tested programs to Ohio Benefits.** The Ohio Benefits system has been designed and built with the vision of supporting most of Ohio's income-based health and human services programs. Currently, all of Ohio's Medicaid expansion population and all of the family and children population are currently enrolled in Medicaid via the Ohio Benefits system. During fiscal years 2016 and 2017, eligibility determination for additional programs will transition to the Ohio Benefits platform, including Medicaid ABD, SNAP, TANF, WIC, and Child Care. The transition of these programs to Ohio Benefits will mark a significant milestone toward Ohio's vision of streamlining eligibility determination across all health and human services programs.
- **Create new opportunities for counties to share services to be more efficient.** The value of a streamlined eligibility system extends beyond just helping citizens access benefits. An integrated approach provides new opportunities for state and county workers to provide citizens better service and work more efficiently. The Ohio Benefits system, along with other OHT and OHSI initiatives, will finally allow county JFS offices to adopt a shared services model. The system will allow any county to access and process any case regardless of geographic boundaries. The county JFS offices have already begun to organize themselves to take advantage of the new capabilities – nine counties through an initiative called Collabor8 and a coalition of 23 counties in northeast Ohio.
- **Create one clear version of the truth in administering public assistance.** Seamlessly combining eligibility data across Medicaid, SNAP, TANF, WIC, and Child Care will give Ohio a unique ability to begin to holistically understand the benefits and resources families utilize and need on their path to self-sufficiency. The Ohio Benefits project team is also integrating other data such as Medicaid claims and early childhood data. This combined data will allow state policy makers to make data driven decisions and objectively measure the effectiveness of those policies, and it will provide the infrastructure needed to support comprehensive case management at the county level.
- **Replace Ohio's two disability determination systems with one.** Every year, about 50,000 Ohioans with a disability newly qualify for Medicaid coverage. Today, these Ohioans have to prove they are disabled twice, once via county job and family services offices to qualify for Medicaid benefits, and separately through Opportunities for Ohioans with Disabilities (OOD) to qualify for Supplemental Security Income (SSI). Most states (33) have already eliminated this duplication and automatically enroll SSI individuals in Medicaid. The Executive Budget requires Ohio Medicaid and OOD to replace Ohio's two duplicative disability determination systems with one that will determine eligibility for both Medicaid and SSI (see *Simplify Eligibility Determination*).

Updated February 2, 2015

Office of Health Transformation **Simplify Eligibility Determination**

Governor Kasich's Budget:

- *Expands the new Ohio Benefits eligibility system to more programs.*
- *Creates new opportunities for county shared services.*
- *Replaces Ohio's two disability determination systems with one.*

Background:

Eligibility determination for health and human service programs in Ohio is fragmented, overly complex, and reliant on outdated technology. There are different policies, processes and systems in place to determine eligibility for Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), the Women, Infants and Children (WIC) nutrition program, and others. Applying for these programs can be confusing and time consuming. Many individuals and families seeking assistance are required to physically meet with a caseworker at one of the 88 local county department of job and family services (CDJFS) service centers to get through the application process, often with multiple repeat visits to satisfy a myriad of requirements, computations, and verifications.

Eligibility determination can be particularly frustrating for people with disabilities, because they have to prove their disability twice: once to the local CDJFS to receive Medicaid benefits; and separately through Opportunities for Ohioans with Disabilities (OOD) to qualify for federal Supplemental Security Income (SSI).

Ohio's Enhanced Client Registry Information System (CRIS-E) provides intake and eligibility determination support for several of Ohio's health and human services programs and provides some case management functions for several Ohio Department of Job and Family Services programs. When CRIS-E was implemented in 1978, it was able to meet the needs of the counties by allowing for 18,000 users to manually enter cases for Ohio citizens. As time went by, many processes were added to allow the original system to do more, but all of the additions were built on the original foundation, which could only extend so far and long ago reached its limit of new applications. The problem is so severe that Ohio Medicaid estimates 60 percent of CRIS-E's eligibility determinations for Medicaid need to be manually overridden in order to make a correct eligibility determination. CRIS-E is so fragile and technologically obsolete that it is no longer practical or cost effective to invest in enhancing the system.

In August 2011, the federal government announced a time-limited opportunity for states to use enhanced (90 percent) federal matching funds to integrate eligibility determination functions

across programs based on income eligibility.¹ The new policy allows health and human services programs – including TANF, SNAP and Child Care and Development Fund – to utilize systems designed for determining a person’s Medicaid eligibility without sharing in the common system development costs, so long as those costs would have been incurred to develop systems for Medicaid. States may access the 90-percent enhanced federal funding up to but not after December 31, 2018.

First Four Years:

Governor Kasich’s first budget (enacted in 2011) initiated a project to replace CRIS-E with a new integrated eligibility system called “Ohio Benefits.” The Ohio Department of Administrative Services contracted with Accenture to replace CRIS-E with a new, integrated, enterprise solution that supports both state and county operations.² Utilizing modern technology, Ohio Benefits provides a single platform that allows individual programs to have their own distinct policy rules while sharing data across platforms. The combination of distinct rules and shared data provides workers a more accurate and efficient system and provides citizens a more user-friendly experience. The project focused first on Medicaid eligibility, but is designed to expand to other programs that currently depend on CRIS-E (this phase will retire CRIS-E), and eventually support all income-tested health and human services programs. The new system gives individuals and families seeking Medicaid coverage an option to apply online and the ability to provide real-time determination for people who apply.

The Ohio Benefits project is recognized nationally as a model for states to implement large, complex systems quickly and cost effectively. Ohio’s request for proposals (RFP) process for the Ohio Benefits system took less than six months. The RFP, which focused on outcomes the state wanted to achieve and left it to vendors to propose and compete on the best technology to achieve those outcomes, has now been used by several other states. After Ohio’s RFP was awarded, it only took seven months for the Ohio Benefits system to go into full production. As other systems struggled to turn on – including the troubled federal system – Ohio Benefits went live as planned on October 1, 2013. Since then, the system has received 1.4 million applications, most of which (60 percent) were initiated via the Ohio Benefits online self-service portal; processed and determined eligibility for 1.3 million (90 percent) of the applications submitted; converted case data for 1.5 million individuals from CRIS-E into Ohio Benefits; and implemented 20 major system upgrades to continuously improve Ohio Benefits program performance.

Executive Budget Proposal and Impact:

The Executive Budget continues the work to simplify and automate eligibility across systems, and launches a new project to consolidate the two processes used for disability determination into one. The goal of these reforms is to assist Ohioans to prepare for life and the dignity of

¹ Joint USDA, CMS, ACF [Guidance on developing integrated eligibility determination systems](#) (August 11, 2011).

² DAS, [Integrated eligibility and HHS business intelligence procurement](#)

work, and lift them up in their times of need through a better-coordinated, person-centered system of supports.

SIMPLIFY AND AUTOMATE ENROLLMENT ACROSS SYSTEMS

- ***Transition additional income-tested programs to Ohio Benefits.*** The Ohio Benefits system has been designed and built with the vision of supporting most of Ohio's income-based health and human services programs. Currently, all of Ohio's Medicaid expansion population and all of the family and children population are currently enrolled in Medicaid via the Ohio Benefits system. During fiscal years 2016 and 2017, eligibility determination for additional programs will transition to the Ohio Benefits platform, including Medicaid for the aged, blind and disabled (ABD), SNAP, TANF, WIC, and Child Care. The transition of these programs to Ohio Benefits will mark a significant milestone toward Ohio's vision of streamlining eligibility determination across all health and human services programs. Many of the key human services benefits needed to support a family's progress toward self-sufficiency – health care, nutrition assistance, cash assistance and child care – will now be available through a single, integrated system.
- ***Create new opportunities for counties to share services to be more efficient.*** The value of a streamlined eligibility system extends beyond just helping citizens access benefits. An integrated approach provides new opportunities for state and county workers to provide citizens better service and work more efficiently. The Ohio Benefits system, along with other Health Transformation and Human Services Innovation initiatives, will finally allow county JFS offices to adopt a shared services model. The system will allow any county to access and process any case regardless of geographic boundaries. The county JFS offices have already begun to organize themselves to take advantage of the new capabilities – nine counties through an initiative called Collabor8 and a coalition of 23 counties in northeast Ohio. The Ohio Benefits project team has provided resources and structure to facilitate these counties' shared services initiatives. Key deliverables of this work include a shared taxonomy, common business processes and a joint effort to move to the electronic verification of data while minimizing the dependence on paper documents.
- ***Create one clear version of the truth in administering public assistance.*** Seamlessly combining eligibility data across Medicaid, SNAP, TANF, WIC, and Child Care will give Ohio a unique ability to begin to holistically understand the benefits and resources families utilize and need on their path to self-sufficiency. The Ohio Benefits project team is also integrating other data such as Medicaid claims and early childhood data. This combined data will allow state policy makers to make data driven decisions and objectively measure the effectiveness of those policies.

- **Provide infrastructure to support comprehensive case management.** Combining other agency data with Ohio Benefits data provides a holistic view of services Ohioans are receiving, and enables comprehensive case management at the county level.

SIMPLIFY DISABILITY DETERMINATION

Every year, about 50,000 Ohioans with a disability newly qualify for Medicaid coverage, including individuals with developmental disabilities, mental illness, frail elderly and others. Some reside in an institution but most live in the community. Some have income but “spend down” to qualify for Medicaid.³ To qualify for Medicaid, these individuals can keep a house and car but no other assets above \$1,500. Today, these Ohioans have to prove they are disabled twice, once via CDJFS offices to qualify for Medicaid benefits, and separately through OOD to qualify for Supplemental Security Income (SSI). Most states (33) have already eliminated this duplication and automatically enroll SSI individuals in Medicaid.

There are significant benefits for individuals with disabilities and taxpayers in states that administer one disability determination system instead of two. One system is much easier for individuals with disabilities to navigate, and eliminates the significant administrative burden associated with operating two systems, for individuals, counties and providers. In addition, the implementation of the Ohio Benefits eligibility system for Medicaid ABD population (in January 2016) creates an opportunity to also simplify and streamline the disability determination process for people with disabilities. For all of these reasons, the Executive Budget requires Ohio Medicaid and OOD to replace Ohio’s two duplicative disability determination systems with one that will determine eligibility for both Medicaid and SSI.

- **Replace Ohio’s two disability determination systems with one.** As part of the Ohio Benefits implementation, Ohio will seek a state plan amendment to adopt criteria authorized in section 1634 of the Social Security Act that allow for a single disability determination to be used for Medicaid and SSI.⁴ The income standard will be raised from 64 percent of the federal poverty level (FPL) to 75 percent FPL, and the resource limits will be raised from \$1,500 to \$2,000. People on SSI will become automatically eligible for Medicaid and will not have to separately apply through their county agency. Spend down will be eliminated, bringing a substantial reduction of burden for county agencies and for Medicaid recipients. Duplicative disability operations will be eliminated at the state level. The anticipated impact on current Medicaid enrollees is as follows:

³ A spend down program allows individuals who have income over the eligibility threshold but otherwise meet the requirements for Medicaid under the aged, blind or disabled (ABD) categories to receive coverage. Individuals with income over the threshold are assigned an amount of medical expenses they must incur each month (spend down) prior to receiving Medicaid benefits. An individual’s spend down is equal to the amount by which his or her income exceeds the eligibility limit after accounting for applicable income deductions.

⁴ In a 1634 state, individuals eligible for SSI are automatically enrolled in Medicaid. In states that maintain separate systems for Medicaid and SSI (called 209(b) states), individuals granted SSI by the OOD must complete a separate Medicaid application and disability determination process. 209(b) states are required by federal law to operate a Medicaid spend down program; 1634 states are not required to do so.

- No change in enrollment for most current beneficiaries. 403,000 disabled Ohioans in institutions or on home and community based services (HCBS) waivers will continue to receive Medicaid benefits because Social Security and Ohio Medicaid use exactly the same definitions of disability. Some in this group at higher income levels will need to put their income in a Miller Trust (described below) to qualify for Medicaid (currently they spend down income every month to qualify).
- Some “woodwork” will now enroll in Medicaid. 9,500 to 14,500 Ohioans on SSI but not yet enrolled in Medicaid will be automatically enrolled in Medicaid. Most of this group is eligible for Medicaid now but not enrolled. The only newly eligible enrollees will be individuals whose assets are between the current Medicaid limit (\$1,500) and the SSI limit (\$2,000) and, under the proposed changes, will now qualify for Medicaid with assets up to \$2,000.
- Some will leave Medicaid and go the exchange. 4,500 disabled Ohioans not in institutions or on HCBS waivers will no longer qualify for Medicaid because their income is too high (>\$733 monthly). Currently, federal law mandates Ohio cover anyone in this group who spends down income to qualify for Medicaid. Ohio Medicaid will create a special program to continue benefits for persons in this group with mental illness (described below), but everyone else will seek coverage on the exchange or through Medicare. Essential health benefits on the exchange are the same as Medicaid, except exchange plans are not required to cover dental and non-emergency transportation. Otherwise, there are advantages to receiving coverage on the exchange, including: many individuals will find it more affordable to pay premiums and copays on the exchange and preserve income that otherwise would have been spent down for Medicaid; continuous coverage without interruption instead of month-to-month Medicaid eligibility based on spend down; and providers benefit from higher reimbursement on the exchange.
- **Establish Miller Trusts.** As a 1634 state with no spend down, Ohio must provide for income qualifying trusts, referred to as Miller trusts, for people with incomes above the Special Income Limit (SIL), which is about \$2,200 a month currently. A Miller Trust is a legal structure that allows income in excess of the eligibility limit for Medicaid institutional and HCBS waiver services to be disregarded. An individual must place the portion of his or her monthly income that is greater than the current standard (about \$2,200) into the trust. Individuals may apply certain deductions to these funds, and the remaining amount in the trust is paid to the institution or health care providers. On a monthly basis, Miller Trust funds pay for the cost of care, and Medicaid pays for the care not funded by the trust. Upon the recipient’s death, any and all funds remaining in the Miller Trust, up to the total cost of care, are paid to Medicaid. There is a one-time cost to set up a Miller Trust and an annual cost to maintain.

- **Create a special benefit program for adults with severe mental illness.** A majority of people whose income will be above the Medicaid need standard adopted under the new system described above are adults with severe and persistent mental illness (SPMI). These Ohioans will have access to basic health care services through Medicare or private insurance. However, neither Medicare nor private insurance pay for a range of service coordination and community support activities currently covered in the Medicaid program. In order to ensure continued access to these services, Ohio Medicaid will seek a state plan amendment under section 1915(i) of the Social Security Act to provide for eligibility for adults with SPMI with income up to 225 percent of poverty (300 percent of the Federal Benefit Rate) who are not eligible under another Medicaid category and who meet diagnostic and needs assessment criteria established by the state and validated by a third party entity. Ohio will also identify home and community based services needed by this population to be covered as services under the 1915(i) authority. The 1915(i) services will be developed in conjunction with a broader benefit redesign (described in *Rebuild Community Behavioral Health Capacity*).

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