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Budget Landscape: Ohio's Health and Human Services Agencies 2018-2019

Companion to Ohio Department of Medicaid: Budget Preview

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Introduction

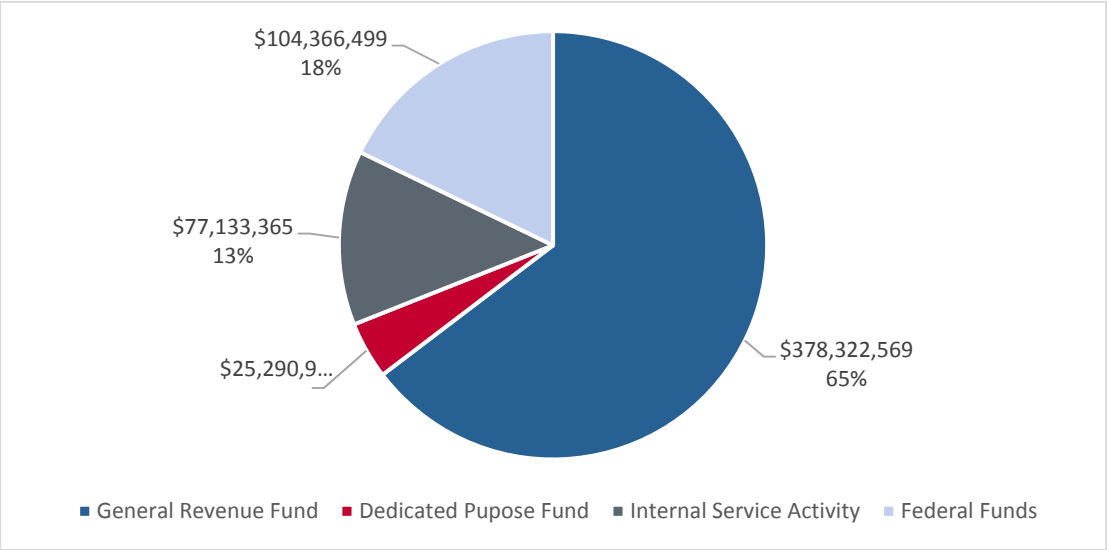
Health and human services play a vital role in the lives of Ohioans. There are several state agencies dedicated to implementing health and human service programs and policies. When Governor John Kasich took office in 2011, he created the Office of Health Transformation (OHT) under Executive Order 2011-02K. The goal of OHT was to improve Ohio's health system performance, along with improving the performance of the Medicaid program. The executive order outlined that the major health and human service-related state agencies would be involved in this work and follow OHT's lead. This included the Ohio departments of Mental Health and Addiction Services, Health, Aging, Job and Family Services, and Developmental Disabilities. This report will look at the work of these agencies over the last several years, provide highlights, and then take a look ahead at the budget landscape for next year, which will be Governor Kasich's last state budget.

Ohio Department of Mental Health and Addiction Services

The Department of Mental Health and Addiction Services (MHAS) is the state agency charged with management of the mental health system and alcohol, drug, and gambling addiction services, as well as prevention efforts in Ohio. The state also maintains and operates six psychiatric hospitals. Mental health and addiction services are delivered by a network of community providers often connected with a local alcohol, drug addiction, and mental health (ADAMH) board. MHAS oversees the network of 52 ADAMH boards in the state. Federal and state dollars in the MHAS budget flow to the ADAMH boards to provide services in communities, in addition to local dollars that are provided in each community through levies or other general operating funds.

Much has changed for mental health and addiction services during the years of the Kasich Administration. At the close of the Strickland Administration, state funding for community treatment and related services drastically declined, but the funding picture has shifted in recent years. In the 2012-2013 budget, the responsibility of making the nonfederal share of Medicaid payments for covered mental health services was "elevated" from the local mental health boards to the state Department of Job and Family Services (now these payments are made by the Department of Medicaid). In previous biennia, local boards used their share of state-funded Medicaid matching dollars and local levy dollars to fund the nonfederal portion of Medicaid if the state dollars did not cover the full amount. With elevation, the state took over this responsibility completely, freeing up local dollars to fill in gaps and cover services that are not covered by Medicaid (non-Medicaid services).

Figure 1: MHAS Funding by Source, FY 2016



Source: LSC Budget in Detail, September 2016

The fact that Medicaid was elevated to the state prior to Medicaid expansion in 2014 laid the groundwork for increasing access to health coverage for people with behavioral health care needs. While the impact of Medicaid expansion is covered more fully in *Ohio Department of Medicaid: Budget Preview*, it is important to acknowledge the impact that access to health coverage has made for people with behavioral health care needs. Prior to Medicaid expansion, uninsured individuals in need of mental health and/or addiction services sought care via their local ADAMH boards, and these services would be funded by the board when funding was available. With Medicaid expansion, individuals under 138 percent of the federal poverty level gained access to health coverage and thus a payer source for health care services. This new dynamic meant that ADAMH boards could shift toward paying for services that, by-and-large, are not covered by Medicaid or other forms of insurance, but are vital to keeping people as healthy as possible.

The 2014-2015 biennium began with the merger of the Department of Mental Health (ODMH) and the Department of Alcohol and Drug Addiction Services (ODADAS) into the Department of Mental Health and Addiction Services (MHAS). The agencies that address mental health and alcohol and drug addiction are also merged at the national level and at most of the local boards in Ohio. Combining these agencies also helped to align fiscal reporting and policy changes that are required of the local boards by the state.

In 2014, the Mid-Biennium Review (MBR) incorporated language requiring local ADAMH boards to provide a full array of services defined as a continuum of care. The services must include at least ambulatory and sub-acute detoxification, non-intensive and intensive outpatient services, medication-assisted treatment, peer mentoring, residential treatment services, recovery housing, and 12-step approaches. The continuum of care includes specific treatment services for

all levels of opioid and co-occurring drug addiction. The implementation of the continuum of care is still being deliberated among the state, providers, and ADAMH boards.

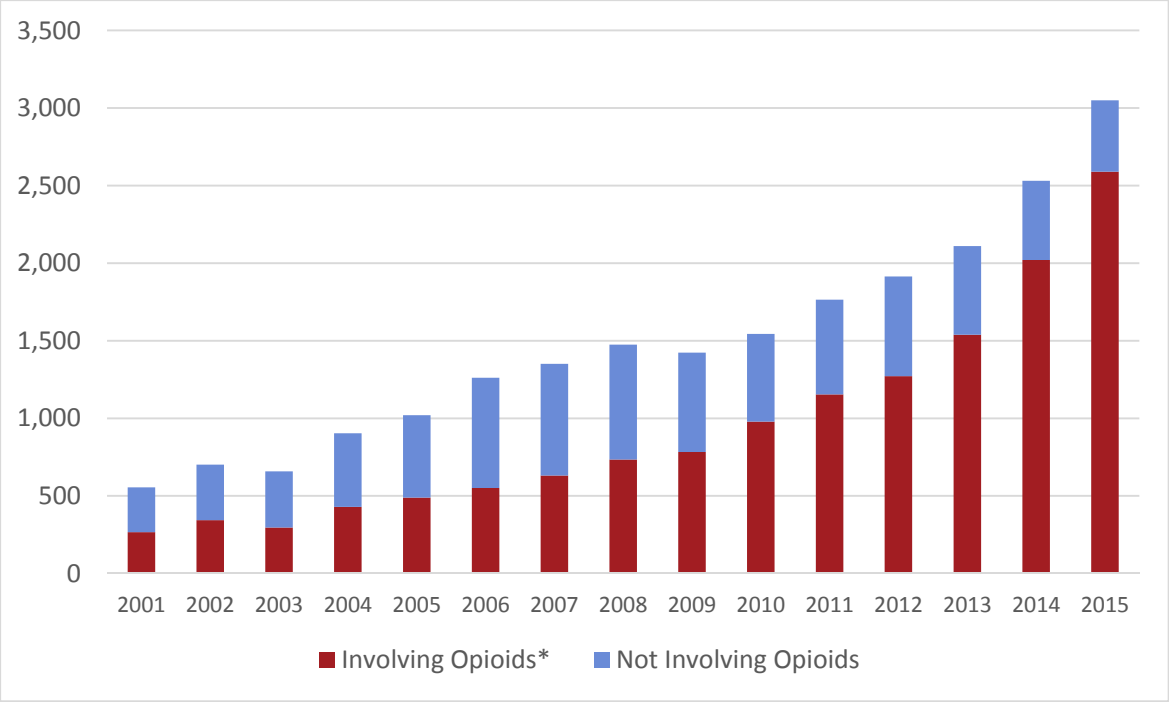
Recent Policy Highlights

Opiate Crisis

A major challenge facing MHAS and the local system of ADAMH boards is opioid addiction. Opioids are a class of drugs including heroin and powerful pain relievers such as morphine, oxycodone (e.g., OxyContin), hydrocodone (e.g., Vicodin), and codeine. Deaths in Ohio from unintentional overdoses have continued to increase each year since 2010. This corresponds to the implementation of House Bill 93 (129th General Assembly) in 2011, which shut down pill mills by tightening the regulation of prescribing pain medications. Deaths involving all opioids continued to grow that year, however, indicating an apparent shift from prescription opioids to heroin. In recent years, there has been an increased number of deaths associated with the powerful painkiller, fentanyl. Fentanyl is estimated to be 30 to 50 times more potent than heroin and 50 to 100 times more potent than morphine.[1] Overdoses involving fentanyl increased from 84 in 2013 to 503 in 2014, reaching 1,155 in 2015.[2]

The administration and General Assembly have implemented a series of initiatives and pieces of legislation to address the ongoing opiate crisis. Early in his tenure, the governor launched the Governor's Cabinet Opiate Action Team (GCOAT) which works across cabinet-level agencies and with stakeholders to fight opiate abuse. The legislature has passed numerous pieces of legislation seeking to tackle different aspects that contribute to opiate abuse, including prescribing practices, access to naloxone (an opiate antidote), abuse deterrent formulas of prescription opiates, drug abuse education in schools, and increasing access to treatment, to name a few.

Figure 2: Unintentional Drug Overdose Deaths- Ohio



Source: Ohio Department of Health

Recovery Housing and Supports

For the first time in its history, the state dedicated a line item in the MHAS budget to recovery housing, funded at $2.5 million each year for 2016 and 2017. This was followed by an appropriation of $5 million in the state's capital budget (which is on a different cycle than the operating budget).[3] Recovery housing is described "as a safe and healthy living environment that promotes abstinence from alcohol and other drugs and enhances participation and retention in traditional clinical treatment."[4] This funding was intended to support access to safe, stable housing in communities. Funding has been allocated to recovery housing providers across the state.[5]

MHAS-DRC Partnership

In order to meet the needs of inmates and to reduce recidivism, the Department of Rehabilitation & Correction's (DRC) Bureau of Recovery Services was transferred to MHAS in the 2016-2017 budget to provide more addiction treatment services within Ohio's prison system. Before release, inmates will enroll in Medicaid and be connected to community behavioral health treatment providers. Medicaid will pay for medication-assisted treatment (MAT) and counseling to help reduce recidivism.

Court Services

Ohio's drug courts are specialized docket programs certified by the state Supreme Court. They operate within existing municipal, common pleas, juvenile, and family courts. Drug courts began as judges realized that repeat drug offenders needed treatment rather than time behind bars to recover and reduce recidivism.[6] With the growing impact that drug use is having on the

state, drug courts have seen increased attention and resources directed their way. In the last state budget, and the previous Mid-Biennium Review, the state dedicated funding to drug court operations and to the addiction treatment pilot project, which helped drug courts, in certain counties, provide medication-assisted treatment in their programs.

Behavioral Health Redesign

The most recent state budget saw major changes for the behavioral health system. Currently, behavioral health services for people enrolled in Medicaid are paid on a fee-for-service basis, while the majority of Medicaid services are funded through managed care. Beginning in 2018, behavioral health services will be "carved in" to managed care as well. This is a major shift for the behavioral health system. A significant amount of time and discussion has gone into the changes required in order to carve-in behavioral health services. The state set up a Website to share information as the redesign is developed and implemented. See *Ohio Department of Medicaid: Budget Preview* for more information.

Trends to Watch

Opiate Crisis

In the spring of 2016, Senate Bill 319 (Eklund) was introduced. This bill seeks to put in place additional protections around the use of medication-assisted treatment, increase access to treatment, implement oversight where appropriate, and expand availability of life-saving Naloxone. This bill passed the Senate, but still has to go through the House process in the lame duck session. If Senate Bill 319 does not pass in this General Assembly, expect these issues and more to be addressed under the 132nd General Assembly.[7]

Behavioral Health Redesign

The discussion over the redesign of the behavioral health system is ongoing. While behavioral health services are set to be "carved in" to managed care in 2018, the administration will continue to address remaining issues over rates paid for services, the set of services, and the capacity of the workforce to meet the needs of the people who are in need of care. See *Ohio Department of Medicaid: Budget Preview* for more information.

Continuum of Care

Legislation was passed in 2014 that required ADAMH boards to provide a full array of services for people with behavioral health disorders, also known as implementing the full continuum of care. The state, ADAMH boards, and providers have discussed how to implement this language, and an associated required waiting list for services. Discussions on this topic are ongoing.

Mental Health Parity

In October of 2016, a federal task force released its recommendations on implementing mental health parity. While regulations were released over the course of the last few years, the task force report is meant to strengthen and guide the implementation of parity. Stakeholders in the field have worked for many years to successfully implement parity and now, armed with this

report, have an additional tool to make sure state and local government and businesses understand the need for, and benefit of, providing mental health and substance use services on par with physical health services.

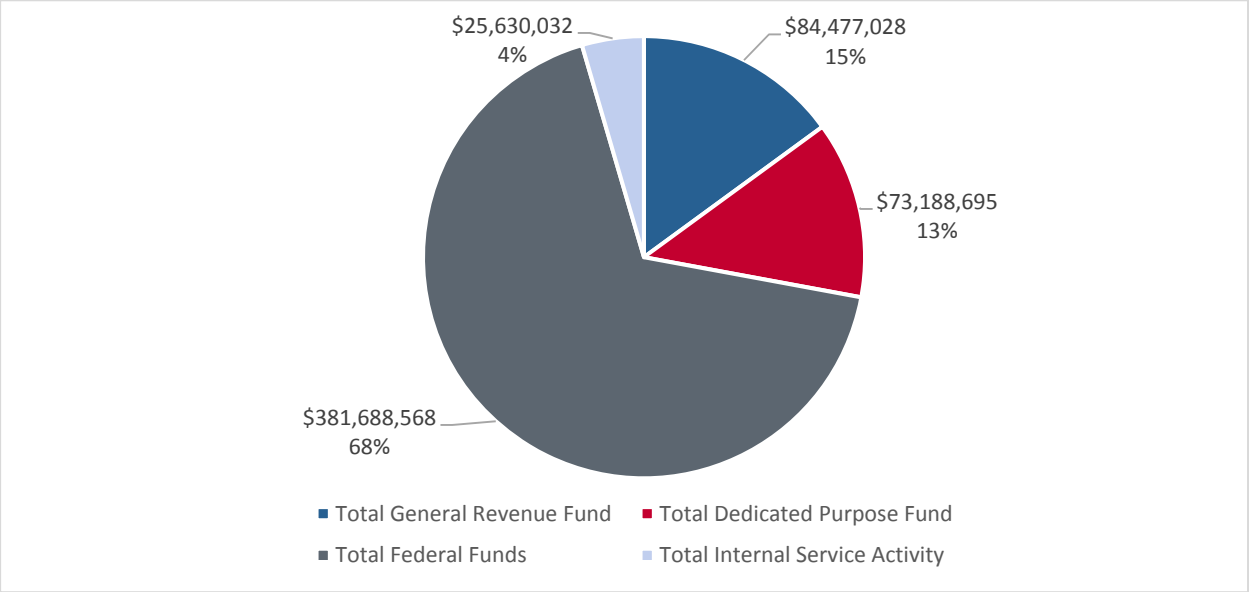
Substance Use Prevention

As the opiate crisis has taken an unrelenting toll on the state, the Administration and legislators have begun focusing on going upstream and preventing addiction before it begins. Governor Kasich launched Start Talking! to encourage parents and teachers to talk with children about the dangers of drugs, both legal and illegal. The Attorney General and General Assembly formed a joint task force to examine drug prevention education in the state and learn from other places across the county. Efforts to increase prevention activities are expected to continue into the 2018-2019 budget.

Ohio Department of Health

The Ohio Department of Health (ODH) is the state's public health agency. ODH works with local health departments (LHDs) in order to address public health needs. In addition to state funds dedicated to ODH, the agency is the recipient of many federal grants to address public health.

Figure 3: ODH Funding by Source, FY 2016*



Source: LSC Budget in Detail, September 2016

*Does not include Highway Safety Fund or Holding Accounts

Recent Policy Highlights

Public Health Accreditation

Over the course of the Kasich administration, there has been a drive for ODH and, subsequently, local health departments to be more strategic in their programming and spending. In 2012, House Bill 487 created the Legislative Committee on Public Health Futures, which was charged with developing recommendations for legislative and fiscal policies related

to public health that could be considered for inclusion in the FY 2014-2015 biennial operating budget bill. They also reviewed a report from the Association of Ohio Health Commissioners, Public Health Futures: Considerations for a New Framework for Local Public Health in Ohio. This committee was re-established in the 2016-2017 state budget and tasked with reviewing previous work and making policy and fiscal recommendations to improve public health going forward.

The committee's work was followed by legislative language in House Bill 59 (the state budget bill for FY 2014-15) that required LHDs to achieve accreditation through the Public Health Accreditation Board (PHAB). Eventually the state funding and federal pass-through dollars that are directed to LHDs will be tied to applying for accreditation by 2018 and achieving accreditation by 2020. This work was the foundation for a holistic look and plan for population health planning through the State Health Assessment and State Health Improvement Plan.

Infant Mortality

Ohio's infant mortality rate is one of the worst in the nation, at 6.8 infant deaths per 1,000 live births in 2014 and 7.2 per 1,000 in 2015.[8] This rate is significantly worse for Black babies in Ohio. Infant mortality is defined as the death of a baby before his or her first birthday. Over the last several years, both the administration and the General Assembly have focused intensely on addressing this dire situation, making infant mortality reduction a priority. The Ohio Collaborative to Prevent Infant Mortality formed in 2010 and is housed at ODH. The Collaborative is the successor to the Ohio Infant Mortality Task Force, which released a report in 2009 outlining the problem of infant mortality and ways to address it. The Collaborative is led by an executive/steering committee, and the full Collaborative meets quarterly.[9]

Table 1: Ohio Infant Mortality Rate (2013-2015), Number of Deaths per 1,000 Live Births

Group	2013	2014	2015
All Races	7.4	6.8	7.2
Race			
White	6.0	5.3	5.5
Black	13.8	14.3	15.1
American Indian	*	*	*
Asian/Pacific Islander	*	*	*
Ethnicity			
Hispanic	8.8	6.2	6.0
Non-Hispanic**	7.3	6.9	7.3

Source: Ohio Department of Health, Bureau of Vital Statistics. Table recreated from 2015 Ohio Infant Mortality Data: General Findings

*Rates based on fewer than 20 infant deaths are unstable and not reported.

**Non-Hispanic births and deaths include those of unknown ethnicity.

Senate Bill 276 (130th General Assembly) created the 15-member Commission on Infant Mortality with the task of completing an inventory of programs provided by the state that address infant mortality. In March, 2016, the Commission on Infant Mortality released its report

after months of hearings and information-gathering about how to address infant mortality in Ohio. Most of the report's recommendations were incorporated into Senate Bill 332 (131st General Assembly), which is pending in the lame duck session of the 131st General Assembly. The bill has passed the Senate and is making its way through the House.

The most recent state budget saw additional initiatives aimed at reducing infant mortality. The ODH director, in coordination with the Ohio Department of Medicaid (ODM), must identify the areas of the state with the highest infant mortality rates (referred to as infant mortality "hot spots"). Under the ODM plan, these are the areas that will be targeted for enhanced care management, under Medicaid managed care, of pregnant women and women of child-bearing age to reduce infant mortality. A portion of the tobacco prevention and cessation line item in the ODH budget was targeted to the Moms Quit for Two Grant Program. Maternal smoking is a known risk factor for pre-term or complicated births which can lead to infant death.

Tobacco Cessation

Only eight states had a higher rate of cigarette use among adults than Ohio in 2015. In Ohio, 21.6 percent of adults used cigarettes in 2015.[10] Tobacco use is an enormous contributor to acute and chronic disease. The administration has made investments in tobacco cessation throughout the course of its tenure. In the 2014-2015 budget, a dedicated line item was created for Tobacco Prevention and Cessation. The addition of dedicated funding to address the issue of tobacco use showed recognition of the impact tobacco use has on public health. This was a long-awaited addition of dedicated funding.[11] This line item was funded at $1.05 million per year in FYs 2014 and 2015 (actual spending for 2014 was $705,543 and $ 1,335,036 in 2015). In the very next budget, this line item was increased to $ 5.05 million in FY 2016 (actual spending in 2016 was $3.4 million) and $7.05 million in FY 2017, showing a greater commitment to prevention, cessation of tobacco use and enforcement of laws related to tobacco use.

Also in the 2016-2017 budget, the per pack cigarette tax was raised by $0.35, from $1.25 per package to the new $1.60 per package.[12] While the revenue from this increase is not entirely directed to tobacco use reduction efforts, increasing the tax can have an impact on consumption.

Syringe Exchange Programs

As the opiate crisis continues to impact Ohio, on many levels, the 2016-2017 budget bill ushered in a change to the state's statute on syringe exchange programs. Up until 2015, a city health district, under home rule authority granted by Ohio's Constitution, could declare a public health emergency related to bloodborne pathogens in order to create a syringe exchange program.

The budget bill changed Ohio law to allow local boards of health to establish a bloodborne infectious disease prevention program to reduce the transmission of infectious diseases without declaring a public health emergency. A local board of health must consult with entities and stakeholders in the community, and local zoning laws apply to the establishment of program sites. The provision in the state budget also requires that the program identify health and

supportive services providers and substance abuse treatment programs, develop and enter into referral agreements with those providers and programs, and refer program participants to them. The law change provides legal protection for program staff or volunteers who distribute hypodermic needles as part of the program as long as they are distributing needles to someone who is within 1,000 feet of a program facility and who has documentation identifying the individual as a program participant. Program participants are also provided this protection within 1,000 feet of where a program is operating as a mobile unit.

Role of Specified Treatment Programs under the Affordable Care Act
JMOC Review
In the 2016-2017 budget, the Ohio House added a provision that requires the Joint Medicaid Oversight Committee (JMOC) to review certain Ohio Department of Health line items within the context of Medicaid expansion. These existing programs are safety net programs and many of the services they provide may be able to be covered through Medicaid. This budget proposal seeks to have JMOC review all sources of funding for these programs, paying attention to maintenance of effort requirements and limitations on the use of funds, and how they can better fit into the broader health care system. The final report, entitled Review of Ohio Department of Health Treatment Programs, was released by JMOC in December, 2015. JMOC followed up with subcommittee hearings on ODH treatment programs, including the Ryan White HIV Care Program, but the legislature has not yet proposed any program changes as a result of the JMOC report. With the uncertain fate of the Affordable Care Act under a new president, any recommendations about how to realign treatment programs are on hold.

Vaccines
In light of expanded coverage under the Affordable Care Act, the 2016-2017 budget bill ended GRF funding for vaccines. These vaccines were provided to local health departments and other providers. LHDs and other providers were instructed to bill insurance for these vaccines going forward. ODH worked with LHDs in order to ensure payment for vaccines prior to January 1, 2016, when GRF funding for vaccines ceased.

Trends to Watch
Opiate Crisis
The opiate crisis continues to take a drastic toll on Ohioans. Efforts to address this crisis span across state agencies. The data related to overdose deaths are compiled and released by ODH. One trend to watch is whether the data can be organized in different ways, perhaps by so-called "hot spots," in order to track overdoses on a more local level. This data are also released annually, and having closer to real-time data may allow prevention, treatment, and enforcement efforts to be more targeted.

Infant Mortality
For several years, there has been a push to have more timely data related to infant mortality. This data could allow more immediate and strategic decisions when addressing the causes of infant mortality, similar to how data about drug overdoses can inform a strategy to reduce the

burden of illegal drugs. ODH has moved toward releasing more information, and on a quicker timeline, as it relates to infant mortality. Recognizing the importance of data in making decisions, Senate Bill 332 continues this push of ODH, in terms of coordinated, timely data. It will be important to continue to watch as data related to infant mortality are gathered and reported over the next few years.

One effective upstream strategy that can result in safer birth spacing, thus decreasing the likelihood of pre-term births, is the use of long-acting reversible contraception (LARC). LARC, which includes implants and intrauterine devices (IUDs), is the most effective form of birth control. The use of LARC is becoming more widespread as a result of successful studies in St. Louis and Colorado which showed that, when given an option of any form of birth control and regardless of cost, women preferred LARCs, and that LARCs reduced unplanned pregnancies. Several states, including Ohio, are discussing and adopting Medicaid policies that make access to LARC easier in both outpatient and inpatient settings. Access to LARC is a component of the State Health Improvement Plan to address maternal and infant health (discussed below).

State Health Improvement Plan

In 2016, the state, by contracting with the Health Policy Institute of Ohio (HPIO), embarked on a state health assessment (SHA) and state health improvement plan (SHIP). The SHA is "a comprehensive and actionable picture of health and wellbeing in Ohio," and the SHIP is "an actionable plan to improve health and control healthcare costs."[13] Development of the SHA and SHIP has involved a large group of stakeholders meeting on a regular basis, in addition to regional meetings to identify issues impacting different areas of Ohio. This process lead to the identification of three priorities for health improvement: chronic disease, maternal and infant health, and mental health and addiction. Each of these priorities fits squarely into much of the work that has been done over the last several years, and the SHIP identifies additional specific strategies to improve health in each of these areas. The SHIP is said to be the framework for the ODH budget in 2018 and 2019, and will align with much of the work across health and human service agencies in Ohio in the coming budget.

Integrated HIV Prevention and Care Plan for 2017-2021

The Integrated HIV Prevention and Care Plan was developed over the last year to look holistically at HIV care and prevention in the state and develop goals and strategies to improve both. The plan was required by the federal agencies that grant dollars for HIV care (the Health Resources and Services Administration, HRSA) and prevention (the Centers for Disease Control and Prevention, CDC), so the state took the opportunity to bring a diverse group of stakeholders together to develop a comprehensive plan to improve HIV prevention and access to care. A recent *State Budgeting Matters* from The Center for Community Solutions details the plan more closely, but there may be opportunities in the next state budget to incorporate pieces of the five-year plan. One recent move in the right direction was that ODH made the decision to shift some state GRF dollars dedicated to both HIV Care and Prevention from the care to the prevention program. Federal funding for HIV care exceeds that of federal funding for HIV prevention, thus prevention is more in need of state dollars to fund its programs. This was an

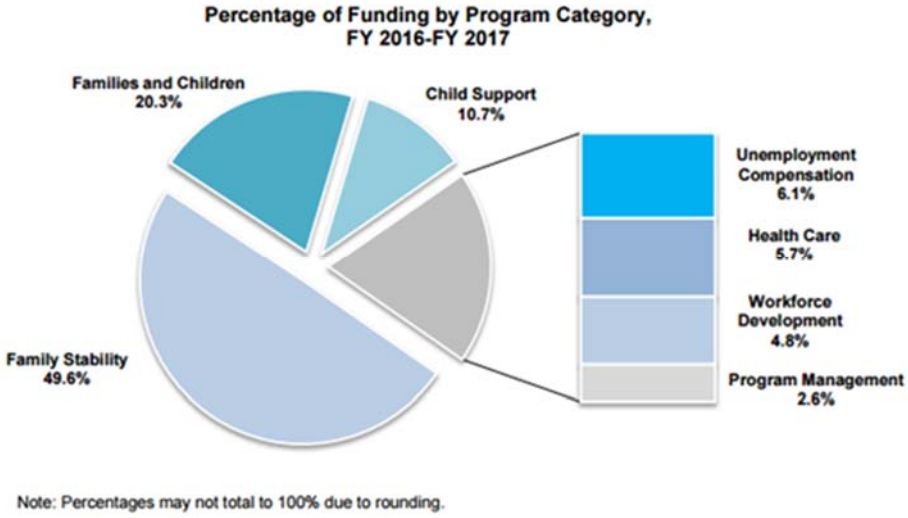
important move that aligns with the goals of, and will help implement the changes associated with, the Integrated Plan.

Ohio Department of Job and Family Services

Programs that provide health care, employment, economic assistance, and services to families and children are developed and overseen by the Ohio Department of Job and Family Services (ODJFS). The service goals of the agency are met through programs in public assistance, child welfare services, child support, workforce development programs, and unemployment compensation. [14]

Included below is the percentage of funding by program category for the key initiatives ODJFS supports.

Figure 4: Funding by JFS Program Category



Source: Ohio Legislative Services Commission

Recent Policy Highlights

From the time that House Bill 64, the state budget bill for fiscal years 2016 and 2017, was signed into law in late June, 2015, ODJFS has been working to make advancements in the areas of adult protective services and childcare. These policy areas are highlighted below to show the progress the state has made.

Adult Protective Services

Adult protective services (APS) are provided by county Departments of Job and Family Services (CDJFS) to local older adults who are in danger of harm or are unable to protect themselves from harm. CDJFSs are required under law to investigate and assess all reports of suspected abuse, neglect, and exploitation of adults age 60 and over.

Changes in the most recent state budget required ODJFS to create and maintain a statewide adult protective services information system. This information system allows for more unity and awareness in counties across the state that are assisting individuals on a case-by-case basis. As a result of numerous changes in the APS system, a charter was written to create the Ohio APS Advisory Council[15]. The council is organized and operated under ODJFS and is used as a platform to advance better APS practices statewide. Established at the end of September, 2016, the council has a long way to go in serving the needs of older adults in protective services. Additionally, the last budget required ODJFS to provide training on the implementation of the adult protective services statutes and require all protective services caseworkers and their managers to complete the training on procedures to be followed when local officials are handling allegations of abuse. The training has been fully developed and implemented. House Bill 24, introduced in early 2015 by Representatives Mike Dovilla and Wes Retherford, advances the aims of the work done in the budget by making more comprehensive changes and revisions to adult protective services in Ohio. This piece of legislation would expand the list of mandatory reporters, establishes a registry of reported abuse, notifies an adult's closest relative of a report, creates the Elder Abuse Commission, and makes additional revisions to the current law. This piece of legislation unanimously passed the Ohio House and is awaiting a vote in the Senate Health and Human Services Committee.

Child Care

For many families in Ohio on the path to economic stability, child care is a necessity. Even so, child care can be one of the largest expenses in a working household. In the last budget, Governor Kasich and the state legislature expanded income eligibility limits for child care programs by waiving co-pays for families at or below the federal poverty limit (FPL). Initial eligibility for publicly funded child care was increased from 125 to 130 percent of the FPL. Families now have the ability to gradually phase out of the program with continued eligibility shifting from 200 to 300 percent of the FPL. This change was highlighted in a recent report by The Center for Community Solutions, "*The Path from Poverty to Prosperity Can be a Roller Coaster: An Examination of Hourly Wages, Expenses, and Monthly Income*," which can be found here. Removing more barriers to allow families to enter the workforce strengthens the economy in Ohio and brings added stability to many Ohio families by encouraging and allowing for self-sufficiency in many households throughout the state. These policy initiatives are allowing individuals the opportunity to increase wages without the sudden and costly drop in a much needed benefit.

Head Start

In an August 1, 2016, letter to the Early Childhood Advisory Council, Director Cynthia Dungey issued clarification on child care funding[16]. It came to the director's attention that some child care programs were being funded by both Head Start and Early Childhood Education, something that cannot happen in Ohio as the state is considered an extended day state.

Many child care providers throughout the state were alarmed by this clarification and the inability to blend funding for services many providers found to be different. After 22 state

senators sent a letter[17] to the governor urging that the department re-examine its decision with proper time and research, ODJFS granted a one-school-year extension to delay the enforcement of program restrictions.

With such widespread interest and concern on this issue throughout the state and in the Senate, it is to be expected that the upcoming budget would allow a platform for the administration or the legislature to address this issue further.

Early Childhood Care and Education

House Bill 64 required the Ohio Department of Education, in consultation with the Governor's Early Childhood Education and Development Office and ODJFS, to establish guidelines for the future advancement of Ohio's Early Childhood System. These guidelines include benchmark performance criteria, evaluation design and implementation, and steps based on outcomes, and were required to be completed by January 1, 2016.

The quality rating system that has been established allows parents and families to make informed decisions on the child care setting they choose to place their child in.
By 2020, it will be mandatory that all child care centers funded by the Department of Education be a part of the Step Up to Quality ratings system.

This rating system will be a good indicator for the state on where they should fund early childhood programs. Centers that receive high quality ratings may receive more funding to maintain their ratings in the future.

Foster Care

House Bill 50 introduced by Representative Dorothy Pelanda and Representative Cheryl Grossman became effective as law on September 13, 2016. This piece of legislation expands foster care and adoption services for individuals up to the age of 21, rather than the age of 18. Extensive testimony was given in both chambers during the committee process for this bill, highlighting the need for additional services and supports for this at-risk population.

The state is in the very early stages of implementation of this legislation and has shown progress in making the necessary steps to move the system into this direction by adopting rules and forming an advisory council, two additional components the legislation called for. We can look to the upcoming budget and possible future legislation to address additional needs that may arise with such large and transformational changes to the foster care system in Ohio.

Trends to Watch

As the state looks forward, there are a few entirely new trends to watch as the governor prepares for the upcoming state budget. The Comprehensive Case Management and Employment Program, Healthier Buckeye Council, and early childhood care and education were all modified or created in the last budget, and aspects of these programs have been transforming from the early days of Governor Kasich's time in office. Many of these trends are

continuations from the governor's last budget, while others such as child welfare have grown from larger issues impacting the state.

Child Welfare

The opiate epidemic in Ohio has had many tragic consequences and wreaked havoc on many Ohio communities in more ways than one. The child welfare system has seen a 9 percent increase in the number of children entering the child protective system due to a parent or parents' drug addiction, accounting for over 1,100 children[18]. This has placed additional strain on the system without additional funding from the state. Due to the growing cost restraints on the Children Service system in Ohio, additional requests for funding for child welfare spending can be expected from parts of the administration and the advocacy community.

Multi-System Youth

The Joint Legislative Committee on Multi-System Youth was created in the 2016-2017 state budget bill. The Committee was tasked with examining issues facing youth who are in need of services from or are involved with two or more of the following:

- The child welfare system
- The mental health and addiction services system
- The developmental disabilities services system
- The juvenile court system[19]

Children served by two or more of these agencies have complex needs. Addressing these needs is often very costly for families and the agencies that serve these children. The overall goal of the legislative committee was to understand the issues facing these children and their families and how to address them holistically.

The Committee made recommendations after seven public hearings. These recommendations were released publicly in June, 2016 and include:

- Improving data collection and sharing related to multi-system youth to inform state and local decision-making capabilities
- Ensuring that youth and families have access to peer support and peer mentor programs with a consistent funding source
- Establishing a safety net of state level funding for multi-system youth
- Ensuring that youth with moderate to severe needs have access to a High Fidelity Wraparound service
- Modernizing Family and Children First Councils
- Creating a Children's Congregate Care Study Committee[20]

While the legislative committee made recommendations, they were not implemented through legislation and can likely be expected to be integrated into the state budget process. Additionally, the Office of Health Transformation has shared that addressing issues related to multi-system youth will be a priority for the budget.

Comprehensive Case Management and Employment Program

On July 1, 2016, Ohio rolled out its new Comprehensive Case Management and Employment Program (CCMEP). CCMEP was a part of the previous state operating budget, House Bill 64, and is a program that was established as a collaboration between funds from two federal programs—the Workforce Innovation and Opportunity Act (WIOA) and Temporary Assistance for Needy Families (TANF) funds.

CCMEP currently targets the at-risk population of 16-24 year olds. For the upcoming budget, as a legacy item, the governor may look to expand the current program to other populations. Other populations could include individuals who may owe or are having issues with paying child support, the large population of able-bodied adults without dependents, or a larger group of dislocated workers. The increased case management the program offers could be a vital asset to these populations when obtaining and maintaining employment.

If expansion of this program is introduced and accepted, it will assist with data collection and the overall health of the program. The program's current strict limitations with the existing hard-to-serve populations, makes it difficult to grasp the full potential of where CCMEP can additionally serve other populations involved in the JFS system.

A more detailed look at the rollout of the CCMEP can be found in a recent The Center for Community Solutions Issue Brief.

Healthier Buckeye Grant Pilot Program

In the 131st General Assembly, House Bill 64 created the Healthier Buckeye Grant Pilot Program and the Ohio Healthier Buckeye Advisory Council.

Local Healthier Buckeye Councils are encouraged to collaborate across employment and community sectors to examine the role that poverty plays in their communities and form solutions to increase financial independence among the individuals living in poverty. Those applying for the Healthier Buckeye grant dollars were required to form local councils and submit annual reports to the Ohio Healthier Buckeye Advisory Council. Twenty-one local Healthier Buckeye Councils were funded with grant amounts ranging from $85,872 to $945,157.

The Cuyahoga County Healthier Buckeye Council was awarded $748,520. The council will use these funds to support Youth Opportunity Unlimited (Y.O.U.). Through the use of the grant dollars, Y.O.U. will identify and support 100 individuals in a comprehensive multi-field summer work program. More information can be found in a recent The Center for Community Solutions blog post.

The initial rollout of the grant program was slightly bumpy as the department and the council developed a grant application process. It was a rather rushed process from the time grant guidelines were established and made public to the time the applications were due, which gave

communities little time to form local councils and comprehensively examine and analyze issues of poverty in their communities.

However, if both state and local councils continue the program, there is a significant amount of experience from this year during the rollout that can assist in advancing the program forward to better reach its goals and specific populations. Like CCMEP, the Healthier Buckeye Councils and grant funding offer a holistic way of looking at individuals to find the best wraparound services they need. With such a large task at hand, it will take some time to decide the specific needs and goals of each community.

Ohio Department of Developmental Disabilities

The Department of Developmental Disabilities (DODD) seeks to provide comprehensive statewide programs and services including public education, prevention, diagnosis, treatment, training, and care for individuals with developmental disabilities and their families wherever they reside in the state. The department offers various programs in partnership with other state agencies and county boards of developmental disabilities to reach these service goals.[21]

Many of the department's goals are met through four DD waiver programs that serve individuals with an array of needs. Those waivers are Individual Options (IO) Waivers, the SELF (Self Empowered Life Funding) Waiver, Transition (TDD) Waiver, and the Level One Waiver. A more comprehensive look at the Developmental Disabilities System in Ohio can be found in this report from The Center for Community Solutions.

Table 2: DODD Waiver Enrollment, 2011-2017

	2011	2012	2013	2014	2015	2016	2017
IO	16,474	16,886	17,347	17,766	18,058	20,073	20,713
LV1	9,942	11,191	12,420	13,431	14,207	14,519	14,597
SELF	0	0	129	285	473	725	920
TDD	2,754	3,081	3,026	2,929	2,857	1,310	1,020
Total	**29,170**	**31,158**	**32,922**	**34,411**	**35,595**	**36,627**	**37,250**

Source: The Ohio Department of Developmental Disabilities.
Note: The TDD waiver was administered by the Ohio Department of Medicaid before FY2013.

Table 2 shows that since 2011, total waiver enrollment has dramatically increased from 29,170 to 37,250, marking an increased trend in services offered throughout the counties and the state from the time Governor Kasich took office.

Recent Policy Highlights

Since the end of the 2015 fiscal year, DODD has been focused on providing employment for individuals with disabilities, expanding waiver accessibility for individuals, and increasing opportunities for individuals with disabilities in their community. These policy areas are highlighted below to show the advancements the state has made.

Move Away from Sheltered Employment

The state has continued to move individuals away from sheltered employment with renewed investment, from House Bill 64, in the Employment First program. This partnership between DODD and Opportunities for Ohioans with Disabilities seeks to connect more individuals with disabilities to employment through significant case management and employment services. A focus of the partnership has been transitioning individuals out of sheltered workshops and into community employment.

Recent Center for Medicaid and Medicare Services rules[22] prohibit county boards from providing direct services and emphasize community options for both employment and housing. These rules have increased pressure on the state to move individuals out of county-run sheltered workshops and into integrated employment.

Adding to the need for policy change in Ohio was a 2016 lawsuit[23] which ruled against a local board-run employment facility. It was determined that Department of Labor standards were not being met. This case shed further light on the need for many similarly run local board sheltered workshops to move out of the business of providing isolated employment at sub-minimum wage to individuals with disabilities.

With these recent policy highlights, work must continue in the next state budget to transition individuals with disabilities into integrated employment.

Increase in State Dollars

With the passing of House Bill 64, DODD received its largest increase in new state dollars in the history of the department. This allowed for nearly 3,000 new waivers to be added to transition individuals into the community-based setting of their choosing and provide for an increase in wages for direct support staff. Additional funding has allowed DODD to actively try to "buy back" beds in large intermediate care facilities (ICFs) so they do not continue to be used.
The capital budget[1] has provided additional state investments to be made in housing and rental assistance. The federal government does not allow waivers to cover housing, thus capital funds are used to increase the availability of community housing for individuals wishing to live in the community. This is done through home purchasing, repairs, and remodeling, as well as assistance with rent.

These funds have started the state towards the slow-moving process of transitioning individuals to community-based settings.

Trends to Watch

As the department moves on from the dramatic changes in the last budget, it is anticipated that the governor will continue this momentum with the upcoming state budget. As highlighted

[1] In the capital appropriations bill, money is allocated for projects involving the acquisition, construction, equipment, or renovations of facilities that belong to agencies.

above, transitioning individuals into community-based settings both for employment and residential living will continue to be a priority of both the state legislature and the governor.

Transitioning Individuals into Community-based Settings

After the passage of House Bill 64, a lawsuit was filed against the state by Disability Rights Ohio. The suit was initiated on behalf of individuals with developmental disabilities who are currently in institutions or are at risk of institutionalization due to the current waiver waiting lists and large institutional-based settings known as Intermediate Care Facilities (ICF).
A significant amount of legislative progress was made in the last budget—progress that is yet to be fully realized by the addition of waivers and supports. In the meantime, the state will continue with its efforts to increase funding for waivers with priorities for this at-risk population as the legislature and the governor try to come together and strike the proper balance between individuals, families, and advocacy groups.

Legislation was passed in the budget to encourage intermediate care facilities to downsize and more supports to be provided for individuals to leave these types of settings. Language was included to provide individuals with information on options and supports they are eligible for in the community. Work will need to continue in the upcoming state budget to increase the number of individuals the 3,000 waivers reach, as the state has not reached its goal and progress has been slow. More information can be found in a blog post from The Center for Community Solutions.

In September, DODD went before the State Controlling Board[24] to ask for a release of funding for an outside organization to assess how Ohio compares to other states in offering opportunities to individuals for community-based services. This examination and further recommendations will move Ohio in a more inclusive direction in the coming years.

Community Employment

As community employment remains a goal for the administration, and with the additional federal rules, expanding the Employment First partnership with Opportunities for Ohioans with Disabilities is something that the governor may seek to do in the upcoming state budget. Additional supports and possible expansion of the program would assist in providing a significant change in the employment landscape in Ohio. With many of the individuals served by the Employment First Partnership waiting for job placements, an increased relationship with businesses and communities would allow more individuals a path to integrate into the community.

Ohio Department of Aging

The Ohio Department of Aging (ODA) provides home and community-based services that help aging Ohioans remain in their own homes and communities as well as support individuals in long-term care. ODA strives to change the way many Ohioans view aging by promoting positive attitudes toward aging and older Ohioans. The department accomplishes this in

multiple ways through outreach, volunteer programs, and other community and statewide efforts.

Recent Policy Highlights

As Ohio begins to grapple with challenges that come with an increasing aging population, the governor and General Assembly have begun to look at ways to improve state policy for aging adults. In the 131st General Assembly, Ohio saw multiple pieces of legislation introduced, and the Department of Aging received wide-reaching attention on various prevention campaigns.

Community Outreach

Falls are the number one cause of injury that lead to emergency room visits for the elderly in Ohio.[25] The Department of Aging has worked with other state entities, the business community, and state agencies to bring about new initiatives that draw awareness to this issue and help improve stability and balance in Ohio's aging population. The agency kicked off 2016 with the Steady U initiative and fall prevention education campaign.

The Steady U initiative had strong winter and fall social media campaigns, coupled with an extremely successful "10 Million Steps to Reduce Falls" initiative that reached more than 3,500 Ohioans walking more than 17 million steps. [26]

The "Aging is Everybody's Business" campaign is a continuation of work the Department of Aging, other state agencies, and local community partners have done "to fundamentally change the way that society thinks about aging." [27]
These initiatives have focused on social media campaigns and the Department of Aging providing more of a visible role in area communities. They have been implemented as part of an effort to expand resources and awareness to Ohio's aging population.

The Scripps Gerontology Center at Miami University projects that by 2030, 3,371,907 individuals age 60 and over will reside in Ohio, totaling nearly 28.7 percent of the entire state population.[28] With a growing population that is living longer, community-based programming is important as the state moves forward with other future efforts. These programs are a reminder that the state will soon have greater demands on its budget as the aging population expands and policies shift to accommodate this large group of Ohioans.

Recent Legislation

Recently, the Ohio House and the Ohio Senate have examined aging policy through three pieces of legislation.

Senator Gayle Manning's Senate Bill 245 aims to create the Malnutrition Prevention Commission to study malnutrition among older adults. The legislation passed the Senate unanimously in May, 2016, and is awaiting additional hearings in the House.

House Bill 293 introduced by Representative Cheryl Grossman and former Representative Michael Stinziano seeks to offer accessibility grants administered by the director of developmental services. This legislation is currently awaiting a hearing in the House, but highlights the importance of responding to the needs of aging Ohioans who are choosing to remain in the community longer than we have traditionally seen.

Legislation that would authorize a township to require snow and ice removal from sidewalks, House Bill 375, sponsored by Representative Steven Arndt and former Representative Tim Brown, passed the House and was assigned to a Senate committee in May of 2016. This bill attempts to address systemic issues around fall prevention many aging Ohioans face when living in the community.

Trends to Watch

As large amounts of the budget for the Department of Aging were transitioned to the Department of Medicaid in past budget cycles, the budget requests of the agency will be slightly reduced. However, as chronic disease becomes a growing issue, the state seeks to address more in the coming budget, and we can expect to see more done at the Department of Aging to combat this growing problem.

Over the past several years federal funding for Older American Act (OAA) programs have been subject to budget cuts, reaching nearly 5 percent in cuts[29]. Funding for these programs have also remained stagnant with inflation, resulting in fewer funds for a growing aging population. Today, the federal government invests $29.75 for every senior, a drastic decrease from the $53.73 (adjusted for inflation) OAA provided in 1993[30]. The state government will need to reexamine in this state budget and future budgets the amount of funding it invests in the growing population of aging Ohioans.

Transitioning Role of the Agency

The role of the Department of Aging has changed as a result of the transfer of large portions of its budget to the Department of Medicaid. The Department of Health also garnered a small portion of Aging's budget involving nursing homes.

These changes led the department to have more of an outreach/public safety role with little legislation directly impacting the agency itself. This may seem surprising as the state sees greater movement towards addressing the needs of aging adults through grant funding, local dollars, and other state agencies.

Chronic Disease

As the state moves to better align its health goals under a unified state health improvement plan, the impact of chronic disease has risen as a universal issue across many agencies and demographics in Ohio.

Chronic disease impacts a large portion of the growing aging population in the state. "According to the Centers for Disease Control and Prevention, nationally about 80 percent of people age 65 and over struggle with at least one chronic disease."[31] Understanding what these issues are and how they can be prevented can save the state future dollars in emergency room visits, allow for individuals to stay in the community longer, and improve overall quality of life for many Ohioans.

The state's commitment to the state health improvement plan and its role in addressing this issue in all populations will allow for greater emphasis on expanding programs that address chronic disease in the aging population in the upcoming budget and state policy initiatives. A recent report, *Investing in Older Adults,* examining federal, local, and state funding and resources investments for senior services can be found here. The Center for Community Solutions will continue to monitor the strong impact the expanding aging population has on the state budget and policy.

Transportation

Most of this *State Budgeting Matters* focuses on the general operating budget. However, there is a separate budget process that is integral to the advancement and development of urban, suburban, and rural communities across the state: the transportation bill.

The State of Ohio transportation budget is typically introduced in February, and it must be approved by March 31. That is in contrast to the deadline for the general operating budget, which is also traditionally introduced in early February but must be approved by June 30, the end of the state fiscal year.

The transportation bill is used to fund four agencies: the Ohio Department of Transportation, the Department of Public Safety, the Public Works Commission, and the Development Services Agency[32]. The revenue used for funding comes from proceeds of the state gas tax, as well as federal dollars from the Highway Trust Fund[33]. The Ohio Turnpike and Infrastructure Commission funding projects are also included in the transportation budget bill, through revenue generated by tolls from turnpike trips.

Demographic Trends and Needs

Transportation is quickly becoming one of the most frequently discussed topics by public policy planning bodies nationwide. According to Pew Research, Baby Boomers will be retiring at a rate of 10,000 per day for the next 19 years[34], and with over 77 million people who are baby boomers according to the U.S. Census[35] (known as the Silver Tsunami), transportation and the transit needs of older adults will quickly become a very important topic. In a recent analysis, The Center for Community Solutions cites Miami University Scripps Gerontology Institute data projecting that by 2030, and maybe sooner, half of Ohio counties will have a population of older adults that outnumber children.[36] In addition, according to that same data, over half of the counties in Ohio will have over 30 percent of their population at ages 60 and older.[37]

As the demographics of the state shift, so too will the needs of Ohio citizens over the years. The population of the state is expected to grow poorer and older in the coming years, according to the State of Ohio Transit Needs Study[38]. Transportation is a very closely watched and frequently discussed topic especially for vulnerable populations, including older adults. As Ohioans age, they will increasingly be looking for ways to ensure that their needs are met, whether it is through public transit, through managed care organization providers, or by county departments that serve those with disabilities and seniors (both of whom governments are trying to figure how best to serve and help to safely remain in their homes). Transportation cuts affect individuals across generational lines, as well as constituency lines—including, for example, those with disabilities, immigrants, and young adults who are moving back into urban areas—and create workforce implications for individuals who rely on public transit to go about their daily life. Much attention has also been paid to maintenance of roads and bridges both in Ohio and across the country, as many of these important infrastructure pieces are quickly deteriorating.

The ability to get to a desired location—to pick up groceries or prescriptions, to get to medical appointments, to attend community activities—is a vital facet of maintaining both physical and mental health. The ability to participate in such activities also fosters community growth and decreases instances of social isolation.

Current Funding Levels

The current transportation budget is $7.06 billion over the biennium. Of that approximately $7 billion, about $5.7 billion is designated for Ohio Department of Transportation (ODOT). Of that $5.7 billion, $5.05 billion (or about 85.9 percent) is specifically earmarked for highway construction or maintenance.

The funding for the Ohio Department of Transportation is not provided by General Revenue Fund (GRF) dollars. Rather, the transportation budget is funded by state motor vehicle tax revenue, as well as the Federal Highway Trust Fund. It is important to note that the transportation bill contains both capital and operating costs for the Ohio Department of Transportation. This is different from the general appropriations bill, where capital and operating budgets for other agencies are considered in two different bills, alternating every other year[39]. It is also important to note that there are state agencies that receive GRF funding in the operating budget for transportation needs including the Department of Education (Pupil Transportation), the Department of Job and Family Services (Medicaid – Local Transportation), and others.[40]

The Ohio Constitution prohibits state gas tax revenue to fund public transit projects, only permitting use for highway projects, stating that it must go towards "urban extensions of state highways and highways within or leading to municipal corporations."[41]

Table 3: Executive Transportation Budget by Agency and Fund Group, FY 2016-FY 2017

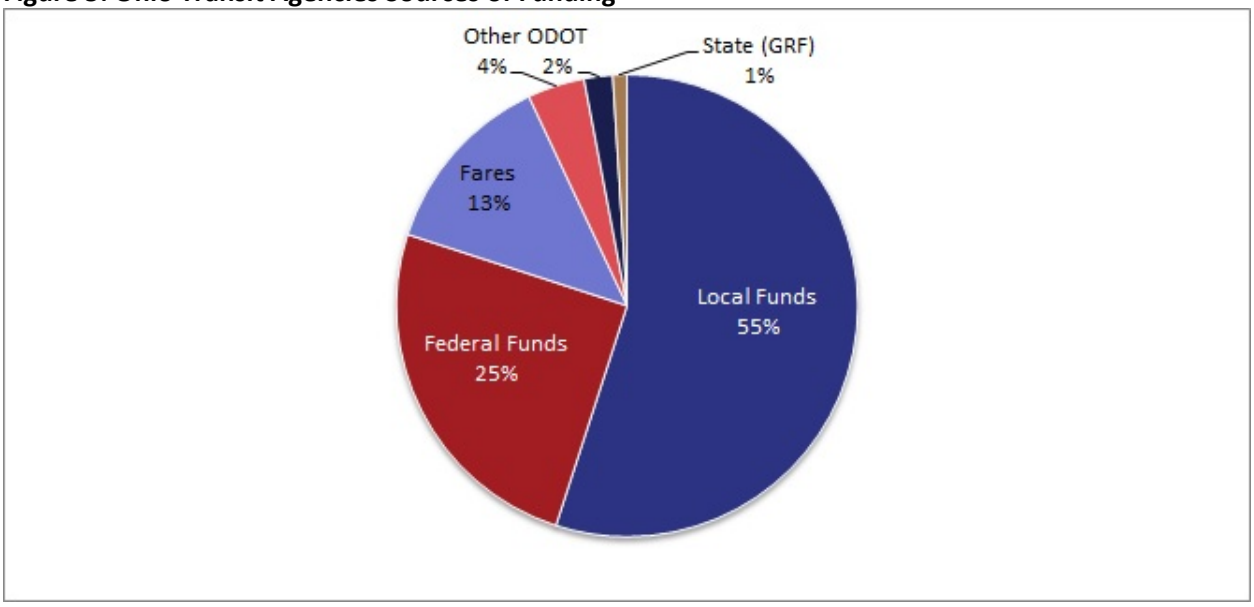
Fund Group	FY 2015*	FY 2016	FY 2017
Department of Transportation			
Highway Operating Fund Group	$2,904,586,567	$2,597,221,370	$2,614,614,032
Capital Projects Fund Group	$216,617,631	$277,539,813	$372,308,081
Dedicated Purpose Fund Group	$3,495,800	$3,495,800	$3,495,800
Subtotal	**$3,124,699,998**	**$2,878,256,983**	**$2,990,417,913**
Department of Public Safety			
State Highway Safety Fund Group	$520,093,392	$477,348,872	$477,346,272
Dedicated Purpose Fund Group	$29,560,032	$3,400,000	$3,400,000
Fiduciary Fund Group	$3,600,000	$3,600,000	$3,600,000
Holding Account Fund Group	$2,235,000	$2,235,000	$2,235,000
Federal Fund Group	$133,292,715	$35,321,000	$35,321,000
Subtotal	**$688,781,139**	**$521,904,872**	**$521,902,272**
Public Works Commission			
Dedicated Purpose Fund Group	$52,296,555	$56,289,020	$58,291,269
Capital Projects Fund Group	$909,665	$899,507	$905,807
Subtotal	**$53,206,220**	**$57,188,507**	**$59,197,076**
Development Services Agency			
Dedicated Purpose Fund Group	$15,199,900	$15,200,000	$15,200,000
Subtotal	**$15,199,900**	**$15,200,000**	**$15,200,000**
Total All Budget Fund Groups	**$3,881,887,257**	**$3,472,550,362**	**$3,586,717,261**

Source: http://www.lsc.ohio.gov/fiscal/transportation/transbudget131/overview.pdf

Public Transit

There are 61 transit systems in Ohio, which provide 115 million rides per year, the 14th highest transit ridership of any state. The lion's share of money that goes to public transit, however, comes from local levies and fares (68 percent). The State of Ohio and ODOT contribute only about 3 percent of the public transit funding. Ohio ranks 41st in the nation in the yearly amount that it spends on public transit.

Figure 5: Ohio Transit Agencies Sources of Funding



Source: Ohio Transit Needs Study, Page 1
https://www.dot.state.oh.us/Divisions/Planning/Transit/TransitNeedsStudy/Documents/OhioStatewideTransitNeedsStudyFinalReport.pdf,
*Other includes advertising, contracts, and miscellaneous income

Trends to Watch

As the transportation budget process moves forward, the Ohio Office of Health Transformation is working with other health and human service agencies at the state level to identify how transportation investments can more closely align with the Ohio Department of Transportation to meet needs of Ohio citizens. The Center for Community Solutions will closely monitor these conversations to ensure that the needs of Ohio's most vulnerable citizens are taken into consideration in the years to come.

Conclusion

The introduction of the next state budget in February, 2017, will be here before we know it. The recent election created many unknowns at the federal level, and state lawmakers will have to begin to address these unknowns during budget deliberations. There will undoubtedly be shifts in federal policy that make a large impact on states and how they move forward. It will be important both to monitor those deliberations and policy decisions, and to understand the shifts in health and human services over the course of the last several years going into what will be the final budget of the Kasich Administration and the unknowns on the horizon.

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