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Financing Ohio's Future: Human Services in Changing Times

Fourth Edition

An Advocate's Guide to the State Budget

May, 2014

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Authors

Terry M. Thomas, Public Policy Consultant
Jon Honeck, Ph.D., Director of Public Policy
Tara Dolansky, MPA, Public Policy & Planning Associate
Matt Bird, Policy and Planning Assistant

Introduction

Human services provide support that helps Ohio families achieve success in a difficult, changing economy. Coordinating these services and providing stable funding are constant challenges. These challenges are even greater because of the involvement of federal, state, and local funding streams and their associated rules and regulations. Ohio's decentralized approach to administration relies on many different local agencies to deliver services, including: county job and family service departments and children's service agencies; local boards for alcohol, drug addiction, and mental health; county boards of developmental disabilities; and, regional PASSPORT agencies for home- and community-based long-term care. Moreover, most of the day-to-day administration of the Medicaid program is regionalized through contracts with managed care organizations.

Financing Ohio's Future: Human Services in Changing Times focuses on the largest programs supported through the state General Revenue Fund (GRF). Readers will gain a basic grasp of funding sources, program structure, and important policy issues in major GRF programs and services, including:

- Medicaid
- Mental Health and Addiction
- Developmental Disabilities
- Temporary Assistance for Needy Families
- Child Protective Services
- K-12 Education
- Higher Education
- Adult Corrections

Financing Ohio's Future is a resource to help social service advocates and stakeholders understand state budget issues and arm them with the facts they need to make their voices heard with policymakers. It is updated annually by The Center for Community Solutions as part of an ongoing effort to provide analysis of human service issues at the state level. Readers may also be interested in our other budget resources, including our *State Budgeting Matters* series, which is published six times a year, and *Follow the Money: State Budgeting in Ohio,* a comprehensive guide to the state budget process

John A. Begala, Executive Director
The Center for Community Solutions
May, 2014

Highlights

- Employment in Ohio has still not bounced back after recessions in 2001-2003 and 2007-2009. Consequently, the poverty rate in the state has grown from 10.6 percent of the population in 2000 to 16.3 in 2012, and there is a continued need for assistance provided through publicly funded health and human services.

- The state General Revenue Fund (GRF) is the primary source of support for major state programs such as health and human services, education, and corrections. The GRF is supported by state tax revenues but also includes reimbursement for the federal share of Medicaid.

- Ohio Works First is a cash assistance program funded through the federal Temporary Assistance for Needy Families (TANF) block grant and a required state contribution (maintenance of effort). The program is intended to help the poorest families, but since 2011, OWF has focused almost solely on meeting federal work requirements to the detriment of the people needing help from the program. The number of participants has fallen by nearly half since 2011.

- Public Children Services Agencies (PCSAs), the county entities responsible for child welfare, investigated a combined 101,000 cases of abuse and neglect in 2011. Despite the need for the services PCSAs provide, Ohio ranks 50th in the nation in state funding for child welfare.

- Governor John Kasich created the Office of Health Transformation to focus on Medicaid spending issues, long-term administration of the program, and overall health system performance in Ohio. This laid the groundwork for the creation of the new single-state agency, the Department of Medicaid.

- Through calendar year 2013, Medicaid served more than 2.2 million mostly low-income children and parents, as well as aged, blind and disabled (ABD) individuals, at a total cost of over $17 billion. The federal government funds the majority of the Medicaid program at a matching rate (federal medical assistance percentage, or FMAP) of 63.58 percent in 2013. Higher federal matching rates are available for some populations within the Medicaid program. The state funds the remainder of the program.

- While most Medicaid beneficiaries are children and parents, over 60 percent of the spending in the program is for aged, blind, and disabled (ABD) enrollees. Long-term care for seniors and the disabled is the primary reason that ABD coverage comprises more of the Medicaid budget. Medicaid is the single largest payer of long-term care services. The state is encouraging a shift from institutional settings in favor of individuals receiving services through home- and community-based programs.

- With the expansion of the Medicaid program in 2014 to primarily low-income, childless adults, the program is expected to serve an additional 366,000 people by June, 2015. The added costs of the expansion population will be fully covered by the federal government as a part of the Affordable Care Act through the 2014-2015 biennium, and the federal share of costs never goes below 90 percent.

- In 2013, the Departments of Mental Health and Alcohol and Drug Addiction Services merged to become the Department of Mental Health and Addiction Services. This aligns the state agency with the combined structure of most of the county behavioral health boards. While state funding is instrumental to providing services for individuals with mental illness, local revenue provides the majority of funding for mental health services through a combination of local levies, donations, and general operating dollars.

- In 2007, drug overdoses surpassed car accidents as the leading cause of accidental death in Ohio. This trend has continued and is being fueled by an epidemic of abuse of prescription opiates and heroin. While several policies have been implemented at the state and local levels to combat this crisis, drug abuse continues to be a major problem plaguing the state.

- The Ohio Department of Developmental Disabilities (DODD) supports long-term programs for individuals with developmental disabilities. Services are coordinated by a county board system. As in long-term care for the aging population, there has been a shift away from institutional care toward a home- and community-based service system (HCBS). While HCBS slots have opened up, limited financial capacity has kept counties from filling them, and they routinely keep waiting lists for services.

- Funding for primary and secondary education comprises the largest piece of state source GRF spending. Ohio's 1.75 million children in kindergarten through 12th grade are served by public schools, joint vocational districts, career centers, charter schools, and educational service centers. State funding for education is 11 percent higher in 2015 than in 2013, but the foundation formula is not fully funded.

- Ohio's public higher education system serves almost 511,000 students annually, and new funding formulas emphasize degree and course completion. State contributions to need-based aid have declined dramatically since 2008, with a slight uptick in the most recent budget. While the state share of funding for instruction increased in the 2014-2015 budget, it has not kept pace with tuition increases.

- Despite sentencing reforms, Ohio's prison population is approaching the record high levels it experienced in 2008, with continued overcrowding placing pressure on prison finances and staff. Recent sentencing reform for nonviolent offenders has not yet had the anticipated effect of substantially lowering the prison population.

House Bill 59: FY 2014 - 2015 Budget Highlights

The enacted FY 2014-2015 budget reflected three main priorities: primary and secondary education funding and policy choices, income tax reductions, and Medicaid expansion and reform. The difficulty of reconciling the first two priorities is obvious. The budget creates a new education formula, but the prospect of fully funding it in the future appears slim due to long-term revenue losses created by the income tax cuts. Moreover, changes to property tax rollbacks might make it more difficult for school districts to request new levies locally.

Medicaid Expansion and Reform

The budget continued program reforms by creating a new Department of Medicaid, enhancing eligibility determination and enrollment procedures, moving toward payment for quality outcomes, directing more funds to safety net providers, and reducing inappropriate utilization.

The administration was unable to accomplish its goal of expanding Medicaid to low-income, childless adults who lack health insurance during the budget process in the spring of 2013. Later that year, the State Controlling Board, which includes six legislative appointees and an executive member, voted to accept the federal funds needed to implement the expansion. **The importance of this achievement cannot be overstated.** The federal government will pay 100 percent of the cost of the expansion for the first three years, providing coverage for hundreds of thousands Ohioans who had been locked out of regular health care coverage. While accomplished in an unorthodox manner outside the normal budget process, it was an essential reform needed to improve and transform Ohio's health care system.

A More Consumption-based Tax System

Tax policy changes reflected the desire of state policymakers for a less progressive, more consumption-based tax structure. For the first time in 30 years, the state sales tax surpassed the personal income tax as the largest generator of GRF resources in FY 2014.

Departmental Merger

Service delivery system integration was improved with the merger of the Department of Mental Health and the Department of Alcohol and Drug Addiction Services into the newly created Department of Mental Health and Addiction Services (MHAS).

School Choice Broadened

While support for primary and secondary education was boosted after years of stagnation and decline, the new formula was far from fully funded. Chartered, non-public schools were the biggest winners in the education budget. A new means-tested component of the Educational Choice Scholarship Program (EdChoice) significantly broadened the historic purpose of school vouchers, beyond the traditional focus on providing private educational alternatives for students in underperforming traditional public schools. A new "Straight-A" Fund provides competitive grants to school districts to try out innovative or cost-savings ideas.

Course and Degree Completion Rewarded
A new higher education funding formula emphasized course and degree completions. Funding for the Ohio College Opportunity Grant (OCOG) program for low-income students remained nearly 40 percent lower than before the Great Recession.

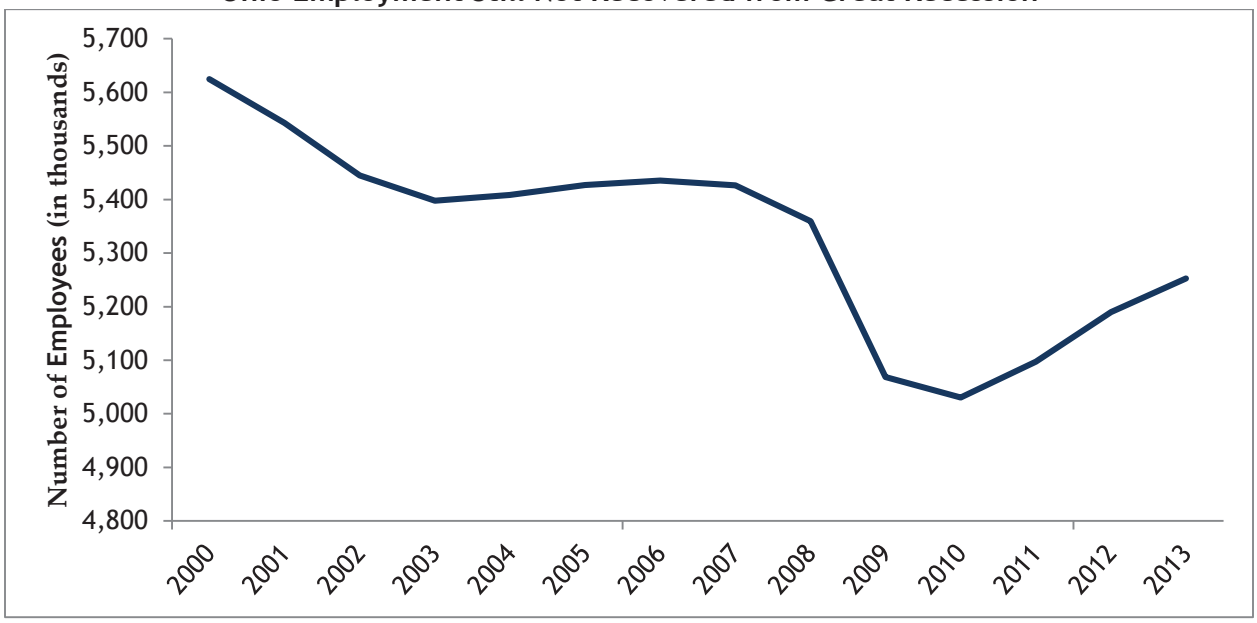
Managing Prison Costs
Recent efforts to reduce prison population and costs have met with only limited success, stabilizing, but not significantly reducing, expenditures.

Economy, Policy Choices Impact State Economy

The 21st century has been a tough time for Ohio's workforce. The state lost almost 400,000 jobs between 2007 and 2010, many of them highly paid manufacturing jobs. Three years later, the state had gained only 222,000 of them back. Current nonagricultural employment is about 5.3 million, which is still 6.6 percent below the level at the turn of the millennium (Figure 1). Persistent unemployment and underemployment have a profound influence on both the demand for human service programs and the ability of the state to finance these programs and other public services.

Figure 1

Ohio Employment Still Not Recovered from Great Recession



Source: U.S. Bureau of Labor Statistics Current Employment Statistics survey.
Note: Non-farm payroll employees.

The official poverty rate, which understates the resources that families need to make ends meet, was 16.3 percent in 2012, having grown from 10.6 percent in 2000. During that time, median household income declined by 14 percent in real terms. By 2012, almost one-fourth of Ohio's children were living in poverty, up from one in seven in 2000.[1]

The increased need for assistance is reflected in many benefit programs, most notably in the growth of the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), and in Medicaid. Today approximately 1.8 million Ohioans receive SNAP benefits, which are paid for entirely by the federal government. Before the recession, the number of recipients averaged 1.1 million. Despite difficult economic conditions and an overwhelmed county department of job and family services system, the state implemented new work requirements for childless adult SNAP recipients in the fall of 2013, which are expected to lead to further reductions in caseloads.

A different story is unfolding in Ohio Works First, the state's program for income assistance for needy families with children. After declining for years in the wake of federal welfare reform, cash assistance caseloads rose by 33 percent from 2007 through 2010. Starting in early 2011, however, caseloads began a precipitous decline, caused not by a recovering economy, but by the state's need to have its adult recipients meet federal work requirements. There are now fewer than 21,000 adults on the program statewide, and 71 percent of the recipients are child-only cases. Failure to meet the requirements would have led to a $135 million reduction in the federal TANF block grant to the state. Failure to meet the needs of Ohio's poorest families, however, will have devastating consequences for their health and well-being. (The TANF program is discussed in greater detail starting on page 23.)

The General Revenue Fund

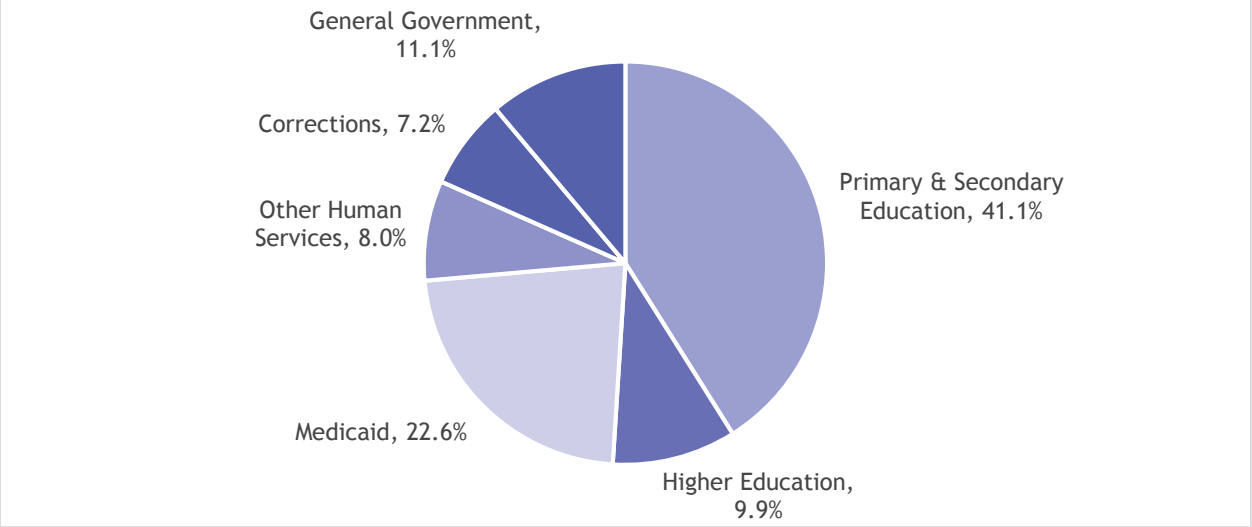
The General Revenue Fund (GRF) is the largest part of Ohio's budget. GRF appropriations are expected to total $31.7 billion in FY 2015. The GRF supports primary and secondary education, higher education, human services, Medicaid, corrections, general government, and property tax relief programs. The GRF is supported primarily by revenue raised through taxation, but also includes the federal share of Medicaid reimbursement. When the federal share of Medicaid is included, the GRF comprises slightly more than one-half of all state spending, which is expected to reach a record $61.64 billion in FY 2015.

The distinguishing aspect of the GRF is that it operates under the fewest restrictions of any fund on how it can be used. This can be contrasted with the state's transportation budget, which is largely financed by dedicated revenues from federal grants and the state gas tax, and restricted for highway and other designated transportation-related purposes. These expenditures are appropriated in a separate budget bill and are not part of the GRF. Likewise, operations of the Industrial Commission and Bureau of Workers' Compensation are appropriated in separate budget bills financed using dedicated revenues generated from a tax on employers, and are not part of the GRF.

In this discussion we will focus on programs that the state supports with its own revenues. Primary and secondary (K-12) education is the largest state-source GRF expenditure item. Spending on human services programs (including Medicaid) encompasses just over 30 percent of all state-source GRF spending (Figure 2).

Figure 2

FY 2015 State-Source GRF Appropriations

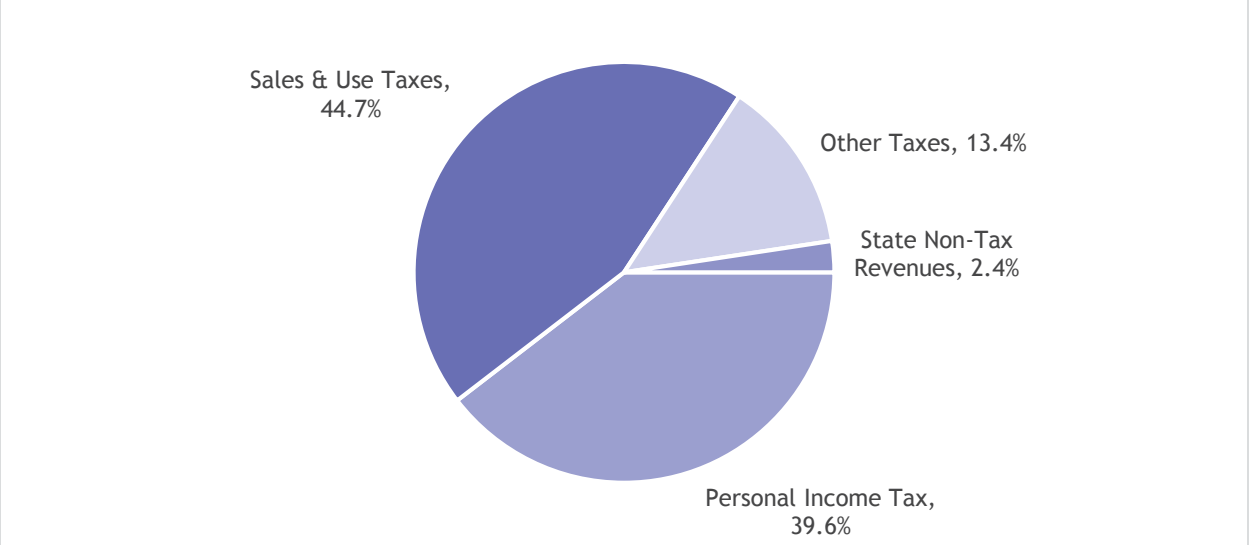


Source: Ohio Legislative Service Commission Budget in Brief, HB 59/130th General Assembly – As Enacted.

It is anticipated that state taxes will yield $21.59 billion in FY 2015. The sales tax and the individual income tax are the two largest state sources of GRF tax revenue. Together, they will comprise an estimated 58.8 percent of total GRF revenue in FY 2015, and 84.3 percent of state-source GRF revenue if federal Medicaid reimbursements are excluded. Most of the remaining tax revenue comes from the commercial activity tax (CAT), public utility excise taxes, financial institutions taxes, kilowatt-hour (electricity use) excise taxes, cigarette and alcoholic beverage taxes ("sin" taxes), and insurance taxes (Figure 3).

Figure 3

FY 2015 State-Source GRF Revenues



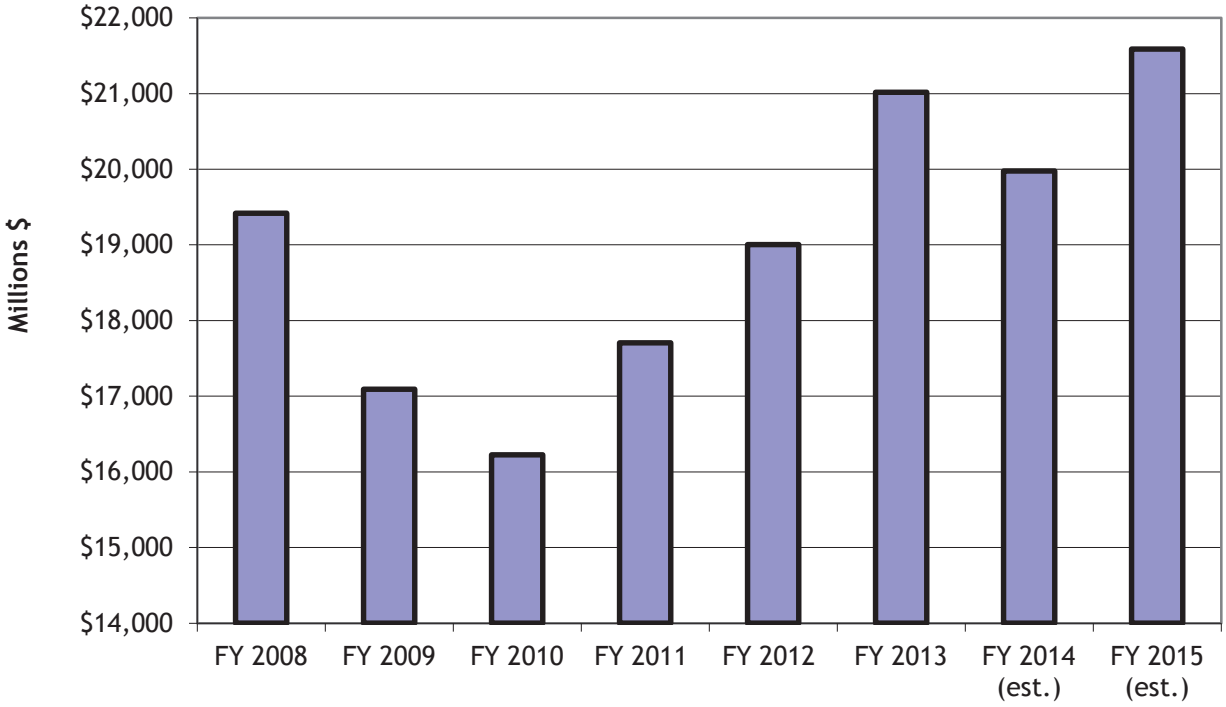
Source: Ohio Legislative Service Commission Budget in Brief, HB 59/130th General Assembly- As Enacted

GRF tax revenues are not much higher now than they were before the recession. This is due not only to the economy, but to tax cuts that started in 2005 that lowered income tax rates and business taxes. GRF revenues were further boosted by reductions in revenue sharing with governments (counties and municipal corporations) and public libraries. Since the recession of 2000, the state has shortchanged or modified revenue sharing formulas in order to help balance the GRF. In 2008, the Local Government Fund received 3.68 percent of GRF revenues, and the Public Library Fund received 1.97 percent. After being drastically reduced in the FY 2012-2013 budget, a new formula was created that provides 1.66 percent of GRF tax revenue for both funds, leaving them significantly reduced from previous levels.

The FY 2014-2015 budget added an additional income tax cut that will reduce 2012 rates by 10 percent over three years and a 50 percent small business deduction. These changes are expected to reduce total FY 2014 GRF tax receipts by 3 percent. The FY 2014 budget is balanced in part by carrying over a large FY 2013 year-end surplus, equal to about 5 percent of annual revenue. Natural revenue growth from an anticipated improvement in the Ohio economy is projected to increase state tax revenues by 8 percent in FY 2015 (Figure 4).

Figure 4

Total State GRF Tax Receipts Impacted by Economy and Tax Cuts



Source: Ohio Office of Budget and Management and Ohio Legislative Service Commission Budget in Brief, HB 59 - As Enacted.

In times of financial emergency, the legislature can authorize the use of the state's Budget Stabilization Fund (BSF), a step it took at the end of FY 2009 during the height of the Great Recession. The BSF, better known as the Rainy Day Fund, was all but empty in FY 2009 and FY 2010. It contained only 89 cents until the end of FY 2011, when $247 million was added. Another $235 million was added at the end of FY 2012, and $996 million more was deposited in early FY 2014. The fund now contains nearly $1.5 billion, which equals 5 percent of annual GRF revenues, the recommended level established by law.

Key Spending Areas: Funding Human Service Programs

Health Policy

Governor John Kasich signed Executive Order 2011-02K in January, 2011, creating the Office of Health Transformation (OHT) to focus on Medicaid spending issues, the long-term administration of the Ohio Medicaid program, and improvement of overall health system performance in Ohio.[2] Each state agency that was responsible for a budget and provision of services through Ohio's Medicaid plan fell under the directive of OHT. This includes the departments of Job and Family Services (ODJFS), Aging (ODA), Developmental Disabilities (ODDD), Mental Health (ODMH), and Alcohol and Drug Addiction Services (ODADAS). The Department of Health (ODH) also falls under the OHT umbrella. Since 2011, OHT has worked to streamline Medicaid, reorganize health and human service operations, and eventually leverage state purchasing power and leadership to make changes in the wider health care economy. This laid the groundwork for the creation of the new Department of Medicaid which is now responsible for the majority of Medicaid spending in Ohio.

OHT set forth an ambitious plan to modernize Medicaid, streamline health and human service operations, and pay for value. Key objectives of the transformation include efforts to improve care coordination, integrate physical and behavioral health care, and rebalance long-term care. Initiatives completed or currently in process by OHT include creating a single Medicaid agency, a demonstration project for those dually eligible for Medicaid and Medicare, and updating the state's antiquated financial eligibility determination system.

Medicaid Enrollment and Costs

Medicaid is a joint federal-state program and is the largest program in state government. In FY 2012, Ohio spent more than $17 billion per year on the program across all agencies and served more than 2.2 million people.[3] The 2014-2015 state budget merged nearly all Medicaid programs and spending into a single state agency, the new Department of Medicaid (ODM).

Around 11.5 million people live in Ohio and, on average, about 2.2 million or 20 percent are enrolled in Medicaid. Medicaid provides care for a large share of Ohio's children. In state Fiscal Year 2012, 1.15 million children were enrolled. Additionally, Medicaid covered 45 percent of all births in the state.[4] Medicaid coverage is available for children up to 200 percent of the federal poverty level, which has contributed to the state having only 9 percent of children uninsured. Rising health care costs and decline of offers of employer-sponsored health insurance, as well as

the general state of the economy since Medicaid eligibility is income-based, have contributed to increased Medicaid enrollment.

Implementation of Federal Health Reform in Ohio

Many OHT initiatives have taken advantage of opportunities created by the Patient Protection and Affordable Care Act (ACA), which was signed into law by President Obama in March, 2010. Among other provisions--such as expanding access to health coverage, reforming the health care delivery system and requiring most everyone to have health insurance coverage (individual mandate)--the ACA expands the Medicaid program to cover all uninsured individuals age 19-64 up to 138 percent of the federal poverty level. The major provisions of the law went into effect at the beginning of 2014.

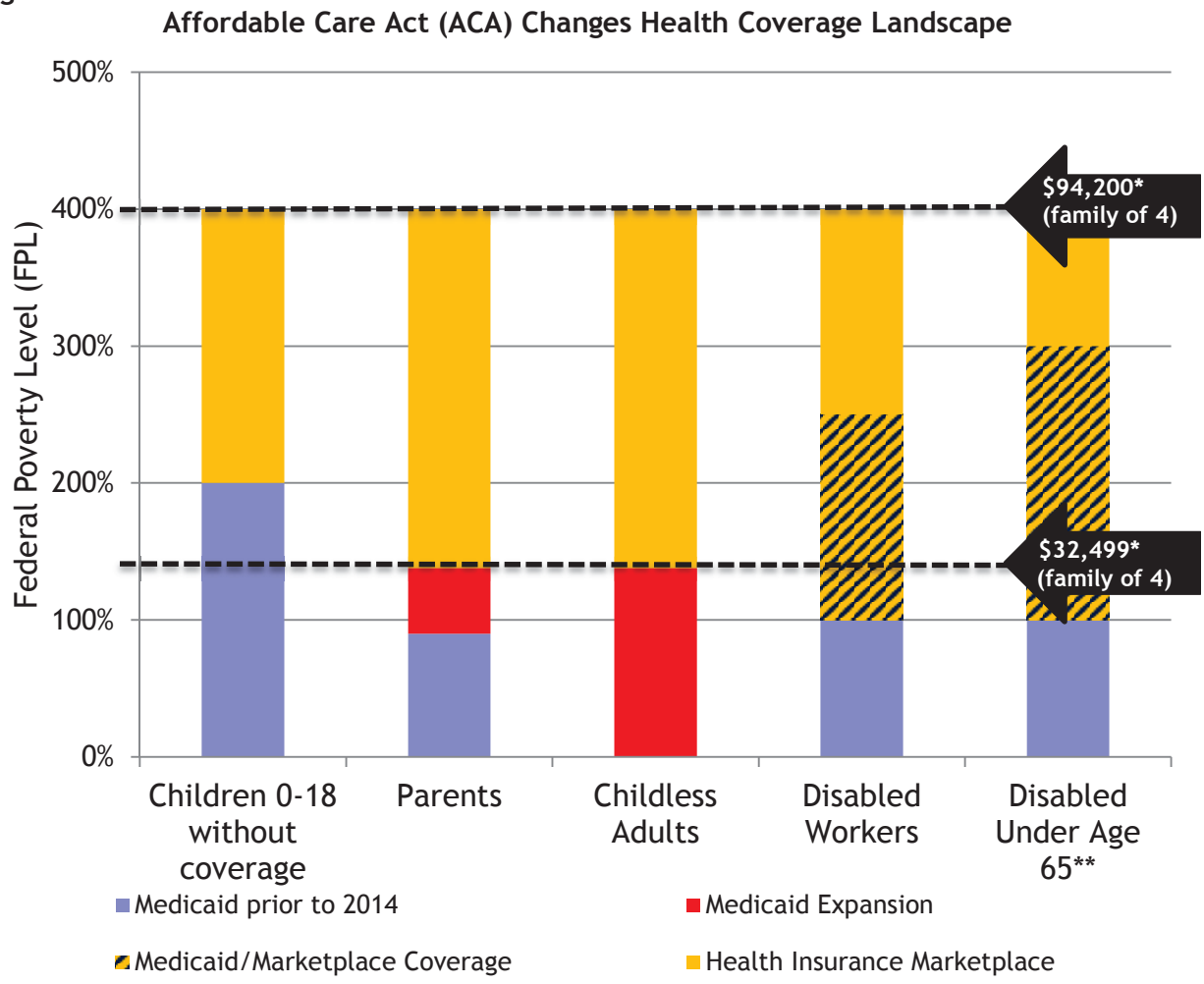
Prior to 2014, in Ohio, parents with incomes up to 90 percent of the poverty level were eligible for Medicaid, and children with no other coverage could be eligible up to 200 percent of the poverty level (see blue area in Figure 5). Income eligible disabled individuals could also access Medicaid. Low-income childless adults (under 138 percent FPL) and parents above 90 percent of poverty were not covered by Medicaid in the state. This is the target population for the expansion of Medicaid (red area in Figure 5 gained coverage through the Medicaid expansion). The ACA sought to fill gaps in coverage by setting the Medicaid eligibility level higher and implementing insurance exchanges otherwise known as the health insurance marketplace.

Uninsured individuals and families above 138 percent of the federal poverty level gained access to health insurance through the exchange, or health insurance marketplace. Anyone with incomes between 100 percent and 400 percent of the poverty level is eligible for tax subsidies from the federal government to help pay for the cost of insurance (see yellow area in Figure 5). Individuals can purchase health insurance through an online marketplace that allows purchasers to choose from a variety of insurance plans that are required to provide a minimum level of coverage. Uninsured individuals at any income range can purchase insurance on the marketplace, but only those between 100 and 400 percent of poverty are eligible for subsidies.

Anyone under age 65 who is between 100 and 138 percent of poverty is technically eligible to purchase insurance on the marketplace and receive subsidies and at the same time are eligible for Medicaid under the expansion of the program. This may be a benefit to low-income individuals in states that did not expand Medicaid, unlike Ohio.

The lined area in Figure 5 indicates that Medicaid is available to these individuals in certain circumstances (and has been prior to 2014), but under the ACA, plans through the marketplace are available as well.

Figure 5



Source: Ohio Governor's Office of Health Transformation
*The 2013 poverty threshold (100 percent FPL) for an individual is $11,490 and for a family of four is $23,550
**Coverage for individuals over age 65 is provided through Medicare

Medicaid Expansion

The governor included Medicaid expansion in his FY 2014-2015 budget proposal, with the major selling point being 100 percent federal funding of services for the expansion population for the first three years. After contentious debate, the legislature rejected the governor's Medicaid expansion proposal and removed it from the final version of the state budget.

Later in 2013, Ohio expanded Medicaid through the State Controlling Board, a joint legislative and executive panel that can approve the state's receipt of federal grants that are consistent with agencies' existing budgetary authority. The Department of Medicaid applied for a State Plan Amendment (SPA) that specifically covered the expansion population (adults without dependent children between 0 and 138 percent of the Federal Poverty Level (FPL) and parents

otherwise not covered by current Medicaid eligibility levels up to 138 percent FPL); it was approved by the Centers for Medicare and Medicaid Services (CMS) in October, 2013. State legislative approval to expend the federal funds for Medicaid expansion was required before the SPA could be implemented. The State Controlling Board approved the increased appropriation amount for Medicaid, which allowed expansion to move forward.

Medicaid expansion will greatly increase access to health care in Ohio. The state estimates that 366,000 people would be newly eligible for Medicaid coverage with the expansion during the 2014-2015 biennium.

Medicaid Enrollment and Costs

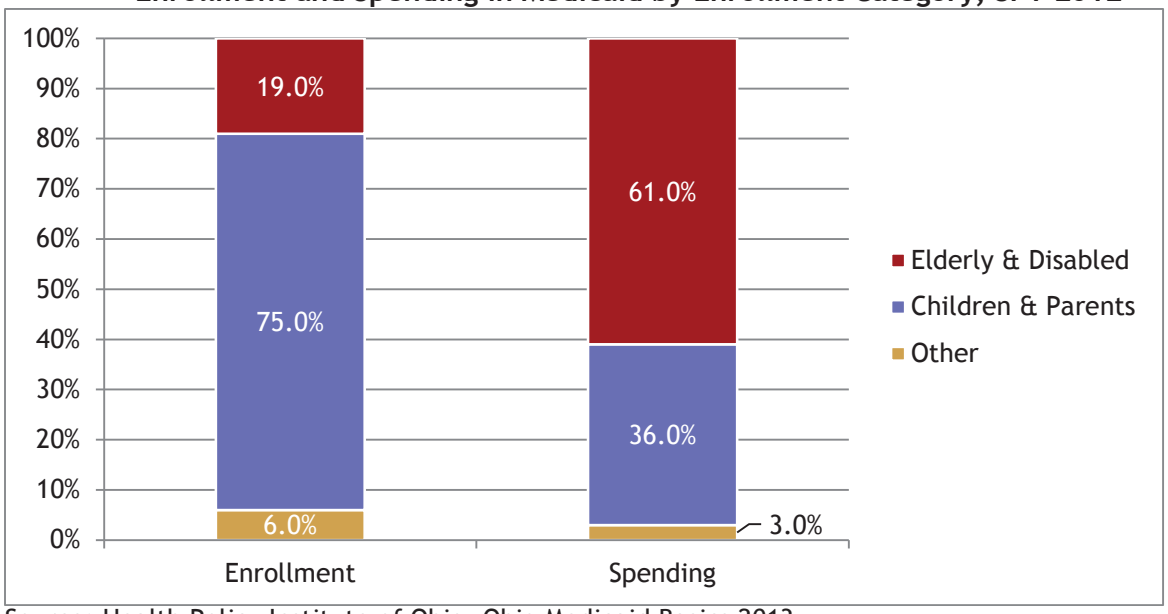
Figure 6 shows Medicaid caseloads by major eligibility group. The largest, Covered Families and Children (CFC), is low-income parents and children. CFC represents 75 percent of the Medicaid caseload but only 36 percent of spending on the program. The average cost per CFC enrollee per month was $288 in SFY 2013.[5]

The Aged, Blind, and Disabled (ABD) category covers low-income adults over 65 and individuals with disabilities. This category comprises about 19 percent of the overall Medicaid caseload but represents about 61 percent of total program spending. The average cost per ABD enrollee per month in 2013 was $2,098. The primary reason for this split in enrollment versus spending is the cost of long-term care for the aged, blind and disabled enrollees.

The "other" category of Medicaid enrollees includes Alien Emergency Medical Assistance, Breast and Cervical Cancer Project, and Limited Benefits (Premium Assistance and Family Planning).

Figure 6

Enrollment and Spending in Medicaid by Enrollment Category, SFY 2012



Source: Health Policy Institute of Ohio, Ohio Medicaid Basics 2013

Spending for Medicaid services (actual services provided) in 2013 was just under $15.7 billion (Table 1). This amount will increase substantially in 2014 and 2015 primarily due to the expansion of Medicaid. The expansion is fully funded by the federal government through 2016, and funding for the expansion population was authorized by the Controlling Board as non-GRF, hence the large increase in non-GRF spending from 2013 to 2014 and again from 2014 to 2015.

Table 1

Medicaid Services Spending, in Billions

	SFY 2013 (actual)	SFY 2014	SFY 2015
Medicaid- GRF*	$12.0	$14.0	$14.9
Medicaid- Non-GRF**	$3.7	$4.9	$6.6
TOTAL for Medicaid Services	$15.7	$18.9	$21.5

Source: LSC Budget in Detail and Fund/Appropriation Request Controlling Board No. MCD0100009
*Includes Medicaid/Health Care Services- Federal and State and Medicare Part D
**Includes Medicaid Services- Recoveries, Medicaid Services-Payment Withholding, Medicaid Services-Federal, Medicaid Services- Hospital/UPL, Medicaid Services- Long Term Care

Federal Funding for Medicaid

The federal government provides significant funds to states through a formula known as Federal Medical Assistance Percentage or FMAP. The FMAP is calculated yearly based on the three-year average of the state's per capita personal income compared to the national average. Ohio's rate for federal Fiscal Year 2013 is 63.58 percent, a slight decline from the previous year. Matching rates vary between different parts of the Medicaid program, and enhanced rates are available for certain services and populations. Administration of the Medicaid program is matched at 50 percent. Under the ACA, the federal government will cover 100 percent of Medicaid costs associated with the expansion population through 2016, and in future years will cover 90 percent of these costs.

State Funding for Medicaid

The state uses a combination of GRF and revenue from other sources to fund the state share of the Medicaid program. These include rebates on prescription drugs, collections from third-party payers for individuals who had other insurance coverage, and provider taxes (also known as franchise fees) on hospitals, nursing facilities, and intermediate care facilities for the developmentally disabled.

The state sales tax also applies to payments to Medicaid managed care organizations, helping to boost GRF revenue.

Local levies are used in some areas to fund certain Medicaid services for individuals with a developmental disability. This is no longer the case for behavioral health services, for which the state now pays all Medicaid claims for Medicaid-eligible individuals.

Long-term Care

Long-term care programs help individuals manage activities of daily life that they are unable to do by themselves. Levels of service vary from facilities with round-the-clock skilled nursing, to home- and community-based care that provides help several days each week with a specific task. The Medicaid program is the single largest payer of long-term care services. The cost is substantial. Long-term care expenses made up about 37 percent of all Medicaid spending in FY 2012.[6] The need for long-term care is expected to increase as Ohio's population ages over the coming decades.

Federal Medicaid law makes institutional care in nursing homes an entitlement for those who meet the defined level of care. Over time, Congress changed federal law to allow states to request "waivers" to serve individuals in non-institutional settings. The state maintains separate waiver programs for the elderly (ODA), non-elderly (ODM), and the developmentally disabled (ODDD). The move to home- and community-based services is in part a response to cost pressures: care in institutional settings such as nursing homes and intermediate care facilities for the developmentally disabled (ICFs) is more expensive because they provide intensive services to patients around the clock. The shift to community-based settings is also a response to legal requirements, however. The U.S. Supreme Court, in its *Olmstead* decision, held that under the Americans with Disabilities Act individuals must be cared for in the least restrictive setting.

Substantial progress has been made in rebalancing the system toward home- and community-based care. Among elderly receiving long-term care in 2011, 45 percent were in community settings, up from 29 percent a decade earlier.[7] Among the under-60 population, 50 percent were in community settings in 2011, up from 46 percent a decade earlier.[8] Slower progress among the younger population is in part a reflection of a shift in the standard nursing home business model toward serving the under-60 population.

The state has made significant investments in the past decade in home- and community-based care programs through Medicaid waiver programs such as PASSPORT, a program serving adults age 60 and over. PASSPORT consumers can receive a range of services depending on their specific needs and their individual care plan. Examples of services include help with eating, bathing, and dressing; minor home modifications and repair; and cleaning, meal preparation, and laundry. As of December, 2013, PASSPORT enrollment stood at 34,200 statewide. Medicaid enrollment in the assisted living waiver for seniors, which is smaller but growing rapidly, was at 4,200.[9]

The FY 2014-2015 budget sets policy goals for continuing progress toward rebalancing long-term care. By the end of FY 2015, at least 50 percent of elderly Medicaid recipients and at least 60 percent of disabled Medicaid recipients under age 60 who need long-term care must be in community settings.[10] Several major initiatives were authorized by the budget. Under the Balancing Incentive Payment program the state must promise to create a "no wrong door" system for people of all ages seeking long-term care, conflict-free case management that ensures that consumers get the help they really need, and a standardized assessment instrument. As an

incentive, the state will receive an extra two-percentage-point boost in the federal Medicaid cost share for community-based long-term care services through September, 2015. This is expected to increase federal share by $169 million.

The other major initiative, MyCare, is a three-year demonstration project that will use managed care organizations to coordinate care for consumers who receive both Medicaid and Medicare benefits (Parts A,B, and D; hospitalization, medical services and mental health, and a prescription drug benefit). This initiative is part of a national project to test whether improved care will create cost savings for both Medicaid and Medicare. The "dual-eligibles" in the project include adults of all ages, regardless of their residential setting, but not including the developmentally disabled population. The MyCare project will affect 114,000 people in 29 counties in all of the major urban areas of the state starting in the spring of 2014. Consumers can opt-out of the Medicare portion of the project but enrollment in a managed care plan for Medicaid is mandatory.

Mental Health and Addiction

Ohio's community mental health and addiction services system includes both Medicaid and non-Medicaid services coordinated through 53 local boards of alcohol and drug addiction and mental health (ADAMH) services. Starting in the late 1980s, the state shifted its policy away from utilizing state hospitals to emphasizing treatment in community settings. Sufficient funding did not follow suit, however, leaving gaps not only in treatment services but wrap-around supports as well, such as transportation, housing, and employment.

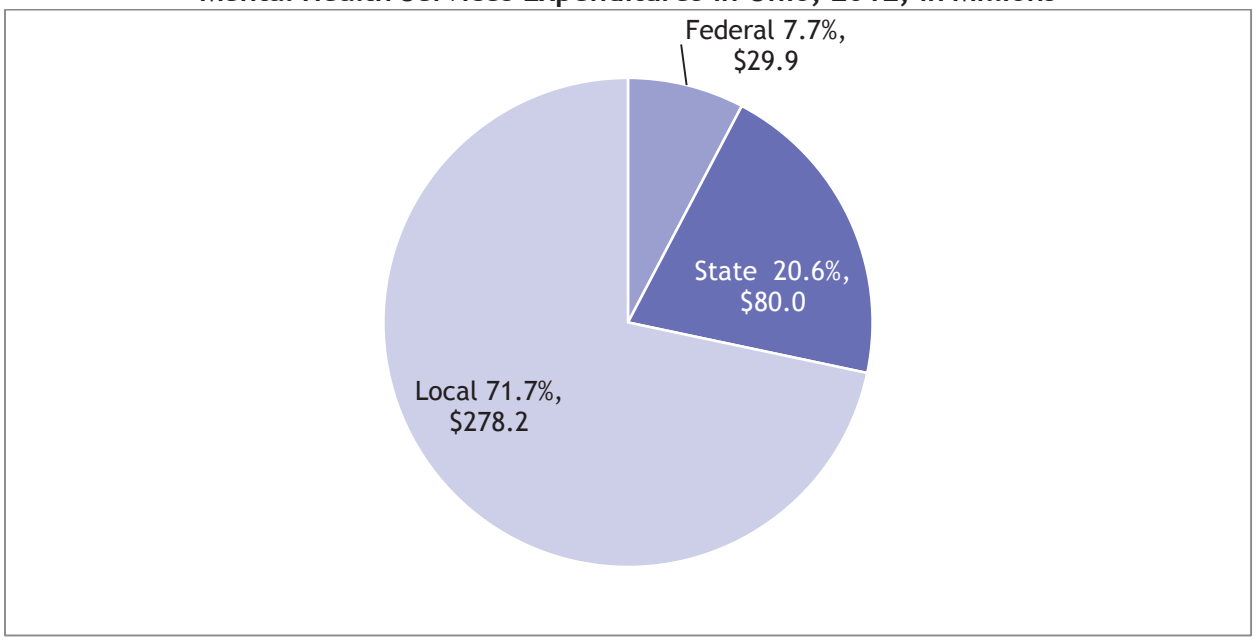
State funding for community treatment and related services was decimated in the 2010-2011 biennium, but the funding picture has shifted in recent years. In the 2012-2013 budget, the responsibility of making the nonfederal share of Medicaid payments for covered mental health services was "elevated" from 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--if the state dollars did not cover the full amount--to fund the nonfederal portion of Medicaid. In FY 2013, the state took over this responsibility completely, which freed up local levy dollars to be used to fill gaps and cover services that are not covered by Medicaid (non-Medicaid services).

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 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.[11]

Figure 7 shows the sources of mental health services expenditures in 2012. (It does not include addiction because it is prior to departmental merger.) It is clear that local funding, through the county board system, plays an important role in financing mental health services.

Figure 7

Mental Health Services Expenditures in Ohio, 2012, in Millions



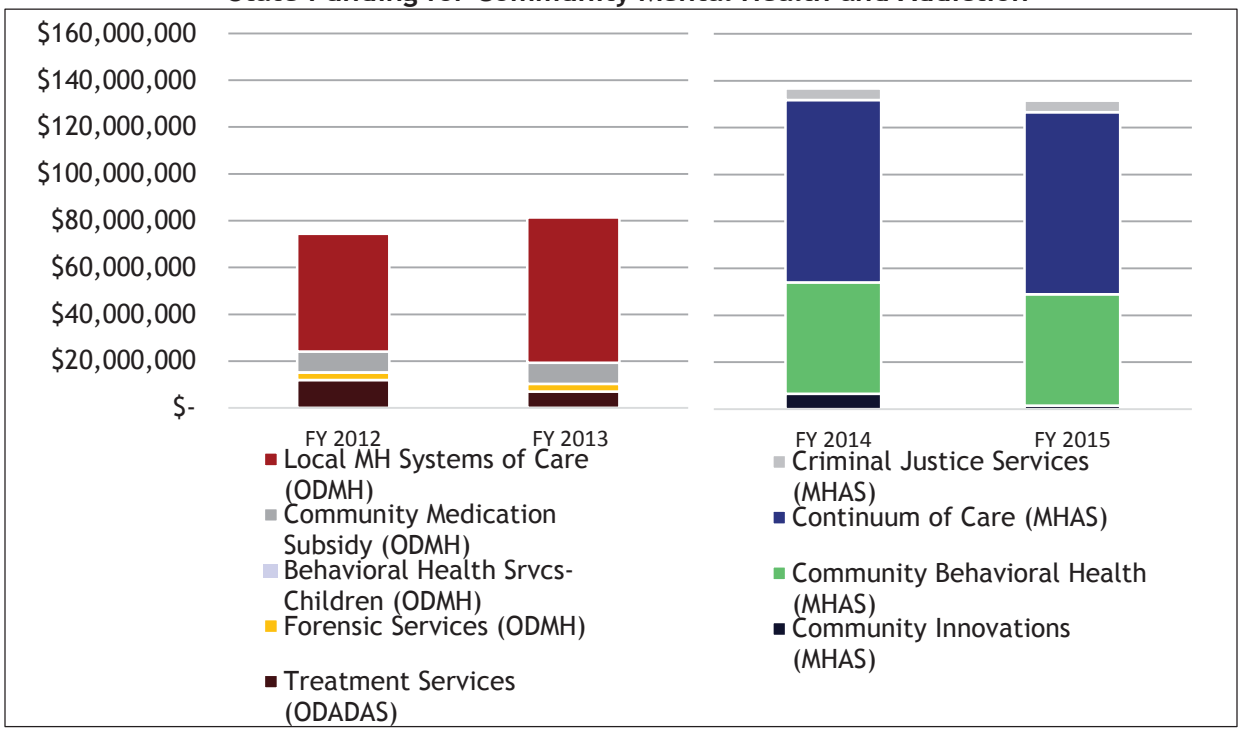
Source: Ohio Department of Mental Health and Addiction Services, Final Board Annual Report, 2012
Does not include Medicaid spending, does not include addiction spending

In 2012, the portion of Medicaid matching dollars provided by the state to the local boards was separated into its own line item in anticipation of "elevating" the Medicaid match to the state in 2013. This allowed for a clearer picture of state funding of community behavioral health. Figure 8 shows the amount of state funding dedicated to community behavioral health, not including Medicaid match. To be consistent, community behavioral health spending is tracked in both ODADAS and ODMH in 2012 and 2013, and then the merged MHAS in 2014 and 2015. This figure follows the same "pots" of money from the separate into the merged agencies, except for the new $47.5 million Community Behavioral Health line item that was added to the budget in an attempt to make up for the removal of the Medicaid expansion (which was later approved via the State Controlling Board).

Line items were restructured to account for all of the services previously provided by both agencies. The GRF line items previously included in the ODADAS budget were collapsed into either existing line items in the ODMH budget or newly created MHAS line items. MHAS Continuum of Care is comprised of funding from former ODMH and ODADAS line items that provided the majority of the funding that is distributed to local boards.

Figure 8

State Funding for Community Mental Health and Addiction



Source: LSC 2014-2015 Budget in Detail
Does not include all sources of state funding, only those determined to be community behavioral health
Does not include Medicaid funding

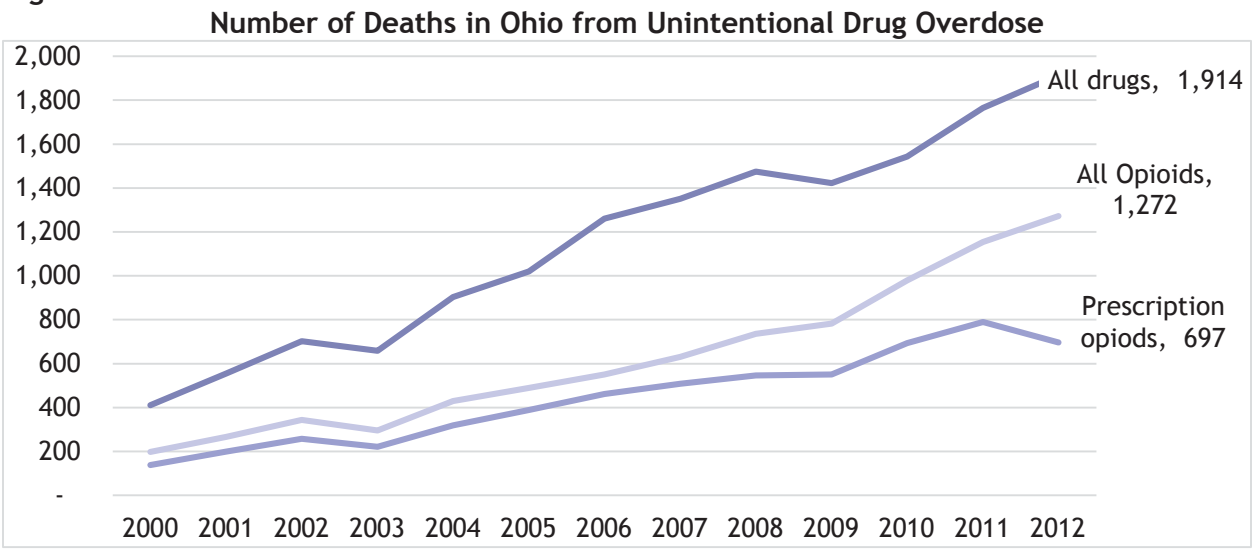
With the rollout of expanded health coverage under the Affordable Care Act through private insurance plans and Medicaid, treatment needs associated with mental health and addiction issues will be covered for more people than ever before. Expanded coverage will eventually allow state and local funds to be freed up to support maintaining recovery in the community, otherwise known as supportive or wraparound services. These services include housing, employment, transportation, and education, among others, that are funded by a mix of local levy and state dollars and are not covered under the state's Medicaid program or by private insurance plans. In SFY 2011, $138.3 million was spent on these services by 46 of the 50 mental health boards in the state.[12]It is expected that more of the local boards' funding will be dedicated to wraparound services in the future as people will be able to access treatment with other payer sources under health care reform.

Impact of Opioid Addiction

A major challenge facing MHAS and the local system of alcohol and drug addiction and mental health boards is opioid addiction. More than a quarter of ODADAS clients had an opiate diagnosis in 2012.[13] As seen in Figure 9, accidental drug overdoses more than quadrupled between 2000 and 2012. Opioids are a growing component in these deaths. In 2000, 48 percent involved opioids. That percentage rose to 66 percent by 2012. Deaths involving prescription opioids decreased for the first time in 2012. This corresponds to the implementation of House Bill 93 (129th General Assembly) in 2011, which shut down "pill mills" by tightening the

regulation on prescribing practices of pain medications. Deaths involving all opioids continued to grow that year, however, indicating an apparent shift from prescription opioids to heroin.

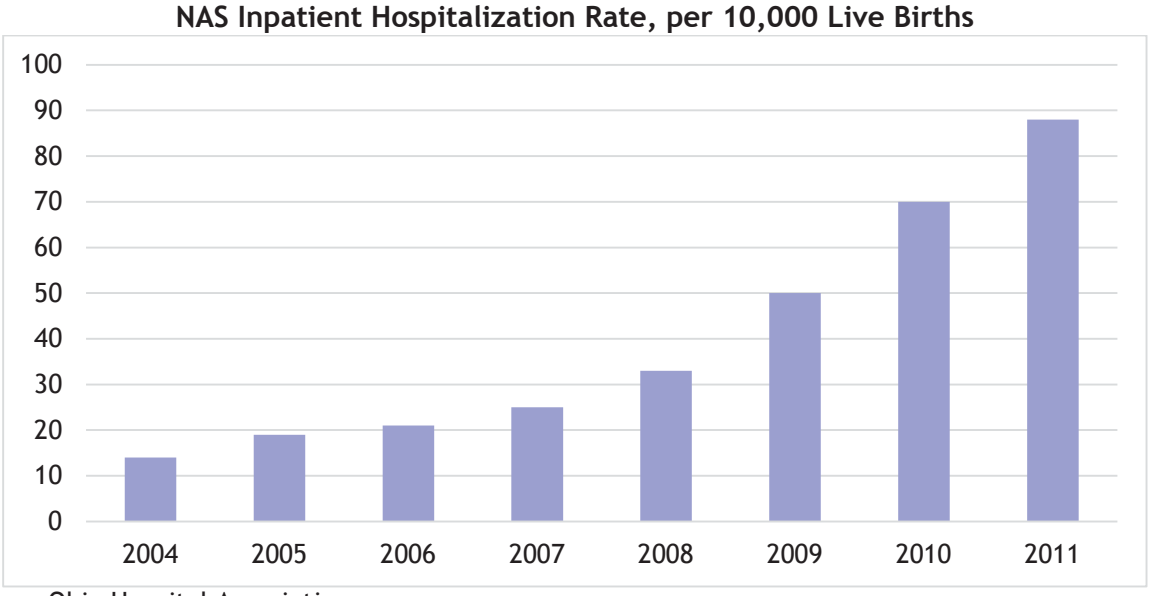
Figure 9



Note: More than one drug is usually involved in a single death.
Source: ODH Office of Vital Statistics

Rising opiate abuse also harms the younger generation. Neonatal Abstinence Syndrome (NAS) occurs when a child who is prenatally exposed to opioids experiences withdrawal upon birth. Hospitalization rates for NAS in 2011 were more than six times greater than in 2004, increasing from 14 to 88 hospitalizations per 10,000 live births (Figure 10). House Bill 315, signed by the governor in April, 2014, will require hospitals to report incidences of NAS to the Ohio Department of Health.

Figure 10



Source: Ohio Hospital Association

Developmental Disabilities

The Ohio Department of Developmental Disabilities supports long-term care programs for individuals with developmental disabilities. The department's total budget is over $2.5 billion per year, with nearly 60 percent of the resources coming from federal Medicaid match.[14] Services are coordinated by a county board system similar to that of behavioral health. The system is confronted with a challenge of deinstitutionalization driven in part by the U.S. Supreme Court *Olmstead* decision, an Ohio-specific legal settlement (*Martin* settlement), and the need to lower costs. The number of residents in state developmental centers has been declining steadily, and funding for these centers and the more numerous Intermediate Care Facilities (ICFs) is flat-lined in FY 2014-2015.

The budget calls for the number of residents receiving care from community-based Medicaid waivers to grow by nearly 6,000 individuals (18 percent) from FY 2013 to FY 2015. County boards are expected to provide resources to help meet Medicaid match. The budget anticipated that county levies would provide $336 million for this purpose in FY 2015.

Despite rapid growth in waiver capacity, there is insufficient financial capacity to meet demand, so county boards must keep waiting lists for services. Statewide, there were 41,260 individuals on waiting lists as of June, 2013.[15] According to a 2014 survey, the median waiting time for people on the list was more than six years.[16] Nearly half of these individuals did not have a current unmet need, indicating that many had signed up in anticipation of future needs. Still, meeting current needs would require an estimated 19,000 individual waiver slots at an expected nonfederal cost of $282 million annually.[17]

State policy traditionally has emphasized employment in sheltered workshops for individuals with developmental disabilities. In 2010, just 22 percent of individuals using ODDD employment services were placed in integrated community settings.[18] This policy was changed in 2012.[19] Under the change, service providers and state agencies will presume that individuals with disabilities are capable of community employment in integrated settings with non-disabled workers. The ODDD coordinates the policies of other state agencies to reach this objective. The budget continues the Medicaid "Buy-in" program for workers with disabilities to support this change.

The Temporary Assistance for Needy Families (TANF) Budget

Under federal welfare reform, the federal government provides a block grant to the states to fund TANF programs. Ohio's TANF cash assistance program is Ohio Works First (OWF). States are required to provide annual funding amounts to meet a required "maintenance of effort" (MOE) level. Regular federal TANF funds to Ohio are about $730 million per year, and the state MOE is about $390 million, so that the annual OWF budget is generally about $1.1 billion. The federal Recovery Act provided some temporary, emergency funding between 2009 and 2011, which was used for cash assistance and for a youth summer jobs program. The state meets part of the MOE requirement by counting GRF funds used for child care services. Also included in MOE are donations to food banks and child support payments intended for OWF recipients.

States have considerable discretion in managing and designing their TANF programs, as long as they meet one of the four purposes of TANF. These purposes are:

- assisting needy families so that children can be cared for in their own homes;
- reducing the dependency of needy parents by promoting job preparation, work, and marriage;
- preventing out-of-wedlock pregnancies; and
- encouraging the formation and maintenance of two-parent families.[20]

Ohio Works First is administered by county job and family service departments. The state sets the income eligibility limit for OWF at a very low level, just 50 percent of the poverty line. Only families with children are eligible. Most cases are "child only" in which the child is living with a grandparent or other relative. The maximum monthly benefit for an individual is $273; for a family of three, it is $458. The average monthly benefit, per person, is $182. This is considerably less than working 30 hours per week at Ohio's minimum wage rate of $7.95 per hour (120 hours per month at $7.95 is $954 per month).

Cash assistance is not the only purpose for which TANF funds are used. Federal welfare reform laws envisioned states providing an array of work support services to help recipients find jobs and keep them employed. Over the first decade of the program, OWF caseloads declined, but the state did not make a concerted effort to spend all of its federal TANF grant funds. By 2006, surplus funds grew to over $1 billion. Spending levels increased under the administration of former Governor Ted Strickland, however, as the state embarked on a major expansion of funding for child care--a critical support for low-income parents--and designated other funds for special initiatives. Base funding for child care came from the federal child care development funds and associated state match.

Unfortunately, the increased spending effort coincided with the recession, which increased cash assistance caseloads and decreased GRF resources. Despite the increasing hardship of many Ohioans, OWF–supported programs have been forced to compete with each other for a diminishing pool of resources. Prevention, Retention, and Contingency (PRC) programs are a critical part of Ohio's safety net and provide short-term, non-cash assistance to families in need. The PRC component of OWF provides support services that assist people in the program to work. Programs and eligibility varies by county in response to local need and philosophy and are limited by available resources. Counties use PRC in two ways: (1) to help families on cash assistance meet their requirements for self-sufficiency, and (2) to stabilize needy families who are at risk of needing the cash assistance program. These services range from training to transportation, but they are not sufficiently or consistently provided across Ohio's counties.

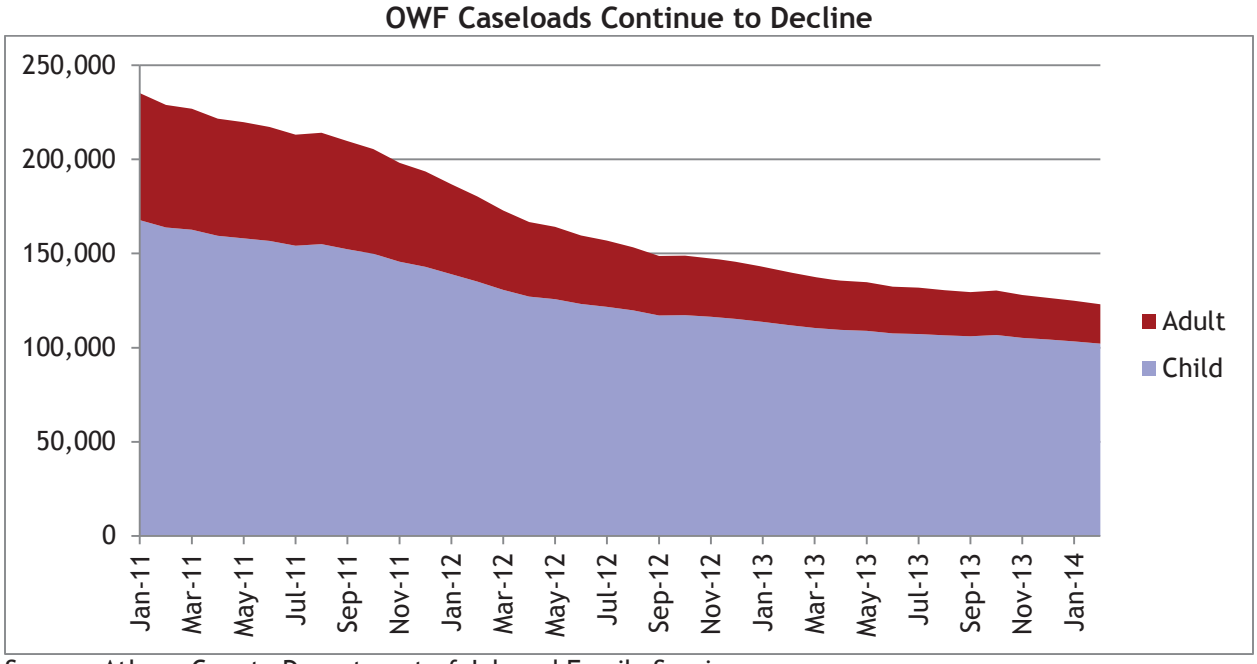
From 2008 to 2011, funding for PRC programs in Ohio dropped by 65 percent, from $327.6 million to $113.9 million.[21] These cuts occurred when the recession was at its worst. They continued from FY 2011 to FY 2012. Overall, from FY 2008 to the projected amount for FY 2013, funding was cut by 83 percent. Annual funding for PRC services is set to increase from $55.1

million in FY 2013 to $97.1 million in FY 2014, which is encouraging, but it is still less than one-third of its FY 2008 level.

TANF funds can be spent on programs and services other than cash assistance and PRC. The largest portion of Ohio's TANF budget is dedicated to funding child care. Nearly 36 percent, or $426.7 million, of the SFY 2014 TANF budget was dedicated to funding child care, more than the amount that goes toward cash assistance ($303.1 million). This amount increases to $446 million in SFY 2015. A significant portion ($72.8 million in SFY 2014) of the TANF budget is transferred to Ohio's share of the federal Title XX program (Social Security Block Grant), which is a source of flexible funding for human services that counties can utilize.[22]

Since early-2011, state TANF cash assistance policy has focused on one goal: meeting federal work requirements. Federal policy requires that 90 percent of two-parent families and 50 percent of one-parent families receiving cash assistance work 30 hours per week. A limited number of training or other job readiness activities may count toward this total, but federal rule changes severely limited educational options.

Figure 11



Source: Athens County Department of Job and Family Services

Ohio had not met this work requirement for years. By 2011, potential penalties accumulated to $135 million. The federal government refused the Kasich administration's request for a waiver in 2011. Since 2011, there has been a single-minded focus on meeting the work requirement without providing sufficient resources to clients for transportation or other work supports. This has led to a drastic decline in OWF caseloads, especially for adults. The caseload is now almost 72 percent child-only cases, which means that for the most part, a child is living with someone other than his or her parent. There is no work requirement for child-only cases. There are now

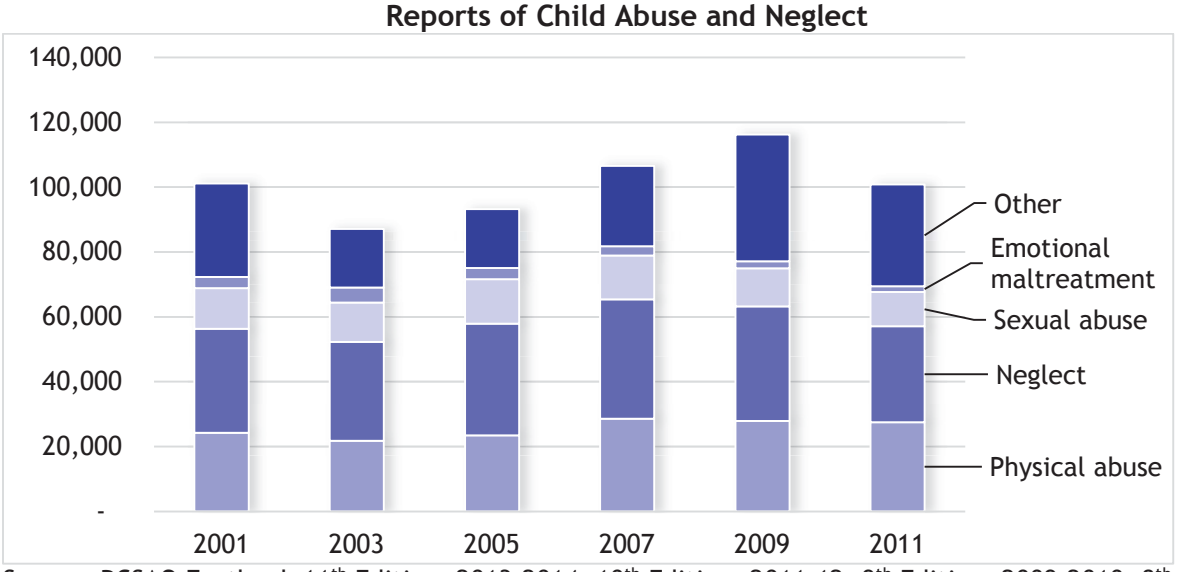
fewer than 124,000 total people served by the program, which includes fewer than 21,000 adults. Overall participation has fallen by 112,000 people, or 48 percent, over the more than three-year period depicted in Figure 11. The caseload decline has eased pressure on the TANF budget and should give the state an opportunity to boost benefit levels or reinvest in efforts to increase employment and training opportunities for Ohio's poorest families.

Public Children Services Agencies

Public Children Services Agencies (PCSAs) are responsible for child welfare, including child protective services, foster care, and kinship care. Each of Ohio's 88 counties is served by a PCSA; for 63 counties, these are located within county departments of job and family services, and 25 counties have separate children service boards. There are five counties whose PCSAs are within merged departments of job and family services which cover two or more counties.

In 2011, PCSAs investigated a combined 101,000 reports of abuse and neglect across the state, as seen in Figure 12. The Ohio Department of Job and Family Services provides support to PCSAs at the state level. Differential Response is a program which creates two pathways for the PCSA to respond to reports of abuse and neglect, depending on the safety of the child. The Department of Job and Family Services was directed to plan the expansion of the Differential Response program statewide by the 129th General Assembly in House Bill 153. The program has been expanding in the remaining counties since then, with the full implementation to be complete by June, 2014.[23]

Figure 12



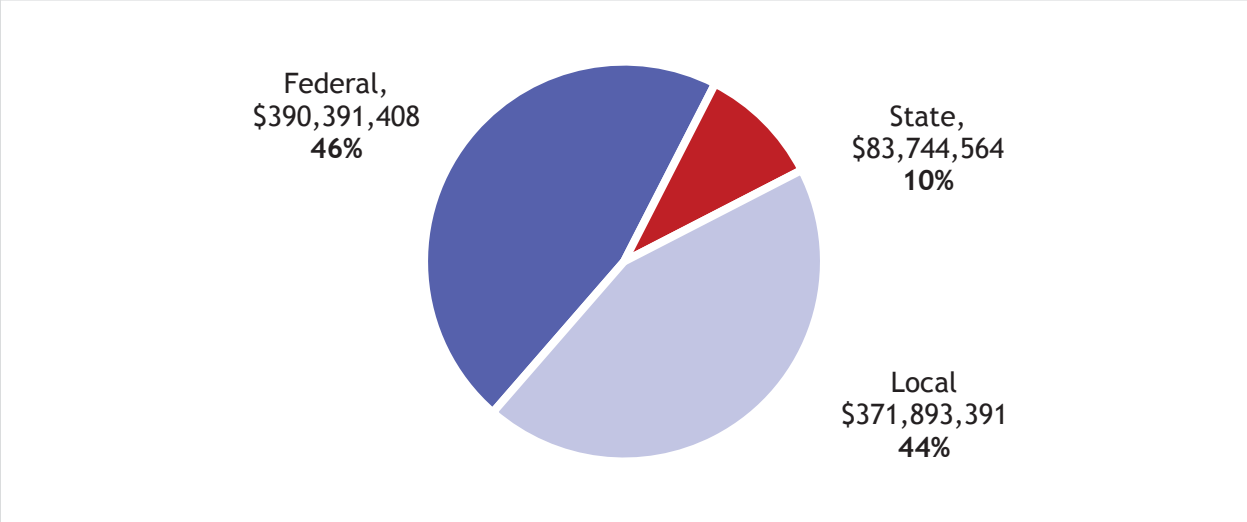
Source: PCSAO Factbook 11th Edition, 2013-2014; 10th Edition, 2011-12; 9th Edition, 2009-2010; 8th Edition, 2007-2008; 7th Edition, 2005-2006; 6th Edition, 2003-2004.

PCSAs are funded through a combination of federal, state, and local dollars (Figure 13). In 2011, state sources accounted for only 10 percent of expenditures by PCSAs.[24] State dollars are distributed to PCSAs from several line items within the ODJFS budget to fund various functions. The Children and Families Services line item through ODJFS is used to fund several

programs, among them the state allocation to PCSAs. In FY 2012, this line item was funded for a total of $51.1 million. In FY 2014, this amount is $54.3 million, a 6 percent increase in funding.[25] The state relies on the local PCSAs to provide the matching funds for federal foster care payments and adoption subsidies through the state allocation to the PCSAs or through local funding.[26]

Figure 13

Public Children Services Expenditures for FY 2011



Source: PCSAO Factbook, 11th Edition 2013-2014

Primary and Secondary Education

Education spending has always been at the center of budget discussions in Ohio. Over the past two decades, issues regarding the adequacy of funding and the overreliance on local property taxes to support schools have been central to this debate. Variations in local wealth and willingness to raise local taxes have led to disparities in educational opportunities across the state. In its landmark 1997 *DeRolph v. Ohio* decision, the Ohio Supreme Court ruled in favor of a coalition of 500 low-wealth school districts, finding the state's public education funding system to be unconstitutional. While the Court subsequently released jurisdiction of the *DeRolph* case in 2002 citing good faith progress by the state, many critics maintain that Ohio's educational system remains unconstitutional.

At the same time, educational policy in Ohio and across the nation began to follow a new paradigm. State policymakers have sought to improve the educational system through standards-based reform with progress measured through student testing and other metrics.

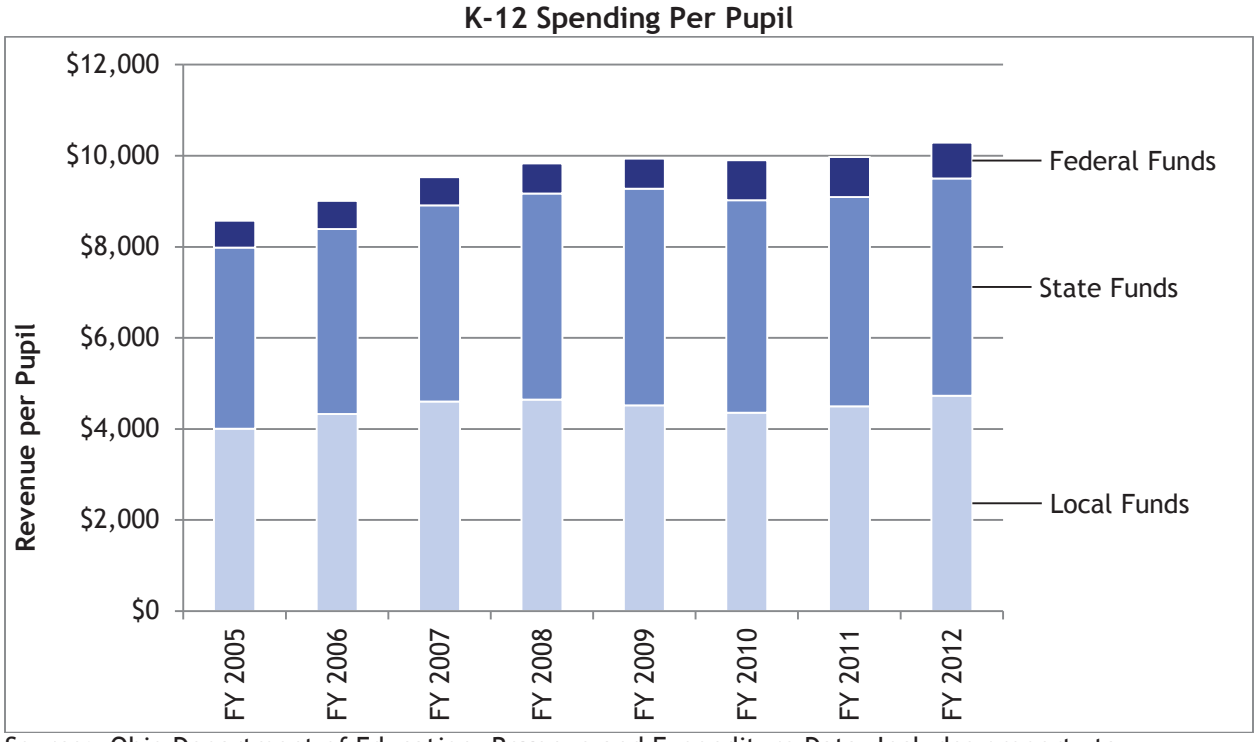
Today, Ohio's primary and secondary education system serves a diverse population of 1.75 million children in kindergarten through 12th grade. Forty-three percent of these children are economically disadvantaged, 13 percent are disabled, and 2 percent are limited in English proficiency. They are served by 614 public school districts with 3,615 public schools. The system also encompasses 49 joint vocational districts, 72 career centers, 755 nonpublic

community schools (commonly called "charters"), 385 non-chartered, nonpublic schools, and 56 educational service centers.[27]

FY 2014-2015 Education Funding

Ohio schools receive funding from a combination of state, local, and federal sources. Average per pupil spending from all sources exceeded $10,000 for the first time in FY 2012 (Figure 14).

Figure 14



Source: Ohio Department of Education, Revenue and Expenditure Data. Includes property tax allocation.
* 2010, 2011, & 2012 data exclude the school districts on Lake Erie islands.

Most state funding comes through the school foundation formula in the Ohio Department of Education (ODE) budget, which receives both GRF funds and lottery profits. The foundation allocation from each source varies by district based on characteristics of the student population and the district.

The FY 2014-2015 budget provided the first significant boost in primary and secondary education funding in several biennia. Total funding for primary and secondary education from the GRF and lottery profits is increased by 6.8 percent in FY 2014 over FY 2013, and by an additional 6.2 percent in FY 2015. Funding from these sources in FY 2015 will be 13.3 percent higher than in FY 2013. Foundation funding through these sources is increased by 4.8 percent in FY 2014 over FY 2013, and by an additional 6.4 percent in FY 2015. Foundation funding in FY 2015 is fully 11 percent higher than the FY 2013 support level.

While indeed notable, the FY 2014-2015 funding increases are provided over a funding base that had been significantly diminished in recent years. Nevertheless, in FY 2015, total K-12 education spending through the GRF and lottery profits will total $9.4 billion. Of this amount, $7.0 billion will come through the foundation formula. Primary and secondary education is the greatest area of state investment when only the state share of the GRF is considered, accounting for 41 percent of state share GRF.

Base funding provided through the foundation formula had not changed since FY 2009, until the adoption of the new school funding plan for the FY 2014-2015 biennium. Per pupil base funding was increased from $5,732 to $5,745 in FY 2014 and $5,800 in FY 2015. However, the "hold harmless" guarantee was maintained for districts that would lose funds under the formula changes. Moreover, annual funding growth was restricted to 6.25 percent in FY 2014 and 10.5 percent in FY 2015. These artificial limits greatly minimized the impact of any formula or funding change. The guarantee impacts 191 school districts in FY 2014 and 177 districts in FY 2015, while the limit on funding growth, or "gain cap," impacts 342 or over half of all the districts in FY 2014 and 242 districts in FY 2015.[28]

The budget also included a $250 million initiative to provide school districts with implementation grants for creative and transformational instructional practices. Patterned after the successful Third Frontier Program, grants funded through the lottery profits supported Straight A Fund are intended to be self-sustaining once start-up funding is exhausted. The item is funded at $100 million in FY 2014 and $150 million in FY 2015.

In addition, early childhood programs were provided $78.6 million to serve families with children older than three but not yet eligible for kindergarten and with household incomes below 200 percent of the federal poverty level.

Finally, community schools were appropriated $57 million more than they received in the prior school year. Community schools, referred to as charter schools in other states, are independent public schools operated by a sponsor on a contractual basis. Low-performing community schools will receive an additional $479 per pupil, while community schools rated "Excellent" or higher will receive an average increase of only $83 per pupil.

Community schools have experienced the same difficulties serving low-income or disadvantaged students as traditional public schools. Table 2 summarizes the rankings of the 258 charter schools listed on the Performance Index rankings.[29] Not all charters are rated. The majority of charter schools overall received a grade of D or F. By law, charter schools can only be located in low-performing school districts – large urban districts and districts in states of academic emergency or academic watch. These school districts, served by both public and charter schools, tend to have poorer, disadvantaged students. Also, the public school count excludes the schools in districts currently under investigation by the Department of Education, which may inflate their rankings. In 2013, Auditor of State Yost found nine school districts –

Campbell, Canton, Cincinnati, Cleveland, Columbus, Marion, Northridge, Toledo, and Winton Woods - had manipulated attendance records to artificially inflate their report card rankings.[30]

Table 2

2013 Community vs. Traditional Public School Performance

		Elementary	Middle or Junior High	High School
Community Schools	Number	130	33	93
	Percent with grade of A or B	13%	18%	15%
	Percent with grade of D or F	65%	45%	59%
Public Schools[31]	Number	1,649	609	1,424
	Percent with grade of A or B	59%	66%	68%
	Percent with grade of D or F	17%	6%	4%

Source: Performance Index Score Rankings, Ohio Department of Education

The mid-biennium budget is attempting to address quality issues with charter schools. Provisions include withholding state payments to new charter schools for a year in order to make sure they meet certain requirements. It also prohibits a permanently closed charter school from simply reopening under a different name.

Education Privatization

In addition to community schools, Ohio provides qualifying students with publicly funded vouchers for private school tuition. Ohio is among 12 states, and the District of Columbia, that support nonpublic chartered schools. With the addition of the income-eligibility component of the EdChoice scholarship program in the enacted budget, Ohio has no fewer than five separate school voucher programs, more than in any other state.[32]

The oldest existing school choice program, the Cleveland Scholarship and Tutoring Program, was created in 1995. New scholarship programs were added for students with autism and special-needs students, the Jon Peterson Special Needs Scholarship Program, in 2003 and 2011, respectively. The largest such program to date, the Educational Choice Scholarship Program, or EdChoice, was created in 2005. It is available to students outside the Cleveland City School District whose local public school was ranked low-performing for two of the last three years. Together, the four programs enrolled 26,272 students during the 2012-2013 school year. While significant, utilization fell far short of the 60,000 scholarships that were available.

The most significant educational policy changes in the FY 2014-2015 budget resided in the area of school choice. A new component of EdChoice for families with incomes less than 200 percent of the federal poverty level, or $46,400 for a family of four, was created in the FY 2014-2015 budget. This eligibility is not dependent on the quality of the traditional public school that the student would otherwise attend. Once qualifying, students will remain eligible to receive a

voucher even if their family income surpasses this threshold, provided that it does not exceed 400 percent of the poverty level, or $95,400 for a family of four in 2014. The scholarship will be limited to 2,000 kindergartners during the 2013-2014 school year and to 4,000 kindergartners and first graders during the 2014-2015 school year, regardless of the academic performance of their local public schools. One additional grade level will be added each year.

While initially limited to 2,000 students in the 2013-2014 school year and 4,000 the following school year, approximately 60,000 kindergartners and an equal number of first graders potentially qualify for the new means-tested component of EdChoice. The expanded program will attract some students who would have otherwise attended nonpublic schools using private funds without the EdChoice scholarship, thereby increasing state enrollments and costs. The new income-based voucher program is also significant in that it fundamentally changes the historic purpose of the program. It extends scholarships for the first time to students without disabilities, even if they reside in communities with high-performing public schools.

An additional category of students will qualify for EdChoice scholarships beginning with the 2016-2017 school year. Students in kindergarten through third grade will become eligible to receive a scholarship if enrolled in a school district receiving a grade of "D" or "F" in making progress in improving K-3 literacy in two of the previous three state report cards.

The EdChoice program continues to expand at a pace faster than demand would seem to warrant. Less than one third of available EdChoice vouchers will be used this academic year.[33]

Higher Education

As one of the largest comprehensive systems of public higher education in the nation, the University System of Ohio is comprised of 14 main university campuses with 24 regional, or branch campuses, and 23 community colleges. The system also encompasses over 120 adult workforce education and training centers, including both Ohio Technical Centers and Adult Basic Education and Literacy Education (ABLE) programs. These public higher education institutions and adult education programs serve almost 600,000 students, offering every option from the GED to a Ph.D.[34] Nearly 200,000 additional students are served by either nonprofit or for-profit private higher education institutions. While system enrollments have declined in recent years since peaking in 2010, they remain 10.4 percent larger than a decade ago. Community college enrollments rose significantly faster than university enrollments between 2003 and 2010, but have also fallen more precipitously over the last few years (Table 3). All sectors of higher education are impacted by changing demographics, but community college enrollments are much more sensitive to prevailing economic trends.

Ohio has historically lagged the nation in college degree attainment. This educational attainment gap becomes more problematic as Ohio and the nation move increasingly into an information and service economy. In 2011, just 35.5 percent of Ohio's workforce between 25 and 64 years of age had an associate degree or higher, compared with 38.7 percent for the nation; and 26.6 percent of Ohioans had a bachelor's degree or higher, compared with 30.1 percent for

the nation. Ohio ranked 30th in the nation in the percent of its population with an associate degree or higher. It ranked even lower, 33rd in the nation, in its population attaining at least a bachelor's degree. Ohio ranks in the top half of states in graduate or professional degree attainment, residing in 19th place among the states, but still falls below the national average in this measure.

Table 3

Changing Higher Education Enrollment Patterns

Type of Institution	2003	2010	2013
University Main and Regional Campuses	297,333	338,300	330,041
Community Colleges	165,530	211,260	180,866
University System of Ohio Total	**462,863**	**549,560**	**510,907**

Source: Ohio Board of Regents, Headcount Enrollment by Institution, 2013.[35]

It is encouraging that Ohio fares better when looking only at its emerging workforce, the population between ages 25 to 34. It ranks 27th in the percent of this population with at least an associate degree, 32nd for a bachelor's degree or higher, and 15th for a graduate or professional degree (Table 4). However, if recent enrollment trends continue, it will almost certainly impact these results in an adverse manner in years to come.

Table 4

Ohio Lags Nation in College Degree Attainment

Ohio's Educational Attainment	Current Workforce			Emerging Workforce		
	Age 25-64			Age 25-34		
	% Degrees at level or higher	Ohio's National Rank	US Average	% Degrees at level or higher	Ohio's National Rank	US Average
Associate Degree	35.5%	30	38.7%	38.6%	27	40.1%
Bachelor's Degree	26.6%	33	30.1%	29.5%	32	31.5%
Graduate Degree	9.7%	19	10.8%	9.1%	15	9.3%

Source: National Center for Higher Education Management Systems, State Profile Report, 2011.

Affordability

Ohio exceeds the national average in student borrowing and debt. The state assists Ohioans in paying for higher education through two major programs supported by GRF dollars, the State Share of Instruction (SSI) and the Ohio College Opportunity Grant (OCOG), the state's need-based financial aid program. Historically, the SSI provided operating subsidies to each public campus under a formula based on enrollment and average cost of instruction, which reduced the amount of tuition students needed to pay to support each institution.

A new funding formula developed for the FY 2014-2015 budget provides rewards to public universities whose students attain degrees and successfully complete their coursework. Since many community college students are more interested in skill acquisition than degree

completion, the formula for these institutions is more varied. It is based on a mix of course completions, completion milestones, and success points, which are indicators of other measures of student achievement. As of FY 2015, enrollments will no longer be part of the funding equation. The new formula will also completely end the stop-loss institutional guarantee in FY 2015, allowing for a greater distribution between campuses based on performance.

The SSI is increased modestly by 2.3 percent in FY 2014 and by an additional 1.6 percent in FY 2015. Despite the increase, SSI funding will actually be $19.9 million less in FY 2014 than it was five years earlier. In FY 2015, funding for the State Share of Instruction will exceed FY 2009 funding for this item, but only by a meager $8.6 million, or 0.5 percent. Even this is quite misleading, however, as two large items, Access Challenge and Success Challenge, have now been rolled into the State Share of Instruction. Since SSI is easily the largest item in the Board of Regents budget, total GRF support for higher education is similarly increased by 1.8 percent in FY 2014 and by an additional 2.1 percent in FY 2015.

The impact of these formula and funding changes will be tempered for students through a 2 percent annual cap on tuition growth. However, the impact will likely be quite significant for some institutions. (On a related issue, the budget creates a new undergraduate tuition guarantee program that would guarantee a cohort of students a set rate for general and instructional fees for four years for participating institutions.) Constrained state funding and tuition caps have forced colleges and universities to manage costs and maintained student affordability through an ever-increasing reliance on adjunct faculty, or in the case of universities, with instruction provided by graduate assistants as well as adjuncts. A full-time professor's salary can average between $72,000 and $160,000 per year, while adjuncts average $25,000 to $27,000 per year and often less.[36] While adjunct faculty can provide valuable real world experience in the classroom, without proper supervision, the results can be uneven to the detriment of both the student and the institution.

Based on financial need, the state provides assistance to students on a sliding scale through the Ohio College Opportunity Grant (OCOG). In the FY 2010-2011 budget, the state drastically reduced GRF funding for OCOG, cutting support from the previous levels by approximately 60 percent. GRF support for OCOG decreased to just under $70 million in FY 2012. It is expected to exceed $90 million in FY 2014, but even at this level, need-based financial aid is about 41 percent of its FY 2008-2009 level.

Most Ohio students receiving need-based state aid also qualify for federal Pell grants that help with tuition. Pell grants, unlike OCOG, can be used for other costs besides tuition and fees, such as living expenses. To manage the deep cut in OCOG funding in FY 2010, the state required students to use Pell grants first for tuition and fees. No one was formally excluded from the program.[37] However, since most community college students have virtually all of their tuition costs covered by Pell grants, it effectively excluded them from receiving OCOG. Students at community colleges are frequently non-traditional students from families with very low incomes, or are adults supporting their own families. Without financial support to cover their

basic living expenses, these students either fall further into debt, or become discouraged altogether and do not enter college.

Table 5

Trends in State Support for Higher Education, in millions

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014 (App.)	FY 2015 (App.)
State Share of Instruction	$1,673	$1,843	$1,698	$1,704	$1,735	$1,750	$1,790	$1,818
Need-Based Financial Aid	$223	$222	$88	$78	$69	$83	$90	$90

Source: Ohio Legislative Service Commission Budget in Detail, HB 59, not including federal stimulus and Office of Budget and Management FY 2014-2015 Operating Budget.

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Adult Corrections

Ohio's adult prison population skyrocketed in the middle part of the last decade, rising 16 percent between 2004 and 2008 to a record high of 51,273 inmates.[39] By comparison, Ohio's adult prison population was only about 14,000 in 1980. Prison population growth was tied to changes in Ohio's sentencing laws that increased penalties for lesser crimes, particularly those that were drug related. By 2009, the prison population exceeded the corrections system capacity by fully 30 percent. Either additional prison beds needed to be added or the number of prisoners had to be reduced.

Spending on prison programs nearly mirrored these trends. The Department of Rehabilitation and Correction (ODRC) budget grew by 18 percent between 2000 and 2008. Spending on state prisons has been among the fastest growing expenditures in state budgets across the nation, according to a report by Pew Charitable Trust, and Ohio has been no exception.[40] By FY 2013, state GRF spending on ODRC programs topped $1.5 billion.

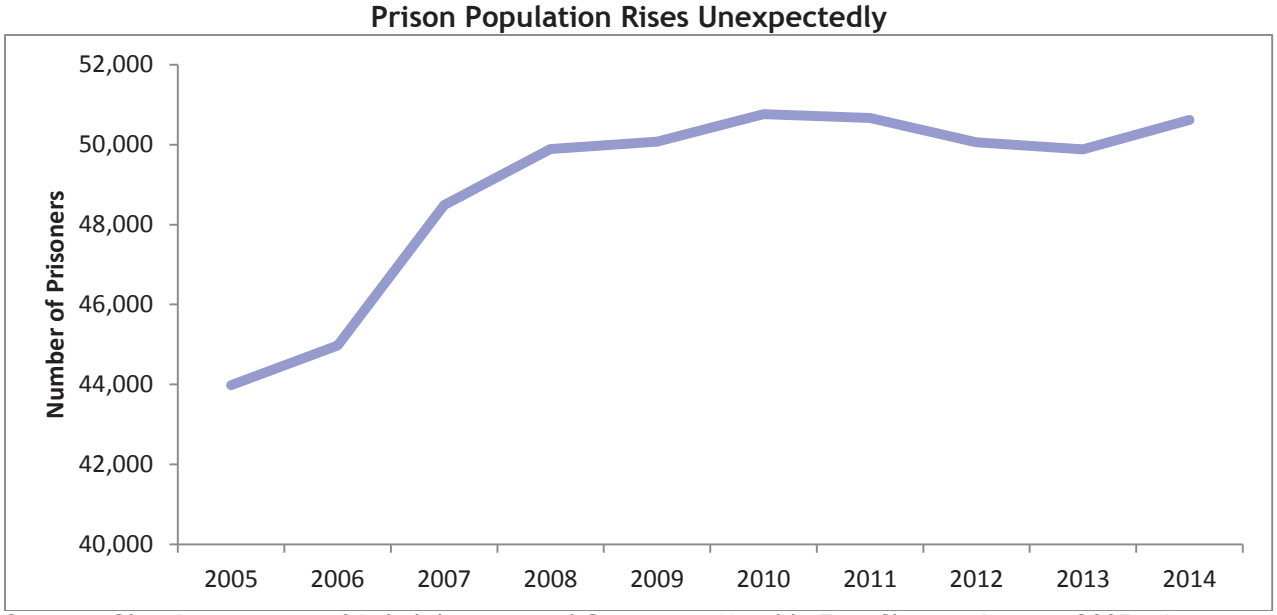
Managing Prison Population and Costs

Research has shown that reducing recidivism, reforming sentencing requirements, and investing in community corrections, can both improve public safety and reduce costs. In 2011, Governor Kasich signed House Bill 86 into law, making major changes to the justice and adult corrections system intended to reverse the growth in the prison population and reduce recidivism. Known as the criminal sentencing reform bill, the legislation was passed with bipartisan support. Among other provisions, the bill:

- diverted some nonviolent offenders into community-based services, such as halfway houses, treatment programs, and community supervision;
- allowed some inmates to reduce their sentences, by 8 percent, with the completion of treatment and/or training programs;
- allowed some inmates to be released early, with court approval, after at least 80 percent of their sentence is served;
- Eliminates distinction between crack cocaine and powder cocaine as it pertains to criminal penalties; and
- increased the monetary threshold for theft and other nonviolent crimes, so that they are misdemeanors.[41]

House Bill 86 was expected to produce a significant net savings of $46.2 million through FY 2015, due to a reduction in the number of inmates.[42] Ohio's prison population did decline by 2 percent, but this was much smaller than the projected 6 percent; the overall trend in the population has continued to move up since a slight dip in 2013. (Figure 15).

Figure 15



Source: Ohio Department of Rehabilitation and Correction Monthly Fact Sheets, January 2005 - January 2014.

Adult corrections expenditures are expected to plateau at $1.5 billion per year in the FY 2014-2015 biennium. Neither sentencing reform nor privatization has produced the savings anticipated to date, although ODRC will continue to privatize food services, laboratory services, and recovery services. What has balanced the books for ODRC has been a significant, if problematic, increase over time in the ratio of corrections staff to inmates. This ratio, which was 5.8 to 1 in 2004, had risen to 7.1 to 1 by 2014.[43] Staff reductions have largely offset increases in prescription drug costs, energy prices, inpatient hospitalization, and improvements in care required in the *Fussell v. Wilkinson*[44] class action lawsuit settlement agreement. The Mid-Biennium Review (130th General Assembly, House Bill 483) includes additional funding over the 2014-2015 biennium for the Department of Rehabilitation and Corrections, the majority of which will go toward increasing staffing levels at prisons around the state.

Ohio's recidivism rate has been on the decline. The percentage of the total number of people released from prison in 2010 who had returned by 2013 was 27.1 percent. Recidivism rates are determined by following the group of people released from prison in a given year and evaluating how many of them returned to prison within the following three years. This three-year period is known as the follow-up period. The percentage of people released in 2009 who had returned to prison by 2012 was 28.7 percent, and of the 2008 group, 31.2 percent had returned during their follow-up period. A decade ago, of the group of people released in 2000, 39 percent of them had returned by 2003.[45]

Conclusion: Looking Forward to the Next Budget

Ohio took advantage of an historic opportunity to expand Medicaid to cover low-income childless adults, but many important challenges remain. In health care, the state's focus must turn to ensuring quality and timeliness of care, and integrating physical and behavioral health. Access to health services remains an issue in many parts of the state; insurance coverage alone does not guarantee that a provider is available.

In social service programs, the state is struggling to ensure that basic needs are being met. Administrative decisions have led to significant reductions in caseloads in the Ohio Works First and SNAP as counties struggle to place low-income recipients in employment and training programs. Important social trends also continue to work against Ohio families, including increased poverty rates and the opiate addiction crisis that is overwhelming the under-funded treatment and recovery systems. The addiction crisis is affecting the child welfare system as some parents are neglecting their children and more babies are born drug-addicted. Behavioral health services continue to be a major area of concern as we look ahead to the next budget.

In education, crucial challenges remain unresolved in reaching low-income students and keeping them in school through graduation. Neither traditional public schools nor charters have shown that they have been able to solve these challenges, and indeed, they may not be able to do so without interventions that tackle poverty. The next frontier for social service programs will be to knit together a fragmented social service system with education and health care to make sure that all of a family's needs are met.

[1] The percentages for Ohio children in poverty were 23.6 in 2012 and 14.1 in 2000, according to U.S. Census statistics. Real household median income is calculated by Community Solutions from Census data.
[2]Governor John R. Kasich Executive Order 2011-02K Creating the Governor's Office of Health Transformation, January 13, 2011.
[3] Health Policy Institute of Ohio Medicaid Basics 2013
[4] *Ibid*.
[5] Ohio Department of Medicaid, Projected Medicaid Services Expenditures SFY 2013-2015
[6] Kaiser Family Foundation, Distribution of Medicaid Spending by Service, available at http://kff.org/medicaid/state-indicator/spending-by-service/
[7] Robert Applebaum, Shahla Mehdizadeh, and Ian M. Nelson, "Delivering Long-Term Services to Ohio Elders: Good Progress, But Challenges Await," Scripps Gerontology Center, Miami University, March 2013, page 2, Figure 4., Percent Distribution of Ohio's Medicaid Long-Term Care Services and Supports Utilization by People Age 60 and Older, 2011.
[8] *Ibid*, p. 39, Fig. 5, "Percent Distribution of Ohio's Long-term Care Services and Supports Utilization by People Under Age 60, 2011."
[9] PASSPORT monthly report, Ohio Department of Aging, December 2013.
[10] Section 323.150 of H.B. 59, 130th G.A.
[11] Consolidation of Ohio Departments of Mental Health and Alcohol and Drug Addiction Services, http://www.adamh.ohio.gov/Portals/0/docs/ODMH%20and%20ODADAS%20Consolidation%20Opportunities%20FINAL_2_1.pdf
[12] 46 of the 50 mental health boards in the state responded to a request for data
[13] Orman Hall, Update on Ohio's Opiate Epidemic, http://www.oacbha.org/docs/Medical_Pre_Conference_-_Orman_Hall.pdf
[14] LSC Greenbook, Ohio Department of Developmental Disabilities.
[15] Barry Jamieson, Timothy Sahr, and Chris Wilks, *What are we waiting for?: Waiver supported services needed by individuals and their caregivers.* Ohio Developmental Disabilities Council and the Ohio Governmental Resource Center, Ohio Colleges of Medicine Government Resource Center. February 2014.
[16] *Ibid.*
[17] *Ibid.*
[18] John Butterworth, et al., *State Data: The National Report on Employment Services and Outcomes, 2011.* Institute for Community Inclusion, University of Massachusetts – Boston. Winter 2012, page 289. Table 5: Intellectual and Developmental Disability (IDD) Agency Outcomes by Employment Settings (Ohio).
[19] Senate Bill 362, 129th G.A. See R.C. 5123.022.
[20] Temporary Assistance for Needy Families (TANF) Overview, www.hhs.gov
[21] TANF Spending Plans
[22] Temporary Assistance for Needy Families (TANF), Executive Budget Submission, SFY 2014-2015. February 6, 2013.
[23] Differential Response Statewide Implementation Schedule, Ohio Department of Job and Family Services
[24] PCSAO Factbook, 11th Edition 2013-2014
[25] LSC Greenbook and Catalogue of Budge Line Items, Ohio Department of Job and Family Services.
[26] LSC Redbook, Department of Job and Family Services, HB 59 of the 130th General Assembly, pp 44 & 50.
[27]Ohio Department of Education Fact s and Figures, Schools and Districts - 2013.
[28] Ohio Education Association Analysis, House Bill 59 (State Budget), June 30, 2013.

[29] Of the 389 charter schools listed on the directory from the Board of Education, 258 were ranked in the Performance Index. Another 86 were dropout recovery schools, which are ranked by different standards. This leaves another 45 unaccounted for in the rankings.
[30] "Ohio Auditor Dave Yost says Cleveland school district missing key attendance data, calls for further investigation," *The Cleveland Plain Dealer*, Feb 11, 2013.
[31] This excludes the school districts currently under review by the Department of Education due to 2011 findings by the Auditor of State.
[32] Catherine Candisky, "Deadline Near to Apply for Vouchers, *The Columbus Dispatch*, July 16, 2013.
[33] Benjamin Lanka, "Voucher Supply Outpaces Demand," *Lancaster Eagle-Gazette*, January 20, 2014.
[34] Ohio Board of Regents, Ohio Campuses, University System of Ohio, 2014.
[35] Preliminary Headcount Enrollment at University System of Ohio Institutions, Fall 2000 to Fall 2011 and Ohio Board of Regents, 15th Day Headcount, Fall Term 2012.
[36] Claudio Sanchez, "Part-time Professors Demand Higher Pay; Will Colleges Listen?," National Publuc Radio, February 3, 2014.
[37] Ohio Board of Regents, Ohio College Opportunity Fact Sheet, 2014.
[38] Ohio Board of Regents, Ohio College Opportunity Fact Sheet, 2014.
[39] Urban Institute and U.S. Department of Justice Bureau of Justice Assistance, *Justice Reinvestment Initiative State Assessment Report*, 2014.
[40] Pew Center on the States, *One in 31: The Long Reach of American Corrections* (Washington, DC: The Pew Charitable Trusts, March 2009).
[41] Legislative Service Commission, Final Analysis, House Bill 86, 129th General Assembly.
[42] *Ibid*.
[43] Ohio Department of Rehabilitation and Correction Monthly Fact Sheets, 2004 - 2014.
[44] The *Fussell v. Wilkinson* lawsuit alleged that Ohio's prisoners were not receiving medical care which violated their rights under the Eighth Amendment to the United States Constitution. As a stipulation of the settlement agreed to in 2005, the state had to improve medical and dental care for inmates including increasing the number of medical professionals on staff at the Department of Rehabilitation and Correction.
[45] Ohio Department of Rehabilitation and Correction, DRC Recidivism Rates Report for CY 2010.

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1501 Euclid Avenue, Suite 310
Cleveland, OH 44115
(216) 781-2944
FAX (216) 781-2988
www.CommunitySolutions.com