CHAPTER 13:

Health and Human Services Funding and Policy

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"The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little."

—President Franklin D. Roosevelt

The beginning of each odd-numbered year in Ohio means everyone dives into the state budget deliberations. During the Kasich Administration, when the governor introduced his budget recommendations at this time, everyone around Capitol Square knew to expect weighty policy and funding proposals. This was no exception in health and human services. This chapter explores the major changes across the Ohio departments of Job and Family Services, Mental Health and Addiction Services, Health, Developmental Disabilities, Aging, and Rehabilitation and Correction starting in 2011 through 2018.

HEALTH AND HUMAN SERVICES MILESTONES OF THE KASICH ADMINISTRATION

2011	2013	2015	2016	2018
• Office of Health Transformation created • Establishment of the Governor's Cabinet Opiate Action Team (GCOAT)	• Merger of the departments of Mental Health and Alcohol and Drug Addiction Services into Department of Mental Health and Addiction Services • Public Health Accreditation requirements	• Increase in Department of Developmental Disabilities (DODD) Waiver Slots	• Comprehensive Case Management and Employment Program	• Behavioral Health Redesign

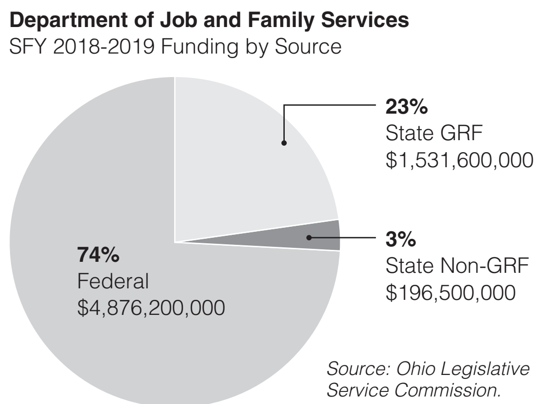
Ohio Department of Job and Family Services

Many of the 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.[2] Ohio

is what is commonly referred to as a "state-supervised, county-administered" system as it relates to health and human services programs. The state supervises and distributes some funds for programs, but the day-to-day operation, administration, and interpretation of the programs happens at the county level through local departments of job and family services and county administration (Board of County Commissioners in most counties). These entities design their own delivery system, ranging from one agency for health and human services at the county level to multiple agencies with jurisdiction over just one program (for example, a standalone child welfare agency).

As can be seen in Figure 13-1, nearly three quarters of ODJFS funding is derived from the federal government.

Figure 13-1: Source of Funding for ODJFS



While many programs are housed within ODJFS, there are several primary programs that this chapter will focus on in terms of funding and people affected during the Kasich Administration. These include the Temporary Assistance for Needy Families (TANF) program, Supplemental Nutrition Assistance Program (SNAP), child care, child welfare (or child protective services), and adult protective services. Additionally, the federal Title XX funding, also known as the Social Services Block Grant, flows primarily through ODJFS and is divided across state agencies and programming. This source of funding is described later in this chapter.

TANF

The Temporary Assistance for Needy Families (TANF) program was created in 1996 in a move to reform welfare at the federal level from the former Aid to Families with Dependent Children (AFDC) program. The change from AFDC to TANF fundamentally changed the safety net and shifted the entire nature of the program. Aid to Dependent Children (ADC) originated in the wake of the Great Depression with the intention of supporting single mothers with cash assistance. There was no requirement in the program to complete work or skills training. In the 1960s, this program evolved to become the Aid to Families with Dependent Children (AFDC) and was expanded to two-parent families with one unemployed or incapacitated parent. The TANF program was created in the mid-1990s as a part of the Personal Responsibility and Work Opportunity Act (PWROA), better known as federal welfare reform. The major changes that PRWOA made included mandatory work requirements and time limits for cash assistance. Under TANF, states' cash-assistance recipients are required to work a set amount of hours per week and at least 50 percent of the total adult caseload must meet the work requirement. TANF also limits enrollment in the program to no more than five years; Ohio has set its time limit at three years. The federal government provides the State of Ohio with a block grant based on funding levels from the time of the program's inception, and in return, the state pays an annual "maintenance of effort" (MOE) set by those initial funding levels. The amount of the block grant has not increased since welfare reform. TANF's statutory purpose is to increase states' flexibility in achieving four goals.[3] The goals of TANF are to:

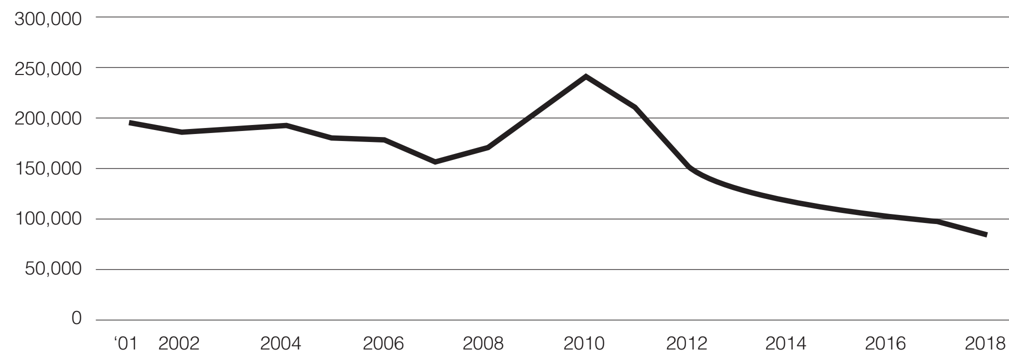
- Provide assistance to needy families so that children can be cared for in their own homes or homes of relatives.
- Reduce the dependency of needy parents by promoting job preparation, work, and marriage.
- Prevent and reduce the incidence of out-of-wedlock pregnancies.
- Encourage the formation and maintenance of two-parent families.[4]

While the first two goals are focused on needy families (that is, income-eligible families), the second two goals have no such limitation and can be achieved through spending on programs that help individuals and families who have higher income.

Cash Assistance

Recent spending in the state's TANF budget has been a frequent focus as it pertains to ODJFS' overall budget. While the annual TANF block grant amount is $727.2 million per year, TANF block grant spending appropriations were $836.4 million for FY 2017 and remained the same for FY 2018, with a 1.5 percent increase in FY 2019 to $848.9 million. This is due to carryover/underspending that is then budgeted into future years. This masks what has been happening with program spending though, because each year these budgeted amounts anticipate spending down all of the dollars, both current and carryover funds. In recent years, that has not happened, and the program is left with significant, accumulated underspending. The projected amount of underspending in FY 2018 is more than $570 million. Part of this overall underspending and inaccurate expectation of spending down funds is due to declining caseloads in a core TANF program, cash assistance, otherwise known as Ohio Works First (OWF). Ohio sets the income eligibility limit for OWF at 50 percent of the federal poverty level (FPL), and only families with children are eligible. Refer to Table 12-1 for more information on federal poverty levels. Federal policy requires 90 percent of two-parent families, and 50 percent of one-parent families, receiving cash assistance work 30 hours per week.[5] In December 2005, ahead of the Great Recession, there were over 180,000 cash assistance recipients.[6] In the middle of the Great Recession (July 2008), there were over 173,000 individuals receiving cash assistance. Nearly 10 years later in April, 2018, this number declined to just over 93,000, the vast majority of the current recipients being children (90 percent), who have no work requirement to meet. Figure 13-2 depicts changes in the OWF caseload since 2001.

Figure 13-2: Ohio Works First Caseload



Source: Ohio Department of Job and Family Services, Public Monthly Assistance Statistics.

Other TANF Funded Programming

Aside from cash assistance, TANF funds are used to support myriad programs that meet one of the purposes of the program listed above. The nature of a block grant is that states do have flexibility in how they spend the program dollars. The majority of Ohio's TANF funds are spent on child care assistance for low-income Ohioans. Additionally, TANF has been used to support programs that address issues faced by this population. Such programs include the Comprehensive Case Management and Employment Program (CCMEP), a key ODJFS initiative of the Kasich Administration.

Comprehensive Case Management and Employment Program

On July 1, 2016, Ohio rolled out its Comprehensive Case Management and Employment Program (CCMEP). CCMEP was enacted as part of the FY 2016–2017 budget and is a program that was established as a collaboration between funds from two federal programs: the Workforce Innovation and Opportunity Act (WIOA) and TANF. CCMEP targets the at-risk population of 14–24 year olds. The increased case management the program offers is intended to be a vital asset to this population in obtaining and maintaining employment. Data that speaks to the results of this program have been mixed and hard to interpret thus far.

SNAP

The Supplemental Nutrition Assistance Program (SNAP), commonly known as food stamps, provides nutrition assistance to nearly 1.4 million eligible, low-income Ohioans and is entirely federally funded.[7] In general, families with incomes at or below 130 percent FPL are eligible for SNAP. SNAP is intended to supplement a family's food budget. During the recession that began in 2007, Ohio, among other states, applied for a waiver of SNAP rules that required able-bodied adults without dependents (ADAWDs) to meet a work requirement. In 2013, as the economy began to improve, the Kasich Administration requested that this waiver be extended only for counties with higher-than-average unemployment. As a result, ABAWDs in the majority of Ohio counties were subject to a work requirement of 20 hours per week after three months of SNAP enrollment. Five years later, partially as a result of this change, there are nearly 370,000 fewer SNAP enrollees.[8]

Child Care

For many families in Ohio on the path to economic stability, child care is a necessity. Publicly funded child care is regulated by ODJFS. Federal and state funding for this purpose also flows through ODJFS. 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 level (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.

Early Childhood Care and Education

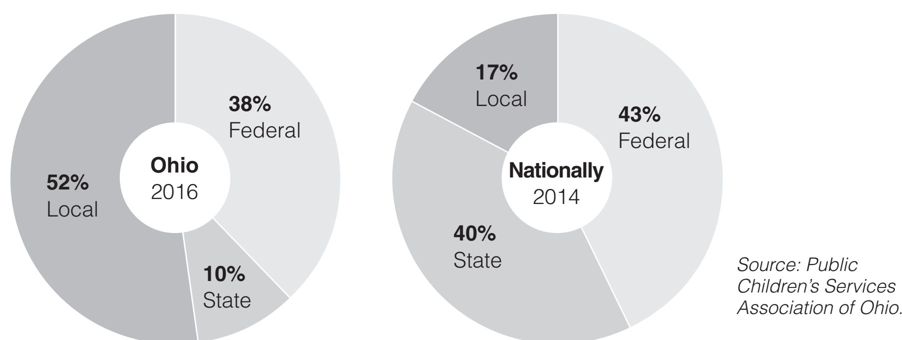
The FY 2016–2017 budget required the Ohio Department of Education, in consultation with the Governor's Early Childhood Education and Development Office and ODJFS, to establish guidelines for the future advancement of Ohio's Early Childhood System. These guidelines include benchmark per-

formance 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. Centers that receive high quality ratings, which are determined by ODJFS and the Ohio Department of Education, may receive more funding to maintain their ratings in the future. Funding for Early Childhood Education programs through the Department of Education tripled during the course of the Kasich Administration as described in Chapter 14.

Child Protective Services

Public children services agencies (PCSAs) are required to investigate every suspected case of child abuse or neglect. This is a role played by local PCSAs across Ohio. In 2016, there were 97,602 cases of abuse and neglect screened in, resulting in 15,561 transferred into ongoing cases.[9] PCSAs are locally governed by the Boards of Commissioners implementing the laws, procedures, and rules, and are governed by the state and federal laws to protect abused and neglected children. PCSAs provide screening and assessment, and whenever possible, supportive services to keep families together. However, if it is determined the safety and health of the child or youth is at risk, then alternative placements must be found with either kinship caregivers or relatives, licensed foster homes, and in some cases, in residential placements. The regulations, and 10 percent of total funding, for child protective services comes from the state. Figure 13-3 depicts the sources of funding for child protective services in Ohio compared to the sources nationally.

Figure 13-3: Sources of Funding for Child Welfare in Ohio vs. Nationally



The opioid epidemic in Ohio has impacted 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 because of a parent or parents' drug addiction, accounting for more than 1,100 children.[10] Primarily as a result of this crisis, the FY 2018–2019 budget included increased funding in the amount of $13.5 million each year, for child welfare.

Foster Care

In 2016, the state expanded foster care and adoption services for individuals up to the age of 21,

rather than the age of 18. The state is working through implementation, and the FY 2018–2019 budget included funding to accommodate this expansion.

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. CDJFS agencies are required under law to investigate and assess all reports of suspected abuse, neglect, and exploitation of adults age 60 and over. The Adult Protective Services line item (600534) within the ODJFS budget is the only dedicated source of state funding for APS in Ohio. It funds a substantial portion of the APS program for many counties in the state, although additional allocations to APS and supportive services can be found in other state agencies and in county levies.

There have been numerous policy changes to APS during the Kasich Administration. Legislative changes in the FY 2016–2017 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. This information system went live in October 2017. As a result of numerous changes in the APS system, a charter was written to create the Ohio APS Advisory Council.[11] The council is organized and operated under ODJFS and is used as a platform to advance better APS practices statewide.

Additional changes included in the FY 2016–2017 state budget required ODJFS to provide training on the implementation of the adult protective services statutes and required 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 49, the FY 2018–2019 state budget, increased APS funding by $100,000 in each fiscal year. This change provided much needed services to counties as they worked to ensure the safety and security of Ohio's aging population. Included in the enacted version of the budget were provisions that codified the Attorney General's Elder Abuse Commission, allowing the commission to continue through changes in administration. Requirements were added for ODJFS to create, and make available, educational materials for individuals within the department and mandated reporters. In total, the key provisions of the bill included:

- Notifies an adult's closest relative of a report in the event of a court order.
- Codifies the Elder Abuse Commission.[12]
- Permits county prosecutors to petition the courts for orders involving APS.
- Requires APS to notify law enforcement if they feel an individual may be criminally exploited.
- Modifies information being released to the state APS information technology (IT) system.
- Exploitation definition change, from "caregiver" to "person."

Social Services Block Grant

The Social Services Block Grant (SSBG) or Title XX, named for the governing section of the Social Security Act, is a source of federal funding that provides states some flexibility in meeting the social service needs of its population and is aimed at five goals:

- To prevent, reduce, or eliminate dependence on public assistance.

- To maintain self-sufficiency once it is achieved.
- To prevent or remedy the neglect, abuse, or exploitation of children and vulnerable adults.
- To reduce inappropriate institutionalization by providing community-based care.
- To provide quality institutional care when other forms of care are insufficient.

The majority of the Ohio's SSBG award, 72.5 percent or $42 million per year, flows through ODJFS. The departments of Developmental Disabilities and Mental Health and Addiction Services receive 14.57 percent and 12.93 percent, respectively. SSBG funds flow through ODJFS to local JFS agencies and are utilized for a variety of programs including child and adult protective services.

On the Horizon

Unemployment Compensation

While solvency of the state's unemployment compensation (UC) system has been a major focus of both the 131st and 132nd General Assembly, interested parties have yet to reach an agreement on how to bring the program into balance. Over the course of the Great Recession, the state relied heavily on loans from the federal government to sustain the unemployment system. Ohio was not alone in this, but Ohio remained in debt to the federal government until 2016.[13] If the state were to face another economic downturn, the UC system would likely face the same issues because the structural underfunding of the state's system has not been addressed.

Multi-System Youth

The Joint Legislative Committee on Multi-System Youth (MSY) was created in the FY 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[14]

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.[15]

While the legislative committee made recommendations, they were not implemented through legislation. These changes were sought during the FY 2018–2019 state budget, but only one major change was made. The budget included an appropriation of $5 million in TANF funding per year for children with complex care needs whose parents or legal guardians are at risk of relinquishing custody solely to obtain access to needed services. State agencies and stakeholders developed a process by which these funds could be expended, but this is only one element of the MSY work. These funds have been restricted to helping families at 200 percent of the federal poverty level and below, which has created a challenge in reaching the families above this threshold who need assistance.

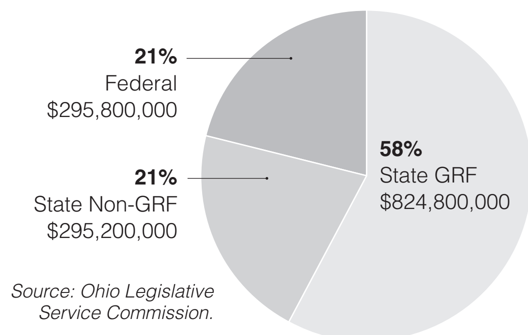
Ohio Department of Mental Health and Addiction Services

The Ohio 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) services board. MHAS oversees the network of 51 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 often 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 in part as a result of the Great Recession, but the funding picture has shifted in recent years. In the FY 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 made by the since-created Ohio Department of Medicaid). 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 13-4 shows that more than half of funding in MHAS is derived from state funding.

Figure 13-4: Source of Funding for MHAS

Department of Mental Health and Addiction Services
SFY 2018-2019 Funding by Source



Source: Ohio Legislative Service Commission.

The fact that Medicaid was elevated to the state-level prior to Medicaid expansion in 2014, as explained in Chapter 12, laid the financing groundwork for increasing access to health coverage for people with behavioral health care needs. 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 non-

Medicaid funding was available. With Medicaid expansion, individuals under 138 percent of the federal poverty level gained access to health coverage, and thus a statewide, uniform payer source for both physical and behavioral health care services was created. 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, such as housing and other recovery supports.

Agency Merger

The FY 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 Ohio 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.

Continuum of Care

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 requirements and establishment of a waiting list for services began in 2017 after revisions to make the policy more workable for providers and ADAMH boards.

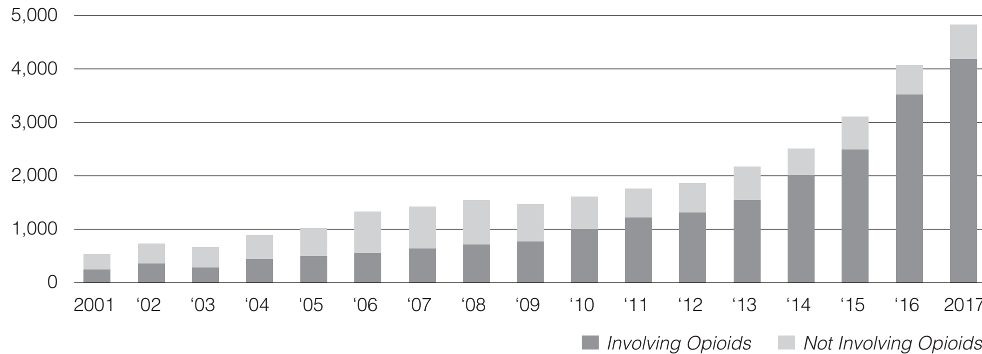
Opioid Crisis

A major challenge facing the state as a whole, but acutely 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 HB 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 in 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.[16] Overdoses involving fentanyl and related drugs increased from 84 in 2013 to 2,357 in 2016.[17]

The Kasich Administration and General Assembly implemented a series of initiatives and 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 just a few.[18] Figure 13-5 shows the increasing rates of overdose deaths that Ohio has been experiencing since the early 2000s.

Figure 13-5: Unintentional Drug Overdose Deaths-Ohio



Source: Ohio Department of Health.

Trauma-Informed Care

The state developed an initiative to expand the use of trauma-informed care across Ohio. Trauma-informed care acknowledges the impact that trauma has on people's lives and how care may need to be tailored as a result. Through six regional collaboratives the state launched this initiative, which has expanded the opportunity for Ohioans to receive trauma-informed care.[19] This effort is done in collaboration with the Ohio Department of Developmental Disabilities.

Recovery Housing and Supports

For the first time in its history, the state dedicated a line item in the MHAS budget to recovery housing in the FY 2016–2017 budget. 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.[20] Funding for recovery housing continued at $1 million in FY 2018 and $2.5 million in FY 2019. 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."[21] This funding was intended to support access to safe, stable housing in communities. Funding has been allocated to recovery housing providers across the state.[22]

MHAS-DRC Partnership

In order to meet the needs of inmates and to reduce recidivism, the Department of Rehabilitation and Correction's (DRC) Bureau of Recovery Services was transferred to MHAS in the FY 2016–2017 budget to provide more addiction treatment services within Ohio's prison system. Before release, eligible inmates enroll in Medicaid and are 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 when judges realized that repeat drug offenders needed treatment rather than time behind bars to recover and reduce recidivism.[23] With the growing impact that drug use is having on the state, drug courts have seen increased attention and resources directed their way. 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 Behavioral Health Redesign (Redesign) is made up of a four-step strategic plan by the state that began in 2012.[24] The Redesign is the process of modernizing the publicly funded behavioral health system. The first phase changed responsibility for the Medicaid match reimbursement for behavioral health treatment services from the local ADAMHS boards to the state. The second phase expanded Medicaid in 2014 to provide coverage to approximately 670,000 low-income adults. Since its inception, 500,000 people in the expansion group have received care for mental health needs, and many have also accessed substance use disorder (SUD) treatment services. Ohio began the third phase, modernization, in January 2018. The key components include:

- Aligning billing codes with the National Correct Coding Initiative
- Re-pricing Medicaid reimbursement rates for treatment services
- Updating the menu of Medicaid-covered services

The final phase, integration, began July 1, 2018. The final phase of Redesign is the integration of behavioral and physical health care. All providers that bill Medicaid must contract with at least one of Ohio's five Medicaid managed care plans for payment of services.

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 Chapter 12 for more information on this topic.

On the Horizon

Addressing the Impact of Mental Illness and Substance Use Disorders

While progress has been made, Ohio is nowhere near out of the woods as it relates to the opioid crisis. And the state is not just dealing with opioids. While opioids have drawn the most attention, issues related to both mental illness and substance use disorders are impacting the state. Ohio has seen increased rates of suicide and overdose deaths involving drugs other than opioids, and alcohol. Since 1999, Ohio's suicide rate has increased 36 percent, according to the U.S. Centers for Disease Control and Prevention. The most recent data on overdose deaths in Ohio shows that deaths involving drugs have increased in nearly every category, except for those resulting from prescription opioids, which have been on the decline since Ohio introduced additional regulations, effectively shutting pill mills and limiting prescription quantities, among other policy changes. Data from the Ohio Department of Health shows that deaths involving alcohol, for example, increased by 42 percent from 2015 to 2016.

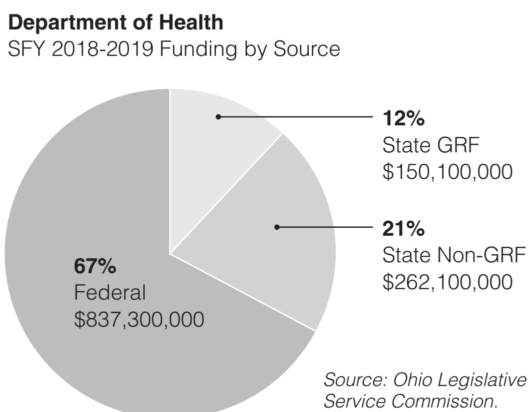
Substance Use Prevention

As the opiate crisis has taken an unrelenting toll on the state, the Kasich Administration and legislators began focusing on going upstream and preventing addiction before it started. Governor Kasich launched Start Talking! to encourage parents and teachers to talk with children about the dangers of drugs, both legal and illegal. The Ohio Attorney General and the 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 continued into the FY 2018–2019 state budget, but there remains a lack of consistency and comprehensiveness as it relates to the provision of prevention services and activities across the state.

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 13-6 shows that the majority of funding through ODH comes from the federal government.

Figure 13-6: Source of Funding for ODH



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, HB 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. This committee was re-established in the FY 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 HB 59 (the state budget bill for FY 2014–2015) that required local health districts (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. Going into the FY 2018–2019 budget deliberations, 14 out of 118 local health departments were accredited.[25]

State Health Assessment and 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.” 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. In early 2017, the state released its SHIP for 2017–2019 and identified maternal and infant health, mental health and addiction, and chronic disease as the priorities. Each priority area has identified outcome objectives and evidence-based strategies. 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. This plan is the lens through which the administration’s health priorities are viewed for the entire FY 2018–2019 budget.

Infant Mortality

Ohio’s infant mortality rate is one of the worst in the nation. Over the last several years, Ohio has committed to broad-based efforts and has dedicated resources to addressing the state’s high rate of infant mortality, which in 2016 was 7.4 infant deaths per 1,000 live births (a total of 1,024 deaths).[26] Ohio has made progress since the beginning of the Kasich Administration, although small increases in the rates have occurred during this time. Governor Kasich highlighted Ohio’s high rate of infant mortality in his first State of the State in 2011 when the rate was 7.9 infant deaths per 1,000 live births.[27] Ohio is still working toward reducing this rate. This rate is significantly worse for African-American babies in Ohio. Infant mortality is defined as the death of a baby before his or her first birthday. Table 13-1 shows the rate of infant mortality, by race and ethnicity, in Ohio from 2014–2016.

Table 13-1: Ohio Infant Mortality Rate (2014–2016), Number of Deaths per 1,000 Live Births

	2014	2015	2016
All Races	6.8	7.2	7.4
Race			
White	5.3	5.5	5.8
African-American	14.3	15.1	15.2
Asian/Pacific Islander	3.6*	3.7*	3.8*
Ethnicity			
Hispanic	6.2	6.0	7.3
Non-Hispanic**	6.9	7.3	7.4

Source: Ohio Department of Health, Bureau of Vital Statistics.

** Rates based on fewer than 20 infant deaths should be interpreted with caution.*

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

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.[28]

SB 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 SB 332 (131st General Assembly).

In the FY 2016–2017 state budget, there were additional initiatives aimed at reducing infant mortality. The ODH director, in coordination with the Ohio Department of Medicaid (ODM), was tasked with identifying the areas of the state with the highest infant mortality rates, referred to as infant mortality "hot spots." These areas were then 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.

Efforts to reduce infant mortality were continued into the FY 2018–2019 budget. Dedicated state funding in ODH's budget was $6.9 million each fiscal year, a $3 million per year increase. This line item was dedicated "to be used to fund a multipronged population health approach to address infant mortality."[29] Funding within the Ohio Department of Medicaid's budget was also dedicated to reducing infant mortality.

Tobacco Cessation

While the smoking rate nationwide continues to decline, Ohio's is frustratingly stagnant. Nationally, the adult smoking rate declined from approximately 16 percent in 2016 to about 14 percent in 2017. Ohio's remained unchanged at 22.5 percent.[30] In Ohio's Medicaid program, 23 percent of adults (19 and over) smoke.[31] Tobacco use is an enormous contributor to acute and chronic disease. The Kasich Administration made investments in tobacco cessation throughout the course of its tenure. In the FY 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 return of dedicated funding.[32] While the 1998 Tobacco Master Settlement had made a major long-term commitment for this purpose, it was undone 10 years later when the revenues were securitized for other purposes. See Chapter 11. This line item was funded at $1.05 million per year in both FY 2014 and FY 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 FY 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.[33] While the revenue from this increase is not entirely directed to tobacco use reduction efforts, increasing the tax can have an impact on consumption.[34]

The FY 2018–2019 budget dedicated $12.5 million per year to tobacco prevention, cessation, and enforcement. These funds support a tobacco Quit Line, counseling services and cessation supplements, community grants, and surveillance and evaluation services. The funds are targeted to the most at-risk populations, youth, minority and regional populations, pregnant women, and others disproportionately impacted by tobacco use.[35]

Syringe Exchange Programs

As the opiate crisis continues to impact Ohio, on many levels, the FY 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 that apply to the establishment of program sites. The provision in the state budget also required 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 provided 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.

On the Horizon

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 is also released annually, and having closer to real-time data may allow prevention, treatment, and enforcement efforts to be more targeted.

Infant Mortality and Maternal Mortality and Morbidity

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, SB 332 (131st General Assembly) 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 that showed that, when given an option of any form of birth control and regardless of cost, women preferred LARC, and that LARC 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.

In the United States, women are dying from complications related to pregnancy and childbirth at a higher rate than other industrialized nations, and the rate is increasing. Approximately 700 women die each year in the U.S., and thousands more experience complications.[36] Non-Hispanic African-American women are dying at a rate three to four times that of non-Hispanic white women.[37] The

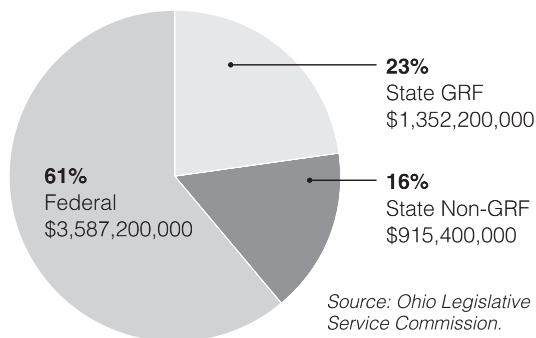
most recent data available shows that between 2008 and 2014, there were 408 pregnancy-associated deaths in Ohio.[38] Severe maternal morbidity is defined as “a physical or psychological condition that either results from, or is aggravated by, pregnancy and has an adverse effect on a woman’s health.”[39] There has been an increase in severe maternal morbidity (SMM) of 75 percent, nationally, over the last decade.[40] In 2014, more than 50,000 women were affected by SMM.[41] In Ohio, the SMM rate per 10,000 deliveries in 2013 was 143.[42] There is a similar racial disparity for SMM, with the incidence in Ohio for Non-Hispanic African-American women at 210 per 10,000 deliveries and 215 per 10,000 deliveries for Hispanic women. Rates for African-American and Hispanic women are around 50 percent higher than the overall rate and around 70 percent higher than the rate for non-Hispanic white women. These are worrisome trends that will need to be addressed by public policy decisions in the future, similar to how there has been a focus on infant mortality.

Integrated HIV Prevention and Care Plan for 2017–2021

The Integrated HIV Prevention and Care Plan was developed in 2016 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. This plan comes at a time when the state is facing additional challenges related to the opioid crisis. The Ohio Department of Health data from 2017 shows that state HIV rates are increasing (in addition to increases in Hepatitis C rates), at least partially driven by the opioid crisis. In 2017, HIV infections associated with injection drug use (IDU) were up for the third straight year in Ohio, and now represent 12 percent of new HIV infections diagnosed each year — compared to 5 percent of new infections just a few years ago.[43] New Hepatitis C infections in Ohio have more than doubled since 2015. Given this startling information and the collaboration happening between HIV treatment and prevention, there may be opportunities ahead to incorporate pieces of the five-year plan to improve HIV and Hepatitis prevention and care moving forward.

Ohio Department of Developmental Disabilities

Figure 13-7: Source of Funding for DODD



The Ohio 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.[44] Figure 13-7 shows that the majority of funding through DODD comes from the federal government.

Many of the department's goals are met through four developmental disability (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 (LV1) Waiver. The Center for Community Solutions examined this system extensively in its report, *Ohio at a Crossroads*. Table 13-2 displays waiver enrollment starting in 2011.

Table 13-2: DODD Waiver Enrollment, 2011–2017

	2011	2012	2013	2014	2015	2016	2017
IO	16,474	16,886	17,347	17,592	17,943	19,145	21,312
LV1	9,942	11,191	12,420	12,998	13,918	14,374	14,584
SELF	0	0	129	224	381	579	1,104
TDD	2,754	3,081	3,026	2,960	2,878	2,004	631
Total	**29,170**	**31,158**	**32,922**	**33,774**	**35,120**	**36,102**	**37,631**

Source: Ohio Department of Developmental Disabilities.

Note: The TDD waiver was administered by Ohio Medicaid before FY 2013.

Table 13-2 shows that since 2011, total waiver average monthly enrollment has 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.

Changes During the Kasich Administration

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. There have been major changes made in the developmental disabilities system.

Waiting List Changes

In recent years, the department has been examining the long-standing waiting list of individuals who are waiting to receive the limited amount of waivers that are available in the state. The Fix the List Initiative has proposed new rules designed to address problems with the Medicaid Waiver Home and Community Based Services (HCBS) Waiting List. These changes will likely lead to a shorter list, which more accurately reflects those currently in need of services. Critics argue the change may create challenges for families seeking to plan for the future and may remove some individuals from the list unnecessarily or without the supports they need.[45] Through the use of surveys and robust stakeholder engagement, the department is evaluating the severity of needs for individuals waiting for a waiver slot. In addition to waiver services, survey data will target services in addition to, or other than a waiver, that an individual may utilize right away.

Move Away from Sheltered Employment

The state has continued to move individuals away from sheltered employment with renewed investment 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[46] 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[47] that ruled against a local board-run employment facility. It was determined that U.S. 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 will likely continue in the next state budget to transition individuals with disabilities into integrated employment.

Increase in State Dollars

With the passing of the FY 2016–2017 budget, 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.

In the FY 2018–2019 state budget, the state continued in these efforts and further increased funding.[48] This increase will account for additional home and community-based waivers for individuals who desire to live and work in the community, in addition to an increase in wages for direct-care staff who play an integral part in making transitions into the community a reality.

Funding through the capital budget[49] has provided additional state investments to be made in housing and rental assistance. The federal government does not allow waivers to cover housing;[50] 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.

On the Horizon

The department will move ahead with the completed and in-progress changes. Transitioning individuals into community-based settings both for employment and residential living will likely continue to be on the radar of both the General Assembly and Governor Mike DeWine.

Transitioning Individuals into Community-based Settings

After the passage of major legislative changes in the Kasich Administration, 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 because of the current

waiver waiting lists and large institutional-based settings known as Intermediate Care Facilities (ICF).

A significant amount of legislative progress has been made, but this progress has 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.

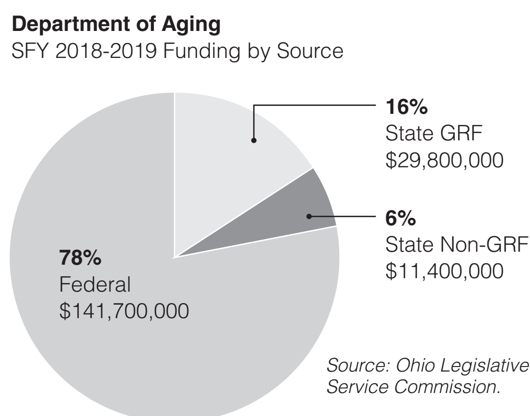
Legislative changes were also made to encourage intermediate care facilities to downsize and more supports to be provided for individuals to leave these types of settings. Language was included to provide individuals with information on options and supports they are eligible for in the community.

Community Employment

Community employment remained a goal for the Kasich Administration, and with the additional federal rules, expanding the Employment First partnership with Opportunities for Ohioans with Disabilities is something that Governor DeWine 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

Figure 13-8: Source of Funding for ODA



The Ohio Department of Aging (ODA) provides funding for home and community-based services that help aging Ohioans remain in their own homes and communities as well as supports 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. Figure 13-8 shows that, by far, the majority of funding for ODA comes from the federal government.

Recent Policy Highlights

As Ohio examines the challenges that come with an increasing aging population, Governor Kasich and the General Assembly looked at ways to improve state policy for older Ohioans. 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.[51] 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.

Community Outreach

Falls are the number one cause of injury that lead to emergency room visits for the elderly in Ohio.[52] 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.[53]

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."[54]

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.

Ombudsman

The Ombudsman program provides advocacy on behalf of residents in home and community-based services and in long-term care such as nursing facilities, residential facilities, and assisted living. Suspected cases of abuse, neglect, or exploitation that occur in these settings are handled through the Ombudsman. The Ombudsman provides these services regardless of the age of the resident. The State Ombudsman coordinates with 12 regional Ombudsman agencies in Ohio. In the FY 2018–2019 biennium, the Ombudsman program was funded at $1.5 million each year.[55]

On the Horizon

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 have been smaller. 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.

In 1965, Congress passed the Older Americans Act (OAA) to help older Americans stay safe and healthy in their homes and communities.[56] Funding through the OAA supports services such as meal delivery, job training, senior centers, support for caregivers, transportation, and public awareness programs. In the FY 2018–2019 biennium, Ohio received about $58.7 million each year and matched it with about $8.1 million in state funds.

Over the past several years, federal funding for OAA programs have been subject to budget reductions, reaching nearly 5 percent in cuts.[57] 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, as adjusted for inflation that OAA provided in 1993.[58] 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 Ohio Department of Medicaid. The Ohio 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."[59] 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.

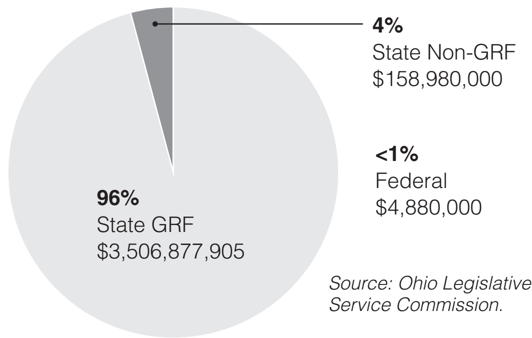
The state's commitment to the state health improvement plan and its role in addressing this issue in all populations will allow for greater emphasis on expanding programs that address chronic disease in the aging population in the upcoming budget and state policy initiatives.

Ohio Department of Rehabilitation and Correction

The Ohio Department of Rehabilitation and Correction (ODRC) is the agency responsible for all adult felony sanctioning ranging from state prison facilities to community control sanctions.[60] All adults in Ohio who are convicted of felonies with a statutory minimum sentence of at least six months come through ODRC, although this does not necessarily mean they will be in a prison setting. This sentence can also include supervision in the community through probation or other community corrections alternatives.[61] ODRC has 28 institutions; three of these institutions are operated by private companies under contract with the state.[62] The Kasich Administration sought ways to connect the work of ODRC through partnership with other agencies. An example of this is the partnership between ODRC and MHAS to provide substance use disorder treatment to incarcerated individuals.

Figure 13-9 shows nearly the entire budget of ODRC comes from state sources.

Figure 13-9: Source of Funding for ODRC



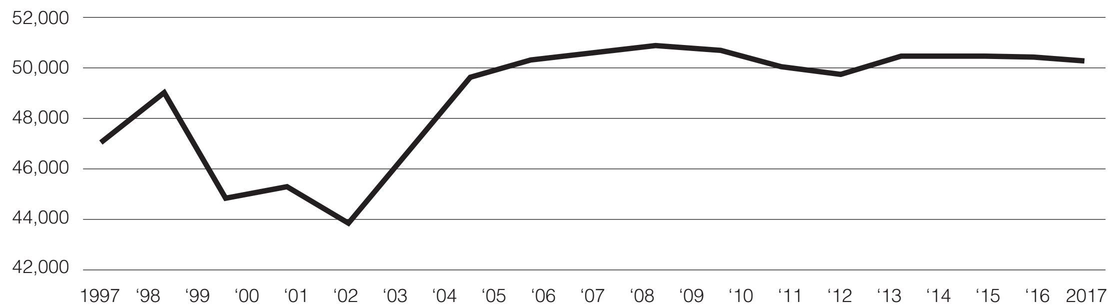
Source: Ohio Legislative Service Commission.

Funding

ODRC is primarily funded through state sources, meaning that major shifts in policy and/or funding make an impact on the state's bottom line. In the FY 2018–2019 budget cycle, 96 percent of the department's budget was comprised of state GRF, while federal dollars were expected to cover just 3 percent.[63]

Throughout the course of the Kasich Administration, a trend was evident in the Governor's policies, as well as from much of the legislature, to reduce the prison population through sentencing reform. Driven in part by the Great Recession beginning in 2007, and the fact that ODRC's budget is primarily composed of state funding, policymakers sought ways to reduce the state's share of funding for prisons. This trend was seen across the country. Ohio leaders looked at what strategies they could employ to safely reduce the prison population.[64] This review led many Ohio legislators to look at the large increase in state spending, coinciding with an increasing prison population in recent decades. Figure 13-10 shows that the prison population increased and then essentially has stagnated for several years.

Figure 13-10: Ohio Prison Population 1997–2017



Source: Ohio Department of Rehabilitation and Correction.

Ohio's prison population reached its peak of 51,273 in November, 2008.[65] Despite efforts to safely divert people from prison settings, ODRC saw near record numbers of people coming into the prison system during the Kasich Administration, due in part to the opioid crisis covered earlier in this chapter.

In 2011, the 129th General Assembly passed HB 86, the "Justice Reinvestment Act," which averted prison growth by 2,900 people by encouraging judges to place first-time offenders of felony levels four and five[66] on probation.[67] As of early 2018, Ohio had its lowest rate of entry into state prisons in 27 years.[68] Governor John Kasich and General Assemblies serving during his terms in office have worked to dismantle legislation, like SB 199 (115th G.A.), that created mandatory longer sentence lengths for aggravated and repeat offenders.[69] The state mid-biennium budget review in the 130th

General Assembly, HB 483, incorporated a provision that created the Criminal Justice Recodification Committee. The committee was tasked with reviewing the expanded criminal code in Ohio, targeting ways the state can better "prosecute, sentence, and rehabilitate criminal offenders in this state."[70]

Partnership with Mental Health and Addiction Services

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

Medicaid Pre-Release Enrollment Program

Following Ohio's adoption of Medicaid expansion in 2014, the Ohio Department of Medicaid (ODM) and the Ohio Department of Rehabilitation and Correction, began to develop plans for Ohio's Medicaid Pre-Release Enrollment Program (MPRE), with the goal of connecting incarcerated individuals with Medicaid managed care coverage upon release. ODRC piloted the MPRE program in the Ohio Reformatory for Women in Marysville in October 2014, with the first participants enrolling the following month. Over the next two years, MPRE rolled out in all 28 ODRC facilities throughout the state, becoming fully operational in all facilities in March 2017.

Each ODRC facility begins a process of consultation with incarcerated individuals 120 days prior to an inmate's release. During enrollment, ODRC conducts a screening for care management, during which some program participants are identified as "critical risk," or having a serious need for ongoing health care services to manage chronic conditions. Critical-risk participants engage in an ODM-mandated videoconference with their managed care organizations (MCOs) prior to release, and MCOs report to ODM monthly and quarterly regarding their follow up with these individuals.

In the fall of 2017, ODM's Office of Health Innovation and Quality conducted an initial evaluation of the MPRE program:[71]

Key findings of the evaluation included the following:

- MPRE retention rate is comparable to other Medicaid populations.
- MPRE included a higher percentage of consumers with mental health and substance use disorder diagnoses as compared to the Group VIII (Medicaid expansion) population.
- MPRE enrollees accounted for a higher percentage of substance-use-disorder- and mental-health-related inpatient-admitting diagnoses as compared to other Medicaid populations.
- Consumers flagged with a critical-risk indicator (CRI) demonstrated an inpatient psych-utilization rate four times higher and other service-utilization rate twice as high in comparison with non-CRI consumers. CRIs indicate an infectious disease (HIV+ or Hepatitis C) or at least two of the following: a serious mental illness, engaged in recovery services for addiction, or have a chronic disease.

Community Transition Program

An estimated 80 percent of offenders in Ohio's prison have documented histories of drug and alcohol

addiction.[72] Beginning July 1, 2016, the Ohio Department of Rehabilitation and Correction (ODRC) and the Ohio Department of Mental Health and Addiction Services (MHAS) began contracting with CareSource, one of Ohio's five MCOs, to provide the Community Transition Program (CTP). This program connects returning individuals with substance use disorders to treatment and recovery support services. Participants in this voluntary program have support accessing continued treatment, including Medication Assisted Treatment (MAT), housing assistance, vocational supports, life skills, transportation, and other supportive services.

Funded through the biennial budget, CTP financing is secured through June 2019. Within its first 18 months, the program enrolled over 3,000 returning citizens and expects to serve over 3,000 participants each year moving forward.

Summary

Health and human services covers a broad range of issues, making it a challenge to sum up changes in these areas begun during the Kasich Administration. There were major transformations in the developmental disabilities and behavioral health systems as it relates to how people receive services. Child welfare and the substance use disorder treatment system are overwhelmed by the effects of the opioid crisis, and these will continue to be a challenge for Governor DeWine and the 133rd General Assembly. Funding available through underspending in the TANF program could be a major discussion point for the FY 2020–2021 budget and beyond. The Kasich Administration proposed lofty plans for health and human services and made significant progress on many of its proposals. The way agencies worked through and with the Office of Health Transformation was a major shift, but it certainly promoted cross-agency collaboration in a way that had not been done before.

Endnotes

1 The chapter author would like to thank Brie Lusheck, Associate, Public Policy and External Affairs, The Center for Community Solutions, and Rose Frech, Consultant to The Center for Community Solutions, for their important contributions to Chapter 13, especially as it relates to descriptions of programs in the Ohio Departments of Job and Family Services, Aging, and Developmental Disabilities. The chapter author would also like to thank Loren Anthes, who provided much of the information about the connections between ODRC and Medicaid in this chapter.

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