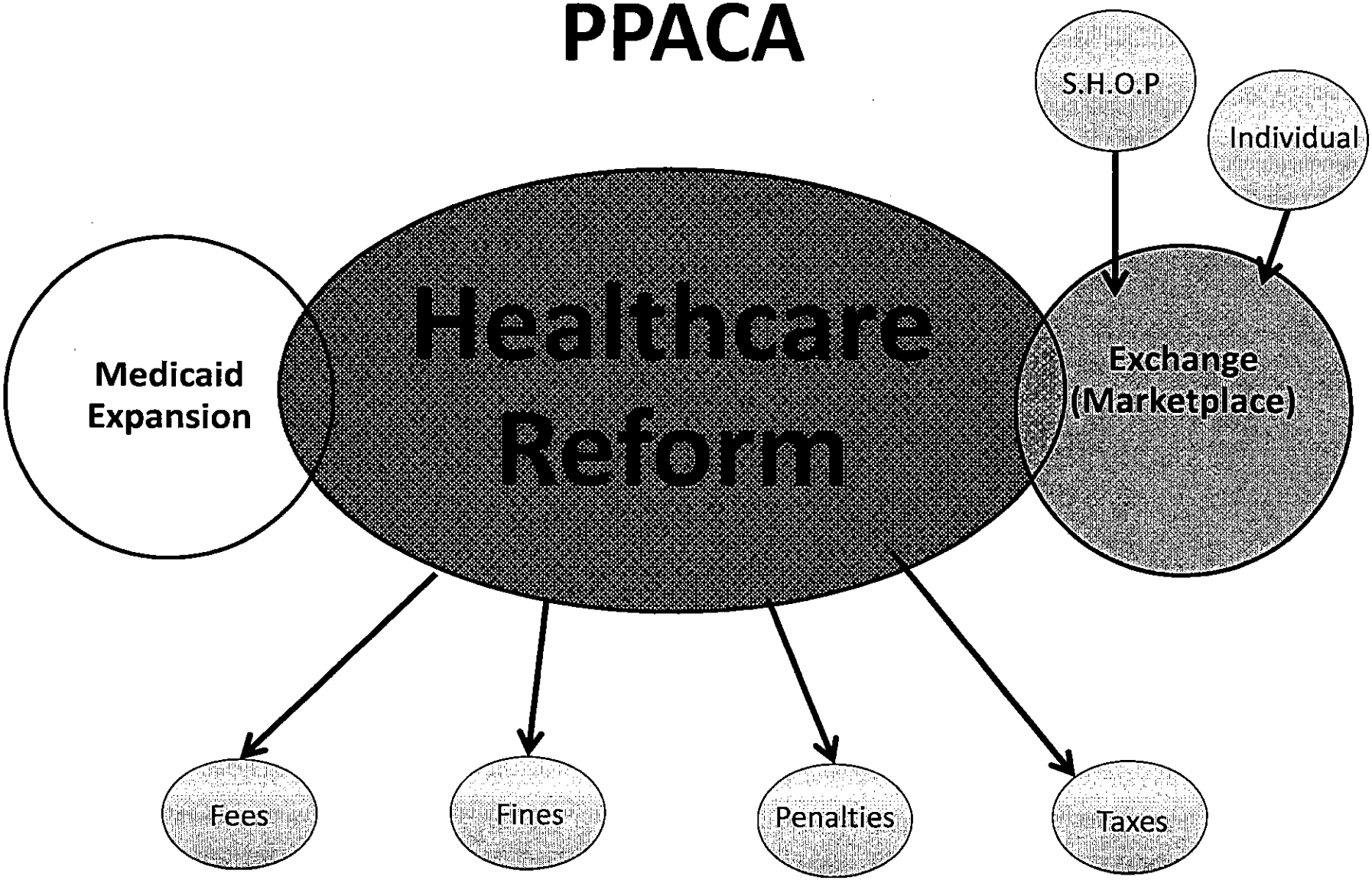
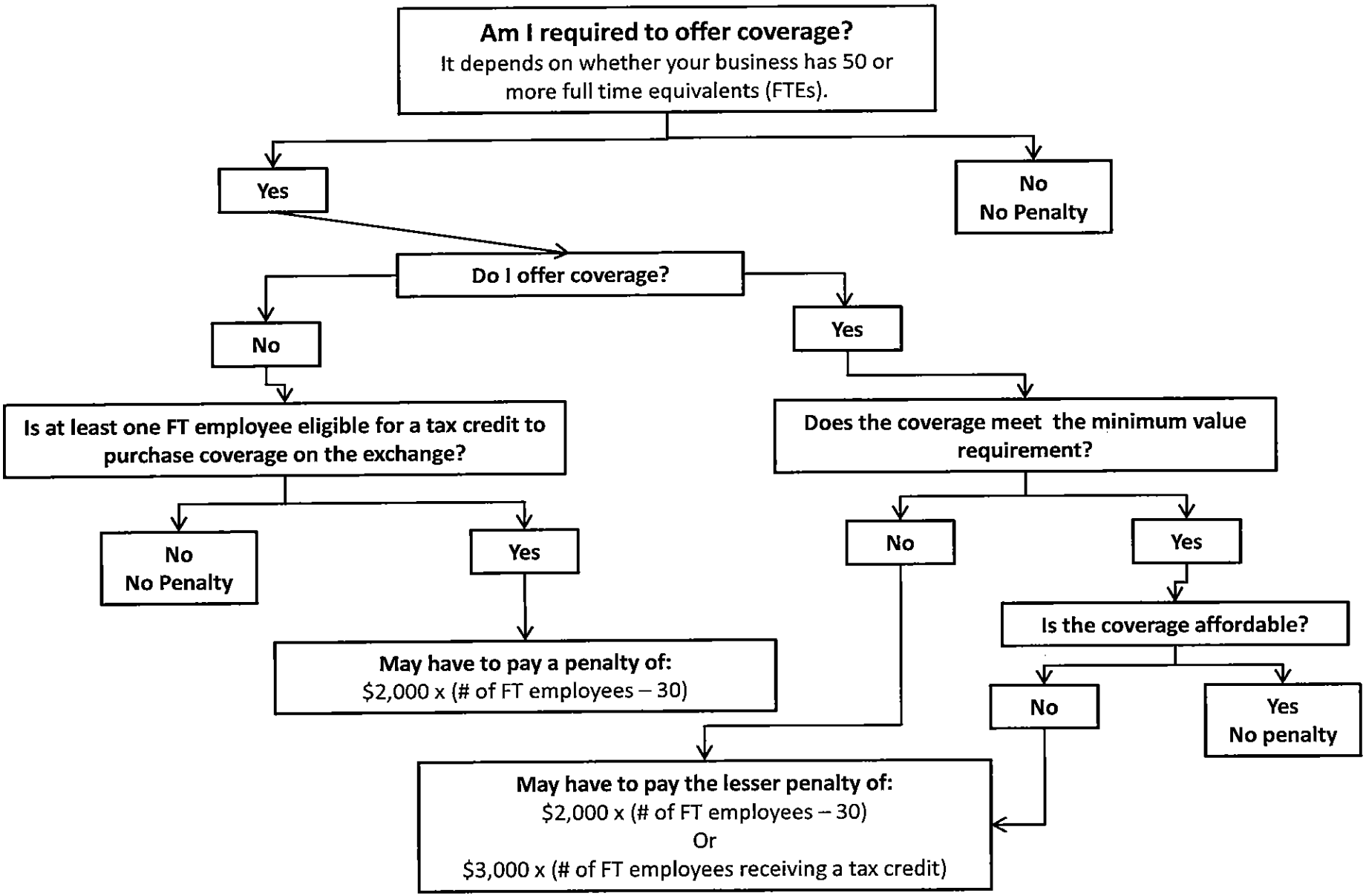
PPACA


S.H.O.P
Individual
Medicaid Expansion
Healthcare Reform
Exchange (Marketplace)
Fees
Fines
Penalties
Taxes

Coverage or Penalty?



AMERICANS for TAX REFORM NEWS
WWW.ATR.ORG

FOR IMMEDIATE RELEASE

28 JUNE 2012

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Full List of Obamacare Tax Hikes: Listed in order of effective date

--Obamacare law contains 20 new or higher taxes on American families and small businesses--

WASHINGTON, DC – Obamacare contains 20 new or higher taxes on American families and small businesses. Arranged by their respective effective dates, below is the total list of all $500 billion-plus in tax hikes (over the next ten years) in Obamacare, where to find them in the bill, and how much your taxes are scheduled to go up as of today:

Taxes that took effect in 2010:

1. Excise Tax on Charitable Hospitals (Min$/immediate): $50,000 per hospital if they fail to meet new "community health assessment needs," "financial assistance," and "billing and collection" rules set by HHS. ***Bill: PPACA; Page: 1,961-1,971***

2. Codification of the "economic substance doctrine" (Tax hike of $4.5 billion). This provision allows the IRS to disallow completely-legal tax deductions and other legal tax-minimizing plans just because the IRS deems that the action lacks "substance" and is merely intended to reduce taxes owed. ***Bill: Reconciliation Act; Page: 108-113***

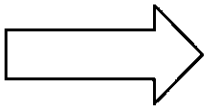
3. "Black liquor" tax hike (Tax hike of $23.6 billion). This is a tax increase on a type of bio-fuel. ***Bill: Reconciliation Act; Page: 105***

4. Tax on Innovator Drug Companies ($22.2 bil/Jan 2010): $2.3 billion annual tax on the industry imposed relative to share of sales made that year. ***Bill: PPACA; Page: 1,971-1,980***

5. Blue Cross/Blue Shield Tax Hike ($0.4 bil/Jan 2010): The special tax deduction in current law for Blue Cross/Blue Shield companies would only be allowed if 85 percent or more of premium revenues are spent on clinical services. ***Bill: PPACA; Page: 2,004***

6. Tax on Indoor Tanning Services ($2.7 billion/July 1, 2010): New 10 percent excise tax on Americans using indoor tanning salons. ***Bill: PPACA; Page: 2,397-2,399***

Taxes that took effect in 2011



13. High Medical Bills Tax ($15.2 bil/Jan 2013): Currently, those facing high medical expenses are allowed a deduction for medical expenses to the extent that those expenses exceed 7.5 percent of adjusted gross income (AGI). The new provision imposes a threshold of 10 percent of AGI. Waived for 65+ taxpayers in 2013-2016 only. ***Bill: PPACA; Page: 1,994-1,995***

14. Flexible Spending Account Cap – aka "Special Needs Kids Tax" ($13 bil/Jan 2013): Imposes cap on FSAs of $2500 (now unlimited). Indexed to inflation after 2013. There is one group of FSA owners for whom this new cap will be particularly cruel and onerous: parents of special needs children. There are thousands of families with special needs children in the United States, and many of them use FSAs to pay for special needs education. Tuition rates at one leading school that teaches special needs children in Washington, D.C. (National Child Research Center) can easily exceed $14,000 per year. Under tax rules, FSA dollars can be used to pay for this type of special needs education. ***Bill: PPACA; Page: 2,388-2,389***

15. Elimination of tax deduction for employer-provided retirement Rx drug coverage in coordination with Medicare Part D ($4.5 bil/Jan 2013) ***Bill: PPACA; Page: 1,994***

16. $500,000 Annual Executive Compensation Limit for Health Insurance Executives ($0.6 bil/Jan 2013). ***Bill: PPACA; Page: 1,995-2,000***

Taxes that take effect in 2014

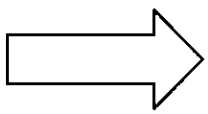
17. Individual Mandate Excise Tax (Jan 2014): Starting in 2014, anyone not buying "qualifying" health insurance must pay an income surtax according to the higher of the following

	1 Adult	2 Adults	3+ Adults
2014	1% AGI/$95	1% AGI/$190	1% AGI/$285
2015	2% AGI/$325	2% AGI/$650	2% AGI/$975
2016 +	2.5% AGI/$695	2.5% AGI/$1390	2.5% AGI/$2085

Exemptions for religious objectors, undocumented immigrants, prisoners, those earning less than the poverty line, members of Indian tribes, and hardship cases (determined by HHS). ***Bill: PPACA; Page: 317-337***

18. Employer Mandate Tax (Jan 2014): If an employer does not offer health coverage, and at least one employee qualifies for a health tax credit, the employer must pay an additional non-deductible tax of $2000 for all full-time employees. Applies to all employers with 50 or more employees. If any employee actually receives coverage through the exchange, the penalty on the employer for that employee rises to $3000. If the employer requires a waiting period to enroll in coverage of 30-60 days, there is a $400 tax per employee ($600 if the period is 60 days or longer). ***Bill: PPACA; Page: 345-346***

Combined score of individual and employer mandate tax penalty: $65 billion/10 years



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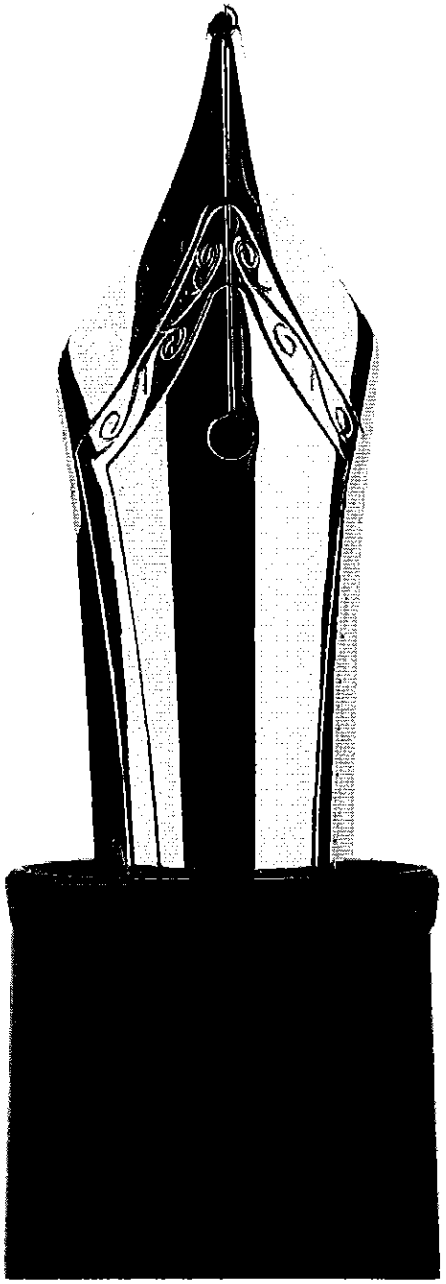
The Affordable Care Act (ACA) of 2010 May 2013 Progress Report

The Affordable Care Act (ACA) of 2010 had two aims per the President's address to Congress on February 24, 2009: 1) to reduce costs and 2) to increase access to affordable health insurance coverage that could serve as one of the key elements of our nation's economic recovery. The ACA implementation spans a decade including five election cycles, apprehension about job creation, domestic unease about homeland security, and concern about the role the U.S. should play in an increasingly complicated global marketplace of ideas, cultures and resources.

This document outlines the major elements of the law, the specific indicators of its progress, and the status of its implementation. The magnitude of resources and outreach required for effective implementation of the ACA may have been underestimated, and stakeholder attitudes are mixed. But overall, the majority of ACA provisions are on track.

- **No one knows for sure what the outcome of the ACA will be. It's too soon to know.** The results of many of the more formidable reforms in the law are indeterminant. There are precedents for many elements in the ACA – like mandates for coverage in Massachusetts Health Reform in 2006 and the Physician Group Demonstration projects sponsored by Centers for Medicare and Medicare Services (CMS) – but the bulk of the law, and its effort to combine cost savings with systemic reform is its most significant characteristic. When affirmed by the U.S. Supreme Court on June 28, 2012, it became the most significant law in health care since the passage of Medicare in 1965. There are likely to be four big bets in the law:
  - How will states handle their expanded/new responsibilities in the law to oversee exchanges, Medicaid expansion, insurance industry oversight, scope of practice issues in the healthcare workforce, etc.? They've got lots on their plates, and limited resources.



Deloitte Center
for Health Solutions

ACA implementation: a progress report

Focus # 1: increase access to affordable health insurance coverage		
Key Elements	**Indicators**	**Implementation Status**
Streamlined enrollment and price transparency; consumer education; structured appeals processes. **(ACA Section 1311)**	Establish health insurance exchanges (HIX) in every state by January 1, 2014.	**EXCHANGE PREPAREDNESS UNCLEAR** Open enrollment begins October 1, 2013. 18 states and D.C. will operate state-based exchanges, seven states will operate state-partnership exchanges, and there will be 25 federally-facilitated exchanges (FFE).[i] As of April 2013, CMS has spent $393.7 million establishing the FFE, and $3.8 billion in HIX grants to states.[ii] The IRS issued a proposed rule on April 29, 2013 on the HIX premium tax credits and methods to determine whether employer-sponsored health insurance is affordable per the ACA.[iii]
Develop standards for benefits covered by health insurance plans. **(ACA Section 1302)**	Ten statutorily defined essential health benefits (EHB) must be covered on the individual and small group market on and off HIXs.	**IN PROGRESS** Per the U.S. Department of Health and Human Services (HHS), states had the choice of four benefit packages (i.e. benchmark plans) that they could adopt as a model for health insurers designing benefits offered on the small and individual markets beginning in 2014.[iv] 25 states and D.C. have recommended their benchmark plans, and the remaining 25 adopted the "default" benchmark plan identified by HHS. On February 20, 2013 CMS issued a final rule.[v]
Required coverage for preventive services with no cost-sharing. **(ACA Section 4103)**	Plans covered by these rules must offer coverage for 15 preventive services for all adults, 22 services for women, and 26 services for children with no co-payment, co-insurance, or deductible.	**IN PROGRESS** 71 million Americans in private health insurance plans received coverage for at least one free preventive health care service in 2011 and 2012; an estimated 34 million in traditional Medicare and Medicare Advantage plans have received at least one preventive service with no out-of-pocket cost.[vi]
Increase access to employer-sponsored health insurance. **(ACA Sections 1401, 1402)**	Employer pay-or-play mandate. Penalty: $2,000 annually for every full-time employee minus the first 30 employees.	**NOT YET IMPLEMENTED** Begins January 1, 2014. 81% of companies representing 84% of the workforce plan to continue offering benefits vs. 9% of companies representing 3% of the workforce anticipate dropping coverage in the next 1-3 years; 10% of companies representing 13% of the workforce are not sure.[vii]

Focus # 2: reduce cost without compromising safety and quality by changing incentives from volume to value, clinical integration of the delivery system, and widespread adoption of evidence		
Key Elements	**Indicators**	**Implementation Status**
Limits on aggregate spending **(ACA Sections 3403, 10320)**	If the Medicare spending growth per capita is projected to exceed an established targeted growth rate, CMS must calculate a savings target and the 15-member Independent Payment Advisory Board (IPAB) must propose recommendations to stay in target range.	**IN PROGRESS** President Barack Obama's Administration has solicited board member appointment recommendations from Congress; as of April 2013 no appointments have been made.[xx] CMS' Chief Actuary submitted a report on April 30, 2013 projecting that the average growth rate for Medicare spending will be 1.15%, and will not exceed target growth rate of 3.03% in 2015.[xxi]
Improved care coordination & reduced errors through demonstrations and pilots. **(ACA Section 3022, 3023)**	Allows providers in Accountable Care Organizations (ACOs) that meet quality thresholds to share in the cost savings.	**IN PROGRESS** As of January 2013, more than 280 ACOs serving over four million Medicare beneficiaries had been established. In addition, the private sector has launched more than 150 ACOs targeting the commercially-insured and Medicaid enrollees.[xxii]
	Creates a national pilot program to make a bundled payment program for different types of health care.	**IN PROGRESS** HHS announced the national pilot program on bundling payments in January 2013. It will be implemented 2013 through 2016. By January 2016, HHS must submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending.[xxiii]
Standardization around evidence-based guidelines. **(ACA Sections 6301, 3021)**	Patient-Centered Outcomes Research Institute (PCORI) established to promote comparative effectiveness research.	**PCORI EFFORTS UNDERWAY BUT TOO SOON TO REPORT PROGRESS** A 21-member board was appointed in September, 2011. As of December 2012, 25 awards had been granted amounting to $40.7 million.[xxiv]
	Created the Centers for Medicare and Medicaid Innovation (CMMI) to fund new payment and delivery system models aimed at reducing cost while improving quality.	**IN PROGRESS** Began January 1, 2011. On January 26, 2012 CMMI released a report outlining the new initiatives. In fiscal year (FY) 2012, 14 initiatives were launched. $10 billion has been allocated to CMMI through 2019.[xxv]

Focus #3: funding – half through industry taxes and fees, and half through increased taxes on consumers		
Key Elements	**Indicators**	**Implementation Status**
Medical device tax. **(ACA Section 9009)**	The tax equal to 2.3% of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of such device in the U.S.	**IMPLEMENTED** Began calendar year, 2013. The U.S. Senate voted to repeal the tax during budget resolution process in March 2013; the vote was non-binding. Estimated cost of repealing: $29 billion 2013-2022.[xxxiii]
Insurance excise tax. **(ACA Section 9006)**	Excise tax on high premium health insurance plans. Projected to generate $102 billion in revenue over ten years.[xxxiii]	**BEGINS CALENDAR YEAR 2014.** The IRS released a proposed rule on March 2013.
Prescription drug excise tax and rebates. **(ACA Sections 3301, 2501)**	Closure of Medicare Part D donut hole: in 2013, beneficiaries pay 47.5% for brand name drugs and 79% for generics; in 2020, 25% for brand-names and 25% for generics.	**IN PROGRESS** $80 billion committed over ten years; President Obama's FY2014 budget proposed closing the Part D donut hole by 2015 rather than 2020, which would cost the industry an additional $11.2 billion.[xxxiv]
	Increased discount on drugs in Medicaid: 23.1% for innovator drugs; 17.1% for blood clotting drugs and pediatric use only; 13% of average manufacturer price per unit for non-innovator drugs.	**IN PROGRESS** Began calendar year 2010. 600 drug manufacturers participate in the Medicaid drug rebate program. President Obama's FY2014 budget proposed expanding the rebate, which was projected to cost an additional $8.8 billion over ten years.
Lower payments to hospitals. **(ACA Section 3401)**	$155 billion/10-year reduction in scheduled payment increases (market basket).	**IN PROGRESS** Retroactive to calendar year 2010. In April 2013, CMS released the FY2014 Inpatient Prospective Payment Systems proposed rule with no change to the market basket update.[xxxv]
Medicare tax increases. **(ACA Section 9015)**	Additional 0.9% hospital insurance tax on wages over $200,000 ($250,000 for joint filers).	**IMPLEMENTED** Began calendar year 2013. Projected to increase federal revenue by $87 billion over the next 10 years.[xxxvi] The IRS issued proposed regulations in December 2012.

Deloitte Center for Health Solutions

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About the Deloitte Center for Health Solutions
The Deloitte Center for Health Solutions is the health services research arm of Deloitte LLP. Our goal is to inform all stakeholders in the health care system about emerging trends, challenges, and opportunities using rigorous research. Through our research, roundtables, and other forms of engagement, we seek to be a trusted source for relevant, timely, and reliable insights.

Governor's Office of Health Transformation
Guiding Principles

With forward-thinking, solutions-oriented strategies we can transform Ohio into a model of health and economic vitality – and bring the system back in line with our heartland values:

MARKET-BASED
Reset the basic rules of health care competition so the incentive is to keep people as healthy as possible.

PERSONAL RESPONSIBILITY
Reward Ohioans who take responsibility to stay healthy – and expect people who make unhealthy choices to be responsible for the cost of their decisions.

EVIDENCE BASED
Rely on evidence and data to complement a lifetime of experience, so doctors can deliver the best quality care at the lowest possible cost.

TRANSPARENT
Make information about price and quality transparent, and get the right information to the right place at the right time to improve care and cut costs.

VALUE
Pay only for what works to improve and maintain health – and stop paying for what doesn't work, including medical errors.

PRIMARY CARE
Transform primary care from a system that reacts after someone gets sick to a system that keeps people as healthy as possible.

CHRONIC DISEASE
Prevent chronic disease whenever possible and, when it occurs, coordinate care to improve quality of life and help reduce chronic care costs.

LONG-TERM CARE
Enable seniors and people with disabilities to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home.

INNOVATION
Innovate constantly to improve health and economic vitality – and demonstrate to the nation why Ohio is a great place to live and work.

Ohio | Governor's Office of Health Transformation

Ohio Health and Human Services Innovation Plan

		MODERNIZE MEDICAID	STREAMLINE HEALTH AND HUMAN SERVICES	IMPROVE HEALTH SYSTEM PERFORMANCE
Executive Order		Advance the Governor's Medicaid modernization and cost containment priorities	Recommend a permanent health and human services organizational structure and oversee transition to that structure	Engage private sector partners to set clear expectations for better health, better care, and lower costs through improvement
Problem		Our current health care system is fragmented in a way that leads to disrupted relationships, poor information flows, and misaligned incentives that combine to degrade quality and increase cost	Ohio HHS policy, spending and administration is split across multiple state and local government jurisdictions, and this inefficient structure impedes innovation and lacks a clear point of accountability	Ohioans spend more per person on health care than residents in all but 17 states, yet higher spending is not resulting in better health outcomes for Ohio citizens (Ohio ranks 37 in health outcomes)
Policy Priorities		• Improve care coordination • Integrate behavioral and physical health care • Rebalance long-term care	• Share services to increase efficiency • Right-size state and local service capacity • Streamline governance	• Get the right information in the right place at the right time • Make health care price and quality information transparent • Pay for value instead of volume
Initiatives	*2011*	**Phase I: Enact Medicaid Modernization Authority (HB 153)** • Enact common-sense Medicaid modernization and cost containment proposals	**Phase I: Streamline Medicaid Programs (HB 153)** • Reorganize funding and control of Medicaid programs to be more efficient (e.g., unified long-term care budget)	**Phase I: Leverage Medicaid Purchasing Power (HB 153)** • Reward best practices in health care delivery system reform (e.g., health homes, accountable care organizations)
	2012	**Phase II: Implement Medicaid Modernization Initiatives** • Oversee program design, rules process, and implementation • Secure federal support to implement reforms	**Phase II: Streamline Health and Human Service Operations** • Restructure and consolidate HHS operations to be more efficient (e.g., integrated eligibility determination)	**Phase II: Align Public/Private Health System Priorities** • Engage private sector partners to improve health care quality and reduce health care costs by changing how we pay
	2013	**Phase III: Evaluate Medicaid Modernization Initiatives** • Oversee program design, rules process, and implementation • Secure federal support to implement reforms	**Phase III: Streamline Health and Human Service Governance** • Reorganize state agencies to be more efficient • Recommend a permanent HHS organizational structure	**Phase III: Leverage Public/Private Purchasing Power** • Standardize and publicly report performance measures • Reform the health care delivery payment system
Governance		**Medicaid Cabinet** AGE, MHAS, DD, ODH, Medicaid with connections to JFS	**Health and Human Services Cabinet** DAS, OBM, OHT (executive sponsors); JFS, RSC, AGE, MHAS, DD, ODH, Medicaid; with connections to ODE, DRC, DYS, DVS, ODI, TAX	**Payment Innovation Task Force** DAS, DEV, ODH, ODI, OHT, JobsOhio, Medicaid, DRC, TAX, BWC, DYS, PERS, BOR; Governor's External Advisory Council
Current Work Teams		• Extend Medicaid coverage to more low-income Ohioans • Eliminate fraud and abuse • Prioritize home and community based services • Enhance community developmental disabilities services • Integrate Medicare and Medicaid benefits • Rebuild community behavioral health system capacity • Create health homes for people with mental illness • Restructure behavioral health system financing • Improve Medicaid managed care plan performance	• Implement a new Medicaid claims payment system • Create a unified Medicaid budgeting and accounting system • Create a Department of Medicaid • Consolidate mental health and addiction services • Simplify and automate eligibility determination • Coordinate programs for children • Implement Public Health Futures recommendations • Share services across local jurisdictions • Recommend a permanent HHS structure (coming soon)	• Participate in Catalyst for Payment Reform • Provide access to medical homes for most Ohioans • Use episode-based payments for most acute medical events • Coordinate health sector workforce and training programs • Accelerate electronic health information exchange • Report and measure performance • Promote insurance market competition and affordability • Support regional payment reform initiatives

Updated May 2013

Ohio | Governor's Office of Health Transformation

John R. Kasich, Governor
Greg Moody, Director

Health and Human Services 2011 Accomplishments

When Governor Kasich took office in January, he challenged the Administration's health and human services (HHS) cabinet agencies to improve services to vulnerable Ohioans, reduce cost and increase efficiency and support the Administration's efforts to create jobs and reduce unemployment. Through collaboration and innovation, the Governor's Office of Health Transformation (OHT), the Departments of Health (ODH), Developmental Disabilities (DODD), Aging (ODA), Mental Health (ODMH), Alcohol and Drug Addiction Services (ODADAS) and Job and Family Services (ODJFS) and the Rehabilitation Services Commission (RSC) have achieved significant accomplishments in 2011. Below is a snapshot of these accomplishments:

REFORMING MEDICAID

Governor Kasich championed comprehensive Medicaid reforms in the Jobs Budget (HB 153) that will improve the quality of health care for the 2.2 million individuals served in the Medicaid program and save the state $1.5 billion over the next two years. These improvements in Medicaid, the health-care entitlement program for low-income Ohioans that accounts for 30 percent of the state's budget, will deliver coordinated physical health and behavioral health care for people on Medicaid, allow more seniors to live at home instead of in nursing homes, help prevent illness and reduce costly emergency room visits. By resetting Medicaid payment rules to reward value rather than volume, the budget will improve the quality of health care for Ohio's most vulnerable citizens, reduce costs for taxpayers and ensure the fiscal stability of the Medicaid program.

For the full list of Medicaid reforms in the Jobs Budget, see this report.

IMPROVING HEALTH FOR ALL OHIOANS

Ohio is working to improve health outcomes for all citizens and offer employers a healthy and productive workforce.

- **Championing a New Approach to Health Transformation:** When Governor Kasich took office, Ohio was spending more than all but 13 states on health care, but we ranked 42nd in health outcomes. Ohio was not giving taxpayers the best value for their dollar, and Ohio lagged other states in offering employers a healthy and productive workforce. Governor Kasich said this was not acceptable and he created the Office of Health Transformation (OHT) to change it. OHT is coordinating the activities and policies of the six state agencies involved in Medicaid to implement the Medicaid modernization and cost-containment priorities in the budget. OHT is also taking the lead on the Administration's efforts to improve overall health-system performance by streamlining how government health systems and programs interact with each other and with our customers and by engaging private-sector partners to drive system-wide reform and make all Ohioans healthier. *For more details, see: www.healthtransformation.ohio.gov.*

- **Improving Quality in Ohio's Nursing Homes:**
  - ✓ ***The Jobs Budget increased Medicaid quality incentive payments for nursing facilities from 1.7 percent of the average Medicaid nursing home rate in SFY 2011 to 9.7 percent in SFY 2013.*** In September, a subcommittee of the Unified Long-Term Care System Advisory Workgroup, which was chaired by OHT Director Greg Moody, recommended new accountability measures to be used in awarding points for the quality incentive payments and the methodology for calculating the quality incentive payments. The legislature approved SB 264 in December to implement this new methodology beginning in SFY 2013.
  - ✓ ***Ohio was one of four states chosen by the Advancing Excellence in America's Nursing Homes campaign to participate in the Critical Access Nursing Home Project.*** The project works to improve care in selected nursing homes and develop a model of nursing home improvement that can be used across the country.
  - ✓ ***ODH implemented the federal Quality Indicatory Survey (QIS) to help improve quality of care in Ohio nursing homes.*** QIS is a resident-centered, outcome-oriented quality review that entails structured resident, family and staff interviews, resident observations, record reviews and analysis of health assessment data. Data from QIS will be used to track certain quality-of-care and quality-of-life indicators that lead to improved care. The new survey process will also be monitoring deficiencies constituting immediate jeopardy and violations of federal staffing requirements.
- **Providing Accountable Care for Children:** The Jobs Budget invests $87 million in start-up funding and encourages children's hospitals and networks of physicians to team up to create pediatric Accountable Care Organizations (ACOs), which will provide additional attention and care to the unique needs of 37,000 disabled children on Medicaid. Pediatric ACOs will hold the hospital and participating physicians responsible for the quality of care delivered to patients and provide a financial incentive back to the providers for delivering high-quality, efficient care. Model ACOs have demonstrated the ability to increase access to care for rural and urban children, improve quality and safety, implement a wellness programs to ensure that children with special health needs reach their full potential, and reduce preterm births and decrease the length of stay in neonatal intensive care units.
- **Building the Patient-Centered Medical Home:** ODH, through the Ohio Patient-Centered Primary Care Collaborative, is leading a statewide expansion of the Patient-Centered Medical Home (PCMH) model of care in Ohio. A PCMH facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. Care is coordinated through registries, information technology, health information exchange and other means to assure that patients get the appropriate care when and where they need and want it in a culturally appropriate manner. By making primary care and prevention the foundations of medical practices and paying providers for improving the health of patients and clients through measurable outcomes, Ohio will reduce health care spending and increase health outcomes for Ohioans.
- **Creating Health Homes for People with Chronic Conditions:** Medicaid beneficiaries with chronic conditions have poor health outcomes and their care is costly. The budget invests $47.25 million over the biennium to enhance coordination of the medical and behavioral health care needs of individuals with severe and/or multiple chronic illnesses—with a focus on individuals with severe and persistent mental illness—by expanding on the traditional medical home model of care.
- **Reducing Waiting Lists for People with Disabilities:** RSC's waiting list has been reduced for the first time since 2009. After peaking at almost 5,000 people, the total number of individuals with disabilities on the waiting list has been trimmed by more than 1,100 thanks to diligent management of available counselors and contract providers.

PROTECTING CHILDREN

The Kasich Administration is keeping children safe and supporting strong and vibrant families.

- **Expanding Medicaid Presumptive Eligibility for Pregnant Women and Children:** The Jobs Budget provides temporary coverage so that a child or pregnant woman can receive medical care while their Medicaid application is officially processed. It also recognizes new qualified entities that may establish Medicaid eligibility. By simplifying the eligibility and enrollment processes, and including additional points of access for children and pregnant women, medical attention will be provided in the early stages of life when intervention is the most successful. The result will be improved health outcomes for children and pregnant women and reduced Medicaid expenditures.
- **Providing High-Quality Child Care:** The Jobs Budget will allow all children currently enrolled in Ohio's subsidized child care system to stay on the program so that parents can work while children learn in safe, healthy environments that prepare children for K-12 education. The program will continue to serve current enrollees, about 104,000 children per year, while also maintaining the Step Up To Quality Initiative (SUTQ). SUTQ rewards child-care providers in Ohio for meeting quality criteria in their curriculum, facilities and staff (measures include, for example, qualified classroom teachers and materials that promote growth and development). The Jobs Budget also increases the efficiencies in the state child-care system by decreasing regulatory burdens for child-care providers, addressing the number of providers per family allowed and supporting the implementation of a statewide card-swipe time-and-attendance system. The result will be improved accountability and increased efficiency within the child-care system.
- **Investing in the Child Welfare System to Keep Children out of Harm and Support Stable Families:**
  - ✓ ***The Jobs Budget lays the groundwork to expand Alternative Response statewide.*** Alternative Response keeps children safe, keeps families together and reduces the number of children in foster care, which saves money. ODJFS is piloting Alternative Response in 40 counties with great success.
  - ✓ ***The Jobs Budget provides $2 million in funding each year for Independent Living services for young adults who have aged out of foster care.*** Independent living services such as academic counseling, life-skills instruction and housing assistance help give former foster children the skills and support necessary to achieve self-sufficiency and lead productive lives.
- **Empowering Families through Early Intervention and Autism Therapy Training:** DODD, in conjunction with the Ohio Center for Autism and Low Incidence (OCALI), provided training for autism early intervention and autism therapy to 42 County Boards of Developmental Disabilities employees from 18 different counties. The training is part of a pilot program called Play and Language for Autistic Youngsters (P.L.A.Y. Project). The project is a relationship-based therapy program that emphasizes helping parents become their child's best P.L.A.Y. partner. The project empowers parents to have access to effective, family-focused, and affordable therapy and intervention for young children with autism, which will help children with autism connect, communicate and build relationships with others.
- **Providing GRF Funding for Pneumococcal Vaccines for Children:** Streptococcus pneumonia is the leading cause of bacterial meningitis among children younger than 5-years-old. The FY13 GRF funding of $2.5 million allows for continued purchase of PCV-13 vaccine for underinsured children in Ohio who are not eligible for the federal Vaccines for Children program. This GRF funding enables ODH to continue to supply the vaccine to local health district clinics for underinsured children with no ability to pay. At the current cost per dose, the budget will allow for the purchase of approximately 25,700 doses of vaccine that can serve approximately 6,400 children (4 doses per child). Prior to the routine use of vaccine in children, this disease caused 13,000 cases of bacteremia, 700 cases of meningitis, 200 deaths and 5,000,000 cases of acute otitis media (middle ear infections) in children in the U.S. each year.

- **Promoting Recovery to Work:** A partnership between RSC, ODADAS and ODMH led to the creation of a statewide program that allows Alcohol, Drug Addiction and Mental Health boards to contract with local agencies to provide vocational rehabilitation and treatment services to eligible Ohioans. State funds were used to draw down a three-to-one federal match, resulting in $36 million in total funding, which will be used to help Ohioans fighting addiction and mental illness receive care and prepare for employment.
- **Increasing Employment Opportunities for People with Developmental Disabilities:** DODD joined the State Employment Leadership Network (SELN), a multi-state venture of state developmental disability agencies that shares ideas, best practices and system-change recommendations to improve employment and outcomes for individuals with developmental disabilities. Work is underway with SELN to complete a comprehensive assessment of Ohio's employment barriers and opportunities. Meanwhile, targeted federal funding from the Centers for Medicare and Medicaid Services for a Medicaid Infrastructure Grant has been secured to provide training for people with developmental disabilities to increase their ability to secure meaningful employment.

INCREASING EFFICIENCY, IMPROVING SYSTEM PERFORMANCE, SHARING SERVICES AND DELIVERING COMMON-SENSE REGULATORY RELIEF

The HHS state agencies have created efficiencies through shared services and other means and supported shared-service arrangements among stakeholders and customers. These agencies are also contributing to the Administration's Common Sense Initiative by implementing a series of common-sense regulatory reforms that will improve service to our customers. For a full list of the HHS Common Sense Initiatives, see this report.

- **Improving Medicaid Information Technology:**
  - ✓ ***ODJFS launched the Medicaid Provider Incentive Program***, which provides federal incentive payments of up to $63,750 to eligible Medicaid providers who adopt, implement or upgrade to certified electronic health records (EHRs) and demonstrate meaningful use of EHRs over six years. EHRs can enhance health care outcomes and reduce overall health care costs by consolidating a patient's health information and making it available any medical professional who needs it while still ensuring the patient's privacy.
  - ✓ ***ODJFS launched the Medicaid Information Technology System (MITS), replacing Ohio's outdated, 25-year-old Medicaid Management Information System.*** MITS automates and transforms existing business processes that previously relied on paper and were labor-intensive. It allows providers to submit claims through the web and get instant feedback on whether their claims were approved or denied, lowering administrative costs for the state and for health care providers. MITS also positions Ohio's Medicaid program to address current and emerging business demands; offers enhanced claims decision support to ODJFS and sister state agencies; and provides ODJFS with near real-time data about health care trends and the medical needs of Ohio's Medicaid population. Together, EHRs and MITS will help to digitize and streamline medical and billing information for Medicaid providers and beneficiaries across Ohio.
- **Ensuring Financial Sustainability and Medically Necessary Treatment in Behavioral Health:** ODMH and ODADAS have established much-needed utilization-management controls and cost-containment tools for community mental health and substance abuse Medicaid services. These tools were designed with a great deal of input from providers, boards and consumers with the goal of containing Medicaid costs so that funding for non-Medicaid services can continue and be maximized. These strategies, which are already required for other services provided under Medicaid, are needed to improve the coordination of physical and behavioral health care and ensure the wise use of program dollars.

- **Reducing RSC Overhead:** RSC has reduced rent costs by $1.2 million by reducing site offices from 31 to 14. As a result, RSC has embedded counselors in the community at local ODJFS One-Stop Centers, schools and other convenient locations, placing the vocational counselors closer to consumers and providing opportunities for staff to network and build working relationships with other health and human services providers.
- **Detecting Fraud:** RSC's Division of Disability Determination (DDD) fraud unit led the nation in 2011 in identifying fraud and recovering funds, resulting in a savings of almost $41 million. DDD had the lowest cost per case in the region, and the division served 211,857 Ohioans who filed a claim this year, exceeding its goal by 3,000 people.
- **Planning for a Growing Population of Older Adults:** ODA has developed a strategic plan that will position Ohio on the leading edge of innovation and improve our ability to respond to the growing and changing needs of Ohio's older population. As part of this plan, the department is implementing an agency-wide reorganization to better align functions and work products with measurable outcomes. ODA has implemented an agency-wide customer service policy and is building infrastructure and shared-service partnerships to ensure it delivers high-quality services more efficiently.
- **Providing Nursing Facility Regulatory Relief:** The Jobs Budget included changes to the nursing home licensure statute to authorize much-needed regulatory relief for the nursing home industry. ODH is working with interested parties to adopt rules to implement these changes. In addition, the certificate of need (CON) rules were amended to allow a change in project site after submittal of the application and before it is deemed complete. This change saves an applicant for nursing home beds money because the facility no longer has to submit a new application and fee if they change a project site after submittal.
- **Making ODA Rules More User-Friendly:** ODA has made enrollment to the Medicaid funded Assisted Living program easier and now begins paying for residents immediately while their eligibility is being determined. ODA has also eased contract timelines and requirements for assessments and has made the "front-door" service to seniors more effective and efficient.
- **Improving Customer Service and Efficiency at ODA:** ODA has implemented an agency-wide customer service policy and is reorganizing to share services between programs.

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Ohio | Governor's Office of Health Transformation

John R. Kasich, Governor
Greg Moody, Director

Ohio Health and Human Services 2012 Accomplishments

Governor Kasich created the Office of Health Transformation (OHT) to lead the Administration's efforts to modernize Medicaid, streamline health and human services programs and improve overall health system performance. Using an innovative approach that involves collaboration among multiple state agency partners, the Administration has taken significant steps to improve services to vulnerable Ohioans, reduce costs, increase efficiency and support the Governor's efforts to create jobs and reduce unemployment. Below is a snapshot of these accomplishments in 2012.

IMPLEMENT MEDICAID REFORMS LAUNCHED IN HB 153

Governor Kasich championed comprehensive Medicaid reforms in the Jobs Budget (HB 153) to modernize Ohio's Medicaid program, the health-care entitlement program for 2.2 million low-income Ohioans. The bill included significant new tools to reset Medicaid payment rules to reward value rather than volume, improve the quality of care for Ohio's most vulnerable citizens, reduce costs for taxpayers and ensure the fiscal stability of the Medicaid program. In 2012, the Kasich Administration utilized these tools to drive Medicaid program improvements and deliver savings that were more than $500 million above previously projected savings levels in the first year of the biennium.

For the full list of Medicaid reforms in the Jobs Budget, see this report. Below is a 2012 progress report on key budget initiatives.

☑ **Integrate Medicare and Medicaid benefits.** The budget bill authorized the Office of Medical Assistance (Ohio Medicaid) to seek approval through the federal Center for Medicare and Medicaid Innovation to design and implement a Medicare-Medicaid Integrated Care Delivery System (ICDS). The goal of the ICDS program is to coordinate a full continuum of benefits for Medicare-Medicaid enrollees, including physical and behavioral health care and long-term services and supports.

Project update: Ohio Medicaid announced in December that it reached an agreement with the federal government on a memorandum of understanding to launch the ICDS, making Ohio only the third state to enter into such an agreement. A proposed three-year demonstration in 29 counties will improve care for approximately 114,000 individuals who are eligible for Medicare and Medicaid, lead to greater efficiency and reduce costs in both programs. (more info)

☑ **Create health homes for people with mental illness.** The budget authorized Ohio Medicaid to design a person-centered system of care, called a health home, to improve care coordination for high-risk beneficiaries. Ohio Medicaid teamed up with the Department of Mental Health (ODMH)

New contract language, based on model health plan contract language created by Catalyst for Payment Reform, will move the plans from paying for volume to paying for value. To accomplish this, managed care plans will be required to develop incentives for providers that are tied to improving quality and health outcomes for enrollees. Additionally, the new contracts will increase expectations around nationally recognized performance standards the plans must meet to receive financial incentive payments. Enrollment in the newly selected plans is expected to begin in March 2013 with coverage beginning in July 2013. (more info)

☑ **Rebalance long-term services and supports.** The budget made a significant investment in home- and community-based services for seniors and people with disabilities. All told, the budget allocated $532 million more for home- and community-based services over the biennium (above SFY 2011 levels). The bill also required the creation of a unified budget for long-term care services for seniors and people with physical disabilities, expansion of waiver services for people with developmental disabilities and the consolidation of Medicaid programs for people with disabilities in the Department of Developmental Disabilities (DODD), eliminating barriers that keep people from accessing services they need in the settings they prefer.

Project update: The changes in HB 153 have improved access into and within the service delivery system, provided consistent opportunity for individual choice and achieved greater transparency in price and quality for individuals who need long-term care services. Seniors now have access to services in their homes or in a community-based setting, with no waiting lists for waiver services. DODD has fully assumed the administration of institutional and home- and community-based developmental disability services, improving the ability for individuals to transition smoothly from developmental centers or other institutional settings into other supportive programs. DODD has added services to the Individual Options (IO) waiver to give Ohioans with developmental disabilities more choices regarding the support they receive for daily living needs. DODD has also created a new self-directed waiver, called SELF, for individuals with developmental disabilities. Enrollment in the new SELF waiver began in July. (more info)

☑ **Reform nursing facility payments.** The budget completed the transition from a cost-based payment methodology for nursing homes to a price-based system, a change that was initiated by the legislature in 2005 (HB 66) to reward efficiency. Additional nursing home payment reforms in HB 153 link more of the Medicaid payment to quality measures and increase the amount of funding for services provided directly to residents. The bill also enacted common-sense regulatory-reform provisions that will provide nursing facilities with greater flexibility in how they provide care, while increasing the focus on quality. The final budget reduced nursing facility rates 5.8 percent on average in 2012, providing a savings of $360 million that was invested in home- and community-based alternatives.

Project update: A subcommittee of the Unified Long-Term Care System Advisory Workgroup, chaired by the Office of Health Transformation, developed research-based quality measures and a methodology for linking almost $300 million of what Ohio pays nursing homes directly to practices

☑ **Lead statewide transition to patient-centered medical homes.** In January, the Department of Health (ODH) and the Office of Health Transformation announced that Ohio would invest $1 million to assist primary health-care practices around the state transition to a patient-centered medical home (PCMH) model of care and expand the number of PCMH practice sites in Ohio. The PCMH model of care promotes partnerships between patients and their primary health-care providers to improve care coordination, bolster individuals' health outcomes, and reduce health-care costs. As of November, 182 practices were officially recognized as PCMH practices in Ohio. (more info)

☑ **Invest in transformational programs.** Ohio has invested $15.5 million it has received for increasing enrollment and retention of eligible children in Medicaid to seed innovative projects that will improve health outcomes throughout the state, such as implementing Medicaid presumptive eligibility for pregnant women and children and improving early identification and intervention for individuals with autism spectrum disorders. See the full list of projects.

☑ **Reduce infant mortality.** ODH is leading a collaborative effort to reduce infant mortality in Ohio. In late November, the department convened Ohio's first statewide summit on infant mortality, drawing nearly 1,000 advocates to develop and refine strategies to make measurable improvements in the rate of pre-term births and infant deaths. ODH was also recognized in 2012 with the *Vision Award* from the Association of State and Territorial Health Officials for a "39-week" project it led in conjunction with the Ohio Perinatal Quality Collaborative. As a result of the project, nearly 26,000 babies that would have been delivered at 36-38 weeks were delayed to 39 weeks, representing an increase of 8 percent in full-term deliveries. The state has also invested significant resources in reducing the incidence of low-weight babies.

☑ **Increase employment opportunities for people with developmental disabilities.** In March, Ohio launched the Employment First Initiative to increase meaningful employment opportunities for individuals with developmental disabilities. Governor Kasich issued an executive order making community employment the preferred and priority outcome for working-age adults with developmental disabilities. The executive order also created the Employment First Task Force to review policies and programs and make recommendations for increasing community employment opportunities. In addition, the Governor's mid-biennium review legislation paved the way for additional opportunities by requiring all state agencies affecting developmental disability services and programs to align policies for supporting community employment. The bill required individual education plans for youth with developmental disabilities to include strategies for preparing for community employment after school. (more info)

☑ **Improve early diagnosis and intervention for people with autism.** DODD, in conjunction with the Ohio Center for Autism and Low Incidence, provides training for autism early intervention and autism therapy to employees of county boards of developmental disabilities. The training is part of a pilot program called Play and Language for Autistic Youngsters (PLAY), a relationship-based therapy program that emphasizes helping parents become their child's best PLAY partner. PLAY

☑ **Actively engage diverse stakeholders in creating solutions.** Over the past two years, the Office of Health Transformation has achieved a high level of stakeholder participation in health transformation. More than 3,500 Ohioans have signed up to follow Office of Health Transformation activities through regular email updates. Stakeholder input significantly influenced the final design of the Medicare-Medicaid ICDS system, Medicaid health homes for people with serious mental illness and ongoing efforts to create patient-centered medical homes. Sister HHS agencies have also implemented robust stakeholder outreach and communication activities.

STREAMLINE HEALTH AND HUMAN SERVICES

Ohio health and human services policy, spending and administration are split across multiple state and local government jurisdictions. Governor Kasich has challenged state and local leaders to think creatively and find new and better ways to deliver services. In addition to the reforms in HB 153, the Kasich Administration has taken a series of steps in 2012 to share services in a way that improves customer service, increases program efficiencies and reduces costs for taxpayers.

☑ **Modernize eligibility determination systems.** Current eligibility processes for health and human services in Ohio are fragmented, overly complex and rely on outdated technology. For example, Ohio uses more than 150 categories and two separate processes to determine Medicaid eligibility. This results in duplication, inefficiency and excessive cost for state and local governments to operate Medicaid and other health and human service eligibility programs.

The Office of Health Transformation initiated an eligibility modernization project to simplify client eligibility based on income, streamline state and local responsibility for eligibility determination and modernize eligibility systems technology. These actions will improve the consumer experience and significantly reduce the costs associated with the eligibility-determination processes, particularly those that rely on information technology. Ohio is on schedule to design and implement a new system by 2014. (more info)

☑ **Restructure HHS agency operations.** Governor Kasich is committed to creating a health and human services governance structure that maximizes efficiency and productivity. In July, the Kasich Administration announced plans to transform Ohio Medicaid into a state agency. In May, the Governor announced that the departments of Mental Health and Alcohol and Drug Addiction Services would be combined into a single state agency. Both moves will improve the level of services that the agencies will provide to their customers and to taxpayers. A package of legislative changes to transition to the new structure will be proposed in the 2014-2015 operating budget.

☑ **Update life and safety code to make nursing homes more like home.** ODA partnered with the Department of Commerce and ODH to change the Ohio building and mechanical code to support person-centeredness in nursing facilities. Ohio's proposed building code updates align with National Fire Protection Association recommendations and will allow facilities to apply for a CMS waiver in order to make environments for residents more like home.

programs provided an opportunity for the HHS agencies to identify new and better ways to deliver services and eliminate barriers to innovation. More than 50 initiatives to streamline and improve HHS program performance were included in MBR legislation (HB 487 and SB 316) and became law in 2012.

For the full list of HHS reforms in the MBR, see this report. Below are some highlights.

☑ **Protect individuals in home- and community-based services.** The Administration identified gaps and inconsistencies in statutes and regulations governing criminal background checks and disqualifying criminal convictions for workers providing home-health and waiver-transportation services under the Medicaid program. HB 487 language and subsequent changes to administrative rules will close these gaps to protect individuals receiving home- and community-based services from harm.

☑ **Target regional "hot spots" in mental health service capacity.** The Administration provided $3 million in additional resources to fund community mental health services that will create better outcomes through collaboration and coordinated care for high-cost and difficult-to-serve populations. The funding will be distributed through a new approach that targets "hot spots" in the system and rewards innovation and collaboration at the local level. This consumer-focused approach has earned the support of advocates representing consumers and families.

☑ **Fight addiction to opiates and other drugs.** During the MBR process, the Kasich Administration worked closely with key stakeholders to identify and target specific "hot spots" related to addiction treatment. As a result of this review, more than $17 million in additional state and federal funding was made available for addiction treatment services in communities throughout the state.

☑ **Accelerate the adoption of electronic health information exchange.** Current state privacy law in some cases applies standards for information sharing that are inconsistent with the federal law, impeding electronic health information exchange (HIE). Information sharing through HIEs will improve health outcomes for individuals and lay the foundation for price and quality transparency. HB 487 harmonizes state law with the standards adopted in the federal HIPAA privacy rule with respect to individual access to protected health information, proper safekeeping of protected health information and the use and disclosure of protected health information and will speed the adoption of HIEs in Ohio.

☑ **Pay for performance in hospitals.** The Administration worked closely with hospitals during the budget process to adopt payment reforms for Medicaid inpatient hospital reimbursement. HB 487 expanded this effort by linking some of the funds in the hospital reimbursement pool to meeting or exceeding new quality benchmarks. This pay-for-performance initiative will ensure that available funds are distributed to hospitals and promote better health outcomes for individuals in hospital settings.

Ohio | Department of Job and Family Services

FACT SHEET

Ohio Works First

Ohio Works First was established to provide time-limited cash assistance to eligible families through Ohio's Temporary Assistance to Needy Families program, which emphasizes employment, personal responsibility and self-sufficiency. Applications are processed at county departments of job and family services, and cash assistance is provided to eligible families for up to 36 months. For child-only cases, there are no time limits for cash assistance.

Each county agency develops its own policies for hardship and good cause extensions. After a 36-month time limit, cash assistance is not available unless the county agency approves an extension. A family may apply for a hardship extension at any time after its 36-month time limit has ended. A family may apply for a good cause extension after a 24-month waiting period following the 36-month time limit.

Who is eligible?

Families with earned income who do not currently participate in Ohio Works First, and who have not participated in at least one of the previous four months, must meet a "gross monthly income test" for eligibility. Gross monthly income includes unearned income and earned income before taxes. The gross monthly income limit for a family of three is currently $773, but this increases annually. If a family member works and pays for child care, the actual verified cost of child care can be deducted. There is no resource limit for Ohio Works First because resources are not considered in determining eligibility.

Ohio Works First has the following additional requirements:

- Adults and minor heads of household must participate in work activities.
- Minor children in assistance groups and women who are at least six months pregnant may be eligible to receive individual assistance.
- Children must reside with a parent, specified relative, legal guardian or a legal custodian.
- Unmarried minor parents and pregnant minors must be in approved adult-supervised living arrangements or live with a parent, legal guardian, specified relative or legal custodian.
- Adults and minor heads of household who apply for or receive benefits must sign a self-sufficiency contract.

Failure to sign the self-sufficiency contract without good cause can result in denial or termination of benefits which would affect the entire family. The contract explains the requirements for the participant, the requirements for the county department of job and family services and, if applicable, the requirements for the child support enforcement agency and/or public children services agency.

Continued

BUTLER COUNTY
Department of...
JOB & FAMILY SERVICES

Learning, Earning and Parenting (LEAP)

Description:

Learning, Earning and Parenting (LEAP) is a program designed to assist and counsel teen parents under the age of nineteen. As a condition of eligibility, these individuals are required to enroll or remain in a program that will lead to a high school diploma or GED.

NOTE: Failure to do so will result in money sanctions to their Ohio Works First (OWF) benefits.

Benefits:

- Assistance with transportation
- Assistance with child day care services
- Monetary incentives/bonuses for good attendance, graduation and enrollment

How to Qualify:

OWF participants who are custodial parents, or at least six months pregnant and who do not have their high school diploma or GED.

How to Get Started:

Enroll in the Ohio Works First (OWF) program.

What to Bring:

Proof of OWF enrollment or OWF cash.

Contact Information:

Phone: (513) 887-5600 or Toll Free: 1-800-582-4267

Medicaid Per Member/Per Month – All Agency

	FY 2007	FY 2008	FY 2009	FY 2010
Service Cost	$ 11,804,659,514	$ 12,315,957,215	$ 13,266,749,057	$ 14,661,974,173
Member Months	1,768,783	1,789,934	1,886,843	2,046,072
PMPM	$ 556.16	$ 573.39	$ 585.93	$ 597.16
% Increase		3.10%	2.19%	1.92%

	FY 2011	FY 2012	FY 2013 Estimate
Service Cost	$ 15,660,041,336	$ 16,008,369,555	$ 16,530,298,041
Member Months	2,157,606	2,215,290	2,369,929
PMPM	$ 604.84	$ 602.19	$ 581.25
% Increase	1.29%	-0.44%	-3.48%

**From Ohio Department of Medicaid, Projected Medicaid Service Expenditures, Executive Budget Submission (page 15)*

Target "Hot Spots" in Mental Health and Addiction Services

Updated May 11, 2012

Governor Kasich's Jobs Budget (HB 153) took bold steps to stabilize funding for mental health and addiction services after years of erosion, and it implemented management tools to improve the delivery of community behavioral health services to people in need. The budget created a single point of accountability for Medicaid-funded behavioral health services; elevated the responsibility for funding these services to the state, freeing up millions of local levy dollars for services to people who are uninsured and indigent; and established much-needed utilization-management controls and cost-containment tools for Medicaid to ensure the best and most efficient use of treatment dollars.

These reforms have challenged the state and local delivery systems to improve how they do business. During the Mid-Biennium Review (MBR), the Kasich Administration evaluated the progress of these reforms. Through this process, and in consultation with stakeholders, the Administration identified specific "hot spots" where targeted adjustments are needed.

- **Invest in housing for Ohioans with mental illness.** The Capital Bill proposes to invest $10 million in community mental health projects, all of which will be dedicated to housing for people with a mental illness. Safe and supportive housing is critical to recovery and the current supply does not meet the demand in the mental health safety net. This would be the largest capital investment in community mental health since the 2001 Capital Bill.

- **Advance the fight against opiate abuse.** Governor Kasich has pledged to fight opiate abuse in every corner of the state. Ohio will provide Medicaid coverage of Medication Assisted Therapy (MAT) for an additional 21,000 Ohioans receiving services from ODADAS provider agencies. These services will be covered under currently approved procedure codes. This change will prevent unnecessary hospitalizations and other high-cost services.

- **(NEW ITEM) Target regional needs for non-Medicaid services.** ODADAS will provide county behavioral health authorities an additional $3 million ($1.05 million that was previously committed and $1.95 million that was committed on May 11) to administer addiction treatment services for Ohioans with opiate and other addictions who are not eligible for Medicaid.

- **Target regional "hot spots" in mental health service capacity**. The MBR legislation includes $3 million for targeted community mental health projects that provide the biggest impact for individuals who need services. Funds will be allocated by ODMH via a new approach that targets "hot spots" in the system, transcends traditional board areas and rewards local innovation and collaboration. This consumer-focused approach has earned the support of advocates representing consumers and families.

- **Identify additional areas for savings.** As part of the mid-biennial review process, the Office of Budget and Management asked each state agency to suggest areas for efficiency. ODADAS was exempted from any reductions. ODMH will cut $200,000 from pre-admission screening expenses and $1 million from hospital services. These cuts will be implemented without affecting services to individuals with mental illness.

Q: What are the Workforce Investment Act (WIA) funding levels for the FY14-15 biennium?

A: The Workforce Investment Act (WIA) of 1998 requires the establishment of a state-wide workforce delivery system while providing formula based funding to states for its implementation. The Ohio Department of Job and Family Services (ODJFS) administers this program. The federal formula allocates funding based on each state's unemployment and poverty rates. Therefore, the formula allocates higher WIA dollars to states whose unemployment and poverty rates have increased in relation to other states. Table A summarizes Ohio's WIA formula based funding from SFY09-13.

Table A: Workforce Investment Act (WIA) Formula Funding

Distribution	FY09 Actual	FY10 Actual	FY10/FY09 % Change	FY11 Actual	FY11/FY10 % Change	FY12 Actual	FY12/FY11 % Change	FY13 Estimate	FY13/FY12 % Change
Local Area Funds	$127,680,260	$105,312,337	-17.5%	$95,521,216	-9.3%	$89,207,656	-6.6%	$79,603,015	-10.8%
Statewide Funds	$26,059,943	$21,053,976	-19.2%	$19,133,607	-9.1%	$5,274,252	-72.4%	$4,681,878	-11.2%
Rapid Response	$19,992,751	$13,993,528	-30.0%	$12,902,555	-7.8%	$11,003,127	-14.7%	$9,352,675	-15.0%
Total	$173,732,954	$140,359,841	-19.2%	$127,557,378	-9.1%	$105,485,035	-17.3%	$93,637,568	-11.2%

The Local Area Funds category represents WIA formula funds federally required for Workforce Investment Boards (WIBs) which provide direct employment services. State-wide Funds are designated for state WIA administration; recently reduced to five percent of the total WIA formula allocation. Finally, Rapid Response represents funding for the Rapid Response program which returns layoff affected works to re-employment as soon as possible.

Total WIA formula funds have decreased by **$80.1 million**, 46.1%, when comparing FY09 actuals to FY13 estimates. This is due to Ohio's lower unemployment and poverty rates in comparison to other states; reducing the Ohio WIA allocation. Also, federal WIA appropriation levels have declined. These reductions are due to federal, not state, WIA formula funding policies. For reference, the FY13 level of $93.6 million represents the lowest WIA formula funding level ODJFS has ever federally received in the history of the Ohio WIA Program.

In order to respond to WIA formula fund decreases, ODJFS continues to apply for US Department of Labor (USDOL) non-formula discretionary and National Emergency Grants to serve affected workers. From these efforts, the FY14-15 Budget shows the appropriation line item which receives WIA formula and non-formula funds at a small increase (0.2%) when compared to FY13 estimates, or $136.0 million in both FY14 and FY15. The ODJFS WIA fund is Fund 3V00, ALI 600688 Workforce Investment Act. ODJFS strongly believes WIA programs and services are an essential component of Ohio's economic recovery and will continue to leverage existing and new resources to support eligible Ohioans.

Effective Date	July 1

Task	Due Date	Time Allotted	Total Time
Final File (JCARR)	June 21	- 10 days	-10 days
Original File (JCARR)	April 17	- 65 days	-75 days
Staff Time for Changes	April 12	- 5 days	-80 days
BIA Process/Review	March 18	- 25 days	-105 days
Staff Time for Changes	March 15	- 3 days	-108 days
Clearance Process	March 1	- 14 days	-122 days