

LSC Redbook

Analysis of the Executive Budget Proposal

**Department of
Job and Family Services**

*Ivy Chen, Senior Economist
Todd A. Celmar, Economist
Deauna Hale, Budget Analyst
Maggie Priestas, Budget Analyst
Legislative Service Commission*

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READER'S GUIDE

The Legislative Service Commission prepares an analysis of the executive budget proposal for each agency. These analyses are commonly called "Redbooks." This brief introduction is intended to help readers navigate the Redbook for the Ohio Department of Job and Family Services (ODJFS).

The ODJFS Redbook contains the following sections:

- ODJFS Overview;
- Medicaid;
- Medicaid Primer;
- Family Stability;
- Children and Families;
- Child Support;
- Workforce Development;
- Unemployment Compensation; and
- Administration.

Except for the Medicaid Primer, each of these sections includes an Overview and an Analysis of Executive Proposal. Some sections also include Facts and Figures or Requests Not Funded depending upon the specific aspects of that section. The back of the Redbook includes the Catalog of Budget Line Items (COBLI) for ODJFS, which briefly describes each line item, as well as the LSC budget spreadsheet for ODJFS.

TABLE OF CONTENTS

OVERVIEW OF DEPARTMENT OF JOB AND FAMILY SERVICES.....	1
Agency Overview.....	1
Staffing Overview.....	2
Appropriations Overview.....	3
FY 2009 Appropriation Reductions.....	3
Appropriations by Fund Group.....	4
Appropriations by Object of Expense.....	5
Appropriations by Program Category.....	6
Major Medicaid Initiatives.....	6
Line Item Category Introduction.....	7
MEDICAID	11
Overview.....	11
Program Overview.....	11
Appropriation Overview.....	11
Major Initiatives.....	13
Federal Stimulus.....	13
Managed Care Assessment.....	13
Managed Care Prescription Drug Carve Out.....	14
Hospital Rates and Assessment.....	14
Hospitals and Managed Care.....	14
Nursing Facilities.....	14
Highlights of FY 2008-FY 2009 Biennium Budget.....	15
Administrative Change.....	15
Executive Medicaid Management Agency (EMMA).....	15
Funding Issues.....	15
Medicaid Reserve Fund.....	15
Budget Stabilization Fund Transfer.....	16
Line Item 600525, Appropriation Assumptions.....	16
Cost Containment Strategies.....	19
Administrative Component of Managed Care Rates.....	19
Third Party Liability for Medicaid Claims.....	19
Annual Hospital Recalibration.....	20
Expedite Managed Care Enrollment.....	20
Medicaid Managed Care and Hospitals.....	20
Claims Editing.....	20
Pre-Approval of Atypical Antipsychotic Drug.....	21
Managed Care Pharmacy Utilization Management Programs.....	21

New Programs and Eligibility Expansions.....	21
Medicaid Buy-In for Workers with Disabilities Program	21
Pregnant Women Eligibility Expansion to 200% FPG.....	22
Children's Eligibility Expansion to 300% FPG.....	23
Medical Assistance for Children with Income Over 300% FPG.....	23
Medicaid Eligibility for Former Foster Children.....	24
Money Follows the Person Grant	24
Ohio Access Success Project	24
Medicaid Optional Services.....	25
Medicaid School Component	26
Provider Rates.....	26
Medicaid Rates for Nursing Facilities.....	26
Medicaid Rates for Intermediate Care Facilities for the Mentally Retarded.....	28
Inpatient Hospital Reimbursement	29
Supplemental Payment Program for Children's Hospitals	30
Community-Based Providers.....	30
Dispensing Fees for Generic Drugs.....	30
Audits and Estate Recovery	30
Medicaid Nursing Facility and ICF/MR Audits	30
Medicaid Provider Audits	30
Medicaid Estate Recovery Program	31
Reports	33
Unified Long-Term Care Budget Workgroup	33
State Coverage Initiatives	33
PACT Program	34
Public Assistance Reporting Information System (PARIS).....	34
Facts and Figures	35
Medicaid Caseloads and Services: ABD vs. CFC.....	35
Medicaid Caseloads	36
Medicaid Managed Care Caseload Expands.....	39
Total Medicaid Expenditures.....	41
Medicaid Expenditures by Service Category	42
Mandatory and Optional Services	44
Analysis of Executive Proposal	47
Introduction.....	47
Medicaid Services.....	48
Health Care/Medicaid (600525).....	48
Medicare Part D (600526).....	53
Nursing Facility Capital Compensation (600529)	53
Children's Hospital (600537)	54

Supplemental Inpatient Hospital Payments (600619)	55
Money Follows the Person (600631)	55
Medicaid Payment Withholding (600638)	56
Interagency Reimbursement (600655)	56
Health Care – Federal (600623)	56
Medicaid Provider Taxes	58
Managed Care Assessments (600653)	58
Nursing Facility Franchise Permit Fee (600608, 600613)	59
ICF/MR Bed Assessments (600621)	61
New Hospital Assessment (600656)	62
Medicaid Revenue and Collections	63
Medicaid Program Support (600671)	63
Medicaid Revenue and Collections (600639)	63
Health Care Services (600692)	64
Medicaid Administration	66
Medicaid Provider Audits (600417)	66
Office of Ohio Health Plans (600425)	67
Nursing Home Assessments (600605)	67
Residential State Supplement Payments (600618)	67
Health Care Compliance (600625)	68
MR/DD Medicaid Administration and Oversight (600629)	68
Health Care Services Administration (600654)	68
Hospital Care Assurance Program	70
Hospital Care Assurance Program (600649, 600650)	70
MEDICAID PRIMER	71
Medicaid and the Economy	74
Medicaid vs. Medicare	75
Dual Eligibles	76
Medicare Part D	77
Ohio Medicaid	78
Administration	81
Eligibility	82
Covered Services	88
Delivery Systems	110
Financing and Funding	112
Information Technology & Data Reporting	115
Hospital Care Assurance Program	116
Disability Medical Assistance (DMA) Program	116

FAMILY STABILITY	119
Overview.....	119
Program Overview	119
Appropriations Overview	119
Welfare Reform.....	121
TANF Overview	122
Ohio Works First	123
Prevention, Retention, and Contingency.....	124
Child Care.....	125
Early Learning Initiative.....	126
Federal Stimulus.....	126
Facts and Figures	129
TANF Expenditures	129
Ohio's TANF Surplus.....	130
Prevention, Retention, and Contingency Expenditures	131
Child Care Caseloads.....	132
Analysis of Executive Proposal	133
Introduction.....	133
Temporary Assistance for Needy Families.....	134
Federal Stimulus Assumptions	134
TANF State (600410)	134
Child Support Collections (600658).....	135
TANF Block Grant (600689).....	135
Child Care.....	137
Federal Stimulus Assumptions.....	138
Child Care Match/MOE (600413).....	138
Early Care and Education (600535)	138
Child Care – Federal Stimulus (600661).....	139
Child Care Federal (600617)	139
Food Assistance Programs	141
Federal Stimulus Assumptions	142
Food Stamp Intercept (600601).....	142
Food Assistance and State Administration (600610)	143
Emergency Food Distribution (600641)	143
Food Assistance (600630)	144
Other Assistance Programs.....	145
Disability Financial Assistance (600511).....	145
Refugee Services (600614).....	146
Faith Based Initiatives (600675).....	146

Administration.....	148
Office of Family Stability (600421).....	148
CHILDREN AND FAMILIES	149
Overview.....	149
Program Overview	149
Appropriation Overview.....	149
Children and Family Services.....	150
Major initiatives	151
Facts and Figures	153
Analysis of Executive Proposal	155
Introduction.....	155
Office of Children and Families (600423)	155
Children and Families Services (600523)	157
Adoption Services (600528)	157
Adult Protective Services (600534)	158
Child Welfare (600606)	159
Special Activities/Child and Family Services (600616).....	160
Social Services Block Grant (600620).....	160
Adoption Maintenance/Administration (600627)	161
IV-E Foster Care Maintenance (600628).....	162
Children's Trust Fund (600647 and 600648).....	164
Child and Family Services Collections (600604).....	165
Foundation Grants/Child and Family Services (600609).....	165
Adoption Assistance Loan (600634)	166
Children and Family Support (600663).....	166
CHILD SUPPORT	169
Overview.....	169
Program Overview	169
Appropriation Overview.....	169
Child Support Activities.....	171
Analysis of Executive Proposal	173
Introduction.....	173
Child Support Enforcement (600420, 600502, and 600626)	173
Child Support Projects (600622).....	179
Support Intercept (600646 and 600642).....	180
Requests Not Funded.....	181

WORKFORCE DEVELOPMENT	183
Overview.....	183
Program Overview	183
Appropriation Overview.....	185
American Recovery and Reinvestment Act.....	186
FY 2008-FY 2009 Highlights	187
One-Stop Continuous Improvement Program	187
Transitioned and Consolidated Workforce Development Programs	187
Rapid Response Program Reform	188
Facts and Figures	191
Participation in Employment Services	191
Analysis of Executive Proposal	193
Workforce Development	193
Training Activities (600645).....	193
Federal Operating (600686).....	193
Workforce Investment Act (600688).....	196
Military Injury Grants (600637).....	196
UNEMPLOYMENT COMPENSATION.....	199
Overview.....	199
Program Overview	199
Appropriation Overview.....	201
Federal Stimulus.....	202
Extension of Unemployment Benefits.....	202
Unemployment Insurance Modernization.....	202
Unemployment Compensation Trust Fund Solvency	203
Unemployment Compensation Advisory Council.....	204
Facts and Figures	205
Unemployment Compensation Trust Fund Balance	205
Initial Unemployment Claims Filed.....	206
Analysis of Executive Proposal	207
Unemployment Compensation	207
Federal Unemployment Programs (600678)	207
Unemployment Compensation Review Commission (600694 and 600679).....	208
Unemployment Compensation Administration Fund (600607)	209
Banking Fees (600687)	209

ADMINISTRATION	211
Overview.....	211
Analysis of Executive Proposal	213
Administration.....	213
Support Services (600321)	213
Computer Projects (600416).....	214
Entitlement Administration – Local (600521)	217
BCII Services/Fees (600665)	217
Administration and Operating (600633).....	217
County Technologies (600677)	217
Building Consolidation (600667).....	217
Building Consolidation (600668).....	218
Refunds and Audit Settlements (600643)	218
Forgery Collections (600644)	218
Requests Not Funded	219

ATTACHMENTS:

- Catalog of Budget Line Items
- Budget Spreadsheet By Line Item

Overview of Department of Job and Family Services

- Executive budget assumes \$2.9 billion in additional federal reimbursements for Medicaid as part of the federal stimulus
- Ohio is to pay interest of \$64.5 million in FY 2011 for borrowing from the federal government to pay unemployment benefits
- Expected increases in enrollment for Medicaid, cash assistance, non-cash supports, food assistance, and other public assistance programs

Agency Overview

The Ohio Department of Job and Family Services' (ODJFS) mission is, through state and local partnerships, to help all Ohioans improve the quality of their lives. ODJFS has 3,688 employees and a budget of approximately \$18.55 billion in FY 2009.

ODJFS develops and oversees programs that provide health care, employment and economic assistance, child support, and services to families and children. Medicaid is a publicly funded health insurance program for low-income individuals. The State Children's Health Insurance Program (SCHIP) provides health care coverage for children in low- and moderate-income families who are ineligible for Medicaid but cannot afford private insurance. Family Stability is a group of programs and services that deliver cash assistance, non-cash supports, and food assistance to low-income families with the goal of equipping these families to achieve self-sufficiency. Workforce Development is a partnership between ODJFS, various state agencies, local workforce investment boards, and a variety of stakeholders that seek to promote job creation and to advance Ohio's workforce. Unemployment insurance was created as a federal and state partnership for income maintenance during periods of involuntary unemployment, by providing partial compensation for lost wages to eligible individuals. ODJFS is also responsible for ensuring children receive the child support to which they are entitled from a noncustodial parent and supervising county child welfare practice through the formulation of policy, promulgation of regulations, and the promotion of best practices.

The administration and funding of job and family services programs represent a unique cooperative partnership between three levels of government: federal, state, and local. The federal government contributes funds in forms of reimbursements and grants for most programs operated by ODJFS and sets guidelines for program operations. ODJFS supervises the administration of these programs, channels funds to local agencies to respond to local needs, and provides technical support to ensure

compliance with federal and state regulations. The direct delivery of services is administered by ODJFS and a combination of county offices, which includes 88 county departments of job and family services.

The executive recommended funding for ODJFS is approximately \$19.43 billion in FY 2008 and \$20.56 billion in FY 2009.

Staffing Overview

As of December 2008, ODJFS had 3,688 employees. Table 1 below lists the number of employees in each division as of December 2008 and compares them to staffing levels two years prior.

Table 1. Department of Job and Family Services Staffing Levels			
Division	As of Dec. 2006	As of Dec. 2008	% Change
Director's Office	19	20	5.3%
Office of Legislation	11	7	-36.4%
Office of Fiscal Services	135	126	-6.7%
Office of Research, Assessment, & Accountability	238	195	-18.1%
Office of Legal Services	89	75	-15.7%
Office of Employee and Business Services	187	126	-32.6%
Office of Management Information Services	557	523	-6.1%
Office of Local Operations	949	965	1.7%
Office of Child Support	178	140	-21.3%
Office of Ohio Health Plans	494	398	-19.4%
Office for Children and Families	226	226	0.0%
Office of Workforce Development	114	122	7.0%
Office of Family Stability	102	84	-17.6%
Office of the Chief Inspector	32	28	-12.5%
Office of Unemployment Compensation	504	546	8.3%
Office of Unemployment Compensation Review Committee	56	63	12.5%
Office of Communications	9	10	11.1%
Office of Contract Administration	23	22	-4.3%
Governor's Office of Faith Based and Community Initiatives	4	12	200.0%
TOTAL	3,927	3,688	-6.1%

The reduction in staff is mainly attributable to the mandated executive budget reductions in February 2008. By July 2008, 179 positions were eliminated due to this mandate (of these, 27 employees were eligible for and accepted early retirement). An additional 134 employees opted for early retirement incentive whose positions were not eliminated. However, ODJFS filled some needed positions during this time, which

offset some of the reductions. ODJFS has also experienced some loss of personnel through attrition, and in some cases these positions are left unfilled.

Appropriations Overview

FY 2009 Appropriation Reductions

In December 2008, OBM estimated a shortfall of \$634 million in state revenues for FY 2009. In response to this, OBM issued budget reductions across GRF line items. Table 2 below lists ODJFS's GRF line item appropriations for FY 2009 (as of July 2008) as well as the adjusted appropriation level due to the executive Budget Directive #11. This Redbook uses FY 2009 *adjusted* appropriation amounts when comparing executive recommendations for FY 2010 to FY 2009. These are the appropriations as of January 2009.

GRF ALI	ALI Name	FY 2009 Original Appropriations	FY 2009 Adjusted Appropriations	Reduction
600321	Support Services	\$63,861,650	\$54,180,625	-\$9,681,025
600410	TANF State	\$267,619,061	\$254,907,156	-\$12,711,905
600413	Child Care Match/MOE	\$84,120,596	\$80,124,868	-\$3,995,728
600416	Computer Projects	\$137,611,150	\$106,205,968	-\$31,405,182
600417	Medicaid Provider Audits	\$2,000,000	\$1,573,876	-\$426,124
600420	Child Support Administration	\$10,641,446	\$7,723,936	-\$2,917,510
600421	Office of Family Stability	\$4,614,932	\$2,720,599	-\$1,894,333
600423	Office of Children and Families	\$5,900,000	\$4,842,705	-\$1,057,295
600425	Office of Ohio Health Plans	\$45,918,368	\$34,697,854	-\$11,220,514
600502	Administration – Local	\$34,014,103	\$26,948,050	-\$7,066,053
600512	Non-TANF Disaster Assistance	\$1,000,000	\$950,750	-\$49,250
600521	Entitlement Administration – Local	\$130,000,000	\$118,609,231	-\$11,390,769
600523	Children and Families Services	\$78,115,135	\$68,935,460	-\$9,179,675
600525	Health Care/Medicaid**	\$9,538,884,187	\$9,206,412,349	-\$332,471,838
600526	Medicare Part D	\$271,854,640	\$235,817,392	-\$36,037,248
600528	Adoption Services	\$93,174,366	\$86,500,697	-\$6,673,669
600534	Adult Protective Services	\$500,000	\$497,403	-\$2,597
TOTAL		\$10,769,829,634	\$10,291,648,919	-\$478,180,715

**The FY 2009 adjusted appropriation for GRF line item 600525, Health Care/Medicaid, is currently \$9,877,719,907. This is explained in the paragraph below the table.

Though the directive reduced GRF line item 600525, Health Care/Medicaid, other legislative provisions allowed for additional appropriations, which result in the adjusted appropriation used in the executive's recommendations being \$9,877,719,907.

These include an additional appropriation of \$525,641,026 from the Medicaid Reserve Fund authorized in H.B. 119, as well as an additional appropriation of \$145,666,532 in H.B. 562.

Appropriations by Fund Group

The executive budget provides a total appropriation of \$19.43 billion in FY 2010 and \$20.56 billion in FY 2011 for ODJFS. Chart 1 and Table 3 below present the executive recommended appropriations by fund group. As the chart shows, appropriations from the GRF make up a majority of ODJFS's funding for the biennium at 55.3%. The GRF appropriations in ODJFS include the federal grant amounts for Medicaid made out of the GRF, as well as federal grant amounts for administration activities related to Medicaid and Adoption Assistance. Federal funds account for the next largest portion of ODJFS's funding at 36.3%, which include federal reimbursement from non-GRF Medicaid payments, and the TANF Block Grant. The State Special Revenue Fund Group and the General Services Fund Group account for 7.7%, and Agency and Holding Account represent 0.8%.

Chart 1: Executive Budget Recommendations by Fund Group, FY 2010-FY 2011

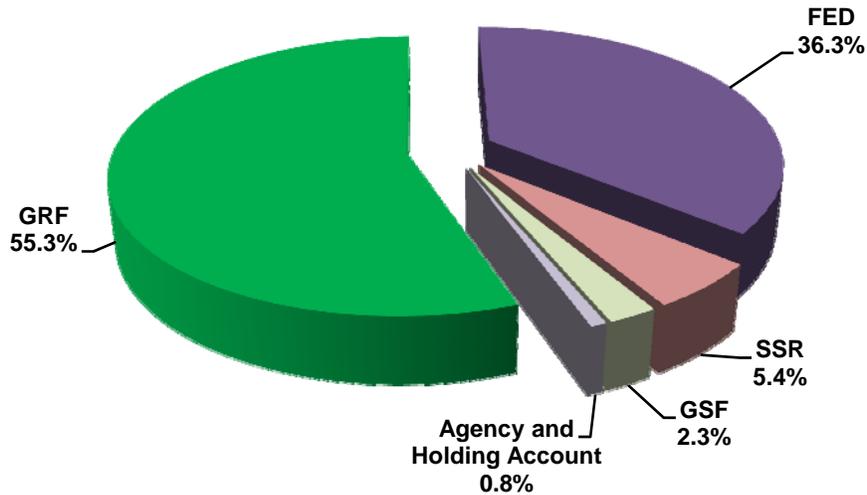


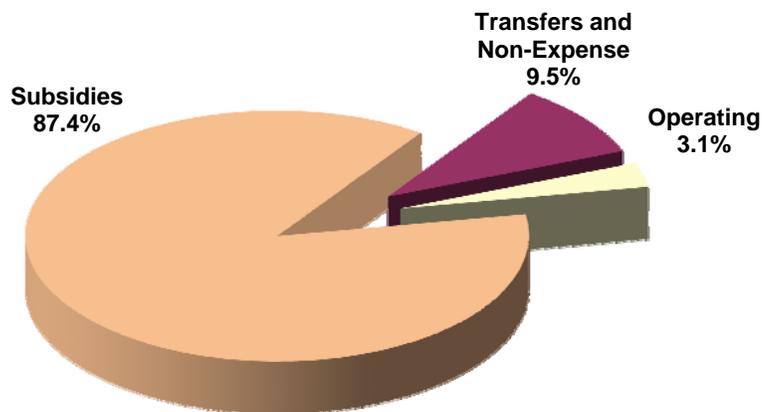
Table 3. Executive Budget Recommendations by Fund Group, FY 2010-FY 2011					
Fund Group	FY 2009*	FY 2010	% Change	FY 2011	% Change
General Revenue	\$10,988,292,387	\$10,116,558,778	-7.9%	\$11,983,393,541	18.5%
General Services	\$520,185,381	\$495,761,804	-4.7%	\$431,458,423	-13.0%
State Special Revenue	\$596,870,540	\$1,050,918,707	76.1%	\$1,110,036,686	5.6%
Federal Special Revenue	\$6,292,097,628	\$7,615,479,159	21.0%	\$6,886,910,832	-9.6%
Agency	\$148,000,000	\$148,000,000	0.0%	\$148,000,000	0.0%
Holding Account	\$3,610,000	\$3,610,000	0.0%	\$3,610,000	0.0%
TOTAL	\$18,549,055,936	\$19,430,328,448	4.8%	\$20,563,409,482	5.8%

*FY 2009 figures represent adjusted appropriations.

Appropriations by Object of Expense

Chart 2 shows the executive recommended appropriations by object of expense. More than 87% of ODJFS's budget is paid out as subsidies, mainly to persons receiving public assistance services such as Medicaid.

Chart 2: Executive Budget Recommendations by Expense Category, FY 2010-FY 2011

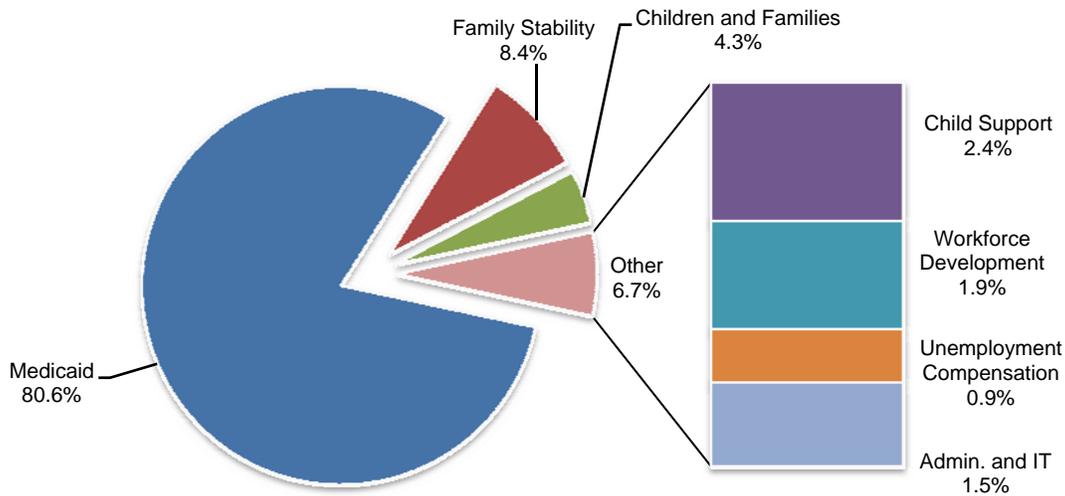


ODJFS retains approximately \$1.26 billion (3.1%) of its recommended budget for the biennium at the state level for operating expenses including personal services, purchased services, maintenance, and equipment spending. Personal services accounts for approximately \$666.4 million (51.2%) of these funds expended at the state level.

Appropriations by Program Category

Chart 3 shows the executive recommended appropriations by program category. About 81% of ODJFS's budget is budgeted for Medicaid expenses.

Chart 3: Percentage of Funding by Program Category, FY 2010-FY 2011



The "Family Stability" category includes appropriations for TANF programs as well as publicly funded child care. The "Children and Families" category includes appropriations for adoption assistance and the Social Services Block Grant.

Major Medicaid Initiatives

- The state is to receive a total of \$2.9 billion in additional federal reimbursements for Medicaid, reducing the need for the GRF to support Medicaid.
- To replace the \$550 million annual revenue loss resulting from the termination of the 5.5% franchise tax on Medicaid managed care plans (MCPs) beginning October 1, 2009, the executive budget proposes to subject MCPs to the state sales and use tax (5.5%) and to the existing health insuring corporation tax. MCPs are currently exempted from the latter tax.
- The executive budget "carves out" the MCP pharmacy program to increase Medicaid drug rebate revenue. The combined state and federal shares of revenue increases are estimated at \$5.2 million in FY 2010 and \$235.5 million in FY 2011.

- The executive budget increases inpatient and outpatient hospital payment rates by 5% beginning January 2010. It also establishes a new hospital assessment at 1.27% and 1.37% of total facility cost for FY 2010 and FY 2011, respectively. State-share revenue generated from the assessment is estimated at \$282.8 million and \$315.6 million, respectively. These funds will be used to support Medicaid programs.
- The executive budget increases the nursing facility (NF) franchise fee from \$6.25 to \$11.00 per bed per day, increasing state-share revenue by \$122.2 million in FY 2010 and \$162.9 million in FY 2011. It also proposes to pay NFs based on a *standard price* determined by a statutory formula without applying a "stop-loss" (annual loss floor) or "stop-gain" (annual increase cap) limit.

Line Item Category Introduction

ODJFS's line items are grouped into seven major program categories. These seven categories are as follows:

1. Medicaid;
2. Family Stability;
3. Children and Families;
4. Child Support;
5. Workforce Development;
6. Unemployment Compensation; and
7. Administration.

To aid the reader in finding each item in the analysis, the following table shows the program category in which each appropriation has been placed, listing the line items in order within their respective fund groups and funds. This is the same order the line items appear in the budget bill.

Table 4. Categorization of ODJFS's Appropriation Line Items for Analysis of Executive Proposal		
Fund	ALI and Name	Category
General Revenue Fund Group		
GRF 600321	Support Services	7: Administration
GRF 600410	TANF State	2: Family Stability
GRF 600413	Child Care Match/Maintenance of Effort	2: Family Stability
GRF 600416	Computer Projects	7: Administration
GRF 600417	Medicaid Provider Audits	1: Medicaid
GRF 600420	Child Support Administration	4: Child Support
GRF 600421	Office of Family Stability	2: Family Stability
GRF 600423	Office of Children and Families	3: Children and Families
GRF 600425	Office of Ohio Health Plans	1: Medicaid
GRF 600502	Administration – Local	4: Child Support
GRF 600511	Disability Financial Assistance	2: Family Stability
GRF 600521	Entitlement Administration – Local	7: Administration
GRF 600523	Children and Families Services	3: Children and Families
GRF 600525	Health Care/Medicaid	1: Medicaid
GRF 600526	Medicare Part D	1: Medicaid
GRF 600528	Adoption Services	3: Children and Families
GRF 600529	Capital Compensation Program	1: Medicaid
GRF 600534	Adult Protective Services	3: Children and Families
GRF 600535	Early Care and Education	2: Family Stability
GRF 600537	Children's Hospital	1: Medicaid
GRF 600661	Child Care – Federal Stimulus	2: Family Stability
General Services Fund Group		
4A80 600658	Child Support Collections	2: Family Stability
4R40 600665	BCII Services/Fees	7: Administration
5BG0 600653	Managed Care Assessment	1: Medicaid
5C90 600671	Medicaid Program Support	1: Medicaid
5DL0 600639	Medicaid Revenue and Collections	1: Medicaid
5DM0 600633	Administration and Operating	7: Administration
5FX0 600638	Medicaid Payment Withholding	1: Medicaid
5N10 600677	County Technologies	7: Administration
5P50 600692	Health Care Services	1: Medicaid
6130 600645	Training Activities	5: Workforce Development

Table 4. Categorization of ODJFS's Appropriation Line Items for Analysis of Executive Proposal		
Fund	ALI and Name	Category
Federal Special Revenue Fund Group		
3270	600606 Child Welfare	3: Children and Families
3310	600686 Federal Operating	5: Workforce Development
3840	600610 Food Assistance and State Administration	2: Family Stability
3850	600614 Refugee Services	2: Family Stability
3950	600616 Special Activities/Child and Family Services	3: Children and Families
3960	600620 Social Services Block Grant	3: Children and Families
3970	600626 Child Support	4: Child Support
3980	600627 Adoption Maintenance/Administration	3: Children and Families
3A20	600641 Emergency Food Distribution	2: Family Stability
3AW0	600675 Faith Based Initiatives	2: Family Stability
3D30	600648 Children's Trust Fund Federal	3: Children and Families
3F00	600623 Health Care Federal	1: Medicaid
3F00	600650 Hospital Care Assurance Match	1: Medicaid
3G50	600655 Interagency Reimbursement	1: Medicaid
3H70	600617 Child Care Federal	2: Family Stability
3N00	600628 IV-E Foster Care Maintenance	3: Children and Families
3S50	600622 Child Support Projects	4: Child Support
3V00	600688 Workforce Investment Act	5: Workforce Development
3V40	600678 Federal Unemployment Programs	6: Unemployment Compensation
3V40	600679 Unemployment Compensation Review Commission – Federal	6: Unemployment Compensation
3V60	600689 TANF Block Grant	2: Family Stability
State Special Revenue Fund Group		
1980	600647 Children's Trust Fund	3: Children and Families
4A90	600607 Unemployment Compensation Admin Fund	6: Unemployment Compensation
4A90	600694 Unemployment Comp Review Commission	6: Unemployment Compensation
4E30	600605 Nursing Home Assessments	1: Medicaid
4E70	600604 Child and Family Services Collections	3: Children and Families
4F10	600609 Foundation Grants/Child & Family Services	3: Children and Families
4J50	600613 Nursing Facility Bed Assessments	1: Medicaid
4J50	600618 Residential State Supplement Payments	1: Medicaid
4K10	600621 ICF/MR Bed Assessments	1: Medicaid
4R30	600687 Banking Fees	6: Unemployment Compensation
4Z10	600625 Healthcare Compliance	1: Medicaid
5AJ0	600631 Money Follows the Person	1: Medicaid
5DB0	600637 Military Injury Grants	5: Workforce Development
5DP0	600634 Adoption Assistance Loan	3: Children and Families
5ES0	600630 Food Assistance	2: Family Stability

Table 4. Categorization of ODJFS's Appropriation Line Items for Analysis of Executive Proposal			
Fund		ALI and Name	Category
5F20	600667	Building Consolidation	7: Administration
5F30	600668	Building Consolidation	7: Administration
5GF0	600656	Medicaid – Hospital	1: Medicaid
5Q90	600619	Supplemental Inpatient Hospital Payments	1: Medicaid
5R20	600608	Medicaid – Nursing Facilities	1: Medicaid
5S30	600629	MR/DD Medicaid Administration and Oversight	1: Medicaid
5U30	600654	Health Care Services Administration	1: Medicaid
5U60	600663	Children and Family Support	3: Children and Families
6510	600649	Hospital Care Assurance Program Fund	1: Medicaid
Agency Fund Group			
1920	600646	Support Intercept – Federal	4: Child Support
5830	600642	Support Intercept – State	4: Child Support
5B60	600601	Food Assistance Intercept	2: Family Stability
Holding Account Redistribution Fund Group			
R012	600643	Refunds and Audit Settlements	7: Administration
R013	600644	Forgery Collections	7: Administration

Medicaid

- \$2.9 billion in additional federal reimbursements for Medicaid
- Replacement for Managed Care Assessment
- New hospital assessment

OVERVIEW

Program Overview

Medicaid is a publicly funded health insurance program for low-income individuals. The program covers as many as 2.2 million low-income parents, children, pregnant women, seniors, and individuals with disabilities each year. Ohio Medicaid is the largest health insurer in the state. It is also the largest single state program with annual spending of more than \$13 billion in combined federal and state dollars. Medicaid accounts for 3% of Ohio's economy.

Medicaid services are an entitlement for those who meet eligibility requirements. Entitlement means that if an individual is eligible for the program then they are guaranteed the benefits and the state is obligated to pay for them.

Another state health care program, which has been implemented as a Medicaid expansion in Ohio, is the State Children's Health Insurance Program (SCHIP). This program provides health care coverage for children in low- and moderate-income families who are ineligible for Medicaid but cannot afford private insurance.

Lastly, the Department of Job and Family Services is also responsible for administering the Hospital Care Assurance Program and the state-funded Disability Medical Assistance (DMA) Program. Under the Hospital Care Assurance Program, states are required to make subsidy payments to hospitals that provide uncompensated, or charity, care to low-income and uninsured individuals at or below 100% of the federal poverty guideline (FPG). The DMA Program provides a limited health care benefit package to non-Medicaid eligible individuals based on income, resources, and severity of disability. DMA is not part of Ohio Medicaid and is completely funded with state revenue.

Appropriation Overview

As can be seen in Table 1 below, the executive recommended total funding of \$15.5 billion in FY 2010, an increase of 6.0%, and \$16.7 billion in FY 2011, an increase of 7.4%. Under the executive recommendations, GRF appropriations decrease by 9.7% in FY 2010, but increase by 20.0% in FY 2011. The comparisons for FY 2009 to FY 2010 may be somewhat misleading. FY 2009 figures in the table are adjusted appropriations, not estimated spending. If ODJFS ends up spending less than what appears for FY 2009, which is likely, the percentage change from FY 2009 to FY 2010 would be smaller.

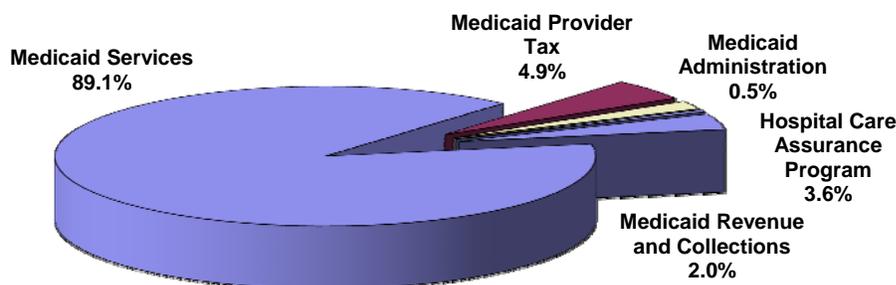
Most of the fluctuation in the appropriations between GRF and non-GRF funds can be attributed to the impact of the additional federal Medicaid reimbursement, also known as enhanced Federal Medical Assistance Percentage (FMAP), Ohio may receive for the period of October 1, 2008 through December 31, 2010. During this period, the enhanced FMAP may vary quarterly based on Ohio's unemployment rate. In addition, the fluctuation reflects the executive's efforts of shifting the Medicaid spending away from GRF line items to non-GRF line items.

Fund Group	FY 2009*	FY 2010	% Change	FY 2011	% Change
General Revenue	\$10,149,809,031	\$9,163,686,039	-9.7%	\$11,011,733,267	20.2%
General Services	\$487,084,196	\$448,761,247	-7.9%	\$384,382,716	-14.3%
State Special Revenue	\$3,458,870,542	\$4,919,374,935	42.2%	\$4,239,849,123	-13.8%
Federal Special Revenue	\$565,007,046	\$1,005,326,178	77.9%	\$1,053,732,656	4.8%
TOTAL	\$14,660,770,815	\$15,537,148,399	6.0%	\$16,689,697,762	7.4%

*FY 2009 figures represent adjusted appropriations.

Chart 1 below shows the executive budget recommendations for the FY 2010-FY 2011 biennium by expense category. The largest expense category for Medicaid is Medicaid services. As seen from the chart below, 92.9% of the executive budget recommendations for the biennium are for Medicaid services, 5.1% for spending from Medicaid provider tax, and 2% for spending from Medicaid revenue and collections.

Chart 1: Executive Budget Recommendations by Expense Category, FY 2010-FY 2011



Major Initiatives

Federal Stimulus

The state is to receive a total of \$2.9 billion in additional federal reimbursements for Medicaid, reducing the need for the GRF to support Medicaid. Table 2 below shows the enhanced Federal Medical Assistance Percentage (FMAP) assumptions used in the executive's budget. The additional federal Medicaid reimbursement will be for the period of October 1, 2008 through December 31, 2010. During this period, the enhanced FMAP may vary quarterly based on Ohio's unemployment rate. The regular FMAP is 62.14% for federal fiscal year (FFY) 2009, 63.42% for FFY 2010, and an estimated 63.42% for FFY 2011. (The official FFY 2011 FMAP will be available November 2009.) The executive has assumed the enhanced FMAP will be 8.11 to 10.05 percentage points above the regular FMAP.

Federal Fiscal Year	Federal Fiscal Quarter	Calendar Year	Calendar Quarter	Enhanced FMAP
2009	Q1	2008	Oct-Dec	70.25%
2009	Q2	2009	Jan-Mar	70.25%
2009	Q3	2009	Apr-Jun	71.29%
2009	Q4	2009	Jul-Sep	71.29%
2010	Q1	2009	Oct-Dec	73.47%
2010	Q2	2010	Jan-Mar	73.47%
2010	Q3	2010	Apr-Jun	73.47%
2010	Q4	2010	Jul-Sep	73.47%
2011	Q1	2010	Oct-Dec	73.47%

Managed Care Assessment

Due to changes in the Deficit Reduction Act of 2005, Ohio will no longer be allowed to collect the Medicaid managed care assessment effective October 1, 2009. The amounts of the Medicaid managed care assessment are reimbursed to Medicaid managed care plans through capitation rate payments. The capitation rates will be adjusted downward to account for the rollback of the Medicaid managed care assessment. To replace the \$194 million in revenue to the state, as well as the resulting federal match received when these funds would be used to pay for Medicaid services (roughly \$550 million including both state and federal shares), the executive budget proposes to subject managed care plans (MCPs) to the state sales and use tax (5.5%) and to the existing health insuring corporation tax. MCPs are currently exempted from the latter tax.

Managed Care Prescription Drug Carve Out

The executive budget "carves out" the MCP pharmacy program to increase Medicaid drug rebate revenue. The executive proposes to carve out the pharmacy program from Medicaid managed care in order to maximize drug rebates. According to the executive, Ohio is able to benefit from significant pharmacy rebate arrangements that are available only to state Medicaid programs. The managed care plans are not able to take advantage of this rebate structure and thus have not been as successful in recouping rebate dollars for reinvestment. By carving out the pharmacy benefit from managed care and returning its administration to ODJFS, the executive expects to generate \$5.2 million in savings and cost avoidance in FY 2010 and \$235.5 million in FY 2011. This proposal is subject to review and approval by the Centers for Medicare and Medicaid Services.

Hospital Rates and Assessment

The executive budget increases inpatient and outpatient hospital payment rates by 5% beginning January 1, 2010. It also establishes a new hospital assessment at 1.27% and 1.37% of total facility cost for FY 2010 and FY 2011, respectively. State-share revenue generated from the assessment is estimated at \$282.8 million and \$315.6 million, respectively. These funds will be used to support Medicaid programs.

Hospitals and Managed Care

The executive budget requires hospitals that provide Medicaid services, but are not under contract with a Medicaid managed care plan, to accept the fee-for-service reimbursement as payment in full for treatment of the managed care plan's participants. The executive expects to save \$35.1 million in FY 2010 and \$110.5 million in FY 2011.

Nursing Facilities

The executive budget increases the nursing facility (NF) franchise fee from \$6.25 to \$11.00 per bed per day, increasing state-share revenue by \$122.2 million in FY 2010 and \$162.9 million in FY 2011. It also proposes to pay NFs based on a standard price determined by a statutory formula without applying a "stop-loss" (annual loss floor) or "stop-gain" (annual increase cap) limit.

Highlights of FY 2008-FY 2009 Biennium Budget

This section contains budget highlights for the FY 2008-FY 2009 biennium. The section has been organized into the following categories:

1. Administrative change;
2. Funding issues;
3. Cost containment strategies;
4. New programs and eligibility expansions;
5. Provider rates;
6. Audits and estate recovery; and
7. Reports.

Administrative Change

Executive Medicaid Management Agency (EMMA)

H.B. 119 required the Governor to create an administration to manage all Medicaid policies and functions and promote the efficient and effective delivery of health care and required the body to hire an executive director who reports directly to the Governor. In December 2007, Governor Strickland established the Executive Medicaid Management Agency (EMMA) by executive order to serve as an "umbrella agency" to oversee Ohio Medicaid across all seven agencies and coordinate and consolidate administration of the program. H.B. 119 provided \$3 million in funding (both state and federal) in FY 2009 for EMMA. These appropriations can be found in the Office of Budget and Management's (OBM's) budget.

Funding Issues

Two budget bills have significantly impacted the Medicaid Program during the FY 2008-FY 2009 biennium: Am. Sub. H.B. 119 of the 127th General Assembly (the biennium budget) and Am. Sub. H.B. 562 of the 127th General Assembly (the biennium budget corrective bill). H.B. 119 appropriated \$8.6 billion in FY 2008 and \$9.3 billion in FY 2009 in GRF line item 600525, Health Care/Medicaid. In addition to the \$8.6 billion appropriation for FY 2008, \$632.5 million in encumbrances from FY 2007 were carried into FY 2008 to be spent that year. H.B. 562 increased the appropriation to GRF line item 600525, Health Care/Medicaid, by \$198,295,986 in FY 2009.

Medicaid Reserve Fund

H.B. 119 created the Medicaid Reserve Fund in the state treasury and required the Director of Budget and Management to transfer \$185 million in FY 2008 and \$205 million in FY 2009 from the GRF to the Medicaid Reserve Fund. The bill allows the Director of Budget and Management to transfer cash from the Medicaid Reserve Fund to the GRF, increase the corresponding state share of appropriations in GRF line item

600525, Health Care/Medicaid, and adjust the federal share accordingly. The bill further requires, at the end of each fiscal year, the Director of Budget and Management to transfer from the Medicaid Reserve Fund all the cash balance, in excess of any transfer, to the credit of the GRF.

Budget Stabilization Fund Transfer

H.B. 562 allowed the Director of Budget and Management, with Controlling Board approval, to transfer up to \$63,333,420 cash in FY 2009 from the Budget Stabilization Fund to the GRF, if additional appropriations are needed to fund the Medicaid Program. The Director of Budget and Management is to transfer the approved amounts, increase the state share of appropriations to GRF line item 600525, and adjust the federal share accordingly. According to OBM, they do plan to make this transfer before the end of FY 2009.

Line Item 600525, Appropriation Assumptions

H.B. 119 made many changes to the Medicaid Program, including eligibility expansions, rate adjustments, and operational improvements. Table 3 below shows a summary of the changes, the executive's original estimate of the fiscal impact, and assumed starting date for each change. The estimated fiscal impact was reflected in the H.B. 119 appropriations in GRF line item 600525, Health Care/Medicaid.

Table 3. GRF Line Item 600525, Appropriation Assumptions in H.B. 119			
	Assumed Starting Date	FY 2008	FY 2009
Baseline, Line Item 600525		\$8,953,987,785	\$10,039,610,271
Policies:			
Eligibility Expansions			
Buy-in for working with disabilities	1/1/2008	\$1,724,797	\$14,626,445
Foster care	1/1/2008	\$5,100,740	\$10,438,413
Pregnant women to 200% FPG	1/1/2008	\$5,592,183	\$19,274,391
Children to 300% FPG	1/1/2008	\$5,900,871	\$34,371,730
Children to 250% FPG	N/A	\$0	\$0
Children over 300% FPG	1/1/2008	\$4,567,266	\$17,082,357
Children's Buy-in 250% to 300% FPG	N/A	\$0	\$0
Rate Adjustments			
Hospital rate increase	1/2008, 1/2009	\$24,357,051	\$79,368,740
Community providers rate increase	1/2008, 1/2009	\$10,663,794	\$39,169,583
Annual hospital recalibration	1/2008, 1/2009	(\$3,682,993)	(\$11,352,911)
Managed care	1/2008, 1/2009	(\$103,971,561)	(\$186,838,151)
Adult dental restoration	1/1/2008	\$15,429,227	\$30,211,697
Operations Improvements			
Improve TPL management	7/1/2007	(\$41,500,000)	(\$83,000,000)
Improve Medicare enrollment	7/1/2007	(\$8,543,343)	(\$37,463,393)
Claims editing	1/1/2008	(\$9,327,520)	(\$39,734,330)
Expedite managed care enrollment	7/1/2007	(\$2,643,728)	(\$2,035,615)
Pre-approve psych drugs	1/1/2008	\$0	(\$20,000,000)
Increased medical support collections	1/1/2008	(\$12,500,000)	(\$37,500,000)
DME proposed savings by ODJFS	N/A	\$0	\$0
Total policy impact		(\$108,833,216)	(\$173,381,044)
Total expenditure estimated		\$8,845,154,569	\$9,866,229,227
Medicaid Reserve Fund		\$300,000,000	\$525,641,026
H.B. 119 line item 600525, appropriation		\$8,545,154,569	\$9,340,588,201

H.B. 562 also made many changes to Medicaid. Table 4 below shows a summary of the changes and the executive's updated estimate of the fiscal impact and assumed starting date. The estimated fiscal impact was reflected in the appropriations included in H.B. 562.

Table 4. GRF Line Item 600525, Appropriation Assumptions in H.B. 562			
	Assumed Starting Date	FY 2008	FY 2009
Baseline, Line Item 600525		\$9,086,382,466	\$10,236,932,434
Policies:			
Eligibility Expansions			
Buy-in for working with disabilities	4/1/2008	\$724,151	\$22,558,092
Foster care	1/1/2008	\$657,663	\$3,075,482
Pregnant women to 200% FPG	1/1/2008	\$7,800,865	\$19,646,934
Children to 300% FPG		\$0	\$0
Children to 250% FPG	1/1/2009	\$0	\$3,748,482
Children over 300% FPG	4/1/2008	\$1,340,172	\$8,801,403
Children's Buy-in 250% to 300% FPG	1/1/2009	\$0	\$2,445,162
Rate Adjustments			
Hospital rate increase	1/2008 & 1/2009	\$0	\$0
Community providers rate increase	7/2008 & 1/2009	\$2,527,029	\$88,095,445
Annual hospital recalibration		\$0	\$0
Managed care	1/2008 & 1/2009	(\$98,691,322)	(\$177,284,815)
Adult dental restoration		\$1,783,216	\$19,820,018
Operations Improvements			
Improve TPL management		(\$16,086,240)	(\$45,000,000)
Improve Medicare enrollment		\$0	\$0
Claims editing		\$0	\$0
Expedite managed care enrollment		\$0	\$0
Pre-approve psych drugs		\$0	\$0
Increased medical support collections		\$0	\$0
DME proposed savings by ODJFS		\$0	(\$10,291,347)
Total policy impact		(\$99,944,466)	(\$64,385,144)
Total expenditure estimated		\$8,986,438,000	\$10,172,547,290
Medicaid Reserve Fund		\$300,000,000	\$525,641,026
Additional non-GRF resources		\$51,007,396	\$52,631,579
Spending needs biennium (additional to H.B. 119)			\$343,962,519
Budget Stabilization Fund			\$145,666,532
H.B. 562 line item 600525, appropriation			\$9,538,884,188

Cost Containment Strategies

Administrative Component of Managed Care Rates

The appropriation to GRF line item 600525, Health Care/Medicaid, in H.B. 119 was based on an assumption that the administrative component of the capitated rate paid to Medicaid managed care organizations could be reduced in future contracts to a level that would result in \$104.0 million in savings in FY 2008 and \$186.8 million in savings in FY 2009. According to the Ohio Department of Job and Family Services' (ODJFS's) Quarterly Cost Management Report on Ohio's Medicaid Program (July 1, 2008), the savings were \$87.9 million for FY 2008 (\$16.1 million below estimate).

Third Party Liability for Medicaid Claims

The federal Deficit Reduction Act (DRA) of 2005 made several changes to provisions of federal Medicaid law to enhance states' ability to identify and obtain payments from liable third parties. The DRA clarifies the specific entities that are considered third parties that may be liable for payment and cannot discriminate against individuals on the basis of Medicaid eligibility. It requires states to enact laws requiring health insurers to do all of the following: provide the state with coverage, eligibility, and claims data needed by the state to identify potentially liable third parties; honor the assignment to the state of a Medicaid recipient's right to payment by the insurers for health care items or services; and not deny assignment or refuse to pay claims submitted by Medicaid based on procedural reasons (e.g., the failure of the recipient to present an insurance card at the point of sale, or the state's failure to submit an electronic, as opposed to a paper, claim).

H.B. 119 made changes to current law required by the DRA. As a result, Ohio has improved its management on the Medicaid's Third Party Liability (TPL) Program for FY 2008 and FY 2009. The TPL Program ensures Medicaid is the payer of last resort, which means other insurers must pay their share of a claim prior to Medicaid making a payment. Approximately 20% of Ohio Medicaid enrollees have health care coverage from some other insurance carrier, including commercial health insurance, Medicare, employer-sponsored health insurance, auto insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other state and federal programs. Successful TPL functions rely on several factors such as avoiding costs up front before Medicaid pays, also known as "cost avoidance"; collecting payments that have been made in error (also known as "pay and chase"); and capturing and updating insurance coverage information for all Medicaid enrollees.

According to ODJFS's Quarterly Cost Management reports on Ohio's Medicaid Program (July 1, 2008 and October 1, 2008), \$99.7 million in costs (\$66.6 million in Medicare and \$33.1 million in commercial insurance) were avoided in FY 2008 and

\$31.4 million in costs (\$20.3 million in Medicare and \$11.2 million in commercial insurance) have been avoided in FY 2009 through August 2008.

Annual Hospital Recalibration

For the FY 2006-FY 2007 biennium, ODJFS recalibrated the Diagnostic Related Groups (DRGs) used in the prospective payment system for hospital services. According to OBM, the recalibration that took effect in January 2006 has resulted in savings to the state. H.B. 119 allowed recalibration updates every year for all DRG hospitals. However, there has been no recalibration since 2006.

Expedite Managed Care Enrollment

ODJFS planned to reduce from 90 days to 30 days the average time for a Medicaid consumer to enroll in a managed care plan. The executive originally assumed savings of \$2.6 million in FY 2008 and \$2.0 million in FY 2009 due to expedited enrollment in managed care. ODJFS reports that it has reduced the number of days from 90 to 60 and produced savings of \$1.5 million in FY 2008 and \$586,000 in FY 2009 as of August 2008.

Medicaid Managed Care and Hospitals

H.B. 119 required health care providers that do not participate in Medicaid to accept the Medicaid fee-for-service payment rate for emergency services furnished to a Medicaid recipient enrolled in a Medicaid managed care organization, in the same manner that the fee-for-service payment rate applies to Medicaid-participating providers that are not under contract with the managed care organization. H.B. 119 also eliminated authority for performance-based financial incentives in the state's Medicaid care management system contracts. Furthermore, H.B. 119 eliminated the Medicaid Care Management Working Group, which was required to annually submit a report with recommendations regarding the state's Medicaid care management system.

Claims Editing

Several of the ODJFS staff were to identify claims and obtain payments from liable third parties by going through claims using the Medicaid Management Information System (MMIS) or Medicaid Information Technology System (MITS). Later, ODJFS described the claims editing as implementing a system to group and ungroup claims as needed to identify questionable claims prior to payment. The executive originally assumed savings of \$9.3 million in FY 2008 and \$39.7 million in FY 2009. According to ODJFS, the Claims Editor System will be delayed until FY 2010 when MITS is implemented (October 2009). Thus, cost savings are now expected to be realized in FY 2010.

Pre-Approval of Atypical Antipsychotic Drug

According to the Office of Budget and Management and ODJFS, the patent for Risperdal, an atypical antipsychotic drug that is currently prescribed, was to expire during the FY 2008-FY 2009 biennium, opening the market for cheaper generic versions of the drug from other companies. The executive planned to require that the new extended release version of the drug, Invega, which recently received U.S. Food and Drug Administration approval, be prior approved before a doctor may prescribe it to Medicaid recipients. The executive estimated that the state could avoid approximately \$20.0 million in costs in FY 2009 as a result of this initiative. ODJFS reports that the rule governing prior approval for select antipsychotic drugs was approved by the Joint Committee on Agency Rule Review on August 25, 2008 with an effective date of October 1, 2008.

Managed Care Pharmacy Utilization Management Programs

H.B. 119 allowed a Medicaid-participating health insuring corporation to implement a pharmacy utilization management program under which a Medicaid recipient must (1) receive prior authorization to obtain a controlled substance and (2) if the person is at high risk for fraud or abuse involving controlled substances, have prescriptions for those drugs filled by a designated pharmacy, medical provider, or health care facility.

New Programs and Eligibility Expansions

Medicaid Buy-In for Workers with Disabilities Program

H.B. 119 required ODJFS to establish a new component of Medicaid to be known as the Medicaid Buy-In for Workers with Disabilities (MBIWD) Program. The program was established in accordance with the provision of the Ticket to Work and Work Incentives Improvement Act of 1999 that authorizes Medicaid buy-in eligibility expansions. Effective April 2008, the MBIWD Program was established in Ohio.

To qualify for MBIWD, a person must:

- Be 16 to 64 years old;
- Be disabled as per the Social Security Administration or as determined by Ohio Medicaid or eligible under the MBIWD medically improved category;
- Be employed in paid work (including part-time and full-time work);
- Pay a premium (if applicable);
- Be a U.S. citizen or meet Medicaid citizenship requirements;

- Be an Ohio resident;
- Have or get a social security number; and
- Meet certain financial requirements.

Financial Requirements for Medicaid Buy-In for Workers with Disabilities

In order to be eligible for the MBIWD Program an applicant's annual income must be less than or equal to 250% of the Federal Poverty Guideline (FPG) after income deductions, and their resources may not exceed \$10,580. (This resource limit is adjusted annually.) Income and resources including cash, stocks, and bonds are used to determine the financial eligibility for the program.

Premiums

Monthly premiums must be paid by those eligible for the MBIWD Program who have annual gross income greater than 150% FPG. To obtain and maintain health coverage, ODJFS must receive the full amount of the premium by the due date or it is considered nonpayment. Any late payments are applied to the most delinquent premium. Eligibility for those individuals who do not pay their premium for two consecutive months is subject to termination.

Pregnant Women Eligibility Expansion to 200% FPG

Prior to H.B. 119, a pregnant woman who also met other requirements was eligible for Medicaid if her family income was at or below 150% FPG. H.B. 119 raised the income eligibility limit for pregnant women to family income of 200% FPG. Effective January 1, 2008, the income eligibility limit was raised.

In 2007, the average health care cost per pregnant woman was \$6,518, including health services unrelated to pregnancy. The average cost includes the delivery payment, monthly managed care payments, and fee-for-services payments (including fee-for-services payments made under expedited enrollment). Table 5 shows the pregnancy-related services covered under Ohio Medicaid.

Table 5. Pregnancy-related Medicaid Services		
Service	Eligibles	Limits
Prenatal and postpartum doctor visits	All female recipients	All pregnancy-related services are covered by Medicaid. Newborns can get health care and immunizations through Healthchek.
Ultrasounds	Pregnant women	If medically necessary.
Childbirth classes	Pregnant women	No limit.
Labor and delivery/Hospital stay	Pregnant women (except Expedited Medicaid)	Labor and delivery is covered for individuals with full Medicaid coverage. The hospital stay for newborn child is also covered.

Children's Eligibility Expansion to 300% FPG

Currently, in Ohio, uninsured children in families with income below 200% of the FPG are eligible for the State Children's Health Insurance Program (SCHIP). H.B. 119 authorized SCHIP III to include persons under age 19 with family incomes up to 300% FPG starting not earlier than January 1, 2008. In December 2007, the Centers for Medicare and Medicaid Services (CMS) denied Ohio's proposal for this SCHIP expansion. In February 2008, ODJFS resubmitted an SCHIP expansion request to CMS to cover children up to 250% FPG but later withdrew this request. In July 2008, ODJFS submitted yet another proposal to CMS for an SCHIP expansion to 300% FPG. In December 2008, CMS approved Ohio's SCHIP III expansion. The executive plans to implement this expansion beginning July 1, 2009.

Medical Assistance for Children with Income Over 300% FPG

H.B. 119 required the Director of Job and Family Services to establish the Children's Buy-In Program for individuals under age 19 who have countable income exceeding 300% FPG, have not had creditable health insurance for at least six months, and meet other eligibility requirements. H.B. 119 required the Director of Job and Family Services to seek federal matching funds for the Children's Buy-In Program under Medicaid or SCHIP, but required the Director to implement the Children's Buy-In Program with state funds only if federal matching funds were denied.

In April 2008, the Director of Job and Family Services established the Children's Buy-In Program. The program is state funded. ODJFS may close enrollment at any time.

To qualify for Children's Buy-In Program, a child must:

- Be younger than age 19;
- Be a United States citizen and a resident of Ohio;
- Be in a family whose gross income is more than 300% FPG;
- Have not had any insurance for at least 6 months before enrolling; and
- Not be eligible for Medicaid;

A child must also meet one of the following to qualify:

- Unable to obtain creditable coverage due to a pre-existing condition;
- Lost only available creditable coverage due to exhausting a lifetime benefit;
- Only available coverage is more than twice the state premium for Children's Buy-In Program; and
- Participates in ODH's Bureau for Children with Medical Handicaps Program.

Medicaid Eligibility for Former Foster Children

H.B. 119 required the Director of Job and Family Services to amend the state Medicaid Plan to implement, beginning January 1, 2008, a federal option under which an individual under age 21 qualifies for Medicaid if the individual (1) was in foster care under the responsibility of the state on the individual's 18th birthday, (2) received Title IV-E foster care maintenance payments or independent living services before turning age 18, and (3) meets all other applicable eligibility requirements. This expansion began on January 1, 2008 and is expected to provide coverage for approximately 900 individuals.

Money Follows the Person Grant

Ohio is one of 34 states that were awarded federal funding for the Money Follows the Person demonstration projects, which were enacted by Congress as part of the Federal Deficit Reduction Act of 2005. The total grant amount is \$100 million over a five-year period. The funding will allow Ohio to relocate about 2,200 seniors and persons with disabilities from institutions to home and community-based settings. The federal government allocates a portion of the grant each year based upon the projected enrollment numbers as estimated by ODJFS. ODJFS cannot enroll more than their estimated projected enrollment. The grant is realized by the state as federal reimbursement on expenditures for transitioning eligible Medicaid members out of institutional settings and into home or community-based care. More specifically, for qualified and demonstrative services the federal government reimburses Ohio at an enhanced federal match rate of nearly 80% for Medicaid members for their first 12 months in home or community-based care, while other supplemental services will be reimbursed at the regular Medicaid federal reimbursement. After the 12-month period, ODJFS will draw down the regular federal reimbursement for each transitioned Medicaid member.

Ohio Access Success Project

H.B. 94 of the 124th General Assembly authorized the Director of Job and Family Services to establish the Ohio Access Success Project to help Medicaid recipients make the transition from residing in a nursing facility to residing in a community setting. The bill provided \$150,000 in FY 2002 and \$250,000 in FY 2003 to fund one-time benefits to not more than 75 Medicaid recipients in FY 2002 and not more than 125 Medicaid recipients in FY 2003. No person was to receive more than \$2,000 worth of benefits under the project. H.B. 95 of the 125th General Assembly continued the Ohio Access Success Project.

H.B. 66 of the 126th General Assembly allowed for the continuation of the Ohio Access Success Project. ODJFS was permitted to limit the number of persons who may participate in the project. H.B. 66 provided \$350,000 in both FY 2006 and FY 2007 to

fund one-time transitional benefits. H.B. 66 eliminated the requirement that a Medicaid recipient reside continuously in a nursing facility for not less than 18 months before applying to participate in the project. H.B. 66 required that ODJFS, if an application was received before six months, ensured that an assessment was conducted as soon as practicable to determine whether the applicant was eligible to participate in the project. To the maximum extent possible, the assessment and eligibility determination was to be completed not later than the date that occurred six months after the applicant became a recipient of Medicaid-funded nursing facility services. During FY 2006, the Ohio Access Success Project assisted 75 consumers in relocation from a nursing facility to the community; half occurring in the last quarter.

H.B. 119 allowed ODJFS to use up to \$350,000 from the Home and Community-Based Services for the Aged, Fund 4J50, in both FY 2008 and FY 2009 to provide one-time transitional benefits under the Ohio Access Success Project.

Medicaid Optional Services

Medicaid Coverage of Chiropractic, Psychologist, and Dental Services

H.B. 95 of the 125th General Assembly (the FY 2004-FY 2005 budget) eliminated two optional services for adults: chiropractic care and psychologist services, effective January 1, 2004. H.B. 66 of the 126th General Assembly (the FY 2006-FY 2007 budget) required that Medicaid continue to cover adult dental services, but provided only half funding. H.B. 66 also required that Medicaid continue to cover adult vision services, but explicitly stated that the act did not limit ODJFS's ability to adopt, amend, or rescind rules applicable to vision coverage, including rules that limited or reduced services, reduced reimbursement levels, or subjected covered services to copayments. H.B. 66 provided full funding for vision services.

H.B. 119 provided additional funding for dental care for adults, and the provision of psychology services for adults. H.B. 119 also provided funding for chiropractic services for Medicaid recipients age 22 or older in an amount, duration, and scope that the Director of Job and Family Services is to specify in rules. The regulations for dental and psychologist services are in administrative rules; therefore, no statutory changes were necessary to make changes in these services. Chiropractic and psychology benefits were restored on January 1, 2008; dental benefits were restored on July 1, 2008.

Medicaid Coverage of Occupational Therapy Services

H.B. 119 required Medicaid to cover occupational therapy services, provided that coverage is not limited to services provided in a hospital or nursing facility, and permitted any licensed occupational therapist to enter into a Medicaid provider agreement with ODJFS. The executive estimates that the additional setting will cost approximately \$1.75 million all funds in FY 2008 and \$3.5 million all funds in FY 2009.

H.B. 119 provided funding for this in GRF appropriation item 600525, Health Care/Medicaid.

Medicaid School Component

H.B. 562 required the Director of Job and Family Services to seek federal approval to establish the Medicaid School Component of the Medicaid Program. H.B. 562 allowed the Director of Budget and Management to increase the appropriation to line item 600655, Interagency Reimbursement, for FY 2009 by the amounts ODJFS receives from the federal government for the federal share of Medicaid services provided under, and administrative costs of, the Medicaid School Component. In addition, the bill provided for money that the Department of Education pays to ODJFS, if any, for the nonfederal share of the administrative expenses that ODJFS incurs in performing its duties regarding the Medicaid School Component be deposited into the Health Care Services Administration Fund (Fund 5U30).

Provider Rates

Medicaid Rates for Nursing Facilities

FY 2008 Medicaid Reimbursement

H.B. 119 established adjustments to the FY 2008 Medicaid rates for nursing facilities. The cost per case mix-unit calculated as part of direct care costs, rate for ancillary and support costs, rate for capital costs, and rate for tax costs were to be adjusted as follows:

1. Increase the cost and rates by 2%;
2. Increase the amount calculated above by another 2%; and
3. Increase the amount calculated above by 1%.

Instead of adjusting the mean quality incentive payment by the same adjustment factors, H.B. 119 provided that the mean payment for FY 2008 was to be \$3.03 per Medicaid day.

In addition to establishing the adjustments, H.B. 119 provided that if a nursing facility's rate for FY 2008 as determined using the adjustments is more than 102.75% of the rate the provider is paid for nursing facility services the facility provides at the end of FY 2007, ODJFS must reduce the facility's FY 2008 rate so that it is not more than 102.75% of its rate for the end of FY 2007. If the rate determined using the adjustments is less than 100% of the rate the nursing facility is paid at the end of FY 2007, ODJFS was to increase its rate for FY 2008 so that it was not less than 100% of its rate for the end of FY 2007.

FY 2009 Medicaid Reimbursement

H.B. 119 established the same adjustments for nursing facilities' FY 2009 Medicaid rates as in FY 2008. The cost per case mix-unit calculated as part of direct care costs, rate for ancillary and support costs, rate for capital costs, and rate for tax costs for nursing facilities were to be adjusted as follows:

1. Increase the cost and rates by 2%;
2. Increase the amount calculated above by another 2%; and
3. Increase the amount calculated above by 1%.

The mean quality incentive payment for FY 2009 was to be the same as FY 2008 and was to be \$3.03 per Medicaid day.

If the adjusted rate for a nursing facility is more than 102.75% of the Medicaid rate paid the nursing facility for the end of FY 2008, its FY 2009 rate was to be reduced so that it is not more than 102.75% of its rate for the end of FY 2008. If the adjusted rate was less than 100% of the nursing facility's Medicaid rate for the end of FY 2008, its FY 2009 rate was to be increased so that it is not less than 100% of its rate for the end of FY 2008.

Additional Payments to Nursing Facilities Related to Capital

H.B. 119 provided for qualifying nursing facilities to receive additional quarterly payments during FY 2008 and FY 2009. It provided that nursing facilities that qualify for the payments are (1) certain nursing facilities that are new as of FY 2006, FY 2007, or FY 2008, (2) certain nursing facilities that completed a capital project before June 30, 2008, (3) certain nursing facilities that completed an activity for which a certificate of need is not needed before June 30, 2008, and (4) certain nursing facilities that completed a renovation before June 30, 2008. H.B. 119 created formulas to be used to determine the amount of the payments. H.B. 119 also terminated all nursing facilities' eligibility for the payments at the earlier of July 1, 2009, or the date the total amount of the payments equals \$7 million. Furthermore, H.B. 119 appropriated \$7 million in FY 2008 to GRF appropriation item 600529, Capital Compensation Program, in the Department of Job and Family Services and earmarked those dollars for payments to nursing facilities for capital costs.

H.B. 562 revised certain laws governing per diem payments for nursing facilities' uncompensated capital costs and capped the expenditures for the uncompensated capital costs at \$4.2 million rather than \$7.0 million. In addition, H.B. 562 provided that the ceiling applicable to the FY 2009 Medicaid rates for certain nursing facilities with uncompensated capital costs is to be not more than 102.75%, and not less than 100%, of the sum of the FY 2008 rate and another amount reflecting uncompensated capital costs. H.B. 562 also required the Director of Budget and Management to increase for FY 2009 the state share of appropriations to GRF line item 600525, Health Care/Medicaid, by the

amount of the unencumbered balance for FY 2008 of GRF line item 600529, Capital Compensation Program, with a corresponding increase in the federal share. ODJFS disbursed approximately \$1.5 million of the \$7.0 million in FY 2008.

Medicaid Rates for Intermediate Care Facilities for the Mentally Retarded

FY 2008-FY 2009 Medicaid rates

H.B. 119 established limitations on the FY 2008 and FY 2009 Medicaid rates for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Medicaid rates paid to ICFs/MR were to be subject to the following caps:

1. For FY 2008, the mean total per diem rate for all ICFs/MR as calculated under codified sections of state law governing Medicaid payments to ICFs/MR was not to exceed \$266.14, which is about 2% growth, as weighted by Medicaid days and calculated as of July 1, 2007;
2. For FY 2009, the mean total per diem rate for all ICFs/MR as so calculated was not to exceed \$271.46, which is about 2% growth, as weighted by Medicaid days and calculated as of July 1, 2008.

If the mean total per diem rate for all ICFs/MR for FY 2008 or FY 2009, weighted by Medicaid days and calculated as of the first day of July of the calendar year in which the fiscal year begins, exceeded the cap, ODJFS was required to reduce the total per diem rate for each ICF/MR by a percentage that is equal to the percentage by which the mean total per diem rate exceeded the cap. Subsequent to any reduction required because of the caps, an ICF/MR's Medicaid rate was not to be subject to any adjustments authorized by codified law governing Medicaid payments to ICFs/MR during the remainder of the year.

H.B. 562 provided that, for FY 2009, the mean total per diem rate for all ICFs/MR under Medicaid, weighted by May 2008 Medicaid days and calculated as of July 1, 2008, was not to exceed \$274.98 rather than \$271.46.

The executive projected cost savings of \$43.1 million in FY 2008 and \$57.1 million in FY 2009 by limiting the ICF/MR rate increases to 2% each year. According to ODJFS's Quarterly Cost Management Report on Ohio's Medicaid Program (July 1, 2008 and October 1, 2008), the savings were achieved in FY 2008 and will be achieved in FY 2009.

Offsite day programming part of ICFs/MR's direct care costs

H.B. 119 added offsite day programming to the costs included in ICFs/MR's direct care costs. According to ODJFS, this was related to the termination of the habilitation center services under Medicaid. The system by which Medicaid paid for habilitation center services was often referred to as the Community Alternative Funding System (CAFS). H.B. 66 permitted ODJFS to increase the Medicaid rate paid to an ICF/MR for FY 2006 and FY 2007 by an amount specified in rules to reimburse the

ICF/MR for active treatment day programming because of the termination of CAFS. Rather than repeating such authority for FY 2008 and FY 2009, H.B. 119 added offsite day programming to ICFs/MR's direct care costs.

The executive estimated that by limiting the reimbursement growth to 2% for both FY 2008 and FY 2009, the state could avoid costs of approximately \$43.1 million in FY 2008 and \$57.1 million in FY 2009. H.B. 119 reflected the cost reductions in the appropriation in GRF line item 600525, Health Care/Medicaid. ODJFS increased the Medicaid rates paid to ICFs/MR by 2% on July 1, 2007. ODJFS increased the rate again on July 1, 2008 to reflect the increase of the per diem from \$266.14 to \$274.98 required by H.B. 119 and the franchise fee increase of \$2.25 required by H.B. 562.

Intensive behavioral needs programs and ICF/MR franchise permit fee

H.B. 562 required the Director of Mental Retardation and Developmental Disabilities (MRDD) to establish one or more programs for individuals under age 21 who have intensive behavioral needs, including such individuals with a primary diagnosis of autism spectrum disorder. The programs could include one or more Medicaid waiver components that the Director of MRDD administers under current law. The Director of MRDD was to collaborate with the Director of Job and Family Services and consult with the Executive Director of the Ohio Center for Autism and Low Incidence and university-based programs that specialize in services for individuals with developmental disabilities when establishing these programs.

H.B. 562 increased the franchise permit fee on ICFs/MR to \$11.98 effective July 1, 2008, and provides for 5.72% of the revenue raised by the ICF/MR franchise permit fee to be deposited into a new fund created in the state treasury, the Intensive Behavioral Needs Programs Fund, which is to be used for the purposes of the programs described above.

Inpatient Hospital Reimbursement

H.B. 95 allowed no increase in rates for inpatient hospital services provided by general hospitals until January 2005. However, H.B. 95 also required ODJFS to pay to each children's hospital participating in the Medicaid Program an inflation adjustment. H.B. 66 froze inpatient hospital reimbursement rates in FY 2006 and FY 2007 at the FY 2005 level.

H.B. 119 allowed reimbursement rates to increase for inpatient hospitals by 3.3% in January 2008, and another 2.9% in January 2009. H.B. 119 provided funding for these rate increases in GRF line item 600525, Health Care/Medicaid. However, there has been no rate increase for hospitals during the current biennium.

Supplemental Payment Program for Children's Hospitals

H.B. 119 required ODJFS to make supplemental Medicaid payments to children's hospitals for inpatient services of up to \$6 million state share in GRF line item 600525, Health Care/Medicaid, in each fiscal year plus the corresponding federal match.

Community-Based Providers

H.B. 119 allowed for increasing reimbursement rates for all state plan Medicaid community-based providers by 3% in January 2008, and another 3% in January 2009 (excluding federally qualified health centers, hospice providers, rural health centers, which all receive federally mandated increases). The reimbursement rates for community-based providers are adjusted through administrative rules; no statutory change is necessary. ODJFS increased the reimbursement rates for most of the community-based providers by 3% on July 1, 2008. The Medicaid managed care capitation rates were adjusted accordingly on July 1, 2008.

Dispensing Fees for Generic Drugs

H.B. 119 required the Director of Job and Family Services to analyze the fiscal impact that federal upper limits (FULs) affecting reimbursement rates for generic drugs, as amended by the Deficit Reduction Act (DRA) of 2005, would have on pharmacists in FY 2008 and FY 2009. The bill required the Director to increase, not later than ten days after completing the fiscal impact analyses, the dispensing fee paid to each pharmacist with a valid Medicaid provider agreement for dispensing a generic drug to a Medicaid recipient in FY 2008 or FY 2009. It required that the amount of the increases in the dispensing fees be determined in a manner that compensates pharmacists for the loss of revenue the Director projected that pharmacists, on average, would incur as a result of the changes to FULs enacted by the DRA. H.B. 119 prohibited the total amount the Director expends to pay the increase in the dispensing fee in each of the fiscal years from exceeding the total amount Medicaid was projected to save in those fiscal years as a result of the changes to FULs enacted by the DRA.

Audits and Estate Recovery

Medicaid Nursing Facility and ICF/MR Audits

H.B. 119 allowed ODJFS to use up to \$1.0 million in each fiscal year for FY 2008 and FY 2009 to fund the state share of audits of nursing facilities and ICFs/MR from Fund 4J50, Home and Community-Based Services for the Aged.

Medicaid Provider Audits

H.B. 119 earmarked \$2,000,000 state share in each fiscal year in GRF line item 600417 to be used by the Auditor of State to perform audits of Medicaid providers. The Governor vetoed this provision. The Governor stated that ODJFS already performs audits of providers, and paying the Auditor to repeat this task is an unnecessary

expense in view of the funding limitation being imposed on ODJFS in H.B. 119. However, the Governor did not remove the provided funding for the audits.

Medicaid Estate Recovery Program

The Medicaid Estate Recovery Program recoups money paid for Medicaid services from a Medicaid recipient's estate after the recipient dies. In Ohio, ODJFS, which has delegated collection efforts to the Ohio Attorney General's Office (AGO), administers the program. State law stipulates that 9% of amounts collected by the AGO are to be credited to the AGO Claims Fund and is to be used to pay expenses incurred by the AGO. In addition, since Medicaid is a state-federal partnership program, ODJFS is required to return more than half of the money collected to the federal government for its financial share of the Medicaid services provided.

The DRA made several changes to the estate recovery portion of federal Medicaid law. The Act further limited a person's ability to transfer or discount assets in order to impoverish themselves and obtain Medicaid eligibility. As of October 1, 2006, Ohio Medicaid eligibility for long-term care services is modified to reflect changes in the DRA as discussed in the following sections.

Transfer of Resources

Extends the transferred resources review period from three years to five years. Funds used to purchase a life estate in another individual's property or used to purchase a promissory note or mortgage may, in certain circumstances, be considered an improper transfer.

Improper Transfer of Resources (Penalty Period Start Date)

The penalty period for improper transfers of resources now begins the date an individual receives or is eligible to receive long-term care services and would otherwise be eligible for Medicaid coverage, instead of the date the improper transfer was made. Also, multiple transfers of resources will be treated with penalty periods beginning on the earliest date of the improper transfer.

Home Equity Over \$500,000

Certain Medicaid applicants who have home equity above \$500,000 are ineligible for payment of long-term care services through Medicaid (unless the applicant's spouse is residing in the home or the home is occupied by a child who is under age 21, blind, or disabled).

Annuities

Medicaid applicants are now required to disclose information about annuities they have and to name the state of Ohio as the remainder beneficiary. As the remainder beneficiary, Medicaid can recoup medical costs once the consumer (and the consumer's spouse) is deceased. In addition, annuities purchased on or after February 8, 2006 are

evaluated to determine whether the purchase is a proper or improper transfer of resources. To be considered an appropriate transfer of resources, annuities must:

- Be irrevocable, nonassignable, and actuarially sound;
- Have payments dispersed in equal monthly amounts;
- Exclude any deferrals or balloon payments; and
- Be purchased with retirement or IRA funds.

Treatment of Income for Non-Institutionalized Spouses (Income First)

In cases where an institutionalized individual has a spouse who still lives in the community, a county caseworker determines how much income the non-institutionalized spouse needs to maintain themselves in the community. If the non-institutionalized spouse does not have enough income to meet the amount determined by the caseworker, DRA includes a requirement that the non-institutionalized spouse must use all available income from the institutionalized spouse to subsidize their monthly income prior to a reallocation of additional resources. Previously, the law allowed the non-institutionalized spouse to obtain additional resources without taking income from the institutionalized spouse.

H.B. 119 required the following:

1. The person responsible for the estate of a spouse of a decedent subject to Medicaid estate recovery to submit a properly completed Medicaid estate recovery reporting form to the Medicaid Estate Recovery Program Administrator;
2. The Administrator to prescribe forms for the beneficiary of a transfer on death deed, the surviving tenant under a survivorship tenancy, or the representative of such a beneficiary or surviving tenant to indicate whether the deceased owner of the real property was a decedent subject to Medicaid estate recovery or the spouse of such a decedent and whether the real property was part of the estate of such a decedent;
3. A county recorder to obtain the completed form and send a copy to the Administrator before recording a transfer of real property under a transfer on death deed or registering title in the surviving tenants of a survivorship tenancy;
4. That an individual who has received, or is entitled to receive, benefits under a long-term care insurance policy in connection with which assets or resources are disregarded be subject to Medicaid estate recovery for nursing facility and other long-term care services the individual correctly receives under Medicaid.

Reports

Unified Long-Term Care Budget Workgroup

On May 30, 2008, the Unified Long-Term Care Budget Workgroup issued its final report and recommendations, which include a plan for a new budget structure for the \$4.7 billion the state spends annually for long-term care. Among the several hundred recommendations in the report, the Workgroup proposes a five-year plan in three stages to implement the new budget structure.

The first stage, beginning in FY 2009, includes identifying line items in the departments of Job and Family Services, Aging, Mental Health, and Mental Retardation and Developmental Disabilities that currently fund long-term care and transferring, subject to approval of the Controlling Board, funds from these existing line items to new long-term care line items established in those agencies for this purpose by H.B. 119. The second stage, for the FY 2010-FY 2011 biennium, involves appropriating directly to each agency's new long-term care line item rather than individual programs in separate line items, thereby allowing greater flexibility within the agency budget to adjust program spending based on consumer demand. The third stage, for the FY 2012-FY 2013 biennium, entails creation of a single line item in the Department of Job and Family Services' budget to unify all long-term care spending, thereby maximizing flexibility to adjust spending among various programs.

Created in H.B. 119 and led by the Director of Aging, the Workgroup consisted of consumers, providers, advocates, state agencies, legislators, and local entities. The Workgroup was to consider consolidation of agency authority and long-term care budgets to create a more cost-effective and consumer-based system of long-term care with an emphasis on home and community-based care and consumer choice of services.

A complete list of recommendations and steps in the implementation process is available in the Unified Long-Term Care Budget Workgroup's final report, "Building a Cost-Effective, Consumer-Friendly Long-Term Services and Supports System," which can be accessed at www.goldenbuckeye.com/ultcb/ULTCB_final_report.pdf.

State Coverage Initiatives

To address a lack of access to affordable health coverage, Ohio participated in the Robert Wood Johnson Foundation's State Coverage Initiative (SCI). As part of SCI, the Governor appointed a bipartisan team, which worked with a coalition of stakeholders, to develop strategies to expand coverage to more Ohioans and make coverage more affordable. In July 2008, the SCI team submitted its recommendations to the Governor. The final report includes, among others, proposals for Medicaid expansions, guaranteed issuance, individual mandates, a state reinsurance program, and a higher age ceiling for dependents.

PACT Program

The Primary Alternative Care Treatment (PACT) Program is administered by the Surveillance, Utilization and Review (SUR) Section housed in ODJFS's Office of Ohio Health Plans. PACT provides enhanced oversight to certain Medicaid consumers who have a pattern of using health care services that are not directly related to their medical condition. Once these consumers are identified, SUR is responsible for notifying consumers about their enrollment into this program. PACT is a case management program for recipients who have exceeded the utilization criteria for prescribing physicians, number of office visits, and drug use.

If enrolled in PACT, clients are asked to select a primary physician to make referrals and a primary pharmacy to dispense all medications. Any physician who is a Medicaid provider may become an enrollee's primary physician/case manager. Each primary physician may bill ODJFS a monthly case management fee for each month a PACT client is assigned to them. This fee is not available to primary pharmacies, clinics, Federally Qualified Health Centers (FQHCs), or to any other provider, including providers rendering services to an enrolled client on an emergency or referral basis.

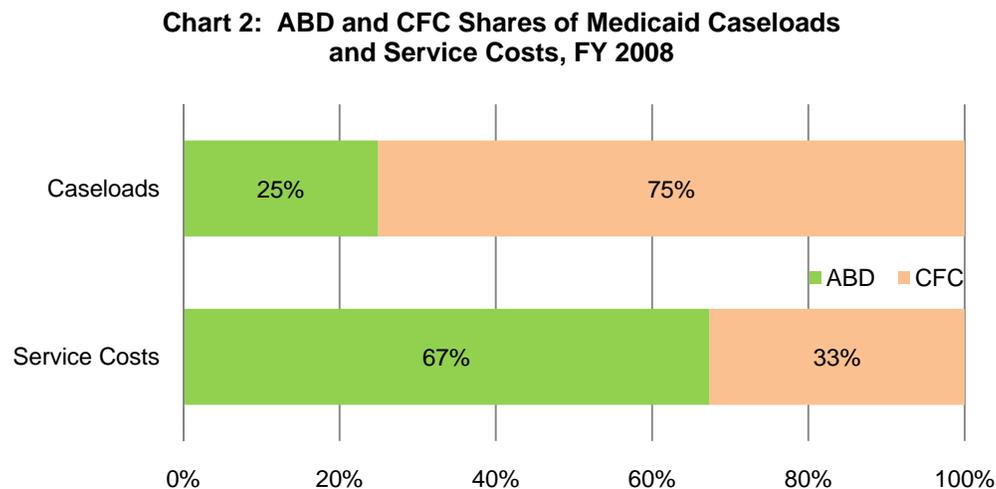
H.B. 119 required the Director of Job and Family Services, no later than January 1, 2008, to submit a report to the General Assembly on the PACT and the average cost of participants before and after participation in the program. H.B. 119 requires the Director, no later than January 1, 2009, to submit an additional report on the total cost savings achieved through the program.

Public Assistance Reporting Information System (PARIS)

The Public Assistance Reporting Information System (PARIS) is a voluntary federal-state partnership which provides the 43 participating state public assistance agencies detailed information and data to assist them in maintaining program integrity and detecting and deterring improper payments. H.B. 119 required the Director of Job and Family Services, no later than August 31, 2007, to submit a report to the General Assembly on the costs and potential three-year cost savings associated with participation in PARIS and, no later than October 1, 2007, to enter into any necessary agreements with the U.S. Department of Health and Human Services and neighboring states to join and participate as an active member in PARIS if cost savings are indicated in the report.

ODJFS issued its report and estimates "that PARIS will result in an annual GRF savings to the state of Ohio of nearly \$4 million. Accordingly, ODJFS will move forward to enter into the necessary agreements to join and participate in PARIS, as required by House Bill No. 119."

FACTS AND FIGURES

Medicaid Caseloads and Services: ABD vs. CFC

In FY 2008, the aged, blind, and disabled (ABD) population made up 25% of the Medicaid caseload but accounted for 67% of the service costs. In comparison, the covered families and children (CFC) population made up 75% of the Medicaid caseload but only accounted for 33% of the service costs. In FY 2008, the average monthly Medicaid cost was \$1,328 for an ABD member compared to \$217 for a CFC member. The cost of long-term care is one of the reasons for the comparatively higher expense of the ABD population. To illustrate, expenditures on nursing facilities alone, which are almost entirely for the benefit of the ABD population, accounted for 24% of the total Medicaid service expenditure in FY 2008. Moreover, the ABD population heavily utilizes some of the services that have the fastest growing costs, such as prescription drugs.

Medicaid Caseloads

Table 6. Total Medicaid Caseloads

Fiscal Year	Monthly Average	Growth Rate
2002	1,380,235	--
2003	1,527,076	10.64%
2004	1,618,900	6.01%
2005	1,687,462	4.24%
2006	1,730,075	2.53%
2007	1,736,143	0.35%
2008	1,759,873	1.37%
2009	1,863,917	5.91%
2010	1,968,916	5.63%
2011	2,030,680	3.14%

Note: Caseload numbers for FY 2009 to FY 2011 are LSC's projections.

Table 7. Aged, Blind, and Disabled (ABD) Caseloads

FY	ABD		Dual ABD		QMB		SLMB		Total ABD	
	Monthly Average	Growth Rate								
2002	170,230		158,291		21,576		18,019		368,116	
2003	176,584	4%	164,418	4%	22,279	3%	17,784	-1%	381,065	4%
2004	184,016	4%	171,909	5%	22,505	1%	15,528	-13%	393,958	3%
2005	188,780	3%	179,217	4%	24,079	7%	16,004	3%	408,079	4%
2006	192,380	2%	175,433	-2%	32,076	33%	18,458	15%	418,347	3%
2007	196,247	2%	165,752	-6%	42,157	31%	23,136	25%	427,292	2%
2008	197,168	0%	170,438	3%	45,931	9%	26,253	13%	439,790	3%
2009	201,848	2%	175,682	3%	47,380	3%	35,302	34%	460,212	5%
2010	207,220	3%	181,744	3%	49,130	4%	36,592	4%	474,687	3%
2011	211,910	2%	186,860	3%	51,397	5%	37,763	3%	487,929	3%

Note: Caseload numbers for FY 2009 to FY 2011 are LSC's projections.

QMB: Qualified Medicare Beneficiaries

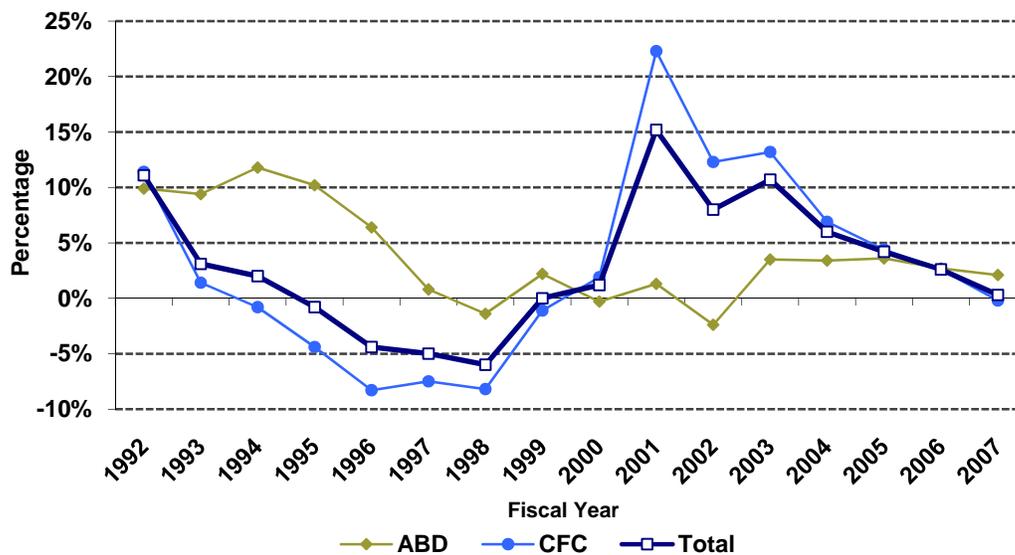
SLMB: Specified Low-income Medicare Beneficiaries

Table 8. Covered Families and Children (CFC) Caseloads

FY	Healthy Families		Healthy Start		CHIP		Total CFC	
	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate
2002	750,288		153,264		108,567		1,012,119	
2003	859,358	15%	164,806	8%	121,847	12%	1,146,011	13%
2004	924,052	8%	169,169	3%	131,722	8%	1,224,942	7%
2005	979,112	6%	164,008	-3%	136,262	3%	1,279,382	4%
2006	1,004,599	3%	167,343	2%	139,785	3%	1,311,728	3%
2007	982,058	-2%	182,566	9%	144,227	3%	1,308,851	0%
2008	995,854	1%	179,770	-2%	144,460	0%	1,320,084	1%
2009	1,078,693	8%	176,744	-2%	148,268	3%	1,403,705	6%
2010	1,160,781	8%	183,600	4%	149,848	1%	1,494,229	6%
2011	1,205,872	4%	185,959	1%	150,920	1%	1,542,751	3%

Note: Caseload numbers for FY 2009 to FY 2011 are LSC's projections.

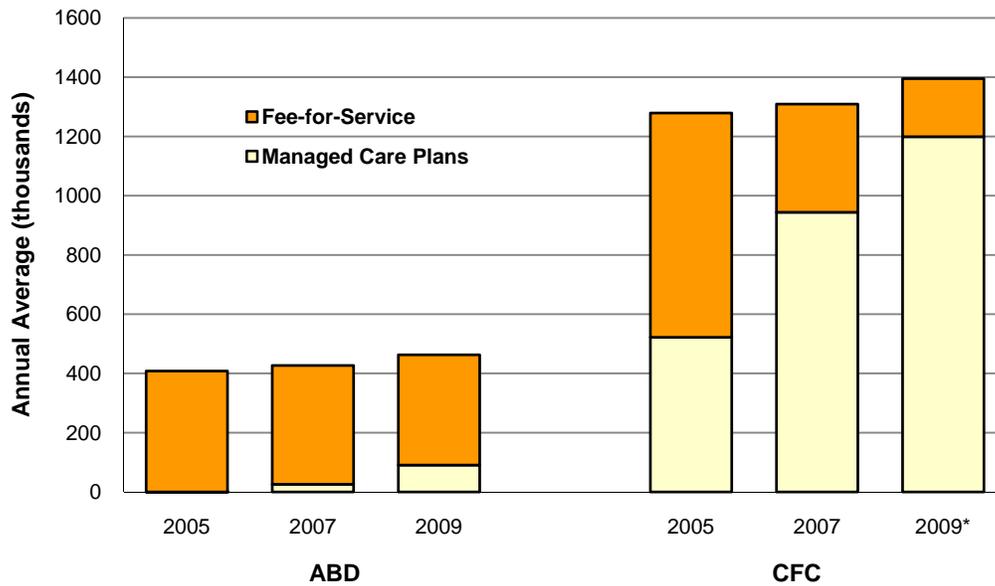
Chart 3: Medicaid Caseload Annual Growth Rate by Eligibility Group



- Due to the economic downturn and several eligibility expansions for family and child coverage, total Medicaid caseloads grew rapidly in the early 2000s. From FY 2000 to FY 2004, total Medicaid caseloads increased by 46%, from 1.1 million to 1.6 million. After FY 2004, caseloads grew modestly before leveling off at 1.7 million in FY 2007. Overall caseload growth between FY 2000 and FY 2007 was 57%.
- The strong economy during most of the 1990s contributed to slower growth in Medicaid caseloads. From FY 1992 to FY 1999, total caseloads decreased by 11%, from 1.2 million to 1.1 million.
- Due to the decline in the Ohio Works First cash assistance caseload as a result of welfare reform, Covered Families and Children (CFC) caseloads declined steadily in the 1990s, reaching a low of 0.7 million in FY 1999. CFC caseloads grew rapidly in the early 2000s, increasing 66% from FY 2000 to FY 2004 when they reached 1.2 million.
- ABD caseloads grew 10% annually, on average, in the first half of the 1990s. Then annual growth slowed to 0.4% on average from FY 1996 to FY 2000, followed by annual growth averaging 2% from FY 2001 to FY 2007.
- On average, CFC caseloads account for three-quarters of the total Medicaid caseloads. Therefore, the overall Medicaid caseload growth rate is more heavily influenced by CFC caseload growth.

Medicaid Managed Care Caseload Expands

**Chart 4: Medicaid Caseloads:
Fee-for-Services vs. Managed Care Plans**



Note: Caseload numbers for FY 2009 are ODJFS's estimates.

Due primarily to the statewide expansion implemented in FY 2006, Medicaid managed care caseloads increased by 135% from FY 2005 to FY 2008. The managed care share of total Medicaid caseloads increased from 31% in FY 2005 to 70% in FY 2008.

For the covered families and children (CFC) category, the managed care caseload increased from 522,000 in FY 2005 to 1.1 million in FY 2008, increasing CFC's managed care share from 41% to 85%. For the aged, blind, and disabled (ABD) category, the caseload increased from 1,000 to 105,000; its share increased from less than 0% to 24%.

Table 9. Total Medicaid Caseloads—FFS vs. MCP

FY	Total FFS		Total MCP	
	Monthly Average	Growth Rate	Monthly Average	Growth Rate
2002	1,045,940		334,295	
2003	1,123,107	7%	403,970	21%
2004	1,135,310	1%	483,590	20%
2005	1,165,277	3%	522,185	8%
2006	1,108,710	-5%	621,364	19%
2007	766,582	-31%	969,561	56%
2008	531,806	-31%	1,228,068	27%
2009	563,835	6%	1,300,082	6%
2010	591,877	5%	1,377,039	6%
2011	609,694	3%	1,420,986	3%

Note: Caseload numbers for fiscal years 2009 to 2011 are LSC's projections.

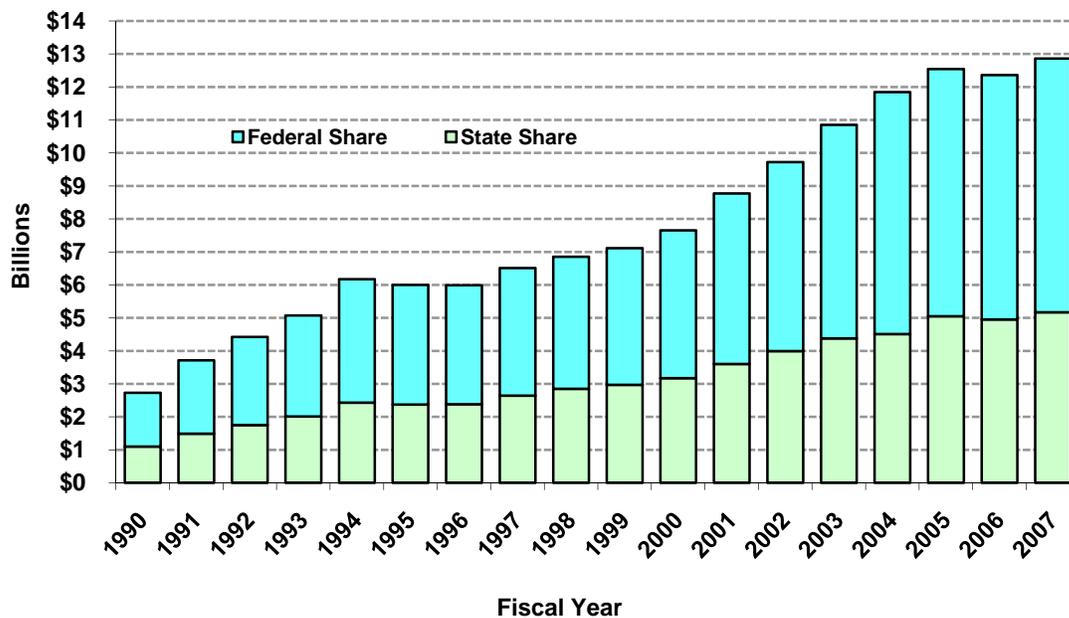
Table 10. Medicaid Caseloads—Fee-for-Services (FFS) vs. Managed Care Plans (MCP)

FY	CFC - FFS		CFC - MCP		FY	ABD - FFS		ABD - MCP	
	Monthly Average	Growth Rate	Monthly Average	Growth Rate		Monthly Average	Growth Rate	Monthly Average	Growth Rate
2002	677,824		334,295		2002	368,116		0	
2003	742,041	9%	403,970	21%	2003	381,065	4%	0	
2004	741,352	0%	483,590	20%	2004	393,958	3%	0	
2005	757,197	2%	522,185	8%	2005	408,079	4%	0	
2006	690,363	-9%	621,364	19%	2006	418,347	3%	0	
2007	364,846	-47%	944,005	52%	2007	401,735	-4%	25,556	
2008	196,253	-46%	1,123,830	19%	2008	335,552	-16%	104,237	308%
2009	193,079	-2%	1,210,625	8%	2009	370,755	10%	89,457	-14%
2010	205,495	6%	1,288,735	6%	2010	386,382	4%	88,304	-1%
2011	212,068	3%	1,330,683	3%	2011	397,626	3%	90,303	2%

Note: Caseload numbers for fiscal years 2009 to 2011 are LSC's projections.

Total Medicaid Expenditures

Chart 5: Total Medicaid Expenditures



As seen in the chart above, Medicaid expenditure growth rose dramatically in the early 1990s and early 2000s, averaging 22.9% per year from FY 1990 to FY 1994 and 11.6% per year from FY 2000 to FY 2004. The rapid growth was a result of an economic downturn, poor labor market conditions, high health care costs, and eligibility expansions.

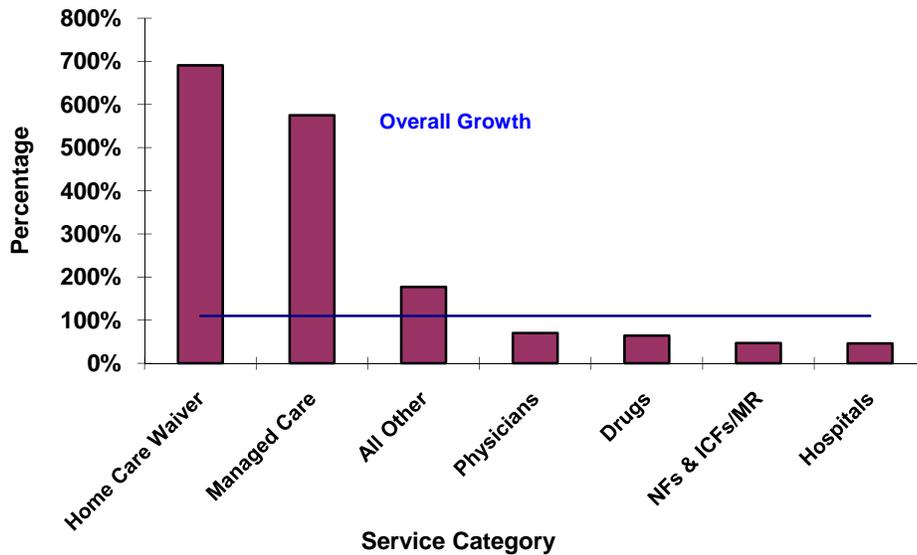
Spending decreased slightly in FY 2006 due to the implementation of pharmacy benefits under Medicare Part D, beginning January 1, 2006. As a result of Medicare Part D, Medicaid no longer pays for prescription drugs for individuals qualified for both Medicaid and Medicare. Of \$13.4 billion in Medicaid service costs in FY 2006, \$9.6 billion was incurred for the benefits of the Aged, Blind, and Disabled population and \$3.8 billion was incurred for the Covered Families and Children population.

Ohio's Medicaid expenditures in FY 2007 totaled \$12.9 billion, 4.8 times greater than FY 1990 expenditures of \$2.7 billion. Eligibility expansions and higher health care costs contributed to the spending growth. The average annual growth rate over this period was 9.5%.

Medicaid Expenditures by Service Category

Medicaid Spending Growth has been Concentrated in Home Care Waiver and Managed Care

Chart 6: Percent Growth by Service Category
FY 1997-FY 2007



Since FY 1997 Ohio's Medicaid spending growth has been concentrated in two categories: Home Care Waiver and Managed Care. While overall growth for Medicaid was 110% from FY 1997 to FY 2007, spending for Home Care Waiver and Managed Care grew by 691% and 575%, respectively. Implemented in the FY 1997-FY 1998 biennium, Home Care is a Medicaid waiver program providing home and community-based services to individuals with serious disabilities and unstable medical conditions who would otherwise be eligible for Medicaid coverage in a nursing home or hospital. H.B. 66 of the 126th General Assembly required that specific Medicaid populations be enrolled in managed care beginning in FY 2006, which is largely responsible for the growth of this category.

Service Category	FY 1997	FY 2007		FY 1997- FY 2007
	\$ in millions	\$ in millions	% of Total	Annual growth
Managed Care	\$414	\$2,793	26.4%	21%
Nursing Facilities	\$1,774	\$2,591	24.5%	4%
Hospitals	\$1,199	\$1,750	16.6%	4%
Prescription Drugs	\$551	\$904	8.6%	5%
All Other Services	\$305	\$905	8.6%	11%
ICFs/MR	\$343	\$519	4.9%	4%
Physicians	\$292	\$497	4.7%	5%
Home Care Waiver	\$43	\$340	3.2%	23%
Medicare Buy-In	\$120	\$272	2.6%	9%
Total	\$5,041	\$10,571	100%	8%

Although spending for nursing facilities (NFs) grew slower than overall Medicaid spending, spending for NFs continues to be one of the major Medicaid spending categories. While mandated managed care expansions have limited the growth in hospital service spending, this too is still a major Medicaid spending category.

In FY 1997, Medicaid spending totaled \$5.0 billion, broken down as follows: NFs and ICFs/MR (42%), Hospitals (24%), Drugs (11%), Managed Care (8%), Other (6%), Physicians (6%), Medicare Buy-In (2%), and Home Care Waivers (1%).

In FY 2007, Medicaid spending totaled \$10.6 billion, broken down as follows: NFs and ICFs/MR (29%), Managed Care (26%), Hospitals (17%), Other (9%), Drugs (9%), Physicians (5%), Medicare Buy-In (2%), and Home Care Waivers (3%).

Mandatory and Optional Services

The Ohio Department of Job and Family Services (ODJFS) provided LSC staff the following table "Medicaid Estimates for Mandatory and Optional Services by Provider Type for FYs 2009-2011." The provider types are grouped by federally mandated and state-optional services. Table 12 also distinguishes expenditures for adults from total expenditures (subtracting expenditures for adults from the total equals the expenditures for children) and provides the percentage of expenditures for adults.

In FY 2009, the three waiver programs administered by ODJFS are expected to cost \$345 million (accounted for in the line, "JFS Home & Community Waivers"). The five other waiver programs, while not included in Table 10, account for a significant share of expenditures for optional services. The Department of Aging administers the PASSPORT, Assisted Living, and Choices waiver programs as well as PACE. The Department of Aging expended \$343.5 million for these programs in FY 2008. The Department of Mental Retardation and Developmental Disabilities administers the Individual Options and Level One waiver programs and expended \$766.6 million for them in FY 2008. These amounts include expenditures for services unique to the waiver programs (i.e., services unique to home or community-based care). Regular Medicaid plan expenditures for individuals enrolled in these waiver programs (e.g., inpatient hospital, prescription drugs) are accounted for in Table 10 above.

Table 12: Medicaid Estimates for Mandatory and Optional Services by Provider Type for FYs 2009-2011

Provider Type	FY 2009 Estimate			FY 2010 Estimate			FY 2011 Estimate		
	Adults	Total	% Adults	Adults	Total	% Adults	Adults	Total	% Adults
Transportation (Ambulance)	\$ 39,150,943	\$ 42,610,514	91.9%	\$ 40,857,925	\$ 44,483,042	91.9%	\$ 44,605,459	\$ 48,433,728	92.1%
Ambulatory Surgical Svcs	\$ 4,377,796	\$ 4,850,117	90.3%	\$ 4,134,414	\$ 4,617,982	89.5%	\$ 4,436,498	\$ 4,937,391	89.9%
Transportation Ambulette	\$ 38,350,470	\$ 39,419,988	97.3%	\$ 40,357,227	\$ 41,521,999	97.2%	\$ 43,491,442	\$ 44,766,645	97.2%
Clinic	\$ 49,257,705	\$ 51,901,713	94.9%	\$ 49,910,644	\$ 52,659,597	94.8%	\$ 53,151,701	\$ 56,048,900	94.8%
Cert. Registered Nurse Anesthetist	\$ 3,023,318	\$ 3,791,319	79.7%	\$ 2,833,655	\$ 3,612,343	78.4%	\$ 2,961,758	\$ 3,764,112	78.7%
Family Planning	\$ 13,082,242	\$ 22,826,923	57.3%	\$ 13,579,367	\$ 23,694,346	57.3%	\$ 13,959,589	\$ 24,357,788	57.3%
Fed Qualf Health Center	\$ 12,415,874	\$ 28,864,652	43.0%	\$ 12,636,870	\$ 30,340,745	41.6%	\$ 13,467,597	\$ 32,520,901	41.4%
Home Health Svcs	\$ 171,192,038	\$ 194,318,757	88.1%	\$ 194,811,374	\$ 221,445,075	88.0%	\$ 225,067,714	\$ 255,641,255	88.0%
Independent Lab	\$ 15,276,342	\$ 18,231,967	83.8%	\$ 15,256,602	\$ 18,531,723	82.3%	\$ 16,926,092	\$ 20,667,936	81.9%
Inpatient Hospital	\$ 722,757,032	\$ 1,008,288,283	71.7%	\$ 704,749,397	\$ 1,000,884,324	70.4%	\$ 762,706,232	\$ 1,071,617,648	71.2%
Nursing Facility	\$ 2,587,927,388	\$ 2,589,515,605	99.9%	\$ 2,574,049,397	\$ 2,575,631,671	99.9%	\$ 2,560,536,083	\$ 2,562,119,692	99.9%
Nursing Home Therapies	\$ 14,820,554	\$ 14,961,572	99.1%	\$ 15,759,929	\$ 15,899,423	99.1%	\$ 17,272,004	\$ 17,411,641	99.2%
Outpatient Health	\$ 205,970	\$ 350,530	58.8%	\$ 186,217	\$ 331,721	56.1%	\$ 190,541	\$ 337,970	56.4%
Outpatient Hospital	\$ 279,564,932	\$ 370,115,137	75.5%	\$ 275,895,611	\$ 371,713,954	74.2%	\$ 297,987,059	\$ 400,294,882	74.4%
Physician	\$ 263,646,153	\$ 321,237,185	82.1%	\$ 258,781,453	\$ 317,620,739	81.5%	\$ 277,098,446	\$ 337,821,193	82.0%
Physiological Lab	\$ 1,908,527	\$ 2,002,170	95.3%	\$ 1,751,904	\$ 1,846,672	94.9%	\$ 1,848,043	\$ 1,944,447	95.0%
Rural Health Svcs	\$ 658,179	\$ 1,512,458	43.5%	\$ 760,924	\$ 1,635,686	46.5%	\$ 885,812	\$ 1,783,885	49.7%
Durable Medical Equipment	\$ 113,752,125	\$ 142,539,930	79.8%	\$ 115,987,326	\$ 146,718,791	79.1%	\$ 121,995,764	\$ 154,868,232	78.8%
Medicare Premiums	\$ 315,766,179	\$ 315,766,179	100.0%	\$ 340,639,672	\$ 340,639,672	100.0%	\$ 361,039,928	\$ 361,039,928	100.0%
Managed Care - Mandatory Services	\$ 2,015,102,355	\$ 3,434,481,359	58.7%	\$ 2,259,734,022	\$ 3,765,161,529	60.0%	\$ 2,444,990,548	\$ 4,064,651,065	60.2%
Total Mandatory	\$ 6,662,236,123	\$ 8,607,586,357	77.4%	\$ 6,922,673,930	\$ 8,978,991,033	77.1%	\$ 7,264,618,308	\$ 9,465,029,238	76.8%
Advanced Practice Nurse	\$ 3,666,288	\$ 5,246,644	69.9%	\$ 3,759,817	\$ 5,385,517	69.8%	\$ 4,007,447	\$ 5,710,592	70.2%
Chiropractic	\$ 424,536	\$ 626,262	67.8%	\$ 424,987	\$ 629,502	67.5%	\$ 441,487	\$ 649,895	67.9%
JFS Home & Community Waivers	\$ 282,982,812	\$ 344,651,257	82.1%	\$ 314,057,658	\$ 375,795,485	83.6%	\$ 344,514,857	\$ 406,443,966	84.8%
Dental	\$ 32,236,354	\$ 48,602,235	66.3%	\$ 31,171,449	\$ 48,356,608	64.5%	\$ 32,033,783	\$ 50,198,064	63.8%
Vision	\$ 8,016,816	\$ 10,452,973	76.7%	\$ 8,009,579	\$ 10,488,200	76.4%	\$ 8,432,715	\$ 10,974,049	76.8%
Hospice	\$ 178,071,899	\$ 178,807,977	99.6%	\$ 192,969,934	\$ 193,763,466	99.6%	\$ 209,542,301	\$ 210,400,281	99.6%
ICF / MR Private	\$ 508,011,306	\$ 549,652,380	92.4%	\$ 507,644,585	\$ 549,234,611	92.4%	\$ 507,258,998	\$ 548,797,924	92.4%
Physical Therapy	\$ 1,218,331	\$ 1,396,131	87.3%	\$ 1,134,537	\$ 1,314,607	86.3%	\$ 1,228,258	\$ 1,411,867	87.0%
Podiatry	\$ 8,952,940	\$ 9,368,305	95.6%	\$ 8,750,113	\$ 9,173,987	95.4%	\$ 9,403,950	\$ 9,838,895	95.6%
Pharmacy	\$ 351,617,297	\$ 536,580,505	65.5%	\$ 318,317,922	\$ 525,757,554	60.5%	\$ 337,264,757	\$ 571,393,655	59.0%
Private Duty Nursing	\$ 30,258,383	\$ 126,153,432	24.0%	\$ 32,440,706	\$ 136,743,477	23.7%	\$ 34,556,018	\$ 147,845,413	23.4%
Independent Psychologist	\$ 1,299,542	\$ 1,615,651	80.4%	\$ 1,335,601	\$ 1,633,822	81.7%	\$ 1,399,712	\$ 1,683,797	83.1%
Managed Care - Pharmacy	\$ 658,778,105	\$ 976,541,283	67.5%	\$ 754,105,658	\$ 1,090,344,200	69.2%	\$ 814,761,992	\$ 1,175,821,774	69.3%
Managed Care - Dental	\$ 83,556,256	\$ 178,784,190	46.7%	\$ 90,777,361	\$ 191,542,031	47.4%	\$ 98,856,376	\$ 207,059,527	47.7%
Managed Care - Vision	\$ 14,309,095	\$ 27,995,963	51.1%	\$ 15,778,104	\$ 30,260,753	52.1%	\$ 17,143,240	\$ 32,695,003	52.4%
Total Optional	\$ 2,163,399,959	\$ 2,996,475,188	72.2%	\$ 2,280,678,010	\$ 3,170,423,820	71.9%	\$ 2,420,845,890	\$ 3,380,924,702	71.6%
Grand Total	\$ 8,825,636,082	\$ 11,604,061,544	76.1%	\$ 9,203,351,940	\$ 12,149,414,854	75.8%	\$ 9,685,464,198	\$ 12,845,953,940	75.4%

Information by Date of Service

ANALYSIS OF EXECUTIVE PROPOSAL

Introduction

This section provides an analysis of the Governor's recommended funding for each appropriation line item in Medicaid's budget. In this analysis, Medicaid's line items are grouped into five major categories. For each category, a table is provided listing the recommended appropriation in each fiscal year of the biennium. Following the table, a narrative describes how the appropriation is used and any changes affecting the appropriation that are proposed by the Governor. If the appropriation is earmarked, the earmarks are listed and described. The five categories used in this analysis are as follows:

1. Medicaid Services;
2. Medicaid Provider Taxes;
3. Medicaid Revenue and Collections;
4. Medicaid Administration; and
5. Hospital Care Assurance Program.

Medicaid Services

This category of appropriations includes the major sources of state and federal funding for Medicaid service expenditures. Some Medicaid service expenditures are paid with provider taxes and other revenue collections, which are discussed in those sections separately. Table 13 lists the line items associated with this category and the recommended amounts.

Table 13. Governor's Recommended Amounts for Medicaid Services				
Fund	ALI and Name		FY 2010	FY 2011
General Revenue Fund				
GRF	600525	Health Care/Medicaid	\$8,814,479,115	\$10,693,668,495
GRF	600526	Medicare Part D	\$271,746,617	\$287,194,790
GRF	600529	Capital Compensation Program	\$40,000,000	\$0
GRF	600537	Children's Hospital	\$6,000,000	\$6,000,000
General Revenue Fund Subtotal			\$9,132,225,732	\$10,986,863,285
General Services Fund Group				
5FX0	600638	Medicaid Payment Withholding	\$26,000,000	\$26,000,000
General Services Fund Group Subtotal			\$26,000,000	\$26,000,000
Federal Special Revenue Fund Group				
3F00	600623	Health Care Federal	\$3,053,505,106	\$2,310,117,015
3G50	600655	Interagency Reimbursement	\$1,503,777,044	\$1,561,905,912
Federal Special Revenue Fund Group Subtotal			\$4,557,282,150	\$3,872,022,927
State Special Revenue Fund Group Subtotal				
5AJ0	600631	Money Follows the Person	\$6,286,485	\$6,195,163
5Q90	600619	Supplemental Inpatient Hospital Payments	\$56,125,998	\$56,125,998
State Special Revenue Fund Group Subtotal			\$62,412,483	\$62,321,161
Total Funding: Medicaid Services			\$13,777,920,365	\$14,947,207,373

Health Care/Medicaid (600525)

This GRF line item is used to reimburse health care providers for covered services to Medicaid recipients. In addition, this line item funds the costs of health care-related contracts such as eyeglass purchases, inpatient hospital peer review, enrollment information centers, and contracted case management. The federal earnings on the payments that are made entirely from this line item are deposited as revenue into the GRF. Although other agencies also provide Medicaid services, the vast majority of Medicaid service spending occurs within this line item.

Spending within this line item generally can be placed into one of nine major categories: long-term care (nursing facilities and ICFs/MR), hospitals (inpatient and

outpatient), physician services, prescription drugs, managed care plans, Medicare buy-in, Ohio Home Care waivers, all other care, and Disability Medical Assistance (FY 2003-FY 2005 and FY 2008-FY 2009). The majority of expenditures from this line item earn the regular Federal Medical Assistance Percentage (FMAP) reimbursement rate at approximately 62%, although family planning expenditures earn an enhanced 90% federal participation rate, and a portion of the buy-in premium payments are state funds only. Expenditures for the State Children's Health Insurance Program (SCHIP) from this line item earn an enhanced federal participation rate of approximately 72%. The Disability Medical Assistance (DMA) Program is a state-funded only program; there are no federal match earnings.

SCHIP part II (SCHIP II) payments were moved from GRF line item 600426, Children's Health Insurance Plan, to this line item beginning in FY 2003. In addition, DMA payments were moved from GRF line item 600511, Disability Financial Assistance, to this line item beginning in FY 2003. However, H.B. 66 of the 126th General Assembly (the FY 2006-FY 2007 biennium budget) provided funding of \$19.5 million in FY 2006 and \$25.5 million in FY 2007 in GRF line item 600513, Disability Medical Assistance, for operation of the DMA Program. H.B. 119 of the 127th General Assembly (the FY 2008-FY 2009 biennium budget) returned the funding for the DMA Program to GRF line item 600525.

The executive recommends \$8,814,479,115 for FY 2010, a 10.8% decrease from the FY 2009 adjusted appropriation of \$9,877,719,909, and \$10,693,668,495 for FY 2011, a 21.3% increase over FY 2010. The recommended appropriation levels are based on the executive's forecast of Medicaid spending, including the following policies:

- Effective January 1, 2008, an individual under age 21 is eligible for Medicaid if the individual (1) was in foster care under the responsibility of the state on the individual's 18th birthday, (2) received Title IV-E foster care maintenance payments or independent living services before turning age 18, and (3) meets all other applicable eligibility requirements. The executive projects that, on the average every month, this expansion will add 271 individuals in FY 2010 and 390 individuals in FY 2011 to the state Medicaid Program. The executive also estimates that this expansion will cost the state \$1.1 million all funds in FY 2010 and \$1.6 million all funds in FY 2011.
- Effective January 1, 2008, the income eligibility limit for pregnant women was raised from 150% to 200% of the Federal Poverty Guideline (FPG). The executive projects that, on the average every month, this expansion will add 1,774 pregnant women in FY 2010 and 1,823 pregnant women in FY 2011 to the state Medicaid Program. The executive also estimates that

this expansion will cost the state \$21.6 million in FY 2010 and \$23.8 million in FY 2011.

- Effective April 2008, a new component of the Medicaid Program known as the Medicaid Buy-In for Workers with Disabilities Program was established. The executive projects that, on the average every month, this expansion will enroll 6,562 individuals in FY 2010 and 7,370 individuals in FY 2011. The executive also estimates that this expansion will cost the state \$37.0 million in FY 2010 and \$46.3 million in FY 2011.
- Effective April 2008, individuals under age 19 who have countable income exceeding 300% FPG, have not had creditable health insurance for at least six months, and meet other eligibility requirements are eligible for the Children's Buy-In Program. The executive projects that, on the average every month, this expansion will enroll 501 individuals in FY 2010 and 718 individuals in FY 2011. The executive also estimates that this expansion will cost the state \$1.2 million in FY 2010 and \$1.9 million in FY 2011.
- The executive plans to expand SCHIP III to include individuals under age 19 with family incomes up to 300% FPG during the FY 2010 and FY 2011 biennium. The executive projects that, on the average every month, this expansion will add a total of 24,856 individuals in FY 2010 and 35,610 individuals in FY 2011 to the state Medicaid Program. Of this total, the executive projects that, on the average every month, this expansion will add 12,428 uninsured individuals in FY 2010 and 17,805 uninsured individuals in FY 2011 to the state Medicaid Program. In addition, of the total, the executive assumed, on the average every month, this expansion will add 12,428 insured individuals in FY 2010 and 17,805 insured individuals in FY 2011 to the state Medicaid Program as a result of the woodwork effect. The executive estimates that this expansion will cost the state \$21.8 million in FY 2010 and \$29.7 million in FY 2011.
- The executive plans to increase the rates for inpatient and outpatient hospitals by 5% effective January 2010.
- Due to changes in the Deficit Reduction Act of 2005, Ohio will no longer be allowed to collect the Medicaid managed care assessment effective October 1, 2009. The amounts of the Medicaid managed care assessment are reimbursed to Medicaid managed care plans through capitation rate payments. The capitation rates will be adjusted downward to account for the rollback of the Medicaid managed care assessment. The executive estimates an annual loss of approximately \$194 million in revenue to the state, as well as the resulting federal match received when these funds would be used to pay for Medicaid services.

Table 14 below provides a summary of the executive's policy recommendations for the FY 2010-FY 2011 biennium. These policy recommendations are all accounted for in the appropriations to GRF line item 600525, Health Care/Medicaid. Some are accounted for directly while others are considered offsets to costs paid out of the line item.

Table 14. Executive's Policy Recommendations		
	FY 2010	FY 2011
Savings or Cost Avoidance (both state and federal share)		
MCP: Change to retrospective payment	(\$270,400,000)	\$0
MCP: Carve out prescription drugs	(\$5,200,000)	(\$235,500,000)
MCP: Non-contracting hospitals	(\$35,100,000)	(\$110,500,000)
MCP: Return ABD to mandatory in NE and NW regions	(\$14,949,000)	(\$29,898,000)
NF: Reimburse based on standard price	(\$55,873,391)	(\$56,287,308)
DME: Change price and contract selectively	(\$5,785,714)	(\$8,100,000)
Rate Increase (both state and federal share)		
MCP: Rate increase due to changes in assessments	\$244,222,760	\$305,864,785
Hospital: Rate increase, one time at 5%	\$87,926,810	\$178,480,874
NF: Rate increase for franchise fee increase	\$80,556,973	\$87,948,920
ICF/MR: Rate increase for franchise fee increase	\$3,573,548	\$4,764,730
Provider Tax Revenue Collected (not including federal matching)		
NF: Increase franchise fee to \$11	\$122,193,750	\$162,925,000
ICF/MR: Increase franchise fee to \$14.25	\$2,707,839	\$3,315,012
Hospital: Impose new assessment	\$282,830,073	\$315,578,067

MCP-Managed Care Plans

NF-Nursing Facility

ICF/MR-Intermediate Care Facility for the Mentally Retarded

Some of the policy changes that are designed to create savings or cost avoidance are explained in more detail below.

- The executive plans to pay Medicaid managed care plans on a retrospective, rather than prospective, basis. With the exception of Medicaid managed care, all other Ohio Medicaid providers are paid after services are rendered. This one-time shift in costs is estimated to be \$270.4 million in FY 2010.
- The executive recommends revising the requirement that a hospital not under contract with a Medicaid managed care organization (MCO) provide services to Medicaid recipients enrolled in the MCO and accept

from the MCO, as payment in full, the amount that would have been paid under Medicaid's fee-for-service reimbursement system by: (1) requiring that medically necessary services be provided whenever authorized by the MCO, rather than only on referral, (2) extending the fee-for-service reimbursement rate to other types of noncontracting providers in a hospital system, including physicians, and (3) eliminating the exemption that applies to any hospital that had a contract with at least one Medicaid MCO before January 1, 2006, and has retained one such contract. The executive estimates that the state can save \$35.1 million in FY 2010 and \$110.5 million in FY 2011.

- The executive recommends making managed care mandatory for ABD in the Northeast and Northwest regions. Currently, only one managed care plan is available in the Northeast and Northwest regions. Because there is only one managed care plan available, ABD Medicaid recipients in these regions are permitted to opt-out of managed care and receive services through the fee-for-service system. The executive estimates that the state can save \$14.9 million in FY 2010 and \$29.9 million in FY 2011.
- Medicare has reduced the reimbursement they pay for certain durable medical equipment by 9.5%. Ohio Medicaid is prohibited from paying a higher reimbursement rate than Medicare. The executive proposes to reduce the reimbursement the state pays for items such as wheelchairs and oxygen. The change is to become effective April 1, 2009. The executive estimates that the state can save \$5.8 million in FY 2010 and \$8.1 million in FY 2011.
- The executive proposes to pay nursing facilities based on a standard price determined by a statutory formula without applying a "stop-loss" (annual loss floor) or "stop-gain" (annual increase cap) limit.

A more detailed discussion of each of executive's recommended policy changes shown in the table above on the topics of rate increases and provider tax revenue collected can be found under the particular line item affected by the policy change.

Medicare Part D (600526)

This GRF line item is used to pay the phased down state contribution, otherwise known as the clawback payment, under the Medicare Part D requirements contained in the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The clawback is a monthly payment made by each state to the federal Medicare Program that began in January 2006. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles, those eligible for both Medicare and Medicaid.

Prior to January 2006, prescription drug payments for dual eligibles were made by Medicaid from GRF line item 600525, Health Care/Medicaid. After January 2006, GRF line item 600526, Medicare Part D, is used for the clawback payments. H.B. 119 allowed the Director of Budget and Management to increase the state share of appropriations in either GRF line item 600525, or this GRF line item 600526, with a corresponding decrease in the state share of the other line item to allow the Ohio Department of Job and Family Services (ODJFS) to implement the Medicare Part D requirements.

The executive recommends \$271,746,617 for FY 2010, a 15.2% increase over the FY 2009 adjusted appropriation, and \$287,194,790 for FY 2011, a 5.7% increase over FY 2010. The recommended funding levels are based on the executive's projected spending. The executive projects that the total number of dual eligibles for Medicare Part D will increase from 181,607 in FY 2009 to 186,908 in FY 2010, a 3% increase, before increasing to 190,365 in FY 2011, a 2% increase. The executive also projects that the average monthly per capita for dual eligibles for Medicare Part D will increase from \$119 in FY 2009 to \$121 in FY 2010, a 2% increase, before increasing to \$126 in FY 2011, a 4% increase.

The executive recommends, as was included in H.B. 119, to allow the Director of Budget and Management to increase the state share of appropriations in either GRF line item 600525, or this GRF line item 600526, with a corresponding decrease in the state share of the other line item to allow ODJFS to implement the Medicare Part D requirements for FY 2010 and FY 2011.

Nursing Facility Capital Compensation (600529)

This GRF line item is used to make payments to nursing facilities for capital costs. H.B. 119 provided for certain qualifying nursing facilities to receive additional quarterly payments for capital costs during FY 2008 and FY 2009. H.B. 119 appropriated \$7.0 million in FY 2008 to this line item for this purpose. ODJFS disbursed approximately \$1.5 million of the \$7.0 million in FY 2008. H.B. 562 of the 127th General Assembly (the FY 2008-FY 2009 biennium corrective budget) revised certain laws

governing per diem payments for nursing facilities' uncompensated capital costs and required the Director of Budget and Management to increase for FY 2009 the state share of appropriations to GRF line item 600525, Health Care/Medicaid, by the amount of the unencumbered balance for FY 2008 of GRF line item 600529, Capital Compensation Program, with a corresponding increase in the federal share.

The executive recommends \$40,000,000 in FY 2010 for GRF line item 600529, Capital Compensation Program. The executive proposes that qualifying nursing facilities receive quarterly capital compensation payments during FY 2010. The nursing facilities that qualify for the payments are (1) certain nursing facilities that are new as of FY 2006, FY 2007, or FY 2008, (2) certain nursing facilities that completed a capital project before December 31, 2008, (3) certain nursing facilities that completed an activity for which a certificate of need is not needed before June 30, 2008, and (4) certain nursing facilities that completed a renovation before December 31, 2008. The executive also proposes to terminate all nursing facilities' eligibility for the capital compensation payments at the earlier of July 1, 2010, or the date the total amount of the payments equals \$40 million.

Children's Hospital (600537)

The executive proposes to create this new GRF line item to replace line item 600636, Children's Hospitals – State. The federal match for the \$6,000,000 will be paid from federal line item 600623, Health Care – Federal. This new GRF line item will be used to make supplemental Medicaid payments to children's hospitals. The executive recommends \$6 million plus the corresponding federal match each year in FY 2010 and FY 2011 for these supplemental Medicaid payments to children's hospitals. The executive recommendation represents flat funding at the FY 2009 level.

H.B. 66 of the 126th General Assembly (the FY 2006-FY 2007 biennium budget) established two line items: 600635, Children's Hospitals – Federal, and 600636, Children's Hospitals – State, to be used by ODJFS to make supplemental Medicaid payments to children's hospitals for inpatient services. Line item 600635, Children's Hospitals – Federal was used for the Medicaid federal share of making supplemental Medicaid payments to children's hospitals for inpatient services. The executive does not recommend funding in this line item. The executive proposes to instead make the federal match of the supplemental Medicaid payments to children's hospitals through federal line item 600623. Line item 600636, Children's Hospitals – State was used for the Medicaid state share of making supplemental Medicaid payments to children's hospitals for inpatient services. The executive does not recommend funding in this line item. The executive instead proposes a new GRF line item 600537, Children's Hospital, for the state share of the supplemental Medicaid payments to children's hospitals.

Supplemental Inpatient Hospital Payments (600619)

This line item is used to disburse the state share of Supplemental Inpatient Hospital Upper Limit Payments to public hospitals. The Supplemental Inpatient Hospital Upper Limit Payment Program gives public hospitals an option for reducing the gap between what Medicare would have paid and what Medicaid actually pays for inpatient services provided to Medicaid recipients. ODJFS estimates what Medicare would have paid for a set of inpatient services provided to Medicaid recipients by each hospital. ODJFS then calculates the "payment gap" or the difference between the two. The public hospitals then send the state share of the payment gap to ODJFS. These dollars are deposited into the Supplemental Inpatient Hospital Fund (Fund 5Q90) and then disbursed back to the public hospitals through line item 600619, Supplemental Inpatient Hospital Payments, along with federal match from federal line item 600623, Health Care Federal. The executive recommends flat funding at the FY 2009 appropriation level of \$56,125,998 for FY 2010 and FY 2011.

Money Follows the Person (600631)

This line item is used to support the federal Money Follows the Person Grant initiative. Ohio is one of 34 states that were awarded federal funding for the Money Follows the Person demonstration projects, which were enacted by Congress as part of the Federal Deficit Reduction Act of 2005. The total grant amount is \$100 million over a five-year period. The funding will allow Ohio to relocate about 2,200 seniors and persons with disabilities from institutions to home and community-based settings. The federal government allocates a portion of the grant each year based upon the projected enrollment numbers as estimated by ODJFS. ODJFS cannot enroll more than their estimated projected enrollment. The grant is realized by the state as federal reimbursement on expenditures for transitioning eligible Medicaid members out of institutional settings and into home or community-based care. More specifically, for qualified and demonstrative services the federal government reimburses Ohio at an enhanced federal match rate of nearly 80% for Medicaid members for their first 12 months in home or community-based care, while other supplemental services will be reimbursed at the regular Medicaid federal reimbursement. After the 12-month period, ODJFS will draw down the regular federal reimbursement for each transitioned Medicaid member.

H.B. 119 provided funding of \$3.5 million in FY 2008 and \$30.5 million in FY 2009 to support the Money Follows the Person Grant initiative. H.B. 562 created the Money Follows the Person Enhanced Reimbursement Fund (Fund 5AJ0) into which the Director of Budget and Management is to transfer the enhanced portion of the federal grant the state receives under the Money Follows the Person demonstration project. Since the deposits made into this fund are "earned reimbursement," the cash in the fund may be expended as state funds. The enhanced federal allotment for FY 2009 is

\$4.4 million based on enrollment estimates made by ODJFS. The executive recommends appropriations of \$6,286,485 in FY 2010 and \$6,195,163 in FY 2011 for this line item. The recommended funding levels are the executive's projected spending.

Medicaid Payment Withholding (600638)

This line item is used to release to providers payments that are withheld from providers that change ownership, and to transfer the withheld funds to the appropriate fund used by ODJFS at final resolution. The funds are withheld and temporarily deposited into the Exiting Operator Fund (Fund 5FX0) until all potential amounts due to ODJFS or the provider reach final resolution. Line item 600638, Medicaid Payment Withholding, was established by the Controlling Board in FY 2009. Creation of the fund allows ODJFS to maintain a distinct fund for Medicaid provider payment withholding. The executive recommended flat funding at the FY 2009 adjusted appropriation level of \$26,000,000 for FY 2010 and FY 2011.

Interagency Reimbursement (600655)

This federally funded line item is used to disburse federal reimbursement (primarily Medicaid) to other agencies for expenditures they have made. The grants deposited into the Interagency Reimbursement Fund (Fund 3G50) are:

- Medical Assistance (Medicaid, Title XIX);
- State Children's Health Insurance Program (SCHIP, Title XXI);
- Foster Care-Title IV-E; and
- State Survey and Certification of Health Care Providers and Suppliers.

The executive recommends \$1,503,777,044 for FY 2010, a 0.7% decrease from the FY 2009 adjusted appropriation, and \$1,561,905,912 for FY 2011, a 3.9% increase over FY 2010. The recommended funding levels are based on the executive's projected spending.

Health Care – Federal (600623)

This federally funded line item is used for the Medicaid federal share when the state share is provided from a source other than GRF line item 600525, Health Care/Medicaid, or line item 600649, Health Care Assurance Program. This line item was created to simplify accounting for the non-GRF federal share of Medicaid funding. Major activity in this line item includes the federal share of nursing facility and intermediate care facility for the mentally retarded franchise fees, eligibility outreach, county administration, and general Medicaid services. These moneys are deposited into the Hospital Care Assurance Match Fund (Fund 3F00). The primary source of the funds is Medicaid. However, in October 2001, the Controlling Board added Health Care Financing Research, Demonstrations, and Evaluations grants to the fund. Effective July 1, 2006, H.B. 530 of the 126th General Assembly (the FY 2006 and FY 2007 biennium

corrective budget) required the federal share of drug rebates and Medicaid revenues also be deposited into the fund.

The executive recommends \$3,053,505,106 for FY 2010, a 90.6% increase over FY 2009 adjusted appropriation, and \$2,310,117,015 for FY 2011, a 24.35% decrease from FY 2010. The increase in the appropriation level from FY 2009 to FY 2010 for this line item is primarily due to the following:

- The executive proposes to increase the nursing facility franchise fee from \$6.25 per bed per day to \$11 in order to maximize federal reimbursement for nursing facility services.
- The executive budget establishes a new assessment on hospitals. The assessment will be 1.27% and 1.37% of total facility costs for FY 2010 and FY 2011, respectively. The state share of the new hospital assessment used to support Medicaid is appropriated in line item 600656, Medicaid – Hospital, and the federal share is appropriated in line item 600623.
- The executive proposes to make the federal match of the supplemental Medicaid payments to children's hospitals through line item 600623, instead of through line item 600635, Children's Hospital – Federal.
- The executive proposes to carve out the pharmacy program from Medicaid managed care and return its administration to ODJFS. The state share of the potential increase in drug rebates is appropriated in line item 600692, Health Care Services, and the federal share is appropriated in line item 600623.
- The executive budget assumes an enhanced federal reimbursement rate for the Medicaid Program based on the American Recovery and Reinvestment Act of 2009.

The decrease in the appropriation level from FY 2010 to FY 2011 for this line item is because the enhanced federal reimbursement rate ends midway through FY 2011.

Medicaid Provider Taxes

This category of appropriations includes the major sources of funding for spending on Medicaid services through the Medicaid provider taxes. Table 15 lists the line items associated with this category and the recommended amounts.

Table 15. Governor's Recommended Amounts for Medicaid Provider Taxes				
Fund	ALI and Name		FY 2010	FY 2011
General Services Fund Group				
5BG0	600653	Managed Care Assessment	\$168,914,857	\$0
General Services Fund Group Subtotal			\$168,914,857	\$0
State Special Revenue Fund Group				
4J50	600613	Nursing Facility Bed Assessments	\$36,713,984	\$36,713,984
4K10	600621	ICF/MR Bed Assessments	\$28,261,826	\$29,482,434
5GF0	600656	Medicaid-Hospital	\$282,830,073	\$315,578,067
5R20	600608	Medicaid-Nursing Facilities	\$329,947,751	\$341,125,000
State Special Revenue Fund Group Subtotal			\$677,753,634	\$722,899,485
Total Funding: Medicaid Provider Taxes			\$846,668,491	\$722,899,485

Managed Care Assessments (600653)

This line item is used to pay for Medicaid services, administrative costs, and contracts with Medicaid health insuring corporations. The source of funds for this line item are the Medicaid managed care franchise fee payments. The money collected from the franchise permit fee is credited to the Managed Care Assessment Fund (Fund 5BG0).

H.B. 66 of the 126th General Assembly (the FY 2006-FY 2007 biennium budget) required each Medicaid health insuring corporation to pay a franchise permit fee for each calendar quarter occurring between January 1, 2006 and June 30, 2007 to help offset the statewide Covered Families and Children managed care expansion. The fee was 4.5% of the managed care premiums the health insuring corporation receives in the applicable calendar quarter, unless (1) ODJFS adopted rules decreasing the percentage or increasing it to not more than 6%, or (2) the fee was reduced or terminated to comply with federal law or because the fee does not qualify for matching federal funds.

S.B. 190 of the 126th General Assembly changed the effective date of the managed care plan assessment from January 1, 2006 to December 1, 2005. The Medicaid managed care assessment continues for the FY 2008-FY 2009 biennium, and the managed care assessment fee was increased from 4.5% to 5.5% in July 2008.

Under current federal law, Medicaid managed care organizations are identified as a separate class of providers, and are therefore not subject to the provisions of the Social Security Act that require provider-based taxes to be broad based in nature. Effective October 1, 2009, the Deficit Reduction Act of 2005, removes this distinction for Medicaid managed care organizations. As such, Ohio's Medicaid managed care franchise fee will no longer be in compliance with federal regulations after that date. Collection of that fee will therefore cease, resulting in an annual loss of approximately \$194 million in revenue to the state, as well as the resulting federal match received when these funds would be applied to Ohio's Medicaid Program.

To replace this lost revenue, the executive recommends removing the Medicaid managed care exemption to the existing health insuring corporation tax, thereby including the Medicaid managed care plans in this tax structure. Additionally, Ohio's Medicaid managed care plans are proposed to be added to another part of the existing state tax structure via the state sales and use tax. The sales and use tax is levied at the same percentage as the current Medicaid managed care franchise fee. Furthermore, the plans' participation in this tax will be recognized in their Medicaid reimbursement rate.

The executive recommends \$168,914,857 for FY 2010, a decrease of 24.1% from FY 2009 adjusted appropriation. The executive does not recommend funding in this line item for FY 2011 due to changes in federal law that no longer allows collection of the Medicaid managed care assessment.

Nursing Facility Franchise Permit Fee (600608, 600613)

Line item 600608, Medicaid-Nursing Facilities, is used to make Medicaid payments to nursing facilities (i.e., nursing homes and hospitals). The source of funds for this line item is 84% of the franchise fee payments from nursing facilities. The franchise fee payments are due to the state in February, May, August, and November of each year.

Line item 600613, Nursing Facility Bed Assessments, is used to (1) fund Medicaid,¹ and (2) transfer funds to the PASSPORT Program in the Department of Aging. H.B. 94 of the 124th General Assembly (the FY 2002-FY 2003 biennium budget) included temporary language to specifically allow the funding of nursing facility audits and the Ohio Access Success Project. Following budget bills have also included this language. The source of funds for this line item is 16% of the franchise fee payments from nursing facilities.

¹ The only medical payments charged to 600613 historically have been the state share of nursing facilities franchise fees and nursing facility costs.

The Ohio Department of Job and Family Services (ODJFS) is required to assess an annual franchise permit fee on each long-term care bed in a nursing home or hospital. Until July 1, 2001, the amount of the fee was \$1.00 for each bed multiplied by the number of days in the fiscal year for which the fee is assessed. The fee is applied to: (1) nursing home beds, (2) Medicare-certified skilled nursing facility beds, (3) Medicaid-certified nursing facility beds, and (4) beds in hospitals that are registered as skilled nursing facility beds or long-term care beds, or licensed as nursing home beds. H.B. 94 raised the franchise permit fee to \$3.30 for FY 2002 and FY 2003. S.B. 261 of the 124th General Assembly (the FY 2002-FY 2003 biennium corrective budget) raised the franchise permit fee to \$4.30 for fiscal years 2003 through 2005. H.B. 66 increased the fee to \$6.25 for FY 2006 and FY 2007. H.B. 119 of the 127th General Assembly (the FY 2008-FY 2009 biennium budget) maintained the fee at \$6.25 for FY 2008 and FY 2009.

The money generated by the franchise permit fee on nursing homes and hospitals has been required to be deposited into two funds. One fund, the Home and Community-Based Services for the Aged Fund (Fund 4J50), gets the first \$1 of the franchise permit fee. ODJFS and the Department of Aging are required to use the money in the fund for Medicaid, including PASSPORT. The other fund into which money generated by the nursing home and hospital franchise permit fee goes is the Nursing Facility Stabilization Fund (Fund 5R20), which was created in H.B. 94. It is to receive all such franchise permit fees and related penalties that are not deposited into the Home and Community-Based Services for the Aged Fund. ODJFS is required to use money in the Nursing Facility Stabilization Fund to make Medicaid payments to nursing facilities.

The executive recommends \$36,713,984 for FY 2010 and FY 2011, a 6.0% increase over the FY 2009 adjusted appropriation of \$34,613,984 for line item 600613, Nursing Facility Bed Assessments. The executive recommends \$329,947,751 in FY 2010, a 88.5% increase over the FY 2009 adjusted appropriation of \$175,000,000, and \$341,125,000 in FY 2011, a 3.4% increase over FY 2010 for line item 600608, Medicaid–Nursing Facilities.

The executive budget proposes to increase the nursing facility franchise fee from \$6.25 per bed per day to \$11.00 in order to maximize federal reimbursement for nursing facility services. Medicaid rates for nursing facilities will be increased to recognize the collection of this increased fee, which is expected to generate approximately \$122.2 million in state revenue in FY 2010 and \$162.9 million in state revenue in FY 2011.

ICF/MR Bed Assessments (600621)

This line item provides the funding mechanism to pay the state share of reimbursements to intermediate care facilities to the mentally retarded (ICFs/MR) for their cost of the franchise fee. Funds are also transferred to the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) to use as state matching funds for their Medicaid waiver programs.

The source of funds for this line item is the ICF/MR franchise fee payments. Money generated by this franchise permit fee and related penalties is required to be deposited into the Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund (Fund 4K10) and the Intensive Behavioral Needs Programs Fund (Fund 5CT0). The departments of Job and Family Services and Mental Retardation and Developmental Disabilities are required to use money in Fund 4K10 for Medicaid and home and community-based services to persons with mental retardation or other developmental disability.

The franchise permit fee was \$9.63 per bed per day for ICFs/MR from FY 2002 through FY 2007. H.B. 119 did not change the amount of the ICF/MR franchise permit fee but added an annual composite inflation factor adjustment. H.B. 562 of the 127th General Assembly (the FY 2008-FY 2009 biennium corrective budget bill) increased the franchise permit fee on ICFs/MR to \$11.98 effective July 1, 2008, and provided for 5.72% of the revenue raised by the ICF/MR franchise permit fee to be deposited into the Intensive Behavioral Needs Programs Fund (Fund 5CT0).

The executive recommends \$28,261,826 for FY 2010, a 21.3% increase over FY 2009 adjusted appropriation of \$23,292,437, and \$29,482,434 for FY 2011, a 4.3% increase over FY 2010. The executive budget increases the franchise permit fee on ICF/MR beds to \$14.25 per day. The executive budget also includes the state developmental centers in the ICF/MR franchise fee. This will provide additional federal reimbursement to support Medicaid costs.

The executive also provides for the money raised by the ICF/MR franchise permit fee to be deposited as follows: (1) 74.89% in FY 2010 and 70.67% in FY 2011 and thereafter into Fund 4K10, (2) 3.78% in FY 2010 and 3.57% in FY 2011 and thereafter into Fund 5CT0, and (3) 21.33% in FY 2010 and 25.76% in FY 2011 and thereafter into a new fund created in the state treasury called the ODMRDD Operating and Services Fund. In addition, the executive proposed budget provides for money in the ODMRDD Operating and Services Fund to be used for ODMRDD programs and administrative expenses.

New Hospital Assessment (600656)

The executive proposes to create this new line item 600656, Medicaid – Hospital, that will be used to support the Medicaid Program. The source of funds for this line item will be the revenue generated from a new hospital assessment. Money generated by the new hospital assessment will be deposited into the newly created Hospital Assessment Fund (Fund 5GF0). The assessment will be 1.27% and 1.37% of total facility costs for FY 2010 and FY 2011, respectively. Revenue generated from the assessment is estimated at \$282.8 million in FY 2010 and \$315.6 million in FY 2011. The additional fee will be collected over the course of three payments during each state fiscal year. This fee is separate from the established assessment fee currently used to support the state's Disproportionate Share Hospital (DSH) Program. The executive recommends \$282,830,073 in FY 2010 and \$315,578,067 in FY 2011 for this new line item 600656, Medicaid – Hospital. The federal match for expenditures from this line item will be made from line item 600623, Health Care Federal.

Medicaid Revenue and Collections

This category of appropriations includes the major sources of funding for Medicaid utilizing various Medicaid revenue and collections such as prescription drug rebates and third party liability (TPL) collections. Table 16 lists the line items associated with this category and the recommended amounts.

Table 16. Governor's Recommended Amounts for Medicaid Collections				
Fund	ALI and Name		FY 2010	FY 2011
General Services Fund Group				
5C90	600671	Medicaid Program Support	\$69,876,838	\$68,313,238
5DL0	600639	Medicaid Revenue and Collections	\$99,916,750	\$63,600,000
5P50	600692	Health Care Services	\$84,052,802	\$226,469,478
Total Funding: Medicaid Collections			\$253,846,390	\$358,382,716

Medicaid Program Support (600671)

This line item is primarily used to support the state share of offsets (i.e., DSH) to GRF line item 600525, Health Care/Medicaid, and transfers to the Ohio Department of Mental Health (ODMH). This line item is supported by Federal Medicaid Institutions for Mental Disease Disproportionate Share (IMD/DSH) funds, which are generated from state-funded expenditures made by ODMH and ODJFS back billing for the Disability Assistance Program. Additionally, this line item is funded with revenue from the Ohio Department of Mental Retardation and Developmental Disabilities' (ODMRDD's) targeted case management and the state share of pharmacy payments made by the Ohio Department of Job and Family Services (ODJFS) for individuals in state developmental centers.

The executive recommends \$69,876,838 for FY 2010, a 12.8% decrease from the FY 2009 adjusted appropriation, and \$68,313,238 for FY 2011, a 2.2% decrease from FY 2010. According to ODJFS, the FY 2009 adjusted appropriation of \$80,120,048 is higher than the anticipated actual disbursement, and thus the recommended appropriation levels for FY 2010 and FY 2011 have been adjusted downward to be closer to the actual disbursement of \$69,374,403 in FY 2008.

Medicaid Revenue and Collections (600639)

This line item is used by ODJFS to pay for Medicaid services and contracts. The sources of funds for this line item are Medicaid revenues and collections such as the third party liability collections. The money collected is deposited into the Medicaid Revenue and Collections Fund (Fund 5DL0).

H.B. 119 of the 127th General Assembly (the FY 2008-FY 2009 biennium budget) allowed the Director of Budget and Management, at the request of the Director of Job and Family Services, to increase the appropriation in this line item by the amounts the Department of Education paid to ODJFS for Medicaid services.

To enhance states' ability to identify and obtain payments from liable third parties, the Deficit Reduction Act of 2005 made several changes to the third party liability provisions of federal Medicaid law that strengthen the authority of states to obtain commercial insurance coverage files for cross reference with Medicaid enrollment information. H.B. 119 made the state law changes accordingly. As a result, Ohio has improved the management and effectiveness of the Medicaid Third Party Liability Program in FY 2008 and FY 2009.

H.B. 562 of the 127th General Assembly (the FY 2008-FY 2009 biennium corrective budget bill) increased the appropriation to line item 600639, Medicaid Revenue and Collections, by \$20 million in FY 2009. The increase in appropriation allowed ODJFS to spend the \$8.9 million that was deposited into the fund from the state's share of a \$30 million settlement with the drug manufacturer, Merck & Co. In addition, H.B. 562 provided for the monthly premiums charged under the Children's Buy-In Program and the Medicaid Buy-In for Workers with Disabilities Program to be credited to Fund 5DL0 and used for the Children's Buy-In Program as well as Medicaid services and contracts.

The executive recommends \$99,916,750 for FY 2010, a 31.0% increase over the FY 2009 adjusted appropriation, and \$63,600,000 for FY 2011, a 36.4% decrease from FY 2010. The fluctuation in appropriations is attributable to the executive's plan to use non-GRF cash balances to offset GRF spending in FY 2010.

Health Care Services (600692)

This line item is used to offset Medicaid expenditures that would otherwise be paid from GRF line item 600525, Health Care/Medicaid. This line item is funded with rebates from drug manufacturers. The money collected from rebates is deposited into the Prescription Drug Rebate Fund (Fund 5P50). The federal match for expenditures from this line item is made from line item 600623, Health Care Federal.

The executive recommends \$84,052,802 for FY 2010, a 2.5% increase over the FY 2009 adjusted appropriation, and \$226,469,478 for FY 2011, a 169.4% increase over FY 2010. The increase in the FY 2011 appropriation is primarily due to the executive's proposal of carving out the pharmacy benefit from Medicaid managed care plans. The executive proposes to carve out the pharmacy program from Medicaid managed care in order to maximize drug rebates. According to the executive, Ohio is able to benefit from significant pharmacy rebate arrangements that are available only to state Medicaid programs. The managed care plans are not able to take advantage of this rebate

structure and thus have not been as successful in recouping rebate dollars for reinvestment. By carving out the pharmacy benefit from managed care and returning its administration to ODJFS, the executive expects to generate \$5.2 million in savings and cost avoidance in FY 2010 and \$235.5 million in FY 2011. This proposal is subject to review and approval by the Centers for Medicare and Medicaid Services.

Medicaid Administration

This category of appropriations includes the major sources of funding for Medicaid administration. Table 17 lists the line items associated with this category and the recommended amounts.

Table 17. Governor's Recommended Amounts for Medicaid Administration				
Fund	ALI and Name		FY 2010	FY 2011
General Revenue Fund				
GRF	600417	Medicaid Provider Audits	\$1,484,001	\$1,497,886
GRF	600425	Office of Ohio Health Plans	\$29,976,306	\$23,372,096
General Revenue Fund Subtotal			\$31,460,307	\$24,869,982
State Special Revenue Fund Group				
4E30	600605	Nursing Home Assessments	\$4,759,914	\$4,759,914
4J50	600618	Residential State Supplement Payments	\$15,700,000	\$15,700,000
4Z10	600625	HealthCare Compliance	\$10,000,000	\$10,000,000
5S30	600629	MR/DD Medicaid Administration and Oversight	\$2,070,707	\$5,493,954
5U30	600654	Health Care Services Administration	\$12,017,389	\$14,393,903
State Special Revenue Fund Group Subtotal			\$44,548,010	\$50,347,771
Total Funding: Medicaid Administration			\$76,008,317	\$75,217,753

Medicaid Provider Audits (600417)

This GRF line item provides the funding mechanism for payroll for the Office of Research, Assessment, and Accountability (ORAA) and the Medicaid provider audits conducted by the Auditor of State. H.B. 119 of the 127th General Assembly (the FY 2008-FY 2009 biennium budget) earmarked \$2,000,000 in FY 2008 and FY 2009 in GRF line item 600417, Medicaid Provider Audits, to be used by the Auditor of State to perform audits of Medicaid providers. The Governor vetoed the provision. The Governor stated that ODJFS already performs audits of providers, and paying the Auditor to repeat this task is an unnecessary expense in view of the funding limitation being imposed on ODJFS in the budget. However, the Governor did not remove the provided funding for the audits. The actual expenditure was \$1,292,040 in FY 2008.

The executive recommends \$1,484,001 for FY 2010, a 5.7% decrease from the FY 2009 adjusted appropriation, and \$1,497,886 for FY 2011, a 0.9% increase over FY 2010. GRF line item 600417 expenditures for FY 2008 and FY 2009 consist of payroll, travel, office supplies, printing, and the interagency agreement for the Auditor of State. In FY 2010 and FY 2011, the expenditures will also include personal service contracts.

Office of Ohio Health Plans (600425)

This GRF line item is used to fund the operating expenses of the Office of Ohio Health Plans. The federal earnings on the payments from this line item are deposited as revenue into the GRF. The Office of Ohio Health Plans is responsible for administering Ohio's Medicaid, State Children's Health Insurance Program (SCHIP), Hospital Care Assurance Program (HCAP), and the state-funded Disability Medical Assistance Program (DMA).

The executive recommends \$29,976,306 for FY 2010, a 13.6% decrease from the FY 2009 adjusted appropriation, and \$23,372,096 for FY 2011, a 22.0% decrease from FY 2010. The decreases in the appropriation levels are due to (1) the reduction in contracts or administrative workload with the implementation of Medicaid Information Technology Systems (MITS), and (2) the executive's efforts to shift the Medicaid administrative spending away from GRF line item 600425, Office of Health Plans, to non-GRF line items such as 600629, MR/DD Medicaid Administration and Oversight.

Nursing Home Assessments (600605)

This line item is used to pay the costs of relocating residents to other facilities, maintaining or operating a facility pending correction of deficiencies or closure, and reimbursing residents for the loss of money managed by the facility. Currently, funds in the line item are transferred to the Department of Aging and the Department of Health. The source of funding for this line item is all fines collected from facilities in which the Ohio Department of Health finds deficiencies. The fines collected are deposited into Nursing Home Assessments Fund (Fund 4E30). The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$4,759,914 for FY 2010 and FY 2011.

Residential State Supplement Payments (600618)

This line item is used to provide payments to Residential State Supplement (RSS) recipients. As a result of H.B. 152 of the 120th General Assembly, control of the Optional State Supplement Program (the former name of RSS) was transferred to the Ohio Department of Aging (ODA), although payments are still to be made by ODJFS. The source of funding for this line item are transfers from ODA. The RSS Program provides a cash supplement to low-income aged, blind, or disabled adults who have need for assistance with daily activities due to a medical condition, but do not require institutional care if other protective care can be arranged. The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$15,700,000 for FY 2010 and FY 2011.

Health Care Compliance (600625)

This line item is used to collect and redistribute sanctions levied against Medicaid providers. Medicaid Managed Care providers who fail to comply with health care data collection requirements are fined. When providers come into compliance, they are reimbursed for the fines paid. The source of funding for this line item is the refundable monetary sanctions levied against Medicaid Managed Care providers that fail to comply with encounter data requirements. The money is deposited into the Health Care Compliance Fund (Fund 4Z10). The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$10,000,000 for FY 2010 and FY 2011.

MR/DD Medicaid Administration and Oversight (600629)

This line item is used to disburse funds received from the Ohio Department of Mental Retardation/Developmental Disabilities (ODMRDD). ODMRDD charges the county boards of MRDD an annual fee of 1.5% of the value of all Medicaid claims paid for home and community-based services. ODMRDD then transfers 30% of the funds collected to the MR/DD Medicaid Administration and Oversight Fund (Fund 5S30). That is the source of funding for this line item.

The executive recommends \$2,070,707 for FY 2010, a 27.8% increase over the FY 2009 adjusted appropriation of \$1,620,960, and \$5,493,954 for FY 2011, a 165.3% increase over FY 2010. The increases in the appropriation levels are the executive's efforts to shift Medicaid administration spending from GRF line item 600425, Office of Health Plans, to non-GRF line items.

Health Care Services Administration (600654)

This line item is used to pay costs associated with the administration of Medicaid, including the Medicaid Information Technology Systems (MITS). MITS will be funded at either 10% state and 90% federal or 25% state and 75% federal depending on the type of expenditure for the project. Funding for this line item comes from a variety of Medicaid financing activities. The money is deposited in the Health Care Services Administration Fund (Fund 5U30).

The executive recommends \$12,017,389 for FY 2010, a 0.1% increase over the FY 2009 adjusted appropriation, and \$14,393,903 for FY 2011, a 19.8% increase over FY 2010. The increase in appropriation levels is mainly due to the shifting of administrative costs from GRF line item 600425 to non-GRF line item 600654. According to ODJFS, the shift was done so ODJFS's GRF budget could be funded at a reduced level while maintaining funding for the Office of Ohio Health Plans.

Medicaid Information Technology Systems

The primary goal and objective of the MMIS/MITS systems is to assure that ODJFS medical policy is efficiently and effectively implemented. The system provides reimbursement to medical providers for services rendered to eligible recipients. MITS is being developed to reduce or eliminate manual and other paper intensive processes. The following are examples of improvements that will come with the implementation of MITS:

- **Provider Claims Submission:** Using the current Medicaid web portal (<https://medicaidremit.ohio.gov/default/home.jsf>), Medicaid providers using professional claims can submit them via direct data entry. Once implemented, MITS will expand this capability to include additional types of Medicaid claims including additional professional, dental and limited institutional claims.
- **Claims Status and Adjustments/Resubmissions:** With MITS implementation, Medicaid providers may check the status of any claim submitted regardless of how submitted (paper, web portal, EDI, etc.) Providers may also submit claims adjustments or resubmit corrected claims.
- **Prior Approval for Medical Services and Equipment:** With MITS implementation, requests for Medicaid prior approval can be submitted electronically using the Medicaid web portal. The only prior approvals requiring documentation in addition to the on-line submission will be those requiring submission of a study model or physical exhibit that cannot be submitted in an electronic format.
- **Submission and Renewal of Provider Applications:** Medical service providers seeking to participate in Medicaid will be able to complete and submit a provider application on-line using the Medicaid web portal. Existing providers whose provider agreements are expiring may also submit application renewals. Independent providers serving Medicaid consumers enrolled in waiver programs will be able to submit their required annual background checks.

Hospital Care Assurance Program

This category of appropriations includes the major sources of state and federal funding for the Hospital Care Assurance Program. Table 18 lists the line items associated with this category and the recommended amounts.

Table 18. Governor's Recommended Amounts for Hospital Care Assurance Program				
Fund		ALI and Name	FY 2010	FY 2011
Federal Special Revenue Fund Group				
3F00	600650	Hospital Care Assurance Match	\$362,092,785	\$367,826,196
Federal Special Revenue Fund Group Subtotal			\$362,092,785	\$367,826,196
State Special Revenue Fund Group				
6510	600649	Hospital Care Assurance Program Fund	\$220,612,051	\$218,164,239
State Special Revenue Fund Group Subtotal			\$220,612,051	\$218,164,239
Total Funding: Hospital Care Assurance Program			\$582,704,836	\$585,990,435

Hospital Care Assurance Program (600649, 600650)

These two line items are used to fund the Hospital Care Assurance Program (HCAP). The federal government requires state Medicaid programs to make subsidy payments to hospitals that provide uncompensated, or charity, care to low-income and uninsured individuals at or below 100% FPG under the Disproportionate Share Hospital (DSH) Program. HCAP is the system Ohio uses to comply with the DSH Program requirement. Under HCAP, hospitals are assessed an amount based on their total facility costs, and government hospitals make intergovernmental transfers to ODJFS. ODJFS then redistributes back to hospitals money generated by the assessments, intergovernmental transfers, and federal matching funds based on uncompensated care costs. ODJFS distributes to hospitals money generated by assessments, intergovernmental transfers, and federal matching funds generated by the assessments and transfers. The federal funds are appropriated in line item 600650, and the state funds (assessment revenues) are appropriated in line item 600649.

The executive recommends \$220,612,051 for FY 2010, a 4.9% decrease from the FY 2009 adjusted appropriation, and \$218,164,239 for FY 2011, a 1.1% decrease from FY 2010 for line item 600649, Hospital Care Assurance Program Fund. The executive recommends \$362,092,785 for FY 2010, a 5.5% increase over the FY 2009 adjusted appropriation, and \$367,826,196 for FY 2011, a 1.6% increase over FY 2010, for line item 600650, Hospital Care Assurance Match. The recommended funding levels for HCAP are based on the executive's projected assessment revenue and spending. Under current law, HCAP is scheduled to sunset on October 16, 2009. Just as in previous budgets, the executive budget proposes to delay the sunset of HCAP for two years until October 16, 2011.

Medicaid Primer

Medicaid was enacted in 1965 under Title XIX of the Social Security Act. Medicaid services are an entitlement for those who meet eligibility requirements. Entitlement means that if an individual is eligible for the program then they are guaranteed the benefits and the state is obligated to pay for these benefits. Medicaid is a publicly funded health insurance program for low-income individuals, initially established to provide medical assistance only to those individuals receiving assistance through Aid to Families with Dependent Children (AFDC), and state programs for the elderly. Over the years, Congress has incrementally expanded Medicaid eligibility to reach more Americans living below or near poverty, regardless of their welfare eligibility.

In 1972, Congress enacted a federal cash assistance program for the aged, blind, and disabled called Supplemental Security Income (SSI), which broadened Medicaid coverage to include this population. But the most significant expansion of Medicaid was to provide health insurance coverage not just to the welfare population but also to other low-income families, especially low-income children and pregnant women. In 1996, Medicaid was delinked with the enactment of Temporary Assistance to Needy Families (TANF) Program. Families who receive TANF benefits do not automatically qualify for Medicaid as they did under the AFDC Program.

In 1997, the State Children's Health Insurance Program (SCHIP) was created. Title XXI of the Social Security Act, enacted by the Balanced Budget Act of 1997, added health care coverage for children in low- and moderate-income families who are ineligible for Medicaid but cannot afford private insurance. SCHIP builds upon the Medicaid Program. States were offered the option of implementing this health care coverage as standalone programs with different benefit packages, or as part of their existing Medicaid benefit. Ohio opted to implement SCHIP as a Medicaid expansion in 1998. States receive an enhanced federal match (greater than the state's Medicaid match) to provide SCHIP. Under the program, each state is entitled to a specific allotment of federal funds each year.

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The Act (Public Law No. 111-3) is designed to provide coverage to more uninsured children and to improve the quality of their care. It reauthorizes SCHIP for the next four and a half years (April 1, 2009 to September 30, 2013). It also increases state SCHIP allotments, modernizes the formula for dividing funds among the states, and establishes a mechanism for "re-

basing" state allotments every two years to ensure that SCHIP funds are targeted to states that are using the funds.

Today, Medicaid/SCHIP is the largest health insurance program in the country. It covers a broad, low-income population, including working families, individuals with diverse physical and mental disabilities, and seniors. Medicaid's beneficiaries include many of the poorest and sickest people in the nation.

Medicaid is a federal-state joint program: administered by the states and funded with federal, state, and, in some states like Ohio, local revenues. The federal government establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services.

State agencies administer Medicaid subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). State participation in Medicaid is voluntary, but all states participate. The federal government provides reimbursement to the states and offers guidance on how to use those funds, but each state shapes and administers its program to suit the needs of its own population. Consequently, Medicaid operates as more than 50 distinct programs – one for each state, territory, and the District of Columbia.

Because states are entitled to federal reimbursement under Medicaid, and there is no funding cap, they are able to provide a broad array of services. As long as a state can provide the match, federal funds are virtually unlimited for federally approved activities. A State Plan is the basis for a state's claim for federal reimbursement, known as federal financial participation (FFP). The State Plan is the funding agreement between the state Medicaid agency and the federal government. States are required to submit a State Plan Amendment (SPA) to CMS for changes to its Medicaid Program. Each state's plan and any amendments to the plan must be reviewed and approved by CMS in order for a state to receive FFP. Federal regulations allow CMS 90 days to review a SPA and make a determination. This 90-day time period may be stopped if CMS has questions regarding the proposed amendment. Therefore, SPAs are written and submitted long before they can be implemented.

The State Plan includes information regarding groups of consumers served, services provided, payment to providers, and other program requirements. The State Plan must meet the following requirements unless a waiver (exemption) is requested and approved by CMS:

- **Statewideness:** All Medicaid services must be available on a statewide basis. States cannot limit the availability of the health care services to a specific geographic location or fail to provide a covered service in a particular area.

- **Freedom of Choice:** Medicaid consumers are provided the freedom to choose which Medicaid contracting providers they use. States may not restrict Medicaid recipients' access to qualified providers.
- **Amount, Duration, and Scope:** For every covered service, determinations are made regarding the amount, duration, and scope of coverage provided to meet recipients' needs. For example, a state could limit the number of days of hospital care provided. States must cover each service in an amount, duration, and scope that is reasonably sufficient. Services must not be arbitrarily limited for any specific illness or condition.
- **Comparability of Services:** States must ensure that the medical assistance available to any recipient is not less in amount, duration, or scope than what is available to any other recipient.
- **Reasonable Promptness:** States must promptly provide Medicaid to recipients without delay caused by the agency's administrative procedures.
- **Equal Access to Care:** States must set payment rates that are adequate to assure Medicaid recipients reasonable access to services of adequate quality.
- **Coverage of Mandatory Services for Mandatory Populations:** CMS requires state Medicaid programs to provide certain medically necessary services to covered populations.

The federal Deficit Reduction Act of 2005 gave states greater flexibility to modify their Medicaid programs. This flexibility allows states to vary the level and range of Medicaid coverage based on recipient characteristics or geographic location. The Deficit Reduction Act, however, maintains Early and Periodic Screening, Diagnostic and Treatment services as a wraparound for children. Some states have used the Deficit Reduction Act to restructure benefits by setting more limited coverage standards for people with relatively good health, while allowing more generous benefits for adults with certain chronic physical or mental conditions and disabilities. As of October 2008, only eight states (Idaho, Kansas, Kentucky, South Carolina, Virginia, Washington, West Virginia and Wisconsin) had approved state plan amendments that implement this section of the Deficit Reduction Act.

States may seek federal waivers to operate their Medicaid programs outside of federal guidelines. The Social Security Act gives the HHS Secretary authority to waive compliance with certain provisions of Medicaid law. Some states have used waivers to expand coverage, provide services that could not otherwise be offered, expand home and community services, and require recipients to enroll in managed care programs. Waivers have also been approved to allow states to limit Medicaid covered services to

existing Medicaid eligibility groups in order to cut spending and to expand coverage to the uninsured.

There are three main types of waivers states may request, each named after the section in the federal Social Security statute that authorizes it. Each waiver has a distinct purpose, and distinct requirements.

Section 1115 Research & Demonstration Projects: Section 1115 provides the HHS Secretary with broad authority to approve experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test the merit of substantially new ideas of policy. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to cover groups of individuals and services not otherwise eligible for federal match and to demonstrate alternative approaches to providing or extending services to recipients.

The 1115 projects are generally approved to operate for a five-year period; states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the federal government more than it would cost without the waiver.

Section 1915(b) Managed Care/Freedom of Choice Waivers: Section 1915(b) provides the HHS secretary with the authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid. This section also provides waivers allowing states to skip provisions requiring comparability of services and statewideness, which together require states to offer the same coverage to all categorically needy recipients statewide. Prior to the 1997 Balanced Budget Act, which allowed states to implement managed care programs under their state plans, states often used these waivers to implement managed care programs by restricting recipients' choice of providers.

Section 1915(c) Home and Community-Based Services Waivers: Section 1915(c) provides the HHS secretary with the authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings. These waivers have been critical in state strategies to provide alternative settings for long-term care services.

Medicaid and the Economy

As the country heads into an economic downturn and employer-provided health insurance and incomes decline, more individuals will turn to Medicaid. At the beginning of this decade, when a weak economy and steady erosion in employer-based

health coverage resulted in a growing number of uninsured adults, increased Medicaid and SCHIP enrollment offset losses of job-based insurance among families and children.

Medicaid is important to not only the millions of low-income Americans who receive benefits but also to the economy of the state where Medicaid funds support thousands of health-related jobs, medical education, and work force development. State and federal dollars spent on health care services help employ health care workers and purchase medical goods and equipment from businesses in the state. Because of this increased employment and steady business in the health sector, other state economic sectors such as grocery stores, retail businesses, automotive services, etc., are also bolstered. Economists call this the multiplier effect. Medicaid spending at the state level injects more money into the state economy than would otherwise be there because of the federal match (i.e., reimbursement). In this way, Medicaid spending, more than other state spending, has uniquely powerful economic impacts on states. The magnitude of the Medicaid multiplier effect varies from state to state, depending on the size of the state's federal match rate, how the initial dollars are spent, and the economic conditions in the state.

Medicaid vs. Medicare

Medicaid and Medicare are two different programs. Medicare is a federal health insurance program that covers individuals age 65 and over, as well as some disabled individuals. Medicaid is a federal-state medical assistance program for low-income individuals. Medicare provides only partial coverage, and requires beneficiaries to pay premiums, deductibles, and copayments. Medicaid provides more complete coverage, without significant cost sharing from the recipients. All persons over age 65 (as well as younger individuals disabled for at least two years) who paid into Social Security are eligible for Medicare, but only low-income persons who are aged, blind, disabled, or are low-income families, are qualified for Medicaid. Table 1 shows the differences between Medicaid and Medicare.

Medicaid	Medicare
State administered under federal guidelines	Federally administered
State and federal funding	Federal funding
Must be low-income	No income limit
Children, parents, disabled, and age 65 plus	Age 65 plus and some people with disabilities
Benefit coverage varies by state	Same benefit coverage nationwide

Medicare has four different benefit packages, or "Parts" commonly referred to as Medicare Parts A, B, C, and D. While Medicare Part A automatically covers most people who qualify, the remaining packages are optional and have associated costs.

Part A Hospital Insurance: Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance: Most people pay a monthly premium for Part B. Medicare Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Part C Advantage Plans: People with Medicare Parts A and B can choose to receive all of their health care services through Medicare Health Plans, which are referred to as Medicare Advantage Plans (MA Plans), under Part C. Medicare beneficiaries must voluntarily select this option and then choose from among a number of MA Plans contracted with the federal government to do business in their state or geographic region. Enrolling in Medicare Part C means the individual transfers their Part A and Part B health care coverage to the responsibility of their MA Plan.

Part D Prescription Drug Coverage: Medicare Part D, Medicare prescription drug coverage, began on January 1, 2006. It is provided through Prescription Drug Plans and MA Plans. It is optional coverage for which Medicare beneficiaries must enroll and pay a monthly insurance premium, an annual deductible, and coinsurance costs.

Dual Eligibles

Individuals who are eligible for both Medicaid and Medicare simultaneously are called "dual eligibles." Medicaid plays different roles for different types of dual eligibles. Most dual eligibles qualify for full Medicaid benefits. For these individuals, Medicaid helps to fill in some of the gaps in Medicare coverage by paying for services that are not part of the standard Medicare benefit package, such as most long-term care services. These individuals account for most of the costs to Medicaid for dual eligibles. For other dual eligibles that do not qualify for full Medicaid benefits, Medicaid helps to make Medicare more affordable by providing assistance with Medicare premiums, deductibles, and other coinsurance requirements. Whether they qualify for full benefits or more limited assistance, most dual eligibles are very low-income individuals – typically have income of less than \$10,000 a year, and often face serious health challenges such as diabetes, heart disease, dementia, or a severe mental illness. The Medicare Premium Assistance Program is Ohio's program that pays Medicare premiums, deductibles, and coinsurance for these low-income individuals enrolled in

Medicare. This program is sometimes referred to as the Medicare Buy-In Program and is considered to be a part of the larger Medicaid Program.

Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The MMA of 2003 represents one of the most significant changes to Medicare since its inception in 1965. Among a number of provisions in MMA, it established a new "Part D" in Medicare that gives people access to a private Medicare prescription drug plan. This Medicare pharmacy benefit, which provides drug coverage for many individuals that previously had none, has broad implications for states. For the first time since 1965, a specific Medicare benefit is financed in significant part by state payments. The MMA requires state Medicaid programs to determine eligibility for new groups of low-income Medicare beneficiaries, and to contribute to the cost of federal prescription drug coverage for dual eligibles.

Pharmacy Benefits under Medicare Part D. Like all other Medicare beneficiaries, dual eligibles have access to the universal Medicare prescription drug benefit starting January 1, 2006. Prior to January 2006, the prescription drugs costs of the dual eligibles were paid by Medicaid. Under MMA, Medicaid no longer pays for prescription drugs for dual eligibles. Instead, they are to obtain their drug coverage by enrolling in one of the Medicare drug plans. Dual eligibles can sign up for a Medicare drug plan on their own, but, if they do not do so, the HHS secretary is required to randomly enroll them in a plan.

Phased-Down State Contribution (Clawback). The mechanism through which the states help finance the new Medicare drug benefit is popularly known as the "clawback" (the statutory term is "phased-down state contribution"). In brief, the clawback is a monthly payment made by each state to the federal Medicare Program. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for prescription drugs through Medicaid on behalf of dual eligibles. A state's clawback payment for any given month is equal to the product of a three-part formula:

$$\text{Payment} = (\text{PCE}/12) \times \text{DE} \times \text{P}\%$$

Per Capita Expenditures (PCE). This is the state's share of its per capita Medicaid expenditure for covered drugs for dual eligibles in calendar year (CY) 2003, increased by the growth in per capita prescription drug spending nationally, and adjusted for the change in the state's relevant Federal Medical Assistance Percentage (FMAP). In calculating the state Medicaid per capita expenditures for prescription drugs for dual eligibles in CY 2003, it must include pharmacist dispensing fees, adjust for manufacturer rebates, and exclude any expenditure for drugs not covered under Part D.

Dual Eligibles (DE). This is the number of dual eligibles in the month who are enrolled in Medicare Part D and have been determined by the state to be eligible for full Medicaid benefits, not just subsidies for Medicare premiums and cost sharing.

Phase-Down Percentage (P%). This is the phase-down percentage for the year specified in the MMA. As seen in Table 2, the phase-down percentage decreases from 90% in CY 2006 to 75% in CY 2015 and thereafter.

Calendar Year	Percentage
2006	90.00%
2007	88.33%
2008	86.67%
2009	85.00%
2010	83.33%
2011	81.67%
2012	80.00%
2013	78.33%
2014	76.67%
2015 and thereafter	75.00%

For example, if, in January 2008, Ohio had 175,000 dual eligibles enrolled in Part D plans, and if the per capita Medicaid spending for prescription drugs for dual eligibles (2003 trended forward) were \$1,500, then Ohio's clawback payment amount for the month would be \$19.0 million.

$$\$19.0 \text{ million} = (\$1,500/12) \times 175,000 \times 86.67\%$$

Ohio Medicaid

Ohio Medicaid is the largest health insurer in the state, covering as many as 2.2 million low-income Ohioans over the course of a year, which equals roughly 19% of the state's population. Ohio Medicaid is also the largest single state program in Ohio. The program comes with an annual price tag of more than \$13 billion in combined federal and state dollars. Medicaid accounts for 3% of Ohio's economy and close to 20% of total state government spending. Medicaid has also been growing faster than most other state programs. Accordingly, Medicaid policy receives considerable attention when the Governor and Ohio General Assembly put together the state's biennium operating budget.

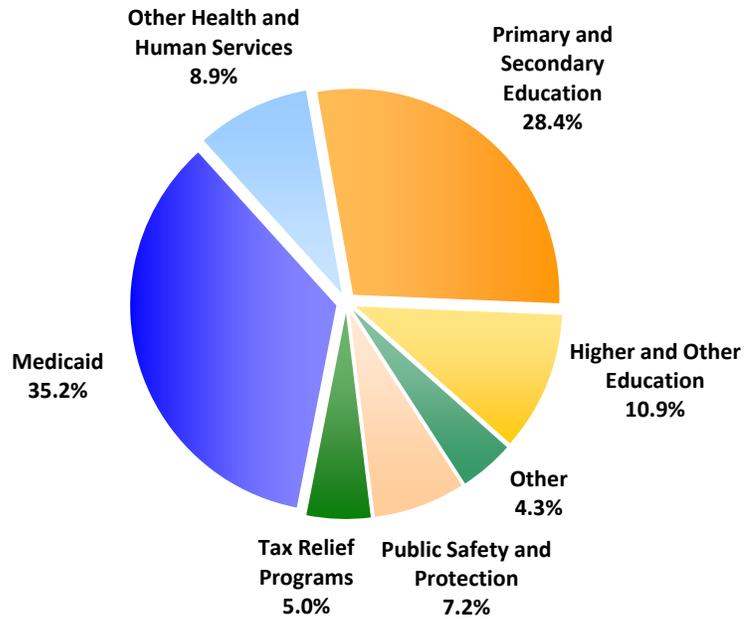
Ohio's Medicaid Program is the sixth largest in the nation. In 2005, it included coverage for the following:

- 1 of every 3 births;
- 45% of all children under age 5;
- 152,000 senior citizens;
- 265,000 non-elderly adults and children with disabilities;
- 490,000 low-income parents;
- nearly 55,000 older and disabled Ohioans in home and community-based waivers.

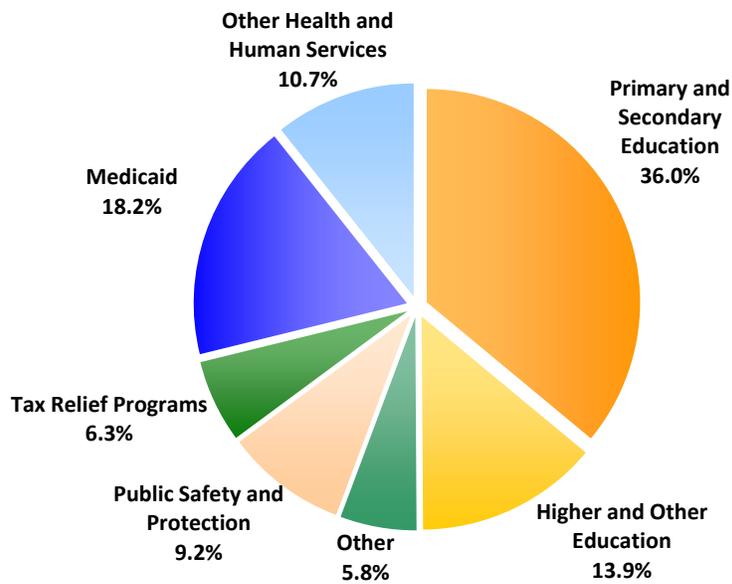
The significance of the Medicaid Program can also be seen from Chart 1 and Chart 2. Chart 1 contains GRF state and federal dollars. Chart 2 contains GRF state dollars only. As seen in Chart 6, Medicaid appropriations account for 35.2% of the GRF budget if both state and federal dollars are included.² Medicaid appropriations account for 18.2% of the GRF budget if only state dollars are included.

² "Other" includes general government, transportation and development, environment and natural resources, and executive, legislative, and judicial.

**Chart 1: FY 2008–FY 2009 Operating Budget
Total General Revenue Fund Appropriations**



**Chart 2: FY 2008–FY 2009 Operating Budget
State-Only General Revenue Fund Appropriations**



Administration

In Ohio, Medicaid is administered by the Ohio Department of Job and Family Services (ODJFS) with the assistance of six state agencies, 88 county departments of job and family services, 88 county boards of mental retardation and developmental disabilities (MR/DD), 45 community Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) boards and five Community Mental Health Services (CMH) boards, 12 Area Agencies on Aging, and more than 90,000 health care providers.

The federal government requires each state to designate a "single state agency" to administer its Medicaid Program. ODJFS is Ohio's single state agency. The Office of Ohio Health Plans (OHP) is the unit within ODJFS that is responsible for the day-to-day administration of the program. As Ohio's single state agency ODJFS must retain oversight and administrative control of the Ohio Medicaid Program and assure CMS that federally set standards are maintained. Failure to comply or meet these standards can result in loss of federal funding. Federal law does allow ODJFS to contract with other public and private entities to manage aspects of the program. ODJFS contracts with six other state agencies to administer various Ohio Medicaid programs through interagency agreements:

- Ohio Department of Aging (ODA);
- Ohio Department of Alcohol and Drug Addiction Services (ODADAS);
- Ohio Department of Education (ODE);
- Ohio Department of Health (ODH);
- Ohio Department of Mental Health (ODMH); and
- Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD).

ODH certifies long-term care and hospital providers. ODMRDD certifies intermediate care facilities for the mentally retarded (ICFs/MR) beds. Certification is required for a provider to receive reimbursement from Medicaid.

ODJFS contracts with Ohio's 88 county departments of job and family services (CDJFSs) to perform eligibility determination and enrollment. These activities are done utilizing a common statewide data system known as the Client Registry Information System-Enhanced (CRIS-E). ODJFS provides technical assistance to counties and assists them to implement eligibility policy.

ODMRDD provides subsidies to Ohio's 88 county boards of MRDD for a variety of community-based services. ODMH works with local mental health boards to ensure the provision of mental health services. Ohio has 45 community ADAMHS and five CMH boards, which serve all 88 counties. The boards are responsible for planning, monitoring, and evaluating the service delivery system within their geographic areas.

The local boards contract with local service providers to deliver mental health services in the community.

Eligibility

Federal law requires states to cover certain "mandatory" groups in order to receive any federal matching funds. To qualify for Medicaid, a person must meet financial criteria and be "categorically eligible" for the program. Financial eligibility is determined by income and assets. Categorical eligibility is determined by the federal government. Individuals must fall into one of the federally determined population categories covered by Medicaid to qualify for the program. If an individual does not fall into one of these categories, he or she cannot qualify for Medicaid even if his or her income and assets meet the financial eligibility requirements. For example, adults without dependent children, no matter how poor they are, are categorically excluded from Medicaid under federal law unless they are disabled or pregnant.

States use the Federal Poverty Guideline (FPG) in developing their income eligibility criteria for various Medicaid groups. FPG is the income guideline established and issued each year in the Federal Register by HHS. Public assistance programs usually define income standards in relation to FPG. Table 3 provides the 2009 poverty guidelines for various family sizes for the 48 contiguous states and the District of Columbia. Alaska and Hawaii are provided a different set of guidelines.

Family Size	Poverty Guideline
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790

The following Medicaid eligibility groups are mandatory:

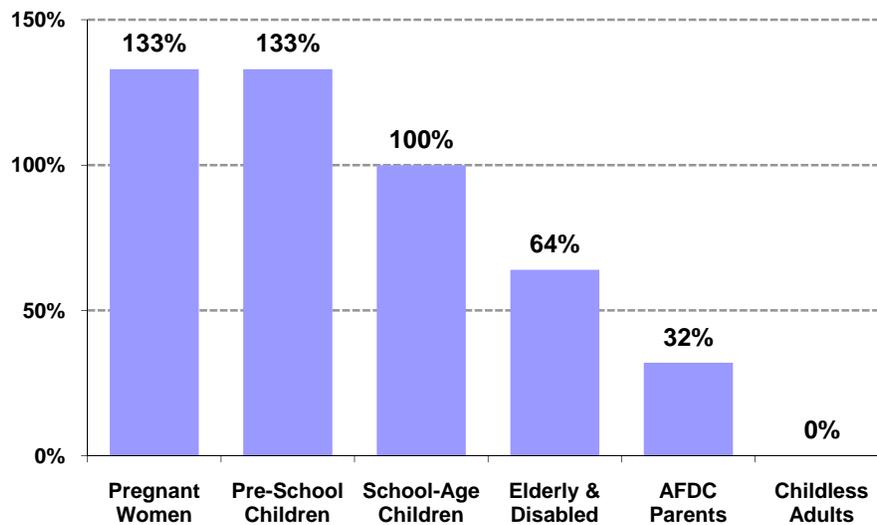
- Parents who would meet the eligibility criteria for participation in the cash assistance program AFDC as of July 16, 1996. In Ohio, families with dependent children with incomes no higher than 32% FPG were eligible for AFDC.
- Children under age six in families with incomes up to 133% FPG, and children age six and older with family incomes up to 100% FPG.
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Pregnant women with incomes up to 133% FPG. In addition, after giving birth, these women and their infants have mandated coverage throughout

the infant's first year, after which women and infants may continue to receive Medicaid coverage if eligible in other eligibility categories.

- Supplemental Security Income (SSI) recipients (or in states using more restrictive criteria – aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI Program and which were in place in the state's approved Medicaid Plan as of January 1, 1972).

Chart 3 shows Ohio's major mandatory Medicaid eligibility groups as percentage of federal poverty guidelines.

**Chart 3: Mandatory Medicaid Eligibility Levels, Ohio
As Percentage of Federal Poverty Guideline, 2008**



While the federal government requires that certain groups be covered, it grants states flexibility in setting Medicaid eligibility. Optional eligibility groups include pregnant women, children, and parents with income exceeding the mandatory thresholds; persons with disabilities and the elderly up to 100% FPG; persons residing in nursing facilities with income below 300% of the SSI standard, and "medically needy" individuals, who have high health expenses relative to their income. Between state expansions of Medicaid and eligibility under SCHIP, Ohio has expanded its coverage above the federal minimum. To be qualified for Ohio Medicaid, an individual must meet basic requirements:

- Be a U.S. citizen or meet Medicaid citizenship requirements;³
- Be an Ohio resident;
- Have or get a Social Security number; and
- Meet certain financial requirements.

Various covered groups under Ohio Medicaid are described in the following sections.

Covered Families and Children

Covered Families and Children (CFC) includes families, children, and pregnant women. CFC is itself made up of several categories, including Healthy Start and Healthy Families. Generally, state law does not specify which persons fit into which categories. Rather, the categories have in large part been created administratively and there may not be a clear consensus as to the specific composition of the different categories.

Healthy Start

Healthy Start includes children under age 19 with family incomes not exceeding 200% FPG and pregnant women with family incomes not exceeding 200% FPG. Part of Healthy Start is funded with regular Medicaid funds. Another part, covering uninsured children under age 19 who do not otherwise qualify for Medicaid, is funded with State Children's Health Insurance Program (SCHIP) funds. The state receives a higher federal match for SCHIP.

In Ohio, SCHIP is commonly discussed as consisting of three parts: SCHIP I, SCHIP II, and SCHIP III. SCHIP I began January 1998 and provides coverage for low-income children up to age 19 in families at or below 150% FPG. Am. Sub. H.B. 283 of the 123rd General Assembly (the FY 2000-FY 2001 budget) established SCHIP II to cover uninsured individuals under age 19 in families with incomes between 150% and 200% FPG. SCHIP II commenced on July 1, 2000. H.B. 119 of the 127th General Assembly (the FY 2008-FY 2009 budget) established SCHIP III to include persons under

³ The citizenship requirement, which became effective September 25, 2006, is a result of the Deficit Reduction Act of 2005. The citizenship requirement is meant to ensure those receiving public assistance are U.S. citizens. The law requires everyone applying for Medicaid to provide original documents to establish legal citizenship. Previously, Medicaid applicants could self-declare their U.S. citizenship. (Immigrants applying for Medicaid have always been required to document their status.) Additionally, Medicaid recipients who were approved before the Deficit Reduction Act was enacted must verify their citizenship status at the time of their reapplication for Medicaid benefits. Citizenship needs to be established only once.

age 19 with family incomes up to 300% FPG starting not earlier than January 1, 2008. ODJFS plans to implement SCHIP III beginning in July 2009.

As stated above, Healthy Start includes pregnant women with family incomes not exceeding 200% FPG. Pregnant women are allowed to receive expedited enrollment into Medicaid by meeting certain criteria. Expedited enrollment allows pregnant women to receive services under the fee-for-service delivery system within 24 hours of applying for Medicaid. Once their eligibility is approved, they may continue to receive services under the fee-for-service delivery system until they enroll in a managed care plan. After a pregnant woman selects a managed care plan, the state pays monthly capitation rates for the woman for the remainder of her pregnancy and pays a separate delivery payment upon birth.

Healthy Families

Healthy Families includes families with children. This category too can be broken down into different subcategories, including families that receive cash assistance under Ohio Works First and other families with family income not exceeding 90% FPG.

Other subcategories of CFC include the following:

- Extended eligibility (up to four months) for families that lose eligibility under the Healthy Families due to collection or increased collection of child or spousal support.
- Transitional Medicaid (up to 12 months) for families that lose eligibility under Healthy Families because their income exceeds 90% FPG due to increased earned income. The family must have received Medicaid under Healthy Families for at least three of the six months before losing eligibility due to the increased earned income.
- Certain low-income individuals age 19 or 20 who do not qualify for Medicaid under Healthy Families.
- Children for whom adoption assistance or foster care maintenance payments are provided.
- Individuals under age 21 who were in foster care on their 18th birthday and for whom foster care maintenance payments or independent living services were furnished before they turned 18.

Aged, Blind, and Disabled

Medicaid covers certain low-income individuals who are aged (age 65 or older), blind, or disabled (ABD). ABD applicants must meet both income and resource criteria to qualify for Medicaid. Assets and resources are items such as: cash, stocks, bonds, bank accounts, and property. Some resources, such as the home in which the person is living, are considered exempt and are not counted when determining Medicaid

eligibility. ABD applicants also must meet transfer of resources criteria that are in place to prevent a person from impoverishing themselves by giving away money to be qualified for Medicaid. In addition to meeting income and resources limits, ABD individuals must be elderly (age 65 or older), significantly visually impaired, or have a disabling condition that meets SSI requirements.

In some states recipients of SSI are automatically eligible for Medicaid. Ohio is a 209(b) state, however, which means persons who receive SSI benefits do not automatically qualify for Medicaid in this state. Ohio uses more restrictive eligibility requirements for ABD. There are different standards for different services, but in general, ABD populations with annual incomes up to approximately 64% FPG are eligible for Medicaid in Ohio. ABD applicants whose income exceeds the Medicaid limit may qualify for Medicaid on a month-to-month basis after they "spend down" some of their income on health care expenses.

Tables 4 and 5 show the annual and monthly income limits for various eligible populations.

Table 4. Annual Income Guidelines					
		Annual Income Guidelines by Number of Persons in Family			
Eligible Population	Income Guidelines	1	2	3	4
Former foster children age 18 to 21	No income limit, restrictions apply	N/A	N/A	N/A	N/A
Workers with disabilities	<= 250%	\$27,075	\$36,425	\$45,775	\$55,125
Children to age 19	<= 200%	\$21,660	\$29,140	\$36,620	\$44,100
Pregnant women	<= 200%	\$21,660	\$29,140	\$36,620	\$44,100
Parents	<= 90%	\$9,747	\$13,113	\$16,479	\$19,845
Disabled persons	<= 64%	\$6,931	\$9,325	\$11,718	\$14,112
Persons 65 & over	<= 64%	\$6,931	\$9,325	\$11,718	\$14,112

Note: These figures are based on 2009 Federal Poverty Guidelines and change annually. Some eligibility categories consider resources other than income. Persons with incomes higher than 64% FPG may have medical expenses deducted from income calculations to spenddown to this level.

		Monthly Income Guidelines by Number of Persons in Family			
Eligible Population	Income Guidelines	1	2	3	4
Former foster children age 18 to 21	No income limit, restrictions apply	N/A	N/A	N/A	N/A
Workers with disabilities	<= 250%	\$2,256	\$3,035	\$3,815	\$4,594
Children to age 19	<= 200%	\$1,805	\$2,428	\$3,052	\$3,675
Pregnant women	<= 200%	\$1,805	\$2,428	\$3,052	\$3,675
Parents	<= 90%	\$812	\$1,093	\$1,373	\$1,654
Disabled persons	<= 64%	\$578	\$777	\$977	\$1,176
Persons 65 & over	<= 64%	\$578	\$777	\$977	\$1,176

Note: These figures are based on 2009 Federal Poverty Guidelines and change annually. Some eligibility categories consider resources other than income. Persons with incomes higher than 64% FPG may have medical expenses deducted from income calculations to spenddown to this level.

Medicare Cost-Sharing Assistance

Medicaid helps certain Medicare beneficiaries with various Medicare cost-sharing expenses. The four major categories of Medicare cost-sharing assistance are as follows:

The first category is Qualified Medicare Beneficiary (QMB). In general, to qualify for the QMB category a Medicare recipient must have family income not exceeding 100% FPG and resources that do not exceed twice the limit for SSI. Medicaid pays QMB beneficiaries' Medicare Part A and B premiums and other Medicare cost sharing expenses (copayments, deductibles, and coinsurance).

The second category is Specified Low-Income Medicare Beneficiary (SLMB). In general, to qualify for SLMB a Medicare beneficiary must have family income above 100% FPG but less than 120% FPG and resources that do not exceed twice the limit for SSI. Medicaid pays SLMB beneficiaries' Medicare Part B premiums.

The third category is Qualified Individual (QI). In general, to qualify for the QI category a Medicare recipient must have family income of at least 120% FPG but not exceeding 135% FPG and resources that do not exceed twice the limit for SSI. Medicaid pays QI beneficiaries' Medicare Part B premiums, subject to an annual federal funding cap. Federal funding for the QI category is currently scheduled to end in December 2009.

The income guidelines and asset limits for these programs are summarized in Tables 6 and 7.

Table 6. Monthly Income Limits		
	Individual Income Limit	Couple Income Limit
QMB	\$903 or less	\$1,214 or less
SLMB	\$904 ~ \$1,083	\$1,215 ~ \$1,457
QI	\$1,084 ~ \$1,218	\$1,458 ~ \$1639

Note: Income based on the 2009 Federal Poverty Guideline and changes annually.

Table 7. Asset Limits	
Individual Income Limit	Couple Income Limit
\$4,000	\$6,000

The fourth category is Qualified Disabled and Working Individual (QDWI). In general, to qualify for the QDWI category an individual must have lost Medicare Part A benefits due to losing eligibility for disability benefits under Title II of the Social Security Act following a return to work but be eligible to purchase Medicare Part A benefits by paying premiums, have family income not exceeding 200% FPG, and resources that do not exceed twice the limit for SSI. Medicaid pays QDWI beneficiaries' Medicare Part A premiums.

Breast and Cervical Cancer

Medicaid covers women under age 65, who have been screened for breast and cervical cancer under the federal Breast and Cervical Cancer Early Detection Program, and need treatment for the cancer. To qualify for the component, a woman cannot be covered by insurance considered to be "creditable coverage." Eligibility for Medicaid is limited to the period in which the woman requires treatment for breast or cervical cancer. The federal government reimburses a higher share of the costs of Medicaid provided under this group than the regular federal reimbursement rate.

Medicaid Buy-In for Workers with Disabilities

The Medicaid Buy-In for Workers with Disabilities Program is available to employed, disabled individuals, who are at least 16 but younger than 65 years of age, have countable income not exceeding 250% FPG, and meet other eligibility requirements including a resource requirement. Individuals with income exceeding 150% FPG must pay an annual premium to be qualified.

Covered Services

Medicaid covers seniors, families, pregnant women, and people with physical and mental illness and chronic diseases. To address the various health care needs of its diverse recipients, Medicaid provides a rich benefit package not typically covered by

private insurance, but also many additional services, such as dental and vision care and transportation, as well as long-term care services.

The Social Security Act specifies a set of mandatory health care services state Medicaid programs must cover and a set of optional services states may choose to cover. Most services provided under a state's Medicaid plan must be available to all covered individuals who have a medical need for that service. Exceptions include services provided only to children or only to individuals enrolled in home and community-based services waivers. As long as these benefits are provided in accordance with federal guidelines, states will receive federal financial participation (reimbursement) for eligible services provided to covered populations. As with private insurance, most of the services can be limited on the amount, duration, or scope of the benefits. For example, state Medicaid programs can choose the setting in which covered services can be provided, limit the number of visits for a certain service, and cap the annual spending per person for a particular service. States are also allowed to use numerous tools to manage utilization, such as copayment, prior authorization, and case management.

Two important Medicaid benefits not covered in most private health insurance plans are Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and long-term care services. EPSDT, known as Healthchek in Ohio, is a federally mandated program established to ensure Medicaid recipients under age 21 have access to periodic preventive care examinations and medically necessary treatment. The purpose of Healthchek is to discover and treat health problems as early as possible to prevent them from progressing. It requires state Medicaid programs to provide for any medical service a physician determines is needed for a Medicaid eligible child. Under this program, children covered by Medicaid receive all the basic medical services such as well-child visits, immunizations, dental, hearing and other screening services. In addition, they are also able to access a wide array of services that states do not otherwise cover in their Medicaid programs. In Ohio, a Healthchek coordinator is available in each Ohio county department of job and family services to assist Medicaid recipients in getting these services. All children eligible for Medicaid qualify for this program regardless of their eligibility category.

Medicaid long-term care includes comprehensive services provided in institutions, such as a nursing home or ICF/MR, and a wide range of services and supports needed by people to live independently in the community, such as home health care, personal care, medical equipment, rehabilitative therapy, adult day care, case management, and respite for caregivers.

All states must provide nursing home care as part of their Medicaid programs for seniors and other individuals with severe physical disabilities. Medicaid is by far the largest payer in Ohio, accounting for almost 70% of all nursing home costs.

Although technically an optional benefit, prescription drugs are covered in all states. Many of the services that are technically optional are particularly vital for persons with chronic conditions or disabilities and the elderly. Despite their "optional" designation in statute, the inclusion of many of these services in state Medicaid packages is evidence that they are often essential as a practical matter. Notably, more than 20% of Medicaid spending in Ohio is attributable to optional services.

Table 12 provided in the Medicaid Facts and Figures section of this Redbook shows the projected expenditure for mandatory and optional services by provider type for fiscal years 2009 to 2011.

Table 8 shows the services covered under Ohio Medicaid for both mandatory (M) and optional (O). Table 8 also provides payment information.

Table 8. Ohio Medicaid Covered Services				
Service	M/O	Process	Special Considerations	Payment Information
Outpatient Services	M	Covered services are those diagnostic, therapeutic, rehabilitative or palliative treatment or services furnished by or under the direction of a physician or other qualified practitioner.	Outpatient visits are limited to 24 per year, except for certain medical conditions. Visits in excess of 24 are subject to post payment review.	These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule. These services are included in the Managed Care Plan (MCP) capitated rates for Medicaid recipients who are enrolled in MCPs.
Rural Health Clinic (RHC)	M	Covered RHC services are as follows: <ul style="list-style-type: none"> • Services furnished by a physician; • Services furnished by a physician assistant, nurse practitioner, or nurse midwife; and • Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife. 	Certain ambulatory services must be billed by RHCs under a separate Medicaid Provider Number as a FFS ambulatory clinic provider. Outpatient visits are limited to 24/year, except for certain medical conditions. Visits in excess of 24 are subject to post payment review.	RHCs are reimbursed using a prospective payment system in accordance with federal legislation. Each RHC's rates are established on a per visit basis, and are increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services. RHC services are included in the capitated rates paid to Managed Care Plans (MCPs).

Table 8. Ohio Medicaid Covered Services				
Service	M/O	Process	Special Considerations	Payment Information
Federally Qualified Health Centers (FQHC)	M	<p>Covered core services for FQHCs are:</p> <ul style="list-style-type: none"> • Services furnished by a physician, physician assistant, or advanced practice nurse; • Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, or advanced practice nurse; and • Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if certain conditions are met. • Covered noncore services include the following: <ul style="list-style-type: none"> • Physical therapy; • Speech pathology and audiology; • Dental services; • Podiatry; • Optometric/optician services; • Chiropractic services; • Transportation services; and • Mental health services provided by a clinical psychologist, clinical social worker, advanced practice nurse certified by a national certifying organization in the specialty of psychiatry, or a professional counselor. 	<p>Outpatient visits are limited to 24 per year, except for certain medical conditions. Visits in excess of 24 are subject to post payment review.</p> <p>FQHCs that contract with MCPs must complete the "ODHS 3454 MCP Worksheet" and return to the Department with the annual FQHC cost report.</p>	<p>FQHCs are reimbursed for covered core and noncore services using a prospective payment system in accordance with federal legislation.</p> <p>Services are billed on an encounter basis.</p> <p>Certain services are not considered covered FQHC services. FQHC's costs for these services are not included in the rate established for core and noncore services. These services should be billed by an FQHC under a separate Medicaid provider number as FFS ambulatory care provider (this would include services such as inpatient hospital surgery and inpatient hospital visits).</p>
Laboratory/ X-ray	M	<p>Laboratory services include:</p> <ul style="list-style-type: none"> • Biological, microbiological, serological, chemical, immunological, immuno-hematological, hematological, cytological, or pathological procedures performed on specimens from the human body; and • Specimen collections. 	<p>Lab tests must be ordered by a physician or other qualified practitioner.</p> <p>All laboratory services must be medically necessary or medically indicated for preventive care.</p> <p>X-rays and other radiological procedures are covered if ordered by a physician or other qualified practitioner.</p>	<p>These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule.</p> <p>These services are included in the Managed Care Plan (MCP) capitated rates for Medicaid recipients who are enrolled in MCPs.</p>

Table 8. Ohio Medicaid Covered Services				
Service	M/O	Process	Special Considerations	Payment Information
Nursing Home	M	<p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Resident assessment; • Preadmission screening and annual resident review; • Comprehensive care; • Physician services; • Nursing services; • Dietary services; • Pharmacy services; • Social services/activities; • Specialized rehab services; • Lab services; • Radiology/other diagnostics; • Dental/vision/hearing services; and • Quality assessment and assurance. 		<p>Nursing homes are reimbursed per diem rates according to a case-mix adjusted prospective payment system. These rates are based on four major cost centers: direct care costs, other protected costs, indirect care costs, and capital costs.</p>
Physician Services	M	<p>Services necessary for the diagnosis and/or treatment of an illness or injury are covered. Such services must be provided within the scope and practice of the medical profession (M.D. or D.O.) as defined by Ohio law, and performed by eligible providers for eligible Medicaid recipients.</p>	<p>Outpatient visits are limited to 24 per year, except for certain medical conditions. Visits in excess of 24 are subject to post-payment review.</p>	<p>These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule. These services are included in the Managed Care Plan (MCP) capitated rates for Medicaid recipients who are enrolled in MCPs.</p>
Dental	O	<p>Diagnostic, preventive, restorative, and surgical services are covered, with certain limitations.</p>		<p>These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule.</p>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program	M	<p>The Ohio EPSDT Program ("Healthchek") includes the following services:</p> <ul style="list-style-type: none"> • Vision services; • Hearing services; • Dental services; • Behavioral health and other rehabilitative services; and • Other medically necessary services, including further diagnosis and/or treatment. 	<p>This federally mandated program of comprehensive and treatment services for children under age 21.</p>	<p>These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule. These services are included in the Managed Care Plan (MCP) capitated rates for Medicaid recipients who are enrolled in MCPs.</p>

Table 8. Ohio Medicaid Covered Services				
Service	M/O	Process	Special Considerations	Payment Information
Family Planning Services and Supplies	M	<p>Covered family planning services include medical and educational services related to:</p> <ul style="list-style-type: none"> • Temporary contraceptive management; • Permanent contraceptive management (sterilization); • Physical and emotional reproductive health of patient; • Genetic counseling and diagnostic testing; and • Pregnancy determination. 	<p>A family planning visit may be performed by either a physician and/or health professional or social service professional qualified under the Ohio Revised Code.</p> <p>Family Planning services not covered under the Ohio Medicaid program include:</p> <ul style="list-style-type: none"> • Infertility services; • Hysterectomies performed for sterilization purposes; • Abortions performed to terminate an unwanted pregnancy. 	<p>These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule.</p>
Clinic Services	O	<p>The following services are covered in an ambulatory clinic setting:</p> <ul style="list-style-type: none"> • Physician services; • Nursing services; • Dental services; • Pharmaceuticals; • Diagnostic services; • Family planning services; • EPSDT; • At-risk pregnancy services; • Vision care services; • Transportation; and • Rehabilitation services. 	<p>Outpatient visits are limited to 24 per year, except for certain medical conditions. Visits in excess of 24 are subject to post-payment review.</p>	<p>These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule.</p>

Table 8. Ohio Medicaid Covered Services				
Service	M/O	Process	Special Considerations	Payment Information
Prescription Drugs	O	<p>Drugs covered by the Ohio Medicaid program are limited to those that are manufactured or labeled by companies participating in the Federal Medicaid Rebate Program, dispensed by duly enrolled providers and which fall into one of the following categories:</p> <ul style="list-style-type: none"> • Legend and over-the-counter drugs listed in the Ohio Medicaid Formulary; • Legend and over-the-counter drugs not included in the formulary but which have been authorized by the Department; and • Compounded prescriptions in accordance with State regulations. 	<p>Nonformulary drugs, other than those excluded below, that are essential for treatment, require prior authorization.</p> <p>Nonformulary drugs where there is a formulary alternative may be authorized when it is documented that a formulary drug cannot be used. The prescribing physician is required to document the medical necessity:</p> <ul style="list-style-type: none"> • Noncovered drugs; • Drugs for the treatment of obesity; • Drugs for the treatment of infertility; • DESI (ineffective) drugs or drugs that have been determined to be identical, similar, or related; and • Drugs being used for non-FDA approved indications unless there is compelling clinical evidence to support the experimental use. 	<p>The Department reimburses pharmacies for drugs at the lesser of the submitted charge or the calculated allowable for the cost of the drug plus a dispensing fee for those drugs listed on the drug formulary.</p> <p>Maximum Allowable Cost drugs: Maximum Allowable Cost (MAC) is equal to Federal Upper Limit (FUL) established by the federal government or an amount set by the Department. Reimbursement for state MAC drugs is based on the 65th percentile of the Estimated Acquisition Cost (EAC) of all readily available generic equivalent drugs.</p> <p>All products, other than those designated as MAC drugs, are considered EAC drugs. Reimbursement is based on the estimate of the Wholesale Acquisition Cost (WAC) determined by periodic review of pricing information from Ohio drug wholesalers, pharmaceutical manufacturers, and a pharmacy pricing update service. Maximum reimbursement for these drugs is WAC plus 9%.</p> <p>In the event that WAC cannot be determined, the Department defines EAC as Average Wholesale Price (AWP) minus 12.8%.</p> <p>The dispensing fee for noncompounded drugs is \$3.75.</p>
Case Management Services	O	<p>Targeted case management is provided to Children with Special Health Care Needs (CSHCN), especially those with high-risk and chronic conditions such as asthma, teen pregnancy, and HIV/AIDS.</p> <p>The Primary Alternative Care and Treatment (PACT) is a case management program for recipients who have exceeded the utilization criteria for prescribing physicians, number of office visits, and drug use.</p>	<p>The CSHCN Program was developed by the Bureau of Managed Health Care, which monitors MCP delivery of these services and performance.</p> <p>If enrolled in PACT, clients are asked to select a primary physician to make referrals and a primary pharmacy to dispense all medications. Any physician who is a Medicaid provider may become an enrollee's primary physician/case manager.</p>	<p>These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule.</p> <p>These services are included in the Managed Care Plan (MCP) capitated rates for Medicaid recipients who are enrolled in MCPs.</p> <p>Each primary physician may bill the Department for a monthly case management fee for each month a PACT client is assigned to him/her. This fee is not available to primary pharmacies, clinics, FQHCs, or to any other provider, including providers rendering services to an enrolled client on an emergency or referral basis.</p>

Table 8. Ohio Medicaid Covered Services				
Service	M/O	Process	Special Considerations	Payment Information
Necessary Medical Transportation	M	Expenses for transportation and other travel expenses necessary to secure medical examinations and treatment are covered. This includes ambulance services and other transportation by common carrier and the cost of meals and lodging to and from medical care for the client and, if necessary, an attendant. Ambulance services are covered only for emergencies and when it is the only medically appropriate option.		These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule.
Services Provided By Nurse Midwife, Certified Pediatric Nurse Practitioner, and Certified Family Nurse Practitioner	M	These practitioners are referred to as Advanced Practice Nurses in Ohio. Services within scope of practice are covered.		These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule. These services are included in the Managed Care Plan (MCP) capitated rates for Medicaid recipients who are enrolled in MCPs.
Extended Services to Pregnant Women	O	Services include: <ul style="list-style-type: none"> • Extensive counseling and education; • Nutrition counseling; • Nutrition intervention; and • Care coordination. 	Women who are enrolled in Managed Care Plans (MCPs), she will access the services through her MCP's network of providers. These services are provided from the date of identification of pregnancy through 60 days after the end of the pregnancy.	These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule. These services are included in the Managed Care Plan (MCP) capitated rates for Medicaid recipients who are enrolled in MCPs.

Table 8. Ohio Medicaid Covered Services				
Service	M/O	Process	Special Considerations	Payment Information
Ambulatory Prenatal Care	M	<p>Antepartum care is all obstetrical care provided from the confirmation of the pregnancy and with onset of established labor, induction, or cesarean section. The antepartum visit is inclusive of:</p> <ul style="list-style-type: none"> • Instruction, education, and counseling on a variety of topics related to pregnancy, nutrition, infant care, and family; • Routine urinalysis screening tests using reagent strips to measure pH and/or to detect the presence of sugar, protein, or other components; • A physician examination which includes recording of weight, blood pressure, and fetal heart tones or similar routine services; and • Coordination of the patient's medical care, including at a minimum, a planned hospital delivery at a designated hospital, arrangements from medical care and/or consultation in case of emergency, and referrals to appropriate medical services. 	<p>In addition to the antepartum visit, reimbursement is available for the following services provided during the antepartum and postpartum periods:</p> <ul style="list-style-type: none"> • Pregnancy-related services; • All obstetrical-related radiology and laboratory procedures (with the exception of urinalysis screening tests); • All obstetrical diagnostic procedures identified in standard code sets; and • All other covered medical services provided in addition to the antepartum visit. 	<p>These services are billed at the lesser of billed charges of the Medicaid maximum contained in the Ohio Medicaid Fee Schedule. For services provided prior to 7/1/03, antepartum visits must be billed on a per-visit basis using the original code for antepartum care, 59420. Antepartum services provided on or after 7/1/03 must be billed on a per-visit basis using the evaluation and management code (office visit code) appropriate for the type of visit documented in the patient's record. When the antepartum visit is billed, providers must specify a diagnosis code to signify pregnancy. Bill the code modified by "TH" to signify "obstetrical services, prenatal or postpartum." These services are included in the Managed Care Plan (MCP) capitated rates for Medicaid recipients who are enrolled in MCPs.</p>

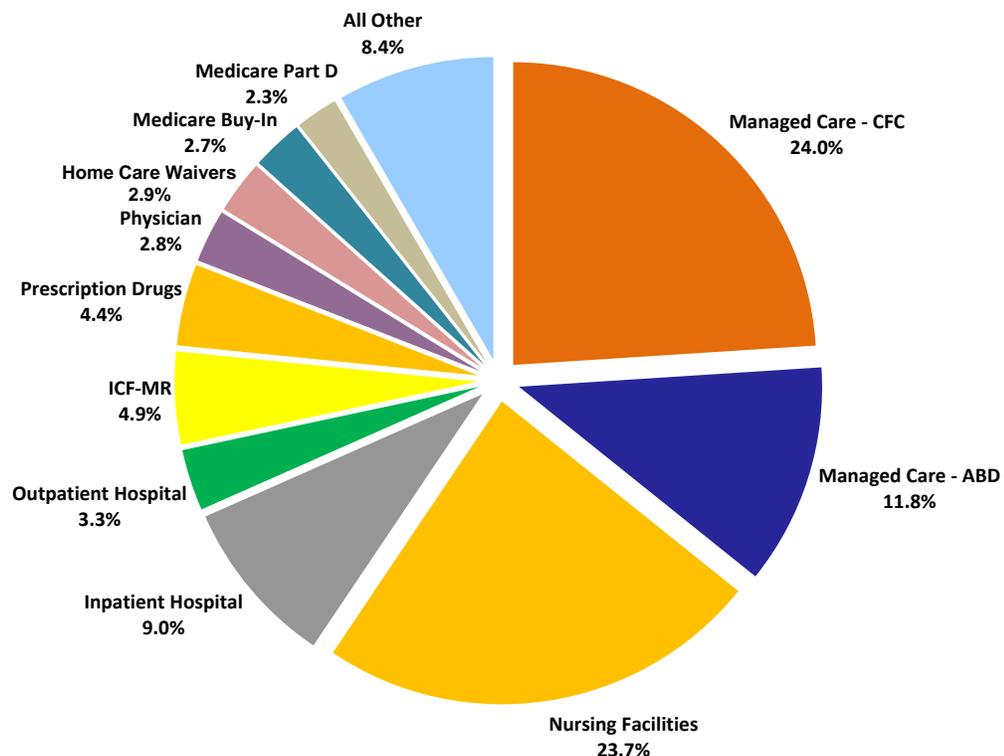
M/O: Mandatory / Optional

Current through 6/2003

Source: <http://www.hrsa.gov/tpr/tech-assistance.htm> Medicaid, Health Resources and Services Administration, U.S. Department of Health and Human Services.

Chart 4 below shows Medicaid spending by service category. As seen in the chart, spending for managed care plans accounts for over one third of Medicaid expenditures. Spending for Nursing Facility services accounts for more than 23% of Medicaid expenditures.

Chart 4: Spending by Service Category (FY 2008)



Basic covered services under Ohio Medicaid are described in the following sections.

Nursing Facility

A nursing facility provides skilled and intermediate nursing care, rehabilitation services, and other health-related care services on a regular basis. Nursing facility services are provided by nursing homes licensed by the Ohio Department of Health (ODH), county operated homes or separate hospital units. To receive Medicaid payment for services, nursing facilities must meet state and federal requirements. ODJFS delegates the certification of these facilities to ODH, which also certifies their participation in the federal Medicare Program. There are about 900 nursing facilities with more than 88,000 Medicaid certified beds providing services to Medicaid recipients in Ohio.

Nursing facility and intermediate care facilities for the mentally retarded (ICFs/MR) are the only Medicaid services for which the Ohio Revised Code establishes the reimbursement formula. The manner in which Medicaid is to pay for the services has undergone extensive changes since it was first enacted into state law. The General Assembly first enacted the law establishing a Medicaid payment system for long-term care services in 1980. This payment system was retrospective in nature. In 1991, the General Assembly replaced the retrospective system with a temporary prospective system. In 1992, a prospective system was codified. For FY 2002 to FY 2006, temporary caps on the system were put in place. Medicaid payments for nursing facility services was based on the facilities' reported costs, with adjustments made to reflect the resident care needs and other limiting parameters. However, Am. Sub. H.B. 66 of the 126th General Assembly (the FY 2006 and FY 2007 biennial budget bill) substantially revised the Medicaid reimbursement formula for nursing facilities. The reimbursement formula was modified from a cost-based formula to a price-based model.

The formula for determining the rate nursing facilities are to be paid under Medicaid for providing covered services is divided into several parts sometimes referred to as cost centers or price centers. The price centers in the nursing facility reimbursement formula are direct care costs, ancillary and support costs, tax costs, capital costs, and franchise permit fees. A nursing facility is paid a rate for each price center; there is a separate formula for determining each rate. There is also a quality incentive payment included in the formula. A nursing facility's total rate is the sum of all of the rates and quality incentive payment.

$$\text{NF Payment} = \text{Direct Care} + \text{Ancillary and Support} + \text{Taxes} + \text{Capital} + \\ \text{Franchise Permit Fees} + \text{Quality Incentive Payment}$$

Direct care

A nursing facility's direct care rate is determined semi-annually by multiplying the cost per case-mix unit determined for the facility's direct care peer group by the facility's semi-annual case-mix score.

ODJFS determines each direct care peer group's cost per case-mix unit at least once every ten years. The first time ODJFS makes the determination, it must use information from calendar year 2003. ODJFS may select which calendar year to use for subsequent determinations. The year used is called the "applicable calendar year." To determine a direct care peer group's cost per case-mix unit, ODJFS must do all of the following based on data for the applicable calendar year:

- (1) Determine the cost per case-mix unit for each nursing facility in the peer group by dividing each facility's desk reviewed actual, allowable, per diem direct care costs by the facility's annual average case-mix score.

(2) Identify which nursing facility in the peer group is at the 25th percentile of the cost per case-mix unit. In making this determination, ODJFS must exclude nursing facilities that participated in Medicaid under the same provider for less than 12 months and nursing facilities whose direct care costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem direct care cost for all nursing facilities in the nursing facility's peer group.

(3) Calculate the amount that is 7% above the cost per case-mix unit for the nursing facility identified under (2) above.

(4) Multiply the amount calculated under (3) above by the rate of inflation for the 18-month period beginning on the first day of July and ending the last day of December of the next calendar year using the employment cost index for total compensation, health services component, published by the United States Bureau of Labor Statistics.

A case-mix score is the measure of the relative direct-care resources needed to provide care and habilitation to a nursing facility resident. ODJFS must calculate an annual average case-mix score for each nursing facility using, in part, data for each resident, regardless of payment source, from a resident assessment instrument specified in rules. ODJFS must also determine a semi-annual case-mix score for each nursing facility. The semi-annual case-mix score, however, is to use, in part, data for each resident who is a Medicaid recipient. The annual average case-mix score is to be used in determining peer groups' cost per case-mix units. The semi-annual case-mix score is to be used to determine a specific nursing facility's rate for direct care costs.

For the purposes of calculating case-mix scores, nursing facilities and ICFs/MR must submit complete assessment data for each resident not later than 15 days after the end of each calendar quarter. Nursing facilities must submit the data to the Department of Health and, if required by ODJFS rules, ODJFS. ICFs/MR are required to submit the data to ODJFS.

Capital

The rate for capital costs for nursing facilities is to be the median rate for capital costs for the nursing facilities in the facility's capital peer group. ODJFS is required to determine the median rate for capital costs for each peer group at least once every ten years. As with the rate for direct care costs, ODJFS must use information from calendar year 2003 the first time it makes the determination and may select which calendar year to use for subsequent determinations. To determine a peer group's median rate for capital costs, ODJFS must do both of the following based on data for the applicable calendar year:

(1) Use the greater of each nursing facility's actual inpatient days or the inpatient days the facility would have had if its occupancy rate had been 100%. For the purpose

of determining a nursing facility's occupancy rate, ODJFS must include any beds that the nursing facility removes from its Medicaid-certified capacity after June 30, 2005, unless the facility also removes the beds from its licensed bed capacity.

(2) Exclude nursing facilities that participated in Medicaid under the same provider for less than 12 months and nursing facilities whose capital costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem capital cost for all nursing facilities in the nursing facility's peer group.

Ancillary and support costs

The rate for a nursing facility for ancillary and support costs is to be the facility's ancillary and support peer group's rate for such costs. ODJFS is required to determine each peer group's rate for ancillary and support costs at least once every ten years. As with the rate for direct care costs and capital costs, ODJFS must use information from calendar year 2003 the first time it makes the determination and may select which calendar year to use for subsequent determinations. To determine a peer group's rate for ancillary and support costs, ODJFS must do all of the following based on data for the applicable calendar year:

(1) Determine the rate for ancillary and support costs for each nursing facility in the peer group by using the greater of the facility's actual inpatient days or the inpatient days the facility would have had if its occupancy rate had been 90%. For the purpose of determining a facility's occupancy rate, ODJFS is to include any beds that the facility removes from its Medicaid-certified capacity unless the facility also removes the beds from its licensed bed capacity.

(2) Identify which nursing facility in the peer group is at the 25th percentile of the rate for ancillary and support costs. In making this determination, ODJFS must exclude nursing facilities that participated in Medicaid under the same provider for less than 12 months and nursing facilities whose ancillary and support costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem ancillary and support costs for all nursing facilities in the facility's peer group.

(3) Calculate the amount that is 3% above the rate for ancillary and support costs for the nursing facility at the 25th percentile identified under (2) above.

(4) Multiply the amount calculated under (3) above by the rate of inflation for the 18-month period beginning on the first day of July and ending the last day of December of the next calendar year using the consumer price index for all items for all urban consumers for the North Central region, published by the United States Bureau of Labor Statistics.

Tax costs

In addition to a rate for the three cost centers discussed above, ODJFS must pay a nursing facility a rate for certain tax costs. The tax costs are real estate taxes, personal

property taxes, corporate franchise taxes, and commercial activity taxes. ODJFS is required to determine a nursing facility's rate for these tax costs at least once every ten years. As with the rate for direct care, capital, and ancillary and support costs, ODJFS must use information from calendar year 2003 the first time it makes the determination and may select which calendar year to use for subsequent determinations. To determine a nursing facility's rate for tax costs, ODJFS must divide the facility's desk-reviewed, actual, allowable, tax costs paid for the applicable calendar year by the number of inpatient days the facility would have had if its occupancy rate had been 100%.

Franchise permit fee rate

ODJFS must pay a nursing facility a rate for the franchise permit fees it pays. The rate is to equal the amount of the franchise permit fee for the fiscal year for which the rate is paid.

Quality incentive payment

ODJFS is required to place each nursing facility in one of the four tier groups annually. Each tier group must consist of one quarter of all nursing facilities participating in Medicaid. Which group a nursing facility is placed in depends on how many quality points the facility earns. The first group is to consist of the quarter of nursing facilities individually awarded the most number of quality points. The second, third, and fourth groups are to consist of the quarters of nursing facilities individually awarded the second, third, or fourth most number of quality points.

A nursing facility earns one quality point for each of the following accountability measures the facility meets:

- (1) Having no health deficiencies on the facility's most recent standard survey;
- (2) Having no health deficiencies with a scope and severity level greater than E, as determined under nursing facility certification standards for Medicaid, on the facility's most recent standard survey;
- (3) Having resident satisfaction above the statewide average;
- (4) Having family satisfaction above the statewide average;
- (5) Having a number of hours of employing nurses that is above the statewide average;
- (6) Having an employee retention rate that is above the average for the facility's direct care peer group;
- (7) Having an occupancy rate that is above the statewide average;
- (8) Having a Medicaid utilization rate that is above the statewide average;
- (9) Having a case-mix score for direct care costs that is above the statewide average.

ODJFS must pay a quality incentive payment to each nursing facility placed in the first, second, or third quality tier groups. Nursing facilities placed in the first group are to receive the highest payment, those in the second group are to receive the second highest payment, those in the third group are to receive the third highest payment, and those in the fourth group are not to receive a payment. The mean payment, weighted by Medicaid days, is to be 2% of the average rate for all nursing facilities calculated under the nursing facility reimbursement formula, excluding the part of the formula regarding the quality incentive payment. Nursing facilities placed in the fourth group must be included for the purpose of determining the mean payment.

Adjustments directed by future legislation

ODJFS is required to adjust the rate determined for a nursing facility as directed by the General Assembly through the enactment of law governing Medicaid payments to nursing facilities. This is to include any law that (1) establishes factors by which the rates are to be adjusted, and (2) establishes a methodology for phasing in the rates from the FY 2006 amounts to rates determined for subsequent fiscal years.

Since the enactment of the new formula, the nursing home reimbursement rates for each fiscal year have been subject to stop loss, stop gain limits.

The average per diem for FY 2007 was \$162.96 and was based on the new formula, subject to a provision that no facility's reimbursement was increased or decreased by more than 2% from its June 30, 2006 level as a result of implementing the new formula. The average per diem for FY 2008 was \$164.37 and was based on the new formula, subject to a provision that no facility's reimbursement was increased by more than 2.75% or not decreased from its June 30, 2007 level. The average per diem for FY 2009 is higher. The increase in the per diem from FY 2008 to FY 2009 is due to the capital compensation that Am. Sub. H.B. 562 of the 127th General Assembly (the FY 2008 and FY 2009 corrective bill) provided for qualifying nursing facilities to receive additional quarterly payments for their capital compensation.

Intermediate Care Facilities for the Mentally Retarded

ODJFS is required to pay the reasonable costs of services that an ICF/MR with a Medicaid provider agreement provides to Medicaid recipients. A cost is reasonable if it is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities and does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider. The amount ODJFS pays an ICF/MR is determined by formulas established by state law.

ICF/MR services are divided into four different categories, referred to in state law as cost centers. Each cost center has its own Medicaid reimbursement formula. The four cost centers are capital, indirect care, direct care, and other protected costs.

Capital costs are the costs of ownership and nonextensive renovation. Cost of ownership covers the actual expense incurred for (1) depreciation and interest on capital assets that cost \$500 or more per item, (2) amortization and interest on land improvements and leasehold improvements, (3) amortization of financing costs, and (4) with certain exceptions, lease and rent of land, buildings, and equipment. Costs of nonextensive renovation covers the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive.

Indirect care costs are all reasonable costs other than the three other cost centers. This includes costs of habilitation supplies, pharmacy consultants, medical and habilitation records, program supplies, incontinence supplies, food, dietary supplies and personnel, housekeeping, security, administration, liability and property insurance, travel, dues, license fees, subscriptions, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, and consumer satisfaction survey fees.

Direct care costs include an ICF/MR's costs for (1) certain staff, including nurses, nurse aides, medical directors, and respiratory therapists, (2) purchased nursing services, (3) quality assurance, (4) training and staff development, employee benefits, payroll taxes, and workers' compensation premiums, or costs for self-insurance claims, (5) consulting and management fees related to direct care, and (6) allocated direct care home office costs.

Other protected costs are costs for medical supplies; real estate, franchise, and property taxes; natural gas, fuel oil, water, electricity, sewage, and refuse and hazardous medical waste collection; allocated other protected home office costs; and any additional costs included in ODJFS rules.

Inpatient Hospital Services

Ohio pays hospitals for Medicaid inpatient admissions using a prospective payment system that includes a pre-established amount for each admission based on a diagnosis-related group (DRG). A small portion of hospital services provided in freestanding rehabilitation or long-term hospitals, in hospitals that are licensed as Health Maintenance Organizations (HMOs), and in cancer hospitals, are paid on a "reasonable cost" basis. Under the DRG system, hospitals are reimbursed based on the principal diagnosis or condition requiring the hospital admission. The DRG system is designed to classify patients into groups that are clinically coherent with respect to the amount of resources required to treat a patient with a specific diagnosis.

ODJFS creates DRGs by examining hospital charges statewide and comparing charges for each DRG to the average charges for all discharges. With constant changes in the resources required for health care services, including shifts in technology and more efficient methods of providing patient care, hospital resource consumption

changes over time. To recognize these changes, ODFJS recalibrates the level of reimbursement offered for each DRG. The most recent recalibration took place in January 2006.

Although a hospital's costs can vary significantly among patients within a specific DRG, the DRG payment is fixed. To compensate hospitals that incur significantly higher costs for Medicaid patients, the state established outlier payments similar to those enacted for Medicare. Congress established Medicare outlier payments for situations in which the costs of treating a Medicare patient are extraordinarily high in relation to the average costs of treating comparable conditions or illnesses. These outlier policies are intended to promote access to care for patients with extremely costly illnesses. Additional payments are also provided, if applicable, for capital costs and medical education.

Medicaid Prescription Drug Services

Prescription drugs often provide an alternative to expensive surgery, shorten hospital stays, and prevent illness. However, prescription drugs can be expensive. The effort to make prescription drugs available and, at the same time, contain costs has created diverse legislative proposals that seek to monitor expenditures, utilization, and access.

Federal law governing Medicaid drug reimbursement has sought to contain costs by placing limits on pharmacy reimbursement and mandatory manufacturer rebates on pharmaceutical products. In 1987, the federal government established a set of limits on payments for drugs in the Medicaid Program. These regulations established several guidelines that have significantly affected public spending on Medicaid and other state-funded programs. The federal government sets a maximum allowable cost for multiple-source drugs and requires state payments for all other drugs not exceed the lesser of the pharmacy's usual and customary charge or the estimated acquisition cost determined by the state. States are allowed to pay pharmacists a reasonable "dispensing fee" to cover pharmacy overhead and profit. Ohio Medicaid presently pays 7% above the wholesale acquisition cost for brand name drugs.

Medicaid prescription drug services in Ohio presently encompass over 30,000 line items of drugs from nearly 300 different therapeutic categories. Pharmacy claims are processed by ACS State Healthcare in an on-line, real-time environment, which allows the dispensing pharmacist access to the terms of coverage. In the event a particular product is not approved, the dispensing pharmacist can notify the prescribing physician of possible alternatives in a timely fashion. The prescribing physician may choose an alternative product or may call a designated toll-free number to request prior authorization for the product originally prescribed.

Ohio receives two types of drug rebates under Medicaid: drug rebates under federal law, and supplemental drug rebates under state law. Federal law requires that pharmaceutical manufacturers enter into rebate agreements with the federal government in order for their products to be eligible for outpatient drug coverage by state Medicaid programs. Prior to the implementation of the supplemental drug rebate program in Ohio, the only rebates the state received were the drug rebates under federal law. Ohio Medicaid presently receives drug rebate revenue of about 40% from both rebate programs.

Am. Sub. S.B. 261 of 124th General Assembly authorized ODJFS to establish a supplemental drug rebate program under which drug manufacturers may be required to provide a supplemental rebate to the state as a condition of having their products covered by Medicaid without prior approval. Am. Sub. H.B. 95 of the 125th General Assembly continued this provision of the law and allowed the full implementation of the Supplemental Drug Rebate Program and a preferred drug list (PDL).

These programs were initiated in April 2003. ODJFS designates the most clinically and cost-effective drug as the preferred drug in a class; in some cases, more than one drug may be designated as preferred. All other (nonpreferred) drugs in that class are covered; however, prior authorization from the Medicaid pharmacy benefit manager is necessary in order to obtain a prescribed, nonpreferred drug. ODJFS seeks supplemental rebates from manufacturers for preferred prescription drugs.

Am. Sub. H.B. 66 of the 126th General Assembly eliminated a requirement that any drug product used to treat mental illness or HIV or AIDS be exempted from the Supplemental Drug Rebate Program. H.B. 66 also authorized ODJFS to receive a supplemental rebate in a provider's primary place of business.

Am. Sub. H.B. 95 of the 125th General Assembly allowed ODJFS to establish copayments for prescription drugs that are not included on the PDL. Beginning January 1, 2004, certain Medicaid consumers are charged copayments for prescription drugs that are not found on the PDL. These copayments are sought only from those recipients who are eligible for cost-sharing under federal requirements. Services for children and those related to pregnancy are federally exempt from copayments, as are services for adults who reside in institutional settings. ODJFS does not actually collect the copayments. Instead, the pharmacist's reimbursement is reduced by the amount of the copayments. Am. Sub. H.B. 66 of the 126th General Assembly also allowed copayments on brand-name drugs.

Medicaid copayments

Medicaid has historically limited patient cost-sharing because the program serves a much poorer and sicker population than private health insurance. Over the past few years, however, most states have introduced or increased cost-sharing requirements for their Medicaid beneficiaries for reasons such as encouraging personal responsibility and controlling prescription drug costs. Cost-sharing may make Medicaid recipients less likely to make unnecessary doctor visits or treatments, and copayments on brand-name drugs can encourage the use of generic drugs. However, it is possible that cost-sharing may force Medicaid recipients to forgo needed health care, causing them to become sicker and need more expensive care later on, increasing costs in the long run.

Cost-sharing requirements for Medicaid recipients are determined by states, but are subject to federal guidelines. Table 9 shows the current copayments required under Ohio Medicaid.

Services	Copayments
Nonemergency services obtained in a hospital emergency room	\$3 per visit
Dental services	\$3 per visit
Routine eye examinations	\$2 per examination
Eyeglasses	\$1 per fitting
Most brand name (nongeneric) medications	\$2 per prescription or refill
Medications that require prior authorization	\$3 per prescription or refill

If a Medicaid recipient is unable to pay the copayment, they cannot be refused medical services. However, they still owe the copayment to the health care services provider. The health care services provider may refuse medical services if there are past unpaid copayments. Copayments are not required for individuals who are:

- Younger than age 21;
- Pregnant or the pregnancy ended up to 90 days prior (there are copayments for routine eye examinations and eyeglass fittings);
- Living in a nursing home or an ICF/MR;
- Receiving emergency services in a hospital, clinic, office, or other facility;
- Receiving family planning-related services;
- Receiving hospice care; or
- In a managed care plan that does not charge copayments.

Home and Community-Based Service Waivers

Home and Community-Based Service (HCBS) waivers provide alternatives to institutional long-term care under state Medicaid programs. The term "waiver" refers to an exception to federal law that is granted to a state by the United States Centers for Medicare and Medicaid Services. Medicaid waivers allow participants, who have disabilities and chronic conditions, to have more control of their lives and remain active participants in their community. Without HCBS waivers, many consumers would live in a hospital, nursing home, or ICF/MR. In addition to providing alternatives to institutional care, waivers allow state Medicaid Program to limited enrollment, limit the locations where services are provided, and waive certain eligibility requirements.

There are currently eight waivers within Ohio Medicaid. ODJFS administers three of them. The others are administered by ODMRDD, which manages two waiver programs, and ODA, which manages three waiver programs. Together, in FY 2007, the eight Ohio Medicaid waivers provided alternative access to long-term care to more than 61,000 individuals.⁴ Table 10 is taken from ODJFS's "Ohio Medicaid Fact Sheet, July 2007" and provides brief information on each of these eight waivers.

Table 10. Medicaid Waivers			
Eligibility	Services	Application	Administrative Agency
Ohio Home Care Waiver (OHCW)			
Specific Financial Criteria Intermediate or Skilled Level of Care Age 59 or younger	Adult day health Emergency response Home-delivered meal Home modification Out-of-home respite Personal care aide Supplemental adaptive and assistive device Supplemental transportation Waiver nursing	The ODJFS 02399 form is the application. It can be obtained and submitted at the local county department of job and family services (CDJFS) A waiting list exists at this time; when space becomes available applicants on the waiting list must re-apply	ODJFS administers this waiver program ODJFS contracts with a case management agency to provide management services
Transitions MR/DD Waiver			

⁴ Source: Home and Community-Based Waivers, July 2007, Ohio Medicaid Fact Sheet, ODJFS.

Table 10. Medicaid Waivers			
Eligibility	Services	Application	Administrative Agency
<p>Specific Financial Criteria</p> <p>ICF/MR Level of Care</p> <p>All Ages</p> <p>Available only to consumers w/an ICF/MR LOC (a) on OHCW 1/1/02, (b) on Core Plus when it closed 7/1/06, or (c) on ODMRDD waiver and receiving home health benefits 7/1/06</p>	<p>Same as above</p>	<p>Closed to new enrollment</p>	<p>ODJFS administers this waiver program</p> <p>ODJFS contracts with a case management agency to provide case management services</p>
Transitions Carve-Out Waiver (T2)			
<p>Specific Financial Criteria</p> <p>Intermediate or Skilled Level of Care</p> <p>The individual must be age 60 or older and must transfer in from the OHCW</p> <p>Available only to consumers (a) on OHCW 7/1/06, (b) on OHCW and turn 60 after 7/1/06, (c) on Core Plus when it closed 7/1/06, or (d) on ODA waiver and receiving home health benefits 7/1/06</p>	<p>Same as above</p>	<p>Closed to new enrollment</p>	<p>ODJFS administers this waiver program</p> <p>ODJFS contracts with a case management agency to provide case management services</p>
Assisted Living Waiver			
<p>Specific financial criteria</p> <p>Be age 21 or older</p> <p>At least an Intermediate Level of Care and in a nursing facility, have resided in a residential care facility for six months prior to applying for this waiver, or be enrolled in either the PASSPORT, CHOICES, Ohio Home Care, or Transitions Carve-Out waivers.</p>	<p>Assisted living</p> <p>Community transition (for nursing home residents only)</p>	<p>Completion of the JFS 02399 form is required and can be obtained and submitted at a local CDJFS or at the regional PASSPORT Administration Agency (PAA) office</p>	<p>The Ohio Department of Aging (ODA) administers this waiver program under the direction of ODJFS</p> <p>The three approved PAAs act as regional administrators and provide case management services</p>
Choices Waiver			
<p>Specific Financial Criteria</p> <p>At least an Intermediate Level of Care</p> <p>Age 60 and older</p> <p>Lives in approved service area (one of three PASSPORT Administrative Agencies (PAA))</p>	<p>Adult day health</p> <p>Alternative meals service</p> <p>Environmental accessibility adaptations</p> <p>Home care attendant</p> <p>Home-delivered meals</p> <p>Personal emergency response systems</p>	<p>Completion of the ODJFS 02399 is required and can be obtained and submitted at a local CDJFS or at one of the three approved regional PAA offices</p>	<p>ODA administers this waiver program under the direction of ODJFS</p> <p>The three approved PAAs act as regional administrators and provide case management services</p>

Table 10. Medicaid Waivers			
Eligibility	Services	Application	Administrative Agency
areas) Attend training and willing and able to direct provider activities and negotiate rates within cost cap	Pest control Specialized medical equipment and supplies		
PASSPORT			
Specific Financial Criteria At least an Intermediate Level of Care Age 60 or older	All of the above except home care attendant, alternative meals, and pest control Chore Independent living assistance Nutritional consultation Personal care services Social work & counseling Transportation	The ODJFS 02399 form is required to make application and can be obtained and submitted at the local CDJFS or the PAA office	ODA administers this waiver program under the direction of ODJFS PAA acts as regional administrator and provides case management services
Level One Waiver			
Specific Financial Criteria ICF/MR Level of Care All Ages	Adult day supports Day habilitation Environmental accessibility and adaptations Homemaker/personal care Personal emergency response system Respite – informal Respite – institutional Specialized medical equipment and supplies Supported employment (community and enclave) – adaptive equipment Transportation (medical and nonmedical) Vocational habilitation	Completion of the ODJFS 02399 form is required and can be obtained and submitted at a local CDJFS or at the local county board of MR/DD	The ODMRDD administers this waiver program under the direction of ODJFS Local county boards of MR/DD provide case management

Table 10. Medicaid Waivers			
Eligibility	Services	Application	Administrative Agency
Individual Options Waiver			
Specific Financial Criteria	Homemaker/personal care	Completion of the ODJFS 02399 form is required and can be obtained and submitted at a local CDJFS or at the local county board of MR/DD	The ODMRDD administers this waiver program under the direction of ODJFS
ICF/MR Level of Care	Transportation		
All Ages	Respite	A waiting list exists at this time; when space becomes available applicants on the waiting list must re-apply	Local county boards of MR/DD provide case management
	Supported employment		
	Environmental accessibility modifications		
	Social work/counseling		
	Nutrition		
	Interpreter		
	Home-delivered meals		
	Adaptive and assistive equipment		
	Day habilitation – adult day support		
	Habilitation – vocational habilitation		
	Supported employment – enclave		
	Supported employment – community		
Supported employment – adapted equipment			
Nonmedical transportation			

Delivery Systems

There are two delivery systems for Ohio Medicaid: "fee-for-service" and "managed care." Both delivery systems provide medically necessary primary care, specialty and emergency care services, and preventive services. Ohio Medicaid also provides home- and community-based, and facility-based long-term care services, exclusively through the fee-for-service system.

Medicaid does not directly provide medical services to eligible individuals enrolled in the program. It provides financial reimbursement to health care professionals and institutions for providing approved medical services, products, and equipment to Medicaid enrollees. Under fee-for-service, Medicaid pays most service providers a set fee for the specific type of service rendered. Payments are based on the lowest of the state's fee schedule, the actual charge, or federal Medicare allowances.

An alternative to the fee-for-service reimbursement is managed care. A typical managed care plan (MCP), also called a capitated at-risk plan, is a plan in which the beneficiary receives all care through a single point of entry, and the managed care provider is paid a fixed monthly premium per beneficiary for any health care included in the benefit package, regardless of the amount of services actually used. The beneficiary is responsible for, at most, modest copayments for services; the provider is

at risk for the remaining cost of care. A capitated plan can be a network of physicians and clinics, all of whom participate in the plan and also participate in other plans or fee-for-service systems, or it can be a plan that hires the physicians who provide all of the care required. Generally speaking, managed care has been shown to achieve an initial spending reduction of 3% to 5% compared to fee-for-service.⁵

Ohio Medicaid has incorporated the use of managed care since 1978. Although Ohio has contracted with managed care plans since the late 1970s to provide care for certain Medicaid eligibles, the use of capitated rates was not given major emphasis in Ohio's program until the state received an 1115 demonstration waiver in January 1995. As one initiative of the federally approved OhioCare proposal, the state was given the freedom to require mandatory managed care enrollment by CFC Medicaid eligibles.

In FY 2004, Medicaid provided health care coverage to approximately 500,000 Ohioans per month through managed care. ODJFS contracted with six managed care providers that served 15 Ohio counties. Managed care membership was mandatory for the CFC population in four counties (Cuyahoga, Stark, Lucas, and Summit) and optional in the other 11 (Butler, Clark, Clermont, Franklin, Greene, Hamilton, Lorain, Montgomery, Pickaway, Warren, and Wood).

Am. Sub. H.B. 66 of the 126th General Assembly (the FY 2006-FY 2007 biennial budget bill) required MCPs be implemented in all counties and required ODJFS to designate the CFC population for participation.⁶ The bill also required ODJFS to designate the participants not later than January 1, 2006. Not later than December 31, 2006, all designated participants were required to enroll in Medicaid MCPs. H.B. 66 also required ODJFS to implement the MCPs for certain aged, blind, and disabled Medicaid recipients in all counties. This requirement did not apply to: (1) individuals under age 21, (2) institutionalized individuals, (3) individuals eligible for Medicaid by spend-down, (4) dual eligibles, and (5) Medicaid waiver recipients. Not later than December 31, 2006, all designated participants were required to enroll in Medicaid MCPs. Prior to these mandated expansions in H.B. 66, Ohio Medicaid MCPs were limited to large metro areas and exclusively focused on the CFC population. The statewide expansion in H.B. 66 included rural areas such as Appalachia where access to health care can be difficult. And for the first time, the elderly population was included in managed care.

⁵ Medicaid Managed Care Weekly, February 1, 2007, Office of Ohio Health Plans, ODJFS.

⁶ According to both state and federal regulations, managed care enrollment is optional for children receiving adoption assistance under the Federal Title IV-E Program, foster care assistance, or out-of-home placement.

In FY 2008, Medicaid provided health care coverage to approximately 1.1 million CFC and 105,000 ABD per month through managed care. According to ODJFS, Ohio's Medicaid managed care expansion is complete for the CFC population.

Program of All-Inclusive Care for the Elderly

The Program of All-inclusive Care for the Elderly (PACE) is authorized through the Medicaid State Plan and operated under an agreement with CMS. PACE is unique in that it is the only program that provides managed care of both Medicare and Medicaid services. PACE average service costs are \$34,040 per year. In 2008, there were 905 individuals enrolled in PACE.

PACE provides home- and community-based care, allowing seniors to live in the community. There are currently two PACE sites – Tri-Health Senior Link, which is in Cincinnati and Concordia Care, which is in Cleveland. PACE is a managed care program. The PACE sites provide participants with all of their needed health care, medical care, and ancillary services at a capitated rate. All PACE participants must be 55 years of age or older and qualify for a nursing home level of care. The PACE sites assume full financial risk for the care of the participants. Indeed, if PACE participants require nursing facility care, the PACE site continues to be responsible for the cost of the participant's care. Consequently, there is an incentive that a broad range of preventive and community-based services be provided as alternatives to more costly care.

Currently, ODA administers PACE. Caseworkers in county departments of job and family services establish a PACE applicant's financial eligibility and Area Agencies on Aging make recommendations regarding an applicant's level of care. ODA determines the applicant's level of care and, if all programmatic criteria are met, enrolls the applicant at the appropriate PACE site.

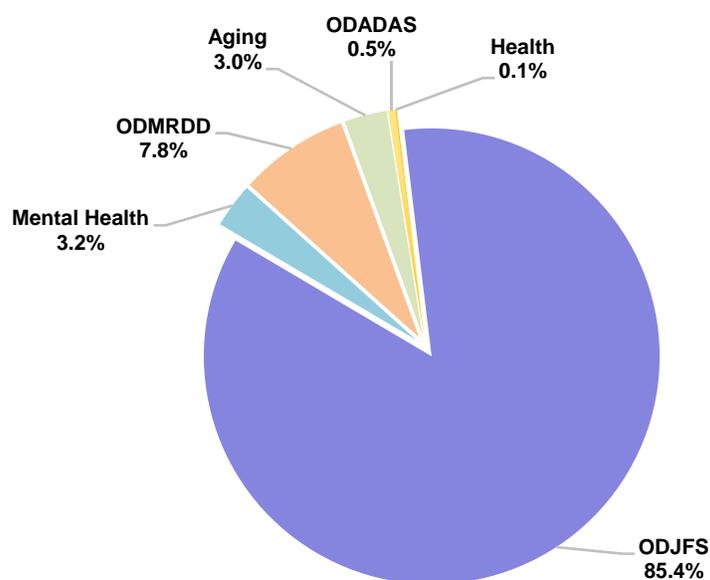
Financing and Funding

States and the federal government share in the cost of Medicaid. The federal government shares in the states' cost of Medicaid at a matching rate known as the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated for each state based upon the state's per capita income for the last three years relative to the entire nation. The higher a state's per capita income relative to the national average, the lower its match rate. And the higher the match rate, the more federal dollars flow into the state. The general "rule of thumb" for how this cost-sharing mechanism works is as follows: for every one dollar Ohio spends on Medicaid, the federal government gives Ohio 62 cents. However, while the majority of the Medicaid spending is reimbursed at the FMAP, a few items, primarily administration and contracts, are reimbursed at 50%, and all family planning services are reimbursed at 90%. In addition, State Health Insurance Program (SCHIP) is reimbursed at an enhanced FMAP of about 72%.

To trigger federal Medicaid matching funds, a state must spend some combination of state or local funds on Medicaid. For example, when a Medicaid recipient receives a health care service, the provider incurs the costs and requests to be paid by the state Medicaid agency, at which point the state pays the provider based on the Medicaid rate for that service. The state is then reimbursed by the federal government at an amount equal to that state's match rate.

For the FY 2008-FY 2009 biennium, state Medicaid funding represented 18% of GRF appropriations. Although six state agencies provide Medicaid services, 85% of Medicaid funding is appropriated in ODJFS's budget. Chart 5 below shows Ohio's Medicaid spending by agency in FY 2007. The majority of Medicaid spending in ODJFS's budget is out of GRF line item 600525, Health Care/Medicaid.

Chart 5: Medicaid Spending by Agency (FY 2007)



Provider Taxes

In addition to funding from the GRF, several provider tax programs and other special revenues are used to pay for Medicaid services. The revenues from these provider taxes are appropriated in ODJFS's budget although some of the revenues are transferred to the other state agencies that also administer Medicaid programs.

State Medicaid revenue comes from several sources, including income, property, sales and estate taxes, and other sources that generally make up states' and counties' general funds. But states can also raise Medicaid revenue by imposing fees, assessments, and other taxes on health care providers. Health care provider taxes have

been commonly used to raise Medicaid match, especially during economic downturns when there are increased revenue pressures on states. In 2008, 44 states were taxing at least one provider category and 30 of these states were taxing more than one provider category. Ohio currently has provider taxes on hospitals, nursing homes, and managed care organizations.

Nursing Facility Franchise Permit Fees

ODJFS is required to assess an annual franchise permit fee on each long-term care bed in a nursing home or hospital. Until July 1, 2001, the amount of the fee was \$1 for each bed multiplied by the number of days in the fiscal year for which the fee is assessed. The fee was applied to: (1) nursing home beds, (2) Medicare-certified skilled nursing facility beds, (3) Medicaid-certified nursing facility beds, and (4) beds in hospitals that are registered as skilled nursing facility beds or long-term care beds, or licensed as nursing home beds.

Am. Sub. H.B. 94 of the 124th General Assembly (the FY 2002-FY 2003 biennial budget bill) raised the franchise permit fee to \$3.30 for FY 2002 and FY 2003. Am. Sub. S.B. 261 of 124th General Assembly (the FY 2002-FY 2003 corrective bill) raised the franchise permit fee to \$4.30 for fiscal years 2003 through 2005, a \$1.00 per bed per day increase for FY 2003, and a \$3.30 per bed per day increase for FY 2004 and FY 2005. Am. Sub. H.B. 66 of the 126th General Assembly (the FY 2006-FY 2007 biennial budget bill) increased the fee to \$6.25 for FY 2006 and FY 2007. H.B. 119 of the 127th General Assembly (the FY 2008-FY 2009 biennial budget bill) maintained the fee at \$6.25 for FY 2008 and FY 2009.

ICF/MR Franchise Permit Fees

All money generated by the ICF/MR franchise permit fee and related penalties is required to be deposited into the Home- and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund (Fund 4K10). The departments of Job and Family Services and Mental Retardation and Developmental Disabilities are required to use money in that fund for the Medicaid Program and home- and community-based services to persons with mental retardation or a developmental disability.

The franchise permit fee for ICFs/MR, at \$9.63 per bed per day, was unchanged from FY 2002 through FY 2007. H.B. 119 of the 127th General Assembly did not change the amount of the ICF/MR franchise permit fee, but added an annual composite inflation factor adjustment. H.B. 562 of the 127th General Assembly increased the franchise permit fee on ICFs/MR to \$11.98 effective July 1, 2008, and provided for 5.72% of the revenue raised by the ICF/MR franchise permit fee to be deposited into the Intensive Behavioral Needs Programs Fund (Fund 5CT0).

Managed Care Assessments

H.B. 66 of the 126th General Assembly required each Medicaid health insuring corporation to pay a franchise permit fee for each calendar quarter between January 1, 2006, and June 30, 2007, to help offset the statewide CFC managed care expansion that biennium. The fee was 4.5% of the managed care premiums the health insuring corporation received in the applicable calendar quarter, unless (1) ODJFS adopted rules decreasing the percentage or increasing it to not more than 6%, or (2) the fee was reduced or terminated to comply with federal law or because the fee did not qualify for matching federal funds.

Am. Sub. S.B. 190 of the 126th General Assembly changed the effective date of the managed care plan assessment from January 1, 2006, to December 1, 2005. The Medicaid managed care assessment continues for the FY 2008-FY 2009 biennium, and the managed care assessment fee was increased from 4.5% to 5.5% on July 1, 2008.

The money collected from the franchise permit fee is used to pay for Medicaid services, administrative costs, and contracts with Medicaid health insuring corporations.

Under current federal law, Medicaid managed care organizations are identified as a separate class of providers, and are therefore not subject to the provisions of the Social Security Act that require provider-based taxes to be broad based in nature. However, effective October 1, 2009, the Deficit Reduction Act of 2005, removes this distinction for Medicaid managed care organizations. As such, Ohio's Medicaid managed care franchise fee will no longer be in compliance with federal regulations after that date. Collection of that fee will therefore cease, resulting in an annual loss of approximately \$194 million in revenue to the state, as well as the resulting federal match received when these funds would be applied to Ohio's Medicaid Program.

Information Technology & Data Reporting

Ohio's Medicaid Program relies on a number of information technology (IT) systems to determine eligibility, generate reimbursement to Medicaid providers, and for data analysis and reporting purposes.

The major computer systems currently supporting Medicaid are as follows:

- Client Registry Information System-Enhanced (CRIS-E) and
- Benefit Eligibility Network System (BEN).

CRIS-E is a statewide integrated public assistance system that supports the major programs of Food Stamps, Medicaid, and TANF. It is designed to provide on-line data collection and eligibility determination. BEN is the automated eligibility system that will replace CRIS-E, which is over twenty years old.

Decision Support System (DSS)

DSS is software that works with the ODJFS data warehouse and other Medicaid data sources to expand Ohio Health Plan's (OHP) decision support environment. DSS creates quality measurements, surveillance and utilization statistics, fraud detection algorithms, and provider and consumer profile reports. DSS also supports OHP's business needs in the area of finance, budgeting, management and administrative reporting, program evaluation, rate setting, risk adjustment, and performance monitoring.

Medicaid Management Information System (MMIS) and Medicaid Information Technology System (MITS)

MMIS supports the benefits administration of Ohio Medicaid, SCHIP, and the Disability Assistance Medical Program. It provides reimbursements to medical providers for services rendered to eligible recipients. MITS will be a replacement system for MMIS, which is over twenty-five years old. Ohio has received federal approval for enhanced federal reimbursement (75% to 90%) for the design, development, and implementation of MITS.

Hospital Care Assurance Program

The federal government requires state Medicaid programs to make subsidy payments to hospitals that provide uncompensated, or charity, care to low-income and uninsured individuals at or below 100% FPG under the Disproportionate Share Hospital (DSH) Program. Health Care Assurance Program (HCAP) is the system Ohio uses to comply with the DSH Program requirement. Under HCAP, hospitals are assessed an amount based on their total facility costs, and government hospitals make intergovernmental transfers to ODJFS. ODJFS then redistributes back to hospitals money generated by the assessments, intergovernmental transfers, and federal matching funds based on uncompensated care costs. In federal fiscal year 2007, HCAP collected \$221 million from Ohio hospitals, matched it with federal dollars, and redistributed \$548 million back to the hospitals.

Disability Medical Assistance (DMA) Program

The Disability Medical Assistance (DMA) Program provides a limited health care benefit package to non-Medicaid eligible individuals based on income, resources, and severity of disability. DMA is not part of Ohio Medicaid and is completely funded with state revenue. Expenditures for the DMA Program are not eligible for federal reimbursement because the recipients are either not Medicaid eligible or have not been determined to be Medicaid eligible. Although it is not part of Medicaid, DMA is funded out of GRF line item 600525, Health Care/Medicaid. The program supports individuals while they are applying for long-term federal disability benefits. The benefit package is a limited version of the primary- and acute-care services offered to

consumers through Medicaid, and all services are received through the fee-for-service delivery system. Services are limited to prescription drugs, physician, clinic, restricted dental service, and restricted durable medical equipment services. Hospital services for this population are provided through HCAP.

Am. Sub. H.B. 95 of the 125th General Assembly allowed the Director of Job and Family Services to enact reforms necessary to contain DMA costs. ODJFS froze enrollment beginning in July 2003. Under the freeze, ODJFS allowed no new enrollment and denied coverage to those who missed their eligibility redeterminations. Enrollment was open for a limited time early in FY 2005 and then closed again in order to keep costs within the \$64 million GRF allocated to operate the program that year. In recent years, due to severe funding limitations, enrollment in DMA was closed to new enrollees. Consequently, the caseload has dropped dramatically, from a high of almost 28,000 individuals in FY 2003 to about 4,485 individuals in FY 2007.

Family Stability

OVERVIEW

Program Overview

- Assumes \$154.6 million in federal stimulus dollars over biennium
- Funds 12,000 Early Learning Initiative enrollment slots each year
- Assumes increases in enrollment for cash assistance, non-cash supports, food assistance, and other public assistance programs

Family Stability is a group of programs and services that deliver cash assistance, non-cash supports, and food assistance to low-income families with the goal of equipping these families to achieve self-sufficiency. Some of the programs are entitlement programs, meaning that individuals or families that meet eligibility requirements are guaranteed to receive services. Other programs may limit enrollment based on available funding. Enrollment in these programs is often affected by the economy or by federal or state changes to eligibility criteria.

The operations of Family Stability programs represent a cooperative partnership between state and local governments. ODJFS supervises the administration of Family Stability programs, channels federal and state funds to local agencies, and provides technical support to ensure compliance with federal and state regulations. The direct delivery of services is administered by a combination of county offices, which includes 88 county departments of job and family services.

Family Stability programs are funded with a combination of federal, state, and local funds. Ohio Works First (OWF) cash assistance and Prevention, Retention and Contingency (PRC) are primarily funded through the federal Temporary Assistance for Needy Families (TANF) Block Grant, and the state GRF match referred to as Maintenance of Effort (MOE). Publicly funded child care, though operated by the Office of Children and Families, is partially funded by the TANF Block Grant and state TANF MOE, and is therefore included in this section. Other assistance programs operated by the Office of Family Stability (OFS), such as food assistance programs, Refugee Services, and Disability Financial Assistance (DFA) are funded with other state, federal, and local funds.

Appropriations Overview

The executive budget recommends total appropriations of \$1.69 billion for FY 2010 and FY 2011 for Family Stability. Chart 1 shows that appropriations for the federally funded line items make up 69.2% of ODJFS's biennial budget for Family Stability. This includes the TANF Block Grant, the Child Care and Development Block Grant, and federal reimbursement to the state and counties for Food Assistance Program (or "Food Stamps") administrative expenditures. Funds from the GRF account for the next largest portion at 29.1%, which includes expenditures for OWF and publicly funded child care. Most GRF expenditures are counted toward the state's MOE for

TANF and child care. The State Special Revenue Fund Group, General Services Fund Group, and Agency Fund Group (AGY) account for the remaining 1.7%.

Chart 1: Biennial Executive Budget Recommendations for Family Stability by Fund Group, FY 2010-FY 2011

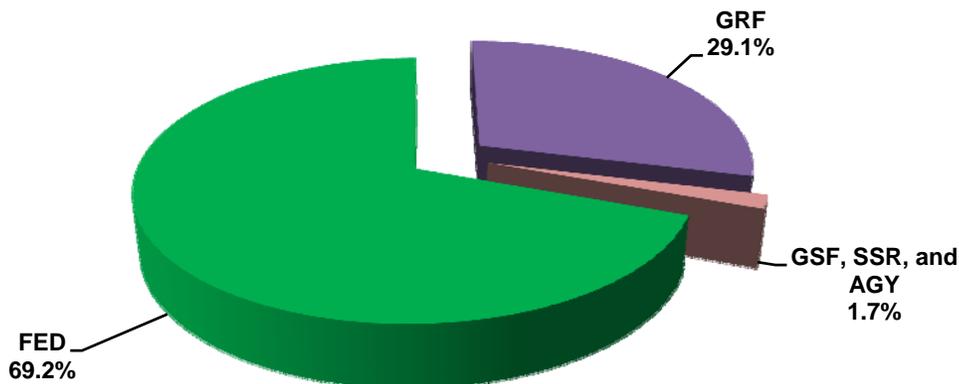


Table 1 below shows the Family Stability budget by fund group for FY 2009 and the executive budget recommendations for FY 2010 and FY 2011. Family Stability will utilize more GRF and less federal funds in the upcoming biennium than in FY 2009. The 31.8% increase in GRF appropriations is mainly attributable to the executive recommendations shifting funding for the Early Learning Initiative from federal funds to the GRF. The 16.5% decrease in federal special revenue appropriations from FY 2009 to FY 2010 is mainly attributable to ODJFS spending down the TANF surplus.

Table 1. Budget for Family Stability by Fund Group					
Fund Group	FY 2009 (adjusted)	FY 2010 (recommended)	% Change	FY 2011 (recommended)	% Change
General Revenue	\$363,088,531	\$478,630,047	31.8%	\$502,827,757	5.1%
General Services	\$31,929,211	\$26,000,000	-18.6%	\$26,000,000	0.0%
State Special Revenue	\$500,000	\$500,000	0.0%	\$500,000	0.0%
Federal Special Revenue	\$1,411,295,482	\$1,178,717,172	-16.5%	\$1,154,162,068	-2.1%
Agency	\$2,000,000	\$2,000,000	0.0%	\$2,000,000	0.0%
TOTAL	\$1,808,813,224	\$1,685,847,219	-6.8%	\$1,685,489,825	-0.02%

Welfare Reform

The federal TANF Program was implemented by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which built on the earlier experience of several states that had pursued experiments in welfare reform. PRWORA eliminated the Aid to Families with Dependent Children Program (AFDC), the Job Opportunity and Basic Skills (JOBS) Program, and the Family Emergency Assistance (FEA) Program, and replaced these programs with TANF.

Prior to TANF, under the AFDC cash assistance program, the federal government provided states with open-ended matching funds as an entitlement if a state decided to participate in the program. The states that participated received a reimbursement for their welfare spending of 50% to 80%, based on per capita income. In Ohio, this reimbursement averaged approximately 60% over the decade prior to PRWORA. Each state that participated determined the income standards for eligibility and the benefit levels of recipients (as continues today under TANF). These benefits were entitled to all individuals and families that met eligibility requirements.

Under TANF, cash benefits remain an entitlement but states receive federal funding through an annual block grant instead of open-ended reimbursement. The block grant amount is based on the amount of federal funds expended in federal fiscal year (FFY) 1994 for the three eliminated programs (AFDC, JOBS, and FEA). In order to receive the block grant, states must meet a MOE requirement equal to 80% of what they spent in FFY 1994 on the three eliminated programs.⁷ After cash entitlements are paid from these sources, the remaining funds may be used to fund other assistance programs that meet at least one of the four purposes of TANF. The four purposes are:

- Assisting needy families so that children can be cared for in their own homes;
- Reducing the dependency of needy parents by promoting job preparation, work, and marriage;
- Preventing out-of-wedlock pregnancies; and
- Encouraging the formation and maintenance of two-parent families.

⁷ If the state fails to meet the MOE, its TANF grant for the next federal fiscal year will be reduced by the amount of the deficit, and the state will be required to increase its TANF spending by an amount equal to the penalty.

TANF Overview

Ohio's annual federal TANF Block Grant award is about \$728.0 million, which is deposited in quarterly installments into the TANF Block Grant Fund (Fund 3V60). Ohio's MOE at the 80% level is \$416.9 million.⁸ Table 2 below lists the line items and amounts that ODJFS plans to use for state TANF MOE in the next biennium.

Table 2. Planned Sources of TANF MOE			
Appropriation Items		FY 2010	FY 2011
General Revenue Fund			
600410	TANF State	\$190,607,468	\$202,858,335
600413	Child Care/MOE	\$45,403,943	\$45,403,943
600535	Early Care and Education	\$134,066,711	\$121,815,845
General Services Fund			
600658	Child Support Collections	\$23,000,000	\$23,000,000
Other*			
600321	Support Services (GRF)	\$23,808,540	\$23,808,540
600416	Computer Projects (GRF)		
600421	Office of Family Stability (GRF)		
600423	Office of Children and Families (GRF)		
600633	Administration and Operating (GSF)		
Totals		\$416,886,662	\$416,886,663

*Specific MOE amounts for each of these line items are not available.

Prior to this biennium, expenditures of the Board of Regents and the departments of Education and Development were counted toward state TANF MOE. Due to recent federal rule changes, these expenditures will no longer be allowed to count toward MOE. Also, in previous years the state counted county spending on TANF programs toward MOE. For this biennium, ODJFS has consolidated MOE at the state level, allowing counties to focus expenditures that they would have spent toward MOE on Medicaid and Food Assistance Program administrative expenditures in order to draw down the federal reimbursements associated with expenditures for those programs.

⁸ The MOE may be lowered to 75% if the state meets its work participation requirements. Ohio was meeting the participation rate requirements until the end of FFY 2007 and MOE was set at 75%. However, due to the changes in the Deficit Reduction Act of 2005, Ohio has experienced challenges in meeting the work participation requirements, and therefore plans state TANF MOE at 80%.

The TANF Block Grant and the state MOE together make up \$1.14 billion in TANF resources each year. These resources primarily fund OWF and PRC, and partially fund publicly funded child care.

Ohio Works First

The OWF Program provides time-limited cash assistance to help needy families with (or expecting) children to care for those children in their own homes, and to eliminate the barriers to work that lead to reliance on government assistance. In addition to cash assistance, OWF provides job placement services, child care services, and transportation. The program also promotes preparation for work, job search, and early entry into employment. In FY 2008, Ohio expended \$317.3 million in OWF cash benefits to an average of 79,400 assistance groups each month (representing 170,600 total individuals), with an average benefit per assistance group of \$333 per month.

To be eligible for OWF cash assistance, applicants must have a minor child or pregnant woman (at least six months pregnant) in the assistance group. Families must also have incomes of no more than 50% of the federal poverty guidelines (FPG) (\$9,155 annually for a family of three). Adults or minor heads-of-household must sign a self-sufficiency contract, which specifies work requirements for the assistance group to receive cash assistance.

In Ohio, individuals are required to begin a qualified work activity as soon as possible after applying for OWF. A single parent in an assistance group is required to work 30 hours per week (with exceptions for a parent with young children), and two parents in an assistance group are required to work 35 hours per week or 55 hours per week if they receive federal child care assistance. All states are required to ensure that 50% of all assistance groups and 90% of two-parent assistance groups are meeting the work requirements. Work activities allowable by the federal government include regular employment as well as other activities that fit into the following categories:

- **Work experience** – work without payment in order to gain work experience;
- **Subsidized employment** – work for payment and the state pays subsidies to the employer for a specified time period;
- **On-the-job training** – combination of classroom instruction and paid or unpaid work experience;
- **Job search and job readiness activities** – programs that assist individuals in obtaining employment;
- **Vocational education** – college, technical, vocational or other course work leading to a degree, certificate or license;

- **Job skills training** – vocational education and structured programs such as rehabilitation services, counseling, etc.;
- **Education related to employment** – any education program for individuals without a high school diploma or GED; and
- **Basic education activities** – high school or equivalent education and adult literacy education.

In addition to these work activities, the federal government allows certain populations to engage in alternative work activities in cases where individuals have difficulty participating in federally allowable work assignments. Alternative work activities include parenting classes, counseling, life-skills training, or other activities deemed to help families achieve self-sufficiency. No more than 20% of OWF assistance groups may participate in these activities.

About half of Ohio's assistance groups (41,500 in FY 2008) are exempt from participating in any work activities. These assistance groups, referred to as "child-only" cases, are typically instances when a child is living with a specified relative caregiver instead of a parent or when the adults in the household are recipients in other public assistance programs such as Supplemental Security Income. These children remain eligible until age 18 and are not subject to adult work participation requirements or income limitations. Cash benefits for child-only assistance groups are also not subject to state or federal time limits.

Federal TANF law limits participation in cash assistance to a maximum of five years. Ohio law limits participation in OWF to a maximum of 36 months. In Ohio, after this 36-month limit, assistance groups may apply for either hardship or good-cause extensions. State hardship extensions may be granted by a county department of job and family services (CDJFS) to assistance groups anytime after the 36-month period if the CDJFS determines that the time limit imposes a significant hardship. Good-cause extensions may be granted by a CDJFS only after an assistance group has not received cash assistance for 24 consecutive months after having met the 36-month limit. Both extensions may not last longer than 24 months, as after that time, assistance groups would reach the federal 60-month limit. A CDJFS may only grant hardship and good-cause extensions to no more than 20% of their OWF assistance groups. CDJFSs may grant federal hardships beyond the 60-month period, but to no more than 20% of OWF assistance groups statewide.

Prevention, Retention, and Contingency

The PRC Program was implemented by H.B. 408 of the 122nd General Assembly, replacing the Family Emergency Assistance Program. PRC is a county-administered "non-cash" support program that is designed to divert families from cash assistance by providing short-term, customized assistance to overcome immediate problems or

barriers that could, if not addressed, result in a situation where families would apply for cash assistance. PRC provides short-term assistance for shelter, job-required clothing, household necessities (like the repair of a furnace or a major appliance), home repair, and transportation. ODJFS refers to these particular services as "hard services," as they have cash value. PRC benefits may also include counseling, employment services, and short-term training, which are referred to as "soft services."

To participate in the PRC Program, an assistance group must include at least one minor child. Additional PRC Program eligibility criteria based on family income are established by counties in each county's partnership agreement with ODJFS. Counties set income ceilings for eligibility for PRC services from 100% FPG (\$18,310 annually for a family of three) to 200% FPG (\$36,620 annually for a family of three); counties are not permitted to extend eligibility beyond the 200% FPG income limit. In addition to setting income eligibility criteria, counties have considerable latitude in determining the types, amounts, and duration of assistance to provide to eligible families. The policies that counties develop must be consistent with state and federal law.

In FY 2008, the state expended \$182.8 million on non-cash supports and services to families through the PRC Program. These expenditures funded approximately 428,000 unique services delivered through the program.⁹

Child Care

ODJFS's Office of Children and Families administers publicly funded child care. ODJFS develops child care eligibility and benefit policy, maintains the information system that contains the program's eligibility and claims history, and contracts with nonprofit community organizations to perform customer outreach and referral services. CDJFSs perform eligibility determinations, provider development and recruitment, home provider inspections and certifications, and vendor payment functions. In addition to administering publicly funded child care, the Office also regulates the licensing and operation of child care programs in the state. Licensing staff certify and license child care centers, investigate complaints of noncompliance, and provide training and consultation regarding quality improvement.

The state provides child care subsidies to a variety of families based on different eligibility criteria (see Facts and Figures Child Care Caseloads page). Families enrolled in OWF are guaranteed to receive subsidies as well as families that are within the lesser of a 12-month period following the last month of eligibility for OWF or until income exceeds 150% FPG (\$27,465 annually for a family of three). Non-OWF families may

⁹ TANF PRC Services Report April – June 2008, ODJFS. ODJFS records the number of *services* delivered; families and individuals may have received multiple PRC services throughout this time period.

continue to qualify for child care (nonguaranteed child care) until their incomes exceed 200% FPG (\$36,620 for a family of three). Families are required to contribute to the costs of child care in the form of copayments. Copayment amounts are established based on a sliding scale of families' incomes. In FY 2008, the state expended \$545.0 million for publicly funded child care for an average monthly caseload of 95,600.

Early Learning Initiative

The Early Learning Initiative (ELI), a component of the child care program, is delivered through a partnership between ODJFS and the Ohio Department of Education. ELI provides young children educational experiences to prepare them for kindergarten while meeting the child-care needs of working families on a full-day or part-day basis. To be eligible for ELI, children must be at least three years of age but not of compulsory school age or enrolled in kindergarten, with family incomes up to 200% FPG (\$36,620 annually for a family of three). In FY 2008, the state expended \$114.6 million for ELI services for 12,000 monthly slots.

Federal Stimulus

Four line items used for Family Stability include estimated federal stimulus dollars in the As Introduced version of H.B. 1 in the amount of \$87.7 million in FY 2010 and \$66.9 million in FY 2011 (\$154.6 million over the biennium). The tables below lists the line items that include federal stimulus assumptions: Table 3 shows federal stimulus assumptions for FY 2010 and Table 4 shows assumptions for FY 2011. The columns in each table show the totals based on the As Introduced version of H.B. 1 for each fiscal year as well as the amount and percentage of the appropriation that is federal stimulus.

Appropriation Item			H.B. 1 Appropriations	Federal Stimulus	% Federal Stimulus
GRF	600661	Child Care – Federal Stimulus	\$8,915,224	\$8,915,224	100.0%
3840	600610	Food Assistance and State Administration	\$159,109,776	\$6,000,000	3.8%
3H70	600617	Child Care Federal	\$241,862,780	\$39,000,000	16.1%
3V60	600689	TANF Block Grant	\$761,733,452	\$33,764,296	4.4%
Total			\$1,171,621,232	\$87,679,520	7.5%

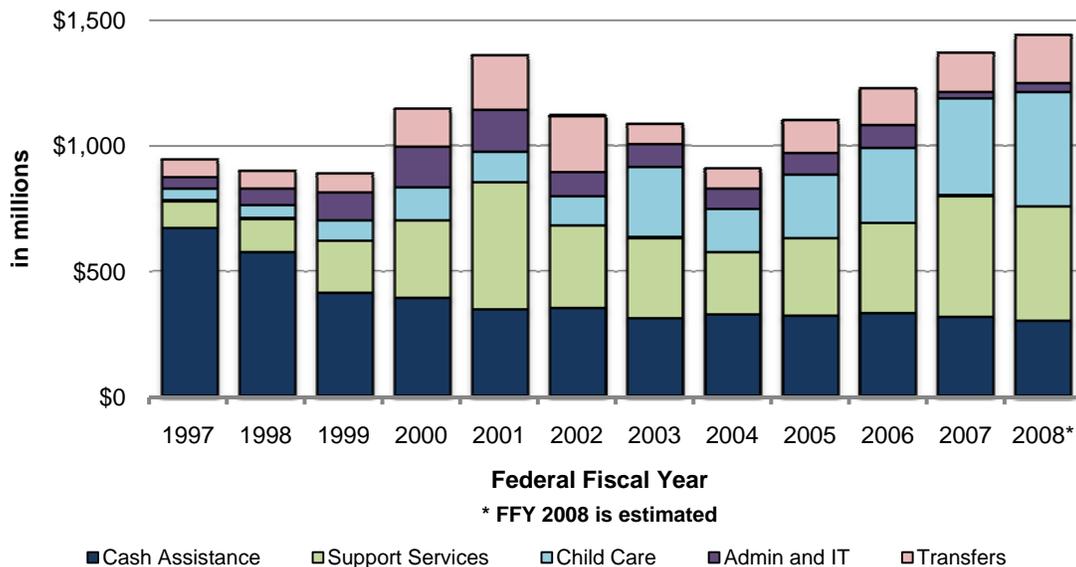
Table 4. FY 2011 Federal Stimulus Assumptions					
Appropriation Item			H.B. 1 Appropriations	Federal Stimulus	% Federal Stimulus
GRF	600661	Child Care – Federal Stimulus	\$13,459,664	\$13,459,664	100.0%
3840	600610	Food Assistance and State Administration	\$159,109,427	\$6,000,000	3.8%
3H70	600617	Child Care Federal	\$241,862,196	\$39,000,000	16.1%
3V60	600689	TANF Block Grant	\$736,410,211	\$8,441,054	1.1%
Total			\$1,150,841,498	\$66,900,718	5.8%

The federal stimulus assumptions shown in the tables are discussed in more detail in the Analysis of Executive Proposal section.

FACTS AND FIGURES

TANF Expenditures

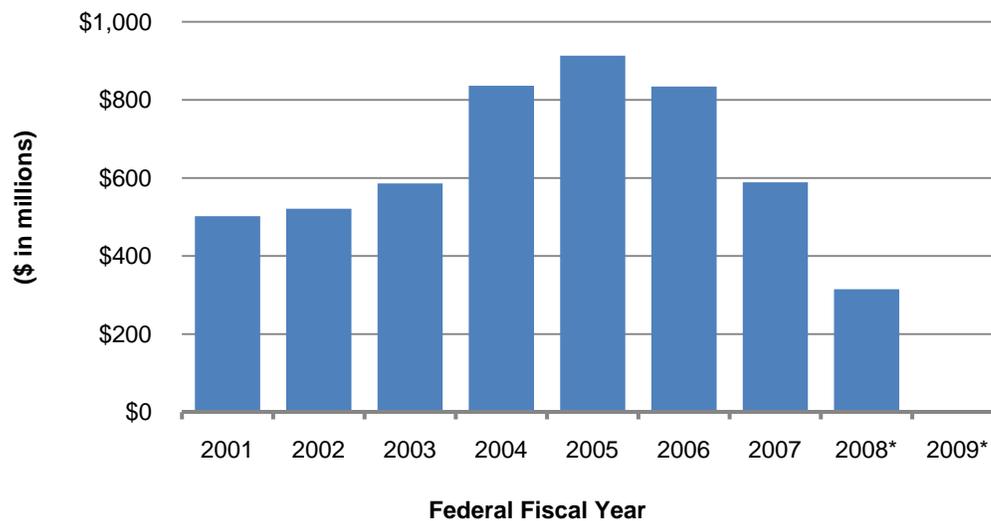
Chart 2: TANF Expenditures by Spending Category



- Expenditures on child care and support services have increased as a proportion of TANF spending over the past ten years, while expenditures on cash assistance have decreased. In federal fiscal year (FFY) 1997 expenditures on child care and support services accounted for 5% and 11% of total TANF expenditures, respectively. Eleven years later in FFY 2008 child care and support services accounted for 32% and 31% of TANF expenditures.
- The increase in expenditures for child care and support services over this period is likely a result of reduced dependency on cash assistance. Ohio law time-limits OWF cash benefits to a maximum of 36 months. TANF allows certain low-income families coming off of cash assistance to still receive child care and PRC services to help mitigate their transition off of government cash assistance.
- "Support Services" includes PRC services including the Help Me Grow Program as well as county services associated with OWF and PRC, such as eligibility determination and case management.
- "Child Care" includes publicly funded child care payments and ELI.
- The Transfers & Interagency category includes transfers to agencies that use TANF funds to supplement their social services programs and the TANF funds transferred to the Social Services Block Grant.
- TANF resources total \$1.14 billion each year (federal and state funds). Amounts in excess of these resources were likely due to spending of an accrued surplus.

Ohio's TANF Surplus

Chart 3: Ohio's Cumulative Unspent TANF Balance

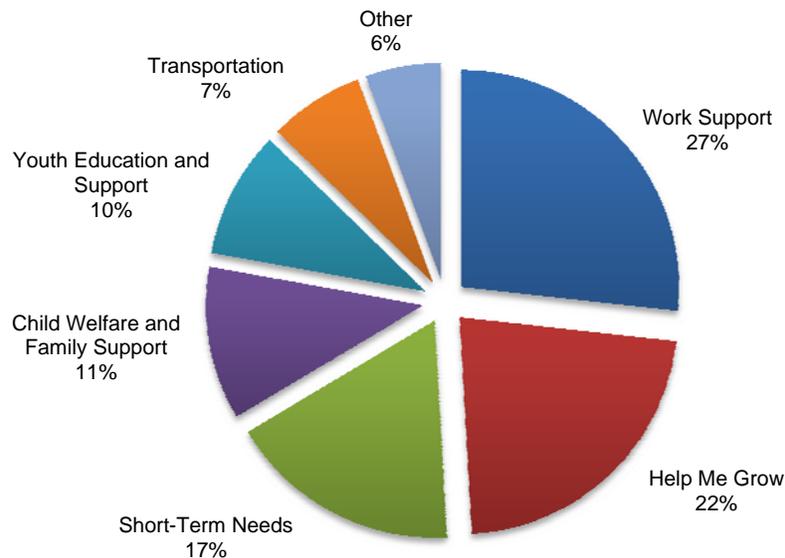


* Amounts for FFY 2008 and FFY 2009 are estimates

- Ohio's cumulative TANF surplus (unobligated and unliquidated dollars from previous grant years) reached a peak of \$913 million at the end of federal fiscal year 2005 (September 30, 2005). Since then, Ohio's TANF surplus has declined steadily every year, to \$315 million at the end of FFY 2008. ODJFS expects the surplus to be fully depleted by the end of FFY 2009.
- Ohio accrued a relatively large surplus between federal fiscal years 2000 and 2005 due to a number of factors including under-spending by counties. Since 2005, the state has made programmatic changes and eliminated county under-spending.
- The federal government allows states to reserve any unobligated and unliquidated TANF Grant funds at the end of a grant year. The surplus is held by the federal government and is available for future spending on benefits that meet the federal definition of "assistance." In Ohio, the only benefit that meets that definition is cash assistance under the OWF program. In past fiscal years surplus amounts were appropriated in federal line item 600689, TANF Block Grant.
- The estimated depleted surplus will impact spending on TANF programs into the coming biennium. In previous fiscal years, the state primarily used the surplus to fund OWF cash assistance benefits, while using current-year state TANF MOE and the TANF Block Grant to fund PRC and publicly funded child care. Without a surplus available to fund OWF, the state must now use current-year state MOE and the TANF Block Grant to fund OWF.

Prevention, Retention, and Contingency Expenditures

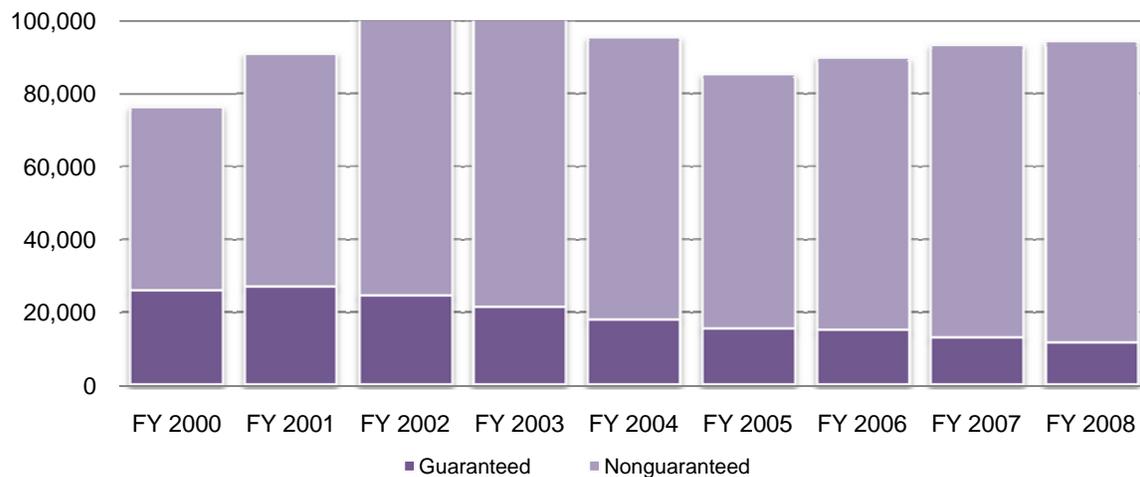
Chart 4: FY 2008 PRC Expenditures by Category



- In FY 2008, the state spent \$182.8 million for services provided through PRC. PRC is a non-cash support program that is designed to divert families from cash assistance by providing short-term assistance to overcome immediate problems or barriers.
- In FY 2008, 428,000 unique PRC services were delivered. This number includes duplicative counts of individuals and families that may have received multiple services, as ODJFS tracks the number of services delivered.
- County departments of job and family services administer the PRC program. Eligibility criteria and services available may vary by county; however, these policies must be consistent with state and federal law.
- "Work Support" includes training and career advancement services as well as work-related transportation and employment.
- Help Me Grow (HMG) coordinates services for expectant parents, newborns, infants and toddlers and their families. HMG educates parents pertaining to the health and developmental needs of their newborns, infants, and toddlers up to age 3. The Ohio Department of Health is the lead agency administering HMG in Ohio. In FY 2008, HMG received \$44.3 million in TANF funds. The program receives other state funds as well as federal and private funds.
- "Short-Term Basic Needs" include clothing, shelter, and other services.
- The "Other" category includes community and economic development, disaster assistance, domestic violence services, and out-of-wedlock pregnancy prevention.

Child Care Caseloads

Chart 5: Guaranteed and Nonguaranteed Child Care Caseloads



- Nonguaranteed child care caseloads have risen over the past four fiscal years, as guaranteed caseloads have steadily declined since FY 2000. The "Nonguaranteed" category includes families that are not enrolled in OWF but have incomes below the threshold established by the state. The "Guaranteed" category includes families enrolled in or transitioning out of OWF.
- Nonguaranteed caseloads generally fluctuate with changes made to the income eligibility threshold based on the federal poverty guidelines (FPG). From FY 2000 to FY 2003 families with incomes up to 185% FPG (\$33,870 annually for a family of three) were eligible for nonguaranteed child care. During that time caseloads for this category increased 69% from about 50,200 to 85,000. In an effort to control costs the state reduced eligibility from 185% to 150% FPG (\$27,470 annually for a family of three), and caseloads subsequently dropped 18% to about 70,000 in FY 2005. The state then increased eligibility back to 185% of FPG in FY 2007, and caseloads increased 18%, from 70,000 in FY 2005 to 82,500 in FY 2008.
- As OWF caseloads for cash assistance have continued to decline as a result of welfare reform, the number of families receiving guaranteed child care subsidies has also continued to decline, decreasing by 55% from about 26,100 in FY 2000 to about 11,800 in FY 2008.
- In FY 2008, Ohio spent \$545.0 million on child care subsidies for an average annual caseload of 95,600. In FY 2009, ODJFS expanded eligibility for nonguaranteed child care to families with annual incomes up to 200% FPG (\$36,620 annually for a family of three).
- Funding sources for publicly funded child care include the state GRF, the federal TANF Block Grant, the federal Child Care Block Grant, and other federal grants.

ANALYSIS OF EXECUTIVE PROPOSAL

Introduction

This section provides an analysis of the Governor's recommended funding for each appropriation item in the Family Stability budget. In this analysis Family Stability line items are grouped into five categories. For each category a table is provided listing the recommended appropriation in each fiscal year of the biennium. Following the table, a narrative describes how the appropriation is used and any changes affecting the appropriation that are proposed by the Governor. The five categories used in this analysis are as follows:

1. Temporary Assistance for Needy Families;
2. Child Care;
3. Food Assistance Programs;
4. Other Assistance Programs; and
5. Administration.

Temporary Assistance for Needy Families

This category of line items includes the major sources of state and federal funding for state TANF programs including Ohio Works First (OWF) cash assistance and Prevention, Retention, and Contingency (PRC). Table 5 below lists the line items associated with this category and the recommended amounts.

Table 5. Governor's Recommended Amounts for TANF				
Fund	ALI and Name		FY 2010	FY 2011
General Revenue Fund				
GRF	600410	TANF State	\$190,607,468	\$202,858,335
General Services Fund Group				
4A80	600658	Child Support Collections	\$26,000,000	\$26,000,000
Federal Special Revenue Fund Group				
3V60	600689	TANF Block Grant	\$761,733,452	\$736,410,211
Total Funding: TANF			\$978,340,920	\$965,268,546

The executive estimates that appropriation levels in these line items are sufficient to provide cash benefits to 85,200 assistance groups in FY 2010 and to 88,300 assistance groups in FY 2011 through OWF as well as support PRC services provided by counties. The executive estimates that appropriation levels are also sufficient to cover the statutory cost of living adjustment for OWF cash benefits in each fiscal year. A portion of the TANF Block Grant is also used to fund publicly funded child care.

Federal Stimulus Assumptions

The executive recommendations assume an additional \$33.8 million in FY 2010 and \$8.4 million in FY 2011 in federal line item 600689, TANF Block Grant, from the federal stimulus. These funds will be used in conjunction with funds from the block grant (\$728.0 million each year). These amounts are estimated from the TANF Emergency Fund provision in the American Recover and Reinvestment Act. This provision states that the federal government will pay 80% of the cash assistance payments for increased OWF caseloads in FFY 2009-FFY 2010 above a base average of the lower of FFY 2007 or FFY 2008 quarterly caseloads, up to 50% of a state's federal block grant amount (\$364.0 million in Ohio). This provision will apply retroactively beginning in October 2008, and last two full years, ending September 2010.

TANF State (600410)

This GRF line item is used to fund the OWF cash assistance program in conjunction with line item 600658, Child Support Collections, and a portion of federal line item 600689, TANF Block Grant. Expenditures from this GRF line item count toward the state's MOE for TANF.

In FY 2008, Ohio expended \$317.3 million in OWF cash benefits to an average of 79,400 assistance groups each month (representing 170,600 total individuals), with an average benefit per assistance group of \$333 per month. ODJFS estimates to expend \$342.0 million on OWF benefits in FY 2009, an 8% increase from FY 2008. Into the coming biennium, ODJFS projects OWF expenditures to increase in FY 2010 to \$368.6 million, an increase of 8% from FY 2009, and to increase in FY 2011 to \$393.2 million, an increase of 7% from FY 2010. These projections include the cost-of-living-adjustment increase.

Included in H.B. 119, the cost-of-living adjustment (COLA) in section 5107.04 of the Revised Code requires ODJFS to increase cash assistance payments in January of each year based on a COLA, as determined by the federal Social Security Administration. The annual COLA rate is based on the Consumer Price Index for Urban Wage Earners and Clerical Workers. In January 2009, benefits increased 5.8%, and the Social Security Administration estimates this index to increase 2.5% in January 2010, and 2.8% in January 2011.

The executive recommends \$190.6 million for FY 2010, a 25.2% decrease from the FY 2009 adjusted appropriation, and \$202.9 million for FY 2011, a 6.4% increase over FY 2010.

Child Support Collections (600658)

This line item is used in conjunction with GRF line item 600410, TANF State, and a portion of federal line item 600689, TANF Block Grant, to cover OWF cash benefits, and is funded from the nonfederal share of county OWF child support collections. Persons receiving child support and OWF cash assistance are required to assign their child support payments to ODJFS to cover part of their cash assistance benefits. OWF cash benefits paid from this line item are counted toward the state's TANF MOE. The executive recommends \$26 million for FY 2010 and FY 2011, an 18.6% decrease from the FY 2009 adjusted appropriation.

The As Introduced version of H.B. 1 requires that this line item be used by ODJFS to meet the state's TANF MOE requirements. Once the state is assured that it will meet the MOE requirements, ODJFS may use the remaining funds to support public assistance activities. ODJFS plans to count \$23.0 million in expenditures in each fiscal year towards the state's TANF MOE.

TANF Block Grant (600689)

This federal line item is used by ODJFS to expend the federal TANF Block Grant for OWF, PRC, publicly funded child care, ODJFS operating and management information system development, and a transfer to the Governor's Office of Faith-Based and Community Initiatives. The executive recommends \$761.7 million in FY 2010, a 27.0% decrease from the FY 2009 adjusted appropriation, and \$736.4 million in FY 2011,

a 3.3% decrease from FY 2010. These amounts include annual the TANF Block Grant award as well as federal stimulus amounts of \$33.8 million in FY 2010 and \$8.4 million in FY 2011. The 27.0% decrease in appropriations from FY 2009 to FY 2010 is attributable to ODJFS spending down the TANF surplus for various earmarks and demonstration projects.

The As Introduced version of H.B. 1 includes permanent law pieces that affect eligibility for PRC as well as other programs funded with federal TANF dollars. The bill amends R.C. 5101.83 to end a prohibition against an assistance group's participation in PRC until a member repays the cost of fraudulent PRC assistance. According to ODJFS, this provision is designed to reduce administrative burden on CDJFSs, as it is difficult to quantify the value of some PRC assistance services (such as training or education) and there are low occurrences of fraudulent uses of PRC services. The prohibition will continue to apply to those who receive fraudulent cash assistance under OWF.

The bill also provides that individuals are not to be denied aid under *any* program funded with TANF dollars on the basis of having been convicted of a felony that has an element of the possession, use, or distribution of a controlled substance. Currently, the law specifies that persons convicted of such a felony cannot be denied aid under the OWF or PRC programs. As TANF dollars are used in Ohio for other public assistance programs in addition to OWF and PRC (such as publicly funded child care and ELI), this provision standardizes participation in all programs that receive federal TANF dollars with respect to the particular felony conviction.

Child Care

This category of line items includes the major sources of state and federal funding for publicly funded child care. Table 6 below lists the line items associated with this category and the recommended amounts.

The As Introduced version of H.B. 1 creates groups to research and make recommendations pertaining to coordinating all state early childhood programs and services under the Department of Education. These groups include the Center for Early Childhood Development, the Early Childhood Financing Workgroup, and the Early Childhood Advisory Council.

Table 6. Governor's Recommended Amounts for Child Care				
Fund	ALI and Name		FY 2010	FY 2011
General Revenue Fund				
GRF	600413	Child Care Match/MOE	\$88,415,688	\$93,105,300
GRF	600535	Early Care and Education	\$150,000,000	\$150,000,000
GRF	600661	Child Care – Federal Stimulus	\$8,915,224	\$13,459,664
General Revenue Fund Subtotal			\$247,330,912	\$256,564,964
Federal Special Revenue Fund Group				
3H70	600617	Child Care Federal	\$241,862,780	\$241,862,779
Federal Special Revenue Fund Group Subtotal			\$241,862,780	\$241,862,779
Total Funding: Child Care			\$489,193,692	\$498,427,743

In addition to the recommended appropriations above, the executive also proposes to use the following appropriations to fund child care:

- \$268.3 million in FY 2010 and \$278.5 million in FY 2011 from federally funded line item 600689, TANF Block Grant;
- \$8.0 million in each fiscal year from federally funded line item 600620, Social Services Block Grant;
- \$37,000 in each fiscal year from federally funded line item 600655, Interagency Reimbursement.

This totals about \$765.5 million in FY 2010 and \$785.0 million in FY 2011 for child care and ELI.¹⁰ The executive estimates that appropriation levels from these line items are sufficient to provide child care subsidies for 102,000 children in FY 2010 and to 105,000 children in FY 2011, and to support 12,000 full-time slots for the ELI. In

¹⁰ About \$13.0 million of federally funded line item 600617, Child Care Federal, is used for regulation of child care.

FY 2008, Ohio spent \$545.0 million on child care subsidies for an average annual caseload of 95,600, and \$114.6 million on ELI for 12,000 full-time slots.

In FY 2009, ODJFS expanded eligibility for nonguaranteed child care to families with annual incomes up to 200% FPG (\$36,620 annually for a family of three). ODJFS expects that this expansion will increase caseloads by 1,700 in FY 2009, and that total caseloads in FY 2009 could grow to 100,600.

Federal Stimulus Assumptions

The executive recommendations include the following assumptions for receiving federal stimulus dollars:

- \$39.0 million in each fiscal year in federally funded line item 600617, Child Care Federal, as part of the increase to the federal Child Care and Development Fund Grant;
- \$8.9 million in FY 2010 and \$13.5 million in FY 2011 in GRF line item 600661, Child Care – Federal Stimulus, as part of the federal stimulus deposited in the GRF.

Child Care Match/MOE (600413)

This GRF line item is used to provide payments for publicly funded child care services. Funds expended from this GRF line item are counted toward the state's MOE for the federal Child Care and Development Grant and the state's TANF MOE. Ohio must contribute at least \$82,951,518 in MOE for publicly funded child care for this grant; \$45.4 million of this appropriation is applied to the state's TANF MOE. The executive recommends \$88.4 million for FY 2010, a 10.3% increase over the FY 2009 adjusted appropriation, and \$93.1 million for FY 2011, a 5.3% increase over FY 2010.

Early Care and Education (600535)

This new GRF line item will primarily be used to fund Ohio's ELI Program. In the last biennium, ELI was funded through earmarks of \$125.3 million in each fiscal year from federally funded line item 600689, TANF Block Grant.

The executive recommends \$150.0 million for FY 2010 and FY 2011, which is estimated to be sufficient to fund 12,000 ELI slots. Funds remaining after ELI expenditures will be used for publicly funded child care payments. ODJFS plans to count \$134.1 million in FY 2010 and \$121.8 million in FY 2011 from this GRF line item towards the state's TANF MOE.

The As Introduced version of H.B. 1 continues the income eligibility ceiling at 200% FPG (\$36,620 annually for a family of three) and expands the number of families that are required to pay copayments for ELI services by reducing the minimum annual income from 165% FPG (\$30,210 for a family of three) to 100% FPG (\$18,310 for a family of three). Families with incomes less than 100% FPG are exempt from paying

copayments. The increase in copayments to providers may not affect state costs for the program, as provider contracts are generally not negotiated based on expected revenue from copayments.

In H.B. 119, the ELI program was budgeted to serve up to 12,000 full-time enrollment slots at a cost of \$125.3 million in each fiscal year for the FY 2008-FY 2009 biennium. H.B. 119 capped eligibility for children in families with incomes up to 185% FPG in FY 2008 and up to 200% FPG in FY 2009.

From FY 2007 to FY 2008, the average number of children enrolled in ELI increased by 18%, from 10,180 to 12,044. Two programmatic changes made by ODJFS likely accounted for much of the enrollment increase. Beginning in FY 2008, ODJFS removed the work requirement for parents whose children participate in ELI and lengthened the eligibility redetermination period from six to twelve months. Removal of the parental work requirement increases the number of eligible children and lengthening of the redetermination period allows any child who is eligible at the beginning of the school year to continue attendance for the entire year regardless of changes in the family income level.

From FY 2007 to FY 2008, expenditures for ELI increased 21% from \$94.7 million to \$114.6 million (\$111.6 million for services, \$3.0 million for administration). In both of these years, however, expenditures remained under the annual earmark of \$128.3 million. The cost per child in FY 2008 was \$10,438 for full-day, full-year services. ODJFS reimburses agencies for hours of child attendance.

Child Care – Federal Stimulus (600661)

This new GRF line item will be used to provide payments for publicly funded child care services. Funds from this line item are part of the federal stimulus that will be deposited in the GRF. The executive recommends \$8.9 million in FY 2010 and \$13.5 million in FY 2011.

Child Care Federal (600617)

This federal line item is used to fund publicly funded child care for low-income families and to fund child care regulation activities. This line item is supported by the federal Child Care and Development Fund Grant, which is deposited into the Child Care Federal Fund (Fund 3H70).

The executive recommends \$241.9 million for FY 2010 and FY 2011, a 20% increase over the FY 2009 adjusted appropriation. This amount includes an assumed additional \$39.0 million in each fiscal year as part of the federal stimulus, which accounts for most of the growth from the FY 2009 adjusted appropriation to FY 2010. This line item is also used on information technology that supports the child care information system. About \$13.0 million from this federal line item is used for the regulation of child care.

ODJFS's Office of Children and Families staff is responsible for regulating child care centers in the state. Ohio child care centers have the capacity to serve 323,392 children at over 4,239 centers, from infants to school age. Regulation activities involve the licensing and monitoring child care centers and Type A family child care homes and registering day camps. In FY 2008, ODJFS received 446 new applications for licensure, an increase of 64 (16.8%) over FY 2007. Of the new applications, ODJFS granted 386 new licenses. ODJFS also offers technical assistance and training to the child care community as a means to promote quality child care.

The Office of Children and Families also investigates complaints and allegations made against licensed programs as well as reports of unauthorized child care. Complaints and alleged licensing violations are required to be investigated. In FY 2008, ODJFS received and investigated 1,687 complaints and received 3,329 allegations of rule violations. The three most frequent allegations included staff/child ratios (802), safe and sanitary equipment (408), and care/nurturing of children (381). ODJFS also collects incident and injury reports from licensed facilities. Of the 1,418 serious incident and injury reports received in FY 2008, the three most frequently specified types of injury reported in FY 2008 were falls (566), cuts (332), and bumps and bruises (254).

ODJFS also sets standards through administrative rules and inspects all licensed child care programs. Licensed programs are required to submit a corrective action plan for all rule violations. ODJFS provides technical support, and varying degrees of monitoring occur to assure that the center has achieved compliance. If a center is unable to achieve compliance, the program's license could potentially be suspended or revoked. There were a total of 19 active enforcement cases at the end of FY 2008, including eight new recommendations for revocation of a license submitted during this reporting period.

Food Assistance Programs

This category of line items supports food assistance programs including the Food Assistance Program, the Emergency Food Assistance Program, and the Ohio Association of Second Harvest Food Banks. Table 7 below lists the line items associated with this category and the recommended amounts.

The federal government recently changed the name of the Food Stamp Program to the Supplemental Nutrition Assistance Program (SNAP). The As Introduced version of H.B. 1 allows ODJFS to continue to refer to the program as the "Food Stamp Program" or to rename it the "Food Assistance Program" in rules and documents. ODJFS plans to use the term the "Food Assistance Program" to refer to this program. This analysis will refer to the program as the Food Assistance Program.

Table 7. Governor's Recommended Amounts for Food Assistance Programs				
Fund	ALI and Name		FY 2010	FY 2011
Agency Fund Group				
5B60	600601	Food Assistance Intercept	\$2,000,000	\$2,000,000
Agency Fund Group Subtotal			\$2,000,000	\$2,000,000
Federal Special Revenue Fund Group				
3840	600610	Food Assistance and State Administration	\$159,109,776	\$159,109,427
3A20	600641	Emergency Food Distribution	\$4,970,000	\$4,970,000
Federal Special Revenue Fund Group Subtotal			\$164,079,776	\$164,079,427
State Special Revenue Fund Group				
5ES0	600630	Food Assistance	\$500,000	\$500,000
State Special Revenue Fund Group Subtotal			\$500,000	\$500,000
Total Funding: Food Assistance Programs			\$166,579,776	\$166,579,427

In addition to these appropriations, the As Introduced version of H.B. 1 requires ODJFS to provide funds to the Ohio Association of Second Harvest Food Banks in each fiscal year in an amount equal to the funds provided in FY 2009. In the last biennium \$8.5 million was designated through appropriations and earmarks to the Association in each fiscal year. In H.B. 119 the General Assembly appropriated and earmarked the following amounts for the Ohio Association of Second Harvest Food Banks in each fiscal year:

- \$5.5 million in federally funded line item 600651, Second Harvest Food Banks, from funds in the Social Services Block Grant Fund (Fund 3960);
- \$1.5 million in federally funded line item 600689, TANF Block Grant;

- \$1.0 million in federally funded line item 600659, TANF/Title XX Transfer from funds earned as federal reimbursement for transferring TANF Block Grant funds to the Social Services Block Grant;
- \$500,000 in line item 600630, Food Assistance, through a transfer from the Food Stamp Program Fund (Fund 3840) to the Food Assistance Fund (Fund 5ES0).

In FY 2008, the Association received the full \$8.5 million and the executive expects that they will receive \$8.5 million in FY 2009.

According to ODJFS, in the coming biennium the Association will be funded with \$8.5 million in each fiscal year from the following sources:

- \$8.0 million in federal line item 600620, Social Services Block Grant;
 - \$6.0 million transfer from TANF Block Grant to the Social Services Block Grant;
 - \$2.0 million from funds in the Social Services Block Grant Fund (Fund 3960);
- \$500,000 in line item 600630, Food Assistance, through a transfer from Fund 3840 to Fund 5ES0.

Federal Stimulus Assumptions

The executive recommendations assume \$6.0 million in each fiscal year in federally funded line item 600610, Food Assistance and State Administration, from the federal stimulus. These funds will be used for county administrative expenses related to the expected influx of Food Assistance Program applicants over the next biennium. This stimulus amount would not require a county match, as is normally the case for Food Assistance Program administrative expenses.

ODJFS expects to receive an additional \$5.0 million in federal funds from the Emergency Food Assistance Program Grant as part of the federal stimulus in FFY 2009. The expected additional amounts from this grant are not included in the executive's appropriation recommendations, as the exact amount Ohio will receive is not final.

Food Stamp Intercept (600601)

This line item receives the collections the Internal Revenue Service makes through the Food Stamp Intercept Program. The moneys from this line item are sent back to the United States Department of Agriculture for reimbursement for fraudulent food stamp payments. A small portion of the collection is sent back to the county where the fraudulent benefits were issued as an incentive payment for participation in this program.

The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$2.0 million for FY 2010 and FY 2011.

Food Assistance and State Administration (600610)

This federally funded line item is used to reimburse state and county departments of job and family services' costs of administering the Food Assistance Program. The goal of the Food Assistance Program is to increase nutritional intake of low-income persons by supplementing their income with food benefits. For most activities, the federal government reimburses states 50% for managing the program. The amount of the appropriations is the federal match for state and county allowable expenditures for administrative activities.

The executive recommends \$159.1 million for FY 2010 and FY 2011, a 3.9% increase over the FY 2009 adjusted appropriation. The executive estimates that this funding level will support administrative activities involved with providing 1.1 million individuals with Food Assistance benefits. Included in this appropriation is \$6 million in each fiscal year, as part of an assumed federal stimulus payment for Food Assistance administration. The executive recommendations include plans to use \$2 million in each fiscal year from this line item to fund information technology expenses related to Food Assistance benefits, including the Electronic Benefit Transfer System.

Emergency Food Distribution (600641)

This federally funded line item appropriates funds received from the Emergency Food Assistance Program (TEFAP) Grant and the Commodity Supplemental Food Program (CSFP) Grant. TEFAP funds are used by ODJFS and local organizations for administrative expenses related to processing, storage, and distribution of food commodities in local storage centers. ODJFS passes most of these funds to emergency feeding organizations and retains a small amount for state administrative costs. All CSFP funds are distributed by the state to local food banks for administrative costs associated with distributing food items. Food items distributed under CSFP are provided separately by the federal government.

The executive recommends \$4.97 million for FY 2010 and FY 2011, a 42.0% increase over the FY 2009 adjusted appropriation. The increase is due to an expected increase in the allotment of the grant that Ohio will receive.

State grant allotments are established by the federal government based on funds available, the number of individuals with incomes under the poverty level, and the number of unemployed in each state. The federal 2008 Farm Bill increased funds available for state distribution; and, the state has increasing numbers of individuals with incomes under the poverty level and increasing numbers of unemployed. ODJFS expects to receive an additional \$5 million in federal funds from the grant as part of the federal stimulus in FFY 2009. The expected additional amounts from this grant are not included in the executive's recommendations, as the exact amount Ohio will receive is not final.

In FFY 2008, the state received about \$2.0 million from the TEFAP Grant and \$1.0 million from the CSFP Grant. According to ODJFS, 850,000 individuals receive food benefits through the TEFAP Program every month.

Food Assistance (600630)

This line item is used to distribute funds to the Ohio Association of Second Harvest Food Banks. The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$500,000 for FY 2010 and FY 2011.

The As Introduced version of H.B. 1 includes a provision that permits the Director of Budget and Management to transfer \$1.0 million in cash from Fund 3840 to Fund 5ES0. The transfer supports expenditures from this line item over the biennium.

Other Assistance Programs

This category of line items supports other assistance programs in the state including the Disability Financial Assistance Program, Refugee Services, and faith-based initiatives. Table 8 below lists the line items associated with this category and the recommended amounts.

Table 8. Governor's Recommended Amounts for Other Assistance Programs				
Fund	ALI and Name		FY 2010	FY 2011
General Revenue Fund				
GRF	600511	Disability Financial Assistance	\$36,037,712	\$38,684,457
General Revenue Fund Subtotal			\$36,037,712	\$38,684,457
Federal Special Revenue Fund Group				
3850	600614	Refugee Services	\$10,497,024	\$11,265,511
3AW0	600675	Faith Based Initiatives	\$544,140	\$544,140
Federal Special Revenue Fund Group Subtotal			\$11,041,164	\$11,809,651
Total Funding: Other Assistance Programs			\$47,078,876	\$50,494,108

Disability Financial Assistance (600511)

This GRF line item is used for the Disability Financial Assistance (DFA) program. DFA provides financial assistance to disabled persons who are unemployable due to physical or mental impairment, and who are not eligible for public assistance programs that are supported in whole or in part by federal funds (for example, OWF or Supplemental Security Income). Eligibility is limited to individuals that received financial assistance under the program in June 2003, or to individuals age 60 and older that are determined disabled by ODJFS Disability Determination Unit. Applicants to DFA must also apply for federal Social Security Disability Insurance.

In FY 2008, 16,400 recipients on average per month were enrolled in DFA at a cost of \$27.9 million. The DFA program provides a maximum cash grant of \$115 per month for a one-person assistance group and \$159 for a two-person assistance group. This benefit is not time-limited. Counties contribute a share of these expenditures based on caseloads.

The executive recommends \$36.0 million for FY 2010, a 42.2% increase over the FY 2009 adjusted appropriation, and \$38.7 million for FY 2011, a 7.3% increase over FY 2010. The executive estimates that these appropriations will provide assistance to 21,100 individuals in FY 2010 and 22,500 individuals in FY 2011. ODJFS estimates that increases in enrollment mainly due to forecasted economic conditions over the biennium as well as enrollment trends and processing of back-log applications.

Refugee Services (600614)

This federally funded line item funds the operation and administration of Ohio's Refugee Services programs. These programs are designed to temporarily provide refugees with cash assistance, medical assistance, and social services in order to help their transition to living in the United States. These programs are fully funded by the federal government.

The executive recommends \$10.5 million for FY 2010, a 5.1% decrease from the FY 2009 adjusted appropriation, and \$11.3 million for FY 2011, a 7.3% increase over FY 2010. ODJFS estimates that these appropriations will provide social services to 5,000 refugees and cash assistance to 1,500 refugees in each fiscal year. In FY 2008, 1,360 primary refugees settled in Ohio.

Refugees are eligible for cash assistance and medical assistance (these are separate from OWF and Medicaid) for up to eight months after arriving in the country (as opposed to eight months after applying for benefits). In FY 2008, 320 refugees received refugee cash assistance and 460 received refugee medical services on average per month. Refugees are eligible to receive social services for five years after entering the country. In FY 2008, about 3,000 refugees received social services. Social services include citizenship classes, acculturation assistance, English language training, employment training, job placement, transportation, and child care.

Faith Based Initiatives (600675)

This federally funded line item is used to expend the Healthy Marriage Initiative Grant, which is deposited into the Faith Based Compassion Grants Fund (Fund 3AW0), used by the Governor's Office of Faith-Based and Community Initiatives (GOFBCI). The grant amount is \$544,410 annually for five years and is allowed to be expended on activities that promote and support marriages. GOFBCI uses funds from this grant specifically for marriage education courses in five Ohio metropolitan areas: Akron, Cincinnati, Cleveland, Columbus, and Toledo.

The executive recommends \$544,140 for FY 2010 and FY 2011, a 46% decrease from the FY 2009 adjusted appropriation. In the last biennium, this federal line item was appropriated to expend funds from both the Healthy Marriage Initiative Grant and the Compassion Capital Fund Demonstration Grant, which was a three-year grant that ended in FY 2008. The decrease in the recommended appropriation is due to the expiration of that grant.

The main functions of GOFBCI include disbursing grants to nonprofit organizations, administering the Ohio Benefit Bank, and overseeing the Ohio Anti-Poverty Task Force. In addition to receiving federal grants, the GOFBCI receives funds from other line items in ODJFS's budget. In the last biennium, H.B. 119 had earmarked the following amounts to the GOFBCI in each fiscal year:

- \$13.0 million in federally funded line item 600689, TANF Block Grant;
- \$300,000 in FY 2008 and \$500,000 in FY 2009 in federally funded line item 600659, TANF/Title XX Transfer;
- \$300,000 in GRF line item 600321, Support Services.

The \$13.0 million was used by GOFBCI to fund several initiatives pertaining to youth reentry, fatherhood support, and youth mentoring. Funds were also used to support the Ohio Benefit Bank.

In the As Introduced version of H.B. 1 there are no other specified funding sources for GOFBCI besides the appropriations in federally funded line item 600675, Faith Based Initiatives. However, according to ODJFS, GOFBCI will receive \$7.3 million in FY 2010 and \$6.5 million in FY 2011 from the TANF Block Grant to fund community initiatives. Also, expenditures for administration and the Ohio Benefit Bank will be supported through GRF line items 600321, Support Services, and 600416, Computer Projects.

Administration

This category of line items supports administrative activities in the Office of Family Stability. Table 9 below lists the GRF line item associated with this category and the recommended amounts. In addition to this GRF line item, administrative expenditures for TANF programs, publicly funded child care, food assistance programs, and other assistance programs are sourced from those programs' respective line items.

Table 9. Governor's Recommended Amounts for Administration				
Fund	ALI and Name		FY 2010	FY 2011
General Revenue Fund				
GRF	600421	Office of Family Stability	\$4,653,955	\$4,720,001
Total Funding: Administration			\$4,653,955	\$4,720,001

Office of Family Stability (600421)

This GRF line item is the primary source of administrative and operating expenses for the Office of Family Stability. The executive recommends \$4.7 million in each fiscal year, a 71.1% increase from the FY 2009 adjusted appropriation. Part of this increase in appropriation from FY 2009 to FY 2010 is due to planning to pay some existing staff out of this line item instead of GRF line item 600416, Computer Projects.

Children and Families

- Funding of \$856.5 million for FY 2010 and \$848.8 million for FY 2011
- Possible statewide implementation of alternative response

OVERVIEW

Program Overview

ODJFS is responsible for supervising county child welfare practice through the formulation of policy, promulgation of regulations, and the promotion of best practices. ODJFS also provides support to the counties by providing training programs for county workers and foster parents, information systems, and fiscal mechanisms for properly claiming federal reimbursement for allowable expenses.

The Office of Children and Families (OCF) is responsible for state level administration and oversight of programs that prevent child abuse and neglect. OCF provides services to abused and neglected children and their families (birth, foster, and adoptive) and licenses foster homes, residential facilities, child care homes and centers.

Ohio operates in a state supervised, county administered system. ODJFS sets the policies and procedures and guides county agencies in program and service delivery. Each county is responsible for creating, operating, and financing a child welfare program within the context of state and federal laws, regulations, and policies. State and federal laws require county child welfare agencies to investigate reports of child abuse and neglect, issue a finding concerning an investigation, and if necessary, intervene to protect children who are at risk of maltreatment.

Child welfare services are provided by 88 county public children services agencies (PCSAs) which provide direct services to children and families. The PCSAs were created by Ohio law and the structure of each is determined at the local level. There are 55 PCSAs located within the administrative body of the county departments of job and family services. The remaining 33 are separate children services boards.

Appropriation Overview

For the Children and Families category, the executive recommends \$856.5 million for FY 2010, an increase of \$39.3 million (4.8%) over the FY 2009 adjusted appropriation, and \$848.8 million for FY 2011, a decrease of \$7.6 million (0.9%) over FY 2010.

Table 1 below shows the Children and Families budget by fund group for FY 2009 and the executive budget recommendations for FY 2010 and FY 2011. Almost

79% of the biennial budget for Children and Families comes from the Federal Special Revenue Fund Group; almost 20% comes from the GRF; and 1.4% comes from the State Special Revenue Fund Group.

Fund Group	FY 2009 (adjusted)	FY 2010 (recommended)	% Change	FY 2011 (recommended)	% Change
General Revenue	\$162,776,265	\$169,741,611	4.3%	\$169,817,261	<1.0%
Federal Special Revenue	\$641,625,887	\$675,073,186	5.2%	\$667,347,721	-1.1%
State Special Revenue	\$12,767,240	\$11,650,481	-8.8%	\$11,650,481	0.0%
TOTAL	\$817,169,392	\$856,465,278	4.8%	\$848,815,463	0.9%

Children and Family Services

Protective Services – PCSAs are required to receive reports of child abuse and neglect, and to investigate those reports in a timely manner. When necessary, the PCSA works with families to identify services and develop a case plan that reduces the risk of future abuse or neglect.

Adoption – ODJFS provides support to local agencies in their efforts to decrease the number of children waiting for permanent homes; to prevent discrimination in the placement of children; to identify and recruit permanent families who can meet each child's needs; and to provide support to families to ensure the stability and well-being of children in their care. To assure permanency is maintained, ODJFS provides a variety of services to birth parents, adoptive parents and children, particularly those children who have been in foster care. These services are largely provided by PCSAs, private child placing agencies, and private noncustodial agencies in collaboration with ODJFS.

Foster Care – ODJFS develops rules and guidelines to aid counties in implementing programs for children who cannot safely remain in their own homes. Foster/substitute care for children is one of the major program components of Ohio's child welfare system and is provided through public and private agencies. The program's main purpose is to reunify children with their families or find other permanent living arrangements when children cannot safely return home. Foster or substitute care includes kinship care, foster care, residential substitute care in group homes and treatment facilities, the independent living program, and the Interstate Compact for the Placement of Children.

Kinship Care – Kinship Care refers to a temporary or permanent arrangement in which a relative or any nonrelative adult, who has a long-standing relationship or bond with the child and/or family, has taken over substitute care of a child. Kinship Care

includes those relationships established through an informal arrangement, legal custody or guardianship order, a relative foster care placement or kinship adoption.

Alternative Response – ODJFS is currently conducting the Alternative Response Pilot Program. This program tests a broader set of responses to possible cases of child abuse or neglect. Under the pilot program, if a child's safety is not in question, case workers can use early intervention and prevention strategies with families to address issues pertaining to child welfare and safety and improve access to other supportive services. This program is meant to improve Ohio's response to reports of child abuse and neglect. This program will conclude in the upcoming biennium and is under consideration for statewide implementation.

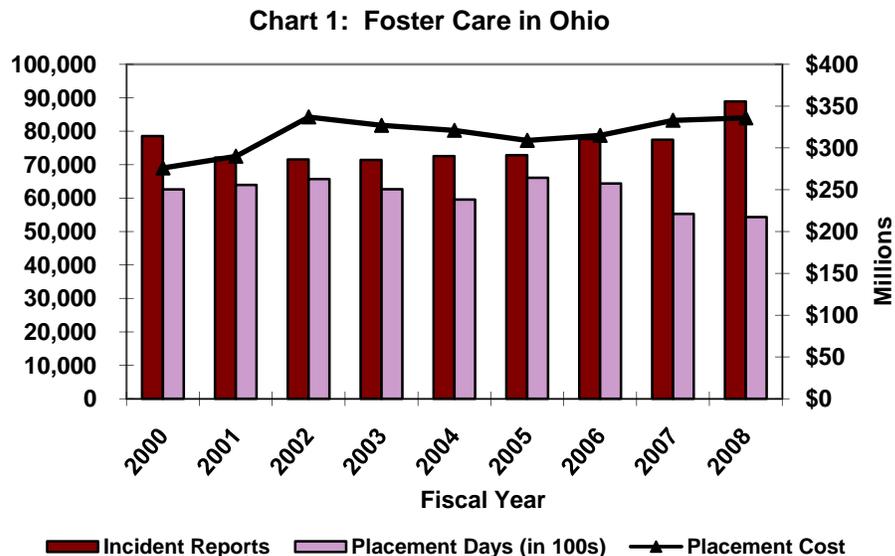
Adult Protective Services – Adult protective services are provided by the county departments of job and family services to the elderly who are in danger of harm and/or are unable to protect themselves. County departments of job and family services are mandated to investigate and evaluate all reports of suspected abuse, neglect, and exploitation of adults age 60 and over.

Major initiatives

OCF will continue to support improved outcomes for children and families in Ohio during the FY 2010-FY 2011 biennium, by carrying out federal mandates and implementing rule changes that support the counties in performing statutorily mandated services. In addition, OCF plans to conduct a statewide assessment of adoption recruitment measures and develop a statewide adoption model in order to develop strategies for increasing permanency for children in substitute care. Other initiatives will include the conclusion and potential statewide implementation of the Alternate Response Pilot Program, the development of screening and assessment protocols for Adult Protective Services, developing the National Youth in Transition Database, and working with the Supreme Court of Ohio to implement the second annual Summit on Children.

FACTS AND FIGURES

Chart 1 shows some trends relative to foster care by showing the number of incident reports, number of placement days, and placement costs from FY 2000 through FY 2008.



- The cost of foster care is driven primarily by two variables – volume and unit cost. Volume is best measured by counting total placement days (a measure of the total number of days a child spends in foster care each year). Unit cost is calculated by dividing total placement cost by total placement days. The relationship between the two may provide some insight into the acuity of the caseload. Static or decreasing placement days yet rising unit costs suggest that the children being placed have more difficult care issues. The unit cost of foster care has increased from about \$44.07 per placement day in FY 2000 to about \$61.85 per placement day in FY 2008, a 40.3% increase.
- Placement days increased between FY 2000 and FY 2002 by about 309,500 and decreased until FY 2005 when placement days peaked at about 6.6 million. Beginning in FY 2006, placement days decreased. The downward trend continued and in FY 2008, the number of foster care placement days was about 5.4 million.
- In FY 2000, placement costs were about \$276.0 million. From FY 2000 to FY 2002, these costs increased about \$61 million, peaking in FY 2002 at about \$337.0 million. Since FY 2002, placement costs have not fluctuated greatly. In FY 2008, placement costs were about \$336.0 million.
- Since FY 2003, the number of incident reports has generally been increasing. In FY 2008, the number of incident reports increased by 11,471 (14.8%) over FY 2007.

ANALYSIS OF EXECUTIVE PROPOSAL

Introduction

This section provides an analysis of the Governor's recommended funding for the Children and Families category. This category of appropriations includes the major sources of state and federal funding for child welfare and adoption. Table 2 shows the line items within this category and the recommended amounts.

Table 2. Governor's Recommended Amounts for Children and Families				
Fund		ALI and Name	FY 2010	FY 2011
General Revenue Fund				
GRF	600423	Office of Children and Families	\$6,494,545	\$6,580,782
GRF	600523	Children and Families Services	\$74,209,378	\$74,209,378
GRF	600528	Adoption Services	\$88,515,648	\$88,515,648
GRF	600534	Adult Protective Services	\$522,040	\$511,453
General Revenue Fund Subtotal			\$169,741,611	\$169,817,261
Federal Special Revenue Fund Group				
3270	600606	Child Welfare	\$33,972,321	\$33,984,200
3950	600616	Special Activities/Child and Family Services	\$3,113,200	\$2,813,200
3960	600620	Social Services Block Grant	\$120,000,000	\$120,000,000
3980	600627	Adoption Maintenance/Administration	\$346,622,373	\$346,865,342
3D30	600648	Children's Trust Fund Federal	\$2,040,524	\$2,040,524
3N00	600628	IV-E Foster Care Maintenance	\$169,324,768	\$161,644,455
Federal Special Revenue Fund Group Subtotal			\$675,073,186	\$667,347,721
State Special Revenue Fund Group				
1980	600647	Children's Trust Fund	\$5,881,011	\$5,881,011
4E70	600604	Child and Family Services Collections	\$300,000	\$300,000
4F10	600609	Foundation Grants/Child and Family Services	\$250,000	\$250,000
5DP0	600634	Adoption Assistance Loan	\$500,000	\$500,000
5U60	600663	Children and Family Support	\$4,719,470	\$4,719,470
State Special Revenue Fund Group Subtotal			\$11,650,481	\$11,650,481
Total Funding: Children and Families			\$856,465,278	\$848,815,463

Office of Children and Families (600423)

This GRF line item is used to provide the primary source of funding for the operating expenses of the OCF including payroll, purchased personal services, conference fees, maintenance, and equipment. Also included in this line item is funding

for the Bureau of Automated Services, which is responsible for the implementation of the Statewide Automated Child Welfare Information System. The executive recommends funding of \$6.5 million in FY 2010, 34.1% increase over the FY 2009 adjusted appropriation and \$6.6 million in FY 2011, a 1.3% increase over FY 2010. The increase in recommended appropriations for this line item will allow OCF to pay the nonfederal share of the Bureau of Automated Services staff.

The OCF is responsible for the oversight of ODJFS programs at both the state and county levels. Programs and services offered include: performing licensing and regulatory inspections of childcare and child welfare providers; administering child abuse prevention and protection, adoption and foster care services, child care subsidies for low income working families; licensing inspection and regulation of child care and foster care providers; developing and maintaining information systems for child care and child welfare operational needs; developing and maintaining program plan requirements related to federal funding for family and children services; managing and developing state administrative policies and rules for county administration of state funded ODJFS child welfare and adoption programs and services; supervising county practice performance and adherence to state and federal program mandates; and providing technical assistance and training to all 88 county agencies.

Child and Family Service Review (CFSR) – The CFSR was developed as the result of the 1994 Amendment to the Social Security Act which authorizes the federal Department of Health and Human Services (HHS) to review state and family service programs for compliance with state plan requirements in Titles IV-B and IV-E. The reviews are intended to help states improve child welfare service programs and outcomes for children and families who use those services. The CFSR process includes two components, a statewide assessment and an on-site review.

The CFSR assess each state's achievement of these goals as well as compliance with federal laws. The CFSR also examines how each state supports the delivery of effective child welfare services with training, computer systems, policy and practice changes, and the recruitment of foster parents. HHS may institute federal penalties should the state not meet the goals of its Program Improvement Plan (PIP) after findings of nonconformity. The CFSR process takes three to five years to complete. Variance is based on when site visits are scheduled, when the state receives the federal review findings, negation of data indicators, and development and implementation of the state's PIP.

Ohio successfully implemented its PIP in Round 1 and was not assessed any fines; however, if the state does not achieve Round Two goals, it is currently estimated that Ohio would lose more than \$9 million in federal IV-B and IV-E funds. Results from the on-site review are expected by the end of March 2009.

Statewide Automated Child Welfare Information System – ODJFS, in partnership with county PCSAs, operates the Statewide Automated Child Welfare Information System (SACWIS). SACWIS serves as a comprehensive case management system that assists county staff in managing their workloads by providing current and accurate data that assist in decision making and program modification. The system contains records regarding investigations into children and families, children's care in out-of-home placements, care and treatment provided to children and families, and other information that state or federal law requires to be maintained. SACWIS allows for access to case and client information for intake purposes, investigations and child-protective services statewide.

Children and Families Services (600523)

This GRF line item provides the state share for the Foster Parent Stipends Program and the federal Chaffee Education Training Vouchers, which allows ODJFS to reimburse foster care givers for attending and completing ODJFS-approved training courses; the State Operating Allocation, which provides state funds to supplement the Title XX funds a county receives; the State Child Protection Allocation, which is a general block grant to each PCSA to partially reimburse costs incurred by the PCSA in performing its duties; and to implement the Feisal Case Review recommendations. In FY 2008, the Foster Parent Stipends program awarded \$4.6 million to about 9,658 recipients. In that same year, \$1.8 million in Education Training Vouchers was awarded to 476 youth. The executive recommends funding of \$74.2 million for FY 2010 and FY 2011, a 7.7% increase over the FY 2009 adjusted appropriation.

Adoption Services (600528)

This GRF line item is used for the state adoption program, which provides maintenance payments to families who adopt children with special needs. Many of the children available for adoption are considered special needs because they are of an older age, part of a siblings group, or have physical, mental, or emotional health, and developmental delays. Some children labeled as special needs have behavioral and attachment disorders that can present financial challenges for adopting families. ODJFS provides maintenance payments and subsidies to help offset some of these costs. In FY 2008, about 70% of the children adopted through the child welfare system had special needs. The executive recommends funding of \$88.5 million for FY 2010 and FY 2011, a 2.3% decrease from the FY 2009 adjusted appropriation.

There are four types of state-funded adoption subsidies.

- The **Title IV-E Adoption Subsidy** is provided for children who meet TANF eligibility guidelines. The average IV-E adoption subsidy in FY 2008 was \$267.91 per child per month. This line item provides both the federal and nonfederal share of the IV-E adoption assistance payments to

the counties up to a maximum of \$300 per child per month; the earned federal reimbursement for this portion of the payment is deposited into the GRF. The counties are responsible for the nonfederal share of payments above \$300; the federal share for amounts over \$300 is paid from federally funded line item 600627, Adoption Maintenance/Administration. At the close of FY 2008, there were 21,762 recipients of the IV-E adoption subsidy.

- The **State Adoption Maintenance Subsidy** is currently limited to \$300 per child per month. At the close of FY 2008, there were 1,809 recipients of this adoption subsidy. In FY 2008, ODJFS paid out about \$6.5 million under this subsidy program.
- The **Non-Recurring Adoption Payment** provides reimbursement for out-of-pocket costs incurred by families that adopt special needs children. Such costs include attorney fees and court costs, medical evaluations, and travel. The state will reimburse up to \$2,000 per child adopted. The federal government reimburses about half of the costs for these payments. In FY 2008, ODJFS paid out about \$1.8 million (state and federal funds) under this subsidy program.
- The **Post Adoption Special Services Subsidy** provides reimbursement to PCSAs for some post adoption services needed by some special needs children. The maximum benefit amount is \$10,000 per child per year, but may be increased to \$15,000 in extraordinary circumstances. The child's adoptive parents are expected to share in the cost of services through a 5% copayment requirement. However, the PCSAs may waive the co-pay requirement if the gross annual income of the child's adoptive family is not more than 200% of the federal poverty guidelines. In FY 2008, there were over 900 recipients of this subsidy and ODJFS paid out about \$3.7 million for PASSS.

Adult Protective Services (600534)

This GRF line item is used to provide supplemental funding to county department of job and family services for the adult protective services, which are provided to the elderly who are in danger of harm and/or are unable to protect themselves. County departments of job and family services are required to investigate and evaluate all reports of suspected abuse, neglect, and exploitation of adults age 60 and over. Investigations of reports alleging abuse, neglect, and exploitation are mandated to be initiated within 24 hours, if any emergency exists, or within three working days after the report is received. Upon completion of the investigation, the county department must determine whether or not the person is in need of protective

services. Adults who experience abuse, neglect, or exploitation are offered supportive services for protection and self-sufficiency.

Social, medical, and mental health care professionals are mandated by law to immediately report suspected abuse, neglect (including self-neglect), or exploitation to the county department of job and family services. Other mandated reporters include attorneys, peace officers, senior service providers, coroners, clergymen and professional counselors. In FY 2008, there were 15,050 reports involving the abuse, neglect, and exploitation of individuals over the age of 60. The executive recommends \$522,040 for FY 2010, a 5% increase over the FY 2009 adjusted appropriation and \$511,453 for FY 2011, a 2% decrease from FY 2010.

Child Welfare (600606)

This federally funded line item provides the funding mechanism for the Federal Child Welfare Services Title IV-B, Parts 1 and 2, under Title IV of the Social Security Act. The Title IV-B, Part 1 grant allows states to claim child welfare administrative costs and child welfare program costs. The administrative costs claimed to the grant are capped at 10% of expenses. The balance of the grant award is distributed between ODJFS and PCSA for child welfare program related expenses. The Title IV-B, Part 2 grant permits states to claim expenditures for family preservation, support services, case worker visitation, and adoption promotion services at 75%. Funds from the Title IV-B, Part 2 grant are predominantly allocated to the PCSAs. The executive recommends \$34.0 million for FY 2010 and FY 2011, a 29.1% decrease from the FY 2009 adjusted appropriation. According to ODJFS, the appropriations are consistent with the cash value of the awarded grants.

Public Children Service Agency Activities and Oversight – PCSAs are required to receive reports of child abuse and neglect, and to investigate those reports in a timely manner. When necessary, the PCSA works with families to identify services and develop a case plan that reduces the risk of future abuse or neglect. In most cases, the PCSA provides services to the child and family while the child remains in the home. However, there are instances when the child cannot remain safely in the home and it becomes necessary for the PCSA to work with the local court system to remove the child from the situation. When the child is placed outside of the home, the PCSA must develop a plan detailing the activities that must occur to ensure that the child is able to return home safely. If that is not possible, the plan will identify an alternative safe, stable, permanent living situation that promotes the child's health, growth, and development. Alternative living arrangements include: kinship care, foster care, and adoption.

ODJFS has a systematic process for monitoring and oversight of the PCSAs compliance with state law and administrative rules. The monitoring and oversight process, called Child Protection Oversight and Evaluation (CPOE), occurs at least every 18 months for each PCSA and is conducted by ODJFS staff. Following an on-site review, ODJFS prepares a final report that is shared with the PCSA. The PCSA is then required to submit a quality improvement plan to ODJFS that will be implemented to correct findings of noncompliance.

The on-site review consists of data validation as well as identification of systemic, policy or practice areas of strength, weakness, and concern for each core indicator and development of strategies that affect positive improvement of the outcome indicators. Case records are reviewed for rule compliance, and quality improvement plans are prepared for areas needing improvement. Benchmarks based on national standards found in the Federal Child and Family Services Review (CFSR), are used to determine compliance.

Special Activities/Child and Family Services (600616)

This federally funded line item provides the funding mechanism for three federal grants used for children and adult welfare activities. The Children's Justice Act Grant funds the handling of child abuse and neglect cases, particularly investigation of cases of child sexual abuse and exploitation. The Child Abuse, Neglect, and Treatment Grant is used for creating and improving the use of multidisciplinary teams and interagency protocols to enhance investigations and improving legal preparation and representation, including procedures for appealing and responding to appeals of substantiated reports of abuse and neglect, and provisions for appointment of an individual to represent a child in judicial proceedings. The Adoption Incentive Grant is awarded to states that exceed the overall foster child adoption, older child adoption, or special needs adoption baselines. All activities allowable under Title IV-B and Title IV-E, including post adoption services, may be funded from this grant. The executive recommends \$3.1 million for FY 2010, a 45.5% decrease from the FY 2009 adjusted appropriation and \$2.8 million for FY 2011, a 9.6% decrease from FY 2010. According to ODJFS, the appropriations are consistent with the cash value of the awarded grants.

Social Services Block Grant (600620)

This federally funded line item is used to expend ODJFS's share of the federal Social Services Block Grant (SSBG). The SSBG is appropriated under Title XX of the Social Security Act. Three state departments share in the total grant received: ODJFS (72.50%), the Department of Mental Health (12.93%), and the Department of Mental Retardation and Developmental Disabilities (14.57%). The SSBG provides funds for administration, training, and direct services. The services are for adults and children and include: adoption, day care, adult day care, physical protection, homemaker

services, job training, counseling, and legal services. This line item also includes TANF funds transferred to the SSBG. The executive recommends funding of \$120.0 million for FY 2010 and FY 2011, a 4.8% increase over the FY 2009 adjusted appropriation.

By federal statute, the delivery of SSBG services must be directed toward 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; and to provide quality institutional care when other forms of care are insufficient.

To address these national goals, ODJFS established 28 service categories that are designed to provide flexibility in targeting the populations to be served. Some examples of the service definitions include adoption; family planning; employment services; prevention and intervention; home delivered meals; and legal services. All counties are required to provide these services. However, counties have broad discretion, flexibility, and autonomy in deciding what services will be offered in that county. Therefore, the amount, duration, and scope of services vary from county to county. Under current law, all counties are required to investigate allegations of abuse, neglect, and exploitation of persons age 60 and older.

Of the 401,694 individuals served through the SSBG in FY 2008, 88,941 (22.1%) were children. The majority of services (68%) were received in two areas; there were 233,749 (58.2%) recipients of information and referral services and 37,429 (9.3%) recipients of case management services.

Adoption Maintenance/Administration (600627)

This federally funded line item is used to pass federal funds through to the counties for the administrative costs of placing children in public or private institutions and family foster homes. Counties are reimbursed for 50% of allowable costs incurred on behalf of eligible children. Reimbursement is made quarterly to counties for their administrative and training expenses. This line item is also used to pass the federal share of Title IV-E adoption assistance payments over \$300 to the counties. This line item also provides Independent Living Grants to assist states and localities in establishing and carrying out programs designed to assist foster care children in making the transition from foster care to independent living. The executive recommends funding of \$346.6 million for FY 2010, a 9.2% increase over the FY 2009 adjusted appropriation and \$346.8 million for FY 2011, a 0.1% increase over FY 2010.

Adoption – ODJFS provides support to local agencies in their efforts to decrease the number of children waiting for permanent homes; to prevent discrimination in the placement of children; to identify and recruit permanent families who can meet each child's needs; and to provide support to families to ensure the stability and well-being

of children in their care. To assure permanency is maintained, ODJFS provides a variety of services to birth parents, adoptive parents and children, particularly those children who have been in foster care. These services are largely provided by PCSAs, private child placing agencies, and private noncustodial agencies in collaboration with ODJFS. ODJFS provides maintenance payments and subsidies to help offset associated costs. In addition, ODJFS maintains the Ohio Adoption Photo Listing web site which allows potential families to view pictures and profiles of children who are available for adoption over the Internet. In FY 2008, 1,693 children were adopted, of those 696 (41%) were adopted by foster parents. In addition, 153 sibling groups were adopted. According to ODJFS, the average length of time a child spends in foster care prior to being adopted is 31.6 months, which is below the national median of 32.4 months.

Independent Living Program – The county PCSAs are required to provide independent living services for youth 16 to 18 years old that are in substitute care. The goal of this program is to help these youth successfully transition into adulthood and become self-sufficient. Program services include life-skills development training, education and vocational training, preventative health activities, financial assistance, housing, employment services, self-esteem counseling, and assistance with developing positive relationships and support systems. Individuals 15 to 21 years old, who have been emancipated from substitute care, are also eligible to receive independent living services upon request. The PCSAs are also permitted to use a portion of their allocation to assist these individuals with rent and other costs. In FY 2008, over \$6.6 million was spent on the Independent Living Program which served 4,510 individuals, including 789 that were over the age of 18.

IV-E Foster Care Maintenance (600628)

This federally funded line item is used to issue monthly foster care payments to foster parents or institutions to support an out-of-home placement for a child. The executive recommends funding of \$169.3 million for FY 2010, a 10% increase over the FY 2009 adjusted appropriation and \$161.6 million for FY 2011 biennium, a 5% decrease from FY 2010. In FY 2008, placement costs were about \$336.0 million. Costs in excess of amounts provided from state and federal sources are paid by the county.

Foster Care

ODJFS develops rules and guidelines to aid counties in implementing programs for children who cannot safely remain in their own homes. Foster or substitute care for children is one of the major program components of Ohio's child welfare system and is provided through public and private agencies. The program's main purpose is to reunify children with their families and/or, find other permanent living arrangements when children cannot safely return home. Foster or substitute care includes kinship care, foster care, residential substitute care in group homes and treatment

facilities, independent living, and placement through the Interstate Compact for the Placement of Children.

When it is determined that a child must be removed from the home, and a court grants temporary custody of the child to the public children services agency, the caseworker attempts to find a placement with a suitable relative to help maintain familial bonds. When a suitable relative is not available, the worker attempts to find a placement with a suitable nonrelative with whom the child or family has a relationship. Suitable relatives and nonrelatives are either licensed by ODJFS or approved by the local public children services agency. If the agency is unable to place the child with a relative or a nonrelative who has a relationship with the family, the child is placed into a licensed foster care setting. Once a child enters foster care, the state must ensure that the child is safe and treated well through the duration of the placement. This is accomplished via the enforcement of provider licensing standards. As of June 30, 2008, foster children were placed in 9,658 licensed foster homes in Ohio, including 412 with adoptive placements. As of January 31, 2009, there were 13,097 children in foster care. In FY 2008, there were 85,262 reports of abuse and neglect for children in foster care.

Licensing Adoption and Substitute Care Providers – PCSAs and private network foster care agencies are responsible for making recommendations for licensing adoption and substitute care providers. The goal of licensing adoption and substitute care providers is to determine the fitness of those providing foster care, residential care, adoption, and independent living services. Placement settings such as foster homes, group homes, and residential centers are routinely monitored to assure compliance with ODJFS rules. When it is necessary, technical assistance is provided to improve compliance with regulations. Licenses may be revoked for noncompliance.

Kinship Care – This type of care refers to a temporary or permanent arrangement in which a relative or any nonrelative adult, who has a long-standing relationship or bond with the child and/or family, has taken over substitute care of a child. Kinship care includes those relationships established through an informal arrangement, legal custody or guardianship order, a relative foster care placement, or kinship adoption.

Kinship care represents the most desirable out-of-home placement option for children who cannot live with their parents. It offers the greatest level of stability by allowing children to maintain their sense of belonging and enhances their ability to identify with their family's culture and traditions. In FY 2008, 6,221 children were placed in certified or approved relative care.

The Kinship Permanency Incentive (KPI) program provides financial support for minor children in the legal and physical custody of grandparents, relatives, or nonrelative adults that have a long-standing relationship or bond with the child and/or family. The KPI program is designed to promote a permanent commitment by the

kinship caregiver through becoming guardians and custodians over minor children who would otherwise be unsafe or at risk of harm if the child remained in their own home.

The KPI program provides time-limited incentive payments to families caring for their kin. Eligible families receive an initial payment of \$1,000 per child to defray the costs of initial placement. Families may continue to receive payments of \$500 per child at six-month intervals to support the stability of the child's placement in the home. Families may receive up to a maximum of \$3,500. Families who assumed custody on or after July 1, 2005 are eligible for the KPI program. In FY 2008, the KPI program paid out \$6.1 million in incentive payments.

Interstate Compact for the Placement of Children – The Interstate Compact for the Placement of Children authorizes the placement of any child in Ohio from another state or placement of a child from Ohio in another state. Out-of-state and Ohio agencies must have placements approved before the child enters or leaves Ohio for placement with an adoptive family, in foster care, or in a group home or institutional setting. In FY 2008, 98 children were placed using this method.

Children's Trust Fund (600647 and 600648)

Line item 600647, Children's Trust Fund, provides the state funding mechanism for the expenditures related to the Ohio Children's Trust Fund (OCTF). The executive recommends \$5.9 million for FY 2010 and FY 2011, 13.4% decrease from the FY 2009 adjusted appropriation.

The OCTF was created in 1984 and is the state's primary funding agent for programs designed to prevent child abuse and neglect. The OCTF is governed by a 15 member board which consists of state agency administrators, gubernatorial appointees, and legislators. Board members are responsible for overall child abuse and neglect prevention policy, program direction, and monitoring expenditures from the Ohio Children's Trust Fund. The daily operations of OCTF are managed by the ODJFS Bureau of Prevention staff that review proposals, participate in grantee selection, monitor services and expenditures, and provide technical assistance and training to grantees.

Revenues are generated from fees collected on divorce and dissolution filings, and nominal surcharges for birth and death certificates. These funds are earmarked for each county through a formula based on the number of children living in each county. As required by state law, OCTF funding focuses exclusively on support for primary and secondary prevention activities. Primary prevention services available to the community are designed to prevent child abuse and neglect before they occur, and include advocacy efforts, public awareness campaigns, and training of professionals. Secondary prevention services include those services that target populations at risk for

child abuse and neglect, such as respite care for single parents, crisis intervention for families experiencing acute stress, parent education and support services, personal safety classes, and life skills training for youth. Specific local programs funded with OCTF dollars include Incredible Years, Strengthening Families, and Help Me Grow, among others. In FY 2008, OCTF allocated about \$3.8 million to counties for these services.

Federally funded line item 600648, Children Trust Fund Federal, provides Community Based Family Resource Program Grant dollars to support family resource centers. The goal of family resource centers (FRC) is to provide a continuum of prevention services that target at-risk populations. FRCs attempt to reach parents early and provide interventions that can positively influence long-term parent-child relationships. The centers can offer parent education and support, early development screening of children, parent mentoring, job readiness and counseling, and crisis intervention. The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$2.0 million for FY 2010 and FY 2011.

Child and Family Services Collections (600604)

This line item funds the Putative Father Registry. This registry is designed to allow a man who believes he has fathered a child to register his interests in the child. By registering, the father will be notified if his child is placed for adoption. This may decrease the possibility for adoption disruption. The Putative Father Registry receives in excess of 1,000 requests to search each year. In FY 2008, 98 men registered with the Registry. The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$300,000 for FY 2010 and FY 2011.

Foundation Grants/Child and Family Services (600609)

This line item is used to expend grants for families and children awarded to ODJFS by nonprofit private philanthropic foundations. The major expenditures funded by this line item include state-issued subgrants to counties and nonprofit private organizations. Currently this line item is being used to implement the Alternative Response Pilot Program. The executive recommends funding of \$250,000 for FY 2010 and FY 2011, a 67% decrease from the FY 2009 adjusted appropriation. In FY 2009, ODJFS had anticipated funding from this grant at \$750,000 per year, the actual amount awarded was \$250,000 with the remainder being given directly to the counties participating in the Alternate Response Pilot Program. The recommended appropriations in FY 2010 and FY 2011 reflect the amount of grant funding that ODJFS anticipates receiving in those years.

The Alternative Response Pilot Program began July 1, 2008 and will last 18 months using foundation funds from the Casey Family Programs Grant. This program tests a broader set of responses to possible cases of child abuse or neglect. Under the pilot program, if a child's safety is not in question, case workers can use early intervention and prevention strategies with families to address issues pertaining to child welfare and safety and improve access to other supportive services. The pilot program will include a 15 month evaluation period that runs concurrently with the program. This program is meant to improve Ohio's response to reports of child abuse and neglect.

ODJFS anticipates that over the course of the pilot program 15,000 cases will be assigned to the program. Of these, half will receive alternative response services, while the other half will serve as a control and receive services under current protocols. Ten counties are participating in the pilot program: Clark, Fairfield, Franklin, Greene, Guernsey, Licking, Lucas, Ross, Trumbull, and Tuscarawas. Once the pilot program ends, Casey Family Programs, the entity providing the grant, intends to work with independent program evaluators to determine best practices. If the independent evaluation recommends statewide implementation, a provision in the executive recommendation requires ODJFS to seek a statutory framework for the alternative response approach.

Adoption Assistance Loan (600634)

This line item is the funding mechanism for providing loans for the financial needs of prospective adoptive parents. Prospective adoptive parents with an approved home study may apply for the loan. A prospective parent can receive no more than \$3,000 if the child being adopted resides in Ohio and no more than \$2,000 if the child resides in another state. This loan program has not yet begun as ODJFS has not yet determined the eligibility and repayment requirements. The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$500,000 for FY 2010 and FY 2011.

Children and Family Support (600663)

This line item funds the state portion of the Ohio Child Welfare Training Program (OCWTP) for county personnel and child welfare related administrative expenses. OCWTP provides a comprehensive annual calendar of in-service child welfare training. Most of this training is mandated by law and ODJFS administrative rule. OCWTP's training and operations budget is funded through a 5% hold-back imposed on Title IV-E administrative payments that are made to juvenile courts that have agreements with ODJFS. OCWTP also provides tuition assistance to students using a 2.5% hold-back imposed by ODJFS on Title IV-E administrative payments that are made to county child welfare agencies in addition to federal funding that the hold-

back revenue draws, in part, as matching money. In FY 2008, OCWTP provided \$355,000 in financial assistance to 67 students. The executive recommends funding of \$4.7 million for FY 2010 and FY 2011, a 4.2% decrease from the FY 2009 adjusted appropriation.

Child Support

OVERVIEW

Program Overview

- Funding of \$485.1 million for FY 2010 and \$484.7 million for FY 2011
- \$2.0 billion in child support collected and disbursed

Title IV-D of the Social Security Act of 1975 designates the Ohio Department of Job and Family Services (ODJFS) as the state's Child Support Enforcement Agency. The Act requires ODJFS to be responsible for supervising local entities in the establishment and enforcement of support obligations owed by noncustodial parents. Within ODJFS, the Office of Child Support (OCS) has the responsibility for providing program direction, overseeing local activity, and administering statewide contracts for some services (i.e., genetic testing). The local support enforcement agency has the responsibility for the direct administration and provision of services to all individuals in need of child support services, including location of an absent parent, paternity and support establishment, support collection, and enforcement of financial and medical obligations. There are over one million child support cases statewide. In federal fiscal year (FFY) 2008, Ohio collected and disbursed almost \$2.0 billion in child support. Of the amount collected, approximately \$1.53 billion (76.7%) was current support obligations; approximately \$417.6 million was collected toward arrears.

The objective of the Child Support Enforcement Program is to ensure children in Ohio receive the child support to which they are entitled from a noncustodial parent. The program is a cooperative venture between the federal, state, and county governments with the federal government paying 66.0% of the costs to operate the program. The program is administered locally by the 88 county child support enforcement agencies providing services to the residents of that county, as well as any other counties and states over which the county court may have jurisdiction.

For this category of appropriation, the executive recommends \$485.1 million for FY 2010 and \$484.7 million for FY 2011. The recommended appropriation will generally allow OCS to maintain operations at the FY 2009 level.

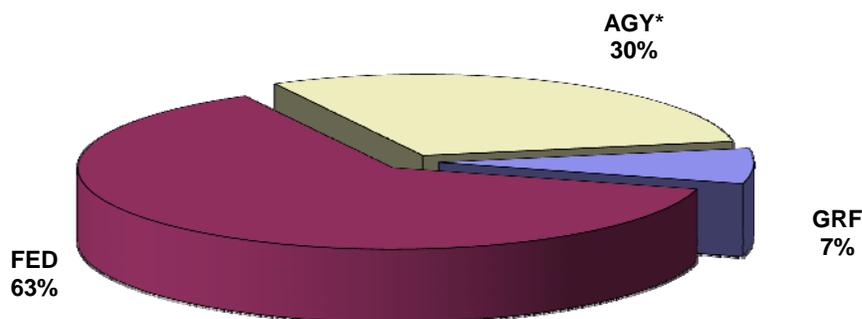
Appropriation Overview

The state IV-D Child Support Program is funded through a mix of state and federal funds. Federal reimbursement is available for IV-D allowable state and county administrative expenditures. In order for a case to be considered an IV-D case, a custodial parent must either receive federal assistance or fill out an IV-D application; there are no other eligibility requirements. Around 96% of child support enforcement agency (CSEA) cases are considered IV-D and thus eligible for federal reimbursement. The federal share is referred to as federal financial participation (FFP). The FFP

reimbursement rate is 66.0%; so for every state dollar spent on IV-D allowable expenditures, the federal government reimburses the state \$.66.

Federal reimbursement dollars are allocated to the state for operation and administration expenses associated with the Child Support Enforcement Program. The state then passes a portion of these funds, the federal share of county administrative expenditures, on to the counties as part of each county's GRF administrative advance. The remaining funding for the Child Support category comes from state appropriated general revenue and agency funds. The state and county GRF earn federal reimbursement, a portion of which is allocated to the county CSEAs. Chart 1 shows the recommended appropriations for the Child Support category by fund group for the FY 2010-FY 2011 biennium.

Chart 1: Office of Child Support Recommended Appropriations for the FY 2010-FY 2011 Biennium by Fund Group



* The Agency Fund generally consists of federal and state intercept dollars.

The executive recommends funding of \$485.1 million for FY 2010, a \$371,575 increase over the FY 2009 adjusted appropriation and \$484.7 million for FY 2011, a \$368,584 decrease from FY 2010. Table 1 shows the executive budget recommendations for OCS by fund group for the FY 2010-FY 2011 biennium when compared to the FY 2009 adjusted appropriations.

Table 1. Child Support Budget Recommendations by Fund Group					
Fund Group	FY 2009*	FY 2010	% Change	FY 2011	% Change
General Revenue	\$34,671,986	\$32,751,542	-5.5%	\$32,381,598	-1.1%
Federal Special Revenue	\$304,073,012	\$306,365,031	0.8%	\$306,366,391	0.0%
Agency	\$146,000,000	\$146,000,000	0.0%	\$146,000,000	0.0%
TOTAL	\$484,744,998	\$485,116,573	0.1%	\$484,747,989	-0.1%

*FY 2009 figures represent adjusted appropriations.

Child Support Activities

The responsibility for implementation of the Child Support Program is shared by federal, state, and local agencies, each with clearly defined roles. The federal government provides program funding; sets program standards, policy, and regulations; evaluates and audits the state/local programs; and provides technical assistance and training to states. In Ohio, ODJFS is the designated IV-D agency and within ODJFS, the OCS has the primary responsibility for the Child Support Program. Each county in Ohio is required to establish a child support enforcement agency (CSEA). Thus, responsibility for the child support program in Ohio is shared by the state and each of Ohio's 88 counties.

CSEAs assist in the location of absent parents using several different databases including the New Hire Reporting Center, which fulfills state and federal law requirements of employers to report all newly hired and rehired employees to ODJFS within 20 days of the date of hire. The New Hire Reporting Center speeds up the child support income withholding order process; expedites collection of child, spousal, and medical support from parents who change jobs frequently; and locates noncustodial parents so that paternity orders can be established.

Front-line child support professionals use the Support Enforcement Tracking System (SETS) for a variety of purposes including: to initiate and maintain cases; locate absent parents; establish paternity and support; adjust support obligations; collect, allocate, and disburse support payments; and increase inter-county access to data through a single statewide database. CSEAs also enforce obligations owed by absent parents and disburse support obligations. The Financial Institution Data Match (FIDM) is used to identify accounts belonging to noncustodial parents who are delinquent in their child support payments and, if necessary, freeze and seize the accounts of the delinquent obligor.

ANALYSIS OF EXECUTIVE PROPOSAL

Introduction

This section provides an analysis of the Governor's recommended funding for each appropriation item in the Child Support category. In this analysis, a table is provided listing the recommended appropriation in each fiscal year of the biennium. Following the table, a narrative describes how the appropriation is used and any changes affecting the appropriation that are proposed by the Governor. Table 2 shows the executive's recommended appropriation for each line item in the Child Support category.

Table 2. Governor's Recommended Amounts for Child Support				
Fund	ALI and Name		FY 2010	FY 2011
General Revenue Fund				
GRF	600420	Child Support Administration	\$7,369,234	\$7,431,310
GRF	600502	Administration – Local	\$25,382,308	\$24,950,288
General Revenue Fund Subtotal			\$32,751,542	\$32,381,598
Federal Special Revenue Fund Group				
3970	600626	Child Support	\$305,830,981	\$305,832,341
3S50	600622	Child Support Projects	\$534,050	\$534,050
Federal Special Revenue Fund Group Subtotal			\$306,365,031	\$306,366,391
Agency Fund Group				
1920	600646	Support Intercept – Federal	\$130,000,000	\$130,000,000
5830	600642	Support Intercept – State	\$16,000,000	\$16,000,000
Agency Fund Group Subtotal			\$146,000,000	\$146,000,000
Total Funding: Child Support			\$485,116,573	\$484,747,989

Child Support Enforcement (600420, 600502, and 600626)

This group of line items provides the main sources of funding for the Child Support Enforcement Program. GRF line item 600420, Child Support Administration, provides the state share of administrative expenditures; GRF line item 600502, Administration – Local, is used to provide funds to the counties for operating expenses; and federal line item 600626, Child Support, provides the federal share of all county and state administrative expenditures.

The state operates the automated child support computer system, processes payments at a single centralized site, maintains a registry of all child support cases in the state (State Case Registry) and maintains a database of all newly hired employees in the state (New Hire Directory). GRF line item 600420, Child Support Administration,

provides the state share of administrative expenditures. This line item supports operating expenses of ODJFS's Office of Child Support. Expenditures from this line item earn federal reimbursement at a rate of 66.0%. The executive recommends funding of \$7.37 million for FY 2010, a 4.6% decrease from the FY 2009 adjusted appropriation and \$7.43 million for FY 2011, a 0.8% increase over FY 2010.

GRF line item 600502, Administration – Local, is used to provide funds to counties for operating expenses of the county child support enforcement agencies (CSEAs). This line item also provides a portion of the nonfederal share of county child support administrative expenditures for non-IV-D cases. The executive recommends \$25.4 million for FY 2010, a decrease of 5.8% from the FY 2009 adjusted appropriation and \$24.9 million for FY 2011, a 1.7% decrease from FY 2010.

Federally funded line item 600626, Child Support, provides the federal share of all county and state child support administrative expenditures. The three major components of this line item are County Administration, which provides funding for the CSEAs monthly based on current expenditures and county estimates; State Administration, which includes personal services, purchased personal services, maintenance, equipment, and the federal share of the Support Enforcement Tracking System (SETS); and the federal child support incentive dollars. In addition, the FFP reimbursement is deposited into the Child Support Fund (Fund 3970) and appropriated through this line item. The executive recommends funding of \$305.8 million for FY 2010 and FY 2011, a 0.8% increase over the FY 2009 adjusted appropriation.

Child support activities include: locating absent parents; establishing paternity; obtaining child, spousal, and medical support; enforcing obligations owed by the absent parent; and disbursement of support obligations.

Location of Absent Parents

The Child Support Enforcement Program can help find the whereabouts of the noncustodial parent, their employer, or other sources of their income and assets so that the county CSEA may take the next step to secure or enforce a child support order. The county CSEAs use database information from the Bureau of Motor Vehicles, the Bureau of Employment Services, the Internal Revenue Service, the Social Security Administration, and the New Hire Reporting Center to aid in the location of noncustodial parents.

New Hire Reporting

The Ohio New Hire Employer Directory fulfills the federal requirement established in the Personal Responsibility and Work Reconciliation Act of 1996 for employers to report new hires and rehires to a state directory. State and federal law requires employers to report all newly hired and rehired employees to ODJFS within 20 days of the date of hire. The reports are made to Policy Studies Inc. with whom ODJFS

contracts for collection of this information. The information is kept for 12 months and is used for location purposes and identification of employment resources for nonresidential parents who may be delinquent on their child support payments. In FY 2008, the database processed over 2.6 million records from approximately 29,348 Ohio employers and processes an average of 51,069 employer records each week. In FY 2008, ODJFS paid Policy Studies Inc., \$788,799 for their services related to new hire reporting.

Paternity and Support Establishment

The Personal Responsibility and Work Reconciliation Act of 1996 requires each state to develop a methodology for establishment of paternity and support obligations. These are the first two steps in collecting child support. The state's portion of federal incentive dollars is based on performance measures related to paternity and support order establishment. The Child Support Enforcement Program assists the counties in meeting these performance measure goals through contracts and interagency agreements.

In Ohio, licensed contractors provide DNA testing for establishment of paternity. ODJFS contracts with several vendors so that all 88 counties have access to genetic testing procedures. Statewide contracts allow the state to negotiate a lower price per test. By utilizing the statewide contracts, the county CSEAs do not need to go through the process of securing individual vendors. For a paternity order to be established, it can be court determined, an Acknowledgement of Paternity Affidavit can be signed, or the genetic test results must show at least a 99% probability of fatherhood. Once paternity is established, the county CSEAs proceed with support establishment and enforcement of support collections. In FY 2008, ODJFS processed 59,752 Acknowledgement of Paternity Affidavits, 4,610 court determinations of paternity, and completed 27,563 genetic tests.

In January 1998, the Office of Child Support (OCS) created the Central Paternity Registry (CPR). The purpose of the CPR is to collect and process all paternity documents initiated by the county CSEAs, hospitals, vital statistics registrars, and courts. The CPR extracts specific data elements from each source and within a few days the information is made available to the CSEAs to allow them to move quickly in establishing support. During FY 2008, the registry processed 60,535 paternity-related documents.

ODJFS contracts with Policy Studies Inc. for CPR's operation and maintenance. This vendor is also responsible for collecting the documents, continuing training, and monitoring hospital compliance. The current contract with Policy Studies Inc. ends on June 30, 2009. A request for proposal for CPR services was released on February 10, 2009 for future services.

The Ohio Department of Health (ODH), pursuant to an interagency agreement with ODJFS, processes all paternity paperwork that comes through the CPR. Processing the paperwork requires ODH to coordinate with the vendor and involves comparing all paternity documentation with the child's birth record and updating the birth record, if necessary. ODH is responsible for permanently housing the original documents and assuring the paternity affidavits correspond to the child's birth record.

Medical Support

State and federal laws require the inclusion of health care coverage in child support orders when coverage is available and reasonable, or expected to become available. Health insurance coverage is considered available and reasonable if either parent, through the parent's employer or other group health insurance plan, can obtain it. Health insurance includes fee-for-service, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other types of coverage that could provide medical services to the child. Other group coverage may include, but is not limited to, retirement, disability, or union plans. The county CSEA is responsible for establishing and enforcing health insurance orders.

When medical support is first ordered, the county CSEA is required to send a National Medical Support Notice (NMSN) to the employer of the medical insurance obligor when new or changed employment occurs. The employer must then send the NMSN to the health plan administrator within 20 business days, unless the employer does not provide insurance. The health plan administrator will enroll children 20 business days after receiving the NMSN, unless there is a waiting period or there is more than one health insurance plan option. In those cases, enrollment takes place when the waiting period ends or when the plan option is selected. The CSEA must also obtain proof of insurance and report that information periodically to ODJFS, through the Office of Ohio Health Plans.

The Office of Ohio Health Plans must determine if there have been lapses in health care coverage for Medicaid recipients. The objective of the program is to increase the number of children with health care coverage who are in child support families where health care coverage has been ordered. Medical support can also include orders to pay cash medical support. These orders are treated as cash obligations and are enforced using income or bank account withholding, tax intercept, and other methods used in the enforcement of any cash obligation. The executive recommendation includes a provision that requires health insurance providers, including the Office of Ohio Health Plans, to send information to OCS identifying policy holders and policy information upon request. OCS could experience cost savings as a result of this provision as it will allow access to already collected information. In FFY 2008, Ohio reported a total of 436,444 medical support orders. Of those, 230,471 (53%) were enforced using the NMSN and cash obligation enforcement techniques.

Enforcement and Collection

The child and medical support enforcement and collection services assist the county CSEAs in locating absent obligors, enforcing orders, and collecting child support, medical support, and other monetary obligations from individuals who owe support. The role of ODJFS is to provide the county CSEAs with resources to assist individual's owed support to obtain that support. The OCS maintains statewide contracts for new hire reporting, financial institution data match (FIDM), paternity registry, and genetic testing.

The Personal Responsibility and Work Reconciliation Act of 1996 requires ODJFS to establish and operate a State Disbursement Unit for centralized collection and disbursement of child support payments. The State Disbursement Unit in Ohio, Child Support Payment Central (CSPC), processes over \$2 billion in payments annually. CSPC services are provided through a contract with Affiliated Computer Services, which was awarded through the request for proposal process in 2002. The current contract is renewable through June 2009. In addition to CSPC, ODJFS operates the Payment Analysis and Reconciliation Bureau to handle the state's responsibilities not covered by the CSPC contract including handling payment and disbursement exceptions and financial oversight and reconciliation of the master account.

During FY 2008, ODJFS contracted with G.C. Services to provide collection assistance to the CSEAs for the most difficult to collect cases (those with arrears only). The 2008 contract allowed the vendor to work on a contingency basis and receive 9.98 cents for each dollar collected. During FY 2008, the vendor worked on 2,079 cases. The contract provided for a maximum of 100,000 cases that could be referred to G.C. Services. In FY 2008, G.C. Services collected approximately \$4 million in child support and was paid \$402,085 for its services. Due to executive ordered budget reductions, this contract was not extended to FY 2009. Counties may contract at the local level for these services as well. Stark and Summit counties have local contracts with National Child Support Inc. for collection assistance. These contracts are paid at the local level using county and federal funds.

Driver's License Suspension and Passport Denial

Pursuant to sections 3123.41 through 3123.63 of the Revised Code, upon a finding that an individual is in default of a child support order or has failed to comply with a subpoena or warrant issued by a CSEA or a court regarding the enforcement of a child support order, the CSEA may initiate the suspension or stop the issuance of the obligor's license (professional or driver's) by an Ohio license issuing agency. In FY 2008, 49,924 driver's licenses were suspended. ODJFS does not track suspension of professional licenses.

States submit child support cases with past due amounts to the federal Office for Child Support Enforcement. If the past due amount owed exceeds \$2,500, the federal office automatically forwards the case to the U.S. State Department for passport denial. In FY 2008, there were 318 lump-sum collections associated with passport denial, totaling \$1,067,743.

Disbursement

In addition to paper checks, Ohio provides electronic disbursement of child support payments through direct deposit and e-QuickPay, which allows child support recipients to access payments through a Debit Master Card. The e-QuickPay cards have the Master Card logo on them and can be used anywhere Master Card is accepted and can be used at any bank or ATM to withdraw cash. There is no service fee if the card is used at a point of sale or to withdraw cash at a bank teller window. There is a \$.75 transaction fee to withdraw cash at an ATM, plus any service fee charged by that ATM, however; Fifth Third, PNC Bank, and Alliance One have all agreed to waive the surcharge for e-QuickPay transactions. There is a \$.40 transaction fee for a balance inquiry.

ODJFS began mandatory enrollment of all new orders and conversion of existing cases to a form of electronic disbursement in December 2005. Conversion of existing cases was completed in July 2006. At the end of FY 2008, approximately 85% of all child support payments were being disbursed electronically through e-QuickPay, Ohio's electronic child support disbursement system. Currently, there are 263,975 participants enrolled in direct deposit and 934,754 participants enrolled in e-QuickPay. Through December 2008, the OCS has seen a cost savings of about \$10.2 million due to electronic disbursement of child support.

Support Enforcement Tracking System

The Family Support Act of 1988 mandated that each state develop an automated system to manage child support enforcement by October 1, 1995. In Ohio, the automated system is called the Support Enforcement Tracking System (SETS). The system aids in the location of absent parents and in the establishment and enforcement of child support cases. Funding for SETS is 66% federal funds with a 34% state match. SETS is designed to aid front-line child support professionals in a number of tasks including initiating and maintaining cases; locating absent parents; establishing paternity and support; adjusting support obligations; collecting, allocating, and disbursing support payments; and increasing inter-county access to data through a single statewide database. SETS supports over one million cases representing over four million individuals, and processes and disburses over \$1.9 billion in child support payments annually. On average, SETS processes in excess of 1.7 million transactions per day; it is one of the largest statewide child support systems in the nation.

Financial Institution Data Match

The Personal Responsibility and Work Reconciliation Act of 1996 established the FIDM in order to increase collection of delinquent child support, maintain the integrity and security of financial institution and child support data, and make use of technology to aid in the collection of child support. The FIDM is used to identify accounts belonging to noncustodial parents who are delinquent in their child support payments and, if necessary, freeze and seize the accounts of the delinquent obligor.

There are two segments to the FIDM Program: the multi-state (MS) FIDM and the single state (SS) FIDM. Banks, savings and loans, federal and state credit unions, benefit associations, insurance companies, safe deposit companies, money market, mutual funds, and similar institutions have the option to participate in the multi-state program or participate on a state-by-state basis. The MSFIDM, established in 1999, is operated and funded through the federal Office of Child Support Enforcement (OCSE). The SSFIDM, established in 2002, includes those institutions doing business in only one state and those multi-state institutions that do not participate in the MSFIDM Program. FIDM collections follow OCSE distribution guidelines, meaning that payments apply to assigned current support before arrears. In FY 2008, 6,506 cases had an MSFIDM payment allocated to case arrears and approximately \$7.3 million was collected toward delinquent child support. In that same year, 3,626 cases had an SSFIDM payment allocated to case arrears and approximately \$2.6 million was collected toward delinquent child support.

Executive Recommendations

The executive recommendation includes provisions that affect child support enforcement administration procedures. These provisions require the Director of ODJFS to adopt rules for the compromise and waiver of child support arrearages owed to the state and federal governments, consistent with the federal Title IV-D guidelines, and requires employers with more than 50 employees to send child support payments electronically. There may be some initial costs associated with the adoption of rules regarding the compromise and waiver of owed child support arrearages, however; ODJFS expects this to result in overall administrative savings, as it will reduce the amount of permanently assigned arrears. The electronic income withholding is also likely to result in administrative savings for ODJFS.

Child Support Projects (600622)

This line item uses federal grant dollars to provide funding for the Access/Visitation Program. The program supports and facilitates the nonresidential parents' access to, and visitation of, their children to encourage the payment of child support obligations. These services include mediation centering on access and visitation, parenting education classes, and the development of visitation enforcement

orders. CSEAs apply for these funds from OCS. Funding for this program is provided exclusively through federal grant dollars. In FY 2008, there were 515 child participants in the program. During that year, the program served 278 fathers, 305 mothers, 21 grandparents, and 52 legal guardians. The executive recommends flat funding at the FY 2009 level of \$534,050 for FY 2010 and FY 2011.

Support Intercept (600646 and 600642)

The Support Intercept – Federal Fund (Fund 1920) and the Support Intercept – State Fund (Fund 5830), which fund these two line items, are used to collect overdue child support payments from federal and state personal income tax returns. ODJFS partners with the Internal Revenue Service (IRS) and the Department of Taxation as part of a tax off-set program for obligors who owe arrearages. Through this program, the county CSEAs are able to submit the names of obligors who owe arrearages, and the obligor's tax returns are offset and forwarded to ODJFS. Upon receipt, the collections are disbursed to CSPC for processing and distributed to the obligee. The IRS retains a processing fee from the collections forwarded to ODJFS.

In FY 2008, Agency Fund Group line item 600646, Support Intercept – Federal, provided \$124.6 million collected through the federal tax off-set program. The executive recommends flat funding at the FY 2009 level of \$130.0 million for FY 2010 and FY 2011. In that same year, Agency Fund Group line item 600642, Support Intercept – State, provided \$14.5 million collected through the state tax off-set program. The executive recommends flat funding at the FY 2009 level of \$16.0 million for FY 2010 and FY 2011.

REQUESTS NOT FUNDED

This section describes ODJFS's request for the Child Support Program that was not funded in the executive budget. Table 3 shows the amount of the appropriation requested by ODJFS and the executive recommendation.

Table 3. Child Support						
Fund Line Item	FY 2010 Recommended	FY 2010 Requested	Difference	FY 2011 Recommended	FY 2011 Requested	Difference
GRF 600502	\$25,382,308	\$30,603,693	(\$5,221,385)	\$24,950,288	\$30,603,693	(\$5,653,405)

ODJFS had requested additional funds to compensate for no longer having the authority to use federal incentive dollars as match to draw down federal reimbursement. The economic stimulus bill has temporarily reinstated this authority from October 1, 2008 through September 30, 2010 and is expected to provide a portion of the unfunded request. There will be approximately nine months of FY 2011 where ODJFS will be unable to use federal incentive dollars to draw down federal financial participation, which will ultimately result in a loss of federal funding through reimbursement.

Workforce Development

- WIA funding increases 30% over the biennium
- Rapid Response will focus on transitioning dislocated workers

OVERVIEW

Program Overview

Workforce Development is a partnership between the Ohio Department of Job and Family Services (ODJFS), the Department of Development (DOD), Board of Regents (BOR), the Governor's Office, U.S. Department of Labor (DOL), local workforce investment boards, and a variety of stakeholders, including business partners that seek to promote job creation and to advance Ohio's workforce. The Office of Workforce Development in ODJFS works with the various partners, distributes federal grant dollars to local workforce investment areas, provides administration and operational management for several federal programs, and offers specific services in support of the programs.

The main source of funding for Workforce Development comes from DOL pursuant to the Workforce Investment Act of 1998 (WIA). WIA repealed the Job Training Partnership Act and replaced it with a locally based employment and training service delivery system for youth, adults, and dislocated workers with an emphasis on flexibility in the use of program dollars. These three categories designate the three funding streams of WIA. Each year, Congress establishes an appropriation for Workforce Investment Act Youth, Adult, and Dislocated Worker programs. Based on the latest available data from the Census Bureau for disadvantaged youth and adults, the federal government allocates funds to each state for the program year that begins the following July 1. Upon receiving the allotment notice, states then suballocate funds to local workforce investment areas in accordance with federally prescribed allocation procedures.

For the Youth, Adult, and Dislocated Worker programs, ODJFS retains 15% of the total allotment of each program for statewide use. The dollars retained for statewide use are often called the Governor's discretionary funds. States have considerable flexibility in how these dollars may be used; no more than one-third may be used for administrative costs. For the Dislocated Worker Program, ODJFS may retain an additional 25% for Rapid Response, which allows ODJFS to provide additional assistance to local areas experiencing workforce-related events that create substantial increases in the number of unemployed individuals.

Provisions of WIA promote individual responsibility and personal choice through the use of Individual Training Accounts that allow adult customers to "purchase" the training that best fits their needs. Adults and dislocated workers may access, depending on an eligibility assessment of their needs, employment and training activities that fall into three categories: core, intensive, and training services. Youth activities under WIA attempt to move away from one-time, short-term interventions to a systematic approach that offers youth a broad range of coordinated services that may be provided in combination or alone. Such offerings for youth include opportunities for assistance in both academic and occupational learning, developing leadership skills, and preparing for further education, additional training, and eventual employment.

WIA is business focused as well. Business is seen to be a critical partner in the development and design of service delivery systems with strong ties to economic development. WIA requires that business representatives comprise the majority of the membership of state workforce investment boards, providing leadership and information to ensure that the service delivery system prepares people for current and future jobs.

In Ohio, the Office of Workforce Development (OWD) administers WIA. OW D has three main goals in its implementation of WIA. These are: (1) to create a vertically integrated workforce investment system with all elements coordinated and complementary, (2) to promote Ohio's economic competitiveness by improving employment opportunities, fostering job retention, and increasing earnings of all Ohio workers, and (3) to build a workforce development system that prompts all stakeholders to agree that "it works for me."

OWD develops and administers programs and services designed to support and enhance state and local workforce development initiatives that address the needs of workers, families, and employers throughout Ohio. OW D provides services that seek to assist Ohioans to remove barriers, enter employment, maintain employment, and gain self-sufficiency and independence. OW D also provides programs to assist Ohio's businesses with recruitment of skilled workers, technical assistance with identification of funds, and resources for skills training for new and incumbent workers; it also provides federally and state-required training programs and other support services tailored to meet specific business needs.

Core to WIA is the One-Stop approach to service delivery. In fact, WIA mandates that states and localities develop One-Stop delivery systems for service integration and elimination of duplicative efforts. In Ohio, funding is allocated to 20 workforce investment boards for the establishment of One-Stops and the delivery of training services. These systems are mandated to serve communities by functioning as the primary public resource for job and career counseling, training, job searching,

employment services, and a range of other ancillary services that include child care and transportation.

There are currently 31 comprehensive, full-service One-Stops with 59 affiliate sites. There is a Level 1 or 2 site in every county. Either site can be housed in any number of facilities such as the county department of job and family services, the county workforce development agency, a community college, a community action organization, a joint vocational school, or a stand-alone One-Stop.

Level 2 One-Stops are the full-service, comprehensive, integrated employment and training sites required by WIA. This includes full partner participation in resources (services and staff), which includes core and intensive services and may also include training services. All Level 2 partners are required to participate in cost-sharing of operational costs. These resources and cost-sharing are captured in an area-wide memorandum of understanding (MOU) between the chief local elected officials, the workforce investment board, the One-Stop operator, and the partners. Level 2 sites in Ohio have a fully functional resource room, training rooms, computer labs, updated technology, job search/upgrade resource materials, meeting/interview rooms, and other employment-related amenities. A number of Level 2 sites also include a youth resource room.

Level 1 One-Stops must be affiliated within each One-Stop system with a Level 2 site. In many One-Stop systems there are multiple Level 1 sites associated with a Level 2 site. The minimum (Ohio) requirement for a Level 1 site is the participation of three or more distinct partners providing, at a minimum, core services. These partners also enter into an MOU outlining resource and cost-sharing commitments. All Level 1 sites must have a fully functional resource room. Many of the Level 1 sites provide far more than the minimum services and commitments noted above. Both Level 1 and Level 2 sites must have Americans with Disabilities Act access and accessible technology.

Appropriation Overview

For the Workforce Development category, the executive recommends \$379.7 million for FY 2010, an increase of \$70.4 million (22.8%) over the FY 2009 adjusted appropriation, and \$380.8 million for FY 2011, an increase of \$1.1 million (0.3%) over FY 2010.

Table 1 below shows the Workforce Development budget by fund group for FY 2009 and the executive budget recommendations for FY 2010 and FY 2011. Over 99% of the biennial budget for Workforce Development comes from the Federal Special Revenue Fund Group and less than 1% comes from the State Special Revenue Fund Group and General Services Fund Group.

The largest appropriation for Workforce Development is in federally funded line item 600688, Workforce Investment Act, which is funded at \$326.9 million for FY 2010,

an increase of \$76.1 million (30.3%) over the FY 2009 adjusted appropriation, and \$327.1 million for FY 2011, an increase of \$222,492 (0.1%) over FY 2010. This single line item accounts for 86.1% of the budget for Workforce Development.

Fund Group	FY 2009 (adjusted)	FY 2010 (recommended)	% Change	FY 2011 (recommended)	% Change
General Services	\$135,000	\$110,000	-18.5%	\$110,000	0.0%
State Special Revenue	\$2,000,000	\$2,000,000	0.0%	\$2,000,000	0.0%
Federal Special Revenue	\$307,125,066	\$377,578,220	22.9%	\$378,715,528	0.3%
TOTAL	\$309,260,066	\$379,688,220	22.8%	\$380,825,528	0.3%

American Recovery and Reinvestment Act

The American Recovery and Reinvestment Act of 2009 (ARRA), the federal stimulus act, contains several provisions that impact workforce development and other employment services. The Act increases funding for several labor grants, including WIA. In addition to funding for the adult, dislocated worker, and youth, the Act includes funding for national emergency grants, which provide income and support services that enable individuals in high unemployment or high-poverty areas to participate in job training. The Act also contains funding for worker training and job placement in high growth and emerging industry sectors, with a portion reserved to prepare workers for efficiency and renewable energy careers and for preparation of workers in the health sector. States will also receive additional funding under the Wagner-Peyser Act for re-employment and job-matching assistance. A portion of those dollars are designated for re-employment service grants to provide customized re-employment services to unemployment insurance claimants. Those dollars may also be used to improve the integrated information technology required to identify and serve the needs of unemployment insurance claimants. The additional funds will be allocated to states based on three factors: the number of individuals in the labor force, rates of unemployment, and the relative share of long-term unemployed individuals.

According to recently released allotment figures from DOL, Ohio is expected to receive \$56.2 million for the Youth Program, \$23.4 million for the Adult Program, and \$58.5 million for the Dislocated Worker Program. According to ODJFS, these funds are expected to be disbursed to states in April 2009. The Office of Workforce Development is currently awaiting guidance from DOL to distribute funding and implement provisions in the Act.

FY 2008-FY 2009 Highlights

One-Stop Continuous Improvement Program

In January 2008, Ohio implemented the One-Stop System Certification and Quality Assurance Initiative, named the "Gold Standard" Continuous Improvement Program. The program is designed to examine the quality assurance and continuous improvement efforts within the state's full-service One-Stops. The program provides a consistent standard for Ohio's local workforce investment areas to measure the quality and delivery of business and job-seeker services, accessibility of services, and the effectiveness of One-Stop management. The goal of the quality assurance process is to encourage continuous improvement as a regular activity of the One-Stop system and to certify each system.

OWD manages the program and, in coordination with state and local stakeholders, developed 12 benchmarks of excellence for One-Stop system quality assurance and certification. The benchmarks are captured within three categories: business services, job-seeker services, and One-Stop management. Continuous improvement and achievement results are captured using a scorecard and provided periodically to the local workforce investment boards.

Transitioned and Consolidated Workforce Development Programs

On March 27, 2008, the Governor signed Executive Order 2008-05S that realigned the state's workforce development activities. The realignment is meant to allow agencies with workforce development programs to better serve the workforce needs of their primary customers and maximize the benefits of their area of expertise.

Effective July 1, 2008, the Governor reallocated the responsibilities of ODJFS, ODOD, and BOR. ODJFS coordinates services that assist individuals seeking employment, ODOD serves businesses looking for qualified employees, and BOR oversees activities related to skill development and job training.

In 2008, ODJFS transferred 28 employees to ODOD's Division of Workforce and Talent. The Division of Workforce and Talent administers customized training programs for employers. ODJFS transfers WIA dollars to ODOD to administer employer-related workforce development programs.

ODJFS's Office of Workforce Development will continue to administer services and training for job seekers through the One-Stops. ODJFS will also continue to administer the Apprenticeship Program in cooperation with the Ohio State Apprenticeship Council, maintain the Ohio Means Jobs web site, in partnership with ODOD and BOR, which identifies and provides job seekers with electronic access to job opportunities from all of the major commercial job boards, specialized industries, national and Ohio Fortune 100 companies, and the state of Ohio, and continue to

administer programs for job seekers, including the Migrant Seasonal Farm Worker, the Work Opportunity Tax Credit, and Foreign Labor Certification programs.

Rapid Response Program Reform

ODJFS commissioned a study by the National Employment Law Project (NELP) to evaluate the current status and effectiveness of Ohio's Rapid Response service delivery system and to provide recommendations for improvement. NELP evaluated Ohio's Rapid Response system in August 2008, and issued a report in late September 2008. Upon release of NELP's plan, ODJFS created an internal team, which included a representative from ODOD, to review and develop a strategy and implementation plan related to the NELP study. ODJFS's implementation plan addressed the recommendations outlined in the NELP study. The internal team identified three strategic activities to achieve success in reforming the Rapid Response Program. The three key activities identified by the team were internal and external communications, training, and policy implications.

The first strategic activity involves communications. Internally, the team suggested open dialogue with local partners and providers who play a major role in delivering Rapid Response services. The team also identified ways to maintain ongoing communication with stakeholders beyond the July 1, 2009, implementation date of the reform plan.

The second strategic activity is training. Successful implementation of the Rapid Response process is dependent upon a solid training plan. The strategy for implementing an in-house curriculum for training is scheduled for March 2009, and creating a certified training curriculum by May 15, 2009.

Policy implications were identified as the third strategy. The internal team identified the following policies, guidance, and procedures for development:

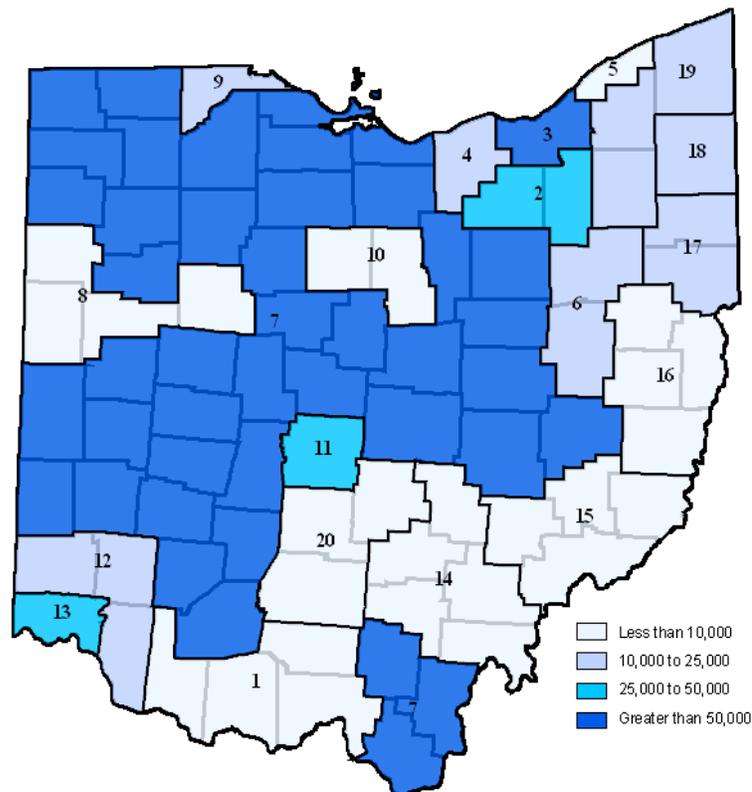
- Rapid Response reporting requirements (including co-enrollment);
- Roles and responsibilities of the local area rapid response coordinators;
- Rapid Response procedures;
- Allowable use of Rapid Response funds;
- Application procedures/requirements for accessing Rapid Response funds;
- Sequence of services – from Rapid Response to formula-funded programs; and
- Required Rapid Response services.

In addition to the policies listed above, the internal team recommended that an evaluation of existing waiver policy be conducted in order to ensure the effectiveness of transferring funds between the Adult and Dislocated Worker programs and using Rapid Response funds for incumbent worker training. ODJFS anticipates fully implementing the strategies outlined by the internal team on July 1, 2009, and is currently finalizing the reform plan.

FACTS AND FIGURES

Participation in Employment Services

Chart 1: Number of Participants who Received Employment Services in FY 2008 by Workforce Investment Area



Source: Ohio Department of Job and Family Services

- In FY 2008, about 487,000 individuals participated in Ohio's Workforce Development Program through the One-Stop system that is governed by 20 workforce investment boards. The system, which includes 31 full-service and 59 satellite workforce development One-Stop sites, provides services such as training referrals, job listings, employment search assistance and referral, and career counseling and brings employers and individual job seekers together in one place.
- Ohio's One-Stop system is funded with federal Workforce Investment Act and Wagner-Peyser dollars. In FY 2008, Ohio had a total of \$267 million available from these two sources. Of the total, an estimated \$179 million was spent in FY 2008. Remaining funds are available for use in FY 2009.

ANALYSIS OF EXECUTIVE PROPOSAL

Workforce Development

This section provides an analysis of the Governor's recommended funding for each appropriation item in the Workforce Development category. Table 2 shows the line items included in this category and the recommended amounts. Following the table, a narrative describes how the appropriation for each line item is used and any changes affecting the appropriation that are proposed by the Governor.

Table 2. Governor's Recommended Amounts for Workforce Development				
Fund	ALI and Name		FY 2010	FY 2011
General Services Fund Group				
6130	600645	Training Activities	\$110,000	\$110,000
General Revenue Fund Subtotal			\$110,000	\$110,000
Federal Special Revenue Fund Group				
3310	600686	Federal Operating	\$50,655,096	\$51,569,912
3V00	600688	Workforce Investment Act	\$326,923,124	\$327,145,616
Federal Special Revenue Fund Group Subtotal			\$377,578,220	\$378,715,528
State Special Revenue Fund Group				
5DB0	600637	Military Injury Grants	\$2,000,000	\$2,000,000
State Special Revenue Fund Group Subtotal			\$2,000,000	\$2,000,000
Total Funding: Workforce Development			\$379,688,220	\$380,825,528

Training Activities (600645)

This line item pays the costs for the Apprenticeship Council Conference each year. Funding for this line item comes from conference registration fees. The executive recommends \$110,000 in FY 2010 and FY 2011, an 18.5% decrease from the FY 2009 adjusted appropriation.

The Ohio Apprenticeship Program provides on-the-job training and related instruction for qualified applicants seeking employment in skilled occupations. The program holds an annual conference that promotes awareness in apprenticeships. The conference includes a multitude of workshops and speakers.

Federal Operating (600686)

This federally funded line item is used primarily to fund the operations of the Office of Workforce Development, as well as the Office of Unemployment Compensation and the Office of Local Operations. Revenue to support this line item comes from Wagner-Peyser Act allocations to states through the U.S. Department of Labor. The executive recommends \$50.7 million for FY 2010, a 10% decrease from the

FY 2009 adjusted appropriation, and \$51.6 million for FY 2011, a 1.8% increase over FY 2010. At the recommended level, main services for covered programs will be provided. This line item funds the administrative functions of the following programs.

Labor Exchange Services

As part of the One-Stop system, the Labor Exchange Services Program provides services to both job seekers and employers. Office of Workforce Development employees provide policy guidance and performance management measures while ODJFS Office of Local Operations employees provide services statewide that include job search assistance, referral and placement assistance to job seekers, re-employment services to unemployment insurance claimants, and recruitment services to employers with employment opportunities. In federal fiscal year (FFY) 2007, the latest data available, more than one million individuals registered with the Labor Exchange Program. More than 460,000 received staff-assisted services, 130,690 received referrals to employment opportunities, and more than 176,000 obtained employment within 90 days of receiving Labor Exchange services.

Migrant Seasonal Farm Workers Program

The Migrant Seasonal Farm Workers Program insures that workers receive appropriate information regarding employment, such as career guidance, housing, job development and referral, and training as needed. In addition, the program ensures housing for these workers meet standards set by the Occupational Safety and Health Administration (OSHA), and agricultural growers receive the information and support to locate and employ the seasonal workers they need. In FFY 2007, more than 2,400 farm workers registered for employment; more than 2,300 were referred to and placed in employment.

Foreign Labor Certification Program

The Foreign Labor Certification Program insures that foreign workers who enter the United States on a temporary or permanent basis do not adversely affect the job opportunities, wages, and working conditions of naturalized workers. Through this program, the Office of Workforce Development oversees the process employers utilize when seeking foreign workers on a temporary or permanent basis. Foreign Labor Certification employees work with employers to identify naturalized citizens who are qualified, willing, and able to fill job vacancies. In FFY 2007, the Foreign Labor Certification unit processed 340 foreign labor certification applications and provided 3,144 prevailing wage determinations (the average wage paid to similarly employed workers in an occupation with similar functions) to employers.

Work Opportunity Tax Credit Program

The Work Opportunity Tax Credit Program encourages employers to hire from nine target groups of disadvantaged individuals. The groups are:

- TANF recipients;
- Veterans;
- Ex-felons;
- Individuals between the ages of 18 and 40 years old who are residents of one of the federally designated Empowerment Zone, Enterprise Communities or Renewal Communities, or a Rural Renewal County;
- Vocational rehabilitation consumers;
- Summer youth employees;
- Social Security Income recipients; and
- Individuals who are a member of a family that received TANF or benefits under a successor program for at least 18 consecutive months.

Employers that hire such individuals receive federal tax credits that range from \$1,200 to \$2,400 for most groups. Employers may receive up to \$9,000 for each new, long-term family assistance recipient hired during a two-year period. Primary activities for this program involve marketing the tax credit to employers and processing certifications for the tax credit for employers. In FFY 2007, the Office Workforce Development processed more than 70,000 applications from about 1,600 employers. The certified tax credits reduced Ohio employers' federal income tax liability by more than \$103.5 million and more than 33,000 job seekers with barriers to employment received assistance in finding job opportunities.

Labor Market Information

The Labor Market Information Program collects, analyzes, publishes, and disseminates information about Ohio's industry, labor force, and economy. The program focuses on serving business initiatives and planning needs to support workforce and economic development activities and decisions. Delivery of this information is primarily via the Internet. Program staff also provide data support and administrative reports and assist in federal reporting activities for the Unemployment Compensation program. The Office prepares reports on employment levels, unemployment levels, wages and earnings, employment outlook by industry and occupation, and other economic and industry-specific data.

Services to Veterans

The Local Veterans Employment Representatives (LVER) Program ensures veterans receive a range of workforce and employment services needed to meet their employment and training needs. Program staff advocate on behalf of veterans for

employment and training; establish, maintain, and facilitate regular contact with employers to develop employment and training activities for veterans; provide and facilitate employment and training services for veterans in the workforce development system; and assist transitioning military personnel to civilian jobs through Ohio Transitional Assistance Program workshops. They also report Ohio's compliance with state directives on services to veterans and progress toward meeting Ohio's performance standards on a quarterly basis.

The Disabled Veterans Outreach Program Specialist (DVOPS) Program provides intensive services to veterans that may include job-search coaching, vocational counseling, and specialized one-on-one job development assistance to meet veterans' needs. DVOPS services target veterans who are economically or educationally disadvantaged, including homeless veterans and veterans with barriers to employment. In FFY 2007, 1,240 veterans received intensive services.

There are an estimated 28,000 unemployed disabled, combat, and other eligible veterans seeking employment at any given time. Nearly 90% (25,200) of those veterans registered to use Ohio's public labor exchange system. In FFY 2007, 1,240 veterans received 3,287 intensive services.

Workforce Investment Act (600688)

This federally funded line item is used to distribute WIA dollars to local workforce investment boards to administer the Youth, Adult, and Dislocated Worker activities through local One-Stops. ODJFS retains a portion of these dollars for statewide use, Rapid Response, and administration. In FY 2008, WIA funds provided services through the One-Stop system to 40,000 adults, 20,000 dislocated workers, and 30,000 youth. The Rapid Response unit responded to 132 layoffs in FY 2008. In FY 2009, Rapid Response funding is focused on transitioning dislocated workers.

The executive recommends \$326.9 million in FY 2010, a 30.3% increase over the FY 2009 adjusted appropriation, and \$327.1 million in FY 2011, a 0.1% increase over FY 2010. The amount of WIA dollars a state receives can vary each year since state allotments are based on several factors, including the state's unemployment rate. According to ODJFS, the majority of funding for Rapid Response in the FY 2010-FY 2011 biennium will continue to be focused on transitioning dislocated workers to new employment.

Military Injury Grants (600637)

This line item is used to provide military injury grants. In order to be eligible, an individual must have been injured while serving on active duty during Operation Enduring Freedom (Afghanistan) or Operation Iraqi Freedom or have been diagnosed with post traumatic stress disorder after having served in those operations. The injury must have occurred while the individual was receiving hazardous duty, combat, or

hostile fire pay. Applicants are eligible for one grant per fiscal year. The grant program was created by H.B. 66 of the 126th General Assembly. In FY 2008, 303 grants totaling \$151,500 were awarded. ODJFS increased the military injury relief grant amount from \$500 in FY 2008 to \$750 in FY 2009. During the first five months of FY 2009, ODJFS awarded 273 grants totaling \$204,750. Funding for this grant program is supported by donations made through the state income tax refund contributions system. Since its creation in FY 2006, the fund has received about \$500,000 each year. At the beginning of FY 2009, the fund balance was \$1.5 million. The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$2 million in FY 2010 and FY 2011. At the recommended level, ODJFS will be able to provide about 2,600 grants to veterans at the current rate of \$750 per grant.

Unemployment Compensation

- Trust Fund depleted in January 2009, Ohio now borrowing against federal line of credit
- Federal stimulus provides that interest on borrowing due in 2010 and 2011 are considered "paid"

OVERVIEW

Program Overview

Unemployment insurance was created as a federal and state partnership for income maintenance during periods of involuntary unemployment, by providing partial compensation for lost wages to eligible individuals. Such compensation provides support to local economies in times of economic downturn. Benefits are paid through the Unemployment Compensation Trust Fund, which is funded through state insurance taxes that are paid by employers and collected by the Ohio Department of Job and Family Services (ODJFS). Funds for administration of the Unemployment Insurance Program are provided by the U.S. Department of Labor (DOL) from revenues collected from employers by the Internal Revenue Service pursuant to the Federal Unemployment Tax Act (FUTA).

State law classifies employers into one of two categories – a "reimbursing" employer or a "contributory" employer. Reimbursing employers generally include most public employers and nonprofit organizations that have elected to be reimbursing employers instead of contributory employers. Reimbursing employers are billed once a month, after the fact, for the amount of benefits paid to the employer's former employees from the Unemployment Compensation Trust Fund. Contributory employers pay four times a year. Most private employers are contributory employers. Thus, if a contributory employer has a lay off, payment of the unemployment compensation benefit is paid from the employer's account in the Trust Fund. When the system is operating normally, each employer should have sufficient funds in the employer's account to cover any charges against the employer. As the balance in an employer's account goes down, the future rate of contributions for the employer will increase to replenish those losses.

Depending on an employer's "experience" of unemployment claims paid from the employer's account, the state tax rate ranges from 0.7% to 9.4%, paid on the first \$9,000 of each employee's taxable wage. For new employers, the rate is set at 2.7%, until the employer's account has been chargeable with benefits for four consecutive calendar quarters ending June 30; after that, the employer is eligible for an experience rate. Construction industry employers pay a different and higher rate than other employers.

In 2009, employers that are eligible for an experience rate also pay an additional 0.4% called a mutualized rate. This rate is being charged to restore the mutualized account to a positive balance. This account is separate from employer accounts in the Trust Fund and maintained for the primary purpose of recovering the costs of unemployment benefits that were paid and not chargeable to individual employers for a variety of reasons.

There is also what is called the minimum safe level (MSL) tax. When the Trust Fund balance reaches a certain low point, employers who qualify for an experience rate must also pay the MSL tax. Ohio employers are currently paying between 0.2% and 2.5% for this tax.

Each employer also pays the federal unemployment tax rate of 0.8% on the first \$7,000 of each employee's taxable wage, known as the FUTA tax. The actual federal tax rate is 6.2%; however, employers in states that have an unemployment program that is approved by DOL, receive a 5.4% credit on the federal rate. Approval requires state adherence to strict federal law requirements and DOL regulations. The 5.4% tax credit is also affected by a state's borrowing from the federal government to pay benefits. After two years of borrowing, a state will begin to lose percentages of the tax credit each year until borrowing stops and the state's trust fund returns to solvency.

The Office of Unemployment Compensation (OUC) within ODJFS administers the Unemployment Insurance Program. The functions of OUC include:

- Payment of unemployment compensation benefit claims;
- Collection of state unemployment taxes;
- Development of policies and procedures;
- Review of current state and federal policies and procedures;
- Support of the Unemployment Compensation Advisory Council;
- Administration of the Trade Adjustment Program;
- Facilitation of training opportunities for trade-affected workers; and
- Provision of job search and relocation activities.

The Trade Adjustment Program supports activities related to the Trade Act of 2002. The program is designed to help workers affected by increased imports from, or shifts in production to, foreign countries. Depending on their situation, workers can receive trade readjustment allowances, training, re-employment services, job search allowances, relocation allowances, a health coverage tax credit, and alternative trade adjustment assistance services.

OUC is organized into three bureaus.

- The **Tax Bureau** is responsible for collecting unemployment taxes, as well as wage information from all Ohio employers on a quarterly basis.

- The **Benefits Bureau** provides oversight and support services for the claims adjudication and benefit control processes, including issuance of monetary determinations for special claims, issuance of decisions on reconsideration of appeals of monetary and nonmonetary determination, and provision of technical assistance to local offices relative to policy, procedure, and state and federal law. This bureau is also responsible for the automated benefits delivery system.
- The **Program Services Bureau** is responsible for research, legislation, and policy in support of the Unemployment Compensation Advisory Council and represents the Director of Job and Family Services before the Unemployment Compensation Review Commission (UCRC). This bureau is responsible for a number of special unemployment tax and benefit determinations in cases involving employer unemployment tax appeals or benefit eligibility during labor disputes.

Appropriation Overview

For the Unemployment Compensation category, the executive recommends \$188.6 million in FY 2010, an increase of \$17.7 million (10.4%) over the FY 2009 adjusted appropriation, and \$181.4 million in FY 2011, a decrease of \$7.2 million (3.8%) from FY 2010. Unemployment compensation benefits are paid from Ohio's Unemployment Compensation Trust Fund; appropriation is not needed to pay benefits. Appropriation for this program category is for the sole purpose of administration of the program.

Table 1 below shows the Unemployment Compensation budget by fund group for FY 2009 and the executive budget recommendations for FY 2010 and FY 2011. Almost 81% of the biennial budget for Unemployment Compensation comes from the Federal Special Revenue Fund Group and about 19% comes from the State Special Revenue Fund Group.

The largest single appropriation for Unemployment Compensation is federally funded line item 600678, Federal Unemployment Programs, which is funded at \$154.9 million for FY 2010 and \$137.0 million for FY 2011. This line item accounts for about 79% of the total budget for this program category over the biennium.

Fund Group	FY 2009 (adjusted)	FY 2010 (recommended)	% Change	FY 2011 (recommended)	% Change
State Special Revenue	\$14,800,000	\$30,192,048	104.5%	\$40,903,549	35.5%
Federal Special Revenue	\$156,035,273	\$158,370,615	1.5%	\$140,470,001	-11.9%
TOTAL	\$170,835,273	\$188,562,663	10.4%	\$181,373,550	-3.8%

Federal Stimulus

Extension of Unemployment Benefits

The American Recovery and Reinvestment Act of 2009 (ARRA) included several provisions that related to the Unemployment Insurance Program. In July 2008, Congress passed the Supplemental Appropriations Act that extended federal unemployment compensation benefits an additional 13 weeks through March 31, 2009 for eligible claimants who exhausted the 26-week state benefits. In November 2008, Congress passed the Unemployment Compensation Extension Act that allowed eligible claimants through August 27, 2009 to receive an additional seven weeks of unemployment benefits in addition to the 13-week extension in the Supplemental Appropriations Act, and then another 13 weeks for states with a high unemployment rate. (Ohio is a rate with what is considered "high" unemployment.) These provisions bring the total number of weeks for which unemployment benefits are available to 59. The ARRA extends the Supplemental Appropriations Act extension (the first 13 weeks of federal benefits) scheduled to expire on March 31, 2009 to December 31, 2009 and the Unemployment Compensation Act (the additional 7 and then 13 weeks) extension scheduled to expire on August 27, 2009 to May 31, 2010.

Under current Ohio law, when the Insured Unemployment Rate (IUR) reaches 5%, state extended benefits are available for an additional 13 weeks, beyond the 59 weeks described above, for a total of 72 weeks. Ordinarily, state extended benefits are funded 50/50 by the state and federal government. However, the federal stimulus package offers 100% federal funding of state extended benefits through December 31, 2009. According to ODJFS, Ohio is projected to reach 5% IUR by May 2009; however, ODJFS has not projected how much the state will save due to ARRA.

Unemployment Insurance Modernization

ARRA will also provide incentive payments to states that agree to amend their unemployment compensation laws to provide more generous base-period calculations and adopt less restrictive grounds for disqualification based on availability of an applicants' search for work. The ARRA provides one-third of the incentive payment contingent on a state adopting a more generous base period. According to ODJFS, Ohio meets the base period determination under current law and will likely receive about \$88.2 million.

To qualify for the remaining two-thirds of the distribution, ARRA requires states to meet two provisions. The first is to allow unemployed individuals who worked part-time to be eligible for unemployed benefits and allow those individuals to seek part-time employment. According to ODJFS, Ohio would have to modify existing law to meet the part-time eligibility provision. The second provision is to increase the allowance to unemployment benefit claimants who have dependents to at least \$15 per

dependent for each week of eligibility. Ohio would qualify for this provision if the average of all claimants with dependents is considered. However, every claimant in Ohio with dependents does not receive at least \$15 for each eligible dependent. According to ODJFS, Ohio may have to modify existing law to meet this provision if DOL does not accept the average calculation. If Ohio meets these requirements, the state will receive \$176.3 million.

Unemployment Compensation Trust Fund Solvency

Unemployment benefits are funded by a tax on employers in Ohio. ODJFS collects the tax and deposits the revenue into a clearing account which is then transferred to a federal bank account (the Unemployment Compensation Trust Fund) and made available to Ohio for the payment of benefits. From FY 1997 through FY 2000, trust fund revenues exceeded expenditures every year; as a result, the fund balance increased \$434.6 million. Since then, trust fund expenditures have exceeded revenues consistently, leading to the significant decrease in the fund balance. Between FY 2000 and FY 2008, manufacturing employment declined by approximately 250,000, accounting for 24% of the total employment loss during this period. Heavy job losses in the manufacturing sector have contributed to Ohio's growing unemployment rates.

The Unemployment Compensation Trust Fund balance decreased 81.8% from its peak of \$2.35 billion at the end of FY 2000 to \$427.6 million at the end of FY 2008. If necessary, states may request a line of credit from the federal government to cover benefit payments. On January 12, 2009, Ohio's Trust Fund balance was depleted and ODJFS began borrowing against its federally approved line of credit. As of March 5, 2009, Ohio has borrowed about \$394.7 million; lines of credit have been approved in March (\$225 million) and April (\$50 million). The April and May amounts reflect the fact that at that time, ODJFS will begin to receive first quarter tax receipts and will not need to borrow as much. Pay back of the principal on the moneys borrowed will come from Ohio's Trust Fund once a balance has been restored. Interest must be paid from state revenue sources.

The federal stimulus includes a provision that interest that is due on borrowings on September 30th of 2009 and 2010 is considered to be paid in full (essentially a waiver of accrued interest). On October 1, 2010, interest will begin to accrue on any remaining principal and future borrowings. If the principal is not paid by October 1, 2010, Ohio's first interest payment will be due September 30, 2011.

The Unemployment Compensation Advisory Council, the governing body that recommends changes in unemployment law, was asked to provide a solution to rebuilding the state Unemployment Compensation Trust Fund balance. The Council could not agree on solid recommendations and is currently waiting for its new legislative appointees to resume discussions on ways to rebuild the Trust Fund balance.

Unemployment Compensation Advisory Council

The executive budget proposal removes current and future Unemployment Compensation Advisory Council members from the Public Employees Retirement System (PERS) on and after the effective date of the bill. The General Assembly's intention is not to prohibit council members from using service on the Council for calculating benefits under PERS law for service prior to the provision's effective date. The budget proposal specifies that the \$50 per day each Council member currently receives is to be considered a "meeting stipend."

The budget proposal also removes the requirement that the Director of Job and Family Services receive approval from the Unemployment Compensation Advisory Council in order to use the Unemployment Compensation Special Administrative Fund (UCSAF) for any of the following reasons: (1) the proper administration of the Unemployment Compensation Law (UCL) and either (a) no federal funds are available for the specific purpose for which the expenditure is to be made, under specified conditions, or (b) for which purpose appropriations from federal funds have been requested and approved but not received, provided the fund would be reimbursed upon receipt of the federal appropriation, (2) to the extent possible, the repayment to the Unemployment Compensation Administration Fund of moneys found by the proper U.S. agency to have been lost or expended for purposes other than, or an amount in excess of, those found necessary by the agency for UCL administration.

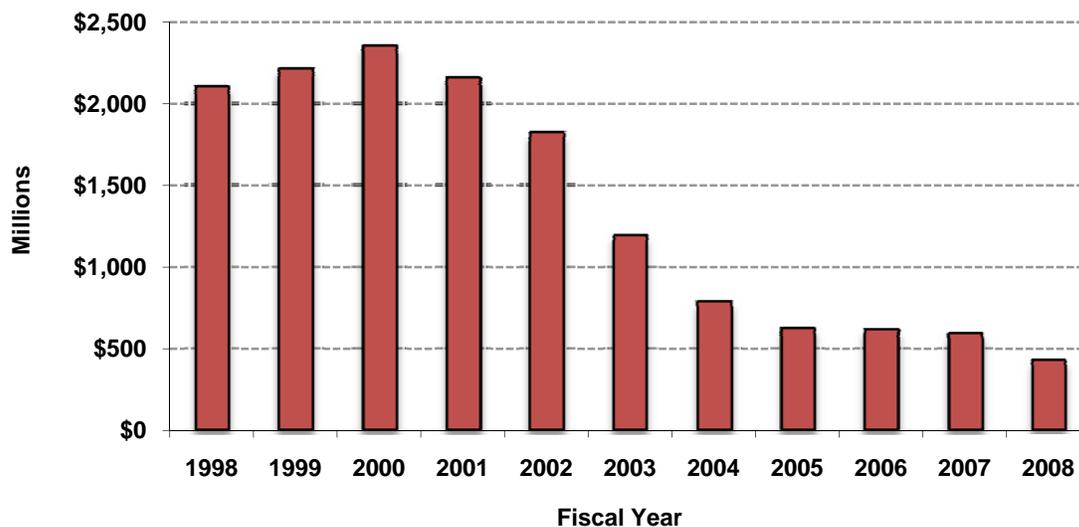
The budget proposal also allows the Director of Job and Family Services, rather than the Council under current law, to determine whether amounts in the UCSAF are considered to be excessive in order to have the excessive amounts transferred into the Unemployment Compensation Fund and removes the requirement that UCSAF funds be continuously available to the Council for expenditures consistent with the UCL, but retains the requirement that those funds be continuously available to the Director.

FACTS AND FIGURES

Unemployment Compensation Trust Fund Balance

The Unemployment Compensation Trust Fund receives revenue from state unemployment taxes collected by ODJFS. Chart 1 below shows the balance in the trust fund from FY 1998 to FY 2008. The Fund balance decreased 81.8% from its peak of \$2.35 billion at the end of FY 2000 to \$427.6 million at the end of FY 2008. From FY 1998 through FY 2000, revenues exceeded expenditures; as a result, the fund balance grew to \$434.6 million. Since then, trust fund expenditures have exceeded revenues consistently, leading to the significant decrease in the fund balance. In January 2009, Ohio's Trust Fund balance was depleted and ODJFS began borrowing against its federally approved line of credit to pay benefits.

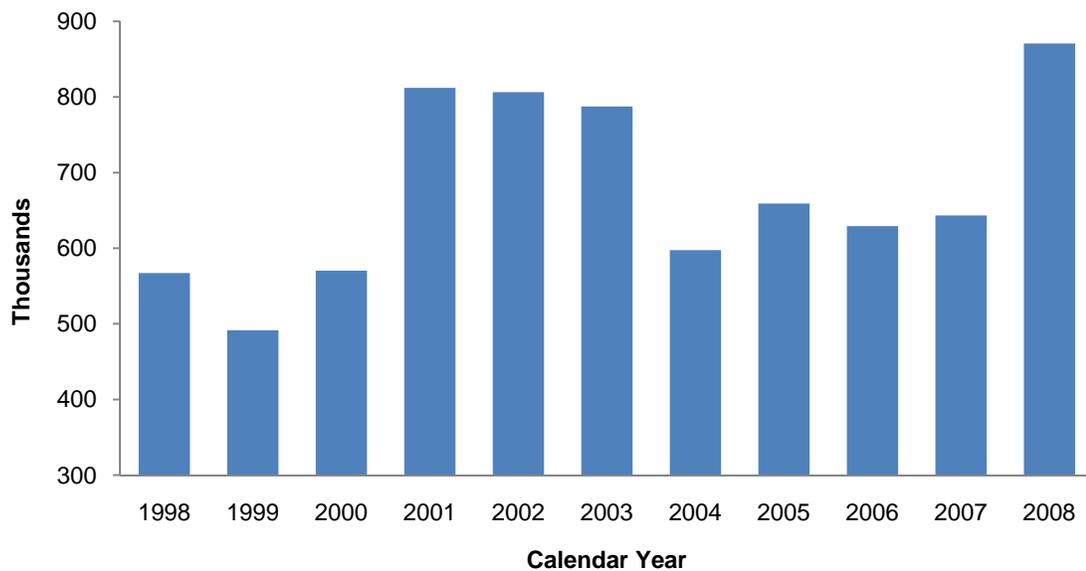
Chart 1: Trust Fund Balance from FY 1997 to FY 2008



Initial Unemployment Claims Filed

Chart 2 below shows the number of initial claims received each calendar year from 1998 to 2008. Heavy job losses and the economic downturn have contributed to increasing rates of unemployment in Ohio. Individuals who lose their jobs, through no fault of their own, may apply for unemployment compensation benefits. From 2000 to 2001, initial claims increased by 42.4% (241,692), the highest percentage during this period. From 2003 to 2004, claims decreased by 24.1% (189,942). More recently, in 2008, the number of claims rose to 227,397, an increase of 35.3% over 2007.

Chart 2: Initial Claims from 1998 to 2008



ANALYSIS OF EXECUTIVE PROPOSAL

Unemployment Compensation

This category of appropriations includes the major sources of funding the Office of Unemployment Compensation (OUC) receives to administer the Unemployment Compensation Program. Table 2 shows the line items included in this category and the recommended amounts.

Table 2. Governor's Recommended Amounts for Unemployment Compensation				
Fund	ALI and Name		FY 2010	FY 2011
Federal Special Revenue Fund Group				
3V40	600678	Federal Unemployment Programs	\$154,883,142	\$136,982,528
3V40	600679	Unemployment Compensation Review Commission – Federal	\$3,487,473	\$3,487,473
Federal Special Revenue Fund Group Subtotal			\$158,370,615	\$140,470,001
State Special Revenue Fund Group				
4A90	600607	Unemployment Compensation Administration Fund	\$27,134,851	\$37,772,416
4A90	600694	Unemployment Compensation Review Commission	\$2,357,197	\$2,431,133
4R30	600687	Banking Fees	\$700,000	\$700,000
Federal Special Revenue Fund Group Subtotal			\$30,192,048	\$40,903,549
Total Funding: Unemployment Compensation			\$188,562,663	\$181,373,550

Federal Unemployment Programs (600678)

This federal line item is used to support the functions of the OUC, Office of Workforce Development, and the Office of Local Operations to administer federal unemployment programs. Funding for this line item is provided by the federal government in the form of grants for administration of unemployment services, including federal unemployment taxes paid by employers to the Internal Revenue Service pursuant to FUTA, as well as a Trade Adjustment Assistance grant and a Disaster Unemployment Assistance grant.

OUC administers the Unemployment Compensation Program, which includes processing claims for unemployment benefits and Trade Act programs that provide benefit payments and services to individuals who have been dislocated due to the relocation of their employer or laid off due to foreign competition. In FY 2007, OUC processed 802,000 unemployment claims, collected more than \$1 billion in tax contributions from nearly 229,000 employers, and processed more than 24 million wage records from employers. Depending on their situation, workers may receive trade

readjustment allowances, training, re-employment services, job search allowances, relocation allowances, a health care coverage tax credit, and alternative trade adjustment assistance services. Each program has its own eligibility criteria and compensation arrangement.

The OUC office is responsible for collecting the state unemployment tax for ODJFS. In addition, the Office of Local Operations maintains six call centers and 16 processing centers throughout the state to process unemployment claims. The executive recommends \$154.9 million in FY 2010, a 1.3% increase over the FY 2009 adjusted appropriation, and \$137.0 in FY 2011, an 11.6% decrease from FY 2011. At the recommended level, OUC will be able to maintain its current UI operations.

The budget proposal includes a provision that allows any unspent funds in this line item from FY 2009 to be reappropriated in FY 2010 and any unspent funds in FY 2010 may be reappropriated in FY 2011. The funds must be used for administrative activities for the Unemployment Compensation Program, employment services, or any other allowable expenditure under section 903(d) of the Social Security Act. The provision limits the reappropriation to the balance of federal funds remaining after benefits are paid and obligated administrative expenditures are deducted. According to ODJFS, this provision would allow ODJFS to carry forward approximately \$9.96 million for the Employer Resource Information Center, ODJFS's web-based employer unemployment compensation tax system currently being developed to replace the Employment Security Tax Accounting System.

Unemployment Compensation Review Commission (600694 and 600679)

These line items fund the payroll costs for the Unemployment Compensation Review Commission (UCRC). The commission conducts reviews for applicants who wish to appeal a benefit determination. In FY 2007, UCRC received 26,373 appeals. Of that number, UCRC issued 23,337 dispositions.

For federally funded line item 600679, Unemployment Compensation Review Commission – Federal, the executive recommends \$3.5 million in FY 2010 and FY 2011, a 9.3% increase over the FY 2009 adjusted appropriation. Funding for this line item comes from DOL from revenues collected from employers by the IRS pursuant to FUTA.

For line item 600694, Unemployment Compensation Review Commission, the executive recommends \$2.36 million in FY 2010, a 30.2% increase over the FY 2009 appropriated level, and \$2.43 million in FY 2011, a 3.1% increase over FY 2010. Funding for this line item comes from the interest collected on delinquent employer contributions to the Unemployment Compensation Trust Fund plus all fines and forfeitures assessed on employers.

Unemployment Compensation Administration Fund (600607)

This line item is used to fund operations related to unemployment services for which federal funds are not available. Funding for this line item comes from the interest collected on delinquent employer contributions to the Unemployment Compensation Trust Fund plus all fines and forfeitures assessed on employers. The executive recommends \$27.1 million in FY 2010, a 122.6% increase over the FY 2009 estimated levels and \$37.8 million in FY 2011, a 39.2% increase over FY 2010. The increase for FY 2010 and FY 2011 is intended to replace federal dollars that are no longer available so that OUC could continue operations at the current level.

Banking Fees (600687)

This line item is used to pay charges assessed by the Treasurer of State for clearing and accounting for unemployment compensation benefit warrants and other various processing charges. The Treasurer charges \$0.14 for each warrant cleared and \$150 for each roll of microfilm. ODJFS has reduced the number of checks mailed out to recipients for unemployment benefits by offering direct deposits to a claimant's bank account and electronic fund transfers to debit cards. Paper checks now account for only 28% of methods of payment used to disburse benefits. Funding for this line item comes from interest earned on the unemployment compensation benefit account and unemployment compensation clearing account. The executive recommends \$700,000 for FY 2010 and FY 2011, a 12.5% decrease from the FY 2009 adjusted appropriation.

Administration

- Phase I of MITS is scheduled for implementation during the biennium
- Executive recommends \$103 million in FY 2010 and \$104 million in FY 2011 for Computer Projects

OVERVIEW

Administrative services to ODJFS program offices are provided by the Director's Office and the offices of Legislation; Legal Services; Communications; Employee and Business Services; Research, Assessment, and Accountability; Contracts and Acquisition; Chief Inspector; and Fiscal Services. Services include budget development, management, and monitoring; payroll projections; human resources processing; facilities management; responses to legislative, constituent, and media requests; performance management; contracting and acquisition procedures; accounting services, funding, and auditing of counties and service providers; financial reporting; legal services; mail processing; quality control; and internal audit compliance program implementation.

Through its Office of Management Information Services (MIS), ODJFS provides various computer systems to meet operational and managerial decision-making needs. The Office reviews and approves state and county data processing needs. It designs, develops, implements, and provides technical support for computer systems for Medicaid, public assistance, social services, child support enforcement programs, employment services, and workforce development. The Office provides support services for information technology such as network and mainframe support, security, database maintenance, systems programming for all mainframe applications, client server support, standards, and configuration MIS applications and business functions.

ANALYSIS OF EXECUTIVE PROPOSAL

Administration

This category of appropriations includes the major sources of funding for ODJFS general administration activities that do not particularly align with any one of the program categories. Administrative line items which focus on one program category are included in this Redbook in that respective category. Table 1 below lists the line items associated with this category.

Table 1. Governor's Recommended Amounts for Administration				
Fund		ALI and Name	FY 2010	FY 2011
General Revenue Fund				
GRF	600321	Support Services	\$61,684,755	\$62,137,769
GRF	600416	Computer Projects	\$103,038,603	\$103,602,603
GRF	600521	Entitlement Administration – Local	\$107,026,181	\$100,893,286
General Revenue Fund Subtotal			\$271,749,539	\$266,633,658
General Services Fund Group				
4R40	600665	BCII Services/Fees	\$36,974	\$36,974
5DM0	600633	Administration and Operating	\$19,853,583	\$19,928,733
5N10	600677	County Technologies	\$1,000,000	\$1,000,000
General Services Fund Group Subtotal			\$20,890,557	\$20,965,707
State Special Revenue Fund Group				
5F20	600667	Building Consolidation	\$250,000	\$250,000
5F30	600668	Building Consolidation	\$1,000,000	\$1,000,000
State Special Revenue Fund Group Subtotal			\$1,250,000	\$1,250,000
Holding Account Redistribution Fund Group				
R012	600643	Refunds and Audit Settlements	\$3,600,000	\$3,600,000
R013	600644	Forgery Collections	\$10,000	\$10,000
Holding Account Redistribution Fund Group Subtotal			\$3,610,000	\$3,610,000
Total Funding: Administration			\$297,500,096	\$292,459,365

Support Services (600321)

This GRF line item is the primary source of funding for operating expenses for support services provided by ODJFS component offices to the rest of the agency. Expenditures from this GRF line item for federal programs earn federal reimbursement, which is deposited into the GRF. The executive recommends \$61.7 million in FY 2010, a 13.9% increase over the FY 2009 adjusted appropriation, and \$62.1 million in FY 2011, a 0.7% increase over FY 2010.

Computer Projects (600416)

This GRF line item provides funding for the development, implementation, and maintenance of computer systems used by ODJFS and the county departments of job and family services. Expenditures from this GRF line item for federal programs earn federal reimbursement, which is deposited into the GRF.

The Medicaid Management Information System (MMIS) is funded from this GRF line item. MMIS, implemented in 1984, currently supports benefits administration and payment services for Medicaid. MMIS is a federally certified system for the processing of all Medicaid payments and includes several subsystems. The Medicaid Information Technology System (MITS) is expected to replace MMIS during the coming biennium (MITS is funded out of line item 600654). Some MITS functions, such as a web portal for providers to submit claims electronically to ODJFS, are already on-line and functioning. Phase one of MITS, which includes all current MMIS functions such as benefits administration and payment services, is expected to be functioning by the end of calendar year 2009.

Other major computer projects include:

- Client Registry Information System-Enhanced (CRIS-E) – provides eligibility determination services for public assistance programs such as Medicaid, Food Assistance, and Temporary Assistance for Needy Families;
- Statewide Automated Child Welfare Information System (SACWIS) – provides information to support the protection of children and families and aligns with state and federal child welfare reporting requirements;
- Child Support Enforcement Tracking System (SETS) – monitors child support payments;
- Child Support Payment Central (CSPC) – provides employers the option of forwarding child support collections to one location;
- Electronic Benefit Transfer (EBT) System – provides Food Assistance benefits (formerly "Food Stamps") through the Ohio Direction Card, an on-line magnetic strip card; and
- The Medicaid Decision Support System (DSS) – provides a data warehouse and software tools to analyze aspects of the Medicaid Program.

In addition to these projects, other networking activities are paid from this GRF line item including personal computer maintenance, third party software support, office automation, and network management.

Table 2 below outlines the various computer projects that are funded out of 600416, Computer Projects, and the budgeted amounts for FY 2010 and FY 2011.

Table 2. ALI 600416, Computer Projects, by Project		
Project Name/Series	FY 2010	FY 2011
MIS Staffing		
Payroll	\$41,588,534	\$41,665,924
Office Administration	\$157,716	\$112,666
Training (contracts)	\$388,595	\$182,560
MIS Staffing Total	\$42,134,845	\$41,961,150
Network Administration		
Project Contracts	\$1,936,602	\$1,936,602
OIT	\$5,026,164	\$5,026,164
Maintenance	\$15,902,853	\$15,902,853
Equipment	\$1,969,548	\$2,421,454
Network Administration Total	\$24,835,167	\$25,287,073
SETS		
CSPC Contract	\$8,120,145	\$8,120,145
CSPC Contract (state funds only)	\$1,256,988	\$1,256,988
Project Contracts – MIS	\$307,632	\$307,632
OIT – MIS	\$1,533,929	\$1,533,929
Maintenance – MIS	\$2,457	\$2,457
Equipment – MIS	\$213,367	\$213,367
SETS Total	\$11,434,518	\$11,434,518
EBT/EPC		
EBT Contract (ACS)	\$7,420,829	\$7,979,829
EBT/EPC Total	\$7,420,829	\$7,979,829
CRIS-E		
QDA Contract – MIS	\$910,455	\$910,455
IRS OTI Contract – MIS	\$52,325	\$32,500
OIT – CRIS-E	\$5,249,186	\$5,249,186
CRIS-E Total	\$6,211,966	\$6,192,141
GOFBCI		
Governor's Initiatives	\$2,000,000	\$2,000,000
Ohio Benefit Bank	\$2,220,000	\$2,220,000
GOFBCI Total	\$4,220,000	\$4,220,000
Child Welfare System		
Contract Support – MIS	\$1,086,815	\$1,086,815
OIT – SACWIS	\$1,663,608	\$1,663,608
OIT – FACSIS	\$0	\$0
Maintenance – MIS	\$23,954	\$23,954
Equipment – MIS	\$253,384	\$253,384
Child Welfare System Total	\$3,027,761	\$3,027,761

Table 2. ALI 600416, Computer Projects, by Project		
Project Name/Series	FY 2010	FY 2011
MMIS		
Project Contracts – MIS	\$0	\$0
OIT – MIS	\$2,745,326	\$2,745,326
Maintenance – MIS	\$53,592	\$53,592
Equipment – MIS	\$0	\$0
MMIS Total	\$2,798,918	\$2,798,918
DSS		
Contract – OHP (Medstat)	\$458,940	\$458,940
Contract – Data Warehousing	\$0	\$0
Contract – OHP (FileNet)	\$0	\$0
DSS Total	\$458,940	\$458,940
HIPAA		
OIT – MIS	\$102,273	\$102,273
Maintenance – MIS	\$10,000	\$10,000
Contract – OHP (EDI)	\$130,000	\$130,000
HIPAA Total	\$242,273	\$242,273
Totals		
Payroll	\$41,588,534	\$41,665,924
Project Contracts	\$26,289,326	\$26,622,466
OIT	\$16,320,486	\$16,320,486
Maintenance	\$16,150,572	\$16,105,522
Equipment	\$2,436,299	\$2,888,205
Total	\$102,785,217	\$103,602,603

Data Source: ODJFS

MIS – Management Information Systems
 OIT – Office of Information Technology
 GOFBCI – Governor's Office of Faith Based and Community Initiatives
 FACSIS – Family and Children Services Information System
 OHP – Office of Ohio Health Plans
 HIPAA – Health Insurance Portability and Accountability Act

The executive recommends \$103,038,603 for FY 2010, a 3.0% decrease from the FY 2009 adjusted appropriation, and \$103,602,603 for FY 2011, a 0.5% increase over FY 2010.

According to ODJFS, this GRF line item will also be used to fund the Ohio Benefit Bank (OBB). Expenditures for OBB totaled \$2.5 million in FY 2008. This includes expenditures on salaries and benefits, technology and administration, and outreach activities. In the FY 2008-FY 2009 biennium, OBB was mainly funded from a combination of federally funded line items with a small portion from GRF line item 600321, Support Services. OBB provides web-based, counselor-assisted help to connect low and moderate income Ohioans to support services including income tax filing

assistance and public assistance programs. The OBB is a public entity that partners with 600 private nonprofit groups across Ohio to deliver this assistance.

Entitlement Administration – Local (600521)

This GRF line item is used by ODJFS to advance counties the state's share of county administration for public assistance programs including the Food Assistance Program, Medicaid, and Disability Assistance programs. The executive recommends \$107.0 million for FY 2010, a 9.8% decrease from the FY 2009 adjusted appropriation, and \$100.1 million for FY 2011, a 5.7% decrease from FY 2010.

BCII Services/Fees (600665)

This line item is used to pass through fees collected from individuals for the cost of criminal records checks to the Bureau of Criminal Identification and Investigation (BCII). A criminal records check is required for persons who have applied for employment as child care providers and employees. The executive recommends flat funding at the FY 2009 adjusted appropriation level of \$36,974 for FY 2010 and FY 2011.

Administration and Operating (600633)

This new line item proposed in the executive budget will be used to pay costs associated with state hearings, audit adjustments, and other related costs pertaining to grants. The executive recommends \$19.9 million for FY 2010 and FY 2011. Funds appropriated will come from a transfer from the Refunds and Audit Settlements Fund (Fund R012). Currently, this transfer is deposited into the Food Assistance Fund (Fund 3840) and appropriated in 600610, Food Assistance and State Administration. The new line item will separate expenditures for state hearings and adjustments from administration for Food Assistance.

County Technologies (600677)

This line item is used to collect reimbursement from counties to ODJFS for the purchase of computer-related equipment. This allows the counties to contribute a share toward the purchase of computer equipment while ensuring that the equipment meets ODJFS's technical specifications. ODJFS purchases the equipment and the counties reimburse ODJFS. The executive recommends flat funding at the FY 2009 appropriation level of \$1.0 million for FY 2010 and FY 2011.

Building Consolidation (600667)

This line item is used to reimburse the Department of Labor (DOL) funds received as a down payment or escrow from the sale of offices that were originally purchased with DOL funds. Amounts remaining in the fund associated with selling the property are transferred to the BES Building Enhancement Fund (Fund 5F30) and appropriated in line item 600668, Building Consolidation. The executive recommends flat funding at the FY 2009 appropriation level of \$250,000 for FY 2010 and FY 2011.

Building Consolidation (600668)

This line item is used to reimburse DOL for funds used to purchase offices. The collection of the sale proceeds less any costs associated with the sale of the properties will be deposited into Fund 5F30, then returned to DOL. The executive recommends flat funding at the FY 2009 appropriation level of \$1.0 million for FY 2010 and FY 2011.

Refunds and Audit Settlements (600643)

This line item is used to disburse funds that are held for checks whose disposition cannot be determined at the time of receipt. Upon determination of the appropriate fund into which the check should have been deposited, a disbursement is made from this line item to the appropriate fund. The executive recommends flat funding at the FY 2009 appropriation level of \$3.6 million for FY 2010 and FY 2011.

Forgery Collections (600644)

This line item is used to receive funds from banks and other entities that have cashed forged public assistance warrants. The executive recommends flat funding at the FY 2009 appropriation level of \$10,000 for FY 2010 and FY 2011.

REQUESTS NOT FUNDED

This section describes agency requests that are not funded in the executive budget.

Fund Line Item	FY 2010 Recommended	FY 2010 Requested	Difference	FY 2011 Recommended	FY 2011 Requested	Difference
GRF 600521	\$107,026,181	\$128,704,745	\$21,678,564	\$100,893,286	\$123,500,000	\$22,606,714

GRF line item 600521, Entitlement Administration – Local, is used by ODJFS to advance to the counties the state's share of county administration for family services programs including Food Assistance, Medicaid, and Disability Assistance. Administration activities mainly consist of eligibility determination for these programs. Though not fully funded at the requested amount, ODJFS expects that counties will have sufficient funds to support eligibility determination activities. In this biennium, counties may redirect their mandated share for Temporary Assistance for Needy Families (TANF) expenditures to use for other public assistance programs (Medicaid and the Food Assistance Program) that receive federal reimbursement for administrative activities in order to draw down the federal reimbursements.

In previous years, county spending on TANF programs counted toward state TANF maintenance of effort (MOE).¹¹ This amounted to about \$28.5 million each fiscal year. In this biennium, ODJFS plans to count state TANF MOE with state-only expenditures.

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¹¹ Please refer to the Overview in the Family Stability section of this Redbook for more information pertaining to TANF MOE.

General Revenue Fund

GRF 600321 Support Services

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$58,360,571	\$60,434,887	\$56,316,319	\$54,180,625	\$61,684,755	\$62,137,769
	3.6%	-6.8%	-3.8%	13.9%	0.7%

Source: GRF

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in FY 2002)

Purpose: This line item is the primary source of funding for operating expenses for support services provided by ODJFS component offices to the rest of the agency. For federal programs, expenditures from this line item earns federal reimbursement, which is deposited into the GRF.

GRF 600410 TANF State

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$272,619,061	\$272,619,061	\$262,618,810	\$254,907,156	\$190,607,468	\$202,858,335
	0.0%	-3.7%	-2.9%	-25.2%	6.4%

Source: GRF

Legal Basis: ORC 5101.80 through 5101.91; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used in conjunction with other appropriation items for Temporary Assistance for Needy Families program expenditures including cash assistance payments under the Ohio Works First Program. Expenditures from this appropriation item are counted toward the state's maintenance of effort (MOE) for the federal TANF Block Grant. Other appropriation items are used towards the state's TANF MOE, which is about \$417 million each year.

GRF 600413 Child Care Match/Maintenance of Effort

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$84,120,596	\$84,120,551	\$84,120,576	\$80,124,868	\$88,415,688	\$93,105,300
	0.0%	0.0%	-4.7%	10.3%	5.3%

Source: GRF

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in FY 1997)

Purpose: This line item is used in conjuncture with other appropriation items for publicly funded child care expenditures. Expenditures from this appropriation item are counted towards the state's MOE for the federal Child Care and Development Grant and the TANF Block Grant; \$82 million in each fiscal year is counted as the state MOE required for the Child Care and Development Grant, and \$45 million in each fiscal year is counted as the state MOE for the TANF Block Grant.

GRF 600416 Computer Projects

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$132,458,765	\$130,531,165	\$137,561,869	\$106,205,968	\$103,038,603	\$103,602,603
	-1.5%	5.4%	-22.8%	-3.0%	0.5%

Source: GRF

Legal Basis: ORC 5101, 4141, and 6301; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item provides funding for the development, implementation, and maintenance of computer systems used by ODJFS and the county departments of job and family services. Major computer projects include: Medicaid Management Information System (MMIS), Client Registry Information System - Enhanced (CRIS-E), Statewide Automated Child Welfare Information System (SACWIS), and Support Enforcement Tracking System (SETS). This line item also funds various network administration activities and the Ohio Benefit Bank.

GRF 600417 Medicaid Provider Audits

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$1,292,040	\$1,573,876	\$1,484,001	\$1,497,886
		N/A	21.8%	-5.7%	0.9%

Source: GRF

Legal Basis: Section 309.30.18 of Am. Sub. H.B. 119 of the 127th G.A

Purpose: This line item is used to fund payroll for the Office of Research, Assessment, and Accountability (ORAA) and the Medicaid provider audits conducted by the Auditor of State.

GRF 600420 Child Support Administration

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$4,189,836	\$4,927,636	\$6,673,686	\$7,723,936	\$7,369,234	\$7,431,310
	17.6%	35.4%	15.7%	-4.6%	0.8%

Source: GRF

Legal Basis: ORC 3109.05; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item provides the non-federal share of state administrative expenditures for the Child Support Enforcement Program.

GRF 600421 Office of Family Stability

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$4,055,431	\$2,896,456	\$3,486,555	\$2,720,599	\$4,653,955	\$4,720,001
	-28.6%	20.4%	-22.0%	71.1%	1.4%

Source: GRF

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in FY 2002)

Purpose: This line item is used as the primary source of funding for the operating expenses of the Office of Family Stability. The Office administers programs and services that deliver cash assistance, non-cash supports, and food assistance to low-income families with the goal of equipping these families to achieve self-sufficiency.

GRF 600422 Local Operations

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$140	\$0	\$0	\$0	\$0	\$0

Source: GRF

Legal Basis: Discontinued line item (originally established by Controlling Board in FY 2002)

Purpose: This line item provided some of the funds needed for implementation of the local operations transition plan.

GRF 600423 Office of Children and Families

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$4,817,485	\$5,304,320	\$5,257,898	\$4,842,705	\$6,494,545	\$6,580,782
	10.1%	-0.9%	-7.9%	34.1%	1.3%

Source: GRF

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A (originally established by Controlling Board in FY 2002)

Purpose: This line item provides funding for payroll, purchased personal services, conference fees, maintenance, and equipment for the Office of Children and Families.

GRF 600424 Office of Workforce Development

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,718	\$0	\$0	\$0	\$0	\$0

Source: GRF

Legal Basis: Discontinued line item (originally established by Controlling Board in FY 2002)

Purpose: This line item was the primary source of funding for the operating expenses of the Office of Workforce Development. In FY 2006, the Department began supporting workforce development activities with line item 600607, Unemployment Compensation Administrative Fund.

GRF 600425 Office of Ohio Health Plans

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$40,683,091	\$46,004,057	\$40,515,832	\$34,697,854	\$29,976,306	\$23,372,096
	13.1%	-11.9%	-14.4%	-13.6%	-22.0%

Source: GRF

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in FY 2002)

Purpose: This line item is the primary source of funding for the operating expenses of the Office of Ohio Health Plans and the Office of Research, Assessment, and Accountability (ORAA). The federal earnings on the payments from this line item are deposited as revenue into the GRF.

GRF 600435 Unemployment Compensation Review Committee

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$3,044	\$0	\$0	\$0	\$0	\$0

Source: GRF

Legal Basis: Discontinued line item (originally established by Am. Sub. H.B. 94 of the 124th G.A.)

Purpose: This line item was used to support the expenses of the Unemployment Compensation Review Commission. In FY 2006, funding was shifted to a nonGRF source.

GRF 600439 Commission to Reform Medicaid

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$43,780	\$0	\$0	\$0	\$0	\$0

Source: GRF

Legal Basis: Discontinued line item (originally established by Sections 59 and 59.01 of Am. Sub. H.B. 95 of the 125th G.A.)

Purpose: This line item was used to fund the Ohio Commission to Reform Medicaid. Am. Sub. H.B. 95 of the 125th G.A. required the Commission to evaluate the Medicaid Program and make recommendations about reform and cost containment initiatives by January, 2005. The Commission completed its work and presented its recommendations.

GRF 600440 Ohio's Best Rx Start Up Costs

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$971,616	\$825,528	\$36,858	\$0	\$0	\$0
	-15.0%	-95.5%			

Source: GRF

Legal Basis: Discontinued line item (ORC 5110.33,originally established by Section 4 of H.B. 311 of the 125th G.A.)

Purpose: This line item was used to pay for the administrative and operational expenses for the Ohio's Best Rx Program.

Am. Sub. H.B. 468 of the 126th G.A. transferred the Ohio's Best Rx Program to Department of Aging.

GRF 600502 Administration-Local

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$16,814,102	\$16,297,110	\$33,660,414	\$26,948,050	\$25,382,308	\$24,950,288
	-3.1%	106.5%	-19.9%	-5.8%	-1.7%

Source: GRF

Legal Basis: ORC 3109.05; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item provides state funds to the counties for the administration of the Child Support Enforcement Program.

GRF 600511 Disability Financial Assistance

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$21,658,726	\$25,338,275	\$26,896,418	\$25,335,908	\$36,037,712	\$38,684,457
	17.0%	6.1%	-5.8%	42.2%	7.3%

Source: GRF

Legal Basis: ORC 5115; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used for the Disability Financial Assistance (DFA). The DFA Program provides cash assistance to persons who are unemployable due to a physical or mental impairment, and who are not receiving cash assistance from other public assistance programs that are supported by federal funds (such as Ohio Works First or Social Security Income).

GRF 600512 Non-TANF Disaster Assistance

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$3,000,000	\$91,007	\$138,056	\$950,750	\$0	\$0
	-97.0%	51.7%	588.7%		

Source: GRF

Legal Basis: Discontinued line item (originally established by Am. Sub. H.B. 215 of the 122nd G.A.)

Purpose: This line item was used to provide funding to counties for emergency assistance to elderly and disabled individuals who are ineligible for federal public assistance programs.

GRF 600513 Disability Medical Assistance

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$27,532,714	\$25,411,648	\$0	\$0	\$0	\$0
	-7.7%				

Source: GRF

Legal Basis: Discontinued line item

Purpose: This line item was used to operate the Disability Medical Assistance (DMA) Program.

Funding for the DMA Program for FY 2008-FY 2009 biennium is provided through GRF line item 600525, Health Care/Medicaid.

GRF 600521 Entitlement Administration-Local

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$123,770,007	\$129,998,988	\$125,930,450	\$118,609,231	\$107,026,181	\$100,893,286
	5.0%	-3.1%	-5.8%	-9.8%	-5.7%

Source: GRF

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in FY 2002)

Purpose: This line item is used to advance to counties the state's share of county administration expenditures for Medicaid, Food Assistance, and Disability Assistance programs.

GRF 600523 Children and Families Services

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$67,797,879	\$68,496,272	\$73,625,846	\$68,935,460	\$74,209,378	\$74,209,378
	1.0%	7.5%	-6.4%	7.7%	0.0%

Source: GRF

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A (originally established by Controlling Board in FY 2002)

Purpose: This line item provides the state share for the Foster Parent Stipends Program and the federal Chaffee Education Training Vouchers, which allows ODJFS to reimburse foster care givers for attending and completing ODJFS-approved training courses; the State Operating Allocation, which provides state funds to supplement the Title XX funds a county receives; the State Child Protection Allocation, which is a general block grant to each PCSA to partially reimburse costs incurred by the PCSA in performing its duties; and to implement the Feisal Case Review recommendations.

GRF 600525 Health Care/Medicaid

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$9,143,137,516	\$8,984,065,496	\$9,102,667,207	\$9,877,719,909	\$8,814,479,115	\$10,693,668,495
	-1.7%	1.3%	8.5%	-10.8%	21.3%

Source: CFDA 93.778, Medical Assistance Program (Medicaid: Title XIX)

Legal Basis: ORC 5111; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: The primary purpose of this line item is to reimburse health care providers for covered services to Medicaid eligible recipients. In addition, this line item funds the costs of health care related contracts such as eyeglass purchases, inpatient hospital peer review, enrollment information centers, and contracted case management. The federal earnings on the payments that are made entirely from this line item are deposited as revenue into the GRF. These earnings are drawn in accordance with the guidelines of the Cash Management Information Act.

Although other agencies also provide Medicaid services, the vast majority of Medicaid spending occurs within this line item. Spending within the line item generally can be placed into one of nine major groupings: long-term care (nursing facilities, and Intermediate Care Facilities for the Mentally Retarded), hospitals (inpatient and outpatient), physician services, prescription drugs, managed care plans, Medicare buy-in, waivers, all other care, and Disability Medical Assistance (FY2003-FY2005 and FY2008-FY2009).

The majority of expenditures from this line item earn the basic Federal Medical Assistance Percentage (FMAP) reimbursement rate at approximately 62%, although family planning expenditures earn an enhanced 90% federal participation rate, and a portion of the buy-in premium payments are state funds only. Expenditures for the State Children's Health Insurance Program (SCHIP) from this line item earn an enhanced FMAP at approximately 72%. Disability Medical Assistance is a state funded only program, there are no federal match earnings.

SCHIP phase II (SCHIP II) payments were moved from line item 600426, Children's Health Insurance Plan, to this line item beginning in FY 2003. In addition, Disability Medical Assistance payments were moved from line item 600511, Disability Financial Assistance, to this line item beginning in FY 2003. However, Am. Sub. H.B. 66 of the 126th G.A. provided funding of \$19.5 million in FY 2006 and \$25.5 million in FY 2007 in appropriation item 600513, Disability Medical Assistance, for operation of the Disability Medical Assistance Program. Am. Sub. H.B. 119 of the 127th G.A. changed back again to include funding for the Disability Medical Assistance in this

line item.

GRF 600526 Medicare Part D

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$89,973,932	\$235,817,868	\$243,172,531	\$235,817,392	\$271,746,617	\$287,194,790
	162.1%	3.1%	-3.0%	15.2%	5.7%

Source: GRF

Legal Basis: Section 309.31.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used by ODJFS for the implementation and operation of the Medicare Part D requirements contained in the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Am. Sub. H.B. 119 of the 127th G.A. allowed the Director of Budget and Management to increase the state share of appropriations in either GRF line item 600525, or this line item, with a corresponding decrease in the state share of the other line item to allow ODJFS to implement and operate the Medicare Part D requirements.

GRF 600528 Adoption Services

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$70,432,889	\$74,957,627	\$69,359,417	\$86,500,697	\$88,515,648	\$88,515,648
	6.4%	-7.5%	24.7%	2.3%	0.0%

Source: GRF

Legal Basis: ORC 5101.14; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 291 of the 115th G.A.)

Purpose: This GRF line item is used to for the state adoption subsidy programs, which provide maintenance payments to families who adopt children with special needs.

GRF 600529 Capital Compensation Program

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$5,858,572	\$1,504,320	\$0	\$40,000,000	\$0
	N/A	-74.3%			

Source: GRF

Legal Basis: Section 309.30.41 of Am. Sub. H.B. 119 of the 127th G.A. (originally established in Section 606.19.03 of Am. Sub. H.B. 530 of the 126th G.A.)

Purpose: This line item is used to make payments to nursing facilities for capital costs.

This line item was used to make payments to nursing facilities and intermediate care facilities for the mentally retarded under Section 606.18.06 of Am. Sub. H.B. 530 of the 126th G.A. The unencumbered balance of this appropriation item at the end of FY 2006 was appropriated to FY 2007 for use under the same line item.

H.B. 119 of the 127th G.A. provided for certain qualifying nursing facilities to receive additional quarterly payments for capital costs during FY 2008 and FY 2009. H.B. 119 appropriated \$7 million in FY 2008 to this line item. ODJFS disbursed approximately \$1.5 million of the \$7 million in FY 2008.

H.B. 562 of the 127th G.A. revised certain laws governing per diem payments for nursing facilities' uncompensated capital costs and required the Director of Budget and Management to increase for FY2009 the state share of appropriations to GRF line item 600525, Health Care/Medicaid, by the amount of the unencumbered balance for FY 2008 of GRF line item 600529, Capital Compensation Program, with a corresponding increase in the federal share.

GRF 600534 Adult Protective Services

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$497,403	\$522,040	\$511,453
			N/A	5.0%	-2.0%

Source: GRF

Legal Basis: ORC 5101.61; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item provides funding to county departments of job and family services for adult protective services.

GRF 600535 Early Care and Education

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$0	\$150,000,000	\$150,000,000
					0.0%

Source:

Legal Basis: Proposed by the Executive Budget

Purpose: This line item will be primarily used to fund 12,000 slots in Ohio's Early Learning Initiative (ELI) program. Funds remaining after ELI expenditures will be used for publicly funded child care direct services. Expenditures for ELI and publicly funded child care will count toward the state's TANF MOE. In the last biennium ELI was funded through an earmark of funds in appropriation item 600689, TANF Block Grant.

GRF 600537 Children's Hospital

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$0	\$6,000,000	\$6,000,000
					0.0%

Source: GRF

Legal Basis: Section 309.10 of the bill, As Proposed

Purpose: This line item will be used to make supplemental Medicaid payments to Children's Hospitals.

GRF 600661 Child Care - Federal Stimulus

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$0	\$8,915,224	\$13,459,664
					51.0%

Source: GRF

Legal Basis: Proposed by the Executive Budget

Purpose: This line item will be used to make payments for publicly funded child care. This line item is being used to appropriate federal stimulus that is being deposited into the GRF,

General Services Fund Group

4A80 600658 Child Support Collections

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$23,508,044	\$24,182,572	\$31,244,887	\$31,929,211	\$26,000,000	\$26,000,000
	2.9%	29.2%	2.2%	-18.6%	0.0%

Source: GSF: Assigned child support collections

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 111 of the 118th G.A.)

Purpose: This line item appropriates funds collected from the non-federal share of all county Ohio Works First (OWF) child support collections. Persons receiving child support and OWF cash benefits are required to assign their child support payments to ODJFS to cover part of their OWF cash benefits. Expenditures from this appropriation item are used in conjunction with appropriation items 600410, TANF State, and 600689, TANF Federal Block Grant, to cover cash assistance payments issued directly to OWF participants. These expenditures are counted toward the state's TANF MOE.

4R40 600665 BCII Services/Fees

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$5,201	\$735	\$561	\$36,974	\$36,974	\$36,974
	-85.9%	-23.7%	6490.7%	0.0%	0.0%

Source: GSF: Background check fees

Legal Basis: ORC 5101.012 and 5101.013; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item was created to pass through fees collected from individuals for the cost of criminal records checks to the Bureau of Criminal Identification and Investigation (BCII). A criminal records check is required for persons who have applied for employment as child care providers and employees.

5BG0 600653 Managed Care Assessment

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$18,224,884	\$99,410,121	\$172,178,992	\$222,667,304	\$168,914,857	\$0
	445.5%	73.2%	29.3%	-24.1%	

Source: GSF: Medicaid managed care franchise permit fee: a 5.5% fee on each Medicaid Managed care provider’s total revenues

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established in Section 206.66 of Am. Sub. H.B. 66 of the 126th G.A.)

Purpose: This line item is used to help offset the statewide managed care expansion for Covered Families and Children.

5C90 600671 Medicaid Program Support

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$71,462,972	\$75,956,265	\$69,374,403	\$80,120,048	\$69,876,838	\$68,313,238
	6.3%	-8.7%	15.5%	-12.8%	-2.2%

Source: GSF: Earned federal reimbursement from the Institutions for Mental Disease Disproportionate Share (IMD/DSH) program, transfer from DMR for the non-federal portion of targeted case management costs, state share of pharmacy payments for those in developmental centers, back billing for the disability assistance program, state funded drug expenditures made by ODMRDD

Legal Basis: ORC 5101.80 through 5101.91; Section 309.32.20 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 215 of the 122nd G.A.)

Purpose: This line item is supported by the Federal Medicaid Institutions for Mental Disease Disproportionate Share (IMD/DSH) funds, which are generated from state fund expenditures made by the Department of Mental Health. The federal funds are drawn into this General Services Fund (Fund 5C90) as earned federal funds. This line item is used to support the state share of offsets to GRF line item 600525 (DSH offsets) and transfers to the Department of Mental Health.

This line item is also used to pay target case management costs. The federal match for expenditures from this line item are made from line item 600-623, Health Care Federal.

5DL0 600639 Medicaid Revenue and Collections

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$56,137,358	\$51,238,266	\$76,296,844	\$99,916,750	\$63,600,000
	N/A	-8.7%	48.9%	31.0%	-36.3%

Source: GSF: Recoveries and collections under the Medicaid program

Legal Basis: Section 309.31.80 of Am. Sub. H.B. 119 of the 127th G.A. (originally established in Section 606.17 of Am. Sub. H.B. 530 of the 126th G.A.)

Purpose: This line item is used by ODJFS to pay for Medicaid services and contracts.

Am. Sub. H.B. 119 of the 127th G.A. also allowed the Director of Budget and Management, at the request of the Director of Job and Family Services, to increase the appropriation in this line item by the amounts the Department of Education paid to ODJFS pursuant to ORC 3317.023 for Medicaid services.

5DM0 600633 Administration and Operating

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$0	\$19,853,583	\$19,928,733
					0.4%

Source: GSF: Federal reimbursement for expenditures that are claimed towards federal grants.

Legal Basis: Proposed in the Executive Budget

Purpose: This line item will be used for expenditures towards state hearings, audit adjustments, and other related costs associated with grant administration in ODJFS.

5FX0 600638 Medicaid Payment Withholding

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$26,000,000	\$26,000,000	\$26,000,000
			N/A	0.0%	0.0%

Source: GSF: Withheld funds of the providers that change ownership

Legal Basis: Established by Controlling board in December 2008

Purpose: This line item is used to release to providers payments that were withheld in accordance with ORC 5111.681, and/or transfer the withheld funds to the appropriate fund used by ODJFS at final resolution.

5N10 600677 County Technologies

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$227,535	\$534,910	\$472,703	\$1,000,000	\$1,000,000	\$1,000,000
	135.1%	-11.6%	111.5%	0.0%	0.0%

Source: GSF: Collections received for the purchase of computer related equipment on behalf of the counties

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line provides the accounting mechanism for reimbursement by counties to ODJFS for the purchase of computer related equipment. This allows the counties to purchase additional computer related equipment with local funds while ensuring that the equipment meets ODJFS' technical specifications. ODJFS purchases the equipment and the counties reimburse ODJFS.

5P50 600692 Health Care Services

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$781,988,116	\$177,924,254	\$89,261,895	\$82,000,000	\$84,052,802	\$226,469,478
	-77.2%	-49.8%	-8.1%	2.5%	169.4%

Source: GSF: Prescription drug manufacturer rebates to Ohio Medicaid

Legal Basis: ORC 5111.081; Section 309.32.40 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 94 of the 124th G.A.)

Purpose: This line item is also used to pay for Medicaid services and contracts and offset Medicaid expenditures that would otherwise be paid from GRF line item 600525, Health Care/Medicaid.

6130 600645 Training Activities

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$13,235	\$4,646	\$0	\$135,000	\$110,000	\$110,000
	-64.9%		N/A	-18.5%	0.0%

Source: GSF: Conference registration fees

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A (originally established by Controlling Board in September 1986; originally part of the State Special Revenue Fund)

Purpose: This line item pays the costs for the Apprenticeship Council Conference. The Ohio Apprenticeship Council Conference promotes awareness in apprenticeships and includes a multitude of workshops and speakers.

Federal Special Revenue Fund Group

3160 600602 State and Local Training

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$290,779	\$0	\$0	\$0	\$0	\$0

Source: FED: Various federal grants

Legal Basis: Discontinued line item

Purpose: This line item was used to conduct training programs for state and county job and family services employees.

3270 600606 Child Welfare

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$30,195,436	\$32,856,236	\$24,507,846	\$47,947,309	\$33,972,321	\$33,984,200
	8.8%	-25.4%	95.6%	-29.1%	0.0%

Source: FED: CFDA 93.645, Child Welfare Services State Grant; CFDA 93.566, Promoting Safe and Stable Families grant

Legal Basis: ORC 5101.14; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to expend matching federal funds (Title IV-B) for the costs associated with providing child welfare services to children and their families.

3310 600686 Federal Operating

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$38,377,468	\$43,560,506	\$43,604,892	\$56,263,223	\$50,655,096	\$51,569,912
	13.5%	0.1%	29.0%	-10.0%	1.8%

Source: FED: CFDA 17.002, Labor Market Information (LMI); CFDA 17.203, Alien Labor Certification; CFDA 17.207, Employment Services (Wagner-Peyser); CFDA 17.801, Disabled Vets Outreach; CFDA 17.804, Local Vets Employment Reps

Legal Basis: ORC 4141 and 6301; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 283 of the 123rd G.A.)

Purpose: This line item is used primarily to fund the operations of the Office of Workforce Development, as well as the Office of Unemployment Compensation and the Office of Local Operations.

The Office of Unemployment Compensation administers the Unemployment Insurance program; the Office of Workforce Development provides policy guidance and performance management measures for workforce development and labor exchange services; and the Office of Local Operations operates call centers and processing centers to process unemployment claims and provides services statewide to employers and unemployed individuals that include job search assistance, referral and placement assistance, reemployment services, and recruitment services to employers.

3840 600610 Food Assistance and State Administration

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$127,754,385	\$134,463,811	\$126,980,901	\$153,147,118	\$159,109,776	\$159,109,427
	5.3%	-5.6%	20.6%	3.9%	0.0%

Source: FED: CFDA 10.561, State Administrative Matching Grants for the Supplemental Nutrition Assistance Program

Legal Basis: ORC 5101.49; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to reimburse the state and county departments of job and family services' costs of administering the Food Assistance Program. For most activities, the federal government reimburses states 50% for managing the program. The amount of the appropriations is the federal match for state and county allowable administration expenditures. This line item is expected to receive funding from the federal stimulus in the amount of \$6 million in each fiscal year.

3850 600614 Refugee Services

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$6,095,912	\$7,417,212	\$7,148,354	\$11,057,826	\$10,497,024	\$11,265,511
	21.7%	-3.6%	54.7%	-5.1%	7.3%

Source: FED: CFDA 93.566, Refugee and Entrant Assistance - State Administered Programs; CFDA 93.576, Refugee and Entrant Assistance - Discretionary Grant

Legal Basis: ORC 5101.49; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used for Ohio's Refugee Services programs. These programs are designed to temporarily provide refugees with cash assistance, medical assistance, and social services in order to help with their transition to living in the United States. These programs are fully funded by the federal government.

3950 600616 Special Activities/Child and Family Services

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$2,492,363	\$1,978,995	\$2,140,330	\$5,717,151	\$3,113,200	\$2,813,200
	-20.6%	8.2%	167.1%	-45.5%	-9.6%

Source: FED: CFDA 93.643, Children's Justice Act; CFDA 93.669, Child Abuse Neglect and Treatment Grant; CFDA 93.603, Adoption Incentive Payments

Legal Basis: ORC 5153; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 171 of the 118th G.A.)

Purpose: This line item provides the funding mechanism for special federal grants for children and adult welfare activities.

3960 600620 Social Services Block Grant

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$110,656,099	\$119,991,315	\$119,969,771	\$114,474,085	\$120,000,000	\$120,000,000
	8.4%	0.0%	-4.6%	4.8%	0.0%

Source: FED: CFDA 93.667, Social Services Block Grant

Legal Basis: ORC 5101.46; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board on January 17, 1972)

Purpose: This line item is used to expend ODJFS's share of the federal Social Services Block Grant (SSBG). Three departments share in the total grant received: the Department of Job and Family Services (72.50%); the Department of Mental Health (12.93%); and the Department of Mental Retardation and Developmental Disabilities (14.57%). The SSBG provides funds for administration, training and direct services. The services are for adults and children and include: adoption, day care, adult day care, physical protection, homemaker services, job training, counseling, and legal services.

3960 600651 Second Harvest Food Banks

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$5,500,000	\$5,500,000	\$0	\$0
			0.0%		

Source: FED: CFDA 93.667, Social Services Block Grant

Legal Basis: Discontinued line item

Purpose: This line items was used to provide a grant to the Ohio Association of Second Harvest Food Banks.

3970 600626 Child Support

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$234,906,550	\$242,253,390	\$207,916,986	\$303,538,962	\$305,830,981	\$305,832,341
	3.1%	-14.2%	46.0%	0.8%	0.0%

Source: FED: CFDA 93.563, Child Support Enforcement

Legal Basis: ORC 3119, 3121, 3123, and 3125; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to provide the federal share of all county and state child support administrative expenditures, including the federal share for the Support Enforcement Tracking System (SETS).

3980 600627 Adoption Maintenance/Administration

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$223,865,145	\$234,940,185	\$229,126,145	\$317,483,676	\$346,622,373	\$346,865,342
	4.9%	-2.5%	38.6%	9.2%	0.1%

Source: FED: CFDA 93.658, Foster Care-Title IV-E; CFDA 93.659, Adoption Assistance; CFDA 93.674, Independent Living; CFDA 93.599, Chaffee Education and Training Vouchers Program

Legal Basis: ORC 5153.16 and 5153.163; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 238 of the 116th G.A.)

Purpose: This line item is used to pass through federal funds to counties for the administrative costs of placing children in public or private institutions and family foster homes and is used to pay the federal share of Title IV-E adoption assistance payments. This line item also provides funds for the Independent Living Program and the Education and Training Vouchers Program.

3A20 600641 Emergency Food Distribution

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$2,425,279	\$2,587,158	\$2,574,863	\$3,500,000	\$4,970,000	\$4,970,000
	6.7%	-0.5%	35.9%	42.0%	0.0%

Source: FED: CFDA 10.568, Emergency Food Assistance Program (Administrative Costs) and CFDA 10.565, Commodity Supplemental Food Program

Legal Basis: ORC 5101.48; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used for administrative expenses related to processing, storage, and distribution of food commodities in local storage centers. ODJFS develops policies, performs audits, and negotiates contracts pertaining to the distribution of surplus food.

3AW0 600675 Faith Based Initiatives

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$914,242	\$1,140,143	\$617,393	\$1,000,000	\$544,140	\$544,140
	24.7%	-45.8%	62.0%	-45.6%	0.0%

Source: FED: CFDA 93.086, Healthy Marriages Initiatives Grant

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board September 2004)

Purpose: This line item is used to expend funds from the Healthy Marriage Initiative Grant from the federal Department of Health and Human Services. The grant amount is \$544,140 annually for five years and fiscal years 2010 and 2011 are the last two years that Ohio will receive this grant. Funds from this grant are required to be expended on activities that promote and support marriages. The Governor's Office of Faith-Based and Community Initiatives uses funds from this grant to deliver marriage education courses through regional partners in the Akron, Cincinnati, Cleveland, Columbus, and Toledo metropolitan areas.

3D30 600648 Children's Trust Fund Federal

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,542,862	\$1,500,000	\$1,500,000	\$2,040,524	\$2,040,524	\$2,040,524
	-2.8%	0.0%	36.0%	0.0%	0.0%

Source: FED: CFDA 93.590, Community Based Family Resource and Support grant

Legal Basis: ORC 3109.14 through 3109.18; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 171 of the 117th G.A.)

Purpose: This line item provides is used to support family resource centers, which provide a continuum of prevention services that target at-risk populations. These centers may offer parent education and support, early development screening of children, parent mentoring, job readiness and counseling, and crisis intervention.

3F00 600623 Health Care Federal

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$514,619,836	\$970,960,616	\$987,727,014	\$1,601,775,530	\$3,053,505,106	\$2,310,117,015
	88.7%	1.7%	62.2%	90.6%	-24.3%

Source: FED: CFDA 93.778 Medical Assistance Grants (Medicaid); CFDA 93.779, Health Care Financing Research, Demonstrations and Evaluations (added by Controlling Board in October 2001); federal share of drug rebates and other Medicaid revenues

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in October 1997)

Purpose: This line item was created to simplify accounting for the non-GRF federal share of Medicaid funding. Major activity in this line item includes the federal share of Medicaid payments, eligibility outreach, and county administration. This line item is used as the Medicaid federal match for the following line items: 600416, Computer Projects; 600521, Family Stability Subsidy; 600608, Medicaid Nursing Facilities; 600613, Nursing Facility Bed Assessments; 600619, Supplemental Inpatient Hospital Payments; 600621, ICF/MR Bedd Assessments; 600629, MR/DD Medicaid Administration and Oversight; 600639 Medicaid Revenue and Collections; 600653, Managed Care Assessments; 600654, Health Care Services Administration; 600671, Medicaid Program Support; and 600692, Prescription Drug Rebate-State.

3F00 600635 Children's Hospitals - Federal

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$4,459,022	\$8,934,745	\$3,994,090	\$0	\$0	\$0
	100.4%	-55.3%			

Source: FED: Medical Assistance Program (Medicaid: Title XIX)

Legal Basis: Discontinued line item (originally established in section 606.17 of Am. Sub. H.B. 530 of the 126th G.A.)

Purpose: This line item was used for the Medicaid federal share of making supplemental Medicaid payments to children's hospitals for inpatient services based on federal upper payment limits for children's hospitals. ODJFS paid children's hospitals the federally allowable supplemental payment in FY 2006 and FY 2007. The amount used for the program was not to exceed \$6 million (state share) in each fiscal year plus the corresponding federal match.

3F00 600650 Hospital Care Assurance Match

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$327,976,613	\$327,692,309	\$328,655,603	\$343,239,047	\$362,092,785	\$367,826,196
	-0.1%	0.3%	4.4%	5.5%	1.6%

Source: FED: CFDA 93.778, Medical Assistance Program (Medicaid: Title XIX)

Legal Basis: ORC 5112.01 through 5112.21; Section 309.31.90 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to disburse the federal matching funds generated as a result of the deposits to Fund 6510 under the Hospital Care Assurance Program (HCAP).

3F00 600699 ABD Managed Care Program - Federal

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$91,693,604	\$0	\$0	\$0	\$0
	N/A				

Source: FED: CFDA 93.778, Medical Assistance Program (Medicaid: Title XIX)

Legal Basis: Discontinued line item (originally established by Section 606.17 of Am. Sub. H.B. 530 of the 126th G.A.)

Purpose: This line item was used to fund the Medicaid Mandatory Managed Care for the Aged, Blind, and Disabled (ABD).

Am. Sub. H.B. 119 of the 127th G.A. appropriates the federal share of the Aged, Blind, and Disabled Managed Care Program expenditures in the line item 600525, Health Care/Medicaid.

3G50 600655 Interagency Reimbursement

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,196,206,073	\$1,149,814,148	\$1,258,402,177	\$1,513,855,965	\$1,503,777,044	\$1,561,905,912
	-3.9%	9.4%	20.3%	-0.7%	3.9%

Source: FED: CFDA 93.658, Foster Care-Title IV-E; CFDA 93.777, State Survey and Certification of Health Care Providers and Suppliers; CFDA 93.778, Medical Assistance Program (Medicaid: Title XIX); CFDA 93.777 Children's Health Insurance Program

Legal Basis: Sections 309.10 and 309.30.50 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 111 of the 118th G.A.)

Purpose: This line item disburses to other agencies the federal reimbursement (primarily Medicaid) for expenditures made by the other agencies.

3H70 600617 Child Care Federal

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$197,593,939	\$174,261,446	\$201,714,009	\$200,167,593	\$241,862,780	\$241,862,779
	-11.8%	15.8%	-0.8%	20.8%	0.0%

Source: FED: CFDA 93.596, Child Care and Development Fund (Mandatory/ Matching); CFDA 93.575, Child Care and Development Fund (Discretionary)

Legal Basis: ORC 5104; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to make payments for publicly funded child care and for related quality programs. This line item is also used to pay expenses for child care licensing in the Office of Children and Families. This item is expected to receive funding from the federal stimulus in the amount of \$39 million in each fiscal year.

3N00 600628 IV-E Foster Care Maintenance

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$109,079,847	\$99,202,065	\$104,572,138	\$153,963,142	\$169,324,768	\$161,644,455
	-9.1%	5.4%	47.2%	10.0%	-4.5%

Source: FED: CFDA 93.658, Foster Care-Title IV-E

Legal Basis: ORC 5101.141; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 152 of the 120th G.A.)

Purpose: This line item is used to issue foster care maintenance payments to foster parents or institutions to assist in the support of foster care.

3S50 600622 Child Support Projects

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$206,701	\$184,734	\$235,192	\$534,050	\$534,050	\$534,050
	-10.6%	27.3%	127.1%	0.0%	0.0%

Source: FED: CFDA 93.597, State Access and Visitation Program

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A (originally established by Controlling Board on October 20, 1997)

Purpose: This line item provides funding that is used to facilitate non-custodial parents' access to, and visitation of, their children and to encourage the payment of child support obligations. County departments of job and family services apply for these funds from the Office of Child Support.

3V00 600688 Workforce Investment Act

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$146,644,402	\$154,195,281	\$153,024,447	\$250,861,843	\$326,923,124	\$327,145,616
	5.1%	-0.8%	63.9%	30.3%	0.1%

Source: FED: CFDA 17.255, Workforce Investment Act (WIA); CFDA 17.258, Workforce Investment Act - Adult; CFDA 17.259, Workforce Investment Act - Youth; CFDA 17.260, Workforce Investment Act - Dislocated Worker; CFDA 17.257, WIA - Faith Based Initiative for States

Legal Basis: ORC 6301; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in April 2000)

Purpose: This line item is used to distribute WIA dollars to local workforce investment boards to administer the Youth, Adult, and Dislocated Worker activities through local One-Stops. ODJFS retains a portion of these dollars for statewide use, Rapid Response, and administration.

3V40 600678 Federal Unemployment Programs

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$135,157,841	\$131,978,148	\$123,819,664	\$152,843,411	\$154,883,142	\$136,982,528
	-2.4%	-6.2%	23.4%	1.3%	-11.6%

Source: FED: CFDA 17.225, Unemployment Insurance; CFDA 17.245, Trade Adjustment Assistance; CFDA 83.541, Disaster Unemployment Assistance; revenues collected from employers by through the Internal Revenue Service (IRS) pursuant to the Federal Unemployment Tax Act; Trade Adjustment Assistance grant; Disaster Unemployment Assistance grant

Legal Basis: ORC 4141; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 94 of the 124th G.A.)

Purpose: This federal line item is used to support the functions of the Office of Unemployment Compensation as well as the Office of Workforce Development and the Office of Local Operations to administer federal unemployment programs.

The Office of Unemployment Compensation administers the Unemployment Insurance program; the Office of Workforce Development provides policy guidance and performance management measures for workforce development and labor exchange services; and the Office of Local Operations operates call centers and processing centers to process unemployment claims and provides services statewide to employers and unemployed individuals that include job search assistance, referral and placement assistance, reemployment services, and recruitment services to employers.

3V40 600679 Unemployment Compensation Review Commission - Federal

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$2,435,220	\$3,042,017	\$2,976,704	\$3,191,862	\$3,487,473	\$3,487,473
	24.9%	-2.1%	7.2%	9.3%	0.0%

Source: FED: CFDA 17.245, Unemployment Insurance; United States Department of Labor from revenues collected from employers by the IRS pursuant to Federal Unemployment Tax Act

Legal Basis: ORC 4141; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 94 of the 124th G.A.)

Purpose: This line item funds the federal share of operating costs for the Unemployment Compensation Review Commission (UCRC). The commission conducts reviews for applicants who wish to appeal a benefit determination from Office of Unemployment Compensation.

3V60 600689 TANF Block Grant

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$746,384,903	\$941,902,300	\$947,935,288	\$1,043,322,945	\$761,733,452	\$736,410,211
	26.2%	0.6%	10.1%	-27.0%	-3.3%

Source: FED: CFDA 93.558, Social Security Act, Title IV, Part A, as amended

Legal Basis: ORC 5101.80 through 5101.91; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item expends funds from the federal TANF Block Grant towards Ohio's TANF programs Ohio Works First cash assistance and Prevention, Retention, and Contingency. TANF is the first title of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) that establishes a comprehensive welfare reform program designed to move welfare recipients into work and limiting public assistance. This appropriation item is expected to receive funding from the federal stimulus in amounts \$33.8 million in FY 2010 and \$8.4 million in FY 2011.

3W30 600659 TANF/ Title XX Transfer

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$10,449,489	\$5,067,402	\$10,477,423	\$6,672,366	\$0	\$0
	-51.5%	106.8%	-36.3%		

Source: FED: CFDA 93.558, Social Security Act, Title IV, Part A, as amended (Temporary Assistance for Needy Families), and claimed as earned federal reimbursement as a result of being transferred to the Social Services Block Grant

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in August, 2001)

Purpose: This line item supports various state activities not confined to the Department of Job and Family Services. This line item receives and disburses earned federal reimbursement resulting from transfers of the federal TANF Block Grant funds to the Social Services Block Grant.

State Special Revenue Fund Group

1980 600647 Children's Trust Fund

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$4,384,189	\$4,503,501	\$4,454,772	\$6,788,522	\$5,881,011	\$5,881,011
	2.7%	-1.1%	52.4%	-13.4%	0.0%

Source: SSR: Fees charged for copies of birth and death certificates, and for filing a decree of divorce or dissolution; interest earned on these deposits

Legal Basis: ORC 3109.15 through 3109.18; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 319 of the 115th G.A.)

Purpose: This line item provides state funding for expenditures related to the Children's Trust Fund, which was created in 1984 and is the state's primary funding agent for programs designed to prevent child abuse and neglect.

4A90 600607 Unemployment Compensation Admin Fund

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,898,901	\$27,923	\$8,244	\$12,188,996	\$27,134,851	\$37,772,416
	-98.5%	-70.5%	147752.9%	122.6%	39.2%

Source: SSR: Interest collected on delinquent employer contributions to the Unemployment Compensation Trust Fund, plus all fines and forfeitures assessed on employers

Legal Basis: ORC 4141; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 283 of the 123rd G.A.)

Purpose: This line item is used to fund operations related to unemployment services for which federal funds are not available.

4A90 600694 Unemployment Comp Review Commission

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$2,894,987	\$2,046,563	\$2,261,177	\$1,811,004	\$2,357,197	\$2,431,133
	-29.3%	10.5%	-19.9%	30.2%	3.1%

Source: SSR: Interest collected on delinquent employer contributions to the Unemployment Compensation Trust Fund, plus all fines and forfeitures assessed on employers

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item funds the state share of operating costs for the Unemployment Compensation Review Commission (UCRC). The commission conducts reviews for applicants who wish to appeal a benefit determination from Office of Unemployment Compensation.

4E30 600605 Nursing Home Assessments

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,151,042	\$842,517	\$0	\$4,759,914	\$4,759,914	\$4,759,914
	-26.8%		N/A	0.0%	0.0%

Source: SSR: Assessments against nursing facilities for deficiencies

Legal Basis: ORC 5111.35 through 5111.62; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board on August 17, 1992)

Purpose: This line item is used to protect the health and property of residents of nursing homes in which the Department of Health finds deficiencies. Expenditures include payment for the costs of relocation of residents to other facilities, maintenance or operation of a facility pending correction of deficiencies or closure, and reimbursement to residents for the loss of money managed by the facility. Services provided are considered allowable services under federal Medicaid regulations. Currently, funds in the line item are transferred to the Department of Aging and the Department of Health.

4E70 600604 Child and Family Services Collections

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$408,607	\$153,494	\$121,318	\$300,000	\$300,000	\$300,000
	-62.4%	-21.0%	147.3%	0.0%	0.0%

Source: SSR: \$30 of the \$50 filing fee assessed to adoptive parents

Legal Basis: ORC 5101.80 through 5101.91; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in April 1996)

Purpose: This line item funds the Putative Father Registry. This registry is designed to allow a man who believes he has fathered a child to register his interests in the child. By registering, the father will be notified if his child is placed for adoption. This may decrease the possibility for adoption disruption.

4F10 600609 Foundation Grants/Child & Family Services

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$61,420	\$250,000	\$750,000	\$250,000	\$250,000
	N/A	307.0%	200.0%	-66.7%	0.0%

Source: SSR: Various gifts and grants

Legal Basis: Section 337.10 of Sub. H.B. 1 of the 128th G.A. (originally established by Am. Sub. H.B. 152 of the 120th G.A.)

Purpose: This line item is used to provide funds from private foundations in support of pilot projects that promote programs that enhance the health, safety, and well-being of children and families.

4J50 600613 Nursing Facility Bed Assessments

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$34,185,096	\$34,823,081	\$33,849,279	\$34,613,984	\$36,713,984	\$36,713,984
	1.9%	-2.8%	2.3%	6.1%	0.0%

Source: SSR: Tax on nursing home beds for each day of use. The funding source for this line item comes from the first dollar of Nursing Facility Franchise fees and transfers from the Department of Aging to support the RSS program. Prior to FY 2002, the amount of the franchise fee was \$1 per day for each such bed. Am. Sub. H. B. 94 of the 124th General Assembly raised the franchise fee to \$3.30 for FYs 2002 and 2003. Am. Sub. S. B. 261 of the 124th General Assembly raised the franchise fee to \$4.30 for FYs 2003 through 2005. Am. Sub. H.B. 66 of the 126th G.A. increased the fee to \$6.25 for FYs 2006 and 2007. Am. Sub. H.B. 119 of the 127th G.A. maintained the fee at \$6.25 for FYs 2008 and 2009.

Legal Basis: ORC 3721.51; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 152 of the 120th G.A.)

Purpose: This line item provides the state share of franchise fee reimbursements to the nursing facilities. The federal share is paid through line item 600-623, Health Care Federal. This line item is also used to (1) transfer moneys to the Department of Aging and provides funds for PASSPORT; (2) fund the nursing facility audits and the Ohio Access Success Project.

4J50 600618 Residential State Supplement Payments

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$9,856,290	\$10,560,409	\$9,470,125	\$15,700,000	\$15,700,000	\$15,700,000
	7.1%	-10.3%	65.8%	0.0%	0.0%

Source: SSR: Nursing home franchise fee payments available for Residential State Supplement (RSS) and any transfers from the Department of Aging

Legal Basis: ORC 173.35 and 3721.56; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 152 of the 120th G.A.)

Purpose: This line item is used to make payments to Residential State Supplement (RSS) recipients. As a result of Am. Sub. H.B. 152 of the 120th G.A., control of the Optional State Supplement program (the former name of RSS) was transferred to the Department of Aging, although payments are still made by ODJFS. Funding for RSS payments is transferred from the Department of Aging. There are no federal funds generated by this line item.

The RSS program provides a cash supplement to low-income aged, blind, or disabled adults who have need for assistance with daily activities due to a medical condition, but do not require institutional care if other protective care can be arranged.

4K10 600621 ICF/MR Bed Assessments

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$19,393,464	\$19,332,437	\$19,281,090	\$23,292,437	\$28,261,826	\$29,482,434
	-0.3%	-0.3%	20.8%	21.3%	4.3%

Source: SSR: Bed tax for each day of use of an ICF/MR bed

Legal Basis: ORC 5112.31; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 152 of the 120th G.A.)

Purpose: This line item is used to fund the state share of reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) for the cost of the franchise fee. The federal share is paid through 600623, Health Care Federal.

Moneys from this account are also transferred to the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD), to provide funds for use as state match for the Medicaid waiver programs under ODMRDD.

This line item provides the state share of reimbursements to the ICFs/MR, the federal share is paid through 600623, Health Care Federal.

4R30 600687 Banking Fees

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$357,825	\$165,871	\$32,328	\$800,000	\$700,000	\$700,000
	-53.6%	-80.5%	2374.7%	-12.5%	0.0%

Source: SSR: Interest earned on the unemployment compensation benefit account and the unemployment compensation clearing account

Legal Basis: ORC 4141; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 283 of the 123rd G.A.)

Purpose: This line item is used to pay charges assess by the Treasurer of State for clearing and accounting for unemployment compensation benefit warrants and other various processing charges.

4Z10 600625 Healthcare Compliance

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$90,216	\$879,178	\$372,074	\$10,000,000	\$10,000,000	\$10,000,000
	874.5%	-57.7%	2587.6%	0.0%	0.0%

Source: SSR: Fine revenue from Medicaid providers

Legal Basis: ORC 5111.171; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in October 1998)

Purpose: This line item is used to redistribute sanctions levied against Medicaid providers. Medicaid Managed Care providers who fail to comply with health care data collection requirements are fined and the moneys are deposited in Fund 4Z10. When providers come into compliance, they are reimbursed for the fines paid from this line item.

5A50 600685 Unemployment Benefit Automation

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,059,145	\$0	\$0	\$0	\$0	\$0

Source: SSR: Interest earned on money deposited into the Unemployment Compensation Benefit Reserve Fund (Fund 5B4)

Legal Basis: Discontinued line item (originally established by Am. Sub. H.B. 275 of the 121st G.A.)

Purpose: This line item was created to help fund automation of the Unemployment Compensation Benefit delivery system and Ohio Job Net.

5AA0 600673 Ohio's Best Rx Administration

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$5,000,000	\$0	\$0	\$0	\$0
	N/A				

Source: SSR: Fund was transferred from the Ohio's Best Rx Program Fund

Legal Basis: Discontinued line item (ORC 5110.33, originally established by Section 4 of H.B. 311 of the 125th G.A.)

Purpose: This line item was used on an ongoing basis to cover expenses associated with the Ohio's Best Rx Program.

Am. Sub. H.B. 468 of the 126th G.A. transferred the Ohio's Best Rx Program to the Department of Aging.

5AJ0 600631 Money Follows the Person

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$0	\$6,286,485	\$6,195,163
					-1.5%

Source: SSR: CFDA 93.791, earned reimbursement from the Money Follows the Person Grant

Legal Basis: Section 751.20 of Am. Sub. 562 of the 127th G.A.

Purpose: This line item is used to support the Money Follows the Person Grant initiative. The funds are to be used for system reform activities related to the initiative.

5AX0 600697 Public Assistance Reconciliation

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$42,043,374	\$0	\$0	\$0	\$0	\$0

Source: SSR: Transfers from the GRF

Legal Basis: Discontinued line item

Purpose: This line item was used to pay the state TANF liability to the federal government.

5BE0 600693 Child Support Operating

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,487,538	\$1,998,692	\$399,079	\$0	\$0	\$0
	34.4%	-80.0%			

Source: SSR: A portion of federal incentives received from the U.S. Department of Health and Human Services related to child support enforcement

Legal Basis: Discontinued line item

Purpose: This line item was used for programs and administrative purposes associated with the Child Support Enforcement Program.

5BZ0 600698 ABD Managed Care Program - State

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$62,000,000	\$0	\$0	\$0	\$0
	N/A				

Source: SSR: ABD Managed Care Program - State Fund (Fund 5BZ0)

Legal Basis: Discontinued line item (originally established by Section 206.67.21 of Am. Sub. H.B. 66 of the 126th G.A.)

Purpose: This line item was used to fund the Medicaid Mandatory Managed Care for the Aged, Blind, and Disabled (ABD).

Am. Sub. H.B. 119 of the 127th G.A. appropriates the state share of the Aged, Blind, and Disabled Managed Care Program expenditures in GRF line item 600525, Health Care/Medicaid.

5CR0 600636 Children's Hospitals - State

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$3,000,000	\$6,000,000	\$3,000,000	\$0	\$0	\$0
	100.0%	-50.0%			

Source: SSR: Transfers from the Tobacco Master Settlement Agreement Fund (Fund 0870)

Legal Basis: Discontinued line item (originally established in Sections 206.66.79 and 312.24 of Am. Sub. H.B. 66 of the 126th G.A.)

Purpose: This line item was used for the Medicaid state share of making supplemental Medicaid payments to children's hospitals for inpatient services based on federal upper payment limits for children's hospitals. ODJFS paid children's hospitals the federally allowable supplemental payment in FY 2006 and FY 2007. The amount used for the program was not to exceed \$6 million (state share) in each fiscal year plus the corresponding federal match.

5DB0 600637 Military Injury Grants

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$137,500	\$2,000,000	\$2,000,000	\$2,000,000
			1354.5%	0.0%	0.0%

Source: SSR: State income tax check-off

Legal Basis: ORC 5101.98; Sections 309.10 and 309.70.10 Am. Sub. H.B.119 of the 127th G.A.

Purpose: This line item is used to provide military injury grants. In order to be eligible, an individual must have been injured while serving on active duty during Operation Enduring Freedom (Afghanistan) or Operation Iraqi Freedom or have been diagnosed with post traumatic stress disorder after having served in those operations.

5DP0 600634 Adoption Assistance Loan

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$0	\$500,000	\$500,000
					0.0%

Source: SSR: Monies transferred from the Unclaimed Funds Trust Fund by the Department of Commerce for FY 2010. Future revenue will be collections received on the repayment of loans from this line item.

Legal Basis: Sections 3107.018 and 5101.143 of Sub. H.B. 562 of the 127th G.A.

Purpose: This line item provides loans for the financial needs of a prospective adoptive parent.

5ES0 600630 Food Assistance

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$500,000	\$500,000	\$500,000	\$500,000
			0.0%	0.0%	0.0%

Source: SSR: Transfer of \$1.0 million from federal special revenue fund, Food Stamps and State Administration Fund (Fund 3840), and federal reimbursement for food stamp program administrative expenses and other food stamp program expenses

Legal Basis: ORC 5101.541; Sections 309.10 and 309.40.20 of H.B. 119 of the 127th G.A.

Purpose: This line item is used to provide funds to the Ohio Association of Second Harvest Food Banks.

5F20 600667 Building Consolidation

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$117,500	\$61,288	\$0	\$250,000	\$250,000	\$250,000
	-47.8%		N/A	0.0%	0.0%

Source: SSR: Down payments on the sale of buildings (local offices) purchased with U.S. Department of Labor (DOL) funds by the former Ohio Bureau of Employment Services

Legal Basis: ORC 4141.131; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to reimburse the Department of Labor (DOL) funds received as down payment or escrow from the sale of offices that were originally purchased with DOL funds. Amounts remaining in the fund associated with selling the property are transferred to the BES Building Enhancement Fund (Fund 5F30) and appropriated in line item 600668, Building Consolidation.

5F30 600668 Building Consolidation

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,941,102	\$373,661	\$0	\$1,000,000	\$1,000,000	\$1,000,000
	-80.8%		N/A	0.0%	0.0%

Source: SSR: Proceeds from the sale of buildings (Local Offices) purchased with U.S. Department of Labor (DOL) funds by the former Ohio Bureau of Employment Service and transfers from the Building Consolidation Fund (Fund 5F2)

Legal Basis: ORC 4141.131; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to reimburse DOL for funds used to purchase offices. The collection of the sale proceeds less any costs associated with the sale of the properties are deposited into Fund 5F30, then returned to the DOL.

5GF0 600656 Medicaid - Hospital

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$0	\$282,830,073	\$315,578,067
					11.6%

Source: SSR: Money generated by a 1.3% assessment on hospital revenues

Legal Basis: Section 309.10 of the bill, As Proposed

Purpose: This line item will be used to fund Medicaid costs that would otherwise be charged to GRF line item 600525, Health Care/Medicaid.

5Q90 600619 Supplemental Inpatient Hospital Payments

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$37,028,322	\$11,797,137	\$7,395,445	\$56,125,998	\$56,125,998	\$56,125,998
	-68.1%	-37.3%	658.9%	0.0%	0.0%

Source: SSR: The difference between what Medicare would have paid and what Medicaid actually paid for services provided to Medicaid recipients by hospitals.

Legal Basis: OAC 5101:3-2-50; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in October 2001)

Purpose: This line item and fund were created to collect and disburse the state share of Supplemental Inpatient Hospital Upper Limit Payments to Public Hospitals. The Supplemental Inpatient Hospital Upper Limit Payment program gives public hospitals an option for reducing the gap between what Medicare would have paid and what Medicaid actually pays for inpatient services provided to Medicaid recipients.

ODJFS estimates what Medicare would have paid for a set of inpatient services provided to Medicaid recipients by each hospital. ODJFS then calculates the "payment gap" or the difference between the two. The public hospitals then send the state share of the payment gap to ODJFS. These dollars are deposited into fund 5Q90 and then disbursed back to the public hospitals through line item 600619 along with federal match from line item 600623, Health Care Federal.

5R20 600608 Medicaid-Nursing Facilities

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$150,269,661	\$168,109,766	\$175,000,000	\$175,000,000	\$329,947,751	\$341,125,000
	11.9%	4.1%	0.0%	88.5%	3.4%

Source: SSR: franchise fee assessment on nursing facilities

Legal Basis: ORC 3721.56; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 94 of the 124th G.A.)

Purpose: This line item provides the state share of reimbursements for the nursing facility franchise fee to nursing facilities. The federal share is paid through line item 600623, Health Care Federal.

5S30 600629 MR/DD Medicaid Administration and Oversight

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$568,267	\$423,458	\$595,378	\$1,620,960	\$2,070,707	\$5,493,954
	-25.5%	40.6%	172.3%	27.7%	165.3%

Source: SSR: An annual fee charged by the Department of Mental Retardation and Developmental Disabilities to the county boards of MR/DD

Legal Basis: ORC 5123.0412; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in October 2001)

Purpose: This line item was created to disburse funds received from the Department of Mental Retardation and Developmental Disabilities (ODMRDD) as limited by ORC 5123.0412, which describes the purpose of Fund 5S30, which includes MRDD related administration and oversight, and county board technical support.

ODMRDD charges the county boards of MRDD an annual fee of 1.5% of the value of all Medicaid claims paid for case management or home and community based services. ODMRDD then transfers 30% of the funds collected to ODJFS.

5T20 600652 Child Support Special Payment

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,061	\$0	\$0	\$0	\$0	\$0

Source: SSR: Food stamp earned federal reimbursement owed to Ohio by Food and Nutrition Services in the U.S. Department of Agriculture and AFDC quality control funds owed to Ohio by the U.S. Department of Health and Human Services

Legal Basis: Discontinued line item (originally established by Am. S.B. 170 of the 124th G.A.)

Purpose: This line item was used to refund state income tax returns that were intercepted between October 1997 and September 2000 to offset the cost of public assistance.

5U30 600654 Health Care Services Administration

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$2,966,064	\$4,112,000	\$4,763,485	\$12,000,349	\$12,017,389	\$14,393,903
	38.6%	15.8%	151.9%	0.1%	19.8%

Source: SSR: Variety of Medicaid financing activities

Legal Basis: ORC 5111.92 through 5112.11; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to pay costs associated with the administration of the Medicaid Program, including the Medicaid Information Technology Systems (MITS). MITS will be funded at either 10% state and 90% federal, or 25% state and 75% federal, depending on the type of expenditure for the project.

5U60 600663 Children and Family Support

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$2,836,036	\$1,962,181	\$2,874,735	\$4,928,718	\$4,719,470	\$4,719,470
	-30.8%	46.5%	71.4%	-4.2%	0.0%

Source: SSR: Various withholding allowances of pass-through dollars

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Controlling Board in June 2002)

Purpose: This line item funds the state portion of the Child Welfare Training Program for county personnel and child welfare related administrative expenses.

5Z90 600672 TANF Quality Control Reinvestments

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$377,319	\$559,089	\$656,620	\$546,254	\$0	\$0
	48.2%	17.4%	-16.8%		

Source: SSR: Settlement with the U.S. Department of Health and Human Services (HHS) for a disallowance under the former Aid to Families with Dependent Children (AFDC) due to quality control findings. The negotiated disallowance amount refunded to the state is 15% of the total disallowance, or \$2,853,088.

Legal Basis: Discontinued line item (originally established by Controlling Board, March 2004)

Purpose: This line item was used for the Temporary Assistance for Needy Families Quality Control program, which was a payment accuracy review process for Ohio Works First cash assistance payments. The program was planned to end in FY 2009.

6510 600649 Hospital Care Assurance Program Fund

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$221,606,986	\$219,575,282	\$219,304,532	\$231,893,404	\$220,612,051	\$218,164,239
	-0.9%	-0.1%	5.7%	-4.9%	-1.1%

Source: SSR: HCAP assessments on hospitals

Legal Basis: OAC 5101:3-2; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 738 of the 117th G.A.)

Purpose: This line item is used to disburse the hospital share of funding for the Hospital Care Assurance Program. Hospitals are assessed an amount on their total facility costs. The total anticipated assessments from all Ohio hospitals are combined with the anticipated federal revenue in Fund 3F00, Hospital Care Assurance Match. These funds are distributed to the hospitals based on methodology provided in the Ohio Administrative Code.

Agency Fund Group

1920 600646 Support Intercept-Federal

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$90,174,722	\$91,700,872	\$124,582,476	\$130,000,000	\$130,000,000	\$130,000,000
	1.7%	35.9%	4.3%	0.0%	0.0%

Source: AGY: Overdue child support payments collected by the Internal Revenue Service

Legal Basis: ORC 5101.32; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to collect overdue child support payments from federal income tax refunds. This line item was created to comply with federal law, which required states to have procedures for income tax refund withholdings.

5830 600642 Support Intercept-State

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$12,378,458	\$11,615,979	\$14,459,126	\$16,000,000	\$16,000,000	\$16,000,000
	-6.2%	24.5%	10.7%	0.0%	0.0%

Source: AGY: Overdue child support payments collected by the Department of Taxation

Legal Basis: ORC 5101.321; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item is used to collect overdue child support payments from state personal income tax refunds. This line item was created to comply with federal law, which required states to have procedures for income tax refund withholding.

5B60 600601 Food Assistance Intercept

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$1,748,932	\$437,310	\$80,008	\$2,000,000	\$2,000,000	\$2,000,000
	-75.0%	-81.7%	2399.8%	0.0%	0.0%

Source: AGY: Collections from IRS intercept program for food stamp fraud

Legal Basis: ORC 5101.80 through 5101.91; Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.

Purpose: This line item receives the collections the IRS makes through the Food Stamp Intercept program. The moneys from this line item are sent back to the United States Department of Agriculture for reimbursement for fraudulent food stamp payments. A small portion of the collection is sent back to the county where the fraudulent benefits were issued as an incentive payment for participation in this program.

Holding Account Redistribution Fund Group

R012 600643 Refunds and Audit Settlements

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$2,193,433	\$1,111,080	\$660,758	\$3,600,000	\$3,600,000	\$3,600,000
	-49.3%	-40.5%	444.8%	0.0%	0.0%

Source: 090: Unidentified checks received by JFS

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A. (originally established by Am. Sub. H.B. 238 of the 116th G.A.)

Purpose: This line item acts as a holding account for checks whose disposition cannot be determined at the time of receipt. Upon determination of the appropriate fund into which the check should have been deposited, a disbursement is made from this line item to the appropriate fund.

R013 600644 Forgery Collections

2006	2007	2008	2009	2010 Executive Proposal	2011 Executive Proposal
\$0	\$0	\$0	\$10,000	\$10,000	\$10,000
			N/A	0.0%	0.0%

Source: 090: Funds from banks and other entities that have cashed a forged public assistance check that was repaid to the state

Legal Basis: Section 309.10 of Am. Sub. H.B. 119 of the 127th G.A.; ORC 5101 (originally established by Am. Sub. H.B. 238 of 116th G.A.)

Purpose: The line item was created to receive funds from banks and other entities that have cashed forged public assistance warrants.

LSC Budget Spreadsheet by Line Item, FY 2010 - FY 2011

<i>Fund</i>	<i>ALI</i>	<i>ALI Title</i>	<i>2008</i>	<i>2009</i>	<i>As Introduced 2010</i>	<i>% Change 2009 to 2010</i>	<i>As Introduced 2011</i>	<i>% Change 2010 to 2011</i>
JFS Department of Job and Family Services								
		Support Services-State	\$ 46,698,055	\$ 44,037,441	\$ 52,432,042	19.1%	\$ 52,817,104	0.7%
		Support Services-Federal	\$ 9,618,264	\$ 10,143,184	\$ 9,252,713	-8.8%	\$ 9,320,665	0.7%
GRF	600321	Support Services - Total	\$ 56,316,319	\$ 54,180,625	\$ 61,684,755	13.9%	\$ 62,137,769	0.7%
GRF	600410	TANF State	\$ 262,618,810	\$ 254,907,156	\$ 190,607,468	-25.2%	\$ 202,858,335	6.4%
GRF	600413	Child Care Match/Maintenance of Effort	\$ 84,120,576	\$ 80,124,868	\$ 88,415,688	10.3%	\$ 93,105,300	5.3%
		Computer Projects-State	\$ 113,488,542	\$ 90,457,387	\$ 92,734,743	2.5%	\$ 93,242,343	0.5%
		Computer Projects-Federal	\$ 24,073,327	\$ 15,748,581	\$ 10,303,860	-34.6%	\$ 10,360,260	0.5%
GRF	600416	Computer Projects - Total	\$ 137,561,869	\$ 106,205,968	\$ 103,038,603	-3.0%	\$ 103,602,603	0.5%
GRF	600417	Medicaid Provider Audits	\$ 1,292,040	\$ 1,573,876	\$ 1,484,001	-5.7%	\$ 1,497,886	0.9%
GRF	600420	Child Support Administration	\$ 6,673,686	\$ 7,723,936	\$ 7,369,234	-4.6%	\$ 7,431,310	0.8%
GRF	600421	Office of Family Stability	\$ 3,486,555	\$ 2,720,599	\$ 4,653,955	71.1%	\$ 4,720,001	1.4%
GRF	600423	Office of Children and Families	\$ 5,257,898	\$ 4,842,705	\$ 6,494,545	34.1%	\$ 6,580,782	1.3%
		Office of Ohio Health Plans-State	\$ 19,893,274	\$ 16,260,433	\$ 14,688,390	-9.7%	\$ 11,452,327	-22.0%
		Office of Ohio Health Plans-Federal	\$ 20,622,558	\$ 18,437,421	\$ 15,287,916	-17.1%	\$ 11,919,769	-22.0%
GRF	600425	Office of Ohio Health Plans - Total	\$ 40,515,832	\$ 34,697,854	\$ 29,976,306	-13.6%	\$ 23,372,096	-22.0%
GRF	600440	Ohio's Best Rx Start Up Costs	\$ 36,858	\$ 0	\$ 0	N/A	\$ 0	N/A
GRF	600502	Administration-Local	\$ 33,660,414	\$ 26,948,050	\$ 25,382,308	-5.8%	\$ 24,950,288	-1.7%
GRF	600511	Disability Financial Assistance	\$ 26,896,418	\$ 25,335,908	\$ 36,037,712	42.2%	\$ 38,684,457	7.3%
GRF	600512	Non-TANF Disaster Assistance	\$ 138,056	\$ 950,750	\$ 0	-100.0%	\$ 0	N/A
GRF	600521	Entitlement Administration-Local	\$ 125,930,450	\$ 118,609,231	\$ 107,026,181	-9.8%	\$ 100,893,286	-5.7%
GRF	600523	Children and Families Services	\$ 73,625,846	\$ 68,935,460	\$ 74,209,378	7.7%	\$ 74,209,378	0.0%
		Health Care/Medicaid-State	\$ 3,550,108,456	\$ 3,140,517,018	\$ 2,499,164,487	-20.4%	\$ 3,458,406,646	38.4%
		Health Care/Medicaid-Federal	\$ 5,552,558,751	\$ 6,737,202,891	\$ 6,315,314,628	-6.3%	\$ 7,235,261,849	14.6%
GRF	600525	Health Care/Medicaid - Total	\$ 9,102,667,207	\$ 9,877,719,909	\$ 8,814,479,115	-10.8%	\$ 10,693,668,495	21.3%
GRF	600526	Medicare Part D	\$ 243,172,531	\$ 235,817,392	\$ 271,746,617	15.2%	\$ 287,194,790	5.7%
		Adoption Services-State	\$ 32,331,631	\$ 43,693,916	\$ 38,722,700	-11.4%	\$ 41,060,302	6.0%

LSC Budget Spreadsheet by Line Item, FY 2010 - FY 2011

<i>Fund</i>	<i>ALI</i>	<i>ALI Title</i>	<i>2008</i>	<i>2009</i>	<i>As Introduced 2010</i>	<i>% Change 2009 to 2010</i>	<i>As Introduced 2011</i>	<i>% Change 2010 to 2011</i>
JFS Department of Job and Family Services								
		<i>Adoption Services-Federal</i>	\$ 37,027,786	\$ 42,806,781	\$ 49,792,948	16.3%	\$ 47,455,346	-4.7%
GRF	600528	Adoption Services - Total	\$ 69,359,417	\$ 86,500,697	\$ 88,515,648	2.3%	\$ 88,515,648	0.0%
GRF	600529	Capital Compensation Program	\$ 1,504,320	\$ 0	\$ 40,000,000	N/A	\$ 0	-100.0%
GRF	600534	Adult Protective Services	\$0	\$ 497,403	\$ 522,040	5.0%	\$ 511,453	-2.0%
GRF	600535	Early Care and Education	\$0	\$ 0	\$ 150,000,000	N/A	\$ 150,000,000	0.0%
GRF	600537	Children's Hospital	\$0	\$ 0	\$ 6,000,000	N/A	\$ 6,000,000	0.0%
GRF	600661	Child Care - Federal Stimulus	\$0	\$ 0	\$ 8,915,224	N/A	\$ 13,459,664	51.0%
GRF - STATE			\$ 4,630,934,417	\$ 4,163,953,529	\$ 3,716,606,713	-10.74%	\$ 4,669,075,652	25.63%
GRF - FEDERAL			\$ 5,643,900,686	\$ 6,824,338,858	\$ 6,399,952,065	-6.22%	\$ 7,314,317,889	14.29%
General Revenue Fund Total			\$ 10,274,835,103	\$ 10,988,292,387	\$ 10,116,558,778	-7.9%	\$ 11,983,393,541	18.5%
4A80	600658	Child Support Collections	\$ 31,244,887	\$ 31,929,211	\$ 26,000,000	-18.6%	\$ 26,000,000	0.0%
4R40	600665	BCII Services/Fees	\$ 561	\$ 36,974	\$ 36,974	0.0%	\$ 36,974	0.0%
5BG0	600653	Managed Care Assessment	\$ 172,178,992	\$ 222,667,304	\$ 168,914,857	-24.1%	\$ 0	-100.0%
5C90	600671	Medicaid Program Support	\$ 69,374,403	\$ 80,120,048	\$ 69,876,838	-12.8%	\$ 68,313,238	-2.2%
5DL0	600639	Medicaid Revenue and Collections	\$ 51,238,266	\$ 76,296,844	\$ 99,916,750	31.0%	\$ 63,600,000	-36.3%
5DM0	600633	Administration and Operating	\$0	\$ 0	\$ 19,853,583	N/A	\$ 19,928,733	0.4%
5FX0	600638	Medicaid Payment Withholding	\$0	\$ 26,000,000	\$ 26,000,000	0.0%	\$ 26,000,000	0.0%
5N10	600677	County Technologies	\$ 472,703	\$ 1,000,000	\$ 1,000,000	0.0%	\$ 1,000,000	0.0%
5P50	600692	Health Care Services	\$ 89,261,895	\$ 82,000,000	\$ 84,052,802	2.5%	\$ 226,469,478	169.4%
6130	600645	Training Activities	\$0	\$ 135,000	\$ 110,000	-18.5%	\$ 110,000	0.0%
General Services Fund Group Total			\$ 413,771,707	\$ 520,185,381	\$ 495,761,804	-4.7%	\$ 431,458,423	-13.0%
3270	600606	Child Welfare	\$ 24,507,846	\$ 47,947,309	\$ 33,972,321	-29.1%	\$ 33,984,200	0.0%
3310	600686	Federal Operating	\$ 43,604,892	\$ 56,263,223	\$ 50,655,096	-10.0%	\$ 51,569,912	1.8%
3840	600610	Food Assistance and State Administration	\$ 126,980,901	\$ 153,147,118	\$ 159,109,776	3.9%	\$ 159,109,427	0.0%
3850	600614	Refugee Services	\$ 7,148,354	\$ 11,057,826	\$ 10,497,024	-5.1%	\$ 11,265,511	7.3%

LSC Budget Spreadsheet by Line Item, FY 2010 - FY 2011

<i>Fund</i>	<i>ALI</i>	<i>ALI Title</i>	<i>2008</i>	<i>2009</i>	<i>As Introduced 2010</i>	<i>% Change 2009 to 2010</i>	<i>As Introduced 2011</i>	<i>% Change 2010 to 2011</i>
JFS Department of Job and Family Services								
3950	600616	Special Activities/Child and Family Services	\$ 2,140,330	\$ 5,717,151	\$ 3,113,200	-45.5%	\$ 2,813,200	-9.6%
3960	600620	Social Services Block Grant	\$ 119,969,771	\$ 114,474,085	\$ 120,000,000	4.8%	\$ 120,000,000	0.0%
3960	600651	Second Harvest Food Banks	\$ 5,500,000	\$ 5,500,000	\$ 0	-100.0%	\$ 0	N/A
3970	600626	Child Support	\$ 207,916,986	\$ 303,538,962	\$ 305,830,981	0.8%	\$ 305,832,341	0.0%
3980	600627	Adoption Maintenance/Administration	\$ 229,126,145	\$ 317,483,676	\$ 346,622,373	9.2%	\$ 346,865,342	0.1%
3A20	600641	Emergency Food Distribution	\$ 2,574,863	\$ 3,500,000	\$ 4,970,000	42.0%	\$ 4,970,000	0.0%
3AW0	600675	Faith Based Initiatives	\$ 617,393	\$ 1,000,000	\$ 544,140	-45.6%	\$ 544,140	0.0%
3D30	600648	Children's Trust Fund Federal	\$ 1,500,000	\$ 2,040,524	\$ 2,040,524	0.0%	\$ 2,040,524	0.0%
3F00	600623	Health Care Federal	\$ 987,727,014	\$ 1,601,775,530	\$ 3,053,505,106	90.6%	\$ 2,310,117,015	-24.3%
3F00	600635	Children's Hospitals - Federal	\$ 3,994,090	\$ 0	\$ 0	N/A	\$ 0	N/A
3F00	600650	Hospital Care Assurance Match	\$ 328,655,603	\$ 343,239,047	\$ 362,092,785	5.5%	\$ 367,826,196	1.6%
3G50	600655	Interagency Reimbursement	\$ 1,258,402,177	\$ 1,513,855,965	\$ 1,503,777,044	-0.7%	\$ 1,561,905,912	3.9%
3H70	600617	Child Care Federal	\$ 201,714,009	\$ 200,167,593	\$ 241,862,780	20.8%	\$ 241,862,779	0.0%
3N00	600628	IV-E Foster Care Maintenance	\$ 104,572,138	\$ 153,963,142	\$ 169,324,768	10.0%	\$ 161,644,455	-4.5%
3S50	600622	Child Support Projects	\$ 235,192	\$ 534,050	\$ 534,050	0.0%	\$ 534,050	0.0%
3V00	600688	Workforce Investment Act	\$ 153,024,447	\$ 250,861,843	\$ 326,923,124	30.3%	\$ 327,145,616	0.1%
3V40	600678	Federal Unemployment Programs	\$ 123,819,664	\$ 152,843,411	\$ 154,883,142	1.3%	\$ 136,982,528	-11.6%
3V40	600679	Unemployment Compensation Review Commission - Federal	\$ 2,976,704	\$ 3,191,862	\$ 3,487,473	9.3%	\$ 3,487,473	0.0%
3V60	600689	TANF Block Grant	\$ 947,935,288	\$ 1,043,322,945	\$ 761,733,452	-27.0%	\$ 736,410,211	-3.3%
3W30	600659	TANF/ Title XX Transfer	\$ 10,477,423	\$ 6,672,366	\$ 0	-100.0%	\$ 0	N/A
Federal Special Revenue Fund Group Total			\$ 4,895,121,232	\$ 6,292,097,628	\$ 7,615,479,159	21.0%	\$ 6,886,910,832	-9.6%
1980	600647	Children's Trust Fund	\$ 4,454,772	\$ 6,788,522	\$ 5,881,011	-13.4%	\$ 5,881,011	0.0%
4A90	600607	Unemployment Compensation Admin Fund	\$ 8,244	\$ 12,188,996	\$ 27,134,851	122.6%	\$ 37,772,416	39.2%
4A90	600694	Unemployment Comp Review Commission	\$ 2,261,177	\$ 1,811,004	\$ 2,357,197	30.2%	\$ 2,431,133	3.1%
4E30	600605	Nursing Home Assessments	\$ 0	\$ 4,759,914	\$ 4,759,914	0.0%	\$ 4,759,914	0.0%

LSC Budget Spreadsheet by Line Item, FY 2010 - FY 2011

<i>Fund</i>	<i>ALI</i>	<i>ALI Title</i>	<i>2008</i>	<i>2009</i>	<i>As Introduced 2010</i>	<i>% Change 2009 to 2010</i>	<i>As Introduced 2011</i>	<i>% Change 2010 to 2011</i>
JFS Department of Job and Family Services								
4E70	600604	Child and Family Services Collections	\$ 121,318	\$ 300,000	\$ 300,000	0.0%	\$ 300,000	0.0%
4F10	600609	Foundation Grants/Child & Family Services	\$ 250,000	\$ 750,000	\$ 250,000	-66.7%	\$ 250,000	0.0%
4J50	600613	Nursing Facility Bed Assessments	\$ 33,849,279	\$ 34,613,984	\$ 36,713,984	6.1%	\$ 36,713,984	0.0%
4J50	600618	Residential State Supplement Payments	\$ 9,470,125	\$ 15,700,000	\$ 15,700,000	0.0%	\$ 15,700,000	0.0%
4K10	600621	ICF/MR Bed Assessments	\$ 19,281,090	\$ 23,292,437	\$ 28,261,826	21.3%	\$ 29,482,434	4.3%
4R30	600687	Banking Fees	\$ 32,328	\$ 800,000	\$ 700,000	-12.5%	\$ 700,000	0.0%
4Z10	600625	Healthcare Compliance	\$ 372,074	\$ 10,000,000	\$ 10,000,000	0.0%	\$ 10,000,000	0.0%
5AJ0	600631	Money Follows the Person	\$ 0	\$ 0	\$ 6,286,485	N/A	\$ 6,195,163	-1.5%
5BE0	600693	Child Support Operating	\$ 399,079	\$ 0	\$ 0	N/A	\$ 0	N/A
5CR0	600636	Children's Hospitals - State	\$ 3,000,000	\$ 0	\$ 0	N/A	\$ 0	N/A
5DB0	600637	Military Injury Grants	\$ 137,500	\$ 2,000,000	\$ 2,000,000	0.0%	\$ 2,000,000	0.0%
5DP0	600634	Adoption Assistance Loan	\$ 0	\$ 0	\$ 500,000	N/A	\$ 500,000	0.0%
5ES0	600630	Food Assistance	\$ 500,000	\$ 500,000	\$ 500,000	0.0%	\$ 500,000	0.0%
5F20	600667	Building Consolidation	\$ 0	\$ 250,000	\$ 250,000	0.0%	\$ 250,000	0.0%
5F30	600668	Building Consolidation	\$ 0	\$ 1,000,000	\$ 1,000,000	0.0%	\$ 1,000,000	0.0%
5GF0	600656	Medicaid - Hospital	\$ 0	\$ 0	\$ 282,830,073	N/A	\$ 315,578,067	11.6%
5Q90	600619	Supplemental Inpatient Hospital Payments	\$ 7,395,445	\$ 56,125,998	\$ 56,125,998	0.0%	\$ 56,125,998	0.0%
5R20	600608	Medicaid-Nursing Facilities	\$ 175,000,000	\$ 175,000,000	\$ 329,947,751	88.5%	\$ 341,125,000	3.4%
5S30	600629	MR/DD Medicaid Administration and Oversight	\$ 595,378	\$ 1,620,960	\$ 2,070,707	27.7%	\$ 5,493,954	165.3%
5U30	600654	Health Care Services Administration	\$ 4,763,485	\$ 12,000,349	\$ 12,017,389	0.1%	\$ 14,393,903	19.8%
5U60	600663	Children and Family Support	\$ 2,874,735	\$ 4,928,718	\$ 4,719,470	-4.2%	\$ 4,719,470	0.0%
5Z90	600672	TANF Quality Control Reinvestments	\$ 656,620	\$ 546,254	\$ 0	-100.0%	\$ 0	N/A
6510	600649	Hospital Care Assurance Program Fund	\$ 219,304,532	\$ 231,893,404	\$ 220,612,051	-4.9%	\$ 218,164,239	-1.1%
State Special Revenue Fund Group Total			\$ 484,727,181	\$ 596,870,540	\$ 1,050,918,707	76.1%	\$ 1,110,036,686	5.6%
1920	600646	Support Intercept-Federal	\$ 124,582,476	\$ 130,000,000	\$ 130,000,000	0.0%	\$ 130,000,000	0.0%

LSC Budget Spreadsheet by Line Item, FY 2010 - FY 2011

<i>Fund</i>	<i>ALI</i>	<i>ALI Title</i>	<i>2008</i>	<i>2009</i>	<i>As Introduced 2010</i>	<i>% Change 2009 to 2010</i>	<i>As Introduced 2011</i>	<i>% Change 2010 to 2011</i>
<i>JFS Department of Job and Family Services</i>								
5830	600642	Support Intercept-State	\$ 14,459,126	\$ 16,000,000	\$ 16,000,000	0.0%	\$ 16,000,000	0.0%
5B60	600601	Food Assistance Intercept	\$ 80,008	\$ 2,000,000	\$ 2,000,000	0.0%	\$ 2,000,000	0.0%
Agency Fund Group Total			\$ 139,121,610	\$ 148,000,000	\$ 148,000,000	0.0%	\$ 148,000,000	0.0%
R012	600643	Refunds and Audit Settlements	\$ 660,758	\$ 3,600,000	\$ 3,600,000	0.0%	\$ 3,600,000	0.0%
R013	600644	Forgery Collections	\$0	\$ 10,000	\$ 10,000	0.0%	\$ 10,000	0.0%
Holding Account Redistribution Fund Group Total			\$ 660,758	\$ 3,610,000	\$ 3,610,000	0.0%	\$ 3,610,000	0.0%
<i>Total All Budget Fund Groups</i>			\$ 16,208,237,591	\$ 18,549,055,936	\$ 19,430,328,448	4.8%	\$ 20,563,409,482	5.8%