John J. White
State Representative, 38th House District

COMMITTEES
Health (Chair)
Elections and Ethics
Financial Institutions, Real Estate and Securities
Insurance

December 27, 2006

TO: All members of the Legislative Committee on the Future Funding of the Bureau for Children with Medical Handicaps

FROM: Chairman White

RE: The Final Report of the Committee

Please find attached a copy of the final report of the Legislative Committee on the Future Funding of the Bureau for Children with Medical Handicaps. After extensive discussions between my office and certain committee members, the report shall be submitted with the understanding that it serves to provide an excellent framework for the legislature as we move into the budget process for fiscal years 2008 and 2009.

BCMH is a vital program to many Ohio citizens. Anything less than the continuance of the program in its current form and the invaluable services it provides would be completely unacceptable to this body. After a comprehensive look into current funding mechanisms as well as new possibilities to be explored, the committee has produced the following report and set of recommendations therein. The recommendations included in the report are not and should be assumed to be universally agreed-upon by the full committee, as they were never formally voted upon, but they are our best possibilities in moving forward to sustaining this program at its current levels as well as looking for opportunities to expand and grow in the future.

I have submitted this report and this committee's recommendations to the Administration and will be waiting to hear which proposals will be considered. The time has finished for this committee to meet in its current form. We are now at a point where the active participation and advocacy of all of our members is required to make some of these recommendations a reality in the upcoming budget process. I thank you all for the work you have done as a member of this committee for the past year, and I look forward to working with you in the future.

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THE BUREAU FOR CHILDREN WITH MEDICAL HANDICAPS (BCMH)

DECEMBER 2006 REPORT

TABLE OF CONTENTS

ENABLING LANGUAGE & CHARGE

The Legislative Committee on the Future Funding of the Bureau for Children with Medical Handicaps (BCMH) was formed with the passage of the Ohio fiscal year 2006-2007 operating budget. The intent of the committee was to find an option(s) that addresses the current and future needs of the program. As a result, Amended Substitute House Bill 66 of the 126th Ohio General Assembly – the 2007-2007 operating budget – (Section 206.42.12) charged the committee with the following:

1. Examine the current status of the program and recommend "best practices" to be used in assisting working parents who have children with special health needs.
2. Review all existing statutes and rules in Ohio pertaining to the program.
3. Review payment strategies in other states that facilitate adequate care for children with chronic conditions and support their families.
4. Review all funding sources for the program, including funding received from county levies, the General Revenue Fund and other state-based sources, as well as the Maternal and Child Health Block Grant of Title V of the "Social Security Act," 40 Stat. 620 (1935), 42 U.S.C. 301.
5. Request testimony from parents of children with special health needs, as well as the children themselves and from health care professionals and other individuals who provide services to Bureau patients.
6. Not later than December 31, 2006, the Committee shall make recommendations and submit a report to the governor, the president and minority leader of the senate, and the speaker and minority leader of the House of Representatives. The report shall include an analysis of the current system of services covered by the program and may include determinations and recommendations regarding how the state can best address the current and future needs of patients served by the program. On submission of the report, the Committee shall cease to exist.

The committee took a hard look at the existing program to see if there was a "silver bullet" to ensure the program's stable future. The BCMH program is a valuable asset to many families, but the program has struggled in times of high health care inflation and budget shortfalls. Health care inflation has hovered just below 8 percent for the last four years, according to the Center for Studying Health System Change. Even though the BCMH program is run efficiently and is able to buck that trend, it cannot fight against such overall system pressures.

After an exhaustive look at the program, the committee did not find one special "fix" that would keep BCMH running for the long-term and would allow the program to expand and grow. The concepts that follow are a result of extensive brainstorming by members of the committee. Several ideas have been lifted out as possible immediate approaches for the short-term. The committee recognizes that this issue will require continued future collaboration between all stakeholders, including state and local health officials, benefit recipients, providers, and legislators.

CURRENT BCMH SERVICE SYSTEM

The Bureau for Children with Medical Handicaps is a unique health care safety net for Ohio's vulnerable children. The mission is to assure, through the development of high-quality, coordinated systems, that children with special health care needs and their families obtain comprehensive care and services, which are family centered, community based, and culturally competent. Program components include establishing standards of care, funding services for the diagnosis and treatment of medically eligible conditions, collaborating with public health nurses and local health departments to increase access to care, and helping families use the appropriate sources of payment for services.

There are three main children's programs within the bureau: Treatment, Diagnostic, and Service Coordination. To become BCMH eligible, applicants must be less than 21 years of age (with the exception of the adult cystic fibrosis and adult hemophilia insurance premium payment programs) who have or may have a chronic medical condition, must be a permanent Ohio resident, and be under the care of a BCMH approved physician (MD or DO). Financial criteria must also be met for the treatment program.

The diagnostic program provides diagnostic services to children for up to three months in order to diagnose and determine a treatment plan or rule out any special health care needs. There are no financial eligibility requirements for the diagnostic program. The treatment program benefit period – once a child is medically and financially approved – is for one year and conditions must be chronic, physically handicapping and amenable to treatment. The Bureau for Children with Medical Handicaps covered treatment services include doctor visits, prescription medication, medical equipment and supplies, hospitalizations, and surgeries. Service coordination is the third program and it is provided through the utilization of public health nurses, hospital-based team service coordinators, physician care management, and a new initiative advanced by the American Academy of Pediatrics known as the medical home initiative. Additionally, adults who have been diagnosed and are financially eligible can receive treatment for cystic fibrosis and metabolic disorders.

COMMITTEE MEMBERSHIP

- State Representative John White, Chairman
- State Senator Patricia Clancy, Vice-Chair
- Minority Leader of the House Joyce Beatty
- State Senator Larry Mumper
- State Representative Jon Peterson
- State Senator Tom Roberts
- Rosemary Bradford, public member (appointed by the Speaker of the Ohio House)
- Jenifer Watson, public member (appointed by the Speaker of the Ohio House)
- Melissa Wulliger, public member (appointed by the Speaker of the Ohio House)
- Randi Clites, public member (appointed by the Speaker of the Ohio House)
- Kim Mathews, public member (appointed by the Ohio Senate President)
- Cindi Sutter, public member (appointed by the Ohio Senate President)
- Jim Pearsol, Ohio Department of Health
- Dan Tierney, Ohio Department of Insurance
- Heather Burdette, Ohio Department of Job and Family Services
- Suzanne Dulaney, County Commissioners Association of Ohio
- Dr. Jeff Hord, Ohio Children's Hospital Association
- Owen Johnson, Ohio Association of Health Plans
- Dr. Ron Levin, American Academy of Pediatrics
- Dr. Carolyn Green, Ohio Hospital Association
- Marjorie Broadhead, Ohio Association of Health Commissioners
- Mary Etta Fizer, Ohio Nurses Association

LEGISLATIVE COMMITTEE ON THE FUTURE FUNDING OF THE BCMH MEETING SYNOPSIS

The committee met seven times with the first meeting convening on November 15, 2005 in which state Representative John White was officially installed as the committee's chairman and state Senator Patricia Clancy serving as the vice-chairwoman. Also at the meeting, the Ohio Department of Health outlined the program history and current status. (See Appendix A: ODH provided manual)

DECEMBER

At the December meeting, the Legislative Service Commission (LSC) provided a document reviewing all of the existing Ohio statutes and rules governing the BCMH program. (Appendix B: LSC document) Additionally, a representative from the County Commissioners Association of Ohio (CCAO) summarized the county funding structure, specifically addressing the inside mills that counties contribute to the program. Committee members posed a number of questions asking what happens to the unspent money earmarked for BCMH, why is it (county dollars) only used for treatment and not other services, and how does the department (ODH) factor county dollars in its budget? The County Commissioners Association of Ohio responded that the unspent dollars go back to that particular counties general revenue fund (GRF) and county money is only used for treatment because, historically, that was the only need. The Ohio Department of Health stated it was difficult to anticipate the county dollar factor because demand drives the cost.

JANUARY

Public testimony was heard at the January meeting and included individuals who are beneficiaries of the BCMH program, providers, and family members. The committee heard from individuals like Zachary Rumm, who is an adult living with Cystic Fibrosis, Dr. James Duffee from the Rocking Horse Center, and Molly Howlett, who is the parent of a child with Type 1 Diabetes. The chairman asked that those testifying also include a recommendation or an idea for the committee to consider in its deliberations. (Appendix C: Public Testimony) Prior to adjourning, Chairman White announced that subcommittees would be created to address funding, payment strategies, and best practices.

FEBRUARY

The three subcommittees began meeting in February with state Senator Patricia Clancy serving as funding chair, state Senator Larry Mumper as payment strategies chair, and state Representative Jon Peterson as best practices chair. Committee members were assigned to subcommittees (See Appendix D: Subcommittee assignments) in which their respective expertise would serve best, however, being a part of one subcommittee did not limit participation in another subcommittee as the subcommittee meetings were public

meetings. The following sections contain both the full committee and subcommittee concepts for consideration.

RECOMMENDATIONS

It was demonstrated very clearly to the committee that there is a need for the state of Ohio to maintain this program, not only for its value to public health, but also as a factor in the well-being of the families involved and the economic stability it can provide to keep these parents in the workforce. After productive discussions with many ideas presented in the subcommittees,[1] the full committee made five recommendations.

The main concepts of these five ideas were captured in one way or another in subcommittee discussions, and as such, you will find these recommendations repeated in different forms throughout this report. Keep in mind that this is not meant to be repetitive; rather, these ideas were the most discussed and appeared to have the most support and agreement amongst committee members.

The following five recommendations are significant in that they can be accomplished in the short term to accomplish the long-term goal of keeping the program viable. Many of the other ideas presented by the subcommittees are commendable for the long-term.

1. Institute new fees, increase existing fees, and/or reallocate fees with revenues ear-marked for BCMH.
    - Requires legislative actions – the amount generated will depend on the chosen fees.
    - Examples: birth and death certificate fees, statewide immunization fees – i.e. flu vaccines (see Appendix D: earmarked state fees and other states' fees)
2. Institute mandatory manufacturer rebates for prescription medication and special nutritional formulas.
    - For inclusion on the BCMH formulary
    - Additional Preferred Drug List (PDL) rebates for select therapeutic categories within the formulary
    - Requires legislative action
    - Amounts negotiated with manufacturers, no estimates available

[1] Subcommittee reports are included later in the report.

- Concept is similar to formularies used by private health plans and Medicaid

- Institute a generic drug preference if applicable

3. Bill counties for diagnostic services provided by BCMH (which would save BCMH approximately $400,000 annually) and bill counties for administrative costs of BCMH's case management functions, including Nurse Case Managers, Field Nurse Consultants and Resource Payment Specialists, which account for approximately $3 million annually in BCMH's federally-funded payroll costs. Together, both billing methods would help maximize the use of the counties' one-tenth mill set-aside.

4. Increase GRF funding to match what the counties contribute to BCMH.

5. The committee itself should be continued in some form and its composition and specific roles put into statute in order to guarantee its continuation as an evaluating entity. Through legislative action in the 127th General Assembly, the make up of such a committee could be established to include legislators and members of the BCMH community.

Other suggestions raised during the full committee meeting included:

- Implement provisions of the recent federal Family Opportunity Act, which could benefit children with disabilities through the Medicaid program.
- Make local health departments, in conjunction with children's hospitals responsible for distributing a resource guide in order to reach out to and educate the public about what resources are available to them.
- Look at services within and between programs at the state level to prevent the possibility of duplication of services.

FUNDING SUBCOMMITTEE

SUBCOMMITTEE MEMBERS

- State Senator Patricia Clancy, Chairwoman
- Marjorie Broadhead, Ohio Association of Health Commissioners
- Suzanne Dulaney, County Commissioners Association of Ohio
- Kim Mathews, public member (appointed by the Ohio Senate President)
- Jim Pearsol, Ohio Department of Health
- Melissa Wulliger, public member (appointed by the Speaker of the Ohio House)

Chairwoman Clancy's committee, which met a total of five times, was charged with reviewing program-funding sources and discussing additional avenues to assist with escalating costs. The subcommittee's open dialogue gave members a chance to voice their own solutions to the problem. In some instances, general consensus was not reached in support of the following concepts. A summary of the ideas discussed by the subcommittee are as follows:

SHORT TERM RECOMMENDATIONS

- Institute new fees and/or increase existing fees with revenues earmarked for BCMH
    - Requires legislative action – the amount generated will depend on the chosen fees.
    - i.e. birth and death certificate fees, statewide immunization fees
- Institute mandatory manufacturer rebates for prescription medication and special nutritional formulas
    - For inclusion on the BCMH formulary
    - Additional Preferred Drug List (PDL) rebates for select therapeutic categories within the formulary
    - Requires legislative rule change
    - Amounts negotiated with manufacturers, no estimates available
- Create incentives and discounts for participating physicians and service providers
- Combine related programs to prevent duplication of services

- Closely review services already provided by specific agencies and programs like "Help Me Grow", "Early Start", "Maternal Child Health Services" and "Public Health Nursing Programs" to eliminate duplication of services

- Increase GRF funding to match what the counties contribute to BCMH

- Invite Kathy Stiffler, the Director of Michigan's Children's Special Health Care Services program to testify before the committee and answer questions about Michigan's programs for BCMH clients

- Direct DAS to research the possibility of including BCMH clients in the state employee insurance program

- Generate revenue through fees

    - For example, examine the funds generated through vital statistics fees that are currently funneled through the Department of Public Safety (DPS) to pay for domestic violence shelters.

    - Perhaps DPS can find another source of funding for this worthwhile program so that the funds collected through ODH for this program would go to BCMH instead.

    - The consensus was that the funding for the domestic violence shelters should not be cut completely.

- Explore the possibility of bringing in outside experts to thoroughly review the funding for the BCMH program. These experts should have knowledge of the BCMH budget, the ODH budget, as well as the state budget in general. Discuss the possibility of paying these experts for their services.

- Research the possibility of allowing BCMH patients to pay out of pocket expenses at BCMH rates

- Investigate the federal 340B drug discount program and if it is possible to utilize the program for BCMH patients. Examine how California is utilizing this program.

LONG TERM RECOMMENDATIONS

- Discuss the expansion of services and/or eligibility

- Explore Medicaid related options

- Expand CHIP eligibility

- Create a home and community based waiver for the BCMH population
- Create a BCMH Buy-In
- Create a medical income disregard for CHIP based on diagnosis severity
- Expand the scope of Medicaid covered services, leveraging the federal draw down
- Increase the cost share for individual families based on income
    - Based on a family's adjusted gross income, require BCMH families to pay a percentage of the bill for the services their child receives. This amount would be calculated after the BCMH discount has been applied. This will include a maximum out-of-pocket cost cap for each family each year.
    - Require BCMH families who are over the income requirements for Medicaid to pay a qualifying fee (cost share, buy-in). These families would be asked to pay 1 percent of their adjusted gross income to BCMH.
- Create an Ohio Health Insurance Risk Pool incorporating BCMH clients into the type of pool created by state Senator Lynn Wachtmann's legislation (Senate Bill 272, 126th General Assembly) – similar to Indiana's program. (Senate Bill 272 is currently pending in the Senate Insurance, Commerce, and Labor Committee.)
- Require BCMH pay a client's private insurance premium in order to stay covered by insurance

PAYMENT STRATEGIES SUBCOMMITTEE

SUBCOMMITTEE MEMBERS

- State Senator Larry Mumper, Chairman
- Heather Burdette, Ohio Department of Job and Family Services
- Randi Clites, public member (appointed by the Speaker of the Ohio House)
- Dr. Jeff Hord, Ohio Children's Hospital Association of Ohio
- Owen Johnson, Ohio Association of Health Plans
- Dan Tierney, Ohio Department of Insurance
- Jenifer Watson, public member (appointed by the Speaker of the Ohio House)

Chairman Mumper's subcommittee, which met a total of four times, was charged to look at other possible payment methods and how other states facilitate care for their children with special health care needs (CSHCN). The Legislative Service Commission provided the subcommittee a document outlining the state of Michigan's Children's Special Health Care Services program (See Appendix D). Additionally, LSC presented a synopsis to a question raised in both the funding and payment strategies subcommittee on the increased utilization of county inside mills (See Appendix E).

There were three recommendations consistently suggested by the vast majority of the payment strategies subcommittee members:

1) Consider maximizing the one-tenth inside millage of county property taxes

2) Allow a buy-in or cost share for the BCMH program

3) Seek out other Medicaid alternatives including potential expansions in existing programs, buy-in options or exploration of additional or new waivers.

The subcommittee suggested the following short- and long-term recommendations: (It is important to note that votes were not taken in the subcommittee and certain items may not have unanimous consensus.)

SHORT TERM RECOMMENDATIONS:

1) Utilize the one-tenth inside millage of county property taxes for treatment services, diagnostic services, and administrative services provided to residents of their particular county. Currently, these dollars are only used for treatment services and not administrative or diagnostic functions and thus the counties retain roughly $7.9 million per year of the one-tenth mills for use in their general revenue streams. These changes would obviously reduce the amount

of dollars being returned to the counties and would require a legislative change.

- If counties were billed for diagnostic services as opposed to BCMH absorbing the cost, approximately $400,000 would be generated annually.

- If counties were billed for administrative costs of BCMH's case management functions:

    - Nurse Case Managers, Field Nurse Consultants and Resource Payment Specialists (These work units would account for $3 million annually in BCMH's federally funded payroll costs.)

    - Initial estimates show approximately $1.3 to $1.5 million would be generated annually.

    - Would allow for the maximizing Medicaid Administrative Match dollars that are currently not leveraged.

- ODH could maintain the current level of Maternal and Child Health Block Grant funding allocated to BCMH, with the administrative cost savings allocated to treatment services.

(Note: This concept is strongly opposed by the Ohio County Commissioners' Association with the concern of having a state program being funded with local property tax dollars.)

2) Institute mandatory manufacturer rebates for prescription medications and special nutritional formulas for inclusion on the BCMH formulary.

    - Additional Preferred Drug List (PDL) rebates for select therapeutic categories with the formulary.

3) A license plate fee increase earmarked for BCMH

4) A fee for filing certain documents with the secretary of the state

5) An increase in the alcohol tax

6) The standardization of Public Health Nurse Services by contracting with each Local Health Department to assure every family has access to Public Health Nurse Services.

7) The requirement of private insurance companies to refer families who have children with special health care needs to Medicaid and BCMH

LONG TERM RECOMMENDATIONS:

1) Allow a buy-in or cost share for the BCMH program.

   - This would allow families to access the needed care and services more quickly and affordably while qualifying them for the BCMH rates currently paid to providers.
   - By doing this, the patient becomes a BCMH qualified patient and the billing from the provider is then sent directly to BCMH and creates an advantage by taking the patient collections out of the hands of the provider and may make being a BCMH provider more attractive.
   - In addition, BCMH can use the buy-in dollars to help provide this administrative and medical service.

2) Seek out other Medicaid alternatives to potentially include the following:

   - Some type of buy-in option – need further exploration of provisions included in the recent federal Deficit Reduction Act
   - Expand the eligibility for the CHIP program
   - Create a waiver for the Home and Community Based Waiver for the BCMH population
   - Disregard the medical income for the CHIP program based on the diagnosis severity

3) Continue exploring the possibility of a high-risk insurance pool, such as those sponsored in Senate Bill 272 (Senator Lynn Wachtmann) of the 126th General Assembly.

4) Thorough utilization of private insurance and Medicaid for the Diagnostic Program.

   - Pursue Medicaid eligibility or premium reimbursement for those with BCMH as primary health care provider either quarterly or semi-annually instead of annually
   - Explore billing Medicaid for Public Health Nurse Services for those with dual coverage
   - Continue to seek federal funding for new waivers or pilot studies (.i.e. for services to children with autism)
   - Buy into the state employee insurance program and make it the primary payer for those who have BCMH coverage

BEST PRACTICES SUBCOMMITTEE

SUBCOMMITTEE MEMBERS

- State Representative Jon Peterson, Chairman
- Rosemary Bradford, public member (appointed by the Speaker of the Ohio House)
- Mary Etta Fizer, Ohio Nurses Association
- Dr. Carolyn Green, Ohio Hospital Association
- Dr. Ron Levin, American Academy of Pediatrics
- Cindi Sutter, public member (appointed by the Ohio Senate President)

The best practices subcommittee was chaired by state Representative Jon Peterson, and the recommendations presented have unanimous subcommittee support.

SHORT TERM RECOMMENDATIONS

1. **It is the recommendation of the BCMH Best Practices Subcommittee that an electronic, statewide, web based application be developed, implemented, and utilized for disability programs administered or sponsored by the state of Ohio.**

   This Web site will present a comprehensive, concise overview of state-sponsored disability programs and provide links to national and local resources for the family. The site will also have an annotated description of each program's benefits and eligibility requirements. This one-stop Web site will be a critical part of a family's educational research journey to a greater understanding of their child's condition.

2. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH reinstate coverage for disposable undergarments for children over the age of three on appropriate treatment plans for specific diagnoses.**

   The addition of disposable undergarments to applicable BCMH service packages would help families of children with incontinence needs. The ability to have an adequate supply of disposable undergarments that are anatomically structured for growing children and young adults will decrease skin breakdown and the associated medical and social complications. The client's quality of life will be positively impacted and the potential for increased costs of care associated with skin breakdown will be minimized.

3. **It is the recommendation of the BCMH Best Practices Subcommittee that coverage be restored for inpatient hospitalization for individuals enrolled in the Adult Cystic Fibrosis Program.**

   Adults with Cystic Fibrosis must undergo very complex and rigorous daily medical routines in order to maximize their positive health status. Daily medical regimes include four lung drainage sessions, eight aerosol treatments and the need for numerous oral medications.

   Cystic fibrosis patients are often required to receive antibiotics intravenously every six hours in a home setting after an infection. Access to inpatient hospital days would have a positive impact on the need to receive extended antibiotic treatments at home.

   The addition of inpatient hospital days to the adult cystic fibrosis benefit package will allow clients to receive needed preventive care, when medically necessary, in the hospital setting. This would have the potential for long term cost savings and promote a positive impact on the quality of life for these adults.

4. **It is the recommendation of the BCMH Best Practices Subcommittee that legislation should be supported, which will require health care insurance to provide benefits for the expenses of amino-acid-based formulas, and formulas which provide individuals with their primary or sole source of nutrition. (House Bill 419, 126th General Assembly – State Representative Jon Peterson)**

   Each year in the state of Ohio, there are approximately 50 children born with rare metabolic disorders. These disorders include Phenylketonuria (PKU), Maple Syrup Urine Disease (MSUD), and other genetic diseases that can result in a myriad of physical and developmental disabilities, if left untreated. To treat these conditions, children are prescribed a special medical formula. For many of these children, the consequence of life without these formulas is death. These formulas are not life enhancing – they are life sustaining.

   These formulas are expensive. They range in cost from $160 - $1100 per month. Many insurance companies do not cover the cost of these formulas. Acquisition of these formulas presents a huge financial hardship on a middle-income families not covered by a government benefit program. The subcommittee recommends support for legislation which has been introduced during the last three sessions of the general assembly, which would mandate insurance coverage in these instances.

5. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH should increase reimbursement for compounded medications as defined in Ohio law.**

An increase in the reimbursement amount for drug compounding would increase access to medically necessary compounded medications and nutrition products. Due to the cost of equipment, the time involved in making the suspension and trained pharmacists needed to perform the compounding, reimbursement rates should be increased to more closely reflect the cost of service provision.

6. **It is the recommendation of the BCMH Best Practices Subcommittee that the state increase reimbursement to local health departments or their contracted agencies for public health nursing services.**

   An increase in the reimbursement amount for public health nursing services would help to maintain and guarantee access to locally based public health nurses who have expertise in caring for children with complex medical needs. The current reimbursement has not been adjusted since 1996.

   Due to the increased costs to recruit and retain qualified public health nurses at the local level, reimbursement rates should be increased to more closely reflect the actual cost incurred by the local health department to provide public health nursing service to this vulnerable population.

7. **It is the recommendation of the BCMH Best Practices Subcommittee that the Director of the Department of Health facilitate a review and examination of best practices related to preventative health measures for the population served by BCMH. This review should include an evaluation of reimbursement to health care providers for parental instruction.**

   Preventive Health Care and the use of ancillary health care providers has been shown to be cost effective and to produce significant savings to the health care system overall. Through the incorporation of the principles of preventive health care and the use of a physician or lead ancillary health care personnel, BCMH can take a lead in cost effective, family focused quality health care.

8. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH decrease the processing time for medical and financial eligibility.**

   It is important that eligibility decisions are made in a timely manner. While clients' effective dates are backdated and thus not affected by the processing time, the amount of money expended by the family while they are waiting on a determination is often high. The BCMH should continue to investigate and implement options to streamline the application approval process while maintaining the standards of care associated with the BCMH treatment program. Positive outcomes associated with decreased processing time

include fewer fax and phone inquiries regarding case status, and fewer families requesting refunds of payments made during their waiting period.

9. **It is the recommendation of the BCMH Best Practices Subcommittee that coverage for otitis media, hernia, sinusitis, tonsillitis and adenoiditis be reinstated.**

   The loss of BCMH coverage for children with the above mentioned diagnosis has caused a hardship for many children in Ohio who have these disorders. Many of these families have no or inadequate insurance coverage for their children with these disorders. Funding should be provided to reinstate coverage for these diagnoses to ensure that these children are not negatively impacted.

LONG TERM RECOMMENDATIONS

1. **It is the recommendation of the BCMH Best Practices Subcommittee that Regional Advocacy Centers be established to assist families in identifying appropriate programs for their children.**

   Such centers may be located at hospitals, children's hospitals, colleges or universities, local health departments, county departments of job and family services, or other appropriate locations.

   The Ohio Department of Health should support the development of new and/or existing regional advocacy centers that would provide valuable resources and services to families of children with special health care needs. These centers would make available to families a wide variety of information on the disease state of their child as well as the community-based services and programs that could impact and improve their quality of life.

   These centers should be regionally based to capitalize on the local expertise of parents of children who have a special health care need and medical professionals who possess knowledge of the communities and resources surrounding the advocacy center.

2. **It is the recommendation of the BCMH Best Practices Subcommittee that the Director of the Department of Jobs and Family Services facilitate a working committee to modify, simplify, redesign and eliminate duplication in the enrollment system for disability benefit programs. The working committee of key stakeholders shall include but not be limited to consumers, parents, state agency representatives, local public health agency representatives, and health care providers.**

   The subcommittee believes a group comprised of interested parties will be able to identify inefficiencies and duplication in the application and enrollment process. The recommendations of the committee should be presented to policymakers for implementation and utilization.

3. **It is the recommendation of the BCMH Best Practices Subcommittee that the state promotes and standardizes outreach and education efforts regarding Institutional Medicaid.**

   There is a great deal of variance, county by county, in regard to the amount of knowledge health care providers have about Institutional Medicaid. There are varying degrees of accurate information regarding the application process and in regard to the existence of the program and eligibility for participation in the program. An outreach and education effort should be directed toward eliminating these regional variances and disparities.

4. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH develop, implement, and fund a BCMH Home Care Program.**

   Home Health Care has been shown to be an important adjunct to facilitate early hospital discharge and improve a patient and a family's ability to care for the patient in the home. This allows the child and family to be reconnected to their home and community. The Bureau for Children with Mental Handicaps currently pays for some home care interventions, but does not pay for home health nursing. The Bureau for Children with Mental Handicaps should develop a comprehensive home care model and study the funding needed to implement such a model.

5. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH continue to work with its medical subcommittees and community health partners to develop, expand, and refine the care standards and outcome measures for eligible complex health care conditions.**

   Medicine continues to develop new procedures, medications, and innovations to improve the quality of care and outcomes. The Bureau for Children with Mental Handicaps must continue to work with medical experts and community partners to evaluate and keep pace with these advancements.

   This partnership will allow BCMH to be a leader in the development of Standards of Care and Outcome Measures and ensures access to treatments that will enhance the quality of life for the program recipients.

6. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH continue to analyze new and emerging treatments, procedures, and products for inclusion in the BCMH service package.**

   The Bureau for Children with Mental Handicaps continually researches new and emerging treatments, products and procedures and, when appropriate, includes them in the condition-specific service packages. The willingness to reimburse medical professionals for new technologies, treatments and modalities provides for a more efficient diagnosis and the effective treatment of children with special health care needs.

   These incremental improvements to the BCMH service packages have the potential to decrease the longer term cost of care and increase the quality of life for BCMH clients.

7. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH continue coverage for items not covered or inadequately covered by insurance or other government programs.**

As a state-sponsored safety net program, BCMH covers many medically necessary procedures, medications, supplies, and durable medical equipment that are not otherwise covered by primary insurers, both public and private. Examples of these safety net products range from nutritional formula and formula thickeners, specially fitted mobility devices (e.g. electric wheelchairs), to routine and specialty dental care.

The provision of these safety net items decreases the total cost of care for BCMH clients by avoiding medical complications related to the inability to obtain the necessary prescribed nutritional supplements or medical equipment.

8. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH continue payment of health insurance premiums and/or Medicaid spend downs to allow for continued access to quality health care.**

   The Bureau for Children with Mental Handicaps should continue to pay insurance premiums and Medicaid spend downs when it is found to be cost-effective for the program. The Bureau for Children with Mental Handicaps can maximize treatment dollars by remaining a secondary payer. Additionally, clients will be afforded a wider range of medical coverage than their condition-specific BCMH benefit package offers.

9. **It is the recommendation of the BCMH Best Practices Subcommittee that BCMH continue to reimburse for the expense of physician case management services and to expand coverage to include physician designees.**

   Physicians and their designees (advanced practice nurses or social workers) provide many case management and care coordination services to families of children with special health care needs that occur within the medical home practice for the child. The Bureau for Children with Mental Handicaps is currently one of the only health care payers to reimburse physicians for their time spent on these activities.

   Medicare reimburses physicians for this service for the elderly home-bound patient. The Bureau for Children with Mental Handicaps should establish a billing mechanism that will permit the physician designee to bill for these services provided under the direction of the managing physician.

   Establishing such a billing mechanism that reimburses physician's offices for the comprehensive medical home case management and care coordination functions will enable more families to access these valuable services and will ultimately decrease the cost of care for these children.

10. **It is the recommendation of the BCMH Best Practices Subcommittee that The ODJFS investigate the DRA option of extending Medicaid benefits to**

CSHCN less than 19 years of age up to 300 percent of the poverty level and the legislature to investigate passing legislation that would require insurers to allow adults with disabilities to remain on their Parent or Guardian's Health Insurance policy up to the age of 30 years.

The first recommendation would allow more CSHCN to be covered by Medicaid and for the state to receive the federal matching funds for these children. The second recommendation would allow young adults with disabilities to be covered by their Parent or Guardian's Health Insurance Policy while they establish their role in the community and in the Job market. Both of these recommendations will encourage the young adult with a disability to become more independent and economically productive.

CONCLUSION

The vast majority of these recommendations, if not all, will require some form of legislative action and thus was used as a guide to determine whether something was short or long term. Also, another factor used to determine if recommended changes could be implemented in the short or long term was recognizing the need to maintain a stable and viable BCMH program.

It is also important to note that these recommendations do not factor in political considerations or some of the long term implementation issues which could dramatically alter the outcome of many suggestions. For example, the recommendation of the full utilization of the one-tenth inside millage of county property taxes could be easily changed from a legislative perspective and be a quick short term fix, but could potentially be heavily debated making it a long term contentious issue.