What’s in the 2016-2017 state budget?

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Health Policy Institute of Ohio
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Strategic priorities

**Access.** Ensuring timely access to comprehensive, integrated and appropriate health services

**Prevention:** Promoting healthy community environments and behaviors

**Payment:** Encouraging payment models that drive cost-effective and evidence-based prevention and care
Today’s topics

- Medicaid-related initiatives
- Tobacco prevention and cessation
- Other provisions related to prevention, wellness and public health
- Graduate medical education
- Price and data transparency
- Telehealth
Our goal is that by the end of this webinar, you will...

- Be familiar with the budget process and timeline
- Understand what’s in the final state budget for SFYs 2016 - 2017
- Know where to go for more information
What is the state budget and why is it important?
Budget process

Office of Budget and Management and agencies

OBM and Governor

Executive Budget presented to General Assembly

House of Representatives and Senate

Conference Committee

Governor signs Appropriations Bill
Coverage for optional Medicaid groups

- The Executive budget eliminated coverage for pregnant women, BCCP and family planning above 138% FPL (Previously, these groups had been covered up to 200% FPL)
- The Senate restored coverage for pregnant women and BCCP

Final Budget:
- Pregnant women and BCCP are eligible for Medicaid coverage up to 200% FPL
- No Medicaid coverage for family planning services for people between 138 – 200% FPL

Related resource:
OHT white paper, “Coverage for Pregnant Women”
Personal responsibility in Medicaid

- Executive budget assessed premiums for adults above the poverty line
- The House created the Healthy Ohio Program.
- The Senate added a more limited waiver program.

Final Budget:

- ODM will seek a federal waiver requiring all adult Covered Families and Children (CFC) and Group 8 Medicaid enrollees to participate in the Healthy Ohio Program and make monthly contributions to a “Buckeye Account.”
- Participants (excluding pregnant women) who fail to pay will have their coverage terminated until payments resume.

Related resource:
OHT white paper, “Health Savings Accounts”
Health and Human Services Fund

- The Senate budget created the Health and Human Services Fund. OBM is required to transfer $200 million to the fund.
- The House budget limited the Controlling Board’s authority to expend unanticipated GRF revenue above a certain amount and from creating new funds to receive unanticipated revenue above a certain amount.

Final Budget:
- The Health and Human Services Fund remains and will be the source of the state share of Medicaid expansion in SFY 2017.
- The Governor vetoed the Controlling Board limits.
Managed behavioral health

- The Executive budget repeals provisions prohibiting BH services from being included in the managed care system and calls for “carving in” by Jan. 1, 2017.
- The House removed these provisions, but they were reinstated by the Senate. The Senate version included changes to the implementation timeline and the inclusion of legislative oversight.

Final Budget:
- Behavioral health will be included in Medicaid managed care by Jan. 1, 2018.
- The implementation will be monitored by JMOC.

Related resource:
Ohio Mental Health and Addiction Services budget summary
Beyond mental health and addiction parity: Are Ohioans getting the services they need?

Monday Aug. 31, 2015

Click here for more information
Community health workers

- The Senate budget included provisions requiring Medicaid managed care organizations to cover CHW services for pregnant women or those who may become pregnant who live in hubs with high rates of infant mortality and other criteria.
- The legislature passed this proposal.

Final Budget:
- The Governor vetoed the use of Medicaid MCPs to provide CHW services through community hubs.

Related resource:
- OHT white paper, “Reducing Infant Mortality”
Dental provider rates

- The Executive budget increased dental provider rates 1% statewide.
- The House budget kept the statewide rate increase and created a demonstration pilot program that would pay Medicaid dental providers in 16 Appalachian counties at 65% of the ADA survey of fees.
- The legislature passed the House version of these provisions.

**Final Budget:**
- Medicaid dental providers will receive a 1% rate increase statewide.
- The Appalachian dental pilot program was vetoed.
Cigarette tax

- Executive budget included $1 increase (from $1.25 to $2.25)
- House removed the tax
- Senate included $0.40 increase (from $1.25 to $1.65)
- Conference compromised at $0.35 increase

Final Budget:
- $0.35 increase in price of pack of cigarettes
  - From $1.25 to $1.60
  - 28% increase in the tax amount
  - Approx. 5% increase in the total cost of a pack of cigarettes
Tobacco cessation and prevention funding (ODH line item 440473)

- Executive budget appropriated $2.05 million in FY16 and in FY17
- House appropriated $1.05 million in FY16 and FY17
- Senate and conference committee increased allocation

Final Budget:
- $5.05 million in FY16 and $7.05 million in FY17 = $12.1 million over biennium
- Increase of $4 million from FY15 to FY16 (was $705,543 in FY14 and $1.05 million in FY15)
- Highest level of tobacco prevention and cessation funding since TUPCF was abolished in 2008
Moms Quit for Two

- Grant program introduced by Senate

**Final Budget:**
- $1 million in each fiscal year
- Grants to private, nonprofit entities to deliver evidence-based tobacco cessation interventions for pregnant women and women living with children
- Targeted for communities with high infant mortality rates
- Within tobacco prevention and cessation line item
Tobacco provisions **NOT** in final budget

- Increased other tobacco product (OTP) tax
- E-cigarette and vapor tax
- Minimum pricing and elimination of discounts
- Strengthened provisions for tobacco-free K-12 schools, colleges and universities

Related resource:
[OHT white paper: “Reduce Tobacco Use”](#)
The state of tobacco use prevention and cessation in Ohio
Environmental scan and policy implications

Policy landscape and tobacco use prevalence

Smoking and secondhand smoke exposure are associated with many of Ohio's most pressing health policy challenges, including asthma, heart disease, lung cancer, and stroke. Tobacco use also contributes to preventable health care costs and high rates of chronic diseases such as diabetes and cancer.

Ohio stands behind most other states in terms of adult smoking rates.

Key facts
- Ohio ranks 4th for adult cigarette smoking and 4th for secondhand smoke exposure for children, indicating that Ohio has high tobacco use rates from most other states.
- Ohio's youth tobacco use rate (12.8%) is slightly below the national rate (14.9%).
- Youth smoking rates are higher for girls than for boys.
- Cigarette tobacco use is highest among high school students and lower among middle school students.
- Ohio's cigarette smoking prevalence rate is 14.9%.
- Ohio has made significant progress in reducing smoking rates.

A decade ago, Ohio was making significant progress in reducing smoking rates, but they halted in 2006, according to the Centers for Disease Control and Prevention, when 21% of adults smoked cigarettes.

When the MSA was canceled and the Foundation was established in 2006, Ohio's implementation of evidence-based strategies to prevent and reduce smoking was greatly diminished.

Ohio's implementation of evidence-based strategies

There is a strong body of evidence on what works to prevent tobacco use, help smokers quit, and reduce exposure to secondhand smoke. Ohio's current implementation of evidence-based strategies includes the following:

- Comprehensive smoke-free workplaces
- Medicaid cessation benefits
- Cigarette smoking patterns
- Evidence-based recommendations for cessation counseling and medications

The majority of adult cigarette smokers (59%) report they want to stop smoking. Yet, tobacco use is the leading cause of preventable death and disease in the U.S. and is a significant contributor to high healthcare costs. Research estimates that 31% of annual medical spending is related to tobacco smoking in the U.S. associated with cigarette smoking - amounting to $174.9 billion. Across state Medicaid programs, the cost of tobacco use is estimated to be even higher. The Centers for Disease Control and Prevention (CDC) estimates that 15% of annual Medicaid expenditures are for services related to tobacco use.

There are large disparities in tobacco use across demographic groups in Ohio.

Key facts about tobacco use in Ohio

- 23.4% of Ohio adults smoked cigarettes in 2013.
- There are significant disparities in tobacco use by income, education, and race.
- Tobacco use is particularly high among individuals with mental health and substance use disorders.

Mapping accountability to improve Ohio's performance on tobacco use

Goal

Ohio

Well above the Healthy People 2020 goal of 12%

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Legislative Committee on Public Health Futures

- Introduced by Senate

Final Budget:
- Re-establishes Legislative Committee on Public Health Futures
  - Committee shall be convened by ODH and issue a report by Jan. 31, 2016
  - Review effectiveness of recommendations of previous Public Health Futures reports
  - Make recommendations to improve local public health services

Related resource:
ODH Public Health Futures page
Public Health Futures
Considerations for a New Framework for Local Public Health in Ohio
Final Report

Prepared by the Health Policy Institute of Ohio
June 15, 2012

October 31, 2012
Population health planning **NOT in final budget**

- Executive budget included new Population Health Planning and Hospital Community Benefit Advisory Workgroup
- Workgroup was to make recommendations regarding:
  - Regional Community Health Assessments (CHAs) and developing regional Community Health Improvement Plans (CHIPs), and
  - Extent to which hospital community benefit should be used to address prioritized population health outcomes aligned with regional CHIPs
- Removed by House and not reinstated by Senate

**Related resource:**

[OHT white paper: “Improve Population Health Planning”](#)
Making the most of community health planning in Ohio
The role of hospitals and local health departments

Introduction
Community health planning is a collaborative process that engages a variety of partners to identify and implement strategies that address a community’s most pressing health needs. The overarching aim of community health planning is to improve the health and wellbeing of community residents.

Recent federal and state policy changes require nonprofit hospitals and local health departments (LHDs) to engage in community health planning activities. Hospitals and LHDs are required to collaborate with organizations within their community to prioritize their community’s health needs, and develop plans and implement strategies to address these needs. Under this new policy landscape, hospitals and LHDs can play a critical role in aligning and leveraging community health planning activities across the state to improve the overall health of Ohioans.

Key community health planning terms

Community health needs assessment (CHNA): an assessment conducted by a hospital every three years to identify and prioritize its community’s health needs and identify potential measures and resources available to address its community’s prioritized health needs.

Implementation strategy (IS): a plan identifying how a hospital will address the significant health needs identified in the CHNA.

Community health assessment (CHA): a collaborative assessment conducted at least every five years by a LHD to describe the health of the population, identify areas for health improvement, contributing factors that impact health outcomes and community assets and resources that can be mobilized to improve population health.

Community Health Improvement Plan (CHIP): a collaborative plan conducted by a LHD that builds upon the CHA to set priorities, direct the use of resources, and develop and implement projects, programs, and policies to improve the health of the population of the jurisdiction that the LHD serves.

PART 1: Community health planning requirements for hospitals, LHDs and other entities

Part 2: Hospital community benefit: Promoting a population health approach to community health planning

Part 3: Selected findings from a study of hospital and LHD community health planning documents

Part 4: Opportunities for increasing the effectiveness of community health planning
Blood-borne infectious disease prevention

- Introduced by Senate
- Revised in Conference

Final Budget:
- Authorizes local boards of health to establish blood-borne infectious disease programs
- Applies to prevention of HIV and Hepatitis B and C
- Referrals to substance abuse treatment programs
- Immunity from criminal prosecution for “furnishing a hypodermic needle to another person”
- Does not require declaration of public health emergency
- Program cost is responsibility of local board of health

Related resource:
Center for Community Solutions blog post
Additional wellness and prevention-related provisions: ODH

Final Budget:

- Master Settlement Agreement funding allocated to various tobacco prevention and cessation activities
- Public Health Emergency Preparedness Fund
- Emergency preparation and response $500,000 each fiscal year (earmark for local boards of health)
- ODH will no longer provide GRF-funded vaccines or GRF funding for vaccines
- Infant vitality programs: GRF appropriations for Safe Sleep Campaign, Progesterone Prematurity Prevention Project, and Prenatal Smoking Cessation Project
- Krabbe disease newborn screening
Final Budget:
✓ Healthy Food Financing Initiative, $1 million each year (Community Development Financial Institution to implement initiative to improve food access for underserved urban and rural communities) (ODJFS)
✓ Abolishes Healthy Choices for Healthy Children Council (ODE)
✓ Prevention and wellness funding (up to $1.5 million) and suicide prevention funding (up to $1 million) (OMHAS)
✓ Water quality (ODNR)
Graduate medical education

- The Senate budget created a Graduate Medical Education Study Committee.

Final Budget:
- OHT will convene a Graduate Medical Education Study Committee
- The committee will issue a report by Dec. 31, 2015
Ohio all-payer health claims database and Ohio hospital report card

- The House budget requires OHT to create an all-payer health claims database (APCD).
- The House budget required OHT to create an Ohio hospital report card to provide information on a public website about clinical data and other outcomes to allow consumers to compare health care services at different facilities.

Final Budget:

- Does not include an APCD
- Does not include an Ohio hospital report card

Related HPIO resources:

All Payer Claims Databases resource page
Health services price disclosure

- The Senate budget created the Health Services Providers Cost Estimate Study Committee.
- This provision was included in the final version of the budget passed by the legislature.
- The BWC budget (H.B. 52) created the Health Services Price Disclosure Study Committee.

Final Budget:
✓ The Governor vetoed the legislature’s study committee, keeping the language in the BWC budget.

Related HPIO resources:
Data Transparency resource page
Healthier Buckeye grant program

- The House budget requires each county to establish a local Healthier Buckeye Council by Dec. 15, 2015 and included an appropriation of $17.5 million over the biennium.
- The Senate budget made creating a local board optional and did not include an appropriation.
- The Conference Committee reinstated funding.

Final Budget:

- Establishes the Healthier Buckeye grant pilot program and allocates $11 million over the biennium.
- Creating a local Healthier Buckeye Council is optional.

Related resource:

Telehealth prescribing

- House budget included language around physician prescribing based on remote examination of a patient.
- The language was included in the legislature’s passed budget.

Final Budget:
- The Governor vetoed the remote prescribing provision.
- Legislation expected requiring State Medical Board to adopt rules governing physician prescribing based on remote examination.
Telehealth resource page
updated 06.09.2015

For the past two years, HPIO has provided a neutral forum for telehealth stakeholders to convene and discuss telehealth policy and implementation in Ohio. HPIO has focused attention on telehealth as a promising practice that has implications for improving health outcomes, increasing access to care, and controlling or reducing cost. HPIO’s work around telehealth has helped to inform and mobilize stakeholders to engage in policy decisions around telehealth at the state level. For more information on HPIO’s telehealth work or to join our Telehealth Initiative, contact Reem Aly at raly@hpio.net.

Proposed legislation and rules

Telemedicine services-insurance and Medicaid coverage

- Senate Bill 32 – As introduced (link automatically downloads pdf)

Prescribing to persons the physician has never personally examined
Ohio budget bill resources

General Assembly
www.legislature.ohio.gov
• Find the full text of the budget bill by searching for House Bill 64

Office of Budget and Management (OBM)
http://obm.ohio.gov/Budget/operating/fy16-17.aspx
• See the Governor’s veto message
Ohio budget bill resources, cont.

Legislative Service Commission
http://www.lsc.ohio.gov/budget/mainbudget.htm

- **Comparison Document** – highlights the differences between the different versions of the bill
- **Greenbooks** will be published later this summer/early fall – analyze the enacted budget by agency
HPIO Resources

Policy Briefs:

✓ The state of tobacco use prevention and cessation in Ohio

✓ Mapping accountability to improve Ohio’s performance on tobacco use

✓ Making the most of community health planning in Ohio: The role of hospitals and local health departments
HPIO Resources

Resource pages:

✓ Telehealth resource page
✓ Health data transparency resource page
✓ Ohio and All Payer Claims Databases resource page
Upcoming events:

**Beyond mental health and addiction parity: Are Ohioans getting the services they need?**

Monday, August 31, 2015
10:00 am – 3:00 pm
Dublin Integrated Education Center (Dublin, OH)

Please join us to discuss the status of mental health and addiction treatment parity in Ohio and the nation. What have been the early impacts of the Mental Health Parity and Addiction Equity Act (MHPAEA) on access, utilization, and cost? What challenges remain?
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