Health Policy Basics

Understanding and influencing state health policy

Cincinnati, Ohio

March 11, 2019

Objectives

Participants will:

- Have increased knowledge about how Ohio performs on health outcomes and healthcare spending metrics
- Understand what health equity is, as well as the social drivers of health disparities and inequities
- Learn about examples of evidence-informed policies that can be implemented at the state and local levels to close Ohio's health outcome gaps

Objectives (cont.)

Participants will:

- Be equipped to find credible sources of research evidence for effective health policy
- Understand how public policy is created, with a focus on state-level policymaking, and how it can be impacted
- Learn both about the basics of Ohio's Medicaid program and about innovative policies to address the social drivers of health

THE HEALTH COLLABORATIVE

Technology Powered by HealthBridge

THE HEALTH GENERATION

GEN-H

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HPIO core funders

- Interact for Health
- Mt. Sinai Health Care Foundation
- The George Gund Foundation
- Saint Luke's Foundation of Cleveland
- The Cleveland Foundation
- HealthPath Foundation of Ohio
- Sisters of Charity Foundation of Canton
- Sisters of Charity Foundation of Cleveland
- Nord Family Foundation
- North Canton Medical Foundation
- Mercy Health
- CareSource Foundation

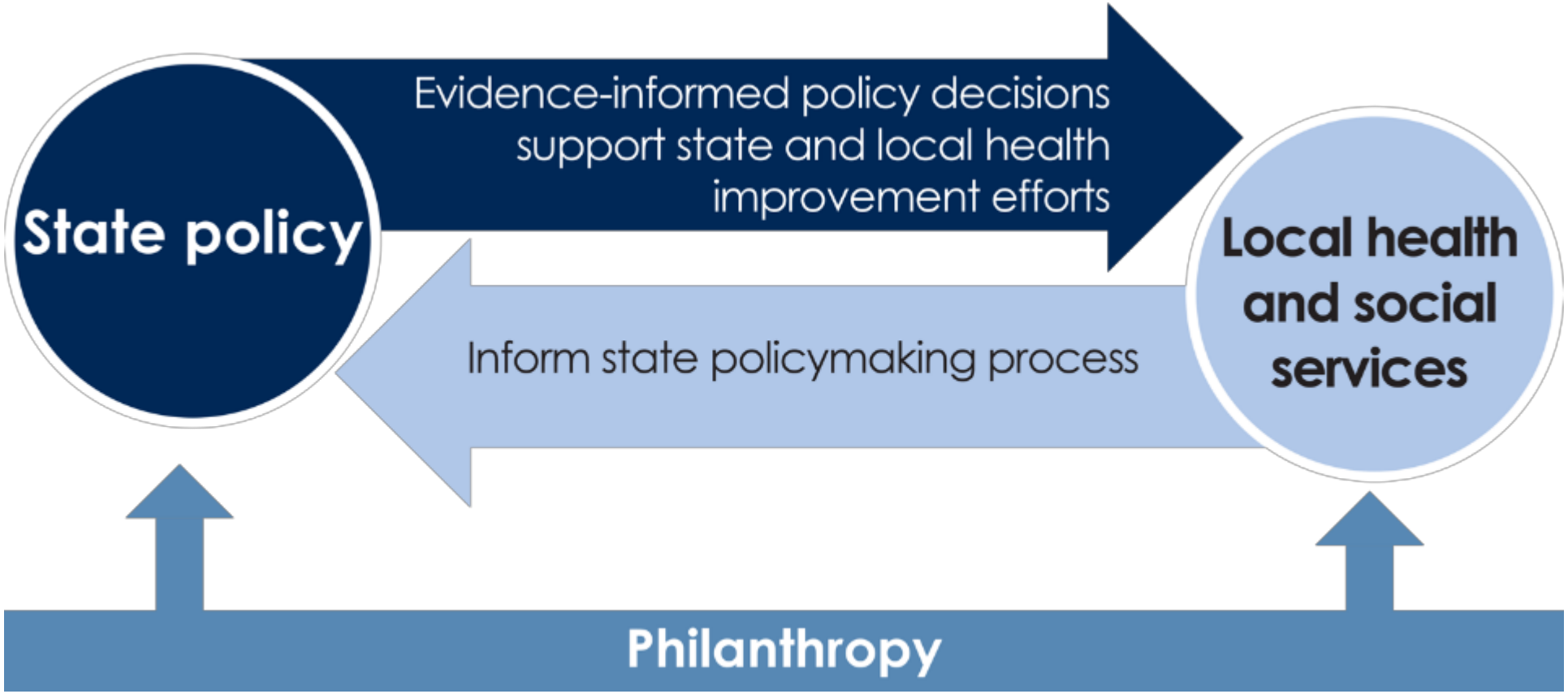
Vision

To improve the health and well-being of all Ohioans.

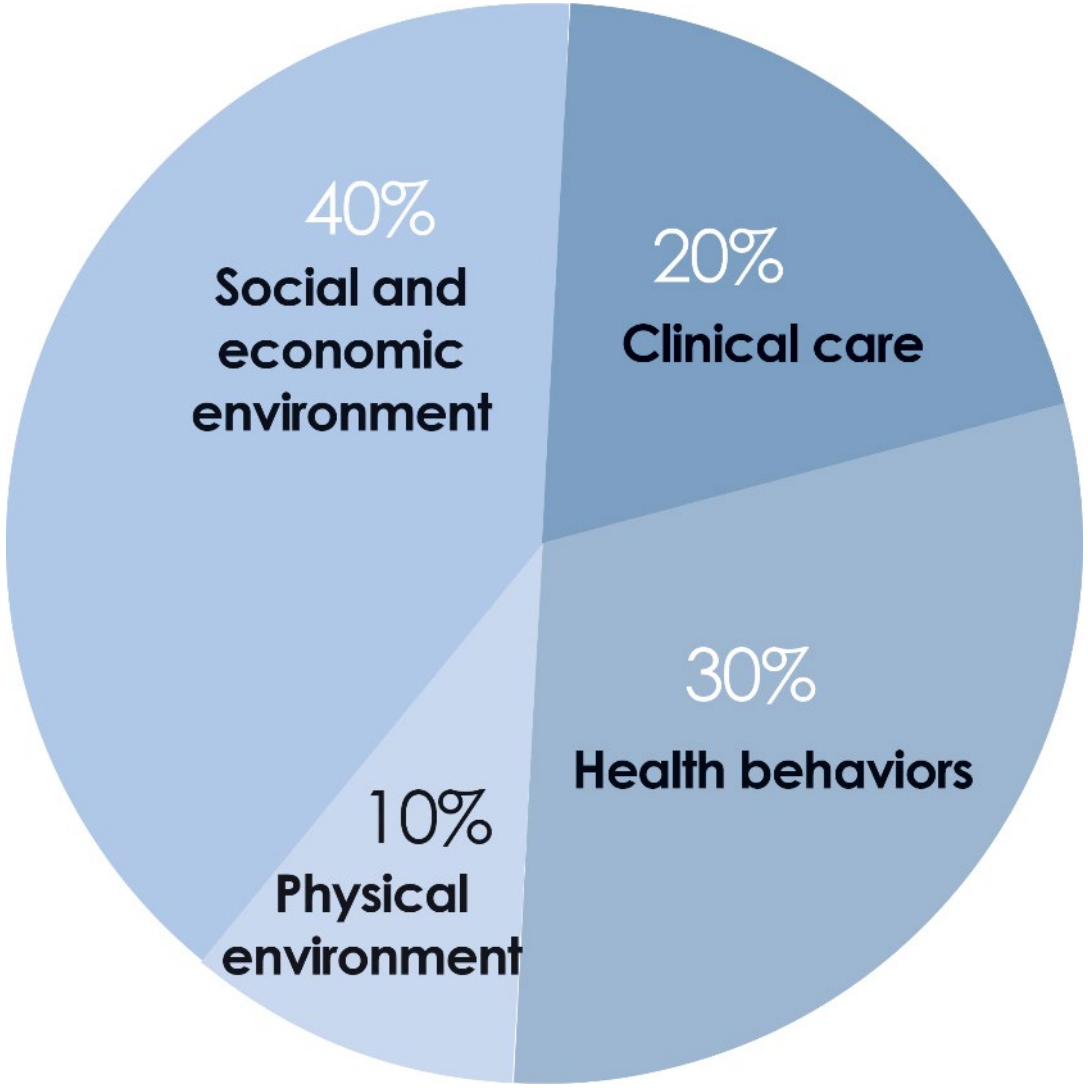
Mission

To provide the independent and nonpartisan analysis needed to create evidence-informed state health policy.

The relationship between state policy and local health and social services

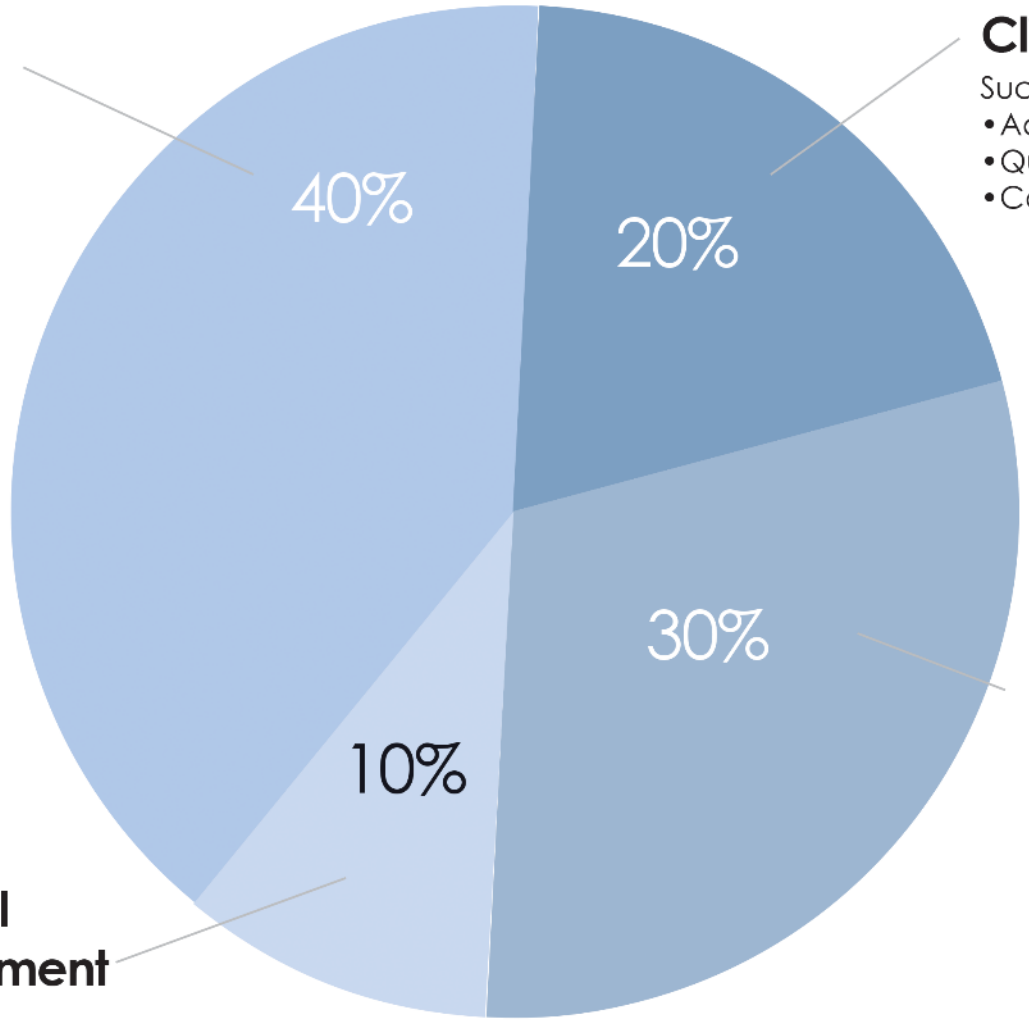


Modifiable factors that impact health



Source: Booske, Bridget C. et. Al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.

Modifiable factors that impact health



Social and economic environment
Such as:
- Housing conditions
- Air quality
- Access to green spaces and parks

Clinical care
Such as:
- Access
- Quality
- Care coordination

Health behaviors
Such as:
- Physical activity
- Nutrition
- Tobacco use

Physical environment
Such as:
- Education
- Income
- Neighborhood violence
- Racism and discrimination

Source: Booske, Bridget C. et. Al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.

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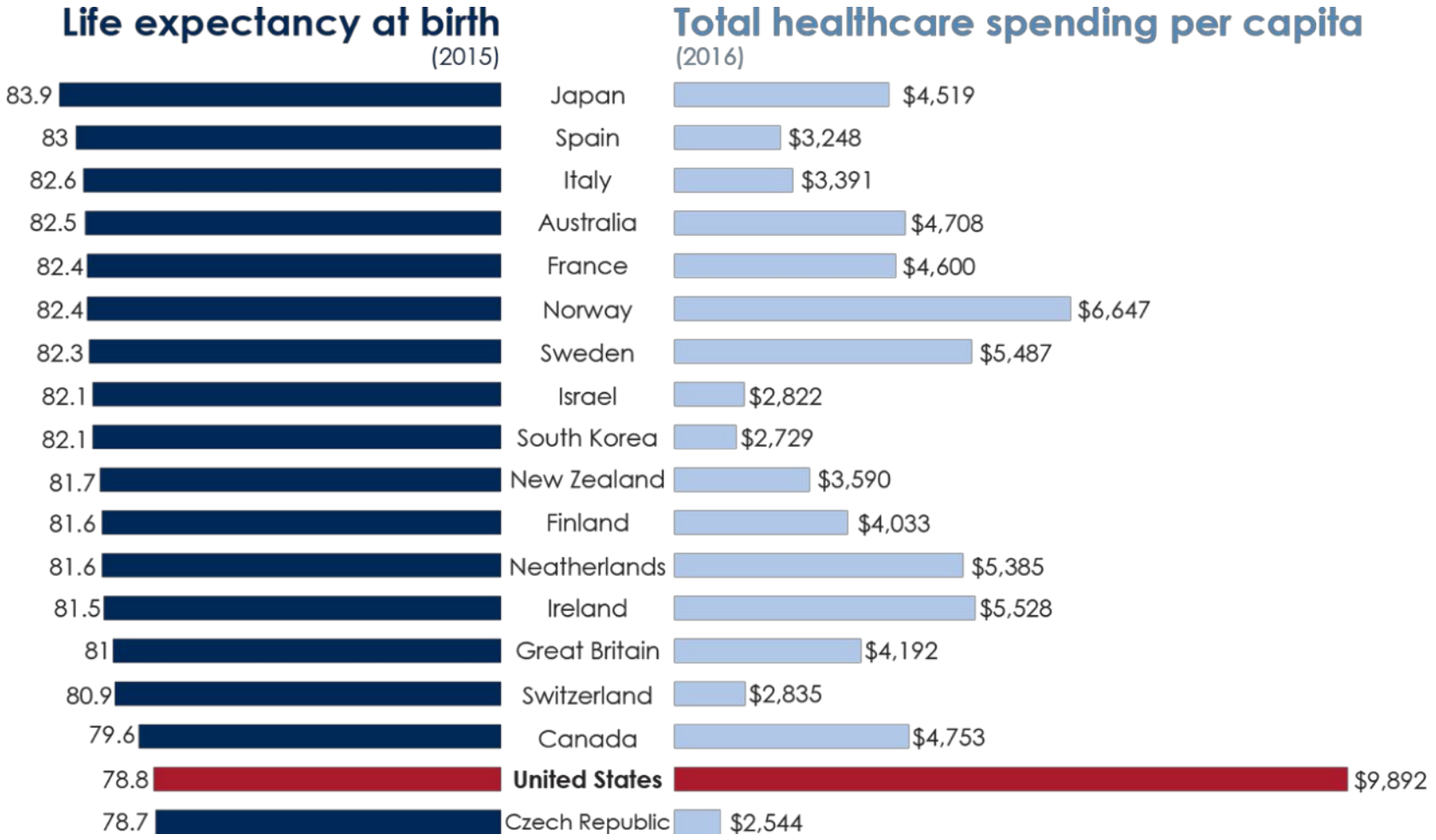
2019 Health Value Dashboard

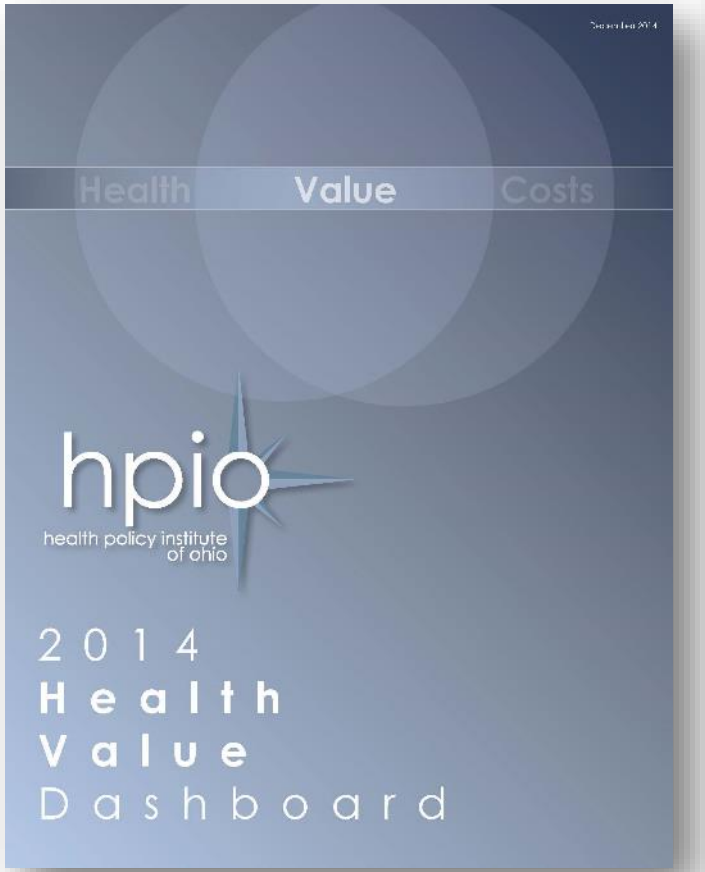
Using data to drive high-impact, equitable state health policy

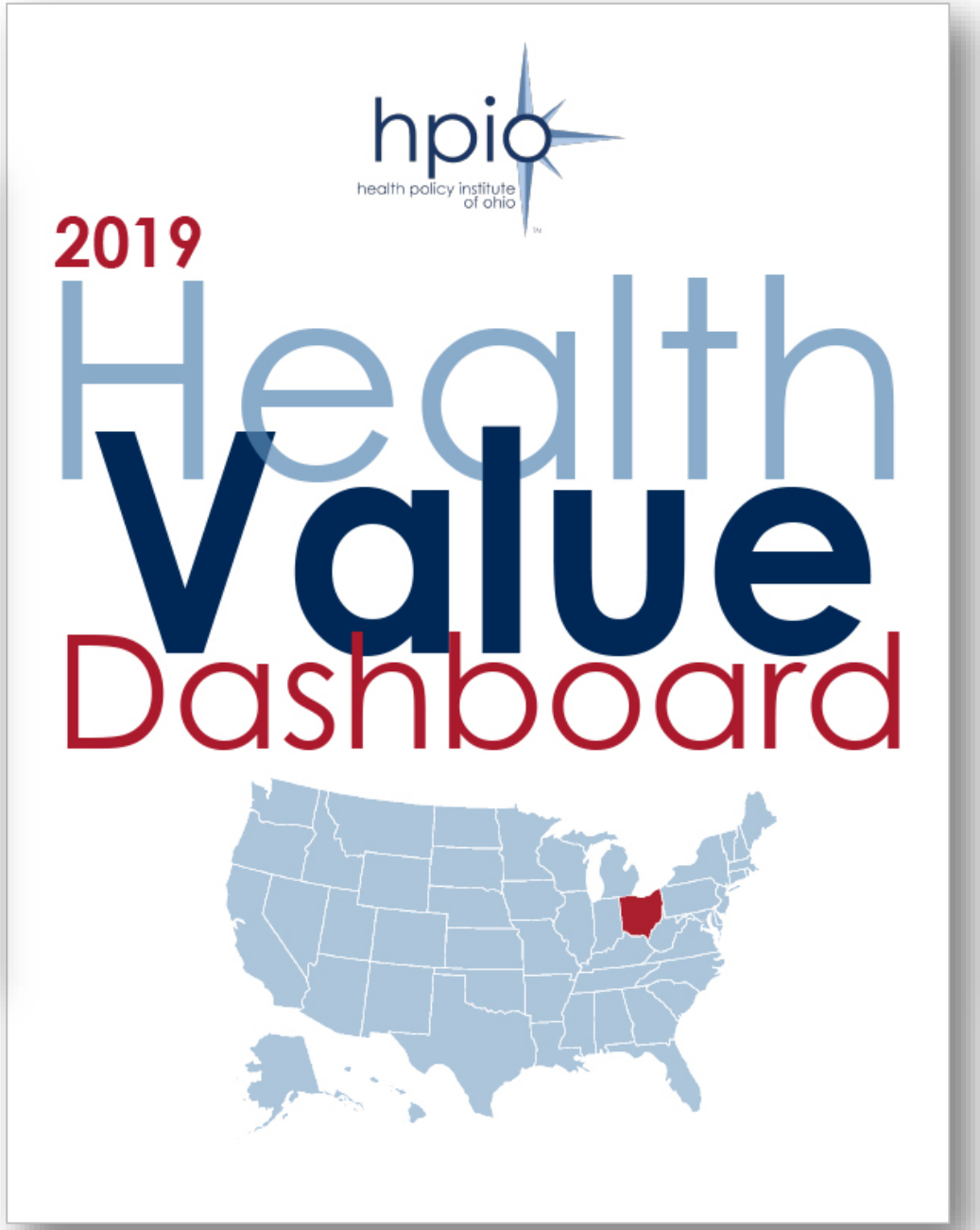
Amy Rohling McGee

U.S. outcomes and spending compared to other nations



Source: Organization for Economic Co-operation and Development





Where does Ohio rank?

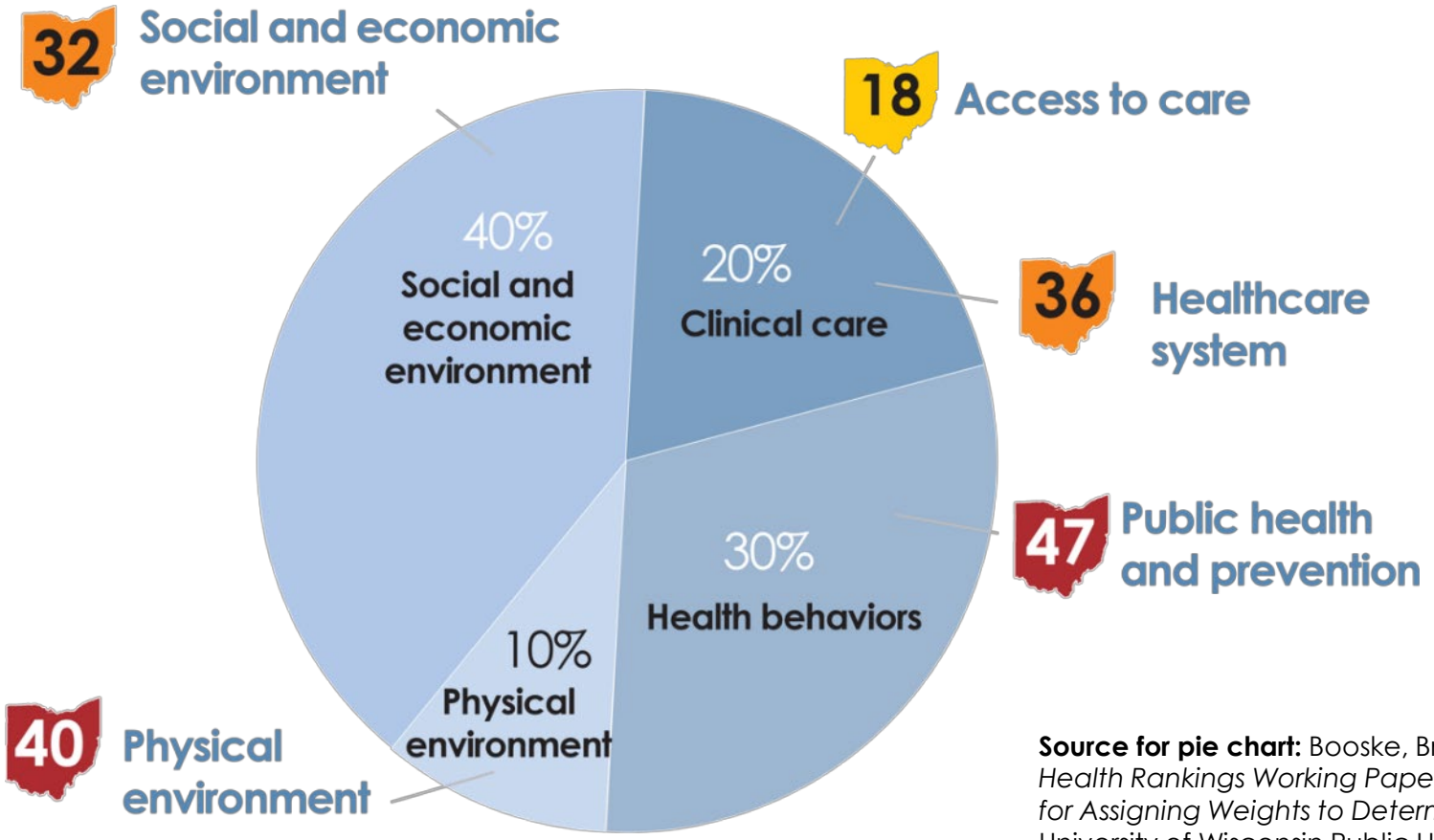
Population health

+

Healthcare spending

Health value in Ohio

Modifiable factors that influence health



Source for pie chart: Booske, Bridget C. et. Al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.

Why do we rank poorly on health value?

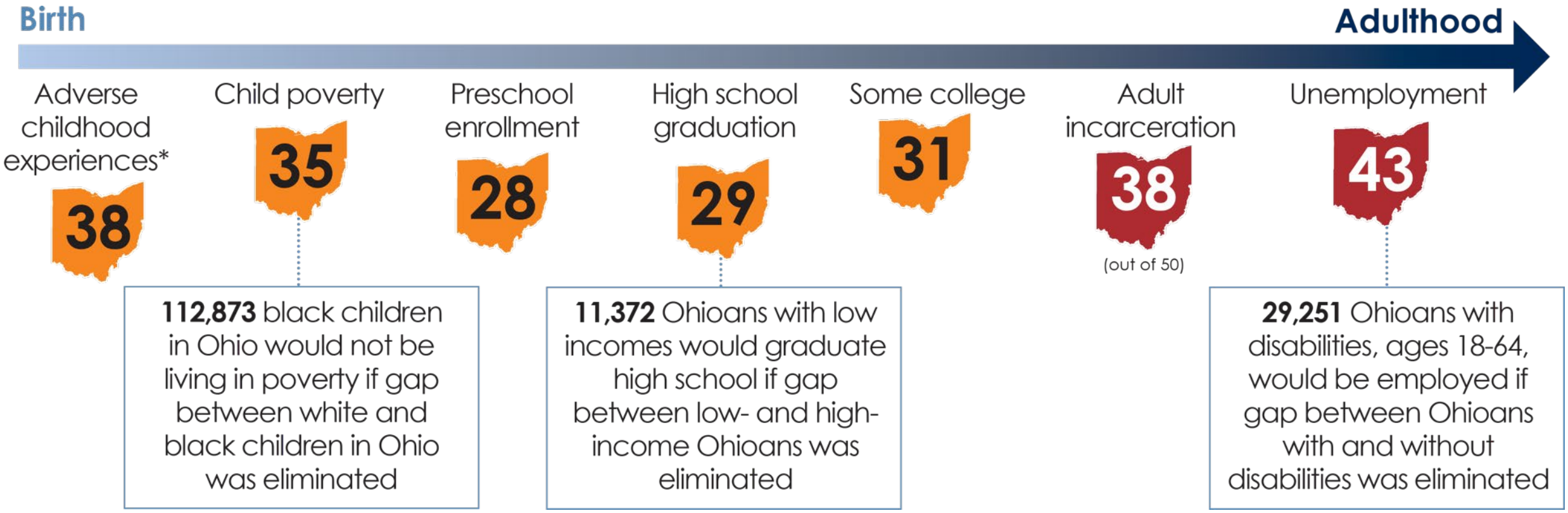
Too many Ohioans are left behind

Resources are out of balance

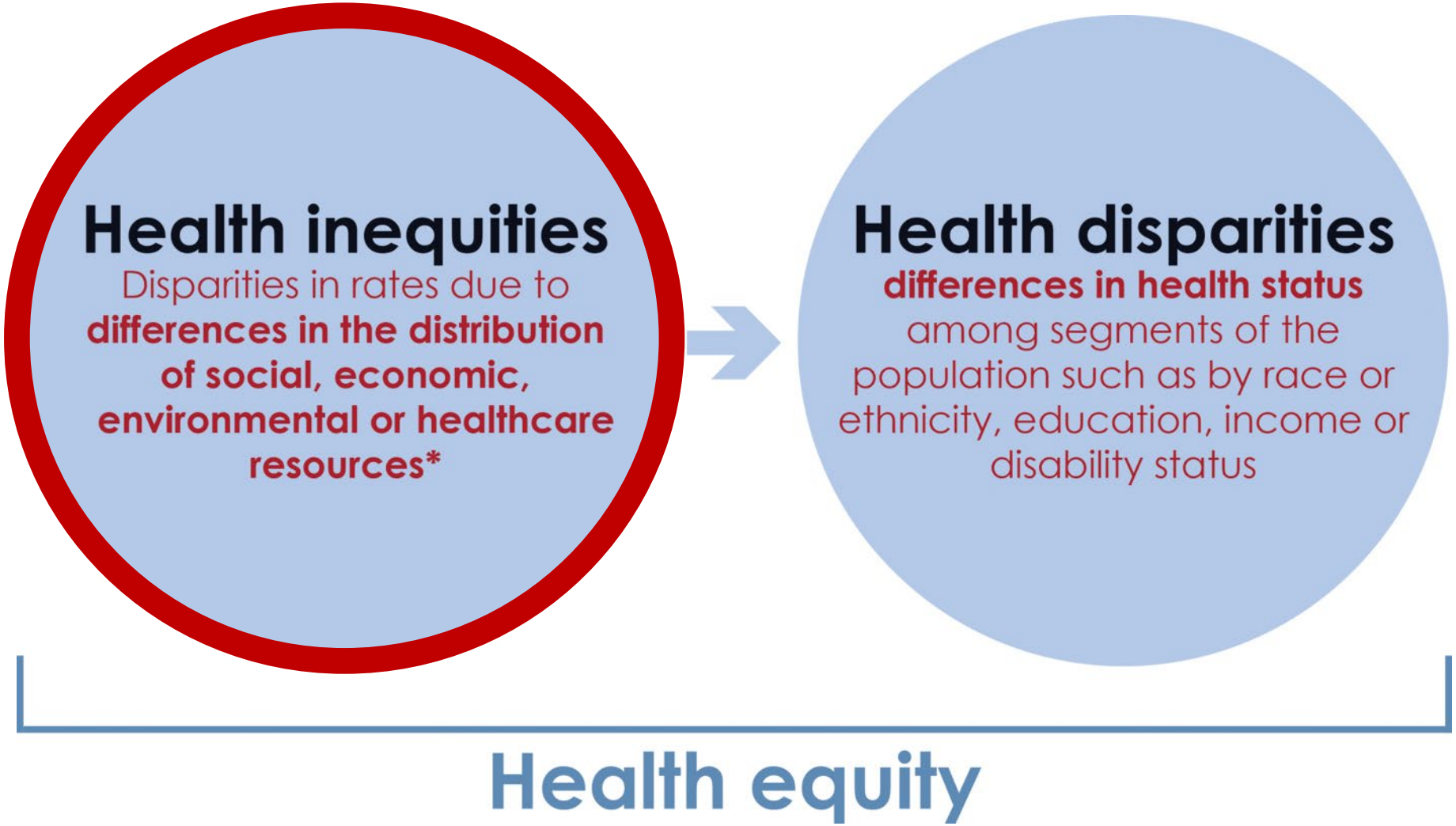
Addiction is holding Ohioans back

Too many Ohioans left behind

Without a strong foundation, not all Ohioans have the same opportunity to be healthy

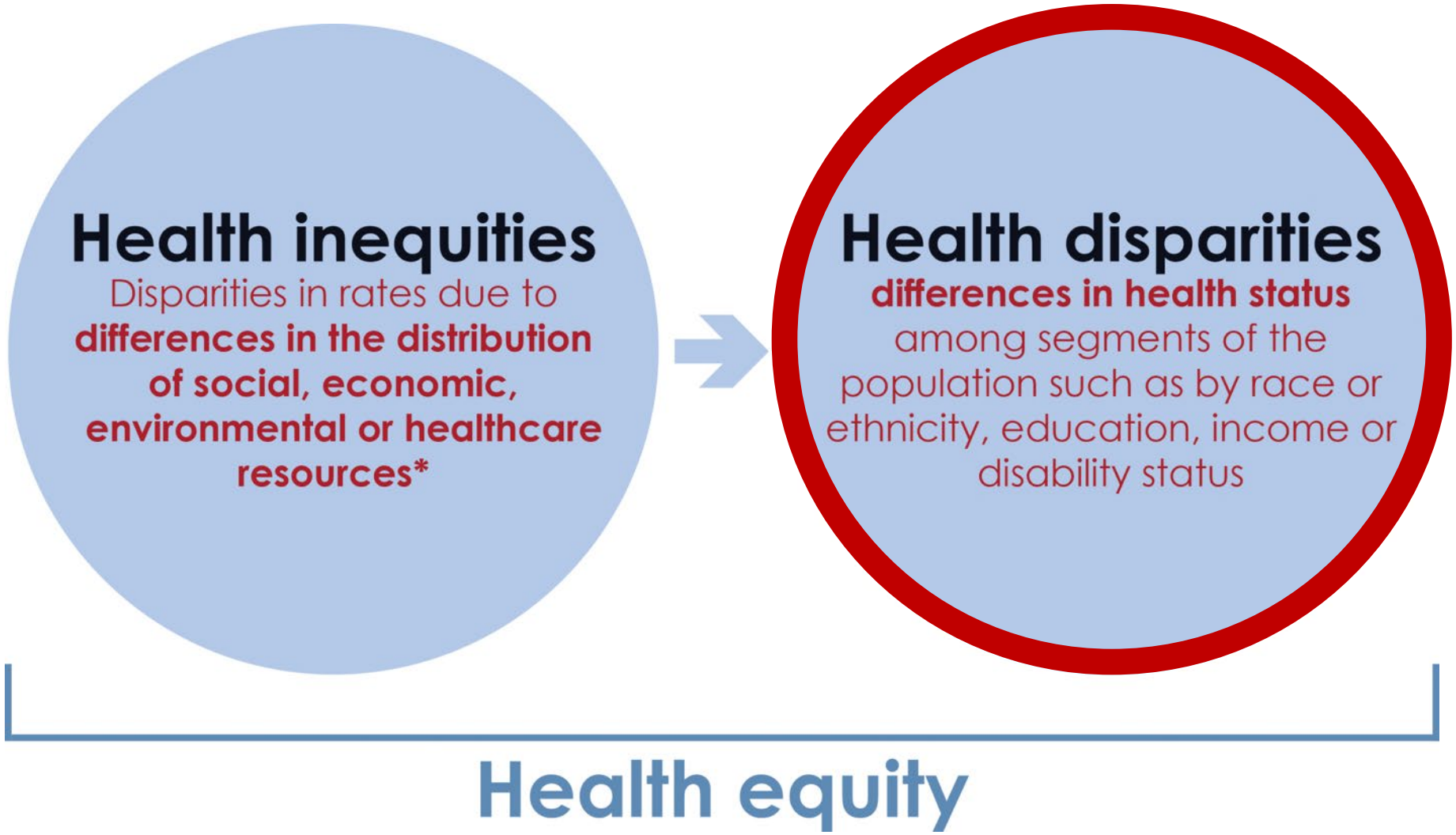


Health inequities, disparities and equity



*Working definition from the CDC Health Equity Working Group, October 2007

Health inequities, disparities and equity



*Working definition from the CDC Health Equity Working Group, October 2007

2019 **Health Value Dashboard**

Equity profiles

Race/ethnicity: Black Ohioans

- Racist policies such as slavery, Jim Crow laws and redlining were eliminated years ago, but the long-term impact of these policies persists.
- Coupled with continued discrimination and racism, these policies have led to poorer socioeconomic and community conditions for black Ohioans. Because of this, **black Ohioans do not have the same opportunity as white Ohioans to live healthy lives.**

This profile describes the magnitude of difference in outcomes between black Ohioans and white Ohioans.

Black children in Ohio are **4.7 times more likely to attend a high poverty school than white Ohioans**, which often have lower graduation rates.

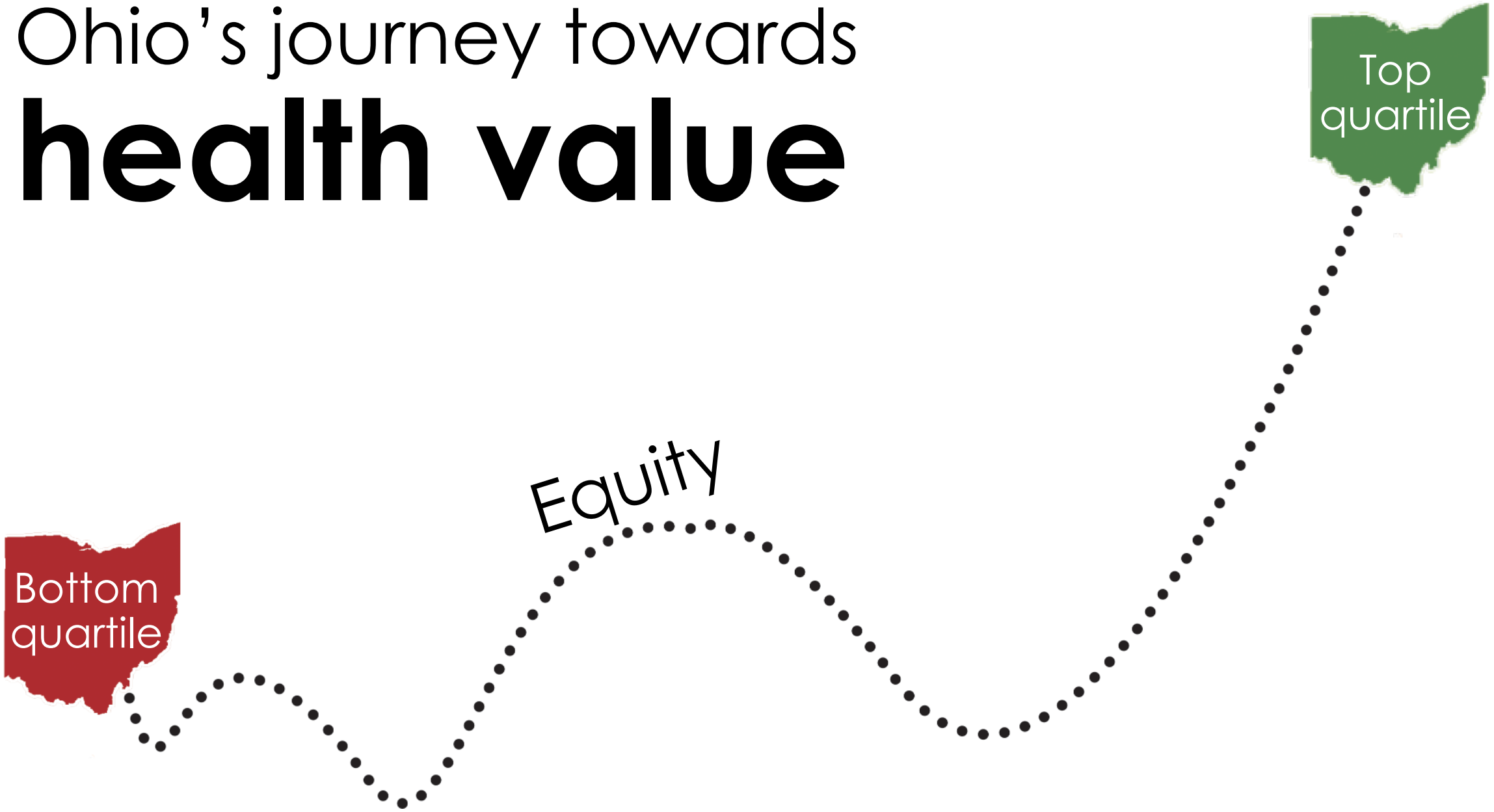
Lacking a sufficient education makes it more difficult to provide basic needs, such as quality housing. If the gap in quality housing between black and white Ohioans was eliminated, more than **79,000 black Ohioans would live in higher quality housing.**

These differences have led to poorer health outcomes for black Ohioans. For example, **black infants are dying at nearly three times the rate** of white infants in Ohio.

Socio-economic factors	
Child poverty	2.9 times **worse** for black Ohioans
Unemployment	2.7 times **worse** for black Ohioans
High school graduation	2.7 times **worse** for black Ohioans
Adult poverty	2.5 times **worse** for black Ohioans
Fourth-grade reading	1.5 times **worse** for black Ohioans
Community conditions	
Attending a high-poverty school	4.7 times **worse** for black Ohioans
Housing quality	2.3 times **worse** for black Ohioans
Living in a high-homicide county	1.7 times **worse** for black Ohioans
Food deserts	Little or no disparity for black Ohioans*
Health care	
Prenatal care	1.7 times **worse** for black Ohioans
Unable to see doctor due to cost	1.6 times **worse** for black Ohioans
Uninsured, adults	1.4 times **worse** for black Ohioans
Without a usual source of care	1.3 times **worse** for black Ohioans
Health outcomes	
Infant mortality	2.9 times **worse** for black Ohioans
Premature death	1.5 times **worse** for black Ohioans
Adult diabetes	1.3 times **worse** for black Ohioans
Overall health status	1.3 times **worse** for black Ohioans
Adult overweight and obese	Little or no disparity for black Ohioans
Adult depression	Little or no disparity for black Ohioans*

Note: Darker red indicates larger magnitude of difference. Metric information (description, year, source) is in the *Dashboard* appendix.
*Disparity ratio is less than 1, indicating that outcomes are better for black Ohioans compared to white Ohioans

Ohio's journey towards **health value**



Why do we rank poorly on health value?

Resources are out of balance

Bottom quartile spending metrics

41	Nursing home care spending, per capita
41	Hospital care spending, per capita
39	Total Medicare spending, per beneficiary
39	Average total cost, per Medicare beneficiary with three or more chronic conditions

Medicaid benefit spending, per full year equivalent enrollee, aged category, 2014

Source: 2014 Medicaid Statistical Information System (MSIS) and Urban Institute estimates from CMS-64 reports, as compiled by the Kaiser Family Foundation. Includes full or partial benefit enrollees; State Health Access Data Assistance Center. "State Health Compare."

ROI of lead poisoning prevention

Every $1 invested in these strategies returns…

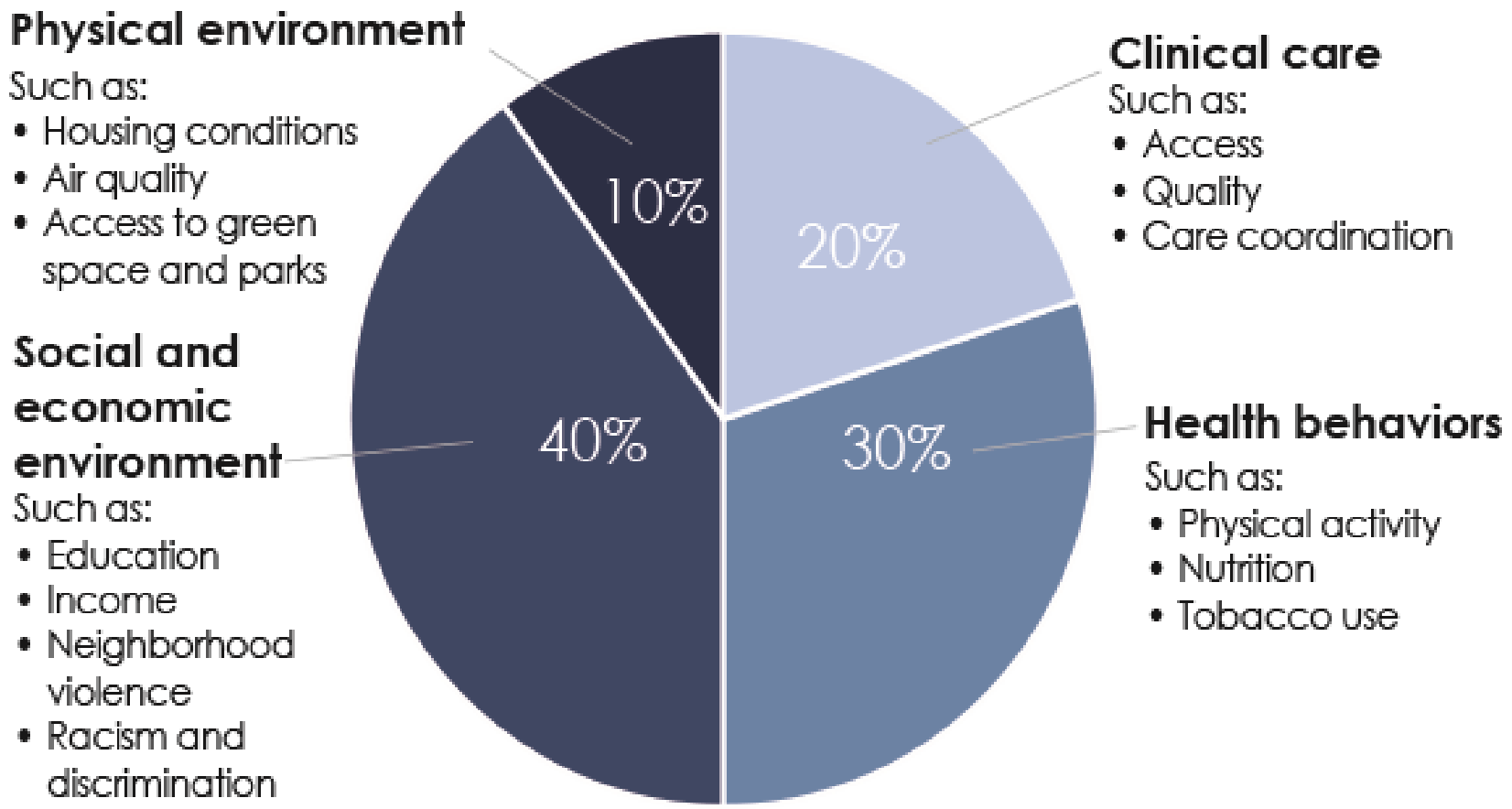
$1.33
Removing leaded drinking water service lines

$1.39
Eradicating lead paint hazards from older homes

$3.10
Ensuring contactors comply with EPA lead-safe renovation rule

Source: The Pew Charitable Trusts, Robert Wood Johnson Foundation and Health Impact Project, *Ten Policies to Prevent and Respond to Childhood Lead Exposure*, 2017.

Modifiable factors that influence health



Source: Booske, Bridget C. et. al. County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Public Health Institute. 2010.

Why do we rank poorly on health value?

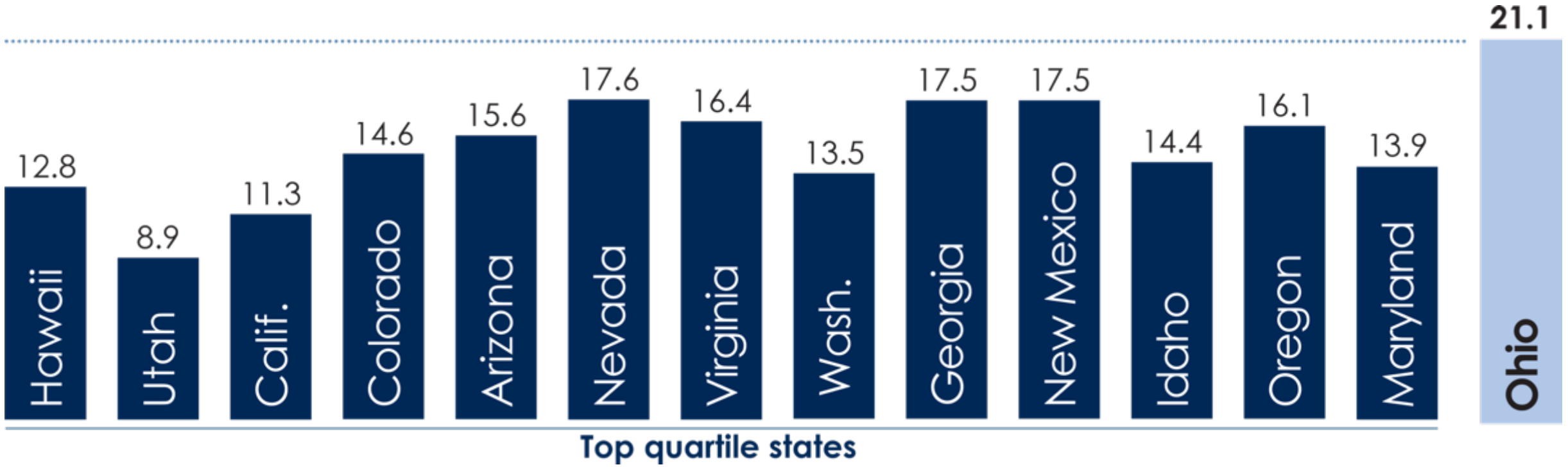
Addiction is holding Ohioans back

Addiction is holding Ohioans back

Critical gaps remain in addressing Ohio's addiction crisis

50	Drug overdose deaths
48	Child in household with a smoker
44	Adult smoking

All states in the top quartile for health value have lower rates of adult smoking than Ohio



Sources: HPIO 2019 *Health Value Dashboard* (value rank), 2017 Behavioral Risk Factor Surveillance System (smoking)


Improvement
is possible.

Policy goals

Create opportunities for all Ohio children to thrive

Invest upstream in employment, housing and transportation

Build and sustain a high-quality addiction prevention, treatment and recovery system

Dashboard analysis led to 3 policy goals

Too many Ohioans are left behind → Create opportunities for all Ohio children to thrive

Strategies and resources are out of balance → Invest upstream in employment, housing and transportation

Addiction is holding Ohioans back → Build and sustain a high-quality addiction prevention, treatment and recovery system

9 policies & strategies that improve health value

Create opportunities for all Ohio children to thrive	Invest upstream in employment, housing and transportation	Build and sustain a high-quality addiction prevention, treatment and recovery system
1. Home visiting 2. Quality early childhood education and child care subsidies 3. Lead screening and abatement	4. Earned income tax credit 5. Safe, accessible and affordable housing 6. Public transportation	7. Tobacco prevention and cessation 8. K-12 drug prevention and social-emotional learning 9. Behavioral health workforce

Historical and contemporary obstacles to health

Four levels of racism

Structural racism
is racial bias among institutions and across society

Institutional racism
occurs within institutions and systems of power

Interpersonal racism
occurs between individuals

Internalized racism
lies within individuals

Source: Adapted from "Four Levels of Racism" Racing Forward 2015

What can my organization do?

- Share the ***Dashboard***
- Select one or more of the **nine strategies** and advocate
- Focus on **equity**

Key takeaways

1. **Ohioans are less healthy and spend more on health care than people in most other states.**

2. **Improvement is possible.** The *Dashboard* includes nine evidence-based strategies to advance health value in Ohio.

3. **You can contribute to improving health value in Ohio.** Everyone has a role to play!


Improvement
is possible.

Questions?

Evidence-informed health policy

Amy Bush Stevens


promising practice
recommended
emerging
model program
best practice
effective
evidence-informed
proven program
evidence-based

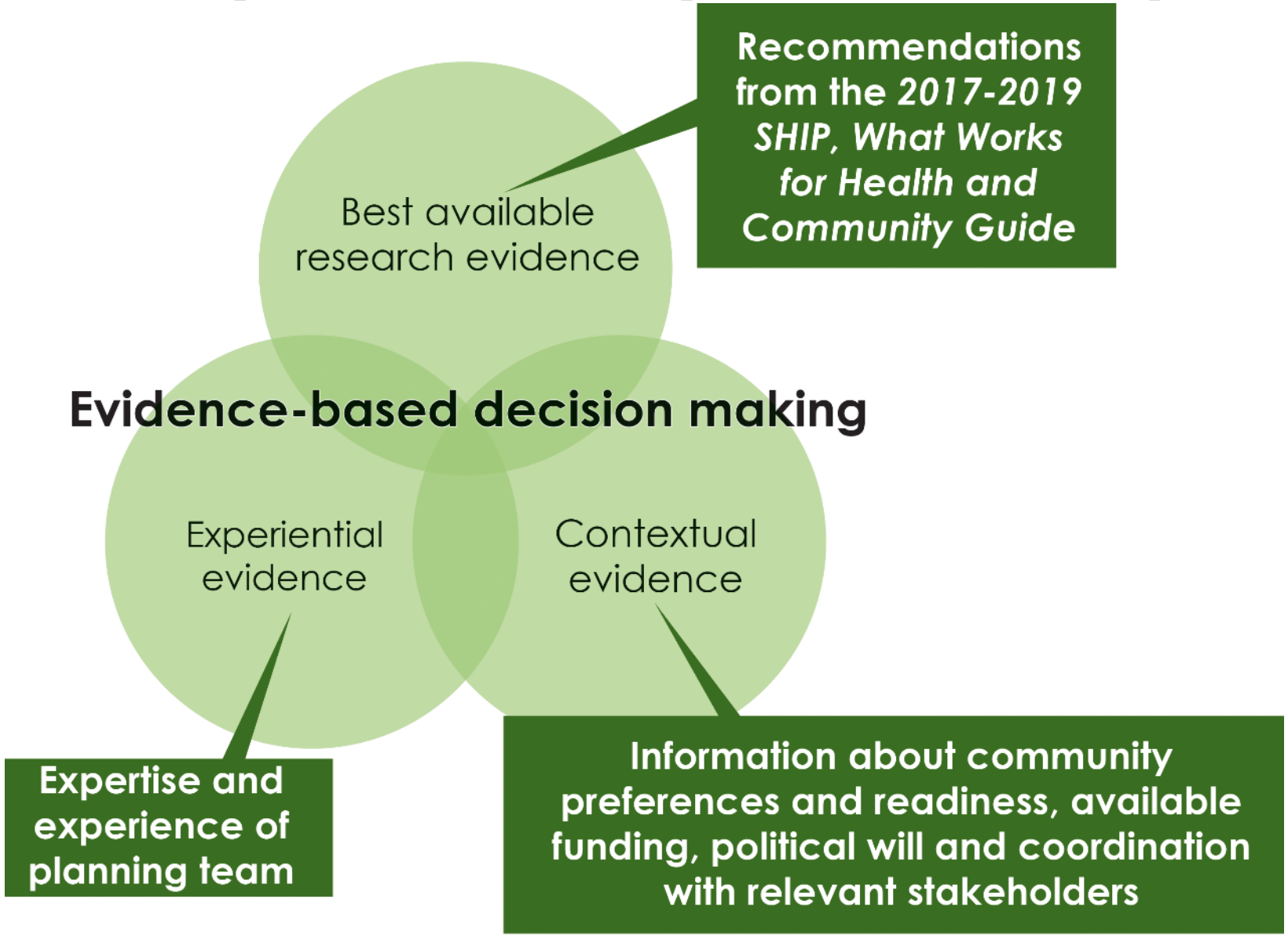
Evidence-based strategy

(HPIO definition)

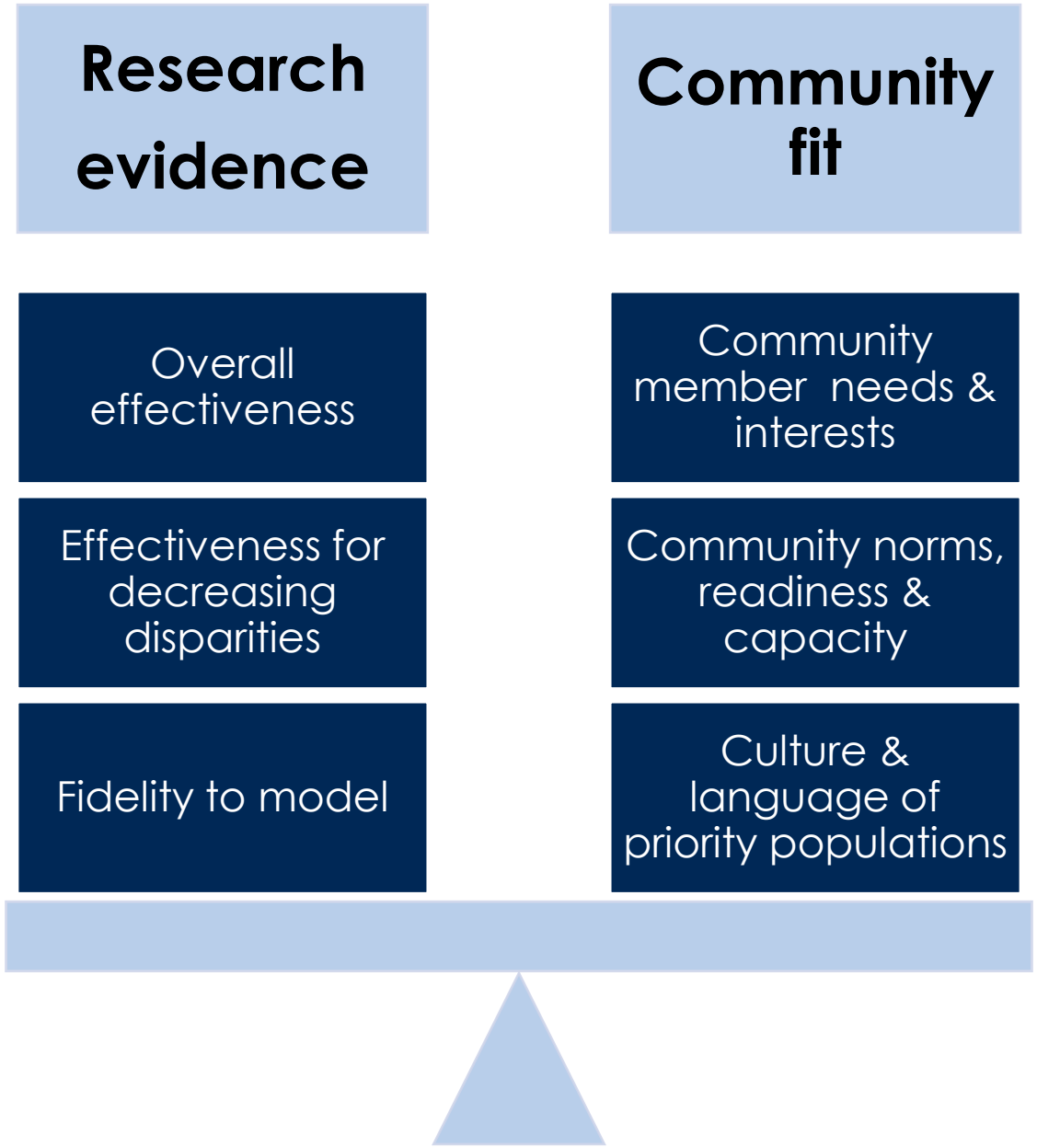
Programs, policies or other strategies that have been **evaluated** and demonstrated to be **effective** in improving outcomes based upon the **best-available research evidence**, rather than upon personal belief or anecdotal evidence.

A framework for thinking about evidence

Local community health improvement plan example



Source: Puddy and Wilkens (2011)



Evidence helps us to steer resources toward what really works


The Guide to Community Preventive Services
THE COMMUNITY GUIDE
What Works to Promote Health
LEARN HOW COMMUNITIES ARE WORKING TO PROTECT AND IMPROVE HEALTH
County Health Rankings
Mobilizing Action Toward Community Health
What Works for Health
Promising Practices Network
on Children, Families and Communities
NREPP
National Registry of Evidence-based Programs and Practices
Blueprints
FOR HEALTHY YOUTH DEVELOPMENT
Where should we look for effective strategies?
NACCHO
al Association of County & City Health Officials
Model Practic
Accelerating Progress in Obesity Prevention
SOLVING THE WEIGHT OF THE NATION

Systematic reviews and evidence inventories

What Works for Health (UW/RWJF)

Community Guide (CDC)

Hi-5 and 6/18 (CDC)

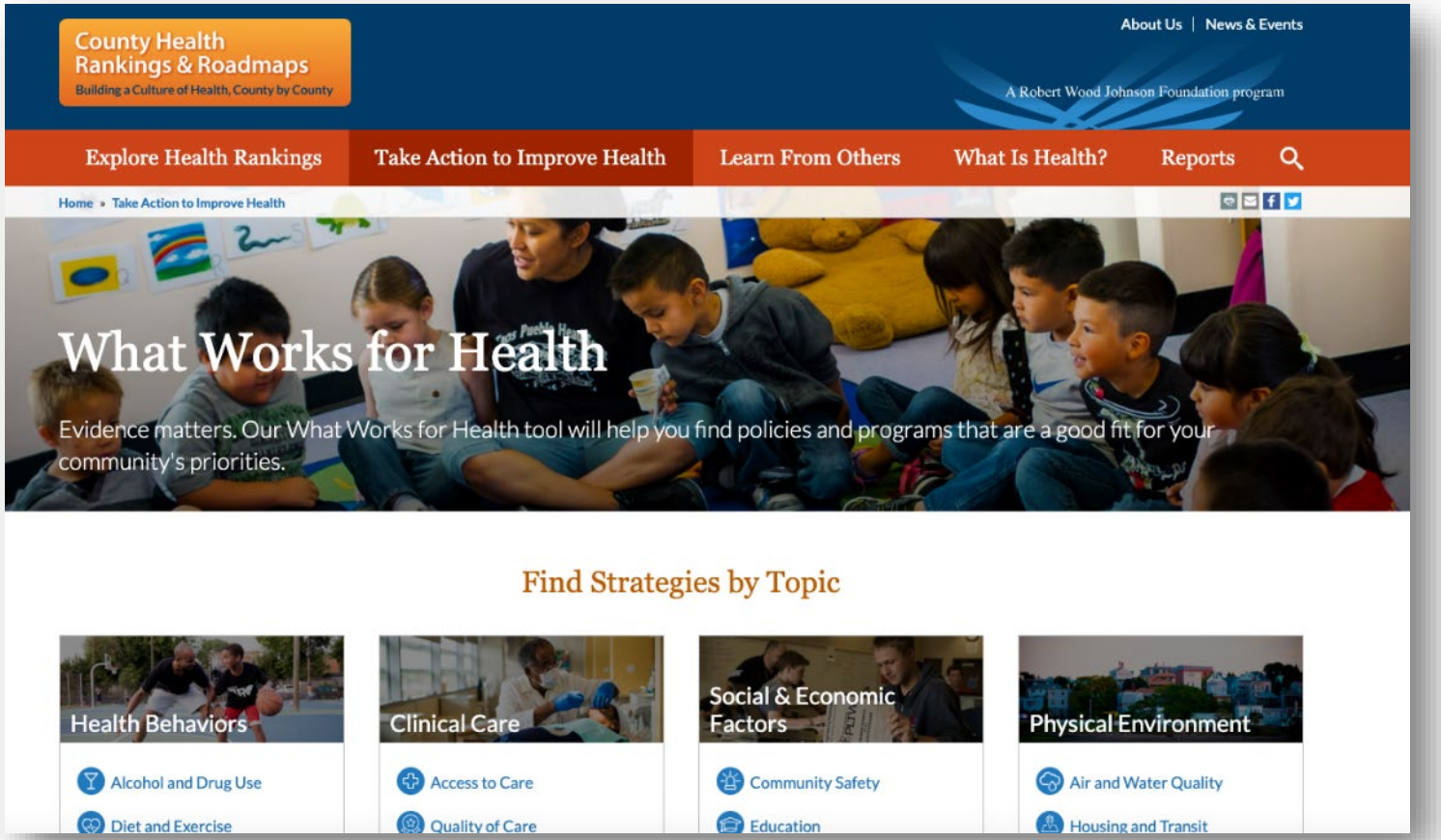
Additional topic-specific sources

9 strategies that work to improve health value

Create opportunities for all Ohio children to thrive	Invest upstream in employment, housing and transportation	Build and sustain a high-quality addiction prevention, treatment and recovery system
1. Home visiting 2. Quality early childhood education and child care subsidies 3. Lead screening and abatement	4. Earned income tax credit 5. Safe, accessible and affordable housing 6. Public transportation	7. Tobacco prevention and cessation 8. K-12 drug prevention and social-emotional learning 9. Behavioral health workforce

How did we prioritize the 9 strategies?

- Dashboard analysis
- Strong evidence of effectiveness
- Alignment with evidence-based initiatives in Ohio
- Cost savings or cost effectiveness
- Likely to reduce disparities
- Actionable for state policymakers



The Community Guide


Ohio 2017-2019
STATE HEALTH
IMPROVEMENT PLAN
February 2017

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What works to increase
self-sufficient employment

Assessment of
Child Health and Health Care in Ohio

January 2017

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Health Policy Brief
Connections between education and health

This brief provides an overview of the relationship between education and health. In 2017, the Health Policy Institute of Ohio will release a series of fact sheets discussing specific policy recommendations to improve health and educational outcomes in Ohio.

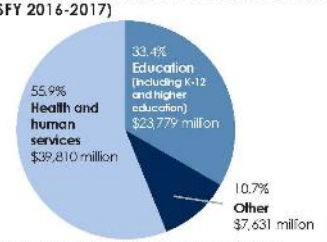
Health and education are areas of significant focus for Ohio policymakers, representing the largest shares of Ohio's biennial budget for state fiscal years (SFY) 2016-2017 (See Figure 1). Among the 971 bills introduced in the 131st General Assembly between Jan. 1, 2015 and Nov. 4, 2016, 42 percent were related to health and/or education.[1]

The relationship between education and health

There is widespread agreement that factors outside of the healthcare system influence health. Research consistently shows a strong relationship between educational attainment and health, even after accounting for factors such as income, race, ethnicity and access to health care.[2]

People with more education live in healthier communities, practice healthier behaviors, have better health outcomes and live longer than those with less education.[3] At age 25, college graduates in the U.S. can expect to live nine years longer than adults without a high school [illegible]

Figure 1. **Ohio biennial budget appropriations (SFY 2016-2017)**



Note: Includes total state and federal general revenue fund appropriations
Source: Ohio Legislative Service Commission Budget in Brief (House Bill 64 – As Enacted)

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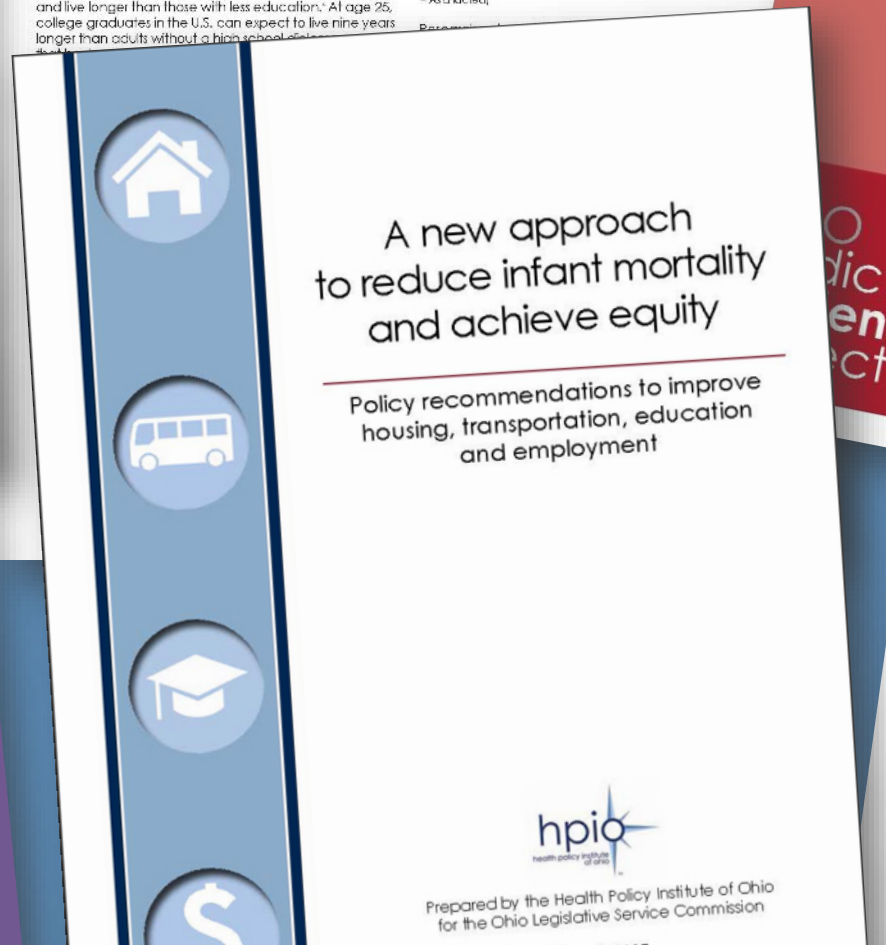
Ohio addiction policy inventory and scorecard

1. Prevention, treatment and recovery



A new approach to reduce infant mortality and achieve equity

Policy recommendations to improve housing, transportation, education and employment

hpio
health policy institute of ohio

Prepared by the Health Policy Institute of Ohio for the Ohio Legislative Service Commission

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Health Policy Brief
Closing Ohio's health gaps
Moving towards equity

October 2016

Ohio has troubling health gaps

There is more than a 29 year gap in life expectancy at birth depending on where a person lives in Ohio. The lowest life expectancy is 60 years in the Franklinton neighborhood of Columbus (Franklin County) compared to 89.2 years in the Stow area (Summit County).[1] This troubling disparity is attributed to the fact that not all Ohioans have the same opportunity to live a healthy life based on geography, race and ethnicity, income, education or other social, economic or demographic factors.

As a result, many groups of Ohioans experience large gaps in health outcomes:

- Black infants are nearly three times as likely to die in the first year of life compared to white infants.[2]
- Ohioans with disabilities are four times as likely to experience depression than Ohioans without disabilities.[3]
- Ohioans with less than a high school education are 2.7 times more likely than Ohioans with some post-high school education to report fair or poor health.[4]

The underlying drivers of these gaps in outcomes are complex and rooted in many factors.

3 key findings for policymakers

- **Many groups of Ohioans experience troubling gaps in health outcomes.** Not all Ohioans have the same opportunity to live a healthy life based on geography, race and ethnicity, income, education or other social, economic or demographic factors.
- **The choices we make are often shaped by the environments in which we live.** Because of this, many Ohioans face barriers to being healthy due to, for example, unequal access to high-quality education, a job that pays a self-sufficient income and adequate, stable housing.
- **There are evidence-based approaches to closing Ohio's health gaps.** Closing Ohio's health gaps requires a comprehensive approach that involves multi-sector, public- and private-sector stakeholder collaboration.

What is health equity?

Health equity is a term widely used in health policy discussions regarding efforts to eliminate health gaps, but the term has many different definitions. To provide a foundation for advancing health equity in Ohio, HPIO convened an **Equity Advisory Group** to come to consensus on a definition of health equity. The group reviewed existing definitions of health equity[5] and, after a series of discussions, developed the following:

"Everyone is able to achieve their full health potential. This requires [illegible]

The definition highlights the what and the how of health equity:

- What does health equity mean? Everyone is able to achieve their full health potential.
- How can we achieve health equity? By addressing historical and contemporary injustices and removing obstacles to health such as poverty, discrimination, and their consequences.

In addition, the Advisory Group identified [illegible] following definitions [illegible]

Impact on spending

HI-5

Approaches with evidence reporting cost effectiveness and/or cost savings over the lifetime of the population or earlier

Example: Researchers estimate a return of investment of $2.49-$10.83 for early childhood education, depending on the model used

Impact on spending

Washington State Institute for Public Policy (WSIPP)

Benefit-cost analyses for substance use disorder, public health and prevention and other topics

Example: The Good Behavior Game nets a benefit of $66.29 for every $1 spent

Impact on spending

Community Health Advisor

Estimates of health and cost impact of policies and programs designed to reduce tobacco use and cardiovascular disease and increase physical activity

Example: Expanded anti-tobacco media campaigns projected to save Ohio $481 million in medical costs over 10 years

Impact on disparities

What Works for Health

Rates each strategy's likely effect on racial/ethnic, socioeconomic, geographic or other disparities

Example: Earned income tax credit rated "likely to decrease disparities" (e.g., decreases low birthweight births, particularly among black mothers)

Impact on disparities

Community Guide

Recommends health equity strategies, based on systematic reviews of evidence

Example: Recommends center-based early childhood education as an effective health equity strategy if targeted to low-income or racial and ethnic minority communities


KeyBank
KeyBank

How did we prioritize the 9 strategies?

- Dashboard analysis
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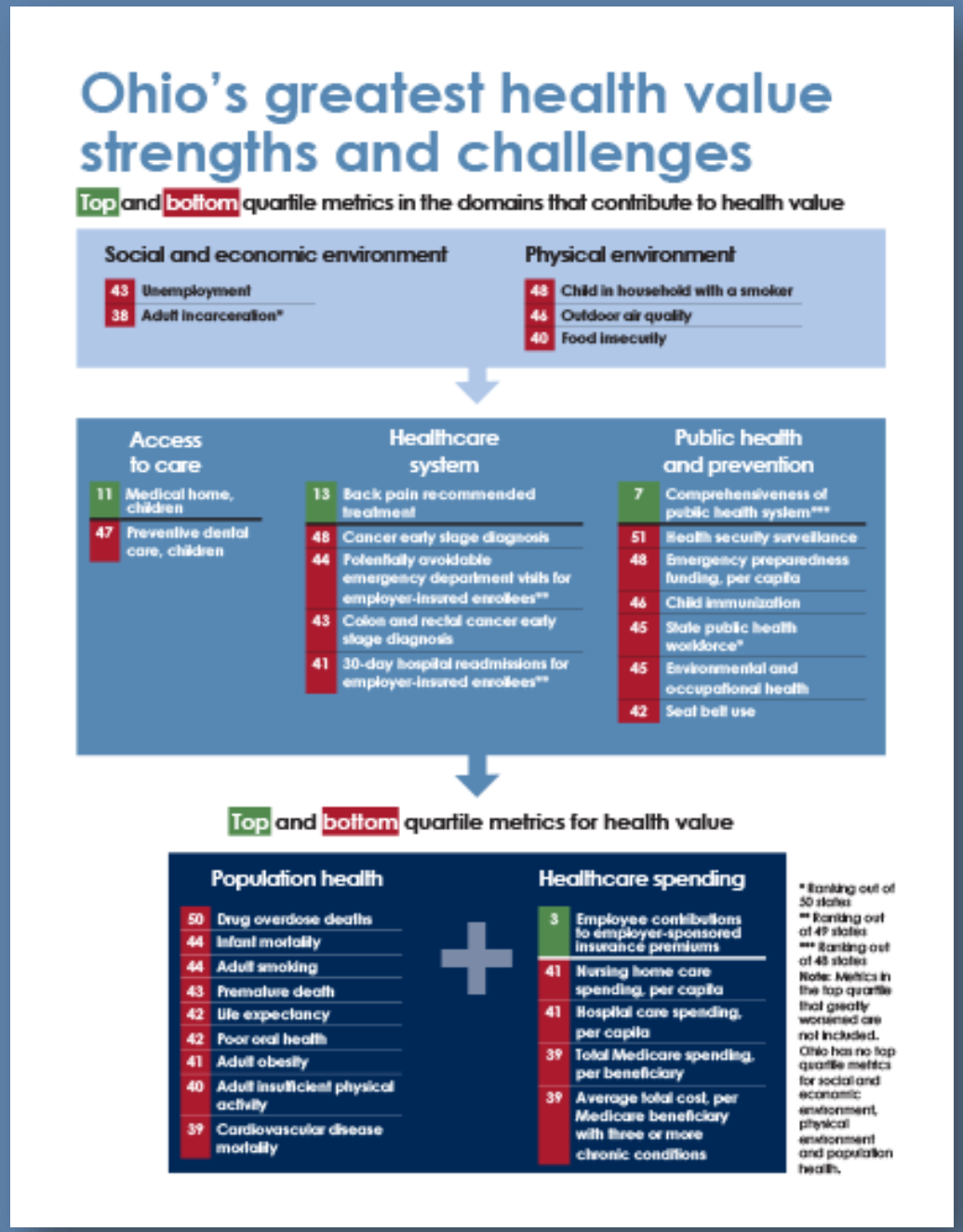
- Alignment with evidence-based initiatives in Ohio
- Cost savings or cost effectiveness
- Likely to reduce disparities
- Actionable for state policymakers

Why do we rank poorly on health value?

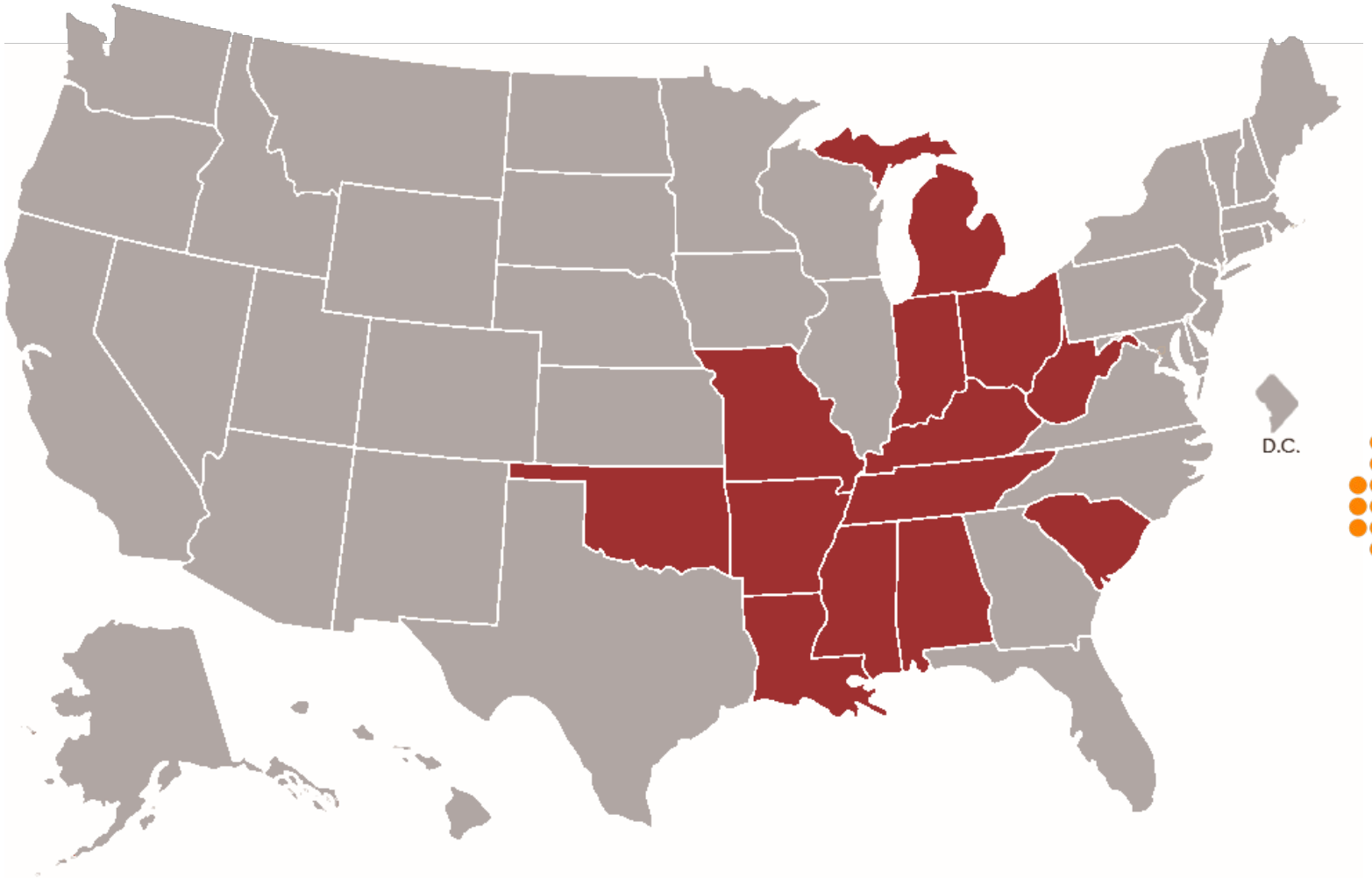
Addiction is holding Ohioans back



Adult smoking

Child in household with a smoker

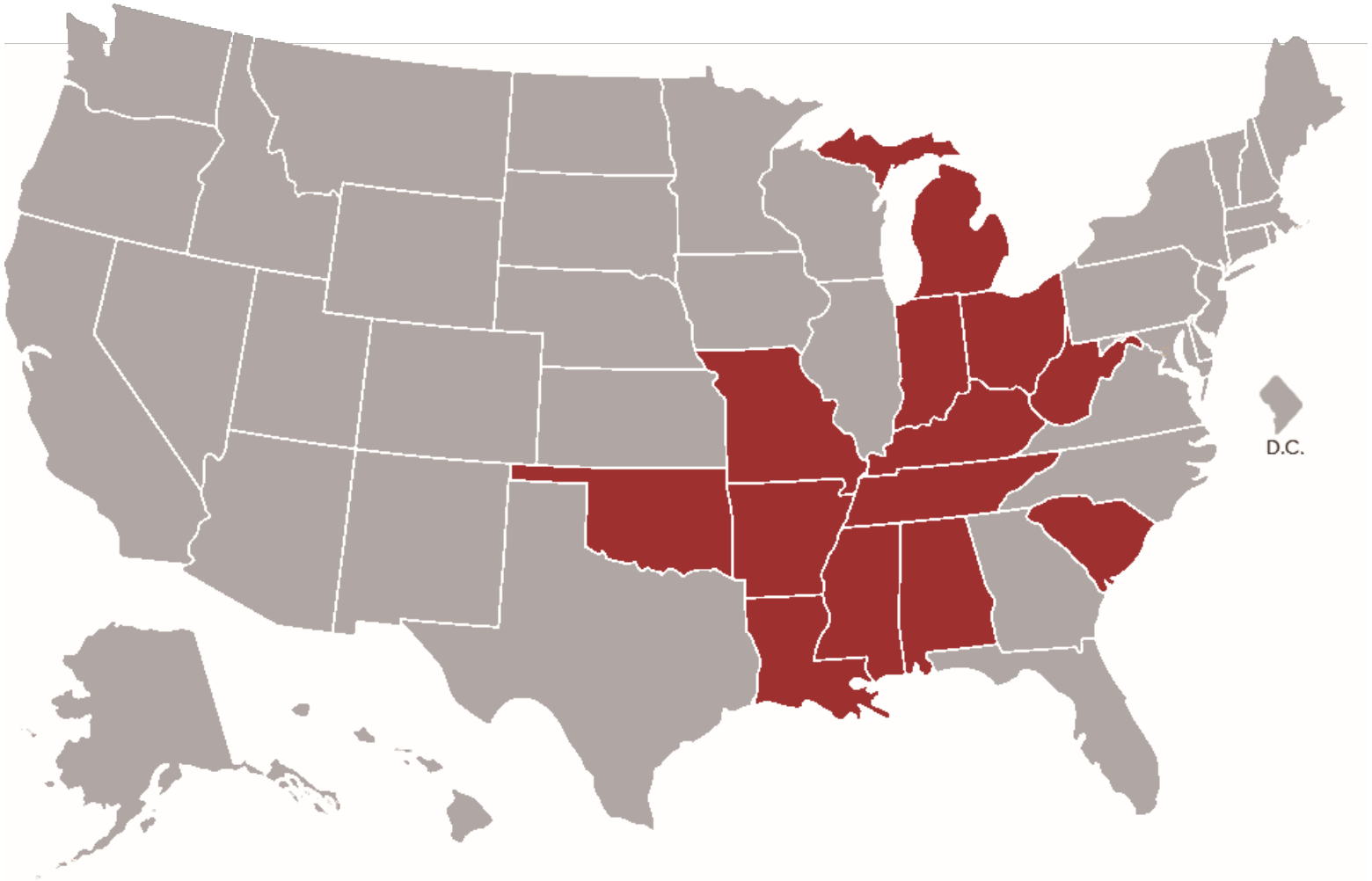
“Tobacco Nation”

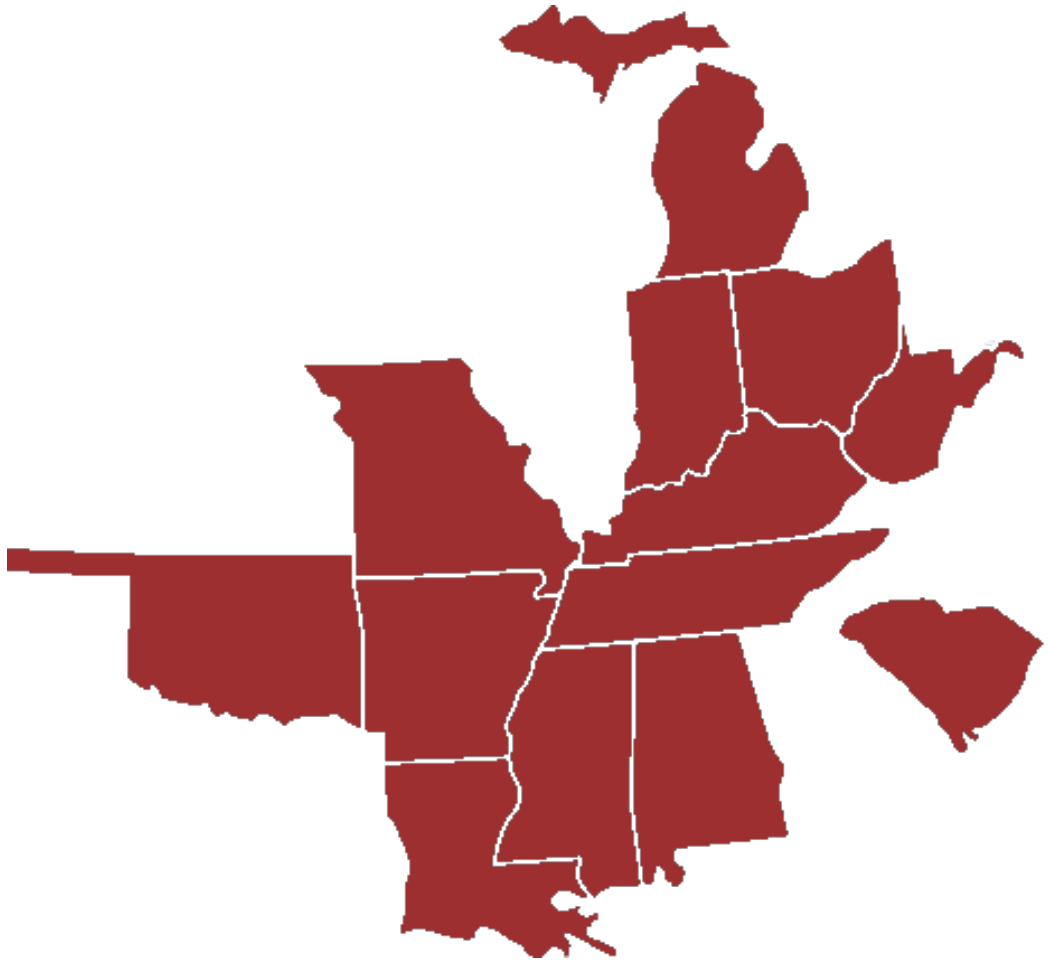


truth initiative®
INSPIRING TOBACCO-FREE LIVES

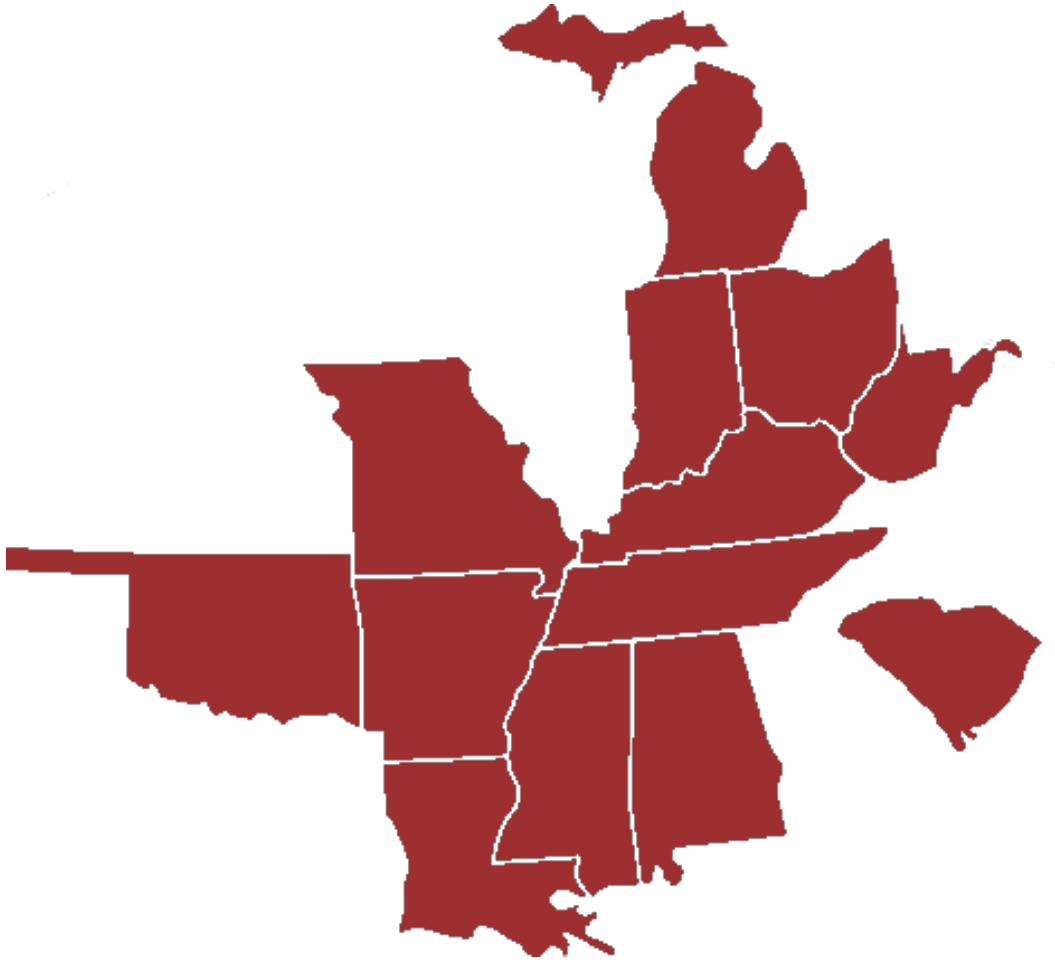
Source: Truth Initiative, “tobacco use in these 12 u.s. states is on par with a number of developing countries. why?”

Health Value Dashboard bottom quartile states for population health





"Tobacco Nation"



Poor population health nation

Mass media campaigns against tobacco use

Evidence Rating

Scientifically Supported

Health Factors

Tobacco Use

Decision Makers

Funders

Government

Public Health

Nonprofits

Mass media campaigns use television, print, digital or social media, radio broadcasts, or other displays to share messages with large audiences (Cochrane-Carson-Chahhoud 2017). Tobacco-specific campaigns educate current and potential tobacco users about the dangers of tobacco and often include graphic portrayals or emotional messages to influence attitudes and beliefs about tobacco use (CG-Tobacco use).

Expected Beneficial Outcomes (Rated)

- Reduced youth smoking
- Reduced number of tobacco users
- Increased quit rates

Other Potential Beneficial Outcomes

- Reduced tobacco consumption
- Increased use of cessation treatment

Tobacco Control Interventions

HI-5
HEALTH IMPACT IN 5 YEARS

Helping people quit tobacco

What are effective statewide tobacco interventions?

Effective population-based tobacco control interventions include tobacco price increases, high-impact anti-tobacco mass media campaigns, and comprehensive smoke-free policies. The evidence shows that implementing and enforcing these strategies, both individually and as part of a comprehensive tobacco prevention and control effort, can reduce smoking initiation and use among adults and youths. Comprehensive tobacco prevention and control efforts involve the coordinated implementation of population-based interventions to prevent tobacco initiation among youth and young adults, promote quitting among adults and youth, eliminate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities among population groups.[1] Tobacco products include cigarettes, cigars, pipes, hookah, smokeless tobacco, and others. Programs combine and integrate multiple evidence-based strategies, including educational, regulatory, economic, and social strategies at local, state, or national levels.[1]

Selected Resources

- CDC: Best Practices for Comprehensive Tobacco Control Programs—2014
- CDC Office on Smoking and Health
- CDC Media Campaign Resource Center (MCRC)
- Community Health Advisor: Large tobacco tax increase

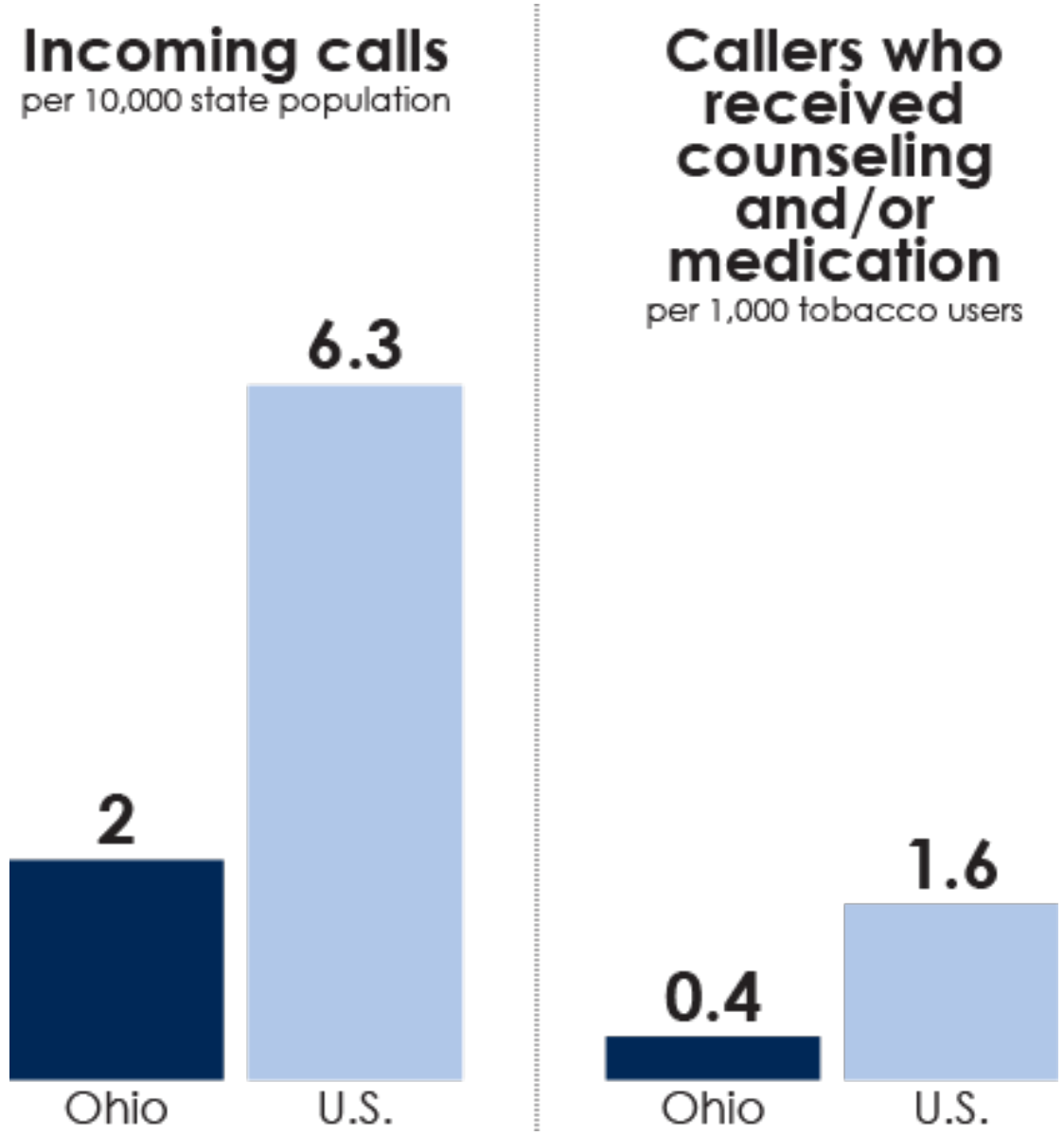
What would effective cessation policy look like?

- **Media campaigns** are everywhere
- **Call volume to Ohio Tobacco Quit Line** increases
- **Cessation is prioritized in Medicaid**
- **Baby and Me Tobacco Free** is available everywhere
- **Cessation services are tailored to meet the needs of Ohio's most at-risk groups**, including Ohioans living with toxic stress, mental illness and disability

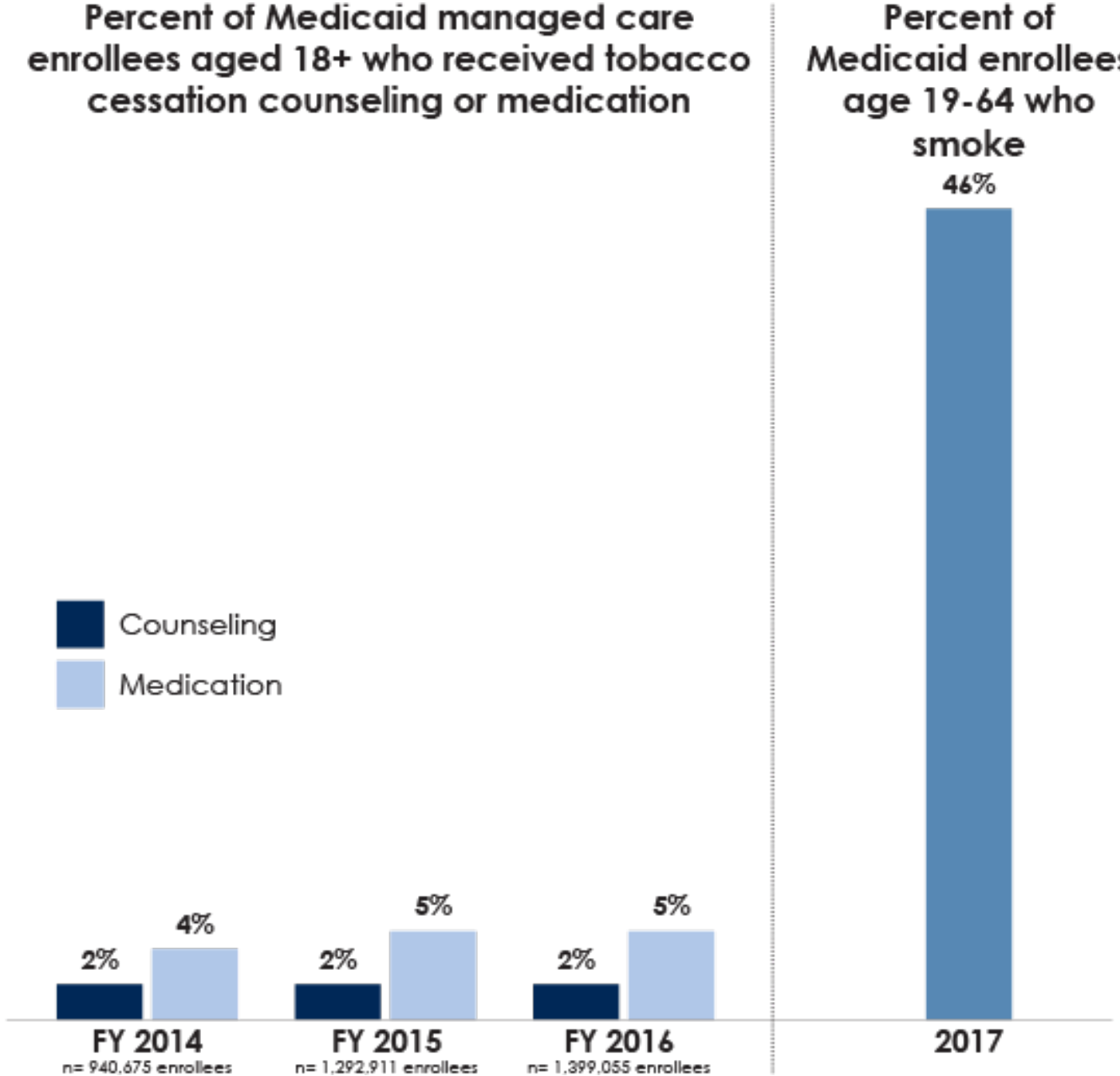
Tips from former smokers

Quit Line service utilization, Ohio and U.S.

Q4 2016

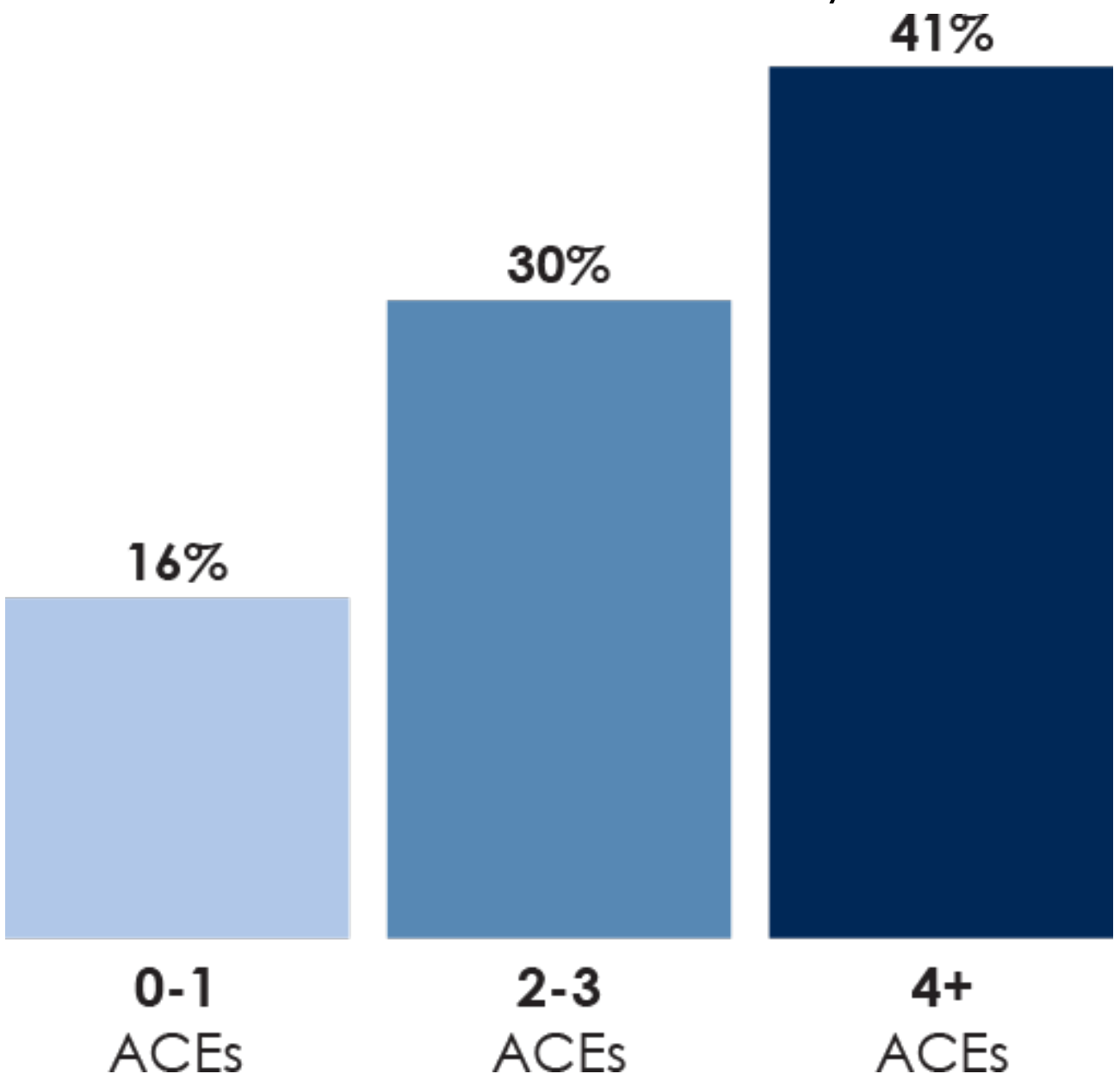


Source: CDC State Tobacco Activities Tracking and Evaluation (STATE) System. Custom report accessed 3/29/19. 2016 Q4 is most recently-available data.



Source for counseling and medication data: Ohio Department of Medicaid, 2016
Note: Counseling refers to cessation counseling of various durations (procedures). Medication refers to smoking determinants and nicotine receptor partial agonists (DM therapeutic class)
Source for smokers in Medicaid data: Data provided by the Ohio Colleges of Medicine Government Resource Center. Ohio Medicaid Assessment Survey. Provided March 15, 2019.

Adult smoking and adverse childhood experiences in Ohio, 2015



Source: Behavioral Risk Factor Surveillance Survey data provided by the Ohio Department of Health, 2/28/19

Questions?

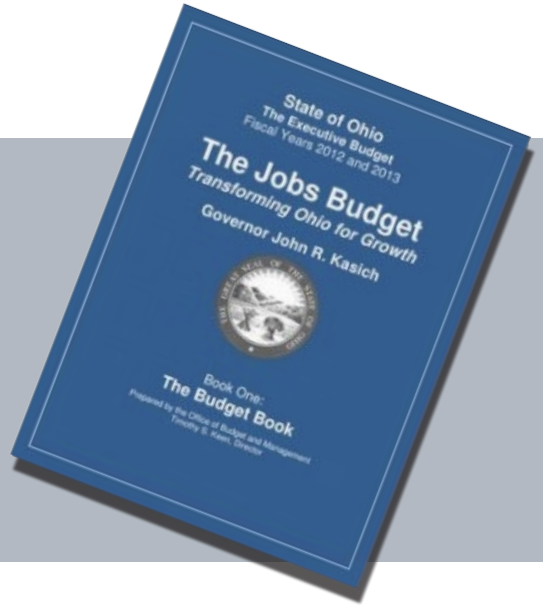
Policymaking basics

Amy Rohling McGee

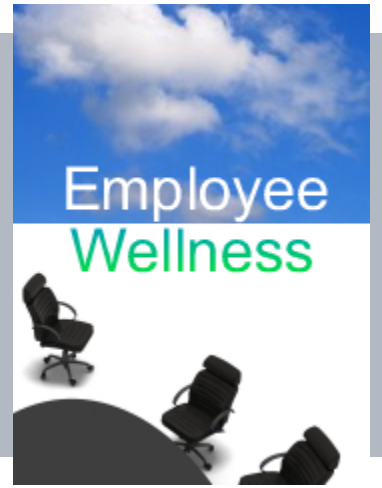

Sales tax
Nutrition labeling
Restaurant inspections
Food safety
EXTRA LOW PRICES
CHINA HOUSE
FOOD LION
Farm subsidies
Built environment
Motor vehicle safety

What is public policy?

public



organizational



federal

state

local

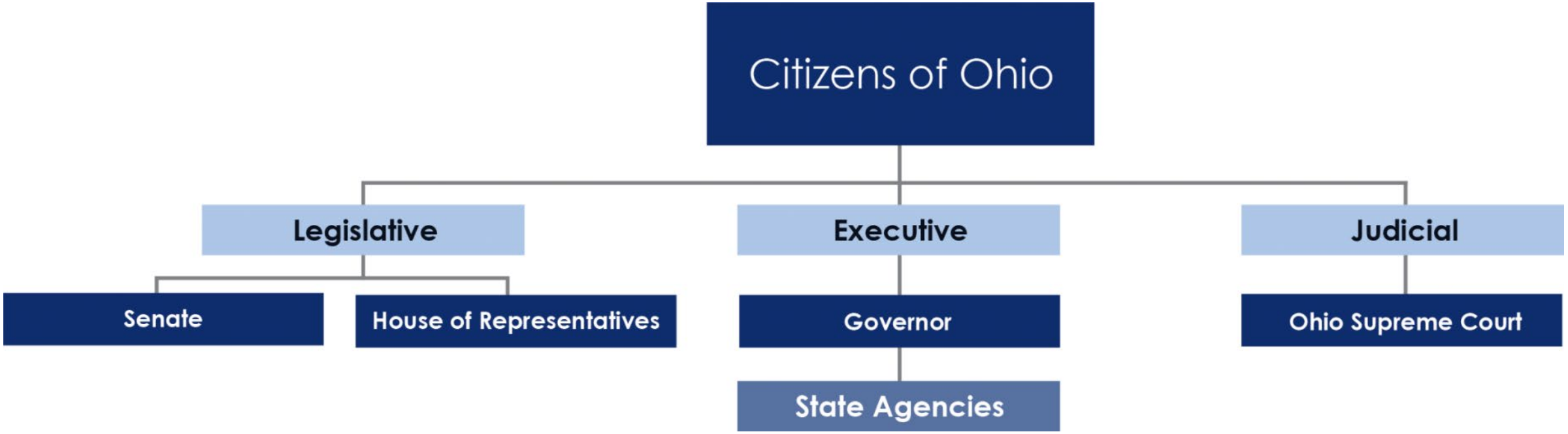
Separation of power

legislative

executive

judicial

State government organization



A

B

C

D

A

Sen. Stephanie Kunze

B

Sen. Larry Obhof

C

Rep. Kent Smith

D

Policy levers

Types of policy levers

- Taxes, fees and disincentives
- Subsidies and incentives
- Budgets, grants, contracts, etc.
- Regulations
  - Setting standards and requirements
  - Monitoring and evaluation
  - Enforcing existing regulations
  - Deregulating
- Information and education


KeyBank
CHASE
CHASE

2016-2017

2018-2019

biennium

2020-2021

2022-2023

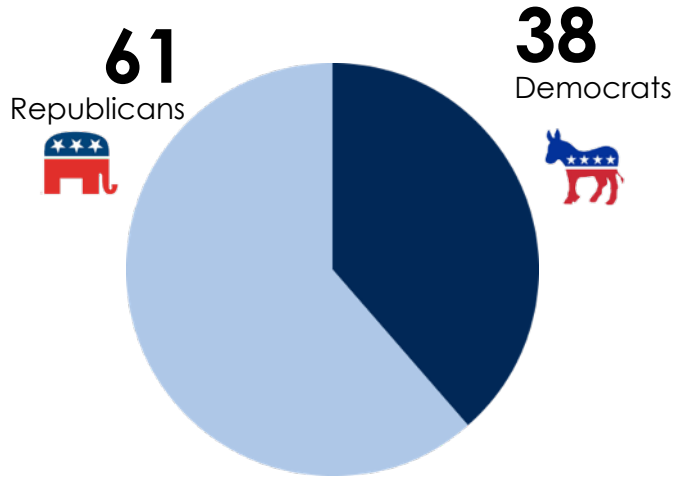
2024-2025

133nd General Assembly

House

Rep. Larry Householder
Speaker

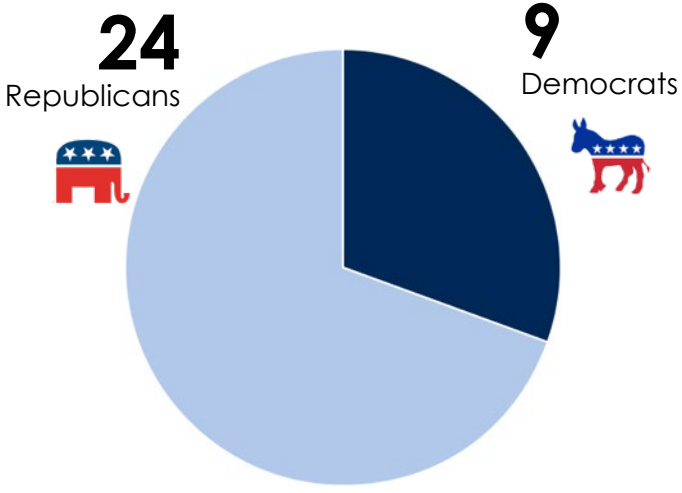
Rep. Emilia Sykes
Minority Leader



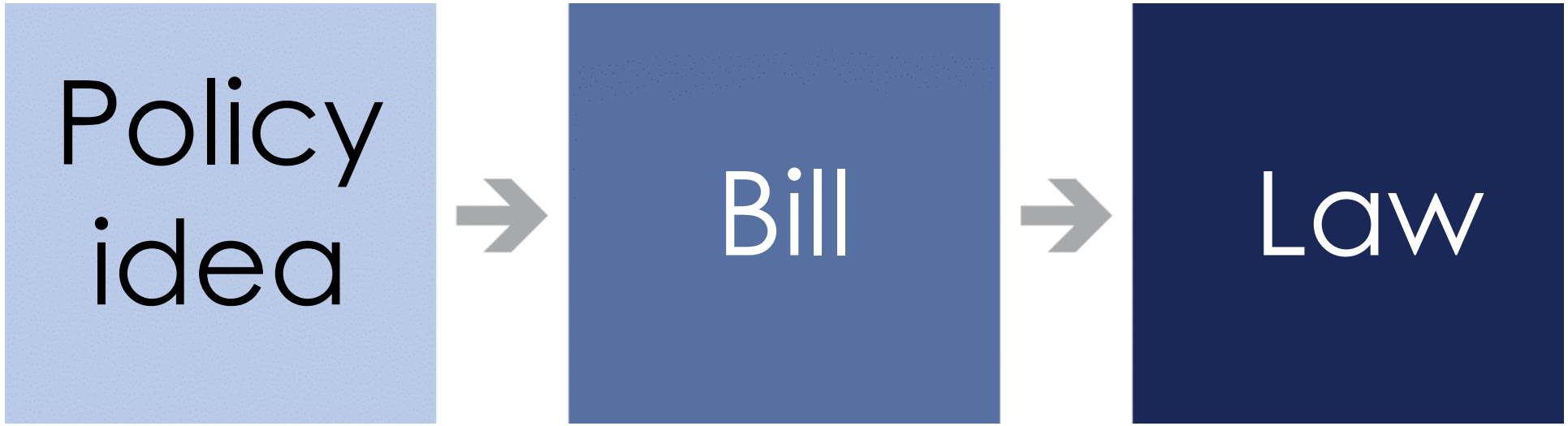
Senate

Sen. Larry Obhof
Senate President

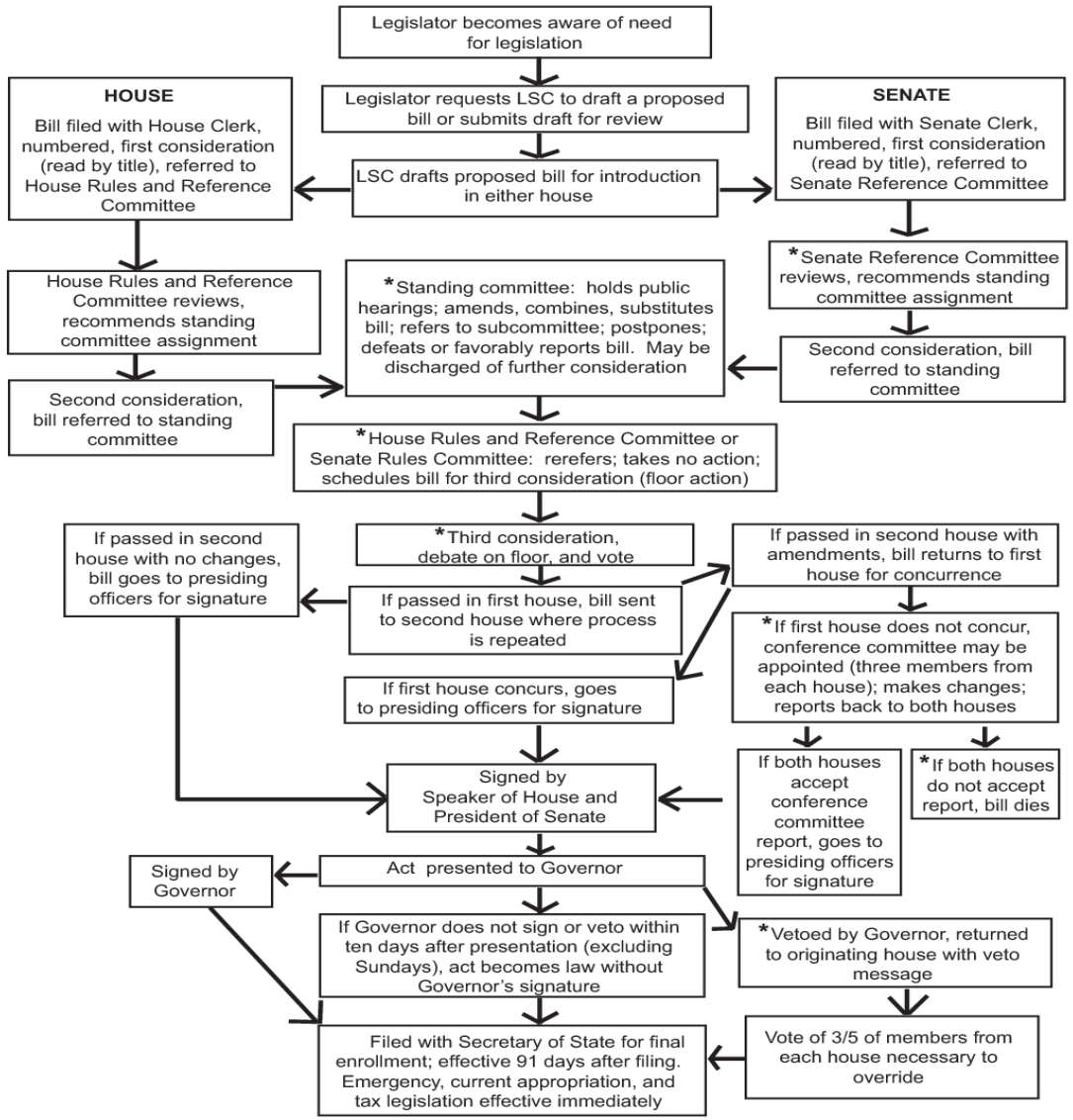
Sen. Kenny Yuko
Minority Leader



How is legislation created and enacted?



How a Bill Becomes a Law in Ohio



Standing committees and subcommittees
133rd General Assembly

House

- Aging and Long Term Care
- Agriculture and Rural Development
- Armed Services and Veterans Affairs
- Civil Justice
- Commerce and Labor
- Criminal Justice
  - Criminal Justice Subcommittee on Criminal Sentencing
- Economic and Workforce Development
- Energy and Natural Resources
  - Energy and Natural Resources Subcommittee on Energy Generation
- Federalism
- Finance
  - Finance Subcommittee on Agriculture, Development and Natural Resources
  - Finance Subcommittee on Health and Human Services
  - Finance Subcommittee on Higher Education
  - Finance Subcommittee on Primary and Secondary Education
  - Finance Subcommittee on Transportation
- Financial Institutions
- Health
- Higher Education
- Insurance
- Primary and Secondary Education
- Public Utilities
- Rules and Reference
- State and Local Government
- Transportation and Public Safety
- Way and Means

Senate

- Agriculture and Natural Resources
- Education
- Energy and Public Utilities
- Finance
  - Finance Subcommittee on Health and Medicaid
  - Finance Subcommittee on Primary and Secondary Education
- General Government and Agency Review
- Government Oversight and Reform
- Health, Human Services and Medicaid
- Higher Education
- Insurance and Financial Institutions
- Judiciary
- Local Government, Public Safety and Veterans Affairs
- Rules and Reference
- Transportation, Commerce and Workforce
- Ways and Means

A current list of committees can be found on the Ohio House and Ohio Senate websites.

SFY 20-21 Ohio budget timeline

March	Governor's proposed budget introduced in the House
April	House passage
May/June	Senate passage
June	Conference committee
June 30	Governor signs

Advocacy

- Education
- Facts
- Bipartisan
- Balanced
- No call to action (position not taken)
- Activities that defend, support or maintain a cause
- Usually broad issues

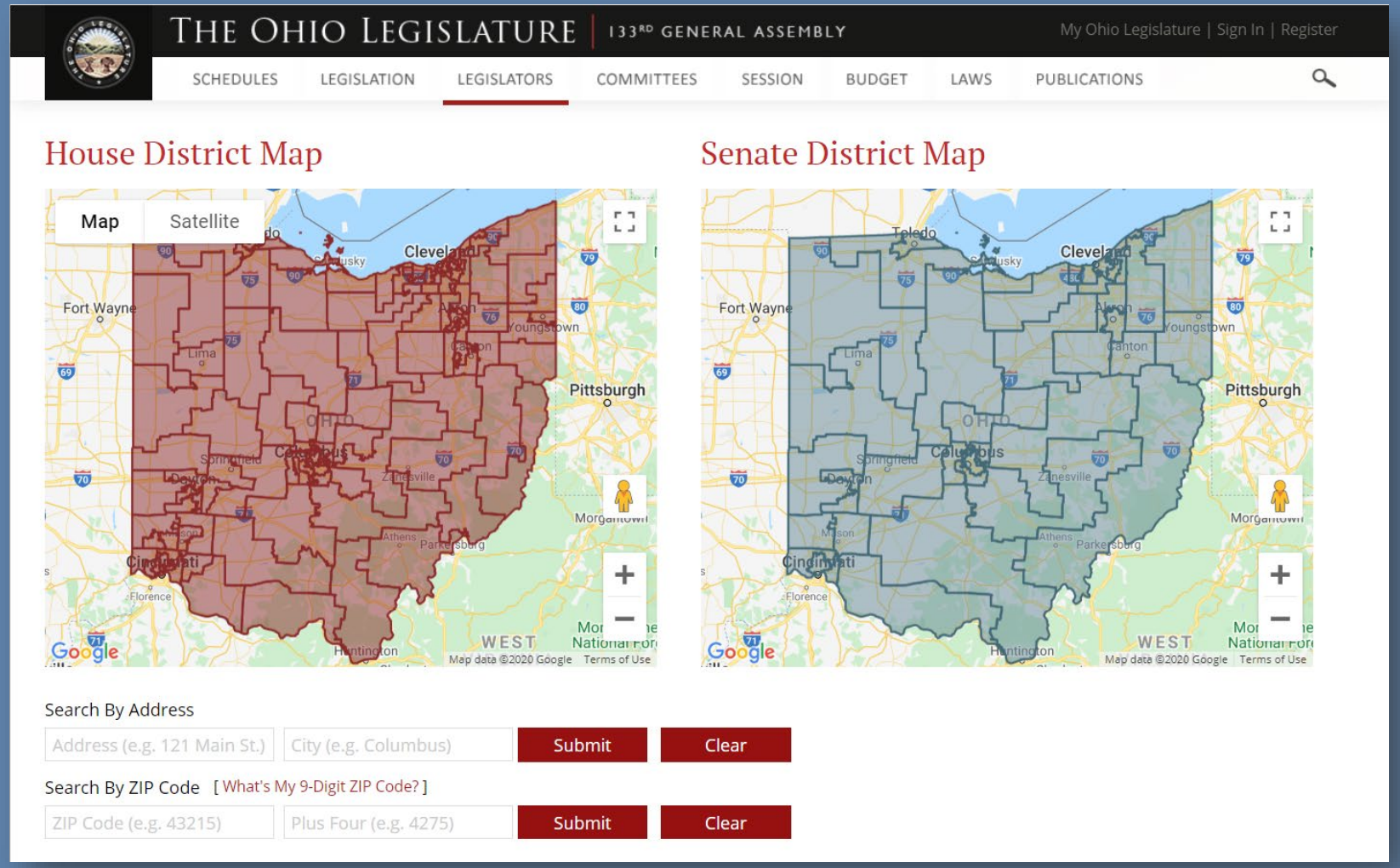
Lobbying

- Influencing legislation, regulation, funding
- Actions aimed at influencing public officials to promote or secure passage of specific bill or funding
- A paid representative for a particular organization

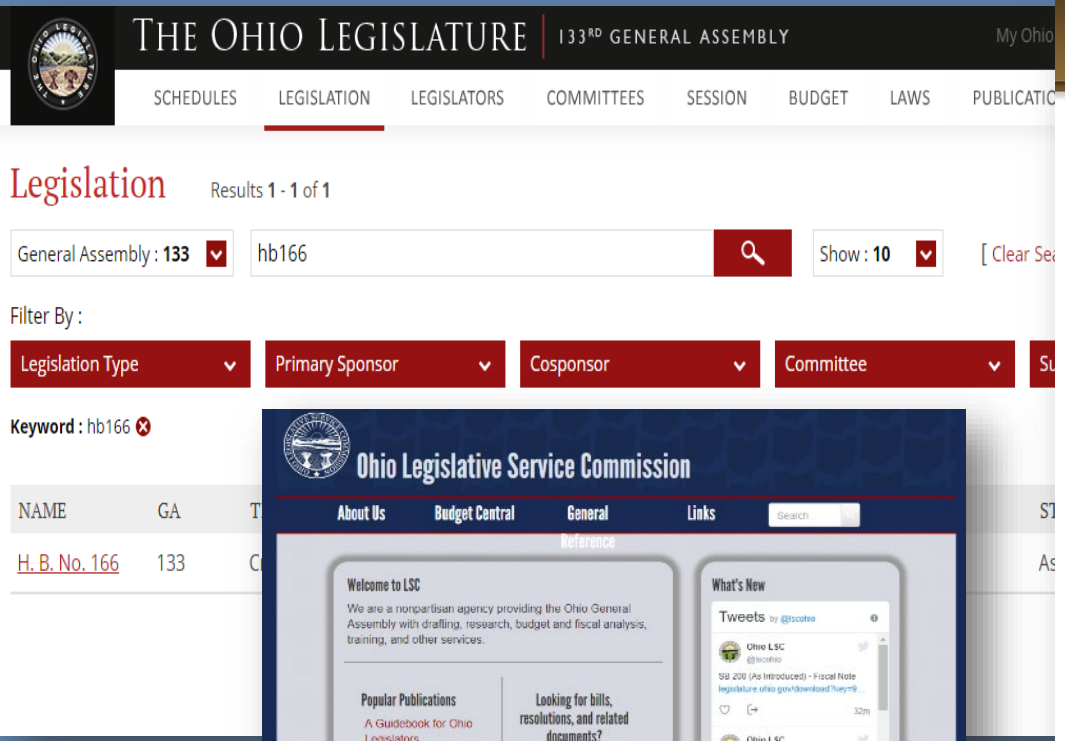
Ways to influence policy

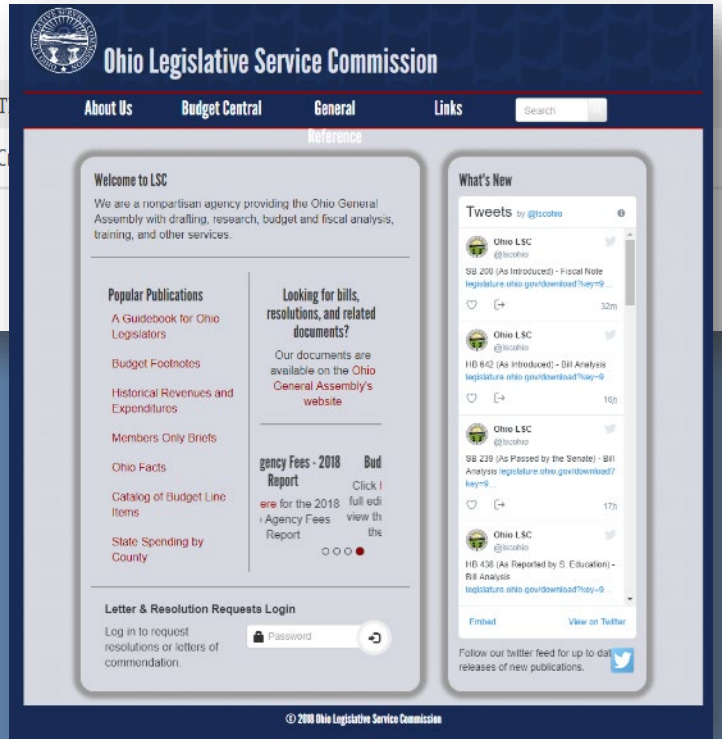
- Write letters, emails or make phone calls
- Provide district specific data
- Provide analysis of a bill
- Provide testimony at a legislative hearing
- Provide a one-page fact sheet
- Organize community partners to visit key policymakers
- Invite policymakers to visits your organization or speak at a meeting you host

Learn who represents you at the Statehouse



Resources


THE OHIO LEGISLATURE
133RD GENERAL ASSEMBLY
SCHEDULES
LEGISLATION
LEGISLATORS
COMMITTEES
SESSION
BUDGET
LAWS
Legislation
Results 1 - 1 of 1
General Assembly : 133
hb166
Show : 10
Filter By :
Legislation Type
Primary Sponsor
Cosponsor
Committee
Keyword : hb166
NAME
GA
H. B. No. 166
133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LEGISLATION
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ABOUT
RESOURCES
INTERNSHIP OPPORTUNITIES


MENU
The Ohio Senate
133RD GENERAL ASSEMBLY
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We're glad you're here.
We encourage you to explore, connect and engage.


I
VOTING
www.OhioSecretaryofState.gov

“It’s a marathon, not a sprint.”

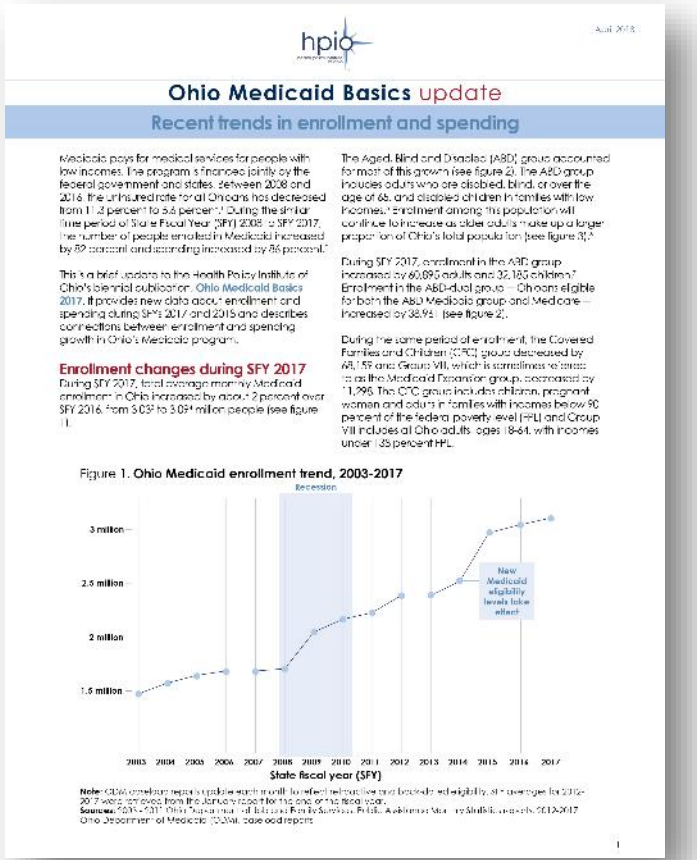
Medicaid basics

A lever for achieving health value and equity

Zach Reat

3 key takeaways

1. **Ohio Medicaid is big.** The program provides health insurance to more than 2.8 million Ohioans.
2. **Ohio Medicaid is a significant investment.** Ohio's total spending for the program in SFY2019 was $26.8 billion dollars.
3. **Ohio Medicaid is changing.** Ohio policymakers are considering different approaches to manage the program's size and cost.



Ohio Medicaid Basics update

Recent trends in enrollment and spending

Medicaid pays for medical services for people with low incomes. The program is financed jointly by the federal government and states. Between 2008 and 2016, the uninsured rate for all Ohioans has decreased from 11.3 percent to 5.6 percent.[1] During the similar time period of State Fiscal Year (SFY) 2008 – SFY 2017, the number of people enrolled in Medicaid increased by 82 percent and spending increased by 86 percent.[2]

This is a brief update to the Health Policy Institute of Ohio's biennial publication, Ohio Medicaid Basics 2017. It provides new data about enrollment and spending during SFYs 2017 and 2018 and describes connections between enrollment and spending growth in Ohio's Medicaid program.

Enrollment changes during SFY 2017

During SFY 2017, total average monthly Medicaid enrollment in Ohio increased by about 2 percent over SFY 2016, from 3.03[3] to 3.09[4] million people (see figure 1).

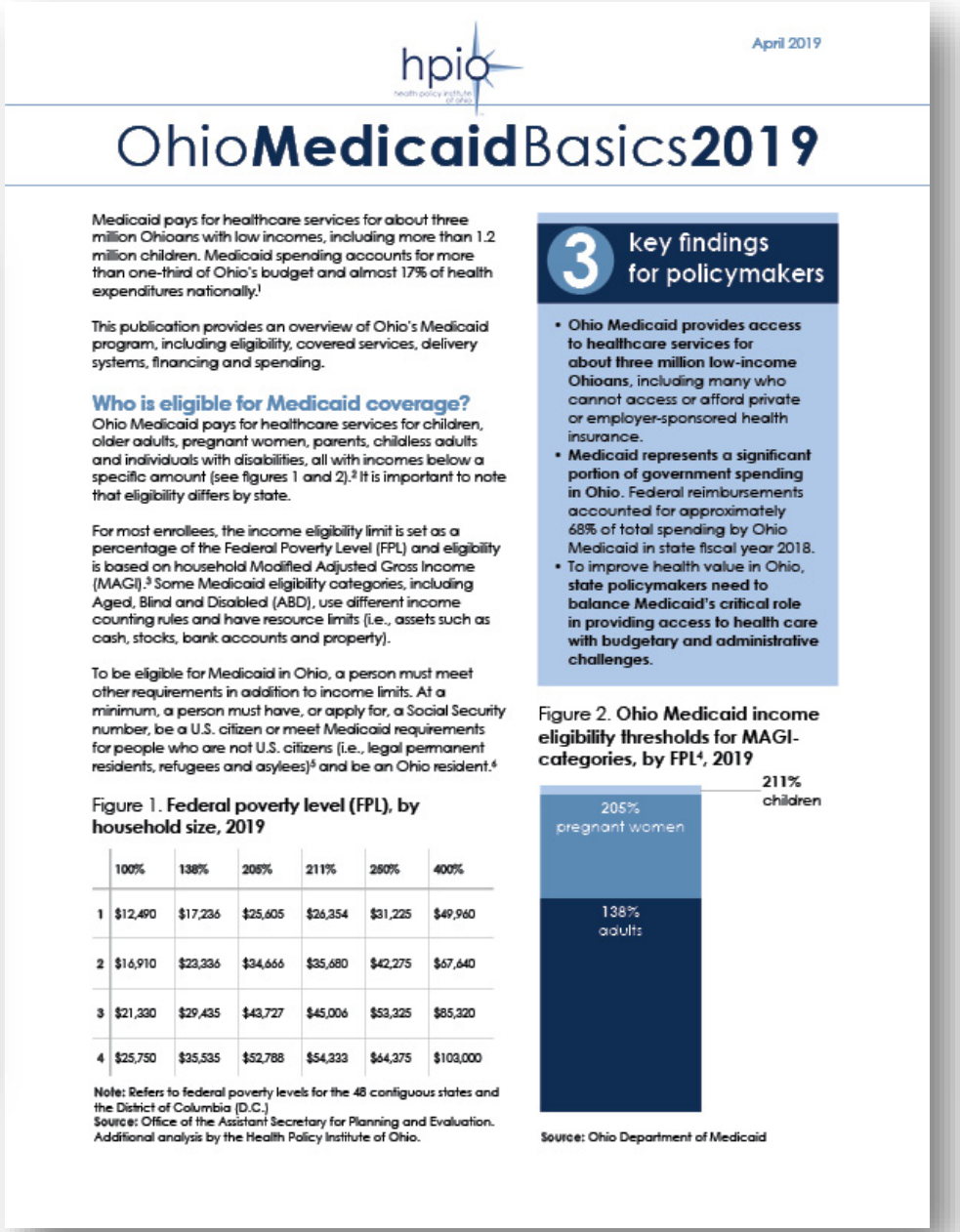
The Aged, Blind and Disabled (ABD) group accounted for most of this growth (see figure 2). The ABD group includes adults who are disabled, blind, or over the age of 65, and disabled children in families with low incomes.[5] Enrollment among this population will continue to increase as older adults make up a larger proportion of Ohio's total population (see figure 3).[6]

During SFY 2017, enrollment in the ABD group increased by 60,690 adults and 32,185 children.[7] Enrollment in the ABD-dual group – Ohioans eligible for both the ABD Medicaid group and Medicare – increased by 38,951 (see figure 2).

During the same period of enrollment, the Covered Families and Children (CFC) group decreased by 68,159 and Group VII, which is sometimes referred to as the Medicaid Expansion group, decreased by 11,996. The CFC group includes children, pregnant women and adults in families with incomes below 90 percent of the federal poverty level (FPL) and Group VII includes all Ohio adults ages 18-64, with incomes under 138 percent FPL.

Figure 1. **Ohio Medicaid enrollment trend, 2003-2017**

Note: CDW enrollment reports update each month to reflect retroactive and backdated eligibility, so averages for 2016-2017 were retrieved from the January report for the end of the fiscal year.
Sources: 2003 – 2011: Ohio Department of Job and Family Services Public Assistance Year-Month Statistical Reports, 2012-2017: Ohio Department of Medicaid (ODM), data oad reports



April 2019

Ohio**Medicaid**Basics**2019**

Medicaid pays for healthcare services for about three million Ohioans with low incomes, including more than 1.2 million children. Medicaid spending accounts for more than one-third of Ohio's budget and almost 17% of health expenditures nationally.[1]

This publication provides an overview of Ohio's Medicaid program, including eligibility, covered services, delivery systems, financing and spending.

Who is eligible for Medicaid coverage?

Ohio Medicaid pays for healthcare services for children, older adults, pregnant women, parents, childless adults and individuals with disabilities, all with incomes below a specific amount (see figures 1 and 2).[2] It is important to note that eligibility differs by state.

For most enrollees, the income eligibility limit is set as a percentage of the Federal Poverty Level (FPL) and eligibility is based on household Modified Adjusted Gross Income (MAGI).[3] Some Medicaid eligibility categories, including Aged, Blind and Disabled (ABD), use different income counting rules and have resource limits (i.e., assets such as cash, stocks, bank accounts and property).

To be eligible for Medicaid in Ohio, a person must meet other requirements in addition to income limits. At a minimum, a person must have, or apply for, a Social Security number, be a U.S. citizen or meet Medicaid requirements for people who are not U.S. citizens (i.e., legal permanent residents, refugees and asylees)[5] and be an Ohio resident.[6]

Figure 1. **Federal poverty level (FPL), by household size, 2019**

	100%	138%	205%	211%	250%	400%
1	$12,490	$17,236	$25,605	$26,354	$31,225	$49,960
2	$16,910	$23,336	$34,666	$35,680	$42,275	$67,640
3	$21,330	$29,435	$43,727	$45,006	$53,325	$85,320
4	$25,750	$35,535	$52,788	$54,333	$64,375	$103,000

Note: Refers to federal poverty levels for the 48 contiguous states and the District of Columbia (D.C.)
Source: Office of the Assistant Secretary for Planning and Evaluation. Additional analysis by the Health Policy Institute of Ohio.

3 key findings for policymakers

- **Ohio Medicaid provides access to healthcare services for about three million low-income Ohioans, including many who cannot access or afford private or employer-sponsored health insurance.**
- **Medicaid represents a significant portion of government spending in Ohio. Federal reimbursements accounted for approximately 68% of total spending by Ohio Medicaid in state fiscal year 2018.**
- **To improve health value in Ohio, state policymakers need to balance Medicaid's critical role in providing access to health care with budgetary and administrative challenges.**

Figure 2. **Ohio Medicaid income eligibility thresholds for MAGI-categories, by FPL[4], 2019**

Source: Ohio Department of Medicaid

April 2017

Ohio**Medicaid**Basics**2017**

Introduction

Medicaid pays for medically necessary healthcare services for over three million Ohioans and is the primary source of coverage for low-income Ohioans who generally do not have access to or cannot afford other health insurance coverage. The program also pays for services for people who are elderly and disabled, including long term services and supports that are not covered by Medicare and most private health insurance coverage.[1] As a healthcare payer for one in four Ohioans, Medicaid enables improved access to care[2], as well as treatment of chronic health conditions (including mental health conditions), injuries, illnesses and addictions. Medicaid also pays for preventive care, prescription drugs and screenings.

While there is evidence that Medicaid coverage improves access to care[3], it is important to note that overall health is influenced by a number of other factors. Research estimates that of the modifiable factors that influence overall health outcomes, 80 percent is attributed to non-clinical factors including our social, economic and physical environments, as well as our health behaviors, and only 20 percent is attributed to clinical care (see figure 1).[4] This indicates that access to quality clinical care is necessary, but not sufficient, to improving overall health.

Figure 1. **Modifiable factors that influence health**

Source: County Health Rankings and Roadmaps population health model

Medicaid and the U.S. healthcare system

Medicaid is financed jointly by the federal government and states, including some local-level funding to support the state share.

Medicaid accounted for 17 percent of U.S. total healthcare expenditures in 2015, making the program the second-largest payer of healthcare services in terms of total expenditures.[5] Through Medicare, Medicaid and the Federal Employees Health Benefit Plan, the federal government is the largest payer for healthcare services in the country, and because of this, often drives change and industry innovation, particularly through new payment rates and models.[5]

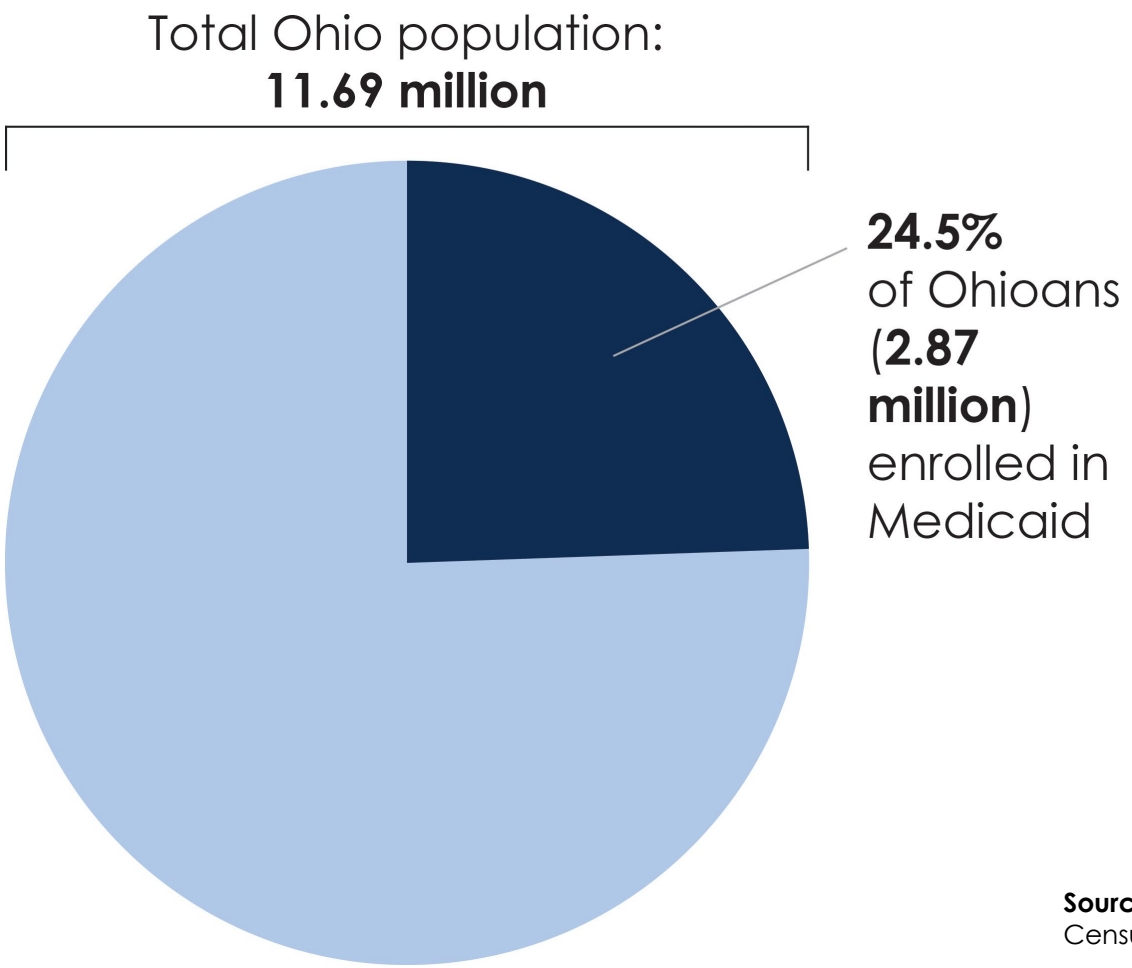
At the state level, the Ohio Department of Medicaid (ODM) and the managed care plans under contract with ODM are important partners in payment reform initiatives led by the Governor's Office of Health Transformation (OHT) (see "Paying for value in Medicaid" beginning on page 10 of this publication).

Covered groups

- Children
- Older adults
- Women who are pregnant
- Adults without dependents
- People with disabilities

Estimated percent of Ohioans enrolled in Medicaid

state fiscal year 2019



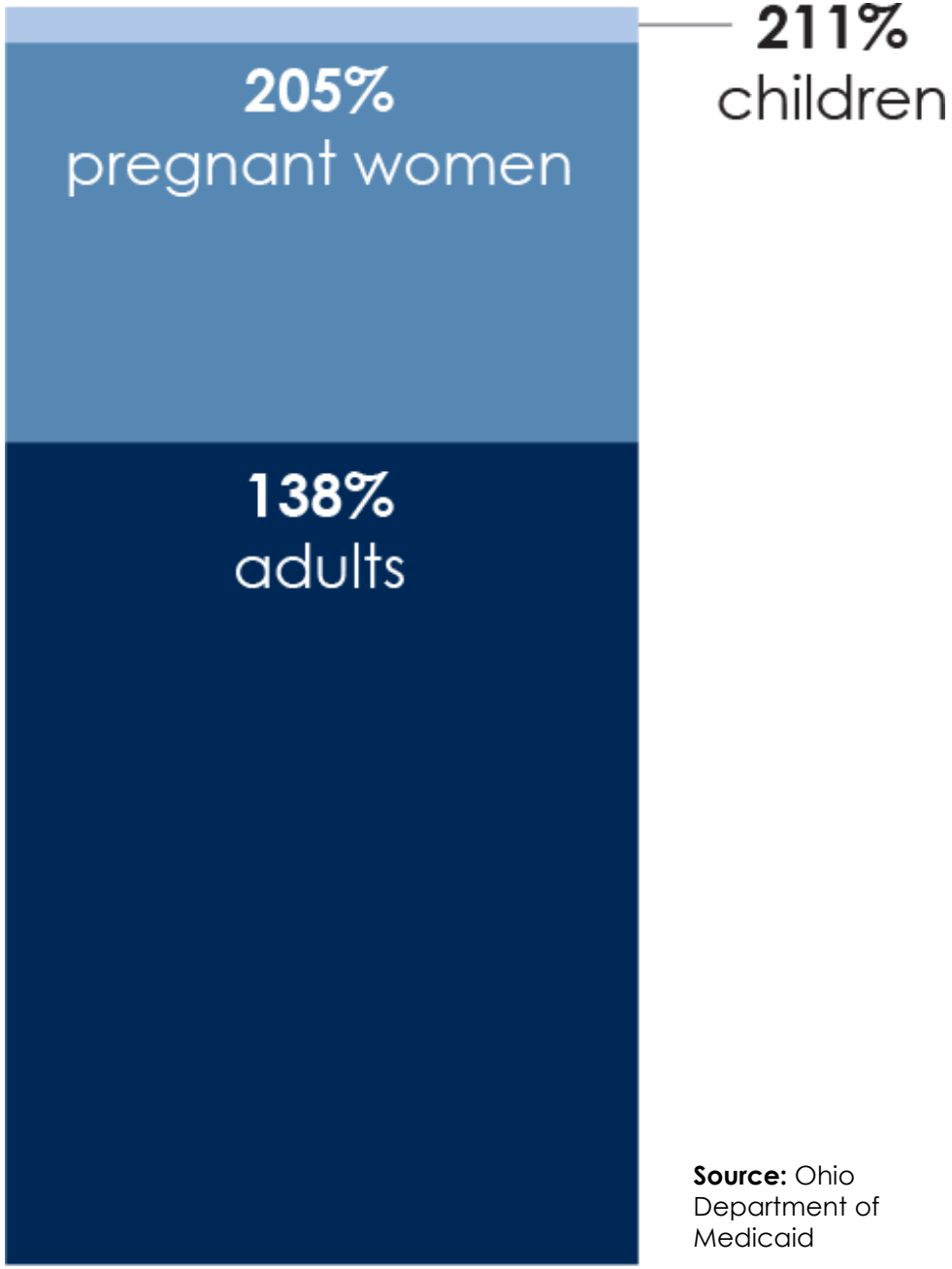
Sources: Ohio Department of Medicaid and U.S. Census Bureau, American Community Survey

Eligibility

- Income
- Assets, such as stocks, bonds, real estate
- Household size
- Disability status and medical conditions (in some cases)
- Residence (state)
- Citizenship/immigration status

Ohio Medicaid income eligibility thresholds for MAGI-categories

by percent of Federal Poverty Level, 2019



Source: Ohio Department of Medicaid

Federal poverty level (FPL)

by household size, 2020

	100%	138%	200%	250%	400%
1	$12,760	$17,609	$25,520	$31,900	$51,040
2	$17,240	$23,791	$34,480	$43,100	$68,960
3	$21,720	$29,974	$43,440	$54,300	$86,880
4	$26,200	$36,156	$52,400	$65,500	$104,800

Note: Refers to federal poverty levels for the 48 contiguous states and the District of Columbia (D.C.)
Source: Office of the Assistant Secretary for Planning and Evaluation. Additional analysis by the Health Policy Institute of Ohio.

Federal poverty level (FPL)

by household size, 2020

Scenario

- Single adult without dependents
- Eligibility for adults without dependents (138% FPL)

	100%	138%	200%	250%	400%
1	$12,760	$17,609	$25,520	$31,900	$51,040
2	$17,240	$23,791	$34,480	$43,100	$68,960
3	$21,720	$29,974	$43,440	$54,300	$86,880
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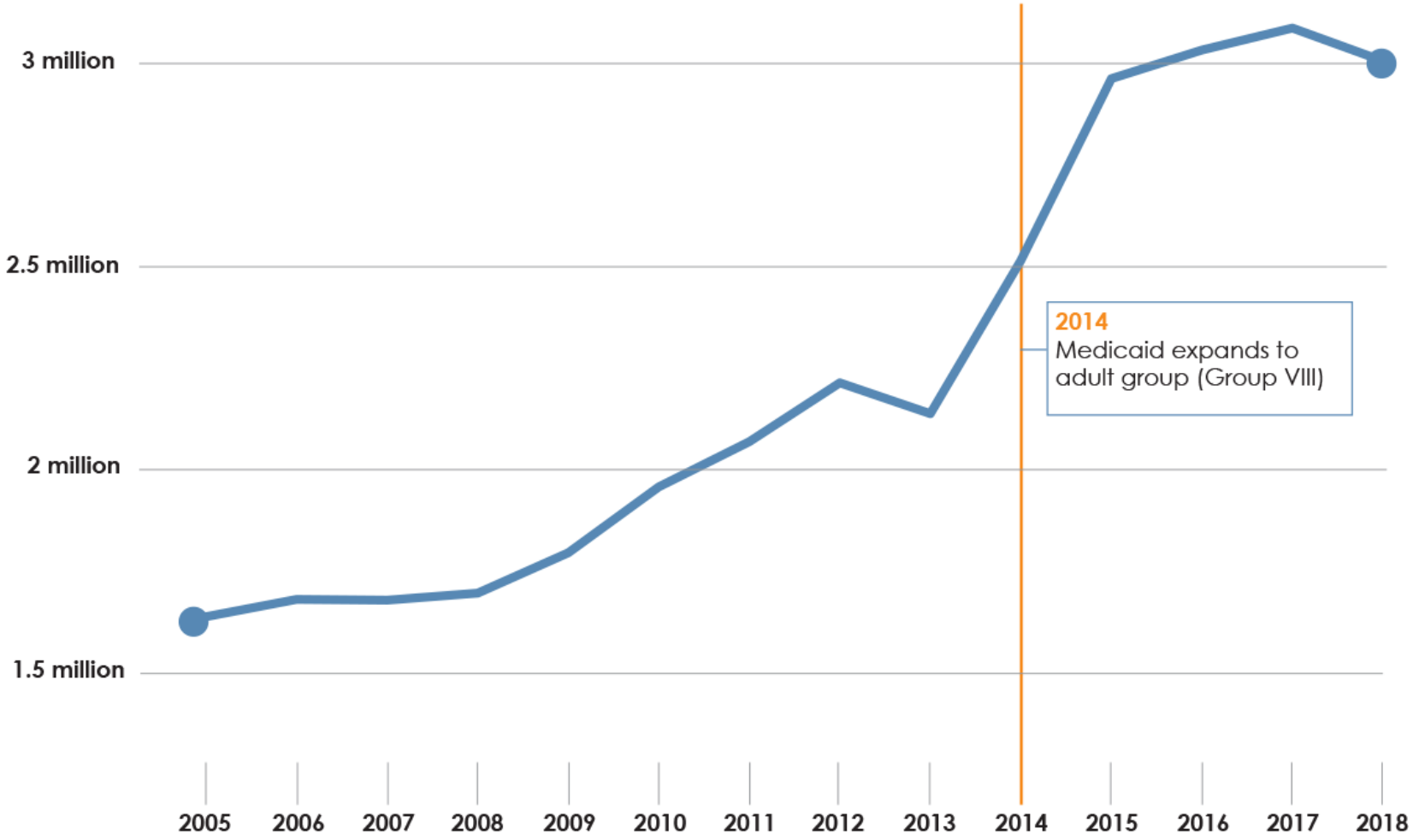
Note: Refers to federal poverty levels for the 48 contiguous states and the District of Columbia (D.C.)
Source: Office of the Assistant Secretary for Planning and Evaluation. Additional analysis by the Health Policy Institute of Ohio.

Eligibility

- Income
- Citizenship/immigration status
- Residence (state)
- Disability status and medical conditions (in some cases)
- Assets, such as stocks, bonds, real estate

Ohio Medicaid enrollment trend

SFY 2005-2018



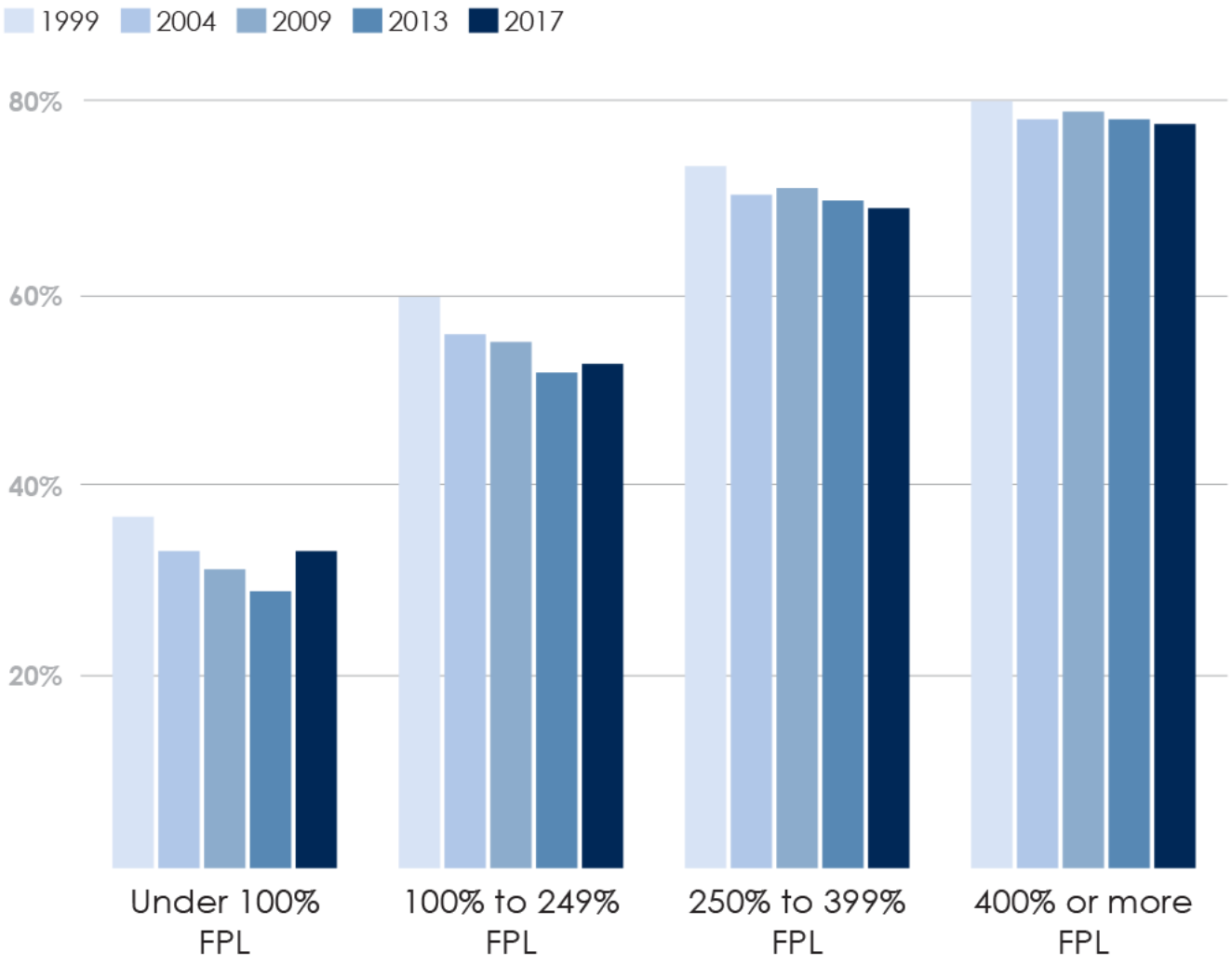
Sources: SFY 2005-2011 Ohio Department of Job and Family Services, Public Assistance Monthly Statistics reports; SFY 2012-2018 Ohio Department of Medicaid

Reasons people enroll in Medicaid

- Unemployment and other changes that impact coverage
- Price of individual (non-group) health insurance coverage
- Coverage for long term services and supports (LTSS)

Percent of non-elderly population enrolled in employer-sponsored insurance

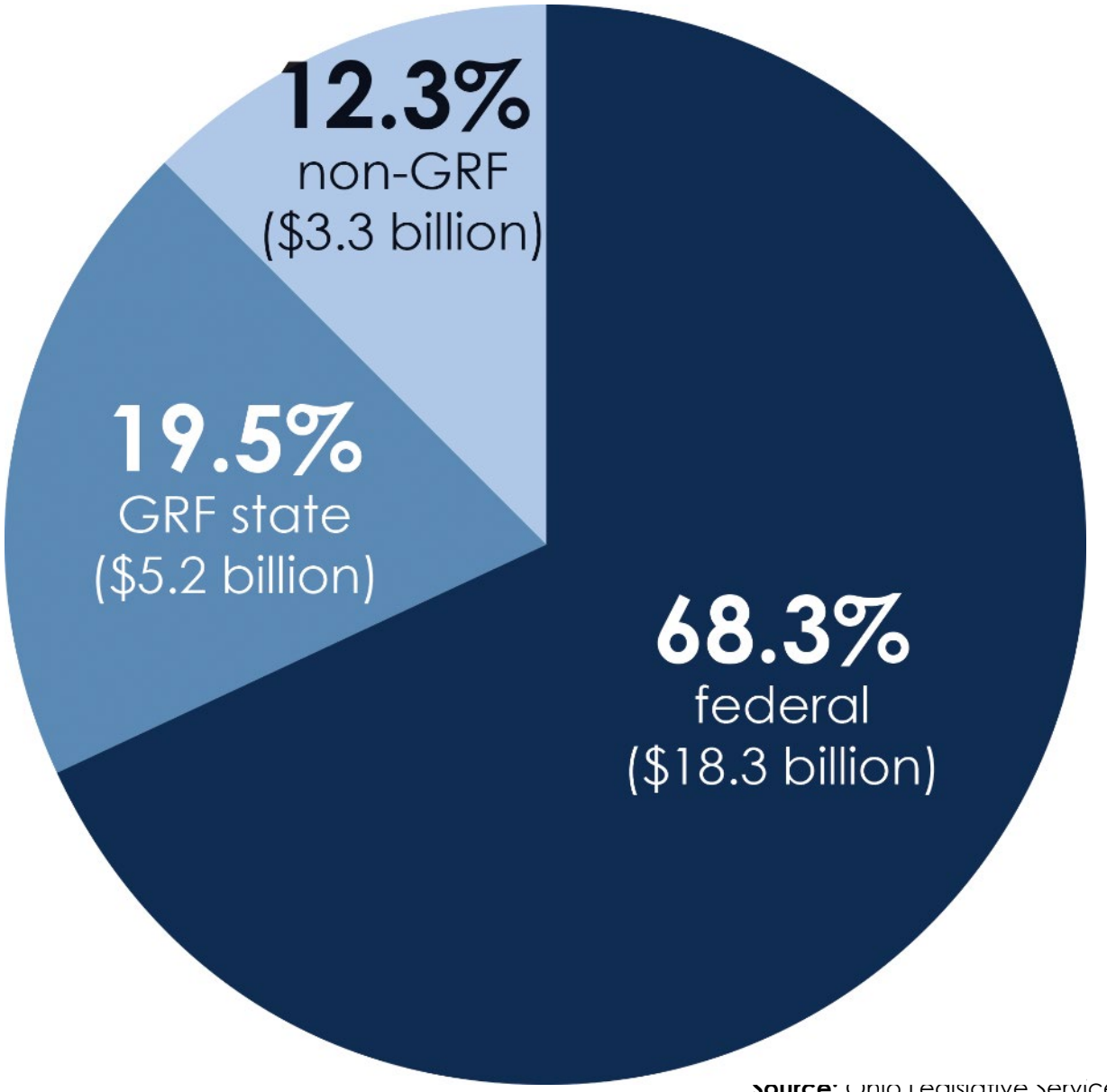
by percent of Federal Poverty Level, by year, 1999, 2004, 2009, 2013 and 2017



Source: Kaiser Family Foundation analysis of the National Health Interview Survey. 1999-2017

Ohio Medicaid spending,

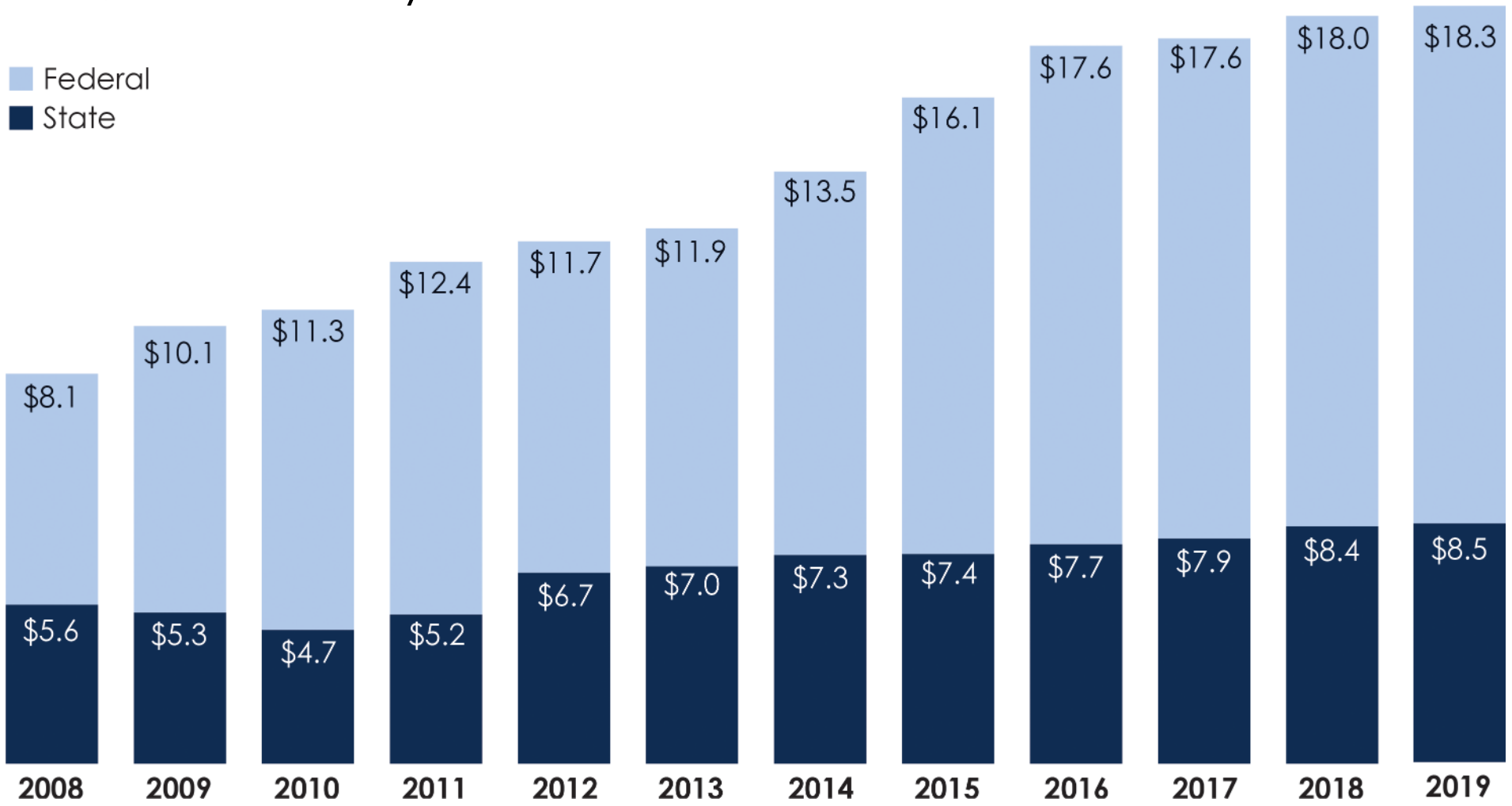
by source, state fiscal year 2019



Source: Ohio Legislative Service Commission

Ohio Medicaid spending

in billions, state fiscal years 2008 – 2019



Source: Ohio Department of Medicaid (via Ohio Legislative Service Commission)

Changes

Growing enrollment and spending has put policymaker attention on:

- Work and community engagement of enrollees
- Managed care performance

Levers

- Waivers
- Managed care contracts
- Payment arrangements

Waivers

Research and demonstration waivers

- Section 1115

Program waivers

- Sections 1915(b) and 1915(c)

Limitations of waivers

- Require federal approval
- Limited in scope
- Budget neutrality and other federal requirements
- Time limited (typically five years)

Managed care contracts

Payment arrangements

- Ohio Comprehensive Primary Care
- Pay-for-performance

2020 Ohio CPC clinical quality metrics

PRELIMINARY

Update for 2020; detail follows

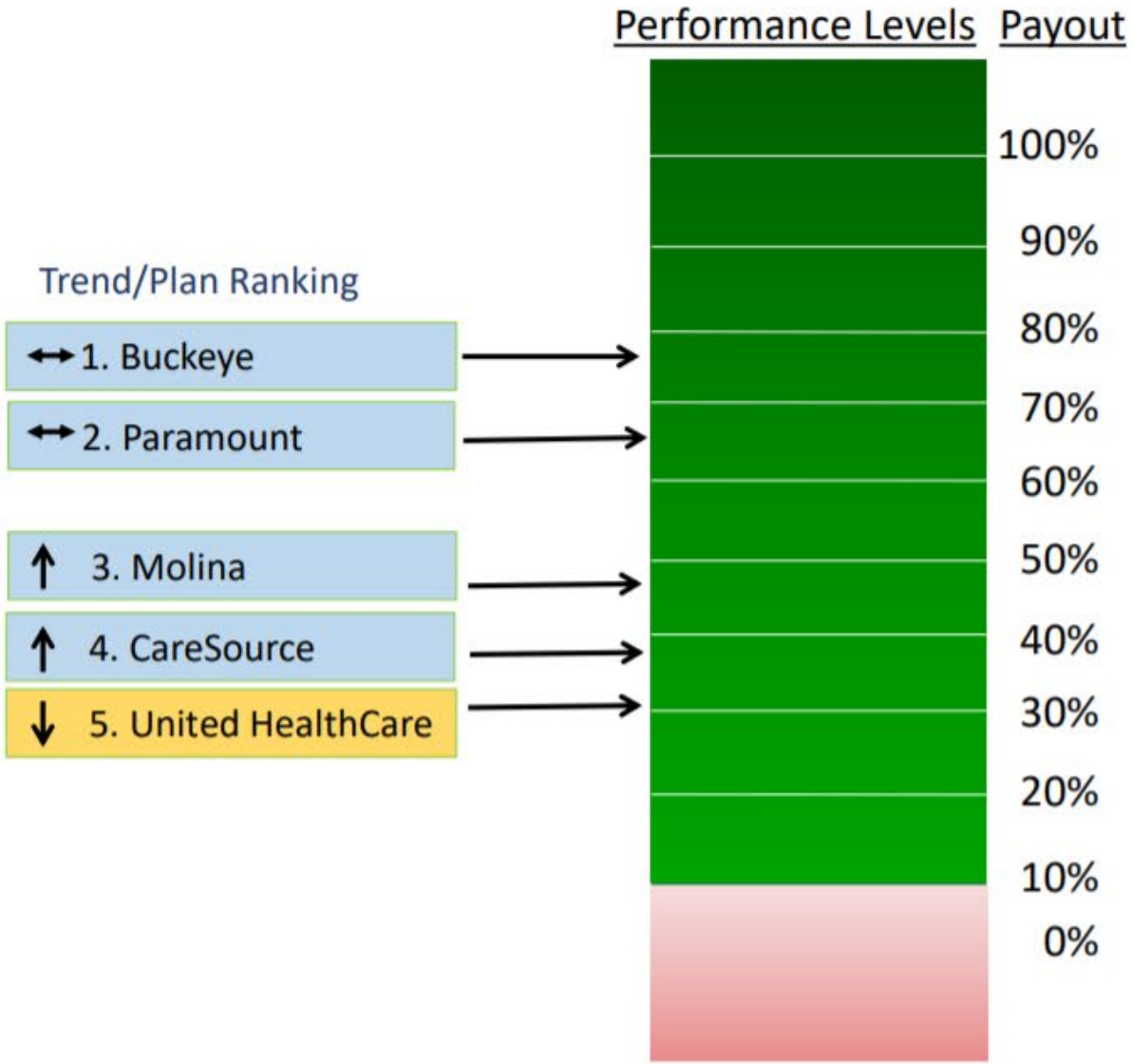
Category	Measure Name
Pediatric Health (4)	Well-Child Visits in the First 15 Months of Life
	Well-Child visits in the 3rd, 4th, 5th, 6th years of life
	Adolescent Well-Care Visits
	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents
Women's Health (5)	Timeliness of prenatal care
	Live Births Weighing Less than 2,500 grams
	Postpartum care
	Breast Cancer Screening
	Cervical cancer screening
Adult Health (7)	Adult BMI Assessment
	Controlling high blood pressure[1]
	Medication management for people with asthma
	Statin Therapy for patients with cardiovascular disease
	Comprehensive Diabetes Care: HgA1c poor control (>9.0%)
	Comprehensive diabetes care: HbA1c testing
	Comprehensive diabetes care: eye exam
Behavioral Health (4)	Antidepressant medication management
	Follow up after hospitalization for mental illness
	Preventive care and screening: tobacco use: screening and cessation intervention
	Initiation of alcohol and other drug dependence treatment: Engagement

Source: ODM working group conversations and stakeholder input.

Note: All CMS metrics in relevant topic areas were included in list except for those for which data availability poses a challenge (e.g.,, certain metrics requiring EHR may be incorporated in future years).

2018 P4P – Plan Ranking

Percent Awarded for All Measures



2018
MCPs awarded $66 million (43%) of $153.6 million possible

2017
MCPs awarded $47 million (33%) of $143.8 million possible

MCPs with increase in % of Potential Payout Awarded from 2017

MCPs with decrease in % of Potential Payout Awarded from 2017

3 key takeaways

1. **Ohio Medicaid is big.** The program provides health insurance to more than 2.8 million Ohioans.
2. **Ohio Medicaid is a significant investment.** Ohio's total spending for the program in SFY2019 was $26.8 billion dollars.
3. **Ohio Medicaid is changing.** Ohio policymakers are considering different approaches to manage the program's size and cost.

Local panel

Impacting health policy issues in real life

tobacco

Health Policy Basics

Understanding and influencing state health policy

Cincinnati, Ohio

March 11, 2019