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House Finance Subcommittee on Health and Human Services
SFY 2018-19 State Operating Budget
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Chairman Romanchuk and members of the House Finance Subcommittee on Health and Human Services, thank you for the opportunity to present the Ohio Department of Health's (ODH) priorities included in the Governor's Executive Budget for State Fiscal Years 2018-19.

Today I request your support for a budget that will strengthen Ohio's public health system and prioritize spending to improve outcomes in maternal and infant health (including infant mortality), mental health and addiction (including drug dependence and abuse, and drug overdose deaths), and chronic disease – the greatest priorities identified in Ohio's 2016 State Health Assessment and addressed through strategies identified in Ohio's 2017-2019 State Health Improvement Plan. The department's overall appropriation levels in the Executive Budget to support state health priorities are $638.4 million in SFY 2018 (an approximately $2.5 million, or 0.4 percent, increase over the original SFY 2017 appropriation amount of $636.0 million) and $640.0 million in SFY 2019 (an approximately $1.5 million, or 0.2 percent, increase over SFY 2018). The department's General Revenue Fund (GRF) appropriation is $79.8 million in SFY 2018 (an approximately $3.9 million, or 4.7 percent, decrease over the SF 20Y17 appropriation amount of $83.7 million) and $81.3 million in SFY 2019 (a $1.5 million, or 1.9 percent, increase over SFY 2018).

ODH is proud to lead Ohio's public health system at the state level as we partner with local health districts and other stakeholders across Ohio to protect and improve the health of the communities we serve. Public health is all around us. It's in the air we breathe, the water we drink, the food we eat, and the places where we live, learn, work, and play.

We fulfill our mission through what we call our "*Pillars of Public Health*" which serve every Ohioan throughout their lifespan. These include: preventing and controlling the spread of infectious diseases, emergency preparedness and response; health improvement and wellness; health equity and access; environmental health; and smart regulation to assure quality healthcare services.

Each year, ODH and its local health district partners work together to control the spread of several hundred infectious disease outbreaks, including viral infections like mumps and flu that spread easily from person-to-person; bacterial infections like Legionnaire's disease from contaminated water; mosquito-borne infections like West Nile virus; foodborne illnesses such as food poisoning; and healthcare-associated infections.

Working with other state and local partners, ODH is responsible for preparing for and responding to events that threaten the public's health, such as water contamination issues and environmental contamination issues. ODH also inspects and licenses Ohio's long-term care facilities and other healthcare facilities to ensure that they meet state regulatory requirements designed to protect the health, safety and well-being of residents and patients.

We work to improve health outcomes among Ohioans by promoting better population health planning, curbing tobacco use, combatting the opiate epidemic, and addressing infant mortality to help more Ohio babies reach their first birthdays.

Governor Kasich has challenged those of us in his cabinet to take new, more aggressive steps to bring innovation to our agencies' programs. This includes making advanced data analytics work for state government as it has for businesses across our nation. By unlocking the mountains of data that state government has, we can better understand how to make more progress on solving some of our most

complex problems impacting the health, security and well-being of every Ohioan. We already have some examples of how ODH and our public health partners are using technology and data to address public health issues in Ohio.

One example is a syndromic surveillance system called EpiCenter, which we use to track drug overdoses across hospital emergency departments and alert local authorities in near real time if the number of drug-related ED visits is higher than predicted. EpiCenter automatically generates an alert for ODH, other state agencies and the local health district. The local health district investigates the spike and works with its community to address it.

However, we know that given all of the data that we collect, we have many more opportunities to use this data in new ways to help protect and improve the health of all Ohioans. For example, we are exploring predictive analytics – a technique used by data analysts to make predictions about the future based on current and historical data. In public health, predictive analytics may be used to identify a health problem before it arises, providing an opportunity to try to prevent it.

I'd like to summarize for you some of ODH's most significant proposals in the Governor's Executive Budget. I am excited about our ambitious budget proposals because they strengthen the core of what we do to protect and improve the health of all Ohioans.

Our budget proposals also help us expand our efforts to improve Ohio's public health infrastructure and address important public health issues like combatting opiate abuse and overdose deaths, and reducing infant mortality.

Strengthening the Public Health Infrastructure

Ohio's performance on population health outcomes has steadily declined relative to other states. Ohio also has significant disparities for many outcomes by race, income and geography and spends more on healthcare than most other states. There are many factors that contribute to poor health outcomes, and the following have been targeted for reform and improvement in Ohio: (1) Alignment and collaboration at the state and local levels for population health assessment and planning; and (2) Ensuring capacity at the local level to provide public health services at an appropriate scale and in accordance with national standards. I will briefly summarize these initiatives below, and direct you to the Office of Health Transformation's white paper (also posted on its website) for additional details.

As of January 1, 2017, there were 118 county and city health districts in Ohio operating at various levels of capacity and capabilities. For 50 years, experts have been recommending better ways to organize public health, including minimum population sizes served and a minimum package of local public health services.

Governor Kasich's second budget (enacted in 2013) included several new initiatives designed to give public health more tools to collaborate and integrate programs, and required all local health districts to meet a common set of national standards through accreditation by the Public Health Accreditation Board by July 1, 2020.

In 2016, ODH made a substantial investment of nearly $5 million to support local health district accreditation activities, including a direct subsidy for IT infrastructure and accreditation, accreditation

assistance facilitated through the OSU College of Public Health's Center for Public Health Practice, and funding assistance for community health assessment and improvement plans.

The Executive Budget aligns public health in Ohio with improving population health outcomes and supports local health districts on their path toward providing accredited public health services through the following:

- Provides $1 million in one-time funding over the biennium (Fund 1420, ALI 440646) that will provide grants to local health districts to assist them in transitioning from a five-year planning cycle to a three-year planning cycle for community health assessments and community health improvement plans. Changes to Ohio law recently required local health district and tax-exempt hospitals to align on the same timeline for community health assessments and improvement plans beginning in 2020 providing for population health planning in an integrated, meaningful and effective way.
- Provides $3.5 million in one-time funding over the biennium (Fund 1420, ALI 440646) for accreditation fees, accreditation coordination, and infrastructure costs for local health districts who merge resources in order to gain the necessary scale to provide the quality and level of public health services required by an accredited health district.
- At the Director of Health's discretion, extends the accreditation deadline (currently established in law as July 1, 2020) for local health districts that merge before July 2019.
- In order to remove financial barriers to the merger of local health districts, the Executive Budget authorizes newly merged health districts to propose a joint levy funded by both jurisdictions.
- Increases the state's investment in local public health through a tiered system subsidizing local health districts who obtain accreditation either individually or through a merger with another local health district. This proposal will increase state subsidy in SFY 2018-19 from $0.188 per capita to $0.38 for accredited health districts (GRF, ALI 440413).

Aligning population health planning and strengthening our public health infrastructure will allow us to more effectively address population health outcomes and public health issues like opiate abuse and drug overdoses, infant mortality, and tobacco use among Ohioans.

Combatting Opiate Abuse and Overdose Deaths

We believe that Ohio already has one of the most aggressive and comprehensive approaches in the nation to fighting opiate abuse and overdose deaths. The Executive Budget proposes an additional $1 million each year over the SFY 2018-19 biennium (GRF, ALI 440482) to launch local Project DAWN (Deaths Avoided with Naloxone) programs in communities with unmet needs. These programs give naloxone kits to family and friends of people who use drugs to administer during an overdose while waiting on first-responders to arrive. It can be the difference between life and death.

ODH is also proposing to authorize a county or region to voluntarily establish a Drug Overdose Fatality Review Committee to give Ohio's communities another tool for better understanding circumstances surrounding drug overdose deaths to help them target their local efforts in preventing overdoses and saving lives. Existing Ohio privacy laws restrict access to an individual's protected health information, and the proposed language gives a Committee's local experts the legal authority to access confidential data that contains protected health information, such as coroner's investigation notes and a person's medical history including controlled substance use and mental health issues.

This proposal does not shield any public records that are currently available under Ohio's public records laws. Current public records – such as police reports, coroner's reports, autopsy reports and death certificates – will continue to be public records. Since Committee meetings and discussions will involve protected health information, the meetings must be closed to conform to existing privacy laws. This approach is not new – it is modeled after existing law regarding county Child Fatality Review Boards which shields protected health information and ensures that public records continue to be public records. Just as with Child Fatality Review Boards, this proposal requires Drug Overdose Fatality Review Committees to complete an annual report which will be a public record. The annual report must include the number of drug overdose deaths in the county or region; number of overdose deaths the Committee reviewed; demographic information; trends and patterns; and make recommendations for preventing drug overdoses.

Improving Birth Outcomes

In March 2011, Governor Kasich made reducing low birth weight babies a priority in his State of the State address. In the years since, the State of Ohio implemented an unprecedented package of reforms to improve health system performance for pregnant women and infants. ODH has invested nearly $41.3 million over the past five years to support state and local initiatives that help address infant mortality, and the state is surging millions of new dollars into local communities to improve birth outcomes and reduce racial and ethnic disparities in infant mortality.

ODH's budget request is part of a $41 million state investment in infant mortality over the biennium. The Executive Budget proposes a $3 million increase each year in ODH's budget compared to the SFY 2017 funding level, for a total of $7.1 million each year of the SFY 2018-19 biennium for the Infant Vitality ALI (GRF, ALI 440474). This funding supports intensive community based pilots, including evidence-based approaches such as safe birth spacing, maternal smoking cessation and safe sleep interventions. The funding also provides for increased investment in the Centering Pregnancy evidence-based model of care, including a pilot Centering Pregnancy model for opiate-addicted pregnant women.

Smoking during pregnancy accounts for 20-30 percent of low birth weight babies, up to 14 percent of preterm deliveries, and about 10 percent of all infant deaths. To help reduce infant mortality associated with smoking during pregnancy, ODH will continue to provide funding during the SFY 2018-19 biennium at $500,000 per year (GRF, ALI 440473) for tobacco cessation interventions for women in communities at high-risk for infant mortality. The funding will not be used for women who are eligible for Medicaid as Medicaid covers tobacco cessation services.

Infant mortality in Ohio is trending downward over time, and Ohio's infant mortality rates improved faster than the national rates during the past five years. However, Ohio still has a lot of work to do to save babies lives, especially African-American babies who die at nearly three times the rate as white babies. That is why the state is providing substantial funding to support local initiatives targeting neighborhoods at risk for poor birth outcomes, and encouraging communities to pursue identified promising practices in reducing infant mortality.

Decreasing Smoking and Tobacco Use Among Ohioans

In addition to maternal smoking cessation activities, the Executive Budget proposes to increase the cigarette tax 65 cents from $1.60 to $2.25 per pack; to increase the tax rate on other tobacco products

from 17 percent to 69 percent of the wholesale price; and to extend the other tobacco products tax to vapor products (such as e-cigarettes) at the new 69 percent rate.

Tobacco use is the single most preventable cause of death and disease. It increases the risk of chronic diseases – cancer, heart disease, stroke, lung diseases, and diabetes – that cost Ohio more than $50 billion every year in health care costs and lost productivity from work. Every year, approximately 20,000 Ohio adults die from smoking attributed causes.

According to a 2012 report by the U.S. Surgeon General, studies demonstrate that the effect of a 10% increase in the price of cigarettes is an estimated 3-5% reduction in cigarette use, and that youth are even more responsive to price increases.[1]

Decreasing the prevalence of smoking is critical to preventing and reducing infant mortality and the burden of chronic disease in Ohio. The most recommended and proven strategy for decreasing smoking prevalence and preventing youth from starting to smoke is to increase the price of tobacco.

Reducing Childhood Lead Poisonings

The Executive Budget also aims to protect Ohio's children through the reduction of child lead poisonings. Children are especially at risk for lead poisoning if they live in an older (pre-1978) house or apartment that may have deteriorating lead-based paint – which is the cause of most cases of elevated blood lead levels in children. Ohio is committed to making sure that children aren't living in housing known to have unsafe lead levels.

The Ohio Healthy Homes and Lead Poisoning Prevention Program oversees local health districts who have requested delegated authority to conduct public health lead investigations, and provides lead investigation and case management assistance as well as conducts data collection analysis and education. The Centers for Disease Control and Prevention has called Ohio's program "one of the nation's flagship childhood lead poisoning prevention programs."

The Executive Budget provides greater opportunity for Ohio families to identify lead-safe homes when looking for a place to live. The proposed language establishes a voluntary mechanism for landlords to register lead-safe housing in a new online Lead-Safe Housing Registry. To qualify for listing in the registry, property owners of pre-1978 rental residential units must comply with and document lead-safe maintenance practices and dust sampling. Lead-safe maintenance practices must be performed by an individual who has successfully completed a training program approved by ODH, and there is no fee in order for a property owner to register a property. The registry will be developed in partnership with the Ohio Housing Finance Agency, which currently maintains a self-listing statewide rental housing locator.

In addition, during the SFY 2018-19 biennium, ODH and the Ohio Department of Medicaid (ODM) will work together to leverage up to $5 million per year over the next biennium in new Children's Health Insurance Program (CHIP) and other funding to abate lead hazards in residential units where children live.

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[1] *U.S. Department of Health and Human Services, Preventing Tobacco Use Among Youth and Young Adults (2012)*

Currently, the main source of funding to assist Ohio property owners with lead abatement is federal lead hazard control funding provided through the U.S. Department of Housing and Urban Development (HUD). ODH and ODM are proposing a similar eligibility model used by HUD to be used to distribute the funds described above for lead abatement. Property owners and families are eligible for participation in the program if the occupants are at or below 250 percent of the Federal Poverty Level (FPL). Priority will be given to properties that are the primary residence for at least one child under six years of age or for a pregnant woman, and properties which are contributing to a child's elevated blood lead level.

Approximately $4.8 million of the funding each year will be used for remediation and associated testing services for homes under lead hazard orders. The remaining $200,000 each year will be used to develop, support, and market the Lead-Safe Housing Registry.

Building a Sustainable Program for Children with Medical Handicaps

In 1919, Ohio law first mandated care for children with medical handicaps. Since its inception, the program has evolved and is now known as the Children with Medical Handicaps program, or BCMH, housed within ODH. Despite improvements in access to health care, today's program is not structured in a way that ensures future program sustainability for children and families with the greatest needs.

Ohio's existing BCMH program pays for health care services for children with special health care needs who are uninsured, underinsured, or whose insurance does not cover the services they need. Eligibility for BCMH is determined by a complex methodology that takes into consideration family income, service level credits, maximum ability to pay calculations, and cost sharing requirements. There are no limits on the number of enrollees in the program. Additionally, while these services already exist in the Medicaid system, BCMH essentially spends taxpayer dollars twice on similar services for BCMH-enrolled children who are also enrolled in Medicaid – once through Medicaid for services that Medicaid managed care plans are required to provide (e.g., care coordination), and then again through BCMH for similar services. As a consequence, and in part due to continued enrollment increases (even after the adoption of the Affordable Care Act and Medicaid expansion), BCMH's unfunded liability has climbed over time to the current amount of approximately $11 million.

In order to ensure Ohio has the ability to support children with medical handicaps and their families with the greatest level of need, the Executive Budget establishes a new Children with Medical Handicaps (CMH) program under the Ohio Department of Medicaid (ODM) that maximizes existing state resources to ensure long-term program sustainability, seeks to limit disruption to those currently in the BCMH program by grandfathering all enrolled non-Medicaid eligible children into the existing program, and delivers medically necessary services related to the eligible medical condition and quality care coordination for CMH program enrollees moving forward.

Under the Executive Budget proposal, individuals currently receiving CMH services will not lose access to the program until they age out of the program, or their financial or medical eligibility changes. The proposal seeks to limit disruptions for those currently enrolled in the existing BCMH program by allowing these individuals to be grandfathered into the existing BCMH program. Additionally, anyone who applies for the BCMH program through June 30, 2017, and is not currently eligible for Medicaid, will be grandfathered into the existing BCMH program until they age out, or their financial or medical eligibility changes.

Any Medicaid eligible children currently enrolled in the existing BCMH program will transition to Medicaid beginning January 1, 2018.

Individuals who apply for CMH services on or after July 1, 2017, and are not eligible for Medicaid but meet the medical and financial eligibility requirements of the new Medicaid CMH safety net program, will have access to Medicaid CMH services. The complex methodology for determining financial eligibility under the existing BCMH program will be simplified. The Medicaid CMH program maintains the same medical eligibility criteria and sets new financial eligibility at 225 percent of the Federal Poverty Level (FPL).

Ohio Medicaid has a strong foundation of clinical expertise and care management that will allow for the seamless integration of existing benefits for children with medical handicaps. Additionally, ODM is committed to working with its managed care plan partners to ensure quality services are delivered.

A white paper providing greater detail on this proposal and *Frequently Asked Questions*, which will be updated as needed, have been posted on the Office of Health Transformation's website. An email address (CMHquestions@ohio.gov) has been established for public inquiries. ODH and ODM will communicate with current enrollees and future applicants who will be impacted by the proposed changes to ensure a smooth transition on January 1, 2018. Information about the transition process will be shared with local health districts, providers, and other appropriate stakeholders.

Protecting Ohio's Long-Term Care Population

The Executive Budget proposes a number of reforms to strengthen ODH's oversight of long-term care facilities to help ensure the health, safety and well-being of residents. The Executive Budget proposes the following statutory changes.

Provides ODH the authority to impose a civil monetary penalty on Residential Care Facilities (RCFs) not in compliance with state regulations as an intermediate step prior to license revocation.

Current Ohio law gives ODH authority to either impose a nominal fine ($100-$500) on an RCF that is not in compliance with state rules designed to protect the health and safety of residents, or to revoke the facility's license. License revocation is reserved for worst-case situations and there are no intermediate sanctions available for less severe situations. The proposed civil monetary penalty structure incentivizes RCFs to correct non-compliance issues more quickly, which benefits residents that state regulations are designed to protect.

Expands authorization to investigate long-term care facility employees for alleged abuse, neglect, exploitation, or misappropriation of a resident's property.

Currently, ODH has no authority under state law to investigate long-term care employees for alleged exploitation of residents or allegations of psychological abuse against a resident. ODH is only authorized to investigate allegations of physical abuse of a resident, neglect, of a resident or misappropriation of a resident's property. Nursing home employees have exploited residents by videotaping residents in compromising and dehumanizing situations and posting videos on social media. And, existing law is ambiguous regarding whether sexual abuse by an employee of a home results in harm to the resident.

The Executive Budget authorizes ODH to investigate long-term care facility employees for alleged abuse (including physical, psychological, and sexual), neglect, exploitation, or misappropriation of a resident's

property; places responsibility for reporting allegations by nursing home employees on the nursing home operator rather than on individuals; allows the ODH Nurse Aide Registry to include anyone who is found to have committed an act of abuse, neglect, or misappropriation and consequently bar these individuals from working in long-term care facilities in the future; requires notification to appropriate law enforcement and state licensing boards by the director of health; and extends whistleblower protection to nursing home employees who report or cause to be reported allegations of resident abuse, neglect, or misappropriation by other employees.

Authorizes emergency authority for the ODH director to order directed actions by nursing homes and residential care facilities to address patient health and safety issues.

Under current law, ODH has no authority to directly intervene in immediate situations that jeopardize the health, safety, and well-being of residents of long-term care facilities. While ODH and ODM have legal mechanisms to take control of a long-term care facility, that authority requires court action or other cumbersome processes that take time.

The Executive budget ensures that long-term care facilities quickly take necessary action to address situations that jeopardize the health, safety and well-being of their residents. ODH is proposing authority for the Director of Health to order long-term care facilities to take directed actions to address situations that jeopardize their residents. If a long-term care facility fails to comply with an order or does not take action quickly enough, ODH could take the necessary action and get reimbursed by the facility for any expenses. ODH could also fine a facility up to $250,000 for each instance in which the facility fails to comply.

It is ODH's preference to have long-term care facilities take necessary action to address these situations and ODH would only exercise its authority to directly take action when facilities refuse to do so themselves.

Allows the Ohio Department of Aging access to the names of residents in ODH complaint and licensure surveys of Residential Care Facilities (RCFs).

ODH currently shares nursing home and RCF surveys with the Department of Aging, but residents are identified by a number and not a name. The Department of Aging will use the names to identify whether its assisted living waiver program serves any of the residents in a particular facility. If there is a problem in a facility, the Department of Aging will know which residents are under their jurisdiction and can work to address the issue.

Other Statutory Changes

The Executive Budget also proposes the following changes to the Ohio Revised Code:

- Eliminates outdated and duplicative hospital reporting requirements. Current statutory requirements for Ohio hospital charge and diagnosis data reporting and performance measures are outdated, the information gathered is generally not useful to the public, and some of it duplicates what the Centers for Medicare and Medicaid Services already offers. ODH receives few requests for this data. The proposed language does not rescind existing law which requires hospitals to make available to the public price information.

- Corrects a drafting error to restore the intent of legislation (HB 463, 130th General Assembly) to place more dentists in underserved communities. The proposed language applies the existing new dentist licensure application fee increase to licensure renewals, rather than only new licenses as included in HB 463, which will double the portion going to support the Ohio Dentist Loan Repayment Program.
- Corrects a drafting error from the previous biennial budget (HB 64, 130th General Assembly) to allow ODH to distribute an existing cash balance from previous years to counties for the Choose Life Program. Choose Life funds are generated through license plate revenue and used for promoting adoption by helping crisis pregnancy centers, maternity homes, adoption agencies, and adoption-minded pregnant mothers with their prenatal and delivery expenses, temporary housing, transportation, utility bills, food, clothing, and similar expenses of infants until placed with an adoptive family.
- Eliminates gas chromatography mass spectrometry as the sole technology used to measure the concentration of marijuana metabolite for purposes of the OVI law, allowing the use of different technologies to test the equipment in the public health laboratory.
- Aligns Ohio privacy law regarding individuals with HIV/AIDS with the federal Health Insurance Portability and Accountability Act (HIPAA). The proposed language clarifies that the confidentiality provisions currently in state law pertaining to HIV/AIDS and substance abuse, to the extent that they are more stringent than HIPAA, default to HIPAA standards related to disclosure and sharing of protected health information.
- Updates vital statistics statutes to reflect the streamlined process for maintaining and issuing birth and death records across the state. The proposed language reduces signature and paper filing requirements and more clearly allows for an electronic record registration system.
- Encourages local health districts to bill for services or items payable by private insurance or Medicaid. The Executive Budget proposes that beginning January 1, 2018, ODH will not pay for services or items that are payable by private insurance or Medicaid, and will require its sub-recipients and contractors to access third-party payments when available for the services or items. ODH may continue to provide general revenue funding and federally funded services when required to do so by statute or other funding requirements, when required to stop the spread of infectious disease, or in exceptional circumstances.
- Transfers the ODH asbestos program to Ohio EPA to streamline the asbestos abatement project notification and inspection process, effective January 1, 2018. ODH's asbestos program licenses and certifies companies and individuals involved in asbestos abatement work. ODH must be notified in advance of asbestos abatement projects that are inspected by asbestos program staff. Ohio EPA also must be notified in advance of asbestos abatement projects, and also conducts inspections of these projects.

Other Accounting Changes

The Executive Budget includes several accounting changes outlined in further detail below:

- The AIDS Prevention and Treatment ALI (GRF, ALI 440444) is transitioning from being primarily a funding source of HIV/AIDS treatment to one that solely supports HIV prevention work. GRF funding for HIV prevention will increase from an estimated $1,650,000 in SFY 2017 to $3,039,621 in SFY 2018 and $4,039,621 in SFY 2019. In addition, the increase in availability of

drug rebate funding through the HIV Care and Miscellaneous Expenses ALI (Fund 4L30, ALI 440609) will ensure that ODH's budget does not reduce state funding for HIV/AIDS treatment.

- ODH's state funding (GRF and Tobacco Use Prevention Fund (5BX0)) for tobacco prevention, cessation, and enforcement for SFY 2018 will be over four times greater in SFY 2018 ($11.1 million) compared to SFY 2015 ($2.5 million). When this administration began, there was no GRF funding at all designated for these activities. In addition, the administration has devoted $38.6 million in disputed tobacco payments toward curbing tobacco use (ODH received $30.6 million).

- In March 2014, the Centers for Medicare and Medicaid Services (CMS) restructured the funding of home health agency (HHA) surveys. As a result, ODH has to contribute more state funding to meet a federal Medicaid matching requirement. The number of HHAs in the state has also increased in recent years. The incurred additional state funding cost to ODH is estimated at $400,000 annually (GRF, ALI 654453). Appropriation must also be increased in one of ODH's federal funds to cover increased costs charged to Medicaid (Fund 3GD0, ALI 654601).

- Under GRF restructuring, a new GRF ALI (Chronic Disease/Health Promotion, 440482) will replace the existing Cancer Incidence Surveillance System (440412), Access to Dental Care (440467), and Chronic Disease/Injury Prevention (440468) ALIs. Activities funded by the three currently existing ALIs will continue to be funded by the new Chronic Disease/Health Promotion ALI (440482); although, at a lower funding amount. The new Chronic Disease/Health Promotion ALI (440482) will also fund $1 million per year in new drug overdose intervention and prevention activities described above. The lower funding amount for existing activities will not impact services as more federal funding for chronic disease has been made available to ODH in recent years through the Preventive Block Grant (Fund 3870, ALI 440602) and other chronic disease grants.

- GRF funding for immunizations will be reduced to $4,040,827 per year in SFY 2018-19 (to be provided from a new ALI, Infectious Disease Prevention and Control (440483), instead of the current Immunizations ALI (440418)). However, no impact on services is anticipated as ODH was able to reduce GRF spending during SFY 2016-2017 by no longer providing GRF funded vaccines to insured individuals. Local health districts and other providers can now bill private insurers to recoup the cost of providing these vaccinations. In SFY 2018-19, restructuring is also occurring which moves funding for the Zoonotic Disease and Hepatitis Surveillance from the Public Health Laboratory ALI (440451) to the Infectious Disease ALI (440418).

Conclusion

In closing, our decisions about how to allocate and spend financial resources have a direct impact on the health of Ohioans. This proposed budget that I bring to you today supports ODH's core public health responsibilities and leverages support for priorities identified in our State Health Assessment and new State Health Improvement Plan.

Additional detail on many of these proposals is available on the Governor's Office of Health

Transformation website through a series of white papers more fully explaining policy detail and background.

Thank you for the opportunity to present the ODH's proposed budget for SFY 2018-19. I am happy to answer any questions you have at this time.