HB 49, 131th General Assembly

Presented by Association of Ohio Health Commissioners

Before the Finance Committee

March 22, 2017

Chairman Romanchuk and committee members, thank you for the opportunity to testify today on HB 49, which, among many items, attempts to codify the recommendations of the 2012 Legislative Subcommittee on Public Health Futures. My name is Dr. Jason Orcena and I am the current Health Commissioner for the Union County General (Combined) Health District, speaking on behalf of the Association of Ohio Health Commissioners.

As you are aware, Ohio has a decentralized public health system with local health departments and a state health department funded and controlled through separate mechanisms rooted in statute and the Ohio constitution. Both parts of this system have distinct and separate purposes, but operating together provide the basis of Ohio's public health system—the system that provides surveillance and response to innumerable threats to health and safety 24 hours per day, 7 days a week, 365 days per year. I am fortunate to have worked with many excellent and dedicated public servants at both the state and local level.

Having served the communities of Union County for the past decade, I have developed an appreciation for the interrelation between strong communities and the public's health. Between strong businesses and public's health. Between strong families and the public's health. Strong families are our mission and our strength. Strong families lead to strong communities and strong communities are the building blocks of a strong Ohio. Public Health is a small, but important piece to the strength of the families and communities I serve.

As I speak to the budget proposals provided by the Governor through his Office of Health Transformation, know that I not just advocating for my own agency or the agencies of my peers, but to promote strong families and strong communities.

In general terms, I would like it to be known that the Governor's efforts to reform Medicaid and align health priorities with funding are critically important and lasting measures to improve Ohio's health value. The Medicaid expansion has been important to many families in my community as has the various efforts to streamline the enrollment process.

Similarly, aligning health planning from the state to the local community should improve the delivery of critical services to the communities most in need. Building and supporting linkages between the state and local health departments is the mortar of our public health infrastructure. We look forward to working with the state through its process in the future.

To that end, I would like to draw the Committee's attention to three areas of the Executive Budget:

1. Local Public Health Support
2. Targeted funding of population health initiatives
3. CMH (BCMH)

Local Public Health Support

The 130th General Assembly put significant administrative and financial burdens on local health departments by enacting Revised Code 3701.13,

> "As a condition precedent to receiving funding from the department of health, the director of health may require general or city health districts to apply for accreditation by July 1, 2018, and be accredited by July 1, 2020, by an accreditation body approved by the director."

This Executive Budget 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).

Improving Population Health

The Governor's budget proposes several initiatives that align with the State Health Improvement Plan (SHIP) and target critical public health issues. The Department of Health budget includes:

- An additional $3 million per year to support infant mortality reduction efforts (intensive community based pilots)
- An additional $1 million per year to support 20 additional Project DAWN sites.
- Establishment of the voluntary lead-safe housing registry and $5 million per year to support lead abatement activities and the registry (CHIP funding)

In addition to the Project DAWN sites, 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 circumstance surrounding drug overdose deaths to help them target their local efforts in preventing overdoses and saving lives. 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.

In addition to on-going support for maternal tobacco prevention and cessation efforts, 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.

AOHC recognizes the value these initiatives bring to local public health issues and is supportive of the administration's efforts.

CMH (BCMH)

Children with Medical Handicaps, formerly known as BCMH, has been in existence since 1919 when Ohio law first mandated care for children with medical handicaps. This program is designed to provide medical services and supports to children with qualifying medical diagnoses who may not have another payment source for those services. The program may cover hospital expenses, doctor visits, durable medical equipment, special formulas and other nutritional items, therapies, eye glasses, hearing aids and other items not covered by insurance plans, and/or if a family has reached its limits of insurance coverage. In addition, the program has provided case management/care coordination services by registered public health nurses at local health departments.

The executive budget submitted by the Governor's office for the two year biennium beginning on July 1, 2017 includes the following changes in administration of the BCMH program:

- Creation of a new Ohio Medicaid Children with Medical Handicaps (CMH) program as the state's primary payer for CMH services. o Effective January 1, 2018 all individuals who apply for the CMH program on or after July 1, 2017 will be transitioned into a new CMH program administered by Ohio Medicaid.

- All individuals enrolled in the BCMH program on or before June 30, 2017 (including pending applications on or before that date) that are not Medicaid eligible will be grandfathered into the existing program until they age out, or their medical or financial eligibility changes.
- Any Medicaid eligible children currently enrolled in the existing BCMH program will transition to Medicaid beginning January 1, 2018.
- A safety net program for those not eligible for Medicaid will be maintained by Ohio Medicaid.
- Individuals who apply for CMH services on or after July 1, 2017 and are not eligible for Medicaid but meet medical and financial eligibility requirements of the new Medicaid CMH safety net program will have access to CMH services.
- The Medicaid CMH program maintains the same medical eligibility criteria and sets new financial eligibility at 225% of the federal poverty level (FPL).

While encouraged by the Administration's promise to Grandfather existing clients and expanding eligibility under Medicaid to 225% of FPL for services, AOHC remains concerned about new families (after 2018) who, under the proposal, would not be eligible for any services. This will cause undue hardship for many working, middle class families currently served by the CMH program. Furthermore, it may unintentionally cause strain on other local, safety net services. Raising eligibility to 500% or higher with a cost share –similar to the current BCMH structure--would protect those most vulnerable middle class families.

AOHC is supportive of efforts to improve the efficiency and administration of any program as it relates to the care of medically fragile children providing it does not compromise the quality of that care nor create barriers to access for those in need. With this in mind, AOHC is not opposed to the payer source being Medicaid (and GRF). AOHC agrees that our current system of health care coverage remains complex and often times fractured, leading to inequities/disparities in care and among clients, poorer health outcomes and higher costs. As demonstrated by the Health Policy Institute of Ohio's 2017 Health Value Dashboard, Ohio still has a number of challenges. Consequently, AOHC supports reforms that result in better care and health outcomes at a lower cost. Examples of how this can be achieved include such things as: 1) automation of claims and payment processes and/ or 2) removal of duplication of care coordination efforts – currently the responsibility of MCOs, ACOs, and LHDs.

Lastly, if the care model is changing, parent choice becomes critically important. We believe that allowing local public health nurses to be a viable option and guaranteed provider of services would allow families the choices in the market they need to make good decisions about their child's care. Ultimately, parents need to be able to choose the care coordinated that best fits their needs and local public health nurses—BCMH nurses—bring many value to a family's care coordination by:

- Providing linkages to services for individuals and families across the state;
- Providing expertise to complex case management for many programs (CMH, BCCP, Ryan White, Maternal and Child Health, others);
- Detailed knowledge of local community resources and social/ cultural expectations;

- Acting as a nexus between person/family and medical home without prejudice to system or payer;
- Assistance in coordination of services with local agencies as well as various providers - increasing efficiency and decreasing costs;
- Assistance in navigating through complexity of health care services, health care providers, insurance forms, what to do and how to do it.

Thank you! I am happy to answer any questions you may have.