OHIO CHILDREN'S BUDGET 2022-2023

December 2020

ISSUE BRIEF

Maternal and Infant Health

The COVID-19 pandemic has brought to light many of the shortcomings in our healthcare system. We have layered a public health crisis and an economic crisis on top of a healthcare system already fraught with racial inequities in maternal and child health.

The United States is the only industrialized nation with a maternal mortality rate that is rising—increasing 26% between 2000 and 2014. According to CDC figures, the death rate between 2012 and 2016 for pregnant women in Ohio was 19.2 out of 100,000 births, ranking Ohio 27 out of 47 states that report this data. Ohio's Pregnancy-Associated Mortality Review Panel (PAMR) published a report showing that between 2008-20016, over half the deaths of women who were pregnant or who died within one year of pregnancy were preventable. The report also showed that Black women died at a rate more than two and a half times that of white women.

Infant mortality continues to be a leading public health issue in the United States. Ohio's rate of infant mortality is substantially higher than in the rest of the country and the statistics facing Black infants are staggering. In 2018, the Black infant mortality rate in Ohio was 13.9 deaths per 1000 births, compared to the white infant mortality rate of 5.4 deaths per 1000 births. In 2018, 6.2% of Ohio women in urban areas received late or no prenatal care, and in that same year 10.5% of urban infants were born preterm. When we look at the data through a lens of health equity, we can see that in 2018, 1 in 10 babies was born preterm in Ohio. The rate of preterm birth in Ohio is highest for Black infants (14.1%), followed by American Indian/Alaska Natives (11.8%), Hispanics (10.5%), whites (9.5%) and Asian/Pacific Islanders (8.8%).

Policy

Currently, pregnant women earning up to a certain income level are automatically eligible for Medicaid coverage—in fact, in 2017, 52% of Ohio births were covered by Medicaid. In Ohio, Medicaid covers pregnant women up to 200% of the Federal Poverty Level (FPL); however, federal Medicaid law only requires this coverage be available for 60 days after the end of pregnancy. After that period, it is up to the states to decide if they will provide additional coverage to new mothers. At this time, Ohio cuts off Medicaid eligibility and access to new moms 60 days after birth.

In January of 2017, Ohio established Help Me Grow as Ohio's evidenced-based parent support program that encourages early prenatal and well-baby care, as well as parenting education to promote the comprehensive health and development of children. Gov. DeWine and the legislature made a substantial investment of $70 million in the FY 20-21 budget in evidence-based home visiting programs.

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Medicaid covers nearly 1.2 million children in Ohio. Most of those children are covered by one of 5 managed care organizations operating in the state. Every child enrolled in Medicaid is entitled to EPSDT (Early and Periodic Screening, Diagnostic, and Testing) benefits that cover a broad array of preventive and treatment services such as developmental screenings, immunizations, and lead testing. Ohio's performance in child health metrics has been consistently mediocre. Pre-pandemic, Ohio was consistently in the bottom half of states to ensure that federally mandated EPSDT services were received.

Challenge

Ohio, by statute, is required to have a balanced budget. The challenge for Ohio, and indeed for every state, is how to pay for the cost of the pandemic while preserving, and in some cases, increasing spending in needed areas. At the height of the pandemic, unemployment in Ohio was over 15%, representing over 1 million people who lost their jobs and in many cases their health insurance. In May, Governor DeWine made the decision to implement Executive Order Reductions amounting to over $775 million. These reductions were taken in education ($465 million), other agency reductions ($100 million), and taking back $210 million from the Managed Care Organizations as a result of decreases in service utilization. Nine months into the pandemic, the total number of new jobless claims have reached 1.85 million, and the state has paid out $7.2 billion in unemployment claims. Many of these newly unemployed families enrolled in Ohio Medicaid to protect their health during the pandemic. Enrollment in Medicaid remains well above what it was this time last year – up 269,512, or 9.6%, compared to the previous October. Medicaid GRF spending was $176.6 million, or 13.8%, above what it was in October 2019.

Opportunity

The Families First Coronavirus Response Act, signed in March 2020, increased the FMAP (federal share of certain Medicaid spending) by 6.2 percentage points. In October, this enhanced FMAP represented approximately $107.5 million in increased federal funding for Ohio Medicaid. The enhanced FMAP is scheduled to continue to bring enhanced federal financing into Ohio Medicaid through March 2021.

Thanks to a stable economy pre-pandemic, Ohio's Rainy Day Fund (surplus revenue set aside for use during unexpected deficits) currently sits at $2.7 billion. Money that should be considered before any cuts are made to Ohio's safety net programs such as Medicaid.

Support Infant and Maternal Health: Budget Recommendation

1. **Expand the current 12 month continuous care waiver** to include pregnant women with high-risk pregnancies, chronic conditions, and mental health diagnoses. More than half of pregnancy-related deaths occur in the postpartum period, and 12 %are after the standard six-week (42 days) postpartum visit. Federally, the **Helping Medicaid Offer Maternity Services Act** of **2020**, is a bipartisan bill that would allow states to provide one year of postpartum coverage under Medicaid and the Children's Health Insurance Program (CHIP). Currently, states must apply for an 1115 demonstration waiver if they want to draw down federal funds for the Medicaid services.
2. **Medicaid coverage of Doula services**. There is a strong and growing body of evidence that access to doula care during pregnancy reduces the incidence of preterm birth, the prevalence of cesarean births, and increases positive birth experience and healthy outcomes for both mother and child. In 2018, there were 13,845 preterm births in Ohio, representing 10.3% of live births. According to The Ohio Perinatal Quality Collaborative a preterm birth in Ohio costs $32,000. Doulas provide emotional, physical, and educational support to a mother who is

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expecting, is experiencing labor, or has recently given birth. Doulas act as advocates for the women they care for to make sure their voices are heard. Doulas should be considered essential health workers through the pandemic to enable women to have the support they need in the delivery area.

3. **Increase utilization of Ohio's Evidence-based Home Visiting Programs (Help Me Grow)** Home visiting programs are one proven approach to mitigating infant mortality. For every $1 invested in home visiting programs, the state return on investment is $6. Ohio made a substantial investment of $70 million over the biennium in evidence-based home visiting programs in the FY 20-21 budget. Governor DeWine has announced the goal of tripling participation in Ohio's home visiting program. Ohio should continue to fully fund the Help Me Grow program at current levels, and make it an opt out program that is offered automatically to all families with a mental health diagnosis, previous contact with the child welfare system, or previous infant mortality.
4. **Continue supporting Ohio's Infant Mortality Collaboratives throughout the state at existing funding levels.** Ohio continues to struggle with high infant mortality rates in regions of the state, and existing funding streams support the work of Federally Qualified Health Centers, Community Health Workers, and other partners who reach out into communities to support pregnant people before, during and after pregnancy. Without continued funding, group prenatal care, infant loss support groups, and preventative health and wellness services may be at risk.
5. **Expand antiracism training, evaluation, and accountability measures, as well as cultural competency training in health care.** Health disparities adversely affecting people of color continue to plague our health care systems. By encouraging and incentivizing anti-racism and implicit bias training, and the state could reduce poor health outcomes related to disparities in care.
6. **Ensure every pregnant person has access to the technology needed to safely access health care visits.** The effect of the COVID-19 pandemic on pregnant people and infants is still unknown, but there is growing evidence that being able to safely access medical personnel and attend visits without having to visit a medical office was beneficial to some. However, the lack of equally accessible internet in both hardware and connectivity left some areas of the state far behind their peers. The state should make ensuring access to consistent connectivity a high priority, and continue to align Medicaid rules and policies to allow for tele-health visits for those who prefer them.

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Published: December, 2020

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