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Ohio Supports Evidence-Based Home Visits to Address Infant Mortality

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. Infant mortality is defined as the death of a baby before their first birthday. In 2018, the Black infant mortality rate in Ohio was 13.9 deaths per 1000 births, compare that to the White infant mortality rate of 5.4 deaths per 1000 births. According to the Ohio Department of Health (ODH) Butler Co., Cuyahoga Co., Franklin Co., Hamilton Co., Lucas Co., Mahoning Co., Montgomery Co., Stark Co., and Summit Co. accounted for close to two-thirds of all infant deaths, and 90 percent of Black infant deaths.

One proven approach to mitigating infant mortality is evidenced-based home visiting programs. Home visiting is a prevention strategy used to support pregnant moms and new parents to promote infant and child health, support educational development and school readiness, and help prevent child abuse and neglect. Home visits may be conducted by trained nurses, social workers or child development specialists. Their visits focus on linking pregnant women with prenatal care, promoting strong parent-child attachment, and helping parents understand child development and the role of being a supportive parent. Home visitors also conduct regular screenings to help parents identify possible health and developmental issues.

Federal Support for Evidence Based Home Visiting

In 2010, with bipartisan support, the federal government established the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), which included an opportunity for states to access federal funding through HRSA. This led to a significant expansion of home visiting in states. Ohio received awards through the MIECHV program in 2017, 2018, and 2019 totalling over $22.5 million.

How is Ohio Addressing Infant Mortality?

Ohio took an important step to address Ohio's infant mortality crisis in December of 2016, with the passage of Senate Bill 332, which established Help Me Grow as Ohio's evidenced-based parent support program. Ohio uses three models to provide home visiting services to at-risk children and families, Nurse-Family Partnership, Healthy Families America, and Parents as Teachers.. An additional 1,865 families are served through Moms & Babies First, a home visiting program focused on Black families.

The Governor's Advisory Committee on Home Visitation was formed in 2019, to develop recommendations on how to help at-risk families develop the tools they need to give their children the best possible start in life, and how to direct the state's investment in proven home visitation programs.

Ohio's Funding Commitment

Ohio made a substantial investment of $70 million over the biennium in evidence-based home visiting programs in the FY 20-21 budget.

Evidence-Based Home Visiting Cont'd

Investments and support for infants and babies early makes sense. For every $1 invested in home visiting programs, the state return on investment is $6. Further, all babies in Ohio should thrive - not just survive - to through their first year of life and beyond. Gov. DeWine has a stated goal of tripling the reach of the program, which currently only reaches 6 percent of eligible families.

Home Visiting During a Pandemic
During the COVID-19 public health emergency, home visiting programs continue to play a vital role in addressing the needs of pregnant women, young children, and families, whether in-person or virtually. The potential impacts of the emergency on pregnant women and families' access to critical health, early care and education, and family economic supports make continued connections with families essential. As State policy makers begin to put together budgets for the upcoming biennium, they face difficult decisions about how to use limited funding to support vulnerable children and families and how to ensure programs achieve desired results. Evidence-based home visiting programs have the potential to achieve important short- and long-term outcomes.

2019 Evidence-Based Home Visiting

51% are covered through CHIP
45% are uninsured
4% are covered through private insurance

CDF-Ohio Recommendations to fight infant mortality with Evidence-Based Home Visiting:

- Protect Medicaid funding. For Ohio's most in-need pregnant women, Medicaid provides maternal care, and home visiting is one of Medicaid's most critical strategies for reducing infant mortality and promoting family and child health.
- Expand and streamline eligibility requirements. Any family under 200 percent of poverty should be eligible for voluntary services through Help Me Grow, and black mothers of all ages should be eligible for Moms & Babies First. The state should consider including home visiting services in the array of benefits accessible through the Ohio Benefits portal
- Create a central point of intake for all home visiting programs.

A coordinated state system of home visiting requires a single point of entry for all programs. All home visiting providers funded by the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Children's Trust Fund, and the Commission on Minority Health, should use the state's central intake system as their primary referral source. The system will connect families to all state-funded models of home visiting. This would minimize the duplication of services and ensure that home visiting services are not siloed and being provided across systems.

Ohio Home Visiting Statistics (2019)

126,151
home visits provided

11,546
families served

14,420
children served

Protect and Expand School-Based Health Centers to Support Students and Families During COVID-19

As children head back to school during the COVID-19 pandemic, school-based health centers (SBHC) will be on the front line of keeping children safe in the classroom and ready to learn. SBHCs are medical health centers within schools that can provide comprehensive healthcare, physicals, health education, health screenings, immunizations, and first aid. They can also treat acute and chronic health problems like asthma, lowering the chance of an emergency room or hospital visit. Having a SBHC located in a school lowers school absences and helps prevent parents from missing work. Many SBHCs in underserved areas also offer services to the surrounding community, and if funding is available, may also provide mental health services, dental care, vision services, and reproductive health services. Not only do SBHCs increase access to services, they also save money. A 2014 economic systematic review of several studies found that using SBHCs resulted in net savings to state Medicaid programs of between $30 and $969 per visit.

Many Ohio SBHCs remained open during the summer and could be accessed by making an appointment. They also expanded the use of telehealth to reach more students during the Stay-at-Home order. Now that schools are beginning to reopen, SBHCs can assess students with COVID-19 symptoms and immediately act to get them home to quarantine until it is safe to return to school. They can also identify eligible students and help them enroll in Medicaid and connect a student's family members with health coverage. In Ohio, most of the state's 62 SBHCs are partnerships between school districts and either a federally qualified health center (FQHC) or hospital system. Medicaid is a major source of funding for SBHCs, and most centers are located in schools with large populations of lower-income students, many covered by Medicaid. The Health Resources and Services Administration (HRSA) has limited funding available for SBHCs and in 2019, three Ohio organizations were granted $298,625 in HRSA money to increase access to mental health, substance abuse, and childhood obesity-related services in Ohio SBHCs.

Beyond Medicaid payments, Ohio does not directly fund school-based health care. State funding would allow SBHCs to engage in activities like health promotion or services to students who are uninsured. In the FY20-21 state biennial budget, $675 million was dedicated to student wellness to help districts support students' academic achievement through mental health counseling, wraparound services, mentoring, and after-school programs. Every district was slated to get a minimum of $25,000 for FY20 and $36,000 in FY21. The Ohio Department of Education determined that some of these dollars could go toward SBHCs at the superintendent's discretion. However, very little was used to support SBHCs in FY2020. At this time, we must prioritize funding for SBHCs so children get timely, comprehensive care to stay well and prevent the spread of COVID-19 the school and the community.

CDF-Ohio Policy Recommendations

SBHCs are an efficient and cost-saving way for children and families to access quality health care, behavioral health, and dental and vision services, regardless of ability to pay. The following recommendations support SBHC sustainability and encourage more school districts and FQHCs or hospitals to enter into partnerships to bring services closer to children.

1. **Protect Medicaid Enrollment.** Maintaining coverage is an important factor in SBHC finances. If the number of uninsured patients were to increase, the uncompensated care costs would increase as well, threatening SBHCs sustainability.

2. **Dedicated funding for SBHCs.** There are over 62 centers in Ohio uniquely poised to address health needs. A dedicated funding stream for these centers would enable expanded access to health care services, closing gaps in care both during and after the pandemic.

3. **Community Health Center Program (Section 330 Public Health Service Act).** Support CHC funding as this also benefits the SBHC they partner with.

Increasing Federal Medicaid Funding Will Protect Ohio Families and Help Stabilize our Economy

Ohio is in the midst of an economic and health care crisis. The COVID-19 pandemic forced the closure of businesses, schools, bars, and restaurants. At its height, the unemployment rate reached 17% and currently sits at more than twice the pre-COVID rate. This loss of jobs means the loss of income and, in many cases, the loss of health insurance as well. For many Ohioans, it means that their children have also lost access to insurance through their parents' jobs. According to data available in Ohio, Medicaid enrollment has increased by over 220,000 between January and July of 2020, as many people turned to Medicaid as their health care safety net. However, what does this mean for the hundreds of thousands of Ohioans who have not enrolled in COBRA, not secured other employment with insurance coverage, and not enrolled in Medicaid? Congress has taken several important steps to address the pandemic, including passing the Families First Coronavirus Response Act which provides continuous coverage to Medicaid enrollees and those who become newly eligible for the duration of the public health emergency. It also provided a temporary 6.2 percentage point increase in the federal Medicaid matching rate (FMAP) to help states provide health coverage at a time when the economic crisis has reduced state revenues. But this is not enough. CDF-Ohio, along with groups like the National Governors Association and the National Association of Medicaid Directors, is urging Congress to increase the FMAP from 6.2 to 14 percentage points through at least June of 2021 as part of the next COVID-19 stimulus bill. This additional federal support will be critical in addressing the higher state Medicaid costs and overall budget deficits Ohio will experience in coming weeks, months, and years.

The last time Ohio faced this level of economic crisis was the Great Recession (2007-2009) when Ohio's revenue decreased by nearly $3.1 billion. At that time, Congress passed The American Recovery and Reinvestment Act of 2009 (ARRA) to provide additional resources to states to help them address serious economic circumstances. ARRA included an increase in the FMAP of 6.2 percentage points, and it provided state-specific FMAP increases tied to a state's unemployment rate. Increasing federal matching rates is easier to administer than trying to distribute funds directly to businesses or providers. It would move considerable funding to Ohio, reducing revenue pressures or painful cuts in other spending, actions that would worsen the recession and harm families. Medicaid enrollment and costs related to the COVID-19 crisis will likely be significantly greater than that caused by the Great Recession. According to the Bureau of Labor Statistics (BLS), Ohio's unemployment rate reached a height of 11.1 percent in December 2009. By contrast, BLS data shows the COVID-19 unemployment rate was 17.6 percent in April of 2020, and it's unpredictable how that might change given the pandemic and its continuing economic impact.

Currently, Ohio's budget shortfall is projected to be $2.4 billion, and Governor DeWine has instructed state agencies to prepare budgets that reflect cuts of 10-20 percent. If the original 6.2 percentage point increase is extended through June 30, 2021, it will bring $2.3 billion in additional federal support to Ohio. Further increasing the FMAP to 14 percentage points through June 30, 2021, would result in $4.3 billion in additional support to Ohio.

CDF-Ohio Policy Recommendations

Federal leadership and resources are needed to stabilize Ohio's budget. Congress has an opportunity to expedite the economic recovery of states by increasing the FMAP. Ohio's families and children are looking to policymakers and Congress to take action on this issue. The following are recommendations that CDF-Ohio urges Congress to include in the next stimulus package.

1. Increase the e-FMAP to 14 percentage points. Increasing the current enhanced FMAP from 6.2 percentage points to 14 percentage points will It will help the state handle the increase in the Medicaid caseload without cutting services, provider payments, or affecting other priorities.
2. Extend the e-FMAP through at least June 2021. It is clear that the economic downturn will beyond the public health emergency declaration.

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