INFANT MORTALITY IN OHIO

A 10-Year Look at the Impact of Policy Changes and Opportunities for the Future

Groundwork OHIO

INTRODUCTION

The death of an infant is a profound tragedy for families, but it also serves as an indicator of broader systemic challenges.

A decade ago, Ohio faced a grim reality: its infant mortality rate ranked among the highest in the nation. Despite steady declines in infant deaths since the 1990s, Ohio had fallen behind most other states, with significant racial disparities exacerbating the issue. The mortality rate for Black infants was nearly double that of white infants, and one zip code in Akron recorded the highest infant mortality rate in the country. In response, a coalition of state and local leaders launched focused efforts to combat this pressing public health crisis.

The death of an infant is a profound tragedy for families, but it also serves as an indicator of broader systemic challenges. Infant mortality reflects not only the quality of health care but also the persistent inequities in access to care. It underscores the importance of addressing disparities and strengthening the overall health system to mitigate future public health challenges. Improving maternal and child health is not just a moral imperative; it is essential for reducing long-term health care costs, promoting well-being, and building healthier, more equitable communities for the future.

This report reviews the data and key policy changes in Ohio over the past decade, celebrating successes, pinpointing areas where progress remains inadequate, and identifying opportunities to help more of Ohio's children reach their first birthday. I trust it will serve as a valuable resource as we recommit ourselves to improving outcomes for our most vulnerable.

Thank you for your continued dedication and passion in advocating for Ohio's babies.

Sincerely,

Lynanne Gutierrez

Lynanne Gutierrez
President & CEO,
Groundwork Ohio

Reflecting on Progress and Opportunities in Pursuit of More First Birthdays

Eleven years ago, we set aside our party labels, forged a trusted partnership, and came together to address Ohio's alarming infant mortality crisis. This collaboration, which began with a statewide listening tour, grew into a multi-year legislative effort aimed at reducing infant deaths in Ohio. It culminated in the passage of landmark legislation designed to tackle the systemic issues at the heart of this crisis. Yet, years later, despite numerous initiatives, Ohio continues to grapple with unacceptably high infant mortality rates—particularly for Black infants, who die at more than twice the rate of white infants.

In 2012, Ohio's infant mortality rate (IMR) was 7.6 deaths per 1,000 live births, ranking 45th worst state in the nation. The disparity was staggering: Black infants had an IMR of 13.9, more than double that of white infants, whose IMR was 6.4. This stark reality spurred the creation of the Ohio Commission on Infant Mortality and the eventual passage of Senate Bill 332, legislation aimed at fostering transparency, accountability, and equity in health care for Ohio's most vulnerable mothers and babies.

Fast forward to today, and the latest data paints a disappointing picture. By 2022, Ohio's IMR has improved but the disparity rate, or the difference between infant mortality rates for Black and white infants, has widened over time. This persistent disparity highlights the troubling reality that, despite legislative efforts and targeted interventions, Black babies in Ohio are still dying at alarming rates. In addition, the overall rate of low-birth-weight babies among Medicaid enrollees remains high at 11.4%, placing Ohio among the bottom ten states in the nation. Premature birth rates have also worsened since 2019, with the March of Dimes giving Ohio a "D" on its 2023 report card.

This report reveals a sobering reality: while significant efforts have been made, they are insufficient. Progress can no longer be measured by the number of programs or policies implemented. True success lies in the outcomes—how many babies have been saved and whether disparities have been eradicated. Achieving meaningful change requires strong, consistent, and accountable leadership at both the state and local levels, with an unwavering focus on improving the health and well-being of Ohio's mothers and infants. The slow pace of progress over the past decade demands a renewed and united commitment from all stakeholders to prioritize maternal and infant health and to hold themselves accountable through data-driven results.

Our journey, like our friendship, is far from over. Together, we remain committed to fighting for the health and well-being of Ohio's mothers and babies.

JOIN US.

Sincerely,

Shannon Jones
Former Republican State Senator from Warren County and Senior Advisor to Groundwork Ohio

Charleta B. Tavares
Former Democratic State Senator from Franklin County and CEO of PrimaryOne Health

Ohio's Journey to More First Birthdays

In 2012, the national infant mortality rate was 5.98 deaths per 1,000 live births, while Ohio's rate was 7.6 infant deaths per 1,000 live births. Disappointingly, the mortality rate was nearly double for Black babies with the national rate being 10.9 deaths per 1,000 births compared to Ohio's at 13.9 deaths per 1,000 live births in 2012. The leading causes of infant death in Ohio remain prematurity (a birth less than 37 weeks' gestation), congenital (birth) defects, and external injury.

The chart below shows how the state's infant mortality rate has changed over time. Between 2012 and 2020, the state's overall rate declined steadily, from 7.6 deaths per 1,000 births in 2012 to 6.7 in 2020. A closer look reveals that this success was driven by a decline in deaths of white infants. The infant mortality rate for white infants fell from 6.4 deaths per 1,000 in 2012 to 5.1 in 2020. During this same period, the Black infant mortality rate increased steadily through 2017 before ending the decade slightly below the 2012 starting point.

Ohio continues to rank among the ten worst states for infant mortality.

The infant mortality rate in Ohio and across the nation has increased since the start of the pandemic. It is not yet clear if this is a short-term anomaly or part of a larger trend.

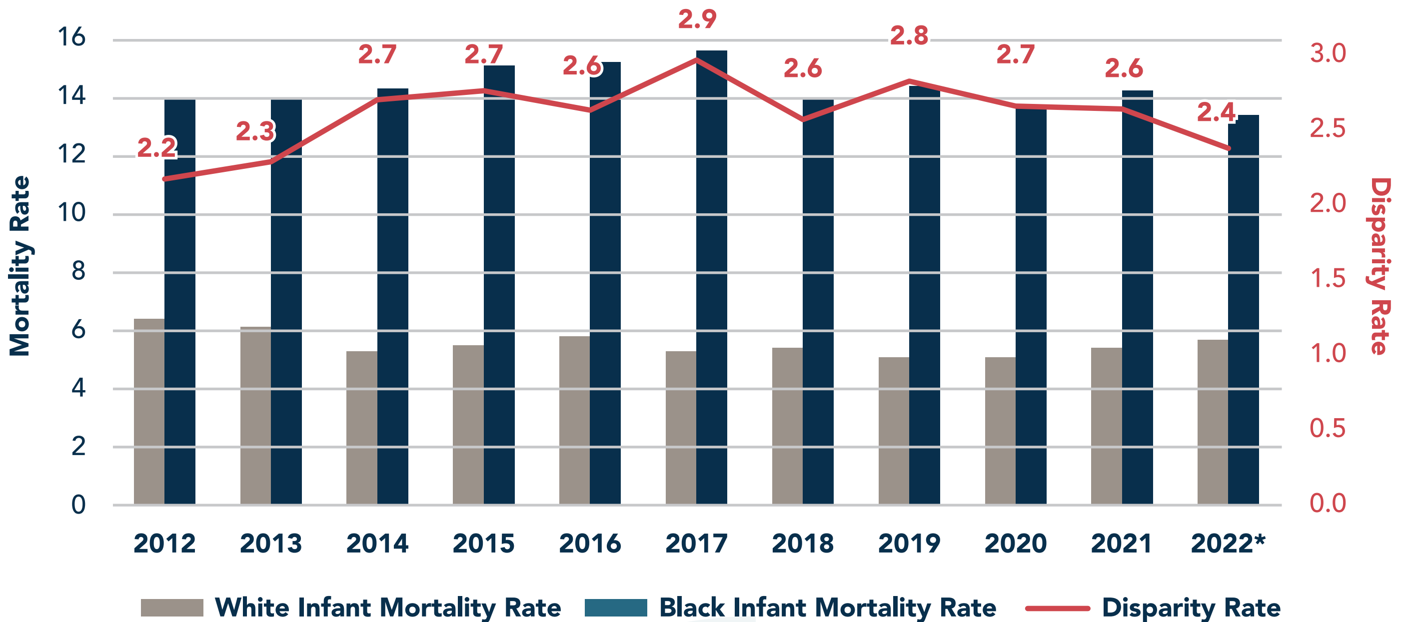
Ohio's Infant Mortality Rate Over Time

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Overall	7.6	7.4	6.8	7.2	7.4	7.2	6.9	6.9	6.7	7.0	7.1
White Infants	6.4	6.1	5.3	5.5	5.8	5.3	5.4	5.1	5.1	5.4	5.7
Black Infants	13.9	14.0	14.3	15.1	15.2	15.6	13.9	14.3	13.6	14.2	13.4

*Source: ODH 2021 Infant Mortality Report, *2022 data is preliminary, CDC Wonder*

The white infant mortality rate fell below the national Healthy People 2020 goal of 6.0 deaths per 1,000 births in 2014 and remained below this level for the rest of the decade. The Black infant mortality rate rose steadily through 2017 before beginning to drop; however, progress has been uneven. The Black infant mortality rate in 2022 was 13.4 compared to 13.9 deaths per 1,000 births in 2012. Of particular concern is the change in the disparity rate. The disparity rate, or the difference between infant mortality rates for Black and white infants, has widened over the past decade. In 2022, Black infants were dying at 2.4 times the rate of white infants compared to 2.2 in 2012. Largely this is because the infant mortality rate for white infants has fallen at a faster rate than for Black infants.

Ohio's Infant Mortality Rates for White and Black Babies and the Disparity Rate Between the Two



Ohio's Current Infant Mortality Goal is 6.0, the National Average Set in 2006

Ohio maintains a state health improvement plan with specific goals, including reducing infant mortality. This plan promotes the alignment of state and local activities to address major health priorities and provides accountability for meeting those goals. It also influences the work of many local partners, including hospitals and local health departments who have planning requirements under Ohio law, ensuring that systemic changes at the state level are effectively implemented locally.

The 2017-2019 plan set a target for reducing infant mortality to no more than 6.0 deaths per 1,000 births by 2022. The 2020-2022 plan maintained the overarching goal of 6.0 but pushed the target date to achieve this goal out to 2028. The updated plan sets the same reduction target (6.0) for all subpopulations, including Black infants.

Ohio State Health Improvement Plan, 2020-2022

Goals for Infant Mortality Rate Reduction

	Baseline (2018)	Healthy People 2020 Target	Short-Term Target (2022)	Inter-mediate Target (2025)	Long-Term Target (2028)	Healthy People 2030 Target
Infant Mortality Rate	6.9	6.0	6.5	6.3	6.0	5.0
Black (non-Hispanic)	14.0		10.8	8.4	6.0	

Since 1980, the Healthy People initiative has set measurable objectives to improve the health and well-being of people nationwide. At the beginning of every decade, a new iteration of the initiative is set with updated targets and goals that address the latest public health priorities and challenges.

Ohio's current plan has the state meeting the 2006 national average in 2028... more than two decades later.

The Healthy People 2020 target for infant mortality was 6.0 deaths per 1,000 births. This target reflects a 10% improvement from the national infant mortality rate of 6.7 in 2006. This target was updated for Healthy People 2030 to 5.0 deaths per 1,000, reflecting improvement from a national baseline set in 2017 of 5.8 infant deaths per 1,000 births.

While other states have continued to reduce infant deaths, Ohio has failed to keep pace with the rest of the nation. A more recent Ohio plan has not been published.

Compared to Other States, Ohio Makes Progress on Clinical Metrics, but Outcomes Still Lag

While the impact is not limited to Medicaid, more than half of the infant deaths that occurred in Ohio in 2022 (57%) were to mothers reporting Medicaid as their source of insurance. The Medicaid program plays a crucial role in maternal and infant health, as it covers nearly half of all births in Ohio.

Given its significant role in providing access to health care to more than one of every five individuals—including almost half of all children and more than 40% of all births in the nation—the Centers for Medicare and Medicaid (CMS), who oversees state Medicaid programs at the federal level, works to improve the quality of care and health outcomes for its beneficiaries. To monitor and evaluate performance at the state level, CMS maintains a set of measures, known as the Child and Adult Core Sets. This data, which is released annually, provides an assessment of the quality of care provided to beneficiaries in each state to allow for comparisons between states and nationally. CMS's work continues to evolve to better support improvement in outcomes and to reduce inequity with the implementation of mandatory state reporting on certain metrics (beginning in FFY 2024) and the measurement and reporting of health disparities.

To better understand maternal behaviors, perinatal experiences, and their impact on the health of mothers and infants, the Ohio Department of Health administers a survey to a sample of new mothers. Ohio began surveying new mothers in 1999 using the Pregnancy Risk Assessment Monitoring System (PRAMS), which is a joint surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. In 2016, Ohio developed its own survey, known as the Ohio Pregnancy Assessment Survey (OPAS). While the goals of the two surveys are similar, OPAS allows for the use of state-specific questions and data is available to the state more quickly, but this strategy limits the comparisons of some data. The PRAMS survey continues to be used by 46 states.

This section compiles clinical and outcome data from these sources along with other publicly available sources to show the state of maternal and infant health in Ohio. Clinical metrics measure inputs, such as processes associated with high quality health care, while outcome metrics measure the change in the health of an individual or population.

While Ohio is performing better on some of the clinical metrics compared to other states, these metrics continue to show that our efforts miss too many pregnant women. Our health outcome metrics trail the nation in most cases.

Despite our best efforts, interventions are still missing too many women.

Measuring Inputs: Clinical Metrics

Timely Prenatal Care: This refers to the initiation of prenatal care during the first trimester of pregnancy. Early prenatal care includes a comprehensive assessment of a woman's health history, pregnancy risk, and health knowledge. Early screening and referrals for specialized care can prevent pregnancy complications resulting from pre-existing health conditions or promote access to recommended care.

Postpartum Follow-Up: The postpartum visit provides an opportunity to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions (such as diabetes and hypertension), mental health status (including postpartum depression), and family planning (including contraception and birth spacing).

Low Risk Cesarean Deliveries: Cesarean deliveries place both mothers and infants at higher risk for adverse outcomes. Reducing the rate of cesarean births for individuals at low risk of adverse outcomes from a vaginal birth provides an opportunity to improve both maternal and infant health.

Postpartum Contraception: Access to effective contraceptive care during the postpartum period can improve birth spacing and timing and improve the health outcomes of women and children. Shorter intervals between pregnancies have been associated with increased risk of complications for both mothers and infants. This measure assesses the percentage of postpartum women who were provided a mostly or moderately effective method of contraception as well as the percentage who received a highly effective long-acting reversible method of contraception (LARC) within 3 days (prior to hospital discharge) and 60 days of delivery (postpartum visit).

Most Recent Results: Clinical Metrics[1]

	Ohio Medicaid Population	National Medicaid Average	Ohio Population	National Average
Timely Prenatal Care	84.8%	76.5%	77.1%	77.0%
Postpartum Follow Up	77.4%	69.2%	91.6%	n/a
Low Risk Cesarean Deliveries	25.7%	24.7%	n/a	25.8%

	Most or Moderately Effective Method of Contraception		Long-Active Reversible Method of Contraception	
	3 Days	60 Days	3 Days	60 Days
Ohio Medicaid	14.9	40.7	4.9	11.7
National Medicaid Average	12.0	37.8	2.4	11.4

Highlights

- A higher rate is better for all of these metrics except for low-risk cesarean deliveries.
- Ohio Medicaid's performance on timely prenatal care is much higher than Ohio's overall population and the national average for both Medicaid and all populations.
- Ohio Medicaid's performance on postpartum follow up is significantly less than Ohio's overall population but much higher than the national average for the Medicaid population.
- Ohio Medicaid's rate of low-risk cesarean deliveries is about the same as the national average for all populations but higher than the national average for Medicaid populations.
- Ohio Medicaid's rate of postpartum contraceptive care is higher than the national average for Medicaid populations. Ohio Medicaid is among the ten best states for care provided prior to hospital discharge (within 3 days).

[1]Ohio Medicaid and national Medicaid averages are from the FFY 2022 CMS Adult and Child Core Sets, state and national population averages for timely prenatal care are from the 2022 CDC WONDER database, the postpartum follow up rate for the Ohio population is from the 2022 Ohio Pregnancy Assessment Survey, and the national average low risk cesarean rate is from the National Center for Health Statistics 2022 Natality data.

Measuring Outputs: Outcome Metrics

Maternal Death Rate: Maternal mortality refers to the death of a woman during pregnancy, childbirth, or within 42 days after delivery due to pregnancy-related complications. The maternal death rate has been increasing over time and disproportionately affects Black mothers. This rate is measured as a rate per 100,000 births.

Severe Maternal Morbidity: Approximately 60,000 women nationally are affected by severe maternal morbidity each year. Severe maternal morbidity refers to life threatening complications during labor or delivery and can lead to serious long-term health impacts. This rate has been increasing over time and as a rate per 10,000 hospitalizations.

Low Birth Weight Babies: Infants weighing less than 2,500 grams at birth may experience serious health problems and/or developmental delays.

Preterm Births: Preterm birth, or a birth before 37 weeks gestation, is a leading factor in infant mortality and can significantly increase the risk for long-term health complications for newborns.

Most Recent Results: Outcome Metrics[2]

	Ohio Medicaid Population	National Medicaid Average	Ohio Population	National Average
Maternal Death Rate	n/a	n/a	23.7	22.4
Severe Maternal Morbidity	n/a	n/a	84.9	88.3
Low Birth Weight Babies	11.4%	10.2%	8.7%	8.6%
Preterm Births	12.8%	n/a	10.8%	10.4%

Highlights

- A lower rate is better for all of these metrics.
- Ohio's maternal death rate is higher than the national average, while the rate of severe maternal morbidity is lower. These rates are not available for the Medicaid population.
- Ohio's Medicaid program has a higher proportion of low birth weight babies compared to the national Medicaid average, in fact Ohio Medicaid is among the ten worst states for this metric. The overall Ohio population rate is much lower than the Ohio Medicaid rate and very close to the national average.
- Ohio Medicaid's preterm birth rate is much higher than for Ohio's overall population. Ohio's overall population rate is higher than the national average.

The health of mothers and their infants is closely connected. Despite the progress, there is still more work to be done to ensure that health outcomes for Ohio's mothers and infants meet or exceed those of other states.

[2]Ohio and national Medicaid averages for low birth weight babies are from the FFY 2022 CMS Adult and Child Core Sets, preterm and low birth weight state and national population averages are from the 2022 CDC WONDER database, Ohio Medicaid's preterm birth rate is from the Ohio Report on Pregnant Women, Infants, and Children SFY 2021, maternal death rate data are from the 2017-2021 America's Health Rankings, and severe maternal morbidity data are from the 2020 America's Health Rankings.

Major Policy Changes to Improve Health Outcomes for Pregnant Women and Infants

Ohio has made a number of population health- and Medicaid-focused investments and policy changes to move the needle on maternal and infant health. The most impactful changes are highlighted below.

Ensuring Broader Access to Care, Including Preventive Services

Maternal and infant health are interconnected, so it is essential to ensure women are healthy before pregnancy. The expansion of Medicaid coverage to low-income adults provides access to critical health care services including preventive services to help ensure women are healthy before they become pregnant. Ohio also extended Medicaid coverage during the postpartum period—from 60 days to one year following the birth of a child—to ensure continuous coverage during this critical period when complications are more likely to occur and to allow for better management of chronic conditions and mental health support, which can significantly improve health outcomes for mothers and infants. Even with these changes, almost 20% of pregnant women were well into their second trimester by the time they enrolled in Medicaid, which delays the start of prenatal care.[3]

Targeting Infant Mortality Hot Spots

Ten counties in the state accounted for 84% of Ohio's Black infant deaths in 2020 and 62% of all infant deaths.[4] The state cannot make meaningful improvement in its infant mortality rate without making substantial and sustained change in its hardest-hit communities. The state has targeted local communities through the Ohio Equity Institute (OEI), a collaboration between the Ohio Department of Health and local communities, to address racial inequities in birth outcomes. OEI started in 2012 with nine counties and has since expanded to more counties. Targeting investment in the OEI communities has helped to increase community engagement, fund promising strategies such as Centering Pregnancy and community health workers, and improve collaboration among health care providers, community support organizations, and the communities that they serve. While this is the right strategy, the implementation has fallen short in some areas—as not all of the major providers are engaged in this work in their communities. The state does not have the capacity to do deep collaborative work at the community level, but it can ensure that the providers come to the table along with the women directly affected by the policies and hold all accountable for outcomes.

Ohio cannot make meaningful improvement without substantial change in its hardest-hit communities.

The state's current strategy of using its Medicaid managed care plans to drive collaboration has limitations. As the relationship between payers and providers has historically been adversarial, plans have limited ability to do the deep work to build trust across all parties at the community level—leadership in this area must come from community organizations, with managed care and local providers equally engaged and unified behind the shared responsibility of better birth outcomes for every woman and baby.

[3]In CY 2020 the average gestational age at Medicaid enrollment was 16.3 weeks. Ohio Medicaid Director Corcoran's presentation to the Joint Medicaid Oversight Committee in March 2024.

[4]Ohio Equity Initiative, Ohio Department of Health.

Collective Impact at Work

Cradle Cincinnati in Hamilton County stands out as a beacon of what is possible when a community follows its data and works together to achieve a goal. In 2023, this community was able to lower their county infant mortality rate to the national average of 5.5 per 1,000 live births and reduce Black infant mortality to single digits at 9.0 per 1,000 live births. The community attributes their success to focusing on the structural factors that are driving racial disparities in infant mortality. Data showed that racial discrimination, not socioeconomic factors, was a key driver in Black infant mortality. The direction of the group's work shifted towards addressing the structural factors driving racial disparities in infant mortality and centering the voices of Black women in this work. *Cradle Cincinnati* has been successful because they hold themselves accountable to the data and have steadfastly held to the belief that the women affected must be actively engaged.

Read the full report at https://tinyurl.com/5yt6v2yz

Expansion of Home Visiting Services

Voluntary, evidence-based home visiting programs offer significant benefits for families and communities by improving maternal and child health, promoting positive parenting practices, and enhancing early childhood development. Ohio has been able to substantially increase investment in home visiting to ensure that more parents and children are able to benefit from the program. Even with expansion, home visiting is still missing many families, particularly those who are harder to reach and engage—those who would benefit from the service the most.

Medicaid Managed Care Improvements

Managed care has become the predominant delivery system for Ohio Medicaid, and the state has added to the health plans' responsibilities over time. One of the greatest strengths available to states through managed care is the ability to create care coordination and outreach programs that can be targeted to priority populations. Ohio has used this strategy to better engage pregnant women to ensure that they are receiving the prenatal care and supports that they need to have a healthy baby. Day one enrollment in Medicaid managed care ensures that pregnant women who are enrolling in Medicaid for the first time are immediately connected to care coordination services, which has helped ensure more women receive early prenatal care.

New Medicaid Services and Initiatives

Over the past ten years, the state has made a number of improvements to the Medicaid Program to improve health outcomes for pregnant women and their infants. Highlights include:

- Adding new Medicaid benefits including lactation support, group prenatal care, and nurse home visiting, along with the soon-to-be-implemented doula benefit.
- Eliminating barriers to promising treatments including smoking cessation screening and treatment, changing prior authorization and clinic practices to prevent prematurity with Progesterone,[5] and helping providers change internal processes to make long-acting reversible contraception more available to the women who want it.
- Improving data collection and data sharing by leveraging vital statistics data to better identify women at higher risk for poor birth outcomes, reforming the Ohio Pregnancy Assessment Survey (OPAS) to better meet the state's data needs, and implementing the electronic pregnancy risk assessment form (PRAF) with a financial incentive to providers for its use to ensure Medicaid eligibility is not disrupted and to facilitate outreach and connection to needed supports.
- Funding outcomes through alternative payment structures by providing payments to Pathways Community HUBs for achieving healthy births and comprehensive maternal care that provides additional payments to help providers change the way that care is delivered.

[5] *Note that the FDA has since withdrawn approval of Progesterone for use in preventing premature birth.*

Short Term Opportunities to Improve Outcomes

Even with all of these activities, Ohio has not made significant progress toward its infant mortality reduction goals. While many of the changes implemented have led to marked improvement in other states, Ohio has not seen the same benefits. Momentum, the availability of data to drive progress, and implementation of some strategies have fallen short in some areas and should be remedied quickly to maintain focus on this important issue.

Momentum Has Slowed with Pandemic

While state focus shifted during the pandemic to respond to the ongoing public health emergency, the pandemic also laid bare the impact of health inequities within the state. Almost four and half years later the state still lacks an updated state health assessment and state health improvement plan that sets the goals and strategies to address maternal and child health as well as other pressing health needs of our state. Many of the maternal and infant health initiatives that were included in the state's 2020-2022 implementation plan remain unimplemented.

Ohio should update its state health improvement plan to promote collective action on addressing the most pressing health needs of Ohioans. The plan should reflect implementation strategies currently underway and initiatives that the state plans to pursue to meet the goals set within the time covered by the plan. The plan should increase collaboration between the medical care and public health systems to better leverage the strengths of each to improve health outcomes.

Timely Data and Transparency on Progress Are Missing

In order to make meaningful progress, data, evaluation, and transparency are critical. Good intentions aside, a lot of investments have been made and people are working very hard all around the state on this issue, yet we have not substantially moved the needle on population health.

To make meaningful progress, Ohio must lead by example and be open and honest about successes, shortcomings, and failures. Resources are limited, and too many families are being hurt by the status quo and the glacial pace of change. Transparency helps to build public trust and provides accountability to ensure that programs are meeting goals and achieving outcomes for those for whom care is intended.

Without data there is no accountability or understanding of what has worked and why.

Much of the performance data used for this report was pulled from national sources using data that originated in Ohio. Yet this data is not publicly available at the state level. Ohio has not reported publicly on some key data points since 2021—including many statutorily required reports. For example, ODM is statutorily required to publish an annual report on the effectiveness of the Medicaid program in meeting the health care needs of low-income pregnant women, infants, and children (ORC 5162.13). An updated report has not been published since 2021. And limited performance data has been made available to assess the impact of the many new initiatives launched over the past decade.

Implementation Seems to Have Fallen Short of Intended Outcomes in Some Areas

The state has implemented a number of new initiatives, particularly in Medicaid, but it is not clear that they have been implemented with enough fidelity to achieve the intended outcome, particularly in the areas of the state with the highest needs. One example is the use of Medicaid funding for home visiting through Nurse Family Partnership (NFP). Home visiting in Ohio has largely been funded with a blend of state and federal block grant funds, which have not been sufficient to meet the need for services. Many states are leveraging Medicaid funds to expand access to these evidence-based home visiting models to ensure more families can benefit from their services. The state has added nurse home visiting as a new Medicaid benefit but limited the providers who can offer the service to clinics and physician groups, which excludes current home visiting providers who were better positioned to expand services.

Medicaid rates must be sufficient to ensure appropriate capacity in the community to meet the needs.

We face a similar risk with Medicaid funded doula services. The strength of the intervention is from the community-based provider who has a trusted relationship with the mother. We will not achieve the expected outcome from this intervention if the doula selected by the mother is not able to fully participate in the mother's care as a member of the mother's support team in the hospital setting. Further, Medicaid rates must be sufficient to ensure appropriate capacity in the community to meet the needs.

Statewide Collaboration is Focused on Clinical Providers

While there are several statewide forums that focus on improving clinical outcomes, the forums that allow for collaboration between clinical and community providers have waned. There is a lot of work to be done to improve clinical practices to ensure all patients receive high quality care consistently. But meaningfully engaging patients and overcoming non-clinical barriers to care are critical to improving health outcomes, and these issues cannot be solved without their active participation in the work. Finding pregnant women early and engaging them in care is still the hardest part. We are failing at this.

Additional Policy Strategies to Make Meaningful Systemic Change

While a lot has been done, much work remains, particularly to change care delivery at the local level. The state can play an important role in driving this action.

Expand Consumer and Stakeholder Engagement

To ensure better health outcomes are achieved, those most affected by the policies must be at the decision-making table and empowered to fully participate in the process at the local and state levels. This will not only build trust but also a shared understanding of the challenges and how to overcome them.

Ohio will not be able to make meaningful improvement without sustained change at the local level that leverages the lived experiences from consumers.

As the state develops policies and regulations, it is important to include consumer voice in the process as they are the true experts in their own lives. Currently, administrative policy changes are generally vetted among a narrow set of trade associations and a handful of affected providers. Consumer voice can provide valuable insights that can help improve trust and engagement among the people the Medicaid program serves.

One immediate opportunity is to add at least one member from a local infant mortality reduction organization to the state's Medical Care Advisory Group. Under new federal rules, The Centers for Medicare and Medicaid (CMS) is requiring states to expand the scope of work and participation of their Medical Care Advisory Group to include stakeholders including consumers with lived experience. The state will also be required to create a Beneficiary Advisory Group. To enable consumers to participate, the state should provide a stipend and cover travel expenses, as is currently done for members of other state boards and commissions.

Support Infrastructure and Workforce for Birthing Providers

The state has a larger responsibility for maternal health birthing providers. The state is the largest purchaser of maternal health in the state—through the Medicaid program that covers about half of all births and as an employer covering more than 50,000 state employees and their families. This gives the state an oversized responsibility for the financial health of these providers and a strong influence over the way that care is delivered. Timely access to

maternity care is an increasing concern in Ohio. Ohio has 13 counties with no access to a birthing hospital and no access to an obstetric provider.[6] This problem will only get worse without concerted efforts to reverse course.

- ***Ensuring the financial health of birthing providers.*** Physician rates are established using a set of inputs that reflect the cost of delivering care to the patient. These inputs include physician effort and expertise along with the cost of clinical and nonclinical resources, including malpractice insurance. Medicare uses these factors to set payment rates, which often become the basis for state Medicaid fee schedules. While Medicare rates reflect the average cost of providing a service, the actual cost of care can vary between providers. This methodology creates inequities among providers who have higher input costs like obstetricians/gynecologists (OB/GYNs) who must spend more time per patient and face higher practice expenses and malpractice insurance costs. Ohio generally sets its Medicaid rates as a proportion of Medicare's rates. Currently Ohio Medicaid rates for commonly billed prenatal care codes are less than 60% of Medicare. Unlike Medicare, who updates rates annually, it is not uncommon for Ohio Medicaid rates to remain flat for more than a decade. This means that providers must subsidize the cost of providing Medicaid services through higher rates to other payers. However, more than half of Ohio's commercially insured members are enrolled in high deductible plans. High deductible plans, which require consumers to pay higher out of pocket costs, are likely to have a larger negative impact on birthing providers, as this out-of-pocket cost falls on younger consumers who have fewer resources to pay their deductible for maternity care. Ohio Medicaid rates for physician services are among the lowest in the nation, and it is critically important that Medicaid rates for birthing providers cover the cost of providing care to ensure access to care for all pregnant women.

- ***Ensuring an Adequate Workforce.*** Ohio has an increasing number of counties that are maternity or OB/GYN deserts. Ohio operates six public medical schools and many other public institutions that train nurses and other birthing professionals. Ohio must produce quality health professionals that are trained to provide care in collaborative settings with multidisciplinary teams made up of both clinical and non-clinical members. This model of care can drive better outcomes by addressing all of the factors that support the health of patients that they will serve. This means working upstream to recruit and train health care professionals who reflect the patients that they serve. The state should also offer incentives such as reduced tuition to recruit more professionals to primary and OB/GYN care. Because of the time it takes to train health professionals, the state needs to develop a plan to meet workforce needs five to ten years out. The state should also report on demographic and outcome data of the students in health professional programs, including how many students applied, how many were admitted, how many graduated, and how many passed licensing tests for each program. This data should be used to inform upstream strategies to address barriers to ensure more people—and more people of color—successfully enter the health care workforce.

[6] *March of Dimes, Maternity Care Deserts Report*

Leverage All Opportunities to Increase Focus and Collaboration Among Key Providers

As hospitals and other providers seek additional Medicaid funding, ODM should use this as an opportunity to bring health care leaders into the performance improvement work. The state should require ongoing training on health equity including cultural competency and implicit bias for all staff who interact with patients, require active participation in local collaborative efforts that include consumers who have an equal seat at the table, and publicly report on maternal and infant health metrics at the hospital level similar to what is being done in Cincinnati through Mama Certified.[7]

Single Front Door for Non-Medicaid Supports

We know that women must be able to meet their basic needs if they are going to have a healthy baby. As a first step to better understand the magnitude of need, the state should increase reporting through the use of Z codes,[8] which can be used to document a patient's social determinants of health needs, and uniform screening tools, similar to what is currently done in Arizona and Oregon. This data can be used to better meet the needs of patients and to help quantify larger systemic issues that impede better health outcomes.

As the need for and importance of non-medical services to support health outcomes grows, the need for better integration increases. Too many consumers and providers struggle to find the help that they or their patients need and are often unaware of what is available as it can change frequently. The Help Me Grow program has created an interactive community resource directory to help identify available resources,[9] and some local communities have invested in closed loop referral systems such as Unite Us.

However, the current situation often leads to duplication as providers create their own solutions. At its worst, this perpetuates inequities, especially in low-resource and rural areas. The state should facilitate a collaborative to develop an IT strategy to create a bridge between health and social services, similar to what is being done through the Gravity Project.

Too many consumers and providers struggle to find the help that they or their patients need and are often unaware of what is available as it can change frequently.

[7]Mama Certified provides public data on maternal and infant efforts across Cincinnati health systems to help ensure Black parents and babies are respected and cared for.

[8]Z codes refer to a set of diagnosis codes that a provider can use to document SDOH data, such as housing, food insecurity, or transportation, in their patient's health record.

[9]This guide is available online at: https://brightbeginningskids.knack.com/communityresourcedirectories#directory/?view_71_page=1&view_71_filters=%5B%7B%22field%22%3A%22field_67%22%2C%22operator%22%3A%22is%22%2C%22value%22%3A%2265f9f5c9167e000039fe3b81%22%7D%5D.

Expand State Leadership in Value-Based Purchasing

The health care delivery system has been moving away from fee for service or volume-based care to payment for outcomes and value. Value-based payments seek to incentivize high quality care that produces positive outcomes and promote health equity. Often the cost to support better outcomes—like patient education and screening and referrals to address health and social needs—is much less than the cost of caring for a poor birth outcome such as a NICU stay for a premature infant, but current reimbursement favors clinical intervention. Redesigning the way care is delivered and paid for takes significant effort and time—often three years or more. Previous studies have shown that initiatives that only affect a small percentage of a practice's patients are not enough to justify the needed investment in the infrastructure and personnel to transform care. If Ohio is going to be successful, the state, managed care plans, and health care systems must commit to changing payment models and care delivery. A change of this magnitude cannot happen without state leadership to organize efforts and drive change across all payers.

While the rewards can be great, large scale payment reform is challenging. More must be done to incentivize providers for health not sickness. One opportunity to work alongside CMS and other states with rigorous evaluation was through CMS's Transforming Maternal Health grant. This grant would have provided the state with $17 million over ten years to help Ohio move towards better value and outcomes for maternal care.

CONCLUSION

While other states have made significant strides in reducing infant mortality and addressing disparities in birth outcomes, progress in Ohio has stagnated. This challenge is far too critical to overlook, as the future of our state depends on the health and well-being of its children.

Addressing Ohio's infant mortality crisis demands a sustained focus and unwavering commitment. Cradle Cincinnati in Hamilton County has demonstrated that by leveraging data-driven decision-making, fostering community accountability, and authentically engaging with the women most affected, meaningful improvements are possible. By working closely with health care providers and the community, they've shown that positive outcomes can be achieved through trusted collaboration and transparency. This longstanding collaboration may serve as a model for other communities to emulate.

State leadership also plays a crucial role in supporting transformation at the local and state levels. By using its unique leverage to incentivize health systems to partner with its state-contracted managed care plans and those in the community with lived experience, ensuring sufficient provider rates to sustain and build capacity of both primary care and OB/GYN professionals who are trained to provide care in multidisciplinary teams that include both clinical and nonclinical experts, and by promoting a shared accountability through regular public reporting of state investments and outcomes, Ohio can create a culture that demands lasting change.

The time has come for a renewed commitment to Ohio's mothers and babies. We must move beyond simply measuring activity and focus on outcomes. While the road ahead may be complex, the stakes are too high to delay. Now is the moment to act—to build a healthier, more equitable future where Ohio's youngest children can thrive.

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