Ohio Legislative Service Commission

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Fiscal Note & Local Impact Statement

Bill: S.B. 332 of the 131st G.A. **Date**: November 10, 2016

Status: As Passed by the Senate **Sponsor**: Sens. Jones and Tavares

Local Impact Statement Procedure Required: No

Contents: Provides for the implementation of certain recommendations made by the Commission on Infant Mortality

State Fiscal Highlights

- **Qualified community hubs**. The Ohio Department of Health (ODH) will realize an increase in costs to establish qualified hubs in communities identified by the Commission on Minority Health. ODH is to use federal dollars received from the Maternal and Child Health Block Grant to establish these. Start-up costs are approximately $250,000 per hub.
- **Community health worker services**. The Ohio Department of Medicaid (ODM) will realize an increase in costs to provide certain services, including community health worker services, to certain Medicaid recipients. The total increase will depend on several factors, but may eventually be significant according to ODM.
- **Presumptive Medicaid eligibility for pregnant women**. ODM may experience an increase in fee-for-service Medicaid costs for services provided to pregnant women presumed to be eligible for Medicaid.
- **Medicaid claims for long-acting reversible contraceptives (LARCs)**. ODM may realize an impact in costs if LARC insertions are billed separately instead of as part of a hospital inpatient maternity care claim or freestanding birthing center claim.
- **LARC First Practices**. ODM and ODH are required to use any available funds from the Children's Health Insurance Program Reauthorization Act of 2009 or any unallotted General Revenue Funds within ODH's budget to provide technical assistance and grants to specified entities to promote LARC awareness and use.
- **Safe sleep training**. ODH will experience an increase in costs to provide annual training classes at no cost to individuals who provide safe sleep education to parents and infant caregivers who reside in infant mortality hot spots. The costs will depend on the number of trainings conducted.
- **Home visiting**. ODH could realize an increase in administrative and subsidy costs to allocate funds for certain home visiting pilot projects and to create and administer a central intake and referral system for all home visiting programs.

- **Various data collection and sharing provisions**. ODH and ODM will realize an increase in administrative costs related to various data collection and sharing provisions in the bill.
- **Evaluation of state policies and programs**. The Legislative Service Commission will realize an increase in costs to contract with a nonprofit organization who will in turn evaluate state policies and programs.

Local Fiscal Highlights

- **Medicaid hospitals claim for long-acting reversible contraceptives (LARCs)**. Government-owned hospitals may realize an impact in costs if LARC insertions are billed separately instead of as part of a Medicaid hospital inpatient maternity care claim.

Detailed Fiscal Analysis

The bill enacts many of the recommendations made by the Commission on Infant Mortality in a March 2016 report.[1]

Community hubs

Establishment of qualified hubs

Under the bill, a qualified community hub is a community-based agency that meets certain criteria and connects at-risk individuals to physical health, behavioral health, social, and employment services. The bill requires the Commission on Minority Health, no later than 120 days after the effective date of the bill, to identify each community that is not served by a qualified community hub. The Ohio Department of Health (ODH) is required to establish a qualified community hub in each community identified. According to a representative of the Community Health Access Project, a Pathways hub located in Richland County, there are three existing Pathways hubs (Cincinnati, Richland County,[2] and Toledo) and three in the process of development (Akron, Columbus, and Youngstown).[3] The representative estimates start-up costs for each hub to be approximately $250,000. This would include costs associated with training personnel, legal representation, information technology, community needs assessments, and community engagement activities. It is possible that there are

[1] Recommendations related to tobacco taxes and the minimum purchase age for tobacco products are not included.

[2] The Richland County hub is trying to expand services into five surrounding counties.

[3] In H.B. 64 of the 131st General Assembly, the Commission on Minority Health received $2.0 million for the biennium to provide funds to six agencies to help support the continuation or establishment of a Pathways Community Hub model. Funds were provided for expansion activities to the three existing hubs and to replicate the model in the three developing hubs.

additional hubs that are not affiliated with the Pathways model. The bill states that ODH is to use federal dollars received from the Maternal and Child Health Block Grant to establish the hubs. The total cost will depend on the number of hubs necessary to serve each community in Ohio. According to the Commission, the next priority areas for hub development are southeast Ohio, Dayton, and Cleveland. The bill requires the Commission to convene quarterly meetings with the hubs to discuss performance data and best practices. The Commission could realize an increase in administrative costs to identify communities and to convene meetings.

Community health worker services for Medicaid recipients

The bill requires the Ohio Department of Medicaid (ODM), when contracting with a Medicaid Managed Care Organization (MCO), to require the MCO to provide to an eligible Medicaid recipient, or arrange for the Medicaid recipient to receive, certain services provided by a community health worker who is certified by the Board of Nursing and employed by, or working under a contract with, a qualified community hub. The bill specifies that a Medicaid recipient is eligible to receive these services if the recipient is pregnant or capable of becoming pregnant, resides in a community served by a qualified community hub, has been recommended to receive the services by a physician or another licensed health professional, and is enrolled in the Medicaid MCO providing or arranging for the services.

There are approximately 670,000 Medicaid recipients in Ohio who are capable of becoming pregnant.[4] If they were all to receive services, approximately 6,700 certified community health workers would be needed (assuming a worker to client ratio of 1:100). If this is the case, costs could increase by tens of millions of dollars. ODM would receive federal Medicaid reimbursement for a portion of these costs. It is likely, however, that fewer new workers will be needed. First, it will depend on the number of women who are recommended for the services by a licensed health professional. It is not known what percentage of the 670,000 this will be. Second, it will depend on when and how many qualified hubs are established. As stated in the section above, there are currently at least three qualified hubs in Ohio and three hubs that are in the process of being certified. The Commission on Minority Health anticipates that these new hubs will receive certification within the next year. Initially, ODM would be required to provide, or arrange to provide, services to Medicaid recipients residing in the communities served by these hubs. As hubs are added, the number of recipients entitled to services will increase. Third, some community health worker services are already being provided to Medicaid recipients, so any services currently provided through a qualified hub will not represent an additional cost. However, many community health worker services are provided outside of the hub. Two of the existing hubs (Toledo and Richland County locations) already contract with Medicaid MCOs[5] to

[4] This number is based on the number of females aged 15 to 40, on full Medicaid, during FY 2014.

[5] http://mih.ohio.gov/Portals/0/Documents/Updated%20HUB%20Abstracts.pdf, pages 1 and 5.

serve certain at-risk recipients. However, the number of women served appears to be relatively few in number.[6] Both the Toledo and Cincinnati hubs have received ODM grant dollars[7] to address infant mortality. These funds are to be used by the Toledo hub to train 12 additional community health workers. The Cincinnati hub will use funds to serve as the community hub for referral distribution of clients received from the centralized intake for partner agencies employing community health care workers and utilizing the community Pathways model of care.

Studies indicate that providing community health worker services could result in a reduction in duplication of services and better health outcomes. If this occurs, then there could be an offsetting reduction in Medicaid costs. However, as some of these services are currently being provided, some savings may have already occurred.

Presumptive Medicaid eligibility for pregnant women

The bill permits any entity that is eligible to be, and requests to serve as, a qualified provider to make presumptive Medicaid eligibility determinations for pregnant women if ODM determines that the entity is capable of making such determinations. This provision could allow for some individuals to be enrolled in Medicaid sooner than they otherwise might be. Thus, ODM may experience an increase in costs for any services provided under fee-for-service until the individual, who is determined to have presumptive eligibility, is enrolled in a managed care plan. ODM would receive federal Medicaid reimbursement for a portion of these costs. ODM might experience a minimal increase in administrative costs to determine if entities are capable of conducting presumptive eligibility determinations.

Long-acting reversible contraceptives

Medicaid claims for long-acting reversible contraceptives

The bill authorizes a hospital, or freestanding birthing center, that is a Medicaid provider to submit to ODM a Medicaid claim that is both of the following: (1) for a long-acting reversible contraceptive (LARC) device that is covered by Medicaid and provided to a Medicaid recipient after giving birth and prior to discharge from the location, and (2) separate from another Medicaid claim for other hospital inpatient care the hospital or center provides to the Medicaid recipient.

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[6] *Ibid*. The Toledo hub has served more than 2,000 pregnant women since 2007. It is unknown how many of these are Medicaid recipients.

[7] ODM provided $13.4 million in each fiscal year of the current biennium to address infant mortality in nine geographic areas. The following areas have received funding: Akron, Butler County, Canton, Cleveland, Cincinnati, Columbus, Dayton, Toledo, and Youngstown. For a list of projects funded please refer to the following website – http://www.medicaid.ohio.gov/NEWS/PressReleases.aspx.

The fiscal impact of this provision depends on whether the reimbursement rate for hospital inpatient services related to maternity care or the healthcare common procedure coding system for freestanding birthing centers[8] is recalculated and on how many separate bills ODM receives for LARC insertion. On July 1, 2013, ODM increased the rate paid for hospital inpatient maternity care claims from an average of $2,986 per claim to an average of $3,749 per claim. ODM stated that this increase led to an additional $32.3 million in reimbursements for maternity care claims in FY 2013. According to ODM, all hospital inpatient services related to maternity care were used to develop the new reimbursement rate, including the placement of LARCs. LARCs were actually included in calculating both the hospital base rates as well as the relative weights for diagnostic-related groups (DRGs).[9] Thus, if the insertion of LARCs was allowed to be billed separately, ODM states that the DRG for inpatient maternity care might need to be recalculated. If this occurs, associated Medicaid costs would decrease and hospitals would receive lower reimbursements for maternity care claims. It is unknown how much of the increase in maternity care claims is attributed to LARC placement and thus, how much of an adjustment would be made to these rates if LARC insertion was billed separately. If LARC insertions are included in the rate paid to freestanding birthing centers, then it is possible that this rate would also need to be adjusted. If this occurs, then ODM could realize a decrease in costs. However, the number of licensed freestanding birthing centers is small, so any impact will be relatively small.

If LARC insertions were allowed to be billed separately, then ODM would reimburse for any bills received. ODM typically reimburses between $668.75 and $867.25 under the physician administered pharmaceuticals fee schedule, depending on the LARC device inserted. In calendar year (CY) 2015, 137 Medicaid recipients received LARCs during their inpatient stay. If these were billed separately, ODM would have paid approximately $92,000 to $120,000 during CY 2015. Medicaid costs would increase if the number of Medicaid recipients receiving LARCs increased. ODM would receive federal Medicaid reimbursement for a portion of these costs. Further,

[8] Freestanding birthing centers are licensed by ODH and are limited to serving "low-risk" expectant mothers. These facilities can provide services during pregnancy, delivery, and the postpartum period. According to ODH's real-time database that displays licensee information, there are currently two licensed birthing facilities. In order to receive Medicaid reimbursement a freestanding birthing center must be licensed and have a current Medicaid provider agreement. Reimbursements are based on a rate for each "healthcare common procedure coding system."

[9] ODM uses the All Patient Refined, Diagnosis-Related Group prospective payment method to pay for acute care hospital services. This method is based on the DRG system, whereby hospitals are reimbursed according to the patient's principal diagnosis or condition and the resources required to treat a patient with that specific diagnosis. The method also allows costs to be adjusted for severity of diagnosis. These payments are part of the base rate. Additional payments may be added for capital, medical education, and outliers.

government-owned hospitals would receive Medicaid reimbursements for any LARC insertions conducted in their facilities.

Lastly, ODM could realize costs to amend the state plan, Medicaid rules, and the Medicaid Information Technology System as a result of this change.

LARC First Practices

The bill requires the Director of Health to coordinate with the Medicaid Director to provide technical assistance and grants to federally qualified health centers (FQHCs) and FQHC look-alikes that seek to include the practice of a prescriber who promotes awareness and use of LARC devices (a "LARC First Practice"). The bill requires ODH and ODM to use any available funds from the Children's Health Insurance Program Reauthorization Act of 2009 or any unallotted General Revenue Funds within ODH's budget to fund these activities. Based on currently funded grant projects, ODH estimates that providing technical assistance and training to these entities would be approximately $80,000 per site.

Health professional curricula

The bill requires the Director of Health, with participation from the Medical Board and Board of Nursing, to collaborate with health professional schools to develop and implement appropriate curricula on patient counseling regarding efficacy-based contraceptives, including LARC devices. ODH is also to collaborate with these entities to develop curricula to prepare health professionals to practice within the patient-centered medical home model of care. ODH, the Medical Board, and the Board of Nursing could experience a minimal increase in administrative costs to develop and implement the curricula.

Administration of certain medications by pharmacists

The bill authorizes pharmacists with specified training to administer the following medications by injection, so long as the medication is prescribed by a physician who has a relationship with the patient: an opioid antagonist used for drug addiction administered in long-acting or extended-release form, an antipsychotic drug administered in long-acting or extended-release form, hydroxyprogesterone caproate (a prescription hormone used to lower the risk of preterm birth), medroxyprogesterone acetate (Depo-Provera), and cobalamin. The medications must be administered pursuant to a prescription and physician protocol. The State Board of Pharmacy and the Medical Board are required to adopt rules pursuant to the bill's provisions. Violators of the adopted rules would be subject to the Board of Pharmacy's professional disciplinary procedures. These duties are not expected to create any discernible ongoing costs for either board.

Uniform form for progesterone administration

The bill also requires ODM, when contracting with a Medicaid MCO, to use a uniform prior approval form that is not more than one page for progesterone. Prior authorization is required in some instances and for some progesterone therapies.

According to ODM the removal of prior authorization is currently being tested at Ohio Perinatal Quality Collaborative[10] sites participating in the Progesterone Performance Improvement Project. ODM plans to remove prior authorization requirements for progesterone by January 1, 2017; thus, there should be no fiscal impact associated with this provision. However, ODM states that there will still need to be identification of pregnancy and risk so the MCOs can assist with care management.

Tobacco cessation

The bill requires ODH's tobacco use and cessation plan to emphasize reducing tobacco use by Medicaid recipients, account for the increasing use of electronic health records, and ensure that ODH collaborates with community organizations in infant mortality hot spots to help them secure grants from the Moms Quit for Two Grant Program. ODH anticipates no additional costs associated with these provisions.

The bill requires ODM to enter into an interagency agreement with ODH requiring ODM to pay the federal and nonfederal shares of Ohio Tobacco Quit Line services provided to Medicaid recipients. The bill also requires ODM to make Medicaid providers aware of the Quit Line services available to Medicaid recipients. The Quit Line provides personal coaching and telephone counseling free of charge to certain individuals. Currently, ODM has an interagency agreement to reimburse ODH up to $150,000 for FY 2016 and for FY 2017 for the federal share of operating the Tobacco Quit Line. ODH pays the required state match of $150,000 during these years, per the agreement. As a result of the bill, ODM and ODH would need to amend the interagency agreement to specify that the nonfederal share would come from ODM instead of ODH. ODM currently covers smoking cessation services, including individual and group counseling and seven United States Food and Drug Administration-approved cessation medications,[11] for all Medicaid recipients.

Enhancing current interventions

Home visiting

The bill requires home visiting services be provided through evidence-based home visiting models and that the goals of the Help Me Grow Program be consistent with the goals of the federal home visiting program. The bill also requires home visiting grantees report certain data to ODH. No later than six months after the effective date of the bill, ODH, with input from the Ohio Department of Developmental Disabilities (ODODD), is to select one or more persons or government entities to create and operate a central intake and referral system for all home visiting programs. ODH and ODODD could realize an increase in costs to create the intake and referral system.

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[10] The Collaborative is a consortium of perinatal clinicians, hospitals, and government entities that have a goal of reducing preterm births and improving birth outcomes.

[11] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6442a3.htm.

The bill also requires that ODH rules specify that families residing in infant mortality hot spots are to receive priority for Help Me Grow home visiting services. ODH could realize a minimal increase in costs if any rule promulgation is necessary. Additionally, as a condition of receiving payments for home visiting services, providers are required under the bill to promote the use of technology-based resources, such as mobile telephone or text messaging applications, that offer tips on having a healthy pregnancy and healthy baby to families with a pregnant woman or infant who is less than one year of age.

The bill requires ODH, no later than nine months after the effective date of the bill, and after considering recommendations made by the Ohio Home Visiting Consortium, to do all of the following with respect to the home visiting component of the Help Me Grow Program and other home visiting programs: allocate funds for home visiting pilot projects targeted at families with the most challenging needs and transition to paying for home visiting services based on outcomes rather than processes. ODH could realize an increase in administrative costs related to these provisions, as well as costs to fund the pilot projects.

The bill requires, beginning in FY 2018, ODH to facilitate and allocate funds for a biannual summit on home visiting programs. The summit is to convene persons and government entities involved with the delivery of home visiting services in this state. As a result, there could be a minimal increase in costs to ODH.

Ohio Home Visiting Consortium

The bill creates the Ohio Home Visiting Consortium with the purpose of ensuring that home visiting services operating in this state, as well as home visiting services provided or arranged for by Medicaid MCOs are high-quality and delivered through evidence-based or innovative models. The bill specifies the Consortium's duties, including making recommendations to ODM and to initiate, as pilot projects, innovative, promising home visiting models. The members of the Consortium are specified by the bill. Members are to serve without compensation. ODH is to provide meeting space and staff to support the Consortium, so ODH could realize a minimal increase in costs as a result.

Safe sleep education

The bill requires ODH to provide annual training classes at no cost to individuals who provide safe sleep education to parents and infant caregivers who reside in infant mortality hot spots. This includes child care providers, hospital staff and volunteers, local health department staff, social workers, individuals who provide home visiting services, and community health workers. The bill also requires facilities that procure safe cribs for at-risk families, as well as ODH, to ensure that crib recipients receive safe sleep education and crib assembly instructions. ODH may experience additional costs to provide the required annual training and ensure crib recipients receive the safe sleep education and crib assembly instructions.

The bill requires ODH to include in a report on safe sleep initiatives an assessment of whether at-risk families are sufficiently being served by the crib distribution and referral system specified under existing law. ODH does not expect any costs to comply with the reporting requirements.

Additionally, the bill requires each recipient of a grant that ODH administers that pertains to safe crib procurement to annually report ODH demographic information specified by ODH regarding the individuals to whom safe cribs were distributed as well as the extent to which the cribs are being used.

Technology-based mobile phone or text promotion

The bill requires ODM to contractually require Medicaid MCOs to promote the use of technology-based resources, such as mobile phone or text messaging applications, that offer tips on having a healthy pregnancy and healthy baby to pregnant women and new mothers. There are five MCOs that provide care management to Medicaid recipients. According to each MCO's website, it appears that the MCOs are currently utilizing the Text4Baby application, which is a technology-based messaging application that would meet the bill's requirements. Thus, there should be no direct fiscal impact associated with this provision.

The bill also requires ODH to adopt rules that require a contract that the Department enters into with a local Women, Infants, and Children (WIC) clinic to include provisions requiring the clinic to promote the use of technology-based resources, such as mobile phone or text messaging applications, that offer tips on having a healthy pregnancy and healthy baby to clinic clients who are pregnant or have an infant who is less than one year of age.

Data collection and sharing

Medicaid claims data and vital statistics training

The bill requires the State Registrar of Vital Statistics, under ODH, to make preliminary vital statistics information, available to each board of health. The State Registrar is required to ensure that these entities have access to the Ohio Public Health Information Warehouse and is also required to provide a data analysis toolkit that assists the users with using the data in a manner that promotes consistency and accuracy among users. ODH could realize a minimal increase in administrative costs to compile the information, ensure access to the Ohio Public Health Information Warehouse, and provide a data analysis toolkit. The bill requires ODM to make summary data regarding perinatal services available on request to certain local organizations and grant recipients. ODM could realize an increase in costs to compile this summary information.

The bill requires the State Registrar to offer to provide annual training for hospital and freestanding birthing center staff, as well as funeral service workers, on their responsibilities under the vital statistics law. ODH may experience a minimal increase in costs to provide such training.

Infant mortality scorecards and quarterly data

The bill requires ODH and ODM to create infant mortality scorecards that report quarterly data regarding pregnancy-and birth-related population health and outcome measures. The bill specifies what is to be included in these scorecards. ODH and ODM could realize an increase in administrative costs to compile the necessary information and to create the scorecards.

The bill requires ODH to make publicly available preliminary quarterly infant mortality and preterm birth rates delineated by race and ethnic group. ODH is required to make each report available on its website not later than five business days after the rates are determined. ODH could experience an increase in administrative costs to publish this data.

Medicaid performance reports

The bill requires the annual report that ODM must complete on the effectiveness of the Medicaid Program to include additional information related to perinatal care and infant mortality initiatives. ODM could realize an increase in costs to include this additional information in the report.

The bill requires ODM to submit a report to the General Assembly and the Joint Medicaid Oversight Committee (JMOC) regarding each Medicaid managed care organization's progress, during FY 2016 and FY 2017, in improving infant mortality measures through the provision of enhanced care management and targeted initiatives in infant mortality hot spots. The report is also to describe, in detail, the uses, amounts spent of, and outcomes from, the $13.4 million allocated in each fiscal year by ODM for infant mortality initiatives. ODM could experience a minimal increase in costs as a result of this requirement.

Survey regarding maternal behaviors related to pregnancy

The bill requires ODH to create a population-based questionnaire designed to examine maternal behaviors related to pregnancy similar to the Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire that was recently discontinued. The 2016 Ohio Pregnancy Assessment, a project conducted through a Medicaid Technical Assistance and Policy Program (MEDTAPP)[12] project, is currently conducting a statewide targeted population-based survey that uses PRAMS methodology. Thus, there will be no costs associated with this provision.

Barriers to access

The bill requires ODM to conduct periodic reviews to determine the barriers that Medicaid recipients face in gaining full access to interventions intended to reduce tobacco use, prevent prematurity, and promote optimal birth spacing. The first review will occur no later than 60 days after the effective date of the bill. Thereafter, the

[12] ODM and ODH requested the Ohio Colleges of Medicine Government Resource Center to administer this project.

reviews will be conducted every six months. ODM is required to prepare a report that summarizes each review. ODM would realize an increase in administrative costs to conduct the reviews and prepare the reports.

Assessment of Shaken Baby Syndrome Education Program

The bill adds to the responsibilities the Director of Health must fulfill in assessing the effectiveness of the Shaken Baby Syndrome Education Program, including reviewing the content of educational materials to determine if updates or improvements should be made, as well as reviewing the manner in which the materials are distributed. ODH anticipates no additional costs associated with these provisions.

Evaluation of state policies and programs

The bill requires the Legislative Service Commission (LSC) to contract with a nonprofit organization no later than 30 days after the effective date of the bill to convene and lead a stakeholder group concerned with matters regarding the social determinants of health for infants and women of child-bearing age. The bill specifies what the stakeholder group must do, including submitting a report to the General Assembly and the Governor by December 1, 2017, regarding the stakeholder group's findings. LSC will realize an increase in costs to contract with such an entity.

Ohio Health Transformation duties

The bill requires the Executive Director of the Ohio Health Transformation (OHT) to establish goals for continuous quality improvement pertaining to episode-based payments for prenatal care. The goals are to be published on OHT's website. The bill further requires OHT, in consultation with ODH, to identify the adoption of best practices on family planning options, reducing poor pregnancy outcomes, wellness activities, etc. OHT is to inform various entities of these best practices and to encourage the entities to incorporate them into their practices. OHT may realize an increase in administrative costs to establish goals and promote best practices.

Cultural competency for health care providers

The bill requires the State Dental Board, the Board of Nursing, the State Board of Optometry, the State Board of Pharmacy, the State Medical Board, the State Board of Psychology, and the Counselor, Social Worker, and Marriage and Family Therapist Board to annually provide its licensees or certificate holders with a list of continuing education courses and experiential learning opportunities addressing cultural competency in health care treatment. If a state board determines that a sufficient number of courses do not exist, the board is to collaborate with organizations or similar entities to create such courses. As a result, the boards may experience an increase in administrative costs to provide a list of courses and to potentially create such courses.

Housing

Housing Finance and Development Services agencies

The bill requires the Ohio Housing Finance Agency (OHFA) and the Ohio Development Services Agency (DSA) to include pregnancy as a priority in its housing assistance and local emergency shelter programs. Additionally, the bill requires both entities to investigate current investment in state-funded programs that support middle- to low-income homebuyers in communities identified with high levels of infant mortality and evaluate whether current investment should be rebalanced. The bill also requires OHFA to include reducing infant mortality as a priority housing need in the agency's annual report. OHFA may establish a housing assistance pilot program to expand housing opportunities for extremely low-income households that include pregnant women or new mothers. The bill specifies certain requirements if such a program is established.

The bill also places requirements on recipients of grants targeting homelessness, for grants awarded by DSA. The grant recipients must both (1) ask and report, to the extent possible, the number of pregnant women and the ages of any children receiving assistance at emergency shelters, and (2) require, when possible, pregnant women be offered placement in family shelters. The bill requires OHFA, in consultation with DSA, to adopt rules necessary to implement these requirements. As a result, this may minimally increase administrative costs for OHFA and DSA to implement these requirements and adopt rules. OHFA, as a quasi-public agency, would bear their administrative costs from revenue which is managed outside the state budget system, while DSA would utilize their housing program operating funds, such as the Housing Trust Fund (Fund 6460) or available federal housing funding.

Commission on Infant Mortality

The bill requires the Commission on Infant Mortality to work with the Ohio Housing and Homelessness Collaborative to: develop a rental housing assistance program to expand housing opportunities for extremely low-income households that include pregnant women or new mothers, and submit an implementation plan regarding the rental housing assistance program. ODH and DSA could realize a minimal increase in administrative costs if they provide any support to these entities.

Crib bumper pad sales

The bill prohibits crib bumper pad sales and specifies that the Superintendent of Industrial Compliance is to issue a notice of violation to any person found to have violated the prohibition. The bill also specifies that continued violations are subject to a fine of up to $500 per day. The Division of Industrial Compliance, which is under the Department of Commerce, will realize an increase in administrative, enforcement, and investigative costs associated with this provision.