Maryland
DEPARTMENT OF HEALTH

Maternal and Child Health Population Health Improvement Fund

Program Year Three – FY 2024

Annual Report

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Background

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of healthcare quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. The collaboration also included an agreed upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. In December 2020, the State submitted its proposal for population health priorities of the TCOC Model, which aligns statewide efforts across three domains: hospital quality, care transformation across the system, and total population health. Under the third domain, total population health, the State identified three key health priority areas for improvement: diabetes, opioid use, and maternal and child health (MCH). CMMI approved the State's proposal on March 17, 2021.

While the State identified diabetes and opioid use as key population health priority areas in the first year of the TCOC Model, the third priority area—MCH—was not selected until fall 2020. Consistent with the State's guiding principle to select goals, measures, and targets that are all-payer in nature, maternal and child health was deliberately considered as a priority area even though it is not primarily Medicare-focused. The selection of maternal and child health as a priority area reflects its importance in the State and acknowledges both the longstanding history of disparities, as well as the potential for improvement.

The U.S. faces higher maternal and infant mortality rates[1] compared to other industrialized countries, with large racial/ethnic disparities for each outcome. Between 2016 and 2020, Black non-Hispanic women had a maternal mortality ratio (MMR) 2.6 times greater than White non-Hispanic women, a disparity that has persisted since the 1940s. In Maryland, similar disparities in rates were observed for 2016-2020; the Black non-Hispanic MMR was 2.3 times the White non-Hispanic MMR.[2]

In addition, pediatric asthma contributes to increased healthcare utilization and spending, missed school days, and sub-optimal overall health and well-being in Maryland children. Pediatric asthma also has a significant impact on parental productivity. In Maryland, approximately 6.8 percent of children have asthma.[3]

As part of the proposal, the State identified two areas to improve MCH as measured by both overall reduction, as well as stratified by race and ethnicity:

- Severe maternal morbidity rate; and
- Asthma-related emergency department (ED) visit rates for ages 2-17.

[1] A maternal death is defined by the World Health Organization (WHO) as "the death of a female from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy." Source: World Health Organization. (n.d.). https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622

[2] Maryland Department of Health. (2022). *Maryland Maternal Mortality Review: 2022 Annual Report Health – General Article §13-1212.* https://health.maryland.gov/phpa/mch/Documents/MMR/2022%20MMR%20Report.pdf

[3] Centers for Disease Control. (2023). *Table C1: Child Current Asthma Prevalence and Weighted Numbers* [Data file]. Retrieved from https://www.cdc.gov/asthma/brfss/2021/child/tableC1.html

Table 1A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed 2023 Rates, Maryland by Race/Ethnicity

Race	Baseline 2018[4,5]	2023 Year 5 Target	2023 Rate (% Change)	2026 Year 8 Target
NH White	181.4	7.5% decrease	250.7 (+38.2%)	15% decrease
NH Black	334.2	10% decrease	452.3 (+35.3%)	20% decrease
Hispanic	242	10% decrease	282.8 (+16.9%)	20% decrease
NH Asian	249	10% decrease	293.1 (+17.7%)	20% decrease
Other	205.2	10% decrease	294.3 (+43.4%)	20% decrease
Total	243.1	9.6% decrease	319.0 (+31.2%)	18.7% decrease

Table 1B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed 2023 Rates, Maryland by Race/Ethnicity

Race	Baseline 2018[4,5]	2023 Year 5 Target	2023 Rate (% Change)	2026 Year 8 Target
NH White	59.0	7.5% decrease	83.8 (+42.0%)	15% decrease
NH Black	124.3	10% decrease	168.7 (+35.7%)	20% decrease
Hispanic	57.2	10% decrease	66.1 (+15.6%)	20% decrease
NH Asian	93.4	10% decrease	68.4 (-26.8%)	20% decrease
Other	59.5	10% decrease	94.7 (+59.2%)	20% decrease
Total	80.7	9.6% decrease	103.9 (+28.7%)	18.7% decrease

[4] There is a slight variation from what was presented in 2021, because the SMM analysis was analyzed by CRISP with an updated CASE mix file and with code/analysis that is updated by AIM/HRSA and the CDC.

[5] Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data, including blood transfusions. Accessed November 3, 2023.

Table 2. Childhood Asthma-ED Visit Rates per 1,000, Maryland by Race/Ethnicity

Race	Baseline 2018[6,7]	2023 Year 5 Target	2023 Rate (% Change)	2026 Year 8 Target	2026 Year 8 Target
NH White	4.1	3.5	3.3 (-19.5%)	3.0	26% decrease
NH Black	19.1	14.36	14.6 (-23.6%)	9.6	50% decrease
Hispanic	5.4	4.7	6.1 (+13.0%)	4.0	25% decrease
NH Asian	2.7	2.6	3.5 (+29.6%)	2.5	9% decrease
Other	10.6	7.3	8.1 (-23.6%)	5.5	48% decrease
Total	9.2	7.2	7.5 (-21.7%)	5.3	42% decrease

In 2021, the Health Services Cost Review Commission (HSCRC) approved cumulative funding of $40 million across four years (Fiscal Year (FY) 2022 through FY 2025) to support MCH investments led by Medicaid and the Prevention and Public Health Administration (PHPA) under the Maryland Department of Health ("the Department"), in conjunction with the Medicaid HealthChoice managed care organizations (MCOs). This funding has supported the scaling of existing statewide evidence-based programs and promising practices, as well as the expansion of new services for mothers and children. Additionally, using the funding in this manner creates an opportunity for the State to receive federal match funding to nearly double the investment, specifically for the Medicaid programs. Approval of this investment was contingent upon Commissioner approval of the proposed programs (outlined below); the Department and HSCRC staff work in close partnership to oversee and monitor implementation.

Funds are added to hospital annual rates as temporary adjustments through a uniform, broad-based assessment. Hospitals transfer funds to the Maternal and Child Health Population Health Improvement Fund ("the Fund"). The Fund, created through the 2021 Budget Reconciliation and Financing Act (BRFA), receives funding from hospital rates to invest in maternal and child health initiatives, as approved by Commissioners. The Fund is currently slated to sunset in 2025; as of fall 2024, the HSCRC and Department leadership are preparing a formal extension request to the Maryland General Assembly.

The Fund committed $8 million in annual funding from FY 2022 through FY 2025 to support Medicaid initiatives to address severe maternal morbidity, in alignment with the inclusion of MCH as a population health priority area. As noted earlier, these monies are eligible for federal matching dollars, bringing the combined total to $16 million annually. An additional $2 million in annual funding is directed to PHPA to support childhood asthma initiatives and additional interventions to address severe maternal morbidity.

[6] There is a slight variation from what was presented in 2021, because the SMM analysis was analyzed by CRISP with an updated CASE mix file and with code/analysis that is updated by AIM/HRSA and the CDC.
[7] CRISP analysis of HSCRC data, including blood transfusions. Accessed November 3, 2023.

Funding supports the following MCH initiatives within Maryland Medicaid:

- Home Visiting Services pilot expansion;
- Reimbursement for doula services;
- CenteringPregnancy, a clinic-based group prenatal care model;
- HealthySteps, a clinic-based intensive prenatal and postpartum case management framework; and
- MOM Program (formerly the Maternal Opioid Misuse (MOM) Model) expansion/intensive case management for high-risk pregnancies.

Funding to PHPA supports the expansion and/or implementation of mutually-reinforcing programs:

- Asthma home visiting program (Medicaid partnership);
- Community-based asthma home visiting initiatives (all-payer); and
- Community-based perinatal home-visiting services and CenteringPregnancy implementation (all-payer).

The initiatives were selected to build, expand, and sustain existing evidence-informed innovations in the state to ensure a continuum of support services to improve maternal and child health outcomes. These initiatives, while selected previously in FY 2022, support more recently-released action plans such as the Moore-Miller Administration 2024 State Plan, the Department's Women's Health Action Plan (May 2024) and Maryland's State Health Improvement Plan (State Health Improvement Plan).

The Memorandum of Agreement (MOA) between the HSCRC and the Department that governs the Fund requires the Department to submit an annual report that will outline progress toward the Fund's goals.

This document serves as the annual report for the second year of funding and details the progress of the five Medicaid programs and the initiatives under Public Health Services; further outcome measures will be incorporated into future reports as data become available. The report culminates with a report on FY 2024 expenditures and spending plans for upcoming years.

Medicaid Programs

This section presents an overview and implementation update for each of the Medicaid programs supported by the Fund, followed by a synopsis of preliminary data from calendar year (CY) 2023, due to claims run-out.[8]

Home Visiting Services Expansion

Program Overview

In 2017, the Department established a Medicaid Home Visiting Services (HVS) Pilot under the authority of the §1115 HealthChoice demonstration to test a service expansion initiative in Maryland aimed at improving both maternal and child health. This pilot included reimbursement for two evidence-based home visiting models, Healthy Families America (HFA) and Nurse Family Partnership (NFP). Both models employ specific developmental and health screenings, and have an established track record of improving the health

[8] Run-out refers to the length of time that providers are allowed to submit claims after a service has been provided. Providers submitting claims to MCOs have six months following provision of a service for their run-out period.

and well-being of both the birthing parent and the child. Sites requesting coverage for this service must maintain certification of accreditation or fidelity by the national HFA or NFP organization. Effective January 13, 2022, as catalyzed by the Fund, Maryland promulgated regulations that provided coverage for both models to shift from a pilot to a new statewide benefit for Medicaid participants.

Implementation Update-PY3

As of September 2024, there are 16 sites enrolled as Medicaid providers for home visiting services, covering 14 of 24 Maryland jurisdictions. The Department continues to serve as a resource for home visiting programs as they enroll as Medicaid providers and implement Medicaid billing mechanisms.

In CY 2023, there were 5,412 HVS services delivered to 627 unique participants, for an average of 8.6 per participant. The demographic breakdowns of these participants are below. Note: for the tables below and throughout the document, small cell values (counts between one and 10) are suppressed with an asterisk in accordance with CMS' guidelines to protect Medicaid participant confidentiality.

Table 3. Medicaid Home Visiting Services (HVS) Utilization, CY 2023

HVS Utilization	
Total Participants	627
Number of Services	5,412
Services per Participants	8.6

Table 4A. Medicaid Home Visiting Services (HVS) Participant Demographics: Age Groups, CY 2023

Age Groups	HVS
Under 2	398
03 to 11	61
12 to 15	0
16 to 21	30
Over 21	84
Total	573

Table 4B. Medicaid Home Visiting Services (HVS) Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	HVS
Asian	*
Black	119
White	204
Hispanic	220
Native American	*
Other	28
Total	573

Table 4C. Medicaid Home Visiting Services (HVS) Participant Demographics: Regions, CY 2023

Region	HVS
Baltimore City	*
Baltimore Suburban	40
Eastern Shore	142
Southern Maryland	34
Washington Suburban	131
Western Maryland	219
Out of State	*
Total	573

Doula Reimbursement

Program Overview

Effective February 21, 2022, the Department began Medicaid coverage for doula/birth worker services to Medicaid participants. A doula, or birth worker, is a trained professional who provides continuous physical, emotional and informational support to birthing parents before, during and after birth. Certified doulas serving Medicaid participants provide person-centered, culturally competent care that supports the racial, ethnic and cultural diversity of members while adhering to evidence-based best practices.

Under Maryland Medicaid's reimbursement model, doulas provide three kinds of services: prenatal visits, attendance at labor and delivery, and postpartum visits. Medicaid provides coverage for up to eight perinatal (*i.e.,* prenatal and postpartum) visits, as well as attendance at labor and delivery, known as the 8:1 model. The 8:1 model allows for any combination of prenatal and postpartum visits that equals eight or fewer visits per birthing parent. Doulas can enroll as individual providers or be affiliated with a doula

practice that bills for provided services on their behalf. To recruit more doula providers and, in line with other states' rates, Maryland Medicaid increased the reimbursement rate for attendance at labor and delivery in July 2023. All doulas must be trained by one of 30 Medicaid-approved doula certifying organizations. The Department is continually expanding this list to increase the number of enrolled doulas, as detailed below.

Doula Implementation - PY3 Update

As of the beginning of October 2024, there are 26 doulas enrolled as Medicaid providers. During the year, the Department monitored doula provider enrollment and implemented several measures to build out the network. First, the Department permitted MCOs to use single case agreements with doulas until network adequacy requirements are reached. Second, the Department updated its regulations, effective June 2024, to: 1) facilitate quicker expansion of the number of approved doula certification organizations; and 2) make the doula benefit self-referral until 2025–a temporary removal of an administrative step for the doulas, *i.e.,* contracting with MCOs after registering Medicaid providers with the Department. Third, Medicaid implemented a bi-annual nominations process to add additional certification programs, in order to increase the number of doulas who are eligible to become Medicaid providers. As of September 2024, there are 30 approved certification organizations. Lastly, as noted earlier, the Department increased the rate for attendance at labor and delivery from $350 to $800 on July 1, 2023.

In CY 2023, 220 doulas services were delivered to 69 unique Medicaid participants, for an average of 3.2 services per participant. The demographic breakdowns of these participants are below. Maryland Medicaid will continue its efforts to partner with the Department's Maternal and Child Health Bureau (MCHB) to promote the doula benefit and bolster the doula workforce across the state.

Table 5. Medicaid Doula Services Utilization, CY 2023

Doula Utilization				
	Prenatal	**Labor and Delivery**	**Postpartum**	**Total**
Total Participants	55	*	*	**69**
Number of Services	188	*	*	**220**
Services per Participants	3.4	*	*	**3.2**

Table 6A. Medicaid Doula Services Participant Demographics: Age Groups, CY 2023

Age Groups	Doulas
Under 2	0
03 to 11	0
12 to 15	*
16 to 21	*
Over 21	59
Total	61

Table 6B. Medicaid Doula Services Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	Doulas
Asian	*
Black	42
White	*
Hispanic	*
Native American	*
Other	*
Total	61

Table 6C. Medicaid Doula Services Participant Demographics: Regions, CY 2023

Region	Doulas
Baltimore City	*
Baltimore Suburban	23
Eastern Shore	*
Southern Maryland	*
Washington Suburban	23
Western Maryland	*
Out of State	0
Total	61

CenteringPregnancy

CenteringPregnancy

Starting in 2022, the Department utilized the Fund to expand access to innovative approaches to prenatal care through CenteringPregnancy. CenteringPregnancy is an evidence-based group prenatal care model for low-risk pregnancies. The model focuses on three core components: health assessment, interactive learning and community building. Facilitators support a cohort of eight to 10 individuals of similar gestational age through a curriculum of 10, 90- to 120-minute interactive group prenatal care visits that largely consist of discussion sessions. Discussion topics include medical and non-medical aspects of pregnancy, such as nutrition, common discomforts, stress management, labor and birth, breastfeeding and infant care. Studies have shown that CenteringPregnancy improves health outcomes, such as decreased risk of preterm birth, as well as improves patient satisfaction. [9]

CenteringPregnancy Implementation - PY3 Update

Following an MCO infrastructure support program in CY 2022, effective January 1, 2023, the Department began paying an enhanced rate to CenteringPregnancy providers for prenatal care visits. The enhanced payment supports the overall operations of CenteringPregnancy practices and may be billed alongside the typical prenatal care procedure code for up to 10 perinatal care visits per pregnancy (*i.e.,* the period from conception to 60 days postpartum).

There are three active CenteringPregnancy practices in Maryland as of October 2024, including one funded by the MCHB's grant (additional detail under 'Public Health Programs', below). Medicaid anticipates that the rest of MCHB's funded providers will work towards the CenteringPregnancy model implementation, and enroll as Medicaid providers in 2025 due to the partnership and grants from the Department's MCHB.

In CY 2023, 777 CenteringPregnancy services were billed for 357 unique participants, for an average of 2.2 per participant, the demographic breakdown is below. The Department believes these numbers may be artificially low due to underbilling, as CY 2023 was the first year of implementation of the enhanced rate. To increase uptake and monitor adherence, Medicaid and the Centering Healthcare Institute, CenteringPregnancy's parent organization, continue to partner to support providers. Medicaid attends the bi-annual Centering Consortium of Maryland to connect with providers, answer Medicaid-related questions, and encourage provider enrollment in Medicaid. The Centering Healthcare Institute and Medicaid collaborate in the event that issues arise between Consortium meetings.

[9] Centering Healthcare Institute. (2020). *Centering Saves Lives & Money.* Centering Healthcare Institute: Payment Policy & Advocacy. Downloaded from: https://centeringhealthcare.org/why-centering/payment.

Table 7. Medicaid CenteringPregnancy Utilization, CY 2023

CenteringPregnancy Utilization	
Total Participants	345
Number of Services	864
Services per Participants	2.5

Table 8A. Medicaid CenteringPregnancy Participant Demographics: Age Groups, CY 2023

Age Groups	Centering Pregnancy
Under 2	0
03 to 11	*
12 to 15	*
16 to 21	66
Over 21	281
Total	357

Table 8B. Medicaid CenteringPregnancy Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	Centering Pregnancy
Asian	*
Black	127
White	49
Hispanic	164
Native American	*
Other	12
Total	357

Table 8C. Medicaid CenteringPregnancy Participant Demographics: Regions, CY 2023

Region	Centering Pregnancy
Baltimore City	61
Baltimore Suburban	48
Eastern Shore	32
Southern Maryland	*
Washington Suburban	158
Western Maryland	56
Out of State	*
Total	357

HealthySteps

Program Overview

Starting in 2022, the Department utilized the Fund to expand access to innovative approaches to early childhood well-being through HealthySteps. HealthySteps, a program of the national accrediting body ZERO TO THREE[10], is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened and placed into a tiered model of services of risk-stratified supports, including care coordination and on-site intervention at accredited, or pending accreditation HealthySteps sites. The HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide referrals to external services, and follow-up to the whole family.

HealthySteps Implementation - PY3 Update

Similar to CenteringPregnancy, on January 1, 2023 the Department began providing an enhanced payment for evaluation and management (E&M) services rendered by providers at a HealthySteps sites categorized as accredited or pending accreditation, following an MCO infrastructure support program. Like CenteringPregnancy, the enhanced payment supports the overall operations of HealthySteps practices, including the salary of the HealthySteps Specialist. The enhanced payment should be billed alongside each well-child visit or E&M service the child receives, regardless of the tier the child is placed into.

There is one eligible provider in Maryland (University of Maryland Pediatrics Associates) and three in DC (MedStar Georgetown - MedStar Medical Group at Fort Lincoln, Children's National - Children's Health Center at THEARC, and Anacostia locations), however in 2023 only one provider billed HealthySteps

[10] What We Do. (n.d.). https://www.healthysteps.org/what-we-do/

services. In addition, Kaiser Permanente transformed its practices in South Baltimore and Woodlawn into HealthySteps sites to comply with the new Medicaid requirement in late 2023. Maryland's implementation of the HealthySteps program, including the enhanced Medicaid payment, was recognized by the Prenatal-to-3 Policy Impact Center at Vanderbilt University in 2023.[11]

Maryland's efforts align closely with recent CMS guidance,[12] clarifying Early and Periodic Screening, Diagnosis and Treatment requirements for Medicaid and CHIP, in its emphasis on improving care for children with specialized needs, early identification, and family-centric treatment of pediatric mental health disorders.

In CY 2023, 3,176 HealthySteps services were billed for 1,372 unique participants, for an average of 2.3 services per participant, the demographic breakdown is below. The Department believes these numbers may be artificially low due to underbilling, as CY 2023 was the first year of implementation of the enhanced rate. In tandem, the University of Maryland conducted a quality improvement study on its HealthySteps site that demonstrated a variable, but improved rate of reimbursement of the HealthySteps service over the course of the year, after monthly reminders and education of residents and attending physicians.13 Maryland Medicaid will continue to work closely with ZERO TO THREE, along with HealthySteps providers, to promote the enhanced payment of rendered HealthySteps services.

Maryland Medicaid staff continue this engagement with partners through external opportunities, including presenting at the 2024 Pediatric Mental Health Summit, and updating policy experts on Maryland's strategy to support HealthySteps practices. Moreover, Maryland Medicaid staff work alongside HealthySteps providers in the State by serving on the advisory board for the Health Resources and Services Administration's (HRSA) Transforming Pediatrics for Early Childhood (TPEC), University of Maryland and Johns Hopkins University High Five for P-5: Improving Health Equity Through Early Child Development Supports.

It is important to note that the reimbursement model allows for an enhanced payment service to be billed alongside each well-child visit provided at a HealthySteps site. However, this reimbursement model–and the resulting Medicaid data–do not reflect the intensity of services received by each patient according to their tier; therefore, a 'dose-response' evaluation cannot be used for HealthySteps services.

[11] Prenatal-to-3 Policy Impact Center. 2023 Maryland Roadmap Summary. https://pn3policy.org/pn-3-state-policy-roadmap-2023/md/

[12] State Health Office Letter [#24-005]: RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements. September 26, 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

[13] Onigbanjo M, Connors, K, and Edwards, S "Using Enhanced Rates to Support and Financially Maintain a HealthSteps Program at a Primary Care Practice". Poster Presentation. Pediatric Academic Societies Region IV Annual Meeting, Charlottesville, VA. February 24, 2024

Table 9. Medicaid HealthySteps Utilization, CY 2023

HealthySteps Utilization	
Total Participants	1,370
Number of Services	3,171
Services per Participants	2.3

Table 10A. Medicaid HealthySteps Participant Demographics: Age Groups, CY 2023[14]

Age Groups	HealthySteps
Under 2	974
03 to 11	395
12 to 15	0
16 to 21	*
Over 21	*
Total	1,370

Table 10B. Medicaid HealthySteps Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	HealthySteps
Asian	*
Black	1,162
White	60
Hispanic	46
Native American	*
Other	73
Total	1,370

[14] As HealthySteps services are for those ages zero to three, any claim for individuals above aged 4 is considered a billing error.

Table 10C. Medicaid HealthySteps Participant Demographics: Regions, CY 2023

Region	HealthySteps
Baltimore City	981
Baltimore Suburban	365
Eastern Shore	*
Southern Maryland	*
Washington Suburban	13
Western Maryland	*
Out of State	0
Total	1,370

MOM Case Management Services (MOM Program)

Program Overview

The MOM program addresses fragmentation in the care of pregnant and postpartum Medicaid participants with opioid use disorder (OUD) through enhanced case management services, with an emphasis on increasing health service utilization, as well as screening and referral for social determinants of health.

Initially funded as part of a CMMI demonstration, the MOM program has supported efforts in increasing provider capacity to treat the maternal OUD population; in addition, in FY 2022, the demonstration funded a per member, per month (PMPM) payment to MCOs for the enhanced case management services. Starting July 1, 2022, the payments transitioned to the Fund, with federal matching dollars authorized under the §1115 HealthChoice demonstration. As of January 1, 2023, Maryland has ceased its participation in the federal CMMI demonstration; implementation of MOM case management services continued seamlessly.

MOM Program Implementation - PY3 Update

MOM program services started on July 1, 2021 as a pilot in St. Mary's County, continuing for one year before expanding to select counties a year later. Starting January 1, 2023, the MOM program became available statewide, open to all eligible HealthChoice members. As of the end of September 2024, there have been 106 participants in the MOM program; the demographic breakdown of those who participated in CY 2023 is below. Program participants to date have demonstrated an interest in engaging in treatment for their OUD, as well as efforts to change life circumstances, including enrolling in educational courses, learning to drive and securing stable housing. The program experienced a sharp increase in enrollment following the statewide expansion.

In CY 2023, the Department leveraged support from both the Fund and CMMI to continue two partnerships–with the Maryland Addiction Consultation Service (MACS) and Bowie State University–to augment MOM's impact. Through the partnership, MACS continued the MACS for MOMs program to build provider capacity to better treat the maternal OUD population. The program includes teleECHO clinics, a warmline for phone consultations, and a variety of trainings, including those for receiving a DATA 2000 Waiver which allows providers to prescribe buprenorphine. To strengthen the MOM program by making it more attractive to communities of color, the Department partnered with Historically Black Colleges and Universities (HBCUs), led by Bowie State, to tailor the program to be more culturally responsive to Maryland's Black population.

Bowie State University finished their research in December 2023. Their study examined wrap-around social service providers who were outside of the MOM program, but who have successfully recruited and retained women from similarly stigmatized populations. Many participants praised the MOM program and expressed beliefs about its value and potential to be impactful to the clients it aims to serve. Funding for MACS for MOMs has since transitioned over to MCHB. During this year, MACS for MOM is conducting a needs assessment to understand what further challenges and resources are needed.

Table 11. Medicaid MOM Program Utilization, CY 2023

MOM Utilization	
Total Participants	57
Number of Services	250
Services per Participants	4.4

Table 12A. Medicaid MOM Participant Demographics: Age Groups, CY 2023

Age Groups	MOM
Under 2	0
03 to 11	0
12 to 15	*
16 to 21	*
Over 21	56
Total	57

Table 12B. Medicaid MOM Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	MOM
Asian	0
Black	*
White	46
Hispanic	*
Native American	*
Other	*
Total	57

Table 12C. Medicaid MOM Participant Demographics: Regions, CY 2023

Region	MOM
Baltimore City	*
Baltimore Suburban	16
Eastern Shore	*
Southern Maryland	*
Washington Suburban	*
Western Maryland	24
Out of State	0
Total	57

PY3 Medicaid Performance

To assess the outcomes of the Maryland Medicaid MCH Initiatives, the Hilltop Institute at the University of Maryland, Baltimore County analyzed the administrative data from the program participants, based off of several relevant HEDIS measures. For the purposes of the analysis, all program participants were identified based on FFS claims and MCO encounters that include the program-specific procedure codes, provider types, and ICD-10 diagnosis codes designated by the Department.

Due to enrollment increases, the PY3 report is the first year that there is a sufficient number of participants for the metrics to be reported at the program level. Results are presented for enrollees who had at least one qualifying visit as well as enrollees who met the minimum evaluation inclusion criteria. To meet the inclusion criteria for the evaluation, HVS, HealthySteps, doula services, and CenteringPregnancy participants

were required to have at least three visits, and MOM program participants had to be enrolled in the program for at least three months. All enrollees who met the inclusion criteria and were enrolled after their respective programs' start dates were flagged as evaluation-eligible. It is important to note that many of the measure criteria also include a delivery in 2023, which reduces the number of participants included below.

All records were deduplicated so that each enrollee had one record that contained their enrollment start date, the number of program visits or number of months enrolled, and the evaluation eligibility flag. Each enrollee was then sorted into a cohort by calendar year according to the enrollment start date. Thereafter, the demographic variables birth data, sex, and region were obtained and merged from Hilltop Medicaid data sets. The 1184 newborn data set was used to merge infants to their mothers and mothers to their infants where possible, keeping the infants' birth weight, sex, and date of birth.

Separately, Hilltop used the diagnoses and the revenue and procedure codes provided by the Department to identify claims and encounters for cesarean section deliveries, SMM, and birth complications. Identified claims and encounters were collapsed so that there was only one record per enrollee with flags indicating if they experienced the above medical conditions. HEDIS software was used to provide the flags indicating whether enrollees had timely prenatal visits, postpartum care, childhood immunizations, child well-care visits and neonatal intensive care unit (NICU) admission for CY 2023. Medical and procedure flags were then merged with the cohort data sets to create a data set of mother and infant pairs with enrollee demographics and evaluation and measure flags.

It should be noted that although enrollment has increased, the sample size is small for certain programs. Therefore, care should be used when interpreting some of the results. Again, for the tables below and throughout the document, small cell values (less or equal to 10) are suppressed with an asterisk in accordance with CMS' guidelines to protect Medicaid participant confidentiality.

Data Results

Note: In the tables below, 'denom' stands for denominator, and 'numer' stands for numerator.

Timely Initiation of Prenatal Care

Prenatal care plays a crucial role in supporting healthier pregnancies and infants; the early initiation of prenatal care - ideally in the first trimester - is particularly important. The preliminary data presented in the PY 2 report identified the timely attendance at a prenatal visit metric as a potential place for growth. The three benefits that had sufficient CY 2023 data to report ranged from a 36.1 percent (HVS) to a 58.1 percent completion rate (doula services), indicating that there is still room for improvement.

Table 13. Deliveries in where Participant had a Prenatal Visit in the First Trimester, on or before the Enrollment Start Date or within 42 Days of Enrollment in the Organization, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	13	36.1%	28	*	*
Doula Services	31	18	58.1%	18	*	*
CenteringPregnancy	73	40	54.8%	60	34	56.7%
MOM	25	*	*	22	*	*

Postpartum Care Visits - Seven through 84 Days

After giving birth, a postpartum care visit provides an important opportunity to evaluate the birthing individual's healing from labor and delivery, in addition to screening for postpartum depression. The PY 2 report also identified timely attendance at a postpartum visit metric as another potential place for improvement. This year's data shows a similar trend, reinforcing the idea that there is opportunity for growth in this area. The two benefits that had sufficient data to publish, doula services and CenteringPregnancy, ranged from 56.7 percent to 60.0 percent completion of a timely postpartum visit within 7 and 84 days of delivery.

Table 14A. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 84 days after Delivery, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	*	*	28	*	*
Doula Services	31	17	54.8%	18	*	*
CenteringPregnancy	73	42	57.5%	60	36	60.0%
MOM	25	*	*	23	*	*

Postpartum Care Visits - Seven through 84 Days

As part of discussions to improve timely attendance at a postpartum visit, stakeholders raised the possibility that participants are attending postpartum visit beyond the 84 day postpartum period due to lack of appointment availability. To account for this, the analysis added an additional metric which extended the time period of postpartum visit to 120 days following the birth. The CY 2023 data shows a minimal improvement for HVS and CenteringPregnancy data and no change for the doula services.

Table 14B. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 120 days after Delivery, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	11	30.6%	28	*	*
Doula Services	31	17	54.8%	18	*	*
CenteringPregnancy	73	44	60.3%	60	37	61.7%
MOM	25	*	*	22	*	*

Cesarean Births

While cesarean births can be warranted in some cases, reducing unnecessary cesareans is a priority in maternal health. In CY 2023 only one of the benefits, CenteringPregnancy, had a reportable number of cesarean births. There was a notable difference between the groups that had any services and those who met evaluation criteria.

Table 15. Deliveries that were Cesarean Section among Participants, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	*	*	28	*	*
Doula Services	31	*	*	18	*	*
CenteringPregnancy	73	44	60.3%	60	24	40.0%
MOM	25	*	*	22	*	*

Severe Maternal Morbidity

As outlined above (see *Background*), SMM is an area of particular importance to the State. The CY 2023 data shows preliminary positive results for this metric: two of the benefits had no instances of SMM and the remaining two each had very few instances of it.

Table 16. Pregnancies Associated with Severe Maternal Morbidity among Participants, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	*	*	28	*	*
Doula Services	31	0	0.0%	18	0	0
CenteringPregnancy	73	*	*	60	*	*
MOM	25	0	0.0%	22	0	0

Birth Complications

Birth complications, while related to SMM, refer to any problems that occur during labor and delivery that affect the birthing parent or baby.[15] As with any type of medical complication, reducing ones that occur during birth are a priority. The CY 2023 data is extremely promising - none of the benefits had a single instance of a birth complication during this time.

Table 17. Percentage of Deliveries that had Birth Complications among MCH Participants, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	0	0.0%	28	0	0.0%
Doula Services	31	0	0.0%	18	0	0.0%
CenteringPregnancy	73	0	0.0%	60	0	0.0%
MOM	25	0	0.0%	22	0	0.0%

Infant Birth Weight

Infant birth weight can be a good indicator of the newborn's overall health. Low birth weight (less than 2,500 grams) and very low birth weight (less than 1,500 grams)[16] can be caused by a variety of factors including gestational age, multiple gestation pregnancies, maternal health, and environmental factors.

In CY 2023, the proportion of infants of normal birth weight whose birthing parent was enrolled in HVS, doula services, and CenteringPregnancy ranges from 89.3 percent to 94.4 percent. The proportion of infants of normal weight whose birthing parent was enrolled in in the MOM program

[15] Only around 3 percent of the birth complication ICD-10 codes appear on the list of SMM codes, primarily ones related to anesthesia complications.

[16] Centers for Disease Control. (2024). *Birthweight and Gestation.* https://www.cdc.gov/nchs/fastats/birthweight.htm

increased from 80 percent to 86.4 percent when any dose was compared with those who meet inclusion criteria. The reason that a smaller proportion of individuals in the MOM program have an infant of a normal birth weight may be related to the fact that those with prenatal exposure of opioids are at a greater risk of being of low birth weight.[17]

Table 18A. Newborns who are Normal, Low, or Very Low Birth Weight for all Participants Enrolled before Delivery, CY 2023

	CY 2023				
	Denom	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight	
				Counts	Percent
HVS	36	*	*	33	91.7%
Doula Services	31	*	*	28	90.3%
CenteringPregnancy	73	*	*	68	93.2%
MOM	25	*	*	20	80.0%

Table 18B. Newborns who are Normal, Low, or Very Low Birth Weight for all Participants Enrolled before Delivery and who meet the Inclusion Criteria, CY 2023

	CY 2023				
	Denom	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight	
				Counts	Percent
HVS	28	*	*	25	89.3%
Doula Services	18	*	*	17	94.4%
CenteringPregnancy	60	*	*	55	91.7%
MOM	22	*	*	19	86.4%

Neonatal Intensive Care Unit (NICU) Admissions

In cases where a newborn is experiencing health issues following its birth, they may be admitted to a NICU of a hospital. While important for treatment, these admissions can be stressful for the family and newborn, as well as costly. The CY 2023 data appears promising regarding NICU hospitalizations. For any participants of any dose, two of the four benefits had zero NICU admissions and for those who met evaluation criteria, only one benefit had any participants admitted to the NICU.

[17] Yen, E., & Davis, J. M. (2022). The immediate and long-term effects of prenatal opioid exposure. Frontiers in pediatrics, 10, 1039055. https://doi.org/10.3389/fped.2022.1039055

While MOM did have some infants admitted to the NICU, it was a very small number. This is notable as infants exposed to opioids or medications for the treatment of OUD are at risk for a condition called neonatal abstinence syndrome (NAS) which often requires them to be admitted to the NICU.

Table 19. Percentage of Infants with a NICU Admission near Date of Birth, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	0	0.0%	28	0	0.0%
Doula Services	31	*	*	18	0	0.0%
CenteringPregnancy	73	0	0.0%	60	0	0.0%
MOM	25	*	*	22	*	*

Child Well-Care Visits

An important tool for keeping children healthy is that they receive a well-child visit from a provider at the cadence recommended by the American Academy of Pediatrics. The CY 2023 data shows that around one quarter of HVS participants and up to 43 percent of HealthySteps participants had received a well-care visit during the calendar year. The Department's Health Choice evaluation shows that, for 2022, 57 percent of Medicaid participants received their well-child visits in the first 15 months.[18] The Department will continue to investigate these rates, and work with MCOs and providers to increase the rate of well-child visits among its participants.

Table 20. Number of Children with at least one Qualifying Visit who Received a Well-Care Visit during the Calendar Year by Program Enrollment, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	361	87	24.1%	297	74	24.9%
HealthySteps	1,151	495	43.0%	394	73	18.5%

[18] The Hilltop Institute. (2024, June 30). Evaluation of the Maryland Medicaid HealthChoice program: CY 2018 to CY 2022. https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice%20Monitoring%20and%20Evaluation/HealthChoice%20Post-Award%20Forum/2024/Final%20HealthChoice%20Evaluation%20CY%202018-CY%202022.docx.pdf

Childhood Immunizations

As part of the well-care visits described above, children receive immunizations against a variety of diseases at a set schedule. By the age of two, children should have received the following vaccines: diphtheria, tetanus, and acellular pertussis (DTAP); polio (IPV); measles, mumps, and rubella (MMR); haemophilus influenzae type B (HiB); hepatitis B (HepB); chicken pox (VZV); pneumococcal conjugate (PCV); hepatitis A (HepA); rotavirus (RV); and influenza (Influ); several of which are combined into "combination 3". In CY 2023, MMR had the largest completion rate and influenza had the smallest.

Table 21A. Number of Children Aged 2 Years Old Enrolled in Home Visiting Services (HVS) that Received Childhood Immunizations, CY 2023

	CY 2023												
		DTAP		IPV		MMR		HiB		HepB		VZV	
	Denom	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
At Least One Qualifying Visit	49	29	59.2%	37	75.5%	40	81.6%	39	79.6%	30	61.2%	40	81.6%
Meets Eval. Inclusion Criteria	40	21	52.5%	29	72.5%	32	80.0%	31	77.5%	24	60.0%	32	80.0%

Table 21A. Cont.

	CY 2023										
		PCV		HepA		RV		Influ		Combo 3	
	Denom	Count	%	Count	%	Count	%	Count	%	Count	%
At Least One Qualifying Visit	49	33	67.3%	39	79.6%	31	63.3%	19	38.8%	23	46.9%
Meets Eval. Inclusion Criteria	40	25	62.5%	31	77.5%	23	57.5%	15	37.5%	17	42.5%

Table 21B. Vaccination Acronym List

DTAP	Diphtheria, Tetanus and Acellular Pertussis	**PCV**	Pneumococcal conjugate
IPV	Polio Vaccine	**HepA**	Hepatitis A
MMR	Measles, Mumps and Rubella Vaccine	**RV**	Rotavirus
HiB	Haemophilus Influenzae type B Vaccine	**Influ**	Influenza
HepB	Hepatitis B	**Combo 3**	Combination 3 (DTaP, IPV, MMR, HiB, HepB, VZV, PCV)
VZV	Chicken Pox Vaccine		

Public Health Programs

The Public Health Services/Prevention and Health Promotion Administration administers funds to improve maternal and child health. Specifically, for the Fund, the MCHB implements the maternal health initiatives, and the Environmental Health Bureau (EHB) implements initiatives related to asthma.

Maternal Health Initiatives

Home Visiting Expansion

Program Overview

Home visiting programs can impact maternal morbidity in different ways, including: 1) creating human- to-human relationships that enable home visitors to provide tailored support based on the specific needs of each family; 2) reducing pregnancy induced hypertensive disorders, preterm birth, and maternal depression; 3) creating connections between mothers and health practitioners in the community, breaking down barriers to care, and strengthening the link between healthcare resources and the families who need them; 4) providing screenings for maternal depression both prenatal and postpartum and connecting mothers in need with the appropriate community-based behavioral health care; 5) providing referrals for mothers when certain risk factors, including trauma or domestic violence, are present in the home; and 6) targeting social determinants of health (SDOH) affecting families, such as social support, parental stress, access to health care, income and poverty status and environmental conditions.[19]

The Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) funds 12 jurisdictions and 15 programs that meet federal evidence-based criteria across Maryland. Maryland Medicaid reimburses three MIECHV sites operating under the Nurse-Family Partnership and Healthy Families America models. As part of the Department's efforts to improve maternal and population health, the Department is awarding a total of $2.26 million over three years (August 15, 2022 through June 30, 2025) to four sites through the Fund.

Implementation Update

Since Fall 2022, the Department has supported four sites to provide expanded home visiting models. Two sites (Montgomery County and Washington County) are utilizing funds to expand existing home visiting programs, while the other two sites (Baltimore Healthy Start and Family Tree) utilize funds to pilot a new, evidence-based home visiting curriculum. What follows is a brief description of each of the four sites.

> **Montgomery County Health Department** utilizes funding to expand its Babies Born Healthy (BBH) program, a prenatal care coordination initiative that connects its participants to home visiting services and offers the March of Dimes Becoming Mom (BAM) curriculum for all BBH participants who wish to participate through group classes or individual sessions. This program enhances maternal understanding through a collaborative community-based model of care, offering prenatal education and ensuring access to quality prenatal care. The program focuses on providing services to

[19] American Academy of Pediatrics. Home visiting to Reduce Maternal Mortality and Morbidity Act. https://www.socialworkers.org/LinkClick.aspx?fileticket=7mhUWCPtNL4%3D&portalid=0

the following high-risk zip codes in Montgomery County: 20903, 20904, 20906, and 20912.

Washington County Health Department began the expansion of their existing home visiting services via the local program affiliate of HFA, which is currently funded by MIECHV. The program successfully organized and conducted three virtual family groups, with an average monthly attendance of 18 families. The virtual family groups have proven invaluable, facilitating meaningful connections among families, providing essential parenting insights, and creating a platform for the sharing of experiences. The Washington County Health Department is a Medicaid-enrolled HVS provider, meaning that the expansion will further benefit the Fund's Medicaid investments as well.[20]

Baltimore Healthy Start (BHS) collaborated with Chase Brexton Glen Burnie Health Center, Total Health Care, and with the Administrative Care Coordination Unit (ACCU) of the Anne Arundel County Department of Health to expand home visiting services to postpartum women in the following zip codes: 20724, 21060, 21061, 21225 and 21226. This initiative utilizes the Great Kids curriculum, designed for home visits to commence from prenatal to when a child reaches 36 months of age. In addition to the home visits, families who are in need of the services are offered the standard BHS case management and care coordination services through Baltimore Healthy Start's clinical partner. In summer 2024, BHS shifted its partnership from Chase Brexton Glen Burnie to Total Health Care, with which it has existing relationships in Baltimore City.

The Family Tree facilitated the expansion of home visiting services in Baltimore City through the Parents as Teachers (PAT) model. Home visitors conduct regular visits, supporting families from pregnancy through their child's kindergarten year. The PAT curriculum addresses critical areas including mental health, nutrition, maternal depression, substance use and domestic violence. In FY 2023, the program received certification to operate as a PAT-affiliated site from the Parents as Teachers National Center, successfully recruited and onboarded staff to empower the growth of the PAT home visiting initiative. The program's collaborative efforts extended to partnerships with the following organizations: Health Care Access Maryland (HCAM), Urban Strategies, and The Parent Helpline.

Collectively between FY 2022 and FY 2024, Fund-supported Home Visiting Expansion Initiatives enrolled over 109 families to home visiting programs in priority jurisdictions. Table 22 indicates the number of those enrolled by race and ethnicity and Table 23 indicates the number of enrolled by insurance provider. The majority of the home visiting sites experienced challenges with recruitment of staff for the expansion of their programs. The Department will continue to provide technical support to its Fund grantees in FY 2025 to enhance the enrollment of all home visiting sites to improve SMM rates in the state.

[20] Washington County Health Department is an approved Medicaid HVS provider therefore solely Medicaid funds were used for Medicaid participants.

Table 22: Number of Enrolled in Fund-Supported Home Visiting Expansion by Race/Ethnicity

Race/Ethnicity	No. Enrolled
non-Hispanic White	*
non-Hispanic Black	82
Hispanic	14
Asian	*
Native American/ Alaska Native	*
Multiracial NOT Hispanic	*
Multiracial and Hispanic	*

Table 23: Number of Enrolled in Fund-Supported Home Visiting Expansion by Insurance

Enrolled Insurance Type	No. Enrolled
Medicaid	93
Private	*
Uninsured	13
Other	*

Increasing Access to CenteringPregnancy Sites

Program Overview

The effectiveness of CenteringPregnancy is shown most dramatically among Black birthing persons in Maryland, who disproportionately experience adverse maternal outcomes. In response to the disproportionate (SMM) severe maternal morbidity rates affecting Black birthing persons in Maryland, the Department has reserved a total of $429,197 for a period of three years (from FY 2022 to FY 2025) to fund the implementation of CenteringPregnancy in seven additional sites across Maryland. In alignment, participating practices may be eligible for Medicaid's CenteringPregnancy enhanced reimbursement benefit, detailed above.

Implementation Update

During FY 2022 to FY 2025, funding was allocated to expand CenteringPregnancy in five new sites across Maryland. In FY 2024 and FY 2025, the MCHB also braided funding with its BBH program, to fund an

additional six sites. This expansion will result in a total of 11 funded sites and aims to enhance quality maternal healthcare access, particularly for at-risk populations.

Mercy Health Foundation received funding in FY 2022 through April 2024. Funds supported the launch of CenteringPregnancy at one of their OB/GYN practices in downtown Metropolitan Baltimore. As of April 2024, Mercy Health Foundation has successfully enrolled 156 individuals and hosted 29 Centering cohorts over two years. They achieved accreditation in July 2024.

Since 2022, the Department has partnered with the **Centering Healthcare Institute** to support the recruitment and provision of start-up funds to sites interested in implementing the CenteringPregnancy model. Based on an open application process and assessment of readiness, four prenatal clinics, strategically located in Baltimore County, Montgomery County, and Prince George's County, were recruited in FY 2023 and FY 2024. Utilizing the braided BBH funding, Centering Healthcare Institute recruited an additional four sites in FY 2024, located in Baltimore City, Frederick, and Montgomery Counties. The eight currently-funded clinics are:

- Kaiser Gaithersburg in Montgomery County
- Mary's Center Silver Spring in Montgomery County
- University of Maryland St. Joseph's Women's Health Associates in Baltimore County
- Luminis Health Greenbelt in Prince George's County
- Frederick Health in Frederick County
- Baltimore Medical System at Yard 56 in Baltimore City
- CCI Health Silver Spring in Montgomery County
- Lifebridge Sinai Hospital in Baltimore City

Currently, St. Joseph's is enrolled with Medicaid to bill for the enhanced rate. The Department anticipates that sites will complete their implementation plans, apply for accreditation, and enroll Medicaid providers between November 2024 and July 2025. Site timelines may differ depending if they entered during the two-year Centering Implementation Plan, or the one-year Centering365 model. All sites receive the same high-quality technical assistance, training, and support from the Centering Healthcare Institute. Once accredited or pending accreditation, Maryland Medicaid provides enhanced reimbursement to CenteringPregnancy-certified providers and MCOs that are enrolled in the CenteringPregnancy model, thus allowing for sustainability.

Improving Childhood Asthma Initiatives

Program Overview

Environmental home visiting programs have been shown to improve asthma outcomes, including adolescent asthma, by addressing asthma triggers in the home and other related environments. This section describes the efforts of the Department to improve childhood asthma outcomes. The Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program benefits children suffering from moderate to severe asthma by providing up to six home visits from a local health department (LHD) community health worker (CHW), facilitated by a supervising case manager. The

program emphasizes cooperative goal setting with the family to reduce or eliminate asthma triggers such as environmental tobacco smoke, pets, fabrics, the presence of vermin due to inadequate sanitation, or other critical objectives.

In addition to the identification of environmental triggers, the follow up visits include parent education and provision of supplies shown to reduce asthma severity, including a high efficiency particulate air (HEPA) vacuum cleaner and other interventions demonstrated to improve outcomes for children with moderate to severe asthma.

Implementation Update

The Department has utilized funds from Maryland Medicaid's CHIP Health Services Initiative (HSI) to support the Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program operating in 11 jurisdictions: Anne Arundel, Baltimore, Charles, Dorchester, Frederick, Harford, Montgomery, Prince George's, St. Mary's, and Wicomico Counties, as well as Baltimore City.

The program also ensures care coordination amongst providers who interact with the child through the use of asthma action plans. In FY 2024, 897 children with asthma received services through this program. In support of the goal of addressing health disparities, 72 percent of the children with asthma served in the program were Black or African American.

Table 24. Children with moderate to severe asthma served in the Medicaid/CHIP Home Visiting program, by jurisdiction (2020-2024)[21]

Jurisdiction	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Anne Arundel*	-	-	-	92	158
Baltimore	*	*	14	122	146
Baltimore City	17	40	183	251	331
Charles	46	*	*	11	*
Dorchester	86	17	24	57	32
Frederick	13	12	*	18	24
Harford	263	109	82	96	59
Montgomery*	-	-	-	23	72
Prince George's	49	31	84	36	12
St. Mary's	0	53	36	35	35
Wicomico	54	38	85	66	22
Total	530	315	521	807	897

[21]The addition of Anne Arundel and Montgomery County, and expanded staffing of the 9 original jurisdictions, was made possible in 2022 with additional funding through the Health Services Cost Review Commission. That funding ends in 2025.

Improving Referrals to Local Health Department Asthma Home Visiting Programs

One of the most significant challenges to the Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program is recruiting families into the program. The Department developed several strategies to improve the referral process, including:

- Finder files developed by the Hilltop Institute using fee-for-service (FFS) claims as well as MCO encounters to identify children who may be eligible for services, which are then distributed to LHD nurse case managers;
- Care alerts to health care providers through the state's health information exchange, Chesapeake Regional Information System for our Patients (CRISP);
- Direct electronic referrals to LHDs of children recently discharged from emergency departments or inpatient admissions for asthma exacerbations through CRISP; and
- Direct referrals from hospitals and managed care organizations to LHD home visiting programs.

Taken together, these strategies have significantly increased referrals to LHD home visiting programs and improved the recruitment of families into the program. In particular, on September 8, 2022, the first direct electronic referrals of children with recent emergency department visits or hospitalizations due to asthma were from CRISP to LHDs and have continued at the rate of at least 10 children per LHD per week. Table 25 below shows the growth in and impact of CRISP referrals on asthma enrollment in the home visiting program over time. It should be noted that the decrease in 2024 is due in part to the fact that it includes totals only through June 30, 2024, and a technical programming error that resulted in several weeks of interrupted referrals to the LHDs that have since been corrected.

Table 25. Number and Status of Children Referred to Local Health Department Home Visiting Programs by CRISP, 2022-2024

Status of Child/Family	CY 2022	CY 2023	CY 2024	Total
Attempting to enroll/determine eligibility	53	64	63	180
Could not contact family	360	787	349	1,496
Family/child discharged from Program	205	307	147	659
Family/child eligible and enrolled in Program	24	163	140	327
Family/child eligible but declines participation in Program	234	770	356	1,360
Family/child lost to follow up	106	228	69	403
Family/child NOT eligible for Program	92	301	168	561
Family/child pending eligibility determination	*	*	*	*
Total	1,075	2,622	1,293	4,990

Community-Based and Other Programs Focused on Asthma

In addition to the $1 million from the Fund used to strengthen the LHD-operated Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program, the Department released a $250,000 competitive request for applications for community-based programs to address pediatric asthma. The Green and Healthy Homes Initiative, Inc. (GHHI) received funding for two programs, one in Baltimore City, the other in Prince George's County, two jurisdictions with high numbers of children with more severe asthma. With these funds, GHHI is addressing asthma through both educational interventions and home-based interventions and will also expand the number of children and families in the state who may be eligible for services.

The GHHI program is using a tiered intervention approach to conduct interventions to reduce exposures to home-based environmental asthma triggers such as dust-borne antigens, mold and other asthma triggers. All properties approved to participate in the program receive a resident education, an environmental assessment and an asthma trigger reduction prevention supplies kit (cleaning supplies to control dust and other triggers). Based on the home environment and the severity of the child's asthma, additional supplies and services may also be provided, including air purifiers, dehumidifiers or air conditioners, mold remediation, as well as Tier I Plus services by GHHI Environmental Health Educators, Environmental Assessors and Hazard Reduction Workers. Those receiving Tier II services will receive Tier I Plus services as well.

Tier I Asthma Trigger Reduction Interventions include:

- HEPA Vacuum
- Simple Green
- Buckets (2)
- Gloves
- Sponges
- Mop
- Mop Refill
- Pillowcases (2)
- Mattress cover
- Smoke Detector
- Carbon Monoxide Detector
- Basic IPM—Integrated Pest Management

Tier II Higher Level Asthma Trigger Reduction Interventions include:

- Air purifying machine installation
- Dehumidifier installation
- Air conditioner installation
- Intermediate to Severe IPM-Integrated Pest Management
- Mold remediation
- Plumbing repair
- CO/smoke detector installation

- Door replacement
- Gutter replacement
- Stabilization of baseboards
- Air filter replacement
- Caulk building corners
- R-9 Fiberglass
- Dryer vent install
- Drain cleaning

There were delays at the Department in making both awards to GHHI from the original intended start date of August 19, 2022 to the actual contract award letter in April 2023. This resulted in delays in starting the project that have affected enrollment numbers described subsequently. The most recent GHHI interim report for Prince George's County summarizes the performance measures and progress to date.

> Objectives: The original intention was to enroll a total of 210 children in the Program over 42 months (3.5 years). In the initial six months, GHHI planned to enroll and serve 30 asthma-diagnosed children and their households. After the conclusion of the initial six months, GHHI would enroll and provide services to 60 clients annually for the next 36 months. In total, 210 children would receive full services including in-home asthma prevention resident education and case management, asthma trigger environmental assessment, and Tier I Plus and Tier II asthma trigger reduction housing interventions.
>
> Interim Report Update: GHHI received 2,300 referrals of Prince George's County children ages two to 17 who are diagnosed with asthma and whose asthma is deemed to be uncontrolled. GHHI started serving clients in Prince George's County after receiving their award letter in April 2023 and hiring staff. Because of these delays from the originally planned start date of August 2022, MDH agreed to consolidate the deliverables of Years 1 and 2. As of April 30, 2024, GHHI had met its original goal for Years 1-2 of the award (90 families served). The Year 3 goal of 60 clients served by June 30, 2024 was not met; only 50 clients were enrolled and served. GHHI has ten unserved clients from its Year 4 goal of 60 clients, which then increased the target to 70 clients. As of October 22, 2024, 19 of 70 clients had been completed.

In Baltimore City, GHHI has also had some challenges in receiving referrals from its primary source (a large managed care organization).

Objectives: A total of 280 children will be enrolled in the Program over 42 months. In the initial six months, GHHI planned to enroll and serve 40 asthma diagnosed children and their households. After the conclusion of the initial six months, GHHI would enroll and provide services to 80 clients annually for the next 36 months. In total, 280 children would receive full services including in-home asthma prevention resident education and case management, asthma trigger environmental assessment, and asthma trigger reduction housing interventions.

Interim Report Update: GHHI received 1,900 referrals of Baltimore City children ages two to 17 who are diagnosed with asthma and whose asthma is deemed to be uncontrolled. From the date of the grant award in April 2023, through August 31, 2023, GHHI met its target of serving 120 clients. From August 31, 2023 through February 28, 2024, GHHI met its Year 3 target of 80 clients served. For Year 4, GHHI's goal for Baltimore City is to serve 80 clients in total; as of October 10, 2024 they have served 67 of 80.

Asthma Community of Practice (CoP) and Provider Education

The Asthma Community of Practice (CoP) was created by EHB with the vision that all people and families living with asthma in Maryland receive the best possible care so that asthma does not affect their quality of life, and with the mission of improving practice through information and resource sharing. The purpose of the Asthma CoP is to:

1. Serve as a forum to exchange best practices and information regarding asthma treatment, management, and prevention;
2. Improve collaboration among stakeholders involved in asthma care; and
3. Ensure that Marylanders with asthma get the best possible care and access to prevention services.

In FY 2024 EHB successfully held three Asthma CoP meetings (August and November of 2023, and March 2024). More than 100 people now receive invitations to the meetings, and represent asthma stakeholders across the state, including care providers, academic researchers, parents, insurance companies and MCOs, medical systems, local health departments, school health personnel, and community health workers.

Public Health Program Performance

The Department's staff closely monitor performance on the SMM and childhood asthma goals as part of their ongoing implementation responsibilities under the Fund. COVID-19 has had an undeniable impact on SMM and childhood asthma goals.

Pandemic lockdowns led to a notable decrease in ED visits for asthma exacerbation. This decline can be attributed to reduced exposure to viral infections, environmental allergens, limited access to primary physicians, and families being hesitant to seek ED care. At the onset of the pandemic, the CDC categorized individuals with moderate to severe asthma as a high-risk group vulnerable to severe COVID-19 outcomes.[22] Consequently they advocated for strategies to mitigate asthma exacerbation risks, including avoiding triggers, adhering to prescribed medications, following personalized asthma action plans.

The Department remains committed to closely monitoring childhood asthma rates across pre- pandemic,

[22] Moore WC, Ledford DK, Carstens DD, Ambrose CS. Impact of the COVID-19 Pandemic on Incidence of Asthma Exacerbations and Hospitalizations in US Subspecialist-Treated Patients with Severe Asthma: Results from the CHRONICLE Study. J Asthma Allergy. 2022 Aug 31;15:1195-1203. doi: 10.2147/JAA.S363217. PMID: 36068863; PMCID: PMC9441176.

pandemic, post pandemic periods to ensure optimal improvement in asthma management and child health, while improving overall well-being and reducing asthma related issues.

Severe Maternal Morbidity Performance

Statewide Performance

The State's SMM rate has increased since 2018 and remains above the State's 2018 baseline. In FY 2023, an SMM literature review was conducted to better understand the continued rise in SMM cases. The literature review suggested that blood-transfusion-only events may artificially inflate the prevalence of SMM and in 2021 Federal partners (HRSA) updated the SMM indicators to exclude blood transfusions alone, due to lack of specificity.[23] Other significant contributors of elevated SMM rates revealed in the literature review included: COVID-19, comorbidities, hypertension, mental health, racial disparities, clinical level, and patient factors.

In FY 2024, the Department began working with CRISP to understand the impact of blood transfusions on the state SMM rate. This is in response to an update made by HRSA to remove blood transfusions as one of the procedure codes in its definition of SMM. Upon further analysis, the Department and CRISP discovered that blood-transfusion-only events account for 66 percent of all SMM events. In January 2024 CRISP updated their dashboard to show SMM rates with blood transfusion and SMM rates excluding blood-transfusion-only events.

Based on data through June 2024, Maryland had 319.0 SMM-related hospitalizations per 10,000 delivery discharges over the prior 12 months. This rate is 99.7 hospitalizations per 10,000 higher than the 2023 target (219.3) and 75.9 hospitalizations per 10,000 higher than the 2018 baseline (243.1). Over the same period, approximately two thirds of the SMM events that occurred involved blood transfusions only. Removing these events, the SMM rate of cases with blood transfusions excluded was 107.3 events per 10,000 delivery discharges.

[23] Federally Available Data (FAD) Resource Document for FY25/FY23 Application/Annual Report. (2024, July 10). https://mchb.tvisdata.hrsa.gov/Admin/FileUpload/DownloadContent?fileName=FadResourceDocument.pdf&isForDownload=False

Figure 1. SMM Hospitalizations for Rolling 12- Months, 2018 - June 2024

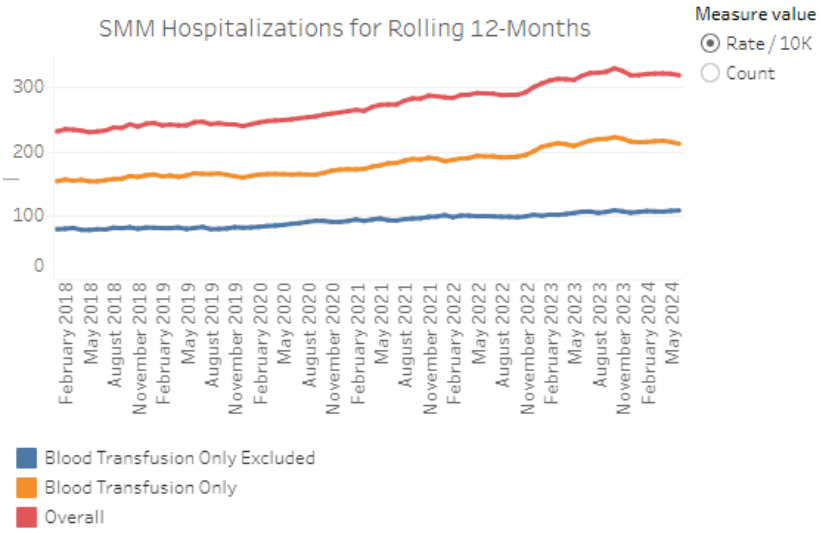


Table 26A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed July 2023-June 2024 Rates, Maryland

	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months
Rate per 10,000	243.1	9.6% decrease (Not Met)	319.0	197.6	-121.4
SMM Events	1,585	-	1,900	-	-
Eligible Deliverables	65,199	-	59,557	-	-

Table 26B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed July 2023-June 2024 Rates, Maryland

	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months
Rate per 10,000	80.7	9.6% decrease (Not Met)	107.3	65.6	-41.7
SMM Events	526	-	639	-	-
Eligible Deliverables	65,199	-	59,557	-	-

Health disparities are also increasing due to challenges discussed earlier in this report, further illustrating the critical need to invest in evidence-based interventions dedicated to addressing maternal health.

Figure 2A, Figure 2B, Table 27A, and Table 27B show SMM rates disaggregated by race and ethnicity. While disparity gaps have decreased slightly compared to last year's report, substantial progress is still required to meet the 2026 target rates.

Figure 2A. SMM Hospitalizations, Including Blood Transfusions, for Rolling 12-Months by Race/Ethnicity, January 2018-June 2024

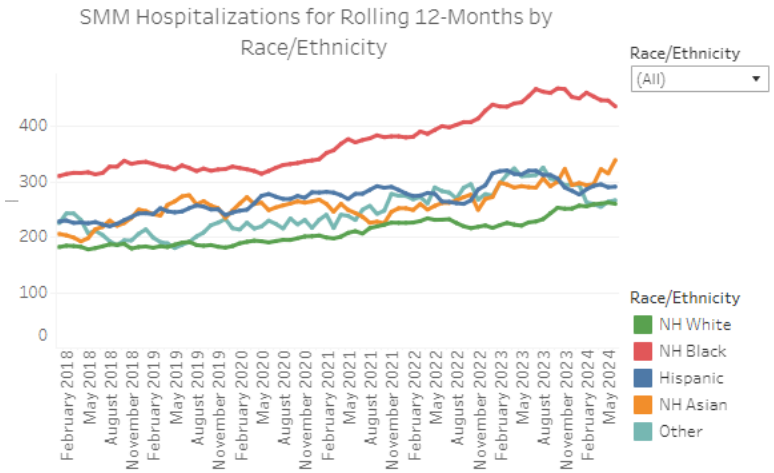


Figure 2B. SMM Hospitalizations, Excluding Blood Transfusion-Only Events, for Rolling 12-Months by Race/Ethnicity, January 2018-June 2024

Table 27A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed July 2023-June 2024 Rates, Maryland by Race/Ethnicity

Race/Ethnicity	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months	Disparity Index - Most Recent 12 Months
NH White	181.4	7.5% decrease (Not Met)	259.3	15% decrease	-105.1	1.0
NH Black	334.2	10% decrease (Not Met)	435.4	20% decrease	-168.0	1.7
Hispanic	242.0	10% decrease (Not Met)	290.3	20% decrease	-96.7	1.1
NH Asian	249.0	10% decrease (Not Met)	338.4	20% decrease	-139.2	1.3
Other	205.2	10% decrease (Not Met)	265.8	20% decrease	-101.6	1.0
Statewide Total	243.1	9.6% decrease (Not Met)	319.0	18.7% decrease	-121.4	1.2

Table 27B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed July 2023-June 2024 Rates, Maryland by Race/Ethnicity

Race/Ethnicity	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months	Disparity Index - Most Recent 12 Months
NH White	59.0	7.5% decrease (Not Met)	50.2	15% decrease	-42.0	1.0
NH Black	124.3	10% decrease (Not Met)	99.5	20% decrease	-63.9	1.8
Hispanic	57.2	10% decrease (Not Met)	45.8	20% decrease	-25.8	0.8
NH Asian	93.4	10% decrease (Met)	74.7	20% decrease	-16.7	1.0
Other	59.5	10% decrease (Not Met)	47.6	20% decrease	-43.5	1.0
Statewide Total	80.7	9.6% decrease (Not Met)	65.6	18.7% decrease	-41.7	1.2

Performance by Payer

Staff is also monitoring SMM performance by payer. Both Medicaid and commercial payers are trending upward for SMM rates including blood transfusions, in line with Statewide performance (Figure 3A). However, when excluding blood transfusion-only events, rates among Medicaid participants have remained fairly stable in recent years (Figure 3B). Additionally, while Medicaid SMM rates are higher than commercial SMM rates, both including and excluding blood transfusions, Medicaid SMM rates have grown at a slower pace than commercial SMM rates since 2018. SMM rates and percent increases are highest among individuals with Medicare, though counts are low and rates may be unstable; interpret with caution (Tables 28A and 28B).

Figure 3A. SMM Rates, Including Blood Transfusions, by Payer, 2018-2023, Excluding Medicare[24,25]

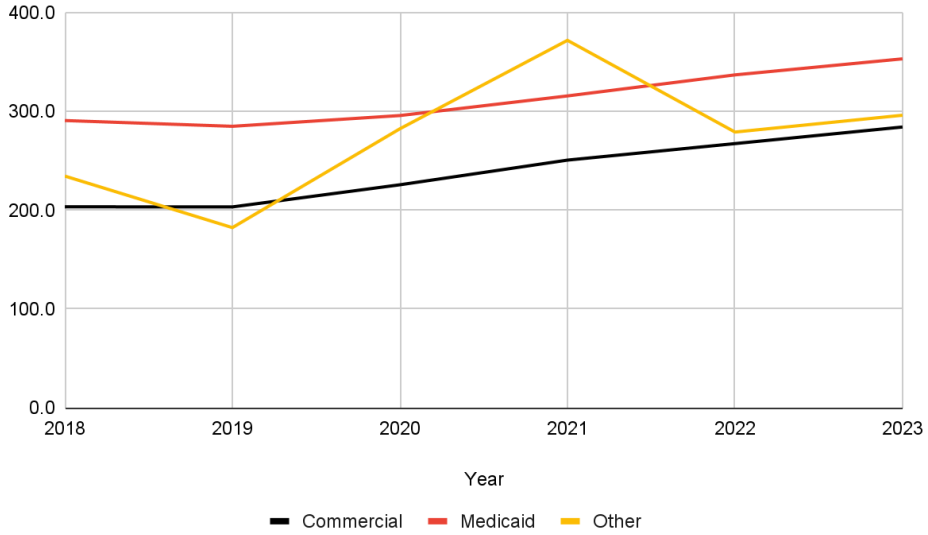


Figure 3B. SMM Rates, Excluding Blood Transfusion-Only Events, by Payer, 2018-2023, Excluding Medicare[24,25]

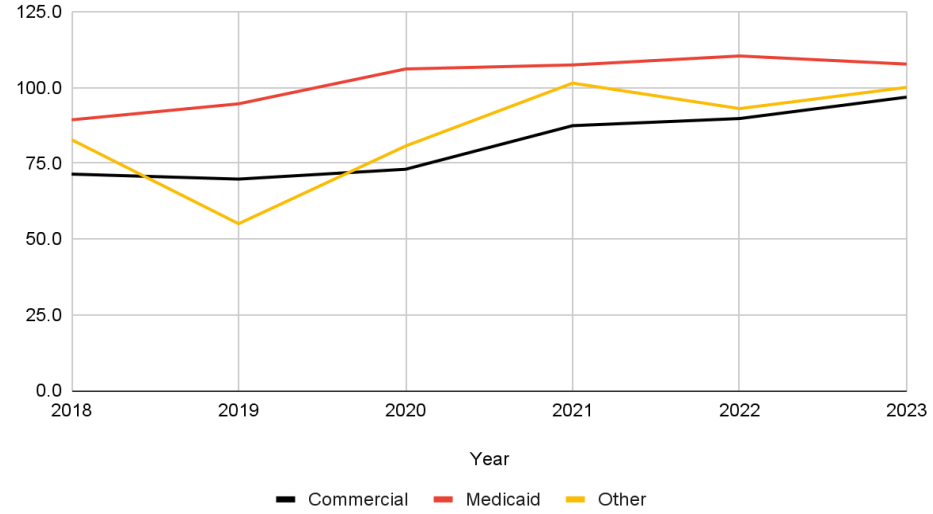


Table 28A. SMM Rate, Including Blood Transfusions, by Payer, 2018 – 2023[28,29]

Payer	2018	2019	2020	2021	2022	2023	% Change Since 2018
Commercial	203.5	203.4	225.8	250.8	267.5	284.3	+39.7%
Medicaid	290.9	285.0	295.9	315.8	337.1	353.3	+21.5%
Medicare	692.3	641.5	848.7	962.3	717.5	1315.8	+90.1%
Other	234.6	182.4	282.5	372.1	279.2	296.2	+26.3%

[24] Source: MCHB Data & Epidemiology Program analysis of Health Services and HSCRC in-patient case-mix as of September 2024.

[25] Note: Medicare data are not shown in the figure due to low counts of SMM events, and to allow better visualization.

Table 28B. SMM Rate, Excluding Blood Transfusion-Only Events, by Payer, 2018 – 2023[26,27]

Payer	2018	2019	2020	2021	2022	2023	% Change Since 2018
Commercial	71.4	69.8	73.1	87.4	89.8	96.9	+35.7%
Medicaid	89.4	94.6	106.1	107.5	110.4	107.8	+20.6%
Medicare	423.1	*	516.6	502.1	*	684.2	+61.7%
Other	82.8	55.1	80.7	101.5	93.1	100.1	+20.9%

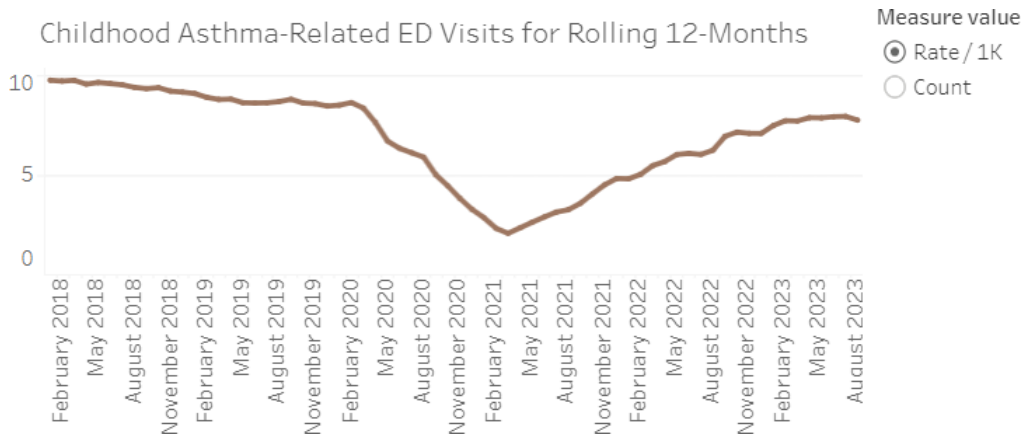
Childhood Asthma Emergency Department (ED) Visit Rate

As is true for hospitals nationally, Maryland hospitals saw sharp declines in ED volumes in 2020 and early 2021 due to COVID-19. Understandably, Maryland's asthma-related ED visit rate for ages 2-17 declined during this period. While 2022 volumes are trending back to 2018 baselines, they are still artificially low. Despite lower ED volumes, staff believe that the underlying dynamics of childhood asthma in Maryland did not change and is working in earnest to implement interventions that will reduce childhood asthma and associated health disparities.

Statewide Performance

Based on data through August 2022, Maryland had 6.2 asthma-related emergency department visits per 1,000 children over the prior 12 months. This rate is 1.0 visits per 1,000 children lower than the 2023 target.

Figure 4. Childhood Asthma-Related ED Visits for Rolling 12-Months



[26] Source: MCHB Data & Epidemiology Program analysis of Health Services and HSCRC in-patient case-mix as of September 2024.

[27] Note: Medicare data are not shown in the figure due to low counts of SMM events, and to allow better visualization.

Table 29. Childhood Asthma-Related ED Visits Compared to 2023 Target

	2018 Baseline	Most Recent 12 Months	2023 Target	Different - Most Recent 12 months to Target
Rates per 1,000	9.2	7.8	7.2	0.6
Total Count	10,974	9,258	-	-

As with the SMM rate, the impacts of COVID-19 have had a deleterious impact on health disparities, most notably with the non-Hispanic Black population. Continued investment in initiatives and programs to address childhood asthma is critical to eliminating these disparities and putting Maryland back on a path to reach the improvement goals.

Figure 5. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2023

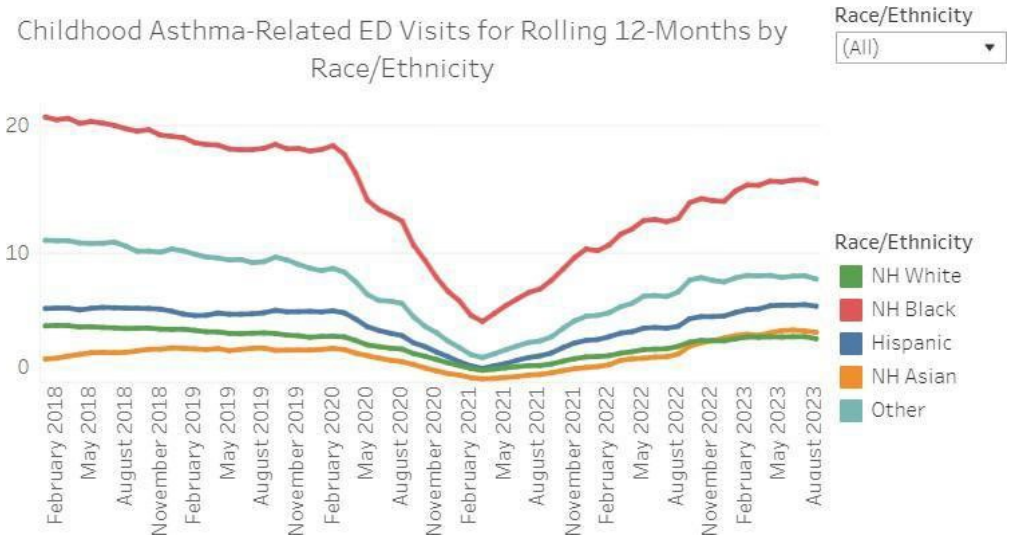


Table 30. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2023

Race	2018	2023 Year 5 Target	2026 Year 8 Target	Absolute Change	Relative Percentage Change
Total	9.2	7.2	5.3	3.9	42%
NH White	4.1	3.5	3.0	1.1	26%
NH Black	19.1	14.36	9.6	9.6	50%
Hispanic	5.4	4.7	4.0	1.4	25%
NH Asian	2.7	2.6	2.5	0.2	9%
Other	10.6	7.30	5.5	5.1	48%

Performance by Payer

The State is also monitoring performance by payer. As stated earlier in the report, the State believes these declines in the asthma-related ED visit rate in Maryland mirror both State and national reductions in overall ED visits due to COVID-19. Continued and expanded interventions to address childhood asthma are critical to preventing further growth in health disparities resulting from patients potentially not seeking care during the pandemic.

Table 31. Childhood Asthma-Related ED Visit Rate per 1,000 by Payer, 2018-September 2022

Payer	2018	2019	2020	2021	2022	% Change since 2018
Medicaid	13.3	12.5	5.0	7.1	6.8	-49%
Non - Medicaid	5.4	4.8	1.7	2.6	3.0	-44%

Year Three Spending

The Medicaid program devoted its efforts in FY 2024 to continuing expansion of all implemented benefits. As detailed above, implementation efforts spanned benefit design, systems changes for both payment and provider enrollment, and development and approval of regulations (state authority) and Medicaid State Plan Amendments (federal authority), in addition to provider enrollment and education. The Medicaid program intends to continue to maximize the Fund's contribution by pulling down federal matching funds, which relies

on service implementation.

Utilization of some services was lower than desired. Therefore, Medicaid developed flexibilities for new doula providers that decrease the administrative burden of provider enrollment, with the goal of increasing the number of providers, and therefore access. Similarly, Medicaid reached out to the Centering Healthcare Institute and ZERO TO THREE to discuss strategies to troubleshoot low rates of claiming for CenteringPregnancy and HealthySteps services.

The Medicaid program is building the full $16 million into its budget for CY 2025 and expects service delivery to increase as provider networks continue to grow and additional participants become aware of the new benefits. Medicaid will continue to work with PHPA to support the conversion of the MPRA–a major referral source for MCH programs–from paper to electronic, and increase outreach and awareness amongst the IMHS pilot sites.

PHPA dedicated FY 2024 to providing technical support to grantees as they continue the implementation of the asthma and maternal health initiatives.

Table 32. PHPA Grant Funds Expenditures - FY 2024

Initiative	FY 2024 Spending
Asthma Home Visiting Program	$427,408
Community-Based Asthma Programs	$233,558
Maternal Home Visiting	$866,613
CenteringPregnancy	$188,280
Program Total	**$1,715,859**

Compared to FY 23, spending by all sites increased substantially. Staffing challenges continued to impact all grantees, which contributed to sites not being able to spend their full award. The Department is working with all sites to address these challenges and will support the sites in their final year as they begin planning for sustainability and continuation of grant activities in FY 25.

Conclusion

In FY 2024, the Department remains committed to strategically investing in maternal and child health initiatives, through these evidence-based initiatives. Preliminary data shows positive outcomes for several key measures, in addition to identifying some measures in need of further monitoring. The Department will actively use its programmatic data to improve the delivery of the services and tailor strategies effectively, ensuring that resources reach those who need them most.

The various interventions align with priorities of the State and the Department as well as national

recommendations to improve the prenatal-to-childhood system of care in Maryland[28]. The Department will continue to facilitate seamless coordination and collaboration among various stakeholders. Fostering peer-to-peer learning opportunities to offer guidance and support to home visiting sites and community-based asthma programs will allow further alignment, collaboration, and integration amongst home visiting sites, LHDs, and community-based health organizations, which ultimately lead to improved outcomes and better care.

Finally, the Department looks forward to continued partnership with the HSCRC to strengthen maternal child health across the State. The commissioners and key stakeholders identified improving MCH as a critical priority for Maryland, and the Department remains a committed partner in this important work.

[28] Prenatal-to-3policy.2023 Maryland Roadmap Summary. https://pn3policy.org/pn-3-state-policy-roadmap-2023/md/ Accessed 6 December 2024