



**Maternal and Child Health Population Health
Improvement Fund
Program Year Four – FY 2025
Annual Report**

November 2025

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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 rates¹ 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 (SMM) 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 1. Severe Maternal Morbidity (SMM) Rates per 10,000 Deliveries, 2018 Baseline and Targets, Maryland by Race/Ethnicity^{4 5}

Race	Baseline: Including Blood Transfusions 2018	Baseline: Excluding Transfusion-Only Events 2018	2023 Year 5 Target	2026 Year 8 Target
NH White	181.4	59.0	7.5% decrease	15% decrease
NH Black	334.2	124.3	10% decrease	20% decrease
Hispanic	242.0	57.2	10% decrease	20% decrease
NH Asian	249.0	93.4	10% decrease	20% decrease
Other	205.2	59.5	10% decrease	20% decrease
Total	243.1	80.7	9.6% decrease	18.7% decrease

Table 2. Childhood Asthma-ED Visit Rates per 1,000, 2018 Baseline and Targets, Maryland by Race/Ethnicity⁵

Race	Baseline 2018	2023 Year 5 Target	2026 Year 8 Target
NH White	4.1	3.5	3.0
NH Black	19.1	14.4	9.6
Hispanic	5.4	4.7	4.0
NH Asian	2.7	2.6	2.5
Other	10.6	7.3	5.5
Total	9.2	7.2	5.3

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

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 Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

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 initially 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. House Bill 170 (2025) extended the sunset of this funding by 2 years from December 31st, 2025 to December 31st, 2027, meaning that the Department will administer this program for an additional 2 years.⁶ The Budget Reconciliation and Financing Act of 2025 reallocated \$13 million of the Fund to the general fund. However, Medicaid and PHPA are committed to spending down the remaining monies by 2027, and Medicaid will continue to maximize Fund dollars by pulling down federal match. The Department will evaluate sustainability plans for these investments after the Fund ends.

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](#). These initiatives also align Medicaid with statewide efforts to reduce the cost of hospital care and improve access to primary care in line with our agreements with CMS through the [Total Cost of Care Model](#) and upcoming [Achieving Healthcare Efficiency through Accountable Design \(AHEAD\) Model](#).

⁶ [2025 Regular Session - House Bill 170/Chapter 29](#)

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 fourth 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 2025 expenditures and spending plans for upcoming years.

Medicaid Programs

This section presents an overview and implementation update, in addition to demographic and utilization data for each of the Medicaid programs supported by the Fund: Home Visiting Services, doulas, CenteringPregnancy, HealthySteps, and MOM case management services. These summaries are then followed by an analysis of benefit quality performance using select maternal and child health metrics.

Table 3. Population Health Improvement Fund Medicaid Benefit Start Dates

Name	Start Date
CenteringPregnancy	January 1, 2023
Doulas	February 21, 2022
HealthySteps	January 1, 2023
Home Visiting Services	January 13, 2022
MOM Program ⁷	July 1, 2021

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 and well-being of both the mother⁸ 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-PY4

As of September 2025, there are 12 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.

⁷ Initially launched as a small pilot program, MOM has been available statewide since January 1, 2023.

⁸ This report uses the term "mother" to refer to the birthing parent. The Department recognizes and respects that individuals have a range of gender identities and do not always identify with this term.

Since CY 2022, there were 2,531 HVS services delivered to 277 unique mothers⁹ enrolled in the benefit, for an average of 9.1 visits per participant. During the same time period, there were a total of 20,013 services delivered to 746 unique children enrolled in the benefit for an average of 26.8 per participant.

Compared to the other benefits, the mothers enrolled in HVS tended to be slightly younger, with 60 percent falling between the ages of 19 and 29 at the time of enrollment. As one of the HVS models is only open to enrolled who have never had a previous live birth, a larger proportion of younger mothers is expected. Of the children enrolled in the HVS benefit, nearly three quarters are under the age of one. This distribution is likely due to the fact that most participants are enrolled while pregnant or immediately postpartum.

Geographically, the largest number of enrolled mothers live in Western Maryland (32.5 percent), followed by Southern Maryland (23.1 percent), and the Eastern Shore (19.1 percent). For children enrolled in HVS, however, the top three regions are Western Maryland (35.0 percent), the Eastern Shore (26.4 percent), and Washington Suburban (22.5 percent). While the distribution of participants may appear somewhat unexpected, this is likely due to the fact that HVS providers generally render services at the jurisdictional level. This structure likely explains why there is high enrollment being from relatively rural regions, for example Western Maryland and the Eastern Shore, as both are home to multiple HVS sites. By the same token, this may also explain why a more populous region such as Baltimore Suburban has comparatively few participants, as several jurisdictions in the region lack Medicaid HVS sites.

The most common race/ethnicity of the mothers enrolled in the benefit were White (39.7 percent), Black (31.4 percent), and Hispanic (22.0 percent). While this breakdown differs from the statewide average, it aligns almost perfectly with the race/ethnicity of individuals who gave birth in Western Maryland, Southern Maryland, and the Eastern Shore which comprise the largest proportion of HVS mothers enrolled. For the children enrolled in HVS, the most common race/ethnicity was Hispanic (41.4 percent), White (32.2 percent), and Black (20.2 percent). This does not align as closely with the breakdown of Medicaid enrollment for White and Black children of the same age in those regions, which account for 16.1 percent and 31.9 percent, respectively.

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.

⁹ This report uses the term "mother" to refer to the birthing parent. The Department recognizes and respects that individuals have a range of gender identities and do not always identify with this term.

Table 4. Medicaid Home Visiting Services (HVS) Utilization^{10 11 12 13}

	HVS Mothers			HVS Children		
	Total Visits	Unique Enrollees	Per Enrollee	Total Visits	Unique Enrollees	Per Enrollee
CY 2021	-	-	-	-	-	-
CY 2022	141	31	4.5	1,130	148	7.6
CY 2023	883	130	6.8	7,156	505	14.2
CY 2024	1,507	237	6.4	11,727	642	18.3
Total	2,531	277	9.1	20,013	746	26.8

Table 5A. Medicaid Home Visiting Services (HVS) Participant Demographics: Age Groups^{13 14}

Parent

Age	HVS
Under 19	*
19 to 29	166
30 to 40	82
Over 40	*
Total	277

Child

Age	HVS
Under 1	553
Aged 1	112
Aged 2	65
Aged 3+	16
Total	746

¹⁰ Dashes represent years in which the benefit is not yet active. The start dates are listed in Table 3.

¹¹ This is the first year that the PHIF report has broken out the HVS data by mother and child. In previous reports, all of the participants were aggregated.

¹² As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.

¹³ Data source: The Hilltop Institute

¹⁴ The tables reflect the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

Table 5B. Medicaid Home Visiting Services (HVS) Participant Demographics: Race/Ethnicity^{15 16}

Parents

Race/Ethnicity	HVS
Asian	*
Black	87
White	110
Hispanic	61
Native American	*
Other	15
Total	277

Children

Race/Ethnicity	HVS
Asian	*
Black	151
White	240
Hispanic	309
Native American	*
Other	41
Total	746

Table 5C. Medicaid Home Visiting Services (HVS) Participant Demographics: Regions¹⁶

Parents

Region	HVS
Baltimore City	*
Baltimore Suburban	20
Eastern Shore	53
Southern Maryland	64
Washington Suburban	31
Western Maryland	90
Out of State	*
Total	277

¹⁵ In cases where an individual is listed as Hispanic along with any race, they are categorized as “Hispanic”. The “Other” category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

¹⁶ Data source: The Hilltop Institute

Children¹⁷

Region	HVS
Baltimore City	13
Baltimore Suburban	48
Eastern Shore	197
Southern Maryland	59
Washington Suburban	168
Western Maryland	261
Out of State	0
Total	746

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 mothers¹⁸ 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 mother. 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 - PY4 Update

As of the end of September 2025, there are 61 doulas enrolled as Medicaid providers, more than double the number from the previous year. 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 agreements¹⁹ 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 January 1,

¹⁷ Data source: The Hilltop Institute

¹⁸ This report uses the term "mother" to refer to the birthing parent. The Department recognizes and respects that individuals have a range of gender identities and do not always identify with this term.

¹⁹ A single case agreement (SCA) is a one-time agreement between an insurance provider, in this case an MCO, and an out-of-network provider, in this case a doula.

2027 – 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 nominations process to add additional certification programs, in order to increase the number of doulas who are eligible to become Medicaid providers. As of August 2025, there are 30 approved certification organizations; this is a major increase from the nine approved organizations when the benefit was first introduced in February 2022. The Department will host another iteration of the nominations process in the autumn of 2025. Lastly, as noted earlier, the Department increased the rate for attendance at labor and delivery from \$350 to \$800 on July 1, 2023.

Since CY 2022, 1,397 doula services were delivered to 285 unique Medicaid participants, for an average of 4.9 services per participant. The sharp increase in the number of participants receiving doula services coincides with the increase in the number of enrolled providers, in addition to an increase in reimbursement rates. 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.

The individuals enrolled in the doula benefit are very evenly distributed by age between the 19 to 29 and the 30 to 40 categories, at 49.8 and 47.4 percent, respectively. This aligns with the distribution of deliveries in the overall Medicaid population.

The vast majority of individuals enrolled in the doula benefit identify as Black (69.8 percent), followed by White (9.8 percent), and Hispanic (7.4 percent). This distribution reflects much of the academic literature, which describes doulas as playing a key role in improving birthing outcomes for Black individuals.

The geographic distribution of individuals enrolled in the doula benefit are predominantly located in Washington Suburban (36.5 percent) and Baltimore Suburban (33.7 percent), followed by Baltimore City (11.6 percent) and the Eastern Shore (11.2 percent). This aligns fairly closely with where the majority of Maryland's doulas are located - Washington Suburban, Baltimore City, and Baltimore Suburban regions - all of which have large Black populations.

Table 6. Medicaid Doula Services Utilization^{20 21 22 23}

	Doula		
	Total Visits	Unique Enrollees	Per Enrollee
CY 2021	-	-	-
CY 2022	44	14	3.1
CY 2023	264	69	3.8
CY 2024	1,089	254	4.3
Total	1,397	285	4.9

Table 7A. Medicaid Doula Services Participant Demographics: Age Groups^{22 23}

Age	Doula
Under 19	*
19 to 29	142
30 to 40	135
Over 40	*
Total	285

Table 7B. Medicaid Doula Services Participant Demographics: Race/Ethnicity^{22 23 24}

Race/Ethnicity	Doula
Asian	*
Black	199
White	28
Hispanic	21
Native American	*
Other	21
Total	285

²⁰ Dashes represent years in which the benefit is not yet active. The start dates are listed in Table 3.

²¹ As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.

²² Data source: The Hilltop Institute

²³ The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

²⁴ In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

Table 7C. Medicaid Doula Services Participant Demographics: Regions^{25 26}

Region	Doula
Baltimore City	33
Baltimore Suburban	96
Eastern Shore	32
Southern Maryland	*
Washington Suburban	104
Western Maryland	12
Out of State	*
Total	285

CenteringPregnancy

Program Overview

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.²⁷

CenteringPregnancy Implementation - PY4 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).

By partnering with the Centering Healthcare Institute (CHI), the Department is able to expand the number of CenteringPregnancy sites and reduce maternal and infant disparities in the state. CHI provides training, technical assistance, and tools to help providers implement the CenteringPregnancy model. As of September 2025, there are 17 CenteringPregnancy sites. Eleven are currently accredited by CHI, with the remaining six expecting to receive accreditation by 2027. Currently there are seven Maryland Medicaid CenteringPregnancy providers and 13 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

²⁵ The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

²⁶ Data source: The Hilltop Institute

²⁷ Centering Healthcare Institute. (2020). *Centering Saves Lives & Money*. Centering Healthcare Institute: Payment Policy & Advocacy. Downloaded from: <https://centeringhealthcare.org/why-centering/payment>

partnership and grants from the Department's MCHB.

Since CY 2023, 4,060 CenteringPregnancy services were billed for 699 unique participants, for an average of 5.8 per participant, the demographic breakdown is below. Utilization of these services have clearly increased between CY 2023 and CY 2024, with the number of services rendered more than doubling, in addition to a large jump in unique enrollees during the same period. Medicaid will continue to work with CHI, CenteringPregnancy's parent organization, to build on this success by attending the bi-annual Centering Consortium of Maryland to connect with providers, answer Medicaid-related questions, and encourage provider enrollment in Medicaid.

The majority of participants enrolled in CenteringPregnancy reside in the Washington Suburban region (51.4 percent), followed by Baltimore City (15.3 percent) and Baltimore Suburban (15.2 percent). As CenteringPregnancy is a practice-based benefit, this geographic distribution reflects where CenteringPregnancy practices are located in Maryland. While the benefit is open to individuals in other regions, possibly fewer individuals have the time to travel such a distance for prenatal care.

The most common race/ethnicity of CenteringPregnancy enrollees is Hispanic (55.5 percent), followed by Black (30.2 percent) and White (10.6 percent). The race/ethnicity distribution of participants generally aligns with that of the regions in which the majority of enrollees live. For Washington Suburban, Baltimore City, and Baltimore Suburban combined, the largest proportion of deliveries is to Hispanic participants (41.1 percent), followed by Black (37.1 percent) and White (12.3 percent).

Individuals enrolled in CenteringPregnancy were generally younger than some of the other benefits. One possible explanation is that younger individuals or first time parents are more likely to want to participate in a group prenatal program.

Table 8. Medicaid CenteringPregnancy Utilization^{28 29 30}

	CenteringPregnancy		
	Total Visits	Unique Enrollees	Per Enrollee
CY 2021	-	-	-
CY 2022	-	-	-
CY 2023	1,341	344	3.9
CY 2024	2,719	622	4.4
Total	4,060	699	5.8

²⁸ Dashes represent years in which the benefit is not yet active. The start dates are listed in Table 3.

²⁹ As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.

³⁰ Data source: The Hilltop Institute

Table 9A. Medicaid CenteringPregnancy Participant Demographics: Age Groups^{31 32}

Age	Centering Pregnancy
Under 19	54
19 to 29	409
30 to 40	215
Over 40	21
Total	699

Table 9B. Medicaid CenteringPregnancy Participant Demographics: Race/Ethnicity^{31 32 33}

Race/Ethnicity	Centering Pregnancy
Asian	*
Black	211
White	74
Hispanic	388
Native American	*
Other	18
Total	699

Table 9C. Medicaid CenteringPregnancy Participant Demographics: Regions^{31 32}

Region	Centering Pregnancy
Baltimore City	107
Baltimore Suburban	106
Eastern Shore	55
Southern Maryland	*
Washington Suburban	359
Western Maryland	69
Out of State	*
Total	699

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

³¹ The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

³² Data source: The Hilltop Institute

³³ In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

“ZERO TO THREE”³⁴, 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 - PY4 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 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.

The first eligible provider in Maryland was University of Maryland Pediatrics Associates, in addition to three in DC (MedStar Georgetown - MedStar Medical Group at Fort Lincoln, Children's National - Children's Health Center at THEARC, and Anacostia locations). Later, 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 2023.³⁵

Maryland's efforts align closely with recent CMS guidance,³⁶ 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.

Since CY 2023, 11,719 HealthySteps services were billed for 3,428 unique participants, for an average of 3.4 services per participant, the demographic breakdown is below. Similar to CenteringPregnancy, the HealthySteps saw a steep uptake in utilization of the benefit. Between CY 2023 and CY 2024, the number in HealthySteps visits increased 168.9 percent and the number of unique participants saw a similarly large increase. Maryland Medicaid will continue to work closely with ZERO TO THREE, along with HealthySteps providers, to promote the enhanced payment of rendered HealthySteps services.

The youngest participants represented the largest portion of HealthySteps enrollees with 46.8 percent under the age of one, with the rest of the age bands accounting similar portions to one-another, ranging

³⁴ What We Do. (n.d.). <https://www.healthysteps.org/what-we-do/>

³⁵ Prenatal-to-3 Policy Impact Center. 2023 Maryland Roadmap Summary. <https://pn3policy.org/pn-3-state-policy-roadmap-2023/md/>

³⁶ 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>

from 16.1 to 18.9 percent. This distribution is likely attributable to the fact that infants are brought to the doctor more frequently than older children.

The vast majority of enrollees reside in Baltimore City (51.8 percent) and Baltimore Suburban (43.6 percent). This distribution reflects where the limited number of HealthySteps sites are located. While individuals residing in other regions are permitted to receive the benefit, it is likely that fewer will due to the travel required.

As with other benefits with high concentrations in select jurisdictions, the distribution by race/ethnicity is closer to that of the regions in which they are located, rather than the state averages. In HealthySteps, the largest portion of enrollees by race/ethnicity are Black (70.2 percent) and Hispanic (10.7 percent). In the Baltimore City and Baltimore Suburban regions, these race/ethnicity groups also represent the largest portion of children from that group, however with fewer Black (42.4 percent) and more Hispanic (25.3 percent) participants.

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. In late PY4, the Department convened HealthySteps stakeholders to inform providers how to update their Medicaid enrollment to be eligible for the enhanced payment, as well as discuss barriers to billing. 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.

Table 10. Medicaid HealthySteps Utilization^{37 38 39}

	HealthySteps		
	Total Visits	Unique Enrollees	Per Enrollee
CY 2021	-	-	-
CY 2022	-	-	-
CY 2023	3,177	1,369	2.3
CY 2024	8,542	3,138	2.7
Total	11,719	3,428	3.4

Table 11A. Medicaid HealthySteps Participant Demographics: Age Group^{39 40}

Age	HealthySteps
Under 1	1,606
Aged 1	621
Aged 2	552
Aged 3+	649
Total	3,428

Table 11B. Medicaid HealthySteps Participant Demographics: Race/Ethnicity^{39 40 41}

Race/Ethnicity	HealthySteps
Asian	225
Black	2,408
White	170
Hispanic	367
Native American	23
Other	235
Total	3,428

³⁷ Dashes represent years in which the benefit is not yet active. The start dates are listed in Table 3.

³⁸ As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.

³⁹ Data source: The Hilltop Institute

⁴⁰ The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

⁴¹ In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

Table 11C. Medicaid HealthySteps Participant Demographics: Regions^{42 43}

Region	HealthySteps
Baltimore City	1,775
Baltimore Suburban	1,493
Eastern Shore	*
Southern Maryland	*
Washington Suburban	131
Western Maryland	11
Out of State	0
Total	3,428

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 - PY4 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 2025, there have been 169 pregnancies to 166 unique participants in the MOM program; several participants have re-enrolled for subsequent pregnancies. A demographic breakdown of the unique MOM participants is listed 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 annual enrollment remained similar between CY 2023 and CY 2024 however there was a decrease in the number of visits per enrollee.

Of the benefits, MOM had the oldest enrollee base with 63.9 percent of participants between the ages 30

⁴² The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

⁴³ Data source: The Hilltop Institute

to 40. Internal MOM data indicates that this is not the first child for a significant portion of MOM enrollees.

Geographically, the largest portion of MOM enrollees reside in Western Maryland (38.5 percent), followed by Baltimore Suburban (23.8 percent) and Baltimore City (16.4 percent). There are several possible explanations for this distribution, one being that the opioid epidemic is not equally spread across the state, some regions have higher rates than others. Zip codes with some of the highest rates of fatal opioid overdose are located in these regions. While not a one-to-one comparison, this may serve as a proxy for prevalence of OUD.

As with other benefits concentrated in select jurisdictions, the race/ethnicity breakdown of MOM enrollees differs from the statewide average. The largest portion of enrollees is White (71.3 percent), followed by Black (13.9 percent). This aligns more closely with the data from Western Maryland, where White participants account for 47.9 percent of deliveries; however this data represents the general population of this region, not specifically individuals with OUD.

In CY 2024, the Department leveraged support from both the Fund and CMMI to continue our partnership with the Maryland Addiction Consultation Service (MACS) 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. Funding for MACS for MOMs has since transitioned over to MCHB.

In CY 2024, the Department worked closely with MCOs to help identify best practices for outreach, and implemented a new billing process to allow MCOs to submit electronic encounters for the MOM program.

Table 12. Medicaid MOM Program Utilization^{44 45 46}

	MOM		
	Total Months	Unique Enrollees	Per Enrollee
CY 2021	14	*	*
CY 2022	39	*	*
CY 2023	477	58	8.2
CY 2024	384	59	6.5
Total	914	122	7.5

⁴⁴ The MOM benefit is reimbursed by member-month, therefore the utilization is listed by month.

⁴⁵ As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.

⁴⁶ Data source: The Hilltop Institute

Table 13A. Medicaid MOM Participant Demographics: Age Group^{47 48}

Age	MOM
Under 19	*
19 to 29	42
30 to 40	78
Over 40	*
Total	122

Table 13B. Medicaid MOM Participant Demographics: Race/Ethnicity^{47 48 49}

Race/Ethnicity	MOM
Asian	0
Black	17
White	87
Hispanic	*
Native American	*
Other	12
Total	122

Table 13C. Medicaid MOM Participant Demographics: Regions^{47 48}

Region	MOM
Baltimore City	20
Baltimore Suburban	29
Eastern Shore	13
Southern Maryland	*
Washington Suburban	*
Western Maryland	47
Out of State	0
Total	122

PY4 Medicaid Performance

Methodology

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 on several relevant HEDIS measures, value sets, and Centers for Disease Control and Prevention (CDC) definitions.⁵⁰ For the purposes of the analysis, all program participants were identified based on FFS claims

⁴⁷ The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

⁴⁸ Data source: The Hilltop Institute

⁴⁹ In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

⁵⁰ Some programming deviates from HEDIS specifications based on the specific program structures, as needed.

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 and the decision to aggregate data for all calendar years, the PY4 report is the first year that there is a sufficient number of participants for the metrics to be reported at the program level without a large number of cells having to be suppressed.

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. In addition to the data for enrollees in the benefits, this analysis presents a comparison group for each of the benefit populations: CenteringPregnancy - Mothers, Doula - Mothers, MOM - Mothers, Home Visiting Services - Mothers, Home Visiting Services - Children, and HealthySteps - Children. To create the comparison groups for the mothers, the Hilltop Institute performed a matching analysis that identified recently pregnant Medicaid participants who had similar characteristics as an enrollee in one of the PHIF benefits. The characteristics for the mother comparison groups include age (at program entry), region, comorbidity score⁵¹, race, cohort year (i.e. calendar year in which pregnancy/birth occurred), and OUD diagnosis (for the MOM comparison group only). For the child comparison groups, the Hilltop Institute selected matching individuals based on age (at program entry), region, race and cohort year (birth year). In cases where the Hilltop Institute was unable to find an exact match they selected an individual with a very similar characteristic, for example selecting a 28 year old instead of a 29 year old. Only individuals who were enrolled in a benefit at the time a metric was measured were included in the calculations; for example, if someone were to enroll in home visiting services at 20 weeks gestation, they would not be included in the metric for early initiation of prenatal care since they were not yet receiving the benefit's services.

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. When applicable, 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 set⁵² 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 deliveries, SMM, birth complications, and child developmental screenings. Identified claims and encounters were collapsed per program enrollment year with flags

⁵¹ A person's comorbidity level is estimated based on the Johns Hopkins Adjusted Clinical Groups (ACG) methodology, which uses claims data to classify individuals based on their projected and/or actual utilization of health care services. Hilltop assigns individuals to one of four comorbidity categories (Low, Moderate, High, Very High) based on their claim records in the measurement years

⁵² Hospitals are required to complete the 1184 Newborn Form and submit it to Medicaid for children born of Medicaid-eligible mothers in order to enroll the newborn in the mother's MCO effective on the date of birth.

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. 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 counts may be small for certain metrics, particularly ones where an outcome is expected to be rare (e.g. birth complications). 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.

Quality Performance Highlights⁵³

Overall, the PY4 data shows promising results for a variety of metrics, for both the mothers and children enrolled in the benefits.

- CenteringPregnancy: As a practice-based benefit, CenteringPregnancy enrollees had particularly strong results for metrics related to perinatal visits, specifically the timely initiation of prenatal care, in addition to postpartum visit completion rates.
 - Timely Initiation of Prenatal Care: Participants enrolled in CenteringPregnancy were **14.6 percent more likely** than the comparison group to initiate prenatal care in a timely manner.
 - Postpartum Care Visits: Individuals enrolled in CenteringPregnancy were **12.4 percent more likely** to complete a postpartum visit than their comparison group.
- Doulas: Individuals enrolled in the doula benefit performed particularly well for metrics measured during the prenatal period and at the time of delivery, namely timely initiation of prenatal care and cesarean delivery rates. This aligns with the timing of when the majority of enrollees received their doula care.
 - Timely Initiation of Prenatal Care: Participants enrolled in the doula benefit were **13.3 percent more likely** than the comparison group to initiate prenatal care in a timely manner.
 - Cesarean Births: Enrollees in the doula benefit saw a **20.6 percent lower** rate of cesarean deliveries than their comparison group.
- HealthySteps: As a practice-based benefit, HealthySteps enrollees had particularly high completion rates for metrics related to pediatric practices, most notably child well-care visits.
 - Well-Care Visits: Children enrolled in HealthySteps had a well-care visit completion rate **16.6 percent higher** than the comparison group, at a **99.8 percent completion rate**.
- Home Visiting Services: Individuals enrolled in HVS performed well in a fairly wide variety of metrics, with particularly strong results for timely initiation of prenatal care (for the mothers), as well as immunizations and well-care visit rates (for the children).
 - Immunizations: Children enrolled in HVS had a higher vaccination rate for each of the immunizations measured than the comparison group, ranging from a **177.5 percent to a**

⁵³ Unless otherwise stated, data in this section reflects individuals in the “meets evaluation criteria” group.

258.7 percent increase.

- Well-Care Visits: Children enrolled in HVS had a well-care visit completion rate **6.9 percent higher** than the comparison group, at a **97.9 percent completion rate**.
- MOM: Individuals in MOM tended to show especially positive outcomes for metrics measured after enrollees had been in the benefit for some time, specifically lower cesarean delivery rates and improved postpartum visit completion rates.
 - Cesarean Births: Enrollees in the MOM benefit saw a **19.0 percent lower rate** of cesarean deliveries than their comparison group.
 - Postpartum Care Visits: Individuals enrolled in MOM were **30.0 percent more likely** to complete a postpartum visit than their comparison group.

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 data shows that individuals enrolled in the HVS, doula, and CenteringPregnancy benefits were far more likely to complete a timely prenatal visit than those in the comparison groups. This difference was particularly apparent for individuals in the doula services and CenteringPregnancy benefits who performed 13.3 percent to 14.6 percent higher than their comparison groups. This result was expected for those in CenteringPregnancy since the benefit centers around prenatal visits; the doula benefit aligns with studies that show individuals receiving doula care have greater attendance at prenatal visits.⁵⁴ While enrolled in the MOM benefit did not have as high a completion rate than those in their comparison, there was a clear improvement between those in the “at least one qualifying” and “meets evaluation criteria” groups, showing that a higher “dose” of the MOM benefit is associated with an increased rate of timely initiation of prenatal care.

⁵⁴ Falconi, A., et. al., (2022). Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. eClinicalMedicine, Volume 50, 2022, 101531, ISSN 2589-5370, <https://doi.org/10.1016/j.eclinm.2022.101531>.

Table 14. 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^{55 56}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	80	69	86.3%	71	60	84.5%	166	132	79.5%
Doula Services	78	63	80.8%	58	47	81.0%	144	103	71.5%
CenteringPregnancy	108	96	88.9%	76	69	90.8%	298	236	79.2%
MOM⁵⁷	34	19	55.9%	29	18	62.1%	81	54	66.7%

Postpartum Care Visits - Seven through 84 Days

After giving birth, a postpartum care visit provides an important opportunity to evaluate the mother’s healing from labor and delivery, in addition to screening for postpartum depression. Two of the benefits, CenteringPregnancy and MOM, had higher completion rates than their respective comparison groups. This increase was particularly pronounced for the MOM benefit where the “meets evaluation criteria” group had a 30.0 percent higher rate than the comparison group. While individuals in the MOM benefit had lower completion rates than those in the other benefits, the MOM comparison group is also substantially lower than the other comparison groups.

Of individuals who enrolled in one of the benefits in the first trimester, postpartum completion rates were markedly higher. For this population, all four of the benefits showed a markedly higher completion rate than their respective comparison groups. This increase was particularly notable for individuals enrolled in the doula, CenteringPregnancy, and MOM benefits, which saw an increase ranging from 19 percent to 68 percent. When compared with participants who enrolled at any point in the pregnancy, individuals who enrolled during the first trimester consistently performed better, ranging from 7 percent to 21 percent. The cause of this improvement is not definitive, the “enrolled during the first trimester” comparison groups tended to do slightly better than “enrolled any time during the pregnancy” comparison groups, however not enough to account for the total increase. This suggests that individuals who enrolled earlier in the benefit and therefore had been in the benefit for longer when this metric was measured, meaning they had had a higher “dose” at that point.

The Department attempted to perform an analysis to establish whether visits from a doula during the postpartum period is associated with a higher postpartum visit completion rate, however there was insufficient data at this time.

⁵⁵ Data source: The Hilltop Institute

⁵⁶ The table reflects the sum of unique participants since the benefit’s inception. These start dates are listed in Table 3.

⁵⁷ The MOM benefit is reimbursed by member-month, therefore the “at least one qualifying visit” and “meets evaluation inclusion criteria” groups refers to the number of visits, rather than discrete visits.

Table 15A. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 84 days after Delivery, Participants Enrolled Anytime During the Pregnancy^{58 59}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	83	71.6%	102	74	72.5%	428	306	71.5%
Doula Services	158	116	73.4%	120	88	73.3%	289	213	73.7%
CenteringPregnancy	184	146	79.3%	140	117	83.6%	830	617	74.3%
MOM ⁶⁰	56	33	58.9%	50	30	60.0%	143	66	46.2%

Table 15B. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 84 days after Delivery, Participants Enrolled During First Trimester^{58 59}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	80	62	77.5%	71	55	77.5%	166	124	74.7%
Doula Services	78	68	87.2%	58	51	87.9%	144	106	73.6%
CenteringPregnancy	108	96	88.9%	76	71	93.4%	298	232	77.9%
MOM	34	24	70.6%	29	21	72.4%	81	35	43.2%

Postpartum Care Visits - Seven through 120 Days

As part of discussions to improve timely attendance at a postpartum visit, stakeholders raised the possibility that participants are attending their 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 data shows a very slight improvement in postpartum visit completion rates for participants in the HVS, doula, and CenteringPregnancy benefits when compared with the “within 84 days” metric. The comparison groups for each of the three benefits also showed a similar change between the two time spans. As with the “within 84 days” metric, the data showed that individuals enrolled in a benefit in the first trimester were more likely to complete a postpartum visit. The increase between the “enrolled during the first trimester” and “enrolled at any point during the pregnancy” groups was nearly identical to that of the “within 84 days” metric; the same was also observed for their respective comparison groups.

The enrollees in the MOM benefit showed no change between the “within 84 days” and the “within 120 days” metrics. It appears that the participants who completed their postpartum visits did so in a timely manner. As with the “within 84 days” metric, enrollees in the MOM and

⁵⁸ Data source: The Hilltop Institute

⁵⁹ The table reflects the sum of unique participants since the benefit’s inception. These start dates are listed in Table 3.

⁶⁰ The MOM benefit is reimbursed by member-month, therefore the “at least one qualifying visit” and “meets evaluation inclusion criteria” groups refers to the number of visits, rather than discrete visits.

CenteringPregnancybenefits were far more likely to complete a postpartum visit than those in their respective comparison groups.

Table 15C. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 120 days after Delivery, Participants Enrolled Anytime During the Pregnancy^{61 62}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	86	74.1%	102	77	75.5%	428	318	74.3%
Doula Services	158	118	74.7%	120	89	74.2%	289	216	74.7%
CenteringPregnancy	184	149	81.0%	140	119	85.0%	830	627	75.5%
MOM ⁶³	56	33	58.9%	50	30	60.0%	143	70	49.0%

Table 15D. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 120 days after Delivery, Participant Enrolled During the First Trimester^{61 62}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	80	66	82.5%	71	59	83.1%	166	127	76.5%
Doula Services	78	69	88.5%	58	52	89.7%	144	108	75.0%
CenteringPregnancy	108	98	90.7%	76	72	94.7%	298	230	77.2%
MOM	34	24	70.6%	29	21	72.4%	81	38	46.9%

Cesarean Births

While cesarean births can be warranted in some cases, reducing unnecessary cesareans is a priority in maternal health.

The enrollees in the MOM and doula benefits both showed markedly lower cesarean delivery rates than their respective comparison groups. This is particularly notable as both of the comparison populations had extremely high cesarean rates, far higher than the state average.⁶⁴ For the doula benefit, the lower rate aligns with the literature that has shown doulas are associated with a reduction in cesarean deliveries.⁶⁵ While a reduction in cesarean deliveries is beneficial for many

⁶¹ Data source: The Hilltop Institute

⁶² The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

⁶³ The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

⁶⁴ CDC, (n.d.). "Cesarean Deliveries: Birth Data Maps." <https://www.cdc.gov/nchs/state-stats/births/cesareans.html>

⁶⁵ Sobczak, A., Taylor, L., Solomon, S., Ho, J., Kemper, S., Phillips, B., Jacobson, K., Castellano, C., Ring, A., Castellano, B., & Jacobs, R. J. (2023). The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. *Cureus*, 15(5), e39451.

<https://doi.org/10.7759/cureus.39451>; Alvarado, G. et. al., (2024). United States Doula Programs and Their Outcomes: A Scoping Review to Inform State-Level Policies, *Women's Health Issues*, Volume 34, Issue 4, 350-360.

<https://www.whijournal.com/action/showCitFormats?doi=10.1016%2Fj.whi.2024.03.001&pii=S1049-3867%2824%2900021-5>

populations, it is particularly so for individuals with OUD, like those enrolled in the MOM benefit. Many individuals with OUD also live with pain issues⁶⁶ and a surgery, such as a cesarean delivery, can exacerbate it. Post-surgery pain management while avoiding a recurrence of use (i.e. relapse) can pose difficulty for individuals with OUD.⁶⁷

Enrollees in the HVS benefit had similar cesarean delivery rates to those in the comparison group. The rates were slightly worse for the “meets evaluation criteria” group than the “at least one qualifying” group.

Of the four benefits, CenteringPregnancy was the only one where enrollees were more likely to have a cesarean delivery than the comparison group. This data was also notable because the “meets evaluation criteria” group had a significantly higher rate than those in the “at least one qualifying” group. Because of this difference in the data, the Department performed an additional analysis to further investigate this trend. Additionally, the data showed that many enrollees delivered at one specific hospital with a high level birthing center, and these enrollees were more likely to have a cesarean. However this may simply indicate that there was something about the patient that necessitated a higher level of care. While there is no clear cause for a higher cesarean rate for individuals in the “meets evaluation criteria” group, one potential explanation is that individuals with even a slightly higher risk pregnancy may be more likely to attend multiple prenatal visits, meaning that they will be more concentrated in that analysis group.

Table 16. Deliveries that were Cesarean Section among Participants^{68 69}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	32	27.6%	102	31	30.4%	166	49	29.5%
Doula Services	158	54	34.2%	120	41	34.2%	144	62	43.1%
CenteringPregnancy	184	64	34.8%	140	56	40.0%	298	100	33.6%
MOM⁷⁰	56	20	35.7%	50	18	36.0%	81	36	44.4%

⁶⁶ Hser, Y. I., Mooney, L. J., Saxon, A. J., Miotto, K., Bell, D. S., & Huang, D. (2017). Chronic pain among patients with opioid use disorder: Results from electronic health records data. *Journal of substance abuse treatment*, 77, 26–30.

<https://doi.org/10.1016/j.jsat.2017.03.006>

⁶⁷ Ellis, J. D., Cairncross, M., Struble, C. A., Carr, M. M., Ledgerwood, D. M., & Lundahl, L. H. (2019). Correlates of treatment retention and opioid misuse among postpartum women in methadone treatment. *Journal of addiction medicine*, 13(2), 153-158.

⁶⁸ Data source: The Hilltop Institute

⁶⁹ The table reflects the sum of unique participants since the benefit’s inception. These start dates are listed in Table 3.

⁷⁰ The MOM benefit is reimbursed by member-month, therefore the “at least one qualifying visit” and “meets evaluation inclusion criteria” groups refers to the number of visits, rather than discrete visits.

Severe Maternal Morbidity

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

Table 17. Pregnancies Associated with Severe Maternal Morbidity among Participants^{71 72}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	0	0.0%	102	0	0.0%	166	0	0.0%
Doula Services	158	0	0.0%	120	0	0.0%	144	0	0.0%
CenteringPregnancy	184	*	*	140	*	*	298	0	0.0%
MOM ⁷³	56	0	0.0%	50	0	0.0%	81	0	0.0%

Birth Complications

Birth complications, while related to SMM, refer to any problems that occur during labor and delivery that affect the mother or baby.⁷⁴ As with any type of medical complication, reducing ones that occur during birth are a priority. The data shows preliminary positive results for this metric: three of the benefits had no instances of SMM and the remaining one had very few instances of it.

Table 18. Deliveries that had Birth Complications among Participants^{71 72}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	*	*	102	*	*	166	*	*
Doula Services	158	0	0.0%	120	0	0.0%	144	0	0.0%
CenteringPregnancy	184	0	0.0%	140	0	0.0%	298	*	*
MOM ⁷⁵	56	0	0.0%	50	0	0.0%	81	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)⁷⁶ can be caused by a variety of factors including gestational age, multiple gestation pregnancies, maternal health, and environmental

⁷¹ Data source: The Hilltop Institute

⁷² The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

⁷³ The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

⁷⁴ Only around 3 percent of the birth complication ICD-10 codes appear on the list of SMM codes, primarily ones related to anesthesia complications.

⁷⁵ The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

⁷⁶ Centers for Disease Control. (2024). *Birthweight and Gestation*. <https://www.cdc.gov/nchs/fastats/birthweight.htm>

factors. Since infants being of very low birth weight is a relatively rare occurrence, there were not a reportable number for any of the four benefits, requiring that the low birth weight data also be suppressed. Due to this issue, the Department elected to only report the number of infants born of normal birth weight.

The proportion of infants of normal birth weight whose mother was enrolled in HVS, doula services, and CenteringPregnancy were generally similar to those in their respective comparison groups. While the proportion of infants of normal weight whose mother was enrolled in in the MOM program was similar between the “meets evaluation criteria” and the comparison groups, there was a clear improvement between “any qualifying” and the “meets evaluation criteria” groups. This indicates that mothers who received the MOM benefit for a longer period of time had better outcomes. The reason that a smaller proportion of individuals in the MOM program have an infant of a normal birth weight compared to those enrolled in the other benefits may be related to the fact that those with prenatal exposure to opioids are at a greater risk of being of low birth weight.⁷⁷

Table 19. Newborns who are Normal Birth Weight for all Participants Enrolled before Delivery^{78 79}

	Any Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Normal Weight	Percent	Denom	Normal Weight	Percent	Denom	Normal Weight	Percent
HVS	116	103	88.8%	102	90	88.2%	166	150	90.4%
Doula Services	158	142	89.9%	120	105	87.5%	144	124	86.1%
CenteringPregnancy	184	173	94.0%	140	131	93.6%	298	275	92.3%
MOM⁸⁰	56	44	78.6%	50	41	82.0%	81	66	81.5%

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. At this time, the Department has elected not to present the NICU admissions data as the counts are extremely low and it would be difficult to draw any conclusions from the results. Although still a very small number, the MOM benefit and their comparison both had more NICU admissions than the other benefits. This aligns with what is known about the population - 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.

⁷⁷ 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>

⁷⁸ Data source: The Hilltop Institute

⁷⁹ The table reflects the sum of unique participants since the benefit’s inception. These start dates are listed in Table 3.

⁸⁰ The MOM benefit is reimbursed by member-month, therefore the “at least one qualifying visit” and “meets evaluation inclusion criteria” groups refers to the number of visits, rather than discrete visits.

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 data shows that both HVS and HealthySteps had higher rates of children with any well-care visits than their respective comparison groups. The Department had anticipated the very high HealthySteps completion rate since the benefit is administered by the same provider office that provides the well-care visits; however the HVS completion rates were more notable as this benefit is offered by a completely different entity, often a local health department.

Table 20. Children with at least one Qualifying Visit who Received a Well-Care Visit during the Calendar Year by Program Enrollment^{81 82}

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Ave Well-Care Visits per Child	Children with Any Well-Care	Denom	Ave Well-Care Visits per Child	Children with Any Well-Care	Denom	Ave Well-Care Visits per Child	Children with Any Well-Care
HVS	692	5.5	97.5%	624	5.7	97.9%	2,597	3.9	91.6%
Healthy Steps	3,428	3.0	98.1%	1,764	4.0	99.8%	8,606	3.0	85.6%

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 (Infl); several of which are combined into “combination 3”. For enrollees in both HVS and HealthySteps, MMR and HepA had the largest completion rates and influenza had the smallest.

Children enrolled in the HVS benefit - both those in “at least one qualifying” and “meets evaluation criteria” - had significantly higher vaccination rates than those in the comparison group. For several vaccinations, those in the “meets evaluation criteria” were greater than three times more likely to receive the vaccine.

For each of the vaccinations, HealthySteps enrollees had markedly lower completion rates than their comparison group. One possible explanation for the comparatively lower vaccination completion rates for individuals enrolled in the HealthySteps benefit is that many of the participants likely are served by the same small group of primary care providers. Because of this commonality, any differences associated with these provider’s vaccination claims apply to all of the participants in the benefit,

⁸¹ Data source: The Hilltop Institute

⁸² The table reflects the sum of unique participants since the benefit’s inception. These start dates are listed in Table 3.

artificially lowering the average. The Department will continue to monitor the vaccination completion rates for this population.

Table 21A. Children Aged 2 Years Old Enrolled in Home Visiting Services (HVS) and HealthySteps that Received Childhood Immunizations^{83 84}

		Denom	DTAP	IPV	MMR	HiB	HepB	VZV
HVS	At Least One Qualifying Visit	611	20.3%	23.6%	27.7%	25.2%	21.3%	27.3%
	Meets Eval. Inclusion Criteria	558	21.1%	24.7%	29.0%	26.5%	22.4%	28.7%
	Comparison Group	2,550	7.4%	8.9%	9.7%	9.3%	6.6%	9.6%
Healthy Steps	At Least One Qualifying Visit	2,227	6.7%	7.7%	8.7%	7.8%	7.4%	8.5%
	Meets Eval. Inclusion Criteria	1,480	5.9%	6.8%	7.6%	6.9%	6.7%	7.4%
	Comparison Group	7,339	11.7%	14.9%	17.5%	16.0%	12.4%	17.5%

Table 21A. Cont.

		Denom	PCV	HepA	RV	Influ	Combo 3
HVS	At Least One Qualifying Visit	611	21.4%	28.2%	21.1%	13.1%	15.7%
	Meets Eval. Inclusion Criteria	558	22.6%	29.6%	22.2%	13.8%	16.5%
	Comparison Group	2,550	7.7%	9.9%	7.7%	4.1%	4.6%
Healthy Steps	At Least One Qualifying Visit	2,227	6.7%	8.8%	7.2%	5.7%	6.2%
	Meets Eval. Inclusion Criteria	1,480	6.0%	7.6%	6.8%	5.3%	5.5%
	Comparison Group	7,339	12.9%	17.3%	12.8%	7.0%	8.3%

⁸³ Data source: The Hilltop Institute

⁸⁴ The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

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		

Children who were Screened for Risk of Developmental, Behavioral and Social Delays using a Standardized Tool

Screenings for developmental, behavioral, and social delays using a validated standardized tool allow for earlier identification, meaning that appropriate therapies can be initiated sooner.

The data for this metric shows that both HVS and HealthySteps had completion rates either equivalent to or better than the comparison groups. Within each benefit, however, completion rates decreased over time. One notable trend is that the annual number of children screened remained fairly constant year over year (i.e. the numerator) however the rate decreased steadily as there was a sharp increase in the number of children enrolled in each benefit (i.e. the denominator).

While the completion decreased for both benefits, it was far greater for HealthySteps. There are several possible explanations for this change. First, HealthySteps has a somewhat complex claims/encounters submissions procedure, wherein providers are able to receive an enhanced payment for all pediatric evaluation and management (E&M) or well-child visits, not just ones where the child development specialist participates. It is possible that at the start of the benefit, some HealthySteps providers were only submitting the claim when the screening was performed, meaning that the ratio would be much higher. As providers became more familiar with the model, they began submitting claims/encounters as the Department intended, however this may have artificially lowered the completion rates. Another possibility is that as new providers became accredited, they had different billing procedures. Since there are so few HealthySteps providers, even one new provider could create noticeable changes to the annual rates. The Department will investigate this change further.

Table 22A. Children who were Screened for Risk of Developmental, Behavioral and Social Delays using a Standardized Tool, Aged 1⁸⁵

Program	Year	Any Qualifying Visit		Meets Eval. Inclusion Criteria		Comparison Group	
		Denom	Percent	Denom	Percent	Denom	Percent
HVS	CY 2022	38	71.1%	38	71.1%	213	63.4%
	CY 2023	159	66.0%	151	67.5%	180	63.3%
	CY 2024	233	65.7%	219	65.8%	203	62.6%
HealthySteps	CY 2022	-	-	-	-	-	-
	CY 2023	356	83.4%	284	85.9%	924	50.3%
	CY 2024	700	51.0%	519	55.7%	2,269	51.5%

Table 22B. Children who were Screened for Risk of Developmental, Behavioral and Social Delays using a Standardized Tool, Aged 2⁸⁵

Program	Year	Any Qualifying Visit		Meets Eval. Inclusion Criteria		Comparison Group	
		Denom	Percent	Denom	Percent	Denom	Percent
HVS	CY 2022	29	79.3%	29	79.3%	103	62.1%
	CY 2023	80	77.5%	73	76.7%	121	62.0%
	CY 2024	133	65.4%	131	65.6%	112	63.4%
HealthySteps	CY 2022	-	-	-	-	-	-
	CY 2023	256	84.8%	149	88.6%	463	59.0%
	CY 2024	597	47.2%	388	60.1%	1,300	62.2%

Table 22C. Children who were Screened for Risk of Developmental, Behavioral and Social Delays using a Standardized Tool, Aged 3⁸⁵

Program	Year	Any Qualifying Visit		Meets Eval. Inclusion Criteria		Comparison Group	
		Denom	Percent	Denom	Percent	Denom	Percent
HVS	CY 2022	20	90.0%	18	88.9%	27	74.1%
	CY 2023	50	76.0%	47	76.6%	18	55.6%
	CY 2024	61	68.9%	58	69.0%	14	64.3%
HealthySteps	CY 2022	-	-	-	-	-	-
	CY 2023	246	66.7%	102	69.6%	515	48.9%
	CY 2024	518	37.5%	210	56.2%	1,001	54.3%

Doula-Specific Metrics

The doula benefit has three different visit types (prenatal visits, postpartum visits, and attendance at labor and delivery); participants have the option of selecting which types they wish to receive, up to nine visits per

⁸⁵ Data source: The Hilltop Institute

pregnancy. Since each participant has a different combination of visits, the Department elected to perform an analysis, comparing outcomes from the different visit types.

Four metrics were selected for this analysis. The first two metrics were for SMM and birth complications, comparing participants who had a doula at labor and delivery with those who had a doula but not during the delivery. Since there was not a single instance of either SMM or birth complications of anyone in the doula benefit, the analyses could not be performed. The third metric was completion of a postpartum care visit between seven and 84 days, comparing the participants who had a doula visit in the postpartum period and those who had a doula visit but not during the postpartum period (i.e. a prenatal visit and/or attendance at labor and delivery. Of individuals who receive doula services, relatively few receive doula visits in the postpartum period, therefore there were not enough to publish the analysis at this time. The fourth metric was for cesarean delivery, comparing participants who had a doula at labor and delivery with those who had a doula but not during the delivery. This metric did have sufficient data for an analysis, outlined below.

Cesarean Births among Doula Program Enrollees with and without a Doula at the Delivery

Of the individuals who received “any qualifying visit” of doula services, there was little difference in cesarean delivery rates between those who had a doula present at labor and delivery and those who did not. However when comparing those in the “meets evaluation criteria”, there was a small decrease in cesarean deliveries among the enrollees who had a doula present at the birth. This indicates that the combination of prenatal visits *and* attendance of a doula at labor and delivery is associated with a reduction in cesarean deliveries. In addition to Table 23A, the data from this metric is presented as a contingency table in Table 23B which shows the number of individuals for the “exposure” categories (i.e. presence of a doula at labor and delivery) and the number of individuals for the “outcome” categories (i.e. cesarean delivery).

Table 23A. Number of Cesarean Deliveries among Doula Program Enrollees with and without a Doula at the Delivery^{86 87}

Program	Any Qualifying Visit				Meets Eval. Inclusion Criteria			
	Doula at Delivery	Denom	Cesarean Delivery	Percent	Doula at Delivery	Denom	Cesarean Delivery	Percent
Doula	Yes	91	31	34.1%	Yes	82	27	32.9%
	No	67	23	34.3%	No	38	14	36.8%

⁸⁶ Data source: The Hilltop Institute

⁸⁷ The table reflects the sum of unique participants since the benefit’s inception. These start dates are listed in Table 3.

Table 23B. Contingency Table of Cesarean Deliveries among “Any Qualifying Visit” Doula Program Enrollees with and without a Doula at the Delivery^{88 89}

		Cesarean Performed		
		Yes	No	Total
Doula at Delivery	Yes	31	60	91
	No	23	44	67
	Total	54	104	158

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 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 (e.g. preeclampsia), preterm birth, and maternal depression; 3) reducing barriers to care by connecting mothers and health practitioners (nurses, pediatric care, specialists, etc.); 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.⁹⁰

The Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) funds 18 jurisdictions and 21 programs that meet federal evidence-based criteria across Maryland. Maryland Medicaid reimburses ten 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 \$2.44 million over four years (August 15, 2022 through June 30, 2026) to four sites through the Fund. Three of those sites also receive MIECHV funding. In FY25, the Department supported an additional Nurse Family

⁸⁸ Data source: The Hilltop Institute

⁸⁹ The table reflects the sum of unique participants since the benefit’s inception. These start dates are listed in Table 3.

⁹⁰ Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program a Report to Congress. 2016, mchb.hrsa.gov/sites/default/files/mchb/programs-impact/reportcongress-homevisiting.pdf.

Partnership program.

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. In Fall 2024, the Department supported an existing Nurse Family Partnership Program (St. Mary's County). What follows is a brief description of each of the five sites.

Montgomery County Health Department utilizes funding to expand its prenatal care coordination initiative Babies Born Healthy (BBH) to connect its participants to home visiting services and offers the March of Dimes Becoming A Mom (BAM) curriculum for those 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 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 organizes and conducts family groups where home visiting staff convene families for educational and social experiences. Families describe the family groups as invaluable, where they facilitate meaningful connections among families, provide essential parenting insights, and create 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.⁹¹

Baltimore Healthy Start (BHS) collaborated with 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. The program received PAT certification in FY2023, and has since been able to recruit and onboard staff to grow the PAT home visiting initiative. The program's collaborative efforts extended to partnerships

⁹¹ Washington County Health Department is an approved Medicaid HVS provider therefore solely Medicaid funds were used for Medicaid participants.

with the following organizations: Health Care Access Maryland (HCAM), Urban Strategies, and The Parent Helpline.

St. Mary's County Health Department utilized funding for their Nurse Family Partnership (NFP) program through MIECHV. NFP is an evidence-based community health program offered to first-time moms facing significant socioeconomic barriers who struggle to access the resources and support needed to achieve the best health and wellness outcomes. The program pairs a first-time mom with a specially educated nurse, who will make regular visits with the mom starting in the early stages of pregnancy and lasting until the child's second birthday. This funding was used for outreach activities to the community for the recruitment of families into the program.

In FY 2025, fund-supported Home Visiting Expansion Initiatives enrolled 104 families to home visiting programs in priority jurisdictions. Table 24 indicates the number of those enrolled by race and ethnicity, Table 25 indicates the number enrolled by insurance provider, and Table 26 indicates the timing of enrollment. The majority of the home visiting sites experienced challenges with recruitment of home visiting staff for the expansion of their programs. In FY 2026, The Department will focus on shifting the funding focus from expansion of home visiting expansion to sustainability planning for grantees.

Table 24. Number of Enrolled in Fund-Supported Home Visiting Expansion by Race/Ethnicity in FY 2025⁹²

Race/Ethnicity	No. Enrolled
non-Hispanic White	13
non-Hispanic Black	69
Hispanic	17
non-Hispanic Asian	*
non-Hispanic Native American/ Alaska Native	0
non-Hispanic Multiracial	*
Total	104

⁹² Data source: Maryland Department of Health, Maternal and Child Health Bureau

Table 25. Number of Enrolled in Fund-Supported Home Visiting Expansion by Insurance Provider⁹³

Enrolled Insurance Type	No. Enrolled
Medicaid	94
Private	0
Uninsured	*
Other	*
Total	104

Table 26. Number of Enrolled in Fund-Supported Home Visiting Expansion by Timing of Enrollment⁹³

Timing of Enrollment	No. Enrolled
1st Trimester	14
2nd Trimester	50
3rd Trimester	24
Postpartum/Unknown	16
Total	104

In FY 2025, the five sites enrolled 104 new participants in home visiting programs with demographics as follows:

- 66 percent of enrollees identified as non-Hispanic Black
- 45 percent were ages 25-34 years old
- 90 percent were enrolled in Medicaid
- 85 percent of enrollments happened during the prenatal period
- 94 participants reported an end in pregnancy, all of which ended in a live birth

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 rates affecting Black birthing persons in Maryland, the Department has reserved a total of \$429,197 from the fund for a period of four years (from FY 2022 to FY 2026) for the implementation of

⁹³ Data source: Maryland Department of Health, Maternal and Child Health Bureau

CenteringPregnancy. Braided with state general funds, this will result in a total of \$846,194 for the expansion of 13 additional CenteringPregnancy sites across Maryland. In alignment, participating non-Federally Qualified Health Center (FQHC) practices may be eligible for Medicaid's CenteringPregnancy enhanced reimbursement benefit, detailed above.

Implementation Update

During FY 2022 to FY 2025, PHIF funding was allocated to expand CenteringPregnancy in five new sites across Maryland. In FY 2024 and FY 2025, funding for six additional sites was allocated using braided funding from the Babies Born Healthy (BBH) program, a program whose goal is to reduce disparities in infant mortality. In FY 2026, the BBH program will continue to fund the expansion of two additional sites. This expansion will result in a total of 13 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. In FY 2025, they recruited one additional site in Montgomery County. One site had to close due to leadership changes. The active sites implemented by Centering Healthcare Institute include:

- Baltimore Medical System at Yard 56
- CCI Greenbelt
- CCI Health Services Silver Spring
- Chesapeake Health Care
- Frederick Health
- Greater Baden Medical Services: Capitol Heights II
- Kaiser Permanente Gaithersburg Medical Center
- Kaiser Permanente Largo
- Luminis Health Greenbelt
- Luminis Health Women's Collaborative Care
- Maternal Care Center at Shady Grove
- Mercy Medical Center
- Michel Mirowski Medical Office Building OBGYN
- University of Maryland Baltimore Washington Medical Group - Glen Burnie
- University of Maryland Women's Center
- Women's Health Associates (U of Maryland - St Joseph's Medical Center)

In FY25, seven of the sites received accreditation from the Centering Healthcare Institute. In FY25, MCHB worked with Medicaid to facilitate connections and encourage provider enrollment, and will continue in FY26.

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 childhood 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 2025, 962 children with asthma received services through this program. In support of the goal of addressing health disparities, 63 percent of the children with asthma served in the program were Black or African American.

Table 27. Children with moderate to severe asthma served in the Medicaid/CHIP Home Visiting program, by jurisdiction (2020-2025)^{94 95}

Jurisdiction	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Anne Arundel	-	-	-	92	158	158
Baltimore	*	*	14	122	146	182
Baltimore City	17	40	183	251	331	254
Charles	46	*	*	11	*	12
Dorchester	86	17	24	57	32	51
Frederick	13	12	*	18	24	19
Harford	263	109	82	96	59	18
Montgomery	-	-	-	23	72	178
Prince George's	49	31	84	36	*	*
St. Mary's	*	53	36	35	35	26
Wicomico	54	38	85	66	22	60
Total	530	315	521	807	897	962

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.

⁹⁴ 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 2027.

⁹⁵ Data source: Maryland Department of Health, Environmental Health Bureau, Medicaid/CHIP Lead and Asthma Home Visiting Program

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 28 below shows the growth in and impact of CRISP referrals on asthma enrollment in the home visiting program over time.

Table 28. Number and Status of Children Referred to Local Health Department Home Visiting Programs by CRISP, 2022-2024⁹⁶

Status of Child/Family	CY 2022	CY 2023	CY 2024	Total
Attempting to enroll/determine eligibility or pending eligibility determination	67	94	464	625
Could not contact family	454	1033	1076	2563
Family/child discharged from Program	207	340	439	986
Family/child eligible and enrolled in Program	16	56	160	232
Family/child eligible but declines participation in Program	295	994	1060	2349
Family/child lost to follow up	141	336	168	645
Family/child NOT eligible for Program	110	350	334	794
Total	1290	3203	3701	8194

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 addressed asthma through both educational interventions and home-based interventions and also expanded the number of children and families in the state who could be eligible for services.

The GHHI program used a tiered intervention approach to conduct interventions to reduce exposures to

⁹⁶ Data source: Maryland Department of Health, Environmental Health Bureau, Medicaid/CHIP Lead and Asthma Home Visiting Program

home-based environmental asthma triggers such as dust-borne antigens, mold and other asthma triggers. All properties approved to participate in the program received 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 were also 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 received Tier I Plus services as well.

Tier I Asthma Trigger Reduction Interventions included:

- 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 included:

- 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 affected initial enrollment. Nonetheless GHHI received 2,300 referrals of children ages two to 17 in Baltimore City and Prince George’s County who were diagnosed with asthma and whose asthma are deemed to be uncontrolled. The final report summarizes the objectives and final count of clients enrolled for each jurisdiction:

Objectives: The original intention was to enroll a total of 210 children in the Program over 42 months (3.5 years). 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 had ten unserved clients from its Year 4 goal of 60 clients, which then increased the target to 70 clients. In FY 2025, GHHI exceeded its goal by enrolling 71 clients.

Table 29. Findings and Enrollment from the Baltimore City and Prince George’s County Regional Catalyst Award Asthma Initiatives, FY 2023 - FY 2025⁹⁷

	Number of Regional Catalyst Clients Served			
	FY23	FY24	FY25	Total
Baltimore City	98	102	118	318
Prince George's	10	130	71	211
Total	108	232	189	529

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 were to be enrolled in the Program over 42 months. In the first two years of the program, SFYs 2022 and 2023, GHHI enrolled 98 families through that period. However, GHHI exceeded their goals for SFYs 2024 and 2025, enrolling 102 and 118 families, respectively. In total, GHHI served 318 households, exceeding their goal of 280 households throughout the program period.

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 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

⁹⁷ Data source: Maryland Department of Health, Environmental Health Bureau, Medicaid/CHIP Lead and Asthma Home Visiting Program

3. Ensure that Marylanders with asthma get the best possible care and access to prevention services.

In FY 2025 EHB successfully held three Asthma CoP meetings (dates: October 10, 2024; January 14, 2025; March 20, 2025). 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.

While the asthma home visiting program was significantly affected by the COVID-19 pandemic and subsequent public health response, by late 2023 the home visiting programs had returned to essentially normal operations. Data on emergency department admissions took slightly longer to return to their pre-pandemic baseline and trajectory, but as noted elsewhere in the report, they have now fully done so. The Department remains committed to achieving the SIHIS goals, and to continuing childhood asthma emergency department rate reductions.

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.⁹⁸ 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 2025, Maryland had 316.1 SMM-related hospitalizations per 10,000 delivery discharges over the prior 12 months. This rate is 118.4 hospitalizations per 10,000 higher than the 2026 target

⁹⁸ 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>

(197.6) and 73.0 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 transfusion-only events excluded was 111.0 events per 10,000 delivery discharges.

Figure 1. SMM Hospitalizations for Rolling 12- Months, 2018 - June 2025⁹⁹

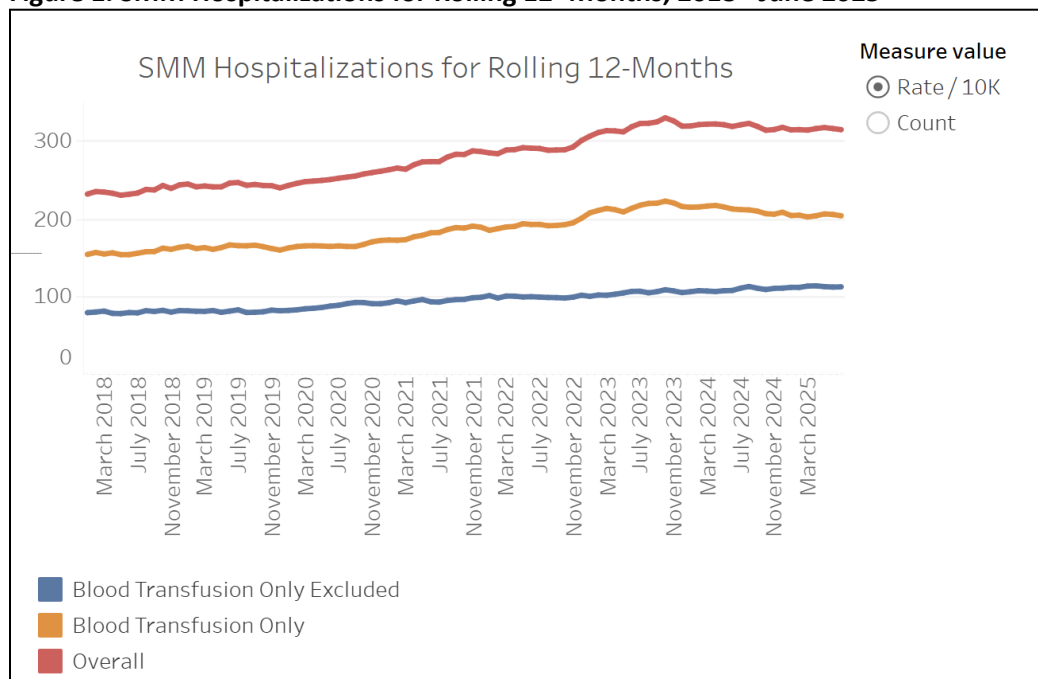


Table 30A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed July 2024-June 2025 Rates, Maryland⁹⁹

	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 (219.8)	316.1	18.7% decrease (197.6)	-118.4
SMM Events	1,585		1,876		
Eligible Deliverables	65,199		59,354		

⁹⁹ Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

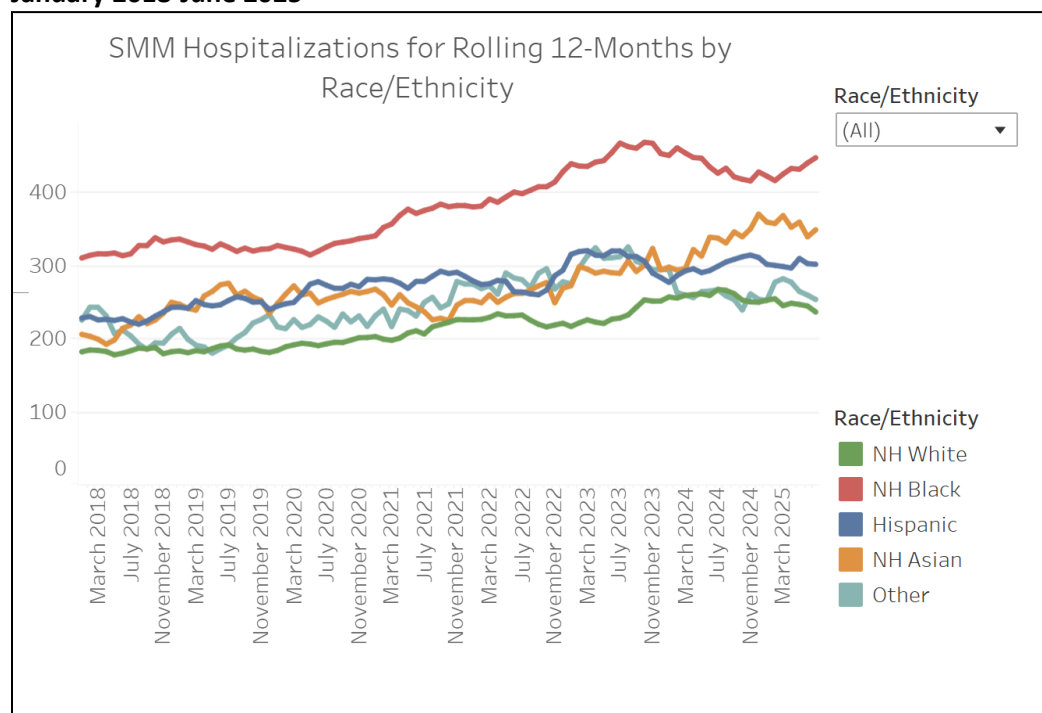
Table 30B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed July 2024-June 2025 Rates, Maryland¹⁰⁰

	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 (72.9)	111.0	18.7% decrease (65.6)	-45.4
SMM Events	526		659		
Eligible Deliverables	65,199		59,354		

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 31A, and Table 31B 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 2025¹⁰⁰



¹⁰⁰ Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

Figure 2B. SMM Hospitalizations, Excluding Blood Transfusion-Only Events, for Rolling 12-Months by Race/Ethnicity, January 2018-June 2025¹⁰¹

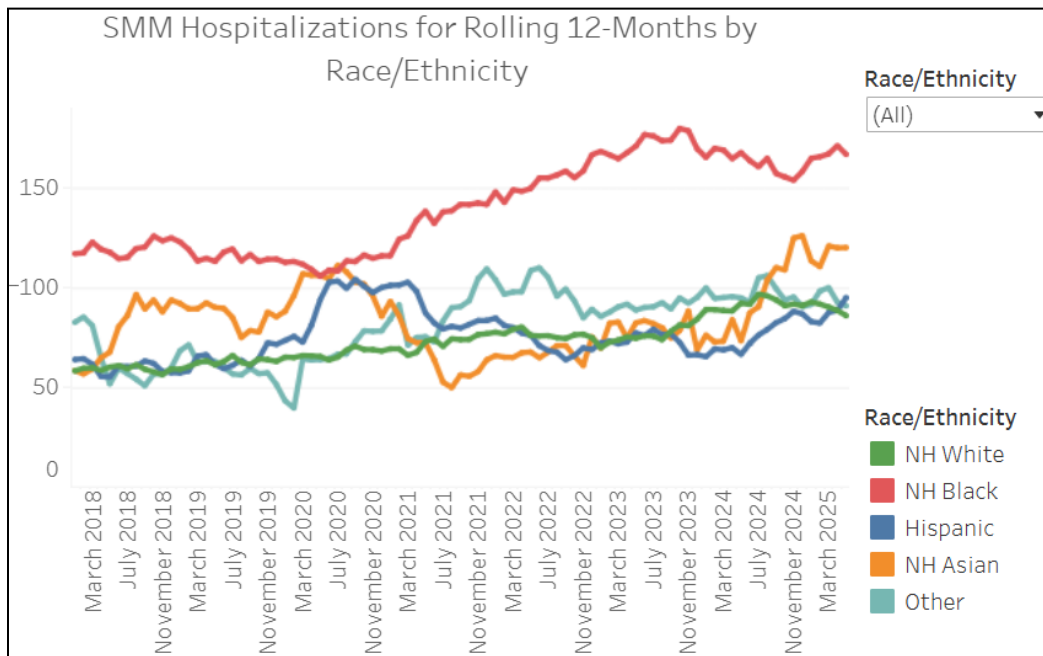


Table 31A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed July 2024-June 2025 Rates, Maryland by Race/Ethnicity¹⁰²

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	243.8	15% decrease	-89.6	1.0
NH Black	334.2	10% decrease	440.2	20% decrease	-172.8	1.8
Hispanic	242.0	10% decrease	301.8	20% decrease	-108.2	1.2
NH Asian	249.0	10% decrease	338.5	20% decrease	-139.3	1.4
Other	205.2	10% decrease	258.8	20% decrease	-94.6	1.1
Statewide Total	243.1	9.6% decrease	316.1	18.7% decrease	-118.4	1.3

¹⁰¹ Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

¹⁰² Data Source: MCHB Data & Epidemiology Program summary of Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed and summarized August 2025.

Table 31B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed July 2024-June 2025 Rates, Maryland by Race/Ethnicity¹⁰³

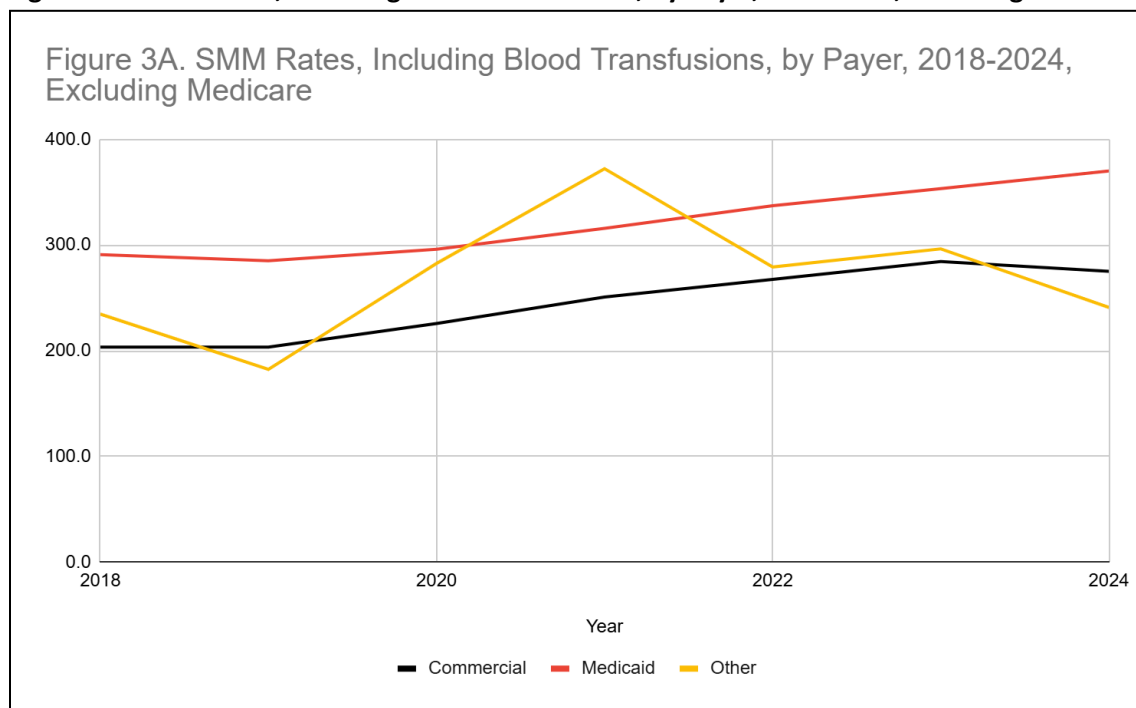
Race/Ethnicity	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months	Disparity Index - Most Recent 12 Months
NH White	59.0	7.5% decrease	85.5	15% decrease	-35.3	1.0
NH Black	124.3	10% decrease	169.2	20% decrease	-69.7	2.0
Hispanic	57.2	10% decrease	89.0	20% decrease	-43.2	1.0
NH Asian	93.4	10% decrease	112.8	20% decrease	-38.1	1.3
Other	59.5	10% decrease	93.9	20% decrease	-46.3	1.1
Statewide Total	80.7	9.6% decrease	111.0	18.7% decrease	-45.4	1.3

Performance by Payer

Staff is also monitoring SMM performance by payer. Both Medicaid and commercial payers are trending upward for SMM rates, in line with Statewide performance (Figure 3A and 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 32A and 32B).

¹⁰³ Data Source: MCHB Data & Epidemiology Program summary of Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed and summarized August 2025.

Figure 3A. SMM Rates, Including Blood Transfusions, by Payer, 2018-2024, Excluding Medicare^{104 105}



¹⁰⁴ Data Source: MCHB Data & Epidemiology Program analysis of Health Services Cost Review Commission (HSCRC) data. September 2025.

¹⁰⁵ Note: Medicare data are not shown in the figure due to low counts of SMM events, and to allow better visualization.

Figure 3B. SMM Rates, Excluding Blood Transfusion-Only Events, by Payer, 2018-2024, Excluding Medicare¹⁰⁶

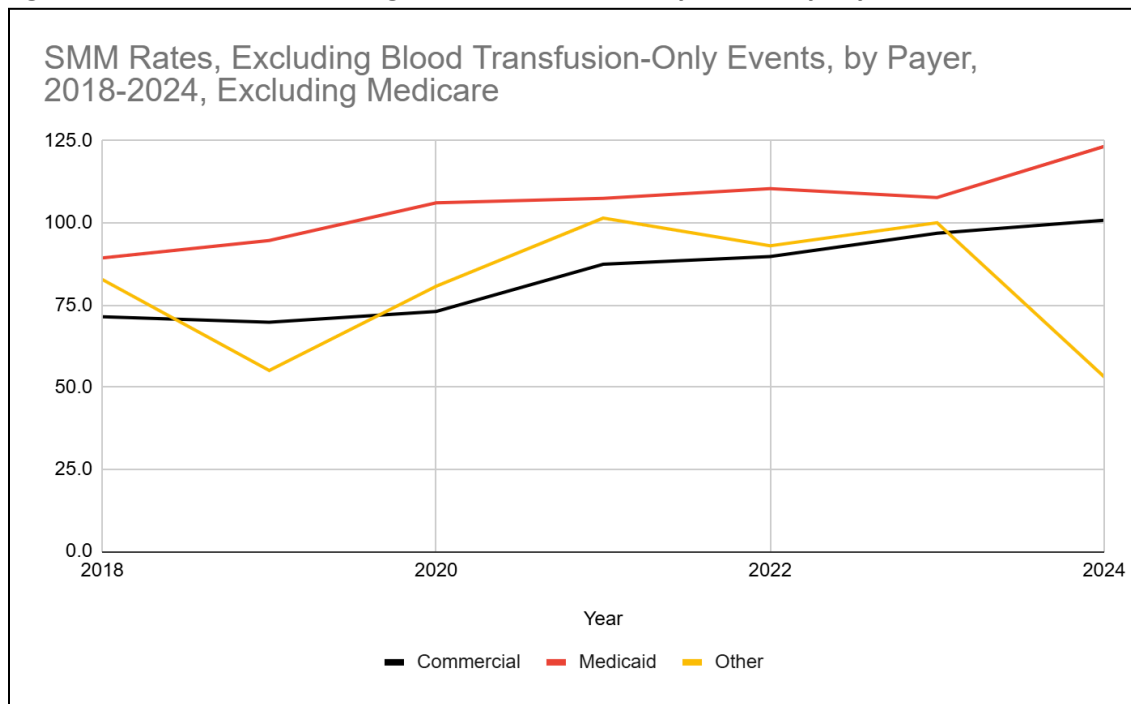


Table 32A. SMM Rate, Including Blood Transfusions, by Payer, 2018 – 2024^{106 107}

Payer	2018	2019	2020	2021	2022	2023	2024	% Change Since 2018
Commercial	203.5	203.4	225.8	250.8	267.5	284.3	275.1	+35.2%
Medicaid	290.9	285.0	295.9	315.8	337.1	353.3	369.9	+27.2%
Medicare	692.3	641.5	848.7	962.3	717.5	1315.8	687.8	-0.7%
Other	234.6	182.4	282.5	372.1	279.2	296.2	241.0	+2.7%

¹⁰⁶ Data Source: MCHB Data & Epidemiology Program Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. September 2025.

¹⁰⁷ Note: Medicare data have low numerator counts. Interpret with caution.

Table 32B. SMM Rate, Excluding Blood Transfusion-Only Events, by Payer, 2018 – 2024^{108 109}

Payer	2018	2019	2020	2021	2022	2023	2024	% Change Since 2018
Commercial	71.4	69.8	73.1	87.4	89.8	96.9	100.8	+41.1%
Medicaid	89.4	94.6	106.1	107.5	110.4	107.8	123.3	+38.0%
Medicare	423.1	*	516.6	502.1	*	684.2	*	N/A
Other	82.8	55.1	80.7	101.5	93.1	100.1	53.2	-35.8%

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. Despite lower ED volumes, staff believe that the underlying dynamics of childhood asthma in Maryland did not change. By 2023, ED rates had recovered from their pandemic lows and resumed their downward trajectory after peaking in July of that year. More recently, rates have flattened out since the winter of 2023-2024, and the Department continues to monitor progress towards the original SIHIS goals.

Statewide Performance

Based on data through June 2025, Maryland had 6.9 asthma-related emergency department visits per 1,000 children over the prior 12 months. This rate is 1.6 visits per 1,000 children higher than the 2026 target.

¹⁰⁸ Data Source: MCHB Data & Epidemiology Program Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. September 2025.

¹⁰⁹ Medicare data have low numerator counts. Interpret with caution. Data for CY 2019, CY 2022, and CY 2024 are suppressed (*) due to count < 11, in alignment with HSCRC data use agreement.

Figure 4. Childhood Asthma-Related ED Visits for Rolling 12-Months, 2018 - June 2025¹¹⁰

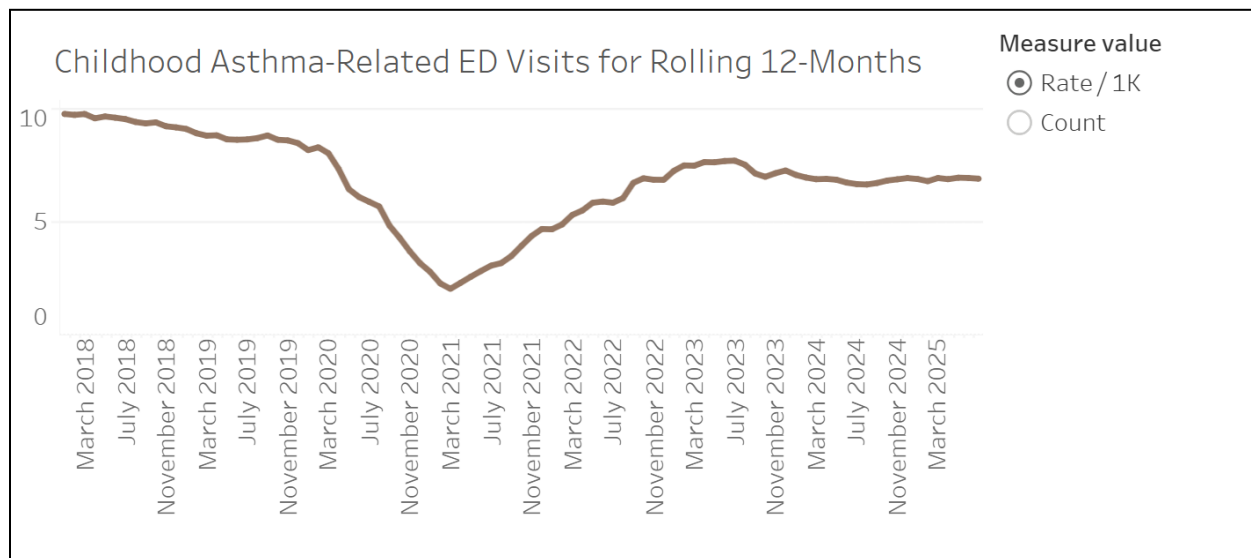


Table 33. Childhood Asthma-Related ED Visits Compared to 2023 and 2026 Target, 2018-June 2025¹¹¹

	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months
Rates per 1,000	9.2	7.2	6.9	5.3	-1.6
Total Count	10,974		8,555		

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.

¹¹⁰ Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

¹¹¹ Data Source: MCHB Data & Epidemiology Program summary of Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed and summarized September 2025.

Figure 5. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018 - June 2025¹¹²

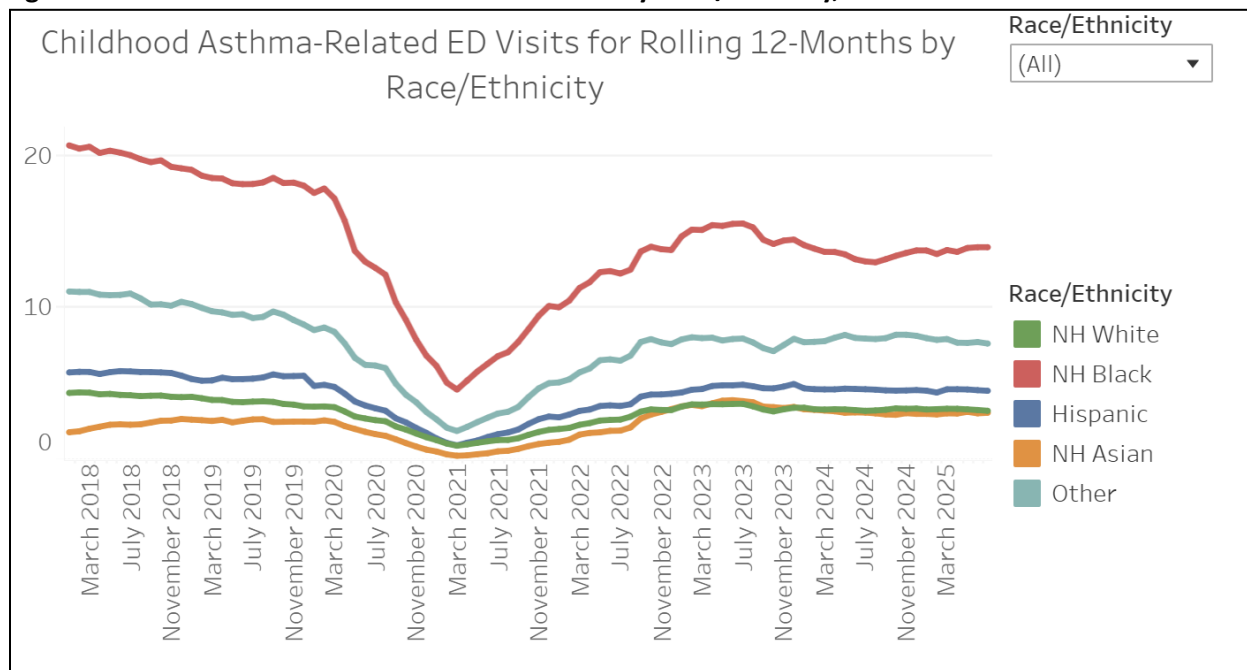


Table 34. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-June 2025¹¹³

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	4.1	3.5	3.2	3.0	-0.2	1.0
NH Black	19.1	14.4	13.9	9.6	-4.3	4.3
Hispanic	5.5	4.7	4.5	4.0	-0.5	1.4
NH Asian	2.6	2.6	3.0	2.5	-0.5	0.9
Other	10.3	7.3	7.7	5.5	-2.2	2.4
Total	9.2	7.2	6.9	5.3	-1.6	2.2

¹¹² Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

¹¹³ Data Source: MCHB Data & Epidemiology Program summary of Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed and summarized September 2025.

Performance by Payer

While the State is committed to improving asthma outcomes for all children, the emergency department visit rates for children on Medicaid have been higher than those of other payers, and the State has focused its efforts on the population of children served by Medicaid, through its home visiting program. The impacts can be seen below, in the significant decrease in visit rates from 2018, even after accounting for the impacts of 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.

Figure 6. Childhood Asthma-Related ED Visit Rate per 1,000 by Payer, 2018-2024¹¹⁴

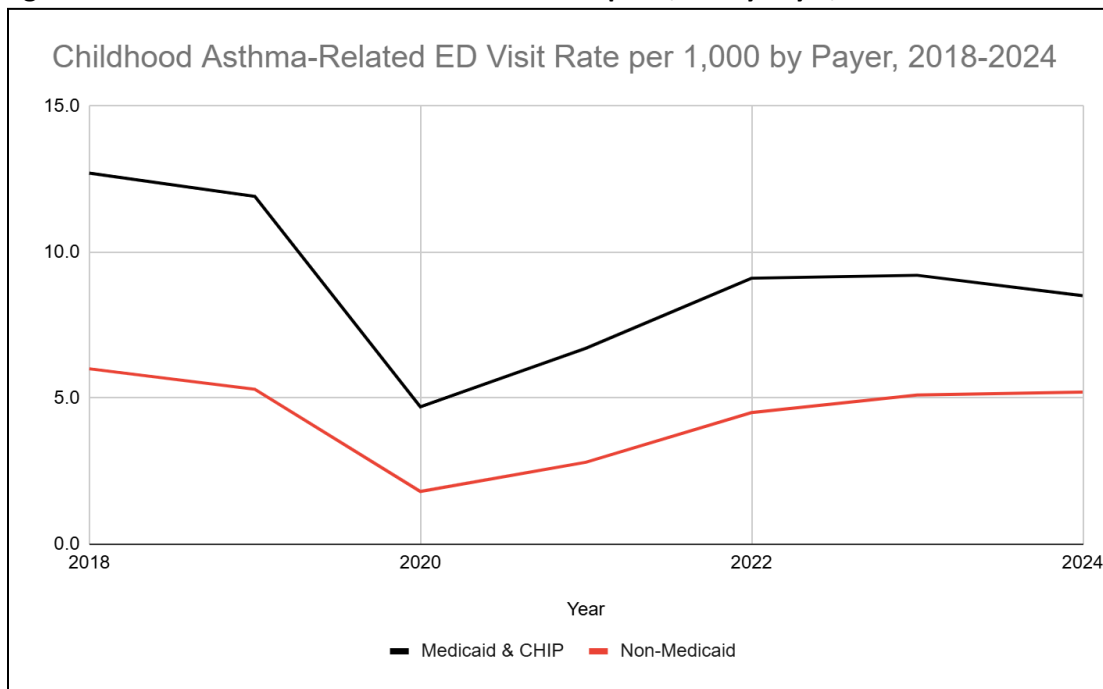


Table 35. Childhood Asthma-Related ED Visit Rate per 1,000 by Payer, 2018-2024¹¹⁵

Payer	2018	2019	2020	2021	2022	2023	2024	% Change since 2018
Medicaid & CHIP	12.7	11.9	4.7	6.7	9.2	9.2	8.5	-33.0%
Non - Medicaid	6.0	5.3	1.8	2.8	4.5	5.1	5.2	-12.6%

¹¹⁴ Data Source: MCHB Data & Epidemiology Program and Environmental Health Bureau analysis of Health Services Cost Review Commission (HSCRC) data. Health Services and HSCRC in-patient case-mix as of September 2025.

¹¹⁵ Data Source: MCHB Data & Epidemiology Program and Environmental Health Bureau analysis of Health Services Cost Review Commission (HSCRC) data. September 2025.

Year Four Spending

Medicaid

The Medicaid program continued its efforts in FY 2025 to expand all implemented benefits. As detailed above, implementation efforts included continued provider outreach, education, support and technical assistance, as well as implementation changes to support increased access. The Medicaid program intends to continue to maximize the Fund’s contribution by pulling down federal matching funds, which relies on service implementation.

Due to efforts in PY3, utilization of HVS, Doulas, CenteringPregnancy and HealthySteps services all saw marked increases from CY23 to CY24. To build on this success, the Department will continue these efforts such as continuing the doula certification nomination process, and working with Centering Healthcare Institute and ZERO TO THREE to support providers and reimbursement. The Department will also work with the MCOs to increase MOM access and utilization.

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

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

Table 36. PHPA Grant Funds Expenditures - FY 2025¹¹⁶

Initiative	FY 2025 Spending
Asthma Home Visiting Program	\$676,259
Community-Based Asthma Programs	\$200,000
Maternal Home Visiting	\$814,051
CenteringPregnancy	\$64,852
Program Total	\$1,755,162

Compared to FY24, 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 2025.

Conclusion

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

¹¹⁶ Data source: Maryland Department of Health

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.

PY4 saw a significant increase in utilization and access for Medicaid's MCH programs, and the Department will continue to build on the successful strategies that led to the increase, namely working with partner agencies to increase awareness and enacting policies to increase provider enrollment. Medicaid's MCH programs also demonstrated encouraging results in some quality measures, most notably marked higher rates of prenatal visits, continued low SMM and NICU visits, and reductions in c-section rates for doula and MOM recipients. The Department will continue to monitor all quality measures and look for opportunities of program improvement.

The Department will also continue to monitor performance on statewide SMM and asthma rates as the State recovers from the COVID-19 pandemic. Successes in Public Health's work include increased access to asthma home visiting services, reduced rates of childhood asthma-related ED visits for Medicaid participants, as well as increased number of CenteringPregnancy accredited sites. The Department will continue to investigate the impact of blood transfusions on SMM rates, and understand the opportunity for interventions.

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.

Appendix 1. Region to Jurisdiction Mapping¹¹⁷

Region	Jurisdiction(s)
Baltimore City	Baltimore City
Baltimore Suburban	Anne Arundel Baltimore County Carroll Harford Howard
Eastern Shore	Caroline Cecil Dorchester Kent Queen Anne's Somerset Talbot Wicomico Worcester
Southern Maryland	Calvert Charles St. Mary's
Washington Suburban	Montgomery Prince George's
Western Maryland	Allegany Frederick Garrett Washington
Out of State	Not Maryland

¹¹⁷ Data source: The Hilltop Institute