MARCH OF DIMES®

2025 March of Dimes Report Card:

The state of maternal and infant health for American families

MARCHOFDIMES.ORG/REPORTCARD

ON THE COVER - ROXY ROMEO

‘I had to be strong, even when I didn’t feel strong’: One mom’s journey through preterm birth

Philadelphia radio personality Roxy Romeo was 25 weeks pregnant when spotting and mild pain brought her to the hospital. Although she was having contractions, doctors sent her home. But the next day, her water broke.

A co-host rushed her back to the hospital, where she was admitted for bed rest in hopes of delaying delivery. But six days later, complications from umbilical cord prolapse led to an emergency Cesarean section. Zara was born at 26 weeks and 4 days, weighing just 2 pounds, 6.7 ounces.

For the next 93 days, Zara fought for her life in the neonatal intensive care unit (NICU), while Roxy juggled post-surgery recovery, caring for her toddler son, returning to work, and daily NICU visits. Today, Zara is healthy and thriving—and the experience turned Roxy into a passionate advocate for maternal health.

“This happened to me, and it’s happening to thousands of moms across the country,” Roxy says. “We need to come together and fight for the health of all moms and babies.”

Roxy’s experience reflects a nationwide crisis, with preterm birth affecting 1 in 10 babies. That’s why March of Dimes is calling for urgent policy changes outlined in our 2025 Report Card to give every family the best possible start.

March of Dimes Report Card 2025 Executive summary

For the past 17 years, the March of Dimes Report Card has told the story of maternal and infant health in the United States through data, revealing both progress and persistent challenges. The story the data tells is sobering: the crisis is not improving, and in many communities, it's getting worse.

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In 2025, the US again earned a D+ for preterm birth, the fourth consecutive year of the worst grade recorded in Report Card history. The national rate remained unchanged at 10.4%, representing over 360,000 babies and their families. Preterm birth is among the leading cause of infant death and lifelong complications, with rates ranging from 7.9% in New Hampshire, the only state to earn an A, to 15% in Mississippi, one of 10 states that received an F. While 19 states improved their preterm birth rates since last year, 21 states saw worsening rates. Black moms continue to face the highest preterm birth rate at 14.7%, underscoring deep systemic inequities in care and outcomes.

Access to early prenatal care continues to decline, with nearly one in four women beginning care after the first trimester, missing critical opportunities to detect and address risks early in pregnancy. This is not a failure of moms, but rather of systems that create barriers, such as limited providers, transportation, and insurance delays. Rising rates of chronic conditions like hypertension and diabetes further increase risks for both moms and babies. Together, these trends paint a picture of a fragile system where too many families are left behind.

The consequences are devastating. Infant mortality, a critical indicator of a nation's health, remains unchanged at 5.6 deaths per 1,000 live births, amounting to over 20,000 infant deaths each year. And while there are some glimmers of progress, such as the 2023 maternal mortality rate returning to pre-pandemic levels, the 669 maternal deaths are only part of the story. An estimated 40,000 women experienced life-threatening complications during childbirth in 2022.

Despite the challenges, progress is possible. Evidence-based policies and programs are making a difference, closing gaps, and improving outcomes. Maternal mortality review committees help states identify and address the drivers of pregnancy-related deaths, and Medicaid expansion and extension help ensure more families have continuous access to care through the first year after birth. This year's Report Card provides a clear view of where action is advancing and where opportunities remain.

Data alone cannot drive change — it must be matched by action. March of Dimes is leading the way through research in our Prematurity Research Centers (recently expanded to Texas), public education campaigns like *Low Dose, Big Benefits*™, and our growing fleet of Mom & Baby Mobile Health Centers®. We continue to advocate for federal policies such as the PREEMIE Reauthorization Act. We are calling on policymakers, healthcare providers, researchers, advocates, and communities to join the fight for all moms and babies — grounded in data and committed to change — to write a new chapter in our nation's story with better outcomes for every family.

Cindy Rahman

Cindy Rahman
President and Chief Executive Officer
March of Dimes

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Policy and Program Actions

March of Dimes Report Card Recommended policy and program actions

PREEMIE Reauthorization Act (S. 1562/H.R. 1197), funding research to prevent preterm birth, the second leading cause of death among newborns

PREEMIE is the federal government's commitment to preventing preterm birth and its long-term consequences through funding research, support and prevention programs and the coordination of government efforts. Among the programs authorized is Centers for Disease Control and Prevention (CDC's) highly successful Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS collects site-specific, population-based data tracking maternal attitudes and experiences before, during, and shortly after pregnancy and is used by researchers and state, territorial, and local governments to plan and review programs and policies aimed at reducing health problems among mothers and infants.
https://www.marchofdimes.org/preemie-act

Postpartum Medicaid extension extends Medicaid healthcare benefits to one year after the birth of a child

The latest data shows that 57% of all pregnancy-related deaths happen one week to one year after delivery.[1] Medicaid finances over 40% of births in the US.[2] However, without extension, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist. Under the American Rescue Plan (2021), states were given the option to extend postpartum healthcare coverage under Medicaid to 12 months.[3] Medicaid extension to a minimum of 12 months postpartum ensures that every mom gets the coverage they need to stay healthy — and alive — after their babies are born.[4]

Arkansas

Extensions in postpartum Medicaid coverage have been implemented in 49 states and Washington, DC. Arkansas remains the state that has not implemented Medicaid extension.[5]

Medicaid expansion increases access to affordable, high-quality public health insurance programs to women before, during, and after pregnancy

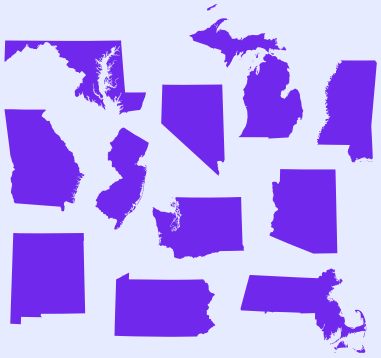
Medicaid expansion covers adults under age 65 with incomes up to 138% of the Federal Poverty Level (FPL). This includes individuals who are not eligible for other affordable health coverage, such as Children's Health Insurance Program (CHIP) or private insurance. Studies have demonstrated reductions in uninsured women of childbearing age and improved maternal and child health outcomes. By providing more accessible and equitable healthcare coverage under Medicaid, more women can access essential prenatal care and preventive services, such as screenings for chronic conditions and health risk behaviors, which promote healthier pregnancies and reduces risk for both mothers and babies.[6,7] Other benefits of Medicaid extension have been seen throughout the US. A nationwide study found that among low-income women who recently gave birth, Medicaid expansion was linked to significant improvements in three key preconception health indicators: more women reported receiving preconception health counseling from a healthcare provider, an increased number reported taking folic acid before pregnancy, and more women reported using effective contraception after pregnancy.[8]

10 states

Expanded Medicaid has been adopted in 40 states. 10 states have not opted to expand Medicaid. These states include Alabama, Georgia, Florida, Kansas, Mississippi, Tennessee, Texas, South Carolina, Wisconsin, and Wyoming.[9]

Requiring and reimbursing for postpartum depression screening during well-child visits can ensure that more people receive the mental health support they need

Postpartum Depression (PPD) affects a significant percentage of new mothers, with estimates ranging from 10-20% of birthing individuals experiencing depressive symptoms during the first year after childbirth.[10] However, many PPD cases go undiagnosed and untreated, often due to lack of screening. Untreated PPD can have severe consequences to physical and mental health for both parents and children, such as inability of new parents to bond with or care for their child, and attachment and behavioral issues for children.[11] Medicaid serves a disproportionately large number of low-income individuals and women of color, who are already at increased risk for PPD. States that require and reimburse for PPD screening at well-child visits can increase diagnosis and access to treatment for behavioral health services and the support families need.[12]

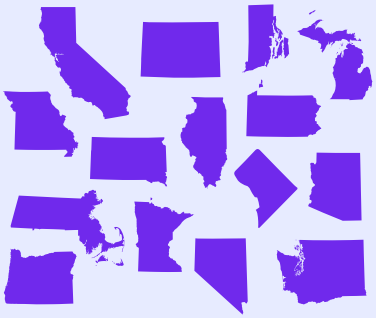


11 States

Medicaid programs in 11 states currently require and reimburse PPD screening during well-child visits. These states include: Arizona, Georgia, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Jersey, New Mexico, Pennsylvania, and Washington.[13]

Reimbursing doula services at a liveable wage creates a stronger workforce and increases access to services when it is reimbursed through Medicaid

Doulas are non-clinical professionals who provide physical, emotional, and informational support to moms before, during and after childbirth, including continuous labor support.[14] They offer guidance and support around topics related to childbirth, breastfeeding, pregnancy health, and newborn care. Supportive care during labor may include comfort measures, information, and advocacy. Increasing access to doula care, especially in under-resourced communities, may improve birth outcomes, improve the experience of care, and lower costs by reducing non-beneficial and unwanted medical interventions. Doula reimbursement needs to be both an equitable and sustainable payment model to provide doulas with a livable wage. Current doula reimbursement under state Medicaid programs are per-birth and per-visit compensation models with a cap on the maximum level of services reimbursed. Current rates among states implementing Medicaid coverage for doula care vary and are not adequate to reimburse doula care services.[15] March of Dimes advocates for state reimbursement rates to take into consideration all doula care models (private and community-based) and provide fair, equitable and sustainable compensation.

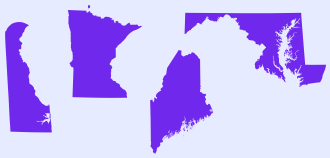


14 States and DC

While currently 25 states and Washington, DC reimburse doula care under Medicaid, 14 states and Washington, DC reimburse at least $1500 or more. These states include: Arizona, California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, Missouri, Nevada, Oregon, Pennsylvania, Rhode Island, South Dakota, Washington, and Washington, DC.[16]

Paid family leave systems support families during parental leave, which is associated with multiple positive outcomes for moms and babies

Paid family leave systems should strive to make benefits available to all workers while also distributing the responsibility for funding this system among employers. March of Dimes supports policies to create an affordable and self-sustaining national system to provide workers with up to 12 weeks of partial income through a family and medical leave insurance fund. The US is the only industrialized nation that does not offer working parents paid time off to care for a new child or sick loved one.[17] Access to paid family leave and sick day benefits fosters parent-infant attachment, creating a vital foundation for safe, stable, and nurturing relationships. These benefits also encourage parenting practices that promote optimal infant health and development, such as improving the establishment and maintenance of breastfeeding and on-time routine childhood vaccinations. Paid leave has also been associated with improved maternal health outcomes, such as reductions in depressive symptoms.[18]



4 States enacted legislation for PFL

Delaware, Maine, Maryland, and Minnesota have newly enacted paid family and medical leave laws and are set to be effective between 2026 and 2028.[19]

Colorado

Colorado enacted legislation that extended paid family leave to 24 weeks for families with a baby in the neonatal intensive care unit, starting January 2026.[25]

Maternal Mortality Review Committees advance our understanding of maternal mortality through data and surveillance

In order to implement strategies to prevent maternal death, we need to understand why moms are dying. Improving data collection and surveillance on maternal mortality and morbidity helps to establish baseline data, understand trends, and monitor changes. Maternal Mortality Review Committees (MMRC) investigate instances of maternal death in a state or community and provide recommendations to prevent future tragedies.[20] Continued support for state MMRCs in collecting robust and standardized data is critical in informing local and national policies that address the nation's maternal health crises. Although many states have an MMRC, the resources available to them for effective operation vary widely across states.[21] March of Dimes supports federal and state funding for MMRCs to establish standardized protocols and policies; review, identify, and develop tools for training and support; and adopt systems for consistent data gathering and development of actionable recommendations.

MMRC in Puerto Rico

Puerto Rico is one of the US territories that participates in the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program. This funding supports maternal mortality review committees (MMRCs) to identify, review, and characterize pregnancy-related deaths; and identify prevention opportunities.[22]

Fetal and infant mortality review is important to identify causes, gather data, and address prevention

Emerging as a public health strategy in the mid- 1980's, Fetal Infant Mortality Review (FIMR) was created as a way to address adverse infant health outcomes in response to alarming increases in the infant mortality rate in the United States. Throughout the country, FIMR is being utilized as an action-orientated community process that continually assesses, monitors, and works to improve service systems and community resources for birthing people, infants and families. Research shows that FIMR is an effective system intervention as it examines infant mortality in the context of social, economic and systemic factors.[23,24] March of Dimes supports funding for FIMR and Community Action Teams (CAT) at state, county, and local levels. Funding for FIMR initiatives can be sought through local, state, and federal opportunities. Many state and local FIMR teams align their work with other programs working on similar issues, such as Title V Maternal and Child Health Block Grant programs, allowing them to leverage funding and resources.

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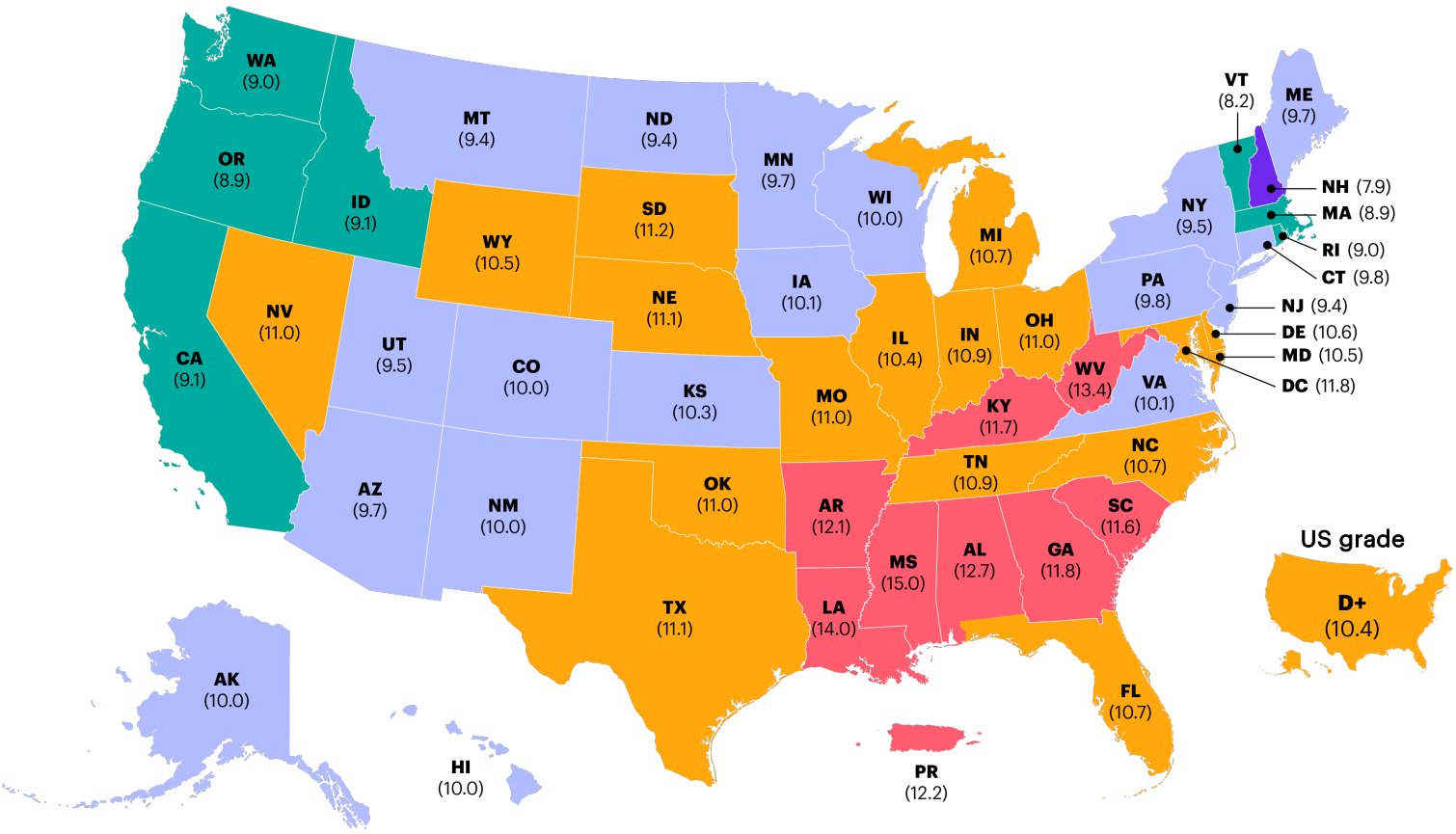
2025
Report Cards

2025 March of Dimes Report Card
United States

Scan for more data

The preterm birth grade was D+ in 2024; half of all US states received a D or an F

Preterm birth rate (born before 37 weeks gestation) and grade by state, 2024



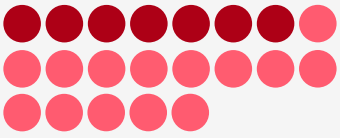
11 states met the Healthy People 2030 target for preterm birth of 9.4% of all live births.

GRADE AND PRETERM BIRTH RATE

A	A-	B+	B	B-	C+	C	C-	D+	D	D-	F
7.7% or less	7.8 to 8.1%	8.2 to 8.5%	8.6 to 8.9%	9.0 to 9.2%	9.3 to 9.6%	9.7 to 10.0%	10.1 to 10.3%	10.4 to 10.7%	10.8 to 11.1%	11.2 to 11.4%	11.5% or greater

More states saw preterm birth worsen than improve in the past year

19 States with **improved** preterm birth rates



21 States with **worsened** preterm birth rates

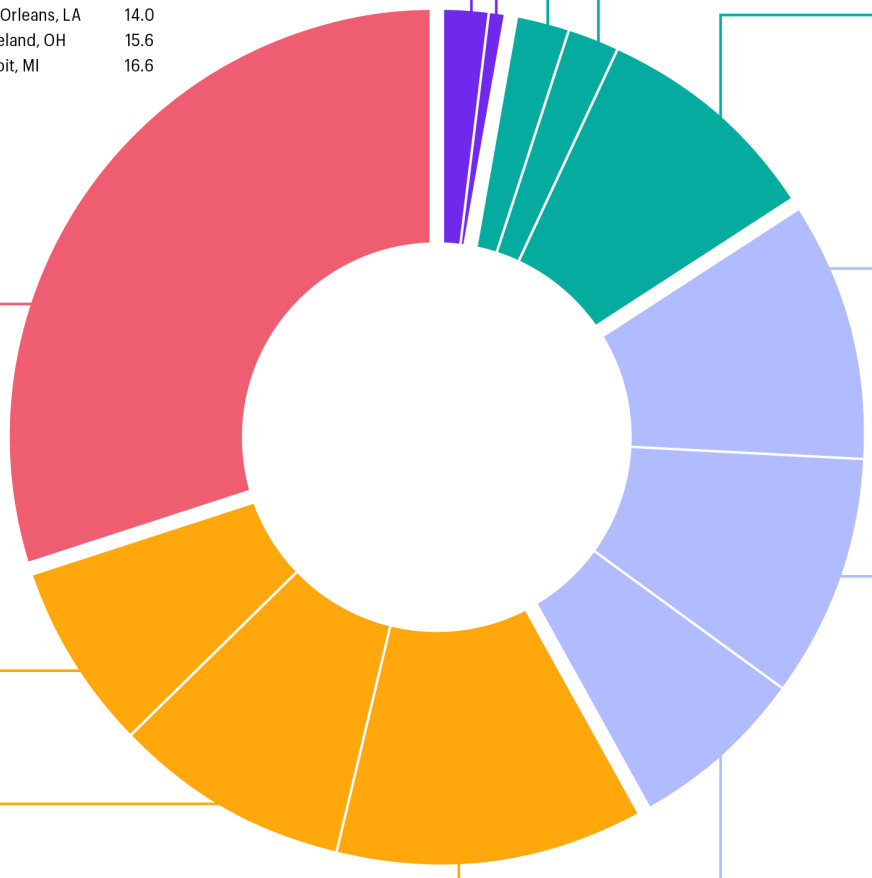
12 States with **no change** in preterm birth rates

Note: Includes District of Columbia and Puerto Rico. Darker shaded circles indicate the number of states with a statistically significant change ($P < 0.05$) in preterm birth rates compared to 2023.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, US Territories Natality data, 2024.

2025 March of Dimes Report Card
Preterm birth rate and grade by city

One third of the 100 US cities with the greatest number of live births had a preterm birth grade of F in 2024



F

Louisville, KY	11.5
Las Vegas, NV	11.6
North Las Vegas, NV	11.6
Virginia Beach, VA	11.6
Lexington-Fayette, KY	11.7
Buffalo, NY	11.8
Washington, DC	11.8
Tulsa, OK	11.9
Cincinnati, OH	12.0
Columbus, OH	12.0
Indianapolis, IN	12.0
Houston, TX	12.1
Lubbock, TX	12.2
San Antonio, TX	12.2
Norfolk, VA	12.5
Richmond, VA	12.5
Brownsville, TX	12.6
Laredo, TX	12.6
St. Louis, MO	12.8
Milwaukee, WI	12.9
Omaha, NE	12.9
El Paso, TX	13.0
Baltimore, MD	13.1
Baton Rouge, LA	13.5
Birmingham, AL	13.7
Memphis, TN	13.8
Toledo, OH	13.9
New Orleans, LA	14.0
Cleveland, OH	15.6
Detroit, MI	16.6

A

Ramapo, NY	5.6
Irvine, CA	6.8

A-

Seattle, WA	7.9

B+

San Francisco, CA	8.4
Irving, TX	8.5

B

Long Beach, CA	8.6
San Diego, CA	8.9

B-

Boston, MA	9.0
Modesto, CA	9.0
Oakland, CA	9.0
Reno, NV	9.0
San Jose, CA	9.1
Dallas, TX	9.2
New York, NY	9.2
Portland, OR	9.2
Raleigh, NC	9.2

C+

Brookhaven, NY	9.3
Chula Vista, CA	9.4
Islip, NY	9.4
Austin, TX	9.5
Plano, TX	9.5
Glendale, AZ	9.6
Hempstead, NY	9.6
Los Angeles, CA	9.6
Mesa, AZ	9.6
Riverside, CA	9.6

C

Miami, FL	9.7
Phoenix, AZ	9.7
Sacramento, CA	9.8
Stockton, CA	9.8
Albuquerque, NM	9.9
Bakersfield, CA	9.9
Anaheim, CA	10.0
Chicago, IL	10.0
Minneapolis, MN	10.0

C-

Fontana, CA	10.1
Fresno, CA	10.1
St. Paul, MN	10.1
Lincoln, NE	10.2
Anchorage, AK	10.3
Denver, CO	10.3
Honolulu, HI*	10.3

D-

Corpus Christi, TX	11.2
Oklahoma City, OK	11.2
Fort Worth, TX	11.3
Fayetteville, NC	11.4
Jacksonville, FL	11.4
Jersey City, NJ	11.4
Winston-Salem, NC	11.4

D

Arlington, TX	10.8
Orlando, FL	10.8
Garland, TX	10.9
Kansas City, MO	10.9
Philadelphia, PA	10.9
Santa Ana, CA	11.0
Atlanta, GA	11.1
Aurora, CO	11.1
Colorado Springs, CO	11.1

D+

Charlotte, NC	10.4	Tucson, AZ	10.5
Durham, NC	10.4	Grand Rapids, MI	10.6
Fort Wayne, IN	10.4	Greensboro, NC	10.6
Newark, NJ	10.4	San Bernardino, CA	10.6
Nashville-Davidson, TN	10.5	Wichita, KS	10.6
Tampa, FL	10.5	Dayton, OH	10.7

GRADE AND PRETERM BIRTH RATE

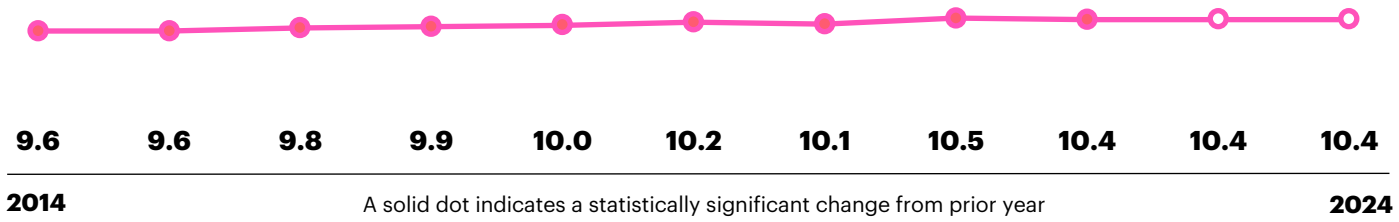
A	A-	B+	B	B-	C+	C	C-	D+	D	D-	F
7.7% or less	7.8 to 8.1%	8.2 to 8.5%	8.6 to 8.9%	9.0 to 9.2%	9.3 to 9.6%	9.7 to 10.0%	10.1 to 10.3%	10.4 to 10.7%	10.8 to 11.1%	11.2 to 11.4%	11.5% or greater

Note: Cities represent those with the greatest number of live births out of all cities with a population of >100,000, as defined by the National Center for Health Statistics; *Data for Honolulu represent the combined city and county of Honolulu.

2025 March of Dimes Report Card
Preterm birth in the US

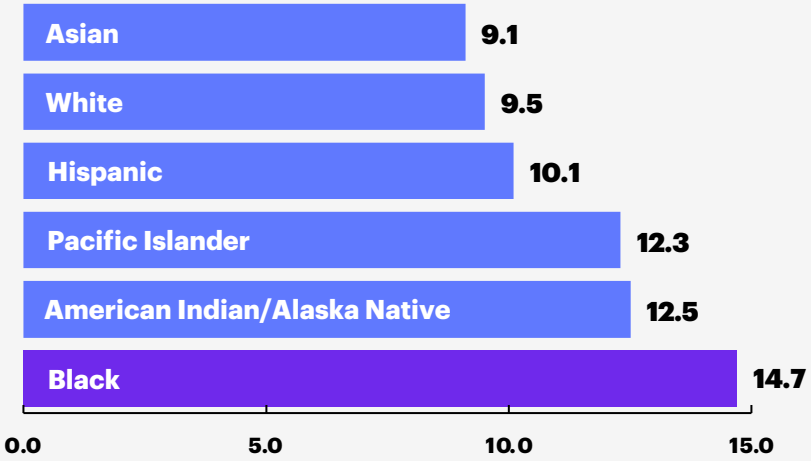
The 2024 preterm birth rate was 10.4% for the third year in a row

Preterm birth by year, 2014 to 2024

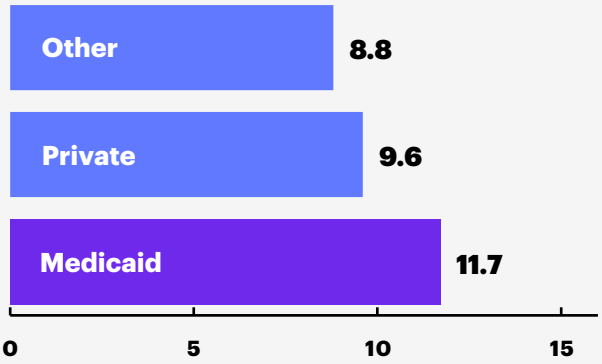


The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



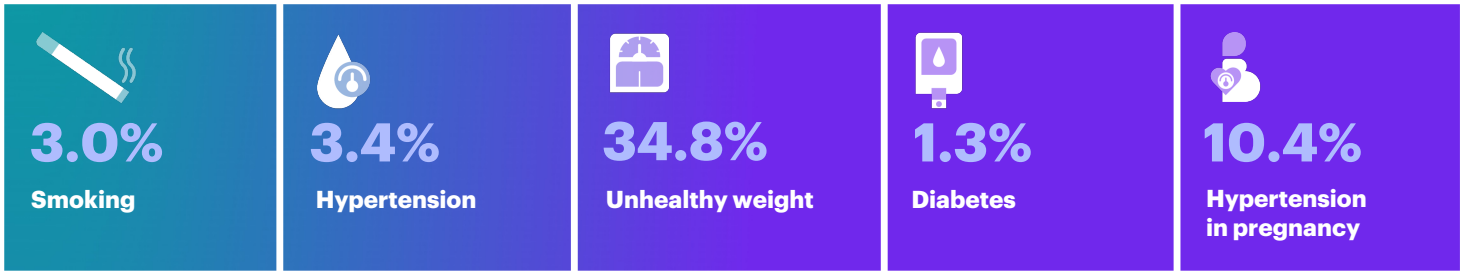
Preterm birth rate by insurance type, 2022-2024



Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay (7.9%), Tricare (9.0%), Indian Health Service (10.5%), and all other types (10.9%).

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

Percentage of all live births exposed to each condition, 2024



Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy.

Source: National Center for Health Statistics, Natality data, 2014-2024.

2025 March of Dimes Report Card
Infant mortality in the US

INFANT MORTALITY RATE

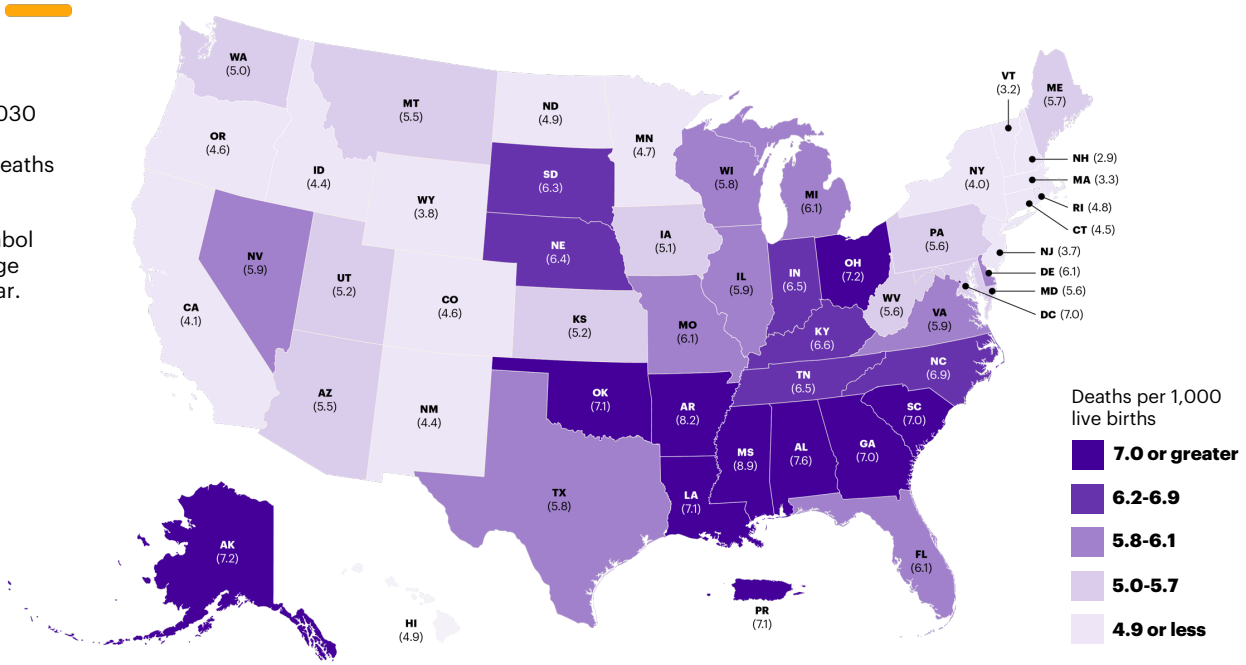
5.6 =

17 states met the Healthy People 2030 target for infant mortality of 5.0 deaths per 1,000 births.

Note: Yellow symbol denotes no change from previous year.

Over 20,000 babies died before their first birthday; the highest rates occurred in the South and Midwest regions

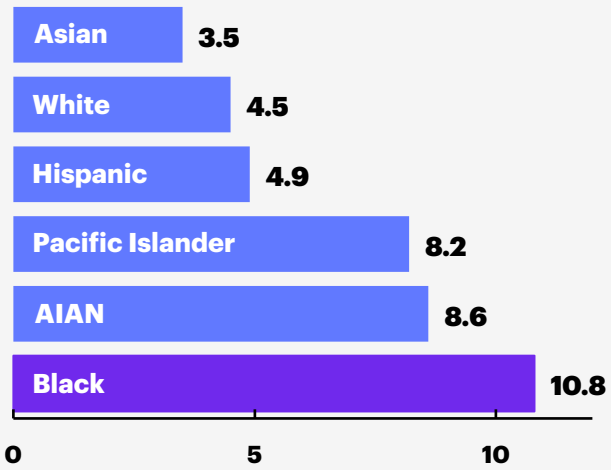
Infant mortality rate (deaths per 1,000 live births) by state, 2023



The infant mortality rate declined nearly 20% in the last two decades but the rate among babies born to Black moms is still 1.9x the national rate

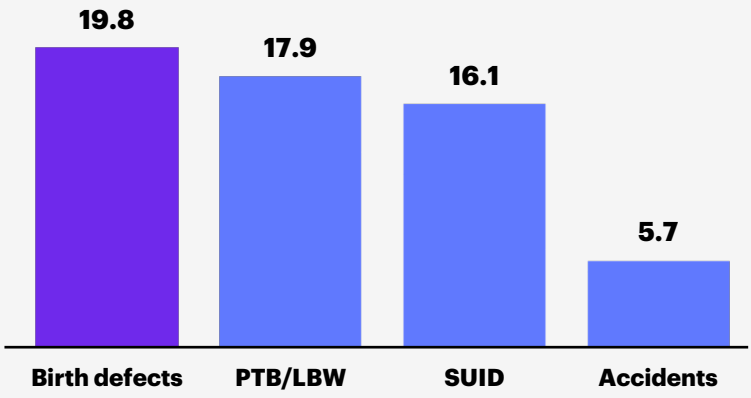
Infant mortality by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death.

Source: National Center for Health Statistics Period Linked Birth/Infant Death File, 2021-2023.

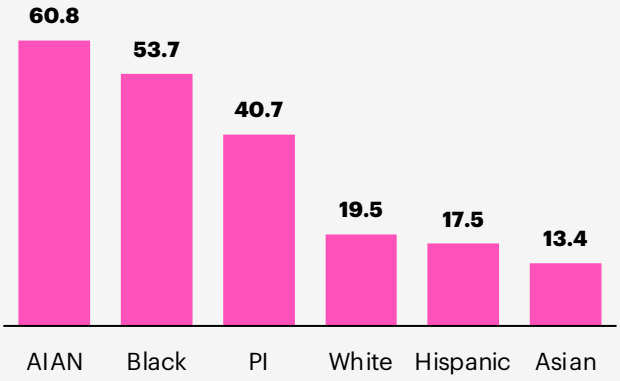
2025 March of Dimes Report Card
Maternal health in the US

Maternal mortality has returned to pre-pandemic rates. Still, 669 maternal deaths occurred in 2023 and disparities by race/ethnicity persist

MATERNAL MORTALITY RATE
18.6

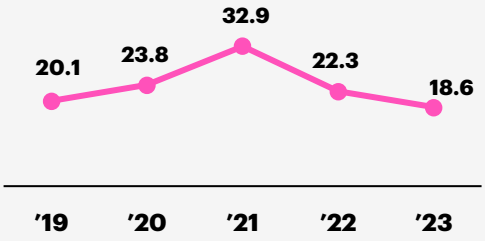
Death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Maternal mortality rate (deaths per 100,000 live births) by race/ethnicity, 2019-2023



Maternal mortality rate, 2019-2023

Changes in maternal mortality rates were statistically significant for all years shown.

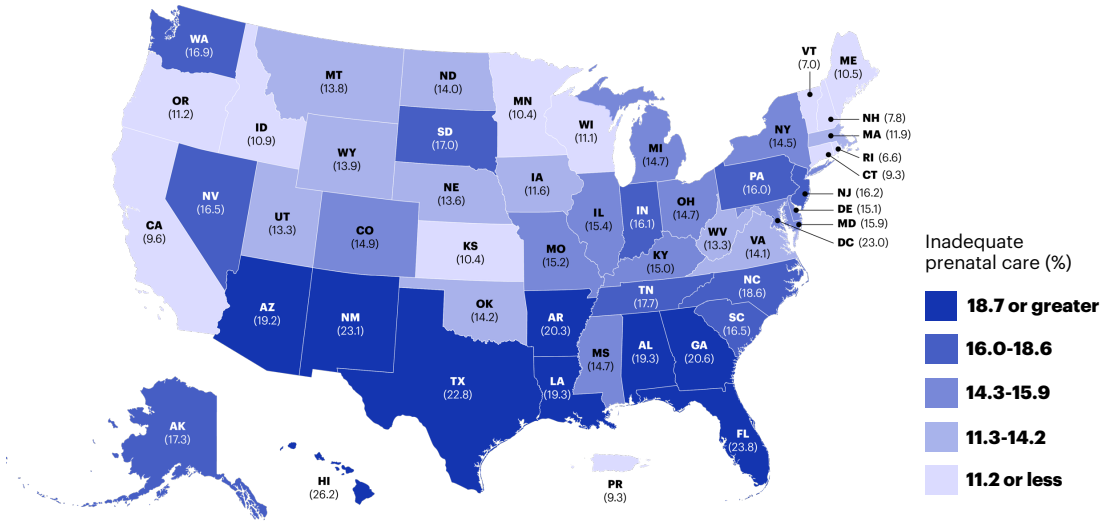


Access to and quality of healthcare before, during, and after pregnancy can affect health outcomes

INADEQUATE PRENATAL CARE
16.1% ↑

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

Inadequate prenatal care by state, 2024



75.5% ↓
FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

26.6% =
LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

93.1 PER 10,000 HOSPITAL DELIVERIES ↓
SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

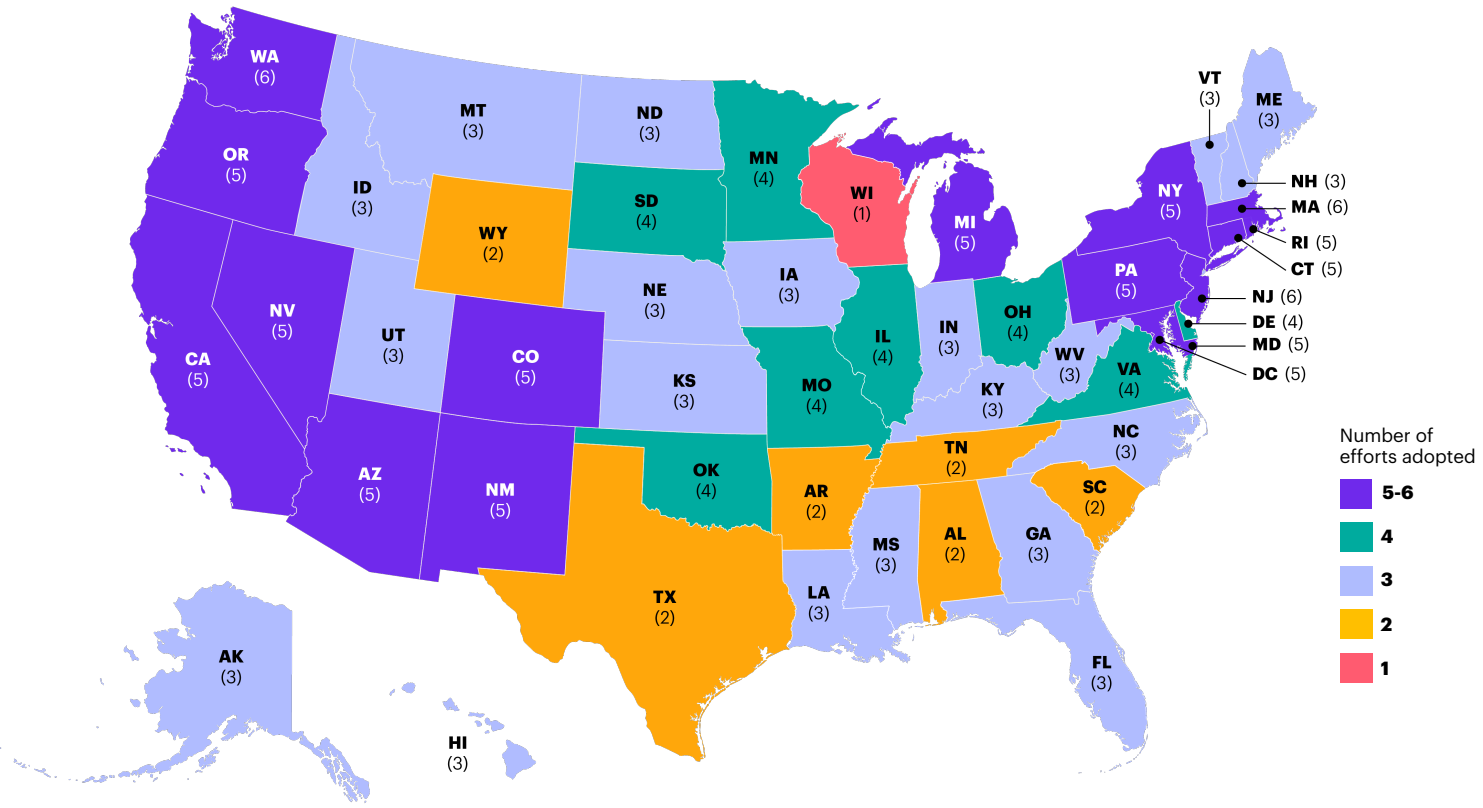
Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native. Symbols denote direction of the change from previous year (red: worsening, green: improving, yellow: no change).

Sources: National Center for Health Statistics, Mortality data, 2019-2023; National Center for Health Statistics, Natality data, 2024; Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, State Inpatient Databases, 2022.

2025 March of Dimes Report Card
Maternal and infant health efforts

Adoption of the following policies and programs, along with sufficient funding, is critical to improving and sustaining maternal and infant health

Number of adopted efforts by state, as of 9/26/2025.



MEDICAID EXTENSION

Adopted in 48 states and DC

Adoption of this policy extends coverage for women to one year postpartum.

MEDICAID EXPANSION

Adopted in 40 states and DC

Adoption of this policy allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

25 states and DC
reimburse for doula care

Adoption of this policy requires that Medicaid reimburse for care and supports the sustainability of the doula workforce.

PAID FAMILY LEAVE

9 states and DC
give 12 weeks paid leave

Adoption of this policy requires employers to provide a paid option for families out on parental leave.

MENTAL HEALTH SCREENING

11 states
require and reimburse

Adoption of this policy requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MORTALITY REVIEW

50 states, DC, and Puerto Rico
review maternal deaths

These committees are used to understand causes of maternal deaths, identify preventive factors, and recommend changes to improve care and save lives.

To see more information about each effort, see our **Policy and Program Booklet**.

2025 March of Dimes Report Card
Alabama

Scan for more data

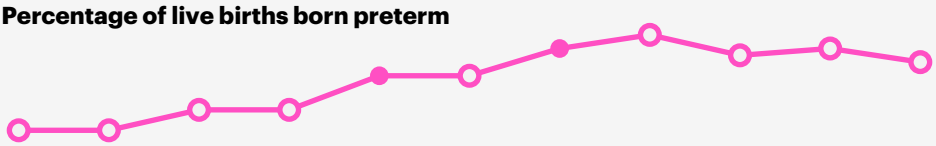
7,379 babies were born preterm in Alabama in 2024. Alabama ranks 49th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 12.7%.

Alabama has made improvement in low-risk Cesarean births and maternal mortality since last year.

Alabama is currently implementing two of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Alabama was 12.7% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **F**



US RATE	AL RATE	AL RANK
10.4	12.7	49

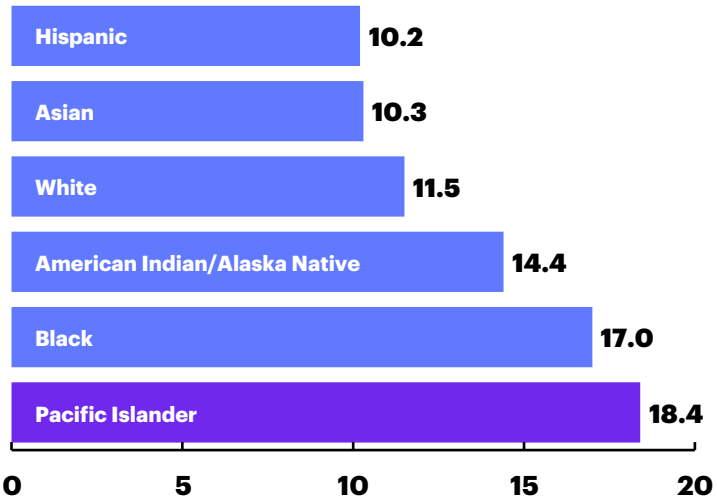
2014										2024
11.7	11.7	12.0	12.0	12.5	12.5	12.9	13.1	12.8	12.9	12.7

A solid dot indicates a statistically significant change from prior year

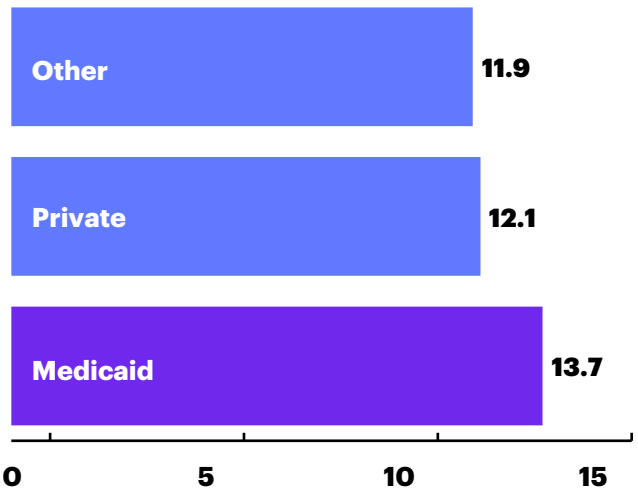
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



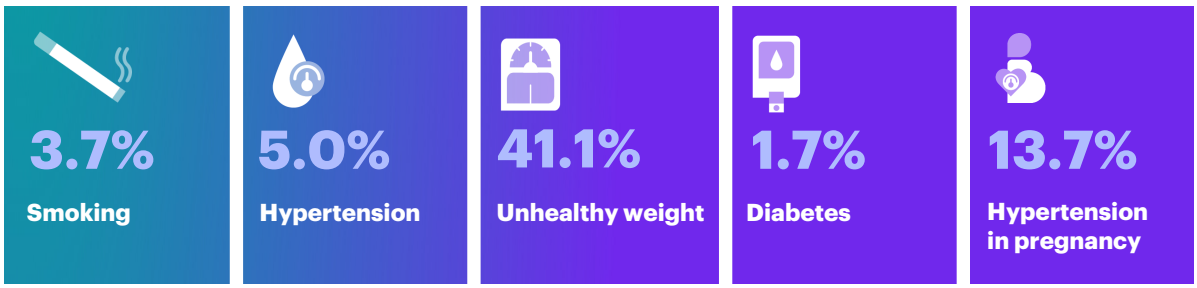
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 13.7%; Tricare: 9.9%; Indian Health Service: N/A; and all other types: 12.3%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Alabama

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



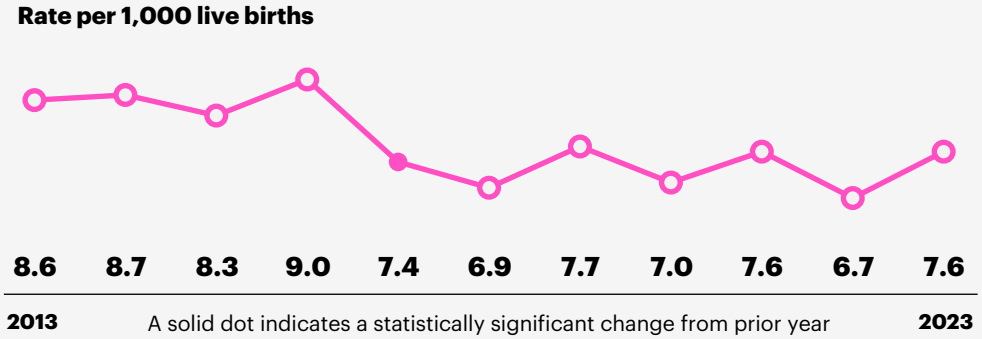
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 442 babies died before their first birthday

INFANT MORTALITY RATE **7.6**

US RATE **5.6**

AL RANK **50**

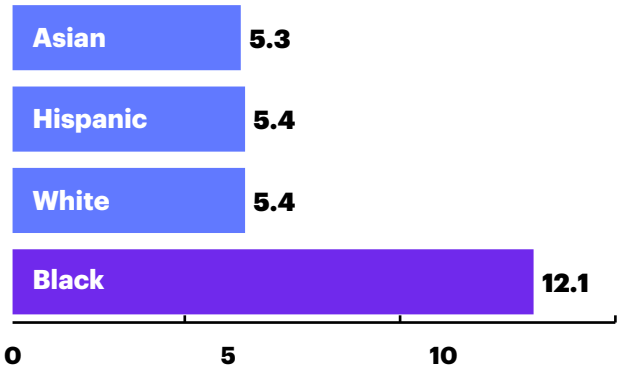


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.6x the state rate

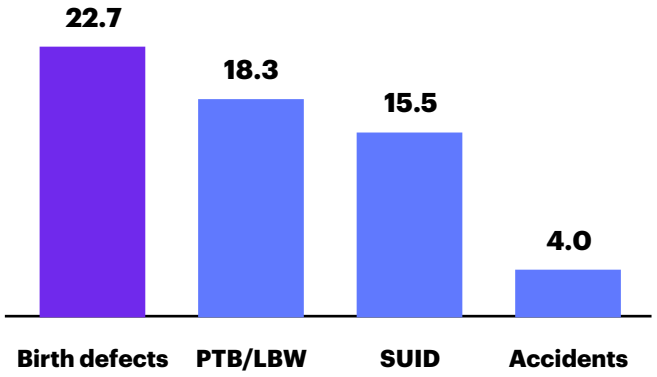
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 39.5% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Alabama

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.0x the state rate

19.3
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

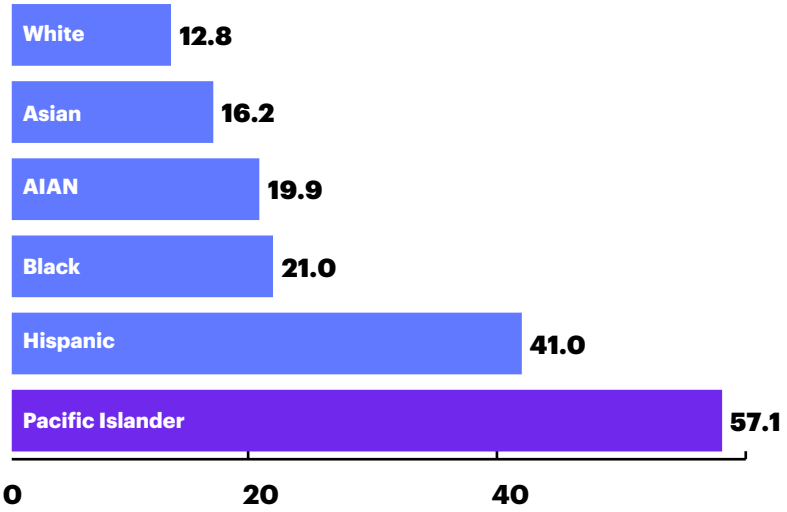
70.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Alabama

28.0
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

N/A
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

The severe maternal morbidity rate cannot be shown due to lack of available data.

35.1
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	12.7%	7.6	28.0%	72.9%	N/A	35.1
Rank	49th of 52	50th of 52	39th of 52	43rd of 52	N/A	43rd of 48
Direction†	Improved	Worsened	Improved	Worsened†	N/A	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Alabama

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Alabama

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Alabama's Medicaid program, Alabama Medicaid, covered 24,321 births in 2024

42.0

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

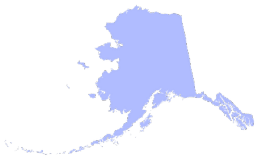
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Alaska

Scan for more data



896 babies were born preterm in Alaska in 2024. Alaska ranks 21st of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.0%.

Alaska has made significant improvement in adequate prenatal care reception since last year.

Alaska is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Alaska was 10.0% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	AK RATE	AK RANK
10.4	10.0	21

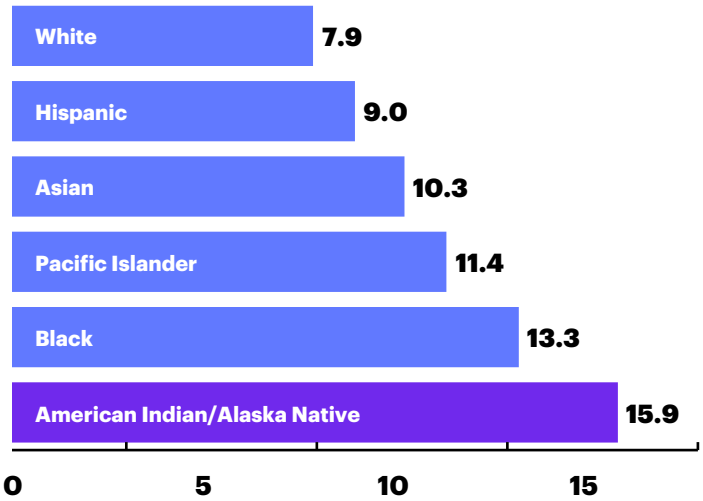
2014										2024
8.5	8.9	8.9	9.0	9.3	9.7	9.8	10.1	10.0	10.3	10.0

A solid dot indicates a statistically significant change from prior year

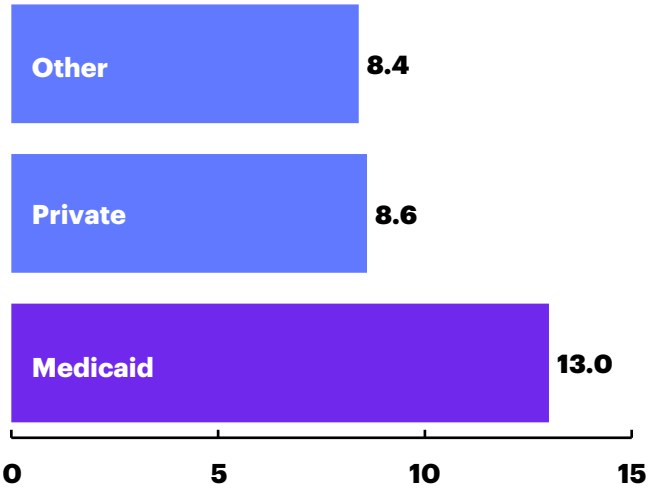
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



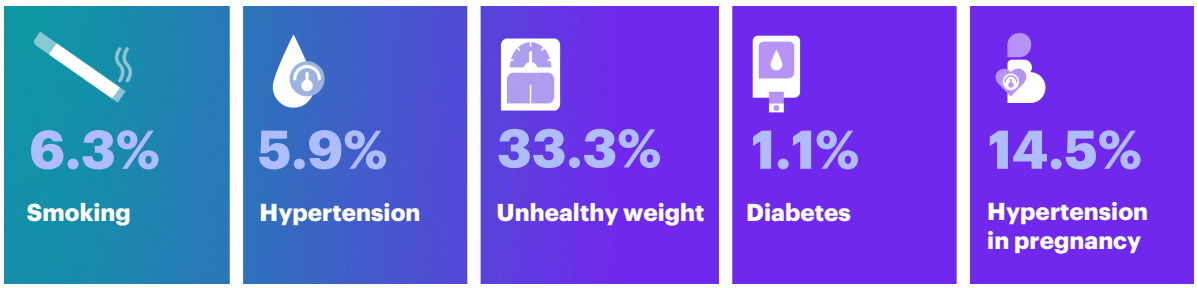
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 9.3%; Tricare: 7.3%; Indian Health Service: 9.7%; and all other types: 11.0%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Alaska

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



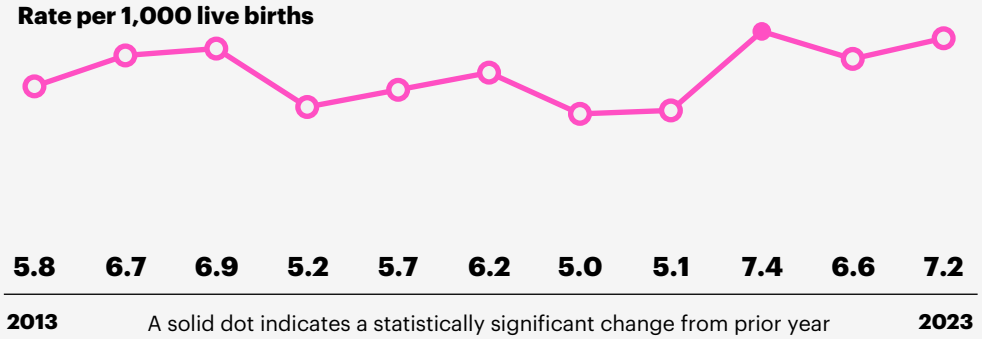
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 65 babies died before their first birthday

INFANT MORTALITY RATE **7.2**

US RATE 5.6

AK RANK 48

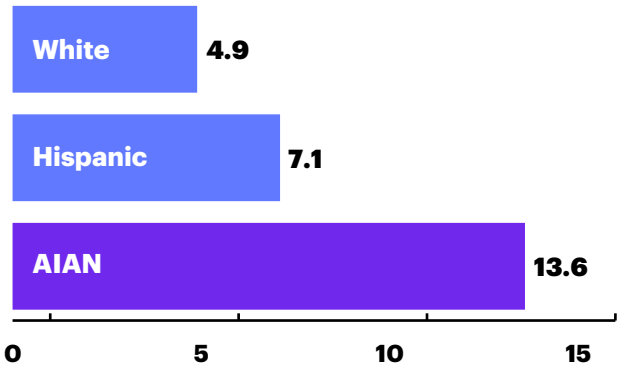


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to American Indian/Alaska Native moms is 1.9x the state rate

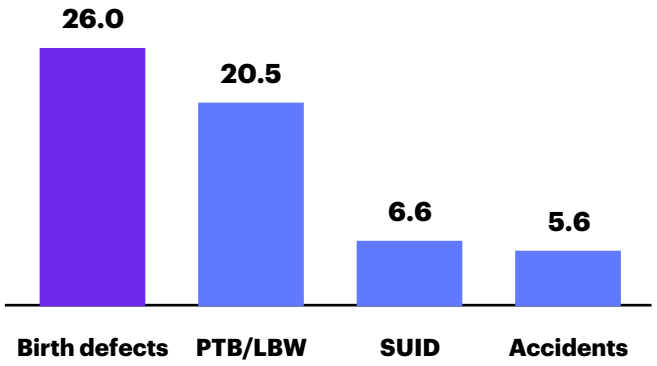
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 41.3% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Alaska

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.3x the state rate

17.3 PERCENT — 16.1

INADEQUATE PRENATAL CARE

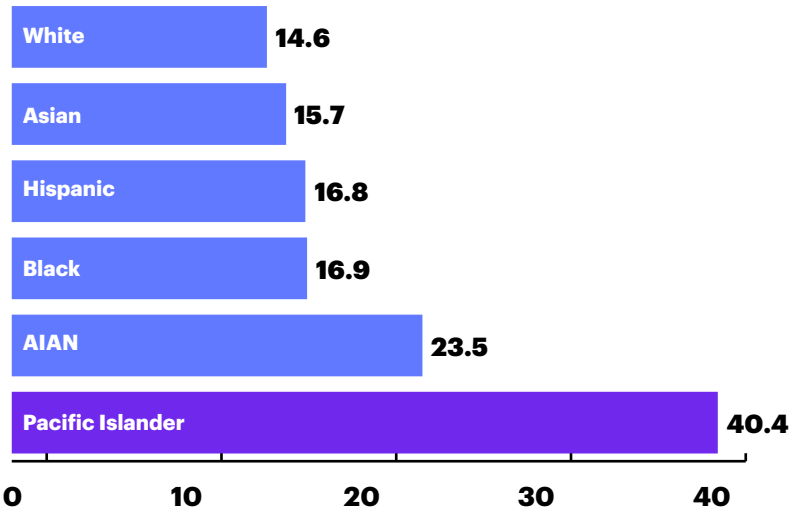
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

75.6 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Alaska

19.7 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

115.8 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

23.4 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.0%	7.2	19.7%	69.4%	115.8	23.4
Rank	21st of 52	48th of 52	2nd of 52	47th of 52	43rd of 47	23rd of 48
Direction†	Improved	Worsened	Improved	Improved†	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Alaska

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Alaska

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Alaska's Medicaid program, DenaliCare, covered 3,192 births in 2024

36.6

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

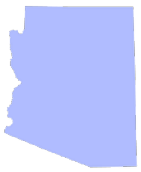
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Arizona

Scan for more data



7,594 babies were born preterm in Arizona in 2024. Arizona ranks 15th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.7%.

Arizona is among the top twenty states with the lowest rates of low-risk Cesarean births and severe maternal morbidity.

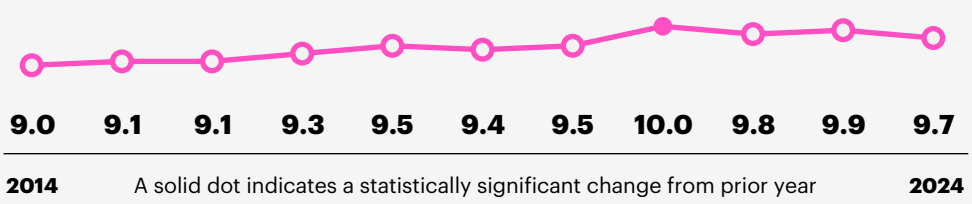
Arizona is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Arizona was 9.7% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	AZ RATE	AZ RANK
10.4	9.7	15

Percentage of live births born preterm



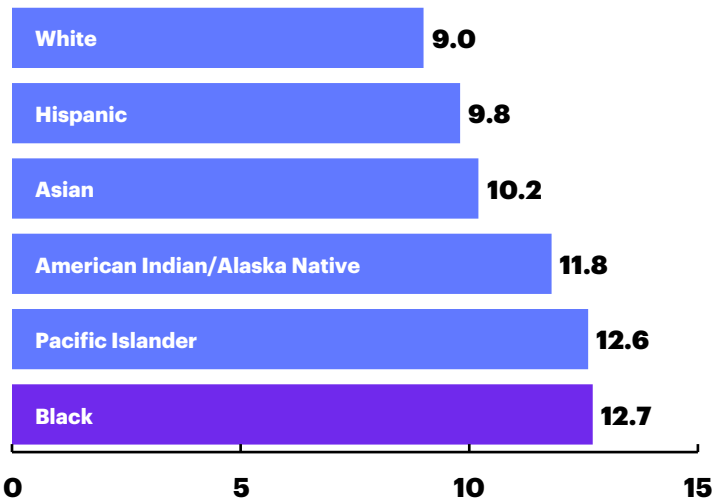
2014										2024
9.0	9.1	9.1	9.3	9.5	9.4	9.5	10.0	9.8	9.9	9.7

A solid dot indicates a statistically significant change from prior year

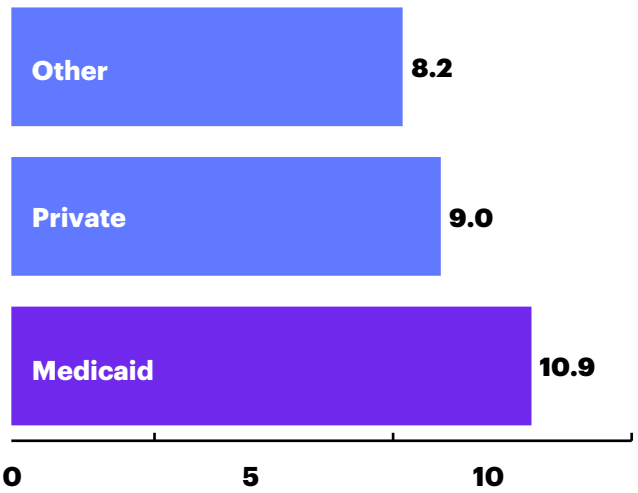
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



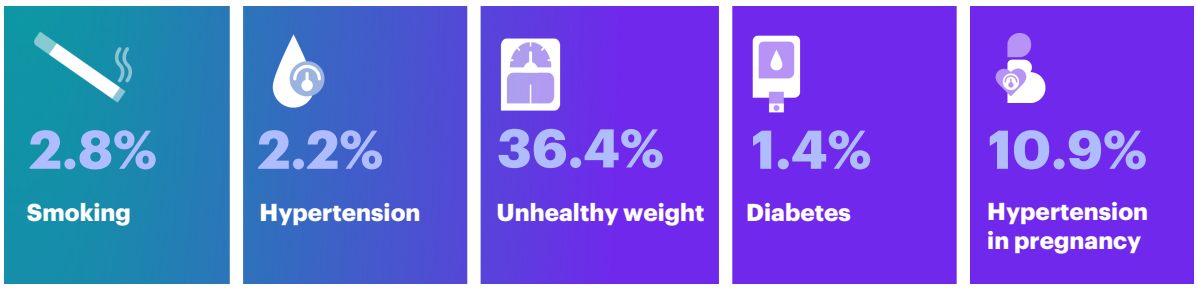
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.7%; Tricare: 8.9%; Indian Health Service: 10.4%; and all other types: 10.0%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Arizona

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



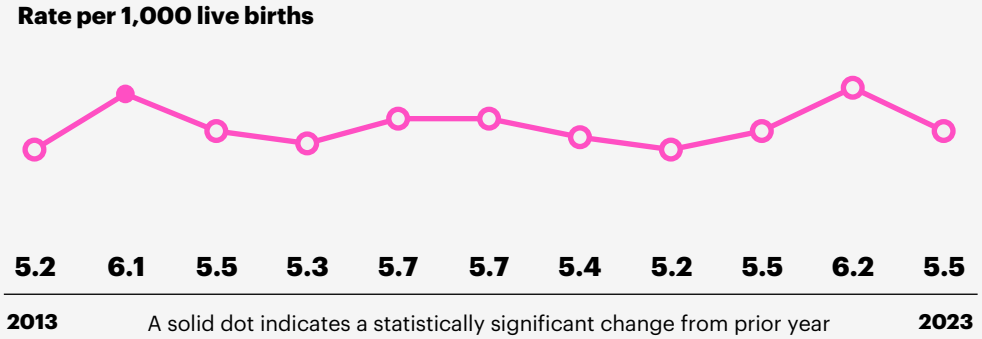
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 433 babies died before their first birthday

INFANT MORTALITY RATE **5.5**

US RATE **5.6**

AZ RANK **21**

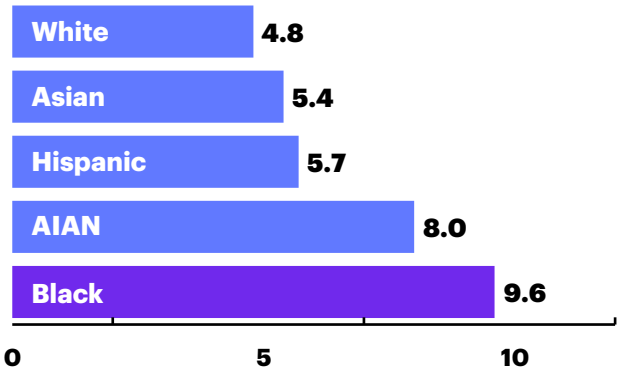


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.7x the state rate

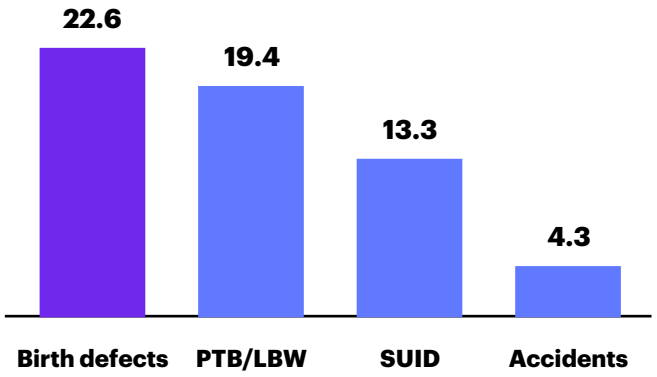
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.3% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Arizona

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.1x the state rate

19.2
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

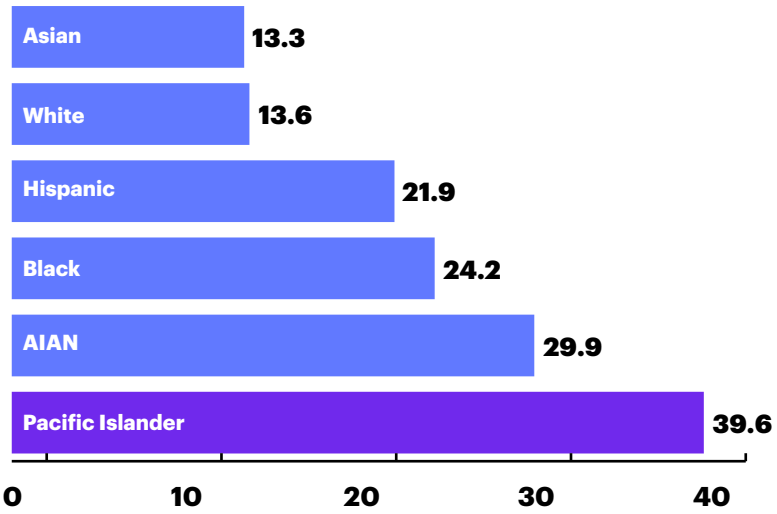
72.8
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Arizona

24.2
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

79.7
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

30.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.7%	5.5	24.2%	71.9%	79.7	30.4
Rank	15th of 52	21st of 52	14th of 52	44th of 52	15th of 47	36th of 48
Direction†	Improved	Improved	Worsened†	Worsened	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Arizona

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Arizona

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Arizona's Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), covered 35,078 births in 2024

44.6

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Arkansas

Scan for more data

4,289 babies were born preterm in Arkansas in 2024. Arkansas ranks 47th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 12.1%.

Arkansas is among the top ten best states with the lowest rates of severe maternal morbidity.

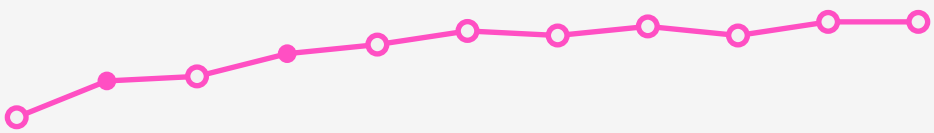
Arkansas is currently implementing two of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Arkansas was 12.1% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **F**

US RATE	AR RATE	AR RANK
10.4	12.1	47

Percentage of live births born preterm



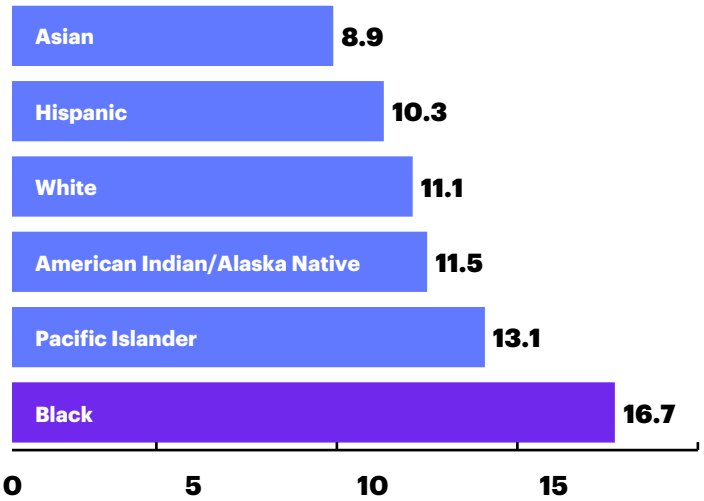
2014										2024
10.0	10.8	10.9	11.4	11.6	11.9	11.8	12.0	11.8	12.1	12.1

A solid dot indicates a statistically significant change from prior year

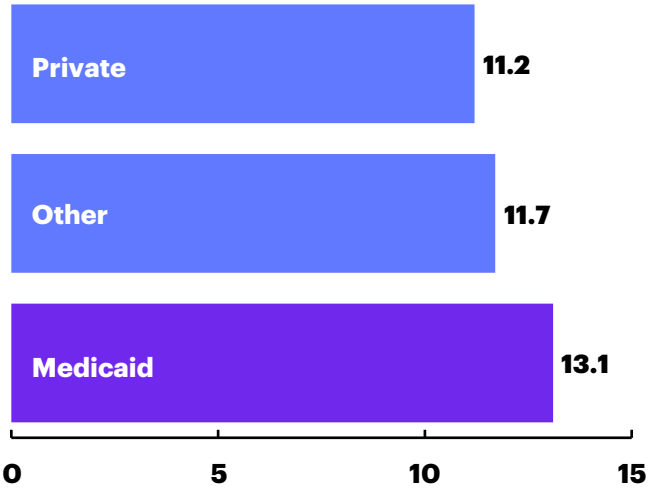
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



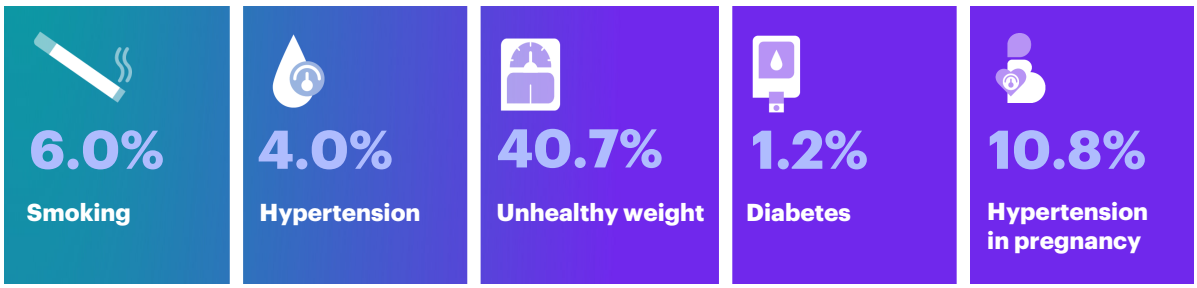
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 10.9%; Tricare: N/A; Indian Health Service: N/A; and all other types: 16.3%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Arkansas

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



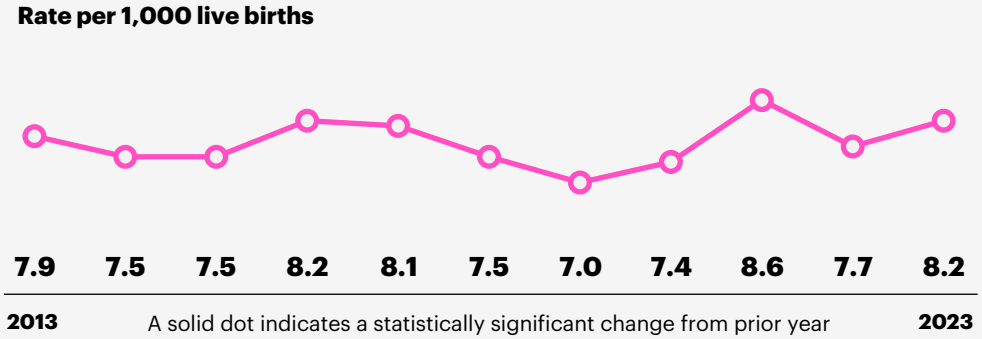
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 290 babies died before their first birthday

INFANT MORTALITY RATE **8.2**

US RATE **5.6**

AR RANK **51**

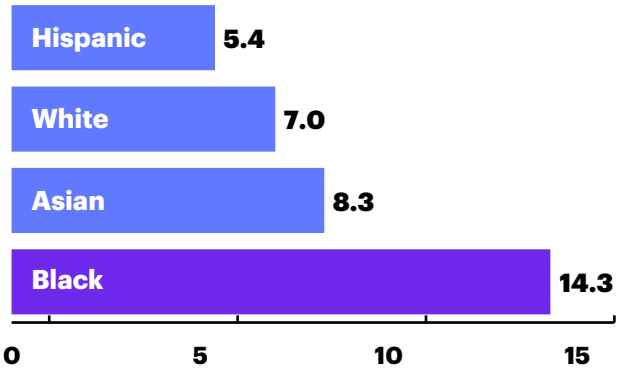


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.7x the state rate

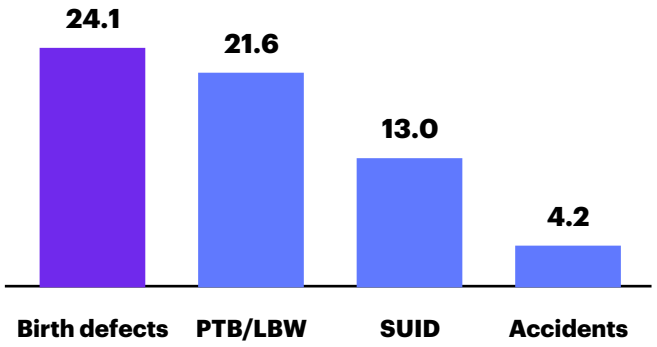
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 37.2% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Arkansas

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.6x the state rate

20.3 PERCENT — 16.1

INADEQUATE PRENATAL CARE

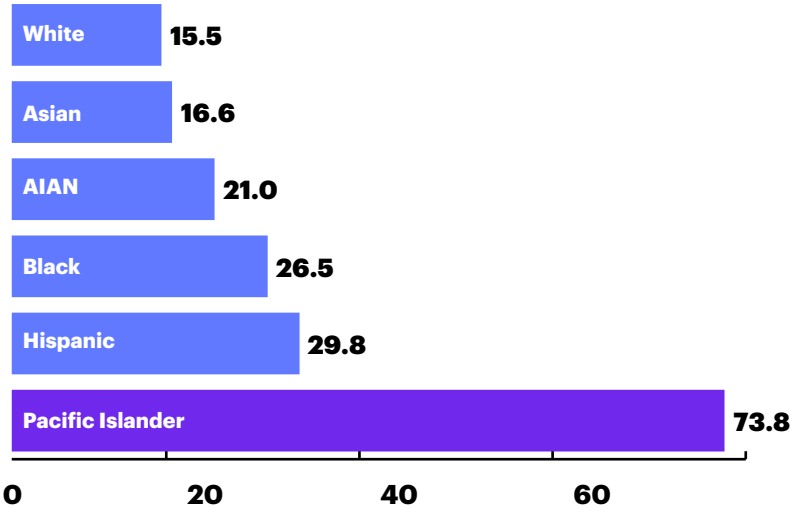
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

70.8 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Arkansas

27.9 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

66.4 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

35.3 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	12.1%	8.2	27.9%	73.6%	66.4	35.3
Rank	47th of 52	51st of 52	37th of 52	39th of 52	5th of 47	44th of 48
Direction†	No change	Worsened	Worsened	Worsened	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Arkansas

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Arkansas

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

State has the indicated program/policy

State reimburses up to $1,500

State is progressing legislation but not yet active

State does not have the indicated program/policy

Arkansas' Medicaid program, Arkansas Medicaid, covered 14,610 births in 2024

41.6

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
California

Scan for more data

36,468 babies were born preterm in California in 2024. California ranks 7th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.1%.

California has made significant improvement in adequate prenatal care reception since last year.

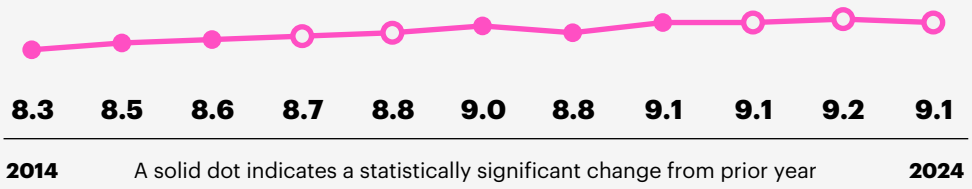
California is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in California was 9.1% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **B-**

US RATE	CA RATE	CA RANK
10.4	9.1	7

Percentage of live births born preterm



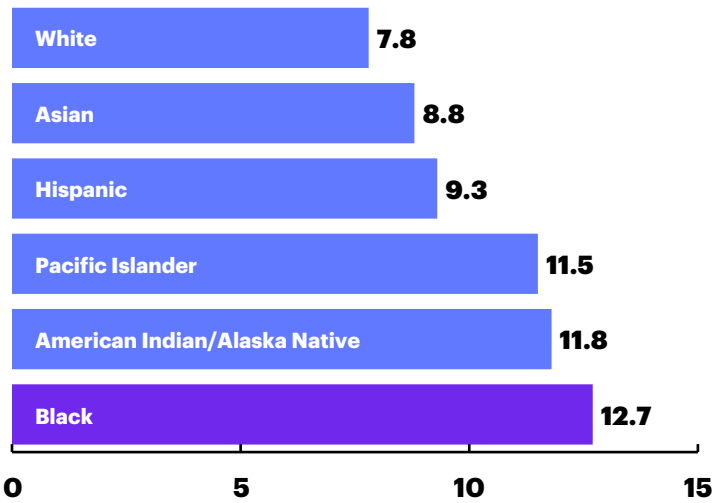
2014										2024
8.3	8.5	8.6	8.7	8.8	9.0	8.8	9.1	9.1	9.2	9.1

A solid dot indicates a statistically significant change from prior year

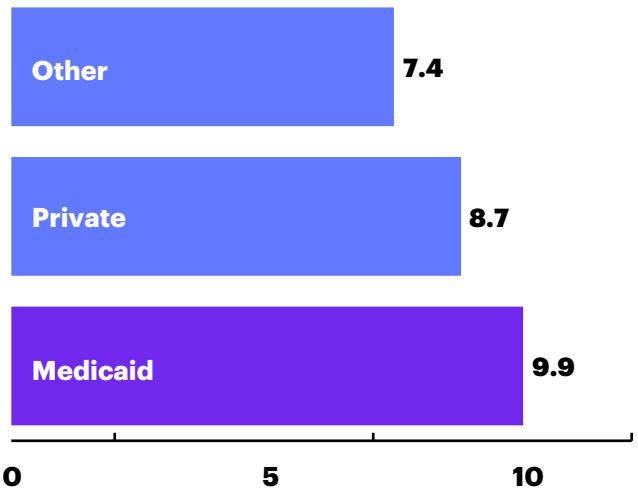
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



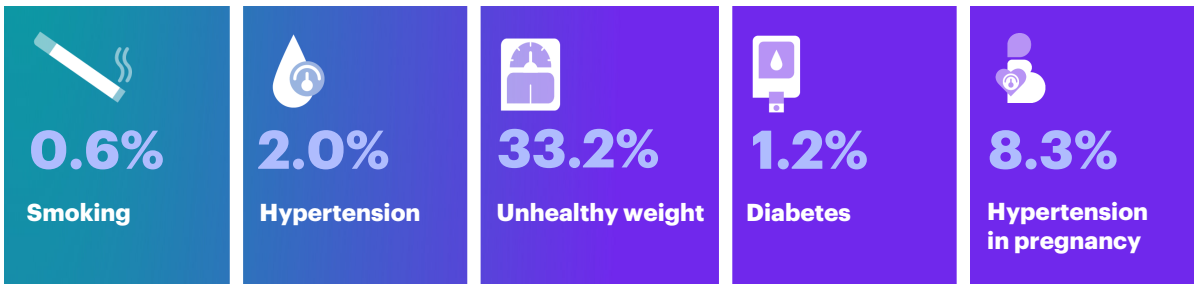
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 5.1%; Tricare: 9.0%; Indian Health Service: N/A; and all other types: 8.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

California

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



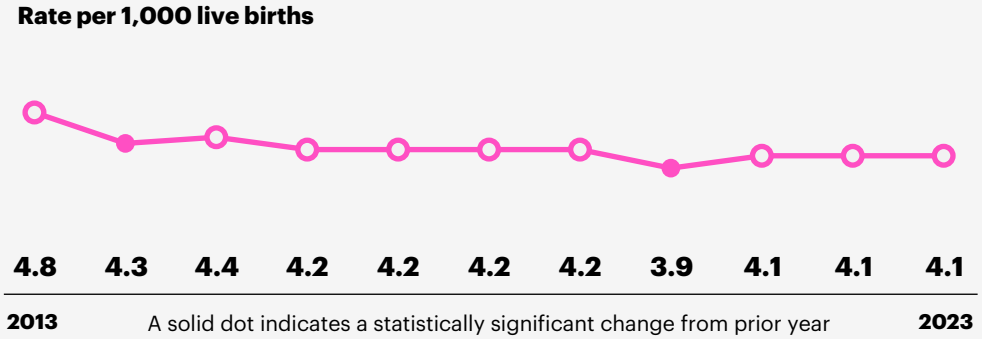
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 1,642 babies died before their first birthday

INFANT MORTALITY RATE **4.1**

US RATE **5.6**

CA RANK **6**

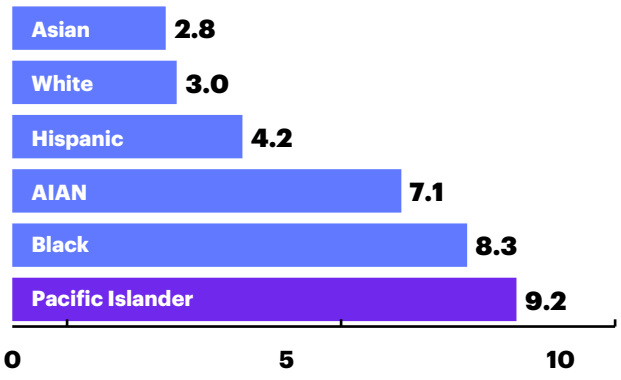


Note: The change in 2023 was not a statistically significant increase or decrease compared to 2022.

The infant mortality rate among babies born to Pacific Islander moms is 2.2x the state rate

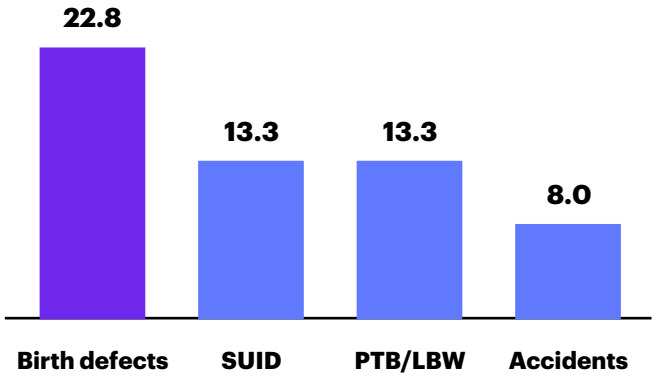
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 42.6% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

California

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.0x the state rate

9.6
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

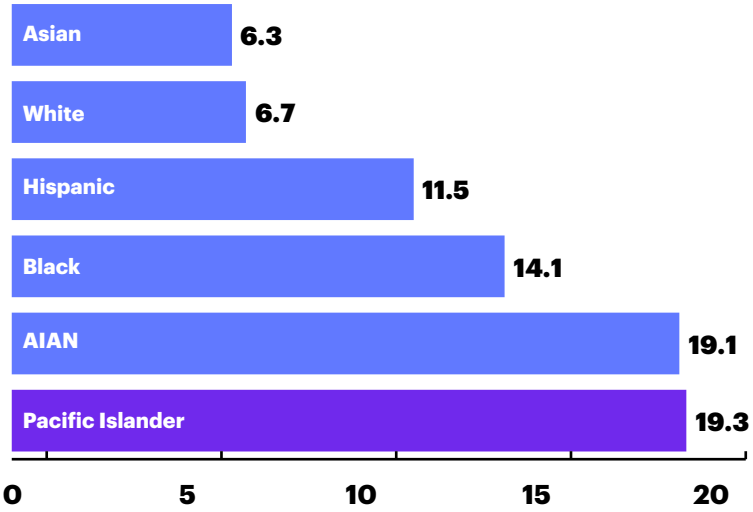
84.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in California

26.2
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

110.5
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

10.1
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.1%	4.1	26.2%	75.4%	110.5	10.1
Rank	7th of 52	6th of 52	28th of 52	34th of 52	41st of 47	1st of 48
Direction†	Improved	No change	Worsened	Improved†	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

California

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in California

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

California's Medicaid program, Medi-Cal, covered 162,193 births in 2024

40.6

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Colorado

Scan for more data

6,398 babies were born preterm in Colorado in 2024. Colorado ranks 21st of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.0%.

Colorado is among the top ten best states with the lowest rates of low-risk Cesarean births and maternal mortality.

Colorado is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Colorado was 10.0% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	CO RATE	CO RANK
10.4	10.0	21

Percentage of live births born preterm

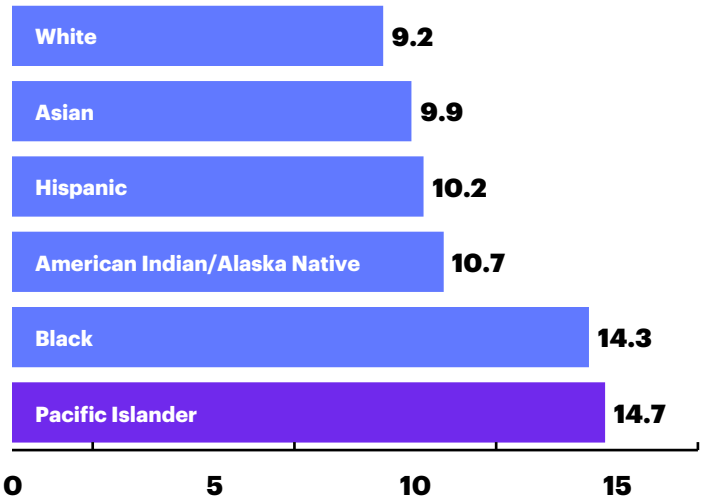
2014										2024
8.4	8.7	8.9	8.8	9.2	9.6	9.1	9.7	10.0	9.7	10.0

A solid dot indicates a statistically significant change from prior year

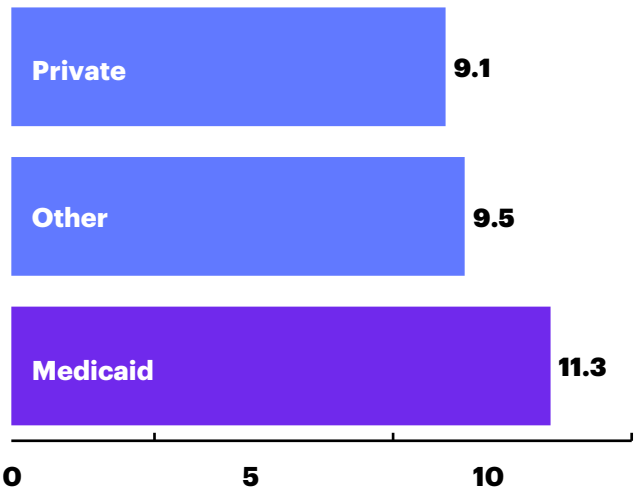
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



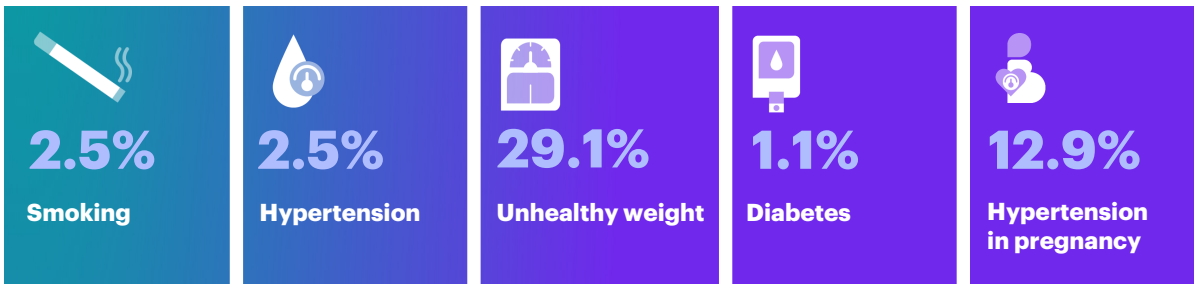
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 8.3%; Tricare: 9.8%; Indian Health Service: N/A; and all other types: 11.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Colorado

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



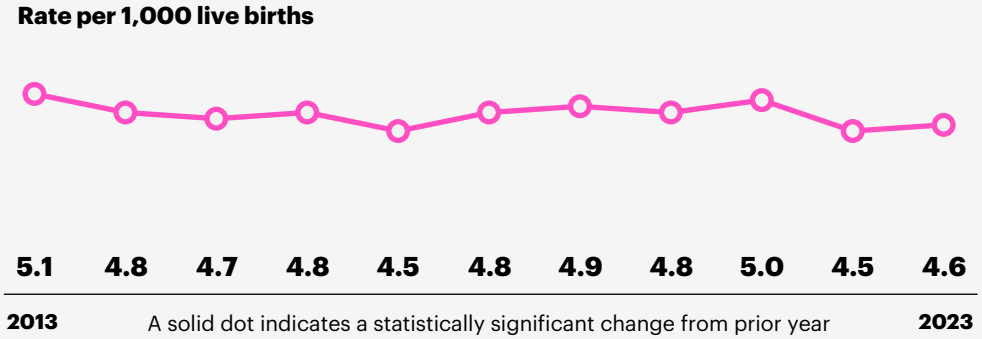
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 280 babies died before their first birthday

INFANT MORTALITY RATE **4.6**

US RATE 5.6

CO RANK 11

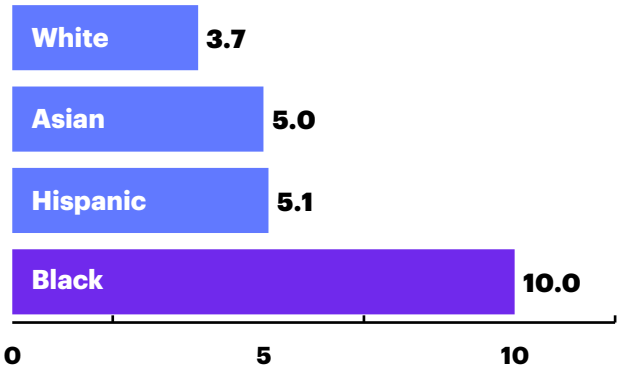


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 2.2x the state rate

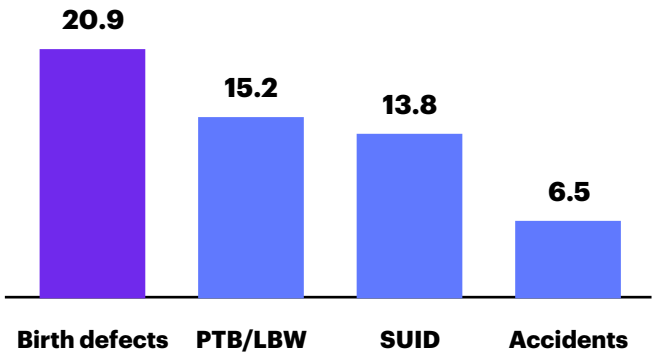
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 43.6% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Colorado

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.6x the state rate

14.9 PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

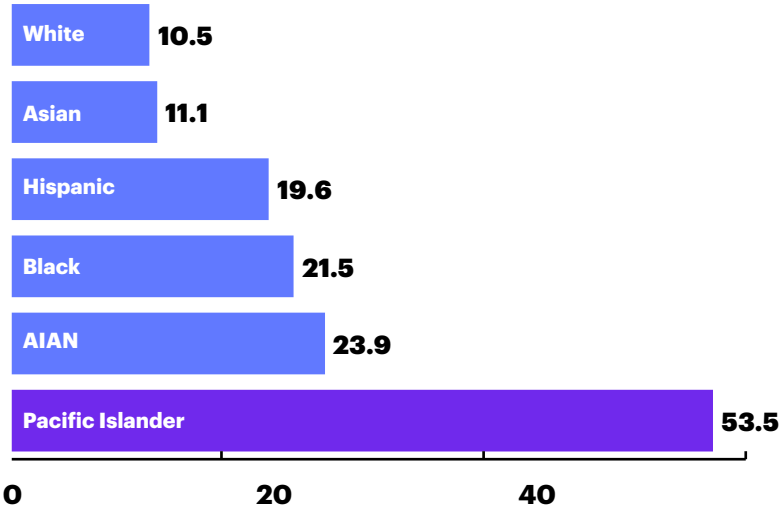
77.4 PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Colorado

22.6 PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

108.7 PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

17.0 PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.0%	4.6	22.6%	70.2%	108.7	17.0
Rank	21st of 52	11th of 52	9th of 52	46th of 52	38th of 47	8th of 48
Direction†	Worsened	Worsened	Improved	Improved	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Colorado

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Colorado

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Colorado's Medicaid program, Health First Colorado, covered 22,357 births in 2024

34.9

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

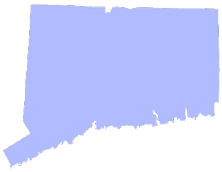
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Connecticut

Scan for more data



3,398 babies were born preterm in Connecticut in 2024. Connecticut ranks 17th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.8%.

Connecticut has made significant improvement in adequate prenatal care reception since last year.

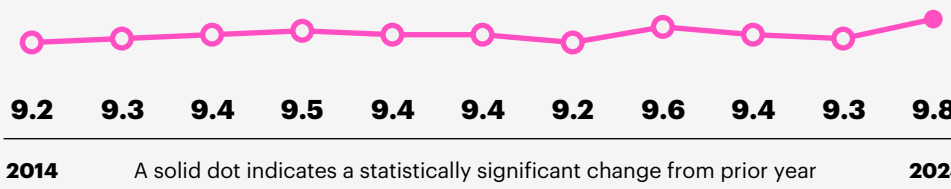
Connecticut is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Connecticut was 9.8% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	CT RATE	CT RANK
10.4	9.8	17

Percentage of live births born preterm



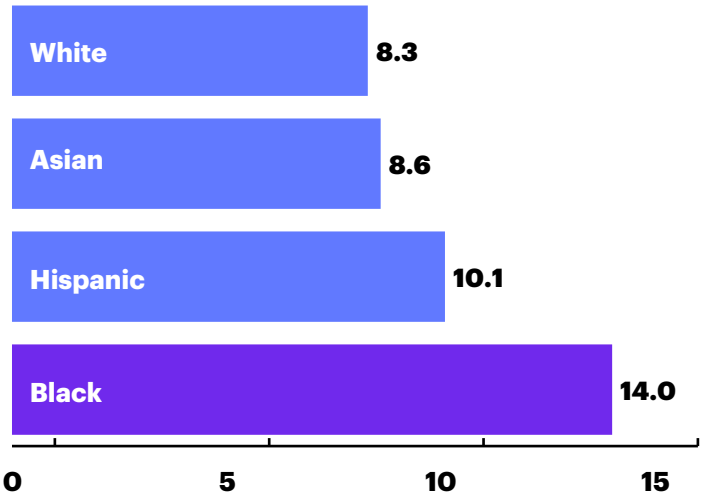
2014										2024
9.2	9.3	9.4	9.5	9.4	9.4	9.2	9.6	9.4	9.3	9.8

A solid dot indicates a statistically significant change from prior year

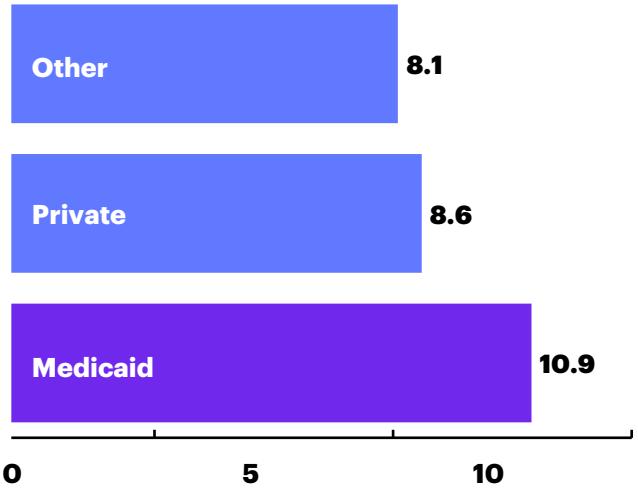
Note: The change in 2024 was a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



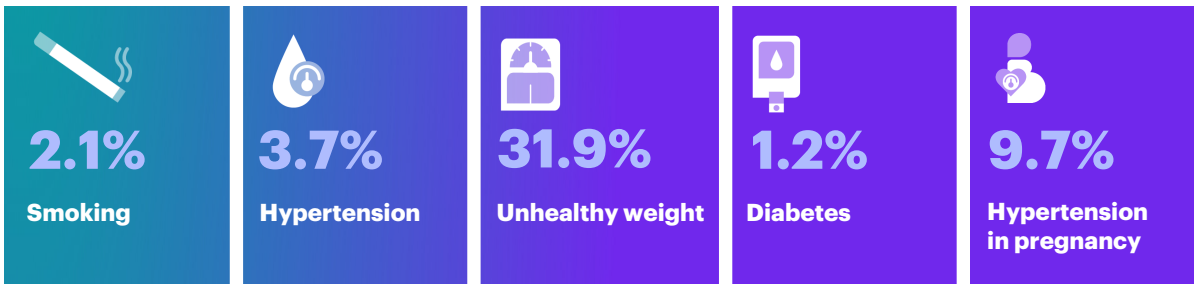
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.7%; Tricare: 8.0%; Indian Health Service: N/A; and all other types: 14.5%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Connecticut

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



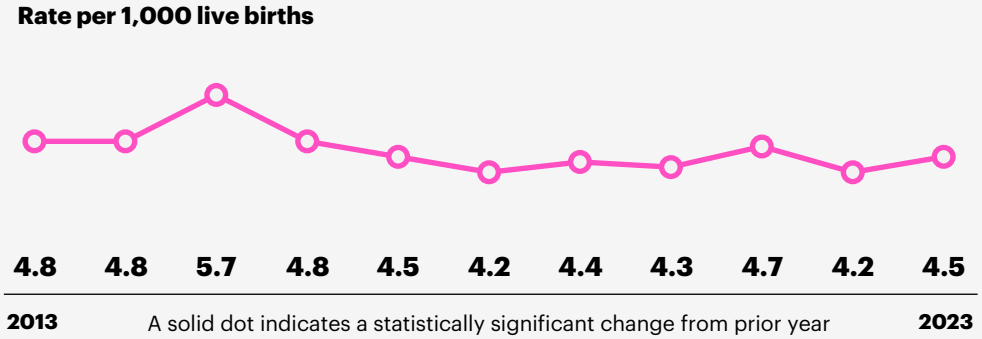
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 155 babies died before their first birthday

INFANT MORTALITY RATE **4.5**

US RATE 5.6

CT RANK 10

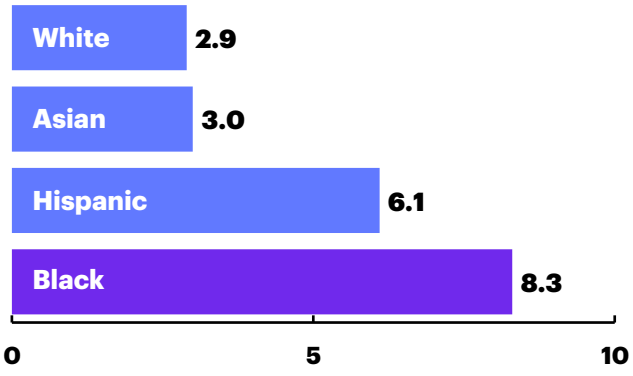


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.9x the state rate

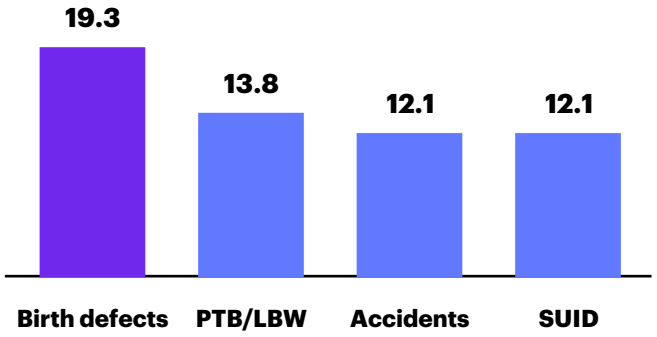
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 42.7% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Connecticut

The rate of inadequate prenatal care among babies born to American Indian/Alaska Native moms is 2.7x the state rate

9.3
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

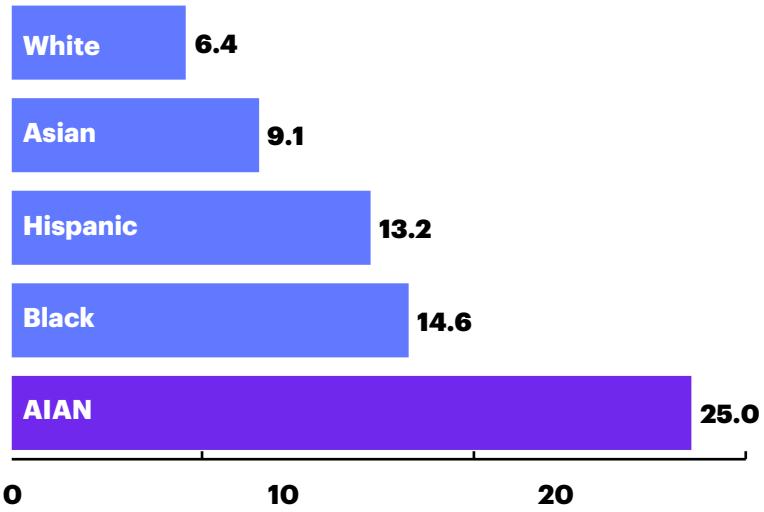
83.7
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Connecticut

30.6
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

104.7
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

16.2
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.8%	4.5	30.6%	85.7%	104.7	16.2
Rank	17th of 52	10th of 52	49th of 52	5th of 52	34th of 47	5th of 48
Direction†	Worsened†	Worsened	Worsened	Improved†	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Connecticut

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Connecticut

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Connecticut's Medicaid program, HUSKY Health, covered 14,056 births in 2024

40.6

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Delaware

Scan for more data

1,113 babies were born preterm in Delaware in 2024. Delaware ranks 30th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.6%.

Delaware has made improvement in infant mortality since last year.

Delaware is currently implementing four of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Delaware was 10.6% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **D+**

US RATE	DE RATE	DE RANK
10.4	10.6	30

Percentage of live births born preterm

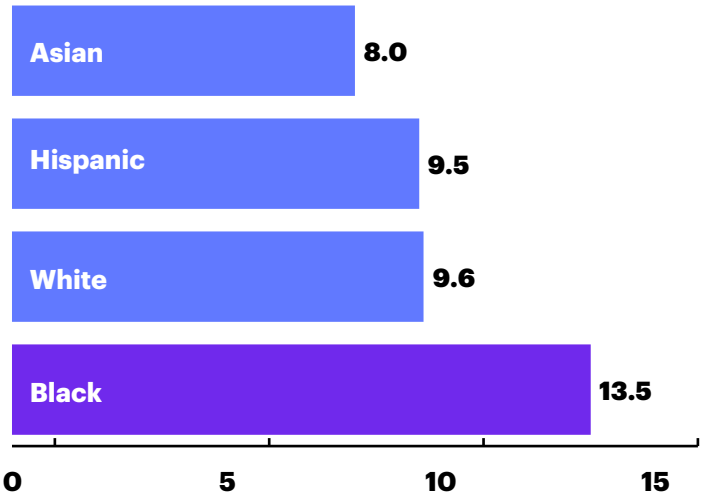
2014										2024
9.3	9.9	10.1	10.2	9.6	10.7	10.4	11.0	10.8	10.4	10.6

A solid dot indicates a statistically significant change from prior year

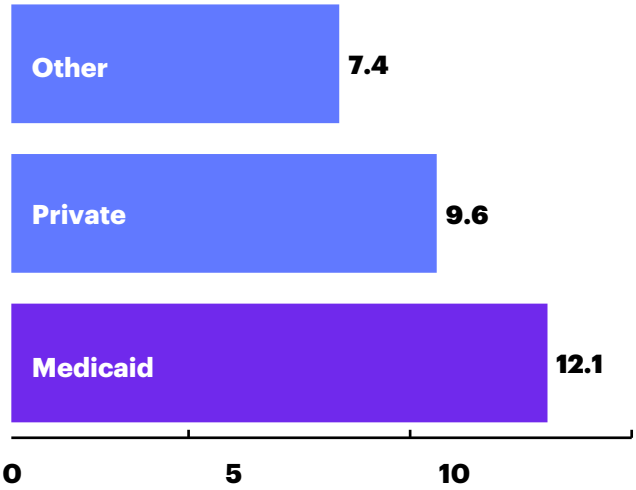
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



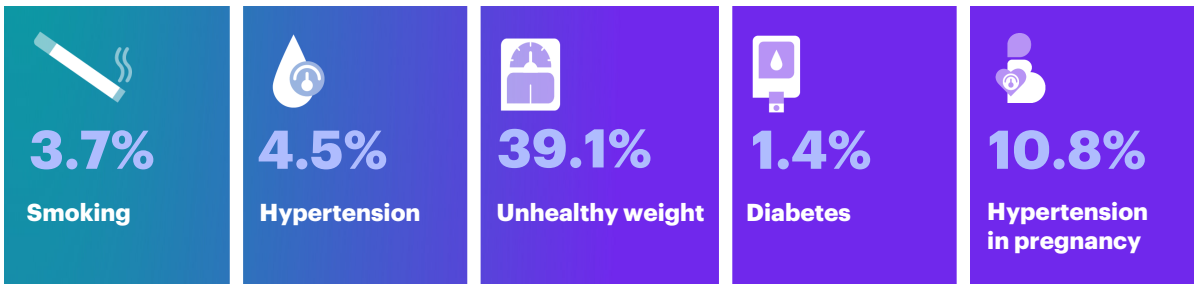
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 5.3%; Tricare: 7.7%; Indian Health Service: N/A; and all other types: 9.3%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Delaware

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



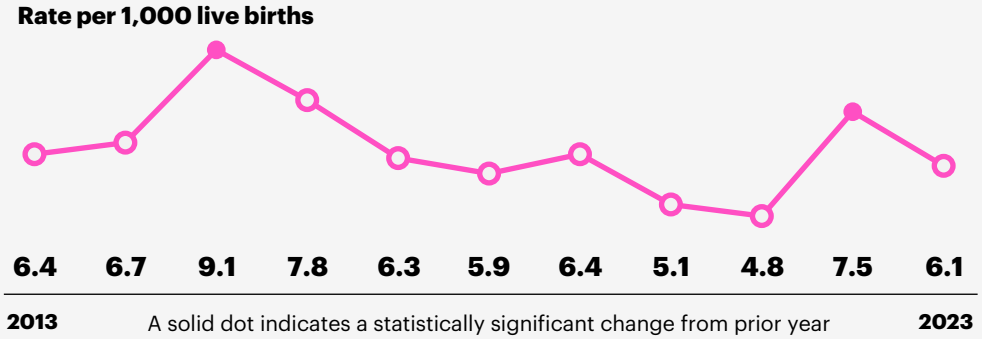
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 64 babies died before their first birthday

INFANT MORTALITY RATE **6.1**

US RATE 5.6

DE RANK 33

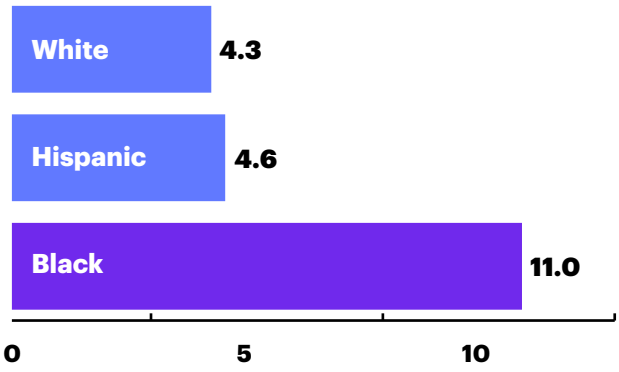


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.8x the state rate

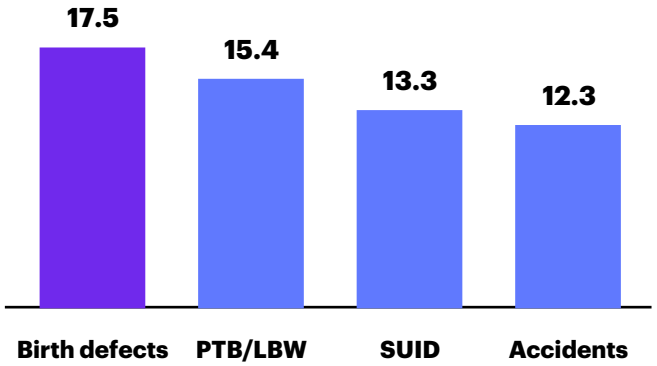
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 41.5% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Delaware

The rate of inadequate prenatal care among babies born to Hispanic moms is 1.7x the state rate

15.1
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

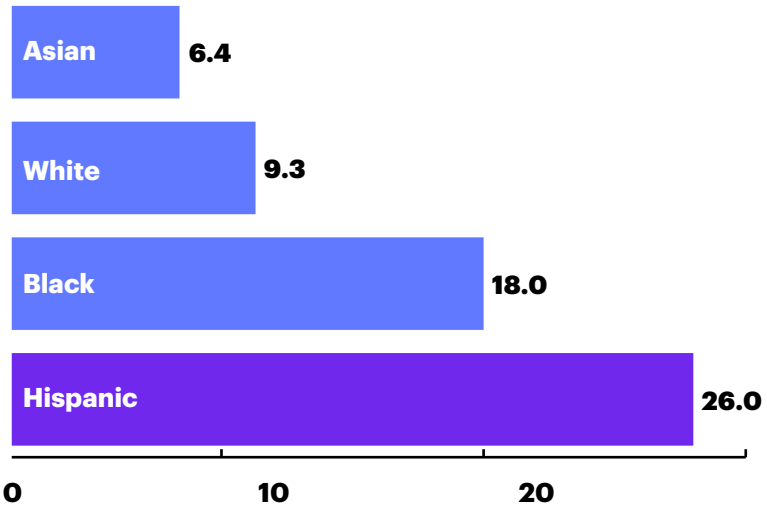
75.8
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Delaware

28.0
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

108.9
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

N/A
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

The maternal mortality rate cannot be shown due to unreliable estimates and concerns with confidentiality.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.6%	6.1	28.0%	78.0%	108.9	N/A
Rank	30th of 52	33rd of 52	39th of 52	27th of 52	39th of 47	N/A
Direction†	Worsened	Improved	Worsened†	Worsened	Worsened	N/A
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Delaware

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Delaware

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Delaware's Medicaid program, Delaware Medicaid, covered 4,430 births in 2024

42.2

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
District of Columbia

Scan for more data

898 babies were born preterm in District of Columbia in 2024. District of Columbia ranks 45th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.8%.

DC has made improvement in pre-pregnancy hypertension since last year.

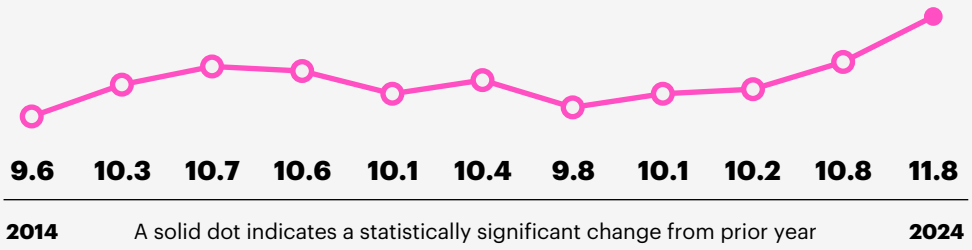
District of Columbia is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in District of Columbia was 11.8% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **F**

US RATE	DC	DC
10.4	11.8	45

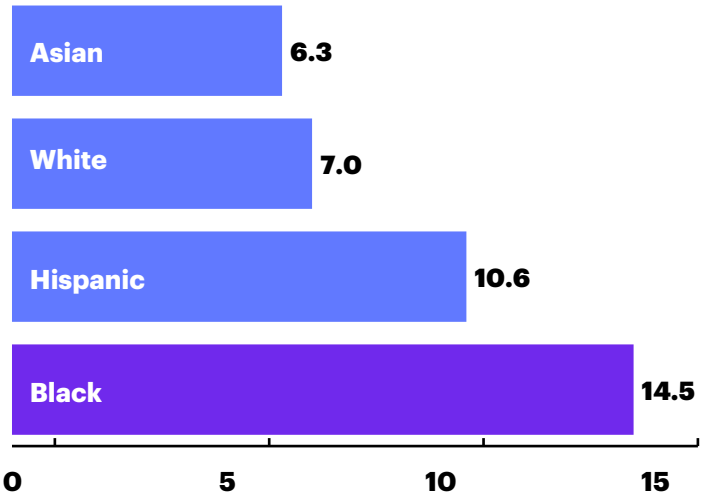
Percentage of live births born preterm



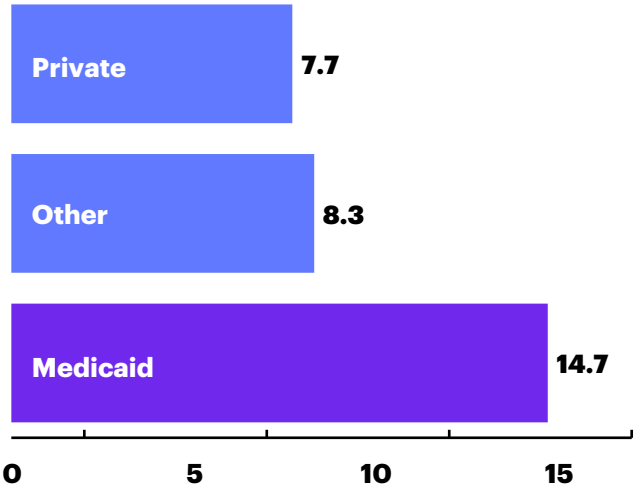
Note: The change in 2024 was a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



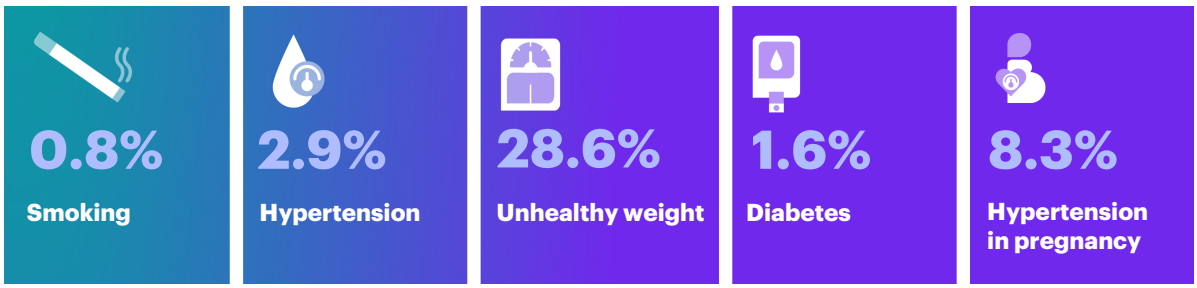
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.9%; Tricare: 6.4%; Indian Health Service: N/A; and all other types: 10.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

District of Columbia

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



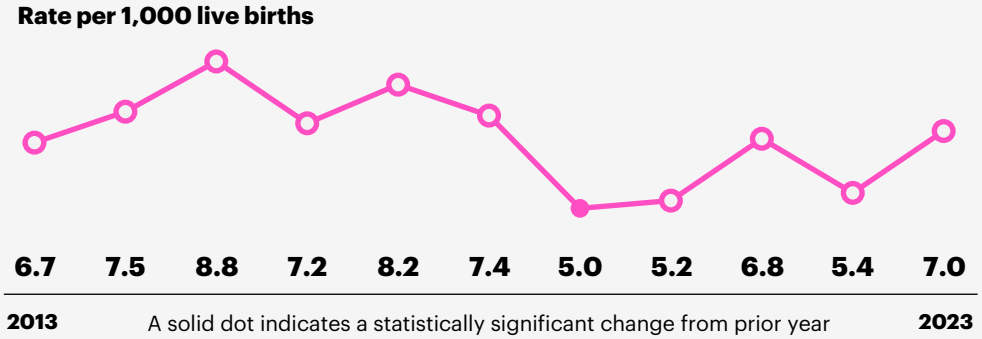
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 55 babies died before their first birthday

INFANT MORTALITY RATE **7.0**

US RATE **5.6**

DC **43**

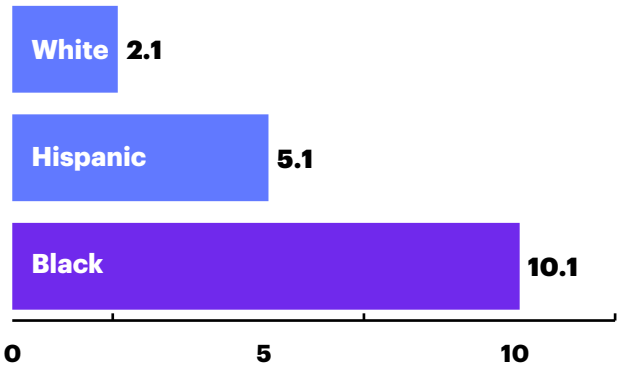


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.5x the state rate

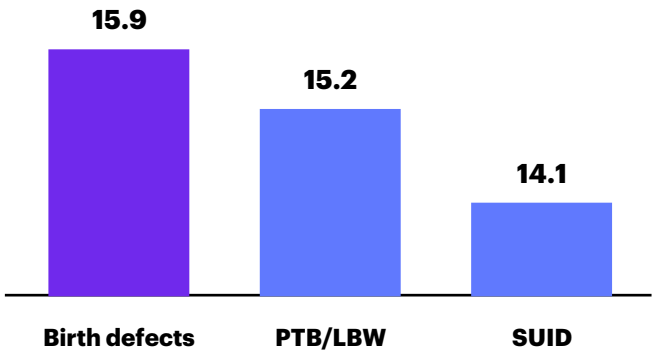
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 54.8% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

District of Columbia

The rate of inadequate prenatal care among babies born to Black moms is 1.3x the state rate

23.0 PERCENT (16.1)

INADEQUATE PRENATAL CARE

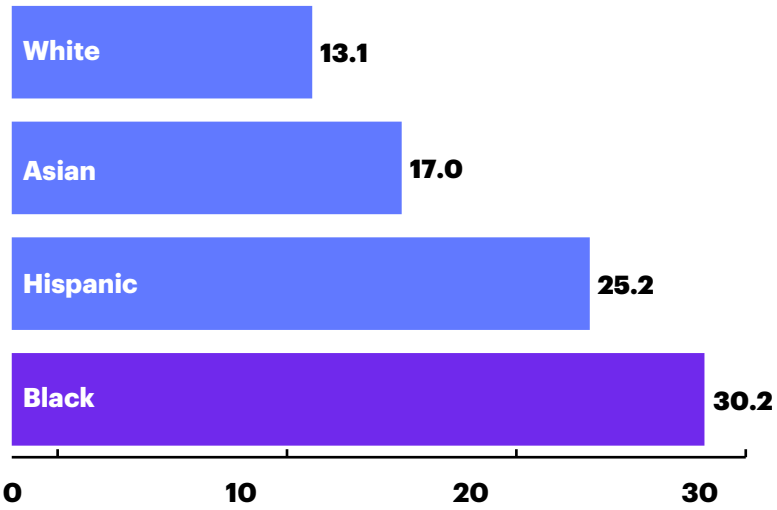
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

71.3 PERCENT (75.5)

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in District of Columbia

31.6 PERCENT (26.6)

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

132.8 PER 10,000 HOSPITAL DELIVERIES (93.1)

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

28.2 PER 100,000 BIRTHS (23.5)

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.8%	7.0	31.6%	63.6%	132.8	28.2
Rank	45th of 52	43rd of 52	51st of 52	51st of 52	46th of 47	32nd of 48
Direction†	Worsened†	Worsened	Worsened	Worsened	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

District of Columbia

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in District of Columbia

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

District of Columbia's Medicaid program, DC Medicaid, covered 3,416 births in 2024

45.1

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Florida

Scan for more data

23,803 babies were born preterm in Florida in 2024. Florida ranks 32nd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.7%.

Florida has made improvement in pre-pregnancy unhealthy weight and cigarette smoking since last year.

Florida is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Florida was 10.7% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **D+**

US RATE	FL RATE	FL RANK
10.4	10.7	32

Percentage of live births born preterm

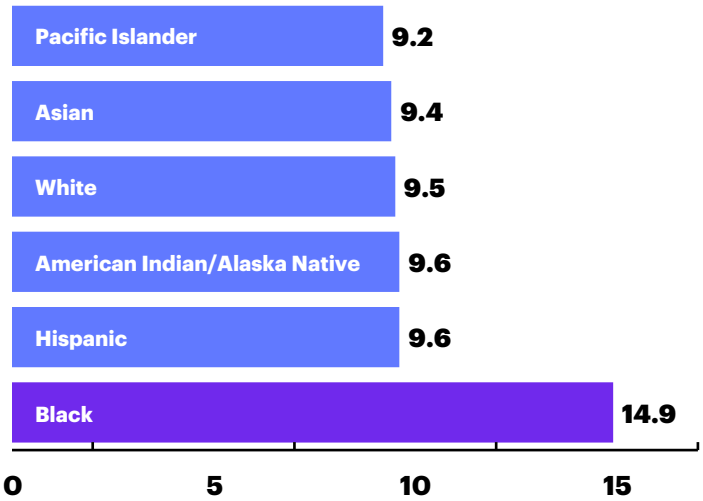
2014										2024
9.9	10.0	10.1	10.2	10.3	10.6	10.5	10.9	10.6	10.7	10.7

A solid dot indicates a statistically significant change from prior year

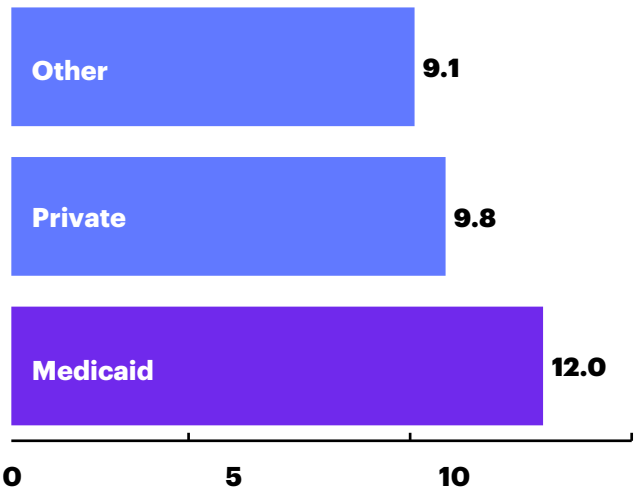
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



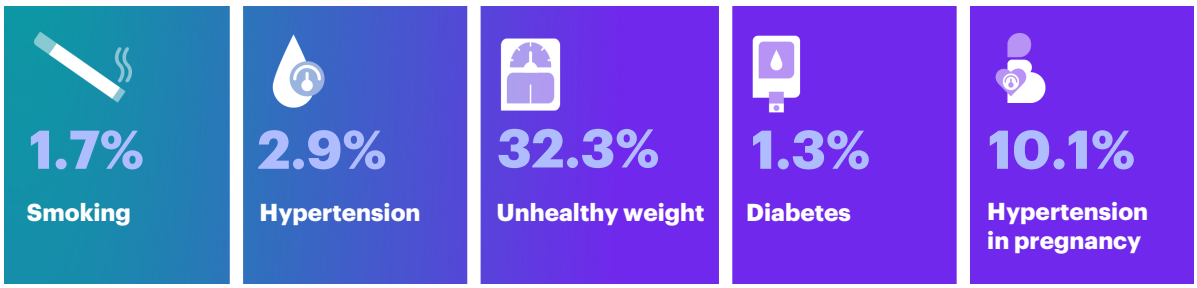
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 8.3%; Tricare: 9.9%; Indian Health Service: N/A; and all other types: 10.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Florida

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



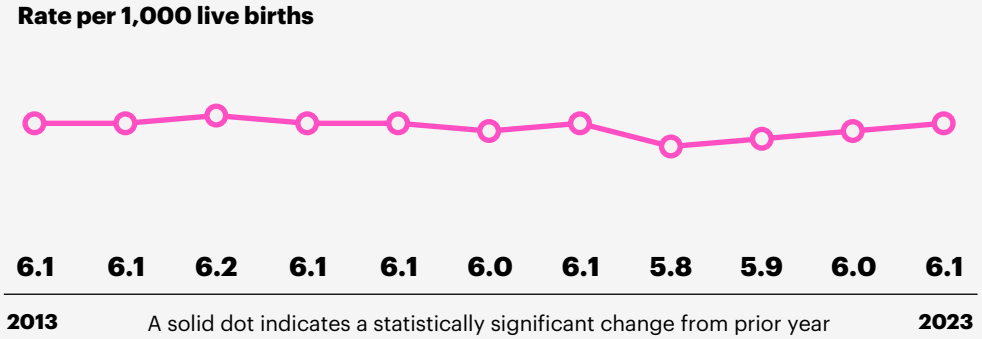
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate did not improve in the last decade; in 2023, 1,351 babies died before their first birthday

INFANT MORTALITY RATE **6.1**

US RATE **5.6**

FL RANK **33**

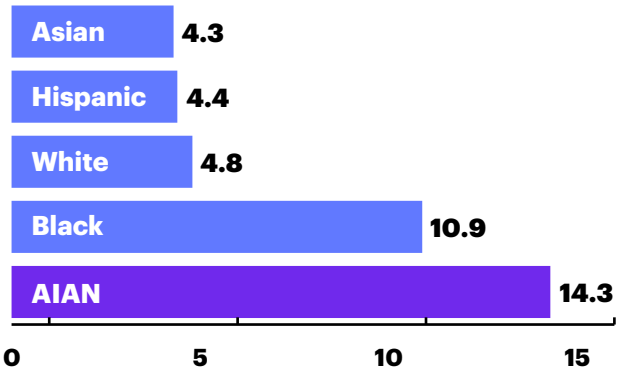


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to American Indian/Alaska Native moms is 2.4x the state rate

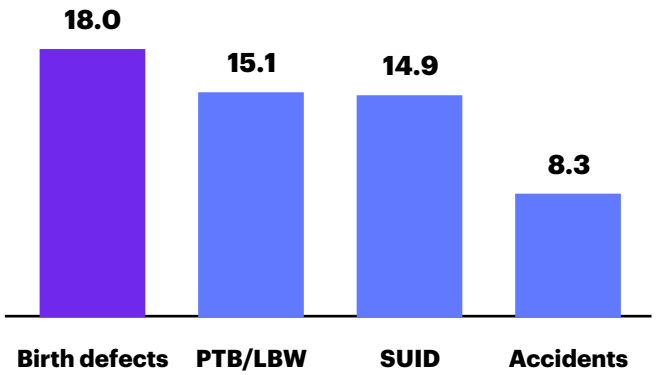
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 43.8% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Florida

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 1.5x the state rate

23.8 PERCENT — 16.1

INADEQUATE PRENATAL CARE

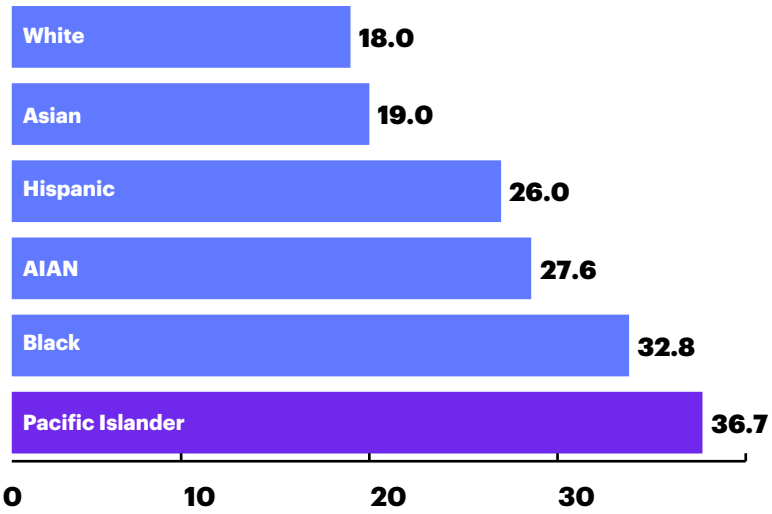
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

65.2 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Florida

30.1 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

103.5 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

24.5 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.7%	6.1	30.1%	65.9%	103.5	24.5
Rank	32nd of 52	33rd of 52	48th of 52	50th of 52	33rd of 47	28th of 48
Direction†	No change	Worsened	Worsened	Worsened	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Florida

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Florida

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Florida's Medicaid program, Florida Medicaid, covered 87,047 births in 2024

39.2

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Georgia

Scan for more data

14,907 babies were born preterm in Georgia in 2024. Georgia ranks 45th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.8%.

Georgia has made significant improvement in low-risk Cesarean births since last year.

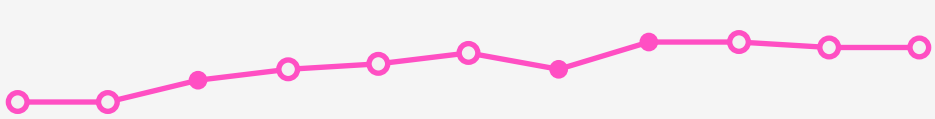
Georgia is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Georgia was 11.8% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **F**

US RATE	GA RATE	GA RANK
10.4	11.8	45

Percentage of live births born preterm



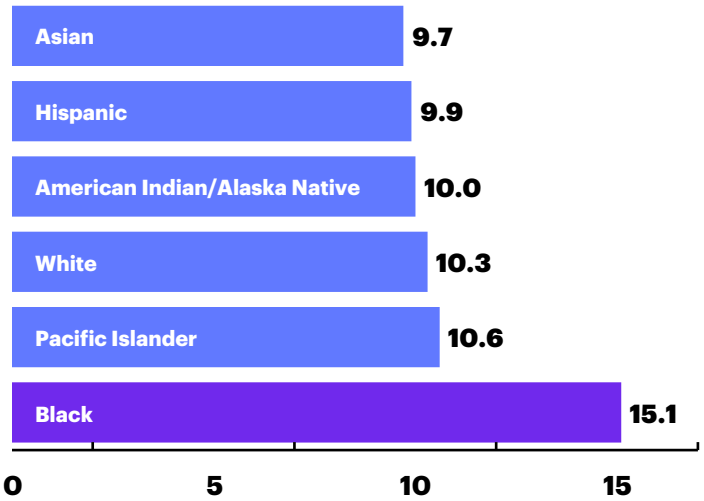
2014										2024
10.8	10.8	11.2	11.4	11.5	11.7	11.4	11.9	11.9	11.8	11.8

A solid dot indicates a statistically significant change from prior year

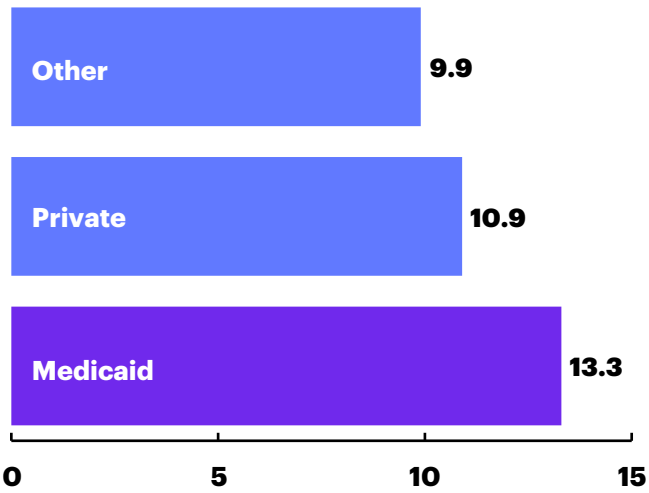
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



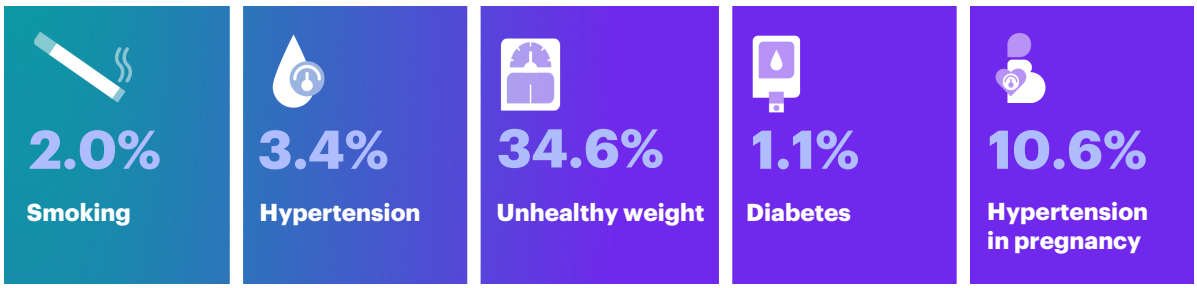
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 9.6%; Tricare: 9.4%; Indian Health Service: N/A; and all other types: 11.7%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Georgia

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



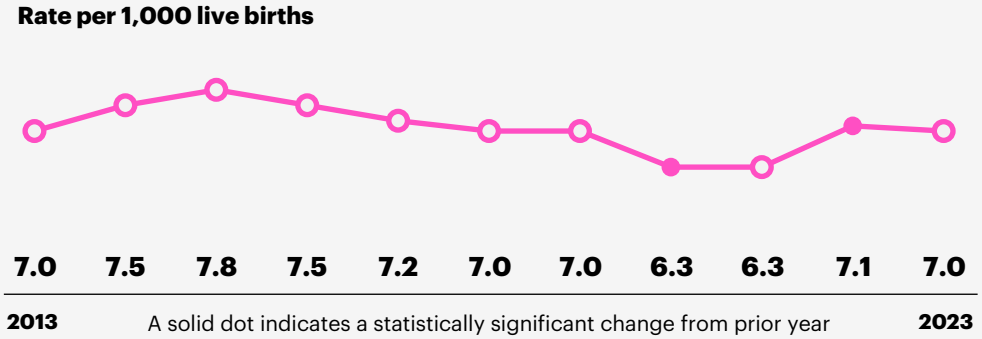
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate did not improve in the last decade; in 2023, 874 babies died before their first birthday

INFANT MORTALITY RATE **7.0**

US RATE **5.6**

GA RANK **43**

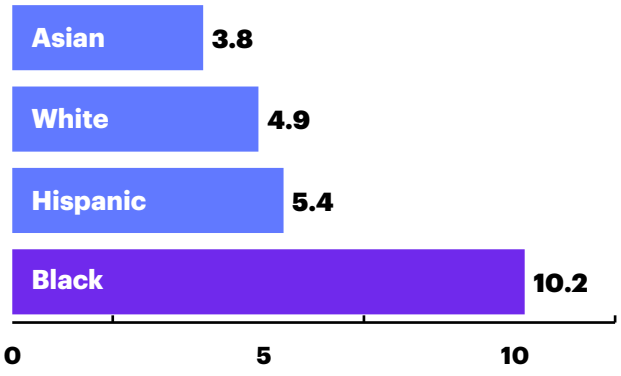


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.5x the state rate

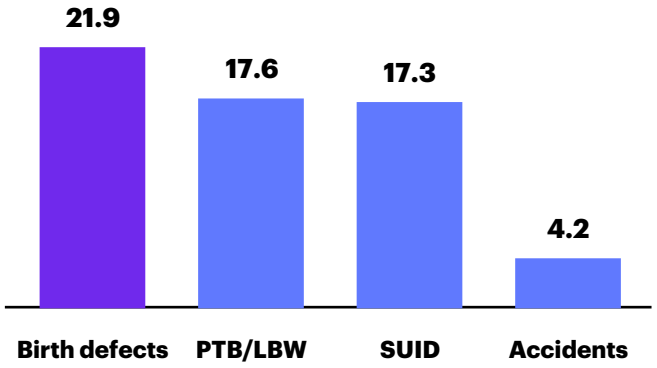
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 39.0% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Georgia

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.1x the state rate

20.6
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

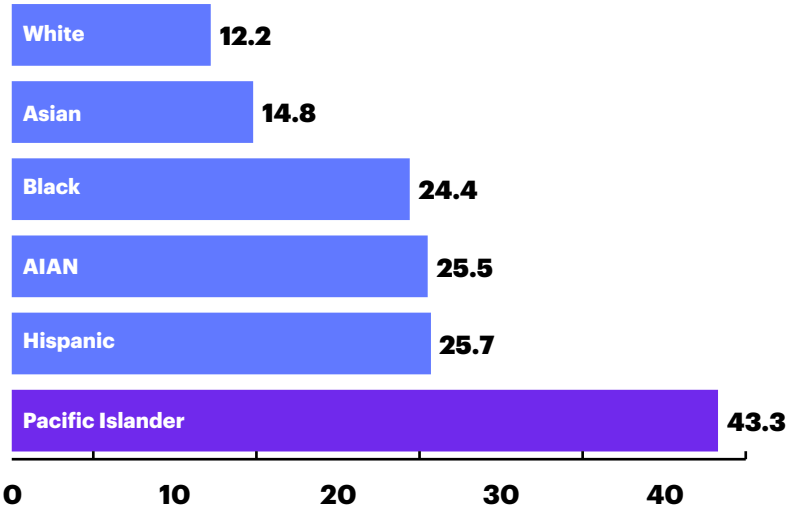
70.5
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Georgia

28.2
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

99.7
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

30.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.8%	7.0	28.2%	73.2%	99.7	30.4
Rank	45th of 52	43rd of 52	41st of 52	41st of 52	30th of 47	36th of 48
Direction†	No change	Improved	Improved†	Worsened†	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Georgia

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Georgia

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Georgia's Medicaid program, Georgia Medicaid, covered 52,967 births in 2024

41.9

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Hawaii

Scan for more data

1,494 babies were born preterm in Hawaii in 2024. Hawaii ranks 21st of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.0%.

Hawaii is among the top ten best states with the lowest rates of maternal mortality.

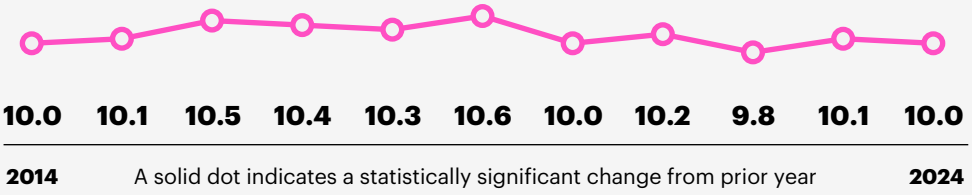
Hawaii is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Hawaii was 10.0% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	HI RATE	HI RANK
10.4	10.0	21

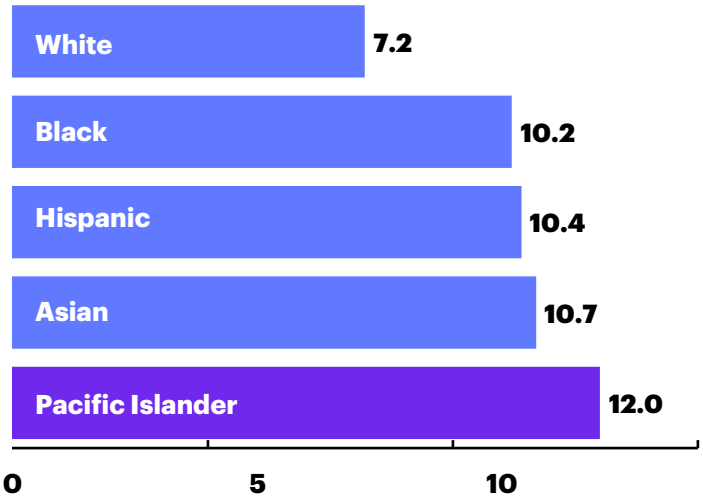
Percentage of live births born preterm



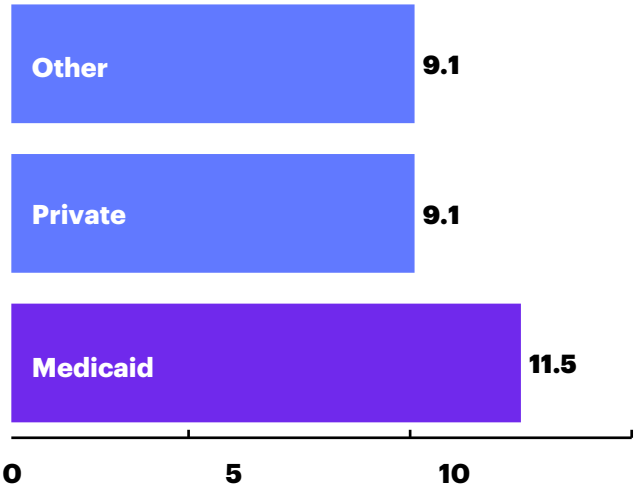
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



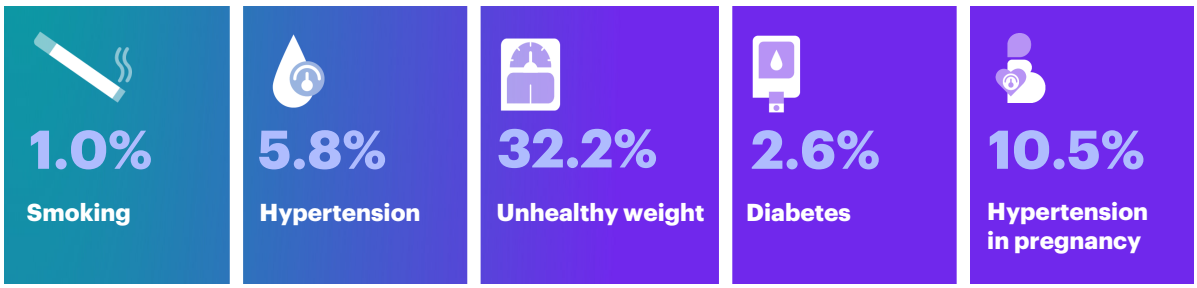
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 4.4%; Tricare: 8.9%; Indian Health Service: N/A; and all other types: 14.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Hawaii

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



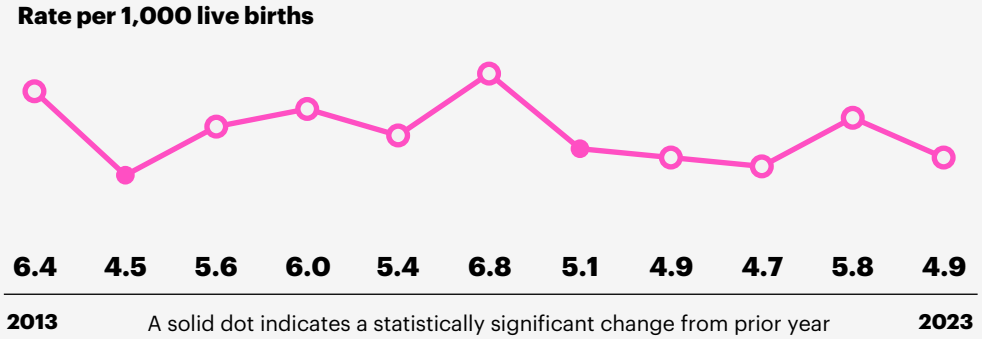
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 72 babies died before their first birthday

INFANT MORTALITY RATE **4.9**

US RATE **5.6**

HI RANK **15**

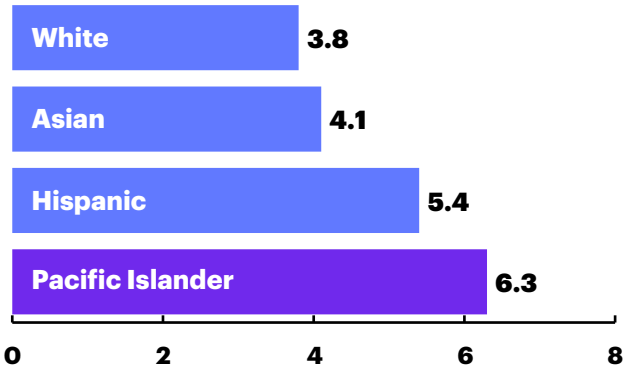


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Pacific Islander moms is 1.3x the state rate

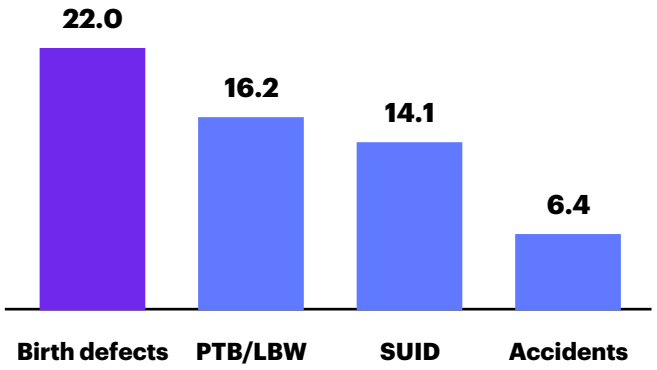
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 41.2% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Hawaii

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.1x the state rate

26.2 PERCENT — 16.1

INADEQUATE PRENATAL CARE

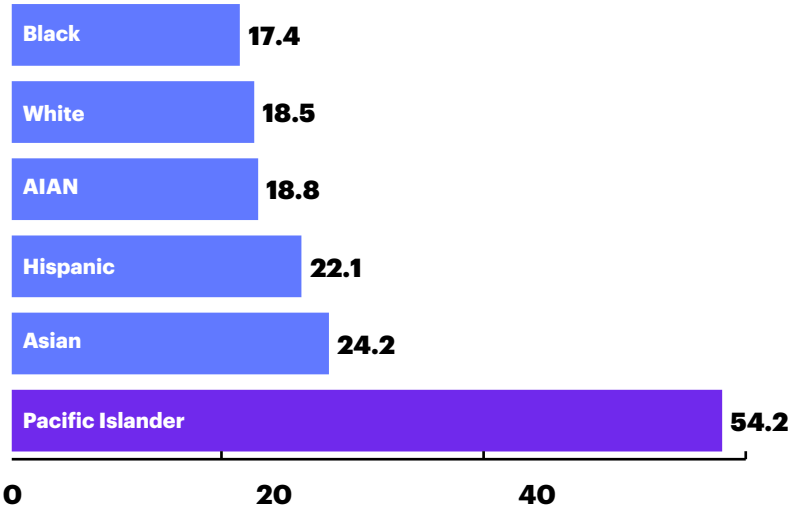
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

66.3 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Hawaii

23.1 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

107.6 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

16.6 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.0%	4.9	23.1%	63.4%	107.6	16.6
Rank	21st of 52	15th of 52	11th of 52	52nd of 52	36th of 47	7th of 48
Direction†	Improved	Improved	Improved	Improved	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Hawaii

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Hawaii

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Hawaii's Medicaid program, Med-QUEST, covered 5,075 births in 2024

34.2

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Idaho

Scan for more data

2,113 babies were born preterm in Idaho in 2024. Idaho ranks 7th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.1%.

Idaho is among the top ten best states with the lowest rates of low-risk Cesarean births and infant mortality, as well as the highest rates of adequate prenatal care reception.

Idaho is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Idaho was 9.1% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **B-**

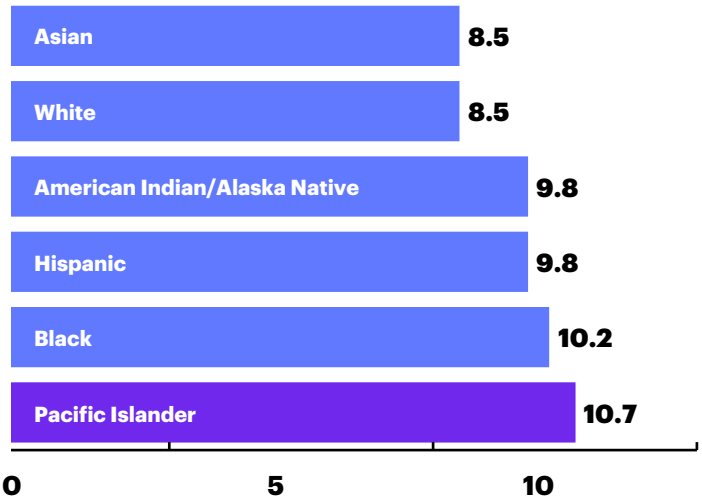
US RATE	ID RATE	ID RANK
10.4	9.1	7

Percentage of live births born preterm

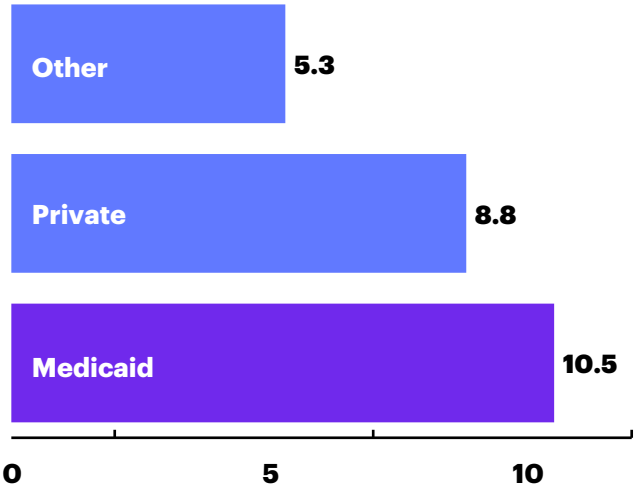
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



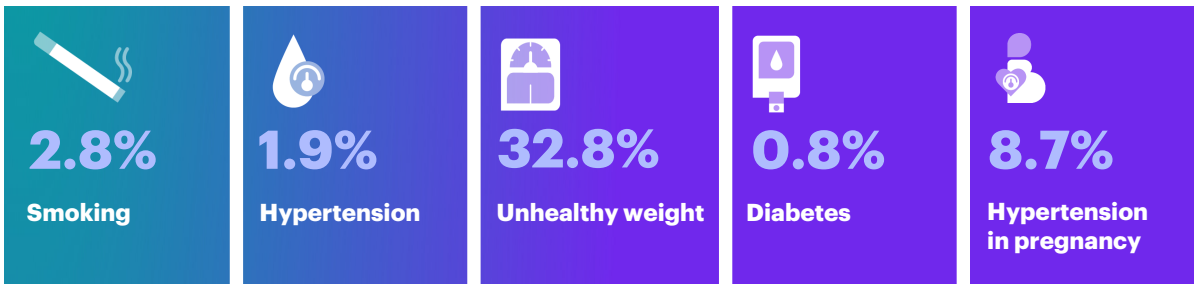
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 4.5%; Tricare: 7.5%; Indian Health Service: N/A; and all other types: 6.3%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Idaho

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

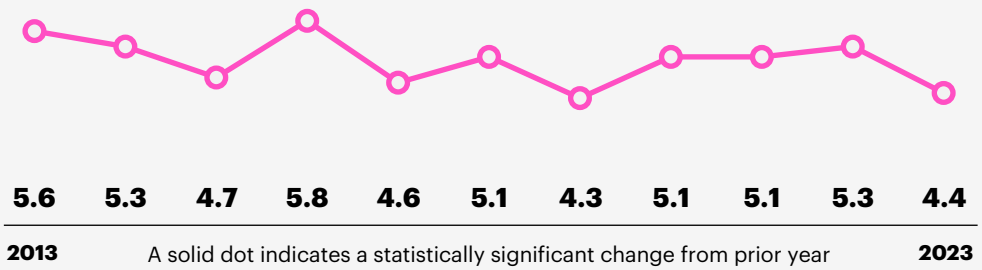
The infant mortality rate decreased in the last decade; in 2023, 98 babies died before their first birthday

INFANT MORTALITY RATE **4.4**

US RATE 5.6

ID RANK 8

Rate per 1,000 live births

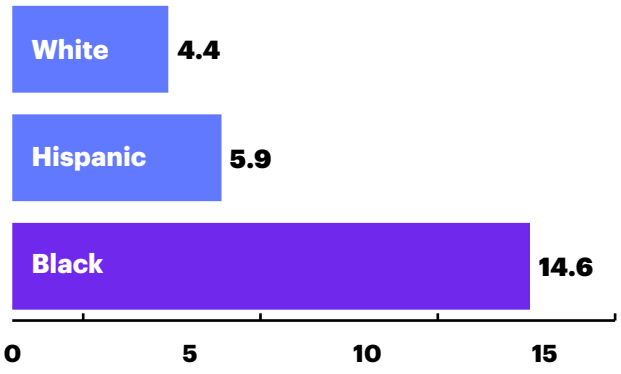


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 3.3x the state rate

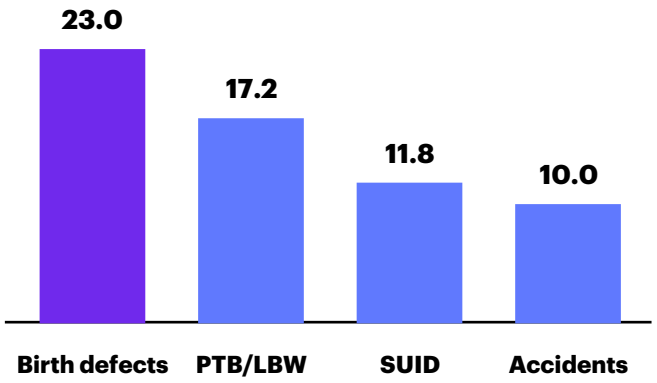
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 38.1% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Idaho

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.8x the state rate

10.9
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

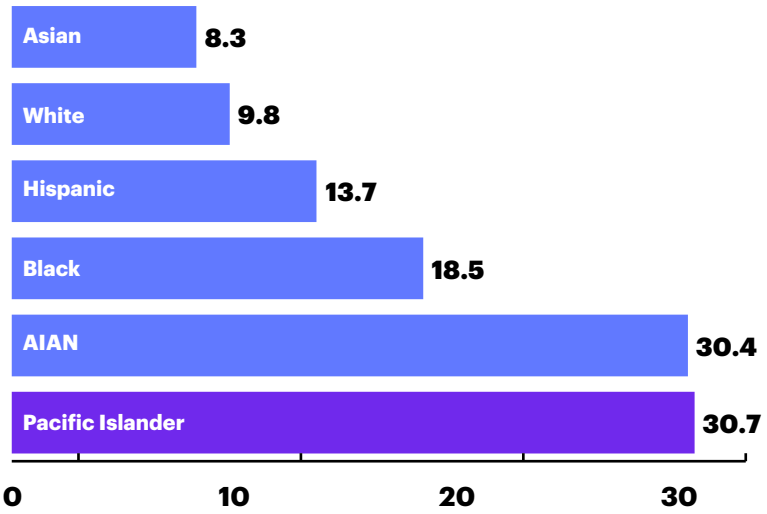
81.4
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Idaho

20.1
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

N/A
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

The severe maternal morbidity rate cannot be shown due to lack of available data.

19.9
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.1%	4.4	20.1%	82.2%	N/A	19.9
Rank	7th of 52	8th of 52	3rd of 52	10th of 52	N/A	15th of 48
Direction†	Worsened	Improved	Worsened	Worsened	N/A	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Idaho

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Idaho

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Idaho's Medicaid program, Idaho Medicaid, covered 6,411 births in 2024

27.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Illinois

Scan for more data

13,042 babies were born preterm in Illinois in 2024. Illinois ranks 27th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.4%.

Illinois is among the top twenty states with the lowest rates of low-risk Cesarean births and maternal mortality.

Illinois is currently implementing four of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Illinois was 10.4% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **D+**

US RATE	IL RATE	IL RANK
10.4	10.4	27

Percentage of live births born preterm

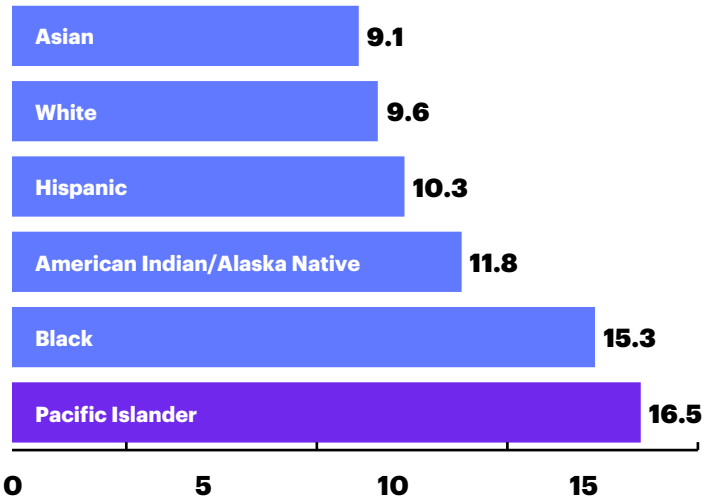
2014										2024
10.1	10.2	10.3	10.4	10.7	10.7	10.3	10.7	10.6	10.8	10.4

A solid dot indicates a statistically significant change from prior year

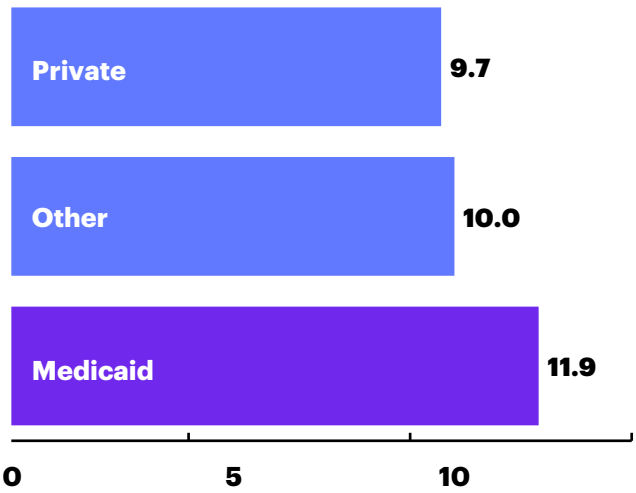
Note: The change in 2024 was a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



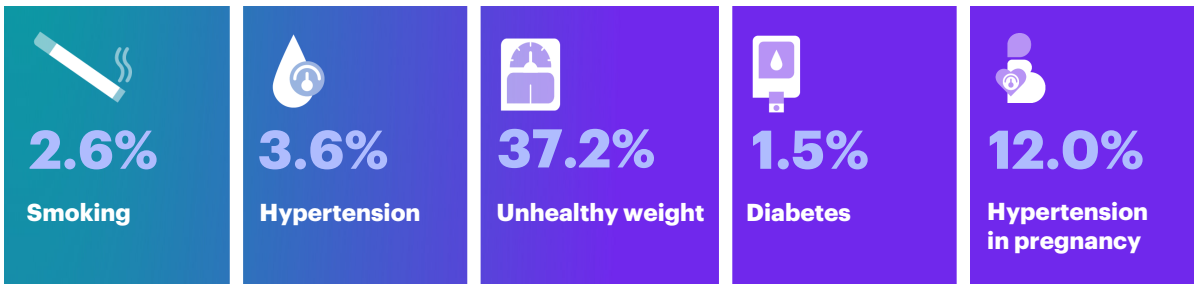
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 8.5%; Tricare: N/A; Indian Health Service: N/A; and all other types: 13.0%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Illinois

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



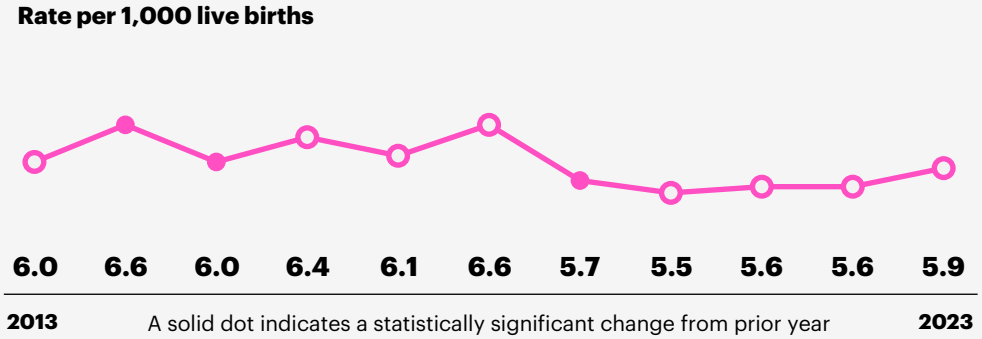
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 738 babies died before their first birthday

INFANT MORTALITY RATE **5.9**

US RATE **5.6**

IL RANK **30**

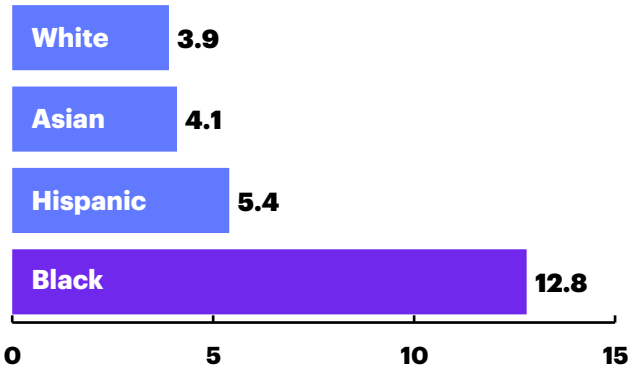


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 2.2x the state rate

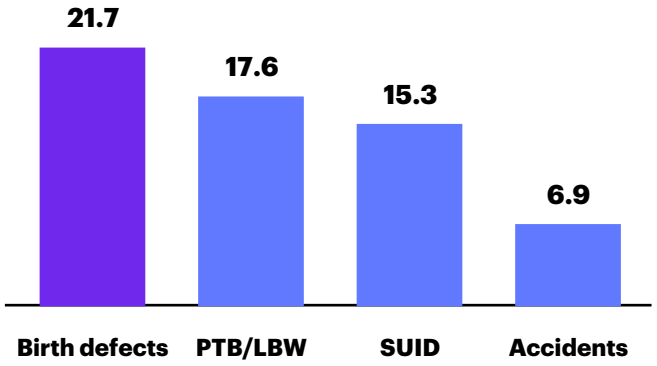
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 38.4% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Illinois

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.0x the state rate

15.4
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

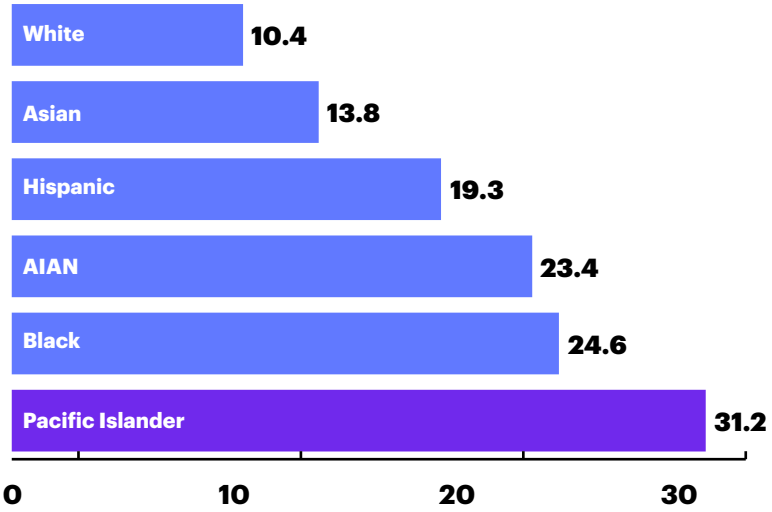
76.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Illinois

24.3
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

90.4
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

20.0
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.4%	5.9	24.3%	77.3%	90.4	20.0
Rank	27th of 52	30th of 52	16th of 52	28th of 52	23rd of 47	17th of 48
Direction†	Improved†	Worsened	Worsened	Worsened†	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Illinois

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Illinois

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Illinois' Medicaid program, HealthChoice Illinois, covered 49,730 births in 2024

39.6

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Indiana

Scan for more data

8,766 babies were born preterm in Indiana in 2024. Indiana ranks 34th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.9%.

Indiana is among the top twenty states with the lowest rates of low-risk Cesarean births and severe maternal morbidity.

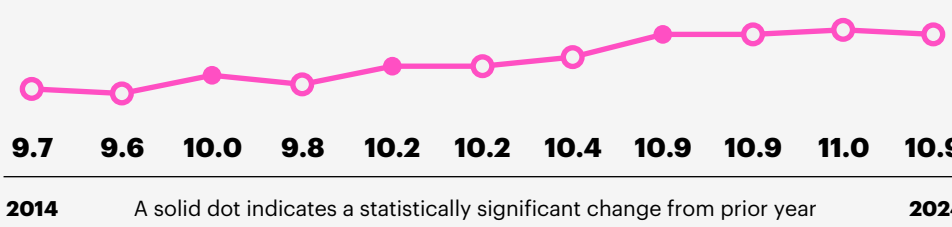
Indiana is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Indiana was 10.9% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **D**

US RATE	IN RATE	IN RANK
10.4	10.9	34

Percentage of live births born preterm



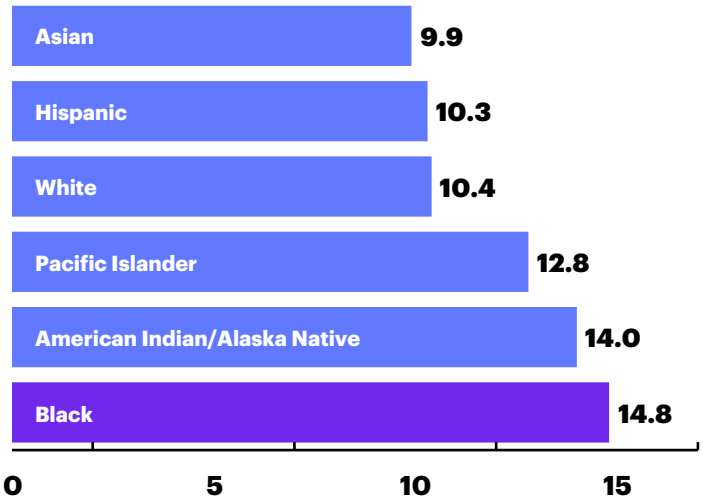
2014										2024
9.7	9.6	10.0	9.8	10.2	10.2	10.4	10.9	10.9	11.0	10.9

A solid dot indicates a statistically significant change from prior year

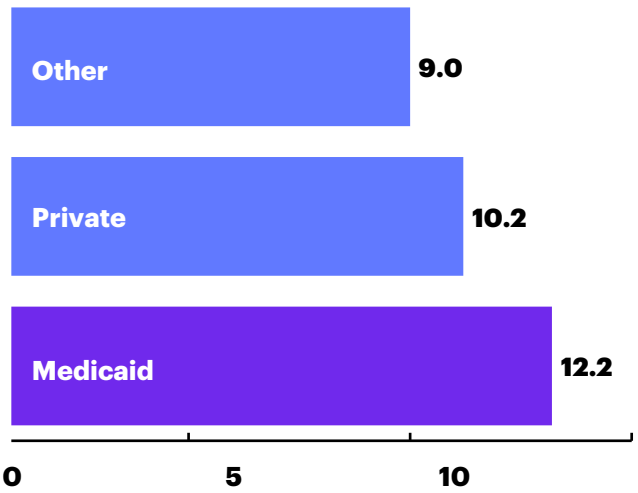
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



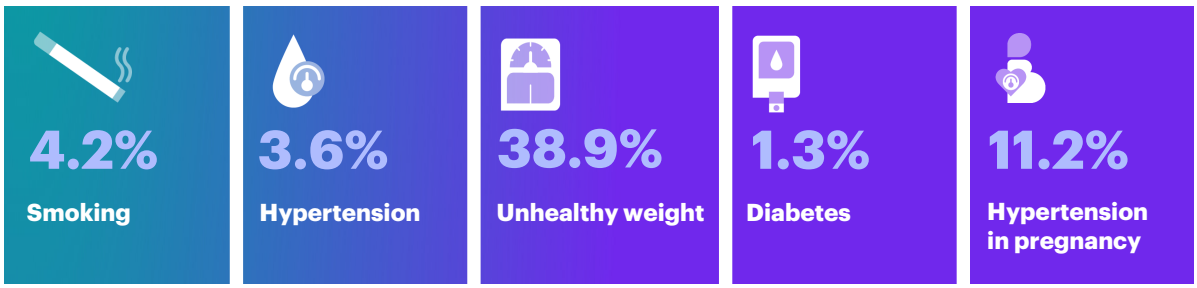
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 5.7%; Tricare: 10.0%; Indian Health Service: 29.2%; and all other types: 14.1%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Indiana

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



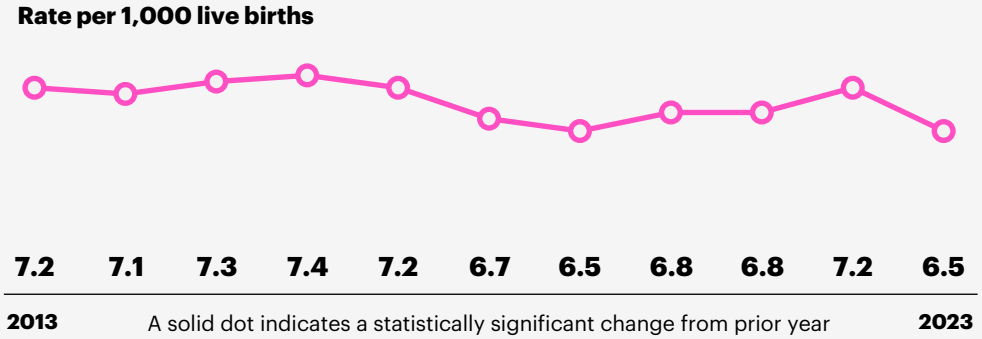
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 514 babies died before their first birthday

INFANT MORTALITY RATE **6.5**

US RATE **5.6**

IN RANK **38**

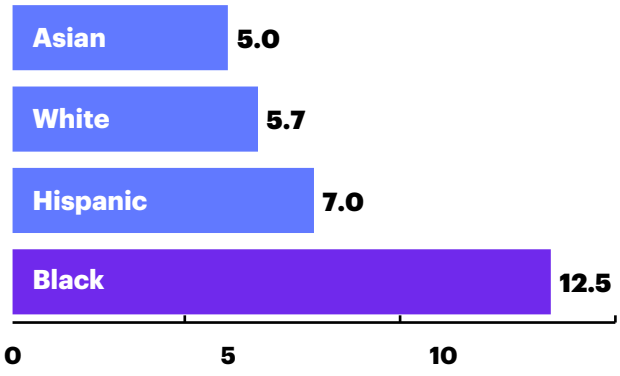


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.9x the state rate

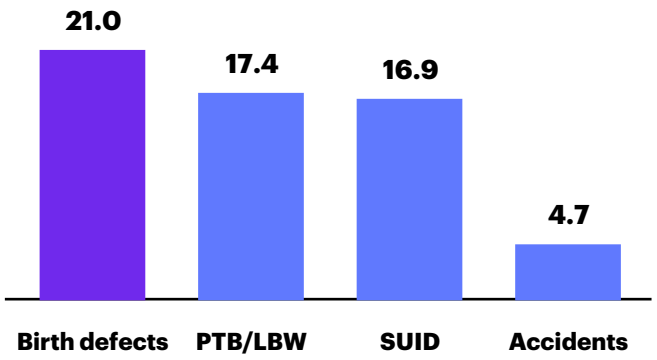
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.0% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Indiana

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.8x the state rate

16.1
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

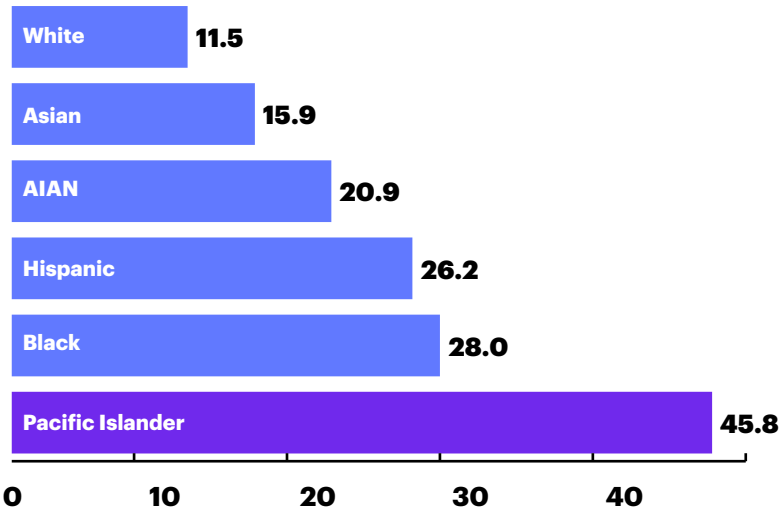
74.2
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Indiana

24.9
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

83.1
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

31.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.9%	6.5	24.9%	78.9%	83.1	31.4
Rank	34th of 52	38th of 52	20th of 52	21st of 52	19th of 47	38th of 48
Direction†	Improved	Improved	Improved	Worsened	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Indiana

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Indiana

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Indiana's Medicaid program, Hoosier Healthwise / Healthy Indiana Plan (HIP), covered 32,379 births in 2024

40.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

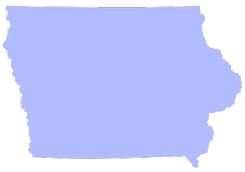
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Iowa

Scan for more data



3,672 babies were born preterm in Iowa in 2024. Iowa ranks 24th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.1%.

Iowa has made significant improvement in low-risk Cesarean births since last year.

Iowa is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Iowa was 10.1% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **C-**

US RATE	IA RATE	IA RANK
10.4	10.1	24

Percentage of live births born preterm

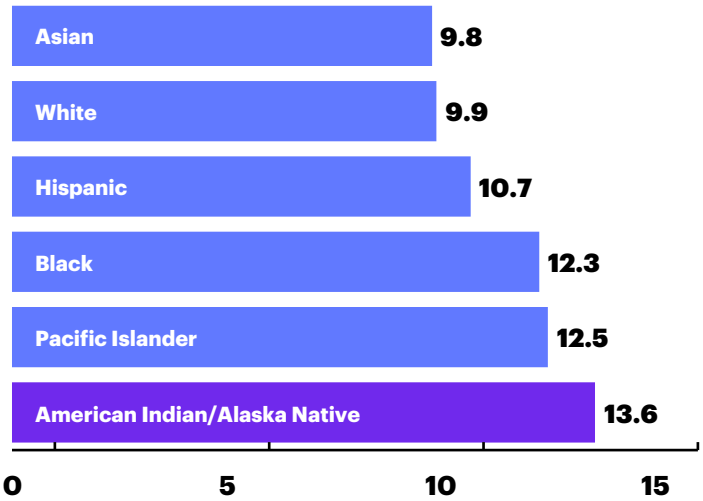
2014										2024
9.3	9.0	9.3	9.2	9.9	9.5	9.9	10.0	10.2	10.4	10.1

A solid dot indicates a statistically significant change from prior year

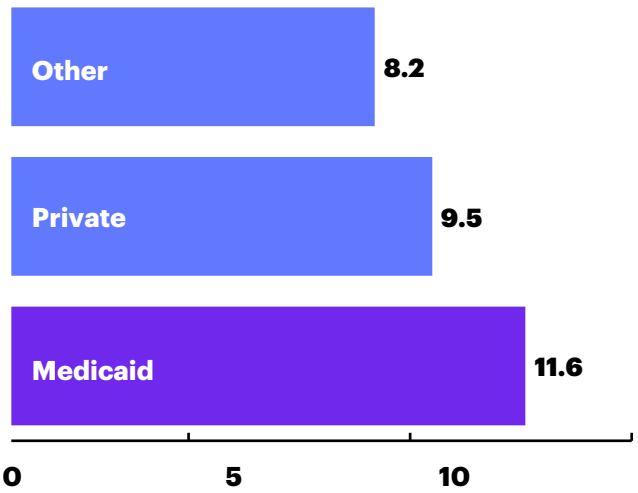
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



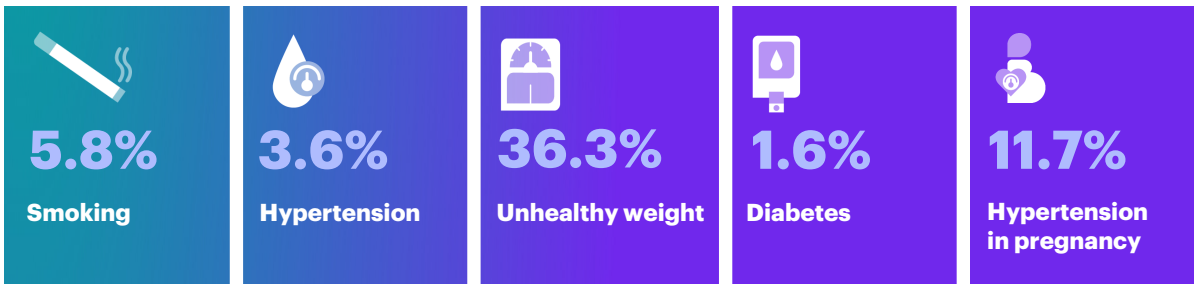
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 7.7%; Tricare: 11.5%; Indian Health Service: N/A; and all other types: 8.4%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Iowa

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



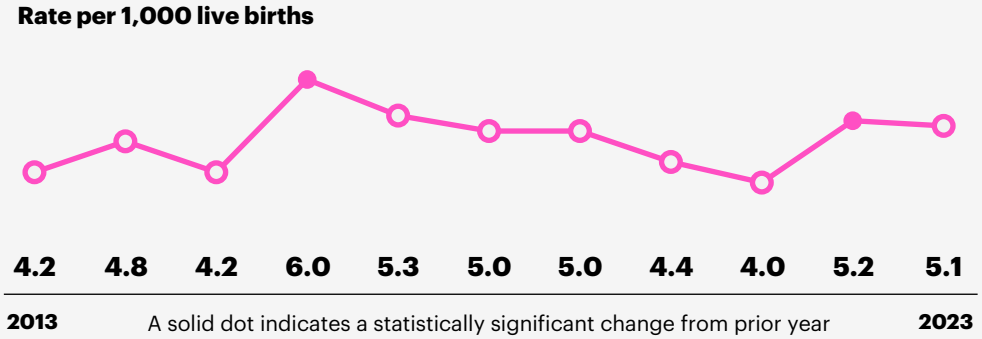
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 184 babies died before their first birthday

INFANT MORTALITY RATE **5.1**

US RATE **5.6**

IA RANK **18**

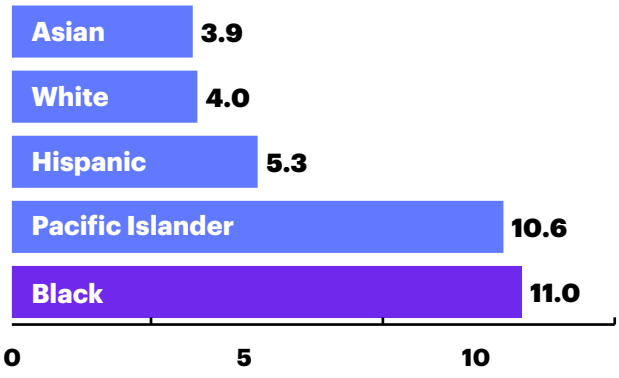


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 2.2x the state rate

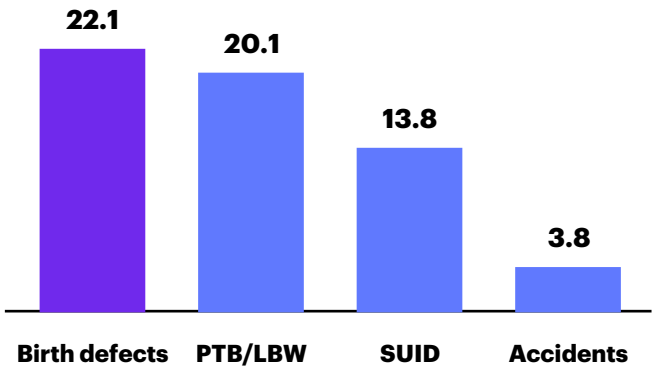
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.1% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Iowa

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 5.0x the state rate

11.6
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

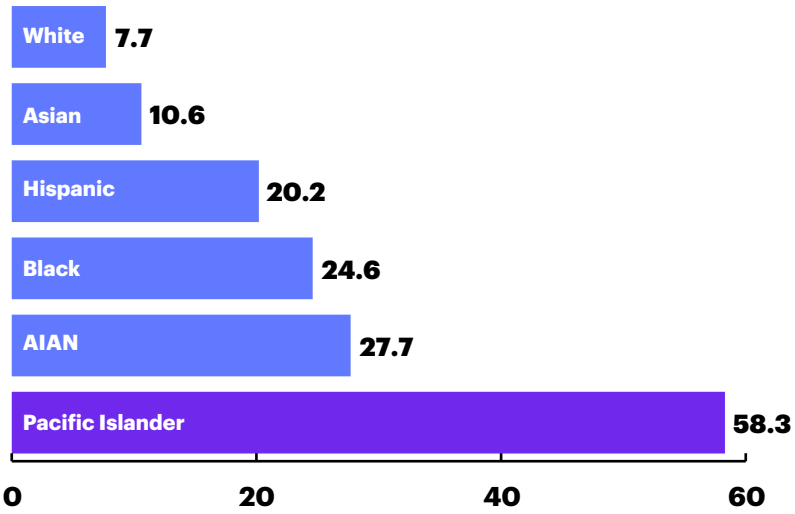
80.1
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Iowa

23.3
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

67.2
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

19.7
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.1%	5.1	23.3%	84.1%	67.2	19.7
Rank	24th of 52	18th of 52	12th of 52	8th of 52	6th of 47	13th of 48
Direction†	Improved	Improved	Improved†	No change	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Iowa

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Iowa

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Iowa's Medicaid program, IA Health Link, covered 13,129 births in 2024

36.0

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Kansas

Scan for more data

3,488 babies were born preterm in Kansas in 2024. Kansas ranks 26th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.3%.

Kansas has made significant improvement in adequate prenatal care reception since last year.

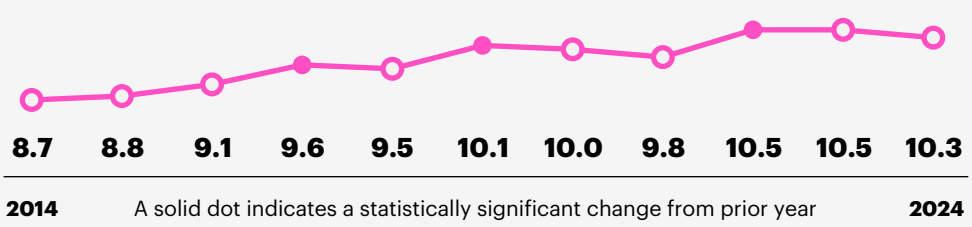
Kansas is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Kansas was 10.3% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **C-**

US RATE	KS RATE	KS RANK
10.4	10.3	26

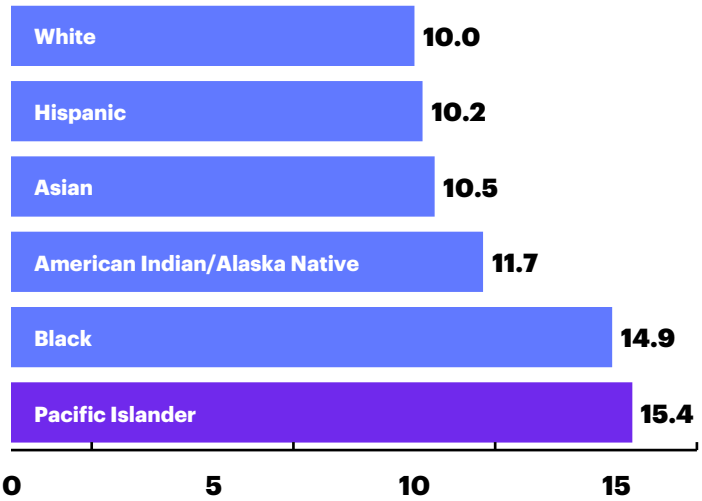
Percentage of live births born preterm



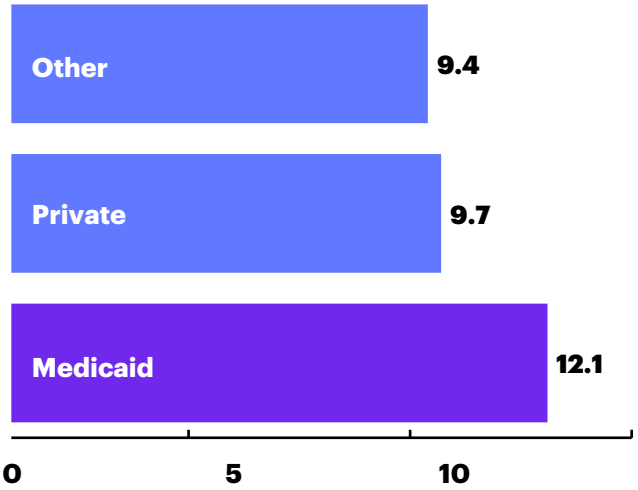
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



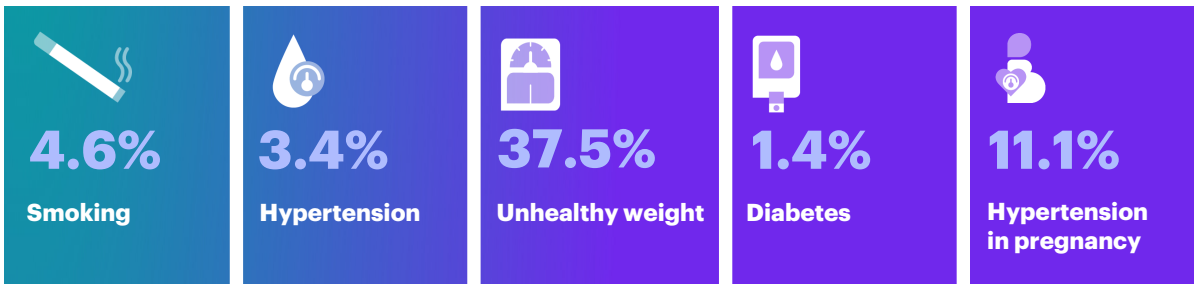
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 9.1%; Tricare: 9.2%; Indian Health Service: N/A; and all other types: 11.2%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Kansas

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



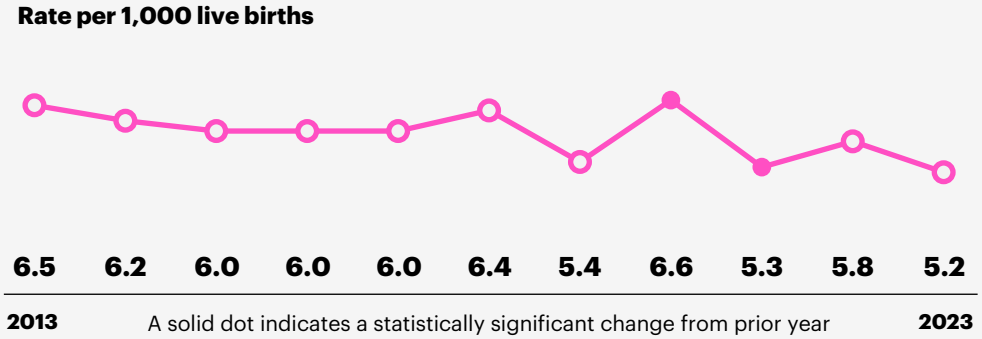
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 178 babies died before their first birthday

INFANT MORTALITY RATE **5.2**

US RATE **5.6**

KS RANK **19**

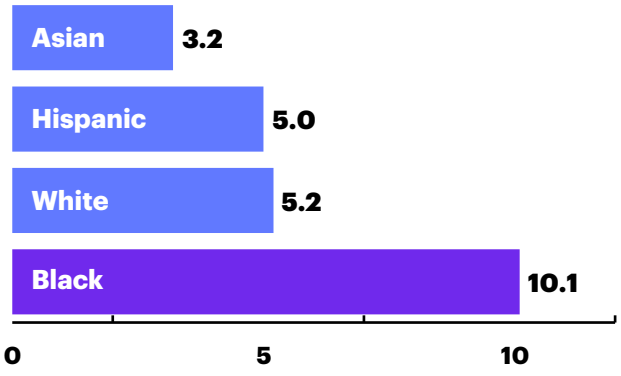


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.9x the state rate

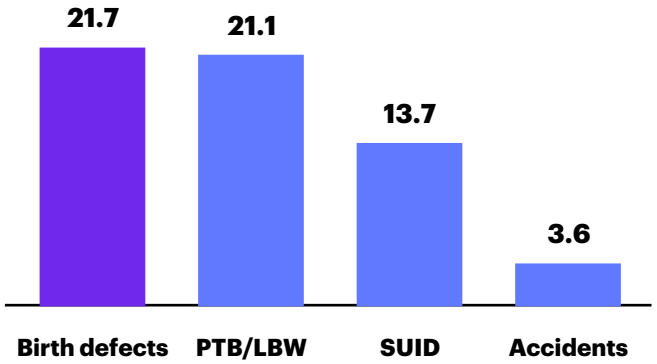
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 39.9% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Kansas

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 4.6x the state rate

10.4
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

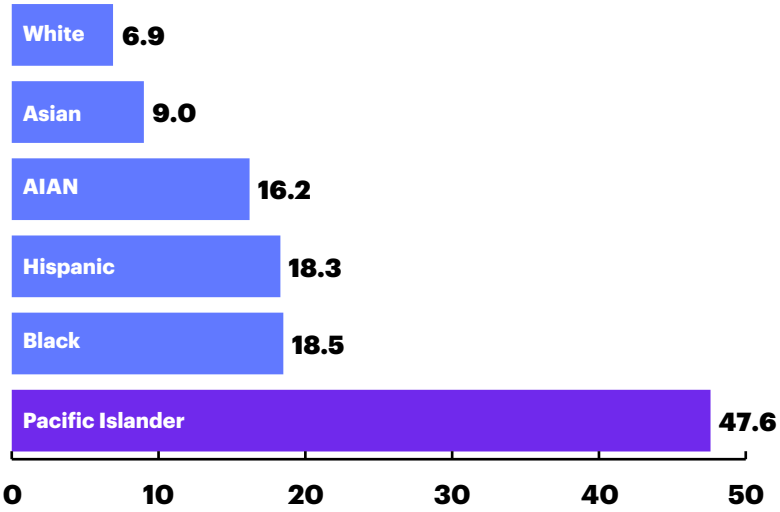
83.0
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Kansas

24.2
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

70.5
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

23.1
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.3%	5.2	24.2%	84.2%	70.5	23.1
Rank	26th of 52	19th of 52	14th of 52	7th of 52	9th of 47	21st of 48
Direction†	Improved	Improved	Improved	Improved†	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Kansas

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Kansas

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Kansas' Medicaid program, KanCare, covered 10,250 births in 2024

30.6

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Kentucky

Scan for more data

6,209 babies were born preterm in Kentucky in 2024. Kentucky ranks 44th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.7%.

Kentucky is among the top twenty states with the highest rates of adequate prenatal care reception.

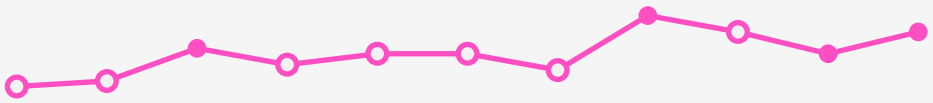
Kentucky is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Kentucky was 11.7% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **F**

US RATE	KY RATE	KY RANK
10.4	11.7	44

Percentage of live births born preterm



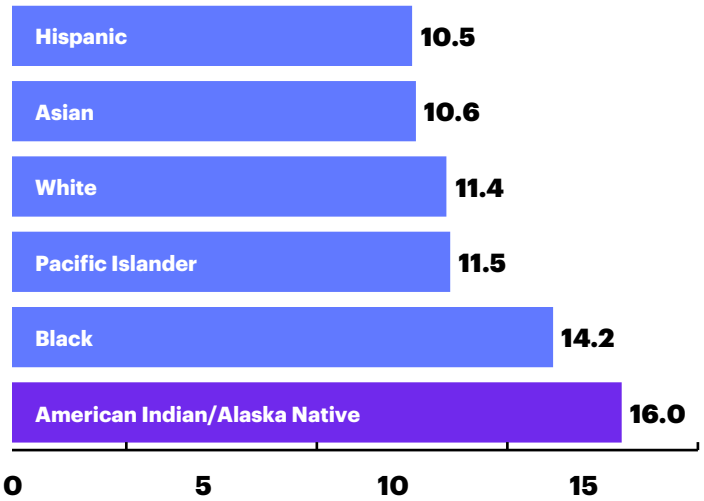
2014										2024
10.7	10.8	11.4	11.1	11.3	11.3	11.0	12.0	11.7	11.3	11.7

A solid dot indicates a statistically significant change from prior year

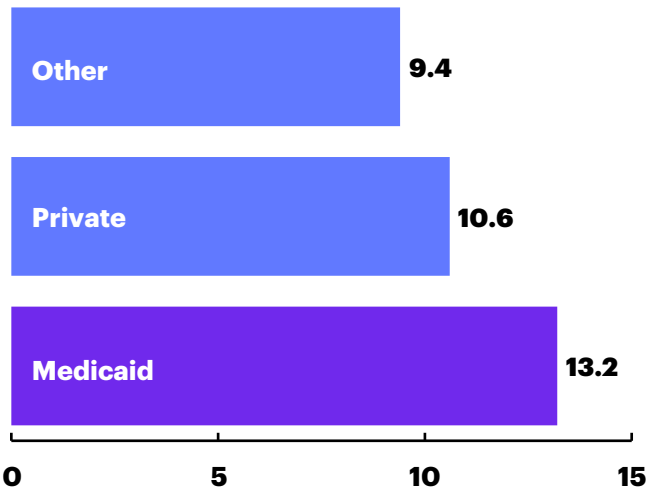
Note: The change in 2024 was a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



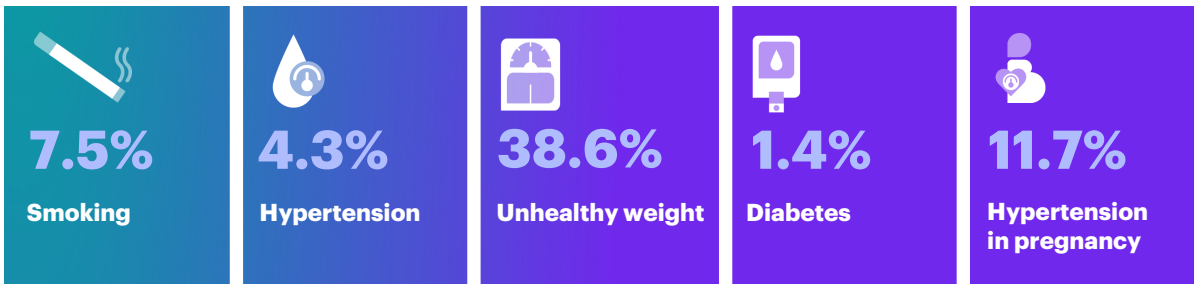
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 7.1%; Tricare: 10.0%; Indian Health Service: N/A; and all other types: 11.5%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Kentucky

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



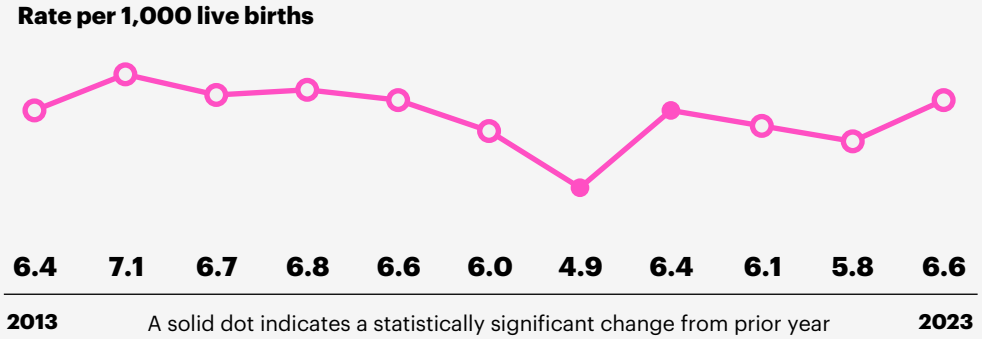
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 342 babies died before their first birthday

INFANT MORTALITY RATE **6.6**

US RATE **5.6**

KY RANK **40**

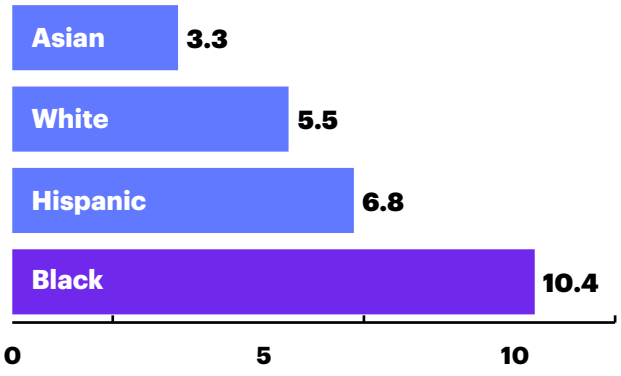


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.6x the state rate

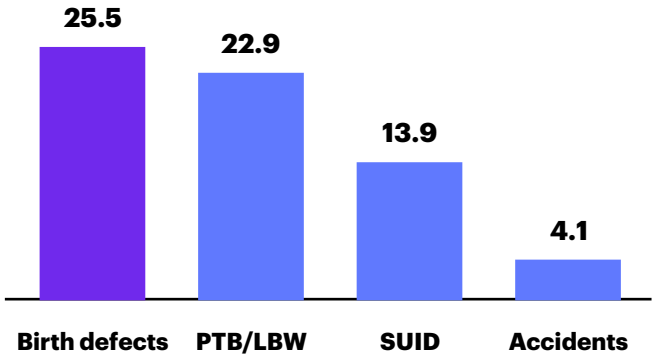
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 33.6% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Kentucky

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.2x the state rate

15.0
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

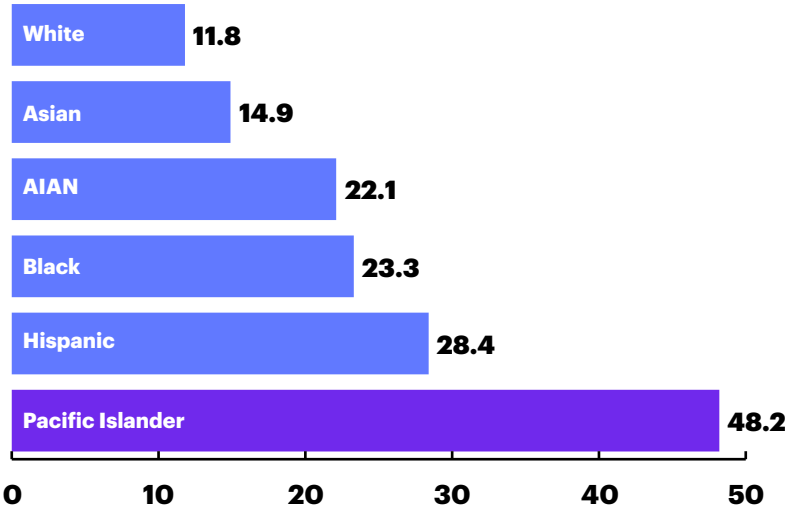
77.5
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Kentucky

26.5
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

86.3
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

31.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.7%	6.6	26.5%	79.2%	86.3	31.4
Rank	44th of 52	40th of 52	30th of 52	18th of 52	22nd of 47	38th of 48
Direction†	Worsened†	Worsened	Improved	Improved	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Kentucky

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Kentucky

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

State has the indicated program/policy

State reimburses up to $1,500

State is progressing legislation but not yet active

State does not have the indicated program/policy

Kentucky's Medicaid program, Kentucky Medicaid, covered 22,375 births in 2024

42.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Louisiana

Scan for more data

7,454 babies were born preterm in Louisiana in 2024. Louisiana ranks 51st of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 14.0%.

Louisiana is among the top twenty states with the lowest rates of severe maternal morbidity.

Louisiana is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Louisiana was 14.0% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **F**

US RATE	LA RATE	LA RANK
10.4	14.0	51

Percentage of live births born preterm

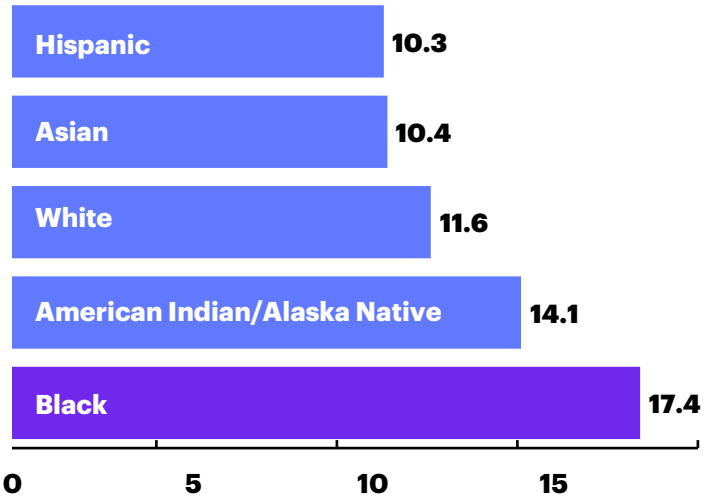
2014										2024
12.3	12.3	12.6	12.7	13.0	13.1	12.9	13.5	13.3	13.4	14.0

A solid dot indicates a statistically significant change from prior year

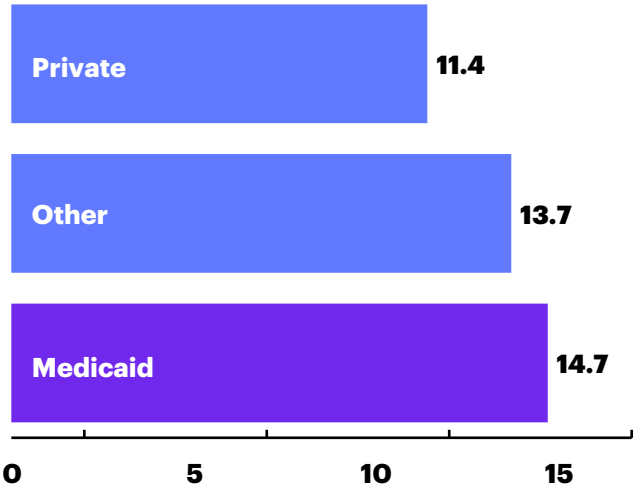
Note: The change in 2024 was a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



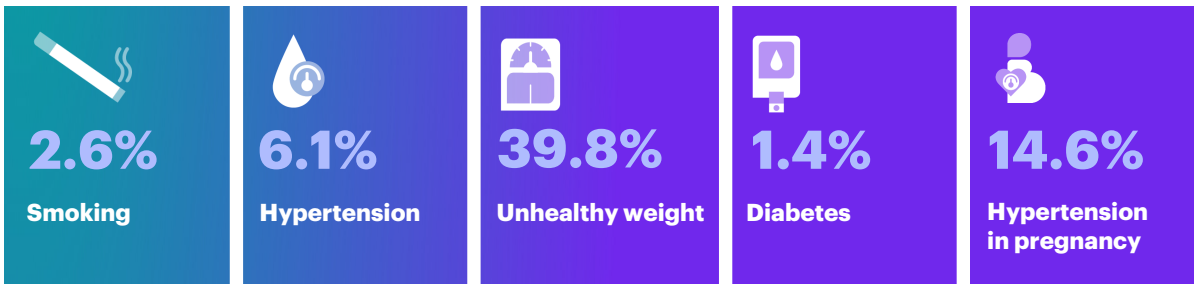
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 13.0%; Tricare: 10.1%; Indian Health Service: N/A; and all other types: 19.1%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Louisiana

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



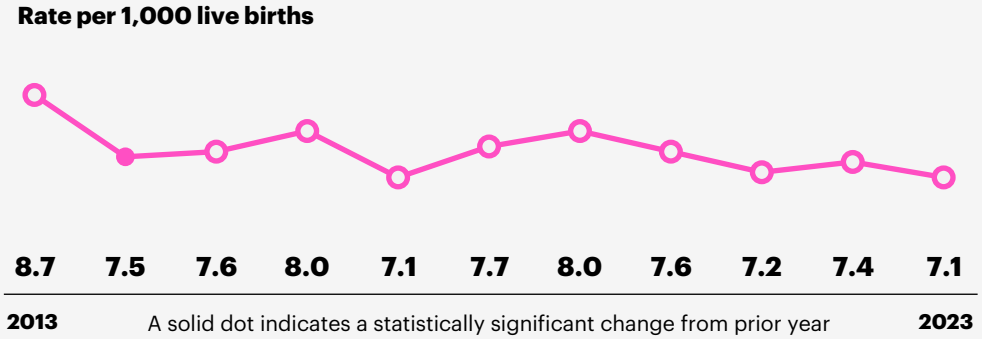
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 392 babies died before their first birthday

INFANT MORTALITY RATE **7.1**

US RATE **5.6**

LA RANK **46**

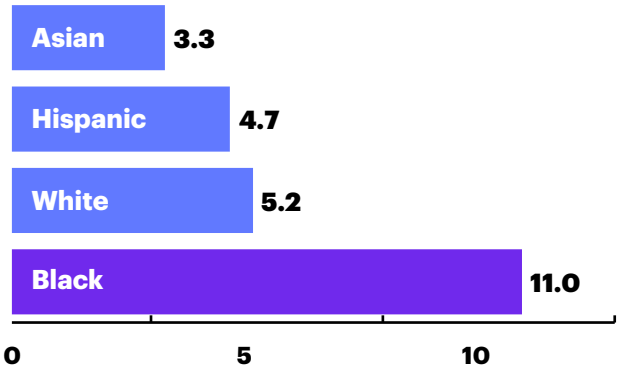


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.5x the state rate

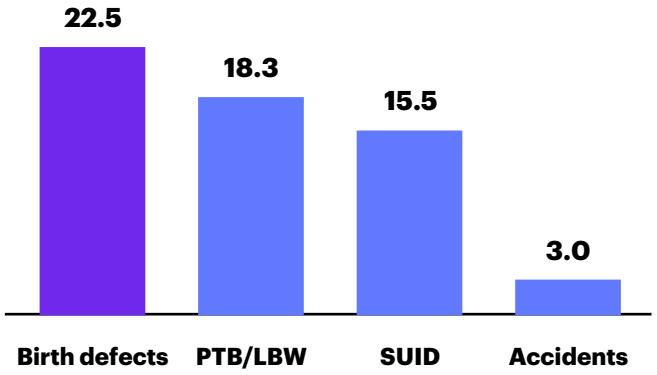
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.6% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Louisiana

The rate of inadequate prenatal care among babies born to Hispanic moms is 1.9x the state rate

19.3
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

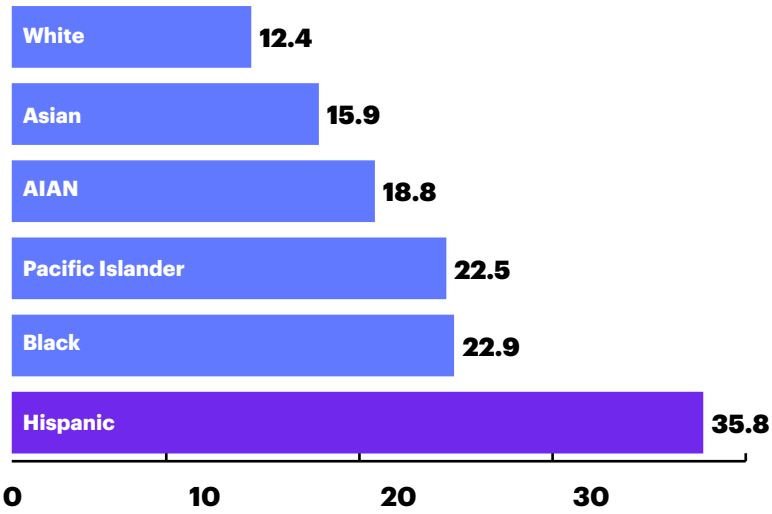
71.2
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Louisiana

28.9
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

79.5
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

40.7
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	14.0%	7.1	28.9%	73.8%	79.5	40.7
Rank	51st of 52	46th of 52	44th of 52	38th of 52	14th of 47	47th of 48
Direction†	Worsened†	Improved	Worsened	Worsened†	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Louisiana

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Louisiana

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Louisiana's Medicaid program, Healthy Louisiana, covered 32,999 births in 2024

61.9

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Maine

Scan for more data

1,125 babies were born preterm in Maine in 2024. Maine ranks 15th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.7%.

Maine is among the top ten best states with the highest rates of adequate prenatal care reception.

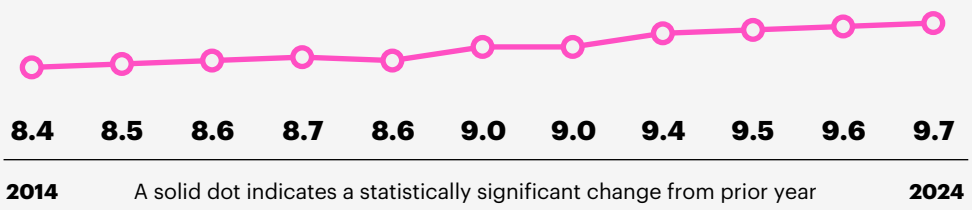
Maine is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Maine was 9.7% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	ME RATE	ME RANK
10.4	9.7	15

Percentage of live births born preterm



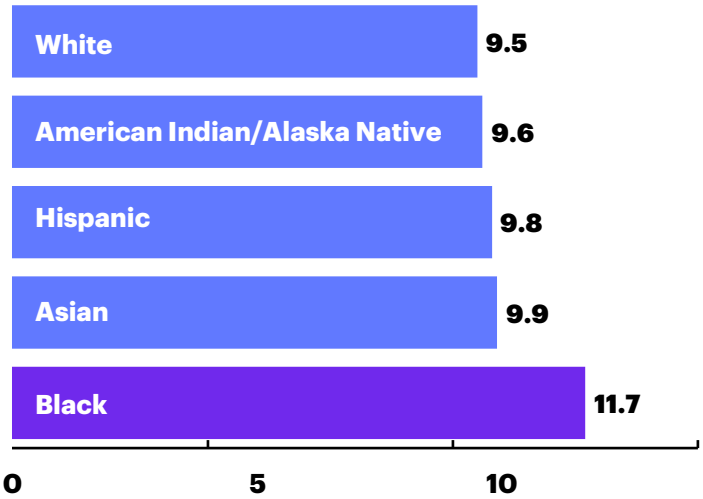
2014										2024
8.4	8.5	8.6	8.7	8.6	9.0	9.0	9.4	9.5	9.6	9.7

A solid dot indicates a statistically significant change from prior year

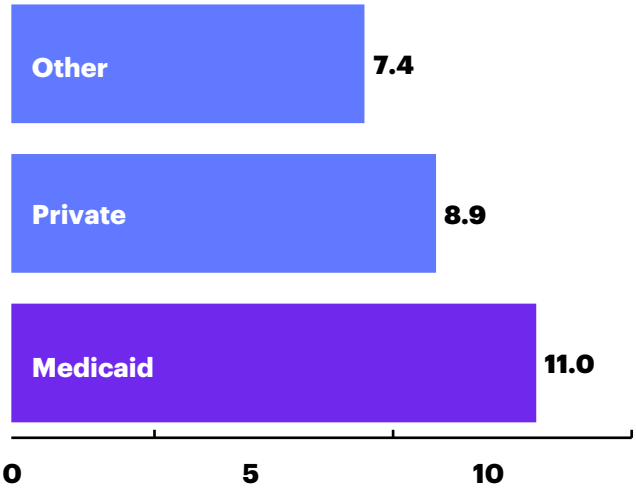
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



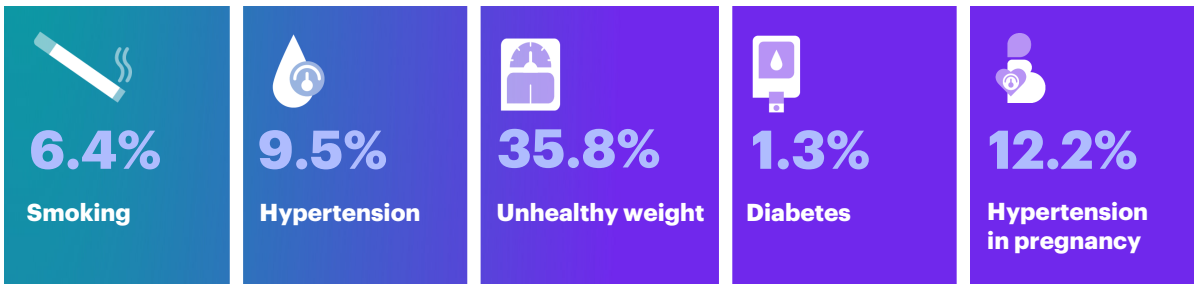
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 5.3%; Tricare: 9.7%; Indian Health Service: N/A; and all other types: 11.1%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Maine

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



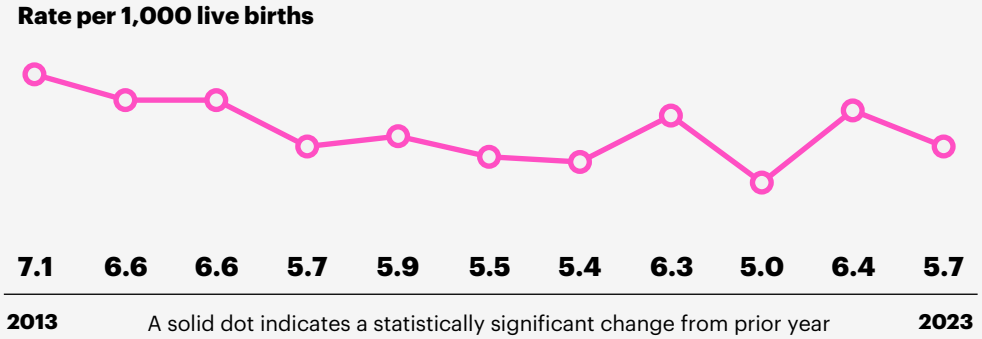
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 66 babies died before their first birthday

INFANT MORTALITY RATE **5.7**

US RATE **5.6**

ME RANK **26**

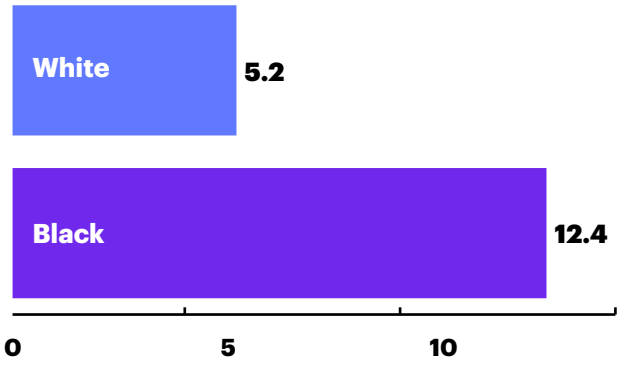


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 2.2x the state rate

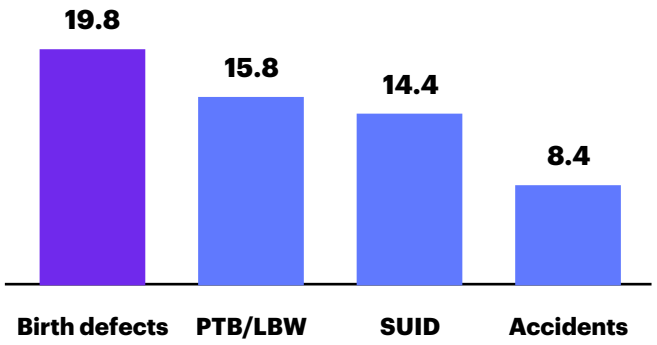
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 41.6% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Maine

The rate of inadequate prenatal care among babies born to Black moms is 3.2x the state rate

10.5
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

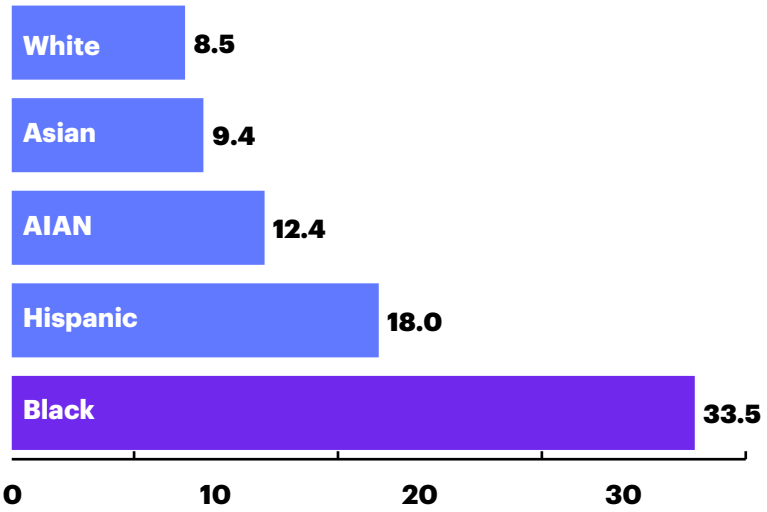
82.9
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Maine

24.6
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

81.2
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

N/A
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

The maternal mortality rate cannot be shown due to unreliable estimates and concerns with confidentiality.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.7%	5.7	24.6%	84.6%	81.2	N/A
Rank	15th of 52	26th of 52	19th of 52	6th of 52	17th of 47	N/A
Direction†	Worsened	Improved	Improved	Improved	Worsened	N/A
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Maine

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Maine

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Maine's Medicaid program, MaineCare, covered 4,604 births in 2024

39.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Maryland

Scan for more data

6,896 babies were born preterm in Maryland in 2024. Maryland ranks 28th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.5%.

Maryland has made significant improvement in adequate prenatal care reception since last year.

Maryland is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Maryland was 10.5% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **D+**

US RATE	MD RATE	MD RANK
10.4	10.5	28

Percentage of live births born preterm

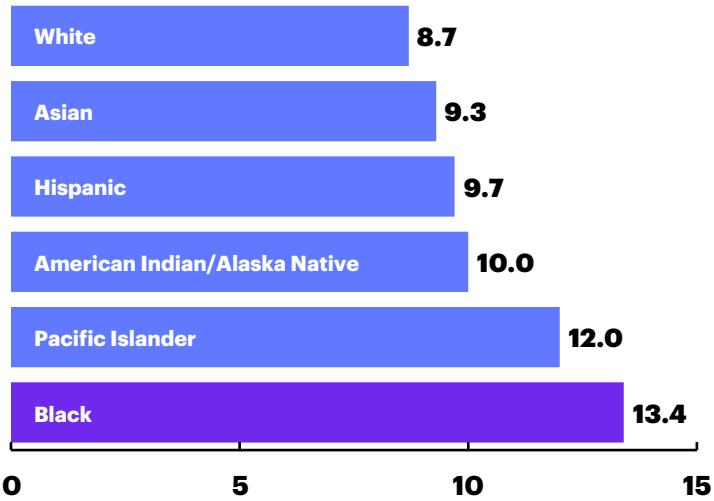
2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
10.1	10.0	10.1	10.5	10.2	10.3	10.1	10.7	10.3	10.2	10.5

A solid dot indicates a statistically significant change from prior year

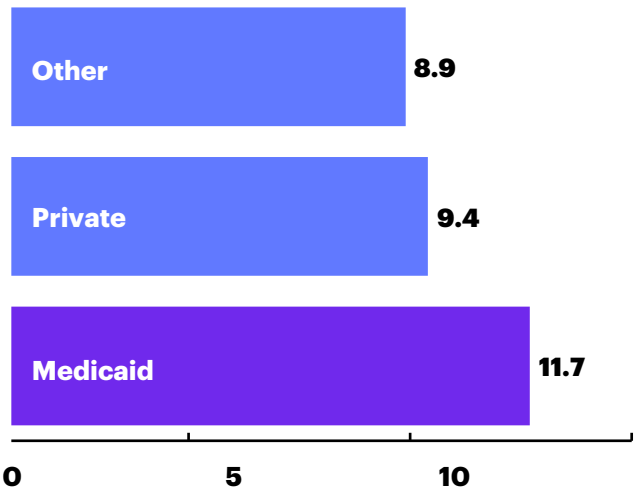
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



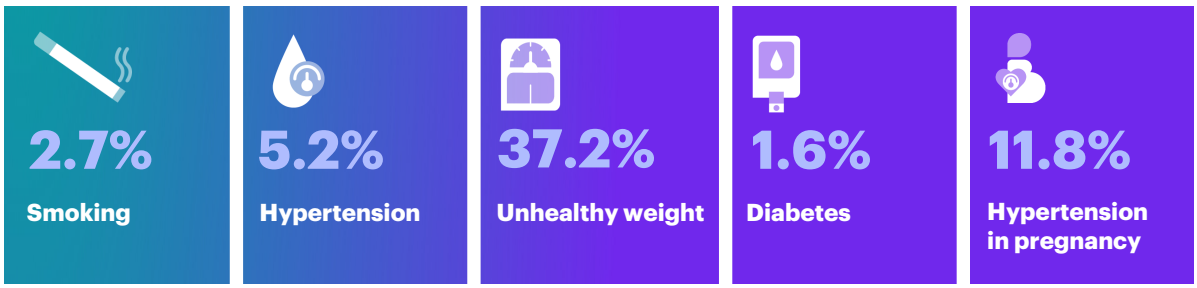
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 8.8%; Tricare: 8.2%; Indian Health Service: N/A; and all other types: 12.0%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Maryland

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



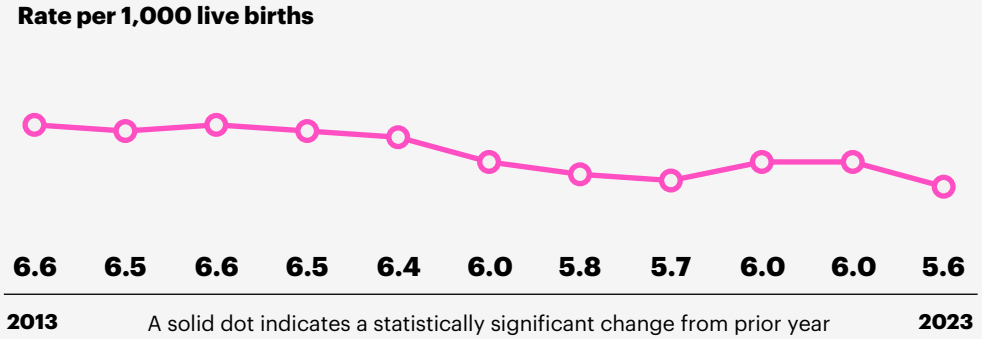
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 368 babies died before their first birthday

INFANT MORTALITY RATE **5.6**

US RATE **5.6**

MD RANK **24**

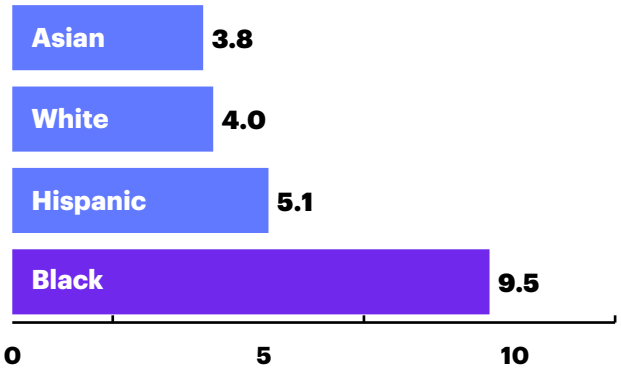


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.7x the state rate

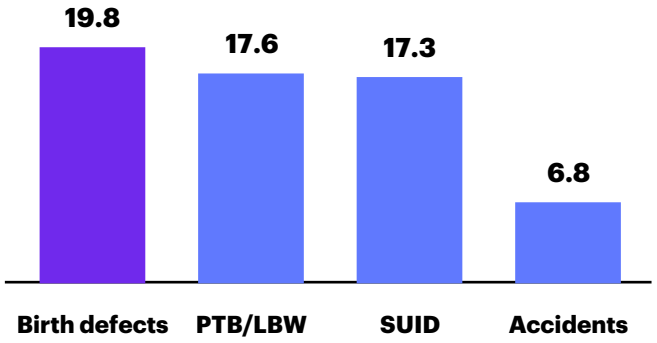
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 38.5% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Maryland

The rate of inadequate prenatal care among babies born to Hispanic moms is 1.8x the state rate

15.9
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

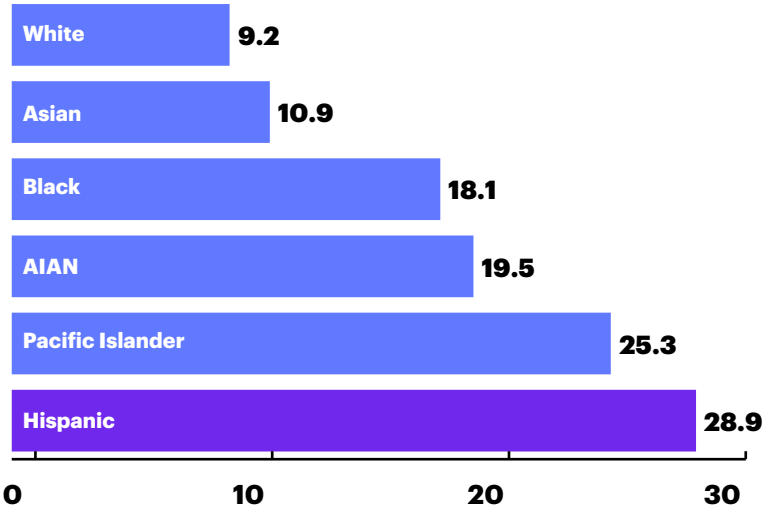
74.8
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Maryland

30.7
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

100.4
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

21.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.5%	5.6	30.7%	76.3%	100.4	21.4
Rank	28th of 52	24th of 52	50th of 52	33rd of 52	32nd of 47	18th of 48
Direction†	Worsened	Improved	Worsened	Improved†	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Maryland

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Maryland

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Maryland's Medicaid program, Maryland Medical Assistance Program, covered 28,719 births in 2024

43.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

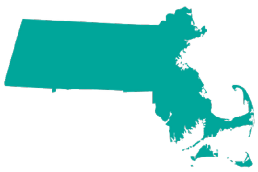
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Massachusetts

Scan for more data



6,048 babies were born preterm in Massachusetts in 2024. Massachusetts ranks 3rd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 8.9%.

Massachusetts is among the top ten best states with the lowest rates of infant mortality and maternal mortality.

Massachusetts is currently implementing six of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Massachusetts was 8.9% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **B**

US RATE	MA RATE	MA RANK
10.4	8.9	3

Percentage of live births born preterm

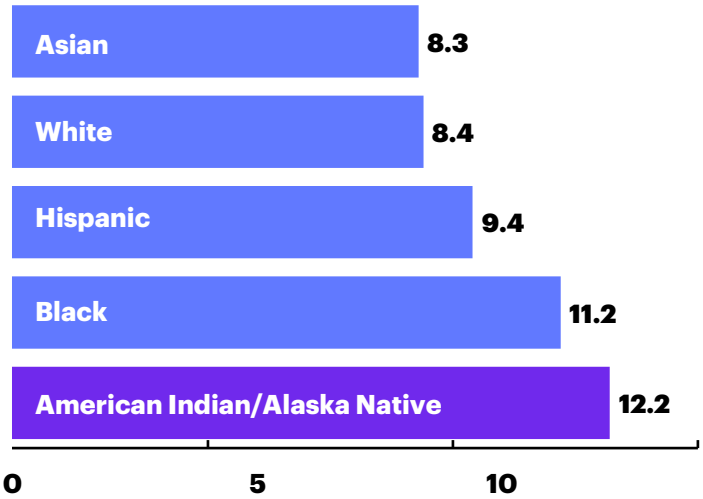
2014										2024
8.6	8.4	8.7	8.9	8.9	9.0	8.8	9.0	9.1	9.1	8.9

A solid dot indicates a statistically significant change from prior year

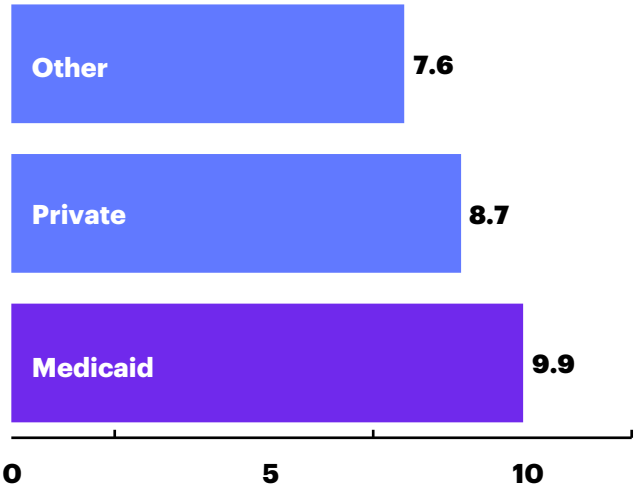
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



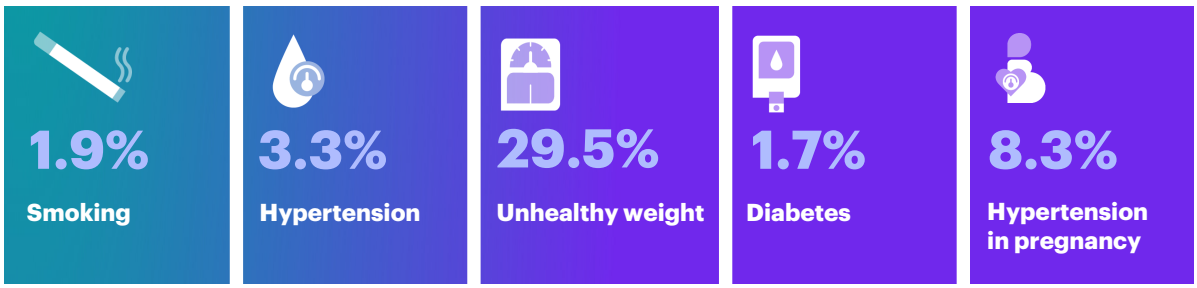
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 7.7%; Tricare: 6.6%; Indian Health Service: N/A; and all other types: 7.7%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Massachusetts

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



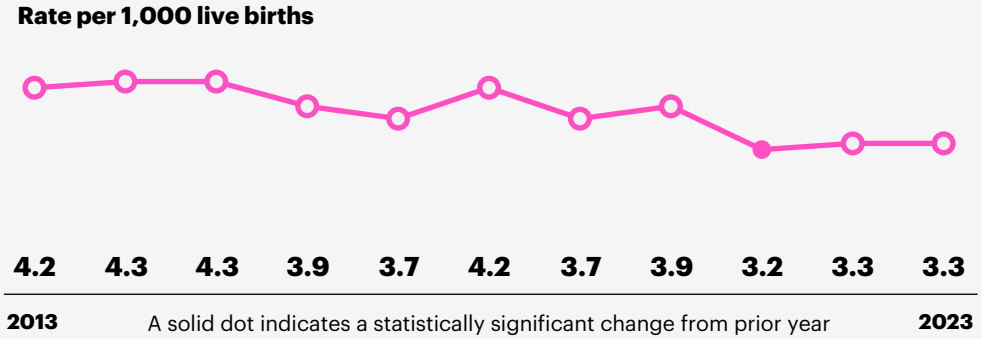
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 220 babies died before their first birthday

INFANT MORTALITY RATE **3.3**

US RATE **5.6**

MA RANK **3**

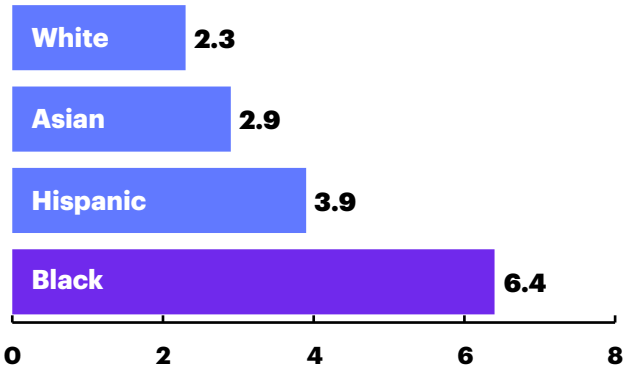


Note: The change in 2023 was not a statistically significant increase or decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 2.0x the state rate

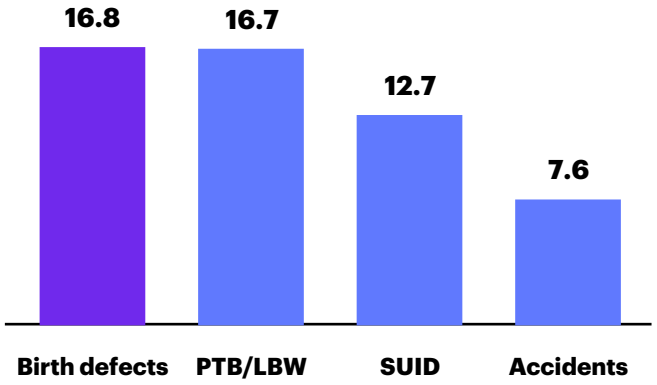
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 46.2% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Massachusetts

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.4x the state rate

11.9
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

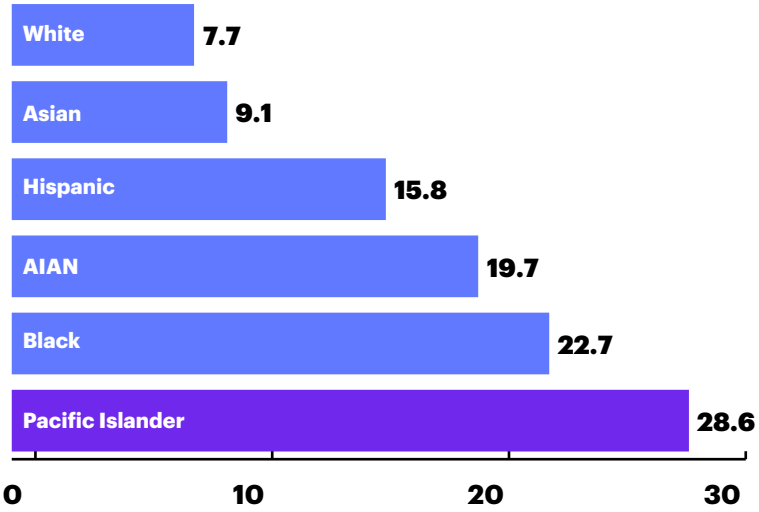
80.8
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Massachusetts

28.4
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

108.3
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

14.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	8.9%	3.3	28.4%	81.7%	108.3	14.4
Rank	3rd of 52	3rd of 52	42nd of 52	12th of 52	37th of 47	3rd of 48
Direction†	Improved	No change	Worsened†	Improved	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Massachusetts

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Massachusetts

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Massachusetts' Medicaid program, MassHealth, covered 21,597 births in 2024

31.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Michigan

Scan for more data

10,619 babies were born preterm in Michigan in 2024. Michigan ranks 32nd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.7%.

Michigan has made significant improvement in low-risk Cesarean births since last year.

Michigan is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Michigan was 10.7% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **D+**

US RATE	MI RATE	MI RANK
10.4	10.7	32

Percentage of live births born preterm

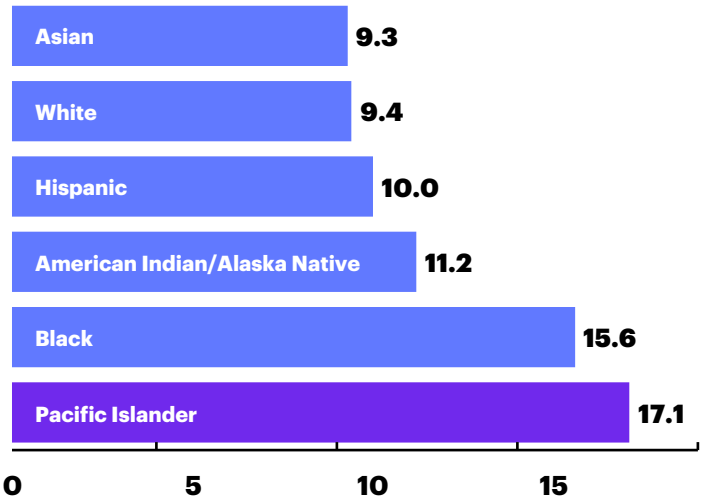
2014										2024
9.8	9.9	10.1	10.2	10.0	10.3	10.2	10.6	10.4	10.3	10.7

A solid dot indicates a statistically significant change from prior year

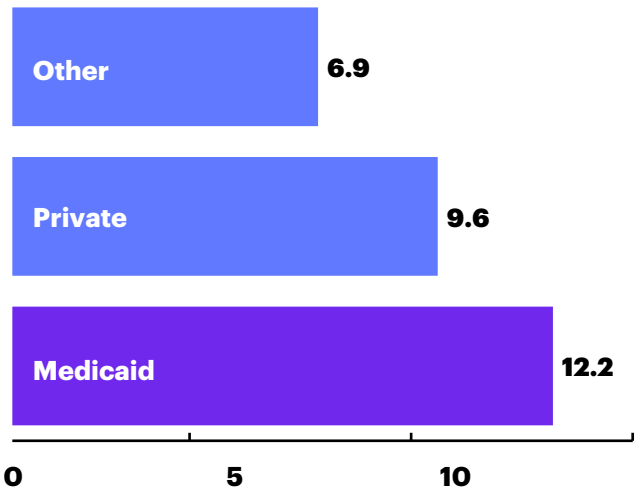
Note: The change in 2024 was a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



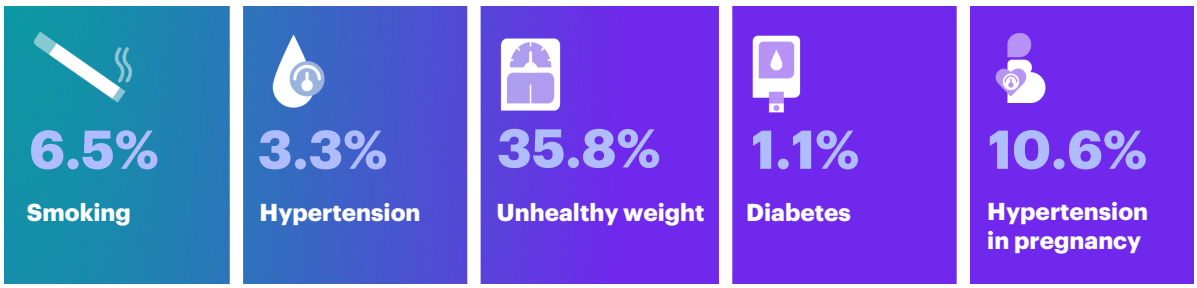
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 4.9%; Tricare: N/A; Indian Health Service: N/A; and all other types: 11.0%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Michigan

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



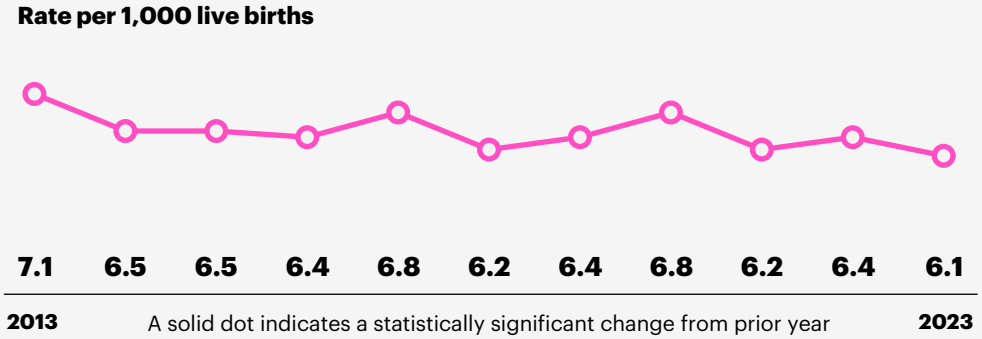
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 604 babies died before their first birthday

INFANT MORTALITY RATE **6.1**

US RATE **5.6**

MI RANK **33**

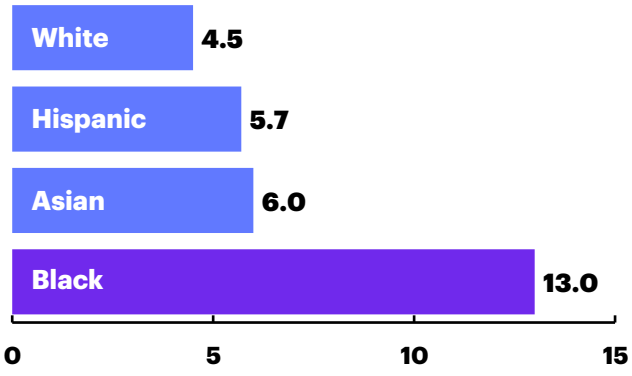


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 2.1x the state rate

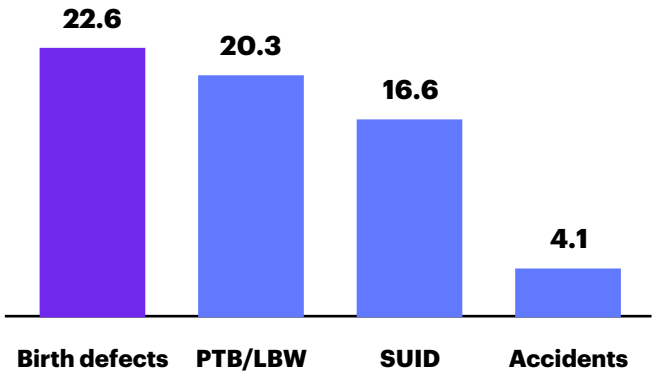
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 36.4% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Michigan

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.2x the state rate

14.7
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

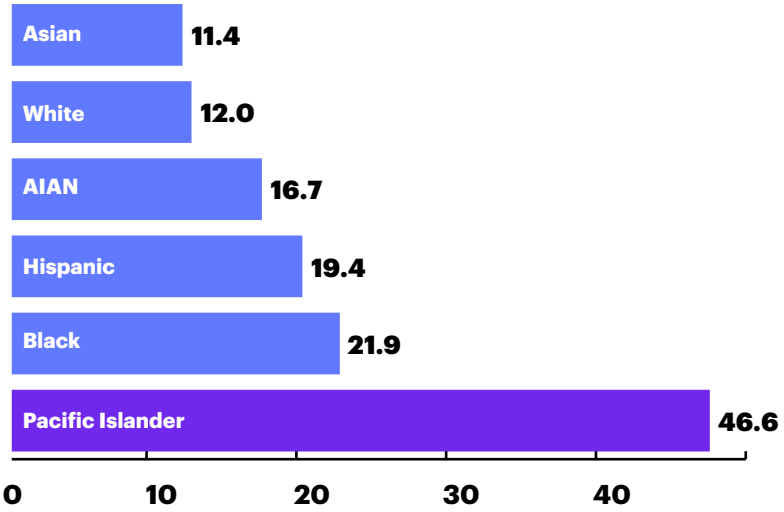
77.9
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Michigan

27.4
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

94.1
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

18.7
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.7%	6.1	27.4%	77.3%	94.1	18.7
Rank	32nd of 52	33rd of 52	35th of 52	28th of 52	28th of 47	12th of 48
Direction†	Worsened†	Improved	Improved†	Worsened	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Michigan

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Michigan

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Michigan's Medicaid program, Michigan Medicaid, covered 36,360 births in 2024

36.9

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

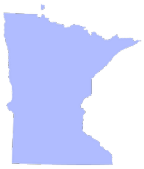
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Minnesota

Scan for more data



6,039 babies were born preterm in Minnesota in 2024. Minnesota ranks 15th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.7%.

Minnesota has made significant improvement in adequate prenatal care reception since last year.

Minnesota is currently implementing four of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Minnesota was 9.7% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE C

US RATE	MN RATE	MN RANK
10.4	9.7	15

Percentage of live births born preterm

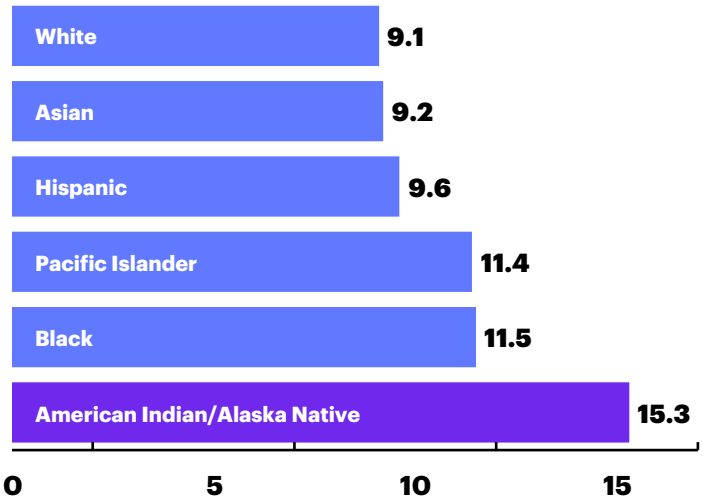
2014										2024
8.7	8.5	8.8	8.9	8.9	9.3	9.1	9.6	9.6	9.4	9.7

A solid dot indicates a statistically significant change from prior year

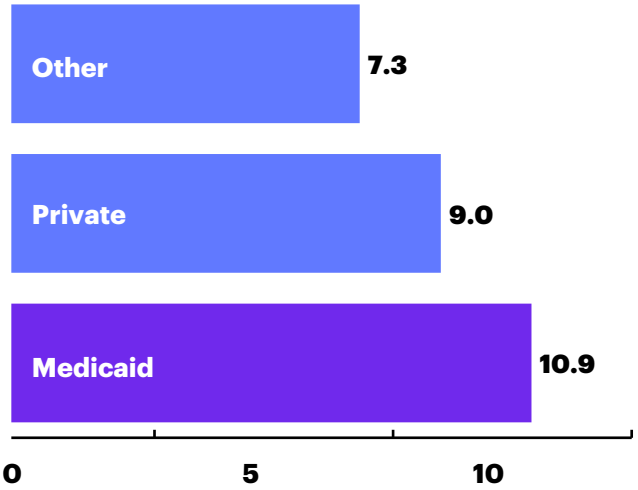
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



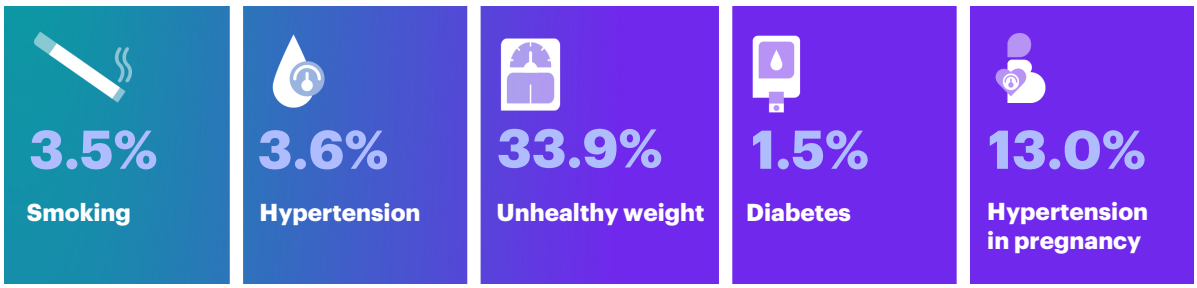
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 5.9%; Tricare: 9.6%; Indian Health Service: N/A; and all other types: 10.0%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Minnesota

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



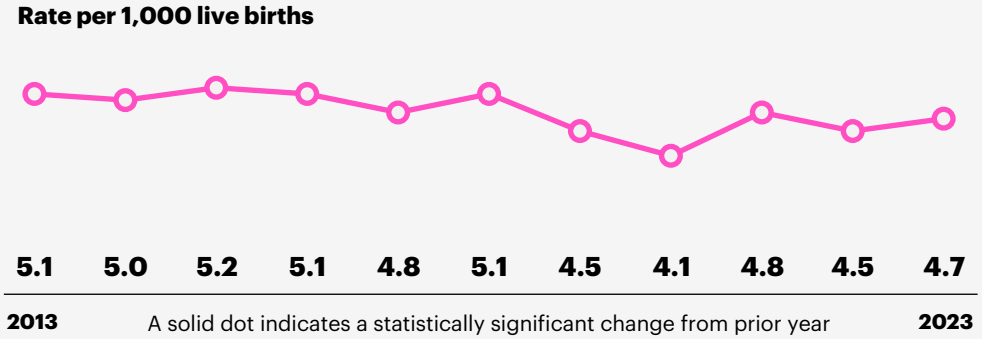
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 292 babies died before their first birthday

INFANT MORTALITY RATE **4.7**

US RATE **5.6**

MN RANK **13**

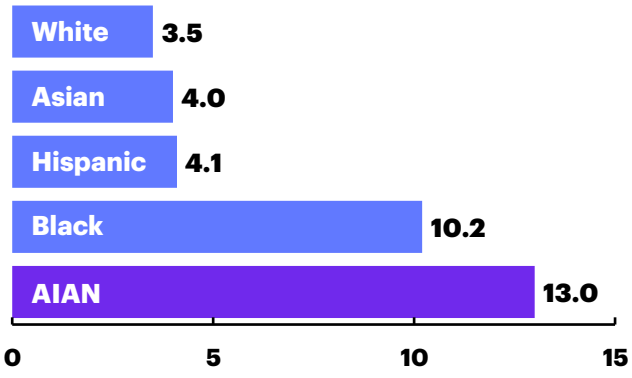


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to American Indian/Alaska Native moms is 2.7x the state rate

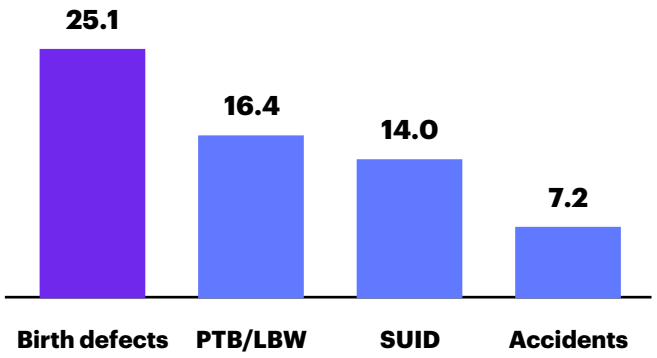
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 37.3% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Minnesota

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 4.4x the state rate

10.4 PERCENT — 16.1

INADEQUATE PRENATAL CARE

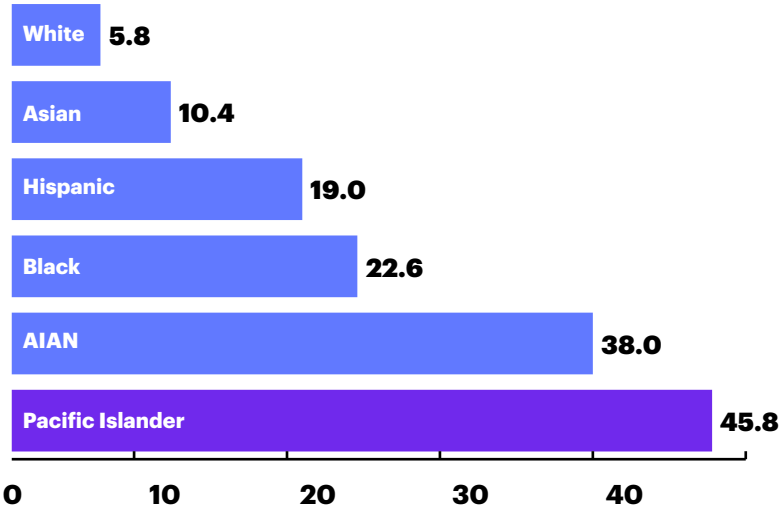
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

82.7 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Minnesota

26.8 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

114.6 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

14.1 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.7%	4.7	26.8%	81.0%	114.6	14.1
Rank	15th of 52	13th of 52	34th of 52	13th of 52	42nd of 47	2nd of 48
Direction†	Worsened	Worsened	Worsened	Improved†	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Minnesota

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Minnesota

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Minnesota's Medicaid program, Minnesota Medical Assistance (MA), covered 20,944 births in 2024

33.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Mississippi

Scan for more data

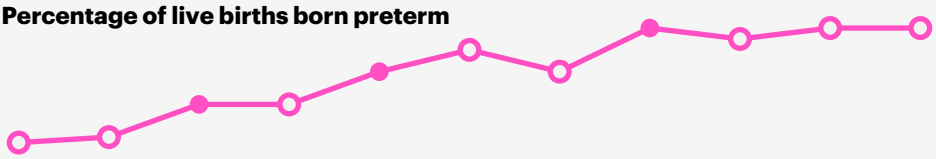
5,017 babies were born preterm in Mississippi in 2024. Mississippi ranks 52nd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 15.0%.

Mississippi is among the top ten best states with the lowest rates of severe maternal morbidity.

Mississippi is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Mississippi was 15.0% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **F**



US RATE	MS RATE	MS RANK
10.4	15.0	52

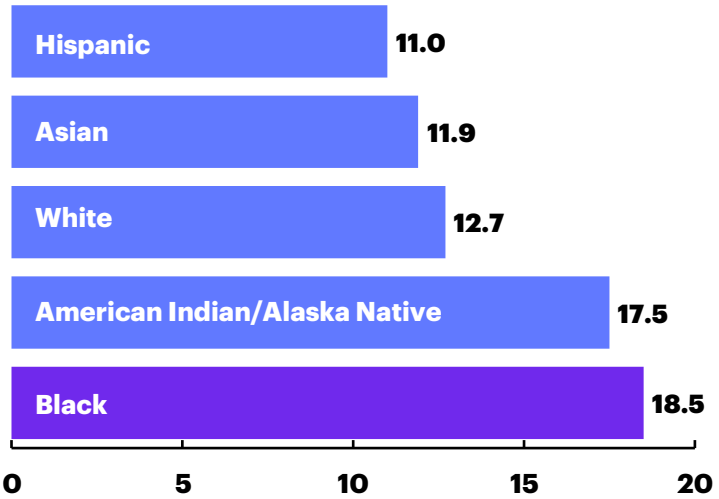
2014										2024
12.9	13.0	13.6	13.6	14.2	14.6	14.2	15.0	14.8	15.0	15.0

A solid dot indicates a statistically significant change from prior year

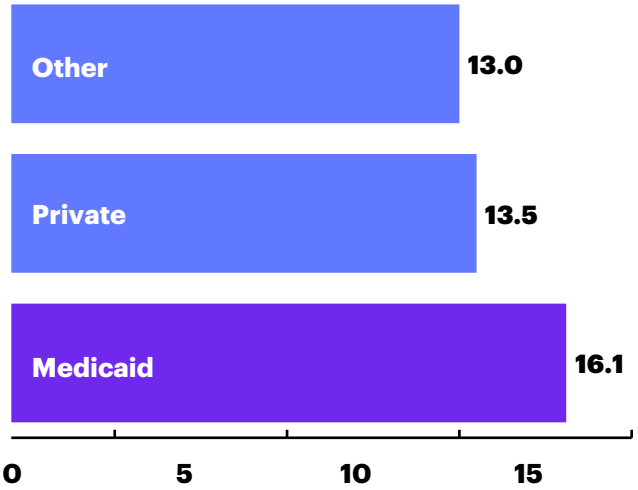
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



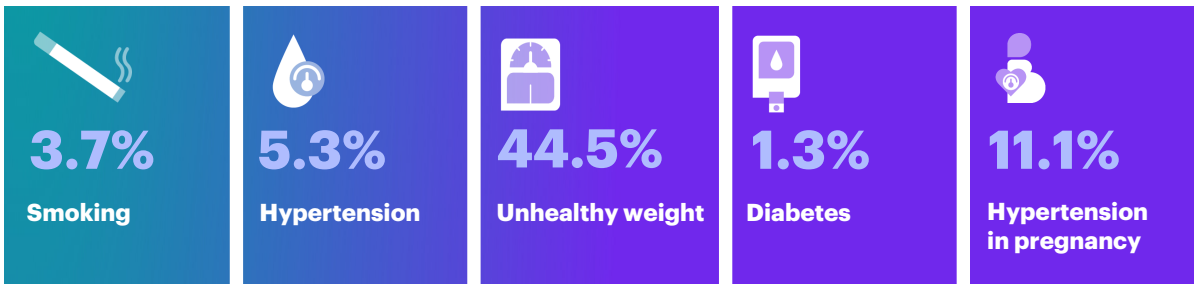
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 12.9%; Tricare: 17.7%; Indian Health Service: N/A; and all other types: 12.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Mississippi

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



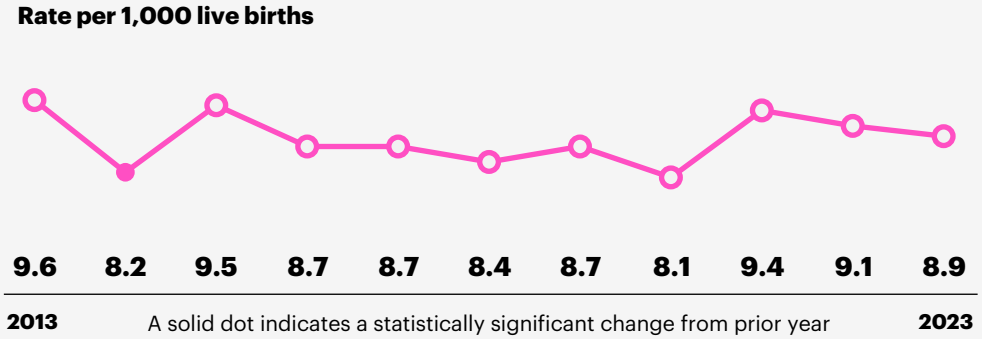
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 308 babies died before their first birthday

INFANT MORTALITY RATE **8.9**

US RATE **5.6**

MS RANK **52**

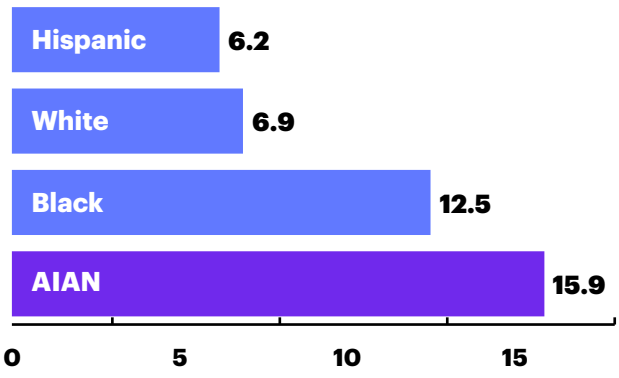


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to American Indian/Alaska Native moms is 1.8x the state rate

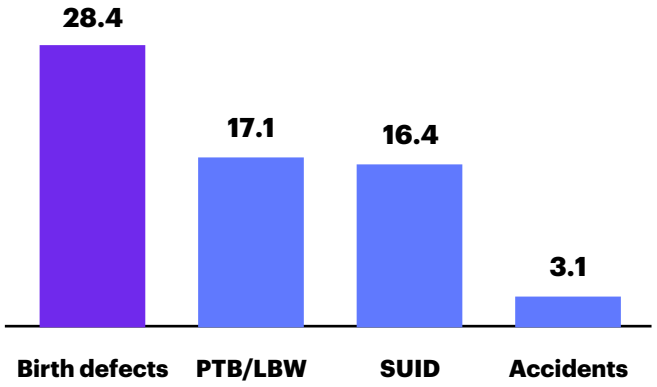
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 35.0% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Mississippi

The rate of inadequate prenatal care among babies born to American Indian/Alaska Native moms is 2.5x the state rate

14.7
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

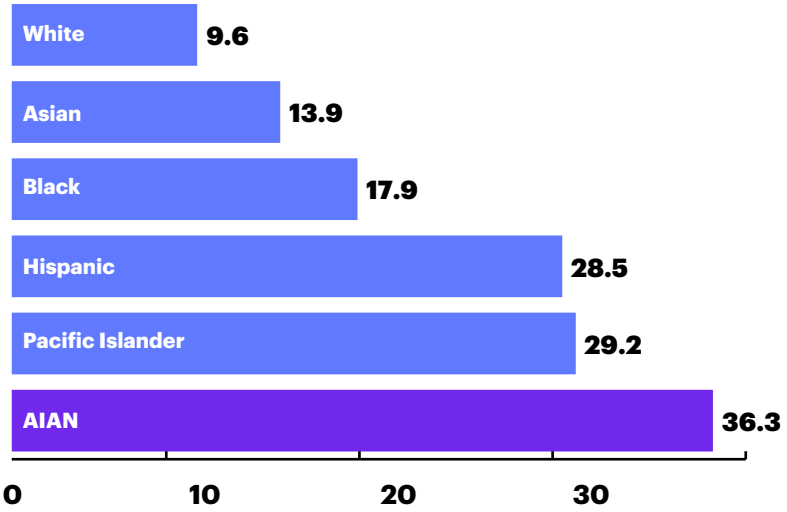
76.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Mississippi

29.7
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

68.0
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

39.7
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	15.0%	8.9	29.7%	79.3%	68.0	39.7
Rank	52nd of 52	52nd of 52	47th of 52	17th of 52	7th of 47	46th of 48
Direction†	No change	Improved	Improved	Worsened†	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Mississippi

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Mississippi

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Mississippi's Medicaid program, Mississippi Medicaid, covered 17,890 births in 2024

53.5

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Missouri

Scan for more data

7,441 babies were born preterm in Missouri in 2024. Missouri ranks 37th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.0%.

Missouri has made significant improvement in adequate prenatal care reception since last year.

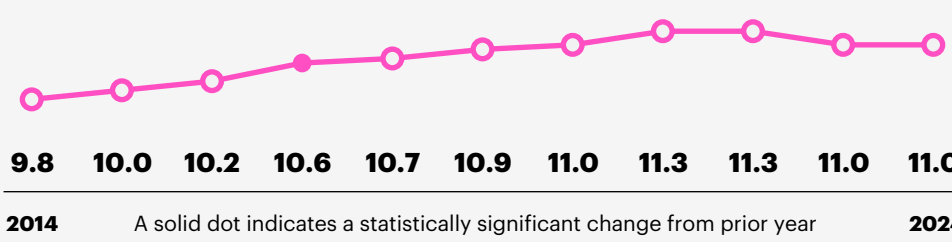
Missouri is currently implementing four of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Missouri was 11.0% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **D**

US RATE	MO RATE	MO RANK
10.4	11.0	37

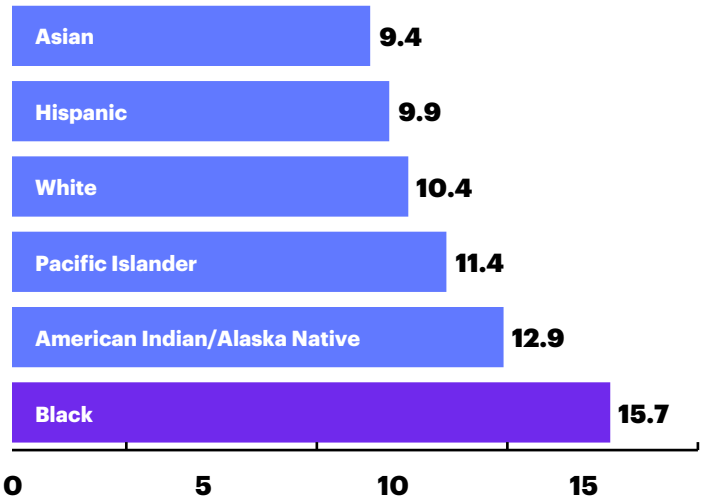
Percentage of live births born preterm



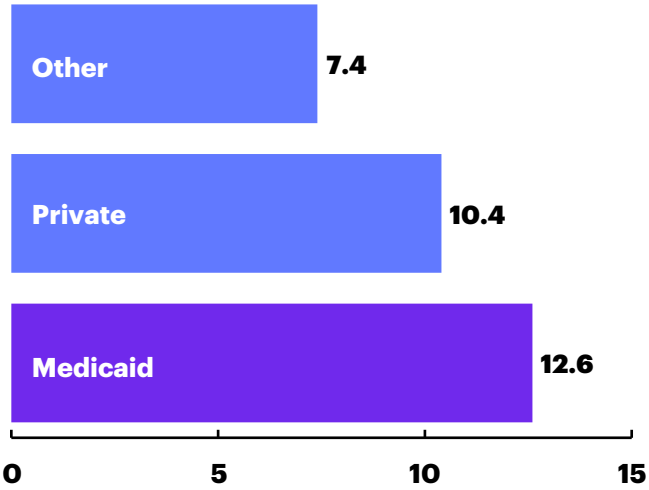
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



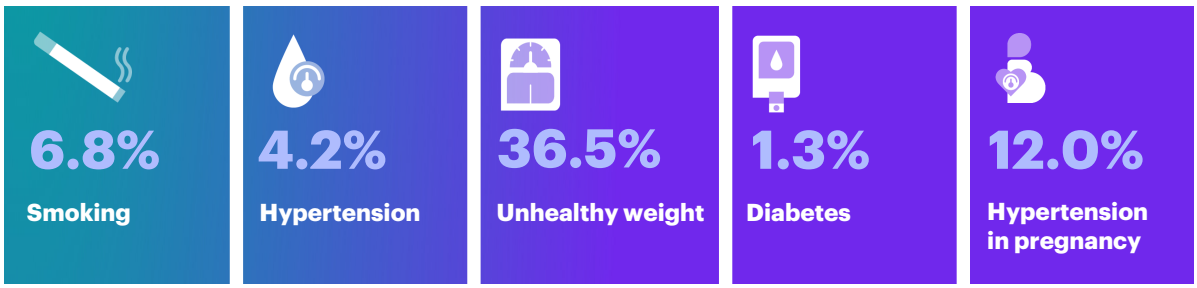
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.6%; Tricare: 19.0%; Indian Health Service: N/A; and all other types: 9.1%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Missouri

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



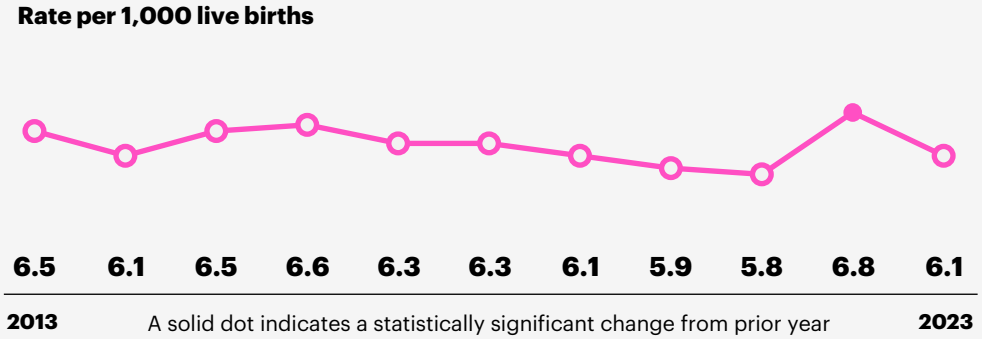
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 411 babies died before their first birthday

INFANT MORTALITY RATE **6.1**

US RATE **5.6**

MO RANK **33**

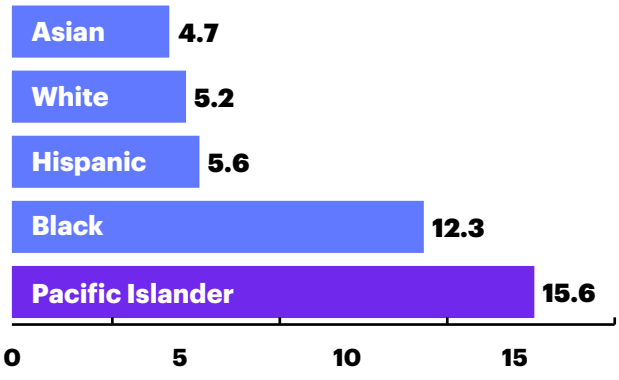


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Pacific Islander moms is 2.5x the state rate

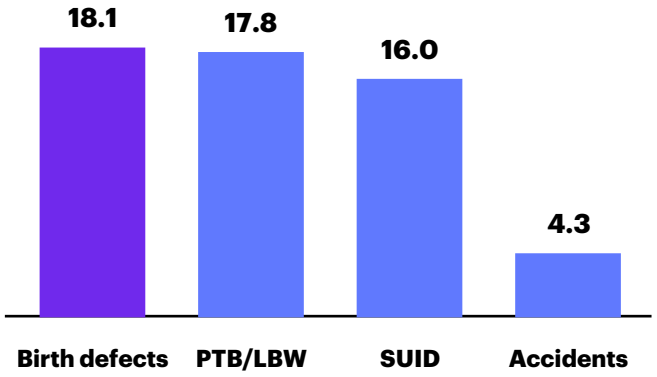
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 43.9% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Missouri

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 4.3x the state rate

15.2
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

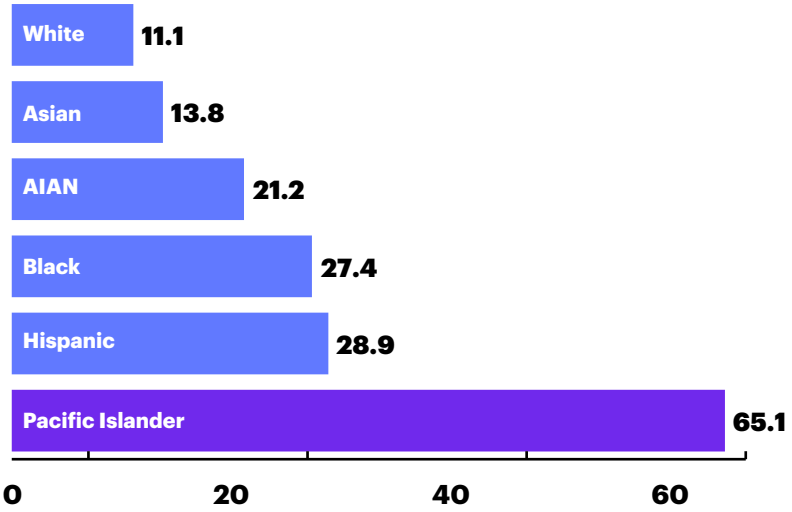
75.6
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Missouri

24.5
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

98.9
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

25.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.0%	6.1	24.5%	78.7%	98.9	25.4
Rank	37th of 52	33rd of 52	17th of 52	24th of 52	29th of 47	29th of 48
Direction†	No change	Improved	Worsened	Improved†	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Missouri

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Missouri

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Missouri's Medicaid program, MO HealthNet, covered 26,061 births in 2024

38.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

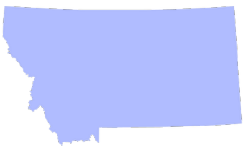
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Montana

Scan for more data



1,066 babies were born preterm in Montana in 2024. Montana ranks 10th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.4%.

Montana is among the top ten best states with the lowest rates of low-risk Cesarean births.

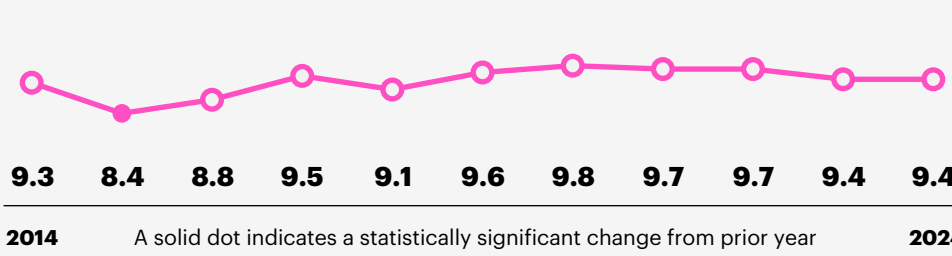
Montana is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Montana was 9.4% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **C+**

US RATE	MT RATE	MT RANK
10.4	9.4	10

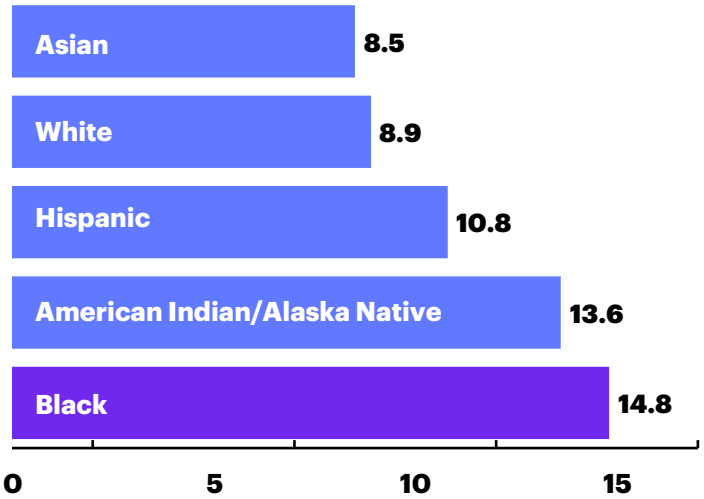
Percentage of live births born preterm



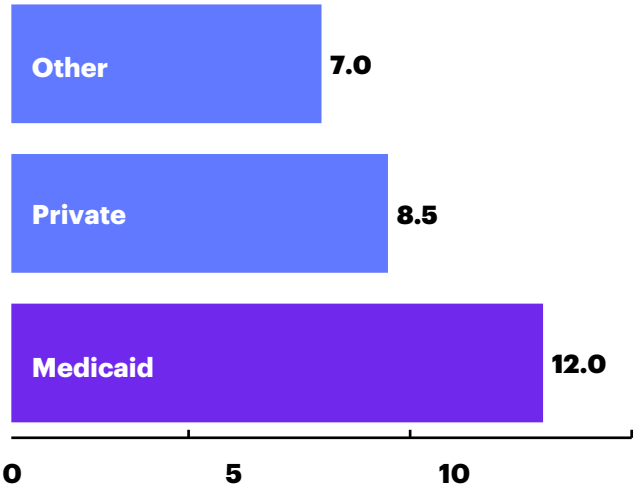
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



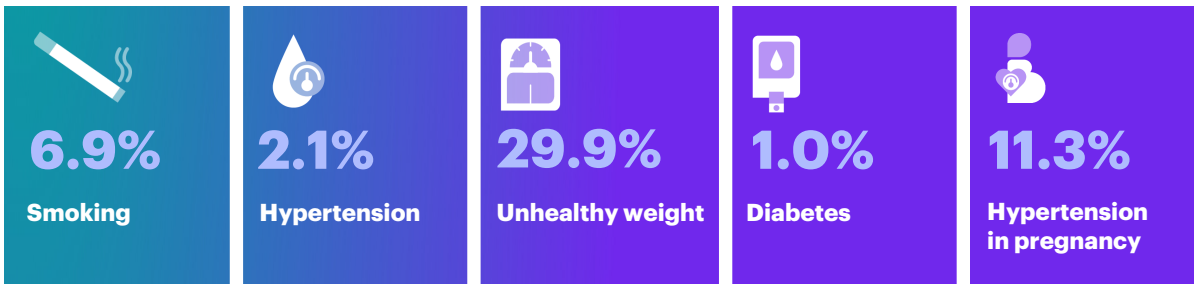
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.0%; Tricare: 7.3%; Indian Health Service: 11.5%; and all other types: 8.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Montana

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



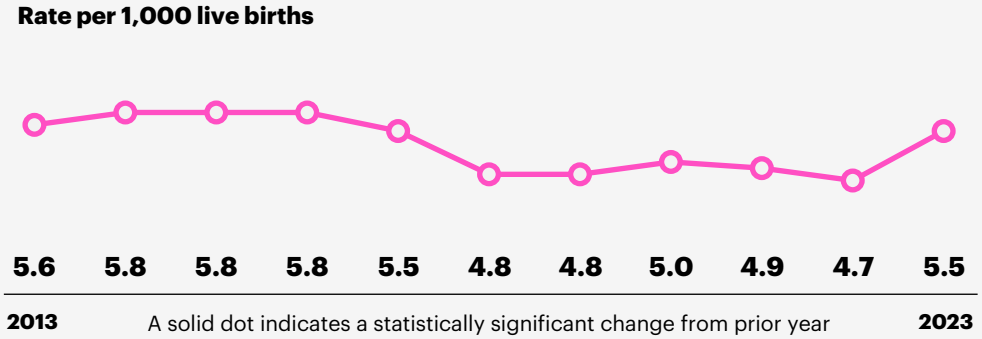
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 61 babies died before their first birthday

INFANT MORTALITY RATE **5.5**

US RATE **5.6**

MT RANK **21**

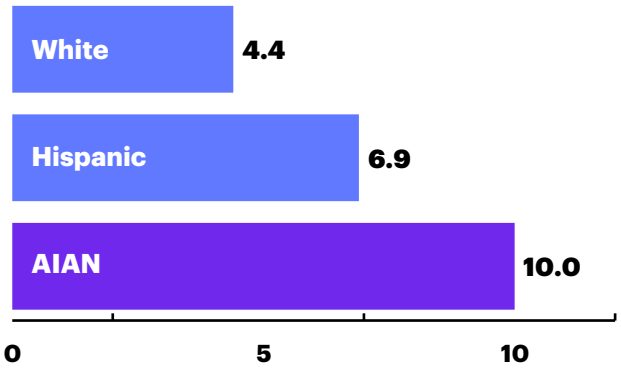


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to American Indian/Alaska Native moms is 1.8x the state rate

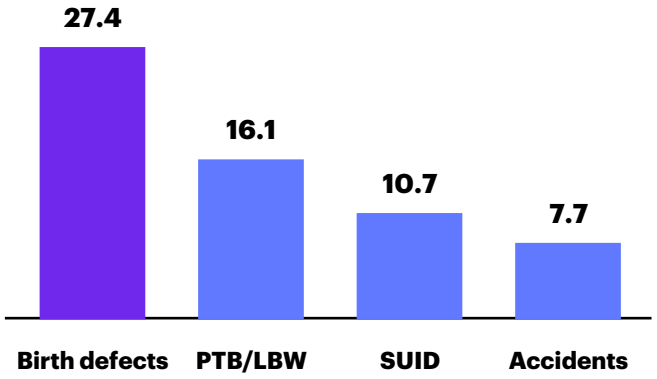
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 38.1% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Montana

The rate of inadequate prenatal care among babies born to American Indian/Alaska Native moms is 3.1x the state rate

13.8
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

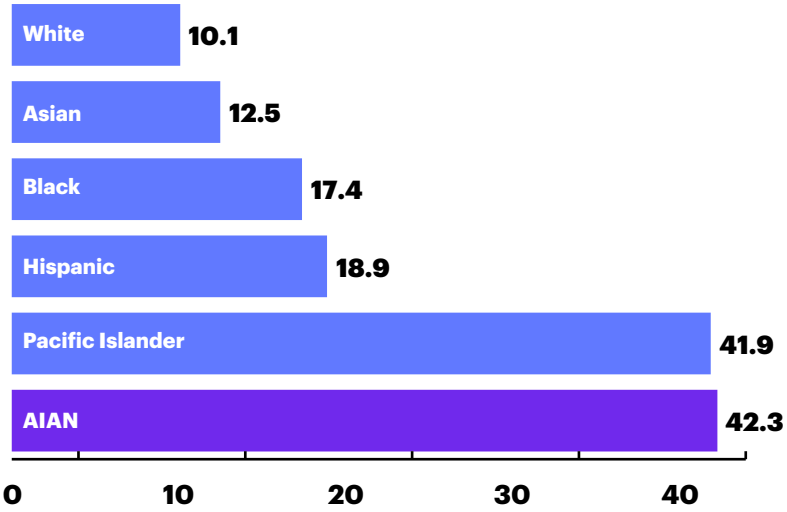
79.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Montana

21.1
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

73.5
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

32.5
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.4%	5.5	21.1%	78.1%	73.5	32.5
Rank	10th of 52	21st of 52	8th of 52	26th of 52	11th of 47	41st of 48
Direction†	No change	Worsened	Improved	Worsened	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Montana

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Montana

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Montana's Medicaid program, Montana Medicaid / HELP Plan, covered 3,478 births in 2024

30.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Nebraska

Scan for more data

2,741 babies were born preterm in Nebraska in 2024. Nebraska ranks 40th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.1%.

Nebraska is among the top ten best states with the lowest rates of severe maternal morbidity.

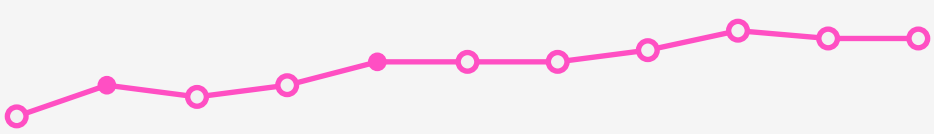
Nebraska is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Nebraska was 11.1% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **D**

US RATE	NE RATE	NE RANK
10.4	11.1	40

Percentage of live births born preterm



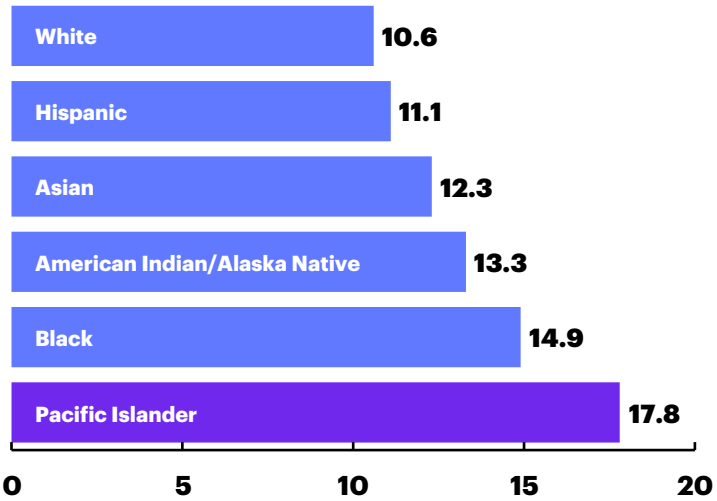
2014										2024
9.1	9.9	9.6	9.9	10.5	10.5	10.5	10.8	11.3	11.1	11.1

A solid dot indicates a statistically significant change from prior year

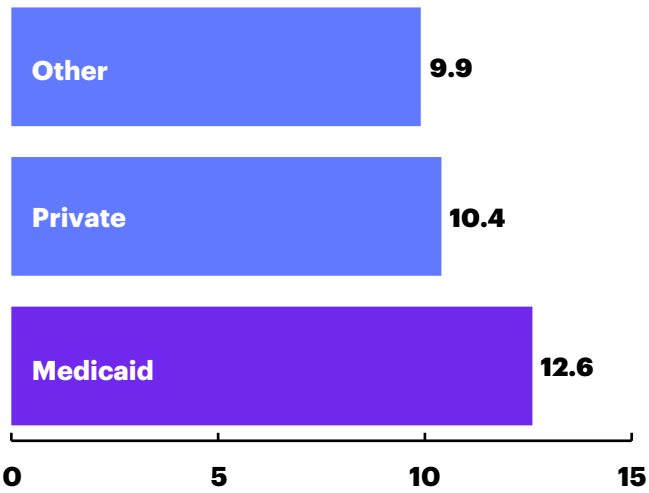
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



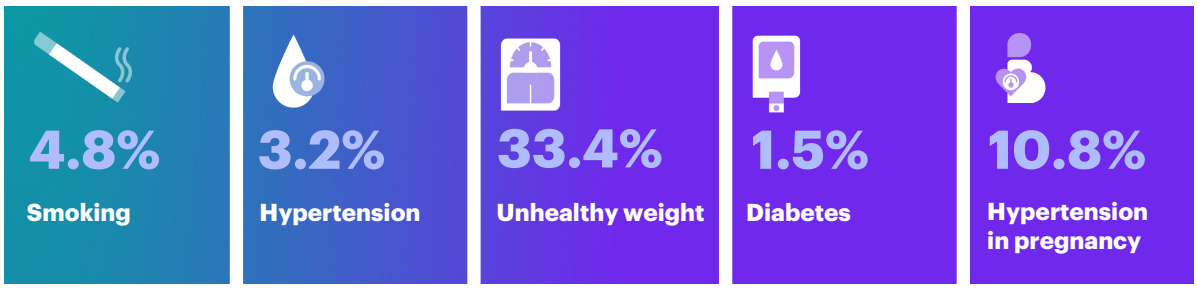
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 9.3%; Tricare: 10.1%; Indian Health Service: N/A; and all other types: 11.9%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Nebraska

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



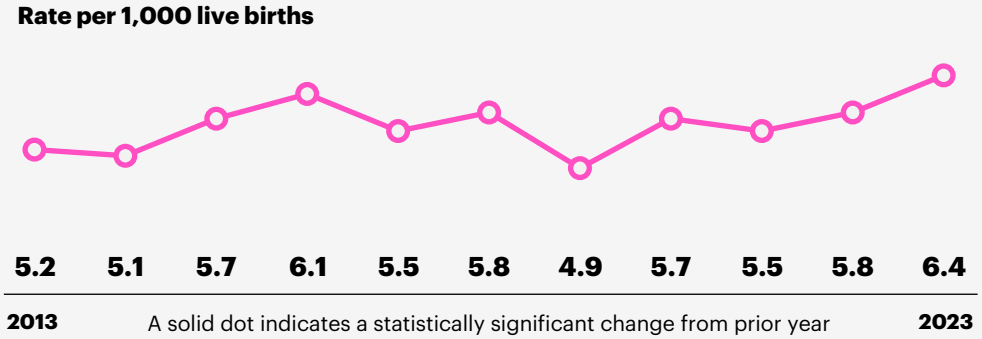
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 154 babies died before their first birthday

INFANT MORTALITY RATE **6.4**

US RATE **5.6**

NE RANK **37**

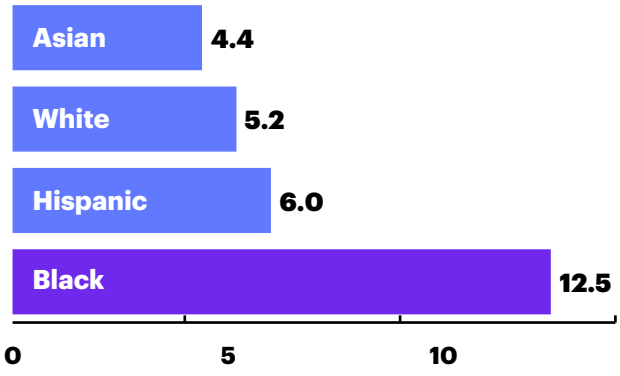


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 2.0x the state rate

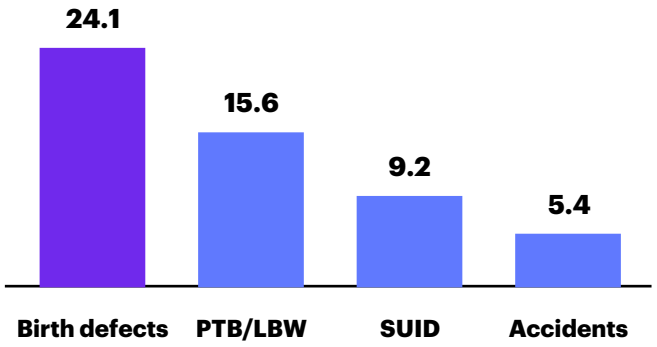
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 45.6% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Nebraska

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.4x the state rate

13.6
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

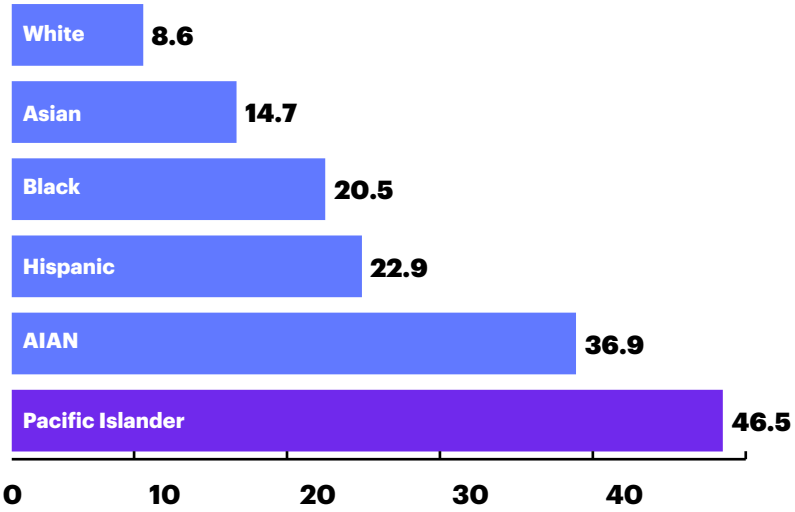
79.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Nebraska

24.5
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

64.4
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

23.7
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.1%	6.4	24.5%	78.9%	64.4	23.7
Rank	40th of 52	37th of 52	17th of 52	21st of 52	4th of 47	24th of 48
Direction†	No change	Worsened	Worsened†	Worsened†	Worsened	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Nebraska

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Nebraska

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Nebraska's Medicaid program, Hertitage Health, covered 9,366 births in 2024

38.0

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Nevada

Scan for more data

3,552 babies were born preterm in Nevada in 2024. Nevada ranks 37th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.0%.

Nevada is among the top twenty states with the lowest rates of maternal mortality.

Nevada is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Nevada was 11.0% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **D**

US RATE	NV RATE	NV RANK
10.4	11.0	37

Percentage of live births born preterm

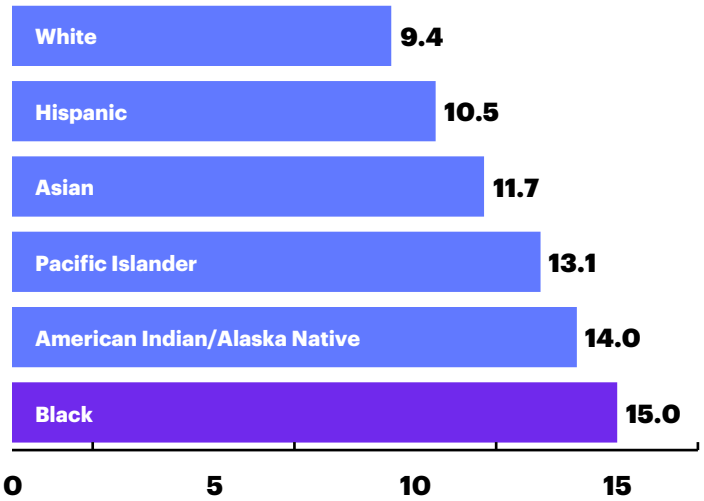
2014										2024
10.1	9.9	10.4	10.7	10.1	10.7	10.7	11.2	10.9	11.1	11.0

A solid dot indicates a statistically significant change from prior year

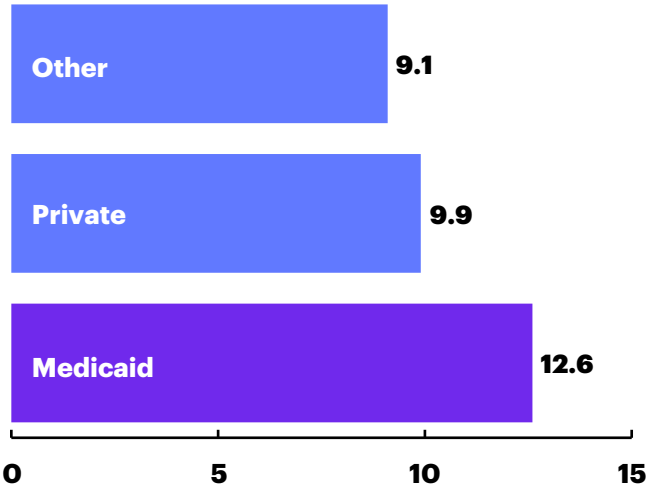
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



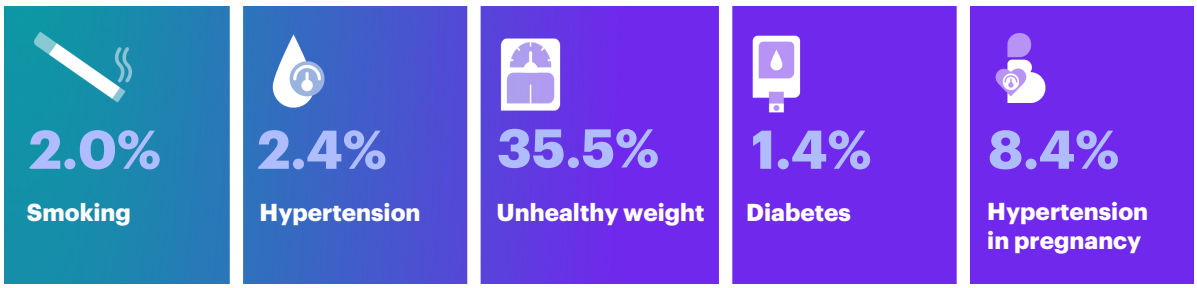
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 7.5%; Tricare: 7.0%; Indian Health Service: N/A; and all other types: 12.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Nevada

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



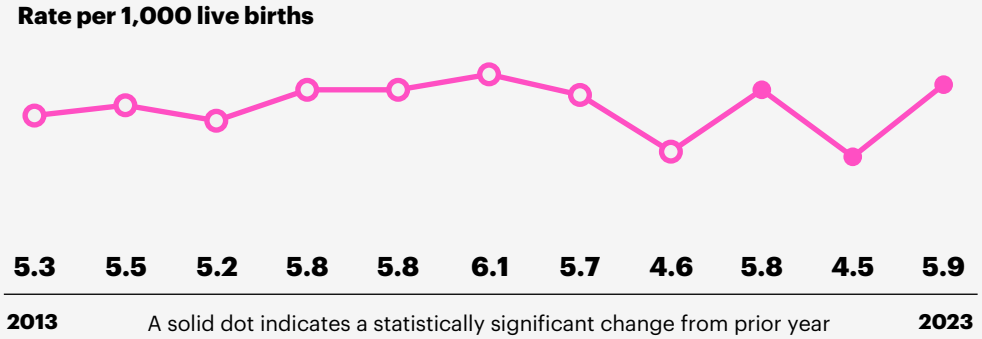
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 187 babies died before their first birthday

INFANT MORTALITY RATE **5.9**

US RATE **5.6**

NV RANK **30**

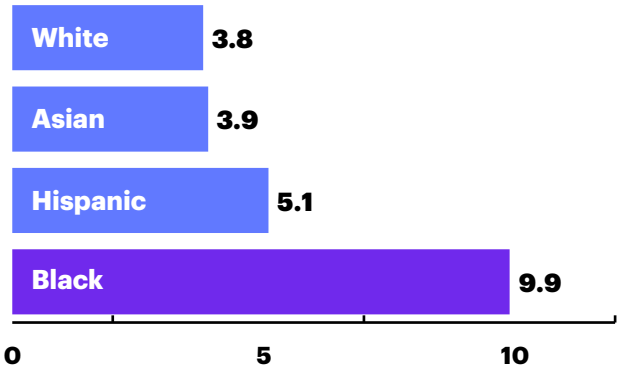


Note: The change in 2023 was a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.7x the state rate

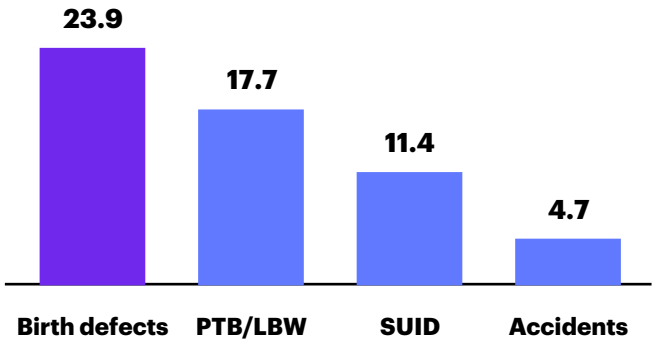
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 42.3% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Nevada

The rate of inadequate prenatal care among babies born to American Indian/Alaska Native moms is 1.9x the state rate

16.5
PERCENT
16.1

INADEQUATE PRENATAL CARE

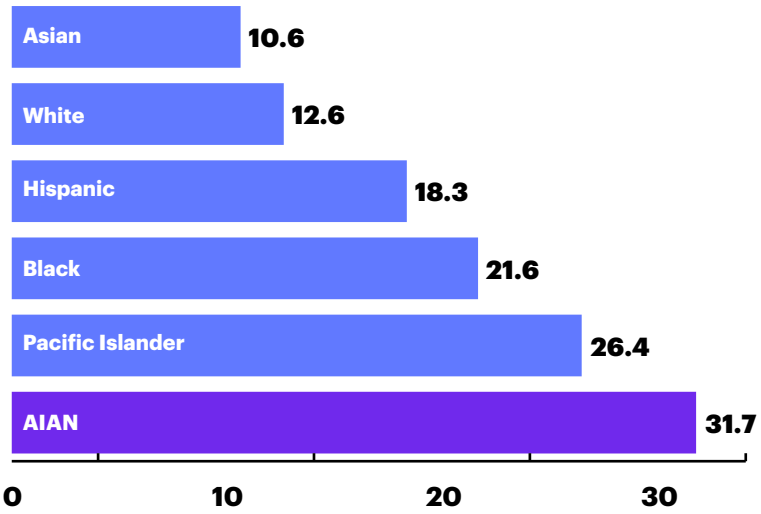
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

76.8
PERCENT
75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Nevada

27.7
PERCENT
26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

N/A
PER 10,000 HOSPITAL DELIVERIES
93.1

SEVERE MATERNAL MORBIDITY

The severe maternal morbidity rate cannot be shown due to lack of available data.

22.7
PER 100,000 BIRTHS
23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.0%	5.9	27.7%	73.3%	N/A	22.7
Rank	37th of 52	30th of 52	36th of 52	40th of 52	N/A	20th of 48
Direction†	Improved	Worsened†	Improved	No change	N/A	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Nevada

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Nevada

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Nevada's Medicaid program, Nevada Medicaid, covered 13,501 births in 2024

41.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
New Hampshire

Scan for more data

932 babies were born preterm in New Hampshire in 2024. New Hampshire ranks 1st of 52 (includes all states, District of Columbia, and Puerto Rico) for preterm birth with a rate of 7.9%.

New Hampshire has made significant improvement in adequate prenatal care reception since last year.

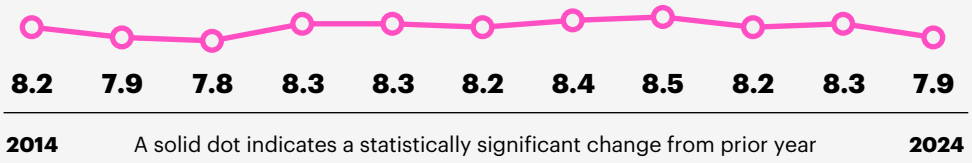
New Hampshire is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in New Hampshire was 7.9% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **A-**

US RATE	NH RATE	NH RANK
10.4	7.9	1

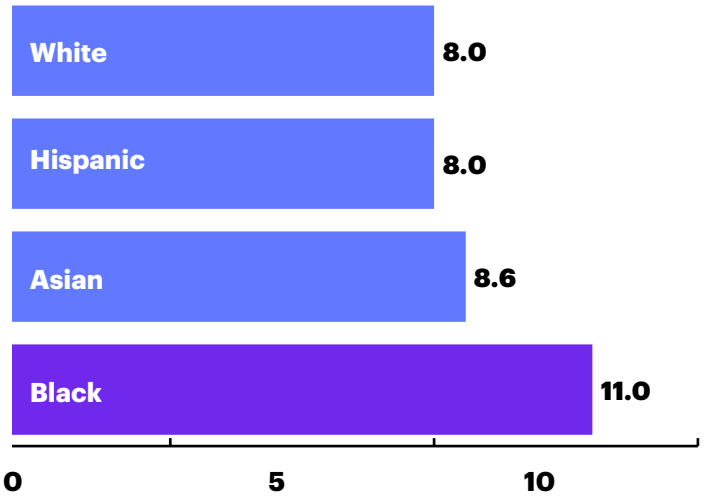
Percentage of live births born preterm



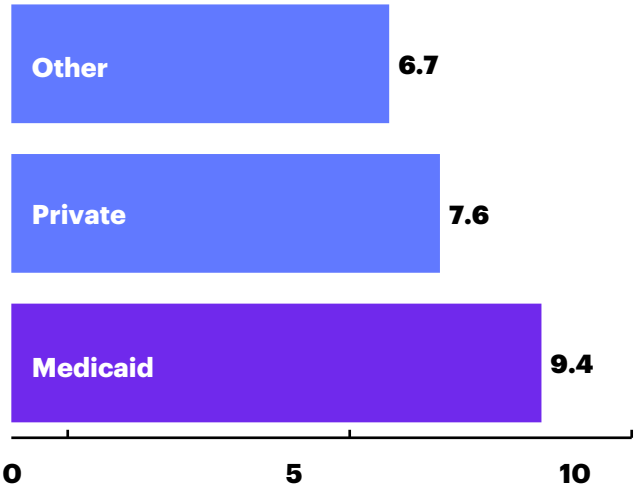
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



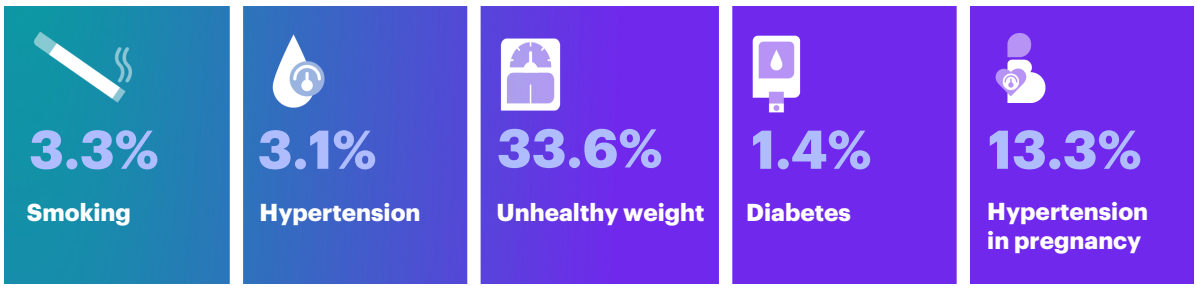
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 5.7%; Tricare: N/A; Indian Health Service: N/A; and all other types: 7.5%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

New Hampshire

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



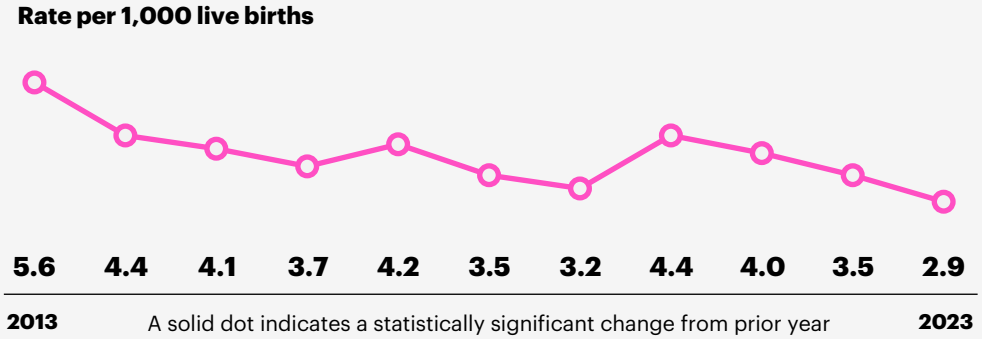
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 35 babies died before their first birthday

INFANT MORTALITY RATE **2.9**

US RATE **5.6**

NH RANK **1**

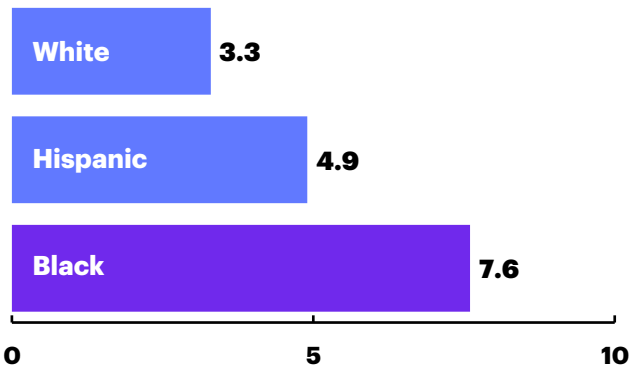


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.4x the state rate

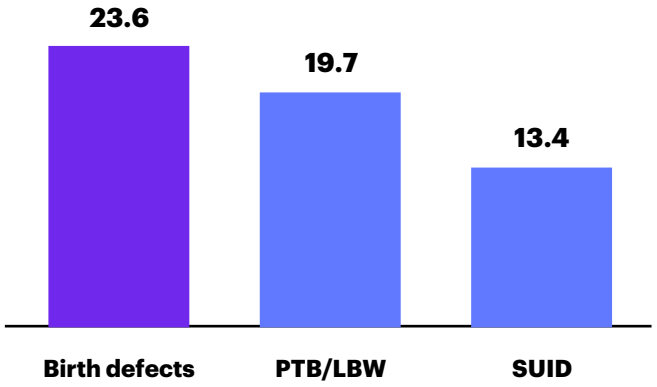
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2019-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 43.3% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

New Hampshire

The rate of inadequate prenatal care among babies born to Black moms is 2.3x the state rate

7.8
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

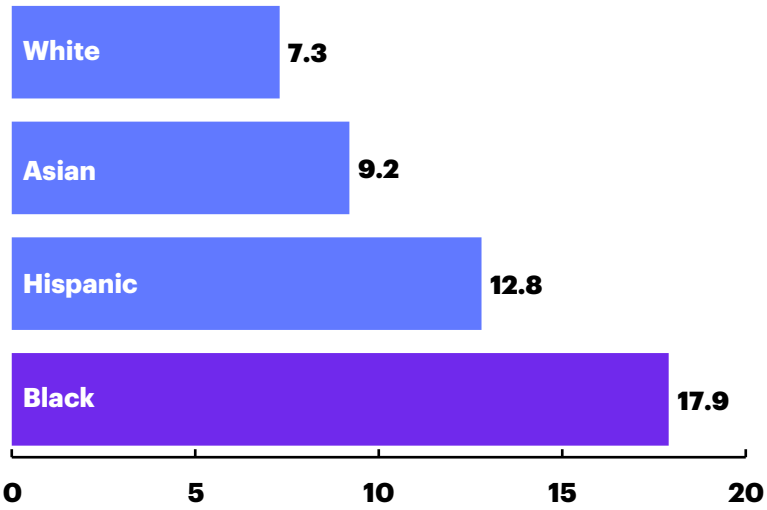
87.7
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in New Hampshire

26.6
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

67.2
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

19.9
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; New Hampshire Department of Health and Human Services. (2024, February 26). State of Maternal Health. https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/state-of-maternal-health-nh-feb-2024.pdf.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	7.9%	2.9	26.6%	87.2%	N/A	19.9
Rank	1st of 52	1st of 52	32nd of 52	2nd of 52	N/A	15th of 48
Direction†	Improved	Improved	Improved	Improved†	N/A	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

New Hampshire

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in New Hampshire

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

New Hampshire's Medicaid program, New Hampshire Medicaid, covered 2,436 births in 2024

20.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
New Jersey

Scan for more data

9,516 babies were born preterm in New Jersey in 2024. New Jersey ranks 10th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.4%.

New Jersey has made significant improvement in low-risk Cesarean births since last year.

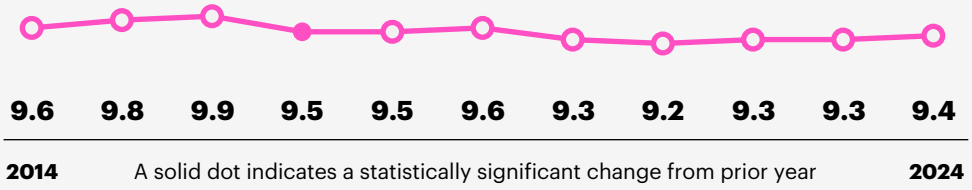
New Jersey is currently implementing six of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in New Jersey was 9.4% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE C+

US RATE	NJ RATE	NJ RANK
10.4	9.4	10

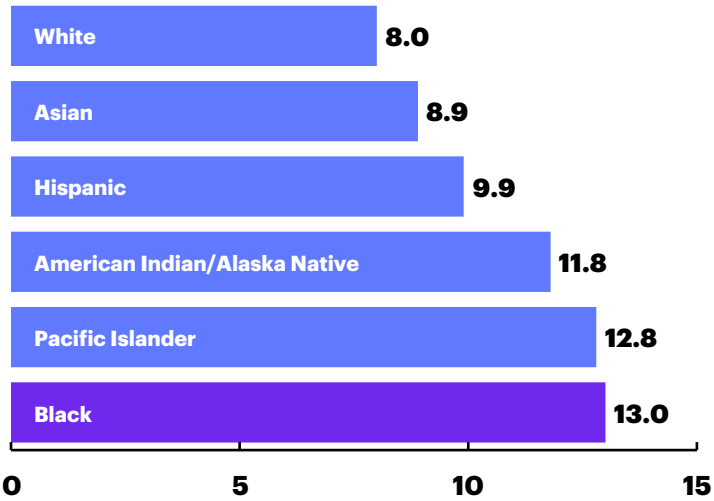
Percentage of live births born preterm



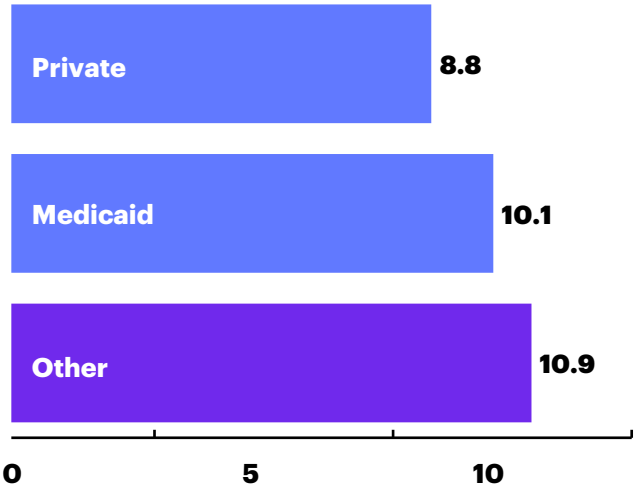
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 11.3%; Tricare: N/A; Indian Health Service: N/A; and all other types: 9.1%.

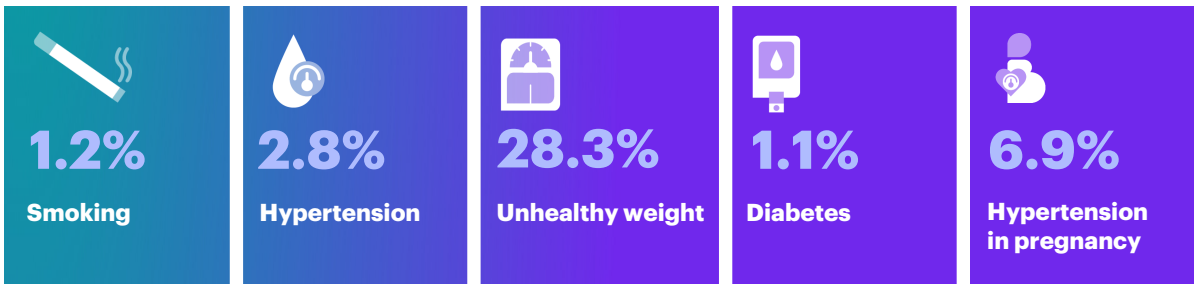
Source: National Center for Health Statistics, Natality data, 2014-2024.

Supported by THE BURKE FOUNDATION

New Jersey

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



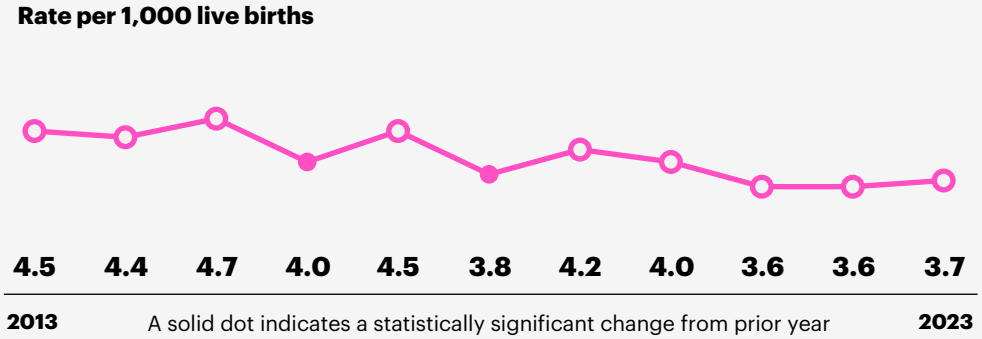
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 373 babies died before their first birthday

INFANT MORTALITY RATE **3.7**

US RATE **5.6**

NJ RANK **4**

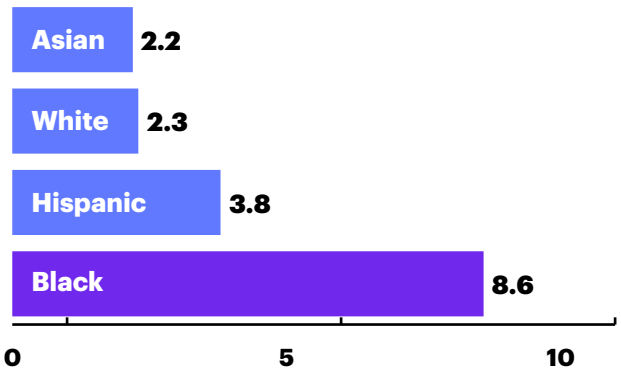


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 2.3x the state rate

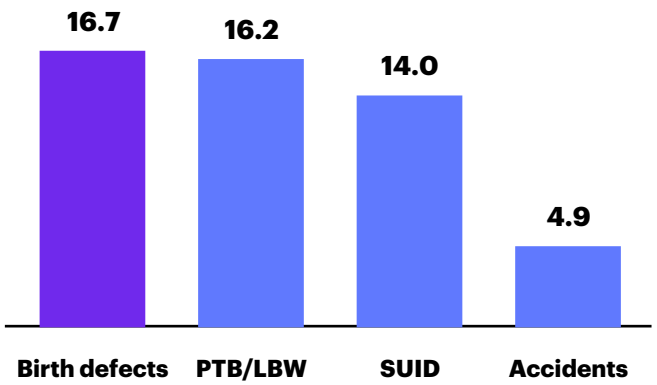
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 48.2% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

New Jersey

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.2x the state rate

16.2
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

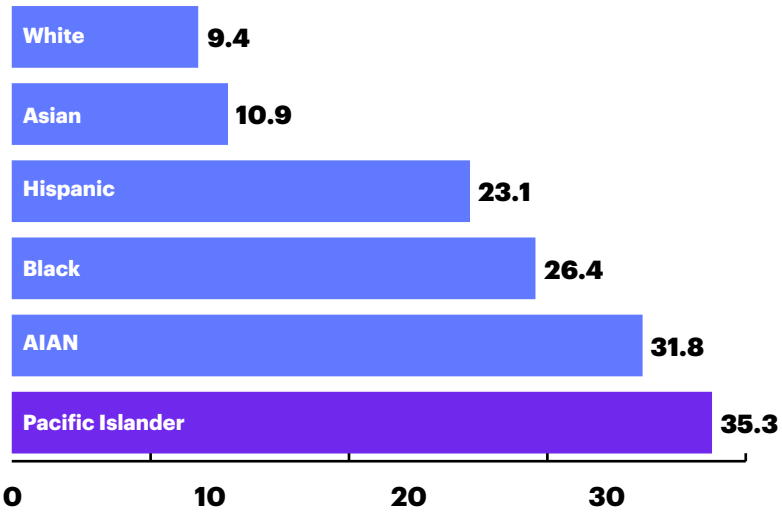
74.8
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in New Jersey

26.7
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

78.7
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

23.9
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.4%	3.7	26.7%	73.0%	78.7	23.9
Rank	10th of 52	4th of 52	33rd of 52	42nd of 52	13th of 47	25th of 48
Direction†	Worsened	Worsened	Improved†	Worsened†	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

New Jersey

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in New Jersey

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

New Jersey's Medicaid program, NJ FamilyCare, covered 29,951 births in 2024

29.6

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

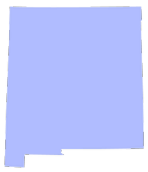
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
New Mexico

Scan for more data



2,128 babies were born preterm in New Mexico in 2024. New Mexico ranks 21st of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.0%.

New Mexico has made significant improvement in infant mortality since last year.

New Mexico is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in New Mexico was 10.0% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	NM RATE	NM RANK
10.4	10.0	21

Percentage of live births born preterm

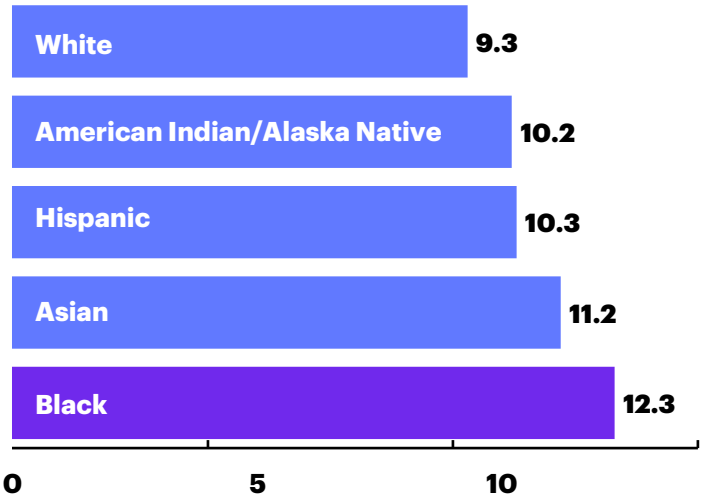
9.2	9.5	10.0	10.3	9.8	10.1	9.6	10.0	10.2	10.1	10.0
2014										2024

A solid dot indicates a statistically significant change from prior year

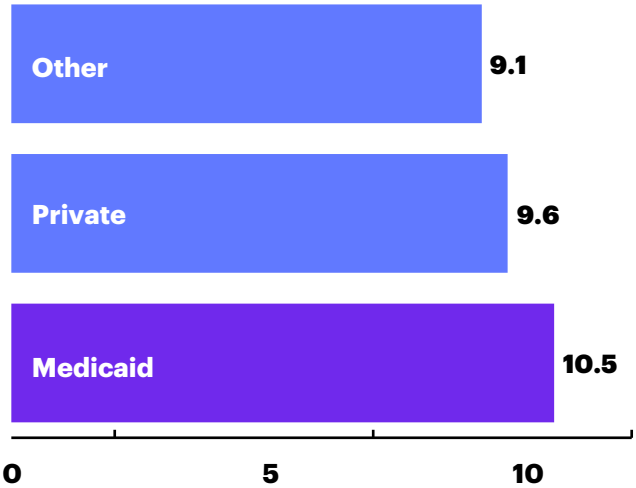
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



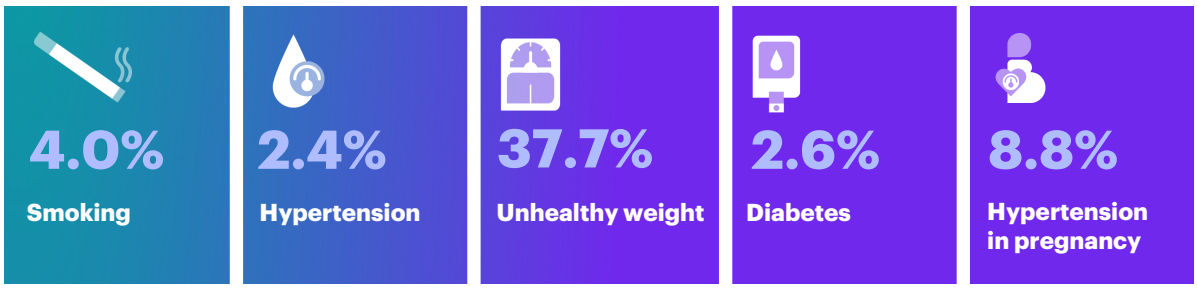
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 9.0%; Tricare: 6.1%; Indian Health Service: 15.3%; and all other types: 11.4%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

New Mexico

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



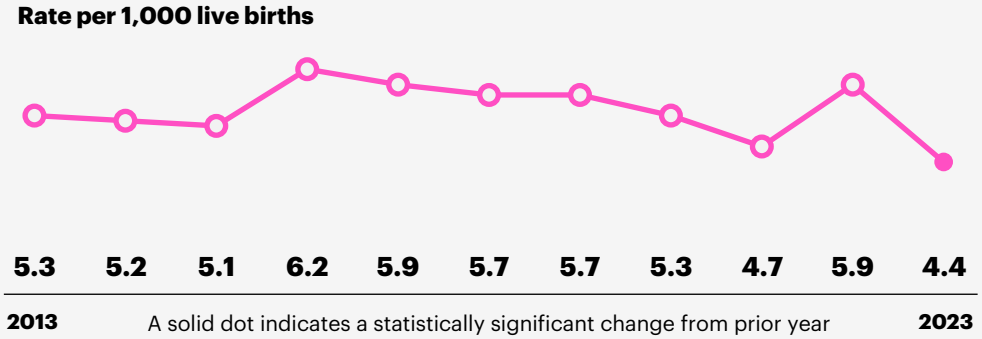
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 92 babies died before their first birthday

INFANT MORTALITY RATE **4.4**

US RATE 5.6

NM RANK 8

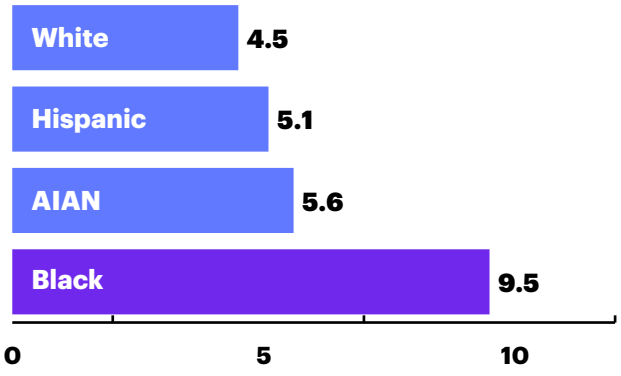


Note: The change in 2023 was a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 2.2x the state rate

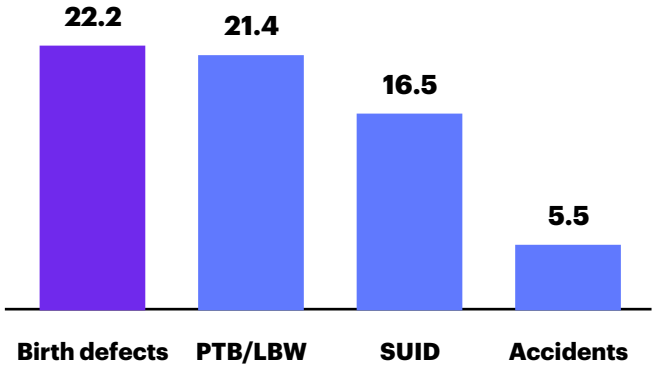
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 34.4% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

New Mexico

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.1x the state rate

23.1
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

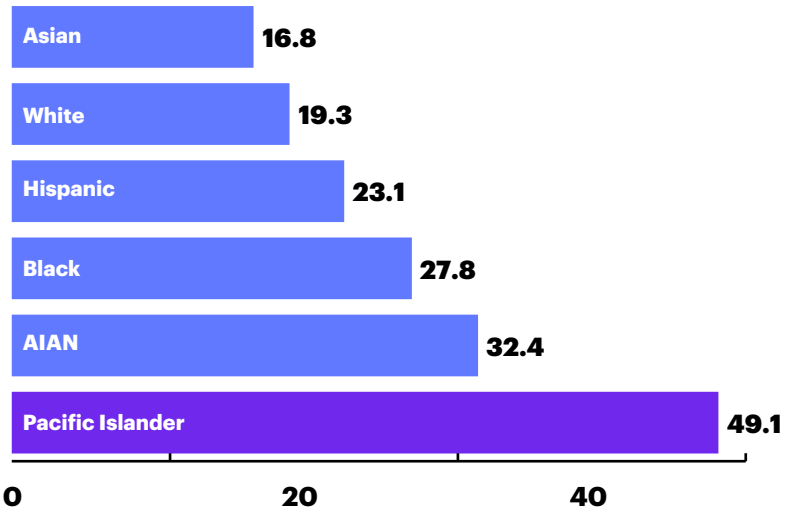
68.6
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in New Mexico

24.1
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

120.1
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

28.5
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.0%	4.4	24.1%	67.0%	120.1	28.5
Rank	21st of 52	8th of 52	13th of 52	49th of 52	44th of 47	33rd of 48
Direction†	Improved	Improved†	Worsened	Worsened	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

New Mexico

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in New Mexico

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

New Mexico's Medicaid program, Centennial Care, covered 11,437 births in 2024

53.9

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
New York

Scan for more data

19,458 babies were born preterm in New York in 2024. New York ranks 12th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.5%.

New York is among the top ten best states with the lowest rates of infant mortality.

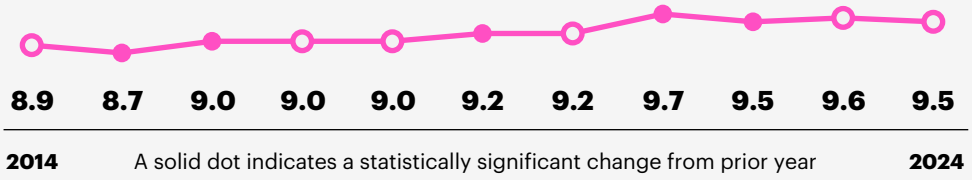
New York is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in New York was 9.5% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE C+

US RATE	NY RATE	NY RANK
10.4	9.5	12

Percentage of live births born preterm



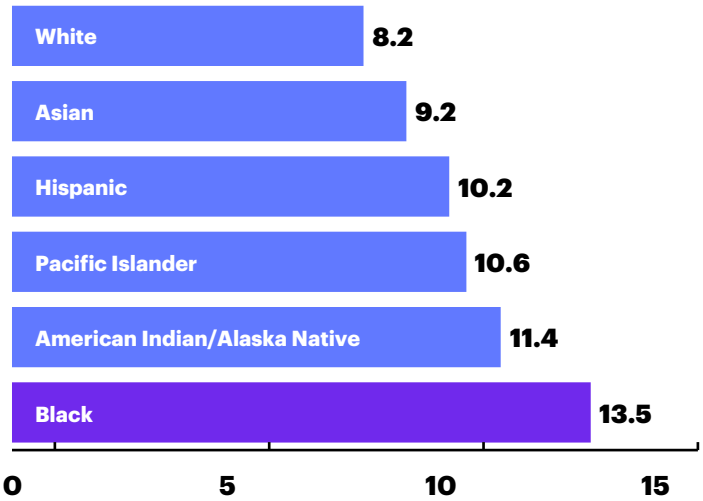
2014										2024
8.9	8.7	9.0	9.0	9.0	9.2	9.2	9.7	9.5	9.6	9.5

A solid dot indicates a statistically significant change from prior year

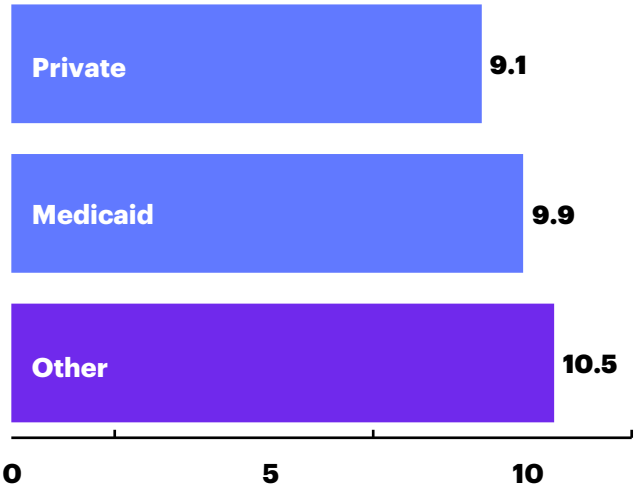
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 9.3%; Tricare: 8.6%; Indian Health Service: 9.3%; and all other types: 11.7%.

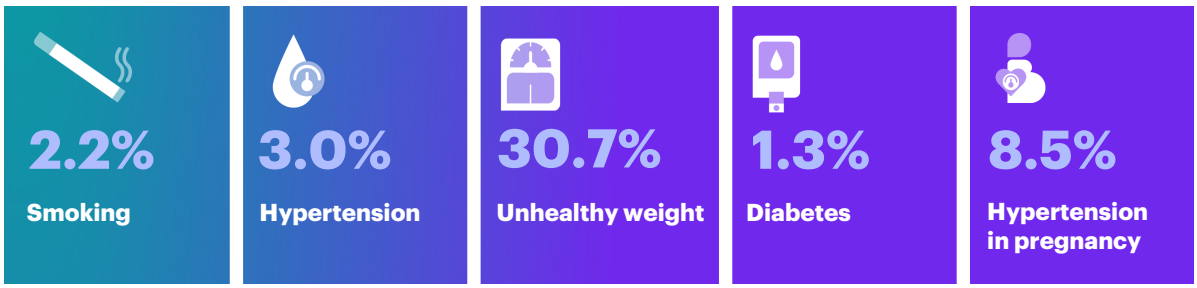
Source: National Center for Health Statistics, Natality data, 2014-2024.

Supported by Health Foundation for Western & Central New York
Investing in Better Health for People and Communities

New York

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



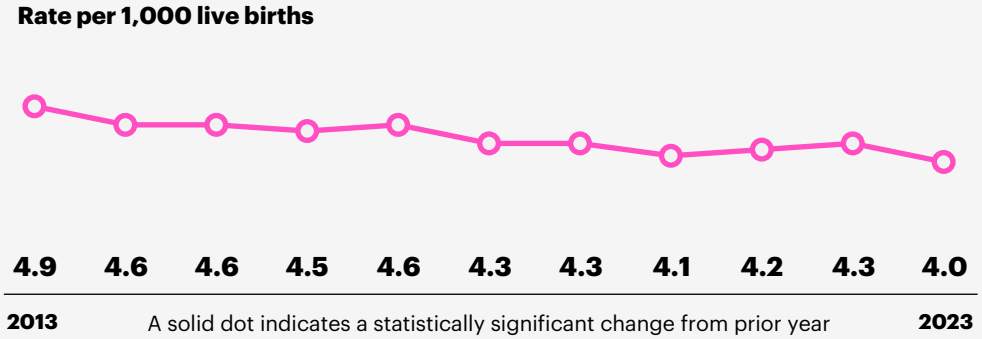
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 821 babies died before their first birthday

INFANT MORTALITY RATE **4.0**

US RATE 5.6

NY RANK 7

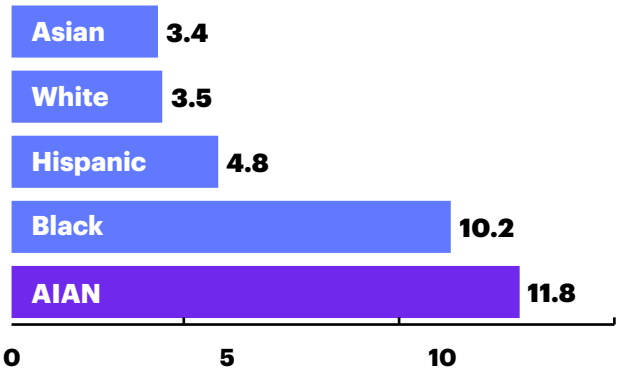


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to American Indian/Alaska Native moms is 2.9x the state rate

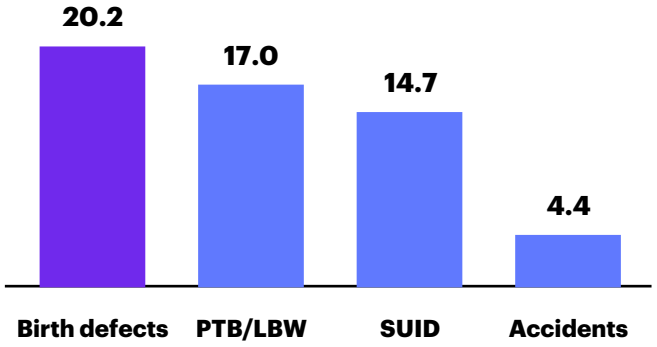
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 43.8% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

New York

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 1.6x the state rate

14.5
PERCENT
16.1

INADEQUATE PRENATAL CARE

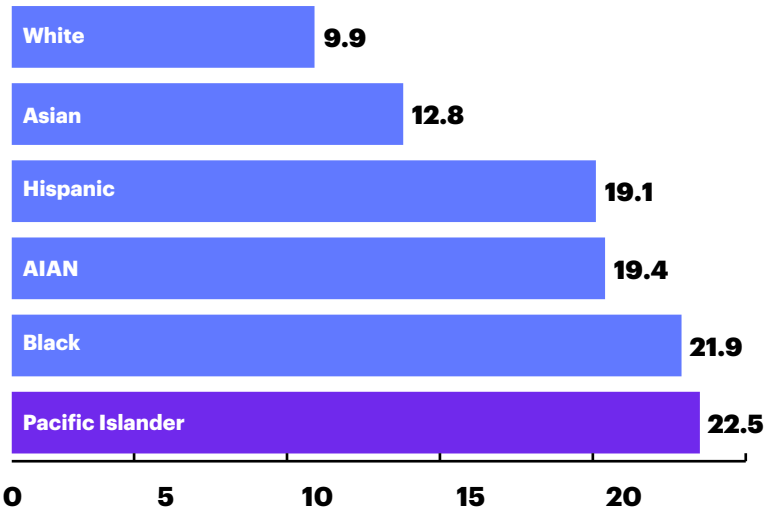
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

78.0
PERCENT
75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in New York

29.2
PERCENT
26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

127.4
PER 10,000 HOSPITAL DELIVERIES
93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

21.8
PER 100,000 BIRTHS
23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.5%	4.3	29.2%	75.2%	127.4	21.8
Rank	12th of 52	7th of 52	45th of 52	35th of 52	45th of 47	19th of 48
Direction†	Improved	Improved	Improved	Worsened†	Worsened	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

New York

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in New York

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

New York's Medicaid program, New York Medicaid, covered 98,672 births in 2024

48.3

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
North Carolina

Scan for more data

13,112 babies were born preterm in North Carolina in 2024. North Carolina ranks 32nd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.7%.

North Carolina is among the top twenty states with the lowest rates of low-risk Cesarean births.

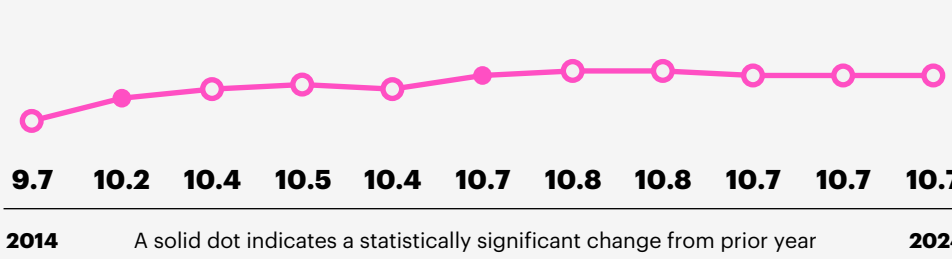
North Carolina is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in North Carolina was 10.7% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **D+**

US RATE	NC RATE	NC RANK
10.4	10.7	32

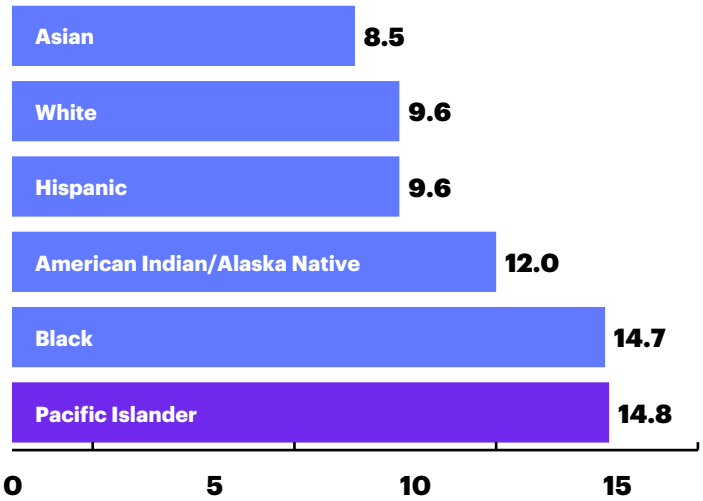
Percentage of live births born preterm



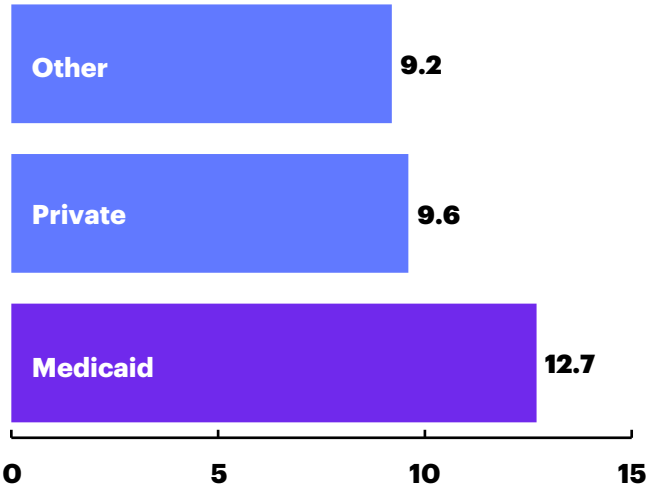
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



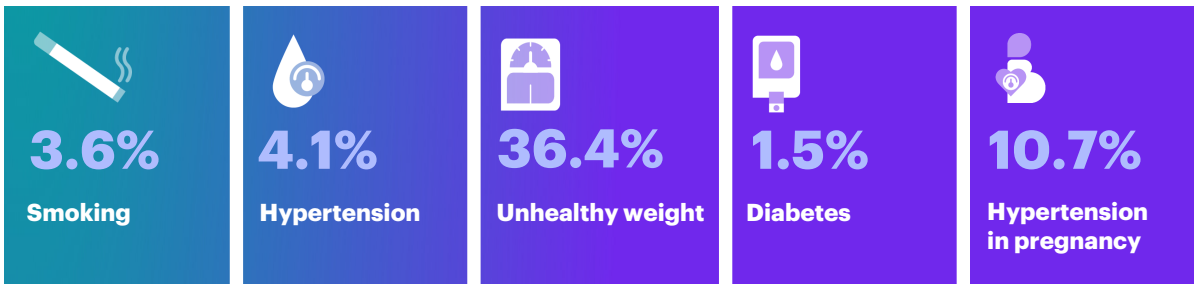
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 9.5%; Tricare: 12.5%; Indian Health Service: N/A; and all other types: 8.5%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

North Carolina

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



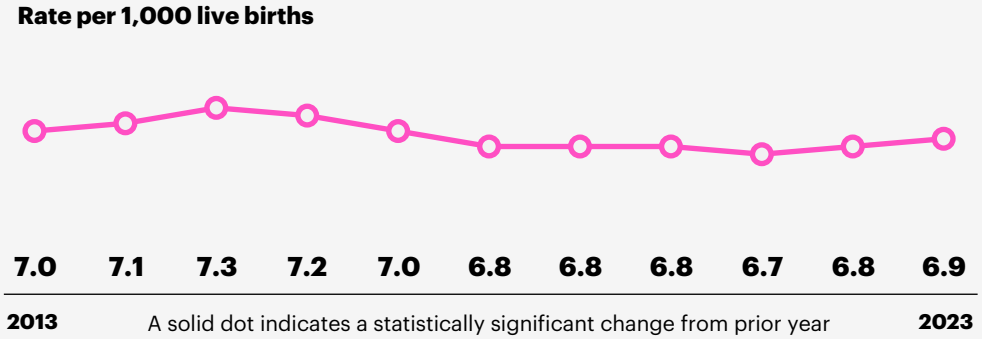
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 834 babies died before their first birthday

INFANT MORTALITY RATE **6.9**

US RATE **5.6**

NC RANK **41**

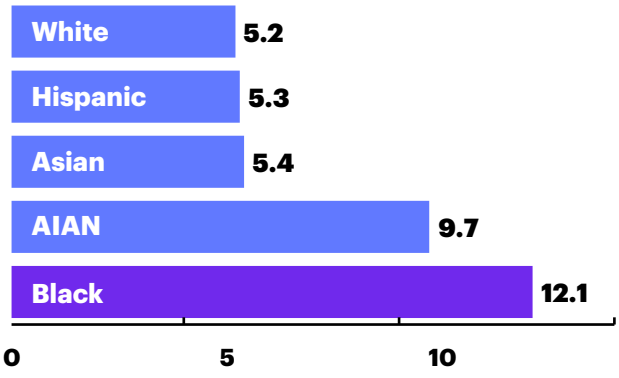


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.7x the state rate

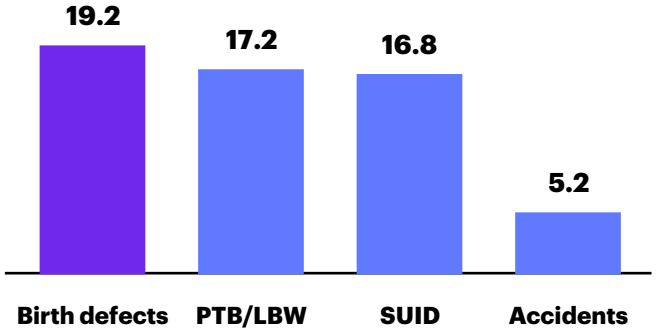
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 41.5% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

North Carolina

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 1.8x the state rate

18.6
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

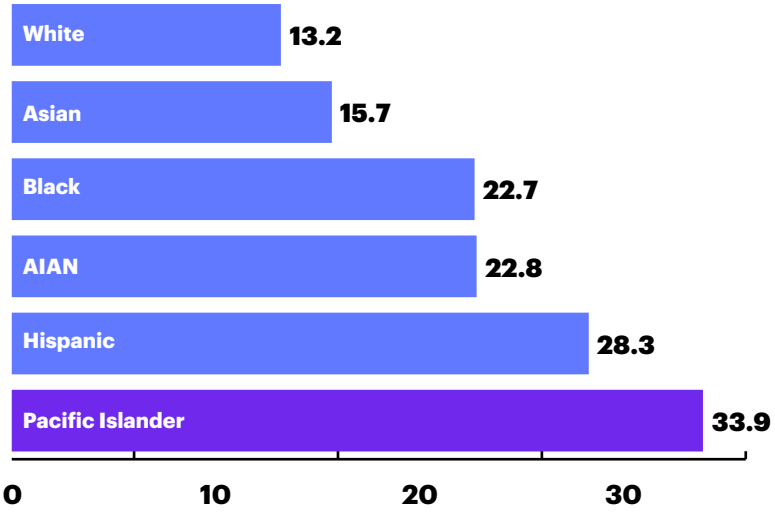
72.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in North Carolina

24.9
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

91.0
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

29.8
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.7%	6.9	24.9%	76.8%	91.0	29.8
Rank	32nd of 52	41st of 52	20th of 52	31st of 52	24th of 47	35th of 48
Direction†	No change	Worsened	No change	Worsened†	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

North Carolina

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in North Carolina

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

North Carolina's Medicaid program, NC Medicaid, covered 43,842 births in 2024

35.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

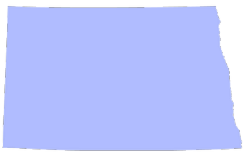
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
North Dakota

Scan for more data



905 babies were born preterm in North Dakota in 2024. North Dakota ranks 10th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.4%.

North Dakota is among the top ten best states with the lowest rates of low-risk Cesarean births and severe maternal morbidity.

North Dakota is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in North Dakota was 9.4% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE C+

US RATE	ND RATE	ND RANK
10.4	9.4	10

Percentage of live births born preterm

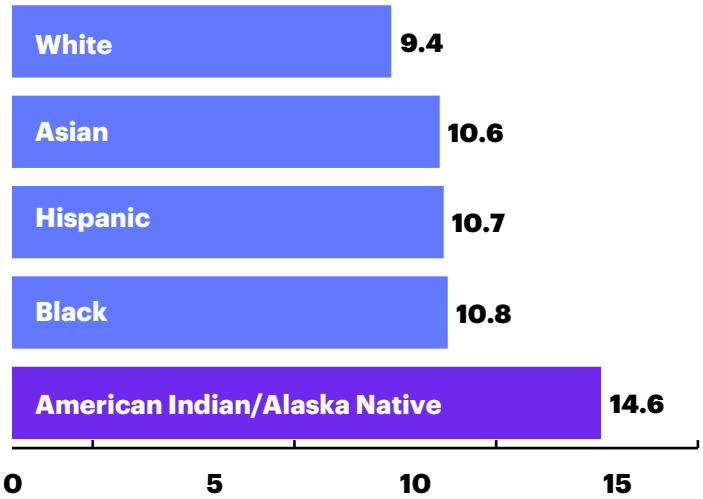
2014										2024
8.4	8.4	9.1	8.8	9.6	9.5	9.8	9.6	10.3	10.3	9.4

A solid dot indicates a statistically significant change from prior year

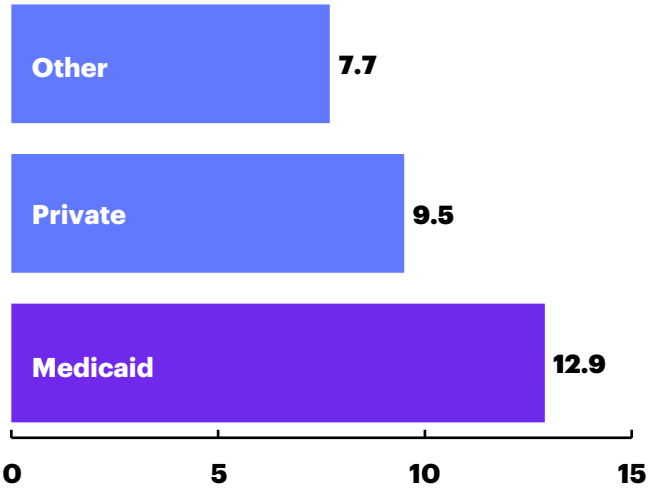
Note: The change in 2024 was a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



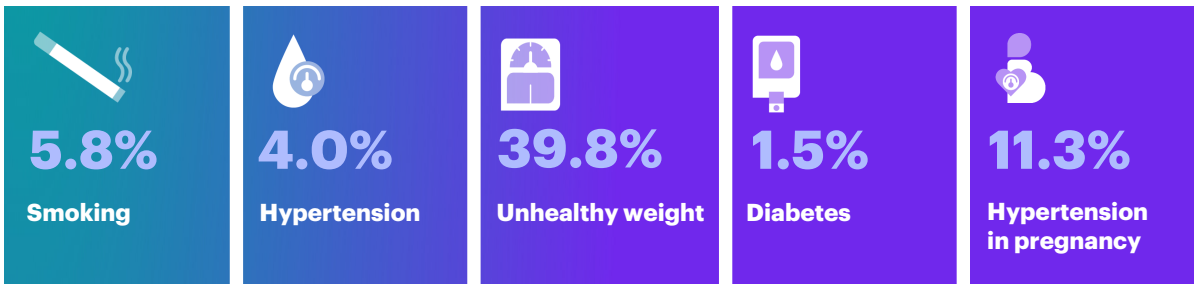
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 5.3%; Tricare: 7.7%; Indian Health Service: 11.9%; and all other types: 8.4%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

North Dakota

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 47 babies died before their first birthday

INFANT MORTALITY RATE **4.9**

US RATE **5.6**

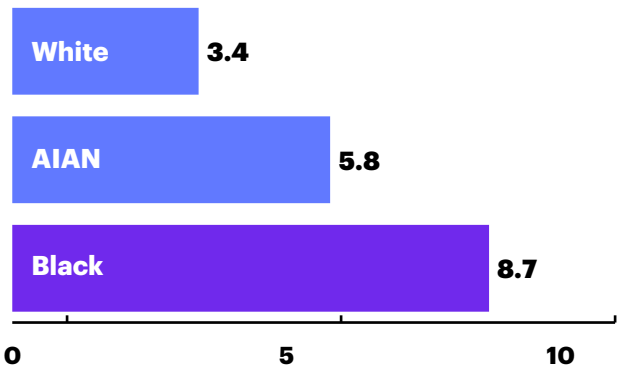
ND RANK **15**

Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.8x the state rate

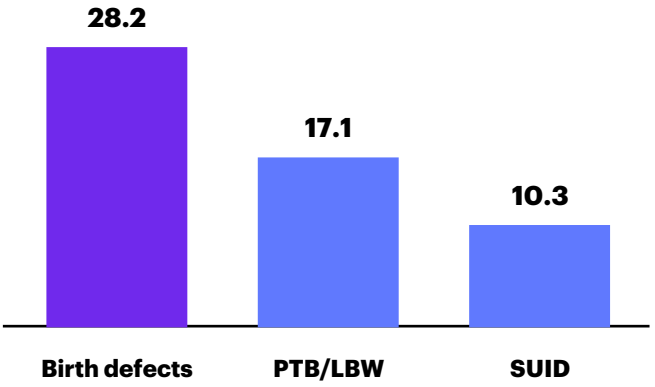
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 44.5% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

North Dakota

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 4.1x the state rate

14.0 PERCENT — 16.1

INADEQUATE PRENATAL CARE

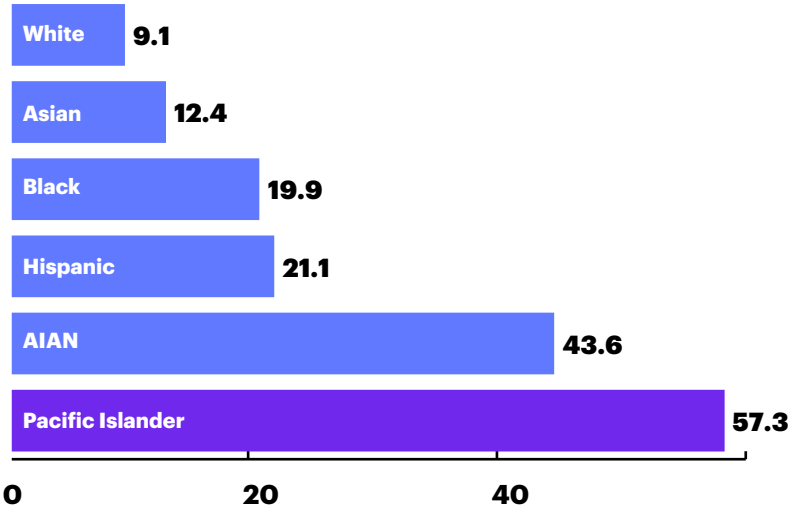
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

79.5 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in North Dakota

20.2 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

69.5 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

24.1 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.4%	4.9	20.2%	78.2%	69.5	24.1
Rank	10th of 52	15th of 52	4th of 52	25th of 52	8th of 47	26th of 48
Direction†	Improved†	Worsened	Worsened	Worsened	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

North Dakota

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in North Dakota

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

North Dakota's Medicaid program, North Dakota Medicaid, covered 2,219 births in 2024

23.4

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Ohio

Scan for more data

13,914 babies were born preterm in Ohio in 2024. Ohio ranks 37th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.0%.

Ohio is among the top twenty states with the highest rates of adequate prenatal care reception.

Ohio is currently implementing four of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Ohio was 11.0% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **D**

US RATE	OH RATE	OH RANK
10.4	11.0	37

Percentage of live births born preterm

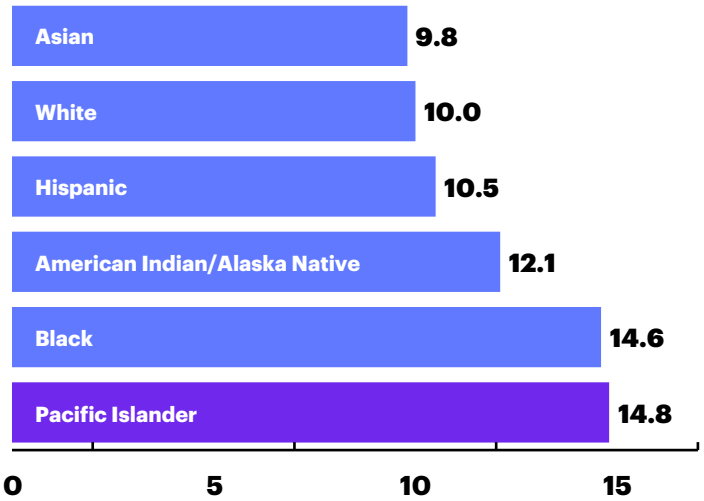
2014										2024
10.3	10.3	10.4	10.4	10.3	10.5	10.3	10.6	10.8	10.7	11.0

A solid dot indicates a statistically significant change from prior year

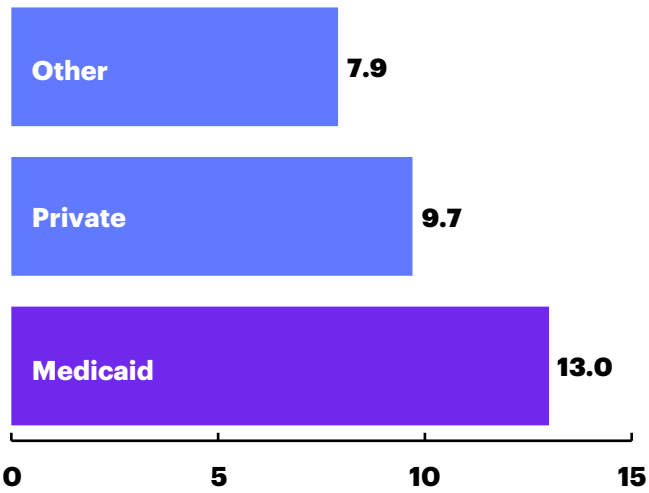
Note: The change in 2024 was a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



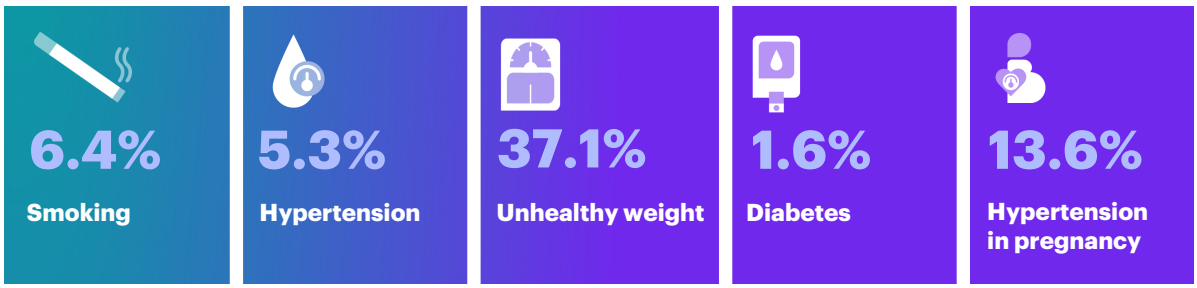
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 7.4%; Tricare: 8.2%; Indian Health Service: N/A; and all other types: 9.6%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Ohio

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



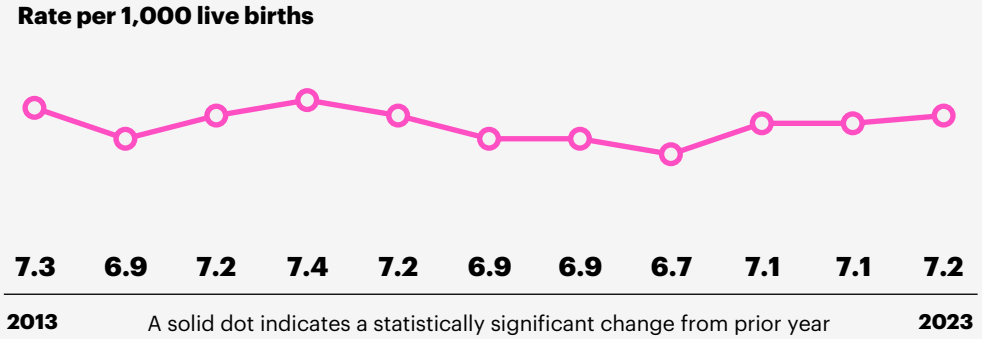
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 909 babies died before their first birthday

INFANT MORTALITY RATE **7.2**

US RATE **5.6**

OH RANK **48**

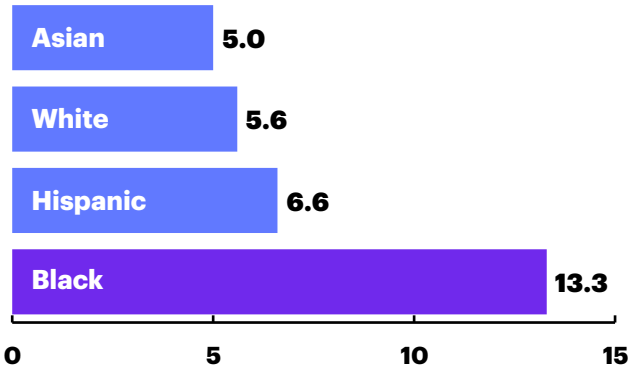


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.9x the state rate

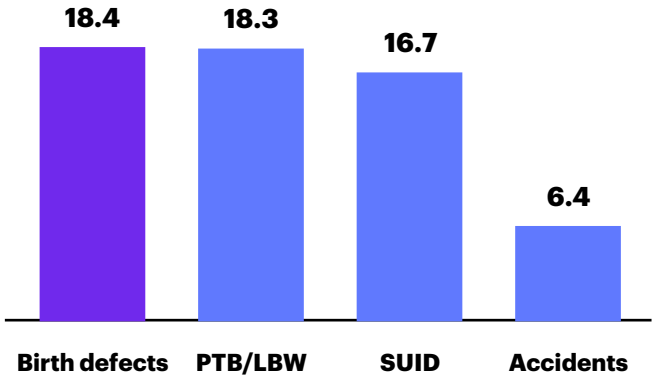
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.2% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Ohio

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.6x the state rate

14.7
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

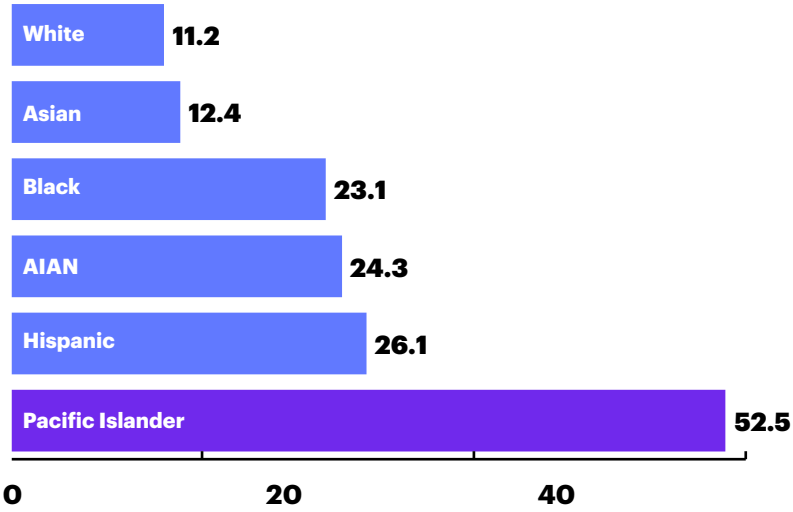
76.9
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Ohio

26.5
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

93.4
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

25.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.0%	7.2	26.5%	79.8%	93.4	25.4
Rank	37th of 52	48th of 52	30th of 52	14th of 52	26th of 47	29th of 48
Direction†	Worsened†	Worsened	Worsened†	Improved	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Ohio

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Ohio

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Ohio's Medicaid program, Ohio Medicaid, covered 46,463 births in 2024

36.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Oklahoma

Scan for more data

5,273 babies were born preterm in Oklahoma in 2024. Oklahoma ranks 37th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.0%.

Oklahoma is among the top twenty states with the lowest rates of severe maternal morbidity.

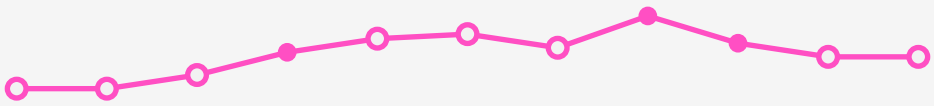
Oklahoma is currently implementing four of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Oklahoma was 11.0% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **D**

US RATE	OK RATE	OK RANK
10.4	11.0	37

Percentage of live births born preterm



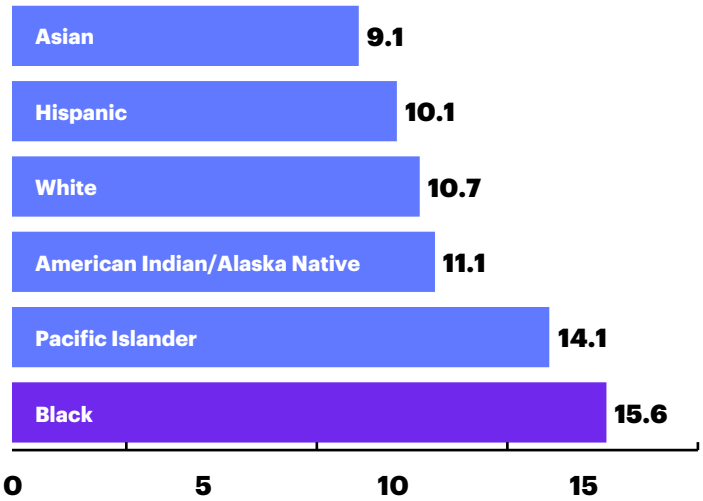
2014										2024
10.3	10.3	10.6	11.1	11.4	11.5	11.2	11.9	11.3	11.0	11.0

A solid dot indicates a statistically significant change from prior year

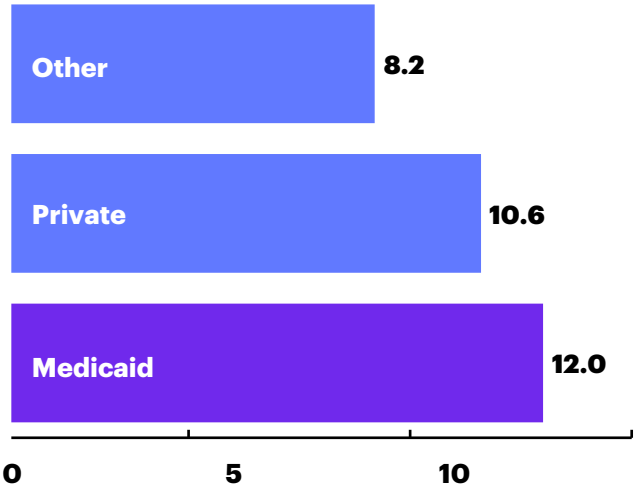
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



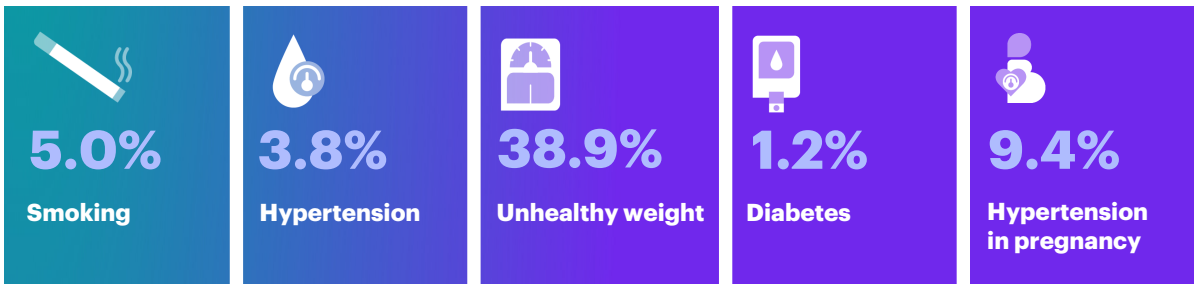
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.9%; Tricare: 8.9%; Indian Health Service: 7.5%; and all other types: 10.2%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Oklahoma

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



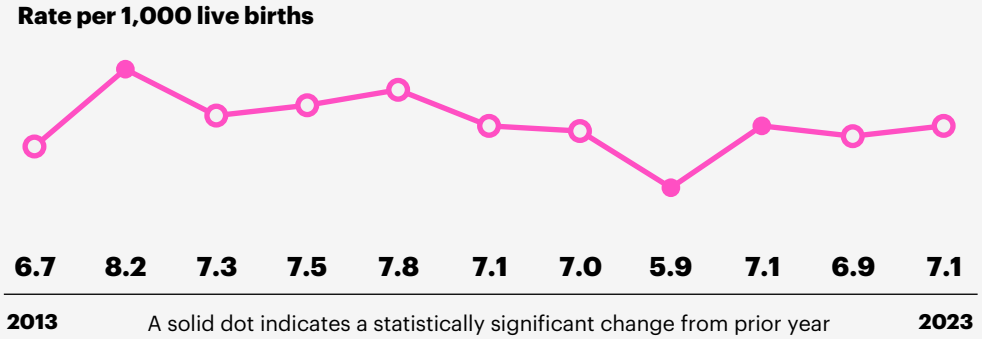
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 341 babies died before their first birthday

INFANT MORTALITY RATE **7.1**

US RATE **5.6**

OK RANK **46**

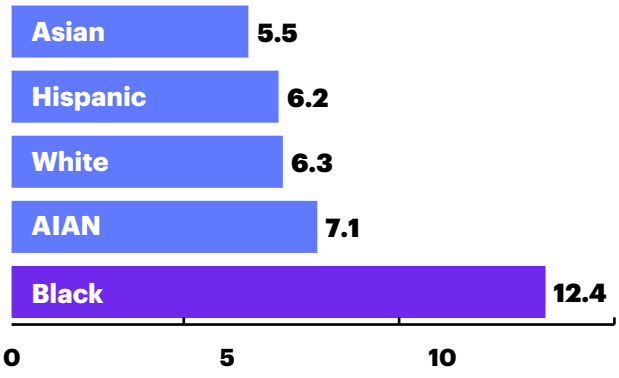


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.7x the state rate

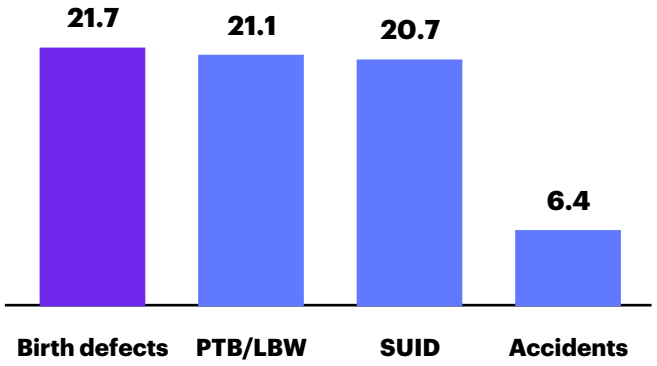
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 30.1% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Oklahoma

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.7x the state rate

14.2
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

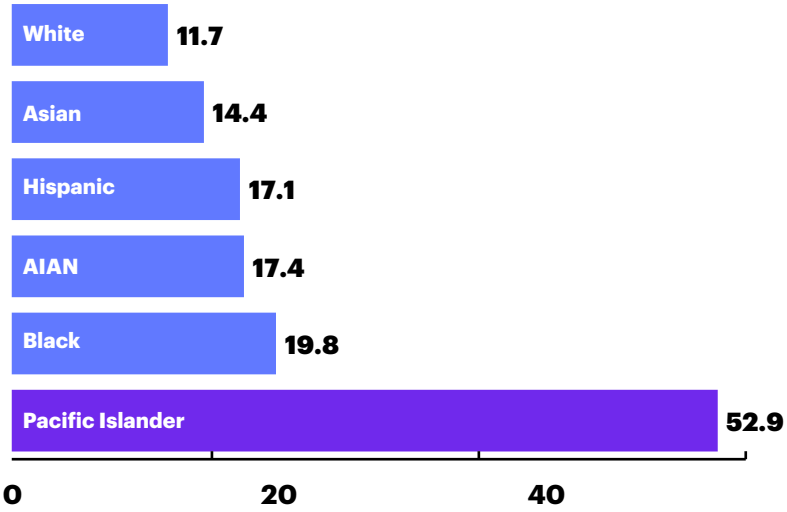
76.4
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Oklahoma

25.4
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

77.9
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

27.3
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.0%	7.1	25.4%	78.9%	77.9	27.3
Rank	37th of 52	46th of 52	23rd of 52	21st of 52	12th of 47	31st of 48
Direction†	No change	Worsened	Improved	Improved	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Oklahoma

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Oklahoma

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Oklahoma's Medicaid program, SoonerCare, covered 23,694 births in 2024

49.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Oregon

Scan for more data

3,466 babies were born preterm in Oregon in 2024. Oregon ranks 3rd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 8.9%.

Oregon has met the Healthy People 2030 target for infant mortality.

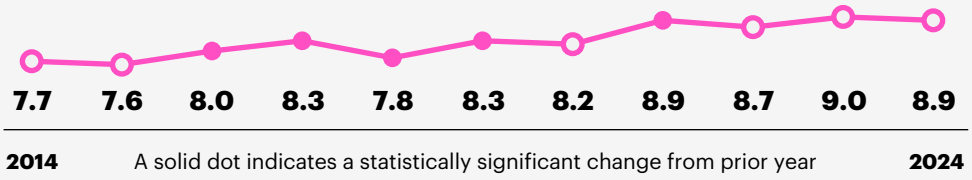
Oregon is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Oregon was 8.9% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **B**

US RATE	OR RATE	OR RANK
10.4	8.9	3

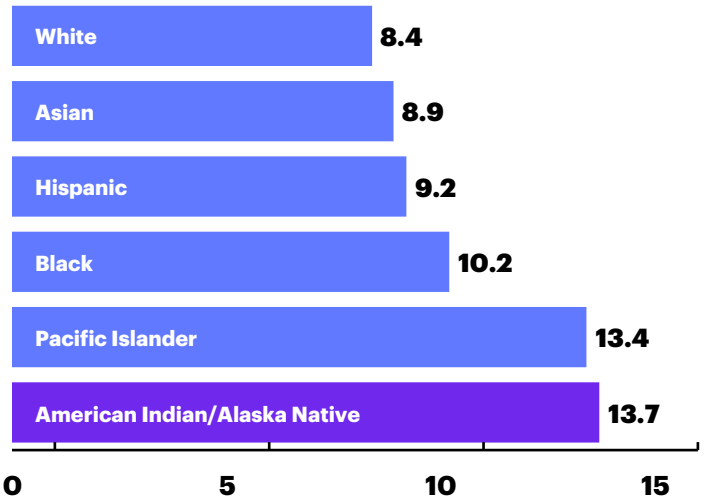
Percentage of live births born preterm



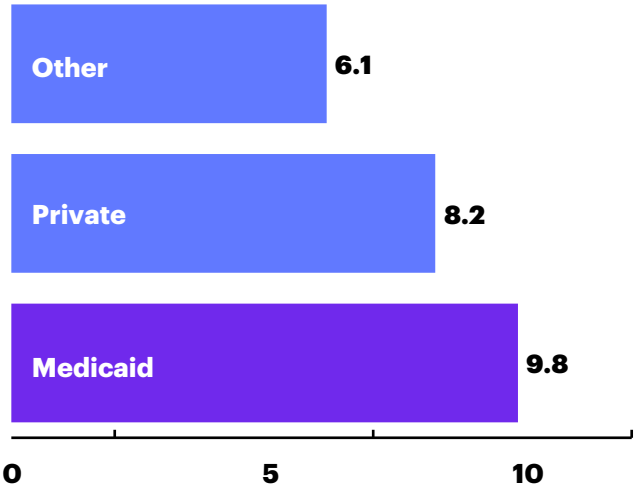
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



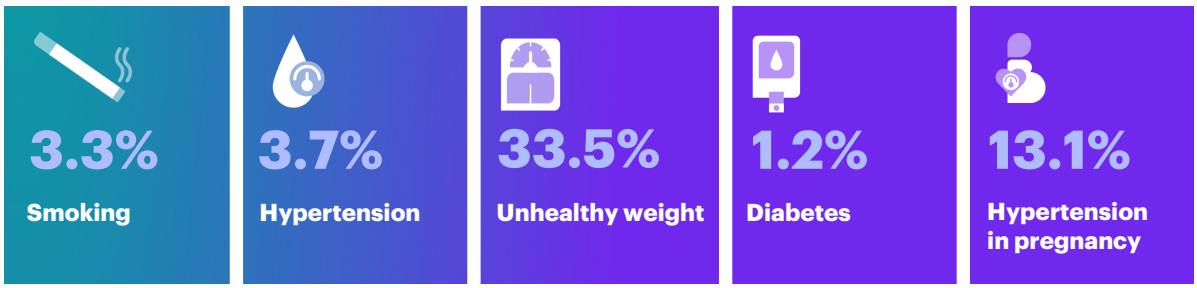
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 4.5%; Tricare: 7.0%; Indian Health Service: 15.5%; and all other types: 12.7%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Oregon

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



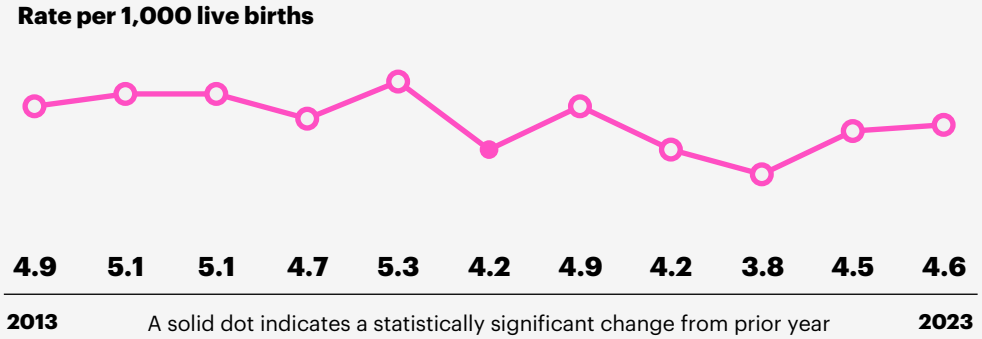
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 177 babies died before their first birthday

INFANT MORTALITY RATE **4.6**

US RATE **5.6**

OR RANK **11**

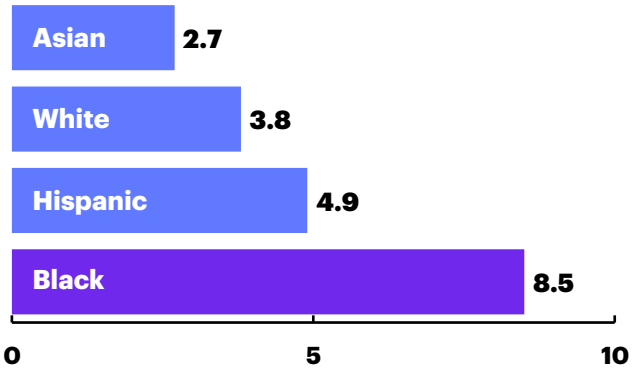


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.8x the state rate

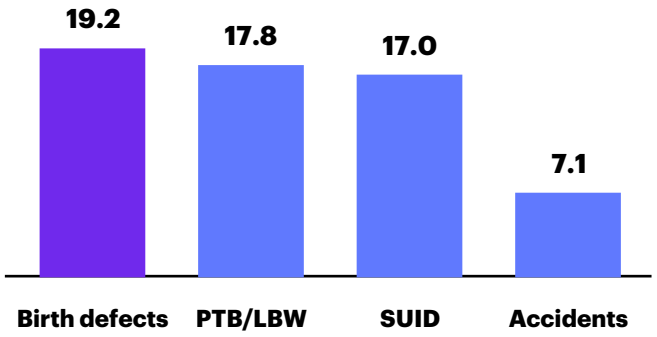
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 38.9% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Oregon

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.8x the state rate

11.2
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

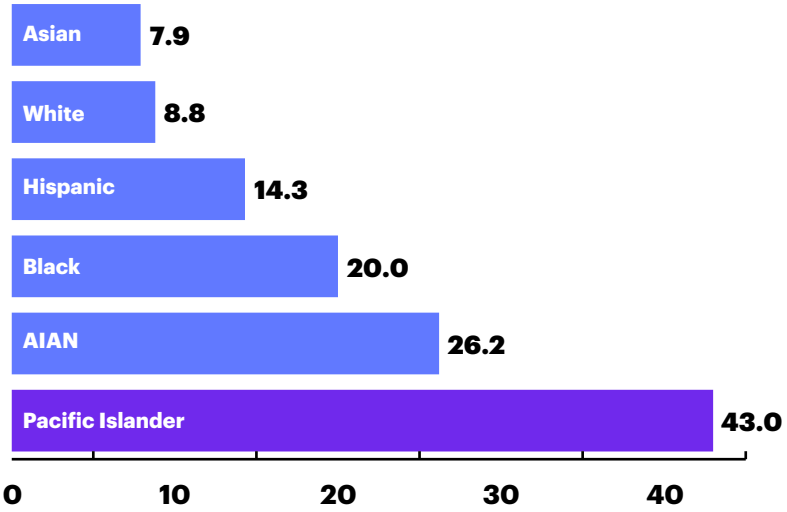
82.0
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Oregon

25.1
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

81.7
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

18.5
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	8.9%	4.6	25.1%	78.8%	81.7	18.5
Rank	3rd of 52	11th of 52	22nd of 52	23rd of 52	18th of 47	11th of 48
Direction†	Improved	Worsened	Worsened†	No change	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Oregon

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Oregon

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Oregon's Medicaid program, Oregon Health Plan (OHP), covered 17,597 births in 2024

45.4

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Pennsylvania

Scan for more data

12,417 babies were born preterm in Pennsylvania in 2024. Pennsylvania ranks 17th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.8%.

Pennsylvania is among the top ten best states with the lowest rates of maternal mortality.

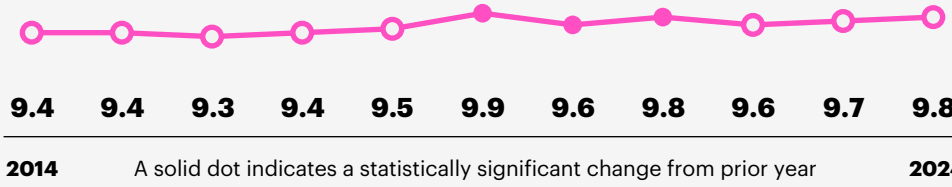
Pennsylvania is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Pennsylvania was 9.8% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	PA RATE	PA RANK
10.4	9.8	17

Percentage of live births born preterm



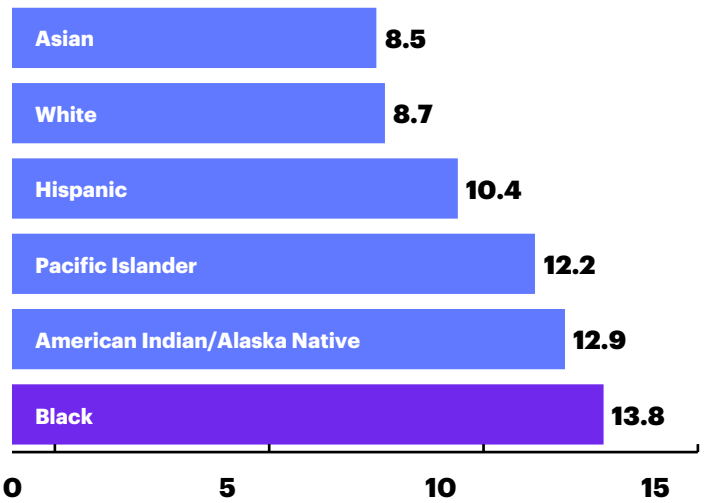
2014										2024
9.4	9.4	9.3	9.4	9.5	9.9	9.6	9.8	9.6	9.7	9.8

A solid dot indicates a statistically significant change from prior year

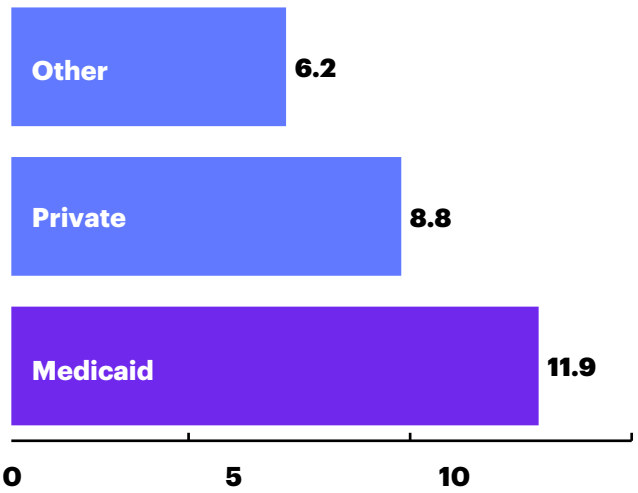
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



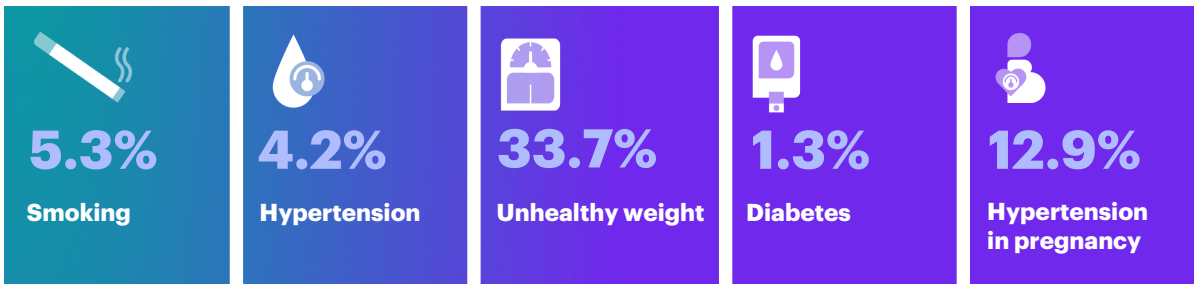
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 4.7%; Tricare: 18.4%; Indian Health Service: N/A; and all other types: 12.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Pennsylvania

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



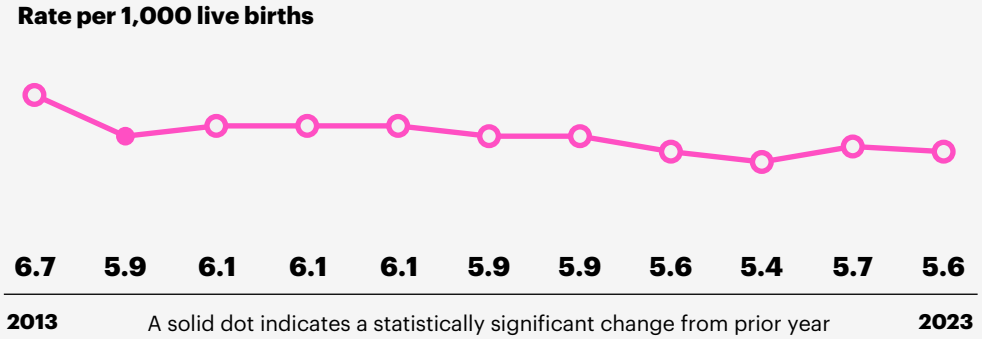
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 707 babies died before their first birthday

INFANT MORTALITY RATE **5.6**

US RATE 5.6

PA RANK 24

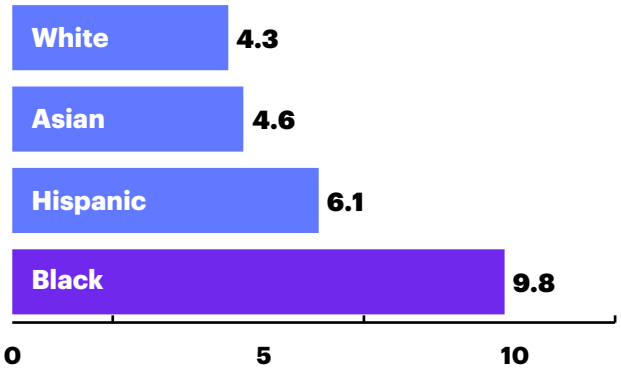


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.8x the state rate

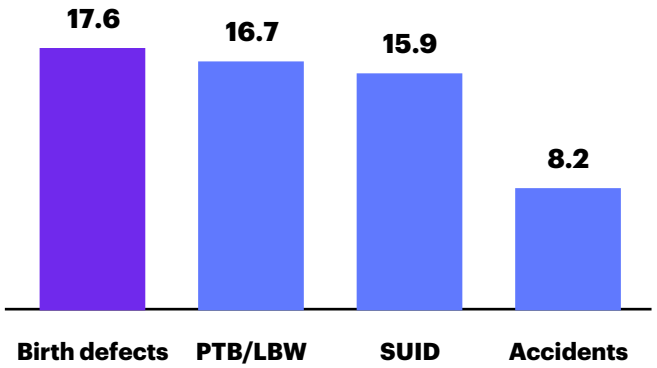
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 41.6% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Pennsylvania

The rate of inadequate prenatal care among babies born to American Indian/Alaska Native moms is 1.9x the state rate

16.0
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

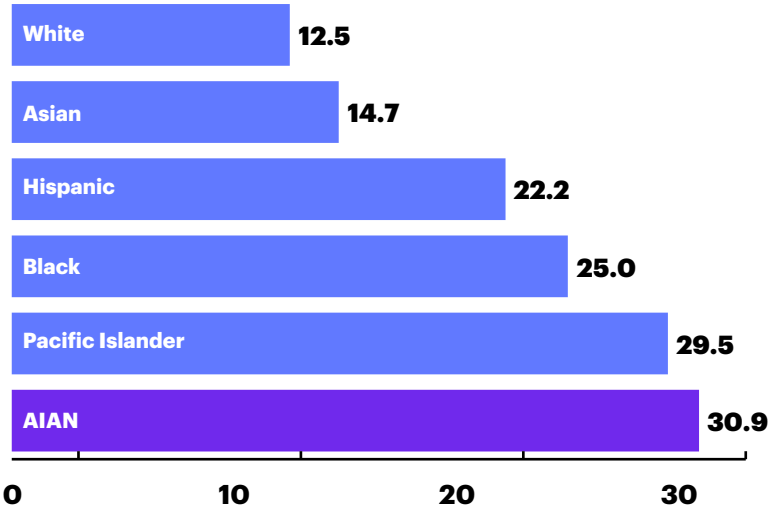
76.9
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Pennsylvania

26.0
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

105.1
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

17.7
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.8%	5.6	26.0%	74.8%	105.1	17.7
Rank	17th of 52	24th of 52	26th of 52	36th of 52	35th of 47	10th of 48
Direction†	Worsened	Improved	Worsened	Improved	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Pennsylvania

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Pennsylvania

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Pennsylvania's Medicaid program, Pennsylvania Medical Assistance (MA), covered 43,557 births in 2024

35.2

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Rhode Island

Scan for more data

897 babies were born preterm in Rhode Island in 2024. Rhode Island ranks 5th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.0%.

Rhode Island has made significant improvement in adequate prenatal care reception since last year.

Rhode Island is currently implementing five of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Rhode Island was 9.0% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **B-**

US RATE	RI RATE	RI RANK
10.4	9.0	5

Percentage of live births born preterm

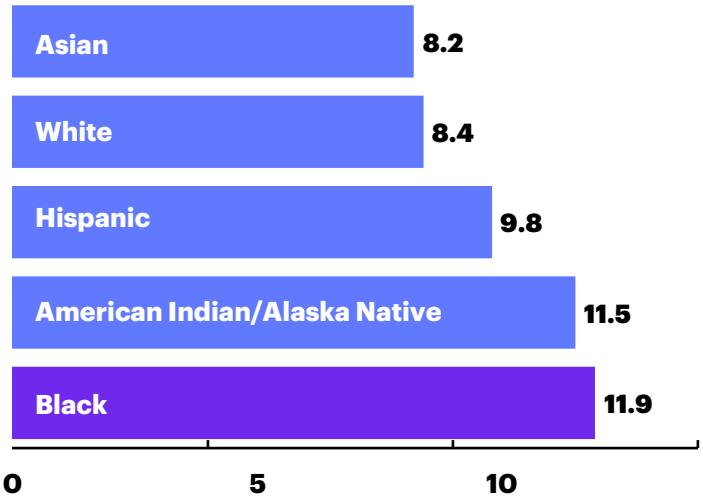
2014										2024
8.6	8.6	9.3	8.3	9.0	9.5	9.1	9.6	9.0	9.6	9.0

A solid dot indicates a statistically significant change from prior year

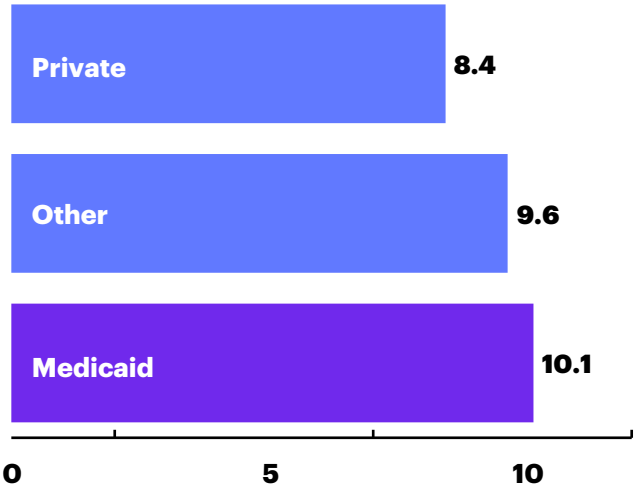
Note: The change in 2024 was not a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



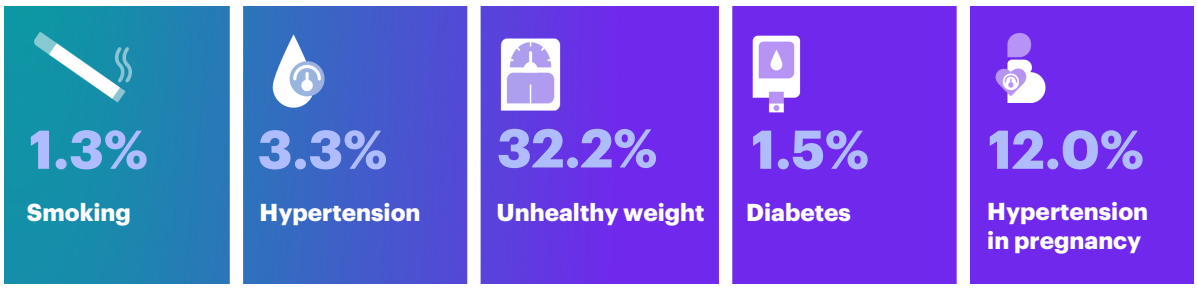
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 17.0%; Tricare: 8.1%; Indian Health Service: N/A; and all other types: N/A.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Rhode Island

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



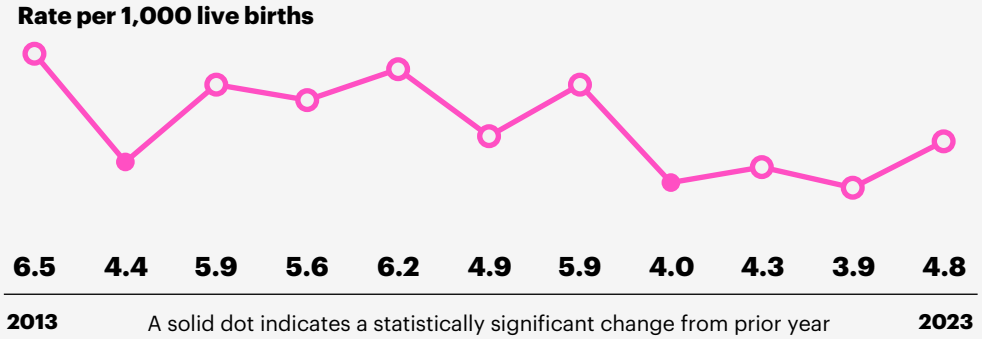
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 47 babies died before their first birthday

INFANT MORTALITY RATE **4.8**

US RATE **5.6**

RI RANK **14**

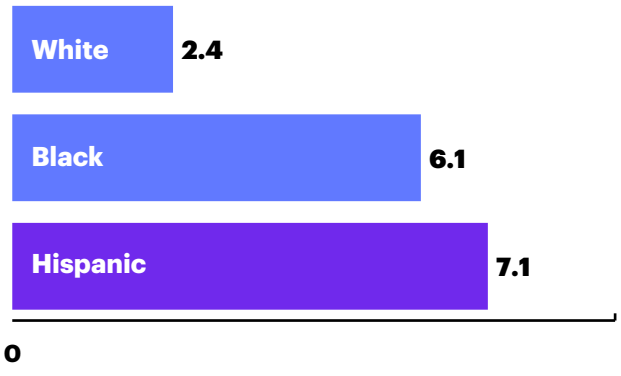


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Hispanic moms is 1.5x the state rate

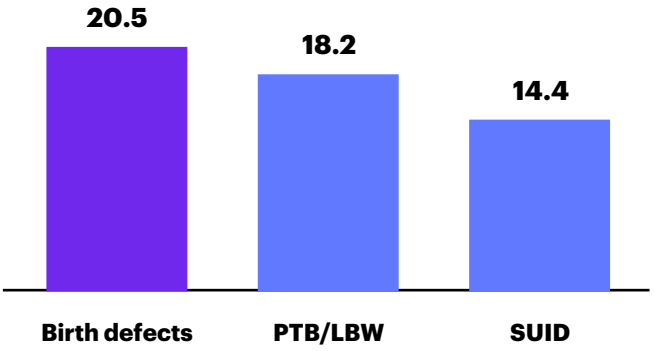
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 47.0% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Rhode Island

The rate of inadequate prenatal care among babies born to American Indian/Alaska Native moms is 2.0x the state rate

6.6
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

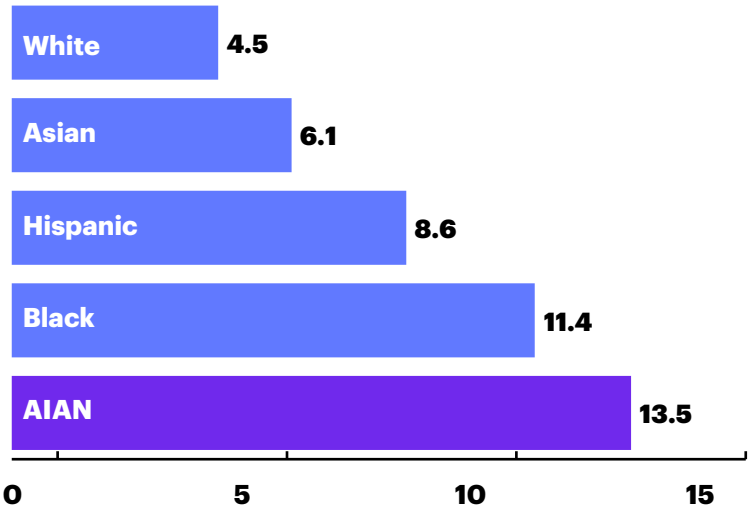
85.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Rhode Island

28.5
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

109.4
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

19.7
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.0%	4.8	28.5%	87.6%	109.4	19.7
Rank	5th of 52	14th of 52	43rd of 52	1st of 52	40th of 47	13th of 48
Direction†	Improved	Worsened	Worsened	Improved†	Improved	N/A
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Rhode Island

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Rhode Island

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Rhode Island's Medicaid program, Rhode Island Medicaid, covered 4,186 births in 2024

41.9

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
South Carolina

Scan for more data

6,844 babies were born preterm in South Carolina in 2024. South Carolina ranks 43rd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.6%.

South Carolina is among the top twenty states with the highest rates of adequate prenatal care reception.

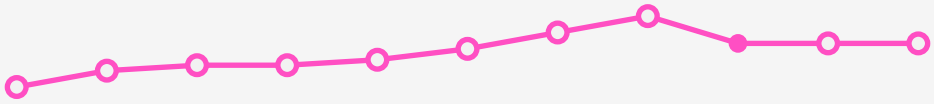
South Carolina is currently implementing two of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in South Carolina was 11.6% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **F**

US RATE	SC RATE	SC RANK
10.4	11.6	43

Percentage of live births born preterm



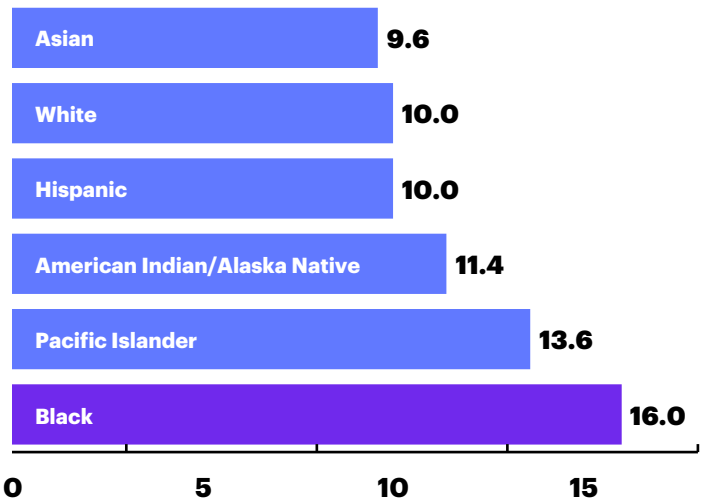
2014										2024
10.8	11.1	11.2	11.2	11.3	11.5	11.8	12.1	11.6	11.6	11.6

A solid dot indicates a statistically significant change from prior year

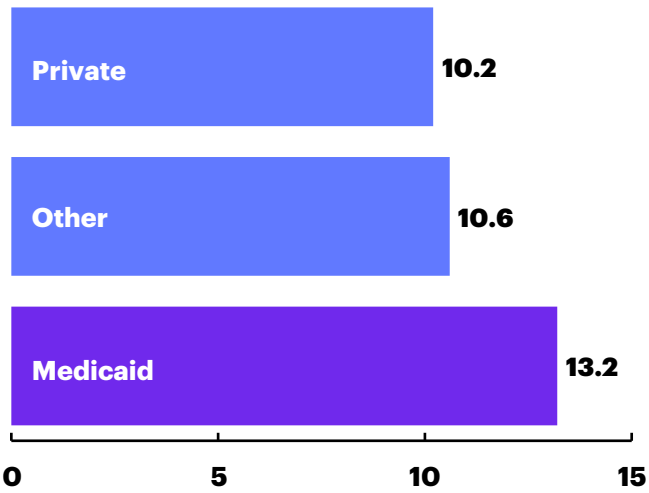
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



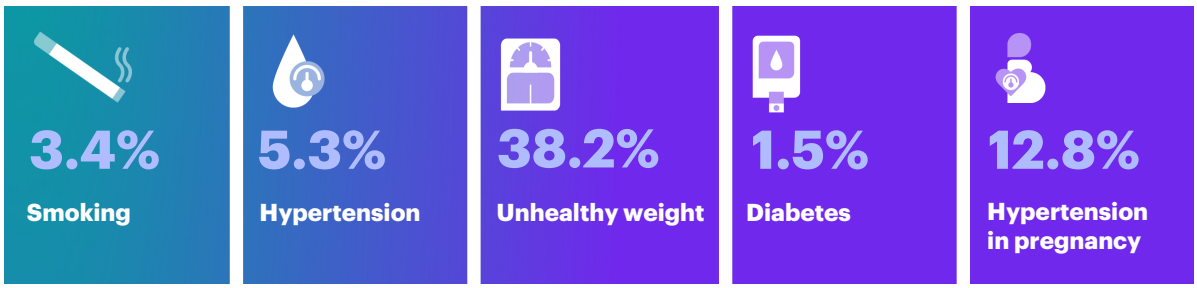
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 10.1%; Tricare: 10.3%; Indian Health Service: N/A; and all other types: 12.1%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

South Carolina

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



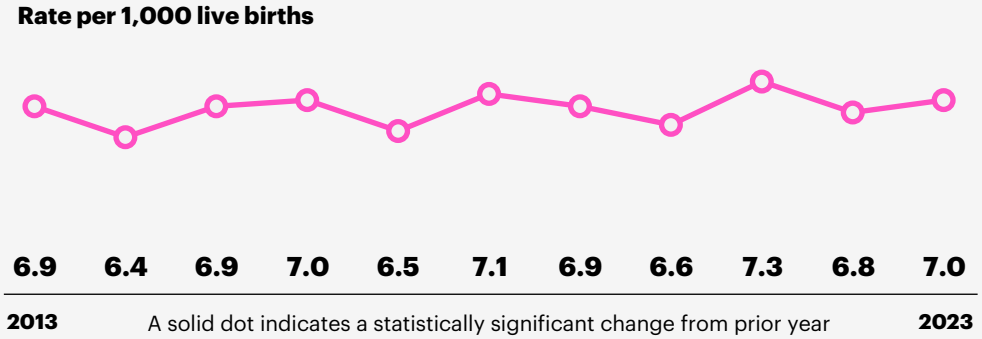
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 402 babies died before their first birthday

INFANT MORTALITY RATE **7.0**

US RATE 5.6

SC RANK 43

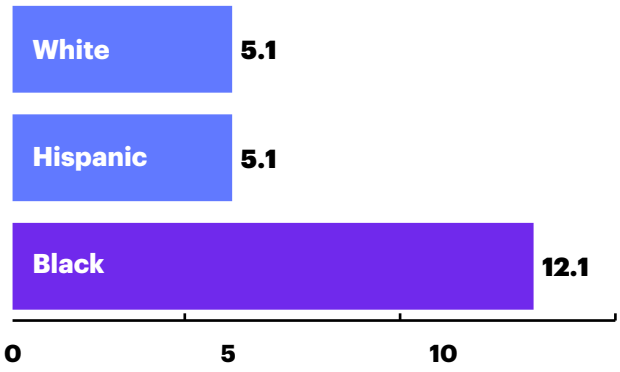


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.7x the state rate

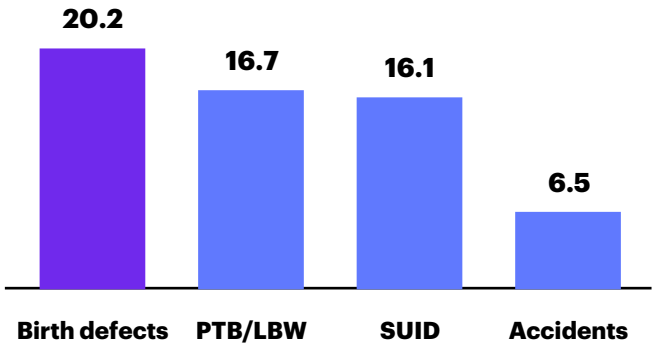
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.5% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

South Carolina

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.3x the state rate

16.5
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

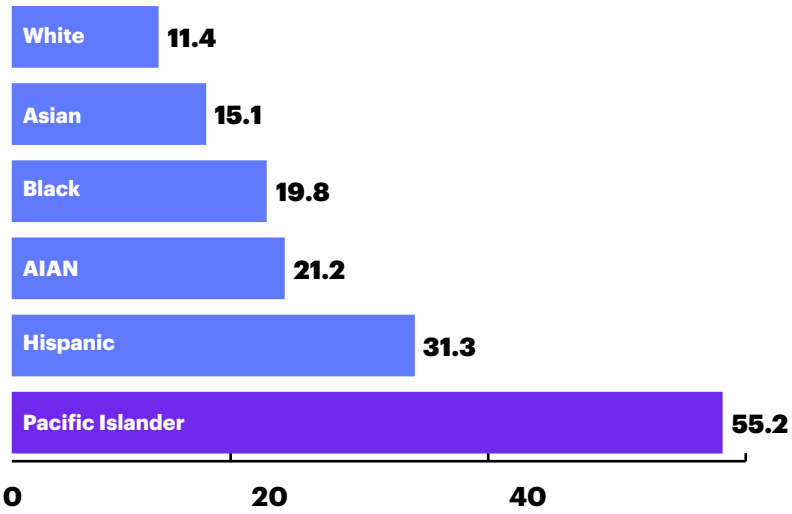
74.5
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in South Carolina

25.6
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

85.9
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

31.5
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.6%	7.0	25.6%	79.4%	85.9	31.5
Rank	43rd of 52	43rd of 52	24th of 52	16th of 52	21st of 47	40th of 48
Direction†	No change	Worsened	Worsened	Worsened	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

South Carolina

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in South Carolina

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

South Carolina's Medicaid program, South Carolina Healthy Connections, covered 25,310 births in 2024

43.1

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
South Dakota

Scan for more data

1,282 babies were born preterm in South Dakota in 2024. South Dakota ranks 42nd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.2%.

South Dakota is among the top ten best states with the lowest rates of low-risk Cesarean births and severe maternal morbidity.

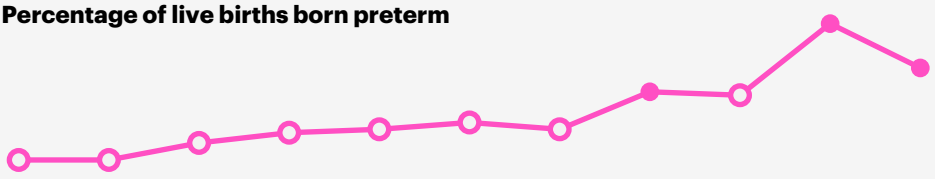
South Dakota is currently implementing four of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in South Dakota was 11.2% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **D-**

US RATE	SD RATE	SD RANK
10.4	11.2	42

Percentage of live births born preterm



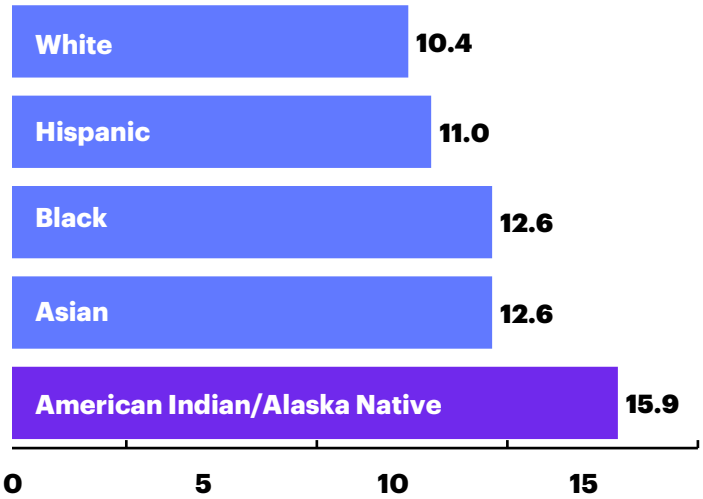
2014										2024
8.5	8.5	9.0	9.3	9.4	9.6	9.4	10.5	10.4	12.5	11.2

A solid dot indicates a statistically significant change from prior year

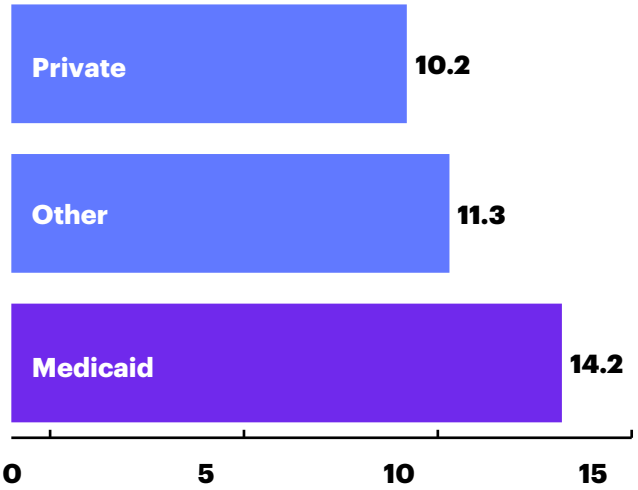
Note: The change in 2024 was a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



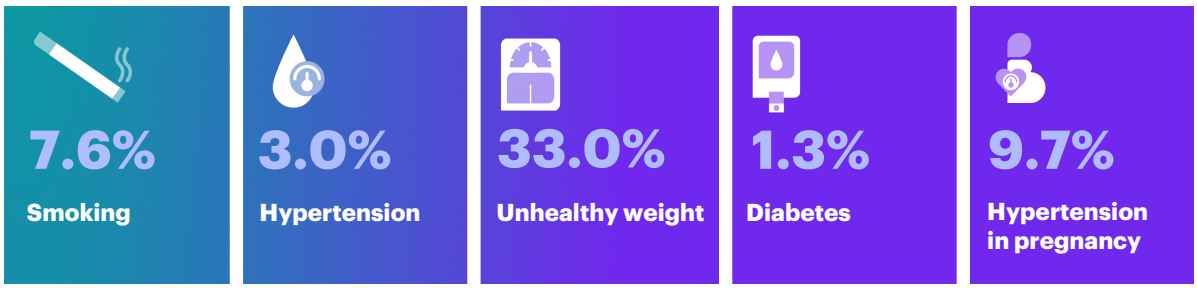
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 8.9%; Tricare: 11.4%; Indian Health Service: 14.9%; and all other types: 17.4%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

South Dakota

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



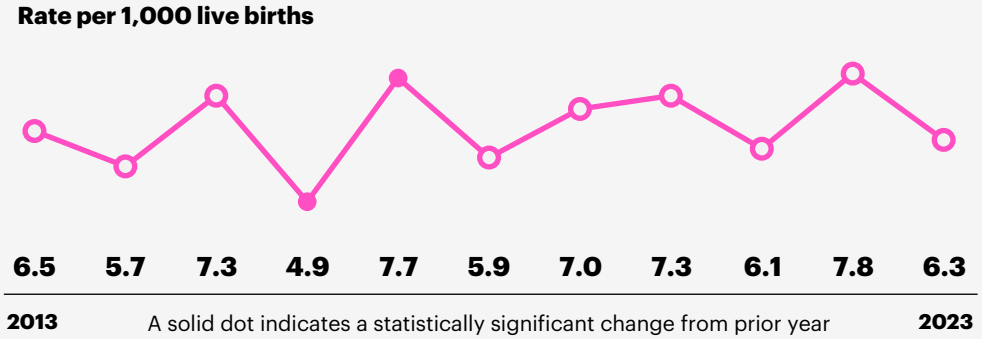
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 71 babies died before their first birthday

INFANT MORTALITY RATE **6.3**

US RATE **5.6**

SD RANK **36**

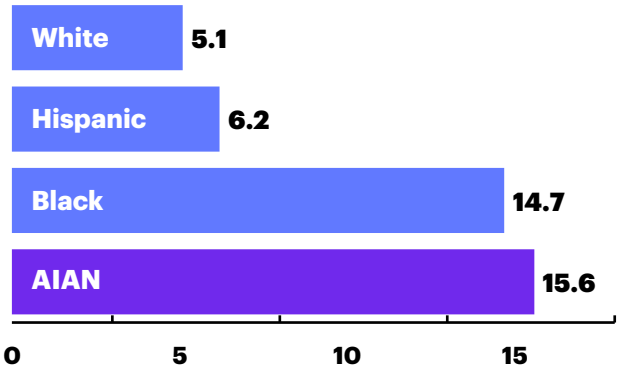


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to American Indian/Alaska Native moms is 2.5x the state rate

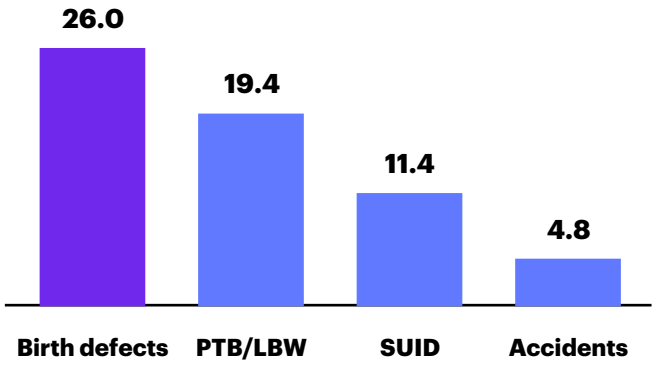
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 38.3% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

South Dakota

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.2x the state rate

17.0
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

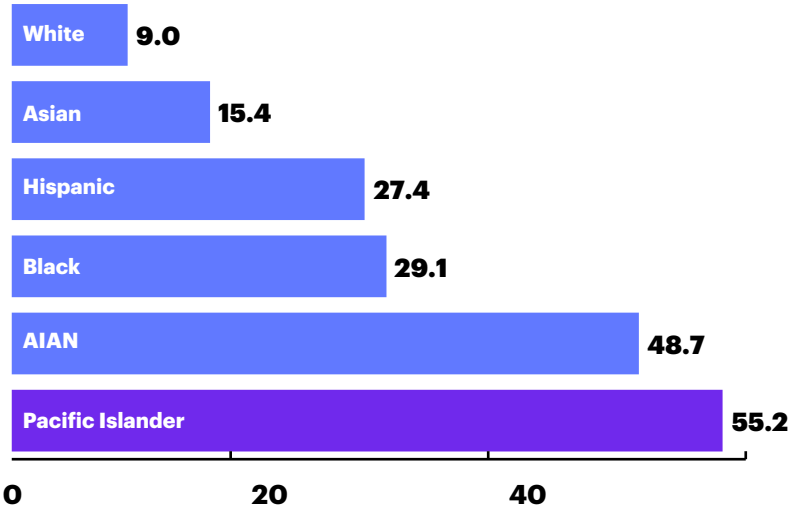
76.2
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in South Dakota

17.9
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

44.9
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

23.1
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.2%	6.3	17.9%	76.6%	44.9	23.1
Rank	42nd of 52	36th of 52	1st of 52	32nd of 52	2nd of 47	21st of 48
Direction†	Improved†	Improved	Improved	Improved	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

South Dakota

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in South Dakota

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

South Dakota's Medicaid program, South Dakota Medicaid, covered 2,800 births in 2024

24.5

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Tennessee

Scan for more data

9,127 babies were born preterm in Tennessee in 2024. Tennessee ranks 34th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.9%.

Tennessee has made significant improvement in low-risk Cesarean births and adequate prenatal care reception since last year.

Tennessee is currently implementing two of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Tennessee was 10.9% in 2024, lower than the rate in 2023

PRETERM BIRTH GRADE **D**

US RATE	TN RATE	TN RANK
10.4	10.9	34

Percentage of live births born preterm

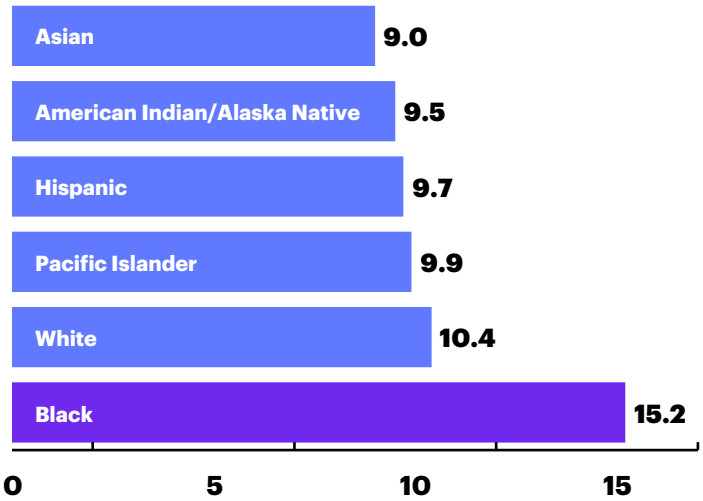
2014										2024
10.8	11.0	11.3	11.1	11.1	11.2	10.9	11.3	11.0	11.3	10.9

A solid dot indicates a statistically significant change from prior year

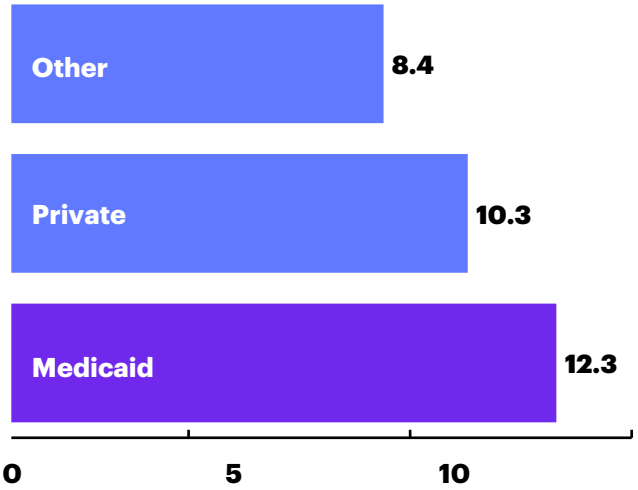
Note: The change in 2024 was a statistically significant ($P<0.05$) decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



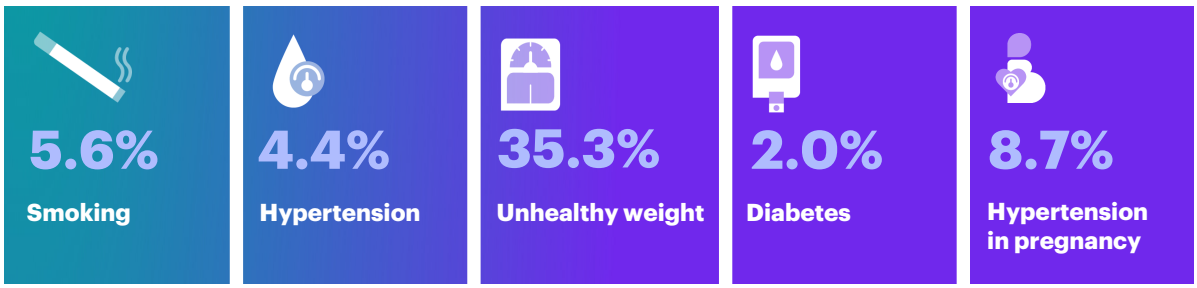
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.9%; Tricare: 9.4%; Indian Health Service: N/A; and all other types: 12.2%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Tennessee

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



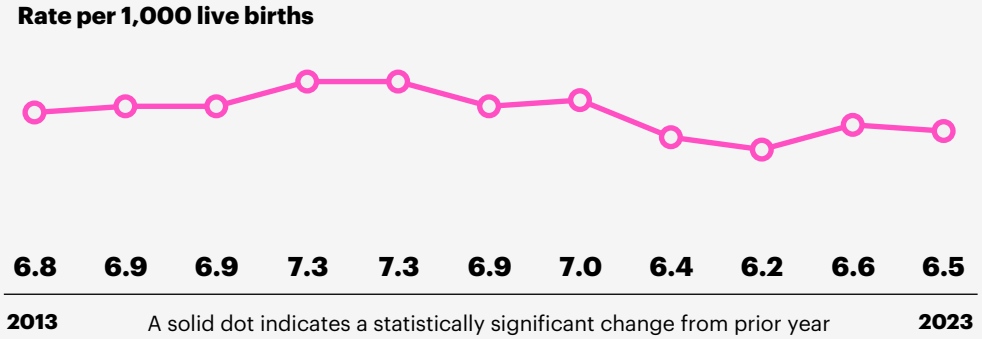
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 538 babies died before their first birthday

INFANT MORTALITY RATE **6.5**

US RATE **5.6**

TN RANK **38**

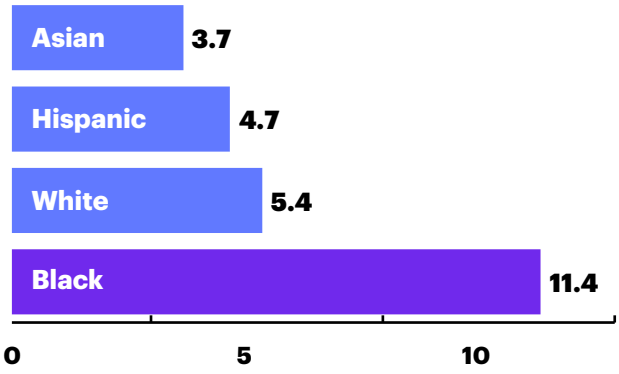


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.8x the state rate

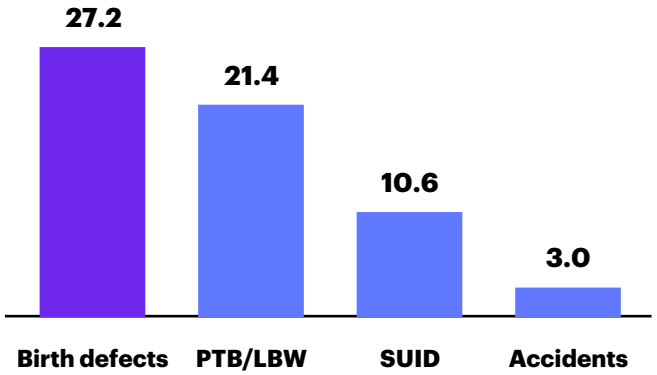
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 37.9% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Tennessee

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 3.0x the state rate

17.7 PERCENT — 16.1

INADEQUATE PRENATAL CARE

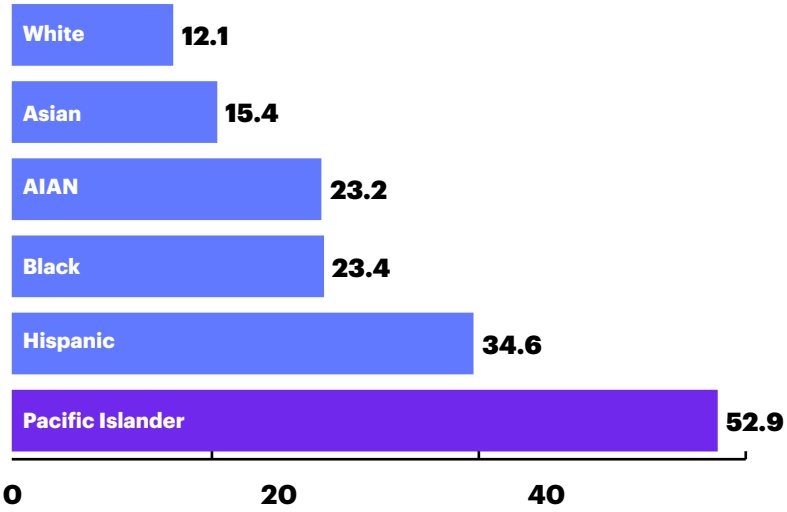
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

73.2 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Tennessee

25.7 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

91.3 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

42.1 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.9%	6.5	25.7%	74.3%	91.3	42.1
Rank	34th of 52	38th of 52	25th of 52	37th of 52	25th of 47	48th of 48
Direction†	Improved†	Improved	Improved†	Improved†	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Tennessee

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Tennessee

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

Tennessee's Medicaid program, TennCare, covered 38,766 births in 2024

46.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Texas

Scan for more data

43,344 babies were born preterm in Texas in 2024. Texas ranks 40th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 11.1%.

Texas is among the top twenty states with the lowest rates of severe maternal morbidity.

Texas is currently implementing two of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Texas was 11.1% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **D**

US RATE	TX RATE	TX RANK
10.4	11.1	40

Percentage of live births born preterm

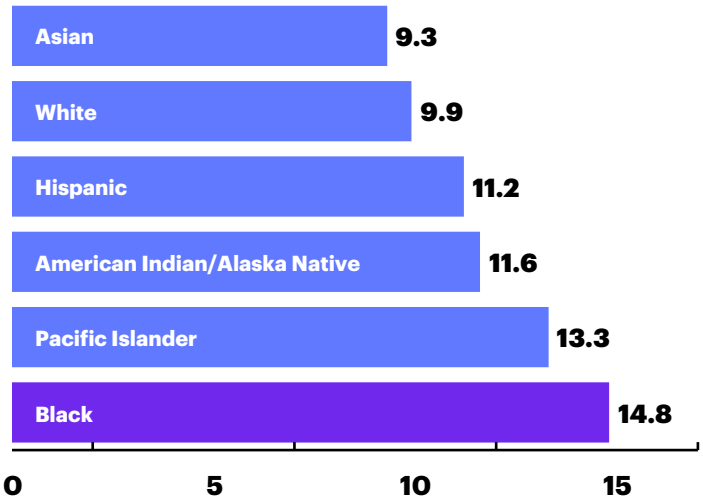
2014										2024
10.3	10.2	10.4	10.6	10.8	11.0	10.8	11.4	11.3	11.1	11.1

A solid dot indicates a statistically significant change from prior year

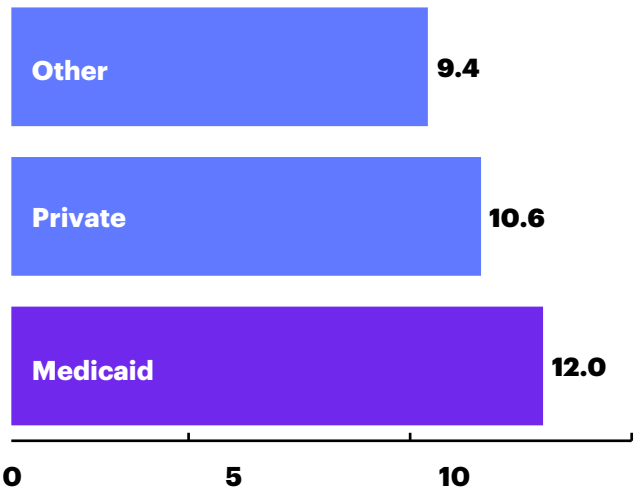
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



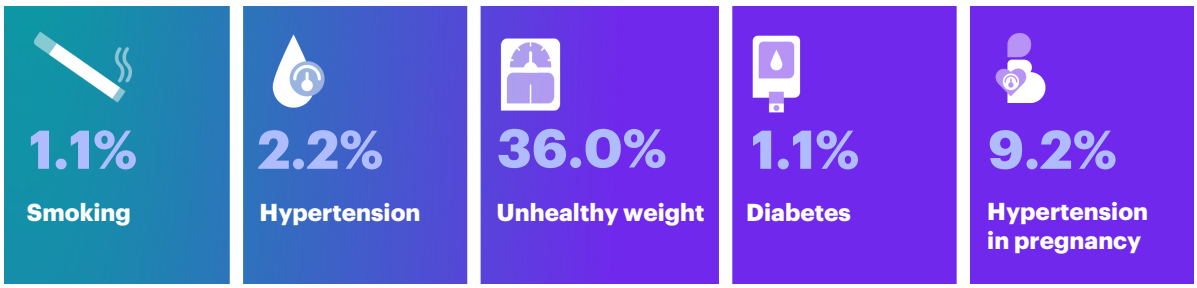
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 9.1%; Tricare: 13.9%; Indian Health Service: N/A; and all other types: 12.5%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Texas

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



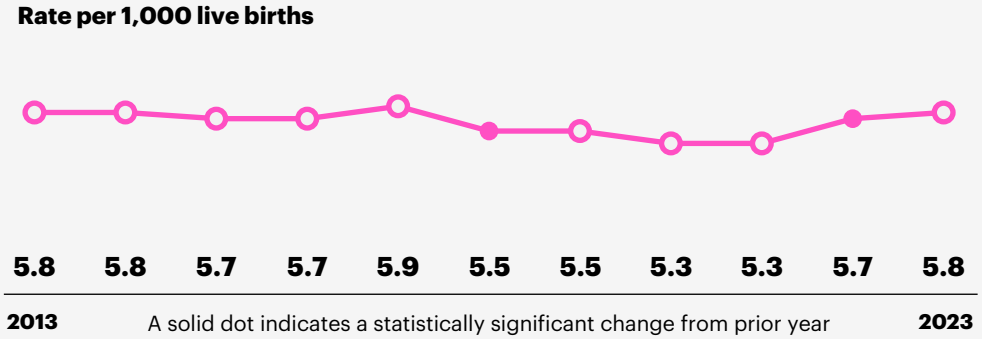
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate did not improve in the last decade; in 2023, 2,263 babies died before their first birthday

INFANT MORTALITY RATE **5.8**

US RATE 5.6

TX RANK 27

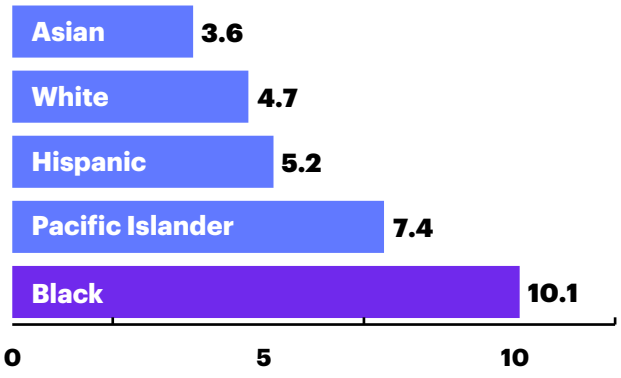


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 1.7x the state rate

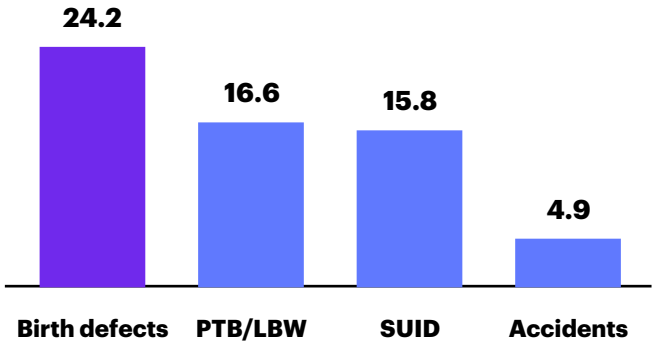
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 38.5% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Texas

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 1.7x the state rate

22.8 PERCENT — 16.1

INADEQUATE PRENATAL CARE

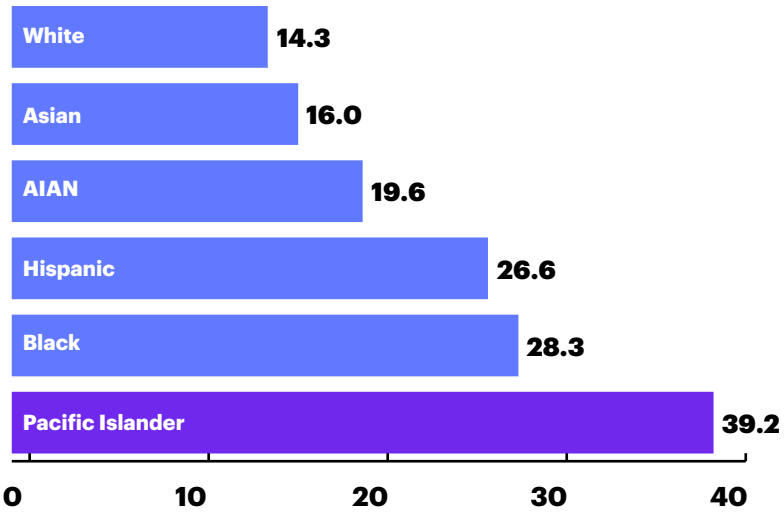
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

66.5 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Texas

27.9 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

79.8 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

29.3 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	11.1%	5.8	27.9%	67.7%	79.8	29.3
Rank	40th of 52	27th of 52	37th of 52	48th of 52	16th of 47	34th of 48
Direction†	No change	Worsened	Worsened	Worsened†	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Texas

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Texas

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Texas' Medicaid program, STAR, covered 175,110 births in 2024

45.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

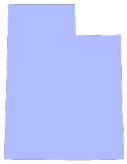
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: STAR also includes STAR Kids and STAR health. See **Policy and Program Booklet** for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Utah

Scan for more data



4,444 babies were born preterm in Utah in 2024. Utah ranks 12th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.5%.

Utah is among the top ten best states with the lowest rates of low-risk Cesarean births, severe maternal morbidity, and maternal mortality.

Utah is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Utah was 9.5% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE C+

US RATE	UT RATE	UT RANK
10.4	9.5	12

Percentage of live births born preterm

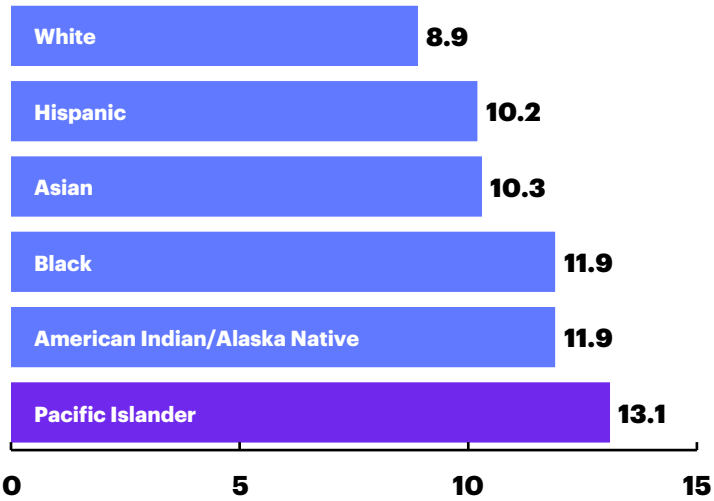
2014										2024
9.1	9.3	9.6	9.4	9.4	9.7	9.3	9.9	9.4	9.4	9.5

A solid dot indicates a statistically significant change from prior year

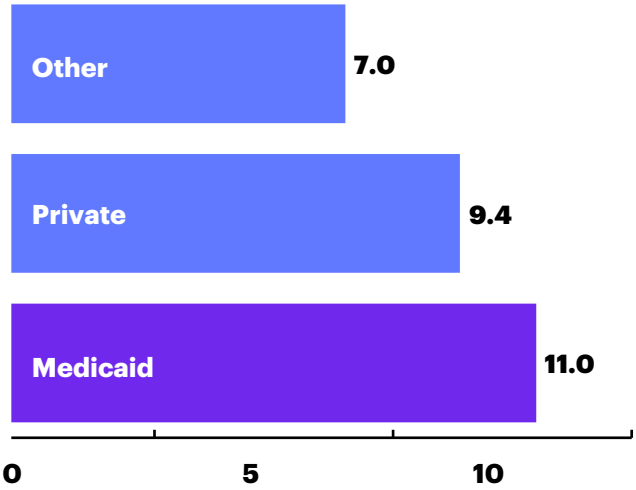
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



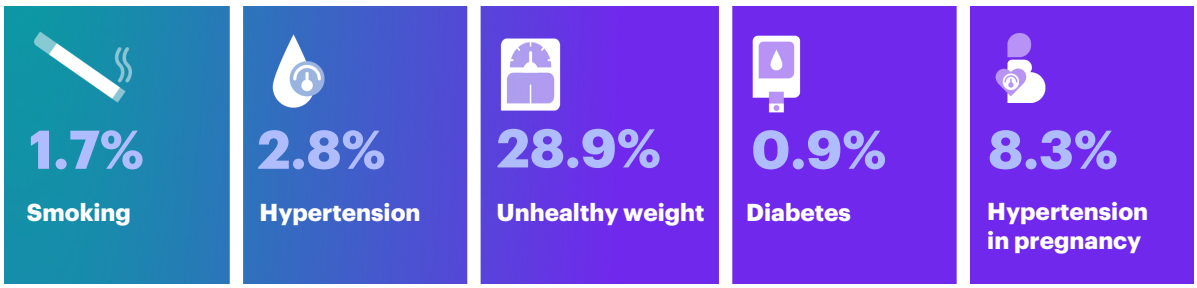
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.1%; Tricare: 8.9%; Indian Health Service: N/A; and all other types: 11.6%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Utah

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



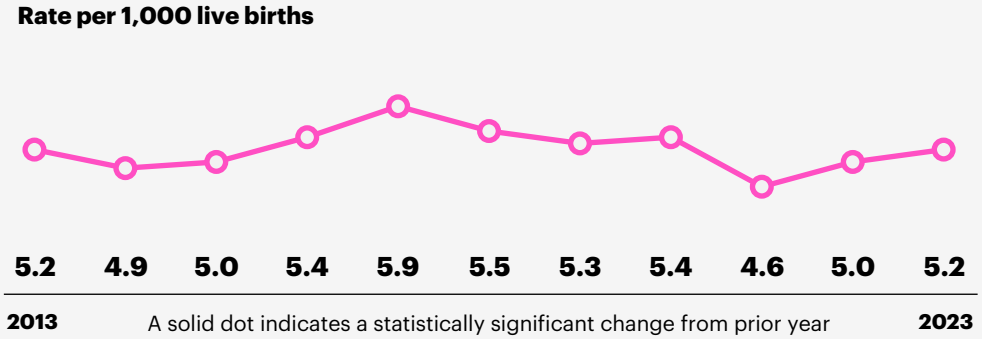
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate did not improve in the last decade; in 2023, 235 babies died before their first birthday

INFANT MORTALITY RATE **5.2**

US RATE **5.6**

UT RANK **19**

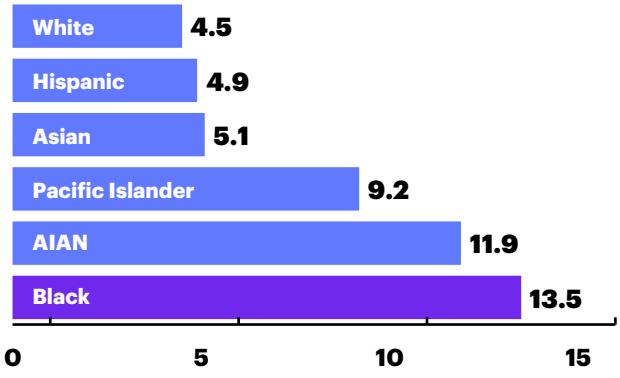


Note: The change in 2023 was not a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Black moms is 2.6x the state rate

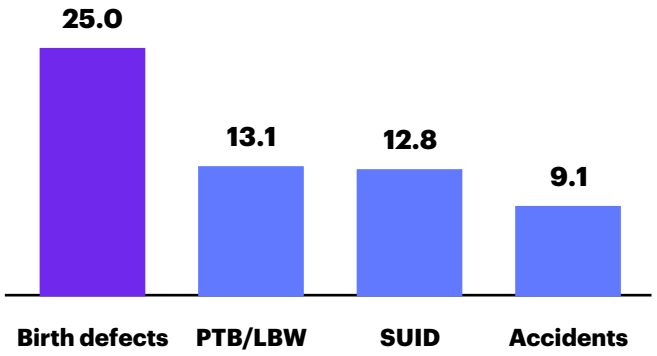
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 39.9% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Utah

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.7x the state rate

13.3
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

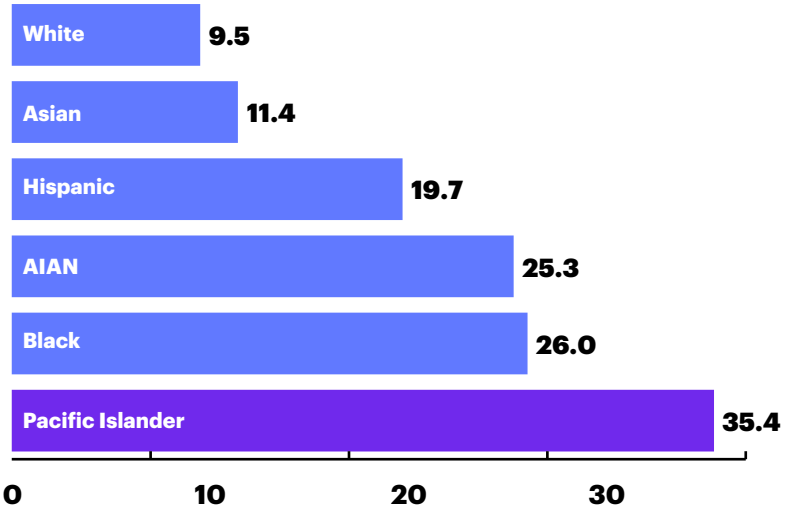
78.5
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Utah

20.6
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

60.0
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

16.1
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.5%	5.2	20.6%	79.0%	60.0	16.1
Rank	12th of 52	19th of 52	5th of 52	19th of 52	3rd of 47	4th of 48
Direction†	Worsened	Worsened	Worsened	Worsened†	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Utah

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Utah

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Utah's Medicaid program, Utah Medicaid, covered 7,831 births in 2024

16.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Vermont

Scan for more data

411 babies were born preterm in Vermont in 2024. Vermont ranks 2nd of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 8.2%.

Vermont has made significant improvement in low-risk Cesarean births since last year.

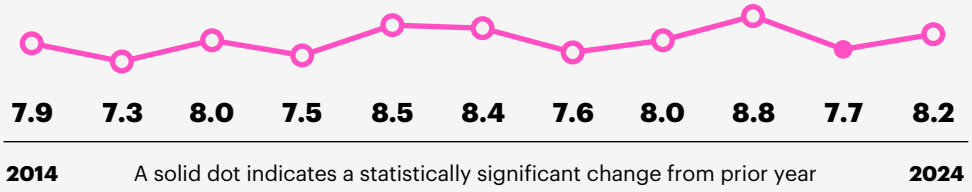
Vermont is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Vermont was 8.2% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **B+**

US RATE	VT RATE	VT RANK
10.4	8.2	2

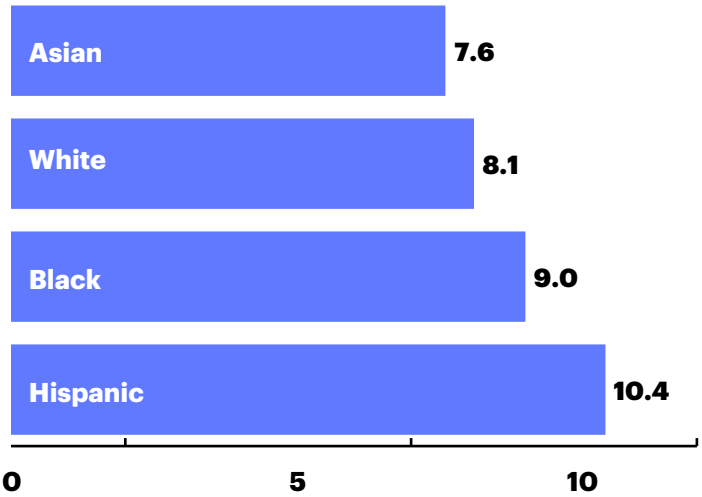
Percentage of live births born preterm



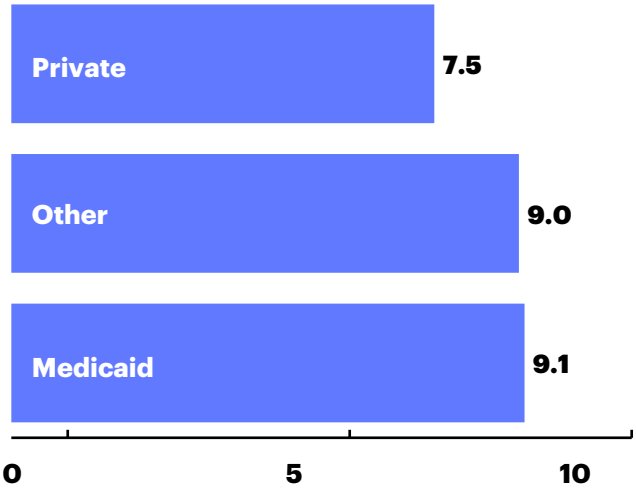
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



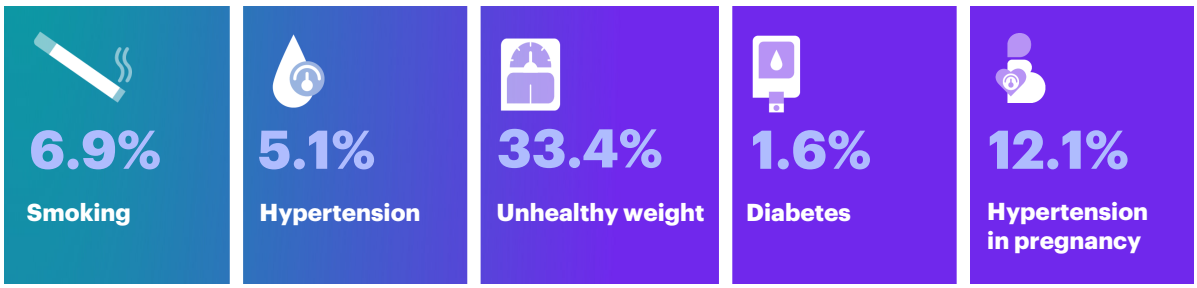
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.9%; Tricare: N/A; Indian Health Service: N/A; and all other types: 10.7%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Vermont

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



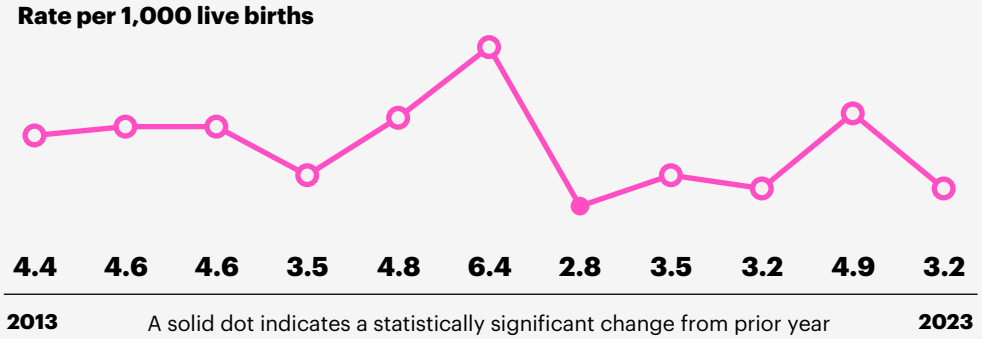
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 16 babies died before their first birthday

INFANT MORTALITY RATE **3.2**

US RATE 5.6

VT RANK 2

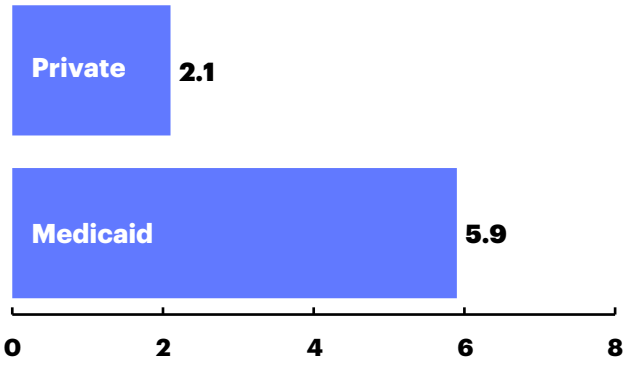


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

Birth defects were the leading underlying cause of infant death, accounting for one in five infant deaths in Vermont

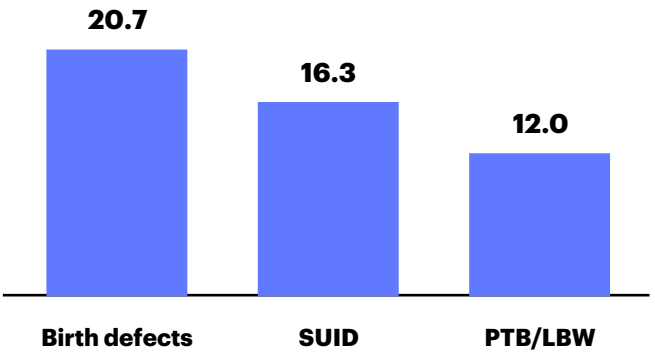
Infant mortality rate by insurance type

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2019-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 51.0% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Vermont

The rate of inadequate prenatal care among babies born to Black moms is 2.7x the state rate

7.0
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

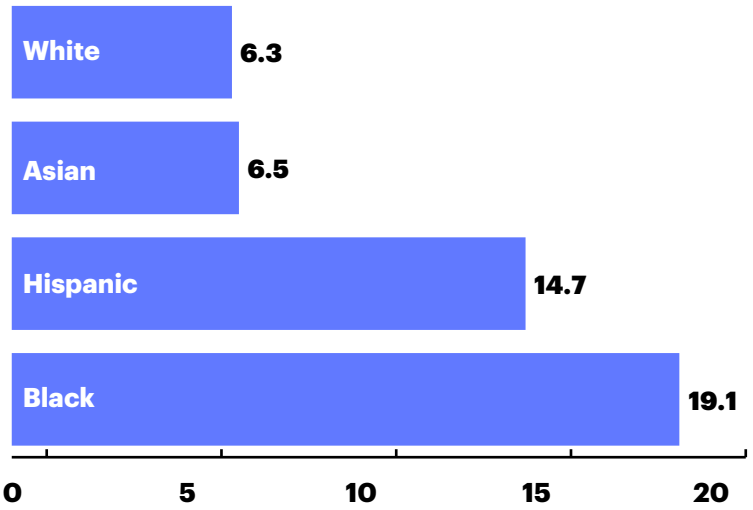
87.8
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Vermont

20.6
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

137.0
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

N/A
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

The maternal mortality rate cannot be shown due to unreliable estimates and concerns with confidentiality.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	8.2%	3.2	20.6%	86.8%	137.0	N/A
Rank	2nd of 52	2nd of 52	5th of 52	3rd of 52	47th of 47	N/A
Direction†	Worsened	Improved	Improved†	Worsened	Worsened	N/A
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Vermont

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Vermont

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Vermont's Medicaid program, Green Mountain Care, covered 1,845 births in 2024

36.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

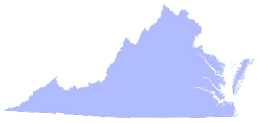
- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Virginia

Scan for more data



9,467 babies were born preterm in Virginia in 2024. Virginia ranks 24th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.1%.

Virginia is among the top twenty states with the lowest rates of severe maternal morbidity and adequate prenatal care reception.

Virginia is currently implementing four of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Virginia was 10.1% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **C-**

US RATE	VA RATE	VA RANK
10.4	10.1	24

Percentage of live births born preterm

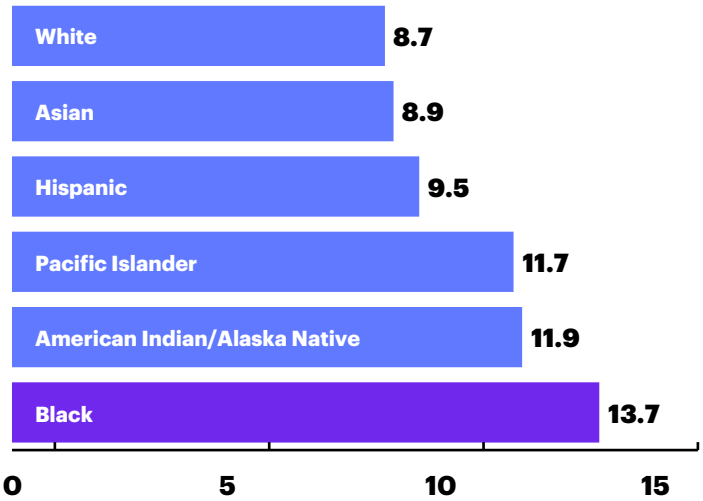
2014										2024
9.2	9.2	9.6	9.5	9.4	9.9	9.6	9.9	9.7	9.8	10.1

A solid dot indicates a statistically significant change from prior year

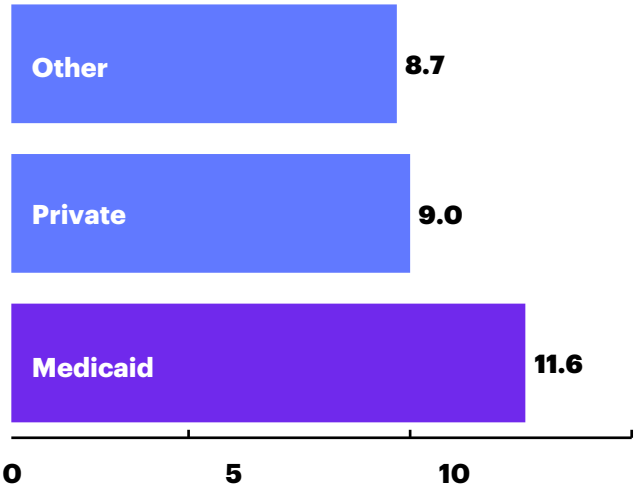
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



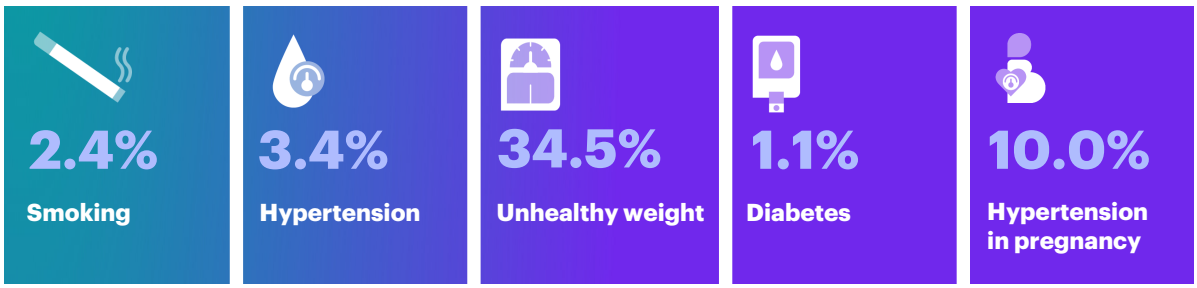
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 7.7%; Tricare: 8.8%; Indian Health Service: N/A; and all other types: 10.6%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Virginia

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



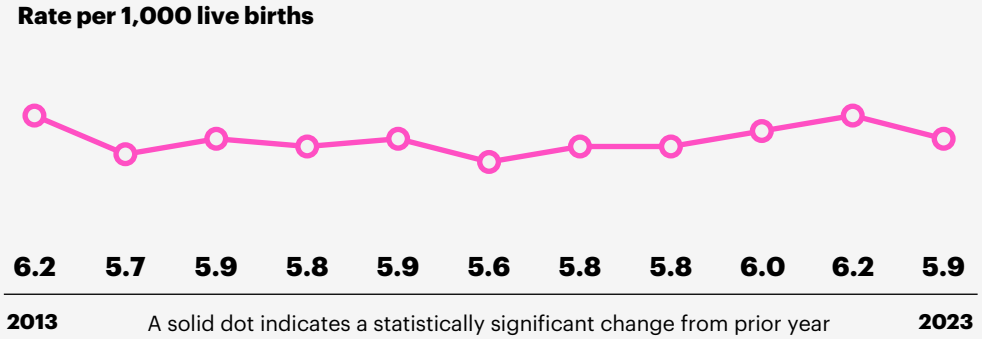
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 544 babies died before their first birthday

INFANT MORTALITY RATE **5.9**

US RATE **5.6**

VA RANK **30**

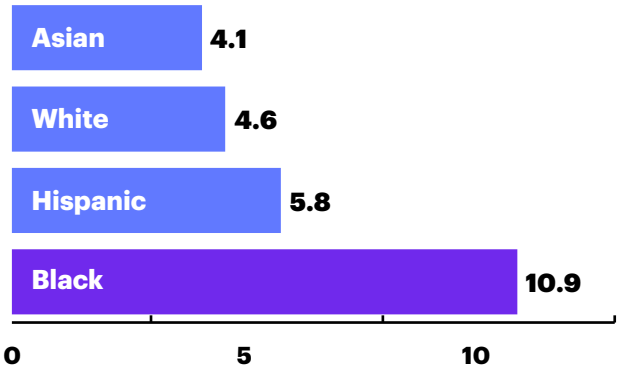


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 1.9x the state rate

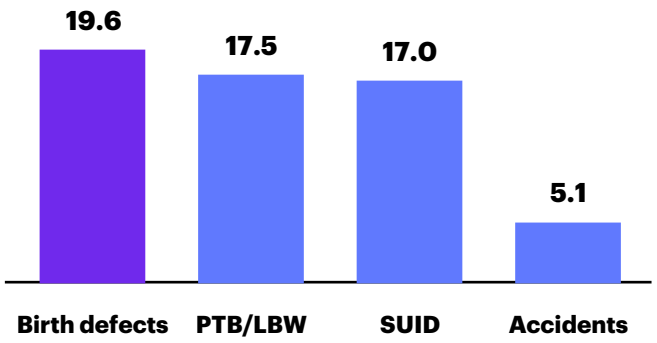
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.7% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Virginia

The rate of inadequate prenatal care among babies born to Hispanic moms is 1.9x the state rate

14.1
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

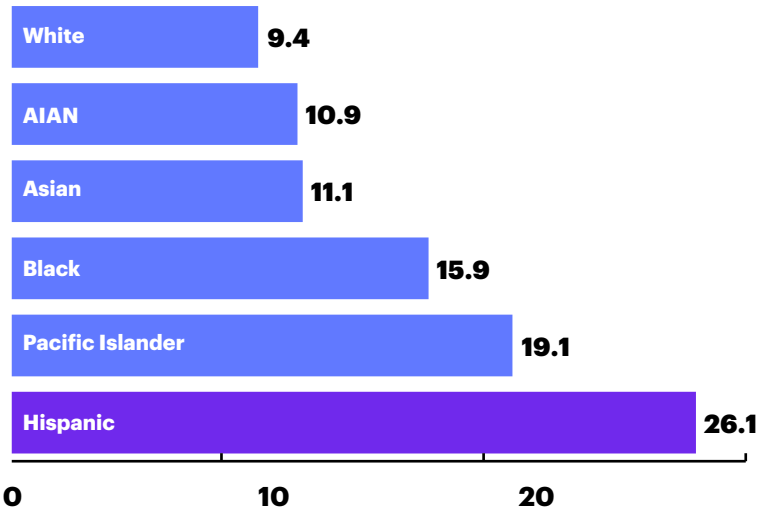
78.2
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Virginia

26.1
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

84.0
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

33.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.1%	5.9	26.1%	79.5%	84.0	33.4
Rank	24th of 52	30th of 52	27th of 52	15th of 52	20th of 47	42nd of 48
Direction†	Worsened	Improved	Improved	No change	Worsened	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Virginia

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Virginia

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Virginia's Medicaid program, Cardinal Care, covered 32,791 births in 2024

34.9

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Washington

Scan for more data

7,467 babies were born preterm in Washington in 2024. Washington ranks 5th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 9.0%.

Washington is among the top ten best states with the lowest rates of maternal mortality.

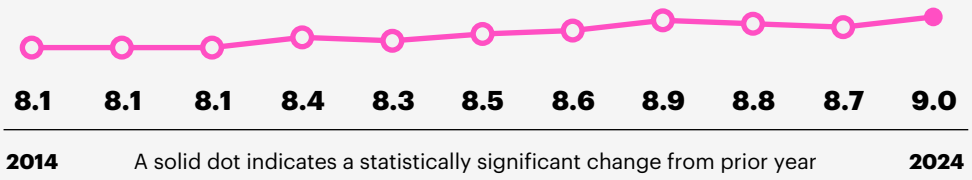
Washington is currently implementing six of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Washington was 9.0% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **B-**

US RATE	WA RATE	WA RANK
10.4	9.0	5

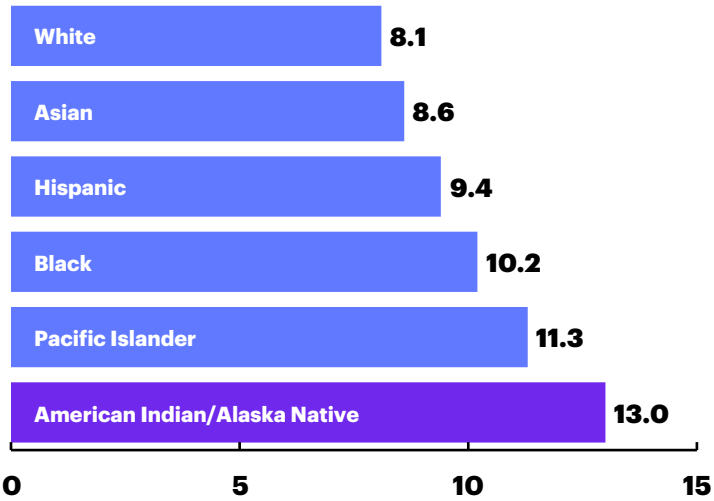
Percentage of live births born preterm



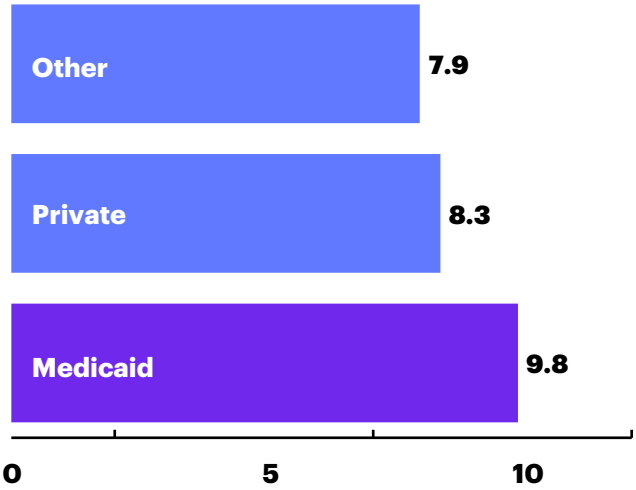
Note: The change in 2024 was a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



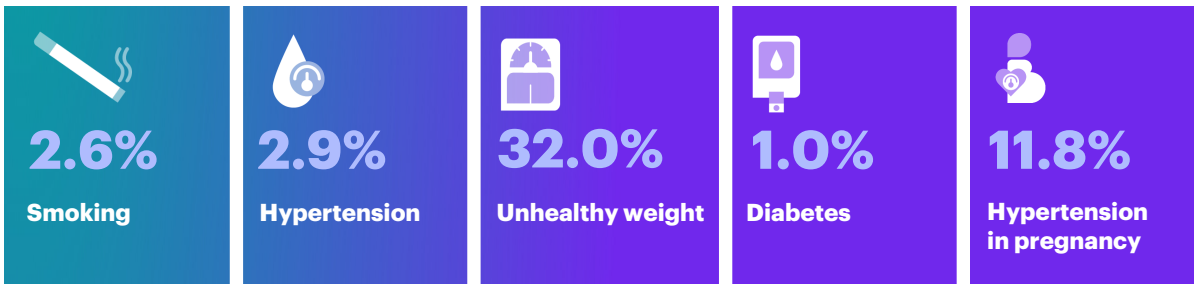
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 4.5%; Tricare: 8.1%; Indian Health Service: 15.1%; and all other types: 10.0%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Washington

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



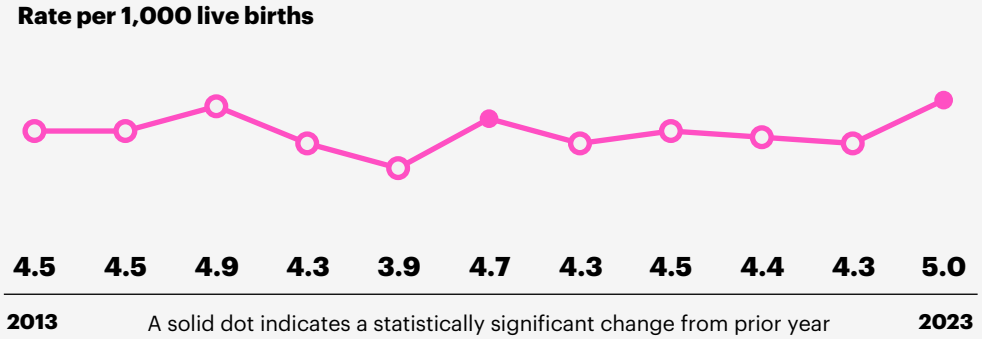
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate increased in the last decade; in 2023, 408 babies died before their first birthday

INFANT MORTALITY RATE **5.0**

US RATE **5.6**

WA RANK **17**

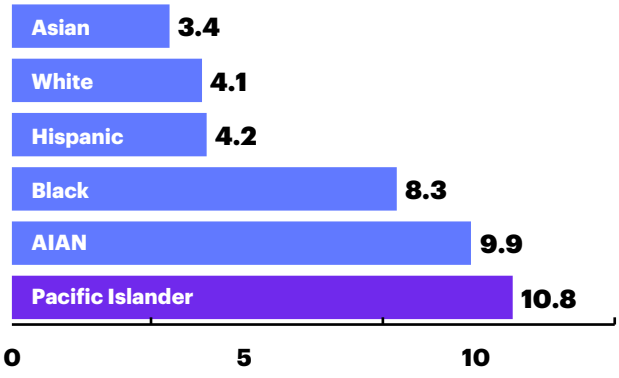


Note: The change in 2023 was a statistically significant increase compared to 2022.

The infant mortality rate among babies born to Pacific Islander moms is 2.1x the state rate

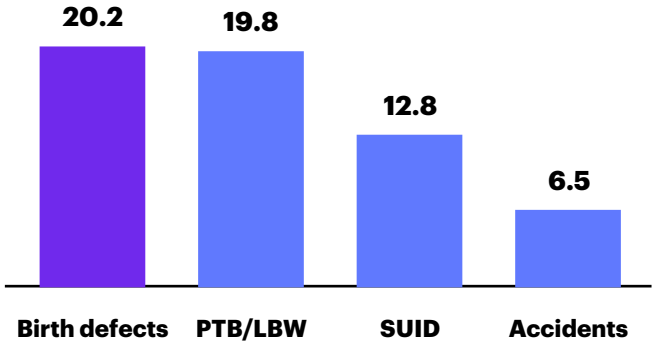
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.7% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Washington

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 2.7x the state rate

16.9
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

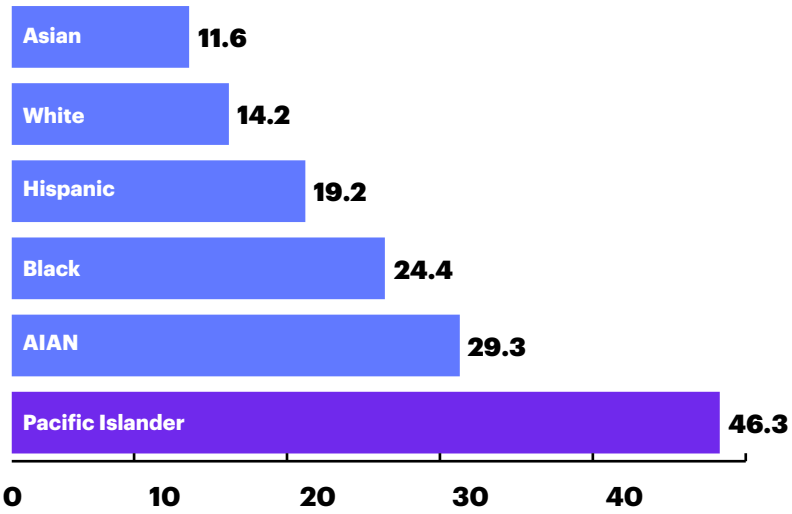
74.9
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Washington

26.3
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

100.0
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

17.3
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	9.0%	5.0	26.3%	71.0%	100.0	17.3
Rank	5th of 52	17th of 52	29th of 52	45th of 52	31st of 47	9th of 48
Direction†	Worsened†	Worsened†	Worsened	Worsened	Improved	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Washington

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Washington

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Washington's Medicaid program, Washington Apple Health, covered 28,830 births in 2024

35.7

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
West Virginia

Scan for more data

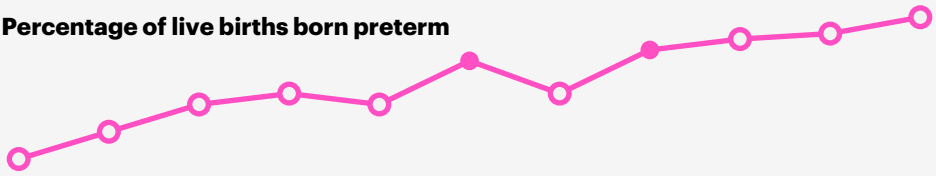
2,281 babies were born preterm in West Virginia in 2024. West Virginia ranks 50th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 13.4%.

West Virginia has made significant improvement in infant mortality since last year.

West Virginia is currently implementing three of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in West Virginia was 13.4% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **F**



US RATE	WV RATE	WV RANK
10.4	13.4	50

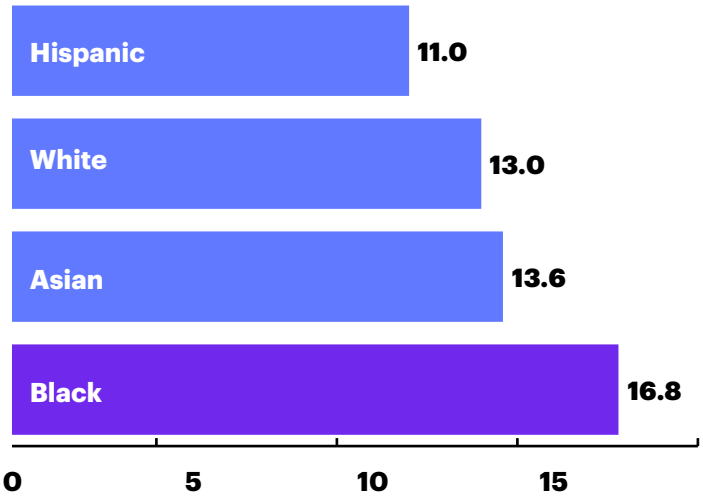
2014										2024
10.8	11.3	11.8	12.0	11.8	12.6	12.0	12.8	13.0	13.1	13.4

A solid dot indicates a statistically significant change from prior year

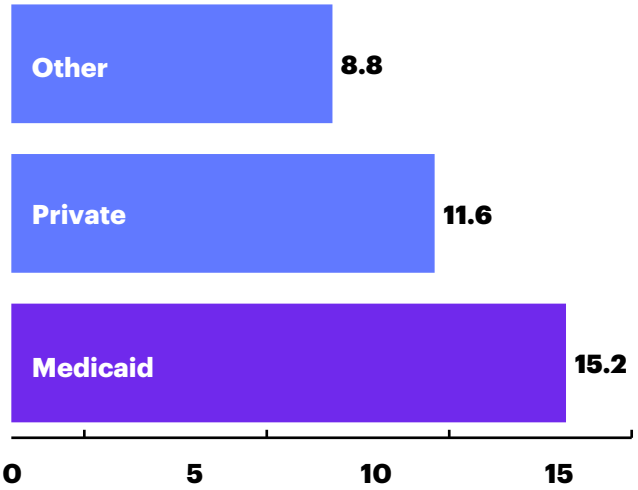
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



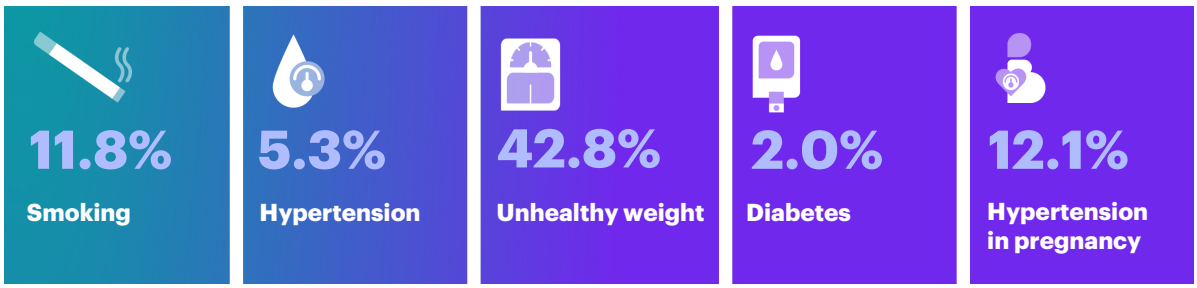
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 6.6%; Tricare: 9.5%; Indian Health Service: N/A; and all other types: 12.2%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

West Virginia

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



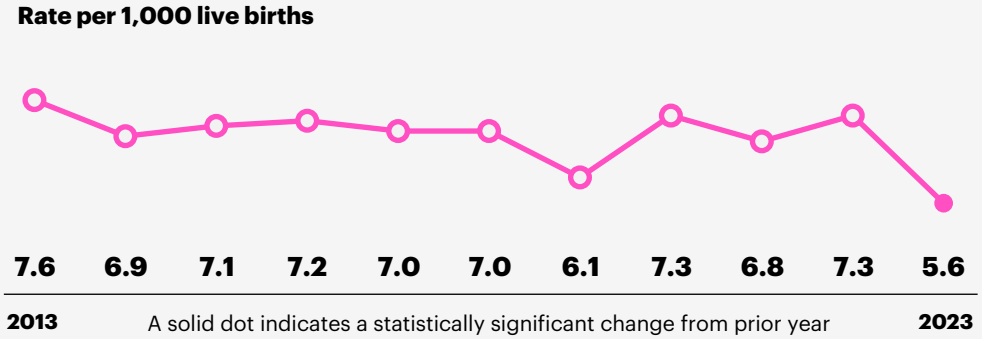
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 93 babies died before their first birthday

INFANT MORTALITY RATE **5.6**

US RATE **5.6**

WV RANK **24**

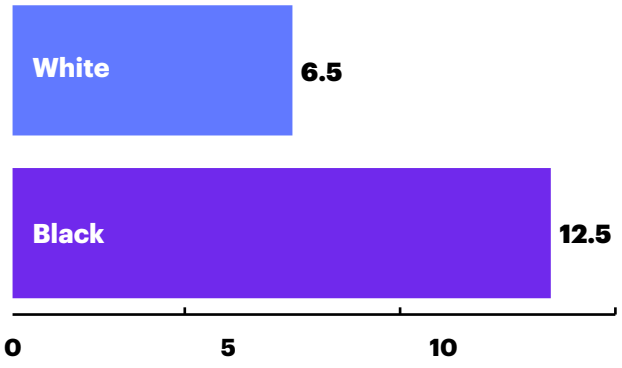


Note: The change in 2023 was a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 2.2x the state rate

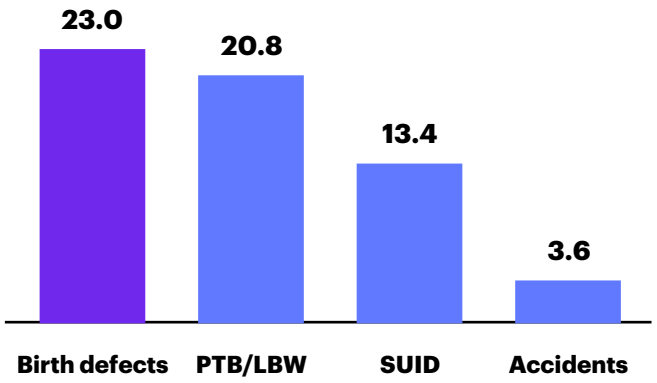
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 39.2% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

West Virginia

The rate of inadequate prenatal care among babies born to American Indian/Alaska Native moms is 3.5x the state rate

13.3 PERCENT — 16.1

INADEQUATE PRENATAL CARE

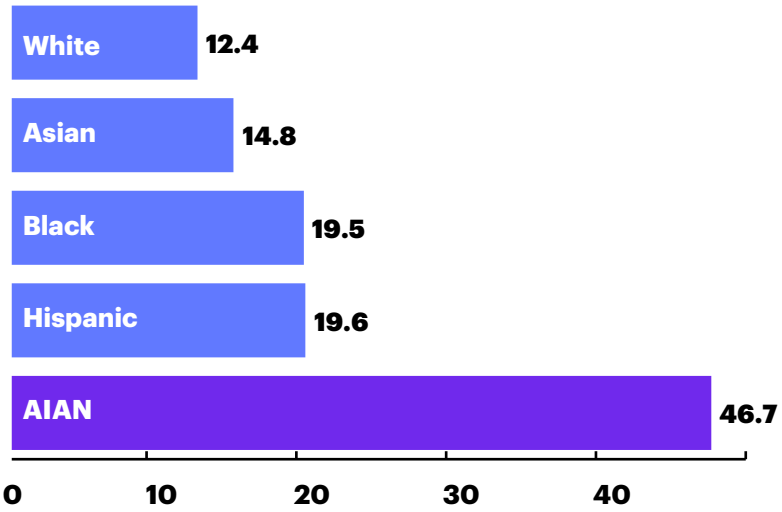
Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

80.0 PERCENT — 75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in West Virginia

29.4 PERCENT — 26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

93.7 PER 10,000 HOSPITAL DELIVERIES — 93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

24.4 PER 100,000 BIRTHS — 23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	13.4%	5.6	29.4%	81.8%	93.7	24.4
Rank	50th of 52	24th of 52	46th of 52	11th of 52	27th of 47	27th of 48
Direction†	Worsened	Improved†	Worsened	Worsened	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

West Virginia

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in West Virginia

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 State has the indicated program/policy

 State reimburses up to $1,500

 State is progressing legislation but not yet active

 State does not have the indicated program/policy

West Virginia's Medicaid program, West Virginia Medicaid, covered 7,319 births in 2024

43.5

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Wisconsin

Scan for more data

5,955 babies were born preterm in Wisconsin in 2024. Wisconsin ranks 21st of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.0%.

Wisconsin is among the top ten best states with the lowest rates of low-risk Cesarean births, severe maternal morbidity and maternal mortality, as well as the highest rates of adequate prenatal care reception.
Wisconsin is currently implementing one of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Wisconsin was 10.0% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **C**

US RATE	WI RATE	WI RANK
10.4	10.0	21

Percentage of live births born preterm

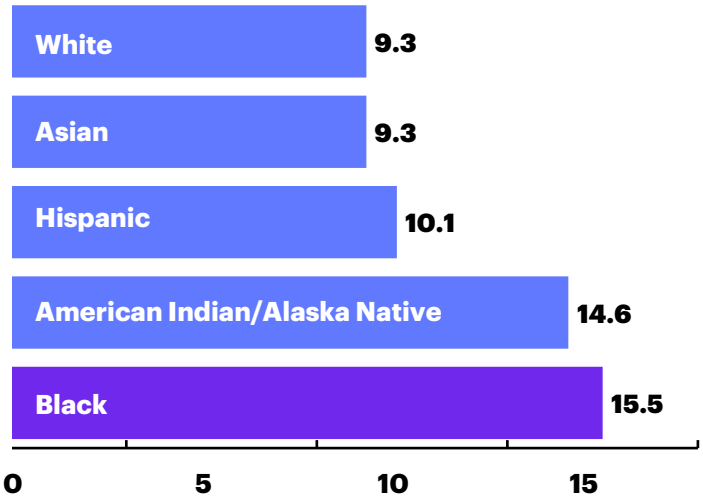
2014										2024
9.2	9.4	9.6	9.6	9.9	10.1	9.9	10.0	10.3	9.9	10.0

A solid dot indicates a statistically significant change from prior year

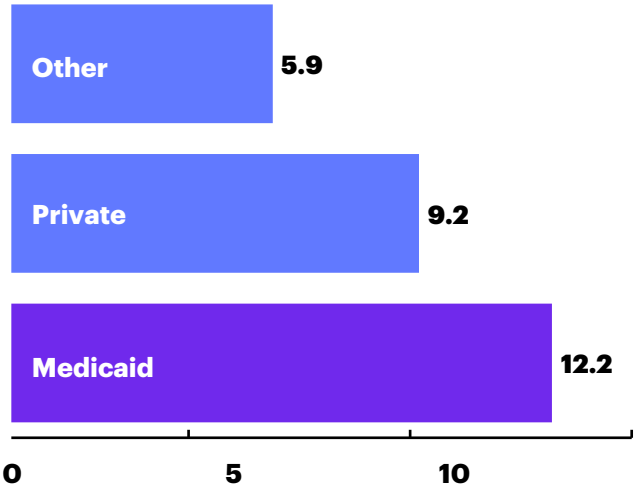
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



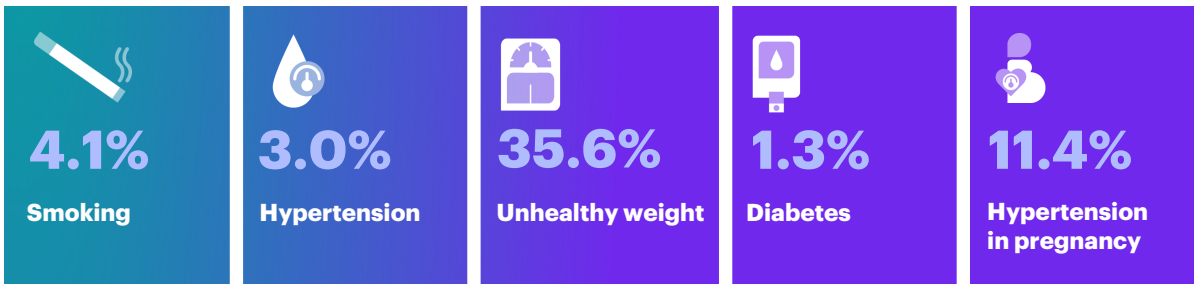
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 4.6%; Tricare: 8.3%; Indian Health Service: N/A; and all other types: 10.8%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Wisconsin

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



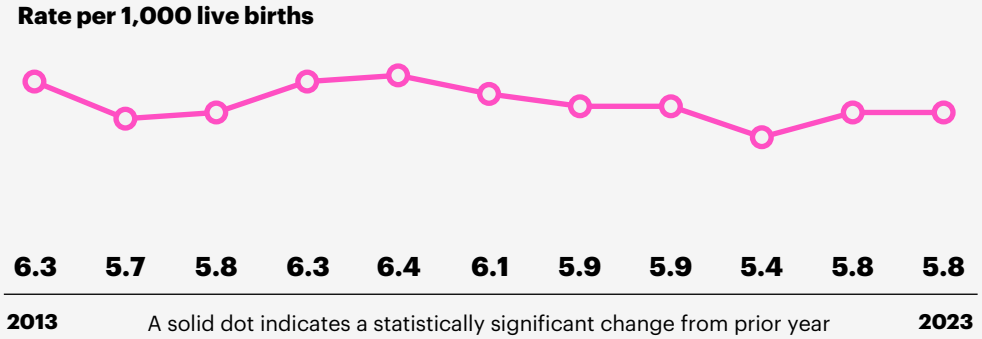
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 345 babies died before their first birthday

INFANT MORTALITY RATE **5.8**

US RATE **5.6**

WI RANK **27**

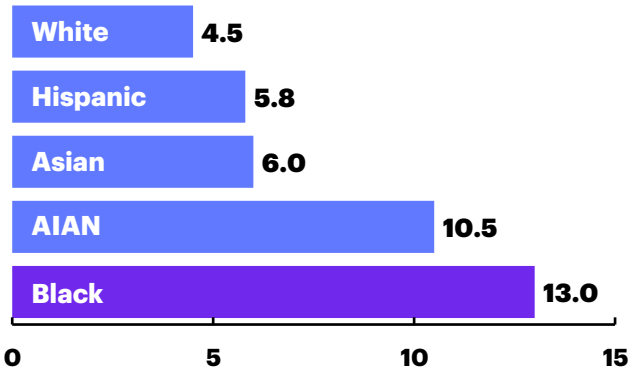


Note: The change in 2023 was not a statistically significant increase or decrease compared to 2022.

The infant mortality rate among babies born to Black moms is 2.3x the state rate

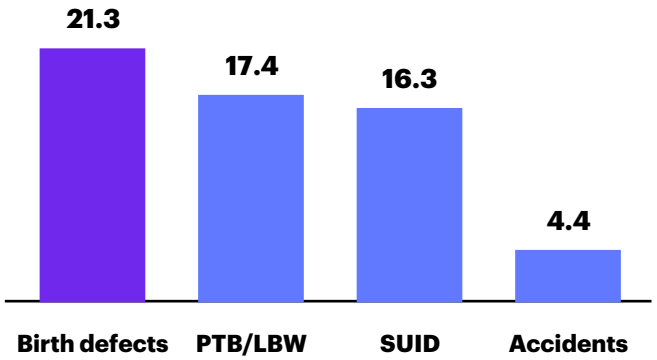
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 40.4% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Wisconsin

The rate of inadequate prenatal care among babies born to Pacific Islander moms is 4.5x the state rate

11.1
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

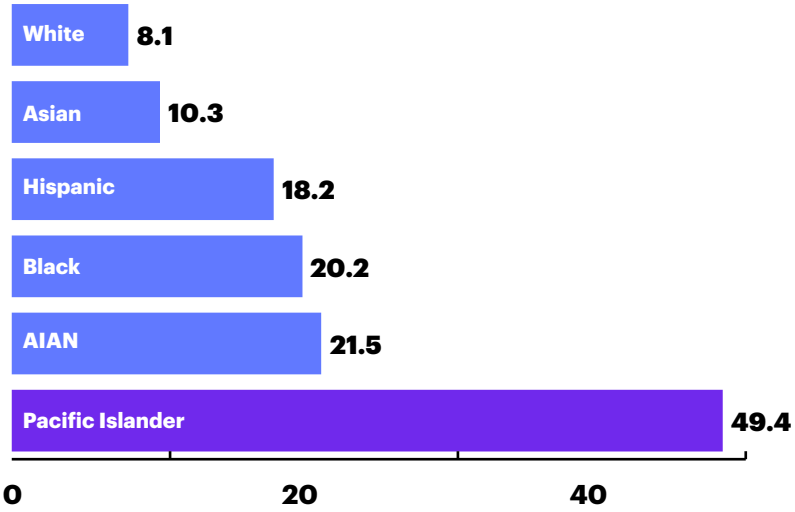
82.5
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Wisconsin

22.7
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

72.8
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

16.4
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.0%	5.8	22.7%	82.5%	72.8	16.4
Rank	21st of 52	27th of 52	10th of 52	9th of 52	10th of 47	6th of 48
Direction†	Worsened	No change	Worsened	Improved	Improved	Worsened
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Wisconsin

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Wisconsin

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

State has the indicated program/policy

State reimburses up to $1,500

State is progressing legislation but not yet active

State does not have the indicated program/policy

Wisconsin's Medicaid program, BadgerCare Plus / Wisconsin Medicaid, covered 20,192 births in 2024

34.2

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Wyoming

Scan for more data

639 babies were born preterm in Wyoming in 2024. Wyoming ranks 28th of 52 (includes all states, DC, and Puerto Rico) for preterm birth with a rate of 10.5%.

Wyoming has made significant improvement in adequate prenatal care reception since last year.

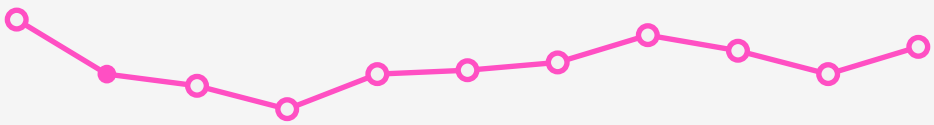
Wyoming is currently implementing two of six supportive maternal and infant health initiatives included in this year's Report Card.

The preterm birth rate in Wyoming was 10.5% in 2024, higher than the rate in 2023

PRETERM BIRTH GRADE **D+**

US RATE	WY RATE	WY RANK
10.4	10.5	28

Percentage of live births born preterm



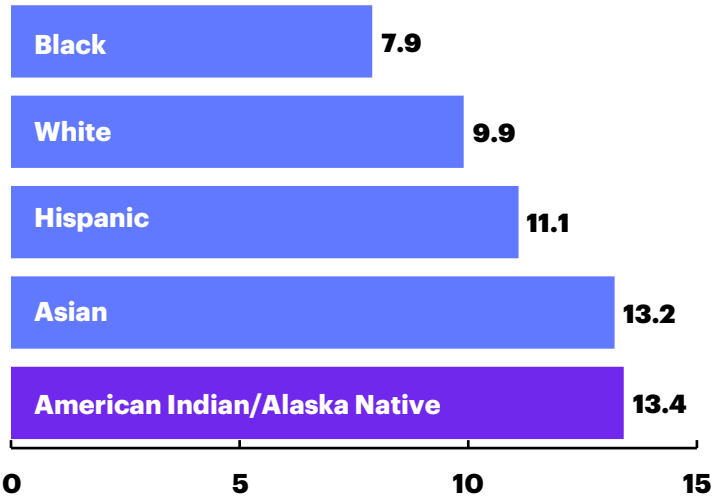
2014										2024
11.2	9.8	9.5	8.9	9.8	9.9	10.1	10.8	10.4	9.8	10.5

A solid dot indicates a statistically significant change from prior year

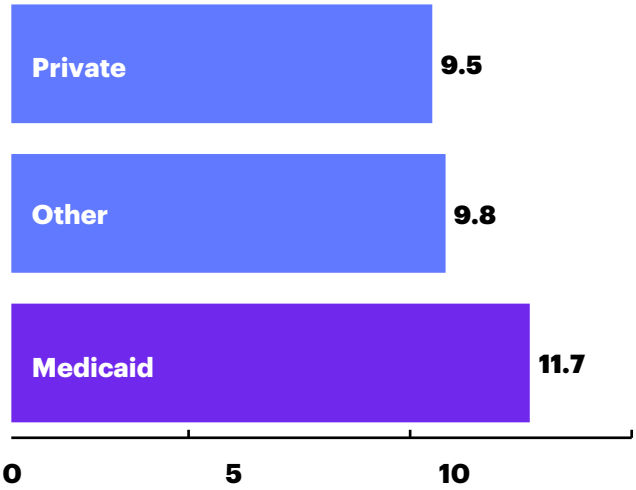
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



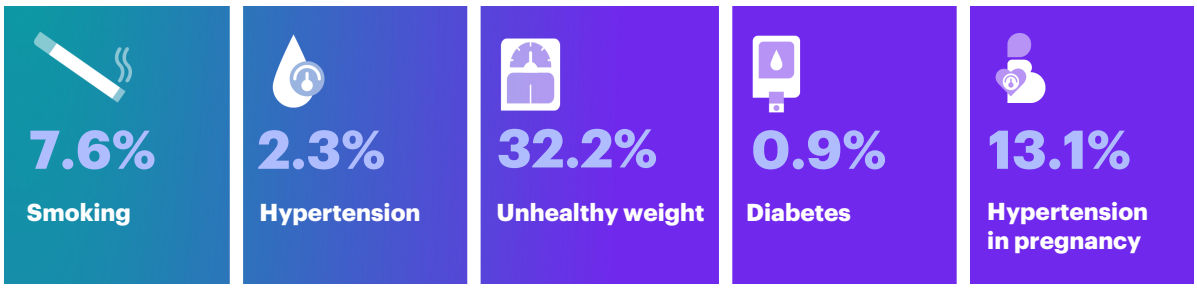
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 8.9%; Tricare: 9.2%; Indian Health Service: N/A; and all other types: 16.9%.

Source: National Center for Health Statistics, Natality data, 2014-2024.

Wyoming

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 23 babies died before their first birthday

INFANT MORTALITY RATE **3.8**

US RATE **5.6**

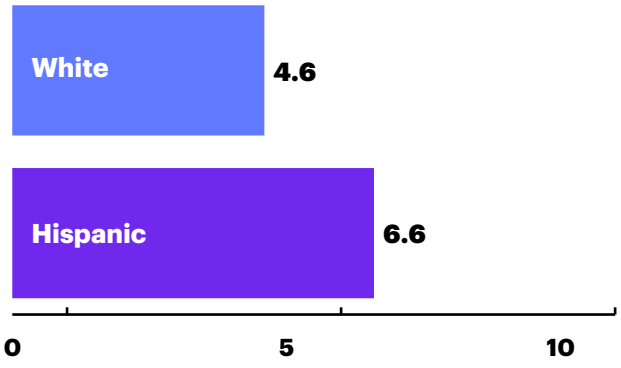
WY RANK **5**

Note: The change in 2023 was not a statistically significant decrease compared to 2022.

The infant mortality rate among babies born to Hispanic moms is 1.7x the state rate

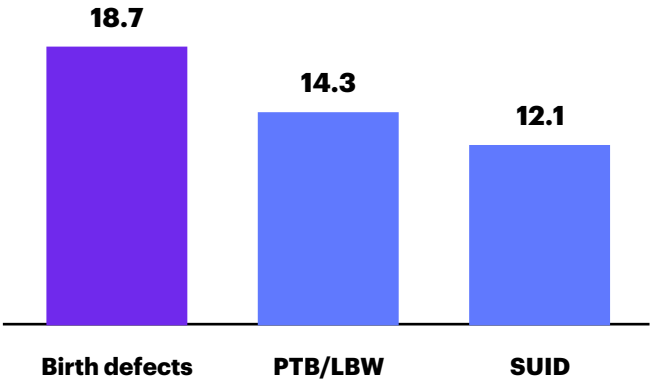
Infant mortality rate by maternal race/ethnicity

Rate per 1,000 live births, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native; PTB/LBW = preterm birth and low birth weight; SUID = sudden unexpected infant death. Other causes account for 54.9% of infant deaths.

Source: National Center for Health Statistics, Period Linked Birth/Infant Death data, 2013-2023.

Wyoming

The rate of inadequate prenatal care among babies born to American Indian/Alaska Native moms is 2.3x the state rate

13.9
PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

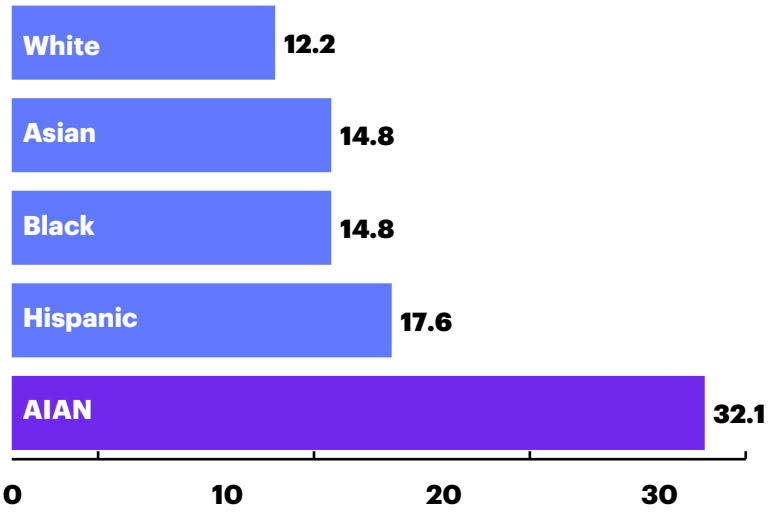
80.3
PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



Note: PI = Pacific Islander; AIAN = American Indian/Alaska Native.

The measures below are important indicators for the health of pregnant and postpartum women in Wyoming

20.8
PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

40.4
PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

35.5
PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	10.5%	3.8	20.8%	77.1%	40.4	35.5
Rank	28th of 52	5th of 52	7th of 52	30th of 52	1st of 47	45th of 48
Direction†	Worsened	Improved	Improved	Improved†	Improved	N/A
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Wyoming

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Wyoming

All efforts were assessed on 9/26/2025.

MEDICAID EXTENSION

State has extended coverage for women to one year postpartum.

MEDICAID EXPANSION

State has adopted this policy, which allows for greater access to preventive care before, during, and after pregnancy.

DOULA REIMBURSEMENT

State Medicaid agency is actively reimbursing doula care.

PAID FAMILY LEAVE

State has required employers to provide a paid option for families out on parental leave.

MENTAL HEALTH

State requires clinicians to screen Medicaid insured women for postpartum depression during a well-child visit and reimburses for the screening.

MATERNAL MORTALITY REVIEW

State has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

- State has the indicated program/policy
- State reimburses up to $1,500
- State is progressing legislation but not yet active
- State does not have the indicated program/policy

Wyoming's Medicaid program, Wyoming Medicaid, covered 1,827 births in 2024

30.3

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, Natality data, 2024.

2025 March of Dimes Report Card
Puerto Rico

Scan for more data

2,217 babies were born preterm in Puerto Rico in 2024. Puerto Rico ranks 48th of 52 (includes all states, District of Columbia, and Puerto Rico) for preterm birth with a rate of 12.2%.

Puerto Rico has made significant improvement in low-risk Cesarean births since last year.

Puerto Rico is currently implementing three of four supportive maternal and infant health initiatives.

The preterm birth rate in Puerto Rico was 12.2% in 2024, the same as the rate in 2023

PRETERM BIRTH GRADE **F**

Percentage of live births born preterm

US RATE	PR RATE	PR RANK
10.4	12.2	48

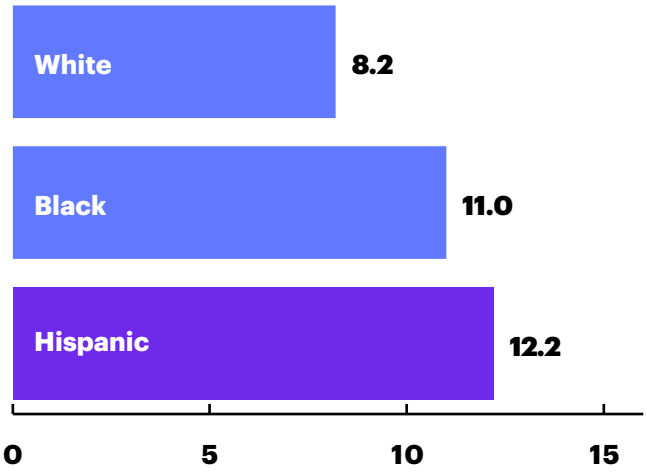
2014										2024
11.8	11.4	11.5	11.4	11.9	11.8	11.6	12.0	11.8	12.2	12.2

A solid dot indicates a statistically significant change from prior year

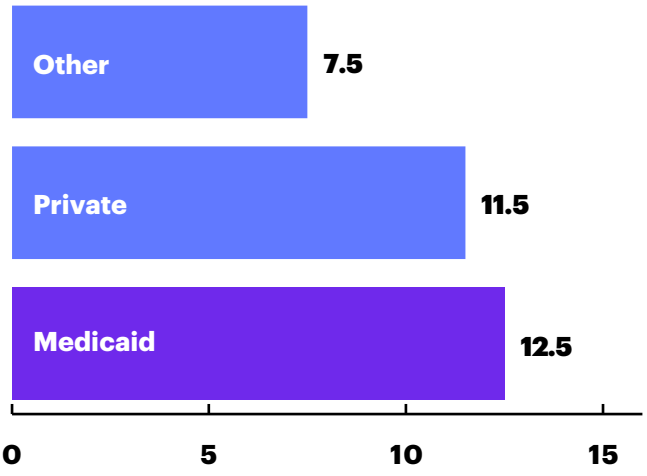
Note: The change in 2024 was not a statistically significant ($P<0.05$) increase or decrease compared to 2023. Statistical significance means the difference is unlikely to be due to chance and likely reflects a meaningful change, though it may not always be large.

The data below illustrates differences in preterm birth rates by race/ethnicity and insurance type, which may reflect broader social and economic factors

Preterm birth rate by maternal race/ethnicity, 2022-2024



Preterm birth rate by insurance type, 2022-2024



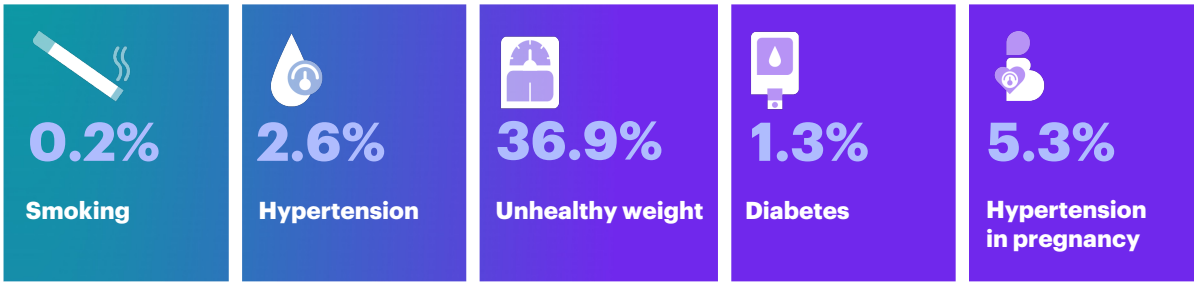
Note: These data can serve as a starting point for discussions about addressing disparities caused by community factors and experiences. Preterm birth rates for "other" insurance types: self pay: 7.0%; Tricare: N/A; Indian Health Service: N/A; and all other types: 15.9%.

Source: National Center for Health Statistics, US Territories Natality data, 2014-2024.

Puerto Rico

Some health conditions make people more likely to have a preterm birth or experience other poor birth outcomes

The tiles display the percentage of all live births exposed to each condition in 2024.



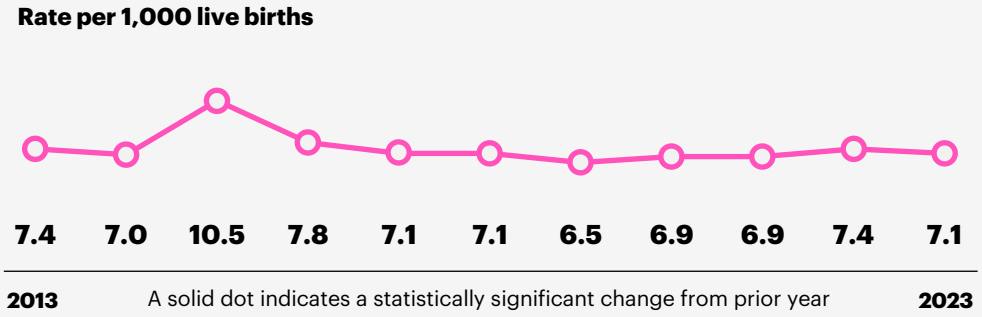
Note: More than one factor can occur at the same time. Hypertension, diabetes, smoking, and unhealthy weight occur prior to pregnancy. US percentages are as follows: smoking: 3.0%; hypertension: 3.4%; unhealthy weight: 34.8%; diabetes: 1.3% and hypertension in pregnancy: 10.4%.

The infant mortality rate decreased in the last decade; in 2023, 132 babies died before their first birthday

INFANT MORTALITY RATE **7.1**

US RATE **5.6**

PR RANK **46**

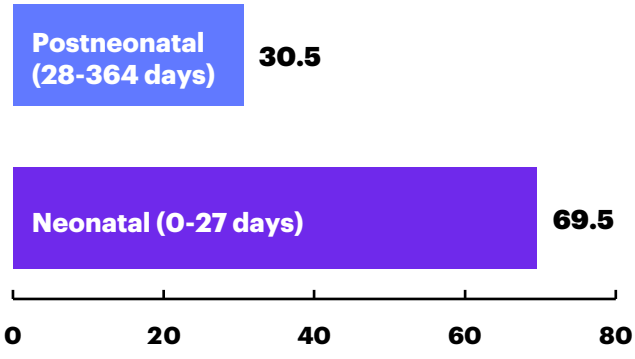


Note: The change in 2023 was not a statistically significant decrease compared to 2022.

Over one third of all infant deaths in Puerto Rico occur in the first 4 weeks of life, higher than the US percent

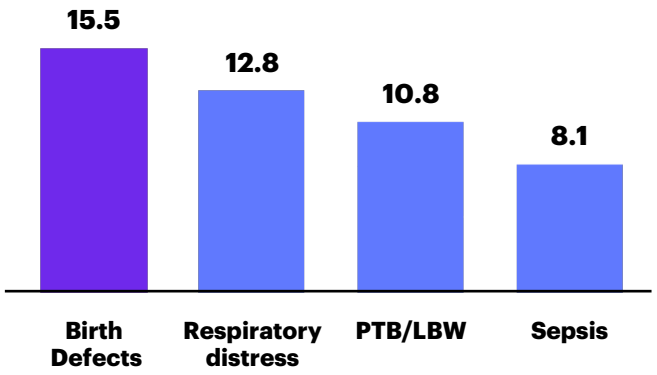
Infant mortality rate by timing of death

Percent of total deaths by period, 2021-2023



Leading causes of infant death

Percent of total deaths by underlying cause, 2021-2023



Note: PTB/LBW = preterm birth and low birth weight. Other causes account for 52.8% of infant deaths.

Source: National Center for Health Statistics, US Territories. Period Linked Birth/Infant Death data, 2013-2023.

Puerto Rico

The rate of inadequate prenatal care among babies born to Black moms is 2.7x the territory rate

9.3 PERCENT

16.1

INADEQUATE PRENATAL CARE

Percentage of babies whose mom received care beginning in the fifth month or later or less than 50% of the appropriate number of visits for the infant's gestational age.

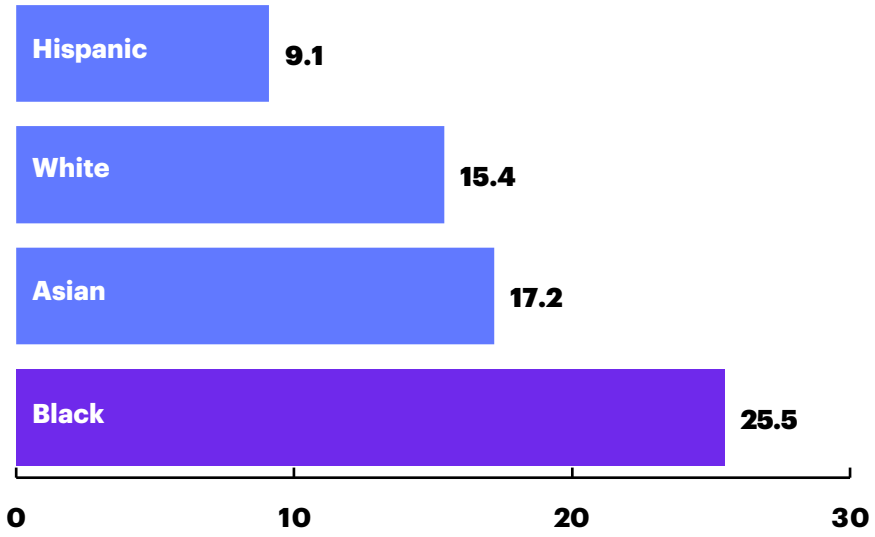
82.9 PERCENT

75.5

FIRST TRIMESTER INITIATION OF PRENATAL CARE

Percentage of babies whose mom started prenatal care in the first trimester of pregnancy.

Inadequate prenatal care by maternal race/ethnicity, 2022-2024



The measures below are important indicators for the health of pregnant and postpartum women in Puerto Rico

47.1 PERCENT

26.6

LOW-RISK CESAREAN BIRTH

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

307.0 PER 10,000 HOSPITAL DELIVERIES

93.1

SEVERE MATERNAL MORBIDITY

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

59.2 PER 100,000 BIRTHS

23.5

MATERNAL MORTALITY

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

Sources: National Center for Health Statistics, US Territories Natality data, 2024; Death and Birth Certificates, 2019-2022. Puerto Rico Department of Health; Puerto Rico Maternal Mortality Surveillance System, 2023; Puerto Rico Health Insurer Commissioner, 2022.

	Preterm birth	Infant mortality	Low-risk Cesarean	Adequate PNC*	Severe maternal morbidity	Maternal mortality
Measure	12.2%	7.1	47.1%	86.1%	307.0	59.2
Rank	48th of 52	46th of 52	52nd of 52	4th of 52	N/A	N/A
Direction†	No change	Improved	Improved†	Worsened	N/A	Improved
HP2030 Target	9.4% of live births	5.0 deaths per 1k births	23.6% of low-risk births	80.5% of live births	64.4 per 10K hospital deliveries	15.7 deaths per 100K births

Note: *Measure differs from inadequate PNC. Adequate is presented to align with Healthy People 2030 target. Rank determined for all states with available data with 1 being the best. †Denotes statistically significant change from prior year (P <0.05). See Technical Notes for details.

Puerto Rico

Adoption of the following policies and programs, along with sufficient funding, is critical to improving maternal and infant health in Puerto Rico

All efforts were assessed on 9/26/2025.

PAID FAMILY LEAVE

Territory requires private sector employers to provide a paid option while out on parental leave.

DOULA REIMBURSEMENT

Territory Medicaid agency is actively reimbursing doula care.

MENTAL HEALTH

Territory Medicaid program requires and reimburses for postpartum mental health screening.

MATERNAL MORTALITY REVIEW

Territory has a maternal mortality review committee to understand causes of deaths, identify preventive factors, and recommend changes to improve care and save lives.

Legend

 Territory has the indicated funding/policy

 Territory reimburses up to $1,500

 Territory is progressing legislation but not yet active

 Territory does not have the indicated funding/policy

Puerto Rico's Medicaid program, Plan Vital, covered 11,855 births in 2024

65.8

PERCENT

LIVE BIRTHS PAID BY MEDICAID

March of Dimes recognizes the vital importance of Medicaid, which pays for 4 in 10 deliveries nationwide (as high as 62% in some states). Access to Medicaid coverage ensures that individuals can receive preventive services and other clinical care before, during, and after pregnancy.

Given Medicaid's critical role in supporting maternal, infant, and child health, March of Dimes urges states to:

- Maintain or expand eligibility and benefits for pregnant and postpartum individuals, caregivers, and children.
- Ensure that Medicaid enrolled moms and babies continue receiving care without disruption during the implementation of policy changes.
- Clearly communicate any policy changes, including work requirements, address verification, frequent eligibility reviews, and retroactive coverage limits, and allow ample time for contacting and completion of updates.
- Increase access to care in communities impacted by hospital closures or maternity care deserts.
- Increase access to evidence-based, quality telehealth services and technology, including remote monitoring, and support alignment of reimbursement across payers.
- Provide sufficient reimbursement to all providers to encourage participation in Medicaid programs.

Note: See Policy and Program Booklet for more details.

Source: National Center for Health Statistics, US Territories Natality data, 2024.

Technical Notes

2025 March of Dimes Report Card
Technical Notes

Preterm birth rate

Preterm birth is a birth occurring before 37 completed weeks of gestation, based on the obstetric estimate of gestational age. The data used in this report card are derived from the National Center for Health Statistics (NCHS) natality files, which compile information from 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.[1] This national data source ensures consistency and comparability across state and jurisdiction-specific report cards. Data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies due to the timing of data submission and handling of missing data. The preterm birth rates shown at the top of the report card were calculated using NCHS 2024 final natality data for all US states and District of Columbia (DC). The trend graph includes preterm birth rates from NCHS final natality data for the years 2014-2024. County and city preterm birth rates are based on NCHS 2024 final natality data for US states and DC. Preterm birth rates for bridged racial and ethnic categories and insurance payer were calculated from NCHS 2022-2024 final natality data. All provided measures for Puerto Rico are obtained from the Puerto Rico Department of Health for 2024 or the US territorial natality file, 2014-2024. Preterm birth rates were calculated by dividing the number of preterm births by the total number of live births with known gestational age, then multiplying the result by 100. Statistical significance was evaluated using pooled two proportion z-tests, with significance determined at the 95% confidence level.

Preterm birth grading methodology

Preterm birth grades range from an F to an A. Expanded grade ranges were introduced in 2019. Each score within a grade was divided into thirds to create +/- intervals. The resulting scores were rounded to one decimal place and assigned a grade. The grade ranges remain based on how far each state's or jurisdiction's preterm birth rate deviates from the March of Dimes goal of 8.1 percent. This deviation is measured using the standard deviation of the final 2014 preterm birth rates for all US states and DC. The formula used to score grades is as follows: (current preterm birth rate of each jurisdiction – 8.1 percent) / standard deviation of final 2014 state and DC preterm birth rates.

Grade	Preterm Birth Rate Range Scoring Criteria
A	Preterm birth rate less than or equal to 7.7%.
A-	Preterm birth rate of 7.8 to 8.1%.
B+	Preterm birth rate of 8.2 to 8.5%.
B	Preterm birth rate of 8.6 to 8.9%.
B-	Preterm birth rate of 9.0 to 9.2%.
C+	Preterm birth rate of 9.3 to 9.6%.
C	Preterm birth rate of 9.7 to 10.0%.
C-	Preterm birth rate of 10.1 to 10.3%.
D+	Preterm birth rate of 10.4 to 10.7%.
D	Preterm birth rate of 10.8 to 11.1%.
D-	Preterm birth rate of 11.2 to 11.4%.
F	Preterm birth rate greater than or equal to 11.5%.

Preterm birth by city

The US report card displays cities with the greatest number of live births. Cities are shown if they ranked in the top 100 for total number of live births in 2024 among all cities in the US with populations greater than 100,000. City grading followed the methodology described above. For example, Detroit, Michigan ranked as the top city for preterm births and received a city preterm birth grade of F, calculated as: (the city preterm birth rate – 8.1 percent)/standard deviation of all final 2014 preterm birth rates.

Preterm birth by maternal race/ethnicity

Maternal race and Hispanic ethnicity are reported separately on the birth certificate. Rates for Hispanic women include all bridged racial categories (White, Black, American Indian/Alaska Native, Asian, and Pacific Islander). Rates for non-Hispanic women are classified according to race. The Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 10 or more.

Preterm birth by insurance payer

Insurance payer is classified as the payment method used at time of birth. Insurance types presented are private, Medicaid, and other. Other includes those who self-pay or have insurance through TRICARE/CHAMPUS, Indian Health Service, other government programs, and all other types. Unknown payment types are excluded. To provide stable rates, insurance groups are shown on the report card if the group had 10 or more.

Preterm birth ranks

All US states, DC, and Puerto Rico were ranked by preterm birth rate (rounded to tenths place as presented on the report card), with a rank of 1 being assigned to the state or territory with the lowest rate and ranks increasing as preterm birth rates increase. States that tied were given the same rank and the next rank would be skipped. For example, if two states had the same preterm birth rate and were tied for 15th place, they both would receive the rank of 15, and the next state to be ranked would be in 17th place.

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Chronic health conditions

Selected chronic health conditions are presented in the Report Card to show additional circumstances that may increase the risk of preterm birth and other poor birth outcomes. These include smoking (pre-pregnancy), hypertension (pre-pregnancy), hypertension (during pregnancy), unhealthy weight (pre-pregnancy), and diabetes (pre-pregnancy) (see definitions below). All risk conditions presented are not mutually exclusive, meaning more than one can occur at the same time. For instance, a pregnant person could have both diabetes prior to pregnancy and have an unhealthy weight prior to pregnancy. Rates provided reflect the percentage of live births exposed to the given condition, i.e., the percentage of births where the mom was diagnosed with pre-pregnancy hypertension.

Smoking before pregnancy

Smoking status was ascertained when the mom reported having any cigarettes in the 3 months prior to pregnancy regardless of the number of cigarettes consumed. Smoking before pregnancy is a self-reported measure and data did not include those that smoked during their pregnancy. Smoking status does not capture individuals who use electronic cigarettes or vape.

Pre-pregnancy hypertension

Pre-pregnancy hypertension was defined as the elevation of blood pressure above normal for the moms age and physiological condition prior to onset of the current pregnancy. Data presented for pre-pregnancy hypertension does not include gestational hypertension and pregnancy induced hypertension (or preeclampsia).

Hypertension during pregnancy

Hypertension during pregnancy was defined as the elevation of blood pressure above normal for the moms age and physiological condition where the onset of the condition occurred during the current pregnancy. Data presented for hypertension during pregnancy includes gestational hypertension and pregnancy induced hypertension (or preeclampsia).

Unhealthy weight before pregnancy

Body mass index (BMI) is a measure of body fat based on height and weight. The percent of moms with an unhealthy weight before pregnancy was calculated as the number of moms with a BMI that is categorized as either underweight (BMI less than 18.5) or obese (BMI 30 or higher) divided by the number of moms who had a live birth multiplied by 100.

Diabetes

Diabetes was defined as pre-pregnancy diabetes (type 1 or type 2) and does not include gestational diabetes (diabetes during pregnancy).

Infant mortality rate

Infant mortality rates were calculated using the NCHS 2023 period-linked infant birth and death data.[2] The rates were determined by dividing the number of infant deaths by the number of live births in a given year and then multiplying by 1,000. The trend graph reflects infant mortality rates from the NCHS 2013-2023 period-linked infant birth and infant death files. Weights were applied to account for deaths in which linking was not possible. Statistical significance was evaluated using pooled two proportion z-tests, with significance determined at the 95% confidence level.

Infant mortality rank

All US states, DC, and Puerto Rico were ranked by infant mortality rate (rounded to tenths place as presented on the report card), with a rank of 1 being assigned to the state or territory with the lowest rate and ranks increasing as infant mortality rates increase. See preterm birth ranks (page 1) for additional details.

Infant mortality by maternal race/ethnicity

Mother's race and Hispanic ethnicity are reported separately on the birth certificate. Rates for Hispanic women include all bridged racial categories (White, Black, American Indian/Alaska Native, Asian, and Pacific Islander). Rates for non-Hispanic women are classified according to race. The Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 10 or more infant deaths. To calculate infant mortality rates by maternal race/ethnicity on the report card, three years of data were aggregated (2021-2023). Infant mortality rates for not stated/unknown race are not shown on the report card. Weights were applied to account for deaths in which linking was not possible.

Leading causes of infant death

NCHS period linked birth/infant death files (2021-2023) were used for cause of death analyses. See Appendix A for a detailed list of ICD10 codes and their groupings.[3] SUID deaths were further classified using Centers for Disease Control and Prevention methodology.[4] The top four cause of death categories by percent of total deaths per state were selected for chart inclusion. The percent of deaths attributed to causes outside of the categories selected were combined in an "other" category. Weights were applied to account for deaths in which linking was not possible.

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Age at infant death

For Puerto Rico, age of infant death data is presented as percentages of total deaths. Infant deaths are classified as either neonatal (0 to 28 days old) or postneonatal (>28 days to 1 year).[5]

Maternal mortality

Maternal mortality refers to death from complications of pregnancy or childbirth that occur during the pregnancy or within 6 weeks after the pregnancy ends.[6] Maternal deaths are ascertained using the NCHS 2019-2023 mortality data.[7] Puerto Rico data were provided by the Puerto Rico Department of Health. The number of maternal deaths does not include all deaths occurring to pregnant or recently pregnant women, but only deaths with the underlying cause of death assigned to *International Statistical Classification of Diseases, 10th Revision* code numbers A34, O00–O95, and O98–O99. Rates are calculated by dividing the number of maternal deaths by the number of births in the same geographic region during the same data year(s) and multiplying by 100,000.

Maternal mortality rates fluctuate from year to year because of the relatively small number of these events and possibly due to issues with the reporting of maternal deaths on death certificates.[8] Five-year aggregate rates are presented for all racial and ethnic groups and by state, still, some states do not have enough deaths to provide reliable estimates and are therefore suppressed. Individual year rates at the US level were provided for 2019-2023. Statistical significance was evaluated using pooled two proportion z-tests, with significance determined at the 95% confidence level.

Additional maternal health indicators

Prenatal care adequacy

Adequacy of prenatal care is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate and adequate plus) by combining information about the timing of prenatal care, the number of visits and the infant's gestational age.[9] Inadequate prenatal care is defined as an infant whose mom received less than 50% of their expected visits or started care in or after the fifth month. Adequate prenatal care is defined as an infant whose mom received 80-109% of their expected visits and started their care before the fifth month of pregnancy. Adequate plus prenatal care (presented in combination with adequate care) is defined as an infant whose mom received over 110% of their expected visits and started their care before the fifth month of pregnancy. Prenatal care adequacy is calculated using the NCHS 2024 final natality data for all records with complete data on the timing of prenatal care initiation and number of visits. Statistical significance was evaluated using pooled parameter significance tests.

Prenatal care initiation

Prenatal care initiation is measured from the month of pregnancy a mom began prenatal care. First trimester (early) prenatal care initiation is when a mom began prenatal care in the first to third month of pregnancy. Initiation rates are calculated as a percentage of live births. Prenatal care initiation is calculated using the NCHS 2024 final natality data.

Inadequate prenatal care by maternal race/ethnicity

Inadequate prenatal care rates by race/ethnicity use 3-year aggregate data from NCHS 2022-2024. Maternal race and Hispanic ethnicity are reported separately on the birth certificate. Rates for Hispanic women include all bridged racial categories (White, Black, American Indian/Alaska Native, Asian, and Pacific Islander). Rates for non-Hispanic women are classified according to race. The Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 10 or more.

Low-risk Cesarean birth rate

A low-risk Cesarean birth occurs when a woman undergoes the surgical procedure if the baby is a single infant, is positioned head-first (vertex position), the mother is full-term (at least 37 weeks) and has not given birth prior.[10] This is also referred to as a NTSV Cesarean birth. NTSV abbreviated to mean Nulliparous (or first-time mother), Term, Singleton, Vertex.

Low-risk Cesarean birth rates were calculated using the NCHS 2024 final natality data for the US, DC, and Puerto Rico. Low-risk Cesarean birth rates were calculated as the number of Cesarean births that occurred to first-time mothers of a single infant, positioned headfirst with a gestational age of at least 37 weeks (NTSV) divided by the number of first-time mothers of a single infant, positioned headfirst with a gestational age of at least 37 weeks (NTSV) multiplied by 100. Statistical significance was evaluated using pooled parameter significance tests.

Severe maternal morbidity

Severe maternal morbidity is the rate of unexpected outcomes of labor and delivery that result in significant short- or long-term health consequences per 10,000 in-hospital deliveries. Blood transfusions are not included. The rate is calculated and published by the Healthcare Cost and Utilization Project (HCUP)[11] and the Puerto Rico Health Insurer Commissioner.

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Summary table

Preterm birth, infant mortality, low-risk Cesarean birth, adequate prenatal care, maternal mortality, and severe maternal morbidity are summarized on page 3 of state Report Cards. For each measure, the table includes the state's rate; rank among other states, districts, and territories with available and comparable data (includes all states, DC, and Puerto Rico); direction of change compared to the prior year, including whether the change was statistically significant; how the measure is calculated e.g., as a percentage or rate and of which denominator group; and the corresponding Healthy People 2030 target. For maternal mortality, 2019-2023 data is compared to 2018-2022 data. For severe maternal morbidity, statistical significance was not assessed.

Calculations

All calculations were conducted by March of Dimes Perinatal Data Center. Contact: PerinatalDataCenter@MarchofDimes.org

State level policies and programs

Medicaid extension

The adoption of this Medicaid extension allows women to qualify for pregnancy-related Medicaid coverage for more than the standard 60 days after pregnancy for up to one year. Extending this coverage option can be done through a State Plan Amendment (SPA) or Section 1115 Waiver. Medicaid extension status is provided by Kaiser Family Foundation as adopted, progressing or not adopted.[12]

Medicaid expansion

Medicaid expansion allows more people to be eligible for Medicaid coverage—it expands the cut-off for eligibility. Medicaid expansion status is provided by the Kaiser Family Foundation as adopted, progressing, or not adopted.[13] Medicaid expansion has reduced the rates of uninsured. Increased access and utilization of health care are significantly associated with Medicaid expansion.

Paid family and medical leave

Paid family and medical leave refers to policies that enable workers to receive compensation when they take extended time off work for qualifying reasons, such as bonding with a new child, recovering from one's own serious illness or caring for a seriously ill loved one.[14] The measure is reported as: state has an active policy that provides an option for pay while out on extended leave or it does not have an active policy in place. Data is provided by A Better Balance.[15]

Doula policy on Medicaid coverage

Doulas are non-clinical professionals that emotionally and physically support moms during the perinatal period, including birth and postpartum.[16] Doula policy status show states that have enacted bills relating to Medicaid coverage of doula care, or not. The measure is reported as: state Medicaid agency is actively reimbursing doula care or state Medicaid agency does not reimburse doula care. An additional measure includes identifying states that reimburse up to $1,500 for doula services. Data is provided by the National Health Law Program under the Doula Medicaid Project.[17] Data for Connecticut is provided by Connecticut Social Services and data for Delaware is provided by Delaware First Health.[18,19]

Maternal mortality review committees (MMRC)

These committees investigate deaths related to pregnancy to determine underlying causes of death and respond to improve conditions and practices. The committees can be made up of representatives from public health, nursing, maternal-fetal medicine, obstetrics and gynecology, midwifery, patient advocacy groups and community-based organizations.[20] The MMRC measure is provided by the Centers for Disease Control (CDC) and is categorized as; state has a MMRC or the state does not have an MMRC.[21] Data for Texas is provided by Texas Department of State Health Services.[22] Data for Washington, DC is provided by The Office of Chief Medical Examiner (OCME).[23]

Postpartum maternal mental health screening

The adoption of this policy requires postpartum depression screening and reimbursement during well-child visits for mothers and/or caregivers of children enrolled in Medicaid (except Washington that basis eligibility on the mother's Medicaid status). These efforts reflect 2016 federal policy guidance from the Centers for Medicare & Medicaid Services (CMS) allowing states to provide Medicaid coverage under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Data was provided by the National Academy for State Health Policy.[24] The measure is reported as: state requires and reimburses for postpartum depression screening during well-child visits or state does not require and reimburse for postpartum depression screening during well-child visits.

All policies were assessed as of September 26, 2025.

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Appendix A: Cause of Death Categories and Corresponding codes

Cause of death category	ICD10 codes included
Birth defects	Q00–Q99
Preterm birth/low birth weight	P07
SUID	R95, W75, R99
Maternal complications	P01
Respiratory distress of newborn	P22
Complications of the placenta, cord, or membranes	P02
Accidents (unintentional injury)	V01–X59,Y85–Y86
Bacterial sepsis of newborn	P36
Diseases of the circulatory system	I00–I99
Neonatal hemorrhage	P50–P52, P54

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