

The 2022 March of Dimes Report Card continues to elevate the latest data on infant and neonatal outcomes and maternal risk factors. We continue to provide updated measures on preterm birth, infant mortality, social drivers of health, rates of low-risk Cesarean births and inadequate prenatal care. This year we include an update to our social drivers of health by including the Maternal Vulnerability Index (MVI).

This year's report card highlights a worsening state of maternal and infant health with increases in preterm birth and low-risk Cesarean births. Additionally, the health equity gap continues to increase among these outcomes. Comprehensive data collection and analysis of these measures inform the development of policies and programs that move us closer to health equity. As in previous years, the Report Card presents policies and programs that can help improve equitable maternal and infant health outcomes for families across the country.

2022 MARCH OF DIMES REPORT CARD

UNITED STATES

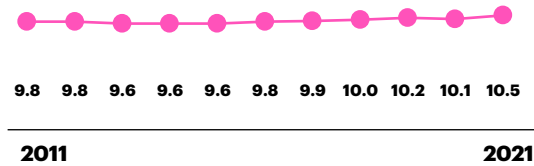
PRETERM BIRTH GRADE

D+

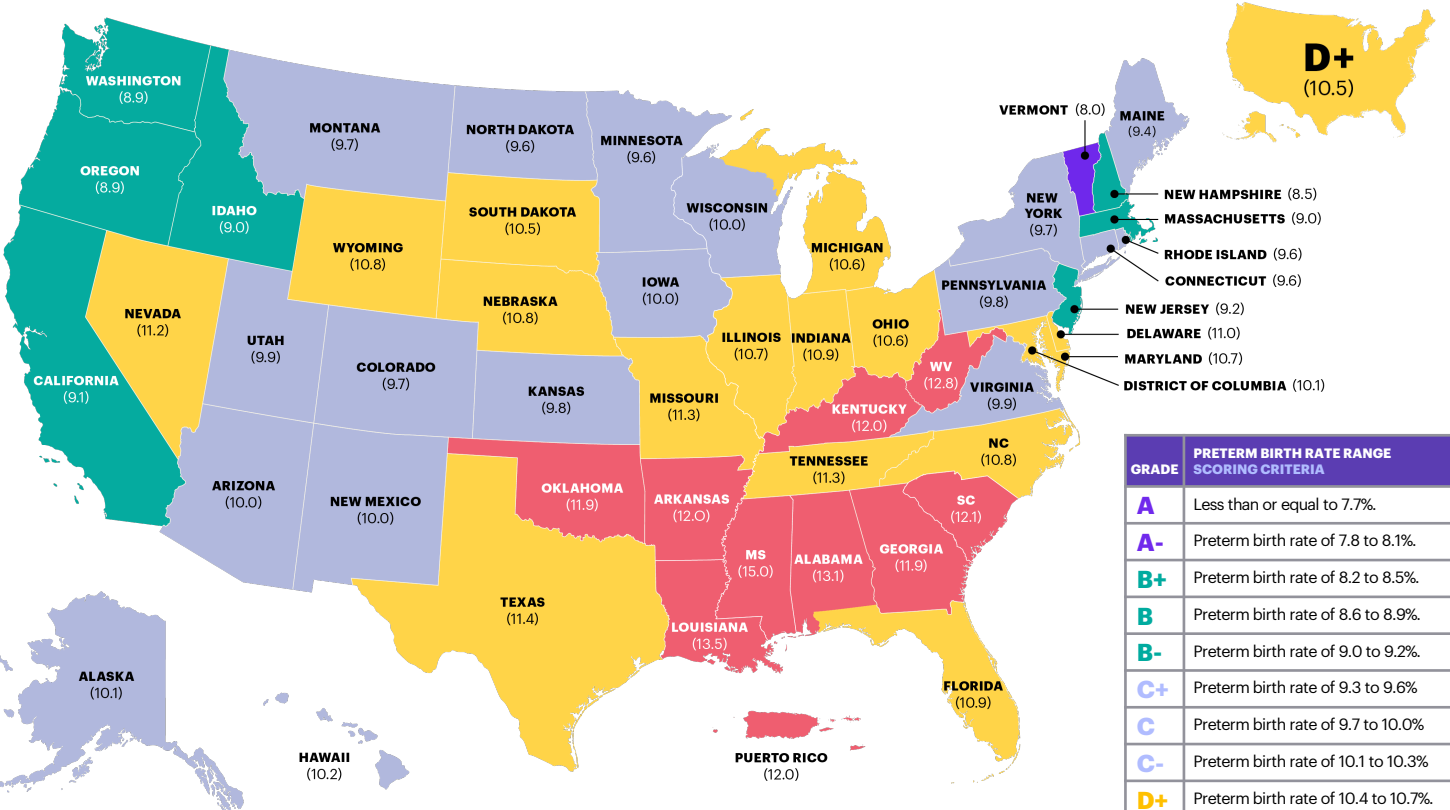
PRETERM BIRTH RATE

10.5%

Percentage of live births born preterm



PRETERM BIRTH RATES AND GRADES BY STATE



Preterm is less than 37 completed weeks of gestation, based on obstetric estimate of gestational age.

Grades assigned by March of Dimes Perinatal Data Center.

Puerto Rico is not included in the United States total.

Source: Preterm birth rates are from the National Center for Health Statistics, 2021 final natality data and U.S. Territories natality data.

GRADE	PRETERM BIRTH RATE RANGE SCORING CRITERIA
A	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%.

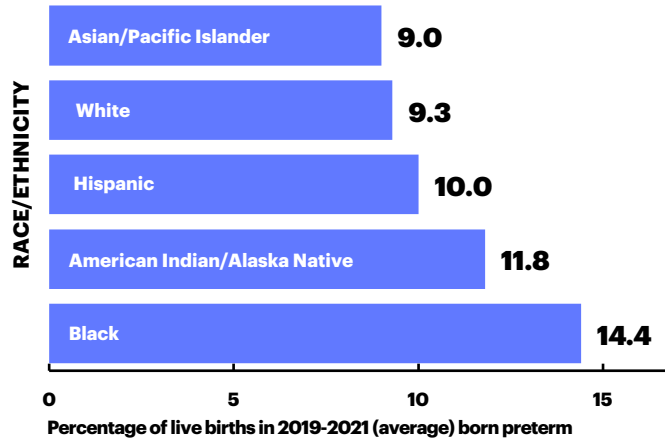
THE 2022 MARCH OF DIMES REPORT CARD: STARK AND UNACCEPTABLE DISPARITIES PERSIST ALONGSIDE A TROUBLING RISE IN PRETERM BIRTH RATES

March of Dimes recommends state policy actions that are rooted in addressing disparities in maternal and infant health outcomes, see www.marchofdimes.org/reportcard

For details on data sources and calculations, see Technical Notes: <https://bit.ly/ReportCardTechnicalNotes>

2022 MARCH OF DIMES REPORT CARD RACE & ETHNICITY IN THE U.S.

Aggregate 2019-2021 preterm birth rates are shown for each of the five bridged racial and ethnic groups. The racial/ethnic group with the highest rate is compared to the combined rate for all other racial/ethnic groups.



In the United States, the preterm birth rate among Black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.26

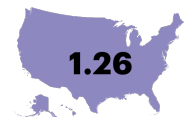
CHANGE FROM BASELINE:

Worsened

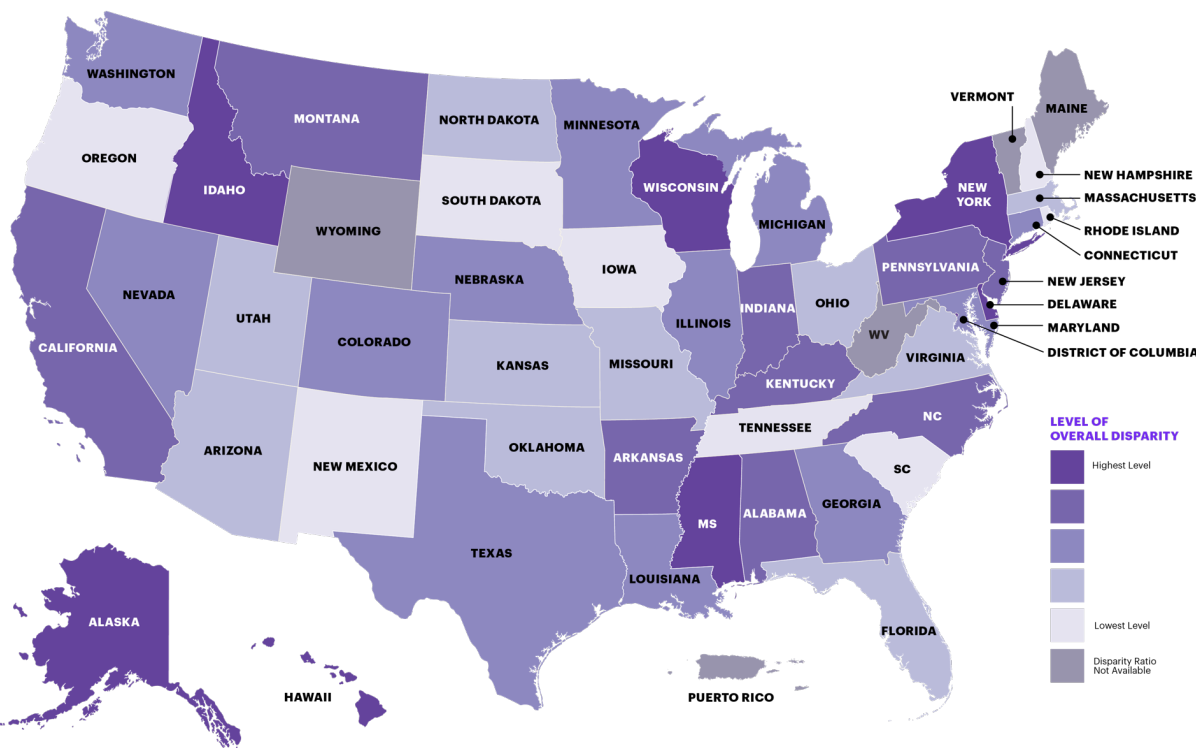
RACE & ETHNICITY DISPARITY BY STATE

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

U.S. disparity ratio



The U.S. Disparity Ratio has **worsened** from baseline



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UNITED STATES

MATERNAL HEALTH

There is a critical connection between infant health, maternal health and the health of a family. All are dependent on their lived social context, the quality and accessibility of healthcare and the policies within a state. Each factor can provide insight into how a state serves its population.

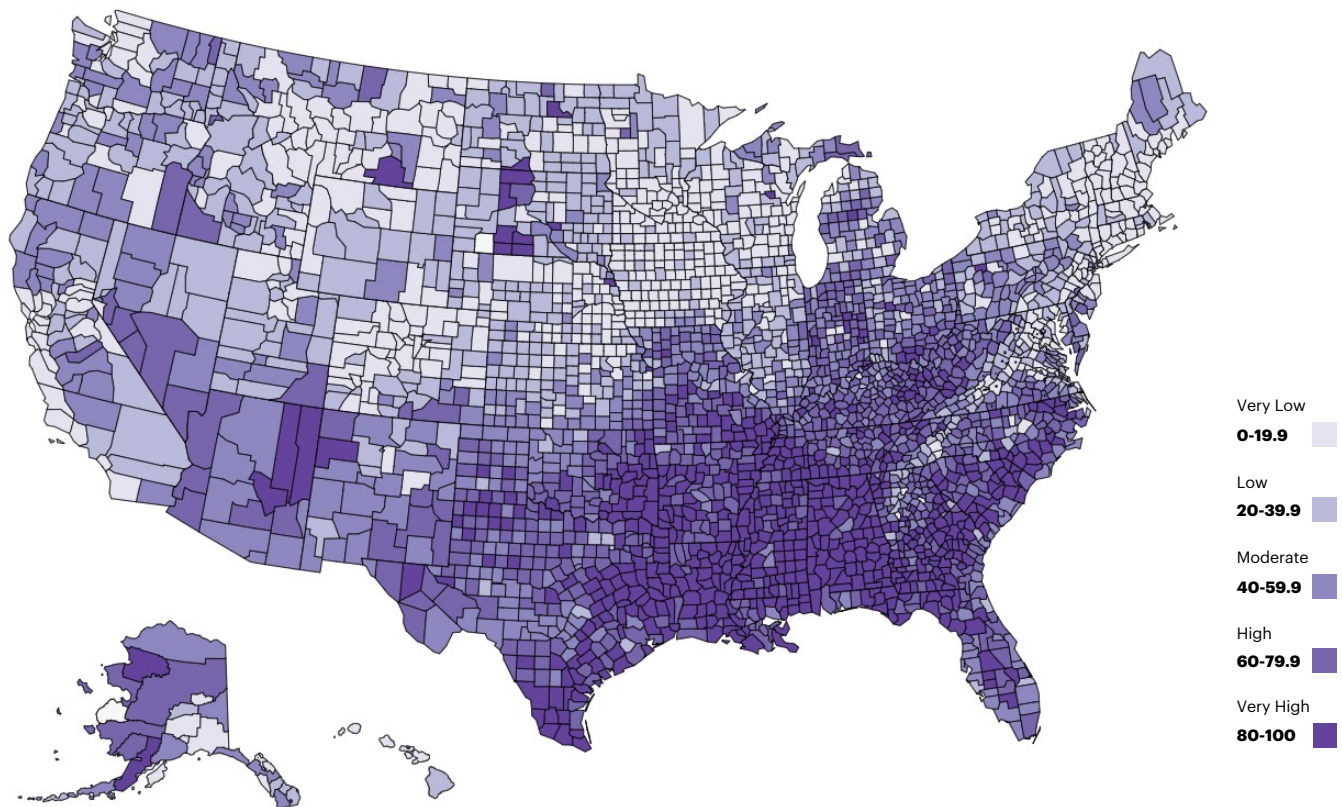
MATERNAL VULNERABILITY INDEX

Where you live matters.

March of Dimes, in partnership with Surgo Ventures, examines determinants of maternal health using the **Maternal Vulnerability Index (MVI)***. The MVI is the first county-level, national-scale tool to identify where and why moms in the U.S. are vulnerable to poor pregnancy outcomes and pregnancy-related deaths. The MVI includes not only widely known clinical risk factors, but also key social, contextual, and environmental factors that are essential influencers of health outcomes.

Differences in counties are measured using numerous factors broken into six themes: reproductive healthcare, physical health, mental health and substance abuse, general healthcare, socioeconomic determinants and physical environment. The MVI assigns a score of 0-100 to each geography, where a higher score indicates greater vulnerability to adverse maternal outcomes.

*Visit <https://mvi.surgoventures.org/> for more information.



CLINICAL MEASURES

Your healthcare matters.

Access to and quality of healthcare before, during and after pregnancy can affect health outcomes in the future. An unnecessary Cesarean birth can lead to medical complications and inadequate prenatal care can miss important milestones in pregnancy.

26.3

PERCENT

LOW-RISK CESAREAN BIRTH

Percent of women who had Cesarean births and were first-time moms, carrying a single baby, positioned head-first and at least 37 weeks pregnant. These births are frequently considered low-risk.

14.5

PERCENT

INADEQUATE PRENATAL CARE

Percent of women who 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.

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UNITED STATES

MATERNAL HEALTH

ADOPTED in 39 STATES (INCLUDING D.C.)

MEDICAID EXPANSION

States that adopt Medicaid expansion⁷ enable all people in the state to qualify for Medicaid insurance benefits up to 138% of the federal poverty level thereby reducing the rates of uninsured pregnant individuals of childbearing age. Medicaid expansion plays an essential role in improving maternal and infant health. Increased access and utilization of health care are significantly associated with Medicaid expansion.⁸

RECENT ACTION in 10 STATES 26 STATES HAVE FULLY EXTENDED (INCLUDING D.C.)

RECENT ACTION ON MEDICAID EXTENSION

States that adopt Medicaid extension enable pregnant persons to qualify for medical-related Medicaid coverage for up to a year after the birth of their child. This policy extends the standard 60 days after pregnancy.⁹ Extending this coverage typically requires both state legislation and an appropriation in addition to a Section 1115 waiver in order to receive federal match.¹⁰

37 STATES REIMBURSE CERTIFIED NURSE MIDWIVES

MIDWIFERY POLICY

States that reimburse midwifery care on Medicaid insurance plans¹⁸ at a high rate enable women to have increased access to midwifery care which can reduce the likelihood of medical interventions that contribute to the risk of maternal mortality and morbidity in initial and subsequent pregnancies, lower costs and potentially improve the health of mothers and babies. This is especially true in under-resourced areas. Midwives are health care professionals that may be part of the birth care team or stand alone in providing prenatal, delivery and postpartum care.

8 STATES REIMBURSE DOULA SUPPORT

DOULA LEGISLATION

States that reimburse doulas¹⁷ enable women to have expanded access to doula support in their state and may be a way to improve birth outcomes. Doulas are non-clinical professionals that emotionally and physically support women during the perinatal period, including birth and postpartum.¹⁶ Increased access to doula support can help improve birth outcomes and reduce the higher rates of maternal morbidity and mortality among women of color in the United States. Doula support is not routinely covered by health insurance.

40 STATES (INCLUDING D.C.) REVIEW MATERNAL DEATHS UP TO ONE YEAR AFTER BIRTH

MATERNAL MORTALITY REVIEW COMMITTEE (MMRC)

States that review pregnancy-associated deaths¹² up to one year after birth enable review committees to best understand all causes of pregnancy-associated mortality. MMRCs 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.¹¹ States that have an MMRC are better equipped to prevent pregnancy-related deaths.

47 STATES (INCLUDING D.C.) HAVE A PQC TO IMPROVE QUALITY OF CARE

PERINATAL QUALITY COLLABORATIVE (PQC)

States that have an active PQC¹⁵ enable collaborative work towards improving the quality of health care in clinical settings for moms and babies. Perinatal Quality Collaboratives are made up of state-level partnerships that come together to identify and initiate actions. The key to success is the variety of local stakeholders (including community and clinical perspectives) that work together for innovative solutions.¹⁴

*To access the full citation list, see our Technical Notes document below.

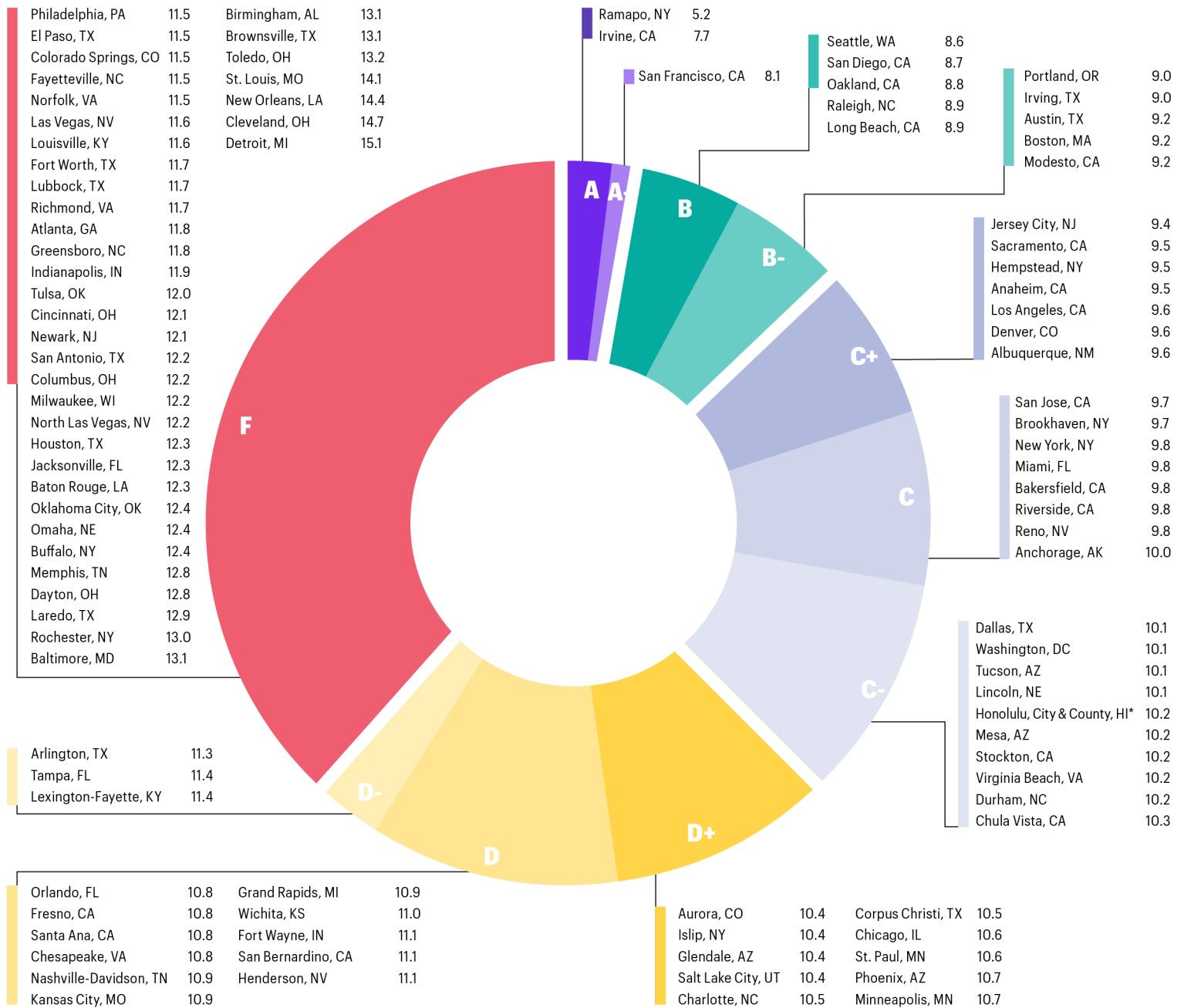
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100 U.S. CITIES WITH THE GREATEST NUMBER OF BIRTHS 2021 PRETERM BIRTH RATES AND GRADES

The 2022 U.S. March of Dimes Report Card assigns grades to the 100 cities with the greatest number of live births in 2021. Report Card grades are assigned by comparing the 2021 preterm birth rate in a city to the March of Dimes goal of 8.1 percent by 2020.



GRADE AND RANGE

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

Notes:

- Preterm is less than 37 weeks gestation based on obstetric estimate of gestational age.
- 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.

Source: National Center for Health Statistics, 2021 final natality data. **Prepared by:** March of Dimes Perinatal Data Center, 2022.