



Department of Medicaid

Report on Pregnant Women, Infants, and Children

State Fiscal Year 2025

Governor Mike DeWine | Lt. Governor Jim Tressel | Director Scott Partika

medicaid.ohio.gov

December 31, 2025

Ohio House Speaker, the Honorable Matt Huffman
Ohio Senate President, the Honorable Rob McColley
Ohio House Minority Leader, the Honorable Dani Isaacsohn
Ohio Senate Minority Leader, the Honorable Nickie Antonio
Ohio Legislative Service Commission Director, Bill Rowland

RE: Pregnant Women, Infants, and Children Report - State Fiscal Year 2025

The attached report is provided in compliance with Section 5162.13 of the Ohio Revised Code requiring Ohio Department of Medicaid (ODM) to report annually about the effectiveness of the Medicaid program meeting the healthcare needs of low-income pregnant women, infants, and children. In addition, this report focuses on infant mortality, preterm births, and low birthweight infants.

The rates reported for infant mortality, preterm births, and low birthweight infants are calculated for individuals who have Medicaid and individuals who do not have Medicaid. This information is based on both Medicaid data and infant death and birth files from the Ohio Department of Health Bureau of Vital Statistics.

The linkage process to match vital statistics information to Medicaid deliveries was updated and improved beginning with the report issued in 2020. At the same time, the methodology used to calculate infant mortality rates was revised to align with the standard utilized by public health officials, including the National Center for Health Statistics (NCHS) and the Ohio Department of Health (ODH). These changes have been applied to all years 2017 forward. Given these notable revisions and a greater match success with the new linkage process, direct comparison to outcomes reported in prior years (2016 and earlier) is not informative.

This data is critical to our continued work to address the DeWine Administration's priorities to meet the healthcare needs of moms and babies. We look forward to our continued work with our interagency partners at the ODH and future collaborations with the newly created Department of Children and Youth.

Sincerely,



Scott Partika, Director

Contents

Section 1: Profile of Ohio Births.....	5
1.2 Profile of Ohio Births and Medicaid Demographics	5
1.3 Demographic Information Related to Ohio Births	6
1.4 Ohio Births by Maternal Race/Ethnicity	7
1.4.1 Maternal Age	9
1.4.2 Marital Status.....	10
1.5 Medicaid Program Enrollment and Gestational Age	11
Section 2: Birth Outcomes and Risk Factors	15
2.1 Infant Mortality	15
2.2 Very Preterm Birth, Preterm Birth, and Low Birthweight	18
2.2.1 Risk Factors for Preterm Birth and Low Birthweight	21
2.3 Preterm Birth Reduction Effort	26
2.4 Smoking Cessation	29
2.5 Maternal and Infant Support Program	30
Section 3: Prenatal and Postnatal Visits	33
3.1 Measure Results by Statewide Average and Medicaid MCOs.....	33
Section 4: Behavioral Health Services.....	36
Section 5: Medicaid Prenatal Care, Delivery, and Infant Costs	39
Section 6: Children in Medicaid	42
6.1 Summary of Medicaid’s Children’s Eligibility and Demographics CY 2024	42
6.2 Children’s Chronic and Behavioral Health Conditions Frequency Distribution	43
6.3 Quality Measures for Children	44
6.3.1 Primary Care Access and Preventive Care	44
6.3.2 Acute and Chronic Conditions	48
6.3.3 Behavioral Healthcare.....	48
6.4 School-Based Healthcare.....	49
6.4.1 School-Based Measures Comparing Medicaid to Non-Medicaid Youth	50

6.5 Children’s Initiatives	55
Section 7: References	58
Appendix A: Data Sources and Methodologies for Calculations	59
Data Sources	59
Linkage of Ohio Birth Certificates to Medicaid Data	59
Calculation of Costs During Pregnancy and the Cost of Deliveries	60
Calculation of Costs of Infants in Medicaid	61
Chronic and Behavioral Health Conditions	61
Appendix B: Low Birthweight (LBW) Births by County, CY 2024 ^{†††}	62
Appendix C: Preterm Births by County, CY 2024 ^{†††}	66
Appendix D: Managed Care Rates for Child Quality Measures	70

Section 1: Profile of Ohio Births

Figure 1 (Overall Medicaid Enrollment) presents the average monthly enrollment in Ohio Medicaid for calendar years (CY) 2017-2024. Fluctuations in average enrollment are caused by many factors. Policy and program changes in eligibility criteria or enrollment processes and economic factors impact enrollment. Medicaid is a countercyclical program. As such, enrollment generally increases when there is a downturn in the economy leading to increased unemployment.

Between February 2020 and April 2023, amid a national public health emergency (PHE), Ohio Medicaid’s net enrollment climbed 29.3%. The federally required maintenance of effort (MOE), a condition of receiving enhanced Federal Medical Assistance Percentage (FMAP) throughout the PHE, required Ohio Medicaid to maintain eligibility standards, methodologies, benefits, and procedures for those enrolled on or after March 20, 2020. Since then, more than 755,000 Ohioans enrolled in the state Medicaid program for the first time, with children making up 41% of those new to the program.

Following the end of the PHE, Ohio began its Return to Routine Eligibility Determinations (aka “Unwinding”) process. Over the course of the year from March 2023 through March 2024, Ohio completed redetermination processing for all of the roughly 3.4 million enrolled members. As a result, more than 903,000 individuals were disenrolled from Ohio Medicaid, approximately 26% of these were children.

Figure 1: Ohio Medicaid Enrollment, CYs 2017-2024							
Average Monthly Enrollment							
2017	2018	2019	2020	2021	2022	2023	2024
3,071,625	2,928,962	2,813,449	2,945,326	3,228,116	3,419,352	3,448,349	3,098,315

1.2 Profile of Ohio Births and Medicaid Demographics

Medicaid plays a significant role in access to healthcare for pregnant women and children in Ohio. In CYs 2017-2024, Medicaid paid for approximately 52-55% of births in Ohio (see Figure 2). The information below is based on the total number of births to Ohio residents found on the CYs 2017-2024 birth files provided by ODH Vital Statistics (VS). Medicaid-paid deliveries are identified via Medicaid claims/eligibility data.

Throughout this report, comparisons are made between individuals with Medicaid and individuals without Medicaid based on the linked VS birth and death data and Medicaid claims/eligibility data. Please see appendix A for more information on the linkage process.

The population of individuals without Medicaid, often referred to collectively as “non-Medicaid” in this report, includes Ohioans with commercial insurance, without insurance, and those who are self-employed or otherwise able to obtain private insurance.

Figure 2: Ohio Births by Payer, CYs 2017-2024

	# of Births (N)			% of Total Births		
	All	Medicaid	Non-Medicaid	All	Medicaid	Non-Medicaid
2017	133,892	74,174	59,718	100%	55.4%	44.6%
2018	132,136	71,344	60,792	100%	54.0%	46.0%
2019	131,423	69,532	61,891	100%	52.9%	47.1%
2020	126,340	67,714	58,626	100%	53.6%	46.4%
2021	126,742	65,744	60,998	100%	51.9%	48.1%
2022	125,112	65,297	59,815	100%	52.2%	47.8%
2023	123,785	65,655	58,130	100%	53.0%	47.0%
2024	123,745	63,911	59,834	100%	51.6%	48.4%

1.3 Demographic Information Related to Ohio Births

Throughout CYs 2017-2024, there are notable but consistent differences in the demographics of mothers with Medicaid-paid deliveries as compared to mothers with non-Medicaid paid deliveries (Figures 3-5). This report includes comparisons between individuals with Medicaid and those without Medicaid by demographic factors known to be associated with birth outcomes: race/ethnicity, maternal age, and marital status.*

* This number reflects births that occurred in Ohio by Ohio residents.

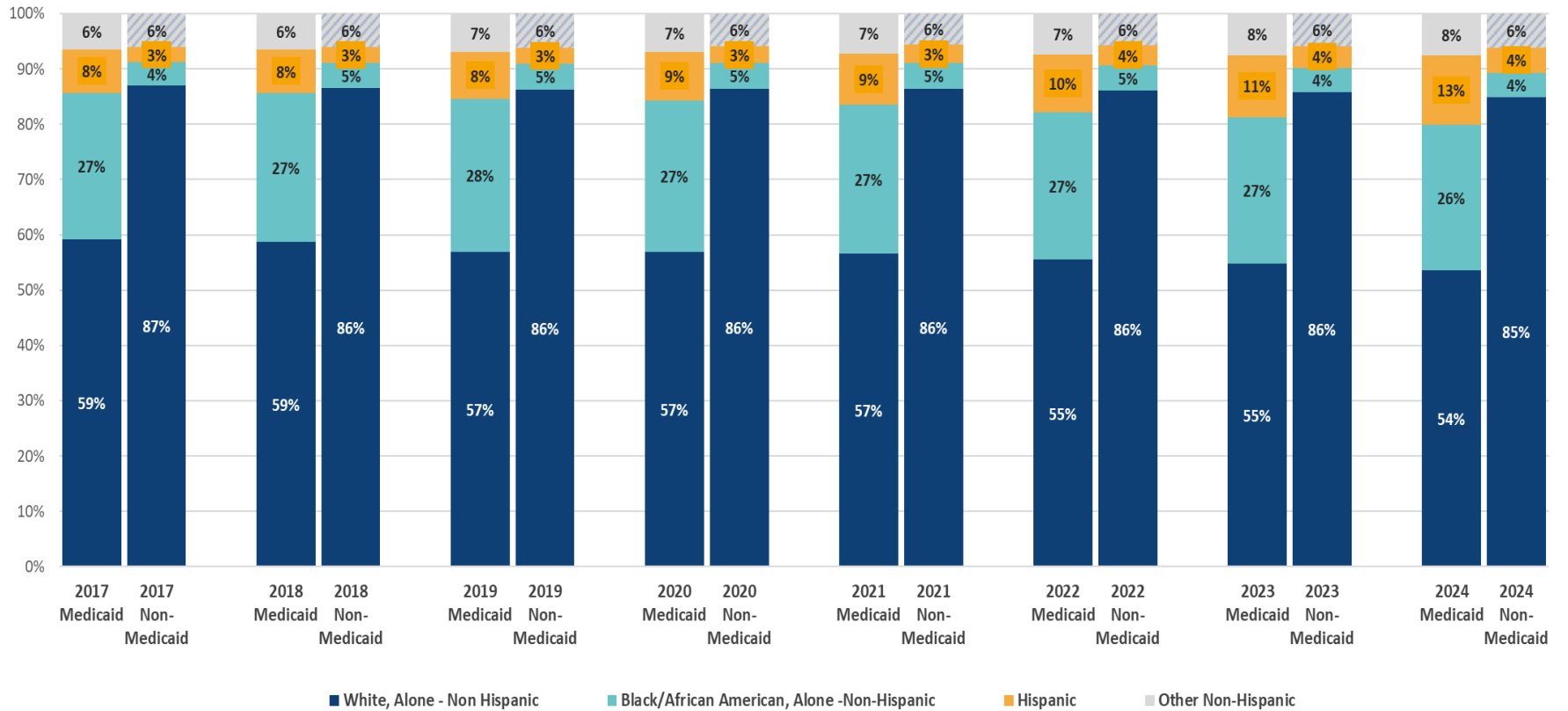
1.4 Ohio Births by Maternal Race/Ethnicity[†]

The composition of Ohio's population has been stable over the last several years. As the graph on the following page shows, there are significant differences in race/ethnicity between the populations with and without Medicaid insurance. The population with Medicaid continues to have a six-fold greater proportion of Black/African American, Alone -Non-Hispanic births compared to the population without Medicaid. Similarly, Medicaid has consistently covered more births among the Hispanic population compared to non-Medicaid payers. Please note that the Race and Ethnicity categories have been updated to align with reporting in ODH's VS data and is different from definitions in PWIC reports previous to 2022.

[†] Race and Ethnicity categories do not match those reported in previous PWIC reports for CYs17-21. This report presents data on race and ethnicity using a new combined race and ethnicity category. Prior years VS data files were re-linked and re-run to produce rates based on the new category for CYs 2017-2023.

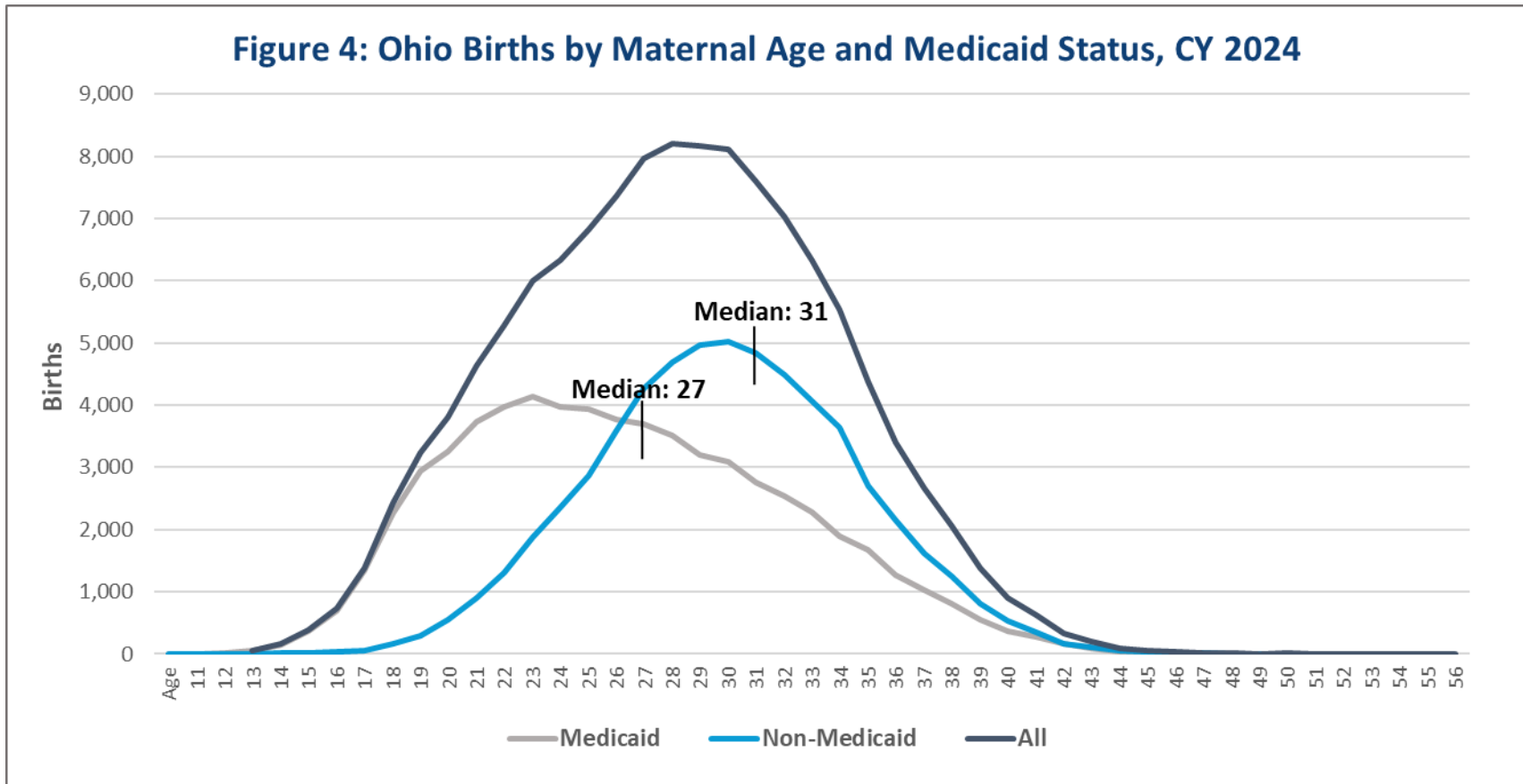
As a result of the re-linking, there may be small differences when rates determined using the VS files are compared to previous reports.

Figure 3: Ohio Births by Maternal Race and Ethnicity, CYs 2017 - 2024



1.4.1 Maternal Age

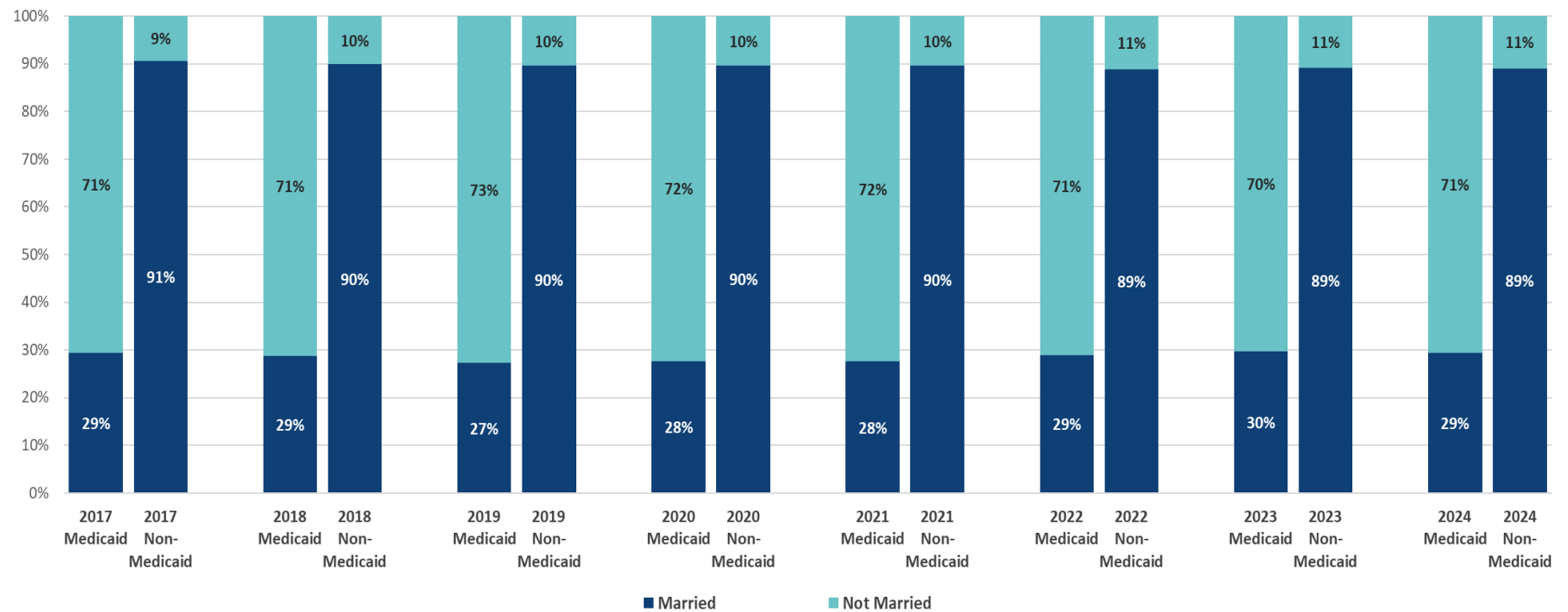
As shown in Figure 4, the median maternal age of Ohio mothers with Medicaid differs from the median maternal age of women not receiving Medicaid benefits at the time of delivery. For CYs 2017-2022, the median age for mothers with a Medicaid-paid delivery was 26 years of age, increasing to 27 in CYs 2023-2024. The median age for women with non-Medicaid-paid deliveries was 30 years of age in 2017, increasing to 31 in CYs 2018-2024.



1.4.2 Marital Status

In 2024, 29% of women with Medicaid-covered deliveries were married as compared to 89% of women with non-Medicaid paid deliveries. This is similar to 2023, when 30% of women with Medicaid-paid deliveries were identified as being married.

Figure 5: Ohio Births by Marital Status, CY 2017-2024

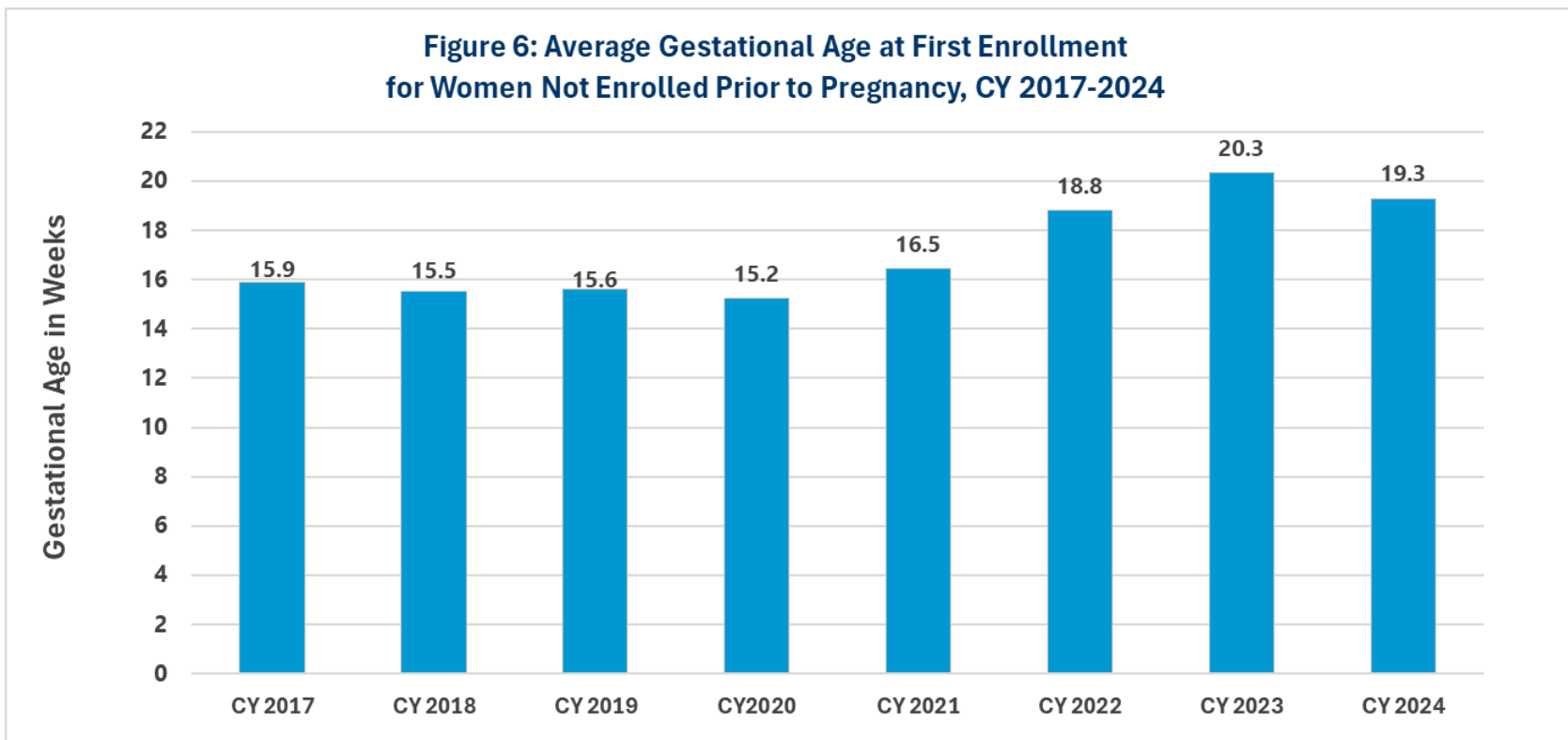


1.5 Medicaid Program Enrollment and Gestational Age[‡]

Access to high-quality prenatal care can improve maternal and infant outcomes. With that in mind, average gestational age at first enrollment is monitored and tracked for improvement purposes. Using the linked VS/Medicaid data, the numbers of women enrolled in Ohio Medicaid who delivered a liveborn infant[§] are as follows: 69,872 (CY 2017), 67,017 (CY 2018), 65,824 (CY 2019), 63,056 (CY 2020), 61,395 (CY 2021), 60,712 (CY 2022), 61,117 (CY 2023), and 58,957 (CY 2024).

[‡] The methodology for calculating time of enrollment in Medicaid was updated in the 2023 report to look at Medicaid eligibility rather than limited to Managed Care enrollment from previous reports.

[§] The number is lower than the total number of births because the total births includes both linked mothers and babies whereas this only includes mothers who were enrolled at delivery. Mothers who gave birth twice (e.g., January and December) were counted twice, once for each delivery. In the case of a multiple birth delivery (e.g., twins), the mother was counted once.



Since 2021, at least 72% of the women were enrolled in Ohio Medicaid nine months prior to the delivery date (71% in CY 2017, 70% in CY 2018, 67% in CY 2019, 65% in CY 2020, 72% in CY 2021, 76% in 2022, 77% in 2023, and 72% in 2024). As these women were enrolled in Medicaid throughout their entire pregnancy, they were removed from the analysis below, which details gestational age at enrollment into the Medicaid program.

In this analysis, 20,100 (CY 2017), 20,390 (CY 2018), 21,669 (CY 2019), 22,029 (CY 2020), 17,441 (CY 2021), 14,548 (CY 2022), 13,933 (CY 2023), and 16,217 (CY 2024) women who delivered while covered by Medicaid were not enrolled in Medicaid prior to their pregnancy. Of the women who were not already enrolled in Medicaid prior to their pregnancy, 51% (CY 2017), 52% (CY 2018), 52% (CY 2019), 53% (CY 2020), 49% (CY 2021), 42% (CY 2022), 37% (CY 2023), and 40% (CY 2024) were enrolled in Medicaid during their first trimester. For these women, the average gestational age at first enrollment was 19.3 weeks in CY 2024 (see Figures 6-8).

Please note that the date of first enrollment in Figures 6-8 reflects the initial Medicaid enrollment date regardless of program type. It is not specific to fee for service (FFS) or managed care organization (MCO) enrollment.

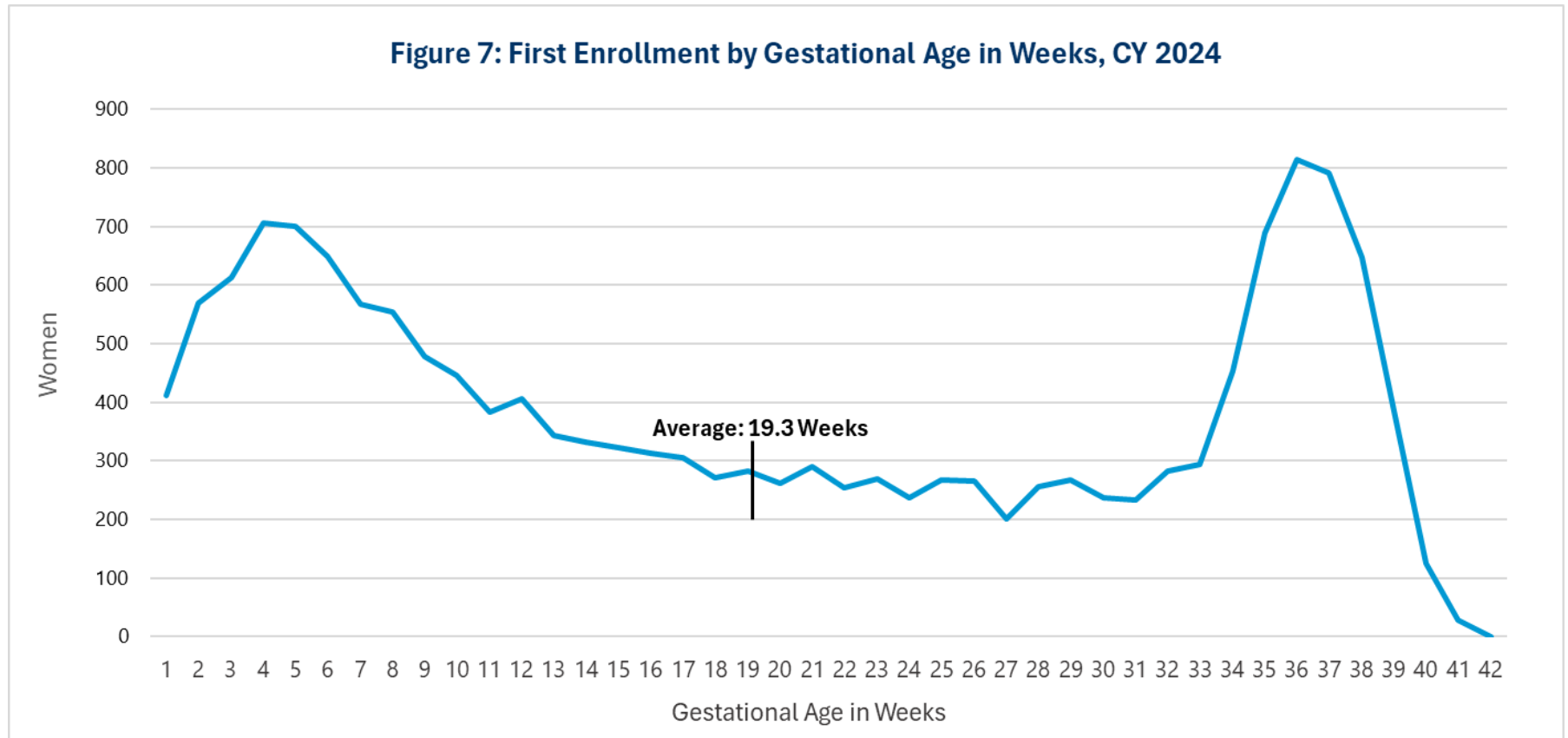
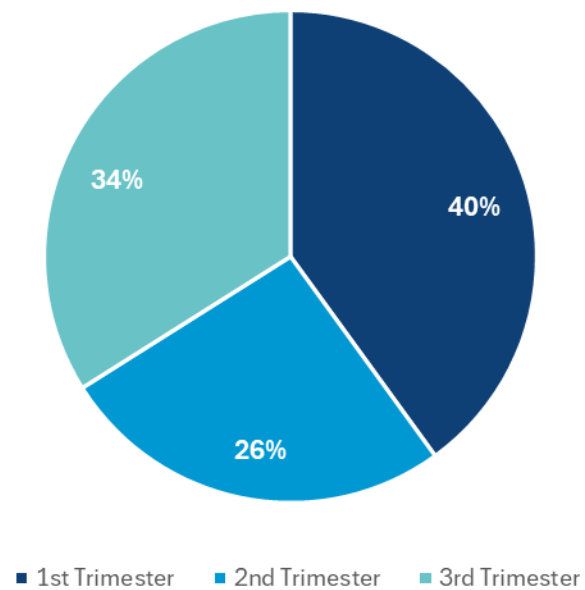


Figure 8: First Enrollment by Trimester, CY 2024



Section 2 Birth Outcomes and Risk Factors

2.1 Infant Mortality**

The methodology used to calculate infant mortality rates aligns with the standard utilized by public health officials, including NCHS and ODH. This rate represents the number of deaths in a specific year divided by the number of live births within that same year, multiplied by 1,000. ODM calculated Ohio's infant mortality rate based on the linked VS/Medicaid data. The numerator for rates (deaths) is produced using information from death certificates (mortality dataset), while the denominator (live births) is calculated from information on the birth certificates (birth dataset). Therefore, for race and ethnic-specific rates, the numerator is based on infant race/ethnicity as reported on the death certificate, while the denominator is based on the mother's race/ethnicity as reported on the birth certificate. Please note that ODM's rates do not include Ohio residents who gave birth out of state, which is an important distinction between the rates published by ODH and those generated by ODM.

Between 2017 and 2020 in Ohio, there was a downward trend in both Black/African American, Alone -Non-Hispanic and White, Alone - Non-Hispanic infant mortality rates, with a slight increase for both in 2021 and slight variation in these rates between 2021 and 2024. Mothers in the Medicaid program experienced 8.52 deaths per 1,000 live births in 2017, 9.10 deaths per 1,000 live births in 2018, 8.87 deaths per 1,000 live births in 2019, 8.77 deaths per 1,000 live births in 2020, 8.94 deaths per 1,000 live births in 2021, 9.39 deaths per 1,000 live births in 2022, 9.15 deaths per 1,000 live births in 2023, and 8.95 deaths per 1,000 lives in 2024.

** The methodology for calculating infant mortality rates changed based on ODH's specifications from previous reports to exclude those infants with missing race or ethnicity data; therefore, the historical rates on previous reports may be slightly different than the 2023 and 2024 reports.

The Ohio Department of Children and Youth (DCY) calculations may differ for the Medicaid population as DCY identifies Medicaid members based on self-reported data from birth certificates. In contrast ODM identifies Medicaid members using the linked VS birth and death data and Medicaid claims/eligibility data.

Figure 9: Ohio Medicaid Infant Mortality Rates by Medicaid Status, CYs 2017-2024

	Medicaid	Non-Medicaid
2017	8.52	5.66
2018	9.10	5.31
2019	8.87	5.24
2020	8.77	4.09
2021	8.94	4.82
2022	9.39	4.45
2023	9.15	4.78
2024	8.95	4.15

Figure 10: Ohio Infant Mortality Rates by Race/Ethnicity, CYs 2017-2024

	White, Alone - Non-Hispanic		Black/African American, Alone -Non-Hispanic		Other Non-Hispanic		Hispanic	
	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid
2017	7.45	3.49	15.05	14.33	8.19	6.08	6.88	9.94
2018	7.56	3.85	13.42	13.43	8.92	6.02	5.31	2.31
2019	7.11	3.66	13.34	13.36	6.51	10.39	6.77	3.40
2020	7.09	3.46	12.96	9.09	9.33	7.76	6.98	4.58
2021	7.33	4.12	13.53	13.57	8.66	9.63	6.55	3.46
2022	8.18	3.60	13.17	12.73	10.07	8.97	5.61	6.87
2023	7.61	3.97	13.38	13.18	9.76	7.34	6.38	9.24
2024	7.79	3.15	12.01	12.73	10.32	10.20	6.63	6.02

Figures 9 and 10 show the infant mortality rate broken down by Medicaid status, and race/ethnicity. The infant mortality rate for Medicaid-covered Black/African American, alone -non-Hispanic births had been decreasing between 2017 and 2020, with 2017 among the highest rates of infant mortality in the last 10 years for the Black/African American, Alone -non-Hispanic population. Between 2020 and 2023, the rate remained relatively stable, ranging from 12.96 to 13.53. In 2024, the rate was 12.01, a 10.2% decrease compared to the 2023 rate. The 2024 rate is the lowest since 2017 for this population.

Infant mortality rates among Medicaid covered White, alone – non-Hispanic and Other-non-Hispanic births were higher in 2024 than in 2023. Hispanic mothers historically have had the lowest overall infant mortality rates. It is important to take denominator size (N) into account when comparing demographic breakdowns, including those of race/ethnicity. The Hispanic population is much smaller than the others, particularly in the non-Medicaid population, resulting in fairly wide swings in the rates.

2.2 Very Preterm Birth, Preterm Birth, and Low Birthweight

Prematurity is a broader public health issue across the state and is not limited to the Medicaid population. Prematurity (birth prior to 37 weeks gestation) and low birthweight (a birthweight under 2,500 grams) are significant risk factors for infant mortality.^{††} Very preterm birth (VPTB:<32 weeks gestation), preterm birth (PTB:<37 weeks gestation), and low birthweight (LBW) rates have remained consistent over time (CYs 2017-2024) for both Medicaid- and non-Medicaid-paid births (Figure 11).

Figure 11: Ohio Very Preterm, Preterm, and Low Birthweight Rates by Medicaid Status, CYs 2017-2024

	Very Preterm Birth		Preterm Birth		Low Birthweight	
	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid
2017	3.13%	1.20%	12.25%	7.95%	10.86%	5.53%
2018	3.18%	1.04%	12.32%	7.73%	10.90%	5.34%
2019	3.36%	1.03%	12.77%	7.74%	10.96%	5.45%
2020	3.14%	0.88%	12.80%	7.29%	11.03%	5.19%
2021	3.48%	0.89%	13.17%	7.68%	11.47%	5.39%
2022	3.35%	0.90%	13.37%	7.89%	11.33%	5.46%
2023	3.47%	0.85%	13.28%	7.74%	11.38%	5.40%
2024	3.63%	0.77%	13.66%	8.03%	11.73%	5.32%

Similar to the race/ethnicity breakdown of infant mortality rates in section 2.1, the VPTB, PTB, and LBW rates by Medicaid status and race/ethnicity remain consistent over time, with infants in the Medicaid program not faring as well (Figures 12 and 13). In parallel to the trends seen with infant mortality rates by race and ethnicity, the rates for VPTB, PTB, and LBW are higher for the Black/African American, Alone -Non-Hispanic population for all eight measurement years with or without coverage by Medicaid.

^{††} Centers for Disease Control and Prevention. Infant Mortality. Retrieved December 18, 2014, from <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>.

Figure 12: Very Preterm, Preterm, and Low Birthweight Rates in Ohio Medicaid-Paid Births by Race and Ethnicity, CYs 2017- 2024

	White, Alone - Non-Hispanic	Black/African American, Alone - Non-Hispanic	Other - Non- Hispanic	Hispanic
Very Preterm Births				
2017	2.64%	4.47%	2.67%	2.56%
2018	2.89%	4.11%	3.20%	2.18%
2019	2.99%	4.43%	3.26%	2.34%
2020	2.83%	3.97%	3.45%	2.35%
2021	3.27%	4.42%	3.18%	2.19%
2022	3.01%	4.41%	3.57%	2.30%
2023	3.45%	3.92%	3.52%	2.48%
2024	3.55%	4.46%	3.25%	2.45%
Preterm Births				
2017	11.35%	14.88%	10.69%	11.35%
2018	11.74%	14.33%	11.51%	10.18%
2019	12.19%	14.47%	12.20%	11.28%
2020	12.15%	14.96%	12.25%	10.73%
2021	12.50%	15.63%	12.40%	10.63%
2022	12.94%	15.38%	12.94%	10.84%
2023	12.95%	14.56%	13.72%	11.46%
2024	13.43%	15.63%	12.38%	11.16%
Low Birthweight				
2017	9.39%	14.62%	11.10%	8.97%
2018	9.78%	14.02%	11.23%	8.17%
2019	9.68%	14.16%	11.68%	8.26%
2020	9.81%	14.64%	10.68%	8.05%
2021	10.21%	15.31%	11.07%	8.11%
2022	10.07%	15.03%	11.96%	8.09%
2023	10.02%	14.95%	12.28%	8.90%
2024	10.64%	15.61%	10.96%	8.70%

Figure 13: Very Preterm, Preterm, and Low Birthweight Rates in Ohio Non-Medicaid Paid Births by Race and Ethnicity, CYs 2017-2024

	White, Alone - Non-Hispanic	Black/African American, Alone - Non-Hispanic	Other - Non- Hispanic	Hispanic
Very Preterm Births				
2017	1.10%	2.91%	1.27%	1.68%
2018	0.94%	2.73%	0.99%	0.87%
2019	0.88%	2.60%	1.65%	1.30%
2020	0.80%	1.93%	1.14%	1.09%
2021	0.78%	2.68%	1.42%	0.84%
2022	0.79%	2.33%	0.97%	1.56%
2023	0.74%	2.55%	0.97%	1.06%
2024	0.68%	1.91%	1.02%	0.94%
Preterm Births				
2017	7.57%	12.84%	9.09%	9.51%
2018	7.52%	12.15%	7.34%	7.32%
2019	7.44%	11.58%	8.88%	7.93%
2020	7.00%	11.20%	7.76%	8.30%
2021	7.43%	12.09%	8.21%	7.52%
2022	7.61%	10.97%	8.68%	9.31%
2023	7.60%	10.82%	7.90%	7.18%
2024	7.76%	11.42%	8.47%	9.04%
Low Birthweight				
2017	5.09%	10.10%	8.06%	6.50%
2018	4.92%	11.30%	6.88%	4.96%
2019	5.01%	9.39%	8.26%	5.84%
2020	4.77%	9.81%	7.23%	6.08%
2021	4.99%	10.45%	7.86%	5.00%
2022	5.08%	9.08%	7.57%	6.40%
2023	5.00%	10.50%	7.39%	5.57%
2024	4.86%	9.76%	8.06%	5.77%

2.2.1 Risk Factors for Preterm Birth and Low Birthweight

In the section that follows ODM describes risk factors for mothers covered by the Medicaid program compared to those who do not have Medicaid coverage. As the data shows, there is a greater risk for a preterm and/or low birthweight delivery if the mother had a previous preterm birth, low maternal weight gain, smoking history during pregnancy, delivery within 18 months of a prior delivery (birth spacing), or little to no prenatal care.¹⁻³

As shown in Figure 14, women with Medicaid experience higher rates of these risk factors compared to women without Medicaid, with the exception of birth spacing, which is slightly lower in the Medicaid population. In CY 2024, 8.22% of mothers covered by Medicaid had a previous preterm birth, a slight increase from 7.99% in 2023. For mothers without Medicaid, the rate in 2024 was 4.06%, a slight increase from 3.90% in 2023. The measure for low maternal weight gain shows a gradual increase in prevalence over time (CYs 2017-2024) for both Medicaid and non-Medicaid-covered populations. Although smoking rates have decreased for mothers with and without Medicaid coverage over the years, the rates for pregnant women with Medicaid were eight to ten times higher than rates for mothers not covered by Medicaid. In CY 2024, 9.19% of mothers with Medicaid coverage smoked during pregnancy, compared to 0.96% of mothers without Medicaid.

The rate of less than 18 months between births was 8.59% for mothers covered by Medicaid and 10.07% for mothers not covered by Medicaid, a slight increase compared to CY 2023 for both populations. Between CYs 2017 and 2024, the rate of mothers with no prenatal care has been essentially stable at 2.23%-2.35% for Medicaid pregnancies, and 0.64%-0.81% for non-Medicaid pregnancies. For all the tables and trends below please note the limited number of observations. More data is required to ascertain the strength of the trends.

Figure 14: Selected Risk Factors for Prematurity and Low Birthweight, CYs 2017-2024

Previous Preterm Birth			Low Maternal Weight Gain		Smoking During Pregnancy		Birth Spacing (<18 months)		No Prenatal Care	
	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid	Non-Medicaid
2017	7.45%	3.94%	33.68%	23.39%	22.63%	2.67%	6.44%	7.97%	2.23%	0.64%
2018	8.15%	4.18%	34.14%	24.25%	21.84%	2.67%	6.89%	8.24%	2.18%	0.68%
2019	8.30%	4.05%	34.35%	24.36%	19.75%	2.45%	6.97%	8.60%	2.24%	0.70%
2020	7.95%	4.13%	34.11%	24.91%	19.27%	2.17%	6.88%	8.55%	2.21%	0.61%
2021	7.86%	3.92%	35.13%	25.25%	16.19%	1.83%	7.11%	8.73%	2.40%	0.77%
2022	8.07%	3.92%	37.02%	26.44%	13.35%	1.50%	7.83%	9.25%	2.44%	0.83%
2023	7.99%	3.90%	36.35%	26.50%	11.03%	1.10%	7.91%	9.53%	2.47%	0.89%
2024	8.22%	4.06%	36.49%	27.11%	9.19%	0.96%	8.59%	10.07%	2.35%	0.81%

Figure 15: Selected Risk Factors for Prematurity and Low Birthweight in Ohio Medicaid-Paid Births by Race and Ethnicity, CYs 2017-2024

Previous Preterm Birth					Low Maternal Weight Gain				Smoking During Pregnancy			
	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic
2017	6.30%	10.46%	6.07%	7.00%	31.23%	37.61%	34.52%	38.16%	30.45%	11.11%	15.44%	8.61%
2018	6.92%	11.41%	6.18%	7.68%	31.66%	37.80%	34.06%	40.20%	29.78%	10.39%	15.29%	7.22%
2019	7.11%	11.14%	7.37%	7.79%	32.03%	37.43%	34.52%	39.83%	27.33%	9.45%	14.17%	6.71%
2020	7.04%	10.61%	6.24%	6.98%	30.99%	37.89%	35.03%	41.94%	26.87%	8.83%	14.00%	6.52%
2021	6.73%	10.58%	7.35%	7.25%	32.59%	37.94%	35.92%	41.97%	22.91%	7.29%	10.65%	5.41%
2022	6.76%	11.10%	7.81%	7.29%	34.59%	40.21%	36.16%	42.72%	18.91%	6.46%	9.43%	4.20%
2023	7.20%	10.20%	7.61%	6.87%	32.86%	40.55%	36.89%	43.19%	15.75%	5.73%	7.07%	3.03%
2024	7.33%	10.69%	7.66%	7.06%	32.16%	42.48%	35.66%	42.86%	13.38%	4.80%	5.96%	2.47%

Figure 15 continued: Selected Risk Factors for Prematurity and Low Birthweight in Ohio Medicaid-Paid Births by Race/Ethnicity, CYs 2017-2024

Birth Spacing (< 18 months)					No Prenatal Care			
	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic
2017	6.56%	6.64%	5.89%	5.44%	2.04%	2.93%	1.95%	1.47%
2018	6.85%	7.36%	6.53%	6.07%	2.08%	2.72%	1.76%	1.52%
2019	7.22%	7.04%	6.50%	5.48%	2.11%	2.65%	1.87%	2.00%
2020	7.02%	7.22%	5.64%	5.93%	2.10%	2.51%	2.11%	2.07%
2021	7.03%	7.79%	6.98%	5.76%	2.39%	2.58%	2.22%	2.14%
2022	7.72%	8.88%	7.32%	6.30%	2.42%	2.57%	2.29%	2.25%
2023	7.94%	8.70%	7.21%	6.48%	2.24%	2.72%	3.15%	2.44%
2024	8.83%	9.14%	8.24%	6.65%	2.22%	2.69%	1.88%	2.41%

Figure 16: Selected Risk Factors for Prematurity and Low Birthweight in Ohio Non-Medicaid Paid Births by Race and Ethnicity, CYs 2017-2024

Previous Preterm Birth					Low Maternal Weight Gain				Smoking During Pregnancy			
	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic
2017	3.81%	6.93%	3.32%	4.97%	22.45%	33.23%	27.30%	29.92%	2.84%	1.67%	1.33%	1.87%
2018	4.01%	7.10%	3.72%	5.54%	23.30%	34.47%	27.44%	29.48%	2.85%	1.73%	1.34%	1.62%
2019	3.88%	8.01%	3.36%	4.13%	23.37%	33.51%	28.76%	29.34%	2.64%	1.65%	0.91%	1.25%
2020	3.95%	7.23%	4.01%	4.58%	23.83%	35.71%	29.86%	29.42%	2.33%	1.60%	0.91%	1.20%
2021	3.69%	7.16%	3.91%	5.19%	24.42%	34.65%	27.39%	30.26%	1.98%	1.50%	0.55%	0.54%
2022	3.73%	6.99%	4.01%	4.59%	25.42%	35.96%	30.36%	32.52%	1.59%	1.17%	0.70%	1.06%
2023	3.71%	5.99%	4.46%	4.75%	25.32%	35.98%	31.47%	34.21%	1.19%	0.84%	0.35%	0.66%
2024	3.92%	6.89%	3.38%	4.78%	25.95%	36.05%	30.68%	35.45%	1.01%	0.75%	0.65%	0.72%

Figure 16 continued: Selected Risk Factors for Prematurity and Low Birthweight in Ohio Non-Medicaid Paid Births by Race and Ethnicity, CYs 2017-2024

Birth Spacing (< 18 months)					No Prenatal Care			
	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic	White, Alone - Non Hispanic	Black/African American, Alone -Non-Hispanic	Other Non-Hispanic	Hispanic
2017	8.04%	8.01%	7.26%	7.42%	0.55%	1.55%	0.90%	1.13%
2018	8.36%	8.35%	7.20%	6.48%	0.62%	1.65%	0.58%	1.05%
2019	8.71%	8.90%	7.40%	7.42%	0.64%	1.10%	0.70%	1.43%
2020	8.63%	8.51%	7.73%	7.68%	0.56%	1.14%	0.63%	1.04%
2021	8.80%	9.27%	8.06%	7.40%	0.73%	1.22%	0.85%	1.05%
2022	9.24%	10.80%	9.05%	7.62%	0.77%	0.95%	1.00%	1.71%
2023	9.84%	8.43%	7.50%	7.09%	0.85%	1.29%	0.65%	1.55%
2024	10.37%	8.81%	8.24%	7.97%	0.74%	1.40%	0.76%	1.67%

When comparing these pregnancy risk factors across race/ethnicity breakdowns within the Medicaid program, mothers who are White, alone – non-Hispanic, mothers who are Other non-Hispanic, and mothers who are Hispanic only have fewer risk factors (Figure 15) compared to mothers who are Black/African American, alone – non-Hispanic. This disparity is most pronounced in the measures of previous preterm birth and low maternal weight gain. In CY 2024, only 7.33% of White, alone – non-Hispanic mothers, 7.66% of Other non-Hispanic mothers, and 7.06% of Hispanic mothers had a previous preterm infant compared to 10.69% of mothers who are Black/African American, alone -non-Hispanic. And only 32.16% of White, alone – non-Hispanic mothers, and 35.66% of Other non-Hispanic mothers had a low maternal weight gain compared to 42.48% of Black/African American, alone – non-Hispanic mothers. Hispanic mothers experience greater rates of low maternal weight gain compared to non-Hispanic populations (42.86% in CY 2024). The risk factor that is substantially more pronounced for white, alone – non-Hispanic mothers is smoking cigarettes. The measure of smoking during pregnancy in the population of White, alone – non-Hispanic mothers covered by Medicaid is well over twice the rate for Black/African American, alone – non-Hispanic -mothers covered by Medicaid, and five times the rate for Hispanic mothers covered by Medicaid.

The trends in risk factors for individuals without Medicaid are generally lower in all categories with similar patterns by race/ethnicity stratification. Black/African American, alone -non-Hispanic mothers without Medicaid coverage again experience greater rates of risk factors, particularly for previous preterm births, but also for low maternal weight gain and no prenatal care. For those women not insured by Medicaid, smoking rates are lower for Black/African American, alone -non-Hispanic women, Other non-Hispanic women, and Hispanic women (0.75%, 0.65%, and 0.72% respectively in CY 2024) compared to 1.01% for white women in CY 2024 – strikingly less than the 4.80% for Black/ African American, alone -non-Hispanic women, 5.96% for Other on-Hispanic women, 2.47% for Hispanic women, and 13.38% for white women covered in the Medicaid program in CY 2024.

2.3 Preterm Birth Reduction Effort

The State of Ohio remains committed to reducing the incidence of preterm birth, one of the largest contributors to infant mortality. In CY 2019, ODM began the process of formalizing its population health management framework as it designed Ohio's Next Generation of managed care. ODM's population health approach focuses on identifying populations at highest risk of poor health outcomes, assessing medical and social needs, and designing policies, programs, and initiatives to address these needs. ODM's Next Generation model emphasizes a person-centered approach to strategies with the co-designing of interventions with individuals, families, communities, and providers. This approach facilitates state and local alignment and collaboration across health systems and communities for greater collective impact and sustainability.

To support this approach, ODM is continuing its long-standing preterm birth prevention partnerships with perinatal clinicians and hospitals affiliated with the Ohio Perinatal Quality Collaborative (OPQC) as well as Medicaid managed care organizations (MCO), partner state agencies, home health agencies, pharmacies, and community organizations. ODM is also encouraging increased data usage, data sharing, and key metric alignment by these partners across the healthcare system. This includes encouraging greater MCO use of the enhanced maternal care file which combines vital statistics and claims history for Medicaid-insured individuals, allowing for proactive MCO efforts to support individuals.

The timely identification and mitigation of pregnancy and pregnancy-related risk factors has been found to have one of the greatest impacts in preventing preterm births. Building on past quality improvement efforts, ODM worked with partners to first create and then update a standardized web-based reporting form to communicate pregnancy status and key medical and social needs: the Pregnancy Risk Assessment Form (PRAF 2.0). In CY 2020, ODM also introduced a second electronic form, the Report of Pregnancy (ROP), which can be utilized by non-obstetrical entities to report the need for women to be connected to a prenatal care provider.

Both forms are used for timely pregnancy identification and directly link to Ohio's eligibility system to prevent the inadvertent loss of healthcare coverage during pregnancy. They also serve as referrals to the Ohio Department of Health's home visiting, tobacco cessation, and Women, Infant, and Children (WIC) nutrition programs, and allow Medicaid managed care organizations to link women to other needed services.

In July 2020, ODM introduced a policy change to incentivize the use of the electronic version of the PRAF 2.0 through increased reimbursement. As part of ongoing quality improvement efforts, new questions were added to allow for greater connectivity to resources for mothers and infants impacted by substance use disorders. Further revisions will be established based on the input from mothers, clinicians, and others charged with improving maternal and infant health outcomes.

In July 2022, Ohio's Medicaid MCOs began a collaborative 18-month quality improvement effort to increase the use of the PRAF 2.0 to identify pregnancy and connect women to needed services and supports. Key interventions included technical assistance to practices that provide prenatal care to aid them in submitting the PRAF 2.0, the use of gap reports to identify practices that were not submitting PRAF 2.0s for their pregnant patients, and an additional incentive from the MCOs to encourage PRAF 2.0 submission. MCOs met their improvement goal in 2023, increasing median weekly submissions from 330 to 840 by December 31, 2023.

In January of 2025, ODM incorporated the use of the PRAF into its population health management strategy for ensuring that women and infants are connected care and needed resources. This strategy was also incorporated into the MCO population health strategies and MCOs were incentivized to further increase performance through incorporation of ODM's population health framework into Medicaid Managed Care Quality Withhold Program. This change with increased ease of submission through incorporation of the PRAF 2.0 into nine EPIC electronic health record systems and seven Azara systems, and allowing postpartum PRAF submissions resulted in the average median PRAFs per week further increasing to 924 per week in SFY 2025.

Trends that warrant further exploration are adverse pregnancy outcomes due to the lack of needed community services and supports. These challenges may also be communicated through the PRAF for timely linkages to community services and supports. As described in Section 2.5 below, the PRAF may also serve as a key communication tool for multiple facets of ODM's Maternal and Infant Support Program (MISP) as well as a backbone for quality and care improvement fueled by the Next Generation of managed care.

ODM continues to work with preterm birth prevention partners, especially in the 10 communities that experience the greatest racial disparities in infant mortality. In 2016, ODM and Medicaid's managed care organizations began the Community Infant Mortality Partnership with nine of the communities to support addressing racial disparities, social challenges, and isolation that negatively impact maternal and infant outcomes. Initial emphasis included building capacity and expanding services for women in their communities by funding community-based organizations to provide services within the nine communities.

In July 2022, MCOs awarded more than \$26 million in grants to 106 community-based organizations for State Fiscal Year (SFY) 2023-2024 to focus on key evidence-based interventions including the use of doulas, start-up and expansion funds for prenatal care (group education formal and informal) and nurse home visiting (e.g., Nursing Family Partnership), and utilization of community health workers who practice under supervision. In

addition, a variety of other interventions were funded including peer-to-peer support, women's neighborhood advisory groups, support groups, breastfeeding support, fatherhood initiatives, and centralized intake/care connectors.

To date, more than 35,000 women and their families have received support and services through the Community Infant Mortality Partnership. Community-based organizations have engaged with communities/neighborhoods and report improvements such as greater connectivity among women with the health system and increased trust of maternal care providers, improved breastfeeding rates, and reduced preterm births.

ODM also continues to listen to the perspectives of Medicaid-insured women as they share their pregnancy and postpartum experiences. In initial focus groups, women in the Medicaid program expressed distrust in the health systems, citing lack of provider empathy and inadequate communication. They also expressed a lack of social supports, community resources, and routine coverage of community services such as doulas and lactation nurses. These are all being considered as ODM implements strategies to continuously improve maternal and infant outcomes.

Based on the experiences and learnings from the MCOs' community-based infant mortality reduction grant efforts, as well as the feedback provided to ODM in the focus groups referenced above, Ohio Medicaid began implementing new statewide benefits and enhanced coverage for additional perinatal supports through its MISP, which extends well beyond preterm birth prevention. Additional information about the MISP can be found in Section 2.5 below.

2.4 Smoking Cessation

Smoking is one of the most common modifiable risk factors for infant mortality as it increases the risk of preterm birth, low birthweight, and sleep-related deaths. Ohio is expanding publicly funded maternal and child health programs and recommended clinical practice guidelines from the U.S. Public Health Service that teach best practices in smoking cessation. The state also promotes a nationally recognized, evidence-based smoking cessation model to reduce smoking among women during pregnancy. The Moms Quit for Two program utilizes the “Baby and Me – Tobacco Free” model and is offered across Ohio by many local health departments, Ohio Equity Initiative teams, and other community organizations.

ODM is continuing to partner with the Ohio chapter of the American Academy of Pediatrics in the Care2 project which aims to promote interconception care by identifying maternal risk through assessments at well visits and provide treatment and/or referrals to help moms improve interconception health. The target population is Ohio mothers aged 18 and over who are attending well-child visits for their children under age 5. The interventions employed by the project are designed to help families with tobacco and vaping cessation, improve family planning and multivitamin use, increase the safety of sleeping environments for Ohio infants, and increase screening and treatment of maternal depression. State fiscal year 2023 focused on applying lessons learned from the Smoke Free Families (SFF) Learning Collaborative which focused on identifying and addressing caregiver smoking and the national Interventions to Minimize Preterm and Low Birth Weight through Continuous Improvement Techniques (IMPLICIT) model. This work continued with the recruiting of additional sites in SFYs 2023-2025 with interventions focused on using the 5As to assess for tobacco exposure and support of the quitting process, as well as referral of individuals who are willing-to-quit to treatment (e.g., Ohio Quitline)

Success in SFY 2025 included more rapid implementation of electronic health record tools such as SMARTSets and EHR forms to streamline the charting process while making it easier to ensure that screening is accomplished during the visit, increased consistency in tobacco screening. Additionally, many of the sites have integrated sustainability planning to ensure that process improvements are maintained over time.

There has been a dramatic increase in the rates of tobacco screening and counseling for women across all races and ethnicities in the Medicaid program. Beginning in 2017, the Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention measure was added to the list of quality metrics for providers participating in Ohio’s patient-centered medical home initiative, the Comprehensive Primary Care (CPC) program. This level of accountability, as well as additional focus through the Smoke-Free Families quality improvement efforts, the Baby and Me – Tobacco Free model, and the 2018 Medicaid support for the Quitline may all have influenced these improvements as detailed in the table below.

Figure 17: Tobacco Cessation and Counseling for Women 15-44 Years of Age by Race and Ethnicity, CYs 2017-2024

		Race			Ethnicity	
	Overall Rate	White	Black	Other	Hispanic	Non-Hispanic
2017	10.72%	11.72%	8.87%	9.19%	9.55%	10.76%
2018	21.14%	22.23%	18.92%	20.58%	23.55%	21.04%
2019	35.89%	36.53%	33.43%	41.60%	38.99%	35.74%
2020	33.01%	33.09%	31.94%	38.05%	37.69%	32.76%
2021	31.48%	31.71%	32.29%	26.24%	31.65%	31.47%
2022	32.12%	32.39%	32.11%	29.91%	36.30%	31.88%
2023	33.43%	34.35%	32.04%	31.21%	36.56%	33.25%
2024	37.61%	39.02%	35.20%	35.27%	38.86%	37.54%

2.5 Maternal and Infant Support Program

In 2021, Ohio began implementation of its Maternal and Infant Support Program (MISP), which establishes services and strategies to improve care and reduce differences in maternal and infant outcomes, including infant mortality. MISP supports high-quality perinatal and infant care using clinical interventions and evidence-based or -informed community-based services. The program also promotes improved population health management and individually configured services. Personalized care gives families the clinical and community supports they need, while helping them build a longitudinal trusting relationship with their healthcare team.

Ohio has initiated several key program and policy changes as a result of MISP since 2021. These include expanded prenatal and postnatal services to ensure more Ohio mothers have healthy births and quality care post-birth. Ohio has made several updates to identify

pregnant women and their health and social needs as early in pregnancy as possible. These changes allow ODM and its partners to provide care and supports early in pregnancy, including eligibility retention and Medicaid enrollment. Ohio has added a \$30 reimbursement for electronic submission of a demographic Report of Pregnancy (ROP) form for non-OB/GYN providers, increased reimbursement to \$90 for an electronic submission of a Pregnancy Risk Assessment Form (PRAF) for OB/GYNs, and worked with its Managed Care Organizations (MCOs) to increase PRAF submissions to over 80% of all pregnant women having a PRAF submitted during pregnancy.

Ohio has made several updates to its lactation counseling and supports benefit to improve opportunities to sustain breastfeeding, including increasing payments for, increasing the frequency of, and improving the reimbursement process for lactation supplies, including breast pumps, breast pump parts, and breast milk storage bags. Ohio has also expanded the types of providers with IBCLC certification who can be reimbursed for providing lactation services, in addition to working with the MCOs and the Women, Infants and Children (WIC) program to improve member outreach materials and streamline processes for members to receive breastfeeding services and supplies. As a result of these efforts, as one example, breast milk storage reimbursement increased from 163,000 bags in 2022 to 379,000 bags in 2023.

In collaboration with Ohio's Department of Children and Youth, ODM added reimbursement for group prenatal care and group pregnancy education to increase the number of pregnant women benefitting from programs such as CenteringPregnancy, funding group prenatal care for over 1500 women in state fiscal years 2024 and 2025. ODM also added a reimbursement structure for nurse home visiting provided via Nurse Family Partnership to provide additional funding so that more people with Medicaid coverage can receive nurse home visits.

In April 2022, Ohio extended its window of postpartum Medicaid eligibility from 60 days to 12 months, ensuring over 10,000 recently postpartum people retain care per year and can afford to breastfeed longer and get care for pregnancy-related or exacerbated chronic conditions such as diabetes and cardiovascular conditions.

Along with the MCOs, ODM continued to fund its Infant Mortality reduction grants, ensuring that over 20,000 pregnant and postpartum women with babies at the greatest risk for infant mortality received community-based support services.

Together with the Ohio Board of Nursing, Ohio initiated Medicaid reimbursement for doula providers and services effective October 2024, supporting improved pregnancy and birth

outcomes for pregnant and postpartum women. Since October 2024, ODM has enrolled over 120 doulas, providing almost 200 women with doula services supported by Medicaid.

Ohio has enrolled more than 140 obstetrical practices in its Comprehensive Maternal Care program, which started in 2023, and now includes over 48,000 pregnant or postpartum women receiving care each quarter and over six million dollars in payments to OB practices to support population health activities and improve patient experience of care.

In close collaboration with the Department of Children and Youth, ODM successfully enrolled its first Pediatric Recovery Center, allowing reimbursement for services to substance-exposed infants outside of a NICU. ODM also established the ability to reimburse for postpartum nurse home visiting via the Family Connects program, established and maintained by the Department of Children and Youth.

Section 3: Prenatal and Postnatal Visits

3.1 Measure Results by Statewide Average and Medicaid MCOs

HEDIS, the Healthcare Effectiveness Data and Information Set, is a healthcare quality measurement tool developed by the National Committee for Quality Assurance (NCQA) that is used by more than 90% of America's health plans to monitor the provision of health services across five domains of care. Self-reported, audited HEDIS data from Ohio's seven MCOs were used to examine prenatal and postpartum care within the Medicaid program, as detailed in Figure 18. Self-reported, audited HEDIS rates may contain data from both claims and medical record reviews (hybrid methodology)^{††}.

Figure 18: Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2017-2024

	Timeliness of Prenatal Care		Postpartum Care	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE				
2017	81.1%	P25-P50	63.4%	P25-P50
2018	83.5%	P50-P75	65.8%	P50-P75
2019	86.89%	P50-P75	77.53%	≥P90
2020	85.11%	P25-P50	76.79%	P50-P75
2021	84.77%	P25-P50	77.38%	P50-P75
2022	82.65%	P25-P50	72.57%	P10-P25
2023	83.29%	P25-P50	75.83%	P25-P50
2024	88.30%	P50-P75	81.10%	P50-P75
AMERIHEALTH				
2024	90.37%	P75-P90	87.41%	≥P90
BUCKEYE				
2017	86.6%	P50-P75	63.7%	P25-P50
2018	79.1%	P25-P50	59.4%	P10-P25
2019	90.75%	P75-P90	78.35%	≥P90
2020	84.91%	P25-P50	75.43%	P25-P50

^{††} The newer Next Generation Managed Care Organizations did not have reportable HEDIS results for certain measures in CY 2023.

2021	84.91%	P25-P50	76.89%	P25-P50
2022	82.73%	P25-P50	71.29%	P10-P25
2023	82.48%	P25-P50	74.70%	P25-P50
2024	90.02%	P75-P90	85.64%	P75-P90
CARESOURCE				
2017	78.6%	P25-50	62.3%	P25-50
2018	83.7%	P50-P75	66.4%	P50-P75
2019	82.00%	P25-P50	75.67%	≥P90
2020	87.10%	P25-P50	76.89%	P50-P75
2021	85.16%	P25-P50	77.86%	P50-P75
2022	81.75%	P25-P50	71.29%	P10-P25
2023	83.21%	P25-P50	76.64%	P25-P50
2024	88.56%	P50-P75	79.08%	P25-P50
HUMANA				
2024	85.64%	P50-P75	84.18%	P75-P90
MOLINA				
2017	82.8%	P25-50	62.6%	P25-50
2018	83.0%	P25-P50	67.4%	P50-P75
2019	98.54%	≥P90	79.81%	≥P90
2020	84.43%	P25-P50	74.21%	P25-P50
2021	83.21%	P25-P50	75.67%	P25-P50
2022	82.73%	P25-P50	73.72%	P25-P50
2023	82.32%	P25-P50	73.48%	P10-P25
2024	85.64%	P50-P75	79.56%	P25-P50
PARAMOUNT/ANTHEM				
2017	83.0%	P25-50	69.1%	P50-75
2018	86.4%	P50-P75	70.3%	P75-P90
2019	91.48%	≥P90	79.56%	≥P90
2020	86.13%	P25-P50	79.56%	P50-P75
2021	83.70%	P25-P50	79.32%	P50-P75
2022	85.40%	P50-P75	76.89%	P25-P50
2023	NA	NA	NA	NA
2024	87.83%	P50-P75	82.73%	P50-P75
UNITED HEALTH				
2017	83.7%	P50-75	64.3%	P25-50
2018	85.5%	P50-P75	65.5%	P50-P75
2019	87.35%	P50-P75	80.05%	≥P90
2020	82.97%	P10-P25	77.86%	P50-P75

2021	85.16%	P25-P50	76.16%	P25-P50
2022	84.18%	P25-P50	75.43%	P25-P50
2023	85.64%	P50-P75	75.91%	P25-P50
2024	88.32%	P50-P75	78.83%	P25-P50

Using HEDIS methodology, in 2024, 88.30% of women in Medicaid MCOs received timely prenatal care (i.e., visit in the first trimester or within 42 days of MCO enrollment), which was an increase from 83.29% in 2023. The percentage of women who received a postpartum visit on or between 7 and 84 days after delivery also increased in 2024 to 81.10% from 75.83% in 2023.

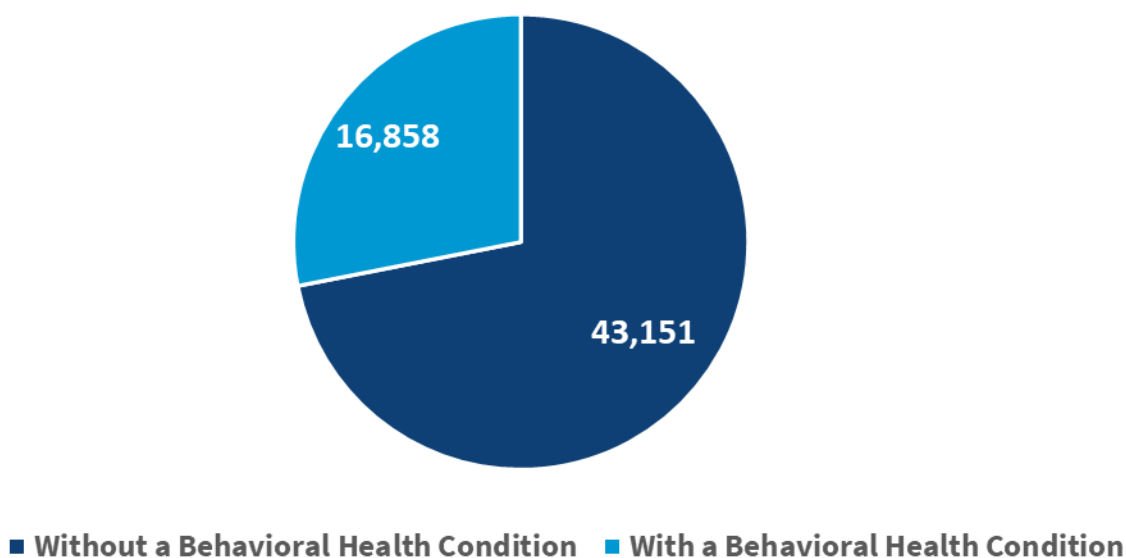
The percentile ranking represents how Ohio’s Medicaid MCOs’ HEDIS results compare with national Medicaid benchmarks collected by NCQA. MCO’s performance for each calendar year is evaluated relative to benchmarks that were developed by NCQA using previous measurement year data. A higher benchmark comparison indicates better performance – an ODM statewide MCO rate comparable to the national 75th percentile for a particular measure indicates that ODM’s performance is better than 75% of the rates reported for Medicaid plans across the country. Ohio’s Medicaid MCOs were between the 25th and 50th national percentiles for the timeliness of prenatal care HEDIS measure in comparison with other Medicaid MCOs across the country in CYs 2020-2023, and between the 50th and 75th percentile in 2018, 2019 and 2024. For the postpartum visits (between seven and 84 days after delivery), Ohio’s Medicaid MCOs were between the 50th and 75th percentile in 2020, 2021 and 2024, and between the 10th and the 25th percentile in 2022. In 2023, Ohio’s Medicaid MCOs were between the 25th and the 50th percentile. Please note that the period evaluated for the postpartum visit was changed for 2019 to “between seven and 84 days after delivery.” For prior years the postpartum visit period was “21 to 56 days after delivery.” This change should be taken into consideration when comparing the 2019 Postpartum Care Visit rates to prior year rates.

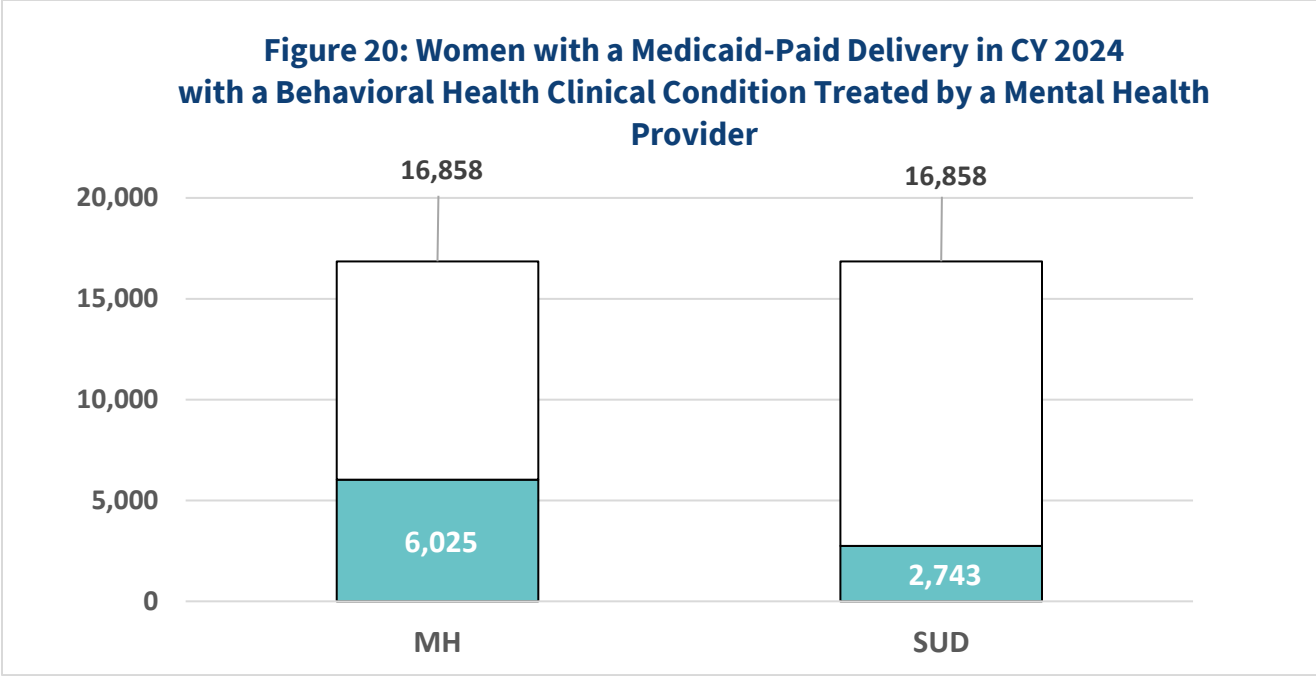
Section 4: Behavioral Health Services

ODM, in collaboration with the Ohio Department of Mental Health and Addiction Services (OMHAS), implemented significant revisions and enhancements to the Medicaid behavioral health benefit beginning January 2018. Changes included the addition of new services for people with high intensity needs and alignment of the procedure codes used by Ohio's behavioral health providers to better integrate physical and behavioral healthcare. In 2020, pregnant women in Medicaid with a behavioral health (BH) condition continued to receive behavioral health services at levels comparable to pre-pandemic rates.

Of the women enrolled in Ohio Medicaid identified as having had a birth via the linked VS/Medicaid data[†], 25% (17,723) had a BH condition as a primary diagnosis in CY 2017. This rate gradually increased to 28.1% (16,858) in CY 2024, as identified by a primary diagnosis on a Medicaid claim[†] (Figures 19 and 20). Thirty-six percent received services from a community mental health center (CMHC) and 16% from a substance use disorder (SUD) clinic. These numbers are not mutually exclusive, and women could have received services from both. Of women receiving SUD clinic services, 36% (975) utilized medication-assisted treatment (MAT) services for substance abuse issues in CY 2024.

Figure 19: Women with a Medicaid-Paid Delivery in CY 2024 with a Behavioral Health Clinical Condition





As the state addressed emerging health threats due to coronavirus, Governor DeWine enacted an emergency telehealth rule to protect Ohioans from the virus without disrupting care. That rule enabled more than 860,000 Medicaid members to take advantage of telehealth services, filing more than 5.8 million claims during the first year of the pandemic.

Telehealth was particularly critical to members with behavioral and mental healthcare needs, including those battling addiction, who were most vulnerable to the isolation and economic pressures resulting from COVID-19. Emergency telehealth flexibilities allowed providers to maintain needed services in urban settings and to increase access to care for members in rural communities and small towns. More than 3.3 million behavioral health services were rendered via telehealth from Ohio Department of Mental Health and Addiction Services providers during the period.

In Ohio, as well as other parts of the nation, substance use has increased over recent years⁵⁵, and while the care of an infant may increase the motivation to obtain and maintain sobriety,

⁵⁵ Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, [National Survey on Drug Use and Health \(NSDUH\), 2019 and 2020](#).

the postpartum period is also a time of increased risk of relapse and pregnancy-associated deaths.^{***,†††}

Building on the past work and lessons from the maternal Opioid Medical Supports (MOMS) effort, ODM has partnered with Ohio’s Perinatal Quality Collaborative (OPQC) to leverage quality improvement science to optimize care and support for mothers with opioid use disorder (OUD) and their babies throughout the first 12 months postpartum. Participating sites that care for women are collaborating with participating sites that care for infants, allowing them to share best practices focused on improving:

- Use of behavioral health counseling during pharmacotherapy.
- Continuity of pharmacotherapy.
- Well visit attendance among infants of women with opioid use disorder.
- Child safety and health while maintaining parental trust.

^{***} Wilder, C., Lewis, D., & Winhusen, T. (2015). Medication assisted treatment discontinuation in pregnant and postpartum women with opioid use disorder. *Drug and alcohol dependence*, 149, 225-231.

^{†††} Smid, M. C., Schauburger, C. W., Terplan, M., & Wright, T. E. (2020). Early lessons from maternal mortality review committees on drug-related deaths—time for obstetrical providers to take the lead in addressing addiction. *American Journal of Obstetrics & Gynecology MFM*, 2(4).

Section 5: Medicaid Prenatal Care, Delivery, and Infant Costs

The average total cost during pregnancy of a woman enrolled in Medicaid (all covered services for nine months prior to the delivery month to one month after the delivery month) increased from \$8,652 in 2017 to \$10,856 in 2024 as detailed in Figure 25. Prenatal and delivery costs paid by Medicaid include direct FFS payments to service providers as well as capitation and birth premium payments to managed care providers for women enrolled in managed care.

In 2024, the total cost paid by Medicaid for prenatal care and deliveries was \$693,817,816 for 63,911 births. Of these Medicaid payments, 54% of these dollars (\$372,025,931) paid for deliveries compared to 46% (\$321,791,885), which covered prenatal care. Only costs and member months for the period in which a woman had Medicaid eligibility were included. A woman may have utilized Medicaid for only a portion of her pregnancy and, in some instances, only for the delivery of the infant⁴

Costs paid by Medicaid during an infant's first year of life included direct FFS payments to service providers as well as capitation payments to managed care providers for infants enrolled in managed care. In 2024, 65,655 infants were eligible and enrolled in Medicaid for at least a portion of their first year of life.

The total cost paid by Medicaid for the first year of life for infants enrolled in 2024 was \$1,102,656,675. Only costs and member months for those months of the infants' first year of life in which the infant had Medicaid eligibility were included; an infant may have utilized Medicaid for only a portion of their first year of life.

Overall, the number of deliveries and costs for prenatal care and deliveries decreased by 3% from CY 2023 to CY 2024. The number of deliveries decreased from 65,655 in 2023 to 63,911 in 2024 (i.e., 3% decrease). The average total delivery and prenatal care cost per delivery increased from \$10,622 in CY 2023 to \$10,856 in CY 2024. For infants in the first year of life, total costs decreased slightly from 2023 to 2024; the average cost per infant was \$16,930 in CY 2023 and \$16,795 in CY 2024. The average cost per infant member month decreased by approximately 1% (from \$1,359 in CY 2023 to \$1,345 in CY 2024). The percent of managed care member months (as a percent of total managed care plus FFS member months) for newborns increased from 91% for CY 2023 to 95% for CY 2024; FFS newborn member months decreased from 9% for CY 2023 to 5% for CY 2024.

For CY 2024, managed care costs accounted for approximately 88% of the total Medicaid costs for infants in the first year of life, approximately 90% of delivery costs(excluding pharmacy), and approximately 91% of the total costs for deliveries and prenatal care

(excluding pharmacy). The FFS costs for infants in the first year of life, deliveries, and total costs for deliveries and prenatal care accounted for 12%, 10%, and 9% of total Medicaid costs for each category, respectively. There were no industry standard data sources available with current costs of national Medicaid prenatal care, deliveries, and/or infant care for comparison with Ohio data.

Figure 21: Total and Average Cost of Deliveries, Prenatal Care, and Infants, CYs 2017-2024

	Deliveries	Prenatal Care	Total Prenatal Care and Delivery Care	Infants—First Year of Life
Total Beneficiaries				
2017	74,174	74,174	74,174	70,004
2018	71,344	71,344	71,344	74,174
2019	69,532	69,532	69,532	71,344
2020	67,714	67,714	67,714	69,532
2021	65,744	65,744	65,744	67,714
2022	65,297	65,297	65,297	65,744
2023	65,655	65,655	65,655	65,297
2024	63,911	63,911	63,911	65,655
Total Cost				
2017	\$340,829,530	\$300,849,744	\$641,753,448	\$863,649,749
2018	\$335,816,208	\$297,219,104	\$633,035,312	\$983,028,022
2019	\$334,796,580	\$303,576,712	\$638,373,292	\$985,688,704
2020	\$363,282,264	\$314,316,366	\$677,598,630	\$1,071,835,780
2021	\$354,876,021	\$301,450,149	\$656,326,171	\$1,126,108,931
2022	\$356,323,362	\$332,454,638	\$688,778,000	\$1,101,146,256
2023	\$365,391,743	\$332,005,403	\$697,397,146	\$1,105,472,986
2024	\$372,025,931	\$321,791,885	\$693,817,816	\$1,102,656,675
Average Cost/Beneficiary				
2017	\$4,595	\$4,056	\$8,652	\$12,337
2018	\$4,707	\$4,166	\$8,873	\$13,253
2019	\$4,815	\$4,366	\$9,181	\$13,816
2020	\$5,364	\$4,641	\$10,005	\$15,415
2021	\$5,398	\$4,585	\$9,983	\$16,630
2022	\$5,457	\$5,091	\$10,548	\$16,749
2023	\$5,565	\$5,057	\$10,622	\$16,930
2024	\$5,821	\$5,035	\$10,856	\$16,795
Total Member Months				
2017	N/A	578,599	724,286	883,697
2018	N/A	547,423	687,371	938,016
2019	N/A	528,879	665,666	884,819
2020	N/A	510,204	643,178	864,969
2021	N/A	513,461	641,398	850,269
2022	N/A	512,451	640,162	825,745
2023	N/A	500,028	624,248	813,601
2024	N/A	483,167	606,515	820,031

Average Cost/Member Month				
2017	N/A	\$520	\$886	\$977
2018	N/A	\$543	\$921	\$1,048
2019	N/A	\$574	\$959	\$1,114
2020	N/A	\$616	\$1,054	\$1,239
2021	N/A	\$587	\$1,023	\$1,324
2022	N/A	\$649	\$1,076	\$1,334
2023	N/A	\$664	\$1,117	\$1,359
2024	N/A	\$666	\$1,144	\$1,345

Section 6: Children in Medicaid

Ohio Medicaid provides care to more than 3 million Ohioans – including approximately 1.4 million youth, 44,173 of whom are in the foster care and adoption system. The demographics of infants, children, adolescents, and adults under 21 years of age are delineated in Figure 22.

6.1 Summary of Medicaid’s Children’s Eligibility and Demographics CY 2024

Figure 22: Medicaid Monthly Average by Age Group, Gender, Race, and Plan Type, CY 2024

AGE IN YEARS	Monthly Average	% of Total Medicaid Children
<1 Year	71,274	5.4%
1-5 Years	317,155	23.9%
6-12 Years	466,824	35.2%
13-18 Years	378,640	28.6%
19-20 Years	90,672	6.8%
GENDER		
Female	650,850	49.1%
Male	673,716	50.9%
Unknown	1	<0.1%
RACE		
Caucasian	743,036	56.1%
Black	420,346	31.7%
Asian/Pacific Islander	29,828	2.3%
American Indian or Alaskan Native	8,946	0.7%
Other	10	<0.1%
Not Provided	119,012	9.0%
PLAN TYPE		
MCO (Managed Care)	1,286,175	97.1%
Indemnity (FFS)	38,391	2.9%
TOTAL MEDICAID CHILDREN	1,324,566	

6.2 Children's Chronic and Behavioral Health Conditions Frequency Distribution

Figure 23: Top 10 Most Prevalent Chronic Health Conditions among Medicaid Youth CY 2024

	Patient Count	All Medicaid Children
Asthma	57,261	4%
Other specified and unspecified upper respiratory disease	42,930	3%
Menstrual disorders	24,046	2%
Acute and chronic tonsillitis	21,089	2%
Sleep wake disorders	17,885	1%
Headache; including migraine	16,067	1%
Esophageal disorders	15,405	1%
Hearing loss	14,421	1%
Allergic reactions	14,315	1%
Obesity	13,872	1%

Figure 24: Top 10 Most Prevalent Behavioral Health Conditions among Medicaid Youth CY 2024

	Patient Count	All Medicaid Children
ADHD (Attention-Deficit/Hyperactivity Disorder)	123,319	9%
Anxiety Disorders	84,528	6%
Adjustment Disorders	69,836	5%
Autism	33,968	3%
Major Depression	32,887	2%
Conduct Disorders	29,617	2%
PTSD	27,014	2%
Other Depression	20,758	2%
Self-Harm	12,398	1%
Other Psychological	11,095	1%

6.3 Quality Measures for Children

Just as HEDIS results were used to assess quality for the maternity population, HEDIS specifications were utilized to assess care across three domains for children: primary care access and preventive care, acute and chronic care, and behavioral healthcare.

Data displayed in Figures 25, 26, and 27 include self-reported, audited HEDIS data from Ohio Medicaid's seven MCOs. Self-reported, audited HEDIS rates may contain data from both claims and medical record reviews (hybrid methodology)^{†††}.

6.3.1 Primary Care Access and Preventive Care

HEDIS Well-Child and Well-Care visit measures assess child and adolescent access to primary and preventive care. In 2024, 62.86% of infants in the Medicaid program had six or more Well-Child visits with a primary care physician during their first 15 months of life, an increase from 62.21% in 2023. The percentage of infants between 15 and 30 months of age who had at least two visits with a primary care physician in 2024 was 71.21%, up from 67.40% in 2022.

The percentage of children and adolescents who had at least one Well-Care visit with a primary care physician in 2024 was 60.20% (increasing from 57.19% for 2023) for children ages 3 to 11, 60.20% (increasing from 50.86% for 2023) for adolescents ages 12 to 17, and 29.98% (increasing from 26.32% for 2023) for adolescents/young adults ages 18 to 21. Older adolescents ages 18 through 21 represent the group of youth least likely to be seen for preventive services.

^{†††} The newer Next Generation Managed Care Organizations did not have reportable HEDIS results for certain measures in CY 2023.

Figure 25: Well-Care Measures Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2020-2024

	Well-Child Visits in the First 30 Months of Life (First 15 Months of Life, Six or More Visits)		Well-Child Visits in the First 30 Months of Life (Age 15-30 Months, Two or More Visits)		Child and Adolescent Well-Care Visits (3-11 Years)		Child and Adolescent Well-Care Visits (12-17 Years)		Child and Adolescent Well-Care Visits (18-21 Years)	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE										
2020	56.63%	P50-P75	66.30%	P10-P25	49.89%	P25-P50	45.18%	P50-P75	24.02%	P25-P50
2021	57.67%	P50-P75	62.26%	P25-P50	55.30%	P25-P50	49.78%	P25-P50	24.99%	P50-P75
2022	60.38%	P50-P75	64.49%	P25-P50	55.18%	P25-P50	49.16%	P25-P50	24.73%	P50-P75
2023	62.21%	P50-P75	67.40%	P50-P75	57.19%	P50-P75	50.86%	P50-P75	26.32%	P50-P75
2024	62.86%	P50-P75	71.21%	P50-P75	60.20%	P50-P75	53.71%	P50-P75	29.98%	P50-P75
AMERIHEALTH										
2023	NA	NA	NA	NA	46.48%	P10-P25	35.43%	<P10	16.88%	P10-P25
2024	67.44%	P75-P90	68.48%	P25-P50	52.61%	P10-P25	43.21%	P10-P25	21.04%	P10-P25
BUCKEYE										
2020	51.44%	P25-P50	62.03%	P10-P25	45.12%	P10-P25	40.19%	P25-P50	21.55%	P25-P50
2021	51.81%	P25-P50	57.24%	P10-P25	49.16%	P10-P25	43.16%	P10-P25	21.63%	P25-P50
2022	60.47%	P50-P75	59.74%	P10-P25	50.41%	P10-P25	43.79%	P10-P25	21.72%	P25-P50
2023	64.85%	P75-P90	67.88%	P50-P75	58.02%	P50-P75	51.01%	P50-P75	26.39%	P50-P75
2024	65.99%	P75-P90	72.19%	P50-P75	62.70%	P50-P75	54.93%	P50-P75	30.24%	P50-P75
CARESOURCE										
2020	55.40%	P50-P75	67.17%	P25-P50	52.04%	P50-P75	47.36%	P50-P75	25.70%	P50-P75
2021	57.21%	P50-P75	62.70%	P25-P50	57.20%	P50-P75	52.10%	P50-P75	26.46%	P50-P75
2022	59.49%	P50-P75	64.56%	P25-P50	56.88%	P50-P75	51.22%	P50-P75	26.25%	P50-P75
2023	60.78%	P75-P90	67.22%	P50-P75	58.21%	P50-P75	52.55%	P50-P75	27.59%	P50-P75

2024	63.82%	P50-P75	71.33%	P50-P75	60.91%	P50-P75	55.43%	P50-P75	31.61%	P50-P75
HUMANA										
2023	NA	NA	NA	NA	40.94%	<P10	33.21%	<P10	15.91%	<P10
2024	47.90%	P10-P25	65.31%	P10-P25	50.06%	P10-P25	39.92%	<P10	21.07%	P10-P25
MOLINA										
2020	61.50%	P75-P90	67.53%	P25-P50	49.44%	P25-P50	44.73%	P25-P50	23.04%	P25-P50
2021	61.46%	P75-P90	65.95%	P50-P75	56.15%	P50-P75	50.38%	P25-P50	24.85%	P50-P75
2022	62.70%	P75-P90	66.80%	P50-P75	55.68%	P25-P50	49.70%	P25-P50	24.84%	P50-P75
2023	64.83%	P75-P90	67.50%	P50-P75	58.05%	P50-P75	50.96%	P50-P75	26.14%	P50-P75
2024	63.43%	P50-P75	71.78%	P50-P75	60.22%	P50-P75	52.85%	P50-P75	30.07%	P50-P75
PARAMOUNT/ ANTHEM										
2020	61.35%	P75-P90	68.49%	P25-P50	49.71%	P25-P50	45.42%	P50-P75	23.39%	P25-P50
2021	59.02%	P50-P75	62.66%	P25-P50	54.19%	P25-P50	48.30%	P25-P50	23.86%	P25-P50
2022	59.61%	P50-P75	65.81%	P25-P50	53.78%	P25-P50	48.19%	P25-P50	23.25%	P25-P50
2023	70.00%	≥P90	72.46%	P75-P90	53.43%	P25-P50	47.32%	P25-P50	24.34%	P50-P75
2024	61.70%	P50-P75	70.17%	P50-P75	57.41%	P25-P50	50.95%	P25-P50	29.11%	P50-P75
UNITED HEALTH										
2020	58.94%	P50-P75	64.76%	P10-P25	46.51%	P25-P50	41.66%	P25-P50	20.95%	P25-P50
2021	62.13%	P75-P90	62.96%	P25-P50	55.35%	P25-P50	48.46%	P25-P50	23.64%	P25-P50
2022	62.41%	P75-P90	67.13%	P50-P75	54.82%	P25-P50	47.20%	P25-P50	22.83%	P25-P50
2023	62.14%	P50-P75	67.30%	P50-P75	55.88%	P50-P75	47.43%	P25-P50	24.37%	P50-P75
2024	60.55%	P50-P75	71.29%	P50-P75	59.76%	P50-P75	51.22%	P25-P50	27.56%	P25-P50

Additional primary and preventive care measures related to dental services, immunizations, and lead testing are listed in Figure 26. Although the pandemic had a substantial impact on dental utilization for children enrolled in Medicaid, childhood rates for immunizations and lead screenings were relatively stable. In 2024, 35.561% of members under 21 years of age received a comprehensive or periodic oral evaluation with a dental provider (an increase from 33.71% for 2023). It should be noted that HEDIS retired the Annual Dental Visits and included the Oral Evaluation, Dental Services measure as a first-year measure in 2023.

The percentage of children 2 years of age with a Childhood Immunization Status, Combination 3^{§§§} by their second birthday, decreased slightly from 64.48% in 2023 to 64.01% in 2024. The rate of lead screening in children 2 years of age increased from 67.89% in 2023 to 70.97% in 2024. See Appendix D for a breakout of specific rates by managed care organization.

	Oral Evaluation, Dental Services		Childhood Immunization Status, Combination 3 ^{§§§}		Lead Screening in Children	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE MCO						
2017	NA	NA	63.3%	P10-P25	68.9%	P25-P50
2018	NA	NA	63.9%	P10-P25	67.7%	P25-P50
2019	NA	NA	62.00%	P10-P25	66.61%	P25-P50
2020	NA	NA	63.65%	P25-P50	64.53%	P25-P50
2021	NA	NA	59.55%	P25-P50	62.50%	P25-P50
2022	NA	NA	60.74%	P25-P50	63.87%	P25-P50
2023	33.71%	NA	64.48%	P50-P75	67.89%	P50-P75
2024	35.56%	NA	64.01%	P25-P50	70.97%	P50-P75

^{§§§} Combination 3 vaccinations for Childhood Immunization Status includes DTaP, IPV, MMR, HiB, HepB, VZV, and PCV.

6.3.2 Acute and Chronic Conditions

In 2024, among children 3 to 17 years of age who were diagnosed with pharyngitis and received an antibiotic, 88.69% received a strep test, an increase from 85.68% in 2023. The percentage of children with asthma who were dispensed the appropriate rate of controller asthma medications to total asthma medications (0.50 or greater) was 72.18% for children 5-11 years of age, up from 72.02% in 2023. And for youth 12-18 years of age, the rate slightly increased from 67.73% in 2023, to 68.57% in 2024. Please note that the HEDIS age group specifications for the pharyngitis measure were changed prior to 2020 and therefore comparable prior year rates are not available for comparison.

Figure 27: Acute and Chronic Conditions Measures - Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2020-2024

	Appropriate Testing for Pharyngitis, 3-17 years		Asthma Medication Ratio, 5-11 years		Asthma Medication Ratio, 12-18 years	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE MCO						
2020	80.79%	P25-P50	78.74%	P25-P50	72.95%	P50-P75
2021	75.27%	P25-P50	74.71%	P25-P50	68.78%	P25-P50
2022	73.79%	P25-P50	71.74%	P10-P25	67.63%	P25-P50
2023	85.68%	P75-P90	72.02%	P25-P50	67.73%	P25-P50
2024	88.69%	P50-P75	72.18%	P25-P90	68.57%	P50-P75

6.3.3 Behavioral Healthcare

The subset of measures described in Figure 28 can be used to gauge behavioral health services for youth in the Medicaid program. In 2024, the rate of children and adolescents who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment (i.e., psychosocial care visit with 90 days prior to 30 days after the prescription) was 77.78%, an increase from 76.10% in 2023. The 2024 rate exceeded the national Medicaid 90th percentile benchmark. Please note that for 2022, the ‘Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment’ measure was revised and renamed ‘Initiation and Engagement of Substance Use Disorder Treatment’. Due to the revisions, the rates for 2022 are not compared to prior year’s Ohio Medicaid’s rates and national benchmarks. For adolescents 13-17 years of age, the percentage of new Substance Use Disorder (SUD) treatment episodes that resulted in treatment engagement within 34 days of SUD treatment initiation was 19.28% in 2024, an

decrease from 22.83% in 2023. Although the engagement rate decreased in 2024, the 2024 rate was between the 75th and 90th national percentile; individual plan performance on this measure will be monitored for future reporting periods. The rate of children who had a prescription for attention deficit hyperactivity disorder (ADHD) medication and remained on the medication for at least 210 days and had at least two follow-up visits in the nine months after the initiation phase was 54.80% in 2024, an increase from 53.65% in 2023. See Appendix D for a breakout of results by managed care organization.

Figure 28: Behavioral Health Measures - Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2017- 2024

	Use of First-Line Psychosocial Care for Children on Antipsychotics		Engagement of Substance Use Disorder Treatment, 13-17 Years*		Follow-Up Care for Children Prescribed ADHD Medication Continuation/ Maintenance Phase	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE MCO						
2017	75.1%	P≥P90	22.5%	P75-P90	65.5%	P75-P90
2018	78.3%	P≥ P90	23.4%	P25-P50	64.6%	P75-P90
2019	81.25%	P≥ P90	23.56%	P75-P90	59.76%	P50-P75
2020	79.02%	P≥P90	19.77%	P75-P90	59.27%	P50-P75
2021	78.03%	P≥P90	19.46%	P≥P90	55.67%	P50-P75
2022	76.73%	P≥P90	20.02%	NA	55.98%	P50-P75
2023	76.10%	P≥P90	22.83%	P≥P90	53.65%	P25-P50
2024	77.78%	P≥P90	19.28%	P75-P90	54.80%	P50-P75

*Due to methodology revision, 2022 and 2023 results not comparable to prior years.

6.4 School-Based Healthcare

Ohio Department of Medicaid recognizes the importance of encouraging and supporting a robust partnership between healthcare and education providers. School-based health initiatives help ensure students are in school, healthy, and ready to learn through a school or district's partnerships with healthcare providers and other community organizations. ODM supports several efforts connecting primary care and behavioral health to school systems and education networks.

In CY 2024, the Medicaid Managed Care Plans began working to establish with the Nelsonville-York Local School District and Cleveland Alfred A. Benesch School. In SFY 2024, the

Nelsonville effort included increasing access to food and healthcare, educational programming for middle school and high school girls, and increased community engagement. Cleveland efforts in SFY 2024 focused on increased access to food, vision services, and tools to help children and youth understand and manage their feelings, show empathy, and build positive relationships with others.

6.4.1 School-Based Measures Comparing Medicaid to Non-Medicaid Youth

Because health is an important factor in shaping educational outcomes, ODM and the Ohio Department of Education and Workforce (DEW) (formerly Ohio Department of Education) partnered to understand the relationship of academic outcomes to the health status for youth in the Medicaid program. The school-based measures are standard measures routinely calculated by DEW and include touchpoints on a student's journey from kindergarten through high school graduation. Results for Medicaid and non-Medicaid populations in school years 2018-2025 are detailed in Figure 29, with substantially lower performance on all academic performance measures for youth in the Medicaid program. In conjunction with school-based measures described in this report, Ohio has developed Healthy Students profiles for every school district in the state. These profiles offer district and building-level insights into how key children's health indicators (e.g., asthma rates) correlate with key educational success indicators (e.g., chronic absenteeism). School districts can download their profiles, along with a guide and frequently asked questions, from the Ohio Department of Education and Workforce's website.

Percent of kindergarteners demonstrating readiness on the Kindergarten Readiness Assessment (KRA-R) increased slightly for both Medicaid and non-Medicaid populations from the 2023-2024 school year to the 2024-2025 school year. For the Medicaid population, students demonstrating readiness increased from 21.2% in 2023-2024 to 21.5% in 2024-2025. For the non-Medicaid population, students demonstrating readiness increased from 49.7% in 2023-2024 to 50.2% in 2024-2025. KRA rates for the most recent school year of data are still lower than pre-pandemic levels for both Medicaid and non-Medicaid populations.

Percent of third graders proficient on English Language Arts (ELA) state assessment decreased for both Medicaid and non-Medicaid populations from the 2023-2024 school year to 2024-2025 school year. For the Medicaid population, this proficiency rate decreased from 52.0% in 2023-2024 to 48.1.% in 2024-2025. For the non-Medicaid population, the rate decreased from 74.6% in 2023-2024 to 72.5% in 2024-2025.

Percent of seventh graders proficient on the mathematics state assessment increased for both Medicaid and non-Medicaid populations from the 2023-2024 school year to 2024-2025 school year. For the Medicaid population, this proficiency rate increased from 31.5% in 2023-

2024 to 32.3% in 2024-2025. For the non-Medicaid population, the rate increased from 62.7% in 2023-2024 to 63.6% in 2024-2025. It is noteworthy that the rates have increased every year over the last four school years for both Medicaid and Non-Medicaid. However, the percent of seventh graders proficient on the mathematic state assessment for both Medicaid and non-Medicaid populations has still decreased substantially from the 2018-2019 school year to the 2024-2025 school year.

High school on-time graduation rates increased for the Medicaid population and decreased slightly for the non-Medicaid population from the 2022-2023 school year to 2023-2024 school year. For the Medicaid population, this rate went from 78.9% in 2022-2023 to 79.8% in 2023-2024. For the non-Medicaid population, this rate went from 93.7% in 2022-2023 to 93.5% in 2023-2024. It is noteworthy that the Medicaid rate is highest Medicaid rate in any year documented here from 2017-2018 to 2023-2024. In 2023-2024, the rate was 79.8%, which is 6.4 percentage points higher than in 2017-2018, when it was 73.4%. Also, it is necessary to note that this measure is lagged one year behind the other measures (the most recent year with data is 2023-2024 compared to 2024-2025 for the other measures). This is due to data reporting timelines.

Chronic absenteeism decreased slightly for both the Medicaid and the non-Medicaid populations from the 2023-2024 school year to 2024-2025 school year. For the Medicaid population, this rate decreased from 37.7% in 2023-2024 to 37.4% in 2024-2025. For the non-Medicaid population, this rate decreased from 16.5% in 2023-2024 to 15.9% in 2024-2025. However, these percentages are still much higher than pre-pandemic numbers for both Medicaid and non-Medicaid (See table below).

Due to the challenges posed by the COVID-19 pandemic, the Ohio Department of Education and Workforce's state report cards for academic years 2019-2020 and 2020-2021 do not contain overall ratings for any districts or buildings, nor ratings for the given components and measures. In keeping with legislation passed previously, which acknowledged the various obstacles to education the pandemic presented, information provided on report cards for these academic years continues to include graduation rates, Prepared for Success indicators, and demographic and enrollment data, along with other district and school operational details. The following observations are reflective of these anomalies; thus, in school years 2019-2020, and 2020-2021 measures should be viewed accordingly in making comparisons between years

- Chronic absenteeism rates in the 2019-2020 school year are likely anomalous due to the COVID-19 pandemic and should not be used for comparison purposes.

- Assessment data for 3rd grade ELA and 7th grade Mathematics are not available for 2019-2020 due to COVID-19.

Figure 29: School Years 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024, 2024-2025 Measures by Medicaid Enrollment Status

ACADEMIC MEASURES	Percentage - Measure		N Size (Denominator)	
	Medicaid Enrolled	Non-Medicaid	Medicaid Enrolled	Non-Medicaid
% Demonstrating Readiness Kindergarten Readiness Assessment				
2017-2018 School Year	27.9%	52.9%	53,996	64,102
2018-2019 School Year	26.6%	53.4%	55,688	63,621
2019-2020 School Year	26.6%	53.3%	54,017	65,322
2020-2021 School Year	25.9%	54.2%	38,984	51,287
2021-2022 School Year	22.9%	49.8%	51,501	65,029
2022-2023 School Year	20.6%	47.4%	50,189	61,948
2023-2024 School Year	21.2%	49.7%	51,633	59,763
2024-2025 School Year	21.5%	50.2%	51,248	57,036
% 3rd Graders Proficient on English Language Arts State Assessment				
2017-2018 School Year	48.3%	72.0%	62,150	73,560
2018-2019 School Year	53.5%	78.2%	60,801	69,926
2019-2020 School Year	NA	NA	NA	NA
2020-2021 School Year	35.4%	64.7%	51,770	66,498
2021-2022 School Year	46.0%	70.5%	54,360	70,440
2022-2023 School Year	49.1%	73.0%	55,774	69,085
2023-2024 School Year	52.0%	74.6%	54,135	67,194
2024-2025 School Year	48.1%	72.5%	59,222	69,596
% 7th graders Proficient on Mathematics State Assessment				
2017-2018 School Year	43.3%	69.9%	48,627	74,156
2018-2019 School Year	41.0%	69.5%	52,350	72,508
2019-2020 School Year	NA	NA	NA	NA
2020-2021 School Year	26.3%	57.0%	47,354	67,123
2021-2022 School Year	28.8%	57.8%	50,966	69,589
2022-2023 School Year	30.9%	60.5%	50,748	65,932
2023-2024 School Year	31.5%	62.7%	51,172	65,191
2024-2025 School Year	32.3%	63.6%	49,816	64,223

On-time Graduation Rate (High School)				
2017-2018 School Year (2018 Grad Cohort)	73.4%	91.6%	47,749	90,289
2018-2019 School Year (2019 Grad Cohort)	74.5%	92.1%	48,407	89,287
2019-2020 School Year (2020 Grad Cohort)	77.0%	92.4%	46,190	89,672
2020-2021 School Year (2021 Grad Cohort)	76.6%	92.5%	46,694	88,113
2021-2022 School Year (2022 Grad Cohort)	77.7%	92.9%	49,678	84,724
2022-2023 School Year (2023 Grad Cohort)	78.9%	93.7%	51,321	80,687
2023-2024 School Year (2024 Grad Cohort)	79.8%	93.5%	50,684	82,973
2024-2025 School Year (2024 Grad Cohort)	NA (Year Lag)	NA (Year Lag)	NA (Year Lag)	NA (Year Lag)
Chronic Absenteeism Rate				
2017-2018 School Year	25.0%	9.9%	653,822	966,765
2018-2019 School Year	28.0%	10.8%	695,540	986,013
2019-2020 School Year	19.7%	7.2%	677,847	989,602
2020-2021 School Year	37.4%	14.7%	666,190	948,349
2021-2022 School Year	43.7%	20.9%	638,777	928,185
2022-2023 School Year	38.6%	18.2%	657,981	902,211
2023-2024 School Year	37.7%	16.5%	662,330	887,277
2024-2025 School Year	37.4%	15.9%	655,593	877,151

6.5 Children's Initiatives

Shortly after taking office at the beginning of 2019, Governor DeWine signed an executive order to create the Governor's Office of Children's Initiatives. This office has been charged with taking bold steps to give Ohio kids a platform for lifelong success by:

- Elevating the importance of children's programming in Ohio and driving improvements within the many state programs that serve children.
- Advancing policy related to home visiting, early intervention services, early childhood education, foster care, and child physical and mental health.
- Initiating and guiding enhancements to the early childhood, home visiting, foster care, education, and pediatric health systems.
- Improving communication and coordination across all state agencies that provide services to Ohio's children.
- Engaging local, federal, and private sector partners to align efforts and investments in order to have the largest possible impact on improving outcomes.

Medicaid is incredibly important to ensuring coverage and access to care for Ohio's youngest citizens. As the health insurance for more than 1.3 million children in the state, and, in some Ohio counties, as the insurer for more than 80% of children under the age of 5 residing in the county, Medicaid has great opportunity to improve the lifelong potential for Ohio's kids.

Governor DeWine's administration has been enthusiastically and financially supportive of Ohio's ability to provide healthcare to low-income children and families. Ohio's governor remains focused on children. As referenced in multiple places above, ODM initiated and continued several programs to support the Governor's Children's Initiative in CY 2023-2024, including:

- Implementing a two-year continuation of Ohio Medicaid's Infant Mortality grant program to support coordinated community programs that target differences in the infant mortality rate. ODM awarded \$26 million in 10 counties for state fiscal year 2024 to support this targeted effort.
- Continuing implementation of the MISP by creating additional access to pregnancy-related services including lactation consulting, group pregnancy education, and evidence-based home visiting. In 2023, ODM administered its inaugural year of its new population health model for OB-GYN practices, Comprehensive Maternal Care (CMC). CMC invested \$5 Million in its first year, reaching over 14,000 pregnant and postpartum patients, enrolling over 77 medical practices that are caring for patients. In program

year 2025, the CMC program has invested \$7 million and is reaching nearly 50,000 pregnant and postpartum women with 129 practices enrolled.

- Continuing its multisystem youth custody relinquishment prevention program in partnership with all child-serving state sister agencies. In SFYs 2020-2023 (as of December 2023) ODM spent \$77 million in 88 counties to serve 1,456 multisystem youths. The statewide program has also provided technical assistance to additional counties to assist with individual cases and to build local capacity to serve even more children.
- Continued its child-focused patient-centered medical home program, Comprehensive Primary Care for Kids, which incentivizes pediatric primary care providers to meet children's specific quality metrics, such as immunizations and lead testing, as well as performing pediatric-specific activities like caring for foster youth, transitioning older children to adult care, and providing school-based care.

In recognition of the importance of investing in Ohio's youth, Governor DeWine led the creation of The Department of Children and Youth (DCY). Established in the 2023-2024 operating budget and will focus on the efficient and effective delivery of services to Ohio's more than 2.5 million children and their families. DCY combines the functions and programs from six state agencies, reduces duplicative programs and bureaucracy, increases administrative efficiency, and improves delivery of services to families.

In July 2022 the state introduced OhioRISE (Ohio Resilience through Integrated Systems and Excellence), a new Ohio Medicaid specialized managed care behavioral health program for children and young people with the most complex needs.

OhioRISE is an integral part of ODM's Next Generation managed care overhaul that rolled out in phases in 2022. The Next Generation of managed care aims to grow capacity and expand access to in-home and community-based services. At its core, OhioRISE is about coordinating care across multiple state and local child-serving state agencies and systems to improve behavioral health outcomes and prevent custody relinquishment while serving youth in the community and keeping families together. Additionally, a new 1915(c) home- and community-based waiver was approved by CMS to help serve those youth who are most vulnerable for out-of-home placement if they meet certain level-of-care needs.

- In collaboration with child-serving state agencies, stakeholders, local community partners, care providers, and the Child and Adolescent Behavioral Health Center of Excellence, ODM developed the program's key components and services. These services include Intensive and Moderate Care Coordination, Intensive Home-Based Treatment (IHBT), Behavioral Health Respite, Primary Flex Funds, and Mobile

Response and Stabilization Services (MRSS), a service that provides immediate help for youth age 20 and under who are experiencing overwhelming mental, emotional, or behavioral distress or trauma that is impacting their ability to function. MRSS deploys a team of trained professionals to respond within 60 minutes to help calm the situation, ensure safety and create a plan for comprehensive wrap around care.

- In 2023 ODM incorporated Psychiatric Residential Treatment Facilities (PRTF) into OhioRISE, which previously only had services available out of state. Over the next three years, 11 PRTFs will be licensed and able to serve approximately 100 children per year. The first facility began admissions, serving 12 youth ages 10-17 of both genders.
- ODM has continued working with partners at OhioMHAS to ensure access to MRSS services statewide. The departments have designed a model that will leverage existing providers and community capacity by identifying regionally accountable providers who will be responsible for delivering high-quality, in-person services and 24/7 telephonic triage.

In 2024, Ohio maintained focus on children. In addition to continuing to administer the program changes initiated in CY 2023, Ohio plans to:

- Continue implementation of the MISP by adding Medicaid coverage for additional programs, providers, and services to the extent possible that support moms and babies through data-driven, evidence-based initiatives.
- Continue implementation of the OhioRISE program referenced above to support multisystem youth through services and supports provided within a framework of coordinated care. Improve access to care by supporting the expansion of services such as intensive home-based treatment, mobile response and stabilization and behavioral health respite.
- Focus on the individual through the Next Generation of managed care, including improvements in the design, delivery, and timeliness of care coordination. ODM is working on strong collaboration and partnership among managed care organizations, vendors, and partner state agencies to support specialization in addressing critical needs.
- Continue efforts to efficiently identify pregnancy and pregnancy related needs using the Pregnancy Risk Assessment Form (PRAF) and Report of Pregnancy (ROP) in order to reduce inadvertent coverage loss and improve timely linkage of women to needed care and supports during pregnancy and postpartum.

Section 7: References

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Appendix A: Data Sources and Methodologies for Calculations

Data Sources

Medicaid information was obtained from Medicaid claims, premium payment records, and eligibility records from ODM's Medicaid Information Technology System (MITS), Business Intelligence and Analytical Research (BIAR) system, and Medicaid's Quality Decision Support System (QDSS). In addition, the ODH Bureau of Vital Statistics provided birth certificate data and linked birth certificate/death certificate data. Where information is reported for Medicaid individuals and non-Medicaid populations, the linked VS/Medicaid data was used.

Linkage of Ohio Birth Certificates to Medicaid Data

Individuals were matched between the vital statistics birth records and Medicaid administrative data using two methods: a match using Social Security Numbers (SSN) plus two or more of first name, last name and date of birth (DOB), as well as a probabilistic match.^{****} When unique identifiers such as SSN are not available or do not provide an accurate match when confirmed using name and DOB, probabilistic linkage is typically the most efficient and effective way to minimize the risk of linkage error.⁺⁺⁺

The probabilistic linkage algorithm utilized⁺⁺⁺ all identifying information in order to assess whether two records in two different datasets refer to the same individual. For identifiers that were not names, such as ZIP code or date of birth, the algorithm assessed both perfect agreement as well as similarity. Searching for similarity is critical when linking administrative data because a certain percentage of cases contain errors. For example, the date "3/24/1998" shares a certain resemblance to "3/24/2998" and it is possible that the latter is a typographical error and was supposed to be recorded as "3/24/1998." For names, the similarity criteria were more complex because names may differ across datasets for legitimate reasons such as the use of nicknames, name changes, and misspellings. Since mothers and infants appear in the same "Case" in the Medicaid systems, higher confidence in linkage results was obtained via confirming that the mother-infant pair in the vital statistics record matched both the mother and infant on the same case in the Medicaid system.

^{****} Fellegi, Ivan P, and Alan B. Sunter. 1969. "A Theory of Record Linkage." *Journal of the American Statistical Association* 64:1183-1210.

⁺⁺⁺ Tromp, Miranda, Anita C. Ravelli, Gouke J. Bonsel, Arie Hasman, and Johannes B. Reitsma. 2011. "Results from Simulated Data Sets: Probabilistic Record Linkage Outperforms Deterministic Record Linkage." *Journal of Clinical Epidemiology* 64:565-572.

⁺⁺⁺ Link Plus, Centers for Disease Control and Prevention.
<https://www.cdc.gov/cancer/npcr/tools/registryplus/lp.htm>.

Beyond perfect string matches, first and last names were assessed for similarity using a variety of methods, including but not limited to a string-matching score, phonetic equivalence, one of the names is a nickname of the other, the names share a string of five or more common characters, and the first and last names appear to have been swapped. The linkage algorithm then compared this to a population-level database containing names, birthdays and other demographic information and estimate two probabilities: the probability *m* that two records on a certain field would agree if they belong to the same individual, and the probability *u*, that the two fields would agree, but the records belong to different individuals. These probabilities were then used to create agreement and disagreement weights for each field within each record pair to translate the agreement, similarity, and disagreement patterns for a given record pair into a score linked to the probability that the two records referred to the same individual. Record pairs with extremely high-matching scores were accepted as matches while record pairs with somewhat high matching scores will be manually reviewed to determine match status.

Match statistics are generated throughout the process and are ultimately used to quantify the success of the linkage process. The proportion of Medicaid mothers joined to their infants via a common Ohio birth certificate is known as the “match rate.” The historical annual match rates for the VS-claims birth linkage are depicted in Table 1A.

Table 1A: Combined Average Match Rate to Vital Statistics Birth Records for Mothers (Deliveries) and Infants (Births) in Medicaid Administrative Data

2017	2018	2019	2020	2021	2022	2023	2024
98.4%	99.4%	98.5%	98.9%	98.6%	98.2%	98.3%	98.7%

Calculation of Costs During Pregnancy and the Cost of Deliveries

Costs were included for all Medicaid deliveries in CYs 2017-2023. Costs during pregnancy, for the purposes of this report, include all costs for the nine months prior to the month of delivery, the month of delivery, and the month following the month of delivery.

The costs of deliveries for women enrolled in managed care include birth premium payments and estimated birth premium payments for women with managed care encounter claims for a delivery service(s), but no delivery premium payment (incurred but not paid deliveries). Estimated birth premium payments were determined using the mother’s county of residence, the last date of service on the delivery encounter claim, and the applicable managed care delivery rate cell code and premium amount (delivery encounter claims included those with a

\$0 payment and no indication of third-party payment, and those with a net claim payment > \$0).

Delivery payments for mothers with FFS claims include net payments for inpatient hospital claims with an Ohio diagnosis-related group (DRG) code for a delivery, as applicable for the date of service/delivery. For those mothers with FFS claims indicating delivery, but no inpatient claim with an applicable DRG, the cost of delivery was estimated using the statewide FFS average net payment for inpatient claims with an Ohio DRG code for a delivery. There were deliveries identified for both managed care and FFS for which the Ohio Medicaid cost was \$0: 1) managed care deliveries for which third party payment was rendered and the net payment (by the MCO) was \$0; and 2) FFS claims with an Ohio DRG delivery code in a paid status where the net payment was \$0. Delivery and prenatal care costs were estimated for infants with Medicaid identification number (ID) available on the ODH VS birth file where the mother's Medicaid ID could not be determined.

Calculation of Costs of Infants in Medicaid

Infant costs include all managed care premium payments for dates of service in the month of birth through the month of the infant's first birthday if the infant was enrolled in an MCO. In addition, infant costs include FFS claims with dates of service in the month of birth up through the first 365 days of life. Infants may have both FFS claims and managed care premium payments included in the analysis.

Chronic and Behavioral Health Conditions

Chronic conditions were derived using a chronic condition indicator included in the Clinical Conditions Software (CCS), developed by the Healthcare Cost and Utilization Project (HCUP). The chronic condition indicator flags claims as chronic at the diagnosis code level and then groups the claim by clinical condition. With that, it is possible for a clinical condition to be acute or chronic, but a member is not included in the count unless the diagnosis code was flagged as chronic by the chronic condition indicator (Figure 27).

Behavioral health conditions also were derived from the CCS. The CCS looks at the primary diagnosis code on FFS claims and encounter data and flags them according to what clinical condition they fall under. For some clinical conditions, diagnosis codes were modified to best capture the prevalence of behavioral health conditions across the Medicaid population (Figure 28).

Appendix B: Low Birthweight (LBW) Births by County, CY 2024

County	Medicaid			Non-Medicaid		
County Name	LBW Births	Total Births	LBW Rate	LBW Births	Total Births	LBW Rate
Adams	16	189	8.47%			
Allen	85	750	11.33%	23	484	4.75%
Ashland	22	233	9.44%	6	316	1.90%
Ashtabula	40	444	9.01%	9	359	2.51%
Athens	30	308	9.74%	7	160	4.38%
Auglaize	25	222	11.26%	18	313	5.75%
Belmont	8	79	10.13%			
Brown	15	236	6.36%			
Butler	256	2,386	10.73%	102	1,832	5.57%
Carroll	7	111	6.31%			
Champaign	15	180	8.33%	11	211	5.21%
Clark	125	1,233	10.14%	27	484	5.58%
Clermont	100	906	11.04%	49	1,286	3.81%
Clinton	26	236	11.02%	7	218	3.21%
Columbiana	54	532	10.15%	19	330	5.76%
Coshocton	19	189	10.05%	9	235	3.83%
Crawford	31	274	11.31%	8	164	4.88%
Cuyahoga	940	6,711	14.01%	389	5,675	6.85%
Darke	19	230	8.26%	18	302	5.96%
Defiance	15	184	8.15%	7	131	5.34%
Delaware	66	465	14.19%	100	1,798	5.56%
Erie	29	312	9.30%	10	285	3.51%
Fairfield	80	731	10.94%	63	923	6.83%
Fayette	21	187	11.23%	6	129	4.65%

Franklin	1,200	9,928	12.09%	444	7,397	6.00%
Fulton	16	180	8.89%	13	220	5.91%
Gallia	16	154	10.39%			
Geauga	19	143	13.29%	50	805	6.21%
Greene	68	672	10.12%	44	965	4.56%
Guernsey	24	268	8.96%	14	213	6.57%
Hamilton	748	5,376	13.91%	238	4,507	5.28%
Hancock	43	353	12.18%	22	428	5.14%
Hardin	20	184	10.87%	6	176	3.41%
Harrison						
Henry	8	103	7.77%			
Highland	33	272	12.13%	10	225	4.44%
Hocking	9	160	5.63%			
Holmes	9	111	8.11%	42	715	5.87%
Huron	34	303	11.22%	20	304	6.58%
Jackson	19	197	9.65%	8	156	5.13%
Jefferson	15	178	8.43%			
Knox	28	263	10.65%	21	424	4.95%
Lake	88	788	11.17%	73	1,291	5.65%
Lawrence						
Licking	98	885	11.07%	45	973	4.62%
Logan	14	230	6.09%	13	267	4.87%
Lorain	177	1,558	11.36%	84	1,518	5.53%
Lucas	334	2,683	12.45%	88	1,733	5.08%
Madison	21	186	11.29%	17	233	7.30%
Mahoning	216	1,343	16.08%	39	766	5.09%
Marion	57	463	12.31%			
Medina	48	415	11.57%	67	1,211	5.53%
Meigs						

Mercer	18	165	10.91%	17	421	4.04%
Miami	35	512	6.84%	32	633	5.06%
Monroe						
Montgomery	409	3,607	11.34%	126	2,308	5.46%
Morgan	12	95	12.63%			
Morrow	12	133	9.02%	7	257	2.72%
Muskingum	77	671	11.48%	18	382	4.71%
Noble						
Ottawa	11	134	8.21%	7	147	4.76%
Paulding	7	85	8.24%			
Perry	13	217	5.99%	7	150	4.67%
Pickaway	33	276	11.96%	14	387	3.62%
Pike	22	185	11.89%			
Portage	64	606	10.56%	40	753	5.31%
Preble	17	177	9.61%	12	180	6.67%
Putnam	16	113	14.16%	9	282	3.19%
Richland	99	809	12.24%	29	564	5.14%
Ross	41	449	9.13%	19	276	6.88%
Sandusky	35	330	10.61%	13	268	4.85%
Scioto	40	492	8.13%	11	213	5.16%
Seneca	24	318	7.55%	12	217	5.53%
Shelby	25	253	9.88%	14	366	3.83%
Stark	254	2,045	12.42%	82	1,714	4.78%
Summit	353	2,694	13.10%	140	2,610	5.36%
Trumbull	127	1,099	11.56%	36	741	4.86%
Tuscarawas	48	612	7.84%	31	519	5.97%
Union	25	192	13.02%	30	624	4.81%
Van Wert	12	104	11.54%			
Vinton	7	65	10.77%			

Warren	82	769	10.66%	85	1,672	5.08%
Washington	26	285	9.12%	8	201	3.98%
Wayne	37	426	8.69%	40	953	4.20%
Williams	9	167	5.39%			
Wood	42	476	8.82%	28	718	3.90%
Wyandot	14	128	10.94%	8	112	7.14%

Appendix C: Preterm Births by County, CY 2024

County County Name	Medicaid Preterm Births	Total Births	Preterm Rate	Non-Medicaid Preterm Births	Total Births	Preterm Rate
Adams	28	189	14.82%	8	84	9.52%
Allen	94	754	12.47%	32	485	6.60%
Ashland	41	235	17.45%	16	316	5.06%
Ashtabula	60	446	13.45%	24	360	6.67%
Athens	48	307	15.64%	12	160	7.50%
Auglaize	27	222	12.16%	23	314	7.33%
Belmont	11	79	13.92%			
Brown	22	236	9.32%	8	217	3.69%
Butler	292	2390	12.22%	154	1835	8.39%
Carroll	9	111	8.11%	8	130	6.15%
Champaign	16	180	8.89%	15	210	7.14%
Clark	155	1239	12.51%	45	486	9.26%
Clermont	132	908	14.54%	111	1286	8.63%
Clinton	38	236	16.10%	13	218	5.96%
Columbiana	80	532	15.04%	32	331	9.67%
Coshocton	22	189	11.64%	18	235	7.66%
Crawford	38	274	13.87%	10	164	6.10%
Cuyahoga	1056	6735	15.68%	483	5686	8.50%
Darke	22	230	9.57%	23	303	7.59%
Defiance	21	184	11.41%	12	131	9.16%
Delaware	76	464	16.38%	130	1800	7.22%
Erie	31	312	9.94%	20	285	7.02%
Fairfield	97	733	13.23%	98	923	10.62%
Fayette	29	184	15.76%	9	129	6.98%
Franklin	1339	9961	13.44%	628	7406	8.48%

Fulton	19	180	10.56%	19	220	8.64%
Gallia	15	153	9.80%	6	130	4.62%
Geauga	19	144	13.19%	64	806	7.94%
Greene	86	677	12.70%	69	965	7.15%
Guernsey	27	268	10.08%	13	213	6.10%
Hamilton	783	5387	14.54%	335	4514	7.42%
Hancock	59	354	16.67%	33	429	7.69%
Hardin	28	184	15.22%	15	176	8.52%
Harrison				6	53	11.32%
Henry	9	103	8.74%	12	160	7.50%
Highland	41	272	15.07%	15	225	6.67%
Hocking	15	160	9.38%	7	110	6.36%
Holmes	13	111	11.71%	47	717	6.56%
Huron	35	303	11.55%	24	304	7.90%
Jackson	27	198	13.64%	11	157	7.01%
Jefferson	23	178	12.92%			
Knox	26	263	9.89%	38	424	8.96%
Lake	110	789	13.94%	107	1293	8.28%
Lawrence						
Licking	109	885	12.32%	86	976	8.81%
Logan	23	230	10.00%	25	267	9.36%
Lorain	220	1561	14.09%	135	1520	8.88%
Lucas	414	2693	15.37%	143	1739	8.22%
Madison	29	186	15.59%	17	233	7.30%
Mahoning	223	1346	16.57%	78	765	10.20%
Marion	48	464	10.35%	13	197	6.60%
Medina	55	416	13.22%	113	1212	9.32%
Meigs	11	135	8.15%			
Mercer	25	165	15.15%	35	421	8.31%

Miami	60	515	11.65%	59	634	9.31%
Monroe						
Montgomery	457	3614	12.65%	193	2309	8.36%
Morgan	14	95	14.74%			
Morrow	16	133	12.03%	17	257	6.62%
Muskingum	94	671	14.01%	24	383	6.27%
Noble				8	84	9.52%
Ottawa	16	135	11.85%	14	149	9.40%
Paulding	12	84	14.29%			
Perry	19	217	8.76%	11	150	7.33%
Pickaway	42	277	15.16%	35	387	9.04%
Pike	27	184	14.67%	11	119	9.24%
Portage	69	606	11.39%	59	756	7.80%
Preble	26	178	14.61%	20	180	11.11%
Putnam	14	114	12.28%	17	282	6.03%
Richland	112	810	13.83%	40	564	7.09%
Ross	57	450	12.67%	28	276	10.15%
Sandusky	42	331	12.69%	26	268	9.70%
Scioto	70	493	14.20%	26	214	12.15%
Seneca	41	318	12.89%	25	217	11.52%
Shelby	26	255	10.20%	13	366	3.55%
Stark	296	2050	14.44%	108	1716	6.29%
Summit	370	2704	13.68%	207	2611	7.93%
Trumbull	147	1100	13.36%	70	741	9.45%
Tuscarawas	72	613	11.75%	38	521	7.29%
Union	27	192	14.06%	46	623	7.38%
Van Wert	15	104	14.42%	7	96	7.29%
Vinton	6	65	9.23%			
Warren	89	767	11.60%	140	1677	8.35%

Washington	39	285	13.68%	15	201	7.46%
Wayne	60	426	14.09%	57	954	5.98%
Williams	19	167	11.38%			
Wood	61	477	12.79%	53	718	7.38%
Wyandot	12	128	9.38%	9	112	8.04%

Appendix D: Managed Care Rates for Child Quality Measures

	Oral Evaluation, Dental Services		Childhood Immunization Status, Combination 3		Lead Screening in Children	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	N/A	N/A	65.9%	P10-P25	65.6%	P25-P50
2015	N/A	N/A	62.8%	P10-P25	66.2%	P25-P50
2016	N/A	N/A	60.9%	P10-P25	71.4%	P50-P75
2017	N/A	N/A	63.3%	P10-P25	68.9%	P25-P50
2018	N/A	N/A	63.9%	P10-P25	67.7%	P25-P50
2019	N/A	N/A	62.00%	P10-P25	66.61%	P25-P50
2020	N/A	N/A	63.65%	P25-P50	64.53%	P25-P50
2021	N/A	N/A	59.55%	P25-P50	62.50%	P25-P50
2022	N/A	N/A	60.74%	P25-P50	63.87%	P25-P50
2023	33.71%	N/A	64.48%	P50-P75	67.89%	P50-P75
2024	35.56%	N/A	64.01%	P25-P50	70.97%	P50-P75
AMERIHEALTH						
2023	15.15%	N/A	N/A	N/A	N/A	N/A
2024	20.74%	N/A	64.48%	P25-P50	72.02%	P75-P90
BUCKEYE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	N/A	N/A	66.2%	P10-P25	60.0%	P25-P50
2015	N/A	N/A	63.9%	P10-P25	58.6%	P25-P50
2016	N/A	N/A	62.0%	P10-P25	87.7%	P≥90

2017	N/A	N/A	63.3%	P10-P25	80.2%	P75-P90
2018	N/A	N/A	61.8%	P10-P25	75.4%	P50-P75
2019	N/A	N/A	61.80%	P10-P25	62.77%	P10-P25
2020	N/A	N/A	60.34%	P10-P25	58.39%	P10-P25
2021	N/A	N/A	59.37%	P10-P25	57.16%	P25-P50
2022	N/A	N/A	62.53%	P25-P50	60.07%	P25-P50
2023	33.77%	N/A	63.26%	P25-P50	66.15%	P50-P75
2024	37.88%	N/A	64.08%	P25-P50	71.09%	P50-P75
CARESOURCE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	N/A	N/A	67.9%	P25-P50	68.4%	P25-P50
2015	N/A	N/A	63.3%	P10-P25	68.1%	P25-P50
2016	N/A	N/A	61.1%	P10-P25	69.6%	P25-P50
2017	N/A	N/A	64.0%	P10-P25	68.1%	P25-P50
2018	N/A	N/A	64.7%	P10-P25	67.6%	P25-P50
2019	N/A	N/A	61.07%	P10-P25	67.64%	P25-P50
2020	N/A	N/A	65.21%	P25-P50	65.30%	P25-P50
2021	N/A	N/A	56.69%	P10-P25	63.95%	P25-P50
2022	N/A	N/A	59.12%	P25-P50	66.42%	P50-P75
2023	37.45%	N/A	65.69%	P50-P75	69.34%	P50-P75
2024	37.84%	N/A	62.75%	P25-P50	70.06%	P50-P75
HUMANA						
2023	0.32%	N/A	N/A	N/A	N/A	N/A
2024	19.59%	N/A	67.15%	P50-P75	72.99%	P75-P90
MOLINA						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	N/A	N/A	63.1%	P10-P25	66.6%	P25-P50

2015	N/A	N/A	60.0%	P10-P25	72.2%	P50-P75
2016	N/A	N/A	59.6%	P10-P25	66.7%	P25-P50
2017	N/A	N/A	65.5%	P25-P50	68.1%	P25-P50
2018	N/A	N/A	63.3%	P10-P25	65.9%	P25-P50
2019	N/A	N/A	63.26%	P10-P25	68.15%	P25-P50
2020	N/A	N/A	63.99%	P25-P50	70.07%	P25-P50
2021	N/A	N/A	62.53%	P25-P50	66.05%	P50-P75
2022	N/A	N/A	64.23%	P50-P75	65.07%	P50-P75
2023	35.63%	N/A	63.26%	P25-P50	68.29%	P50-P75
2024	39.85%	N/A	65.69%	P50-P75	76.16%	P75-P90
PARAMOUNT/ ANTHEM						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	N/A	N/A	61.8%	P10-P25	56.5%	P10-P25
2015	N/A	N/A	62.3%	P10-P25	58.9%	P25-P50
2016	N/A	N/A	63.3%	P10-P25	58.4%	P10-P25
2017	N/A	N/A	58.4%	P10-P25	66.4%	P25-P50
2018	N/A	N/A	66.9%	P25-P50	64.0%	P25-P50
2019	N/A	N/A	62.29%	P10-P25	66.18%	P25-P50
2020	N/A	N/A	65.45%	P25-P50	65.45%	P25-P50
2021	N/A	N/A	62.04%	P25-P50	59.85%	P25-P50
2022	N/A	N/A	63.26%	P50-P75	54.26%	P25-P50
2023	35.63%	N/A	N/A	N/A	N/A	N/A
2024	31.21%	N/A	68.13%	P50-P75	68.86%	P50-P75
UNITED HEALTH						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	N/A	N/A	60.1%	P10-P25	59.4%	P25-P50
2015	N/A	N/A	63.5%	P10-P25	62.3%	P25-P50

2016	N/A	N/A	57.7%	P<10	79.1%	P50-P75
2017	N/A	N/A	61.3%	P10-P25	61.4%	P10-P25
2018	N/A	N/A	60.6%	P10-P25	63.8%	P25-P50
2019	N/A	N/A	65.21%	P10-P25	63.75%	P25-P50
2020	N/A	N/A	63.26%	P25-P50	63.50%	P25-P50
2021	N/A	N/A	66.91%	P50-P75	61.31%	P25-P50
2022	N/A	N/A	59.70%	P25-P50	64.72%	P50-P75
2023	28.50%	N/A	62.09%	P25-P50	63.70%	P50-P75
2024	32.92%	N/A	62.95%	P25-P50	70.56%	P50-P75

Table 2: Behavioral Health Measures Medicaid MCO Self-Reported, Audited HEDIS Rates, CYs 2013-2024

	Use of First-Line Psychosocial Care for Children on Antipsychotics		Engagement of Substance Use Disorder Treatment, 13-17 years*		Follow-Up Care for Children Prescribed ADHD Medication Continuation/Maintenance Phase	
	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range	Overall Reported Rate	NCQA Percentile Range
STATEWIDE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	75.5%	N/A	6.7%	P10-P25	61.7%	P75-P90
2015	77.1%	≥P90	16.1%	P50-P75	63.8%	P75-P90
2016	74.7%	≥P90	21.1%	P50-P75	64.3%	P75-P90
2017	75.1%	≥P90	22.5%	P75-P90	65.5%	P75-P90
2018	78.3%	≥P90	23.4%	P25-P50	64.6%	P75-P90
2019	81.25%	≥P90	23.56%	P75-P90	59.76%	P50-P75
2020	79.02%	P75-P90	19.77%	P75-P90	59.27%	P50-P75
2021	78.03%	≥P90	19.46%	≥P90	55.67%	P50-P75
2022	76.73%	≥P90	20.02%	N/A	55.98%	P50-P75
2023	76.10%	≥P90	22.83%	≥P90	53.65%	P25-P50
2024	77.78%	≥P90	19.28%	P75-P90	54.80%	P50-P75
AMERIHEALTH						
2023	N/A	N/A	N/A	N/A	N/A	N/A
2024	70.11%	P75-P90	23.81%	≥P90	65.22%	≥P90
BUCKEYE						
2013	N/A	N/A	N/A	N/A	N/A	N/A

2014	65.5%	N/A	9.5%	P25-P50	57.5%	P50-P75
2015	66.9%	P50-P75	11.9%	P25-P50	53.6%	P50-P75
2016	81.6%	≥P90	21.8%	P75-P90	54.5%	P50-P75
2017	78.9%	≥P90	23.1%	P75-P90	66.2%	P75-P90
2018	78.7%	≥P90	20.8%	≥P90	67.6%	P75-P90
2019	79.94%	≥P90	17.05%	P50-P75	57.29%	P50-P75
2020	78.17%	P75-P90	16.55%	P50-P75	56.62%	P50-P75
2021	79.15%	≥P90	17.37%	P75-P90	56.70%	P50-P75
2022	76.16%	≥P90	24.09%	N/A	53.39%	P50-P75
2023	75.88%	≥P90	21.46%	≥P90	50.19%	P25-P50
2024	75.92%	≥P90	17.92%	P75-P90	50.20%	P25-P90
CARESOURCE						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	81.2%	N/A	5.5%	P10-P25	64.7%	P75-P90
2015	81.1%	P≥90	19.4%	P50-P75	68.2%	≥P90
2016	74.2%	P75-P90	23.7%	P75-P90	69.2%	≥P90
2017	76.3%	≥P90	25.8%	≥P90	68.1%	P75-P90
2018	78.4%	≥P90	22.5%	≥P90	69.9%	≥P90
2019	81.30%	≥P90	23.27%	P75-P90	61.43%	P50-P75
2020	78.85%	P75-P90	20.51%	P75-P90	59.45%	P50-P75
2021	78.46%	≥P90	20.09%	≥P90	54.78%	P50-P75
2022	77.70%	≥P90	19.06%	N/A	56.53%	P50-P75
2023	76.78%	≥P90	24.03%	≥P90	54.58%	P50-P75
2024	79.02%	≥P90	19.46%	P75-P90	56.41%	P50-P75
HUMANA						
2023	N/A	N/A	N/A	N/A	N/A	N/A
2024	77.78%	≥P90	31.34%	≥P90	36.05%	<P10
MOLINA						

2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	67.0%	N/A	7.3%	P10-P25	62.2%	P75-P90
2015	70.4%	P75-P90	8.2%	P10-P25	67.0%	P75-P90
2016	68.9%	P75-P90	8.5%	P10-P25	61.5%	P50-P75
2017	68.8%	P75-P90	12.8%	P25-P50	67.2%	P75-P90
2018	75.9%	≥P90	35.6%	≥P90	57.9%	P50-P75
2019	78.71%	≥P90	23.79%	P75-P90	62.01%	P50-P75
2020	80.31%	≥P90	19.16%	P75-P90	60.32%	P50-P75
2021	77.30%	≥90	18.21%	P75-P90	57.36%	P50-P75
2022	76.66%	≥P90	19.29%	N/A	57.17%	P50-P75
2023	75.61%	≥P90	22.88%	≥P90	22.88%	≥P90
2024	78.56%	≥P90	21.08%	≥P90	52.04%	P25-P50
PARAMOUNT/ ANTHEM						
2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	80.6%	N/A	6.7%	P10-P25	63.8%	P75-P90
2015	81.1%	≥P90	7.6%	P10-P25	62.2%	P50-P75
2016	80.9%	≥P90	10.0%	P10-P25	69.5%	≥P90
2017	81.6%	≥P90	8.3%	P10-P25	69.1%	P75-P90
2018	81.0%	≥P90	17.6%	≥P90	65.8%	P75-P90
2019	84.01%	≥P90	23.77%	P75-P90	55.91%	P50-P75
2020	79.72%	≥P90	15.76%	P50-P75	59.65%	P50-P75
2021	75.59%	≥P90	17.75%	P75-P90	53.46%	P50-P75
2022	78.59%	≥P90	12.00%	N/A	51.60%	P25-P50
2023	N/A	N/A	19.72%	P75-P90	N/A	N/A
2024	68.55%	P75-P90	20.44%	≥P90	53.28%	P25-P50
UNITED HEALTH						

2013	N/A	N/A	N/A	N/A	N/A	N/A
2014	60.2%	N/A	7.4%	P10-P25	40.2%	P25-P50
2015	68.6%	P75-P90	9.0%	P10-P25	42.8%	P25-P50
2016	71.2%	P75-P90	14.6%	P25-P50	45.2%	P25-P50
2017	66.9%	P50-P75	6.9%	P10-P25	40.8%	P10-P25
2018	77.7%	≥P90	22.2%	≥P90	40.3%	P10-P25
2019	82.49%	≥P90	31.73%	≥P90	54.35%	P25-P50
2020	79.28%	P75-P90	22.79%	≥P90	60.00%	P50-P75
2021	76.91%	≥P90	22.01%	≥P90	59.18%	P75-P90
2022	72.33%	P75-P90	24.59%	N/A	59.29%	P75-P90
2023	73.05%	P75-P90	19.20%	P75-P90	19.20%	P75-P90
2024	78.96%	≥P90	15.65%	P50-P75	60.04%	P75-P90

*Due to methodology revision, 2022 and 2023 and 2024 results not comparable to prior years.