

The Role of the Title V MCH Services Block Grant in Improving Maternal and Infant Health



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Overview and Background

Maternal and Infant Health Crisis in the US

The United States is facing a crisis in maternal and infant health—with rising rates of maternal and infant death accompanied by persistent racial/ethnic disparities in both outcomes, with the burden felt most by Black and American Indian/Alaska Native birthing people and their families.

Each year in the United States, more than 60,000 women experience life-threatening health complications and conditions related to pregnancy, and 700-800 die of maternal causes. Data from the two US maternal mortality surveillance approaches measure mortality over different time periods. The Maternal Mortality Rate (deaths during and within 42 days of the termination of pregnancy from associated causes) increased in recent years and then decreased from 32.9 deaths per 100,000 live births in 2021 to 22.3 in 2022,¹ and further decreased to 18.6 in 2023.² The Pregnancy-Related Mortality Ratio (deaths during or within one year of pregnancy from a cause related to or aggravated by pregnancy) was 33.2 deaths per 100,000 live births in 2021, falling to 18.4 in 2024.³ Both approaches document significant and persistent disparities in maternal deaths by race/ethnicity with Black and American Indian or Alaska Native mothers having the highest rates. Importantly, a large share of pregnancy-related deaths occur 43-365 days after the end of pregnancy, accounting for approximately 1 in 4-5 maternal deaths.^{4 5 6} The tragedy of maternal death is even more poignant when we understand over 80% of pregnancy-related deaths are preventable.^{4 6}

Parallel to the maternal mortality crisis in the US are the significant disparities in US infant mortality rates by race/ethnicity. While infant mortality rates had been coming down over the last several decades (e.g., in 1995, the reported infant mortality rate was 7.6 deaths per 1,000 live births, dropping to 5.4 deaths per 1000 live births in 2020), of special concern have been the very high rates of infant death among Black and American Indian/Alaska Native babies in the United States. For decades, the risk of death in the first year of life for infants born to Black mothers has consistently been more than two



times greater than the risk of infant death for infants born to White mothers. Importantly, the most current infant mortality data have been even more concerning as the overall progress in reducing infant mortality rates appears to have stalled. The US infant mortality rate was 5.6 infant deaths per 1,000 live births in 2022 and 2023, a 3% increase from the rate of 5.4 in 2021. Infants born to Black mothers continued to have the highest mortality rate (10.9 per 1,000 live births) in 2023. American Indian and Alaska Native, and Native Hawaiian or Other Pacific Islander infants also have high mortality rates (9.2 and 8.2, respectively), particularly in comparison to White infants (4.5 per 1,000 live births).^{7 8}

In a wealthy nation such as the United States, both infant and maternal deaths can be considered sentinel events, that is, deaths that should not occur if a nation's health care, public health, economic, and social support systems were optimally functional. Given these twin crises and their sentinel nature, it is important to understand the extent of the investments in maternal and infant health of the federal Maternal and Child Health Bureau (MCHB) which aims to "Assure access to high-quality and equitable health services to optimize health and well-being for all Maternal and Child Health (MCH) populations" (MCHB Mission and Vision, 2023). In particular, it is important to specifically explore the distinct role of the Title V MCH Block Grant, a joint federal/state partnership, operating in every US jurisdiction, all 50 states, Washington, DC, and the US territories.

One important strategy for addressing the US maternal and infant health crisis is to ensure adequate Title V investment at both the federal and state levels. Notably, states set the level of Title V funding dedicated to supporting maternal and infant health. As such, the purpose of this report is to understand the unique role of the Title V MCH Block Grant program in addressing maternal and infant health disparities through an examination of the fiscal investments for pregnant women and infants made by Title V in the 59 states and territories.

Overview of the Title V Maternal and Child Health (MCH) Services Block Grant

The Title V MCH Block Grant is a federal state partnership focused on improving the capacity of public health systems to address the needs of women, children, and families. To achieve its purposes, the Title V program provides federal funding to support MCH infrastructure and initiatives in every US state and territory. Federal law requires matching contributions (ratio of \$3 non-federal funds for every \$4 federal funds) from each jurisdiction. Many states secure and spend funds beyond this 3:4 requirement resulting in an "overmatch." Overall, the total Title V federal-state partnership results in more than \$2.5 billion in funds being available in recent years for maternal and child health programs and activities at the state and local levels. (For trend data, visit: <https://mchb.tvisdata.hrsa.gov/>). The program has three legislatively defined populations: preventive and primary care for all pregnant women, mothers, and infants up to age one; preventive and primary care services for children age 1-21; and, services for Children with Special Health Care Needs (CSHCN), which for the purposes of state planning are further divided into five population domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; and, 5) CSHCN.

Since 1989⁹, states have been required to use at least 30% of their federal block grant allocations for the population of CSHCN, and 30% for services for preventive and primary care services for children.¹⁰ Notably, administrative expenditures for federal grant dollars are capped at 10%. This effectively means that 30% of a state's federal Title V Block Grant allocation is available for additional funding for either of these groups or for other populations and additional appropriate MCH activities, leading to what is essentially a 30-30-30-10 federal allocation. Non-federal matching funds from state dollars and other sources are not required to be directed toward specific populations in the same proportions as the Title V federal block grant allocation, giving the states flexibility to direct those funds where needed. Importantly, the level of funding used to support MCH Block Grant programs varies greatly by state, not only in the amount of the federal allocation (determined by a formula at the federal level), but also in the amount and sources of other funds provided by the state or territory.

Building on federal requirements set in 1989 for the Title V MCH Block Grant, the MCHB developed a robust design for a performance measurement system in 1993 and began performance measurement with states in 1997.¹¹ In the latest iteration of the MCH Block Grant Guidance, there are multiple National Performance Measures (NPMs) focused on maternal health (i.e., the first three measures address Postpartum Care and the fourth addresses Perinatal Care Discrimination). There are three specific infant health related NPMs including a multi-pronged safe sleep measure. In addition, the Standardized State Performance Measures (SSPM) include additional maternal and infant health related measures such as the Well-Woman Visit, Early Prenatal Care, Low-Risk Cesarean Delivery, Drinking During Pregnancy, and Smoking During Pregnancy. A state must report on a minimum of five NPMs which includes the two universal NPMs (Postpartum Visit, and Medical Home) and at least one for each of the population domains delineated above.¹²

In addition to the block grants for states, the Title V statute designates some of the Congressionally appropriated dollars as “federal set-aside” funds. Of the amounts appropriated up to \$600 million, 15% is to be retained for Special Projects of Regional and National Significance (SPRANS)¹³ and of the amounts appropriated in excess of \$600 million, the federal agency retains 12.75% for projects under what is known as Community Integrated Service Systems (CISS).¹⁴ These two federal set-aside components support discretionary and competitive project grants, which complement state efforts to improve the health of mothers, infants, children, including CSHCN and their families. In some instances, Congress has directed appropriations to select SPRANS priorities.



Maternal and Child Health Bureau Investments in Maternal and Infant Health

Historically, MCHB has invested in maternal and infant health through the Title V grants to states, through Title V federal set aside funds via SPRANS and CISS, and through other programs assigned to MCHB by Congress but authorized through separate funding.

Programs specifically focused on serving families with pregnant women, infants, and young children include the Healthy Start Program (<https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap6A-subchapII-partD-subparti-sec254c-8.pdf>) and the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program, the latter created as another part of Title V of the Social Security Act (https://www.ssa.gov/OP_Home/ssact/title05/0511.htm). Both Healthy Start and MIECHV are linked to and required to coordinate with the Title V MCH Block Grant program. Other programs funded by MCHB with Title V funds or Congressionally designated funds focus more directly on the health and survival of infants, including the National Fetal, Infant, and Child Death Review Program, and the Newborn Screening and Genetics Program.

Over the last decade, MCHB has funded more programs and initiatives focused specifically on maternal health including the Alliance for Innovation on Maternal Health (AIM), the Maternal Health Innovation (MHI) Program, the National Maternal Mental Health Hotline, and the Women's Preventive Services Initiative (WPSI). However, the single largest source of funding from MCHB to address maternal and infant health is the Title V MCH Block Grant program and its grants to states.



Analysis: Deeper Dive into State Title V Investments for Maternal and Infant Health

Research Questions

To examine the role of the Title V MCH Block Grant in addressing maternal and infant health disparities through an examination of the fiscal investment made by Title V in the 59 states and territories for pregnant women and infants, we focused on four research questions.

1. What is the ratio of non-federal to federal MCH Block Grant funding overall and for each of the three legislatively defined populations? What is the extent of the overmatch overall and by population group?
2. To what extent is there variability in the funds budgeted for Title V across the states for federal Title V funds only, for non-federal Title V funds only, and for combined federal and non-federal funds for each population group?
3. If we assume a 30-30-10 percentage contribution from states based on the federal requirements (and a benchmark of 30% for pregnant women and infants), how many states budget at least 30% of their federal dollars, non-federal dollars, and combined dollars for each population group?
4. Is the differential Title V funding across states for pregnant women and infants associated with:
 - a. Infant mortality rates greater than the Healthy People 2020 objective for infant mortality,
 - b. Racial disparities in infant mortality rates, and
 - c. Maternal mortality rates greater than the national maternal mortality rate?

Methods

State Title V budget data were extracted from the Title V Information System (TVIS) and from the FY 2023 Title V Block Grant application /FY 2021 Annual Report for each state, territory and Washington, DC. (Note: This analysis began before the FY2024 Title V Block Grant application data were available. The most recent 2026 application/2024 Annual Report can be found at <https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport#>.)

Using Forms 2 and 3a of each state's Title V application, the following FY 2023 application budgeted amounts for each state were extracted. (Note: We combine the funding amounts for pregnant women and infants <1 year for this analysis.)

- a. *Federal Allocation*: Form 2.
- b. *Federal Total*: Form 3a. (Note: The Federal Total on Form 3a does not include administrative costs which are included as part of the Federal Allocation on Form 2. In addition, Form 2 is used by MCHB to ensure that states are in compliance. They do not use Form 3a for this purpose.)
- c. *Non-Federal Total*: Form 3a.
- d. *Federal funds*: Form 3a: pregnant women, infants < 1 year, children 1-21 years, and CSHCN.
- e. *Non-federal funds*: Form 3a: pregnant women, infants < 1 year, children 1-21 years, and CSHCN.
- f. *Combined federal and non-federal funds*: Derived from Form 3a: pregnant women, infants < 1 year, children 1-21 years, and CSHCN.

Analytic Assumptions

To conduct this maternal and infant health focused analysis, there were several important methodological decisions and assumptions:

1: Designation of Geographic Areas: This brief includes data for the 59 state and territorial jurisdictions that receive Title V MCH Block Grant federal funds. Throughout the brief, the term “state” refers to the 50 states, 8 territories, and the District of Columbia. The 8 territories may appear separately on some tables, maps, or in summary data points in the narrative. However, the observational analysis (Research Question #4) related to maternal and infant mortality includes only the 50 states.

2: Calculations: Most tables and state counts reflect rounding up such that any percentage ending in 0.5 or greater was rounded to the next whole number. To calculate overmatch, non-federal funding in excess of 0.75, in deference to the Title V matching expectation of \$3.00 in state funds for every \$4.00 provided by the federal government was considered overmatch. Using this approach, total overmatch and the overmatch for each population group were generated for each state.

3: Data Sources for Budget Information: Forms 2 and 3a have some overlapping information, particularly related to the amount of federal funding for two of the three main populations: children 1-21, and CSHCN. The data are different between the two forms. The decision was made to base most of these analyses on Form 3a information since Form 3a also includes the population group specific dollar amounts for both the federal and non-federal portions of the MCH Block Grant, including the federal and non-federal dollar amounts for pregnant women and infants < 1 year.

Research Question Approach

This section provides an overview of the analytic approach and data source for each of the four research questions addressed in this brief report:

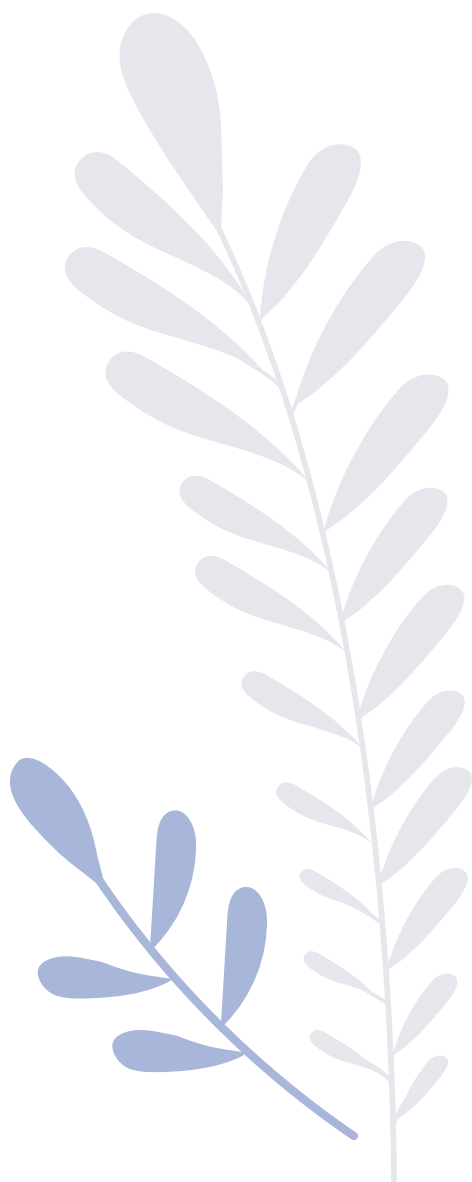
- *Research Question #1:* Total federal funding and the total non-federal funding information from Form 3a was used to create ratios of non-federal to federal spending overall and by population group, and to determine the overall and population specific overmatch. (Note: The MCHB uses Form 2 to monitor compliance with federal law. Additional analysis of data from Form 2 forthcoming.)
- *Research Question #2:* Form 3a data were used to calculate the percentages of federal, non-federal, and combined total funding overall and for each population group. (Note: The MCHB uses Form 2 to monitor compliance with federal law. Additional analysis of data from Form 2 forthcoming.)
- *Research Question #3:* Although the Title V MCH Block Grant only specifies a 30% federal allocation for two of the three core populations: 1) children and adolescents (children 1-21), and 2) CSHCN, and no more than 10% to be spent on administrative costs, this report used a benchmark of 30%-30%-30%-10% to determine, the number of states that budget: a) at least 30% (i.e., greater than or equal to, or ≥ 29.5) of their federal Title V dollars, b) at least 30% of their non-federal dollars, and c) at least 30% of their combined dollars, for each of the three populations. A focal point of these analyses is to understand how spending on pregnant women and infants (no federal amount required) compares to spending on children/adolescents (federal amount required) and CSHCN (federal amount required). This analysis was based on Form 3a.

- *Research Question #4: Observational Comparison of Spending on Pregnant Women and Infants to State Maternal and Infant Mortality Data.* In addition to the data derived from Forms 2 and 3a as described above, overall infant mortality data (2021) were downloaded from the CDC’s website and verified with rates published in a Vital Statistics Surveillance Report.¹⁵ The racial/ethnic specific infant mortality (2021) data were downloaded from CDC Wonder.¹⁶ Maternal mortality data were also downloaded from the CDC’s website.¹⁷ These three sets of data were used to observe correlations between state infant and maternal mortality rates as well as disparities in these outcomes, with state spending on pregnant women and infants. A particular focus was on observed correlations between maternal and infant mortality rates and whether states spend less than 30% of their combined Title V dollars on pregnant women and infants, and whether states overmatch for pregnant women and infants. Benchmarks for this analysis include the Healthy People 2020 objective for infant mortality of 6 infant deaths per 1000 live births,¹⁸ a Black-White ratio in infant mortality of greater than 2, and the overall 2018-2021 42-day maternal mortality ratio for the United States (23.5 deaths per 100,000 live births).¹⁷

In the analyses for Question #4 in this report, the focus of spending on pregnant women and infants is on those states spending less than 30% of their combined federal and non-federal funds on these populations. This is slightly different than the framing and table shading for Questions #2 and 3, in which the focus is on spending at least 30% on these populations (particularly for Question #3). In the Question #4 analysis in this report, the focus was on “deficits” as a way to highlight those states that spend less on pregnant women and infants than on the populations of children and CSHCN, but also have high rates of maternal and infant mortality.



Findings



Question 1: What is the ratio of total non-federal to federal funding for each of the three populations and overall? What is the extent of the overmatch overall and by population group?

Findings for Question 1:

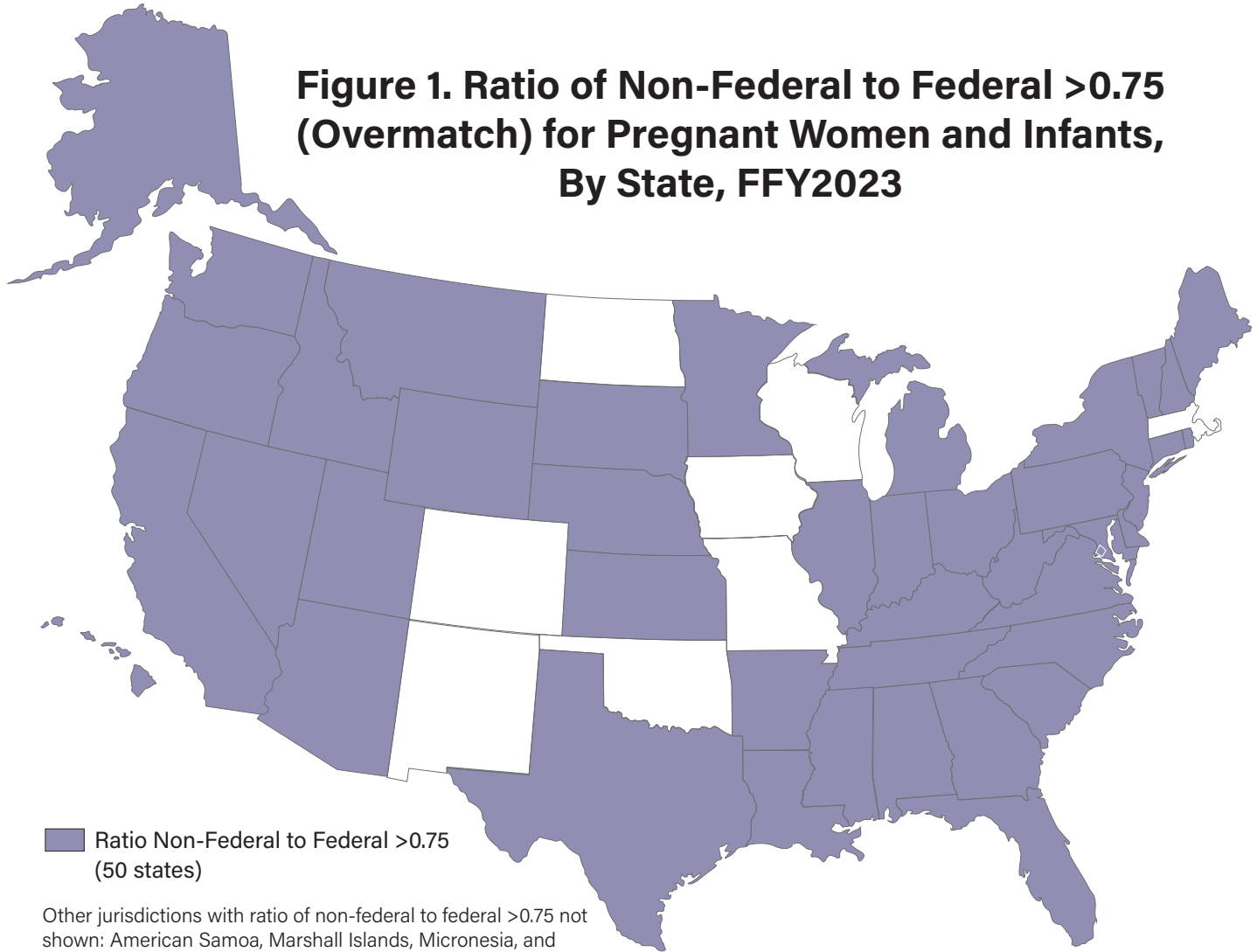
Based on an analysis of data reported by states on Form 3a, the number of states with ratios greater than 0.75, in other words, with overmatch, are shown below and in Table 1.

Ratio non-federal to federal funds in budget:

- 55 states have ratios greater than 0.75 when comparing overall non-federal to federal Title V funding.
- 44 states have ratios greater than 0.75 for non-federal to federal funding for preventive and primary care for children 1-21.
- 35 states have ratios greater than 0.75 for non-federal to federal funding for CSHCN.
- 50 states have ratios greater than 0.75 for non-federal to federal funding for pregnant women and infants. Ratios range from 47 (GA) to 0 (NM). The 9 states with match at or below 0.75 for pregnant women and infants include: CO, GU, IA, MA, MO, NM, ND, OK, WI. (Figure 1).

Federal law requires matching contributions at a ratio of \$3 non-federal funds for every \$4 federal funds. A large majority of states secure and spend funds beyond this 3:4 requirement resulting in an overmatch.

Figure 1. Ratio of Non-Federal to Federal >0.75 (Overmatch) for Pregnant Women and Infants, By State, FFY2023



Summary and Interpretation of Findings from Question 1

As can be seen from these data, the majority of states spend more than the required 3:4 ratio on their overall-MCH Block Grant budgets and for each of the three populations. Of interest is that the number of states that have overmatch (ratio of non-federal to federal dollars greater than 0.75) for the combined pregnant women and infant population is greater than for the other two populations. Despite the general appearance of a robust matching effort, these data also demonstrate the great variability in funding across states overall, and within the three populations.

Question 2: To what extent is there variability in the funds budgeted for Title V across the states for federal Title V funds only, for non-federal Title V Funds only, and for combined federal and non-federal funds for each population group?

Findings for Question 2

Based on analysis of data reported by states on Form 3a, the findings are shown below, in Figure 2, and in Tables 2.A, 2.B, and 2.C.

Federal Title V Funds in budget (Table 2.A):

- Federal Title V Funds budgeted for preventive and primary care for children 1-21, states range from 56.1% (AL) to 19.2% (RI), and for CSHCN, from 62.1% (NY) to 29.9% (TN). (Note: This analysis uses data from Form 3a. The data in Form 2 show that all states are in compliance with federal law for 30% allocated to the two categories of children.)
- For federal Title V Funds budgeted for pregnant women and infants, states range from 37.3% (RI) to 1.3% (NY).

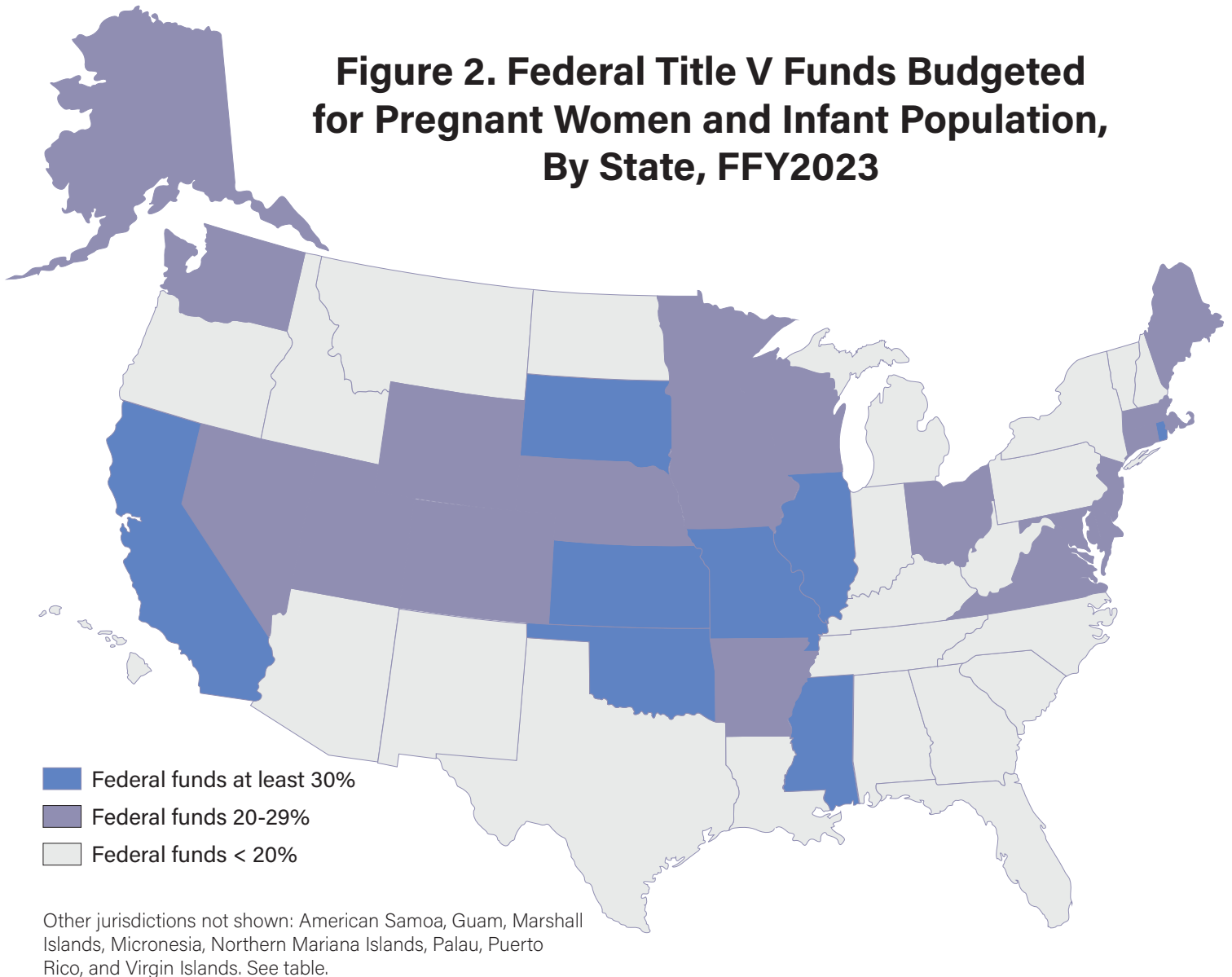
Non-federal Title V Funds in budget (Table 2.B):

- States' budgets range from 78.2% (VT) to 1.3% (LA) for preventive and primary care for children 1-21, and from 74.8% (NJ) to 0.2% (ID) for CSHCN.
- For non-federal Title V funds budgeted for pregnant women and infants, states range from 80% (WY) to 0.0% (NM).

Combined federal and non-federal Title V funds in budget (Table 2.C):

- States' budgets range from 70.9% (KY) to 7.0% (SC) for preventive and primary care for children 1-21, and from 72.8% (NJ) to 7.3% (RI) for CSHCN.
- For combined Title V funds budgeted for pregnant women and infants, states range from 63.1% (WY) to 1.7% (SC).

Figure 2. Federal Title V Funds Budgeted for Pregnant Women and Infant Population, By State, FFY2023



Summary and Interpretation of Findings from Question 2

Based on the data above, there is clear variability across states in federal and non-federal funding within and across populations, even with a requirement for spending at least 30% of federal Title V funds for preventive and primary care for children, and for CSHCN. Although not the focus of this analysis, it is likely that this variation may be the result of some combination of historical spending patterns, state legislative budget decisions, and population needs identified.

Question 3: If we assume a 30-30-10 percentage contribution from states based on the federal requirements (and 30% for pregnant women/infants), how many states budget at least 30% of their federal dollars, non-federal dollars, and combined dollars for each population group?

Findings for Question 3

Based on analysis of data reported by states on Form 3a, the number of states that budget at least 30% of their federal, non-federal, and combined funds in Title V budgets for each of the three populations is described below. Table 3 and Figure 3 (combined funds only) present this information specifically for pregnant women and infants whereas Tables 2.A-2.C present this information for all three populations.

Federal Title V funds in budget:

- With rounding, all states except three (based on Form 3a, not Form 2) budgeted at least 30% of their federal funds for preventive and primary care for children 1-21, and all states budgeted at least 30% of their federal funds for CSHCN (Table 2.A).
- For pregnant women and infants, 10 states budgeted at least 30% of their federal funds (CA, GU, IL, KS, MH, MS, MO, OK, RI, SD) for this population (Table 2.A, Table 3, and Figure 2).

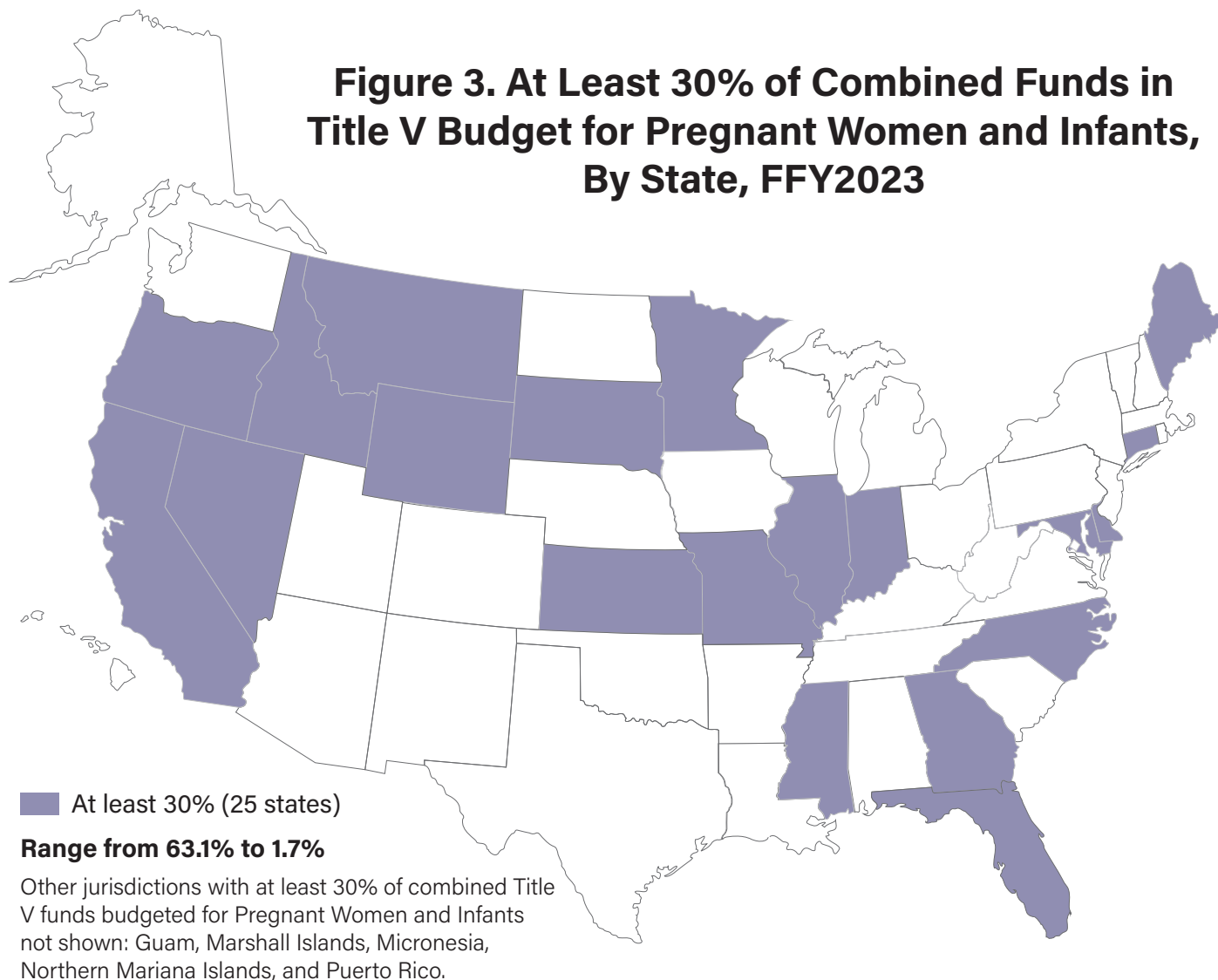
Non-federal Title V funds in budget:

- For non-federal Title V dollars, 33 states budgeted at least 30% for preventive and primary care for children 1-21, and 24 states budgeted at least 30% for CSHCN (Table 2.B).
- For pregnant women and infants, 31 states budgeted at least 30% of their non-federal funds (AZ, AR, CA, CT, DE, FL, GA, GU, ID, IL, IN, KS, LA, ME, MH, MD, FM, MN, MS, MP, MT, NE, NV, NC, OR, PW, PR, SD, TX, WA, WY). (Table 2.B and Table 3).

Combined federal and non-federal Title V funds in budget:

- For combined federal and non-federal Title V dollars, 36 states budgeted at least 30% for preventive and primary care for children 1-21, and 27 states budgeted at least 30% for CSHCN (Table 2.C).
- For pregnant women and infants, 25 states budgeted at least 30% of combined funds (CA, CT, DE, FL, FM, GA, GU, ID, IL, IN, KS, ME, MH, MD, MN, MP, MS, MO, MT, NV, NC, OR, PR, SD, WY) (Table 2.C, Table 3, and Figure 3).

Figure 3. At Least 30% of Combined Funds in Title V Budget for Pregnant Women and Infants, By State, FFY2023



Summary and Interpretation of Findings from Question 3

Almost all states budget well beyond the requirement to spend 30% of federal funds on children 1-21 and CSHCN; however, very few (10 states) spend at least 30% of their federal dollars on pregnant women and infants.

Perhaps because there are very few states spending at least 30% of their federal Title V funds on pregnant women and infants, the number of states that overmatch (ratio of non-federal to federal dollars is greater than 0.75) is highest for this population group as demonstrated in the Question 1 analysis. Given that there isn't a specific requirement for budgeting 30% of federal funding for pregnant women and infants, it appears states may be providing additional state level Title V dollars for activities for this group, likely to compensate for the low percentage of their federal Title V funds directed at this population. However, it is clear that even with overmatch of state Title V funds targeted to pregnant women and infants, in over half the states (n=34), the extra investment provided by the overmatch is still not sufficient for the states' combined federal and state Title V funding for pregnant women and infants to reach 30% as only 25 states budget at least 30% of combined federal and non-federal Title V dollars for this population.

Question 4: Is differential Title V funding across states for pregnant women and infants associated with:

- Infant mortality rates greater than the Healthy People (HP) 2020 objective for infant mortality (Table 4.A),
- Racial disparities in infant mortality rates (Table 4.B), and
- Maternal mortality rates greater than the national maternal mortality rate (Table 4.C)?

Findings for Question 4

States with 2021 infant mortality rates greater than the 2020 HP objective of 6.0/1000 live births (Table 4.A):

- 16 states out of 49 (AL, AK, AR, GA, IN, KY, LA, MI, MS, NC, OH, OK, SC, SD, TN, WV) have IMR greater than the 2020 HP objective (Note: No data are available for Vermont. In addition, DC and other jurisdictions are not included in this analysis.)
- 11 of these 16 states (AL, AK, AR, KY, LA, MI, OH, OK, SC, TN, WV) with IMR greater than the HP 2020 objective are also among those with less than 30% of their combined federal and non-federal Title V funding (n=30) budgeted towards pregnant women and infants.
- However, only 1 (OK) of the 11 states with both IMR above the HP 2020 objective and with less than 30% of combined funding budgeted towards pregnant women and infants has a non-federal to federal match ratio below 0.75 for this population group. (Note: There are a total of 8 states out of the 49 with no overmatch for this population group).

States with 2021 Black-to-White infant mortality ratio greater than 2 (Table 4.B):

- 34 states (AL, AZ, AR, CA, CO, CT, FL, GA, IL, IN, IA, KS, KY, LA, MD, MA, MI, MN, MS, MO, NE, NV, NJ, NY, NC, OH, OK, PA, SC, TN, TX, VA, WA, WI) have reliable data for purposes of comparing Black to White IMR. (Note: No data are available for Vermont. In addition, DC and other jurisdictions are not included in this analysis.)
- Among these 34 states, 22 states (AZ, CO, CT, FL, IA, IL, KS, LA, MA, MI, MN, MO, NE, NV, NJ, NY, NC, OH, PA, SC, VA, WI) have a Black-to-White infant mortality ratio greater than 2.0.
- 14 of the 22 states (AZ, CO, IA, LA, MA, MI, NE, NJ, NY, OH, PA, SC, VA, WI) whose Black-to-White infant mortality ratio is greater than 2.0 are also among the states (n=21) who budgeted less than 30% of their combined federal and non-federal Title V funding for pregnant women and infants.
- However, only 4 (CO, IA, MA, WI) of the 14 states whose Black-to-White infant mortality ratio is greater than 2.0 and who also budget less than 30% of their combined federal and non-federal Title V funding for pregnant women and infants, have a non-federal to federal match ratio below 0.75 for this population group. (Note: A total of 6 states out of the 34 have no overmatch for this population group).

**States with 2018-2021 42-day MMR greater than the US rate of 23.5 per 100,000
(Table 4.C and Figure 4):**

- 37 states have reliable maternal mortality rates for 2018-2021 (AL, AZ, AR, CA, CO, CT, FL, GA, IL, IN, IA, KS, KY, LA, MD, MA, MI, MN, MS, MO, NE, NV, NJ, NM, NY, NC, OH, OK, OR, PA, SC, TN, TX, UT, VA, WA, WI).
- Among these 37 states, 20 states (AL, AZ, AR, FL, GA, IN, KY, LA, MS, MO, NE, NJ, NM, NC, OH, OK, SC, TN, TX, VA) have a 42-day MMR greater than 23.5 per 100,000 (2018-2021).
- 14 states (AL, AZ, AR, KY, LA, NE, NJ, NM, OH, OK, SC, TN, TX, VA) among the 20 with a 42-day MMR greater than 23.5 per 100,000 are also among those (n= 23) who budgeted less than 30% of their combined federal and non-federal Title V funding for pregnant women and infants (Figure 4).
- However, only 2 states (NM, OK) have an MMR greater than 23.5 per 100,000 and spend less than 30% of their combined federal and non-federal funds on pregnant women and infants who also have a non-federal to federal match ratio below 0.75 for this population group. (Note: NM has a ratio of 0.0 for non-federal to federal spending for pregnant women and infants. Also, note that there are 7 states out of the 37 who do not have overmatch for this population group).



Discussion

Since the passage of OBRA 1989, states have been required to use at least 30% of their federal Title V MCH Block Grant allocation for CSHCN and 30% for services for preventive and primary care services for children 1-21, with no more than 10% for administration. This leaves 30% remaining for initiatives for either of the aforementioned populations, or for other populations, and/or for other appropriate MCH efforts. Importantly, states are not required to follow the allocation requirements of federal funding for the non-federal portion of dollars spent on children 1-21 and CSHCN.

At the time of passage of OBRA 89, Congress did not dedicate Title V funds specifically for pregnant women and infants, in part because Medicaid expansions had provided coverage for this population.¹⁹ Thus, under current law, states are not required to provide any Title V federal or non-federal funding for pregnant women and infants in the same proportion as the other two populations or at all. Instead, states have the flexibility to direct those funds where needed. However, 10 states do spend at least 30% of their federal dollars, and 31 states spend at least 30% of their non-federal Title V dollars on pregnant women and infants.

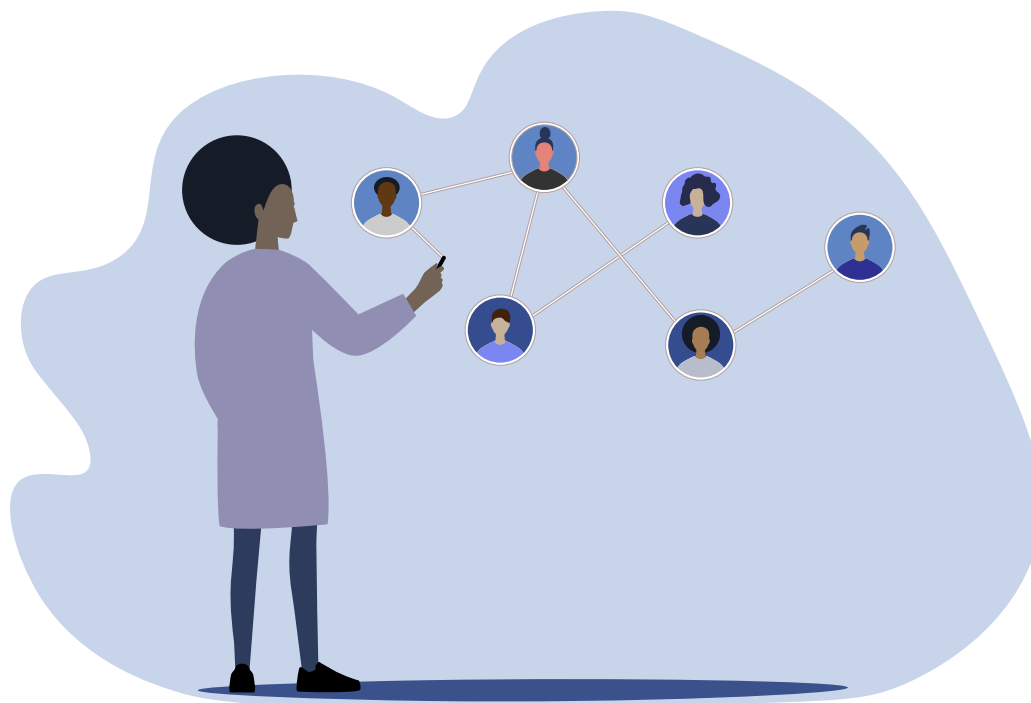
It should be noted that because there is no explicit requirement for at least 30% of federal Title V funds be spent on pregnant women and infants, the analysis presented here rests on a decision by the authors to use a benchmark of 30-30-30-10 to undergird our understanding of the amount of federal, non-federal, and combined funding spent on all three major populations: Pregnant Women and Infants, Children 1-21, and CSHCN. While states might consider this an unfair benchmark by which to judge their efforts given that they are all in compliance with the statute and guidance, the authors believe this approach allows for a simple comparison of the spending on pregnant women and infants with the other two populations. The approach used here also allows for a simple comparison of federal versus non-federal Title V funding, thus providing an anchor for understanding the funding commitment and priorities of the states.

Given the maternal and infant mortality crisis in this nation, the federal Title V Block Grant funding budgeted by states for initiatives focused on pregnant women and infants appears to be disproportionately lower than the federal Title V Block Grant funding budgeted for the other two MCH focal populations of children and CSHCN. It could be argued that the current 30-30-10 requirement for federal Title V dollars affords states the most flexibility to address maternal and infant health issues. The current formula is not prescriptive with respect to the remaining 30% of the federal allocation and provides no prohibition with respect to spending state funding.²⁰ In addition, it is clear that although states are trying to compensate for this lower federal spending with high rates of overmatching for this population group, in more than half of the states, this extra investment is still not sufficient for the states combined federal and state funding for pregnant women and infants to reach 30%. Of note, however, Title V funding does not represent all maternal and infant health focused funding in each state, as many states invest state or other dollars into a variety of programs such as case management and care coordination programs for pregnant women and infants. Although this is true, Title V remains the essential anchor of the maternal and infant health delivery system. Often for example, state Title V programs are responsible for the maternal and infant health surveillance activities that take place in each state, which should drive programming for this population group.

In the last decade, some federal dollars have been specifically designated for maternal health initiatives through MCHB including the AIM bundles, the Maternal Health Initiative (MHI), the Maternal Mental Health Hotline, and the Center for Maternal and Child Health Medicaid Partnerships, and states also receive separate grants from other MCHB administered programs based such as Healthy Start and MIECHV. These grant dollars are for designated initiatives or programs under which awardees (e.g., state agencies, community agencies, universities) must comply with the specific requirements of each funding opportunity. Importantly, many of these programs are in jeopardy in the current funding climate and may not be available going forward as part of the maternal and infant health delivery system.

Notably, the Title V MCH Block Grant provides states with the flexibility to utilize their Title V funding, whether federal (within the 30-30-10 limitation) or non-federal dollars, to address their own state's needs and priorities. This provides states with the opportunity to review the trends in their data, assess their needs through both quantitative and qualitative methods, a process formally undertaken every five years, and on a continual basis less formally, and to develop strategies that work best for the unique needs of their own states. As one of the oldest federal-state partnerships aimed at improving the health and well-being of the population, Title V has survived and been strengthened since its inception in 1935 because states are empowered to respond to their own needs within a larger national system and framework. This framework is aimed at maximizing state flexibility and autonomy while also ensuring state adherence to Title V guidance and performance metrics.

As stated above, part of the national framework which MCHB provides to undergird the efforts and focus of state Title V agencies is a National Performance Measurement system in which maternal and infant health are both given considerable attention through the NPMs as well as the SSPMs.¹² However, MCHB does not provide guidance for selection of the NPMs/SSPMs for those states particularly interested in elevating their focus on pregnant women and infants, perhaps a missed opportunity to provide support to states at a time in which the nation faces significant maternal and infant health inequities.



Recommendations for Strengthening the Role of the Title V MCH Block Grant in Addressing Maternal and Infant Health Inequities Moving Forward

Historically, MCHB has explicitly funded and supported multiple initiatives to address maternal and infant health disparities through Title V SPRANS (and/or CISS) federally guided investments, and by using other programs external to Title V (e.g., Healthy Start). However, given the important role of the Title V MCH Block Grant in establishing and funding MCH priorities and strategies for each state, direct investment by state Title V agencies in pregnant women and infants through MCHB Block Grant expenditures is also warranted.

Federal Level

- MCHB can consider potential modification of the Title V MCH Block Grant Guidance. Only 10 states spend at least 30% of their federal Title V dollars on pregnant women and infants. Given that many states attempt to compensate for their lower federal spending on pregnant women and infants with high rates of overmatching for this population group, and that in more than half the states this extra investment is still not sufficient for the combined federal and state Title V funding to reach 30% for this population group, MCHB should conduct a review of the current federal Title V Block Grant Guidance. MCHB should consider the feasibility of an explicit designation of 30% for pregnant women and infants with regards to the federal portion of Title V funding in the next revision of the Block Grant Guidance. Alternatively, designation of 30% of federal funds for pregnant women and infants could be implemented through Congressional action as a way to balance population categories within the MCH Block Grant.
- MCHB can encourage states, particularly those with high rates of maternal and/ or infant mortality and morbidity, to review the amount of federal and state Title V dollars directed toward this population group, and to determine if the amount of funding is sufficient to meet their states' priorities and to implement their desired strategies. Without Congressional action or an explicit change to the Block Grant Guidance, MCHB can support greater parity in the state Title V investment in pregnant women and infants by encouraging states to spend at least 30% of their federal funds, and/or at least 30% of their non-federal Title V funds on pregnant women and infants. Another possible approach is to encourage states to spend at least 30% of their combined federal and non-federal Title V funds on pregnant women and infants, without prescribing exactly where these funds should come from each year. This strategy may have the most potential to provide flexibility to the states, allowing them to effectively respond to the maternal and infant mortality crisis while ensuring greater parity in spending across populations.
- At the federal level, the MCH community can advocate for an additional discretionary national funding stream to address the maternal and infant mortality crisis. This funding stream can be considered a temporary or permanent add-on to the federal Title V MCH Block Grant dollars provided to the states. It also may be differentially targeted to states with the highest rates of maternal and infant mortality.

State Level

- At the state level, MCH leaders (e.g., families, providers, community agencies, and others) can advocate for an additional funding stream to address the maternal and infant mortality crisis. This funding stream might be via a new appropriation of state general revenues dedicated to maternal and infant mortality reduction. It also might be differentially targeted to communities with the highest rates of maternal and infant mortality in the state.
- At the state level, states can increase their focus on maternal and infant health by adopting National Performance Measures (NPMs) and State Specific Performance Measures (SSPMs) in their Title V Action Plans for the next five-year period (2026-2030) as part of a Maternal and Infant Health Bundle across the reproductive and perinatal continuum.

State Title V Performance Measures: Maternal and Infant Health Bundle

National Performance Measures	Standardized State Performance Measures	Reproductive and Perinatal Continuum Focus
	Well-Woman Visit	Prior to Pregnancy Health
	Early Prenatal Care	Pregnancy
	Drinking During Pregnancy	Pregnancy
	Smoking-Pregnancy	Pregnancy
	Smoking-Household	Pregnancy
Preventive Dental Visit - Pregnancy		Pregnancy
	Low-Risk Cesarean Delivery	Delivery
Perinatal Care Discrimination		Pregnancy, Delivery, Postpartum
Risk Appropriate Perinatal Care		Delivery/Infant Health
Postpartum Visit (a and b)		Postpartum
Postpartum Mental Health Screening		Postpartum
Postpartum Contraception Use		Postpartum
Housing Instability - Pregnancy and Child		Social Determinants of Health
Breastfeeding		Infant Health
Safe Sleep		Infant Health

Conclusion

The Title V MCH Block Grant is one of the most significant partnerships in the United States focused on the well-being of women, pregnant/postpartum persons, infants, children, adolescents, CSHCN, and families. The success of this investment not only rests on the federal requirements of the MCH Block Grant and a robust performance measurement system¹¹ but on the fact that in the implementation of Title V, both the federal government and state governments jointly contribute to the effort, while allowing states to establish their priorities and strategies to best meet their own needs. This flexibility granted to states is fundamental to the effectiveness of the Title V effort.

As the anchor for federal and state investments in the health of women, infants, and children (including CSHCN), continued and expanded funding for the Title V MCH Block Grant is not only warranted, but essential. As demonstrated by this analysis in particular, to efficiently and effectively address the maternal and infant health crisis, additional concerted focus on the pregnant and infant populations is needed by the Title V Block Grant at both the federal and state levels. To do so, moving forward, Title V MCH Block Grant funding, with its flexibility, must be strengthened and fully supported.



References

1. Hoyert DL. Maternal mortality rates in the United States, 2022. *NCHS Health E-Stats*. Centers for Disease Control and Prevention, 2024. <https://dx.doi.org/10.15620/cdc/152992>.
2. Hoyert DL. Maternal Mortality Rates in the United States, 2023. *NCHS Health E Stats*. Centers for Disease Control and Prevention, 2025. <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/Es-tat-maternal-mortality.pdf>. Also available at: <https://pubmed.ncbi.nlm.nih.gov/39946528/>. Accessed December 12, 2025.
3. Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. (Website). <https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/index.html>.
4. Centers for Disease Control and Prevention. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees (Website). <https://www.cdc.gov/maternal-mortality/php/data-research/mmrc/index.html>
5. Wang S, Rexrode KM, Florio AA, Rich-Edwards JW, Chavarro JE. Maternal mortality in the United States: Trends and opportunities for prevention. *Annual Review of Medicine*. 2023;74:199-216. <https://doi.org/10.1146/annurev-med-042921-123851>.
6. Trost SL, Busacker A, Leonard M, et al. *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 38 U.S. States, 2020*. Centers for Disease Control and Prevention. 2024. <https://restoredcdc.org/www.cdc.gov/maternal-mortality/php/data-research/index.html>. Accessed December 12, 2025.
7. Ely DM, Driscoll AM. Infant mortality in the United States, 2022: Data from the period linked birth/infant death file. *National Vital Statistics Reports*. 2024;73(5):1-19. DOI 10.15620/cdc/157006. Available at: <https://stacks.cdc.gov/view/cdc/157006>. Accessed December 17, 2025.
8. Ely DM, Driscoll AK. Infant mortality in the United States, 2023: Data from the period linked birth/infant death file. *National Vital Statistics Reports*. 2025;74(7):1-20. DOI 10.15620/cdc/174592. Available at: <https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-07.pdf>. Accessed December 17, 2025.
9. P. L. 101-239. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89).
10. Social Security Act Section 504 [42 U.S.C. 705] "(3) except as provided under subsection (b), provides that the State will use— (A) at least 30 percent of such payment amounts for preventive and primary care services for children, and (B) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 501(a)(1)(D));" Available at: https://www.ssa.gov/OP_Home/ssact/title05/0500.htm.
11. Kogan MD, Dykton C, Hirai AH, Strickland BB, Bethell CD, Naqvi I, Cano CE, Downing-Futrell SL, Lu MC. A new performance measurement system for maternal and child health in the United States. *Maternal and Child Health Journal*. 2015;19(5):945-57. <https://doi.org/10.1007/s10995-015-1739-5>.
12. Health Resources and Services Administration. Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report. (OMB No. 0915-0172). Expires 12/31/2026.
13. SPRANS defined in Social Security Act Section 501 [42 U.S.C. 701] "(a) (2) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs..." Available at: https://www.ssa.gov/OP_Home/ssact/title05/0501.htm The SPRANS set aside formula is defined in Section 502 (a) (1).
14. CISS not named in the statute but defined in Social Security Act Section 501 [42 U.S.C. 701 https://www.ssa.gov/OP_Home/ssact/title05/0501.htm] "(a) (3) subject to section 502(b) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding the following— (A) maternal and infant health home visiting programs in which case management services as defined in subparagraphs (A) and (B) of subsection (b)(4), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified nonprofessional acting under the supervision of a health care professional, (B) projects designed to increase the participation of obstetricians and pediatricians under the program under this title and under state plans approved under title XIX, (C) integrated maternal and child health service delivery systems..., (D) maternal and child health centers which (i) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, and (ii) operate under the direction of a not-for-profit hospital, (E) maternal and child health projects to serve rural populations, and (F) outpatient and community based services programs (including day care services) for children with special

health care needs whose medical services are provided primarily through inpatient institutional care." The CISS set aside formula is defined in Section 502 (b) (1) (A). Available at: https://www.ssa.gov/OP_Home/ss-act/title05/0501.htm.

15. Ely DM, Driscoll AK. Infant mortality in the United States, 2021: Data from the period linked birth/infant death file. *National Vital Statistics Reports*. 2023;72(11). Centers for Disease Control and Prevention. DOI 10.15620/cdc:131356. Available at: <https://stacks.cdc.gov/view/cdc/131356>. Accessed December 10, 2025.

16. Centers for Disease Control and Prevention. CDC WONDER. (Website). <https://wonder.cdc.gov/lbd.html> Accessed December 10, 2025.

17. Centers for Disease Control and Prevention, National Center for Health Statistics, Vital Statistics System. Table. Maternal Deaths and Mortality Rates: Each State, the District of Columbia, United States, 2018-2021. <https://www.cdc.gov/nchs/maternal-mortality/mmr-2018-2021-state-data.pdf>. Accessed December 10, 2025.

18. Centers for Disease Control and Prevention. *Healthy People 2020 Midcourse Review*. Chapter 26: Maternal, Infant, and Child Health (MICH). January 11, 2017, revised April 20, 2017. Available at: <https://www.cdc.gov/nchs/data/hpdata2020/HP2020MCR-C26-MICH.pdf>. For 2030 objective, see: <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/infants/reduce-rate-infant-deaths-mich-02>.

19. Medicaid and CHIP Payment and Access Commission (MACPAC). Federal Legislative Milestones in Medicaid and CHIP. (Website). <https://www.macpac.gov/reference-materials/federal-legislative-milestones-in-medicaid-and-chip/#:~:text=Omnibus>.

20. P.L. 101-239. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) did not require a specified level of Title V state spending for pregnant women. It did set aside funds at the federal level to enhance maternal and infant services and emphasized the importance of maternal and infant health in states' overall MCH efforts.



Appendix Tables

Table 1. Ratio of Non-Federal to Federal Funding in Title V Budget, Overall and for Each of the Three Population Groups, By State, FFY2023

Table 2.A. Percentage of Federal Funds in Title V Budget for Each of the Three Populations, By State, FFY2023

Table 2.B. Percentage of Non-Federal Funds in Title V Budget for Each of the Three Populations, By State, FFY2023

Table 2.C. Percentage of Combined Federal and Non-Federal Funds in Title V Budget for Each of the Three Populations, By State, FFY2023

Table 3. Percentage of Federal, Non-Federal, and Combined Funds in Title V Budget for Pregnant Women and Infants, By State, FFY2023

Table 4.A. Infant Mortality Rates Greater than the 2020 HP Objective of 6.0 per 1,000 Live Births Compared to Title V Budget for Pregnant Women and Infants, By State, FFY2023

Table 4.B. Black-to-White Infant Mortality Ratio Greater than 2 Compared to Title V Budget for Pregnant Women and Infants, By State, FFY2023

Table 4.C. Maternal Mortality Rate (2018-2021) Greater than the US Rate of 23.5 per 100,000 Compared to Title V Budget for Pregnant Women and Infants, By State, FFY2023

Table 1. Ratio of Non-Federal to Federal Funding in Title V Budget, Overall and for Each of the Three Populations, By State, FFY2023

Ratios with shading in color are greater than 0.75 (with overmatch).

State 2-letter code	State Name	Overall Ratio	Ratio for Children 1-21	Ratio for CSHCN	Ratio for Pregnant Women and Infants	Ratio >0.75 for all three populations
AL	Alabama	6.29	4.07	9.59	4.07	Yes
AK	Alaska	7.37	2.57	15.78	3.18	Yes
AS	American Samoa	0.75	0.96	0.46	1.04	
AZ	Arizona	1.73	2.11	0.03	4.62	
AR	Arkansas	2.91	0.97	1.01	4.29	Yes
CA	California	3.56	3.18	2.32	5.10	Yes
CO	Colorado	0.79	1.09	0.31	0.16	
CT	Connecticut	1.56	2.50	0.20	2.40	
DE	Delaware	5.04	5.98	0.99	11.76	Yes
DC	District of Columbia	6.08	11.80	3.75	2.80	Yes
FL	Florida	8.30	13.53	0.84	13.54	Yes
GA	Georgia	19.41	19.55	7.07	46.76	Yes
GU	Guam	0.75	0.75	0.75	0.75	
HI	Hawaii	23.42	24.25	22.80	23.27	Yes
ID	Idaho	0.80	1.12	0.01	2.13	
IL	Illinois	1.92	1.01	0.75	4.66	
IN	Indiana	3.04	0.89	3.76	6.77	Yes
IA	Iowa	2.66	4.94	1.70	0.39	
KS	Kansas	1.62	1.68	0.98	2.19	Yes
KY	Kentucky	6.75	9.97	3.48	3.60	Yes
LA	Louisiana	1.55	0.04	1.93	4.30	
ME	Maine	1.31	0.92	1.53	1.56	Yes
MH	Marshall Islands	5.09	2.47	2.65	10.17	Yes
MD	Maryland	0.78	0.41	0.19	2.20	
MA	Massachusetts	8.70	5.96	13.64	0.61	
MI	Michigan	3.40	0.32	6.43	5.95	
FM	Micronesia	0.93	0.62	0.69	2.28	
MN	Minnesota	4.94	2.06	3.24	11.79	Yes
MS	Mississippi	0.83	0.24	0.28	1.98	
MO	Missouri	0.83	0.11	1.61	0.66	
MT	Montana	4.78	3.49	0.89	16.33	Yes
NE	Nebraska	0.85	0.39	0.70	1.12	
NV	Nevada	0.83	0.75	0.75	1.03	
NH	New Hampshire	3.87	0.90	3.22	2.09	Yes
NJ	New Jersey	15.57	9.17	28.36	3.39	Yes
NM	New Mexico	1.15	1.59	1.20	0.00	
NY	New York	2.48	2.84	0.39	39.71	
NC	North Carolina	9.51	8.73	3.65	22.76	Yes
ND	North Dakota	0.75	0.83	0.75	0.58	
MP	Northern Mariana Islands	1.13	1.19	0.84	1.70	Yes

OH	Ohio	2.95	1.83	4.93	1.97	Yes
OK	Oklahoma	0.83	0.98	0.83	0.65	
OR	Oregon	5.33	4.74	0.72	14.39	
PW	Palau	0.89	0.66	0.79	2.38	
PA	Pennsylvania	2.46	4.09	0.58	1.72	
PR	Puerto Rico	0.85	1.37	0.05	1.35	
RI	Rhode Island	25.34	50.30	4.71	5.34	Yes
SC	South Carolina	7.27	0.31	2.82	1.31	
SD	South Dakota	1.24	1.29	0.41	1.85	
TN	Tennessee	1.05	1.03	0.70	1.92	
TX	Texas	1.13	0.24	1.61	4.08	
UT	Utah	5.47	3.87	7.26	5.64	Yes
VT	Vermont	0.75	1.09	0.14	0.80	
VI	Virgin Islands	0.96	0.51	0.74	0.90	
VA	Virginia	0.82	0.75	0.75	0.84	
WA	Washington	0.89	0.79	0.77	1.35	Yes
WV	West Virginia	2.48	1.02	4.93	1.41	Yes
WI	Wisconsin	1.14	1.27	0.48	0.67	
WY	Wyoming	2.39	0.65	0.59	8.34	
Total number with ratio >0.75		55	44	35	50	25

Source: Title V Information System (TVIS)

<https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport#>

Table 2.A. Percentage of Federal Funds in Title V Budget for Each of the Three Populations, By State, FFY2023

Percentages with shading in color indicate at least 30% of funds budgeted.

State 2-letter code	State name	% Federal Funds for Children 1-21	% Federal Funds for CSHCN	% Federal Funds for Pregnant Women & Infants	State budgeted at least 30% federal funds for all three populations
AL	Alabama	56.1%	33.3%	10.6%	
AK	Alaska	39.5%	34.0%	23.5%	
AS	American Samoa	30.5%	30.0%	15.0%	
AZ	Arizona	37.7%	34.3%	14.2%	
AR	Arkansas	45.1%	34.3%	20.6%	
CA	California	33.8%	32.0%	34.2%	Yes
CO	Colorado	37.2%	39.5%	23.3%	
CT	Connecticut	32.5%	39.2%	28.0%	
DE	Delaware	32.7%	44.8%	22.5%	
DC	District of Columbia	33.3%	33.3%	27.5%	
FL	Florida	39.7%	41.2%	19.1%	
GA	Georgia	40.7%	41.0%	18.3%	
GU	Guam	33.3%	33.3%	33.3%	Yes
HI	Hawaii	33.8%	49.8%	12.5%	
ID	Idaho	35.6%	30.9%	19.0%	
IL	Illinois	23.6%	32.5%	30.1%	
IN	Indiana	43.6%	34.8%	19.8%	
IA	Iowa	39.3%	37.0%	23.7%	
KS	Kansas	32.4%	33.7%	33.9%	Yes
KY	Kentucky	50.0%	34.9%	15.1%	
LA	Louisiana	47.2%	37.8%	11.1%	
ME	Maine	36.6%	34.6%	28.8%	
MH	Marshall Islands	33.3%	33.3%	33.3%	Yes
MD	Maryland	32.7%	41.2%	26.0%	
MA	Massachusetts	32.3%	43.8%	22.7%	
MI	Michigan	33.6%	38.3%	12.2%	
FM	Micronesia	33.1%	35.0%	20.6%	
MN	Minnesota	38.4%	35.5%	24.2%	
MS	Mississippi	33.3%	33.3%	33.3%	Yes
MO	Missouri	33.8%	33.2%	32.9%	Yes
MT	Montana	39.8%	36.6%	12.5%	
NE	Nebraska	34.6%	36.5%	23.3%	
NV	Nevada	33.3%	33.3%	27.6%	
NH	New Hampshire	29.4%	44.0%	16.1%	
NJ	New Jersey	33.3%	41.1%	25.6%	
NM	New Mexico	36.4%	48.2%	15.4%	
NY	New York	35.0%	62.1%	1.3%	
NC	North Carolina	35.4%	40.2%	15.7%	

Table 2.B. Percentage of Non-Federal Funds in Title V Budget for Each of the Three Populations, By State FFY2023

Percentages with shading in color indicate at least 30% of funds budgeted.

State 2-letter code	State name	% Non-federal Funds for Children 1-21	% Non-federal Funds for CSHCN	% Non-federal Funds for Pregnant Women & Infants	State budgeted at least 30% non-federal funds for all 3 populations
AL	Alabama	36.3%	50.8%	6.9%	
AK	Alaska	13.8%	72.9%	10.1%	
AS	American Samoa	39.2%	18.3%	20.9%	
AZ	Arizona	46.0%	0.6%	37.9%	
AR	Arkansas	15.0%	12.0%	30.4%	
CA	California	30.1%	20.8%	49.0%	
CO	Colorado	51.3%	15.4%	4.7%	
CT	Connecticut	52.0%	5.0%	43.0%	
DE	Delaware	38.8%	8.8%	52.4%	
DC	District of Columbia	64.7%	20.6%	12.7%	
FL	Florida	64.8%	4.2%	31.1%	
GA	Georgia	41.0%	14.9%	44.1%	
GU	Guam	33.3%	33.3%	33.3%	Yes
HI	Hawaii	35.0%	48.5%	12.4%	
ID	Idaho	49.6%	0.2%	50.2%	
IL	Illinois	12.4%	12.6%	73.0%	
IN	Indiana	12.8%	43.1%	44.1%	
IA	Iowa	72.9%	23.7%	3.5%	
KS	Kansas	33.6%	20.4%	46.0%	
KY	Kentucky	73.9%	18.0%	8.0%	
LA	Louisiana	1.3%	47.1%	30.7%	
ME	Maine	25.6%	40.2%	34.3%	
MH	Marshall Islands	16.2%	17.3%	66.5%	
MD	Maryland	17.1%	10.0%	72.9%	
MA	Massachusetts	22.1%	68.6%	1.6%	
MI	Michigan	3.2%	72.4%	21.3%	
FM	Micronesia	22.2%	26.1%	50.6%	
MN	Minnesota	16.0%	23.3%	57.8%	
MS	Mississippi	9.5%	11.2%	79.3%	
MO	Missouri	4.6%	64.3%	26.0%	
MT	Montana	29.1%	6.8%	42.8%	
NE	Nebraska	15.9%	30.1%	30.4%	
NV	Nevada	30.0%	30.0%	34.0%	Yes
NH	New Hampshire	6.8%	36.6%	8.7%	
NJ	New Jersey	19.6%	74.8%	5.6%	
NM	New Mexico	50.0%	50.0%	0.0%	
NY	New York	40.1%	9.8%	20.3%	

NC	North Carolina	32.5%	15.4%	37.7%	
ND	North Dakota	41.4%	42.2%	14.5%	
MP	Northern Mariana Islands	35.7%	26.3%	37.9%	
OH	Ohio	24.4%	57.6%	17.5%	
OK	Oklahoma	43.1%	33.3%	23.6%	
OR	Oregon	42.4%	4.5%	38.6%	
PW	Palau	25.0%	30.0%	35.0%	
PA	Pennsylvania	65.3%	9.3%	12.8%	
PR	Puerto Rico	53.8%	2.1%	44.1%	
RI	Rhode Island	38.1%	6.3%	7.9%	
SC	South Carolina	1.9%	13.2%	1.1%	
SD	South Dakota	32.8%	10.9%	53.3%	
TN	Tennessee	37.9%	20.1%	13.8%	
TX	Texas	10.5%	57.3%	32.1%	
UT	Utah	27.0%	50.2%	21.8%	
VT	Vermont	78.2%	5.9%	15.9%	
VI	Virgin Islands	18.1%	26.7%	19.9%	
VA	Virginia	32.0%	31.0%	28.0%	
WA	Washington	33.3%	33.3%	33.3%	Yes
WV	West Virginia	18.8%	69.8%	9.1%	
WI	Wisconsin	37.3%	13.6%	16.8%	
WY	Wyoming	10.0%	10.0%	80.0%	
Number with at least 30% non-federal funds budgeted		33	24	31	3

Source: Title V Information System (TVIS). Based on Form 3A.
<https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport#>

Table 2.C. Percentage of Combined Federal and Non-Federal Funds in Title V Budget for Each of the Three Populations, By State, FFY2023

Percentages with shading in color are at least 30% of funds budgeted.

State 2-letter code	State	% Combined Funds for Children 1-21	% Combined Funds for CSHCN	% Combined Funds for Pregnant Women & Infants	State budgeted at least 30% combined funds for all three populations
AL	Alabama	39.0%	48.4%	7.4%	
AK	Alaska	16.9%	68.2%	11.7%	
AS	American Samoa	34.3%	25.0%	17.6%	
AZ	Arizona	43.0%	12.9%	29.2%	
AR	Arkansas	22.7%	17.7%	27.9%	
CA	California	30.9%	23.3%	45.8%	
CO	Colorado	43.4%	28.9%	15.0%	
CT	Connecticut	44.4%	18.3%	37.1%	
DE	Delaware	37.8%	14.8%	47.5%	
DC	District of Columbia	60.3%	22.4%	14.8%	
FL	Florida	62.1%	8.1%	29.8%	
GA	Georgia	41.0%	16.2%	42.8%	
GU	Guam	33.3%	33.3%	33.3%	Yes
HI	Hawaii	35.0%	48.5%	12.4%	
ID	Idaho	41.8%	17.2%	32.9%	
IL	Illinois	16.3%	19.4%	58.3%	
IN	Indiana	20.4%	41.1%	38.0%	
IA	Iowa	63.7%	27.3%	9.0%	
KS	Kansas	33.2%	25.4%	41.4%	
KY	Kentucky	70.9%	20.2%	9.0%	
LA	Louisiana	19.3%	43.4%	23.0%	
ME	Maine	30.3%	37.8%	31.9%	Yes
MH	Marshall Islands	19.0%	19.9%	61.1%	
MD	Maryland	25.9%	27.5%	46.6%	
MA	Massachusetts	23.2%	66.1%	3.8%	
MI	Michigan	10.1%	64.6%	19.3%	
FM	Micronesia	27.9%	30.7%	35.0%	
MN	Minnesota	19.8%	25.3%	52.1%	
MS	Mississippi	22.5%	23.3%	54.2%	
MO	Missouri	20.6%	47.3%	29.8%	
MT	Montana	30.9%	11.9%	37.6%	
NE	Nebraska	26.0%	33.6%	26.6%	
NV	Nevada	31.8%	31.8%	30.5%	Yes
NH	New Hampshire	11.5%	38.1%	10.2%	
NJ	New Jersey	20.4%	72.8%	6.8%	
NM	New Mexico	43.7%	49.2%	7.2%	
NY	New York	38.6%	24.8%	14.8%	
NC	North Carolina	32.7%	17.8%	35.6%	

Table 3. Percentage of Federal, Non-Federal, and Combined Funds in Title V Budget for Pregnant Women and Infants, By State, FFY2023

Percentages with shading in color indicate at least 30% of funds budgeted.

State 2-letter code	State	% Federal Funds for Pregnant Women & Infants	% Non-Federal Funds for Pregnant Women & Infants	% Combined Funds for Pregnant Women & Infants
AL	Alabama	10.6%	6.9%	7.4%
AK	Alaska	23.5%	10.1%	11.7%
AS	American Samoa	15.0%	20.9%	17.6%
AZ	Arizona	14.2%	37.9%	29.2%
AR	Arkansas	20.6%	30.4%	27.9%
CA	California	34.2%	49.0%	45.8%
CO	Colorado	23.3%	4.7%	15.0%
CT	Connecticut	28.0%	43.0%	37.1%
DE	Delaware	22.5%	52.4%	47.5%
DC	District of Columbia	27.5%	12.7%	14.8%
FL	Florida	19.1%	31.1%	29.8%
GA	Georgia	18.3%	44.1%	42.8%
GU	Guam	33.3%	33.3%	33.3%
HI	Hawaii	12.5%	12.4%	12.4%
ID	Idaho	19.0%	50.2%	32.9%
IL	Illinois	30.1%	73.0%	58.3%
IN	Indiana	19.8%	44.1%	38.0%
IA	Iowa	23.7%	3.5%	9.0%
KS	Kansas	33.9%	46.0%	41.4%
KY	Kentucky	15.1%	8.0%	9.0%
LA	Louisiana	11.1%	30.7%	23.0%
ME	Maine	28.8%	34.3%	31.9%
MH	Marshall Islands	33.3%	66.5%	61.1%
MD	Maryland	26.0%	72.9%	46.6%
MA	Massachusetts	22.7%	1.6%	3.8%
MI	Michigan	12.2%	21.3%	19.3%
FM	Micronesia	20.6%	50.6%	35.0%
MN	Minnesota	24.2%	57.8%	52.1%
MS	Mississippi	33.3%	79.3%	54.2%
MO	Missouri	32.9%	26.0%	29.8%
MT	Montana	12.5%	42.8%	37.6%
NE	Nebraska	23.3%	30.4%	26.6%
NV	Nevada	27.6%	34.0%	30.5%
NH	New Hampshire	16.1%	8.7%	10.2%
NJ	New Jersey	25.6%	5.6%	6.8%
NM	New Mexico	15.4%	0.0%	7.2%
NY	New York	1.3%	20.3%	14.8%
NC	North Carolina	15.7%	37.7%	35.6%
ND	North Dakota	18.7%	14.5%	16.9%
MP	Northern Mariana Islands	25.1%	37.9%	31.9%

OH	Ohio	26.1%	17.5%	19.7%
OK	Oklahoma	30.0%	23.6%	27.1%
OR	Oregon	14.3%	38.6%	34.8%
PW	Palau	13.1%	35.0%	23.4%
PA	Pennsylvania	18.3%	12.8%	14.4%
PR	Puerto Rico	27.8%	44.1%	35.3%
RI	Rhode Island	37.3%	7.9%	9.0%
SC	South Carolina	6.1%	1.1%	1.7%
SD	South Dakota	35.8%	53.3%	45.5%
TN	Tennessee	7.5%	13.8%	10.7%
TX	Texas	8.9%	32.1%	21.3%
UT	Utah	21.1%	21.8%	21.7%
VT	Vermont	14.9%	15.9%	15.4%
VI	Virgin Islands	21.1%	19.9%	20.5%
VA	Virginia	27.2%	28.0%	27.5%
WA	Washington	22.0%	33.3%	27.3%
WV	West Virginia	16.1%	9.1%	11.1%
WI	Wisconsin	28.4%	16.8%	22.2%
WY	Wyoming	22.9%	80.0%	63.1%
Number with at least 30% budgeted		10	31	25

Source: Title V Information System (TVIS)

<https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport#>

Table 4.A. Infant Mortality Ratio Greater than the 2020 HP objective of 6.0 per 1,000 Live Births Compared to Title V Budget for Pregnant Women and Infants, By State, FFY2023

Cells with shading meet cut offs.

State	IMR per 1000 Live Births (2021)	IMR Rate >6.0 per 1,000	% Combined Title V Funds for Pregnant Women & Infants	IMR >6.0 and Combined Funds <30%	State Title V Non-Federal to Federal Ratio for Pregnant Women and Infants	IMR >6.0, Combined Funds <30%, and No Overmatch
Alabama	7.56	Y	7.4%	Y	4.07	
Alaska	7.37	Y	11.7%	Y	3.18	
Arizona	5.47		29.2%		4.62	
Arkansas	8.59	Y	27.9%	Y	4.29	
California	4.07		45.8%		5.10	
Colorado	4.99		15.0%		0.16	
Connecticut	4.65		37.1%		2.40	
Delaware	4.77		47.5%		11.76	
Florida	5.90		29.8%		13.54	
Georgia	6.25	Y	42.8%		46.76	
Hawaii	4.67		12.4%		23.27	
Idaho	5.13		32.9%		2.13	
Illinois	5.62		58.3%		4.66	
Indiana	6.75	Y	38.0%		6.77	
Iowa	3.99		9.0%		0.39	
Kansas	5.30		41.4%		2.19	
Kentucky	6.15	Y	9.0%	Y	3.60	
Louisiana	7.24	Y	23.0%	Y	4.30	
Maine	5.00		31.9%		1.56	
Maryland	5.99		46.6%		2.20	
Massachusetts	3.23		3.8%		0.61	
Michigan	6.22	Y	19.3%	Y	5.95	
Minnesota	4.83		52.1%		11.79	
Mississippi	9.39	Y	54.2%		1.98	

Missouri	5.85		29.8%		0.66	
Montana	4.90		37.6%		16.33	
Nebraska	5.49		26.6%		1.12	
Nevada	5.76		30.5%		1.03	
New Hampshire	3.96		10.2%		2.09	
New Jersey	3.57		6.8%		3.39	
New Mexico	4.77		7.2%		0.00	
New York	4.16		14.8%		39.71	
North Carolina	6.72	Y	35.6%		22.76	
North Dakota	2.77		16.9%		0.58	
Ohio	7.06	Y	19.7%	Y	1.97	
Oklahoma	7.13	Y	27.1%	Y	0.65	Y
Oregon	3.79		34.8%		14.39	
Pennsylvania	5.37		14.4%		1.72	
Rhode Island	4.30		9.0%		5.34	
South Carolina	7.26	Y	1.7%	Y	1.31	
South Dakota	6.07	Y	45.5%		1.85	
Tennessee	6.18	Y	10.7%	Y	1.92	
Texas	5.29		21.3%		4.08	
Utah	4.58		21.7%		5.64	
Vermont	*		15.4%		0.80	
Virginia	5.96		27.5%		0.84	
Washington	4.36		27.3%		1.35	
West Virginia	6.80	Y	11.1%	Y	1.41	
Wisconsin	5.36		22.2%		0.67	
Wyoming	5.45		63.1%		8.34	

<i>Number of states</i>	<i>States with reliable IMR Rate</i>	<i>IMR Ratio >6.0 per 1,000</i>	<i>Does not have 30% Combined Funds in Title V Budget for Pregnant Women & Infants</i>	<i>IMR >6.0 and Combined Funds <30%</i>	<i>No Overmatch (<0.75)</i>	<i>IMR >6.0, Combined Funds <30%, and No Overmatch</i>
	49	16	30	11	8	1

Table 4.B. Black-to-White Infant Mortality Ratio Greater than 2 Compared to Title V Budget for Pregnant Women and Infants, By State, FFY2023

Cells with shading meet cut offs.

State	B:W IMR Ratio (2021)	B:W IMR Ratio >2	% Combined Title V Funds for Pregnant Women & Infants	B:W Ratio >2 and Combined Funds <30%	State Title V Non-Federal to Federal Ratio for Pregnant Women and Infants	B:W IMR Ratio >2, Combined Funds <30%, and No Overmatch
Alabama	1.8		7.4%		4.07	
Arizona	2.2	Y	29.2%	Y	4.62	
Arkansas	2.0		27.9%		4.29	
California	2.0		45.8%		5.10	
Colorado	2.2	Y	15.0%	Y	0.16	Y
Connecticut	2.2	Y	37.1%		2.40	
Florida	2.4	Y	29.8%		13.54	
Georgia	1.9		42.8%		46.76	
Illinois	2.7	Y	58.3%		4.66	
Indiana	1.8		38.0%		6.77	
Iowa	4.7	Y	9.0%	Y	0.39	Y
Kansas	2.1	Y	41.4%		2.19	
Kentucky	1.8		9.0%		3.60	
Louisiana	2.2	Y	23.0%	Y	4.30	
Maryland	2.0		46.6%		2.20	
Massachusetts	2.3	Y	3.8%	Y	0.61	Y
Michigan	2.9	Y	19.3%	Y	5.95	
Minnesota	2.3	Y	52.1%		11.79	
Mississippi	1.9		54.2%		1.98	
Missouri	2.4	Y	29.8%		0.66	
Nebraska	2.7	Y	26.6%	Y	1.12	
Nevada	2.2	Y	30.5%		1.03	
New Jersey	2.5	Y	6.8%	Y	3.39	
New York	2.6	Y	14.8%	Y	39.71	
North Carolina	2.1	Y	35.6%		22.76	
Ohio	2.3	Y	19.7%	Y	1.97	
Oklahoma	1.8		27.1%		0.65	
Pennsylvania	2.1	Y	14.4%	Y	1.72	
South Carolina	2.4	Y	1.7%	Y	1.31	
Tennessee	2.0		10.7%		1.92	
Texas	2.0		21.3%		4.08	
Virginia	2.1	Y	27.5%	Y	0.84	
Washington	1.5		27.3%		1.35	
Wisconsin	2.9	Y	22.2%	Y	0.67	Y

	States with reliable B:W IMR Ratio	B:W IMR Ratio >2	Does not have 30% Combined Funds in Title V Budget for Pregnant Women & Infants	Ratio >2 and Combined Funds <30%	No Overmatch (<0.75)	B:W IMR Ratio >2, Combined Funds <30%, and No Overmatch
Number of states	34	22	21	14	6	4

**Table 4.C. Maternal Mortality Rate Greater than the US Rate of 23.5 per 100,000 (2018-2021)
Compared to Title V Budget for Pregnant Women and Infants, By State, FFY2023**

Cells with shading meet cut offs.

State	Maternal Mortality Rate per 100,000 Live Births (2018-2021)		MMR Rate >23.5 per 100,000	Combined Funds in Title V Budget for Pregnant Women & Infants	State MMR > US and Combined Funds <30%	State Title V Non- Federal to Federal Ratio for Pregnant Women and Infants	State MMR > US, Combined Funds <30%, and No Overmatch (<0.75%)
	per 100,000 Live Births (2018-2021)	MMR Rate >23.5 per 100,000					
Alabama	41.4	Y		7.4%	Y	4.07	
Arizona	31.4	Y		29.2%	Y	4.62	
Arkansas	43.5	Y		27.9%	Y	4.29	
California	10.1			45.8%		5.10	
Colorado	15.2			15.0%		0.16	
Connecticut	16.7			37.1%		2.40	
Florida	26.3	Y		29.8%		13.54	
Georgia	33.9	Y		42.8%		46.76	
Illinois	17.3			58.3%		4.66	
Indiana	31.1	Y		38.0%		6.77	
Iowa	20.2			9.0%		0.39	
Kansas	22.0			41.4%		2.19	
Kentucky	38.4	Y		9.0%	Y	3.60	
Louisiana	39.0	Y		23.0%	Y	4.30	
Maryland	21.2			46.6%		2.20	
Massachusetts	15.3			3.8%		0.61	
Michigan	19.4			19.3%		5.95	
Minnesota	12.6			52.1%		11.79	
Mississippi	43.0	Y		54.2%		1.98	
Missouri	25.7	Y		29.8%		0.66	
Nebraska	26.2	Y		26.6%	Y	1.12	
Nevada	21.7			30.5%		1.03	
New Jersey	25.7	Y		6.8%	Y	3.39	
New Mexico	30.2	Y		7.2%	Y	0.00	Y
New York	21.7			14.8%		39.71	
North Carolina	26.5	Y		35.6%		22.76	
Ohio	23.8	Y		19.7%	Y	1.97	
Oklahoma	30.3	Y		27.1%	Y	0.65	Y
Oregon	16.4			34.8%		14.39	
Pennsylvania	16.7			14.4%		1.72	
South Carolina	32.7	Y		1.7%	Y	1.31	
Tennessee	41.7	Y		10.7%	Y	1.92	
Texas	28.1	Y		21.3%	Y	4.08	
Utah	16.1			21.7%		5.64	
Virginia	29.1	Y		27.5%	Y	0.84	
Washington	20.4			27.3%		1.35	
Wisconsin	11.6			22.2%		0.67	

	States with reliable MMR Rate	MMR > US Average	Does not have 30% Combined Funds in Title V Budget for Pregnant Women & Infants	State MMR > US and Combined Funds <30%	No Overmatch (Ratio <0.75)	State MMR > US, Combined Funds <30%, and No Overmatch
Number of states	37	20	23	14	7	2