Congressional Research Service
Informing the legislative debate since 1914

The Maternal and Child Health Services Block Grant: Background and Funding

(name redacted)
Specialist in Social Policy

April 28, 2016

Congressional Research Service
7-....
www.crs.gov
R42428

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The Maternal and Child Health (MCH) Services Block Grant program, authorized under Title V of the Social Security Act, is a flexible source of funds that states use to support maternal and child health programs. The program provides grants to states and territories to enable them to coordinate programs, develop systems, and provide a broad range of direct health services. In addition to block grants to states, the MCH Services Block Grant includes a set-aside for Special Projects of Regional and National Significance (SPRANS), and another set-aside for the Community Integrated Service Systems (CISS) program. The Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS) administers the block grant. The Maternal and Child Health Bureau of HRSA also receives funding for other maternal and child health programs authorized under both Title V of the Social Security Act and the Public Health Service Act, including maternal and infant home visiting and autism services.

The MCH Services Block Grant received an appropriation of $638.2 million in FY2016. Of that amount, an estimated $550.8 million was for block grants to states (86%), $77.1 million was for SPRANS (12%), and $10.3 million was for CISS (2%). The President's budget requested the same amount for the program in FY2017. Funding for the MCH Services Block Grant is discretionary and subject to the annual appropriations process. Full-year appropriations for FY2017 have yet to be enacted.

Title V programs, including the MCH Services Block Grant, serve women and children who are covered by public and private insurance, as well as those who have no insurance coverage. MCH Services Block Grant funds are distributed for the purpose of funding core public health services provided by maternal and child health agencies. These core services are often divided into four categories: infrastructure-building, population-based, enabling, and direct health care. A wide array of programs is supported in each of these categories, including newborn screening, health services for children with special health care needs, and immunization programs. Another main objective of the MCH Services Block Grant is to increase pediatric workforce capacity, and to link low-income children and families to other services and programs, such as Medicaid.

To receive MCH Services Block Grant funds, states are required to (1) conduct a needs assessment every five years; (2) provide an annual report, including program participation data, state maternal and child health measures, and state pediatric and family workforce measures; and (3) ensure that an independent audit is performed every two years. HRSA, in turn, must report to Congress on the activities carried out under the SPRANS and CISS programs, in addition to providing a summary of state reports on block grant activities.

This report provides MCH Services Block Grant background and funding information. It also includes selected program participation data. Selected maternal and child health indicators are presented to provide readers with context on issues that Congress has sought to address through MCH Services Block Grant funding. Although improvement in these measures is an objective of Title V funding, it is important to note that Title V funding is only one component affecting these measures. Other federal and state health and social services policies, as well as complex societal issues, substantially affect these measures and maternal and child health in general.

Contents

Figures

Tables

Appendixes

Contacts

Background

Title V of the Social Security Act (SSA) authorizes funding for services and projects that are intended to improve the health of mothers and children. These include the Maternal and Child Health (MCH) Services Block Grant; the Maternal, Infant, and Early Childhood Home Visiting Program; and other funding related to abstinence education, postpartum depression, and personal responsibility education programs.[1] This report focuses on the MCH Services Block Grant, which receives the largest single appropriation under Title V. The MCH Services Block Grant is administered by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (HHS).

Title V was enacted by Congress in 1935 as part of the Social Security Act (SSA, P.L. 74-271) to promote and support the health of mothers and children. Two grant programs were established under the original Title V of the SSA,[2] to enable states (1) to improve maternal and child health services, especially those in low-income and rural areas, and (2) to extend and improve services for crippled children. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) replaced the term "crippled" with the term "children with special health care needs." Children with special health care needs (CSHCN) are defined by HRSA as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

Over time, additional programs targeting children with special health care needs and low-income women and children were added to the Public Health Service Act (PHSA) and the SSA, including certain services for children with disabilities who receive Supplemental Security Income (SSI, formerly §1615 [c] of the SSA); lead-based paint poisoning prevention programs (formerly §316 of the PHSA); genetic disease programs (formerly §1101 of the PHSA); sudden infant death syndrome programs (formerly §1121 of the PHSA); hemophilia treatment centers (formerly §1131 of the PHSA); and adolescent pregnancy grants (P.L. 95-626).

Title V was converted to the MCH Services Block Grant in 1981 by the Omnibus Budget Reconciliation Act (OBRA).[3] OBRA 1981 consolidated the existing categorical programs listed above into a single block grant. The consolidated block grant was intended to give the states more flexibility in determining how to use federal funds to address maternal and child health needs. It required that each state receive, at a minimum, the combined funding of the programs that were consolidated under OBRA 1981. Additional changes were made to the block grant under the Omnibus Budget Reconciliation Act of 1989; these changes increased the authorization of appropriations, called for greater accountability, and created stricter rules for application and reporting requirements for the states, including the addition of a statewide needs assessment requirement.[4]

The MCH Services Block Grant currently has three components: block grants to states, a set-aside for Special Projects of Regional and National Significance (SPRANS), and another set-

[1] A list of Title V programs and their authorizing laws can be found in **Appendix A**.

[2] A third grant program for child welfare services was also included in the 1935 law. That program was moved to Title IV-B of the SSA in 1968 (P.L. 90-248) and is now administered by the Administration for Children and Families in HHS.

[3] OBRA 1981, P.L. 97-35; §§2191-2194.

[4] OBRA 1989, P.L. 101-239; §§6501-6510.

aside for the Community-Integrated Services Systems (CISS) program. The MCH Services Block Grant was appropriated $638.2 million in funding for FY2016.[5]

The majority of this funding is distributed to the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa, the Federated States of Micronesia, the Marshall Islands, and Palau (referred to collectively as "states" in this report) through the block grant to states. However, some of these funds are reserved for CISS grants, and others are devoted to research via the SPRANS grants.

Goals

Title V of the Social Security Act established seven broad goals for the MCH Services Block Grant. Maternal and child health services, research, training, demonstrations, and other activities funded by the block grant must be linked to one or more of these goals. The seven goals are as follows:

- ensure access to quality health care for mothers and children, especially those with low income or limited availability of care;
- reduce infant mortality;
- provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women);
- increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
- provide and ensure access to preventive and health care services for certain blind and disabled children, as well as rehabilitative services;
- implement family-centered, community-based systems of coordinated care for children with special health care needs;
- provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid.

Programs and Services

The primary use of funds under the MCH Services Block Grant, including formula grants to states, discretionary grants for Special Projects of Regional and National Significance (SPRANS), and discretionary grants for Community Integrated Services Systems (CISS), is to fill gaps in core public health services for low-income mothers and children. Projects funded by SPRANS include MCH workforce development, genetic services, and diagnostic and treatment services for hemophilia. CISS grants fund projects that support integrated maternal and child health services at the community level.

Maternal and Child Health Block Grants to States

The law provides that block grant funds are to be used by the states "to provide and to assure mothers and children (in particular those with low income or with limited availability of health

[5] Health Resources and Services Administration, Department of Health and Human Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*, February 9, 2016, http://www.hrsa.gov/about/budget/budgetjustification2017.pdf.

services) access to quality maternal and child health services."[6] States are required to use at least 30% of their block grant allocations for preventive and primary care services for children, 30% for services for children with special health care needs (CSHCN),[7] and 40% for services for either of these groups or for other appropriate maternal and child health activities.[8] Beyond these broad requirements, states determine the actual services provided under the block grant. Services funded by the block grant may include prenatal care, well-child care, dental care, immunization, family planning, and vision and hearing screening services. They may also include inpatient services for children with special health care needs, screening services for lead-based poisoning, and counseling services for parents of sudden infant death syndrome victims. Block grant funding is also used to support school-based health centers.

Title V programs, including the Maternal and Child Health Services Block Grant, serve women and children who are covered by public and private insurance, as well as those who have no insurance coverage. For the purposes of allocating block grant funds for this program, low-income mothers and children are defined as those with family income below 100% of federal poverty guidelines.[9] However, due to the broad reach of Title V programs and services, this definition is used only in the allocation formula, and not as a criterion for receiving Title V-funded services. There is no federally prescribed means test for recipients of services funded by the block grants to states.

Use of Block Grant Funds

Block grants to states provide funding for core public health services provided by maternal and child health agencies. These core services are often presented as a four-level pyramid. The four levels of services are infrastructure building, population-based, enabling, and direct health care, as illustrated in **Figure 1**.[10] Infrastructure building services, which are at the base of the pyramid, are foundation-building activities that provide for the development and maintenance of health services systems. Infrastructure building services increase a health system capacity by supporting training and other workforce development activities, coordinating health care systems and data system architecture, providing funding for applied research, and developing guidelines. Population-based services promote core public health functions such as universal screening, health promotion, and disease prevention campaigns. Population-based services include newborn screening, lead screening, immunization, oral health, and injury prevention. Enabling services provide access to services for vulnerable populations, including those with special health care needs. Enabling services are services that facilitate access to care, such as case management, transportation, purchase of insurance, and coordination with other programs. Direct health care services provided under Title V are intended to fill the gaps in primary and preventive health care that are not otherwise available through other funding sources or providers, such as private insurance, Medicaid, or the State Children's Health Insurance Program (CHIP).

[6] SSA, §501(a)(1)(A).

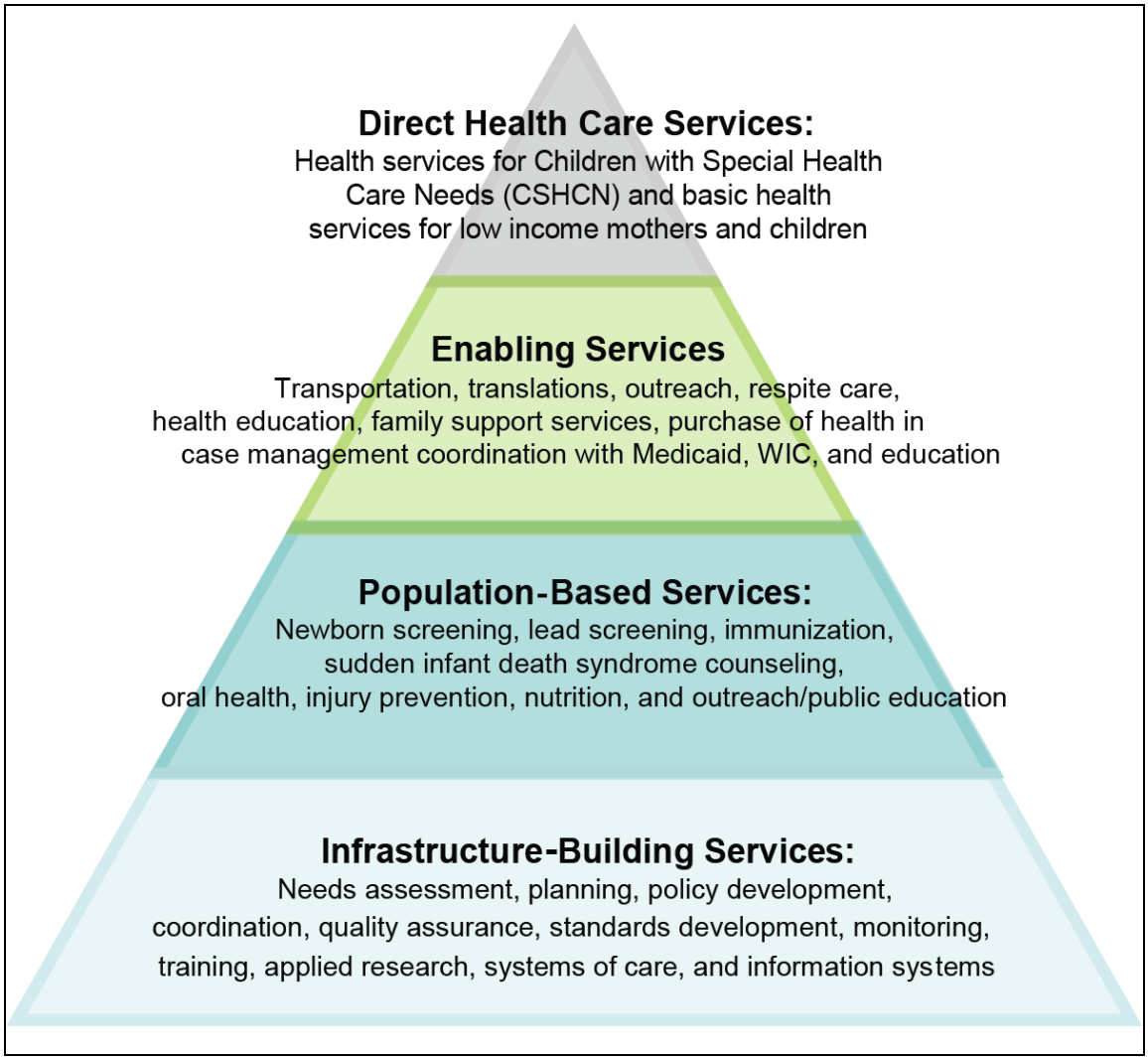
[7] SSA, §505(a)(3).

[8] States may request a waiver of these requirements.

[9] The federal poverty guidelines are defined by the Office of Management and Budget (OMB) and revised annually in accordance with §673(2) of the Omnibus Budget Reconciliation Act of 1981. For more information, see https://aspe.hhs.gov/poverty-guidelines.

[10] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health, http://mchb.hrsa.gov/programs/.

Figure 1. The MCH Pyramid of Health Services



Source: Maternal and Child Health Bureau, Health Resources and Services Administration.

In FY2015, the largest category of expenditures nationwide under the block grant was direct health care services for low-income mothers and children and children with special health care needs (63.3%), followed by enabling services (18.7%), population-based services (10.5%), and infrastructure (7.6%).[11] Although the expenditures nationwide are inverse to their location in the MCH pyramid, the distribution of funds between service categories varies widely by state and depends on the needs of each state's population. Additionally, direct health care services may cost more per person served than other services.[12] Distribution of funds depends on the needs of the

[11] See Federal-State Title V Block Grant Partnership Budget, by Category of Service FY2015 at https://mchdata.hrsa.gov/tvisreports/FinancialData/FinancialSearch.aspx?FinSearch=C (scroll to the end of the page).

[12] For example, the base laboratory cost for newborn screening, a population-based service, has been estimated at $15; a direct health care service such as Maternal, Infant, and Early Childhood Home Visiting costs approximately $1,250-$3,348 per year per family. Sources: Schoen E et al., "Cost-Benefit Analysis of Universal Tandem Mass Spectrometry for Newborn Screening," *Pediatrics*, vol. 110, no. 4 (October 2002), p. 782; and CRS Report R40705, *Home Visitation for Families with Young Children*, by (name redacted) and (name redacted).

states' populations, and the gaps left by other health and social service programs that are identified by the states. (Data on state and national indicators and funding are provided on HRSA's website, and summarized in the program participation and reporting section of this report.)

Prohibited Uses

Although the formula block grants to states are intended to fill gaps in a broad range of health services provided to women and children, certain uses of block grant funds are prohibited. Funds may not be used for inpatient services, other than for children with special health care needs, high-risk pregnant women, and infants (unless approved by the Secretary of HHS). States may not use the block grant funds to provide cash payments to recipients of health services, or for the purchase of land, facilities, or major medical equipment. Further, states may not use funds to satisfy any requirement for the expenditure of federal funds, and may not transfer block grant funds to any other program. Finally, block grant funds may not be used for research or training at a private, for-profit entity.

Requirements to Receive Funds

In order to receive block grant funds, states must submit to the Secretary of HHS an application that includes a statewide needs assessment (to be conducted once every five years) and a plan for meeting the needs identified in the needs assessment. The needs assessment must identify statewide health status goals (consistent with national health objectives, such as Healthy People 2020);[13] the need for preventive and primary care services for pregnant women, mothers, infants, and children; and services for children with special health care needs. The plan to address the needs assessment must include a description of how and where block grant funds will be used within the state to address those needs. Beginning in 2015, the result of that Needs Assessment will be integrated into the Application/Annual Report for that reporting year, with updates to follow in the interim years.[14]

Coordination with Related Programs

Title V requires the state agency or agencies administering the Title V program to create an agreement coordinating block grant services with the state's Medicaid program (specifically, the Early Periodic Screening, Diagnosis, and Treatment Program [EPSDT]). The primary purpose of this coordination effort is to make Medicaid services accessible, to enroll those who are eligible, and to avoid duplication of effort among the programs. State block grant administrators must also coordinate with other related programs, including the Special Supplemental Program for Women, Infants, and Children (WIC); related education programs; and other health, developmental disability, and family planning programs.

Coordination varies among states and jurisdictions.[15] Most state MCH and Medicaid agencies have created interagency agreements that outline the expected areas and levels of coordination between the programs. HRSA's analysis showed a wide variety in the scope and level of formality

[13] See http://www.healthypeople.gov/2020/default.aspx.

[14] U.S. Department of Health and Human Services, 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," pp. 9-10.

[15] Health Resources and Services Administration, *State MCH-Medicaid Coordination: A Review of Title V and Title XIX Interagency Agreements (2nd Ed)*, 2008, p. 27, http://mchb.hrsa.gov/pdfs/statemchmedicaid.pdf.

among interagency agreements. Most states specify the services provided by each agency under the agreement. Commonly, the Title V agency contracts with health providers to provide the services, and the agency administering the state's Medicaid program assumes the responsibility for reimbursement of those services, when possible. States may also include coordination with other services, such as WIC, under the agreement. HRSA's 2008 analysis recommended specific components for interagency agreements and provided a model interagency agreement.[16] Adoption of a model agreement could build upon the Title V effort to ensure coordination among the block grant, Medicaid, and other programs.

Special Projects of Regional and National Significance (SPRANS)

The SPRANS program is a HRSA-administered discretionary grant program for research and training for maternal and child health and children with special health care needs. Public or nonprofit private institutions of higher learning that train health care and maternal and child health personnel or public or nonprofit private organizations or institutions of higher learning that conduct maternal and child health research are eligible for these grants. SPRANS projects must (1) support national needs and priorities or emerging issues, (2) have regional or national significance, and (3) demonstrate ways to improve state systems of care for mothers and children. Approximately 15% of MCH Services Block Grant funds are set aside for SPRANS programs. The FY2016 budget included appropriations language that provided SPRANS set-aside funds for oral health ($5.00 million); epilepsy ($3.64 million); sickle cell ($2.96 million); and fetal alcohol syndrome ($0.48 million).[17]

SPRANS may also be used for genetic disease testing, counseling, and information development and dissemination programs; for grants relating to hemophilia without regard to age; for the screening of newborns for sickle cell anemia and other genetic disorders; and for follow-up services. Preference is given to applicants who demonstrate that activities in these categories will be carried out in areas with a high infant mortality rate.

Generally, the priority for funding SPRANS projects is determined by HRSA. However, Congress has sometimes provided specific directives for certain programs, including set-asides for the programs listed above. In FY2016, these congressional directives comprised about 16% of SPRANS funding.[18]

In addition, the Family-to-Family Health Information Centers (F2F HICs) program funds family-staffed and family-run centers in the 50 states and the District of Columbia.[19] The F2F HICs provide information, education, technical assistance, and peer support to families of children (including youth) with special health care needs (CSHCN) and health professionals who serve such families. They also assist in ensuring that families and health professionals are partners in decisionmaking at all levels of care and service delivery.[20]

---

[16] Ibid.

[17] Department of Health and Human Services, Health Services and Resources Administration, *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*, http://www.hrsa.gov/about/budget/budgetjustification2017.pdf., p. 203.

[18] Ibid.

[19] SSA, §501(c).

[20] The F2F HICs program was originally authorized and funded by P.L. 109-171 with funding of $3 million for FY2007, $4 million for FY2008, and $5 million for FY2009. The ACA (P.L. 111-148) funded the program at $5 million for each of the years FY2010 through FY2012. P.L. 112-240 also funded the program at $5 million for FY2013. P.L. 113-67 funded the program at $2.5 million for the first six months of FY2014. P.L. 113-93 funded the (continued...)

Community Integrated Service Systems (CISS)

CISS is a HRSA-administered discretionary grant program that funds projects which seek to increase service delivery capacity at the local level and to promote community-based health systems for mothers and children, particularly for children in rural areas and those with special health care needs. Public or private organizations or institutions are eligible for these grants.

CISS grants and contracts support development and expansion of integrated services at the community level. Strategies used include maternal and infant health home visiting; projects to increase participation of obstetricians and pediatricians in Title V and Medicaid; integrated maternal and child health service delivery systems; maternal and child health centers providing pregnancy services for women and preventive and primary care services for infants (up to one year) that operate under the direction of a not-for-profit hospital; maternal and child health projects to serve rural populations; and outpatient and community-based services programs for children with special health care needs who are primarily treated through inpatient institutional care.[21]

Funding

The statute provides that roughly 85% of the funds appropriated for MCH Services Block Grant must be distributed by formula to states and territories and that 15% be distributed on a competitive basis under SPRANS. The statute also requires that 12.75% of any amounts appropriated above $600 million must be reserved for CISS.

Block Grant Formula

Individual state allocations are determined by a formula that takes into consideration the proportion of the number of low-income children in a state compared to the total number of low-income children in the United States. Specifically, the first $422 million[22] is distributed to each state based on the amount the state received under the consolidated MCH programs in 1983. Any funds above that amount are distributed based on the number of children in each state who are at or below 100% of the federal poverty level (FPL) as a proportion of the total number of children below 100% of the FPL nationally.[23]

In addition, the MCH Services Block Grant requires a state match. Each state must contribute $3 for every $4 of federal funds awarded.[24] States may use no more than 10% of their federal

(...continued)

program at $2.5 million for the last six months of FY2014. P.L. 114-10 funded the program at $5 million per year for each of FY2015, FY2016, and FY2017.

[21] Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015*, March 7, 2014, http://www.hrsa.gov/about/budget/budgetjustification2015.pdf.

[22] This amount is the sum of the funding for the individual programs consolidated into the MCH Services Block Grant under OBRA 1981 (P.L. 97-35).

[23] Historically, the state Title V MCH Block Grant allocations were calculated based on the child poverty data reported in the U.S. Census Bureau's decennial census. The American Community Survey (ACS) has replaced the decennial census long form as the source for annual state-specific child poverty statistics. Beginning in FY2013, data from the ACS is being used as the reference data for calculating the annual state Title V MCH Block Grant formula allocations. (Source: U.S. Department of Health and Human Services, *Health Resources and Services Administration, FY2015 Justification of Estimates for Appropriation Committees*, p. 205.)

[24] Section 503(a) of the Social Security Act (42 U.S.C. §703(a)).

allocations for administrative costs.[25] In addition, states are required to maintain at least the state's FY1989 level of funding for maternal and child health programs.[26]

Block grant funds are awarded each fiscal year in quarterly installments and remain available for expenditure for the current and subsequent fiscal year.[27] If a state chooses to not apply for block grant funds, is not qualified for such funds, or indicates that it does not plan to use its full allotment, that state's allotment is redistributed among the remaining states in the proportion otherwise allotted to the state.[28] **Appendix B** shows the federal allocation and state match for FY2015, by state.

SPRANS

By law, 15% of the amount appropriated to the MCH Services Block Grant (up to $600 million) is awarded on a competitive basis to public and private not-for-profit organizations for SPRANS. The program also receives 15% of funds remaining above $600 million after CISS funds are set aside.[29]

As noted above, Congress has directed some SPRANS funds through authorizations and appropriations for specific programs. Currently, SPRANS has additional funding of $5 million to develop Family to Family Information Centers through FY2017.[30]

CISS

The CISS program is initiated whenever the MCH Services Block Grant appropriation exceeds $600 million. Of any amount appropriated over $600 million, 12.75% is set aside for CISS.[31] These funds are distributed on a competitive basis to public and private organizations; entities that propose activities focusing on areas with a high infant mortality rate are given preference.

Appropriations History

The MCH Services Block Grant program is currently authorized to receive $850 million annually. The final appropriation for FY2016 was $638.2 million. Of the amount appropriated, an estimated $550.8 million was for block grants to states (86%), $77.1 million was for SPRANS (12%), and $10.3 million was for CISS (2%).

The President's budget requested $638.2 million for the program for FY2017. Funding for the MCH Services Block Grant is discretionary and subject to the annual appropriations process. Full-year appropriations for FY2017 have yet to be enacted.

[25] Section 504(d) of the Social Security Act (42 U.S.C. §704(d)).

[26] Section 505(a)(4) of the Social Security Act (42 U.S.C. §705(a)(4)).

[27] Section 503(b) of the Social Security Act (42 U.S.C. §703(b)).

[28] Section 502(d)(1) of the Social Security Act (42 U.S.C. §702(d)(1)).

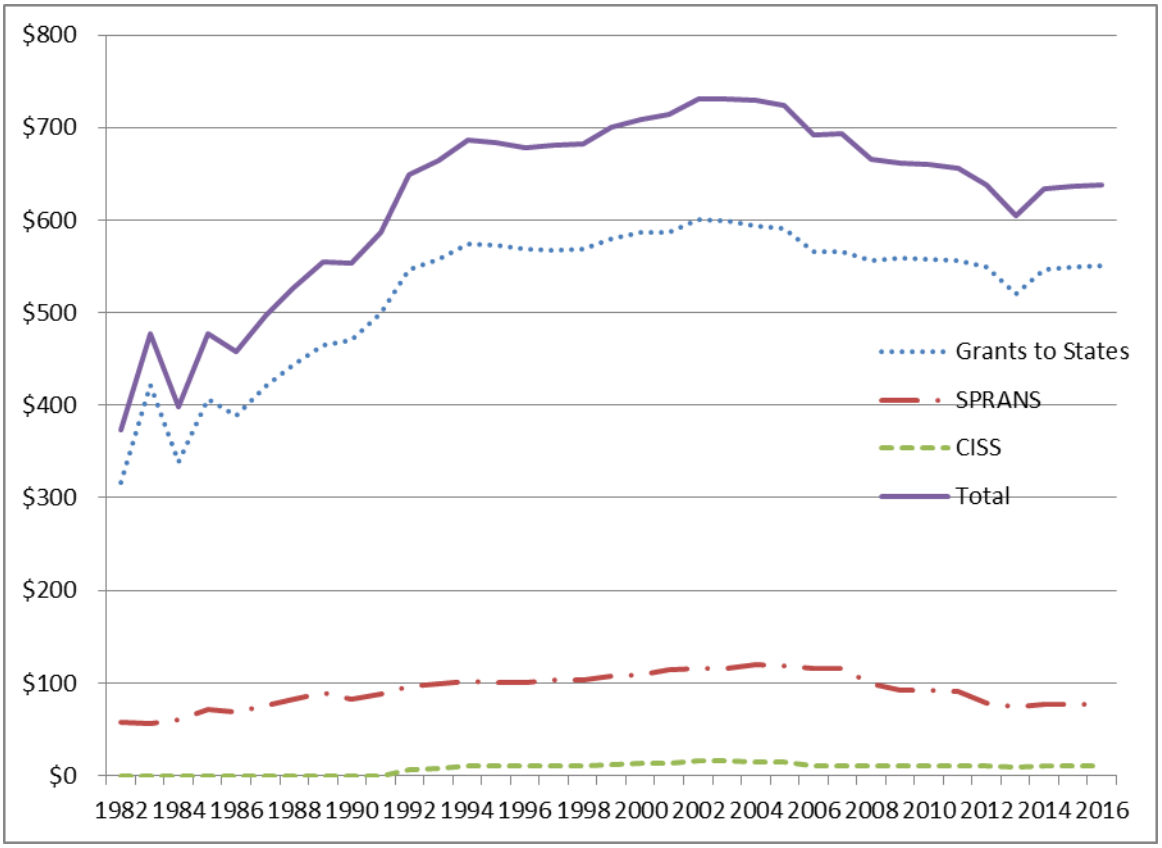
[29] Section 502(a)(1) and Section 502(b)(1)(B) of the Social Security Act (U.S.C. 42 §702(a)(1) and 42 U.S.C. §702(b)(1)(B)).

[30] See footnote 20 for additional information.

[31] Section 502(b)(1)(A) of the Social Security Act (U.S.C. 42 §702(b)(1)(A)).

Figure 2. Federal Allocations to the MCH Services Block Grant, FY1982-FY2016

(In millions of dollars)



Source: Prepared by CRS using annual Department of Health and Human Services, Health Resources and Services Administration budget justifications and appropriations legislation for the relevant years. Funding levels are not adjusted for inflation.

Notes: Data for this table can be found in **Appendix C**.

Figure 2 shows historical and current funding in total and for the three components of the MCH Services Block Grant. As shown in **Figure 2**, MCH Services Block Grant funding was $638.2 million in FY2016. Funding for the program peaked at $731.3 million in FY2002, and has seen an overall $93.1 million decrease since then. However, decreased federal funding for the block grant may be temporarily offset by funding for new Title V programs authorized in the ACA, including the Maternal, Infant, and Early Childhood Home Visiting program, which is funded through FY2016.[32] While this program is not intended as a flexible source of funds (as the block grant is), the home visiting program has maternal and child health objectives that are consistent with those of the MCH Services Block Grant.

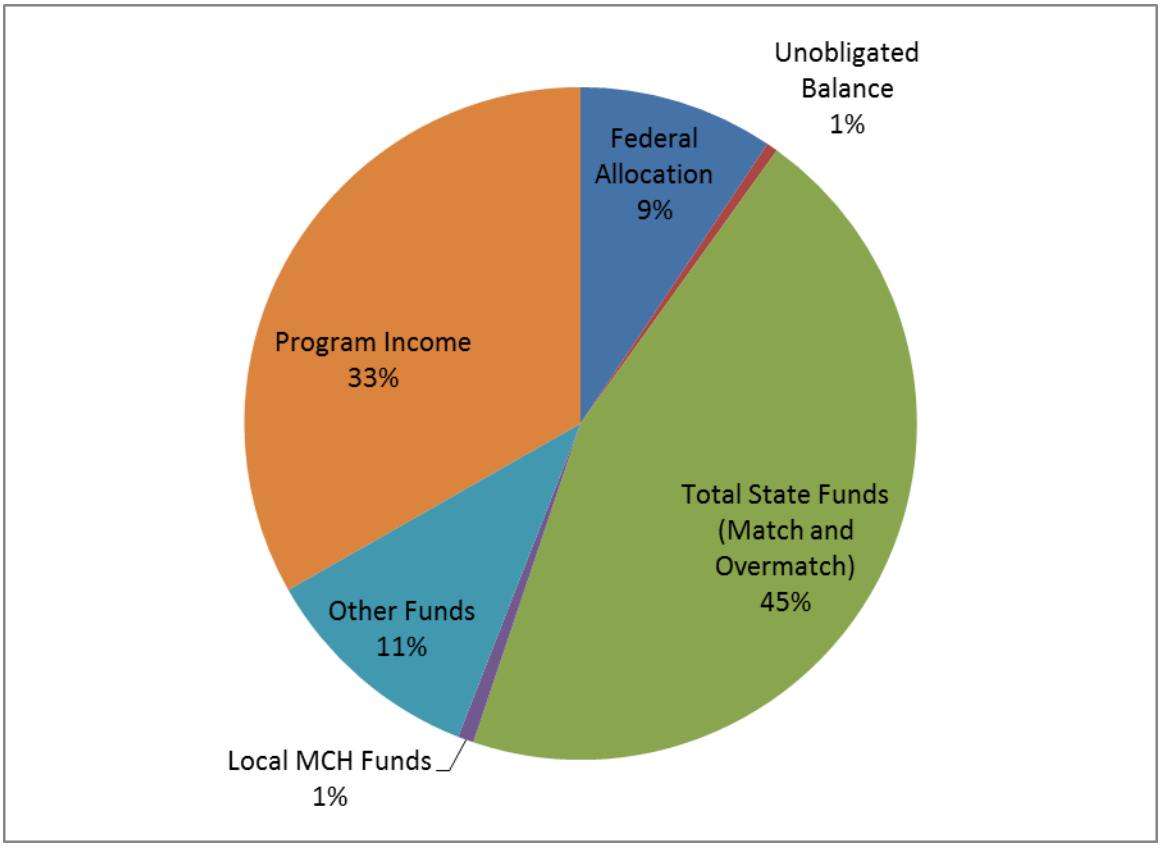
Funding for MCH services is not determined solely by federal funding; states are required to provide $3 for every $4 of federal block grant funding. In addition to the federal allocation and state match, other local, state, or federal funds may be used to support MCH activities, and certain MCH programs generate income through insurance payments and Medicaid reimbursements.

[32] Funding for the Maternal, Infant, and Early Childhood Home Visiting Program was appropriated by the ACA for each of FY2010-FY2014 and is funded through FY2017 pursuant to P.L. 114-10. For more information on this program and others authorized by the ACA, see **Appendix A**.

Figure 3 shows national Title V block grant partnership funding by source of funding for FY2015.

Figure 3. Federal-State Title V Block Grant Partnership Budget, FY2015

By Source of Funding



Source: HRSA Title V Information System: https://mchdata.hrsa.gov/tvisreports/FinancialData/FinancialSearch.aspx?FinSearch=A.

Note: The Federal Allocation and the Unobligated Balance are synonymous to the MCH Services Formula Block Grant. Other Funds are funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to, WIC, Emergency Medical Services for Children, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC, MCH Education funds, and foundation and other public and private and nonprofit monies, used for Title V programs. Program Income is money collected by State MCH agencies from insurance payments, Medicaid reimbursements, HMO payments, etc.

Program Participation and Maternal and Child Health Reporting at the State and National Levels

The MCH Services Block Grant has several reporting mechanisms required by law: first, the needs assessment, as discussed in a previous section of this report; second, an annual report, including program participation data, state maternal and child health measures, and state pediatric and family workforce measures; third, an independent audit must be performed every two years. HRSA, in turn, must report to Congress on the activities carried out under the SPRANS and CISS programs, in addition to providing a summary of state reports on block grant activities.

HRSA has developed national performance measures in coordination with states and grantees. States have also developed and reported additional state-level measures.

The first national performance measures (NPMs) for MCH were instituted in 1997. In 1998, HRSA introduced the Title V Information System (TVIS) to collect and publicly report state-level Title V data. This interactive, web-based system provides public access to Title V performance measures by state.[33] Since 2011, all states have reported annually on their progress toward achieving the targets they set for 18 National Performance Measures (NPMs) that will end with the FY2015 annual report (see **Table E-1**).

Changing trends in MCH risk factors, outcomes, health services, data sources, and advances in scientific knowledge, in conjunction with budgetary constraints led the Maternal and Child Health Bureau (MCHB) to design a new performance measurement system. The new performance measurement system has three tiers: NPMs, national outcome measures (NOMs), and evidence-based/informed strategy measures (ESMs).

Beginning with the annual report for FY2016, each state Title V program selects 8 out of 15 NPMs for programmatic focus during the five-year reporting cycle (with at least one NPM from each of the following population groups/areas: maternal and women's health, perinatal health, child health, children with special health care needs, adolescent health, and cross-cutting areas). Once its NPMs are selected, a state annually tracks them to determine progress and program impact (see **Table E-2**). The new performance measurement system is expected to increase the flexibility and reduce the reporting burden for states by allowing them to choose eight NPMs to target, and increase accountability by having states develop actionable ESMs.

A comprehensive list of national performance measures is provided in **Appendix E**.

In addition to state-reported measures, the Maternal and Child Health Bureau administers two surveys, the National Survey of Children's Health and the National Survey of Children with Special Health Care Needs, which are described in the text box below.[34]

The National Survey of Children's Health and the National Survey of Children with Special Health Care Needs

These nationally representative surveys are each administered by the Maternal and Child Health Bureau of HRSA once every four years, and provide national and state-level data on the Title V target populations. The surveys provide data for Title V performance measures, which are presented in reports to Congress and other HRSA publications.

The National Survey of Children's Health (NSCH) is a national telephone survey that collects a broad range of information on children's health and well-being, including insurance coverage, access to health care, and includes information on the family environment. NSCH data are collected in English and Spanish in a manner that allows for valid state and national level comparisons. The NSCH has been administered three times (in 2003, 2007, and 2011-2012). According to the Maternal and Child Health Bureau, while many indicators were measured consistently over the three rounds of the survey, many of the survey's questions were revised or reordered, some of the composite indicators have been redefined, and the sample design was changed to incorporate cell-phone-only households in 2011-2012. The 2011-2012 chartbook from NSCH was published in June 2014. In 2011-2012, nearly 96,000 surveys were completed for children and adolescents from birth to age 17. (In the 2011-2012 NSCH, surveys were conducted in English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean.) The NSCH is currently being redesigned, with the first public release of data scheduled for spring 2017.

[33] See https://mchdata.hrsa.gov/tvisreports/Default.aspx.

[34] See http://www.childhealthdata.org/browse/survey. Also see http://mchb.hrsa.gov/nsch/2011-12/health/ and http://www.cdc.gov/nchs/slaits/cshcn.htm.

The National Survey of Children with Special Health Care Needs (CSHCN) is a national telephone survey that collects information on health insurance, access to services, and care coordination for children and adolescents from birth to age 17 with special health care needs. For the 2009-2010 survey, a little over 40,000 interviews were conducted with households with at least one child with special health care needs. This survey has been conducted three times (2001, 2005-2006, and 2009-2010). The CSHCN is currently being combined with the NSCH to provide one unified survey.

State Reporting Requirements

Each state must prepare and submit an annual report to the Secretary on all Title V activities. The reports must be presented in a standardized format. States must provide a list of activities and recipients of Title V funding, along with a description of progress toward meeting national and state health objectives, and their consistency with the state's needs assessment. Specifically, these reports must include information on program participation, standardized measures of maternal and child health, and data on maternal and child health systems, including measures of the pediatric and family practice workforce. While the measures are designed to standardize reporting across the states, there is still variation among states in terms of capacity for collecting and reporting data.

In addition to the above-mentioned annually reported indicators, states select and report 7 to 10 priority needs in their five-year strategic plans; states may annually adjust the strategic plans as their priorities change. Priority needs that were frequently identified in states' FY2013 MCH Services Block Grant applications include family support services; oral health services; childhood obesity treatment and prevention; mental and behavioral health systems; and access to services for children with disabilities.

Program Participation

The statute requires states to provide the number of individuals served, either in person or by phone, by the Title V block grant. The numbers provided by states may be estimates if the actual numbers are not available. States are also required to report expenditures by the four broad categories of service (direct health care services, enabling services, population-based services, and infrastructure-building services) discussed earlier under "Use of Block Grant Funds."

Maternal and Child Health Measures

Maternal and child health measures provide information on the overall health of mothers and children in each state (see **Appendix E**, **Table E-3** and **Table E-4**). These measures include data on maternal mortality rates, infant mortality rates, and vaccination rates. HRSA differentiates between health "performance" measures and health "outcome" measures. The performance measures include data on breastfeeding, oral health care, the suicide rate, and the teenage birth rate. Outcome measures include the infant mortality rate, the ratio of the black infant mortality rate to the white infant mortality rate, and the child death rate. These measures are compiled from a number of different sources, including state birth and death certificates, hospitalization data, and surveys. States are required to report data on these maternal and child health indicators by county, race, and ethnicity.

Maternal and Child Health Systems Indicators

States are required to annually report pediatric and family practice workforce data to HRSA, including information on the number of obstetricians, family practitioners, certified family nurse

practitioners, certified nurse midwives, pediatricians, and certified pediatric nurse practitioners who were licensed in the state in that year. They are also required to report data on whether individuals who are eligible for programs such as Medicaid and SSI are receiving services, or whether pregnant women have access to adequate prenatal care. For example, states report the number of Medicaid-eligible individuals who received a service paid for by the Medicaid program. (See **Appendix E**, **Table E-3** and **Table E-4**.)

National Reporting on MCH Services Block Grant Participation and Maternal and Child Health Indicators

HRSA must annually compile the information reported by states and present the data to the House Committee on Energy and Commerce and the Senate Committee on Finance in a Report to Congress. This report must include a summary of the information reported to the Secretary of HHS by the states (described in the previous section), and a compilation of specified maternal and child health indicators, nationally and broken down by state. The Secretary must also provide a report on funded SPRANS and CISS projects to those committees.

As noted above, a list of other maternal and child health measures reported to HRSA by the states can be found in **Appendix E** (see **Table E-3** and **Table E-4**). Data on these measures as reported by the states and aggregated by HRSA can be found on the Title V Information System and Discretionary Grants Information System websites.[35]

Program Participation Data

In FY2014, 59 states and jurisdictions received MCH Services Block Grant Funding. These programs directly served 2.0 million pregnant women and 36.9 million children (aged 1 to 22), including 2.7 million children with special health care needs. States also reported that 3.7 million infants and 7.7 million others[36] received services funded by the block grant.

Figure 4 shows the proportion of children, pregnant women, infants, children with special health care needs (CSHCN), and others (called "classes of individuals") served nationally by the MCH Services Block Grant. In FY2014, there were nearly 50.4 million persons served by Title V programs. The largest category of individuals served nationally are children aged 1 to 22, followed by women of childbearing age, infants, children with special health care needs, and pregnant women.

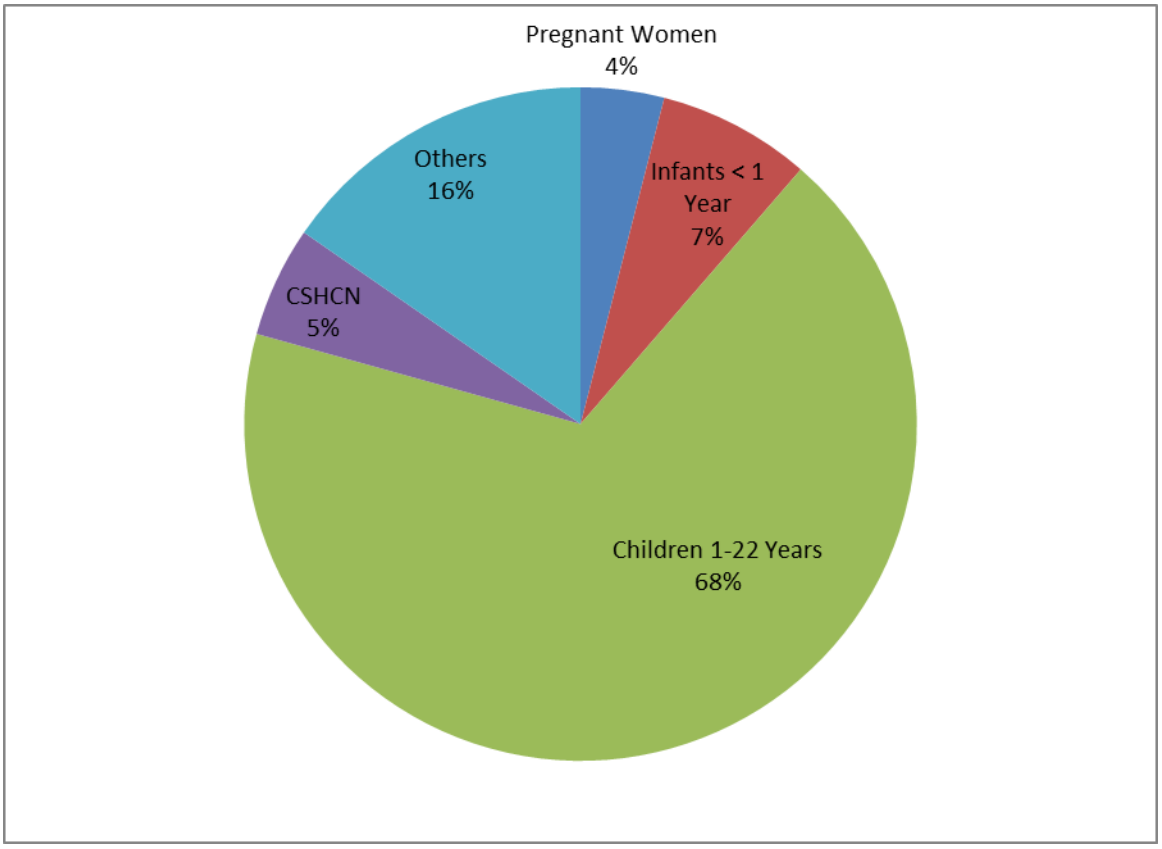
Title V programs, including but not limited to the MCH Services Block Grant, serve women and children who are covered by private and public insurance, as well as those who have no insurance coverage. In FY2012, the most recent year for which data are published from the HRSA TVIS, 33% of pregnant women who received Title V-funded services were covered by private health insurance, 56% were enrolled in Medicaid, 4% had no insurance coverage, and the insurance coverage status of 7% of pregnant Title V clients was unknown. Among children ages 1 to 22 years old who received Title V-funded services, 34% were covered by Medicaid, 4% were covered by CHIP, 29% were covered by private health insurance, and 6% had no insurance coverage. Insurance coverage status was unknown for 27% of children receiving Title V-funded services.

[35] See Title V Information System (https://mchdata.hrsa.gov/tvisreports/) and Discretionary Grants Information System (https://perf-data.hrsa.gov/MCHB/DGISReports/default.aspx).

[36] The class of individuals labeled "others" includes women of childbearing age and any others defined by the state that are not otherwise included in any of the other listed classes of individuals.

Figure 4. Individuals Served by Title V, by Class of Individual, 2014

Percentage of Total Individuals Served



Source: HRSA Title V Information System: https://mchdata.hrsa.gov/tvisreports/ProgramData/PercentageServed.aspx.

Note: "Others" includes reproductive-age women.

As stated above, the proportion of the combined federal/state block grant partnership funds that are directed toward specific populations varies by state, depending on each state's needs. By law, at least 30% of federal block grant funds must be used for primary and preventive care for children with special health care needs, unless a waiver is granted by HRSA. State matching funds and other sources of maternal and child health funding are not required to follow the allocation requirements of federal funds, which provides more flexibility for the states to direct those funds where they are needed. Similarly, state funds are not required to be directed toward specific populations in the same proportions as the federal block grant allocation.

National Maternal and Child Health and Health Systems Measures

The following sections present selected national and state indicators of maternal and child health and maternal and child health systems as reported to HRSA by the states. Data from the Centers for Disease Control and Prevention (CDC), when available, are also presented as a point of comparison. Selected measures are presented in this report to provide readers with context on the maternal and child health issues that Congress has chosen to address through the MCH Services Block Grant. The indicators have been selected for this report based on their relevance to the

seven goals of the MCH Services Block Grant, as specified in Title V. Although they do not represent the universe of relevant measures reported to HRSA, they provide examples of how maternal and child health is measured. The implications of these measures for the MCH Services Block Grant, as well as other maternal and child health funding, are discussed in the following section.

Although these and other indicators are referred to as outcome measures and performance indicators by HRSA, and improvement in these measures is an objective of Title V funding, it is important to note that Title V funding is only one component affecting these measures. Other federal and state programs and policies, including Medicaid, and WIC, as well as complex societal issues, also substantially affect the health and well-being of low-income children and their families.

Goal 1: Ensure access to quality health care for mothers and children, especially those with low income or limited availability of care.

Access to quality health care for mothers and children is measured by several questions in the National Survey of Children's Health. Participants were asked whether they have public, private, or no insurance coverage. Participating families were also asked if their children had at least one preventive care visit in the prior year, whether they had unmet health care needs, and whether or not they had a medical home.[37]

According to the 2011-2012 National Survey of Children's Health, almost 95% of all children have health insurance coverage (including public and private insurance). However, the survey found that the proportion of children with health insurance coverage varies considerably by race, ethnicity, and poverty status. For example, 81% of children living in households at or below the federal poverty level have health insurance, compared with 99% of children living in households at 400% or more of the federal poverty level. The survey also found that 90% of Hispanic children had health insurance, compared with 96% of non-Hispanic white children and 95% of non-Hispanic black children.[38]

Goal 2: Reduce infant mortality.

The infant mortality rate (IMR) is frequently used as a proxy indicator for the health status of children generally, as well as for national and international comparisons of children's health status. The most recent data reported to HRSA by the states are shown in **Figure D-1**, although current reporting years vary among the states.[39]

CDC's National Center for Health Statistics has published the most recently available single-year linked birth and death certificate information on IMR. Comparing data from both HRSA and CDC, the data show similar variability in rates by state and region. IMR is generally higher in the South and Midwest, and lower in other regions. Of the 50 states, Mississippi had the highest IMR (9.97 per 1,000 live births) and New Hampshire had the lowest (3.95 per 1,000 live births) in 2008.[40]

---

[37] Medical homes provide patients with access to a primary care medical provider and a coordinated care team.

[38] See http://mchb.hrsa.gov/nsch/2011-12/health/child/childs-health-care/current-health-insurance.html.

[39] The HRSA data show that of the 50 states, Mississippi had the highest IMR (9.4 infant deaths per 1,000 live births) and Alaska had the lowest (3.8 infant deaths per 1,000 live births) in the most current reported year (2011). Source: https://mchdata.hrsa.gov/tvisreports/MeasurementData/HSCI/HSCI05Search.aspx?measurenum=05B&from=pd.

[40] CRS Report R41378, *The U.S. Infant Mortality Rate: International Comparisons, Underlying Factors, and Federal* (continued...)

A number of health and social factors affect IMR.[41] Risk factors for infant mortality, including higher rates of teenage births, prematurity, and inadequate prenatal care in the first trimester, disproportionately affect low-income families.[42] Thus, the infant mortality rate is generally higher among Medicaid-eligible populations. HRSA data show that, in addition to the state-by-state differences in infant mortality noted above, the disparity in infant mortality between women enrolled in Medicaid and those who are not also varies widely by state. According to 2012 data reported to HRSA by South Dakota, the infant mortality rate for women enrolled in Medicaid was 10.3 infant deaths per 1,000 live births, compared with 7.7 per 1,000 for those not in the Medicaid program.[43]

Goal 3: Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women).

Prenatal care is recognized as an important factor in the health and well-being of mothers and children. Women who receive late or no prenatal care are more likely to experience complications of childbirth, including low birth weight.[44]

The rate of pregnant women entering prenatal care in the first trimester is generally higher among non-Medicaid populations than among women enrolled in Medicaid. As state data reported to HRSA show (see **Figure D-2**), these rates also vary by state. For example, in 2012, 92% of pregnant women in Maine received prenatal care in the first trimester. However, in the same state, this rate was 90% among those enrolled in Medicaid and 97% among the non-Medicaid population. In Georgia in 2012, 45% of pregnant women received care in the first trimester; this rate was 41% among the Medicaid population and 52% among non-Medicaid populations.

There may be a number of reasons women do not receive prenatal care in the first trimester, including lack of insurance coverage and lack of access to a primary care provider.[45] These barriers tend to be higher among racial and ethnic minorities. Among Medicaid enrollees, researchers have identified limited availability of maternity care providers, limited availability of transportation, and late enrollment in Medicaid as barriers to early prenatal care.[46]

(...continued)

Programs, by (name redacted) (available upon request).

[41] TJ Matthews and M MacDorman , *Infant Mortality Statistics From the 2007 Period Linked Birth/Infant Death Data Set*, National Center for Health Statistics, Center for Disease Control and Prevention, vol. 59 no. 6, Hyattsville, MD, June 29, 2011, http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_06.pdf.

[42] C Dollfus et al., "Infant Mortality: A Practical Approach to the Analysis of the Leading Causes of Death and Risk Factors ," *Pediatrics*, vol. 86, no. 2 (August 1, 1990), pp. 176-183; and Finch B, "Early Origins of the Gradient: The Relationship Between Socioeconomic Status and Infant Mortality in the United States," *Demography*, vol. 40, no. 4 (November 2003), pp. 675-699.

[43] The IMR for South Dakota (as a whole) was 8.6 infant deaths per 1,000 live births in 2012.

[44] Office on Women's Health, Department of Health and Human Services, *Prenatal Care*, Fact Sheet, March 6, 2009, http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.pdf.

[45] N.C. Pregnancy Risk Assessment Monitoring System, *Barriers to Prenatal Care*, June 2005, http://www.epi.state.nc.us/SCHS/prams/pdf/BarriersToPrenatal.pdf.

[46] J Kiely and M Kogan, *From Data to Action:CDC's Public Health Surveillance for Women, Infants, and Children, Prenatal Care: Public Health Importance*, Centers for Disease Control and Prevention, Atlanta, GA, 1994, pp. 105-118, http://www.cdc.gov/reproductivehealth/ProductsPubs/DatatoAction/DataToAction.htm.

Goal 4: Increase the number of children receiving health assessments and follow-up diagnostic and treatment services.

Regular preventive health care has long been considered a core component of child growth and development. However, researchers have identified persisting barriers to regular preventive health care visits for children; various federal programs, including EPSDT, have been established to ensure that all children receive regular, quality care.[47]

Overall, 84% of children had one preventive health care visit in the year preceding the 2011-2012 National Survey of Children's Health.[48] In the 2011-2012 survey, there was slight variation among racial and ethnic groups; non-Hispanic white children had the highest rate (86%) of preventive health care visits in the preceding year, followed by non-Hispanic black children (84%), and Hispanic children had the lowest rate (81%). Children who were uninsured (54%) were less likely than those covered by public insurance (84%) to have received preventive health care in the past year, and privately insured (88%) children were more likely to have received preventive care than those covered by public insurance. These rates also varied by age, with older children and teenagers less likely to have received preventive care than infants and preschool-aged children.

Goal 5: Provide and ensure access to preventive and health care services for certain blind and disabled children, as well as rehabilitative services.

Children with special health care needs often need health, mental, and social services beyond preventive care. They also are more likely to have injuries that require medical care. Accessing these additional services may create additional access and financial burdens on families. Children with special health care needs may qualify for Medicaid or CHIP, and they are more likely to have health insurance.[49]

In the 2009-2010 National Survey of Children with Special Health Care Needs, access to preventive and health care services is measured by a series of questions on use of services and unmet needs. Overall, 76% of children did not have an unmet need for specific health care services in the year prior to the survey.[50] However, the proportion of children with an unmet health care need was much higher among children with no insurance (56% had one or more unmet health care needs) than children with insurance (23% had one or more unmet health care needs).[51]

[47] P Chung et al., *Preventive Care for Children in the United States: Quality and Barriers*, The Commonwealth Fund, Annual Review of Public Health, New York, NY, April 2006, http://www.allhealth.org/briefingmaterials/preventive_care_children-575.pdf.

[48] See http://mchb.hrsa.gov/nsch/2011-12/health/child/childs-health-care/preventive-medical-care-visits.html.

[49] Health Resources and Services Administration, *Children with Special Health Care Needs in Context: A Portrait of the States and Nation 2007*, Rockville, MD, September 2011.

[50] See http://www.childhealthdata.org/browse/survey/results?q=1624&r=1.

[51] See http://www.childhealthdata.org/browse/survey/results?q=1624&r=1&g=87 (http://www.childhealthdata.org/browse/survey).

Goal 6: Implement family-centered, community-based systems of coordinated care for children with special health care needs.

Shared decisionmaking between families of children with special health care needs and their children's health care providers is another goal for the MCH Services Block Grant. Multiple components determine whether a family is receiving family-centered care. These components include the amount of time spent with health care providers, their level of attentiveness, sensitivity to families' values and customs, the relevance of information provided to families, and whether the family felt like a partner in their child's health care.

The 2009-2010 National Survey of Children with Special Health Care Needs found that families with insurance coverage were more likely to report family-centered coordinated care than families without insurance coverage. The Survey indicated that 45% of families with private insurance coverage reported that they received family-centered care, compared with 25% of families without insurance coverage.[52]

Another approach to ensuring family-centered, community-based care is the medical home.[53] Medical homes, which provide patients access to primary care medical providers and a coordinated care team, have been associated with improved health care among children with special health care needs.[54] According to the 2011-2012 National Survey of Children's Health, 47% of children with special health care needs had a medical home.[55] As others have noted, access to medical homes for children with special health care needs varies widely across states.[56]

Goal 7: Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid.

Access to care is often cited as a barrier to health services. To facilitate access to coverage for maternal and child health services, state toll-free hotlines provide callers with state-specific Medicaid enrollment information. In 2012, state toll-free hotlines recorded 1.3 million calls regarding Medicaid enrollment.[57]

Discussion

The Maternal and Child Health Services Block Grant is not a single program, but rather a combination of block grants to states and two discretionary grant programs to achieve national maternal and child health objectives, including increased access to health care, coverage for

[52] Data Resource Center for Child and Adolescent Health, Health Resources and Services Administration, http://www.childhealthdata.org/browse/survey/results?q=1921&r=1&g=87 (http://www.childhealthdata.org/browse/survey).

[53] A "medical home" generally is defined as a model of care that provides for a source of ongoing, comprehensive, coordinated, family-centered care in the child's community. In most cases, each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians.

[54] CJ Homer et al., "A Review of the Evidence for the Medical Home for Children With Special Health Care Needs," *Pediatrics*, vol. 122, no. 4 (October 2008), pp. e922-e937.

[55] See http://mchb.hrsa.gov/nsch/2011-12/health/child/childs-health-care/medical-home.html.

[56] G Singh et al., "Geographic Disparities in Access to the Medical Home among US CSHCN," *Pediatrics*, vol. 124, no. Suppl 4 (December 2009), pp. S352-S360.

[57] State toll-free hotlines received 1.4 million calls in 2008, 1.5 million in both 2009 and 2010, and 1.8 million in 2011.

preventive services and other health care, and progress toward national health objectives. This combination of approaches provides flexibility to states in achieving maternal and child health goals, while allowing both Congress and HRSA to maintain a degree of control in guiding national initiatives. The issues related to the MCH Services Block Grant span the intersection of clinical health services, prevention, and public health, and include optimizing the balance of federal and state resources to achieve the program's objectives, and ensuring program effectiveness and accountability.

According to HRSA, the MCH Services Block Grant provided services to over 34 million children in FY2013.[58] Of those children, nearly 15 million had Medicaid or CHIP coverage. Changes to public and private insurance markets under the ACA may affect the number of pregnant women and children served by the block grant, because of expanded Medicaid eligibility,[59] coverage of preventive care without cost-sharing, and provisions for coverage of individuals with preexisting conditions.[60] Some policymakers contend that during this time of transition, the MCH formula block grant and its discretionary grants are integral to assuring the continuity of care and to reducing coverage gaps created by shifts in the insurance eligibility status of individuals. In addition, states may argue that block grant funds can and should be redirected to meet other maternal and child health goals, and not decreased, if Medicaid and CHIP coverage expands to those who currently receive block grant-funded services.[61]

One general concern with block grants may be that federal funds are being used to address state-specific issues and are not held accountable to national concerns.[62] Congress has addressed the issue of national concerns with MCH Services Block Grant by requiring the SPRANS set-aside. However, states may be best suited to use block grant funds in situations where there is wide variability in burden and cost, as shown by data collected by both HRSA and CDC. Filling in the gaps left by Medicaid and CHIP is one such area, due to variable enrollment eligibility among the states.

As mentioned earlier, the indicators discussed in this report are referred to as outcome measures and performance indicators by HRSA, and improvement in these measures is an objective of Title V funding. However, it is important to note that Title V funding is only one component affecting these measures. Other federal and state programs and policies, including Medicaid and WIC, as well as complex societal issues, also affect the health and well-being of low-income children and their families.

Progress toward national health objectives, such as reduction of the infant mortality rate, has shown past improvement but has stagnated in recent years. Due to the flexibility of funding, varying circumstances in states, and other societal issues, it is impossible to globally track the direct impact of maternal and child health block grant funds on national health indicators such as

[58] Department of Health and Human Services, Health Services and Resources Administration, Justification of Estimates for Appropriations Committees, Fiscal Year 2017, http://www.hrsa.gov/about/budget/budgetjustification2017.pdf., p. 203.

[59] CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by (name redacted) et al.

[60] S McMorrow, G Kenney, and C Coyer, *Addressing Coverage Challenges for Children Under the Affordable Care Act*, Robert Wood Johnson Foundation and the Urban Institute, May 2011, http://www.rwjf.org/files/research/72428qskids201105.pdf.

[61] Department of Health and Human Services, Health Services and Resources Administration, *Justification of Estimates for Appropriations Committees*, *Fiscal Year 2015*, Rockville, MD, http://www.hrsa.gov/about/budget/budgetjustification2015.pdf.

[62] CRS Report R40486, *Block Grants: Perspectives and Controversies*, by (name redacted) and (name redacted).

IMR. Congress and the executive branch cannot direct states to specifically target one data point, such as IMR, with block grant funding, but may use other approaches. As an alternative to block grant funding, programs such as the Maternal, Infant, and Early Childhood Home Visiting Program and Strong Start and targeted national public health initiatives such as CDC's Safe Motherhood and Infant Health program have been promoted by policymakers as direct approaches to improving this particular health objective.[63] Healthy Start, a national program that targets the infant mortality rate in selected communities, has been successful in targeted communities.[64]

Some have argued that the decentralized nature of block grants makes it difficult to measure program performance and accountability and to hold state and local governments accountable for their decisions. In addition, the quality of services provided under block grant funding is not currently tracked. However, the existing data required by Title V may be used to determine whether states are efficiently funding their gap areas with block grant funds.

[63] American Academy of Pediatrics, Council on Child and Adolescent Health, "The Role of Home Visitation Programs in Improving Health Outcomes for Children and Families," *Pediatrics*, vol. 101, no. 3 (March 1, 1998), pp. 486-489; Department of Health and Human Services, "HHS Launches Strong Start Initiative to Increase Healthy Deliveries and Reduce Preterm Births," press release, February 8, 2012, http://www.hhs.gov/news/press/2012pres/02/20120208a.html.

[64] Department of Health and Human Services, Health Services and Resources Administration, Justification of Estimates for Appropriations Committees, Fiscal Year 2017, http://www.hrsa.gov/about/budget/budgetjustification2017.pdf., pp. 237-243.

Appendix A. Programs in Title V Added or Amended by the ACA

In addition to the MCH Services Block Grant, Title V contains a number of provisions that were added or amended by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148). This appendix provides a summary of those provisions. Most of the provisions created under the ACA included mandatory appropriations for FY2010 through FY2014, with the exception of the Postpartum Depression program, which was authorized but has not been funded.

SSA §510, Abstinence Education

This program provides funding to states for abstinence education. Abstinence from sexual activity outside of marriage must be the exclusive focus of the programs funded by these grants. The ACA appropriated $50 million for each of FY2010 through FY2014 for this program. P.L. 113-93 (the Protecting Access to Medicare Act of 2014), which was enacted on April 1, 2014, extended the Title V Abstinence Education block grant ($50 million per year) through FY2015 (i.e., September 30, 2015). P.L. 114-10, the Medicare Access and CHIP Reauthorization Act of 2015, increased the Title V Abstinence Education block grant to $75 million per year for FY2016 and FY2017.[65]

SSA §511, Maternal, Infant, and Early Childhood Home Visiting Programs

This program provides grants to states, territories, and tribes for the support of evidence-based early childhood home visiting programs. These programs support in-home visits by health or social service professionals with at-risk families. The ACA appropriated a total of $1.5 billion for FY2010 through FY2014 for the home visitation grant program: $100 million for FY2010; $250 million for FY2011; $350 million for FY2012; $400 million for FY2013; and $400 million for FY2014. P.L. 113-93 extended funding for the program through the first six months of FY2015. P.L. 114-10 extended funding for the program through FY2015 and also provided $400 million for FY2016 and $400 million for FY2017.

Of the amount appropriated for this program, 3% must be reserved for research and evaluation, and 3% for making grants to tribal entities for home visitation services to Indian families. The new early childhood home visitation grant program is collaboratively administered by the Administration for Children and Families and the Maternal and Child Health Bureau at HRSA.[66]

SSA §512, Postpartum Depression

This program provides grants for epidemiologic research, improved screening and diagnosis, clinical research, and public education to expand understanding of the causes and treatments for postpartum depression and related conditions. The ACA authorized funding of $3 million for these grants for FY2010, and such sums as necessary for each of FY2011 and FY2012. Funds were not appropriated for this program.

---

[65] For additional information, see CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*, by (name redacted) .

[66] For additional information, see CRS Report R43930, *Maternal and Infant Early Childhood Home Visiting (MIECHV) Program: Background and Funding*, by (n ame redacted) .

SSA §513, Personal Responsibility Education

The Personal Responsibility Education program is administered by the Administration for Children and Families. A Personal Responsibility Education program is defined as a program that is designed to educate adolescents on both abstinence and contraception for prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, and at least three of the six stipulated adulthood preparation subjects. The adulthood preparation subjects are (1) healthy relationships, including marriage and family interactions; (2) adolescent development, including the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (3) financial literacy; (4) parent-child communication; (5) educational and career success, including developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; and (6) healthy life skills, including goal-setting, decisionmaking, negotiation, communication and interpersonal skills, and stress management. The ACA appropriated $75 million annually for each of the five fiscal years FY2010 through FY2014. P.L. 113-93 (the Protecting Access to Medicare Act of 2014 extended PREP ($75 million per year) through FY2015. P.L. 114-10 (the Medicare Access and CHIP Reauthorization Act of 2015) extended PREP ($75 million per year) through FY2017 (i.e., September 30, 2017).[67]

[67] For additional information, see CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*, by (name redacted) .

Appendix B. Source of Funding for Title V Block Grants to States, the District of Columbia, and Other Jurisdictions, by State, FY2015

Table B-1. Source of Funding for Title V Block Grants to States, FY2015

(Dollars in millions)

State	Federal Allocation	Total State Funds (Match and Overmatch)[a]	Other Funds (including local MCH funds)	Program Income (Reimburse-ments)[b]	Total
Alabama	$11.2	$23.7	$2.6	$55.2	$92.8
Alaska	1.0	14.5	0	0.1	15.7
Arizona	8.0	8.0	7.4	0	23.4
Arkansas	6.8	6.4	0.7	23.7	37.4
California	37.7	1,535.9	0	1,549.1	3,122.8
Colorado	7.1	5.3	0	0	12.5
Connecticut	4.7	6.8	0	0	11.5
Delaware	2.4	9.4	0	1.3	13.1
District of Columbia	7.0	17.0	0	0	24.0
Florida	19.0	169.5	0	0	188.5
Georgia	16.4	92.8	157.3	3.8	270.3
Hawaii	2.4	25.2	0.1	19.2	46.8
Idaho	3.2	2.4	0	0	5.6
Illinois	20.9	27.3	234.2	6.4	288.7
Indiana	12.2	13.8	1.5	0.8	28.4
Iowa	6.5	6.2	7.3	0.4	20.3
Kansas	4.7	3.5	4.4	0	12.6
Kentucky	10.6	35.8	17.1	0	63.5
Louisiana	13.8	9.9	3.4	4.6	31.7
Maine	3.3	5.5	0	0	8.8
Maryland	11.6	8.7	0	0	20.3
Massachusetts	11.6	45.1	0	0	56.6
Michigan	18.7	41.3	1.0	67.5	128.5
Minnesota	9.0	6.8	12.5	66.7	28.4
Mississippi	9.1	6.8	0	3.7	19.6
Missouri	13.8	13.0	8.0	0	26.7
Montana	2.2	2.5	3.7	1.8	10.3
Nebraska	4.0	3.5	0.5	0	8.0

State	Federal Allocation	Total State Funds (Match and Overmatch)[a]	Other Funds (including local MCH funds)	Program Income (Reimburse-ments)[b]	Total
Nevada	2.0	1.5	0	0	3.4
New Hampshire	2.0	7.4	0.9	0	10.2
New Jersey	11.2	109.4	0	0	120.6
New Mexico	4.0	7.3	0	0	11.3
New York	38.9	29.2	22.2	12.8	103.1
North Carolina	17.0	36.6	65.5	72.0	191.0
North Dakota	2.3	1.7	0	0	4.0
Ohio	26.4	29.3	54.8	0	110.5
Oklahoma	6.9	5.2	0	0.1	12.2
Oregon	6.1	12.4	7.5	0	26.0
Pennsylvania	23.3	57.5	0	0	80.8
Rhode Island	2.1	2.0	1.4	24.3	29.8
South Carolina	11.3	10.2	34.1	14.1	69.8
South Dakota	2.1	1.6	0.4	0.6	4.8
Tennessee	17.1	14.2	0	3.4	34.6
Texas	45.4	40.2	0	0	85.6
Utah	8.4	15.6	17.4	5.8	47.2
Vermont	1.6	1.8	0	1.1	4.6
Virginia	11.9	9.0	1.0	0	22.0
Washington	8.8	7.6	0	0	16.4
West Virginia	5.9	8.8	0	17.5	32.3
Wisconsin	10.7	9.0	0	5.3	25.0
Wyoming	1.1	1.9	0.5	0	3.5
Other Jurisdictions					
American Samoa	0.5	0.5	0	0	1.0
Federated States of Micronesia	0.5	0.4	0	0	0.9
Guam	0.7	0.7	0	0	1.4
Marshall Islands	0.3	0.2	0	0	0.4
Northern Mariana Islands	0.4	0.4	0	0	0.9
Palau	0.2	0.1	0	0	0.3
Puerto Rico	16.0	12.0	0	0.1	28.1
Virgin Islands	1.5	0	1.2	0	2.6
Total	$565.5	$2,580.1	$660.9	$1,894.8	$5,701.4

Source: HRSA Title V Information System, Federal-State Title V Block Grant Partnership Budget FY2015 at https://mchdata.hrsa.gov/tvisreports/FinancialData/FinancialSearch.aspx?FinSearch=A. Some totals are imprecise because of rounding.

a. States are allowed to exceed the matching requirement of $3 for every $4 of federal funds awarded. This amount is an "overmatch."

b. Program income includes funding from private entities and income collected from insurance payments and Medicaid. For purposes of meeting the state match requirement, states are allowed to use nonfederal program income toward their match.

Appendix C. MCH Services Block Grant Funding History

Table C-1. MCH Services Block Grant Funding History, FY1982-FY2016

(Dollars in millions)

Fiscal Year	Grants to States	SPRANS	CISS	Total
1982	$316.2	$ 57.6	N.A.	$373.8
1983	422.1	55.9	N.A.	478.0
1984	339.2	59.8	N.A.	399.0
1985	406.3	71.7	N.A.	478.0
1986	388.8	68.7	N.A.	457.5
1987	421.1	75.7	N.A.	496.8
1988	444.3	82.3	N.A.	526.6
1989	465.3	89.0	N.A.	554.3
1990	470.6	83.0	N.A.	553.6
1991	499.2	88.1	N.A.	587.3
1992	547.1	96.1	$6.4[a]	649.6
1993	557.9	98.4	8.2	664.5
1994	574.5	101.4	11.1	687.0
1995	572.3	101.0	10.7	684.0
1996	568.5	100.3	10.0	678.8
1997	567.9	103.1	10.0	681.0
1998	569.3	103.6	10.0	683.0
1999	580.5	107.4	12.1	700.0
2000	586.8	109.1	13.1	709.0
2001	587.2	113.7	13.3	714.2
2002	600.6	115.1	15.6	731.3
2003	599.0	115.9	15.8	730.7
2004	594.4	120.4	15.0	729.8
2005	591.1	118.2	14.6	723.9
2006	566.1	115.9	10.6	692.5
2007	566.5	115.9	10.6	693.0
2008	556.6	99.2[b]	10.4	666.2
2009	559.2	92.6[b]	10.4	662.1
2010	558.0	92.4	10.4	660.7
2011	555.7	90.2	10.4	656.3
2012	549.7	78.6	10.3	638.6

Fiscal Year	Grants to States	SPRANS	CISS	Total
2013	520.7	74.5	9.7	604.9[c]
2014	546.6	77.1	10.3	634.0
2015	549.6	77.1	10.3	637.0
2016	550.8	77.1	10.3	638.2

Source: Prepared by CRS using annual Department of Health and Human Services, Health Resources and Services Administration budget justifications and appropriations legislation for the relevant years. Funding levels are not adjusted for inflation.

a. In FY2008, $20 million was transferred from SPRANS to the Autism program line. In FY2009, $6.9 million was transferred from SPRANS to the Heritable Disorders line. The Autism program and the Heritable Disorder program also are administered by HRSA's Maternal and Child Health Bureau.

b. Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees, Fiscal Year 2013*, http://www.hrsa.gov/about/budget/budgetjustification2013.pdf.

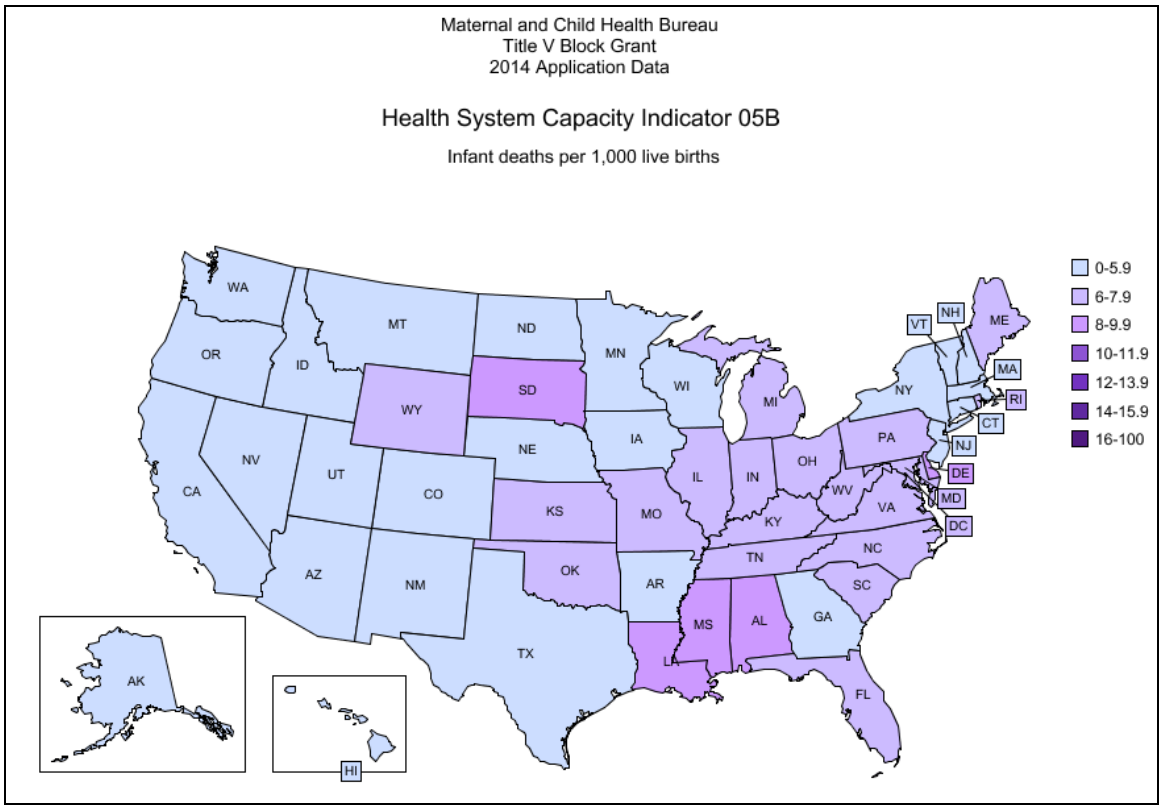
c. Reflects the final appropriation after sequestration.

Note: N.A. = Not Available.

Appendix D. Selected Maternal and Child Health Measures, by State

Figure D-1. Infant Mortality Rate

The number of infant deaths per 1,000 live births.

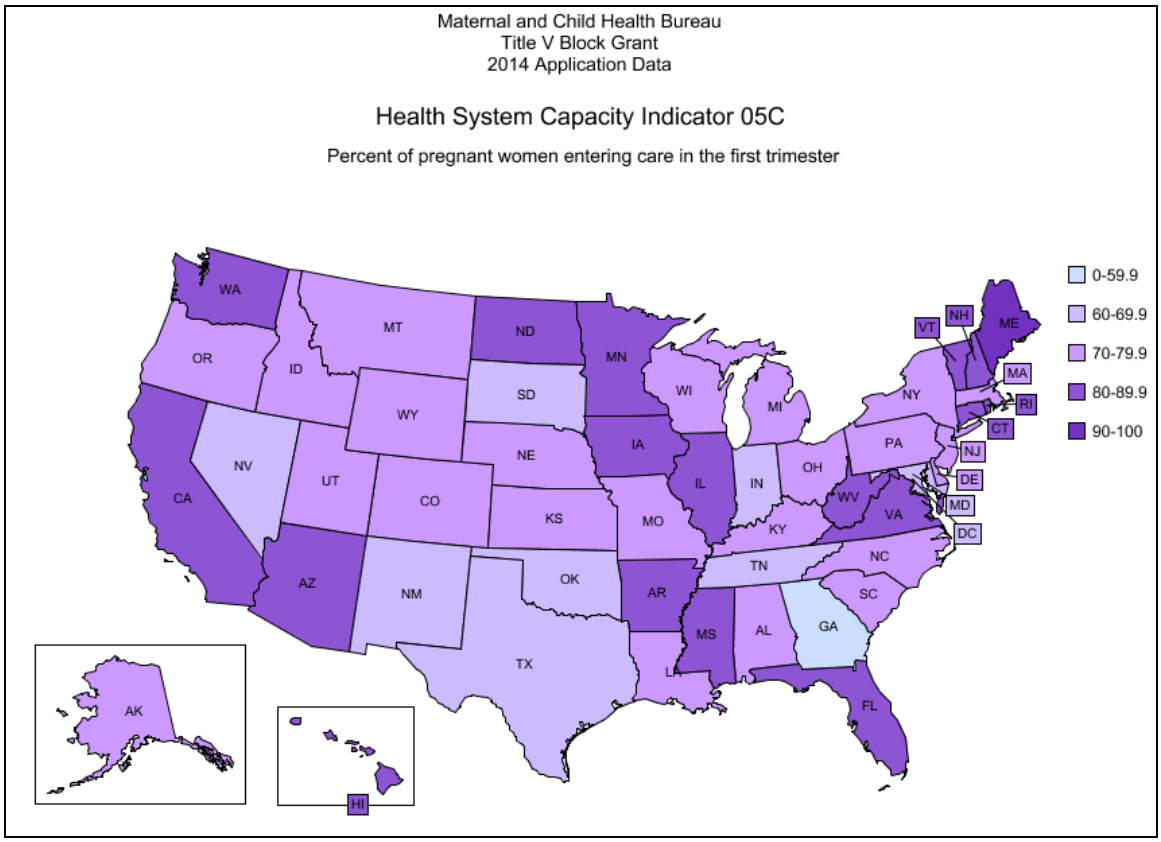


Source: HRSA Title V Information System: https://mchdata.hrsa.gov/tvisreports/Charts/MedicaidNonMedicaidCompMap.aspx?MeasureNum=05B&States=all&AppYear=2014 (map). For data, see https://mchdata.hrsa.gov/tvisreports/MeasurementData/HSCI/HSCI05Search.aspx?measurenum=05B&from=pd.

Note: Data represent the most recent year (FY2008-FY2012) reported by each state and are provisional for some states.

Figure D-2. Prenatal Care in the First Trimester

Percent of pregnant women entering care in the first trimester.



Source: HRSA Title V Information System: https://mchdata.hrsa.gov/tvisreports/Charts/MedicaidNonMedicaidCompMap.aspx?MeasureNum=05C&States=all&AppYear=2014 (map). For data, see https://mchdata.hrsa.gov/tvisreports/MeasurementData/HSCI/HSCI05Search.aspx?measurenum=05C&from=pd.

Note: Data represent the most recent year (FY2009-FY2012) reported by each state and are provisional for some states.

Appendix E. National Title V Performance and Outcome Measures

Table E-1 shows the national performance measures for Title V for FY2011-FY2015. **Table E-2** shows the national performance measures for Title V for FY2016 and later years.

Table E-3 and **Table E-4** show the national outcome measures. In addition, the Maternal and Child Health Bureau (MCHB) funds more than 700 projects each year through discretionary grants. **Table E-5** shows the Discretionary Grant Information System (DGIS) Performance Measures.

Table E-1. Title V Information System (TVIS) National Performance Measures, FY2011-FY2015

Description
1. Percentage of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their state-sponsored newborn screening programs.
2. Percentage of CSHCN[a] age 0 to 18 years whose families partner in decisionmaking at all levels and are satisfied with the services they receive. (CSHCN survey)
3. Percentage of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)
4. Percentage of CSHCN age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)
5. Percentage of CSHCN age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)
6. Percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
7. Percentage of 19- to 35-month-olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8. The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
9. Percentage of third grade children who have received protective sealants on at least one permanent molar tooth.
10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
11. The percentage of mothers who breastfeed their infants at 6 months of age.
12. Percentage of newborns who have been screened for hearing before hospital discharge.
13. Percentage of children without health insurance.
14. Percentage of children, aged 2 to 5 receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
15. Percentage of women who smoke in the last three months of pregnancy.
16. The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
17. Percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Source: HRSA Title V Information System (TVIS): https://mchdata.hrsa.gov/tvisreports/MeasurementData/StandardNationalMeasureIndicatorSearch.aspx?MeasureType=Performance&YearType=MostRecent.

Note: TVIS is HRSA's Title V Information System, which provides Title V program and performance data.

a. *Children with special health care needs* (CSHCN) are defined by HRSA as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

Table E-2. Title V Information System (TVIS) National Performance Measures, Beginning with FY2016 Annual Report

Description
1. To increase the number of women who have a preventive medical visit.
2. To reduce the number of cesarean deliveries among low-risk first births.
3. To ensure that higher risk mothers and newborns deliver at appropriate level hospitals.
4. To increase the proportion of infants who are breastfed and who are breastfed at six months.
5. To increase the number of infants placed to sleep on their backs.
6. Percentage of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.
7. To decrease the number of hospital admissions for non-fatal injury among children ages 0 through 19.
8. To increase the number of children and adolescents who are physically active.
9. To reduce the number of adolescents who are bullied or who bully others.
10. To increase the number of adolescents who have a preventive medical visit.
11. To increase the number of children with and without special health care needs who have a medical home.
12. To increase the percentage of adolescents with and without special health care needs who have received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
13. (A)To increase the number of pregnant women who have a dental visit during pregnancy and (B) To increase the number of children, ages 1 through 17 who had a preventive dental visit in the past year.
14. (A) To decrease the number of women who smoke during pregnancy and (B) To decrease the number of households where someone smokes.
15. To increase the number of children who are adequately insured.

Source: https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures.

Table E-3. TVIS National Outcome Measures, FY2011-FY2015

Description
The infant mortality rate per 1,000 live births.
The ratio of the black infant mortality rate to the white infant mortality rate.
The neonatal mortality rate per 1,000 live births.
The postneonatal mortality rate per 1,000 live births.
The perinatal mortality rate per 1,000 live births plus fetal deaths.
The child death rate per 100,000 children aged 1 through 14.
TVIS National Health Systems Capacity Indicators
The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.
The percentage of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
The percentage of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.
The percentage of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
Percentage of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
The percentage of EPSDT eligible children aged 6 through 9 who have received any dental services during the year.
The percentage of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN program.
Health Status Indicators
The percentage of live births weighing less than 2,500 grams.
The percentage of live singleton births weighing less than 2,500 grams.
The percentage of live births weighing less than 1,500 grams.
The percentage of live singleton births weighing less than 1,500 grams.
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24.
The rate per 100,000 of all nonfatal injuries among children aged 14 and younger.
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 and younger.
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24.
The rate per 1,000 women aged 15 through 19 with a reported case of chlamydia.
The rate per 1,000 women aged 20 through 44 with a reported case of chlamydia.

Source: HRSA Title V Information System, **Description:** http://mchdata.hrsa.gov/TVISReports/FinancialData/FinancialMenu.aspx; **TVIS National Health Systems Capacity Indicators:** https://mchdata.hrsa.gov/tvisreports/MeasurementData/StandardNationalMeasureIndicatorSearch.aspx?MeasureType=HSCI&YearType=MostRecent; **Health Status Indicators**: https://mchdata.hrsa.gov/tvisreports/MeasurementData/StandardNationalMeasureIndicatorSearch.aspx?MeasureType=HSI&YearType=MostRecent.

a. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

Table E-4. TVIS National Outcome Measures, Beginning with FY2016 Annual Report

Description
1. Percentage of pregnant women who receive prenatal care beginning in the first trimester.
2. Rate of severe maternal morbidity per 10,000 delivery hospitalizations.
3. Maternal mortality rate per 100,000 live births.
4. Percentage of low birth weight deliveries (<2,500 grams).
4.2. Percentage of very low birth weight deliveries (<1,500 grams).
4.3. Percentage of moderately low birth weight deliveries (1,500-2,499 grams).
5. Percentage of preterm births (<37 weeks).
5.2. Percentage of early preterm births (<34 weeks).
5.3. Percentage of late preterm births (34-36 weeks).
6. Percentage of early term births (37, 38 weeks).
7. Percentage of non-medically indicated early elective deliveries.
8. Perinatal mortality rate per 1,000 live births plus fetal deaths.
9. Infant mortality rate per 1,000 live births.
9.2. Neonatal mortality rate per 1,000 live births.
9.3. Post neonatal mortality rate per 1,000 live births.
9.4. Preterm-related mortality rate per 100,000 live births
9.5. Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births.
10. Percentage of infants born with fetal alcohol exposure in the last three months of pregnancy.
11. The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations.
12. Percentage of eligible newborns screened for heritable disorders with on time physician notification for out-of-range screens who are followed up in a timely manner. (Developmental).
13. Percentage of children meeting the criteria developed for school readiness (Developmental).
14. Percentage of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months.
15. Child mortality rate, ages 1 through 9 per 100,000.
16. Adolescent mortality rate ages 10 through 19 per 100,000.
16.2. Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000.
16.3. Adolescent suicide rate, ages 15 through 19 per 100,000.
17. Percentage of children with special health care needs.
17.2. Percentage of children with special health care needs (CSHCN) receiving care in a well-functioning system.
17.3. Percentage of children diagnosed with an autism spectrum disorder.
17.4. Percentage of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD).
18. Percentage of children with a mental/behavioral condition who receive treatment or counseling.
19. Percentage of children in excellent or very good health.
20. Percentage of children and adolescents who are overweight or obese (BMI at or above the 85th percentile).

Description
21. Percentage of children without health insurance.
22. Percentage of children ages 19 through 35 months, who completed the combined 7-vaccine series.
22.2. Percentage of children 6 months through 17 years who are vaccinated annually against seasonal influenza.
22.3. Percentage of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine.
22.4. Percentage of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine.
22.5. Percentage of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine.

Source: https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures.

The Maternal and Child Health Bureau (MCHB) funds more than 700 projects each year through discretionary grants. The MCHB Discretionary Grant Information System (DGIS) electronically captures performance measures (see **Table E-5**), program, financial, and abstract data, and products and publications about these discretionary grants from the grantees. The data collected are used by MCHB project officers to monitor and assess grantee performance as well as assist in monitoring and evaluating MCHB's programs. The MCHB is planning to revise the performance measures requirements for its discretionary programs. The notice pertaining to changes in the DGIS was published in the *Federal Register* on March 15, 2016. According to the MCHB,

> MCHB's purpose in revising the performance measures is to better measure progress toward program goals. These program goals include alignment with and support of the Title V Block Grant, specifically population domains and National Performance Measures, where reasonable. Further, the revised measures will more accurately capture the scope of services provided through this grant funding. The overall number of performance measures has been reduced from prior DGIS data collection, and the average number of performance measures each grantee will be required to report is reduced as well. Further, the structure of the data collection has been revised to better measure the various models of programs and the services each funded program provides. This revision will allow a more accurate and detailed picture of the full scope of services provided through grant programs administered by MCHB.[68]

Table E-5. Discretionary Grant Information System (DGIS) Performance Measures

Description
The degree to which HRSA's Maternal and Child Health Bureau (MCHB) supported programs ensure family participation in program and policy activities.
The percentage of graduates of MCHB long-term training programs who demonstrate field leadership after graduation.
The percentage of participants in MCHB long-term training programs who are from underrepresented groups.
The degree to which MCHB-supported programs have incorporated cultural competence elements into their policies, guidelines, contracts, and training.
The degree to which MCHB long-term training grantees include cultural competency in their curricula/training.
The degree to which states and communities use "morbidity/mortality" review processes in MCH needs assessment, quality improvement, and/or data capacity building.
The degree to which grantees have assisted states in increasing the percentage of children with special health care needs, aged 0 to 18, whose families have adequate private and/or public insurance to pay for needed services.
The percentage of all children from birth to age 18 participating in MCHB-supported programs who have a medical home.
The degree to which grantees have assisted states in increasing the percentage of children with special health care needs aged 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home
The percentage of women participating in MCHB supported programs who have an ongoing source of primary and preventive care services for women.
The percentage of women participating in MCHB supported programs requiring a referral, who receive a completed referral.

[68] *Federal Register*, vol. 81, no. 50, March 15, 2016, Health Resources and Services Administration, "Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request Notices," pp. 13805-13806.

Description
The degree to which MCHB supported programs facilitate health providers' screening of women participants for risk factors.
The degree to which grantees have assisted states in increasing the percentage of children who are screened early and continuously for special health care needs and linked to medical homes, appropriate follow-up, and early intervention.
The degree to which state agencies work collaboratively to develop a plan for building early childhood service systems.
The degree to which grantees have assisted states in organizing community-based service systems so that families of children with special health care needs can use them easily.
The number of states that include in their oral health plans at least 5 of the 10 essential elements of the guidelines included in the Association of State and Territorial Dental Directors' (ASTDD) "Building Infrastructure & Capacity in State and Territorial Oral Health Programs."
The degree to which states and communities have implemented comprehensive systems for women's health services.
The percentage of pregnant participants of MCHB-supported programs who have a prenatal care visit in the first trimester of pregnancy.
The degree to which grantees have assisted states in increasing the percentage of youth with special health care needs who have received services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
Percentage of very low birth weight live births.
Percentage of live singleton births weighing less than 2,500 grams.
The infant mortality rate per 1,000 live births.
The neonatal mortality rate per 1,000 live births.
The post-neonatal mortality rate per 1,000 live births.
The perinatal mortality rate per 1,000 live births.
The percentage of MCH training faculty who demonstrate field leadership in the areas of academic, clinical, public health/policy, and advocacy.
The degree to which a training program collaborates with state Title V agencies, other MCH or MCH-related programs.
The percentage of long-term trainees who, at 1, 5, and 10 years post training, work in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families).
The degree to which Leadership Education in Neurodevelopmental Disabilities (LEND) programs incorporate medical home concepts into their curricula/training.
The degree to which the Leadership Education in Adolescent Health (LEAH) program incorporates adolescents and parents from diverse ethnic and cultural backgrounds as advisors and participants in program activities.
The percentage of individuals who participated in long-term nutrition training that are practicing in a MCH-related field within five years after receiving training.
The percentage of families with Children with Special Health Care Needs (CSHCN) that have been provided information, education, and/or training by Family-to-Family Health Information Centers.
The percentage of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
The percentage of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
The percentage of hospitals with an Emergency Department (ED) in the state/territory that have written inter-facility transfer guidelines that cover pediatric patients and that contain all the components as per the implementation manual.

Description
The degree to which the state/territory has established permanence of emergency medical services for children (EMSC) in the state/territory EMS system.
The degree to which the state/territory has established permanence of EMSC in the state/territory EMS system by integrating EMSC priorities into statutes/regulations.

Source: HRSA Title V Discretionary Grant Information Systems (DGIS): https://mchdata.hrsa.gov/dgisreports/PerfMeasure/PerfMeasureReports.aspx?Report=PMsByTopic&archived=0.

Author Contact Information

(name redacted)
Specialist in Social Policy
[redacted]@crs.loc.gov , 7-....