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SUMMARY

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Alexandria K. Mickler
Analyst in Health Policy

Maternal and Child Health Services Block Grant: Overview and Issues for Congress

The Maternal and Child Health (MCH) Services Block Grant program aims to support and improve the health and well-being of mothers, children, and families, particularly those with low income or limited access to health services. The program consists of three separate activities: (1) the State MCH Block Grant program, (2) Special Projects of Regional and National Significance (SPRANS), and (3) Community Integrated Service Systems (CISS). These activities are permanently authorized under Title V, Section 501, of the Social Security Act (SSA). The program is administered by the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS).

State MCH Block Grant

The State MCH Block Grant program is the nation's oldest federal-state partnership and receives the largest proportion of MCH Services Block Grant funding. States and jurisdictions (collectively referred to as *states* in this report) must match $3 for every $4 in federal funding allotted to the state; federal allotments are determined based on prior federal funding levels and state-specific child poverty data. State MCH Block Grant funds aim to provide each state the flexibility to meet the unique needs of its population of pregnant women, infants, and children, including children and youth with special health care needs (CYSHCNs). State MCH Block Grant funds can be used to provide a variety of MCH services, including direct health care services (e.g., preventive and primary care services), enabling services (e.g., case management and care coordination services), and public health services and systems (e.g., workforce training and quality improvement activities).

Special Projects of Regional and National Significance

SPRANS funding provides grants for projects that aim to address national or regional needs, priorities, or emerging MCH issues. SPRANS funding is intended to complement other MCH Block Grant activities and related federal programs by building capacity through pilot programs, research, training, data, quality improvement, and workforce development. Specific set-asides, such as for sickle cell disease research, and directives toward priority areas, such as reducing maternal morbidity and mortality, are typically established through annual appropriations acts. The remaining funding supports additional activities authorized by statute. Funding is open to a variety of entities, including institutions of higher learning, nonprofit organizations, and community organizations.

Community Integrated Service Systems

CISS funding provides grants for projects aimed at increasing local service delivery capacity and fostering comprehensive and integrated community services for MCH populations. CISS authorizing legislation specifically mentions the following topics: MCH home visiting and case management, health education and social support services, health workforce participation under Medicaid and the Title X Family Planning Program, integrated MCH delivery systems, and programs that focus on rural populations and CYSHCNs. CISS funding is preferentially awarded to projects implemented in an area with a high infant mortality rate.

Appropriations

Funding for the MCH Services Block Grant is discretionary and determined through the federal annual appropriations process. Current law permanently authorizes $850 million across all three components from FY2001 onwards. In FY2024, the program received an appropriation of $815.7 million. Of this amount, $593.3 million was allotted to the State MCH Block Grant component (73%), $210.1 million to SPRANS (26%), and $10.3 million to CISS (1%). The President's FY2025 budget request is $831.7 million.

Topics Covered in This Report

This report provides background, funding, and program information for each of the three program activities authorized in Title V, Section 501. Additionally, it identifies selected MCH policy issues for Congress's consideration. Other programs authorized under SSA Title V are briefly summarized in **Appendix L**.

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Introduction

Title V of the Social Security Act (SSA; P.L. 74-271, as amended; 42 U.S.C. §§701-709) permanently authorizes the Maternal and Child Health (MCH) Services Block Grant, which aims to support and improve the health and well-being of mothers, children, and families, particularly those with low income or with limited access to health care services. The program provides services to pregnant women, infants, children, and children and youth with special health care needs (CYSHCNs), though other individuals may also benefit from block grant-funded activities.[1] The MCH Services Block Grant is administered by the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA), an agency within the U.S. Department of Health and Human Services (HHS).

SSA Section 501 permanently authorizes three activities within the MCH Services Block Grant program (hereinafter referred to as *components*):

1. State MCH Block Grants (§501(a)(1)).[2]
2. Special Projects of Regional and National Significance (SPRANS; §501(a)(2)).
3. Community Integrated Service Systems (CISS; §501(a)(3)).

The first and largest component is awarded directly to states and other jurisdictions (referred to hereinafter as *states*)[3] through a formula-based, federal-state partnership. The State MCH Block Grant program aims to provide states the flexibility to meet the unique needs of its population of pregnant women, infants, and children. The remaining two components provide competitive grant funding to projects that intend to complement state efforts to improve access to quality MCH services. SPRANS projects focus on national or regional needs and priorities, including specific set-asides or directives that are typically established through annual appropriations acts. CISS projects aim to build comprehensive, integrated systems of care to improve access and outcomes for all children, including CYSHCNs.

History

Title V of the Social Security Act (SSA), enacted by Congress in 1935, authorizes funding for services and projects that are intended to improve the health of mothers and children. Originally,

[1] This report uses "pregnant women" to refer to pregnant individuals who have the capacity to give birth to be consistent with terms used in both Title V legislation and in the Health Resources and Services Administration's (HRSA's) current Title V MCH Block Grant guidance documents, available at https://mchb.tvisdata.hrsa.gov/Home/Resources. According to the MCHB, children and youth with special health care needs (CYSCHN) "have or are at increased risk for having chronic physical, developmental, behavioral, or emotional conditions. They have conditions such as asthma, sickle cell disease, epilepsy, anxiety, autism, and learning disorders. They may require more specialized health and educational services to thrive, even though each child's needs may vary." For more information, see https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn.

[2] The State MCH Block Grant program is often referred to as "Title V MCH Services Block Grant to States Program," "MCH Block Grant," "State Formula Grants," or colloquially and simply as "Title V." This report uses "State MCH Block Grant" and "State MCH Block Grant Program" to avoid confusion with the overarching program and legislative title (Title V—MCH Services Block Grant) and to align with the terms used in HRSA's FY2024 and FY2025 Congressional Budget Justifications. This terminology also allows for nuanced descriptions of the three program components authorized under Section 501 of Title V (State MCH Block Grants, SPRANS, and CISS). This report focuses exclusively on the three programs authorized and described in SSA §§501-509. Additional information on other Title V programs is available in **Appendix L**.

[3] Referred to collectively as "states" in this report, all 50 states and nine jurisdictions are eligible to apply for the State MCH Block Grant program. The nine jurisdictions consist of (1) American Samoa, (2) District of Columbia, (3) Federated States of Micronesia, (4) Guam, (5) Marshall Islands, (6) Northern Mariana Islands, (7) Palau, (8) Puerto Rico, and (9) U.S. Virgin Islands.

four separate grant programs were created under the previous SSA statutory heading, "Title V–Grants to States for Maternal and Child Welfare," two of which related to MCH. These programs aimed to (1) provide and improve health services for mothers and children, particularly those with low-income or who live in rural settings, and (2) provide and improve health care services for "children who are crippled or who are suffering from conditions which lead to crippling," respectively.[4] Over time, additional categorical programs for low-income women and children were added to both the SSA and the Public Health Service Act (PHSA).

In 1981, seven of the aforementioned programs were combined with Title V through the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981; P.L. 97-35).[5] This consolidated and renamed statute, "Title V–Maternal and Child Health Services Block Grant," was intended to provide states additional flexibility in determining how to use federal funds to address state-specific MCH needs. It required each state to receive, at a minimum, the combined funding of the programs consolidated under OBRA 1981 and authorized a federal set-aside for discretionary grants—thereby establishing the SPRANS program.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989; P.L. 101-239) made additional changes to the MCH Services Block Grant. These changes increased the amount of federal funding authorized, called for greater accountability, and created stricter application and reporting requirements for states, including the requirement for a statewide needs assessment to be conducted every five years in order to receive State MCH Block Grant Program funds. OBRA 1989 also introduced the requirement for states to maintain a level of state contributions equal to or greater than that of the state contributions in 1989, known today as the *Maintenance of Effort* level. Additionally, OBRA 1989 added Section 501(a)(3), which authorized federal funding to develop and expand a variety of community-based care coordination services to "promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families." This new authorization designated funding to such services when the amount appropriated to the MCH Services Block Grant exceeds $600 million; this component is now known as the CISS program.[6]

In addition to the three components of the MCH Services Block Grant, current Title V legislation authorizes funding for additional services and projects aimed to improve the health of mothers and children, many of which were added or amended by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). These include the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and other categorical grant programs such as those focused on personal responsibility and abstinence education.[7] A brief discussion of these

[4] The other two grant programs under the previous SSA statutory heading were related to child welfare services and vocational rehabilitation for physically disabled individuals. For more information on programs contained in the original statute, see https://www.ssa.gov/history/35actv.html#Part3.

[5] The programs that were consolidated by P.L. 97-35 were maternal and child health and services for children with special health needs; supplemental security income for children with disabilities; lead-based paint poisoning prevention programs; genetic disease programs; sudden infant death syndrome programs; hemophilia treatment centers; and adolescent pregnancy prevention grants.

[6] Section 501(a)(3) authorized funds in FY1989, but the CISS program did not receive funds until FY1992. FY1992 was the first fiscal year since 1989 that appropriations for the Title V MCH Services Block Grant exceeded $600 million. Note that CISS is not explicitly mentioned by name in the SSA; however, the program is operationalized as such by MCHB in alignment with the authorizing legislation.

[7] Also authorized under SSA Title V, these programs are not part of the Title V MCH Services Block Grant programs authorized under Section 501. To learn more about the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, see CRS In Focus IF10595, *Maternal, Infant, and Early Childhood Home Visiting Program*. To learn more about the Personal Responsibility Education Program (PREP) and the Title V Sexual Risk Avoidance Education Program (Title V SRAE), see CRS In Focus IF10877, *Federal Teen Pregnancy Prevention Programs*.

programs is available in **Appendix J**. This report focuses exclusively on the MCH Services Block Grant program (authorized in SSA §501 and referred to in SSA §§501-509), which receives the largest single federal appropriation of all programs authorized under Title V.[8] Current law permanently authorizes $850 million across all three components of the MCH Service Block Grant program.[9]

Funding

Figure 1 displays the MCH Services Block Grant federal appropriation history by program component from FY2020 through FY2024. Additional federal appropriation history appears in **Table A-1** in **Appendix A**.

SSA Section 502 mandates the following annual allocation formula (per fiscal year) for federal funds across each of the MCH Services Block Grant components:

- SPRANS: 15% of the appropriation that does not exceed $600 million, and 15% of funds remaining above $600 million after CISS funds are set aside.
- CISS: 12.75% of the appropriation that is above $600 million.
- State MCH Block Grants: remainder of the total federal appropriation.

Annual appropriations acts have frequently deviated from this formula. For example, the Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), mandated that no more than $219.116 million of FY2023 funds would be made available to SPRANS and that $10.276 million would be made available for CISS, "notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act."[10] Through this approach, Congress effectively increased the proportion and amount of FY2023 funds allocated to SPRANS ($219.116 million, compared with $119.5 million per the §502 formula) and decreased the amount appropriated to CISS ($10.276 million, compared with $28.394 million that would have been available under the §502 formula). Conversely, Congress has used this approach to decrease the proportion of funds for SPRANS and increase the proportion for CISS, such as in FY2014.[11]

[8] As of FY2024, the MCH Services Block Grant received $816.2 million. See **Figure 1** and **Table A-1** for additional funding history.

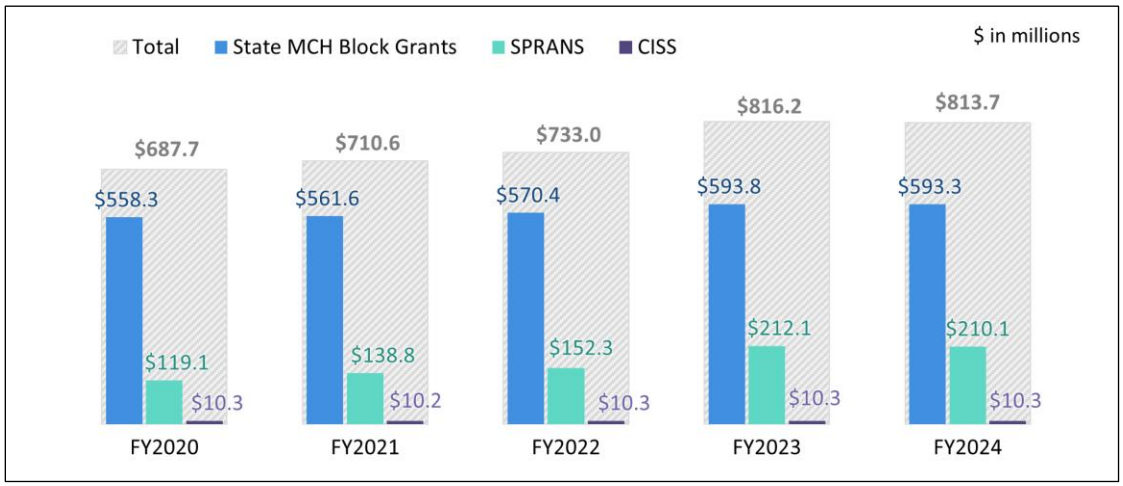
[9] P.L. 106-554 substituted "$850,000,000 for fiscal year 2001" for "$705,000,000 for fiscal year 1994" in introductory provisions.

[10] Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), 136 STAT. 4856

[11] The Consolidated Appropriations Act, 2014 (CAA 2014; P.L. 113-76), 128 STAT.364, designated not more than $77.1 million to SPRANS (compared with $94.3 million per the §502 formula) and $10.3 million to CISS (compared with $9.7 million under the §502 formula).

Figure 1. MCH Services Block Grant Funding, by Component

FY2020–FY2024



Source: Figure created by CRS using final funding levels as reported in annual Department of Health and Human Services, Health Resources and Services Administration (HRSA) Congressional Budget Justifications for FY2020-2023. FY2024 figures reflect enacted totals, rather than final numbers, based on P.L. 118-47 and *Congressional Record,* vol. 170, no. 51, book II, March 22, 2024, p. H1887.

Notes: MCH = Maternal and Child Health; FY = Fiscal Year. Amounts not adjusted for inflation.

State MCH Block Grant Program

The majority of MCH Services Block Grant funding is allotted to states through the formula-based, State MCH Block Grant program. The State MCH Block Grant program is the oldest federal-state partnership program and aims to "*create partnerships that enable each state/jurisdiction to address the health service needs of its mothers, infants, and children, which includes children with special health care needs and their families*."[12] State health agencies are typically responsible for the overall administration and supervision of activities implemented under the program.[13]

Purpose

Section 501(a)(1) of Title V establishes the purpose of the State MCH Block Grant program as aiming to enable each state to

- ensure access to quality health care services for mothers and children, particularly to those with low income or limited availability of care;
- reduce the number of infant deaths, preventable diseases, and children with disabilities;
- reduce the need for inpatient and long-term care services;
- increase the number of children receiving immunizations, health assessments, and follow-up diagnostic and treatment services;
- provide prenatal, delivery, and postpartum care for low-income, at risk-women;

[12] HRSA, *Explore the Title V Federal-State Partnership*, https://grants6.tvisdata.hrsa.gov/Home.

[13] SSA §509(b).

- provide preventive and primary care services for low-income children;
- provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Social Security Insurance (SSI) (Title XVI of the SSA),[14] if the services are not provided under Medicaid (SSA Title XIX);[15]
- promote and provide family-centered, community-based coordinated care services for CYSCHNs; and
- facilitate the development of community-based systems of services for CYSCHNs and their families.

According to HRSA, all State MCH Block Grant programs are guided by four key principles that support the delivery of public health services and systems to address the needs of MCH populations.[16] These principles are as follows:

1. Delivery of MCH services within a public health service model.[17]
2. Data-driven programming and performance accountability.[18]
3. Partnerships with individuals, families, and family-led organizations to ensure systems and services that support the interests of all MCH populations.
4. Health equity and assurance that all MCH populations achieve their full health potential.

Funding

The State MCH Block Grant program receives the remaining federal appropriation after federal funds for both SPRANS and CISS are allocated (see the "Funding" section above). All 50 states and nine jurisdictions may apply for State MCH Block Grant funds. Historically, all 59 have applied for and been awarded State MCH Block Grant funds since HRSA began administering the program in 1981.[19] Each state is responsible for using block grant funds to meet the unique needs of its MCH populations in alignment with federal requirements.[20]

Federal funds are annually allotted to individual state recipients using a formula-based approach that considers (1) the amount of federal funds historically allotted to each state, and (2) the proportion of low-income children in each state relative to the total number of low-income children nationwide. Specifically, the first $422 million of the annual federal appropriation is distributed to each state based on the amount it received under the consolidated maternal and child health program in FY1983.[21] Remaining federal appropriations are distributed to each state

[14] Title XVI of the SSA refers to Supplemental Security Income for the Aged, Blind, and Disabled.

[15] Title XIX of the SSA refers to Grants to States for Medical Assistance Programs (Medicaid).

[16] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report*, p. 2., OMB No: 0915-0172, https://mchb.tvisdata.hrsa.gov/Admin/FileUpload/DownloadContent?fileName=BlockGrantGuidance.pdf&isForDownload=False. Hereinafter HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report.*

[17] See "Services Provided" for more information on HRSA's suggested public health service model.

[18] See "Application and Reporting Requirements" for more information on performance accountability.

[19] Email correspondence with HRSA staff, February 16, 2024.

[20] This report generally uses "states" to refer to both states and jurisdictions, except as noted.

[21] This amount ($422 million) is the sum of the funding for the individual programs that were consolidated into the Title V MCH Services Block Grant under OBRA 1981 (P.L. 97-35).

using child poverty-based allotments.[22] Historically, poverty allotments were calculated based on data reported in the U.S. Census Bureau's long-form decennial census. The annual American Community Survey (ACS) replaced the decennial census as the block grant's source for child poverty data in FY2013.[23] Historically, the U.S. Territories (American Samoa, Northern Mariana Islands, Guam, U.S. Virgin Islands, and Puerto Rico) and the Freely Associated States (Federated States of Micronesia, Marshall Islands, and Palau) have not been included in the ACS. For these jurisdictions, HRSA distributes funds in excess of the 1983 level in a manner proportionate to each jurisdiction's share of overall State MCH Block Grant funding in 1983.[24] This approach does not incorporate poverty-based allotments.

In FY2022, the year for which the most recent federal data are available, final federal allotments to individual states ranged from $150,340 (Palau) to $39.6 million (California).[25] The distribution of State MCH Block Grant federal funds by state in FY2022 is displayed in **Figure 2** and is listed in **Table B-1** in **Appendix B**.

[22] SSA §502(c).

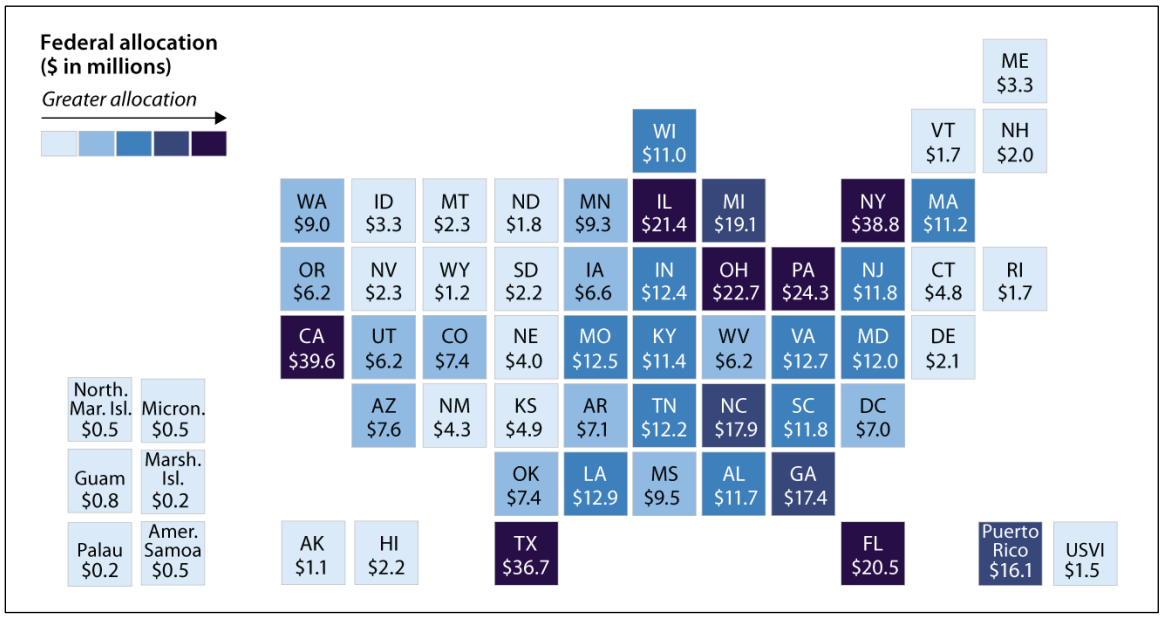
[23] From FY2013 to FY2016, block grant poverty allocations were based on three-year rolling ACS estimates. The Census Bureau discontinued three-year ACS estimates for FY2017, prompting HRSA to use pooled data across three one-year estimates. HRSA implemented a temporary change in this method due to ACS 2020 survey disruptions and data quality issues resulting from the COVID-19 pandemic. Under this change, FY2020 ACS data were to be excluded from poverty calculations for FY2023-FY2025. HRSA will resume three consecutive one-year estimates for FY2026 calculations. See https://www.federalregister.gov/documents/2022/09/09/2022-19477/notice-of-intent-to-make-temporary-changes-in-the-state-title-v-maternal-and-child-health-block.

[24] Email correspondence with MCHB staff, June 7, 2024.

[25] Final state allocations for FY2023 were reported in HRSA's FY2025 Congressional Budget Justification. However, at the time of this report, the most recent data for all other metrics published on the Title V Information System (TVIS) are from FY2022. As such, this report uses FY2022 figures for consistency. Full data for FY2023 is expected to be available on the Title V Information System (TVIS) between November-December 2024; see https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport.

Figure 2. State MCH Block Grant: Federal Allotments

FY2022



Source: Figure created by CRS using final FY2022 federal funding allotments as reported in HRSA's FY2024 Congressional Budget Justification, pp. 198-200.

As part of a federal-state partnership program, each state is required to match at least $3 for every $4 of federal block grant funds allotted to the state.[26] States must also maintain a level of state contribution that is at or above the state's total contribution from FY1989, known as the *Maintenance of Effort*.[27] States are allowed to exceed the match requirement; this is called an *overmatch.*

HRSA categorizes the total funding for the State MCH Block Grant program as coming from five sources:[28]

1. **Federal Allocation:** Federal funding provided to states under the MCH Services Block Grant.
2. **State MCH funds:** Nonfederal funds derived from the state that are used for program activities and meet the legislatively mandated match requirements.
3. **Local MCH funds:** MCH-dedicated funds from local governments or jurisdictions within the state.
4. **Program Income**: Funds collected by state MCH agencies from insurance payments, Medicaid, health maintenance organization (HMO) payments, private grants/entities, etc.
5. **Other federal funds:** Monies other than Title V funds that are under control of the person responsible for administering the Title V program (e.g., funds from Centers for Disease Control and Prevention [CDC]; Healthy Start; and the

[26] SSA §503(a).

[27] SSA §504(a)(4). Each state's FY1989 Maintenance of Effort total is documented by the state in the combined Application/Annual Report, which are publicly available on the Title V Information System (TVIS).

[28] HRSA, Title V Information System, *Glossary*, https://mchb.tvisdata.hrsa.gov/Glossary/Glossary.

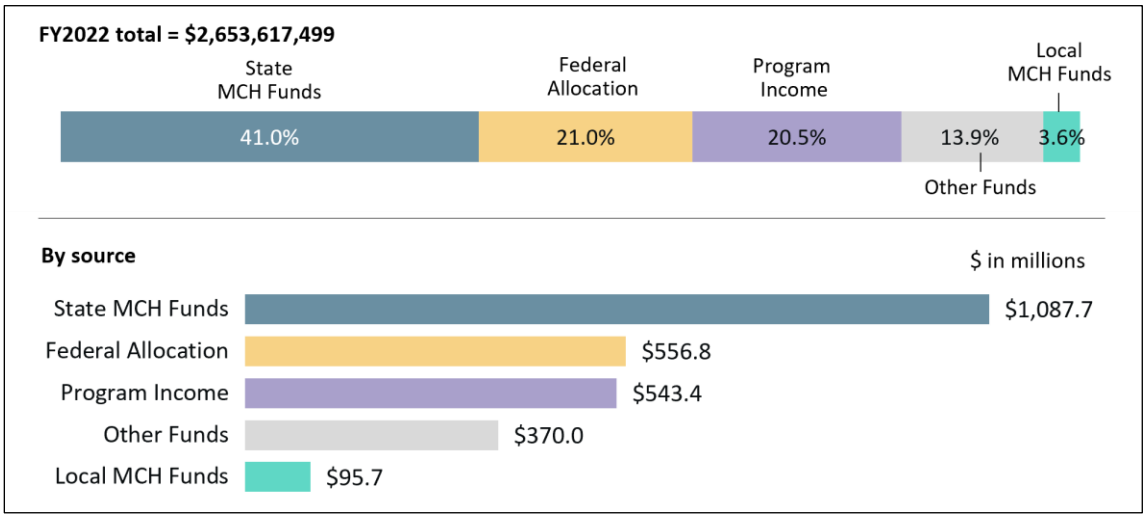
Supplemental Special Nutrition Program for Women, Infants, and Children [WIC]).

States are allowed to put all nonfederal funding sources toward meeting the state match requirement; that is, state MCH funds, local MCH funds, and program income may contribute to the required maintenance of effort total (items 2-4 above).

In FY2022, state MCH funds constituted the largest proportion of total State MCH Block Grant program funding (41.0%), whereas federal allocations accounted for 21.0% (see **Figure 3**). Combining all five funding sources, the State MCH Block Grant program totaled an estimated $2.65 billion in FY2022. Individual state totals across each of these five funding sources are presented in **Table B-1** in **Appendix B**. Trends in program expenditures by service category and population group are discussed below (see "Expenditures by Service Category" and "Expenditures by Population Group," respectively). Unless otherwise noted, all expenditure data hereinafter are inclusive of all funding sources.

Figure 3. State MCH Block Grant Funding, by Source

FY2022



Source: Figure created by CRS using final federal allocation data reported in HRSA's FY2024 Congressional Budget Justification, pp. 198-200. State funds, other local funds, and program income totals were extracted from individual state Application/Annual Reports, Form 2, FY2022 Expenditures column. Each state Application/Annual Report is located on HRSA's Title V Information System (TVIS); https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport.

Notes: TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. The FY2022 expenditures presented above were reported in July 2023 and thus may not reflect final state, local, or program income expenditures. Not all states submit data on the "other funds" or "program income" categories.

Nonuse and Redistribution

According to SSA Section 502(d), if a state chooses not to apply for funds, is not qualified for such funds, or indicates that it does not plan to use its full allotment, that state's federal allotment is redistributed among the remaining states in the proportion otherwise allotted to the state.[29] All states have applied for and been awarded funds since HRSA began administering the program in

[29] SSA §502(d).

1981.[30] Each state has 24 months to expend its full federal allotment. MCHB staff monitor expenditure drawdown and identify expenditure plans with any states that have more than one-quarter of funds remaining at the 18-month mark. Any funds not expended at the end of the 24-month period are returned to the U.S. Treasury Department.[31]

Services Provided

States are required to use State MCH Block Grant funds "to provide and to assure [that] mothers and children (in particular those with low income or with limited availability of health services) [have] access to quality maternal and child health services."[32] Specifically, states may use block grant funds for the provision of health services and related activities, which may include "planning, administration, education, and evaluation, including payment of salaries and other related expenses of National Health Service Corps personnel."[33] According to MCHB, State MCH Block Grant Programs are encouraged to incorporate the four key principles discussed in the "Purpose" section above and to ensure that MCH systems are family centered, community based, and culturally competent.[34]

The MCHB provides a guiding framework, known as the *MCH Pyramid of Services*, to support states in identifying which MCH services and activities to fund with block grant resources. Broadly, pyramid structures are used in various public health capacities to visually communicate the potential impact of certain public health interventions, with the base of the pyramid reflecting interventions that reach larger populations at once. Interventions that aim to change individual contexts are presented in ascending order. The MCH Pyramid of Services is also referenced in states' Application/Annual Reports to measure program participation, reach, and expenditures across three service categories: (1) direct health care services, (2) enabling services, and (3) public health services and systems. **Figure 4** contains definitions of each service category and an illustrative, nonexhaustive list of examples by service category.

[30] Email correspondence with HRSA staff, February 16, 2024.

[31] Email correspondence with HRSA staff, April 29, 2024.

[32] SSA §501(a)(1)(A).

[33] SSA §504(a). For more information on the National Health Corps, see CRS Report R44970, *The National Health Service Corps*.

[34] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 82.

Figure 4. MCH Pyramid of Services and Illustrative Examples

Direct Health Care Services

- Primary care or emergency department visits
- Inpatient services for CYSHCN
- Occupational, physical, and/or speech therapy
- Prescription drugs
- Mental and behavioral health services
- Durable medical equipment or medical supplies
- Dental and/or vision care

Enabling Services

- Translation and/or interpretation services
- Case management and/or care coordination
- Environmental health risk reduction activities
- Health education for individuals and/or families
- Outreach and/or eligibility assistance
- Salary or operational support to health facilities that provide access to MCH care

Public Health Services and Systems

- Development of policies, standards, and/or guidelines
- Health promotion campaigns for MCH services (e.g., newborn screening, safe-sleep education)
- Implementing MCH programs and/or evaluations
- Health workforce development activities, such as training on MCH core competencies
- Quality assurance and improvement activities

Source: Figure created by CRS using HRSA's *Title V Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report*. pp. 82-83. OMB No: 0915-0172, illustrative examples.

In addition to the MCH Pyramid of Services, the MCHB provides an illustrative list of 11 strategies for states to use in their program planning. This list draws upon (1) the three core functions of public health, as defined by the Institute of Medicine; (2) the revised Ten Essential Public Health Services; and (3) legislative requirements for Title V services.[35] The full list of strategies is presented in **Appendix C**. States also have the flexibility to implement additional

[35] A 1988 Institute of Medicine (IOM) report defined the core functions of public health as assessment, policy development, and assurance. For more information, see Institute of Medicine, *The Future of Public Health*, National Academy Press, 1988. To ensure that the IOM functions were operationalized and supported the unique needs of women and children, the MCH community worked with the Public Health Service and the IOM to further identify 10 Essential Public Health Services in 1994. For more information, see *Public Health in America* (1994), Washington, DC: US Public Health Service, Essential Public Health Services Working Group of the Core Public Health Functions Steering Committee. The IOM is now known as the National Academy of Medicine.

frameworks or health service models to better understand how various factors influence the health and well-being of a state's unique MCH population.

Service Requirements for Federal Funds

States are required to use at least 30% of federal allocations for preventive and primary care services for children and 30% for CYSHCNs.[36] These requirements may be waived by the HHS Secretary if the state (1) demonstrates "extraordinary unmet need" for either of the required populations, and (2) provides assurances that some funds will be allocated toward each required population by specifying the substitute percentages.[37] This waiver may be requested in the state's annual application.[38] Additionally, no more than 10% of federal allocations may be used for administrative costs.[39]

Prohibited Services

Section 504 of the SSA prohibits the use of State MCH Block Grant funds for the following activities:[40]

- inpatient services, other than for children with special health care needs, high-risk pregnant women, and infants, unless otherwise approved by the Secretary of HHS;
- cash payments to intended recipients of health services;
- purchase or improvement of land, buildings, or facilities (other than minor remodeling), or the purchase of major medical equipment;[41]
- to satisfy any requirement for the expenditure of nonfederal funds as a condition for the receipt of federal funds;[42]
- research or training at a private, for-profit entity,[43] and
- payment for any item or service (other than an emergency item or service) furnished by an individual, entity, or physician excluded under Titles V, XVIII, XIX, or XX of the SSA.[44]

[36] SSA §505(a)(3).

[37] SSA §505(b)(1-2).

[38] Based on a February 2024 CRS review of all FY2024 state applications, no states have requested this waiver.

[39] SSA §504(d).

[40] SSA §405(a-c).

[41] Per SSA §504(b), "The Secretary may waive the limitation ... upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this title."

[42] For example, this requirement would seem to prohibit states from using federal allotments from the State MCH Block Grant to satisfy a state match or maintenance of effort (MOE) requirement for other federal programs.

[43] Per §504(c), "A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, and administering programs funded under this title."

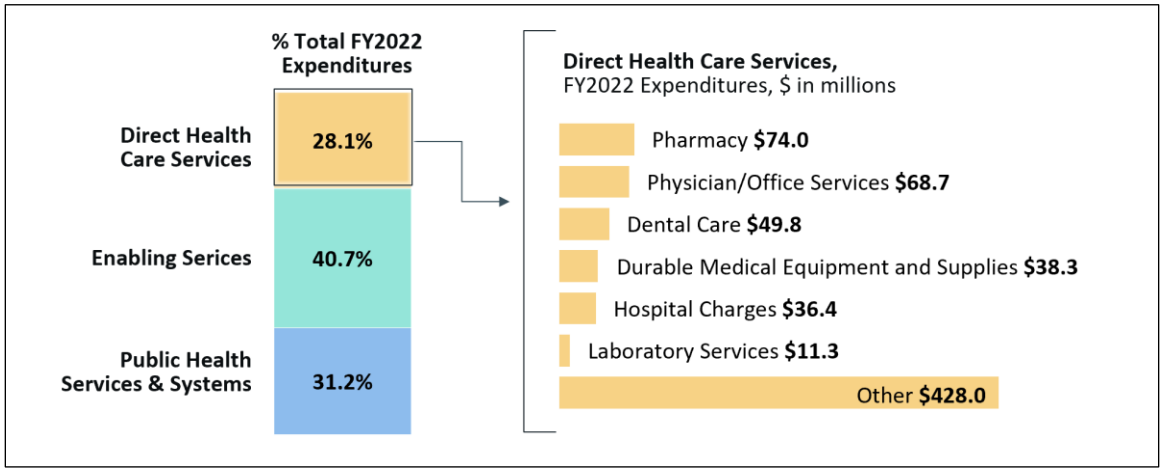
[44] Title XVIII of the SSA refers to Health Insurance for the Aged and Disabled. Title XX of the SSA refers to Block Grants and Programs for Social Services and Elder Justice, which includes the Social Services Block Grant (SSBG). For more information on SSBG, see CRS Report 94-953, *Social Services Block Grant: Background and Funding*.

Expenditures by Service Category

States are required to provide budgeted and actual program expenditure data as part of the *Application/Annual Report*.[45] This includes detail on all expenditures by service category (see **Figure 4**), in addition to other requirements. Across all states and all five funding sources, the largest proportion of FY2022 funds were expended on enabling services (40.7%), followed by public health services and systems (31.2%), and direct health care services (28.1%) (see **Figure 5**).

Figure 5. State MCH Block Grant Expenditures, by Service Category

FY2022



Source: Figure created by CRS using data from HRSA's Title V Information System (TVIS); https://mchb.tvisdata.hrsa.gov/Financial/FundingByServiceLevel.

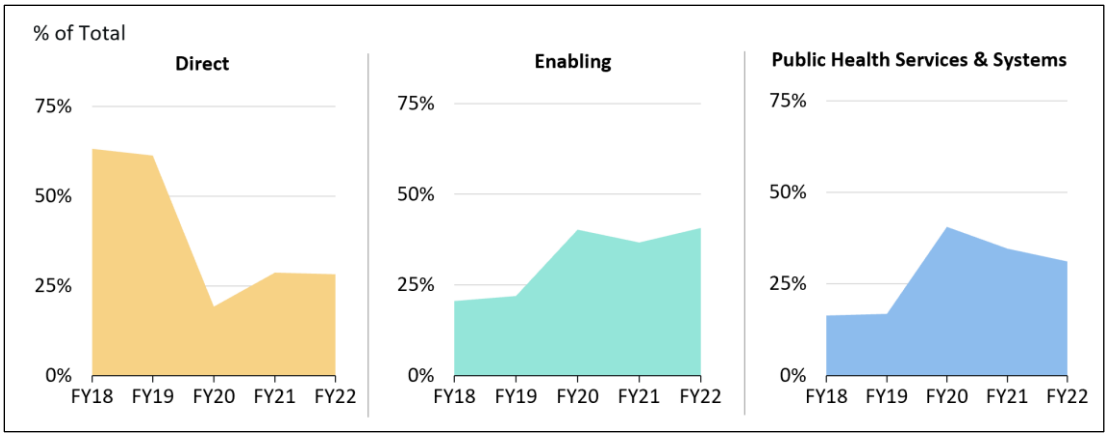
Notes: TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. The FY2022 expenditures presented above were reported in July 2023 and thus may not reflect final expenditures.

Within the category of direct health care services, states report on the types of direct services provided using predefined categories; however, over half of direct services funds are allocated to the category of *other* services. For example, in Texas, *other* direct services included home health services, whereas Washington, DC, included adolescent mental health services under this category. Conversely, California did not fund any direct services with State MCH Block Grant program funding in FY2022. Additional detail on what *other* direct services include is available in *FY2024 Application/FY2022 Annual Reports* among those states that provide direct services with State MCH Block Grant funds. **Figure E-1** in **Appendix E** displays FY2022 expenditures by service category with an additional disaggregation of expenditures by federal and all nonfederal funding sources.

From FY2018 to FY2019, direct services accounted for over 60% of total program expenditures; more recently, expenditures have increasingly shifted toward enabling and public health services and systems (see **Figure 6**). In FY2022, these two respective categories constituted over 85% of total expenditures. Additional information on program expenditures, including changes in specific dollar amounts, is available in **Table F-1** in **Appendix E**.

[45] Detailed section-by-section requirements are available on HRSA's "Guidance and Documents" page, available at https://mchb.tvisdata.hrsa.gov/Home/Resources.

Figure 6. State MCH Block Grant Expenditures, by Service Category, FY2018-FY2022



Source: Figure created by CRS using data from HRSA's Title V Information System (TVIS); https://mchb.tvisdata.hrsa.gov/Financial/FundingByServiceLevel.

Notes: TVIS data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. State reporting on direct and enabling services does not include services that are reimbursed by Medicaid, CHIP, or other public or private payers. Figure reflects total program expenditures, inclusive of federal and nonfederal funds.

Populations Served

The populations served by the State MCH Block Grant include pregnant women, infants, children, CYSCHN, and others. HRSA defines these five population groups as follows:

- **Pregnant Women.** A female from the date of conception to 60 days after childbirth, delivery, or expulsion of the fetus.[46]
- **Infants.** Children less than one year old.
- **Children.** Children from age 1 through 21 years old.[47]
- **Children and Youth with Special Health Care Needs (CYSHCN).** CYSHCN are infants and children who have or are at risk of having a disability, chronic illness/condition, or educational/behavioral issue.[48]
- **Others.** This category consists of women and men who are over 21 years of age.[49]

[46] Maternal and Child Health Bureau, *Glossary*, Appendix K of the MCH Block Grant - Application/annual Report Guidance, Appendix of Supporting Documents, https://mchb.tvisdata.hrsa.gov/Glossary/Glossary. Although not defined in HRSA's guidance documents, "expulsion of the fetus" may refer to birth and pregnancy outcomes that do not result in a live birth, such as miscarriage, stillbirth, or abortion.

[47] A pregnant female child is classified by HRSA as a pregnant woman.

[48] Children who "have or are at risk of having chronic physical, development, behavioral, or emotional conditions" and who generally require more intensive types or an increased volume of services than other children are considered as children or youth with special health care needs. HRSA classifies infants (0-12 months) with special health care needs as a child with special health care needs. See HRSA, *Glossary*, https://mchb.tvisdata.hrsa.gov/Glossary/Glossary.

[49] Services for this group may include well-woman visits or other education and family-centered care provided to parents/guardians.

Populations Reached

Using annual state-reported data, the MCHB publishes estimates of the number of individuals reached across each of the five population groups described above. These estimates are developed by (1) quantifying the number of individuals who received direct and enabling services (i.e., the top two categories in the MCH Services Pyramid; see **Figure 4**), and (2) estimating the proportion of each population group who were reached by State MCH Block Grant-funded services across all three service categories (i.e., direct, enabling, and public health services and systems).

States typically derive estimates of the number of individuals reached by direct and enabling services from reimbursement data or individual client service records. As part of the estimate, states outline the total number of individuals served, by population group, and indicate the types of health insurance coverage to ensure that only services funded by the State MCH Block Grant without full reimbursement from another source (e.g., Medicaid, private health insurance) are included in the final estimate.

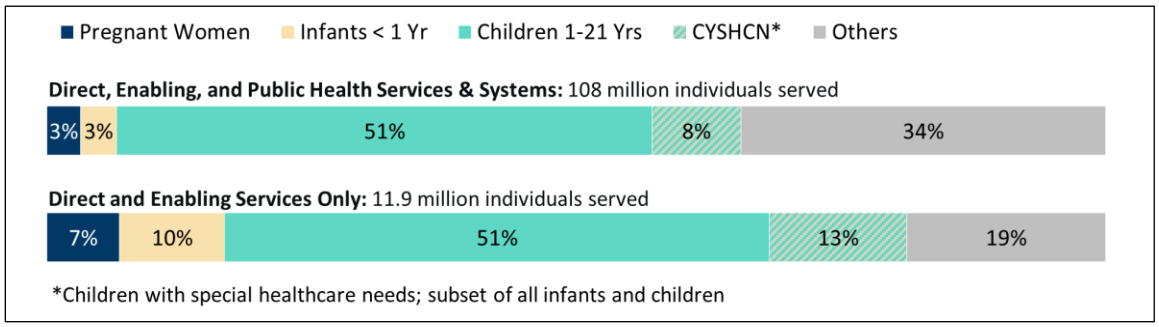
Estimating the number of individuals reached through public health services and systems can be challenging. For instance, quantifying the number of individuals who were exposed to a mass media campaign, such as those promoting safe newborn sleep practices, can be difficult since public health promotion activities do not typically measure the discrete number of individuals who heard, saw, or were otherwise influenced by the message. With the design of public health campaigns in mind, HRSA's reporting forms guide recipients through the development of these estimates using various denominators and data sources.[50] To avoid double-counting, states are encouraged to focus on the programs and services that have the largest reach for a given population and approximate percentages for each numerator. States describe their methods, data sources, and the specific programs or services that were included in the estimate as part of the Application/Annual Report.

Across all three MCH service categories—direct, enabling, and public health services and systems—over 108 million individuals were estimated to have been reached by State MCH Block Grant activities in FY2022 (see **Figure 7**). The majority of recipients across the three service categories were children aged 1-21 years (51%), followed by "others," which includes men and women over age 21 (34%). When examining population groups reached by direct and enabling services only (11.9 million individuals), children continued to make up the majority of individuals reached (51%). Combined, pregnant women, infants, children, and CYSCHN made up a larger share of the population reached by both direct and enabling services (81%) compared with their share across all three service categories (65%). This demonstrates that State MCH Block Grant-funded direct and enabling services tend to focus primarily on pregnant women, infant, and child populations (81%); however, a relatively larger proportion of *other* groups (34%) and a larger overall population (108 million individuals compared with 11.9 million) is reached when examining block grant activities across all three types of services, particularly since public health services and systems aim to reach a broader population than that of direct and enabling services.

[50] States are able to provide their own denominators; however, population denominators are generally derived from the National Vital Statistics System, U.S. Census Bureau Population Estimates, and the National Survey of Children's Health. See https://mchb.tvisdata.hrsa.gov/Home, "Data Notes."

Figure 7. State MCH Block Grant Distribution of Populations Reached, by Service Category

FY2022



Source: Figure created by CRS using data from HRSA's Title V Information System (TVIS); https://mchb.tvisdata.hrsa.gov/, see "Reporting Domains."

Notes: TVIS data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. For example, FY2022 data were reported in July 2023 and may not reflect final totals of individuals reached. TVIS provides estimates only across these two aggregated categories; separate totals by individual service category are not available. State reporting on direct and enabling services does not include services that are reimbursed by Medicaid, CHIP, or other public or private payers. The figure reflects individuals reached across all program activities, inclusive of those funded by federal and nonfederal funds. "Others" include men and women over age 21.

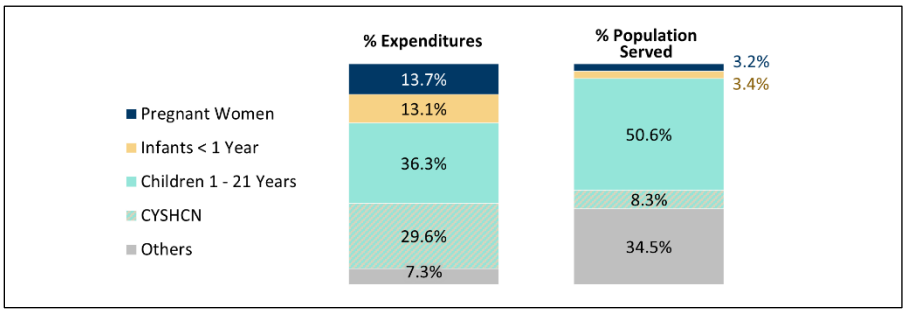
Both of these estimates can be found in TVIS; however, TVIS does not provide individual estimates for each of the three service categories. Rather, estimates are totaled across (1) direct and enabling services, and (2) direct, enabling, and public health services and systems. Considerable variation exists across individual states.

Expenditures by Population Group

In addition to annually reporting on expenditures by service category, states are also required to report on program expenditures by each population group. In FY2022, children composed the largest proportion of total expenditures (36.3%; see **Figure 8**). Notably, CYSCHN accounted for nearly one-third (29.6%) of all program expenditures, yet this group accounted for 8.3% of the total individuals served across all service categories (see "Populations Reached"). Conversely, *others* accounted for the lowest proportion of expenditures (7.3%) despite representing over one-third (34.5%) of individuals reached. Considerable variation in program expenditures by population group exists across all states.

Figure 8. State MCH Block Grant Distribution of Expenditures, by Population Group

FY2022



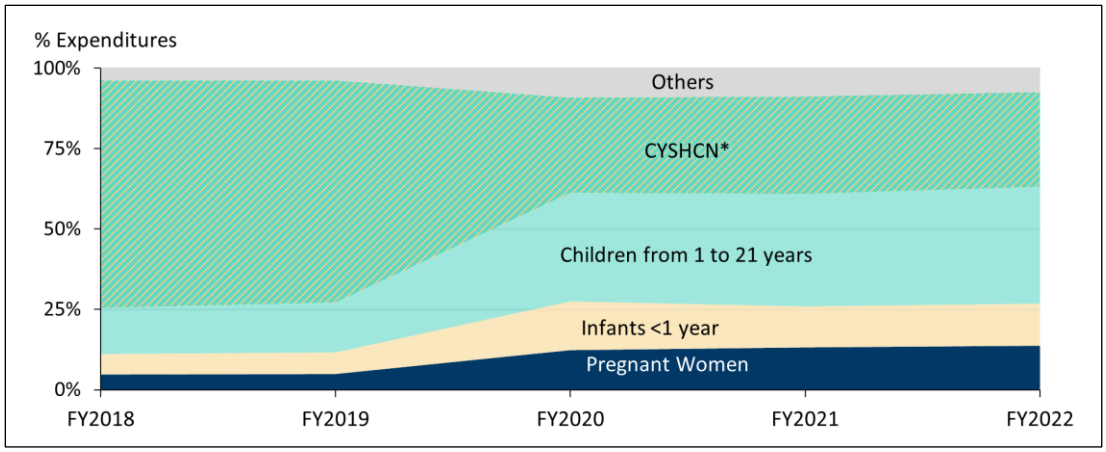
Source: Figure created by CRS using data from HRSA's Title V Information System (TVIS); https://mchb.tvisdata.hrsa.gov/Financial/FundingByIndividualsReached.

Notes: TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. The FY2022 expenditures presented above were reported in July 2023 and thus may not reflect final expenditures. "Others" include men and women over age 21. CYSCHN refers to children and youth with special health care needs.

Figure G-1 in **Appendix G** displays FY2022 expenditures by population group with an additional disaggregation of expenditures by federal and all nonfederal funding sources.

From FY2018 to FY2019, CYSCHNs accounted for approximately 70% of total program expenditures; more recently, expenditures have increasingly shifted towards children, with smaller increases towards pregnant women and infants (see **Figure 9**). Additional information on expenditures by population group, including changes in specific dollar amounts, is available in **Table H-1** in **Appendix H**.

Figure 9. State MCH Block Grant Expenditures, by Population Group, FY2018-FY2022



Source: Figure created by CRS using data from HRSA's Title V Information System (TVIS); see https://mchb.tvisdata.hrsa.gov/Financial/FundingByIndividualsServed.

Notes: TVIS data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. For example, FY2022 data were reported in July 2023 and may not reflect final expenditures. The figure reflects individuals reached across all program activities, inclusive of those funded by federal and nonfederal funds.

Application and Reporting Requirements

All block grant recipients must annually submit a combined application for the forthcoming fiscal year along with an annual report for the prior fiscal year (hereinafter referred to as the *Application/Annual Report*). This section provides a brief overview of some of the Application/Annual Report requirements, including information on the program's national performance measurement framework.[51]

Section 505(b) of the SSA requires the Application/Annual Report to be developed by, or in consultation with, the state MCH agency, and SSA Section 506(a) requires the standardized report to be submitted to the Secretary of HHS. States must solicit public comments (including from community members and other federal or public agencies) throughout the Application/Annual Report development process. A description of this process, including how public comments were addressed, must be discussed in the Application/Annual Report.[52] In addition, state MCH and CYSCHN Directors attend an annual Application/Annual Report review meeting, which provides an opportunity for HRSA staff to assess each state's progress relative to its selected performance measures and to discuss the state's plan for the coming year. Reviewers also include information on former state and federal MCH leaders, MCH experts and academics, and family/parent reviewers. During the review process, states can request additional technical assistance from HRSA to support activity planning and implementation; however, HRSA does not provide additional funding to support technical assistance.[53]

As part of the Application/Annual Report, states must submit standardized information including an overview of all funding sources, program participation and reach, program expenditures and other budget data, standardized MCH measures, and a narrative update on state MCH data systems and infrastructure. States must also perform a biennial independent audit of all program expenditures.[54] Specific requirements, templates, and additional guidance are published on HRSA's TVIS, which also publishes each state's final Applications/Annual Reports.[55]

Needs Assessment and State Action Plan

Each state is required to conduct and submit a comprehensive statewide needs assessment once every five years.[56] The needs assessment must identify statewide goals that align with national health objectives, including the need for preventive and primary care services for pregnant women, mothers, infants, and children, and services for CYSHCN.[57] This process includes data collection and analysis regarding a state's MCH capacity and infrastructure, needs and desired outcomes, and relevant legislative mandates, among other topics. The needs assessment process is intended to be a systematic and collaborative process that includes MCHB, a state's department

[51] Detailed section-by-section requirements documents are available on HRSA's "Guidance and Documents" page, available at https://mchb.tvisdata.hrsa.gov/Home/Resources.

[52] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 39.

[53] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 11 and email correspondence with HRSA staff, April 2024.

[54] SSA §506(b).

[55] To view a state's application, see HRSA, *State Application/Annual Report*, https://grants6.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport. To view a state action plan table, see HRSA, *State Action Plan Table*, https://grants6.tvisdata.hrsa.gov/Home/StateActionPlan.

[56] SSA §505(a)(1).

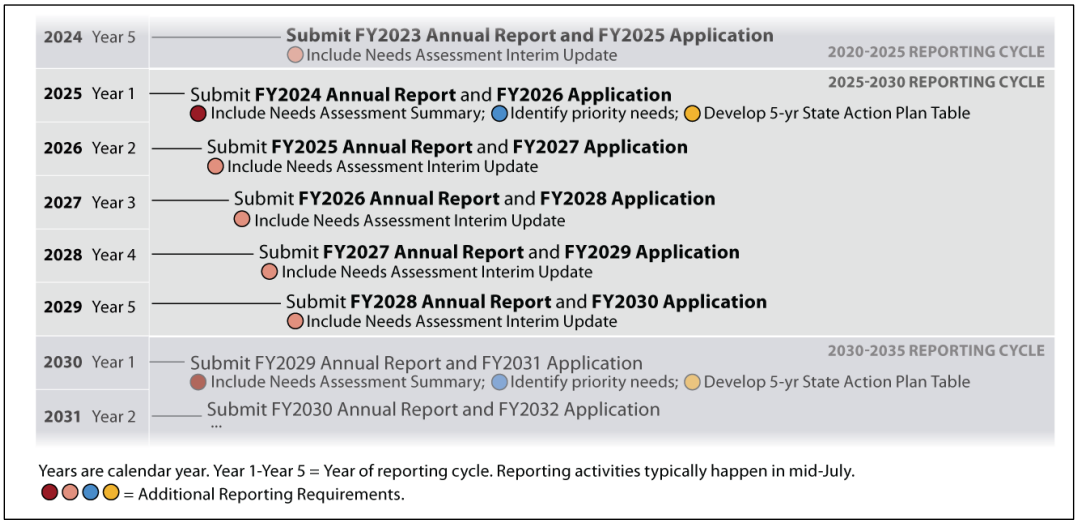
[57] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 25

of health, families, health care practitioners, and other agencies, organizations, and state MCH stakeholders.

Findings from the needs assessment are submitted in the form of a *Needs Assessment Summary,* which drives the development of a state's annual application for block grant funds. These needs assessment results also inform the development of a five-year *State Action Plan*, which outlines 7-10 priority needs and statewide objectives and strategies, typically compiled in a table format.[58] The plan must also convey areas of alignment between the priority needs, objectives, and strategies and performance measures (see "Performance Measurement Framework").

In each of the four interim years following the needs assessment, states must include *Needs Assessment Interim Updates* as part of the Application/Annual Report process. These updates may reflect changes to program strategies, demographics, and/or other emerging MCH issues. **Figure 10** summarizes the annual reporting cycle based on the five-year needs assessment.

Figure 10. State MCH Block Grant Application/Annual Report Timeline



Source: Figure created by CRS using example deadlines provided in HRSA's Title V *Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report.*

Relationship with Medicaid

The State MCH Block Grant program and the Medicaid program (SSA Title XIX) share a common goal of improving health for the MCH population through the provision of affordable health care delivery systems and adequate coverage. Section 509(a)(2) of the SSA cites the need to promote "coordination at the Federal level of activities authorized under this title [Title V] and under title XIX." Further, SSA Section 1902(a)(11) requires state Medicaid agencies to enter into Inter-Agency Agreements (IAAs) with agencies administering programs authorized under SSA Title V, including those agencies that receive State MCH Block Grant funding.

Medicaid law further clarifies that the Medicaid program should serve as the payor of first resort for services covered under both Title V and Medicaid. This means that State MCH Block Grants cannot be used to reimburse a claim for a service otherwise covered under Medicaid. HRSA's MCHB encourages robust IAAs that outline specific areas of program collaboration. The goal of this partnership and collaboration is to allow for the effective leveraging of federal and state

[58] State Action Plans are available at https://mchb.tvisdata.hrsa.gov/Home/StateActionPlan.

resources to help ensure that MCH populations receive necessary preventive services, health examinations, treatments, and follow-up care. IAAs are publicly available in the TVIS.

As part of the Application/Annual Report, states are required to provide a detailed description of the existing relationship between the State MCH Block Grant program and the Medicaid program to build upon the IAA. This includes information on program outreach and enrollment, health care financing, waivers or state-specific amendments that affect the MCH population, joint policy-level decision-making, and Medicaid Core Set measures.[59]

Relationship with Other Programs

States are required to describe partnerships with other federal, state, and local entities and how such collaboration may address priorities identified in the Needs Assessment (see the "Needs Assessment and State Action Plan" section). Every five years (at minimum), states must describe the relationship between the State MCH Block Grant program and other programs, including (1) other MCHB investments (e.g., Maternal Health Innovation Grants); (2) other HRSA investments (e.g., HIV/AIDS programs); (3) other federal investments (e.g., CDC-funded programs); (4) local programs and organizations (e.g., local health departments); (5) other State Department of Health programs (e.g., health promotion activities); (6) other governmental agencies (e.g., the State Children's Health Insurance Program (CHIP);[60] (7) tribes, tribal, and urban Indian organizations; (8) related public health universities and educational programs; and (9) relevant nongovernmental organizations.

Performance Measurement Framework

The State MCH Block Grant program uses a three-tiered performance measurement framework to track annual progress toward MCH goals. The framework consists of Evidence-based or -informed Strategy Measures (ESMs), National Performance Measures (NPMs), and National Outcome Measures (NOMs). According to the program guidance, ESMs are structural and process measures that influence the NPMs, which are short- and medium-term indicators. NPMs are hypothesized to influence NOMs, the longer-term, population-level MCH indicators. **Table 1** displays the relationship of these measures as identified in the performance measurement framework; each measure category is further described below.

[59] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 23.

[60] The State Children's Health Insurance Program (CHIP) is a federal-state program that provides health coverage to certain uninsured, low-income children and pregnant women in families that have annual incomes above Medicaid eligibility thresholds but do not have health insurance. CHIP is jointly financed by the federal government and the states and is administered by the states. States may design their CHIP programs in three ways. They may cover eligible children under their Medicaid programs (i.e., CHIP Medicaid expansion), create a separate CHIP program, or adopt a combination approach where the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. When states provide Medicaid coverage to CHIP children (i.e., CHIP Medicaid expansion), Medicaid rules (Title XIX of SSA) typically apply. When states provide coverage to CHIP children through separate CHIP programs, Title XXI of SSA rules typically apply. In all cases, federal CHIP funding is available to pay for the costs for services provided to CHIP children.

Table 1. Performance Measurement Framework

STANDARDIZED NATIONAL MEASURES

	ESMs	NPMs	NOMs
Purpose	Quantify short-term outcomes and assess progress of specific evidence-based or evidence-informed strategies.	Assess short- or medium-term outcomes related to clinical health systems, health behaviors, and social determinants of health.	Measure trends in longer-term indicators to understand MCH population health, and inform future needs assessments and program strategies.
Requirements	States must develop at least one ESM for every strategy in the State Action Plan. Each ESM must be clearly aligned to a state priority.	Selected NPMs must represent state priorities and activities, directly link to at least one NOM, and represent health areas with significant disparities. States must report on a minimum of five NPMs, with at least one NPM for each of the five population domains. Two of the five NPMs are Universal NPMs and reported by each state.	HRSA collects and reports data on NOMs using a variety of federal data sources. States may, but are not required to, report on NOMs as part of the Application/Annual Report.
Measure Options	States develop unique ESMs and provide detail on each measure in the Application/Annual Report. HRSA does not provide a required list.	20 NPMs, including two Universal NPMs (Postpartum Visit; Medical Home). States may also develop their own unique State Performance Measure (SPM) or use standardized measures provided by HRSA if existing NPMs do not appropriately reflect an activity or state priority.	33 NOMs. States may also develop their own unique State Outcome Measure (SOM) if existing NOMs do not appropriately reflect an activity or state priority.

Source: Table developed by CRS using information from HRSA's Title V *Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report* and HRSA's Title V *Maternal and Child Health Services Block Grant to State Program. Technical Assistance Resources.*

Notes: The full list of NPMs is available in **Appendix I.** The full list of NOMs is available in **Appendix J.**

Evidence-Based or Informed Strategy Measures

ESMs quantify and assess outputs related to NPMs and support states in setting improvement objectives across the five-year reporting cycle. States are required to develop and report on at least one ESM for each NPM. States must detail the ESM's relationship to state priorities, describe of the scientific evidence informing the measure and its significance, and present additional considerations about data availability and measure definition.[61]

[61] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report. Technical Assistance Resources*, p. 15. Available at https://mchb.tvisdata.hrsa.gov/Home/Resources. Hereinafter, HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report. Technical Assistance Resources*.

National Performance Measures

NPMs are short- and medium-term measures that are intended to improve NOMs. NPMs are considered to be more directly modifiable by the specific activities that states implement with block grant funds.[62]

The 20 NPMs are organized across five MCH population domains—(1) Women/Maternal Health, (2) Perinatal/Infant Health, (3) Child Health, (4) Children with Special Health Care Needs, and (5) Adolescent Health—as well as across three measure domains. Measure domains were introduced in the most recent guidance and reflect different ways in which a health strategy or activity may improve NOMs. These include (1) clinical health systems, (2) health behaviors, and (3) social determinants of health. The full list of measures, including each measure's population and measure domain, is available in **Appendix I**. States must report on a minimum of five NPMs, with at least one NPM for each of the five MCH population domains. Two of the mandatory five NPMs are "Universal NPMs," which all states are required to report on.[63] The Universal NPMs, *Postpartum Visit* and *Medical Home*, were introduced in the 10th version of the guidance in January 2024 (see **Appendix I** and text box, right). According to MCHB, these NPMs were selected for their ability to measure access and quality of primary and preventive care specific to maternal health and improving care networks for CYSCHN.[64]

Universal National Performance Measures (NPMs)

Universal NPMs were recently introduced in the 10th version of the State MCH Block Grant program guidance. To accelerate progress toward national and state priorities, HRSA designated *Postpartum Visit* and M*edical Home* as NPMs that all states must report on beginning in FY2025. These measures are briefly highlighted below; see **Appendix I** for more information.

Postpartum Visit measures the percentage of women who attend a timely and thorough postpartum checkup. Evidence indicates that a comprehensive postpartum visit is an opportunity to identify, prevent, and treat adverse maternal health outcomes. According to HRSA, this measure was chosen to drive improvements in maternal mortality rates nationwide.

Medical Home refers to a health care approach that is accessible, family centered, stable, and comprehensive, among other elements. Evidence suggests that children with a medical home are more likely to receive appropriate preventive measures and treatment, and are less likely to be hospitalized. According to HRSA, this measure was selected to drive improvements in the health of CYSHCN and improve quality health care for infants, children, and adolescents.

National Outcome Measures

NOMs are longer-term measures of health status that the block grant program aims to improve overall. For instance, NOMs can reflect measures about quality of life at the population level, such as preventable morbidity and mortality, emerging health priorities, and health across the life course.[65] States do not individually report on NOMs; rather, MCHB prepopulates NOM data across all states using a variety of federal and state data sources (see the "Selected Federally Available Data Sources" text box below) to better monitor the impact of the State MCH Block

[62] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 25.

[63] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 6.

[64] Ibid.

[65] The life course approach, also referred to as life course theory, identifies critical life stages that can influence lifelong health and well-being. For more information, see HRSA, *Title V Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report*, p. 5.

Grant without duplicating federal data collection efforts. The full list of 33 NOMs is available in **Appendix J**.

If state priorities are not adequately reflected by NOMs or NPMs, states may use unique State Outcome Measures (SOMs) or State Performance Measures (SPMs). States may develop these measures independently or use a list of Standardized Measures provided by HRSA. States provide a detailed overview of unique measure definitions, data sources, and multiyear data points in the Application/Annual Report.

Performance Measurement Considerations

The 10th version of the Application/Annual Report Guidance notes that the performance measurement framework underwent a revision to better address the social determinants of health,[66] provide more choices for NPMs across population domains, and introduce optional standardized SPMs.[67] In addition to the new Universal NPM requirement, the revised guidance allows states to select priority populations for each NPM and includes NOMs to reflect emerging priorities such as stillbirth rates, among other changes.[68] MCHB notes the revised guidance puts a greater emphasis on health equity as a guiding principle.[69] MCHB updated the guidance following consultation with state MCH agencies, MCH leaders and stakeholders, and the public—a process implemented in past iterations.[70]

While the measures are designed to standardize reporting across states and capture progress toward state and national health objectives, variation exists among states in terms of capacity for collecting and reporting data. MCHB and individual states may use federally available data sources, in addition to state-collected data, to track NOMs, NPMs, and ESMs. A selection of MCH data sources is presented in the text box below. States are required to provide an update on data capacity and enhancement activities every five years.[71]

[66] The Social Determinants of Health (SDOH) are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide variety of health, functioning, and quality-of-life outcomes and risks." For more information on the five SDOH domains, see https://health.gov/healthypeople/priority-areas/social-determinants-health.

[67] Since the program became a block grant in 1981, the application and reporting guidance has undergone multiple changes. According to Michael C. Lu et al., one of the largest transformations occurred with the introduction of the three-tiered measurement framework. For more information, see Lu et al., "Transformation of the Maternal and Child Health Services Block Grant," *Maternal and Child Health Journal*, vol. 19, issue 2 (May 2015), pp. 927-931.

[68] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 17.

[69] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. iv.

[70] Michael C. Lu et al., and Health Resources and Services Administration, "Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request; Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB No. 0915-0172-Revision," 88 *Federal Register* 63963-63965, 2023.

[71] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program: Guidance and Forms for the Title V Application/Annual Report*, p. 31.

Selected Federally Available MCH Data Sources

National Vital Statistics System (NVSS): Coordinated by the CDC National Center for Health Statistics, NVSS collects and disseminates data from states on vital events, which include births, deaths, marriages, divorces, and fetal deaths, to calculate statistics on maternal and perinatal mortality rates, among others.

Pregnancy Risk Assessment Monitoring System (PRAMS): PRAMS is a joint research project between the CDC Division of Reproductive Health and state, territorial, or local health departments. PRAMS collects data on high-risk MCH populations. It is the only surveillance system that provides data through pregnancy and the early postpartum period.

National Survey of Child Health (NSCH): Led by HRSA's MCHB, the NSCH produces state and national-level data on the physical and emotional health of children aged 0-17. Topics include physical and mental health, access to health care, and children's social and familial environments.

State Inpatient Databases (SID): Developed for the Healthcare Cost and Utilization Project (HCUP), led by the Agency for Healthcare Research and Quality (AHRQ), SID contains discharge data from inpatient stays in community hospitals. Data can be used to identify preventable hospitalizations, estimate costs, assess access to quality care, and categorize diagnoses, among other things.

Sources: Centers for Disease Control and Prevention, *About the National Vital Statistics System*, https://www.cdc.gov/nchs/nvss/about_nvss.htm; Centers for Disease Control and Prevention, *What is PRAMS?*, https://www.cdc.gov/prams/index.htm; United States Census Bureau, *National Survey of Children's Health (NSCH)*, https://www.census.gov/programs-surveys/nsch.html; Agency for Healthcare Research and Quality, *Overview of the State Inpatient Database*, https://hcup-us.ahrq.gov/sidoverview.jsp.

Additional Reporting Requirements

In addition to the components discussed above, states must submit standardized information including an overview of all relevant funding sources, program participation and reach, program expenditures and other budget data, standardized MCH measures, and a narrative update on state MCH data systems and infrastructure. This also includes reporting on an annual "MCH Success Story," which highlights the contributions of the State MCH Block Grant, as well as narratives on the broader health of MCH populations in each state and the context of the state's health care system. States must also perform a biennial independent audit of all program expenditures.[72]

Reports to Congress

Section 506(a)(3) requires HRSA to annually compile the information reported by states and to present reports to the House Committee on Energy and Commerce and the Senate Committee on Finance. This report must include a summary of the information reported to the Secretary of HHS by the states and a compilation of specified maternal and child health indicators at both the national and state levels. All information included in this requirement can be found in the publicly accessible TVIS.[73]

Special Projects of Regional and National Significance (SPRANS)

The SPRANS component of the MCH Services Block Grant competitively provides federal funds to projects aimed at driving innovation, improving systems of care for MCH populations, and addressing emerging needs, priorities, or issues.[74] SPRANS funding complements other Title V

[72] SSA §506(b).

[73] HRSA, Title V Information System, https://mchb.tvisdata.hrsa.gov/Home.

[74] HRSA, *FY2025 Justification of Estimates for Appropriations Committees*, pp. 183-184.

MCH Services Block Grant components, as well as other federal and state efforts, by building capacity through pilot programs, research, training, data collection, quality improvement, and workforce development.[75]

SPRANS authorizing legislation specifically mentions the following focus areas: (1) MCH research and training; (2) genetic disease testing, counseling, and information dissemination; (3) comprehensive hemophilia diagnostic and treatment centers; and (4) newborn screening and follow-up services, including sickle cell and other genetic disorders.[76]

Grant Recipients

Unlike the State MCH Block Grant program, SPRANS funding can be competitively awarded to and administered by other entities beyond state health agencies. Typically, projects funded through the SPRANS component are open to public or nonprofit private institutions of higher learning that train health care personnel (particularly those focused on MCH populations), or public or private nonprofit organizations or institutions of higher learning that conduct MCH research. Community-based organizations, tribal organizations, and faith-based organizations may also be eligible to receive SPRANS funding. Since SPRANS funding is competitively awarded into discrete projects, eligibility requirements, application timeframes, and reporting requirements may vary by project.[77]

Funding and Program Topics

The total amount of MCH Services Block Grant funding for SPRANS (per fiscal year) is made available under the following formula:

- **SPRANS:** 15% of the annual federal appropriation that does not exceed $600 million, and 15% of funds remaining above $600 million after CISS funds are set aside.[78]

Annual appropriations acts have frequently deviated from this formula. For example, the Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), mandated that no more than $219.116 million of FY2023 funds would be made available to SPRANS and that $10.276 million would be made available for CISS, "notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act."[79] Through this approach, Congress effectively increased the proportion and amount of FY2023 funds allocated to SPRANS ($219.116 million, compared with $119.5 million per the §502 formula) and decreased the amount appropriated to CISS ($10.276 million, compared with $28.394 million that would have been available under the §502 formula).

Historically, parameters for SPRANS funding have been outlined through authorizations and appropriations for specific programs or activities, including funding set-asides for particular priority issues. **Table 2** outlines specific SPRANS set-asides and directives from FY2022 to FY2024. Appropriations have historically been provided for oral health, epilepsy, sickle cell, and fetal alcohol spectrum-related projects; in FY2024, these accounted for 8% of total SPRANS

[75] Ibid.

[76] SSA §501(a)(2).

[77] Specific eligibility details, application timeframes, and reporting requirements are typically included as part of HRSA's funding announcements on grants.gov.

[78] Unlike the State MCH Block Grant program, which is a federal-state partnership program, SPRANS activities are funded with federal appropriations.

[79] Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), 136 STAT. 4856.

funding. Other SPRANS set-asides may reflect areas of interest identified by HRSA in the annual budget justification process or other areas of congressional interest laid out in appropriations reports. In FY2024, Congress directed approximately 59% of total SPRANS funding to address specific priority issues in appropriations report language.

Other priority areas for SPRANS funding may be highlighted by Congress in committee reports. For example, the FY2023 House Committee on Appropriations highlighted concerns with the rising prevalence of congenital syphilis and encouraged HRSA to expand prenatal screening and testing opportunities with SPRANS funding.[80] Remaining SPRANS funds support additional activities as authorized by statute.

Table 2. Special Projects of Regional and National Significance (SPRANS)

FY2022–FY2024 ($ in Millions)

Set-Asides				
Focus Area	**Purpose**	**FY2022**	**FY2023**	**FY2024**
Oral Health	Improve perinatal and infant oral health.	$5.2	$5.2	$5.2
Epilepsy	Improve access to quality health care services for children and youth with epilepsy or seizure disorders.	$3.6	$3.6	$3.6
Sickle Cell Disease	Improve care coordination for children and families with sickle cell diseases.	$5.9	$7.0	$7.0
Fetal Alcohol Syndrome	Decrease incidents of alcohol use during pregnancy through the dissemination of provider and consumer information.	$1.0	$1.0	$1.0
Directives and Other Programs Authorized by Statute				
Focus Area	**Purpose**	**FY2022**	**FY2023**	**FY2024**
Children's Health and Development	Study ways to improve child health through a statewide system of early childhood developmental screenings and interventions.	$3.5	N/A	$10.0
Infant-Toddler Court Teams	Provide ongoing training and technical assistance, implementation support, and evaluation research to support research-based Infant-Toddler Court Teams, which aim to improve child welfare practices and the early developmental health and well-being of infants, toddlers, and families.	$12.8	$18.0	$18.0
Maternal Mortality (State Maternal Health Innovation Grants)	Support state-led demonstrations to implement evidence-based interventions to address critical gaps in maternity care service delivery and reduce maternal mortality.	$28.8	$55.0	$55.0
Maternal Mental Health Hotline[a]	Support state-specific actions that address disparities in maternal health and improve maternal health outcomes, including the prevention and reduction of maternal mortality and severe maternal morbidity.	$4.0	$7.0	N/A
Minority Serving Institutions	Establish a research network that is composed of and supports minority-serving institutions to study health disparities in maternal health outcomes.	N/A	$10.0	$10.0

[80] H.Rept. 117-403, p. 56.

Early Childhood Education Expert Grants	Place early childhood development experts in pediatrician offices that serve a population with a high percentage of Medicaid and CHIP patients.	$4.9	$10.0	$10.0
Regional Pediatric Pandemic Network	Coordinate among the nation's pediatric hospitals and their communities to prepare for and coordinate research-informed responses to future pandemics.	$17.9	$25.0	$25.0
Hereditary Hemorrhagic Telangiectasia Centers for Excellence (HHT)	Support coordination and expansion of care for HHT patients and participation in a prospective, longitudinal registry of HHT patients to better understand this rare disease and accelerate the development of new diagnostic and treatment options.	$2.0	$2.0	$2.0
National Fetal Infant and Child Death Review (FICDR)	Expand support and technical assistance to states and tribal communities and improve the availability of data on sudden unexpected infant deaths and child mortality.	$2.1	$5.0	$5.0

Source: Data from FY2022 and FY2023 was compiled by CRS from HRSA's FY2023 Operating Plan and Committee Reports from the Consolidated Appropriations Acts of 2022 and 2023. FY2024 data was compiled by CRS from data contained in the explanatory statement accompanying P.L. 118-47, available in the *Congressional Record*, vol. 170, no. 51, book II, March 22, 2024, pp. H1887-H1888.

Notes: This table focuses on discretionary uses of SPRANS funding. Detail on Family-to-Family Health Information Centers (F2F HICs), a mandatory SPRANS program, is provided in **Appendix K**.

N/A = Not applicable.

a. Division FF of P.L. 117-328 amended the Public Health Service Act (PHSA) to establish a new authority for the Maternal Mental Hotline. Previously, funding for this hotline had been provided within the MCH SPRANS, but starting in FY2024, funding was shifted from SPRANS to a separate budget line item, consistent with the hotline's new statutory authority within the PHSA. The Alliance for Maternal Safety Bundles received SPRANS project funding in FY2022. Starting in FY2023, however, this project was funded under the newly authorized Section 330O of the Public Health Service Act, as established by Division P of P.L. 117-103. This section authorizes HHS to support grants for Innovation in Maternal Health.

SPRANS authority has been used to mandate the development and funding of separate programs. For example, the Family-to-Family Health Information Centers (F2F HIC) program was established through the Deficit Reduction Act of 2005 (DRA; P.L. 109-171). The DRA amended Title V to authorize and appropriate mandatory funding for F2F HIC in all states through FY2009.[81] Subsequent laws have provided mandatory appropriations for this program in each year since. Most recently, the Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42), appropriated funds through the first quarter of FY2025. According to SSA Section 501(c)(2), funds are required to be appropriated to F2F HICs to provide information, education, technical assistance, and peer support to families of CYSCHN and health professionals who serve such families. For additional funding history, see **Table K-1** in **Appendix J**; for more information about this program, see CRS Insight IN12317, *Family-to-Family Health Information Centers: Current Status and Policy Considerations*.

[81] The F2F HIC were established in the Deficit Reduction Act of 2005 (DRA; P.L. 109-171). However, from FY2002 through FY2006, HHS funded F2F HIC in 36 states using a combination of various program authorities and direct appropriations.

SPRANS Spotlight: Minority-Serving Institutions (MSI) Research Collaborative

Over the past several decades, maternal mortality and pregnancy-related morbidity have risen across the United States. Underlying health disparities can further exacerbate differences in maternal health across ethnic and racial groups. In particular, non-Hispanic Black women and American Indian/Alaska Native women are two to three times more likely to die from pregnancy-related causes than are White, Hispanic, and Asian Pacific Islander women.

In alignment with the 2022 *White House Blueprint for Addressing the Maternal Health Crisis*, HRSA's MCHB established a new $10 million minority-serving institutions (MSI) research collaborative. This SPRANS-funded project aims to build the capacity of MSIs to study maternal health disparities, research and address root causes of maternal mortality, develop curricula to train MCH professionals, and examine the impact of climate change on maternal health disparities. Identifying community-based solutions to addressing maternal health disparities and advancing health equity is also a key focus. As of April 2024, 17 MSI awardees received SPRANS funding to coordinate and collaborate on maternal health research.

Sources: Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2022*, National Center for Health Statistics, Health E-Stats, May 2024, https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.htm; HRSA, *FY2024 Justification of Estimates for Appropriations Committees*, p. 185; Health Resources and Services Administration, *Maternal Health Research Collaborative for Minority Serving Institutions (MSIs)*, April 2024, https://mchb.hrsa.gov/data-research/research-investments/maternal-health-research-colloborative-minority-serving-institutions.

Community Integrated Service Systems (CISS)

The CISS component of the MCH Services Block Grant provides federal funds to projects that seek to increase local service delivery capacity and build comprehensive and integrated community service systems for mothers and children. In particular, CISS funding supports the development, innovation, and expansion of services in rural areas or for MCH populations with special health care needs.[82]

CISS authorizing legislation mentions the following topic areas: MCH home visiting and case management, health education and social support services, health workforce participation under Medicaid and Title X, integrated MCH delivery systems, and programs focusing on rural populations and CYSHCN. SSA Section 502 also requires HRSA to give preference to applicants that demonstrate that a CISS project will be carried out in an area with a high infant mortality rate.[83]

Grant Recipients

Similar to the SPRANS component, CISS funding can be awarded to and administered by other entities beyond state health agencies. Public and private entities, including faith-based and community-based organizations, may be eligible to receive CISS funding. Since CISS funding is typically partitioned into discrete projects, eligibility requirements, application timeframes, and reporting requirements may vary by project.[84] According to HRSA, there were 26 CISS awards as of FY2024.[85]

[82] HRSA, *FY2024 Justification of Estimates for Appropriations Committees*, pp. 191-192.

[83] SSA 502(b)(2)(A).

[84] Specific eligibility details, application timeframes, and reporting requirements are typically included as part of the HRSA's funding announcements on grants.gov.

[85] HRSA, *FY2025 Justification of Estimates for Appropriations Committees*, p. 190.

Funding and Program Topics

The total amount of federal MCH Services Block Grant funding for CISS (per fiscal year) is made available under the following formula:

- **CISS:** 12.75% of the annual federal appropriation that is above $600 million.[86]

The first tranche of CISS funding was allocated in FY1993 ($6.4 million). Since then, Congress has not appropriated less than $600 million to the Title V MCH Services Block Grant. Since FY2006, CISS levels have remained relatively consistent (see **Table A-1** in **Appendix A**) with appropriations acts often deviating from the above formula. For example, the Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), mandated that no more than $219.116 million of FY2023 funds would be made available to SPRANS and that $10.276 million would be made available for CISS, "notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act."[87] Through this approach, Congress effectively increased the proportion and amount of FY2023 funds allocated to SPRANS ($219.116 million, compared with $119.5 million per the §502 formula) and decreased the amount appropriated to CISS ($10.276 million, compared with $28.394 million that would have been available under the §502 formula). Conversely, Congress has used this approach to decrease the proportion of funds for SPRANS and increase the proportion for CISS, such as in FY2014.[88]

One of HRSA's longest-standing CISS projects is the Early Childhood Comprehensive Systems (ECCS) program. Since 2002, ECCS have helped states improve access to and the quality of preventive health services for young children and families. The current iteration, ECCS: Health Integration Prenatal-to-Three, focuses on promoting early developmental health and well-being, increasing family-centered access to care, and building MCH systems that are equitable, sustainable, comprehensive, and inclusive.[89] HRSA currently awards $5.1 million annually (FY2021-FY2026) to 20 state-level ECCS entities.[90]

CISS Spotlight: Enhancing Systems of Care for Children with Medical Complexity

Nationwide, there are approximately 3 million children with medical complexity (CMC), many of whom have co-occurring behavioral health diagnoses. In FY2022, HRSA announced the Enhancing Systems of Care for Children with Medical Complexity Program. The purpose of this program is to optimize the health, quality of life, and well-being of CMC and their families. Within the program, HRSA defines CMC as a subset of CYSHCN who have family-identified service needs, severe chronic clinical conditions, functional limitations, and a high utilization of health resources. HRSA funded five demonstration sites and one coordinating center to implement, evaluate, and support evidence-informed, patient/family-centered models of care delivery. These five-year demonstration projects are intended to develop and disseminate innovative and evidence-based care models for CMC and their families. According to HRSA, over $5.1 million has been awarded across all six grantees as of FY2023.

Sources: HRSA funding announcement, https://www.hrsa.gov/grants/find-funding/HRSA-22-088; AcademyHealth, https://academyhealth.org/about/programs/enhancing-systems-care-children-medical-complexity-cmc-coordinating-center.

[86] Unlike the State MCH Block Grant program, which is a federal-state partnership program, CISS activities are funded with federal appropriations.

[87] Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), 136 STAT. 4856.

[88] The Consolidated Appropriations Act, 2014 (CAA 2014; P.L. 113-76), 128 STAT.364, designated not more than $77.1 million to SPRANS (compared with $94.3 million per the §502 formula) and $10.3 million to CISS (compared with $9.7 million under the §502 formula).

[89] HRSA Early Childhood Comprehensive Systems (ECCS), https://mchb.hrsa.gov/programs-impact/early-childhood-systems/early-childhood-comprehensive-systems

[90] Ibid.

Issues for Congress

Recent congressional attention has increasingly been directed toward maternal, infant, and child health topics, particularly as the number of maternal deaths in the United States remains higher than comparable high-income countries and amid recent increases in infant mortality.[91] Current executive branch initiatives, such as the Biden Administration's *White House Blueprint for Addressing the Maternal Health Crisis*, highlight rising maternal morbidity and mortality rates and ongoing racial disparities across both measures. Moreover, the improvement of various maternal, infant, and child health indicators is considered among the high-priority objectives in the Healthy People 2030 framework, which aims to "promote, strengthen, and evaluate the nation's efforts to improve the health and well-being of all people."[92]

The MCH Services Block Grant can support a variety of services, activities, and public health efforts to prevent maternal and child mortality and improve the overall health and well-being of MCH populations. This section outlines selected policy issues Congress may consider in the current MCH landscape relevant to the MCH Services Block Grant, should Congress wish to explore changes to the MCH Services Block Grant or maintain the status quo.

Funding

Allocation Trends. The State MCH Block Grant program has historically received the largest proportion of federal MCH Services Block Grant funds (see **Table A-1** in **Appendix A**). This proportion has decreased since FY2017 as increasingly larger amounts are reserved for SPRANS activities. For example, in FY2013, State MCH Block Grant funds accounted for 86.1% of total program funding and SPRANS accounted for 12.3%; in FY2024, the State MCH Block Grant and SPRANS components accounted for 72.9% and 25.8%, respectively. Similarly, the FY2025 HRSA Budget Justification reflects a $16 million increase to SPRANS, while State MCH Block Grant levels remain consistent with FY2024.[93] Congress may consider whether this shift in the proportion of funds across components aligns with national MCH priorities.

Allocation Formulas and Set-Asides. Congress may wish to examine the relevance of the federally defined allocation formula across all three programs in the MCH Services Block Grant, given that appropriation laws frequently deviate from these requirements (see "Funding"). For example, a CRS analysis of final MCH Services Block Grant funding levels from FY2013 to FY2024 revealed that across this 12-year period, there were seven years where the CISS program received an allocation greater than that specified by the formula and six years where SPRANS received an allocation greater than that specified by the formula.[94] Congress may also consider whether the federal allotment formula for the State MCH Block Grant adequately allots federal funds to individual states. The formula directs the first proportion of funds based on historical individual state allotments in 1983 and directs remaining funds based on child poverty statistics. However, U.S. Territories and Freely Associated States do not receive child poverty-based

[91] Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization, 2023. Ely DM, Driscoll AK, "Infant mortality in the United States: Provisional data from the 2022 period linked birth/infant death file," National Center for Health Statistics, Vital Statistics Rapid Release, no 33, Hyattsville, MD: National Center for Health Statistics, 2023.

[92] U.S. Department of Health and Human Services, *Healthy People 2030, Building a healthier future for all,* https://health.gov/healthypeople.

[93] HRSA, *FY2025 Justification of Estimates for Appropriations Committees*, p. 185.

[94] In FY2019, both CISS and SPRANS received final federal funding levels that were higher than the amount specified by formula.

allotments due to a historical lack of ACS data in these jurisdictions – instead receiving a second proportion of funds that is proportionate to each jurisdiction's share of overall State MCH Block Grant funding in 1983. Congress may examine whether these formulas and approaches adequately achieve program goals and if other MCH-related disparities, measures, data sources, or factors should be taken into consideration.

The State MCH Block Grant program is distinct from various other federal health and human services block grants, in that there is no mandate or set-aside to fund services specifically for tribal populations. Whereas some federal block grant programs reserve a proportion of funds for tribal entities (e.g. MIECHV, Tribal Opioid Response Grants), and may also allow federally recognized tribes to operate such programs (e.g. Temporary Assistance for Needy Families), the State MCH Block Grant does not specify, nor request states to report on, the extent to which funds are specifically used to support tribal populations.[95] In addition, tribes cannot specifically operate their own State MCH Block Grant program, but must instead coordinate with states for funding. Congress may examine the extent to which tribal populations are reached by State MCH Block Grant services, or assess the degree to which these populations face gaps in MCH services that could be fulfilled by the State MCH Block Grant program. Such considerations may also be framed within the program's overarching goal of improving the health and well-being of MCH populations, particularly those with low income or limited access to health services.

State Contributions. State contributions to the State MCH Block Grant program have decreased following the COVID-19 pandemic (see **Table D-1** in **Appendix D**). In FY2019, nonfederal, state-matched and overmatched funds totaled over $5 billion, representing nearly 91% of program funds totaled across all sources. In FY2020, state contributions decreased by 63.3% to $2 billion. Although there is no evidence to suggest that any states did not fulfill the required match of $3 for every $4 in federal funds, this decrease drove the total program funding from over $6 billion in FY2019 to $2.5 billion in FY2020. As of FY2022, State MCH funds, local MCH funds, and program income contributions have not returned to prepandemic levels, and federal contributions have remained relatively flat. Congress may choose to examine barriers or facilitators that have affected nonfederal funding sources following the COVID-19 pandemic. Congress may also consider examining trends in nonfederal contributions to the State MCH Block Grant across the near future to assess whether funding and/or spending patterns eventually reflect pre-pandemic totals. Congress may also consider whether supplemental federal funds are needed to support states that face ongoing or acute MCH issues.[96]

[95] Currently, the F2F HIC program (established under SPRANS authority) is the only program within the overarching MCH Services Block Grant where funding shall be used to fund program activities for Indian tribes. According to SSA Section 501(c)(5), the term "Indian tribe" refers to the definition provided in section 4 of the Indian Health Care Improvement Act (25 U.S.C 1603).

For more information on the MIECHV program, see CRS In Focus IF10595, *Maternal, Infant, and Early Childhood Home Visiting Program*. For more information on Tribal Opioid Response Grants, see CRS In Focus IF12116, *Opioid Block Grants*. More information on tribal TANF programs can be found in CRS Report RL32748, *The Temporary Assistance for Needy Families (TANF) Block Grant: A Primer on TANF Financing and Federal Requirements*.

Some states may indicate the proportion of their total State MCH Block Grant funds that are reserved for tribal populations. For instance, Nebraska specifies that 5 percent of State MCH Block Grant funds are annually set-aside for four recognized tribes headquartered in Nebraska. However, this is not a requirement across all State MCH Block Grant programs. For more information, see Nebraska Dept. of Health and Human Services, *Title V - Maternal & Child Health Block Grant*, https://dhhs.ne.gov/Pages/Title-V.aspx.

[96] For example, such funding was provided during the Zika virus in 2017 (P.L. 114-223).

State MCH Block Grant: Relationships with Related Programs

Coordination and Monitoring. State MCH Block Grant programs must coordinate with other programs and stakeholders through both formal and informal partnerships. These partnerships may include other MCHB investments (e.g., Healthy Start grants), other HRSA programs (e.g., community health centers), and other federal investments (e.g., Maternal Mortality Review Committees), among others. Congress may consider examining how federally funded programs coordinate and avoid duplication of MCH-related efforts, including the degree to which existing programs address MCH needs in various settings or contexts.

Financing and Implementation. Congress could also examine how changes to other federal programs potentially affect how State MCH Block Grant programs are financed or implemented. For example, as discussed in the "Relationship with Medicaid" section, State MCH Block Grant funds should be used as a "payor of last resort" for direct health care expenditures and specifically cannot be used to reimburse a claim for a service covered under Medicaid.[97] Recent changes to Medicaid policy may affect how State MCH Block Grant programs utilize their funding. For instance, under the Families First Coronavirus Response Act (FFCRA; P.L. 116-127), as amended by the CARES Act (P.L. 116-136), states were required to implement continuous Medicaid enrollment during the COVID-19 public health emergency as a condition of receipt of enhanced Medicaid funds. This, along with other related federal and state policies (as well as economic and social factors), led to substantial increases in Medicaid enrollment.[98]

From FY2019 to FY2022, the proportion of State MCH Block Grant funds used toward direct services substantially decreased, from over 60% to less than one-third of the total program funding (see **Table F-1** in **Appendix F**). While the overall use of preventive and primary direct health care services declined as some individuals delayed or missed medical care during the acute phases of the pandemic, this shift in the types of services funded with State MCH Block Grant Funds may also reflect increased Medicaid enrollment. From FY2020 to FY2022, State MCH Block Grant Funds were increasingly used toward enabling and public health services and systems.

The Consolidated Appropriations Act of 2023 (CAA 2023; P.L. 117-328) ended the continuous Medicaid enrollment condition on March 31, 2023. The law specified a process for redetermining eligibility for all Medicaid enrollees and terminating coverage for individuals who are no longer eligible. Congress may consider how State MCH Block Grant funds could be leveraged to address potential gaps in coverage following the redetermination process, and to assess whether current federal funding levels adequately meet the needs of MCH populations. Congress may also consider closely examining current and future State MCH Block Grant spending patterns. For instance, if State MCH Block Grant funds are increasingly used toward direct services in a state that previously expanded public health service activities in FY2021, such activities may face financial constraints and need to be scaled back. Congress may consider the degree to which such situations occur and how, if at all, they affect national MCH needs.

[97] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report*, p. 22.

[98] For example, CMS data indicate that Medicaid enrollment grew by 32.6% from February 2020 to December 2022. See https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/ for more information.

Oversight and Accountability

State MCH Block Grant Performance Measurement Framework. In January 2024, MCHB released updated State MCH Block Grant program guidance, which included a revised performance monitoring framework. As discussed in the "Performance Measurement Framework" section, NOMs and NPMs track progress toward state and national health priorities. However, individual State MCH Block Grant programs are not the only factors affecting these measures, and thus changes to NOMs and NPMs are not necessarily directly related to impact of a singular program. Other federal and state programs (e.g., Title X programs, Healthy Start, MIECHV, Medicaid), as well as interrelated societal issues, may affect the health and well-being of certain populations. Due to the flexibility of funding and multifaceted nature of MCH issues, determining the impact of a single funding stream on certain health indicators is challenging. These estimates should be interpreted by policymakers accordingly.

The updated performance monitoring framework requires all states to report on two "universal NPMs," thereby attempting to "accelerate progress on federal and state priorities."[99] The implementation of universal NPMs will facilitate the first estimate of two nationwide performance measures, since all states were not previously required to report on specific NPMs. Congress may choose to monitor the success of this new requirement and assess whether such reporting supports a more comprehensive snapshot of State MCH Block Grant performance. Additionally, the current framework does not assess the quality of health services provided under State MCH Block Grant programs. Congress may consider whether additional oversight is needed in this area.

SPRANS and CISS. Although the State MCH Block Grant program implements a formalized Application/Annual Report across all recipients, reporting requirements can vary widely across individual SPRANS and CISS grants depending on the topic and type of program being implemented. As such, no centralized or structured reporting is available for all SPRANS- or CISS-funded activities. A recent Government Accountability Office (GAO) report similarly highlighted the need for improved standardization of performance metrics across other related HRSA programs (i.e. MIECHV, Healthy Start, State MCH Block Grant)—a recommendation that was agreed upon by HHS.[100] Congress may consider whether current program monitoring activities across MCH Services Block Grant programs, and the monitoring of new MCH initiatives, are complementary or duplicative to the overarching goals of the MCH Services Block Grant.

[99] HRSA, *Title V Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report*, p. iv.

[100] U.S. Government Accountability Office, *Maternal and Infant Health: HHS Should Strengthen Process for Measuring Program Performance*, GAO-24-106605, March 2024, https://www.gao.gov/products/gao-24-106605.

Appendix A. MCH Services Block Grant Federal Funding History

Table A-1. MCH Services Block Grant Federal Funding History

FY2014-FY2024 ($ in Millions)

Fiscal Year	State MCH Block Grant	SPRANS	CISS	Total Federal Appropriations
2014	545.3	76.9	10.3	632.5
2015	549.6	77.1	10.3	637.0
2016	550.8	77.1	10.3	638.2
2017	549.5	80.4	10.3	640.2
2018	556.4	83.5	10.3	650.2
2019	555.4	109.1	10.3	674.8
2020	558.3	119.1	10.3	687.7
2021	561.6	138.8	10.2	710.6
2022	570.4	152.3	10.3	733.0
2023	593.8	212.1	10.3	816.2
2024	593.3	210.1	10.3	813.7

Source: Table prepared by CRS using final federal funding levels as reported in annual Department of Health and Human Services, Health Resources and Services Administration Congressional Budget Justifications for FY2014-FY2023. FY2024 figures reflect enacted totals, rather than final numbers based on P.L. 118-47 and the *Congressional Record,* vol. 170, no. 51, book II, March 22, 2024, p.H1887.

Note: Funding levels are not adjusted for inflation.

Appendix B. State MCH Block Grant Funding, by State

Table B-1. State MCH Block Grant Funding, by State

FY2022 ($ in Millions)

State	Federal Allocation	State MCH Funds	Local MCH Funds	Other Funds	Program Income	Total–All State Match Funds	Total–All Federal and State Funds
Alabama	11.7	38.3	—	0.9	29.0	68.3	80.0
Alaska	1.1	7.7	—	—	—	7.7	8.8
Arizona	7.6	5.8	—	6.7	—	12.5	20.1
Arkansas	7.1	4.0	—	0.5	13.0	17.5	24.7
California	39.6	36.0	20.7	—	31.2	87.9	127.5
Colorado	7.4	5.6	—	—	—	5.6	13.0
Connecticut	4.8	6.8	—	—	—	6.8	11.6
Delaware	2.1	10.0	—	2.1	—	12.0	14.1
Florida	20.5	14.9	—	224.7	13.7	253.3	273.8
Georgia	17.1	98.4	—	—	199.3	297.7	314.8
Hawaii	2.2	28.2	—	—	5.8	34.1	36.3
Idaho	3.3	—	2.5	—	—	2.5	5.8
Illinois	21.4	35.6	0.7	—	—	36.3	57.7
Indiana	12.4	33.8	—	—	—	33.8	46.2
Iowa	6.6	6.7	—	7.1	0.5	14.3	21.0
Kansas	4.9	3.4	3.2	—	—	6.6	11.5
Kentucky	11.4	50.0	—	—	48.0	98.0	109.4
Louisiana	12.9	10.2	—	2.9	5.4	18.5	31.3
Maine	3.3	3.9	—	—	—	3.9	7.2
Maryland	12.0	10.2	—	—	—	10.2	22.3
Massachusetts	11.2	71.0	—	—	—	71.0	82.3
Michigan	19.1	47.1	—	0.7	5.6	53.4	72.5
Minnesota	9.3	6.9	3.1	29.2	—	39.3	48.5
Mississippi	9.5	0.4	0.7	5.5	0.4	7.0	16.4
Missouri	12.5	10.0	—	—	—	10.0	22.5
Montana	2.3	2.9	6.0	—	3.2	12.0	14.3
Nebraska	4.0	2.9	0.3	—	—	3.2	7.3
Nevada	2.3	1.8	—	—	—	1.8	4.0
New Hampshire	2.0	5.1	—	1.7	—	6.7	8.7
New Jersey	11.8	148.8	—	—	—	148.8	160.6

State	Federal Allocation	State MCH Funds	Local MCH Funds	Other Funds	Program Income	Total–All State Match Funds	Total–All Federal and State Funds
New Mexico	4.3	4.1	—	—	7.2	11.2	15.5
New York	38.8	29.3	36.9	—	26.2	92.4	131.2
North Carolina	17.9	45.8	—	57.7	70.3	173.8	191.8
North Dakota	1.8	1.4	0.1	—	—	1.5	3.3
Ohio	22.7	56.9	—	—	—	56.9	79.6
Oklahoma	7.4	8.0	1.1	—	—	9.1	16.5
Oregon	6.2	17.2	4.0	9.2	—	30.5	36.7
Pennsylvania	24.3	48.9	—	—	—	48.9	73.2
Rhode Island	1.7	2.2	—	2.3	39.6	44.1	45.8
South Carolina	11.8	14.0	4.9	0.7	17.4	37.0	48.8
South Dakota	2.2	1.6	—	—	0.9	2.4	4.7
Tennessee	12.2	11.6	—	—	2.0	13.6	25.8
Texas	36.7	40.2	—	—	—	40.2	76.9
Utah	6.2	17.5	2.7	14.8	1.1	36.2	42.3
Vermont	1.7	1.0	—	—	—	1.0	2.6
Virginia	12.7	9.3	—	1.7	2.3	13.3	26.0
Washington	9.0	7.6	—	—	—	7.6	16.5
West Virginia	6.2	11.9	—	—	20.5	32.4	38.6
Wisconsin	11.0	4.7	6.7	—	—	11.4	22.4
Wyoming	1.2	1.9	—	—	0.5	2.4	3.6
Other Jurisdictions							
American Samoa	0.5	—	—	—	—	0.4	0.5
District of Columbia	7.0	30.8	—	—	—	30.8	37.8
Federated States of Micronesia	0.5	0.1	0.8	—	—	0.9	1.5
Guam	0.8	0.6	—	—	—	0.6	1.3
Marshall Islands	0.2	2.4	—	—	—	2.4	2.6
Northern Mariana Islands	0.5	—	—	0.5	—	0.5	0.9
Palau	0.2	0.2	—	—	—	0.2	0.3
Puerto Rico	16.1	11.8	—	1.1	0.2	13.1	29.3
Virgin Islands	1.5	—	1.4	—	—	1.4	2.9
Total	**$556.6**	**$1,087.3**	**$95.7**	**$370.0**	**$543.4**	**$2,096.8**	**$2,653.0**

Source: Table prepared by CRS using final FY2022 federal allocation data reported in HRSA's FY2024 Congressional Budget Justification, pp. 198-200. State funds, other local funds, and program income totals were extracted from individual state Application/Annual Reports, Form 2, FY2022 Expenditures column. Each state

Application/Annual Report is located on HRSA's Title V Information System (TVIS); https://mchb.tvisdata.hrsa.gov/Home/StateApplicationOrAnnualReport.

Notes: TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. FY2022 expenditures were reported in July 2023 and may not reflect final state, local, or program income expenditures.

Not all states submit data on the "other funds" or "program income" categories; these are indicated with a dash. States are allowed to exceed the match requirement of at least $3 for every $4 in federal funds; this is called an *overmatch*.

Appendix C. Essential Public Health Services for MCH Populations

1	Conduct ongoing assessment of the changing health needs of the MCH population to drive priorities for achieving equity in access and positive health outcomes.
2	Expand surveillance and other data systems capacity to support rapid investigation of emerging health issues that affect the MCH population.
3	Inform and educate the public and families about the unique needs of the MCH population.
4	Mobilize partners, including families and individuals, at the federal, state, and community levels in promoting shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services, and developing supportive policies.
5	Provide expertise and support for the formation and implementation of state laws, regulations, and other policies pertaining to the health of the MCH.
6	Integrate systems of public health, health care, and related community services to ensure equitable access and coordination to achieve maximum impact.
7	Promote the effective and efficient organization and utilization of resources to ensure access to necessary comprehensive services for CYSHCN and families through public health services, systems, and population health efforts.
8	Educate the MCH workforce to build the capacity to ensure innovative, effective programs and services and the efficient and equitable use of resources.
9	Support or conduct applied research resulting in evidence-based policies and programs.
10	Facilitate rapid innovation and dissemination of effective practices through quality improvement and other emerging methods.
11	Provide services to address unmet needs in health care and public health systems for the MCH population.

Source: Adapted from *Title V Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report*, p. 4.

Appendix D. State MCH Block Grant Funds, by Source (FY2018-FY2022)

Table D-1. State MCH Block Grant Funds, by Funding Source

($ in Millions)

Funding Source	2018	2019	2020	2021	2022
Federal Allocation	536	545	547	549	557
State MCH Funds	2,884	2,773	1,046	1,063	1,088
Local MCH Funds	341	263	126	109	96
Other Funds	309	306	427	274	370
Program Income	2,443	2,228	443	517	543
Total	**$6,512**	**$6,114**	**$2,590**	**$2,512**	**$2,654**

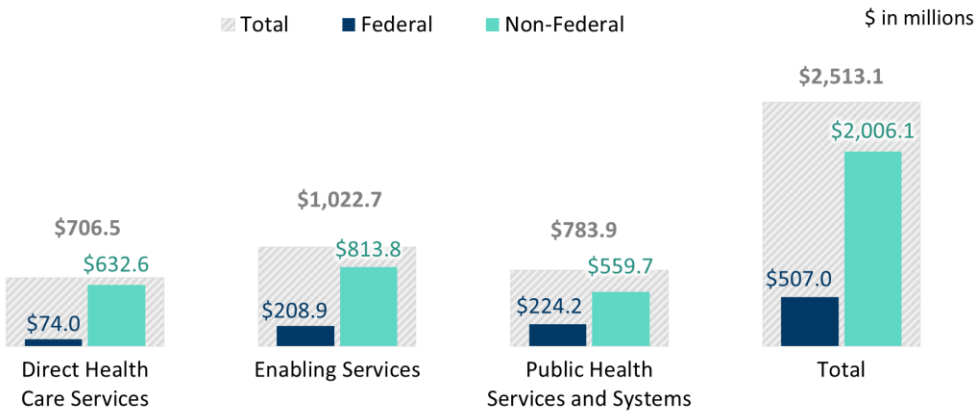
Source: Table prepared by CRS using Annual Reports for state, local, other, and program income totals, found on HRSA's Title V Information System; https://mchb.tvisdata.hrsa.gov/Financial/FundingBySource. Final federal allocations were derived from HRSA's annual Congressional Budget Justifications, FY2020-FY2023.

Notes: TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. For example, FY2022 data were reported in July 2023 and may not reflect final state, local, or program income totals.

Appendix E. State MCH Block Grant Expenditures, by Service Category and Funding Source

Figure E-1. State MCH Block Grant Expenditures, by Service Category and Funding Source

FY2022



Source: Table prepared by CRS using data from state Annual Reports, found on HRSA's Title V Information System; https://mchb.tvisdata.hrsa.gov/Financial/FundingByServiceLevel.

Notes: "Federal" funds reflect federal allotments from the State MCH Block Grant. "Non-Federal" funds may include state, local, program income, and other funds, which may also include federal funds from other programs under the control of the agency administering the State MCH Block Grant program (see "Funding"). TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. FY2022 expenditures were reported in July 2023 and may not reflect final state, local, or program income expenditures.

Appendix F. State MCH Block Grant Expenditures, by Service Category (FY2018-FY2022)

Table F-1. State MCH Block Grant Expenditures, by Service Category

($ in Millions)

Service Category	FY2018	FY2019	FY2020	FY2021	FY2022
Direct	4,094	3,718	473	647	707
Enabling	1,325	1,327	996	829	1,023
Public Health Services & Systems	1,058	1,024	1,004	783	784
Total	**$6,477**	**$6,070**	**$2,474**	**$2,260**	**$2,513**

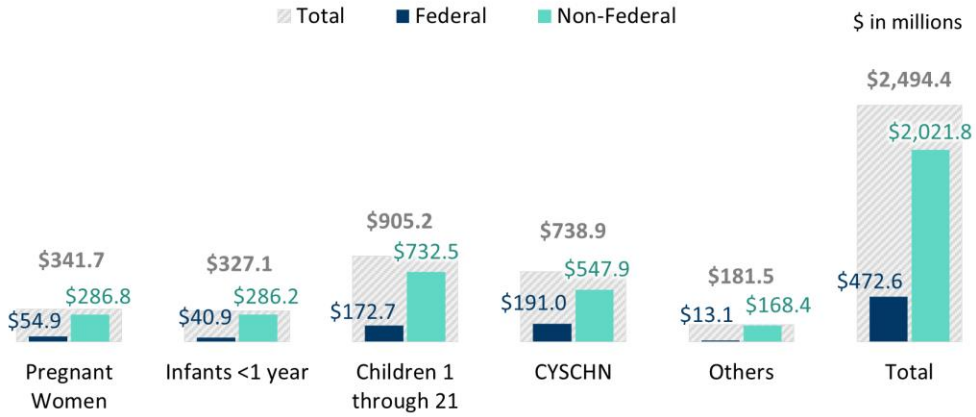
Source: Table prepared by CRS using data from state Annual Reports, found on HRSA's Title V Information System; https://mchb.tvisdata.hrsa.gov/Financial/FundingByServiceLevel.

Notes: TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. For example, FY2022 expenditures were reported in July 2023 and may not reflect final state, local, or program income expenditures.

Appendix G. State MCH Block Grant Expenditures, by Population Group and Funding Source

Figure G-1. State MCH Block Grant Expenditures, by Population Group and Funding Source

FY2022



Source: Table prepared by CRS using data from state Annual Reports, found on HRSA's Title V Information System; https://mchb.tvisdata.hrsa.gov/Financial/FundingByIndividualsServed.

Notes: "Federal" funds reflect federal allotments from the State MCH Block Grant. "Non-Federal" funds may include state, local, program income, and other funds, which may also include federal funds from other programs under the control of the agency administering the State MCH Block Grant program (see "Funding"). TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. FY2022 expenditures were reported in July 2023 and may not reflect final state, local, or program income expenditures.

Appendix H. State MCH Block Grant Expenditures, by Population Group (FY2018-FY2022)

Table H-1. State MCH Block Grant Expenditures, by Population Group

($ in Millions)

Population Group	FY2018	FY2019	FY2020	FY2021	FY2022
Pregnant Women	304	290	303	310	342
Infants < 1 Year	409	409	367	303	327
Children 1 through 21 Years	928	939	826	828	905
CYSHCN	4,554	4,159	724	717	739
Others	242	226	222	205	181
Total	**$6,437**	**$6,023**	**$2,442**	**$2,362**	**$2,494**

Source: Table prepared by CRS using data from state Annual Reports, found on HRSA's Title V Information System; https://mchb.tvisdata.hrsa.gov/Financial/FundingByIndividualsServed.

Notes: TVIS funding data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. For example, FY2022 expenditures were reported in July 2023 and may not reflect final state, local, or program income expenditures.

Appendix I. State MCH Block Grant National Performance Measures

Table I-1. List of National Performance Measures (NPM)

No.	Short Title	Full NPM Title	Population Domain(s)	Measure Domain
1	**Postpartum Visit**	**A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth** **B) Percent of women who attended a postpartum checkup and received recommended care components**	Women/Maternal Health	Clinical Health Systems
2	Postpartum Mental Health Screening	Percent of women screened for depression or anxiety following a recent live birth	Women/Maternal Health	Clinical Health Systems
3	Postpartum Contraception Use	Percent of women using a most or moderately effective contraceptive following a recent live birth	Women/Maternal Health	Health Behavior
4	Perinatal Care Discrimination	Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting health care during pregnancy, delivery, or at postpartum care	Women/Maternal Health or Perinatal/Infant Health	Social Determinants of Health
5	Risk-Appropriate Perinatal Care	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Perinatal/Infant Health	Clinical Health Systems
6	Breastfeeding	A) Percent of infants who are ever breastfed B) Percent of children, ages 6 month through 2 years, who were breastfed exclusively for 6 months	Perinatal/Infant Health	Health Behavior
7	Safe Sleep	A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult	Perinatal/Infant Health	Health Behavior
8	Housing Instability–Pregnancy Housing Instability–Child	Percent of women with a recent live birth who experienced housing instability in the 12 months before a recent live birth Percent of children, ages 0 through 11, who experienced housing instability in the past year	Perinatal/Infant Health, Women/Maternal Health, and/or Child Health	Social Determinants of Health
9	Developmental Screening	Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	Child Health	Clinical Health Systems

No.	Short Title	Full NPM Title	Population Domain(s)	Measure Domain
10	Childhood Vaccination	Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months	Child Health	Clinical Health Systems
11	Preventive Dental Visit–Pregnancy	Percent of women who had a preventive dental visit during pregnancy	Women/Maternal Health, Child Health, and/or Adolescent Health	Clinical Health Systems
	Preventive Dental Visit–Child	Percent of children, ages 1 through 17, who had a preventive dental visit in the past year		
12	Physical Activity	Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	Child Health	Health Behavior
13	Food Sufficiency	Percent of children, ages 0 through 11, whose households were food sufficient in the past year	Child Health	Social Determinants of Health
14	Adolescent Well-Visit	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	Adolescent Health	Clinical Health Systems
15	Mental Health Treatment	Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling	Adolescent Health	Clinical Health Systems
16	Tobacco Use	Percent of adolescents, grades 9 through 12, who currently use tobacco products	Adolescent Health	Health Behavior
17	Adult Mentor	Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance	Adolescent Health	Social Determinants of Health
18	**Medical Home[a]–Overall**	**Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**	CYSCHN, Child Health, and Adolescent Health	Clinical Health Systems
	Medical Home–Personal Doctor	Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse		
	Medical Home–Usual Source Of Sick Care	Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care		
	Medical Home–Family Centered Care	Percent of children with and without special health care needs, ages 0 through 17, who have family centered care		
	Medical Home–Referrals	Percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals		

No.	Short Title	Full NPM Title	Population Domain(s)	Measure Domain
	Medical Home–Care Coordination	Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination		
19	Transition	Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	CYSCHN, Adolescent Health	Clinical Health Systems
20	Bullying	Percent of adolescents with and without special health care needs, ages 12 through 17, who are bullied or bully others.	CYSCHN, Adolescent Health	Social Determinants of Health

Source: Table prepared by CRS using data from *HRSA, Title V Maternal and Child Health Services Block Grant to State Program. Guidance and Forms for the Title V Application/Annual Report*, OMB No: 0915-0172, pp. 8-9, https://mchb.tvisdata.hrsa.gov/Home/Resources.

Notes: The two **bolded NPMs** represent the universal performance measures, which all block grant recipients must report on.

CYSCHN = Children and Youth with Special Health Care Needs.

NPMs with multiple sub-measures (e.g., "A" and "B" components) include NPM numbers 1, 6, and 7.

NPM numbers 8, 11, and 18 have multiple population domains and/or sub-components. These can be individually selected and count once toward the minimum requirement of 5 NPMs

a. HRSA defines "Medical Home" as "an approach to providing comprehensive, high quality health care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Care occurs in an environment of trust and mutual responsibility between the family, patient, and primary care provider." For more information, see https://mchb.tvisdata.hrsa.gov/Glossary/Glossary.

Appendix J. State MCH Block Grant National Outcome Measures

Table J-1. List of National Outcome Measures (NOM)

Short Title	Full NOM Title
Severe Maternal Morbidity	Rate of severe maternal morbidity per 10,000 delivery hospitalizations
Maternal Mortality	Maternal mortality rate per 100,000 live births
Teen Births	Teen birth rate, ages 15 through 19, per 1,000 females
Low Birth Weight	Percent of low birth weight deliveries (<2,500 grams)
Preterm Birth	Percent of preterm births (<37 weeks gestation)
Stillbirth	Stillbirth rate per 1,000 live births plus fetal deaths
Perinatal Mortality	Perinatal mortality rate per 1,000 live births plus fetal deaths[a]
Infant Mortality	Infant mortality rate per 1,000 live births
Neonatal Mortality	Neonatal mortality rate per 1,000 live births
Postneonatal Mortality	Postneonatal mortality rate per 1,000 live births
Preterm-Related Mortality	Preterm-related mortality rate per 100,000 live births
SUID Mortality	Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Neonatal Abstinence Syndrome	Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
School Readiness	Percent of children meeting the criteria developed for school readiness
Tooth Decay/Cavities	Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
Child Mortality	Child mortality rate, ages 1 through 9, per 100,000
Adolescent Mortality	Adolescent mortality rate, ages 10 through 19, per 100,000
Adolescent Motor Vehicle Death	Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000
Adolescent Suicide	Adolescent suicide rate, ages 10 through 19 per 100,000
Adolescent Firearm Death	Adolescent firearm mortality rate, ages 10 through 19 per 100,000
Child Injury Hospitalization	Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
Adolescent Injury Hospitalization	Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Women's Health Status	Percent of women, ages 18 through 44, in excellent or very good health
Children's Health Status	Percent of children, ages 0 through 17, in excellent or very good health
Children's Obesity	Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile)
Postpartum Depression	Percent of women who experience postpartum depressive symptoms
Postpartum Anxiety	Percent of women who experience postpartum anxiety symptoms
Behavioral/Conduct Disorders	Percent of children, ages 6 through 11, who have a behavioral or conduct disorder
Adolescent Depression/Anxiety	Percent of adolescents, ages 12 through 17, who have depression or anxiety

Short Title	Full NOM Title
CYSHCN Systems of Care	Percent of children and youth with special health care needs (CYSHCN), ages 0 through 17, who receive care in a well-functioning system
Flourishing—Young Child	Percent of children, ages 6 months through 5, who are flourishing
Flourishing—Child/Adolescent	Percent of children with and without special health care needs, ages 6 through 17, who are flourishing
Adverse Childhood Experiences	Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences

Source: Table prepared by CRS using data from *HRSA, Title V Maternal and Child Health Services Block Grant to State Program. Technical Assistance Resources*, p. 31. Available at https://mchb.tvisdata.hrsa.gov/Home/Resources.

a. The perinatal mortality rate is calculated by adding the total number of fetal deaths of 28 weeks or more gestation and total number of early neonatal deaths (less than seven days old). This sum is divided by the total number of live births and fetal deaths at 28 weeks or more gestation, per 1,000 live births. Fetal death data are published annually by the National Center for Health Statistics (NCHS), which defines fetal death as "the spontaneous intrauterine death of a fetus." Fetal deaths later in pregnancy, such as at 28 weeks or more, are sometimes referred to as stillbirths. Fetal deaths do not include induced terminations of pregnancy, also known as abortion. Additional information is available at https://www.cdc.gov/nchs/nvss/fetal_death.htm.

Appendix K. Family-to-Family Health Information Centers (F2F HIC): Legislation and Appropriation History

Table K-1. F2F HIC Legislation and Appropriation History

Law	Mandatory Appropriations (millions)	Years	Changes
Deficit Reduction Act of 2005, (P.L. 109-171)	$3 $4 $5	FY2007 FY2008 FY2009	Authorized and appropriated incremental funding increases for FY2007-FY2009; established statewide program under Title V of the Social Security Act.
Patient Protection and Affordable Care Act, (P.L. 111-148)	$5	FY2010–FY2012	Authorized and appropriated funding for FY2010-FY2012.
American Taxpayer Relief Act of 2012, (P.L. 112-240)	$5	FY2013	Authorized and appropriated funding for FY2013.
Bipartisan Budget Act of 2013, (P.L. 113-67)	$2.5	FY2014 (half-year)	Authorized and appropriated funding for FY2014 (half-year).
Protecting Access to Medicare Act of 2014, (P.L. 113-93)	$2.5 $2.5	FY2014 (half-year) FY2015 (half-year)	Authorized and appropriated half-year funding for both FY2014 and FY2015.
Medicare Access and CHIP Reauthorization Act of 2015, (P.L. 114-10)	$5	FY2015 (full)–FY2017	Authorized and appropriated full-year funding for FY2015-FY2017; Struck partial funding for FY2015.
Bipartisan Budget Act of 2018, (P.L. 115-123)	$6	FY2018–FY2019	Authorized and appropriated funding for FY2018-FY2019; required F2F HIC to be developed in all territories and at least one developed for tribal communities.
Sustaining Excellence in Medicaid Act of 2019, (P.L. 116-39)	$6	FY2020–FY2024	Authorized and appropriated funding for FY2020-FY2024.
Consolidated Appropriations Act, 2024	$1.5	Through January 1, 2025	Authorized and appropriated funding for the first quarter of FY2025.

Source: CRS analysis of legislation on Congress.gov.

Appendix L. Other Title V Programs

In addition to the MCH Services Block Grant, Title V of the Social Security Act contains a number of sections that were added or amended by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). This appendix provides a summary of those sections and references to other CRS reports, where relevant.

SSA §510, Separate Program for Abstinence Education

This program provides funding to states for abstinence education. This program was formerly known as the Title V Abstinence Education Grant Program, as authorized by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA; P.L. 104-193). The Bipartisan Budget Act of 2018 (BBA; P.L. 115-123) renamed the ACA-reauthorized program to the *Title V Sexual Risk Avoidance Education Program.* The program focuses on implementing sexual risk avoidance, meaning voluntarily refraining from sex before marriage. Grantees may set aside funds to conduct rigorous and evidence-based research on sexual risk avoidance.

The authorization and funding have been extended multiple times, most recently through FY2024 in the Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42). For more information on this program, see CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs*.

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

The MIECHV program provides grants to states, territories, and tribal entities for the support of evidence-based early childhood home visiting programs. The program seeks to provide and strengthen home visiting services to families residing in at-risk communities and to improve coordination of supportive services. MIECHV is collaboratively administered by the Maternal and Child Health Bureau within HRSA and the Administration for Children and Families.

The authorization and funding have been extended multiples times, most recently through FY2027 under the Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022 (Section 6101 of the Consolidated Appropriations Act, 2023; CAA 2023; P.L. 117-328). For more information on this program, see CRS In Focus IF10595, *Maternal, Infant, and Early Childhood Home Visiting Program*.

SSA §512, Services to Individuals with a Postpartum Condition and Their Families

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. No funds have been appropriated for this program.

SSA §513, Personal Responsibility Education

The Personal Responsibility Education Program (PREP) is administered by the Administration for Children and Families. PREP is defined as a program 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, (2) adolescent development, (3) financial literacy, (4) parent-child communication, (5) educational and career success, and (6) healthy life skills.

Established in 2010 by the ACA (P.L. 111-148, as amended), PREP funding and authorization have been extended multiple times, most recently through the first fiscal quarter of FY2025 by Division G of the Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42). For more information on this program, see CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs*.

Appendix M. Abbreviations Used in This Report

ACA	Patient Protection and Affordable Care Act
CDC	Centers for Disease Control and Prevention
CHIP	State Children's Health Insurance Program
CISS	Community-Integrated Services System Program
CMS	Centers for Medicare & Medicaid Services
CYSHCN	Children and Youth with Special Health Care Needs
ESM	Evidence-Based (or informed) Strategy Measures
FY	Fiscal Year
GAO	Government Accountability Office
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
MCH	Maternal and Child Health
MCHB	Maternal and Child Health Bureau
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
NOM	National Outcome Measure
NPM	National Performance Measure
OBRA	Omnibus Budget Reconciliation Act
PHSA	Public Health Service Act
SSBG	Social Services Block Grant
SPRANS	Special Projects of Regional and National Significance Program
SSA	Social Security Act
TVIS	Title V Information System
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Author Information

Alexandria K. Mickler
Analyst in Health Policy

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