HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

National Snapshot

FY 2023 Application / FY 2021 Annual Report

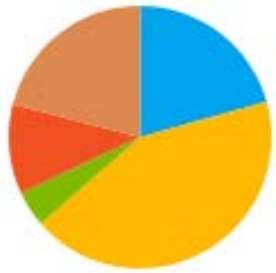
November 2022

Title V Federal-State Partnership - National

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data contained in the FY2023 Application/ FY2021 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov).

Funding by Source

FY 2021 Expenditures

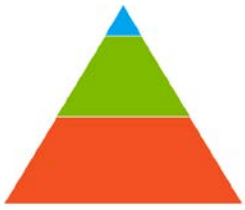


Source	FY 2021 Expenditures	%
Federal Allocation	$510,501,327	20.6%
State MCH Funds	$1,062,912,884	43.0%
Local MCH Funds	$108,820,390	4.4%
Other Funds	$273,829,370	11.1%
Program Income	$517,314,797	20.9%
Total	$2,473,378,768	100.0%

Funding by Service Level*

FY 2021 Expenditures Federal & Non-Federal

FY 2021 Expenditures Federal



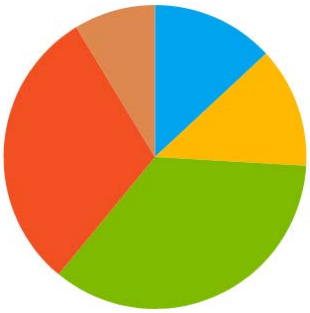
FY 2021 Expenditures Non-Federal

Service Level	Federal & Non-Federal	Federal	Non-Federal
Direct Services	$473,385,278	$86,847,968	$386,537,310
Enabling Services	$996,386,542	$203,853,921	$792,532,621
Public Health Services and Systems	$1,004,136,128	$225,191,644	$778,944,484

*Funding by service level amounts do not include administrative funds

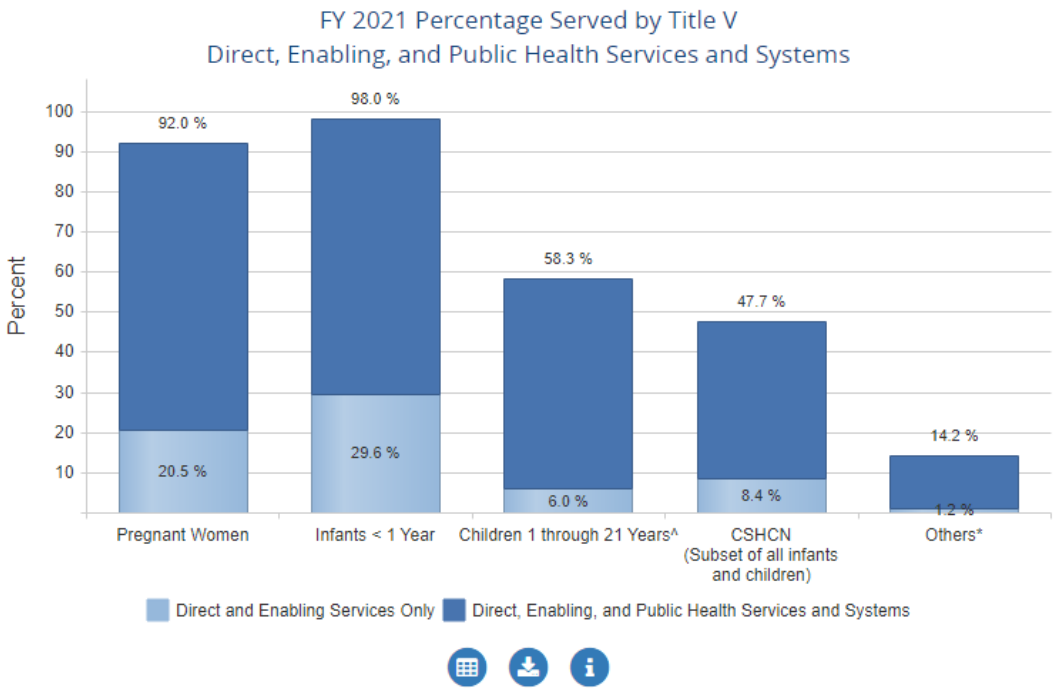
Population Served by Title V

FY 2021 Expenditures
Total: $2,362,256,213



Population Served	FY 2021 Expenditures	%
Pregnant Women	$309,518,237	13.1%
Infants < 1 Year	$302,733,550	12.8%
Children 1 through 21 Years	$827,763,989	35.0%
CSHCN (Subset of all Children)	$716,767,143	30.3%
Others*	$205,473,294	8.8%
Total^	$2,362,256,213	100%

*Others– Women and men, over age 21
^Total Expenditures amount does not include administrative funds



^States are required to report data on Children (ages 1 through 21 years) as one of the three legislatively defined MCH populations. These data are used for reporting purposes for both the Child and Adolescent Health Population Domains.

*Others – Women and men, over age 21.

National Performance Measures – Selection Breakdown

Measure Number	Measure Short Name	Reporting Domain(s)	Number of States
NPM 1	Well-Woman Visit	Women/Maternal Health	47
NPM 2	Low-Risk Cesarean Delivery	Women/Maternal Health	6
NPM 3	Risk-Appropriate Perinatal Care	Perinatal/Infant Health	14
NPM 4	Breastfeeding	Perinatal/Infant Health	42
NPM 5	Safe Sleep	Perinatal/Infant Health	37
NPM 6	Developmental Screening	Child Health	38
NPM 7	Injury Hospitalization	Child Health, Adolescent Health	17
NPM 7.1	Injury Hospitalization - Ages 0 through 9	Child Health	5
NPM 7.2	Injury Hospitalization - Ages 10 through 19	Adolescent Health	7
NPM 7.1 and NPM 7.2	Injury Hospitalization	Child Health, Adolescent Health	5
NPM 8	Physical Activity	Child Health, Adolescent Health	20
NPM 8.1	Physical Activity - Ages 6 through 11	Child Health	14
NPM 8.2	Physical Activity - Ages 12 through 17	Adolescent Health	2
NPM 8.1 and NPM 8.2	Physical Activity	Child Health, Adolescent Health	4
NPM 9	Bullying	Adolescent Health	18
NPM 10	Adolescent Well-Visit	Adolescent Health	32
NPM 11	Medical Home	Child Health, Adolescent Health, Children with Special Health Care Needs	39
NPM 12	Transition	Adolescent Health, Children with Special Health Care Needs	36
NPM 13	Preventive Dental Visit	Women/Maternal Health, Child Health, Adolescent Health	28

NPM 13.1	Preventive Dental Visit - Pregnancy	Women/Maternal Health	3
NPM 13.2	Preventive Dental Visit - Child/Adolescent	Child Health, Adolescent Health	15
NPM 13.1 and NPM 13.2	Preventive Dental Visit	Women/Maternal Health, Child Health, Adolescent Health	10
NPM 14	Smoking	Women/Maternal Health, Child Health, Adolescent Health	16
NPM 14.1	Smoking - Pregnancy	Women/Maternal Health	11
NPM 14.2	Smoking - Household	Child Health, Adolescent Health	3
NPM 14.1 and NPM 14.2	Smoking	Women/Maternal Health, Child Health, Adolescent Health	2
NPM 15	Adequate Insurance	Child Health, Adolescent Health, Children with Special Health Care Needs	6

Number of NPMs & SPMs by State

State Name	Number of NPMs	Number of SPMs
Alabama	7	6
Alaska	5	5
American Samoa	6	4
Arizona	10	0
Arkansas	10	4
California	5	1
Colorado	5	4
Connecticut	6	3
Delaware	7	3
District of Columbia	6	6
Federated States of Micronesia	5	5
Florida	8	3
Georgia	9	3
Guam	8	5
Hawaii	5	5
Idaho	8	4
Illinois	9	5
Indiana	7	9
Iowa	8	7
Kansas	5	0
Kentucky	7	7

Louisiana	6	2
Maine	8	4
Marshall Islands	7	5
Maryland	9	5
Massachusetts	5	6
Michigan	6	6
Minnesota	6	5
Mississippi	8	13
Missouri	5	3
Montana	5	2
Nebraska	5	5
Nevada	8	4
New Hampshire	6	3
New Jersey	9	6
New Mexico	5	2
New York	5	2
North Carolina	6	5
North Dakota	5	3
Northern Mariana Islands	6	2
Ohio	6	5
Oklahoma	8	3
Oregon	6	3
Palau	5	3
Pennsylvania	6	8

Puerto Rico	7	2
Rhode Island	6	6
South Carolina	12	4
South Dakota	5	2
Tennessee	8	22
Texas	7	5
Utah	7	3
Vermont	7	5
Virgin Islands	8	4
Virginia	7	6
Washington	6	10
West Virginia	7	4
Wisconsin	7	5
Wyoming	6	4

Executive Summary

Legacy

The **Title V Maternal and Child Health (MCH) Services Block Grant** program (hereafter referred to as the MCH Block Grant) is administered by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB). Enacted in 1935 as a part of the Social Security Act, the MCH Block Grant is the nation's oldest Federal-State partnership. For more than 80 years, the MCH Block Grant has provided a foundation for ensuring the health of mothers, children, and families.

The MCH Block Grant contains three funding sources:

1. **MCH Formula Grants to 59 states and jurisdictions** (hereafter referred to as "state")
2. Special Projects of Regional and National Significance (SPRANS)
3. Community Integrated Service Systems (CISS)

The largest funding component (approximately 85%) of the MCH Block Grant is awarded to state health agencies based on a legislative formula that considers, in part, the number of children in poverty in a state compared to the total number of children in poverty in the U.S. The remaining two funding components support discretionary and competitive project grants, which complement state efforts to improve the health of mothers, infants, children, including children with special needs (CSHCN), and their families. SPRANS funds projects (through grants, contracts, and other mechanisms) in research, training, genetic services, and newborn screening/follow-up, sickle cell disease, hemophilia, and MCH improvement. CISS projects (through grants, contracts, and other mechanisms) seek to increase the capacity for service delivery at the local level and to foster formation of comprehensive, integrated, community-level service systems for mothers and children.

Each year, 59 state MCH agencies, which are usually located within a state health department, apply for and receive a formula grant. Annual submission of an Application is required by law (Section 505) to entitle a state to receive MCH Block Grant funds. Section 505(a) further requires a state to conduct a statewide Needs Assessment every 5 years. The most recent Five-Year Needs Assessment Summary was submitted in September 2022, as part of the fiscal year (FY) 2023 Application/FY 2021 Annual Report. In the next two interim years, states will provide an annual update on their ongoing needs assessment activities in the MCH Block Grant Application/Annual Report.

Section 506 requires a state to submit an Annual Report on the expenditure of its previous year's funds. As mandated by Section 506, information provided by states

through the State MCH Block Grant Annual Report and other sources of state data gathered by HRSA's MCHB is aggregated and made publicly available through the Title V Information System (TVIS) Web Reports.

Purpose

The purpose of the MCH Block Grant is to **create federal/state partnerships** in all 59 states that support service systems for addressing current and emerging MCH challenges, such as:

- Significantly reducing infant mortality;
- Providing comprehensive care for women before, during, and after pregnancy and childbirth;
- Providing preventive and primary care services for infants, children, and adolescents;
- Providing comprehensive care for children and adolescents with special health care needs;
- Immunizing all children;
- Reducing adolescent pregnancy;
- Putting into community practice national standards and guidelines for prenatal care, for healthy and safe child care, and for the health supervision of infants, children, and adolescents;
- Assuring access to care for all mothers and children; and
- Meeting the nutritional and developmental needs of mothers, children, and families.

Investment

Every $4 of federal Title V funding received by a state must be matched by at least $3 of state and/or local money. The legislation also contains a Maintenance of Effort (MOE) requirement, which mandates that each state maintains a level of expenditure for MCH programs at a level that is equal to the amount provided in fiscal year 1989. Combined, the Title V MCH federal-state partnership investment totaled more than $2.4 billion in FY 2021.

HRSA believes public health and well-being come not by simply treating a problem, but by investing in system-wide solutions to promote health and prevent disease. Title V-supported programs provide MCH services at three levels – direct services, enabling services, and public health services and systems. The level of investment in each service level varies across states and by source of funding. A comparison of federal and non-federal Title V expenditures in FY 2021 indicates that federal Title V program funds primarily supported enabling services (41 percent) and public health services and

systems (44 percent), while 33 percent of non-federal (state and local) Title V dollars were expended on direct services.

Of the federal funds received each year, each state must expend at least 30 percent on preventive and primary care services for children and an additional 30 percent or more on services for CSHCN. States report annually on their federal, non-federal, and Title V Partnership (federal and non-federal) budget and expenditures by participant class (i.e., pregnant women, infants, children, CSHCN, and others). In FY 2021, infants and children, including CSHCN, accounted for approximately 79 percent of the reported Title V Partnership expenditures. Title V is a key source of support in providing and assuring specialty services for CSHCN. Approximately one-third of the reported total Title V Partnership expenditures in FY 2021 supported services for CSHCN.

Title V has and continues to play a lead role in improving MCH outcomes across states, with noted contributions in assuring universal newborn screening and timely follow-up, reducing infant mortality, and preventing child deaths and injuries. MCH Block Grant-funded programs also work to increase access to quality care, provide prenatal and postnatal care, increase the number of children who receive health assessments and follow-up diagnostic and treatment services, and implement family-centered systems of coordinated care for CSHCN. In FY 2021, approximately 92 percent of pregnant women, 98 percent of infants, and 58 percent of children nationally benefitted from a Title V-supported service.

Operated as a Federal-State partnership and consistent with the block grant concept, states have discretion in determining how to best invest their federal Title V funds to most effectively complement state-supported efforts in addressing the unique needs of each individual state's MCH population. This flexibility is balanced with financial and performance accountability, as documented through annual financial, programmatic, and performance reporting.

Accountability

Accountability in improving program performance and health outcomes for the MCH population is a shared goal between Federal and State Title V partners. **Reporting requirements in the MCH Block Grant Application/Annual Report adhere to the specific statutory requirements contained in Sections 501 and 503-509 of the Title V legislation.** HRSA's MCHB provides technical support to states in developing Five-year Action Plans that incorporate evidence-based and –informed strategies and measures.

Based on an individual state's identified MCH priority needs, each state selects a minimum of five of 15 National Performance Measures (NPMs). In FY 2021, NPMs that addressed well-woman visits, breastfeeding, developmental screening, and medical

home were selected by 38 or more of the 59 states. Each NPM is linked to a National Outcome Measure (NOM). Collectively, they address five MCH population domains, which include Women/Maternal Health, Perinatal/Infant Health, Child Health, CSHCN, and Adolescent Health. For each selected NPM, states develop at least one Evidence-based and –Informed Strategy Measure. In addition, states may develop one or more State Performance Measures (SPMs) or State Outcome Measures (SOMs) to address identified MCH priority needs that are not addressed by the national performance or outcome measures. Reflective of the flexibility that State Title V programs have, the number of performance measures selected by an individual state ranged from 5-12 NPMs and 0-22 SPMs for the 2020 Needs Assessment reporting cycle.

As mandated by Section 506, information provided through the State MCH Block Grant Annual Report and other sources of state data gathered by HRSA's MCHB are aggregated and made publicly available through the Title V Information System (TVIS) Web Reports.

Annual state reporting on their performance relative to the NPMs and NOMs is used by the MCHB to assess national progress around key MCH indicators and to facilitate the Bureau's annual budget/performance reporting. The MCHB further uses these data to identify current and emerging national MCH priority areas, to guide strategic planning efforts, and to inform the allocation of resources.

States use the national and state-specific MCH Block Grant data to establish priorities for their individual MCH populations, to support ongoing assessment of MCH population needs, to determine effectiveness of current Title V program strategies, and to monitor progress in achieving the Title V MCH Block Grant Five-Year State Action Plan.

Partnership

Partnerships and cross-program collaborations at all levels define Title V. Success in improving, innovating, and transforming MCH can be achieved only through continued commitment and partnership. Title V programs partner with a range of federal, state, and local entities in planning and implementing their Five-Year State Action Plans. These partnerships include HRSA and other federally administered programs, state, and local MCH programs, Tribes and Tribal Organizations, public health and health professional educational programs, and state and local public and private organizations that serve the MCH population.

Within a state, Title V and Title XIX programs share the common goal of improved health for the MCH population through provision of affordable health care delivery systems and adequate coverage. Section 509(a)(2) of the Title V legislation cites the need to promote "coordination at the Federal level of activities authorized under this title [Title V] and under title XIX…." Section 1902(a)(11) of the Title XIX legislation requires

State Medicaid agencies to enter into Inter-Agency Agreements (IAAs) with State Title V agencies. Section 1902(a)(11) further clarifies that Medicaid funds are to be used to reimburse expenditures made by the Title V agency for Medicaid-covered services to Medicaid recipients, as appropriate, (i.e., that Medicaid should be the first payer).

The Title V-Title XIX Inter-Agency Agreements (IAAs) for each state can be viewed in the TVIS. A recent focus of the MCHB has been the strengthening of the Title V and Title XIX partnership through development of robust IAAs. Noted areas of collaboration in the state IAAs were Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, immunizations, and addressing the needs of high-risk pregnant and post-partum women. Additional activities included CSHCN, developmental disabilities, lead screening, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program, sexually transmitted diseases, and oral health. A majority of the IAAs included information on how data would be exchanged to meet reporting and billing requirements.

Family engagement and leadership are longstanding priorities in MCHB programs. Beyond CSHCN programs, increased emphasis is being placed on the need for a state to demonstrate the value of family partnership in improving health outcomes for all sectors of the MCH population. States are expected to work closely with family partnerships in conducting their Five-Year Needs Assessments, in writing their five-year State Action Plans and in developing ESMs to address the selected NPMs. **Family partnership is defined as: “patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy making – to improve health and health care.”**