USING THE TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT TO SUPPORT CHILD DEVELOPMENT SERVICES

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DEDICATION

The authors would like to dedicate this report in memory of Vince L. Hutchins, M.D., former Maternal and Child Health Bureau director (1977–1992) and Distinguished Research Professor and Chair, Division of Policy, National Center for Education in Maternal and Child Health, Georgetown Public Policy Institute, Georgetown University. Dr. Hutchins, through his work, teachings, and writings, devoted his life to promoting better child health and development for all children in the United States.

EXECUTIVE SUMMARY

This report explains how services provided through the Title V Maternal and Child Health Services Block Grant can be used to foster optimal child development intervention services in the early years of life. The flexibility of the Title V Maternal and Child Health Services Block Grant program allows it to be an originating and supportive source of funding for child development programs, including direct care for mothers and children and interventions for an entire family. Title V can work alone or with other sources of funding, specifically Medicaid and CHIP. By paying for services that Medicaid cannot, Title V allows for the creation of more comprehensive and "wraparound" child development services.

This is the fourth in a series of reports presenting an overview of federal health policy related to child development.[1] It contains an overview of the Title V Maternal and Child Health Services Block Grant, and discusses how to use these funds—either alone or in combination with money from other sources (i.e., the State Children's Health Insurance Program (CHIP) and Medicaid)—to support the creation of comprehensive development services for young children and their families. The report also offers recommendations on how Title V can be used to promote child development programs for young children.

Title V is administered by the Maternal and Child Health Bureau, which is part of the Health Resources and Services Administration of the U.S. Department of Health and Human Services (HHS). The Title V budget for fiscal year (FY) 2001 totaled more than $4.3 billion, made up of federal, state, local, and other funds (e.g., program income and unobligated balances). The program served more than 27 million women, infants, and children in FY 1999—about 3 million more than in FY 1997. Most Title V funds are of two basic types: allotments to states to carry out permissible activities and funds set aside for the HHS Secretary to use to develop and carry out "Special Projects of Regional and National Significance" (SPRANS) projects. The statute requires that 85 percent of the total appropriated allotment go toward service delivery and infrastructure; the remaining 15 percent is reserved for SPRANS projects.

[1] See Sara Rosenbaum, Michelle Proser, and Colleen Sonosky, *Health Policy and Early Child Development: An Overview* (New York: The Commonwealth Fund, July 2001); Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, *Room to Grow: Promoting Child Development Through Medicaid and CHIP* (New York: The Commonwealth Fund, July 2001); and Sara Rosenbaum, Michelle Proser, Peter Shin, Sara E. Wilensky, and Colleen Sonosky, *Child Development Programs in Community Health Centers* (New York: The Commonwealth Fund, January 2002).

Because it is a block grant, Title V does not create an individual federal entitlement to services. As a result, states may structure their Title V programs as broadly targeted grants to qualified communities and entities (as defined by the state), rather than as a system of specified payments for certain classes of covered medical services for eligible individuals, as with Medicaid. Consequently, services that enhance child health through the provision of health care interventions aimed at parents and caregivers would be considered permissible Title V-assisted activities. The law contains very few prohibitions on states' use of allotment funds, none of which would impede delivery or enhancement of child development services.

States have the policy flexibility to use Title V funds to improve the provision of preventive health services to low-income children younger than three years who are eligible for Medicaid or CHIP (as well as to those who are not). There are four basic approaches that state Title V agencies can take in coordinating with their state Medicaid and CHIP programs:

1. Advising state Medicaid and CHIP programs on the purchase of child development services.

2. Combining outreach and the provision of child development services.

3. Providing child development services not covered by the state's Medicaid or CHIP program.

4. Providing child development services to uninsured or underinsured parents.

Specific recommendations on ways to use Title V to continue to promote child development programs include:

- Priority setting in SPRANS projects that focus on child development in the early years (ages 0 to 3);

- Program guidance to Title V grantees on implementing coordination for child development programs in their Title V/Title XIX Interagency Agreements, as well as in their Title V/Title XXI Interagency Agreements;

- Guidance to states for annual reports on setting priorities for child development programs and coordination with other federal, state, and local child development initiatives;

- Guidance to state Title V grantees on the definition of child development services and opportunities for states to set child development as a high priority in their programs; and

- Dissemination and replication of best practices and child development benefit packages.

USING THE TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT TO SUPPORT CHILD DEVELOPMENT SERVICES

I. INTRODUCTION

A recent and noteworthy study by the Institute of Medicine presents scientific evidence that points to the long-term influence of certain key interventions in the early years of life on a child's development.[2] The study's results reinforce the importance of development services to the healthy physical, emotional, and cognitive development of young children. These services are particularly important for children in low-income families because (1) they are at greater risk for developmental delays resulting from low birth weight, malnutrition, and other poverty-related conditions; and (2) their parents are less likely to engage in child-rearing activities that promote healthy development.[3] This report explains how services provided through the Title V Maternal and Child Health Services Block Grant can be used to foster optimal child development intervention services in the early years of life.

This is the fourth in a series of reports presenting an overview of federal health policy related to child development.[4] It provides an overview of the Title V Maternal and Child Health Services Block Grant and discusses how to use these funds—either alone or in combination with money from other sources (i.e., the State Children's Health Insurance Program (CHIP) and Medicaid)—to support the creation of comprehensive child development services for infants and young children. The report also offers recommendations on how Title V can be used to promote child development programs for young children.

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[2] Institute of Medicine (IOM), *From Neurons to Neighborhoods* (Washington, D.C.: National Academy Press, 2000).

[3] Karen Scott Collins, Kathryn Taaffe McLearn, Melinda Abrams, and Brian Biles, *Improving the Delivery and Financing of Developmental Services for Low-Income Children* (New York: The Commonwealth Fund, November 1998).

[4] See Sara Rosenbaum, Michelle Proser, and Colleen Sonosky, *Health Policy and Early Child Development: An Overview* (New York: The Commonwealth Fund, July 2001); Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, *Room to Grow: Promoting Child Development Through Medicaid and CHIP* (New York: The Commonwealth Fund, July 2001); and Sara Rosenbaum, Michelle Proser, Peter Shin, Sara E. Wilensky, and Colleen Sonosky, *Child Development Programs in Community Health Centers* (New York: The Commonwealth Fund, January 2002).

II. BACKGROUND AND OVERVIEW

The Title V Maternal and Child Health Services Block Grant program originated with the Social Security Act of 1935, which included grants to participating states to establish health services for mothers and infants, as well as rehabilitation services for "crippled children."[5] Title V established a federal/state partnership to promote maternal and child health, with goals that include: significant reductions in infant mortality; the provision of comprehensive pre- and postnatal care; the provision of preventive and primary care services for children; encouraging the use of health supervision guidelines; ensuring access to care for all mothers and children; and meeting the nutritional and developmental needs of mothers, children, and families.[6] States could use grants to improve the health of mothers and infants and to assist in the cost of medical care, case-finding, and aftercare for children with chronic illnesses and conditions.[7]

Several decades of expansion and consolidation followed. In 1967, Title V was amended to require states to provide early and periodic screening, diagnosis, and treatment for children covered by Medicaid.[8] In 1981, the law was once again amended and combined with a series of smaller categorical programs.[9] Since then, Title V has undergone further amendments aimed at refining its purposes and modestly increasing program funding levels. Fundamentally, however, Title V remains a broadly conceived, highly flexible source of federal financial assistance that states may use to develop and support a wide range of primary and specialized health-related services for mothers and children.

Title V is administered by the Maternal and Child Health Bureau (MCHB), which is part of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). MCHB provides leadership, partnership, and resources to promote the health of women, infants, and children through comprehensive, coordinated, family-centered, culturally appropriate, and community-based health care services.

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[5] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); and Karen Davis and Cathy Schoen, *Health and the War on Poverty* (Washington, D.C.: Brookings Institution Press, 1978).

[6] Maternal and Child Health Bureau, Health Resources and Services Administration, USDHHS, "History and Mission," www.mchb.hrsa.gov/html/historymission.html.

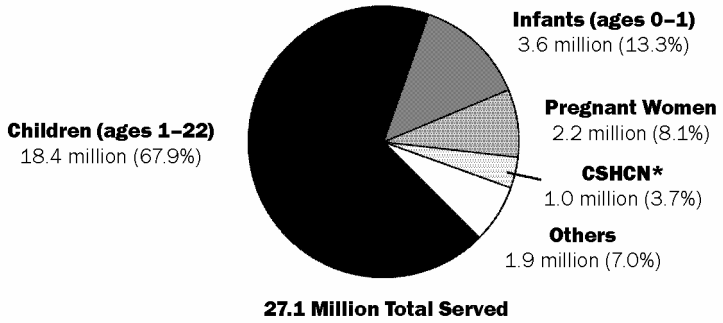
[7] Vincent Hutchins, "Maternal and Child Health Bureau: Roots," *Pediatrics* 94 (May 1994): 696–97.

[8] The amendments offered initially to Title V were codified into the Medicaid program (Title XIX of the Social Security Act) in 1967 as the Early and Periodic Screening, Diagnosis and Treatment benefit.

[9] Sara Rosenbaum, "The Title V Maternal and Child Health Services Block Grant: Teaching an Old Program New Tricks," *Clearinghouse Review* (1983). Programs consolidated into the block grant were rehabilitation services for children receiving Supplemental Security Income, services to screen and identify children for lead poisoning, programs for identifying genetic diseases, programs to detect and manage sudden infant death syndrome, hemophilia treatment for children, and adolescent pregnancy prevention programs.

The Title V budget for fiscal year (FY) 2001 totaled more than $4.3 billion, made up of federal, state, local, and other funds (e.g., program income and unobligated balances).[10] The program served more than 27 million women, infants, and children in FY 1999—about 3 million more than in FY 1997.[11] Figure 1 presents an age breakdown of the recipients of Title V services in FY 1999—3.6 million (13.3%) were infants and 2.2 million (8.1%) were pregnant women.

Figure 1. Women, Infants, and Children Served by Title V Programs, FY 1999



27.1 Million Total Served

Note: Unduplicated counts of individuals who received a direct service in person or by phone from the Title V program, as reported by states in their Title V Block Grant FY 1999 Annual Report and FY 2001 Application. Figures include U.S. terroritories.

* Children with Special Health Care Needs

Source: Title V Information System, MCHB, HRSA, USDHHS, "Number of Individuals Served by Title V, by Class of Individuals, FY 1999." See www.mchdata.net.

Most Title V funds are of two basic types: allotments to states to carry out permissible activities and funds set aside for the HHS Secretary to use to develop and carry out "Special Projects of Regional and National Significance" (SPRANS) projects.[12] The statute requires that 85 percent of the total appropriated allotment go toward service delivery and infrastructure; the remaining 15 percent is reserved for SPRANS projects.

State Allotments and the Allotment Formula

Title V sets forth several purposes for which funds can be spent; those directly relevant to the issue of child development include:

[10] Title V Information System, MCHB, "Federal-State Title V Block Grant Partnership Budget, FY 2001." See www.mchdata.net.

[11] Title V Information System, MCHB, "Number of Individuals Served by Title V, by Class of Individuals, FY 1999. " See www.mchdata.net. See also FY 1997 data.

[12] For Title V appropriations exceeding $600 million, a second set-aside of 12.75 percent is earmarked for the Community Integrated Service System (CISS) grant program. The CISS program funds projects that develop and expand integrated services at the community level to reduce infant mortality and improve the health of mothers and children, including home visiting, maternal and child health centers, and programs to increase participation in Medicaid by obstetricians and pediatricians. 42 U.S.C. §701(a)(3). A much smaller grant program in comparison with state allotments and SPRANS grants, over 100 grants totaling $12 million were awarded in FY 1999. See MCHB, "History and Mission," www.mchb.hrsa.gov/html/historymission.html. See also Association of Maternal and Child Health Programs, "Frequently Asked Questions About Title V," www.amchp.org/titlev/questions.htm.

- To provide and to ensure mothers and children (in particular those with low incomes or with limited access to health services) access to quality maternal and child health services;

- To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children;

- To increase the number of children from low-income families who receive health assessments and follow-up diagnostic and treatment services; and

- To otherwise promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low-income, at-risk pregnant women and to promote the health of children by providing preventive and primary care services for low-income children.[13]

The statute does not define the terms "health care" and "preventive and primary care services." As a result, states' annual applications for funding may include their own definitions of these services and specify how they will be carried out. State applications vary in the way they address how states will deliver primary and preventive care services, and it is difficult to ascertain whether they include child development services within the definition of primary and preventive care.[14]

Allotments are made in accordance with a formula that provides a basic level of funding to each state that submits an application. The formula takes into account the amount the state received in 1983, plus a proportional amount of funds in excess of those that were available in 1983.[15] States must expend a minimum of $3 for every $4 received from the federal government under the allotment formula; excess federal allotment funds (i.e., funds for which there was no matching state expenditure) can be reallotted to participating states.[16] A state-by-state breakdown of the Title V FY 2001 budget is shown in Appendix A. Each state's projected budget is made up of the state's federal Title V allocation (which includes the federal allotment budgeted for children's preventive and primary care, children with special health care needs, and the administration of the allotment); the state's total funds for the Title V allocation (match and overmatch); the

[13] §501(a)(1) of the Social Security Act, 42 U.S.C. §701(a)(1).

[14] For information on each state's application for Title V funding, see the Title V Information System, www.mchdata.net/DownLOAD/states_narratives/states_narrative.html.

[15] §502(c)(2) of the Social Security Act, 42 U.S.C. §702(c)(2).

[16] States, in fact, invest at least the minimum amount necessary to draw down their full federal allotments.

amount of total maternal and child health (MCH) dedicated funds collected from local jurisdictions; and other funds (includes the amount of carryover from the previous year's Title V allocation, funds available from other sources such as foundations, and income funds collected by the state's MCH agency from insurance payments, Medicaid, HMOs, and other sources). Federal allotments range from more than $1.1 million in Alaska to $43 million in California, and total state funds, including the federal match and overmatch, range from more than $1.1 million in Nevada to over $664.7 million in California.

The SPRANS Program

Federal law requires the Secretary to retain up to 15 percent of annual federal appropriations for investment in authorized SPRANS activities in accordance with a project-specific allocation formula that gives the Secretary limited flexibility to move investment funds among SPRANS categories.[17] These categories are numerous,[18] and include maternal and child health research, early intervention training, genetic disease testing and counseling, support for hemophilia diagnostic and treatment centers, maternal and child health improvement projects, and traumatic brain-injury services. MCHB funded approximately 500 SPRANS grants in FY 1999, totaling $102 million.[19]

[17] §502(a) of the Social Security Act, 42 U.S.C. §702(a). Many of the activities funded through SPRANS were previous categorical programs that were consolidated with Title V in 1981. The relatively restricted SPRANS funding rules reflect Congress' decision to consolidate programs while at the same time ensuring a minimum level of funding for previously appropriated activities.

[18] §502(a)(2) of the Social Security Act, 42 U.S.C. §702(a)(2).

[19] MCHB, "History and Mission," www.mchb.hrsa.gov/html/historymission.html. This amount does not include funding for traumatic brain injury services.

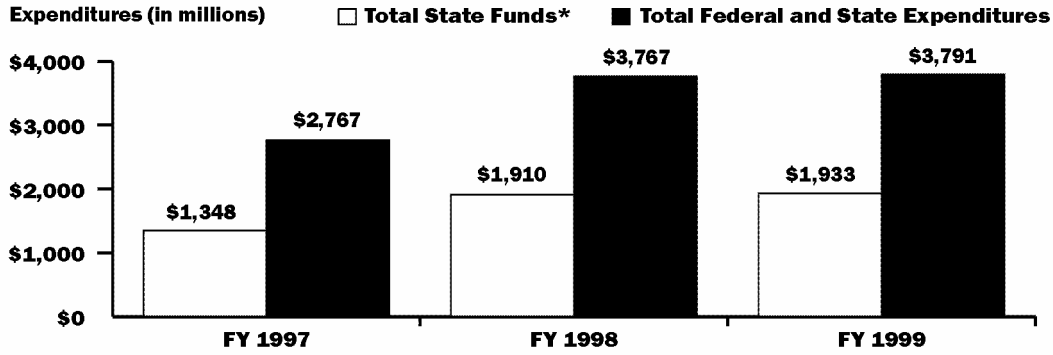
III. AN OVERVIEW OF TITLE V EXPENDITURES

Data on states' use of Title V funds are limited. Most of the information comes from states' annual reports and funding applications. The following figures provide an overview.

Total Expenditures

Figure 2 shows aggregate state expenditures for Title V activities, as well as total federal and state expenditures, which include federal allotments, state funds (match and overmatch), local funds, and other funds (e.g., program income and unobligated balances). In FY 1998 and FY 1999, states spent nearly $3.8 billion each year in total expenditures on Title V programs and services. Total state expenditures grew by approximately 43 percent between 1997 and 1999.

Figure 2. Total Title V Expenditures, FY 1997–1999



* Includes match and overmatch.

Note: Figures include U.S. terroritories.

Source: Title V Information System, MCHB, HRSA, USDHHS, "Federal–State Title V Block Grant Partnership Expenditures, FY 1997, FY 1998, and FY 1999." See www.mchdata.net.

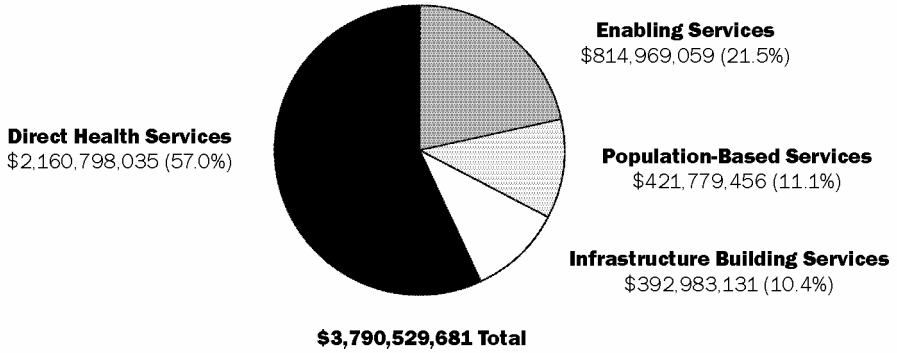
Use of Funds

Because it is a block grant, Title V does not create an individual federal entitlement to services. As a result, states may structure their Title V programs as broadly targeted grants to qualified communities and entities (as defined by the state), rather than as a system of specified payments for certain classes of covered medical services for eligible individuals, as with Medicaid. Consequently, services that enhance child health through the provision of health care interventions aimed at parents and caregivers would be considered permissible Title V-assisted activities. The law contains very few prohibitions on states' use of allotment funds, none of which would impede delivery or enhancement of child development services.[20]

[20] §504(b) of the Social Security Act, 42 U.S.C. §704(b). For example, expenditures on inpatient services are limited to certain circumstances, and the payment of cash to health services recipients is prohibited. States may not use their federal Title V allotments to meet nonfederal funds expenditure requirements under other federal grant-in-aid programs.

There are four categories of Title V services (Figure 3). In FY 1999, states spent 57 percent of their Title V funds on "direct health services," defined as basic health services provided where services are lacking, and generally delivered one-on-one between a health care professional and a patient. Another 21.5 percent was spent on "enabling services," defined as services that provide for access to basic health care. These include case management, transportation and translation services, purchase of insurance, and coordination with other programs. States invested 11.1 percent in "population-based services," which consist of preventive interventions and personal health services for a state's entire MCH population. The remaining 10.4 percent was invested in "infrastructure building services," defined as services that support the development and maintenance of comprehensive health services systems. Infrastructure building involves training, data collection, developing guidelines, and other functions.[21]

Figure 3. Title V Expenditures by Category of Service, FY 1999



Note: Figures include U.S. terroritories.

Source: Title V Information System, MCHB, HRSA, USDHHS, "Federal–State Title V Block Grant Partnership Expenditures by Category of Service, FY 1999." See www.mchdata.net.

Expenditure Variations by State

States' total MCH expenditures vary widely, as does the proportion of expenditures by category of service. Appendix B breaks down national Title V expenditure patterns for FY 1999. The total amount states spent on Title V-funded programs for FY 1999 is broken up into the four categories of Title V services described above. Total Title V expenditures range from more than $2.7 million in Nevada to more than $1.1 billion in California. As with total expenditures, the proportion of expenditures attributable to different types of services ranges broadly across the states:

[21] Title V Information System, MCHB, HRSA, USDHHS, "Federal-State Title V Block Grant Partnership Expenditures by Category of Service, FY 1999." See www.mchdata.net.

- Direct health care services range from 0.2 percent in Connecticut[22] to 91.1 percent in Ohio;

- Enabling services range from 0.3 percent in Ohio to 60.9 percent in Alaska;

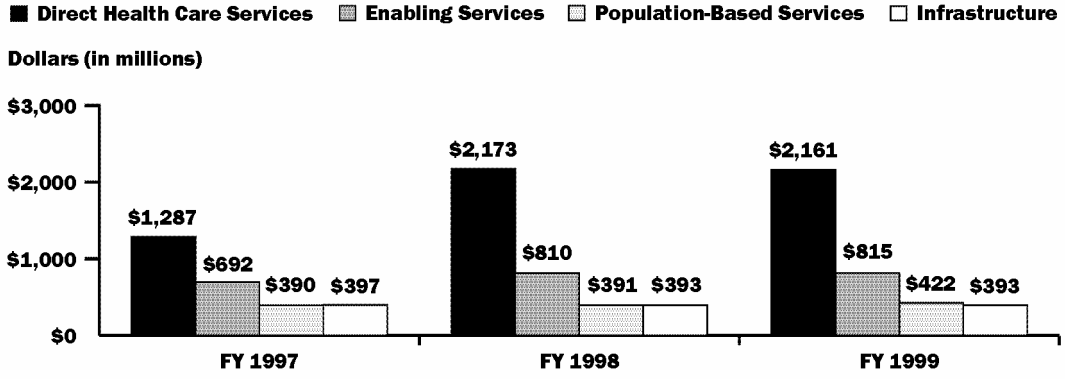
- Population-based services range from 1.4 percent in Alabama to 51.6 percent in Pennsylvania; and

- Infrastructure building services range from 0 percent in Michigan to 44.1 percent in North Dakota.

Investment in direct health services may be a function of numerous factors, such as the scope of Medicaid and CHIP coverage in a state, the proportion of children and mothers who are uninsured, and the perceived need for investment in services that are not covered by Medicaid or CHIP.

Title V state allotment investment patterns have changed only slightly in the past few years (Figure 4). The portion spent on direct health care services increased considerably from FY 1997 to FY 1999, from 46.5 percent to 57 percent.

Figure 4. Title V Expenditure Categories, FY 1997–1999



Note: Figures include U.S. terroritories.

Source: Title V Information System, MCHB, HRSA, USDHHS, "Federal–State Title V Block Grant Partnership Expenditures by Category of Service, FY 1997, FY 1998, and FY 1999." See www.mchdata.net.

Examples of Title V-Funded Programs

State Title V dollars are often integrated into the fabric of state health care systems. The following examples of Title V-funded programs (Massachusetts' Early Intervention

[22] Connecticut has previously financed some direct medical care payments through what is classified as Population Based Services & Infrastructure. See Title V Information System, "Federal-State Title V Block Grant Partnership Expenditures by Category of Service," FY 1997 and FY 1998. See www.mchdata.net. After Connecticut, the next lowest is Washington State at 8.3 percent.

Services, Vermont's Healthy Babies, Louisiana's Infant Mental Health Initiative, and Ohio's Help Me Grow Program) do not use Title V funds to finance direct health care services. Rather, Title V grants fund staff, infrastructure, and program development.

Early Intervention Services, Massachusetts

Massachusetts' Early Intervention (EI) program[23] provides direct care and encourages parental involvement for children younger than age 3 who are at risk for or experience developmental delay. The program recognizes the importance of comprehensive, integrated health care services to the improvement of developmental outcomes. Each child enrolled in an EI program works with a team of speech, physical, and occupational therapists, nurses, psychologists, social workers, and developmental educators. Teams work closely with families to create an Individualized Family Service Plan (IFSP), which details all educational, training, therapy, and support services the family will receive. EI programs also may offer parent support groups, home visits, parent training and education, toddler groups, parent-child groups, and group and individual sessions, as well as referral services. Transportation for children and families is also available. There is no direct cost to participating families. The Massachusetts Department of Public Health, Medicaid, health insurance companies, and health maintenance organizations sponsor EI.

Healthy Babies, Vermont

Vermont's Healthy Babies program,[24] which combines Medicaid and Title V funding, is a statewide home-visit program for pregnant women and infants up to one year. Participation is voluntary and open to those who receive Medicaid or who are enrolled in Vermont's Children's Health Insurance Program, Dr. Dynasaur. Visiting public health nurses direct families to high-quality health care and support services, help them develop good parenting skills, answer questions, assist with medical care coordination and finding day care or play groups, and provide information on nutrition, immunizations, lead screening, and age-appropriate medical care for children, as well as school and work opportunities for parents. In addition, Healthy Babies offers enabling services, such as case management and transportation to medical appointments, and educational programs, such as pregnancy, childbirth, and parenting classes. The program creates a system of care for pregnant women and newborns by collaborating with health care providers, community

[23] Massachusetts Department of Public Health, Division for Special Health Needs, "Early Intervention Services," www.magnet.state.ma.us:80/dph/shcn/ei.htm. See also Massachusetts Family TIES (Together in Enhancing Support), "Welcome: An Introduction to Early Intervention Services," www.massfamilyties.org/ei/index.htm.

[24] Association of Maternal and Child Health Programs, "State Profiles 2000: Title V Maternal and Child Health Programs," Pre-Published Addition. See also Vermont Department of Health website, Healthy Babies, www.state.vt.us/health/hbabies.htm and www.state.vt.us/governor/babies.htm.

organizations, hospitals, schools, and others. Approximately 3,000 to 5,000 women and infants participate annually.

Infant Mental Health Initiative, Louisiana

Louisiana's Infant Mental Health Initiative addresses the state's need for parenting education and family support systems.[25] The initiative provides statewide training of public health nurses and other public health professionals in health and psychosocial assessment based on *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (see below). Training topics include parenting roles and styles, social and emotional development, psychopathology in infancy, and social, cultural, and ethnic influences on parenting. The program also added a mental health component to its Nurse Home Visiting Program in order to improve prenatal care, birth outcomes, parenting skills, and healthy child development. The program targets first-time, low-income mothers beginning before the 28th week of pregnancy and running until the infant is two years old. Half-time mental health specialists support visiting nurses. The Nurse Home Visiting Program component of the initiative is now funded through Medicaid.

Help Me Grow, Ohio

Ohio's Help Me Grow is an early childhood program that educates families and realigns a variety of direct services into a more accessible system.[26] The program provides educational materials on prenatal and infant care and development, parenting skills, safety, and other topics. Direct services include home visits to newborns; health, vision, and hearing screening; identification of children with developmental delays; parent education on child development; and family literacy.

SPRANS Expenditures and Activities

Figure 5 shows the Secretary's investment in SPRANS projects in FY 1999. Of the $101.9 million available for approximately 500 grants, approximately 40.7 percent was invested in training, 8.3 percent in research, 5.2 percent in hemophilia screening and treatment, 8.9 percent in genetic services, and 36.8 percent in maternal and child health improvement projects (MCHIP). An additional $5 million, not included in the total, supported the Traumatic Brain Injury Demonstration Grant Program (TBI), which helped states maintain comprehensive and coordinated TBI services.[27]

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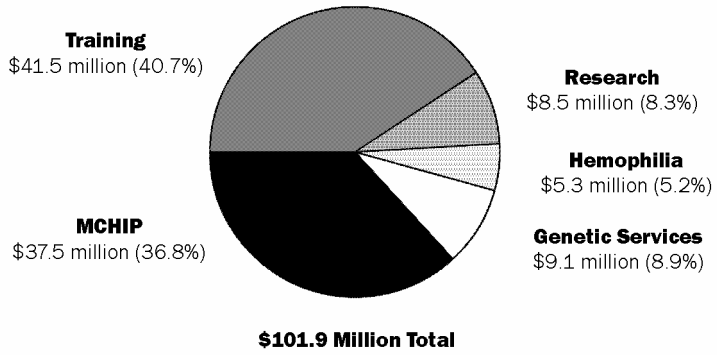
[25] Based on written information from the April 25, 2001, forum entitled "The Early Childhood Challenge: Ready to Learn? New Science, New Policy, New Solutions," sponsored by the Heller School Alumni Association and the Association of Maternal and Child Health Programs.

[26] Ibid.

[27] Personal communication with Office of Budget, Assistant Secretary for Management and Budget, USDHHS.

Figure 5. SPRANS Allocations by Activity Category, FY 1999



Notes: $0.5 million was also allocated for technical assistance, and $5 million for TBI. Percentages do not total 100% because of rounding.

Source: USDHHS Budget Office.

Below are several examples of Title V-supported programs, each of which is also supported by other agencies, such as Medicaid and state health departments. These examples demonstrate ways in which these special-purpose funds can be invested in child development-related services.

Bright Futures

Title V funds have supported the publication of child health supervision guidelines since 1990. The National Center for Education in Maternal and Child Health (NCEMCH) recently produced the second edition of *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*[28] with support from MCHB (by way of a SPRANS grant), the Center for Medicare and Medicaid Services, and Pfizer Pediatric Health. *Bright Futures* is a comprehensive set of children's health supervision guidelines for professionals and families with a community-, developmental-, and preventive-oriented approach. It is adaptable to meet varying regional needs, encourages use of community resources, and promotes efficient organization of health practices to best meet patient needs. *Bright Futures* is an effective tool for promoting the overall health and well-being of children because it stresses the importance of and teaches about child development to both health professionals and families.

MCHB has been active in promoting the use of *Bright Futures* through SPRANS and other grants. For example, the Massachusetts Department of Public Health used a SPRANS grant for a maternal and child health improvement project to begin the Massachusetts Bright Futures Campaign to improve utilization of age-appropriate

[28] See Morris Green and Judith S. Palfrey, eds., *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 2nd Edition (Arlington, Va.: National Center for Education in Maternal and Child Health, 2000), www.brightfutures.org.

preventive primary care. SPRANS grants have also funded several training programs to develop provider curriculums based on *Bright Futures* in whole or in part, and to instruct providers on how to appropriately implement the guidelines.[29] MCHB has supported the dissemination of *Bright Futures* and the development of other *Bright Futures* materials[30] by partnering with other organizations, such as the National Institute for Health Care Management (NIHCM), NCEMCH, and Family Voices.[31]

Information on states' use of *Bright Futures* is still being collected. Massachusetts and Washington promote the use of *Bright Futures* among providers on a state level.[32] Other states have used it as a source of training materials for particular programs. The Oregon Health Division, for instance, trained public health nurses and educators on how to use *Bright Futures in Practice: Nutrition.*[33]

Physicians who use *Bright Futures* find the guidelines valuable because of their positive effect on the quality of care children receive. Some providers and managed care organizations (MCOs) have actively encouraged the use of these guidelines. For example, after Kaiser Permanente Northern California implemented *Bright Futures* as an office system, it was voluntarily adopted by more than 1,000 of the MCO's physicians. Several other Kaiser Permanente regions are using the system as well. Blue Cross of California, meanwhile, provides financial incentives to physicians enrolled in their Medi-Cal and Healthy Families programs (California's Medicaid and CHIP programs) for using *Bright Futures* during appropriate office visits.[34] Soon all pediatricians will have access to a web-based health risk appraisal form based on *Bright Futures* developed by Dr. Kelly Kelleher at the University of Pittsburgh School of Medicine. Pfizer also assists with the dissemination of the guidelines by providing them to thousands of pediatricians around the country during visits by sales representatives.[35]

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[29] See NCEMCH's MCH Projects Database, www.ncemch.org:591/search/default.htm.

[30] Major *Bright Futures* publications include: *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 2nd Edition; Bright Futures in Practice: Nutrition; Bright Futures in Practice: Oral Health and Quick Reference Cards; Bright Futures Anticipatory Guidance Cards;* and *Bright Futures Encounter Forms for Professionals and Families.* For ordering and additional information, see www.brightfutures.org or contact the National Maternal and Child Health Clearinghouse at (703) 356-1964.

[31] Based on spoken communication with Mary O'Neill, Project Director of *Bright Futures* at the NCEMCH.

[32] Ibid.

[33] NCEMCH, "Around the U.S.A.," *Bright Notes Newsletter* (Fall 2000), www.brightfutues.org/op/bnfall2000/bnfall00.html.

[34] NCEMCH, "Around the U.S.A.," *Bright Notes Newsletter* (Fall 1999), www.brightfutures.org/newsletter/fall1999.html.

[35] Based on spoken communication with Mary O'Neill, Project Director of *Bright Futures* at the NCEMCH.

Prenatal-to-Pediatric Transition Project, New Haven, Connecticut

Fair Haven Community Health Center, the sole source of pediatric and obstetric care in an isolated section of New Haven, Connecticut, received a SPRANS grant for a maternal and child health improvement project. The Prenatal-to-Pediatric Transition Project links the center's prenatal and pediatric care programs. The project aims to improve access to preventive and culturally sensitive prenatal and pediatric care by enhancing coordination among existing community health care resources. It also developed community-based education programs to increase parents' understanding of child development and the importance of the parental role. Subjects include early literacy, safety, nutrition, and the importance of quality pediatric care and child care services.[36]

Partners in Prevention, North Carolina

Partners in Prevention (PIP) is an office-based program designed to enhance the quality and delivery of comprehensive preventive care, including the content and scope of anticipatory guidance for child health supervision, through coordinated activities organized by primary care practices. Preventive services include immunizations, screenings (e.g., vision, hearing, TB, lead, and anemia), and injury-prevention education. Program staff collaborate with pediatric and family practice office staff, as well as with patients, to improve the coordination of primary care for children zero to five years old in a cost-effective manner. The University of North Carolina Children's Primary Care Research Group (CPCRG), in collaboration with professional organizations, state agencies, and pediatric clinicians, runs PIP. CPCRG received a SPRANS grant for research from 1997–2000.[37]

[36] See NCEMCH's MCH Projects Database, www.ncemch.org:591/search/default.htm.

[37] For more information, contact the UNC Children's Primary Care Research Group at (919) 966-0268.

IV. COORDINATION OF TITLE V, MEDICAID, AND CHIP IN PROMOTING CHILD DEVELOPMENT

The two state-administered programs that finance the purchase of health care services for eligible low-income children are Medicaid and CHIP. Like Title V, these are federal-state matching programs authorized in the Social Security Act (Title XIX and Title XXI, respectively). Unlike Title V, these programs are targeted at low-income children only, and their primary role for these children is as health care insurers. In addition, while Title V is a discretionary (i.e., annually appropriated) federal grant program, CHIP is a capped federal entitlement to the states, and Medicaid is an open-ended entitlement to the states (and an individual entitlement to eligible low-income children).

Current law gives the states flexibility to administer their Medicaid and CHIP programs to provide preventive health services that promote child development for low-income children under age 3. The second report in this series examines states' options for enhancing child development through Medicaid and CHIP with respect to six different program elements: (1) eligibility rules and enrollment procedures; (2) definition of covered benefits; (3) service settings; (4) the range of participating providers; (5) provider compensation incentives; and (6) quality measurement and improvement.[38] This section examines the options that states have to coordinate the administration of their Title V, Medicaid, and CHIP programs to enhance child development for low-income children under age 3.

Coordination Requirements Under Federal Law

Federal requirements that states coordinate the administration of their Title V, Medicaid, and CHIP programs are limited and general. There are no coordination requirements in any of these programs specific to the provision of preventive health services to low-income children younger than 3 years.

At the federal level, the HHS Secretary is required to designate an administrative unit with responsibilities that include coordination of the activities authorized under Title V, those authorized under Title XIX (especially Early and Periodic Screening, Diagnosis, and Treatment [EPSDT]), and related activities under health block grants such as CHIP.[39] MCHB has been designated for this purpose.

[38] See Sara Rosenbaum et al., *Room to Grow: Promoting Child Development Through Medicaid and CHIP* (New York: The Commonwealth Fund, July 2001).

[39] §509(a)(2) of the Social Security Act, 42 U.S.C. §709(a)(2).

States, on the other hand, have the authority to designate which agencies will administer Title V, Medicaid, and CHIP as well as to designate a coordinating administrative unit, but they are not required to have such a unit. Neither the Title V, the Medicaid, nor the CHIP statutes require that states coordinate the provision of preventive health services to low-income children among the three programs. States clearly have the authority to do so, however.

The Title V statute does impose a few coordination requirements on state Title V programs vis-à-vis state Medicaid programs. It expressly requires state Title V agencies to "participate in the coordination of activities between" the state Title V program and the Medicaid EPSDT benefit "to ensure that such programs are carried out without duplication of effort."[40] This coordination must include "the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services."[41] There is ample scope within the EPSDT benefit to accommodate many preventive health services that promote child development (see report no. 2 in this series, *Room to Grow: Promoting Child Development Through Medicaid and CHIP*).

Another relevant coordination requirement imposed on state Title V programs has to do with maternal and infant care.[42] State Title V agencies are required to provide, directly and through contractors, for "services to identify pregnant women and infants who are eligible for [Medicaid] and, once identified, to assist them in applying for such assistance."[43] This requirement offers state Title V agencies an opportunity to link their outreach efforts to the provision of child development services to those pregnant women and infants who are identified and enrolled. The Title V statute does not impose any similar requirements on state Title V agencies with regard to state CHIP programs.

Title XIX requires that state Medicaid agencies enter into "agreements" with Title V agencies that (1) provide for the participation of the agency (or its grantees) in Medicaid; (2) make "appropriate" provision for reimbursing the Title V agency (or its grantees) for covered services rendered to Medicaid beneficiaries; and (3) provide for "coordination of information and education on pediatric vaccinations and delivery of immunization services."[44] There is also a reciprocal requirement in Title V.[45]

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[40] §505(a)(5)(F)(i) of the Social Security Act, 42 U.S.C. §705(a)(5)(F)(i).

[41] Ibid.

[42] State Title V agencies must also establish a toll-free telephone number for parents to access information about health care providers and practitioners who furnish services under Title V and under Medicaid. §505(a)(5)(E) of the Social Security Act, 42 U.S.C. §705(a)(5)(E).

[43] §505(a)(5)(F)(iv) of the Social Security Act, 42 U.S.C. §705(a)(5)(F)(iv).

[44] §1902(a)(11)(B) of the Social Security Act, 42 U.S.C. §1396a(a)(11)(B).

[45] §505(a)(5)(F)(ii) of the Social Security Act, 42 U.S.C. §705(a)(5)(F)(ii).

Medicaid law does not impose any specific coordination requirements on state CHIP programs vis-à-vis state Title V programs. Title XXI does, however, require each participating state to describe the procedures it uses to coordinate administration of its CHIP program with "other public and private health insurance programs,"[46] and to provide a "review and assessment" of "State activities to coordinate" the CHIP program with "other public and private programs," including "Medicaid and maternal and child health services."[47]

Federal law does make clear that, with regard to Medicaid and CHIP, Title V is the last-dollar payer. That is, if a child is enrolled in Medicaid (or CHIP), and if that child receives a service such as a home visit that is covered under Medicaid (or CHIP) and also by the state's Title V program, the Medicaid (or CHIP) program pays for the service, not the Title V program.[48] The Title V funds can be used to pay for services for which Medicaid (or CHIP) funds are not available or allowed.

State Flexibility to Maximize Title V Funding

Within this statutory framework, states have the policy flexibility to use Title V funds to improve the provision of preventive health services to low-income children younger than three years who are eligible for Medicaid or CHIP (as well as to those who are not). There are four basic approaches that state Title V agencies can take in coordinating with their state Medicaid and CHIP programs. These approaches can work whether or not the state administers its Medicaid and CHIP programs separately, and the approaches are not mutually exclusive—a state Title V agency could undertake two or more of them simultaneously if it so chose.

1. *Advising state Medicaid and CHIP programs on the purchase of child development services.* State Title V agencies can serve as a source of expertise on the delivery of child development services. If this expertise is not available in-house from state agency staff, it can be obtained through technical assistance grants to, or consulting arrangements with, knowledgeable pediatric practitioners. This expertise can be of considerable help to state purchasing agencies such as the Medicaid and CHIP programs, which may not be aware of the importance of child development services for their enrollees under age 3 or how those services should be purchased

[46] §2102(c)(2) of the Social Security Act, 42 U.S.C. §1397bb(c)(2).
[47] §2108(b)(1)(D) of the Social Security Act, 42 U.S.C. §1397hh(b)(1)(D).
[48] For example, one of the statutory purposes of the Title V program is to provide rehabilitation services to children under age 16 with disabilities who are receiving Supplemental Security Income (SSI) benefits, but only "to the extent medical assistance for such services is not provided under Title XIX." §501(a)(1)(C) of the Social Security Act, 42 U.S.C. §701(a)(1)(C). See also §1902(a)(11)(B)(ii) of the Social Security Act, 42 U.S.C. §1396a(a)(11)(B)(ii).

through fee-for-service or managed care arrangements. As discussed above, the Title V statute requires state MCH agencies to coordinate with their state Medicaid agencies in the establishment of "periodicity and content standards" for the EPSDT benefit; these standards could include an articulation of child development services.[49] More generally, a state Title V agency could advise a state Medicaid or CHIP agency on defining a child development services benefit (or integrating child development services into the program's existing benefits package) and identifying the practitioners and institutions in the state who are competent to deliver child development services. In addition, drawing on its own purchasing experience and cost data, the Title V agency could advise the purchasing agency with respect to enhanced payment options in fee-for-service or managed care arrangements.[50]

2. *Combining outreach and the provision of child development services.* As discussed above, Title V agencies are required to provide, directly or through contractors, for outreach services to identify pregnant women and infants eligible for Medicaid and to assist them in enrolling. In the course of these outreach efforts, a Title V agency (or its contractors) could identify low-income children under age 3 who do not have a medical home and initiate the delivery of child development services. The services could continue until the child is enrolled in Medicaid or CHIP and has established a relationship with a pediatric practitioner who can deliver the services.

3. *Providing child development services not covered by the state's Medicaid or CHIP program.* Although all state Medicaid programs are required to cover EPSDT services for all enrolled children under age 21, and although the main elements of the EPSDT benefit are specified in federal statute and regulation, the content of the EPSDT benefit will nonetheless vary somewhat from state to state. Similarly, separate state CHIP programs vary with respect to the benefits packages they offer enrolled children. This variation creates a potential role for state Title V agencies to fill the gaps in coverage of child development services that are not included in their state's Medicaid or CHIP benefits package. For example, a state Medicaid or CHIP program may not cover home visits for children under age 3 for purposes other than acute medical need, or it may limit the number of such visits. In such cases, the state Title V agency could operate or contract for a home-visit program that is preventive and developmental in its orientation.

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[49] See Sara Rosenbaum et al., *Room to Grow: Promoting Child Development Through Medicaid and CHIP* (New York: The Commonwealth Fund, July 2001, Appendix D).

[50] See Center for Health Services Research and Policy (CHSRP), *Optional Purchasing Specifications for Child Development Services in Medicaid Managed Care* (June 2000), www.gwhealthpolicy.org.

Examples of child development services that would not be covered under Medicaid include respite care, group health education, special toys, resources for parents (including educational materials), and medical foods and nutritional therapies. A number of states have programs that do provide such services under the auspices of Title V, often as part of a state's Children with Special Health Care Needs (CSHCN) program. The Oregon State CSHCN program uses Title V funds to subsidize pediatric specialty clinics, transportation and lodging for families when traveling to receive services, and respite care. The Oklahoma and Vermont CSHCN programs also cover respite care. In Pennsylvania, the Title V-supported CSHCN program offers a variety of services, including nutritional supplements, appliances, and disposable supplies. Pennsylvania's Family Consultant Program offers family support when a child with special needs is hospitalized, provides in-service training to hospital staff, informs staff of the families' problems and concerns, and helps families become more effective caregivers.[51]

4. *Providing child development services to uninsured or underinsured parents.* Because the Medicaid eligibility criteria for parents are significantly lower than those for their children (especially children under age 6) in most states, parents of a Medicaid-eligible child often will not be eligible for Medicaid. In such instances, there are limits on the extent to which federal Medicaid funds may be used to pay for health education, counseling, and other child development services directed at the ineligible parent, at least in a fee-for-service context.[52] State Title V agencies could make resources available for those child development services targeted at the parent for which federal Medicaid funds may not be used.

   Such services are largely interventions, and involve the provision of medical care, case management supports that help parents and caregivers obtain necessary medical and health services, group parenting classes, peer support programs, etc. Medicaid prohibits payments for such services. For example, the District of Columbia's Use Your Power! Parent Council educates Medicaid beneficiaries on how to use the District's mandatory managed care system. Iowa's Child Health Centers are similar. Sponsored by Iowa's Medicaid agency and state and community Title V programs, 26 centers educate newly enrolled Medicaid families

[51] Association of Maternal and Child Health Programs, "State Profiles 2000: Title V Maternal and Child Health Programs." Pre-Published Addition.

[52] HCFA, Dear State Child Welfare and State Medicaid Director Letter, January 19, 2001 (SMDL #01-013), www.hcfa.gov/medicaid/smd119c1.htm.

on preventive well-child services and provide care coordination for families not yet in managed care.[53]

Except in states that operate their CHIP programs under waivers, the parents of children under age 3 who are enrolled in CHIP will not themselves be eligible for the program. This does not, however, preclude the use of federal CHIP funds to pay for health education, counseling, and other child development services directed at parents, because the constraints on the use of federal Medicaid funds in such cases do not apply to CHIP funds. In those states that elect to structure their CHIP benefit packages to include child development services focused on the parents as well as the child, there may be no "wraparound" role for the state Title V agency. In states that largely limit their CHIP coverage of child development services to those targeted at children, the state Title V agency could supply some or all of the child development services needed by the parents.[54]

[53] Association of Maternal and Child Health Programs. "State Profiles 2000: Title V Maternal and Child Health Programs." Pre-Published Addition.

[54] For more information on expanding health services to uninsured parents, see Sara Rosenbaum, "Options for Assisting Uninsured Parents to Secure Basic Health Services," for the National Academy for State Health Policy (February 2001).

V. CONCLUSION AND RECOMMENDATIONS

The flexibility of the Title V Maternal and Child Health Services Block Grant program allows it to be an originating and supportive source of funding for child development programs, including direct care for mothers and children and interventions for an entire family. Title V can work alone or with other sources of funding, specifically Medicaid and CHIP. By paying for services that Medicaid cannot, Title V allows for the creation of more comprehensive and "wraparound" child development services.

Specific recommendations on ways to use Title V to continue to promote child development programs include:

- Priority setting in SPRANS projects that focus on child development in the early years (ages 0 to 3);

- Program guidance to Title V grantees on implementing coordination for child development programs in their Title V/Title XIX Interagency Agreements, as well as in their Title V/Title XXI Interagency Agreements;

- Guidance to states for annual reports on setting priorities for child development programs and coordination with other federal, state, and local child development initiatives;

- Guidance to state Title V grantees on the definition of child development services and opportunities for states to set child development as a high priority in their programs; and

- Dissemination and replication of best practices and child development benefit packages.

APPENDIX A. FEDERAL–STATE TITLE V BLOCK GRANT PARTNERSHIP BUDGET, FY 2001

The Title V Block Grant projected budget for each state consists of the state's federal Title V allocation (the allotment for children's preventive, primary, and special needs' care, and administration of the allotment); total funds for the Title V allocation; amount of total maternal and child health (MCH) dedicated funds collected from local jurisdictions; and other funds (including the amount of carryover from the previous year's Title V allocation, funds available from other sources, and income funds collected by state MCH agencies from insurance payments, Medicaid, HMOs, etc.).

State	Federal Allocation	Total State Funds	Local MCH Funds	Other Funds*	Total
Alabama	$12,487,088	$31,007,981	$0	$34,303,434	$77,798,503
% of Total	16.1%	39.9%	0%	44.1%	—
Alaska	$1,126,986	$9,766,600	$0	$425,000	$11,318,586
% of Total	10%	86.3%	0%	3.7%	—
Arizona	$7,200,362	$13,619,090	$	$11,354,511	$32,173,963
% of Total	22.4%	42.3%	0%	35.3%	—
Arkansas	$7,581,008	$7,387,079	$0	$16,448,846	$31,416,933
% of Total	24.1%	23.5%	0%	52.4%	—
California	$43,010,496	$664,726,146	$	$456,519,946	$1,164,256,588
% of Total	3.7%	57.1%	0%	39.3%	—
Colorado	$7,674,220	$5,755,665	$	$0	$13,429,855
% of Total	57.1%	42.9%	0%	0%	—
Connecticut	$4,874,049	$9,327,940	$0	$376,387	$14,578,376
% of Total	33.4%	64%	0%	2.6%	—
Delaware	$1,965,540	$10,296,759	$0	$625,000	$12,887,299
% of Total	15.3%	79.9%	0%	4.9%	—
District of Columbia	$7,031,721	$5,300,000	$	$0	$12,331,721
% of Total	57%	43%	0%	0%	—
Florida	$19,511,836	$279,787,306	$	$32,256,448	$331,555,590
% of Total	5.9%	84.4%	0%	9.7%	—
Georgia	$16,990,732	$140,644,766	$0	$84,837,163	$242,472,661
% of Total	7%	58%	0%	35%	—
Hawaii	$2,252,894	$22,373,250	$	$6,900,739	$31,526,883
% of Total	7.1%	71%	0%	21.9%	—
Idaho	$3,303,178	$2,477,384	$0	$160,000	$5,940,562
% of Total	55.6%	41.7%	0%	2.7%	—
Illinois	$23,500,272	$53,165,956	$2,125,600	$13,815,650	$92,607,478
% of Total	25.4%	57.4%	2.3%	14.9%	—
Indiana	$12,476,277	$23,200,228	$	$1,579,316	$37,255,821
% of Total	33.5%	62.3%	0%	4.2%	—
Iowa	$7,022,990	$6,004,025	$	$2,589,316	$15,616,331
% of Total	45%	38.4%	0%	16.6%	—
Kansas	$5,013,648	$3,820,236	$2,028,444	$0	$10,862,328
% of Total	46.2%	35.2%	18.7%	0%	—
Kentucky	$12,331,266	$41,594,895	$0	$525,749	$54,451,910
% of Total	22.6%	76.4%	0%	.9%	—
Louisiana	$15,259,349	$20,814,737	$1,526,389	$7,930,000	$45,530,475
% of Total	33.5%	45.7%	3.4%	17.4%	—
Maine	$3,497,292	$12,497,780	$	$0	$15,995,072
% of Total	21.9%	78.1%	0%	0%	—
Maryland	$12,168,163	$9,126,123	$	$	$21,294,286
% of Total	57.1%	42.9%	0%	0%	—
Massachusetts	$11,884,500	$96,868,475	$0	$1,144,255	$109,897,230
% of Total	10.8%	88.1%	0%	1%	—
Michigan	$20,627,000	$37,130,300	$	$51,346,200	$109,103,500
% of Total	18.9%	34%	0%	47%	—
Minnesota	$9,672,943	$7,455,784	$5,443,525	$7,072,219	$29,644,471
% of Total	32.6%	25.2%	18.4%	23.9%	—

State	Federal Allocation	Total State Funds	Local MCH Funds	Other Funds*	Total
Mississippi	$10,928,315	$8,244,167	$	$	$19,172,482
% of Total	57%	43%	0%	0%	—
Missouri	$13,103,064	$10,858,571	$0	$2,535,000	$26,496,635
% of Total	49.5%	41%	0%	9.6%	—
Montana	$2,567,703	$1,389,673	$2,604,648	$0	$6,562,024
% of Total	39.1%	21.2%	39.7%	0%	—
Nebraska	$4,185,740	$3,885,843	$	$	$8,071,583
% of Total	51.9%	48.1%	0%	0%	—
Nevada	$1,545,737	$1,159,303	$	$507,988	$3,213,028
% of Total	48.1%	36.1%	0%	15.8%	—
New Hampshire	$2,006,169	$4,482,204	$0	$250,616	$6,738,989
% of Total	29.8%	66.5%	0%	3.7%	—
New Jersey	$11,806,608	$11,526,285	$	$	$23,332,893
% of Total	50.6%	49.4%	0%	0%	—
New Mexico	$4,700,000	$4,833,000	$	$	$9,533,000
% of Total	49.3%	50.7%	0%	0%	—
New York	$41,970,563	$246,896,800	$304,815,796	$295,738,900	$889,422,059
% of Total	4.7%	27.8%	34.3%	33.3%	—
North Carolina	$16,928,823	$52,050,425	$	$99,217,674	$168,196,922
% of Total	10.1%	30.9%	0%	59%	—
North Dakota	$1,979,933	$1,493,634	$448,090	$593,980	$4,515,637
% of Total	43.8%	33.1%	9.9%	13.2%	—
Ohio	$24,418,602	$34,060,367	$0	$9,969,518	$68,448,487
% of Total	35.7%	49.8%	0%	14.6%	—
Oklahoma	$7,869,642	$7,442,280	$833,687	$205,941	$16,351,550
% of Total	48.1%	45.5%	5.1%	1.3%	—
Oregon	$6,382,795	$9,304,214	$	$20,093,864	$35,780,873
% of Total	17.8%	26%	0%	56.2%	—
Pennsylvania	$25,648,613	$66,973,000	$0	$4,866,000	$97,487,613
% of Total	26.3%	68.7%	0%	5%	—
Rhode Island	$1,739,885	$6,842,191	$0	$5,813,729	$14,395,808
% of Total	12.1%	47.5%	0%	40.4%	—
South Carolina	$11,972,698	$25,732,339	$2,808,369	$37,879,805	$78,393,211
% of Total	15.3%	32.8%	3.6%	48.3%	—
South Dakota	$2,431,940	$1,834,629	$155,785	$748,940	$5,171,294
% of Total	47%	35.5%	3%	14.4%	—
Tennessee	$12,453,189	$13,250,000	$0	$6,580,538	$32,283,727
% of Total	38.6%	41%	0%	20.4%	—
Texas	$37,526,660	$59,900,000	$	$24,514,176	$121,940,836
% of Total	30.8%	49.1%	0%	20.2%	—
Utah	$6,267,131	$15,088,700	$2,848,527	$16,72,269	$40,376,627
% of Total	15.5%	37.4%	7.1%	40%	—
Vermont	$1,732,529	$1,697,344	$0	$0	$3,429,873
% of Total	50.5%	49.5%	0%	0%	—
Virginia	$12,764,996	$11,598,037	$0	$1,192,644	$25,555,677
% of Total	49.9%	45.4%	0%	4.7%	—
Washington	$9,200,528	$15,000,000	$0	$0	$24,200,528
% of Total	38%	62%	0%	0%	—
West Virginia	$6,950,837	$5,213,129	$	$11,463,367	$23,627,333
% of Total	29.4%	22.1%	0%	48.5%	—
Wisconsin	$11,740,481	$10,323,848	$	$4,385,412	$26,449,741
% of Total	44.4%	39%	0%	16.6%	—
Wyoming	$1,316,012	$2,469,518	$0	$0	$3,785,530
% of Total	34.8%	65.2%	0%	0%	—
National Total	$581,690,658	$2,164,232,834	$325,817,175	$1,274,734,804	$4,346,475,471
% of Total	13.4%	49.8%	7.5%	29.3%	—

* Includes unobligated balance (1.3% of total), program income (22.9% of total), and other funds (5.1% of total).

Note: Totals include U.S. territories. Because states use different data methodologies and multiple sources of data, data reported in this table may include actual counts, estimates, or blank cells (if data are not available at the time of reporting). Column totals may not sum to the total budget column because of missing data. Figures displayed here are for the federal fiscal year (October 1 through September 30). Some states use different fiscal years or budget on a biannual basis.

Source: Title V Information System, "Federal-State Title V Block Grant Partnership Budget, FY 2001." See www.mchdata.net.

APPENDIX B. STATE EXPENDITURES BY CATEGORY OF SERVICE, FY 1999

The total amount states spent on Title V-funded programs for FY 1999 is broken up into the four categories of Title V services: direct health care services, enabling services, population-based services, and infrastructure.

State	Direct Health Care Services	Enabling Services	Population-Based Services	Infrastructure	Total
Alabama	$64,690,452	$6,801,904	$1,053,869	$3,132,913	$75,679,138
% of Total	85.5%	9%	1.4%	4.1%	—
Alaska	$1,164,700	$6,568,000	$222,700	$2,836,400	$10,791,800
% of Total	10.8%	60.9%	2.1%	26.3%	—
Arizona	$6,065,918	$255,608	$4,736,636	$4,347,069	$15,405,231
% of Total	39.4%	1.7%	30.7%	28.2%	—
Arkansas	$16,131,386	$4,741,685	$961,309	$2,423,508	$24,257,888
% of Total	66.5%	19.5%	4%	10%	—
California	$921,285,959	$104,055,410	$64,509,761	$30,987,060	$1,120,838,190
% of Total	82.2%	9.3%	5.8%	2.8%	—
Colorado	$4,045,218	$2,834,268	$2,076,925	$4,350,572	$13,306,983
% of Total	30.4%	21.3%	15.6%	32.7%	—
Connecticut	$28,277	$6,429,986	$1,053,054	$4,985,330	$12,496,647
% of Total	.2%	51.5%	8.4%	39.9%	—
Delaware	$3,210,562	$3,988,921	$1,003,991	$3,317,624	$11,521,098
% of Total	27.9%	34.6%	8.7%	28.8%	—
District of Columbia	$5,872,994	$1,859,603	$2,000,000	$2,500,000	$12,232,597
% of Total	48%	15.2%	16.3%	20.4%	—
Florida	$44,617,889	$103,209,512	$33,585,994	$63,739,842	$245,153,237
% of Total	18.2%	42.1%	13.7%	26%	—
Georgia	$127,854,180	$43,167,786	$54,334,845	$26,717,996	$252,074,807
% of Total	50.7%	17.1%	21.6%	10.6%	—
Hawaii	$8,226,718	$8,243,201	$3,527,159	$3,827,418	$23,824,496
% of Total	34.5%	34.6%	14.8%	16.1%	—
Idaho	$2,678,182	$48,222	$3,050,017	$682,986	$6,459,407
% of Total	41.5%	.7%	47.2%	10.6%	—
Illinois	$43,601,611	$65,152,224	$5,143,762	$8,572,937	$122,470,534
% of Total	35.6%	53.2%	4.2%	7%	—
Indiana	$4,543,610	$17,999,393	$1,602,912	$5,929,270	$30,075,185
% of Total	15.1%	59.8%	5.3%	19.7%	—
Iowa	$8,266,484	$1,173,469	$1,166,565	$2,659,508	$13,266,026
% of Total	62.3%	8.8%	8.8%	20%	—
Kansas	$4,230,862	$4,178,657	$753,674	$1,410,287	$10,573,480
% of Total	40%	39.5%	7.1%	13.3%	—
Kentucky	$28,581,995	$3,566,320	$7,792,752	$2,923,353	$42,864,420
% of Total	66.7%	8.3%	18.2%	6.8%	—
Louisiana	$26,597,865	$4,232,183	$6,913,687	$3,160,681	$40,904,416
% of Total	65%	10.3%	16.9%	7.7%	—
Maine	$4,946,974	$897,724	$845,545	$2,047,096	$8,737,339
% of Total	56.6%	10.3%	9.7%	23.4%	—
Maryland	$5,891,837	$5,267,896	$2,271,312	$7,533,808	$20,964,853
% of Total	28.1%	25.1%	10.8%	35.9%	—
Massachusetts	$20,220,919	$40,558,166	$7,039,612	$13,498,569	$81,317,266
% of Total	24.9%	49.9%	8.7%	16.6%	—
Michigan	$48,103,022	$45,606,310	$3,424,009	$0	$97,133,341
% of Total	49.5%	47%	3.5%	0%	—
Minnesota	$9,961,105	$1,225,977	$11,280,323	$6,853,917	$29,321,322
% of Total	34%	4.2%	38.5%	23.4%	—
Mississippi	$9,943,115	$872,828	$1,306,964	$5,949,787	$18,072,694
% of Total	55%	4.8%	7.2%	32.9%	—
Missouri	$6,177,046	$5,003,561	$7,138,315	$4,088,545	$22,407,467
% of Total	27.6%	22.3%	31.9%	18.2%	—

State	Direct Health Care Services	Enabling Services	Population-Based Services	Infrastructure	Total
Montana	$2,413,651	$1,912,331	$1,101,026	$1,110,953	$6,537,961
% of Total	36.9%	29.2%	16.8%	17%	—
Nebraska	$2,547,601	$2,290,188	$1,001,632	$2,659,406	$8,498,827
% of Total	30%	26.9%	11.8%	31.3%	—
Nevada	$1,260,846	$402,281	$487,227	$572,803	$2,723,157
% of Total	46.3%	14.8%	17.9%	21%	—
New Hampshire	$2,394,944	$237,542	$1,170,939	$1,704,073	$5,507,498
% of Total	43.5%	4.3%	21.3%	30.9%	—
New Jersey	$7,382,106	$7,404,563	$3,281,032	$5,483,825	$23,551,526
% of Total	31.3%	31.4%	13.9%	23.3%	—
New Mexico	$5,620,146	$3,317,375	$557,684	$2,238,771	$11,733,976
% of Total	47.9%	28.3%	4.8%	19.1%	—
New York	$322,789,050	$128,235,877	$57,283,551	$64,977,705	$573,286,183
% of Total	56.3%	22.4%	10%	11.3%	—
North Carolina	$92,706,907	$75,769,737	$19,435,023	$11,797,788	$199,709,455
% of Total	46.4%	37.9%	9.7%	5.9%	—
North Dakota	$558,579	$219,124	$1,311,639	$1,647,520	$3,736,862
% of Total	14.9%	5.9%	35.1%	44.1%	—
Ohio	$49,567,844	$163,231	$1,849,952	$2,829,340	$54,410,367
% of Total	91.1%	.3%	3.4%	5.2%	—
Oklahoma	$13,812,588	$484,646	$1,334,020	$403,872	$16,035,126
% of Total	86.1%	3%	8.3%	2.5%	—
Oregon	$6,618,719	$7,554,884	$5,879,531	$7,194,131	$27,247,265
% of Total	24.3%	27.7%	21.6%	26.4%	—
Pennsylvania	$18,493,594	$8,128,266	$42,929,195	$13,691,169	$83,242,224
% of Total	22.2%	9.8%	51.6%	16.4%	—
Rhode Island	$2,312,466	$520,446	$5,671,092	$4,355,821	$12,859,825
% of Total	18%	4%	44.1%	33.9%	—
South Carolina	$40,143,839	$35,652,108	$1,465,045	$3,235,978	$80,496,970
% of Total	49.9%	44,3%	1,8%	4%	—
South Dakota	$673,276	$1,501,479	$1,095,659	$1,633,000	$4,903,414
% of Total	13.7%	30.6%	22.3%	33.3%	—
Tennessee	$20,926,500	$3,327,515	$2,389,133	$2,141,585	$28,784,733
% of Total	72.7%	11.6%	8.3%	7.4%	—
Texas	$67,586,300	$7,210,510	$15,339,531	$10,716,974	$100,853,315
% of Total	67%	7.1%	15.2%	10.6%	—
Utah	$5,956,078	$13,884,907	$6,844,965	$7,629,405	$34,315,355
% of Total	17.4%	40.5%	19.9%	22.2%	—
Vermont	$1,599,233	$1,130,307	$420,905	$361,304	$3,511,749
% of Total	45.5%	32.2%	12%	10.3%	—
Virginia	$16,523,196	$588,523	$2,252,767	$3,501,327	$22,865,813
% of Total	72.3%	2.6%	9.9%	15.3%	—
Washington	$2,029,770	$4,178,794	$10,392,852	$7,912,877	$24,514,293
% of Total	8.3%	17%	42.4%	32.3%	—
West Virginia	$13,693,757	$8,434,467	$1,906,579	$6,463,648	$30,498,451
% of Total	44.9%	27.7%	6.3%	21.2%	—
Wisconsin	$16,722,785	$2,799,036	$529,262	$4,305,631	$24,356,714
% of Total	68.7%	11.5%	2.2%	17.7%	—
Wyoming	$2,306,980	$545,046	$535,372	$387,722	$3,775,120
% of Total	61.1%	14.4%	14.2%	10.3	—
National Total	$2,160,798,035	$814,969,059	$421,779,456	$392,983,131	$3,790,529,681
% of Total	57%	21.5%	11.1%	10.4%	—

Note: Totals include U.S. territories. Because states use different data methodologies and multiple sources of data, data reported in this table may include actual counts, estimates, or blank cells (if data are not available at the time of reporting). Column totals may not sum to the total budget column because of missing data. Figures displayed here are for the federal fiscal year (October 1 through September 30). Some states use different fiscal years or budget on a biannual basis. Not all states can track expenditures by these service categories.

Source: Title V Information System, "Federal-State Title V Block Grant Partnership Expenditures by Category of Service, FY 1999." See www.mchdata.net.

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#480 *Child Development Programs in Community Health Centers* (January 2002). Sara Rosenbaum, Michelle Proser, Peter Shin, Sara E. Wilensky, and Colleen Sonosky, George Washington University. This report, the third in a series of analyses exploring federal and state health policy in the area of early childhood development, notes that states have the policy flexibility to use Title V funds to improve the provision of preventive health services to low-income children under age 3 who are eligible for Medicaid or CHIP (as well as those who are not). The report presents four approaches state Title V agencies can take to coordinate with their state Medicaid and CHIP programs.

Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years (December 2001). Michael Regalado and Neal Halfon. *Archives of Pediatrics and Adolescent Medicine,* vol. 155, no. 12. Copies are available from Michael Regalado, M.D., Cedars Sinai Medical Center, 8700 Beverly Blvd, MOT 475W, Los Angeles, CA 90048, E-mail: Michael.Regalado@cshs.org.

#451 *Room to Grow: Promoting Child Development Through Medicaid and CHIP* (July 2001). Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, George Washington University. This report, the second in a series of analyses exploring federal and state health policy in the area of early childhood development, examines how public insurance programs covering low-income children—namely, Medicaid and the State Children's Health Insurance Program (CHIP)—can be used to support and foster optimal child development interventions.

#450 *Health Policy and Early Child Development: An Overview* (July 2001). Sara Rosenbaum, Michelle Proser, and Colleen Sonosky, George Washington University. This report is the first in a series of analyses exploring federal and state health policy in the area of early childhood development. It provides an overview of the evolution of federal health policy related to the financing and provision of preventive health services for young children.

#452 *No Place Like Home: State Home Visiting Policies and Programs* (May 2001). Kay A. Johnson, Johnson Group Consulting, Inc. This report summarizes the results of a survey of states regarding home visiting activities, assessing the direction of state policies and programs through a nationwide examination of state-based home visiting programs targeting low-income families with young children.

#448 *Child Development and Medicaid: Attitudes of Mothers with Young Children Enrolled in Medicaid* (March 2001). Susan Kannel and Michael J. Perry, Lake Snell Perry & Associates. This report on mothers with young children enrolled in Medicaid finds that while generally pleased with the overall care their sons and daughters receive, many mothers feel that the program—as well as pediatricians—could do a better job of providing guidance on early development.

#404 *Appraisals of Parenting, Parent–Child Interactions, Parenting Styles, and Children: An Annotated Bibliography* (September 2000). The Commonwealth Fund Pediatric Parenting Project. Few measures of parenting skills offer an appraisal that is brief, comprehensive, parent-sensitive,

psychometrically sound, nonintrusive, and appropriate to child development. This annotated bibliography provides clinicians, clinical researchers, and researchers interested in applied issues with information about those parenting skills measures that are available.

Child Development Services in Medicaid Managed Care Organizations: What Does It Take? (July 2000). Carolyn Berry, Pamela Butler, Linda Perloff, and Peter Budetti. *Pediatrics,* vol. 106, no. 7. Copies are available from American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007-1098, Phone: 888-227-1773, Fax: 847-434-8000, E-mail: journals@aap.org.

#367 *Assuring the Healthy Development of Young Children: Opportunities for States* (February 2000). Peter Budetti, Carolyn Berry, Pamela Butler, Karen Scott Collins, and Melinda Abrams. This issue brief examines opportunities for states to enhance the provision of health-related developmental services to children in low-income families, particularly by emphasizing the importance of preventive developmental services in primary, pediatric practices.

#304 *Improving the Delivery and Financing of Developmental Services for Low-Income Young Children* (November 1998). Karen Scott Collins, Kathryn Taaffe McLearn, Melinda Abrams, and Brian Biles. This issue brief examines the effects of inadequate health care services on the development of young children, and discusses efforts at the federal and state level to improve access and developmental outcomes for young children in low-income families. It also introduces the Fund's new Assuring Better Child Health and Development Program.