

HRSA/MCHB 2007 FEDERAL/STATE PARTNERSHIP MEETING

Building Blocks for Promising Practice Models

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MCHB History, Vision, Mission, Strategic Plan, and

MCHB Partnership of Investment

PETER VAN DYCK: Good afternoon. Thank you, John. Well, I'm going to talk briefly about the law, the budget, some legislation, and some history, and some of the philosophy of the bureau, and I'll try to make it as interesting as possible. They allow us old guys, to do this kind of presentation, so I do enjoy it a lot. And I think it's important for us to ground ourselves in this kind of material.

Leadership. The bureau, and the state partnership, and the MCH partners provide leadership to the nation. To work in partnership with states and communities and others, assure the availability and use of medical homes, build the knowledge of human resources in order to assure continued improvement in the health safety and well-being of the MCH population. And what is the MCH population? Well, it's all of America's women, infants, children, adolescents and their families, including women of reproductive age, fathers and children with special health care needs. So it's a very broad definition for the population of who we serve. And if you think about these different categories, you will be able to think of all of these kind of categories in your programs.

The Maternal Child Health Bureau has values, mission, goals and objectives. They're available on the MCHB website in our strategic plan. We have a five-year strategic plan, which is available there. It maybe in your booklet, I'm not sure. But just to reiterate briefly the values that we have, to achieve its mission, we rely on personal, population-based systems and resource building approaches to promote health safety and well-being of the nations, MCH population.

Bureau efforts are driven by a commitment to the following values: affordable and accessible high-quality care for all; accountable, regularly monitored and evaluated evidence-based quality care; preventive, protective health care that address individual's physical, psychological and social needs; comprehensive and coordinated care in medical homes; consumer-oriented, family-oriented and culturally competent care linked to community; and to continually improving health care based on research, evaluation training, education, technical assistance and the dissemination of up-to-date information.

These values are carried into the goals and we have a set of four or five goals: one, to provide national leadership in Maternal and Child Health by providing leadership and accountability, forging strong, collaborative partnerships; to eliminate health disparities, economical, social, cultural barriers receiving comprehensive timely and appropriate health care; three, to assure the highest quality of care through the development of practice guidance, data monitoring and evaluation tools, evidence-based research, and having a well-trained

culturally diverse workforce; four, to facilitate access to care through infrastructure and systems of care to enhance the provision of necessary coordinated quality health care.

Mission, values, goals. Now, these are engendered in performance. They lead to performance. And performance is something we all share. We are all in this together, and we try to talk about what the bureau and its partners do in the form of a pyramid. And you've seen the pyramid before, it's in your guidances, but just let me say a few words about it. This was developed because when we talk about the breadth of the MCH programs, we talk for five minutes or 10 minutes or 15 minutes or 20 minutes and after five minutes, people's eyes glass over. And this was a way to conceptualize the delivery of MCH services that we provide the national, state, local, city, county level.

Top of the pyramid or pyramid or direct healthcare services, those services we all know are clinical and clinically related. The second layer down are enabling services: care coordination, family support, respite care, health education, case management. The next level, population-based services: immunization, sudden infant death, lead screening, newborn screening, those things that we deliver to a group of people, to a population. And at the bottom or at the seat of this pyramid are infrastructure building services: needs assessment, evaluation, legislation, policy development, standards development, quality assurance, all of those

things that we think shore up, provide the base, provide the importance of this pyramid.

Now, of all these services, I like to say that the MCH program, whether it's at the national, state or local level, is the only program that deliberately provide services at all levels of this pyramid. And I think each of you can think of services you provide at any one of those levels. If we look at community health centers, they provide direct care, good direct care, enabling services, some population-based services, but certainly not infrastructure services and certainly not infrastructure services to a broad statewide or countywide or certainly at the national level. If we look at the Medicaid side and look at either EPSDT or SCHIP, they also provide reasonably good direct health care services. There are a few gaps here and there, that's why the dotted line. Enabling services, they provide immunization down into the population-based services, but they don't provide infrastructure services certainly not for any large geographic area in any blanketed way.

So, out of this core of MCH services--we have partners in the delivery of services, but we have nobody that covers all services and certainly nobody that covers the bottom of this pyramid, which we think shores up the pyramid and makes it all work.

We're a performance measurement system. Follow me from the left hand side of the screen here. The left hand side of the screen is needs assessment, health status indicators, whether they're state indicators, national indicators, Healthy People 2000, legislative priorities, governor's priorities, state health officer priorities, your priorities, whatever, the beginning of this diagram is the development of a set of indicators. Those indicators then lead to the development of goals. And the goals I've listed here are those that I listed for the bureau in the beginning: disparities, reducing disparities, increasing quality, and improving infrastructure. They can be any set of goals and each of you has a set of 7 to 10 goals that you follow.

From the development of those goals comes program. You hire staff, you issue grants, you issue contracts, you work with partners, and you develop a program. And then you develop a program and you may, you may not, but you may think of what I'm going to do for direct services, or I'm going to think about what I'm going to do for population-based services, or I may think about what I'm going to do for legislation or data in the infrastructure part of the pyramid. But in some way, you develop a set of programs to try to address those indicators and goals that you usually developed in your five-year needs assessment.

And then there's an attempt to measure what we do. We've developed programs. Now, how do we measure it? And we have a set of performance measures. And you have some state performance measures. And we have GPRA. And we have

Congress. And we have OMB. And we have other people on our backs. But we not only try to satisfy them, we try to satisfy ourselves and to manage the program better by having measurements that make sense, and that we can track in some meaningful way. And then OMB as well as us, desire outcome measures, true outcome measures, and in the Block Grant, and in the bureau we have a set of six outcome measures, which are basically death-related or non-death-related, we hope, perinatal mortality, infant mortality, et cetera.

So, this is the diagram. If those performance measures and national outcome measures don't improve, then we need to rethink, we need to rethink our programmatic efforts, we circle back and think through it again.

Now that is the bureau performance measurement system. We have a Title V system for the Block Grant, and we have a system called the discretionary grant information system and performance measures for all other grants that are not the state Block Grants. So, these two separate but parallel paths that follow this same diagram. And just to describe the discretionary grant program for a minute, we have the 59 states and territories, who receive a Block Grant, and then you get this array of other grants from it: Emergency Medical Services grants, Healthy Start grants, Early Childhood grants, training grants to universities, and on and on, those total 800, 900 or 1,000 grants. Here is a performance measurement system for those grants that is well in the process of being rolled out, we should say. And in that program, there's a set of 30 to 35 national

performance measures. Each grantee gets in their guidance two or three or four or 10 of these performance measures to report on. And together, basically all of the 30 or 35 national performance measures get reported on by some subset of our grantees. There's a set of standardized forms, budget forms, and reporting forms similar to the Block Grant, which most of you are familiar with, each division, and you've heard the presentations from all the divisions but one so far, has a minimal set of data that's in addition to the performance measures.

Selected grantees like the LEND grantees or pulmonary grantees, the same as you in states, can develop a set of state or individual grantee levels--performance measures separate from the Federal performance measures, and then there's some other data that we need to elect. So, this is the discretionary grant performance measurement system.

Now, we can follow this same diagram, and I don't need to go through this again. But whether it's the discretionary grant performance measurement system or it's the Title--it's the SPRANS performance measurement system or the DGIS, this basic algorithm applies, and that next to the last column changes in the DGIS because SPRANS and other programmatic efforts, grant efforts, are attached to the divisions you've heard from today, and they've described those programs.

Now, we're in performance, and we perform in the Block Grant, and there's going to be three of these slides, and what I'd like you to look at here is just the last column in these first two. These are the numbers served in 1997 for the

categories of clients you see on the left. Our first column, the numbers are served in '97, the second column in 2003, the next slide will be 2004, and the next slide will be 2005. So, 24 million clients served in 1997, 28 million--did I say 24,000, 24 million--28 million served in 2003, 62 percent of all pregnant women touched by the MCH program Title V, basically Block Grant program. This is one of the reasons we want to acquire data from that other set of 800, 900 or 1,000 grantees so we can add to the clients we serve and add to the service provision totals that we develop. So, this is for the Block Grant. Basically, 100 percent of all infants, and you can see the other numbers, but that total is 28 million in 2003. If we look at that column for 2004, you can see it went up to 32 million. And it particularly rose in the area of children served to 28 percent. And if we look at 2005, it went up again to 33 million. This is the most children ever served in the Title V Block Grant program, 33 million folks including, again, over 60 percent of all pregnant women, 100 percent of all infants, 30 percent or a third of all kids, and 12 percent of all children with special health care needs. Folks, this is a significant program and serves more children in the Medicaid program.

Accountability. We like to pride ourselves, feel proud of ourselves, and pride ourselves on accountability. We have great program strengths that we always like to talk about, and I think resonate with congress and others. It's a partnership—it's a true partnership. We work together, we have the same goals and objectives, and we (inaudible) on them uniformly. We have priorities consistent with the Healthy People 2010 goals. And I'll show some of that

tomorrow in my opening talk. There's a commitment from the states for \$3 of match for every \$4 Federal received. And basically, all of you have more than that in the pot. This is tremendous positive talking point for us as we work with congress.

There's a five-year needs assessment, planning cycle that begins with a five-year needs assessment that you write and then become very, very good at this.

There's a framework that targets state expenditures to the entire MCH population. We can say who we serve and how much money goes to each segment. Yet, in all of this, what seems like, perhaps, some inflexibility, there's great flexibility for states to tailor their programs to meet their particular state needs, which, again, is another very positive talking point when you talk with congress whether it's state legislatures or congress. And there's a commitment for coordination, that's in the law and there's really a true commitment and a spirit of commitment in the programs for partnership with the other major programs.

Now, we have some federal grant authorities, and I'm going to talk about these for a minute because I think everybody can use a review of these. SPRANS, stands for Special Projects of Regional and National Significance, and 15 percent is set aside from the Title V legislation for SPRANS. And then there is CISS, what we call CISS, C-I-S-S, Community Integrated Service Systems. And that's to enhance state and local communities' ability to increase the comprehensiveness of local service delivery systems, and in the amount above

\$600 million in the Block Grant, Title V legislation, 12 and three-fourths percent get set aside for grants in this area.

We have face-to-face reviews. We're still on accountability here. We have face-to-face reviews with you and the states and with outside experts. We have an extensive narrative description that includes performance measures. We have financial tables and program tables and service provision tables. We have budget and expenditures for the different levels of the pyramid. We have achievement towards performance measures. We have positive impact on the outcome measures or at least, what we hope is positive impact on the outcome measures. We have electronic reporting, which is available to the public or to legislators or OMB or administration or whoever else, state health officers. We have sharing of data with states and other constituencies. And we have our preparation of special data reports, some of which you've heard about such as Child Health USA and Women's Health USA and the Chart Books from surveys and on and on. So, we have great strengths and we have great accountability. And we foster this and try to push it. So that's a piece about the bureau.

Now, I'd like to move on and talk about budget for 2008. And this is a little complicated, so we'll just take a few minutes and then you certainly can ask questions at any time now. Just raise hand and I'll try to see you. We have authorizing legislation. We are not just Title V of the Social Security Act passed in 1935. That is the authority for the MCH services Block Grant and for SPRANS

and CISS. But we have other authorities as well. The Traumatic Brain Injury program or TBI is two of the sections of the Public Health Service Act. The Healthy Start program is Title III in the Public Health Service Act. The Emergency Medical Services for Kids program, EMSC, again, is another section of the Public Health Services Act. Newborn Hearing Screening is part of a Public Health Services Act. This is a separate act from Title V and each of these has a budget line attached to it and gets appropriated each year. There's a sickle cell demonstration program that's been several years old, and you can see it was created in 2004 under the American Jobs Creation Act, which is the Sickle Cell Service Demonstration program. And then the new Family-to-Family Health Information Centers is a specific section in legislation of the Social Security Act Section 501C1A.

Now, just to go over this formula again for the budget. Whenever the total appropriation exceeds 600 million, and it does right now, it's 693 million for 2007. So if you want to write down these numbers and kind of play with this a little bit, you'll understand it fairly easily. When the total appropriation exceeds 600 million, this is just for Title V Social Security legislation, 12 and three-fourths percent of that amount is used to fund the Community Integrated Services System, the CISS that I talked about. So if we have a total appropriation right now of 693 million, that's 93 million, that would be 12 and three-fourths percent of 93 million goes to that program. Once that money is taken off so that what--10 million, 11 million--15 percent is set aside for SPRANS, and the remainder and

85 percent goes to the states in the formula, in the state Block Grant formula. Let me see what my next slide is. And I think we all remember that the formula, the 85 percent, the amount determined for each state is the percent of poor kids under 18 in your state as a percentage of all poor kids in the nation. So if California has 16 percent of all poor children under 18, they get 16 percent of that allocation of that 85 percent allocation. If Rhode Island has half of one percent, they get half of one percent. So it's a fairly simple, straightforward formula except there is a base, there is a core that is not touchable. And funds appropriated up to 422 million are distributed on the basis the amount awarded in fiscal year '83. So out of that 85 percent, the formula is run on the 422 million that's not touched, and the changes that occur in the appropriation above 422 are the amount that provides flexibility in the amount you get in the Block Grant. Is that fairly clear up to this point?

So now let's look at the budget, specifically for 2008. PB means President's Budget, H means the House mark, and S means the Senate mark. 2007 is what happened in 2007 officially. 2007 ended on September 30th. We are now in 2008, fiscal year 2008 as of October 1st. We do not have a budget. What we have is a continuing resolution until November 16th or 17th, which is around 10 or 12, 15 percent of the year. And those of you in the states will be getting an amount equal to that prorated to the continuing resolution till November 16th or 17th. The president submits a budget to Congress. That's the president's budget. He does that at the beginning of the year, usually in January. The House and the

Senate separately work on the administrations or the President's Budget and they preliminarily decide on how much money each agency should get, and that's called the House mark or the Senate mark. That's what these columns are. The House committees have met, the Senate committees have met, and this is the amount they have decided publicly. We will get in these charts I'm showing you. Now, until there is a budget, until the House and Senate talk together and conference, we won't know what our 2008 budget is, and so we'll keep getting continuing resolutions, which means we'll spend money as in that first 2007 column until we get a new budget, so we're locked to last year's budget in the continuing resolution and can't begin new programs. We will get a budget some time probably at the end of the year, maybe end of January. That's a particularly contentious period. So, here are the numbers: President's budget was 693; the same. And you can see that those numbers are relatively the same. The House voted 750 million for the MCH Block Grant, and the Senate, 673 million. Now, this--trust me, you'll see a slide in a few minutes, which really means at 693, not 673, so it's even with the president's budget. You can see what that would relate to in SPRANS and CISS money, and you can see earmarks. Earmarks are those programs which are not in the president's budget--there's a zero line there--but which some particular congressman feels he would like to fund. So, he may like to fund some oral health programs or they may like to fund some early intervention programs, so they may like to fund some newborn screening programs. And so they earmark a certain piece of the budget to come to the bureau, put it in our budget in a special legislative tool, and allow us to spend it in

a way that they prescribe. And I'll talk about some earmarks here in a minute, and you can see that there are \$70 million in earmarks in the House appropriation per mark, I should call it, and 16 in the Senate. Now, some of these become more clear as we look at these next slides.

Now, we talked about this public health service authorities. This slide basically has those public health service authorities on it: Healthy Start, Hearing Screening, EMSC, TBI, Sickle Cell and Family-to-Family. You can see the difference here in the House and the Senate marks. We had 101 million in Healthy Start this year. The president said we get 100.5, the House says 120, the senate says 101.5. What will we get? I don't know. Sometimes they meet together and split the difference which should be 110 million. If it's a particularly tough year and the president holds tight on vetoing appropriations, we may get 101 million. So we're in the beginning of the year, and we don't have a budget, but this is what we are working within the future here for this year. Hearing Screening, you can see both House and the Senate mark are up a little bit. EMSC, both the Senate and the House mark are up a little bit. TBI, the Senate mark is up a little bit. Sickle Cell, the Senate mark is up a little bit. Family-to-Family is already appropriated three million last year, four million this year, five million next year, so all states will be in the Family-to-Family Program if they apply successfully by the end of next year. And then there's some additional money for autism, and in the Senate mark, it's \$37 million except it's really not quite \$37 million because remember here, the 673 and how that--I said that was

the same as 693, well, the Senate took 20 million out of the Block Grant that is going towards LEND programs who deliver autism services as well as other developmental services, added it to \$17 new million to create a new programmatic effort for autism which comes the \$37 million. So the Block Grant is held harmless, the money--that \$20 million still goes to those programs but is combined with another \$17 new million for autism for a specific program which the senate feels they can control and monitor better if it's together--those dollars are all together. Similarly, the House in this \$750 million appropriation, 20 million of that and maybe a little more is for autism. And somehow the Senate and the House are going to have to get together on how they're going to divide this money. So there is new money for autism, we think. Then there are all these earmarks. And these are not tied to any specific legislation like a Public Health Service Act or Title V but they come in the Appropriations Act, oral health, sickle cell, epilepsy, genetics, mental health, fatal alcohol; you have grants in these areas and you can see the earmarks here. They tend to be higher generally than what we've gotten. So, this is really a relatively good budget year for us particularly if we're going to get money at the high-end of these marks. If we get money at the low-end, we'll still get some increases, but we don't know how much. Then you can see the 30 million for autism, it's in that house mark, which comes out of that increased Block Grant appropriation.

Now, there are two new earmarks that have all zeroes all the way across. One is first motherhood and the other is preparation for birth. Just let me read to you

what those are very briefly here. The first-time motherhood. The committee, this is the Senate committee that's dealing with the budget, provides money for our first-time motherhood demonstration program equally divided between urban and rural settings. Funding for urban setting should be used to improve infant health, strengthen families and provide supports to ensure family success through a community-based dual program. Then funding in the rural portion of the demonstration should be focused on the best ways of delivering supportive services including delivery outside the hospital setting both before and after the birth of the child. So, that's the kind of language we get, and we would have to craft a program then if we got this money on how to spend that 1.5 million related to that language. And the 15 million in the house mark, that's for public awareness for first-time parents, is competitive grants to states to increase public awareness of resources available to women preparing for childbirth and new parents through advertising campaigns and toll-free hotlines. The committee recommends this funding as part of the initiative to help reduce the number of abortions in America by alleviating the economic pressures and other real-life conditions that can sometimes cause women to decide not to carry their pregnancies to term. So, that's the entire language for that \$15 million appropriation that we would have to craft the program then if we have that money.

Any questions on the budget? Okay. Good. Now, history. The early organization unit in United States' federal government concerned with maternal and child

health was the Children's Bureau, which was established in 1912 in the Department of Labor. And its purpose was to serve all children to try to work out the standards of care and protection, which shall give to every child it's fair chance in the world, and the bureau's initial role as a fact finding agency. And the Children's Bureau funding for that first year in 1912, the entire funding for the children's bureau was \$25,640. We've come a ways since 1912. 1913 and 1914, some real seminal publications were published that were prenatal care and infant care so the beginning of publication. And in 1921, the Shepherd-Towner Act was first passed, and it was administered by the Children's Bureau from 1921 to 1929. It was based on agriculture--Department of Agriculture legislation. It was the first federal grant and aid program to states for health establishing the principle of public responsibility for child health. But it was extremely controversial and was labeled radical and socialistic by its critics. Get this, the American Medical Association, the Catholic church and the Public Health Service were instrumental in having it repealed eight years after its enactment. And because of a disagreement within the AMA over opposition to this legislation, the American Academy of Pediatrics was founded in 1930. 1935, the Social Security Act was passed, and that was the end of the Shepherd-Towner Act, and the impact of the Great Depression eroded the states abilities to continue useful child health work. So, the Children's Bureau response to this was to get the Title V Social Security Act passed and it made clear that it was not intended to simply pay for services, but was to extend and improve services available in each state for the target group.

1943, autism was officially described. 1950, disposable diapers were first invented. 1957 was the initiation of mental retardation programs when they did-- and Congress earmarked a million for demonstration programs. Saint Jude was founded in '62. '63 to '65, the maternal and infant care programs and the children and youth programs were developed. Also, a newborn intensive care unit was first funded for the first time through the Maternal and Child Health Bureau, family planning and dental care. In 1968 federal fetal monitoring was first used. And in 1969, administration of the Maternal and Child Health activities were transferred to the Public Health Service. And at that time, 50 percent of the appropriation was for MCH and crippled children's programs, what we called CCS programs at that time. And 40 percent of the appropriation was for the Maternal and Infant Care program, the CNY program and these--the NICU family planning and dental care, and 10 percent was for research. And there was a new requirement introduced in 1969 or '68, '69, which was a maintenance of effort level for MCH and CCS activities by state. And this became known as the maintenance of effort requirement, which you know about from your application.

In 1981, OBRA '81 was passed, which converted Title V to a Block Grant by combining seven categorical programs. OBRA means Omnibus Budget Reconciliation Act. It's when Congress doesn't pass a budget in the correct way and just lumps everything together in a big package and passes it. And so there was an OBRA '81 and that's what created the Block Grant. And in the creation of

that Block Grant in 1981, it granted a great deal of leeway to states for the first time. It pooled all the money in these seven programs, added it up, divided it among the states by a formula that's a little different than what I just talked about but was a little more complicated, and reduced it by 19 percent, basically, because states could achieve greater efficiency by combining all these programs together, right? And so that was how the program was Block Granted in 1981. And that's when the 85 percent-15 percent split; 85 percent for states and 15 percent for SPRANS first appeared.

And we'd like to talk about basically the federal government. The theory was give the states total flexibility, ask a little in return from data or reporting, and that the states will create wonderful programs for children and mothers. And, in fact, I think states did develop wonderful programs for mothers and children. But Congress and the administration didn't really have a handle on what was happening because as the money was given and the states were allowed the flexibility, there was no reporting back to the federal government. And so in 1989, OBRA '89 and other legislative appropriation act introduced major changes. The application with a needs assessment and states setting priorities that are approved together with the federal government in partnership, some measurable objectives, budget accountability, documentation of match, and the maintenance of effort was strengthened. And this is the clear ticking of the pendulum swinging from, really, total state flexibility with little reporting, swinging the other direction back with Congress saying, 'We need more information. We're not castigating

the programs. We think they're good, but we'd like to be able to talk about them and know where the money goes and know what programs and people are being served so as we appropriate more money, we'll know where money is being spent.' And so there was this tightening, I guess you could call it, of effort in 1989.

Healthy Start was enacted in 1991. Abstinence was first appropriated in '96, and I think, as you know, that program is now in administration for children and families. Our performance measures were introduced by the bureau in 2000. Newborn screening, abstinence, poison control, bioterrorism first became very popular and funded to some extent in 2004. We instigated the Children with Special Health Care Needs Survey, which had been done a couple of years before. The Child Health Survey, the Bullying campaign, you can see strengthened. Newborn screening introduced the discretionary grants information system, et cetera.

And then, in 2006, we continued on by updating the surveys, multiple special publications, strategic plan revision began and we're in that process now. We have MCHB survey websites where you can go and get information from these surveys in a very easy format. We have this wonderful new history website, which much, much more material than I've present it very briefly. It's available. You can get to it by going to the MCHB website and learn all this history in a

timeline, and certainly women's health has been important. So that's history, very briefly.

Now, I got to finish by a very quick review of the law. Title V is a great law. It prescribes certain things but gives us great flexibility. We are loath to change it at this point. Now we get—little feelers to see if we're interested in changing a word here or there. We really don't want to open it up to change, because we think it gives us great flexibility within a framework that fits. Title V authorizes, these are quotes, these are from the law, authorizes appropriations of states, improve the health of all mothers and children, the only legislation that has that word "all" in it. To provide, and these are truncated quotes, to provide and assure mothers and children access to quality maternal and child health services, to reduce infant mortality, preventable diseases and handicapping conditions among children, increase the number of immunized children, to increase low-income children receiving health assessments, diagnosis and treatments services. See how broad these are, and give us so much flexibility to develop new programs as we get money. To promote health by providing prenatal delivery and postpartum care. To promote health of children by providing preventive and primary care services. And in the children with special health care needs area, the variety of rehabilitation services for individuals under 16 receiving benefits from Title XVI. And to provide and promote family-centered, community-based coordinated care for children with special health care needs and to facilitate community-based systems of services for such children and their families. So these are straight

from the law. They are truncated but they give you the essence of what our responsibilities are. And our total MCH program is developed from these tenets or attributes in the law.

The SPRANS authority is to provide for, SPRANS, Special Projects in Regional and National Significance, research and training for MCH and children with special needs for genetic disease testing, counseling, information development dissemination. For grants, including funding for comprehensive hemophilia diagnostic treatment centers, relating to hemophilia without regard to age, and for the screening of newborns for sickle cell anemia, other genetic disorders and follow-up services. How broad can something be to provide money for research and training that allow us to develop a program but enables and requires us, in fact, to do it?

And the CISS program that we talked about has six provisions and you can read them: develop integrated MCH deliver systems; develop MCH centers, which provide prenatal delivery and postpartum care; develop MCH projects to serve rural populations. So that's the broad underpinning of the MCH law.

Now, there are some other things tucked into this law which are important for us. First, some restrictions, and then some things we're required to do, and then I'll finish. We cannot pay for inpatient services other than those services to children with special health care needs, which all states basically do, or to high-risk

pregnant women and infants. We cannot make cash payments to intended recipients of health services. So, we couldn't, for example, pay a person to buy insurance, which has come up in the past, several times. We can't make cash payments to intended recipients of health services. We can't purchase or improve LEND, when I say we, I mean the states and their Title V Block Grant, to improve land buildings or other major medical equipment.

Now, there is a caveat here. Some of you have used some Title V money to provide some updating of equipment or some remodeling. This is on a case-by-case basis with a special waiver. So, if you raise your hand and say, 'We did something,' you got a special waiver, I hope to do it. Cannot use for satisfying a requirement for expenditure of non-Federal funds. So, if there's a match requirement, say, for Medicaid, by the state, for state matching dollars, they can't take the Federal dollars from the MCH block and match Medicaid. That Federal money is inviolable. Now, they can steal state match from you that you're using for MCH and match Medicaid instead of the state MCH dollars, but they can't match both. Cannot pay for research or training other than to a public or nonprofit private entity. Now, any questions about those?

Okay. There are some things, then, that you must do, you shall do. You must establish a fair method for allocating funds among such individuals, areas and localities who need MCH services. You can't randomly give 29 counties different amounts of money. You have to have some method for doing that. You have to

have some rationale for doing it, either by population or by infant mortality rate or something. There has to be some rationale for a fair method for allocating funds.

You have to or shall apply guidelines for content of health care assessments and services and for assuring their quality. We would hope that you'd hear--I'm sure you heard about the new Bright Futures for children. We would hope you would apply guidelines, such as those, for EPSDT in your state, for your own well child clinics, or for your pregnancy clinics, or for your adolescent clinics. Applying guidelines for content of health care assessments, and we'd like to think you'd be able to apply those statewide, to more than just the MCH programs or MCH clinics.

You must or shall assure charges that if they're imposed, will be public, are not for low-income mothers and children, and will be adjusted to reflect income resource and family size. If you charge families, and many of you do, in fact, most of you do in some clinic or other, you must have a public schedule of charges. You must not charge poor people below the poverty level. Their service must be for free. And for people above the poverty level, you have to have some sliding scale that charges those who are most poor less than those who are less poor.

You shall provide for a toll-free hotline for use of parents to access information about providers for Title V and Title XIX and about other relevant health care

providers. So, your toll-free hotline has to provide information both about Title V and XIX providers and it has to be active. And most of you have it active most of the day. It does not have to be active 24 hours.

You must coordinate activities with EPSDT, including periodicity and content standards, and ensure no duplication between EPSDT and Title V, or EPSDT and SCHIP. You must coordinate these activities. And again, when you are recommending periodicity and content standards for EPSDT, we would hope you'd think about Bright Futures. We would hope you'd be involved with Medicaid in setting those standards or recommending those standards. And you must arrange and carry out coordination agreements for care and services with Title XIX. You are supposed to have a written, signed agreement between Medicaid and state health, or MCH and EPSDT, signed by both parties that outlines how you work together, how you recommend services to one another, how you refer between yourselves or among your clinics, et cetera, and it should be current.

You must coordinate activities with other related Federal programs: WIC, education. These are all quotes from the law. Other health, developmental disability and family planning program, you all do this really quite well. You must provide for services to identify pregnant women and infants eligible for Medicaid and assist them in applying for assistance. Most of you do that through the toll-free hotline where pregnant women can call, and you refer them on to Medicaid if eligible. Or for eligibility, you might refer from your WIC clinics, you might refer

from your prenatal clinics to Medicaid. You may have collocated eligibility stations with Title V and Medicaid. But you must provide services to poor pregnant women in helping them apply for assistance with Medicaid. And you shall make your application public within the state to facilitate comment from any person, including other Federal agencies or other public agencies, during its development and after its development. So, most of you do this. I think it could be done better with a real public input, but that's discussed in your block grant to review each year. So, that's a list of shalls, and here's one more. The state agency shall be responsible for the administration, or the state health agency, I should say, shall--must be responsible for the administration, or at least the supervision of the administration, of programs carried out under this title, MCH, except for those states which have some other arrangement on July 1st, 1967. The most common of that is the university--well, the state university may have responsibility for our children with special health care needs program. And if they had that responsibility and you contracted with them on July 1st, 1967, they can be grandfathered through this quark in the law, and they can still be administering that children with special health care needs program. But no other agency other than a state health agency, for anybody who does not have an arrangement before 1967, can supervise the provision of these funds except the state health agency. And if some other agency has some responsibility, there must be a signed agreement outlining and detailing that responsibility in great detail.

Well, history, budget, law, authorities, leadership, performance, accountability, we've really got a good partnership and a good program going. You folks do wonderful work, as does our staff. And I know I sometimes feel, maybe you do, like doing a good job here is like wetting your pants in a dark suit, it gives you a warm feeling, but nobody notices. But if we stick to it, work hard, and have compassion in caring, people will notice and services for the MCH population will improve. Thank you very much.