



The Patient Protection and Affordable Care Act

Summary of Key Maternal and Child Health Related Highlights with Updates on Status of Implementation

The Patient Protection and Affordable Care Act has many provisions that will impact health services and programs directed at women, infants, children and children with special health care needs (CSHCN). These provisions range from expanding access to insurance coverage to significant investments in prevention and public health.

This fact sheet provides a summary of the maternal and child health (MCH) related highlights of the law and related implementation of the law in states.

Prevention And Public Health

Maternal, Infant and Early Childhood Home Visiting Programs

Created a new section in Title V to provide \$1.5 billion over five years to states, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant and Early Childhood Visitation model(s). Model options are targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal and newborn health; child health and development; parenting skills; school readiness; juvenile delinquency; and family economic self-sufficiency.

IMPLEMENTATION OF THE PROVISION

- June 2010: A Funding Opportunity Announcement was released for Indian Tribes, consortia of Indian Tribes, Tribal Organizations and Urban Indian Organizations.
- June 2010: The Health Resources and Services Administration (HRSA) issued a funding announcement indicating that approximately \$90 million in formula grants are available to states to provide for evidence-based home visiting programs. The first step to receive funding via the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program was submission of an application for funding; state applications were due Jul. 9, 2010. These applications included plans for completing the statewide needs assessment and initial state plans for developing the program in order to meet the criteria identified in the legislation.
- July 2010: The U.S. Department of Health and Human Services (HHS) allocated \$88 million in grants to support home visiting programs. The states' portion of funds was allocated by a formula based on the number of young children in families at or below 100 percent of the federal poverty level. \$500,000 was immediately available for states to support their planning, needs assessments and to begin planning programs.
- July 2010: HHS requested public comments on the criteria for evidence of effectiveness of home visiting models. To view the AMCHP comments, click [here](#).
- September 2010: Submission of the required statewide needs assessment was due in order to receive funding. Guidance was provided for completing the statewide needs assessment required by law of all states, irrespective of whether they intend to apply for home visiting grants, as a condition for receiving FY 2011 Title V MCH Services Block Grant allotments.
- September 2010: Thirteen grants, totaling \$3 million, were made. A list of FY 2010 Tribal Maternal, Infant, and Early Childhood Home Visiting grantees, along with grantee abstracts, is available [here](#).
- February 2011: HHS released the third supplemental information request (SIR) for the submission of the updated state plan for a home visiting program.
- March 2011: HRSA and the Administration for Children and Families announced the establishment of the Advisory Committee on the MIECHV Program Evaluation.



- June 2011: HHS announced the availability of \$224 million to eligible states and jurisdictions under the MIECHV program for FY 2011. Up to \$99 million supports competitive grants and \$125 million is available on a formula basis. Specifically, the competitive grants are awarded in the form of “expansion grants” for states and jurisdictions that have already made significant progress toward implementing high-quality home visiting programs or “development grants” for states and jurisdictions that currently have modest home visiting programs.
- September 2011: HHS awarded \$224 million to 49 states. Formula grant awards totaling \$124 million were awarded to 55 eligible agencies; including 49 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands and America Samoa. A total of \$100 million in competitive funding was awarded to those states that have sufficiently demonstrated the interest and capacity to expand and/or enhance the development of their home visiting efforts. Specifically:
 - Approximately \$66 million was awarded to nine states and jurisdictions that have already made progress toward implementing a high-quality home visiting program as part of a comprehensive, early childhood system.
 - Approximately \$34 million was awarded to 13 states and jurisdictions that currently have modest home visiting programs and want to build on existing efforts.
- April 2012: HHS announced \$72 million in funding as part of the MIECHV program that will allow 10 states to expand home visiting programs. The awards go to states that have already established and wish to expand current programs, as well as states that wish to develop new home visiting programs using proven strategies.
- June 2012: HRSA announced the availability of funds for application by nonprofit organizations in North Dakota and Wyoming. This competition is open to nonprofit organizations proposing to provide services under the Affordable Care Act (ACA) MIECHV grant program in Wyoming or North Dakota. Both Wyoming and North Dakota have relinquished MIECHV funds and are not participating in the MIECHV grant program. Accordingly, grant funding is being made available to qualified nonprofit organizations for the purposes described in this funding opportunity announcement.
- July 2012: HHS announced the availability of about \$12 million in fund for the MIECHV Program for states that have existing, modest home visiting programs to build on existing efforts. The funding provided will build on the formula funding already provided to states and territories to support the quality implementation of home visiting programs.

Prevention and Public Health Fund

To provide for an expanded and sustained national investment in prevention and public health programs (over the FY 2008 level). The

fund supports programs authorized by the *Public Health Service Act*, for prevention, wellness, and public health activities, including prevention research and health screenings, such as the Community Transformation Grant Program, the Education and Outreach Campaign for Preventive Benefits and immunization programs. AMCHP continues to work to ensure that an adequate portion of resources in the Prevention and Public Health Fund (PPHF) address MCH issues and needs.

IMPLEMENTATION OF THE PROVISION

- June 2010: HHS announced allocations of \$500 million for FY 2010, which included the following:
 - \$126 million for Community and Clinical Prevention
 - Federal, state and local prevention initiatives
 - Integrating primary care into community-based behavioral settings
 - Obesity prevention and fitness
 - Tobacco cessation
 - \$70 million for public health infrastructure
 - \$31 million for research and tracking
 - Data collection and analysis
 - Centers for Disease Control and Prevention (CDC) Community Guide
 - Clinical Preventive Services Task Force
 - \$23 million to expand CDC public health workforce training program
 - \$250 million for workforce training of primary care professionals
- September 2010: Additional information was released about some of the FY 2010 funding
- February 2011: HHS announced allocations of \$750 million for FY 2011, which included the following:
 - \$298 million for Community Prevention
 - Federal, local and state prevention initiatives
 - Tobacco prevention
 - Obesity prevention and fitness
 - \$182 million for Clinical Prevention
 - Increase awareness of new preventive benefits, expand immunization services and strengthen employer wellness programs
 - Coordinate and integrate primary care services into community mental health and other community-based behavioral health settings
 - \$137 million for public health infrastructure and training
 - \$133 million for research and tracking
- February 2012: Congress passed the *Middle Class Tax Relief and Job Creation Act of 2012* that cuts the fund by 33 percent or \$6 billion over 10 years, starting in FY 2013, which begins Oct. 1, 2012. For more information on how AMCHP is working in broad coalition to oppose further reductions in the fund, click [here](#).

- June 2012: HHS announced funding to increase the number of women screened for breast and cervical cancer by providing high quality screening, follow-up, tracking, and patient navigation support services to low income, uninsured and under-insured women in conjunction with the existing CDC National Breast and Cervical Cancer Early Detection (NBCCEDP) program.
- June 2012: HHS announced funding for capacity building assistance to strengthen public health infrastructure and performance. The of the funding is to provide state, tribal, local and territorial (STLT) health departments available capacity building assistance (CBA) that will improve public health infrastructure, investment planning, coordination, implementation, evaluation, and dissemination of evidence-based practices.
- July 2012: HHS announced \$4 million in funding for behavioral surveillance systems partially financed by the PPHF.
- September 2012: HHS announced the PPHF Reporting Database. This database includes funding opportunity announcements, requests for proposals, and other funding solicitations for activities funded from the PPHF. You can find reports either by doing a keyword search using the box below or by clicking "View All" to see the entire database.
- For the latest funding amounts on the Prevention and Public Health Fund, [here](#) is the Trust for America's Health chart (last updated in June 2012).

National Prevention, Health Promotion and Public Health Council

To provide coordination and leadership at the federal level, and among federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system and integrative health care in the United States. This provision tasks the council with creating a national strategy to: set goals and objectives for improving health through federally supported prevention, health promotion and public health programs; establish measurable actions and timelines to carry out the strategy; and make recommendations to improve federal prevention, health promotion, public health and integrative health care practices.

The law also establishes an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. The group, which shall be no more than 25 members, is charged with developing policy and program recommendations, and advising the National Prevention Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.

IMPLEMENTATION OF THE PROVISION

- June 2010: President Obama signed an executive order establishing the council.

- June 2010: The council released a 2010 Annual Status Report.
- October 2010: The council released a draft framework to guide the development of the national strategy. AMCHP submitted formal comments in January 2011. To view the comments, click [here](#).
- June 2011: The National Prevention, Health Promotion, and Public Health Council, announced the release of the National Prevention Strategy, a comprehensive plan that will "help increase the number of Americans who are healthy at every stage of life." To view the report, click [here](#).
- July 2011: The council released a 2011 Annual Status Report. To view the report, click [here](#).
- April 2012: The Advisory Group on Prevention, Health Promotion, and Integrative and Public Health met in Washington, DC. This is the fifth meeting of the Advisory Group. For more information on the group and its members, please click [here](#).
- June 2012: Surgeon General Regina Benjamin and members of the National Prevention Council announced the release of the National Prevention Council Action Plan. The Action Plan builds from the vision, goal, recommendations, and actions of the landmark National Prevention Strategy. For more information and to read the plan, click [here](#).
- July 2012: The council released the 2011 Annual Status Report. To read the report, click [here](#).

Prevention and Health Promotion Outreach and Education Campaign

To provide for the planning and implementation of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. This provision directs the HHS secretary to provide guidance and relevant information to states and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. States shall design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services. The secretary shall report on the status and effectiveness of these efforts.

Childhood Obesity Demonstration Project

Appropriates \$25 million to carry out Childhood Obesity Demonstration Project authorized under *Children's Health Insurance Program Reauthorization Act (CHIPRA)*.

IMPLEMENTATION OF THE PROVISION

- January 2011: Funding was published for four grants not to exceed \$5.25 million each. The objective of the demonstration is to determine whether an integrated model of primary care and public health approaches in the community can improve underserved children's risk factors for obesity. These

approaches may include policy, systems, and environmental supports that encourage nutrition and physical activity for underserved children and their families. For more information, click [here](#).

- September 2011: HHS provided \$25 million in funding awards to identify effective health care and community strategies to support children's healthy eating and active living and help combat childhood obesity. The project targets children ages 2–12 years covered by the Children's Health Insurance Program (CHIP). The project grantees include three research facilities, the University of Texas Health Science Center at Houston, San Diego State University and the Massachusetts State Department of Public Health. Each of these facilities will receive approximately \$6.2 million over four years to identify effective childhood obesity prevention strategies. The evaluation center located at the University of Houston will receive about \$4.2 million over four years to determine successful strategies and share lessons and successes.

Oral Health Care Prevention and Education

This provision establishes a five-year national public health education campaign focused on oral health care prevention and education. It establishes demonstration grants to show the effectiveness of research-based dental caries disease management. It also includes various oral health improvement provisions relating to school-based sealant programs, oral health infrastructure and surveillance.

Community Transformation Grants

Authorizes CDC to award competitive grants to state and local government agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programming.

IMPLEMENTATION OF THE PROVISION

- May 2011: HHS announced the availability of over \$100 million in funding for up to 75 Community Transformation Grants (CTG). The transformation grant guidance places an emphasis on chronic disease but specifies within that overall focus, states and communities "may also address additional areas of disease prevention and health promotion that will contribute to the overall goal of reducing chronic disease rates. These areas include adolescent health; arthritis and osteoporosis; cancer; diabetes; disabilities and secondary conditions; educational and community-based services; environmental health; HIV; injury and violence prevention; maternal, infant, and child health; mental health and mental disorders; health of older adults; oral health; and sexually transmitted diseases."

- June 2011: HHS announced the availability of \$4 million in cooperative agreements to national networks of community-based organizations to expand the reach and impact of the CTG program and to ensure that the CTG is a national program. Networks of community-based organizations with activities in at least 85 percent of U.S. states and territories were eligible to apply for this funding opportunity announcement. Minority serving organizations that have local affiliates and chapters in at least four states and have the ability to reach at least 30 percent of their selected racial and ethnic population were also eligible to apply for funding.
- September 2011: The CDC awarded \$103 million to 61 states and communities with over 120 million residents to fight chronic disease. All grantees will work to address the following priority areas: 1) tobacco-free living; 2) active living and healthy eating; and 3) quality clinical and other preventive services, specifically prevention and control of high blood pressure and high cholesterol. Grantees may also focus on creating healthy and safe environments and reducing health disparities. Grantee activities include:
 - Thirty-five grantees will implement proven interventions to help improve health and wellness. Funding amounts range from \$500,000 to \$10 million depending on population size and scope of project.
 - Capacity Building - Twenty-six grantees will work to build capacity by laying a solid foundation for sustainable community prevention efforts. Funding amounts range from \$147,000 to \$500,000, depending on population size and scope of project. For more information about CTG, click [here](#).
 - Dissemination and Acceleration National Networks: In order to disseminate and amplify the proven strategies of the CTG program in communities nationwide, two national networks received \$4.2 million. For more information on these grants, click [here](#).
- September 2012: HHS awarded \$70 million in new CTGs to support 40 communities with fewer than 500,000 people in neighborhoods, school districts, villages, towns, cities, and counties to increase opportunities to prevent chronic diseases and promote health. These new awards will benefit about 9.2 million Americans - bringing the total number of people reached through the CTG program to about 130 million Americans, or more than 4 out of 10 U.S. citizens. For more information, click [here](#).

Personal Responsibility Education Program

Provides \$75 million per year through FY 2014 for Personal Responsibility Education Program (PREP) grants to states to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Funding is also available for 1) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable and culturally underrepresented populations; 2) allotments to Indian

tribes and tribal organizations; and 3) research and evaluation, training; and technical assistance.

IMPLEMENTATION OF THE PROVISION

- September 2010: HHS awarded \$55 million total in PREP funds to states, territories and communities. Of this total amount, \$45 million was awarded as formula grants to 46 states (including the District of Columbia) and U.S. territories for programs that replicate evidence-based teen pregnancy prevention strategies and incorporate other adult responsibility subjects, such as maintaining healthy relationships, developing healthy attitudes and values about growth and development, increasing healthy parent-child communication and enhancing financial literacy. An additional \$10 million was awarded competitively through a joint application process with the teen pregnancy prevention Tier 2: Innovative Approaches funding to support programs that test innovative strategies to reducing teen pregnancy and repeat pregnancy among high-risk, vulnerable and culturally underrepresented youth populations.
- June 2011: HHS announced the availability of \$6.5 million in the form of discretionary, competitive grants to tribes and tribal organizations to support the development of comprehensive, teen pregnancy prevention programs. PREP emphasizes a medically accurate approach, replicating effective programs or elements of programs that have been proven—on the basis of rigorous, scientific research — to change behavior. Behavioral changes may include delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy.

Restoration of Funding For Abstinence Education

Appropriates \$50 million per year through FY 2014 for abstinence education.

IMPLEMENTATION OF THE PROVISION

- August 2010: HHS awarded \$33.4 million to 29 states and Puerto Rico to fund abstinence education activities.
- March 2011: HHS awarded \$37.5 million to 37 U.S. states and territories to fund abstinence education activities.

Reasonable Break Time for Nursing Mothers

Amends the *Fair Labor Standards Act of 1938* to require that employers provide a reasonable break time for an employee to express breast milk for her nursing child for one year after the child's birth and provide a place, other than a bathroom, that is shielded from view and free of intrusions from coworkers and the public.

IMPLEMENTATION OF THE PROVISION

- December 2010: The Department of Labor issued a request for comments on their interpretation of the "Break Time for Nursing Mothers" provision. The department was specifically interested

in hearing from the community about what constitutes a reasonable break time for nursing mothers, what it means to provide a "place" to express milk, and how the federal government can inform the public about the specifics of this law. The department will consider the comments received as they formulate further guidance for the regulated community to comply with the new break time requirement.

- February 2010: AMCHP submitted joint comments on the proposed provision. To view, click [here](#).

Support, Education and Research for Postpartum Depression

This provision amends Title V to provide \$3 million for new state grants in 2010 to provide services to individuals with, or at risk of, postpartum depression and their families. However, no funding has been provided to date. Activities could include delivering or enhancing home-based and support services, including case management and comprehensive treatments; inpatient care management services ensuring the well-being of the mother, family and infant; improving support services (including transportation, attendant care, home maker services, respite care) and providing counseling; promoting earlier diagnosis and treatment; and providing information to new mothers. The secretary is encouraged to continue research to expand the understanding of the causes of, and treatments for, postpartum conditions and the National Institute of Health is encouraged to conduct a study on the mental health of women who resolve pregnancy in various ways.

Coverage And Benefits

Medicaid Expansion

Creates a new mandatory Medicaid eligibility category for all individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning Jan. 1, 2014. However, due to the Supreme Court ruling in June 2012, states may now opt-out of expanding Medicaid coverage to this population. Prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence. From 2014 through 2016, the federal government will pay 100 percent of the cost of covering newly eligible individuals. In 2017 and 2018, states that initially covered less of the newly-eligible population (called "Other States") would receive more assistance than those states that covered at least some non elderly, non pregnant individuals ("Expansion States").

IMPLEMENTATION OF THE PROVISION

- August 2011: HHS issued proposed regulations to implement sections of the Affordable Care Act related to Medicaid and CHIP eligibility, enrollment simplification and coordination.
- February 2012: The Centers for Medicare & Medicaid Services (CMS) announced a partnership with Text4Baby, a free national health texting service, to build on the ACA efforts to expand

coverage and promote enrollment in both Medicaid and the CHIP and provide pregnant women and new mothers free text messages on important health care issues.

- March 2012: CMS released the Medicaid eligibility and enrollment final rule, which implements Medicaid and CHIP improvements established by the Affordable Care Act. The final rule establishes a seamless system of coverage between Medicaid, CHIP and the Affordable Insurance Exchanges. The full text of the rule can be found [here](#). AMCHP is analyzing the rule and will provide more information in the near future.
- November 2012: CMS released [a guidance letter](#) to State Medicaid Directors that offers details about what types of benefits should be provided for low-income adults if states choose to expand their programs.
- December 2012: CMS released an [informational bulletin](#) that provides guidance to states on the Modified Adjusted Gross Income (MAGI) Conversion “Effective Jan. 1, 2014, a methodology for determining income based on MAGI will apply to both Medicaid and CHIP eligibility for most enrollees, including pregnant women, children, parents and other caretaker relatives, and the new adult group (as applicable in a state). This new methodology is aligned with the one that will be used to determine eligibility for the premium tax credits and cost sharing reductions available to certain individuals purchasing coverage on the Exchange.”

CHIP

Upon enactment, states would be required to maintain income eligibility levels for CHIP through Sept. 30, 2019. From FY 2014 to 2019, states would receive a 23 percent increase in the CHIP match rate, subject to a cap of 100 percent. CHIP-eligible children who cannot enroll in CHIP due to federal allotment caps would be eligible for tax credits in the State Exchange.

IMPLEMENTATION OF THE PROVISION

- March 2012: CMS released the Medicaid eligibility and enrollment final rule, which implements Medicaid and CHIP improvements established by the Affordable Care Act. The final rule establishes a seamless system of coverage between Medicaid, CHIP and the Affordable Insurance Exchanges. The full text of the rule can be found [here](#).
- January 2013: CMS issued an [informational bulletin](#) announcing the availability of \$32 million for grants to states, local governments, community-based and non-profit organizations to continue efforts to find and enroll children in Medicaid and CHIP.
- See MAGI explanation in Medicaid section above.
- November 2012: CMS released a [FAQ](#) on the implementation of Medicaid and CHIP under the ACA. The document mainly provides technical explanations about interactions between the states and the federally facilitated exchanges, however, there are important details included regarding state/federal

responsibilities in either determining or assessing eligibility for Medicaid and CHIP programs.

Health Insurance Marketplaces

The law sets up a state health insurance marketplace to offer basic health programs. States can either establish a marketplace on their own, partner with the federal government, or let the federal government establish the marketplace entirely. States would have the option to offer a community health insurance plan, similar to the state plan, and be able to offer a waiver to plans showing innovation around care management, care coordination and incentives for using preventive services. States could offer premium tax credits and cost-sharing reduction assistance. At first, marketplaces will serve individuals or small employers purchasing insurance. States will have the option of opening the exchanges to larger employers a few years after implementation.

IMPLEMENTATION OF THE PROVISION

- September 2010: HHS announced \$49 million in grants for states to help set up exchanges. These grants, of up to \$1 million each; give states the resources they need to conduct the research and planning needed to build a better health insurance marketplace and determine how their exchanges will be operated and governed.
- October 2010: HHS announced competitive funding opportunities via early innovator grants for states to design and implement the information technology (IT) infrastructure needed to operate Health Insurance Exchanges.
- November 2010: The Office of Consumer Information and Insurance Oversight issued guidance to the states seeking to establish an exchange. Additional information can be found [here](#).
- March 2011: CMS and the Treasury Department sought comments on procedural framework for submission and review of initial applications for a Waiver for State Innovation.
- July 2011: HHS sought comments on the “Establishment of Exchanges and Qualified Health Plans” in a proposed rule, which provides a framework from which states will build their health insurance exchanges.
- August 2011: HHS awarded \$185 million in grants to 13 states and the District of Columbia to help them build exchanges.
- February 2012: HHS announced the award of \$229 million in Affordable Insurance Exchange grants to 10 states (Arkansas, Colorado, Kentucky, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania and Tennessee) to help them create exchanges, giving these states new flexibility and resources to implement the Affordable Care Act. [Click here](#) to view the fact sheet.

- February 2012: HHS, along with the Department of Treasury, finalized a rule on State Innovation Waivers. Under the law, State Innovation Waivers are available in 2017, and the final rules provide detail on how states can work with HHS to ensure their residents have the protections provided in the Affordable Care Act and access to innovative state approaches. [Click here](#) to view the final rule.
- March 2012: HHS released the final rule on the establishment of health insurance exchanges and qualified health plans. This final rule provides the framework for states and the federal government to establish health insurance exchanges. AMCHP is analyzing the potential impact and will provide information in the near future.
- May 2012: HHS announced that Illinois, Nevada, Oregon, South Dakota, Tennessee and Washington will receive more than \$181 million in grants to help implement the new health care law. The grants will help states establish Affordable Insurance Exchanges.
- May 2012: HHS provided more guidance to states on health insurance exchanges, including the Draft Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges, which can be found [here](#). Additionally, a frequently asked questions page can be found [here](#).
- May 2012: HHS also provided guidance on the Federally Facilitated Exchanges (FFE). The FFE guidance describes the principles under which FFEs will operate in states that do not elect a state-based exchange. States electing a SPE approach must undergo the Blueprint process. The guidance document can be found [here](#).
- June 2012: HHS announced the availability of funding for states, the District of Columbia and a consortia of states for the establishment of exchanges. For more information, click [here](#).
- August 2012: HHS released the final Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges. States seeking to operate a state-based exchange or electing to participate in a state partnership exchange must submit a complete Exchange Blueprint no later than 30 business days prior to the required approval date of Jan. 1 (Nov. 16, 2012, for plan year 2014). States that plan to operate in the federally facilitated exchange without partnership – that intend to operate their own reinsurance programs – should submit a declaration letter addressing how they meet or will meet the requirements of section 5.2: reinsurance program. They are invited to submit a declaration letter otherwise, but they do not need to complete the Exchange Application. For more information on the blueprint, click [here](#).
- August 2012, HHS announced the award of grants to California, Connecticut, Hawaii, Iowa, Maryland, Nevada, New York and Vermont to help with the implementation of affordable insurance exchanges. California, Hawaii, Iowa and New York have been awarded Level One Exchange Establishment Grants, which provide one year of funding to states that have begun the process of building their exchange. Connecticut,

Maryland, Nevada and Vermont were awarded Level Two Establishment Grants, which are provided to states that are further along in building their exchange and offers funding over multiple years. For a detailed breakdown of each grant award and what each state plans to do with its exchange funding, click [here](#).

- August 2012: CMS announced the award of nearly \$20 million in to fund the Consumer Assistance Program. These new grants will help strengthen and enhance ongoing efforts in the States and local communities to protect consumers from some of the worst insurance industry practices. For more information and the list of awardees, click [here](#).
- September 2012: HHS Announced a new round of funding to support states in their efforts to establish insurance marketplaces. In this round of funding, Arkansas, Colorado, Kentucky, Massachusetts, Minnesota and the District of Columbia received funding. For more information, click [here](#).
- December 2012: states had to indicate to HHS whether they intended a state-based insurance marketplace. Earlier in the year, the deadline was extended from the end of October at the request of state leaders.
- December 2012: HHS issued a [proposed rule](#) on the governance of the federally facilitated exchanges.
- January 2013: HHS announced a batch of states that are conditionally approved to operate state-based health insurance exchanges. Those states are California, Hawaii, Idaho, Nevada, New Mexico, Vermont and Utah. These states are in addition to Colorado, Connecticut, the District of Columbia, Kentucky, Massachusetts, Maryland, Minnesota, New York, Oregon, Rhode Island and Washington that also are conditionally approved to run a state-based exchange. Additionally, conditional approval was given to Delaware to operate a state partnership exchange.
- January 2013: CMS provided [guidance](#) on state partnership exchanges.
- For a map on state positions, click [here](#).

Insurance Reforms

ACA includes several insurance market reforms including no lifetime or unreasonable annual limits, prohibits discriminatory premium rates, and provides for guaranteed availability of coverage. Reforms include prohibition of preexisting condition exclusions or other discrimination based on health status. The bill also eliminates co-pays for services recommended by the United States Preventive Services Task Force, immunizations recommended by CDC, and with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA (i.e. Bright Futures). The Affordable Care Act requires any group health plan or plan in the individual market that provides dependent coverage for children to continue to make that coverage available up to age 26.

IMPLEMENTATION OF THE PROVISION

- July 2010: HHS issued regulations extending dependent coverage for adult children up to age 26 for all individual and group policies for plans or policy years beginning on or after Sept. 23, 2010.
- August 2010: Departments of Treasury, Labor and HHS issued regulations that prohibit the use of lifetime limits in all health plans and insurance policies issued or renewed on or after Sept. 23, 2010. The rules will phase out the use of annual dollar limits over the next three years until 2014 when the ACA bans them for most plans. Plans issued or renewed beginning Sept. 23, 2010, will be allowed to set annual limits no lower than \$750,000. This minimum limit will be raised to \$1.25 million beginning Sept. 23, 2011, and to \$2 million beginning on Sept. 23, 2012. These limits apply to all employer plans and all new individual market plans. For plans issued or renewed beginning Jan. 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.
 - Under the regulations, insurers and plans will be prohibited from rescinding coverage – for individuals or groups of people – except in cases involving fraud or an intentional misrepresentation of material facts. Insurers and plans seeking to rescind coverage must provide at least 30 days advance notice to give people time to appeal. There are no exceptions to this policy.
 - The new regulations will prohibit insurance plans from denying coverage to children based on a preexisting condition. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for a child with cancer because the child had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the family for the child because of the child's preexisting medical condition). These protections will apply to all insurance types except for individual "grandfathered" policies and will be extended to Americans of all ages starting in 2014.
- September 2010: HHS issued regulations requiring new health plans beginning on or after Sept. 23, 2010, to provide, at minimum, coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force; recommended immunizations; preventive care for infants, children, and adolescents; and additional preventive care and screenings for women.
- August 2011: HHS issued guidelines requiring new health insurance plans beginning on or after Aug. 1, 2012, to cover eight women's preventive health services without charging a co-payment, co-insurance or a deductible. These eight preventive health services include: well-woman visits, screening for gestational diabetes, human papillomavirus (HPV) DNA testing for women 30 years and older, sexually-transmitted infection counseling, human immunodeficiency virus (HIV) screening and

counseling, FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies, and counseling; and domestic violence screening and counseling. These guidelines are based on recommendations from an Institute of Medicine committee. Click [here](#) to view the recommendations.

- February 2012: HHS, the Department of Labor, and the Internal Revenue Service issued the final regulations "authorizing the exemption of group health plans and group health insurance coverage sponsored by certain religious employers from having to cover certain preventive health services under provisions of the *Patient Protection and Affordable Care Act*." The exemption has two parts, one that exempts churches, synagogues, and other houses of worship from the coverage requirement completely, and an exemption for nonprofit employers that hold religious objections to contraceptives. For these nonprofit groups, there is a one-year grace period, until August 2013, when further guidance will be released on how employees and their dependents can obtain contraceptives. For more information on this issue, please visit the Kaiser Family Foundation website [here](#).
- August 2012: Non-grandfathered plans and issuers are required to provide coverage without cost sharing for the women's preventive services recommended by the Institute of Medicine guidelines in the first plan year (in the individual market, policy year) that begins on or after Aug. 1, 2012. For more information, click [here](#).
- September 2012: Insurance companies and employers are now required to provide consumers in the private health insurance market with a brief summary of what a health insurance policy or employer plan covers called a [Summary of Benefits and Coverage](#) (SBC). This is meant to help consumers to know what they are buying when shopping for insurance.
- November 2012: the Department of Treasury, Labor and Health and Human Services released [a proposed rule](#) that provides details on nondiscriminatory wellness programs in group health plans.

Essential Health Benefits

Under the ACA, qualified health plans will include the following essential health benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. The ACA also requires the coverage of comprehensive tobacco cessation services for pregnant women in Medicaid and a state option to cover family planning services.

IMPLEMENTATION OF THE PROVISION

- January 2011: the Institute of Medicine (IOM) hosted a

meeting to begin the process of developing recommendations on the criteria and methods for determining and updating the essential health benefits package. The IOM will not define specific service elements of the benefit package.

- April 2011: the Department of Labor issued a report detailing the results of a survey of employer-sponsored health coverage. This survey identified the benefits covered by employers and multi-employer plans. This report will be used to help HHS better understand the scopes of benefits provided under employer-sponsored insurance.
- June 2011: CMS released information to assist states as they work to reduce tobacco utilization. The letter includes guidance on implementation of a provision included in the Affordable Care Act, which provides for Medicaid coverage of comprehensive tobacco cessation services for pregnant women, including both counseling and pharmacotherapy, without cost sharing. This letter also provides guidance on “tobacco telephone quitline” activities, which may be provided to Medicaid beneficiaries as an allowable Medicaid administrative cost expenditure. The specific recommendations for pregnant women include: person to person psychosocial interventions that exceed minimal advice to quit and tobacco-dependence interventions to pregnant smokers at the first prenatal visit, as well as throughout the course of pregnancy.
- October 2011: The IOM released a report entitled “Essential Health Benefits: Balancing Coverage and Cost,” which provides a process to help HHS define the minimum benefits that certain health plans must cover. The charge of the committee specifically was not to decide what is covered in the essential health benefits (EHB), but rather to propose a set of criteria and methods that should be used in deciding what benefits are most important for coverage.
- December 2011: HHS released a bulletin informing stakeholders about the proposed approach to essential health benefits. Under this approach states would have the flexibility to select an existing health plan to set the “benchmark” for the items and services included in the essential health benefits package. States would choose one of the following health insurance plans as a benchmark: one of the three largest small group plans in the state; one of the three largest state employee health plans; one of the three largest federal employee health plan options; or the largest HMO plan offered in the state’s commercial market. The entire bulletin can be viewed [here](#).
- January 2012: AMCHP submitted comments in response to the HHS Essential Health Benefits Bulletin. To view the letter, click [here](#).
- February 2012: CMS published a fact sheet that deals with questions that have been raised by states, patient groups and others about how states should choose their essential health benefits packages. Notably the FAQ confirms that plans offered

in state exchanges will be required to provide the full panel of recommended preventive health services, including the Bright Futures guidelines and women’s health preventive services package. [Click here](#) to view the CMS fact sheet.

- October 2012: The [Essential Health Benefits Bulletin](#) released by the HHS in December 2011 indicates that states should select a benchmark plan for the essential health benefits by the end of the third quarter of 2012. As of now, states are at varying stages of selection of essential health benefits benchmark. For more information on how states are proceeding in the selection, click [here](#).
- November 2012: CCIIO posted the [proposed state benchmark plans](#) and a [guide for reviewers](#) to its website.
- AMCHP encouraged states to comment on proposed essential health benefits benchmark plans. AMCHP provided a memo containing background information and how states can comment that can be found [here](#). Comments were due Dec. 26, 2012. (Dec. 17, 2012).
- November 2012: HHS released a [proposed rule](#) that details standards for health insurance issuers, a timeline for qualified health plans to be accredited, and details on accreditation of qualified health plans. A fact sheet can be found [here](#).
- AMCHP [provided comments](#) on the proposed regulation in Dec. 2012.

Access

Health Homes in Medicaid

Creates a state option to provide health homes for Medicaid enrollees with chronic conditions. The secretary may award \$25 million in planning grants to states to develop a state plan amendment to provide health homes. Health homes are provided by a designated provider (physician, clinical group practice, rural clinic, community health center, community mental health center, pediatricians, gynecologists, or obstetricians, etc.) or team (includes physicians and other professionals such as nurse care coordinator, social worker, behavioral health, etc.) and must provide comprehensive case management, care coordination and health promotion, transitional care, patient and family support, referral to community services, and the use of health information technology as appropriate.

IMPLEMENTATION OF THE PROVISION

- November 2010: CMS issued a State Medicaid Directors Letter providing guidance on how states may take advantage of the new Medicaid Health Home option. Click [here](#) to view the letter.

Pediatric Accountable Care Organization Demonstration Project

Authorizes participating states to recognize pediatric medical providers as an accountable care organization (ACO) for purposes

of receiving incentive payments (states and the secretary will establish an annual minimum savings level to be achieved by the ACO for services covered under Medicaid or CHIP in order to receive savings). The demonstration project established with the ACO should last three years.

CMS Center for Medicare and Medicaid Innovation (CMI)

To test innovative payment and service delivery models for Medicare, Medicaid and CHIP programs. Models should promote payment and practice reform in primary care, including patient-centered medical home models for high-need individuals, and medical homes that address women's unique health care needs. Additional factors for consideration include whether the model places the individual, including family members and other informal caregivers, at the center of the care team and provides for the maintenance of a close relationship between care coordinators, primary care specialists and community-based organizations.

IMPLEMENTATION OF THE PROVISION

- July 2011: HHS announced the availability of \$500 million in funding for the Partnership for Patients. This funding was made available to help hospitals, health care provider organizations and others improve care and stop millions of preventable injuries and complications related to health care acquired conditions and unnecessary readmissions.
- August 2011: HHS announced a request for applications to the Bundled Payments for Care Improvement initiative, which will align payments for services delivered across an episode of care, such as heart bypass or hip replacement, rather than paying for services separately.
- November 2011: HHS announced the Health Care Innovation Challenge, which will award up to \$1 billion in grants to applicants who will implement the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP, particularly those with the highest health care needs.
- January 2012: HHS announced 73 individuals will serve as Innovation Advisors. These advisors will be expected to support CMI in testing new models of care delivery, to form partnerships with local organizations to drive delivery system reform, and to improve their own health systems so their communities will have better health and better care at a lower cost.
- January 2012: CMS received approximately 3,000 applications for its Health Care Innovation Challenge. Final announcements on awardees are expected soon.
- February 2012: the CMMI Innovation announced Strong Start for Mothers and Newborns and a funding announcement for up to \$43 million is available in cooperative agreements to "test new innovative payment and service delivery models to reduce

program expenditures while preserving or enhancing the quality of care." The deadline for applications has been extended as of Aug. 9, 2012. For more information, visit [here](#).

- May 2012: HHS announced the first batch of organizations for the Health Care Innovation awards. Made possible by the Affordable Care Act, the awards will support 26 innovative projects nationwide that will save money, deliver high-quality medical care and enhance the health care workforce. The preliminary awardees expect to reduce health spending by \$254 million over the next three years. One interesting project that received financing is a University Hospitals of Cleveland initiative to increase access and care coordination for children beyond the walls of the doctor's office. This initiative aims to save money and improve the quality of care by extending the expertise of an elite children's hospital to local pediatric practices treating children with complex chronic conditions and behavioral health problems with physician extension teams and telehealth. For more information, click [here](#).
- July 2012: HHS announced the State Innovation Models Initiative. The initiative is a \$275 million competitive funding opportunity for States to design and test multi-payer payment and delivery models that deliver high-quality health care and improve health system performance.

State Grants to Promote Community Health Teams

State grants to promote community health teams that support the patient-centered medical home. Community-based interdisciplinary teams will provide support services to primary care practices, including OBGYN practices. The team may include specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral/mental health providers and physicians' assistants. Health teams should collaborate with local primary care and health providers; coordinate disease prevention and management; coordinate transition between health care providers and settings; provide case management for patients, including children; incorporate patients and caregivers in program design and oversight; provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care; establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems; and should provide support for transitional health care needs from adolescence to adulthood. No funding has been provided to date.

Community Health Centers

Creates a Community Health Center Fund that provides \$11 billion in mandatory funding (over five years) for the Community Health Center program, the National Health Service Corps, and construction and renovation of community health centers.

IMPLEMENTATION OF THE PROVISION

- October 2010: HHS announced \$727 million for community health centers to support major construction and renovation at 143 centers.
- October 2010: HHS announced \$335 million for existing community health centers across the country under the Expanded Services (ES) initiative. These funds are made possible by the Affordable Care Act and will increase access to preventive and primary health care, including dental health, behavioral health, pharmacy, vision, and/or enabling services, at existing health center sites.
- November 2010: HHS announced \$8 million for existing Community Health Center Cooperative Agreements. These agreements will provide additional training and technical assistance on a national, regional and state basis to community-based organizations that support community health centers.
- August 2011: HHS announced awards of \$28.8 million to 67 community health center programs. HRSA received 810 applications for this funding. These funds are expected to help establish new health service delivery sites to care for an additional 286,000 patients.
- May 2012: HHS announced the availability of \$728 million to support 398 renovation and construction projects. Approximately \$629 million will go to 171 existing health centers across the country for longer-term projects to expand their facilities, improve existing services, expanding access to an additional 860,000 patients. The second set of awards will provide approximately \$99.3 million to 227 existing health centers to address pressing facility and equipment needs.
- June 2012: HHS announced funding for 219 community health centers in 41 states, the District of Columbia, Puerto Rico and the Northern Mariana Islands. A total of \$128.6 million was awarded as part of the Affordable Care Act and is expected to extend services to 1.25 million additional patients. Eligible applicants included public or nonprofit private entities, including tribal, faith-based and community-based organizations who meet health center funding requirements. For more information and a list of awardees, please visit the HRSA website [here](#).
- September 2012: HHS announced \$44.4 million dollars of funding for 810 community health centers to help them become patient centered medical homes and increase the rates of cervical cancer screening. For more information on the health centers that were funded, click [here](#).

School-Based Health Clinics

Authorizes \$50 million over four years to establish a new grant program to support school-based health clinics that provide health services to children and adolescents.

IMPLEMENTATION OF THE PROVISION

- October 2010: HRSA issued a funding announcement for rural

public and rural nonprofit entities to apply for funding for school-based health clinics to provide more effective, efficient and quality health care. Funding applications were due in Dec. 2010.

- July 2011: HHS announced that \$95 million in grants will be awarded to 278 school-based health centers throughout the country to improve facilities and care to an additional 440,000 children. The awards are targeted for capital improvements to establish new sites or for the centers to upgrade their current facilities.
- December 2011: HHS announced that \$14 million in grants will be awarded to 45 school-based health centers. This funding will enable the centers to expand their capacity and modernize their facilities, which will allow them to treat an estimated additional 53,000 children in 29 States.
- May 2012: HHS announced the availability of funding for the construction and renovation of school-based health centers. These new investments, totaling up to \$75 million, are part of the School-Based Health Center Capital Program, which was created by the Affordable Care Act. For more information, click [here](#).

Workforce

Increasing Primary Care and Public Health Workforce

Includes numerous provisions intended to increase the primary care and public health workforce by including amended and expanded health workforce programs authorized under Title VII (health professions) and Title VIII (nursing) of the *Public Health Service Act* (PHSA). A variety of incentives are included to support education and training of pediatric specialists, oral health providers and nurses. The bill also authorizes the secretary to conduct programs for public health workforce development by providing grants or contracts to schools, state and local health agencies, and others to operate public health training and retraining programs.

IMPLEMENTATION OF THE PROVISION

- August 2010: HHS awarded \$159 million to support workforce training. The grants focused on three types of programs: nursing workforce development, interdisciplinary geriatric education and training programs and Centers of Excellence programs for underrepresented minority students. For more information, click [here](#).
- November 2010: HHS announced \$290 million in new funding for the National Health Service Corps loan repayment program.
- August 2012: HHS [announced](#) about \$19 million in funding to support the Teaching Health Center Graduate Medical Education (THCGME) Program. This program provides payments to qualified teaching health centers to support the expansion of primary care medical and dental residency training in community-based ambulatory settings. For more information,

Promoting Community Health Workers

Requires the CDC director to award grants that promote the use of community health workers. Funds would be used to educate, guide, and provide outreach, including enrollment in federal and state health programs; to identify and refer underserved populations to community-based programs; and to provide home visitation services. No funds have been allocated to date.

Training in Cultural Competency and Working with Individuals with Disabilities

Requires the secretary to support the development and evaluation of research, demonstration projects, and model curricula for use in health professions schools and continuing education programs for providing training in cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities.

IMPLEMENTATION OF THE PROVISION

- February 2012: HHS announced \$40 million to improve information resources, clinical education, curricula and cultural competence as they relate to minority health issues. The grantees also focus on facilitating faculty and student research on health issues particularly affecting underrepresented minority groups. The ultimate goal of the program is to strengthen the national capacity to produce quality health care workforce whose racial and ethnic diversity is representative of the U.S. population. Applications for funding were due Apr. 2, 2012.

Other Key MCH Investments

EMSC Program

Reauthorizes the Wakefield Emergency Medical Services for Children program at \$25 million for FY 2010 going up to \$30.8 million for FY 2014.

IMPLEMENTATION OF THE PROVISION

- March 2012: HHS announced \$1.5 million in funding for a cooperative agreement to provide support for a resource center to provide integrated support to the HRSA Emergency Medical Services for Children (EMSC) program grantees through dissemination and knowledge transfer. Applications were due Apr. 30, 2012.
- March 2012: HHS announced \$2.8 million in funding for the support of clinical investigators to serve the data functions for the EMSC program, which includes serving as the National EMSC Data Analysis Resource Center (NEDARC) and the Pediatric Emergency Care Applied Research Network (PECARN) Data Coordinating Center (DCC).
- June 2012: HHS Announced funding for the EMSC State

Partnership Program. The program will award approximately \$7.4 million to state governments and accredited schools of medicine in states for the expansion and improvement of emergency medical services for children who need treatment for trauma or critical care. For more information, click [here](#).

Family-to-Family Health Information Centers

Would extend Family-to-Family Health Information Centers through FY 2012 at the current funding level.

IMPLEMENTATION OF THE PROVISION

- October 2010: HHS announced \$3.9 million for Family-to-Family Health Information Centers. The funding will continue support for Family-to-Family Health Information Centers located in 40 states and the District of Columbia. Centers in the remaining 10 states (Alabama, Alaska, Arkansas, Idaho, Iowa, Kentucky, Ohio, South Carolina, West Virginia and Wyoming) were funded during FY 2009. Because they are in their second year of three-year funding, they are not eligible for this funding opportunity.
- May 2011: HHS announced \$4.9 million in new and continuing grants to support the Family-to-Family Health Information Centers. Specifically, this funding supported 51 centers, of which six are newly supported by HRSA (Delaware, the District of Columbia, Connecticut, Florida, Indiana and Oregon).
- January 2013: Congress extended funding for F2Fs through FY2013 at the previous level of \$5 million.

Pregnancy Assistance Fund

Authorizes and appropriates \$25 million annually for 10 years (FY 2010-FY 2019) for a new pregnancy assistance fund, which requires the HHS Secretary (in collaboration with the Secretary of Education) to establish a competitive grant program to states to help pregnant and parenting teens and women. Grants are available to institutions of higher education, high schools and community service centers, a state's attorney general, and/or to increase public awareness and education. Institutions that receive grant funds would be required to identify public and private providers, establish programs with providers to meet the specified needs (housing, childcare, parenting education, post-partum counseling) of pregnant or parenting students, assist eligible persons in locating and obtaining appropriate services, and make necessary referrals for prenatal care and delivery, infant or foster care, or adoption.

IMPLEMENTATION OF THE PROVISION

- September 2010: HHS awarded \$24 million to 17 states and tribes.

Medicaid Grants for Chronic Disease Prevention

Authorizes grants to states to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. The initiatives or programs are to be comprehensive, evidence-based, widely available, and easily accessible. The programs must use relevant evidence-based research and resources, including: the Guide to Community Preventive Services; the Guide to Clinical Preventive Services; and the National Registry of Evidence-Based Programs.

care entities that enter into contracts with Medicaid. Included in the core set are the following measures related to maternal and child health: appropriate use of antenatal steroids, elective delivery, medical assistance with smoking and tobacco use cessation and prenatal and postpartum care rate. As required in statute, by Jan. 1, 2013, CMS will issue guidance for submitting the initial core set to CMS in a standardized format. States choosing to collect the initial core set of measures will use that reporting template to submit data to CMS. Voluntary reporting will not begin until December 2013.

IMPLEMENTATION OF THE PROVISION

- February 2011: CMS announced a funding opportunity for this grant program. A grant solicitation directs that applicants must demonstrate they are addressing at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving the management of the condition. The Office of the Governor or the state Medicaid agency may apply for funding under this grant opportunity. State notices of intent are due to CMS by Apr. 4, 2011. Complete grant applications are due to CMS by May 2, 2011.
- September 2011: HHS awarded funding to Wisconsin, Minnesota, New York, Nevada, New Hampshire, Montana, Hawaii, Texas, California and Connecticut.

Quality

National Quality Strategy

Requires the Department of Health and Human Services to develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes and population health. ACA also creates a process to the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. The national strategy is due to Congress by January 2011. The development of these measures will lead to quality improvement of maternity care.

IMPLEMENTATION OF THE PROVISION

- March 2011: AMCHP submitted [comments](#) on the initial core set of health quality measures for Medicaid-eligible adults. These comments included a strong endorsement of the maternity quality measures which are part of the core set including appropriate use of antenatal steroids, elective delivery prior to 39 completed weeks gestation, medical assistance with smoking and tobacco use cessation and prenatal and postpartum care.
- January 2012: CMS released the initial core set of health care quality measures for Medicaid-eligible adults, for voluntary use by Medicaid programs, health insurance issuers and managed



Access this document electronically!

This QR code to the right will allow your smart phone or tablet to access the website where this document is posted electronically. To use the code using your device:

- 1) Either download a bar code reader for your device or access the bar code reader on your device.
- 2) Open the bar code reader application.
- 3) Aim your device's camera at the QR code.
- 4) The bar code reader will scan and process the code and then produce the link to the AMCHP website.
- 5) Follow the instructions from the application to either email the link to yourself or open it directly on your device.
 - If your device is having trouble reading the code, adjust the angle and distance of your device from the code.
- 6) Enjoy the document!



Contact

For additional information, please contact Brent Ewig, Director of Policy, at bewig@amchp.org or Carolyn McCoy, Senior Policy Manager for the National Center for Health Reform Implementation at cmccoy@amchp.org.



Association of Maternal & Child Health Programs

2030 M Street, NW, Suite 350
Washington, DC 20036

MAIN 202 775 0436

FAX 202 775 0061

WWW.AMCHP.ORG