January 20, 2012

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 would be 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: the Health Resources and Services Administration (HRSA) issued a funding announcement indicating that approximately $90 million in formula grants would be made available to states to provide for evidence-based home visiting programs. The first step to receive funding via the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program was submission of an application for funding; state applications were due July 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 state's 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 also requested public comments on the criteria for evidence of effectiveness of home visiting models. To view AMCHP's comments go to: http://tiny.cc/qblko.
- The second step to receive federal funding was submission of the required statewide needs assessment. These documents were due to HHS by September 2010. 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 Block Grant allotments.
- The last step for a state electing to apply for a home visiting grant was submission of an Updated State Plan. On February 8, 2011, HHS released the third supplemental information request (SIR) for the submission of the updated state plan for a state home visiting program. The SIR provided instructions for completing the last step necessary for the release of home visiting grant funds. Submissions are expected within 90 to 120 days of issuance.

- On March 9, 2011 HRSA and ACF announced the establishment of the Advisory Committee on the Maternal, Infant and Early Childhood Home Visiting Program Evaluation.
- A separate Funding Opportunity Announcement for funding available to Indian Tribes, consortia of Indian Tribes, Tribal Organizations, and Urban Indian Organizations was released on June 24, 2010, and the award of 13 grants, totaling $3 million, under this program was announced on September 29, 2010. A list of FY 2010 Tribal Maternal, Infant, and Early Childhood Home Visiting grantees, along with grantee abstracts, is available at http://www.acf.hhs.gov/programs/ccb/initiatives/hvgp/hvgp_grantees.htm.
- June 2011: HHS announced the availability of $224 million to eligible states and jurisdictions under the MIECHV program for fiscal year 2011. Up to $99 million will support competitive grants and $125 million will be available on a formula basis. Specifically the competitive grants will be awarded in the form of “expansion grants” for states and jurisdictions that have already made significant programs 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 to enhance the development of their home visiting efforts. Specifically:
    - Approximately $66 million was awarded to nine states and jurisdictions that have already made progress towards 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.

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 assure that an adequate portion of resources in the Prevention and Public Health Fund address MCH issues and needs. Funding levels: FY 2010 - $500 million; FY 2011 - $750 million; FY 2012 - $1 billion; FY 2013 - $1.25 billion; FY 2014 - $1.5 billion; FY 2015 and each fiscal year thereafter - $2 billion.

IMPLEMENTATION OF THE PROVISION

- June 2010: HHS announced allocations of $500 million for FY2010, 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
    - 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 FY2010 funding
- February 2011: HHS announced allocations of $750 million for FY2011, 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

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.

IMPLEMENTATION OF THE PROVISION

- President Obama signed an executive order establishing the Council in June 2010.
- 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 go to: http://alturl.com/xzp8a.
- 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, go to: healthcare.gov/center/councils/nphpphc/strategy/report.html
- July 2011: The Council released a 2011 Annual Status Report.

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 lifespan. This provision directs the Secretary of the U.S. Department of Health and Human Services (HHS) 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 CHIPRA.

IMPLEMENTATION OF THE PROVISION

- A funding announcement 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: http://alturl.com/2va7r. Applications are due by April 8.
- 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 will target 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 Healthcare Prevention and Education

This provision establishes a five-year national public health education campaign focused on oral healthcare prevention and education. Establishes demonstration grants to show the effectiveness of research-based dental caries disease management. 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 governmental 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. 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." Applications were due July 2011.
- 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 Community Transformation Grants (CTG) program and to ensure the CTG is a national program. Networks of community-based organizations with activities in at least 85-percent of U.S. states and territories are 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 are also eligible to apply for funding. The funding application deadline was July 22, 2011.
- 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:
    - Implementation – 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.

Personal Responsibility Education Program (PREP)

Provides $75 million per year through FY 2014 for Personal Responsibility Education grants to States for programs 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 under-represented 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 TPP 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 under-represented youth populations.

Restoration of Funding For Abstinence Education

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

IMPLEMENTATION OF THE PROVISION

September 2010: HHS awarded $33.4 million to 29 states and Puerto Rico 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 1 year after the child's birth and provide a place, other than a bathroom, that is shielded from view and free from intrusion 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" law which was included as part of the Affordable Care Act (ACA). The Department is specifically interested in hearing from the community about what

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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's submitted joint comments. To view, go to: http://alturl.com/pqzto

Support, Education and Research for Postpartum Depression

This provision amends Title V to provide $3 million for new grants to states in 2010 to provide services to individuals with, or at risk, of postpartum depression and their families. Activities would 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 January 1, 2014. 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. Comments about this regulation are due to HHS by October 31, 2011.

CHIP

Upon enactment, States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2014 to 2019, States would receive a 23 percentage point 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.

State Health Insurance Exchange

The bill sets up a state health insurance exchange to offer basic health programs. States would have option to offer a community health insurance plan, similar to 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. Individuals would be required to maintain minimum essential coverage or face a penalty and there would be automatic enrollment for employees of large an employer requirement to inform employees of coverage options and employers would face a penalty if they do not offer coverage.

IMPLEMENTATION OF THE PROVISION

- September 2010: HHS announced $49 million grants for states to help set up exchanges. These grants of up to $1 million each will 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 at: http://alturl.com/5nkg5.
- 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. To view the proposed regulation, go to: http://tiny.cc/2tzaw Comments are due May 2011.
- 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.

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). 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

- 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 September 23, 2010
- HHS issued regulations requiring new health plans beginning on or after September 23, 2010, to provide at a 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.
- Prohibits the use of lifetime limits in all health plans and insurance policies issued or renewed on or after September 23, 2010.
- The rules will phase out the use of annual dollar limits over the next three years until 2014 when the affordable care act bans them for most plans. Plans issued or renewed beginning September 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 September 23, 2011, and to $2 million beginning on September 23, 2012. These limits apply to all employer plans and all new individual market plans. For plans issued or renewed beginning January 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 pre-existing 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 pre-existing medical condition). These protections will apply to all types of insurance except for individual policies that are "grandfathered," and will be extended to Americans of all ages starting in 2014.
- August 2011: HHS issued guidelines requiring new health insurance plans beginning on or after August 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 go to: http://tinyurl.com/3b83z7h to view the recommendations.

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 (DOL) 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 the HHS better understand the scopes of benefits provided under employer sponsored insurance.

- June 2011: The Centers for Medicare & Medicaid Services (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 Institute of Medicine released a report entitled "Essential Health Benefits: Balancing Coverage and Cost," which provides a process to help the Department of Health and Human Services (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 at: http://cciio.cms.gov/resources/regulations/index.html#hie

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, obstetricians) or team (includes physicians and other professionals such as nurse care coordinator, social worker, behavioral health) 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 HIT as appropriate.

IMPLEMENTATION OF THE PROVISION

- November 2010: the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Directors Letter (http://www.cms.gov/smdl/downloads/SMD10024.pdf) providing guidance on how states may take advantage of the new Medicaid Health Home option.

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 will be 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 $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. All proposals should include the following elements: workforce development and deployment, speed to implementation and model sustainability. All proposals are expected to define a clear pathway to sustainability, and should consider scalability and diffusion of the proposed model. Awards will range from approximately $1 million to $30 million for a three-year period.

- January 2012: HHS announced 73 individuals will serve as Innovation Advisors. These Advisors will be expected to support the Innovation Center 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

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.

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, made available by the Affordable Care Act, are expected to help establish new health service delivery sites to care for an additional 286,000 patients.

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 non profit entities to apply for funding for school based health clinics to provide more effective, efficient, and quality health care. Funding applications were due December 2010.
- July 2011: The Department of Health and Human Services 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 additional 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.

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 re-training programs.

IMPLEMENTATION OF THE PROVISION

November 2010: HHS announced $290 million in new funding for the National Health Service Corps loan repayment program.

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 regarding enrollment in federal and state health programs; to identify and refer underserved populations to community-based programs; and to provide home visitation services.

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.

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.

Family to Family Health Information Centers

Would extend Family-to-Family Health Information Centers through FY 2012 at 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 HRSA-supported (Delaware, the District of Columbia, Connecticut, Florida, Indiana, and Oregon).

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.

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 April 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. To read the full comments go to: http://tiny.cc/32dye.
- 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 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.

Contact

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