

## Chapter One

### Overview of Title V and Title XIX

*To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000, there are authorized to be appropriated \$850,000,000 for fiscal year 2001 and each fiscal year thereafter.*

-- Introduction to §501 of the Social Security Act

One of Medicaid’s critical roles is to provide financial coverage for important preventive and primary care services and specialty services for those eligible; Title V is essential to help translate those funds into a system of care that is accessible. This chapter outlines the respective roles of the Title V MCH Block Grant and the Medicaid programs and the ways through which partnerships can be forged between them. Print and electronic resources that can aid in strengthening such partnerships are provided in *Appendix A* and are available online at <http://www.mchlibrary.info/IAA>.

#### A. The Title V MCH Block Grant Program

Beginning with its enactment in 1935 as part of the Social Security Act (§§501-510), the goal of Title V echoes that of the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) [then the Children’s Bureau], “to serve all children, to try to work out standards of care and protection which shall give to every child [a] fair chance in the world” (Julia Lathrop, first Chief of the Children’s Bureau, 1912).

This legislation allows for specific MCH programs to provide a base to build upon, with the goal of improving the health of *all* women, children, youth, and families; indeed, Title V remains the only Federal program with this broad of a mandate.

During its seventy years of implementation Title V has undergone many refinements such as conversion into a block grant program as well as increased flexibility and accountability. (Specific legislative changes affecting both Title V and Title XIX will be discussed in *Chapter Two*).

***Title V remains the only Federal program that focuses solely on improving the health of all mothers and children.***

As a result of these changes, Title V has cemented itself as a foundation to identify and address emerging health services needs and to measure performance of such efforts. States have a large degree of flexibility in determining priorities and allocating Federal funds in order to address the needs of their populations more appropriately. This flexibility has allowed States to develop effective and cost-efficient approaches in services provided; they can address local needs through tailored programs and policies and then evaluate and replicate such new program models.

On a national level the Title V MCH Services Block Grant is charged with:

- Promoting coordination of activities authorized under Title V and Title XIX, especially Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (under Title XIX) as well as other related activities funded by the Departments of Agriculture, Education, and HHS.
- Disseminating preventive health care information to the States.
- Collecting, maintaining, and disseminating information on the health status and health service needs of mothers and children (in conjunction with the National Center for Health Statistics).
- Providing technical assistance to Congress; assisting States in developing care coordination services; distributing a national directory listing State toll-free numbers of programs and providers who offer services under Title V and Title XIX.

## **Funding**

As a permanently authorized discretionary Federal grant program, Title V is currently authorized at \$850 million. The actual funding has fluctuated since 1992; see *Appendix D* for a summary of recent Title V Block Grant appropriations. It requires that every \$4 of Federal Title V money be matched by at least \$3 of State or local funds. The program also requires that a minimum of 30 percent of Title V funds to states be used to support services for children with special health care needs (CSHCN) and that a minimum of 30 percent be used to provide preventive and primary care services for children. States may spend no more than 10 percent of Title V funds on administrative costs.

Title V is administered by the Maternal and Child Health Bureau. The Title V MCH Services Block Grant consists of **two major funding categories**: (1) the formula grants to the States and (2) competitive, discretionary grants for (a) demonstration, research, and training projects (Special Projects of Regional and National Significance or SPRANS grants) and (b) grants focused on development and expansion of integrated services at the community level (Community Integrated Service Systems or CISS grants).

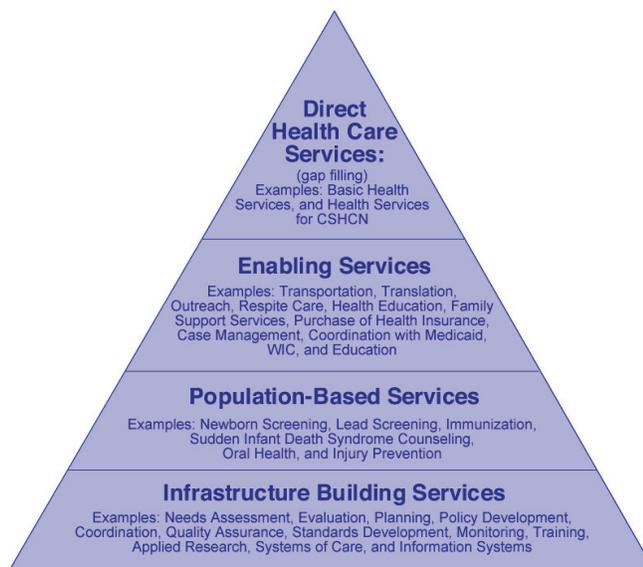
**Funding Category 1: Title V MCH Block/Formula Grants to the 59 States and jurisdictions** are awarded according to a formula based on (1) the historical share awarded to each State in 1981 and (2) the remaining amount is distributed based on the number of children in a State who are at or below the Federal Poverty Level (FPL) in relation to national figures. These grants focus on the creation of Federal/State partnerships to provide service systems to meet challenges facing MCH, including:

- Reducing infant mortality and the incidence of disabling conditions among children.
- Increasing the number of children appropriately immunized against disease.
- Increasing the percentage of low-income children who receive health assessments and follow-up diagnostic and treatment (i.e., EPSDT) services.
- Coordinating activities of the Title V programs with those of Medicaid (specifically EPSDT), WIC, and other health and developmental disability programs.
- Providing and ensuring access to:
  - Comprehensive perinatal health care for women.
  - Preventive and primary child and adolescent health care services (including nutritional and developmental services).
  - Comprehensive health care, including long-term care services, for CSHCN.
  - Access to rehabilitation services for children under 16 years of age who are blind and disabled and receive benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX.
- Facilitating the development of family-centered, community-based, and culturally competent comprehensive care for CSHCN and their families.
- Putting into community practice national preventive health standards and guidelines (e.g., *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.*)
- Providing information to parents about health care practitioners who provide services under Title V and Title XIX.

Data from annual Block Grant applications and reports submitted by all States, territories, and the District of Columbia are collected and available through the Title V Information System (available at <https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp>). This Web site allows for searching on key measures and indicators of maternal and child health, both nationally and by State.

Services provided to mothers and children by the Title V MCH Block Grants are represented in the *MCH Pyramid of Health Services* (see *Appendix D* for a detailed view of the pyramid).

This pyramid consists of four levels of service and funding that build upon each other and provide comprehensive coverage. Once a State determines its MCH priorities, it allocates resources to activities that specifically address those priorities. The collective effort of all States, in all levels of the pyramid, contributes to the national health of mothers and children.



The MCH Pyramid of Health Services

**Funding Category 2: Federally administered discretionary grants** are awarded on a competitive basis to a variety of applicants and extend the Federal partnership for mothers and children to include such groups as health professionals, health organizations, communities, institutions of higher learning, and others. These grants consist of:

- ***Special Projects of Regional and National Significance (SPRANS)*** that include MCH research; training grants; genetic disease testing, counseling, and information dissemination; hemophilia diagnostic and treatment centers; and other special MCH improvement projects that support a broad range of innovative strategies.
- ***Community Integrated Service Systems (CISS) discretionary grants*** that seek to reduce infant mortality and improve the health of mothers and children – including those living in rural areas and those with special health care needs – by funding projects for the development and expansion of integrated services at the community level. These systems are public/private partnerships of health-related and other relevant community organizations and individuals working collaboratively to use local resources to address community-identified health problems. Such projects include home health visiting programs; projects to increase participation of health care providers under Title V and Title XIX programs; integrated MCH service delivery systems; MCH centers providing pregnancy, preventive, and primary care services; MCH projects to serve rural populations; and outpatient and community-based services programs for CSHCN.

## Division of Funding

The varied funding streams of the Title V Block Grant work in concert to fulfill the charge of improving the health of all women and children. The formula that binds these grants together, last amended by the Omnibus Budget Reconciliation Act (OBRA-1989), sets forth that of the funds authorized for Title V:

- CISS grants account for 12.75 percent of appropriated funds *in excess* of \$600 million.
- SPRANS grants account for approximately 15 percent of appropriated funds up to \$600 million as well as 15 percent of the amount that remains above the \$600 million after CISS funds are set-aside.
- The formula grants to the States account for approximately 85 percent of appropriated funds up to \$600 million as well as 85 percent of the amount that remains above the \$600 million after CISS funds are set-aside.

## Services

Through these funding mechanisms, Title V programs serve as the foundation for identifying and addressing emerging health service needs, gaps in service delivery, and successful programs and resources within the MCH community. Title V funding allows for the creation and maintenance of a cost-effective infrastructure upon which to build successful public and private health services. In addition, Title V programs support population-based services such as newborn screening, lead poisoning prevention, injury and violence prevention, and sudden infant death syndrome (SIDS) awareness activities. Title V programs assist families in using resources

available to them by working with Medicaid and the State Children’s Health Insurance Program (SCHIP) to inform and enroll these groups in available programs. Title V programs also fund preventive and primary care services, promote home visiting and school-based health programs, and help in coordinating services.

***Title V supported programs provide prenatal health services to more than 2 million women, and primary and preventive health care to more than 17 million children, including almost 1 million CSHCN.***

Title V historically has had more flexibility in its use of funds than individual entitlement programs (in which spending is determined through eligibility criteria, not by a specific level of funding). This has permitted Title V programs to improve the infrastructure of the health care system, while Medicaid funds medical assistance for some of the populations that MCH programs serve. Currently, the Title V MCH Block Grant funds programs that serve over 33 million individuals.

## B. The Medicaid Program

Medicaid, authorized by Title XIX of the SSA in 1965 as a joint Federal/State entitlement program, pays for medical assistance to both “categorically” and “medically” eligible groups with limited resources (see next page for a description of these eligibility groups). It provides health and mental health care coverage for children and families with low incomes, long-term health care services for seniors and people with disabilities, and provides gap funding for seniors who qualify for both Medicare and Medicaid.

Programmatically operating under broad Federal standards, States are given flexibility to determine eligibility requirements, set service standards, set payment rates, and administer their State programs.

***Medicaid is the largest source of funding for health care services for America’s poorest and most vulnerable people.***

More than 52 million people received Medicaid-supported services in 2004, including 26 percent of all children, 50 percent of low-income children, 37 percent of pregnant women, and 20 percent of persons with disabilities; State and Federal Medicaid funds for such services topped \$305 billion in that year. In light of these numbers, Medicaid is the largest funding source for health services for the country’s most financially strained populations.

In recent years, the Medicaid program has faced significant fiscal challenges. The Deficit Reduction Act of 2005 (DRA) was signed by the President on February 8, 2006 to address program spending. Over the course of the next 5 years the DRA calls for net reductions of \$4.8 billion; over the next 10 years, \$26.1 billion. The DRA gives States flexibility to reconfigure benefits and cost sharing for certain populations; some early analysis predicts that changes contained in the DRA may shift costs to Medicaid beneficiaries and could limit specific coverage and services. Reductions planned for in the DRA would be offset by certain areas of increased spending and coverage including the Family Opportunity Act and relief related to Hurricane Katrina.

Based on National Health Care Expenditure Data from CMS, Office of the Actuary, Medicaid finances approximately 17 percent of all personal health care spending in the country, including 37 percent of all births, 17 percent of all hospital care, 12 percent of health professional services, 17 percent of prescription drug costs, and 48 percent of nursing care costs. (See *Appendix D* for a breakdown of Medicaid spending).

## ■ Eligibility

While States have substantial control over Medicaid eligibility for their constituents, there are set Federally-determined *mandatory* Medicaid “categorically needy” eligibility groups targeted for matching funds, including:

- Persons who meet requirements for Temporary Assistance for Needy Families (TANF).
- Children under 19 and whose family income is at or below 100 percent of the FPL.
- Children under 6 years and pregnant women whose family income is at or below 133 percent of the FPL. (Only services related to pregnancy, complications of pregnancy, delivery, and postpartum care are covered for eligible women).
- Supplemental Security Income (SSI) recipients (or in States that rely on more restrictive Medicaid eligibility requirements that pre-date SSI, this group includes the aged, blind, and disabled who meet criteria that were in place in the State’s approved Medicaid plan as of January 1, 1972).
- Recipients of Title IV adoption or foster care assistance.
- Special protected groups (e.g., people who lose cash assistance because of work earnings or increased Social Security benefits) and certain Medicare beneficiaries.

Other “categorically related” or “optional” groups may also be covered (at the determination of the State). These groups include:

- Pregnant women and infants 0-1 years whose family income is less than 185 percent (or an amount determined by the State) of the FPL.
- Children under 21 who meet TANF requirements and are recipients of SSI payments.
- Low-income institutionalized persons.
- Low-income women who are screened for breast or cervical cancer.
- “Optionally targeted low-income children” (covered under SCHIP) and low-income people infected with tuberculosis.
- “Medically needy” persons.
- Aged, blind, or disabled adults whose income is at or below the FPL.

Medicaid is a prime source of funding for children and members of low-income working families. Nearly 65 percent of Medicaid beneficiaries are in working families. While historically States have had the ability to impose nominal deductibles, co-insurance, or co-payments on certain Medicaid services and beneficiaries, the DRA of 2005 allows States to charge premiums and co-payments of up to 20 percent of the medical service’s cost for certain groups with a family income above 150 percent of the FPL. Cost sharing for individuals with a family income below 100 percent of the FPL remains nominal. Co-payments of up to 10 percent of the cost of the services can be charged for beneficiaries (including children) with incomes between 100-150 percent of the FPL. Regardless of the family income, cost sharing and premiums for all Medicaid beneficiaries can not exceed 5 percent of the family income.

Medicaid is administered as a partnership between the States and the Centers for Medicare and Medicaid Services (CMS), which also has authority over the State Children’s Health Insurance Program (SCHIP), Medicare, and health insurance portability standards. SCHIP allows States to expand Medicaid, create their own separate State insurance programs, or a combination of both. SCHIP also provides Federal funds for States to expand eligibility to cover: (1) mainly low-income children who do not qualify for Medicaid and (2) beneficiaries during the Medicaid presumptive eligibility period.

## Services

Title XIX allows States to receive matching Federal funds for providing certain mandatory and optional services to most categorically needy populations. State Medicaid programs generally cover hospital services (inpatient and outpatient); services provided by physicians, midwives, and certified nurse practitioners; laboratory services and x-rays; nursing home and home health care services for persons aged 21 and above; EPSDT services for persons under age 21; family planning services and supplies; and rural health clinic and Federally qualified health center services. Optional services often include prescription drugs, prosthetic devices, hearing aids, and dental care.

The DRA of 2005 gives States the ability to provide “benchmark” coverage. This would include the Federal Employee Health Benefits Plan’s Blue Cross Blue Shield benefits, State employees’ health coverage, or the largest State HMO’s coverage. The DRA of 2005 also includes coverage determined by CMS to be “appropriate” for the State’s unique populations. However, States are still required to provide EPSDT benefits.

In addition to choosing which optional services are covered under Medicaid, under broad Federal guidelines States have the authority to set the duration of such services. The duration of Medicaid services must be of sufficient length to accomplish the goals of the benefits and must not discriminate among those covered based on diagnosis or medical condition. As Medicaid’s comprehensive and preventive child health program for individuals under the age of 21, EPSDT preventive care services must be provided by the States during beneficiaries’ well-child visits to identify physical (including vision, hearing, and dental) and mental conditions. States also must provide other necessary health care, diagnosis services, treatment, and other measures to correct or ameliorate defects as well as physical and mental illnesses and conditions discovered by the screening services. States must facilitate access to rural health clinic and federally-qualified health center (FQHC) services.

Medicaid is an entitlement program; it provides health insurance based on the program’s eligibility criteria, not by a capped level of funding. Medicaid services are handled as a *vendor payment program*, with States paying providers on a fee-for-service basis or through prepayment services. Payments to providers must be at a set rate and must be considered payment in full. Deductibles or co-payments may be charged on some Medicaid services and benefits; additional payments may be made to hospitals that serve large numbers of Medicaid patients.

A percentage of these payments, called the Federal Medical Assistance Percentage (FMAP), is covered by Federal funds based on a formula comparing each State’s average per capita income with the national average. This amount varies from 50 percent to 83 percent and is determined annually; in FY 2003 the average was 56.6 percent nationally. States with a higher per capita income are reimbursed at a smaller percentage of their costs.

Medicaid expenditures are increasing at a rapid rate due in part to rising medical and long-term care services, increases in Medicaid populations, and increasingly more numerous and expensive prescription drugs. At the current rate of expansion, Medicaid expenditures are expected to top \$425 billion by FY 2008. States are looking for ways to reduce Medicaid spending such as limiting prescription spending, reducing provider payments and recipient benefits, and limiting eligibility.

## C. Comparing the Title V Program and Medicaid: At a Glance

Title V was authorized in 1935; Medicaid in 1965. Both programs are complex in their own right and during the span of their existence have become even more so. Many of the details that make each program unique have been discussed in the preceding sections, yet blur amidst complex regulations and ever-changing policy.

See <https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp> for a history and current legislation on the Title V MCH Block Grant or <http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp> for a summary of the Medicaid program. For MCH data sources, see <http://mchb.hrsa.gov/data>. Additional resources are also available in *Appendix A* and at <http://www.mchlibrary.info/IAA>.

Highlights of the Title V and Medicaid programs are presented in the following chart to aid in obtaining a clearer view of each program’s mandates, requirements, foci, and strengths.

Title V and Medicaid, Compared		
	Title V	Medicaid
<b>Authorized By</b>	Sections 501-510, SSA, in 1935	Sections 1901-1936, SSA, in 1965
<b>Administered By</b>	U.S. Department of Health and Human Services (HHS), Health Resources Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).	U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations (CMSO).
<b>Overarching Goal</b>	To improve the health of <i>all</i> women, children, youth, and families.	To pay for medical assistance to both “categorically” and “medically” eligible children and families with low incomes.
<b>Funding Mechanism</b>	Discretionary Federal “block” grant.	Joint Federal/State entitlement program.
<b>Funding and/or Beneficiary Requirements</b>	<p><b>Funding Requirements:</b></p> <ul style="list-style-type: none"> <li>• Every \$4 of Federal funds must be matched by at least \$3 of State/ local funds.</li> <li>• At least 30% of funds must support CSHCN.</li> <li>• At least 30% of funds must support preventive and primary care services for children.</li> <li>• No more than 10% of funds can be used for administration.</li> </ul>	<p><b>FMAP Requirements:</b></p> <ul style="list-style-type: none"> <li>• Federal funds (the “Federal Medicaid matching rate”) are provided for services/administration dependant on State per capita income (from 50-83% with average of 57%).</li> </ul> <p><b>Eligibility groups include:</b></p> <ul style="list-style-type: none"> <li>• “Mandatory” categorically needy persons (pregnant women and infants at or below 133% FPL).</li> <li>• “Optional” categorically needy persons (pregnant women and infants with incomes between 133%-185% FPL).</li> <li>• Medically needy persons (who qualify for coverage because of high medical expenses).</li> </ul>

Title V and Medicaid, Compared (continued)		
	Title V	Medicaid
Introduction	<p><b>People Served and/or Covered</b></p> <p><b>Title V <i>provides services to:</i></b></p> <ul style="list-style-type: none"> <li>• Over 33 million women and children total, consisting of:                             <ul style="list-style-type: none"> <li>• 2.5 million pregnant woman</li> <li>• 3.9 million infants less than 1 year</li> <li>• 22.5 million children 1 to 22 years</li> <li>• 1.4 million CSHCN</li> </ul> </li> <li>• Of the 33 million individuals:                             <ul style="list-style-type: none"> <li>• 1.1 million are Medicaid-eligible pregnant women</li> <li>• 1.4 million are Medicaid-eligible infants under 1 year old</li> <li>• 6.9 million are Medicaid-eligible children 1-22 years old.</li> <li>• 0.5 million are Medicaid-eligible CSHCN.</li> </ul> </li> </ul>	<p><b>Medicaid <i>covers:</i></b></p> <ul style="list-style-type: none"> <li>• 52 million people total (2004 data), consisting of:                             <ul style="list-style-type: none"> <li>• 26% of all children,</li> <li>• 50% of low-income children</li> <li>• 37% of pregnant women</li> <li>• 20% of persons with disabilities</li> </ul> </li> </ul>
Overview		
Legislation	<p><b>Legislative Reform/ Program Services</b></p> <ul style="list-style-type: none"> <li>• Omnibus Budget Reconciliation Act (OBRA-1981):                             <ul style="list-style-type: none"> <li>• Incorporated five other smaller, related programs into Title V.</li> <li>• Granted States increased spending flexibility.</li> <li>• Required each State Title V agency to participate “in the arrangement and carrying out of the coordination agreements ...related to coordination of care and services under this title and Title XIX” [§505(2)(F)(ii)].</li> </ul> </li> <li>• OBRA-1989: provided stricter application, spending, and reporting requirements.</li> <li>• 1998: Title V Information System developed to collect and report data.</li> </ul>	<ul style="list-style-type: none"> <li>• Personal Responsibility and Work Opportunity Reconciliation Act (1996): restricted eligibility for SSI coverage for certain populations.</li> <li>• Balanced Budget Act (BBA) (1997): reinstated eligibility for those children and those included under SCHIP.</li> <li>• Ticket to Work and Work Incentives Improvement Act (1999): provided a sliding scale payment income-based premium.</li> <li>• Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) (2000): allowed for additional payments to hospitals serving large Medicaid populations.</li> <li>• Deficit Reduction Act (DRA) (2005): scheduled to create \$39 billion in Medicaid reductions from 2006-2010 by shifting costs to beneficiaries and limiting certain services for low-income recipients.</li> </ul>
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## D. Coordination Between Title V and Title XIX

The MCH Services Block Grant and Medicaid both play a key role in improving access and health outcomes for children, youth, and families. Coordination and partnerships between the two programs is key in achieving this purpose. “Through the Title V Maternal and Child Health Block Grant to States Program, core public health functions for mothers and children are strengthened, State MCH needs are assessed, and gaps in services are identified so that statewide systems of health care for all mothers and children, regardless of race, ethnicity, or culture, are ensured. The outcomes of these MCH efforts are captured as evidence of progress and to provide accountability to the States and the nation as a whole.” [cited from [https://perfdata.hrsa.gov/mchb/mchreports/LEARN\\_More/Title\\_V\\_Today/title\\_v\\_today.asp](https://perfdata.hrsa.gov/mchb/mchreports/LEARN_More/Title_V_Today/title_v_today.asp)]. Title V programs help to provide a structure and assistance in using that funding to support a system that those persons can use. Medicaid provides health care coverage, including preventive, primary and some specialty services, to those persons who are eligible.

Specific details of the two programs are distinct. The Title V Block Grant administers a set amount of grant funding to the States, which are given great flexibility in deciding innovative ways to meet the program’s mission of improving the health of *all* women and children, including those eligible for Medicaid. Title V is thus a public health program to be used by State Health Agencies to meet State-determined goals and objectives consistent with the National Healthy People 2010 goals. Title V programs assess the needs of their populations and then plan and ensure that adequate policies and programs are in place to address those needs.

Title V programs have great expertise in providing an infrastructure and access to services that Medicaid in turn can build upon. Title V programs have knowledge in developing model programs and materials that can be used by Medicaid; Title V personnel are also skilled in providing outreach and enrollment services to Medicaid beneficiaries thus enabling access on behalf of Title XIX.

Medicaid, on the other hand, often serves as a health insurance program that purchases or provides reimbursement for preventive services and primary care to persons of limited income, with disabilities, or of advanced age who meet specific requirements. As such, Medicaid deals with a specific sub-set of the Title V population. Medicaid often relies on Title V programs to provide access to and delivery of health and mental health services.

Partnerships between Title V and Medicaid have had a long history of providing increased services and preventing duplication of effort. Such coordination is the result of a long and well-planned series of legislative decisions that mandate that the two programs work together (these legislative mandates are examined in the next chapter). By tying the two together through mutual requirements, the potential for a dynamic synergy has been established.

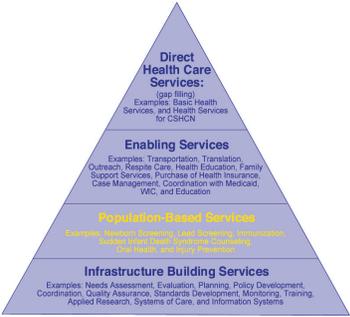
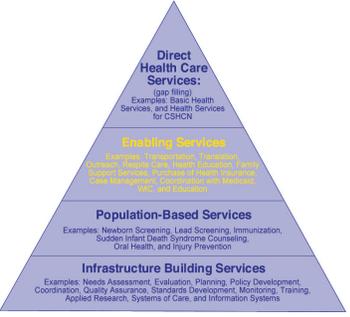
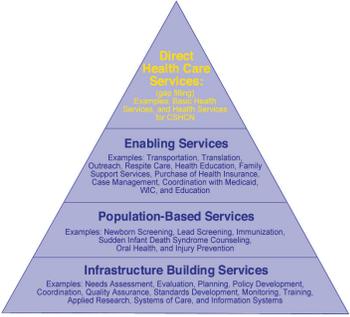
## E. The Importance of Interagency Agreements

Interagency Agreements (IAAs) [required in §509(a)(2) and referenced to in §1902(a)(11)(b)], can serve as a major resource in coordinating activities and providing mutual support between the two agencies (or divisions within an agency in the State department of health) that administer the two programs. As required by Federal mandate the IAAs must (1) utilize Title V agencies (or their grantees) who can furnish care and service to Medicaid beneficiaries, (2) make “appropriate” provisions to reimburse Title V agencies (or their grantees) for covered services provided, and (3) provide for sharing of information and education on pediatric vaccinations and delivery of immunization services.

IAAs are crucial for several reasons. They provide a formal structure delineating the programmatic and administrative responsibilities of each agency. They also provide for continuity in implementing policies over time. Finally, they build in a system of communication and accountability between programs. Bolstered by these IAAs, strong partnerships have been established on the State level that address, and often go beyond, the legislative requirements. Through such partnerships, Title V programs are often not highly visible to the general public because their goal is to collaborate with Medicaid staff to ensure linkage among multiple programs (Title V, Medicaid, and others) to provide a *seamless* system of care for beneficiaries.

While these IAAs and the partnerships they establish vary by State, there are many common strategies in which Title V works with Medicaid to increase access to care. These strategies can be organized in terms of the four-tiered *MCH Pyramid of Health Services* (explained more fully on page 6), beginning from the base up with *Infrastructure Building Services*.

Methods Through Which Title V and Medicaid Coordinate	
<b>Infrastructure Building Services:</b> <i>These include evaluation, policy development, coordination, standards development, training, and information systems.</i>	
	<ul style="list-style-type: none"> <li>• Title V provides funding and experience for development and implementation of model programs that benefit Medicaid beneficiaries.</li> <li>• Title V and Medicaid develop jointly agreed upon policies and standards of care for Medicaid beneficiaries (especially relevant with EPSDT services).</li> <li>• Title V provides expertise to Medicaid in analyzing utilization patterns and recommending ideas for services provided such as more effective treatment services or options for families.</li> <li>• On a State level, Medicaid utilizes Title V population data collected through such systems as the Title V Information System to provide key population and service statistics, performance and outcome measures, and benchmarks.</li> <li>• Medicaid uses materials developed by Title V grantees, either directly or with modifications for Medicaid audiences.</li> <li>• Title V and Medicaid collaborate in planning activities such as designing benefit packages, application forms, enrollment procedures, and referral and follow-up protocols.</li> </ul>

<p><b>Population-based Services:</b> <i>These include screenings, immunizations, oral health, nutrition and outreach, and public education.</i></p>	
	<ul style="list-style-type: none"> <li>Title V programs and Medicaid perform EPSDT services for infants, children, and adolescents, including CSHCN.</li> <li>Title V programs coordinate services such as lead screening and referral to Title V programs for additional evaluation and management, if necessary.</li> <li>Title V programs provide public education to Medicaid beneficiaries on nutrition and oral health issues, stressing the need for such services from an early age.</li> </ul>
<p><b>Enabling Services:</b> <i>These include outreach, health education, family support services, case management, and coordination with Medicaid.</i></p>	
	<ul style="list-style-type: none"> <li>Title V programs provide outreach and enrollment services to eligible beneficiaries, allowing Medicaid funds to pay for those services.</li> <li>Medicaid performs outreach to audiences traditionally supported by Title V programs and vice-versa.</li> <li>Title V agencies administer programs that support Medicaid beneficiaries, not only to ensure enrollment but to track and/or provide follow-up treatment.</li> <li>Medicaid utilizes Title V programs for care coordination and assistance in accessing treatment services (e.g., facilitating transportation).</li> </ul>
<p><b>Direct Health Care Services:</b> <i>These include basic health services and health services for CSHCN.</i></p>	
	<ul style="list-style-type: none"> <li>Title V pays for gap-filling services to Medicaid beneficiaries.</li> <li>Title V provides funds for services needed by uninsured children and pregnant women and for necessary services not covered by Medicaid or other sources.</li> <li>Medicaid coordinates with Title V programs to pay for community specialists who provide appropriate care for CSHCN.</li> </ul>

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While these strategies vary widely, they are powerful examples of how States partner Title V and Medicaid services; all such strategies rely on unique strengths that each program brings to the table. Title V has a broad, inclusive definition of health care that includes prevention and early intervention services; its programs have experience in working with and coordinating broad networks of service providers and public health experts. In addition, Title V has the experience with surveillance of health status and has data systems in place to collect and monitor data. Title V programs also have knowledge of services that insurance plans don't cover as well as what services Medicaid beneficiaries need. Finally, Title V programs already have "best practice" performance guidelines such as the *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* that directly relate to the services required by Medicaid.

One of Medicaid’s greatest strengths is due to its extensive funding. Next to education it is the second largest category of State spending and is the largest source of Federal funding to the States. Nationally, Medicaid covers 1 in every 5 children and as such plays a critical role in insuring the country’s 34 million low income children and parents. At the same time, Medicaid plays a critical role in addressing the needs of over 13 million persons with disabilities and persons over age 65. By operating on both Federal and State funds under the FMAP plan, States have a degree of support during both strong and weak economic times and are encouraged to invest in the Medicaid program while utilizing partnerships such as those with Title V programs.

The partnerships established between Title V programs and Medicaid are much more than lists of services and strengths. Title V programs play a key partnership role in developing services for Medicaid. Such partnerships are essential; Title V and Title XIX programs are much more effective working collaboratively. The interagency agreements provide the bridge to link these powerful programs together.