Chapter Two

Federal Legislation, Regulations, and Policy

These services are "about people -- children and adults who are sick, poor, and vulnerable -- for whom life, in the memorable words of poet Langston Hughes, ain't been no crystal stair.
It is written in the dry and bloodless language of the law... but let there be no forgetting the real people to whom this language gives voice...
Behind every fact found herein is a human face and the reality of being poor in the richest nation on earth."

-- Judge Gladys Kessler, U.S. District Court

Ongoing and successful coordination between Title V and Title XIX is supported by a series of Federal legislation, regulations, and policies. These legal requirements, summarized in the tables below and discussed in detail on pages 20-25, pave the way for the development of successful IAAs and ongoing coordination.

Summary of Requirements for Title V and Title XIX Coordination	
Federal Legislation: the Social Security Act *(http://www.ssa.gov/OP_Home/ssact/)*	
Title XIX	**Requires Medicaid agencies to:** • Enter into IAAs [§1902(a)(11)(B)]. • Use Title V programs to provide services [§1902(a)(11)(B)(i)]. • Reimburse Title V agencies for services [§1902(a)(11)(B)(ii)]. • Coordinate information on immunizations [§1902(a)(11)(B)(iii)].
Title V	**Requires Title V agencies to:** • Enter into IAAs [§505(a)(5)(F)(ii)]. • Coordinate EPSDT services [§505(a)(5)(F)(i)]. • Provide information to beneficiaries about services & providers [§505(a)(5)(E)]. • Identify, help enroll, and provide services to beneficiaries [§505(a)(5)(F)(iv)].
Federal Medicaid Regulations *(http://www.gpoaccess.gov/cfr/index.html)*	
Title 42, Chapter IV, CFR	**Requires Medicaid agencies to:** • Enter into IAAs that outline collaboration with Title V programs. • Use Federal funds to reimburse Title V programs for services.
Federal Policy	
CMS's *State Medicaid Manual*	**Requires Medicaid agencies to:** • Enter into IAAs with Title V, placing special emphasis on payment arrangements. • Coordinate with Title V grantees, especially in regards to EPSDT services. • Reimburse Title V providers. *(http://www.cms.hhs.gov/manuals/pub45/pub_45.asp)*
MCHB's *Title V Guidance*	**Requires Title V agencies to:** • Examine and report on coordination activities with Medicaid as well as numbers of Medicaid-eligible people served and services provided. *(https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp)*

The summary of requirements for Title V and Title XIX coordination can be viewed within the broader overview of Federal legislation, regulations, and policy in the table below.

Overarching Federal Legislation, Regulations, and Policy	
Federal Legislation and Regulations	
Title V	
Title V of the Social Security Act [enacted 1935, amended by Omnibus Budget Reconciliation Acts (OBRAs)] *(http://www.ssa.gov/OP_Home/ssact/)*	
OBRA-1981	• Converted Title V into a block grant program. • Incorporated five other related programs into Title V. • Granted States increased spending flexibility.
OBRA-1989	• Provided stricter application, spending, and reporting requirements. • Stressed the importance of State Title V agencies in meeting requirements set forth in Title XIX of the SSA, with a particular emphasis on coordination, accountability, and reporting requirements. • Required Title V agencies to: ○ Participate in developing and carrying out agreements on coordination of care and services [§1902(a)(11); §505(a)(5)(E)(ii)]. ○ Coordinate activities with the EPSDT program [§505(a)(5)(E)(i)]. ○ Assist in identifying and registering pregnant women and infants who are eligible for medical assistance [§505(a)(5)(F)(iv)]. ○ Provide a toll-free telephone number to help parents obtain information about services under Title V and Title XIX [§505 (a)(5)(E)].
Title XIX	
Title XIX of the Social Security Act [enacted 1965] *(http://www.ssa.gov/OP_Home/ssact/)*	
Amended (1967, 1981)	• Expanded requirements for cooperation with health agencies to include Title V [§1902(b)(11)(B)]. • Required Medicaid agencies to act as the payer of first resort and to: ○ Use Title V-funded agencies to provide services for Medicaid-eligible clients if such services are included in the State plan [§1902(a)(11)(B)(i)]. ○ Reimburse agencies for the cost of services provided to any individual for which payment would otherwise be made to the State [§1902(a)(11)(B)(ii)]. ○ Coordinate information and education on pediatric vaccinations and delivery of immunization services [§1902(a)(11)(B)(iii)].
Title 42, Chapter IV, Code of Federal Regulations *(http://www.gpoaccess.gov/cfr/index.html)*	
§431.615(b)	Title V grantees may receive Federal payments for services including: • Maternal and child health services. • Children with Special Health Care Needs (CSHCN). • Maternal and infant care projects. • Children and youth projects. • Projects for the dental health of children.
§431.615(c)	Each State plan must: • Describe cooperative arrangements with Title V and other programs and grantees to maximize use of services. • Provide arrangements for Title V grantees to deliver services on behalf of the State Medicaid agency. • Ensure that all arrangements meet Federal requirements. • Ensure that the Medicaid agency reimburses the Title V grantee or provider for the cost of service (if requested by the grantee).

§431.615(d)	IAAs must specify, as appropriate: • The mutual objectives and responsibilities of each party to the arrangement. • The services each party offers and in what circumstances. • The cooperative and collaborative relationships at the State level. • The kinds of services to be provided by local agencies. • Methods for beneficiary identification, referrals, reimbursement, etc.
§431.615(e)	• Federal financial participation (FFP) is available for expenditures for Medicaid services provided to beneficiaries under such cooperative arrangements.
Deficit Reduction Act (DRA) of 2005 *(http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf)*	
	• Scheduled to reduce spending by $4.7 billion over the 2006-2010 period for provisions that cover Medicaid, SCHIP, and funding for health care costs in areas affected by Hurricane Katrina.
Federal Policy	
Title V	
MCHB's *Title V Guidance* *(https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp)*	
	• As part of their 5 year needs assessment, requires States to assess how local delivery systems (including regional areas) meet the population's health needs by examining existing systems and collaborative mechanisms with Medicaid and other programs [Part II(II)(B)(4)(d), p. 29]. • Requires States to report in four areas: o Coordination with other State human services agencies, including Medicaid. o Health Systems Capacity Indicators (HSCIs), including Medicaid data. o National and State Performance Measures (NPMs), often documenting a State's partnership and coordination activities with Title XIX agencies and populations. o Program data, including individuals eligible and served by Title XIX.
Title XIX	
CMS's *State Medicaid Manual* *(http://www.cms.hhs.gov/manuals/pub45/pub_45.asp)*	
	• Issues mandatory, advisory, and optional Medicaid policies and procedures to State agencies for use in administering their Medicaid programs. • Serves as guidance to overarching coordination with Title V programs and with Title V grantees, with special emphasis on EPSDT coordination. • Requires that each State have in effect an IAA that: o Provides for care and services available under MCH programs. o Utilizes MCH grantees to develop more effective uses of Medicaid resources. • States that Medicaid agencies are responsible for reimbursing Title V providers for services provided to Medicaid beneficiaries even if these services are provided free of charge to low-income uninsured families. • Stresses the importance of including a detailed description of payment arrangements in the IAA. • Advises: o Limiting reimbursement of overhead costs under IAAs to those identifiable as supporting EPSDT services. o Specifying within the IAA the conditions under which private practitioners may bill through Title V for services provided to Medicaid beneficiaries. o Detailing the conditions under which services are covered (since services are often provided by professionals who are not physicians).

A. Federal Legislation and Regulations

Title V Requirements Related to Coordination with Title XIX

Related to coordination, **Title V of the Social Security Act** requires the Title V agency to:

- Participate "in the arrangement and carrying out of coordination agreements described in section 1902(a)(11) (relating to coordination of care and services available under this title and title XIX)" [§505(a)(5)(F)(ii)].
- Participate "in the coordination of activities between such program and the early and periodic screening, diagnostic, and treatment program under section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services), to ensure that such programs are carried out without duplication of effort" [§505(a)(5)(F)(i)].
- Provide "for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and title XIX and about other relevant health and health-related providers and practitioners" [§505(a)(5)(E)].
- Provide "directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1) and, once identified, to assist them in applying for such assistance. [§505(a)(5)(F)(iv)]. For a complete list of Title V requirements, see *http://www.ssa.gov/OP_Home/ssact/title05/0500.htm*.

Overall, Title V of the SSA stresses the importance of State MCH agencies in meeting similar requirements set forth in Title XIX, with a particular emphasis on coordination, accountability, and reporting requirements. For example, States must report (1) the number of deliveries to pregnant women who received prenatal, delivery, or postpartum care under Title V or were entitled to such services under Medicaid during the year; and (2) the number of infants who received Title V services or were entitled to Medicaid services during the year.

Enhancing the reporting mechanisms for Title V/Title XIX activities and services remains a priority for MCHB. The Title V Information System (TVIS, available at *https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp*), the guidance and reporting system for State Title V agencies, was developed through the support of MCHB. This system has become a valuable instrument in measuring the performance and effectiveness of State Title V activities, including coordination with Medicaid.

Title XIX Requirements Related to Coordination with Title V

Related to coordination, **Title XIX of the Social Security Act** requires the Title XIX agency to:

- Enter "into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) title V" [§1902(a)(11)(B)].
- Provide "for utilizing such agency, institution, or organization in furnishing care and services which are available under such title or allotment and which are included in the State plan approved under this section" [§1902(a)(11)(B)(i)].
- Make "such provision as may be appropriate for reimbursing such agency, institution,

or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1903" [§1902(a)(11)(B)(ii)].

- Provide "for coordination of information and education on pediatric vaccinations and delivery of immunization services provide for coordination of the operations under this title" [§1902(a)(11)(B)(iii)]. For a complete list of Title XIX requirements, see *http://www.ssa.gov/OP_Home/ssact/title19/1900.htm*.

The Code of Federal Regulations (CFR), available online at *http://www.gpoaccess.gov/cfr* addresses cooperative arrangements in Title 42, Chapter IV, focusing on Medicaid regulations. In these regulations, a Title V grantee is described as an "agency, institution, or organization receiving Federal payments for part or all of the cost of any service program or project authorized by Title V" [§431.615(b)]. Covered activities include:

Coordination between [Title V and Title XIX] will enhance their effectiveness by, at a minimum, avoiding duplication of effort and effecting better and more organized outreach, screening, and follow-up efforts. ***(Senate Report No. 97-139)***

- Maternal and child health services.
- Children with Special Health Care Needs (CSHCN).
- Maternal and infant care projects.
- Children and youth projects.
- Projects for the dental health of children.

Under Medicaid regulations, each State plan must:

(1) Describe cooperative arrangements with Title V and other programs and grantees to maximize use of services;
(2) Provide arrangements for Title V grantees to deliver services on behalf of the State Medicaid agency;
(3) Ensure that all arrangements meet Federal requirements (described below); and
(4) Ensure that the Medicaid agency acts as the payer of the first resort and reimburses the Title V grantee or provider for the cost of service (if requested by the grantee) [§431.615(c)].

The Federal regulations further specify that IAAs must specify, as appropriate:

- The mutual objectives and responsibilities of each party to the arrangement.
- The services each party offers and in what circumstances.
- The cooperative and collaborative relationships at the State level.
- The kinds of services to be provided by local agencies.
- Methods for:
  - Early identification of individuals under 21 in need of medical or remedial services.
  - Reciprocal referrals.
  - Coordinating plans for health services provided or arranged for recipients.
  - Payment or reimbursement.
  - Exchange of reports of services furnished to recipients.
  - Periodic review and joint planning for changes in the agreements.
  - Continuous liaison between the parties, including designation of State and local liaison staff.
  - Joint evaluation of policies that affect the cooperative work of the parties [§431.615(d)].

Federal financial participation (FFP) is available for expenditures for Medicaid services provided to beneficiaries under such cooperative arrangements [§431.615(e)].

B. Federal Policy

Title V Requirements

The *2006 Maternal and Child Health Services Title V Block Grant Program: Guidance and Forms for the Title V Application/Annual Report* (the "Title V Guidance"), valid through May 31, 2009, mainly addresses Title V and Title XIX coordination and IAAs through its reporting requirements. As part of the "enabling services" segment of the MCH Pyramid of Health Services, coordination activities with Medicaid must be reported in each State's 5 year needs assessment.

The *Title V Guidance* (available at *http://mchb.hrsa.gov/data)* requires States to assess how local delivery systems (including regional areas) meet the population's health needs by examining existing systems and collaborative mechanisms with Medicaid and other programs as part of their 5 year needs assessment [Part II(II)(B)(4)(d), p. 31].

Related to Medicaid, Title V guidance requires States to report on: (1) coordination with other State human services agencies, including Medicaid, (2) Health Systems Capacity Indicators (HSCIs); (3) State Performance Measures (SPMs); and (4) a range of program data.

(1) Coordination among State human service agencies and providers. States must provide their plans for coordination (1) with the EPSDT program; (2) with other Federal grant programs (e.g., WIC, related education programs, and other health, developmental disability, and family planning programs); and (3) with service providers in order to identify pregnant women and infants who are eligible for Title XIX services and to assist them in applying for these services [Part II(III)(E), p. 38, reflecting §505(a)(5)(F) of the Social Security Act].

(2) Health Systems Capacity Indicators (HSCIs). Information on the State Title V agency's systems and program capacity to promote women's and children's health (including coordination with Medicaid) must be reported annually and is summarized through a series of Health Systems Capacity Indicators. The indicators that focus upon Medicaid include:

- The percent of Medicaid enrollees whose age is less than 1 year who received at least one initial or periodic screen (HSCI 2, p. 141).
- Comparison of HSCIs for Medicaid, non-Medicaid, and all MCH populations in the State (HSCI 5, p. 145).
- The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women (HSCI 6, p. 145).
- The percent of potentially Medicaid-eligible children, aged 1 to 21 years, who have received a service paid by the Medicaid Program (HSCI 7A, p. 142).
- The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year (HSCI 7B, p. 142).

(3) State Performance Measures (SPMs). The *Title V Guidance* requires States to report on 7–10 State Performance Measures designed to meet specific priorities determined through the State needs assessment. These SPMs often document a State's partnership and coordination activities with Title XIX agencies and populations.

(4) Program Data. States are required to report a wide range of program data, including their overall priority needs, individuals served, and health screenings provided. Program data to be reported that address individuals covered by Medicaid include:

- Number and percentage of individuals served by Title V (by "class of individuals" and by "source of coverage," including Title XIX).
- Number of deliveries and number of infants served under Title V who are eligible for services under Title XIX (by State, by race, and by Hispanic ethnicity).

Title XIX Requirements

The *State Medicaid Manual* (available at *http://www.cms.hhs.gov/manuals/pub45/pub_45.asp*) is the official document used by CMS to issue mandatory, advisory, and optional Medicaid policies and procedures to State agencies for use in administering their Medicaid programs. The *State Medicaid Manual* provides guidance on Parts 42 and 45 of the Code of Federal Regulations (specifically 42 CFR 431.615), with emphasis on Title V and Title XIX coordination of EPSDT. This document replaces the *Medical Assistance Manual* (§5-40-20). While these provisions place an emphasis on EPSDT coordination, they serve as guidance to overarching coordination with Title V programs and with Title V grantees.

Title V (MCH block grant) grantees and Medicaid share many of the same populations, providers, and concerns for child health. Assure that each MCH grantee and the State Medicaid agency have in effect a functional relationship. ***(§5230.1)***

The introduction of §5230 summarizes Medicaid's emphasis on coordination:

> *Written agreements are essential to effective working relationships between the Medicaid agency and agencies charged with planning, administering or providing health care to low-income families. Although agreements by themselves do not guarantee open communication and cooperation, they can lay the groundwork for collaboration and best use of each agency's resources.*

CMS's guidance cites several key factors for effective coordination and partnership in the IAAs:

- Detailed planning.
- Clearly identified roles and responsibilities.
- Program monitoring.
- Periodic evaluation and revision.
- Constant communication.

CMS states that the IAA, defined as a formal document signed by each agency's representative or a written statement of understanding between units of a single department, should be developed by both parties and should provide a clear statement of each agency's responsibilities.

The *State Medicaid Manual* further requires that each IAA be signed by persons with authority to make it binding and should specify the participating parties, their intent, and the effective agreement date. The IAA should also be reevaluated annually and when a major reorganization occurs to determine if it remains applicable to the organization, functions, and programs of the participating parties. The recommended content of the IAA, as outlined by the CMS policy, repeats 42 CFR 431.615(d) word-for-word.

Section 5230.1 specifically deals with "relations with State MCH programs" and requires that each State have in effect an IAA that:

- Provides for the maximum utilization of the care and services available under MCH programs.
- Utilizes MCH grantees to develop more effective uses of Medicaid resources in financing services to Medicaid-eligible children.

Goal of MCH-Medicaid Interagency Agreements. Coordination is essential to the overall goal of State MCH-Medicaid IAAs of improving "the health status of children by ensuring the provision of preventive services, health examinations, and the necessary treatment and follow-through care." This is most effective in the context of an ongoing provider-patient relationship and from comprehensive, continuing care providers.

CMS's manual states that Medicaid agencies should inform Title V-eligible recipients of available services and refer them to the appropriate Title V grantees that provide such services.

CMS advises State Medicaid programs to enlist the assistance of Title V programs in a number of areas, which include:

- Recruiting providers from both the private and public sectors to provide comprehensive, continuing care for children.
- Providing outreach and referral services at the local levels.
- Using Maternal and Infant Care (MIC) projects, Children and Youth Projects (CYP), and other specialty and primary care programs as providers of comprehensive, continuing care.
- Delegating tasks by the Medicaid agency to State MCH programs to ensure that Medicaid-eligible children have access to and receive the full range of assessment, diagnostic, and treatment services.
- Developing health services policies and standards, and assessing quality of care issues.
- Ensuring continuity of care. Public Health Service (PHS)-supported primary care projects provide continuing care to all eligible children, regardless of their payment status. State MCH programs develop linkages with these projects to ensure the full range of care for mothers, infants, and children, including CSHCN [§5230.1(A)].

CMS reminds Medicaid agencies that they are to act as the payer of first resort and that MCH programs have extensive experience establishing standards, policies, and procedures for health care services that may be relevant to Medicaid populations [§5230.1(C)]. The *State Medicaid Manual* calls for mutual program referral arrangements and outreach activities by State MCH and EPSDT programs, specifically requiring both programs to refer those eligible for EPSDT

services to MCH programs, where appropriate, and to cover this implementation in the IAA [§5230.1(D)].

While coordination with Title V programs is primarily addressed in §5230 of the *State Medicaid Manual,* CMS emphasizes partnership in a number of provisions. For example, CMS urges development of examination and diagnostic resources and centers with the assistance of Title V programs, medical and dental societies and schools, other practitioner organizations, and State, regional, and local health departments [§5310(A)].

Reimbursement and Documentation. The *State Medicaid Manual* clearly states that Medicaid agencies are responsible for reimbursing Title V providers for services provided to Medicaid beneficiaries even if these services are provided free of charge to low-income uninsured families. The manual stresses the importance of including a detailed description of payment arrangements in the IAA.

The manual reiterates that Medicaid is to be considered the payer of first resort and contains the following payment, reimbursement, and documentation provisions related to IAAs between Medicaid agencies and Title V (and other) programs:

- Title V programs that enter into IAAs with Medicaid agencies must specify in the IAA the terms of reimbursement for services to be provided.
- A fee schedule for each service billed to Medicaid by Title V must be established; information and billing of all third party liable resources must be obtained and documented [§5340(A)].
- Medicaid agencies must *document* the payment mechanism of services provided. This may consist of two alternatives:
  - If the *same* payment mechanism is used, agencies must specify that payment is based on the Medicaid fee schedule or reasonable charge.
  - If an *alternative* payment mechanism is used, agencies must specify the type of arrangement, which may include:
    - Prospective interprogram transfer of funds, with retrospective adjustments based on the volume of services actually delivered;
    - Capitation payments for a pre-determined package of services; or
    - Reimbursement for actual costs [§5230.1(B)].
- IAAs with Title V (and other) programs may provide payment for certain administrative functions (outreach, quality assessment, and transportation; the DRA of 2005 has limited the scope of services related to targeted case management, which previously had qualified as allowable administrative functions); 75 percent Federal matching funds are available for the cost of medical personnel and direct support staff employed by the Medicaid agency if they meet requirements of 42 CFR 432.50 [§5340(B)].

CMS further advises (1) limiting reimbursement of overhead costs under IAAs to those identifiable as supporting EPSDT services when this is the focus of the IAA; (2) specifying within the IAA the conditions under which private practitioners may bill through Title V for services provided to Medicaid beneficiaries; and (3) detailing the conditions under which services are covered (since services are often provided by professionals who are not physicians).