Chapter Three

Analysis of State Title V / Title XIX Interagency Agreements

The updated [State MCH-Medicaid Coordination of Title V and Title XIX Interagency Agreements] publication will provide summaries of individual State IAA between State Medicaid and MCH programs and will highlight programs with successful partnerships.

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From MCHB's call for State IAAs

A. Documents Reviewed

A call for State Title V/Title XIX IAAs was issued to MCH and CSHCN directors by the Maternal and Child Health Bureau in the spring of 2004 for the purpose of updating this publication. Thirty-six States from across the country responded to the request, providing a substantial body of material to review. From these responses, 47 IAAs were collected and analyzed. Additional material was also gathered from cover letters, e-mails, and follow-up phone calls, mostly explanatory in nature about the process of IAA development. One State (Texas) provided details on the ways its respective agencies collaborate in the absence of a formal agreement.

This analysis, therefore, is based on the review of IAAs and supplemental information from the following States (*Chapter Five* contains summary tables of these State IAAs):

Alabama (AL)
Arizona (AZ)
California (CA)
Colorado (CO)
Connecticut (CT)
Florida (FL)
Georgia (GA)
Hawaii (HI)
Idaho (ID)
Illinois (IL)
Indiana (IN)
Iowa (IA)
Kansas (KS)
Kentucky (KY)
Louisiana (LA)
Maryland (MD)
Michigan (MI)
Minnesota (MN)
Mississippi (MS)
Missouri (MO)
Nebraska (NE)
New Mexico (NM)
New York (NY)
North Carolina (NC)
North Dakota (ND)
Ohio (OH)
Oklahoma (OK)
Oregon (OR)
Rhode Island (RI)
South Carolina (SC)
South Dakota (SD)
Utah (UT)
Virginia (VA)
Washington (WA)
Wisconsin (WI)

The States surveyed represent wide geographic diversity – ranging from the East Coast to the Midwest to the Pacific Coast to the South – as well as great differences in size and population density. While not every IAA of each State in the country was collected and analyzed, the group surveyed represents a wide variety of racial, ethnic, and economic diversity among its respective populations. Of the States surveyed, 2 were from Region I (CT and RI), 1 from Region II (NY), 2 from Region III (MD, VA), 7 from Region IV (AL, FL, GA, KY, MS, NC, SC), 6 from Region

V (IL, IN, MI, MN, OH, WI), 4 from Region VI (LA, NM, OK, TX), 4 from Region VII (IA, KS, MO, NE), 4 from Region VIII (CO, ND, SD, UT), 3 from Region IX (AZ, CA, HI), and 3 from Region X (ID, OR, WA).

While the documents provide a great deal of data to review, there are certain limitations imposed by the scope of material. First, many of the documents did not contain specific expiration dates, but rather stated that they would remain in effect until mutually revised or cancelled. There is the possibility, therefore, that these documents may have been or soon will be superceded by newer agreements. Further, many of the IAAs were unsigned and/or marked "draft," so there remains some uncertainty about their authority. (Despite this, it appears from the accompanying documentation and conversations with the States involved that most of these documents remained the basis for coordination among agencies.) A number of other documents were submitted with end dates that have since passed, so those specific IAAs may have also been superceded. However, from documentation accompanying these agreements, it was evident that in most (if not all) of these cases, the State agencies were planning on the continued use of the IAA with only a change of end date and slight (if any) modification of content.

This report, thus, provides an analysis of a substantial sampling of IAAs from across the country. There are other IAAs, either in current use or in process, that despite continued collection efforts could not be included in the review. As such, the material collected does not represent the entire range of State coordination agreements, but rather a strong, demonstrative group to base conclusions upon.

The IAAs differ greatly in format, length, and level of detail. Some IAAs are boilerplate agreements with the names of each agency and their responsibilities written in, while others are clearly consensus documents, the result of many hours of focused planning and negotiation. The documents range from 3 to over 50 pages with many averaging around 10-12 pages. Some documents are a simple statement that the Title V and Title XIX agencies should work together in ways to be mutually determined, while others rigorously outline objectives, responsibilities, and detailed tasks, timelines, and budgets.

There are several differing format styles that are used in the IAAs:

- About half of the States have developed a single IAA for outlining a full range of activities to be coordinated between their Title V and Title XIX agencies; the remaining States use a series of individual IAAs to detail activities related to specific areas of coordination, such as EPSDT, outreach, CSHCN, confidentiality, and record keeping. Similarly, some of the IAAs collected are part of a larger set of State-wide agreements that detail activities between multiple other agencies.
- Most (42) of the IAAs are strictly between two agencies (almost exclusively specified as Title V and Title XIX); however, several documents include agreements between a larger number of State agencies, including WIC and local provider organizations.
- The majority of the IAAs are specifically written for the agencies involved, highlighting their respective responsibilities and areas for collaboration; however, several (e.g., AZ) IAAs contain only standard contract provisions. These IAAs often include addenda that dealt with specific areas of focus, such as identification of beneficiaries, lead screenings, and CSHCN. Some of these IAAs are actually a basic Medicaid provider agreement that can also be used

for individual providers (e.g., NM).

- Many of the IAAs highlight specific activities that require special attention (e.g., agency coordination, referrals, outreach, and reimbursement) in separate sections; however, an equal number of IAAs include such activities in an overarching list of activities to be carried out between agencies.
- In cases where a State's Title V and XIX agencies are administratively housed within the same State agency, their corresponding agreements are often referred to as "intra-agency agreements."

B. Methodology: Format of the State IAA Tables

The summary tables (provided fully in Chapter Four) are divided into four sections for clarity, although each IAA itself may not conform to this format: (I) a general description of the document; (II) a summary of the contractual details (Sections 1-5); (III) a summary of the agreement components that relate to CMS requirements outlined in 42 CFR 431.615(d) (Sections 6-18); and (IV) a listing of general contract provisions (Section 19). Information in the summary tables is excerpted directly from the actual IAAs, wherever possible.

Federal Medicaid regulations provide a logical framework to analyze the State IAAs. Under 42 CFR 431.615(c) State plans are required to describe the cooperative arrangements between the relevant agencies in order to make maximum use of services [CFR 431.615(c)(1)]; to allow for Medicaid to utilize services listed in the State plan that are provided by Title V grantees [CFR 431.615(c)(2)]; and to allow the Title V grantees be reimbursed by the State's Medicaid agency [CFR 431.615(c)(4)].

CMS continues in CFR 431.615(d) to describe the actual content required, as appropriate, in the State IAAs. The main component of the Chapter Four summary tables follows this regulation very closely. Thus, many of the table sections directly address CMS requirements:

Summary Table Section: (Section number) and description	**CMS Requirement Addressed:**
(6) Objectives and (7) Responsibilities	***42 CFR 431.605(d)(1):*** The mutual objectives and responsibilities of each party to the arrangement.
(8) Services Provided by Agency	***42 CFR 431.605(d)(2):*** The services each party offers and in what circumstances.
(9) Cooperative Relationships	***42 CFR 431.605(d)(3):*** The cooperative and collaborative relationships at the State level.
(10) Services Provided by Local Agencies	***42 CFR 431.605(d)(4):*** The kinds of services to be provided by local agencies.

(11) Identification and Outreach	***42 CFR 431.605(d)(5)(i):*** The methods for early identification of individuals under 21 in need of medical or remedial services.
(12) Reciprocal Referrals	***42 CFR 431.605(d)(5)(ii):*** Methods for reciprocal referrals.
(13) Coordinating Plans	***42 CFR 431.605(d)(5)(iii):*** Methods for coordinating plans for health services provided or arranged for recipients.
(14) Reimbursement	***42 CFR 431.605(d)(5)(iv):*** Methods for payment or reimbursement.
(15) Reporting Data	***42 CFR 431.605(d)(5)(v):*** Methods for exchange of reports of services furnished to recipients.
(16) Review	***42 CFR 431.605(d)(5)(vi):*** Methods for periodic review and joint planning for changes in the agreements.
(17) Liaison	***42 CFR 431.605(d)(5)(vii):*** Methods for continuous liaison between the parties, including designation of State and local liaison staff.
(18) Evaluation	***42 CFR 431.605(d)(5)(viii):*** Methods for joint evaluation of policies that affect the cooperative work of the parties.

While the State IAAs follow this structure to varying degrees (from an almost one-to-one correspondence to a more general reliance on the Federal Code for structural guidance), it nevertheless provides a consistent benchmark to look at the documents as a whole. In many cases, an IAA addresses a topic that is similar to but not an exact match to one of the summary table sections (and its corresponding CMS requirement); in these cases, the topic is reported in the table element to which it is most closely related. Often an IAA does not treat specific elements outlined in 42 CFR 431.605(d). In such cases, "N/A" (not addressed) is listed under that table element. This does not mean that the document is lacking in any way, merely that it does not address that specific topic (which may be implicit or treated in another document).

In many of the IAAs, specific activities are addressed in separate sections to highlight their importance (e.g., reimbursement is often addressed in its own section). When this occurs, the related requirements are described in that specific table element. However, many IAAs summarize all of their activities together. In this case, specific table elements cross reference the appropriate activity to its appropriate section (e.g., in New York, a discussion of reimbursement is integrated in a list of overall services. Thus, the table element for reimbursement refers back to the list of overall services: "See Section 8, Service A7, B1.")

C. Analysis and Findings

A summary of the findings of the review of State IAAs is presented in the following table, followed by a more detailed analysis.

Analysis of the State Interagency Agreements: Summary Based on 47 Documents
Contractual Details
1. Effective Date: • 42 specify an effective date (exceptions: AZ, CT#2, FL, NY, SD) • 40 specify a specific date/specific "date of issuance or amendment" • 2 specify a general "date of issuance or amendment," but no specific date
2. Duration • 39 address the IAA's duration (exceptions: AL, AZ, CT#1, LA, NY, RI#1-2, ID) • 16 denote a specific date (CO#1-2, HI, IL, IA#1-4, KS, KY, MS, OH, OK, OR, SC, WA)
3. Type of Agreement • 12 "Cooperative Agreements" • 11 "Interagency Agreements;" 1 "Intra-angency Agreement" • 5 "Memorandum of Agreements;" 7 "Memorandum of Understandings" • 2 "Intergovenmental Agreements" • 6 miscellaneous (2 "Provider Contracts/Agreements," 2 "Agreements;" 1 "Joint Powers Agreement," 1 "Action Plan," 1 "Standard Business Agreement," 1 "Master Agreement")
4. Agencies Involved • 39 are between two agencies (most specified as Title V and Title XIX) • 7 include additional agencies (CA, CO, KY, MD, ND, OH, RI#2) • 1 specifies only the Title V role (RI#1)
5. Authority Cited • 33 cite specific requirements on legislation, often citing multiple sources • 12 cite SSA§1902(a)(11) (CA, FL, HI, ID, IN, IA#2, KS, LA, MD, NE, RI#1, SC) • 20 cite 42 CFR 431.615 (CA, GA, IN, IA#1-3, KS, LA, MD, MO#1,3-6, ND, OH, OR, SC, UT, VA) • 14 cite State legislation (CO#1-2, CT#1, HI, IL#2, IA#1, KY, MN, MS, ND, OK, OR, SD, WA)
Analysis Related to CMS Requirements
6. Objectives • 46 contain readily identifieable objectives • 24 list increased coordination, strengthened relationships, and/or establishing strong cooperative relationships (CA, CT#1-2, IA#1-3, ID, IL#2, IN, KS, LA, MD, MN, ND, NE, NY, OH, OK, RI#1, SC, SD, UT, WA, WI)
7. Responsibilities • 30 provide a summary of each agency's programmatic/administrative accountabilities (CA, CO#1, CT#1, FL, GA, IA#1-2, ID, IL#2, KS, KY, LA, MD, MN, MO#1,3-6, MS, ND, NE, NY, OK, OR, RI#1-2, SD, WA, WI) • 17 only included information on which agency is identified as Title V and Title XIX (AL, AZ, CO#2, CT#2, HI, IA#3-4, IL#1, IN, MI, MO#2, NC, NM, OH, SC, UT, VA)
8. Services Provided by Agency • All 47 provide a breakdown of services provided by agency • 39 provide specific services provided by each agency, and/or mutual services (CO#1-2, CT#1-2, FL, GA, HI, ID, IL#1-2, IN, IA#2-4, KS, KY, LA, MD, MI, MN, MO#1-6, NE, NM, NY, NC, ND, OH, OK, RI#2, SC, SD, UT, VA, WA) • 5 break down services by topic/objective (CA, MS, ND, RI#1, WI) exclusively or in addition to services provided by agency

9. Cooperative Relationships

- 27 address cooperation between agencies (CA, CO#1-2, GA, IA#1-2, ID, IL#1, IN, KS, LA, MD, MI, MN, MO#1,4, NC, ND, NY, OH, OK, RI#1, SD, UT, VA, WA, WI)
  - 17 of these 27 address cooperation/coordination as part of *Section 8* or elsewhere (CA, CT#2, GA, IL#1, IN, MD, MI, MO#4, ND, NY, OH, OK, RI#1, SD, UT, VA, WA)
  - 10 of these 27 address cooperation/coordination as an indivudual section (CO#1, IA#1-2, ID, KS, LA, MN, MO#1, NC, WI)

10. Services Provided by Local Agencies

- 13 address collaboration with local agencies and services to be provided (CA, IA#3, IL#1, KS, MI, NC, ND, NE, NY, OH, VA, WI)
- 12 integrate engagement of local agencies into overall division of services (Section 8), stating that plans for coordination and services are often developed in conjunction with community partners (CA, IA#3, IL#1, IN, KS, MI, ND, NE, NY, OH, VA, WI)

11. Identification and Outreach

- 34 address outreach to various degrees (AL, AZ, CA, CO#1, CT#2, FL, HI, IA#1-4, ID, IL#1-2, KS, MD, MI, MN, MO#3-6, MS, NC, NE, NM, NY, OH, RI#1, SD, UT, VA, WA, WI)
- 17 address outreach as part of overall division of services (AL, AZ, CT#2, FL, HI, IA#3, IL#2, MI, MO#4-5, NM, NY, OH, RI#1, SD, UT, WI)
- 1 focuses entirely on outreach (IA#4)

12. Reciprocal Referrals

- 28 address referrals (AL, CA, CO#1, CT#2, FL, HI, IA#1-2,4, ID, IL#2, KS, KY, MD, MI, MN, MO#1,3, 5-6, NC, ND, NE, NY, OH, SD, WA, WI)
- 16 incorporate referrals as part of overall division of services (AL, CA, CO#1, CT#2, IA#4, IL#2, KY, MD, MI, MN, MO#5, NC, NY, OH, SD, WA)

13. Coordinating Plans

- 30 include plans for coordination (CA, CO#1, CT#2, GA, IA#1-2,4, ID, IL#1, IN, KS, KY, MD, MI, MN, MO#1-4, MS, NC, ND, NY, OK, RI#1, SD, UT, VA, WA, WI)

14. Reimbursement

- Only 8 do not cover reimbursement topics (AZ, CO#2, CT#1-2, MN, MO#6, RI#1, SC)
- 18 incorporate reimbursement into overall division of services (FL, ID, IL#1, IN, MI, MO#1-5, ND, NM, NY, OH, OK, RI#2, SD, UT)

15. Reporting Data

- Only 3 do not cover data reporting (OR, RI#1, MO#6)
- 22 address data as part of the division of services (AL, FL, HI, IA#3-4, IL#1-2, IN, KY, MI, MO#1-5, NM, NY, OH, OK, SD, UT, WA)

16. Review

- 19 detail a plan for periodic review of the IAA (CA, IA#2, IL#1-2, IN, KS, KY, LA, MN, MO#1,3-5, NC, ND, OH, RI#1, UT, WI)
- 8 incoporate a review into other sections of the IAA (IA#2, IN, KS, KY, MO#4-5, OH, WI)

17. Liaison

- 32 establish a method or individual for liaison (CA, CO#1-2, FL, GA, IA#1-3, ID, IL#1, IN, KS, KY, LA, MI, MN, MO#1-5, NC, ND, NY, OH, OK, RI#2, SD, UT, VA, WA, WI)

18. Evaluation

- 23 establish a system for evaluating the effectiveness of the programs and/or IAA (CA, IA#2, ID, IL#1-2, IN, KS, KY, LA, MN, MO#1-6, NC, ND, OH, RI#1-2, UT, WI)
- 12 discuss evauation as a separate topic, outside the general division of services (CA, IA#2, ID, IL#1, KY, LA, MO#3-6, ND, RI#1)

General

19. General Contract Provisions

- Only 7 do not contain general contract provisions (AL, CT#2, ID, LA, NY, RI#1-2)
- 37 contain termination of agreement clauses, 29 lay out procedures for amendment, 26 define standards of confidentiality in record keeping.

Detailed Analysis

A detailed analysis of the manner in which the State IAAs correspond to the review components are presented in the following section. Most often, a common trend emerges as to how States approach each topic. These common trends are explained and examples of States that either greatly differ from or reflect the norm are given.

General Document Description

Title and Author

Many of the documents collected contain an easy to find title, most often consisting of the type of agreement, followed by the agencies involved, and concluding with the scope of the agreement. However, most of the documents do not provide an easily identifiable author or originating agency, which has to be inferred by the contractual language. Many States also do not include the State name in the title or opening pages of the document, making it initially difficult to identify what State is being discussed.

Document Date, Number of Pages, and Document URL

This information has been taken from a physical review of each document. The Web site address for each document is given; the full electronic text of every document surveyed is available from *http://www.mchlibrary.info/IAA*.

Contractual Details

(1) Effective Date

Of the 47 IAAs collected, only 5 do not contain any language related to an effective date (AZ, CT#2, FL, NY, and SD). Most of the documents list specific dates or state that they would take effect upon signature (e.g., MD, OH) or upon the date of issuance (e.g., GA). In the case where the effective date depends upon the date of signature, the summary table lists that date in brackets (e.g., for WA, [January 1, 2000]). Several of the IAAs list both an issuance date and an effective date of amendment (e.g., AL, MI).

(2) Duration

Sixteen of the 47 IAAs collected denote specific dates of duration (CO#1-2, HI, IL, IA#1-4, KS, KY, MS, OH, OK, OR, SC, and WA), while 8 (AL, AZ, CT#1, LA, NY, RI#1-2, and ID) identify no period of duration. However, for all of these IAAs, supporting documentation reveals that the IAAs are currently in effect. Several of the documents indicate that they will remain in effect for a period of 1, 3, or 5 years from an unspecified effective date.

Many of the IAAs specify that they will remain in effect in perpetuity (e.g., NE) or until

cancelled (e.g., MO, NM) or modified (e.g., CA) by one or both parties. Several IAAs require periodic review and unless modifications are required, they are set to automatically renew at the end of each year unless written notice is provided to request amendment or nullification of the agreement (e.g., IN, MI).

(3) Type of Agreement

There are many permutations of the type of agreement entered into by the various State Title V and Title XIX agencies. Agreements between separate State agencies are often described as "interagency agreements" (e.g., CA, CO), while those housed within the same division or department often describe themselves as "intra-agency agreements" (e.g., LA). On the whole, terms used to describe the contract vary widely from "Action Plan" to "(Cooperative) Agreement" to "Memorandum of Agreement/Understanding" (MOA or MOU). In such instances, there does not seem to be a direct correlation between the type of agreement and the nature of the relationship between agencies. It is likely that the types of agreement are stock titles used in legal agreements across the various States or similarly that specific State regulations require a specific form of agreement to be entered into between parties. In a few states such as AL and NM, the format of the IAA is specified as a "Provider Contract" or a "Provider Participation Agreement" that the Title XIX agency obviously uses with other provider contracts as well as with Title V agencies.

(4) Agencies Involved

Thirty-nine of the 47 IAAs surveyed are between two agencies, most specified as the agencies that administer Title V and Title XIX. Many of the agreements, however, stated only the agency title without clearly specifying what its exact role is (either Title V or Title XIX). However, in the majority of these cases, it is fairly evident as to each agency's respective identity, roles, and responsibilities. One of the documents (RI#1) lists only the participation of the agency that administers Title V without specifying the corresponding Title XIX agency's responsibilities. Several other States (CA, CO, KY, MD, ND, OH, and RI#2) also include other agencies (e.g., Title XXI, WIC, and local provider organizations), assigning each specific responsibilities.

(5) Authority Cited

From the 47 documents collected, there are a variety of sources relied upon for authority in delineating each agency's respective roles and responsibilities. While each State cites the authority that is most relevant to their specific IAA, there are some overall trends:

- ***Legislative or Regulatory Medicaid Federal Law.*** Most States (33 total) cite specific requirements in legislative or regulatory Medicaid Federal law [either exclusively (13) or in combination with another authority (20)]. Most often, the IAAs cite:
  - ***SSA §1902(a)(11)*** or related sections (CA, FL, HI, ID, IN, IA#2, KS, LA, MD, NE, RI#1, and SC) and/or
  - ***42 CFR 431.615*** (CA, GA, IN, IA#1-3, KS, LA, MD, MO#1,3-6, ND, OH, OR, SC, UT, and VA).

- ***State Requirements.*** Fourteen IAAs cite State authority for establishing their agreements (CO#1-2, CT#1, HI, IL#2, IA#1, KY, MN, MS, ND, OK, OR, SD, and WA), including both State legislature and other/previous IAAs.

- ***Multiple Authorities Cited.*** Many IAAs thoroughly cite a combination of Federal, State, and other (program-specific) authorities for the establishment of their agreements.

Only 12 of the IAAs do not refer to any overarching authority as the basis for establishing their agreements (AL, AZ, CT#2, IL#1, IA#3, IA#4, MI, MO#2, NM, NY, NC, and RI#2); two (ID, RI) cite the SSA in general, but do not give a specific reference. One (WI) does not cite an authority for the statutory basis for its IAA, but instead refers to authority for specific programs such as EPSDT and WIC.

Analysis Related to CMS Requirements

(6) Objectives

Overall, States are highly conscientious in providing clear sets of objectives for their IAAs. Forty-six of the 47 documents surveyed contain readily identifiable objectives at the beginning of their narratives. The objectives range in descriptiveness, from extremely direct (Florida's IAA states its objective "to better serve the needs of Florida's pregnant women and children at risk for poor birth and health outcomes") to highly detailed (Ohio's IAA lists 13 separate objectives, detailing numerous goals for almost all of its activities).

Often the objectives contain general statements followed by State- or program-specific goals. In every IAA, the goals are stated as being mutually shared between the two (or more) agencies involved, and the majority (24) list increased coordination, strengthened relationships, and/or establishing strong cooperative relationships as part of their overall objectives.

Common objectives often include:

General and Coordination:

- To improve the health of women, pregnant women, infants, children, and adolescents, CSHCN, etc.
- To meet the requirements of the Social Security Act and to comply with other applicable State and Federal statutes, regulations, and guidelines, including HIPAA.
- To increase coordination/collaboration between the Title V and Title XIX (and other, if applicable) agencies.
- To maintain clear communication between agencies.
- To develop and implement initiatives that address the underlying causes of preventable diseases.
- To develop and implement standards of care.

Programmatic and Local Relationship Building:

- To prevent duplication, overlap, and/or fragmentation of effort and/or services.
- To promote long-range planning.

- To strengthen relationships with local health agencies.
- To develop and maintain local capacity for MCH Services and to provide Medicaid information and care coordination.
- To strengthen relationships with multi-cultural and multi-ethnic organizations.

Identification, Outreach, and Referral:

- To coordinate identification of infants, children, adolescents, and women who are potentially eligible for services.
- To provide outreach and increase public awareness of the need for health care coverage and services for women and children.
- To provide outreach related to the services provided by Title V and Title XIX.
- To provide resource and referral information; to refer the child and family to appropriate services.
- To implement an established joint referral process.

Reimbursement and Financial:

- To specify the reimbursement and financial arrangements applicable.
- To facilitate the claim for Federal matching funds for the efficient and effective administration of the State Plan.
- To ensure the maximum utilization of Title XIX resources.

Data Sharing:

- To promote timely sharing of programmatic data.
- To allow joint access to critical Medicaid and public health data.
- To cooperate in creating linked, de-identified data files that will be used for public health and health care research, program evaluation, and surveillance.

States that have issued separate IAAs addressing specific topics (such as outreach, EPSDT services, hotline establishment, non-emergency medical transportation) most often include objectives that are specific to the programs addressed. These agreements (e.g., IA#1-4 and MO#1-6) spend less time stating overarching goals than IAAs that deal with Title V/Title XIX activities as a whole.

(7) Responsibilities

States are divided when it comes to specifying agency responsibilities. Thirty States provide a summary of each agency's programmatic and/or administrative accountabilities, while 17 States do not include such a summary beyond what agency is identified as Title V and Title XIX.

In the documents that do include a listing of responsibilities, a series of "whereas" paragraphs at the beginning of the agreement is often used to delineate specific agency responsibilities. (e.g., "Whereas the [North Dakota] Department of Human Services…is the state agency responsible for administering Children's Special Health Services in conformity with Title V of the SSA…" and "Whereas the [North Dakota] Department of Health is the state agency responsible for administering the MCH Program…").

Many of the responsibility statements also include specific tasks beyond a listing of the programs for which an agency has oversight (e.g., "the Georgia Department of Community Health is responsible for all health planning issues in the state," and similarly, "the Kentucky Department of

Community Based Services is responsible for providing protective services, such as targeted case management and rehabilitative services").

These "whereas" statements are often used to "set the stage" by introducing the objectives, services, and other components of the IAA. These responsibilities are often closely followed by a summary rationale for the establishment of the agreement (e.g., "Now, therefore, be it resolved that the Department of Human Services and the Department of Health agree to perform the following in connection with this agreement: …").

Most of the IAAs that include responsibilities break them out by agency, describing first what the Title V agency's responsibilities are and then the corresponding Title XIX responsibilities. However, a few States (e.g., MO and NY) list joint or shared responsibilities. Often the line between shared responsibilities and shared objectives is blurred, so that it is difficult at times to differentiate the two. Indeed, Federal Medicaid regulation 42 CFR 431.605(d)(1) combines objectives and goals into one requirement.

(8) Services Provided by Agency

The primary focus of most State IAAs is the specification of services to be provided by each agency entering into the agreement. The format and amount of information included by each State varies substantially: some documents include bulleted or numbered lists under each agency while other States provide narratives of various lengths to enumerate the division of services. Often, the documents summarize services to be supplied by both parties and then treat the services to be provided by each respective agency. Some IAAs (e.g., IN) break these services down by topic, such as coordination, confidentiality, data sharing, and reimbursement. Other States divide this section by objective (e.g., IA#2) or by State program (e.g., KS). Section 8 of the State Summary Tables (listed in *Chapter Five*) attempts to standardize the reporting of these services across the States (in numbered lists) and to present them in a manner that is easy to summarize by State or to compare across State, region, or IAA section.

At their best, the State IAAs present divisions of tasks in such a way as to make such services more than just "laundry lists" of activities that each agency is assigned to complete. It is obvious that across the country States have put great thought and effort into coordinating activities between various agencies to satisfy (and in many cases, to go beyond) their stated objectives.

In the most standard approach to services provided by agency, the respective Title V agency agrees to be the administrative unit responsible for providing services (either through local programs or by direct contracting with health providers) while the Title XIX agency assumes responsibility for providing reimbursement for such services. Often, the two agencies further agree to a series of mutual services or responsibilities in addition to those tasks for which they are each responsible.

The range of activities provided by the respective Title V, Title XIX, and other State agencies greatly varies, in part due to the structure of the State health system and the specific needs of the population served. However, there are many activities that appear repeatedly in the IAAs. General services that appear often in State IAAs are outlined below (typically appearing in more

than half of the IAAs summarized); these are not meant to be exhaustive lists, but rather an overview of typical activities. Specific activities, such as those related to identification and outreach, referrals, coordination, reimbursement, data, and liaison are discussed in detail in their corresponding sections.

Agencies that administer Title V often have the responsibility to:

- Provide EPSDT, family planning, immunizations, prenatal care, early intervention, and/or case management and related services to those who meet eligibility requirements.
- Determine the level, intensity, frequency, appropriateness, and service modality of services to be provided.
- Identify and fund local health departments and other contractors to provide the infrastructure for health care programs.
- Use Medicaid funding to contract for development, implementation, and direction of services to eligible children and mothers.
- Provide required financial and statistical data/records to document reimbursement for Medicaid services. Collect and maintain appropriate records and health data (e.g., records of covered services furnished to eligible participants) and/or to identify needs and to ensure that the Medicaid agency will be able to collect Federal matching funds.
- Refer potentially eligible children and pregnant women to the Medicaid program and/or assist them in applying for Medicaid.
- Inform potentially eligible families of the availability and scope of the EPSDT program.
- Support provider outreach; require Title V providers to also be Medicaid providers.
- Develop outreach materials for informing recipients about Medicaid services.
- Maintain a toll-free number that women and families can contact and receive information from appropriately trained personnel.

Agencies that administer Title XIX often have the responsibility to:

- Develop reimbursement methodologies for the payment of MCH care services.
- Provide timely reimbursement for the services provided by the Title V agency, its local health departments, or contracting providers with current Medicaid rates and fees for all services within the scope of Medicaid benefits.
- Provide Medicaid data to the agency that administers Title V.
- Provide case management services.
- Refer eligible children, adolescents, and/or pregnant women to Title V providers for EPSDT screenings and/or other Medicaid services.
- Provide the agency that administers Title V and/or local health departments with a listing of EPSDT and/or other Medicaid eligible beneficiaries and related data.
- Provide training to Title V providers on Medicaid services, and particularly, Medicaid billing procedures.
- Monitor the quality of services being provided by the Title V providers.
- Collect and analyze expenditure data for Medicaid-covered services; develop, implement, and monitor Medicaid provider and contract agreements; investigate inappropriate billing/utilization of Medicaid reimbursement.

Agencies administering Title V and Title XIX often share responsibility to:

- Work collaboratively to improve the health of State residents.
- Ensure that Title V, Title XIX (and other) services are consistent with the needs of the participants and the programs' objectives and requirements.
- Coordinate program initiatives to avoid duplication of effort among agency programs.
- Encourage referrals between various programs.
- Develop and implement, in cooperation, health care standards, program policies, and pilot programs.
- Develop, in cooperation, provider manuals, billing instructions, and provider training.
- Develop statewide advisory groups to oversee the implementation of care coordination.
- Provide liaison between agencies for interagency communication and coordination.
- Provide financial support/reimbursement to local health agencies and other groups and individuals engaged in the delivery of health services to mothers and children.
- Comply with all applicable State and Federal laws, regulations, and rules regarding confidentiality of participant information, ensuring that information is disclosed only for the purpose of activities necessary for administration of the respective program(s) and for audit and examination authorized by law.

The majority of the State IAAs present services in this manner, separated by the agency responsible for their implementation. However, several documents (CA, IA#2, IN, MD, and RI#2) further categorize services by objective or by type of service.

For example, California lists the following clearly defined objectives and then relates agency activities directly to each objective:

- *Objective 1: Assure and support the provision of a comprehensive, coordinated, and accountable health services delivery system for all eligible pregnant women, infants, children, and adolescents.*
- *Objective 2: Assure the provision of high quality health care by organizations and providers who meet professional practice standards.*
- *Objective 3: Improve access to perinatal and preventive health care services for low-income women, particularly adolescents and children, respectively, and services to CSHCN.*
- *Objective 4: Assure maximum utilization of Title XIX funds by Title V contractors and providers, including reimbursement by Title XIX for all medically necessary services within the Title XIX scope of benefits.*
- *Objective 5: Plan and support the delivery of training and education programs for health professionals and the community, including beneficiaries of Title V and XIX services.*
- *Objective 6: Develop and implement data collection and reporting systems that support assessment, surveillance, and evaluation with respect to health status indicators and health outcomes among the populations served by both programs.*
- *Objective 7: Improve ongoing intra departmental communication between staff of the two programs for information sharing, problem solving, and policy setting (this includes sharing of information and maintaining regular, formal communications).*
- *Objective 8: Maintain adequate Title XIX and Title V program staff with the necessary expertise necessary to carry out the specific functions and responsibilities of providing*

direct support in administering the Title XIX program.

- *Objective 9: Maximize utilization of third party resources available to Title XIX recipients.*

In this IAA, each objective is followed by a list of the Title V services to be provided followed by a similar list of Title XIX services.

The Indiana MOU groups services provided by agency according to type: coordination, confidentiality, data sharing, and reimbursement. Similarly, the Maryland cooperative agreement groups services according to the following divisions: administration and policy; reimbursement and contract monitoring; confidentiality and data exchange; recipient outreach and referral; training and technical assistance; provider capacity; system integration; and quality assurance activities.

Several IAAs group services by the State program they fall under. For example, the Colorado Title V/Title XIX IAA (CO#1) organizes its services by the following programs: Family Planning; Prenatal Plus; Health Care Program for Children with Special Needs; Developmental Evaluation Clinic Services; Immunization Program; Lead Poisoning Prevention Program; Breast and Cervical Cancer Program; and the Nurse Home Visitor Program.

Many of the IAAs focus specific attention on a specific set of activities. Often, in such cases the State issues a separate IAAs for each program rather than combine all Title V and Title XIX activities into one document. Colorado has issued a specific IAA (CO#2) on HIPAA requirements; other States such as Connecticut, Indiana, and South Carolina have written their IAAs to focus on data files and sharing of confidential data. Iowa has submitted a separate IAA on EPSDT services. Missouri maintains multiple cooperative agreements focusing on very specific topics: prenatal case management and/or service coordination for pregnant women; well child outreach; the Head Injury Program; administration of the medical home and community-based service waivers to targeted individuals with physical disabilities; non-emergency medical transportation; and case management for the Healthy Children and Youth Program.

Finally, several States used their IAAs to include services to be provided by other State programs. Maryland's cooperative agreement is between its Title V and Title XIX agencies and the State WIC program; Wisconsin's MOU includes Title V, Title XIX, Title XXI, and WIC.

(9) Cooperative Relationships

One of the main purposes of the IAA is to define how the agencies that administer Title V and Title XIX (hereafter referred to as the "Title V and Title XIX agencies") will work together efficiently to provide services to a shared population. As such, most documents are filled with language emphasizing the need for cooperative relationships at the State level. Many States stress the need for cooperative interagency ties by integrating relationship-building into each agency's required activities (e.g., CA, IN, MO, and WA). Such states emphasize activities that need to be done in collaboration; by planning and implementing services together, the State Title V and Title XIX agencies are building the cooperative relationships necessary to fulfill the IAA's objectives.

Many IAAs follow the example of Colorado, which specifically requires agencies to "collaborate via mutually agreed upon activities." Wisconsin requires its Title V, Title XIX, and WIC programs to "establish cooperative and collaborative relationships, including work groups and periodic meetings, with respect to [its] programs and services." Idaho likewise requires its respective agencies to "jointly participate in implementation of collaborative services, such as an outreach campaign and a toll-free information line and referral service."

As can be seen in these examples, the line between strictly defining cooperative relationships (described here in Section 9) and actively coordinating plans for health services (Section 13, summarized below) is often quite thin, since the establishment of cooperative relationships should lead to coordinated plans between agencies.

(10) Services Provided by Local Agencies

While Federal Medicaid regulations require a description of the kinds of services provided by local agencies [42 CFR 431.605(d)(4)], most of the IAAs do not deal directly with this issue (indeed, 34 of the documents discuss local agency services only in the most general terms or do not include such services at all). Instead, in most instances services provided by local agencies are integrated within those provided by the Title V agency.

However, one aspect relating to local health agencies that is addressed in a number of IAAs involves ongoing communication and coordination between local groups and Title V/Title XIX agencies. For example, the Illinois intragovernmental agreement (IL#2) requires its Title XIX agency to "provide to the local health departments data related to children enrolled in the Medical programs within their jurisdiction to increase EPSDT participation, including immunizations and lead screening." The Indiana MOU requires both Title V and Title XIX agencies to inform local health departments of the agreement and "of the responsibilities of the local program staff affected" by it. Michigan's IAA requires its respective agencies to provide accurate lists of clients due for screenings to local health departments or other organizations; however, it does not spell out the screening services that are to be provided by the local agencies. Nebraska requires the Title XIX agency to inform and educate all local health departments to make them aware of the Medicaid services offered.

There are a few examples of strong coordination with local agencies that stand out. North Dakota lists a section for "local coordination" under each one of its service categories (in Section 8). Local agencies are thus tasked with making Title XIX eligibility determinations for potentially eligible individuals referred by other programs; referring Title XIX eligible persons to the appropriate services; and providing information to eligible recipients about Medicaid services. Wisconsin also discusses services to be provided by local agencies in detail: these agencies are to participate in Medicaid managed care advisory groups; provide information to HMOs about the services they provide; and join in collaboration with WIC projects, HMOs, Title V, and Title XIX.

(11) Identification and Outreach

42 CFR 431.605(d)(5)(i) calls for a description of the methods used for early identification of individuals under 21 in need of medical or remedial services. States, however, are split as to whether their IAAs address this topic to any great extent. Of the documents surveyed, 11 (AL, CA, HI, IL#2,

KS, MI, MN, MO#3, MO#5, MO#6, and UT) assign the role of identification to one of the State agencies or some combination of the 2. In such instances when identification of potential eligible beneficiaries is discussed, outreach to such individuals is often paired with the discussion. States are usually direct in their assignment of an agency to identify potential beneficiaries. Alabama's provider contract states that the Title V agency shall identify children who have not received screenings and then follow up with the appropriate sickle cell and metabolic screenings, newborn hearing screens, and immunization status. The contract also calls for the Title V agency to utilize proper diagnosis codes to identify high-risk children. California's IAA tasks its Title V agency to identify infants, children, adolescents, and women who are potentially eligible for Medicaid and, once identified, assist them in applying. Title V must then collaborate with the Medicaid agency in performing outreach and informing all EPSDT eligible individuals and/or their families about the program.

In Kansas, the Title V agency has the responsibility of providing early identification and referral of individuals of potential beneficiaries to Medicaid and must also provide State and local Title XIX offices with MCH program brochures for distribution to these Medicaid consumers. In the Minnesota interagency MOU, the Title XIX agency is to receive screening and referral information from managed care health plans that is entered into a tracking system in order to help identify children under 21 in need of medical or remedial services. It then contracts with counties to perform outreach and follow-up EPSDT services to eligible children. Three of the six Missouri cooperative agreements (MO#3, 5, 6) also require their Title V agency to identify possible eligible beneficiaries for their respective Head Injury, Non-Emergency Medical Transportation, and Healthy Children and Youth Programs.

The topic of outreach is addressed in 25 of the IAAs. Usually, this is done in a straightforward manner as a subset of services to be provided by agency. Most often outreach activities consist of similar activities:

- Informing families about Medicaid benefits, especially EPSDT services through a combination of oral and written formats at venues such as health fairs, immunization clinics, community health services offices, physician and public health offices, and hospitals.
- Conducting outreach (such as scheduling appointments and reminding families when exams are due) to ensure that families are benefiting from Medicaid services.
- Developing brochures and other materials for informing recipients about Medicaid services.
- Maintaining a toll-free number that women and families can contact and receive information from appropriately trained personnel who provide information and referrals for prenatal care, family planning, and well-child services.

Outreach activities often are seen as a joint responsibility of the Title V and Title XIX agencies (e.g., CA, CO#2), although they may also be assigned specifically to one agency (e.g., CN#2, FL) or split among agencies (e.g., HI). Some States (e.g., IA) have issued a separate IAA dealing specifically with outreach activities or have devoted large portions of *Section 8: Services Provided by Agency* to outreach activities (e.g., MD). These documents serve as good models in defining the need for and activities related to outreach.

(12) Reciprocal Referrals

Reciprocal referrals are dealt with briefly yet effectively in the majority of the IAAs collected. Most States include the responsibility for reciprocal referrals to necessary services within the listing of their services provided by agency (see Section 8). Usually, the mandate for the agency is quite simple, such as to "refer the child and family to appropriate services" (ID). The Kansas cooperative agreement is more encompassing: "each party to this Agreement will establish a system of referrals for those services not directly rendered by the agency, but which are essential to meet the individual's need. To the degree possible, these referrals will be made at the time of client contact. Programs such as [those provided by the Title V and Title XIX agencies,] WIC, and Healthy Start will fall into this category."

Nebraska also includes a compelling requirement for referrals in its IAA; it charges both its Title V and Title XIX agencies to "encourage comprehensive and continuous care to mutual clients by encouraging or requiring providers in each program enjoined by this Agreement, to identify and refer potentially eligible individuals through the use of reciprocal referrals."

A few States go beyond a general mandate requiring reciprocal referrals. As part of its program planning activities, Idaho requires its Title V and Title XIX agencies to work together in developing a common referral form to be used across the State. Iowa's IAA on outreach specifically requires its Title V agency to maintain a toll-free number that women and families can receive information and referrals for prenatal care, family planning, and well-child services. In many other States, referrals are grouped together with identification of potential eligibles and with outreach; as such, referral language appears to be integrated in the overall services provided by both Title V and Title XIX agencies.

(13) Coordinating Plans

With a basis in the cooperative relationships established in Section 9, the logical next step regarding collaboration is the coordination between agencies for the development and implementation of health service plans. Here again, States vary widely in their approach, although there are some familiar trends. Many of the IAAs (e.g., MO, NC) integrate the message of coordination throughout their division of services. Such IAAs often call for activities that involve "collaboration," taking part in "joint initiatives," and "coordinating activities between agencies." Other States such as Indiana list coordination as a separate category of service to be provided with mutual responsibilities as well as agency-specific tasks underneath it. Here again, language such as "coordinating program activities," and "working collaboratively" appears regularly in the agreements.

The Commonwealth of Virginia summarizes its policy on coordinating plans with a powerful rationale: "The scope of services covered under the [Title XIX] may impact [Title V's] program plans and budgets. Similarly, actions of [Title V] may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted."

Most of the States that emphasize the coordination of health plans (CA, CO, CT, GA, ID, IL, IN, IA, KS, KY, MD, MI, MN, MS, MO, NY, NC, ND, OK, RI, UT, VA, and WA) include a similar rationale. Rhode Island devotes an entire section to interagency coordination and explains that such coordination will "improve the cost effectiveness of the health care delivery system, improve the availability of services, focus services on specific population groups or geographic areas in need of special attention and [help to] define the scope of each agency's programs" and that working together to provide services will "maximize effectiveness of service delivery and accessibility to services and [will] minimize duplication [of effort]."

(14) Reimbursement

As would be expected, a plan for the billing of and payment for services provided to beneficiaries is an integral component of almost every agreement between State Title V and Title XIX agencies. Generally, the relationship outlined in the IAA is based upon the Title V agency, grantee, or contractor providing services that the Medicaid agency will reimburse either partially or in full according to an agreed upon rate or limit. Payment for services by Title XIX is also closely tied to the provision of data from the Title V agency in regard to the services it has provided (see Section 15 below). Often the IAAs go into great detail outlining the exact mechanism(s) for filing reimbursement claims, the periodicity for such claims or invoices, pursuit of third party payment, ongoing documentation of services provided and payments received, and options for payment dispute resolution. These documents often emphasize Medicaid as the payer of the first resort.

While a few States outline payment responsibilities generally, the trend in most of the documents collected is to provide as detailed information as possible about payment policies, responsibilities, and mechanisms. The rate and/or total amount of reimbursement is one of the primary concerns addressed in these documents. Many of the IAAs specify that billing and reimbursement shall be made at the current Medicaid reimbursement rate or at the State match/share of costs based on a mutually agreed upon fee schedule (and always a level that shall not exceed the cost of providing the service). States often cite 45 CFR Part 74 or similar (State and/or Federal) regulation(s) as the determination of reimbursable costs. In many of the agreements, reimbursement is guaranteed only up to a certain specified dollar amount (e.g., CO#2, HI, IA#1,4); additional expenditures will be reimbursed only if the necessary State match is provided to the Title XIX agency. Most documents also spell out what the reimbursement will cover in terms of administration costs and/or the cost of services. In most of the agreements, the need is stressed for the Title V agency to provide the Title XIX agency with the proper documentation to ensure appropriate reimbursement for services.

States differ on the ways they approach their discussions of reimbursement. About half of the documents contain separate sections outlining payment mechanisms, while the remainder include these mechanisms integrated with other required services by each party. There is further difference to the timing each State assigns to reimbursement activities. Some States require monthly invoices for services, while others accept quarterly billing and payment; almost half of the documents do not assign a timetable to such activities. Throughout the majority of the IAAs, there is a common theme that the reimbursement requirements are established to ensure that Medicaid funds are being used appropriately, that the State receives the appropriate Federal Financial Participation amount, and that providers are compensated fairly and in a timely manner.

A large number of the IAAs (e.g., KS, NE) remind the respective State agencies that according to Federal legislation and regulations, Title XIX funds are to be considered the first and primary source of payment for billed services. Most agreements reiterate legislation stating that the Title V agency must consider payment from Medicaid to be in full. Title V funds cannot be used to supplement Medicaid reimbursement rates.

The following table summarizes how several IAAs treat reimbursement. These examples are not meant to be exhaustive as to how States coordinate billing and payment, but provide a sample of the creativity found amid State plans. For a more detailed presentation of how each IAA deals with this issue, see Chapter Four.

Reimbursement Discussed in Sample State IAAs (listed alphabetically)
Alabama (Region IV)
Medicaid will reimburse Title V for care coordination services based on Medicaid's current reimbursement rates. Title V agrees to reimburse Medicaid the State's share of costs associated with providing care coordination services.
Colorado (Region VIII) (CO#1)
A. Title XIX shall intervene with the Department's Designated Entity to ensure payment of the correct rate for Medicaid covered services. B. Title XIX shall bill the State match for Medicaid expenditures to CMS. C. Title V shall bill the Department no less than quarterly. D. Title V shall submit a request for reimbursement within 45 working days after the final State fiscal year. E. Family planning client claims are paid directly out of MMIS. F. Payments shall be made from State funds not to exceed $102,346 for the administrative costs of the Medicaid Prenatal Plus Program. G. HCP specialty clinic providers are paid out of MMIS. H. HCP Developmental and Evaluation Clinic services are billed directly by Medicaid providers and paid through the Department Designated Entity. I. Immunizations and vaccines are paid out of the MMIS. J. Medicaid covered Lead Poisoning Prevention Program benefits are paid out of MMIS. K. Benefits to BCCP clients are paid directly out of MMIS. L. Payment shall be made to the NHVP providers as earned.
Georgia (Region IV)
Title XIX agrees to provide to Title V the FFP payments received by Title XIX that are attributable to the administrative cost of these services on a quarterly basis. For specified services, Title XIX agrees to pay Title V the appropriate non-Federal share of the benefit cost on a regular basis. Both Title V and Title XIX agencies agree that this is a cost reimbursement agreement. Title V agrees to provide the State portion of matching funds necessary to receive FFP for all applicable supplements. Title V agrees that reimbursable costs will be determined in accordance with 45 CFR Part 74. This includes reimbursement for administration cost and reimbursement for benefit cost.

Hawaii (Region IX)
The Title V agency shall submit a monthly invoice to Title XIX for Early Intervention Services provided to Medicaid infants and toddlers receiving services. A. The Title XIX agency shall pay the Title V agency for the Federal share at the Hawaii Federal Medical Assistance Percentage (FMAP) in place for the month for which reimbursement is made. The Title V agency is responsible for the State share of the expenditures. B. All Federal reimbursement funds received under this agreement will be deposited into the Early Intervention Special Fund. C. The total amount of the MOA shall not exceed $2,500,000 in Federal funds per State fiscal year. D. Title V shall reimburse Title XIX any amount disallowed by CMS for services provided under this MOA. E. If State and/or Federal regulations and/or QAP standards are not met, the Medicaid division will provide Title V with notice and such other due process protections as the State may provide. Title V and Title XIX will collaborate to develop a Correction Action Plan that will include clearly stated objectives and time frames for completion.
Iowa (Region VII) (IA#2)
Each of the parties to this agreement shall continue to cooperate in their usual and customary fiscal relationship to ensure Federal dollars will be used more productively. It is intended that WIC funds will be the first and primary source of payment for nutritional products and services for persons eligible for WIC services. Title XIX will be the primary source of payment for Title XIX medical services provided to mutual beneficiaries through Title V providers.
Kansas (Region VII)
Unless there are other third party resources, Title XIX shall reimburse eligible providers for any service covered under the State Medicaid Plan for eligible Medicaid consumers. Services provided to consumers covered under managed care programs will be paid in accordance with managed care guidelines. Title XIX funds shall be the first and primary source of payment for medical services provided to mutual beneficiaries of the Title V and Medicaid Programs.
Kentucky (Region IV)
A. The Title XIX Agency shall be billed for services as per this agreement. B. The Title XIX Agency shall pay for services under this agreement up to a specified amount in State and Federal matching funds. Any additional expenditures in excess of that amount will be reimbursed only if the necessary state match is provide to the Title XIX Agency. C. The Title XIX Agency shall reimburse the certified and enrolled provider at payment levels that shall not exceed the cost of providing the service.

Maryland (Region III)

1. Title V and Local Health Departments shall:
A. Ensure that clinical services are furnished.
B. Maintain adequate medical and financial records.
C. Refrain from knowingly employing or contracting with entities that have been disqualified from the Medicaid program.
D. Not require additional payment from an individual after Medicaid makes payment to the Title V designee for a covered service. If Medicaid denies payment or request repayment on the basis that an otherwise covered service was not medically necessary or preauthorized, the Title V Agency will not seek payment for that service from the recipient.
E. Title XIX funds will be used to reimburse providers for services covered by that program if the individual is eligible for services covered by both Title XIX and Title V programs.
F. Collaborate with Medicaid regarding oral health initiatives.
G. Provide specialty services that are not covered by Medicaid.
2. Mutual Services (Title V and Title XIX).
A. All parties will ensure that services provided by its grantees are not duplicative.
B. All parties will maintain a system to ensure coverage for special infant formulas.

Mississippi (Region IV)

The case management agencies shall be reimbursed as a provider of medical services through the Title XIX's Fiscal Agent on the basis of the service cost as set out in appropriate regulations. The case management agencies shall bill Title XIX through its fiscal agent for their services within 60 days from the date of service or within 30 days of the recipient's receipt of the Medicaid card. Title V will be responsible for providing state matching funds only for case management and extended services actually provided by Title V to those individuals determined to be eligible. Reimbursement shall be made from monthly billings. The reimbursement fees will be at a flat rate per month.

Nebraska (Region VII)

A. Title XIX Agency.
1. Reimburse Title V program providers who are also Medicaid providers.
2. Establish a formal method of communication, collaboration, and cooperation with Title V regarding procedures, periodicity, and content standards for EPSDT, rates and reimbursement methods by regularly scheduled meetings.
3. Encourage and support the Title V policy to recover third party reimbursement and other revenues. It is the intent to make Medicaid funds the first and primary source of payment for medical services provided to Medicaid clients through the Title V programs.
4. Plan, in conjunction with the Title V agency, to address billing concerns.
5. Identify overall services and provide the maximum allowable rate information for procedures.
B. Title V Agency.
1. Ensure that Medicaid providers shall bill the Title XIX agency.
2. Respond to and attend annual meetings regarding rates and reimbursement methods.
3. Assure all third-party revenues shall be retained by the Medicaid provider.
4. Cooperate and participate in the planning process.

Oregon (Region X)
Billings will be done on the UB-92 in accordance with billing instructions and requirements in the Title XIX agency's Hospital Services Guide. Title V agrees that it is not a direct provider of augmentative communicative devices or other large items of durable medical equipment. Title V is not required to obtain prior authorization before billing for covered services, except that it agrees to conform to all limitation on services in the provision of hearing aids.
Virginia (Region III)
Title XIX will reimburse Title V by one of three methods (Pass Through Transaction; Vendor Transaction; Licensure and Certification; or Claims Processing). Title V shall bill Title XIX via Interagency Transfer (IAT) for its monthly costs within 24 days of the close of each month. The IAT shall reflect the total expenditures (both direct and indirect). Specific amounts for reimbursement are detailed for each section: 1. Long-term Care Agreements; 2. Business Associate Agreement and Data Projects; 3. Maternal and Child Health Collaborative.
Washington (Region X)
A. Consideration for the work provided in accordance with this Agreement has been established under the terms of RCW 39.34.130. Compensation for services shall be based on established rates or in accordance with establish terms. B. For all Title XIX delegated program and administrative activities included in this agreement, Title V is responsible for maintaining compliance with Medicaid Federal regulations and any overpayments requested as a result of audit findings.
Wisconsin (Region V)
Title V-funded agencies will adhere to the precedence of Medicaid billing principles: Medicare and private third party payers as first recoverable dollar, Medicaid as second dollar, and Title V as third dollar, in payment for services rendered. Medicaid-certified Title V agencies must have an established fee schedule on file and bill Medicaid according to the schedule.

(15) Reporting Data

The need to delineate a process for sharing information is quite evident throughout the IAAs collected; of these documents all but three address the issue of data exchange. Often, the topic of data is addressed with a preface that related activities are to be undertaken to fulfill State and related Federal requirements. As such, there is an overall obligatory sense that a system of information exchange has to be addressed; however, most States also see beyond the requirements to added benefits of reporting data.

Many of the States require an exchange of reports relating to services provided to recipients in order to document charges that the Title V agency or grantee has billed to the Title XIX agency. The Title XIX agency then uses this documentation to provide the appropriate level of financial reimbursement to the grantee. Often, as with Missouri and Nebraska, the specified goal is to provide the information necessary to request Federal funds available under the State Medicaid match rate. Another goal often expressed is to provide the data necessary for the MCH Block Grant Application and Annual MCH Report. (e.g., MD, UT).

The ultimate goal listed for sharing of data in many of these agreements is first to identify service delivery gaps and barriers and then to improve the delivery of services. The California IAA lists this as one of its main objectives: "to develop and implement data collection and reporting systems that support assessment, surveillance, and evaluation with respect to health status indicators and health outcomes among the populations served by both programs."

The Indiana MOU also lists data sharing as one of its primary responsibilities and provides a model summary of services to be provided jointly and by each agency (see details in the summary of Indiana's MOU in Chapter Four). In this agreement, the Title V and Title XIX agencies agree to work together to utilize program data to improve program administration and outcomes; to develop performance measures that rely on linked data as a means of better understanding the needs of vulnerable populations and targeting resources to them more effectively; and to use shared data for program monitoring and evaluation.

The frequency and specific details of the method of sharing data between agencies varies widely from State to State, depending on their individual structures. However, throughout all the agreements the need for an ongoing, regular exchange of information (no less frequently than monthly) is expressed quite clearly. The agreements are also very sensitive to issues of confidentiality of information and security of data transmission and storage. These issues are discussed further in each document's general contract provisions (Section 19).

(16) Review

A built-in process for periodic review and planning for coordinated changes in the IAA between agencies would seem to be an automatic item for inclusion in any agreement of the type collected. However, 28 of the agreements have no comparable clause other than a brief statement that the document can be modified and/or terminated upon mutual agreement. Nevertheless, in documents where a coordinated review is agreed upon, a powerful mechanism for maintaining the relevance of the agreement for all parties (and thus the mutual constituents they serve) is established.

Often, in documents that do include a mechanism for review, the language is straight-forward and follows Illinois' example: "this Agreement may be reviewed periodically and, if necessary, amended upon mutual agreement of the parties. Any amendments shall be in writing and signed by the authorized representative of each party."

Some States, however, do go into greater detail about the process for document review. Louisiana's intra-department agreement states that their Title V agency will establish, jointly with Medicaid, an advisory committee to monitor implementation of their Agreement, to coordinate services offered, and to review and update its provisions as necessary. This advisory committee will be comprised, at a minimum of the MCH Director, the MCH Medicaid Director, the WIC Director, and a Medicaid representative; it will meet at least every 6 months when either party requests that a formal meeting be conducted.

California's IAA calls for meetings to be held "at least once a year, and more frequently if necessary, among the Branch Chiefs, or their representatives…for the purpose of reviewing the

need for any changes or clarifications to the Agreement, carrying out the services, evaluating activities and policies set out, and providing coordinated input to the required plans of the respective programs." Finally, Illinois' IAA (IA#1) calls for a multi-tiered approach, consisting of both an annual review of the entire document and a periodic review. The annual review is necessary for the purpose of continuing the Agreement, maintenance of the services agreed upon, and/or including clarifications as may be necessary. The periodic review, which can be scheduled at the request of either agency, may be conducted to modify, amend, or terminate the Agreement.

The cooperative agreement established in Kansas also handles periodic review by committee. It requires that a committee be appointed to ensure coordination between the State Title V Assurance Statement and the Title XIX State Plan. The committee meets at the request of either agency's Secretary or designee, or at least annually, to permit the parties to the Agreement to provide input, to resolve any problems/issues which may arise, to review, evaluate, and make recommendations to the Secretaries regarding the conditions of the Agreement or the services to be provided.

(17) Liaison

The maintenance of a formal agreement between parties ensures that accountabilities are established and provides a record of the services to be provided between the various groups. However, this agreement cannot exist in a vacuum; it needs the ongoing attention of both parties. The establishment of a system of continuous liaison between agencies is thus vital in ensuring that the State IAAs remain current and meaningful.

The majority of State IAAs collected recognize the need for such liaison and make ample provisions for it in various ways. Some States (e.g., ID, KS) address the need for continuous liaison in general ways, requiring that meetings to take place on a regular basis and also that Title V and Title XIX Agency Chiefs (or similar positions) promote liaison between the regional directors, the district health department directors, and others.

Other States take a more focused approach by calling for specific staff members to serve as that liaison. New York's action plan states that there is a shared responsibility to designate specific personnel from Title V and Title XIX to be responsible for continuous liaison activities. It requires that designated personnel from relevant divisions meet on a regular basis, at least quarterly, for the following purposes: (1) to discuss all areas of mutual and singular responsibility for respective programs; (2) to update each other on new developments; and (3) to maintain and enhance communication and cooperation between the entities. North Dakota acts similarly in requiring that its Title V and Title XIX agencies identify staff that will serve as liaisons between programs. These persons are to have the authority to represent their respective agencies in the development and implementation of work plans and in the resolution of any programmatic problems.

Some States (e.g., GA, NC) assign the role of liaison to a specific title; for example, in North Carolina the Assistant Director of Medical Policy in the Division of Medical Assistance [Title XIX] and the Deputy Division Director in the Division of Public Health [Title V] are assigned

as the positions responsible for liaison. A few IAAs (e.g., MN, VA) actually list the name of the individual responsible for liaison. While this allows for the document to become quickly dated as personnel in State agencies change, it does provide a high degree of accountability.

(18) Evaluation

A joint evaluation of policies that affect the cooperative work of the agencies involved is closely related to the agreement review and continuous liaison between parties (Sections 16 and 17, respectively). It is through ongoing liaison between agencies that a review of the IAA can occur to lay the foundation for an overall evaluation of their work together. Almost exactly one-half of the documents collected (23 out of 47) contained instructions to carry out such evaluation. In many cases, as with the review of the IAA, such evaluation is to take place in a committee comprised of representatives from each agency. Idaho's cooperative agreement further tasks the Title V agency to plan, collect, analyze, interpret, and report data demonstrating the effectiveness of MCH services and the impact on the health status of mothers and children.

Louisiana devotes a section of its intra-departmental agreement to the "joint evaluation of policies." It calls for a joint Medicaid/Title V Advisory Committee to review periodically the tenants of their agreement with the aim of ensuring: (1) that all Medicaid-eligible persons in need of Title V services receive them; (2) that appropriate fiscal documentation is ongoing; and (3) that information flows freely between both parties.

Missouri's multiple agreements similarly call for evaluation by committee, in this case a task force that meet at least quarterly, for the purpose of program development, review, and evaluation to discuss problems, and to develop recommendations to improve programs for better and expanded services to individuals. The task force is to concentrate on multiple topics, including: (1) the evaluation of policies, duties, and responsibilities of each agency; (2) arrangement for periodic review of the agreements and for joint planning for changes in the agreements; and (3) arrangements for continuous liaison between the divisions and departments and designated staff responsibility for liaison activities at both the State and local levels. As such, this neatly wraps up requirements in Sections 16-18.

General

(19) General Contract Provisions

The list of general contract provisions below summarizes those items most often dealt with in the 47 IAAs reviewed. These items, often found near the end of the documents, are most often highly contractual in nature. A number of the provisions, such as confidentiality of records and non-discrimination clauses, often are required by State and/or Federal law. While formulaic in structure, they can provide additional information about the nature of the relationship between State agencies and the environment in which they operate.

General Contract Provisions in the IAAs:

- Amendment/modification of agreement.
- Audit.
- Confidentiality/HIPAA compliance.
- Default.
- Dispute resolution mechanisms.
- Drug-free workplace provisions.
- Failure to satisfy scope of work (SOW).
- Indemnification/liability clauses.
- Provisions for lack of funds.
- Lobbying statements.
- Systems for maintenance of records.
- Nondiscrimination clauses.
- Methods for payment.
- Regulations regarding subcontracts.
- Tobacco policies.
- Grounds for termination of agreement.

States vary in the number and detail of general contract provisions included in their IAAs. Some documents include only a listing of the appropriate provisions, while others include addenda for provisions to cover specific services and/or responsibilities. Some of these provisions and addenda appear to be boilerplate and most likely appear in other State-authorized documents, while others seem to be written for the specific purpose of the IAA.

Of particular note in this section is how States deal with medical record and data confidentiality. Twenty-six of the 40 documents that include general contract provisions deal with confidentiality to various degrees. Often, as in the case of Kentucky, the State will provide contractual language requiring that any employee or representative of the agencies involved will abide by the State and Federal rules and regulations governing access to and use of information provided in the administration of the contract. Standard State agreements must often be signed and maintained that govern the access to confidential data.

The mandates of the Health Insurance Portability and Accountability Act (HIPAA, mandated in 42 USC 1320d and set forth in Federal regulations at 45 CFR Parts 160 and 164) are also addressed in detail by the majority of the IAAs in the use and disclosure of protected health information. The agreement to comply with HIPAA ensures that individually identifiable information in any medium pertaining to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual is protected by law.

Several States such as Illinois (IL#1) include, as an attachment to their IAA, a list of HIPAA compliance obligations that includes definitions and citations of HIPAA; permitted uses and disclosures; limitations on uses and disclosures; and interpretations dealing with cases of ambiguity. Colorado treats HIPAA in even greater detail by creating a separate interagency memorandum of understanding (CO#2; see summary in Chapter Four). This extensive document contains stipulations dealing with: permitted uses; permitted disclosures; appropriate safeguards; reporting of improper use or disclosure; accounting rights; governmental access to records; data ownership; retention of protected information; notification of breach; audits, inspection, and enforcement; and safeguards during data transmission.

One final recurrent general contract provision that deserves attention is the nondiscrimination clause found in many of the IAAs. Most of the documents that include such a clause agree to comply with the provisions of the Americans with Disabilities Act (ADA), Public Law 101-336, and other applicable Federal regulations relating to prohibiting discrimination against otherwise qualified disabled individuals. The parties of these agreements agree to take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, religion, color, national origin, sex, age, or disability. Some States, most notably California, take this commitment a step further by including in their agreed-upon services, additional provisions such as to "support the retention of culturally and linguistically competent, and geographically strategic, safety net and traditional providers of MCH services."