Appendix A: Title V and Title XIX Resources

The following recent resources provide additional information and are available electronically.

### Title V/Title XIX Coordination


### Title V


### Title XIX/Medicaid


Appendix B: List of Abbreviations

The following list of abbreviations are those used throughout this document and are commonly used in the field. A glossary of select terms follows this list.

ACF: Administration for Children and Families
AMCHP: Association of Maternal and Child Health Programs
BBA: Balanced Budget Act
BIPA: Benefits Improvement and Protection Act
BPHC: Bureau of Primary Health Care
CDC: Centers for Disease Control and Prevention
CFR: Code of Federal Regulations
CISS: Community Integrated Service Systems
CMS: Centers for Medicare and Medicaid Services
CSHCN: Children with Special Health Care Needs
CYP: Children and Youth Projects
EPSDT: Early and Periodic Screening, Diagnostic and Treatment
DSH Payments: Disproportionate Share Hospital Payments
FFP: Federal Financial Participation
FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
FMAP: Federal Medical Assistance Percentage
GU: Georgetown University
HHS: U.S. Department of Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act
HMO: Health Maintenance Organization
HRSA: Health Resources and Services Administration
IAA: Interagency Agreement
MCH: Maternal and Child Health
MCHB: Maternal and Child Health Bureau
MCO: Managed Care Organization
MIC: Maternal and Infant Care
NCHS: National Center for Health Statistics
NPM: National Performance Measure
OBRA: Omnibus Budget Reconciliation Act
PHS: Public Health Service
PIC: Partnership in Communication Interorganizational Workgroup
SCHIP: State Children’s Health Insurance Program
SIDS: Sudden Infant Death Syndrome
SPM: State Performance Measure
SPRANS: Special Projects of Regional and National Significance
SSA: Social Security Act
SSI: Supplemental Security Income
TANF: Temporary Assistance for Needy Families
Title V IS (TVIS): Title V Information System
WIC: Women, Infants, and Children Program
Appendix C: Glossary

The following list of terms related to Title V and Title XIX is not meant to be comprehensive, but to serve as an introductory quick-reference. For more information, see the (1) the Glossary of the Title V Guidance at http://www.mchdata.net; (2) the Medicaid Glossary (in English and Spanish) at http://www.cms.hhs.gov/glossary; and/or (3) the MCH Leadership Skills Training Institute Glossary at http://www.soph.uab.edu/mch-leadership/resources.htm.

**Beneficiary:** A person who is eligible for and enrolled in a Medicaid or similar program.

**Block Grant:** Also known as a “formula grant,” a transfer of a capped amount of Federal funds to States and/or local governments for broad purposes such as health. A block grant usually gives States larger discretion on how the funds are to be used.

**Categorical Eligibility:** Medicaid’s policy of providing services to individuals in specified groups (e.g., children, senior citizens, persons with disabilities).

**Categorically Needy:** Specified groups of Medicaid beneficiaries who qualify for basic benefits. These groups include pregnant women and infants (1) with incomes at or below 133 percent of the FPL (who States participating in Medicaid are required to cover); and (2) with incomes between 133-185 percent of the FPL (who States participating in Medicaid have the option to cover).

**Centers for Medicare and Medicaid Services (CMS):** [Formerly Health Care Financing Administration (HCFA)]. The agency under the U.S. Department of Health and Human Services that administers Medicare, Medicaid, and SCHIP. Online at http://www.cms.hhs.gov.

**Children’s Health Insurance Program:** SEE State Children’s Health Insurance Program.

**Children with Special Health Care Needs (CSHCN):** Individuals from birth through age 21 who have health problems requiring more than routine and basic care

**Community Integrated Service Systems (CISS) Discretionary Grants:** Seek to reduce infant mortality and improve the health of mothers and children – including those living in rural areas and those with special health care needs – by funding projects for the development and expansion of integrated services at the community level. Such projects include health home visiting programs; projects to increase participation of health care providers under Title V and Title XIX programs; integrated MCH service delivery systems; MCH centers providing pregnancy, preventive, and primary care services; MCH projects to serve rural populations; and outpatient and community-based services programs for CSHCN.

**Discretionary Grant:** An award of money or supplies by the Federal government, usually awarded through a competitive review process.
Disproportionate Share Hospital (DSH) Payments: Additional payments to hospitals that serve large populations of patients with low incomes.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: States must provide periodic screenings to identify physical (including vision, hearing and dental) and mental conditions, to Medicaid-eligible children under age 21. State Title V and Medicaid agencies are required to participate in coordination of EPSDT services.

Entitlement Program: A program (such as Medicaid and Medicare) that requires the Federal government to provide a specified service to identified persons. Spending is determined through the program’s eligibility criteria, not by a specific level of funding.

Federal Financial Participation (FFP): Federal matching funds paid to States to cover Medicaid services or administrative costs.

Federal Medical Assistance Percentage (FMAP): Also known as the “Federal Medicaid matching rate,” it is the share that the Federal government provides for Medicaid services or administration dependent on a State’s per capita income. While it varies from 50-83 percent, it averages to 57 percent across the States.

Federal Poverty Level (FPL): The definition of poverty used as the income standard for certain categories of beneficiaries. The current HHS Poverty Guidelines and related materials are available online at http://aspe.hhs.gov/poverty.

Federally Qualified Health-Center (FQHC) Services: FQHC Services are primary and other ambulatory care services provided by community health centers and migrant health centers receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. States are required to include services provided by FQHCs in their basic Medicaid benefit package as well as benchmark benefit packages.

Financial Eligibility: Medicaid’s policy of providing services to individuals with limited income. Financial eligibility varies by State and category.

Formula Grant: SEE Block Grant.

Health Insurance Portability and Accountability Act (HIPAA): Requires State Medicaid programs to use national codes for electronic transmission of information related to health claims and to have a Medicaid Management Information System (MMIS).

Health Maintenance Organization (HMO): A plan that provides health care from specific doctors and/or hospitals within a set plan.

Interagency Agreement (IAA): A binding agreement between two or more agencies (or divisions within a single agency) that specify the roles and responsibilities of the participating agencies. IAAs can serve as a major resource in coordinating activities and providing mutual support between the agencies.
Managed Care Organization (MCO): A type of Managed Care Entity (MCE) that provides certain benefits to Medicaid beneficiaries for a monthly capitation payment for each beneficiary as set forth in a State contract.

Medicaid: The Federal/State program that pays for medical assistance for certain individuals and families with low incomes. Assists States in providing medical long-term care to people who meet defined eligibility requirements.

Medical Assistance: Payment for services covered under a State’s Medicaid program.

Medically Needy: Beneficiaries who qualify for Medicaid coverage because of high medical expenses.

Performance Measure: A description of a specific health need, that when addressed will improve that health outcome in a defined place and time frame.

Population Based Services: Preventive services developed for the entire population rather than for beneficiaries in an individual basis.

Prepaid Inpatient Health Plan (PIHP): A health plan that provides less than comprehensive inpatient services on an at-risk reimbursement basis.

Presumptive Eligibility Period: The time period between when a provider determines that a beneficiary’s income does not exceed the eligibility threshold until a formal eligibility determination is made by the State Medicaid agency.

Preventive Services: Those that are aimed at reducing health problems, disease, or personal risk factors for such conditions.

Risk Factors: Scientifically established direct and indirect causes of morbidity and mortality.

Social Security Act (SSA): Full text of Title V and Title XIX of the SSA are available online at http://www.ssa.gov/OP_Home/ssact.

Special Projects of Regional and National Significance (SPRANS) Grants: Activities under SPRANS include MCH research; training grants; genetic disease testing, counseling, and information dissemination; hemophilia diagnostic and treatment centers; and other special MCH improvement projects that support a broad range of innovative strategies.

State: In this document, State refers to the 50 States, the District of Columbia, and the 9 political jurisdictions.

Supplemental Security Income (SSI): A Federal entitlement program that provides monetary assistance to specific beneficiaries. In most States (with the exception of Section 209(b) States), SSI beneficiaries are also eligible for Medicaid.
**State Children’s Health Insurance Program (SCHIP):** A Federal-State matching health care block grant program for uninsured low-income children. Children who are eligible for Medicaid are not eligible for SCHIP, although States can administer SCHIP through their Medicaid programs.

**Temporary Assistance for Needy Families (TANF):** A Federal block grant program that provided matching funds and services to States for low-income families with children.

**Title V:** Enacted by Congress in 1935 as part of the Social Security Act, the only legislation to promote and improve the health of *all* mothers and children. Title V authorized the creation of the MCH programs, providing the infrastructure to achieve this mission.

**Title XIX:** Enacted by Congress in 1965 as part of the Social Security Act, the legislation that authorizes the Medicaid program that pays for medical assistance for certain individuals and families with low incomes who meet defined eligibility requirements.
Appendix D: Supplemental Figures

Supplemental Figure 1:
The MCH Pyramid of Health Services

Supplemental Figure 2:
Recent Title V Block Grant Appropriations

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Source: The Association of Maternal and Child Health Programs, Recent Funding History for the Title V Maternal and Child Health Block Grant.
Supplemental Figure 3:
Coverage for Personal Health Care Spending

Medicaid -- This covers:
- 37% of all births
- 17% of all hospital care
- 12% of all health professional services
- 17% of all prescription drug costs
- 48% of all nursing care costs

Source: National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary
Appendix E: Document Development

The first edition of this document was developed for the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) under a cooperative agreement with the Association of Maternal and Child Health Programs (AMCHP).

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